Rural Health, Mental Health, and Social Work

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Answer Sheet to NetCE by mail or fax, or complete online at www.NetCE.com. Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.

Faculty Disclosure

Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Senior Director of Development and Academic Affairs

Sarah Campbell

Director Disclosure

The director has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for social workers, counselors, and therapists involved in providing care to clients in rural areas.

Accreditations & Approvals

As a Jointly Accredited Organization, NetCE is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. Regulatory boards are the final authority on courses accepted for continuing education credit.

NetCE has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 6361. Programs that do not qualify for NBCC credit are clearly identified. NetCE is solely responsible for all aspects of the programs.

This course, Rural Health, Mental Health, and Social Work, Approval #20230925-3, provided by NetCE, is approved for continuing education by the New Jersey Social Work Continuing Education Approval Collaborative, which is administered by NASW-NJ. CE Approval Collaborative Approval Period: September 25, 2023 through August 31, 2024. New Jersey social workers will receive 5 Clinical and Social & Cultural Competence CE credits for participating in this course.

NetCE is recognized by the New York State Education Department's State Board for Social Work as an approved provider of continuing education for licensed social workers #SW-0033.

This course is considered self-study, as defined by the New York State Board for Social Work. Materials that are included in this course may include interventions and modalities that are beyond the authorized practice of licensed master social work and licensed clinical social work in New York. As a licensed professional, you are responsible for reviewing the scope of practice, including activities that

A complete Works Cited list begins on page 20.

Mention of commercial products does not indicate endorsement.

are defined in law as beyond the boundaries of practice for an LMSW and LCSW. A licensee who practices beyond the authorized scope of practice could be charged with unprofessional conduct under the Education Law and Regents Rules.

NetCE is recognized by the New York State Education Department's State Board for Mental Health Practitioners as an approved provider of continuing education for licensed mental health counselors. #MHC-0021.

This course is considered self-study by the New York State Board of Mental Health Counseling.

NetCE is recognized by the New York State Education Department's State Board for Mental Health Practitioners as an approved provider of continuing education for licensed marriage and family therapists. #MFT-0015.

This course is considered self-study by the New York State Board of Marriage and Family Therapy.

This course has been approved by NetCE, as a NAADAC Approved Education Provider, for educational credits, NAADAC Provider #97847. NetCE is responsible for all aspects of their programming.

NetCE is approved as a provider of continuing education by the California Consortium of Addiction Programs and Professionals (CCAPP). Provider Number 5-08-151-0624.

NetCE is approved as a provider of continuing education by the California Association for Alcohol/Drug Educators. Provider Number CP40 889 H 0626.

NetCE is approved as a provider of continuing education by the California Association of DUI Treatment Programs (CADTP). Provider Number 185.

Designations of Credit

Social workers completing this intermediate-to-advanced course receive 5 Cultural Competency continuing education credits.

NetCE designates this continuing education activity for 1.5 NBCC clock hours.

NetCE designates this continuing education activity for 5 continuing education hours for addiction professionals.

Individual State Behavioral Health Approvals

In addition to states that accept ASWB, NetCE is approved as a provider of continuing education by the following state boards: Alabama State Board of Social Work Examiners, Provider #0515; Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health, Provider #50-2405; Illinois Division of Professional Regulation for Social Workers, License #159.001094; Illinois Division of Professional Regulation for Licensed Professional and Clinical Counselors, License #197.000185; Illinois Division of Professional Regulation for Marriage and Family Therapists, License #168.000190.

About the Sponsor

The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

Our contributing faculty members have taken care to ensure that the information and recommendations are accurate and compatible with the standards generally accepted at the time of publication. The publisher disclaims any liability, loss or damage incurred as a consequence, directly or indirectly, of the use and application of any of the contents. Participants are cautioned about the potential risk of using limited knowledge when integrating new techniques into practice.

Disclosure Statement

It is the policy of NetCE not to accept commercial support. Furthermore, commercial interests are prohibited from distributing or providing access to this activity to learners.

Course Objective

The purpose of this course is to provide mental and behavioral health professionals with the knowledge and skills necessary to effectively meet the unique needs of rural clients, ultimately improving care and addressing existing disparities in health and mental health.

Learning Objectives

Upon completion of this course, you should be able to:

1. Define the term rural and review the demographic characteristics of those living in rural areas in the United States.
2. Identify how cultural values and norms characteristic of a rural culture can be strengths as well as limitations.
3. Discuss cultural competency and how it applies to rural communities.
4. Describe health, mental health, and social services disparities in rural areas of the United States.
5. Provide an overview of the unique health, mental health, and social work practice problems and issues experienced by various subpopulations residing in rural areas.
6. Discuss the role of and benefits of interprofessional collaboration in rural areas.
7. Describe ethical issues that emerge when working with clients in rural areas.

INTRODUCTION

Individuals live in rural areas of the United States for many reasons [1]. Although there are benefits and necessities to living in rural areas, many residing in these areas experience significant health and mental health disparities and challenges in accessing services. As of 2020, about 63 million Americans live in rural areas [2]. However, to some extent, the needs of this population remain invisible and vulnerable. Rural residents have remained largely neglected in the fields of health, mental health, and social work. In a meta-analysis of literature published in the top 14 social work journals between 2004 and 2008, only 71 of the 3,004 peer-reviewed articles (2.36%) focused on rural populations [3].

There is no one definition of the term rural, and how it is defined is controversial. Some definitions focus on population density, which falls under a spatial definition classification [4; 5]. Most generally, rural has been defined as all territory, persons, and housing units not defined as urban [6]. Urban areas have a population threshold consisting of 65,000 or more people, with a density of 1,000 people per square mile [6]. The U.S. government defines rural areas as those with populations of 2,500–64,999 [5]. This dichotomous definition of urban/not urban masks the nuances of rural experiences and different levels of rurality and urbanicity [7]. Other definitions focus more on socioeconomic classification, which emphasizes geographic isolation and socioeconomic factors, such as employment and availability of and access to resources [4; 5].

More than 64% of the estimated 63 million Americans who live in rural areas resides east of the Mississippi River; 46.7% live in the South, and 10% live in the West [8]. Maine and Vermont have the greatest proportion of residents living in rural areas; California has the lowest proportion [9].

The goal of this course is to examine working in and with rural communities and the need for cultural sensitivity and competence. Health, mental health, and social work service disparities, barriers to help-seeking, and specific issues relevant to various subpopulations will be explored. Ethical issues unique to working in rural communities will also be discussed.

DEMOGRAPHIC OVERVIEW

In the United States, the largest rural population (6.8 million residents) is found in the East North Central region; this is followed by the South Atlantic (5.7 million) [10]. The five states with the largest proportion of rural residents are Vermont, Wyoming, Maine, Montana, and Mississippi [9].

Rural residents tend to be older than the average in the United States. The median age in rural areas is 51 years, compared with 45 years in urban areas [11]. In addition, 27% of rural households are headed by a senior, compared with 21% of urban households. By 2040, it is projected that 25% of the population in rural areas will be 65 years of age and older, compared with 20% in urban areas [10].

Rural residents are more likely to be married than urban residents (61.9% vs. 50.8%). There is also less mobility compared with urban populations. An estimated 65.4% of rural residents live in the same state they were born in, compared with 48.3% of their urban counterparts [11].

Rural residents tend to have achieved lower levels of education than urban residents. In rural areas, 19.5% have attained a bachelor's degree or higher, compared with 29% of those in urban areas. The digital divide is greater in rural communities; 23.8% of rural households do not have Internet access, while 17.3% of urban households do not have Internet access [11].

Residents in rural areas also tend to be of lower socioeconomic statuses. The average per capita income for rural areas is lower by $9,242 than the national average [12]. Between 2009 and 2013, 17.7% of residents in rural communities lived in poverty (vs. 15.4% for the general population) [10]. This is even more marked in southern rural areas, which have a poverty rate of 20.5%, and western areas (16.2%) [13]. In mostly rural counties, the median income is $47,020, with a poverty rate of 16.3%; in completely rural counties, the median income is $44,020, with a poverty rate of 17.2% [14]. Mostly rural counties are defined as those in which 50% to 99.9% of the population lives in rural areas; in completely rural counties, 100% of the population lives in a rural environment [14].

Rural civilian employment among persons 18 to 64 years of age is lower (67.6%) than that reported for urban residents (70%) [15]. Three major service industries together with manufacturing provide more than 70% of rural employment: education and health (25%); trade, transportation, and utilities (20%); and leisure and hospitality (11%). Manufacturing, farming, and mining have historically been the goods production focus for rural areas [16]. Rural employment was severely impacted by the 2008 recession, and rates have still not fully recovered. According to the USDA, half of the observed decline in the unemployment rate since 2010 is due to a reduction in the size of the labor force, not an increase in employment, which is partly the result of little or no population growth in rural America [17]. Regardless, employment for rural America lags below the 2007 figures. This has been further complicated by the COVID-19 pandemic. By April 2020, mainly due to COVID-19 and related pressures, rural unemployment rates reached 13.6%, a level not seen since the 1930s. As of the end of 2021, unemployment rates among rural residents had returned to pre-pandemic numbers, recovering more quickly than unemployment in metropolitan areas [16; 17].

Rural communities in the United States tend to be predominantly White and less racially and ethnically diverse. In 2020, 76% of the rural population identified as non-Hispanic White, compared with 64.1% of the general U.S. population [18]. An estimated 7.7% of the rural population is African American/Black and 9.0% are Hispanic, compared with 13.6% and 18.9%, respectively, of the general population [18]. Black Americans in rural areas tend to be clustered in the south, in areas that were historically linked to slavery, particularly in Alabama, Georgia, Mississippi, North Carolina, South Carolina, and Virginia [18]. Minority rural populations are disproportionately affected by poverty. In 2018, the poverty rate among rural Black Americans was 31.6%, and the rate among rural Native American communities is 30.9%. This compares to a rate of 13.2% among rural non-Hispanic White Americans [19].

RURAL CULTURE: STRENGTHS AND CHALLENGES

CULTURAL NORMS AND VALUES AS STRENGTHS

Culture has been conceptualized as a diversity domain, characterized by having specific value systems, norms, and social and behavioral patterns [20]. Specifically, culture refers to the values and knowledge of groups in a society; it consists of approved behaviors, norms of conduct, and value systems [21; 22]. Culture also involves attitudes and beliefs that are passed from generation to generation within a group. These patterns include language, religious beliefs, institutions, artistic expressions, ways of thinking, and patterns of social and interpersonal relations [23]. Culture can also represent worldviews—encompassing assumptions and perceptions about the world and how it works [24]. Culture has two components: the observable and the unobservable [25]. The observable include things such as language, customs, and specific practices, while the unobservable include beliefs, norms, and value systems. Culture helps to elucidate why groups of people act and respond to the environment as they do [26].

Working with clients from rural areas requires cultural competency; providers should be aware of the unique cultural differences of rural communities [27]. Some have argued that rural residents are a minority group that experiences prejudice and cultural microaggressions from the dominant culture [28]. Although there is a positive stereotype of rural life as bucolic and idyllic, there are also negative stereotypes regarding rural residents as uneducated and backward [28].

The concept of culture can encompass geographical characteristics, not just social and behavioral norms [29]. For example, there are often particular language nuances in rural cultures [29]. It is important to remember that there is tremendous diversity within rural groups, and it is vital to avoid stereotyping all rural residents by a single set of values.

One of the main cultural values among rural residents in the United States is self-reliance and autonomy [27; 29; 30]. There tends to be an attitude of individualism and Puritan work ethic; rural residents often adhere to the ideal of "pulling yourself up by your bootstraps" in challenging times [35]. These values are learned early, partially because rural residents often live far from other people and services. Geographic isolation, limited resources, and constrained finances (both personal and community) reinforce self-sufficiency as a social identity. However, providers should not assume that all rural clients will want to rely upon the legacy of self-reliance as a means of compensating for lack of services or access [30].

Family, church, and community are the traditional underpinnings of rural life [29; 31]. There is a more collectivistic approach compared with urban communities [31; 32]. Community and mutuality are shared values, and families rely on each other and their community for help [33]. Support networks are naturally occurring [34]. Rural areas are also characterized by more informal social relationships. Rural residents tend to utilize long-standing community institutions as social outlets, such as schools, churches, community clubs, and farmers' organizations [34; 36]. Neighbors, family, and friends are crucial components of one's natural support networks, particularly in times of crisis [37]. The Walsh Center for Rural Analysis reported that rural residents described their communities as having a "community spirit" and a "culture of cooperation," exhibited by residents having close ties not only to their families but with community and neighborhood associations and strong religious affiliations [35].

RURAL CHALLENGES

While self-reliance and independence are values that can assist individuals during times of crisis, they can also negatively influence health beliefs and help-seeking behaviors. Persons with this perspective seek health services only when problems are severe. This is especially true of mental health services, as mental illness is often incorrectly perceived as a problem with personal willpower [38]. Because self-reliance is a major part of the cultural rural fabric, obtaining help may be viewed as a sign of weakness and burdensome to others [7]. For this same reason, rural residents often feel that obtaining services from safety net programs is stigmatizing.

Another barrier to formal help-seeking is the core cultural value of family, community, and mutuality, which results in rural individuals relying on coping strategies that focus on self-care and informal networks rather than formal agencies [38]. Confidentiality and discretion are also important, as there is a feeling in small, rural communities that everyone is aware of everyone else's movements. Individuals may be impeded from engaging with formal services if they fear their privacy will be violated [28].

Another cultural characteristic of rural communities is their general distrust of outsiders. Because of its emphasis on family and community, rural residents are often mistrustful of people and institutions that are not part of the community. This is particularly true in rural areas that are geographically isolated, like the Appalachian area [39]. Rural areas tend to be more traditional and conservative, with an embrace of religious values [27; 29]. Those leaning toward more liberal beliefs may be ostracized by family, friends, and the community. Diversity is not easily accepted [34; 40]. However, this is only a general trend; in some rural communities, as certain industries grow, diversity is increasing [29].

Geographic and environmental characteristics also help shape specific rural cultures [29]. These features can serve as literal structural barriers that reinforce rural cultural values and norms. Geographically isolated areas are slower to incorporate technological advances, and one area that has lagged behind is telecommunications [1; 34; 40]. Rural areas often do not have the infrastructure for high-speed connections. In 2019, 63% of rural residents had broadband Internet access at home. They also go online less often, with 76% reporting that they go on the Internet at least daily, compared with 83% of urban dwellers [41]. Public transportation may not be available or easily accessible, which can impede rural residents' ability to travel to health clinics, medical appointments, and/or mental health and social services [37]. The availability of these services could also be limited due to financial constraints and workforce shortages [37]. All of these barriers reinforce cultural values of independence and autonomy. The interplay of place and culture is inextricably intertwined.

CULTURAL COMPETENCY

Cultural competence is a professional mandate in the health professions [42]. The Joint Commission has standards for cultural competence for health organizations [43]. In its Code of Ethics, the National Association of Social Workers requires that all social workers "demonstrate understanding of culture and its function in human behavior and society, recognizing the strengths that exist in all cultures" [44]. Cultural competency is a dynamic process and an ongoing journey that is informed by cultural encounters [45]. It cannot be achieved by completing a course or training; rather, cultural competence involves continual learning throughout one's professional career in four different areas [22; 46]:

- Cultural awareness
- Knowledge acquisition
- Skills development
- Inductive learning

Expanding on this paradigm, cultural awareness is a practitioner's ability to [48]:

- Identify key cultural values of the client.
- Understand how these cultural values influence the client and his/her/their environment.
- Develop skills in order to apply and implement services that are congruent to the client's value systems.
- Acknowledge that this is an inductive learning process that involves a continual journey and quest to learn about different cultural value systems and beliefs and apply them to Western intervention models.

Other related concepts are cultural humility and cultural safety. Cultural humility refers to an attitude of humbleness, acknowledging one's limitations in the cultural knowledge of groups. Practitioners who apply cultural humility readily concede that they are not experts in others' cultures and that there are aspects of culture and social experiences that they do not know. From this perspective, patients are considered teachers of the cultural norms, beliefs, and value systems of their group, while practitioners are the learners [49]. Cultural humility is a lifelong process involving reflexivity, self-evaluation, and self-critique [50].

Cultural safety focuses on a practitioner's own culture, position, and power, and how the practitioner can unconsciously control a cultural group's values and behaviors [51]. Cultural safety as a concept applies particularly well to Native and indigenous populations in rural areas [51]. The goal of cultural competence, humility, and safety is to reduce the gap between the norms and belief systems of clients from diverse cultural groups and the institutional cultural norms of service delivery agents and organizations. Ultimately, this will mitigate the disparities that exist in mental health and healthcare systems [52]. Inherent in the assumptions of cultural competency, humility, and safety is the acknowledgement that a group's core values and norms are strengths. It is important to take a strengths-based perspective versus a deficit or pathological lens.

DISPARITIES AND UTILIZATION PATTERNS IN RURAL AREAS

DEFINITION OF DISPARITIES

Health disparity can be an ambiguous term, and there is not yet a consensus definition. Very basically, health disparities are differences in health or mental health status that systematically and adversely affect less advantaged groups [53]. These inequities are often linked to historical and current unequal distribution of resources due to poverty, structural inequities, insufficient access to health care, and/or environmental barriers and threats [54]. Healthy People 2030 has defined a health disparity as [55]:

> ...a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

Health disparities are closely tied to healthcare disparities, which are defined as unequal access to services in the health or mental health service sector or differences in quality of these services to individual(s) or groups due to disadvantages and marginalization [56]. Health equity is a goal but can be a nebulous concept; therefore, health disparities are employed to measure whether the goal of health equity is being accomplished [57]. Health equity is a form of social justice in the health arena and is based on the belief that no one should be denied good health simply for being in a group that may have been or is marginalized [57].

HEALTH AND MENTAL HEALTH DISPARITIES IN RURAL COMMUNITIES

Rural health disparities exist on a global level. Worldwide, 56% of rural residents lack health insurance, compared with just 22% in urban areas [58]. In the United States, national physical and mental health outcomes have improved over the years; however, these improvements are not as large in rural communities. Today, incidences of obesity, diabetes, cancer, heart disease, and respiratory illness are all higher in rural areas than urban areas [59; 60]. For example, in 2016, the diabetes prevalence rate was 12.6% for rural U.S. communities but 9.9% in urban areas in the United States [12]. In addition, high-risk behaviors, such as not using a seat belt, tobacco use, and substance abuse, are more prevalent in rural communities [59; 60]. Furthermore, rural residents are more likely to consume calorie-dense and lower nutrient foods and are less physically active [60]. More rural residents themselves rate their health as fair to poor (19.5%), compared with urban residents (15.6%) [29].

Mortality rates are also higher in rural areas of the United States. While overall life expectancy has improved, the rural-urban gap has widened, increasing from 0.4 years in 1969 to 2 years by 2014 [12; 61]. As rurality increases, so do infant mortality rates, primarily due to sudden unexpected infant deaths and congenital anomalies [62]. There are particularly high mortality rates among Native American Indian and non-Hispanic White infants outside of metropolitan areas [62].

Rural Americans with mental health needs typically enter care later, have more serious symptoms, and require more costly and intensive treatment [63]. In 2020, 21% of adults in nonmetropolitan counties had some form of mental illness and 6% experienced serious mental illness [64]. Suicide rates have been increasing across the United States, led by areas considered less urban, with the gap in rates between less urban and urban areas widening between 1999 and 2016; furthermore, suicide with a firearm is two times higher among rural residents than those in urban areas [65; 66; 67]. While White

men are at highest risk for suicide nationally, in rural areas American Indians/Alaska Natives are the most affected [65; 66]. In 2020, 5% of rural adults reported serious thoughts of suicide [64].

Substance use disorder refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes [68]. In 2020, 13% of rural adults experienced a substance use disorder [64]. Rural areas can vary on type of substance(s) abused. Residents of rural areas are more likely to experience unintentional opioid overdose deaths than those in urban areas [68].

The rate of opioid misuse and related fatalities are considered public health emergencies in the United States. The general rate of drug use in urban and rural areas are similar (10.4% and 10.9%, respectively) [69]. The rate of drug overdose deaths is greater in rural areas, with the rural overdose rate (unintentional injury) 50% higher than the urban rate [70]. Between 1999 and 2015, the rural opioid death rate quadrupled among those 18 to 25 years of age and tripled for women [70]. Socioeconomic factors, behavioral factors, and access to services contribute to these rural-urban differences. An understanding of how rural areas are different when it comes to drug use and drug overdose deaths, including opioids, can help public health professionals identify, monitor, and prioritize their response to the opioid epidemic [70]. To develop this understanding, ongoing data collection, analysis of data, and reporting of findings are critical to staying ahead of the drug crisis in public health.

In the past few decades, the manufacture and abuse of methamphetamine in the United States has gained increased attention. The admissions rates for treatment of methamphetamine-related disorders have ballooned alarmingly in some areas, particularly in rural or frontier areas, causing public health concerns. National reports of methamphetamine use have shown an increase since 2014. Regional use of methamphetamine continues to vary widely, with the highest rates in the West and Midwest, and a strong presence in the Southeast, with rural areas being the most severely impacted. According to a 2020 report, the Northeast, an area previously not a major market for methamphetamine, had seen a recent increase in use rates [71]. The higher use of methamphetamine in Western states is also reflected by the number of persons under its influence who come into contact with law enforcement.

Methamphetamine users in rural areas, especially areas designated as frontier regions, are likely to experience great difficulty in accessing medical, psychiatric, or substance abuse services. Even self-help groups are likely to be nonexistent in these areas, and when they are available, the degree of anonymity in a 12-step group in a small town may be compromised. The nearest available small city often serves as the population center for the region. Social services in these cities may be overwhelmed by numbers of transient persons from the surrounding rural areas needing services in addition to the inhabitants of the city [72].

CONTRIBUTING FACTORS TO DISPARITIES IN RURAL COMMUNITIES

It is difficult to isolate a single contributing factor to health and care disparities. There are multiple factors, and they work in conjunction to affect rural health inequities [73]. The following sections will provide a snapshot of individual/family, community, systemic/institutional, and societal/cultural factors that contribute to and perpetuate rural health disparities.

Individual/Family-Level Factors

Demographic factors, such as education level and personal and household income, play a role in health and mental health disparities; this is mainly related to lack of access to resources [58]. As noted, rural areas tend to have a higher unemployment rate, lower median household income, higher poverty rate, and higher uninsured rate [12]. Each one of these factors can contribute to lack of access to health and mental health services. Even when access is available, travel and time off of work may be more difficult for rural clients.

Rural men are more likely than urban inhabitants to subscribe to gender role stereotypes that support self-reliance; therefore, they are less likely to seek help for health and mental health concerns [74]. As discussed, rural communities are tightly knit, with a high level of social proximity, which results in low levels of anonymity [7]. Further, rural families have been shown more likely to attach stigma to mental health disorders, including depression, compared with their urban counterparts [75]. Being circumspect and avoiding stigma can be challenging in small communities, where movements, activities, and visitors are public knowledge [76].

Community-Level Factors

Demographic and physical characteristics, availability of resources, and the social and economic environment of the community also play a role in maintaining health disparities. For example, some rural communities are considered food deserts, defined as areas in which one must travel more than 10 miles to a supermarket to obtain fresh foods at affordable prices [77]. These areas lack easy access to fresh produce; instead, dollar stores and convenience stores are the most common sources of groceries for rural families. Food deserts are linked to poor health outcomes, including obesity and chronic illness [78; 79]. It is estimated that a total of 23.5 million people in the United States reside in food deserts, and urban and rural areas are affected [77]. In total, 2.3 million individuals reside in rural communities that are classified as low income and food deserts [77]. Studies have shown that simply opening grocery stores/supermarkets in food deserts does not ameliorate the issue, because rural residents may continue to purchase groceries at dollar or convenience stores if their transportation options are limited or if it is less expensive [78; 80]. Schools and government workplaces are potential sources of food for low-income rural residents; farmers' markets have also begun to accept Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and vouchers from the Farmers' Market Nutrition Program [81]. Typically, a combination of policies and environmental interventions is used in order to meet the food needs of rural residents.

Lack of access to public transportation in rural communities also affects rural health. Health and mental health clinics are often located at a distance. Public transportation options are limited or nonexistent, and missing work can be a financial burden, particularly for those who require regular, long-term appointments [82]. Transportation times can be longer than appointment times, making it difficult to convince rural residents that the help is worth the trouble.

Where there are shortages in trained professionals, development and support for community educational training and resources are also lacking. As a result, the health and mental health literacy in rural communities is often low, which contributes to a lack of interest in seeking formal help. At least one study has identified a gender divide, with rural men less likely to have good understanding of depression compared with rural women [83]. In this study, depression literacy did not predict the perceived need to seek formal help. When participants did seek help, they tended to prefer to seek a religious leader, perhaps because they viewed such help-seeking less stigmatizing.

Systemic/Institutional Level Factors

Rural health disparities can be partially attributed to chronic staffing shortages in the health, mental health, and social services sectors in rural areas. A chief characteristic of the rural health workforce is one of maldistribution. In most of the country, health professionals concentrate in urban areas, creating an insufficient supply and unequal distribution of primary healthcare providers [84; 85]. Per 10,000 population, there are 5.3 primary care physicians, 6.5 nurse practitioners, and 2.9 dentists, compared with 79, 81, and 43, respectively, in urban areas [86]. The difference is even more marked among behavioral health professions. Per 10,000 population, there are 0.3 psychiatrists, 1.6 psychologists, 5.8 social workers, and 8.8 counselors in rural areas. In urban areas, there are 1.3 psychiatrists, 4.0 psychologists, 9.6 social workers, and 13.1 counselors per 10,000 population [86]. This disparity is expected to grow as a result of demographic changes, insurance coverage expansions, and a decline in the primary care physician workforce [86; 87]. Specialists and subspecialists are particularly limited in rural areas, as they tend to concentrate in areas with larger population bases, where they have enough demand for their services to be economically viable [88; 89]. Rural counties are also historically disadvantaged in terms of mental health services [90]. According to the Centers for Disease Control and Prevention, more than 85 million Americans live in areas with an insufficient number of mental health providers; this shortage is particularly severe among low-income rural communities [91]. Patients in rural care settings are also more likely to be given pharmacotherapy for psychiatric illness due to a shortage of professionals qualified to provide psychotherapy.

Lower population density also means fewer social service programs in rural areas, which results in the attraction of fewer social workers [92]. The Council on Social Work Education (CSWE) conducted a study in 2017 to better understand the landscape of new social work graduates entering the workforce. Online surveys were sent to newly graduated social workers from 84 different social work programs. Of the graduates holding a master's degree in Social Work (MSW), only 7.2% were practicing social work in rural communities; 25.9% took jobs in large cities (i.e., 1 million population or greater) [93]. In a smaller descriptive study examining 115 social work students' career plans and views of rural social work practice, 70% of respondents preferred to practice social work in an urban or near an urban area [94]. This finding is interesting in light of the fact that more than half reported residing in a rural community at the time of their high school graduation. These social work students expressed concerns with lower salaries and professional and personal opportunities if they were to practice in rural areas.

Overall, an array of factors contributes to the shortage of professionals in rural areas, including [95]:

- Challenges recruiting and retaining newly graduated professionals to small, rural communities
- Lower salaries
- Geographic and social isolation
- Retirement/aging of current providers
- Unwillingness to accept new patients by providers who are seeking to lighten workloads

For social workers and other mental health professionals who work in rural areas, burnout is common and affects agencies' ability to retain practitioners. A survey study examining factors related to job satisfaction and burnout among social workers in rural areas found that, in general, participants were moderately satisfied with their jobs. Not surprisingly, those with higher salaries and who had been at their workplaces longer tended to report higher levels of satisfaction. Higher levels of burnout were predicted by older age, non-White race (particularly Black race), and employment in child welfare agencies [96].

In a qualitative study about older adults' access to primary care physicians in rural areas, researchers found an implicit social contract between physicians and patients [97]. Rural physicians expected patients to be "easy" and not bother them with minor complaints. If the patient adheres to the contract, he or she can expect to be readily seen by the physician. However, many participants complained about difficulty in scheduling appointments and feeling unwelcome.

Societal and Cultural Level Factors

On a macro level, structural barriers contribute to health and mental health disparities. While the Affordable Care Act has increased the number of individuals with health insurance, rural residents may still find that co-pays are too financially restrictive when accessing care or services. Smaller agencies and businesses (with fewer than 50 employees) may not be able to attain full reimbursement, and in rural communities, smaller agencies and private companies are more common [98]. During the COVID-19 pandemic, Medicaid expanded coverage for telehealth services, but after the national health crisis is lifted in 2023, coverage will again be limited (and vary by state) [99].

One of the challenges in rural areas is the likelihood of cultural norms of self-reliance and stoicism impeding help-seeking. Self-care is generally not a priority, and when symptoms emerge, rural residents are more likely to use home-based remedies. In many cases, a physician is only contacted in the event of serious symptoms and after other avenues have been exhausted (i.e., at the last minute) [100]. There is cultural pride in being independent and being hard working. Taking time to take care of oneself is often seen as a luxury, especially in light of personal financial stress [29]. In a study with women in rural Appalachia, depressive symptoms of low energy, apathy, and low mood were considered at odds with cultural values of self-sufficiency. The women reported carrying on because they had little or no support in working or child and family care [101]. "Keeping going" had a moral and cultural undertone.

SPECIAL POPULATIONS IN RURAL COMMUNITIES

CHILDREN AND ADOLESCENTS

In the rural United States, there are 13.4 million children younger than 18 years of age [102]. The child poverty rate is lower among rural children than urban children (18.9% vs. 22.3%). However, more rural children (7.3%) are uninsured than urban children (6.3%) [102]. Just as there are health disparities among adults in rural and urban areas, health disparities also exist for children. Rural children are more likely to have a body mass index (BMI) greater than the 85th percentile than urban children [103]. In a study of 186 rural children, 37% were overweight or obese and 43% of the families were at risk for food insecurity. Not surprisingly, families who were at risk for food insecurity were more likely to have children who were obese [104].

Adverse childhood experiences (ACEs) are defined as potentially traumatic experiences that affect an individual during childhood (before 18 years of age). These experiences place individuals at risk for future health and mental health issues and risky behaviors in adulthood [105]. ACEs include witnessing family abuse and/or community violence, experiencing a family member attempting or dying by suicide, and experiencing child abuse and/or neglect. It can also encompass adverse family challenges, such as parental divorce, substance use, and parental incarceration [105]. Rural children have higher exposure rates to ACEs compared with urban children [106]. In general, regardless of where they live, children with more than four ACEs are more likely to live below the poverty line [106].

Higher levels of poverty, substance use disorder, unemployment, and other stressors are risk factors for child maltreatment. According to the Fourth National Incidence Study of Child Abuse and Neglect, children in rural communities have a higher incidence of maltreatment compared with their urban counterparts [107]. Another national study found that the rate of child maltreatment was 1.7 times higher in rural areas than urban areas [108].

However, a 2020 systematic review presented mixed findings regarding rural/urban differences in child maltreatment rates [109]. In this analysis, only five studies that showed that rural communities had higher incidences of child maltreatment. In terms post-identification, rural children are 1.18 times more likely than urban children to be discharged from foster care [110].

Adolescents in rural areas are more likely to report tobacco, alcohol, and cocaine use compared to their urban counterparts. They are also more likely to binge drink and to drive under the influence [103]. In general, rurality is associated with higher adolescent mortality related to unintentional injuries and suicide [103].

Chronic school absenteeism is also high in rural areas. Almost half of preschool children in an Appalachian school setting missed 10% or more of their school year. This then was related to fewer gains in literacy during the school year [111].

Rural adolescent girls are more likely than their urban counterparts to become pregnant and to elect to continue their pregnancy and keep their child. Birth rates for rural communities are approximately one-third higher than urban areas [112]. More than urban women, rural women's first adolescent pregnancies are more likely to be unplanned and to result in a live birth [113]. This disparity was particularly marked among Black rural women [113]. Mortality rates are higher for rural children than urban children regardless of gender and racial/ethnic minority group.

WOMEN

In a large-scale study, analyzing data from 12,600 mothers in Maine, rural mothers tended to be younger than urban mothers, and 10% of all rural patients who gave birth were adolescents, compared with 6.2% of urban patients [114]. Rural mothers were more likely to smoke prior to and during their pregnancies and had higher BMIs prior to pregnancy. These women were less likely to have higher education or to be married and more likely to reside in households with lower incomes [114].

Given these social determinants and overall rural health disparities, it is not surprising that maternal health disparities are a concern in rural communities. Compared with urban women, rural women had a 9% increased probability of mortality and severe maternal morbidity (i.e., a risky condition that requires a life-saving procedure during or immediately following childbirth) [115].

Infant mortality rates are also 6% higher in rural areas compared with small and medium urban areas and 20% higher compared with large urban counties [116]. Neonatal deaths, defined as the death of an infant during the first 28 days of life, are also 8% higher in rural communities compared with urban areas [116].

Pregnant rural women may experience challenges accessing regular prenatal care and hospitals with obstetric units. Increasingly, rural hospital obstetric units are closing due to budget cuts and low reimbursement rates as well as challenges retaining staff [117]. Rural counties without a hospital with an obstetric unit and that are not located near an urban area have higher rates of out-of-hospital births, births in non-obstetric hospital units (e.g., emergency departments), and preterm births [118]. In a qualitative study exploring reasons rural women delay obtaining prenatal care, rural women reported lack of support or encouragement for prenatal care from family members (specifically, mothers) and the community [119]. Other women in the community often feel that doing without these services is the norm for rural women.

Rural and urban women who are vulnerable to high-risk pregnancies have similar life stressors (e.g., financial limitations) that impede seeking prenatal care. However, rural women who have two or more barriers are 2.85 less likely to have a regular source of prenatal care than urban women with comparable barriers [120]. Individual and community barriers, such as lack of insurance, transportation logistics, difficulty locating a physician/provider, and lack of affordable prenatal health services, are also considerations. Finally, structural issues often result in poor continuity of care.

Poverty, early parenthood, lack of education, and sparse resources can place women at risk of intimate partner violence, particularly in rural areas characterized by more conservative, patriarchal values that reinforce male dominance [121]. It has been postulated that traditional values may make attitudes toward intimate partner violence more tolerant. However, a large national study found that lifetime intimate partner violence victimization rates in rural areas (26.7% in women, 15.5% in men) are similar to the prevalence found among men and women in non-rural areas [122]. There is some evidence that intimate partner homicide rates may be higher in rural areas than in urban or suburban locales [123; 124].

Substance use disorders and unemployment are more common among intimate partner violence perpetrators in rural areas [123]. Poverty in rural areas is also associated with an increased risk for intimate partner violence victimization and perpetration for both men and women [125]. It has been suggested that intimate partner violence in rural areas may be more chronic and severe and may result in worse psychosocial and physical health outcomes. Residents of rural areas are less likely to support government involvement in intimate partner violence prevention and intervention than urban residents [123]. Although the rates are similar, the risk factors, effects, and needs of rural victims are unique. For example, research indicates that rural women live three times further from their nearest intimate partner violence resource than urban women. In addition, domestic violence programs serving rural communities offer fewer services for a greater geographic area than urban programs [126].

OLDER ADULTS

Overall, a greater proportion of the rural population (20%) is 65 years of age and older than the proportion in urban areas (16%) [127]. Approximately 75% of rural older adults live with someone in a household; very few (1.4%) elderly rural residents live in skilled nursing facilities [128]. Older rural adults experience similar challenges as other rural residents, but their experiences may be exacerbated by impaired mobility, frailty, and limited income. Food security and transportation are key issues.

Food insecurity is defined as adjusting the amount and quality of food one eats in response to limited financial or physical resources [129]. Persons with food insecurity may resort to consuming calorie-dense foods high in fat and sugar, which tend to be less expensive. As discussed, some also rely on convenience stores that are closer to their homes to obtain groceries; these stores generally do not supply fresh fruits and vegetables. Food insecurity is linked to social determinants and contributes to higher incidences of obesity, diabetes, and chronic illness [129; 130].

Food insecurity and transportation challenges are related. Rural areas in the United States have limited and unreliable public transportation, especially in areas with poor roads and more extreme weather conditions. In general, life expectancy exceeds driving expectancy by 6 years for women and 10 years for men [131]. Older adults want to retain their ability to drive and related independence, but this is made more difficult in rural areas [132]. For rural older adults who can still drive, they are twice as likely as urban older adults to be hurt or die on the road because of the longer driving distances and poorer road conditions [133].

Although Medicaid will pay for transportation needs for non-emergency health services, there are variations in Medicaid coverage in different states [134]. Therefore, some older adults will be unable to obtain healthcare services because of lack of transportation. It is estimated that 3.6 million Americans fall in this category, especially women, rural residents, those with mobility issues, and those with multiple chronic conditions [135]. Other transportation options, such as ride shares (e.g., Uber, Lyft) may be cost-prohibitive and or unavailable in some rural areas [131].

GENDER AND SEXUAL MINORITIES

Approximately 3% to 5% of those who live in rural communities in the United States identify as gender and/or sexual minorities [136]. The gender and sexual minorities umbrella encompasses lesbian, gay, bisexual, transgender, queer/questioning, intersex/intergender, asexual/ally (LGBTQIA) people as well as less well-recognized groups, including non-binary, aromantic, two-spirited, and gender-fluid persons.

The rural context may have significant influence on an individual's sexual identity development. Rural communities have been characterized as more conservative and religious, and thereby more heterocentric [137]. By extension, this often results in less supportive attitudes toward LGBT+ individuals and more discriminatory policies and laws [136]. Because rural communities tend to be small in population and tightly knit, there is greater likelihood that anti-LGBT+ attitudes and behaviors will affect residents. For example, parishioners in a worship service are often also the same people one interacts with at work, at grocery stores, and in healthcare settings [136].

However, there is some evidence of a shift in attitudes in rural areas. In a 2015 study, nearly 80% of rural participants were supportive/accepting of same-sex marriages; gender, educational level, and relationship status did not appear to affect attitudes [138]. In a survey study of 113 rural primary care providers, 54.8% had received education aimed at LGBT+ health and 88% believed that health education targeted to LGBT+ patients should be a required part of the training curricula. However, as religiosity increased, favorable attitudes toward LGBT+ persons declined [139].

The coming out process can be challenging under normal circumstances, but it may be even more challenging in the rural context. Because maintaining privacy can be challenging, individuals may find it difficult or impossible to avoid coming out to the entire community or to avoid scrutiny and stigmatization [136]. In some cases, they may feel ostracized in their places of worship and spiritually excommunicated [137]. Older rural LGBT+ individuals report higher levels of guardedness about their sexual orientation with people in their social networks compared with their urban counterparts [140]. Rural communities tend to have very limited LGBT+-friendly spaces (e.g., bars, clubs, bookstores, coffee shops), so LGBT+ individuals may feel that they do not have the support to come out or that their environment does not affirm their identity. Because of the discrimination, rejection, and ostracism they face, LGBT+ individuals may experience greater minority stress, which is associated with an increased risk for various health and mental health issues. For example, transgender and gender nonconforming individuals living in rural communities experience greater levels of social anxiety compared to urban individuals who have greater social supports (a protective factor) [141].

VETERANS

Approximately 5 million veterans live in rural areas of the United States, representing about 25% of the total veteran population [142]. Historically, the U.S. military has focused recruiting efforts in Southern rural areas [143]. Rural veterans tend to be older than urban veterans, a reflection of rural populations in general. Given that this population skews older, it is not surprising that about 27.8% of rural veterans served in the Vietnam War [142]. In addition, 9.7% of rural veterans served in Iraq and Afghanistan [144]. Because the median age of rural veterans is 65 years, this population also has a higher rate of chronic medical conditions, such as

hypertension, diabetes, and obesity [142; 144]. Similar to the general health and mental health trends in rural areas, rural veterans are more likely than urban veterans to have a diagnosed psychiatric condition (e.g., post-traumatic stress disorder [PTSD], anxiety disorders, depression, substance use disorders) and are at an increased risk of suicide [143; 145]. Veterans from very rural areas tend to smoke more than their urban counterparts, perhaps due to the higher rates of under- or unemployment and lack of specialized smoking cessation services [146]. More rural veterans than urban veterans are enrolled in the Veterans Affairs (VA) healthcare system (57% vs. 37%); however, rural residents often have to travel greater distances to access VA health services [144].

As a group, rural veterans are marked by low income (57% earn less than $35,000 annually) and economic instability [144]. Therefore, housing affordability, accessibility, and availability can be a challenge [147]. The lower household incomes and higher rates of substance use disorders and mental illness seem like they would increase the risk of homelessness, but rural veterans actually have lower rates of homelessness compared with urban veterans [148]. This has been attributed, in part, to the supportive environment and accessibility of informal networks in rural communities [148]. It may also be that homelessness is exhibited differently in rural areas. For example, rural veterans might reside with family members or friends for a period of time or live in tents or vehicles [148]. The ability to live in vehicles, tents, and non-residential structures without law enforcement intervention is also increased in rural areas. In a study with 151 homeless male veterans in Nebraska, those living in micropolitans (i.e., areas with population of at least 10,000 but less than 50,000) were more likely to be unmarried, transient, and living in transitional housing [149]. They were also more likely to access health services and spend less time traveling to these services.

INTERPROFESSIONAL COLLABORATION IN THE RURAL CONTEXT

The biomedical model is the traditional foundation of the U.S. healthcare system. This model is considered individualistic and perhaps even paternalistic. U.S. healthcare providers tend to work in silos and decision-making is one-sided [150]. In rural communities, services for health, mental health, and social work are often inadequate to meet the needs of the population due to provider shortages and lack of facilities. In this setting, interprofessional and interdisciplinary collaborations are increasingly vital and an essential means to address the complex and multifaceted needs of rural communities [151]. When working in an interprofessional context, practitioners will learn about each other's roles, work within a team, and develop and enhance community networks so a streamlined referral system can easily be accessed [151; 152]. Interprofessional collaboration deviates from the silo model and shifts to a team perspective.

DEFINITION AND CHARACTERISTICS

Interprofessional collaboration is defined as a partnership or network of providers who work in a concerted and coordinated effort on a common goal for clients/patients and their families to improve health, mental health, social, and/or family outcomes [153]. Providers come together and view and discuss the same client problem from different lenses, which can ultimately produce more innovative solutions [152]. The client is not excluded from the process; rather, there is shared decision making among all team members, with the objective to improve client outcome [153]. Key elements of interpersonal collaboration include [150; 152; 153; 154]:

- Coordination
- Shared knowledge and skills
- Sharing of resources
- Understanding of each team member's roles and competencies

- Autonomy
- Mutual trust and respect of each members' professional roles, identity, and culture
- Building relationships
- Communication
- Responsibility
- Accountability
- Patient-centeredness

POSITIVE OUTCOMES

There are many benefits of interprofessional collaboration at each system level. On a micro or individual level, clients experience [154; 155; 156]:

- Reduced patient mortality
- Increased patient safety
- Increased patient satisfaction
- Improved health outcomes
- Improved quality of life

Practitioners experience professional benefits, including [154; 156; 157]:

- Increased job satisfaction
- Greater equality of status between practitioners
- Improved working relationships within teams, reducing team conflict
- Increased staff retention
- Greater creativity to come up with innovative solutions

On an organizational level, agencies, organizations, and hospitals should expect to see [150; 154; 156]:

- Reduction of medical errors
- Decreased length of hospital stays
- Improved care coordination and continuity
- More holistic services
- Improved efficiency
- Decreased adverse events
- Reduction of cost of care
- Lessened financial/budget constraints
- Improved use of specialty care and services

On macro or societal level, interprofessional collaboration has been linked to improved outcomes in areas of infectious diseases, epidemics, and humanitarian efforts by the World Health Organization [150].

CHALLENGES FACILITATING INTERPROFESSIONAL COLLABORATION

Most practitioners would agree that interprofessional collaboration is vital. However, there are challenges in promoting this approach. Most commonly, this includes [152; 158]:

- Lack of clear leadership
- Lack of understanding of different providers' roles
- Limited time and resources
- Different professional values and traditions among the various disciplines
- Time and effort required to develop an interprofessional collaborative climate

In order to facilitate interprofessional collaboration, providers should develop the following skills and competencies [159; 160; 161; 162]:

- Enhanced communication (e.g., giving constructive feedback, listening, facilitating positive discussions, keeping all parties informed, asking for input)
- Team building (e.g., building consensus, talking and resolving conflict)
- Developing effective relationships across providers in different disciplines
- Joint problem-solving
- Implementing stages of change models
- Sharing expertise and knowledge and, in turn, learning what each member contributes or could contribute and the discipline-specific processes and procedures
- Developing trust and interdependence

Professionals can convey an understanding of the roles and responsibilities of each member of the interprofessional team by discussing and clarifying roles while recognizing limitations within each discipline.

ETHICAL ISSUES AND STANDARDS OF PRACTICE IN RURAL COMMUNITIES

The characteristics, values, and norms of rural communities and the culture of rurality influence how ethical standards are applied and emphasized. Most clearly, this applies to the ethical values of confidentiality, distributive justice, fidelity, and autonomy [163]. Rurality can affect how these ethical principles are applied in the day-to-day practice of rural practitioners.

CONFIDENTIALITY AND PRIVACY

As discussed, the smaller population size and tightly knit formal and informal social networks of rural communities can make for open and permeable boundaries, potentially negatively affecting practitioner-client confidentiality. Consider the following scenario [164]:

> A pastor of a rural church also serves as a chaplain of a rural hospital. He sees two patients who are scheduled for surgery for the following week; these patients are also congregants. The surgeon is also a member of the church. At a weekly service, the pastor calls for prayer and divine guidance for the surgeon and the two patients by name.

Does this violate privacy and HIPAA regulations? The pastor may believe that the importance of community support and prayer are far more vital than statutory regulations. Are there legal or ethical ramifications?

As discussed, clients may fear that living in small communities can compromise their desire for privacy and confidentiality. The disclosure of sensitive health or mental health information to friends or family can be stigmatizing. If a rural community resident seeks counseling because they are experiencing depression, other residents may see their vehicle parked outside the counselor's office and ask questions or gossip [165]. Agency supervisors may also be concerned with confidentiality in hiring and staffing and information that could accidentally be released in different spheres of life (e.g., church, work, grocery stores) [166].

The acquisition of third-hand information and how it is used in the clinical setting is another important issue in rural communities. Because most members of the community are familiar with each other, practitioners may obtain third-hand information through community gossip or through living in the community. Even if this information appears to be vital therapeutic information, the question of whether it can or should be used remains [167]. For example, a counselor might notice that his client is entering a local bar when, in their last session, the client had indicated that she was no longer drinking. Should the counselor then bring this observation into the next session? The management of information requires a careful, deliberate maneuvering to ensure that professional and personal boundaries are not blurred [167].

DUAL RELATIONSHIPS

This leads to the issue of dual relationships, which are defined as situations in which a professional has more than one role in a client's life (e.g., a financial, sexual, personal, and/or religious relationship). This is frowned upon and can rise to the level of an ethical violation because of the potentially coercive nature of the relationship resulting from the inherent power dynamics between the practitioner and the client [165]. Dual relationships have been identified as the top ethical challenge for social workers, counselors, and therapists working in a rural community [168].

However, dual relationships can be almost impossible to avoid. In a qualitative study with 10 social work research participants in a rural Alaskan community, participants reported difficulty avoiding dual relationships because their social, personal, and family lives often inevitably overlapped with clients' lives in a rural community with only one school, church, mechanic, and medical office [164; 167]. Because of the overlapping roles, it was difficult for practitioners to maintain a professional identity and distance. Rural practitioners may feel they are always on call, even when they are not working. Attempting to maintain professional distance may be perceived as unfriendly and unhelpful. Practitioners' personal lives are often on community display or part of community discussions, and this information may be used in part to evaluate their credibility and trustworthiness [167].

Experts have identified steps that can be taken to mitigate the challenges of dual relationships in rural communities [169]. Referring clients to non-local agencies that offer telehealth options can help. Another option is to employ the strong, naturally occurring helping relationships that exist in the community to meet client needs. However, this has its drawbacks, specifically potential lack of confidentiality. Finally, practitioners can offer to exchange services with practitioners in other rural communities via telehealth technology [169].

DISTRIBUTIVE JUSTICE

Because residents of rural communities often have limited financial and transportation resources, practitioners may struggle with the ethical principle of distributive justice, which emphasizes the role of fairness in the distribution of services [170]. A practitioner might be unsure if referring a client to services is the correct step, knowing that the client has no health insurance and would have to travel long distances to access the service [163]. Practitioners should also have boundaries surrounding in-kind payment for services [164].

COMPETENCE

The limited number of providers in rural areas can raise questions about competence. In professional ethical codes, competence is defined as a practitioner's knowledge, skills, and training and the importance of continuous education for professional development. It also encompasses the need to practice within one's professional competence. In its Code of Ethics, the National Association of Social Workers defines competence as a value requiring social workers to practice within their areas of competence and to continue to expand their professional knowledge and skills [44]. The American Counseling Association's Code of Ethics prescribes the same value and principle [171[. The issue that arises when the number of available practitioners is limited is balancing the need to limit practice to areas of competence but also meet the needs of an underserved population [172]. Is providing potentially incompetent care more detrimental than providing no care? In addition, coworkers and supervisors may be reticent to report incompetent care or ethical violations because it would further exacerbate the existing practitioner shortage. This can then be perpetuated, and professional silence might become the accepted norm [168]. If a practitioner feels he/she is not sufficiently trained in a particular area, it is common practice to refer a client to a specialist, but this may not be an easy solution in rural communities. Finally, practitioners do not have the same access to supervision, ethics committees, and trained ethics consultants to attain advice, consultation, and direction [163].

CONCLUSION

Rural populations are a vulnerable and marginalized population. They are often neglected, perhaps in part because many practitioners are trained in urban areas. Consequently, the professional lens is often urban-centered, with practice and research biased toward an urban perspective [3]. This compounds already inadequate services in rural communities. Practitioners who work in rural communities should be cognizant of the rural culture. Just as when practitioners work with any minority groups, it is important to recognize and appreciate the array of strengths that come with rural residents' unique cultural values and norms. Yet, when describing rural communities as "individualistic," "self-reliant" or "having rich informal support networks," it is important to remember that these are merely categorizations—they do not capture the multilayered and heterogeneous complexities of each rural community. As such, there is no universal practice template. What is clear is that all clients need to feel safe. Studies indicate that when vulnerable and marginalized clients feel that their cultural differences are pathologized, they feel unsafe and are more likely to prematurely terminate services [47].

The health, mental health, and social service disparities that exist in rural communities are the result of multiple factors, one of which is related to service delivery. Because of the low population density of many rural areas, health, mental health and social service availability is limited [92]. Although interprofessional collaboration is key in mitigating the challenges of providing services in rural areas, developing such relationships can be time consuming and, at times, fraught with interpersonal tension and conflict. The use of technology and telehealth services is recommended to help overcome challenges in rural access to services.

Works Cited

1. Nayani F. Rural Culture in America. Available at https://www.executivediversity.com/2009/10/25/rural-culture-in-america. Last accessed March 17, 2023.
2. U.S. Census Bureau. Redefining Urban Areas Following the 2020 Census. Available at https://www.census.gov/newsroom/blogs/random-samplings/2022/12/redefining-urban-areas-following-2020-census.html. Last accessed March 17, 2023.
3. Slovak K, Sparks A, Hall S. Attention to rural populations in social work's scholarly journals. *Journal of Social Service Research*. 2011;37(4):428-438.
4. Nicholson LA. Rural Mental Health. Available at https://www.cambridge.org/core/journals/advances-in-psychiatric-treatment/article/rural-mental-health/C83E79A4B4C8C04357C7B5BC1A0B43D5/core-reader. Last accessed March 17, 2023.
5. U.S. Department of Agriculture. What is Rural? Available at https://www.ers.usda.gov/topics/rural-economy-population/rural-classifications/what-is-rural. Last accessed March 17, 2023.
6. Ratcliffe M, Burd C, Holder K, Fields A. *Defining Rural at the U.S. Census Bureau*. Washington, DC: U.S. Census Bureau; 2016.
7. Jensen EJ, Mendenhall T. Call to action: family therapy and rural mental health. *Contemporary Family Therapy*. 2018;40(4):309-317.
8. U.S. Census. Life Off the Highway: A Snapshot of Rural America. Available at https://www.census.gov/newsroom/blogs/random-samplings/2016/12/life_off_the_highway.html. Last accessed March 17, 2023.
9. U.S. Census Bureau. Nation's Urban and Rural Populations Shift Following 2020 Census. Available at https://www.census.gov/newsroom/press-releases/2022/urban-rural-populations.html. Last accessed March 17, 2023.
10. Pendall R, Goodman L, Zhu J, Gold A. The Future of Rural Housing. Available at https://www.urban.org/sites/default/files/publication/85101/2000972-the-future-of-rural-housing_6.pdf. Last accessed March 17, 2023.
11. U.S. Census Bureau. Measuring America: Our Changing Landscape. Available at https://www.census.gov/library/visualizations/2016/comm/acs-rural-urban.html. Last accessed March 17, 2023.
12. Rural Health Information Hub. Rural Data Explorer. Available at https://www.ruralhealthinfo.org/data-explorer. Last accessed March 17, 2023.
13. U.S. Department of Agriculture, Economic Research Service. Rural Poverty and Wellbeing. Available at https://www.ers.usda.gov/data-products/charts-of-note/charts-of-note/?topicId=14912. Last accessed March 17, 2023.
14. Guzman G, Posey KG, Bishaw A, Benson C. Poverty Rates Higher, Median Household Income Lower in Rural Counties than in Urban Areas. Available at https://www.census.gov/library/stories/2018/12/differences-in-income-growth-across-united-states-counties.html. Last accessed March 17, 2023.
15. U.S. Census Bureau. Change in Rural and Urban Population Size: 1910–2010. Available at https://www.census.gov/content/dam/Census/library/visualizations/2016/comm/acs-rural-urban.pdf. Last accessed March 17, 2023.
16. U.S. Department of Agriculture Economic Research Service. Rural America at a Glance: 2021 Edition. Available at https://www.ers.usda.gov/webdocs/publications/102576/eib-230.pdf?v=660.4. Last accessed March 17, 2023.
17. U.S. Department of Agriculture Economic Research Service. Rural Employment and Unemployment. Available at https://www.ers.usda.gov/topics/rural-economy-population/employment-education/rural-employment-and-unemployment/. Last accessed March 17, 2023.
18. Johnson K, Lichter D. Growing Racial Diversity in Rural America: Results from the 2020 Census. Available at https://carsey.unh.edu/publication/growing-racial-diversity-in-rural-america. Last accessed March 17, 2023.
19. U.S. Department of Agriculture, Economic Research Service. Poverty Rates by Race/Ethnicity and Metro/Nonmetro Residence, 2018. Available at https://www.ers.usda.gov/data-products/chart-gallery/gallery/chart-detail/?chartId=63424. Last accessed March 17, 2023.
20. Patel SG, Tabb K, Sue S. Diversity, multiculturalism, and inclusion. In: Bond MA, Serrano-García I, Keys CB, Shinn M (eds). *APA Handbook of Community Psychology: Theoretical Foundations, Core Concepts, and Emerging Challenges*. Washington, DC: American Psychological Association; 2017: 253-273.
21. Gordon MM. *Assimilation in American Life: The Role of Race, Religion, and National Origins*. New York, NY: Oxford University Press; 1964.
22. Lum D. *Culturally Competent Practice*. 4th ed. Belmont, CA: Brooks/Cole; 2011.
23. Hodge JL, Struckmann DK, Trost LD. *Cultural Bases of Racism and Group Oppression*. Berkeley, CA: Two Riders Press; 1975.
24. Sue DW, Sue D. *Counseling the Culturally Different: Theory and Practice*. 6th ed. New York, NY: John Wiley & Sons; 2013.
25. Ridley CR, Sahu A, Console K, et al. The process model of multicultural counseling competence. *Counseling Psychologist*. 2021;49(4):534-567.
26. Jackson AP, Meadows FB. Getting to the bottom to understand the top. *J Couns Dev*. 1991;70(1):72-76.
27. Slama K. Rural Culture is a Diversity Issue. Available at https://www.apa.org/practice/programs/rural/rural-culture.pdf. Last accessed March 17, 2023.
28. Riebschleger J, Norris D, Pierce B, Pond DL, Cummings C. Preparing social work students for rural child welfare practice: emerging curriculum competencies. *Journal of Social Work Education*. 2015;51(4):S209-S224.

29. Holmes C, Levy M. Rural Culture Competency in Health Care. Available at https://reachhealth.org/wp-content/uploads/2016/12/REACH-RCC-White-Paper-Final.pdf. Last accessed March 17, 2023.
30. Page-Carruth A, Windsor C, Clark M. Rural self-reliance: the impact on health experiences of people living with type II diabetes in rural Queensland, Australia. *International Journal of Qualitative Studies on Health and Well-Being*. 2014;9(1):1-10.
31. Esterman K, Hedlund D. Comparing rural adolescents from farm and nonfarm families. *Journal of Research in Rural Education*. 1995;11(2):84-91.
32. Halfacree K. Talking about rurality: social representations of the rural as expressed by residents of six English parishes. *Journal of Rural Studies*. 1995;11:1-20.
33. Pesut B, Robinson CA, Bottorff JL. Among neighbors: an ethnographic account of responsibilities in rural palliative care. *Palliative & Supportive Care*. 2014;12(2):127-138.
34. Waltman GH. Reflections on rural social work. Families in Society. 2011;92(2):236-239.
35. The Walsh Center for Rural Analysis. Leveraging Culture and History to Improve Health and Equity in Rural Communities. Available at https://www.norc.org/PDFs/Walsh%20Center/Practice%20Briefs/Practice%20Brief_Culture%20and%20History_2-5-18_long.pdf. Last accessed March 17, 2023.
36. Lewis ML, Scott DL, Calfee C. Rural social service disparities and creative social work solutions for rural families across the life span. *Journal of Family Social Work*. 2013;16:101-115.
37. Cook JF, Alford KA, Conway P. Introduction to rural families and reshaping human services. *Journal of Family Social Work*. 2012;15(5):351-358.
38. Gjesfjeld CD, Weaver A, Schommer K. Rural women's transitions to motherhood: understanding social support in a rural community. *Journal of Family Social Work*. 2012;5:435-448.
39. Carpenter R, Theeke LA. Strategies for recruiting a sample of adults with type 2 diabetes from primary care clinics in rural Appalachia: incorporating cultural competence. *International Journal of Nursing Sciences*. 2018;5(3):230-237.
40. Gumpert J, Saltman JE. Social group work practice in rural areas: the practitioners speak. *Social Work with Groups*. 2019;21(3):19-34.
41. Pew Research Center. Digital Gap Between Rural and Nonrural America Persists. Available at https://www.pewresearch.org/fact-tank/2019/05/31/digital-gap-between-rural-and-nonrural-america-persists. Last accessed March 17, 2023.
42. Danso R. Cultural competence and cultural humility: a critical reflection on key cultural diversity concepts. *Journal of Social Work*. 2018;18(4):410-430.
43. Horvat L, Horey D, Romios P, Kis-Rigo J. Cultural competence education for health professionals. *Cochrane Database of Systematic Reviews*. 2014;5(5):CD009405.
44. National Association of Social Workers. NASW Code of Ethics. Available at https://www.socialworkers.org/about/ethics/code-of-ethics/code-of-ethics-english. Last accessed March 17, 2023.
45. Campinha-Bacote J. The process of cultural competence in the delivery of healthcare services: a model of care. *Journal of Transcultural Nursing*. 2002;13(3):181-184.
46. Cai L-B, Xu F-R, Cheng Q-Z, et al. Social smoking and mental health among Chinese male college students. *American Journal of Health Promotion*. 2017;31(3):226-231.
47. Rogers-Sirin L, Melendez F, Refano C, Zegarra Y. Immigrant perceptions of therapists' cultural competence: a qualitative investigation. *Professional Psychology Research and Practice*. 2015;46(4):258-269.
48. Fong R, Furuto S (eds). *Culturally Competent Practice: Skills, Interventions, and Evaluations*. Needham Heights, MA: Allyn & Bacon; 2001.
49. Lekas H-M, Pahl K, Lewis CF. Rethinking cultural competence: shifting to cultural humility. *Health Services Insights*. 2020;13:1178632920970580.
50. Velott D, Sprow FK. Toward health equity: mindfulness and cultural humility as adult education. *New Directions for Adult & Continuing Education*. 2019;161:57-66.
51. Schill K, Caxaj S. Cultural safety strategies for rural Indigenous palliative care: a scoping review. *BMC Palliative Care*. 2019;18(1):21.
52. Nyatanga B. Cultural competence: a noble idea in a changing world. *International Journal of Palliative Nursing*. 2008;14(7):315-315.
53. Dehlendorf C, Bryant AS, Huddleston HG, Jacoby VL, Fujimoto VY. Health disparities: definitions and measurements. *American Journal of Obstetrics and Gynecology*. 2010;202(3):212-213.
54. Centers for Disease Control and Prevention. Health Disparities. Available at https://www.cdc.gov/healthyyouth/disparities/index.htm. Last accessed March 17, 2023.
55. Healthy People 2030. Health Equity in Healthy People 2030. Available at https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030. Last accessed March 17, 2023.
56. Fink AM. Toward a new definition of health disparity: a concept analysis. *Journal of Transcultural Nursing*. 2009;20(4):349-357.
57. Braveman P. What are health disparities and health equity? We need to be clear. *Public Health Reports*. 2014;129(Suppl 2):5-8.
58. Doogan NJ, Roberts ME, Wewers ME, Tanenbaum ER, Mumford EA, Stillman FA. Validation of a new Continuous Geographic Isolation Scale: a tool for rural health disparities research. *Social Science & Medicine*. 2018;215:123-132.

59. Centers for Disease Control and Prevention. Leading Causes of Death in Rural America. Available at https://www.cdc.gov/ruralhealth/cause-of-death.html. Last accessed March 17, 2023.
60. Richman L, Pearson J, Beasley C, Stanifer J. Addressing health inequalities in diverse, rural communities: an unmet need. *SSM Population Health*. 2019;7:100398.
61. Singh GK, Siahpush M. Widening rural-urban disparities in life expectancy, US, 1969–2009. *American Journal of Preventive Medicine*. 2014;46(2):e19-e29.
62. Womack LS, Rossen LM, Hirai AH. Urban–rural infant mortality disparities by race and ethnicity and cause of death. *American Journal of Preventive Medicine*. 2020;58(2):254-260.
63. National Conference of State Legislatures. Improving Rural Health: State Policy Options. Available at http://www.ncsl.org/research/health/improving-rural-health-state-policy-options.aspx. Last accessed March 17, 2023.
64. National Alliance on Mental Illness. Mental Health by the Numbers. Available at https://www.nami.org/mhstats. Last accessed March 17, 2023.
65. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Preventing Suicide: A Technical Package of Policies, Programs, and Practices. Available at https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf. Last accessed March 17, 2023.
66. Centers for Disease Control and Prevention, Rural Health Policy Brief: Preventing Suicide in Rural America. Available at https://www.cdc.gov/ruralhealth/suicide/pdf/18_290906-A_Turner_Policy-Brief_Suicide-002_508.pdf. Last accessed March 17, 2023.
67. Steelesmith DL, Fontanella CA, Campo JV, Bridge JA, Warren KL, Root ED. Contextual factors associated with county-level suicide rates in the United States, 1999 to 2016. *JAMA Netw Open*. 2019;2(9):e1910936.
68. Healthy People 2030. Drug and Alcohol Use. Available at https://health.gov/healthypeople/objectives-and-data/browse-objectives/drug-and-alcohol-use. Last accessed March 17, 2023.
69. Rural Health Information Hub. Substance Abuse in Rural Areas. Available at https://www.ruralhealthinfo.org/topics/substance-abuse. Last accessed March 17, 2023.
70. Centers for Disease Control and Prevention. Rural America in Crisis: The Changing Opioid Overdose Epidemic. Available at https://blogs.cdc.gov/publichealthmatters/2017/11/opioids. Last accessed March 17, 2023.
71. U.S. Drug Enforcement Administration. 2020 National Drug Threat Assessment. https://www.dea.gov/sites/default/files/2021-02/DIR-008-21%202020%20National%20Drug%20Threat%20Assessment_WEB.pdf. Last accessed March 17, 2023.
72. Freese TE, Obert J, Dickow A, Cohen J, Lord RH. Methamphetamine abuse: issues for special populations. *J Psychoactive Drugs*. 2000;32(2):177-182.
73. Lutfiyya MN, McCullough JE, Haller IV, Waring SC, Bianco JA, Lipsky MS. Rurality as a root or fundamental social determinant of health. *Rural Medicine*. 2012;58(11):620-628.
74. Crumb L, Mingo TM, Crowe A. "Get over it and move on:" the impact of mental illness stigma in rural, low-income United States populations. *Mental Health & Prevention*. 2019;13:143-148.
75. Rost K, Smith GR, Taylor JL. Rural-urban differences in stigma and the use of care for depressive disorders. *Journal of Rural Health*. 1993;9(1):57-62.
76. Hastings SL, Cohn TJ. Challenges and opportunities associated with rural mental health. *Practice Journal of Rural Mental Health*. 2013;37(1):37-49.
77. U.S. Department of Agriculture, Economic Research Service. Access to Affordable and Nutritious Food: Measuring and Understanding Food Deserts and Their Consequences. Available at https://www.ers.usda.gov/webdocs/publications/42711/12716_ap036_1_.pdf. Last accessed March 17, 2023.
78. Miller WC, Rogalla D, Spencer D, Zia N, Griffith BN, Heinsberg HB. Community adaptations to an impending food desert in rural Appalachia, USA. *Rural Remote Health*. 2016;16(4):3901.
79. Ramirez AS, Diaz Rios LK, Valdez Z, Estrada E, Ruiz A. Bringing produce to the people: implementing a social marketing food access intervention in rural food deserts. *Journal of Nutrition Education and Behavior*. 2017;49(2):166-174.
80. Lloyd JL. From Farms to food deserts: food insecurity and older rural Americans. *Generations*. 2019;43(2):24-32.
81. Centers for Disease Control and Prevention. 2018 State Indicator Report on Fruits and Vegetables. Available at https://www.cdc.gov/nutrition/data-statistics/2018-state-indicator-report-fruits-vegetables.html. Last accessed March 17, 2023.
82. Robinson WD, Geske J, Backer E, et al. Rural experiences with mental illness: through the eyes of patients and their families. *Families, Systems & Health*. 2012;30(4):308-321.
83. Deen TL, Bridges AJ. Depression literacy: rates and relation to perceived need and mental health service utilization in a rural American sample. *Rural Remote Health*. 2011;11(4):1-13.
84. National Rural Health Association. Community Health Workers: Recommendations for Bridging Healthcare Gaps in Rural America. Available at https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/Community-Health-Workers_Feb-2017_NRHA-Policy-Paper.pdf. Last accessed March 17, 2023.

85. National Conference of State Legislatures. Closing the Gaps in the Rural Primary Care Workforce. Available at http://www.ncsl.org/research/health/closing-the-gaps-in-the-rural-primary-care-workfor.aspx. Last accessed March 17, 2023.
86. Rural Health Information Hub. Rural Healthcare Workforce. Available at https://www.ruralhealthinfo.org/topics/health-care-workforce. Last accessed March 17, 2023.
87. National Conference of State Legislatures. Improving Rural Health: State Policy Options. Available at http://www.ncsl.org/research/health/improving-rural-health-state-policy-options.aspx. Last accessed March 17, 2023.
88. National Conference of State Legislatures. Scoping Out Health Care Worker Shortages. Available at http://www.ncsl.org/blog/2017/06/01/scoping-out-health-care-worker-shortages.aspx. Last accessed March 17, 2023.
89. WWAMI Rural Health Research Center. The Rural Health Workforce: Challenges and Opportunities. Available at http://depts.washington.edu/uwrhrc/uploads/RHRC_PB146-1.pdf. Last accessed March 17, 2023.
90. Schmeida M. *Telehealth Innovation in the American States*. Kent, OH: Kent State University; 2005.
91. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Preventing Suicide: A Technical Package of Policies, Programs, and Practices. Available at https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf. Last accessed March 17, 2023.
92. Carson JA, Mattingly MJ. "We're all sitting at the same table:" challenges and strengths in service delivery in two rural New England counties. *Social Service Review*. 2018;92(3):401-431.
93. Council on Social Work Education. New Social Workers: Results of the Nationwide Survey of 2017 social work graduates. Available at https://ncwwi-dms.org/resourcemenu/resource-library/recruitment-and-selection/recruitment/1480-new-social-workers-the-results-of-the-nationwide-survey-of-2017-social-work-graduates/file. Last accessed March 17, 2023.
94. Phillips A, Quinn A, Heitkamp T. Who wants to do rural social work? Student perceptions of rural social work practice. *Contemporary Rural Social Work Journal*. 2010;2(1):7.
95. Ewing J, Hinkley KN. Meeting the Primary Care Needs of Rural America: Examining the Role of Non-Physician Providers. Available at http://www.ncsl.org/documents/health/RuralBrief313.pdf. Last accessed April 17, 2020.
96. Walters JE, Jones AE, Brown AR. Work experiences of rural social workers in the United States. *Journal of Social Service Research*. 2020;6:770-788.
97. Ford JA, Turley R, Porter T, Shakespeare T, Wong G, Jones AP, Steel N. Access to primary care for socio-economically disadvantaged older people in rural areas: a qualitative study. *PLoS One*. 2018;13(3):e0193952.
98. Cassity-Caywood W. Contemporary mental health care in rural areas: challenges and strategies. *Contemporary Rural Social Work Journal*. 2019;11(1):13.
99. Health Resources and Services Administration. Billing for Telehealth During COVID-19. Available at https://telehealth.hhs.gov/providers/billing-and-reimbursement. Last accessed March 17, 2023.
100. Simmons LA, Wu Q, Yang N, Bush HM, Crofford LJ. Sources of health information among rural women in Western Kentucky. *Public Health Nursing*. 2015;32(1):3-14.
101. Snell-Rood C, Carpenter-Song E. Depression in a depressed area: deservingness, mental illness, and treatment in the contemporary rural U.S. *Social Science & Medicine*. 2018;219:78-86.
102. U.S. Census Bureau. New Census Data Show Differences between Urban and Rural Populations. Available at https://www.census.gov/newsroom/press-releases/2016/cb16-210.html. Last accessed March 17, 2023.
103. Probst JC, Barker JC, Enders A, Gardiner P. Current state of child health in rural America: how context shapes children's health. *Journal of Rural Health*. 2018;34:S3-S12.
104. Jackson JA, Smit E, Branscum A, et al. The family home environment, food insecurity, and body mass index in rural children. *Health Education & Behavior*. 2017;44(4):648-657.
105. Centers for Disease Control and Prevention. Fast Facts: Preventing Adverse Childhood Experiences. Available at https://www.cdc.gov/violenceprevention/aces/fastfact.html. Last accessed March 17, 2023.
106. Crouch E, Radcliff E, Probst J, Bennett K, McKinney S. Rural-urban differences in adverse childhood experiences across a national sample of children. *Journal of Rural Health*. 2020;36(1):55-64.
107. U.S. Department of Health and Human Services. Fourth National Incidence Study of Child Abuse and Neglect (NIS-4): Report to Congress. Available at https://www.acf.hhs.gov/opre/report/fourth-national-incidence-study-child-abuse-and-neglect-nis-4-report-congress. Last accessed March 17, 2023.
108. Child Welfare Information Gateway. Rural Child Welfare Practice. Available at https://www.childwelfare.gov/pubPDFs/rural.pdf. Last accessed March 17, 2023.
109. Maguire-Jack K, Jespersen B, Korbin JE, Spilsbury JC. Rural child maltreatment: a scoping literature review. *Trauma, Violence & Abuse*. 2021;22(5):1316-1325.
110. Griffiths A, Murphy AL, Harper W. Child sexual abuse and the impact of rurality on foster care outcomes: an exploratory analysis. *Child Welfare*. 2016;95(1):57-76.

111. Rhoad-Drogalis A, Justice LM. Absenteeism in Appalachian preschool classrooms and children's academic achievement. *Journal of Applied Developmental Psychology*. 2018;58:1-8.

112. Hamilton BE, Rossen LM, Branum AM. *Teen Birth Rates for Urban and Rural Areas in the United States, 2007–2015*. Atlanta, GA: Centers for Disease Control and Prevention; 2016.

113. Sutton A, Lichter DT, Sassler S. Rural-urban disparities in pregnancy intentions, births, and abortions among us adolescent and young women, 1995–2017. *American Journal of Public Health*. 2019;109(12):1762-1769.

114. Harris DE, Aboueissa A-M, Baugh N. Impact of rurality on maternal and infant health indicators and outcomes in Maine. *Rural Remote Health*. 2015;15(3):3278.

115. Kozhimannil KB, Interrante JD, Henning-Smith C, Admon LK. Rural-urban differences in severe maternal morbidity and mortality in the US, 2007–15. Health Affairs. 2019;38(12):2077-2085.

116. Ely DM, Driscoll AK, Matthews TJ. Infant mortality rates in rural and urban areas in the United States, 2014. *NCHS Data Brief*. 2017;285:1-7.

117. Hung P, Kozhimannil KB, Casey MM, Moscovice IS. Why are obstetric units in rural hospitals closing their doors? *Health Services Research*. 2016;51(4):1546-1560.

118. Kozhimannil KB, Hung P, Henning-Smith C, Casey MM, Prasad S. Association between loss of hospital-based obstetric services and birth outcomes in rural counties in the United States. *JAMA*. 2018;319(12):1239-1247.

119. Meyer E, Hennink M, Rochat R, et al. Working towards safe motherhood: delays and barriers to prenatal care for women in rural and peri-urban areas of Georgia. *Maternal and Child Health Journal*. 2016;20(7):1358-1365.

120. Kitsantas P, Gaffney KF, Cheema J. Life stressors and barriers to timely prenatal care for women with high-risk pregnancies residing in rural and nonrural areas. *Women's Health Issues*. 2012;22(5):e455-e460.

121. Dudgeon A, Evanson TA. Intimate partner violence in rural U.S. areas: what every nurse should know. *American Journal of Nursing*. 2014;114(5):26-35.

122. Breiding MJ, Ziembroski JS, Black MC. Prevalence of rural intimate partner violence in 16 U.S. states, 2005. *J Rural Health*. 2009;25(3):240-246.

123. Edwards KM. Intimate partner violence and the rural-urban-suburban divide: myth or reality? A critical review of the literature. *Trauma Violence Abuse*. 2015;16(3):359-373.

124. AbiNader MA. Correlates of intimate partner homicide in the rural United States: findings from a national sample of rural counties, 2009–2016. *Homicide Studies: An Interdisciplinary & International Journal*. 2020;24(4):353-376.

125. Edwards KM, Mattingly MJ, Dixon KJ, Banyard VL. Community matters: intimate partner violence among rural young adults. *Am J Community Psychol*. 2014;53(1-2):198-207.

126. Peek-Asa C, Wallis A, Harland K, Beyer K, Dickey P, Saftlas A. Rural disparity in domestic violence prevalence and access to resources. *J Womens Health (Larchmt)*. 2011;20(11):1743-1749.

127. U.S. Department of Agriculture, Economic Research Service. Rural America At-A-Glance: 2022 Edition. Available at https://www.ers.usda.gov/webdocs/publications/105155/eib-246.pdf. Last accessed March 17, 2023.

128. Smith AS, Trevelyan E. In Some States, More than Half of Older Residents Live in Rural Areas. Available at https://www.census.gov/library/stories/2019/10/older-population-in-rural-america.html. Last accessed March 17, 2023.

129. Knight CK, Probst JC, Liese AD, Sercy E, Jones SJ. Household food insecurity and medication "scrimping" among U.S. adults with diabetes. *Preventive Medicine*. 2016;83:41-45.

130. Homenko DR, Morin PC, Eimicke JP, Teresi JA, Weinstock RS. Food insecurity and food choices in rural older adults with diabetes receiving nutrition education via telemedicine. *Journal of Nutrition Education & Behavior*. 2010;42(6):404-409.

131. Grantsmakers in Aging. Mobility and Aging in Rural America: The Role for Innovation: An Introduction for Funders. Available at https://www.giaging.org/initiatives/rural-aging/rural-mobility-publications. Last accessed March 17, 2023.

132. Wood J, Brown JR, Bond M, Suguri V. Older adult transportation in rural communities: results of an agency survey. *Journal of Public Transportation*. 2016;19(2):154-167.

133. Somes J, Donatelli NS. Giving up the keys: the older adult driving in a rural setting. *Journal of Emergency Nursing*. 2017;43(1):74.

134. Weirich M, Benson W. Rural America: Secure in a local safety net? Generations. 2019;43(2):40-45.

135. Wallace R, Hughes-Cromwick P, Mull H, Khasnabis S. Access to health care and nonemergency medical transportation: two missing links. *Journal of the Transportation Research Board*. 2005;1924:76-84.

136. Movement Advancement Project. Where We Call Home: LGBT People in Rural America. Available at https://www.lgbtmap.org/file/lgbt-rural-report.pdf. Last accessed March 17, 2023.

137. Dahl AL, Scott RK, Peace Z. Trials and triumph: lesbian and gay young adults raised in a rural context. *Social Sciences*. 2015;4(4):925-939.

138. Anderson RK, Kindle PA, Dwyer A, Nowak JA, Callaghan TA, Arkfeld R. Rural perspectives on same-sex marriage. *Journal of Gay & Lesbian Social Services*. 2015;27(2):201-215.

139. Sharma A, Shaver JC, Stephenson RB. Rural primary care providers' attitudes towards sexual and gender minorities in a midwestern state in the USA. *Rural Remote Health*. 2019;19(4):5476.

140. Lee MG, Guam JK. Comparing supports for LGBT aging in rural versus urban areas. *Journal of Gerontological Social Work*. 2013;56(2):112-126.

141. Kaplan SC, Butler RM, Devlin EA, et al. Rural living environment predicts social anxiety in transgender and gender nonconforming individuals across Canada and the United States. *Journal of Anxiety Disorders*. 2019;66:102116.

142. Holder KA. Veterans in Rural America: 2011–2015. Available at https://www.census.gov/content/dam/Census/library/publications/2017/acs/acs-36.pdf. Last accessed March 17, 2023.

143. Baker A, Mott JM, Mondragon S, Hundt NE, Grady RH, Teng EJ. Utilization of evidence-based psychotherapy for posttraumatic stress disorder by rural and urban veterans. *Journal of Rural Mental Health*. 2015;39(2):81-89.

144. Office of Rural Health. Rural Veterans. Available at https://www.ruralhealth.va.gov/aboutus/ruralvets.asp. Last accessed March 17, 2023.

145. Bumgarner DJ, Polinsky EJ, Herman KG, et al. Mental health care for rural veterans: a systematic literature review, descriptive analysis, and future directions. *Journal of Rural Mental Health*. 2017;41(3):222-233.

146. Coughlin LN, Wilson SM, Erwin MC, Beckham JC, Calhoun PS. Cigarette smoking rates among veterans: association with rurality and psychiatric disorders. Addictive Behaviors. 2019;90:119-123.

147. U.S. Interagency Council on Homelessness. Homelessness in America: Focus on Veterans. Available at https://www.usich.gov/resources/uploads/asset_library/Homelessness_in_America._Focus_on_Veterans.pdf. Last accessed March 17, 2023.

148. Nelson RE, Gundlapalli A, Carter M, et al. Rurality or distance to care and the risk of homelessness among Afghanistan and Iraq veterans. *Housing, Care and Support*. 2017;20(2):45-59.

149. Tsai J, Ramaswamy S, Bhatia SC, Rosenheck RA. A comparison of homeless male veterans in metropolitan and micropolitan areas in Nebraska: a methodological caveat. *American Journal of Community Psychology*. 2015;56(3-4):357-367.

150. Green BN, Johnson CD. Interprofessional collaboration in research, education, and clinical practice: working together for a better future. *The Journal of Chiropractic Education*. 2015;29(1):1-10.

151. Fertman CI, Dotson S, Mazzocco GO, Reitz SM. Challenges of preparing allied health professionals for interdisciplinary practice in rural areas. *Journal of Allied Health*. 2005;34(3):163-168.

152. Goodwin S, MacNaughton-Doucet L, Allan J. Call to action: interprofessional mental health collaborative practice in rural and northern Canada. *Canadian Psychology*. 2016;57(3):181-187.

153. Bridges DR, Davidson RA, Odegard PS, Maki IV, Tomkowiak J. Interprofessional collaboration: three best practice models of interprofessional education. *Medical Education Online*. 2011;16.

154. Gilles I, Filliettaz SS, Berchtold P, Peytremann-Bridevaux I. Financial barriers decrease benefits of interprofessional collaboration within integrated care programs: results of a nationwide survey. *International Journal of Integrated Care*. 2020;20(1):10.

155. Hale GM, Joseph T, Maravent S, et al. Effect of interprofessional collaboration on quality of life in elderly patients with cardiovascular disease. *Journal of Interprofessional Education & Practice*. 2018;12:25-28.

156. Weinberg DB, Miner DC, Rivlin L. "It depends:" medical residents' perspectives on working with nurses. *American Journal of Nursing*. 2009;109:34-43.

157. Keba Kebe NNMK, Chiocchio F, Bamvita J-M, Fleury M-J. Variables associated with interprofessional collaboration: a comparison between primary healthcare and specialized mental health teams. *BMC Family Practice*. 2020;21(1):1-11.

158. Martin JS, Ummenhofer W, Manser T, Spirig R. Interprofessional collaboration among nurses and physicians: making a difference in patient outcome. *Swiss Medical Weekly*. 2010;140:33-39.

159. Garth M, Millet A, Shearer E, et al. Interprofessional collaboration: a qualitative study of non-physician perspectives on resident competency. *Journal of General Internal Medicine*. 2017;33:10.

160. Heath O, Church E, Curran V, et al. Interprofessional mental health training in rural primary care: findings from a mixed methods study. *Journal of Interprofessional Care*. 2015;29(3):195-201.

161. Reising DL, Carr DE, Gindling S, Barnes R, Garletts D, Ozdogan Z. An analysis of interprofessional communication and teamwork skill acquisition in simulation. *Journal of Interprofessional Education & Practice*. 2017;8:80-85.

162. Zabar S, Adams J, Kurland S, et al. Charting a key competency domain: understanding resident physician interprofessional collaboration (IPC) skills. *Journal of General Internal Medicine*. 2016;31(8):846-853.

163. Nelson W, Pomerantz A, Howard K, Bushy A. A proposed rural healthcare ethics agenda. *Journal of Medical Ethics*. 2017;33(3):136-139.

164. Nelson W, Greene MA, West A. Rural healthcare ethics: no longer the forgotten quarter. *Camb Q Healthc Ethics*. 2010;19(4):510-517.

165. Pugh R. Dual relationships: Personal and professional boundaries in rural social work. *British Journal of Social Work*. 2007;37:1405-1423.

166. Blue ET, Kutzler AM, Marcon-Fuller S. Ethical guidelines for social work supervisors in rural settings. *Contemporary Rural Social Work*. 2014;6:1-15.

167. Brownlee K, Halverson G, Chassie A. Multiple relationships: maintaining professional identity in rural social work practice. *Journal of Comparative Social Work*. 2015;7(1):81-91.

168. Warren J, Ahls C, Asfaw AH, Núñez JC, Weatherford J, Zakaria NS. Ethics issues and training needs of mental health practitioners in a rural setting. *Journal of Social Work Values & Ethics*. 2014;11(2):61-75.

169. Piché T, Brownlee K, Halverson G. The development of dual and multiple relationships for social workers in rural communities. *Contemporary Rural Social Work Journal*. 2015;7(2):5.

170. Galambos C. Resolving ethical conflicts in a managed health care environment. *Health and Social Work*. 1999;24(3):191-197.

171. American Counseling Association. 2014 ACA Code of Ethics. Available at https://www.counseling.org/resources/aca-code-of-ethics.pdf. Last accessed March 17, 2023.

172. Shih TL, Goldman JJ. Recognizing and Resolving Ethical Dilemmas in Rural Medicine. Available at https://journalofethics.ama-assn.org/article/recognizing-and-resolving-ethical-dilemmas-rural-medicine/2011-05. Last accessed March 17, 2023.