Rural Health Research
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Rural Health
Research Gateway

Rural Mental Health

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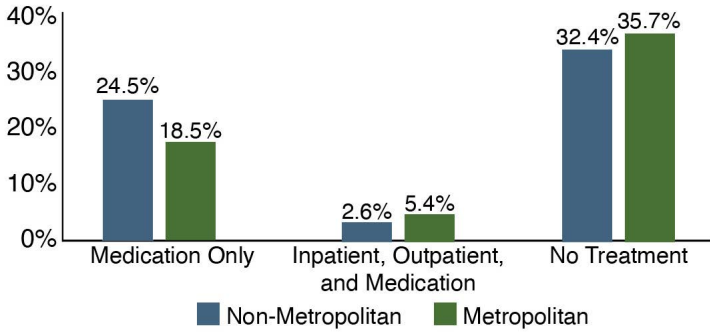
Funded by the Federal Office of Rural Health Policy (FORHP), under the Health Resources and Services Administration (HRSA), the Rural Health Research Gateway disseminates work of the FORHP-funded Rural Health Research Centers (RHRCs) to diverse audiences. This resource provides a summary of recent research, conducted by the RHRCs, on rural mental health.

Serious Mental Illness and Treatment

The National Institute of Mental Health defines serious mental illness (SMI) as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activity. An analysis of 2019 National Survey on Drug Use and Health (NSDUH) data found the prevalence of past year SMI was significantly higher among adults residing in non-metropolitan than metropolitan counties (5.9% vs 5.2%).[1]

Treatment receipt for SMI varied by location. A higher proportion of non-metropolitan than metropolitan (24.5% vs 18.5%) adults received only medication for treatment.[1] In contrast, a lower proportion of non-metropolitan than metropolitan adults (2.6% vs 5.4%) received inpatient, outpatient, and medication treatment services.[1] Approximately 32.4% of non-metropolitan and 35.7% of metropolitan adults with SMI received no mental health treatment in the prior year.[1] Regardless of location, the most commonly reported barriers to receiving mental health treatment among persons with SMI were not knowing where to go, a fear of being committed/medicated, and not having time for treatment.[1] Notably, a significantly higher percentage of non-metropolitan than metropolitan adults (11.6% vs 6.9%) reported that they did not seek treatment because they had no transportation or treatment was inconvenient.[1]

Figure 1. Treatment Receipt for SMI, 2019[1]



Major Depression and Treatment

The NSDUH defines major depression as a period of at least two weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities, and had a majority of specified symptoms, such as problems with sleep, eating, energy, concentration, or self-worth.[2]

A study using the 2017 NSDUH found that 7.8% of nonmetropolitan adults and 7.1% of metropolitan adults experienced major depression in the past year.[2] Although adults in non-metropolitan and metropolitan areas experienced similar rates of depression, non-metropolitan adults were more likely than metropolitan adults (58.2% vs 48.6%) to use prescription medication to manage depression.[2] Additionally, non-metropolitan adults were more likely than metropolitan adults (43.7% vs 34.5%) to see a general practitioner/family doctor, as opposed to a mental health specialist, for depressive states.[2] Among non-metropolitan adults with depression, fewer than 20% received treatment from a mental health professional.[2] This is likely because rural locations frequently lack mental health professionals and instead rely on general practitioners.[2]

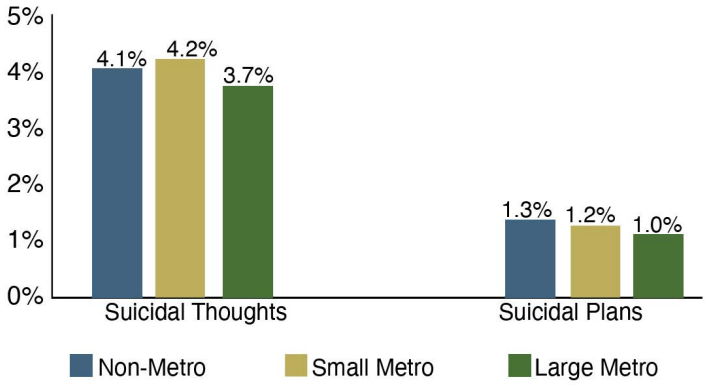
Suicidal Thoughts, Plans, and Attempts

A 2019 study using NSDUH data, for the years 2010-2016, examined suicidal thoughts, plans, and attempts among adults aged 18 years and older. The overall mean prevalence of suicidal thinking was significantly higher among non-metropolitan and small metropolitan adults than large metropolitan adults (4.1% vs 4.2% vs 3.7%).[3] Factors associated with lower prevalence of suicidal thinking included older age, higher income, and higher educational attainment.[3]

The overall mean prevalence of suicidal plans, for the years 2010-2016, was significantly higher among nonmetropolitan adults than small metropolitan and large metropolitan adults (1.3% vs 1.2% vs 1.0%).[3] Regardless of location, persons who were divorced or never married had higher odds of suicidal plans than those who were married.[3] In contrast,

both older age and higher income were associated with lower odds of suicidal plans.[3] The overall mean prevalence of suicidal attempts did not vary significantly by county type.[3]

Figure 2. Percent of Adults Who Experienced Suicidal Thoughts and Plans, 2010-2016[3]

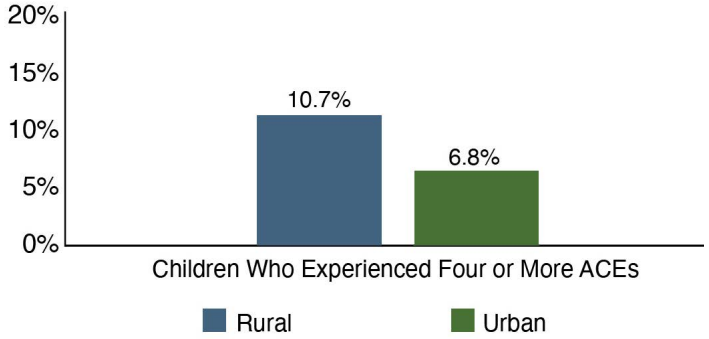


Adverse and Positive Childhood Experiences

Adverse childhood experiences (ACEs) are potentially traumatic events, such as neglect, household dysfunction, or abuse, experienced between birth and age 17, that have been linked to risky behaviors and poor physical and mental health in adulthood.[4] Positive childhood experiences (PCEs), such as a living within a nurturing environment, have been shown to combat the effects of ACEs in a child's development.[4]

Research based on the 2016-2018 National Survey of Children's Health compared ACEs and PCEs experienced by rural and urban children.[4] This study found that rural children were more likely to experience a variety of ACEs, including experiencing economic hardship, witnessing household violence, and living amongst household substance misuse, while urban children were more likely to experience racial/ethnic mistreatment.[4] Not only do the types of ACEs experienced differ between rural and urban populations, so does the amount. Children experiencing more ACEs are more likely to engage in actions that negatively affect their health.[4] Rural children were found to be more likely than urban children to experience four or more ACEs (10.7% vs 6.8%).[4] Rural communities often lack professional mental health care and treatment centers for substance use disorders, which may contribute to more ACEs in rural areas.[4]

Figure 3. Percent of Children Who Experienced Four or More ACEs, 2016-2018[4]



PCE exposure also differed between urban and rural children. Urban children participated in afterschool activities more frequently than rural children, but rural children were more likely to volunteer in their communities – both being measurements of social engagement.[4] Rural children were also more likely to live in a safe neighborhood (97.2% vs 94.5%) and a supportive neighborhood (59.8% vs 56.3%) than urban children.[4]

Several types of ACEs may be impacted by the COVID-19 pandemic, such as experiencing economic hardship or experiencing parental death. Future studies will be needed to assess the impact of the COVID-19 era.

Resources

1. Rural and Underserved HRC (2022). Serious Mental Illness and Mental Health Treatment Utilization Among Adults Residing in Non-Metropolitan and Metropolitan Counties, ruralhealthresearch.org/publications/1475.
2. Rural and Underserved HRC (2020). Major Depression, Treatment Receipt, and Treatment Sources Among Non-Metropolitan and Metropolitan Adults, ruralhealthresearch.org/publications/1348.
3. Rural and Underserved HRC (2019). Suicidal Thoughts, Plans, and Attempts by Non-Metropolitan and Metropolitan Residence, ruralhealthresearch.org/publications/1259.
4. Rural and Minority HRC (2022). Rural-Urban Differences in Adverse and Positive Childhood Experiences: Results from the National Survey of Children's Health, ruralhealthresearch.org/publications/1474.

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