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"It's a common belief that people who see a therapist or psychologist are crazy" : a study of mental health care in Wyoming

Julie Anne Joy
Smith College

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ABSTRACT

This study was undertaken to highlight the barriers to mental health treatment, and the innovations combating these barriers for men in the state of Wyoming. Chapter I provides foundational information regarding the state of Wyoming and the current mental health and substance abuse treatment services available. Chapter II is a comprehensive examination of the rural mental health literature. Chapter III focuses on mental health treatment gaps in Wyoming, and the feedback received at the state level from providers and consumers. Innovative approaches to bridging the gaps in treatment in Wyoming and the Western United States region are described. The Discussion has a topology of key problems identified and possible solutions to improving the barriers to quality, professional mental health care in Wyoming.

"IT'S A COMMON BELIEF THAT PEOPLE WHO SEE A THERAPIST OR PSYCHOLOGIST ARE CRAZY": A STUDY OF RURAL MENTAL HEALTH CARE IN WYOMING

A project based upon an independent investigation,
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Julie Anne M. Joy

Smith College School for Social Work
Northampton, Massachusetts 01063

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CHAPTER I

INTRODUCTION

The purpose of this research paper is to explore the challenges to the delivery of professional mental health services in the sparsely populated, state of Wyoming. There are quantifiable barriers to services for Wyoming's population, such as a lack of qualified professional mental health counselors and doctors, and in addition, there are psychological barriers which keep rural citizens from seeking professional help when experiencing mental health difficulties or crises. This paper will examine all known barriers and challenges to professional mental health care specific to the target population, Wyoming men. Males were chosen as the focus of this work because this population is at the greatest risk for severe mental health problems if these individuals are not treated with professional help: in Wyoming, 4.1 men die by suicide for every woman, and overall Wyoming ranks as the U.S. State with the fifth highest rate of suicide (Powell, 2008). This is in great contrast to Wyoming's ranking as the least populated state in the nation (Powell, 2008).

The challenges facing mental health care in Wyoming are many, yet innovations aimed at improving the mental health landscape in the state are being advanced. Service delivery to rural and frontier areas is being expanded through the use of technology, new Medicaid-approved services such as Peer Specialists have being implemented, and there are efforts in place to make services both client and community-specific. These innovations to the mental health field and other promising programs will be further examined within this research paper.

An in-depth study of mental health services in Wyoming cannot be adequately undertaken without the inclusion of a thorough examination of substance abuse issues among this population. As such, the availability of substance abuse services in the state, and the relationship between substance use and mental health difficulties will be further examined within this paper.

Wyoming, the "Cowboy State", is home to majestic Yellowstone National Park, Grand Teton National Park and the Devil's Tower. What the tourists don't see on their family vacations is that the state's population is grossly underserved by professional mental health and substance abuse services, and the challenges to the delivery of such services in Wyoming is even more obscure to the outsider.

This paper will serve to illuminate these obscurities for the citizens of Wyoming and the policy makers who are positioned to impact this situation. It is my objective to shine light on the barriers to mental health care for Wyoming men and the innovations to improving services so that positive change can impact this at-risk and often-overlooked U.S. population.

Because Wyoming is the least populated state in the country, most research has been conducted outside of the United States in countries with large rural populations such as Australia. As such, a substantial proportion of the rural mental health literature referenced in this paper will be Australian and European-based. Understanding Australian and European-based rural mental health research and advancements is foundational for a better understanding of Wyoming, since all rural areas share some common characteristics.

As researchers we need to ask how an international study can be adapted to fit a target population, and how another study's results and conclusions may apply to our own work. How are the findings of work conducted in Australia similar to those findings for U.S.-based research? How are such findings different?

This paper will include The United States and international rural mental health literature that serves to answer the question of what Wyoming's challenges to providing professional mental health services are, and what innovations are improving this circumstance for current and future generations of the state's citizens.

CHAPTER II

BACKGROUND OF RURAL MENTAL HEALTH SERVICES IN WYOMING

As introduced in Chapter I, the delivery of mental health services in rural Wyoming is challenging. A later chapter will investigate the challenges and the innovative strategies to the delivery of culturally competent, professional mental health services to men living in Wyoming. Chapter II is structured to inform the reader as to *why* the delivery of mental health services is challenging in Wyoming. After a brief definition of the terms used in this document, the realities of rural life will be presented with representations of the culture and demographics of the state's population. The predominant mental health and substance abuse problems in Wyoming will also be examined in this chapter. Lastly, the phenomenon of how rural Wyoming men receive help and from whom they receive this help will be presented.

Definition of terms

In this research the terms "rural", "frontier" and "stigma" are often used. *Rural* is defined by the U.S. Census Bureau definition which states that any area with a population less than 50,000 is belonging to the rural end of an urban-rural continuum (Davenport & Davenport, 2008). Using this definition as a starting point, rural is further narrowed down for the purposes of this paper. Rural areas or communities are herein understood as small-scale, low density settlements within counties with less than 50,000 people. Rural areas are distinct from urban centers in physical distance as well as cultural and social isolation and, lastly, rural communities lack the diversification of industry found in urban locations (Davenport & Davenport, 2008). *Rurality* is defined as being of rural quality or character (Oxford English Dictionary, 1989). *Frontier* is defined as a county which has

fewer than six people per square mile (Wyoming Department of Health, Office of Rural and Frontier Health Division).

The American Heritage Dictionary of the English Language (4th ed.) defines *stigma* as "A mark or token of infamy, disgrace, or reproach" (2000). There exists great stigma towards mental health problems in the U.S. and this stigma is amplified in rural areas such as Wyoming. This concept will be discussed further throughout this research work.

Understanding Rural and Frontier Wyoming

The Statistics

Wyoming's total population is approximately 522,830 (Powell, 2008) and only two counties, Laramie and Natrona, have populations exceeding 50,000 (United States Department of Agriculture Economic Research Service, 2007). Wyoming is the least populated U.S. State (Powell) and 17 of 23 Wyoming counties are classified as frontier (Wyoming Department of Health Office of Rural and Frontier Health Division). In Wyoming 47% of citizens live in frontier areas of the state. All areas within the state are rural with the exceptions of the capital of Cheyenne and the city of Casper (Wyoming Department of Health Office of Rural and Frontier Health Division) and there is an average of 5.4 people per square mile (Powell).

Of the state's population 24% is under 18 years old and 12.2% is aged 65 or over. According to the 2007 U.S. Census, 87.3% of the population is White only (non-Hispanic), 2.3% is Native American only and 7.3% is Hispanic or Latino (Powell, 2008).

In the state of Wyoming 53.2% of households are heading by heterosexual married couples and only 5.8% of homes are single-female headed homes with children younger than 18 (Powell).

Wyoming's population increased 8.9% in the ten years from 1990-2000 and the majority of this growth, 55.2%, was in rural areas outside of incorporated towns and cities (Taylor, n.d.). The annual increase from 2005 to 2006 resulted in the all-time largest population in the state with an increase in 6,206 persons, or 1.2 percent (Liu, 2006). During this time (2005-2006) Wyoming's growth rate was faster than neighboring Montana, South Dakota and Nebraska but slower than Colorado, Utah and Idaho (Taylor).

The Federal Government owns 42.3% of the land in Wyoming and this statistic includes the 96% of Yellowstone National Park which is in Northwestern Wyoming. The entire park is 3,472 square miles (National Park Service). Also owned by the Federal Government are Grand Teton National Park, Devil Tower National Monument and numerous National Forests and National Grasslands within the state.

Of the population aged 25 and over, 91.1% hold a high school Diploma or higher and 20.8% hold a Bachelor's degree or higher. The University of Wyoming has an enrollment of over 12,000 with a 4-year graduation rate of 22.3% (Powell, 2008).

The state's crime rate is one of the lowest in the nation, ranked at the 47th state, however, the crime rate per 100,000 persons is ranked at the 32nd nationally. The murder rate is low (45th), yet the rapes per 100,000 persons is higher and places Wyoming 36th among the States. Aggravated assaults per 100,000 persons is also high, placing 30th and

larcenies and thefts place the state in 22nd place nationally. The prisoner incarceration rate per 100,000 persons coincides at the 25th spot nationally (Powell, 2008).

The Wyoming teenage mother data shows the state is ranked as 15th in births per 1,000 teenage women (aged 15-19). The over-all death rate in the state is also high and places Wyoming at 23rd nationally. Most alarmingly for the least populated state is that Wyoming's suicides per 100,000 persons (reported) is 17.4% or 5th nationally (Powell, 2008). This statistic is for 2004 and has gone down significantly from the previous year when Wyoming led the nation in suicides at a rate of 21.8 deaths by suicide per 100,000 persons (Bittner, 2007).

The Context

Popular film and literature have often depicted the American West as a wide-open, opportunistic landscape of independent-minded men and women. One sees hard-working, stoic people laboring in the hot sun all day and enjoying the simple pleasures. Rural life is often thought of as idyllic and care free, or at least simpler and free of the stresses of more metropolitan living.

So what is real and what is myth? Harland Padfield, author of *The Dying Community* wrote, "It is a fundamental illusion of American culture: the persistent celebration of rural life in the midst of its destruction" (as cited in Davidson, 1990, p. 1). Qualitative research reveals numerous contradictions to idyllic constructions of rurality and the major concerns facing all American also face rural citizens; affordable housing, low pay, poor-quality jobs and a lack of transportation to work and other services are dominating concerns (Boyd & Parr, 2008). Additionally, social isolation is no myth in

rural areas and idyllic notions of communities banding together to support each other in times of need is often not accurate.

By some measures, Wyoming is faring better than other rural states. While one in six people in Iowa are living below the poverty line (Davidson, p. 3, 1990), the situation is slightly better in Wyoming, as 9.4% of the population is below the poverty line (Powell, 2008). Wyoming, unlike many of its neighbors, has a diversified economy. The largest sectors are the mineral extraction industry and tourism. Over $14 billion taxable values in mining and over $1 billion in revenue from tourism were recorded in 2007 (State of Wyoming, n.d.). The state is the national leader in coal production and is ranked 5th in natural gas production, and 7th in crude oil. Additionally, the state is the home to the largest known reserve of Trona in the world. Trona is utilized in the production of glass, paper, soap, baking soda, water softeners and pharmaceuticals. While agriculture is not as large a sector of the Wyoming economy as it has been historically, in 2007 there was over $100 million in agriculture production which includes the state's main agricultural commodities of livestock (beef), hay, sugar beets, grain (wheat and barley) and wool (State of Wyoming).

Wyoming's Economic Summary Report for the fourth quarter of 2008 tells the story of a state surviving the national economic downturn relatively well. Job growth (due primarily to the mining sector) was up 3% from a year before, making it the fastest growing in the nation. Unemployment decreased slightly to 3.2%, less than half of the national average of 6.8%. Yet the drop in the price of natural gas was felt in Wyoming with some producers cutting back on exploration and production, thus increasing

unemployment insurance claims to the highest rate in decades, at a 46% increase from a year before (State of Wyoming Department of Administration and Information).

In terms of personal income, the Summary Report details that individual income declined 0.5%. This contraction was the first since 1994 and is mainly attributed to the drop of almost $200 million in dividends, interest, and rental income. While building permits and home sales were down, the entire year of 2008 saw home prices in Wyoming grow 3.5%, which was the second highest in the nation. Foreclosures are low, in part due to minimal exposure to subprime mortgages, low levels of household debt and a good labor market, although this situation is quickly worsening. From 2006 to the present there has been an exemption on the sales tax on groceries, yet there was still an increase in total sales and mining industry "use tax" collections in late 2008 due to heightened mining activities since the previous year. In terms of agriculture, ranchers suffered losses in late 2008 due to a decrease in the price of livestock and an increase in fuel and corn costs (State of Wyoming Department of Administration and Information).

Mental Health

The poor economy is taking its toll on the mental health of Wyoming's citizens. Causal relationships between poor economic times and poor psychological health have been examined by two researchers, Dooley and Catalano (1984), who sought to answer the question "if the poor economic environment causes increases in psychological disorders, and if so, how and to what extent" (p. 389). They drew on the "life event" research work of Barbara Dohrenwend and conducted a longitudinal, qualitative study in the Los Angeles metropolitan area and found that mental health symptoms varied positively with undesirable economic life events (p. 400). In Wyoming, Alice Russler,

executive director of Yellowstone Behavioral Health in Cody, is among those who see the struggling economy resulting in deteriorating mental health and coping capacity: "It's stress, it's basically a lot of stress." She said recently in an interview for Casper's *Star Tribune* newspaper. She continued, "A lot of it is fear over what is going to happen" (Heinz, p. A3).

When the stress of the current economic crisis is not controlled for, rural and urban populations have similar incidences of mental health problems (Office of Rural Health Policy [ORHP], 2005; Rost, Fortney, Fischer, & Smith, J., 2002). These problems include all Axis I and II diagnoses found in more urban United States populations. In rural America, when and *if* an individual's mental health difficulties are recognized, is another question. Kleinman, as cited by researchers Rogler and Cortes (1993) wrote, "The experience of illness (or distress) is always a culturally shaped phenomenon" (p. 556). Sears and Evans, (as cited in ORHP) found 34-41% of patients at rural primary care settings had a mental health disorder. Moreover, Rost et al. point out that rural individuals report more chronic physical problems, poorer health and a greater number of restricted activity days than their metropolitan counterparts (p. 246). Because rural Americans can seek help for physical ailments without the stigma that surrounds mental distress, it is likely that some of the physical problems that bring rural citizens into their primary care clinicians are somatic and result from stress or psychological difficulties. Because aching backs and high blood pressure are culturally acceptable, the rural citizen's understanding of his or her own mental distress is often times described in those terms.

The relationship between an individual’s perception of his mental health and his willingness to seek professional mental health care will be examined through the lens of

the literature in the next chapter of this paper, but first the relationship between stigma and one's choice to seek out professional mental health support will be considered.

Mental Health Stigma

Mental health stigma exists to varying degrees, nation-wide across the urban-rural continuum. For example, urban Long Island-based Program Director and Marriage and Family Therapist Nancy Cohan, M.A., worked on a public service campaign aimed at breaking through stigma and encouraging 9/11 survivors into treatment by "normalizing" grief and psychological distress caused by this traumatic event. The stigma-fighting campaign included advertisements on subways and buses in metropolitan New York after the professional counseling community found that many survivors and, particularly men, were quietly suffering due to the pull of stigma; i.e., the false, self-perpetuating belief that admitting to needing help is a sign of weak character (N. Cohan, personal communication, September 4, 2008).

Bryan Olson, a Southwestern-raised electrician who lived in rural, Northwest Wyoming for over eight years of his adult life felt there is strong stigma towards mental health services in his Wyoming community: "It's a common belief that people who see therapists or psychologists are crazy" he said recently in an interview. Olson continued,

> I know for a fact that if somebody broke their arm they would go to see a doctor without hesitation; if their car broke down they would go to a mechanic, myself included. In Wyoming I felt like mental health was not a legitimate science, that there are medical professionals that help with your frame of mind. [People in Wyoming] feel like they are relinquishing control of their mind to someone else [if they see a therapist]. I know a lot people think that once you get on that particular path they are going to have to [be seen] as a patient forever,… it [seeing a therapist] requires a lot of deep introspection that I don't think a lot of people feel comfortable doing. (personal communication, May 20, 2009).

Hill, as cited by Parr and Philo (2003) agrees with Mr. Olson. Hill wrote that "people in rural areas construct unique cultural knowledge about health and health care which affects their linkages to the available mental health services" (p. 485).

Likewise, the majority of rural mental health literature is saturated with discussions of stigma as a barrier to seeking professional mental health care. Alice Russler, executive director of Yellowstone Behavioral Health in Cody, Wyoming recently acknowledged "people need to realize mental illness is a medical condition, it's not the result of a character weakness" (Heinz, 2009, p. A3).

In rural America a bumper sticker found on pickup trucks proclaims "SHIT HAPPENS" (Davidson, 1990, p. 9). This attitude that "shit" will happen and one needs to simply deal with it and pull oneself up by the bootstraps is possibly keeping people suffering in silence or relying solely on established support systems such as friends and family, who may not be equipped to recognize mental illness or able to intervene appropriately.

"Acceptability" of professional mental health care is a variable identified as a barrier to access in the *Mental health and Rural America: 1994-2005* report by the ORHP (2005). The report explains:

> Most Americans value self-reliance or utilizing family or other close relationships to solve problems. For this reason, many attach stigma to having or seeking help for mental health or substance abuse problems. However, this appears to be more of an issue in rural communities, as there is less anonymity in seeking help. That is, belief in self-reliance and limited anonymity combine to more significantly limit a rural person's likelihood of seeking services (p. 7).

Despite the best intentions of the professional codes of ethics for psychotherapists, psychologists and other mental health professionals, to assure anonymity for clients in all

situations in which safety is not paramount, the only mental health or substance abuse treatment center in a three-county radius, for example, tends to be highly visible. This issue of visibility is a major barrier to help-seeking (Berry & Davis, 1978). The traffic in and out of these clinics (which tend to be centrally located in towns to better facilitate transportation for clients) lends itself to being a hot topic of local gossip. In one study of the Scottish Highlands the mental health professional took extreme measures to keep a client's identity anonymous: she left her car a mile away during home visits so the client was not at risk for being associated with her (Parr & Philo, 2003).

The "rural paradox of proximity and distance" (p. 477) coined by Parr and Philo of Scotland explains the necessity of such behavior. They believe that while community members in rural areas are often physically separated by many miles, they are more socially proximate then community members in cities as they have an intimate knowledge of each other's lives. These socially-proximate relationships are

> responsible for both the silencing of mental health difficulties and the exclusion of people with mental illness in a way that is more pronounced than what occurs in urban areas, precisely because neighbours want to limit social obligations to those with mental health problems in areas with low densities of formal services (Boyd & Parr, 2008, p. 3)

Stigma colors this statement. The authors are saying that in locations (similar in character to Wyoming) with few professional mental health services, mental health is greatly stigmatized and one is considered "guilty by association". However, family and friends can have great influence on a person's decision on whether or not to turn to professional psychological care. While trusted support persons can invalidate an individual's symptoms and experience, this social network may instead affect an individual's perceived need for professional care by providing positive feedback on his

symptom experience, by providing informal care or by motivating the individual to seek treatment (Rost et al., 2002).

Suicide

Suicide if of particular concern to Wyoming, and one study suggests that rural life itself may have an independent effect on the risk of suicide (Middleton, Sterne & Gunnell, 2006, p. 1040). In Wyoming the highest rate of death by suicide is in Caucasian men aged 70 and over (Suicide Prevention Resource Center, n.d.). Overall, men in Wyoming die by suicide at a rate of 4.1 times more often then women (Suicide Prevention Resource Center). Currently, Wyoming, the least populated state in the nation, is ranked 5th nationally in the rate of suicide per 100,000 individuals with a rate of 17.4 (Powell, 2008). If half of the current "undetermined intent" poisonings in Wyoming were self-inflicted, the suicide rate would be 2% higher (Suicide Prevention Resource Center). The most common means used by men is also the most lethal: the firearm (Suicide Prevention Resource Center).

The efforts of community members organized as local Coalitions for the Prevention of Suicide (utilizing state funding) have made some impact through stigma-fighting campaigns and gun-lock distribution events, but access to firearms remains one of the leading barriers for suicide prevention efforts. Because many rural men are also hunters or gun collectors and feel the need to have at least one gun in their house unlocked and easily assessable in case of an emergency, gun lock distribution and utilization has been limited. Access to these lethal weapons is only one piece of the Wyoming suicide picture. Also contributing is the stigma of mental illness and the

prevailing attitude that "shit happens" which acts to keep individuals silent in times of crisis.

Work, Depression and Acting Out

The mining industry in Wyoming is both a blessing and a curse for the rural and frontier communities which host these large-scale operations. The industry creates many jobs yet also displaces many young men from their families either for short-term or long-term work assignments. The male-dominated, artificial work camp and temporary dorm-like living accommodations have disruptive social consequences such as increasing the rates of divorce, suicide, crime and delinquency (Coward, DeWeaver, Schmidt & Jackson, 1983, p. 11).

Delinquency is shown to be statistically high in Wyoming as discussed in the crime statistics section of this Chapter. Theft, larceny, rape and incarceration rates are all high for such a sparsely populated state. Is there a connection between stress, depression, suicide and acting out behaviors such as committing crimes? Researchers Walinder and Rutz of Sweden believe the answer is affirmative. In their "Male Depression and Suicide" article published in *International Clinical Psychopharmacology,* March 2001 they propose the concept of a "male depressive syndrome" (p. 21). Walinder and Rutz first explained that 50% or more of suicides occur during and as a result of a depressive episode (p. 22), and several studies have shown that the risk of suicide following depressive illness is highest where the rates of diagnosis and professional treatment are lowest (p. 22). Wyoming men continue to be at great risk of suicide due to the norm of living with undiagnosed and untreated depression. The work of Walinder and Rutz offers some insight as to why rates of death by suicide in Wyoming are disproportionately high.

The researchers used findings taken from the Swedish branch of the International Committee for Prevention and Treatment of Depression's study of Gotland, Sweden, which "may indicate that depressive illness among males may manifest itself in ways unrecognizable by current diagnostic systems and/or rejected by the present health care system" (p. 22). This conclusion was reached when education about depression was given to general practitioners and subsequent rates of suicide went down for female patients, but not for male patients. Male symptoms of depression deviated from typical symptomology in the Gotland Study as well, and were primarily irritability, aggressiveness, acting-out behavior, reduced impulse control, lowered stress tolerance and substance abuse, mainly alcohol. Research cited by the authors has found evidence that links these behaviors to neurological dysfunction of serotonergic neurotransmission, and have also found a relationship between suicidal behaviors and low cerebrospinal fluid values of 5-hydroxyindolacetic acid (p. 22). For depressed males, past research tells us this population experiences a breakdown in coping strategies in which an individual's fight-or-flight ability is invoked, whereas in females a breakdown in coping results in a more passive 'play dead' reflex (p. 22).

The social control exerted by social norms, as mentioned above in terms of the Wyoming male norm of living with unexamined depression, is a topic worthy of a closer examination. Norms or standards of behavior serve as powerful indicators of people’s own actions and, as such, researchers have repeatedly found that the perception of what most others are doing influences subjects to behave similarly (Cialdini, Reno, & Kallgren, 1990, p. 1015). Likewise, individuals use their own perceptions of peer norms as the standard against which to compare their own behaviors (Schultz, Nolan, Cialdini,

Goldstein, & Griskevicius, 2007, p. 429). The issue of peer influence has been found to be a powerful factor in behavioral changes, and holds up across many different types of behaviors (S. Wood, personal communication, May 29, 2009) including help-seeking for mental health concerns and alcohol use. This concept will be revisited in the Discussion Chapter, and linked to other barriers to help-seeking.

Substance Abuse

The male depressive syndrome symptoms discussed above are the same as the symptoms that are shown to make individuals more vulnerable to substance abuse (ORHP, 2005, p. 22). It is also believed that males with alcohol dependence suffer from major depression three times more often than is found in the general population (Walinder & Rutz, 2001, p. 22).

Often times rural Wyoming men who are clinically or situationally depressed choose to consume alcohol. Research conducted in the European Union showed that men spoke of an increased “need” to consume alcoholic beverages as a symptom of depression (Angst, Gamma, Gastpar, Lépine, Mendlewicz, & Tylee, 2002) and, while data does not yet prove this finding holds up for Wyoming's male population, it is possible Wyoming men also feel a "need" to consume alcohol when experiencing depression.

Such co-morbidity of substance abuse and mental illness is common (ORHP, 2005, p. 9). A study that looked at the use of illegal substances among a rural population of individuals with mental illness found a usage rate of 40% among this population (Gogek, as cited in ORHP). Moreover, another study that assessed problem behaviors and psychiatric symptoms among seriously mentally ill (SMI) clients in 10 community-

based rural mental health care systems, found those SMI clients who had a current substance abuse problem also had symptoms of anger and trouble with the law (Barry et al., as cited in ORHP, p. 33).

It is believed that overall substance use in rural areas is comparable to usage in more metropolitan areas (ORHP, p. 9), yet there is a higher treatment need for alcohol treatment in the American West then in other geographical areas (McAuliffe & colleagues, as cited in ORHP, p. 28). Drinking "a few" (which can be loosely translated to mean any number two or greater) is routine in all of America, including rural America. Popular music often sings the songs of a society heavy into drinking:

> My boss just pushed me over the limit.
> I'd like to call him somethin',
> I think I'll just call it a day.
>
> Pour me somethin' tall an' strong,
> Make it a "Hurricane" before I go insane.
> It's only half-past twelve but I don't care.
> It's five o'clock somewhere.
>
> Oh, this lunch break is gonna take all afternoon,
> An' half the night
>
> ("It's Five O'Clock Somewhere" sung by Alan Jackson and Jimmy Buffett, written by Jim Brown and Don Rollins).

This song, which hit #1 on Billboard's "Hot Country Singles and Tracks Chart" and #17 on the all-genre "Hot 100 Chart" in 2003 (Billboard), is emblematic of the social acceptability of drinking alcohol to de-stress and forget one's problems. Interestingly, drinking to excess, as described in the song lyrics above, is much more socially acceptable for men then it is for women. A study of alcohol use in the Scottish Highlands, an area which is similar in rurality and drinking culture to Wyoming, found

that, "for men excessive alcohol consumption is a [sic] intrinsic part of a wider regional culture of masculinity and, in contrast to women's drinking practices, is thus 'normalised' within the wider community" (Burns, Parr & Philo, 2002, p. 7) This writer's observations while living in Wyoming for one year validate this claim is also true and, in my observations, if a man chose not to drink excessively, he was socially chastised.

In Wyoming it is not uncommon for men to drive with open containers, although this is illegal. The concept of having "one for the road" and drinking "road sodas" is the social norm. In fact, the state has drive-thru liquor stores which, in part contribute to the lax attitude about drinking and driving. In 2006 there were 9711 total substance abuse-related arrests and in 2007 this number jumped to 11591 (Wyoming Department of Health, 2008, p. 4). The blood alcohol concentration or BAC levels for DUI arrests during these years are also alarming. All counties had average BAC levels for DUI arrests over 0.100, and the average BAC rate for 2006 was .1576, while 2007's rate was slightly less at .1528 (Wyoming Department of Health). These BAC rates loosely correlate to 5-10 drinks and result in little or no judgment functioning and poor coordination (Kinney, 2000, p. 41). Moreover, for accidents involving alcohol nationally, a BAC of .10 or greater is shown to increase the likelihood of a fatality by 8 times the rate for accidents that do not involve alcohol (Kinney, p. 27). The state of Wyoming is beginning to get tougher on offenders; this year Senate File 88 was passed which requires DUI First Offenders with a BAC of .15 or higher or second offenders to install ignition interlock devices in their vehicles (Mothers Against Drunk Driving, n.d.).

Where does the acceptability of drinking high quantities of alcohol originate? Studies show that family members and friends have a significant influence on a person's

development of substance abuse problems (ORHP, p. 22). Such problems do not "just happen" but are rather developed over time and are foreshadowed by behavioral problems in early childhood which result from conflicts among family members (ORHP, p. 22). The relationship individual family members have with their social context of work, school, friend and the legal system is also important (ORHP, p. 22) because a child closely monitors the behavior of his siblings, parents and other family members and often imitates these models of being, whether they are productive or destructive.

Wyoming community members have cited the abuse of prescription medication, illegal street drugs such as cocaine and methamphetamine, and tobacco products as substances being abused in their neighborhoods, (see Chapter IV, "Eliciting Feedback"). This same pool of individuals identified that drinking and drugging culture is interwoven into their landscape. One surveyed individual expressed point-blank, "This is the way we are in Wyoming" and another introduced the concept of "community denial" to comprehend the culture of dominant substance abuse issues she witnesses in her community (Wyoming Department of Health, 2008, p. 14).

Substance abuse issues will continue to be discussed in this paper; first in Chapter II as a key topic from the rural mental health literature, and again in Chapter III when the paper examines the current gaps and innovations in mental health and substance abuse treatment in Wyoming, and lastly, this issue will be revisited in the Discussion Chapter when recommendations for improving care to those with substance abuse issues are presented.

This chapter has presented the reader with foundational knowledge regarding Wyoming industry, poverty, rurality, mental health and mental health stigma, co-

occurring mental health and substance abuse with specific attention to the notion of a "male depressive syndrome". In the next two chapters the barriers to professional treatment for mental health and substance abuse disorders will be presented and analyzed in the larger rural health literature and the voices of Wyoming people, and in reports commissioned by the State of Wyoming and other key stakeholders. However, before this, the paper will now shift in focus to a discussion of the possible informal and formal methods of receiving psychological help.

Informal and formal routes to help-seeking

U. S. researchers Jacquelyn H. Flaskerud and Frederick J. Kviz, (1982), published an article in the *Community Mental Health Journal* that said, "Need for services must be related to consumer preferred resources for mental health problems, rather than to utilization of those services that mental health professionals think consumers should use" (p. 118). While this is a seemingly simple concept, its implementation has been limited. Often mental health treatment models operating in rural areas are carbon copies of models developed for urban settings (ORHP, 2005, p. 16) and thus do not match the unique needs of the communities they are dropped into. Additionally, mental health professionals are often trained in urban areas with urban-centered standards that are not always applicable to rural areas (Wagenfeld & Buffum, as cited in ORHP). Compounding this mismatch is the limited training some professionals have in the arena of substance abuse. One study which was based in Wyoming's rural neighbor, Idaho, surveyed 144 licensed psychologists. In this study 89% of respondents answered that they had contact with substance abusers and most rated their graduate training as having inadequately prepared them for working with this population. Additionally, many said

they limited their treatment to self-help group referral (Celluci & Vik, as cited in ORHP, p. 27). While self-help groups are good matches for some, they do not meet the treatment needs of others. These groups, such as Alcoholics Anonymous, have only limited meetings in rural and frontier Wyoming and in some communities they do not operate at all.

The inadequacies in professional mental health treatment in Wyoming due, at least in part, to the limited availability of these services, (which is further described in Chapter IV) and the stigma surrounding mental health issues, all contribute to the utilization of informal help-seeking and care-taking. Stigma, of course, also limits some individuals from seeking *any* form of help in times of mental health crisis and, tragically, the suicide rates in Wyoming attest to this phenomenon of psychological isolation. Some men, however, do seek help from family or friends in times of emotional distress. While a thorough search of the literature did not find any United States-based work on informal caring, there is some, limited research in this area that has been undertaken in the Scottish Highlands (Parr & Philo, 2003). This group of researchers felt the issues raised in their work are applicable to other rural areas (Parr & Philo, p. 474). They have found that geographical distance, social proximity, stoic cultures and rural gossip networks all play parts in how caring occurs (Parr & Philo, p. 471).

There are limits to the types of help informal networks of support can provide, in part, due to people's poor comprehension and identification of mental illnesses. This concept of "mental health literacy" will be revisited in the next three chapters and efforts to teach a "mental health first aid" skill set to community members in Wyoming and elsewhere will be described.

CHAPTER III

LITERATURE REVIEW

Many people recognize the need for maintaining good psychological health. Despite this, mental health services are often underutilized. One estimate states that as few as one fourth of individuals in the U.S. who experience mental health problems receive the care they need (Smith, 2004).

What does the research say about who is seeking out professional mental health care? What patterns have emerged when examining barriers to help-seeking specifically among rural men in both the United States and internationally? This Chapter will address these questions by providing an overview of the current research findings from a range of longitudinal and short-term studies which span geographical regions, sample sizes, and methodology.

There are a number of Australian-based studies examined as the majority of rural mental health research has come out of this country. These studies are included to help promote an understanding of barriers to mental health care and potential innovations that may be applied to Wyoming. Australian and other internationally-based research and rural mental health initiatives will be included in both this chapter and following chapters to illustrate the possibilities for similar studies in the Western United States and to draw parallels between geographical areas.

What variables are predictive of whether rural individuals seek professional mental health services?

One duo of researchers studied whether age, attitudes toward help-seeking, education, and gender were relative to previous or intended future mental health

utilization in a rural population (Smith & Peck, 2004). They pulled names from a white page directory covering an eight-county rural area in an unnamed Midwestern state. After mailing out letters of consent detailing the study and enclosing the measurement tool, the researchers followed up with a reminder post card and then a duplicate copy of the first mailing. The measurement tool utilized was the Attitude Toward Seeking Professional Psychological Help Scale. The total response was 393 or 26%. The mean age for participants was 53.9 years and the age range was 18-97. The representation among counties was proportionate and 61% of respondents were male, and 71% had graduated high school or completed a higher level of education.

Of all respondents, approximately 78% had not received mental health services in the past and 47% said they would not seek out these services in the future. Of this population 6.6% were undecided whether they would seek services in the future and 46% of respondents said that they would seek out services in the future. The researchers found that all variables except education (the variables being age, attitudes towards help-seeking and sex) were related to previous and future mental health treatment: "positive attitudes toward help-seeking, prior use of a mental health service provider, younger age, and being female were related to someone being willing to seek out mental health treatment in the future" (Smith & Peck, 2004, p. 439).

It is interesting that the researchers defined "mental health professional" broadly to include professional counselor, psychologist, psychiatrist, social worker, family physician or minister. Of the many research projects outlined in this chapter, this is the only project to include clergy as professional mental health care treatment providers. As many of the geographical areas studied in this chapter are Midwestern, rural and defined

as national health care provider shortage areas, I see the inclusion of clergy in this study to be of particular strength. The reality of help-seeking, as the research will highlight, shows preference to general practitioners as the professional that rural citizens already know and trust in their community. Following this logic, clergy are also logical providers of mental health assistance for many individuals and Smith and Peck (2004) were correct in their inclusion of these professionals. This particular study was limited by its small sample size and its non-disclosure of the study site. If the Midwestern state in which this research was conducted was made public, the findings could be more easily reproduced, critiqued or expanded upon.

Hauenstein, Petterson, Merwin, Rovnyak, Heise & Wagner (2006), conducted a study that was on a much larger scale than Smith and Peck. This team conducted a secondary analysis of quantitative data from the Medical Expenditure Panel Survey which surveyed a nationally-representative, adult population of approximately 34,000 respondents in the United States. The researchers were interested in how gender and place of residence contribute to disparities in professional mental health care utilization. Respondents in the survey were asked both about their own mental health and that of their live-in family members. One drawback of the data collection method utilized here is that it encourages triangulation of information which makes the reader question the consistency of responses between one's self analysis and one's analysis of the mental health of a family member.

Hauenstein et al. (2006) found both men and women's mental health deteriorated slightly but significantly as the geographical rurality of respondents increased. Rural men received less specialized mental health care than their urban counterparts. The

researchers surmised that rural men visit mental health professionals less often than urban men because access to these services is limited in rural areas as many of these rural locations are federally-designated mental health care professional shortage areas.

While the researchers' assertion most likely holds some truth, it does not explain the broader complexities of why men chose to seek mental health treatment or not. One empirically-studied indicator of professional help-seeking among rural men is stoicism. The English researchers, Murray, Jackson, Fraser, Komiti & Pattison (2008), examined the character trait of stoicism through the measurement instrument of the Liverpool Stoicism Scale. The authors married the classical and modern definitions of stoicism to mean "imperturbability in the face of challenges" and "denial, suppression and control of emotions" (p. 1370). They found that stoicism scores were higher among men than woman and this finding solidified the original research undertaken by the inventors of the Liverpool Stoicism Scale, Wagstaff and Rowledge (2001), who conducted their research among a sample of 62 adults (32 women and 30 men) from a range of socioeconomic backgrounds and geographical regions of Britain. Murray et al. took this original research by Wagstaff and Rowledge further and his team found high rates of stoicism were positively correlated to negative attitudes towards help-seeking. Furthermore, their findings suggest that stoicism among males may be linked to inter personal difficulties for these individuals.

Are interpersonal difficulties keeping rural men from accessing services? Murray et al.'s research (2008) hypothesizes this to be true, yet there is not a significant body of research to back up this assertion. It is important to keep in mind that there exist both physical barriers to care such as shortages of professional mental health practitioners and

there are also psychological barriers at play such as high rates of stoicism among these populations.

In this examination of barriers to mental health care it is important to expand the literature review to include studies aimed at pin pointing rates of depression across the rural-urban gradient. One such study was aimed at researching whether people in rural areas received less mental health care for depression than their urban counterparts (Rost, Zhang, Fortney, Smith & Smith, 1998). The study's methods involved over 11,000 interviews with adult Arkansas citizens from every region of the state and then categorizing all respondents who screened positive for depression, with the exception of suicidal individuals who were excluded. The 434 participants who remained were interviewed on the phone and then at in-person, three-hour interviews within one month of the phone call. Rural and urban citizens with varying education levels, races, employment statuses and ages were included.

Rost et al. (1998) found both rural and urban citizens of Arkansas who screened positive for depression received out patient treatment at similar rates. There were less specialty care visits with the rural population as most rural respondents were treated by primary care physicians. Interestingly and perhaps contrary to stereotype, there were no differences found in the quality of rural-urban general medical visits for depression when doctors were aware of the depression as the reason the patient sought treatment. However, rural citizens were slightly less likely to follow through the recommended course of treatment.

It is noteworthy that the entire state of Arkansas is classified as a Mental Health Professional Shortage Area (D. Wilson, personal communication, January 23, 2009) and

the researchers did not find that rural citizens received less treatment for depression. The rural individuals were more likely to see a General Practitioner then a mental health professional, but rates of treatment were on par with urban citizens. Perhaps more pertinent is the finding that quality of treatment (defined through judging whether patients receiving depression treatment received medication or counseling in accordance with the recent guidelines set by the U.S. Department of Health and Human Services) was comparable across geography "when doctors were aware of the depression as the reason the patient sought treatment" (Rost et al., 1998, p. 1102). Herein reveals a major barrier to care for many rural people: disclosure of one's mental health issues. Part of disclosure is based in how people understand their own symptomology. The next study discussed further in this report elaborates on this important consideration.

Another group of researchers who chose to examine depression rates in rural areas were Angst, Gamma, Gastpar, Lépine, Mendlewicz and Tylee (2002). Specifically the phenomenon studied were gender differences in depression and in treatment. This work studied a European population collected from existing depression research in European society data. Countries included were Belgium, France, Germany, the United Kingdom, Spain and The Netherlands. Wave I of the study sampled over 38,000 men and 40,000 women from the general population and Wave II sampled over 550 men and 1300 women treated for depression. Participants were interviewed in their homes using the depression section of the Mini International Neuropsychiatric Interview [MINI] screening interview and a specially designed depression questionnaire. Participants were matched country to country in the following areas: gender, age, social class, occupation, paid employment, income, area of residence, size of household and number of children.

The study found that when looking at minor depression (defined as 2-4 symptoms), more males (52%) did not seek treatment compared to females (41%). In the case of both sexes it was most likely the general practitioner who was consulted. Women spoke about lack of energy and appetite changes as symptoms and men spoke of an increased "need" to consume alcoholic beverages as a symptom. Men attributed the onset of depression to stressors like physical illness and problems at work and females more often attributed their depression to relationship problems, illness or death in the family. When examining coping strategies, it was found that women sought out emotional outlets and men tended to drink and participate in sports. Among both sexes 66% of participants thought their symptoms would go away and 19% did not seek help because they did not want medication.

The findings resulting from this study warrant further attention. The differences in how men and women experience depression and understand it varied greatly. As roughly two thirds of men and women believed their symptoms would pass, it can be surmised that individuals' own belief that their condition was temporary in nature was a barrier to seeking professional help. There is a clear difference in Rost et al.'s (1998) population who sought out help and stated depression as the problem, and the participants of this larger study by Angst et al. (2002) who understood their depression as temporary and thus did not seek help. How one perceived his depression influenced how he reacted to it.

It is also worth discussing the Angst et al. (2002) finding that nearly 19% of this large European sample size stated they did not seek help because they did not want medication. As both men and woman believed the onset of the depression was due to

external circumstances, it is logical for both groups to feel as if medication, an internal answer to what they define as an external problem, is not the correct treatment. For men it was found respondents identified a "need" to consume alcohol. Drinking can be understood as a type of self-medication which can numb or mask depression while ultimately adding another layer of sorrow and hopelessness for the individual as alcohol is classified a depressant drug. While drinking alcohol ignites a series of internal reactions in one's body, the act of drinking is an external act. A depressed man might easily have enough drinks to render himself inebriated one night when out with his buddies at a bar, and this action, this form of self-medicating, would not necessarily be identified by his comrades as unusual or socially suspect in any way.

The strengths of this study are the large, multi-country sample, clear findings and presentation. The authors pointed out one limit was that men who cope by acting out may be underrepresented in the sample (see Chapter II for an explanation of "the male depressive syndrome" theory which addresses the connection between depression and acting-out behaviors). I think issues of race and ethnicity should have been addressed. It is unclear as to whether all participants are native to the countries in which they reside. Similar to the United States, the countries included in this study have large immigrant populations. The reader is left wondering how the ethnic identities of the participants affected the data.

The Australian team of Wrigley, Jackson, Judd and Komiti (2005) did not have the same cultural and ethnic considerations as Angst et al. (2002) as their project was much smaller in scale and represented only one ethnic group. The research was conducted in the Australian community of Echuca, a rural area with a population of

10,000 in the state of Victoria. Cluster-sampling was used within a residential population purposely within 30km or less of the local Community Mental Health Service. This was done so that distance to services was not considered to be a barrier to help-seeking. Adults in the homes randomly selected were asked to fill out a survey, handed the survey and asked to mail it back once completed. The first attempt resulted in a low response rate and so a second survey disbursement was undertaken. The final response rate was 28.4% as 142 of 500 surveys were returned. The gender breakdown of respondents was signficant with 35.2% of men and 64.8% of women responding.

In this study researchers were interested in measuring one main phenomenon: the role of perceived stigma and the attitudes towards help-seeking from a general practitioner for mental health problems. Seven scales were utilized. Mental health symptoms were measured using the Centre for Epidemiological Studies Depression Scale and the state component of the State-Trait Anxiety Inventory. Disability was measured with the Medical Outcomes Studies Short Form (12-item version). The Perceived Stigma Scale measured perceived stigma about people with mental illness within a community. Help-seeking attitudes were measured with the aptly named Attitudes Towards Seeking Professional Psychological Help Scale. The Health Beliefs Questionnaire measured knowledge of the prevalence and causes of mental illness. Lastly, the Contact and Experience Questionnaire measured contact with mental illness, help-seeking behavior and preferences.

As seven total scales were used to measure six concepts in this study is it reasonable to anticipate a wide range of findings, which is what resulted. The major findings are as follows: 36% of respondents had received help for mental health issues in

the past and, of this population, 44.6% were women and 20% were men. Of the total sample 66% reported they knew someone with a mental health issue and this issue was most commonly depression. Of the respondents, 43% said they felt they needed to or wanted to seek help at some point for their own mental health and did not do so. The percentage who said they were stopped by embarrassment was 43%, and 34% said they did not know where to go. A significant finding was that fewer men felt comfortable talking to a general practitioner about mental health issues than women. (It is not specified in this research whether the gender of the general practitioner or perceived gender is a contributing factor.)

The finding that men were only half as likely as women to seek professional help for a mental health problem echoes the work of Angst et al. (2002), Hauenstein et al. (2006), and Smith et al. (2004), that men were less likely to seek treatment and receive treatment than women were. Also fascinating is that females who participated in Wrigley et al's (2005) study in numbers almost double that of male participants. Women were over twice as likely to respond that they have received mental health treatment in the past. These findings are significant and thematic of this area of study.

Another group of researchers, Wang, Lane, Olfson, Pincus, Wells and Kessler (2005), had several findings similar to other studies discussed in this Chapter: that men in rural areas of the United States had lower odds of receiving any mental health treatment when compared to females living in the same geographical areas and individuals of both genders in rural areas were less likely to receive any mental health treatment than those individuals in urban areas. Wang et al. conducted original research with a nationally-representative sample of over 9,000 adults through face-to-face interactions utilizing the

World Health Organization's World Mental Health Survey Initiative fully structured diagnostic interview. These interviews were conducted over a two year period, February 2001-April 2003. Limiting this study is that, while this research began just short of six months after the terrorist attacks of September 11, 2001, the researchers did not make mention of this pivotal event and its possible influence on the mental health data collected.

The next group of researchers discussed in this chapter, Hoyt, Conger, Valde and Weihs (1997), differ from the others in that they are specific in their examination of not only "rural" and "urban" populations of people, but they further stratify "rural" individuals living in six categories of locations: farm households, rural non-farm households, rural villages (under 2,500 population), small towns (2,500 to 9,999), small cities (10,000 to 49,999), and rural population centers (50,000 and larger). The term "rural population centers" is used as these metropolitan areas are located in the state of Iowa, which is predominantly agriculturally based (Hoyt et al., 1997, p. 456).

The data utilized comes out of the Iowa Health Poll, a longitudinal survey detailing both mental health needs and service use. The participants were taken from a statewide sample which provided for rural/urban variation and over 90% of the original sampled individuals from the Health Poll who agreed to participate in a new round of telephone interviewing for the purpose of this study. In total the study consisted of over 1,400 adults who answered a large sample of mental health questions over the course of two waves of data collection. The dependent variable in the study, psychological distress, was measured using the Center for Epidemioloigical Studies Depression Scale. Social support was measured using an indicator created by Ross and Huber (1985), and

sense of control was measured with another tool developed by another set of researchers, Mirowsky and Ross (1989). Also measured systematically were prior mental health service use, willingness to seek help from a mental health professional and stigma toward mental health services. Findings of Hoyt et al.'s (1997) work found significant variation in financial stress with the most stress in this area reported by farm residents, followed up by persons living in rural villages and small towns. People living in rural villages and on farms also reported lower levels of sense of control in comparison to people living in the four other location categories established by the researchers.

Hoyt et al. (1997) paid attention to both the experience of men and women, and the results that directly pertain to males will be highlighted here. Increased age was associated with decreased symptoms of depression, a finding that has not been documented in other studies examined for this thesis. Men living in small towns were found to have significantly higher symptoms of depression than those living in rural population centers. Interestingly, the measures of social and personal resources, perceived social support and sense of control were not related to depressive symptoms. Perhaps not surprising was that seeking mental health services was positively correlated to higher levels of depressive symptoms, yet, another finding of the study was that an increase in symptoms was associated with a decreased *interest* in seeking formal help.

When examining the predictors of stigma toward mental health treatment and willingness to seek treatment among both sexes the research found the older the respondent, the lower his stigma towards mental health care. Higher levels of perceived social support for respondents were associated with lower levels of stigma. People in rural places had significantly higher levels of stigma towards services than those in

population centers (50,000 people and larger). As rurality increased, this number grew. Those respondents with higher levels of depressive symptoms were most likely to have stigmatized views of mental health services and past treatment from a mental health professional was associated with significantly lower levels of stigma for women but not for men.

It is important for the reader to realize this current, widespread stigma towards mental health permeates both individual's understandings of their own mental health concerns and their willingness to seek help (Judd et. al., 2006). In Hoyt et al.'s study, men who had an increase in symptoms had a decreased interest in seeking formal help. Stigma is surely part of the explanation for this phenomenon.

A number of empirical research studies have examined the relationship of stigma to help-seeking, yet often the studies make use of the term "attitudes" which is defined much more broadly. One's perceived stigma towards mental health care influences that person's attitude toward receiving care. As the studies examined in this Chapter and the comments of Wyoming mental health providers and consumers presented in the next Chapter of this research consistently attest to, the stigma surrounding the use of professional mental health services is a barrier to help-seeking.

Returning to the findings of Hoyt et. al (1997), it was found that, among those who had received mental health services in the past, there existed an increased likelihood of willingness to seek services in the future. In line with multiple similar studies outlined in this Chapter, this work also found that women were more likely than men to indicate a willingness to seek professional mental heath care. Moreover, the authors found higher levels of personal resources (social support and sense of control), were positively

correlated with an increased likelihood of seeking mental health services when need for services was identified. Also found was that individuals with a greater sense of control were more likely to seek professional help. There was no finding indicating that rural respondents were less likely to seek help than those in small town and population centers and the researchers point out that this may be due to differing definitions of "serious emotional problems" between residents of differing locations, a hypothesis the team was not able to test due to the limitations of their study design (p. 464). However, several studies have examined the phenomenon of differing definitions of one's mental health condition and they will be highlighted now.

The relationship between an individual's perception of his mental health and his willingness to seek professional mental health care

Jorm, Barney, Christensen, Highet, Kelly, and Kitchener (2006), a group of Australian researchers, conducted a survey of mental health literacy or "knowledge and beliefs about mental disorders which aid their recognition, management and prevention" (p. 3) and found many people were not able to give the correct psychiatric label to a disorder portrayed in a depression or schizophrenia vignette. The researchers found "lack of appropriate recognition of disorders in oneself or others may lead to delays in seeking help and inappropriate help-seeking" (p. 3). As the Discussion Chapter of this paper will elaborate, the recognition that low mental health literacy can lead to delays in services or the incorrect services have created a country-wide campaign to improve mental health literacy in Australia in the last ten years. The "Mental Health First Aid" training developed in Australia as part of that country's campaign has been implemented in the

United States as well and efforts to bring this training to Wyoming communities is described in the next chapter.

While there is still little U.S.-based research that explores mental health literacy, researchers have examined the connection between attitudes about mental health and help-seeking in the U.S. As the work highlighted in this chapter has exposed, when individuals perceive their mental health difficulties as temporary or externally-based (such as sadness over the death of a loved one), they are not likely to seek professional help. The literature has also highlighted the hesitance for individuals to seek help when they did not want to be prescribed medication. Jorm et al. (2006) noted that there is a gap in beliefs between the public and professionals when it comes to appropriate treatments for depression and schizophrenia, with the biggest gap being whether or not medication should be used. The authors state that this gap in belief can lead to both "a lack of appropriate help-seeking and a failure to adhere to recommended treatments" (p. 3).

Of course, before the issue of medication can be discussed, individuals need to acknowledge mental health problems exist. How these problems are contextualized varies from one culture and context to the next (Fuller, Edwards, Procter & Moss, 2000).

One exploratory study aimed at understanding how people in rural communities conceptualized mental health problems interviewed 22 "key informants" in South Australia. These participants were not all mental health professionals, but rather people knowledgeable about mental health problems in their communities such as financial counselors, a minister and a police officer. A major theme that arose from this work was that most informants said community members understood mental health problems narrowly as "severe psychiatric disorders that, in the individual's opinion, required

detention" (p. 150). Moreover, a social worker informant recalled "that's exactly what we get from the community, that if we talk about mental health, they talk about psychosis" (p. 150). A financial counselor said no one has ever talked to him about emotional distress. In his eight years of practice, he has found in regard to mental health difficulties ".it's always under the guise of a financial problem". Similarly, the minister reported "They're more likely to say, 'I just feel really down; I just can't be bothered doing anything'. It's more descriptive of what's happening to them, rather than giving it a name" (p. 150). Is this reluctance to "name" difficulties and acknowledge such difficulties as mental health problems just an Australian-specific phenomenon? One comparison study found out.

This study, published in 1994, surveyed individuals in St. Louis, Missouri, United States and Christchurch, New Zealand (Wells, Robins, Bushnell, Jarosz & Oakley-Browne). While neither site is classified as a rural area, the themes from the rural-specific literature in this field of study are echoed in this study grounded in two cities on opposite sides of the world. These communities differ substantially in health care systems, size, and the ethnicity of the population. Moreover, the entire country of New Zealand has a shortage of psychiatrists according to World Health Organization standards and St. Louis has almost four times as many of these doctors as Christchurch (Wells et al., 1994). Citizens of Christchurch most often see a general practitioner for mental health as well as physical health problems which parallels the experience of rural citizens worldwide.

The methodology utilized in the comparison study was in-person interviews with household members randomly chosen from randomly selected homes. Interviewers used

the Diagnostic Interview Schedule [DIS] and Health Services Utilization [HSU] questionnaires in structured interview sessions. Adults aged 18-64 were included and post-stratification was conducted to prevent co-founding due to differences in sample age and sex distribution. Over 1,000 adults in each location made up the samples.

The researchers discovered more Christchurch residents (13.9%) than St. Louis residents (9.4%) reported they did not seek help at some time for problems with emotions, nerves, alcohol or drugs when they or their family thought that they should have done so. These findings were consistent over specific psychiatric disorders, number of disorders experienced, and help received. Depression and alcohol disorder were each found to have significantly higher rates of perceived failure to seek care. Contrary to the finding of other researchers (Smith and Peck, 2004; Hoyt, Conger and Valde, 1997) Wells et al. (1994) discovered that the more help received on other occasions, the more likely it was that there had also been a later occasion of failure to seek help when it was thought to be needed. Moreover, failure to seek help when needed seemed to increase with numbers, and diversity and intensity of indicators of a need for help, whether this was measured by symptoms or actual use of services. As the researchers duly point out, "Greater need undoubtedly creates more occasions for making decisions as to whether or not to seek care, and thus increases the likelihood that help would not be sought in at least one occasion" (p. 160). The research design allowed participants to choose from 16 reasons for not seeking help. Among all the participants in both communities of this comparative study one or two reasons were typically volunteered. Most common in Christchurch and second most common on St. Louis was the reason "you thought it was something you could be strong enough to handle alone". Most answered in St. Louis was

"you couldn't afford the bill". As New Zealand has a system of universal health care, this answer was rarely given there. Also rating high in both cities were "you thought the problem would get better by itself" and "your family thought you should go but you didn't think it was necessary" (p. 161). Wells et al. point out that the most common reasons volunteered for not seeking help are attitudinal and based in self-reliance. When specific disorders were separated out, reasons most given with depression were fear of what others would think, fear of hospitalization, and fear of the treatment. With alcohol disorder the most common reasons were that one's family thought they should go but the person disagreed and that "you hated answering personal questions" (p. 161). Overall, the team of researchers found many more similarities than differences in the proportion of people who said they had failed to seek help, the reasons offered for the failure and the correlations between St. Louis and Christchurch. For the purposes of this thesis, it would be helpful for similar research to examine not only two cities in different countries but also two rural areas and compare data from each of the four locations for both themes and variance. If the existing data is any indication, it is likely that attitudinal reasons for not seeking help would again be the most volunteered reason and the rural areas would have higher rates of this response than the cities.

Beliefs about the helpfulness of mental health interventions.

People's beliefs are a phenomenon worthy of consideration when thinking about barriers to mental health care among a rural population. Why would one seek out mental health care if they believe this intervention will not be helpful? A recent survey of nearly 4,000 Australian adults in a country-wide study asked the respondents to read four vignettes, each of which depicted a person with one of the following conditions:

depression, depression with suicidal thoughts, and early schizophrenia or chronic schizophrenia (Jorm, Mackinnon, Christensen & Griffiths, 2005). The respondents were then asked to select from 34 possible interventions from four different orientations. The four orientations and an intervention choice from each follows: lifestyle ("becoming more actively physically"), psychological ("psychotherapy"), medical ("antidepressants") or information-seeking ("consulting a website that gives information"). It was found that women rated lifestyle and psychological factors as slightly more helpful then men did. There was no significant gender difference for the medical and information-seeking scales. Middle-aged respondents more often rated lifestyle interventions as their choice while younger respondents rated information-seeking interventions as being more helpful. Interestingly, those participants who had received professional help for problems similar to those in the vignettes rated psychological interventions as *less likely* to be helpful than those who had either not experienced similar problems or who had not received treatment for them. Those without problems similar to the vignettes, those with these problems who had received help, and those with these problems that had not received treatment all rated information-seeking interventions as less likely to be helpful. Overall, mean ratings of interventions from the lifestyle, psychological and information-seeking dimension were between neutral and helpful categories while medical interventions were between harmful and neutral points. The researchers stated, "This further reinforces the notion that the dimensions found relate to attitudes to treatment rather than reflecting knowledge-based appraisal" (p. 882).

While these findings are telling of the Australian population's beliefs about the helpfulness of mental health interventions as a large, nationally-representative sample

was used, it is unknown whether the results hold true for other countries such as the United States. Furthermore, the respondents' ability to label the mental health condition depicted in the vignette correctly might have impeded their ability to choose his/her choice of helpful interventions.

Summary

The body of literature presented in this Chapter examined how demographics, stigma, attitude, stoicism and one's perception of his mental health, influence mental health treatment decisions. The literature encompassed a wide range of methodologies, sample sizes and geographical sample areas. Now that the many possible barriers to seeking professional mental health care have been examined through the literature, the next chapter will focus on an in-depth analysis of the barriers to mental health for men in the rural state of Wyoming.

CHAPTER IV

RURAL MENTAL HEALTH SERVICES IN WYOMING

Chapter III of this research discussed the rural mental health literature's identified barriers to service utilization as studied in the United States and abroad. In this Chapter the Wyoming mental health care system will be examined. The challenges of meeting the mental health needs of Wyoming will be highlighted, the work of the state agency responsible for the provision of these services will be discussed, the points of view and suggestions for improvement from providers, consumers and the advocacy group National Alliance on Mental Illness [NAMI] will be given voice and the state's "promising practices" and future-oriented initiatives will be described.

Wyoming's population was 515,004 at the time of the 2006 Census (McDaniel, appendix 7.10, p. 52, 2008) and today it remains the least populated state in the country. The people of Wyoming are thus necessarily self-sufficient as only several of 23 counties contain areas with populations over 2,500 people and no population exceeds 4,999 people per square acre. Within this frontier state gaps exist in both the availability of qualified mental health professionals and the population's utilization of existing services.

There are twenty independent, community-based mental health and substance abuse treatment centers in Wyoming which receive state funding and are thus obligated to provide services on a sliding fee scale to all persons who request services (Wyoming Department of Health Mental Health and Substance Abuse Division website). There are over eighty outpatient substance abuse programs statewide including drug courts, DUI classes, private therapist services, intensive outpatient programs and adolescent services. There are seven residential substance abuse centers in the state for adults and several for

adolescents that contract with the Department of Health. Two of the residential programs offer clinical detoxification services (Wyoming Department of Health Mental Health and Substance Abuse Division website). The Wyoming State Hospital in Evanston has 196 beds and operates as the state's only psychiatric hospital (Wyoming Department of Health Mental Health and Substance Abuse Division website).

Improving services and outcomes

The State of Wyoming's Mental Health and Substance Abuse Services Divisions (MHSASD) of the Department of Health exists to:

> provide access to and insure the quality of mental health and substance abuse prevention, early intervention and treatment services. The Division utilizes three primary tools to fulfill those functions (1) through its authority to promulgate and enforce rules; (2) developing performance-based contracts; and (3) monitoring provider compliance. (McDaniel, 2008, p. 1).

The Division follows five guiding principles: Citizen Advocacy, Community Empowerment, Performance Contracting, Data Collection, Research and Analysis and Integrated Efforts and Collaboration (McDaniel, 2008). How well is the division following its guiding principals and meeting the needs of its constituents?

Eliciting Feedback

An attempt at answering this quandary was undertaken with the Division's Mental Health and Substance Abuse Services Partner Survey last year. The staff at the MHSASD realized "This work is far too important for the Division to go it alone" (McDaniel, 2008, p. 1). and in this spirit the Division commissioned the web-based survey in the summer of 2008 and plans to repeat the survey of partner agencies and organizations, contractors, key contacts and consumers again in May 2009 (J. Jares, personal communication, April 28, 2009).

Of the 235 people included in the summary report, 184 people clarified their primary role within the mental health and substance abuse system: 53 were treatment providers (includes private providers, residential treatment providers, community care providers and center directors), 55 were prevention partners (includes alcohol prevention, tobacco prevention and cessation and suicide prevention) and 31 were consumers. Most counties were represented with distribution similar to state population averages.

When asked if the Division is doing well at implementing their five guiding principles, respondents were asked to use a Likert scale of 1 (strongly disagree) to 5 (strongly agree). Treatment providers (n= 47) gave the lowest score for each principle averaging between a "2" and "3" response or "disagree and "neutral". Prevention staff (n= 51) and consumers (n= 26) gave scores averaging between "3" and "4" or "neutral" to "agree" (p. 9).

Respondents were also asked to use a Likert scale from 1 to 5 (1-poor, 2-below average, 3-average, 4-above average and 5-excellent) to rate the Division staff's responsiveness to nine indicators: staff listen to concerns, quality of response to questions and concerns, timeliness of response, staff knowledge level, inform others about issues, anticipate needs/proactive, services meet your objectives, staff are easy to work with and overall, rank of services to you. Again treatment providers (n= 51) consistently responded with "2" or "3" and both prevention staff (n= 54) and consumers (n= 26) gave "3" and "4" as responses.

Wyoming treatment providers consistently gave the MHSASD low to mid-range scores on how well the agency was meeting its objectives and how well the staff were

doing their individual jobs. Interestingly, both consumers and mental health and substance abuse prevention workers gave higher scores to the agency on this survey.

Another indicator, The Mental Health Consumer Survey, asked consumers to weigh in on the quality of their mental health treatment. This survey has been given annually since 1997. In 2007 a total of 750 adult consumers of community mental health care completed the survey (MHSASD, "*2007 Annual Consumer Survey Project*"). Age was evenly distributed and gender (n= 746) was not: 61% or 456 respondents were female and 39% or 290 respondents were male. Those responding to what his/her race/ethnic background identified as (n= 743) 88% Caucasian, 6% Latino, 1% African American, 3% Native American and 2% Other.

Respondents rated access to mental health services high with 91% (n= 729) stating that he/she feels "services were available at times that were good for me" and 88% of respondents reported (n= 723) that "I was able to get all the services I thought I needed". Most respondents, 91% (n= 714), agreed that "staff here believe I can grow, change and recover." The same percentage of respondents, 91% (n= 729), agreed "I like the services I received here." In terms of outcomes of treatment 65% (n= 675) agreed "I do better in social situations", 62% (n= 569) "I do better in school or work", 58% (n= 688) that "My symptoms are not bothering me as much", 65% (n= 695) that "I am better able to control my life".

The outcomes of this consumer survey show respondents were pleased with the services he/she received and the outcomes of these services in terms of moving towards one's own recovery. Who, then, is *not* included as a respondent? Who is falling through the gaps and not receiving necessary mental health or substance abuse services?

Identifying the Gaps

Now that the indicators of consumer satisfaction with existing services and with Wyoming's Mental Health and Substance Abuse Services Divisions (MHSASD) has been presented, it is important to highlight the MHSASD's 2006 *Executive Summaries for Mental Health and Substance Abuse Gaps Analysis Reports* as well as the gaps in services as reported by key informants. The state *Gaps Analysis Reports* revealed the status of the state's public mental health and substance abuse services in terms of specific services offered and statistics on service utilization. The reports were also intended to "promote the transformation of Wyoming's mental health and substance abuse systems to achieve the goal of providing recovery-based, outcome-oriented, cost-effective services" (Callahan, Whitbeck & Smith, December 2006).

The reports identified three "primary factors" which serve to limit the Systems of Care to deliver needed services to those citizens with the greatest need: (a) lack of funding to hire enough staff to meet the increasing demands for services, (b) staff salaries and benefits are not competitive with surroundings states or other WY departments such as education or corrections, and (c) that it has proven difficult for professionals licensed in other states to transfer their credentials into Wyoming (Callahan, Whitbeck & Smith, 2006). Additionally, The National Association for Rural Mental Health highlighted another key problem faced by all rural areas when it recognized, "Not only do rural areas have shortages of behavioral health professions and specialized behavioral health services, but the turnover rate for service providers is high…" (Sawyer, Gale & Lambert, p. 1, 2006).

The Gaps Reports explained the state's understaffed programs are thus not able to reach all of their constituents who have requested services. An inquiry conducted on April 11, 2009, revealed the state's mental health and substance abuse centers had 35 job openings for mental health professionals, and of these 10 positions were for program supervisors or directors. Most strikingly, 6 of the total open positions have been vacant for *over two years and 10 of the positions have been vacant for three years* (Wyoming Association of Mental Health and Substance Abuse Centers Job Bank). These empty mental health professional posts have exacerbated the existing gaps in services in Wyoming, and with lower than average salaries, difficulty converting professional credentials and a lack of funding allocated to improving the salaries offered, these vital posts will most likely remain vacant. The Gaps reports called for "additional resources and funding" to hire new professionals (Callahan, Whitbeck & Smith, p. 3) yet the 2006 report's recommendations have not been adopted.

There are 24 Gaps in the state's mental health system that act as barriers to the achievement of helping the state's citizens obtain "optimal functioning and recovery" recognized in the Gaps Reports. Among the Gaps identified are: community mental health center (CMHC) average hours per client, psychiatric services by a psychiatrist hours per client and medication management hours per client, supported employment/vocational educational services and individual recreation and socialization services, crisis stabilization services, coordinated services for individuals with both mental health and substance abuse needs, services for older adults, funding for developing apartments and housing, acute impatient psychiatric services and voluntary admissions to the Wyoming State Hospital in Evanston. Identified in the report and in

The National Association on Mental Illness's (NAMI) 2009 "Wyoming Report Card" is that Evanston is the state's only psychiatric hospital and when the facility is full, those in need of services are held temporarily in the state's jails. In NAMI's report an anonymous Wyoming citizen recalled,

> My family member has had two involuntary commitments in the past five years. Both times, he was forced to stay in a local jail because mental health beds were not available in the local hospitals or in the only state mental hospital. (p. 157).

The reality of a person with serious mental illness in need of hospitalization being temporarily held in a jail cell is difficult to imagine for those unfamiliar with such gross shortages of services. This example illustrates what the real life manifestation of a Gap in services can be for an individual in dire need of such services. Another anonymous Wyoming citizen spoke of individual experience with what a gap in service translated into also: "We are a very rural area and it is not uncommon to have to drive 50 miles to receive help. When a person needs care, it needs to be available and that is just not the case in my community" (NAMI, p. 157).

Likewise, treatment providers, consumers and prevention workers who responded to the MHSASD Partner Survey's open ended questions were often blunt in their responses and gave ample feedback when asked, "In your opinion, what are the most important challenges facing the Mental Health or Substance Abuse system this year?" Of the total respondents (n= 138), 25 respondents cited limitations in the workforce. High turnover of providers and the difficulties encountered in frequently training new staff were common responses. One respondent said he sees the challenge of

> Providing care for the adults who have been uncooperative for years. As they age, many refuse to "tell their story" or trust another counselor. So many counselors

> have moved on and the client has to start over and over and over. (Wyoming Department of Health, 2008, p. 14).

After the sizable turnover problem, the next most common response given to the question of what the most important challenges facing the system was "funding limitations". There were 23 respondents who cited this problem and most responded that funding was not adequate to meet the community's needs. Some respondents also said there were challenges as to how the funding was distributed and several said that the Drug Court Program needed additional funding. The third most common response (n= 14) was that the System of Care was not meeting either his/her own professional needs or the needs of clients. These responses were related to the recent increase in state-mandated paperwork, resistance to change from within the community mental health centers, the shortage of services and affordable housing, and the variance in services among different regions in the state, and, lastly, the need for more services all around. Three respondents stated that services specific to older adults are lacking and two respondents noted the problem of individuals illegally selling benzodiazepines in their communities. Similarly, one respondent stated there was an increase in substance abuse clients due to "the progression of addiction" in Wyoming (Wyoming Department of Health, 2008, p. 14).

Another question on the Partner Survey asked, "What is the greatest Mental Health or Substance Abuse concern for your community?" One respondent summed up the macro problem well when he said the greatest concern is "providing a comprehensive array of services in an extremely rural county." There was great variation in other responses given by respondents (n= 147) with many concerned over lack of services across the continuum of care (n= 27) and 7 people specifically cited the need for services

for individuals with co-occurring disorders. There were also 7 people who said mental health services for children were lacking in their communities. Alcohol, street drug and tobacco use was a concern for many (n= 22) and specific substance abuse among teenagers was cited (n= 9). Six people felt methamphetamine was the greatest concern and 2 additional respondents wrote about the compromised safety of children due to methamphetamine use or in-home production of the drug. Chewing or "spit" tobacco was brought up by 4 respondents, one of whom said this is a particular concern among young people at the University.

Other responses to what the greatest mental health or substance abuse concern was in one's community were broad: 4 respondents said population growth and the toll on already tight resources, 4 answered suicide, 4 responded the "monopoly" caused by community health centers as the only providers of services and the resulting "lack of choice" for those in need of services, and 2 people answered the consequences of "fast lives" or breakdowns in family and community functioning which negatively impacts the youth. 5 respondents gave answers that can be classified as concerns with collective psychological barriers to change and are worthy of voicing:

> 1. This is the way we are in Wyoming.
>
> 2. Community denial
>
> 3. Social Norms
>
> 4. The perception that alcohol is just a rite-of-passage and that on the other hand alcohol is just part of our culture.
>
> 5. The idea that [my] County doesn't have a substance abuse problem, the "not in our community" mentality. (Wyoming Department of Health, 2008, p. 14)

The "This is the way we are in Wyoming" mentality needs to be understood before it can possibly be combated. Researchers Bonnie Berry and Ann E. Davis (1978) wrote that it is problematic for urban-born and trained mental health professionals to be responsive to the culture in a rural area. Compounded with the rural population's low rates of mental health literacy, it is clear to the authors that the existing community mental health service system is not meeting the needs of rural citizens (1978).

Filling the Gaps

Drug Courts

Berry and Davis (1978) suggest mental health professionals in rural areas must have "special skills and qualities" such as the knowledge of rural politics and power, the ability to develop relationships with key community members and the sympathy for local values and norms (p. 676). The Wyoming Department of Health's Mental Health and Substance Abuse Divisions Gaps Analysis Report does not specifically discuss the points raised by Berry and Davis, but it does acknowledge the major barriers to hiring and retaining staff in a greater sense. Professionals who are successful collaborate with local officials, courts, schools and other local agencies (Berry & Davis).

The Drug Court Program, first established in Wyoming in 2001, is an example of a successful program which has been closing a crack in the system and expanding over the years. The program began with two drug courts and now operates 23 state-funded drug courts and 3 with other funding streams. The Wyoming Mental Health and Substance Abuse Services Division collects outcome data on all drug courts and these data demonstrate the programs to be effective alternatives to incarceration. The program

also saves the state $120.47 a day per participant over the cost of housing that individual in the State Penitentiary at Rawlings (McDaniel, 2008, p. 4).

It is imperative to remember that Drug Courts operating in the state are limited to referring their clients to existing, local substance abuse treatment centers and while gaps exist in availability of those services exist, the treatment outcomes will continue to be somewhat limited. Heath Miller, LCSW, the Treatment Liaison for the Teton County Drug Court Program, knows one must "remember that our population base here is only 18,000 people and our resource and treatment options are very limited" (personal communication, January 22, 2008). In Mr. Miller's county there are no detoxification or other in-patient or residential services available for the substance abuse population.

The Wyoming Department of Health's Mental Health and Substance Abuse Services Division formally recommended expanding its investment in treatment-based courts in the *Report on Substance Abuse Control Plan* in October of 2008:

> The Division also believes demand for new and expanded drug courts supports an increase in funding for the program and an expansion for the drug court concept to mental health and domestic violence. Given the success of sex offender courts and the growing numbers of sex offender cases around the state, it may be useful to pilot such a program in one of the state's larger judicial districts. (McDaniel, p. 10).

The report also states the Drug Court Steering Committee will recommend these expansions through legislation in the 2009 session.

Mental Health Literacy

The second point raised by Berry and Davis (1978), the poor recognition and understanding of mental health problems among the general population, is a concern recognized internationally and discussed in the last chapter of this research. In the

western United States the Western Interstate Commission on Higher Education (WICHE) is addressing this gap by providing "Mental Health First Aid," 12-hour trainings around the region with the purpose of giving "members of the public key skills to help someone who is developing a mental health problem or experiencing a mental health crisis" (WICHE, n.d.). The training is evidence-based, seeks to build mental health literacy and teaches how to assist an individual through a panic attack, how to help someone who is suicidal, support someone who is experiencing psychosis or an overdose of substances. Moreover, trainees learn risk factors and warning signs of various illnesses, learn to understand the impacts of those illnesses and learn what evidence-based treatments are available.

Nicole Speer, Ph.D, of WICHE, is responsible for the training program in the Western States. While she does not know of any trainings that have taken place in Wyoming, she has trained several individuals from Wyoming mental health centers. Dr. Speer has also received interest from a University of Wyoming professor who is investigating the possibility of providing a university-wide training. Dr. Speer states the research done on Mental Health First Aid proves this model to be more effective in rural areas verses urban areas. At the same time she admits a limitation of the Mental Health First Aid research is that the majority of the research tracks the trainer as opposed to the lasting results for the community receiving the training (personal communication, April 30, 2009). The model itself was created by a team of researchers in Australia.

Recognized "Promising Practices"

The 2006 Gaps Analysis Report by The Wyoming Department of Health's Mental Health and Substance Abuse Services Division recognizes "Promising Practices": three

mental health programs in Wyoming which are both innovative and successful. The *Washakie Works at Washakie Mental Health Services, Worland*, is a supported employment program run by a licensed construction contractor. The program advertises in the community and receives contracts from community members to do general construction and renovation projects. Participants learn construction skills which they are then able to use to find employment with local construction management firms. The *Central Wyoming Counseling Center's Supported Employment Program, Casper,* has been collaborating with the local Division of Vocational Rehabilitation since 1994. In 2006, 73% of the Center's clients with SPMI were working in full or part-time positions in the community. This program has been recognized as one of the twenty-four outstanding "best practice" programs in the nation by the President's Committee on Employment of People with Disabilities. *Affordable, safe housing for SPMI Clients* is the third "Promising Practice" recognized in the Gaps Report. Jackson Hole Community Counseling Center, Pioneer Counseling Services in Evanston, Southwest Counseling Service in Rock Springs and Green River, Cloud Peak Counseling Center in Worland, Northern Wyoming Mental Health Center in four counties, Central Wyoming Counseling Center in Casper, and Peak Wellness Center in Cheyenne all provide this service.

The National Association for Rural Mental Health also recognizes model programs in the report *Rural and Frontier Mental and Behavioral Health Care: Barriers, Effective Policy Strategies, Best Practices.* In this report programs are recognized from rural areas nation-wide, but no Wyoming programs are included. The report's authors acknowledge that the programs which they have chosen to include "share a common theme- the need to make better use of limited resources in rural communities" (Sawyer,

Gale, & Lambert, 2006, p. 5). Also recognized is the frequent loss of funding due to the expiration of a grant and the subsequent loss of an innovative rural and frontier model program.

Other Current Innovations

Telehealth

Wyoming's Rural and Frontier Health Division has an Office of Telehealth and Telemedicine. Currently, there is a project being piloted at the Wyoming Behavioral Institute (WBI) in Casper and its satellite clinics in Gillette and Rock Springs, which are 183 miles and 225 miles away from Casper respectively. The WBI, a 90-bed private behavioral health hospital is a subsidiary of Universal Health Services, Inc., one of the nation's largest providers of healthcare. The telehealth program at WBI is aimed at providing out-patient treatment via a video conferencing link to clients in Rock Springs and Gillette where in the past the two treatment providers (based in Casper) would travel to each town. A summary of the project posted on the Office of Telehealth and Telemedicine website states the provider is able to increase the total number of clients seen which greatly benefits the state as there is a recognized lack of health professionals state-wide.

Another pilot program is also in operation with the support of the Office of Telehealth and Telemedicine. This program is through the Wyoming Recovery, LLC, another provider of in-patient drug detoxification and residential programs for those with substance abuse addictions. This program makes use of telehealth services differently in that this video conferencing is used to allow for continuing support of clients following on-site treatment in Casper. The goal of this use of video conferencing is to provide for

clients to continue to receive on-going peer group and professional support from the same team of people with whom they have worked when in in-patient treatment. This aftercare is provided to clients in Rock Springs, Sheridan and Cheyenne and may be extended in the future (Office of Telehealth and Telemedicine website).

The National Association for Rural Mental Health realizes the potential of telehealth methods. In the current climate of budgetary constraints the organization feels telehealth's "expansion and active use is the single area where improved patient care could be realized" (Sawyer, Gale, & Lambert, p. 6, 2006). Furthermore, this association stated, its use can be expanded to include consultation between professionals, education for both patients and professionals and administrative consultation. One limiting factor that has surely slowed down the proliferation of telehealth's use is the lack of clear reimbursement methods for healthcare delivered through this medium (Sawyer, Gale, & Lambert, 2006, p. 5).

SAGE System of Care

The Wyoming SAGE (Support, Access, Growth, Empowerment) System of Care is a $9 million, 6-year grant from the federal Substance Abuse and Mental Health Services Administration awarded to the Wyoming Department of Health's Mental Health and Substance Abuse Division. A "system of care" is described on the initiative's website as a county-wide movement to drive the way health care is provided by empowering families and youth with serious behavioral and emotional challenges (SED). Through collaboration in service planning, the SAGE program is described as being family-driven, youth-guided, culturally and linguistically competent, comprehensive, individualized, flexible and community-based (WY SAGE website).

The impetus for the SAGE initiative was the 2003 President's New Freedom Commission report which found that the three major barriers for Americans with mental illness to receive high quality care are as follows: stigma, fragmentation of services and disparities in access to services. The SAGE project seeks to combat these problems through the following processes: partnering with SED youth and their families to best serve and empower them as stakeholders and also to keep SED youth in the community whenever possible; studying and making changes to state policies to support system change; inviting communities to be SAGE System of Care pilot sites; providing statewide training and education; engaging in a statewide stigma-fighting campaign; and participating in a federal outcome study (WY SAGE website). The first pilot site, Jackson, Wyoming, is required to implement an evidence-based treatment modality such as Therapeutic Foster Care, Wraparound or day treatment for adolescents with SED. Additionally, the mental health staff at the Jackson Hole Community Counseling Center working on this project will be working to improve access to services and organization of funding while also examining new funding streams.

One innovative project of the SAGE initiative that has already started up in Wyoming is the Photovoice Project. It is described as a "participatory action research strategy (PAR)" and is further described on the SAGE website:

> Photovoice uses photography and participant stories as a means to access the all too silent themes associated with the lives of individuals and families from under-represented, stigmatized groups. Photovoice is NOT a photography project, art therapy, or photojournalism. Photovoice IS…a multi-step process that combines equal parts photography, research, group process, storytelling, social action, and development of awareness of personal and community issues (*What is photovoice?*, WY SAGE website).

The Photovoice project was first created by two graduate students in Social Anthropology at Edinburgh University. Their organization seeks to "bring about positive social change for marginalised communities through providing them with photographic training with which they can advocate, express themselves and generate income" (Photovoice website, *Background*). While the SAGE initiative appears to have taken some creative liberty with their use of the Photovoice mission, social justice is a common threat in both the original Photovoice organization (which continues to operate worldwide) and the Wyoming SAGE System of Care project. The Wyoming project has posted the work of Photovoice projects by both youth and parents/guardians in Wyoming on its website, http://www.photovoicewyoming.com/projects.html.

The Wyoming SAGE System of Care is conceptualized to fill the gaps in service delivery, to make treatment more appropriate for the needs of consumers and to give consumers and their families a voice. The project holds communities that choose to participate accountable through the use of a federal outcome measurement. The Wyoming Department of Health's Mental Health and Substance Abuse Division is held accountable also, and if the department hopes to continue to receive this funding, it must strive to improve its own systems to contract with treatment providers who use evidence-based practices and who properly manage budgets.

Peer Specialists

Wyoming was one of the first states to begin training and employing peer specialists (S. Edwards, personal communication, May 2, 2009). These workers are trained in four core areas: their job responsibilities and the skills necessary to do the job, the recovery process and how to make use of their own recovery story to assist others,

understanding how to establish healing relationships and the understanding of the importance of taking care of oneself (Fricks, 2008). Perhaps most importantly, the work of peer specialists was deemed "evidence-based" by Medicaid (Fricks, 2008) and thus is reimbursable though this major insurer. Moreover, NAMI recognized Wyoming's peer specialists as one of the bright points of the state's mental health care system and recommends expanding this service (NAMI, 2009, p. 157). Unfortunately, recent state cut-backs are threatening peer specialists statewide. In Jackson, Wyoming a $35,000 state grant that funded a peer specialist at the Jackson Hole Community Counseling Center was revoked in April 2009 (Froedge, 2009).

"Rural Proofing"

In the NAMI *Grading the States 2009: A Report on American's health care system for adults with mental illness* there is a "special note on poor rural and frontier communities" (p. 45). This section addresses the organization's support of the need to "rural proof" the policies that guide the transformation and development of rural mental health services. These terms, "rural proof" and "rural proofing" are used by the Northern Ireland Department of Agriculture and Rural Development (DARD). DARD defines "rural proofing" as

> a process which: ensures that all relevant policies are examined carefully and objectively to determine whether or not they have a different impact in rural areas from that elsewhere, because of the particular characteristics of rural areas: and where necessary, what policy adjustments might be made to reflect rural needs and in particular to ensure that as far as is possible, public services are accessible on a fair basis to the rural community (DARD, 2006, p. 4).

While researchers Berry and Davis (1978) and countless others have discussed the need for policy and actual service delivery to be adapted locally to meet the specific needs of

the rural community, the literature shows little progress towards this objective over the last several decades. Having said that, the Wyoming SAGE System of Care can be interpreted to be a positive move in this direction.

WICHE Report

The Western Interstate Commission on Higher Education (WICHE) has an active Center for Rural Mental Health Research. In the February 2009 edition of the newsletter of the Wyoming Rural and Frontier Health Division, it was announced that WICHE is collaborating with the Health Resources and Services Administration's Office of Rural Health Policy, and the Nakamoto Group, Inc. (a private contractor) to identify "promising practices, best practices, models that work, and evidence based practices in rural behavioral health" (p. 6). The goals behind this project are for rural providers to read the resulting report and learn from the model practices, and hopefully adapt these practices into their own communities. In the initial stage of the project, completed in mid-March, 2009, individuals were asked to nominate exemplary practices. From these nominations 30-40 will be selected and additional information will be gathered. Next a selection process will lead to 10-20 practices for which site visits will be conducted. The end products will be "rural promising practices documents" which will be both a summary of the practices and a technical assistance guide for other rural programs that want to move in the same direction as the highlighted programs (Rural Assistance Center, 2009). The project's first document is scheduled to be available in early 2010, and the second in summer or fall of 2010 (N. Speer, personal communication, May 3, 2009), and has the potential to assist Wyoming treatment providers to transform their current practices.

Although there are serious barriers to accessing quality mental health treatment in Wyoming as laid out in this chapter, the hard work of the Western Interstate Commission for Higher Education, the Wyoming SAGE System of Care Initiative (including the work of consumers), the state Department of Health's Rural and Frontier Health Division and Mental Health and Substance Abuse Services Division are all striving to improve this situation for this and future generations of Wyoming citizens.

CHAPTER V

DISCUSSION

In the last few chapters this thesis project has documented the major challenges to the delivery of mental health services in rural areas of the world and the specific challenges to the western state of Wyoming. The last chapter laid out the innovative, collaborative initiatives currently striving towards improving the mental health and substance abuse systems in Wyoming. This Discussion will begin with a topology of the key problems facing the mental health system in Wyoming, the unmet needs created by these problems, and my recommendations towards remedying the problems. Lastly, this thesis project will conclude with commentary on its relevance and possible contribution to the field of clinical social work.

Key Problems facing the mental health and substance abuse treatment systems of Wyoming, unmet needs and suggestions for improvement

- *Mental health stigma*

Several sources (B. Olson, personal communication, May 20, 2009; Hoyt et al., 1997; Fuller, Edwards, Procter & Moss, 2000) have stated that stigma is a significant barrier to help-seeking among rural men. Moreover, when a man has received past psychological treatment, his own stigma towards services does not significantly change (Hoyt et al., 2007). Researchers have quantifiably measured stigma with the Perceived Stigma Scale and other tools, and have knowledge as to how social norms govern behavior and contribute to keeping mental health a socially taboo subject. My recommendation for combating stigma encompasses the next key problem addressed in this paper.

- *Acting out behaviors*

Acting out behaviors such as committing crimes that involve alcohol are symptomatic of the "male depressive syndrome" proposed by Walinder and Rutz (2001). Acting out is repeatedly socially minimized and decriminalized when community members downplay criminal acts as "boys just being boys" or "the guys letting off some steam". The tale of a drunken break-in to a liquor store, for example, is the type of story that could get a lot of laughs when told around the bar by a man to his group of male drinking buddies. As long as cultural norms reframe crimes as shenanigans, and there continues to be great stigma towards the acknowledgement of mental health problems such as depression, acting out will be a common occurrence in Wyoming and other rural areas.

I propose the only method of counteracting the powerful messages of social norms of behavior is through wide-spread broadcast (television, radio) and advertisement (internet, newspaper, magazine) of messages that counter popular norms. Australia has had success with its country-wide campaign to fight stigma and challenge social norms. This ten-year campaign is run by the independent, non-profit organization, *beyondblue: the national depression initiative,* and is funded by Australian national, state and territory governments. The mission of *beyondblue* is to "provide a national focus and community leadership to increase the capacity of the Australian community to prevent depression and respond effectively to it" (Jorm, Christensen & Griffiths, 2005, p. 248). It has five priority areas: community awareness and destigmatization, consumer and carer support, prevention and early intervention, primary care training and support, and applied research (Jorm, Christensen & Griffiths, p. 248).

A study was undertaken before *beyondblue* began and several years into the campaign to evaluate whether the *beyondblue initiative* had influenced the Australian public's ability to identify depression and their beliefs about treatment. It was found that all regions of the country had increased recognition of depression over an eight-year time span (p. 250). In the eight states with high exposure to *beyondblue*, (where the state governments had bought-in) these areas had a greater increase in belief in the helpfulness of several interventions (counselor, phone counseling, antidepressants and tranquillizers) then the states with low-exposure to *beyondblue* (which are New South Wales and Western Australia). The high-exposure states also showed a greater decrease in the belief that it is helpful to deal with depression alone. The researchers commented that the results of this study prove that *beyondblue* has brought the public beliefs closer to those of professionals in terms of counseling and antidepressants as well as the value of help-seeking generally (Jorm, Christensen & Griffiths, 2005, p. 251).

The *beyondblue initiative*'s research results are an encouraging testament to the impact of such a campaign, and encourage the possibility for a similar country-wide campaign in the United States. Would a national campaign to fight stigma and educate the public about a major mental illness such as depression have similar results here in the United States? This question has yet to be answered, but the multiple overlapping outcomes for other mental health research conducted in Australia and that produced in the U.S. implies that similar outcomes would be possible for a *"beyondblue: U.S.A"* initiative.

Additionally, a specific initiative to combat mental health stigma aimed at primary care physicians needs to undertaken. Because of the literature regarding the

significant lack of mental health training among primarily care physicians, and the acknowledgement that these men and women are usually the trusted individuals most positioned to help rural people with psychological issues, it is imperative that these doctors do not consciously or unconsciously encourage non-disclosure of mental health problems due to their own unease with this area of medicine.

- *Lack of qualified, professional mental health counselors and doctors*

Wyoming's Mental Health and Substance Abuse Divisions has articulated that the three "primary factors" which limit the state's service provision to those citizens with the greatest need are (a) lack of funding to hire enough staff to meet the increasing demands, (b) staff salaries are not competitive w/ surroundings states or other Wyoming departments such as education or corrections and, (c) the transferring of credentials into Wyoming is a barrier for professionals (Callahan, Whitbeck & Smith, 2006). Moreover, issues facing rural areas of the country are not always included in graduate psychology or social work education.

I propose that resources be allocated for a "Rural Service Fellowship" for students enrolled in clinical social work, psychology, psychiatry and marriage and family therapy (MFT) studies. Similar to state-funded Child Welfare Fellowships which provide full or partial tuition and education related expenses for students who commit to work for child protective service agencies after graduation, a Rural Service Fellowship would produce specially-trained professionals who are obligated to work in rural areas of the country for a mutually agreed upon amount of time which is proportionate to the monetary value of the education received. Ideally, this program would attract a high percent of its participants from rural areas who would then return to their home communities in service.

In addition to the contracts the host state would have with the individual graduate institutions, the host state would also contract senior and mid-level professional rural social workers, MFTs, psychologists and psychiatrists to be mentors to the new professionals, providing on-going support to them which may result in the new clinicians and doctors choosing to continue their rural service after their obligation has been satisfied.

- *Isolation and low prioritization*

Almost half of Wyoming is classified as frontier (Wyoming Department of Health, Office of Rural and Frontier Health Division). The physical isolation of the citizens combined with high rates of poverty (Powell, 2008) and stoicism contribute to the potential for severe social isolation (Murray, Judd, Jackson, Fraser, Komiti, & Pattison, 2008). Depression can result, which has a causal relationship to suicide (Walinder & Rutz, 2001). Because Wyoming is the least populated state and it is across the country from Washington, D.C., its social problems are not top priorities of law and policy makers. Including the needs of Wyoming in a nation-wide mental illness education and stigma-fighting initiative such as "*beyondblue U.S.A: the national depression initiative,* however, is a cost-effective way of effecting meaningful change country-wide.

Another way of potentially effecting change is the "Mental Health First Aid" training offered in the Western United States by the Western Interstate Commission on Higher Education. Conducting research on the effectiveness of these trainings at the community level through longitudinal study could produce encouraging results which may lead to the proliferation of such trainings. As the limited research conducted in

Australia illustrates, these trainings are valuable tools for communities, and more work needs to be done in this mental health literacy and preparedness area.

Contributions and Conclusion

This thesis addressed why the delivery of professional mental health services is challenging in rural and frontier Wyoming and how help-seeking attempts by men in this state are limited by psychological and socio-cultural barriers to receiving care. This thesis also highlighted localized efforts to combat this phenomenon and wider efforts in other regions and countries which might be adapted to meet Wyoming's needs.

This theoretical research paper is intended to inform rural mental health policy and, to that end, a Wyoming State Department official has requested a copy of it. It is my hope that the presentation of exciting new rural mental health initiatives in the United States and abroad detailed within this paper will be able to inform the important work of Wyoming policy makers.

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