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Mental Health in Rural Communities: Barriers and Solutions to Access

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Abstract

Rural communities encompass a unique culture and a way of life difficult to find anywhere else. Unfortunately, barriers to mental health services exist more frequently in rural than urban and suburban areas. These barriers include stigma, cultural factors, financial concerns, as well as lack of resources and providers. Solutions to these barriers exist in some part, but also present their own challenges. This literature review explores the problem, causes of the problem in the form of barriers, and solutions to accessing mental health resources in rural areas of the United States. A discussion with suggestions for further action and study follow the literature review. Appendix A also discusses the use of advocacy and includes a sample outreach project for increasing awareness of existing mental health resources in rural communities through the use of the T.R.A.I.N.E.R model (Hof et al., 2009).

Keywords: mental health, rural, barriers, solutions

Contents

Introduction …….5

Review of Literature ……...7

Discussion...……...……33

Author's Note……..……36

References …….38

Appendix ……...…….……...42

Mental Health in Rural Communities: Barriers and Solutions to Access

A patchwork quilt of fields, bright red barns, general stores, and neighbors helping neighbors bring to mind rural life. These small communities with deep pride in their way of life can be seen as an escape from the bustle of urban living. While there are many positives to rural life, which will also be shown throughout this paper, there are also difficulties, such as the many barriers to mental health care. Before discussing these barriers, it is essential to define *rural*. Rural-urban commuting codes define what areas in the United States are classified as rural. The codes use U.S. census data to measure population in comparison to land (Cromartie, 2020). The rural-urban commuting codes range in whole numbers from one to ten with one being metropolitan and ten being most rural. Codes numbered four through ten are rural areas. Due to changes in population tracked through the census, an area can change its classification. The most current codes available are from 2010 (Cromartie, 2020).

Studies show that individuals living in rural areas have the same amount of mental illness as individuals living in metropolitan areas, yet their access to services and supports is far less (Andrilla et. al, 2018; Bureau of Health Workforce, 2021; U.S. Health and Human Services, 2021). One of the consequences to having a lack of support is shown through data on suicide (Ivey-Stephenson et al., 2017). Lacking mental health services negatively affects all residents in rural areas, including children (Howell & McFeeters, 2008; Moon et al., 2017).

There are multiple causes to the barriers that rural populations face in accessing mental health services. Stigma towards accessing mental health resources as well as the culture of living in a rural area prevent some individuals from seeking out needed care (Cheesmond et al., 2019; Crumb et al., 2019; Jensen et al., 2020; Stewart et al., 2015). Mental health stigma can have negative effects on children as well (Polaha et al., 2015). The inability to use rural services exists

because of lack of finances, transportation, and knowledge of when mental health services are needed (Fullen et al., 2020; Jensen et al., 2020).

Despite the barriers, there is consistent work being done to increase access to mental health services. Telehealth is a possible solution that has increased in use, especially due to the Covid-19 pandemic which became widespread in the United States in March of 2020 (Jensen et al., 2020; Schroeder et al., 2021). Working from a top-down perspective is another solution as much of the change that needs to occur must be driven by organizations and governmental agencies; one such program is the Behavioral Health Workforce Education and Training program (Johansson et al., 2019; Kepley & Streeter, 2018). Additional solutions include collaboration with already existing and trusted organizations in the community, such as schools and medical facilities (Kelleher & Gardner, 2017; van Vulpen et al., 2018; Wade et al., 2008). Schools specifically offer a unique way to provide services to children and reduce barriers. Increasing knowledge and awareness of mental health services as well as mental health in general, is another way to lessen barriers (El-amin et al., 2018, Siconolfi et al., 2019).

These topics are analyzed in the following literature review. They are then discussed with emphasis on topics for further study as well as connections to current professionals in the mental health field and the implications of these findings.

Review of Literature

The Problem

According to results from the 2020 National Survey on Drug Use and Health, analyzed by the Substance Abuse and Mental Health Services Administration (SAMSHA), the percentages of mental illness among children and people aged 18 and older are very similar across regions of the United States (U.S. Health and Human Services, 2021). The percentage of children aged 12-17 with a major depressive episode is 18.1 for large metro areas, 15.4 for small metro areas, and 16.5 for nonmetro areas. The percentages are even more similar for children aged 12-17 that had a major depressive episode with severe impairment in the past year with large metro areas at 12.8%, small metro areas 10.8% and nonmetro areas 11.7%. For all people aged 18 and older, percentages of mental illness for large metro areas were 19.9%, small metro areas 23.2%, and nonmetro areas at 20.5%. Despite having similar reports of mental illness, people living in rural areas are far more likely to have less mental health resources. In a study published by the American Journal of Preventive Medicine in 2018, data was analyzed to identify variations in the supply of behavioral health providers compared to geographic locations, and a severe lack of service providers in rural areas was discovered (Andrilla et al.). In non-metropolitan counties, 65% lack a psychiatrist, whereas only 27% of metropolitan counties lack a psychiatrist. Similarly, 47% of non-metropolitan counties lack a psychologist compared to 19% of metropolitan counties. Finally, 81% of non-metropolitan counties lack a psychiatric nurse practitioner, compared to statistics of 42% of metropolitan counties. Therefore, it is about 40% more likely for a non-metropolitan county to lack psychiatrists, psychologists, and psychiatric nurse practitioners when compared to metropolitan counties. These percentages are not indicative of a lack of need or demand, as illustrated by the statistics from SAMSHA which

denote that mental illness is equal across regions, but rather a severe lack of resources (Andrilla et. al, 2018).

The lack of services for people struggling with mental illness is also illustrated by Health Professional Shortage Areas (HPSA). In the "Designated HPSA Quarterly Summery," updated as of December 31, 2021, by the Bureau of Health Workforce, Health Resources and Services Administration (HRSA), and the U.S. Department of Health and Human Services, there were 6,078 areas designated as being HPSA for mental health in the United States. These areas are home to 136,575,592 people. Of these areas 57.86% were rural, and 8.49% were partially rural. Therefore, most of the mental health HPSAs are in rural or partially rural areas (Bureau of Health Workforce, 2021).

The severe lack of mental health resources in rural areas is not only seen by lack of services and professionals, but also through suicide rates. Data from the National Vital Statistics System spanning the years of 2001-2015, analyzed by researchers from the Centers for Disease Control and Prevention, denotes differences between suicide rates for nonmetropolitan/rural counties and medium/small and large metropolitan counties. Nonmetropolitan/rural counties have consistently higher suicide rates than other counties. In addition, nonmetropolitan/rural counties have almost double the rates of death with the use of a firearm when compared to large, medium/small counties. Not only are firearms the most common mechanism of death in rural areas, but they also had the highest rates and greatest rate increases in rural counties during the years of 2001-2015. Therefore, it is not only more likely for suicides to occur in rural counties, but it is more likely for these suicides to be completed using a firearm. While it is not known for sure why the use of a firearm to complete suicide is more common in rural areas, the study

hypothesizes that owning a firearm is more common in rural areas, and people living in these areas may be more familiar with firearms and how to use them (Ivey-Stephenson et al., 2017).

As shown through the statistics from SAMSHA (U.S. Health and Human Services, 2021), lack of mental health resources is a problem that affects not only adults, but also children living in rural areas. In 2008, an analysis of the National Survey of America's Families (NSAF) for the years 1997, 1999, and 2002 was completed by Howell and McFeeters to identify whether there are racial and ethnic disparities in children's mental health and mental health care between urban and rural areas. The surveys included 66,982 children with 53,782 residing in urban areas, and 13,200 in rural areas. This study identified that mental health problems are not influenced by the region in which a child lives and is therefore not affected by a child living in a rural area versus an urban area. However, whether a child has a mental health visit or not is affected by region with rural children being significantly less likely to have a mental visit than urban children. Race and ethnicity also affect mental health with Hispanic children being less likely to have mental health visits than White children in both rural and urban settings, Black children in urban areas being less likely than White children to have a mental visit, and finally rural White children being significantly less likely than urban White children to have a mental health visit. Therefore, receiving mental health services is affected by where a child lives, as well as their race/ethnicity (Howell & McFeeters, 2008).

In a study of 786 educators from across a large Midwestern state completed in 2016, it was indicated that 93% of participants had concerns about their student's mental health, and 85% of participants cited a need for further training in mental health (Moon et al., 2017). Students with mental health problems are common, and more than 96% of respondents stated they are likely or very likely to work with a student with a mental health concern. Additionally, 93% of

participants stated they were moderately, or extremely, concerned about their students' mental health. When working with students in a rural school district this becomes a larger problem as 27% of study participants that work in rural/frontier schools state they do not have mental health professionals employed at their school. Regardless of region in which the school was located, 65% of teachers participating disagreed or strongly disagreed that there were adequate mental health resources in their schools. About half of respondents disagreed or strongly disagreed with the statement that they received enough mental health training, and 85% of participants stated that they would like to receive more. Even more telling was that educators also believe that the communities did not have adequate mental health services with over 92% agreeing or strongly agreeing that students and families needed greater access to mental health services. Educators stated they want more training to have better understandings of "mental health disorders, behavior management techniques, and specialized skills" (Moon et al., 2017, p. 389). The study addresses that with better understanding of these topics and the underlying mental health conditions that can contribute to difficulties in the classroom such as externalizing and internalizing behaviors, teachers can be better equipped to assist students by being able to identify possible mental health needs and make referrals for additional services (Moon et al., 2017).

The Causes

Barriers to mental health services go beyond lack of resources. Rural individuals must deal with barriers to access such as stigma, shortage of services, culture, finances, transportation, and a lack of knowledge. These barriers combine to make mental health services very difficult to utilize if they can be accessed at all.

Mental health stigma refers to the negative thoughts or actions an individual or

community may have towards mental illness. Published in 2015 in *Psychological Services*, this study aimed to identify self-stigma, public stigma, and the affects these may have on the attitudes of individuals to seek mental health care (Stewart et al., 2015). The study included 121 adults aged 60 and above from three different regions including isolated rural, metropolitan adjacent rural, and metropolitan as designated by the Rural-Urban Continuum Codes developed by the U.S. Department of Agriculture Economic Research Service. Participants were given three self-report surveys: Self-Stigma of Seeking Help, Perceptions of Stigmatization by Others for Seeking Psychological Help, and Inventory of Attitudes Toward Seeking Mental Health Services. Results of these surveys were then analyzed, and scale correlations and descriptive data were charted to identify relationships. The study results indicate that older adults in isolated rural areas do have higher perceptions of self and public stigma relating to mental health. It also indicates that this population has a higher desire to deal with mental health concerns independently and in private when compared to urban counterparts. This study also revealed the differences between the effects of self-stigma and public stigma, stating that self-stigma was related to the lack of help seeking behaviors across geographical groups, but not public stigma. Older adults living in isolated rural areas had higher levels of public and self-stigma, lower levels of indifference to stigma, and lower levels of "psychological openness" when being compared to urban participants (Stewart et al., 2015). The study hypothesizes that this may be directly related to rural cultural beliefs and values. The differences in results for perception of stigma reveals that geography and proximity to more urban areas lower stigmas negative effects on help seeking behaviors for older adults. The only exception to this statement revealed in the study is that isolated rural and rural adjacent groups both identified the same level of public stigma, and this level was significantly higher than what was presented by the urban group. The study discusses

these findings may contribute to the thought that self-stigma results from cultural norms and values whereas public stigma is from social structure, which is unique to the community itself. A final finding of the study points to hope for the future of help-seeking behavior with the reported willingness to seek help "in the event of experiencing a serious psychological problem" being even across all groups studied. An important limitation to this study is that the rural groups were both recruited from food banks, while the urban population was recruited from a senior center. This means there could be vast differences in socioeconomic status and education between the two groups that are resultant from factors other than geography. Additionally, due to the rural groups being recruited from food banks, this may not be representative of the mental health and views of all rural people as these groups were facing food insecurity which can be resultant from poverty, which is a high indicator for mental health concerns. Furthermore, the rural group were already expressing willingness to receive help in the form of food, which could affect the willingness to receive other forms of help (Stewart et al., 2015).

In the article, "'Get over it and move on': The impact of mental illness stigma in rural, low-income United States populations," a sample of 53 people from a pool of 632 individuals that completed a survey was studied to identify mental illness stigma in rural, low-income adults with mental illness (Crumb et al., 2019). The study identified common themes relating to stigma. The first themes identified were the result of the question "What are some of the negative views your culture has about mental illness that might cause stigma?" This resulted in the themes of faking and pretending, the idea or response that individuals suffering from mental illness should "get over it," and that individuals should look to God when they are struggling and that straying from God may be the reason for their concerns in the first place (Crumb et al., 2019). Fear and shame were discovered as a theme when participants were asked about how mental

health stigma does or does not affect them or others they know. Many participants discussed feeling either fear, shame, or both when trying to seek mental health treatment or when discussing mental health with family and friends. Being perceived as weak or receiving negative judgment were reported by nearly all participants as being the possible negative consequences of pursuing mental health treatment. Fears of losing a job or being thought to be avoiding work or other responsibilities as the reason for seeking mental health treatment were also brought up as possible negative consequences. The overall findings of this study indicate that negative views about mental health and seeking mental health treatment are common in rural areas and continue to have a negative effect on help-seeking behaviors. Additionally, through the reports made by participants, it can be noted that mental illness is often misunderstood and that accurate knowledge about mental health and seeking resources is lacking for this population. The study further indicated that individuals that do have mental health concerns are often not seen as credible when describing the various challenges they face due to their mental health. The effects of this stigma and lack of knowledge can be particularly detrimental for rural people as job loss is a concern. This concern may not be as prevalent for individuals living in urban areas as they have more anonymity and job opportunities (Crumb et al., 2019).

Mental health stigma affects all groups of people, and parental stigma specifically can influence children and their access of mental health services. Published in 2015 in the *Journal of Pediatric Psychology*, Polaha et al. study parental perception of stigma on accessing services for their children with mental health needs, how delivery settings affect perception of stigma, and other barriers to accessing services. The study included surveys completed by 347 caregivers of children with psychosocial concerns. Study participants were primarily mothers (79.8%) and were majority White (94.2%). Participants were from rural Appalachia, which is southwest

Virginia and northeast Tennessee. The mean age of participants' children was 9.21 years, but the study spanned children's ages of 4-16. The settings for receiving mental health services included school, church, doctor's office, private office, behavioral health center, and two-way videoconferencing. The study's results revealed that the higher the level of perceived public stigma the less likely parents would be to seek mental health services for their child at any of the locations presented. This was most prevalent for the settings of school and behavioral health centers. An additional finding of the study was that the more barriers a parent believes exist, the less willing they will be to seek mental health services for their child at church or at a doctor's office. The older a child is the less likely that services would be sought from a child's school. This is due to study findings of older children being less willing to participate in mental health services at school, possibly due to concerns of stigmatizing behaviors from peers such as bullying. A positive factor identified was that parents who have accessed mental health services for their child in the past are more willing to seek services for them again, except for in the settings of church or through videoconferencing. In general, the findings of the study state that parents believe there is reasonably low public stigma in obtaining services for their children, especially in settings such as private practice, primary care, church, or through telehealth. It is hypothesized that the "good parenting" that is shown by seeking help for their child outweighs any of the negative effects of mental health stigma (Polaha et al., 2015).

The unique culture of rural populations can have negative effects on help-seeking behaviors due to specific characteristics that individuals possess. Cheesmond et al. (2019) performed a systematic qualitative review of eleven research articles to answer the question "What do adult rural residents say about why they, or other rural residents, do not, or may not in the future, seek help for problems related to mental health?" A thematic analysis was then

completed on the articles to synthesize the data from the qualitative systematic reviews. The articles were published between the years of 1999 and 2017. The thematic mapping of data revealed four barriers to help seeking. These barriers include stoicism, stigma, distrust, and meaning. Stoicism is defined as "silently coping with mental distress" and was the most cited barrier throughout the articles, being reported in ten of the eleven. Stigma, or the perceived belief that you will be judged or seen negatively due to mental health needs was discussed in all eleven articles. Distrust in mental health services was cited in five of the eleven articles, while meaning, in regard to "the meaning an individual assigns to the key concepts within mental health," was cited to prevent seeking services in seven of the eleven research studies. In addition to these four attitudes, rurality was specifically mentioned in relation to barriers to help-seeking behaviors and was discussed as living in a rural area and the identity that comes with that as being directly related to their lack of help-seeking behaviors. Some specific factors relating to this include characteristics such as "independence, self-reliance, and strength" as well as the lack of confidentiality that comes with living in small communities. For those people who can travel outside of their community for mental health services, working with a provider that was from a nonrural area was described as being "ineffective or inappropriate." Coexistence of barriers was also noted in ten of the eleven studies. Overall, characteristics that were related to living in a rural area were discussed throughout all articles and were almost always connected negatively to help-seeking behaviors. Interestingly, much of the characteristics that were discovered to be inhibitive were identified by participants with pride as being "unchangeable part[s] of their core identity." (Cheesmond et al., 2019, p. 55). Therefore, living in a rural area and identifying with rural culture will have a limit on help seeking behavior-occurring outside of the effects of stigma and lack of access to services—because it is a by-product of rural cultural identity due to the

combinations of traits and values that are intrinsic to the people.

The culture of a rural area not only effects individuals living there, but also practitioners working in the area. A phenomenological study was conducted through interviews of eight mental health professionals working with rural populations to gain a better understanding of the barriers people living in rural areas face. The findings were published by Jensen et al. in the *Journal of Rural Mental Health* in 2020 under the title "A Phenomenological Study of Clinicians' Perspectives on Barriers to Rural Mental Health Care." Some participants in the interviews discussed rural cultural as a unique cultural identity and form of diversity. The strongest values discussed were of independence and self-sufficiency. While individuals in rural areas largely saw these values as positive and necessary for living in such low population areas, mental health professionals explained how these characteristics can negatively affect help-seeking behaviors. For instance, a professional discussed how the value of self-sufficiency was seen in some patients who waited until things were very bad for their mental health instead of reaching out for help. Another cultural phenomenon that rural communities face is tight-knit communities due to having fewer people in the area and thus having a higher level of interconnectedness. This leads to concerns with confidentiality in terms of community members knowing what others are doing, recognizing vehicles at mental health professionals' office, and the general gossip that is common in small communities. With a large amount of agricultural work occurring in rural areas comes difficulties in scheduling and planning mental health services. Schedules must be worked around farming, and certain seasons and times of day are much busier than others due to the nature of the work. Because mental health professionals in rural areas are likely the only such provider in the area, they may face unique challenges of dealing with dual relationships with clients, as well as having to work with a large variety of

mental health concerns that may normally be sent to specialists. With the lack of services in the area, referrals to other mental health services such as crisis, psychiatry, or other specialties can be difficult, and clients often experience increased wait times and thus delays in services. In conjunction with this, because of the uniqueness of rural culture, individuals may feel distrust or a lack of understanding by providers in urban areas. This can lead to a bad fit with providers, a lack of follow through with services, and generally inadequate treatment. Other related concerns with accessing services outside of the area include lack of transportation, cost, and the distance to other providers. Rural areas are generally lower income and due to the nature of the work (family businesses, small businesses, agricultural), many will not have access to health insurance or other benefits. Therefore, even if individuals are able to find services, they may not be able to afford them, or take off work to access them. Because of the nature of rural areas, there is a lack of access to services for mental health, as well as a general lack of other resources and amenities. This can make it difficult for new mental health professionals to be hired or convinced to take up practice in rural areas. Thus, decreasing the availability of services even more. The acceptability of accessing services can also be a daunting task due to the stigma related to mental health. Several interview responses discussed stigma and the barrier it serves to people feeling comfortable pursuing mental health services. The language surrounding mental illness contributes to the negative stigma as respondents discussed clients delaying services due to not wanting to be called “crazy” or be seen going to the “nut hut.” The study also presents possible solutions to these barriers which will be discussed more in depth in the next section of this paper (Jensen et al., 2020).

Stigma, shortages of services that reduce access, as well as culture all effect rural individuals from accessing services. Insurance and financial concerns also limit what services

individuals can access. Published in 2020 in the *Journal of Rural Mental Health*, this study analyzes data about the Medicare mental health coverage gap (MMHCG) from an American Counseling Association (ACA) survey (Fullen et al., 2020). The survey results include data from 3,760 counselors, 601 of which reside in areas identified as being rural by the Health Resources and Services Administration. The study looked to understand the impact of the MMHCG on rural mental health providers and rural communities. To understand the findings of this study it is important to know that services provided by some mental health providers, specifically those licensed as licensed professional counselors (LPCs) and licensed marriage and family therapists (LMFTs), are not reimbursable through Medicare insurance. The policy for Medicare mental health was last updated in 1989. This study notes that since that update, professionals, lawmakers, and educators have all advocated for changes to be made to allow Medicare recipients to be reimbursed for mental health services from these professionals (Fullen et al., 2020). Up to the date of this paper, the only identified professionals that are reimbursable by Medicare for mental health services are psychiatrist or another physician, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner and physician assistant (U.S. Centers for Medicare, n.d.). The study identified that 78% of rural counselors are impacted by MMHCG as compared to nonrural counselors at 68.6%. Results from the study showed 48.6% of rural counselors surveyed had to refer an existing client due to MMHCG as compared to 37.2% of nonrural providers. Applying this date to real world settings shows that rural counselors are 59.3% more likely to have to refer clients to other providers than nonrural counselors. This generally occurs mid-treatment when an existing client's insurance changes to Medicare. Part of this could be caused by the incompatibility between Medicaid and Medicare. Medicaid is a state and federal program that provides insurance at no or low cost to individuals that qualify due to

low income, disability, or other factors. Medicaid can be utilized by children, adults, and the elderly, whereas Medicare is only for individuals 65 and older. Medicaid reimburses far more mental health professionals than Medicare, including LPCs and LMFTs (MN Department of Human Services, 2021). The likelihood of individuals utilizing Medicaid for insurance is quite high in rural areas due to the increase in poverty and lower income households. Therefore, when an existing client switches from Medicaid to Medicare they would no longer be eligible for mental health services with a therapist who is licensed as LPC or LMFT, therefore helping to explain the increase in mid-treatment referrals for rural practitioners identified in the study. Similarly, the odds that a rural provider will use a sliding scale for fees or offer pro-bono services is 34.6% higher than nonrural practitioners. It is possible that sliding scale fees and pro-bono services are a practitioner's solution to maintaining care of patients who become ineligible for their services due to MMHCG. Due to the lack of other providers in rural areas and the inability to make referrals successfully due to other limitations of rural services that have been discussed in this paper, providing alternative paying options may be one of the only ethical options available for rural providers as there are few if any alternatives. The results from this study indicate that the problems with access to mental health services for rural populations extends far beyond lack of resources and negative stigma. Institutional level problems, such as insurance, are also causing rural residents to go without much needed services (Fullen et al., 2020).

What's Being Done

Despite the numerous barriers to accessing mental health services that rural residents face, there is hope for these barriers to be lessened. Telehealth, collaboration of services, increasing rural providers, school-based programs and health centers, psychoeducation, and

home and community-based service funding are all possible solutions. Some proposed solutions may be more effective than others as some solutions create their own barriers.

Returning to the findings of "A Phenomenological Study of Clinicians' Perspectives on Barriers to Rural Mental Health Care" by Jensen et al. (2020), mental health professionals working directly with rural populations provide helpful and workable solutions to the problems discussed earlier in this paper. Telehealth is the first option discussed. Participants in the study had various experience levels with telehealth and ranged from using it exclusively to only reading about it. Those that had the most experience with telehealth discussed that telehealth can be extremely helpful in addressing the problems of access and confidentiality. One practitioner even discussed working with a client through telehealth while the client was at a local medical clinic. In this way, concerns with telehealth that are often presented—such as lack of adequate internet, concerns with safety in utilizing therapy at home, as well as how to address suicidality in clients—are eliminated as the therapy is still being conducted in a medical atmosphere, but patients have the confidentiality of entering the medical facility for a much higher number of reasons. Telehealth was also discussed in the study as being a solution to accessing clinical supervision, which may otherwise be difficult for providers in rural areas and can be a barrier for new practitioners wanting to work in less populated areas. Another solution provided by participants is the recruitment of new mental health providers to rural areas. This was discussed by three of the participants in the study, however only one specific idea was presented. This idea is to increase the number of internships that occur in rural areas. The thought behind this is that if therapists can experience living in a rural environment, and the benefits that come with this, it may be easier to recruit more therapists to rural practice. The final solution presented in the study is to incorporate the already established value of community by collaborating with already

utilized and trusted institutions. Rural communities are characteristically tight-knit and collaborative. By focusing on these values, mental health can be incorporated into the daily lives of rural people. Collaborating with local hospitals and health care clinics, schools, and religious institutions were all discussed by survey participants. Additionally, including collaboration with law enforcement can be beneficial as they are often apart of a person's first experience with a mental health crisis. Therefore, by increasing collaboration better long-term mental health outcomes can occur. Overall, the study identifies that rural culture is a diversity issue that should be studied and understood just like all other cultures. People living in rural areas have "distinct values, norms, religious traditions, and language" (Jensen et al., 2020, p. 60), which need to be understood and respected to serve this population effectively. The background of rural individuals can negatively influence their help seeking behavior, but it can also be used to create innovative solutions to promote mental health services for this population (Jensen et al., 2020).

In its study, Crumb et al. (2019) not only looked at the stigma that mental illness has for rural and low-income adults, but also at what characteristics of mental health providers may help to lower stigma. The characteristics, or qualities, that were identified are being nonjudgmental and willing to listen. While these are characteristics that all mental health practitioners should already possess, participants described past experiences of providers rushing through appointments, or not taking the time to understand the unique concerns that people from rural populations have. With the information provided from the study, suggestions for making improvements for the mental health of rural populations were also made. Increasing knowledge on mental health, including signs and symptoms, common concerns, how to seek help, the relationships between mental health and physical health, were all topics identified as being important for rural, low income populations to know more about. Creating more integrated

services, as well as partnering with already trusted institutions in the community (such as schools, churches, community centers), can also increase the access and trust of mental health services. Confidentiality should also be discussed often by mental health providers to help clients feel comfortable with seeking their services (Crumb et al., 2019).

Telehealth is a possible solution for the lack of mental health services in rural areas. While it has had a positive impact on reducing problems with access, it also causes unique difficulties on its own. The global health pandemic caused by Covid-19 required a rapid shift to telehealth for many professionals, including those that practice in mental health. The article "Rural Mental Health Care During a Global Health Pandemic: Addressing and Supporting the Rapid Transition to Tele-Mental Health" published in the *Journal of Rural Mental Health* in 2021 reviews the efforts of two technology transfer centers that created trainings and materials to support the transition from in-person mental health services to tele-mental health services in March of 2020 (Schroeder et al.). The article reviews the successes and challenges that urban and rural providers faced and the continued barriers that exist for professionals providing mental health care virtually. One of the largest barriers for providing telehealth services to individuals is the lack of access to technology. In addition to this, problems with bandwidth (the speed of internet required to have a real-time conversation with audio and video without interruption) were common in rural areas and needed to be addressed through telephone services as well as hotspots (mobile internet). Providing services through telehealth was also new for many providers in addition to clients, and the effectiveness of providing therapy through this method was concerning for practitioners and clients alike. Additionally, the use of technology can be difficult for people to work with, especially those that have had less exposure to technology in everyday life, which is common for populations living in rural areas (Schroeder et al., 2021).

Lack of reliable internet, and even lack of reliable cell phone services, makes the use of technology by rural residents less common. In addition to these concerns that may be most specific to rural clients, more universal concerns were also brought up in terms of utilizing telemedicine for mental health services. These concerns include: reimbursement for services and whether telehealth services will continue to be reimbursable after the Covid-19 pandemic decreases, the ability to use technology by certain populations due to limits in knowledge as well as accessibility concerns for individuals with special needs, the use and effectiveness of using telehealth for group session, concerns for safety for individuals who may be accessing services from their home, including confidentiality for the individual, as well as how to assist individuals and ensure their safety when they may be dealing with suicidal ideation. Therefore, while telehealth services can be helpful, they can also cause further problems for practitioners and clients (Schroeder et al., 2021).

"Barriers and Solutions to Providing Mental Health Services in Rural Nebraska," published in the *Journal of Rural Mental Health* in 2019, looks at the results from a survey sent to non-prescribing practitioners in the state (Johansson et al.). The survey was sent to all 705 registered practitioners and had a response rate of 35.4% which included 250 responses. Respondents were primarily female (74%), White (90.4%), non-Hispanic (98.8%), and between 46 and 65 years old (62.8%). The study specifically hoped to examine barriers to receiving mental health care in rural areas, possible solutions to increase access, challenges for practitioners in rural areas, and solutions for practitioners. After analyzing the survey results three main barriers to accessing care were listed as being able to afford care, not having enough insurance to cover care, and not having insurance at all. For rural providers, the leading challenges were working with insurance providers, difficulty with Medicaid reimbursement, and

not receiving payment for services. The main solutions that were identified by respondents were increasing options available to individuals with serious mental illness and increasing the number of dual diagnoses facilities. Other solutions were also identified that primarily connected with preventative care and public health. These included: school based mental health promotion, community based mental health promotion, public education on mental health, and education on how to access mental health services. Suggestions that were identified from a top-down approach include tax incentives, increased mental health training for first responders and primary care providers, and creating collaborative coalitions. Overall, the focus of responses was on public initiatives such as educational and awareness campaigns as well as overall public health. Showing that individual problems with mental health access in rural areas needs to be addressed further "upstream" as the article suggests (Johansson et al., 2019).

One of the barriers discussed in this paper is the lack of services available, including the lack of providers. The Health Resources and Services Administration (HRSA) is a federal agency that works to improve access to healthcare for individuals living in designated underserved areas. In an article published in the *American Journal of Preventative Medicine* in 2018, one specific program, the Behavioral Health Workforce Education and Training (BHWET) program, is discussed and analyzed (Kepley & Streeter). The BHWET program works to increase the number of behavioral health providers in these areas by providing training. Grants are provided to universities and non-profit organization by BHWET to support the education of behavioral health professionals and promote those working in underserved communities. Programs that are eligible for this program include doctoral internships, masters level practicums, certificate programs, and even peer workers. As of 2018, the article states 9,293 students had been supported by the program. As stated earlier, one of the programs goals is to

increase the number of behavioral health professionals in underserved areas. At graduation, about 40% indicate the intention of working in these areas, and 72% intend to work with vulnerable and high-risk populations. In a one year follow up study, results from 1,975 surveys show that 97% of program participants are working in clinical settings where they provide behavioral health services. In addition, 47% were working in an underserved community or rural area, and 60% were working with children or transition age youth (identified vulnerable populations). Through this program, underserved communities have the benefit of receiving services from students in training. Additionally, the students working in this community have the benefit of expanding the amount of populations they are working with, which increasing their interest in working with underserved populations, thus helping to achieve the overarching goals of the BHWET program (Kepley & Streeter, 2018).

School-based programs, where mental health services are offered directly in the school, are a unique way to overcome barriers to mental health services in rural areas. Due to clients being children, their parents and guardians have the majority of say in whether they participate in these programs. Therefore, their perceptions of the program, as well as their perception of children's needs and barriers when it comes to mental health have an impact on the success of school-based programs. In a study on rural school-based mental health programs, published in the journal *Children and Schools* in 2018, van Vulpen et al. study the results of 607 parent surveys. These surveys provided information on the expressed needs, perceptions on the role of schools, barriers to receiving services, level of access to services, and who parents would contact for more information on services. Results show that parents do identify a need for mental health services with anxiety, victim of bullying, and peer problems being the most stated reasons. Parents also show an agreement with schools being involved in mental health with 78% agreeing

or strongly agreeing that schools should be a part of addressing mental health concerns. Screening for mental health issues as well as offering social-emotional curriculum in classrooms was supported by 71% of parents. Finally, 85% of parents agree or strongly agree that schools should make referrals for children and families to both school-based and community-based providers for mental health services. In the surveys, parents also identified barriers to receiving services. The most identified barriers include lack of parental support, lack of awareness of mental health problems, lack of supportive programming for parents, and lack of continuous monitoring of mental health needs by school personnel. Of the parents surveyed, 33% stated their child utilized mental health or special education services at school. When asked whom they would contact if they had concerns about their child's mental health, 87% stated their child's primary care provider, 52% stated the school's guidance counselor, and 46% stated a community mental health agency. For information specific to the school based mental health program, 66% would contact the school guidance counselor, 38% would contact their child's primary care provider, and 35% would contact the school-based mental health provider directly. Overall, the results from this study indicate that parents do believe schools should be involved in addressing mental health needs and supporting students with mental health concerns. The primary barriers for not having mental health concerns addressed are related to the parents—their lack of education or understanding of mental health and lack of support. Therefore, education on mental health and mental health programming should be focused on parents. Primary care providers are a trusted source of information for parents according to the results of this study, and provide a unique avenue for spreading information to parents. Educational materials and lists of services could be supplied to primary physicians in order to be available for distribution to families (van Vulpen et al., 2018).

School-based health centers (SBHC) provide students with access to primary health care, mental health care, and in some instances dental health care, directly in their schools. A study completed in 2008 and published in *Public Health Reports*, looked at four rural and four urban school districts with SBHCs during the years of 2000 to 2003 to analyze the differences in access and utilization of SBHCs (Wade et al.). The school districts studied first implemented SBHCs for the 2000-2001 school year. There were 13,046 students at the schools, and all were aged 5-15 (grades Kindergarten to eighth). All data for this study was tracked using the health management database employed by the SBHC. Of the 13,046 students, 7,460(57.2%) enrolled in the SBHC, 4,426 (59.3%) of those enrolled utilized the SBHC at least once in the three years analyzed. Urban students were shown to be more likely to be enrolled in the SBHC and to use it at least once. Of the rural students enrolled, they had a higher rate of utilizing the services. Additionally, students with public insurance, or no insurance, were more likely to use SBHC and had higher rates of utilization than students with private insurance. The highest number of referrals for rural students came from parents (44.8%) while urban students had most referrals come from teachers (64.1%). Mental health referrals most commonly came from school counselors and school social workers. There was a substantial increase in visits across all categories over the three years with the highest increase being in mental health. Boys, students in rural schools, and students with public insurance had the largest amount of mental health visits. As discussed in the study, SBHCs have the potential to lower barriers to mental health as well as other health care that so many rural students face. Earlier in this paper barriers such as access to services, insurance, affordability, transportation, are all discussed. Having SBHCs limits these barriers by providing low-cost or free health care to students at their schools. This means parents do not need to have insurance for their children, do not need to leave work to take their child to an appointment, and

also do not need to deal with finding reliable transportation as children are bussed to school and their health care needs would be met there. Additionally, by having on-site services, children miss less school as they do not have to travel to appointments, which in rural areas can take a substantial amount of time due to distance. The increase in utilization of services over three years shows that with an increased knowledge of services provided there is an increase in trust and thus utilization. Mental health services went from being 1% of services provided to 22% in three years (Wade et al., 2008). It also showed that parent referrals for mental health services were higher than teacher referrals, possibly showing that parents do see the signs of their children needing assistance. SBHCs may be an ideal solution to many of the barriers that children face to accessing services, but they still do not solve the entire problem as parents, caregivers, and other adults living in rural areas are ineligible for these services (Wade et al., 2008).

Rural children cannot access mental health services that do not exist. Published in the *New England Journal of Medicine* in 2017 on the topic of Rural Health Care, this analysis of a CDC report on disparities in mental health care for children living in rural counties, offers possible solutions to the crisis as well as commentary on the further difficulties that these solutions may encounter due to the nature of living in a rural community (Kelleher & Gardner, 2017). First highlighting the difficulties faced by individuals living in rural communities, the article discusses the shortage of specialist mental health providers in many areas, including urban and rural. It explains that because the shortages are widespread and not just in rural areas that telehealth cannot fully solve the problem of lack of rural access. The article also explains the financial and regulation barriers that can occur when trying to use alternative delivery methods of mental health services. Some of these would include the credentials and licenses of mental health providers and whether these would allow for the delivery of telehealth services. School

based services are a possible solution cited, and have been discussed already in this paper (See van Vulpen et al., 2018 & Wade et al., 2008). Kelleher & Gardner (2017) briefly discusses the positives and negatives of utilizing school-based services. Positives include having easy access to services for children, and the collaboration that can occur between mental health professionals, school staff, and families. This is especially beneficial since children spend more time at school during the year than at their own homes. Concerns include lack of resources, staff, and space that many rural schools face. Overall, the article promotes collaboration across settings and coordination of care in order to alleviate the lack of mental health services for children in rural communities while also promoting the need for further study and attention to this growing problem which the writers indicate as being "out of sight and out of mind" for far too long (Kelleher & Gardner, 2017).

Lack of knowledge of mental health and mental health services is discussed earlier in this paper as a barrier to services for rural populations. Mental Health First Aid (MHFA) is a program developed to "address the gaps in mental health literacy" and includes a program specifically tailored for rural communities (El-amin et al., 2018). In a study published in the *Journal of Rural Mental Health*, El-amin et al. analyze the growth of MHFA in rural areas of the United States during the years of 2008-2016. MHFA is taught to community members by a certified instructor. The training is done either in a single eight-hour session or two four-hour sessions. The study analyzes post course evaluations and data from trainings that occurred across the United States and includes 47,660 trainings, taught by 7,855 instructors, and attended by 777,095 individuals. Of the 777,095 participants in the training, 78% or 606,941 completed the post training evaluation. Demographics of participants are 74% female, 25% male, and 1% non-reporting, the most common age was 25-44 with 46%. These demographics were not seen to

change by rural or urban location of the training. Race/ethnicity did vary by urban or rural setting for American Indian/Alaskan Natives (2% urban, 4% rural), Asian Americans (3% urban, 1% rural), African Americans (20% urban, 8% rural), non-Hispanic White (60% urban, 79% Rural), and Hispanic/Latinos (14% urban, 8% rural). MHFA has grown in rural areas from when it was first offered in 2008. Only three courses were offered in rural areas in 2008, this increased to 3,330 courses offered in rural areas in 2016. Rural courses account for approximately 22% of all courses taught in each state. In analyzing post course evaluations, which provide participants with the opportunity to answer on a Likert scale their confidence level on a variety of topics because of the training, rural participants had similar answers to urban participants with the differences being at most 3% points. When differences occurred, rural participants ranked their confidence level as higher than urban participants. The study notes that while the evidence shows MHFA programs have increased in rural areas, the study does not show if this has an impact on long term knowledge of mental health or positive impacts on rural mental health in general. Post course evaluations are completed immediately after the final training and no pre-course evaluation is offered. Evaluation is also not completed again in the future to account for any change due to time. Furthermore, the study specifically analyzes an individual's "confidence" about the specific topics and does not measure any actual behaviors. Therefore, while MHFA can be a helpful tool to increase mental health awareness in rural communities, further study should be completed on long-term impacts to see if there is any actual change for rural residents in seeking or accessing mental health care (El-amin et al., 2018).

Home and Community Based Services (HCBS) offer the opportunity for individuals to continue to live in their homes while still receiving the medical or mental health services they need. These services are generally paid for by the county of residence in the form of waivers and

grants. Individuals are eligible for waivers and grants due to age or disability. HCBS allow individuals to continue to live in their homes longer rather than entering residential facilities. A study completed by Siconolfi et al. in 2019 and published in the *Journal of the American Medical Directors Association,* seeks to identify possible disparities in the access and use of HCBS between urban and rural residents. The qualitative study was completed through interviews of forty "healthcare stakeholders" across fourteen states. Stakeholders include "Medicaid administrators, services agency managers and staff, and patient advocates." One reason researchers chose to pursue this study is because of recent policies that have sought to promote the use of HCBS funds rather than support residential placement or institutional care which the study cites as being far more expensive. This could be problematic for rural residents if they do not have similar access to HCBS when compared to urban residents. The results of the study are broken down into the four topics of "approachability, acceptability, availability and accommodation, and affordability" (Siconilfi et al., 2019, p. 505). Approachability is defined in this study as an individual's access to information, their knowledge of what services are available, and general health literacy. Overall, rural residents are shown to have less access to information due to limited or no access to the internet, which is primarily where information on HCBS is found. Stakeholders discussed that advertisement for waiver services is also primarily on the Internet. Therefore, rural residents may be lacking in approachability. Acceptability is described as the relationship between what services are available and what is acceptable for the population in terms of social or cultural believes. One difference between urban and rural participants was rural populations tended to rely more on informal caregivers, such as family or friends rather than services provided by an agency or HCBS. The study questions whether this is due to preference or an accommodation due to the lack of HCBS in rural areas. Availability and

accommodations refer to individuals' access of services when and where they are needed. Results from the study indicate that services are heavily concentrated in suburban and urban areas with limited availability of HCBS providers in rural areas. Additionally, lack of public transportation in rural areas present further difficulty for accessing what services are potentially available. As mentioned earlier, the use of informal caregivers is more common for rural residents, however, lack of availability of these individuals is common too due to the need for most adults to work full-time jobs in order to support themselves and their families. This brings up the final category, affordability. Affordability refers to the financial accessibility of services. It is difficult to find people to work in HCBS as they are generally paid less than most retail positions and also are generally not needed for forty hours a week. This makes it difficult to recruit and retain individuals to work in HCBS. Overall, having HCBS could be a part of the solution to lack of access to mental health services for rural populations. Unfortunately, HCBS face difficulties as well and therefore, these difficulties need to be overcome before it can be considered a viable solution (Siconolfi et al., 2019).

Discussion

Children are the future. This is no different when looking at mental health in rural America. By focusing on increasing services in schools, the greater community will also have positive effects. As discussed earlier in this paper, data suggests that parents are less affected by stigma when accessing services for young children because it is seen as good parenting. The good parenting outweighs the negative effects of stigma (Polaha et al., 2015). Therefore, utilizing schools for mental health resources not only helps children by increasing their access, but can also mitigate some of the stigma felt by parents. Schools also offer the opportunity to collaborate and reach more individuals by hosting educational events for parents, caregivers, and other community members.

Outreach for mental health education is growing as seen through the data presented on mental health first aid (El-amin et al., 2018). By creating events specific to communities and the services and supports available to them access of these existing supports may increase. An example of how this can be done is shown through an advocacy project in Appendix A. Individuals will not access services that they do not know exist. Therefore, this collaboration through existing resources such as schools, should also be extended to other trusted organizations such as community centers, churches, VFWs, primary care providers, etc. Schools generally are only able to serve children for their mental health needs, but these other organizations can reach much larger populations. By collaborating with these main stays of the community at least the barrier of education and knowledge of resources could be surmounted.

Shortages of resources and providers are also a barrier. The BHWET program funded by the HRSA is a great start, but more programs and incentives must also be researched to continue increasing services (Kepley & Streeter, 2018). While creating services, or even putting on

presentations about existing services may not be feasible for the vast majority of counseling professionals, having knowledge about what services exist in a community is something all professionals should already be doing. Section D of the ACA code of ethics specifically discusses forming relationships with other professionals who are and are not a part of the counseling field to better serve clients and meet their needs (ACA, 2014). Additionally, identifying populations in need of these services and alerting them and their caregivers of what services are available is another helpful act counseling professionals can be performing. Having a running list of services and supports, that is updated for accuracy on a consistent timeline, is essential to advocating for people in need and helpful to have readily available for distribution. Counseling professionals are the people that community members go to for support in their time of need. If they are unable to provide the support needed, they must be able to help them access the supports and services through other means. In this way, they can be helping community members, while also continuing to lessen the gaps of accessing services and supports.

Other barriers, such as transportation, financial concerns, insurance, etc. must also be overcome, but it is not something an individual or small group of people can change on their own. Funding in the form of waivers and grants can supplement some of these concerns, but as discussed earlier, this is not a solution as much of the HCBS also do not have the staffing available to support these programs (Siconolfi et al., 2019).

To fully solve the problems rural individuals face in accessing mental health services, solutions need to come from the top. Tax incentives, government programming, and changes in policies, such as the MMHCG, must all occur in order to provide equitable access for individuals living in rural communities (Fullen et al., 2020; Johansson et al., 2019; Kepley & Streeter, 2018; Sconolfi et al., 2019). Through these suggested programs and initiatives, more providers can be

recruited to rural areas, and those providers that already exist will be able to afford to continue their work (Fullen et al., 2020; Kepley & Streeter, 2018). The MMHCG should have been fixed long ago, but it has clearly not been a priority. By increasing the reimbursable services covered by Medicare more services can be offered to individuals in all areas, which will in turn decrease the service needs in rural areas as well (Fullen et al., 2020).

Access to services in rural areas will continue to be difficult, and in some cases, impossible, until all barriers have been addressed. Therefore, further study, research, and most importantly action still needs to be occurring. The idyllic images of rural communities can still exist, but these images should also not be allowed to remain a façade of health when the realities are harmful to the very people who call those places home.

Author's Note

Rural mental health has been important to me for the last six years when I saw the effects of it as a High School English Teacher in a small rural community. As a teacher in this community, I saw the strengths of this tight-knit community as well as the weaknesses. The community would band together when crises occurred as well as supported the local children in their everyday pursuits at sport's competitions and music productions. Everyone knew everyone and I was welcomed with open arms into this community. Much of the barriers that were discussed in this paper I also experienced when attempting to find resources to assist my students. I started teaching at this school when I was twenty-three years old, and as the by far youngest teacher I brought a sense of the "big city" to my classroom. My openness to talk about mental health, culture, race, sexual orientation, etc. in the classroom was met with joy by some, and disdain by others. I became the confidant for many of my students, generally having a group of them joining me in my classroom during lunch to seek out advice or just feel they had a safe place to be. However, I was unable to assist my students to the best of my ability due to lack of resources both in and outside of the school as well as my personal lack of knowledge and education. It was at this time that I made the decision to look for a career elsewhere as well as begin my education in the Counseling Education Department at Winona State University. I began my work as a Children's Mental Health Case Manager for a local mental health agency during the pandemic in October 2020. My work brought me to another rural community where I now assist children and their families with accessing mental health resources as well as funding to help pay for these services. The barriers and solutions discussed in this Capstone Project are ones that I now encounter every single day. Many of the services that my counterparts in larger counties have are not a possibility for my clients due to these same barriers. Individuals living in

rural areas deserve to have the same access to mental health services as those living in larger urban areas. This unique group of people embody community and neighbors helping neighbors. It is now time for their neighbors, those living in urban areas, as well as their government to help them. Access to mental health services is a human right, not a privilege, and should be treated as such.

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Appendix A

Application of the T.R.A.I.N.E.R. Model[1]

Target

The target for my advocacy project is children in rural communities that need mental health services.

Respond

For the most part, children are unable to access services for mental health on their own; therefore, I will be responding to this groups needs by focusing my advocacy project on the caregivers of children: teachers, parents, and other guardians. These caregivers are the advocates for children and some of the first people who would notice if a child needed additional mental health help.

Articulate a plan

As discussed earlier in this paper, schools provide a unique and efficient way of reaching children and their caregivers. For this reason, a form of advocacy that could be utilized in order to lessen the barriers to services and supports for children in need of mental health services is by hosting trainings and presentations at schools. Ideally these trainings could be held for school staff as well as the community at large. In a study of 786 educators from across a large Midwestern state completed in 2016, it was indicated that 93% of participants had concerns about their student's mental health, and 85% of participants cited a need for further training in mental health (Moon, Williford, & Mendenhall, 2017). Therefore, by completing these trainings at schools, the primary people who are with the youth of the community can all be trained on what resources are available as well as what steps to take to access these resources.

[1] The T.R.A.I.N.E.R. model is a seven-step method of carrying out advocacy in an intentional way that focuses on the participants in the advocacy to explore and discuss a possible solution to the problem explored (For additional information see Hof et al., 2009).

In addition to the presentation, the distribution of inclusive guides that not only include mental health services in a certain area, but also steps and processes to access these services may lessen some of the disparities in mental health access. Not all services are available in all areas. However, there are more services and supports than many people realize. By creating an inclusive guide, parents and caregivers can identify what steps to take to assist their child in obtaining the mental health services they need. Some of the different services that could be included in the guide would be steps to identifying what services are needed, what services are available in the immediate area, how to contact these services, as well as contact information for people and agencies if they have further questions or needs.

By holding a training or presentation as well as passing out guides, information is not only given out verbally, but also presented in a physical way. This combination of presenting materials allows for further people to be reached and the opportunity for professional relationships to begin.

Implement the plan

This plan would be implemented in three phases. The first phase would be in the creation of the guide. This guide would need to include services and supports for the area in which the presentations would be held, as well as information on services that are available in all areas of the state—such as county programming. The guides would also include information on how to determine if services and supports were needed—for instance, common signs and symptoms of mental health disorders and other warning signs of a child needing further support.

The second phase would occur after the completion of the guide. Local schools would be contacted to receive permission to present two trainings. The first training would be for teachers and staff in the school, while the second would be for the community as a whole—specifically

targeting parents and caregivers. These trainings would present the information in the guide in more detail and be engaging for audience members. The presentation would use examples of when a child may need services in order to illustrate the common signs and symptoms. The training for school staff would be tailored to their roles as advocates for children. It would discuss referrals, how to communicate with parents that their child may need additional services, and how to support children in the school environment.

The third phase would be the second training, which would be for the community and caregivers. This would again go through the guide and include examples of common signs and symptoms of when a child may need mental health services. The second training would then also follow a made-up family as they journey through the steps and process of accessing mental health services. In this way, families would become more familiar with what would occur if they are ever accessing these services for their child.

Network for advocacy

Throughout the trainings, advocacy for children and their mental health would be discussed extensively. The main points of the trainings are to increase knowledge of signs and symptoms of mental health needs in children as well as how to access services to increase mental health for these children. Therefore, advocacy for children is the focus. Resources will be presented throughout the training, as well as handed out in the form of a guide to make them easily accessible.

Evaluation

There are a few ways the training will be evaluated. First, comment cards will be distributed to attendees at both trainings. The comment cards will act as a way for participants to comment on what they found helpful, what they still want to know more about, as well as a

section for them to put their own information if they would like to be contacted to receive assistance, ask questions, or to offer their own help and support for future trainings. In this way, participants are not only able to offer anonymous feedback to the presenter, but also receive help in accessing services. Another way to evaluate the training is by seeing if there is an increase in referrals or access of services in the months following the presentations. While this would not be a perfect method of evaluating the training, as referrals and access to services tends to naturally increase and decrease, when comparing to past trends it could be helpful in indicating if the training has a positive effect in increasing services.

Retarget

After receiving feedback through comment cards, as well as evaluating what questions may have been asked during and after the presentation, the presentation would be altered to meet the needs of future participants while also maintaining the goals of the presentation. Ultimately, the goal of increasing knowledge of symptoms of common mental health disorders while simultaneously discussing services and supports and how to access them would remain the main points of the presentation. The goal will still be to increase the access of services for children with mental health needs in rural communities, but if there are needs of the audience that need to be addressed to continue the success of meeting this goal, the presentation would be altered however was necessary.

Source: DuCharme, A. (2021) Advocating for mental health for children living in rural areas. Unpublished manuscript. Winona State University.