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Commonalities Between Urban Mental Health and Rural Mental Health

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CERTIFICATE OF APPROVAL

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CAPSTONE PROJECT

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Commonalities Between Urban Mental Health and Rural Mental Health

This is to certify that the Capstone Project of

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Abstract

During research into mental health, a common theme is the needs of urban and rural communities. There are entire journals dedicated to the mental health needs of these groups. Some common problems faced in both areas are access to mental health services as well as value systems that create barriers to accepting mental health services. The struggle to accept the help from very limited and often underfunded mental health services provides a perfect storm for rampant mental health and drug abuse problems. This is a review the current literature regarding the mental health services and barriers in these communities to draw comparisons and similarities. A review of available research on the commonalities will be discussed as well as identifying gaps in available data. Exploration into each subgroup's similarities could provide a baseline for development of services to address both populations bilaterally. Due to the ever-hostile political landscape, additional research regarding each group's perception of each other will be reviewed. A hypothesized additional impact to be aware of is a reduction of hostility between the groups through information provided to them about their similarities. This may be an important determining factor in providing care to each group through a centralized system that will overcome existing barriers.

Keywords: rural, urban, mental health, accessibility, similarities, substance use, cultural factors, religious beliefs

Contents

Commonalities Between Urban Mental Health and Rural Mental Health

Day after day we hear about the apparent disparity between people living in cities versus rural parts of the United States. A constant barrage of stories from the news, social media, politicians, and celebrities paints a picture that appears to conveniently fit into the narrative of whomever consumes it. With an ongoing global pandemic, financial hardships, and other stressors, people tend to direct their anger toward the out-group and place blame on them creating more of a divide amongst people.

There is no easy answer to solve the differences between these two groups, but it is important to slow things down and look at some of the similarities. These similarities have a chance to bring people together and focus on what can be done to make things better. This idea comes from a ground up approach meaning it starts with the individual. Ensuring mental health needs are met and addressed can make a vast difference in individuals which then has further impacts on communities and populations. To better understand each of these communities, each will be discussed individually followed by a more in depth look at the similarities. This information will be used to formulate more practical applications for mental health providers in these areas as well as troubleshoot ways to bring these communities together. The hypothesis here is that by finding what rural and urban populations have in common regarding their mental health needs will be a way to remove barriers of service of allow for less hostility between the two populations. This conversation will be ongoing and everchanging with the world around it. It is time to stop focusing on what separates people and instead find what can bring them together in a push for a more positive future for all people.

Review of Literature

Urban Mental Health

First it is important to determine the definition of *urban* in this context. As of 2020, the Bureau of the Census defines *urban* as a densely populated territory that must encompass at least 4,000 housing units or at least 10,000 people (Dumas & Jarmin, 2021). This definition will help differentiate the population of this sections review of mental health access and utilization. A defining characteristic mental health services provided in an area is the access provided to children and families.

A good place to start the discussion comes from the article *Increasing Access to Child Mental Health Services for Urban Children and Their Caregivers* by McKay, Mary McKernan, Stoewe, Judith, McCadam, Kathleen, Gonzales, and Jude. This article reviews the results of a study that evaluated the effects of two engagement interventions of 109 children of color and their families. An important element immediately cited in this article is that urban children are at a greater risk of developing psychopathology yet are less likely to be adequately served by outpatient child mental health services (Griffin, Cicchetti, & Leaf, 1993 as cited in McKay et al., 1998). It is important to note the word *adequately* above as it indicates that though there are services available, there are additional complications with utilization. This concerning bit of information as well as the common barriers helps to create a clearer idea of the struggles with mental health services in urban areas.

Some of the barriers to the use of mental health services by low-income clients of color are the stigmas associated with services, lack of information on what is available, inaccessible location, unresponsive service providers, reliance on alternative methods of help (Acosta, 1980;

Aponte et al., 1991; Boyd-Franklin, 1993; Flaskerud, 1986; Keefe, Padilla, & Carlos, 1979; Lin, 1983; Muecke, 1983; Sue et al., 1991; Sue & Morishima, 1983; Wallen, 1992 as cited in McKay et al., 1998). Considering all these barriers combined with the services available, initial engagement and retention are vital in lasting change. The study in this article found that without more intensive engagement efforts, over 50% of cases can be lost between initial request for services and intake (McKay et al., 1998). This can be addressed through phone calls to the client to problem solve any barriers like the ones mentioned above and how to overcome them (McKay et al., 1998). Another important element from the study suggests that to increase retention and avoid service interruption is for therapists to continue addressing barriers during ongoing sessions and problem solve with clients (McKay et al., 1998). Just because the client was able to navigate the initial barriers to start services does not mean the barriers all go away, this could be an important factor for maintaining consistent service among many different populations (McKay et al., 1998).

As mentioned previously, there has been extensive research into the areas of mental health in urban areas. It is important to review that research and evaluate the findings to determine how to move forward. The *Evaluation Findings and Lessons Learned from the Annie E. Casey Foundation Mental Health Initiative for Urban Children: Comprehensive Report* provides a perspective regarding the use of mental health services that were targeted for specific communities within urban centers (2001). The initiative not only worked on providing tailored mental health services but also worked with states on how to improve mental health policies to support services (Joseph et al., 2001). One of the findings in the report indicated that approximately 20% of all children have a diagnosable mental disorder (Joseph et al., 2001). Another point in this evaluation is the impacts of poverty on mental health problems. Poverty

causes mental health problems to be more acute while lack of adequate services results in more children in foster care, special education, inpatient hospitals, and juvenile justice facilities all of which are funded by the public (Joseph et al., 2001).

More focus on preventative methods has a measurable impact on overall cost to communities (Joseph et al., 2001). Using prevention and intervention was shown to increase participation in the mental health initiative and have a larger impact on families and communities (Joseph et al., 2001). A message of prevention tends to go further when obtaining buy in from families who are skeptical of mental health (Joseph et al., 2001). The key takeaway from this evaluation is that broad community change is a complex undertaking and emphasizes the need to devote considerable time to develop, maintain, and establish working relationships and partnerships to create trust (Joseph et al., 2001). So, as it applies to urban mental health, this review helped to illustrate the barriers and takeaways from research regarding this specific population. This information is an important piece to in finding commonalities among distinct populations.

Another solid indicator found regarding access to mental health services in urban centers can be found linked to existing systems such as community centers and schools down (Torres-Pagán & Terepka, 2020). Being tied into an existing system allows for the opportunity and access that is desperately needed in urban areas down (Torres-Pagán & Terepka, 2020). This cohabitation of services can also create additional problems as seen with the recent COVID-19 pandemic. Mental health service providers at these schools become limited in their capacity to provide services when the community-based structure they reside in is shut down (Torres-Pagán & Terepka, 2020). Times where existing community-based structures are shut down correlate with high stress times for the families in those communities making the need for services more

dire down (Torres-Pagán & Terepka, 2020). There needs to be further thought into how services can be continued if access to that community resource is taken away. Another factor found during the pandemic was for clinicians to evaluate the overall needs of the families they serve versus the individual client, this can assist in developing resiliency during times of distress where services cannot be directly administered (Torres-Pagán & Terepka, 2020).

Another community resource that allows for access to social services and provides additional guidance is organized religion. These religious groups are well established in urban areas and provide aid to support their communities (Shin et al., 2011). Most have buildings used for worship services and employ volunteers and members of the communities they serve (Shin et al., 2011). These resources create a system of access for those in need. In a report about the use of faith-based resources in urban communities, the author states that race and ethnicity affect the attitudes toward mental health services and that African Americans who reported psychological distress would more often turn to informal supports such as religious organizations (Shin et al., 2011). It is important to note that the members who staff these organizations often reflect the communities they serve in in terms of diversity (Shin et al., 2011). This could be an important factor regarding trust in services.

It is also important to consider the issues of substance use in urban communities and how that impacts service utilization. A small sample of research found in *Understanding Neighborhoods' Impact on Youth Substance Use and Mental Health Outcomes in Paterson, New Jersey: Protocol for a Community-Based Participatory Research Study*, point out that youth who use substances are more likely to have higher rates of depression and anxiety (Opara et al., 2021). Though this is a specific sample, it helps to create a bigger picture for mental health in urban areas. The research continues to sum up that the use of substances in densely populated,

low-income, urban areas which indicates a higher need for the development of more culturally informed, community-based prevention programs (Opara et al., 2021).

This information is a small window into the world of urban mental health. Exploring barriers, existing research, reviewing current systems, and analyzing the impacts of religion and substance use helps provide a baseline of information to move forward with how to further provide the much-needed assistance. As mentioned, this is not new information. Instead think of this as an exploration on how to utilize the information differently. As the conversation shifts to explore rural communities and mental health, keep in mind what has been discussed and how it can be applied.

Rural Mental Health

In this context the term *rural* encompasses all population, housing, and territory not included within an urban area. (Dumas & Jarmin, 2021). The Bureau of the Census defines *urban* as a densely populated territory that must encompass at least 4,000 housing units or at least 10,000 people (Dumas & Jarmin, 2021). A map illustrating the population density in the continental United States can be found in Appendix A.

First it is important to explore the mental health access and some of the barriers to services. Another factor that can be prohibitive is the out-of-pocket costs associated with rural communities which tend to consist of people of a low socio-economic status (Ziller et al., 2010). Found in *The Journal of Rural Health,* Ziller et al. (2010) found that there is a lower use of office based mental health services and an increased use of prescription drug use among rural adults. They also found no significant difference in out-of-pocket expenditures for services, more that services are provided by lower cost providers (Ziller et al., 2010).

The literature around rural mental health is also quite extensive, dating back decades with a big push in the 1970's. Information regarding rural populations and mental health has been compiled into a book by Jackson Rainer Ph. D., called *Rural Mental Health* (2012). In his book, Dr. Rainer and his contributors describe the stigma of receiving mental health services. There is a negative perception toward those receiving mental health services in rural areas which has a direct impact on other's likelihood to seek care (Rainer, 2012). This stigma makes it difficult for other members of the community to utilize social supports which requires providers to find new ways to provide services (Rainer, 2012). Rural populations can also feel isolated, and their needs left out of policy decision making, leading to more distrust of available systems (Rainer, 2012).

Religious beliefs remain a prevalent part of rural society (Rainer, 2012). These beliefs can have an influence on mental health treatment causing members of the community to instead seek assistance within their family or the church (Rainer, 2012). Practitioners in these communities have to utilize the religious community when developing treatment plans and support systems to best serve the clients in that area (Rainer, 2012).

Rural communities are often considered to revolve around a primarily agricultural economy which due to its volatile nature can lead to economic uncertainty (Rainer, 2012). This has an impact on access to health insurance and the affordability of mental health services (Rainer, 2012). As stated by Ziller et al. previously, the lack of adequate health insurance can lead to an inability to afford in office services and has led to an increase in the use of pharmaceutical alternatives (2010). Poverty appears to play a very important role in rural communities and how they view the world (Rainer, 2012). Drug overdose in rural communities is becoming increasingly more common (Centers for Disease Control & Prevention [CDC],

2017). As of 2015, the rural rate of drug overdose deaths overtook the rate of urban areas (Centers for Disease Control & Prevention [CDC], 2017).

In discussing the depression rates in rural farmers, the *Journal of Rural Mental Health* published an article that brought up the social supports as a protective factor (Bjornestad et al., 2019). The article points out the importance of having a social network to alleviate depressive symptoms and reduce suicidality of rural farmers (Bjornestad et al., 2019). The article makes the point that it is not just about having a support system but that the quality of the support system's relationships has a greater impact placing trust as the top priority (Bjornestad et al., 2019). This falls in with the research found in the Rainer text (2012) regarding the reliance on family and religion for support with mental health needs.

More rural areas tend to employ providers at lower rates than urban areas leading to a lack of experience and quality of service (McNichols et al., 2016). An article titled *The Successes of Experienced Rural Counselor Supervisors and Their Recommendations for Rural Mental Health* helps to address this issue (McNichols et al., 2016). Some of the recommendations presented involved the teaching of parenting skills, the grieving process, addiction information, and even business management and courtroom testimony (McNichols et al., 2016). In addition, the supervisors in this study added an emphasis on the importance of the experience working in rural areas during graduate training (McNichols et al., 2016). Adequate training in any area of counseling is emphasized as important and often rural community training is glossed over if addressed at all (McNichols et al., 2016).

Comparison of Urban and Rural Mental Health

Some of the barriers to mental health services in rural land urban communities overlap. One example being access to mental health services. Access can mean several different issues such as affordability and availability of relevant services (McKay et al., 1998) (Rainer, 2012). Being able to travel to an in-office location for services creates an affordability issue for those areas in poverty which are found in both rural and urban communities (Ziller et al., 2010). Access through established community resources is a commonly shared trait where each of these communities can utilize religious organizations and schools to access care (Shin et al., 2011). Centralized and (mostly) trusted locations offer a place for providers to work with to administer care, allowing a small window into providing mental health services to these populations (Torres-Pagán & Terepka, 2020). Trust appears to be a key factor in the degree of receptiveness to services.

Research conducted in an article titled *Differences in Recruiting and Engaging Rural and Urban Families in Home-Based Parenting Programs* finds that even when connecting both rural and urban families with services, there are three common barriers that prevent the success of the preventative service (Heidari et al., 2018). These include a lack of resources, lack of transportation, and stigma associated with receiving services (Heidari et al., 2018). Even when controlling for the different demographics of the two communities, the research still found those common factors (Heidari et al., 2018).

The racial and ethnic make up of urban and rural areas can be found in Appendix B. This data from Economic Research Service of the U.S. Department of Agriculture states that rural America is less racially and ethnically diverse than urban areas (Castillo & Cromartie, 2018).

Discussion

With the given information and evaluation of the comparable attributes it can be determined that the commonalities of these two groups cannot be ignored. Now how can this information be utilized? The original hypothesis included the possibility to apply services to each community simultaneously. This would have to be done through telehealth sessions or a well-funded, affordable program that provided transportation, and possibly even childcare. Originally the thought to combine each of these communities' needs would allow for an increase in affordability and availability of qualified providers. Unfortunately, through the available research this may be too difficult to implement. The mistrust of outsiders and service providers would become a larger barrier to overcome when combining these two groups. The stigma associated with mental health services would need to be addressed first. It is also important to note the animosity between urban communities and rural communities that has become more apparent in the last few years.

Research to determine the relationship between each of these communities could be conducted more thoroughly and officially. Most data discovered during research found mostly opinion articles that were politically charged. A more comprehensive research project regarding urban versus rural views of each other could be done using the commonalities discovered between the two. Even using the fact each community has trouble trusting others can be used as a common factor. Determining a measurable change in outlook of the other community using common factors would be a good place to start and see if it is possible to have these communities work together. It is more important to establish changes in service delivery and better training of clinicians while more research is conducted to close the gaps in current available information.

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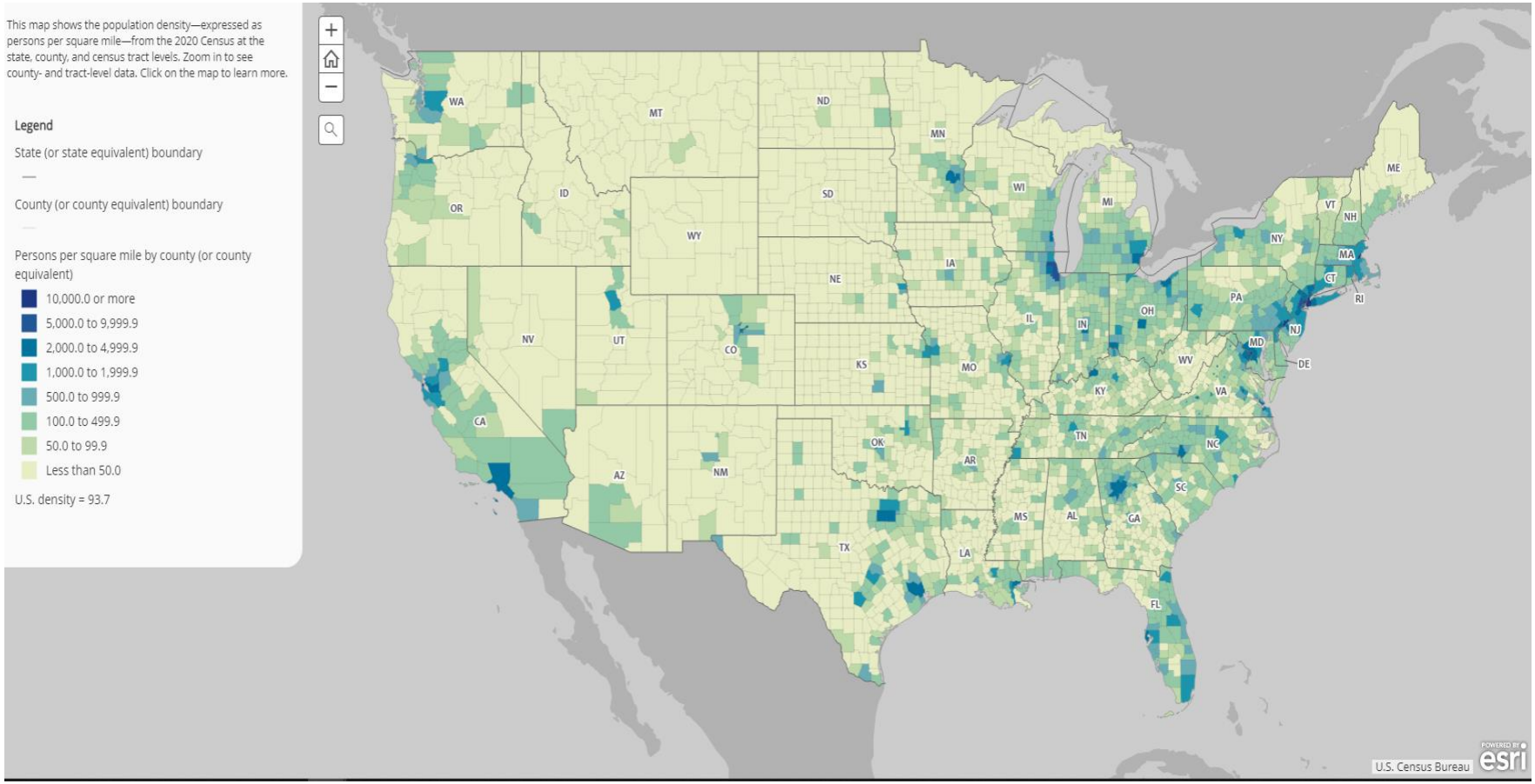
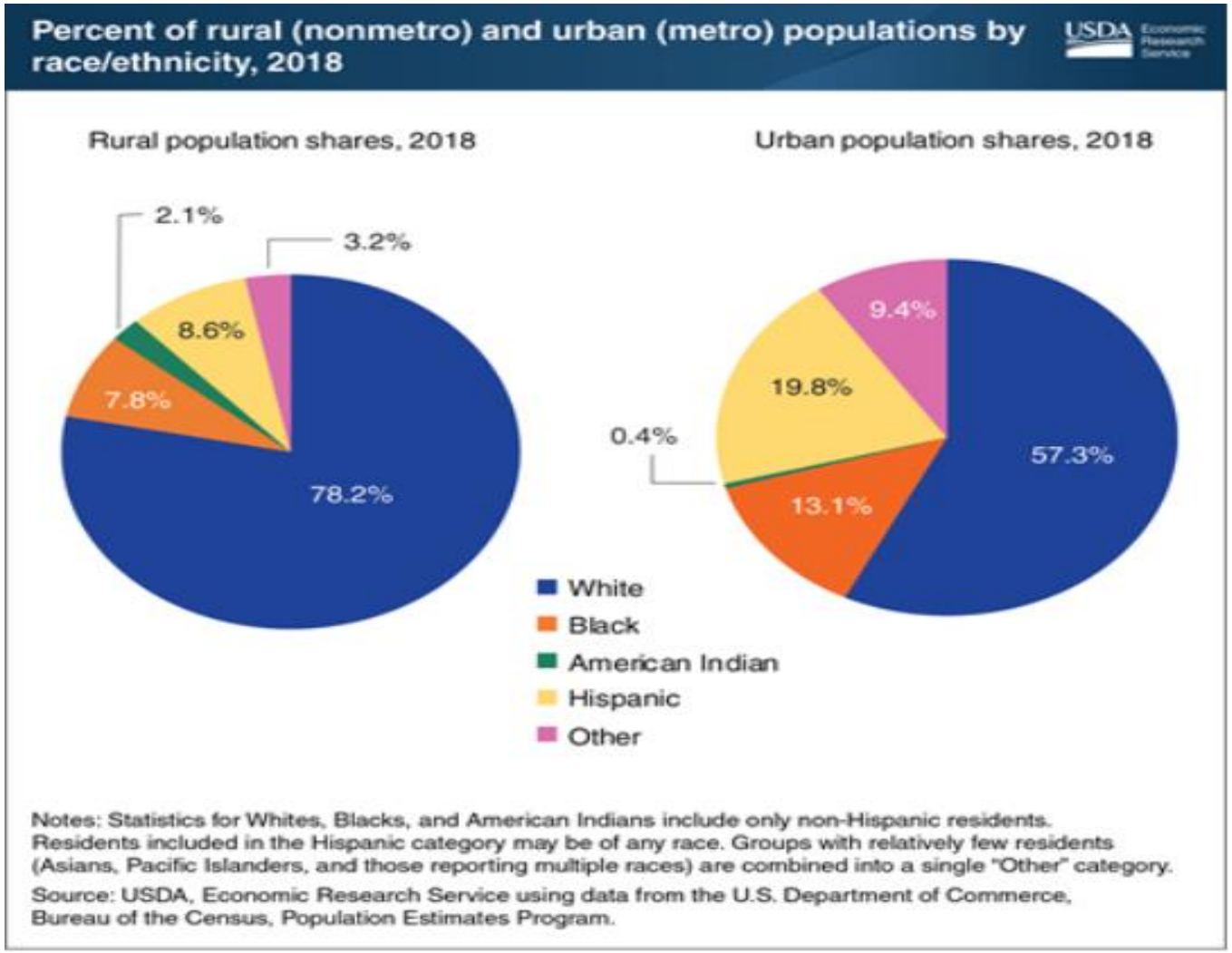
Appendix A



(Census Bureau, 2020)

Appendix B



(Castillo & Cromartie, 2018)