



Some Summary Data on Rural Mental Health

(These tables are reproduced from “Rural Mental Health and Substance Abuse” by David Hartley, Donna Bird and Patricia Dempsey in *Rural Health in the United States*, ed. Thomas C. Ricketts, III, Oxford University Press, 1999. The chapter, and the book, were written with support from the Federal Office of Rural Health Policy, Health Resources and Services Administration, USDHHS)

In general, urban and rural areas do not differ in the prevalence of mental illness.

TABLE 14.1
LIFETIME AND 12-MONTH PREVALENCE OF PSYCHIATRIC* DISORDERS
BY URBANICITY, 1991 (percent of respondents with problem)

		Any Affective Disorder	Any Anxiety Disorder	Any Substance Use Disorder	Any Disorder
National Average	12-month	11.3	17.2	11.3	29.5
	Lifetime	19.3	24.9	26.6	48.0
Rural (n=2000)	12-month	10.0	16.6	10.6	28.6
	Lifetime	16.7	25.2	25.3	46.2
Other Urban (n=607)	12-month	10.9	19.1	11.8	30.8
	Lifetime	19.4	25.2	27.2	48.6
Major Metro (n=5491)	12-month	11.8	17.2	11.5	29.7
	Lifetime	20.2	24.8	27.0	48.6

Kessler, et al. The University of Michigan Institute for Social Research, The National Comorbidity Survey

* According to University of Michigan Composite International Diagnostic Interview and DSM-III-R.
 Rates shown are weighted percentage of those responding to National Comorbidity Survey, 1991, N = 8098.

TABLE 14.2
ADULTS 18 AND OLDER REPORTING MENTAL HEALTH PROBLEMS
BY URBANICITY (percent with problem)

Urbanicity	Major Depressive Episode	Generalized Anxiety Disorder	Agoraphobia	Panic Attack
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Large metro	6.6	1.6	1.5	2.2
Small metro	7.8	2.0	2.1	2.9
Non-metro	7.2	1.8	1.6	2.1

Substance Abuse and Mental Health Service Administration
National Household Survey on Drug Abuse, 1995

One notable exception to the absence of urban-rural differences in the prevalence of mental health problems is the significantly higher rate of suicides in rural areas. Recent publications by the National Association of Rural Mental Health (NARMH) have suggested that constant stress associated with the uncertainty of fragile rural economies in fishing, mining, forestry and agriculture may contribute to rural suicide rates.

TABLE 14.3
ADULT* SUICIDE DEATHS BY REGION AND URBANICITY, 1995

Region	Metro		Non-Metro	
	Number	Rate per 100,000	Number	Rate per 100,000
United States	22,351	14.91	6,694	17.94
New England	973	11.40	222	17.49
Mid-Atlantic	2,851	11.20	351	14.58
East North Central	3,176	12.97	973	15.32
West North Central	1,158	15.10	873	16.47
South Atlantic	4,437	16.36	1,268	17.96
East South Central	1,060	16.17	822	16.78
West South Central	2,463	16.22	857	18.20
Mountain	1,850	23.59	818	26.94
Pacific	4,383	16.19	510	22.34

* People 20 years of age and older
Unpublished Data from The National Center for Health Statistics,
Vital Statistics System, and The Bureau of the Census

The higher rate of suicide in rural areas can be observed among children and adolescents, as well as adults. A recent study from the National Center on Addiction and Substance Abuse at Columbia University reports higher rates of drinking and drug abuse in rural areas than in large urban centers. Such high risk behaviors by rural youth are consistent with these high suicide rates, and may be another facet of the prolonged stress on rural families cited by NARMH.

TABLE 14.8
CHILD AND ADOLESCENT* SUICIDE DEATHS
BY REGION AND URBANICITY, 1995

Region	Metro		Non-Metro	
	Number	Rate per 100,000	Number	Rate per 100,000
United States	1621	5.60	599	7.45
New England	65	4.50	15	8.00
Mid-Atlantic	178	3.97	26	5.40
East North Central	234	4.76	111	8.23
West North Central	115	7.22	87	7.43
South Atlantic	265	5.50	91	6.41
East South Central	90	7.01	70	6.55
West South Central	241	7.05	75	7.10
Mountain	146	8.80	91	11.76
Pacific	287	5.38	33	6.89

* People 10 to 19 years of age

Unpublished Data from The National Center for Health Statistics, Vital Statistics System, The Bureau of the Census

Despite the need indicated by these data, there are severe shortages of mental health practitioners in rural areas. For example, of 518 Mental Health Professional Shortage Areas designated by the Bureau of Primary Health Care, three-fourths are rural. The table below demonstrates the dramatic urban-rural differences in the distribution of psychiatrists, the only mental health profession for which accurate national data indicating practice location are available.

Table 14.18 Distribution of Psychiatrists Engaged in Patient Care by Region, Urbanicity, and Practice Location

Region	metro			non-metro		
	number	rate per 100,000	% office-based	number	rate per 100,000	% office-based
United States	30,977	14.6	78.7	2,046	3.9	72.3
New England	2,950	24.4	78.7	183	14.4	77.6
Mid-Atlantic	7,352	21.1	72.4	202	6.0	64.9
East North Central	3,923	11.3	80.3	293	3.3	72.7
West North Central	1,374	12.6	79.6	250	3.3	64.4
South Atlantic	5,209	13.8	78.2	430	4.3	69.1
East South Central	1,043	11.2	77.9	163	2.4	79.8
West South Central	2,250	10.0	83.2	130	1.9	70.0
Mountain	1,349	11.5	82.7	189	4.4	78.3
Pacific	5,527	14.3	83.6	206	5.6	81.1

Source: American Medical Association Physician Masterfile, 1996

It is unlikely that large numbers of psychiatrists will decide to move to rural areas to address this shortage. Neither is it a certainty that increasing the supply of mental health

practitioners will fully address the problems indicated by the high rural rates of substance abuse and suicide. However, these professionals are a key element in the infrastructure of services and support that is needed to begin to address these problems.