Project EMPOWER: An Innovative Approach to Community Behavioral Health Service Delivery

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Abstract. Project EMPOWER was a grant funded initiative designed to positively impact a rural community by providing behavioral health services and case management to low-income families. An interdisciplinary service team comprised of behavioral health specialists and graduate level interns in the fields of social work, psychiatric nursing, and counseling worked to provide services under the supervision of a doctorate level clinical social work professor. Community partnerships were forged to increase opportunities for community members to have accessible, affordable services. Using an empowerment model rooted in systems and integrated practice, the services included assessments, referrals, group, individual and family counseling, child care, and psychoeducational workshops.

***Keywords*:** behavioral health services, rural community, program delivery

How do partnerships develop in rural communities which allow for meaningful and effective service delivery to occur? How does a partnership between a university social work program, clinical family resource center, and low-income housing agency respond to the gap in mental health/behavioral health services needed by many? This article discusses the development, services, and lessons learned from an initiative referred to as Project EMPOWER (PE).

Contrary to popular belief, knowing better does not mean doing better. And so it is with behavioral health issues for individuals, families, and communities. These issues in rural areas often have the face of depression, anxiety, grief, violence, hopelessness, joblessness, and repeated relationship failures. When resources are sparse and economic and social tensions are high, people and communities fall through the gaps in services. A new more humane approach is required.

According to Syme and Ritterman (2009), "substantial evidence reveals that environmental and community forces also are important determinants of health" (p. 1). Communities are living breathing organisms which are made up of many segments working together to function as a whole. People are the foundation of all communities. The health of communities impacts the health of its residents as strongly as individual genetics. While communities face many barriers to meeting the needs of its memberships, they also have many resources. When partnerships are formed between community agencies, it creates an opportunity to strengthen the community and its members.

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Project EMPOWER (PE) was a concept born from the partnership between a rural university's Clinical Education Complex's Family Resource Program and a Public Housing Authoritys' Family Self-Sufficiency Program. The focus was to break down barriers by using an empowerment model of practice to provide behavioral health services for people who could not afford services or were uninsured. The terms behavioral health and mental health are often used interchangeably. Mental health covers many of the same issues as behavioral health, but this term only encompasses the biological component of this aspect of wellness. *Behavioral health* encompasses all contributions to mental wellness including substances and their abuse, behavior, habits, and other external forces.

In order for people and communities to experience real self-sufficiency, barriers must be removed, and coping skills and resources provided. The behavioral health barriers that individuals face which impact self-sufficiency include low self-esteem, inadequate coping skills, and troubled relationships. Therefore, development of programs to address these areas requires a foundation of individual empowerment. According to McWhirter (1991), the process of empowerment includes the development of skills and reasonable control over one's life that is consistent with the rights of others in their community.

Literature Review

Individuals in rural communities face a myriad of barriers to accessing quality behavioral health services. Until recently, many individuals could not access health care insurance and were, therefore, uninsured. While uninsured individuals have difficulty accessing medical health services, it is even more challenging to access behavioral health care. According to Liberman et al. (2011), "the uninsured face more financial obstacles in obtaining behavioral health care" (p. 734). In addition to financial obstacles, service proximity, qualified providers, and transportation are often the most frequent cause of barriers in seeking or receiving services for those who are uninsured or in poverty (Pepin, Hoyt, Karatzas, & Bartels, 2014). Waiting lists for services can be long, and being on a waiting list in no way guarantees assistance. Individuals may be denied services based on their ability to pay. Also, quality of care differences exist between publically and privately insured populations. Privately insured populations have more frequent care and shorter periods of waiting for services (Cashwell & Starks, 2011; Liberman et al., 2011). Publically insured and underinsured individuals often are caught in the gaps between timely intervention and available intervention. Promptly and effectively meeting the behavioral health needs of individuals with appropriate services is critical.

Behavioral health care in rural areas is often overlooked and disregarded, yet it is pertinent for rural families, communities, and economies to thrive and be prosperous (Cashwell & Starks, 2011). A shortage of trained providers creates another challenge to accessing appropriate behavioral health services. In fact, the majority of rural Americans receive behavioral health services from their primary care physicians who often are under trained in dealing with behavioral health disorders and rarely keep up with the ever-changing trends in psychotropic medications (Cashwell & Starks, 2011). This is a disservice to individuals who need regular care and support for complex behavioral health issues.

In the last decade, U.S. federal agencies have focused more attention and funding on rural areas as a special population in need of behavioral health and drug/alcohol abuse services (National

Institutes of Health, 2004). Increased recognition of rural communities as unique may provide opportunities for continued development of resources, exploration of health problems prevalent in rural areas, and identification of caregiving patterns often used by rural residents (Bushy, 1997). Rural populations have large variations in their demographic, economic, environmental, and cultural characteristics (Cashwell & Starks, 2011; Hart, Larson, & Lishner, 2005).

A key component in addressing service provision in rural areas is connection and rapport. The strength of community and interpersonal relationships directly correlate with the ability to create quality service delivery. Rapport is the cornerstone of all relationships. It is "centered on recognizing the uniqueness of individual situations and that families must be allowed time to process information without feeling rushed" (Rose, Mallinson, & Walton-Moss, 2004, p. 45). Building rapport and connections within communities is essential in breaking down barriers for behavioral health services. Providers need a strong connection with clients in order to promote trust and open the lines of communication (Liberman et al., 2011; Rose et al., 2004). Clients need to feel understood as this allows a validation of their experience. Often, low-income populations and people of color have more difficulty accessing services due to issues of trust than their White middle income counterparts (Cornelius, Simpson, Ting, Wiggins, & Lipford, 2003).

The Project

Overview

Interventions that work best for rural populations of poor and underinsured people tend to be those that are offered in their communities and are easily accessible. Across the country, behavioral health models exist for such programs (Barry & Britt, 2002). These models suggest the importance of accessibility, self-empowerment, collaboration, and community based interventions. Kettner, Moroney and Martin (2014) indicated that program development must be responsive to the needs of the community. Thus, several theories and perspectives informed the development of Project EMPOWER (PE). These underpinnings include systems, empowerment, and force field analysis.

The project's outreach model was designed to break down barriers and enhance supports for clients to access needed resources. The approach is adapted from Kurt Lewin's Force Field Analysis. Burnes and Cooke (2013) describe Force Field Analysis' development as a combination of elements including Gestalt psychology and Cassirer's philosophy of science. Force Field Analysis is about measuring the forces that restrain and forces that support an individual (Lewin, 1947). Each individual's current status related to these forces is assessed. Forces that restrain are those that create barriers or work against changing. Examples of this could be lack of transportation, lack of child care, unsafe home environment, or homelessness. Supporting forces are those that encourage change, such as social support, validation, or easily available resources (Lewin, 1947). When these forces, restraining and supporting, are out of balance, it causes the individuals, groups, families, or communities to seek homeostasis which is achieved either through change or by creating more dysfunction.

Project EMPOWER exemplifies Kurt Lewins' model by meeting clients where they are, by assessing needs, and helping to reduce restraining forces (e.g. transportation, child care) so that the supportive forces (case management, counseling) can be identified, developed, and accessed.

Barriers were reduced by providing bus passes for transportation and free child care services enabling clients to participate. Every attempt was made to schedule appointments when most convenient for clients.

A strengths based approach was used to focus on minimizing the barriers to health care for low-income residents. In rural settings, barriers to health care exist beyond poverty. Utilizing the systems theory model, the project identified helping resources in order to combat the restraining forces. Grant resources were used to facilitate cooperation between partnership organizations. The facilities were housed in a trusted community structure, a local housing authority, which strengthened the collaborative relationship between the Housing Authority, community leaders, and its residents, as well as increased the accessibility for participants as recommended by Barry and Britt (2002).

Project EMPOWER (PE) was developed to reflect the aforementioned service model. This community based outreach service provided case management and counseling services to low-income residents. The project model was informed by the following concepts:

Enhance participant's skills and abilities;

Motivation for goal attainment;

Prosperity which changes surviving into thriving;

Overcome identified challenges;

Work together;

Increase **E**nergy for change;

Respect of self, others, and each individual journey.

The overarching goal of the project was for clients to increase stability and levels of trust to establish an initial comfort space (Jackson, Dinkar & Defranco, 2005). By addressing multiple areas of clients' lives, the clients were empowered to build skills that promoted greater stability, self-sufficiency, and self-reliance. The use of self-rating scales including the Multi-Problem Screening Inventory (MPSI) (Hudson & McMurty, 1997) completed by the clients enabled PE staff and the Behavioral Health Specialists to work with clients to set personalized goals.

PE initially received funding through a grant of $200,000 provided by a national foundation to serve 200 individuals who were low-income. Low-income status was defined by the U.S. federal poverty guidelines (U.S. Department of Health & Human Services, 2013). For example, for a household of one person, the income needed to be below $11,490. For a family of eight, the income would need to be below $39,630. This funding was supplemented by in-kind services from the university and the local public Housing Authority. With receipt of the grant, an advisory team was established to guide the project. The advisory committee was selected to be representative of the health and human service community, the university, and the greater community. The Advisory Committee included the director of the welfare to work program (Reach Higher Program), the director of the local housing authority's sufficiency program (Family Self-Sufficiency Program),

a representative from the local international center, and the area ministerial program. Key academicians were included from a variety of disciplines including nursing, education, social work, counseling, and psychology. Through this financing, services were developed with the ultimate goal to increase the quality of life for recipients and to contribute to the development of fully functioning citizens who make contributions to society.

Setting

Project EMPOWER (PE) was located in a rural community which faced the same issues as most rural communities, that is, lack of transportation, lack of affordable housing, lack of affordable health and behavioral healthcare, and impoverishment. According to the U.S. Census Bureau (2014), 19.1% of this rural community's population were considered below the poverty line. The median household income in this area was $44,135 which is 20% below the national median income. Further, the Census Bureau indicated that 18.8% of the state's population lives in poverty which exceed the national average during the same time period. The local community behavioral health center reported in their 2008-2009 annual report that there were shortages in staff and funding resulting in limited psychiatric services to existing clients, those in crisis, and those referred from the regional state hospital (LifeSkills, 2008-2009).

Participants

Any resident in the local community and surrounding areas who met the established criteria for being low-income was eligible for participation. Exceptions were residents who met exclusion criteria or could not consent to program services. Individuals were excluded from the program if they had severe behavioral health issues which were determined to need more specialized care or if they needed court ordered services. In addition, they were disqualified for services if they were under the influence of drugs and/or alcohol, combative and/or assaultive, or in possession of a weapon. Services were provided on a voluntary basis, and client referrals came from various places including self-referrals and community partner agencies. The majority of the referrals came from the local welfare to work program. Recruitment materials were provided to health care providers, behavioral health providers, and family resource centers located at schools with a high percentage of students from low-income households. Staff attended local health fairs and a variety of local community events to distribute information about the project. PE also referred participants to various community resources and partner agencies based on the client's needs, wants, and goals.

At the end of the first two years of the three-year grant, Project EMPOWER provided over 300 individuals with behavioral health services in individual and group sessions. Participants were predominantly female (65%). Ethnicity was more diverse than that of the region with 63.2% White, 25.7% African American, 4.9% Hispanic, and 4.9% other. Education was diverse with 44.4% holding a high school diploma or GED and 25% having less than a 12^{th} grade education. Tertiary education was noted by 17.8% of the participants with 8.1% holding associate degrees, and 6.5% holding a bachelor's degree. Some participants reported completion of college and graduate level courses without obtaining a degree. Completion of college courses was noted by 14.5% of participants and 3.2% completed some graduate level coursework. Employment was held by 47.4% while 39.6% were unemployed, 3.9% were disabled, and 9.1% were students. The income level of the participants was very low with 89.4% making $20,000 or less a year. The highest

income bracket represented was the $30,000 to $40,000 yearly which was noted by only 2.4% of the participants.

Project EMPOWER Services

The services provided by PE included case management, counseling, education regarding community resources, assessments, and referrals for individuals and families. The intent was to provide behavioral health counseling and case management services to low-income residents of this community with the mission being to empower individuals and families to obtain greater stability, self-sufficiency, and self-reliance. Clients would achieve this through their partnership with case managers and behavior health specialists. Case managers performed the tasks of initial contact and assessment. Behavior health specialists performed the task of providing counseling and other interventions for clients. Through individual and group counseling, along with case management services, clients worked on progressing towards their individual goals. The uniqueness of PE was that clients could be provided services in the areas where they lived.

The primary steps of services included referral or inquiry, intake assessment, assignment to a Behavioral Health Specialist (BHS) for individual, group or family sessions, case plan development, individualized interventions, evaluation, termination, and follow-up. Referral or inquiry was the first contact made to Project EMPOWER (PE) by a community partner or individual seeking services. Intake was the first contact PE had with a potential client, and was most often handled by one of the graduate level interns or case managers. The client would receive individual sessions from a licensed BHS or case manager depending on the client's needs. This worker would help the client develop goals and a plan. Termination was either listed as successful or unsuccessful based on whether or not the client completed an exit self-assessment (MPSI). Termination would be formally recorded as unsuccessful if, after three phone calls and a termination letter, there was no response from the participant. Follow-up was scheduled for both three and six months after termination.

Specialized Services

Behavioral health services were provided by local, contracted, licensed mental health specialists who specialized in a wide range of behavioral health interventions and treatment modalities (e.g., mindfulness training, CBT, hypnosis, play therapy). Each provider had two or more years of experience as a behavioral health specialist with the most senior member having over 30 years of experience. The BHSs provided both individual and group counseling. They were assisted by a case manager who provided linkage to services and resources. The case manager was responsible for making sure the client had the resources they needed to access services. The setting of individual sessions varied. Intake and some case management sessions were held at PE offices which were within the local housing authority facilities; however, specific sessions with BHSs and workshops were held in a variety of locations which were strategically accessible or geographically close to the intended participant residences.

Table 1

Percentage of Participants with Clinically Significant Scores on Each Multi-Problem Screening Inventory[a] Scale

MPSI Scale	**N**	**%**
Depression	31	**26.1**
Self Esteem	16	13.4
Partner Relationship Problems	23	19.3
Sexual Discord	10	8.4
Problems with Child	2	1.6
Problems with Mother	13	10.9
Problems with Father	17	14.3
Personal Stress	36	**30.0**
Problems with Friends	6	5.0
Problems with Neighbors	11	9.2
Problems with School	8	6.7
Aggression	5	4.2
Problems with Work Associates	8	6.7
Family Relationship Problems	32	**26.9**
Suicidal Thoughts	4	3.4
Nonphysical Abuse	13	10.9
Physical Abuse	3	2.5
Fearfulness	9	7.6
Ideas of Reference	4	3.4
Phobias	8	6.7
Feelings of Guilt	14	11.8
Problems with Work	1	0.8
Confused Thinking	23	19.3
Disturbing Thoughts	8	6.7
Memory Loss	7	5.9
Alcohol Abuse	4	3.4
Drug Use	5	4.2

Three highest occurring scales are in boldface.
[a] Alvelo et al., (2001); Hudson & McMurty (1997).

Adjunct services and resources included referrals, vouchers, gifts cards, household supplies, and child care. Although services were provided primarily to adults and families, limited services were also available for children and adolescents. Services such as child care and travel

vouchers were essential in removing barriers for this population to access the needed interventions. Resources were also provided to assist family needs. Goodwill vouchers, parent training materials, holiday assistance, clothing, and various other resources were provided throughout the project. Participants also received referrals to community agencies to assist with specific needs such as medication, food, employment, and housing.

The intake process for individual clients seeking behavioral health services from PE was client centered in the sense that the comfort level of the client was taken into consideration when deciding upon the level of information gathered during intake. The client intake packet was extensive and included an informed consent document, forms for identifying participant availability, personal and demographic information, intake assessment, and the participant Bill of Rights. The intake assessment processed varied depending on each client's ability to tolerate intensive interviewing. Clients were asked to complete a two-page demographic form. Clients who were unsure or uncomfortable were assisted in filling out the form. A biopsychosocial assessment was completed with all clients. As part of the assessment, the Multi-Problem Screening Inventory (MPSI) was administered. Client intake was done by case managers or interns who were part of the Undergraduate Social Work Program or Graduate Social Work, Counseling, or Nursing Programs. Thus, the program also served to train future professionals in the field.

Description of Project EMPOWER Interventions

Clients received both individual and group interventions around identified needs (see Table 1). Individual sessions were either case management or therapeutic intervention. The majority of individual sessions were conducted by the BHSs (see Table 2). Once the BHS and client were connected, they mutually determined location and time for their sessions. The client was

Table 2
Units of Service Provided to Participants

Year	Case Management	Counseling	Psychoeducational Workshop	Total
1	308	304	19	631
2	171	345	16	532
3	178	293	23	494

Note. Units of service are the number of direct service sessions or meetings with participants; case management = meetings, counseling = therapy sessions, and psychoeducational workshop = workshops presented.

encouraged to set their own goals. While each therapist brought their own theoretical orientation or perspective, they all used an integrated approach. The perspectives or orientations included cognitive behavioral, expressive therapies, mindfulness practice (relaxation, guide imagery, centering, staying in the moment), reality choice therapy, and problem solving therapy. In addition, they were trained in motivational interviewing. The BHSs staffed cases every two weeks so the team could provide feedback on the most challenging cases. The staffing allowed for mutual supervision and decreased practitioner isolation.

Another aspect of the intervention was psychoeducational workshops. These workshops facilitated by Project EMPOWER staff aligned with the concerns noted by participants on the MPSI and intake interviews. Content of these workshops could be categorized into three broad areas with the majority focusing on life management strategies and coping skills. Stress relief, self-care, relaxation, self-esteem, healthy choices, goal setting, assertiveness training, empowerment, and healthy relationships were some of the content areas presented. Another category focused on recognizing and managing emotions such as anger, fear, depression, anxiety, and shame. The third category dealt with parenting issues, trauma, and abuse. The workshops were delivered in facilities and partner agencies across the community. Thus the workshops were taken to the areas in which the participants lived and/or facilities with which the participants were familiar.

The termination process for this project included three stages. First, all clients were reviewed after 6 to 8 sessions for continued individualized care or transition into another intervention stage. The BHS would prepare the client for transition to the second phase which was shifting from individual sessions to group therapeutic sessions or support groups. The third stage was follow-up phone calls at 3 and 6 month intervals after completed services in order to determine well-being or if a need for new services other than the project was warranted. If a client was terminated for missing sessions, they proceeded to the third step of termination. Follow up calls were made to determine and recommend services if needed.

Lessons Learned

One of the issues faced by PE was in providing services to clients whose first language was not English. Initially, all of PE's materials, paperwork, and MPSI tests were in English. This limited the ability to communicate and effectively assess/serve the growing client population whose primary language was Spanish. To address this issue, the informational brochures and intake forms were translated during the second year of the project. Project EMPOWER also ordered the MPSI in Spanish (Alvelo, Colazo & Rosario, 2001) to make sure this assessment was available to those clients who would benefit from having it in their language.

A second concern was compliance with service provision. Attendance and adherence to scheduled sessions was continually addressed and monitored for improvement. Incentives were offered in the form of vouchers for needed items and services. The BHSs were more than accommodating with changing meeting locations for sessions and taxi vouchers were provided when needed. Transportation and child care issues were addressed throughout the project. Apathy was often just a reflection of an immediate crisis for which the clients were still unprepared to cope. Examples of these crises were extended family, legal, court, housing, and evictions issues. The professional advisory council was key in the revamping of policies and procedures which lead to increased compliance.

Conclusion

Behavioral health services in rural settings are often lacking in terms of availability of clinics and trained practitioners (Cashwell & Starks, 2011). Effective practitioners are required to be cognizant of the barriers and struggles of their community in order to better understand client needs while creating and accessing needed services. Behavioral health services in rural areas also need trained staff who understand the cultural context of low-income rural residents (Pepin et al.,

2014). Access to quality services involves more than transportation. This unique project, utilizing community partnerships and an interdisciplinary approach to providing outreach services, was able to have a meaningful impact. Feedback from both clients and community partners affirmed the extent of this impact.

Through the work of the first two years of Project EMPOWER over 300 clients received behavioral health services in individual and group sessions. These clients had the benefit of both case management and counseling services. Services grounded in strength based perspectives that worked to empower clients in developing and working on personalized goals were delivered. Also, through the use of bus passes and other incentives, clients were encouraged to utilize the services provided. Although it is unknown how many of the PE participants would have accessed behavioral health services outside of PE, it is evident that a large number of individuals did access and receive services through PE. In meeting their individual needs, the overall behavioral health of the community was enhanced. Clients were able to secure and maintain employment, others returned to school, families were reunited, and women were able to leave abusive relationships.

This unique project has implications for the future of rural community behavioral health service. PE could be replicated to serve as a model to inform the development of other outreach pilot programs. Suggested changes would include expanding services for youth and securing stronger collaborations with local school system personnel. Refugees and immigrants with trauma issues were also identified as populations at risk and in need of behavioral health services. Social work, counseling, nursing, and the other health and human service disciplines could better serve rural community needs by joining forces and developing collaborative outreach training models. A shift toward more inter-professional delivery of services would be desirable. The professional workforce would then increase to include graduates who are better prepared to address the behavioral health issues in rural communities.

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