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# Challenges and Advantages in the Delivery of Mental Health Services to Adolescents in Rural Areas

By

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MSW Clinical Research Paper

Presented to the Faculty of the

St. Catherine University and the University of St. Thomas

St. Paul, Minnesota

In Partial fulfillment of the Requirements for the Degree of

Master of Social Work

Committee Members

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with the basic social research methods. Students must independently conceptualize a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the finding of the study. This project is neither a Master's thesis nor a dissertation.

## **Abstract**

While the rates of adolescent mental health problems in rural areas are similar to those seen in urban areas, serving adolescents in rural settings poses some particular challenges. This research focused on the challenges and advantages in the delivery of mental health services to adolescents in rural areas, surveying a total of 98 respondents with 28 responding, over four rural counties in western Wisconsin.

Respondents consisted of mainly school-based providers. The survey utilized both quantitative and qualitative questions developed by this researcher and questions grounded in existing literature. Respondents noted the importance of social support, including family members and the community, knowing the adolescents well, and partnering with others in the community when delivering mental health services. Respondents spoke to the particular role of school settings in service delivery. Findings suggest a need for continued education and training in the area of the needs of adolescents who experience mental health problems in rural areas.

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According to the National Alliance on Mental Illness (NAMI) there are approximately 60 million Americans every year who experience a diagnosable mental health condition, including one in ten children across the United States (National Alliance on Mental Illness [NAMI], 2013). According to the Center for Disease Control and Prevention (CDC) mental health is defined as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (Center for Disease Control [CDC], 2011). The CDC also mentions that there are three domains that indicate mental health and they are, emotional well-being, social well-being, and psychological well-being. A definition used for adolescents and teens is very similar stating that mental health is a state of behavioral, emotional, and social well-being (Teen Mental Health, 2013). The focus of this paper will be to have a better understanding of the challenges and advantages faced with the delivery of mental health services in rural areas to adolescents.

Similar rates of mental health problems are seen in both rural and urban areas (Bird, Dempsey, & Hartley, 2001; Cohn, & Hastings, 2013; Heflinger & Christens, 2006; Hodges, Markward, Yoon, & Evans, 2005; Slovak, Sparks, & Hall, 2011). However, rural populations face unique mental health challenges that their urban counterparts do not. This is especially the case when looking at the shortage of mental health providers. (A mental health provider is a worker in the health care field who aids one in the improvement of their mental health [Teen Mental Health, 2013]). More than 85% of mental health provider shortages are seen in rural areas (Smalley et al., 2010). Some of the other challenges seen are: lack of adequate staffing, lack of formal resources,



geographical barriers (to include density of population and dispersal), concerns for transportation, burnout, practitioners constantly being in the public eye and difficulty in utilizing the strengths of the community to encourage participation and implementation of services (Bjorklund & Pippard, 1999; Hodges et al., 2005; Humble, Lewis, Scott, & Herzog, 2013, Kos & DeStefano, 2011, Robinson et al., 2012, Smalley et al., 2010, Sullivan, Hasler & Otis, 1993). Unfortunately, most of the research and development of treatments for mental health problems has been done in urban areas where there are more hospitals, universities, training facilities, research centers, and experts (Bjorklund & Pippard, 1999; Heflinger & Christens, 2006). There was little movement to improve these challenges faced in the rural communities until the 1970's (Smalley et al., 2010). Also noted by Smalley et al., (2010) in 1987 the National Rural Health Advisory Committee and Office of Rural Health Policy were formed when the federal government "recognized the health needs of rural Americans" (p.479).

Among all of these challenges there tend to be higher levels of ethical considerations, depression, rates of suicide, isolation, poverty, and using their primary care doctor to treat their mental health when compared to the urban areas (Hodges et al., 2005; Robinson et al., 2012; Shaklee, Bigbee, & Wall, 2012; Smalley et al., 2010; Sullivan et al., 1993; Werth, Hastings, & Riding-Malon, 2010). One of the challenges seen relating to ethics is that a majority of the literature on ethics seem to have more of an urban base (Heflinger & Christens, 2006; Werth et al., 2010). Along with ethical considerations one also needs to consider the dual roles providers may experience in rural areas. Many times providers in rural areas may shop at the same stores, have children in the same school, and attend the same church (Humble et al., 2013).

It has been noted that in rural areas 41% of people with a mental health issue also experience substance abuse (Smalley et al., 2010). A major concern relating to substance abuse in rural areas is the increased use of prescription pain killers, narcotics, alcohol, and methamphetamine (Shaklee et al., 2012). Rural areas also have fewer treatment facilities and detoxification centers than their urban counterparts so adolescents needing treatment for these problems are usually placed in a facility far from their families which can add difficulty to the transitions and family relationships (Heflinger & Christens, 2006; Shaklee et al., 2012; Wahlberg, 2010). Smalley et al., (2010) noted that most of the challenges seem to be linked to three major problems including availability, acceptability, and accessibility.

Another unique challenge is that there is no real clear definition for the word rural so coming to a consensus for a definition can be difficult. In 2002 the United States Census bureau defined rural as an area with a population density of less than 2,500 people in an open countryside (Baffour, 2011; Werth et al., 2010). Now there are several factors that take part in defining the word rural such as population size, population density, and/or economic factors. According to the United States Department of Health and Human Services (2012) there are two main definitions that the federal government uses for the term rural. One of these definitions is from the United States Census Bureau and the other is from the Office of Management and Budget (OMB). The United States Census Bureau definition focuses on separating urban areas from rural areas in the country while the OMB focuses their definition on integrating rural and urban areas with micropolitan and metropolitan areas (Isserman, 2005). Heflinger and Christens (2006) noted that about 21% of adolescents and children live in a rural area. For the purpose of

this paper a definition of rural will be populations with less than 2,500 people in an area with open countryside.

Delivery of mental health services is often thought of as therapy services provided by a trained individual (Kazdin & Rabbitt, 2013). Heflinger & Christens (2006) noted that in rural areas individuals are less likely to access services and when they do the quality is not always nor necessarily the same as seen in urban areas. This may be due to the fact that most mental health providers are found in more populated areas (Kazdin & Rabbitt, 2013). It is important to consider that there are several ways that service can be delivered (i.e. through informal supports, telemedicine, integrating services with primary care physicians) (Benavides-Vaello, Strode, & Sheeran, 2013; Campbell, Gordon & Chandler, 2002; Heflinger & Christens, 2006; Lewis, Scott, & Calfee, 2013; Shaklee et al., 2010; Smalley et al., 2010; Starling, Rosina, Nunn, & Dossetor, 2003; Wahlberg, 2010). It is estimated that there are approximately 700,000 mental health professionals in the United States but this is likely an underestimate in numbers due to the many other people who may be considered mental health providers in rural areas (i.e. schools, pastors, family) (Kazdin & Rabbitt, 2013). For the purpose of this paper the provision of services will not only incorporate the professionals that Kazdin & Rabbitt (2013) refer to but will also include the informal supports seen in rural communities such as schools, family, and churches.

These challenges faced with the delivery of mental health services can directly affect social workers because in these areas the role of the mental health professional is likely to fall on the local social worker. This social worker may be the only worker available in a 100 mile radius and there may be multiple client needs (Humble et al.,

2013; Riebschleger, 2007). To add to these challenges the recession of 2007-2011 left a larger burden felt by rural social service programs because these programs were targets of the budget cuts (Shaklee et al., 2012).

The purpose of this paper was to collect data that suggests what improvements could be made to help reduce or lessen these challenges in rural areas with particular attention to the needs of adolescents. Data were collected across a rural area in western Wisconsin. The tool used was an online survey, via Qualtrics, sampling mental health providers, school social workers, and school counselors. This study sought to explore the challenges that are faced with the delivery of mental health services by the primary research question: What are the challenges and advantages providers face in the delivery of mental health services to adolescents in rural areas that could be applied more broadly to other rural settings?

## **Literature Review**

Mental health is an issue that has received a great deal of attention throughout the years. Unfortunately, mental health providers in rural areas tend to face challenges that their counterparts in urban areas do not. Throughout the literature three themes commonly mentioned when discussing rural mental health were: forms of service delivery, challenges in service delivery, and benefits or advantages of rural areas.

### **Rural Mental Health**

It has been estimated that about one-fourth of the population in the United States lives in rural areas: this accounts for more than 60 million Americans (Baffour, 2011; Bird et al., 2001; Campbell et al., 2002; Heflinger & Christens, 2006; Hodges et al.,

2005; Riebschleger, 2007; Wahlberg, 2010). The numbers of individuals in rural areas who suffer from mental health problems are similar to those living in urban areas (Bird et al., 2001; Cohen & Hastings, 2013; Heflinger & Christens, 2006; Hodges et al., 2005; Slovak et al., 2011). However, a smaller number of people practicing health care in rural areas is a factor that restricts access to appropriate health care in these rural areas. The Affordable Care Act (ACA) offers the potential to decrease some of these restrictions (National Advisory Committee on Rural Health and Human Services [NACRHHS], 2011). This is noted in three particular sections of the ACA: Community Transformation Grants (Section 4201), Prevention and Public Health Fund (Section 4002), and Understanding Health Disparities: Data Collection and Analysis (Section 4302). Community Transaction Grants are used for the purpose of evaluating and implementing stronger evidence-based prevention programming (Substance Abuse and Mental Health Service Administration [SAMHSA], 2010). Prevention and Public Health Funds are used “to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public healthcare costs.” (American Public Health Association [APHA], 2013). The standardization of reporting and analyzing the data collected on health disparities is explained in the Understanding Health Disparities: Data Collection and Analysis section of the ACA (The Office of Minority Health, 2011).

The Community Mental Health Centers Act (PL 88-164, Title II) was passed in 1963 by Congress and authorized the staffing, construction, and programming of community mental health centers (CMHC) (Human & Wasem, 1991). Few if any movements were made to improve the challenges of mental health service delivery in

rural areas until the 1970's (Smalley et al., 2010). In 1978 grants were awarded to develop a link between the community and migrant health centers and the CMHC's (Human & Wasem, 1991). Human & Wasem (1991) also noted that in 1981 the Alcohol, Drug Abuse, and Mental Health Grant mandated that the states now be responsible for the CMHC's. In 1987 the National Advisory Committee on Rural Health and Human Services was formed to report the health problems experienced by rural Americans to the Secretary of Health and Human Services (U.S. Department of Health and Human Services, 2012). Around this same time the Office of Rural Health Policy was formed when the federal government "recognized the health needs of rural Americans" (Smalley et al., 2010, p. 479).

In 2002 the focus of the National Advisory Committee on Rural Health and Human Services (NACRHHS) started to shift to human services as well as health care problems in rural areas (U.S. Department of Health and Human Services, 2012). Even though rural mental health has been a focus by the Office of Rural Health Policy and National Rural Health Advisory for 30 plus years, rural populations continue to face challenges with the treatment of mental health issues (Smalley et al., 2010) and funding for mental health research in rural areas has not been a priority (Bjorklund & Pippard, 1999; Heflinger & Christens, 2006). Certain factors such as ethnic makeup, cultural heritage, geography, and unique history of rural areas shape the lives of individuals and the types of challenges each community may face with regard to the delivery of mental health services (Cohn & Hastings, 2013).

### **The Role of Financial Stress.**

Financial stress is said to have an impact on mental health in rural areas because higher rates of poverty are seen (Baffour, 2011; Heflinger & Christens, 2006; Hodges et al., 2005; Riebschleger, 2007; Shaklee et al., 2012; Slovak et al., 2011; Smalley et al., 2010; Starling et al., 2003; Sullivan et., 1993; Werth et al., 2010). Doing well financially has long-been correlated to the quality of life and well-being of an individual (Gerrior, Crocoll, Hayhoe, & Wysocki, 2011). Twenty percent of people who live in poverty in rural areas remain in poverty for at least 30 years (Shaklee et al., 2012). Along with the higher poverty rates come higher levels of unemployment, more uninsured people, lower incomes, home foreclosures and homelessness, as well as an inability to meet health, educational, and nutritional needs of families (Hodges et al., 2005; Lewis et al., 2013; Shaklee et al.,2012; Werth et al., 2010).

### **Adolescent Rural Mental Health.**

Heflinger & Christen (2006) noted that about 21% of adolescents and children live in rural areas. When looking at rural areas there tends to be higher levels of depression, suicide, and substance abuse among adolescents than in urban settings (Heflinger & Christens, 2006; Hooper, 2010; Smalley et al., 2010). Depression in adolescents is different from adults in the fact adolescents may show symptoms of irritability, acting out, failure to make expected weight gains or losses, and a decline in their performance in school (Hooper, 2010). It has been found that during adolescence is when most mental health problems are first seen, regardless of geographical location (Boyd et al., 2008).

As many as one in five adolescents has a mental health problem but only a small proportion of them are being identified (Yellowless, Hilty, Marks, Neufeld, & Bourgeois, 2008). The difficulty in identifying them may be related to the fact that in rural areas adolescents are most often seen by their primary care physicians for some other physical ailment. Adolescents tend to then use their primary care physicians due to the lack of mental health professionals in the area. The reason for this is when one looks at the number of child psychiatrists in rural areas it has been noted that there are only .3 psychiatrists per 100,000 youth compared to 6.9 per 100,000 children in urban areas (Wahlberg, 2010). These primary care physicians may lack the training and education to recognize symptoms of depression in adolescents. One other concern is that psychiatrists in rural areas may have a wait list of up to two years (Wahlberg, 2010).

The Reach Institute (2010) has developed the Guidelines for Adolescent Depression-Primary Care (GLAD-PC). The Reach Institute recognizes that usually 75% of adolescents with behavior and emotional problems do not receive the care they need because these problems are not identified (The Reach Institute, 2011). As well as GLAD-PC a tool kit called “The ‘Action’ Signs Project” was created to help parents, health professionals, and educators identify emotional and behavioral risks in adolescents. The Reach Institute states the overview of this kit is as follows:

To address these and other related problems, the Surgeon General issued a “call to action” in January 2001, and urged the development of a crisp set of warning signs that when present, warrant additional professional evaluation and possible intervention. Therefore, the Action Signs Project (originally called the “Warning Signs Project”), funded by the Center for Mental Health Services (CMHS) and the National Institute of Mental Health (NIMH), was first developed at the Center for



the Advancement of Children's Mental Health at Columbia University/New York State Psychiatric Institute, and completed by the investigators which at the REACH Institute and at the Mayo Clinic (The "Action" Signs Project p.4).

### **Service Deliveries**

It has been noted that the number of individuals who experience mental health problems is similar in both urban and rural areas, yet the rural areas are underserved when it comes to providing mental health services (Campbell et al., 2002; Gerrior et al., 2011; Hodges et al., 2005; Hooper, 2010; Humble et al., 2013; Slovak et al., 2011). There tends to be a lag in organizations that create consumer-oriented programs resulting in longer wait time for referrals (Bjorklund & Pippard, 1999; Robinson et al., 2012). The literature addressed different ways that mental health services are provided in rural areas. Some of the ways addressed in the literature include the use of informal services (i.e. churches, schools, community and family members), through cooperative extension systems, integrating services with primary care physicians, and telemedicine (Benavides-Vaello et al., 2013; Campbell et al., 2002; Heflinger & Christens, 2006; Lewis et al., 2013; Shaklee et al., 2012; Smalley et al., 2010; Starling et al., 2003; Wahlberg, 2010).

Informal support is common in rural communities. Often people in rural areas prefer more informal sources for the mental health needs (Jackson et al., 2007). Schools play an important role in rural communities and may typically be the center of social activities in the area (Heflinger & Christens, 2006; Lewis et al., 2013). In rural communities children will frequently receive their mental health services in the school setting and schools may go above and beyond what their role is in a student's education (Heflinger & Christens, 2006; Lewis et al., 2013; Wahlberg, 2010). A school setting can

also be less intimidating because several people in the community may pass through the school on a regular basis (Lewis et al., 2013). Related to the schools there are extension systems that have established a strong presence in the rural communities. These services have not only established a strong presence in these communities but they have become a trusted resource in rural areas and small towns because of the rural concerns and historical agricultural roots associated with the extension systems (Shaklee et al., 2012). There are a large number of educators involved with the extension services. The educators that represent Family and Consumer Sciences (FCS) are very relevant to human services and they lead evidence-based programs in youth development, family relations, fitness, health, nutrition, parenting, home safety, and caregiver support (Shaklee et al., 2012).

Churches also play an important role in informal support in rural communities. Similar to schools, churches are often the center of social activities and family gatherings in rural areas (Heflinger & Christens, 2006; Lewis et al., 2013). Campbell et al., (2002) noted that often times people in rural communities tend to turn to pastors because of the strong religious beliefs held in rural communities. Churches are able to provide both the support and the spiritual components people may be looking for when faced with a mental health problem (Lewis et al., 2013). Campbell et al., (2002) noted that often the churches help informally in rural areas because in rural areas many individuals tend to have strong religious beliefs, mainly Christian, and in scripture there is a clear instruction that Christians are to help and serve those people in need.

Another way in which service is provided in rural areas is through the integration of primary care and mental health, which tends to have a great deal of federal support.

Smalley et al., (2010) noted that by integrating these services the access to mental health services is improved. Along with these integrations of services there is an added responsibility of the rural mental health providers to reach out to other professionals to foster networks (Smalley et al., 2010). One needs to remember that community health nurses play an important role in this as well. Community health nurses provide care to families, communities, and individuals and there are increasing numbers of these nurses working in rural areas (Shaklee et al., 2012).

Advancement in technology throughout the years has led to greater access to mental health services to rural communities. There have been many terms used to describe this service delivery such as telemedicine, telehealth, telepsychiatry, and telemental health (Benavides-Vaello et al., 2013). The term telehealth will be used in this paper when referring to the technology used in the delivery of mental health services. Heflinger & Christens (2006) define telehealth as “using technology to link people living in remote rural areas to specialists, who are more likely to be found in urban areas.” (p.383). When the Telecommunication Act passed, in 1996, this was a huge step in improving the mental health services to rural areas (Benavides-Vaello et al., 2013). Telehealth has been used to deliver service to rural areas since the mid 1990’s (Starling et al., 2003). It has been noted that telehealth is beneficial in enhancing mental health services to children (Starling et al., 2013; Yellowless et al., 2008). Along with all the advancements in technology it has been useful to provide training via video-satellite conferencing, (to include Skype [Humble et al., 2013]) in these rural areas (Heflinger & Christens, 2006).

### **Challenges in the Delivery of Services**

There are a variety of challenges mentioned in literature on the delivery of mental health services in rural areas. Hodges et al., (2005) noted that the challenges seen in rural areas can be categorized into four major categories: availability, accessibility, acceptability, and affordability. It should be noted that within each of these four categories there are sub-categories as well. In general, “we see a shortage of mental health providers in both rural and urban settings, however; about 60% of shortages are seen in rural areas” ( Hodges et al., 2005; Hooper, 2010; Robinson et al., 2012; Shaklee et al., 2012; Werth et al., 2010). One article even mentions as much as 85% of the shortage of mental health providers is seen in rural areas (Smalley et al., 2010).

One major problem mentioned as a challenge associated with the lack of mental health providers in rural settings is when primary care physicians become looked upon to provide the mental health services in rural areas (Hodges et al., 2005; Hooper, 2010; Robinson et al., 2012; Shaklee et al., 2012). Many times the primary care physician has little to no training in treating mental health which leads to frustration among recipients (Robinson et al., 2012). Primary care physicians in rural areas tend to have a high workload, which does not allow them sufficient time with a patient (Jackson et al., 2007). In some rural areas the role of the mental health professional falls on the local social worker (Humble et al., 2013) or even the local law enforcement. The challenge with law enforcement handling the mental health issue is that what was originally a mental health issue now becomes a legal issue, so not only does the individual have a mental health issue they now have a legal issue as well (Robinson et al., 2012).

Due to the large land areas that may be considered rural, access to services can be a major challenge. Many times providers in rural areas are more isolated and do not have

the support of coworkers their urban counterparts have due to lower numbers in population (Bjorklund & Pippard, 1999; Hodges et al., 2005; Humble et al., 2012; Werth et al., 2010). Many times office space for mental health services are satellite offices and the space is often shared by many other agencies (Lewis et al., 2013). With the smaller number of people and population density in rural areas, there is often not a priority placed on mental health services in rural budgets (Hodges et al., 2005). With the lack of services individuals who are faced with mental health challenges often then turn to family, friends and other informal supports in their communities (Cohn & Hastings, 2013; Hodges et al., 2005; Smalley et al., 2010; Sullivan et al., 1993). Something to keep in mind when discussing accessibility is many times recipients feel they hit a dead end when trying to find services for mental health (Robinson et al., 2012). This may be due to a lack of knowledge on when and where services are (Smalley et al., 2010) or just a plain lack of resources in the area (Hodges et al., 2005; Hooper, 2010; Humble et al., 2013). Many times facilities (i.e. inpatient programs at a hospital) are not readily available in these areas, especially for adolescents, so if hospitalization is required often these adolescents may be put with adults (Park, McDermott, Loy, & Dean, 2011).

Transportation becomes a challenge more so in the rural areas because unlike urban areas, 14% of rural residents have to travel more than 30 minutes to find a provider: whereas only 10% of urban residents have to travel that distance (Cohn & Hastings, 2013). This leaves individuals in rural settings having to travel far greater distances for services than those in urban areas (Hodges et al., 2005; Jackson et al., 2007; Sullivan et al., 1993). Wahlberg (2010) told a story where a mother was told by a crisis line to bring her daughter into the nearest hospital, which was three hours away. By

having to travel these greater distances, individuals in rural areas have to miss more time from work because of the extra travel required to attend appointments (Robinson et al., 2012).

When thinking of affordability, poverty and lack of insurance are other challenges faced with the delivery of mental health services. Recipients have reported that the cost of mental health care very often will exceed what they can pay and their financial resources are limited (Robinson et al., 2012). People living in rural areas have been characterized as having lower incomes, higher poverty rates, more uninsured people, less than a high school education, and higher unemployment rates (Cohn & Hastings, 2013; Gerrior et al., 2011; Werth et al., 2010).

There is a stigma associated with accessing mental health services as well as a mental health issue itself (Cohn & Hastings, 2013; Hodges et al., 2005). Stigma associated with seeking mental health services in rural areas seems to be even more of a challenge than in urban areas. Individuals may think that the providers will share their information, causing a lack of trust in rural areas (Cohn & Hastings, 2013). There is also less anonymity in rural areas and recipients feel they could be labeled differently in their communities (Hodges et al., 2005; Smalley et al., 2010). Recipients in these areas also feel that they may be labeled “crazy” because they are more “visible” (Hodges et al., 2005). Because of the issues mentioned above it may be that the rural residents are less likely than urban individuals to seek services and experience more social isolation (Hodges et al., 2005; Smalley et al., 2010).

Burnout is another challenge when providing mental health services in rural areas. Exercising regularly, getting enough sleep/rest, and eating healthy are things that are generally recognized as positive physical and emotional health. It was noted that in rural areas it may be more of a challenge for exercise and physical activity specifically because in a rural community one does not have access to gyms, walking paths/parks, sidewalks, and parks, so one needs to become more creative in ways they can be physically active (Cohn & Hastings, 2013). This basic self-care is critical to being successful when providing mental health services. Unfortunately, many providers are much better at advocating such practices for their clients than actually practicing it themselves (Cohn & Hastings, 2013). When a provider is not practicing self-care, this can lead to burnout. Kos & DeStefano (2011) cited Leiter & Maslach's 1988 definition of burnout as "a syndrome of emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment." (Definition of Burnout Section, para.1) When providers have a positive working atmosphere, strong working relationships, and good supervision we see lower levels of burnout and higher levels of job satisfaction (Humble et al., 2013). Burnout also leads to negative outcomes such as employee's missing work, poor morale, attrition, and poor client care (Kos & De Stefano, 2011).

### **Benefits and Advantages of Rural Areas**

As noted earlier approximately one-fourth of the population in the United States lives in rural areas, averaging out to about 60 million or more Americans (Baffour, 2011; Bird et al., 2001; Campbell et al., 2002; Heflinger & Christens, 2006; Hodges et al., 2005; Riebschleger, 2007; Wahlberg, 2010). Many times rural areas can be thought of as a peaceful and serene. Rural communities tend to have a strong sense of identity to their

community, family and church (Bjorklund & Pippard, 1999). Campbell et al., (2002) mentioned that there tend to be two perspectives to rural life. The first one is that it is a very tranquil and peaceful environment where everyone feels part of the community and the second is just the opposite of that focusing on the isolation. A study of providers in rural Alaska found that providers in these areas have a love of rural life. These providers enjoyed the beauty of the area, the slower pace, and not as many stressors like rush hour traffic (Cohn & Hastings, 2013). These providers also enjoyed the flexibility, freedom and autonomy they had in the rural areas. Campbell et al., (2002) also noted that there were four values that were seen on the research of rural areas and these four themes were as follows: “An emphasis on hard work and mastery of the physical environment, an emphasis on the importance of family and community ties, an orientation toward traditional moral standards and conformity to group norms, and fatalism” (p.325). One of the greatest strengths in the rural community is the natural supports that are already in place (Bjorklund & Pippard, 1999). It has also been noted that in rural areas there tend to be high levels of resiliency among the people who live in these areas (Lewis et al., 2013) and a tendency to “take care of their own through informal support” (Slovak et al., 2011).

In rural areas there is a greater chance of “everyone” knowing each other across different jobs or professions individuals in the community may have. Some providers in rural areas have said a very positive aspect of their job is being so engaged in the community (Cohn & Hastings, 2013). Rural communities tend to work together to help each other out in their community (Lewis et al., 2013). Building strong relationships and collaborating with other members in the community help to build a strong support in rural communities (Bjorklund & Pippard, 1999; Cohn & Hastings, 2013; Mason, 2011). A



valuable asset that rural providers have is if they are from the area they are familiar with the local history and the various roles members in the community play (Humble et al., 2013). Some providers even enjoy the visibility in a rural area as being the one people turn to when they need help (Cohn & Hastings, 2013).

## **Conclusion**

It can be argued that for all of the benefits and positive experiences in rural communities there can be just as many drawbacks and challenges of providing services in rural areas. As noted by Campbell et al., (2002) the other perspective of a rural area describes them as being isolated with a lack of communication, resources, and transportation. They go on to say that both perspectives of rural areas can be appropriate because of the variety of people living in rural areas (Campbell et al., 2002). The literature thoroughly addresses challenges that are faced with the delivery of mental health services as seen by providers in these settings. Providers of mental health services can encompass a variety of people such as therapists, counselors, psychiatrists, social workers, and many informal supports to name a few. The literature notes how in a rural community all of these responsibilities can very well land on the social worker since they are the only provider that may be available within a 100-mile radius (Humble et al., 2013). When it comes to providing mental health services in rural areas unique challenges are faced by providers. These providers are continuously redefining, having to be adaptable and flexible, and having to be creative with the existing resources (Bjorklund & Pippard, 1999; Mason, 2011; Rieschleger, 2007).

## **Conceptual Framework**

For the purpose of this paper the lens of generalist social work practice will be used. Using the generalist approach in social work involves connecting individuals to available resources, working with individuals on all levels, working with agencies and organizations to improve their responsiveness to individuals, advocating for social policies to be sure there is an appropriate distribution of the resources, and looking at all aspects of social work (Miley, O'Melia, & DuBois, 2007). Miley et al., (2007) went on to say that the activities of the generalist social worker broadly fall into three functions: consultancy, education, and resource management. With the consultancy role the workers empower individuals by drawing on their strengths, respect their competence, and work collaboratively with them to find solutions. In the education role the workers function is encouraging the sharing of ideas and knowledge. Lastly, in the resource management role the social workers stimulate the exchange of resources that the individual may already be aware of or have available to them.

When using the generalist practice model, one needs to be able to think broadly. What this means is that the provider and the individual have the option to reach out any place in their ecosystem to create changes to work towards a desired outcome (Miley et al., 2007). This type of approach in rural areas could be beneficial given the lack of formal resources and supports. It was noted in the literature that many people in rural areas depend heavily on the informal supports available to them. A generalist approach could be very beneficial because of the emphasis on empowering the individual and the integrations of the resources that are available in rural areas. Individuals in rural areas tend to depend on these supports many times because that is what they are comfortable with or just due to the lack of providers and distance to possible providers.

This framework was chosen because of the emphasis given to looking at the resources that are available and connecting the individual to these resources as well as advocating for social policies to ensure resources are distributed appropriately. It was also noted in a study conducted by Riebschleger (2007) that every one of her focus group participants mentioned that rural workers are generalists. In the generalist framework there really is coordination requiring working with families, individuals, and various systems which is something that presented itself in the literature reviewed for this paper.

## **Methodology**

### **Research Design**

The purpose of the study was to collect data exploring the delivery of mental health services to adolescents in a rural area in western Wisconsin. The research design was in the form of an on-line survey via Qualtrics. An e-mail with the link was sent to social workers, counselors and therapists in 26 public schools in this rural area as well as four surveys sent to counselors and therapists listed on the county's mental health task web page and psychologytoday.com web site who serve this area in Western Wisconsin. The survey included questions relating to methods of service delivery, challenges, benefits, advantages, and successes in working in rural areas (Attached as Appendix A). The survey took approximately fifteen minutes to complete. A second e-mail was sent out to encourage participation.

### **Population and Sample**

The sample chosen was invited to participate in this survey because many times these individuals may be called in to help and provide services when an adolescent is

experiencing a mental health problem. This survey ideally in some way served as a needs assessment. The survey was offered to four counties in a rural area in western Wisconsin, with an initial target of two counties and a second wave including two more counties. A list of the public schools in this rural area was obtained from the county's home web page. Schools were chosen from this list and invited to participate in this survey. The schools were chosen based on the fact they are in this rural area in Wisconsin. From there each web page of the school was used to find out who the social workers, psychologist, and counselors were of the schools. In this area these individuals may serve more than one school due to the fact it is a rural area.

The web site for the mental health task force and psychologytoday.com for this area was also used to find local providers who specialize in child and adolescent services. For the individuals who listed an e-mail address, I sent them an e-mail with the introductory letter for my research project that also served as the consent form (See Appendix B). Snowball sampling was also used in the letter asking potential participants to forward the survey on to other providers they may know.

The study underwent the Institutional Review Board (IRB) at the University of St. Thomas prior to approaching my samples and prior to sending out the surveys via e-mail. The surveys were emailed to the participants along with an introductory letter that served as a consent form (See Appendix B).

### **Protection of Human Participants**

This study was designed to protect the anonymity of the participants in this study. All participants were provided an informed consent letter at the beginning of the survey

and all the information obtained was kept anonymous by deidentifying the IP addresses from computers of people who responded to the survey. All participants of this study were professionals and are not a vulnerable group. Each one of the participants was e-mailed separately by this researcher. The survey included questions that may be seen as sensitive in nature, due to the fact that questions are being asked about minors. This survey was only sent to adults and minors were not interviewed or included on these surveys. Participants may have sent out the survey to individuals they may know with the snowball sampling but they did not know who responded due to the fact the Qualtrics was set up in a way that did not record individual IP address on the responses. There were no identified risks or direct benefits associated with this study. Participation in this study was completely voluntary and if the participant decided to participate they were able to click onto a link which took them directly to the survey.

Results of the survey were kept on my laptop computer in a separate password protected folder. The laptop was locked in the trunk of my vehicle when the laptop was traveling. Results from the survey will be deleted from my computer on July 31, 2014 upon completion of my research project. Participants were informed that with their consent to complete the survey, their responses were included in the study, including the potential use of short answers as quotes.

### **Data Collection**

Participants were chosen based on the fact that they work in the rural community this researcher sampled. Participants consisted of social workers, counselors, psychologists, and or therapists who work with adolescents. The schools that were

sampled are middle school and senior high, which consists of adolescents in grades 6-12. Students were not surveyed. Data was collected voluntarily via on line surveys using Qualtrics. I was responsible for distributing surveys to all social workers, psychologists, and counselors listed on the schools' web page as well as therapists and counselors that were found listed on the county's mental health task force web page and psychologytoday.com. Participants had two weeks to complete the survey, and received a reminder e-mail after one week. Upon return of the surveys I compared the various responses to each of the statements that were asked (see data analysis section below for more detail).

### **Data Analysis**

The survey questions were developed based on themes that were noted in the literature. The first theme noted in the literature addressed the various ways that service is provided in rural areas (Benavides-Vaello, Strode, & Sheeran, 2013; Campbell et al., 2002; Heflinger & Christens, 2006; Lewis et al., 2013; Shaklee et al., 2012; Smalley et al., 2010; Starling et al., 2003; Wahlberg, 2010). A second theme noted in the literature addressed the challenges present with the delivery of mental health services in rural areas (Cohn & Hastings, 2013; Hodges et al., 2005; Humble, Lewis, Scott, & Herzog, 2013; Lewis, Scott, & Calfee, 2013; Robinson et al., 2012; & Smalley et al., 2010). The third theme noted in the literature addressed the benefits and advantages of providing services in rural areas (Bjorklund & Pippard, 1999; Campbell et al., 2002; Cohn & Hastings, 2013; Lewis et al., 2013; Mason, 2011; Slovak et al., 2011).

The survey is broken down into three related sections. The first section asked five demographic questions that were analyzed, using primarily descriptive statistics. The second section of the survey listed three particular statements about the delivery of mental health services for adolescents in rural areas. Participants were asked to rank the statements using a likert scale from 1-5 with (1) = strongly agree (2) = agree (3) = neither agree nor disagree (4) = disagree (5) = strongly disagree when responding to each of the three statements. The last section of the survey contained five open ended questions. Upon receiving the results of these qualitative questions I looked for common themes that participants identified and compared them to what was found in the literature. I also compared the responses I received relating to the ranking of the specific responses. Respondents were asked to rank the top three services they were currently utilizing or could be better utilized in the delivery of mental health services to adolescents. Respondents were also asked to rank the top three challenges they seen in the delivery of mental health service to adolescents and well as the top three advantages. (See appendix A for a copy of the survey questions).

### **Strengths/Limitations**

One of the strengths to this study was the chance participants had to give their own voice with the final five open ended questions which asked what they felt was currently being done in the provision of mental health services and what things they feel could be done to improve mental health services for adolescents in this rural area. Participants were able to identify what they felt was being done and services currently offered that are effective. Participants were also able to identify what they fell can be done to improve services in rural areas. Participants were also asked what unique or

customized roles those in their work setting play to help best deliver mental health services in their area. Participants were also asked how they formally and informally supported adolescent mental health in their area. The last question they were asked was if there were any potential research topics they would like to see researched regarding this topic how to best serve adolescents in rural settings. As far as limitations for this study there were a few to consider. One of them was the possibility of individuals choosing not to participate in the survey. Another limitation is that this survey was only conducted in four counties in the state due to the time constraints with the research project.

### **Findings**

The survey was offered to four counties in a rural area in western Wisconsin, with an initial target of two counties and a second wave including two more counties. A total of 98 surveys were sent out with the initial wave consisting of 70 surveys and the second wave consisting of 28 surveys. A total of 28 surveys were returned, a participation rate of nearly 29% (28.6%). The analysis of the data shows the challenges and advantages in the delivery of mental health services to adolescents in rural areas in the four counties surveyed, as reported in this sample.

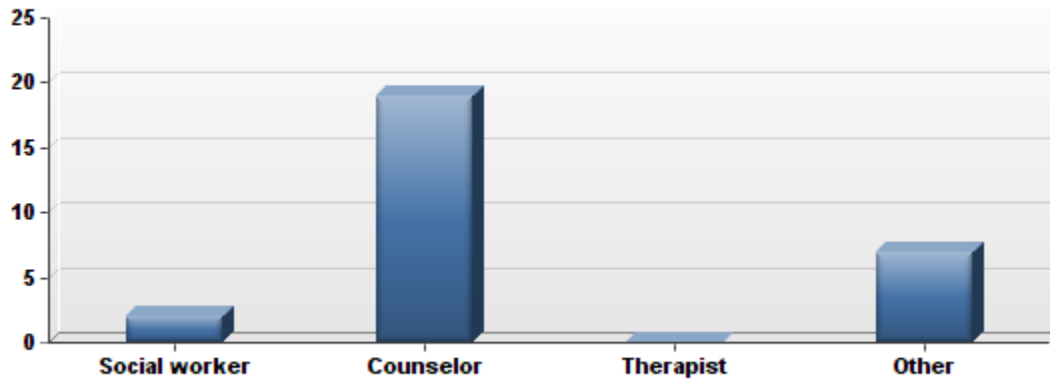
### **Demographics**

Of the 98 surveys that were sent out, 96% (n=27) of the respondents worked in a school setting and 4% (n=1) worked in a social service setting. A second demographic question asked what the respondent's job title was and 7% (n=2) reported they were a social worker, 68% (n=19) reported they were a counselor, and 25% (n=7) listed other.



Other job titles listed included a school psychologist, Alcohol and Other Drug Abuse (AODA) prevention specialist, and school nurse (See Figure 1).

Figure 1. Respondents' Job Titles.



When asked where most of their experience has been 64% (n=18) reported in rural areas (with a population of 2500 or fewer), 21% (n=6) reported urban areas (population of 2500 or more), and 14% (n=4) reported they had worked in both rural and urban areas. A fourth demographic question asked how long the respondent worked in their current position. Fifty percent (n=14) reported they worked in their current position for five to ten years, 25% (n=7) reported it was more than ten years, 7% (n=2) reported three to five years, 4% (n=1) reported one to three years, and finally 14% (n=4) reported it was less than one year. When asked how long the respondent has been working in this field the majority, 54% (n=15), reported it was more than ten years, 36% (n=10) reported five to ten years, 7% (n=2) reported it was three to five years, and 4% (n=1) reported one to five years. This suggests the sample was primarily school based, identified as counselors, and have worked in their setting for a long time.

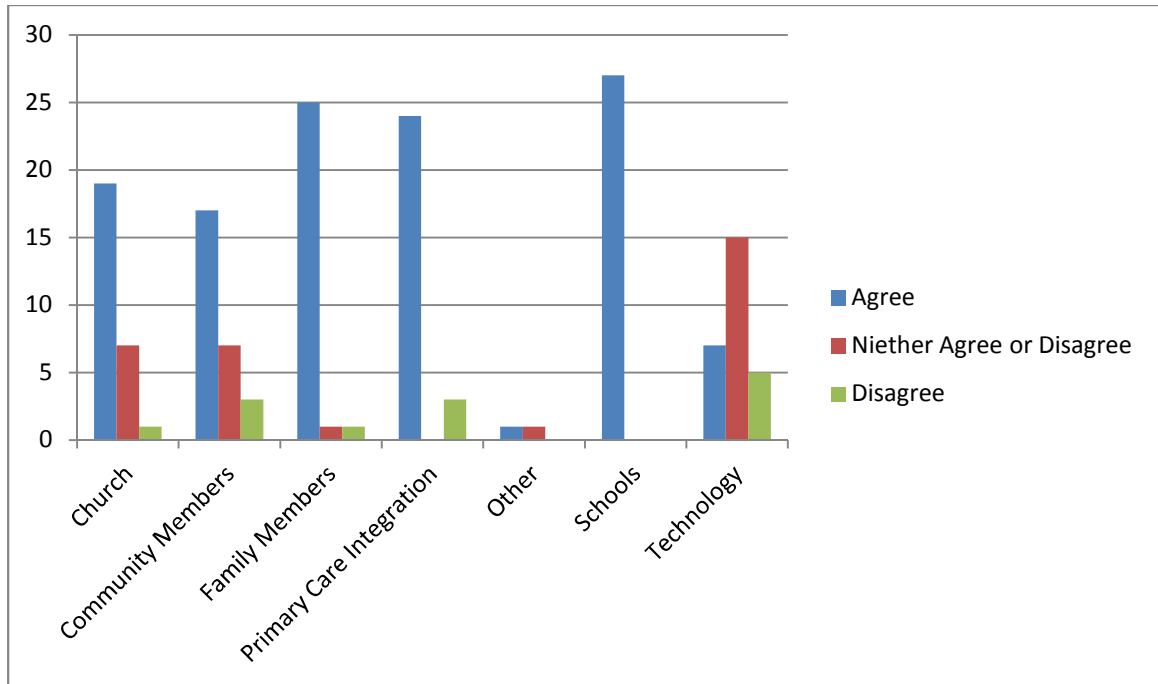
## **Service Delivery**

Respondents were asked about the role informal supports play in delivering mental health services to adolescents. Specifically they were asked: “When looking at the delivery of mental health services for adolescents in rural areas informal supports are important.” A likert scale was used where the respondents could choose “strongly agree,” “agree,” “neither agree or disagree,” “disagree,” or “strongly disagree.” All of the respondents (n=27) either strongly agreed (n=20) or agreed (n=7) with this statement.

A list of informal services including churches, schools, community members, family members, integration of primary care providers (primary care doctors) and mental health providers, technology (telemedicine, telehealth, telepsychiatry), and other were listed as options in order to describe what informal services are being used in their area. A likert scale was used with the respondents choosing “strongly agree,” “agree,” “neither agree or disagree,” “strongly disagree,” or “disagree” for each statement. Recoding was done to include only three different categories for the purpose of the graph and logically the data fell into these three categories. Strongly agree and agree became agree, neither agree or disagree remained the same, and disagree and strongly disagree became disagree. Many of the respondents agreed that the following three services were used when looking at the delivery of mental health services in rural areas: schools (n=27), family members (n=25), and integration of primary care providers (primary care doctors) and mental health providers (n=24). Technology (telemedicine, telehealth, telepsychiatry) (n=14) seemed to be the service that had the largest number of respondents who disagreed that this service is currently being utilized in delivering mental health services to adolescents. The graph below illustrated how the respondents

felt about the services being used in the delivery of mental health services to adolescents in rural areas (See Figure 2).

Figure 2. *Informal supports being used in the delivery of mental health services*

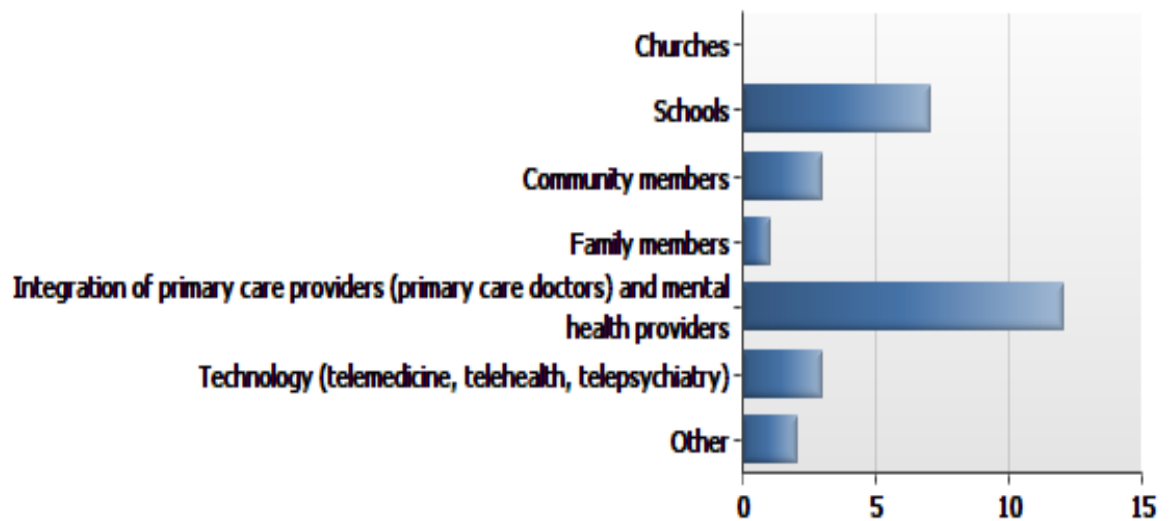


Note: Respondents did not include any write-in information when ‘other’ was selected. Primary Care Integration includes the integrations of primary care providers (primary care providers) and mental health providers

Respondents were then asked the next question: “Which of these services might be better utilized or utilized more in the delivery of mental health services to adolescents?” The services that were listed as potential choices included: churches, schools, community members, family members, integration of primary care providers (primary care doctors), technology (telemedicine, telehealth, telepsychiatry), and other. A total of 43% (n=12) of the respondents reported that the integration of primary care

providers (primary care doctors) and mental health providers can be utilized more in the delivery of mental health services to adolescents. This was the strongest finding with considerably more reporting this, followed next by schools with 25% (n=7) reporting this. These two categories were by far the major findings with 70% (n=19) of the respondents reporting that these services can be utilized more in the delivery of services. The remaining respondents reported as follows: technology 11% (n=3), community members 11% (n=3), and other, including county services 7% (n=2). The respondents felt utilizing family members 4% (n=1) as informal support was least likely to be utilized (See Figure 3).

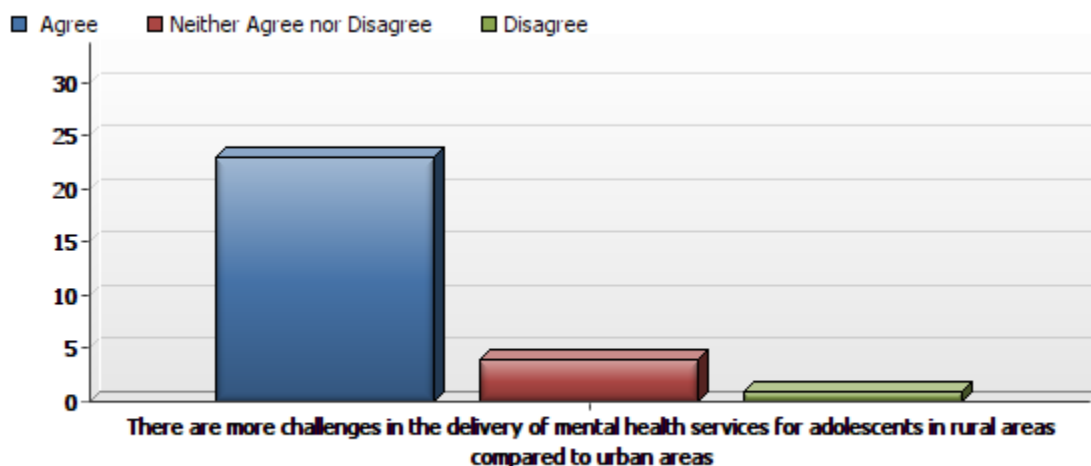
Figure 3. *Informal services utilized in the delivery of mental health services*



## Challenges

Respondents were asked about the challenges in the delivery of mental health services to adolescents. Specifically they were asked: “There are more challenges in the delivery of mental health services for adolescents in rural areas compared to urban areas.” A likert scale was used where the respondents could choose “Strongly agree,” “agree,” “neither agree or disagree,” “disagree,” or “strongly disagree.” Respondents’ answers would signify to what degree they perceived there being more challenges in the delivery of mental health services in rural areas when compared with urban areas. Recoding was done to include only three different categories for the purpose of the graph and logically the data fell into these three categories. Strongly agree and agree became agree, neither agree or disagree remained the same and disagree and strongly disagree became disagree. The majority of the respondents 82% (n=23) agreed, 14% (n=4) neither agreed or disagreed, and 4% (n=1) disagreed. Results suggest there was strong agreement that there are more challenges specific to rural areas than in urban areas as illustrated below (See Figure 4).

Figure 4. *Challenges of service delivery*



Respondents were then asked to rank the items they felt the most challenging from one to three, with one being the most challenging. The choices that were listed as possible challenges included the following: accessibility, transportation, affordability, acceptability (i.e. stigma associated with mental health issues), provider burnout, the idea that everyone may know everyone in the area, isolation, long wait times to be able to see a provider, lack of mental health awareness, and other. Accessibility (n=14) seemed to be the biggest challenge, followed by long wait times to be able to see a provider (n=7), and affordability (n=6). Respondents included two additional challenges as write-ins. One of the challenges respondents wrote in was, the parents not seeing the same need for therapy and the other challenge the respondents added was “good quality so that people would continue going (to therapy)” (See Table 1).

Table 1

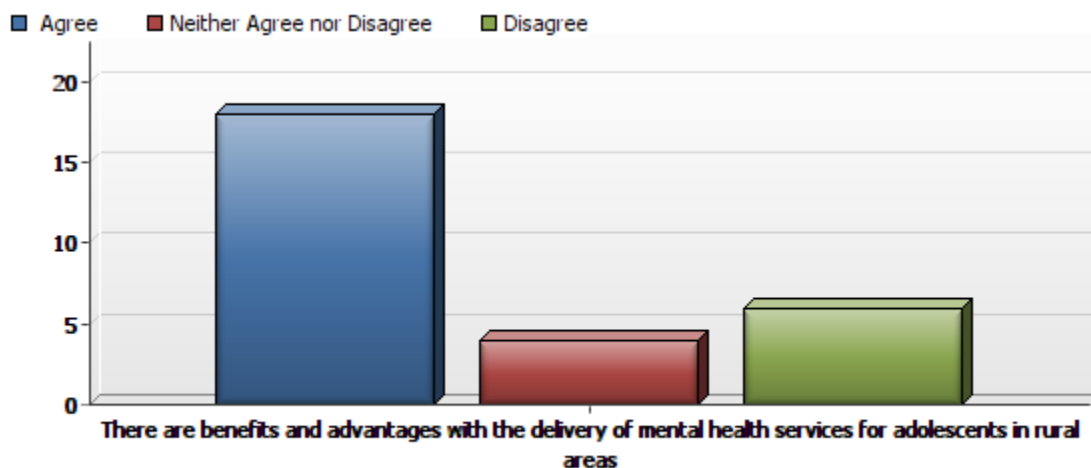
*Ranking of challenges in the delivery of mental health services to adolescents in rural areas*

#	Answer	First	Second	Third
1	Accessibility	14	3	2
2	Transportation	1	6	3
3	Affordability	8	5	6
4	Acceptability (i.e. stigma associated with mental health issues)	5	3	5
5	Provider burnout	1	0	0
6	The idea that everyone may know everyone in the area	0	2	2
7	Isolation	0	1	0
8	Long wait times to be able to see a provider	1	7	5
9	Lack of mental health awareness	3	5	2
10	Other	0	1	1

**Benefits and Advantages**

Respondents were asked about the benefits and advantages in the delivery of mental health services to adolescents. Specifically they were given the statement: “There are benefits and advantages with the delivery of mental health services for adolescents in rural areas.” A likert scale was used where the respondents could choose “strongly agree,” “agree,” “neither agree or disagree,” “disagree,” or “strongly disagree.” As in the previous section, recoding was done to include only three different categories for the purpose of the graph and logically the data fell into these three categories. Strongly agree and agree became agree, neither agree or disagree remained the same and disagree and strongly disagree became disagree. The majority of the respondents 64% (n=18) agreed, 14% (n=4) neither agreed or disagreed, and 22% (n=22) disagreed with the statement. The following graph illustrates how respondents felt about there being more benefits and advantages with the delivery of mental health services in rural areas (See Figure 5).

Figure 5. *Benefits and advantages of service delivery*



Respondents were then asked to rank the items they felt as potential benefits or advantages of delivering mental health services in rural settings from one to three, with



one being the most advantageous or beneficial. The choices that were listed as possible advantages and benefits included the following: there is an emphasis on hard work and mastery of the physical environment, there is an emphasis on the importance of family and community ties there is an orientation toward traditional moral standards and conformity to group norms, there are natural and informal supports, there is resiliency among people who live in rural areas, there is a strong sense of identity to family, church, and community, beauty of the rural area, slower pace, lower levels of stress, recognition in the community, and other. Overall, respondents here noted the importance of social support including family and the community. This is noted by the respondents having ranked emphasis on the importance of family and community ties. This received ranking in all three areas (first n=13, second n=7, and third n=2). Another area that received relatively high rankings in all three categories was the strong sense of identity to family, church, and the community (first n=6, second n=7, and third n=3). One other area that had moderate rankings in all three categories was that of natural and informal supports (first n=4, second n=3, and third n=3). According to the respondents the emphasis on hard work and mastery of the physical environment and lower levels of stress did not appear to be much of an advantage or benefit of the delivery of mental health services in rural areas. Each one of these areas only received one ranking from two respondents (one for each) and they were ranked third (See Appendix C).

There were also five short answer questions at the end of the survey that provided qualitative data. The short answers were coded into themes for each question. The first question was: “What things are currently being done well or what services do you feel are effective that are currently in place to support adolescent mental health in rural areas?”

There were two common themes that were seen in the 24 responses that were given. The first theme was the fact the providers knew the students well. Three separate respondents gave voice to this by writing:

*Small schools, counselors and psychologist know students very well, students feel comfortable seeking people out for help, good working relationships with law enforcement and mobile crisis resources.*

*Well those of us who offer these services usually live in the community and feel a strong sense of responsibility toward helping this population. It is much more than a job.*

*As a school counselor in a small rural community I am able to get to know the students and their families. Other staff (teachers, coaches, etc.) are able to do the same. This enables us to better support our students and often notice if they are struggling.*

The second theme that was seen in the responses was the partnership/cooperation with the other providers in the area and three separate respondents stated:

*In our area, there are currently strong partnerships between schools, hospitals, government agencies and law enforcement that have been able to address the major components of mental health and safety*

*Different groups meet to inform others about suicide prevention, resources posted to the public, supportive school counselors*

*Allowing mental health counselors to work with their clients in school during the school day.*

The second question that was asked was: “What do you think could be done to improve services in rural areas in relation to adolescent mental health?” There were two common themes in the 24 responses received. The first theme was that of accessibility and three separate respondents mentioned:

*More options. Currently I have ONE therapist in the area I can refer students to and they are not necessarily focused on adolescent mental health. Very frustrating.*

*We have ZERO mental health providers in our school district. Students have to travel quite a distance to see one with the exception of the one that is available to meet with students at our school once a week. (limited insurance options)*

*Access to mental health services (parents work and find it hard to schedule/ they don't want their student to miss school for appointments etc.), money/ limited insurance and time (I am the only school counselor in our district).*

The other theme seen in the responses was that of affordability and three respondents mentioned:

*Allowing more places for low income families to get services. Badgercare has stipulations in each county. Get counselors into local clinics to make it easier to access.*

*Provide three free sessions to students/families who can't afford services to get in the door and start the process.*

*Cost and availability through school setting.*

The third question that was asked was: "What unique or customized roles do those in your work setting play to help best deliver mental health services to your rural area?" Again, there were two themes seen with the 20 responses. The first theme was that of teaming and coordination services with other providers in the community and two respondents stated:

*School nurse delivers QPR training, health teacher has a mental health unit, local church doubles as a homeless shelter, retired woman in the community houses teen in (name of county), (name of program).*

*We meet with the local therapists to try and deliver information to the community together.*

QPR training stands for question persuade and refer. QPR is an internationally recognized suicide prevention program (QPR Institute for Suicide Prevention, 2011).

The other theme that was seen is how staff in the school setting seems to be more caring and go above and beyond their 'normal' job duties and two respondents stated:

*Provide scholarships four counseling, provide free mental health counseling to students at the school.*

*Professionals/staff tend to be more flexible in their roles and "wear more hats" because there are generally fewer staff than in urban populations, which ultimately serves adolescents better.*

The fourth question that was asked was: How do you formally and informally support adolescent mental health in your area? Two common themes were seen in the 24 responses received. The first was education and two respondents stated.

*QPR training, education through classes, retreats, individual counseling, anxiety groups, train staff on mental health symptoms/signs.*

*Guest speakers to all students, health education about mental health, etc...school available with communication to parents as needed- referring on if mental health therapy may be helpful.*

The other theme that was seen was partnering with other professionals/providers in the area and three respondents stated:

*Coordination of school and clinical services; screenings for depression, anxiety, or ADHD symptoms, assistance with medications compliance through counseling and coordination with school nursing services.*

*Develop relationships with providers, keep aware of local resources, communicate on concerns/interests.*

*Communicating with staff, family members, and sometimes coaches to ensure everyone is aware of a students' need. Without breaking confidentiality, letting others know to give more attention to students at risk*

The final question asked was: “Are there any potential topics you would like to see researched regarding this topic and how best to serve adolescents with mental health needs in rural setting such as your own. Two major topics were mentioned in the 13 responses received. The first finding was that respondents had asked questions about evidence-based practices in their setting. They asked about what would be or are the best methods and practices for working with adolescents in rural settings. Examples included individual respondents mentioning:

*What does research show is the best method in working with adolescents, choice therapy etc.*

*Research on best practice with limited resources*

*More information of effective strategies on working with students with significant AODA issue*

The other theme that emerged was the benefits of working with outside resources, other mental health providers. This was seen in the following responses from individual respondents:

*How well are counties informing schools of their services? What are ways that county services and schools can collaborate and be supportive to families?*

*We have two medical clinics in our community but no mental health providers. How do we convince the medical community that they need to provide this service?*

*The benefits of working with outside resources, remove the stigma that is attached to talking to a school/mental health counselor.*

Respondents really seemed to be suggesting these are topics that they wanted to be seen researched more as well as improved upon. Respondents also had other suggestions such as more suicide and crisis support and attending therapy outside of the

school. One respondent appeared very open to any and all help by stating “Any and all help is greatly appreciated!” (See Appendix D for all 13 of the responses received).

## **Summary**

These findings represent a segment of adolescent mental health providers in rural areas in four counties who responded to the survey, primarily from school settings. A total of 98 surveys were sent out with 28 of the surveys analyzed (28.6% response rate). This data provided a general idea of what services were being used in the delivery of mental health to adolescents in rural areas, along with challenges and benefits these providers face. Those who responded to the survey were an experienced group with 90% (n=25) of the respondents reporting that they have worked in this field five or more years, with over half of the 25 respondents, 54% (n=15), reporting they have worked in this field for more than ten years. People surveyed also spoke to the importance of the school setting as well as more services available when looking at mental health services. Respondents also mentioned the importance of providing education about mental health issues as well. The survey also allowed the respondents to share things they are currently doing with the delivery of mental health services that they felt are effective (supports in the school and the ability to really know the students). Respondents also spoke to what improvements could be made (more services) and potential topics they would like to see more research on in the future. Specific examples and the complete list can be found in Appendix D.

## **Discussion**

This research set out to discover the challenges and advantages of delivering mental health services to adolescents in rural areas. This section will summarize and analyze the findings, highlighting similarities and differences from previous research, and examine the potential implications for providers of mental health services to adolescents in rural areas.

### **Service Delivery**

Several findings from the literature in relation to service delivery were reinforced in this survey research. The literature noted that informal supports are important in rural areas and are provided in a variety of ways including churches, schools, family and community members, and by integrating services with more formal providers such as primary care physicians, and spoke in particular the importance of telemedicine (Benavides-Vaello et al., 2013; Campbell et al., 2001; Heflinger & Christens, 2006; Lewis et al., 2013; Shaklee et al., 2012; Starling et al., 2003, Wahlberg, 2010). This finding in the literature was consistent with findings from this survey, where all (n=27) of the respondents also agreed that informal supports are important in rural areas. The literature noted that churches play an important role when it comes to informal support. Campbell et al., (2002) found that often times people in rural communities tend to turn to pastors because of strong religious beliefs held in rural communities. Although 70% (n=19) of the respondents in this survey felt that the churches were currently being used in the delivery of mental health services, none of the respondents felt that churches should be utilized more. The literature noted that often times children in rural communities will frequently receive their mental health services in the school settings and the schools may go above and beyond their role in a student's education (Heflinger &

Christens, 2006; Lewis et al., 2013; Wahlberg, 2010). This was noted in the surveys as well when all of the respondents agreed that the schools are used in rural areas to provide mental health services to adolescents. When looking at how much of a role family members play as informal supports in rural areas 93% (n=25) of the respondents agreed that family members are currently serving this role, but only 4% (n=1) felt that family members could be utilized more. Another area that was mentioned in the literature was that of integrating primary care providers (primary care doctors) and mental health providers. Smalley et al., (2010) noted that by the integration of these services, access to mental health services is improved. Ninety-three percent of the respondents (n= 25) agreed that the integration of primary care providers (primary care doctors) and mental health providers is currently being utilized when looking at services that are used in rural areas. Forty-three percent (n=12) also felt that this integration could be utilized more. Telemedicine was also mentioned as something that is used in the delivery of mental health services. The literature noted that telemedicine has been used since the mid 1990's and that it has been very beneficial in delivering services to rural areas (Starling et al., 2003; Yellowless et al., 2008). The respondents in this study did not feel this service was used as much in their rural areas with only 26% (n=7) of the respondents feeling this service was currently being used and 11% (n=3) felt it is something that could be utilized more in the delivery of mental health services.

## **Challenges**

Findings in this study in regard to challenges were largely consistent with the literature. There were a variety of challenges mentioned in the literature when looking at the delivery of mental health services in rural areas. Eighty-two percent (n=23) agreed



that there are more challenges in the delivery of mental health services for adolescents in rural areas when compared to urban areas. When looking at the challenges for the delivery of mental health services in rural areas Hodges et al., (2005) mentioned all challenges could be grouped into four different categories: availability, accessibility, acceptability, and affordability. It should be noted that within these four categories there are subcategories as well. The literature mentioned that there is a significant shortage of mental health providers in rural areas, as much as a 60% shortage (Hodges et al., 2005; Hooper, 2010; Robinson et al., 2012; Shaklee et al., 2012; Werth et al., 2010). This was also seen in the survey with 14 of the 28 respondents ranking accessibility as the number one challenge in delivering mental health services in rural areas. The literature also mentioned that often times the primary care physician is looked upon to provide the mental health services (Hodges et al., 2005; Hooper, 2010; Robinson et al., 2012; Shaklee et al., 2012). This is something that was seen in the respondents' answers as well when 89% (n=24) of the respondents noted the importance the role of their of the primary care physician played in the delivery of mental health services.

Transportation was another area mentioned in the literature as a challenge. Cohn & Hastings (2013) noted that 14% of rural residents have to travel more than 30 minutes to find a mental health provider. This was also seen when individual respondents wrote the following comments:

*Most families have to travel 30 minutes for services if they are on MA and they only have services once per week; if they can't get in there the drive is one hour*

*Families have to travel 60 miles to see a psychiatrist.*

*Provide more mental health services—must drive to bigger city now form many of the services.*

Acceptability was the other major challenge seen in the literature. There is a stigma associated with accessing mental health services as well as a mental health issue itself (Cohn & Hastings, 2013; Hodges et al., 2005). Literature went on to mention that this can be more of a problem in rural areas and individual may be less likely to seek services (Hodges et al., Smalley et al., 2010). Respondents in this study tended to agree that the stigma associated with mental health is a challenge as well. When survey respondents were asked to rank the top three challenges with the delivery of mental health services in rural areas for adolescents, acceptability (i.e. stigma associated with mental health), had a ranking in all three categories with five reporting it as the most challenging, three as the second most challenging, followed by five ranking it as the third most challenging. Respondents clearly believe that the stigma is a challenge in the delivery of mental health services to adolescents in rural areas.

Affordability was another challenge mentioned in the literature. As Robinson et al., (2012) pointed out, recipients reported that the cost of mental health care very often will exceed what they can pay and their financial resources are limited. One respondent went on to report: “Allow more places for low income families to go to for services. Badger Care has stipulations in each county.” Another respondent mentioned: “Provide three free sessions to students/families who can’t afford the services to get in the door and start the process.” Respondents felt that the affordability of mental health services was also a challenge as evidenced in the above comments.

Badger Care is a health care program for children under 19 and families in Wisconsin. When looking at mental health providers in the four counties surveyed who accept Badger Care, there are only nine providers listed and they do not specify they are

providers available for adolescents. One of the counties surveyed does not have any providers listed in their county which is an example of what the respondents noted above regarding people having to travel to find providers.

### **Benefits and Advantages**

Along with challenges there are benefits and advantages in the delivery of mental health services in rural areas. As noted in the literature by Campbell et al., (2002) it was mentioned that there are two dominant perspectives to rural life. One perspective sees rural communities as a peaceful and tranquil environment where everyone feels part of the community and the other perspective is just the opposite, focusing on isolation. Bjorklund & Pippard (1999) mentioned that one of the greatest strengths which comes easily in a rural community is the natural supports that are already in place and building strong relationships and collaborating with other members in the community to help build a strong support. Respondents had the opportunity to rank what they felt was the most advantageous or beneficial aspect of providing mental health services to adolescents in rural areas. Overall, respondents in this study tended to agree with what Bjorklund & Pippard noted referring to the importance of social supports. Respondents here gave high rankings to the importance of family and community ties, a strong sense of identity to family, church, and community, as well as having natural and informal supports when asked to rank the top three advantages or benefits of delivering mental health services in rural settings.

Cohn & Hastings (2013) had conducted a survey of rural providers and these providers enjoyed the slower pace, not as many stressors, and the beauty or practicing in

a rural area. These areas received rankings by the respondents as well, ranking third, but by far respondents gave much higher rankings to the importance of social supports.

### **Implications of Findings**

In referring back to the conceptual framework of this research, the lens of generalist social work practice was used. Miley et al., (2007) mentioned how the activities of a generalist social worker fell into three functions: consultancy, education and resource management. The first function, consultancy, is when one empowers individuals by drawing on their strengths, respecting their competence, and working collaboratively with individuals to find solutions. This was addressed by the respondents in school settings when several of them mentioned that they are able to get to know the students well because of the smaller schools and students can feel more comfortable with them. One of the respondents mentioned that because they are in a rural community they have a better opportunity to get to know students and their families and are better able to support the students and notice if they are struggling. One other respondent added: “The staff here goes way above and beyond to make meaningful connections with clients. They connect students with things that they care about and get to know them on a personal basis.” Two other respondents also mentioned that they take the time talking with the students and really listening to them. With the smaller community the providers are able to get to know the adolescents by taking the extra time to spend with them. Providers who responded to this study were primarily counselors in a school based setting and they report truly getting to know these adolescents, being able to draw out their individual strengths, and really working with them to find solutions, which is something that can be very empowering for these adolescents.

Education is the second function of the generalist social worker. According to Miley et al., (2007) education is the encouraging of the sharing of knowledge and ideas. Education is something the respondents mentioned as things that they are currently doing as well as things that can be improved upon. Several of the respondents mentioned that they are providing education about mental health issues in classes. One of the respondents even mentioned that they provide mood disorder education and depression screening to the entire freshman class in their school. Another respondent indicated that they provide guest speakers to their students on mental health. An individual respondent indicated that they even talk about the use/role of medication along with the importance of working with a medical professional. Education is also being done at the staff level as reported by respondents. Respondents spoke to training being done so that the staff are able to recognize mental health signs or symptoms via classes and retreats. Education as something valued by the respondent came through as a strong theme in this study.

The third function of the generalist social worker is that of a resource manager. Miley et al., (2007) suggests that the social workers stimulate the exchange of resources that the individual may already be aware of or have available to them. Respondents reported this is being done in rural areas, describing providers developing relationships with other mental health providers, keeping up to date on local resources, and communicating mutual concerns or interests. Currently a lot of coordination is taking place between the respondents in the work setting, mainly schools, as well as other providers in the area. One respondent noted that in the smaller community they are able to have a solid knowledge of the other resources and are better able to maintain this knowledge because less change takes place in their area compared to an urban setting.

Providers in these settings truly need to be familiar with the resources in their area because as many of the respondents mentioned there may not be a lot of providers in the area. It is important the providers continue to provide education around mental health because many of the respondents reported that they tend to wear many different hats in their roles including social worker, counselor, and therapist. Both the literature and respondents mentioned the importance of coordination with families, individuals, and various informal supports.

### **Strengths and Limitations**

After data collection and analysis, some strengths and limitations became clear. The sample had a relatively high response rate (28.6%) with 96% (n=27) of the respondents working in a public school setting. Sixty-eight percent (n=19) of the respondents identified themselves as counselors. These individuals in the school often times may spend more time with the adolescents during a school day than their families. The respondents also had the opportunity to have their own voice be heard with the five final open ended questions as the end of the survey. Those who responded to the survey were an experienced group with 90% of the respondents having worked in this field for more than five years.

Survey distribution also has its limitations. This survey was only distributed to four counties in the state due to the time constraints of the project. There were also several people who chose not to participate in this study. Most of the questions offered a place for the respondents to write in a response if there was something they felt would be applicable not currently listed as an option. A few of the respondents had selected the

“other” option but did not include any write-in information. Another limitation was that the survey was intended to reach individual counselors or therapists in these counties as well but the web site that this researcher was going to use, Psychologytoday.com, had limitations as to the size of the text that could be sent. The consent form exceeded the allowed limit so the survey was not sent to as many individual counselors or therapist as was this researches original intent. It was mentioned above as a strength that 96% (n=27) of the respondents worked in a school setting. This can be looked upon as a limitation as well because there the respondents may show some bias with working in the schools.

### **Implications for Practice**

Respondents of this survey noted that they face different challenges compared to their urban counterparts. The literature noted that there are similar rates of mental health problems seen in rural and urban areas (Bird et al., 2001; Cohn & Hastings, 2013; Heflinger & Christens, 2006; Hodges et al., 2005; Slovak et al., 2011). Respondents agreed there are fewer providers in their areas. One of the respondents wrote, “There is one therapist in the area and that therapist does not focus on adolescent mental health.” Another respondent wrote, “It would be helpful to bring in more child psychiatrists and child psychologists as a way to help improve services.” It is important to have therapists who focus on adolescent mental health because the mental health problems seen in adolescents can be very different than those in adults. This survey only covered four counties in a rural area but it is likely that other providers in similar areas may experience the same problems.

## **Suggestions for Future Studies**

Some of the respondents felt further research could be done relating to what might constitute the best practices and best methods in working with adolescents in these settings. One respondent in particular noted that it would be helpful to have more information on effective strategies in working with students who have significant alcohol and other drug abuse (AODA) issues. Some of the findings in the literature about limited resources in rural areas were reinforced by respondents in this survey. The lack of resources for best practice in rural areas and how to bring the resources to the rural areas was an area a few of the respondents commented on. One respondent summed it up when they wrote; “Any and all help is appreciated!”

Another area the respondents would like to see future research in is providing incentives for mental health providers to work in rural areas. One respondent went on to say, “Something needs to be done to promote more mental health professionals in the rural areas, it is a great concern for me”. There are incentives provided for teachers and medical doctors to work in rural and more difficult areas, such as student loan forgiveness. Is this something that could and should be done to keep mental health providers in rural areas? If this were done it could help alleviate the challenge of shortage of mental health providers in rural areas.

## **Summary**

This research provided an evaluation of the challenges and advantages in the delivery of mental health services to adolescents in rural areas. Hopefully, it will provide more insight to the challenges and advantages providers face in rural areas. Overall most



of the information found in the literature is consistent with the survey results. The respondents appear to be using a variety of approaches, including some which are empirically supported, while working with these adolescents. The major challenges mentioned were those of availability, accessibility, acceptability, and affordability. It is crucial to have the social support of the families and the communities in these areas, as these supports are extremely important in rural areas. Ideally providers in rural areas will have a strong knowledge of all available resources, connecting the adolescent with these resources, and continue to advocate for social policies so resources are distributed appropriately in these rural areas.

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## Appendix A

### Survey Questions

What setting best describes where you work?

- School
- Social Services
- Private Practice
- Other \_\_\_\_\_

What is your job title?

- Social Worker
- Counselor
- Therapist
- Other \_\_\_\_\_

Where has most of your experience been?

- Urban (populations of 2500 or more)
- Rural (populations of 2500 or less)
- Both

How long have you worked in your current position?

- Less than 1 year
- 1-3 years
- 3-5 years
- 5-10 years
- More than 10 years

How long have you worked in this field?

- Less than 1 year
- 1-3 years

3-5 years

5-10 years

More than 10 years



In this next section there will be 3 statements relating to the delivery of mental health service to adolescents.

Please check the box representing how you rate the following statement:

When looking at the delivery of mental health services for adolescents in rural areas informal supports are important.

Strongly Agree

Agree

Neither Agree nor Disagree

Disagree

Strongly disagree

Please use the following scale when answering the next questions:

1=Strongly Agree

2=Agree

3=Neither Agree nor Disagree

4=Disagree

5=Strongly disagree

The following services are used in rural areas when looking at the delivery of mental health services to adolescents.

Churches

Schools

Community Members

Family members

Integration of primary care providers (primary care doctors) and mental health providers

Technology (telemedicine, telehealth, telepsychiatry)

Other Please list:

Which of these services might be better utilized or utilized more in delivering mental health services to adolescents

Churches

Schools

Community Members

Family Members

Integration of primary care provider (primary care doctors) and mental health providers

Technology (telemedicine, telehealth, telepsychiatry)

Other Please List

There are more challenges with the delivery of mental health services for adolescents in rural areas compared to urban areas.

Strongly Agree

Agree

Neither Agree nor Disagree

Disagree

Strongly disagree

Potential challenges to delivery of services to adolescents could be due to the following:

Please rank the top three things you see as potential challenges with 1 being the most challenging.

\_\_\_Accessibility

\_\_\_Transportation

\_\_\_Affordability

\_\_\_Acceptability (i.e. stigma associated with mental health issues)

\_\_\_Provider burnout

\_\_\_The idea that everyone may know everyone in the area

\_\_\_Isolation

\_\_\_Long wait times to be able to see a provider

\_\_\_Lack of Mental Health Awareness

\_\_\_Other, please list

Please check the line representing how you rate the following statement:

There are benefits and advantages with the delivery of mental health services for adolescents in rural areas.

\_\_\_Strongly Agree

\_\_\_Agree

\_\_\_Neither Agree nor Disagree

\_\_\_Disagree

\_\_\_Strongly disagree

Potential advantages and benefits of the delivery of mental health services in rural areas:

Please rank the top three things you see as potential advantages or benefits with 1 being the most advantageous or beneficial

\_\_\_There is an emphasis on hard work and mastery of the physical environment

- \_\_\_ There is an emphasis on the importance of family and community ties
- \_\_\_ There is an orientation toward traditional moral standards and conformity to group norms
- \_\_\_ There are natural and informal supports
- \_\_\_ There is resiliency among people who live in rural areas
- \_\_\_ There is a strong sense of identity to family, community, and church
- \_\_\_ Beauty of rural areas
- \_\_\_ Slower pace
- \_\_\_ Lower levels of stress
- \_\_\_ Recognition in the community
- \_\_\_ Other, please explain



The following questions will allow you an opportunity to tell more about your experience. Please answer openly and truthfully

What things are currently being done well or what services do you feel are effective that are currently in place in rural areas?

What do you think could be done to improve services in rural areas in relation to adolescent mental health?

What unique or customized roles do those in your work setting play to help best deliver mental health services in your rural area?

How do you formally and informally support adolescent mental health in your area?

Are there any potential topics you would like to see researched regarding this topic of how best to serve adolescents with mental health needs in rural settings such as yours?

Thank You for your time!

## Appendix B

Dear Potential Participants:

My name is Shannon Uhl and I am currently a graduate student in the St. Catherine University and University of St. Thomas Master of Social Work Program. I am conducting a study about the delivery of mental health services to adolescents in rural areas. The objective of this research project is to better understand challenges, advantages, and benefits seen in rural areas when looking at the delivery of mental health services to adolescents in rural areas. You have been chosen as a potential participant because many times you may be called upon to help and provide services to an adolescent when they are experiencing a mental health problem.

At the bottom of this e-mail is a link to a brief survey (about 15 minutes or so) asking questions about supporting adolescent mental health in rural settings. I'm particularly interested in the challenges, advantages or benefits of service delivery in rural settings.

I hope you'll consider taking fifteen minutes to complete this survey. Your participation is voluntary and there is no penalty if you do not participate. The link to the survey is secure and all answers are anonymous. Individual IP addresses are not recorded from this survey, which uses an online survey program called Qualtrics.

If you have any questions or concerns about completing or participating in this study you may contact me at 715-556-9106 or at uhl68490@stthomas.edu. If you have any questions about your rights as a participant you may contact the University of St. Thomas Institutional Review Board at 651-962-5341.

If you choose to participate please go to the following link:

[http://stthomasbusiness.az1.qualtrics.com/SE/?SID=SV\\_9S0IKXUIJQxb3DL](http://stthomasbusiness.az1.qualtrics.com/SE/?SID=SV_9S0IKXUIJQxb3DL)

By answering the survey, you are consenting to participate in this study and to have your responses included, though not individually identified, in this study. If you know of any other individuals who work with adolescents and would be interested in completing the survey please pass this on to them.

Sincerely

Shannon Uhl

Social Work Graduate Student

St. Catherine University & University of St. Thomas School of Social Work



## Appendix C

*Ranking of advantages or benefits in the delivery of mental health services to adolescents in rural areas.*

#	Answer	First	Second	Third
1	There is an emphasis on hard work and mastery of the physical environment	0	0	1
2	There is an emphasis on the importance of family and community ties	13	7	2
3	There is an orientation toward traditional moral standards and conformity to group norms	1	1	2
5	There are natural and informal supports	4	3	3
6	There is resiliency among people who live in rural areas	2	1	1
7	There is a strong sense of identity to family, church, community, and church	6	7	3
8	Beauty of the rural area	1	1	2
9	Slower pace	0	2	2
10	Lower levels of stress	0	0	1
11	Recognition in the community	2	2	4
12	Other	0	0	0
<b>Other</b>				
The ability to really get to know your clients				

## Appendix D

*Are there any potential topics you would like to see researched regarding this topic of how best to serve adolescents with mental health needs in rural settings such as yours?*

Text Response
Any and all help is greatly appreciated!
How to gain more services in small rural community.
How well are counties informing schools of their services? What are ways that county services and schools can collaborate and be supportive to families?
I know there is a trend for mental health therapists to come in to school settings to deliver services. Although there are benefits to this (easier for parents, students, etc.), I also see benefits when a family goes together for therapy appointments outside of the school setting that may not occur if the therapy is "in the school".
More information on effective strategies on working with students with significant AODA issues would be great!
more staffing in and out of schools to support
providing partnerships with county agencies and healthcare facilities at the school
Research on best practices with limited resources, research on provider burnout and techniques to avoid it, research on how to bring in resources to these areas
Suicide and crisis support.
The benefits of working with outside resources, remove the stigma that is attached to talking to school/mental health counselors
We have two medical clinics in our community but no mental health providers. How do we convince the medical community that they need to provide this service? what does research show is the best method in working with adolescents, ex. choice theory, etc.
What kinds of incentives are there for mental health professionals to work in rural areas?
Something needs to be done to promote more mental health professionals in the rural areas. It is a great concern for me....