PRACTICE BRIEFS

American Counseling Association
counseling.org

Counseling Rural Populations

Contributors: Logan McCarthy, Candace McLain, and Jeff McCarthy

ABSTRACT: Rural mental health counseling in the United States faces significant challenges related to access, workforce shortages, stigma, and cultural factors, despite comparable and sometimes higher rates of mental illness across rural and urban populations. Approximately 60 million individuals reside in rural communities where barriers such as geographic isolation, limited provider availability, poverty, and reduced access to insurance and technology hinder service delivery (American Psychological Association [APA]; Committee on Rural Health, 2025; Shora et al., 2023). Effective counseling in these settings requires culturally responsive and contextually grounded assessment practices, integrated primary care and behavioral health, expanded telehealth services, and advocacy. Ongoing efforts in education, creating policy, and community engagement are vital to ensuring equitable, accessible, and effective mental health services in rural communities.

Introduction

Approximately 60 million people live in rural communities across the United States, where multiple factors shape the delivery and effectiveness of mental health counseling (Shora et al., 2023). Professional counselors can work to acknowledge and address barriers to mental health care in rural settings. These include heightened stigma around seeking mental health services, cultural values emphasizing independence and self-reliance, differences from urban and suburban cultures, and varying levels of access to technology and telemental health (TMH) services (Mental Health America, n.d.).

Additional barriers to accessing mental health counseling in rural communities include workforce shortages. Rural areas have approximately 20% fewer primary care providers than urban regions, and nearly 65% of rural U.S. counties lack a psychiatrist, while 81% do not have access to a psychiatric nurse practitioner (Mental Health America, n.d.). Mental health illness is relatively similar in rural communities as urban areas; however, available services and access to these services are different in rural communities. Those in rural areas typically travel longer to access services, and often shortages exist for qualified mental health providers. The cost of mental health services is often too great for those in rural communities as many live in poverty and have limited access to insurance. In fact, most have either Medicaid or Medicare due to living in poverty or often being older as the average age in rural communities is higher than other locations (Rural Mental Health, 2026). There is also difficulty accessing mental health services in rural communities as many know each other, and this promotes feeling a stigma to access helpful and timely services.

Most rural communities that face the greatest shortages in mental health resources are also those with the highest levels of need. In fact, the Health Resources and Services Administration (HRSA; n.d.) noted more than 4,000 shortage areas in the rural United States and that close to 2,000 counselors would be needed to fill these gaps. A noted approach to help expand mental health counseling in rural

areas would be to increase the use of telehealth counseling and provide incentives for qualified mental health counselors to work in these areas.

Assessment Strategies

Assessment in rural counseling begins with defining key constructs, including client characteristics, case conceptualization, and collaboratively established treatment goals (Johnson et al., 2024). Counselors and clients must agree on goals, as this shared understanding establishes baseline functioning and guides outcome measurement. Aligning interventions with client-identified goals is essential for tracking progress and evaluating treatment effectiveness.

Rural assessment requires attention to cultural, contextual, and systemic factors. Intersectionality in rural settings reflects layered identities shaped by geographic isolation and limited resources. In addition, suicidality is a critical concern, as suicide rates remain disproportionately high in rural populations (Prazak et al., 2025). Additional challenges include stigma around mental health, limited-service access, dual relationships, and confidentiality concerns, all of which can impact client disclosure and assessment validity (Palomino et al., 2023). Although the *ACA Code of Ethics* (American Counseling Association [ACA], 2014) permits dual relationships under certain conditions, counselors must carefully weigh risks, maintain objectivity, and prioritize client well-being.

Assessment practices must reflect community norms such as self-reliance, faith traditions, and resource scarcity. In TMH contexts, counselors should take additional precautions in regard to assessing, including the need to confirm the client's location and local emergency resources at each session. Standardized screening measures, including the Patient Health Questionnaire–9 ([PHQ-9]; Kroenke et al., 2001), Generalized Anxiety Disorder–7 ([GAD-7]; Spitzer et al., 2006), Alcohol Use Disorders Identification Test ([AUDIT]; Saunders et al., 1993), Columbia-Suicide Severity Rating Scale ([C-SSRS]; Posner et al., 2011) and posttraumatic stress disorder symptom checklists (Weathers et al., 2013), are commonly used in rural counseling settings. However, standardized measures should be supplemented with clinical interviews and contextual inquiry to capture rural-specific stressors such as isolation, transportation barriers, and limited healthcare infrastructure (McVay et al., 2025).

Tools like the Assessment of Patient Experience Questionnaire help evaluate perceived quality, communication, and satisfaction (Pettersen et al., 2004). Ongoing progress monitoring using measures such as the PHQ-9, GAD-7, C-SSRS (Posner et al, 2011), and OQ-45 supports identification of improvement or stagnation (Lambert et al., 2004). In addition, safety planning is essential, particularly for high-risk clients. The 988 Safety Plan (Stanley & Brown, 2012) provides structured steps including warning signs, coping strategies, and support contacts, alongside referral to SAMHSA's (2024) 988 Lifeline.

Finally, client satisfaction surveys, interviews, and focus groups strengthen evaluation by incorporating client feedback on access, engagement, and effectiveness (Harkey et al., 2020; Serhal et al., 2020). Integrating collaborative goal-setting, standardized tools, and client-centered feedback allows counselors to conduct ethical, responsive, and effective assessments in rural contexts.

Scope of Practice

Defining scope of practice in rural counseling requires balancing ethical competence with the practical reality of functioning as a generalist in limited-resource settings. Rural counselors frequently address a broad range of concerns, including complex and co-occurring conditions, often serving as the only available provider (McVay et al., 2025). This role is further shaped by intersectional cultural dynamics that may both support resilience and present barriers to care. Counselors must demonstrate competence in working with diverse populations, including individuals who identify as LGBTQIA+, BIPOC, Latinx, Tribal, immigrant, Indigenous, and aging communities, many of whom experience systemic disparities, historical trauma, and challenges related to technology access and health care engagement (Ratts et al., 2016; Sue et al., 1992).

Effective rural counseling practice requires strong foundational clinical skills applied within a flexible generalist framework. Core competencies include the ability to establish psychological safety, maintain cultural responsiveness, ethically manage dual relationships, protect confidentiality, and implement prevention oriented and systems-based interventions. Structural barriers such as limited access to supervision, licensure constraints, and professional isolation increase the complexity of practice and necessitate intentional self-care, ongoing ethical decision making, and adaptive treatment strategies, including the use of TMH when appropriate (McCarthy et al., 2026).

Preparation for rural counseling extends beyond standard Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2024) training. Essential areas of competence include rural cultural and contextual awareness, ethical and legal decision-making, professional identity development, clinical flexibility and crisis response, and community engagement and advocacy (McVay et al., 2025). When integrating TMH, counselors must also demonstrate technological competence and assess client access to digital resources, and safe and private environments.

Professional training and credentials such as National Certified Counselor (NCC), Certified Clinical Mental Health Counselor, (CCMHC), and Board Certified Tele Mental Health (BC-TMH) establish baseline competence, while advanced training in trauma informed care, substance use treatment, telehealth, and integrated behavioral health enhances service delivery in underserved communities (National Board for Certified Counselors, n.d.). TMH introduces additional ethical and legal responsibilities, including licensure portability, Health Insurance Portability and Accountability Act (HIPAA) compliance, data security, and crisis planning. Overall, ethical rural practice requires specialized training, ongoing development, and careful attention to the unique legal, ethical, and contextual demands of rural settings (APA Task Force on Telepsychology, 2024).

Treatment Approaches

There are many available and beneficial treatment approaches to support those in rural communities. Some of these include integrating behavioral and mental health with primary care services and expanding the use of telehealth services (National Advisory Committee on Rural Health and Human Services, 2022).

There are some additional important considerations to consider when providing mental health treatment to those in rural communities. One common need is to recognize that most everyone knows each other in rural areas and this makes confidentiality even more important in these areas (Milden, 2025). This phenomenon enhances stigma of accessing mental health services and requires managing boundaries more so because both the counselor and client likely know the same people. Another consideration is that many must drive long distances to access treatment, and factors such as the cost of gas, weather, and the reliability of a vehicle can each impact being able to regularly access mental health treatment in rural areas (Milden, 2025).

The primary care behavioral integration model seeks to integrate medical and mental health services in one setting. This can be a rural community health center, or often rural schools will include a medical and mental health provider in the school (Rural Health Information [RHI) Hub, 2026). These integrated services include support for mental health and substance use, and a significant benefit of integrating medical and mental health services in a rural area helps to remove the stigma of accessing mental health services as these services are located in the same facility to access medical services.

Cultural and Ethical Considerations

Counseling in rural communities presents distinct ethical and cultural considerations compared to urban areas. Professional counselors should understand that many rural counties are often close-knit communities, and dual/multiple relationships may occur with the overlapping of professional and personal relationships (Palomin et al., 2023). When reviewing the *ACA Code of Ethics* (2014) standards,

there are numerous standards that would be applicable to rural area counselors, which include but is not limited to informed consent and client autonomy (Standard A.2.a.), managing and maintaining boundaries and professional relationships (Standard A.6.), multicultural/diversity considerations (Standard B.1.a.), confidentiality and privacy (Standards B.1.b & B.1.c.), and competence/scope of practice (Standard C.2.a.).

Confidentiality and privacy are major issues in rural communities, as these have been identified as barriers to seeking out counseling services because they are harder to maintain (McVay et al., 2025). Proper informed consent and respect for client autonomy are another essential ethical consideration with clients in rural communities, especially with the areas discussed above. Counselors should also recognize that even if they are the only, or one of the few, providers in a rural area, clients still have the right to begin, continue, or terminate counseling at any time (informed consent; Standard A.2.a.; ACA, 2014).

Professional counselors will want to utilize cultural responsiveness and recognize the rural identity of the rural communities they serve. The 2024 CACREP *Standards* require that counseling programs infuse diverse and multicultural counseling practices with marginalized populations (Standard 2.A.3.), and the *ACA Code of Ethics* (2014) identify that multicultural counseling competency is a requirement with all counseling approaches (boundaries of competence; Section C.2.a.). Rural communities present unique cultural norms, values, and identities that counselors should understand and integrate into their counseling practice to be effective and ethically focused providers.

Advocacy

The *ACA Code of Ethics* (2014) identifies advocacy as an integral part of a counselor's ethics and professional identity to address barriers and obstacles that prevent clients from accessing necessary services (Section A.7.a.). This is also supported by the 2024 CACREP Standards, too (Section 2.B.10.). There are many advocacy areas counselors in rural communities can focus on, but currently, there are two that we believe would aid in the increase and quality of care for rural populations. These include the use of TMH and ways to retain qualified, competent, and ethically focused rural counselors (McCarthy et al., 2026).

Rural Telemental Health

Since the start of the global COVID-19 pandemic in March 2020, TMH services continue to rise in the counseling profession (McCarthy et al., 2026; Nelson et al., 2023). Although TMH services have risen across the counseling profession, there is still more advocacy work that can be done to increase, improve, and implement TMH services in rural communities. Counselors want to focus on advocating at all levels to support the expansion and access of rural TMH (R-TMH) services, as this will help to increase the accessibility rural area counseling. The Counseling Compact involves states allowing licensed counselors to practice in other states without the need for a license in each state, and will help with the expansion of R-TMH and licensure portability (DeDiego et al., 2023). There are currently six states in the counseling compact with 32 other states and the District of Columbia having passed legislation and are working toward becoming part of the compact (Counseling Compact Commission, n.d.).

The continued expansion of TMH services into rural communities has created new opportunities to address long-standing barriers to mental health and substance use treatment (McCarthy et al., 2026; Watanabe et al., 2023). TMH modalities, including videoconferencing and talking, and require more specific effort by the client and mental health provider to ethically and legally connect and maintain an effective relationship (Watanabe et al., 2023). Despite these considerations, TMH services are convenient and help to reduce missed appointments and particularly wait times for clients in rural communities that seek mental health services (Butzner & Cuffee, 2021). TMH services can reduce stigma by allowing services in the client's home, reduce the need to travel long distances, and provide more culturally or specific care as providers can be accessed from further away in the same state. R-TMH

has the potential to improve access to mental health care while addressing many of the traditional challenges associated with rural service delivery (Butzner & Cuffee, 2021).

Counselor Retention

Although the expansion and increase of services in rural communities is important, it is essential to remember that there also needs to be qualified, competent, and ethically focused counselors to provide the services. Advocacy work to aid counselor retention in rural areas will want to focus on reducing burnout, increasing salaries, loan forgiveness, targeted rural counseling trainings, and proper and ongoing supervision, consultation, and support (Belansky et al., 2024; Jordan et al., 2024; McCarthy et al., 2026; McVay et al., 2025; Murphy, 2022). Counselors that feel competent, supported, and valued will not only assist with retention, but increase the quality of care provided to rural populations.

Conclusion

Improving accessibility and quality of counseling and supervision services in rural communities remains a critical priority within the profession. Rural counselors must navigate limited resources, reduced access to training and supervision, distinct ethical challenges, and culturally specific needs. By adhering to bestpractice standards and integrating ethical, culturally responsive approaches, counselors can strengthen service delivery and therapeutic relationships within closeknit rural communities. Ongoing advocacy, education, research, and community outreach are essential to ensure counseling services remain accessible, equitable, and responsive to the diverse needs of rural populations.

Resources

- **Board Certified-TeleMental Health Provider (BC-TMH)**, Center for Credentialing & Education
- **Counseling Compact**, Counseling Compact Commission
- **Telehealth resources**, Health Resources and Services Administration
- **Telehealth models for increasing access to behavioral and mental health treatment**, Rural Health Information Hub
- **Telehealth for mental health services model**, Rural Health Information Hub
- **988 Suicide & Crisis Lifeline**, Substance Abuse and Mental Health Services Administration
- **Rural behavioral health: Telehealth challenges and opportunities**, SAMHSA
- **Safety plan**, SAMHSA
- **Telehealth for rural areas**, U.S. Department of Health and Human Services
- **The National Consortium of Telehealth Resource Centers**
- **Telehealth.org**

References

American Counseling Association. (2014). *ACA code of ethics*. **https://www.counseling.org/docs/default-source/default-document-library/ethics/2014-aca-code-of-ethics.pdf**

American Psychological Association Committee on Rural Health. (2025). *The current landscape of rural, remote, and frontier mental health in America*. **https://www.apa.org/practice/programs/rural/committee/landscape-fact-sheet.pdf**

American Psychological Association Task Force on Telepsychology. (2024). *Guidelines for the practice of telepsychology*. **https://www.apa.org/about/policy/telepsychology-revisions**

Belansky, E. S., Diaz Solodukhin, L., Edelman, A., Hobbs, S., Hazel, C., & Cutforth, N. (2024). Strategies to recruit and retain the rural school mental health workforce. *The Rural Educator, 45*(2), 32–43. **https://doi.org/10.55533/2643-9662.1375**

Butzner, M., & Cuffee, Y. (2021). Telehealth interventions and outcomes across rural communities in the United States: Narrative review. *Journal of Medical Internet Research, 23*(8), e29575. **https://doi.org/10.2196/29575**

Council for Accreditation of Counseling and Related Educational Programs. (2024). *2024 CACREP standards.* **https://www.cacrep.org/for-programs/2024-cacrep-standards/**

Counseling Compact Commission. (n.d.). *Counseling compact*. Retrieved June 3, 2026, from **https://counselingcompact.gov/**

DeDiego, A., Maurya, R. K., Rujimora, J., Simineo, L., & Searls, G. (2023). Counseling and the interstate compact: Navigating ethical practice across state lines. *The Professional Counselor, 13*(3), 177–192. **https://doi.org/10.15241/ad.13.3.177**

Harkey, L. C., Jung, S. M., Newton, E. R., & Patterson, A. (2020). Patient satisfaction with telehealth in rural settings: A systematic review. *International Journal of Telerehabilitation, 12*(2), 53–64. **https://doi.org/10.5195/ijt.2020.6303**

Health Resources and Services Administration. (n.d.). *Health workforce shortage areas*. Retrieved June 3, 2026, from **https://data.hrsa.gov/topics/health-workforce/shortage-areas/dashboard**

Johnson, K. F., Gantt-Howrey, Duyile, B. E., Robins, L. B. & Dockery, N. (2024). Career counselors addressing social determinants of mental health in rural communities. *The Professional Counselor, 14*(1), 1–14. **https://doi.org/10.15241/kfj.14.1.1**

Jordan, S. E., Hampole, S. R., Mackintosh, M.-A., Reyes, S. I., Eliason, K. D., Felker, B. L., & Shearer, E. M. (2024). Implementing efficient systems to monitor competency-based supervision in rural psychology training programs. *Journal of Technology in Behavioral Science, 9*, 26–34. **https://doi.org/10.1007/s41347-024-00384-z**

Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 606–613. **https://doi.org/10.1046/j.1525-1497.2001.016009606.x**

Lambert, M. J., Morton, J. J., Hatfield, D., Harmon, C., Hamilton, S., Reid, R. C., Shimokawa, K., Christopherson, C., & Burlingame, G. M. (2004). *Administration and scoring manual for the OQ-45.2 (Outcome Questionnaire)*. American Professional Credentialing Services L.L.C./OQ Measures, LLC. **https://www.scribd.com/document/241658786/OQ-Manual-pdf**

McCarthy, L., McLain, C., & McCarthy, J. (2026). *Rural telemental health counseling: Effective, ethical, and culturally competent approaches in the 21st century*. Kendall Hunt Publishing Company.

McVay, K. E., Romero, D. E., Prasath, P. R., & Leeth, C. (2025). Rural counseling competencies: A Delphi study. *Journal of Counseling and Development, 103*(4), 418–427. **https://doi.org/10.1002/jcad.70001**

Mental Health America. (n.d.). *Accessing rural mental health care*. **https://mhanational.org/rural/#accessing-rural-mental-health-care**

Milden, Z. (2025). *When everybody knows everybody: Mental health in rural communities*. National Council for Mental Wellbeing. **https://www.thenationalcouncil.org/mental-health-in-rural-communities/**

Murphy, J. (2022). Improving the recruitment and retention of counselors in rural substance use disorder treatment programs. *Journal of Drug Issues*, *52*(3), 434–456. **https://doi.org/10.1177/00220426221080204**

National Advisory Committee on Rural Health and Human Services. (2022). *Behavioral health and primary care integration in rural health faculties: Policy brief and recommendations to the secretary.* **https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/bphc-policy-brief-june-2022.pdf**

National Board for Certified Counselors. (n.d.). *Certified clinical mental health counselor.* **https://nbcc.org/certification/ccmhc**

Nelson, D., Inghels, M., Kenny, A., Skinner, S., McCranor, T., Wyatt, S., Phull, J., Nanyonjo, A., Yusuff, O., & Gussy, M. (2023). Mental health professionals and telehealth in a rural setting: A cross sectional survey. *BMC Health Services Research*, *23*, Article 200. **https://doi.org/10.1186/s12913-023-09083-6**

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**

Pettersen, K. I., Veemstra. M., Guldvog, B., & Kolstad, A. (2004). The Patient Experience Questionnaire: Development, validity, and reliability. *International Journal for Quality in Health Care*, *16(*6), 453–463. **https://doi.org/10.1093/intqhc/mzh074**

Pathman, D. E., de Saxe Zerden, L., Gingras, M., Seel, J., Fannell, J., & Lombardi, B. M. (2024). Preparing behavioral health clinicians for success and retention in rural safety net practices. *The Journal of Rural Health*, *40*(3), 509–519. **https://doi.org/10.1111/jrh.12824**

Posner, K., Brown, G. K., Stanley, B., Brent, D. A., Yershova, K. V., Oquendo, M. A., Currier, G. W., Melvin, G. A., Greenhill, L., Shen, S., & Mann, J. J. (2011). The Columbia–Suicide Severity Rating Scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults. *American Journal of Psychiatry*, *168*(12), 1266–1277. **https://doi.org/10.1176/appi.ajp.2011.10111704**

Prazak, M., Bacigalupi, R., & Hamilton, S. C. (2025). Rural suicide: Demographics, causes, and treatment implications. *Community Mental Health Journal*, *61*(1), 66–75. **https://doi.org/10.1007/s10597-024-01327-x**

Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development*, *44*(1), 28–48. **https://doi.org/10.1002/jmcd.12035**

Rural Mental Health. (2026). *Rural health information hub.* **https://www.ruralhealthinfo.org/ topics/mental-health**

Saunders, J. B., Aasland, O. G., Babor, T. F., de la Fuente, J. R., & Grant, M. (1993). Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption—II. *Addiction*, *88*(6), 791–804. **https://doi.org/10.1111/j.1360-0443.1993.tb02093.x**

Serhal, E., Kirvan, A., Sanches, M., & Crawford, A. (2020). Client satisfaction and experience with telepsychiatry: Development and validation of a survey using clinical quality domains. *Journal of Medical Internet Research*, *22*(9), Article e19198. **https://doi.org/10.2196/19198**

Shora, L., Friberg, E., Park, L. T., DeGennaro, R., Hinton, I., & Zarate, C. A., Jr. (2023). Assessing geographic disparities in mental health research participation. *Contemporary Clinical Trials*, *131*, Articl e107244. **https://doi.org/10.1016/j.cct.2023.107244**

Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine*, *166*(10), 1092–1097. **https://doi.org/10.1001/archinte.166.10.1092**

Stanley, B., & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice*, *19*(2), 256–264. **https://doi.org/10.1016/j.cbpra.2011.01.001**

Substance Abuse and Mental Health Services Administration. (2024). *988 suicide & crisis lifeline* [Resource]. U.S. Department of Health and Human Services. **https://www.samhsa.gov/resource/988/safety-plan**

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development*, *70*(4), 477–486. **https://doi.org/10.1002/j.1556-6676.1992.tb01642.x**

Watanabe, J., Teraura, H., Nakamura, A., & Kotani, K. (2023). Telehealth in rural areas: A systemic review. *Journal of Rural Medicine*, *18*(2), 50–54. **https://doi.org/10.2185/jrm.2022-059**

Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). *The PTSD Checklist for* DSM-5 *(PCL-5)*. National Center for PTSD, U.S. Department of Veterans Affairs. **https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp**

To Cite This Practice Brief:

McCarthy, L., McLain, C., & McCarthy, J. (2026, July). *Counseling rural populations* [Practice Brief]. Counseling Nexus. **https://doi.org/10.63134/GOKO4823**