

THE RURAL HEALTHCARE LANDSCAPE SURVEY



A Behavioral Health Needs Assessment



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A NATIONAL BEHAVIORAL HEALTH NEEDS ASSESSMENT

The Rural Healthcare Landscape Survey: A National Behavioral Health Needs Assessment was designed by rural health researchers affiliated with Oklahoma State University. Results offer a snapshot of pressing concerns, access issues, and advantages associated with rural behavioral health practice. The survey was implemented with the aim of identifying ways the field of psychology can provide more targeted support, advocacy, and direct resources toward rural psychologists, patients, and clients. The team was led by Drs. Douglas Knutson, Mary Louise Cashel, and Cindy Juntunen and sought to identify both needed and desired support for rural and remote behavioral health providers. The entire survey took about 20 to 30 minutes to complete.

The team focused on recruitment of psychologists but opened the survey to participation from a broad range of behavioral health professionals. Inclusion criteria were: (a) age of 18 years or older, (b) provider of mental/behavioral/substance abuse support to rural community, (c) located in a rural community, and (d) ability to read and write in English.

A total of 437 participants completed part or all of the survey. Data were collected from June 2024 to June 2025, but 95% of responses were received between February and April. Research staff forwarded IRB-approved recruitment materials to professional organizations and behavioral health networks. Responses were received from providers in 46 of the 50 states and included participants from Hawaii and Alaska.

The survey was reviewed and approved by the Institutional Review Board at Oklahoma State University (IRB-24-473-STW) and included several components that were presented to participants in the order in which they are listed below:

1. A participant information form
2. A set of 35 questions about common rural dynamics that impact providers
3. A set of demographic questions
4. A series of optional standardized scales
 - a. Burnout: 16-item Oldenburg Burnout Inventory ([OLBI]; Halbesleben & Demerouti, 2005)
 - b. Quality of Life: Professional Quality of Life Scale (Stamm, 2005)
 - c. Social Support: Multidimensional Scale of Perceived Social Support ([MSPSS]; Zimet et al., 1988)
 - d. Self-Efficacy: Counselor Activity Self-Efficacy Scales ([CASES]; Lent et al., 2003)
5. A separate remuneration portal that presented participants with an APA store discount code and an opportunity to enter a drawing for APA merchandise

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Executive Summary

Participants were asked to indicate, “In the last 12 months, to what degree has the following factor impacted your provision of mental and/or behavioral health services to rural areas?”

Even though participants were able to indicate that a given item had “no impact” on their work, it appeared that respondents skipped items they did not believe applied to them. Therefore, items presented later in the survey (e.g., environmental crises) received higher response rates because they presumably applied to more respondents. Skip logic was employed for Medicare and Medicaid items such that participants could automatically skip those times if they did not apply to them. Data for all responses to the rural impact items are presented in Table 1.

Key Findings

Survey respondents were primarily white, heterosexual, cisgender, and identified as women. Thus, clients who hold historically marginalized identities and live rurally may experience difficulties accessing services from psychologists who share key identities with them.

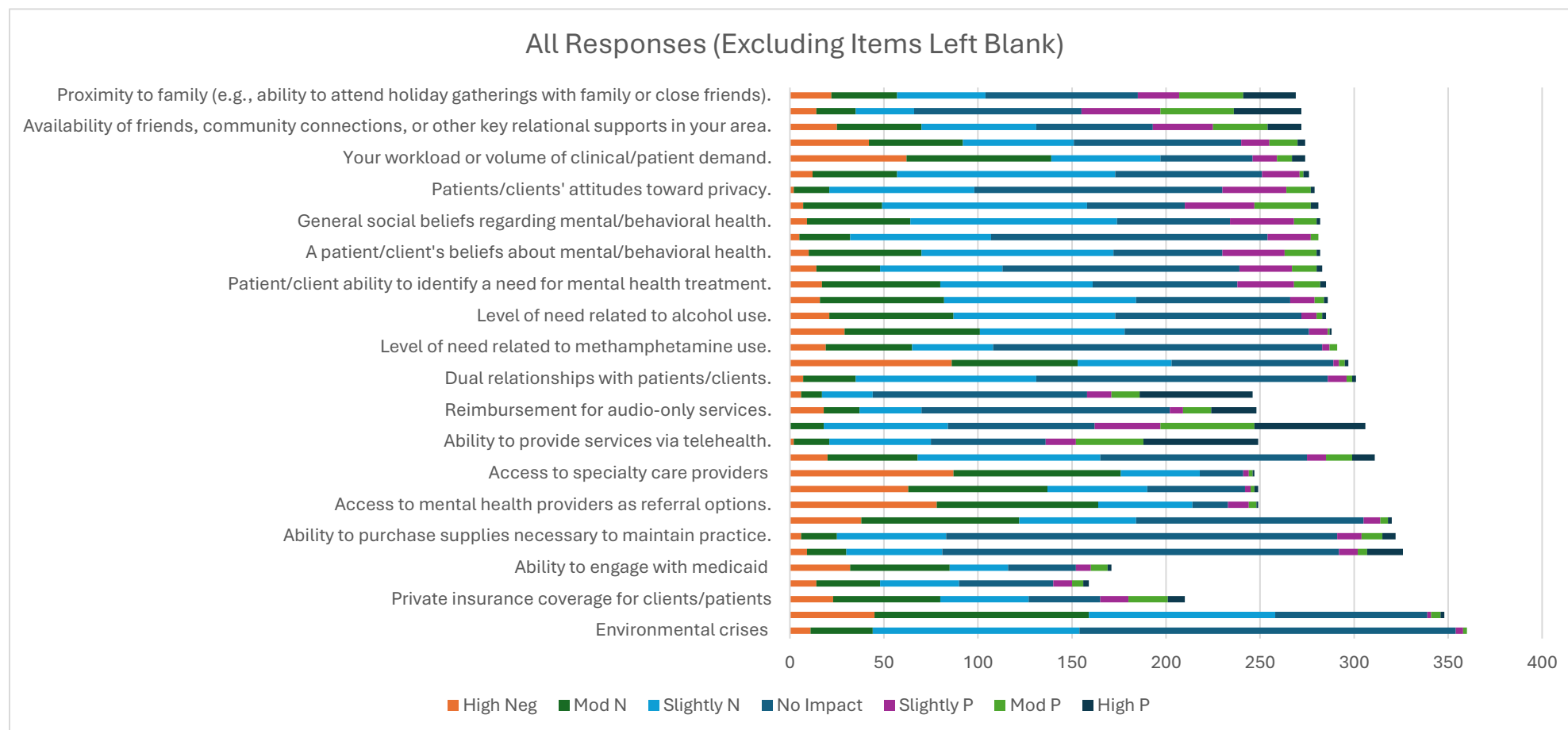
Most respondents had been licensed for a relatively short duration, and most participants denied or declined to answer the question about board certification. Lack of training and experience are not primary indicators of competence with rural populations but may indicate a need for specialized training in rural cultural competence.

Although teletherapy has increased access to more providers in rural areas, behavioral health services accessed by rural and remote residents may not be rural-based. In many cases, providers do not appear to live in the same locations as their clients.

Providers benefit from expanded opportunities to provide and bill for rural services, but that expansion may be impacted by current legislation and funding changes. For example, if reductions in the availability of federal funds leads to clinic closures and billing restrictions, rural service availability may contract.

Variables with the largest negative impact on rural service provision included elevated workloads, limited access to specialty services, emerging legislation, and the ability of clients to pay for services.

Table 1. Raw frequencies for core items that followed the prompt, “In the last 12 months, to what degree has the following factor impacted your provision of mental and/or behavioral health services to rural areas?” (N = 437)



Note: Items were presented in the order displayed in the table. Participants skipped some items.

Survey Demographics

Participants

Participants in this study ($N = 437$) reported an average age of 50 years ($Range = 20 - 87$). Respondents reported having held their first license for an average duration of 18 years and having served in their current rural-facing location for an average duration of 12 ($Range = 1-74$) years. We used a basic demographic form to collect information about age, race, ethnicity, sexual orientation, and aspects of participants' professional practice. Data related to key demographic domains are presented below.

Of the 237 providers who reported seeing clients in very rural areas (open countryside or rural towns), 92 (39%) reported that they did not live in very rural areas at all. A total of 171 providers reported serving clients in the open countryside, but only 21(12%) indicated that both they and their clients lived in the open countryside. A total of 237 reported that their clients lived in rural towns, but only 88 (37%) indicated that both they and their clients lived in rural towns.

Race, Ethnicity, and Gender Identity

The majority of the participants reported identifying as White (56%) and/or not Hispanic or Latino/a/e (~97%). This may be consistent with the demographics of many rural areas, but it has key implications for rural care.

Table 1. Race ($N = 437$)

Race	#	%
American Indian/Alaskan Native	6	1
Asian	8	2
Black/African American	2	.5
Native Hawaiian/Pacific Islander	1	.2
White	244	56
Multi-Racial	7	2
Hispanic and/or Latino/a/e	14	3
No Answer	171	39

Note. Participants could select multiple options. Percentages do not sum to 100%.

Table 2. Gender Identity ($N = 437$)

Gender Identity	#	%
Woman	193	44
Man	65	15
Nonbinary	6	1
Self-Identified	3	1
No Answer	170	39
Identify as Trans?		
Yes	4	1
No	259	59
Decline/No Answer	174	40
Identify as Intersex?		
Yes	1	.2
No	258	59
Decline/No Response	178	41



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Profession

Consistent with the targeted recruitment of psychologists, reported being licensed as psychologists at the doctoral level (70%) and most participants reported providing psychological services to rural areas (46%). The second largest group of respondents reported providing mental health counseling (18%) and and/or were licensed at the master's level (15%) or students (6%).

Table 3. Profession (N = 437)

Profession	#	%
Psychological Services	202	46
Mental Health Counseling	80	18
Social Work	20	5
School Counseling	9	2
Psychiatry	8	2
Public Health	9	2
Peer Support Specialist	7	2
Supervision	59	14
Alcohol & Drug Counseling	22	5
General Community Support	22	5
Practicum/Internship	26	6
Other	39	9
No Response	167	62

Table 4. License (N = 437)

License	#	%
Doctoral-Level Psychologist	187	43
Master's-Level Psychologist	9	2
Psychologist Certification	1	.2
Licensed Professional Counselor	18	4
Licensed Clinical Social Worker	14	3
Medical Field	4	1
Student in License-Eligible Field	14	3
Other/Unlicensed	20	5
No Response	170	39

Table 5. Board Certification (N = 437)

Board Certified	#	%
Yes	77	18
No	192	44
No Answer	168	38



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Regional Data

Location Data

Client and provider locations may differ. Providers were allowed to select more than one practice location, making a direct comparison between client location and provider location difficult. Location data are provided, side-by-side, to facilitate comparisons of frequency-based, general dynamics.

Table 6. Client Location (N = 437)

Client Location	#	%
Open Countryside	171	39
Rural Towns	237	54
Small Urban Areas	178	41
Large Urban Areas	123	28
Metropolitan Areas	58	13
No Answer	187	43
Client Region		
Frontier	63	14
Mountainous	89	20
Forestry-Based	53	12
Agricultural	191	44
Mining	43	10
Coastal	35	8
Do Not Live in a Rural Area	7	2
No Answer	192	44

Table 7. Provider Location (N = 437)

Provider Location	#	%
Open Countryside	29	7
Rural Towns	96	22
Small Urban Areas	88	20
Large Urban Areas	56	13
Metropolitan Areas	18	4
No Answer	192	44
Provider Region		
Frontier	16	4
Mountainous	28	6
Forestry-Based	15	3
Agricultural	67	15
Mining	11	3
Coastal	12	3
Do Not Live in a Rural Area	8	2
No Answer	329	75



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Consultation and Collaboration

Participants were asked to indicate how frequently they have the opportunity to consult with other providers and which providers they most recently contacted. The researchers wanted to know how accessible other providers are, given the resource deserts and dearth of specialty providers that rural locations may include. For the most part, participants indicated weekly contact with other providers both in-person and remotely.

Table 8. Provider Consultation (N = 437)

Provider Consultation	Not at All	Weekly	Monthly	Annually	As Needed	No Answer
Psychologists In-Person	48	76	35	22	65	191
Psychologists Remotely	31	72	47	5	90	192
Other Licensed Providers In-Person	29	103	26	10	77	192
Other Licensed Providers Remotely	25	76	36	2	106	192



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Standardized Scales

After the main survey, participants were allowed to opt into additional survey questions. Participants who agreed to continue the survey were presented with the Professional Quality of Life Measure (ProQOL; Stamm, 2009), Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988), Counseling Self-Estimate Inventory (CSEI; Larson et al., 1992), and Oldenburg Burnout Inventory (OLBI; Halbesleben & Demerouti, 2005). A total of 288 participants declined to continue the survey or dropped out after answering only a few questions and were deleted listwise. An additional 8 participants completed less than 70% of the ProQOL before dropping out of the survey and were also deleted listwise. Additional information about sample sizes and missing data are provided with results from each scale, below.

Professional Quality of Life (ProQOL)

Participants ($N = 141$) who completed the ProQOL (Stamm, 2009) and endorsed moderate-to-high levels of compassion satisfaction ($M = 41.74$; $SD = 5.45$), low-to-moderate burnout ($M = 21.64$; $SD = 5.35$), and low secondary traumatic stress ($M = 19.80$; $SD = 5.04$). According to Stamm (2009), the cutoffs for ProQOL are a score of 22 or less (*low*), a score between 23 and 41 (*moderate*), or a score of 42 or more (*high*). There were no missing data for the ProQOL.

Social Support

A total of 141 participants completed the MSPSS (Zimet et al., 1988) and endorsed an average level of social support in the upper range of the scale ($M = 5.81$; $SD = 0.94$; Range = 1 – 6). Two data points were missing at random and were addressed using mean imputation.

Self-Estimate/Self-Efficacy

A total of 125 participants completed the CSEI (Larson et al., 1992) and endorsed an average level of self-efficacy above the scale midpoint ($M = 166.94$; $SD = 18.24$; Range = 37 – 222). Sub-scale results are reported in Table 9. Four data points were missing at random and were addressed using mean imputation.

Table 9. Self-Efficacy Sub-Scales ($N = 125$)

Sub-Scale	<i>M</i>	<i>SD</i>	<i>Range</i>
Microskills	49.25	5.83	12-72
Process	47.24	7.73	10-60
Difficult Behaviors	32.27	4.96	7-42
Cultural Competence	19.53	2.83	4-24
Awareness of Values	18.66	2.78	4-24



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Burnout

A total of 125 participants completed the OBI (Demerouti, 1999) and endorsed an average level of burnout above the scale midpoint ($M = 34.57$; $SD = 7.72$; Range = 16 – 64). Disengagement sub-scale results indicated lower levels of burnout-related disengagement ($M = 16.34$; $SD = 3.71$; RANGE = 8-32) as compared to exhaustion-related sub-scale results ($M = 18.22$; $SD = 4.57$; RANGE = 8-32). One participant skipped three data points that were addressed using mean imputation.



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Future Research

The present report provides data from the first, national, rural needs assessment conducted by this research team. It provides key insights into rural health care dynamics that the researchers hope to extend longitudinally via future annual or bi-annual surveys. This report is not exhaustive and seeks to represent broad trends in the data.

In the future, researchers may benefit from exploring:

- Depth and breadth of provider training. Rural care is, in many respects, a specialty area. If many rural providers are located in urban areas, researchers may benefit from exploring whether those providers have received specialized training (didactic and experiential) with rural populations. It may not be enough just to increase access to providers if those providers are not prepared to meet the unique needs of rural patients and clients in specific regions.
- Needs of providers in specific geographical areas. For the present study, participants were able to select multiple practice sites, making it nearly impossible to disaggregate which barriers and benefits reported by participants are specific to a single region (e.g., remote, mountainous). In future surveys, the researchers may ask for a primary region to facilitate more granular analyses of regional differences.
- Workload and burnout are clear trends in the data. Researchers may benefit from further exploring how rural providers manage burnout and large workloads. Policy makers and advocates may benefit from exploring ways to address provider burnout and workload issues.
- Diverse sampling may be foregrounded in future studies. Researchers may benefit from deeper insights into the experiences of providers with marginalized identities. Policy makers and advocates may benefit from exploring ways to increase representation of marginalized psychologists in rural areas.



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Resources

American Psychological Association Rural Health Page
<https://www.apa.org/topics/rural-populations>

National Rural Health Association
<https://www.ruralhealth.us/>

Rural Health Information Hub
<https://www.ruralhealthinfo.org/>



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