The Current Landscape of Rural, Remote, and Frontier Mental Health in America

Rural Characteristics that Affect Mental Health and Help-Seeking

- **Resilience:** Rural communities often demonstrate strong resilience, often shaped by histories of inequity. They thrive through interconnectedness, resource sharing, local agency, partnerships, and civic engagement.[1,2]
- **Cultural Barriers**: Stoicism (i.e., emotional control in the face of challenges), self-sufficiency, and mental health stigma can create reluctance to seek care and emotional suppression.[3]
- **Community:** Relying on community coping methods (e.g., culture, faith, family) can serve as a source of support for some rural residents or limit emotional expression and help-seeking for others.[4]
- **Access**: Geographic isolation, transportation, provider shortages, and broadband gaps reduce healthcare access.
- **Economic & Social Strain**: Rural populations may experience high poverty, unemployment, and exposure to trauma (e.g., accidents, disasters), alongside cultural mismatches between rural values and providers.

Population Statistics

Medicaid: 40.6% of children and 18.3% of non-elderly adults in rural areas were enrolled in Medicaid or Children's Health Insurance Program, exceeding rates in metro areas.[7]

Food Insecurity: In 2023, 15.4% of rural households experienced food insecurity and 84% of the highest-child-hunger counties are rural.[8] Access to food banks and food stamps and reducing food deserts are crucial.

In 2023, **22.7%** of nonmetropolitan* adults reported having any mental illness and 4.8% reported having serious thoughts of suicide during the year.[5]

In 2023, **4.8%** of nonmetropolitan adults reported having serious thoughts of suicide.[3] Rural youth are twice as likely to die by suicide.[6]

Poverty: In 2023, 15.3% of rural residents lived below the poverty line compared to 12.0% in metro areas. Poverty rates were highest for children 5 and younger at 20.9%.[9]

Uninsured: In 2022, 10.6% of rural residents under 65 were uninsured, compared to 9.4% in metro areas[10].

Primary Care: Rural patients who need mental health services typically see their primary care provider first.[11]

Religion: About 54% of rural Americans identified as Christian in 2023, similar to metropolitan areas, while 36% reported no religious affiliation.[12]

Population Health Considerations

Intersecting Identities	Rural residing individuals hold overlapping identities and serve in multiple community capacities, that often impact personal, professional, and community roles.
Invisibility	Mainstream approaches dominate medical, social welfare, and mental health treatment. Cultural variants exist in rural communities and are often marginalized or invisible.
Race & Ethnicity	One size fits all psychology approaches are common and minimally effective without adaptation or cultural modifications to fit the unique needs of minoritized racial and ethnic identities.
Tribal Communities	Rural tribal communities are close-knit, land-connected groups with unique cultures, self-sufficient economies, and communal social structures that require nuanced mental health support.
LGBTQ+	Rural LGBTQ+ people face heightened mental health challenges exacerbated by social isolation, stigmatization, and limited access to affirming healthcare services.[13]
Religion	Some rural residents find community and mutual support in religion, while others experience oppressive and assimilative measures. Non-Western practices also serve as sources of healing and spirituality.
Children/Adolescents	Social and environmental conditions impact mental health of youth (e.g. mineral extraction operations, poverty) that require access to Medicaid and other social welfare programs.
Older Adults	Access to programs, services, and peer support networks for rural older adults are limited.
Justice System-Involved	Law enforcement and the justice system are often used as interventions in schools and community settings, with mental health issues being misconceptualized as delinquency.

Mental Health Barriers

Workforce: Rural areas have just 15.8 psychologists per 100,000 people with retention limited by low pay, inadequate training, and contextual demands.[14]

Distance: Median drive time for mental health care is 26.2-30+ mins[15] though many areas have unique travel needs and higher transportation times (e.g., Alaska, Native reserves).

Cultural Humility: Rural providers often lack formal training, relying on supervision and case consultation.[16,17] Poverty and social class are rarely addressed in training.[18]

Insurance & Cost: Rural residents are more likely to be uninsured and forgo or rely on schools/communities for care, with one-third avoiding healthcare to prevent debt.[21,22] No-show rates are high rurally.[14]

Internet & Telehealth: 30% of rural areas lack reliable broadband, despite high telehealth interest.[23,24] Privacy is limited, with 14% of households having multiple people per bedroom.[15]

Education and Training

- **Telehealth Training**: Ensure urban-based clinicians understand rural-specific stressors and resource limitations when providing virtual care to rural communities.
- **Cultural Humility**: Equip providers with the skills to deliver culturally relevant care in rural settings.
- **Rural-Focused Education**: Develop curricula for trainees that highlight rural identities and experiences.
- **Policy & System Knowledge**: Educate providers on policies, funding, and systems that affect rural populations.
- **Ongoing Learning**: Highlight rural-focused resources and continuing education that are available through NARMH, RHIhub, Farm State of Mind, the NIHB, and more.

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*The Centers for Medicare & Medicaid Services defines nonmetropolitan as urbanized (i.e., 20,000-49,999), less urbanized (i.e., 2,500-19,999), and completely rural populations (i.e., <2,500).

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Suggested Citation

APA Committee on Rural Health. (2025). *The current landscape of rural, remote, and frontier mental health in America* [Factsheet].

Acknowledgements

Members of the Committee on Rural Health (CRH) developed this document in collaboration with APA staff. The workgroup included Tess M. Kilwein, PhD, ABPP (Chair); Christianne S. Connelly, PhD; Christine L. McKibbin, PhD; and Royleen J. Ross, PhD. The workgroup extends its appreciation to the APA staff members who facilitated its work, including Madeline Boening, Connie Galietti, JD; and Andrew Strickland, JD.