



AMERICAN
PSYCHOLOGICAL
ASSOCIATION

Rural Mental Health Toolkit

APA COMMITTEE ON RURAL HEALTH



TABLE OF CONTENTS

Section 1: Understanding Rural Contexts	2
Section 2: Clinical Care and Competency in Rural Settings	6
Section 3: Rural Workforce and Training Pipelines	11
Section 4: Policy, Advocacy, and Systems-Level Change	15
Section 5: Building Community Partnerships in Rural Behavioral Health	19
Section 6: Training & Resources	24

SECTION 1:

Understanding Rural Contexts

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This section establishes a foundational understanding of rural mental health contexts, emphasizing the diversity of rural communities and the importance of culturally responsive, equity-informed care. Content will address both structural challenges and community strengths, positioning rural communities as complex and resilient rather than monolithic or deficient.

**INTRODUCTION TO TERMINOLOGY
AND RURAL SUB-POPULATIONS**

Key terms that define rural location continue to evolve. Rural community researchers are increasingly identifying rural sub-populations, including:

- People in distinct geographic regions, such as the Midwest, South, and West
- Ecologies and industries, such as coastal, plains, and forested communities
- Cultural clusters, such as Tribal lands, Appalachia, and the Black Belt
- Racial and ethnic sub-populations, such as Indigenous, Black, and Hispanic
- Older rural adults, including adults aged 65 and older
- Rural-residing LGBTQ+ individuals

These categories continue to develop and vary across initiatives, strategies, research interests, and government agencies. For example, the U.S. Census refers to some areas as rural, while the USDA describes similar areas as non-metropolitan. The Center on Rural Innovation provides a sample of maps using varied definitions of rurality used by the federal government. Providers using a rural-centered model generally adopt the terms used by the communities they serve. For additional context on rural America, see *The Current Landscape of Rural, Remote, and Frontier Mental Health*.

This variety highlights the importance of community-based approaches that recognize existing wisdom, ancestral knowledge, healing practices, and resilience strategies in rural sub-populations. For example, the CDC maintains a resource disseminating Tribal Practices for Wellness in Indian Country (TPWIC) that medical and mental health providers may consult when working with members of American Indian and Alaska Native (AI/AN) communities. Advocates continue to push for community-centered education, practice, research, and advocacy that uses a strengths-based approach, elevating community healing practices rather than replacing them with dominant or urban-centric models.

CULTURAL HUMILITY

Cultural humility is essential in rural and Indigenous behavioral health practice. Clinicians must recognize historical oppression and power dynamics, approach communities with curiosity, and prioritize others’ ways of being—not only ways of doing care—within the community’s cultural and environmental context.

Ways of Being	Ways of Doing Care
• Identities • Experiences • Cultures	• Checking off competencies • Fitting rural clients to urban models • Making cultural assumptions

Cultural humility requires self-reflection, openness, and respect for each patient’s cultural identities and lived experiences (Zhang et al., 2022). In rural practice, this means understanding cultural differences, recognizing broader systemic influences, and remaining attentive to the individual person in front of you in order to build community, support, and safety.

Learn Community Characteristics
Understand how rural heritage, family dynamics, religion, stoicism, self-reliance, and local history may shape clinical presentation
Become a Community Member
Build trust, reduce perceptions of being an outsider, and reflect on your own cultural biases, values, and privileges
Work Within Systems
Use systems-based approaches to help patients understand how communities, schools, policies, churches, and other systems contribute to distress

Providers who are culturally humble understand that cultural competence is not something that a provider can achieve, but rather a life-long journey. Culturally humble providers:

- Build power-balanced relationships (e.g., approach treatment collaboratively, soliciting a rural client’s feedback as treatment plans and interventions evolve)
- Engage in self-exploration (e.g., seek formal CE [continuing education] opportunities and self-directed learning pertinent to recognizing and addressing preexisting attitudes and assumptions about rural populations)
- View clients as experts of their own experiences (e.g., incorporate a rural client’s culturally-informed conceptualization of the causes and maintaining factors of their depression into the treatment plan)

The Behavioral Health Aide (BHA) program is a great model for cultural humility-based educational and practice designs. It builds on the strengths of Indigenous knowledge and centers the experiences and healing practices of Indigenous communities. BHA programs honor the narratives and experiences of clients and incorporate communal traditions into the healing process. They see health as a holistic, life-long, communal practice.

UNIQUE SOCIAL DRIVERS OF HEALTH IN RURAL AREAS

Rural health is shaped by social, economic, ecological, and political forces that often place disproportionate strain on rural communities. These drivers affect access to care, environmental safety, food security, communication, behavioral health, and the ability of rural residents to remain in long-standing communities. Primary drivers include:

- **Industrial Demands** that often support urban areas have a disproportionate negative health impact on rural communities, including mining, oil, and gas exploration; deforestation; mineral extraction; and other resource removal processes. Each may expose rural communities to contaminants, carcinogens, and other epidemiological risks. When industries move out of rural communities, they can lead to widespread poverty, resource shortages, and further exacerbate health impacts. Recently, plans to construct large, resource-demanding data centers supporting artificial intelligence infrastructure in rural areas have caused alarm among residents of numerous rural communities.
- **Medical and Nutritional Deserts**, or areas in which access to health care and healthy foods (e.g., fruits, vegetables, proteins, non-processed foods) are limited, are common in rural areas. Some low-cost food chains may enter those areas, causing local grocery stores and businesses to close, further limiting options for the population to access basic needs locally. When businesses move in and become the only provider of goods to a rural area, any changes in the goods they provide impact the communities around them.
- **Laws and Regulations Favoring Urban Recreation** can push rural people out of long-standing communities by reducing resources, reshaping generational farmland, and increasing pressure from overhunting, fishing, housing and business developments, resorts, corporate farming and ranching, and other ecologically taxing activities.
- **Technology and Communication Barriers**, including limited broadband, geographic isolation, shrinking public broadcasting, and media consolidation can

make it harder to reach rural communities with essential health knowledge and interventions. These barriers may increase reliance on unvetted sources, social media, and online echo chambers that spread harmful health misinformation.

- **Major Ecological Events**, such as droughts, storms, food shortages, and wildfires, heavily impact rural communities and lead to elevations in psychological distress and behavioral health concerns such as suicide risk and substance use.
- **Shifting Rural Age Demographics**, shaped significantly by youth-out migration over the past three

decades, continue to produce communities overrepresented by older adults, with ramifications for rural health care and other workforces.

UNIQUE RESILIENCE AND RESISTANCE STRATEGIES

Rural, remote, Indigenous, and frontier communities have long cultivated resilience through connection, culture, land-based relationships, and collective action. These strategies not only buffer the effects of social and structural inequities, but also reflect powerful forms of resistance, healing, and community survival.

Resilience and Resistance in Action		
	Definition	Practice Example
Community Connections	Buffer the effects of social drivers of health by fostering belonging, resilience, and shared support. In rural communities, multigenerational family and community ties help transmit knowledge, wisdom, and healing practices, while gatherings such as school sports, spiritual events, cultural festivals, and crisis-response efforts strengthen collective care.	Rural Kansas families and community members gather on autumn Friday nights to watch high school football games, creating shared identity and belonging across generations.
Grassroots Movements	Led by community members, grassroots movements build awareness and drive systems-wide change.	Rural and Indigenous groups raising awareness about Missing and Murdered Indigenous Relatives and organizing against pipelines, data centers, and other projects that threaten land, sovereignty, and community wellbeing.
Land & Ecology	Support health and wellbeing through access to green spaces, fresh air, sunlight, water, and other natural elements linked to healing. Rural, remote, Indigenous, and frontier communities are often surrounded by ecological resources that sustain connection, restoration, and cultural meaning.	Mennonite communities near the Finger Lakes of Upstate New York drawing restoration, connection, and meaning from time spent in nature.
Traditional and Cultural Practices	Sustain healing, connection, and shared identity across generations. Practices such as communal barn-building, community-wide harvesting, preparations for ceremonies and celebrations, potlucks, potlatches, and after-church luncheons reflect collective care, cultural continuity, and shared values.	After-church luncheons in rural Black communities in the American South, where food, faith, fellowship, and shared care strengthen community ties.

UNIQUE CARE PRACTICES AND DEMANDS IN RURAL SPACES

Rural behavioral health practice requires flexibility, visibility, and sensitivity to local norms, relationships, and barriers to care. The Rural Health Landscape Survey: A Behavioral Health Needs Assessment offers a snapshot of pressing concerns, access issues, and advantages associated with rural behavioral health practice, including:

- **Multiple Relationships:** Because rural communities are small and highly connected, providers and clients may also serve as coaches, city council members, church figures, or other community leaders. Clinicians must be especially mindful of boundaries, confidentiality, and overlapping relationships.
- **Provider Reputation:** A clinician's reputation can strongly shape their ability to provide services and access local communities. Rural providers are highly visible and may be evaluated based on their social behavior, trustworthiness, and willingness to challenge harmful community norms.
- **Behavioral Health Stigma:** Stigma can reduce help-seeking, especially when residents distrust outside providers. Religiosity, stoicism, and self-reliance may lead some community members to view mental health concerns as spiritual shortcomings or minimize the value of care.

AREAS FOR FURTHER DEVELOPMENT

Beyond this section of the *Rural Mental Health Toolkit*, factors that can help clinicians better understand and promote rural behavioral health include:

- Community-based education and certification programs, such as BHA programs
- Research on feasible, acceptable, and effective community-based interventions
- Strategies that prioritize existing whole-person healing practices and wellness traditions
- Workforce expansion and community-empowerment initiatives for rural communities
- Systems-change efforts that recognize healers, wisdom holders, and community leaders

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SECTION 2:

Clinical Care and Competency in Rural Settings

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Treating patients in rural locations involves numerous facets to consider, including cultural considerations, socioeconomic status, health literacy challenges, characteristics of the community, and stigma. Rural communities are always evolving and we encourage you to explore our resources, but to utilize the tools that work best in your specific setting.

RECOMMENDED STRATEGIES FOR WORK WITH PATIENTS

Recommended strategies include patient-centered care, cultural humility, collaboration, and ongoing professional development in rural practice.

- Ask what wellness means to patients
- Help patients understand systems
- Help patients change systems
- Build a safe, warm environment
- Use empathy and nonjudgment
- Use cultural symptom framing
- Identify cultural differences
- Reduce assumptions
- Have challenging conversations
- Approach language barriers together
- Use authenticity to build trust
- Provide support & empower patients
- Recognize patients as experts
- Maintain ethics competencies
- Stay informed of local events
- Stay informed of national events
- Be flexible
- Collaborate with rural patients
- Engage in advocacy
- Consult colleagues when needed
- Work across disciplines
- Attend community-based CEs
- Refrain from imposing expertise
- Emphasize your relationship

CLINICAL AREAS OF COMPETENCE

Clinical competence in rural settings requires breadth, flexibility, and cultural humility, as providers are often called to respond to diverse needs across populations, systems, and levels of care, including:

Children/Adolescents: Rural children and adolescents are vulnerable to substance use, pregnancy, mental health concerns, behavioral, and learning-related difficulties (Miller et al., 2018). Despite high need, clinicians often carry large geographic caseloads, and communication may be limited primarily to parents (Huscroft-D'Angelo et al., 2018).

Older Adults: Rural communities are rapidly aging, with older adults facing chronic pain, caregiving responsibilities, and dementia-related needs (Alzheimer's Association, 2022).

Indigenous/Tribal Communities: Rural Indigenous communities experience substantial barriers to health care access, financial stability, safety, housing, and discrimination across federal, state, and tribal systems (Findling et al., 2022). AI/AN residents also experience higher rural mortality rates shaped by historical trauma, racism, displacement, family separation, and forced assimilation (Henning-Smith et al., 2019).

Immigrants: Immigrant populations have increased in rural U.S. communities (Sano & Mammen, 2022). Rural immigrants may face heightened barriers to culturally and linguistically responsive behavioral health care, including limited interpreters, bilingual providers, and clinicians familiar with migration-related stressors (Castañeda et al., 2015).

Maternal Mental Health: Pregnant and postpartum individuals in rural communities face elevated risks for depression, anxiety, trauma-related concerns, and substance use disorders. Access to prenatal, perinatal, and postpartum care is often constrained by obstetric clinic closures and long travel distances (Stoneburner et al., 2026).

Suicide: Rural suicide rates have increased since 2000, with elevated risk among Indigenous communities, white males, and farmers (Petrone & Curtin, 2020). Contributing factors include firearm access, substance use, economic stress, and limited behavioral health care access (Mohatt et al., 2021).

Substance Use Disorders: Substance use concerns are prominent in rural communities, particularly in areas facing economic hardship (Rural Health Information Hub, 2025). Stigma may lead substance use disorders to be under-recognized as behavioral health conditions, reducing treatment opportunities (Raver et al., 2024).

Trauma: Trauma is widespread in rural areas and shaped by local histories and conditions. Exposures may include natural disasters, occupational hazards, isolation, child maltreatment, elder abuse, and domestic violence/intimate partner violence (SAMHSA Disaster Technical Assistance Center, 2020; Samp & Diamond, 2025).

Race/Ethnicity: Approximately 20% of rural America is racially and ethnically diverse, a proportion that is growing (Romero, 2020). This demographic experiences intersecting oppression and discrimination that negatively affect mental health (Crumb et al., 2021).

Veterans: Approximately one-quarter of U.S. veterans live rurally (U.S. Department of Veterans Affairs, 2025). Rural veterans experience elevated risk for mental health and suicide, with younger veterans at particularly high risk (Schuler et al., 2025).

Severe Mental Illness: Although rural-specific prevalence data are limited, approximately 1 in 20 U.S. adults live with a serious mental illness, such as schizophrenia or bipolar disorder (SAMHSA, 2023). In rural settings, workforce shortages, delayed emergency response, emergency department closures, and limited residential treatment options can impede timely care (Palomin et al., 2023).

Please see Section 6: Training & Resources for additional information regarding treatment, training, and professional development.

ETHICAL CONSIDERATIONS

When providing clinical care in rural regions, clinicians should follow their ethical codes while also considering community ethics, beneficence, and nonmaleficence when navigating complex dilemmas.

Common Challenges	Description	How to Navigate Ethically
Multiple relationships	As one of few available clinicians, you may encounter patients in public settings	Discuss community interactions and boundaries early
Privacy & Confidentiality	Confidentiality can be harder to protect in small communities because of limited providers, stigma, and overlapping relationships	Discuss privacy practices with staff and patients early to build trust and protect confidentiality
Expertise	Where specialty care is limited, clinicians often practice as generalists and may receive referrals outside their usual areas of competence	Build competencies across common presenting concerns, pursue continuing education, and consult when needed
Community vs. professional ethics	Gift giving, boundary management, and community expectations may conflict with professional ethics	Weigh potential harm when professional boundaries conflict with community norms, such as requests for groceries, fuel, or other material support
Language	Communication style, word choice, and language access can affect care	Use clear, respectful language and account for educational, financial, and language barriers to reduce bias and harm
Psychological Assessment	Many standardized assessments are not normed on diverse populations	Choose assessments intentionally, use culturally informed clinical judgment, and actively reduce bias

PRACTICALITIES OF CLINICAL CARE

Rural patients may present with more severe mental health symptoms with co-morbid health concerns, given their environmental circumstances. In the past, clinicians may have falsely misunderstood patients' clinical presentations and mislabeled symptomology (Campbell, L. & Selby-Nelson, 2019). Utilizing rural-informed approaches with empathy and compassion are key to building supportive, therapeutic relationships. Therapeutic considerations are outlined on the next page.

RECOMMENDATIONS FOR INITIATING TREATMENT

Given that rural areas can be health care access deserts, you may need to be strategic about the care you provide such as using a bipsychosocociocultural model, ensuring basic needs are met, or by acknowledging your role as a frontline care provider.

Therapeutic Considerations		
Multiple Roles	• Serve roles beyond direct clinical care • Help patients navigate Medicaid or other insurance • Connect patients with local nonprofits	• Prioritize nonprofits serving low-income clients • Coordinate transportation through community resources
Office Setting	• Traditional office settings may feel uncomfortable • Consider walk-and-talk sessions • Consider mobile clinics	• Consider schools or other community settings • Dress and decorate thoughtfully
Scheduling	• Be creative and flexible • Allow children to attend when appropriate • Set limits for no-shows and cancellations, but remain flexible. Consider avoiding fees for late cancellations or no-shows	• Use phone check-ins between sessions • Use school-based services when available • Offer flexible timeslots • Offer evening appointments
Telehealth	• Improves access to treatment in remote locations • Cultural context may be harder to assess through technology • Use video and/or phone sessions as needed	• Consider limits related to culture, income, and internet access • Telehealth may not always be a long-term solution
Best Evidence-Based Practices to Use Rurally	• Person Centered Therapy • Eclecticism/integrative approaches • Cognitive Behavioral interventions • Interpersonal psychotherapy • Multisystemic Therapy	• Feminist Therapy • Relational Cultural Therapy • Provide trauma-informed care • Each patient will likely need a variable approach to treatment
Using Manualized Treatments	• Tailor each treatment approach to each individual given their varying perspectives, lived experiences, and knowledge about themselves and their symptoms	
Forensic Work/Mandated Clients	• Use Motivational Interviewing • Build your relationship early • Refer to ethics when communicating with case workers/referral sources openly • Discuss with patients for what is/will be shared early	• Be knowledgeable about testifying • Your expertise guides treatment vs the court • Be aware that you may be one of the only forensic practitioners in a rural area

AREAS FOR FURTHER DEVELOPMENT

1. **Education:** Integrate rural mental health practices into graduate training.
2. **Experiential Training:** Build experience in integrated care settings and pursue specialty training in areas such as substance use, trauma, and crisis care.
3. **Collaboration:** Engage with rural communities, multidisciplinary teams, academic clinics, and professional organizations to strengthen local support.

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SECTION 3:

Rural Workforce and Training Pipelines

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Many rural populations reside in designated Mental Health Professional Shortage Areas, reducing access to quality behavioral health services (Health Resources and Services Administration, 2025). Accordingly, this section explores the importance of rural training programs, recruitment and retention, supervision in rural areas, and preventing burnout.

EXPANSION OF RURAL TRAINING PROGRAMS

Fewer than 1% of programs and institutions awarding doctoral degrees in psychology in the U.S. are located in rural areas (Domino et al., 2019). Rural-focused training programs may increase the likelihood of rural practice post-graduation, improve cultural humility for working with rural populations, and enhance retention through community integration.

Importantly, rural-focused training does not simply refer to geographic location. Training may also address rural culture, resource scarcity, and generalist practice demands (Guerrero et al., 2018) in coursework. To meet needs, some programs have rural training opportunities within existing doctoral programs (e.g., rural practica placements and partnerships with rural clinics or VA systems). Evidence suggests that sending trainees to rural sites rather than building entirely new programs is a more feasible and scalable strategy than creating new rural doctoral programs (Domino et al., 2019).

To identify psychology internships offering training with rural populations, use the APPIC directory search. Under “Expanded Search Criteria” click “Training Opportunities” and select “Rural.”

RECRUITMENT

A barrier to addressing unmet mental health needs in rural areas is recruiting and retaining a rural workforce. Recruitment efforts in rural areas that focus on considering professionals who have lived in, or trained in, rural communities tend to have better success. Trainees are more likely to remain in rural locations given opportunities for available consultation practices, professional growth, organizational support, and a deeper understanding of rural environments.

Domino et al. (2019) identified several strategies to support recruitment of providers to rural areas, including:

- Providing training awards for students from rural areas
- Expanding training opportunities in rural areas (e.g., practica, internships)
- Providing incentives to rural providers to supervise the next generation of practitioners
- Training about and opportunities to use telehealth to serve rural populations

TRAINING

Many psychologists who go on to work in rural and underserved areas lack formal training, either through their doctoral studies or their internship placement. Although there has been a greater push for interdisciplinary work in the field of psychology as a whole, this is particularly relevant in rural areas. Receiving educational training on working with interdisciplinary teams allows a seamless transition for psychologists providing treatment in rural areas as many are likely to work in integrated primary care.

Therefore, graduate training programs should provide training in:

- Understanding interdisciplinary teamwork
- Ethical/legal concerns unique to rural areas
- Cultural competency (see Pursuing Cultural Competence in Rural Mental Health)

SUPERVISION

Telesupervision is common within rural communities often due to a lack of available supervisors and allows increased flexibility, access to care, and likely retention efforts. However, the lack of telesupervision guidelines and varied regulations across states complicates requirements for both supervisors and supervisees.

Noon and colleagues (2025) argue the following:

- Telesupervision greatly reduces barriers for rural providers seeking licensure
- Supervisors should attain competency in providing treatment in rural areas
- Hybrid model of in-person and telesupervision may be recommended

Furthermore, supervision should focus on the management of ethical dilemmas common in rural practice. Supervisors can help trainees gain fluency in this decision making so that complicated ethical situations are less stressful and the risk of burnout is mitigated. See Section 2 for more information.

Ethical Dilemma	Example
Dual Relationships	One of your patients works at the only grocery store in town.
Privacy and Confidentiality Limits	Due to their work schedule, your patient can only attend virtual appointments from their workplace.
Scope of Practice	A primary care provider asks for your opinion about specific psychotropic medications for a shared patient.
Competency Limits	You receive a referral for an adolescent presenting with anxiety, but you primarily treat adults.

Other considerations for supervision in rural locations include supervisors who:

- Are flexible and available
- Build strong working alliances
- Are knowledgeable about clinical assessments & interventions that have been shown to work best with rural patients
- Facilitate case conceptualization given life circumstances of patients, the environment, and co-morbid health issues
- Encourage self-reflection of power differentials in clinical settings
- Can offer support to paraprofessionals as needed
- Model and teach effective ways to have challenging conversations with colleagues in interdisciplinary settings
- Facilitate professional support

How to Prevent Burnout (Rupert et al., 2015)	
Strategy	Examples
Monitor work demands	▪ Avoid consistently working long hours. ▪ Protected time for administrative tasks ▪ Set limits on high-intensity cases ▪ Adjust your workload based on your capacity, values, and needs ▪ Reflect on whether the role is a good fit with your values, interests, and goals
Use Workplace Supports	▪ Identify and use available resources ▪ Seek consultation or supervision ▪ Build social support within your workplace
Use Personal Resources	▪ Engage in regular self-care. ▪ Participate in meaningful activities ▪ Attend personal therapy ▪ Maintain a sustainable work/life balance ▪ Avoid “working outside of work”

BURNOUT

Due to the high probability of understaffing in rural communities, burnout is highly likely as a rural provider. Aspects of burnout include emotional exhaustion, depersonalization of patients/clients, and diminished feelings of personal accomplishment which can lead to poor work performance and overall poor well-being of the clinician (Maslach & Jackson, 1981; Lu et al., 2026).

- Burnout occurs when one experiences increased stress from various sources, including:
 - » Increased caseload
 - » Managing difficult presenting problems
 - » Lack of adequate resources available
 - » Reduced access to continuing education for rural practice
 - » Poor time management
 - » Compassion fatigue

Fortunately, there are several avenues for addressing burnout in providers. For more information regarding causes, signs, and prevention of burnout in behavioral health providers, see The Behavioral Health Leader's Guide to Burnout.

RETENTION

Retention of rural mental health providers is difficult in rural health care settings. This is particularly true for communities with a dearth of mental health services and only one, or a limited few, provider(s) attempting to meet an entire community's need.

Factors that impact rural provider retention include (Selby-Nelson et al., 2022):

- Professional and personal isolation
- Barriers to resources and other services
- High and complex clinical demands
- Lack of referral options and potential colleagues
- Limited opportunities for non-clinical professional roles and activities
- Complex and frequent ethical dilemmas
- Visibility and privacy limits

While recruitment in rural settings is a typical focus of workforce development efforts, retention of rural providers is a less developed domain. Retention of rural providers requires intentional efforts designed to support providers and help build resilience and buffer them from burnout while they strive to manage the numerous professional challenges noted above.

Administrators are encouraged to consider implementing the following retention strategies:

- Create immersion interviews including site visit and community tour
- Ensure that clinicians have experience or training in rural competency and practice
- Offer competitive benefits including loan repayment assistance
- Provide competitive professional development and continuing education funds and time
- Support membership in state, regional, and national professional associations
- Provide resources to assist in case management and care navigation to address social determinants of health
- Facilitate collaboration and partnerships with community leaders and entities
- Prioritize adequate staffing and avoid assigning unsustainable case load demands
- Support activities including advocacy, scholarly work, supervision, and teaching
- Support participation in ECHO (Extension for Community Health Outcomes; <https://projectecho.unm.edu/>) programs or other consultative remote resources

AREAS FOR FURTHER DEVELOPMENT

- **Telesupervision guidelines/regulations:** Create guidance on remote supervision rules, ethics, documentation, privacy, emergency planning, and rural-specific best practices.
- **Rural health graduate programs:** Build a list of graduate programs offering rural mental health training, placements, telehealth experience, or rural-focused research.

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SECTION 4:

Policy, Advocacy, and Systems-Level Change

Tess M Kilwein, PhD, ABPP, CMPC & Ashley Norwood-Strickland, PhD, MSCP

This section offers practical strategies to help psychologists, trainees, and state, territorial, and provincial psychological associations (STPAs) advocate for better access to rural behavioral health care, a stronger workforce, and more coordinated systems of care.

UNDERSTANDING RURAL BEHAVIORAL HEALTH BARRIERS

Rural communities face structural barriers that limit access to behavioral health care. Providers in these settings often navigate fragmented systems, workforce shortages, and infrastructure limitations that contribute to treatment delays, referral gaps, and reduced service use (Health Resources and Services Administration [HRSA], 2022; Morales et al., 2020). Barriers vary among rural communities, and may include:

- Rural hospital and emergency department closures that reduce access to crisis care
- Behavioral health workforce shortages that increase wait times and limit services

- Transportation and geographic barriers that limit appointment and specialty care access
- Limited inpatient and residential treatment availability that reduces crisis care options
- Broadband limitations affecting telehealth delivery that reduce access to virtual services
- Privacy concerns, cultural norms, and dual-role challenges that affect help-seeking

To find community-level data to support documentation and advocacy efforts, explore HRSA Health Professional Shortage Area (HPSA) designations, which identify areas with shortages of primary care, dental, and mental health providers; County Health Rankings & Roadmaps, which

Barrier	What Psychologists can Document	Advocacy Solutions
Broadband limitations	Dropped telehealth sessions, missed visits	Broadband investment, telehealth flexibility
Workforce shortages	Wait times, referral bottlenecks	Loan repayment, training slots, recruitment incentives
Hospital/ED closures	Longer travel, crisis delays	Rural stabilization funding, crisis infrastructure
School access gaps	Youth waitlists, family travel burden	School-based behavioral health support
Psychiatry shortages	Delayed consults, complex PCP prescribing without backup	Reimbursement parity, prescribing psychologists
Crisis response gaps	ED boarding, law enforcement transport instead of mobile crisis	988 funding, mobile crisis, crisis stabilization units

provide county-level data on health outcomes and factors that influence health; and SAMHSA's Behavioral Health Barometer, which offers national and state-level data on substance use, mental health, and treatment trends. These are great data sources to help support your ask!

KEY POLICY AND SYSTEMS FACTORS

Psychologists who understand policy decisions that shape rural behavioral health practice are better positioned to advocate for changes that improve access, such as integrated behavioral health and school-based services (Allen et al., 2020; Sanchez et al., 2018). Others include:

- Medicaid and Medicare policy frameworks that shape coverage, billing, and payment
- Telehealth policy and broadband infrastructure investment that affect virtual care access
- Workforce development initiatives – loan repayment programs, rural training pipelines
- Integrated behavioral health models within primary care and community health settings
- School-based behavioral health programs that expand access for children and families
- Federal rural health initiatives (e.g., HRSA, SAMHSA) that support funding

ENGAGING IN POLICY AND ADVOCACY

Psychologists can help shape policies that affect mental health access and quality of care in rural communities. Current priority issues for rural psychologists include:

- Telehealth reimbursement parity
- PSYPACT/licensure mobility issues

- Broadband access
- Rural training and loan repayment
- School-based mental health funding
- Crisis response and coordination
- Integrated care reimbursement
- Food and other resource access
- Housing instability
- Transportation barriers
- Public education access
- Workforce shortages
- Civil rights protections
- Community-based supports

Advocacy efforts can occur at multiple levels, including state legislatures, federal agencies, and professional organizations. Practical strategies for policy engagement include:

- Learning about legislative issues affecting rural behavioral health
- Participating in advocacy training and policy briefings
- Translating clinical experiences into policy-relevant narratives
- Building relationships with state and federal legislators
- Participating in legislative testimony and public comment processes
- Partnering with state, provincial, and territorial psychological associations

What Advocacy Can Look Like in Practice			
A psychologist in a rural FQHC sees long waitlists for psychiatric consults and brings de-identified workflow data to clinic leadership to support integrated behavioral health staffing.	A private practitioner emails a state legislator about broadband gaps after multiple patients lose telehealth access due to poor connectivity.	An early-career psychologist joins their state psychological association’s advocacy day and shares a story about transportation barriers affecting patients.	A hospital-based psychologist partners with a school counselor and primary care clinic to help develop a local referral pathway for youth in crisis.

Legislators often remember stories more than statistics. Describing recurring patterns can convey scope without compromising confidentiality. Here is one way to start:

Legislative Outreach Template
"I am a psychologist serving rural patients in [state/region]. In my practice, I see how [transportation gaps / workforce shortages / broadband limitations / hospital closures] delay mental health care. Over the past year, multiple patients in our clinic have missed telehealth visits because their broadband could not support video. They then drive an hour each way for in-person care, and when gas money runs out, they stop coming altogether. One policy solution would be [telehealth parity / rural training incentives / integrated care funding / school-based behavioral health support]. I encourage your office to support policies that strengthen rural behavioral health systems."

SYSTEM-LEVEL COLLABORATIONS

Psychologists in rural communities can strengthen care by partnering with multidisciplinary colleagues and community organizations. These partnerships can improve care coordination, expand access, and support integrated behavioral health services. Partnerships include:

System	Opportunities for Collaboration
Hospitals and Health Systems	Referral pathways, discharge planning, crisis coordination
Federally Qualified Health Centers	Integrated care, warm handoffs, coordinated care
Primary Care Clinics	Screening, brief intervention, behavioral health consultations
School-Based Behavioral Health	Prevention, early identification, referrals
Public Health Departments	Prevention, community education, outreach
Law Enforcement & Crisis Response	Crisis pathways, cross-training, diversion from jail
Faith-Based & Community Organizations	Trusted referrals, stigma reduction, outreach
Cooperative Extension Services	Farm stress, suicide prevention, education

PAYMENT AND REIMBURSEMENT CONSIDERATIONS

Addressing reimbursement barriers is critical for maintaining and expanding rural behavioral health services. Financial and reimbursement factors that influence practice include:

- Medicaid and Medicare reimbursement policies – coverage, billing, payment rates
- Reimbursement disparities affecting rural providers – lower rates, administrative burden
- Telehealth reimbursement regulations – eligibility, technology, payment parity
- Integrated care reimbursement – payment for coordination and team-based care
- Financial sustainability of rural practice – workforce costs, payer mix, and patient volume

CORE POLICY AND ADVOCACY RESOURCES

These resources help psychologists identify advocacy priorities, access policy guidance, and support systems-level change in rural behavioral health.

- APA Rural Health - Committee on Rural Health, Division 31 Rural Health Section
- APA Advocacy – advocacy tools, issue briefs, action alerts
- SAMHSA Rural Behavioral Health – community behavioral health supports
- Rural Health Information Hub (RHHub) – rural data, funding, models, and toolkits
- National Rural Health Association (NRHA) – broader rural systems advocacy context
- National Association for Rural Mental Health (NARMH) – rural mental health organization
- CMS Behavioral Health Integration Services – guidance on integrated care billing
- Federal Office of Rural Health Policy (FORHP) – rural programs, grants, policy resources
- Cooperative Extension – mental health and well-being community group
- Indian Health Services – behavioral health resources for tribes and tribal organizations

AREAS FOR FUTURE DEVELOPMENT

Beyond this section of the *Rural Mental Health Toolkit*, practical advocacy and systems-change tools that are still needed for rural psychologists include:

- Rural reimbursement guides for telehealth, integrated care, and school-based services
- Data and storytelling tools for advocacy that help psychologists translate local needs
- Templates for working with multidisciplinary partners (e.g., schools, primary care)
- Rural crisis care and referral pathway tools for communities with limited local resources
- Training tools for psychologists new to advocacy with practical, step-by-step guidance
- Advocacy guidance on integrating behavioral health providers in school-based settings

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SECTION 5:

Building Community Partnerships in Rural Behavioral Health

Ashley Norwood-Strickland, PhD, MSCP

In rural communities, improving access to behavioral health care often depends less on building new systems and more on strengthening connections among the people and organizations already doing the work. You don't have to reinvent the wheel. Psychologists who invest in relationships with local partners can extend their reach, reduce duplication of services, and build the kind of trust that makes people more willing to seek help. This section offers practical guidance on identifying, building, and sustaining community partnerships that support behavioral health in rural settings.

LEVERAGING EXISTING COMMUNITY RESOURCES

Rural communities may have fewer formal behavioral health services, but they are not without resources. Schools, primary care clinics, faith organizations, Cooperative Extension offices, law enforcement agencies, and community nonprofits all serve roles that intersect with behavioral health, whether they define their work that way or not. A practical first step is mapping the community landscape:

- Who provides services that touch behavioral health, even indirectly?
- Where do people naturally gather, seek support, or access care?
- Which organizations already have credibility with the populations most in need?
- What existing infrastructure (e.g., meeting spaces, mailing lists, trusted personnel) could extend the reach of behavioral health programming?
- Which resources are reliable right now, and which exist mostly on paper?

In many rural areas, the school is the largest employer and the most consistent point of contact with children and families. The primary care clinic may be the only health care access point for miles. The Cooperative Extension office may have decades of trust with agricultural families who would never walk into a mental health clinic (Brown et al., 2023). Faith communities often serve as the first place people turn when they are in distress (Perez et al., 2025). Rather than starting from scratch, psychologists can look for ways to embed behavioral health awareness, screening, and referral into the infrastructure already in place.

A resource list is only as useful as it is current. Knowing which food pantry is actually open on Tuesdays, which agency is answering its phone this month, and which program has a waitlist helps psychologists steer patients toward help that will actually be there. A referral that ends at a locked door or an unreturned call can add to a person's distress and reinforce the sense that systems were not built for them. Keeping that knowledge up to date, and sharing it with partners, is part of the work.

Core Community Organizations & Reasons to Collaborate		
Community Partner	Behavioral Health Touchpoints	Partnership Opportunities
Primary care clinics and FQHCs	Screening, brief intervention, medication management	Embedded consultation, warm handoffs, collaborative care
Schools	Early identification, crisis response, family contact	Teacher consultation, universal screening, staff training
Faith communities	Grief support, crisis response, trusted first contact	Mental Health First Aid training, referral pathways, pastoral consultation
Cooperative Extension	Farm stress, family well-being, suicide prevention	Co-delivered workshops, gatekeeper training, community education
Law enforcement	Crisis response, welfare checks, repeat encounters	CIT training, co-responder models, crisis protocols
Public health departments	Prevention, community education, data collection	Outreach campaigns, needs assessments, grant collaboration
Community-based organizations (food programs, shelters, housing and homelessness services)	Basic needs, housing instability, trusted day-to-day contact	Co-located services and community hubs, shared outreach, Continuum of Care participation

BUILDING TRUST THROUGH RELATIONSHIPS

Effective community partnerships in rural areas are built on relationships, not contracts. Trust develops over time through consistent presence, follow-through, and genuine respect for partners' expertise and autonomy. Principles that support effective partnership building in rural contexts include:

- **Start with Listening:** Ask partners what they need rather than leading with what you can offer. A school counselor, a pastor, or a primary care provider may define the behavioral health problem differently than a psychologist would, and their framing often reflects the reality of what will work in that setting.
- **Respect Existing Expertise:** Community partners bring local knowledge, cultural competence, and relational trust that psychologists typically cannot replicate on their own. Extension agents understand agricultural stress. School counselors know which families are in crisis. Faith leaders know who is isolated. Build on those.
- **Go Where People Are:** Lowering barriers at the clinic door matters, but expanded access alone does not change care-seeking for everyone. Some community members will not come in no matter how easy it is. Outreach in the places people already spend time, paired with low-barrier clinic care, builds the close,

credible relationships that can eventually make a first appointment possible.

- **Commit to Consistency:** Rural communities are often wary of outside professionals and institutions that show up for a grant cycle and leave. Even small, sustained contributions, like monthly consultation calls, recurring trainings, or standing availability for warm handoffs, build credibility over time.
- **Navigate Dual Roles Thoughtfully:** In small communities, providers are likely to encounter their partners and their patients in everyday life. Being transparent about boundaries while remaining approachable helps maintain both professional integrity and community trust. At the end of the day though, don't forget to just be a human.
- **Choose Partners Carefully:** Referring to a partner signals that you trust them. Before building referral pathways, consider whether a partner's policies are respectful and trauma-informed. An organization that requires an unrelated or invasive procedure as a condition of receiving any service, for example, can undermine the trust psychologists are working to build. Where concerns exist, limit engagement and look for safer alternatives.

PARTNERSHIP MODELS THAT WORK IN RURAL SETTINGS

Community partnerships can take many forms depending on local needs, resources, and organizational readiness. What they share is an orientation toward collaboration rather than referral alone. Several models have demonstrated effectiveness in rural communities:

- **Primary Care Integration:** Many rural residents access behavioral health services only through their primary care provider. Psychologists embedded in primary care clinics, FQHCs, or Rural Health Clinics can provide brief interventions, support screening and triage, and consult on complex cases. The collaborative care model has demonstrated improved outcomes in rural settings (HRSA, 2022). Even where full integration is not feasible, regular consultation relationships between psychologists and primary care providers can improve detection and management of behavioral health conditions.
- **School-Based Partnerships:** Schools are often the most accessible service delivery point for children and families in rural areas. Psychologists can partner with schools to support universal screening, teacher consultation, crisis response planning, and direct service delivery. Effective school partnerships often involve training school staff in Mental Health First Aid or other gatekeeper models so that the school's existing workforce becomes part of the behavioral health response (Sanchez et al., 2018).
- **Faith Community Collaboration:** Faith leaders in rural communities frequently serve as frontline responders to emotional distress, grief, family conflict, and crisis. Research consistently shows that faith communities hold significant trust and credibility, particularly among populations less likely to seek formal mental health services (Perez et al., 2025). Psychologists can build partnerships with clergy/officials by offering training, developing referral pathways, and providing consultation on recognizing when a congregant may need professional care.
- **Law Enforcement and Crisis Response:** In many rural communities, law enforcement officers are the default first responders to behavioral health crises. Co-responder models, which pair behavioral health clinicians with law enforcement officers, have been effective in diverting individuals from jails and emergency departments into appropriate care. Where co-responder teams are not feasible due to staffing or geography, psychologists can still contribute by providing crisis intervention training for officers, developing local crisis protocols, and helping establish referral pathways for follow-up care.
- **Cooperative Extension Partnerships:** Extension offices are deeply embedded in rural communities and have longstanding trust among agricultural populations. Several states have developed partnerships between extension groups and mental health professionals to address farm stress, suicide prevention, and family well-being (Brown et al., 2023). Psychologists can partner with extension services to provide training on recognizing behavioral health concerns, develop referral resources for agricultural families, and co-deliver community education.
- **Community Hubs and Community-Based Organizations:** People reliably show up for the things they need, like food, housing help, and other basic resources. Community hubs that co-locate those services with health care make behavioral health support an easy add-on to a trip someone was already making, rather than a separate destination with its own intake and its own leap of faith. Psychologists can also take part in local structures that direct resources to these partners.

SUSTAINING PARTNERSHIPS OVER TIME

Building a partnership is one challenge but sustaining it is another. Rural partnerships are particularly vulnerable to disruption from provider turnover, funding instability, and organizational change:

- **Define Shared Goals Early:** Partners do not need identical missions, but they do need a shared understanding of what success looks like. Concrete, measurable goals give partnerships direction and make it easier to demonstrate value.

- **Be Clear About Scope and Safety:** Once a partnership is trusted, partners may start bringing people to you for almost anything, including emergencies your setting cannot safely manage. Tell partners plainly what your clinic can and cannot handle, share simple triage criteria, and agree ahead of time on when someone should go straight to the emergency department or call 911/988. Clear boundaries protect patients and protect the partnership.
- **Formalize (Only) What Matters:** Written agreements, memoranda of understanding, and shared protocols help partnerships survive leadership changes. But rural partnerships also thrive on flexibility and personal commitment.
- **Track and Share Outcomes:** Even simple tracking, like number of warm handoffs completed, training sessions delivered, or crisis calls diverted, provides data that can sustain organizational buy-in and support future funding. Data also positions partnerships to advocate for systems-level changes, as described in Section 4 of this toolkit.
- **Plan for Transitions:** Building partnerships that involve multiple points of contact within each organization, cross-training staff, and documenting workflows all reduce the risk that a single departure will undo years of relationship building.
- **Other Considerations:** Having a chief business officer within your organization may help to offer guidance and support for funding decisions. Understanding the systems with which patients need to navigate will also be key to offer support. In addition, partnerships have varying levels within institutional settings and the community. Providing outreach within clinics and other local organizations will aid in creating long-term effective relationships.
- **Make the Business Case:** Outreach rarely pays for itself directly, and its return on investment is often indirect. Pairing community work with billable (RVU-generating) services or grant-funded activities helps justify the time. Data on unmet need, such as waitlist length, along with evidence of benefits to the broader system, can strengthen requests to leadership for protected time and staffing.
- **Protect Provider Capacity:** In high-need rural settings, demand can feel like a bottomless bucket, and recruitment is hard. When one provider becomes the answer for everyone in the community, burnout follows. Firm boundaries and deliberate trade-offs, such as offering brief screenings when full therapy hours would shut others out, help keep providers in the work. It can also help to treat the community itself as the identified patient, applying behavioral and systems principles to organizations and partnerships, not just individuals.

What Community Partnership Can Look Like in Practice		
A psychologist in a rural FQHC builds a consultation relationship with three local pastors, offering quarterly trainings on recognizing depression and anxiety and providing a direct referral line for congregants in need.	A school-based psychologist partners with the county Extension office to co-facilitate a stress management workshop for farming families during planting season, meeting families where they already gather.	A psychologist in private practice offers monthly case consultation to the local police department, helping officers develop de-escalation strategies and connecting them with follow-up resources for individuals they encounter in crisis.
A hospital-based psychologist works with the school counselor, primary care clinic, and juvenile court to develop a shared referral pathway and safety planning protocol for adolescents in crisis.	A psychologist at a Rural Health Clinic sets up a table at a nonprofit's monthly food distribution, helping hand out groceries and offering brief, optional check-ins to families who would not otherwise come to the clinic.	A psychologist partners with a local church to host a diabetes program in the fellowship hall, building practical food guidance and stress management into the congregation's regular covered-dish dinners.

COMMUNITY PARTNERSHIP RESOURCES

These resources support psychologists in identifying partnership opportunities, accessing collaboration tools, and connecting with networks that strengthen rural behavioral health systems.

- APA Rural Health – Committee on Rural Health, Division 31 Rural Health Section
- Rural Health Information Hub (RHIHub) – community partnerships toolkit, data, models, and funding
- HRSA Guide for Rural Health Care Collaboration – framework for cross-sector partnerships
- National Association for Rural Mental Health (NARMH) – rural mental health organization
- CMS Behavioral Health Integration Services – integrated care billing guidance
- CIT International – crisis intervention team training for law enforcement partnerships
- Cooperative Extension Mental Health Network – connecting Extension and mental health professionals
- Mental Health First Aid – training for community members and partners
- SAMHSA Integrated Care Resources – models and tools for primary care and behavioral health integration
- HUD Continuum of Care (CoC) Program – local homelessness planning bodies and funding competitions

AREAS FOR FUTURE DEVELOPMENT

- Partnership assessment tools that help psychologists map existing community resources and identify collaboration opportunities
- Shared data frameworks and memorandum of understanding templates that support partnership accountability while protecting patient privacy
- Training curricula for psychologists entering rural practice on how to initiate and sustain cross-sector partnerships, with attention to boundary management, tolerance for uncertainty, and process-focused (rather than completion-focused) expectations for trainees
- Models for compensating community partners whose contributions to behavioral health are often unrecognized and unfunded
- Culturally responsive partnership frameworks that center the perspectives of Indigenous, Black, Latino, and other underserved rural populations

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SECTION 6:

Training & Resources

CHILDREN/ADOLESCENTS:

Assessment & Treatment

- Psychoeducational evaluations for:
 - » Learning disorders
 - » Intellectual disabilities
 - » Autism Spectrum Disorder
 - » Attention-Deficit/Hyperactivity Disorder (ADHD)
- Assessment of:
 - » Adolescent substance use concerns
 - » Complex trauma
 - » Juvenile youth
 - » Children involved in abuse and neglect cases
 - » Foster care-related needs
 - » Placement considerations
- Behavioral interventions for behavioral disorders, including:
 - » Operant conditioning techniques, positive reinforcement strategies/effective punishments
 - » Behavior modification approaches
- Child and family-focused interventions, including:
 - » Play therapy
 - » Parent-Child Interaction Therapy (PCIT)
 - » Relationship building with parents, parenting training and connection

Training/Resources

- » APA Division 53: Society for Clinical Child and Adolescent Psychology
- » APA Division 54: Society for Pediatric Psychology
- » Clinical Child and Adolescent Psychology (ABPP)
- » School Psychology (ABPP)
- » Understanding School Psychology and Its Role in Supporting Children and Families (ERIC Journal Article)
- » Treatments for Behavioral and Emotional Problems in Preschool Children (APA)
- » Juvenile Justice Toolkit (Center for Parent Information and Resources)
- » Youth Involved in the Juvenile Justice System (Youth.gov)
- » Resources for Foster, Adoptive, and Kinship Families (National Foster Parent Association)
- » Foster Care and Permanency Resources (Child Welfare Information Gateway)
- » Educational Resources for Students in Foster Care (U.S. Department of Education)
- » Parent Management Training Institute
- » About Behavior or Conduct Problems in Children (CDC)
- » Parent-Child Interaction Therapy (PCIT International)

- **Readings**

- » *The Whole Brain Child* - Dan Siegal and Tina Bryson
- » *Brainstorm* - Dan Siegal
- » *Tough Kids, Cool Counseling* - John Sommers-Flanagan

OLDER ADULTS:

Assessment & Treatment

- Considerations for testing:
 - » Neuropsychological evaluations
 - » Capacity evaluations (medical, financial, decision-making, etc.)
 - » Geriatric Depression Scale
 - » Referral for brain imaging
 - » Assess for activities of daily living
- Support patients through changes in independence, functioning, and physical health
- Normalize and provide support around developmental and life-stage changes
- Develop understanding for nontraditional families (e.g., stress for caregiving of grandchild, loss/difficulties with their child)
- Cognitive Behavioral Therapy (CBT) for Chronic Pain
- Include caregivers and support systems in treatment when appropriate in treatment
 - » Relationship building
 - » Provide education

Training/Resources

- » APA Division 20: Adult Development and Aging
- » Geropsychology (American Board of Professional Psychology)
- » Geropsychology Resources (American Psychological Association)
- » What Practitioners Should Know About Working With Older Adults (APA)
- » Assessment of Older Adults With Diminished Capacity: A Handbook for Psychologists (APA)

- » Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change (APA)
- » Find Help: AARP Foundation Resources
- » Meals on Wheels America
- » 2023 State of Grandfamilies Report: Key Facts and Findings (Generations United)
- » Grandparents Raising Grandchildren: Resources and Support (AAMFT)

INDIGENOUS/TRIBAL COMMUNITIES:

Assessment & Treatment

- **Clinical Focus Areas**

- » Trauma and trauma-related concerns
- » Substance use and addiction
- » Suicide risk assessment and intervention
- » Grief and loss
- » Social determinants of health, including access to food and basic resources

- **Culturally Responsive Practice**

- » Engage in community-based and relationship-centered care beyond the traditional therapy setting
- » Adapt assessment and treatment approaches to better align with client needs and cultural context
- » Critically evaluate and modify Westernized assessment approaches that may not be culturally representative (e.g., cognitive assessments normed primarily on White populations)

Training & Professional Development

- **Community & Cultural Learning**

- » Practicum and internship opportunities in tribal communities
- » Training in working with elders and diverse populations
- » Understanding traditional healing practices and community-based approaches

- **Cultural Humility & Self-Reflection**

- » Ongoing multicultural training
- » Development of cultural humility
- » Reflection on personal identity, privilege, and the impact of systems on client experiences

Training/Resources

- » Society for Indian Psychologists - APA
Indigenous Psychology Toolkit: Mental Health Toolkits (Global Psychology Alliance / APA)
- » Suicide Prevention in Indigenous Communities (NAMI)
- » Office of Tribal Affairs and Policy (SAMHSA)
- » White Bison Treatment Centers and Recovery Resources
- » Alcohol and Substance Abuse Program (Indian Health Service)

IMMIGRANTS:

Assessment & Treatment

- **Clinical Focus Areas**

- » Trauma and related experiences
- » Impact of lived experiences within cultural and community contexts
- » Experiences of discrimination and systemic barriers
- » Assessment considerations for individuals with diverse language backgrounds

- **Language Access & Culturally Responsive Care**

- » Utilize bilingual providers when available and appropriate
- » Collaborate with qualified interpreters/translators when needed
- » Consider linguistic and cultural factors when conducting assessments and providing treatment

Training & Professional Development

- **Language & Clinical Training**

- » Bilingual supervision opportunities

- » Training experiences in bilingual and culturally responsive settings
- » Development of skills for working with multilingual clients

- **Cultural Humility & Community Awareness**

- » Multicultural training
- » Cultural humility development
- » Awareness of current events and media narratives affecting immigrant populations
- » Understanding the impact of immigration-related experiences on mental health and access to care

Training/Resources

- » Migration and Displacement Resources (Global Network of Psychologists for Human Rights)
- » Refugee and Migrant Mental Health (World Health Organization)
- » Mental Health Facts for Refugees (American Psychiatric Association)
- » Bilingual Psychologists Special Interest Group (Society of Clinical Child and Adolescent Psychology)
- » Immigrant Legal Resource Center (ILRC)
- » Immigration Advocates Network

- **Readings:**

- » Displacement, Human Rights, and Sexual and Reproductive Health by Cintra, Owen, and Riggiozzi (2023)
- » Hook, J. N., Davis, D., Owen, J., & DeBlaere, C. (2017). Introduction: Beginning the journey of cultural humility. In J. N. Hook, D. Davis, J. Owen, & C. DeBlaere, *Cultural humility: Engaging diverse identities in therapy* (pp. 3-16). American Psychological Association.
<https://doi.org/10.1037/0000037-001>
- » The Cambridge Handbook of Acculturation Psychology, 2nd ed., Sam & Berry, 2016
- » Savaş & Dutt (2023) - Decolonial and intersectional feminist psychology for the future of (forced) migration and refugee resettlement

MATERNAL MENTAL HEALTH:

Assessment & Treatment

- **Perinatal Mental Health Assessment**

- » Assess mental health symptoms during pregnancy, postpartum, and the transition into parenthood
- » Identify risk factors and concerns through early screening and intervention
- » Support adjustment to pregnancy, childbirth, and parenting experiences

- **Support & Resource Connection**

- » Provide early intervention and appropriate treatment planning
- » Connect new parents with supportive resources and community services
- » Collaborate with health care providers when appropriate (e.g., obstetric and gynecological care teams)

Training & Professional Development

- **Specialized Training & Collaboration**

- » Training through specialized perinatal mental health resources (e.g., Postpartum Support International)
- » Advanced training opportunities in perinatal and maternal mental health settings
- » Collaborative learning experiences within OB/GYN and health care clinics

Training/Resources

- » Maternal Mental Health Conditions and Statistics (Maternal Mental Health Leadership Alliance)
- » Perinatal Depression (National Institute of Mental Health)
- » Maternal Mental Health Care (Association of American Medical Colleges)
- » Advancing Maternal Mental Health Through Psychology and Policy (APA Services)

- » Maternal Early Warning System Implementation Resource Kit (Alliance for Innovation on Maternal Health)
- » PSI Online Support Meetings (Postpartum Support International)

SUICIDE:

Assessment & Treatment

- **Suicide Risk Assessment & Intervention**

- » Assess suicide risk and safety concerns
- » Recognize that chronic suicidal ideation may occur within some populations and clinical presentations
- » Monitor changes in risk related to life circumstances, environmental stressors, and access to means
- » Develop individualized safety planning and connect individuals with appropriate supports
- » Consider cultural, occupational, and contextual factors that may influence suicide risk

Training & Professional Development

- **Resources & Community Supports**

- » Training and resources through organizations such as:
 - National Alliance on Mental Illness (NAMI)
 - Substance Abuse and Mental Health Services Administration (SAMHSA)

- **Specialized Knowledge Areas**

- » Suicide prevention and intervention with specific populations, including:
 - Veterans
 - Indigenous communities
- » Firearm safety education and access to secure storage resources (e.g., gun safety locks)

Training/Resources

- » National Alliance on Mental Illness (NAMI)
- » 988 Suicide & Crisis Lifeline Partner Toolkit (SAMHSA)

- » Suicide Prevention Resources (American Psychological Association)
- » VA/DoD Clinical Practice Guideline: Assessment and Management of Patients at Risk for Suicide (MIRECC)

SUBSTANCE USE DISORDERS:

Assessment & Treatment

- **Comprehensive Substance Use Assessment**
 - » Conduct thorough clinical interviews assessing:
 - Substance use patterns (e.g., frequency, quantity, and duration)
 - Recent use patterns (e.g., past 12 months)
 - Cravings and withdrawal symptoms
 - Impact on functioning and relationships
 - Legal history related to substance use
 - Previous substance use treatment experiences
 - » Utilize evidence-based assessment frameworks, including the ASAM Criteria
 - » Assess for behavioral/process addictions, including gambling
- **Treatment Approaches**
 - » Utilize evidence-based interventions, including:
 - Cognitive Behavioral Therapy (CBT) for Substance Use Disorders
 - Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE)
 - Medication Assisted Treatment for substance use
 - Medications for Opioid Use Disorder
 - Medications for Alcohol Use Disorder
 - » Provide person-centered, trauma-informed care
 - » Incorporate harm reduction approaches when appropriate

Training & Professional Development

- **Clinical Knowledge & Skills.** Understanding the relationship between substance use and:

- » Family systems and relationships
- » Attachment and relational patterns
- » Parenting challenges
- » Child abuse and neglect considerations

- Develop skills for:
 - » Assessing substance use and criminal history in a nonjudgmental, trauma-informed manner
 - » Working with interdisciplinary teams
 - » Understanding pharmacological interventions for Substance Use Disorders
 - » Recognizing and treating process addictions
- **Resources & Continuing Education**
 - » Familiarity with community resources and referral networks
 - » Training and resources through organizations such as:
 - Substance Abuse and Mental Health Services Administration (SAMHSA)

Trainings/Resources

- » Addiction Psychology (American Board of Professional Psychology)
- » Substance Use Treatment Resources (SAMHSA)
- » Assessment and Treatment Resources (Society of Addiction Psychology)
- » ASAM Criteria Intake and Assessment Form (American Society of Addiction Medicine)
- » Alcoholics Anonymous (AA)
- » Narcotics Anonymous (NA)
- » Addiction and Attachment Theory (The Attachment Project)
- » Behavioral Addictions: Types, Signs, and Treatment (American Addiction Centers)
- **Readings:**
 - » Addictive Thinking - Abraham J. Twerski
 - » Trauma and Addiction by Tian Dayton Tep

TRAUMA:

Assessment & Treatment

- **Trauma Assessment**
 - » Assessment of Adverse Childhood Experiences (ACEs)
 - » Evaluation of trauma history and trauma-related symptom presentation
 - » Consideration of neurobiological and physiological responses to trauma (e.g., stress response systems)
- **Trauma-Focused Treatment Approaches**
 - » Evidence-based trauma therapies, including:
 - Eye Movement Desensitization and Reprocessing (EMDR)
 - Written Exposure Therapy (WET)
 - Prolonged Exposure (PE)
 - Cognitive Processing Therapy (CPT)
 - Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
 - Narrative Therapy approaches for meaning-making and integration of experiences
 - Nightmare-focused interventions and sleep-related trauma protocols
- Integration of Polyvagal Theory-informed interventions when clinically appropriate

Training & Professional Development

- **Modality-Specific Training**
 - » Specialized training in evidence-based trauma treatment modalities (e.g., EMDR, CPT, PE, TF-CBT, WET)
- **Continuing Education**
 - » Ongoing continuing education (CE) to maintain competency in trauma-informed care and emerging research
- **Foundational Knowledge Areas**
 - » Neuropsychological and neurobiological responses to trauma

- » Understanding of trauma-related adaptations in cognition, emotion, and physiology

Trainings/Resources

- » Division 56: Trauma Psychology (American Psychological Association)
- » Minnesota Trauma Project
- » EMDR International Association (EMDRIA)
- » EMDR Humanitarian Assistance Programs (EMDR HAP)
- » Cognitive Processing Therapy for PTSD
- » Prolonged Exposure Therapy for PTSD (American Psychological Association)
- » Written Exposure Therapy (U.S. Department of Veterans Affairs)
- » Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- **Readings:**
 - » The Body Keeps the Score - Bessel Van der Kolk
 - » What my Bones Know - Stephanie Foo
 - » My Grandmother's Hands - Resmaa Menakem

RACE/ETHNICITY:

Assessment & Treatment

- **Culturally Responsive Clinical Practice**
 - » Approach clients' life experiences and identities with curiosity and openness
 - » Explore identity factors as part of the clinical formulation process
 - » Consider how systemic, cultural, and environmental contexts shape presenting concerns
- **Equity-Informed Assessment**
 - » Engage in reflective awareness of privilege differences within the therapeutic relationship
 - » Use contextual and community-informed ethical frameworks when conducting psychological assessments

- » Actively reduce bias and minimize assumptions in clinical interpretation and decision-making
- » Integrate understanding of how identity and systemic factors influence symptom presentation and functioning

Training & Professional Development

- **Multicultural Competency Development**
 - » Ongoing multicultural training and continuing education
 - » Development of cultural humility in clinical practice
- **Contextual Awareness & Ongoing Learning**
 - » Stay informed about current events and media narratives affecting diverse populations
 - » Apply updated sociocultural knowledge to clinical conceptualization and assessment

Training/Resources

- » The Forgotten People: Honoring the Voices of Black Rural Americans (CBCF)
- » Treating People of Color in Clinical Practice: Considerations and Best Practices (APA Services)
- » Division 45: Society for the Psychological Study of Culture, Ethnicity and Race (APA)
- » Division 17: Society of Counseling Psychology (APA)
- » Ethnic Minorities and Special Populations Policy (American Psychological Association)
- » Association of Black Psychologists (ABPsi)
- » Working with Latino Clients in Therapy (APA)
- » Rompiendo Barreras: Dismantling Barriers to Latino Mental Health Care (UnidosUS)
- » National Latino Psychological Association (NLPA)
- **Readings:**
 - » How to be an Antiracist by Ibram X. Kendi

VETERANS:

Assessment & Treatment

- **Veteran-Informed Clinical Care**
 - » Develop understanding of military culture and its impact on identity, behavior, and help-seeking
 - » Routinely assess for suicide risk and safety concerns
 - » Assess and conceptualize trauma-related experiences within military and post-military contexts

Training & Professional Development

- **Veteran-Focused Resources & Systems of Care**
 - » Connect with and utilize local Community-Based Outpatient Clinics (CBOCs)
 - » Collaborate with Veterans Affairs (VA) Vet Centers and related support services
- **Continuing Education & Specialty Training**
 - » Engage in continuing education focused on veteran and military-affiliated populations
 - » Build competency in evidence-based treatments for trauma and suicide prevention within veteran communities

Training/Resources

- » Division 18: Psychologists in Public Service
- » Psychology and Psychiatry Clinical Training (Minneapolis VA Health Care System)
- » VA Mental Health Care Services (Minneapolis VA Health Care System)
- » Internships and Fellowships at Minneapolis VA Health Care System
- » Suicide Prevention Services (Minneapolis VA Health Care System)
- » Rural Veterans Health Care (U.S. Department of Veterans Affairs)

SEVERE MENTAL ILLNESS:

Assessment & Treatment

- **Evidence-Based Treatment Approaches**
 - » Dialectical Behavior Therapy (DBT)
 - » Cognitive Behavioral Therapy for Psychosis
 - » Use of structured, evidence-based interventions tailored to clinical presentation
- **Diagnostic & Clinical Assessment**
 - » Differential diagnosis and comprehensive clinical assessment
 - » Assessment of psychosis and related symptom presentations
- **Interdisciplinary Collaboration**
 - » Work within interdisciplinary teams
 - » Collaborate with prescribers and other health care providers to support coordinated care

Training & Professional Development

- **Clinical & Systems Training**
 - » Experience in hospital and clinical settings
 - » Exposure to crisis care environments and acute treatment settings
- **Risk & Safety Competencies**
 - » Development of safety planning skills
 - » Training in risk management and clinical decision-making in high-risk situations
- **Systems Navigation & Resources**
 - » Familiarity with local and regional mental health resources
 - » Understanding referral pathways and levels of care

Training/Resources

- » Serious Mental Illness Psychology (American Board of Professional Psychology)
- » Serious Mental Illness Hub (The National Council for Mental Wellbeing)

- » Serious Mental Illness in Graduate Education and Training (American Psychological Association)
 - » NIMH Statistics on Mental Illness (National Institute of Mental Health)
 - » Serious Mental Illness Resources (Substance Abuse and Mental Health Services Administration)
 - » Community Resource Center: Serious Mental Illness (Treatment Advocacy Center)
- **Readings:**
 - » Jansen, M., Manning, M., Gonzales, L., DeLuca, J., & Stacy, M. (2025). Training guidelines and competencies for serious mental illness (SMI) psychology. *Psychological services*, 22(1), 4-19. <https://doi.org/10.1037/ser0000854>

MISCELLANEOUS

LGBTQ+ Resources

- Rural Health: Breaking Down the Data on LGBTQ+ Youth (The Trevor Project)
- Rural Communities and Racial & Economic Justice (National Center for Lesbian Rights)
- Challenges in Rural Community Mental Health: Ethical and Clinical Implications (APA Journal Article PDF)

Spiritual / Religious Communities

- Culturally Competent Spiritual Care for Amish Clients (EBSCO Social Work Reference Center)
- Amish Cultural Practices and Health (Elizabethtown College Amish Studies)
- Rural Church Network Resources
- Center for Faith-Based and Neighborhood Partnerships (U.S. Department of Agriculture)

Ethical Considerations

- Ethical Principles of Psychologists and Code of Conduct (American Psychological Association)
- Ethics in Psychology (American Psychological Association)

- Ethical Guidance on Artificial Intelligence in Psychological Practice (APA)
- NASW Code of Ethics (National Association of Social Workers)
- ACA Code of Ethics (American Counseling Association)
- **Readings:**
 - » Palomin, A., Takishima-Lacasa, J., Selby-Nelson, E., & Mercado, A. (2023). *Challenges and Ethical Implications in Rural Community Mental Health: The Role of Mental Health Providers. Community Mental Health Journal*, 59(8), 1442-1451. <https://doi.org/10.1007/s10597-023-01151-9>
 - » Werth, J. L., Jr., Hastings, S. L., & Riding-Malon, R. (2010). *Ethical challenges of practicing in rural areas. Journal of Clinical Psychology*, 66(5), 537-548. <https://doi.org/10.1002/jclp.20681>
 - » Boilen, S. *Ethics in Rural Psychology* (book reference)
 - » Effective Practice in Rural Communities (APA Monitor)

Integrated Behavioral Health / Systems of Care

- Behavioral Health Integration Fact Sheet (APA)
- Behavioral Health Services in Primary Care (APA)
- Integrated Primary Care: Transitioning from Guest to Colleague (APA)
- Social Determinants of Health Resource (Center for Health and Social Development)

Telehealth / Digital & Hybrid Care

- Telepsychology: Policy Revisions (American Psychological Association)
- Telehealth and Telepsychology Practice Guidelines (APA)

Mental Health Literacy

- BeThere Certificate: Improving Mental Health Literacy

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