Rural Mental Health
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Rural Mental Health
Issues, Policies, and Best Practices

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Editors

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To my parents, Becky and Terry – Bryant

To my parents, Rita and Mark – Jacob

To my wife, Karen – Jack
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Preface

Rural residents, accounting for 20% of the United States population, represent one of the largest population groups with recognized challenges in receipt of mental health services. For decades, there has been national recognition that individuals and families in rural areas face barriers to health and wellness beyond those faced by urban residents. In addition to being more likely than individuals in urban areas to be without a regular source of health care, without health insurance, and to be coping with a chronic or serious illness, rural residents face stark burdens of mental illness and barriers to receipt of quality mental health services. In addition, mental health clinicians practicing in rural areas face additional challenges not as frequently encountered by their urban counterparts.

The repeating themes of rural mental health involve mounting needs, restricted or limited resources, and widespread provider shortages; unique geographic and cultural challenges to service delivery for which clinicians receive little to no training; service providers struggling to operate under urban models and assumptions imposed by funding sources and regulators; consistent and pervasive misunderstandings of rural realities; and the tendency to not take “rural” into account in public policy or the tendency to want a single policy solution to rural issues. Despite many years of attention, there remain innumerable examples of challenges rural residents face in maintaining and improving their mental health that are widespread and require consideration of multiple unique features of rural living.

In our roles ranging from rural-based clinicians to university-based researchers, we have seen daily the impact that rural residence has on mental health—both in mental health stressors and in ability to receive care. These ongoing observations provided the impetus for this book. While much attention has been paid to rural mental health, there was a lack of a cohesive, up-to-date resource focusing on all areas of need within rural mental health (ranging from cultural factors to specific evidence-based best practices for particular rural groups). We have written *Rural Mental Health* in the hope of bringing much-needed attention to the distinct mental health needs of rural populations. The book first offers a summary and background of the current state of rural mental health and special consideration in working with rural
populations, followed by discussion on some of the major models of service delivery that have been developed to address specific challenges faced in the delivery of quality mental health services. The book then examines specific considerations and best practices for working with distinct subgroups in rural areas, ranging from minority groups to veterans. It concludes with a discussion on the next steps in advancing the mental health of rural groups.

The book has been written for practitioners, researchers, and students seeking recommendations, a guide to best practices and new models of service delivery, and as a useful reference for current issues and concerns in rural mental health. The text examines the intricacies of improving mental health in rural practice and offers clear, research-driven recommendations for clinicians and scholars, able to be adopted into current practice or training programs. In preparing the text, we assembled a group of seasoned researchers and clinicians from Georgia to Alaska to Australia who speak from their direct experience as to the current state of rural mental health, new models for service delivery, and the best practices for working with specific rural populations.

We hope that this text serves as both a resource and a call-to-action for rural mental health. Together, we can help bridge the gap between rural and urban areas and improve the mental health of the 60 million people who live in rural America.

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Rural Mental Health
Introduction and Special Considerations
INTRODUCTION

Rural Americans comprise an estimated 20% of the U.S. population (U.S. Census Bureau, 2010) and represent a larger subgroup of Americans than any racial or ethnic minority. Unfortunately, persistent disparities in rates, severity, and outcomes of mental illness in rural America have remained relatively unchanged over the past several decades, and federal funding for rural mental health research lags behind funding received for other disparity groups. Practitioners and researchers have long recognized the unique mental health challenges faced by rural Americans, but organized movements toward improving mental health in rural areas did not come to the forefront until the 1970s. At the time, the most pressing mental health concerns in rural areas were the lack of doctoral-level psychologists available at community mental health centers in rural areas, the lack of training of mental health professionals in the particular needs of rural residents, and the high rate of turnover in rural mental health positions (Hollingsworth & Hendrix, 1977)—concerns that unfortunately continue today. The federal response to rural mental health has heightened in recent years; one of the most significant advancements was the establishment of the Office of Rural Health Policy and the National Rural Health Advisory Committee in 1987 within the Health Resources and Services Administration (HRSA; DeLeon, Wakefield, Schultz, Williams, & VandenBos, 1989). Many other federal steps have been taken to improve rural mental health (and are discussed in detail in Chapter 2); however, despite nearly 30 years of intensified focus on rural mental health, rural populations continue to face increased mental health burden and distinct challenges in receiving mental health services.

Portions of this chapter are adapted from material that previously appeared in the Journal of Clinical Psychology.
The goal of this book is to summarize the current status of rural mental health and to individually examine the many complex subcomponents of improving mental health throughout rural regions. This chapter provides a broad introduction to the current state of rural mental health, briefly touching on many of the issues that are examined in depth in later chapters.

**WHAT IS RURAL?**

Throughout the psychological literature, inconsistent findings with respect to rural residence abound in mental health diagnoses and outcomes. This is due in large part to the fact that unlike many other underserved populations (such as racial or ethnic minorities), there is no single, consistent definition of what *rural* actually is (HRSA, 2005). Definitions of rurality are frequently based on population size, population density, and/or economic factors—each of which have distinct limitations in their application. For instance, a common definition of “rural” is a county with less than 50,000 residents. This definition, however, does not take into account population density. As a result, counties with more geographic area may not be labeled as rural, even if they have fewer residents per square mile than a geographically smaller county with proportionately more residents.

Similar complications arise with nearly every definition of rural, leading to a vast array of inconsistent definitions applied across the rural health literature. The lack of consistency in the definition of rurality has unfortunately clouded what can definitively be stated about rural mental health prevalence and outcomes. Despite this, some differences have been repeatedly demonstrated, and the impact of the unique culture of rural living on mental health is evident; in fact, being from a rural background can have such strong influence on an individual’s perceptions of mental health that “rurality” can be viewed by mental health practitioners as a diversity issue similar to being from a racial, ethnic, or other minority background (see Chapter 3).

Even within the somewhat nebulous concept of “rural,” there are well-recognized degrees of rurality. Traditionally, rurality has been divided into two main categories, rural and frontier, with frontier communities representing the extreme of rurality (sometimes with “neighbors” separated from each other by miles). As with “rural,” defining “frontier” is difficult; definitions range from having a population density less than or equal to six people per square mile (Hewitt 1989) to complex scoring methods that take into account travel time to market centers and medical care (Center for Rural Health, 2006; Frontier Education Center, 2007). Most frontier communities are concentrated in the Western United States and Alaska. Many of the differences presented below and throughout this book are even more amplified in frontier areas because of their extreme geographic isolation; challenges with geographical...
barriers, poverty, travel distance, and lack of mental health care providers are particularly acute in frontier settings (see Chapter 20).

Regardless of the definition used or the degree of rurality of a given community, rural areas have unique health problems, resource shortages, demographic characteristics, cultural behaviors, and economic concerns that combine to impact on the mental health of its residents. While cultural factors and demographic characteristics vary across rural regions, two consistent characteristics across most rural populations are poverty and inability to access affordable mental health services. An estimated 17% of adult rural residents live below the federal poverty line, as compared with 14% of urban residents (Economic Research Service [ERS], 2011). Poverty rates are even higher for minority rural residents: 32% of rural African Americans and 28% of rural Hispanics live below the poverty line (ERS, 2011). Rural residents have been shown to go longer periods of time without health insurance, and are less likely to seek care when they cannot pay because of pride and the lack of reduced-price medical care services in rural areas (Mueller, Patil, & Ullrich, 1997). Even if an individual decides to seek care, rural areas are plagued by shortages in mental health care professionals (Murray & Keller, 1991). These cultural, economic, and provider shortage challenges combine to sustain mental health problems in rural areas that unfortunately are not easily addressed.

**MENTAL HEALTH IN RURAL AREAS**

The impact of mental health disorders in rural areas is greater than in urban areas due to a three-part problem of accessibility, availability, and acceptability of mental health services (HRSA, 2005; Human & Wasem, 1991). Key challenges with accessibility of mental health services in rural areas include transportation to and from services and ability to pay for services. Availability of services is impacted upon mainly by health professional shortages; more than 85% of Mental Health Professional Shortage Areas (MHPSAs) are in rural areas (Bird, Dempsey, & Hartley, 2001), and more than one half of all the counties in the United States do not have a single psychologist, psychiatrist, or social worker (American Psychological Association, 2001; National Advisory Committee on Rural Health, 1993). Practitioner shortages have been attributed to challenges in recruiting and retaining professionals because of lower salaries, limited social/cultural outlets, and increased risk of professional burnout (HRSA, 2005; see Chapter 8). Rural providers also face additional ethical dilemmas in their practice (see Chapter 7) that may serve as a deterrent to establishing and maintaining a practice in rural areas.

Acceptability of receiving psychological services in rural areas is lowered due to increased stigma and decreased anonymity in seeking psychological services (HRSA, 2005). The impact of stigma is well recognized in rural areas (see Chapter 4), mainly related to traditional cultural beliefs and a lack of
understanding of mental health issues (Letvak, 2002). The level of stigma toward mental health services has been shown to be stronger the smaller the community is (Hoyt, Conger, Valde, & Weihs, 1997). In addition, because of the interconnected nature of rural communities, there is less anonymity when seeking mental health services (Helbok, 2003). For instance, by parking at a psychologist’s office, clients face the possibility of word spreading of their use of services. The increased stigma and decreased anonymity likely make rural residents less likely to seek care than their urban counterparts (Wagenfeld & Buffum, 1983), and may contribute to rural residents’ perceptions that psychological services are less available and accessible to them (Rost, Fortney, Zhang, Smith, & Smith, 1999). Ironically, despite the tight-knit nature of rural communities, rural residents face increased burdens of isolation and loneliness (see Chapter 5) not only because of their often extended geographic separations from friends and family, but because of the high levels of stigma regarding mental illness that can leave those seeking psychological services feeling even more detached from their communities.

Because of lowered accessibility, availability, and acceptability, rural residents suffering from mental health disorders tend to enter mental health care later, enter with more serious symptoms, and as a result require more intensive treatment (Rost, Fortney, Fischer, & Smith, 2002; Wagenfeld, Murray, Mohatt, & DeBruyn, 1994). Not all cultural aspects of rural living have negative impacts on mental health, however. Religiosity, highly prevalent in rural areas, can have a protective and therapeutic effect. Emerging evidence suggests that incorporating religious themes into therapy with rural populations can be particularly effective (see Chapter 6 for more details).

While large-scale, systematic differences are not routinely found in mental health prevalence in rural areas, some relatively consistent differences have emerged. Rural residents have been shown to have higher levels of depression, domestic violence, and child abuse (Bushy, 1998; Cellucci & Vik, 2001) and demonstrate higher involvement in behavioral health risk factors such as sedentary lifestyle and smoking (Eberhardt, Ingram, & Makuc, 2001; Eberhardt & Pamuk, 2004).

Disproportionate burdens of substance use and suicide are among the most robust differences found between rural and urban areas, and the reasons for these differences are complex and often intertwined with the physical and cultural realities of rural living (see Chapter 12). While illegal drugs have traditionally been thought of as an “urban” problem, methamphetamine use in particular is becoming an increasing problem in rural settings (Gfroerer, Larson, & Colliver, 2008). Rural youth face particular drug use disparities, having higher rates of substance use than their urban counterparts, including alcohol, tobacco, methamphetamines, prescription drugs, inhalants, marijuana, and cocaine (Lambert, Gale, & Hartley, 2008; National Center on Addiction and Substance Abuse, 2000; Substance Abuse and Mental Health Services Administration [SAMHSA], 2001). Unfortunately, access to appropriate inpatient
and outpatient substance use care is lower in rural areas and prevents rural populations from accessing evidence-based care for substance use (American Society of Addiction Medicine, 2001, 2005; Center for Substance Abuse Treatment [CSAT], 2000; Sowers & Rohland, 2004). Compounding difficulties in treatment of substance use disorders is the fact that up to 40% of mentally ill individuals in rural areas have a comorbid substance use disorder (Gogek, 1992), complicating the receipt of appropriate services even more.

Rural residents also have higher rates of suicide than their nonrural counterparts. Rural areas have consistently demonstrated more suicide deaths and a higher rate of suicide completion than urban areas (Center for Disease Control and Prevention [CDC] 2007; Goldsmith, Pellmar, Kleinman, & Bunney, 2002; Institute of Medicine, 2002; New Freedom Commission Subcommittee on Rural Issues, 2003); in some areas, the rural–urban differences are as much as 300% (Mulder et al., 2001). The differences in suicide attempts are even more striking among adolescents, sometimes demonstrated to be 15 times higher among rural adolescents when compared to urban (Forrest, 1988). Many factors have been identified as driving these disparities in suicide rates (and are discussed in detail in Chapter 13), including access to lethal means, geographic and social isolation, and mental health stigma.

Although rural populations share many characteristics, there is tremendous diversity within rural populations, and different subgroups of rural populations face varying mental health stressors and experience different mental health burdens. Minority groups face disparate burdens of many mental health conditions (see Chapter 14). Rural minority groups face a disproportionate burden of poverty and an underutilization of mental health services that lead rural minorities to have an increased utilization of mental health emergency services due to delays in receipt of treatment (Snowden, Masland, Libby, Wallace, & Fawley, 2008). When examining nonemergency care, African Americans and Hispanic populations receive less mental health treatment even when age, gender, and insurance status are controlled for (Goodwin, Koenen, Hellman, Guardino, & Struening, 2002; Han & Lui, 2005; Padgett, Patrick, Burns, & Schlesinger, 1994; Zito, Safer, Zuckerman, Gardner, & Soeken, 2005). As with all rural populations, rural minorities face challenges in accessibility, availability, and acceptability of services; however, rural minorities are even more impacted upon by reduced acceptability of services. For instance, rural African Americans have been shown to be less likely to seek mental health care services (even when needed and available) due to distrust of professionals and even more pronounced stigmatization of mental health problems (Corbie-Smith, Thomas, & St. George, 2001; Fox, Blank, Rovnyak, & Barnett, 2001; Fox, Merwin, & Blank, 1995; Menke & Flynn, 2009; Ward, Clark, & Hendrich, 2009).

Rural lesbian, gay, bisexual, and questioning (LGBQ) residents also face unique mental health challenges due to increased prevalence of mental health risk factors including victimization and discrimination, internalized heterosexism, minimal social opportunities with other LGBQ individuals, lack of
family and social support, and decreased comfort in disclosing their sexual identity to others (Kennedy, 2010; Leedy & Connolly, 2007; McCarthy, 2000; Preston, D’Augelli, Kassab, & Starks, 2007; Willging, Salvador, & Kano, 2006a). These risk factors lead to increased concerns regarding substance abuse and suicidality (Waldo, Hesson-McInnis, & D’Augelli, 1998; Willging et al., 2006a) in a setting where mental health providers often have little or no experience or training in the mental health needs of rural LGBQ clients (Willging et al., 2006b; see Chapter 14 for further discussion).

There are also differences by gender in rural mental health (see Chapters 15 and 16). Rural men report poorer levels of overall mental health and higher rates of suicide (Alston, 2010; Dresang, 2001; Hauenstein et al., 2006). Because of gender-based norms of stoicism and self-reliance that are particularly strong in rural areas (Kosberg & Fei Sun, 2010), rural men are more likely to avoid treatment and present at later stages in the course of their mental health diagnosis (Francis, Boyd, Aisbett, Newnham, & Newnham, 2006; Murray et al., 2008). Rural women face mental health concerns in a context with limited mental health services specific for them (Thorndyke, 2005). They face increased risk of hospitalization for depression (Badger, Robinson, & Farley, 1999) and as with their urban counterparts, struggle with eating disorders and loneliness (Birmingham, Su, Hlynsky, Goldner, & Gao 2005). Rural women’s mental health is affected by a number of sociocultural factors including increased risk for abuse, increased isolation, economic instability, and a lack of childcare support that have each been linked with mood disorders (Boyd & Mackey, 2000; Bushy, 1993; Dimmitt & Davila, 1995; Hauenstein & Boyd, 1994).

Other groups that require special consideration in provision of mental health services in rural areas include the elderly, as well as children/adolescents and their families. While the overall U.S. population is increasingly older, rural populations have higher numbers of older adults than nonrural areas (National Advisory Committee on Rural Health and Human Services [NACRHHSS], 2004; U.S. Census Bureau, 2000), leading to unique mental health needs in a context with typically poorer mental health status among the elderly (Guralnick, Kemele, Stamm, & Grevling, 2003). Older adults in rural areas face many challenges (see Chapter 18), including depression, higher burden of medical care, and lack of specialized elderly mental health expertise (Buckwalter, Smith, Zevenbergen, & Russell, 1991; Unutzer et al., 1997). Rural children and adolescents also face significant barriers to maintaining mental health (see Chapter 17), including increased incidence of poverty, obesity, physical abuse, and substance use often coupled with inferior educational, transportation, health care, and mental health care services (Slovak & Singer, 2002; Welsh, Domitrovich, Bierman, & Lang, 2003). Rural children have been shown to be at increased risk of many mental and behavioral health issues including substance use, depression, and anxiety (Peden, Reed, & Rayens, 2005; Sears, 2004; Spoth, Goldberg, Neppl, Trudeau, & Ramisetty-Mikler, 2001), but a low proportion of rural children actually receive care for diagnosed conditions (Angold et al., 2002).
An additional group within rural settings with particular mental health needs is rural veterans (see Chapter 19). With rural recruits overrepresented in the military (Richardson & Waldrop, 2003) and the increased likelihood of rural veterans experiencing combat casualties in recent armed conflicts (O’Hare & Bishop, 2006), there will be an increased demand for mental health services in rural areas for veterans in the coming years. Unfortunately, this increased need occurs in a context that is already recognized as having broad shortages in mental health care. With high rates of posttraumatic stress disorder (PTSD), other anxiety disorders, depression, substance use, and traumatic brain injuries (Fontana & Rosenheck, 2008; Hoge et al., 2008; Petrakis, Rosenheck, & Desai, 2011; Wallace, Weeks, Wang, Lee, & Kazis, 2006; Zatzick et al., 1997), rural veterans have very specific psychological needs that frequently cannot be addressed in rural settings. Unfortunately, the Veterans Affairs (VA) system—the safety net for physical and mental health care of veterans—often does not operate in rural areas and rural veterans frequently find themselves having difficulty securing transportation to distant VA service locations (Weeks, Wallace, West, Heady, & Hawthorne, 2008).

ADDRESSING CORE PROBLEMS IN RURAL MENTAL HEALTH

A number of strategies have been developed to address the problems faced by rural populations in achieving a healthy mental status and are discussed throughout this book. Many of these approaches directly counteract some of the barriers to maintaining mental health or receiving mental health services that rural residents face. Three of the most promising approaches are integrated care services, telehealth technologies, and school- and home-based interventions.

The concept of integrated care (provision of physical and mental health services within the same context) addresses several concerns, including increasing access to services and decreasing stigma in receipt of services. It also addresses the high degree of comorbidity between physical and mental health conditions; an estimated 34% to 41% of patients in primary care in rural areas have a diagnosable mental health disorder (Sears, Evans, & Kuper, 2003), and more than 40% of individuals with mental health needs originally seek treatment in a primary care setting (Chapa, 2004). This high overlap led the President’s New Freedom Commission on Mental Health (2003) to highlight the need of increasing access to and quality of mental health care in rural areas through integrated care, specifically stating that there is a need to “screen for mental disorders in primary health care, across the life span, and connect to treatment and supports” (p. 11). Additional details on integrated care, including best practices and evidence base, can be found in Chapter 9.

Telehealth (the provision of clinical care or consultation via technology-enhanced means) also holds tremendous promise in addressing
the core problems rural residents face in receiving mental health services. Such approaches improve accessibility because they can be deployed in almost any setting, improve availability because they increase the reach of providers into rural settings without requiring providers to actually be within the rural area, and improve acceptability because of their ability to be deployed within trusted settings including doctors’ offices and the home. Chapter 10 presents a comprehensive review of telehealth technologies and the impact they have on rural mental health.

The school is also a natural place for mental health intervention (see Chapter 11) given that nearly all children in rural areas attend school, and transportation to schools is already required (Owens & Murphy, 2004; Stein et al., 2002; Weist & Evans, 2005). Provision of services within the school setting automatically minimizes stigma and accessibility concerns, and centralizes resources in a setting with maximum reach. Telehealth has broadened the possibilities of providing school-based care, connecting students at school with mental health care located in other areas (Myers, Valentine, & Melzer, 2008; Myers et al., 2010; Nelson & Bui, 2010). Many other evidence-based school programs have emerged, including those that involve family–school partnerships and interagency collaborations (Minke, 2006).

CONCLUSION

While there are many challenges in providing for the mental health needs of rural populations, there are also many emerging opportunities for addressing the needs of this highly underserved population. By becoming familiar with the unique needs, mental health burdens, and cultural influences of rural populations and combining that knowledge with the latest information on evidence-based approaches to address barriers to care in rural areas, mental health professionals can begin to make a difference in the lives of rural populations and address the disproportionate mental health burden they face. We hope this book can serve as a guide to this process.

REFERENCES


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