

Achieving Access to Mental Health Care for School-Aged Children in Rural Communities: A Literature Review

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With creativity and collaboration, children in rural communities who have the same mental health needs as children in urban areas can achieve access to mental health care. This review of the literature explores barriers to mental health services facing school-aged children residing in rural communities and focuses on how challenges unique to rural communities affect the type of care rural children ultimately receive. This review aligns with the NREA Research Agenda priority area “access to counseling/mental health services” (NREA, 2018). The discussion incorporates national trends in the treatment of children with mental health concerns and highlights some surprising facts about the state of mental health care in rural school and examines the following factors: (1) belief, (2) family poverty, (3) school support, (4) community resources, and (5) awareness. The review concludes by outlining opportunities for advocacy and proposed solutions for improving mental health care access for rural children and suggesting directions for future research.

Achieving Access to Mental Health Care for School-Aged Children in Rural Communities

Approximately 97% of the landmass in the United States is classified as rural and 19% of the country's total population lives in rural communities (U.S. Census Bureau, 2010). This subset of the population includes 24% of the nation's students (Aud et al., 2013) and 32.9% of its schools (Johnson, Showalter, Klein, & Lester, 2014). Educating and ensuring the well-being of students across such a vast and diverse area presents many challenges. Adolescents who live in rural communities have a higher rate of suicide than adolescents who live in urban areas (New Freedom Commission on Mental Health, 2004). Despite this fact, rural residents, adolescents included, are less likely to have access to mental health services (Huber et al., 2016; New Freedom Commission on Mental Health, 2004).

Recent research suggests that there is a significant gap between the mental health needs of school-aged children and access to mental health care. In a national study of 3,024 children, Merikangas, Brody, Fischer, Bourdon, and Koretz (2010) found that mental health problems were fairly common among American adolescents; 13.1% had disorders without impairment and 11.3% had disorders with severe impairment. Significantly, the study also found that fewer than half of adolescents with a disorder received any sort of treatment. Compounding the already low overall treatment rate

for children with mental health concerns are additional barriers to treatment that are specific to children residing in rural communities such as poverty, limited resources, and mental health stigma. In their literature review of rural challenges pertaining to mental health and mental disorders, Gamm, Stone, and Pittman (2003) observed:

Mental health and mental disorders are serious problems in rural areas. These problems are reflected in the frequent failure to identify such conditions early on, lack of access to mental health professionals to treat such conditions, and the tremendous consequences of mental illness for treatment of physical illnesses and for day-to-day life. Mental health needs occur among men, women, and children of all ages, ethnic groups, and social backgrounds. Some of these groups appear particularly disadvantaged in rural areas in gaining necessary treatment. Among these groups experiencing rural disparities are children, the poor, the elderly, and African Americans and other minority groups. (p. 107)

Despite the fact that there are a number of potential barriers between children and mental health care, very little research has sought to examine barriers specific to the mental health needs of rural school-aged children. Interestingly, two of the fourteen propositions for improving rural mental health research proffered nearly two decades ago by Keller, Murray, and Hargrove (1999) involved examining “barriers to mental health service delivery

in relation to rural context variables” (p. 324), and studying “opportunities for and barriers to preventive mental health interventions in rural communities” (p. 324).

Schools are generally the first, and perhaps most common, environment where children display mental health problems. Multiple studies and mental health experts have stressed the importance of professionals in school settings accurately identifying and addressing mental health concerns and linking students and their families to appropriate treatment providers (Bain, Rueda, Mata-Villarreal, & Mundy, 2011; Evans, Radunovich, Cornette, Wiens, & Roy, 2008; Girio-Herrera, Owens, & Langberg, 2013; Huber et al., 2016; Murphy, 2005). As Wilger (2015) observed: “In rural areas where mental health services are scarce and families face unique barriers to accessing care, schools play a significant role in providing or linking students and their families to mental health services” (p. 1).

The aim of this review of the literature is to provide an overview of existing literature that describes challenges to mental health care for school-aged (K–12) children in rural communities as perceived by parents, children, and mental health professionals in school and community settings. We review five factors identified as challenges to care – (1) belief, (2) family poverty, (3) school support, (4) community resources, and (5) awareness – and provide suggestions for clinical practice and ideas for future research.

Rural Setting

Rural communities are unique in a number of ways when compared with urban counterparts (Gray, 2011). The open spaces might be the most noticeable distinction, but there are many other differences for the people who live there. Lower wage jobs are more common, and rates of childhood poverty are generally greater in rural communities than in urban areas (Mohatt, Bradley, Adams, & Morris, 2005). Rural adults are more likely to be less educated than their urban peers and rural high-school students are less likely to seek a college degree (Mohatt et al., 2005). As a result, many services provided to rural communities are delivered by professionals from outside the community, which can affect service availability, and, in some cases, seriously reduce or eliminate access entirely. The lack of mental health service providers is significant: 85% of federally

designated mental health professional shortage areas are in rural communities (Mohatt et al., 2005).

Rural and urban settings are unique from each other in many ways, but both populations have a legitimate need for accessible mental health care. Although the inclination may be to believe that living in close proximity to the natural world serves to reduce anxiety and depression, studies have repeatedly shown that rural children have the same or greater rates of mental health problems as urban children (Anderson & Gittler, 2005; Polaha, Dalton, & Allen, 2011) along with significant, and largely unsatisfied, needs for mental health care and counseling.

Differences in Type of Care Received

There is a difference between urban and rural settings with regard to the type and amount of mental health care residents receive. Two separate studies of the Medical Expenditure Panel Surveys (MEPS) found some variance between rural and urban residents with regards to mental health care. Ziller, Anderson, and Coburn’s (2010) analysis of the MEPS found that rural, non-elderly adults had a greater rate of psychotherapeutic medication and were less likely to use office-based mental health services, such as traditional one-on-one counseling. Rural residents who received office-based mental health care made fewer visits than their urban counterparts (Ziller et al., 2010). Fortney, Harman, Xu, and Dong (2010) examined the MEPS and found that while rural and urban residents were equally likely to receive treatment, rural residents were significantly more likely to receive psychopharmacotherapy and significantly less likely to receive counseling. The researchers also found that rural residents who did receive counseling were significantly less likely to receive an adequate level of treatment than urban residents. The authors of the study speculated that a lack of access to mental health professionals may lead rural residents to rely more heavily on psychopharmacotherapy (Fortney et al., 2010). These studies point to a trend in mental health care in rural residents that seems to hold true for rural children as well.

Though there is a dearth of research comparing the type of mental health care received by rural children compared to urban children, Anderson, Neuwirth, Lerner, and Hartley (2013) found that rural children were more likely to receive a mental health prescription (8.0%) than they were to receive

counseling (4.3%). Rural children were less likely to receive counseling (4.3% vs. 6.7%) and were more likely to receive a mental health prescription (8.0% vs. 6.4%) compared to urban children (Anderson et al., 2013). This study implies that rural children are likely to follow the same trend that has been identified among rural adults; that is, relying primarily on medication for mental health concerns instead of counseling.

Psychopharmacotherapy versus Other Treatments for Rural Children

Although receiving some form of treatment is better than none, there are several reasons why treating children with medication alone is concerning. For example, in one study 34.8% of children receiving outpatient care only saw primary care physicians for their mental health conditions (Anderson, Chen, Perrin, & Van Cleave, 2015). As a result, the only point of contact for these children is a physician with little specialized training in psychotherapy or the use of psychopharmaceuticals. Even if a child is primarily being seen by a child psychiatrist or general psychiatrist, the issue remains over whether medication alone can provide the best treatment based on symptoms and diagnosis.

With respect to the treatment of anxiety and depression in children and adolescents, medications such as Selective Serotonin Reuptake Inhibitors (SSRIs) are a very common form of treatment. In fact, antidepressants are the most common form of treatment for depression among the entire U.S. population (DeRubeis et al., 2005). Although the use of antidepressants is common, research indicates that medication alone is not the best treatment for mental health care. The combination of Cognitive Behavioral Therapy (CBT) and SSRI was found to be more effective than SSRI or CBT alone for the treatment of adolescent depression (Kennard et al., 2006). Moreover, one meta-analytic review has shown that CBT is the best Evidence-Based Practice (EBP) for children with depression and anxiety (Compton et al., 2004). Additionally, CBT administered by a skilled practitioner is as effective as psychopharmacotherapy provided by a skilled practitioner to treat even moderate to severe depression (DeRubeis et al., 2005).

Medication has been considered the first line treatment for ADHD since the first report of the Multimodal Treatment Study of Children with ADHD (MTA) showed that medication management

provided the same benefit as combined treatment and outperformed behavioral interventions (Jensen et al., 2001). However, the medication management group received more comprehensive care than a typical child getting a prescription from a primary care physician could expect and had higher rates of delinquency than the behavioral intervention group (Jensen et al., 2001; Molina et al., 2007). Later research indicated that improvements shown by the medication-management group tended to taper off and were not significantly different than the other groups at the three-year mark (Swanson et al., 2007). In addition, numerous meta-analyses have found that strategies such as classroom interventions and parent training are well supported treatments for ADHD (Fabiano et al., 2009). DuPaul, Eckert, and Vilaro (2012) recommended “academic, contingency management, and self-regulation interventions first-line treatment strategies when addressing the educational and behavioral needs of students with ADHD” (p. 409).

Behavioral interventions and talk therapy have been shown to be equally effective to medication for disorders such as ADHD, anxiety, and depression (Compton et al., 2004; Currie, Stabile, & Jones, 2014; Jensen et al., 2001; Kennard et al., 2006). In addition, non-medication oriented therapeutic approaches can achieve long-term benefits that medication does not, without putting an individual at risk for side-effects. Moreover, studies conducted with medication management as a treatment option involve a trained child psychiatrist and a collaborative treatment team, which is noticeably different from a short visit to a general practitioner. In short, treating childhood mental health problems with medication alone is not consistent with best practices. This is of particular concern for children in rural areas, as they are more likely than their urban counterparts to receive a mental health prescription instead of talk therapy (Anderson et al., 2013).

These studies suggest that there are barriers between rural children and receiving the best evidenced-based care for mental health concerns. There is clearly a need for care on par with urban areas, yet treatment rates are low and rural residents are more likely to rely on medication rather than talk therapy. The rural community presents certain challenges in addition to the normal barriers to mental health care. Understanding these challenges is the first step in improving access to mental health care for rural children.

Methods

For this literature review, a search was conducted through ProQuest Dissertations & Theses Full Text, Education Research Complete, ERIC, PsycARTICLES, Social Work Abstracts, SocINDEX with Full Text, and PsycINFO. The keywords used for the article search were: *children, adolescent, school-aged, student, youth, rural, barriers to care, barrier, need, talk therapy, mental health, counseling, and psychologist*. The keywords *stigma* and *attitude* were added after being identified as potential factors in the initial review of the literature. This search was augmented with a manual review of references. Search parameters were limited to peer-reviewed articles, written in English, during the last decade, and focused on studies conducting original research that used their own data or conducted analysis of other data sets. A few studies targeting specific minority subgroups within rural communities were excluded as the articles found did not contain enough data directly related to access to mental health care for children. International studies that were conducted in developing countries were also excluded. After completing the search, common factors were identified from the articles. Articles selected for the literature review were those that focused on the experiences of school-aged (K–12) children, examined the ability of rural children to access mental health in rural communities, and included data about perceived barriers to mental health care.

Results

The initial search returned 2,909 results. Results were then narrowed to obtain empirical studies of children aged K–12, which returned 470 results. The authors reviewed the articles' abstracts and titles to select studies that focused on perceived barriers to mental health care for rural children. A separate search on ProQuest Dissertations, a database exclusive to doctoral dissertations, using the same methods and the same keywords as previous searches, produced two additional relevant studies. A review was then conducted of the references in identified studies and studies used for background information. Articles that primarily focused on non-rural populations or were unrelated to barriers to mental health care were eliminated. 12 total articles meeting the criteria for inclusion were found. From this literature review five factors were identified: (1)

belief, (2) family poverty, (3) school support, (4) community resources, and (5) awareness.

Identified Factors in Perceived Barriers to Care Belief

The attention mental illness receives in the media and the impact it has on the lives of millions of Americans makes it reasonable to assume that students and their parents have preconceived beliefs about mental health care. The review of the literature revealed that preconceived beliefs about mental health care and mental illness can create a barrier to care in rural communities. Beliefs about mental health care can be negative or positive, and they can serve to facilitate or hinder access to mental health care. For the purposes this review there are three identified subfactors related to belief – (1) trust of mental health providers, (2) stigma, and (3) attitude.

Trust of Mental Health Providers. Knowledge about a mental health issue is not just about recognizing the existence of a particular problem; it also requires believing in the validity of mental health treatment and trusting a provider to select the most appropriate treatment method. Mistrust of providers can be a significant problem in rural communities. Murphy (2005) found that rural parents had a significantly higher level of concern about the therapist/client relationship than the urban comparison group. In particular, these parents were unsure whether they could trust a mental health provider, and worried over how the provider would treat their children. This lack of trust of mental health providers can be compounded if the providers are not from the community, as rural residents may be suspicious of outsiders. The provider may need to become more involved in the community to win residents' trust (Bradley, Werth, & Hastings, 2011).

Stigma. Stigma associated with mental health issues has been identified as a major problem and a key reason why rural children often do not receive mental health care. Most of the studies reviewed mentioned stigma in one form or another (Anderson & Gittler, 2005; Boydell et al., 2006; Bradley, McGrath, Brannen, & Bagnell, 2010; Bull, 2011; Heflinger, Wallston, Mukolo, & Brannan, 2014; Lee, Lohmeier, Niileksela, & Oeth, 2009; Murphy, 2005; Pullmann, VanHooser, Hoffman, & Heflinger, 2010; Williams & Polaha, 2014). Several studies found stigma to be a significant barrier to mental health care. Others felt the need to address the effect of

stigma in the introduction or conclusion even if their study did not specifically investigate it.

The stigma associated with mental health has been found to create negative attitudes towards those with mental illness (Bull, 2011). Negative attitudes can begin in early childhood despite the fact that children often lack nuanced understanding of what mental illness is (Wahl as cited in Bull, 2011). Murphy (2005) noted that stigma could potentially be more of a factor in rural communities and suggested a useful approach to mitigate stigma associated with help-seeking by finding ways to integrate mental health services with less stigmatized services like routine medical check-ups. Boydell et al. (2006) mentioned that because mental illness is not always visible or obvious, people are likely to worry that others will not be as empathic towards them or will fail to view associated challenges as a legitimate disability. Taken together all of this suggests that stigma is a real concern for rural school-aged children.

A number of qualitative studies have sought to examine the effects of mental health care stigma on children in rural settings. In addition, these studies also provide key insight into how stigma is conceptualized among people in a small town. In a study of a system of care site funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Pullman et al. (2010) conducted a study of participants in the system of care using a qualitative interview guide to interview staff involved with the center ($n = 9$) as well as former patients ($n = 8$). Qualitative data analysis software yielded seven primary barriers to care, three of which were shared between staff and patients. The shared barriers were “stigma/close knit community,” “lack of transportation,” and “lack of money” (Pullmann et al., 2010). Another set of interviews conducted with 30 families by Boydell et al. (2006) indicated that families were worried about potential stigma associated with seeking mental health care and feared that there would be no anonymity in a community where everybody knows everybody (Boydell et al., 2006). In both studies, stigma is tied to the nature of the community, which highlights one of the unique aspects of the rural setting where sense of community can be stronger than in urban environments. Respondents indicated that their town was so small and close-knit that people would know who was seeking mental health counseling and this could be the cause of gossip.

Heflinger et al. (2014) noted that there was a lack of reliable instrumentation to study stigma. In order to study mental health stigma for children, Heflinger et al. developed the Attitudes about Child Mental Health Questionnaire (ACMHQ). The ACMHQ was developed by a panel of experts and examined by focus groups and cognitive interviews before piloting. The pilot study to test the validity and reliability of the ACMHQ was conducted in a rural clinic by handing out packets to caregivers of children being seen at the clinic ($n = 185$; Heflinger et al., 2014). The study produced a well-tested questionnaire, but it also identified some attitudes about mental health. The ACMHQ items with the greatest reported levels of stigma related to the perceived dangerousness and incompetence of a child with an emotional-behavioral problem, closely followed by the belief that children with emotional-behavioral problems are treated unfairly by other children and the belief that teachers do not want such children in their classroom (Heflinger et al., 2014).

Williams and Polaha (2014) piloted the *Parents' Perceived Stigma of Service Seeking* (PPSSS) instrument by testing it alongside several existing instruments administered simultaneously in two separate studies. Both studies were conducted by giving questionnaire packets to caregivers in a pediatric care clinic in rural Appalachia ($n = 347$; $n = 184$). A significant finding of these studies was that the more stigma parents perceived in their communities, the less willing they were to utilize mental health services for their children (Williams & Polaha, 2014). This relationship was true regardless of whether there was an existing mental health concern for the child or what the concern was. Together, these studies suggest that parents are less likely to seek help for a child with a potential mental health concern out of fear that the child might be judged to be incompetent or dangerous which could lead to unfair treatment. There are other aspects to stigma (such as the parents' fear of how *they* will be perceived), but, overall, these studies indicate how stigma can act as a barrier to care.

Attitude. Bull's (2011) study of rural and urban adolescents examined their attitudes towards mental health care. As a group, on average, rural and urban adolescents had somewhat negative attitudes towards mental health care (Bull, 2011). The most common barriers to care listed by adolescents, besides cost, were related to beliefs about mental health care. These barriers included: believing one can handle the

problem alone, believing one should be strong enough to handle the problem, and believing the problem will get better by itself (Bull, 2011). Rural cultural norms such as stoicism and self-reliance can prevent adolescents from accessing mental health services.

Family Poverty

The second identified factor in accessing care, family poverty, is related to all the direct and indirect costs associated with counseling. Mental health counseling for rural children can be expensive and paying for it means either parents or a third party has to produce the funds required to obtain or continue care. There are funds available for mental health care through third-parties such as insurance or government agencies, but this still leaves the problem of access to those services. In a rural community with high levels of poverty, a major problem is private transportation, as a family may not have their own vehicle and thus have trouble reaching a counseling office.

Family poverty, or the cost of services in general, as a factor was discussed in several studies. As mentioned earlier, the study by Pullmann et al. (2010) revealed that both parents and staff saw cost as a barrier to accessing care. Similarly, the study by Boydell et al. (2006) revealed that financial difficulties were a significant barrier to care. This difficulty included barriers unique to the rural setting, such as having to travel greater distances to access care, which could mean taking time off work as well as other travel expenses like food and gas. Also, Bull's (2011) study, which surveyed rural adolescents directly, found that cost was the most commonly cited barrier. Lee, Lohmeier, Niileksela, and Oeth (2009) found that educators listed parental involvement as the third most common barrier to care. The low rate of parental involvement may be related to cost as some parents may not have access to transportation to reach the school. Girio-Herrera et al.'s (2013) study is also relevant, as the fear that treatment would cost too much was the top barrier to care reported by parents in a study of rural kindergarteners.

School Support

The school system is a significant factor in rural students' access to mental health interventions and resources (Huber et al., 2016; Macklem, 2014; National Association of School Psychologists, 2015; Painter & Scannapieco, 2015). From the perspective

of a rural educator, Powell (2017), in her discussion of several equity barriers in rural school environments, noted:

Students live in a difficult and complicated world, and many factors in their lives are out of our control as educators. . . .It's hard work to shift our perspective from 'students being non-compliant' to 'students shutting down due to trauma,' but for me that mindset change has been revolutionary. By changing my perspective, I've rediscovered that a caring adult who builds appropriate relationships with students can become the key to their success. . . .[B]y listening to my students' experiences outside the classroom, I can serve as an advocate for them or point them towards solution partners such as guidance counselors or community health organizations. (para. 3, 6)

Teachers and student support services personnel, such as school counselors and school psychologists, can play significant roles in recognizing potential mental health concerns and taking appropriate and timely steps to address them (Dikel, 2014; Simon, 2016). However, school staff can face difficulties in recognizing and addressing these concerns. In a stratified random sample survey of national rural K–6 teachers, Lee et al. (2009) found that educators listed funding and staff retention as the biggest issues to providing mental health care for students ($n = 80$). The authors also found that lack of professional staff was a significant barrier. Bain et al. (2011), who surveyed school counselors, found that almost half (48%) of school counselors said that less than a quarter of their students were receiving adequate counseling services and 49% said that mental health services at their school were either poor or nonexistent.

However, student support services personnel (e.g., school counselors, school psychologists) in rural communities face a number of challenges. School administrators and mental health staff in rural communities have identified the treatment of mental health concerns such as depression and anxiety as a major area of need. In smaller schools, staff retention and lack of funding limit the services that school counselors can provide (Lee et al., 2009). Bain et al.'s (2011) survey of school counselors in rural Texas revealed that counselors are spending the majority of their time performing duties other than counseling such as administrative activities or academic advising. The school counselors in the study stated that there was a lack of mental health

resources in the community, leaving them without options for referring students. In fact, 59% of school counselors in the study rated the available mental health resources as either poor or nonexistent (Bain et al., 2011). The counselors also perceived a general lack of knowledge about mental health issues and listed this factor as the most prominent barrier to care. In addition, the majority of all school counselors (89%) said that they had experienced at least some degree of burnout (Bain et al., 2011).

With respect to improving mental health services, all of the counselors who were surveyed in Bain et al.'s (2011) study agreed that it would be beneficial to increase the number of mental health resources in schools in tandem with professional development opportunities related to mental health concerns for teachers and staff. When the school counselors were asked what would help improve mental health services in schools, the most common responses were hiring additional staff, implementing education and awareness programs, and reducing non-counseling-specific duties (Bain et al., 2011). As Blaber and Bershad (2011) observed:

Because many rural school districts often have difficulty finding local area mental health providers to work in the schools, they need to develop the capacity of existing school staff (e.g., school psychologists, social workers, counselors) to provide mental health services. In addition, because rural area mental health providers are often long distances away, schools need to have trained providers who are located onsite or nearby and can help students or families in the event of a crisis situation. (p. 17)

Community Resources

Community resources as a barrier to mental health care deals with the *lack of existing services* to facilitate access to mental health care. This can involve a lack of mental health providers in the area, a lack of public transportation to access providers, or a lack of community programs aimed at improving access. Access is a particularly relevant issue for rural communities, as smaller towns may have few mental health providers available. In an interesting approach to examining access, Murphy (2005) reviewed government websites, referral services, the phone book, and the local APA board to locate every available type of mental health provider in a sample of rural communities as well as a comparison group of urban areas. Although all areas had *some* mental

health providers, the urban areas had significantly more providers and the providers were easier to access. The rural communities, comprised of two counties, had a total of eight community mental health centers, *no* private practice psychologists, and some areas were more than 40 miles away from the nearest university-based clinic. This finding coincides with the data from Bull's (2011) study of adolescents in rural settings, who indicated that the lack of local mental health services was a significant barrier to mental health care access whereas the urban comparison group did not report this as a barrier.

The lack of providers is particularly worrisome considering adolescents' own reported preferences for treatment. In a survey of students from a rural high school about depression treatment, Bradley, McGrath, Brannen, and Bagnell (2010) found that students preferred counseling from a professional in a private office setting ($n = 156$). The students selected their preferred treatment, provider, and setting from a list of options and all three preferences were statistically significant. This is a significant finding because talk therapy from a professional in a private office setting might be particularly difficult for rural children to access. Furthermore, the authors of the study suggested that respecting the youth's treatment preference can increase compliance and response to treatment.

One important subcategory associated with the community resources barrier is the lack of any sort of public transportation infrastructure. Although it is not surprising that rural communities lack the same level of public transportation, it presents a significant challenge to rural residents. The participants in the study by Pullman et al. (2010, p. 216) listed "lack of transportation" and "lack of resources" as common barriers. One of the needed resources mentioned in particular was public transportation. Also, important to note is that some participants mentioned having to drive long distances to access care due to a shortage of providers in their area.

Awareness

There is one final identified barrier that plays a significant role in accessing mental health care; one that can prevent a child from accessing mental health care even if none of the other barriers are present. The final barrier is the awareness that a mental health issue exists. In order to access mental health care, one has to be aware of a potential mental health care issue that requires attention. For rural children, this means

that even if the child recognizes a problem and wants to seek help in many cases they also have to seek the approval of their parent. Knowledge is also an issue for school staff, who need training to recognize that a mental health concern exists.

Awareness can be a serious barrier to care; if a parent is unaware that there could be a mental health problem they are unlikely to seek care. In a study of kindergarteners in a rural community, Girio-Herrera et al. (2013) surveyed parents from 18 elementary schools in southeastern Ohio ($n=693$; 63% response rate) about their kindergartener. This study paired a barriers scale with two assessments that tested the children for mental health concerns. Out of all the participants in the study, 51.3% of children scored as either at risk – low, or at risk – high (Girio-Herrera et al., 2013). However, only 31.3% of parents of the low risk group and 37.0% of the high risk group reported that their children had a problem. Similarly, only 22.7% of the parents of the low group and 31.3% of the high group reported that their child had received any sort of help. It is important to note that the percentage of parents who recognized a potential problem for their child was very close to the percentage of children who received care.

Recognizing a mental health concern in a child can be a challenge, and this was identified as an area of concern in the research. Bain et al. (2011) surveyed school counselors in rural South Texas to investigate the mental health resource needs of the schools ($n = 27$). Although most counselors surveyed felt that mental health awareness was at least average at their school, mental health education and awareness were tied for first as the most mentioned item in an open-ended question about improving school mental health (Bain et al., 2011). The counselors surveyed also cited lack of knowledge as the top barrier to care. Additionally, most respondents (52%) listed parent's knowledge of mental health issues as poor (Bain et al., 2011).

Discussion

Research is limited in the area of barriers to mental health care for rural children, and much of the existing, limited research approaches rural health care from a deficit orientation. With an exhaustive database search of articles for this review, many located articles have some serious limitations, including perpetuating a negative bias towards rural communities by an overemphasis on shortcomings rather than opportunities. Other limitations of the

existing research include low response rates which may indicate lack of research strategies that engage rural populations effectively. The survey by Lee et al. (2009), for example, had a response rate of just 3% ($n = 80$). Likewise Murphy (2005) had a response rate of just 7.21% ($n = 232$). Survey response rates this low can significantly affect the generalizability of the study, because a substantial segment of the target population has been missed. Also, several of the studies reviewed were conducted at a single site, which introduces the possibility of confounding variables from the site itself. Further, many studies had small sample sizes. For example, in a nationwide survey Lee et al. (2009) had just 80 participants. The limitations of these studies point to the clear need for more research. In particular, there should be more mixed-methods, regional-level studies with larger sample sizes and urban comparison groups, and more effort on the part of researchers to engage rural populations in research.

The review of the literature made it clear that there are several barriers that come between a school-aged child and mental health care. The barriers include difficulty paying for services, stigma of mental health care, lack of infrastructure, and being able to identify a potential mental health concern. Two of the barriers, however, were more of an issue for rural residents. Several studies highlighted that stigma plays a huge role in preventing mental health care. Many of the articles reviewed mentioned that stigma is a larger barrier in small towns because the close-knit nature of the group means anonymity may be compromised and people may talk. Even if this is not true, and the treatment would be confidential, the fear alone is enough to keep some parents from taking their children to a counselor. Resources were also more of an issue for rural residents (Huber et al., 2016). Studies showed that rural communities have a lack of providers and a lack of public transportation. Clearly, rural residents face additional challenges in accessing mental health care, and this effect carries over to rural children. Yet many of the factors that make small towns and rural communities distinct from urban environments are the same factors that can contribute positively to increasing access to care among the school-aged children in those communities. These factors may include familial relationships and proximity, collectivist cultural values, close knit faith based communities, and values oriented toward resilience and self-reliance (Curtin & Hargrove, 2010; Elder & Conger, 2000; Larson & Dearthmont, 2002).

Implications and Directions for Future Research and Practice

An awareness of the barriers faced by rural residents, and rural children in particular, is vital for the counselor practicing in a rural community: (1) Counselors should know that families may have to borrow transportation and drive long distances to get care; and (2) they should also be aware that their clients may be worried about their privacy. This will help a counselor understand why their clients may be late frequently, or seem particularly nervous in the waiting room. Understanding the client's situation will not only give the counselor a better understanding of the client's context, but also potentially help them identify if there are accommodations they can make to improve their client's access to care. An awareness of these issues will also help the counselor advocate for their client by helping them to identify barriers and advocate for themselves (Bradley et al., 2011). Counselors must also be aware of how their own implicit biases about rural communities might impact their perception of their clients' symptom presentations.

The studies surveyed also pointed to some potential solutions. Bull (2011) suggested a need for more education targeted toward youth that addresses where to get help, the benefits of seeking help, and myths about help-seeking. In addition, both Bull (2011) and Pullman et al. (2010) indicated that specific, awareness-raising programs were needed for the broader community to help reduce the stigma associated with mental health care in rural communities. Girio-Herrera et al. (2013) pointed out that there is also a need for education for parents as well. Parents need to be educated about childhood mental health issues so they can recognize those issues and accept that counseling can be an effective treatment for their children. At the school level, Bain et al. (2011) suggested that families should be made aware of mental health resources in their area. It would be beneficial to create an educational program that reaches parents, teachers, students, and community members to address the following issues: (1) recognizing mental health issues in children; (2) reducing the stigma of help seeking in mental health care; (3) demonstrating the benefits of counseling; and (4) making everyone involved more aware of mental health resources available to them. As McWhirter, McWhirter, McWhirter, and McWhirter (2013) asserted: "When teachers, human service professionals, and parents collaborate in their efforts,

putting the needs of an individual child or one classroom uppermost on their agenda, they increase the effectiveness of their work" (p. 25). Furthermore, Painter and Scannapieco (2015) astutely observed, "Alliances between the school system and the mental health system will move us forward in addressing the prevention and treatment needs of children and families who are at risk of mental health issues" (p. 237).

Education is one key step in addressing this issue, but other steps are needed to address the lack of resources for rural children. One idea to help rural children reach counseling services is online counseling. Online counseling, also known as telemental healthcare (TMH; Hilty et al., 2016), is defined as, "the delivery of a therapeutic intervention by a trained professional to client(s) using synchronous or asynchronous computer mediated communication" (Richards & Viganó, 2013). Hilty et al. (2016) observed: "Most youth who obtain mental healthcare receive those services at school. School-based TMH is a logical progression in service delivery" (p. 292). Online counseling/TMH is a growing field, and a number of studies indicate that online counselors can achieve similar ratings on measures of working alliance as face-to-face counselors (Hilty et al., 2016; Richards & Viganó, 2013). Online counseling/TMH negates the need to for rural residents to travel great distances to receive care, and provides them with a greater choice of providers (Tamukong & Schroeder, 2017, p. 2). However, additional research should be conducted on this method of providing mental healthcare, and there is concern about the level of training practitioners receive specific to this service method, as well as associated informed consent practices and client privacy issues (Centers for Disease Control and Prevention, 2017; Hilty et al., 2016; Richards & Viganó, 2013; Stephan et al., 2016). Also, Tamukong and Schroeder (2017) noted that "growth in telemental health is also burdened by workforce supply challenges, issues with recruitment and retention, and high rates of un-insurance and under-insurance in rural areas" (p. 2). These concerns are to be expected, however, because online counseling/TMH is an evolving field. Overall, the practice shows promise for all, including rural residents (Comer & Myers, 2016; Hilty et al., 2013, 2016): "Continued efforts are needed in order to fully actualize the potential of children's telemental healthcare to optimize the quality and transform the accessibility of mental health services for all

children, regardless of income or geography” (Comer & Myers, 2016, p. 299).

The issue of recruiting and retaining mental health care practitioners in rural communities is also worth examining. Programs tying financial aid reimbursement for providers to rural residence have been shown to have a time-limited effect on medical professionals, but this does not appear to be a long-term solution (Daniels, VanLeit, Skipper, Sanders, & Rhyne, 2007). Desire to return to hometown and the practitioner’s desire to work in a certain sized community are the biggest factors in long-term retention, along with proximity to family (Daniels et al., 2007). If professionals are most likely to return to their hometown or live near their family, then training more professionals from rural communities might encourage them to work in rural communities. This suggests both financial incentives for practicing in rural communities and programs aimed at training practitioners from rural communities to serve their community could be potential solutions.

For rural communities that have a nearby college or university, there is also the option of university-based clinics. University-based clinics help provide low-cost or free counseling to the community and simultaneously help train counselors. One university clinic at Montana State University, for example, is able to provide counseling to more than 100 rural residents at a time, while simultaneously conducting ongoing research on the rural community (Smith, 2003). For communities that have the luxury of a nearby university, this option can be a great resource for the community.

Another key area of impact is research. Professional counselors are in a unique position to contribute to the body of research by acting as scientist-practitioners. Especially in a rural

community, contributions of case studies, surveys, or research collaborations with other counselors can provide valuable data. These data will help counselors, principals, administrators, and policy makers better understand the need of the community and how to best meet that need. In this way, research is synonymous with advocacy, and that is a concrete way to make a difference for rural children.

Furthermore, although it is encouraging that state policy makers have shifted more attention to the mental health needs of rural communities in recent years, an important element of a state’s plan for its mental health care system is consideration by policy makers of how the implementation of state-funded initiatives/programs may be supported differently in rural versus urban communities: “It is clear rural behavioral health programs with extensive community support tend to succeed and grow because improving behavioral health in rural areas is a community-wide effort” (U.S. Department of Health and Human Services, 2011, p. 22).

Conclusions

Rural children live in areas that are too often overlooked, but they make up a quarter of the nation’s students (Aud et al., 2013). For these students, mental health concerns often go unnoticed, and there is a known gap between need for care and receipt of care. There are many challenges to providing mental health care for these children, which include several factors: stigma, knowledge, cost, and resources. This literature review suggests that counselors, teachers, and other professional helpers must be aware of these barriers and that concrete steps can be taken to address them.

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