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# Building Policy Support for School Mental Health in Rural Areas

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E. Rebekah Siceloff, Christian Barnes-Young,  
Cameron Massey, Mitch Yell, and Mark D. Weist

Emotional and behavioral health disorders are prevalent among children and adolescents in the United States, yet the systematic delivery of services to treat these disorders is broadly lacking. In recent decades, schools have been playing an increasingly important role in addressing the mental health needs of youth by serving as a critical point of contact for mental health promotion and intervention services. School mental health (SMH) programs appear to be a particularly valuable source of mental healthcare in rural areas where service providers are in short supply and barriers to adequate care are abundant. Although SMH programs are a promising means to reduce barriers that impede service utilization in rural settings, they remain vulnerable to the challenges that exist in the broader context.

In this chapter, we discuss the unique challenges to addressing the mental health needs of children and youth that exist in rural settings. We

begin by describing the mental health status of children and adolescents nationwide and then focus our attention on rural settings. As part of our discussion, we review what has been done at the federal level to mitigate rural disparities as well as how one southeastern state is addressing the mental health needs of its rural youth. Together, this information provides an important backdrop for understanding and overcoming the unique challenges of implementing SMH programs and services in a rural setting, which we discuss in the final section of this chapter.

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## Emotional and Behavioral Health of Children and Adolescents

Addressing the emotional and behavioral health needs of children and adolescents is a critical public health challenge that requires the collaborative efforts of policy makers, mental health professionals, researchers, families, and other stakeholders, including educators and school administrators. Epidemiological studies of population health and mental healthcare play an essential role in advancing the mental health of children and adolescents by providing evidence of the rate, course, and correlates of emotional and behavioral health concerns and service utilization. These studies also provide important information about the disproportionate mental health burden experienced by subgroups of the

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E.R. Siceloff (✉) • C. Massey • M. Yell  
M.D. Weist  
Department of Psychology, University of South  
Carolina, Columbia, SC, USA  
e-mail: [sicelofe@mailbox.sc.edu](mailto:sicelofe@mailbox.sc.edu)

C. Barnes-Young  
South Carolina Department of Mental Health,  
Tri-County Community Mental Health Center,  
Bennettsville, SC, USA

population, such as rural residents, and establish an empirical basis for the development of national health policy to reduce such disparities and to promote mental wellness.

Numerous federal policy reports emphasize the need to expand SMH programs and services, including reports by the U.S. Surgeon General on Mental Health (U.S. Public Health Service, 1999) and Children's Mental Health (U.S. Department of Health and Human Services, 2000), and presidential calls to action (President's New Freedom Commission on Mental Health, 2003). Conclusions from these reports are bolstered by epidemiologic data that suggest approximately 1 in 4–5 children and adolescents meet the criteria for an emotional or a behavioral health disorder (Carter et al., 2010; Reinherz, Giaconia, Lefkowitz, Pakiz, & Frost, 1993; Roberts, Roberts, & Xing, 2007). In more focused analyses, the National Institute of Mental Health (NIMH) in collaboration with the National Center for Health Statistics assessed select mental health disorders in children and adolescents aged 8–15 years as part of the National Health and Nutrition Examination Survey (NHANES). Findings in the 2001–2004 NHANES estimated that 13.1% of children and adolescents met the criteria for at least one mental health disorder in the previous 12 months (Merikangas, et al., 2010a). Although these data helped to establish a national database on youth mental health, conclusions about the rate of mental health disorders among youth were limited to the relatively narrow array of disorders assessed in the NHANES. Assessing a wider array of mental health disorders in a slightly older sample of 13- to 18-year-old adolescents, the National Comorbidity Survey—Adolescent Supplement (NCS-A) found overall prevalence rates of 40.3% for 12-month disorders (Kessler, Avenevoli, Costello, Georgiades, et al., 2012a) and 49.5% for lifetime disorders (Merikangas, et al., 2010b).

Differences in the prevalence of disorders in the NHANES and NCS-A likely reflect methodological differences in assessment protocols, including the types of disorders assessed in each study and their typical developmental course. For

example, of the emotional and behavioral health disorders in the NHANES, the highest 12-month rates were found for attention-deficit/hyperactivity disorder (ADHD; 8.6%) and mood disorders (3.7%) (Merikangas et al., 2010a). Compared to younger participants (ages 8–11 years) in the NHANES, older participants (ages 12–15 years) had lower rates of ADHD (though this difference did not reach statistical significance) and significantly higher mood disorder rates, particularly major depressive disorder. In contrast, 12-month prevalence estimates in the NCS-A indicated that the most common disorder classes among adolescents (ages 13–18 years) were anxiety disorders (24.9%), behavior disorders (16.3%), and mood disorders (10.0%) (Kessler et al., 2012a).

Findings in the NHANES and NCS-A studies point to the early onset and developmental course of emotional and behavioral disorders. In the NCS-A, parent/caregiver reports indicated that the onset for all disorder classes occurred by age 15 for 50% of adolescents with at least one mental disorder (Merikangas et al., 2010b). Early onset was particularly evident for those with anxiety disorders, with 50% having onset by age 6. The NCS-A also found that mental health disorders are generally moderate and are often comorbid. The majority of disorders represented in the NCS-A sample were largely mild (58.2%) to moderate (22.9%) (Kessler, Avenevoli, Costello, Green, et al., 2012b). However, the 12-month prevalence of serious emotional disturbance was 8%, accounting for a sizeable minority (18.8%) of the adolescents who met the criteria for a mental disorder. Approximately 20% of adolescents in the NCS-A sample (40% of adolescents with clinically elevated symptoms) met the criteria for more than one *DSM-IV* mental disorder, indicating that comorbidities are common among youth with mental health needs (Merikangas et al., 2010b). Importantly, comorbidity was associated with risk of severe emotional disturbance (SED) in this sample (Kessler et al., 2012b). Whereas adolescents with 3 or more disorders accounted for only 29.0% of those with a 12-month disorder, they represented the majority (63.5%) of those with SED.

## Unmet Mental Health Need

Despite the prevalence of mental health disorders among children and adolescents in the United States, the systematic delivery of services to treat these disorders is lacking. Among adolescents in the NCS-A sample, those with a mental health disorder had 12-month and lifetime service utilization rates of 45.0% and 36.2%, respectively (Costello, He, Sampson, Kessler, & Merikangas, 2014; Merikangas, He, & Burstein, et al., 2011). In the 2001–2004 NHANES, approximately 50% of children and adolescents with a mental health disorder had received services in the previous 12 months (Merikangas et al., 2010a). Disorders assessed in the NHANES sample, however, did not include some of the disorders found to have the lowest treatment rates in the NCS-A, such as specific phobias (Costello et al., 2014; Merikangas et al., 2011). Both the NCS-A and the NHANES found that service use was highest for ADHD, CD, and ODD, particularly among boys who are also disproportionately affected by these disorders (Costello et al., 2014; Merikangas et al., 2010, 2011). Although service utilization was significantly associated with disorder severity in both the NHANES and NCS-A, 12-month and lifetime service use rates in these samples suggest that mental health treatment is lacking for a substantial proportion (approximately 50%) children and adolescents with severe disorders (Merikangas et al., 2010a, 2011).

A number of studies examining service-use patterns have found SMH programs to be the primary source of services for youth with emotional and behavioral health concerns (Angold et al., 2002; Burns et al., 1995; Costello et al., 1996; Costello et al., 2014). The Caring for Children in the Community study examined the use of mental health service use among rural youth aged 9–17 years (Angold et al., 2002). In the previous 3 months, 13.3% of all participants (including those not identified as having a mental health diagnosis) received mental healthcare services in one or more professional service sectors, including schools, general medicine, and specialty mental health. School-based mental healthcare was accessed at nearly double the rate of spe-

cialty mental health services. Whereas only 4.6% of the participants received services in the specialty mental health sector, 8.9% of the participants utilized school-based mental healthcare services. Although it is unclear whether participants received different types of services in each sector, findings in this study suggest that SMH services may be especially critical to address the unmet mental health needs of children and youth in rural settings.

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## Mental Health Disparities in Rural Youth

Healthy People 2020, an initiative of the U.S. Department of Health and Human Services (HHS) that provides a guiding framework to support health promotion and disease prevention, describes health disparities as differences in health that are linked with socioeconomic disadvantage (see [healthypeople.gov](http://healthypeople.gov)). Mental health disparities may include higher levels of emotional and behavioral disorders, reduced service access, lower or disrupted service utilization, and poor mental health outcomes among an identified subgroup in comparison to the broader population. To reduce mental health disparities and their impacts, there is a dire need for effective prevention, intervention, and health promotion services that meet the needs of diverse populations.

Rural residents have been found to experience a number of health disparities and have been designated a special population that warrants focused attention to better understand how rural living affects their emotional and behavioral health and mental healthcare (National Center for Health Statistics, 2014). Although only 20% of the population resides in a rural environment, the geographic landscape of the United States is largely rural. While rural environments represent a diverse array of economies, populations, geographies, and ideologies, they are often perceived in terms of certain shared features that comprise a broader “rural culture” that is distinct from the cultural milieu of urban environments (Barbopoulos & Clark, 2003). For example, rural settings have been described as beautiful and serene and as

being relaxed, friendly, and safe, and rural residents are often characterized as being socially and politically conservative and having strong family values (Fagan & Hughes, 1985). Paradoxically, however, many of the social, economic, and geographic conditions that are common in rural areas have been associated with disadvantage. Rural areas are often geographically expansive with sparse populations and high rates of poverty and unemployment, low levels of educational attainment, and a high proportion of elderly people (Monk, 2007; Stamm, 2003; Wagenfeld, 2003).

Together, these and other features of rural living present unique challenges to addressing the emotional and behavioral health needs of children and adolescents. As discussed in a subsequent section of this chapter, mental health provider shortages are a critical concern that disproportionately affect rural areas and reduce the availability, accessibility, and acceptability of mental healthcare options for children and adolescents who reside in these settings. These service barriers have important implications for the continuity, effectiveness, and outcomes of the mental healthcare provided to rural youth and their families. For example, compared to non-rural youth, those residing in rural settings have been found to be more likely to enter services following longer periods of unmet need and with more severe symptoms (Heflinger, Shaw, Higa-McMillan, Lunn, & Brannan, 2015). In turn, service delays or disruptions may contribute to more problematic disorder trajectories and increase the likelihood that more intensive and costly services will ultimately be required (Heflinger et al., 2015; Torio, Encinosa, Berdahl, McCormick, & Simpson, 2015).

Despite evidence linking rural residence with reduced service access and more problematic mental health outcomes, research examining the prevalence of mental health disorders in rural and non-rural youth tends to find few geographic disparities. Similar to the rates observed in community samples of non-rural youth (Carter et al., 2010; Reinherz et al., 1993; Roberts et al., 2007), approximately 1 in 4–5 children residing in a rural area has been found to have an emotional or a behavioral health disorder (Angold et al., 2002; Burns et al., 1995; Polaha, Dalton, & Allen,

2011). Among rural African-American and White youth aged 9–17 years in the Caring for Children in the Community Study, the 3-month prevalence of mental health disorders was 21.1% (Angold et al., 2002). Similarly, 21.1% of rural youth aged 4–16 years attending a pediatric primary care appointment met criteria indicating clinically significant internalizing, externalizing, and/or attention behaviors (Polaha et al., 2011).

Direct comparisons of mental health disorder rates in rural and urban or other non-rural samples of youth also reveal few differences in the overall prevalence of emotional and behavioral health disorders in community samples (Breslau, Marshall, Pincus, & Brown, 2014; Burns et al., 1995) and national surveys (Merikangas et al., 2010b). For example, the Great Smoky Mountains Study of Youth (GSMS) examined the prevalence of mental health disorders in a large community sample of youth aged 9–13 years in western North Carolina, approximately half of whom resided in a rural setting (Burns et al., 1995; Costello, Angold, Burns, Stangl, Tweed, Erkanli, & Worthman, 1996). Overall, 20.3% of the sample met the criteria for a mental disorder in the previous 3 months. No differences in prevalence rates were found between rural and non-rural youth that were not accounted for by poverty. Furthermore, in a nationally representative sample of adolescents, the prevalence of disorders did not differ between residents of metropolitan and other urban areas and those living in rural settings (Merikangas et al., 2010b).

Although available data indicate that the overall prevalence of mental health disorders in rural and urban areas is largely similar, rurality has been consistently linked with disproportionately higher rates of suicide and substance use (Fontanella et al., 2015; Hirsch, 2006; Searles, Valley, Hedegaard, & Betz, 2015; Singh & Siahpush, 2002). Suicide is a major public health concern and is often a complication of mental illness (Avenevoli, Swendsen, He, Burstein, & Merikangas, 2015; Nock et al., 2013). National data indicate that suicide is the second leading cause of death among youth between the ages of 10 and 24 years (National Center for Health Statistics, 2014). Rates in rural

areas are even more concerning. Between 1996 and 2010, suicide rates in rural areas were nearly twice that in urban areas for both boys and girls, and evidence indicates that the gap continues to widen (Fontanella et al., 2015).

Similarly, national estimates of substance use by youth and young adults warrant substantial concern, yet rural adolescents use some substances at even higher rates. Specifically, although overall substance-use rates among all persons aged 12 years and older have been found to be higher in urban than rural settings, rates of alcohol and illicit substances use (other than marijuana) are higher among rural adolescents aged 12–17 years than urban youth (Lambert, Gale, & Hartley, 2008). Rates of methamphetamine and alcohol use have been shown to be particularly high in very rural areas (i.e., those not adjacent to an urban area) (Lambert et al., 2008). Greater rurality has also been linked with higher rates of binge drinking, heavy alcohol consumption, and driving under the influence of alcohol for youth aged 12–17 years (Lambert et al., 2008).

### **Unmet Mental Health Need Among Rural Youth**

The prevalence of mental health disorders among rural youth along with disparate rates of suicide and problematic substance use indicates that there is an urgent need for effective mental healthcare in rural settings. However, there is an abundance of evidence indicating that this need goes largely unmet. As has been found in national samples of youth, the majority of rural youth with emotional or behavioral health concerns do not receive mental health services (Angold et al., 2002). Low service use rates among rural children and adolescents have been attributed, in part, to shortages of mental health providers in rural areas. Although the impact of minimal or no mental healthcare options on service use is apparent, much of the available data do not indicate substantial differences in the rate at which services are utilized by rural and non-rural youth. For example, in the GSMS, 3-month service use

rates of 15.3% and 17.5% were found for 9- to 13-year-old rural and urban youth, respectively (Burns et al., 1995). A comparable service use rate of 13.3% was found in a sample of rural youth aged 9–17 years from counties in western North Carolina (Angold et al., 2002). Similarly, no service use differences were found as a function of metropolitan residence among youth in the NCS-A (Merikangas et al., 2011). Importantly, however, many studies do not account for differences in provider or service sector, service dose, treatment adherence, or a number of other factors that differentiate treatment outcomes. Therefore, findings of negligible differences in service utilization should not be interpreted as evidence that rural and non-rural youth utilize services that are similarly accessible or effective.

Efforts to garner a more nuanced and accurate depiction of rural mental health are constrained by the common treatment of rurality as a dichotomous variable (i.e., rural or not) in both research and practice. Indeed, the dichotomization of the rural-urban continuum is evident in government offices where “rural” is defined as essentially being anything that is not urban (US Census, USDA, and HRSA). Broad generalization of rural settings fails to capture distinguishing features that exist along the rural spectrum. As a result, it remains unclear as to what extent mental health disparities are attributable to characteristics of the rural setting and how rurality may interact with other factors (e.g., poverty, geographic isolation) to mitigate or exacerbate mental health burden in rural youth. Demonstrating the importance of moving beyond a rural vs. non-rural dichotomy, Heflinger et al. (2015) found that mental health service trajectories differed for children residing in areas at the extreme ends of the urban-rural continuum. Specifically, children in the most rural areas were the least likely to receive timely follow-up care (i.e., within 60 days) after being discharged from an out-of-home (OOH) placement and were more likely to receive another OOH placement compared to those in the most urban areas. As these findings suggest, advancing rural mental health requires an appreciation of the differences that exist within a broad rural category.



## Advancing Rural Mental Health: Policy Foundations and Considerations

Understanding the extent to which rurality contributes to the prevalence and outcomes of behavioral health issues is critical in the development of effective policy. Although service providers and researchers have long acknowledged the potential effect of rurality on mental health, organized responses have only emerged in recent decades. A fundamental shift toward understanding mental health disparities occurred at the federal level during the 1970s when President Carter issued an executive order creating a commission to examine mental health in the United States. The President's Commission on Mental Health (PCMH) was groundbreaking not only because it brought attention to mental health as a significant public health concern but also because of the emphasis that was placed on mental *health* rather than *illness* (Grob, 2005). Although rural mental health was not the primary focus, the findings and recommendations of the PCMH (1978) established a need for specialized attention in this area (Grob, 2005). In addition to noting gaps in the availability of rural mental health services and the need for research and data on rural mental health needs, the report brought attention to the plight of children with unmet needs and to the lack of adequate services for this population. The PCMH ultimately contributed to the passage of the short-lived Mental Health Systems Act in 1980. However, this policy never gained traction because it was largely reversed the following year with the inauguration of President Reagan, and associated decreased focus on the role of the federal government in the promotion of mental health during his presidency.

The rural health movement gained significant momentum at the federal level in 1987 with the creation of the Office of Rural Health Policy (ORHP) and the National Rural Health Advisory Committee within the Health Resources and Services Administration (HRSA; DeLeon, Wakefield, Schultz, Williams, & VandenBos, 1989). The ORHP serves as the focal point for federal policy and is responsible for overseeing

nationwide efforts to strengthen and enhance health service delivery to rural populations. The initial focus of the ORHP was physical health issues, but with the passage of the Omnibus Budget Reconciliation Act (OBRA 1989), this focus was expanded to include mental health issues.

Despite efforts to advance rural mental health, the *Commission on Mental Health*—convened by President George W. Bush as part of the *New Freedom Initiative*—identified two critical issues that continue to impede progress: (a) policies and practices developed for metropolitan areas are often inappropriately applied in rural areas, and (b) important rural issues are misconceived, minimized, or disregarded as irrelevant in national policy (President's New Freedom Commission on Mental Health 2003). The report underscored the need to promote awareness of rural mental health concerns and to ensure that these concerns are meaningfully addressed in mental health policies and practices that are appropriate and relevant in rural settings. To meet this need, it is necessary to understand the unique challenges and barriers experienced by providers and consumers in rural settings.

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## Rural Mental Health System Challenges

Rural mental health systems are often characterized as fragmented, comprised of an array of services that are often under-resourced and loosely organized. Despite apparent linkages and the need for collaboration, rural systems tend to operate in silos where they lack meaningful opportunities for integrated care, interagency cooperation, referral options, and collaboration (Gamm, Stone, & Pittman, 2010). Thus, addressing widespread gaps in rural behavioral health-care is a critical public health challenge. The development of effective policies to address these gaps and strengthen rural mental health systems requires an understanding of the core components that, despite being necessary for optimal system functioning in a given context, are missing or insufficient. In the following sections, we review rural mental health system challenges that reduce

the availability, accessibility, and acceptability of mental health services for youth and their families (Barbopoulos & Clark, 2003; Human & Wasem, 1991). Given the importance of these service factors to mental healthcare, challenges to available, accessible, and acceptable services have the potential to create barriers for both providers and consumers that are greater in quantity and impact than barriers in urban areas (Pullmann, VanHooser, Hoffman, & Heflinger, 2010).

### Availability of Services

A critical challenge to behavioral healthcare in rural settings is inadequate infrastructure and human resources. Cummings, Wen, and Druss (2013) found that fewer than 50% of rural counties had a mental health facility providing youth services, with even fewer counties having facilities to serve youth presenting more severe mental health issues. Not only were comprehensive mental health services less available in rural than non-rural areas, but those that were available were narrower in scope. Rural residents are also persistently and disproportionately impacted by an insufficient supply of trained health service providers (Gould, Beals-Erickson, & Roberts, 2012; Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009). Shortages in the supply of mental health providers are apparent across a number of professional categories, including licensed professional counselors, marriage and family therapists, social workers, psychologists, and psychiatrists (Ellis, Konrad, Thomas, & Morrissey, 2009; Thomas & Holzer, 2006). As designated by the HRSA, more than one-third of all rural residents live in a Health Provider Shortage Area (HPSA), and more rural than metropolitan counties receive this designation (see [www.hrsa.gov/shortage](http://www.hrsa.gov/shortage)).

The lack of available behavioral health services and inadequate human resources also have implications for the types and quality of treatment options for youth and their families. Rural youth have been found to use specialty mental health services at lower rates than non-rural youth. For example, the GSMS found that only

2.6% of rural youth used specialty services compared to 6.7% of urban youth (Burns et al., 1995). The use of specialty services has been found to be particularly low among rural minority youth (Angold et al., 2002). The lack of specialty services has been implicated in the increased use of providers other than behavioral health professionals and the increased use of services delivered in hospital or residential settings by rural youth. Pediatricians and other general practitioners have been found to play greater roles in the treatment and pharmaceutical management of behavioral health issues among rural relative to non-rural youth (Komiti, Judd, & Jackson, 2006; Koppelman, 2004; Polaha et al., 2011). Without appropriate training in behavioral health management, however, general practitioners may be underqualified to diagnose and treat behavioral health disorders (Lavigne et al., 1993). Compared to youth in more urban areas, rural youth have also been found to be more likely to use hospital emergency services to treat behavioral health issues and to be twice as likely to receive out-of-home services and to have longer stays in these placements (Heflinger et al., 2015). Mental health provider shortages in rural areas contribute to service barriers that delay the initiation of services and to the presence of greater symptom severity upon service entry among rural residents, thereby increasing the need for more intensive and costly services.

Gaps in rural behavioral healthcare infrastructure and human resources impact not only service consumers and their families but also mental health service providers and stakeholders in other agencies, such as education, juvenile justice, and child welfare. Rural service providers may experience heavy caseloads representing a broad array of behavioral health issues of varying severity that require treatments beyond their expertise. Without an adequate network of mental health professionals and interagency cooperation, providers often have limited referral options and few opportunities for collaboration (Brems, Johnson, Warner, & Roberts, 2006; Gamm et al., 2010). As a result, they may overextend their time and may feel pressure to offer services that are beyond their skills. These challenges can lead to provider

burnout and may negatively affect the retention of effective behavioral health providers (Kee, Johnson, & Hunt, 2002).

Telehealth options, including telepsychiatry, offer an innovative means to address the challenges of provider shortages by using telecommunications technology to support the delivery of health services by a remote professional (Mackie, 2015). The inclusion of technology in behavioral healthcare practice has demonstrated the potential to produce positive outcomes (Benavides-Vaello, Strode, & Sheeran, 2013; Mackie, 2015). Technology may provide a means to access behavioral health services in rural settings with limited availability of behavioral health specialists. However, a key barrier to technology-supported behavioral health services in rural settings is that, for both consumers and providers, access to broadband Internet may be lacking or insufficient. Approximately 27% of rural residents do not have access to high-speed Internet, and rural providers more often identify limited client Internet connectivity or service access as a key barrier than providers in other geographic areas (Mackie, 2015). Further, rural residents may be more uncomfortable with technology use than suburban and urban residents (Ramsey & Montgomery, 2014). These differences highlight the need to ensure opportunities for improved technology literacy among rural populations. Special consideration should also be given to the importance of rapport building within the context of telehealth communications (Goldstein & Glueck, 2016; Nelson & Patton, 2016). In addition to establishing a therapeutic alliance with the child or adolescent receiving services and his or her family, it is important that rapport also be established with other stakeholders, including teachers and the referring provider (Glueck, 2013). Families often have established relationships with these individuals and may value their input about the telehealth services they receive.

Furthermore, the use of technology for mental health service delivery introduces a number of regulatory considerations, including issues related to licensing of professionals (e.g., different standards and bureaucratic demands for

different professionals), differences in policies across jurisdictions, insurance barriers, cumbersome and time-consuming fee-for-service reimbursement, and privacy concerns (Kramer, Kinn, & Mishkind, 2015). To address these issues, state and federal policies are needed that promote healthcare rights and ensure accessibility of behavioral health services to all citizens. For example, most states have adopted telemedicine parity laws to enforce insurance coverage for services provided by telemedicine. Unfortunately, however, there is a general lack of specific policy and procedural guidelines for states and localities for use of telehealth services, limiting their use and impact (Mackie, 2015).

### Accessibility of Services

The extent to which behavioral health services are accessible to youth and their families has important consequences for the initiation and continuation of services and for disorder-related outcomes (Robinson et al., 2012). Gaps in system infrastructure that are common in rural settings contribute to accessibility barriers experienced by youth with behavioral health issues and their families. The dearth of local behavioral health services found in many rural areas requires that families commute to receive services. Because rural areas are often geographically expansive, the travel distance to the nearest available service provider may be great, particularly for residents of areas that are remote or not adjacent to a metropolitan area. Therefore, the accessibility of behavioral health services in rural areas is largely dependent upon the availability of resources that enable travel to and from appointments or that otherwise attenuate travel-related burden. For many rural families, these resources are lacking. Across a number of studies, parents and caregivers of youth with behavioral health issues have reported that transportation is a primary barrier to accessing services (Pullmann et al., 2010; Robinson et al., 2012). Families may lack or have unreliable personal transportation and limited funds to support travel. Public transportation is often absent in rural areas or unable to provide connections to distant locations. Additionally,



as a result of limited funding, rural behavioral health systems are often unable to provide transportation services or to offset travel costs incurred by families. Although some travel support may be available within the community (e.g., transportation that is fee based, church sponsored, or provided by a friend or family member), competing demands (e.g., work, other children) and scheduling restrictions often make it difficult to coordinate transportation to distant services (Robinson et al., 2012).

### Acceptability of Services

The extent to which services are acceptable to consumers of behavioral health services is critical to service utilization. In rural communities, stigma is often cited as a barrier that reduces the acceptability of behavioral health services (Fox, Blank, Rovnyak, & Barnett, 2001; Jameson & Blank, 2007; Schank & Skovholt, 2006; Starr, Campbell, & Herrick, 2002). Stigma may involve holding negative stereotypes of behavioral health issues experienced by others as well as self-stigmatizing (Corrigan, 2004). Studies have shown that rural families not only experience stigmatization related to mental illness but that stigma may prevent families from acknowledging a problem or seeking treatment (Williams & Polaha, 2014).

In addition to the potential negative effect of stigmatization, the extent to which parents perceive their child to be in need of mental health services may be influenced by factors such as general knowledge of mental health, expectations for developmentally appropriate behaviors, and ability to appropriately identify that their child may be in distress (Godoy, Carter, Silver, Dickstein, & Seifer, 2014). Parents and other family members' and caregivers' ability to accurately assess the need for services may be particularly limited for young children. In one study, although half (51%) of children were identified by their kindergarten teacher as being at risk for emotional, behavioral, social, or adaptive problems, only one-third of parents believed that their child had a problem (Girio-Herrera, Owens, &

Langberg, 2013). It may be particularly difficult for parents and caregivers to recognize behavioral health concerns in infants and toddlers; thus, children at this point in development may have an elevated risk of having unmet mental health need (Godoy et al., 2014).

Consumers' perceptions of the quality of services may also influence the extent to which they are perceived to be acceptable. For example, families have reported concerns that primary care providers may offer behavioral health treatment without having the proper training and knowledge to do so and without the consultation of appropriate specialists (Robinson et al., 2012). Such perceptions are important given that the extent to which consumers perceive a provider to be effective has been shown to be predictive of help seeking (Komiti et al., 2006). Families have also noted that their perceived acceptability of services is influenced by factors operating at other levels of influence. For example, families have reported concerns that their child's or adolescent's behavioral health problems may be treated as law enforcement or legal issues, which reduces the perceived acceptability of available services (Robinson et al., 2012).

### Challenges to SMH in Rural Communities

Although schools have been identified as the "de facto" mental health system for children and adolescents (Burns et al., 1995), SMH programs face a number of challenges to meeting students' needs (Weist, Paternite, Wheatley-Rowe, & Gall, 2010). Rural programs often have to contend with shortages of school-based service providers, which may result in delays or gaps in services for students. For example, although transportation barriers are alleviated by the accessibility of SMH services to students, they may continue to hinder engagement in treatment for members of a student's family. Moreover, accessibility remains a challenge for students who receive services from other members of the interdisciplinary team (e.g., psychiatrists, clinical care coordinators, advanced practice nurses) that typically do not

deliver services in schools. Many centers link families with transportation services that can bring clients to appointments and bill a payer source. Other centers provide transportation for their clients and build the expense into their overhead. More recently, centers have been exploring the option of sending other members of the interdisciplinary team—such as a nurse practitioner—to the schools where school-based services are located to provide more services where the clients are readily available.

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### Case Study: School Mental Health in South Carolina

The diversity of rurality and challenges to meeting the mental health needs of rural youth are well represented in South Carolina, a largely rural state. The U.S. Census Bureau (2014) estimates that currently, the majority of the nearly 5 million residents of South Carolina are either non-Hispanic-White (63.9%) or African-American (27.8%). Statewide, the majority of adults over age 25 completed high school (85.0%) and a sizeable minority had at least a bachelor's degree (25.3%). Children and adolescents under age 18 years accounted for 22.4% of the population.

Mental healthcare has a long history in South Carolina, with legislative support for institutionalized services dating back to the 1800s (South Carolina Department of Mental Health, 1996). Expanding its service approach, the state established its first outpatient center in Columbia, the state capital, in 1923. Local mental healthcare received increased government support and funding in the 1960s with the passage of the South Carolina Community Mental Health Services Act (1961) and the Federal Community Health Centers Act (1963). In 1964, South Carolina established a Department of Mental Health, and a few years later, the state became home to the first mental health complex in the southern United States with construction of the Columbia Area Mental Health Center. Since that time, the South Carolina Department of Mental Health (SCDMH) network has grown into one of

the largest hospital and community-based systems of care in the state.

Recent decades have brought continued efforts to address the mental health needs of children and adolescents in South Carolina. A key development came in 2014 when the state legislature extended eligibility for youth mental health services from ages 18 to 21 (A173, R190, H3567). Also that year, the legislature created a taskforce to review and make recommendations on issues of school safety. In the Report of the School Safety Taskforce (2015), much attention is given to the role of schools in meeting child and adolescent mental health needs as well as how that role is best implemented and supported. The SCDMH expanded their capacity by obtaining a youth suicide prevention grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). This 5-year award, which began in 2015, will support *Young Lives Matter*, a project that aims to reduce youth and young adult suicide 20% statewide by 2025.

Despite efforts to elevate youth mental health statewide, addressing the needs of children and adolescents in rural counties continues to be a unique challenge. Given the composition of the state, rural health issues are highly salient. Of the 46 counties in South Carolina, 20 have been identified as rural by the ORHP. These communities face challenges unique to the rural landscape. Residents living in rural South Carolina live in some of the poorest school districts in the country, and over a third of the children attending these schools are from families living below the poverty line (Rural School and Community Trust, 2007). Rates of mental illness in rural areas of southeastern states can be quite high. For example, approximately 25% of youth report having been exposed to a traumatic event sometime in their life (Costello, Erkanli, Fairbank, & Angold, 2002). With the high rates of mental health issues that families living in rural areas of South Carolina face, it is of significant concern that many rural populations are limited in their ability to access quality mental health services.

In the remainder of this chapter, we focus our discussion of behavioral health and policy issues on efforts to elevate the SMH agenda to address

the unmet mental health needs of families in rural South Carolina. We first provide background information about the increased attention to educational funding in the state and the role of the SCDMH SMH program in meeting the mental health needs of children and adolescents in public school settings. We then center our discussion the school-based services provided by the Tri-County Community Health Center (TCCCHC) to families residing in three rural counties located in the northeastern region of the state. Although these counties are all identified as rural, they differ on a number of characteristics, including population density, racial composition, population-level educational attainment, and percentage of residents living in poverty (U.S. Census Bureau, 2014). We describe the innovative strategies and approaches the TCCCHC has developed in collaboration with school districts and other local organizations to address the unique challenges and barriers to advancing SMH in these rural counties.

### **The Development of SMH in Rural SC Counties**

The issue of educational funding has been the focus of much attention in SC, sparked largely by a lawsuit that was initiated in 1993 by a collection of 36 rural school districts to seek greater equity. The ensuing legal debate over educational funding and its role in the provision of minimally adequate education spanned two decades as the case made its way through the state's legal system. Finally, in 2014, the state's Supreme Court decided in favor of the eight remaining plaintiff districts, ruling that the state had failed in its responsibility to provide children in the state's poorest districts with a "minimally adequate" education (*Abbeville County School District v. State of South Carolina*, 2014). Although the remedy is still subject to legislative debate, a resolution to inequitable educational funding will not only support educational objectives, but also has the potential to elevate the SMH agenda.

In this context of attention to enhancing resources for education in SC, there has been

increasing connection to the importance of SMH programs in reducing and removing barriers to student learning. As such, the SCDMH school mental health program has become a prioritized initiative, with a goal to extend to most of the state's 1300 schools. At the start of the 2015–16 academic year, the SCDMH's school-based program had mental health professionals in approximately 500 public schools, serving 13,000 students/year. School-based services are part the array of services offered by the TCCMHC serving the above-mentioned rural counties in northeastern SC. In these three counties, SMH services are provided by counselors who serve students attending schools in each district in the catchment area. These professionals typically have a master's degree in social work, counseling, education, psychology, or other human service programs. One of the strengths of the Center's school-based program is its partnerships with four school districts. The Center's school-based counselors are integrated into the schools they serve and work closely with the school districts' staff to effectively meet the needs to students and their families. The Center has seven mental health professionals providing services in 14 schools, including elementary, middle, and high schools. The Center bills most payer sources (e.g., Medicaid, private insurance) and provides care to the uninsured, including offering services on a sliding scale based on income, and providing case management assistance to these families to obtain insurance.

To address the inherent challenges rural SMH programs face, TCCMHC and the collaborating school districts have developed innovative strategies and services. For example, in order to help expand limited funds, one school district sought and was awarded a grant to implement and evaluate a bullying prevention program. Seeking outside funding sources can help supplement limited financial resources in rural areas. Other such strategies that have been developed to address uniquely rural challenges include addressing the intersection of rural geography and school size. Although rural communities are often considered "small," that descriptor applies only to population and not geographic size. In some rural communities

with low population density, school districts pool students from a large geographic area to one high school or combined middle and high school to create a large number of students per school. Other communities opt to have multiple schools for the large area. In areas served by multiple schools that have smaller student bodies, it may not be sustainable to follow the best practice of one clinician per school. To address this challenge and ensure the sustainability of SMH positions, clinicians can be assigned to two schools so they will have a sufficient number of students to generate a sustainable caseload. Limiting the number of schools served by a clinician to two helps ensure that students have adequate access to services and the school-based counselor is viewed as a member of the school building and team.

The Center helps to address barriers that may reduce participation in services. While the majority of school-based services are provided in schools, many services (e.g., psychiatry, primary health care) are still provided in clinics. Therefore, barriers that reduce the accessibility of these services remain a concern. To enhance the accessibility of these services, TCCMHC assists families with transportation to its clinics for services. The Center also supports service accessibility by being on the cutting edge of telepsychiatry, growing around the nation related to the shortage of psychiatrists especially in highly rural areas (McGinty, Saeed, Simmons, & Yildirim, 2006). A large percentage of the Center's psychiatric services are delivered by telepsychiatry and the Center is exploring opportunities that would allow telepsychiatry services to be delivered directly in schools.

The greatest challenge to the Center's SMH program has been the recruitment and retention of skilled clinicians. Individuals who work in rural communities will sometimes note that a charming aspect to working in these areas is the intimacy and familiarity people have with one another, and how having this awareness of fellow community members can increase a sense of safety and belongingness. Residents in smaller rural communities may emphasize personal themes of resiliency and a "take-care-of-ourselves" mentality.

While this can be a strength, the insulated nature of a small community can present a challenge for new service providers. Successful school-based programs often have one or several staff members that can introduce, train, and serve as role models for new service providers. Essentially, the seasoned, well-known staff member provides a "warm hand-off" of a new staff member to the school. This is particularly useful in rural areas since employee turnover is a significant concern. To help recruit skilled providers, TCCMHC promotes its participation in graduate student loan repayment programs. The Center is also able to provide other recruitment incentives—for example, free supervision for staff seeking licensure.

Given the need for school-based services, significant disparities to access to care in rural communities, and demonstrated value of successful school-based services described above, it has become clear that one agency cannot sufficiently address all the behavioral health needs alone. While TCCMHC has effective partnerships with the school districts in its catchment area, several of the districts also partner with other behavioral health providers and a Federally Qualified Health Center (FQHC) to provide SMH. The combined efforts and collaboration of multiple organizations have helped address the behavioral health needs of the rural communities without one entity becoming overextended to try to provide a full system of care. Developing and maintaining mutual trust and vested interest in improving the mental health of the communities prevented these collaborative efforts from being viewed as competitive.

One organization that has had a tremendous impact on improving coordination and collaboration in this part of the state is the Northeastern Rural Health Network (NRHN). Strongly supported by the SC Office of Rural Health, the NRHN is a collaboration of health and human service providers who are dedicated to improving access to quality healthcare in rural communities. Members of the Network are decision makers for their respective organizations and their participation in the Network has greatly contributed to improved working relationships and partnerships. Members of the NRHN have jointly submitted

grant applications that have been funded and resulted in successful healthcare innovations, including school-based programs.

With the technological advances in telehealth, it is an exciting time to be a mental healthcare provider. As mentioned above, one of the challenges of implementing a telepsychiatry program in rural communities is the access to high-speed Internet. Even in rural communities, schools tend to have broadband access so it is a natural fit for rural communities to have telepsychiatry or other telehealth programs delivered in schools. With broadband access and advances in the equipment needed to deliver telepsychiatry, the service is quickly becoming more and more portable.

Another service delivery model that has proven effective in rural communities is integrated physical and behavioral healthcare. The Center has had a successful grant-funded integration program that served adults, which has been sustained and will expand to serve children through a new partnership with an FQHC. This partnership will also add primary healthcare to SMH services through mobile primary care and dental services, with the goal that these services be added for all schools served by the TCCMHC.

Going forward, TCCMHC and its partners will continue to work on expanding school-based mental health services and integrated healthcare. The Center and school districts have a shared goal of having a clinician from the mental health system in every school. Grants and special funding opportunities from endowments and the like will help with the expansion of school-based programs and create positions; however, the challenge will be sustaining those positions with ongoing typical funding streams. In order to make a case for retaining important programs, it is critical to ensure that appropriate data are collected that accurately reflect and document benefits to the local community. Our experience has been that there are plans to collect these data, and in many cases the data are collected, but efforts fall short in analyzing the data and developing reports that are useful to community stakeholders. Clearly, efforts in this area need to be improved. In addition, efforts to document the cost savings of these programs

(e.g., reduced psychiatric hospitalizations, restrictive special education placements, juvenile justice involvement) would be of great benefit. There are examples of documenting the cost benefits of SMH (see Slade et al., 2009); these efforts should be escalated for rural SMH programs.

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## Conclusion

Youth in rural communities face a unique set of challenges, compared to their urban and suburban counterparts. On the whole, children and adolescents face significant rates of mental health ailments (Kessler et al., 2012a, 2012b; Merikangas et al., 2010a, 2010b) and have frighteningly low rates of service utilization (Costello et al., 2014; Merikangas et al., 2010a, 2011). While the prevalence of such conditions may not vary much across the spectrum of rural-suburban-urban, the severity of mental health needs of youth in rural areas is consistently higher (e.g., increased serious problems such as suicidal behavior, substance abuse) than youth in other settings (Fontanella et al., 2015; Hirsch, 2006; Searles et al., 2015; Singh & Siahpush, 2002). This unmet need requires the attention of mental health personnel and policy makers alike, in order to ensure that youth and their families do not continue to experience severe levels of emotional and behavioral distress.

School mental health programs offer an important solution to the gap between needs and effective services for rural youth, as they are regularly the sole source of services for youth who have emotional and/or behavioral needs (Angold et al., 2002; Burns et al., 1995; Costello et al., 2014). These programs are designed to address many of the barriers to treatment that exist in traditional outpatient settings. For many rural families, the price of gas, taking time off of work, insurance issues, and/or stigma of receiving mental health services present real and significant impediments to obtaining quality healthcare. SMH programs bring services to the individual in need, rather than requiring the individual in need to come to



where services are provided, all while seeking to develop a collaborative relationship with the school and the community as a whole.

However, school-based mental health programs in rural areas face many challenges. One of the most important, the one that looms the largest over these endeavors, is that of sustainability. The question of sustainability of SMH programs in rural areas primarily is related to how these programs are funded. Grants offer a chance for many programs to get off the ground and establish services within a community, and allow for service providers and clinicians-in-training to provide health-care; however, there is no guarantee that funds will be available 5 or 10 years down the road. Direct billing for services allows for licensed practitioners and community agencies to offer their services while being able to keep their doors open; however, with a changing insurance landscape business models may have to adapt in order for agencies to survive. A potential solution therefore is a combination of these practices and a collaboration between entities adept at pursuing funding streams. Partnerships between universities and community agencies can help bolster grant applications, making them more competitive for receiving funding that is set aside for integrative care initiatives. As SMH programs continue to improve and expand, these collaborations between vested parties will help to ensure that financing limitations do not get in the way of the critically important public health agenda of improving mental health promotion and intervention for rural children, youth, and families.

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**E. Rebekah Sicheloff** earned her Ph.D. in developmental psychology from North Carolina State University. Currently, she is a Research Associate in the Department of Psychology at the University of South Carolina. Her research interests include (1) parent–child interactions, particularly as they relate to children's cognitive, social, and emotional development and lifestyle behaviors (e.g., physical activity), and (2) behavioral health interventions. These areas of research converge to promote positive outcomes in children and their families through efforts to understand and optimize the contexts in which they develop.

**Christian Barnes-Young** is the Executive Director of Tri-County Community Mental Health Center—one of the South Carolina Department of Mental Health's 17 community mental health centers. Tri-County serves rural communities in Dillon, Marlboro, and Chesterfield counties. Mr. Barnes-Young is a board member and current chair of the Northeastern Rural Health Network, a collaboration of health and human service providers dedicated to improving access to quality healthcare. Mr. Barnes-Young earned a bachelor's degree in psychology from Coastal Carolina University and a master's degree in clinical psychology from Francis Marion University. He is a licensed professional counselor and certified in primary behavioral healthcare integration by the University of Massachusetts, School of Medicine. Prior to joining Tri-County, Mr. Barnes-Young worked as a master's-level psychologist with the South Carolina Department of Disabilities and Special Needs. He also held positions at the South Carolina's Governor's Office: Continuum of Care for Severely Emotionally Disturbed Children.

**Cameron Massey** completed his B.A. in Psychology from the University of North Carolina—Chapel Hill in 2004 and his M.A. in Clinical Health Psychology from Appalachian State University in 2010. He worked as a licensed masters-level staff psychologist for a community mental health center in rural Western North Carolina before accepting the position of Clinical Research Coordinator at Appalachian State as part of a Title V federal grant project. In this role he worked on a community needs assessment and provided direct clinical service to adolescents through a school-based mental health program. He is currently a doctoral student at the University of South Carolina, working with Dr. Mark Weist and the School Mental Health Team. His areas of interest include diagnosis and treatment of adolescent disorders, school-based mental health, and issues surrounding rural mental health.

**Mitch Yell**, Ph.D., is the Fred and Francis Lester Palmetto Chair in Teacher Education and a Professor in Special Education at the University of South Carolina. His professional interests include special education law, positive behavior support, IEP development, and parent involvement in special education. Dr. Yell has published 112 journal articles, 4 textbooks, and 26 book chapters, and has conducted numerous workshops on various aspects of special education law. His textbook, *Special Education and the Law*, is in its 4th edition. He also serves as a state-level due process review officer in South Carolina. Prior to working in higher education, Dr. Yell was a special education teacher in Minnesota for 16 years.

**Mark D. Weist** received a Ph.D. in clinical psychology from Virginia Tech in 1991 after completing his internship at Duke University, and is a Professor in Clinical-Community and School Psychology in the Department of Psychology at the University of South Carolina. He was on the faculty of the University of Maryland for 19 years where he helped to found and direct the Center for School Mental Health (<http://csmh.umaryland.edu>), providing leadership to the advancement of school mental health (SMH) policies and programs in the United States. He has edited ten books and has published and presented widely in SMH and in the areas of trauma, violence and youth, evidence-based practice, cognitive behavioral therapy, and Positive Behavioral Interventions and Supports (PBIS), and on an Interconnected Systems Framework (ISF) for SMH and PBIS. He is currently coleading a regional conference on school behavioral health (reflecting integrated SMH and PBIS, see [www.schoolbehavioralhealth.org](http://www.schoolbehavioralhealth.org)) and leading a randomized controlled trial on the ISF.

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