

APA RESOLUTION on Prioritizing the Behavioral Health Needs of Rural Communities

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Consistent with the American Psychological Association (APA)'s mission to advance, communicate, and apply psychological science and knowledge to benefit society and improve lives, this Resolution reaffirms APA's commitment to justice, human rights, fairness, and dignity for all, especially for underserved rural communities across the United States (US). These communities are diverse, experience distinct behavioral and physical health needs compared with urban populations, and face unique barriers to timely, effective, and culturally responsive care.

WHEREAS rural communities are not a monolith, with differing behavioral health needs among farming, ranching, fishing, mining, drilling, forestry, mountain, frontier, Pueblos, Tribes, Nations, Appalachian, Delta, desert, industrial, and tourism-based populations (Slama, 2004);

WHEREAS rural populations are becoming increasingly diverse in age, race, ethnicity, and culture, driven in part by disproportionate immigration growth, rapid population aging, youth outmigration, and high rates of grandparent caregiving, particularly in rural and minoritized communities (Johnson, 2022; Anderson et al., 2024). These intersecting dimensions of diversity are frequently segmented rather than integrated in policy and practice considerations (Cohen & Greaney, 2023; Monnat, 2025);

WHEREAS care that recognizes the diverse experiences and cultural perspectives of rural residents is essential, including perspectives related to race, ethnicity, age, sex gender identity, sexual orientation, disability status, socioeconomic background, and cultural traditions (Mendoza et al., 2020). Psychologists recognize that human behavior varies based on cultural norms and influences and are called to consider traditional wisdom derived through those cultures with knowledge derived from psychological research (APA, 2025);

WHEREAS cultural norms emphasizing stoicism and self-reliance may discourage help-seeking (Keller & Owens, 2021), though behavioral health stigma is often overestimated by providers relative to patients' own reports and integrated behavioral health care models can reduce stigma by normalizing services within routine medical settings (Allen et al., 2020);

WHEREAS rural people face structural barriers to safety and behavioral health care, including geographic isolation, limited service availability, transportation constraints, workforce shortages, delayed emergency response, emergency room closures and heightened privacy concerns in small communities, which together hinder timely and effective care (Human Resources and Services Administration [HRSA], 2022; Miller et al., 2020; Palomin et al., 2023);

WHEREAS approximately 15.3% of rural residents live below the poverty line, including 20.9% of children under age five (Farrigan et al., 2024), and economic hardship contributes to housing and food insecurity, barriers to employment and education, and increased reliance on public assistance programs (DeWitt et al., 2020; Mammen & Sano, 2018; Rabbitt et al., 2024; Rural Health Information Hub [RHIH], 2025a; Sano & Mammen, 2022; Theis et al., 2022);

WHEREAS rural communities are disproportionately affected by substance use disorders (RHIH, 2025b), with risks intensified by economic disadvantage (Palomin et al., 2023), long distances to treatment, limited recognition of substance use as a behavioral health condition, and a shortage of prevention programs (Raver et al., 2024);

WHEREAS rural communities experience elevated exposure to trauma, including natural disasters, occupational hazards, geographic and social isolation, economic downturns tied to single industries, child maltreatment, elder abuse, domestic violence/intimate partner violence (DV/IPV), and limited access to emergency and behavioral health services (HRSA, 2022; National Institute for Occupational Safety and Health, 2024; Palomin et al., 2023; SAMHSA Disaster Technical Assistance Center, 2020; Samp & Diamond, 2025). These exposures are compounded by intergenerational adversity, systemic inequities, overburdened child and adult protective services, limited prevention resources, increased suicide risk, and persistent behavioral health stigma, resulting in cumulative impacts distinct from those in urban and suburban contexts (Henninger et al., 2025; Lahr et al., 2024; Polaha, 2015; Western Interstate Commission for Higher Education, 2024);

WHEREAS disparities in maternal mental health are disproportionately affect rural communities, where pregnant and postpartum individuals face elevated risk for depression,

anxiety, trauma-related conditions, and substance use disorders, compounded by limited access to prenatal, perinatal, and postpartum care, workforce shortages, hospital and obstetric unit closures, long travel distances, and fragmented systems of care (Stoneburner et al., 2025; Policy Center for Maternal Mental Health, 2025);

WHEREAS suicide rates for rural groups are increasing at a greater rate than in urban areas since 2000, especially among Indigenous and white males (Petrone & Curtin, 2020) and farmers (Narrod et al., 2023). Contributors to these disparities include access to firearms, substance use, economic stress, and reduced access to behavioral health care (Mohatt et al., 2021);

WHEREAS nursing home residents in non-urban communities are more likely to have diagnoses of dementia, depression, and other psychiatric conditions and have significant behavioral health needs (RUPRI Center for Rural Health Policy Analysis, 2022). Rural communities face shortages of direct care workers, higher mortality rates among persons living with dementia, and persistent rural-urban disparities in dementia care quality (Arsenault-Lapierre et al., 2023; Dill et al., 2023; Santoyo-Olsson et al., 2025);

WHEREAS access to telehealth and remote behavioral health services in rural communities is constrained by limited availability and higher costs of high-speed internet, restricting equitable delivery of care (Andrilla et al., 2018; Connolly et al., 2022; Li et al., 2020; Watanabe et al., 2023);

WHEREAS rural residents are often required to leave their communities for inpatient or residential behavioral health treatment, resulting in separation from family, cultural supports, and community-based sources of belonging and healing, which discourages engagement in needed care (Goss et al., 2017; Johnson & Cameron, 2001). These harms disproportionately affect the American Indian/Alaskan Native population (Cromer et al., 2019), older adults (Sharma et al., 2024), and incarcerated and formerly incarcerated individuals (Zajac et al., 2014);

WHEREAS rural communities face a persistent “rural brain drain,” in which individuals do not return to or remain in their communities of origin, undermining workforce development, continuity of care, and the preservation of cultural and community resources (Artz, 2003; Estes et al., 2016; Henning-Smith et al., 2024);

WHEREAS behavioral health providers in rural communities face distinct ethical challenges, including reduced privacy, frequent dual relationships, overlapping personal and professional roles, caregiving responsibilities across the lifespan, and increased visibility of help-seeking, which can complicate ethical practice and provider well-being (Palomin et al., 2023);

WHEREAS increasing physical and psychological access to behavioral health care that is responsive to the unique needs of rural communities (e.g., threats to land and occupation) improves overall well-being (Mengell et al., 2025; Morales, 2020);

WHEREAS workforce shortages in rural communities cannot be resolved through recruitment pipelines alone due to structural and economic constraints in health care delivery, and evidence supports fully integrated behavioral health care models, characterized by shared workflows, unified clinical identity, warm handoffs, and team-based care within a single system, as more effective than co-located or coordinated care for expanding access and improving outcomes in rural settings (HRSA, 2022; Allen et al., 2020). Concurrently, approximately 65% of rural areas face primary care shortages, and ongoing rural hospital closures further limit access, underscoring the critical role of school-based behavioral health programs (Henry, 2024; Caldwell, 2025; Sanchez et al., 2018);

BE IT RESOLVED APA reaffirms its commitment to prioritizing the behavioral health needs of rural America.

BE IT RESOLVED APA supports policies and adequate funding for federal, state, and local programs that increase access to evidence-based behavioral health services in rural communities, with explicit prioritization of school-based and fully integrated behavioral health care models in both primary care and specialty care that promote inclusive access through a single point of entry, improve care coordination, enhance referral follow-through, and reduce logistical barriers such as transportation and system navigation.

BE IT RESOLVED APA supports health equity for underserved and vulnerable populations in rural America through community-based, evidence-informed training for behavioral health providers and allied professionals emphasizing rural cultural competence, integrated behavioral health care, prevention and early intervention, trauma- and identity-affirming practices, maltreatment and abuse reporting strategies specific to rural populations, mobile crisis units, and strategies to address structural barriers to access.

BE IT RESOLVED APA supports inclusive policy development and education regarding diverse cultural beliefs within rural communities across the lifespan. This includes explicit attention to the unique needs of spiritually, racially, and ethnically diverse rural populations, including Pueblos, Tribes, and Nations.

BE IT RESOLVED APA supports strategies to improve access to prevention, treatment, and recovery for substance use and other mental health disorders in rural communities, including community-based interventions, expanded telehealth, expanded high speed internet access, and increased access to peer-support networks.

BE IT RESOLVED APA advocates for expanding services to increase safe housing, food access, support for youth involved in juvenile justice and child protective systems, DV/IPV and sexual violence resources, elder abuse prevention and response, maternal mental health services, suicide prevention, and stronger partnerships between law enforcement and DV/IPV, sexual violence, and child/elder abuse advocacy agencies.

BE IT RESOLVED APA advocates for policies that reduce the need for rural residents to leave their communities for treatment by expanding local inpatient, residential, integrated behavioral health, independent practice, and culturally grounded services, ensuring family and community supports remain accessible during care, and providing consultation and support to family caregivers and long-term care facilities to deliver trauma-informed care and effectively address behavioral health needs.

BE IT RESOLVED APA supports initiatives to reduce stigma and cultural barriers to help-seeking in rural communities by promoting community education, peer-led programs, and partnerships with trusted local leaders, such as other health care providers, extension professionals, religious leaders, and traditional or community healers.

BE IT RESOLVED APA advocates for the integration of behavioral health education and resources within rural K-12 schools, community centers, senior centers, and long-term care facilities to increase knowledge, reduce stigma, and build early awareness of community support across the lifespan.

BE IT RESOLVED APA supports efforts to strengthen and sustain the rural behavioral health workforce by recognizing the essential role of graduate students and early career professionals, incentivizing rural practice following training, and advancing policies that support viable rural practice through competitive reimbursement, scholarship and loan forgiveness programs, and partnerships with rural training sites across the educational continuum.

BE IT RESOLVED APA supports national and local strategies to retain talent and reduce rural brain drain, including investment in training pathways, mentorship opportunities, and community development efforts that encourage long-term workforce and population stability.

BE IT RESOLVED APA supports expanding training opportunities that prepare psychologists to practice effectively in integrative care models in rural communities, including appropriate consideration of prescriptive authority, and the development of rural-specific training and supervision guidance addressing ethics, role clarity, documentation, consultation boundaries, and professional identity within team-based medical settings.

BE IT RESOLVED APA supports the development and sustainability of rural-focused training pathways, including programs housed in smaller colleges and universities, to cultivate “homegrown” providers, reduce barriers to advanced education, and expand opportunities for academic psychologists in rural regions.

BE IT RESOLVED APA aims to expand access to education on rural health needs through continuing education offerings, dissemination of rural-specific resources, and support for research that identifies disparities and solutions for both behavioral health providers and referral sources (e.g., primary care providers, obstetric and maternal health providers, school psychologists, social workers, community health workers, and public health departments).

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