

# Healthcare Issues and Access to Care in Rural Areas

Patricia K. Gleich  
Associate for National Health Ministries

*This work is dedicated to my three sets of homesteading great-grandparents, who came to the US in search of freedom, land and possibilities.*

Rural communities are facing a multidimensional health crisis. Whether one defines the economic change in the rural US as an agricultural revolution, a farm crisis, or a significant shift in



the cultural paradigm, the health of the people living in small rural communities is vulnerable to the economic change and is suffering. Rural health is directly affected by a number of factors and indirectly affected by the changes in the availability of both public and non-public health services as an result of economic distress. While the health of a community is typically calculated in terms of the health risks and disparities of the people who live

there, the total health measurement of a community must include other attributes and qualities. Health and wholeness, for both individuals and communities as defined by two important policy statements of the Presbyterian Church (USA), *We Are What We Eat*<sup>1</sup> and *Life Abundant; Values, Choices And Health Care*<sup>2</sup> include the very important psychological, social/emotional, relational and spiritual dimensions.

With 45% of all Presbyterian congregations describing themselves as being located in a “rural” area, the changes taking place in rural communities today profoundly affect the membership of the Presbyterian Church (USA). If the culture of the community and the physical, psychological, spiritual and economic health of the people who live who live in rural areas are changing, is the church continuing to meet those needs?

The farm family, historically imaged as the unit of strength and affiliation has been supplanted by pictures of gigantic

## Economic Issue: Farmer Facts

- Nearly half of all farmers are over age 55, while just 8 percent are under age 35.
- In 1920, the United States had over 925,000 African American-operated farms. Today there are less than 18,500. The current rate of agricultural loss by African-American farmers is over two times that of white US farmers.
- In 1998, farmers earned an average of only \$7,000 per year from their farming operations.
- Currently, 88 percent of the average farm operator's household income comes from off-the-farm sources.

machinery, barren homesteads, closed hospitals and vacant businesses. Broadly, the agricultural revolution has produced:

- Economic strain on communities with already inadequate health, mental health and dental services, and,
- Painful individual responses to culture change affecting lifestyle, family relationships, self worth and self-image.

The cultural change brought about by the agricultural revolution evokes for many who have generational ties to the land, feelings of loss and failure. Faith and hope - spiritual and emotional beliefs that help sustain one's sense of well-being - are extremely difficult to maintain in the face of profound cultural and economic change, and, are compounded by an uncertain future.

This article will explore the impact of the agricultural revolution and the resultant economical and cultural impact on health related issues in rural communities and the people who live there. It will begin with an identification of the major health risks of rural populations and the importance of public health programs in addressing these risks. It will also examine access to physical and psychological health care through both institutions and health care providers, and the impact economic changes have had on the availability of services. The article will identify ways in which congregations, and the wider church can help improve the pattern of rural health care and support people living in rural communities. The challenge articulated to the church is crucial; What is the role of the church and how can it respond to the rural health crisis – not only to provide spiritual support and guidance during difficult situations, but, to proactively voice the concerns of the congregations and positively impact the psychological and physical health of the

#### **Economic Issue: Farm Federal Assistance**

- Almost 30% of agricultural subsidies go to the top two percent of farms and over four-fifths to the top 30%.
- US Agra-Corporations, responsible for growing the surpluses of farm produce that is exported, are collecting an ever-greater share of federal farm payments. In 1995, they received \$3.98 billion, or 55 percent of all federal farm payments. In 2002, their portion increased to \$7.8 billion, or 65 percent of all federal payments.
- Large farms receive nearly twice as much in government payments as do small farms
- US agricultural output produced under contract has more than tripled from 10% to 35% in the last two decades.



community – now and for future generations?

## **What major health risks result from changes in rural areas?**

### Personal Health Risks

People living in rural areas have been historically medically underserved and are therefore more vulnerable to increase in health risks when services are interrupted or terminated.

Almost one in three adults living in the rural US describes himself/herself as being in poor to fair health. Nearly half have at least one major chronic illness.<sup>3</sup> Other disparities result from the inability to receive early diagnosis and treatment for both physical, and, psychological health issues and are often exacerbated by the stress of a changing rural economic culture. The health related issues articulated by rural residents are many - tiredness, overwork, anxiety, illness, bereavement, family relationships, passing the farm to the next generation, loneliness, isolation, regulations, debt, business viability, and environmental concerns.

Many of the major health risks experienced by people living in rural communities - hypertension, diabetes, hyperlipodemia (high cholesterol) stem from unhealthy diet and behaviors - tobacco use, lack of exercise and safety. Other disparities result from the inability to receive early diagnosis and treatment for both physical, and, psychological health issues and are often exacerbated by the stress of a changing rural economic culture.

The American Public Health Association (APHA) has issued a resolution urging federal, state, and local governments to impose a precautionary moratorium on all new factory farms - and to initiate and support further research on the health impacts of air and water pollution from such operations.

The health of rural populations was studied and described in a National Center for Health Statistics at the Centers for Disease Control and Prevention (CDC) report released in 2001.<sup>4</sup> The study for the first time looked at health status relative to community urbanization level and documented a number of disparities in health status between rural and non-rural citizens.

- Teenagers and adults in rural counties were more likely to smoke - over 5% more rural residents smoke than urban ones with white males experiencing the highest rates
- Residents of rural communities had the fewest dental care visits
- Rural areas experienced the highest death rates for working-age adults
- Rural areas had a higher percentage of residents without health insurance

- Mental health issues, which for generations have been less prevalent in rural areas - particularly those that co-occur with substance abuse - now occur as frequently among rural populations, however, the services needed to prevent and address these problems are often not provided.
- Residents of rural areas had the highest death rates for unintentional injuries in general and for motor-vehicle injuries specifically and wear seat belts less often than their urban counterparts. ATV accidents were cited as a major risk for young people.

Health risks for older adults living in rural areas were similar to those living in urban areas. However, the risks - physical changes, sensory losses, decreased mobility, loss of friends and concurrent disease processes were compounded by the isolation of living in sparsely populated areas with no public transportation, lack of health insurance, few health care services and in many cases, family who have been forced to move to urban areas in search of employment.

### Health Issues for Rural Children

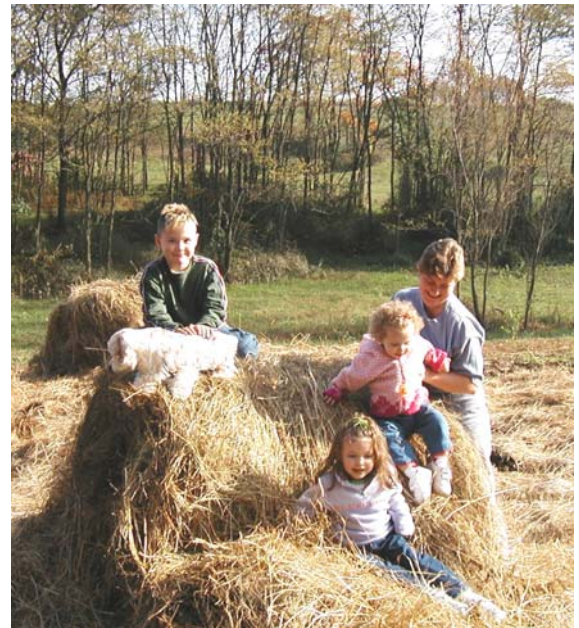
Rural children more often grow up in two parent homes and are more likely to bond with primary and extended family. This provides a foundation that can help in development of a strong sense of self and provide a base of security. However, health disparities among children living in rural areas - particularly those living in the poorest and most isolated areas and for children of color, are a cause for concern.

According to a recent report - America's Forgotten Children,<sup>5</sup> rural areas are home to 2.5 million children living poverty - substantially impacting their health

status. This report identifies the geographic areas of greatest concern as being concentrated in six regions of the country: Central Appalachia, the Deep South, the Rio Grande border, the Southwest, the Central Valley of California, and the American Indian reservations in the Northern Plains states.

Specific issues outlined in the report include:

- Many rural children do not receive adequate health care and fare poorly on several important indicators of child well being.



- Some 1.7 million of them are eligible for the State Child Health Insurance Program (SCHIP) but are not enrolled. And, well over half of parents with children who qualify for SCHIP do not know that the program is available.
- The death rates for children and young adults (ages 1–24) are highest in the most rural counties. In all regions except the Northeast, the 1996–98 death rates for children and young adults in the most rural counties were more than 50 percent higher than those in metro counties.

- A high percentage of rural children and young people are overweight as a result of less nutritious, high-fat diets in many poor areas. Obesity is an important risk factor for many health problems, including high blood pressure, diabetes, and high cholesterol. Yet culture can play a big role in diet; while it may not be always healthy, food can have historical and cultural significance and provide comfort and familiarity.

Many rural families lack basic amenities that people in urban areas take for granted:

- Essential services — adequate plumbing and sewer connections, paved roads, safe drinking water, and public transportation — are much less available in many rural communities.
- In a 1995 study, rental housing in rural America was only half as likely as an urban rental to have indoor plumbing and heating. There were no telephones — essential in quick treatment of emergency medical situations — in 23 percent of the homes of poor rural children in 2000.
- Women head 46 percent of rural households, and of these families, 27 percent are living below the poverty level, compared to 9 percent of male-headed rural families

#### Health Care Access for children

- Rural children were more likely than urban to lack health insurance at a point in time
- Rural children were more likely than urban to have had at least one spell of un-insurance during the 36-month period
- Rural children who lost coverage during the survey were slightly more likely than urban children to have uninsured spells that lasted four months or less, and were more likely to have uninsured spells that lasted 17 months or more
- Rural children had slightly lower rates of private insurance than urban children. The percentage of each with Medicaid coverage was nearly identical.
- The characteristics of rural children differed significantly from those of their urban counterparts. Several of those characteristics likely contributed to differences in insurance coverage, some—such as higher proportion of children living in poverty—contributed negatively, others—such as higher proportion living in two-parent families—contributed positively. <sup>6</sup>

Rural children, more often than those living in urban areas receive immunizations through public health providers. While overall rates for urban and rural children do not differ significantly at this time, shortages of vaccines, and the redirecting of public health funding to bio-terrorism rather than traditional prevention programs could pose substantial future risks.

Separate from risks associated with access to health services, children in rural areas are often exposed to equipment, chemicals, and responsibilities that differ from their urban counterparts. The benefits of families working together are many. The health related challenge of children working alongside parents is sufficient emphasis on safety and supervision.

According to the National Institute for Occupational Safety and Health, an estimated 24,000 children are injured each year on farms. Approximately 5,000 sustain life threatening injuries and 300 children are killed. Farming, particularly family farming employs many individuals whose age is outside that found in other industries – below the age of 18 and over the age of 62. Children on farms may be exposed to a wide array of occupational and environmental hazards that are not present in other industries. In addition to young individuals who work on the farm, many youngsters live and play around the farm exposing themselves to hazards that are uniquely dangerous. Children take on many roles around the farm including working, accompanying adults, and playing. Agriculture-related injuries can occur during all of these facets of farm life.

Injury scenarios can include tractor rollovers, falls from equipment or ladders, and entanglement in power take-off shafts and other machine components such as augers. Children are injured during livestock-related chores, such as feeding animals or cleaning out livestock pens, and are most often kicked, bitten, or trampled by animals much larger than themselves.<sup>7</sup>

#### HIV/AIDS

HIV/AIDS cases are growing rapidly among rural populations. Although the number of cases is relatively small compared to urban areas, according to the CDC, the proportional increase in the number of AIDS cases in rural areas is three times that of urban areas. There also is evidence that rural residents are less likely to seek HIV testing, thus are diagnosed later in the progression of the illness, consequently less responsive to treatment and have a shorter life expectancy than their urban counterparts.

## Psychological Health Issues

Psychological and mental health issues often carry a stigma and sense of shame making self-identification of the problem and treatment seeking difficult. The lack of anonymity in close-knit rural communities compounds these difficulties and can discourage people from seeking social support. Confidentiality is of particular concern for rural residents with long histories in rural communities. They fear stigmatism, not only for themselves, but also for family members.

The negative stereotypes associated with mental illness can also be internalized by individuals with mental illness, leading to despondency, lower self-esteem, and isolation. When no local mental health providers are present, not only are treatment options affected, the education that might decrease the stigma, does not take place. This problem is particularly common in rural areas, given the shortage of mental health providers.<sup>8</sup>

*Ironically, the very qualities that describe the image US society holds of farmers – self-sufficiency, determination, strength, self-reliance and independence, make treatment seeking more difficult. For some, the inability to fulfill that idyllic image is painfully internalized as inadequacy and failure and must be endured with stoicism and silence.*

Among older adults, depression is a major issue and manifested differently than in younger people. While both men and women are likely to see a general practitioner rather than a mental health specialist, men will more likely complain of physical symptoms – lack of energy, loss of appetite, inability to sleep, etc. – while women articulate depression. Some researchers find that primary care physicians deliberately under-diagnose mental illness because of stigma, doubts about the patient's acceptance of a mental disorder diagnosis, or a concern for the patient's future insurability.<sup>9</sup>

Untreated depression in men can result in frustration, discouragement, anger, and, at times



behaviors that become violently abusive. Some men may deal with depression by throwing themselves compulsively into their work, attempting to hide their depression from themselves, family, and friends; other men may respond to depression by engaging in careless or reckless behavior and taking risks.

Perhaps the most devastating mental health issue found in rural communities is suicide. Four times as many men as women die by suicide in the United States, even though women make more suicide attempts during their lives. In light of research indicating that suicide is often associated with depression, the alarming suicide rate among men may reflect the fact that men are less likely to seek treatment for depression. Many men with depression do not obtain adequate diagnosis and treatment, which may be life saving.

The suicide rate among rural men is significantly higher than in urban areas, though it is escalating among rural women and is approaching that of men. <sup>10</sup>

An important study conducted by the National Institutes of Health, found significant relationship between the rates of suicide and the rural nature of the community in which people (specifically males) lived; rising suicide rates correlated with increasing levels of rurality. Rural men, in each age cohort, had about twice the suicide rate of their most urban counterparts. These rural-urban differentials were not observed for women.<sup>11</sup>

Other studies have examined the health disparities in rural areas more closely – determining the differences between farming and non-farming individuals. These results showed that farmers experiencing stress were 2-3 times more likely to be injured, and that the suicide rate for farmers and ranchers – typically twice the national population average doubles during times of economic stress. <sup>12, 13</sup>

Psychological issues also affect families. Domestic violence increases during times of stress and change. The strong cultural emphasis on marriage and motherhood commonly observed in rural communities has an impact on the educational and occupational choices made by rural women, and also impacts their health status. US Census data indicate that women in rural communities often have access to and receive less formal education and exposure to cultures outside their own than many who live in more urbanized settings. They tend to marry earlier and have children at a younger age. Domestic violence, when it occurs is likely to leave rural women more vulnerable than their urban counterparts, with fewer options for escaping the violence, few or no treatment options for the abuser and less family and community support. In small, isolated communities,

violence against women may become a tolerated, even socially accepted norm, supported by the silence of friends, family and at times, the church.

The findings of a 6 year longitudinal study of farm families show an increase in harsh and inconsistent parenting and that contribute to rural adolescent substance abuse and antisocial behavior. Perhaps the most relevant finding from this study is that economic stress causes problems for children because it disrupts parenting. Importantly, income loss itself does not necessarily have negative effects on youth; it is the degree to which income loss affects parents' relationships with each other and their parenting skills that matters for children. <sup>14</sup>

Alcoholism and drug abuse are growing problems in rural areas. With a scarcity of mental health professionals in rural areas, fewer than one in five rural hospitals have treatment services for these conditions. <sup>15</sup>

#### Special needs of Farm Workers

Another result of the agricultural revolution, a growing population of migrant farm workers, experience physical health issues more serious and numerous than the historic population and include unsanitary housing, access to health care, unintentional injury, intentional injury, substance abuse, non-safe sexual practices and agricultural hazards. Migrant workers are also at risk for high infant mortality, delayed immunizations, poor dental health, mental health problems, substance abuse, family violence, malnutrition, diabetes, hypertension respiratory illness (especially TB), anemia and parasites.

#### A Scarcity of Public Health Resources

Public health departments, the agencies primarily charged with health education and prevention programs directed at remediating health risk behavior, and casualties of the agricultural revolution, have lost local funding for prevention programs and personnel. Traditional primary care providers who tend to treat presenting problems rarely have access to population-based prevention programs that discourage unhealthy behaviors and promote healthy ones. Although many rural



health departments have initiated highly successful programs to improve population health behaviors, many more rural areas simply do not have or no longer have, public health agencies, personnel and financial resources for this type of population health intervention.

Although culturally and economically diverse, rural residents across the United States face many common challenges and have many similar needs. However, the needs of rural residents have frequently been overlooked in favor of more readily identified urban concerns.

Rural communities also face increasingly serious environmental health threats resulting from changes in farming techniques, hazardous waste dumps, agricultural runoff, unsafe mining and logging practices. Exacerbating the existing health risks, community disease surveillance capacity, oversight over local sanitation, and adequate assurance of safe food and water supplies have been negatively impacted by the scarcity of funds for local public health agencies.<sup>16</sup>

Rural communities depend on crucial public health services. This creates additional challenges for communities with insufficient public health capacity to meet what is defined as the essential public health services:

- Monitor health status to identify community health problems
- Diagnose and investigate health problems and health hazards in the community
- Inform, educate, and empower people about health issues
- Mobilize community partnerships to identify and solve health problems
- Develop policies and plans that support individual and community health efforts
- Enforce laws and regulations that protect health and ensure safety
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable
- Assure a competent public health and personal health care workforce
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- Research for new insights and innovative solutions to health problems.<sup>17</sup>



## **Access to Care Issues**

All rural residents – regardless of income - face two factors negatively influencing access to health care - distance and time. Emergency and specialized medical services, equipment and personnel simply are not as readily available in areas that do not have dense populations. The problem is exacerbated for those who do not have the ability to pay for services. In order for rural residents to receive care, four conditions must be present. First, there must be an adequately funded health care facility. Second, a health or mental health professional must be available. Third, the person seeking care must be able to pay – at least a portion of the charges incurred. Finally, there must be transportation available.

### Health Care Facilities and Services

Succinctly put, rural America is severely underserved by health care specialists, dentists, and other health services. As of June 2001, 68 percent of all federally designated Health Professional Shortage Areas were rural and affected close to 25 million people. Sixty percent of all rural residents live in federally designated Mental Health Professional Shortage Areas. This serious shortage of doctoral level mental health professionals means that many people are served by primary care doctors who are not trained to diagnose and treat mental illness and behavioral disorders.

There are 2,157 Health Professional Shortage Areas (HPSA's) in rural counties of all states and US territories compared to 910 in urban areas. The deleterious effect of the farm crisis is also seen in the closings of hospitals in rural areas. According to US Health and Human Services, there were 2,489 rural hospitals in 1987. By 1995, the number had declined to 2,141 – a 14% decrease. Currently 25% of the remaining 2,141 rural hospitals have negative operating margins - that is, they are losing money and are at risk of closure. Life saving, emergency services in rural areas are often provided by volunteers (60%) and transportation time to health care facilities is longer than in urban areas. <sup>18</sup>

### Mental Health Service Providers

In 1999, 87 percent of the 1,669 Mental Health Professional Shortage Areas (MHPSAs) in the United States were in non-metropolitan counties. <sup>19</sup> Rural areas suffer shortages in both mental health infrastructure and supply of mental health professionals. Non-metro counties have on

average less than two specialty mental health organizations, while metro counties report an average in excess of 13 mental health organizations. Although understaffed and under funded, individual rural agencies are frequently expected to serve the residents of several counties, often including many culturally distinct groups. <sup>20</sup>

The nearly 60 million Americans living in rural areas also have limited access to and availability of mental health specialists, such as psychiatrists, psychologists, psychiatric nurses and social workers, are seriously lacking. Poverty, geographic isolation and cultural differences further hinder the amount and quality of mental health care available to people in rural areas. Cost of services is a major barrier. Many of the newer psychoactive medications are very expensive.

Lack of quality inpatient care for severely mentally ill people is another serious problem in rural areas. These patients often must obtain care in hospitals that are located far from family and friends, or they are hospitalized in general medical settings where no psychiatric consultation is available. Once discharged back into the community, there are limited psychosocial rehabilitation services available and thus patients are often re-hospitalized at a very high cost compared to outpatient care. <sup>21</sup>

**In times of extreme personal and community stress, the church is called upon to do more.**

#### Funding for Care

Insurance covering health care is often a benefit of employment. In rural areas with high rates of self-employment the benefit is far less prevalent. In rural areas that are economically disadvantaged, access to government support for health care is disproportionately low. Frequently government programs are “means tested” – one must qualify. A rural resident who owns land may not qualify for health care assistance because the value of the land would reduce eligibility – even if the land is nonproductive. Thus, only 25 percent of people living in rural areas qualify for Medicaid (state administered health care assistance) – compared to 43 percent in urban areas.<sup>22</sup>

#### Physician and health care professional shortage

The shortage of physicians and health care professions in rural areas is historic and increasing with the closing of hospitals and changing reimbursement procedures for Medicare and Medicaid

patients. While 25% of the US population lives in rural areas, only 10% of the physicians practice there. Almost 4 times as many specialists practice in urban areas. <sup>23</sup>

Physicians practicing in rural areas also face professional isolation, spouses with career aspirations that often cannot be met in rural areas and the inability to find the type of educational facility desired for children. Physicians also express reluctance to practice in areas which lack specialists an referral physicians, and facilities equipped to provide specialized treatments.<sup>24</sup>

### What is the role of the church ?

In responding to people in crisis, the church must be viewed in the context of the community and within the framework of the resources the community possesses.

Rural congregations may find that they are integral in helping people access the health care system by assisting with appointments or transportation.

Congregations may find an advocacy role in their community, helping bring health care services to the community, calling attention to unhealthy environmental

situations, working to be certain that all groups in the community have voice and support or, taking leadership in attracting health professionals to the community.



At the denominational level, advocacy for essential health resources in each community is a critically important role. In introducing the policy statement – Life Abundant: Values, Choices And Health Care—The Responsibility And Role of The Presbyterian Church (U.S.A.), the writers challenge the church with the following words –

*The health of a society is measured in a very important way by the quality of its concern and care of the health of its people. . . At the minimum, credible commitment to health includes a safe environment; adequate food, shelter and employment or income; and convenient access to quality, affordable preventative and curative health services. <sup>25</sup>*

## The Pastor's Doorstep

In rural congregations, pastors or other religious leaders are frequently the first resources consulted in times of crisis. <sup>26</sup> Pastors are usually more immediately and directly accessible than some other professionals, do not charge fees, and are often known, respected and trusted within a community. They may well be generalists who have some familiarity with a broad spectrum of experiences.



Congregations in small communities, assume and expect that the pastor will serve as pastoral counselor. Often people who are distressed and reaching out for help do call upon the church, implying both an assumption that the church can help and a recognition that there are spiritual dimensions to their dilemmas. The request might be for crisis intervention, or, the request might be for help in dealing with a serious mental health problem. The support of pastors and others in the congregation who are called and trained to provide spiritual care is crucial.

Pastors may or may not have taken classes in counseling during their seminary training and may or may not be comfortable serving in an expanded role, or, the church may be served by a Commissioned Lay Pastor whose training did not include pastoral counseling, and, who may not be as comfortable in a counseling situation. <sup>27</sup>

At times the distinction between pastoral care and the professional discipline of counseling becomes blurred. Pastoral care is regarded as a primary function of ministry by many pastors. In the counseling role, the pastor acts as agent for the congregation, symbolizing the care of the congregation.

Pastors may be confronted with situations in which they are key in recognizing the extent or severity of the crisis being described. They must be keen and non-judgmental observers, and cognizant of the importance that is placed upon their response to the situation. The person seeking out the pastor may not be directly asking, as did King Zedekiah, "Is there any word from the Lord?" (Jeremiah 37:17), but that question may well be in the background of the session. What is shared and advised may be interpreted as coming from a higher source and must have integrity with Scripture and not be in violation of scriptural principles. <sup>28</sup>



Ideally, pastors confronted with a member's personal crisis will have professional resources within the community to which the person can be referred. If referrals are not possible, it may well be the pastor or a specially trained volunteer in the congregation who assess whether or not the presenting individual requires professional help. In rural communities adversely affected by the cultural change accompanying the agricultural revolution, pastors and other church leaders are likely to see behaviors stemming from stress, apprehension and depression. Though not functioning as professional therapists, clergy and lay leaders at times must evaluate behaviors associated with crisis situations. The ability to discern a situation in which harm may be done, or has been done, is critical.

### A role for congregations

Congregations can be pro-active in helping assure that information and resources related to health issues is distributed to members in their congregations. Health Ministry can be a mission of the church.

Examples of proactive activities are:

1. Hold a special Sunday Morning Worship service around the issue of health, healing and wholeness. Include families and children.
2. Use as a sermon topic good stewardship of one's body – taking care of oneself through healthy behaviors. It is important that the minister share stories about the importance of going for check-ups, screenings and maintaining health.
3. Develop a congregational care team ministry.
4. Conduct or sponsor a health fair or the congregation and community. Include screenings for different health issues: blood pressure, cholesterol, diabetes, and other screenings based on the needs of the congregation/community. Set up resource tables/booths with health related information and interactive programs. Provide information sessions throughout the day on different programs such as smoking cessation/interventions, foods and recipes, nutrition and mental health issues. Provide entertainment. For more information about conducting a health fair, go to <http://www.pcusa.org/health/usa/resources/healthfair/index.htm>.
5. Begin a walking program. Exercise has been shown to reduce the risk of diabetes and decrease the incidence of complications for those who have already been diagnosed.
6. Have members come together to share about health concerns and which ones are important to the community. Bring in health professionals from the community to address specific issues. Develop a plan to address ongoing health concerns.
7. Conduct a program on safety. Focus on farm safety. Remind members about the need to wear seatbelts (and use child safety seats), to drive within the speed limit and not to combine drinking and driving or riding with someone who has been drinking. Include bicycle and water (swimming and boating) safety as well.
8. Develop a fun health series for children. Have interactive classes where children can make a game around selecting healthy foods, have cooking classes, play physical games (for exercise) and/or learn about making healthy choices.

9. Create a bulletin board. Change it regularly. At times, let the children develop the health theme. Children can color pictures or make collages around health related issues – healthy foods, behaviors and/or choices. Let it be fun.

10. Conduct a special program on teen suicide risks. Highlight those most vulnerable - Has lived with a number of ineffective or inappropriate parental substitutes because of familial disruption; Has experienced an emotional loss, such as divorce, desertion, or death in the family; and/or Has experienced a past loss through suicide or violence of someone to whom he felt attached.

11. Conduct a program on HIV/AIDS. Describe the risks to certain populations groups, including People of Color, Youth and Older Adults.

12. Create a list of health resources within the community. doctors, clinics, hospitals, HIV testing sites, AA programs, smoking cessation classes, mental health services, diabetes programs, counseling services and other services that would be important to members. Have it easily available to members.

13. Identify a “Congregational Health Liaison” and/or start a Health Ministry or Parish Nurse program in your congregation to assist with the health education of the members. For more information about Parish Nursing, go to <http://www.pcusa.org/health/usa/parishnursing/index.htm>.

In a crisis situation the pastor might be the first point of contact for a person needing assistance, however, trained and organized volunteers have a very important role. Remembering to respect privacy and confidentiality, they might:

1. Support the pastor in providing spiritual counsel and practical assistance.
2. Be observant. At times, people in crisis are embarrassed or humiliated (often blaming themselves) and will not ask for assistance or support. Congregations need a plan for reaching out to people in ways that allow them to make their own choices and maintain their dignity.

3. Talk with the person in crisis and validate the experience in a way that gives permission for both men and women to own the sense and express the loss they feel and respond accordingly.
4. Encourage persons to be open to spiritual and emotional support from active participation in a small group fellowship of the congregation.
5. Develop and maintain a compassionate, open and non-judgmental climate in the congregation. This will make it easier for folks who need help to ask.
6. Emphasize the church as a community and the value of each member. Underscore the interconnectedness of the members and the shared experience.
7. Plan church school electives or weekend workshops that help non-business persons in the congregation to understand the unique risks and problems inherent in business and farming.
8. Schedule regular support groups where encouragement and guidance may evolve.
9. Offer, when appropriate and feasible, temporary financial assistance to cover monthly mortgage payments, food purchases, or health insurance premiums.
10. Help members who are troubled get in touch with professionals in the community, such as public accountants, attorneys and counselors. If possible schedule educational sessions through the church – this helps avoid the need for individuals to feel alone or isolated in their experience.



This article offers only a partial view of the magnitude and complexity of rural health issues. These intricate issues can be addressed through the unique strengths of rural people and with the support of the wider church. ***Life Abundant*** - for all of God's children - is a tenet of the faith we possess, the hope of the authors of the far reaching policy statement on health, and the goal of the Presbyterian National Health Ministries (NHM) office. NHM and other agencies are prepared to help congregations by providing resources and training for congregations in such areas as: depression, suicidal ideations, family violence, and substance abuse.

### Information sources utilized in this study:

- 1 The 214th General Assembly (2002) , "We Are What We Eat," responding to Overture 99-8
  - 2 Life Abundant: Values, Choices And Health Care—The Responsibility And Role of The Presbyterian Church (U.S.A.), a policy statement adopted by the 200th General Assembly (1988).
  - 3 *Bridging the Health Divide: The Rural Public Health Research Agenda*
  - 4 CDC 2001 Study, Health Insurance Access in Rural America
  - 5 America's Forgotten Children [www.savethechildren.org](http://www.savethechildren.org) [accessed 9/6/05]
  - 6 <http://www.muskie.usm.maine.edu/mrhrc>. [accessed 9/06/04]
  - 7 <http://ag.arizona.edu/agsafety/child/childframe.htm> [accessed 9/6/04]
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