

Review Article

Harnessing the social capital of rural communities for youth mental health: An asset-based community development framework

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Abstract

In Australia, we are facing a period of mental health reform with the establishment of federally funded community youth services in rural areas of the country. These new services have great potential to improve the mental health of rural adolescents. In the context of this new initiative, we have four main objectives with this article. First, we consider the notion of social capital in relation to mental health and reflect on the collective characteristics of rural communities. Second, we review lessons learned from two large community development projects targeting youth mental health. Third, we suggest ways in which the social capital of rural communities might be harnessed for the benefit of youth mental health by using asset-based community development strategies and fourth, we consider the role that rural clinicians might play in this process.

KEY WORDS: *rural adolescent mental health, social capital, rural communities, asset-based community development.*

The global state of adolescent mental health is one of great concern.¹ The prevalence of mental disorders in youth increases dramatically in the transition from childhood to adolescence,² yet there is a general paucity of services specific to this age group and a distinct lack of mental health policy to address the needs of young people.³ The mental health needs of rural youth are even more neglected than those of their urban counterparts.⁴

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Access to appropriate mental health care for rural adolescents is limited by a confluence of factors. Rural mental health services face significant challenges in the recruitment and retention of suitably qualified staff.⁵ The availability of public transport in rural areas is poor when many need to travel to regional centres in order to access treatment.⁶ Waiting lists for rural mental health services are lengthy,⁷ and primary care providers are often perceived by rural youth as not being ‘youth-friendly’.^{4,8,9} Social stigma of mental illness, stoic and self-reliant attitudes and concerns about anonymity and confidentiality are also significant barriers to rural adolescents with mental health problems seeking and receiving effective help.^{9,10}

In Australia, we are facing a period of mental health reform with the establishment of Headspace, the National Youth Mental Health Foundation. Assurances have been made that the needs of rural youth will be considered as part of a national strategy to transform youth mental health services;¹¹ such assurances include ‘...work[ing] closely with communities to develop strategies to assist in ensuring that the model developed is sustainable and continues to meet the needs of young people in the local community’.¹¹ Rural communities, however, remain without vision or direction as to how this might be achieved. In this article, we consider ways in which the resources of rural communities can be mobilised for the benefit of youth mental health.

Social capital as a key asset for rural communities

Social capital is fundamentally an ecological characteristic.¹² Its definition incorporates a host of overlapping constructs, including social trust/reciprocity, social cohesion, sense of community and social participation.

Although there is considerable debate over the operationalisation of the construct, theorists have described social capital as the 'glue' that hold society together.¹³ Systematic reviews of the literature that link social capital to mental health outcomes conclude that there is strong evidence of a positive relationship between the two.^{13,14}

Social capital can be operationally defined in a variety of ways from neighbourhood cohesion, which refers to the ability of community members to form strong social connections, to the concept of sense of community. Psychological sense of community involves a feeling of emotional connection, the belief that one's needs are capable of being met within the community and a sense of belonging or mattering to the community.¹⁵ Pretty and colleagues have done extensive work on the construct of sense of community which they define as a 'social environment characteristic of place' which has affective, cognitive and behavioural components. Behavioural components include reciprocity whereby community members, in addition to feeling supported by their community, will respond in kind when the community requires them to.¹⁶ Collective efficacy, another behavioural component of social capital, refers to the ability for community members to share common goals and to work together for the common good whereas community competence is the ability for communities to solve problem and take collective action.

What role does social capital play in rural communities? Rural communities have been characterised as socially proximate or 'close knit',¹⁷ and rural people are said to share traditional values of hard work and cooperation.¹⁸ The communal nature of rural communities has been described as comprising collectivistic family structures and strong community coalitions,¹⁹ and a healthy environment is considered by rural people to include strong community support by churches and schools and a caring community membership.²⁰ Rural youth, particularly women, regard themselves as community citizens, experience a sense of belonging and connection to community and are convinced of the principles of reciprocal support.^{21,22}

This suggests that two aspects of social capital – that is, sense of community and neighbourhood cohesion – are high in rural communities. Empirical evidence exists to support this assertion. In a nationwide study, Vinson assessed the ability of social cohesion to ameliorate the effects of social disadvantage. In so doing, he discovered that '... rural urban and rural areas had approximately two-thirds as many again of the high cohesion postcode areas as might have been expected on a share-of-sample basis'.²³ Chipuer and colleagues found that two aspects of sense of community – support and safety – were significantly higher in rural adolescents than urban adolescents.²⁴ Case study evidence of high collective efficacy

and competence within rural communities also exists, although it is less convincing and perhaps warrants further research attention.^{25,26} Nevertheless, there is a growing body of evidence that suggest that social capital in its various forms represents a considerable asset for rural communities and their youth.

Harnessing social capital for youth mental health: Case examples

A recent community-based youth project that achieved dramatic community change is the Neighbourhood Solutions project in South Carolina in the USA.²⁷ In 1997, when the project commenced, South Carolina had one of the highest rates of youth crime and mental health problems in the USA. By 2001, the crime rate was too low to justify a community policing team. The project involved intensive mental health services utilising multi-systemic therapy (MST), an evidence-based mental health treatment for young people with complex problems. MST is expensive, however, requiring highly trained mental health professionals who have low case-loads and who must ensure that their therapy is delivered with demonstrable outcomes and program fidelity.

The South Carolina project is exemplary because it developed from the grass-roots level, with a strong community grounding and champions for the cause. The overriding philosophy was that programs thrust upon a community by outsiders rarely work and that the community must be empowered for real change to occur. In this case, good clinical care and a cohesive community combined to produce successful mental health outcomes for the community's youth.

Another approach based on building social capital is the Communities that Care (CTC) project. CTC involves a process which aims to bring about change in a community by increasing partnerships between agencies, involving local community members, using evidence-based early intervention programs and bringing family resources to bear within a given community.²⁸ In this model, the first step is to conduct a risk audit, then identify a minimum of five risk factors that can be targeted for change.

Evaluation of the effectiveness of CTC approaches has resulted in mixed findings. Variation in the outcomes from three demonstration sites in the UK was attributed to the substantial implementation issues involved in delivery, for example, withdrawal of strategic leaders once the funding was awarded, personnel changes, loss of CTC champions, low rates of program delivery, poor coordination and collaboration difficulties among professionals.²⁸ Of note is that the successful program maintained a champion at the strategic level. A further investigation of sustainability for 20 CTC sites

in the USA also found that personnel factors were critical, with sustainability dependent on key personnel's knowledge of empirically based prevention, high fidelity in regards to program implementation and a cohesive coalition of members who maintain their focus.²⁹

Using asset-based community development strategies to establish a rural community youth service

The asset-based community development (ABCD) framework first developed as an alternative to needs-based approaches in which agencies, universities or other donor groups 'intervene' on behalf of a community to rectify problems. Kretzman and McKnight, the researchers who developed the approach, observed that needs-based analysis and intervention can be devastating to a community at worst, or at the very least, undermine or compromise existing community capacity-building efforts.³⁰ This in part occurs because outside agencies have a tendency to view communities as a collection of needs, problems and deficiencies rather than recognising a community's inherent strength and existing resources.³¹

The ABCD is an approach as well as a set of strategies for identifying and mobilising community assets for change.³² The first step in ABCD involves developing relationships with local residents with a particular emphasis on the inclusion of marginalised groups.³³ In the case of establishing a rural community youth service, it would be imperative to include young people as advisors who had personal experience of receiving treatment for mental health problems in the context of a rural community. It would also be important to identify the 'champions' of mental health within any given rural community and draw upon the knowledge and experience of these natural leaders in participation and governance of the initiative.

The second step in ABCD involves identifying the network of associations and local groups – large and small, formal and informal – who can contribute to the initiative.³³ In a rural community, this could include football and netball clubs, church groups, arts groups, outdoor adventure groups, union groups, such as farming federations, environmental groups, country associations and auxiliaries. Within each association, the personnel, space, expertise, equipment and economic power that can be contributed to the initiative need to be identified.³⁴ This process of identification is referred to as asset mapping: this step, although the results of it might vary widely between different rural towns, should not be neglected as in many cases these associations have been the 'life blood' of the town in the absence of formally constituted services. Strategies to harness the social capital of local clubs, associations

and groups need to be wide-ranging and might include organising public meetings and circulating information through newsletters and other community networks.

The third, fourth and fifth steps in ABCD involve expanding the asset map to include local organisations, for example, Council, community health/mental health agencies, non-government agencies, schools and hospitals and local businesses – and creating partnerships between these groups. Assets at this level are likely to include professional expertise, workforce, infrastructure, land and other economic development potential.³⁵ This, again, will vary considerably from one rural town to the other, with smaller towns having had poor and inadequate levels of formal mental health care provision, particularly in the area of child and adolescent mental health, for some time.¹⁰

The role of the rural clinician

Rural clinicians are uniquely placed within their communities to see 'both sides of the coin' as a result of their position as an embedded residential member with personal investment in the social capital of the community.³⁶ Combined with their professional clinical roles, this creates a dual relationship,^{37,38} and clinicians admit to the awkward balance that they have between their personal and professional lives. Clinicians struggle with the notion that supervision will enable them to operate effectively and ethically within small rural settings; however, professional and personal lives inevitably intertwine in the rural clinician's life experience.

Rural clinicians interact with community residents as patients during the work day and as friends, neighbours and family outside of work hours. This unique role in the community provides the rural clinician a unique window into the health and well-being of their community's members and places them in a key position for identifying local resources.³⁸

Conclusion

It is timely to revisit the notion of social capital in the context of newly funded youth mental health initiatives in Australia and to increase recognition of social capital as an asset or strength which can be applied to rural clinical settings. In this article, we have presented evidence that rural communities possess high and diverse amounts of social capital, and argue on this basis that collective approaches to youth mental health in rural communities should be considered as superior to individualistic ones. In addition to presenting a number of case examples from the youth mental health literature, we have also presented a systematic framework for working with communities to harness their social

capital as an asset. The success of new government initiatives targeting rural adolescent mental health will depend on their willingness and foresight to incorporate ABCD strategies into their implementation.

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