Frontier and Rural Children's Mental Health Services: Identification of Strengths and Challenges in Western Kansas

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Background

The President's New Freedom Commission on Mental Health report[1] states that "rural issues are often misunderstood, minimized, and not considered when forming national mental health policy" (p. 50) and that "access to mental health care, attitudes toward mental illnesses, and cultural issues that influence whether people seek and receive care differ profoundly between rural and urban areas" (p. 51). While that report had a national focus, its issues are relevant at the state level.

In an effort to begin addressing these issues, the purpose of this report is to identify recommendations specific to child and adolescent mental health in frontier and rural western Kansas[2]. Information for this executive summary and the full report is based on the integration of multiple data sets collected and analyzed between the fall of 2006 and the summer of 2007. Data collection instruments included a resource family[3] survey, county-wide survey, stakeholder interviews, and secondary data analysis. While densely-settled rural counties have unique needs and are not to be overlooked, the goal for this study and report was to focus specifically on frontier and rural counties.

The methodology of this report was designed in consultation with the Frontier and Rural Committee of Mental Health Services for Children and Families.[4] The committee also provided ideas, information, and feedback for the report's recommendations. Funding for the data collection and report was provided through a contract with the Kansas Social and Rehabilitation Services – Division of Health Care Policy (SRS-HCP).

Overarching Recommendations

The key recommendations of this report include the following:

- ***Adopt a standard definition of "rural" that can be used across all state level systems***. Adequately and consistently defining frontier and rural counties as unique groups will help ensure that each group is included in decision making and funding decisions. It will also allow each group's differences and challenges to be considered so that expectations and policy requirements are appropriate to their geographic and cultural realities. Definitions provided in the Population Density Peer Group Map (see Appendix 1) are recommended as an accurate and meaningful description of the frontier to urban continuum.
- ***Develop a systemic process for the inclusion of both frontier and rural feedback.*** State-level policies and funding decisions can have unintended negative consequences if unique frontier and rural perspectives are not carefully considered

[1] President's New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America. Final Report* (DHHS Publication No. SMA-03-3832). Rockville, MD: U.S. Department of Health and Human Services.

[2] Frontier and rural are defined using the population density peer group continuum supported by the Frontier and Rural Committee of Mental Health Services for Children and Families. See Appendix 1 for the definition of all five peer groups. "Western Kansas" is defined as all counties from and including Barton County west to the Colorado border. This includes 46 of the 105 counties in Kansas.

[3] 'Resource families are also known as 'foster' families

[4] For more details on the development of this committee, study methodology, and results, please see the Frontier and Rural Children's Mental Health Services full report (available at http://www.socwel.ku.edu/occ/viewProject.asp?ID=45).

during the development and implementation stages. A system or process is needed that would accomplish the following:

  - Increase frontier and rural representation in state level policy, funding, legislative decision processes, and statewide committees and task forces.
  - Develop research and evaluation projects specifically focused on frontier and rural counties.

- ***Explore a process for frontier and rural system integration across educational, economic, mental health, and other important service areas***. These areas are interdependent; a holistic approach that considers each area's effect on the other areas is thus important. Mental health service needs in frontier and rural counties cannot be adequately addressed without considering other factors in the counties, such as depopulation, struggling businesses, and the needs and strengths of other community providers – including schools, health departments, other social services, and primary care providers.

Major Themes

The results from this report have been organized into five themes: 1) Access and Availability of Services in Frontier and Rural Counties; 2) Stigma; 3) Alcohol and Drug Abuse Prevalence and Services; 4) System Inclusion; and 5) Partnering and Collaboration. Below are a brief summary and specific recommendations for each theme. In order to ensure the relevance and effectiveness of the recommended activities, we encourage the state to continue consulting directly with professionals who have first-hand expertise and backgrounds in frontier and rural issues. The Frontier and Rural Committee of Mental Health Services for Children and Families has expressed a willingness and openness to assist with efforts in these areas.

1. Access and Availability of Services in Frontier and Rural Counties

Both travel distance and service availability emerged as factors that affect access to mental health services in frontier and rural counties. Transportation challenges, particularly with the rising price of gasoline, the need for more weekend and evening appointment times, staffing shortages, and difficulty recruiting providers were consistent concerns in the study data. Recommendations to improve access to and availability of mental health services for children and adolescents in frontier and rural counties include the following:

- ***Create funding formulas that provide frontier and rural differentials and account for the loss of productive staff time during travel periods***. There is a minimum cost to providing services, regardless of the total number of people served. Calculating costs based purely on the total number of people served does not adequately capture the true cost of providing services when the service population is spread over a large geographic area. Costs increase when additional technology (e.g., televideo and long distance telephone) must be added to provide a service.
- ***Address outstanding technological needs of frontier and rural counties***. This could include the following:

- Help to support the cost of telecommunications to provide services in frontier and rural areas.
- Identify outstanding technological needs of frontier and rural counties, including a compatible televideo option with a secure, universal line shared by various providers (e.g., judges, courts, SRS, Larned State Hospital, Child Welfare, Community Mental Health Centers [CMHCs], schools, primary health providers, etc.); reliable internet and cell phone coverage; and technical training and support for those who use the technology.

- ***Discuss with families and community members how to best provide information about services available in each county.*** This applies to mental health and to other health and social services. This would help increase knowledge of service availability and help identify service gaps.
- ***Utilize flexible and creative models that enhance the recruitment and retention of mental health providers in frontier and rural counties***. For example, encourage the use of psychiatric ARNPs and PAs for use in frontier and rural areas and supporting oversight that is appropriate and practical.

2. Stigma

Findings indicate that participants had concerns about mental health stigma. Ninety-three percent of those who participated in the county survey indicated that a parent in their county might not seek services because they would not want people to know their business. Concerns about privacy, confidentiality, and children being teased or labeled – along with the need to increase overall awareness of mental health issues – were identified by county survey participants and stakeholder interviewees. Research, education, and training are necessary to further understand and reduce stigmatized beliefs about mental health. Possible solutions include the following:

- ***Enhance current stigma education initiatives by creating a customized message to help increase understanding of mental health issues in frontier and rural counties***. SRS-HCP has agreed to provide resources from the statewide anti-stigma initiative for frontier and rural activities. We recommend that the state continue to reserve these funds while the Frontier and Rural Committee of Mental Health Services for Children and Families develops this information.
- ***Collect additional data from youth and adults in frontier and rural communities concerning attitudes about mental health issues and services***. The goal would be to 1) assess the current level of stigma; 2) gather more information about specific types of stigma; and 3) understand how stigma might affect behavior.
- ***Develop rural cultural competency training for professionals who work in or with frontier and rural communities.*** Cultural competency is not just specific to ethnic/racial or economic groups. There is a unique culture based on the frontier and rural experience that needs to be acknowledged. The goal is to promote understanding of frontier and rural culture and thereby shape appropriate strategies for delivering services.

3. Alcohol and Drug Abuse Prevalence and Services

Through open-ended questions from both surveys and stakeholder interviews, respondents shared their concerns about the prevalence of alcohol and drug abuse and the less than optimal availability of drug and alcohol services. It is noteworthy how frequently concerns about alcohol and drug abuse appeared, even though direct questions about this issue were not included in survey or structured interview items. Study participants appeared to see a relationship between substance abuse and mental health issues. Given this relationship, as well as research that demonstrates the pervasiveness of adolescent alcohol and drug abuse in rural communities,[5] we recommend investigation of this issue.

4. System Inclusion

Three topics related to system inclusion emerged from the data. First, there was a sense of disconnect between individuals in frontier and rural counties and state level decision/policy makers. Respondents reported that their needs are not understood by those in urban areas and that statewide policy decisions do not always translate well in frontier and rural counties. Specifically, ***only 2%*** of county-wide residents agreed that people in urban areas like Topeka or Kansas City understood their needs and issues. Second, a detailed and thorough definition of rural that is used consistently across systems is needed. When researchers analyzed data using the frontier through urban continuum supported by the Frontier and Rural Committee of Mental Health Services for Children and Families, important differences emerge. These differences suggest that frontier and rural counties are not the homogenous group they are assumed to be. In order for these portions of our state's population to be included and heard, they need to be defined as unique and relevant groups. Third, there is a need to be able to modify some state-level requirements to address frontier and rural realities. Statewide policies that are created for urban communities and then applied in frontier and rural counties create unintended challenges. Recommendations for this theme include the following:

- ***Adopt the definition proposed by the Frontier and Rural Committee of Mental Health Services for Children and Families that defines counties on a frontier through urban continuum***.[6] Both frontier and rural must be adequately defined if frontier and rural counties are to be included and have their voices heard. Ultimately, the goal is to adopt the use of this continuum not only throughout SRS but also across all state level systems. This is one of the key recommendations addressed on page 1 of this *Executive Summary*.
- ***Increase frontier and rural representation in state level policy, funding, legislative decision processes, and statewide committees and task forces.*** Frontier and Rural stakeholders should also be allowed to help select representatives who truly understand the realities of their areas.
- ***Recognize that frontier and rural areas differ in many ways from urban areas***. Decisions made for urban areas often create unintended negative challenges when

[5] Atav, S., & Spencer, G. (2002). Health Risk Behaviors among Adolescents Attending Rural, Suburban, and Urban Schools: A Comparative Study. *Family and community Health,* 25(2), 53-64.

[6] SRS-HCP utilized this definition in the recent FY2008-2010 Mental Health Block Grant. See Appendix 1 for definition details.

applied to frontier and rural counties. Therefore, policy and decision makers need to be well versed in specific frontier and rural needs and realities. Regular forums to engage frontier and rural residents are needed so residents know their voices are being heard and incorporated in decision making. Policy and decision makers need to experience frontier and rural realities by regularly visiting the various counties in western Kansas and by hearing the residents first hand. Additionally frontier and rural stakeholders need to be informed about the ways in which their needs and perspectives have been addressed.

- ***Identify the end goals that policies are designed to achieve and allow stakeholders flexibility in how those goals are met***. This approach would enable policies to be implemented in a practical and culturally sensitive manner.

5. Partnering and Collaboration

Partnering and collaboration are critical for meeting children's mental health needs. Stakeholders from the study reported a reliance on and commitment to working together. Barriers to partnering in frontier and rural counties include competition for a limited number of providers and the distance that providers cover, which makes informal meetings rare. Additionally, partnership meetings are typically not billable for time or travel. Stakeholders felt that it was critical to create an integrated system for children's services, particularly in frontier areas, which includes a method for covering the cost to do administrative and partnering work. Challenges are not exclusive to county-level partnering and collaboration; statewide challenges to partnering and enhancing networks also exist. Statewide meetings typically do not occur in western Kansas. The result is that frontier and rural stakeholders either miss these meetings and thus, the opportunity to connect with others, or they must incur significant time and financial cost to attend. Ideas to address these issues include the following:

- ***Address administrative costs for coordinating and collaborating within the individual frontier and rural counties***. This is a critical need in frontier and rural counties because of the limited number of staff and the distance they must travel to attend partnership meetings.
- ***Hold required meetings and trainings at multiple locations throughout the state***, including a location farther west than Hays or Great Bend.
- ***Consider funding demonstration projects in frontier and rural western Kansas counties.*** This funding could build on the knowledge base of what works in frontier and rural counties. One option would be to begin with the counties involved in the community readiness portion of this study.
- As stated earlier in this summary, ***help to support the cost of telecommunications*** necessary to provide services in frontier and rural areas.
- ***Create a coordinated state televideo system*** that would connect various stakeholders including judges, courts, SRS, Larned State Hospital, Child Welfare, and CMHCs.

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Frontier and Rural Children's Mental Health Services: Identification of Strengths and Challenges in Western Kansas

Introduction to Frontier and Rural

Unmet mental health service needs for rural geographic areas have been established as a national priority by the President's New Freedom Commission. The commission also recognized that certain needs are unique to rural areas. The commission's 2003 report states that **"**Access to mental health care, attitudes toward mental illnesses, and cultural issues that influence whether people seek and receive care differ profoundly between rural and urban areas" (p. 51). According to the commission, these differences include income disparities, fewer providers, less access to care, and stigmatized beliefs about mental health issues in rural areas. These issues have been documented previously in multiple studies. For a full review of the literature and a comprehensive summary of rural mental health issues, please see the Health Resource and Service Administration's *Mental Health and Rural America 1994-2005* report, which can be accessed online at ftp://ftp.hrsa.gov/ruralhealth/RuralMentalHealth.pdf

Challenges to mental health service delivery in frontier[1] and rural areas are also supported by state level data. Beginning in 2004, the University of Kansas School of Social Welfare (KU) began working with individuals in western Kansas on a subcommittee to a statewide group that focused on the mental health needs of the child welfare population. The subcommittee quickly realized that county-specific data from frontier and rural counties were lacking. Members of the subcommittee also knew that their challenges often differed from those faced by their urban counterparts. In the absence of data specific to frontier and rural communities in Kansas, KU and the subcommittee partnered to conduct data collection, to raise awareness, and to begin sketching the rural mental health service picture for western Kansas. Quantitative data on service issues – including estimated staff mileage rates, providers per square mile, and population comparisons – were collected and summarized for use in presentations. These data demonstrated a limited number of mental health service providers currently deliver services across a vast geographic area while facing staffing shortages, non-reimbursable travel time, and other resource challenges.

The work of the subcommittee eventually led to the creation of the Frontier and Rural Committee of Mental Health Services for Children and Families. In the summer of 2006, KU proposed that a part of the KU contract with the Kansas Social and Rehabilitation Services – Health Care Policy (SRS-HCP) be apportioned for work specific to frontier and rural youth in western Kansas. SRS-HCP approved this request, thus creating a full committee independent of any other group and expanding the focus beyond just the mental health needs of children in child welfare. This change has enabled continued community-based research and awareness initiatives developed by individuals with knowledge and expertise in frontier and rural issues.

[1] Frontier refers to counties with less than 6 persons per square mile, as defined by the Population Density Peer Group Categories (see Appendix 1). This is the definition that is utilized and supported by the Frontier and Rural Committee of Mental Health Services for Children and Families and has recently been used by SRS-HCP in the Mental Health Block Grant FY2008-2010.

Both the national priority for improving rural mental health service delivery (e.g., Rural Subcommittee of the President's New Freedom Commission) and descriptive quantitative Kansas data for mental health services have provided the groundwork for further investigation. In 2006-2007, KU worked with the Frontier and Rural Committee of Mental Health Services for Children and Families to design and conduct this study which collected data directly from stakeholders in frontier and rural western Kansas. The overall goal was to better understand children's mental health service issues in frontier and rural western Kansas and to recommend solutions that are relevant to this portion of the state.

Through surveys, interviews, and meetings with stakeholders, we found that the unique challenges faced by frontier and rural counties have a significant impact on these communities. Distance to services certainly affects the ability of parents, caretakers, and resource[2] parents to readily access services for children with mental health needs. Great distances also hamper the ability of mental health professionals to deliver needed services to children and families. In frontier and rural western Kansas, efficient service delivery and economies of scale are offset by allocating theses services across a vast geographical area. Study participants also voiced concerns about provider and staffing shortages and increased needs for specialty care in frontier and rural counties. Additional issues emerged, including privacy concerns, stigma surrounding mental health issues, and the need for increased education and awareness regarding these issues. There was also strong indication of a significant disconnect between the needs of frontier and rural residents and state level policy and decision making.

In the midst of these challenges, remarkable strengths exist, including a commitment to collaboration and partnering, creativity and unique solutions, and the resilience and interdependence of providers, families, and residents of frontier and rural Kansas. The Frontier and Rural Committee of Mental Health Services for Children and Families is encouraged by increased opportunities to share information and feedback on service needs. This study identifies recommendations and potential solutions based on direct feedback from frontier and rural Kansans. These strengths will no doubt provide a firm foundation for the development of solutions to improve mental health service delivery for children and families in frontier and rural Kansas.

Methodology

This report is based on multiple data sources collected and analyzed between the fall of 2006 and summer of 2007. Specific methodology for each data collection effort is described below. The results from each data set were integrated to provide a fuller picture of the mental health service needs for children and adolescents in frontier and rural counties.

Population Density Definitions

All study activities defined frontier and rural using the population density peer group continuum from frontier to urban, which is the definition supported by the Frontier and Rural Committee of Mental Health Services for Children and Families. While densely-settled rural counties have unique needs and are not to be overlooked, the goal for this

[2] Also known as foster parents.

study and report was to focus specifically on frontier and rural counties. The definition makes the following classifications:

- Frontier = less than 6 persons per square mile.
- Rural = 6 to 19.9 persons per square mile.
- Densely-settled rural = 20 to 39.9 persons per square mile.
- Semi-urban = 40 to 149.9 persons per square mile.
- Urban = 150+ persons per square mile.

For more details, see Appendix 1.

Written Surveys

Survey Design: In collaboration with the Frontier and Rural Committee of Mental Health Services for Children and Families, the KU School of Social Welfare distributed written surveys to participants in frontier and rural counties in the western half of the state.[3] The survey was designed to measure a variety of factors related to mental health services for 5-17 year old youth living in the western half of the state including the following:

- The perceptions of frontier and rural respondents regarding state level value of their voices.
- The extent that stigma is an issue in frontier and rural communities and how it might affect families with children in need of mental health services.
- The extent to which distance and travel is an issue in obtaining mental health services.
- How parents, guardians, and resource families locate and access mental health services.

The survey was conducted with two samples. First, a resource family survey was conducted. This was followed by the survey of a broader and randomly selected group of residents in frontier and rural western Kansas. Similar instruments (Appendixes 2 and 3) were used for both groups with minor modifications in wording. The surveys were distributed and returned by mail. Prior to distributing the surveys, a pilot survey was conducted with resource parents living in densely-settled rural counties in western Kansas. Modifications were made based on the feedback received.

Resource Family Sample: The first group to be surveyed involved western Kansas individuals identified by several of the state contracted child welfare providers as being current resource/foster parents at a point in time in late 2006/early 2007. Due to the relatively small number of individuals identified, all identified individuals received a survey. In order to increase participation, a letter of support from the child welfare provider agency was included with each survey, along with a small thank you item. Of the 151 families to receive the written survey, 53 responded, for a 35% response rate. Of the 53 resource family respondents, approximately 43% were from rural counties, and 57% were from frontier counties.

County Sample: In order to expand our understanding of children's mental health service needs, a second survey was conducted in May 2007 with a countywide random sample of

[3] "Western Kansas" is defined as all counties from and including Barton County west to the Colorado border. This includes 46 of the 105 counties in Kansas.

1,370 western Kansas residents from eight counties. The counties were identified through consultation with the Frontier and Rural Committee of Mental Health Services for Children and Families and included five frontier and three rural counties, with representation from all five Community Mental Health Center catchment areas. Participants were informed that the survey was intended to collect countywide feedback on children's mental health services, and they were invited to participate even if they were not a parent or currently caring for a child between the ages of 5-17. Individuals who participated were given a $10 retail store gift card as a thank you for the time they spent completing the survey.

After the initial distribution, 103 surveys were returned with unknown addresses, resulting in an adjusted sample size of 1,267. The total number of respondents was 320, or 25% of the adjusted sample.

- Almost two-thirds (63%) of the survey respondents were from rural counties, while 37% percent represented frontier counties.
- One hundred and three respondents (approximately 32%) identified themselves as parents or primary caretakers for children under the age of 18.
    - Approximately 15% of the parent and caretaker subgroup reported that they had accessed mental health services for their children within the previous 6 months.

Stakeholder Interviews and Community Feedback

In the fall/winter of 2006, the University of Kansas School of Social Welfare (KU) conducted telephone interviews with selected key stakeholders in one rural county and three frontier counties in western Kansas using the Community Readiness structured interview developed by Colorado State University's Tri Ethnic Center. The counties were selected for participation by the Frontier and Rural Committee of Mental Health Services for Children and Families. The committee chose counties that would include different Community Mental Health Centers (CMHCs) and different parts of the western half of the state. The purpose was to collect information on mental health services in the county for 5-17 year olds. Mental health support and services were defined as services and supports for emotional and behavioral problems provided not only at the mental health center, but also through schools, hospitals, private counselors, churches, and natural resources.

We conducted 26 telephone interviews with community participants who were selected by each county's Community Mental Health Center. Two raters from KU independently analyzed the interview responses and generated scores for six dimensions. These scores were based on nine-point scales established in the Community Readiness model and represented a continuum of readiness for each dimension. While certain questions had a direct relationship to specific dimensions, responses from the entire interview were examined for each dimension. Individual scores were combined and averaged to arrive at an aggregate score for each dimension. Next, the aggregate dimension scores were averaged to arrive at an overall community readiness score.

Summary information for each county was shared with its CMHC representative. Following the review of that information, KU asked each of the four CMHCs to convene

a group of stakeholders in each county in August 2007. One of the four counties originally selected could not participate due to the mental health center assisting with recovery efforts from a natural disaster in the area. Individuals involved in the telephone interviews as well as other stakeholders were invited to the stakeholder meeting. The initial goal of the meetings was a member check to share the summarized results of the telephone interviews and the subsequent community readiness score with stakeholders. The meetings were also intended to identify potential next steps based on the information. However, during the time between the telephone interviews and community feedback meeting, the Kansas state plan for Medicaid underwent significant changes, moving to a managed care system. As a result, some of the detailed data collected through the telephone interviews were no longer accurate. Therefore, KU staff provided the overall community readiness county score but not the individual scores for each dimension. Instead, the dimensions were rank-ordered so that participants could see which dimensions might be stronger than others and thus, where the initial focus for change could be. This process allowed stakeholders to comment on how statewide changes may have affected the scoring and prevented researchers from having to conduct the telephone interviews again. See Appendix 4 for results.

Mental Health and Child Welfare Secondary Analysis

Population Studied: The University of Kansas School of Social Welfare (KU) analyzed secondary data on the mental health service usage of children in foster care. The specific goal was to provide a picture of mental health involvement for children in the state's care, particularly for those children living in frontier and rural Kansas communities. Subjects included children who were removed from their home and in foster care between July 2003 and June 2006. Secondary data obtained from the state for this group of children was matched against three other secondary data sets with mental health information to identify which of these children had received mental health services. Data for this subset of children, with particular interest for those children living in frontier or rural counties throughout the state,[4] were analyzed to identify the rate of mental health services involvement.

Secondary Data Sets: Subjects were identified by merging four data sets obtained from the Kansas Department of Social and Rehabilitation Services. First, a data set was obtained from SRS-Child and Family Services containing child welfare information on children in foster care. Second, SRS-Health Care Policy supplied data on mental health services and chronicity of need maintained by Kansas Community Mental Health Centers. Third, Medicaid data were obtained on mental health services provided to this population. Fourth, data were acquired for mental health services provided through child welfare providers. The four data sets were merged to identify which children under age 17 in foster care received mental health services; the total sample included 8,016 removal episodes. Subgroups were identified by factors such as removal reason and area of the state. See Appendix 5 for results.

[4] This data set includes all Kansas counties – therefore, frontier and rural are not exclusive to just western Kansas.

Results and Recommendations

The following results are based on the integration of multiple data sets described above. Data collection instruments were developed in consultation with the Frontier and Rural Committee of Mental Health Services for Children and Families and were designed to be culturally sensitive and to collect data specifically from frontier and rural counties. Frontier and rural were defined using the definition supported by the Frontier and Rural Committee of Mental Health Services for Children and Families (see Appendix 1). The committee also provided information, suggestions, and feedback for the recommendations. The results have been organized by five themes. They are, in no particular order:

1. Access and Availability of Services in Frontier and Rural Counties
2. Stigma
3. Alcohol and Drug Abuse Prevalence and Services
4. System Inclusion
5. Partnering and Collaboration

Each will be discussed below and will contain summary information as well as recommendations.

1. Access and Availability of Services in Frontier and Rural Counties

Summary

Research has demonstrated that the size of a community and its adjacency to metropolitan communities can influence the rate of treatment in rural areas. Residents of metropolitan areas are 47% more likely to access mental health services than rural residents (Hauenstein et al., 2007, p. 255). In June 2004, the Rural Subcommittee of the President's New Freedom Commission reported on the unique challenges that rural persons with mental illness face as they seek mental health care services. Two major themes to emerge from this report were the "accessibility" and "availability" of these services. According to the subcommittee, both access to and availability of services are limited in rural geographic areas due to factors such as scarce resources, a shortage of providers, and transportation costs. Similar themes emerged from the data collected for this report. Specifically, distance to services, the need for additional weekend and evening appointment times, and a lack of available providers were common concerns for resource families, residents, and stakeholders in Kansas frontier and rural counties.

Distance to Services

Community Readiness Stakeholder Interviews consistently identified distance to resources and transportation challenges as problems, particularly with the rising price of gasoline. These concerns were also reflected in both surveys. A number of respondents from the Resource Family Survey identified transportation and distance to services as an important issue for children's mental health in their county. When resource parents were asked about accessing services for children or adolescents in foster care,

- Approximately 67% said they would need to travel 20 miles or more to get to the person they would contact first if their child in foster care needed mental health services.
- Nearly half (49%) indicated they would be willing to take their children in foster care to the Community Mental Health Center but said that they do not have one in their county.
- Nearly 60% indicated that distance to mental health services is a problem, and 66% said they would want services as close to home as possible.
- While a large number of respondents reported less than a 15 minute drive to reach a school counselor or faith-based provider for mental health services, a majority of respondents stated they would need to go outside the county for nearly all other mental health services listed.

County Survey respondents also identified as an important issue for children's mental health in their county the need for local access to services for children and adolescents. When the parent and caretaker subgroup of the County Survey was asked about accessing mental health services for their children,

- Nearly half (45%) of the parent and caretaker respondents indicated that distance to mental health services was a problem at some level, and a similar percentage said they would want to get services as close to home as possible.
- While over half of the parent and caretaker group indicated they could drive less than 15 minutes within their county to access school (72.5%) or faith-based counseling (56.0%), the majority did not know how far they would need to drive for all other services listed or indicated they would have to obtain those services outside the county.

Service Availability

According to the Rural Healthy People 2010 report, there is evidence of an inadequate pool of mental health professionals in rural areas (Gamm, Stone, & Pittman, 2003, p. 101). Studies have shown that communities in rural geographic areas face significant challenges in recruiting professionals to create and sustain a sufficient healthcare workforce (Daniels, VanLeit, Skipper, Sanders, & Rhyne, 2007). Indeed, limited scheduling and staffing availability was a frequently cited concern in the data collected for this report. Stakeholders involved in the community readiness interviews noted staffing barriers, including difficulty attracting and retaining staff in the western half of the state, difficulty paying adequate salaries to retain staff, and competition among providers for the limited number of staff who are available.

Common service needs in the county identified by both resource parents and county survey respondents included expanded hours (e.g., weekend, evening, and afternoon hours) and more local providers and service choices. Similar concerns for service availability were reflected in the community readiness interviews and meetings, in which several stakeholders shared needs for more local services available on more days and for additional mental health staffing and service time slots. Although televideo is one option for addressing unmet needs, not all televideo systems are compatible. Additionally not all service providers have sufficient support to know how to use the technology and know whom they can contact for mental health or physical health services through televideo.

Providers also reported limitations in cell phone coverage, which is essential due to the amount of time they spend driving. They also said internet capabilities were limited. One area only had access to wireless services, which was not always reliable; there is no DSL or dial-up connection available in that town.

Overall, there was a reported need to raise awareness as to the services that are available. This information was not limited to just those services through the mental health center. Stakeholders in the community readiness interviews and the follow-up meetings referenced a need to have more information about services available both within and outside the county. In some areas it was felt that it was not clear what services were available, particularly for families that were not already connected with services or for those that were new to the community. Others expanded on this by saying that information was needed about who to contact to access services and what the eligibility requirements were.

Recommendations

First, based on the findings above, we recommend developing funding formulas that consider the cost of accessing services based on the distance in miles and the number of hours spent in travel. As an example, the Frontier and Rural Committee of Mental Health Services for Children and Families suggested that community based services be supported by the state on a tiered level based on the distance from the largest population center. Changing reimbursement in this way would compensate for transportation costs and loss of productive staff time during traveling.
There is a minimum cost to providing services, regardless of the total number of people served. Calculating costs based purely on the total number served does not adequately capture the true cost of providing services when the service population is spread over a large geographic area. Costs increase when additional technology (e.g., televideo and long distance telephone) must be added to provide a service.

Secondly, the use of technology to bridge distances should be encouraged and could include the following:

- Help support the cost of telecommunications to provide services in frontier and rural areas.
- Identify outstanding technological needs of frontier and rural counties, including a compatible televideo option with a secure, universal line shared by various providers (e.g., judges, courts, SRS, Larned State Hospital, Child Welfare, CMHCs, schools, primary health providers, etc.); reliable internet and cell phone coverage; and technical training and support for those who use the technology.

Third, discuss with families and community members how to best share information about services available in each county. This applies to mental health and to other health and social services. This would help increase knowledge of service availability and help identify service gaps.

Finally, frontier and rural counties need to have flexibility to adapt policy and procedure requirements to enhance and address recruitment and retention of providers and efficient use of current staff. Flexibility could be enhanced in the following ways:

- Explore realistic models for addressing crisis services in frontier and rural counties. Models that work in larger populated areas often do not work in frontier and rural areas where travel is a challenge and crisis staff are at a premium.
- Create legislation to allow CMHCs in medically underserved areas to employ physicians with limited licenses.
- Encourage the use of psychiatric ARNPs and PAs for use in frontier and rural areas and support oversight that is appropriate and practical. Also, nursing programs could be encouraged to add psychiatric ARNP programs in western Kansas.
- Explore the use of financial incentives (loan forgiveness, salary differentials, etc.) when recruiting mental health professionals, including psychiatrists, to frontier and rural counties.

2. Stigma

Summary

The second theme identified through the study data is in the area of stigma. This topic has emerged in national data as well. The Rural Subcommittee of the President's New Freedom Commission highlighted stigma through its theme of "acceptability" which includes rural attitudes about mental health issues. In 2004, that subcommittee reported that stigma is a significant barrier to rural residents receiving mental health services. The report proposed that limited knowledge of available resources and negative attitudes about accessing mental health services may decrease help-seeking behaviors among rural residents. In the current study of Kansas Frontier and Rural Mental Health, we began to assess the influence of stigma through survey questions and feedback from interviews. While stigma did emerge as a potential concern for frontier and rural counties, results varied according to respondent group.

Interestingly, responses from resource parents did not identify stigma as a significant factor affecting their decisions to access mental health services in their counties. When asked about concerns that might prevent them from obtaining mental health services for their children or adolescents in foster care, the possible effects of stigma emerged in the following ways:

- Approximately 20% of resource parents reported that they might not seek help because they wouldn't want their foster child to be labeled.
- Seventeen percent might be prevented from seeking services because their foster child would be afraid of being teased.
- Only 9% indicated that they might not seek services because they would not want people to know their business, would be afraid of their foster child getting teased, or would not want people to think badly of their foster child.

Although these responses indicate some stigma-related patterns, resource parents most frequently cited concerns about services being too far away (32.1%) and services not being available at a convenient time (26.4%). These findings demonstrate that access and availability may be bigger barriers to help-seeking for resource parents than stigma.

In fact, responses to several questions from the Resource Family Survey appeared to reflect the idea that resource parents receive a great deal of support and help addressing the mental health needs of children in foster care. When asked if they thought it was okay to get mental health services for a child in foster care, over 90% of the resource parent respondents said that it was okay.

A majority also indicated the following:

- Resource/foster parents receive support and understanding from others in the county when their foster child needs mental health services (64.2%)
- Children in foster care who receive mental health services are accepted by their peers (69.3%) and can lead healthy lives (94.2%)
- It is easy for resource/foster parents to ask for help if their children or adolescent in foster care experience emotional or behavioral problems (72.5%)
- Ensuring that children and adolescents in foster care receive the mental health services they need is important to them (98.2%) and others living in their county (75.5%).

While these results are encouraging, conducting the survey with non-resource parents allowed us to assess the effects stigma may have with a broader base of residents in frontier and rural counties. What we found supports previous research demonstrating that perceived stigma about mental health services within a community can negatively influence help-seeking behavior (Wrigley, Jackson, Judd, & Komiti, 2005).

Almost all (98%) of the county-wide respondents agree that it is okay to get mental health services for a child and that children with mental health needs can live healthy lives (94%). Nevertheless, stigma-related concerns that might keep families from seeking mental health services were frequently identified.

- Ninety-three percent of the county survey participants indicated that a parent in their county might not seek services because they would not want people to know their business.
- A majority of respondents also indicated that parents might be prevented from seeking services because of concerns about their child being teased (70.8%), labeled (85%), or because people might think badly about their child (69%).

When participants were asked to identify the most important issue for children's mental health in their county, several identified stigma-related issues. Concerns about privacy, confidentiality, and being labeled or teased for seeking services were expressed by respondents. Comments also included a need for increased acceptance of children's mental health issues in the community and the need to improve overall awareness of mental health issues.

In fact, when County Survey participants were asked about their county's service needs, a common response was "I don't know." This response also frequently appeared in the Resource Family Survey, indicating a clear need to increase knowledge of mental health issues and resources in the county.

Stigma was also identified through community readiness interviews and stakeholder meetings. Participants talked about embarrassment associated with asking for and receiving help and negative attitudes about mental health. County stakeholders

acknowledged efforts to increase awareness, and identified the continued need for education and stigma reduction for children's mental health issues and services.

Recommendations

Potential solutions for addressing the issue of stigma involve additional research, training, and awareness efforts. These could include the following:

- Enhance current stigma education initiatives by creating a customized message to help increase understanding of mental health issues in frontier and rural counties. This could be accomplished through the development of anti-stigma campaign advertisements using people, images, and messages that frontier and rural residents could relate to. Representatives from various frontier and rural communities will need to be involved in the development of the messages and activities, which will take time. SRS-HCP has agreed to provide resources from its statewide anti-stigma initiative for frontier and rural activities. We recommend that the state continue to reserve these funds while the Frontier and Rural Committee of Mental Health Services for Children and Families further develops this information.
- Collect additional data from youth and adults in frontier and rural communities concerning attitudes about mental health issues and services. The goal would be to 1) assess the current level of stigma; 2) gather more information about specific types of stigma; and 3) understand how stigma might affect behavior.
- Develop rural cultural competency training for professionals who work in or with frontier and rural communities. Cultural competency is not just specific to ethnic/racial or economic groups. There is a unique culture based on the frontier and rural experience that needs to be acknowledged. Including rural issues in cultural competency training is a direction supported by the Rural Subcommittee of the President's New Freedom Commission. The subcommittee's 2004 report emphasizes that cultural competency training helps providers understand cultural attitudes surrounding mental health. Training thereby shapes appropriate strategies for delivering services. Cultural competency training would facilitate trust between providers and those in need of mental health services. Hopefully, it would result in increased help-seeking behavior (p. 13).

3. Alcohol and Drug Abuse Prevalence and Services

Summary

Data from the 2005 National Survey on Drug Use and Health indicate a relationship between the use of illicit drugs, alcohol abuse, and major depressive disorder (SAMHSA, 2006). Adolescent substance abuse has also been linked with low academic performance and problems with social interactions (Maine Rural Health Research Center, 2007).
A 2002 study on adolescent health risk behaviors found that rural adolescents are more than twice as likely to use drugs other than alcohol or tobacco as their suburban or urban peers. Results from the same study demonstrated a consistent pattern of higher risk behaviors, including alcohol, tobacco, and other drug use, for rural adolescents (Atav & Spencer, 2002, p. 63).

Concerns about alcohol and drug abuse within the counties were repeatedly reported in open-ended responses from the surveys. These concerns also appeared in stakeholder interviews**.** Alcohol and drug abuse counseling was a frequently identified service need; it was often named as one of the most important issues for children's mental health in both the resource family survey and county survey. Feedback from community readiness interviews and stakeholder meetings also included comments about the prevalence and availability of drugs in the community and the need for alcohol and drug abuse education and services.

Interestingly, concerns about drug and alcohol abuse frequently appeared across all data collection methodologies even though the survey instruments and structured interview contained no direct questions about this issue. Respondents seemed to connect substance abuse issues with children's mental health issues in their counties.

Recommendations

As highlighted above, there is a well established connection in the literature among substance abuse, mental health, and risk factors. Concerns about substance abuse recurred throughout data collected for this report. We recommend investigating the relationship between substance abuse and mental health issues for children and adolescents in frontier and rural Kansas counties to assess the prevalence of substance abuse and its potential emotional and behavioral effects.

4. System Inclusion

Summary

Three topics related to system inclusion emerged from the data. First, there was a sense of disconnect between individuals in frontier and rural counties and state level decision/policy makers. Respondents reported that their needs are not understood by those in urban areas and that statewide policy decisions do not always translate well in frontier and rural counties. Second, a detailed and thorough definition of rural that is used consistently across systems is needed. Using a common definition will help ensure that frontier and rural perspectives are included. It will also highlight differences that exist among the various peer groups. Third, there is a need to be able to modify some state-level requirements to address frontier and rural realities. Each of these areas will be discussed separately.

Disconnect Between Frontier and Rural Residents and Policy/Decision Makers

Survey data from both resource parents and countywide respondents reflected a feeling that the needs and issues of frontier and rural residents are not understood. Specifically, as shown in Table 1, only 2% of countywide residents agreed that people in urban areas like Topeka or Kansas City understood their needs and issues. Only one in three (33%) countywide respondents agreed that state level policy makers listen to people in their county (Table 2). As seen in Table 3, only 43% agreed that people in their county have a voice in state level policy decisions (Complete results are in Appendixes 2 and 3.)

Table 1: People in urban areas such as Topeka or Kansas City understand our needs and issues.

	Agree or Strongly Agree (%)	Disagree or Strongly Disagree (%)	Don't Know (%)
Countywide	2.2	89.3	8.5
Resource parents	7.6	83.0	9.4

Table 2: State level policy makers listen to people in our county.

	Agree or Strongly Agree (%)	Disagree or Strongly Disagree (%)	Don't Know (%)
Countywide	33.3	51.7	15.0
Resource parents	38.7	44.9	16.3

Table 3: The people in our county have a voice in state level policy decisions affecting our county.

	Agree or Strongly Agree (%)	Disagree or Strongly Disagree (%)	Don't Know (%)
Countywide	42.8	47.3	9.9
Resource parents	50.0	36.6	13.5

A parallel issue appears to be a lack of clarity as to leaders' positions or commitment to children's mental health in frontier and rural counties. As seen in Table 4 below, 98% of respondents said that it is important to them to ensure that children and adolescents receive needed mental health services. Furthermore, 73% agree that it is important to others living in their county. However, only 44% agree that this issue is important to state level policy makers. Although countywide respondents' totals were reported below, resource parents' responses were quite similar.

Table 4: Countywide Survey Data

	Agree or Strongly Agree (%)	Disagree or Strongly Disagree (%)	Don't Know (%)
Ensuring that children and adolescents in foster care receive the mental health services they need is very important to me.	97.8	0.6	1.6
Ensuring that children and adolescents in foster care receive the mental health services they need is important to others living in our county.	73.4	9.5	17.1
Ensuring that children and adolescents in foster care receive the mental health services they need is important to state level policy makers.	43.7	25.5	30.8

Rural Definition

A barrier to policy making and service delivery in frontier and rural areas is the lack of a sensitive and adequate definition of rural that is consistently used across the state. Data collected for this report indicate that critical differences exist between counties that would all be defined as "rural" under more commonly used dichotomous definitions (e.g., urban or rural.) When researchers analyzed data using the frontier through urban continuum (see Appendix 1), important differences emerge, demonstrating that frontier and rural communities are not the homogenous group they are often assumed to be. Adequately and consistently defining frontier and rural counties as unique groups will help to ensure that they are each included in decision making and funding decisions. Sensitive definitions will also allow peer density differences and challenges to be addressed so that expectations and policy requirements are practical and appropriate to particular geographic and cultural realities.

To illustrate the group differences, data from the Mental Health – Child Welfare Secondary Analysis[5] were analyzed across the frontier through urban continuum. These data provide several examples of the need for an accurate definition of rural and for the inclusion of 'frontier' demographic groups. Important differences are identified when frontier and rural groups are separated out.

1. Table 5 shows that mental health involvement varied by population density and gender. Statewide, we found that 55% of females placed in foster care had mental health involvement while in care. However as shown below, this jumps to 61% in frontier areas. In rural areas, the percentage of females placed in foster care who had mental health involvement rose to 69%.

Table 5: Gender and Mental Health Involvement by Peer Density Group

	Female (%)		Male (%)	
	Mental Health Involvement	No Mental Health Involvement	Mental Health Involvement	No Mental Health Involvement
Frontier	60.7	39.3	55.1	44.9
Rural	68.5	31.5	59.4	40.6
Densely-Settled Rural	59.7	40.3	55.9	44.1
Semi-Urban	54.2	45.8	56.1	43.9
Urban	51.3	48.7	50.4	49.6
Statewide	55.4	44.6	53.5	46.5

2. Just as the gender of children in mental health services varies by peer density group, we also saw peer density group differences among mental health involvement and the reason for removal from the home. For example, combining frontier and rural counties together misses the important variation that exists

[5] For this analysis, we placed the child in the population density group based on the county from which he/she was removed, not the county of the foster home. Additionally, this data set includes all frontier counties and all rural counties, not just those in western Kansas (complete results are in Appendix 5.)

between the number of children removed for reasons of abuse/neglect who have mental health involvement while in care. When frontier and rural counties are combined, 57% of children removed for abuse or neglect had mental health involvement (Table 6). However, when frontier and rural counties were separated, only 48% of children removed for abuse and neglect from frontier counties had mental health involvement, compared to 61% removed from rural counties.

Table 6: Reason for Removal and Mental Health Involvement by Peer Density Group

	Removed for Reasons of Abuse or Neglect (%)		Removed for Non-Abuse/Neglect (NAN) (%)	
	Mental Health Involvement	No Mental Health Involvement	Mental Health Involvement	No Mental Health Involvement
Frontier	48.1	51.9	75.3	24.7
Rural	60.6	39.4	69.3	30.7
Frontier and Rural Combined	56.5	43.5	70.7	29.3

Flexibility for Implementation

While the data collected from the community readiness portion of the study provided a picture of the similarities between frontier and rural counties, it also highlighted their differences. These differences were seen in the resources and strengths that stakeholders identified, the different stakeholders involved from their communities, and the challenges they face in providing mental health services. Each community works differently, based on its community and county structure, the number of resources that can be accessed within the county, and the overall culture of the county. Statewide policies that are created for urban communities and then applied in frontier and rural counties create unintended challenges for these communities. Some of the challenges can be addressed through creative partnering; others are more difficult to solve.

For example, current policies that require mental health crisis response within one hour are not always realistic when the responder is covering multiple counties and is functioning in a generalist capacity. There is also a requirement that some emergency room mental health screens be completed within one hour. This policy requires having staff available who are less than one hour away from the screen that needs to be completed. This is quite difficult in areas where there are significant staffing shortages. Another recent policy change has affected the role of case managers and has had noteworthy consequences in frontier counties. Previously one case manager was allowed to provide and bill for both Community Psychiatric Support and Treatment (CPST) and Targeted Case Management (TCM) services. Recent policy changes require both a CPST case manager and a TCM case manager because one person cannot bill both codes. It is challenging for agencies in frontier settings to determine how to divide tasks among a limited number of staff who must cover a large geographic area. Policies such as these require more human and financial resources in areas facing significant staffing disadvantages.

Even when solutions are found for a frontier county, it cannot be assumed that the model will work in other frontier counties. For example, one community created and implemented an effective method for serving children with mental health needs. As they thought about sharing the model with others, they realized that the model worked for them because it was based on the specific needs of their community. It also was based on utilizing individuals who had been in the community for decades. These individuals were known, respected, and trusted. Transferring this same model to another frontier community might not show the same success.

Recommendations

- Adopt the definition proposed by the Frontier and Rural Committee of Mental Health Services for Children and Families, which defines counties on a frontier through urban continuum (see Appendix 1). SRS – Health Care Policy has begun this work by incorporating the continuum definition that the Frontier and Rural Committee of Mental Health Services for Children and Families supports in the State of Kansas FY2008-2010 Mental Health Block Grant. Ultimately, the goal is to adopt the use of this continuum not only throughout SRS but also across all state level systems.
- Increase frontier and rural representation in state level policy, funding, legislative decision processes, and statewide committees and task forces. Frontier and Rural stakeholders should also be allowed to help select representatives who truly understand the realities of their areas.
- Recognize that frontier and rural areas differ from urban areas in many ways. Decisions made for urban areas often create negative unintended challenges when applied to frontier and rural counties. Therefore, policy and decision makers need to be well versed in specific frontier and rural needs and realities. Regular forums to engage frontier and rural residents are needed so residents know their voices are being heard and incorporated in decision making. Policy and decision makers need to experience frontier and rural realities by regularly visiting the various counties in western Kansas and by hearing the residents first hand. Additionally frontier and rural stakeholders need to be informed about the ways in which their needs and perspectives have been addressed.
- Identify the end goals that policies are designed to achieve and allow stakeholders flexibility in how those goals are met.

5. Partnering and Collaboration

Summary

Partnering and collaboration are critical for meeting children's mental health needs. Noting that this was not limited to mental health, providers discussed the generalist nature of their work due to the limited pool from which they can hire and the limited funds available to them because of smaller population numbers. Stakeholders in frontier and rural areas reported a reliance on and commitment to working together to meet the needs in their communities. This is not to say that competition for a limited number of providers does not exist, nor is it to say that enhanced partnering cannot occur. It is to

underline the foundation for partnering that already exists and to acknowledge that this partnering is highly valued.

Survey results show that working together in frontier and rural areas is essential.

- When countywide respondents were asked how a person living in their county would go about finding mental health services for a child or adolescent ages 5-17 years, 89% reported that they would ask their medical doctor and 71% said they would ask someone at the child's school.
- The community readiness data emphasized the importance of partnering with schools as a way to meet the mental health needs of children. Schools serve as referral sources to other providers; they provide information and in some cases, mental health services to families and children; and they serve as a convenient location for other providers to deliver mental health services.

Despite the strong commitment to partnering, some barriers to collaboration do exist. First, stakeholders in frontier and rural counties may see other stakeholders or clients in their immediate town or community. However, due to the large geographic area they cover, the time it takes to drive, and the limited number of services that are in each frontier county, stakeholders typically do not see each other in other meetings the way that stakeholders in urban areas might. Therefore, stakeholders in frontier and rural counties must make concerted efforts to meet for planning, partnering, and/or collaboration. They must travel a considerable distance for these meetings. Additionally, many statewide meetings, particularly those that deal with policy, are most often held in Topeka. While efforts have been made to locate training meetings in multiple sites throughout the state, most meetings do not occur farther west than Great Bend or Hays, which is still a 2 ¼ to 3 hour drive from some of the larger towns in western Kansas.

Second, although critical to meeting the needs of children and families, partnership meetings are typically not billable for time or travel. Stakeholders at some of the data collection meetings for this study found themselves sharing information with each other about resources that were available and new ways in which they could partner. Face-to-face meetings seem to encourage this type of communication. Stakeholders felt that it was critical to create an integrated system for children's services, particularly in frontier areas, which includes a method for covering the cost to do this administrative and partnering work.

<u>Recommendations</u>

- Address administrative costs for coordinating and collaborating within the individual frontier and rural counties. This is a critical need in frontier and rural counties because of the limited number of staff and the distance required to attend partnership meetings.
- Hold required meetings and trainings at multiple locations throughout the state, including a location farther west than Hays or Great Bend.
- Considering funding demonstration projects in frontier and rural western Kansas counties. This funding could build on the knowledge base of what works in frontier and rural counties. One option would be to begin with the counties involved in the community readiness portion of this study.

- As stated earlier in this report, help support the cost of telecommunications necessary to provide services in frontier and rural areas.
- Create a coordinated state televideo system that would connect various stakeholders including judges, courts, SRS, Larned State Hospital, Child Welfare, and CMHCs.

Overarching Recommendations

Each of sections above contains specific recommendations for the five themes that emerged from the data collected for this report. Overarching recommendations that connect these themes include the need for the following:

- Adopt a standard definition for defining "rural" that can be used across all state level systems. Definitions provided in the Population Density Peer Group Map (see Appendix 1) are recommended as an accurate and meaningful description of the frontier to urban continuum. This definition was originally created by and is in use in the Kansas Department of Health and Environment. Kansas Social and Rehabilitation Services[6] – Health Care Policy has also incorporated this definition in the Mental Health Block Grant FY2008-2010. Use of this definition throughout SRS and ultimately across and throughout other state systems will help ensure meaningful inclusion of these diverse groups in policy and funding.
- Develop a systemic process for the inclusion of both frontier and rural feedback. State-level policies and funding decisions can have negative unintended consequences if the unique frontier and rural perspectives are not carefully considered during the development and implementation stages. A system or process is needed that would accomplish the following:
    - Increase frontier and rural representation in state level policy, funding, legislative decision processes, and statewide committees and task forces.
    - Develop research and evaluation projects specifically focused on frontier and rural counties.
- Explore a process for frontier and rural system integration across educational, economic, mental health, and other important service areas that considers their effect on one another. These areas are interdependent; a holistic approach that considers their effect on one another is thus required. Mental health service needs in frontier and rural counties cannot be adequately addressed without considering other factors in the counties, such as depopulation, struggling businesses, and the needs and strengths of other community providers – including the schools, health departments, other social services, and primary care providers.

In order to ensure the relevance and effectiveness of these educational, research, policy, and professional development activities, the state should continue to consult directly with professionals who have expertise and backgrounds in frontier and rural areas. The Frontier and Rural Committee of Mental Health Services for Children and Families has expressed a willingness and openness to assist with efforts in these areas.

[6] SRS is the equivalent of what is often called Department of Human Services in other states.

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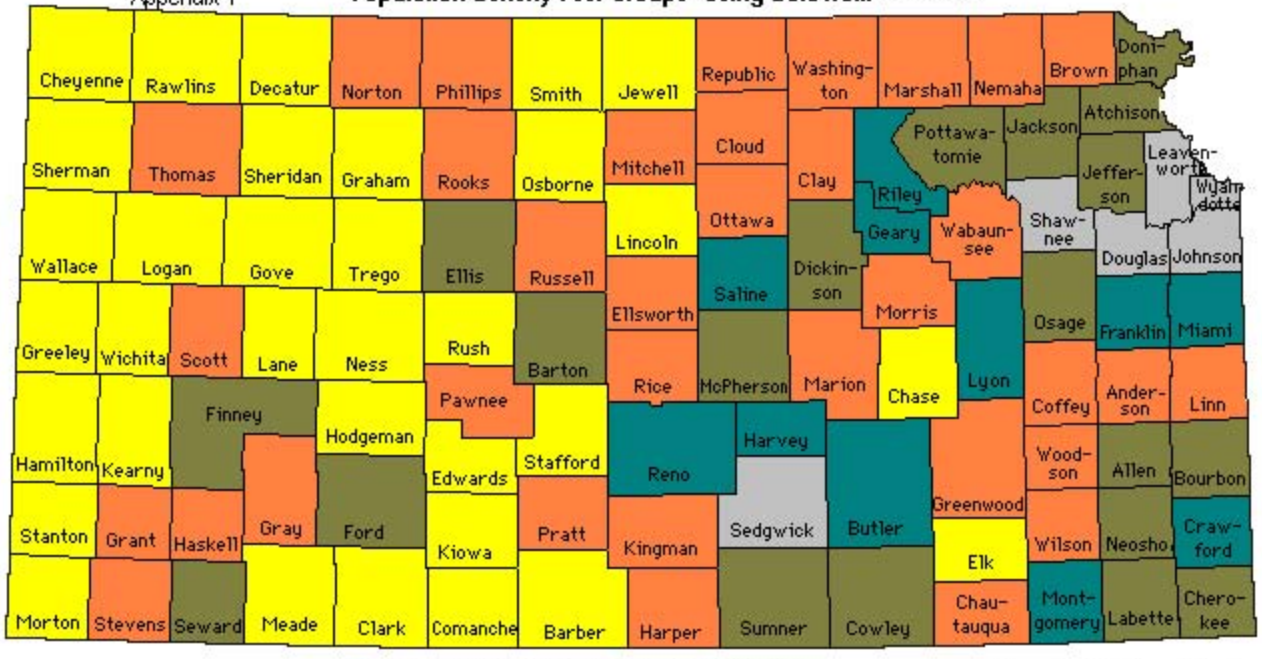
Appendix 1

Population Density Peer Groups* Using Data from 2006 Est.



- Frontier (less than 6 persons per square mile)
- Rural (6 to19.9 persons per square mile)
- Densely-settled rural (20 to 39.9 persons per square mile)
- Semi-urban (40 to 149.9 persons per square mile)
- Urban (150+persons per square mile)

*Based on Definition adopted by Kansas Department of Health and Environment.

Appendix 2

Resource/Foster Family: Frontier & Rural Mental Health Survey Results– Winter 2007

Survey Item Responses

Tell Us About Your County

1. **Please put a check in the column that best describes your opinion.**

	Strongly Agree	Agree	Disagree	Strongly Disagree	I don't know
My county is a good place to raise a family.	**69.8%**	**30.2%**	**0.0%**	**0.0%**	**0.0%**
There are many job opportunities for people who live in my county.	**3.8%**	**26.9%**	**53.8%**	**15.4%**	**0.0%**
There are lots of activities for children **ages 5-12** in my county to be involved in.	**13.2%**	**52.8%**	**26.4%**	**5.7%**	**1.9%**
There are lots of activities for adolescents **ages 13-17 years** in my county to be involved in.	**11.3%**	**41.5%**	**37.7%**	**9.4%**	**0.0%**
My county is strong economically.	**5.8%**	**57.7%**	**23.1%**	**7.7%**	**5.8%**
More people are moving into our county than are leaving it.	**1.9%**	**23.1%**	**34.6%**	**21.2%**	**19.2%**
This is a safe place to live.	**64.7%**	**33.3%**	**2.0%**	**0.0%**	**0.0%**
Families can find affordable housing in our county (requires less than 30% of their income.)	**34.6%**	**48.1%**	**5.8%**	**1.9%**	**9.6%**
People in urban areas such as Topeka or Kansas City understand our needs and issues.	**1.9%**	**5.7%**	**32.1%**	**50.9%**	**9.4%**
The people in our county have a voice in state level policy decisions affecting our county.	**0.0%**	**50.0%**	**23.1%**	**13.5%**	**13.5%**
State level policy makers listen to people in our county.	**2.0%**	**36.7%**	**34.7%**	**10.2%**	**16.3%**
I like living in my county.	**60.4%**	**39.6%**	**0.0%**	**0.0%**	**0.0%**
My county is better off than it was five years ago.	**11.5%**	**42.3%**	**25.0%**	**1.9%**	**19.2%**

Appendix 2

Mental Health Services

2. Please put a check in the column that best describes your opinion.

	Strongly Agree	Agree	Disagree	Strongly Disagree	I don't know
It is okay to get mental health services for a child in foster care.	**69.2%**	**23.1%**	**3.8%**	**3.8%**	**0.0%**
I would prefer to have mental health services provided by a faith-based counselor.	**24.5%**	**30.2%**	**26.4%**	**1.9%**	**17.0%**
Resource/Foster parents receive support and understanding from others in the county when their foster child needs mental health services.	**15.1%**	**49.1%**	**20.8%**	**3.8%**	**11.3%**
Children in foster care who receive mental health services are accepted by their peers at school.	**12.2%**	**57.1%**	**16.3%**	**0.0%**	**14.3%**
If a child in foster care is having emotional or behavioral problems, the social service system makes it easy for resource/foster parents to ask for help.	**9.8%**	**62.7%**	**13.7%**	**2.0%**	**11.8%**
Children in foster care with mental health needs can live healthy lives.	**36.5%**	**57.7%**	**1.9%**	**0.0%**	**3.8%**
Ensuring that children and adolescents in foster care receive the mental health services they need is very important to me.	**64.2%**	**34.0%**	**1.9%**	**0.0%**	**0.0%**
Ensuring that children and adolescents in foster care receive the mental health services they need is important to others living in our county.	**28.3%**	**47.2%**	**11.3%**	**1.9%**	**11.3%**
Ensuring that children and adolescents in foster care living in our county receive the mental health services they need is important to state level policy makers.	**15.7%**	**29.4%**	**17.6%**	**9.8%**	**27.5%**

3. Below are some of the common concerns that might keep families from seeking mental health services. Which of the following might prevent you from asking for mental health help for your child in foster care? *Check as many as apply*

- □ I don't want people to know my business. **9.4%**
- □ I am afraid of the drugs that might be used. **17.0%**
- □ I am afraid my foster child will get teased. **9.4%**
- □ My foster child is afraid of getting teased. **17.0%**
- □ I don't want my foster child labeled. **20.8%**
- □ I don't go because I don't believe the services are faith based. **3.8%**
- □ I don't want people to think badly about my foster child. **9.4%**
- □ I don't think I can afford the services. **0.0%**
- □ The services I need are too far away. **32.1%**
- □ The services I need are not at a convenient time. **26.4%**
- □ Nothing would prevent me from asking for help for my foster child. **83.0%**
- □ Other (Included scheduling conflicts, a need for more provider and care choices, and the need for quality care and services.) **17.0%**

39.6% of the survey respondents indicated that nothing would prevent them from asking for help for their foster child, and did not select any additional concerns.

17% of the survey respondents identified concerns that might prevent them from asking for help for their foster children and did not select the response item "Nothing would prevent me from asking for help for my foster child". Of these 9 respondents, the most common reasons were:

My foster child is afraid of getting teased.
I don't want my foster child labeled.
The services I need are too far away.
The services I need are not at a convenient time.

4. **How would a person living in your county go about finding mental health services for a child or adolescent in foster care ages 5-17 years? *(Check as many as apply.)****

They would:

□ look in the telephone book	**60.4%**	□ I don't know	**0.0%**
□ listen to an ad on the radio	**13.2%**	□ Other, please explain (included referrals, training and screenings)	**5.7%**
□ ask someone at the foster child's school	**49.1%**		
□ ask their medical doctor	**77.4%**		
□ pick up a brochure somewhere	**35.8%**		
□ ask a friend or neighbor	**30.2%**		
□ call a resource home worker/foster care worker	**83.0%**		
□ call SRS	**75.5%**		
□ look in the newspaper	**13.2%**		
□ wait until someone told them mental health services were needed and let that person make a referral	**22.6%**		

5. **If your child in foster care needed mental health services, who would you go to FIRST? *Please check only one.* (If your child or adolescent in foster care already receives mental health services, think back to who you went to first.) ***

□ A staff member at the Community Mental Health Center	**7.5%**
□ A private therapist or other private provider	**1.9%**
□ A minister or clergy member	**1.9%**
□ A counselor at school	**1.9%**
□ A social worker	**13.2%**
□ A resource home worker/foster care worker	**54.7%**
□ A friend or neighbor	**0.0%**
□ My foster child's doctor or pediatrician	**7.5%**
□ I would not ask for mental health services for my foster child	**0.0%**
□ Other, please explain (included mandatory services or referrals)	**5.7%**
□ Two or more responses	**5.7%**

* *These responses likely reflect policy requiring resource parents to contact their resource home worker first if their child in foster care is in need of mental health services.*

Appendix 2

6. **Looking at the person or place you said you would go to <u>FIRST</u>, roughly how many miles would you travel one way to get to that person?**

□ Less than 20 miles one way	**32.7%**
□ 20-40 miles one way	**36.5%**
□ 41-60 miles one way	**21.2%**
□ More than 60 miles one way	**9.6%**

7. **If your child in foster care needed mental health services, would you go to the Community Mental Health Center <u>in your county</u>?**

□ Yes (Also check this if your foster child is currently receiving services from the mental health center in the county)	**37.7%**
□ No	**3.8%**
□ I don't know/ I am not sure	**3.8%**
□ I would be willing to take my child to the Community Mental Health Center, but they do not have an office in my county.	**49.1%**
□ Two or more responses	**5.7%**

8. **To what extent would the distance to get to the mental health services for your child/adolescent in foster care be a problem for you?**

□ The distance is not a problem at all.	**37.3%**
□ The distance is somewhat of a problem.	**45.1%**
□ The distance is a big problem.	**13.7%**
□ I don't know/ I am not sure	**3.9%**

9. **If your child in foster care needed mental health services, where would you want to go to receive them?**

□ I would want to get them as close to home as possible.	**66.0%**
□ I would want them somewhat close but not near where people might recognize us.	**1.9%**
□ The location doesn't matter to me.	**11.3%**
□ I would not access them anywhere.	**0.0%**
□ I don't know/am not sure.	**3.8%**
□ Other, please explain (included the desire to go where the best services for their children would be)	**7.5%**
□ Two or more responses	**9.4%**

10. Throughout the state, a variety of mental health services for 5-17 year olds exist. Please place a mark (X) in the column that shows how far you would need to drive to access each service for your child or adolescent in foster care. ***(Note: Some respondents chose more than one category.)***

	Less than a 15 minute drive one-way but still within the county	15 to 30 minute drive one-way but still within the county	More than 30 minutes one-way but still within the county	Outside the county	I Don't Know/Not Sure
Mental health services/support from a school counselor	**56.6%**	**11.3%**	**1.9%**	**22.6%**	**7.5%**
Mental health services/support from a faith-based provider (minister, clergy)	**42.3%**	**13.5%**	**0.0%**	**9.6%**	**34.6%**
Parenting Training	**21.8%**	**18.2%**	**5.5%**	**47.3%**	**7.3%**
Individual Therapy	**26.8%**	**16.1%**	**3.6%**	**50.0%**	**3.6%**
Group Therapy	**20.4%**	**16.7%**	**1.9%**	**51.9%**	**9.3%**
Parent Support	**20.8%**	**13.2%**	**1.9%**	**50.9%**	**13.2%**
Case Management	**24.5%**	**9.4%**	**5.7%**	**56.6%**	**3.8%**
Attendant Care	**14.8%**	**9.3%**	**9.3%**	**44.4%**	**22.2%**
Respite Care	**12.5%**	**21.4%**	**10.7%**	**39.3%**	**16.1%**
Psychosocial Group	**13.2%**	**11.3%**	**1.9%**	**47.2%**	**26.4%**
Medication Review/ Medication Adjustment	**18.5%**	**9.3%**	**1.9%**	**63.0%**	**7.4%**
Psychiatric Hospitalization	**1.9%**	**0.0%**	**1.9%**	**86.8%**	**9.4%**

11. Please list any mental health services that you feel are needed <u>in your county</u> but are not available for children or adolescents in foster care:

Responses ranged from no services needed in the county to all services being necessary. Specific services identified as necessary included individual therapy, medication consultation, drug and alcohol programs, faith-based counseling, children support groups, educational efforts, after school programs, evening hours and greater choice in providers.

12. What would cause a parent to begin considering mental health services/support for children in foster care <u>age 5-12 years old</u>?

and

13. What would cause a parent to consider mental health services/support for adolescents in foster care <u>age 13-17 years old</u>

Frequently cited reasons for parents to consider mental health services/support for both age groups included behavior problems such as aggressive or odd behavior, emotional disturbances such as anxiety or depression, social interactions, drug or alcohol abuse, problems at school, crisis situations and a child identifying the need for help. Peer pressure, self-esteem and relationship issues were also identified as possible causes for adolescents in foster care age 13-17.

14. What do you think is the most important issue for children's mental health in your county? Common responses included issues related to the quality and effectiveness of service, the need for more choices in service, the need for increased resources and funding as well as community education. Access and availability needs were identified including travel, scheduling and the cost of services. Other important issues included challenges for children or adolescents such as depression, behavior problems, drug abuse and physical abuse.

15. What else would you like to tell us about your county or the area in which you live? Several respondents identified their counties as caring and helpful communities. However, some responses included concerns about poverty, isolation, drug problems and stigma for children and adolescents in foster care. Additional needs identified included more services in general for the county, crisis and disaster services, and training for foster parents.

About you:

16. County Information ***(Respondents were asked what county they lived in, and the counties were then categorized into rural or frontier.)***

□ Rural **43.4%** □ Frontier **56.6%**

17. How many years have you lived in this county?

□ Less than 1 year **0.0%** □ 6-10 years **17.0%** □ I am a life-long resident **30.2%**
□ 1-5 years **7.5%** □ More than 10 years **45.3%**

18. How many people under the age of 18 live in your household?

□ **0** **11.3%** □ **5** **13.2%**
□ **1** **13.2%** □ **6** **9.4%**
□ **2** **30.2%** □ **8** **1.9%**
□ **3** **5.7%**
□ **4** **15.1%**

19. How many people aged 18 or older live in your household?

□ **0** **7.5%**
□ **1** **1.9%**
□ **2** **75.5%**
□ **3** **13.2%**
□ **4** **1.9%**

20. Have any of the foster children/adolescents in your household received mental health services within the last six months?

□ Yes **79.2%** □ No **20.8%**

21. Are you currently a foster parent/resource family for the state?

□ Yes **98.1%** □ No **1.9%**

22. Which describes your marital status?

□ Single, never married **0.0%** □ Divorced **3.9%** □ Separated **0.0%**
□ Married **94.1%** □ Widowed **2.0%**

23. Is English your first language?

□ Yes **98.1%** □ No **1.9%**

24. Is a language other than English spoken in your home?

□ Yes **6.0%** □ No **94.0%**

If yes, which language? **Three respondents identified Spanish as this language.**

25. Are you male or female? □ Male **21.6%** □ Female **78.4%**

26. What is your age?

□ 18-25 **0.0%** □ 41-50 **37.3%**
□ 26-30 **0.0%** □ 51-60 **33.3%**
□ 31-40 **21.6%** □ 61or over **7.8%**

27. What is your highest level of education?

□ Less than High School **0.0%** □ College Graduate **25.0%**
□ High School/GED **5.8%** □ Post Undergraduate **11.5%**
□ Some College **40.4%** □ Vocational Training **3.8%**
□ Other, please explain: **3.8%** □ Two or more responses **9.6%**

28. What is your occupation? *(select the category that best fits your work), Note: Some respondents chose more than one category.*

□ Agriculture **10.4%** □ Construction **0.0%**
□ Social Services **7.5%** □ Retail **0.0%**
□ Health/Medical/Medicine **9.0%** □ Management **4.5%**
□ Government **0.0%** □ Teaching/Education **14.9%**
□ Technical/Trade Work **1.5%** □ Computer-related **0.0%**
□ Animal Processing (Feed Lots etc.) **4.5%** □ Oil and Gas Industry **1.5%**
□ Manufacturing **0.0%** □ Dairy Industry **0.0%**
□ Stay-at-home parent/Homemaker **20.9%** □ Unemployed **1.5%**
□ Trucking **0.0%**
□ Other **23.9%**

29. What is your family income?

□ Under $25,000 **7.7%** □ $60,001 - $75,000 **15.4%**
□ $25,000 - $40,000 **26.9%** □ Over $75,000 **17.3%**
□ $40,001 - $60,000 **15.4%** □ I prefer not to answer **17.3%**

Appendix 3

Frontier & Rural County Mental Health Survey – Spring 2007
Preliminary Results

Tell Us About Your County

1. Please put a check in the column that best describes your opinion.

	Strongly Agree	Agree	Disagree	Strongly Disagree	I don't know
My county is a good place to raise a family.	**54.0%**	**43.2%**	**2.2%**	**0.6%**	**0.0%**
There are many job opportunities for people who live in my county.	**8.6%**	**29.4%**	**45.0%**	**14.4%**	**2.6%**
There are lots of activities for children **ages 5-12** in my county to be involved in.	**11.8%**	**55.4%**	**22.9%**	**5.1%**	**4.8%**
There are lots of activities for adolescents **ages 13-17 years** in my county to be involved in.	**7.2%**	**39.8%**	**35.4%**	**11.3%**	**6.3%**
My county is strong economically.	**5.4%**	**46.1%**	**32.8%**	**10.4%**	**5.4%**
More people are moving into our county than are leaving it.	**3.2%**	**15.9%**	**46.0%**	**20.0%**	**14.9%**
This is a safe place to live.	**33.2%**	**63.9%**	**2.3%**	**0.6%**	**0.0%**
Families can find affordable housing in our county (requires less than 30% of their income.)	**14.8%**	**53.5%**	**15.7%**	**3.1%**	**12.9%**
People in urban areas such as Topeka or Kansas City understand our needs and issues.	**0.3%**	**1.9%**	**39.1%**	**50.2%**	**8.5%**
The people in our county have a voice in state level policy decisions affecting our county.	**2.2%**	**40.6%**	**35.5%**	**11.8%**	**9.9%**
State level policy makers listen to people in our county.	**1.0%**	**32.3%**	**36.4%**	**15.3%**	**15.0%**
I like living in my county.	**44.7%**	**48.7%**	**4.1%**	**1.6%**	**0.9%**
My county is better off than it was five years ago.	**5.1%**	**34.8%**	**34.2%**	**7.0%**	**19.0%**

Appendix 3

Mental Health Services

2. Please put a check in the column that best describes your opinion.

	Strongly Agree	Agree	Disagree	Strongly Disagree	I don't know
It is okay to get mental health services for a child.	**50.3%**	**47.8%**	**0.3%**	**0.6%**	**0.9%**
It is better to have mental health services provided by a faith-based counselor.	**21.2%**	**32.0%**	**30.1%**	**2.8%**	**13.9%**
Parents receive support and understanding from others in the county when their child needs mental health services.	**3.5%**	**46.8%**	**23.7%**	**4.7%**	**21.2%**
Children who receive mental health services are accepted by their peers at school.	**1.9%**	**26.7%**	**35.6%**	**7.9%**	**27.9%**
If a child is having emotional or behavioral problems, the social service system makes it easy for parents to ask for help.	**2.8%**	**28.9%**	**30.5%**	**8.8%**	**28.9%**
Children with mental health needs can live healthy lives.	**26.1%**	**68.2%**	**1.3%**	**0.3%**	**4.1%**
Ensuring that children and adolescents receive the mental health services they need is very important to me.	**48.6%**	**49.2%**	**0.6%**	**0.0%**	**1.6%**
Ensuring that children and adolescents receive the mental health services they need is important to others living in our county.	**22.8%**	**50.6%**	**8.2%**	**1.3%**	**17.1%**
Ensuring that children and adolescents in our county receive the mental health services they need is important to state level policy makers.	**9.7%**	**34.0%**	**21.1%**	**4.4%**	**30.8%**

3. Below are some of the common concerns that might keep families from seeking mental health services. Which of the following might prevent a parent in your county from asking for mental health help for their child? *Check as many as apply.*

- □ Not wanting people to know their business. **92.8%**
- □ Fear that drugs might be used. **43.6%**
- □ Fear that the child would be teased. **70.8%**
- □ The child's fear of getting teased. **66.1%**
- □ Not wanting the child to be labeled. **85.0%**
- □ Not going because the services are not faith based. **17.9%**
- □ Not wanting people to think badly about the child. **69.0%**
- □ Not being able to afford the services. **78.4%**
- □ Services needed are too far away. **46.7%**
- □ Services needed are not at a convenient time. **26.3%**
- □ Nothing would prevent a parent in your county from asking for help for their child. **11.0%**
- □ Other (Included lacking knowledge of available resources, lack of awareness of the problem, lack of access to quality service, limited capacity for services) **9.7%**

Appendix 3

4. **How would a person living in your county go about finding mental health services for a child or adolescent ages 5-17 years? *(Check as many as apply.)***

They would:

- □ look in the telephone book **59.7%**
- □ listen to an ad on the radio **7.5%**
- □ ask someone at the child's school **71.3%**
- □ ask their medical doctor **88.8%**
- □ pick up a brochure somewhere **22.8%**
- □ ask a friend or neighbor **37.2%**
- □ call SRS **47.2%**
- □ look in the newspaper **10.0%**
- □ wait until someone told them mental health services were needed and let that person make a referral **37.8%**
- □ I don't know **5.3%**
- □ Other (included clergy, information from the internet and going to someone outside of the county) **8.1%**

5. **If a child in your county needed mental health services, who would a parent or primary caretaker go to FIRST? *Please check only one.* (If you have a child or adolescent who already receives mental health services, think back to who you went to first.)**

- □ A staff member at the Community Mental Health Center **3.5%**
- □ A private therapist or other private provider **1.9%**
- □ A minister or clergy member **4.7%**
- □ A counselor at school **23.7%**
- □ A social worker **0.9%**
- □ SRS **3.2%**
- □ A friend or neighbor **2.2%**
- □ The child's doctor or pediatrician **34.5%**
- □ They would not ask for mental health services for their child **1.3%**
- □ I don't know to whom people reach out for mental health services. **7.9%**
- □ Other, please explain (included contacting at teacher, health department or going to someone from outside of the county) **1.9%**
- □ 2 or more responses chosen **14.2%**

6. **Looking at the person or place you said a parent or primary caretaker would go to FIRST, roughly how many miles would they travel one way to get to that person?**

- □ Less than 20 miles one way **58.2%**
- □ 20-40 miles one way **30.9%**
- □ 41-60 miles one way **7.2%**
- □ More than 60 miles one way **3.6%**

Appendix 3

7. **Please list any mental health services that you feel are needed <u>in your county</u> but are not available for children or adolescents:** Participants identified a wide range of service needs including local access to mental health centers and SRS offices, more child psychologists or psychiatrists, an increase in children's mental health services, more choices for services, increased affordability of services and availability of alcohol and drug treatment.

8. **What would cause a parent or primary caretaker to begin considering mental health services/support for children <u>age 5-12 years old</u>?** Common causes included dealing with major life events such as divorce or a death in the family, receiving referrals from doctors, teachers or school counselors, abusive family situations, changes in behavior or behavioral problems such as bullying, aggression or withdrawn behavior, depression, drug or alcohol abuse and talking about suicide.

9. **What would cause a parent or primary caretaker to consider mental health services/support for adolescents <u>age 13-17 years old?</u>** Similar causes as those for 5-12 year olds were frequently cited for 13-17 year olds. Additional causes included rebellion, criminal activities and legal problems, extreme mood swings and changes in appearance, friends or lifestyle.

10. **What do you think is the most important issue for children's mental health in your county?** Important issues that were commonly identified included the need to increase availability and affordability of services, the need for education and to increase awareness and acceptance, a lack of confidentiality and privacy, the need for more positive activities for children and youth, alcohol and drug abuse for both children and adults and family and financial stressors.

11. **What else would you like to tell us about your county or the area in which you live?** Many respondents described their county as a good and safe place to live, a caring and supportive community and a community that cares about children. There was common acknowledgement by respondents that there is little privacy in their county. Several respondents also indicated that their county could benefit from increased awareness and that drug and alcohol abuse occurs in their county. Respondents frequently described the declining and aging populations of their counties and indicated a lack of jobs and resources in the area.

Appendix 3

About you:

12. County Information ***(Respondents were asked what county they lived in, and the counties were then categorized into rural or frontier.)***

□ Rural **63.0%** □ Frontier **37.0%**

13. How many years have you lived in this county?

□ Less than 1 year **1.6%** □ 6-10 years **11.9%** □ I am a life-long resident **31.8%**
□ 1-5 years **6.0%** □ More than 10 years **48.7%**

14. Which describes your marital status?

□ Single, never married **5.4%** □ Divorced **11.4%** □ Separated **0.3%**
□ Married **72.9%** □ Widowed **10.1%**

15. Is English your first language? □ Yes **98.8%** □ No **1.2%**

16. Is a language other than English spoken in your home? □ Yes **6.3%** □ No **93.7%**

17. Are you male or female? □ Male **37.0%** □Female **63.0%**

18. What is your age?

□ 18-25	**1.9%**	□ 41-50	**19.2%**
□ 26-30	**5.0%**	□ 51-60	**21.1%**
□ 31-40	**15.7%**	□ 61or over	**37.1%**

19. What is your highest level of education?

□ Less than High School	**3.5%**	□ Associate Degree/Vocational Training	**14.6%**
□ High School/GED	**18.0%**	□ College Graduate	**21.8%**
□ Some College	**28.5%**	□ Post Undergraduate	**11.7%**
□ Other, please explain	**1.9%**		

20. What is your occupation? ***(select the category that best fits your work)***

□ Agriculture	**15.4%**	□ Trucking	**1.3%**
□ Social Services	**2.5%**	□ Construction	**1.6%**
□ Health/Medical/Medicine	**10.1%**	□ Dairy Industry	**0.0%**
□ Government	**5.7%**	□ Retail	**3.8%**
□ Technical/Trade Work	**3.5%**	□ Management	**2.8%**
□ Oil and Gas Industry	**0.9%**	□ Teaching/Education	**9.4%**
□ Animal Processing (Feed Lots etc.)	**0.6%**	□ Computer-related	**1.3%**
□ Manufacturing	**0.0%**	□ Unemployed	**1.3%**
□ Stay-at-home parent/Homemaker	**6.6%**		

□ Other (Included a variety of occupations, but the majority in this category indicated they were retired) **28.6%**

□ 2 or more responses chosen **4.7%**

Appendix 3

21. What is your family income?

□ Under $25,000 **12.6%** □ $40,001 - $60,000 **23.6%** □ Over $75,000 **13.9%**
□ $25,000 - $40,000 **23.9%** □ $60,001-$75,000 **10.0%** □ I prefer not to answer **15.9%**

22. Are you currently a foster parent/resource family for the state? □ Yes **0.9%** □ No **99.1%**

23. How many people under the age of 18 live in your household?

□ **0** **65.0%** □ **3** **5.4%**
□ **1** **14.6%** □ **4** **1.9%**
□ **2** **12.1%** □ **5** **1.0%**

24. Are you currently a parent or primary caretaker of a child or adolescent living in western Kansas? *Primary caretakers would include adults giving care to grandchildren, close relatives or any child or adolescent under 18 years old.*

□ No **67.2%** □ Yes **32.8%**

Parent/Primary Caretaker Section:

Includes results from the 103 participants who selected Yes on Item 25.

25. If your child needed mental health services, would you go to the Community Mental Health Center <u>in your county</u>?

□ Yes (Also check this if your child is currently receiving services from the mental health center in the county) **17.5%**
□ No **20.4%**
□ I don't know/ I am not sure **25.2%**
□ I would be willing to take my child to the Community Mental Health Center, but they do not have an office in my county. **35.0%**
□ 2 or more responses chosen **1.9%**

26. To what extent would the distance to get mental health services for your child/adolescent be a problem for you?

□ The distance is not a problem at all. **53.4%** □ The distance is a big problem. **12.6%**
□ The distance is somewhat of a problem. **32.0%** □ I don't know/ I am not sure **1.0%**

27. If your child needed mental health services, where would you want to go to receive them?

□ I would want to get them as close to home as possible. **46.6%**
□ I would want them somewhat close but not near where people might recognize us. **9.7%**
□ The location doesn't matter to me. **28.2%**
□ I would not access them anywhere. **1.0%**
□ I don't know/am not sure. **1.9%**
□ Other, please explain (Included a church, somewhere outside of the county and finding the best facility for the issue) **8.7%**
□ 2 or more responses chosen **3.9%**

Appendix 3

28. Throughout the state, a variety of mental health services for 5-17 year olds exist. Please place a mark (X) in the column that shows how far you would need to drive to access each service for your child or adolescent.

	Less than a 15 minute drive one-way but still within the county	15 to 30 minute drive one-way but still within the county	More than 30 minutes one-way but still within the county	Outside the county	I Don't Know/ Not Sure
Mental health services/support from a school counselor	**72.5%**	**7.8%**	**2.9%**	**11.8%**	**4.9%**
Mental health services/support from a faith-based provider (minister, clergy)	**56.0%**	**10.0%**	**2.0%**	**15.0%**	**17.0%**
Parenting Training	**23.1%**	**9.6%**	**3.8%**	**34.6%**	**28.8%**
Individual Therapy	**25.3%**	**13.1%**	**3.0%**	**45.5%**	**13.1%**
Group Therapy	**9.9%**	**9.9%**	**4.0%**	**44.6%**	**31.7%**
Parent Support	**24.8%**	**6.9%**	**4.0%**	**30.7%**	**33.7%**
Case Management	**14.9%**	**7.9%**	**4.0%**	**36.6%**	**36.6%**
Attendant Care	**12.9%**	**5.9%**	**2.0%**	**30.7%**	**48.5%**
Respite Care	**13.7%**	**7.8%**	**2.9%**	**31.4%**	**44.1%**
Psychosocial Group	**5.9%**	**6.9%**	**2.0%**	**39.2%**	**46.1%**
Medication Review/ Medication Adjustment	**24.8%**	**10.9%**	**3.0%**	**32.7%**	**28.7%**
Psychiatric Hospitalization	**20.8%**	**3.0%**	**3.0%**	**51.5%**	**21.8%**
Family Therapy	**15.7%**	**10.8%**	**3.9%**	**44.1%**	**25.5%**

29. Which of the following payment sources do children in your household currently have? (Check as many as apply.)

□ Private Insurance **76.7%** □ HealthWave **11.7%** □ No insurance **7.8%**
□ Medicaid **5.8%** □ SED Waiver **1.0%** □ Other **1.9%**

30. Have any of the children/adolescents in your household received mental health services within the last six months?

□ Yes **14.6%** □ No **84.5%** □ I prefer not to answer **1.0%**

Appendix 4

Community Readiness Scores
Overall Study Summary

One rural and three frontier counties[1] were selected for participation by the Frontier and Rural Committee of Mental Health Services for Children and Families for inclusion in this study. The Frontier and Rural Committee of Mental Health Services for Children and Families chose counties that would include different Community Mental Health Centers (CMHCs) from the western half of the state. The purpose was to collect information on mental health services in the county for 5-17 year olds. For this study, mental health support and services were defined as services and supports for emotional and behavioral problems provided not only at the mental health center, but also through schools, hospitals, private counselors, churches, and natural resources. Using a structured interview developed by Colorado State University's Tri Ethnic Center, telephone interviews were conducted with stakeholders in the fall and winter of 2006. The interviews were coded, scored, and aggregated so that a final overall score and score for each of six dimensions was created for each county. In the summer of 2007, stakeholder feedback meetings were convened in each county[2]. The summarized score and overall summary for the county was shared as a member check. Stakeholders were then asked to discuss overall strengths and resources, challenges and barriers, and potential next steps for their county.

The following information is the summary community readiness information from all four counties involved in the 2006-2007 frontier and rural study.

The overall Community Readiness Score for all four counties was in the 4.0 – 4.9 range. This is considered to be the Preplanning Stage meaning that there is clear recognition that something must be done and may even need a group to address it. However, efforts are not focused or detailed.

Similarities that were identified among at least two of the four counties included the following:

- The frontier/rural nature of the counties creates challenges with the distance to and transportation for services. The rising price of gas has compounded this issue. The distance also means that parents often need to take a half day off from work to take their child to an appointment outside the county.
- Some mental health services are available within the county itself. However a need for more services in the county was identified, including more staff available/expanded hours and additional days per week.
- Efforts are made to promote available services and raise awareness about services and children's mental health in the community. However stakeholders identified the need to increase efforts in this area.
- Mental health stigma was identified as a factor surrounding children's mental health.
- Staffing issues identified included competition among providers to hire from a finite number of people available in the areas, difficulty attracting and retaining staff in western Kansas, and difficulty paying competitive salaries. Providers in specialized areas are limited.
- Reliance on technology was identified. However, barriers exist including televideo systems that are not compatible among different providers/systems; limits to reliable cell phone coverage, particularly in frontier areas; limited Internet service in some areas; and needed

[1] Frontier is defined as less than 6 people per square mile; rural is 6.0 – 19.9 people per square mile.
[2] Due to a natural disaster in the region, we were unable to hold the stakeholder feedback meeting in one of the frontier counties.

support to know how to utilize the televideo technology. This last point included both knowing how to use the equipment and how to identify other service providers (mental and physical health) with whom they can connect.

- Issues around drug and alcohol needs were identified, including a lack of services in western Kansas and the fact that there are people in need of services.
- Stakeholders identified a recognition and dependence on partnering to meet the needs of children and families.
- There is a need to confirm diagnoses of ADHD and make sure those with the diagnosis are improving.
- Confidentiality rules and laws make it harder to coordinate services.

The six individual dimensions were analyzed and ordered as to their stage of readiness. A stage is not better or worse than another. The idea is that to create change, the various dimensions must be equally as strong. Strategies can then be created based on the county's specific needs and strengths. The results for each county were grouped into three tiers: the strongest dimension, the three mid-level dimensions, and the two areas for first focus.

Community Readiness Dimensions	Analysis of the Data
Community Efforts: Efforts, programs, and policies that address the issue	This was the strongest dimension in all four counties.
Leadership: The extent that appointed leaders and influential community members are supportive of the issue	Three of the four counties had this as a mid-level dimension. One county had it as an area for first focus. Leadership does not imply the staff at the community mental health center. It can include staff, community leaders, schools, etc. who are committed to children's mental health.
Community Climate: What is the prevailing attitude of the community toward the issue? Is it one of helplessness or one of responsibility and empowerment?	Community climate was a mid-level dimension for all four counties.
Community Knowledge of the Issue: The extent that community members know about the causes of the problem, consequences, and how it impacts the community	Three of the four counties had this dimension as an area of first focus. One county had it as a mid-level dimension.
Community Knowledge of Efforts: The extent that community members know about local efforts and their effectiveness, and the extent to which the efforts are accessible to all segments of the community.	Three of the four counties had this dimension as an area of first focus. One county had it as a mid-level dimension.
Resources: The extent to which local resources – people, time, money, space, etc. – are available to support efforts	Three of the four counties had this as a mid-level dimension. One county had it as an as an area of first focus.

Appendix 5

Mental Health and Child Welfare Secondary Analysis

Demographic Characteristics by Removal Episode between State FY04 and State FY06

		N	%
Population Density	Frontier	245	3.1
	Rural	597	7.4
	Densely Settled Rural	1758	21.9
	Semi-Urban	1655	20.6
	Urban	3761	46.9
(Total)		(8016)	100
Gender	Female	4019	50.1
	Male	3997	49.9
(Total)		(8016)	100
Case type	Abuse and/or Neglect	4726	59.0
	Not Abuse or Neglect	3290	41.0
(Total)		(8016)	100
Mental Health Involvement	Mental Health Involvement	4366	54.5
	No Mental Health Involvement	3650	45.5
(Total)		(8016)	100

Gender and Mental Health Involvement by Peer Density Group

	Female (%)		**Male (%)**	
	Mental Health Involvement	No Mental Health Involvement	Mental Health Involvement	No Mental Health Involvement
Frontier	60.7	39.3	55.1	44.9
Rural	68.5	31.5	59.4	40.6
Densely-Settled Rural	59.7	40.3	55.9	44.1
Semi-Urban	54.2	45.8	56.1	43.9
Urban	51.3	48.7	50.4	49.6
Statewide	55.4	44.6	53.5	46.5

Reason for Removal and Mental Health Involvement by Peer Density Group

	Removed for reasons of Abuse or Neglect (%)		**Removed for Non-Abuse/Neglect (NAN) (%)**	
	Mental Health Involvement	No Mental Health Involvement	Mental Health Involvement	No Mental Health Involvement
Frontier	48.1	51.9	75.3	24.7
Rural	60.6	39.4	69.3	30.7
Frontier and Rural Combined	56.5	43.5	70.7	29.3
Densely-Settled Rural	53.9	46.1	62.4	37.6
Semi-Urban	54.0	46.0	56.7	43.3
Urban	51.8	48.2	49.2	50.8
Statewide	53.2	46.8	56.4	43.6