**REFEREED ARTICLE**

# Mental Health Supports Lacking in Rural Canada: Schools an Effectual Entry Point

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***Abstract***

*Adolescents living in both rural and urban settings experience the same mental health care needs at similar rates, but those living in rural environments experience exacerbated consequences because of localized barriers to receiving support. These barriers are often summarized as the three A's: availability, accessibility, and acceptability. Because Canada has many rural and remote communities, it is important to implement effective interventions that address these barriers within the community context. Tiered intervention at the school level is one such intervention framework that produces positive results.*

The geographic location in which individuals reside can play an important role in their lives: it can determine the language(s) they speak, the seasons they experience, and the people they interact with. More importantly, this location can impact the adequacy in which they experience the social determinants of health such as mental health care. While all adolescents experience mental health disorders such as anxiety or depression at a similar rate (van Vulpen et al., 2018), those living in rural areas receive mental health services much less frequently than those in urban areas (O'Malley et al., 2018). The impact that this disparity has on a student may be detrimental not only during adolescence but into adulthood as well, which can put a strain on a country's social systems (Bronstein & Mason, 2016). The next step seems clear: provide better access to mental health care for those living in rural communities. This access needs to be responsive to the unique setting of these communities with a clear understanding not only of the consequences of untreated mental health concerns but additionally of the unique barriers that adolescents in rural communities have in receiving mental health care. Since the onset of mental health concerns tends to occur in childhood and adolescence and because most of this population accesses education through schools, mental health intervention through the system is an effectual and practical solution in rural communities.

## Considering the Consequences

Untreated mental health concerns can have a myriad of effects on adolescents and the societies in which they live, both immediate and into adulthood. On an individual level, adolescents can experience social-emotional, academic, and physical impairments such as academic failure, risky behaviours, health issues, and an increased risk of suicide (Wilger, 2018), which is the second leading cause of death in adolescents (Berryhill et al., 2022). When mental health concerns are left untreated, adolescents drop out of school at a rate of 37% (McCarter, 2019, p. 7), which can lead to future poverty, unemployment (McCarter, 2019), health issues, divorce, and single parenthood (Bronstein & Mason, 2016). On a societal level, the repercussions include higher affiliated costs and services (Michael & Jameson, 2017) when an adolescent finally seeks treatment, because mental health symptoms are aggravated (Wilger, 2018) and emergency services are often required (Michael & Jameson, 2017). This may also put more pressure on other services, such as child welfare systems (Michael & Jameson, 2017). When adequate care is not received and adolescents with mental health concerns drop out of school, this may lead to adult unemployment and poverty, which exacerbates the use of public assistance programs and incarceration (McCarter, 2019), putting

increased financial strain on a country. These are the consequences of untreated mental health concerns that are encountered by adolescents all over Canada.

Untreated mental health concerns are disconcerting for all who experience them, but the 30% of Manitobans living in rural areas (Statistics Canada, 2017) can expect consequences that are exacerbated by their location. This is because 15% of families living in rural communities also live in poverty (Puskar et al., 2006, p. 14) and students from low-income families can already experience lower rates of academic success and post-secondary education, including higher rates of dropout (Bronstein & Mason, 2016). For example, in 2016, 17% of Manitoba's rural population had less than a high school diploma and the highest level of education reached by 31% of the population was a high school diploma (Manitoba Government, 2021), compared to provincial rates of 14% and 83%, respectively (Statistics Canada, 2017). Rural students also experience higher rates of parents who work multiple jobs (Heitkamp et al., 2019) and lower rates of parental involvement (Michael & Jameson, 2017), which often accounts for higher student absenteeism and school attrition (Harvey & Clark, 2020). Outside of academics, adolescents from low-income families are more likely to encounter adverse childhood experiences including parental divorce, incarceration, mental illness, substance abuse, and violence (Rural Health Information Hub, 2021). As these adolescents become adults, they often experience decreased health care, lower quality jobs, lower life-expectancy (McCarter, 2019), higher rates of unemployment, obesity, opioid abuse, and mental illness (Berryhill et al., 2022). These are the exacerbated consequences for adolescents who face mental health challenges in rural communities.

While all of these statistics seem related more to poverty than to rurality (Michael & Jameson, 2017), this is still concerning because rural adolescents are less likely to seek assistance for mental health concerns (Nichols et al., 2017). It may also explain the increased rate of substance abuse (Bain et al., 2011) and the doubling of suicide rates for adolescents living in rural areas (Michael & Jameson, 2017). The severity of the ramifications of untreated mental health concerns of adolescents living in rural communities is evident and undisputed, so why is it that only 25-35% of children living in these areas receive mental health services (Bain et al., 2011, p. 2)? The answer can be found in the barriers to care that are faced by this group.

## Clarifying the Barriers

There is a tendency for society to view people with mental health disorders as dangerous or uncomfortable to be around, and those who experience mental health concerns often feel embarrassed about reaching out for assistance, especially adolescents who are highly motivated by the approval of others (Michael & Jameson, 2017). This makes it difficult for them to access mental health support. Adolescents living in rural communities face additional unique barriers that are often summarized by the three A's: availability, accessibility, and acceptability (Heitkamp et al., 2019).

Availability is the existence of appropriate health care (Wilger, 2018). While 50% of the world's population lives in rural areas, only 30% of health professionals practice in those areas (Bain et al., 2011, p. 2). Harvey & Clark (2020) described this population as "isolated and underserved" (p. 537), causing longer wait times for assistance. The shortage of mental health providers leads to missed or erroneous diagnoses and treatment, and can result in worsening symptoms requiring intensified treatment that comes with a higher financial burden (Michael & Jameson, 2017). This is because general physicians in rural areas are often used for all health care needs due to a lack of specialized professionals (Bain et al., 2011). General physicians are less likely to follow up with patients experiencing mental health concerns and there is an increased likelihood of prescribing medication in the absence of therapy, resulting in adverse side effects such as the discontinuation of medication, increased suicidal ideation, or death by suicide (Berryhill et al., 2022). Both the quantity and quality of trained professionals are inadequate in these areas (Bronstein & Mason, 2016).

Accessibility is the convenience of mental health services (Wilger, 2018), based on time, knowledge, transportation, and finances. Wait times to be seen by specialized professionals are often lengthy because of the limited availability of services (Michael & Jameson, 2017). This can make accessing the service unattractive. Knowledge of mental health is often termed mental health literacy (Enos, 2020), which is the belief and knowledge of mental health issues (Heitkamp et al., 2019). Without mental health literacy, the anticipation of support is dismissed and the knowledge of resources goes unknown (Bronstein & Mason, 2016). Transportation can be problematic, as well. Individuals living in rural areas must often travel longer distances for mental health services (Rural Health Information Hub, 2021). If those living in rural areas are also living in poverty, they may not have access to a private vehicle. This is not as substantial an issue in urban areas where there are often taxis, ride share programs, and public buses, but in rural areas these options may not be available. For example, in 2016, 35% of Manitobans did not have access to public transportation because they lived in rural locations that had no public transportation services (Statistics Canada, 2017). Furthermore, even if transportation and the costs associated with it were not an issue, individuals living in rural areas may lack insurance or the finances to utilize mental health services (McCarter, 2019). While one solution to the accessibility issue has been technology (such as telephone or video chatting), inconsistent telephone/internet connections, distrust of technology, and the importance of building a personal in-person rapport can be barriers in rural communities (Michael & Jameson, 2017). Also, even when these services are accessed, the rates of attrition in rural areas are higher than in urban areas (Michael & Jameson, 2017). This may be due in part to acceptability.

Acceptability is the willingness of the population to receive support (Wilger, 2018). In rural areas, the stigma of using mental health services is heightened (Nichols et al., 2017), usually a result of misinformation about mental health and mental health supports (Esters et al., 1996). Stigma affects use of service, even if services are available (Esters et al., 1996). Rural communities with denser social networks tend to be more self-reliant, see help-seeking behaviours as weak, and have a higher distrust of outsiders (Michael & Jameson, 2017). The idea of autonomy and self-care is often valued in rural communities, which may impede a family's willingness to seek out assistance (Esters et al., 1996) because they may fear being ostracized for seeking mental health services due to confidentiality/anonymity issues (Harvey & Clark, 2020). Some individuals fear that general physicians are not skilled in treatment (Michael & Jameson, 2017), and there may be skepticism around the purpose and effectiveness of treatment (O'Malley et al., 2018). They may also hold the belief that mental health issues are related to the justice system, not health (Michael & Jameson, 2017), and that when supports from outside of the community are available, treatment is not knowledgeable or culturally sensitive to the specific community's world views or ideologies (Berryhill et al., 2022).

Any of the individual A's may be an enormous barrier to acquiring mental health services by anyone regardless of their location, but the barriers faced by those living in rural areas are not usually limited to just one A. Rural primary care physicians in Saskatchewan and Manitoba listed both availability and accessibility to mental health professionals as the top two issues facing child and adolescent mental health care (Zayed et al., 2016). Any combination of the A's compound the justification for rejecting the services altogether, which puts adolescents living in rural communities at particular risk, because their young age magnifies each of the A's. This is the reason why intervention for this population must look different than it does for adolescents living in urban areas.

## Positing Interventions

Establishing mental health interventions suitable for adolescents living in rural communities requires the support to be easily accessible and readily available, and to include a teaching component that increases its acceptability. With schools being the hub of rural communities (Heitkamp et al., 2019), the place where students spend most of their time outside of the home

(McCarter, 2019) and the place where most adolescents in the community attend regardless of the type of mental health support they require (Michael & Jameson, 2017), a Multi-Tiered Systems of Support (MTSS) at rural schools seems to be the best fit for addressing these needs (O'Malley et al., 2018). MTSS is an evidence-based school system of support with three levels of intervention based on student needs (Wilger, 2018). Tier one is where universal school- or class-wide prevention supports, wellness and engagement promotion, and screening occurs (Michael & Jameson, 2017); tier two is the level in which targeted group intervention and further needs-based assessment take place (Berryhill et al., 2022); and tier three is where intensive individualized support is provided (O'Malley et al., 2018).

The promotion of mental health and identification of risk factors in tier one requires classroom teachers and school counsellors to be literate in mental health because they are the people who are most likely to notice mental health concerns in adolescents. Teachers are often attuned to behavioural differences from "typically presenting" same-aged peers (Michael & Jameson, 2017, pp. 4-6). School counsellors and classroom teachers who have had adequate mental health literacy training can implement interventions such as Social Emotional Learning or Positive Behavioural Interventions and Supports, which have positive impacts on academics, behaviours, and social-emotional well-being, including increased feelings of belonging and connectedness with the school and staff, which influences academic and social-emotional success and is also a protective factor against depression (Michael & Jameson, 2017). Promoting mental health in schools also reinforces the normalization of help-seeking behaviours, which results in reduced stigma associated with poor mental health (Michael & Jameson, 2017) and more positive attitudes about mental health and help-seeking behaviours (Esters et al., 1996). The successful identification of risk factors associated with poor mental health or mental illness requires that school staff be appropriately trained in child development, wellness promotion, social determinants of health, culture, and context (Michael & Jameson, 2017). Understanding these factors and implementing tier two intervention with these students leads to earlier identification of mental health issues (Michael & Jameson, 2017).

In tier two, the at-risk individuals identified in tier one are the target population for intervention. These students typically present with symptoms of failing mental, academic, social, or emotional health (Michael & Jameson, 2017, p. 50), but are not currently experiencing severe mental concerns or illness. Group intervention can be led by school counsellors and can follow a prescribed process such as Cognitive Behavioural Therapy or mindfulness. These interventions can give adolescents the tools they need to improve their mental health and well-being, and may ultimately negate the need for more intensive support.

Students who require the intensive, individualized support in tier three typically present with mental illness such as depression and anxiety (Michael & Jameson, 2017). Students in tier three benefit from collaboration with community agencies, which decreases the single burden of either the school or agency of dealing with all the mental health issues of adolescents. The different systems can also provide support to each other (Bronstein & Mason, 2016), and in fact must, because psychotherapy and medication together have the best results for depression and anxiety in adolescents (Berryhill et al., 2022). While trained school counsellors can provide students who require tier three intervention with individualized therapy, collaborating with community agencies and families will enable students to receive the holistic support they require. This leads to improved mental health, social performance, and academic success of the student (McCarter, 2019), and decreased individual and government costs associated with mental illness (Michael & Jameson, 2017).

Adopting MTSS has resulted in a two-fold increase in the access of mental health supports by adolescents in rural communities (Berryhill et al., 2022). Families are more likely to follow through with treatment when the school is involved (McCarter, 2019), which is important because when parents are involved outcomes are more favourable for students in both mental health and academics (Michael & Jameson, 2017). If the argument ever arises that schools are not the place to support mental health – that they are solely a place to improve the academic

skills of adolescents – it is important to remember that mental health can affect academics (Michael & Jameson, 2017). Another strong case for MTSS in schools is that almost 80% of student in rural communities access mental health supports only in an educational context (Nichols et al., 2017, p. 39). Thus, while schools remain the central institution for academic education of adolescents, they are also the place where social-emotional learning in the context of MTSS should occur because schools are able to provide developmentally appropriate treatments to adolescents (Wilger, 2018) in a comfortable, familiar, youth-friendly environment.

## Conclusion

The geographic area wherein people reside can have a great impact on many crucial elements in their life. For adolescents living in rural areas, the struggle to get support with mental health can have significant negative consequences for their current and future existence. These consequences can be intellectual, social-emotional, physical, and/or behavioural. The challenges that adolescents living in rural areas face in receiving support for mental health are not the same as those faced by their urban counterparts and can be summed up by the three A's: availability, accessibility, and acceptability. The factors that make up these A's must be considered when planning culturally sensitive intervention. MTSS is one approach that has been met with success when implemented in collaboration with the community because it takes into account the unique consequences and barriers of students who need specialized supports. Because nearly all school-aged Canadians already access community schools, they can be a powerful locus for closing the gap of inequitable mental health services support between rural and urban adolescents.

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