

Brief Reports

Use of Paraprofessionals in Enhancing Mental Health Service Delivery in Rural Settings

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It long has been recognized that rural communities, in general, while experiencing a disproportional amount of psychosocial distress, are heavily underserved by the traditional methods of the health delivery system. This is especially evident in the area of mental health (President's Commission on Mental Health, 1978).

Traditionally, helping facilities (i.e., inpatient services, mental health centers, as well as practicing professionals) in rural states are located in, or near, the larger cities. Citizens from remote areas, in need of help, frequently must travel long distances to obtain it. Aside from time and economic issues, there seems to be a hesitancy to utilize such services by those who need them most, for fear of being stigmatized by the community. Too frequently, anyone contacting a mental health facility or a mental health professional is labeled as mentally ill. For many, such misconceptions trigger an irrational fear of people so labeled which, in turn, prevents them from rendering the necessary support at the time when such support is needed.

Establishing local branches or satellites of the Community Mental Health Center makes help available closer to home. Nevertheless, hesitancy to trust outsiders, an apprehension of being seen at a mental health clinic and a strong tendency for self-reliance among rural residents, quite frequently, deter them from fully utilizing available services.

Strong preference for local helping resources was quite evident in a recent survey of 22 counties of northern Nebraska, in which 78.7% of those questioned indicated that the first source of help for mental or emotional problems would be their local doctor, priest, or minister (57.8% doctors, 20.9% priests or ministers; Shybut, Dodgion & Dodgion, *Note 1*). This reliance on local resources is further underscored by Husaini and Neff (*Note 2*), who point out that "the rural residents actively seek to resolve their problems, relying primarily upon informal nonprofessional help, rather than formal, psychiatric help" (p. 6).

It appears then, that the delivery of mental health services in rural areas follows two characteristic approaches: a traditional, centralized, mental health system and a community-based, informal, nonprofessional network. Too frequently, both operate as independent entities characterized by their respective shortcomings. Thus traditional professional services suffer from geographic maldistribution and lack of accessibility and acceptability, while the nonprofessional networks are strained heavily for lack of expertise.

One may assume that a complimentary relationship between the two ap-

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proaches, if established, could integrate the two into a more effective and more efficient mental health delivery system.

Basic Assumptions

The Paraprofessional Roles in Rural Mental Health project was designed to develop a community-based paraprofessional network that would not only create additional mental health personnel, but also provide a link for integrating the two above-mentioned approaches of mental health service delivery. It focuses on training and utilization of Emergency Medical Technicians, law enforcement officers, hospital personnel, and other selected members of the community as community-based mental health paraprofessionals. In brief, basic assumptions underlying the project are:

1. By providing additional mental health training to the members of the rural emergency services network, immediate help will be more available for individuals experiencing emotional, mental, or behavioral problems.

In rural communities, volunteer rescue squads (EMTs), law enforcement personnel (police, sheriffs), and hospital emergency personnel comprise an emergency services network that responds to medical and behavioral emergencies. In general, training of these first responders in mental health is rather limited. Training them in crisis intervention and management of behavioral emergencies should prepare them more adequately to identify and manage individuals with emotional, mental, or behavioral problems. Individuals successfully completing such training would function as community-based mental health paraprofessionals, providing initial basic mental health interventions, as well as facilitating delivery of more specialized services.

2. By providing training in mental health to selected members of the community-based, informal support network, their helping skills will be enhanced.

As pointed out earlier, rural communities in general tend to rely on informal, nonprofessional help in dealing with problems in living. Training of selected members of these informal helping groups in crisis intervention, client advocacy, referral process, community support network building, and primary prevention should strengthen their helping ability. As trained community members, they can assume a variety of functions, from establishing or expanding primary prevention programs to ensuring availability of professional help, when such is needed. In so doing, they would join the other community-based mental health paraprofessionals in developing a community-based Mental Health Paraprofessional Network.

3. Availability of community-based mental health paraprofessionals may serve to enhance accessibility and acceptability of traditional professional services, while strengthening community support systems for individuals with problems in living.

In addition to providing crisis intervention, referral, and prevention services, community-based paraprofessionals may assume advocacy roles in generating community support for citizens needing help in general, and those with emotional, mental, or behavioral problems in particular. In doing this, they may enlist the help of informal support groups as well as the traditional mental health delivery system, thus maximizing utilization of all available resources. Such a team approach to the solution of mental health problems in the community should engender greater acceptance of outside assistance. It also should provide for greater accessibility of professional help through more direct channels of communication.

Project Description

The 3-year project is currently in its final year. It encompasses 22 counties of northern Nebraska with a territory of 20,000 square miles and a population of about a quarter of a million.

Capitalizing on the existing Emergency Services System, the project designated Emergency Medical Technicians, Law Enforcement Personnel and Hospital Personnel for training in emergency mental health (i.e., crisis intervention and management of behavioral emergencies). Each group receives a 10-hour basic course followed by one or two additional seminars or workshops. Being front-line personnel, these workers are called upon to assist in various emergencies. Through specialized training in the area of mental health, they are better equipped to provide assistance and arrange for postcrisis care for individuals with emotional, mental, or behavioral problems. Upon completion of training, these workers are designated by the project as members of the project-initiated community-based Mental Health Paraprofessional Network.

Two additional groups are included in the community-based Mental Health/Paraprofessional Network: the Hotline Helpers and the Community Caretakers.

Hotline Helpers are recruited and selected from the 22 counties served by the project. They receive 18 hours of basic training, and upon successful completion of the course, assume responsibilities as helpers on the Hotline, a 24-hour emergency service of the Northern Nebraska Comprehensive Mental Health Center.

Community Caretakers represent a community-based group of individuals selected on the basis of their interest in helping others, readiness for improving their skills, willingness to serve, and personal suitability. Generally, the program attracts people with diverse backgrounds, with ministers, nurses, school counselors, human service workers, and homemakers well represented. They receive 15 hours of basic training followed by an additional 15 hours of intermediate instruction. Crisis intervention, management of behavioral emergencies, effective communication skills, drug-and-alcohol-related emergencies, psychiatric emergencies, referral process, community support network building and prevention strategies are included in their training.

Among other things, some of the Community Caretakers' efforts are directed at developing community projects to enhance individual coping skills. These projects have included facilitating a self-awareness group, organizing a stress management workshop, introducing prevention education programs into community schools, forming a community drug and alcohol abuse education group, and organizing a parent-teacher discussion group. Projects like these then contribute to a shift in the delivery of mental health services from the traditional clinical treatment-oriented model to a primary prevention model. Such a model, as pointed out by D'Augelli, Vellonce, Young and Danish, (*Note 3*) holds greater promise for dealing with problems in living than does the traditional treatment-oriented model.

Although initially most of the Community Caretakers assume their responsibilities as additional activities and volunteer their services, with further training some may choose to become fully employed mental health workers.

In summary, the major objectives of the community-based Mental Health Paraprofessional's Network are:

1. Better identification and assessment of problems of individuals and problem areas of the community.
2. Delivery of appropriate intervention in a timely fashion.
3. Linking people in crisis with appropriate sources of help.
4. Developing and mobilizing local resources to provide assistance and support for those in need of mental health care.

5. Initiating activities to improve coping skills and abilities of members of the community (primary prevention).
6. Establishing more effective and efficient utilization of regional and state mental health resources.
7. Reducing the financial burden of the already financially strained traditional mental health delivery system through an expanded development and utilization of community-based resources.

Based on observations of the functioning of the various groups participating in the project, their individual roles may be best subsumed under four categories: increasing awareness, facilitating change, providing intervention, and fostering prevention. These roles of Paraprofessionals in Rural Mental Health are summarized in Table I.

Development of Training Materials

A unique feature of the project was the development of training materials to fit the needs of the respective training groups, while incorporating the above-stated objectives of the paraprofessional network. To accomplish this, a review of available training materials was undertaken in conjunction with request for suggestions on curricular structure from representatives of target groups to be trained (i.e., law enforcement, hospital personnel, emergency medical technicians, etc.).

Subsequently, training modules were developed, tested, and modified, resulting in program-specific training manuals. Thus basic Crisis Intervention and Management of Behavioral Emergencies training manuals (10-18 hours) were developed for the Emergency Medical Technicians, Crisis Line Workers and Community Caretakers.¹ Training materials for law enforcement and hospital personnel, for the most part, were adopted from the variety of sources already available.

Continuity of the Program

To ensure continuity of the program beyond the life of the project an early working relationship was established with the regional educational, training, and mental health institutions. Specifically, course accreditation was requested and obtained from the Northwest Nebraska Technical Community College and the National Registry of Emergency Medical Technicians. This, in turn, permitted program participants to obtain continuing education units, and, in the case of the Community Caretakers, regular academic credits. Furthermore, it created a mechanism for course offering by the college.

A linkage with the mental health institutions at the state and local levels provided a support base, in general, and a training resource, in particular. Incorporation of the key components of the program into the state-wide mental health delivery system was recommended to the Nebraska Department of Public Institutions.

Additionally, close contacts with Emergency Medical Services, the Emergency Medical Technicians Association, hospitals, and Law Enforcement, representatives of which were included on the Project's Advisory Council, encouraged the respective organizations to incorporate crisis intervention and management of behavioral emergencies training into their respective programs.

¹These materials may be obtained by contacting John Shybut, Northern Nebraska Comprehensive Mental Health Center, 109 North 15th Street, Norfolk, Nebraska 68701.

TABLE I
Paraprofessional Roles in Rural Mental Health

Awareness	Facilitation	Intervention	Prevention
<ol style="list-style-type: none"> 1. Attitude change <ol style="list-style-type: none"> a. Problems in living vs. living with problems. b. Getting help vs. giving help (over-independence vs. interdependence). c. Mental illness vs. mental health (breakdown vs. personal growth). 2. Identifying problems <ol style="list-style-type: none"> a. Recognition b. Acceptance 3. Identifying sources of help <ol style="list-style-type: none"> a. Community-based resources. b. Regional & State resources. 	<ol style="list-style-type: none"> 1. Improving access to sources of help. 2. Identifying and/or building community support networks. 3. Setting up consultation and education programs. 4. Setting up skills improvement groups (e.g., parenting). 5. Setting up self-help groups. 	<ol style="list-style-type: none"> 1. Providing crisis intervention. 2. Leading self-help groups. 3. Leading community action groups. 4. Serving as Hotline Helpers. 5. Serving as after care or partial care helpers. 6. Serving as drug and alcohol counselors. 7. Serving as senior citizens advocates. 	<ol style="list-style-type: none"> 1. Providing training in a variety of areas that deal with improvement of coping skills (e.g., parenting, assertiveness, communications, referral, crisis intervention, etc.).

Impact Assessment

While the overall impact of the project remains to be assessed, the interim evaluation data support the efficacy of the program implementation model. A standardized pre- and post-training assessment and a structured survey indicated significant changes in performance. For the two groups, for which data are available (i.e., Crisis Line helpers [Dodgion, Agnes, & Smith, 1980] and Community Caretakers), significant positive differences in the basic helping skills of trainees have been obtained. An average increase of 25% in referrals to the mental health system has been reported by the law enforcement personnel, hospital personnel, Emergency Medical Technicians, and Community Caretakers, with hospital personnel showing the smallest (5%) and the Community Caretakers the largest (40%) gain (Shybut et al., *Note 1*).

An average of 83% of trainees report using the acquired skills and knowledge on the job long after the completion of training (3-18 months). Of particular interest is the surprisingly high use of training acquired skills outside one's work (e.g., in "all the time or often" category it reaches 33% for Community Caretakers and 37% for hospital personnel). (Shybut et al., *Note 1*). Response bias of self-reports notwithstanding, the data support a wide use of training acquired skills on and off the job, especially for these two groups.

The impact of the project is further substantiated by the organizational survey of 187 human service organizations and churches in the region, 10% of which report utilizing paraprofessionals trained by the project (Shybut et al., *Note 1*).

At the State level, the Greater Nebraska Health Systems Agency has recommended to the State Health Department that Management of Behavioral Emergencies be included as part of the continuing education training for Emergency Medical Technicians, Paramedics, and emergency hospital personnel. Crisis intervention already is a part of the basic training curriculum for law enforcement personnel.

In conclusion, the interim project assessment suggests that the use of paraprofessionals in the delivery of rural mental health services may be the key element for integrating the community-based informal networks with the formalized, traditional mental health services into one, fully functional, mental health delivery system.

Reference Notes

1. Shybut, J., Dodgion, D.A., & Dodgion, D.K. *Project interim evaluation*. Report No. 40, Northern Nebraska Comprehensive Mental Health Center, Norfolk, NE., 1980.
2. Husaini, B.A., & Neff, J.A. *Psychiatric impairment and service utilization in rural communities*. Paper presented at Conference on Rural Mental Health Care, Orono, Maine, May 1978.
3. D'Augelli, A.R., Vellonce, T.R., Young, C.E., & Danish, S.S. *The community helpers project: A description of prevention strategy for rural communities*. Paper presented at the American Psychological Association, New York, 1979.

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- Dodgion, D.A., Agnew, K., & Smith, D.K. *Paraprofessional roles in rural mental health: A training program for hotline volunteers*. San Rafael, CA.: The National Education Center for Paraprofessional in Mental Health, 1981.
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