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Mental Health & Human Resilience International Journal
ISSN: 2578-5095

Rural Interprofessional Workforce Development in Behavioral Health during COVID-19

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Research Article

Volume 8 Issue 1

Received Date: April 09, 2024

Published Date: May 09, 2024

DOI: 10.23880/mhrij-16000245

Abstract

Rural communities experience substantial disparities in behavioral health outcomes and a paucity of providers. Individuals in rural areas with behavioral health needs require specialty trained providers and digital tools to bridge the digital divide and improve access and hence outcomes. To meet this need, the authors implemented two federally-funded interdisciplinary workforce development programs to train emerging professionals in behavioral health for rural and medically underserved practice demands, and in this descriptive study the program implementation is reviewed in detail for potential replication in other rural areas. Needed program adaptations in response to the COVID-19 pandemic by pivoting to remote behavioral health training and iterative improvements were made to the digital application measuring individual trainee goals and knowledge translation. Program components and adaptations could be implemented in rural areas to decrease the digital divide between clients with rural behavioral health needs and their providers and to increase familiarity for social workers in providing digital interprofessional behavioral health.

Keywords: Rural; Social Work; Interprofessional; Behavioral Health; Outcome Measurement; Goal Attainment Scaling; Goal Scaling Solutions

Abbreviations: HRSA: Health Resources and Services Administration; CDC: Centers for Disease Control and Prevention; SBIRT: Screening Brief Intervention and Referral to Treatment.

Introduction

Rural Interprofessional Workforce Development in Behavioral Health

As behavioral health conditions, specifically opioid misuse, disrupt the lives of millions, the demand for competent behavioral health professionals is surging. This need is particularly evident in rural areas [1].

Rural areas require well-equipped professionals to serve in their communities as many individuals in rural communities face barriers in access to behavioral health services [2,3]. Furthermore, rural communities are likely to experience health professional shortages in physical and mental health, a specific focus of the Health Resources and Services Administration (HRSA) and other federal agencies [4]. Barriers to access and provider shortages combine to create a risk for poorer outcomes for individuals living in rural communities.

To combat the risk for poorer outcomes in rural communities, there is a need for training and tools that enhance communication between helping professionals

in practice or training to serve their clients and eliminate the barrier of place. Helping professionals, including social workers, occupational therapists, counselors, and peer support specialists, require training to prepare for competent practice and tools to perform said practice in rural settings. Training using evidence-informed methods, practice working within interprofessional teams, and familiarization with digital tools for practice yield substantial outcomes for emerging professionals in field placements [5,6]. Such prepared professionals with increased skills can provide better services for rural clientele and communities.

This article provides a descriptive analysis of the methods of implementing two programs which bridge the digital divide between people with rural behavioral health needs and providers through workforce development programs and a digital tool created to expand access to behavioral health and social work services for individuals in rural areas. The authors report on strategies employed to continue provision of workforce development programs during the COVID-19 pandemic, including delivery and training shifts and a digital tele-education tool that enabled a smooth transition to online workforce development. To conclude, the authors offer commentary on future development needs for the rural behavioral health workforce.

Rural America

The paradigm that rural areas are exclusively "rolling hills and farmlands" is a misconception [7]. Urban and rural areas are defined by population. A population of 50,000 or more is considered an urbanized area, while rural areas are defined as areas with a population under 50,000 [8]. By contrast, metropolitan areas are defined by county population, but over half (54.4%) of people living in rural areas are in metropolitan counties [7]. In addition to these population thresholds, density, land use, and distance are considered when understanding the nature of rural areas [9]. It is estimated that about 60 million people, or one in five Americans, live in rural areas [10]. When working in rural areas, behavioral health professionals must account for these areas unique needs, conditions, and circumstances. According to the Rural Health Information Hub, rural areas have disproportionately higher rates of suicide, geographic isolation, poverty, and unemployment and a disproportionate burden of chronic disease relative to other areas [7]. In addition, rural areas can have more cultural or social differences and their community members face increased stigma related to these differences when compared to urban areas [7].

Concurrently, rural areas often have poor infrastructure to address health needs, including a lack of public transportation, restricted access to health providers, and lower rates of health insurance coverage [4,7]. Though the need is great, rural areas often have a small health care workforce and a lack of specialty care providers, including a lack of sufficient behavioral health providers [4].

Conditions in rural communities often yield behavioral health needs. Adverse circumstances, such as high rates of child poverty, coupled with unreliable housing, may be predictors for mental health and substance use problems [11]. Structural and systemic inequalities that disproportionately impact people of color also impact rural residents of color, which results in a broadening of health disparities and poor outcomes for rural Black, Brown, and Indigenous people [12,13]. Substance use significantly disrupts individuals, family systems, and communities, and can be particularly damaging to rural communities due to limited treatment infrastructure and healthcare providers [14].

Among the behavioral health needs in rural areas, opioid use disorder is particularly apparent. The Centers for Disease Control and Prevention (CDC) found that there was a higher number of opioid prescriptions per capita in rural areas compared to urban areas when analyzing opioid prescription data from 2014-2017 [15]. The COVID-19 pandemic has only accelerated the opioid use disorder crisis, as opioid overdose deaths rose by 30.9% nationally in 2020 compared to 2019 [16]. This increase was highest in many primarily rural states, including overdose death rate increases in Vermont (64.7%), West Virginia (51.6%), and Kentucky (59.6%). As each state in the United States experienced increases in overdose death, rural states were especially hard hit due to the numbers of deaths as well as the lack of resources to treat opioid use and other behavioral health disorders [17]. The reported trends have serious implications for behavioral health needs in rural areas as social workers must be equipped to navigate these complex issues compounded by COVID-19 circumstances and barriers.

Rural Southwest Michigan

In this article, Southwest Michigan, a primarily rural area bordered by Lake Michigan to the West and Indiana to the South, is the area of interest. In many ways, the unique needs, conditions, and circumstances observed in rural United States are mirrored in Southwest Michigan [18]. When assessing this area, the following needs, conditions, and circumstances were present at higher rates than other parts of the region. Although there are two small metropolitan areas in Southwest Michigan, Kalamazoo with a population of 76,250, and Battle Creek with a population of 51,093 [19], the areas outside of these communities are primarily rural areas of the state and have many of the same poor outcomes as the rural areas surrounding them. For example, in Kalamazoo County, one of the counties in

Southwest Michigan, child poverty is in the 97th percentile of all US communities, and poverty amongst Black children hit a high of 74% in 2010, as this area was particularly hard hit by the job losses of the Great Recession [20]. Southwest Michigan, following this trend of child poverty, has some of the highest rates of homeless amongst school children in the state, at 7% in Kalamazoo schools, and 11% in Berrien Springs Schools in the rural portion of Berrien County [21]. Four counties in Southwest Michigan (Ottawa, Van Buren, Oceana, and Berrien) have the highest number of migrant and seasonal farmworkers statewide, typically engaged in fruit and vegetable employment, as well as dairy operations [22]. Migrant workers are more likely to be Hispanic and have Spanish as a first language. These complexities call attention to the often-diverse needs for rural residents, who may experience socioeconomic, racial, and linguistic barriers to accessing behavioral health services in addition to the barriers in transportation and other infrastructure common in rural communities.

Southwest Michigan has some of the highest rates of opioid overdose in the state, which has increased during the COVID-19 crisis. Even though the overdose rate throughout Michigan increased by 19.4% in 2020 compared to 2019 (CDC, 2021), during the same period, Southwest Michigan experienced an increase of twice that, 38% [23]. Even as opioid prescribing is decreasing in almost all communities in the US, rural communities still have disproportionately low availability of substance use and buprenorphine providers. There are only six buprenorphine providers to serve the 10 counties in Southwest Michigan [24]. In rural areas, unique needs, conditions, and circumstances intersect, compound, and amplify one another, which yields poorer outcomes and necessitates behavioral health services in response.

Need for Interprofessional Workforce Development

There is a clear necessity for interprofessional collaboration in behavioral health treatment, specifically the comprehensive way a multidisciplinary team is equipped to treat unique circumstances [25]. The presented needs require a response from highly trained professionals to serve rural areas. Social workers, counselors, peer specialists, and occupational therapists all individually and collectively play critical roles in that workforce, and can address principal concerns in rural areas, such as a shortage of behavioral health professionals and a lack of interprofessional [26,27]. Behavioral health professionals who receive training in generalist practice are particularly equipped for practice in rural behavioral health, as the generalist foundation prepares them to serve individuals, families, and communities with a variety of needs despite limited resources [28]. Acting as brokers, social workers and peer specialists specifically can also expedite interprofessional collaboration by linking clients to resources and creating treatment teams. Occupational therapist and counselors with competencies in rural behavioral health needs round out the treatment teams, in addition to nurses and physicians. Treatment teams are a bridge to interprofessional collaboration as they may consist of a variety of professionals working toward a common goal. Professionals with expertise in rural communities and culturally and linguistically responsive behavioral health bring important expertise to such teams are integral to their functioning [29].

Behavioral health professionals with specific training and competency are critically important in rural areas and are key instruments in facilitating interprofessional collaboration, closing gaps in services, and facilitating better outcomes for clients [30,31]. Specialized training is essential to prepare professionals for interprofessional collaboration in rural behavioral health. In some areas, workforce development programs designed to train emerging workers for interprofessional collaboration in rural areas are already in action.

Program Implementation to Address Needs

In mostly rural Southwest Michigan, two federally-funded interdisciplinary workforce development programs developed at Western Michigan University have been implemented in the last five years: Michigan Youth Prevention and Recovery from Opioid Use Disorders (MY-PROUD) and Interprofessional Peer Education and Evidence for Recovery program (I-PEER), with a descriptive analysis of the initial program implementation and the program changes necessitated by the COVID-19 pandemic provided herein [32]. There are multiple components within the I-PEER and MY-PROUD programs including experiential site field placements, training content specific to substance use disorders and mental health, goal attainment scaling using a secure digital application: Goal Scaling Solutions, and interprofessional peer supervision [32]. These components were selected to prepare practitioners to assess, intervene, and evaluate in interprofessional practice settings [33]. A comprehensive review of I-PEER and MY-PROUD program components can be found in Weller, et al. [32]. Some specific components of I-PEER and MY-PROUD program implementation to enhance the rural behavioral health workforce, and the ways in which the programs adjusted to serve the emerging workforce in rural communities during the COVID-19 pandemic, follows.

In preparing rural behavioral health professionals to work in interprofessional teams, collaboratives at the community and larger level are needed. To accomplish this, the I-PEER and MY-PROUD programs partnered with

other grantees, including three universities and one peer-run organization, to develop a state-wide collaborative of interprofessional workforce development programs. This statewide collaborative, which met quarterly, allowed for an overall expansion of included disciplines, to include social work, occupational therapy, peer support specialist, counseling, psychology, nursing, and nurse practitioners. The collaborative shared webinar and training access on topics within their expertise and developed a student leadership group that created materials for student-directed learning activities.

Some of these projects included ethics case studies and interprofessional research poster presentations.

Statewide collaboratives address overarching workforce development needs, but local task forces can add their attention to localized issues and develop culturally- and linguistically- appropriate programming that is close to the communities served. To share in this work, I-PEER and MY-PROUD joined local substance use task forces in several rural counties, and worked alongside representatives from community mental health, substance use and medical providers, police, educators, and county elected officials. Some of the projects completed on those teams included assuring Narcan dispensing, education about vaping and binge drinking, and access to local treatment services.

Preparing Social Workers to Serve Rural Communities During COVID-19

To meet the needs of rural communities, workforce development programs for behavioral health providers must prepare practitioners for the unique conditions they will face in rural practice. This can be accomplished by providing opportunities to intern in rural communities, learning with rural providers about evidence-based methods, and implementing culturally- and linguistically- appropriate practice. One of the ways that I-PEER and MY-PROUD accomplished this was to recruit students from Master of Social Work and Master of Science in Occupational Therapy field placements that included rural Southwest Michigan that had mental health shortages [4]. Qualifying placements included educational and healthcare settings where social workers, occupational therapists, and peer support specialists were providing behavioral health services. Students applied to the program, and sought the approval of their field instructor, who also had access to all training resources through the program. In addition, each student was eligible for a stipend of $10,000, significantly incentivizing a diverse group of students to accept field placements in rural areas [34]. This engaged an interprofessional group of rural and urban providers who normally would not collaborate and gave rural providers a chance to engage in meetings that would normally be held in-person in urban centers. The I-PEER and MY-PROUD programs included key components of

- Remote interprofessional peer supervision,
- Asynchronous training on evidence-based behavioral health topics,
- A stipend to support emerging practitioners in graduate school expenses and attract a diverse group of participants, and
- An innovative digital app, Goal Scaling Solutions, as a knowledge translation and outcome measure [32].

The COVID-19 pandemic caused universities, healthcare providers, and countless other industries to drastically reshape their policies and practices. The interprofessional workforce development programs I-PEER and MY-PROUD were no exception and needed to adapt to the challenges presented by the global pandemic. In response to the COVID-19 pandemic, the I-PEER and MY-PROUD programs shifted to virtual platforms after previously functioning mostly in-person. Online meetings were conducted over WebEx (an online meeting platform like Zoom or Microsoft Teams) and included orientations, regular interprofessional peer supervision sessions for I-PEER participants, and focus groups. Most of the training content that was previously presented in-person was translated to self-paced, asynchronous technology to enhance participant access and delivery. This was accomplished through a collaborative effort with the in-person training providers and professionals specializing in creating online asynchronous learning content. Lastly, the pandemic heavily altered internship field placement plans for students participating in both programs. These changes required I-PEER and MY-PROUD program staff to augment field office personnel in reaching out and recruit internship sites in applicable locations in order to ensure ample opportunities for the students and the services the individuals in those communities relied upon during COVID-19.

Bridging the Digital Divide to Reach Rural Communities

There are unique behavioral health needs and a lack of available providers in rural communities. One of the ways that COVID-19 has changed the behavioral health landscape is the proliferation of telehealth resources, which enabled clients to continue to access social work and other services and remain safe [35]. However, even access to telehealth resources during COVID-19 is limited for rural Americans. Even though 97% of individuals living in urban communities have access to fixed high speed internet, the rate drops to 65% in rural communities, and under 60% on tribal lands [36]. Although the CARES Act has providing substantial funding of $200 million to increase the telecommunications

infrastructure, and $50 million specifically to telehealth, the lack of access to digital resources further enhances the disparity that rural Americans experience in accessing behavioral health during the COVID-19 pandemic and beyond [37]. The number of people who access the internet through their smartphone has nearly doubled (37%) from 2013-2019, with 22% reporting that they do not have access to broadband or the speed is insufficient, and 45% that their smartphones provide all they need [38]. One solution to this internet access issue may therefore be resources that can be accessed on smartphones and do not require fixed internet in order to benefit.

As discussed above, rural communities experience barriers to access, and often unique needs in opioid use and other behavioral health disorders. This is in part related to the lack of well-trained culturally-responsive providers to meet the needs of more dispersed and less dense rural populations [39]. The use of digital tools for outreach to rural individuals and providers offers promise for social workers and other professionals to serve people in rural communities. Social workers can use digital tools as an extension of case management services, and to have between in-person visit connection between clients and the interprofessional team to check on and reinforce progress, or to provide early intervention when problems arise. For clients, digital tools can provide a sense of connection to their providers, and a motivation to continue doing the hard work of behavioral health recovery.

To help shorten the digital divide between people with behavioral health needs in rural areas and their practitioners, I-PEER and MY-PROUD program participants were trained in the use of the digital tool Goal Scaling Solutions (GSS). Drawing from the original method of goal attainment scaling by Kieresuk, et al. [39], GSS uses a five-point Likert scale to measure individual goals [6]. The following guidelines are used when writing these goal scales:

- The goal scale must be "S.M.A.R.T.," meaning it is specific to one goal behavior, measurable, achievable, realistic, time-bound;
- Each goal level must be equidistant in difficulty;
- Only one variable can change from one goal level to another; and
- There cannot be overlapping or missing outcomes [5,40-43].

For a view of a sample goal scale written in accordance with these scaling guidelines, see Table 1. The sample goal scale from Table 1 can be uploaded to the GSS digital application.

Goal attainment levels		Sample Goal Scale
1	Much less than expected outcome	I currently do not participate in trainings related to interprofessional behavioral health workforce development.
2	Less than expected outcome	I participated in one training related to interprofessional behavioral health workforce development in three months.
3	Expected outcome	I participated in two trainings related to interprofessional behavioral health workforce development in three months.
4	More than expected outcome	I participated in three trainings related to interprofessional behavioral health workforce development in three months.
5	Much more than expected outcome	I participated in four or more trainings related to interprofessional behavioral health workforce development in three months.

Table 1: Sample of Goal Scaling Solutions Individualized Goal Scale.

GSS was adapted for use in a HIPAA and FERPA-protected web-based and smartphone app, which allows providers and mentors to set goals with students, clients, and other community stakeholders, and communicate about progress on those goals through the secure app. Participants and providers can update by text, as well as attach supportive documents, photos, or video content. In addition, progress is noted for each goal on a line graph, which provides motivation for small but incremental progress on goals that are individualized and important to the person.

Within I-PEER and MY-PROUD, students selected and scaled a personal and professional goal for each semester and measured their progress with a graduate assistant weekly throughout the semester.

Examples of professional goals included: improvement in understanding of treatment for a specific condition, mastery of clinical documentation, implementation of a specific evidence-based practice, and preparation for supervision. Examples of personal goals included: increasing exercise, healthier eating and meal preparation, improved sleep practices, drinking more water, meditation practices, and increased time with partners and children.

For MY-PROUD, an additional set of goals was added to measure implementation of training skills in the five training areas of Motivational Interviewing, Culturally and Linguistically Appropriate Behavioral Health Services, Opioid Overdose Prevention and Early Intervention, Screening Brief Intervention and Referral to Treatment (SBIRT), and Sensory Interventions for Substance Use Disorders. Each training measured the use of specific skills with students for the five weeks after training completion. GSS acted not only as a measure of knowledge translation, but also a reminder to use the skills within the GSS app.

For example, one goal related to students reporting the frequency of use of OARS skills (a set of skills in motivational interviewing) and another related to the number of substance use disorder screenings they completed in the weeks after Screening, Brief Intervention and Referral to Treatment (SBIRT) training in a given week, encouraging participants to focus on those skills.

I-PEER and MY-PROUD students reported that GSS was helpful in their accountability and motivation. The digital app made GSS accessible to busy students and peer support specialists practicing in rural communities throughout Southwest Michigan and kept them connected to mentors and trainers. As a digital behavioral health innovation, GSS helps to meet challenges in rural communities by creating an accessible avenue for helping professionals and clients to connect for treatment and measure outcomes [5,41,44].

Conclusion

Rural communities often have few behavioral health providers and high behavioral health needs. When this is combined with a lack of infrastructure, poverty, and low levels of access to internet-based healthcare services, rural communities are often not receiving behavioral health services from social work and other progressions that are needed. The COVID-19 pandemic has made some of the disparities more visible, particularly related to the opioid use disorder public health crisis in rural communities.

In response, there is a need for workforce development which trains current behavioral health professionals, as well as emerging professionals. As part of this training, accessible digital tools need to be taught overtly so they can be used in rural settings and is accessible to rural interns and practitioners. In Southwest Michigan, a primarily rural area of the state which has high rates of poverty, homelessness, and opioid use disorders, two interprofessional workforce development programs trained emerging behavioral health professionals in culturally- and linguistically-appropriate behavioral health practice.

The I-PEER and MY-PROUD programs included key components of remote supervision, asynchronous training, use of a digital app, and a stipend to support students were key in these interprofessional workforce development projects. The inclusion of state-wide collaboratives and local task force participation, and the inclusion of Goal Scaling Solutions allowed students and mentors to communicate about behavioral health broadly, and their goals individually in I-PEER and MY-PROUD.

These methods and trainings were shared with local task forces and a statewide workforce development collaborative to bridge the digital divide amongst providers in Southwest Michigan and beyond. The need in rural communities is great, more during the COVID-19 pandemic than ever. Social workers working in collaboration with other professionals and community members can provide services that meet the cultural, linguistic, and technology needs in rural communities, during COVID-19, but also beyond the pandemic in years to come.

Funding Statement

This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant numbers M01HP31394 (Behavioral Health Workforce Education and Training, BHWET) - $1,860,000 total funding, and T98HP33434 (Opioid Workforce Expansion Program, OWEP) - $1,350,000 total funding. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

References

1. Han B, Compton WM, Blanco C, Crane E, Lee J, et al. (2017) Prescription opioid use, misuse, and use disorders in U.S. adults: 2015 National Survey on Drug Use and Health. Annals of Internal Medicine 167(5): 293-301.

2. Comartin E, Burgess-Proctor A, Harrison J, Kubiak S (2020) Gender, geography, and justice: Behavioral health needs and mental health service use among women in rural jails. Criminal Justice and Behavior 48(9).

3. Jones EB (2018) Medication-assisted opioid treatment prescribers in federally qualified health centers: Capacity lags in rural areas. The Journal of Rural Health 34(1): 14-22.

4. Health Resources and Services Administration (2021) Health Professional Shortage Area Find. HRSA.

5. Chapleau A, Harrison J (2015) Fieldwork I Program Evaluation of Student Learning Using Goal Attainment Scaling. American Journal of Occupational Therapy 69(2): 6912185060.

6. Harrison J, Chapleau A, Schell M, Vaughan V, Colzin C (2019) Leveraging technology in field education for digital natives: Using goal attainment scaling. Social Work Education 39(1): 60-70.

7. Rural Health Information Hub (2019) Your First Stop for Rural Health Information. RHIhub.

8. United States Department of the Census (2021) Total Population in Battle Creek city, Michigan. QuickFacts, United States.

9. Ratcliffe M, Burd C, Holder K, Fields A (2016) Defining rural at the U.S. census bureau. In : American community survey and geography brief (Edn.). United States Census Bureau, pp: 1-8.

10. Nasser HE (2019) What is rural America. The United States Census Bureau.

11. Choi KR, Stewart T, Fein E, McCreary M, Kenan KN, et al. (2020) The impact of attachment-disrupting adverse childhood experiences on child behavioral health. The Journal of Pediatrics 221: 224-229.

12. Kozhimannil KB, Henning-Smith C (2018) Racism and health in rural America. Journal of health care for the poor and underserved 29(1): 35-43.

13. Kozhimannil KB, Hung P, Henning-Smith C, Casey MM, Prasad S (2018) Association between loss of hospital-based obstetric services and birth outcomes in rural counties in the United States. JAMA 319(12): 1239-1247.

14. SAMHSA (2020) Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). In: Rockville MD (Ed.), Center for Behavioral Health Statistics and Quality (Edn.). Substance Abuse and Mental Health Services Administration.

15. More Opioids Being Prescribed in Rural America (2019). AAFP Home.

16. Centers for Disease Control and Prevention (2021) Products - Vital Statistics Rapid Release - Provisional Drug Overdose Data. Centers for Disease Control and Prevention.

17. American Medical Association (2023) Issue brief: Nation's drug-related overdose and death epidemic continues to worsen. Advocacy Resource Center.

18. Southwest Michigan (2021) Health & Human Services - Southwest Michigan. Domestic Violence.

19. United States Census Bureau (2010) Rural America: Story Map Series. mtgis.

20. Ready T (2015) The challenge: Why Kalamazoo needs a well-coordinated strategy to promote shared prosperity. West Michigan University Lewis Walker Institute.

21. Erb-Downward J, Evangelist M (2018) A snapshot of homelessness and housing instability in Michigan schools.

22. State of Michigan Interagency Migrant Services Committee (2013). Michigan migrant and seasonal farmworker enumeration profiles study 2013.

23. West Michigan Medical Examiner (2021). Annual Report Comparison, January 1 to June 30, 2019 and 2020. West Michigan University.

24. Michigan gov (2021) Opioid resources: Michigan opioid data to action dashboard. Opioid Resources - Data.

25. Drake RE, O'Neal EL, Wallach MA (2008) A systemic review of psychosocial research on psychosocial interventions for people with co-occurring mental and substance use disorders. Journal of Substance Abuse Treatment 34(1): 123-138.

26. Fiske A, Gatz M, Hannell E (2005) Rural suicide rates and availability of health care providers. Journal of Community Psychology 33(5): 537-543.

27. Ohta R, Ryu Y, Otani J (2020) Rural physicians' perceptions about the challenges of participating in interprofessional collaboration: Insights from a focus group study. Journal of Interprofessional Education & Practice 20: 100345.

28. Mackie PFE (2017) Professional ethics in rural social work practice. National Association for Rural Mental Health 43rd Annual Conference, USA.

29. Zerden LD, Lombardi BM, Richman EL (2019) Social workers on the interprofessional integrated team: Elements of team integration and barriers to practice. Journal of Interprofessional Education & Practice 17: 100286.

30. Long WE, Bauchner H, Sege RD, Cabral HJ, Garg A (2012) The value of the medical home for children without special health care needs. Pediatrics 129(1): 87-98.

31. Reeves S, Pelone F, Harrison R, Goldman J, Zwarenstein

M (2017) Interprofessional collaboration to improve professional practice and healthcare outcomes. Cochrane Database of Systematic Reviews 6(6): CD000072.

32. Weller BE, Carver JN, Harrison J, Chapleau A (2021) Addressing opioid misuse and mental health conditions through interdisciplinary workforce development programs. Social Work in Mental Health 19(3): 220-229.

33. Miller WR, Sorensen JL, Selzer JA, Brigham GS (2006) Disseminating evidence-based practices in substance abuse treatment: A review with suggestions. Journal of Substance Abuse Treatment 31(1): 25-39.

34. Johnstone E, Brough M, Crane P, Marston G, Correa-Velez I (2016) Field placement and the impact of financial stress on social work and human service students. Australian Social Work 69(4): 481-494.

35. Monaghesh E, Hajizadeh A (2020) The role of telehealth during COVID-19 outbreak: A systematic review based on current evidence. BMC Public Health 20: 1193.

36. Pai A (2021) Bridging the Digital Divide. Federal Communications Commission.

37. Holmes EN (2021) Broadband Connectivity and COVID-19: The FCC's Response. Congressional Research Service, pp: 1-5.

38. Anderson M (2019) Mobile technology and home broadband 2019. Pew Research Center, pp: 1-22.

39. Owen JS, Watabe Y, Michael KD (2013) Culturally responsive school mental health in rural communities. In Handbook of culturally responsive school mental health (Edn.). Springer, USA, pp: 31-42.

40. Kiresuk TJ, Sherman RE (1968) Goal attainment scaling: A general method for evaluating comprehensive community mental health programs. Community Mental Health Journal 4(6): 443-453.

41. Chapleau A (2016) Goal attainment scaling: The technological journey from idea and application. SIS Quarterly Practice Connections 1(4): 32-33.

42. Lawlor KB (2012) Smart goals: How the application of smart goals can contribute to achievement of student learning outcomes. Developments in business simulation and experiential learning: Proceedings of the annual ABSEL conference 39(2012): 259-267.

43. Williams C (2012) MGMT 5th (Edn.). SouthWestern College Publishing.

44. Hasselberg MJ (2020) The digital revolution in behavioral health. Journal of the American Psychiatric Nurses Association 26(1): 102-111.