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# Exploring barriers to rural mental health practice: A pilot study

Caitlin Vu
*James Madison University*

# Exploring Barriers to Rural Mental Health Practice: A Pilot Study

Caitlin Vu

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FACULTY COMMITTEE:

Committee Chair: Renee Staton

Committee Member: Robin Anderson

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## Abstract

There is a shortage of mental health professionals in rural areas around the world. Current literature on barriers to healthcare professionals choosing to practice in rural areas mainly focuses on medical professionals, with few studies examining the barriers to rural practice for mental health professionals. Along with examining the perceived barriers and enablers to rural mental health practice, researchers wanted to further examine the reliability of the revised Barriers to Rural Mental Health Practice instrument. Researchers distributed the survey to mental health professionals across the United States. Preliminary findings support high internal reliability for the total scale and three of the five subscales. Results from this study also found that mental health professionals generally believe that rural practices do not have the resources to support incoming professionals. There is also a general agreement on including rural training and experience into graduate training. Researchers recommend that rural employers be transparent about all of the possible benefits they may be able to provide. Additionally, incorporating rural training into school curriculum could increase prospective mental health professionals' awareness of rural areas and get them a foot-in-the-door to working at a rural practice.

# Introduction

## Statement of the problem

In the United States, there is a shortage of providers in rural areas, making it hard for residents to gain access to the health care needed to sustain a healthy life (AMA, 2019; Stajduhar, 2020; Richards et al., 2005). Health care providers in rural areas constantly have waitlists due to a lack of staff (Richards et al., 2005). Many residents in rural areas must make appointments months in advance, meaning that rural residents are not receiving the routine, and sometimes emergent, health care that those living in urban areas have access to. This is true for both medical and mental health care (Richards et al., 2005).

Current literature (e.g., Clayton, 2018; Ludwig et al., 2018; Stajduhar, 2020) explores the barriers medical professionals experience when electing to practice in rural areas; however, there is a gap in the existing research as it relates to mental health professionals specifically. It is easy to assume rural barriers may be the same for all professionals, but more research is necessary to either highlight the similarities or identify the differences between these two professional groups. To do this, researchers need a measure that focuses specifically on mental health professionals' perceptions toward rural practice. For the current study, researchers modified a pre-existing instrument that was originally developed as part of a grant focused on expanding access to substance use treatment in a rural community. The revised instrument (Appendix A) was then administered to mental health professionals to examine the functioning of the items as well as to begin to explore barriers to and enablers for mental health professionals to engage in rural practice.

## Purpose of the Study

The study's purpose is to identify the perceptions and beliefs of mental health professionals that support or deter service providers from choosing to practice in rural areas. We start with an examination of the existing literature on barriers to and enablers for rural practice for primary care providers and then explore how this literature applies to rural mental health practitioners. Although there are studies pertaining to barriers to rural practice, these studies refer to medical professionals and rarely focus exclusively on mental health professionals (e.g., AMA, 2019; Clayton, 2019; Ludwig et al., 2018). Additionally, these studies are largely qualitative. Qualitative measures are beneficial in gaining insight into the experiences of individuals. However, findings from qualitative measures are difficult to generalize to large numbers of individuals (Choy, 2014). Because we wish to generalize in a way that would allow us to make recommendations to training programs and employers, the methods of this study will be quantitative.

## Definitions of Key Terms

To understand the boundaries of the study, it is important to clarify what is meant by rural, barriers, and enablers.

### *Rural*

The term *rural* has been difficult to define in the United States. The U.S. Census Bureau defines rural by what it is *not* (U.S. Census Bureau [USCB], 2010). That is, areas that do not have 2,500 or more people are considered rural. Contrary to the Census Bureau, *rural* is defined by the U.S Department of Agriculture as having either a population density of less than 500 people per square mile or a population consisting of fewer than 2,500 people (U.S. Department of Agriculture [USDA], 2019). In this study,

we used the same definition as the U.S Department of Agriculture and defined a rural area as “settlements with fewer than 2,500 residents”.

***Barriers/Enablers***

For this paper, it is critical to distinguish between barriers and enablers to rural practice. The term *barriers* was rarely defined in the literature. It appeared to be that there was a general consensus for what *barriers* meant in regard to rural health practice. One dissertation (Clayton, 2019) specifically defined *barriers* as factors that “prevent or cause issues for rural practice.” This is a short and easy definition to grasp; so, researchers in this study also used this definition, as it encompasses the researchers’ own conceptualization of the term. The term *enabler* was not defined in any of the reviewed literature. In this study, researchers defined *enabler* as the opposite of what a barrier is, thus stating that it is a factor that encourages or incentivizes an individual to rural practice.

## Literature Review

In examining the literature, there has been a push for universities to include rural training in their medial curriculum because those with a rural background are more likely to work in a rural area (Richards et al., 2005; Rural, 2021). Physicians stress the importance for their local medical schools to give priority to students with a rural background (Rural, 2021). Richards et al. (2005) specially highlights that having a rural background is a “predictor of rural working”, and that having educational training will also increase the probability of working in a rural area.

This trend appears internationally, as well. In Australia, the Australian Medical Association (AMA; 2019) examined the needs of rural doctors and found that that one of

the needs most highlighted is for medical schools to include rural training and experience for their trainees (AMA, 2019). The AMA (2019) also recommended establishing more regional training networks that would specialize in rural areas which would expose more doctors-in-training to rural communities outside of universities. Rural education and exposure during training is crucial but lacking in places like the Scottish Highlands (Richards et al., 2005).

There are copious reasons why a health professional may shy away from working in a rural area. Based on the literature, these factors are divided into five distinct categories: geography, professional factors, personal factors, gender factors, and social factors. For example, when considering geography, a significant enabler for pursuing rural employment is having a rural background. This includes growing up in a rural community and/or having received rural training related to rural population and work (Richard et al., 2005).

**Geography**

Rural health care workers work long hours because these individuals may be the only ones in their profession working in the surrounding community (AMA, 2019). Due to the constant struggle with access and knowledge in rural areas, rural clients have an increased number of medical diseases (AMA, 2019). The combination of higher demands for resources and only a few health professionals qualified to help a particular community makes the waitlists longer and the need for care higher in rural settings.

In spite of these challenges, there are two top predictors on whether a physician will enter rural practice (Rural, 2021). Firstly, most professionals will choose to work in a rural area if they specialize in being a family physician. Secondly, physicians who have a

rural background are more likely to stay in a rural area or, if they have left, move back to a rural community (Rural, 2021). Similarly, in a study conducted by Stajduhar (2020), rural physicians were asked to rate the importance of specific work factors that impacted recruitment and retention. It was noted that almost seventy percent of the participants in this study had a history of being in a rural community at one point in their lives. This suggests that having a rural background plays a factor in whether a professional may start working in a rural area.

A study conducted by Kumar et al. (2020) highlighted that having a rural background, including past living situations, being a rural student, and the recommendation of others to go rural, heavily influenced their decision to go rural. Richards et al. (2005) reports similar data, stating that those born in rural areas were most likely to be working in rural areas. In fact, almost fifty percent of respondents who were born in rural areas also work in a rural community (Richards et al., 2005). Due to these findings, rural practitioners are calling for increased rural training.

## Professional Factors

### *Government Policies and Funding*

Allied health professionals reported that some types of barriers were "out of their employer's hands," but that these barriers hindered the ability to bring in new professionals (Kumar et al., 2020) nonetheless. Nurse practitioners particularly feel limited by national policy (Smith et al., 2019). Specifically, nurse practitioners in rural Australia stated that federal laws limit the medications that can be prescribed by these professionals, as well as constrain the amount of funding health care professions receive (Smith et al., 2019). Kumar et al. (2020) reported that funding was perceived by health

professionals to be extremely helpful and could be identified as an enabler into working in rural practice. For example, financial incentives have been suggested such as providing grants that could be used towards travel and accommodation may be particularly beneficial (Kumar et al., 2020).

### *Autonomy*

Having the freedom and flexibility to make decisions in practice appears to be a leading professional factor when one is considering either a rural or urban work environment. Stajduhar (2020) noted that having autonomy is appealing to physicians and was a defining enabler in rural areas, specifically when given more freedom to practice medicine with less administrative control. Thus, providing leadership opportunities could be a promising way to keep physicians from leaving rural areas. When practitioners feel they can grow professionally, they feel more satisfied in their job. Physicians also stated that positive recruitment outcomes were due to compensation and leadership opportunities (Stajduhar, 2020). Smith et al. (2019) re-enforced this by identifying the ability to gain autonomy once nurse practitioners were established in a rural area as an important macro-level enabler to rural. Also, creating a more flexible schedule is appealing to health professionals (Stajduhar, 2020).

### *Training*

Due to the lack of helping professionals in rural areas, medical practitioners in these areas typically engage in general practice to have a broader scope of information when treating a wide variety of clients (Ludwig et al., 2018). Although some researchers have highlighted the value of having the diverse client load that accompanies general practice, others have focused on how this can result in a lack of professional

development, especially for those hoping to focus on a particular specialty (Kumar et al., 2020; Richards et al., 2005). Further, there are barriers that come with practitioners choosing general practice, including the perceived workload general practitioners face (Ludwig et al., 2018). When adding the rural setting as another factor, the practitioner faces additional barriers, including work-life balance, infrastructure, and proximity to patient contact (Ludwig et al., 2018).

To complicate this, junior doctors especially tend to feel a lack of preparedness in rural practice culture (Smith, 2005). Due to the limited education and training provided in schools, it is common for junior doctors to be unprepared, including not expecting how much responsibility they would be having; being surprised by greater workload than expected; and not understanding rural culture and what to expect from clients (Smith, 2005).

### *Isolation*

Junior doctors, who often have limited experience in their profession, report having little support because they are typically the only doctors in their rural community (Smith, 2005). Specifically, junior doctors have reported getting little support from supervisors, which can be especially true when their supervisors are also overwhelmed with caseloads (Smith, 2005). Other health professionals also report feeling professional isolation in rural areas (Richards et al., 2005). Professional isolation can increase the chances of burn out and can affect a person's decision to stay in a rural area or seek to relocate. Smith et al. (2019) highlighted this by identifying meso-barriers to rural practice, including limited staffing, a lack of breaks, fatigue, and burnout. When a

professional is working in isolation, it is extremely difficult to organize leave coverage when they need reprieve (Smith et al., 2019).

### *Community*

There have been a few identified professional enablers for rural practice which center around the community aspect of working in a rural area. Professionals tend to appreciate working in the patient-focused and collaborative environment that typically define rural practice (Stajduhar, 2020). Prospective health professionals tend to find importance in a team-based environment (Stajduhar, 2020). It makes sense that feeling like part of a community is an identified enabler while feeling isolated is a defined barrier to rural practice.

A community-based barrier to rural practice is a lack of understanding about a particular mental health professional's role from both community members and other health professionals in the surrounding area. Nurse practitioners specifically feel that other health professionals do not understand their role (Smith et al., 2019). This negatively affects forming a connection with the few other health professional colleagues in the areas as well as the number of referrals a nurse practitioner may receive. Lindeke et al. (2005) elaborated, stating that a key barrier for nurse practitioners in rural areas is the lack of knowledge about the nurse practitioner role and what they can provide to clients.

## Personal Factors

The personal factors that determine if a professional considers working in a rural practice include any considerations that may affect their personal lives. Ludwig et al. (2018) showed that the compatibility of having a job and a family was a big determinant of a professional moving to a rural practice. The concern is the possibility of relocating

the entire family to a rural area (Ludwig et al., 2018). A partner needing to also find a new job may also make engaging in rural practice difficult (Ludwig et al., 2018). If a potential practitioner has children, a big consideration is the distance the children must travel to go to school or to engage in extracurricular activities in rural areas (Ludwig et al., 2018). The AMA (2019) suggests that providing family support could entice rural practitioners to move to a rural community. Stajduhar (2020) also mentioned that involving the practitioner's family in the process once an offer is extended can be a determining factor for whether a practitioner chooses to move to a rural community. Knowing that an employer cares not only about a professional's skills, but their wellbeing, can go a long way.

The ability to adapt and integrate into the rural lifestyle is also a crucial factor in retention rates for health professionals in rural areas (Richards et al., 2005). This may be related to the fact that people who already have had experience or training in a rural area tend to stay in rural practices as compared to those coming from urban backgrounds. Richards et al. (2005) noted that a perceived lack of access to amenities in rural communities was another barrier to consider. These amenities may include childcare, education, and a job for their spouse.

**Gender Factors**

Richards et al. (2005) found evidence that female medical students are more eager to enter their profession in a rural area. Nonetheless, there is a shortage of female physicians in rural areas due to the overall shortage of physicians (Clayton, 2019). This means that female residents lack choice in who they see during examinations, especially if one prefers to have a female physician (Clayton, 2019). Although any physician can

treat female clients, some women may feel more comfortable with a female physician. Therefore, female physicians are crucial in rural areas and deserve to have some time spent on considering specific barriers to choosing rural practice.

It has been shown that female physicians are specifically concerned with work-life balance, as well as whether their spouse or partner had a job in the surrounding area (Clayton, 2019). Clayton (2019) noticed that when it comes to considering a rural practice, females focus on professional feelings/experiences (patient relationship, autonomy, and practical experience), and rural lifestyle/experience. Richards et al. (2005) found that the barriers that female professionals identify suggest that, although the professional factors are just as important to both genders, female professionals focus particularly on personal barriers. Because of a specific need for female health practitioners in rural areas, more research should be conducted to assess specific female barriers and enablers, and whether these are different from male barriers.

**Social Factors**

Allied health professionals have emphasized the importance of having support in rural areas (Kumar at al., 2020), and have identified social barriers such as perceived isolation from friends, family, and professional colleagues (Kumar at al., 2020). Smith et al. (2005) also identified that junior doctors in rural areas felt socially isolated, specifically feeling a lack of social support from not only colleagues, but also friends and family, making it hard to adjust to rural life. Although administrators did not believe this to be a key factor, physicians rated “community culture” to be the top factor in choosing a rural practice, which could be a possible identified enabler (Stajduhar, 2020).

Additionally, Ludwig et al. (2018) found that a perceived lack of leisure opportunity in rural areas is a barrier to practitioners working in a rural area. In rural areas, there is a preconceived notion that there is a lack of recreational activities to engage in outside of work (Ludwig et al.,2018). There was also a perceived lack of work-life balance in rural areas because of the belief that patients will contact you after hours (Ludwig et al., 2018).

**Conceptual Framework**

The theoretical framework of this study comes from a concept developed by Clayton (2019). The Rural Practice Pyramid model (Figure 1) was formed as a representation of the barrier and enabler factors for female medical students to work in rural areas. These factors are categorized by known themes in current literature (Clayton, 2019) and include: work/life balance, rural lifestyle/experience, resources/access to care, professional feelings/experience, financial, personal feelings/experience, building/establishing a practice (Clayton, 2019). In Figure 1, the left and right pyramids show why a female physician would and would not choose a rural practice, respectively. The width of the pyramids represents the importance of each category of factors. As shown in Figure 1, barriers and enablers are not perfectly correlated with each other.

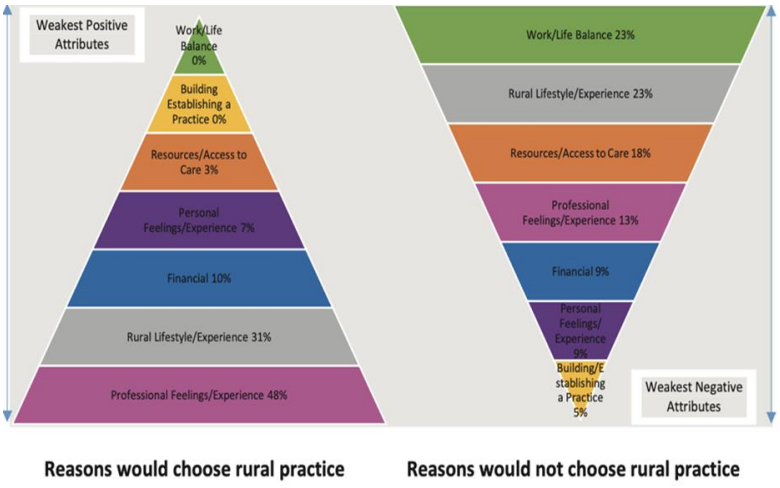


Figure 1: Clayton's Framework for Rural Practice

**Instrument Development**

Using Clayton's framework, the researchers modified a previous version of the Barriers to Healthcare Practice survey to include five of the seven pyramid levels. The researchers narrowed these seven categories into five categories, combining the categories "building/establishing a practice" into "resources/access to care" and "personal feelings/experience" with "rural lifestyle/experience." These categories seemed, conceptually, to be referring to similar ideas. Using these categories, researchers conducted a backwards translation, mapping items back to the levels of the pyramid. The researchers then wrote items to better represent the various levels. After modifying the instrument, the researchers administered the survey to a sample of mental health providers. This study allowed the researchers to continue refining the instrument while also drawing conclusions about barriers to rural health practice.

**Summary**

Gathering information from the literature and the original instrument, researchers asked three questions:

Research Question 1: Which items on the revised version of the barriers to health care practice instrument should stay on the instrument versus which items are in need of removal or continued revision? This requires a more in-depth look at how the items function in relation to one another and the subscales they were designed to assess.

Research Question 2: What common barriers do mental health care professionals cite as impediments to practicing in rural areas? Using the data collected from administering the revised instrument, researchers will attempt to identify existing and/or new barriers to mental health professionals selecting rural practice.

Research Question 3: What enablers may be useful in increasing practice in rural areas? The results of this study will also help to identify what rural mental health professionals find of value in rural areas. This knowledge can help rural employers work to highlight these aspects in their organization to draw in prospective professionals and counselor education programs to identify training that may encourage rural practice.

## Research Method

### Population and Sample

The focus of this study is mental health practitioners in the United States. The study was distributed to professional liservs and to a random sample of members of the American Counseling Association (ACA). ACA members were selected from a purchased list of members. Of the 46 participants who opened the survey, 39 participants actually responded to the questionnaire. From the sample, 55.6% (n=15) of respondents grew up in a rural area while 41.3% (n=19) actually work in a rural area. Additionally, 65% (n=3) had coursework pertaining to rural culture while 17.4% (n=8) had training in a rural area and 45.7% (n=21) had practical experience in a rural area.

### Materials/Instrumentation

During the summer of 2021, a research team administered the original version of the Barriers to Rural Mental Health Practice instrument as part of a needs assessment for a rural grant. The current researchers felt the need to further study the barriers to rural practice after the needs assessment administration did not gather sufficient data for analysis. Researchers then extended the literature review examining the existing literature on barriers to rural practice. With this information, the researchers added more questions

to the instrument to get a clearer sense of specific rural barriers. Researchers then conducted a backwards translation, based on the Clayton (2019) dissertation, in order to ensure that enough questions were asked about each of the identified barrier categories. In the revised instrument, eight questions fall into the work/life balance category, seven questions pertain to establishing a practice/access to care, six ask about personal feelings and experience, three touch on finance, and nine ask about professional feelings/experience for a total of 43 items.

## Study Procedures

Participants were contacted via email with a survey link via Qualtrics assessment software. A follow up was sent two weeks after the initial email, also containing the link to the survey. The survey was opened and distributed during the first week of December 2022 and closed April 2023. Participants completed the survey, on average, in about 25 minutes, responding to each question based on their own perceptions about rural mental health practice.

## Data Collection and Analysis

### *Research Question 1*

Analyses were conducted at the item level, providing information about the relationships among the items. Fifteen of the original items were reverse coded so that all responses that "endorsed" rural practice were coded with five as the most favorable response and one as the least favorable toward rural practice. In addition, two items (31 and 32) were removed from all items/scale analyses as responses to these items were difficult to judge as favorable or not toward rural practice. Overall, the re-coded, forty-three item Barriers to Rural Mental Health Practice scale demonstrated internal

consistency (a= .815) sufficient for making inferences at the group level. Subscale correlations range from .328 (Financial) to .847 (Work-Life Balance). See Table 1 for all subscale reliabilities. Inter-item correlations range from .001 to .878. A review of the inter-item correlation matrix (see Appendix B) demonstrates stronger correlations among the items written to measure work-life balance, the items written to measure resources and access to care, and the items written to measure personal feelings and experiences then those written to measure financial or to measure professional feelings and experiences.

Table 1: Subscale Reliabilities

| | |
|---|---|
| Work-Life Balance (n=8) | .847 |
| Resources and Access to Care (n=9) | .812 |
| Personal Feelings and Experience (n=9) | .739 |
| Financial (n=4) | .328 |
| Professional Feelings and Experiences (n=13) | .454 |

***Research Questions 2 and 3***

The researchers looked at the results of the survey to determine how much people agreed or disagreed with presented barriers and enablers to mental health rural practice. Presented below is an example item from each of Clayton's (2019) pyramid categories.

**Work-Life Balance.** Based on previous literature, the current researchers believed that it was generally perceived that rural areas have an overall unsatisfactory work-life balance (Ludwig et al., 2018; Smith, 2005). The responses for most items in this category showed unexpected variance, with many respondents indicating that they did not have strong feelings about work life balance in rural areas with some even disagreeing with such statements. For example, Item 6 (Figure 2), which is a barriers question, looks at whether respondents believe "rural service delivery has an unsatisfactory work-life balance because patients/clients/community members can contact you around the clock." There was no strong agreement on this item with 34.8% reporting "neither agree nor disagree," almost twenty percent reporting "disagree," and only 15.2% reporting "agree."

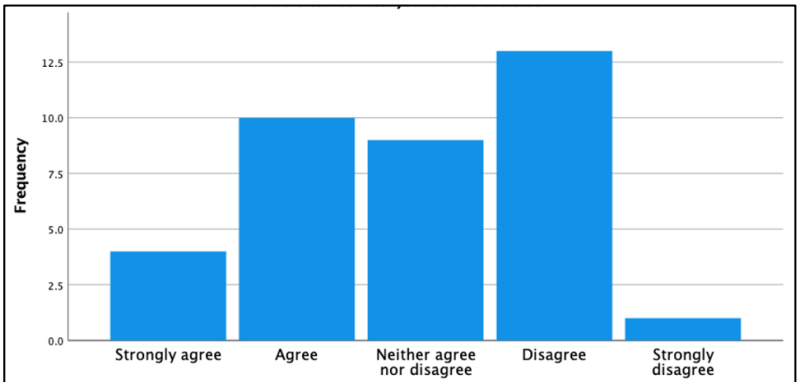

Figure 2: Work-Life Balance Barrier

**Access to Care.** Regarding access to care, most survey responders endorsed the perception that rural areas do not have the resources to support the training of incoming providers. Item 13 (Figure 3), a barriers question, asks respondents how much they agree or disagree with the following statement, "rural

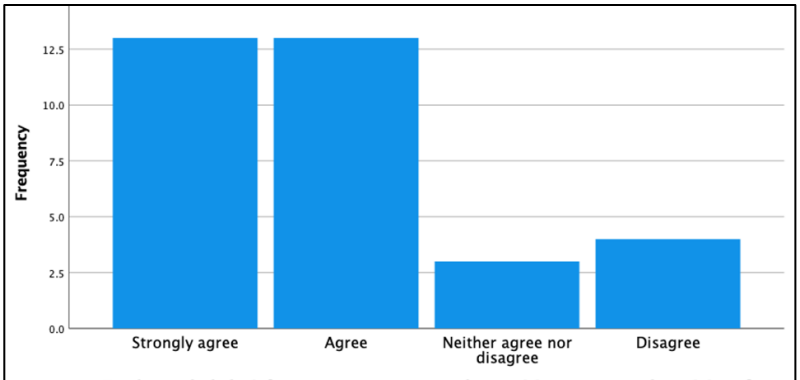

Figure 3: Access to Care Barrier

areas lack the infrastructure, resources, and supervision to support the training of new service providers". Nearly 60% of respondents reported strongly agreeing or agreeing with the statement that "rural areas lack the infrastructure, resources, and supervision to support the training of new service providers." This appears to be a perceived negative consequence of working in rural areas; the implications of this being that those in the field do not feel that they can support having new professionals coming into the community. This perception comes with significant implications: If prospective mental health providers believe that they will not get the training needed to practice, then it could deter them from considering a rural practice, thus further limiting the access of care to rural communities.

**Rural Lifestyle/Experience.** Although participants generally agreed that rural areas are isolating (Item 18), participants perceived that an enabler to rural practice is feeling like part of a community. Item 19 (Figure 4), an enablers question, exemplifies this by showing that 43.6% of responses either agreed or strongly agreed with the statement, "in rural areas, it is easier to feel like part of the community than in urban areas". Participants feel that rural areas can provide a sense of community and connection that urban areas may not be able to achieve. The smaller population size in rural areas could be a reason respondents may feel a sense of community.

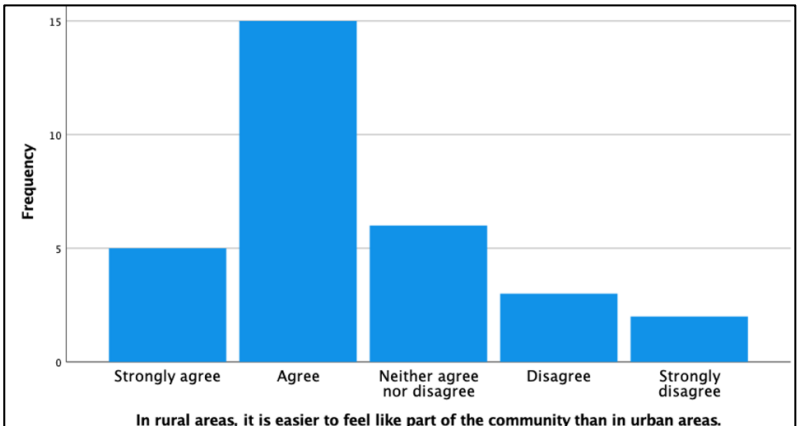

Figure 4: Rural Lifestyle/Experience Enabler

**Financial.** Participants mostly disagreed with the fact that rural employers were willing to offer student loan debt-relief. As an enabler question, Item 27 (Figure 5) showed that 21.7% disagreed and 10.9% strongly disagreed with the statement, "many rural employers are willing to offer student loan debt relief," while only 4.3% agreed and 4.3% strongly agreed. However, based on our literature review, there are some communities that do offer such relief. In addition, considering the extra time in school required for many mental health professionals, offering student loan relief could go a long way to encourage practitioners to work in a rural area.

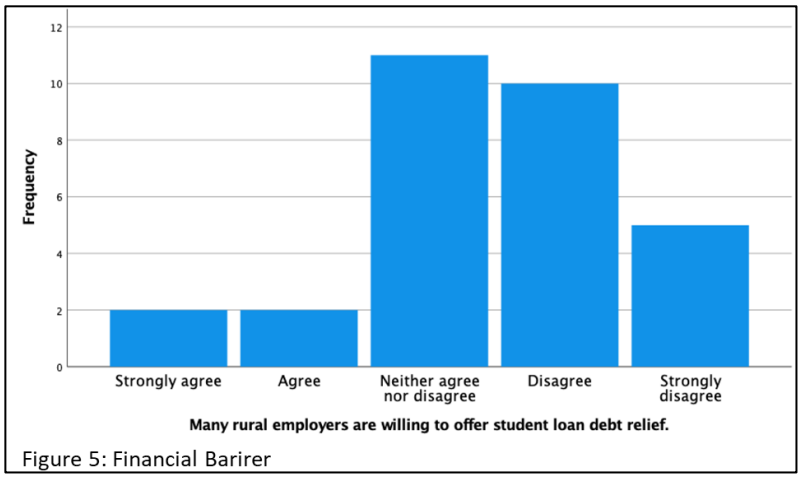

Figure 5: Financial Barirer

**Professional Feelings/Experience.** A big part of the previous research suggested that rural education, training, and experience is needed to bring in more rural practitioners (Richards et al., 2005; AMA, 2019; Smith, 2005; Ludwig et al., 2018). Item 32 (Figure 6), an enabler question, looks at how strongly a respondent believes that "school curriculum should include rural training." Almost twenty percent of

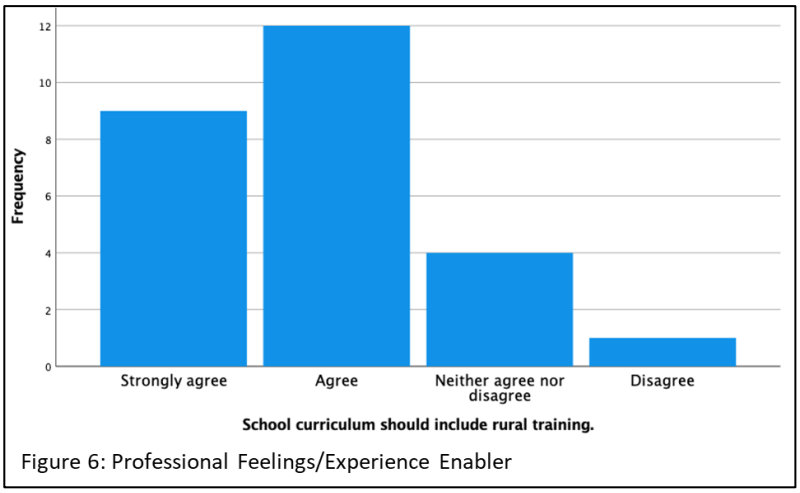

Figure 6: Professional Feelings/Experience Enabler

respondents reported that they strongly agreed with this statement and 26.1% reported that they agreed. Respondents endorse schools implementing rural training in their curriculum. The consensus seems to be that including rural training and experiences in schools can help professionals be more prepared to work in rural settings. Additionally, it can give future professionals a foot in the door to rural practice that could help encourage them to start practicing there.

**Assumptions**

A major assumption from this study is a connection between thoughts on rural practice and identified barriers and enablers. Because a respondent agrees or disagrees with an item in the instrument does not necessarily mean that it is an identified barrier to rural practice; this could instead be an opinion they have of rural practice, but it may not be a consideration for them when looking into rural practice. Future research should investigate how these perceptions of rural practice correlate to identified barriers and the choices practitioners make regarding where to practice.

**Limitations**

There were a few limitations to this study that need to be considered for future research. Firstly, the response rate was low; while we do not know how many individuals received the survey through the listsrv, we do know that 500 ACA members were emailed the survey. Seventy-eight emails were not delivered based on notifications through the email system. This affects the generalizability of the data and future research should attempt to generate a larger sample size. Additionally, this instrument was presented as a survey, where individuals could self-report their perceptions. Findings from self-report, especially in combination with a small sample, must be considered with

caution. While individuals' own experiences are incredibly important, researchers need to remember that not every rural area is experienced the same way.

## Discussion

### Research Question 1: Scale Development

First, researchers examined scale reliability and conducted an initial item analysis. There were not enough respondents to perform a factor analysis. While the full scale (n=43) reliability was high (.815), two of the subscales fell below the desired .70 threshold. This included the group of items designed to measure financial considerations and the items designed to measure professional feelings/experiences. It is not unusual for scales with a small number of items, such as the workload scale (n=4) to have lower reliability. Adding items is often a strategy for increasing reliability. However, the low functioning of item number 29, which is negatively correlated with the other financial items may be impacting the reliability of the subscale. In addition to adding items to the financial scale, item number 29 may need to be removed or re-written. The professional feelings and experiences scale, with 13 items, should have enough items to show a higher reliability if the scale's items measure the same construct. A more extensive review of these items is needed to determine how to best modify the scale. While some items, such as number 36, do not appear to be contributing to scale reliability, there are many items on the scale which are.

### Research Questions 2 & 3: Barriers and Enablers

Next, researchers assessed which factors are considered barriers versus enablers to practicing in rural areas. Results from this study showed that the perception of an unsatisfactory work-life balance in rural areas is not as agreed-upon in the general

population as previous literature suggests. This can conclude a tentative assumption that work-life balance is not a significant barrier or enabler rural mental health practice. On the other hand, when looking at access to care, respondents generally agreed that rural practices have difficulty in providing resources for more professionals to move to a rural area. This seems to be an identified barrier for professionals; believing that an organization will not have the resources to support them will likely encourage practitioners to shy away from rural areas. Another barrier is the belief that rural areas do not provide student loan debt relief. This seems to be a considerable barrier, as few respondents believed that rural employers will offer debt relief.

Identified enablers appear to be those in reference to rural communities and education. Professionals see the community aspect of rural culture to be an incentive to move to a rural area. Those that are considering a rural area may benefit from the fact that rural areas appear to make one feel like one is part of a tight-knit community. Additionally, professionals find that adding rural training and curriculum into university programs would be incredibly beneficial for mental health trainees to get their foot in the door to the rural experience.

**Next Steps**

While the researchers have presented some initial findings, there is still considerable work to be done to fully examine the collected data. Researchers must examine the rest of the data in order to identify other possible barriers and enablers to rural practice. In addition to further examining the responses to each of the items administered, the researchers will also examine the data by conducting crosstabs that allow for the data to be disaggregated by variables such as training location (urban vs

rural) and current work location (urban vs rural). This can give researchers information on what urban professionals perceive versus what rural professionals actually experience. Additionally, it can tell researchers how many of those who have received rural training actually ended up practicing in a rural area.

## Implications, Recommendations, and Conclusions

### Implications

#### *Recommendations for Practice*

Implications for counselor education and employers are preliminary based on a review of overall responses to the survey items and will be refined when a more in-depth analysis is completed (see *Next Steps* above). For example, rural employers may need to examine their transparency with potential employees regarding resources and incentives. Clearly (Items 13 and 27) practitioners do not believe that rural practices have the resources to maintain adequate staffing, which is an identified barrier to rural practice. However, some rural practices do have these incentives (Clayton, 2019); employers must ensure that this asset is highlighted. Rural employers should work towards ensuring their employees feel taken care of, especially in rural areas where support may be limited. Additionally, employers should try to mitigate identified barriers so that their practice looks more appealing to current and future practitioners. Barriers such as a lack of support can be lessened when highlighting support resources within the practice and in the community.

Based on this study as well as previous research, it is suggested that universities implement rural training or offer rural experiences during their graduate programs. Practitioners with rural knowledge can better adapt to rural practices, which may help

combat other barriers to rural mental health practice (Richard et al., 2005; Smith, 2005; AMA, 2019). In the current study, respondents supported the need for schools to include rural training as evidenced by Item 32 discussed above.

### *Recommendations for Future Research*

Further research is required to continue to work on the instrument. The next steps of research would be to conduct a factor analysis in order to further examine the structure of the instrument. This will require further data collection because of the low number of respondents in the current study. A qualitative follow-up is also needed in order to provide more information on what is considered an identified barrier/enabler compared to something that does not feel as important for them to consider. Qualitative results could give researchers a more in-depth understanding of what mental health practitioners are really looking for when deciding where to work. This is especially true for professionals who are already settled in one location but may consider moving to a rural area.

## Conclusion

Rural communities are suffering from the shortage of rural mental health professionals. With the data gathered from this study and existing literature on health practitioners, researchers have concluded that having rural training or experience is one of the crucial factors for practitioners to consider working in a rural area. Additionally, mental health practitioners value the importance of feeling like part of a community. Rural employers are encouraged to work towards being transparent with prospective employees about any possible loan relief or financial support that would incentivize a practitioner to move to a rural community. More research is necessary; there is currently

nothing in the literature that examines barriers to rural practice in regard to mental health professionals. Additional research is critical to take a more in-depth examination of the data and continue to build to the literature. Once rural employers have a better understanding of what common barriers are keeping professionals away from rural areas, they can start to work towards overcoming these hurdles.

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## Appendix A

### Barriers to Rural Practice Instrument

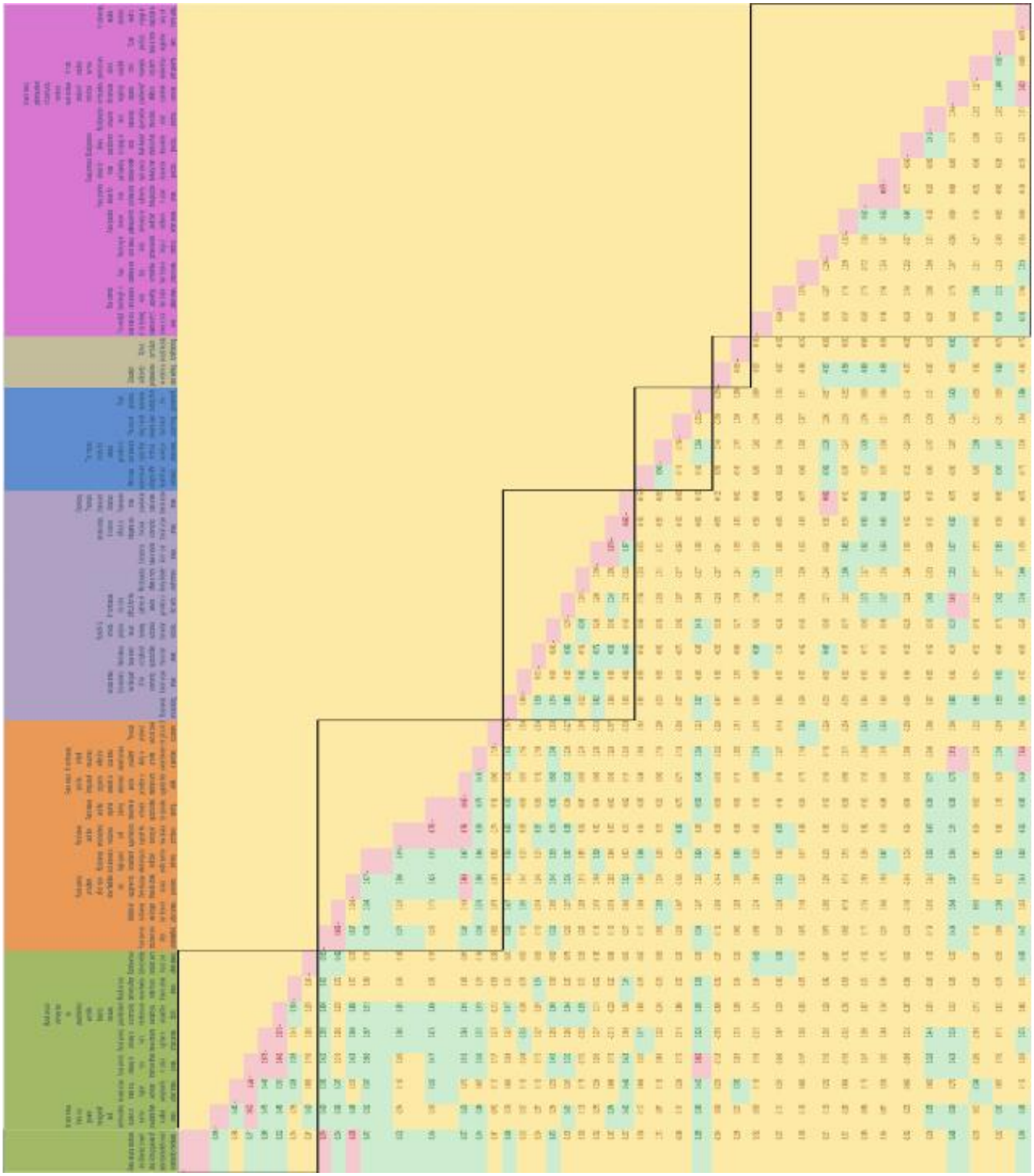
*Questions were asked on a 5-point Likert scale ranging from "Strongly Agree" to "Strongly Disagree":*

1. Rural service providers are often tied to work due to long queues of patients/clients/in need community members.
2. In rural areas there is a greater managerial and administrative burden on service providers than in urban areas.
3. In rural areas there is a higher workload compared to urban areas.
4. Rural service delivery is more intensive than in urban areas.
5. Rural service delivery is more time-consuming than in urban areas.
6. Rural service delivery has an unsatisfactory work-life balance because patients/clients/community members can contact you around the clock.
7. Rural service delivery offers more flexible work hours than in urban areas.
8. Rural service delivery offers reduced work hours over urban areas.
9. Rural service providers are often understaffed.
10. Waitlists in rural areas are longer than those in urban areas.
11. Rural service providers often have older facilities and equipment at their disposal than do urban service providers.
12. Rural areas lack access to high-speed broadband which impacts workflow and/or service delivery.
13. Rural areas lack the infrastructure, resources, and supervision to support the training of new service providers.
14. Rural areas lack the regional training networks to enhance opportunities for specialist training.
15. Rural areas lack the integrated programs needed to allow rural service providers to maintain and upgrade their skills
16. In rural areas, limited resources within the local area impact service providers' ability to provide comprehensive services.
17. The rural practice I work at does not get a lot of exposure.
18. Rural areas are isolating.
19. In rural areas, it is easier to feel like part of the community than in urban areas.
20. Rural areas have fewer recreational opportunities than urban areas.
21. Rural K-12 schools produce lesser learning outcomes than urban schools.
22. In rural areas, it is more difficult for the partners of service providers to find work.
23. Rural practice offers a more family-friendly environment.
24. It is hard to have a social life in rural areas.
25. In rural areas, it is more difficult to integrate into the local community than in urban areas.
26. Secondary Traumatic Stress and Vicarious Trauma are more prevalent in rural areas than in urban areas.
27. Many rural employers are willing to offer student loan debt relief.

28. The median income for service providers in rural areas is higher than for those working in urban areas.
29. The cost of living in rural areas is lower than that of urban living.
30. Rural practices need more funding from the government.
31. Education sufficiently prepared me for work in a rural setting.
32. School curriculum should include rural training.
33. The contract term was one of the defining reasons why I chose a rural area.
34. The contract term/length in rural areas is more appealing than that in urban areas.
35. Rural positions are less competitive than those in urban areas.
36. Practicing in rural areas limits professionals' range of practice.
37. Rural practice is more patient/client/community-focused than practice in urban areas.
38. Rural practice allows for greater professional autonomy than practice in urban areas.
39. Rural practice allows for more participatory decision-making in service delivery than does urban practice.
40. Rural practice allows practitioners to engage in more team-based practice than does urban practice.
41. Rural practice allows for more leadership opportunities than does urban practice.
42. In rural areas, patients'/clients'/community members' need to travel outside of their local communities for services negatively impacts practitioners' ability to coordinate services.
43. In rural practice, service providers are able to establish more meaningful, long-term relationships with patients.
44. Rural practices have a more supportive team.
45. In rural areas, service providers need to engage in long trips to carry out home visits.

# Appendix B

## Item Correlation Matrix



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