

1998

## Editorial: Take Me Home, Down Country Roads

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### Recommended Citation

Ronnau, John (1998) "Editorial: Take Me Home, Down Country Roads," *Journal of Family Strengths*: Vol. 4: Iss. 1, Article 4.  
Available at: <http://digitalcommons.library.tmc.edu/jfs/vol4/iss1/4>

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## Take Me Home, Down Country Roads

Those of us committed to the tenets of Family Preservation must advocate for increased awareness and attention to the needs of children and their families in rural America. "Country roads" and the rural spaces they traverse have been eulogized by many poets and song writers as ideal places to live. But they may not be ideal for everyone. The past few months, it has become all too evident that rural America is not immune to acts of extreme violence by troubled children. Even though almost 1/3 of American youth live in rural areas, they have been "virtually ignored by mental health service planners and providers" (Cutrona, Halvorson, & Russell, 1996, p. 217). Mental health risk factors such as poverty, parental alcohol abuse, and family instability are on the rise in rural areas, and there has been an increase in suicide attempts, family violence, depression, and alcohol abuse (Cutrona, Halvorson, & Russell, 1996; Petti & Leviton, 1986; National Mental Health Association, 1988). Native Americans are especially concerned about the increases in child abuse and neglect, depression, substance abuse, and suicide in their communities (Edwards, 1989).

The mental health needs of youth in frontier counties may receive even less attention. A population density of less than 7 persons per square mile is necessary to earn the designation of "frontier." Fourteen states meet the criteria for either Categories I or II in relation to their frontier populations. Category II states are those with 5 to 14% of their population in frontier counties or with a total frontier population of greater than 250,000. Among the Category II states are New Mexico, Utah, Nevada, Arizona, Colorado, and Texas (Ciarlo, Wackwitz, Wagenfeld, & Mohatt, 1996). The mental health needs of children and youth in frontier communities are typically less attended to than urban youth for several reasons. First, limited financial resources are allocated to meet the mental health needs of young people, especially in rural communities. For example, the Utah Legislature has appropriated enough funds through the state's Community Mental Health Centers (CMHCs) to meet the needs of only 1% of the state's children and youth, but it is estimated that 9-11% of the state's youth may suffer from severe emotional disability (SED) (Federal Register, 1997). Secondly, some of the same characteristics which are the strengths of rural communities (self reliance, conservatism, distrust of outsiders, religion, work orientation, individualism) may contribute to misconception and mistrust of mental health services and a reluctance to identify problems (Kelleher, Taylor, & Rickert, 1992). The third reason is that, too often, attempts are made to impose urban models for conceptualizing and delivering mental health services in rural communities. These models may be contrary to community values, natural support systems, local policy making, and administrative structures. The fourth reason is that it is very difficult for many in rural communities to access mental health services. Qualified providers, if they exist at all, may be located one to six travel hours away. Choice among providers is extremely limited. In many areas, there is only one part-time staff member who is expected to serve both children and adults. And finally, lack of cultural competence among mental health service models and providers may be an impediment.



Contrary to the stereotypes, there may be considerable ethnic and cultural diversity in rural areas. For example, there are 44 different tribes represented in the Salt Lake Valley alone. There are approximately 30,000 members of the Navaho, Ute, Paiute, and Shoshone bands in Utah. About 1/3 of these people reside in rural areas. Another 1/3 move back and forth between urban and rural areas, depending upon the season and work opportunities. Children in families that migrate to obtain work are at a particularly high risk for serious psychiatric problems (Kupersmidt & Martin, 1997). Rural communities may include many other diverse groups with strong social, religious, and political values. Polygamists, environmentalists, ranchers, farmers, and those seeking isolated living environments are but a few examples. The use of natural supports, local resources, and non-traditional services, such as traditional healers, are essential for reaching these groups. Rural communities have many strengths due to their geographical location, cultures, and heritage (e.g., historically strong networks, strong sense of community, recognition and knowledge of community members, informal resources).

There is no single solution or program that will meet the needs of all children and youth with emotional problems in rural communities (Cutrona, Halvorson, & Russell, 1996; Kumpfer, Molgaard, & Spoth, 1996). Any viable response to meeting the needs of youth with SED must be community based and holistic in nature. While research on child and adolescent mental health services is limited, two key issues have been identified. First, providing mental health services to children and youth is a complex challenge because of the "multiple points of entry into care, number of agencies involved, family roles, organization of public sector services, child maturation and development, and lack of consensus on diagnostic categories and treatment modalities" (Kelleher, Taylor, & Rickert, 1992, p. 841). Secondly, the reality is that "most youth with mental disorders are under- or inappropriately served by the current system" (Kelleher, Taylor, & Rickert, 1992, p. 842). Poverty and family disruption are becoming increasingly more common among rural youth, leading to increased numbers of health risk factors, including suicide attempts, family violence, depression, and alcohol abuse (Kelleher, Taylor, and Rickert, 1992).

Based upon their model for rural children's mental health services, Sawyer and Moreines (1995) contend that "the fundamental requirements of a rural model include the ability to identify clients and their needs, ensure access and accessibility of services, creatively and effectively use the limited number of trained professionals and resources available, and coordinate an efficient communication system" ( p. 598).

Kumpfer, Molgaard, and Spoth (1996) have identified eight principles "for best practices in family programs." Four of these principles are especially pertinent to the tenets of the family preservation approach. The authors assert that to be effective, family programs must be: 1) comprehensive; 2) family focused; 3) long term; and 4) tailored to target populations' needs and cultural traditions.

For many families in rural America life is idyllic: clean air, open spaces, little traffic, and friendly caring neighbors. But for families caring for a member with a severe emotional disability, rural living may not be so grand. Essential services and providers simply may not be present in the community. Well meaning family and neighbors cannot provide the specialized and intensive resources which the youth needs. These families are often left largely

on their own to cope. If the trip home on country roads is to be a happy one for families caring for a child with SED, they will need lots of support. Social workers and other helping professionals working in rural areas face unique challenges in providing that support. They are often required to be “generalists” in the best sense of the term (Landon, 1999). Family preservation in rural areas, especially in rural frontier communities, is a very challenging job, which deserves more of our attention and resources.

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