Challenges and Opportunities in Accessing Geriatric Mental Health Services in Rural Minnesota

Kassara Kneeland
St. Catherine University, kassarak@yahoo.com

Challenges and Opportunities in Accessing Geriatric Mental Health Services in Rural Minnesota.

Kassara A. Kneeland, LSW

Committee Members

David Roseborough, MSW, Ph.D., (Chair)

Tanya Rand, MSW, LICSW

Tara Reopelle, LGSW

Abstract

America's aging population is increasing and mental illness among older adults continues to go under-diagnosed and under-treated. The purpose of this research was to collect data and information on the resources available to older adults living with mental illness in rural Minnesota. This research was informed primarily by the text *Rural Mental Health: Issues, Policies, and Best Practices* (2012). A survey was conducted utilizing both quantitative and qualitative questions developed by the researcher. The survey was distributed to 153 recipients in 14 counties surrounding Central Minnesota, with an 11% total response rate. Respondents were primarily county-affiliated, identified as social workers with significant practice experience working with adults in both a rural and urban areas. Three major categories emerged within the data: service delivery challenges, service delivery opportunities, and new innovations in mental health service delivery. Findings suggest that two common barriers to accessing mental health services are stigma and shortage of geriatric trained providers. Findings also suggest promising service delivery methods such as telehealth and in-home services as an option for older adults in rural areas.

Acknowledgements

I would like to thank my friends, family and coworkers who have supported me through the entirety of this clinical research project. I especially want to thank my parents, Kurt and Lori, who inspire me every day to be the best person I can be. I would like to thank my MSW cohort students who have provided endless support and positive feedback throughout this project. Without the support and positive encouragement from my friends and family this project would have been much more difficult.

I would like to thank my University of St. Thomas Chair, David Roseborough, MSW, Ph.D., for his never-ending support throughout the entirety of this clinical research project. His patience, guidance, and vast knowledge helped make this project manageable and his positive attitude decreased my overall anxiety about completing this project.

Lastly, I would like to thank my committee members, Tanya Rand, MSW, LICSW and Tara Reopelle, LGSW, for taking time out of their busy schedules to be a part of my committee. Their generosity and positive feedback helped me stay on task as successfully complete this project. Thank You!

Table of Contents

Lists of Tables and Figures

Imagine being diagnosed with a mental illness and being told that treatment is available, however, accessing the treatment will be extremely difficult. The clinic you were referred to is twelve months out for appointments. Deciding you cannot wait a year for treatment, you try another clinic that can get you in sooner; however it is over an hour away, and you lack adequate transportation to get you to the destination. After expending all your effort in attempting to access treatment, you decide it is easier to continue living with mental illness than access to services to help cope with the disorder.

This is a scenario that many older adults living in rural America are facing today. This is an ever-growing concern for many Americans, as the general population continues to age. There are nearly 40 million older adults living in the United States, and as the general population continues to age this number is projected to double by year 2030 (United States Census Bureau, 2012). By the year 2030 the number of diagnosed and undiagnosed mental illness among older adults is expected to increase to 15 million individuals living with a mental illness (Moak, 2011). A significant concern within the aging population is the growing concern for access to services, more specifically services that can help individuals cope with mental illness. There is a great need for geriatric trained mental health practitioners, who can focus more specifically on the needs of our older Americans.

The National Alliance on Mental Illness (NAMI) describes a mental illness as "medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others, and daily functioning" (NAMI, 2012). NAMI furthermore identifies several disorders that are considered to be mental disorders: major depression, anxiety, and post-traumatic stress disorder to name a few (NAMI, 2012). The themes within the literature have identified two disorders common among older adults: major depression and anxiety. This project focused primarily on depression

and anxiety and the challenges older adults face finding services to assist in the treatment or

management of these disorders, specifically, older adults residing in rural Minnesota. It is also

important to note the definition of older adults. Most health insurance programs classify older

adults as aged 65 and over, as this is the age that adults are eligible to receive Medicare and

Social Security benefits. However, there is a critical gap among older adults aged 55 to 65, who

are also considered to be older adults (Medicare, 2017). This research focused on the age range

of individuals aged 60 and over in an attempt to encompass a broader spectrum of older adults.

The quality of life for older adults is extremely important and living with a mental illness

can greatly affect an older adult's quality of life. According to Moak (2011), "The growth of the

elderly population makes it imperative for the health care system to address late-life mental

disorders more effectively" (p. 274). Older adults with a mental illness such as depression or

anxiety present as being vulnerable to inadequate care, as they are more likely to seek treatment

from their primary care physician and less likely to seek treatment from a geriatric mental health

professional. Unfortunately, most late-life mental disorders go untreated. This could be due to a

lack of knowledge on the provider's part, or because older adults do not have adequate resources

to get to their doctor or other mental health professional (Moak, 2011).

Children, teens, adults, and older adults have one thing in common; when they are

experiencing an illness, they may go to their primary care physician for a check-up. Most older

adults have a good relationship with their primary care physician and often seek guidance when

something medically just isn't right. Moak (2011) explores the idea that most primary care

physicians fail to complete an assessment for depression or anxiety with their elderly clients.

When primary care physicians do address concerns for depression or other mental illnesses, there

tends to be an over utilization of pharmacological interventions: "Mental health interventions

addressed by primary care physicians are characterized by overreliance on psychopharmacologic treatments and underutilization of psychosocial interventions" (Moak, 2011, p. 276).

The purpose of this project was to collect data and information on the resources available to older adults living with mental illness in rural Minnesota. This project focused on the resources available in Central Minnesota with a focus on the surrounding smaller communities. The tool used to collect this data was an online survey using Qualtrics, sampling geriatric mental health providers, primary care physicians, clinic and hospital social workers, and social workers working in a geriatric setting such as housing with services, assisted living, and skilled nursing facilities. This study explored the needs respondents identified and the current challenges faced by older adults when needing mental health services. This study gained a better understanding of the needs of older adults with mental illness and the challenges faced when accessing resources for treatment interventions. Lastly, this study highlighted some of the successes the field of geriatric mental health has experienced, and the promising directions taken to adequately serve this population in rural Minnesota.

Literature Review

The literature addresses several areas of rural mental health. Rural settings in the United States, rural mental health, older adults and mental health, and barriers to accessing mental health services are prevalent themes within the literature. The barriers faced in accessing mental health services can be further broken down by looking at the accessibility of the service, the affordability of the service, and the concerns relating to the present workforce shortage. It is crucial to explore the implications for those in the social work profession who work in settings with older adults and assist in accessing mental health services.

Rural Settings in the United States

Nearly sixty-million Americans live within a rural area of the United States (Hodges, Markward, Yoon, & Evans, 2008) with 19.3 percent of the total United States population considered to be rural (United States Census Bureau, 2012). It is important to understand what constitutes as a rural community, verses an urban city. The United Sates Census Bureau (2012) has three classifications: rural, urban clusters and urbanized areas. To further define these terms, an urbanized area is considered to have 50,000 or more people living within the city limits, urban clusters are considered to have at least 2,500 but less than 50,000 people living within city limits and rural "encompasses all population, housing, and territory not included within an urban area" (United States Census Bureau, 2012). Minnesota has several rural and urban communities, and within these communities there are older adults with mental illness who may face significant barriers to treatment programs needed to maintain a healthy lifestyle.

Rural America is unique, vibrant, vivacious, and has a culture all of its own. For residents of rural America, this culture "is shaped by several key factors: population density and

geography, agricultural heritage, economic conditions, religion, behavioral norms, mental health stigma, and distance to care" (Smalley & Warren, 2012a. p. 39). While it is important to draw attention to rural settings within the United States; this research focused on mental health services in rural areas of the country.

Rural Mental Health

In the United States, nearly 1 in 5 adults has had an experience with mental illness in a given year, with nearly 4% experiencing a mental illness that significantly impacts their daily activities (NAMI, 2017). Furthermore, as the "elderly population life expectancy grows, so does the prevalence of mental illness among the elderly" (Rogers & Delewski, 2008, p. 21). As the nation ages, general practitioners will be the experts turned to when mental health concerns arise. Hodges, et al. (2005) explain "when mental health services are sought in rural areas, general medical practitioners frequently deliver them, with minimal or no training in treating mental disorders" (p. 107). As stated above, literature shows there is an increased need for mental health practitioners who have a focused practice in rural areas. With additional mental health practitioners in rural areas, there may be increased access to services for mentally ill older adults.

One major challenge in rural communities is access to crisis mental health services. In a study conducted by Hodges et al., (2005) it was suggested that if a rural-dwelling older adult experiences a mental health crisis; they are more likely to need hospitalization than their urban counterpart. Lacking access to emergency psychiatric services such as peer support and help lines are more likely to lead to hospitalization. Although hospitalizations may be necessary in times of an emergency, it presents its own challenges. Hodges et al. (2005) further explored the challenges of hospitalization within a rural community stating, "many rural areas lack access to inpatient psychiatric care altogether, forcing consumers to be hospitalized many miles from their

home communities" (p. 108). Hospitalizations could lead to further alienation of social support

and an increase in transportation costs; leading to older adults who are less willing to utilize

services even if the need is great (McGovern, Lee, Johnson, & Morton, 2008). Rural mental

health has proven to be a challenge to access especially for older adults.

Older Adults and Mental Health

As the general population continues to age, the need for geriatric mental health

practitioners is imperative. The literature provided a wealth of knowledge surrounding older

adults and their struggle with mental health concerns. Cummings (2009) shares, "the coming

decades will bear witness to an unprecedented growth in the number of older adults," (p. 17)

especially with severe and persistent mental illness. "Older adults are more likely to experience

mental illness, than their younger cohorts" (Haug, Belgrave, & Gratton, 1984, p. 100) and face

challenges of various medical conditions, which can be difficult to manage even without having

a mental health condition. Cummings (2009) further explains that "older persons with severe

mental illness contend not only with the symptoms and strains of their mental health disorder

but, also struggle with age-related challenges such as chronic and acute illnesses, functional

disability, decreased social support, and reduced financial resources" (p. 17). The dual reality of

growing old with mental illness can be a difficult challenge, however, for each challenge a new

opportunity arises.

Most mental illness in later life go undiagnosed and untreated. Literature indicates this

could be due, in part, to the medical complexity older adults face in late-life (Moak, 2011).

Clinical depression and anxiety are two common conditions older adults face as they enter in to

the end stages of life. Haug and colleagues (1984) found that depression and anxiety are

potentially severe disorders, but that they are treatable even if they frequently go undiagnosed (Haug et al., 1984).

Barriers to Accessing Mental Health Services

   Accessibility. Accessibility can be explored in several contexts. Hodges et al. (2005) state "all agencies working with mentally ill clients whether public or private, urban or rural, have an obligation to ensure their services are accessible" (p. 106). Accessibility can be especially challenging when going to clinics and individualized appointments. In rural areas, public transportation may be minimal, posing a barrier to the access of mental health treatment. Researchers Deleon, Kenkel, and Shaw (2012) explain that:

>   One quarter of America's population lived in rural areas and compared with urban
>
>   Americans, rural residents had higher poverty rates, a larger percentage of elderly, tended
>
>   to be in poorer health; they had fewer doctors, hospitals, and other health resources; and
>
>   faced more difficulties getting to both physical and mental health services. (p. 20).

Due to inadequate transportation and access to mental health professionals, adults living with severe and persistent mental illness, requiring ongoing professional treatment, are being forced to move from their rural homes to urban areas to seek essential care (Smalley, Warren, & Rainer, 2012). These conditions emphasize the need for additional mental health practitioners and resources in rural areas.

   The literature explores the shortage of professional staff within the mental health community which poses a concern for accessibility. Due to the shortage of geriatric mental health staff, when older adults seek help they do so through their primary care physician, as access to self-help services can often be limited in rural communities. Literature indicates that

due to limited access to self-help, "consumer and family input is commonly devalued and quality

of mental health care may not match that found in urban areas." (Hodges et al., 2005, p. 107).

Not only is there a shortage in geriatric mental health practitioners, there is also a lack of general

education about mental illness.

Another aspect of accessing mental health services in rural areas is the lack of

information, as well as social support. Hodges et al. (2005) argue "consumers are likely to lack

information on what services are available and where to go for services" (p. 107). Furthermore,

Rogers & Delewski (2004) argue that the "availability and quality of social support networks for

elders with mental illness also will become an increasing concern" (p. 20). Due to an increase in

technology, awareness for social supports and mental illness is improving, and continues to be a

positive platform for older adults with mental illness.

Affordability. Most older adults aged 65 and over use Medicare or a Medicare

replacement plan as a primary form of health insurance. These plans follow similar rules and

regulations when it comes to the reimbursement for medical services, more specifically, mental

health services. Medicare covers a broad spectrum of treatment services; however, policies and

rules limit coverage and ultimately reimbursement for mental health services. "Medicare's

coverage of services for mental health, behavioral health, and substance abuse disorders is not as

extensive as its coverage for other services" (Center for Medicare Advocacy, n.d.). Because

Medicare is an option for most older adults 65 and older, there is growing concern for the costs

of non-covered services being on the rise.

Health insurance is the preferred option to cover mental health services for most; another

option is to pay privately for mental health services. Realistically, paying privately for medical

services may not be financially feasible for older adults. Poverty among older adults is common,

and studies indicate that older adults who have had low incomes throughout their early lives are more likely to continue with low incomes as they move into older adulthood (McInnis-Dittrich, 2014). Older adults living in poverty may not be able to afford secondary insurance premiums or to pay for mental health services privately, leaving affordability a barrier to accessing mental health services.

Stigma. The stigma around mentally ill older adults can lower the likelihood of older adults seeking treatment for their mental illness. Smalley and Warren (2012a) explain "stigma has a direct impact on not only rural residents' likelihood to seek care in the first place, but also their likelihood of continuing in care for the recommended course of treatment" (p. 42). Mental health stigma is a barrier to accessing mental health services, as older adults may be embarrassed to admit their mental illness. Another concept the literature covers is the idea of public stigma. Not only do older adults face stigma within their personal lives, but also from the public. Public stigma may lead to discrimination potentially affecting one's lifestyle, leading to an escalation of self-stigma, and a decrease in self-esteem (Smalley & Warren, 2012a).

Workforce Concerns. It is no secret that there is a shortage in the health care workforce. This shortage spans across the medical field, more specifically the mental health field. There is a current shortage of geriatric psychiatric providers, measuring at "one geriatric psychiatrist for every 11,000 older Americans" (Moak, 2011, p. 274). The literature indicates that in rural communities, mental health agencies are experiencing difficulties not only hiring staff but, also retaining staff. Difficulties experienced regarding the hiring and retaining of staff is one of the largest barriers in rural mental health services (Sullivan, Hasler & Otis, 1993). New incentives have been created to encourage individuals to practice psychiatric services within rural areas.

Social Work Implications

Social workers often play an important role in geriatric services. With some of the difficulties outlined in the literature, there are some social work implications of which to be aware. The prevalence of suicide among older adults is a significant concern as suicide can be attributed to 16% of all deaths among older adults in the United States (Slovak, Pope, & Brewer, 2016). Slovak et al. (2016) further explored the completion rate of suicides among older adults and found that "the completion rate is higher with one suicide for every four attempts, compared to one suicide for every 25 attempts among the general population" (p. 4). So, what are the implications for geriatric social workers and other providers? Suicide comes with risk factors and warning signs that geriatric and mental health service providers should be trained on (Slovak et al., 2016). In a study conducted by Slovak and colleagues (2016), results suggested that "social service providers working with older adults should be trained on warning signs of depression and suicide, as well as the need to limits access to firearms, because there is an elevated risk for these issues among those who have experienced chronic illness and other life transitions" (p. 3). As noted, it is important to be trained as to the warning signs of depression and to have a plan in place to assist older adults with depression in receiving the treatment needed.

The social work profession encourages professionals to advocate for social justice concerns, and mental illness is no different. Advocating on behalf of the elderly is recommended with the increased needs within rural America. The aging population of the United States raises several public policy topics which those in the gerontological profession have much to advocate for (Deleon et al., 2012). Furthermore, "such interaction between mental health professionals and the policy landscape is essential for advancing the agenda of mental health care across the

nation, and advocates for rural mental health are sorely needed" (Deleon et al., 2012, p. 23).

Literature indicates several ways to advocate for mental health concerns; increasing the

awareness of these concerns in the eyes of legislation and the public eye.

Mental health professionals have to also consider each client's background while they are

working with them, as there may be vital information on how to work with rural residents.

Smalley and Warren (2012a) explained that "clinicians who find themselves working with an

individual from a rural background may wish to explore the client's upbringing and childhood

experiences to see how they might be influencing the client's current mental state and

perceptions of the therapeutic process itself" (p. 43). Furthermore, "failure to fully understand

the cultural realities of clients can lead to mistrust, can damage the rapport that is so important to

effective therapy, and can lead to fundamental misunderstandings of the factors that may

underlie an individual's mental health needs" (Smalley & Warren, 2012a, p. 38). As the

literature shows, it is vital to complete a full and comprehensive history of the older adult

seeking treatment for mental health services. A comprehensive history may help mental health

professionals gain insight into the client they are serving, as well as assist in looking at the bigger

picture of the client and their environment, and any barriers they may face in accessing mental

health services.

Conceptual Framework

This research was informed primarily by the text *Rural Mental Health: Issues, Policies, and Best Practices* (2012)*,* edited by three academic scholars: Smalley, Warren and Rainer. Smalley is a licensed clinical psychologist with experience in research and practice in rural areas whose research has appeared in several journals and texts. Warren is a behavioral epidemiologist with a focus in research around health disparities who has presented at a wealth of conferences both nationally and internationally. Rainer is a psychotherapist who has practiced in both rural and urban areas and serves as a consultant for supervision and psychotherapy. This book was a cumulation of work provided by scholars across the field of rural mental health practice.

In R*ural Mental Health: Issues, Policies, and Best Practices*, Smalley, Warren and Rainer (2012) discuss three important aspects of rural mental health needs: models of service delivery, considerations when working with certain populations, and overall special considerations and looking forward to the future of rural mental health. There are many special considerations when working with adults with mental illness in rural areas. These considerations call attention to the current state of mental health and the federal policies which affect certain areas of mental health practice. Another important factor in adult rural mental health is stigma. In one-chapter Larson, Corrigan and Cothran (2012) explain the impact of public and self-stigma on adults and accessing treatment for their mental illness stating, "an individual with mental illness adapts and copes with symptoms, functional limitations, and disability stigma associated with other spoiled identity" (p. 50). Stigma plays a role in a person's loneliness eventually leading to isolation. Each of these is addressed in great detail in this book.

Three vital methods of service delivery are outlined within this text, placing focus on the significance of integrated care in rural areas. The idea of integrated care speaks to the concerns for access to services and aims to decrease stigma around utilizing services. Another growing service delivery model partners with today's technological advances using telehealth to address rural mental health clients. Telehealth provides psychotherapy to individuals in remote areas of the United States using advanced technology. With advancing technology, it is possible to meet the growing needs of rural clients. (Smalley et al., 2012). All of the service delivery models outlined in this book are still being developed and are on a great path to addressing the barriers of accessibility in rural areas.

Methodology

Research Design

The purpose of this study was to collect data and information on the resources available

to older adults living with mental illness in rural Minnesota. The survey was created using both

quantitative and qualitative questions using purposive sampling in the first round of surveys

distributed. Snowball sampling was used in both rounds of the survey process, where I as the

researcher asked the initial respondents to pass along the survey to other appropriate

professionals who meet the criteria to take the survey. This survey was created using an online

survey tool, Qualtrics. An e-mail with the link to the survey was sent to social workers,

therapists and primary care physicians within nursing homes, assisted living, home care, housing

with services and adult day centers within central Minnesota. An online search engine was used

to connect with professionals with publicly available contact information. I sought sources

currently involved in rural care with relevance to rural mental health care with geriatric focus.

The survey took approximately 10-15 minutes to complete and consisted of questions related to

methods of delivery, barriers to accessing services, and any best practices related to the service

delivery of mental health services.

Population and Sample

Surveys were distributed to professionals in a variety of practice settings including clinic,

county, home and community-based services, skilled nursing facility and mental health agencies

using Psychologytoday.com, an online search engine used to look up counselors and therapists.

The respondents chosen to participate in this survey included professionals who work with rural

clients in rural communities in Benton, Cass, Chisago, Crow Wing, Kanabec, Isanti, Mille Lacs, Morrison, Pine, Sherburne, Stearns, Todd, Wadena and Wright Counties.

The first distribution of surveys consisted of 135 surveys; with a second round consisting of 18 surveys with a total of 153 total surveys distributed. Surveys were sent with an email introducing my research project, consent form, and a link to take the survey. The email invited participants to forward the survey to other professionals they may see fit to take this survey. Prior to sending out this survey a review was conducted by the Institutional Review Board (IRB) at the University of St. Thomas and approved.

Protection of Human Subjects

Protection of human rights is critical to this research since it involved human participants. This study underwent IRB review at the University of St. Thomas to ensure the protection and anonymity of the respondents to this study. All respondents were provided with an informed consent letter before participating in the survey, stating that participation in the survey is completely voluntary. All data collected were kept private and anonymous by removing all identifying material using Qualtrics, for those who responded to the survey.

All participants were professionals working in some capacity with older adults who may have a mental illness. The respondents may have personal experience; however, they are not considered a vulnerable group. Each initial professional asked to participate in this survey was emailed directly by the researcher. Participants were invited to send the survey on to individuals they may know who are appropriate for this study. There were no significant identified risks or direct personal benefits to participating in this study. Participation in this survey was voluntary, and if the participants wished to participate in this survey, they clicked on a link that directed

them to the survey. The survey's questions asked professionals about their roles and

professional opinions. For these reasons, it was reviewed at an expedited level of review.

Results of the survey are kept in a password protected folder on this researcher's laptop.

Results from the survey will be deleted from my computer on May 14, 2018, upon completion of

my research project. Participants were informed in the consent that their written responses might

be included in the final written report, including short answers as a source of direct quotes.

Data Collection

The first round of respondents was chosen using PsychologyToday.com, a public search

tool used to find therapists in Minnesota. A second round of surveys was sent to colleagues who

were asked to send the survey to respondents who qualify to take the survey using a snowball

sample technique. Respondents were chosen based on the location they work and the services

they provide. Participants consisted of social workers, counselors, therapists, physicians, nurse

practitioners, nurses, and other geriatric providers. Although this was the primary target group

of participants, respondents were not limited to these providers. Upon completion of the

surveys, I organized the responses after conducting an in-depth data analysis.

Data Analysis

Data received from respondents were analyzed using both inductive and deductive

approaches. First analyzed were the demographics of the survey respondents. This was with the

goal of giving the readers some initial context regarding the survey respondents. This included

things like describing the roles, titles, and length of practice experience reported by survey

respondents. The next set of data analyzed were the responses to each survey question. The

researcher analyzed each survey response based on the category of questions asked (for example,

barriers, successes, and promising service delivery methods). Specifically, I analyzed the data

using an open coding technique, scanning for themes that were present within the survey

responses where respondents offered brief qualitative responses to open-ended questions. Next, I

analyzed the survey responses a second time, using a deductive analysis, to better understand

survey responses, listening for further emerging themes that are consistent with either literature

and my conceptual framework. Lastly, I went through one last time inductively, to see if I might

have missed any additional ideas or themes in the data to ensure validity.

Strengths and Limitations

The primary limitation within this study is the sample size. The sample of respondents

was initially chosen based on publicly available data. As the literature shows, the pool of

geriatric mental health practitioners is minimal therefore leaving a potential gap within those

participating in the survey. One strength in this study is using a primarily qualitative survey

study with snowball sampling. Using a survey opens the options of reaching more mental health

practitioner in rural parts of Minnesota without the researcher having to travel geographical

distances. This survey was sent to mental health providers with and without specific older adult

focus or training to reach a larger pool of candidates, another strength of the study.

Findings

The survey of mental health services available to older adults was sent to mental health professionals in 14 counties surrounding Central Minnesota. The survey was sent out in two rounds with an invitation to further distribute the survey using snowball sampling. The first round consisted of the electronic distribution of 135 surveys, with a second round consisting of 18 surveys being sent to targeted providers in rural settings, for a total of 153 total surveys distributed. A total of 17 surveys were returned with a participation rate of 11%. Reasons for this modest return rate are discussed in the discussion section. The data analysis shows the challenges and opportunities in the service delivery methods in the 14-county sample population surrounding Central Minnesota.

Demographics

Surveys were distributed to professionals in a variety of practice settings including: clinic, county, home and community-based services, skilled nursing facilities and mental health agencies. Of the 153 surveys returned, 11% of respondents reported working in a clinic, 5% work in a home and community-based setting, 11% work in a skilled nursing facility, 17% work in a mental health agency and 17% reported being employed in another related practice setting. The majority of respondents 35% reported working in a county-based practice setting (See Figure 1).

Figure 1. *Agency based practice setting*
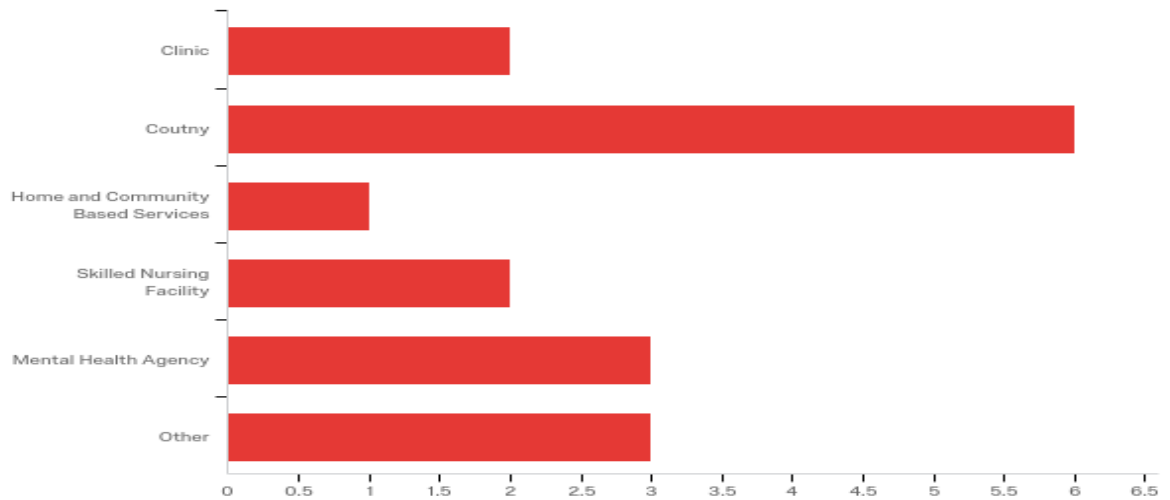
A second demographic question asked about the respondent's job title. Survey respondents weighted largely toward identifying as social workers and as those in mental health-specific roles. 52% reported their primary title to be social worker, 29% identified as a clinical counselor or therapist and 17% reported an unspecified job title relating to mental health services. Of the respondents 35% reported they had less than five years of work related experience, 11% reported they had five to ten years of work related experience and 52% reported they had over ten years work related experience. The majority of the sample thus consisted of those with less than five or greater than ten years of practice experience. Most respondents reported working primarily with adults. When asked about the age of the clients they primarily served, 76% reported working with adults under the age of 65, 11% reported working with adults aged 65-74, 5% reported working with adults aged 75-84 and 5%, report working with adults aged 85 and over (See Figure 2).

Figure 2. *Primary age of clients served*
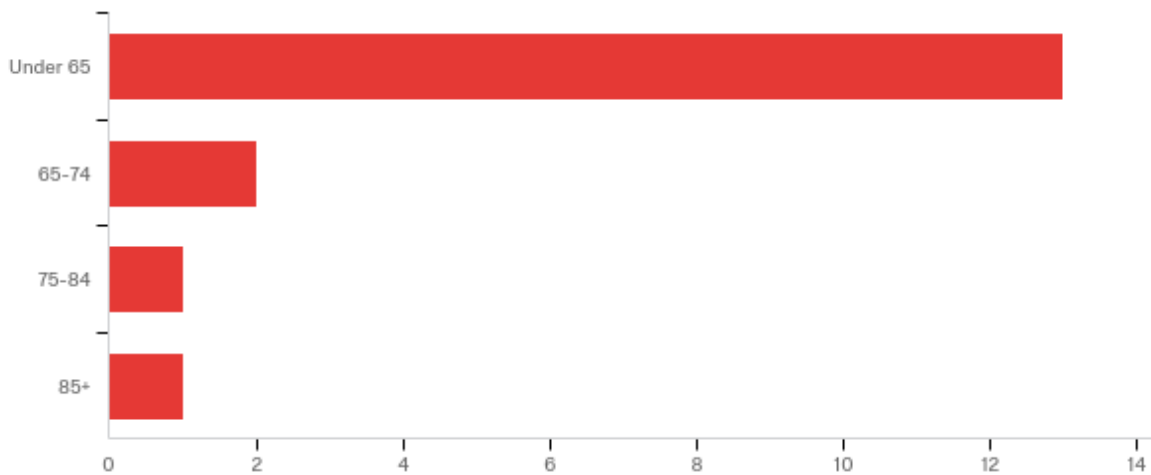
The majority of the respondents reported being from central Minnesota and about a fourth of the entire sample identified as being based primarily or exclusively in rural regions. However, most endorsed working in both rural and urban areas. Of the respondents, 94% reported working in the central Minnesota region with 5% working in the Northwest region of Minnesota. Of those sampled, 25% reported working in rural areas (regions with a population of less than 2,500), 18% reported working in an urban area (population of 2,500 or more people) and 56% reported working in both a rural and urban area.

Overall, the sample was primarily county-based, identified as social workers with years of experience in their practice setting and experience working with adults in both a rural and urban context. There were several short answer questions initiating the survey that sought qualitative responses. Responses to these initial questions were analyzed broadly and then coded into categories and themes within each category of question asked. Three major categories of analysis emerged within the data: service delivery challenges, service delivery opportunities, and new innovations in mental health service delivery explored below.

Service Delivery Challenges

One category that emerged within the data was challenges in the service delivery methods offered in rural settings. Respondents were asked about the barriers older adults face when accessing mental health services in the sample population. Respondents were asked to rank various challenges older adults face when accessing mental health services asking the question: "In your professional experience, please rank the following barriers (1 being the most likely barrier older adults face, 7 being the least likely barrier older adults face) when seeking mental health services." 26% listed acceptability and the stigma associated with mental health services and workforce shortage in a tie as the number one barrier older adults face when accessing mental health services in the sample population. 53% respondents listed accessibility and transportation being the second barrier to accessing mental health services in rural areas (See Table 1 below).

Table 1. *Rank order of barriers to geriatric mental health services.*

The following table lists various challenges older adults face when accessing mental health services. Respondents were asked to rank the barriers with 1 being the most likely barrier older adults face, 7 being the least likely barrier older adults face. For example, 6% of the respondents placed accessibility as the most likely barrier older adults face when accessing mental health services.

#	Field	1	2	3	4	5	6	7
1	Accessibility (Transportation)	6%	53%	20%	20%	0	0	0
2	Affordability (Financial Limitations)	20%	6%	26%	20%	20%	6%	0
3	Acceptability (Stigma)	26%	0	13%	0	33%	20%	6%
4	Workforce (Provider Shortage)	26%	33%	6%	6%	0	20%	6%
5	Wait list (To see provider)	20%	0	26%	6%	40%	6%	0
6	Isolation	0	6%	6%	46%	6%	33%	0
7	Provider Burnout	0	0	0	0	0	13%	86%

Respondents indicated both stigma and a decline in geriatric mental health professionals as primary barriers, with concern for transportation coming in at a close second. Also identified as barriers older adults face are financial limitations and long wait times to see mental health providers; as indicated in the table 1. A decline in geriatric mental health providers will be discussed further in the next section.

Lack of geriatric mental health providers. Another theme identified across providers who responded to the surveys is the *lack of specialty providers* for older adults. This theme

came up as responses in several of the questions in the survey. Here are what respondents had to

say about the need for specialty providers:

> *Lack of psychiatric in general, especially those trained in geriatrics.*

> *Providers with experience working with older adults.*

> *Medicare does not accept certain mental health providers.*

> *Lack of specialty providers, (they) don't see a need for such service.*

> *Able to get residents access to Inpatient Behavior Health units in the area relatively easily when talking about geriatrics but ongoing counseling or psychiatry is very limited.*

> *Most people are open and willing to get the help just lack of providers.*

The responses above outline the overall need for additional providers in geriatric mental

health services. They also outline Medicare's acceptance of mental health services as an area for

(that is, still needing) improvement.

"Strong enough" stigma around mental illness. Stigma was identified as another

theme surrounding the barriers to accessing geriatric mental health services in the sample.

Respondents were asked "how does stigma play a role or influence older adults accessing mental

health services in the rural areas you are familiar with?" All 17 of the respondents shared their

thoughts about how stigma affects mental health services:

> *Yes, it currently does. Older adults do not want to accept mental health services.*

> *I believe stigma exists, but the individuals I work with are confident and comfortable with their mental health.*

> *Adults are unwilling to seek mental health services but also providers often dismiss concerns of the elderly as being "normal" for an older person.*

> *People don't want to be labeled as having a mental illness therefore they may avoid seeking services.*

Many older adults are unaware of symptoms of depression or anxiety or feel they are "strong enough" and don't need help.

A lot of older people have a stigma against mental health because they come from a generation that you just had to "suck it up" I think they have better resilience then this generation.

Families do not often encourage their parents to pursue mental health services.

Many older adults do not access mental health services because of stigma.

Older clients have a much harder time especially males in accepting the fact they have mental illness.

Transportation shortage. Lack of medical transportation emerged as a theme surrounding the barriers to accessing geriatric mental health services in the sample population. Respondents were asked to "list one or two barriers commonly faced to accessing mental health services in your practice setting," and 41% responded with *transportation* being a common barrier. Four respondents share their reasoning behind transportation being a barrier:

Providers who are able to bill Medicare are out of the way and at times transportation needs to pre-approve the trip and see if it is necessary.

Client's ability to set up medical transportation.

We need more transportation and Medicare providers.

Increase access to medical rides, meaning, we need more transportation companies willing to provide services in rural areas.

Respondents identified several challenges that older adults face when accessing mental health services; they also identified opportunities for the field of geriatric mental health services as discussed in the next section.

Service Delivery Opportunities

The second category that emerged within the data is the successes and opportunities with the mental health services among older adults. Respondents were asked in a survey question to "name a few successes with current delivery methods in rural areas" leading to the respondents highlighting both telehealth and in-home services as two successful themes in service delivery methods among rural mental health services.

Telehealth. Respondents highlighted telehealth as a successful service delivery option for rural mental health services. Telehealth is the use of telecommunication services to provide psychiatric services to clients in need. Respondents were asked "what service delivery method(s) seem to work for older adults?" Respondents voiced some positive aspects of using telehealth services:

> *Telehealth services and integrated behavioral health imbedded into the clinics.*
>
> *Telehealth seems to be working well.*
>
> *Make sure the telehealth screens are big enough so the older adult can see well and make sure they have privacy.*
>
> *Some like it, some don't.*
>
> *Impartial. Face to face had significantly positive impact due to people's need for connection.*
>
> *Clients unfamiliar with technology or with paranoid thinking are barrier, however, once clients build trusting relationships with providers telehealth can be great as clients can see providers closer and faster.*
>
> *I work with a lot of patients who have dementia and it does not seem to bother them.*

When asked the question "is there anything you would like to say about your experience with telehealth" respondents shared some negative experiences and considerations when thinking of using telehealth services with older adults:

> *Negative. It is too difficult for older adults to become comfortable with technology piece as well as if there are hearing or visual impairments this is extremely difficult.*

> *Telehealth is not an effective method for older adults to receive this service.*

> *People do not care for telehealth but will accept if that is all that is available.*

> *Telehealth is not very well accepted by most elderly clients. They want in person care.*

> *Telehealth is filling a void particularly for psychiatric services. I don't think that this is ideal for older adults who often need direct human contact.*

> *More difficult with older population.*

> *If there is someone who specializes in the ins and outs of telehealth, setting it up, pitfalls, etc. I'd love to hear about them.*

In-Home Services. A second theme that emerged within this category is in-home services for mental health symptom management. Respondents were asked about the services delivery methods that are successful with older adults and the highlighted responses below speaking to the benefits of in-home services as well as specific programs:

> *In home services are (i.e. have) a better success rate.*

> *Providers meeting individuals in home has worked out well.*

> *Adult Rehabilitative Mental Health Services (ARMHS) has been very helpful for older individuals with mental health diagnoses. They are practitioners but very effective in managing symptoms in the community.*

Respondents were also asked if they are "aware of any successful pilot programs that may make mental health service more accessible for older adults living in rural Minnesota" one respondent spoke to services in their practice area:

We have a Community Support services that is offered in our county for clients with SPMI and it is covered by the local county so will not bill insurance.

New Innovations in Mental Health Service Delivery

A third category identified within the data was that of new innovations in mental health service delivery methods. Respondents were asked what "formal and informal supports for adults" are available or appear promising in their area of practice. Respondents identified several informal and formal supports providing a variety of service delivery options:

Receiving services from practitioners vs. mental health professionals. ARMHS and Community Support Program staff go to the individual's home and help them in the community as well as in their homes to manage their symptoms.

Caregiver support groups, Dementia Friends, volunteers through Family Pathways.

(Senior Center*) and the VA Day Program are opportunities to engage socially and reduce isolation.*

Volunteer services, caregiver specialists, dementia friendly groups, senior center, memory café.

Adult Day Programs, Meals on Wheels.

We have a Community Support services that is offered in our county for clients with SPMI and it is covered by the local county so will not bill insurance.

Home Health Services.

The Miracle Question

The final question of the survey asked respondents "if you could change one thing about mental health services and/or the accessibility to mental health services, what would it be and why?" The respondents had several ideas of how mental health services could be changed to see more accessibility for older adults:

I would like more Medicare providers because many of our elderly have to travel over 35 miles to find a provider that takes their insurance.

More in-home providers and drop in centers for them to socialize.

Increase the number of providers who can see clients for therapy through Medicare.

Change Medicare's rules, this would open up all therapy services for this population.

More providers show an interest or take training specific to working with this population.

Shorter waiting lists.

Expand the Medicare network to include all licensed mental health providers.

As indicated above in the responses, respondents suggest a challenge with health insurance, more specifically Medicare. Respondents suggested that an expansion of Medicare to include all licensed mental health professionals would greatly increase the accessibility of mental health services for older adults living in rural areas.

These findings represent a snapshot of geriatric mental health service providers in the 14-county central Minnesota sample population who responded to the survey. The sample largely consisted of providers working in a county setting and data suggest that the primary sample consisted of social workers. A total of 153 surveys were sent out in two waves of electronic (i.e. email) invitations to participate. These data provide a general idea of the service delivery challenges, service delivery opportunities, and new innovations in mental health service delivery options. The survey ended with a question of if respondents could change one thing, what they would change, allowing respondents to openly express the hope they have for the future of geriatric mental health services. Here respondents spoke to the need for increased accessibility, an increase in geriatric mental health providers and for Medicare to be more open to accepting

mental health services. Specific examples and a complete list of questions and responses not

highlighted can be found in Appendix C.

Discussion

This research collected data and information on the resources available to older adults living with mental illness in rural Minnesota revealing both challenges and opportunities in the field of geriatric mental health services. This study explored the perception of a sample of professionals regarding the needs of and current challenges faced by older adults when needing mental health services. These respondents outlined their understanding of the needs of older adults with mental illness and the barriers faced when accessing mental health services in rural areas. They also highlighted some successes and potential innovations in the field of geriatric mental health services specific to older adults. This section will discuss the findings of this study as they relate to existing research and the three emerging categories respondents highlighted: service delivery challenges, service delivery opportunities, and the new innovations in mental health services.

Interpretation of Findings

Challenges. The data analysis produced several emerging themes that relate to the literature. Respondents identified two specific themes identified as challenges that older adults tend to face while accessing mental health services in rural areas: transportation necessary to accessing mental health services, and stigma as it relates to the acceptability of seeking help as discussed below. It is important to note that although transportation and stigma were identified as the top two challenges associated with accessing rural mental health services, respondents called attention to financial concerns and challenges with health insurance, as discussed in implications.

Of the respondents, 41% specifically identified transportation as a barrier to accessing geriatric mental health services, especially in rural populations. This is consistent with existing

research suggesting that the "unavailability of resources and transportation problems were barriers to access for rural populations" (Larson, Corrigan, & Cothran, 2012, p. 20). Literature further supports the need for transportation services explaining that some rural older adults who have mental illness and need ongoing treatment must often move to urban areas (Deleon, Kenkel, & Shaw, 2012). In response to this challenge, the respondents identified a couple local promising considerations to assist older adults in Central Minnesota with transportation to medical appointments:

There are some excellent providers in the St. Cloud area open to seeing older adults.

There is a transportation company out of the Foley area who provides excellent transportation services.

Of the respondents, 13% specifically identified stigma as a barrier to accessing geriatric mental health services in rural populations. Research by Larson et al. (2012) suggests that acceptability of mental health services presents as a barrier due to the attitudes and fear of the stigma associated with having a mental illness (Larson et al., 2012). Furthermore, respondents identified lack of encouragement from family and reluctance to ask for assistance:

Families do not often encourage their parents to pursue mental health services.

People are reluctant to ask for help or feel their concerns are invalid.

Opportunities. The sample's responses suggest there are promising service delivery methods for older adults living in rural areas of Minnesota. One promising service delivery method identified within the data are in-home mental health services. Several in-home services have similarly been identified within the literature as well as this study. Respondents identified the following as promising in-home mental health services:

> *Community Support Services (that can) meet individuals in their homes*
>
> *Community Support Program grants allowing for some support through County*
>
> *agencies*
>
> *Adult Day Care*
>
> *Telehealth Technology (ITV) Psychiatry*
>
> *Adult Rehabilitative Mental Health Services (ARMHS)*

New Innovations. Respondents suggested there are innovations to service delivery for geriatric mental health services as they relate to older adults living in rural Minnesota. One intervention identified highlighted within the literature and this study is telemedicine. The existing literature also notes that formal supports are imperative to mental health services in rural communities. Telehealth may serve one such role. Telehealth and telepsychology have created new opportunities for service delivery methods for behavioral health care in rural areas of Minnesota. Furthermore, telehealth holds significant promise in focusing on the core challenges older adults face in accessing mental health services (Deleon et al., 2012; Smalley & Warren, 2012a).

Implications of Findings

In referring to the conceptual framework used for this research, Smalley et al. (2012) express implications for both public policy and the field of social work as they relate to rural mental health. The conceptual framework suggests that public policy and advocacy are some important components in shaping the future for mental health services, as lobbying for funding as well as supporting the need for additional mental health practitioners is imperative (Smalley et al., 2012). These authors similarly discussed the need to call attention to public policy and the role social workers can play in advocating for the clients served.

Smalley and Warren (2012b) suggest that in order to continue future improvements in mental health services in rural populations, there is a need for advocacy in relation to policy, requiring reaching out to legislators and related policy makers. Rural social workers and other mental health practitioners can make a difference by advocating for key policy changes needed to improve the mental health services for older adults in rural areas (Smalley & Warren, 2012b). Literature further suggests that certain policy initiatives and legislative agendas support the need for more mental health professionals in rural areas (Larson, Corrigan, & Cothran, 2012). In this study, respondents also supported the need for advocacy and policy considerations as they relate to health care insurance. One respondent spoke to the need for *Medicare to approve all licensed mental health professionals in their network, (so that) many more older adults could be served.* Another respondent went on to note that *Medicare makes it tough for older clients to access mental health programs.*

A second aspect of public policy as identified by Deleon et al. (2012) is the need for advocacy: "interaction between mental health professionals and the policy landscape is essential for advancing the agenda of mental health care across the nation, and advocates for rural mental health are sorely needed" (Deleon et al., 2012, p. 23).

Strengths and limitations

After the data were collected and analyzed, some strengths and limitations of the study were apparent. Although there was a lower than anticipated response rate, a significant percentage of the respondents [35%] reported working in a county-based practice setting. Individuals who work in a county setting often have particularly relevant roles, providing resources to their clients and assisting them in finding mental health services if warranted.

Another strength of this survey was the longevity of the respondents in the field of mental health

services, with 52% reporting they had over ten years of related experience.

Survey response rate was the primary limitation of this study. Although surveys were

distributed to fourteen counties considered to be Central Minnesota the majority of those invited

did not participate in this study for unknown reasons. This remains puzzling, in that initially 135

surveys were sent out using publicly available contact information. The response rate may be due

to many of these sites not allowing for personalization or follow up reminders. Due to the

modest return rate a second round of surveys were distributed using a more personalized

approach. I asked mental health professionals to distribute the survey to other mental health

professionals who would be in a good position to speak to this topic. Another limitation to this

survey was the period available to take it. The initial round of surveys was sent out with ample

amount of time (i.e. several weeks) left for the respondents to complete the survey, however, no

deadline was set. A survey using publicly available contacts may function better with a

definitive timeline. Therefore, the second round of surveys included a date the survey would

close, encouraging respondents to take the survey by a certain date.

Suggestions for Future Research

There are a few suggestions for future research in this field of study. Although this study

was conducted by using a quantitative and qualitative survey, future research in this field would

benefit from in person interviews. Conducting interviews personally provides for a connection

with the respondents and may provide for more detailed responses. Future research in this field

would benefit from asking further questions along the line of the challenges faced by older

adults, and what support is available to overcome certain challenges. It may also be beneficial to

get the perspective of various older adult clients, first-hand, who live in rural areas and have faced some of the challenges in accessing mental health services.

Further research in the effectiveness of telehealth services would be another suggested area of research. Respondents indicated that the use of telehealth services may not be accepted by most elderly clients so further research on the use of telehealth services with older adults is suggested.

Summary

This research provided an analysis of the challenges and opportunities in the accessibility of mental health services for older adults living in rural areas. The goal for this research was to identify specific barriers older adults living in rural areas face when seeking treatment for mental health services. Overall, most information found within the literature has proven consistent with the findings of this research. Three major challenges were mentioned by respondents and identified as a general decline in geriatric mental health providers, stigma of mental illness and a lack of transportation needed when seeking help for mental health disorders. Ideally, there are new innovations in mental health services, such as telehealth service, which can reach older adults living in rural areas of Minnesota, proving to be promising advancements in the field of geriatric mental health services.

References

Center for Medicare Advocacy. (n.d.). Medicare coverage of mental health and substance abuse

    services. Retrieved September 30, 2017, from

    http://www.medicareadvocacy.org/medicare-info/medicare-coverage-of-mental-health-

    services/

Crowther, M. R., Scogin, F., Wayde, E., & Austin, A. L. (2012). Providing mental health

    services for older adults and caregivers in rural areas. *Rural mental health: Issues,*

    policies, and best practices, 297-310.

Cummings, S. M. (2009). Treating older persons with severe mental illness in the community:

    Impact of an interdisciplinary geriatric mental health team. *Journal of Gerontological*

    Social Work, 52(1), 17-31.

DeLeon, P. H., Kenkel, M. B., & Shaw, D. V. (2012). Advancing federal policies in rural mental

    health. *Rural mental health: Issues, policies, and best practices*, 17-36.

Haug, M., Belgrave, L., L., & Gratton, B. (1984). Mental health and the elderly: Factors in

    stability and change over time. *The Journal of Health and Social Behavior, 25*(2), 100-

    115.

Hodges, J. Q., Markward, M., Yoon, D. P., & Evans, C. J. (2005). Rural and urban differences

    among mental health consumers in one midwestern state: Implications for policy,

    practice, and research. *Journal of Social Work in Disability & Rehabilitation, 4*(1), 105-

    120. Retrieved from

http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true
&db=swh&AN=76670&site=ehost-live

Larson, J. E., Corrigan, P. W., & Cothran, T. P. (2012). The impact of mental health stigma on
clients from rural settings. *Rural mental health: Issues, policies, and best practices*, 49-
64.

McGovern, R. J., Lee, M. M., Johnson, J. C., & Morton, B. (2008). ElderLynk: A community
outreach model for the integrated treatment of mental health problems in the rural elderly.
Ageing International, 32(1), 43-53. doi:10.1007/s12126-008-9004-5

McInnis-Dittrich, K. (2014). *Social work with older adults: A biopsychosocial approach to
assessment and intervention.* New Jersey: Pearson

Medicare. (2017). What is medicare? Retrieved July 26, 2017, from www.medicare.gov

Moak, G. S. (2011). Treatment of late-life mental disorders in primary care: We can do a better
job. *Journal of Aging & Social Policy, 23*(3), 274-285.

National Alliance on Mental Illness. (2012). Older Adults. Retrieved September 07, 2017, from
http://www.namihelps.org/education/older-adults.html

Rogers, A., & Delewski, C. (2004). Elders with serious and persistent mental illness (SPMI):
Assessing needs, resources, and service utilization. *Journal of Gerontological Social
Work, 43*(1), 19-36. Retrieved from
http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true
&db=swh&AN=75286&site=ehost-live

Slovak, K., Pope, N. D., & Brewer, T. W. (2016). Geriatric case managers' perspectives on

    suicide among community-dwelling older adults. *Journal of Gerontological Social Work,*

    59(1), 3-15. doi:10.1080/01634372.2015.1111966

Smalley, K. B., Warren, J. C., & Rainer, J. P. (2012). *Rural Mental Health: Issues, Policies, and*

    Best Practices: Issues, Policies, and Best Practices. New York: Springer Publishing

    Company.

Smalley, K. B., & Warren, J. C. (2012)a. Rurality as a diversity issue. *Rural mental health:*

    Issues, policies, and best practices, 37-47.

Smalley, K B., & Warren, J. C. (2012)b. Rural mental health: Future directions and

    recommendations. *Rural mental health: Issues, policies, and best practices,* 349-354.

Sullivan, W. P., Hasler, M. D., & Otis, A. G. (1993). Rural mental health practice: Voices from

    the field. *Families in Society: The Journal of Contemporary Social Services, 74*(8), 493-

    502. Retrieved from

United States Census (2012, September 01). 2010 Census Urban Area Facts. Retrieved

    September 25, 2017, from https://www.census.gov/geo/reference/ua/uafacts.html

United States Census Bureau. (2016, May 19). Newsroom Archive. Retrieved September 08,

    2017, from

    https://www.census.gov/newsroom/releases/archives/facts_for_features_special_editions/

    cb12-ff07.html

Appendix A

UNIVERSITY OF St.Thomas

1153123-1

Challenges and Opportunities in Accessing Geriatric Mental Health Services in Rural Minnesota.

The purpose of this study is to gain better insight in the challenges and barriers older adults face while accessing mental health services living in rural Minnesota. This study will also gather data on the opportunities and success in addressing the needs of older adults in rural Minnesota. You were selected as a possible participant because Participants have been chosen at random because of their professional work in the mental health field.

This study is being conducted by: Kassara A. Kneeland, student at St. Catherine University and the University of St. Thomas. This study was approved by the Institutional Review Board at the University of St. Thomas.

If you agree to participate, I will ask you to answer several survey questions focused on the service delivery methods for rural mental health services with a focus on older adults. Some questions have a focus on the barriers faced by older adults while accessing mental health services; while other questions focus on successful practices geared toward mentally ill older adults in rural areas. The survey should only take 20-25 minutes to complete.

The study has no foreseen risk and there are no direct benefits for participating in the study.

The records of this survey will be kept confidential. In any sort of report, I publish, I will not include information that will make it possible to identify you.

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of St. Thomas. If you decide to participate, you are free to withdraw at any time up to and until the survey is submitted. You may withdraw by closing the survey on your computer. You are also free to skip any questions I ask.

You may contact the University of St. Thomas Institutional Review Board at (651) 962-6035 or muen0526@stthomas.edu with any questions or concerns.

By clicking "Agree," I consent to participate in the study. I am at least 18 years of age.

Please print this form to keep for your records.

Appendix B

Survey of the Accessibility of Geriatric Mental Health Services

The following set of questions is based on your knowledge of geriatric mental health practice and the accessibility of the treatment services available to older adults in rural Minnesota. Please answer these questions to the best of your knowledge.

1. Please list one or two barriers commonly faced by older adults when accessing mental health services in your practice setting. (This may include inadequate transportation, or financial limitations).

2. The following lists various challenges older adults face when accessing mental health services. In your professional experience, please rank the following barriers (1 being the most likely barrier older adults face, 7 being the lease likely barrier older adults face) when seeking mental health services.

   - Accessibility (i.e. Transportation)
   - Affordability (i.e. Financial Limitations)
   - Acceptability (i.e. Stigma associated with Mental Health Services)
   - Workforce Shortage (i.e. A decline in Geriatric Mental Health Professionals)
   - Wait list (i.e. Long wait times to see a Mental Health provider)
   - Isolation (i.e. Living in Rural Areas of Minnesota)
   - Provider Burnout

3. In your experience, please name a few successes within current delivery methods in rural areas? (This could include things that are going well: programs or efforts you are aware of that serve older adults with mental health challenges in a rural setting).

4. Please name, from your perspective, one or two things that can be done to improve the accessibility of geriatric mental health services in rural areas?

5. How does stigma play a role in or influence older adults accessing mental health services in the rural areas you are familiar with?

6. What are formal and informal supports for older adults in your service area? (This might include, Adult Day programs, Volunteer services, Support groups or Transportation).

7. How do you believe age plays a role in the barriers of accessing mental health services in rural areas of Minnesota, if it does?

8. Are you aware of any promising or successful pilot programs that may make mental health services more accessible for older adults living in rural Minnesota?

9. What service delivery method(s) seem to work well for older adults in rural Minnesota? (This could include things like telehealth). Are there ways in which these delivery methods could be improved?

10. Have you used telehealth with older adults in rural areas? If so, what percentage of your practice would you say has used telehealth?

11. Is there anything you would like to say about your experience with telehealth? (Positive, negative, or recommendations you might have to improve its use).

12. Lastly, if you could change one thing about geriatric mental health services and/or the accessibility of these services, what would it be and why?

- -

Demographic Questions

Primary place of employment

- Clinic
- County
- Home and community-based services
- Skilled nursing facility
- Mental health agency
- Other _____

Job title or professional role

- Social worker
- Counselor
- Physician/nurse practitioner
- Nurse
- Other _____

Area of experience

- Rural (population of 2,500 or more people)
- Urban (population of less than 2,500 people)
- Both
- Neither

Region of the state you practice

- Minneapolis-St. Paul
- Southwest Minnesota
- Southeast Minnesota
- Northwest Minnesota
- Northeast Minnesota
- Central Minnesota

How long work in field

- 0-5 years
- 1-5 years
- 5-10 years
- 10 or more years

Primary age of clients served

- Under 65
- 65-74
- 75-84
- 85+
- Other _____

Appendix C

	Text Responses
1.	Please list one or two barriers commonly faced to accessing mental health services in your practice setting? - Provider only at clinic four times per month - Insurance or Medicare coverage for mental services including ARMHS and Therapy - Medicare - Psychiatric Provider shortage - Limited access - Lack of access to services in timely manner, inability to leave facility - Lack of Medicare Providers - Financial limitations
2.	In your experience, please name a few successes within current delivery methods in rural areas? This could include things that are going well: programs or efforts you are aware of that serve older adults with mental health challenges in a rural setting. - ITV Psychiatry - New geriatric unit in Monticello - We do have therapists who will travel to client homes - Dementia friendly community, ACT on Alzheimer's - CSP which is similar to ARMHS and social group - There are some excellent providers in the St. Cloud area open to seeing older adults.
3.	Please name, from your perspective, one or two things that can be done to improve the accessibility of mental health services in rural areas? (For example, this can include things such as transportation). - More providers - Providing affordable insurance that will cover diagnostic assessments and therapy to those 65 and older - Increased options for Medicare providers - Community groups, caregiver support programs - More providers - Incentives for providers, telehealth - Insurance coverage for clients on Medicare - Provide medical transportation awareness - Also, Medicare would need to change their requirements only allowing LP's or LICSW's to provide therapy - Increased Medicare therapists, social programs and transportation - Destigmatize - If Medicare would approve all licensed mental health professionals in their network, many more older adults could be served. Care Cab services should be offered and made available to older adults freely and openly promoted. - Tele med services

	- More clinics that have integrated mental health services when they see their primary care provider and more case managers to help people and families navigate through the complications of funding for supportive living environments without them being stripped of everything they worked for.
4.	How does stigma play a role/influence in older adults accessing mental health services in the rural areas you are familiar with? - In the rural areas that I serve it is more the lack of services than the stigma - Their generation is not as apt to seek such help - Delaying requests for supports, refusing therapeutic options - Most people are open and willing to get the help just lack of providers - Limited - Stigma plays a significant factor - Lack of knowledge about available resources and services
5.	What are formal and informal supports for older adults in your service area? - Adult Day programs and some transportation but it is very limited due to the miles in between pick up and where the appointments might be - Weekly social support groups through the CSP program. It is a non-billable service provided through a county contract - CSP, Family Pathways Senior Supports, faith-based programs - Volunteer services, support programs, transportation - Volunteer programs, housing services, transportation from volunteer drivers, social groups - MLCCVS - Community support services group, ARHMS group, county case management, peer supports and in-home community-based services - Adult Day Care, CSP social group - They exist but I'm not specifically aware - Older adult day care, volunteer services, Meals on Wheels - None of the above
6.	How do you believe age plays a role in the barriers of accessing mental health services in rural areas? - Difficult to schedule appointments, the complexity creates a barrier for older adults - It does not seem to play that big of a role - Again, this generation minimizes their mental health issues - The largest barrier I have experienced is insurance coverage for people age 65 and older and have to get off their MA. - Medicare issues, limited providers have accreditation - Geriatric issues are more complex and often not understood - Complicated processes to complete intakes for mental health services - No barrier - Limited, physical challenges - Ties in with social stigma in geriatric population

		- Elderly can be overlooked and not listened to. This prevents those around them from taking their symptoms seriously and accessing services - Lack of knowledge regarding available services and supports - More cohort effect than anything else - Older adults are sometimes confused by their insurance plans. Medicare itself is poor at providing coverage for mental health services, particularly by limiting the provider's access to the network. - Stigma associated due to generational views - I don't feel it does. I do believe mobility plays a bigger role as a barrier
7.		Are you aware of any promising or successful pilot programs that may make mental health services more accessible for older adults living in rural Minnesota? - No - No, I do not know of any piolet programs - No, but center on aging is a great advocate - We have a Community Support services that is offered in our county for clients with SPMI and it is covered by the local county so will not bill insurance - Not that I'm aware of - It's not a pilot program, but our ARMHS department director is working on starting drop in centers in the communities we serve
8.		What service delivery method(s) seem to work for older adults? Are there ways the delivery method(s) could be improved? - ITV – Telehealth - In home therapy - Don't know - In office is working for my clients
9.		Have you used telehealth with older adults? If so, what percentage of your practice would you say has used telehealth? - No – IIIII I - N/A - 1% - 10% - 50% - I have not used this service - Yes, currently none because this service is no longer available - Older clients have not used my distance services - I have not personally subscribed to telehealth. Many of my clients receive their psychiatric care through telehealth, possibly 60% - Yes, we have telepsychiatry
10.		Is there anything you would like to say about your experience with telehealth? (Positive, negative, or recommendations you might have to improve its use). - N/A - No

11.	Lastly, if you could change one thing about mental health services and/or the accessibility to mental health services, what would it be and why? - Increased accessibility - Insurance coverage - Destigmatization - As a Licensed Marriage and Family Therapist with more diagnostic training than social workers, I feel that I am arbitrarily excluded from the network. So, many more older adults could be served. - That all their assets didn't get striped from them when they need to transition into more supportive living environments