

Understanding the Prevalence of Mental Health Disorders
in Rockbridge Area and the Need for Health Reform

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Winter 2012

Poverty 423

My first incidence of mental health illness came to me when I was working in a remote Aboriginal community in Western Australia known as Looma. Looma was a baron town, with one small shop, a school, a two-room health clinic, an administration building, and miles of uninhabited red dust land. The town population was around five hundred, but the number of jobs was closer to zero. With the nearest town three hours away by car down a dirt road, the community members were dormant in their town with little preoccupation. While this lifestyle may seem leisurely, it was anything but. Many of the community members had severe mental health problems, ranging from depression to the most extreme cases of suicide, which was prevalent among the youth. Through my daily interactions with the locals, I began to develop an understanding of issues that plagued the community, and more importantly, an understanding of what it means to have a mental health illness and how such a disorder can disrupt everyday life.

As I witnessed the effects of mental disorders, I grew increasingly eager for knowledge of the determinants of mental health disorders and avenues of treatment. Upon returning from my short stay in Looma, I was not satisfied, and wanted to expand my knowledge base by applying it in a way that would positively affect the lives of others. With the significant guidance and support of four advisors, Dr. Beckley, Dr. Lowney, Melissa Medeiros and Laura Simpson, as well as the help from local community members and employees of RACS, Eagles Nest, and RAFC, I compiled this paper, which details the mental health services available to the individuals of the greater Rockbridge Area that cannot afford the high cost of insurance or psychiatrist fees. This report identifies the impediments to mental health care in the Rockbridge Area, the scope of mental health illness prevalence within the community, the programs established to

combat these issues, and it ultimately concludes with the shortcomings in services and potential avenues for combating these issues.

In order to discuss the prevalence of mental health disorders and the apparent need for health coverage, we must understand what it means to have a mental health disorder and how such a condition can affect behavior. The National Alliance on Mental Health defines mental health disorders as “medical conditions that disrupt a person’s thinking, feeling, mood, ability to relate to others and daily functioning” (NAMI 1). There are a wide range of mental health disorders, such as anxiety disorders, attention-deficit disorders, personality disorders, mood disorders, eating disorders and autism. Each of these is deemed a serious mental condition that results in a “diminished capacity for coping with the ordinary demands of life” (NAMI 1). It must be noted that each one of these diseases has different symptoms and that within each disease there is a broad continuum of the severity of symptoms. And these symptoms can affect an individual at distinct ends of the spectrum from one day to the next, often times hindering individuals with a severe mental illness from carrying out their daily tasks. The risk of developing a mental illness has adverse affects on the individual as well as society at large.

Mental health diseases are becoming increasingly prevalent, especially in the most vulnerable age groups of adolescence and young adults. The U.S. Surgeon General estimates that ten percent of the adolescent within the United States suffer from one of these serious mental disorders. According to the statistics of the National Institute for Mental Health, mental health disorders affect tens of millions of people each year (NIMH). In any given year, more than 1 in 4 adults are diagnosable for one or more mental health disorders, however, last year, only 41.1% of individuals with one or more

disorders received care, and of those receiving care, 88% are obtaining help through healthcare (NIMH).

These serious mental health disorders have far-reaching implications for society. With an increasingly high number of mental health patients diagnosed each year, more individuals will have diminished capability to achieve financial independence by means of a steady job. The consequences of untreated mental health disorders are alarming; “disability, unemployment, substance abuse, homelessness, inappropriate incarceration, suicide, and wasted lives” are just a few of the most serious long-term implications for the individual (NAMI 1). Likewise, society is affected when its inhabitants experience mental illnesses.

Primarily, serious mental illness decreases the overall efficiency of the economy, as it is “estimated to be associated with a loss of \$193.2 billion in personal earning in the total US population” (Kessler 709). If left untreated, this creates a severe dent in the U.S. economy, as fewer jobs are performed and less money is circulated throughout the country, driving down investments. Further, mental health disorders significantly reduce the overall quality of life of the individual and society “that results from the negative effects of mental illness on parenting abilities, family life, and personal life” (Kurkis 6). In the cyclical fashion of poverty, an individual suffering from a severe mental illness is more likely to have children that develop the disease and more likely to be unable to provide adequate care for their child, especially in the case of an individual who is not receiving proper therapy. Individuals born into mental illness or who developed mental illness as a result of their surroundings are then less likely to contribute to the economy by no fault of their own.

Another cyclical correlate to lower mental health standards is drug and alcohol abuse. It has been well documented that there is a “consistent increase in incidence of psychosis outcome in people who have used cannabis” (Moore 5). There is a bilinear effect associated with cannabis use, as one study found the “causal direction leads from mental disorder to cannabis use,” indicating the intertwined relationship between drug use and mental health (McGee 1). These two factors, mental health and cannabis use, were also found to “share similar pathways of low socioeconomic status” (McGee 1). This compilation of factors is what makes impoverished people more susceptible to mental health disorders.

To better illustrate the cause and effects of mental illnesses within the Rockbridge Area as well as the apparent need for access to therapy, I will introduce an anecdote a woman, whom I will call “Sally,” told me at a local “focus group” held at Rockbridge Area Free Clinic. Sally began by stating that her son, who is now twenty-two, had mental health problems for a long time, but “because he couldn’t afford it, he never got it” (F.G.). Her son, “Rob,” was often bullied at school, and according to his mother, even the “principal was picking at him” (F.G.). Without proper counseling services or a professional to talk to about his emotions, Sally explains that Rob turned to drugs and alcohol as a form of escapism. As time passed and the bullying progressed, Rob grew increasingly frustrated and insecure until one day, he snapped.

He was given the option to leave school at the age of seventeen or the parents of the student with whom he got in an altercation would press charges. Rob chose to drop out of school, and given the situation of constant bullying and lack of therapy for him, it was what he determined to be the best option. According to his mother, with more free

time and no job, Rob became more involved in drugs and alcohol, leading to an inevitable run-in with the law. The judge had him talk to a psychiatrist, who determined that Rob was schizophrenic. The judge ordered him away to Western State Hospital, a psychiatric hospital in Staunton, so he could receive the care he needed. Rob was instated at 129 pounds, and after a month of individual psychiatric care, Rob was released, weighing 179 pounds, drug and alcohol free, and in a stable mental state. Currently, Rob has access to the RAFC now that his is past the age of eighteen, and gets care there on a regular basis.

While this anecdote exemplifies the potential for growth and development through proper mental health care, it also shows a more horrific side to the story. Rob was known to be unstable and in need of mental health care for a while, but it was not until he acted violently that he got the proper care he needed. This lack of care is outright appalling and unjust, not only to Rob but for the community at large. Rob, under his haze of drugs and alcohol coupled with his untreated mental health condition, easily could have physically hurt one of his classmates, teachers, or himself due to his unstable mental health. Not until his outrage did he begin down the path of run-ins with the law that would eventually better his situation. While Rob benefitted from care, society did not fare as well. The potential for Rob to enter into the workforce is a positive outcome in this anecdote; however, the cost to society to uplift this individual may not be the most efficient. The court-ordered psychiatric assessment, according to a local attorney Josh Elrod, was most likely state-funded. Further, the month-long rehabilitation, according to John Young, clinical director of the Rockbridge Area Community Services, would also have been state-funded. These two things in unison would undoubtedly cost the state

more in terms of transportation to Western State, court fees, and therapeutic care than an introduction of proper counseling services within the school would, such as a psychiatrist. However costly the treatments may be, the upside of serious mental health disorders is that their treatments are highly effective.

According to NAMI, “between seventy and ninety percent of individuals have significant reduction of symptoms and improved quality of life with a combination of pharmacological and psychosocial treatments” (NAMI 1). While treatments certainly prove to be an effective method of reducing the symptoms of mental health disorders and fostering the capability of individuals, there are a plethora of impediments to treatment that affect individuals with mental illnesses.

The Stigma of Mental Illnesses

Mental health illness is often overlooked and marginalized, with heart, liver, and lungs diseases dominating the political discussions as well as health outreach programs. However, as noted by undergraduate student, Greg Kurkis, in an unpublished research paper, “neuropsychiatric disorders actually account for a greater share of the total US disability burden, measured in disability-adjusted life years, than all cardiovascular diseases and cancers combined” (Kurkis 3). The stigma associated with mental health disorders is a paramount factor stymieing the progress of social acceptance and understanding of mental disorders. As explained best by Otto Wahl, an expert on media influences, “it is still socially acceptable for cartoonists, policy-makers, health-care professionals, and the public-at-large to mock, stereotype, avoid, and otherwise denigrate people who experience a mental disorder” (Hinshaw 140). The ubiquity of stigmatization

in mental health has not gone unreported: “during the past decade a consensus has formed among research and clinical experts, as well as policy and political leaders, that mental disorders are, in fact, highly stigmatized, with far reaching consequences” (Hinshaw 140).

When *Lancet*, a highly revered medical journal, introduced a special section entitled “Stigma of Mental Illness,” it was apparent that the topic was gaining recognition in both the scientific and professional realms. At this point in history, the paradigm shifted from determining whether or not there was a stigma associated with mental health to reasons why we as a society should invest in programs that would change attitudes and overall acceptance of mental disorders. First of all, stigma and discrimination are the “most significant obstacles to the development of mental health care and to ensuring a life of quality to people suffering from mental illness” (141). The stigma further inhibits the acceptance of mental health disorder within society “because of the attitude of most decision makers and a large part of the general public toward mental illness and all that surrounds it” (141). The disconnect between politicians and programs for mental illnesses is substantiated by John Young, who explains that when politicians are “establishing what needs to occur to save the system money, we are the last people that get asked what should happen” (Young). If this issue is habitually overlooked, especially in the new era of health care, the individuals that need government advocacy the most will fall by the wayside, and will not receive the attention and treatment needed to promote a healthy lifestyle and equal opportunity.

Since the stigma prevents mental health illnesses to be at the forefront of political conversations and social acceptance, the increasing masses of mental health diagnoses are being untreated. This has far reaching implications, as many individuals with mental

health illnesses cannot afford healthcare and do not qualify for government funded healthcare such as Medicaid and Medicare. The problem of lapses in coverage and treatment for healthcare is compounded through analysis of the correlation between mental health disorders and poverty, which has been well documented.

Socioeconomic Status and Mental Illnesses

While mental health disorders affect individuals across all socioeconomic statuses, individuals of the lowest quintile of the SES spectrum are two to three times more likely to have a mental illness than individuals from the top quintile (U.S. Dep. Health). More precisely, “socioeconomic status is inversely related to both major depression and depression symptoms” (Alder 21). The prevalence seems to fit a general continuum of rates, as the most concentrated percentage of mental health diseases is located in the lowest quintile of SES status (18.2%) (Sturm 2). As an individual climbs the rungs of the proverbial SES ladder, her chances of having a mental illness significantly decreases, with a 13.2%, 11.2%, 10%, and 7.4% prevalence of mental disorders in order of increasing quintile of the SES strata (Sturm 2). This correlation effect between lower SES and mental illness is significant, especially when determining the need for mental health services in the greater Rockbridge Area.

In 2008, two undergraduate students, Melissa Caron and Chris Martin, conducted a Rockbridge Poverty Assessment for Washington and Lee University detailing the levels of poverty within the area. Until this research, there had been little documentation of poverty within the Rockbridge area. While the U.S. Census Bureau “confirms that Lexington and Rockbridge County experience rates of poverty that are significant but

below the state average,” these analyses are “generally difficult to determine and of questionable statistical validity” (Caron and Martin 9). The three-month-long research conducted in the form of focus groups, interviews with community leaders, and filed research determined that “employment was the single greatest problem facing the community” (9). High unemployment and low employment opportunities within the community have a direct effect on the mental health status of the inhabitants of the Rockbridge Area. While it is difficult to quantify accurately the number of individuals within the community who suffer from mental illnesses, estimates were made from summing the patients of the Rockbridge Area Free Clinic, Rockbridge Area Community Services, and Eagles Nest. These three organization combined have treated 700 mental health patients in the past month alone, roughly 80% of which were mental health therapy.

These numbers only help determine the number of individuals within the community with treated mental health disorders. However, when comparing these numbers with the national average of individuals who have illnesses but do not get help, it is likely that the Rockbridge Area community fails to meet the needs of all mentally ill persons.

Comprehensiveness of Services

The apparent gaps in coverage within the community are hard to quantify, however. The best way to demonstrate a need for more access to mental health services can be expressed through anecdotes of community members and local leaders. During a focus group in which four patients receiving care from the free clinic were interviewed, the patients were asked to rate the services they receive ranging from dental and primary care to mental health. When the topic of mental health was introduced, the individuals all seemed to agree: “mental health out here is not very good” (F.G.). One patient even went

on to state that the services provided to the community are “a joke” (F.G.). This patient may have hyperbolized the lack of care for mental health patients, but local community members are in unison and agree with Laura Simpson, a nurse and advisor of the Rockbridge Area Free Clinic, that there is an “apparent need for more services that includes mental health care” (Simpson).

While local leaders emphatically state there is a need for mental health services, the current assistance that is in place in Rockbridge Area should not be overlooked. First, the Rockbridge Area Free Clinic, which accepts individuals that are 200% of the poverty line, has two days a week of a licensed clinical social worker primarily for family and marriage therapy and a half-day a week with a psychiatrist. Due to the relative novelty of mental health at the free clinic, the care it provides is limited, despite the fact that mental health was listed at number three on the list of the top five patient-reported reasons for appointments behind hypertension and diabetes (RAFC). When patients are administered into the free clinic for a mental health appointment, they may not necessarily be seeing a counselor or psychiatrists due to the limited availability. The care they are getting is more than likely a drug treatment administered by a primary care provider rather than mental health counseling. Without proper mental health therapy coupled with drug therapy, the individual is significantly less likely to overcome her illness or maintain the disease symptoms at a manageable level. While the Rockbridge Area Free Clinic may be limited in its ability to fund and treat mental health disorders, another non-for-profit organization, Rockbridge Area Community Services, helps to treat individuals in need of psychotherapy.

The RACS accepts individuals on a need basis and does not require individuals to have insurance. The clientele that accesses the services are individuals that do not have insurance or do in the form of Medicaid or Medicare but cannot be seen by local doctors. The primary individuals treated have severe mental illnesses such as schizophrenia, bipolar disorder, major depression, and post-traumatic stress in an attempt to “enhance the quality of life and avoid institutionalization of these individuals” (Young). The care given is primarily emergency mental healthcare. However, individuals have interactions with psychotherapists daily, either through a personal session or a teleconference with a psychiatrist in Richmond, which both patients and physicians agree is substantial way of communicating. There are drawbacks, as noted by Laura Simpson, who works collaboratively with the RACC. “There is not a waitlist for most services, except for psychiatry, and for that the wait is three to four months” (Simpson). According to employees of RACS and RAFC, the service is helpful in providing assistance to the mentally ill. However, the long waitlist suggest RACS is not the most accessible. Admittedly, RACS provides immediate access to emergency mental health services from nine to five, but if the waitlist to treat individuals with non-urgent illnesses is three months, there is a greater need for services to meet the demands of the community.

In contrast to RACS and RAFC, Eagles Nest, a local health organization that works to promote recovery and integration back into the community, does not have a waiting list, and every individual that asks for help receives it. Eagles Nest’s primary objective is to provide support and structure for individuals with major mental illnesses to help them “relearn job skills, relearn life skills, how to take care of themselves, how to run their homes, and how to address medical issues” (Floyd). The aim of this program is

to allow participants to “move out of the patient roles and move towards illness self-management” and independence (Floyd). Eagles Nest offers a wide variety of programs, such as educational services to expand the knowledge of individuals with mental illness, an advocacy and support system, and a social interaction program that allows daily interactions between participants and community members. The Eagles Nest fosters a unique set of soft skills that build the social capital of an individual, which are necessary for acclimatization back into society. This program fosters the subset of individuals that are more often than not overlooked or undertreated for their mental health disorders. They are the ones that have fallen out of system, are unemployed, and reliant on friends and family to nurture them. Eagles Nest plays the role of a support system by providing security for the mentally ill who are in need of rehabilitation into the community.

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These three programs, designed for the impoverished suffering from mental illnesses, indicate that Rockbridge Area community members are working compassionately and effectively to meet the needs of community members. Community members appear to disagree, but rather believe the mental health services are “a joke.” From my unbiased perspective, I believe the total care provided to these individuals lies somewhere in the middle of the extreme ends of the spectrum. Clearly, there is a need, as indicated by the three-month waitlist, but seven hundred per month also receive care for mental illnesses, most of which are pharmacological rather than psychotherapeutic.

Paucity of Providers for the Adolescent

While the three organizations listed above have clearly helped members of the community beyond their role of mental health providers, there is still an unmet need. The

most glaring group whose needs are unmet is the youth. Within the community, the only service where the youth can get access to care is at the Rockbridge Area Community Services, to which it is often difficult for a child to be introduced and continue to access and receive care. It has been well understood and analyzed that “adolescence and early adulthood [is] when the risk for incident anxiety, affective disorders, substance disorders, and development of co-morbidity is obviously the highest” (Wittchen 110). Thus, the majority of the community’s efforts should be localized to the youth and young adults, who are more susceptible to develop disorders. As exemplified by the anecdote about “Rob,” the issue is often times not recognizing a problem, which the mother seemed to be able to do quite well, but rather, finding a way to treat the problem.

Children that are impoverished are entitled to CHIP, FAMIS Plus, or Medicaid, government insurances that are available to children from varying levels of poverty and will provide coverage for primary care providers to mental health specialists. The issue with these programs and mental health in this area is the number of psychotherapists that accept them. I conducted research by calling all practicing local psychotherapists, and of the twelve I contacted, only two confirmed accepting Medicaid or FAMIS Plus. To understand the underlying reason behind the refusal of these services, I interviewed Dr. Worth, a semi-retired psychotherapist who has worked in Lexington since 1972. Dr. Worth noted that he has “turned away a lot of people who could see me for their problems” because he was not an approved Medicaid provider (Worth). Dr. Worth stated his attempts to get approved were unsuccessful because of difficulties contacting Medicaid. While Dr. Worth is semi-retired and would not be able to help most of the community, he stated that other psychotherapists in the area do not accept Medicaid due

to the “hassles with Medicaid and the difficulty getting paid” (Worth). Thus, individuals with Medicaid often turn to Rockbridge Community Services, especially because many of the children do not qualify for Medicaid within the community.

As the clinical director of the Rockbridge Area Community Services puts it, while we see and care for a lot of children with mental illness, many children “still need to be seen sooner” than they are being seen. The problem is many parents and community members “do not realize we are here,” which in combination with the waitlist prevents them from getting care until more extreme symptoms develop (Young). This correlates with the lack of a psychiatrist or education of mental health within the school system. If a program existed in which individuals who were bullied in schools, using drugs, or showed signs of mental disorders could talk to a mental health profession, it is likely that the youth would be less likely to develop mental health disorders and therefore less likely to introduce their disorders and mental health habits to subsequent generations.

The Uninsured

The members of Rockbridge Area at high risk of developing mental health disorders or having their symptoms increase in severity or frequency are the uninsured. These individuals are most likely the working poor, who cannot afford to purchase health insurance but do not qualify for Medicaid or Medicare. The community members without insurance “continue to be a drain on the state fund,” as the cost of treating someone without insurance is significantly higher than treating individuals with Medicaid (Young). Mr. Young states that there is an apparent medical need to treat these people, but the financial barrier that is associated with a lack of insurance forces the RACS to use

their funds less efficiently by providing care in a more costly manner. Further, the individuals “without insurance or Medicaid receive poorer care” for their mental illnesses than someone who has insurance. The uninsured also have the option of going to the RAFC if they are eligible, but with more pharmacological care than psychotherapy care provided at the RAFC, these individuals frequently do not receive the attention they need to recover. Access to care is one of many factors plaguing individuals of the Rockbridge Area, however.

Educational Attainment

One social determinant, which has already been discussed in depth, is SES. Like SES, lower educational attainment is directly correlated to a higher risk of developing a mental disorder. The correlation between lower educational attainment and lower SES is an easy one to understand, as a less formal education usually leads to lower wage jobs, making then the individual with lower education more likely in the lower SES. When analyzed together two factors compound mental health disorders: “low education and low income were associated with increased odds of not receiving any treatment (income), not receiving specialty care among HC patients (education), and receiving less adequate specialty treatment than other patients in the MHS sector (education)” (Wang 631). Both of these social determinants apply directly to Rockbridge area, as Lexington had a 10 percent unemployment rate this past December, and “fewer than 22 percent of Rockbridge County residents have college degrees” (Rolett 1). While Rockbridge Area has a higher percent of community members with college degrees than all its neighboring counties, with the exception of Bedford at 23.5%, the presence of many colleges in the area are driving that number up (“Adults” 1). The city of Lexington alone has 47.6% of

its inhabitants with college degrees, indicating that Rockbridge Area would most likely be more like neighboring Bath County, with 11.4% of its inhabitants having a college degree (1). Thus, Rockbridge Area is significantly more likely to experience forms of mental health illnesses, as a large percentage of the members of the community are uneducated. The lower levels of educational attainment also negatively affect individuals coping with mental illness as their lack of knowledge intensifies the stigma of mental health within the community. A heightened stigma within the community will have deleterious effects, as “stigma’s impact on a person’s life may be as harmful as the direct effects of the disease” (Hinshaw 141). Education attainment is not the only form of educational factor that determines mental health outcomes. One important factor that improves the quality of life of an individual is knowing where and how to access care.

A recurrent theme that I found in interviews with the head of Eagles Nest, RACS, and RAFC is the overall paucity of advertising. These organizations rely heavily on the word of mouth to spread their practices. Economically, it makes sense to allocate the budget they have to treating the need instead of advertising to people that may not know about the programs. As noted by Laura Simpson, “many people do not know about the available services” (Simpson). In the interview with John Young, he stated “community members do not realize we are here” (Young). Clearly, a disconnect prevents individuals within the community from knowing about the available services. I was very skeptical of this idea that members of the community did not know that these organizations existed until I asked a mental health patient at the free clinic whether she had tried to get counseling at RACS. I soon found that she had no idea what I was talking about.

Geography, Transportation and Mental Illness

The rural setting of the Rockbridge Area makes it more at risk of not having access to mental health physicians. The geographical setting of Rockbridge is not correlated to a higher or lower prevalence of mental illnesses, but does make its residents 1.5 times less likely to receive treatment than their counterparts in urban settings (Hauenstein). And when the individuals from rural communities do receive care, it is often incomplete: “research demonstrates that, in comparison to an urban location, rural residence is associated with a significantly higher likelihood of receiving pharmacotherapy but a significantly lower likelihood of receiving psychotherapy” (Fortney 211). The decreased likelihood of receiving care is a result of the lack of access within rural communities, as “90% of mental health professional shortage areas are in rural locations” (Gamm 165). Rockbridge Area is no exception to the rule, as there is only one full time psychotherapist that works in Rockbridge for individuals of the low SES to access. Just a few years ago, RACS had two psychotherapists; however, one retired, leaving RACS shorthanded. John Young has attempted to find a replacement; however, he has struggled and ultimately realized that it is “hard to attract fully licensed psychotherapists to a rural area” (Young). The likelihood of receiving care in a rural area is often times dependent on local transportation services that are established.

In the project conducted in 2008, the participants of a survey were asked to identify the greatest problems facing the community, and affordable transportation was second highest on the list, behind employment opportunity (Caron and Martin 9). One of the study’s goals was to determine the percentage of individuals who do not have regular, permanent access to a vehicle, and compare that to State average of 7.7%. While Rockbridge County fared well in that only 4.7% of individuals did not have a vehicle,

both BV and Lexington were significantly above the state wide average, with 14.2% of individuals in both towns not having access to a vehicle (Caron and Martin 30). The connection between susceptibility to mental health disorders and lack of transportation is transparent, and without an effective public transportation system, the inhabitants of Rockbridge Area are highly vulnerable to mental illnesses. Public transportation programs do exist, notably RATS and Maury Express; however, these services “do not adequately meet the needs of the community” (Caron and Martin 30).

To overcome the paucity of transportation, both Eagles Nest and RACS administer funds intended for patient care on gas money to pick up patients. Eagles Nest even “travel[s] to the individuals’ houses and make sure they are taking their medications” (Floyd). If RACS had the funding, I imagine that it would run a similar program, as the director estimates about “60% of what my mental health staff worry about everyday is whether that person has gotten to their UVA appointment, whether they have gotten their lab work done for that UVA appointment; they are worrying about all their medical conditions; those are what is going to kill the person and make them die younger because of their major mental illnesses” (Young). The severity of transportation now seems significant, and the lack of public transportation for the inhabitants, as expressed by the inhabitants, has far reaching implications not just on mental health, but just about every aspect of life, ranging from ability to attend a job, access the grocery store, and socialize with family and friends. This form of isolation accumulates on a person and develops into stress; stress to find the next paycheck, stress to find the next method of transportation, stress to find the next meal.

Drug Use, Addiction Therapy and Mental Illness

The Rockbridge Area similarly struggles with alcohol and cannabis use within the schools systems. Buena Vista, which is one of the most impoverished areas in the greater Rockbridge Area, reports that 12.8 percent of twelfth graders have used cannabis in the past thirty days and 34.2 percent have consumed alcohol (Pride Survey 10). Further, when asked how easy it was to obtain, 59.5% of twelfth graders reported that cannabis was easy or very easy to obtain (Pride Survey 10). Rockbridge County numbers were reported to be higher than these already high rates of use in the greater Rockbridge Area, with 27.4% of twelfth graders reporting they used cannabis within the past 30 days, and 64.4% of twelfth graders reporting cannabis was easy or very easy to obtain (Pride Survey 10).

The apparent ubiquity of cannabis within the school systems allows for the use and social acceptability of the drug. While there are services to help individuals with drug abuse, they only receive care if they willingly sign themselves up for it or the court mandates treatment. Yet the number of individuals that improve is unclear, as there is still “data needed to determine the number helped and how those individuals are doing after treatment” in the Rockbridge Area (Young). The high prevalence of cannabis use in the school coupled with inadequate drug addiction therapy services at RACS will only exacerbate the symptoms of individuals with mental illnesses. Not only is the service inadequate, but according to John Young, it is highly ineffective, and worst of all, RACS does not follow up with patients to determine its level of inefficiency.

As presented above, there is clearly a need of services to help individuals within the Rockbridge Area to prevent and/or treat mental health disorders. The prevalence within the community is notably high, and health professionals and patients alike agree,

“mental health out here is not very good” (F.G.). Personally, I believe the members of the community are more harsh on the programs than they should be, in part because many of them do not know of the programs existence or fail to utilize them all together. However, I do believe the service within the Rockbridge Area is not adequate, especially within the youth and in terms of psychotherapy. The question to ask now is, why is this a problem that we as a community need to address, and how we can address those problems.

As discussed in Norman Daniels’ “Just Health,” a multitude of factors correlate with mental health disorders, such as family structure, support group, educational attainment, financial stress, living conditions, and drug addiction. Daniels understands the moral obligations we, as a people, have to our fellow citizens and community members. Morally, it is society’s role to protect its citizens and ensure justice for all.

Thus, “if justice requires society to protect opportunity, then justice gives special importance to health care” (Daniels 29). Proper health care coverage and access ensures that every individual will have the opportunity to good health, assuming that the impediments that are currently dormant within the community do not exist. Thus, without the impediments to mental health care that have been discussed in depth, opportunity to good health, in terms of physical, mental, and emotional health allows for equal opportunity for all, in terms of educational attainment, job employment, and the right to make decisions individually. Equal opportunity does not imply that every individual will capitalize on her opportunity with the same success or even be seeking the same outcomes. Rather equal opportunity allows individuals to have the potential to choose from a variety of options and life paths, and decide to do with that opportunity what they will.

Thus, by providing health care for its inhabitants, society ensures that every individual is treated justly. Each individual is free to choose, free to think, and uninhibited from effects of improper healthcare. Morally, Daniels argues, healthcare and subsequent treatment is a necessity that every individual should have a right to and should not be without, especially in a first world country as the United States. This argument is grounded in morality, and if taken into practice, would help to decrease the prevalence of mental health disorders within society, especially in lower SES communities.

The question left to answer is how do you take a moral argument, turn it into a political policy, and provide care for all the individuals that need it. Well, to gain political approval, there usually is some underlying monetary incentive and this argument has already been justified earlier when discussing the nearly 200 billion dollar loss of personal earning annually for individuals with serious mental illnesses. The mental health system as it is set up now is highly inefficient, as noted by the head clinical manager of RACS, as they pay more for uninsured who should qualify for Medicaid or Medicare than the insured person, draining their state funds.

If funding does come in the form of federal assistance, there is a lot the local community should do to combat the vulnerability of the impoverished people of the Rockbridge Area. Primarily, a full-time psychiatrist who has the capability to prescribe medication and give psychotherapeutic care that together helps cure the individual needs. This has to be the outright primary objective of the funding source. Secondly, there needs to be more efficient collaboration with RATS and Maury Express with the healthcare providers. Greater collaboration and increased funding would increase the

efficiency of these programs, effectively allowing for funds to be stretched further.

Thirdly, the RAFC and RACS need to work together and develop more availability to individuals who are not currently insured but will be under the new healthcare act. These programs need to allow for full time psychotherapeutic care that is coupled with psychopharmacological care so that individuals are not receiving segmented care as they are now.

Further, these programs need to advertise their services in local grocery stores and shops so that community members can be fully aware of the services they can receive. This would significantly increase the number of individuals served and would function to decrease the stigma of mental health disorders. If posters were hung throughout the community about mental health disorders and places where treatment can be located, it would enter into the psyche of the community, and desensitize the community to stigma. Lastly, there needs to be an increase in services for the youth. The school needs to have a licensed psychotherapist within the school so that they youth, who are more at risk of developing disorders, can be monitored and treated daily. There needs to be a form of mental health awareness within the schools so that the stigma is decreased and the children realize the effects of cannabis use can have on their development. Drug use appears to be at a heightened level, and this needs to be controlled for and protected so that the adolescence are not desensitized to illicit drug use. However, drug use is going to persist within any community, and the more important aspect that needs to be addressed is effective addiction therapy treatment located locally within the community. Not only do more services need to be available as therapy for the youth, but the lack of

mental health education in the school systems needs to be reversed to prevent further stigmatization and advance the understanding of how to treat mental illnesses.

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