FROM THE GUEST EDITORS—RURAL AMERICA: A CALL FOR NURSES TO ADDRESS MENTAL HEALTH ISSUES

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At the time we were preparing to write this editorial, we received an e-mail from the American Psychiatric Nurses Association (APNA) stating that there would be cuts in the Title VII and VIII programs, which fund the health professions, particularly nursing and public health. They also stated that serious shortages "continue to exist in rural and under- served areas, in part due to market forces, driving health professionals to practice where higher wages are available" (APNA, 2001). Rural areas are notorious for their lack of health care services, especially the delivery of mental health services. Because funding issues continue to impede the delivery of quality mental health care, lack of access to adequate mental health care must be addressed by politicians, insurance companies, health systems, and health care providers, particularly nurses. Attempts to transfer urban models to rural settings have failed, leaving 8 million Americans without mental health care (Olsson, 2000). The purpose of this special issue is to bring to the attention of nurses the mental health needs of special populations residing in rural America.

Although rural is synonymous with a farm residence, only "5% live on farms, while 40% live in towns or villages"; consequently, 45% of the population live in rural America (Bushy, 1994a). Rohland and Rohrer (1998) defined a rural area as "any county with less than 30,000 population" (p. 263). Others defined rural by the number of people per square mile, such as "8.1 persons per square mile" (Dottl & Greenley, 1997, p. 313) or "47.2 people per square mile" (Husted, Wentler, Allen, & Longhenry, 2000, p. 70). Bushy defined rural in terms of time and distance, "30 minutes or greater than 60 miles to a mental health clinic" (p. 255). The people of rural America are incredibly diverse, which compounds the problem of providing services. People often view rural America as a "monolithic culture. There are probably more differences among rural areas than between urban and rural" (Olsson, 2000, p. 67). Consider the differences between the Blacks in the rural South, and the Scotch-Irish of Appalachia, The Germanic-Scandinavians of the Mid-West, the Native Americans of the West and Southwest, and, lastly, the Hispanics, who farm in the west (California, Oregon, and Washington), central U.S., and the southeastern states. Rural Americans come from different cultures, speak different languages, have different traditions, and have different beliefs about mental health care.

The South has the "highest number and the highest percentage of rural residents of the four major regions of the United States" (Blazer, Landerman, Fillenbaum, & Horner, 1995, p. 1384). "One half of the rural poor under age 65 live in the South, over 43% of the nation's elderly live

in the South and 95% of the rural minority elderly live in this region" (Kane & Ennis, 1996, p. 447). People in rural areas lack access to health care because of the following: distance, lack of transportation, lack of telephone services, insufficient numbers of providers, inclement weather, insufficient reimbursement policies, and the inability to obtain public assistance for needed services (Bushy, 1994a). Community stigma and cultural expectations of self-sufficiency also contribute to the difficulties in providing mental health services in rural areas (Bjorklund & Pippard, 1999; Van Hook & Ford, 1998).

Poverty is intrinsic in rural areas and disproportionately affects both Blacks and women. "Sixty-eight percent of all rural Black elderly women live in poverty, whereas only 40% of rural white elderly women live in poverty" (Abraham, Buckwalter, Neese, & Fox, 1994, p. 204). In rural America, the elderly tend to be poorer than their urban counterparts, often having one or two chronic diseases, either physical, mental, or both, but limited health care resources. Many of the rural elderly live in extended families and experience intergenerational conflicts, leading to depression (Abraham et al., 1994). Chalifoux, Neese, Buckwalter, Litwak, and Abraham (1996) stated that higher rates of depression in particular are found among elderly women. Older Americans suffer from other mental disorders, such as anxiety disorders, alcoholism, and schizophrenia. Many elderly suffer from age related disorders, such as dementia. The estimates regarding the incidence and prevalence of all psychiatric disorders among rural elderly range from 20 to 27% (Chalifoux et al., 1996, p. 465).

Olsson (2000) reported higher rates of alcoholism in rural areas. Dottl and Greenley (1997) claimed that rural residents had lower rates of schizophrenia but higher rates of general pathology. According to Abraham et al. (1994), rates of psychiatric disorders, especially depression, are higher in rural communities. Patients who are severely mentally ill are usually totally dependent upon their families for care, a frightening experience for many families. Lack of funding for rural mental health services and other health care is the result of the fact that "agricultural and small business employers are less likely to provide insurance in rural areas ... [thus there are] more persons without insurance and without Medicaid coverage" (Blank, Eisenberg, Hargrove, & Fox, 1996, p. 428).

Children are another vulnerable group among rural populations without resources for mental health care due to lack of funding and services, as well as the lack of coordination of the services that are available. Often children are placed in residential settings outside of their communities and away from families due to lack of services (Shelton-Keller, Koch, Watts, & Leaf, 1996). According to Scahill (2000), "studies show that as much as 20% of children between 0 and 18 years meet criteria for one or more mental disorders" (p. 51), among both urban and rural children. Other vulnerable populations include Native Americans, migrant workers, abused women or women who are socially isolated, people housed away from their home communities in correctional facilities, residential centers, nursing homes, and other unfamiliar settings. Many of these "identified populations at risk" will be discussed in this issue.

Nurses who practice in rural areas are often highly respected leaders of their communities (Bushy, 1994b). They are in a position to provide a bridge between the local community and the health care/mental health care systems. These nurses frequently grew up in the community and currently live with a spouse or with family members, so they are knowledgeable about the

community's power structure, culture, and health beliefs. Rohland and Rohrer (1998) conducted a survey across rural Iowa to examine the skills of the mental health professionals, from the respondents' perspectives. The professionals worked in community mental health centers (CMHCs) in areas defined as "rural." Rohland and Rohrer concluded, "enhancing the role of nurses within CMHCs may provide more cost-effective treatment" (p. 271). They claimed that there is no substitute for medical providers [physicians and nurses] to care for the severely mentally ill. In their study, nurses expressed more confidence than other professionals in their abilities to support families and caregivers, manage patients' medications, and provide psychiatric rehabilitation. The findings of the Rohland and Rohrer study identified skills that nurses must have in order to (a) cross the boundaries between the health care and mental health care systems to provide holistic care, (b) develop and implement case management services across the continuum of care, and (c) provide leadership in developing interdisciplinary teams to build programs that are culturally competent and family centered (Rohland & Rohrer, 1998). The skills necessary to do this are medical, psychiatric, and community health skills and assessment, treatment, and evaluation skills. Bushy (1994b) claimed that case management services have the advantages of avoiding duplication of services, facilitating interdisciplinary collaboration and integrating formal and informal support services, which is a good fit for rural areas. Bushy recommended that rural nurses become case managers.

Gemeinschaft characteristics (the global characteristics) have been identified as the traditional values that are often idealized in rural America (see Table 1). Although some of these characteristics may be barriers, such as the high degree of tolerance for abnormal behavior and the

TABLE 1. Gemeinschaft Characteristics of Rural America: Strengths or Barriers to Access Mental Health Care

Characteristics	Strengths	Barriers
Self-reliance	Self-care	Avoids mental health services
Tolerance for aberrant behavior	Cares for patient	Denies need for mental health services
Distrusts strangers	Relies on family	Trusts indigenous healers
Acceptance of poor health	Ignores need for health care	Underutilizes health care services
Strong kinship ties	Utilizes family to care for patient	Current health care system is individually focused, not family focused
Dense social relationships	Good social supports	Lack of privacy leads to lack of confidentiality
Low critical mass	Mental health can be individualized	Lack of services
Willingness to extend self	Lay helpers as para professionals	Lack of clinical expertise
Church	Strong support system	May substitute for mental health care may be inadequate

(Bjorklund & Pippard, 1999; Kane & Ennis, 1996).

distrust of outsiders, they may also be perceived as strengths that can play an integral role in developing a service delivery model for mental health care (Bjorklund & Pippard, 1999; Kane & Ennis, 1996). Understanding the Gemeinschaft characteristics of their local communities enables nurses to perceive barriers as community assets or strengths.

A new model for mental health care delivery must be developed that is sensitive to the cultural mores of the community, while addressing the needs of the local population. Often overlooked by health professionals, natural support systems are inherent resources that can be integrated into an interdisciplinary care network (Kane & Ennis, 1996). Faith-based mental health services, integrated into a holistic system of care, could build upon a community's strengths. The local schools and their personnel may be another resource. They might donate space or personnel to teach health promotion, or school resources might be available to develop vocational rehabilitation programs for the severely mentally ill. Allegiances to family, church, and community are valuable rural assets when building a system of care that truly meets the individual needs of patients and families. An assessment of a community's strengths is the first step in developing a care delivery model. Other barriers often have to do with poor communication and mistrust among the various health care disciplines (Van Hook & Ford, 1998). Educational programs for professionals that address building interdisciplinary teams and the "how-tos" of collaboration may be as important as stimulating the citizens' interest in building an integrated mental health/health care delivery system. Bushy (1994a) recommended a case management model, while Bjorklund and Pippard (1999) recommended self-help support groups, utilizing the community's strengths and resources. Van Hook and Ford (1998) advocated for an "interorganizational linkage model" between mental health care and general health care to increase "access and coordination" and to promote a "more holistic sense of health care" (p. 53). Kane and Ennis (1996) agreed that mental health and primary care should be joined to improve access. If both services were in one location, perhaps there would be less stigma associated with mental health care. Hicks and Bopp (1996) suggested an "integrated pathway" (p. 65), which was described as a formal arrangement among a variety of providers and agencies to deliver health care and mental health and social services to a given population, coordinated by the local hospital. It is clear that one model cannot fit all communities. The selected model must be flexible enough to adapt to the uniqueness of each rural community. Innovative solutions to building an integrated health care network must be explored. Consumers, families, and other interested citizens should be part of the solution. They should be included on the interdisciplinary team, along with local politicians and health care providers, from the initial design of the care delivery model to its implementation and oversight (Shelton-Keller et al., 1996).

Although this particular journal issue is in no way a comprehensive review of the mental health needs of rural America, each of the authors has written about an identified "at risk" population found in the mental health literature. Hopefully this issue on Rural Mental Health will be a call for nurses residing in rural America to provide leadership in their communities and to build a quality mental health program that is accessible, affordable, adequate, appropriate, and adaptable. It is also a call to nurses contemplating a change in life style to a less stressful environment. Rural America offers many opportunities for nurses to be community leaders, entrepreneurs, and catalysts for change. Providing a vision to local stakeholders to establish an integrated holistic system of care that is family centered and culturally competent presents both a

challenge and an opportunity. Funding for mental health services will remain a problem at the federal and state levels. Building a local health care network for a community's own citizens may prove to be more cost effective than sending loved ones away to urban centers. Rather than using a health care delivery model that has been successful elsewhere, developing a model within the context of the local community by utilizing the assets and resources of the community should improve access to mental health care, should make care more affordable, and should enhance the adequacy and appropriateness of the care to meet the needs of the local population, because it will be a model that has been adapted specifically to the culture of the local community. The challenge for rural nurses will be to empower the local politicians and citizens to use their own resources to build a holistic system of care that is tailored to their own needs in order to care for their own at-risk populations. It is our hope that this issue will inspire nurses to become community leaders on behalf of the mentally ill in rural communities.

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