

**Depression in Rural Populations:
Prevalence, Effects on Life Quality,
and Treatment-Seeking Behavior**



At the Heart of Public Health Policy

Depression in Rural Populations: Prevalence, Effects on Life Quality, and Treatment-Seeking Behavior

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Executive Summary

Study Purpose

Information obtained by the 1999 National Health Interview Survey (NHIS), a nationally representative survey of more than 30,000 US adults, provided a unique opportunity to explore the prevalence of selected mental health diagnoses across rural populations, including rural minority residents. The 1999 NHIS administered the depression scale from the Comprehensive International Diagnostic Interview (CIDI), an instrument that has been widely used to estimate the prevalence of mental health diagnoses in the United States. We used this data set to explore the depression among rural versus urban residents, with “rural” defined as residing in a non-metropolitan area.

Findings

Prevalence of Depression

- The prevalence of major depression was significantly higher among rural (6.11%) than among urban (5.16%) populations ($p = 0.0171$). Among rural residents, the prevalence of depression did not vary significantly with race/ethnicity.
- The increased prevalence of depression among rural individuals does not appear to be a result of rural residence itself, as place of residence was not significant in multivariate analyses that controlled for other characteristics of the individual. Rather, the rural population contains a higher proportion of persons whose characteristics, such as poor health, place them at high risk for depression.

Effects of Depression

- Nearly all individuals scoring positive for depression reported that their symptoms interfered with their life or activities (46.67% rural, 44.25% urban; not significantly different).
- African Americans with depressive symptoms were significantly less likely than whites to report interference with their life and activities due to these symptoms. Hispanics and “other” minorities did not differ from whites.
- Insurance coverage influenced reported effects from depressive symptoms. Among rural residents with private insurance, for example, only 36.52% of respondents experienced interference with life activities, versus 64.65% of those with public insurance and 56.31% of those with no insurance at all (Table 4). The correlation of effects with public insurance might be endogenous: mental illness and related disability may lead to public insurance coverage. The higher prevalence of depression among publicly insured adults than among privately insured persons (12.86% among rural publicly insured adults versus 4.96% among rural privately insured) supports this possibility.

Communication of symptoms

- Slightly more than half of rural residents with depression have reported their symptoms to a physician (56.41%), significantly more than among urban residents (50.29%; $p = 0.0429$). However, in multivariate analysis that held respondent

characteristics constant, rural residence was no longer significantly associated with communication of symptoms to a practitioner.

- Rural minorities were less likely to report their symptoms to a physician than were whites, a pattern also present in urban areas. For African Americans and Hispanics, this pattern persisted even after other characteristics of the individual were held constant in multivariate analysis.
- In both urban and rural areas, the likelihood that an individual with depression would have communicated with a practitioner rose as the person's self reported health declined. For example, 51.3% of rural residents who reported their health as being "excellent" or "very good" had communicated with a practitioner about the feelings they experienced versus 73.0% of rural respondents who reported that their health was "fair" or "poor."
- Persons without any health insurance were less likely to have communicated with a physician than were the privately insured (OR 0.47, CI 0.33-0.66). Publicly insured persons did not differ from the privately insured.

Conclusions

- In light of the greater prevalence of depression among rural populations, rural shortages of mental health personnel should be addressed.
- The ability of the medical care system to address mental health care through tele-education should be expanded.
- The ability of rural first responders to recognize mental health problems should be enhanced through training.
- Rural safety net programs should cooperate with each other and with the community to provide access to mental health services.
- Medicaid fosters access to mental health care among beneficiaries at a level paralleling private insurance.

Issues for Future Research

- Additional research is needed to define how rural minorities conceptualize mental health problems and access mental health professions.
- Addition research is needed into factors that allow primary care physicians to initiate screening for depression in primary care.
- Policy research into the effects of mental health parity laws is essential to planning.