SCHOLARS
STRATEGY NETWORK

How Health Reform Can Help Rural Communities Improve Care for People with Addiction Issues and Mental Illness

Cathleen E. Willging, Behavioral Health Research Center of the Southwest

Over the course of a lifetime, one in every five Americans will grapple with addiction or mental illness. When we picture such problems, we often imagine troubled teenagers or addicted adults in inner city neighborhoods searching for help at a local clinic or a big hospital full of trained professionals. But of course disorders are just as real in tens of thousands of rural communities – where sufficient help often cannot be found nearby. Clinics or nonprofit agencies may be many miles away, impossible to reach without a car and money for gas and perhaps a friend or relative to go along to each appointment. When the troubled person gets there, the staff may be spotty and overwhelmed, or lack the right kinds of professionals to deal with the problem at hand.

National health reform through the Affordable Care Act of 2010 will be implemented over the next eight years – and it includes plenty of good news for low and middle-income people, including rural Americans who struggle with mental and behavioral disorders. Insurance coverage will be extended to millions who currently cannot pay their health-care bills; and health-care providers are required to treat mental and behavioral as well as physical disorders. National reform also includes additional federal grants to community clinics, some of which employ counselors and psychiatric specialists alongside medical doctors and nurses.

But even as they benefit from better facilities and patients who can pay, states and localities face huge challenges – which may be especially knotty in rural areas. Research on earlier reforms in New Mexico underlines these challenges and suggests principles for future reformers.

New Mexico as a Laboratory for Rural Health Reforms

New Mexico is a telling laboratory for behavioral and mental health care, because it is a vast, mostly rural state with some of the largest populations of Latinos and Native Americans in the country. Many citizens live in poverty, and those struggling with mental illness or alcohol and drug problems often have a hard time getting quality services. Most counties have too few health-care professionals. Implementing health reform will be a challenge because many more New Mexicans, particularly childless men, will gain insurance coverage and seek treatment.

In addition to experiencing rural issues to the fullest, New Mexico has already tried to carry out sweeping reorganizations of behavioral and mental health services – and has found out the hard way that blueprints drawn up by bureaucrats and expert planners often do not work out as expected. In 2003, then-Governor Bill Richardson announced reforms in which funds for different kinds of behavioral services would be consolidated and used to contract with managed care firms that were supposed to deliver care more efficiently, collecting data and client reactions along the way to facilitate improvements. The idea of "health homes" was borrowed from urban settings to coordinate various kinds of care for people with serious emotional issues or chronic mental health problems. In keeping with the Affordable Care Act, this idea is being expanded to include people with both mental illness and medical problems such as asthma or diabetes.

Lessons for Future Reform Efforts

On paper, the 2003 New Mexico reforms looked promising. But here are some of the lessons that can be learned from problems that arose during their implementation, especially in rural areas:

- Many localities in New Mexico were not ready for the 2003 reforms, because transitions were not carefully planned and not enough was done to ensure that agencies had good information systems.

Most health reforms these days ask providers to do billing and record information about clients in new ways. But many rural sites lack the right technologies or the capacity to re-train staffers quickly. Planners must fill such deficits in advance.

- Workforces have to be adequate to meet the ongoing demands of delivering new forms of care – and in the case of national health reform, staffs will have to expand to serve many new clients. The New Mexico reforms did little to improve the situation of the rural behavioral health workforce, which has historically struggled to meet the treatment needs of clients with complicated problems. Implementation created new financial shortfalls for rural agencies and lowered employee morale. For the future, if rural providers are to adequately care for both new and existing clients, they will then have to recruit specialty clinicians, particularly psychiatrists, and support the existing workforces through face-to face or web-based training and supervision.

- The "health home" plan for integrated services may require adaptation for rural realities. In New Mexico, models developed and tested in urban areas often did not transfer to rural areas, where sites can be widely dispersed and qualified personnel and financial resources are in short supply. Rural services may require extra investments – for example in internet conferencing capabilities or in subsidized transportation to take providers to clients or ferry clients to several locations. Remote technical assistance centers and consultants can help, as long as local sites already have internet-conference facilities and training to use them.

- For both planning and ongoing improvements, the New Mexico reforms were supposed to be based on "community input" from clients and care providers. But especially in rural places, it doesn't work to just call a meeting. Far-flung clients and staff may not be able to get there; and poor people, especially from minority communities, may not feel confident about speaking up in group meetings – which can end up dominated by bureaucrats.

New Mexico's experience with reforms in health care for people with mental illnesses and addiction issues has much to teach state and national planners as they launch even more ambitious reforms under the Affordable Care Act. Of all the lessons, among the more important may be the need to keep planners and evaluators in better touch with the lived experiences of the people who deliver and receive care. Ethnographic observers and interviewers who travel to clinics and homes may gather insights that cannot be gleaned from questionnaires or public meetings. As health reform advances, there are sure to be surprises, and we need to observe local developments and hear local voices each step along the way.

Read more in Rafael M. Semansky, Cathleen E. Willging, David Ley, and Barbara Rylko-Bauer, "Lost in the Rush to National Reform: Recommendations for Improving the Impact on Behavioral Health Care in Rural Areas," *Journal of Health Care for the Poor and Underserved* 23, no. 2 (2012): 842-56.