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ORIGINAL PAPER

Succeeding in Rural Mental Health Practice: Being Sensitive to Culture by Fitting in and Collaborating

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Abstract Sustainable solutions to the access to mental health care problems are complex and must address both the *availability* of mental health care resources and the *acceptability* of those resources to consumers. The purpose of this study was to determine how to address the acceptability problem by learning from medical and mental health care providers what mental health therapists need to know to be successful in providing care in rural communities. Using a qualitative design, focus groups were conducted in three rural communities (<2,500) with medical and mental health care providers practicing in these communities. Data were analyzed using inductive qualitative methods. Results indicate that in addition to sound clinical skill, mental health therapists should (A) be sensitive to the culture of the rural community in which they are working and (B) practice in a way that accommodates to the care culture of the community. The latter includes spending time with patients commensurate with what is expected by other providers, engaging in generalist practice, and collaborating with local providers in patient care. An important implication of these results is that mental health care must be acceptable to both the residents of the community and the gatekeepers to health care.

Keywords Rural-mental-health · Access-to-care · Collaborative-healthcare · Culture · Cultural-sensitivity

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Introduction

Mental health disparities are prevalent in rural communities throughout North America. Rural residents have higher rates of substance abuse, child abuse, domestic violence, depression, and suicide than their urban counterparts (Bushy 1998; Cellucci and Vik 2001; Eberhardt and Pamuk 2004; Fox et al. 1995; Smalley et al. 2010). They also have fewer mental health care resources to deal with these problems evidenced by the fact that nearly two-thirds (60 %) of the designated mental healthcare professional shortage areas are located in non-metropolitan rural regions (Department of Health and Human Services 2011).

Primary care has been identified as the de facto mental health treatment system (Reiger et al. 1978) because more people seek and receive treatment from their primary care provider for mental health problems than from providers specifically trained in mental health care (AAFP 2011; Reiger et al. 1978; Schurman et al. 1985). This is even more prevalent in rural areas where there are fewer mental health providers and where contextual barriers prevent access to mental health care (see Fox et al. 1995; Rost et al. 1994). Yet, studies have found that the quality of mental health treatment provided by primary care providers is generally below (and sometimes far below) recommended guidelines and that provided by mental health specialty providers (AAFP 2011).

To develop a sustainable solution for mental health disparities, both the *accessibility* of mental health care resources and the *acceptability* of the resources that exist must be addressed. Accessibility refers to the degree to which consumers have reasonable access to mental health care resources (e.g., Bird et al. 2001; Penchansky and Thomas 1981). Factors affecting accessibility can include the number of qualified mental health therapists (MHT) practicing in the area (e.g., Department of Health and Human Services 2011; Robinson et al. 2012), the ability to financially afford these services (e.g., Jackson and Shannon 2012; Willging et al. 2008), the distance needed to travel to receive care and the availability of reliable transportation (e.g., Robinson et al. 2012; Willging et al. 2008), fragmentation of services, and the demands on patient and caregiver time that restrict the ability to make use of services that do exist (e.g., Robinson et al. 2012; Willging et al. 2008). Accessibility can also be influenced by the degree to which consumers know that mental health care services exist (Garcia et al. 2011). Solutions to problems of accessibility can include increasing the numbers of providers, using tele-mental health options (Bischoff et al. 2004; Elder and Quillen 2007; Swinton et al. 2009), offering vouchers or reduced-fee services, and increasing the visibility of services. National, state/provincial, and local government programs such as loan forgiveness and other incentives for providers practicing in rural areas exist to help alleviate the access to care problem (National Health Service Corps 2010; Nebraska Rural Response 2011).

Despite the formidable nature of challenges of *accessibility*, challenges of *acceptability* are often more complex, more difficult to identify, and more difficult to address (Penchansky and Thomas 1981). Acceptability of care refers to the degree to which consumers see care as adequate or appropriate for meeting their needs (Mohatt et al. 2006). This includes whether patients *perceive* that they have access to adequate treatment (Smalley et al. 2010). It can be influenced by the degree to which patients or caregivers see a mental health provider as being able to help them (Robinson et al. 2012). For example, someone who identifies with a cultural minority may not see mental health care as acceptable when the available providers are of the cultural majority, and this may be exacerbated in rural communities (Garcia et al. 2011; Westerman 2010). In rural areas, a similar scenario may play itself out with rural residents preferring providers who come from rural areas

themselves or who demonstrate an understanding of the cultural nuances associated with rural communities (Farmer et al. 2012; Fox et al. 1995). Or, a problem of acceptability may result in a rural area when residents of the community do not see the local mental health provider as an acceptable resource because they attend church with the person and their children are friends at school. Research has found that patients' perceptions of their access to adequate mental health care is more important to determining access to care for rural residents than the number of providers or clinics in a community (Fortney et al. 1998; Hoyt et al. 1997; Rost et al. 2002). The stigma associated with having a mental health problem or of receiving mental health treatment can negatively impact the acceptability of care (Hoyt et al. 1997; Robinson, et al. 2012; Rost et al. 1993; Smalley et al. 2010). Acceptability can also be influenced by how standard-of-care protocols are applied in rural communities (Rainer 2010). Solutions to the acceptability problem can include community education about mental health problems and treatment (Ralph and Lambert 1998) and training providers in the nuances of rural mental health care (Smalley et al. 2010; Weigel and Baker 2002).

This project was designed as a next step toward reducing mental health disparities in rural communities. This was done by learning from local providers what the key ingredients are to being successful in providing acceptable treatment in rural communities. The central question was "What do mental health therapists need to know to successfully practice in rural communities?" The perspective of the local providers is important because they a) make up the de facto mental health service system (Fox et al. 1995) in the community and consequently are the conduits for patients to access specialty mental health services, and b) they are the local experts in making care accessible (they have already succeeded). This paper reports the results of this investigation.

Methodology

A qualitative design using a focus group format for data collection was implemented for this study. Institutional Review Board approval was obtained prior to commencing the research.

Participants

All mental health and primary care providers (i.e., physicians, physicians' assistants, and nurse practitioners) from three rural Nebraska communities were invited to participate in the study. Medical providers working in rural hospitals and medical clinics throughout the state were contacted with a request to accept student interns from a master's degree Marriage and Family Therapy program. The clinical training program is located in an urban area. Participating communities were those expressing an interest in accepting student interns. Participation in the study accomplished two purposes: a) it contributed to the knowledge-base about what constitutes successful practice in rural communities and b) it facilitated the assignment of student-interns at the hospital. Each community has fewer than 2,500 residents. All (100 %) mental health and medical providers practicing in each community participated in the focus group for their community. The number of participants varied from each location as well as their ages, gender, and education. Overall, the focus groups had a total of 17 participants which included four males and 13 females. All participants were Caucasian who ranged in age from 24 to 55+ . Refer to Table 1 for specific location demographics.

Table 1 Specific Data Collection Site Demographics

Focus group	Population of the town where the medical clinic is located	Racial makeup of residents	# of counties in service area	# of participants in the focus group	Type of provider	Gender	Age range
A	1,650	97.2 % Caucasian 1.8 % Hispanic	8	8	4 Medical doctors (family practice) 2 Physician assistants 1 Mental health provider	5 Female 3 Male	30–54
B	1,020	92.8 % Caucasian 4.3 % Hispanic 1.4 % Multi-racial	5	4	2 Medical doctors (family practice) 1 Nurse practicioner 1 Mental health provider	4 Female	30–55+
C	1,957	95.7 % Caucasian 2.0 % Hispanic 1.4 % Multi-racial	7	5	1 Medical doctor (family practice) 1 Physician assistant 1 Nurse practicioner 1 Mental health provider	4 Female 1 Male	24–40

Procedures

One focus group was conducted in each of the three locations. Focus groups were structured and conducted according to methodology recommended by Morgan (1997), supplemented by recommendations by other authors (Breen 2006; Creswell 2007). The principal investigator served as the moderator of the focus group. The moderator ensured effective discussion through active listening, probing of participants' experiences and thoughts, clarifying and eliciting validation of shared experiences from other group members, and comparing the ideas verbalized by all participants (Breen 2006).

Focus groups are useful in obtaining qualitative data because they allow researchers to understand the group dynamics that surround an individual's perception and processing of the subject matter (Stewart et al. 2007), In comparison to individual interviews, the advantages to participants in focus groups include the availability of a wider range of information and experiences that can prompt additional information contributing to a fuller and richer understanding of the topic being studied. Focus group discussion can have a snowball effect where participants add to ideas and comment on experiences expressed by others creating a synergy producing a result that is greater than what could come from any one individual. Focus group interviewing is also advantageous because the means of collecting data through focus group discussion increases the validity of the study by making sure the researchers capture the participants' thoughts and feelings accurately. Participant comments are refined through clarification by the moderator and focus group discussion, decreasing the likelihood that interpretations of the data will be unduly influenced by investigator or participant bias (Creswell 2007). This interview format was also deemed most appropriate in order to honor the collaborative nature in which the providers work with each other and their patients, and the expectation that the researchers and participants would have a relationship after data collection was completed (Madriz 2000).

Although the focus groups were audio recorded and transcribed verbatim, the fourth author, a graduate assistant, also took field notes. It is important for field notes to be taken throughout the course of the discussion to record any non-verbal cues (Morgan 1997) and supplement the data analysis as an additional form of validation.

The focus groups consisted of the same format for all locations and included a welcome, overview of topic, statement of ground rules and confidentiality, focus group questions and discussion, and closing (Breen 2006). Demographic information was obtained through a demographic questionnaire. A focus group guide was used by the moderator to provide structure for the group, however, it was recognized that while it was important for the moderator to have a guide for discussion, it was critical that it not become a "verbal version of a survey questionnaire" (Stewart et al. 2007, p. 61). The following questions were used to guide focus group discussion: (1) What is unique about the practice of mental health care in rural settings? What characteristics make this type of practice different than mental health care practice in an urban setting?; (2) What unique skills are necessary for mental health practitioners to have in order to treat rural patients effectively?; and (3) How important is collaborative care between medical providers and mental health professionals in a rural setting? Do you have any suggestions for creating and maintaining positive collaborative relationships?

Data Analysis

Data were analyzed by the principal investigator, two secondary investigators, and a research assistant using a content analysis approach (Miles and Huberman 1994). Using

this method, the four analysts independently analyzed each focus group transcript by assigning open codes representing salient themes to the passages of text. Each analyst identified themes that were represented across all three focus groups. The researchers then met to share their observations of dominant themes and to reach consensus through a process of reviewing and validating the presence and salience of each theme. Consensus was reached by returning to the text to validate the presence of each theme across all three focus groups and by examining field notes for contextual information to support the dominant themes. Once consensus was reached, the researchers collapsed and sorted each theme into categories and sub-categories.

The validity, or substantive significance, of the data was established through analyst triangulation (Patton 2002). Using a deductive method, three additional secondary coders reviewed and validated the presence and salience of each theme identified by the primary coders. The secondary coders are mental health practitioners who were selected based upon their expertise as behavioral science trainers of medical residents in a rural medicine track. They were presented with a thick description of each theme which included a textual description of the theme and representative exemplars for all three focus group locations. They validated both the salience of each theme according to the data and also their professional experience as collaborative health care providers. A final independent coder was utilized, a graduate student, knowledgeable about general mental health, but mostly unfamiliar with this area of research and practice. She further validated the presence, salience, and cohesiveness of each theme.

Results

Through the data analysis, three prominent themes emerged, each fitting within the attitudinal domain of cultural sensitivity. The discussion of culture, in one form or another, dominated the discussion in each focus group suggesting that participants see cultural sensitivity as the most important ingredient to successful rural practice.

Participants emphasized that they expected MHTs to have excellent diagnostic and clinical skills and that these clinical competencies were the same that would be required in any environment, be it urban or rural. In addition, they agreed with each other that the competencies unique to a rural practice environment were those related to practicing in ways that acknowledge and are sensitive to (a) rural culture, (b) the unique culture of the rural community where one is practicing, and (c) the culture of how care is delivered within the community, or what many of the providers referred to as the "care culture." Each of these attitudinal sub-domains are presented below with exemplars from the data contributing to thick description of each.

Attitudinal Sub-domain 1: Understanding the Uniqueness of Rural Culture

Participants in all three locations were careful to explain how rural communities, in general, are different than urban areas and that these differences affect and include how mental health problems and treatment are perceived. For example, in each focus group, participants asserted that the stigma of mental health problems and treatment is greater than what one might experience in urban areas. An example of this is the statement from one participant:

> I think it [having a mental health problem] is shameful to some people. They are raised to think that anything that is in their head is not right. There is still that

> mentality that it is all in your head. It is different in an urban area where going to a [mental health therapist] isn't a big deal.

Another provider simply said that rural residents often do not "even believe in therapists."

Stigma, fueled by cultural beliefs, attitudes, and misconceptions about mental health problems, was identified as one of the primary challenges to mental health care in rural areas. Participants emphasized that MHTs trained in urban areas have to recognize the prominence of stigma attributed to both mental health problems and to treatment and that they need to address stigma in a way that respects the cultural values and mores of rural communities. The participants explained that rural residents are sensitive to even subtle, unwitting criticism of rural culture. They are especially resistant to attempts to impose urban ways or practices on rural communities. Each of the focus groups included stories of well-intentioned providers who failed in their communities because they did not recognize and appreciate rural culture and the unique role that stigma plays in access to care.

Participants hypothesized that much of the stigma is fueled by the cultural values of being "industrious" and "self-sufficient" and the belief that others will know about their problem and will judge them harshly for not being strong enough to handle it. One provider explained:

> Farm people are very self-sufficient. That is how they are raised, self-sufficient. I can do everything or my family can take care of ourselves. So when they have problems that arise that are out of their scope it is hard for them to accept going to a counselor. There is just a lot of negative connotation to mental health.

Participants cautioned that it is important to look for the value in even cultural characteristics that seem to negatively influence access to care. For example, in each focus group, participants explained that a common perception is that in rural communities "everyone knows everyone else" and "everybody's business is everybody's business." Participants acknowledged that many people see this as a negative characteristic of rural culture and a barrier to getting help when it is needed. They said that even rural residents complain about it. But, they explained, it comes from a desire to look out for one another and help each other; a cultural value that has mental health benefits. Practitioners who can value this characteristic are those who will succeed in rural communities. If practitioners, particularly those coming from an urban setting, criticize or complain about this or other characteristics that are woven into the fabric of the community, they run the risk of criticizing a rural cultural ideal and losing credibility.

Attitudinal Sub-domain 2: Sensitivity to the Unique Culture of the Community

All participants, regardless of focus group, stressed that while all rural communities have some things in common, and exemplify rural culture, each also has idiosyncrasies that make them different and that result in a unique culture. They explained that the population, services, opportunities for entertainment and employment, and structure of city government all play a role in these differences between communities. One participant explained that:

> …between 2,000 and 5,000, these towns are big enough that they are kind of big town city-wannabes so there is a hierarchy in this size of town. You go below 2,000 and everybody is on the same page….They are all for the same team; they all kind of play together.

Another participant added,

> That was very well said. I would agree with that. I practiced in a smaller town and then I came here and there was a complete difference in the mentality of the people and how they interact with each other.

To succeed, MHTs must be sensitive to these idiosyncrasies and how rural culture plays itself out in the specific community in which one is working.

Participants explained that it is important to work to understand and appreciate the local culture and to do so in a visible way. One participant said succinctly, "I think you can't learn it until you experience it." MHTs should know what people do for work and entertainment. They should know how the high school athletic teams are doing and be able to talk about what the people in the community are talking about and to talk about those things using language that the locals are using. A MHT explained that "learning the lingo" and using it is important. She said:

> I know what a pivot is. I know what John Deers are. You know because that's important; that's what the people do every day and if you come to work and there are 63 semis in line at cargo [a grain silo] and you know why they are in line [then you can talk to your patients in a way that they know that you understand]…. I just remember when one of the farmers came in and he was so against therapy and he was just so guarded and as soon as he was talking about [how] he couldn't be sitting there [because] he had to get his irrigation done and the pivots. I remember looking at him and saying 'I don't even want to hear about your pivot [because] we have gated pipe.' And as soon as I did that it was like 'Oh, you know, she speaks my language'.

Participants counseled that MHTs should get to know the community by following and even participating in community events. This helps to break down the intimidating professional hierarchy that exists. One participant explained,

> I think for some people it is intimidating…because they look to people like us, I don't want to say authority [figures], but they come to us for help and it can be intimidating…. If you seem like you are too professional or powerful. I think it is important to be on a more down to earth…level. I think that is important for people to feel that they can trust you or open up to you.

Participants explained that one way to do this is to get involved in the community. They counseled that, as difficult as it may be, "rather than hide behind a curtain of privacy and confidentiality" which often exacerbates the professional hierarchy, MHTs should be visible in the community by eating at local restaurants, shopping at local stores, going to local bowling allies, and attending local events. This is especially important for those providers not living in the community. One participant explained the importance of "being visible in the community" by suggesting that non-resident providers:

> Stop by, for example, the bowling alley or go downtown and meet some people. Make yourself visible in the place showing that [you] care about our community. I think that helps the community feel more at ease and say ok maybe they are serious.

Attitudinal Sub-domain 3: Sensitivity to the Local Care Culture

Participants were careful to explain that each community has a unique culture around how care is provided. While they described the care culture as encompassing all providers, they

were quick to note that because there are often so few providers in rural communities, the impact of any one provider on the care culture is noticeable. Each focus group included stories of the negative impact on the care culture of those who attempted to provide care in ways that are insensitive to either the local culture or the care culture of the community. One participant explained:

> They [the residents of the town] have been burned like [another participant] said. This poor community has been burned over and over again with providers coming and going; being here for a year or three and then gone. And people don't like that because they can't build trust with providers.

When a provider doesn't fit in because they do not respect the way care is provided in a community, the result is always distrust. There was concern expressed that this distrust would extend to other providers in the community. So, our participants expressed that they are careful about who is hired and to whom they refer patients. They said that they want to make sure that the person has the same approach to patient care that they do because their own credibility is on the line. One medical provider explained that the most important thing she would look for in hiring an MHT would be "to make sure she was on the same page as [I am in working with] my patients." Three clinical practices emerged from the focus groups that highlight participant perceptions of what it takes to practice successfully in rural communities: spending time with patients, being a generalist, and collaborative care.

Spending Time with Patients

One participant said with a smile and a hint of pride in his voice, "We do a lot of coddling here, we spoon feed a lot. We spoil our patients bad." Other participants readily agreed admitting that it may not be the most efficient way to provide treatment, but in these rural communities spending time with patients is important to treatment effectiveness because it reflects the pace and cultural ideals of the community. A participant from another focus group said:

> Don't be scared to spend time with them. I'm not saying in mental health you don't do this but I will send a patient to [a larger city] to see a specialist and they'll say 'they only spent five minutes with me; they don't care about me.' Don't be afraid to spend time with them. Being willing to spend time suggests that the provider cares about them and that they are willing to work within the culture of the community.

Generalist Practice

As a practitioner in a town with limited resources, providers, regardless of discipline, need to "know a little about a lot" as opposed to "a lot about a little" and to practice as a generalist rather than as a specialist. One provider said: "I've heard it described as a specialty of breadth rather than a specialty of depth." Another provider stated:

> I think it is pretty common in family practice medicine in rural communities to have to deal with a wide spectrum of psychiatric problems from children with behavioral disorders, academic performance, and hyperactivity issues to adolescent depression and anxiety issues all the way up to marital discord, spousal separation, and deaths…I think there isn't really much that we probably don't put our fingers in a little bit.

As a referral source and collaborator in patient care, medical providers expect MHT to treat the wide variety of problems that they are treating.

Collaborative Care

Collaborative care practices are inherent to the care culture described in each focus group. All participants explained that collaboration reflects the rural cultural ideals of looking out for each other and trying to help one another in the face of limited resources. It reflects a value of united effort and of advocating for one another.

The data are clear that the preeminent collaborative relationship is with the patient and the patients' family. Participant statements about their patients reflect that they sincerely care about their patients and that collaborating with them and their families in health care is important. Also "vital" for success and "sanity" in resource poor communities is collaboration with other providers. When the providers in one focus group were asked if someone could get by without collaborating with other professionals they responded that they "wouldn't recommend it" and "There are too many resources among the group [of providers] that I would hate to see people not utilize people's knowledge to succeed." Participants explained three practices essential to effective collaboration with other health professionals: knowledge of and ability to point others toward existing resources, knowledge of and ability to speak the language of the medical providers, and effective communication about patients.

Know the Resources of the Community To collaborate effectively, MHTs working in rural communities must know the resources available to members of the community and be ready to point others toward those resources. As an example of how one is expected to function as a generalist, one must often perform functions that are not considered standard practice, the medical providers in our focus groups lamented that they did not have medical social workers to help them identify resources for their patients and so they expected the MHT to do that for them. A MHT affirmed the importance of this skill by pointing out that "another point to knowing this community…would be knowing a little bit about the resources that are available in the community." Another MHT described the importance of this competency by saying:

> …especially in rural practice you have to know your resources and you have to know the person on the other line when you call. My cell phone has all those places so I just call. I actually have the person I want to talk to on my phone because doctors may be calling at 2:00 in the morning.

Know the Language of Medicine Participants explained that most patients in their communities turn to their medical providers for help before going to the MHT. Because of this, collaboration with patients and medical providers is facilitated when MHTs know the culture of medicine and common medical language. This helps MHTs be on the same page as both their patients (most of whom are concurrently receiving medical treatment) and the medical providers. Stressing the importance of this competency, one MHT said:

> I think if I was going back to school, knowing this is where I was going to land, I would want to have more knowledge on medications and the medical pieces. Sometimes if the doctors say certain medical things, I'm thinking, 'what are they talking about?' I would have to get my book out and look because they are talking medical terms.

Communicating About Patients The medical providers in our focus groups explained that as the point of first contact for patients, they want to stay involved in patient care even when the problem is mental health and a referral is made to a MHT. Each explained their frustration in making referrals to MHTs who do not provide information about the treatment or who do not even acknowledge the referral. Participants emphasized the importance of developing effective communication. They complained that these MHTs do not understand how they do things in their community; that these MHTs are trying to use a model of care delivery and patient management that does not reflect the culture of the community and how the medical providers work within that community. These medical providers were clear that trust was established between providers to the degree in which they communicate and collaborate to enhance the quality of patient care. When established communication patterns within the identified "care culture" is not adhered to, medical providers are hesitant to refer, and may choose to treat patients' mental health problems on their own.

Discussion

The results of this study are that sensitivity to both (a) the culture of the local community and (b) the local care culture are most important to addressing the acceptability of care problem in rural communities. These results suggest that to be successful, mental health care providers must consider two client groups: the patient-client group and the provider-client group. That patients are clients is intuitive because they are the logical consumers of mental health services. Consideration of this client group could be restricted to only the patient (i.e., the one receiving treatment), or it could be expanded to include patient-caregivers, family members, or others who are part of the patient's system and who may or may not be involved in the treatment. The importance of sensitivity to the patient's culture to treatment success has been well documented in the literature (e.g., Farmer et al. 2012; Park et al. 2011; Polain et al. 2011; Weine 2011). But, our results suggest that mental health providers practicing in rural areas would do well to consider that medical providers practicing in the community are also an important client group and that sensitivity to the culture of providing care in the community is important to successful practice. The interactions of the care providers with each other and with their patients, the mores that inform practice and referral, and the customs of treatment delivery all make up a unique culture that must be understood and respected. Both the patient-client group and the medical provider-client group must see the mental health treatment as both accessible and acceptable. MHTs must recognize how both client groups view acceptability to care in order to deliver culturally sensitive treatments.

Admittedly, these conclusions are drawn from data obtained only from individuals in the provider-client group, and so they only reflect the perspectives of that client-group and not that of the patient-client group. However, as has been established through other research, primary care is the de facto mental health care system (Reiger et al. 1978), especially in rural communities (Fox et al. 1995). As such, primary care has the potential of being the de facto referral source to mental health care provided by those specifically trained to provide it. Acknowledging that the local medical providers are a client group and attending to their perceptions of the acceptability of mental health care is particularly important to succeeding in rural mental health practice.

Our participants universally agreed that the foundation for mental health care to be considered acceptable among the provider-client group is excellent diagnostic and clinical skills. But, they did not think that the diagnostic and clinical skills needed for work in rural communities was different from that needed in urban areas. In their minds, unique (and

essential) to delivering acceptable care to rural communities is the provider's sensitivity to the culture of the community, and willingness to honor, respect, and work within how care is provided in that community.

Our research suggests that the credibility of providers is linked to how well they know the community and are able to talk about things that are important to patients and community members. In fact, participants acknowledged that while a knowledge-based understanding of cultural mores, values, and ideals is the first step toward sensitivity to rural culture, it is not enough. Successful practitioners do not just understand; they do. This means that providers should be aware of local community events, including youth sports and high school athletics. They should know where people shop, what they do for entertainment, and where they go to church. They should know about what people do for work and be able to speak the language of the community. In rural communities, the acceptability of care is dependent, in part, on how much the MHT appears to care about the community and respect how things are done there; and rural residents are attuned to practitioner's sensitivity to the culture.

To fit in the MHT will also need to respect how health care is provided in the community. There is a unique culture surrounding the provision of health care that is informed by a confluence of the culture of the community and the culture of the practice of medicine and mental health care. It reflects both how providers work together to meet the health care needs of the community and how providers, patients, and members of the community interact with each other around available care resources. A care culture is developed over time as providers learn the culture of the community, adapt their practices to that culture, and gain the trust and confidence of patients and community leaders. It is reflected in the patterned ways that the local cultural ideals are operationalized in patient care. It both reflects and informs how care is provided in the community, what members of the community expect from care providers, and the types of health care services that community members will accept. While there may be similarities across communities, a unique care culture develops in each community.

Fitting in with the care culture may require some accommodations in how mental health care is traditionally practiced. Participants cautioned that the traditional models of care provision that students, interns, and residents are trained in are based on urban practices and do not always work in rural communities. Differences between traditional (urban) and rural practices are evident in existing literature (Curtin and Hargrove 2010; Faulker and Faulkner 1997; Larsen and Corrigan 2010; Rainer 2010; Smalley et al. 2010; Werth et al. 2010). Providers trained in urban models of mental health who are successful in rural communities learn how to alter their practices to conform to the mores and standard-of-care practices in the community in which they are providing care (Hovestadt et al. 2002; Larsen and Corrigan 2010; Smalley et al. 2010). Similar to what other research studies have found (Smalley et al. 2010; Weigel and Baker 2002), our participants agreed on three standard-of-care practices that reflect the care culture in rural communities: spending time with patients, being a generalist in practice, and a willingness to collaborate with other providers within and across disciplinary lines.

These standard-of-care practices correspond with current trends in the field toward rethinking health care delivery systems and the boundaries of professional roles. Collaborative care practices, the Patient Centered Medical Home, and other trends designed to improve patient outcomes by increasing patient agency and provider teamwork are all models of care delivery that would appear, based on the results of this study, to be welcomed in rural communities because they would be consistent with the care culture that has been established in these communities. We may find that applications of these twenty-

first century models of care delivery may be particularly welcomed in rural communities. However, the unique circumstances of practice in rural communities may still warrant modifications. Mental health providers should be specially trained for work in rural communities so that appropriate accommodations can be made to any model of care to meet the unique needs of the community.

The rural providers participating in this study made repeated references to differences between urban and rural communities. For example, they unanimously asserted that stigma in rural communities is greater than in urban areas. While this assertion is supported by research (Jones et al. 2011), when these same researchers controlled for education level, the differences between rural and urban residence became non-significant. So, it may be that differences between rural and urban communities are better explained by other factors such as level of education. This is worth further research attention. Regardless, this and other assertions about the differences in what needs to be considered when practicing in rural as opposed to urban areas are beliefs held by rural providers that impact the local practice culture and their acceptance of providers from urban areas or who were trained in urban areas. We think that these beliefs influence and reflect the practice culture and need to be attended to by the mental health provider. It would do little good for a well-meaning mental health provider to correct these kinds of assumptions before attempting to learn from the local providers what is important to consider when serving the local community.

Limitations

Our participants were medical and mental health care providers practicing in the targeted rural communities and consequently, their perspectives carried a bias. However, they constitute the de facto mental health care system (Reiger et al. 1978; Fox et al. 1995) and are the gatekeepers to the community for MHTs coming from the "outside". If the solution to mental health disparities in rural communities is to increase both the accessibility and acceptability of mental health services, an important first step would be understanding what the gatekeepers to the community are looking for and how they provide care. The existing literature suggests that the first step to being accepted into any culture is to gain the trust of the gatekeepers to the community (Allan and Cambell 2011; Bondi 2009; Gibb 2003; Menadue 2008). This may be especially important in communities with small populations. We acknowledge that we did not include individuals from all gatekeeper groups as participants. In conducting this study, the gatekeepers were identified as the existing medical and mental health care providers. Other gatekeepers also exist (e.g., clergy, law enforcement and judicial system personnel, school personnel). We recognize that this may be a limitation of our study and believe it may be helpful for future research to include people in these other gatekeeping roles as participants.

We also acknowledge that we have not included anyone from the patient-client group as participants. There are limitations to attempting to learn about the acceptability of mental health care from those who are not direct consumers of the care. Notably, in conducting the study as we have, we have not contributed to patient agency because we have not elevated the voice of the patient. If we were to allow the provider to be the sole voice in defining the problem and identifying the solution, we run the risk of perpetuating some of the problems of acceptability of care. However, other research has already been conducted illuminating the patient and caregiver perspective of the acceptability of mental health care (Robinson et al. 2012). That paired with the results of this study should provide a fuller picture of the acceptability of care. In that research, the investigators found that acceptability from the

perspective of the patient and caregiver is determined by the degree to which medical and mental health care providers communicate messages that perpetuate stigma and the degree to which they misdiagnose, misapply mental health treatments, and fail to coordinate care with other providers. These two studies complement one another by underscoring the importance of collaborating with medical providers in providing mental health care. This can only be accomplished by acknowledging that medical providers' are "clients" of mental health care on behalf of their patients. The mental health care must be acceptable to them, just as it must be acceptable to those in the patient-client group. But, additional research is needed to illuminate the role of these two perspectives.

Another limitation is that both participant recruitment and small sample size limit the generalizability of the results. However, it is important to note that despite the small number of participants, every eligible provider in these three communities participated in these interviews. Consequently, we feel strongly that the results accurately reflect these providers' experiences in what it takes to be a successful rural practitioner. Also consistent with qualitative research, generalizability of results is not the goal of qualitative data. Rather, it is gaining a deeper understanding of a phenomenon where in-depth description can contribute valuable knowledge in the field (Creswell 2007; Myers 2000). In this regard, we believe that the participants among all sites clearly articulated prominent themes that suggest there are key ingredients to success in working in rural communities; attending to the local culture, and tailoring the treatment to the local community.

Conclusions

The results of this study reaffirm that linearly-derived solutions (e.g., recruit more mental health providers to work in rural communities, decrease stigma through education) will not adequately address the mental health disparities that exist in rural communities. Any real solution to mental health disparities must include attention to both the availability of mental health care and the acceptability of that care. However, what is different about this study from others is that rural providers delineated different levels of rural culture that need to be attended to. This goes beyond just describing the differences between rural and urban practice and includes suggestions for practicing in ways that accommodate the cultures that exist within a single community. Mental health providers practicing in rural communities would be wise to recognize that they have at least two clients with every case—the patient-client and the medical provider-client—and that both need to be considered in addressing the accessibility of care. The results of this study suggest that mental health providers should be specially trained to work in rural.

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