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# Access to mental health services and family impact of rural children with mental health problems

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Maine Rural Health Research Center  
Working Paper #45

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October 2010

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## TABLE OF CONTENTS

EXECUTIVE SUMMARY .....	i
INTRODUCTION .....	1
BACKGROUND .....	2
Prevalence, Need, and Service Use.....	2
Site of Service.....	2
Impact of Income and Insurance Status .....	2
Family Impact .....	3
METHODS .....	4
Data.....	4
Dependent and Independent Variables .....	5
Statistical Analysis.....	5
FINDINGS.....	6
Rates and Characteristics of Children with Mental Health Problems.....	6
Access to Mental Health Services and Problem Severity .....	7
Family Impact.....	7
Factors Associated with Use of Mental Health Services .....	7
LIMITATIONS.....	8
DISCUSSION AND POLICY IMPLICATIONS.....	9
REFERENCES .....	11
APPENDIX.....	1

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## EXECUTIVE SUMMARY

### Introduction

The majority of children with mental health problems go untreated, and the gap between need and service use is assumed to be wider in rural than in urban areas. It is also assumed that rural families of children with mental health problems experience a greater financial and emotional impact than urban families. These assumptions reflect the lower availability of mental health specialty care and support services in rural areas. Lower income and more limited economic opportunities may further hamper the ability of rural families to care for children with more severe mental health problems. The current research literature does not describe how well the needs of children with mental health problems are being met in rural areas, or the impact of these needs on rural families' financial and emotional well-being. Although there are reasons to believe the burden these problems place on families is higher in rural areas, evidence is limited.

### Methods

Using data from the 2005-06 National Survey of Children with Special Health Care Needs (NS-CSHCN) and the 2006 Area Resource File, we compared prevalence, access, problem severity, and family impact for rural and urban children with mental health problems. Because the NS-CSHCN has a complex sampling strategy, we used sampling weights and statistical procedures that adjust for clustering in SAS.

### Findings

Children in rural areas have a small, but significantly higher prevalence of mental health problems compared to children in urban areas (5.8 percent versus 5.3 percent). A greater proportion of rural children with mental health problems have a behavioral difficulty compared to urban children (59.1 percent versus 53.7 percent). Access to *any* mental health care does not differ significantly between rural and urban areas. However, the probability of receiving *all* needed mental health care is lower among children with mental health problems living in rural areas than urban (OR: 0.81, CI: 0.71-0.92). Uninsured children with mental health problems are more likely than privately insured children to receive *any* mental health care, but less likely to receive *all* (OR: 0.4, CI: 0.30-0.53). Among families of children with mental health problems, a greater proportion of rural families spend six or more hours each week coordinating their child's care (12.1 percent) than do urban families (8.5 percent).

### Discussion and Policy Implications

Mental health problems have considerable impact on children and their families and some of these impacts are higher in rural than urban areas. Rural children are slightly but significantly more likely to have a mental health problem than urban children, are more likely to have a behavioral difficulty, and are more likely to be usually or always affected by their condition. Compared to urban children, rural children are more likely to go without access to all parent-reported needed mental health services and their families spend more time coordinating their care. To improve access to care for children with

mental health needs and their families, policymakers and providers should consider models that have been effective for children with other special health care needs, including a medical home with care coordination, adequate insurance coverage, and organized community-based services. Promoting access to public coverage and outreach regarding care coordination benefits are important for ensuring access to mental health care for children in rural areas.

## INTRODUCTION

Children's mental health problems are estimated to range from 2.1 percent of U.S. children with a disabling mental health condition,<sup>1</sup> to 5 percent of U.S. children with an emotional or behavioral health problem,<sup>2</sup> up to an estimated 13 percent of U.S. children with some type of mental health problem.<sup>3</sup> Our previous estimates indicate 7.5 percent of children had a behavioral or mental health problem.<sup>4</sup> Despite this range, use of services consistently lags behind the numbers of children who need mental health services. The majority of children do not receive care for their problem; roughly two-thirds of children who need mental health care do not receive it.<sup>5-7</sup> This gap between need and service use is assumed to be wider in rural than in urban areas, particularly for children with more serious needs.<sup>8</sup>

In addition to unmet needs, families of children with mental health problems are likely to experience negative financial and emotional impacts resulting from their child's condition.<sup>9-11</sup> Research to date on rural family impact has included children with all types of special health care needs, yet families living in rural areas may be especially vulnerable to the financial and emotional impacts of caring for a child with mental health problems because rural families often live in communities with few mental health providers<sup>12</sup> and mental health service use among rural children is lower.<sup>4,13</sup> Moreover, rural families of children with special health care needs spend more time caring for their children at home and experience more financial difficulties related to the child's medical needs than urban families.<sup>14</sup>

The current research literature does not describe how well the needs of children with mental health problems are being met in rural areas. Although there are reasons to believe the burden these problems place on families is higher in rural areas, evidence to support this assumption is limited. Our key study questions include:

1. What proportion of rural and urban children have a mental health problem, and what is the severity of that problem?
2. How well are the mental health problems of these children being met across rural and urban residence?
3. Are there rural-urban differences in the financial and logistical impact of these needs on families?

This paper examines variation in the proportion of children with mental health problems, access to services, problem severity, and family impact of these needs across rural and urban counties. The needs of rural children with mental health problems and the impact of these needs on their families are intertwined and may place rural children and their families at risk of having their mental health and other needs go unmet. This paper aims to provide rural policy makers with critical information to better understand these needs and how best to support rural families.

## **BACKGROUND**

### **Prevalence, Need, and Service Use**

Estimates indicate that anywhere from 2 percent to 13 percent of U.S. children have some type of mental health disorder.<sup>1,2,15,16</sup> Other estimates indicate that five to nine percent of children with mental illness experience symptoms severe enough to result in impaired functioning.<sup>17,18</sup> Untreated mental health disorders can lead to school failure, family conflicts, drug abuse, violence, and suicide.<sup>19</sup> Despite high prevalence and the possibility of poor outcomes, only a proportion of children who need services actually receive them. Nearly two-thirds (64.7 percent) of children who needed mental health care did not receive it in 1997 and 1999.<sup>20</sup> Nearly 40 percent of children with an emotional or behavioral problem used mental health services in 2002.<sup>21</sup> Children with severe emotional disturbances use ten times as many services as youth with less severe mental health problems.<sup>22</sup>

Rates of childhood mental health problems do not differ greatly between rural and urban settings,<sup>23,16</sup> but problems with access to children's mental health services appear to be more pronounced in rural areas. In 1997, 1999, and 2002, children with mental health problems in rural areas were significantly less likely to have had a mental health visit compared to children with mental health problems in urban areas.<sup>23</sup> Controlling for other characteristics that affect access to care, rural children are 20 percent less likely to have a mental health visit than urban children.<sup>16</sup> Stigma toward the use of the mental health system may limit acceptance of mental health treatment by parents in rural settings.<sup>24</sup>

### **Site of Service**

Schools provide the majority of children's mental health services, with specialty mental health services and general medical care contributing a smaller proportion of care. The Great Smoky Mountain Study found that 70-80 percent of children who received services did so within their schools, with schools often serving children without psychiatric diagnoses. The specialty mental health sector provided care to 20 percent of children who received any mental health service and the general medical sector provided care to 11-13 percent. Very few children received care through the child welfare or juvenile justice systems, but when they did these children often had significant mental health impairment.<sup>25</sup> For the majority of children receiving services, the educational system was their sole source of care and the most frequent entry point for first receiving mental health services.<sup>25,26</sup>

### **Impact of Income and Insurance Status**

Prevalence of children's mental health problems is associated with low family income. Among children ages 6-17, 12 percent of children with family income below the federal poverty level (FPL) had a mental health problem, compared to 9 percent of those between 100-200 percent of the FPL, and 6 percent of children above 200 percent of the FPL.<sup>21</sup> Low household income is associated with high levels of depression and antisocial



behavior in children and subsequent improvements in household income reduce children's mental health problems.<sup>27,28</sup>

Prevalence of mental health problems and service use also differs with insurance status. Among children ages 6-17, 12 percent of children with Medicaid or SCHIP had identified mental health problems compared to 9 percent of the uninsured and 6 percent with other coverage. Even among non-poor children, those covered by Medicaid or SCHIP had higher rates of mental health problems than non-poor children covered by other types of insurance. Children may be Medicaid-eligible as a result of severe mental health problems, which may partially explain the high rates of public coverage among children with mental health problems.<sup>21</sup> Children who were uninsured or had public coverage had higher rates of serious emotional disorder than those children with private insurance.<sup>29</sup>

Correspondingly, mental health service use is highest among children with public coverage. Medicaid coverage significantly increased the likelihood of mental health service use over private coverage and being uninsured.<sup>22, 30-33</sup> Children with either public or private coverage were equally likely to use mental health services and three times as likely as children without coverage.<sup>21</sup> This finding likely reflects a higher need for mental health services among Medicaid children as well as Medicaid's more generous coverage compared to private insurance plans.<sup>21, 31-34</sup> Since rural children rely heavily on Medicaid and SCHIP for health insurance,<sup>16</sup> it is possible that rural children may actually have better access to mental health care than their urban counterparts.

## **Family Impact**

Children's mental health problems,<sup>35</sup> serious emotional disturbances,<sup>36</sup> mental disorders,<sup>37</sup> specific behavioral problems,<sup>38,39</sup> and medical conditions with a mental health component<sup>40</sup> have been shown to negatively affect the emotional and financial well-being of families. When children's mental health problems are severe, parents experience high stress levels.<sup>41,42</sup>

Caring for children with mental health problems affects financial well-being more so than caring for children with other special health care needs. Among the privately insured, families of children with mental health problems had higher out-of-pocket costs and were more likely to reduce their labor market participation than families of children with other special health needs.<sup>43</sup> Additionally, families of children with mental health problems were more likely than other families to cut work hours, to quit work, and to spend more time arranging their child's care.<sup>35</sup> Compared to families of children with physical conditions, families of children with behavioral disorders accrued greater total costs for office-based visits and prescription medications, the services least likely to be fully covered by private health insurance.<sup>44</sup>

Since they often live in communities with few mental health providers,<sup>45</sup> families living in rural areas may be especially vulnerable to the emotional and financial impact of caring for a child with mental health problems. Moreover, rural families of children with any special health care need spend more time caring for their children at home and

experience more financial difficulties related to the child's medical needs than urban families.<sup>46</sup>

## **METHODS**

The purpose of this study is to close the knowledge gap about the use of mental health services by rural children with mental health problems and the impact that caring for these children has upon their family. Specifically, we seek to identify any rural-urban differences in whether children with an apparent need for mental health care receive services; the extent to which the amount of care received meets their needs (based on parent perception); and, the specific challenges or impacts families face in providing or coordinating care for their children. To address these questions we analyzed a nationally representative survey of parents of children with special health care needs.

### **Data**

The 2005-06 National Survey of Children with Special Health Care Needs (NS-CSHCN) was conducted by the National Center for Health Statistics (NCHS) on behalf of the federal Maternal and Child Health Bureau between April 2005 - February 2007.<sup>47</sup> The NS-CSHCN was one module of the State and Local Area Integrated Telephone Survey of the Centers for Disease Control and Prevention, using the same sampling frame as the National Immunization Study. Through a random-digit dial sample, households across the 50 states and the District of Columbia were identified as having children under age 18. Then, households with children with special health care needs were identified using the CSHCN Screener. This Screener identified general health needs that could result from chronic health conditions. Follow-up questions were administered to determine if this general health need resulted from a medical, behavioral, or other health condition and whether the condition had lasted or was expected to last 12 months or more. A total of 40,840 special-needs interviews were conducted. The survey examined access to medical homes, adequate health insurance, and needed services as well as functional difficulties, care coordination, satisfaction with care, and transition services among children with special health care needs. The overall response rate for the special-needs interview was 56.1 percent. An additional screener file contains all responses to the CSCHN Screener, including 363,183 children identified with or without a special health need. We used this file to calculate the proportion of U.S. children with mental health problems.

Interviews were conducted with parents or guardians who knew about the child's health. The data file includes 40,723 children under age 18 with special health care needs (117 pre-Katrina hurricane interviews from Louisiana were excluded from the public release file). It contains 15,942 children with a mental health problem such as depression, anxiety, eating disorder, other emotional problem, attention deficit disorder (ADD), or attention deficit hyperactive disorder (ADHD). Approximately 18 percent of the sample resides in a non-metropolitan area.

The NS-CSHCN public use file contains a dichotomous measure of rural-urban that is suppressed in 16 states with either very small metropolitan or non-metropolitan populations. To gain access to the suppressed data, and increase flexibility in the way we defined “rural,” we applied for permission to conduct our final analyses through the remote-access procedure of the NCHS Research Data Center (RDC). Through the RDC, a linked file was created merging the NS-CSHCN with select variables from the Area Resource File including the Rural-Urban Continuum Codes (RUCC). Using the RUCC, we classified rural counties based their adjacency to a metropolitan area, enabling comparisons of populations living in urban counties, rural counties adjacent to urban counties, and rural counties not adjacent to urban counties (abutting only other rural counties).

### **Dependent and Independent Variables**

To examine how well the mental health problems of children are met across rural and urban residence, our dependent variables included two measures of mental health access: whether the child had received *any* needed mental health care or counseling in the past year and whether he or she had received *all* needed mental health care or counseling in the past year. These variables are based on the responses of a parent or guardian who knew about the child’s health and health care, which is subject to that person’s recall and perception. Though we have no reason to suspect that any potential bias differs between rural and urban areas, this variable may not reliably indicate true need for mental health care limiting the usefulness of our findings. Respondents were asked if there was any time in the past 12 months that a child needed mental health care or counseling. If the response was yes, the respondent was then asked if the child received all the mental health care or counseling that he or she needed. If the respondent replied that the child did not receive all needed mental health care, the respondent was asked if the child received any mental health care or counseling.

In addition to access, our dependent variables include measures of family impact, such as out-of-pocket costs for medical care, financial problems resulting from health conditions, need for additional income to cover medical expenses, stopping work or cutting hours to care for the child, need and receipt of mental health care/counseling for the family regarding the child’s condition, need and receipt of respite care for the family, and hours spent by family in coordinating/arranging care for the child.

Our primary independent variable of interest is rural or urban location and adjacency to an urban location as described above. Other covariates include socioeconomic variables known to affect health care use such as age, gender, race/ethnicity, number of adults in the household, region of residence, and health insurance coverage. To assess the level of need a child might have for mental health services, we also included a measure of problem severity (i.e., minor, moderate, severe).

### **Statistical Analysis**

Using bivariate and multivariate analyses, we addressed rural-urban differences in access to mental health services, problem severity, and the impact of mental health problems on

family well-being. At the bivariate level, we used chi-square tests to measure whether prevalence of a mental health problem, access to services, problem severity, and family impact differed by residence, and for individual and family socioeconomic characteristics within residence.

Our multivariate analyses included two logistic regressions to estimate 1) the odds that a child would receive any mental health or counseling services and 2) the odds that a child received all the mental health services the parent felt the child needed in the preceding 12 months. These models were limited to children whose parent reported that they had a mental health problem. Covariates included child's rural or urban residence, age, gender, race and ethnicity, condition severity, region, insurance status, and family income. Results are presented as odds ratios with 95 percent confidence intervals.

Throughout the text and tables, estimates presented are statistically weighted to represent the non-institutionalized U.S. population of children with special health care needs age 17 and under. The sampling weights are provided by the NCHS and are adjusted for number of CSHCN in the household and interview non-response. Because the NS-CSHCN employs a complex sampling strategy, the weights are assigned to each record based on the probability of selection and adjusted for key socio-demographic characteristics. We used these weights in our analyses to correct for sample design, using appropriate statistical procedures that adjust for clustering (e.g., *surveyfreq*, *surveymeans*, and *surveylogistic* in SAS version 9.2). These procedures have been tested and found to yield corrected standard errors that are comparable to SUDAAN and Stata.<sup>48</sup>

## **FINDINGS**

### **Rates and Characteristics of Children with Mental Health Problems**

Among all U.S. children, 5.4 percent have a mental health problem such as depression, anxiety, eating disorder, other emotional problem, ADD, or ADHD, representing nearly four million children (Table 1). A slightly higher proportion of children living in rural areas (5.8 percent), particularly those in adjacent areas (5.9 percent), have a mental health problem compared to children living in urban areas (5.3 percent). This estimate is lower than our previous findings, where we found that 7.5 percent of children had a behavioral or mental health problem with data from National Survey of America's Families.<sup>4</sup> The variation may be a factor of differing survey methods. The NS-CSHCN has been shown to produce lower estimates of children with special health care needs than other surveys using the same screening tool and to identify more children with complex health needs and consequences compared to other surveys.<sup>49</sup>

Children with mental health problems living in a rural, not adjacent area are more likely to be under age 12 (53.1 percent) compared to children living in an urban area (46.2 percent) (Table 2). Children with mental health problems in all rural areas are more likely to be white and not Hispanic (76.1 percent) compared to children in urban areas (64.4 percent). Rural children with a mental health problem are more likely to have family income below 200 percent of poverty (63.8 percent) and to have a public source of

coverage (58 percent) compared to urban children with a mental health problem (45.2 percent and 40.8 percent respectively). There is no appreciable difference between children living in not adjacent and adjacent rural areas in the proportion of those living in poverty and having public coverage.

### **Access to Mental Health Services and Problem Severity**

At the bivariate level, access to mental health care does not differ significantly between rural and urban areas (Table 3). Although point estimates suggest that rural children living in counties not adjacent to an urban area have better access to at least *some* services than their rural adjacent and urban counterparts, this finding was statistically inconclusive. We explore these relationships in greater detail in the logistic regressions described below.

Children with mental health problems in rural areas are somewhat less likely to report a health plan problem as a reason why they did not obtain needed care, compared to children in urban areas (16.6 percent versus 25.1 percent) (data not shown in Appendix). Rural children with mental health problems are just as likely as urban children to report that lack of transportation and limited availability of local services are barriers to care.

Children with mental health problems who live in rural areas are more frequently affected by their condition than those who live in urban areas (36.2 percent “usually or always” compared to 32.8 percent) (Table 3). Behavioral difficulties are most pronounced among not adjacent rural counties (60.8 percent versus 58.3 percent in rural adjacent and 53.7 percent in urban counties).

### **Family Impact**

Urban families are most likely to cut their work hours to care for their child with a mental health problem (22.2 percent); however, rural, not adjacent families (21.3 percent) are more likely than those in adjacent areas to cut their work hours (18.9 percent) (Table 4). Rural families are more likely to provide health care at home for their children with mental health problems, especially those families living in rural, not adjacent areas (47.7 percent in not adjacent compared to 41.0 percent in urban areas). The amount of time spent providing care does not differ by residence. Although the direct provision of care is not more time consuming for rural families, there is a rural-urban difference in the amount of time spent coordinating services for children with mental health problems. Twelve percent of rural families spend 6 or more hours coordinating care for these children each week compared to less than 9 percent of urban families.

### **Factors Associated with Use of Mental Health Services**

As noted earlier, we found no bivariate rural-urban differences in the percent of children with mental health problems that received any or all services their parents felt they needed. To further test this finding, we conducted a series of logistic regressions designed to test the odds of receiving any or all needed mental health services, controlling for sociodemographic characteristics known to affect need and access to

services (Tables 5 and 6). The first column of findings in each table displays the regression model with residence included as a dichotomous variable (rural-urban) and the second where rural residence was divided into adjacent and non-adjacent categories.

The first set of logit models supports the bivariate findings. The probability of receiving *any* needed mental health care among children with mental health problems does not differ by rural or urban residence, controlling for child and family characteristics (Table 5; OR: 0.84, CI: 0.65-1.09). This finding did not change when we separated rural residence into adjacent and non-adjacent categories. The characteristics associated with the likelihood of receiving any mental health care include being uninsured or having public coverage, being between 12 and 17 years old, and having either a moderate or severe condition.

In contrast, the probability of receiving *all* needed mental health care among children with mental health problems is lower among those living in rural areas (Table 6; OR: 0.81, CI: 0.71-0.92) and the uninsured (OR: 0.40, CI: 0.30-0.53). This may result from limited availability of specialty mental health providers in rural areas and reliance on schools for mental health services, an aspect of child development outside of schools' traditional purview. Compared to urban children with mental health problems, those in rural areas (both adjacent and non-adjacent) are 20 percent less likely to receive all needed services, controlling for child and family characteristics. The odds of receiving all needed services are 60 percent lower for uninsured children compared to those with private coverage. Having public coverage increased the likelihood of receiving all needed mental health care for children by 17 percent over private coverage. Additionally, boys, Hispanic persons, and those living in the South are less likely to receive all mental health care. As with receipt of any mental health care, being between 12 and 17 years old, and having either a moderate or severe condition increased the odds of receiving all mental health care. Children living in a household with one adult were 26 percent more likely to receive all services compared to children living with two adults, perhaps because of their greater receipt of other types of health and social services.

## LIMITATIONS

There are several limitations to our study. The NS-CSHCN has a response rate of 56 percent of families whose child was identified as having a special health care need through a series of screening questions. We do not know how families choosing and not choosing to participate in this survey may differ on important study variables. Another limitation is that both children's need for and use of services are based on parental report, which is subject to recall and perception. Parents of children in rural areas may perceive fewer unmet needs for medical care. Researchers suggest that this may result from the historical lack of available providers creating different patterns of use and lower perceived need among rural residents.<sup>50</sup> To the extent that this is true for mental health services, it would suggest that rural-urban differences in unmet need may be

underreported. Additionally, recall and perception may vary by family income, location, severity of children's health, and other factors that figure prominently in our analysis.

We are also limited by a lack of information about where children receive their mental health services and the volume of care they receive. Thus, when rural families report that their child did not receive all needed services, it is unclear whether or not the issue was one of quantity or type. It is possible that rural children are receiving fewer visits than needed, are not receiving care from a provider the parents would prefer (e.g. a child psychologist or psychiatrist versus a primary care provider or other professional), or both.

## DISCUSSION AND POLICY IMPLICATIONS

Children in rural areas have a small, but significantly higher rate of mental health problems compared to children in urban areas (5.8 percent versus 5.3 percent). As in other studies,<sup>21,29</sup> we found that children with mental health problems are more likely to live in poverty and to have public health insurance.

According to parental report, children with mental health problems living in rural areas are more frequently affected by their condition and are more likely to have behavior difficulties. Poverty is associated with behavioral symptoms in children, such as conduct and oppositional disorder.<sup>51</sup> Given the higher poverty rates we found among children with mental health problems in rural areas, poverty may be a factor in this rural-urban difference.

At the bivariate level, we find no rural-urban differences in access to mental health care services. This finding is confirmed at the multivariate level for initial receipt of services: rural children with mental health problems are as likely to receive *any* mental health care as their urban counterparts. However, rural children are 20 percent less likely than urban children to receive *all* mental health care that parents identified as necessary.

Children with mental health problems who are uninsured are more likely than those with private insurance to receive at least some mental health care; however, they are 60 percent less likely to receive *all* needed services. This may be because uninsured children receive limited mental health services through schools and child welfare agencies that are unable to provide the full range of needed services. When a child had public coverage, access to *any* mental health care increased by 37 percent and access to *all* mental health care increased by 17 percent over private coverage. Given the accessibility of mental health care through public coverage in rural areas, promoting and expanding children's access to Medicaid and the State Children's Health Insurance Program are important aspects of ensuring children's use of mental health services in rural areas, especially for low-income families.

Among families of children with mental health problems, a greater proportion of rural families spend six or more hours coordinating their child's care each week. It may be

that rural areas have fewer resources offering care coordination services. Urban schools, in particular, may be well-equipped to offer coordination activities as a result of having more concentrated numbers of children with mental health problems. Since rural children with mental health problems are often covered by Medicaid, and all states but Delaware cover targeted case management under their Medicaid programs,<sup>52</sup> it may be that rural families need more information about resources provided through this benefit.

Families are more likely to experience financial difficulties stemming from their child's condition if he or she has a mental health versus other special health care need (data not shown), confirming prior research.<sup>35,43</sup> This study indicates that this pattern is true for families in both rural and urban areas. In order to improve access to care for children with mental health care needs, and reduce the impact on families, policymakers and providers should consider models that have been effective for children with special health care needs in general. These models include a medical home with care coordination, adequate insurance coverage, and organized community-based services.<sup>53,54</sup>



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**APPENDIX**

*Table 1:*  
**POPULATION ESTIMATES OF U.S. CHILDREN  
 BY MENTAL HEALTH STATUS AND RESIDENCE**

<b>Residence</b>	<b>U.S. Children, Ages 0-17</b>	
	<b>Children with mental health problems, %</b>	<b>Children without mental health problems, %</b>
Rural, Not Adjacent	5.6 (n=229,405)	94.4 (n=3,867,491)
Rural, Adjacent	5.9 (n=470,692)	94.1 (n=7,562,825)
Rural, Total	5.8 (n=700,097)	94.2 (n=11,430,316)
Urban	5.3 (n=3,272,761)	94.7 (n=58,116,963)
US, Total	5.4 (n=3,972,858)	94.6 (n=69,547,279)

Rural-urban differences significant at  $p \leq .01$ .

Note: Due to rounding, totals may not equal 100 percent; n's are weighted.

**Table 2:**  
**SAMPLE CHARACTERISTICS OF**  
**CHILDREN WITH MENTAL HEALTH PROBLEMS BY RESIDENCE**

<b>Characteristics</b>	<b>Rural, Not Adjacent, % (n=2,009)</b>	<b>Rural, Adjacent, % (n=2,064)</b>	<b>Rural, Total, % (n=4,073)</b>	<b>Urban, Total, % (n=11,869)</b>
<b>Age of Child *</b>				
5 or under	8.8	6.9	7.5	6.6
6-11	44.3	41.6	42.5	39.6
12-17	46.9	51.5	50.0	53.8
<b>Gender*</b>				
Male	64.6	61.2	62.3	65.6
Female	35.4	38.8	37.7	34.4
<b>Race/Ethnicity ***</b>				
White, Not Hispanic	76.2	76.1	76.1	64.4
Not White, Not Hispanic	16.1	17.3	16.9	23.3
Hispanic	7.7	6.5	6.9	12.3
<b>Family Income ***</b>				
< 100%	32.3	34.4	33.7	21.6
100-199%	32.4	28.9	30.1	23.6
200% or more	35.3	36.6	36.2	54.9
<b>Condition Severity</b>				
Mild	33.2	33.2	33.2	34.9
Moderate	49.9	53.1	52.0	50.9
Severe	16.9	13.7	14.8	14.2
<b>Health Insurance Coverage ***</b>				
Uninsured	4.4	4.0	4.1	4.2
Private Coverage	37.1	38.2	37.8	55.0
Public Coverage	58.5	57.8	58.0	40.8
<b>Region ***</b>				
Northeast	6.1	12.1	10.2	18.7
Midwest	33.2	26.8	28.9	23.0
South	43.5	49.5	47.6	38.0
West	17.2	11.6	13.4	20.3
<b>Number of Adults in Household</b>				
One adult	21.6	20.2	20.7	20.5
Two or more adults	78.4	79.8	79.3	79.5

Rural-urban differences significant at  $p \leq .05$ , \*  $p \leq .01$ , \*\*  $p \leq .001$ .\*\*\*

Note: Due to rounding, some characteristics may not total 100 percent.

**Table 3:**  
**PROBLEM SEVERITY AMONG**  
**CHILDREN WITH MENTAL HEALTH PROBLEMS BY RESIDENCE**

<b>Access to Care and Problem Severity</b>	<b>Rural, Not Adjacent, % (n=2,009)</b>	<b>Rural, Adjacent, % (n=2,064)</b>	<b>Rural, Total, % (n=4,073)</b>	<b>Urban, Total, % (n=11,869)</b>
Receipt of MH care				
Received any MH care	74.2	60.9	65.4	68.0
Received all needed MH care	83.5	84.0	83.8	84.4
Amount of time child affected by condition over past year *				
Never / Sometimes	64.5	63.5	63.8	67.2
Usually / Always	35.5	36.5	36.2	32.8
How severely has condition affected child's ability to do things				
A great deal	24.5	25.4	25.1	25.9
Some / very little	75.5	74.6	74.9	74.1
Stability of child's health care needs				
Needs change all the time	10.1	10.3	10.3	8.7
Needs change infrequently or never	89.9	89.7	89.7	91.3
Difficulty with feeling anxious or depressed	62.3	63.1	62.8	60.3
Difficulty with behavior problems ***	60.8	58.3	59.1	53.7
Difficulty making and keeping friends	40.3	40.0	40.1	38.5
Severity of child's condition/problem				
Minor	33.2	33.2	33.2	34.9
Moderate	49.9	53.1	52.0	50.8
Severe	16.9	13.7	14.8	14.2

Rural-urban differences significant at  $p \leq .05$ , \*  $p \leq .01$ , \*\*  $p \leq .001$ .\*\*\*



**Table 4:**  
**IMPACT AMONG FAMILIES OF**  
**CHILDREN WITH MENTAL HEALTH PROBLEMS BY RESIDENCE**

Family Impact	Rural, Not Adjacent, % (n=2,009)	Rural, Adjacent, % (n=2,064)	Rural, Total, % (n=4,073)	Urban, Total, % (n=11,869)
Out-of-pocket costs				
\$1,000 or more	65.5	60.2	62.0	63.6
Less than \$1,000	34.5	39.8	38.0	36.4
Financial problems resulting from health condition	26.5	22.1	23.5	24.8
Need additional income to cover medical expenses	24.2	20.4	21.6	21.9
Stopped work to care for the child	16.5	16.9	16.8	17.2
Cut work hours to care for child *	21.3	18.9	19.7	22.2
Family provides health care at home for child ***	47.7	46.9	47.2	41.0
Hours per week spent by family providing care at home ***				
Less than one hour	30.0	29.8	29.9	31.9
1 – 5 Hours	41.4	43.0	42.5	40.8
6 – 10 Hours	10.2	8.7	9.2	9.4
More than 10 Hours	18.4	18.5	18.5	18.0
Hours per week spent by family in coordinating care for child ***				
Less than one hour	38.8	42.8	41.4	44.6
1 – 5 Hours	49.4	44.9	46.4	46.9
6 – 10 Hours	6.7	6.7	6.7	4.4
More than 10 Hours	5.1	5.6	5.4	4.1
Receipt of family mental health care regarding the child's condition	76.0	81.3	79.2	80.0
Receipt of family respite care	51.8	47.6	49.3	44.7

Rural-urban differences significant at  $p \leq .05$ , \*  $p \leq .01$ , \*\*  $p \leq .001$ .\*\*\*

**Table 5:**  
**LOGISTIC REGRESSION PREDICTING PROBABILITY OF RECEIVING**  
**ANY MENTAL HEALTH CARE FOR CHILDREN WITH MENTAL HEALTH PROBLEMS**

<b>Control Variable</b>	<b>Simple Urban-Rural Model O.R. 95% C.I.</b>	<b>Urban, Rural Adjacent and Rural Non-Adjacent Model O.R. 95% C.I.</b>
<u>Residence</u>		
Urban	1.0	1.0
Rural	0.84 (0.65, 1.09)	--
Adjacent	--	0.77 (0.55, 1.07)
Non-Adjacent	--	0.99 (0.73, 1.34)
<u>Health Insurance</u>		
Private	1.0	1.0
None	<b>2.34 (1.54, 3.57)</b>	<b>2.35 (1.54, 3.58)</b>
Public	<b>1.37 (1.03, 1.81)</b>	<b>1.37 (1.04, 1.81)</b>
<u>Age</u>		
0-12	1.0	1.0
13-17	<b>1.34 (1.06, 1.70)</b>	<b>1.34 (1.06, 1.70)</b>
<u>Gender</u>		
Female	1.0	1.0
Male	0.83 (0.66, 1.05)	0.83 (0.66, 1.05)
<u>Race / Ethnicity</u>		
White	1.0	1.0
African American	0.87 (0.64, 1.19)	0.87 (0.64, 1.19)
Hispanic	0.80 (0.54, 1.20)	0.80 (0.54, 1.20)
<u>Condition Severity</u>		
Mild	1.0	1.0
Moderate	<b>3.05 (2.29, 4.06)</b>	<b>3.05 (2.30, 4.06)</b>
Severe	<b>5.20 (3.67, 7.38)</b>	<b>5.20 (3.66, 7.36)</b>
<u>Region</u>		
Northeast	1.0	1.0
Midwest	0.92 (0.63, 1.35)	0.92 (0.63, 1.34)
South	0.97 (0.67, 1.41)	0.97 (0.67, 1.40)
West	1.27 (0.84, 1.91)	1.26 (0.84, 1.90)
<u>Family Composition</u>		
Two adults in household	1.0	1.0
One adult in household	1.13 (0.87, 1.46)	1.13 (0.87, 1.46)

Bold indicates significance at  $p \leq .05$ .

**Table 6:**  
**LOGISTIC REGRESSION PREDICTING PROBABILITY OF RECEIVING**  
**ALL NEEDED MENTAL HEALTH CARE FOR CHILDREN WITH MENTAL HEALTH PROBLEMS**

<b>Control Variable</b>	<b>Simple Urban-Rural Model O.R. 95% C.I.</b>	<b>Urban, Rural Adjacent and Rural Non-Adjacent Model O.R. 95% C.I.</b>
<u>Residence</u>		
Urban	1.0	1.0
Rural	<b>0.81 (0.71, 0.92)</b>	--
Adjacent	--	<b>0.80 (0.69, 0.93)</b>
Non-Adjacent	--	<b>0.82 (0.69, 0.97)</b>
<u>Health Insurance</u>		
Private	1.0	1.0
None	<b>0.40 (0.30, 0.53)</b>	<b>0.40 (0.30, 0.53)</b>
Public	<b>1.17 (1.04, 1.32)</b>	<b>1.17 (1.04, 1.32)</b>
<u>Age</u>		
0-12	1.0	1.0
13-17	<b>1.23 (1.10, 1.38)</b>	<b>1.23 (1.11, 1.38)</b>
<u>Gender</u>		
Female	1.0	1.0
Male	<b>0.87 (0.78, 0.97)</b>	<b>0.87 (0.78, 0.97)</b>
<u>Race / Ethnicity</u>		
White	1.0	1.0
African American	0.94 (0.81, 1.09)	0.94 (0.81, 1.09)
Hispanic	<b>0.79 (0.64, 0.98)</b>	<b>0.79 (0.64, 0.98)</b>
<u>Condition Severity</u>		
Mild	1.0	1.0
Moderate	<b>1.92 (1.70, 2.16)</b>	<b>1.92 (1.70, 2.16)</b>
Severe	<b>2.23 (1.86, 2.67)</b>	<b>2.23 (1.86, 2.67)</b>
<u>Region</u>		
Northeast	1.0	1.0
Midwest	0.87 (0.74, 1.02)	0.87 (0.74, 1.02)
South	<b>0.71 (0.61, 0.83)</b>	<b>0.71 (0.61, 0.83)</b>
West	0.88 (0.72, 1.07)	0.88 (0.72, 1.07)
<u>Family Composition</u>		
Two adults in household	1.0	1.0
One adult in household	<b>1.26 (1.10, 1.46)</b>	<b>1.26 (1.10, 1.46)</b>

Bold indicates significance at  $p \leq .05$ .

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- WP42. Race, M., Yousefian, A., Lambert, D., & Hartley, D. (2009, September). *Mental health services in rural jails.*
- WP41. Lenardson, J., Race, M., & Gale, J.A. (2009, December). *Availability, characteristics, and role of detoxification services in rural areas.*
- WP40. Ziller, E., Anderson, N.J., Coburn, A.F., & Swartz, J. (2008, November). *Access to rural mental health services: Service use and out-of-pocket costs.*
- WP39. Lambert, D., Ziller, E., Lenardson, J. (2008). *Use of mental health services by rural children.*
- WP38. Morris, L., Loux, S.L., Ziller, E., Hartley, D. *Rural-urban differences in work patterns among adults with depressive symptoms.*
- WP37. Yousefian, A. Ziller, E., Swartz, J., & Hartley, D. (2008, January). *Active living for rural youth.*
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- WP35. Lenardson, J. D., & Gale, J. A. (2007, August). *Distribution of substance abuse treatment facilities across the rural-urban continuum.*
- WP34. Ziller, E.C, Coburn, A.F., Anderson, N., Loux, S. (2006). *Uninsured rural families.*
- WP33. Ziller E, Coburn, Yousefian AE. (2005). *Out-of-pocket health care spending and the rural underinsured.*
- WP32. Hartley D, Ziller E, Loux S, Gale J, Lambert D, Yousefian AE. (2005). *Mental health encounters in CAH ERs: A national survey.*
- WP31. Hartley D, Hart, V, Hanrahan N, Loux, S. (2004). *Are advanced practice psychiatric nurses a solution to rural mental health workforce shortages?*

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