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Issue Brief

Rural Youth Mental Health

Issue

Rural New York is facing the pressing public health issue of mental health problems among K-12 children and adolescents. According to the Community-Level Youth Development Evaluation Survey (CLYDE) conducted in the Tompkins, Seneca, and Tioga counties, 39% of 8th graders reported being bullied, 40.3% of 12th graders felt depressed most days, and 49.5% felt worthless at times.[1] Additionally, 38% of 10th graders sometimes felt life was not worth living.[1] This data suggests significant mental health challenges among high school students in Tompkins, Seneca, and Tioga counties. Also, according to a 2023 youth survey report developed by the Rural Health Institute of New York, depressive symptoms are the highest among LGBTQ+ (52.4%) vs. straight (16.9%), transgender (59.8%) vs. cisgender (22.2%), disabled (40.8%) vs. not disabled (9.7%), BIPOC (29.1%) vs white (21.9%), and female (31.1%) vs. male (14.5%) students.[2] The evidence demonstrates a high prevalence of mental health issues among youth in vulnerable communities in rural New York. Consequently, this has led to an increase in suicidal thoughts and tendencies among transgender (58.3%) vs. cisgender (17.4%), LGBTQ+ (49%) vs. straight (11.9%), disabled (33.9%) vs. not disabled (6.6%), BIPOC (24%) vs. whites (17.4%) and females (23.4%) vs. males (12.9%).[2] Rural New York has witnessed an increase in suicide rates from 2004 to 2020, accounting for 83.1%, as compared to urban areas accounting for 27.9%.[3] Moreover, COVID-19 has exacerbated mental health issues and suicidal ideations among all K-12 students from all socioeconomic backgrounds, races, ethnicities, genders, and sexual orientations.[3] The suicide rate among youth in rural New York is 15.2 per 100,000 as compared to 7.5 per 100,000 in urban New York.[3] The high prevalence of mental health issues among K-12 students in rural New York has been attributed to several social determinants of health as follows:

Social Determinants of Health (SDOH)	SDOH causing Youth Mental Health Issues
Economic Instability	Poverty, unemployment, and low-income.[3]
Neighborhood & Built Environment	Lack of healthcare facilities, distance from healthcare facilities, transportation, no mobile clinics, lack of internet coverage/broadband and technology, and lack of mental health support resources and support.[3]
Education Access & Quality	Lack of health literacy.[3]
Social & Community Context	Social Isolation, stigma, culture, demographic characteristics.[3]

Healthcare Access & Quality	Lack of school-based health centers, healthcare workforce shortage, healthcare services closures, long wait times, home environment.[3]

Recommendations

Training Teachers and School Staff: Training teachers and school staff equips them to identify behavioral changes and symptoms among K-12 students, allowing them to build trust and encourage open conversations about mental health issues.[4] Training school drivers enhances the ability to recognize these changes as well as bullying, abuse, or harassment in school buses and report concerns to the appropriate authorities.[5]

Shaping Mental Health Care through Closely Knit Rural Communities: Living in small towns fosters close-knit relationships, making it ideal to engage community representatives in developing and implementing local mental health programs and campaigns.[3] This approach can help reduce the stigma surrounding mental health issues, enhance referral systems, and encourage families to seek help for their children and adolescents. Additionally, it promotes community-level support for youth mental health, creating a more supportive environment for all.

Introducing Healthy School Lunches & Promoting Healthy Diet: Introducing healthy and nutritious school lunches in K-12 schools can improve the mental health of K-12 students, as research suggests that diet has a crucial role to play in the mental health of youth.[6] Also, cooking demonstrations and cooking classes for parents and K-12 students can promote importance of healthy diet.[7]

Developing Comprehensive Family Support Programs: Developing and implementing family support programs that train parents to nurture their children under five years and receive employment and financial help to raise their children.[8] This can prevent them from entering foster homes, thus disrupting their normal childhood at home with their family.[8]

Developing Outreach Programs for K-12 Youth: Developing health messaging techniques that encourage K-12 students to reach out to need-based, formal sources of mental health services can provide the youth with adequate mental health care.[9]

Promoting and Developing Safe & Supportive School Environment: Developing and implementing Diversity, Equity, Inclusion, and Accessibility (DEIA) student focus groups can reduce discrimination, physical activity programs and co-curricular activities can normalize discussion about mental health and foster a friendly and supportive environment among K-12 students.[10]

Current Law

Policy Level Barriers that have posed a challenge for K-12 students to receive mental healthcare services are as follows:

Policy-Level Barriers	**Description**
Lack of School Based Health Centers (SBHCs)	18% School Based Health Centers located in rural areas vs. 76% in urban areas.[11]
Healthcare Professional Shortage	High HPSA scores and notable FTE shortages in rural NY counties indicate a severe shortage of healthcare

	professionals and a high need for health professionals.[12]
Article 31	Prevents healthcare professionals from other specialties to provide mental healthcare services to K-12 students on K-12 school campuses.[13]
Lack of Telehealth services	Unavailability of telehealth services on K-12 school campuses.
Lack of Mobile Clinics	Mobile clinics are not permitted on K-12 school campuses.
Lack of Mental Health education in K-12 Curriculum	Despite the amendment to section 804 of New York Education Law, rural New York K-12 schools lack mental health education.

Background

School-Based Health Centers: Improves accessibility, availability, acceptability, and affordability of mental healthcare services among K-12 students.[14] It also connects K-12 students with various community health programs to improve the mental health and well-being of K-12 students.[15]

Strategies to Increase Healthcare Workforce: Implementing loan repayment and scholarship programs, training initiatives to ease acculturation for foreign medical graduates, fostering professional networks to combat isolation, providing counseling for K-12 students to encourage careers in healthcare, and increasing funding for residency programs aimed at rural healthcare providers can collectively enhance workforce development in the healthcare sector.[16,17,18]

Article 31- Strategies to Find a Path Forward: Establishing satellite clinics in SBHCs can overcome the restriction implemented by Article 31 for healthcare providers.[13]

Telehealth services: Provides cost-effective care, reduces transportation costs and access to mental healthcare providers, and reduces language barriers for K-12 students seeking mental health issues.[19,20,21]

Mobile Clinics: Minimizes long wait times at healthcare facilities, ensures regular mental healthcare and follow-ups, and reduces transportation barriers..[22]

Integrating Mental Health Education in K-12 Schools: Integrating Cognitive Behavioral Therapy, skills training, and coping skills enhances resilience to mental health issues among K-12 students.

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