Chapter 18

Addressing Mental Health Issues in Rural Areas

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Learning Objectives

- Gain an understanding of the contextual, ethical, and diversity issues facing rural citizens with mental health needs.
- Gain knowledge of the unique models to address community needs for primary and mental health services.
- Understand the use of technology to provide mental health services to rural areas.
- Understand the critical role of nondoctoral-level providers within the community to promote healing and health adaptation.

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Glaring disparities in access and availability of **mental health** (services like counseling, therapy, assessment and consultation) care in rural areas necessitates the interdisciplinary collaboration of students, researchers, clinicians, stakeholders, and policy makers in developing realistic, sustainable solutions relevant to particular communities. In this chapter, we will provide an overview of the mental health issues that face rural citizens and present perspectives on the contextual and ethical issues that characterize these problems. We will address empirically supported interventions and conclude with directions for

future work that are informed by a broader perspective of community-based programs and capacity building.

Almost 20 percent (fifty-five million people) of the total US population live in rural areas and are faced with the barriers of low accessibility, availability, and perceived acceptability of mental health services (Health Resources and Services Administration, 2005). Accessibility to mental health services is hindered by higher rates of poverty, inadequate housing and transportation, lower rates of insurance, and poorer health (Stamm et al., 2003; Wagenfeld, 2003). In many cases, mental health care remains scarce or unavailable because more than 85 percent of MHPSAs are in rural areas (Bird, Dempsey, & Hartley, 2001). An estimated one-third of rural counties in the United States lack *any* health professionals equipped to address mental health issues, with a much larger ratio of rural counties lacking any kind of specialty mental health services (Gamm, Stone, & Pittman, 2003).

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When mental health services are present in rural communities, individuals often receive disjointed care across stages of treatment (Fox et al., 1994). And if services are available, people in rural areas who have mental health concerns are more likely to receive pharmacology and less likely to receive psychotherapy (Fortney et al., 2010). Men and women in rural areas are less likely to receive mental health treatment of any sort than their urban counterparts (Hauenstein et al., 2006), and if they do they will likely find a mental health provider with less advanced training than their urban peers (Wagenfeld et al., 1994) or they opt for informal counseling provided by ministers, local self-help groups, family, or friends (Fox, Merwin, & Blank, 1995). Greater travel distances required to obtain expert mental health services (including treatment for substance abuse) are associated with fewer outpatient visits and an increased probability of hospitalization (Fortney et al., 1995; Fortney, Owen, & Clothier, 1999).

Key Concepts

Rural populations often face unique hardships related to mental health and require consideration of several, characteristic ethical concerns. The structure and availability of mental health care services in rural areas are frequently inadequate but multiple, viable alternatives are emerging.

Disparities in Mental Health

We know the prevalence of behavioral disorders and mental health problems are at least as high in rural areas as in metropolitan areas, yet mental health issues in rural communities are exacerbated by the lack of mental health

services and highly trained mental health service providers. There is evidence, however, to suggest that some behavioral problems may be disproportionately higher in rural areas than in their urban counterparts (Hauenstein et al. 2006; Smalley et al., 2010; Stamm et al., 2007). For example, several studies have reported higher rates of depression, substance abuse, and domestic violence in rural areas (Bushy, 1998; Cellucci & Vik, 2001; Murty et al., 2003).

The prevalence of depression among rural women is higher (35.5 percent of those seen in a primary care clinic (Sears, Danda, & Evans, 1999) than those for the general population of women (8.6 percent in the National Comorbidity Survey, http://www.hcp.med.harvard.edu/ncs/publications.php). Women in rural areas experience unique problems that increase their risk for depression and abuse including social isolation, limited occupational options (which contribute to financial instability and poverty), and lack of childcare (Annan, 2006; Hauenstein & Peddada, 2007; Thurston, Patten, & Lagendyk, 2006).

Rates of suicide and suicide attempts are higher in rural areas, particularly among men (Eberhardt & Pamuk, 2004, Singh & Siahpush, 2002). Higher rates of depression and substance abuse (including alcohol, tobacco, cocaine, methamphetamine, inhalants, and marijuana) are found among rural youth (National Center on Addiction and Substance Abuse, 2000; Substance Abuse and Mental Health Services Administration, 2001). Alcohol use is often implicated in the high rates of suicide in rural areas (Johnson, Gruenewald, & Remer, 2009). These complex characteristics and disparities of rural residence provide an important context for understanding rural mental health issues.

Issues of Diversity

Diversity is more than just ethnic variation. All factors that make an individual unique, including gender, age, and rurality in general, affect accessibility, service delivery, and outcomes. Individuals in rural areas vary greatly in their degree of acculturation to modern society (think Amish elder versus small town teenager) and the population density across rural areas can be quite disparate. Furthermore, the value systems and customs of rural areas may have commonalities but generalizing all rural residents as self-sustaining, religious, family folk certainly ignores the reality of a diverse rural culture.

In the past, rural areas have been less ethnically diverse than urban areas, but the percentages of minority residents are rising. Rural communities are on average composed of about 15.9 percent Hispanics and 16.5 percent African Americans (US Census Bureau, 2006).Individuals from ethnic and minority backgrounds often encounter more overdiagnosis and misdiagnosis and poorer treatment outcomes across mental health settings generally (Ridley, 2005), and the health disparities they encounter in rural areas are greater than those

experienced by their urban counterparts (Probst et al., 2004). African Americans and Hispanics underuse mental health services, even among those who have insurance (Padgett et al., 1994) and perceived racial discrimination is associated with depression among both groups (Brown, Brody, & Stoneman, 2000; Kogan et al., 2007; Torres & Ong, 2010). The lack of bilingual mental health providers, language and cultural barriers, and the geographic isolation of rural communities place a hardship on rural Hispanics to receive treatment for depression.

Age is another important diversity consideration relevant to mental health in rural communities. In most rural areas, the elderly constitute a large percentage of rural residents due to the influx of retired individuals and the exodus of young adults to suburban and metropolitan areas (Crowther, Scogin, & Norton, 2010). In fact, in 2004, the National Advisory Committee on Rural Health and Human Services reported that a quarter of the older adult population of America lives in rural areas. What qualifies someone as an "older adult" varies greatly and often ranges from fifty to eighty-five years of age, with sixty-five being a commonly used cutpoint because the Social Security Administration uses this as the designated age for retirement.

Many of the same barriers to mental health care that exist for rural residents are exacerbated for older adults. For example, older adults in rural areas experience higher rates of depression and dementia, less social support and greater isolation, and poorer overall physical health. Care for the mental health of older adults in rural areas must be carefully designed to meet the unique needs of this population. For example, when using technology to increase accessibility, socially acceptable and user-friendly set-ups should be considered. Or when using a psychoeducational approach (such as cognitive behavioral therapy), providers can adjust their approach appropriately to accommodate an older adult's decreased rate of learning and increased difficulty with memory tasks (Crowther et al., 2010).

On the other end of the age spectrum, the mental health of rural adolescents is often overlooked. Studies have shown the incidence of illegal drug and alcohol use, suicide, and depression surpasses their urban counterparts (Biddle, Sekula, & Puskar, 2010; Sloboda, 2002). Of the few national studies that have examined rural-urban differences in children's mental health needs and use of services, prevalence of mental health problems are at a similar rate for rural (36 percent) and urban (37 percent) children (Ziller et al., 2003). However, after controlling for insurance status and accessibility to mental health services, rural children are 20 percent less likely to use mental health services than urban children (Ziller et al., 2003). Rural schools are often placed in the position of identifying and handling students with mental health problems. However, rural schools lack the resources and personnel to address many of the mental health concerns seen in the classroom.

Rural areas are also characterized by a large percentage of military veterans in the population. Rural individuals serve at a disproportionately higher rate in the military than those in urban areas; over 44 percent of current military recruits are from rural areas (Rogers, 2009). Rural-residing veterans tend to be older, less likely to be employed, and report a lower health-related quality of life (physical and mental) than their urban counterparts (Weeks et al., 2004). Rural communities will bear a significant burden with the influx of veterans from Operation Iraqi Freedom and Operation Enduring Freedom with the chronic "signature wounds" of these conflicts—posttraumatic stress disorder and traumatically acquired brain injuries. Our soldiers will encounter "particularly poor access to mental health care" in rural and frontier regions of the country (Tanielian & Jaycox, 2008, p. 302).

Ethical Issues

Several ethical concerns characterize the provision ofmental health services in rural areas. Dual relationships are often inescapable, boundaries of competence can be unclear, confidentiality can be difficult to maintain, and clientele may be less educated about the role and scope of the professional. Not surprisingly, professionals are less inclined to provide psychological services to those living in rural areas where they are subject to greater ethical risk, less compensation, higher burnout rates due to lack of referral sources, increased isolation, and infringement of their personal privacy by the scrutinizing eyes of the community.

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Rural residents often surrender their anonymity when visiting a mental health professional whose office and parking lot are visible to anyone driving by. Also, rural residents are quite familiar with the speed and breadth of communication coverage attained by the town's "grapevine." Often an individual's participation in counseling quickly becomes known within the community resulting in stigmatization of the individual seeking help. Professionals must strive to address issues of stigma by facilitating greater trust in the therapeutic relationship and within the community at large. Without the assurance of anonymity and confidentiality, treatment outcomes are unpredictable and malfeasance is likely. Professionals should take extra steps to provide anonymity outside the building by providing parking not visible from the street and inside the building so that clients feel safe even in the waiting room. Additionally, office staff and professionals must take extreme caution with any information related to a client's involvement in treatment (Werth, Hastings, & Riding-Malon, 2010).

Creating buy-in with community stakeholders must be done thoughtfully to reduce future occurrences of dual relationships. Individuals helping increase

access to mental health services may be a consumer of the service in the future. The American Psychological Association (APA) ethical code explains that not all dual relationships are unethical but that professionals should carefully evaluate each dual relationship and assess whether the dual relationship may impair the professional's objectivity, thereby creating the potential for harming the client (APA, 2002).

Unfortunately, most training programs operate from an urban model and do not emphasize or teach about the specific treatment concerns of rural residents. The APA ethics code states, "Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience" (APA, 2002, p.1063). This ethical standard, paired with the current urban training models, creates a recipe for ethical dilemmas. Moreover, no one clinician can possibly be competent in treating all problems presented in his or her office. Due to the lack of health resources available in rural communities, practitioners are likely to run into issues that are outside the scope of their expertise. It could be tempting to treat the individual because the other options may be limited, nonexistent, or located hours away.

Mental Health Services

Currently, mental health services in rural areas rely on a patchwork of de facto providers composed of formal (primary care clinics, federally qualified health centers [FQHCs], etc.) and informal (churches, law enforcement, etc.) entities in a region (Fox et al., 1995). Provision and care coordination is initiated by "gateway providers" (e.g., ministers, law enforcement officers, primary care and emergency room physicians) who have an understandable unfamiliarity with the complexity of mental health diagnoses and treatment options. Law enforcement is often responsible for handling mental health emergencies. The outcomes of this loose-knit and highly variable system are predictably poor (Hauenstein, 2007).

Alternative systems are distinguished by strategic coordination and integration of available services. For example, FQHCs—particularly community health centers and migrant health centers—are well positioned to provide an array of primary and mental health services. One such program was initiated in a series of state policies in Hawaii to provide behavioral health services to reach medically underserved populations throughout the islands (Oliveira et al., 2006). The program provides behavioral health expertise throughout all primary and mental health care services, ensuring care to individuals with mental health diagnoses and to those who have mental issues comorbid with chronic and acute health conditions.

The Department of Veterans Affairs (VA) has responded to rural military veterans with integrated clinics that address the needs of the chronically mentally ill and those who present in primary care. A network of mental health–intensive case management programs serves veterans in rural and urban areas, employing an assertive community treatment approach to service provision and coordination. Evaluation data indicate that military veterans in smaller and remote rural areas receive less-intensive and fewer recovery services than urban veterans (Mohamed, Neale, & Rosenheck, 2009). To address mental health care needs often seen in primary care, the VA has developed community-based outpatient clinics— satellite facilities to provide primary and ambulatory care—with almost one hundred in areas designated as rural or highly rural (Elder & Quillen, 2007). These clinics are staffed primarily with doctoral-level service providers.

Access to and provision of specific mental health services in rural areas may be best remedied with the use of long-distance **technologies.** Long-distance technologies and telecommunications for health care purposes (commonly referred to as *telehealth*) includes the use of telephone, videoconferencing, or Internet transmissions to provide an array of mental health services (e.g., screening, assessment, consultation, education, counseling, psychotherapy).Telephone use is less expensive, allows for greater anonymity, and greater sense of control and convenience than other methods(Reese, Conoley, & Brossart, 2006).Other work clearly indicates that recipients of telephone counseling are satisfied with the experience and believe it "helped them improve their lives" (Reese, Conoley, & Brossart, 2002, p. 239).

There is considerable evidence supporting the use of telephone counseling for a variety of mental health problems. In a study of depressed patients from a rural primary care clinic, Mohr, Hart, and Marmar (2006) found that providing cognitive behavioral therapy (CBT) in telephone sessions significantly reduced symptoms assessed on two separate depression inventories. Data from relevant randomized control trials (RCTs) indicate similar effects for standardized CBT in reducing depression symptoms among family caregivers of stroke survivors (Grant et al., 2002) and traumatic brain injury (Rivera et al., 2008). Telephone counseling has been found effective for specific problems such as anxiety disorders among children (Lynehan, & Rapee, 2006).

Telephone counseling can also be effectively implemented in treatment and in follow-up programs for behavioral health problems often encountered in primary care. Cupertino et al. (2007) used telephone counseling in a smoking cessation program with rural participants and reported a high rate of satisfaction across the two years of treatment. Participants rated their counseling as a highly important part of the tobacco dependence treatment program. Perri et al. (2008) found that extended care telephone counseling of obese women from rural communities who had completed an initial weight loss program was

an effective option for long-term weight management compared to receiving education alone.

Other technologies, such as videoconferencing, e-mail, and Internet contacts, have considerable promise for providing a variety of mental health services. For example, instant messaging has been used to provide real-time group counseling with rural Latina adolescents (Archuleta, Castillo, & King, 2006). The counseling services were provided in collaboration with three rural school districts and school counseling students at a Texas university located over two hundred miles away. Additional technologies have yet to be implemented in any systematic fashion (e.g., remote monitors, wearable sensors, texting).

Videoconferencing has been used effectively to conduct assessments, consultation, clinical supervision, training, counseling, and psychotherapy in rural settings (McCord et al., 2011; Richardson et al., 2009; Schopp, Demeris, & Glueckauf, 2006). Videoconferencing has increased in usage with favorable Medicare reimbursement policies, and services can be provided in a culturally competent manner to the satisfaction of individuals from ethnic and minority groups (e.g., Native Americans, Shore et al., 2008; Native Hawaiians, Oliveira et al., 2006; Hispanics, Nelson & Bui, 2010). The use of videoconferencing, however, is often limited by the quality of the infrastructure in rural areas for computer transmissions through existing telephone lines or satellite coverage.

Current Issues and Future Directions

To a certain extent, many are aware of the impact rural culture can have on initiating and developing therapeutic rapport, obtaining consent, and providing clinical services to rural clientele. Missing from this equation is the perspective and potential buy-in of stakeholders in the rural community (Sears, Evans, & Kuper, 2003). This kind of community engagement is often time-consuming, and it requires interdisciplinary collaboration to successfully cultivate a long-term investment in, as well as leverage available resources for, the provision of mental health services. These matters are necessary for ensuring adequate use of services, cultivating a positive presence in the community, and defining commitments for local stakeholders—all of which are crucial for sustainability.

Yet many solutions to mental health service delivery issues in rural areas are made in a manner that seems more "linear" (i.e., what is the best way to provide a service?) than systemic (how can the community work together to provide services to its residents?). A systemic perspective requires the involvement and buy-in of stakeholders in the rural community. It requires a

realization of the need to build community capacity to identify needs, potential solutions, and possible collaborations to implement those solutions (Iscoe & Harris, 1984; Trickett, 2009).

This time-intensive process is necessary to develop realistic solutions relevant to a particular community and that are sustainable over time. For example, a recent project in the Brazos Valley region of Texas developed after a series of community surveys of the health status and needs of the residents resulted in the creation of a health resource commission (composed of elected and informal community leaders and representatives from various nonprofit and for-profit service providers and from various state and local agencies including law enforcement), and a series of meetings convened to prioritize needs and identify potential resources to address them (Wendel et al., 2011). As a result of this process, a "town and gown" partnership emerged in which the telehealth capacity of a regional FQHC was expanded to offer counseling and assessment services to a health resource clinic located an hour away in a rural county. The therapeutic services are provided by trainees in an accredited doctoral program in counseling psychology (who gain valuable clinical experiences that count toward their training requirements), supervised by faculty members of the program.

This arrangement illustrates the value of collaborative problem solving and capacity building among constituents in rural communities. But it also reflects the need to identify innovative solutions that maximize the use of nondoctoral-level providers and long-distance technologies in rural areas. It is becoming quite clear that doctoral-level service providers will not relocate to rural areas in numbers that will support sustained activity; therefore, the reliance on doctoral-level providers and third-party payers is unreasonable and unsustainable (Hauenstein, 2007). Despite several policy initiatives (and incentives) for service personnel to work in rural areas, and the recent expansion of Veterans Affairs health care systems, rural communities have not experienced a significant increase in available doctoral-level providers. Current budget constraints throughout the states will undermine the reimbursement of doctoral-level service provision in rural communities. It is also likely that the lack of evidence from well-controlled RCTs of mental health interventions in rural areas will be used by third-party payers to deny coverage (despite the recognized inappropriate reliance on RCTs to determine evidence for the treatment of chronic, complex conditions, particularly with understudied populations in underserved areas).

In order to improve the quality and cost-effective delivery of mental services in rural communities, nondoctoral-level service providers must be strategically implemented. This will involve the use of master's-level counselors to provide counseling and a greater use of physician extenders and other

qualified personnel to administer and monitor prescriptions. In New Mexico and Louisiana, for example, psychologists who have obtained approved training in psychopharmacology can be licensed to have prescription privileges (Jameson & Blank, 2007; Norfleet, 2002). To a great extent, mental health nurses have already played a major role in providing the bulk of mental health services in rural areas (Hauenstein, 2007).

The provision of mental health services by doctoral- and master's-level practitioners is often limited to empirically established psychotherapy treatments. However, psychotherapy is a uniquely Western phenomenon that excludes indigenous methods of healing. Although psychotherapy may be an effective form of mental health treatment for many individuals the number of trained mental health professionals in rural areas limits its capacity. One suggested solution to resolve this issue and at the same time have buy-in of stakeholders in the rural community is to use an ecological approach to addressing mental health issues in a community. The Hawaiian model discussed previously, for example, integrated feedback from Native Hawaiians in developing various treatment options and included native healers as part of the program (Oliveira et al., 2006).

An ecological model—one that emphasizes the relationships between people and settings in which they live (Trickett, 1984)—may be required for developing sustainable services tailored for a specific community. This perspective emphasizes the identification of naturally occurring resources and solutions within communities to promote well-being, healing, and healthy adaptation. Furthermore, it promotes the enhancement of coping and adaptational strategies that enable individuals and communities to respond effectively to stressful situations.

One ecological approach to mental health work involves the training of community-based mental health workers. This approach has its roots in the health-promoter model (Werner & Bower, 1990). In the southwestern border of the United States, community-based health workers are known as *promotoras.* Promotoras are fundamental to prevention efforts aimed at improving the health of disadvantaged populations in southern New Mexico and west Texas. Because promotoras tend to be individuals from the local community and have similar backgrounds to patients, they are more likely to facilitate trust with patients (Castillo & Caver, 2009). In one study, promotoras were trained in mental health screening, recognizing depression and other mental health disorders, ethics, patient privacy and confidentiality, professional behaviors in medical settings, fundamentals of interview, and mobilizing local resources for patients (Getrich et al., 2007). Results of the study found that the use of promotoras was associated with patient empowerment.

Innovative initiatives will necessitate changes in reimbursement policies and collaborations within and between state licensing boards so that services

can be expanded without being circumscribed by guild interests that conflict with the health and well-being of rural residents. Furthermore, private, state, and nonprofit health care systems will have to find ways to collaborate effectively to address the issues that an aging populace and returning veterans will place on rural communities. Many of the mental health problems that will accompany older age will present in primary and emergency care. The demands and needs of rural veterans necessitate a coordinated effort between federal and state community mental health services (Wallace et al., 2006) because the complex nature of the signature wounds from the current conflicts will have chronic, long-lasting, and disruptive effects that will tax health care and legal systems.

Conclusion

Rural communities face dilemmas in mental health care delivery and accessibility that require awareness and purposeful interventions. In this chapter we provided an overview of the contextual, ethical, and diversity issues facing rural citizens and also gave examples of creative ways researchers, clinicians, and policy makers are attempting to meet community needs to provide an array of primary and mental health services. The most effective and sustainable mental health services may be achieved with increased community capacity that facilitates cooperation among various stakeholders to realize strategic solutions. Furthermore, the use of long-distance technology and nondoctoral-level providers may be one of the best ways to provide mental health services for rural areas, and the existing literature is encouraging regarding consumer satisfaction and positive treatment outcomes. Systemic solutions are needed that go beyond linear, single services to helping community stakeholders and invested policymakers to collaboratively develop ecological and sustainable services that respect the unique relationships between the people and the setting in which they live.

Summary

- The prevalence of mental health problems are at least as high in rural areas as in metropolitan areas; however, there is evidence to suggest that some behavioral problems may be disproportionately higher in rural areas. These complex characteristics and disparities provide an important context for understanding rural mental health issues.
- All factors that make an individual unique including gender, age, degree of rurality, ethnicity, veteran status, and so on affect accessibility, service delivery, and treatment outcomes.

- Mental health professionals in rural areas are subject to greater ethical risks related to competence and confidentiality, have higher burnout rates, and must typically work for less compensation.
- Technologies such as telephone, videoconferencing, e-mail, and the Internet have considerable promise for increasing access to mental health care.
- The ecological model for health care provision emphasizes the identification of naturally occurring resources (such as FQHCs, promotoras, and natural healers) within communities to promote healing and health adaptation.

Key Terms

diverse(ity)
mental health
technology(ies)

For Practice and Discussion

1. Working with one or two colleagues from class, discuss the impact of diversity (gender, age, veteran status, etc.) on the accessibility, availability, and acceptability of mental health services.
2. Create your own ecological model to meet a specific community need (refer to Chapter One for an example).
3. Working with one or two colleagues from class, discuss how a broader perspective of community-based programs and capacity programs can improve mental health service delivery in rural areas.

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