Challenges and Opportunities Impacting the Mental Health of Rural Women

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ABSTRACT

Rural mental health has been rated a priority by the President's New Freedom Commission on Mental Health, and is a major concern to health centers, clinics, and state organizations associated with rural health across the nation. Good mental health is critical to personal and physical well-being, family and interpersonal relationships, and community and societal involvement. For many rural women the challenges of living in an isolated environment may negatively impact on mental health. Addressing these challenges through mental health promotion programs and affordable supports available through the Cooperative Extension System is essential to successful outcomes in mental health functioning and quality of life for women and their families living in rural communities.

INTRODUCTION

In 2002, George W. Bush established the President's New Freedom Commission on Mental Health as part of his commitment to eliminate disparities and barriers to accessing mental health care for disadvantaged people across the United States. To address the needs of rural Americans, the Commission was charged with improving mental health promotion and access to care in rural communities (Mental Health Commission, 2002). Rural communities are especially disadvantaged in meeting the mental health needs of some population groups (Holzer, 1998), to include children, the elderly and minorities.

Many of the nearly 60 million Americans living in rural communities are affected by the prevalence of rural mental disorders (Gamm, 2003, US Census Bureau, 2007). This is due to the failure in these communities to identify such mental health conditions early on, the lack of access to mental health professionals to treat such conditions, the consequences of mental illness for treatment of physical illnesses, and from often harsh daily living conditions (Gamm, 2003). In particular, rural women, a group often disadvantaged as to education, income, financial resources, and access to health care are at risk themselves for developing mental health disorders. Rural women may also be affected by mental health problems of family members. The purpose of this paper is to examine some of the physical, mental, and financial health issues faced by rural women, as well as housing considerations and caregiving responsibilities. The paper will also address successful ways to meet these challenges through the Cooperative Extension System (CES) outreach towards positive mental health.

Health of Rural Women

A variety of factors combine to make rural life unfavorable for women, with the highest rates of poverty seen in families headed by women. Rural women were more likely to report poorer health status and more physical limitations than urban women (ERS, 2006) and rural areas report higher rates of chronic diseases, including heart disease and cancer, two diseases that affect women (Rural Assistance Center, 2007a). When compared to urban residents, women in rural areas are older, poorer, less educated, have greater financial hardship, and encounter more geographical barriers (HRSA 2005). Employment opportunities are few or may be unpaid. Family caregiving and child care resources are inadequate or unaffordable for most rural women. And access to technology, such as computers and/or high speed Internet is limited, reducing the opportunity for self improvement through on line education, or to increase income by working from home (Foxhall, 2000, ERS 2006).

Physical Health

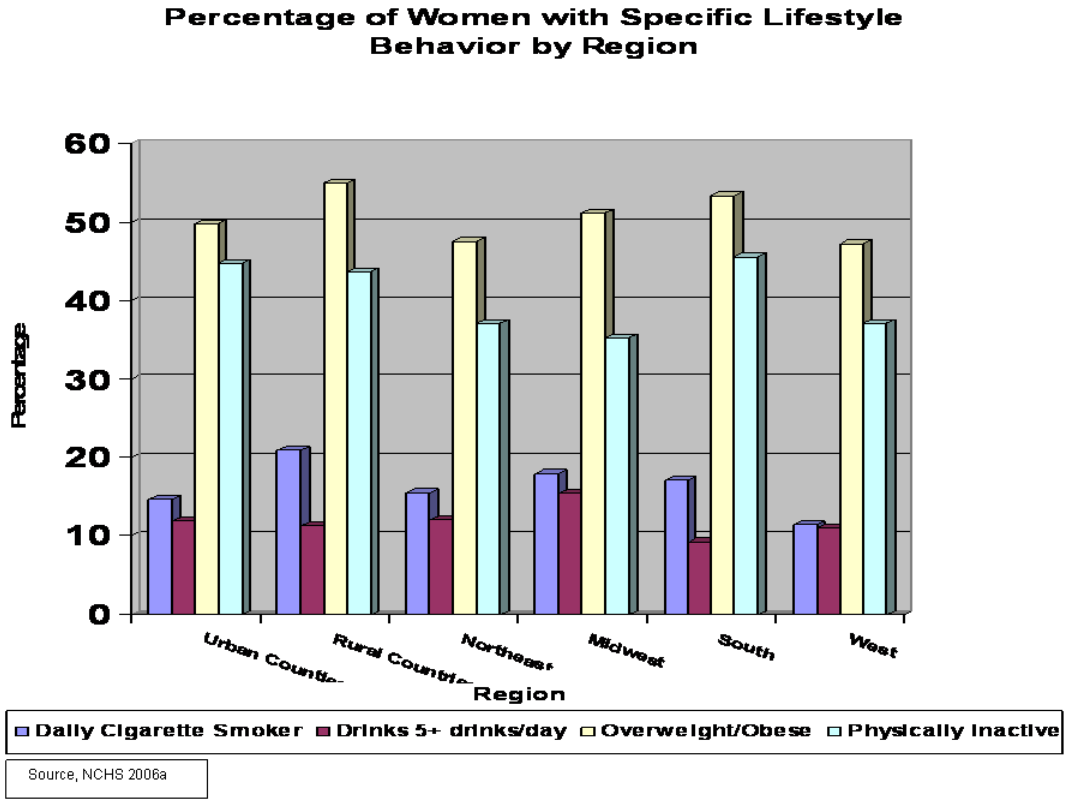
Of women in rural or non-metro regions, 14.5 percent reported their health status to be fair or poor, a percentage not significantly different from men in the same areas, but significantly higher than the 11.1 percent reported by women in urban or metropolitan area. Conversely, only 25.4 percent of rural women described their health status as excellent compared to 29.6 percent of rural men and 29.9 percent of urban women (HRSA, 2005). A number of barriers influence the health status of rural women. Rural communities have fewer health care providers than do urban areas, particularly, obstetric providers. A higher rate of rural poverty, specifically among women, leaves many women and their children medically uninsured or underinsured with limited or no access to health and human services. Also, geographical isolation, lack of public transportation, and lack of funds to pay for transportation disproportionately affect single women with responsibility for transporting her family to health care appointments (ERS, 2006, US HHS, 2000). This concern continues for elderly women who make up 58 percent and 71 percent of the rural population 65 years old and older, and 85 years old and older, respectively (ERS, 2005). With a higher proportion of these older women living in the

south and mid west, they often lack adequate financial resources from earning, savings or pension plans and are most in need of health, medical care and other services (ERS, 2005).

Rural women are more likely than their urban counterparts to have a number of health problems, including diabetes, cancer, heart disease, stroke, lung disease and osteoporosis. In particular, these women are often diagnosed with cancer in later stages of the disease with increased risk of complications and death and for women between 45-64 years of age; the increased risk of death from diabetes is more common than in urban residents. Also, fetal, infant and maternal mortality are higher in rural areas and correlated with low educational attainment of the mother, the delay in or no prenatal care, less adequate care when it is available, more mothers under age 20 or over age 40 than in urban areas, and maternal smoking during pregnancy (Gamm, 2003).

Lifestyle behaviors are important to a number of disease outcomes and overall health. A brief look at four of these behaviors-alcohol use, cigarette smoking, obesity rate and physical activity-- provides some insight into rural life and health.

Figure 1



While heavy alcohol use nationally appears to vary little by urbanicity among 18-49 year olds, there is some regional variation in intake of alcohol with rural areas of the Northeast and Midwest reporting a higher prevalence than their urban counterparts in those regions

(NCHS, 2001). Cigarette use is more prevalent in rural areas than in metro countries (Office of Applied Studies National Household Survey on Drug Abuse Advance Report. 1995) with rural women—adults, adolescents and pregnant women—having high prevalence rates for smoking (NCHS, 2001). This trend reflects two factors characteristic of rural areas: delayed access to medical and media resources and lower educational attainment (NCHS, 2001) Likewise, tobacco intervention efforts in rural settings are limited by the insurance, care giver and transportation barriers previously mentioned along with limited educational resources designed to change unhealthy habits.

Obesity and overweight in American is epidemic. Results from the 2003-2004 National Health and Nutrition Examination Survey (NHANES), using measured heights and weights, indicate that an estimated 66 percent of U.S. adults are either overweight or obese (NCHS, 2007). This problem may be especially severe in rural areas and related to distinctive demographic composition of rural communities (Gamm, 2003)) Rural residents are on average older, less educated and have lower income than urban residents. Rural life may present special cultural and structural challenges to maintaining a healthy weight such as higher dietary fat and calorie consumption, increased physical inactivity, increased television watching, and decreased compliance with dietary and physical activity recommendations. Particular to rural areas is a lack of nutrition education, a decreased access to nutritionists, fewer physical education classes in schools and fewer exercise facilities along with unique challenges to include fewer prevention and treatment facilities and further distances to reach them (Gamm, 2003). In 2002-04, 55 percent of rural women were overweight or obese with highest rates of obesity in the South. Likewise, over 40 percent of rural women were physically inactive during their leisure time with those living in the South being the least active. With decreasing education and increasing poverty common to rural areas both the percent of women who were overweight/ obese and those who were physically inactive in their leisure time was about 60 percent (NCHS, 2006a)

Rural women are also beset with hazards and injuries specific to living and working in rural environments. They are exposed to agricultural chemicals and pesticides throughout their lives increasing the risk of certain types of skin and female organ cancers. They are also susceptible to injury and accidents related to use of farm machinery and are at increased risk of disability from such accidents due in part to transportation problems and adequately trained medical support.

Mental Health

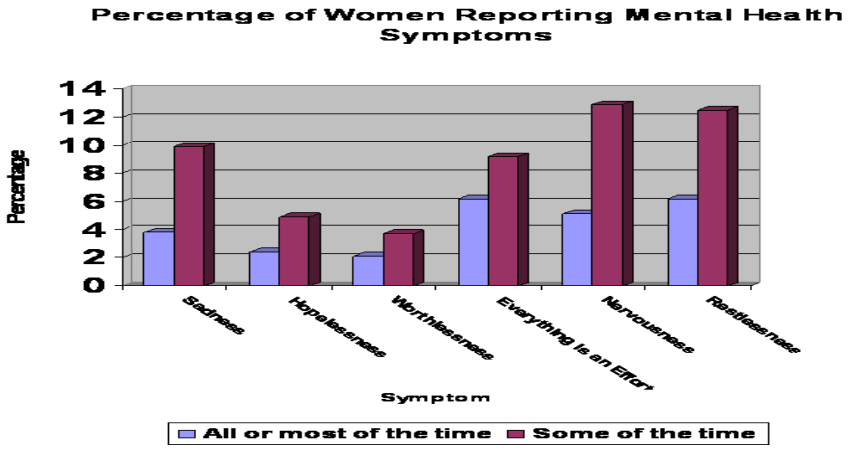
As with physical health, rural women face the same challenges to diagnosis and treatment of specific mental conditions and disorders. Geographic barriers and distance, lack of transportation, lack of child care, poverty, and lack of health insurance are combined with inadequate funding by rural communities for medical and mental health services, lack of sufficient mental health training expertise and coordination among health care providers, and in some cases limited utilization of available mental health services because of stigma or limited awareness of mental disorders (Gamm, 2003). Consequently, rural

women may rely on others for mental health care—such as ministers, self-help groups family and friends or go without treatment with serious consequences.

Although relatively little is known about the causes of mental illness, a number of factors may contribute to mental disorders, to their consequences, or failure to adequately treat the disorder. Mental disorders are important co-morbidities of physical illness and if left untreated they may contribute to suicide and affect the financial capacity of an individual or family to effectively address other health problems (Gamm, 2003). Commonly seen mental disorders in rural women are depression or psychological stress and stress. The prevalence of depression is slightly but significantly higher in rural residents compared to urban areas, possibly due to a number of differing population characteristics (Probst, 2006). Depression or psychological distress is often seen in younger women, unemployed women or those with low education attainment (Hauenstein, 1994). Conditions of rural living such as isolation and harsh climatic conditions may also contribute to these mental disorders. Stress may have personal causes or triggered by one of several factors associated with rural environments. In particular for women stress is associated with multiple roles—mother, caregiver, head of household, farm hand and family mediator, lack of recognition for work done and limited person and family time.

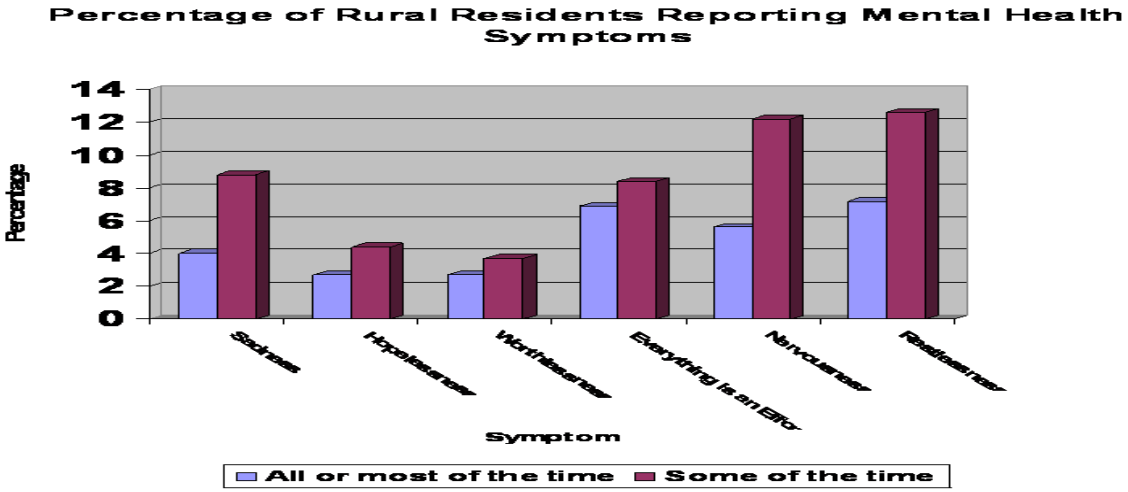
Figures 2 and 3 give a snapshot of mental health symptoms most often reported by women and rural residents, respectively. For each symptom, women reported a higher incidence of the symptoms than men (not shown). There is a comparable pattern between symptoms reported by women and those reported by rural residents, indicating that mental health in rural areas may be shaped by women's mental health problems. Over 12 percent of women and rural residents reported symptoms of "restlessness" and "nervousness" some of the time in the past 30 days. Also 6 -7 percent of women and rural residents reported "restlessness" and that "everything is an effort" all or most of the time in the past 30 days. Older women are particularly at risk for depression and other mental disorders as they often live alone as widows or care for a disable spouse or family member, have coexisting medical conditions and poorer health and tend to be economically disadvantaged (ERS, 2005).

Figure 2



Source, NCHS 2006b

Figure 3



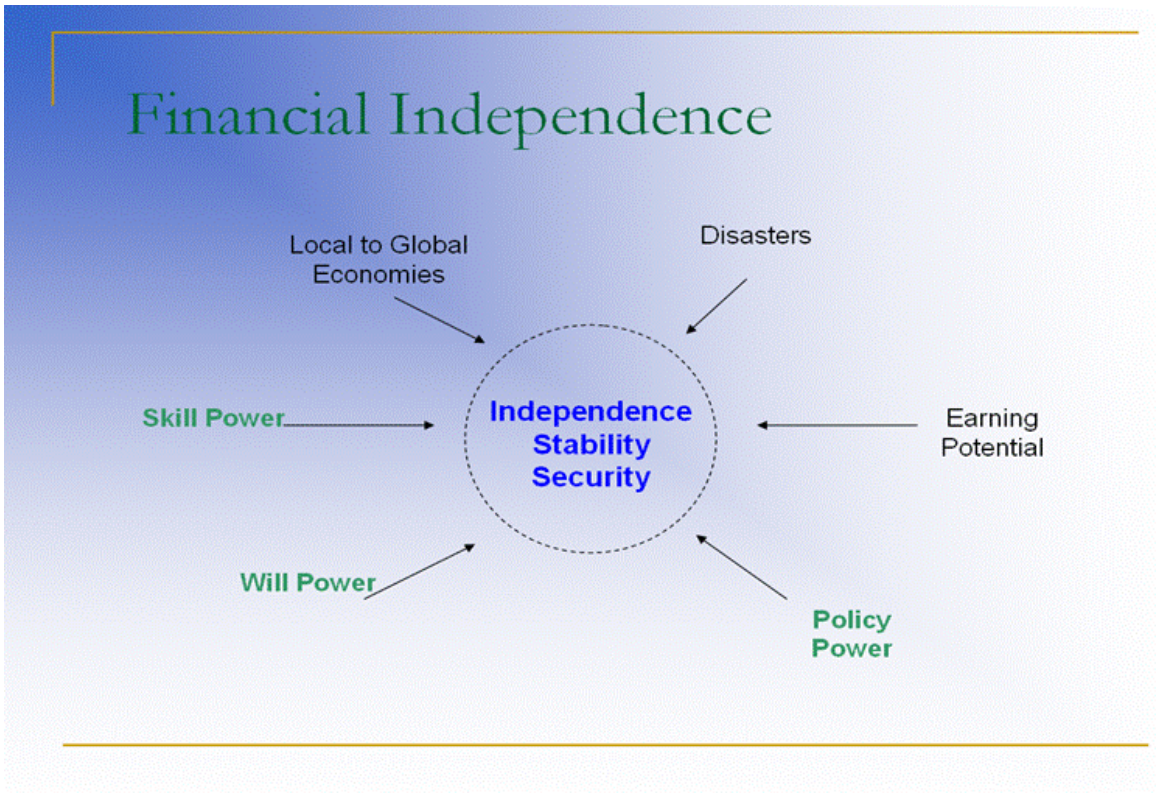
Source NCHS, 2006b

Financial Health

People show a lot of emotion when it comes to money. Money can mean a sense of fulfillment, security, power, and exciting possibilities (Goodman, 2006). Money conflicts arise when people try to satisfy basic internal needs like safety and security, power and control, or love and respect with something external such as money. Financial well-being has long been correlated to general well-being and quality of life (Andrew & Withey, 1976; Schram & Dunsing, 1986).

A person's skills, education, and will power determine earning power and effect financial independence. In particular, educational attainment and income level are often correlated. The earnings gap between rural workers with the highest and lowest educational attainment continues to widen (ERS, 2003). Earnings for rural women without a diploma fall appreciably behind those for women with a high school diploma or college degree. Average earnings in 2002 for a rural female worker with a college degree were 2.5 times more than that made by women without a high school diploma (ERS, 2003). The disparity in income and financial resources experienced by many rural women presents a challenge to achieving financial independence and well being. Having money means fulfillment for oneself and loved ones, provides a sense of security, and allows for exciting possibilities (Goodman, 2006). Also, there is a strong connection between the perception of financial well-being and general well-being with personal or family income strongly related to most indicators of health status, health care access and use and practices health related behaviors. Financial pressures put a strain on the family household dynamic and impact daily living and well-being. Those individuals and families with financial skills are more resourceful in finding solutions to multiple issues in such situations. Financial independence is influenced by many internal and external pressures (Figure 4).

Figure 4



External factors such as natural disasters such as floods, hurricanes, tornadoes, and earthquakes can wipe out homes and businesses in a flash turning peoples lives upside down. Jobs moving off shore in our global economy can really affect rural areas that may only have one large employed in the area. Governmental policy deals with crop subsidies and increased regulations can also impact the economy of rural areas.

People's attitudes about money and about credit impact their ability to manage and save money no matter what their level of income. Money attitudes run the gamut of feelings and beliefs to include obsession, security, power, inadequacy, retention, and effort/ability (Furnham, 1984). Furnham noted that money attitudes are multidimensional and that demographic variables influence a person's money beliefs and behaviors. Obsession and power/spending were significantly related to a person's sex, age, and education. Males and less educated people tended to be more obsessed with money than their counterparts. Younger people were more likely to use money as a means of power than older people.

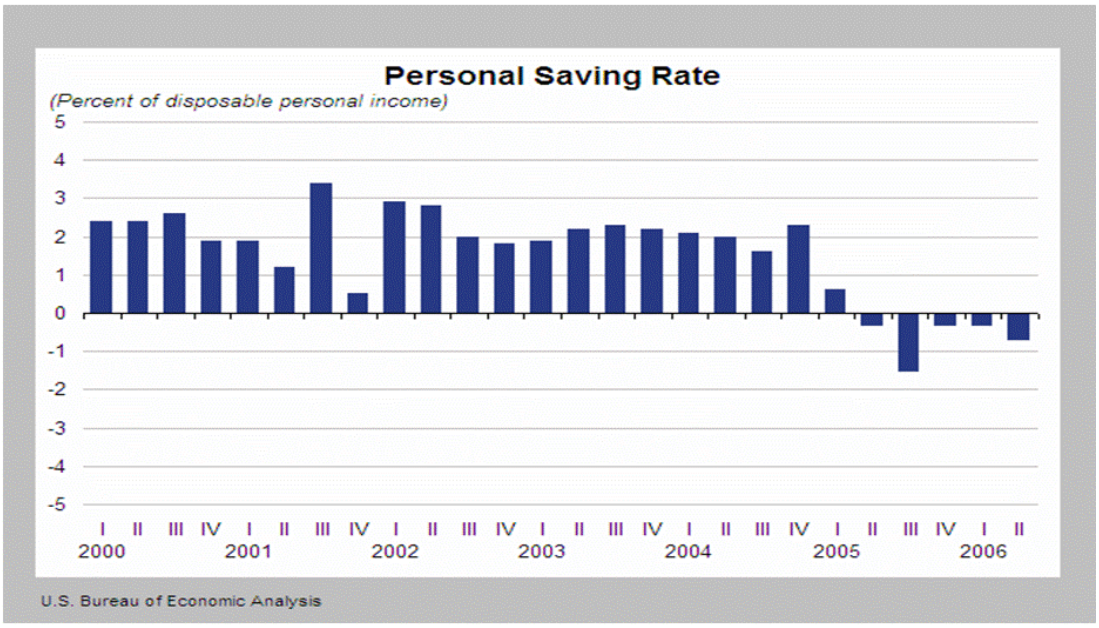
Money personalities are characterized by certain behaviors related to the spending and saving of money. Money personalities include the avoider, saver/hoarder, spender/debt desperado, striver/status seeker, and the money monk. According to Mellan (1993), a 'hoarder' is someone who enjoys holding onto money and finds it difficult to spend money on luxury items for immediate self gratification. A 'spender' loves to spend money on whatever brings pleasure. A 'money monk' tries to avoid having too much money and often feels guilty if he/she is too prosperous. An "avoider" puts off every

everyday money management tasks and may feel anxious or incompetent about dealing with money.

The saver is characterized by certain values and attitudes about money that lead to influence a person's ability to save money. Research is currently being conducted to see the relationship between money attitudes, impulsivity, self-control, materialism, and perfectionism and the stage of saving a person is in. The stages are precontemplation, contemplation, preparation, action, and maintenance (Procaska, DiClements, Norcross, 1992a, 1992b, 1994) not just savers and non-savers as used in previous research.

Data from the Bureau of Economic Analysis shows the decreased rate of personal saving as a percent of disposable personal income, for 2005 and 2006 (BEA, 2006).

Figure 5



Source BEA, 2007

As households have decreased savings they are less able to meet hardships that occur. This may make it hard for rural families who may live in areas where additional employment is difficult to come by. Other impacts on a person's ability to save as well as having the financial resources to save are health status, level of education attainment, gender, ethnicity, access to retirement plans, personal and economic planning and expectations, and planning horizon. Health status may limit one's earning power in addition to raising expenditures on care. Increased education not only improves one's employment possibilities, it may increase a person's knowledge of savings and investment vehicles, tax benefits, etc. Women earn less than men in the same profession and may leave the workforce to care for children and parents thus lowering their ability to save and their benefits form social security. Different cultures view savings and helping

family members differently and that may affect a person's ability to save. Whether a person is eligible to participate in a retirement plan at work and thus have access and tax benefits taken into account and have saving deductions done automatically may make it easier for some people to save than others. People who have an internal locus of control that feel that they can make a difference in their lives and who look to the future are more likely to save than those who feel they have no control and live in the present. Planning horizon deals with how long before you need the money. A person who has a long time until they need the money can take more risk as they have time to recover from things like down markets.

As discussed previously, rural America struggles with many aspects of health care to include the cost of medical insurance and the access to and cost of health care. Associated health care costs are often outside the financial reach of rural residents, contributing to debt and further limiting financial resources for saving. Also, the retirement plan opportunities and outlook for rural residents with many farmers often self employed or women under or unemployed are few and limited. Likewise the ability to save for long-term care is prohibitive for many rural residents due to both the cost and lack of available facilities. Since rural areas generally have a higher proportion of older persons in their total population than urban areas, (ERS, 2005) this adds the additional stress of caregiving of parents and older family members to the lives of many rural women.

Housing

Many rural areas have experienced growth both economically and in population during the past decade. This has impacted on housing needs in rural areas with issues related to both housing adequacy and affordability continuing to affect a substantial number of rural households (Whitener, 1997). Housing costs are the single largest item in a household's budget and the lack of affordable decent housing is one of the most critical housing challenges facing our society. Far too many rural residents live in housing classified as substandard and such households are burdened with high housing costs and related expenses at 30-40 percent of their income. Since the environments or places we live work and play affect us socially, physically (including our health), psychologically, and financially, adequate and affordable housing can be very important to the physical, mental and financial health of women. This is particularly relevant in that 30 percent of female headed households are poor and have limited options and resources for adequate housing women head. In fact, women head 59 percent of the 5.3 million families with the "worst case" housing needs.

People are exposed to a number of safety and health hazards in the home environment capable of producing serious diseases and injuries, sometimes fatal. Lead poisoning, asthma, mold, injuries and other negative health outcomes are attributed to certain housing conditions. Rural women often live in older homes or substandard housing. Such homes are more prone to moisture intrusion due to deterioration, poor maintenance or design deficiencies. The quality of air in these homes can be worse than the quality of outdoor air, contributing to increasing rates of asthma, especially in children. Rural

housing may also be a repository for pesticides or other toxic chemical associated with farming as well as a place where insect pest, rodents and other animals may be found. Unintentional injuries from a house in need of repair or from a fire are also important concerns for rural housing. Accidents in the home injure more than 6 million people with falls and poisoning the major causes of home injuries. The cost of some injury prevention devices, such as smoke alarms, electrical socket covers, stair rail and the like may be too expensive for many rural families to afford.

Rural areas are aging rapidly as a result of aging-in place, out-migration of young adults, and immigration of older persons from metro areas (ERS, 2005). Many older people lead active and independent lives, but as people age, chances increase for physical, mental and financial challenges with living independently. The majority wants to "age in place," but this may require home modification due to disability or illness. For older rural women in particular, older, substandard housing may be a problem as money is not available for housing repairs or upgrades.

However, several housing options do exist for older Americans. These include manufactured housing, assisted living, elder cottages, nursing homes, continuing care, accessory apartments, and home sharing. Also, universal design and visitability of housing which creates safer homes for people of all ages and abilities takes on particular significance for safety in the home for older consumers.

The quality of our everyday lives is significantly affected by our housing. A home's architectural design features influences the quality of living in that home and can support or hinder our ability to live in our homes safely, comfortably and conveniently. Most homes have traditionally been designed with the physical abilities of a 20-year old non-disabled male in mind. Our physical needs change as we age and yet most homes do not accommodate these changes. Universal design features built into a house when it is constructed can accommodate these changing physical requirements. Some general features would include doorways at least 32" wide, at least one step less entrance to the home, stair handrails where there are steps, and turning space in all rooms. (Center for Universal Design, 2003)

Family Caregiving

The need to support informal caregivers is a rural health care issue. Caregiving is full of different stages, transitions, and stresses including financial and family burdens and over 60% of the nation's caregivers are women (National Alliance for Caregiving and AARP, 2004). In many rural areas, low population combines with lack of health services, poverty, underserved areas and geographic isolation. Particularly with the elderly, family members, neighbors and friends often fill the service gap, providing both direct and indirect caregiving services (Rural Assistance Center, 2007b). A 2004 study by the National Alliance for Caregiving and AARP estimated that 21% of the U.S. population provides unpaid care to friends and family age 18 and older. This translates into 44.4 million caregivers in the U.S. today. Finding resources to help with rural caregiving can be difficult, because rural caregivers are isolated from social support, resources, financial

assistance, training, respite options, community programs, and information on caregiving, especially as pertains to the diverse population groups, minorities and the poor. Most families are not prepared to meet growing caregiving responsibilities. This results in significant impact on the health and wellness of women in rural communities (Rural Assistance Center, 2007b).

Family caregivers who provide care 36 or more hours weekly are more likely than non-caregivers to experience symptoms of depression or anxiety. For spouses the rate is six times higher; for those caring for a parent the rate is twice as high (Cannuscio, et. al. 2002). Family caregivers experiencing extreme stress have been shown to age prematurely. This level of stress can take as much as 10 years off a family caregiver's life (Arno, 2006). Family caregivers report having a chronic condition at more than twice the rate of non-caregivers (HHS, 2000).

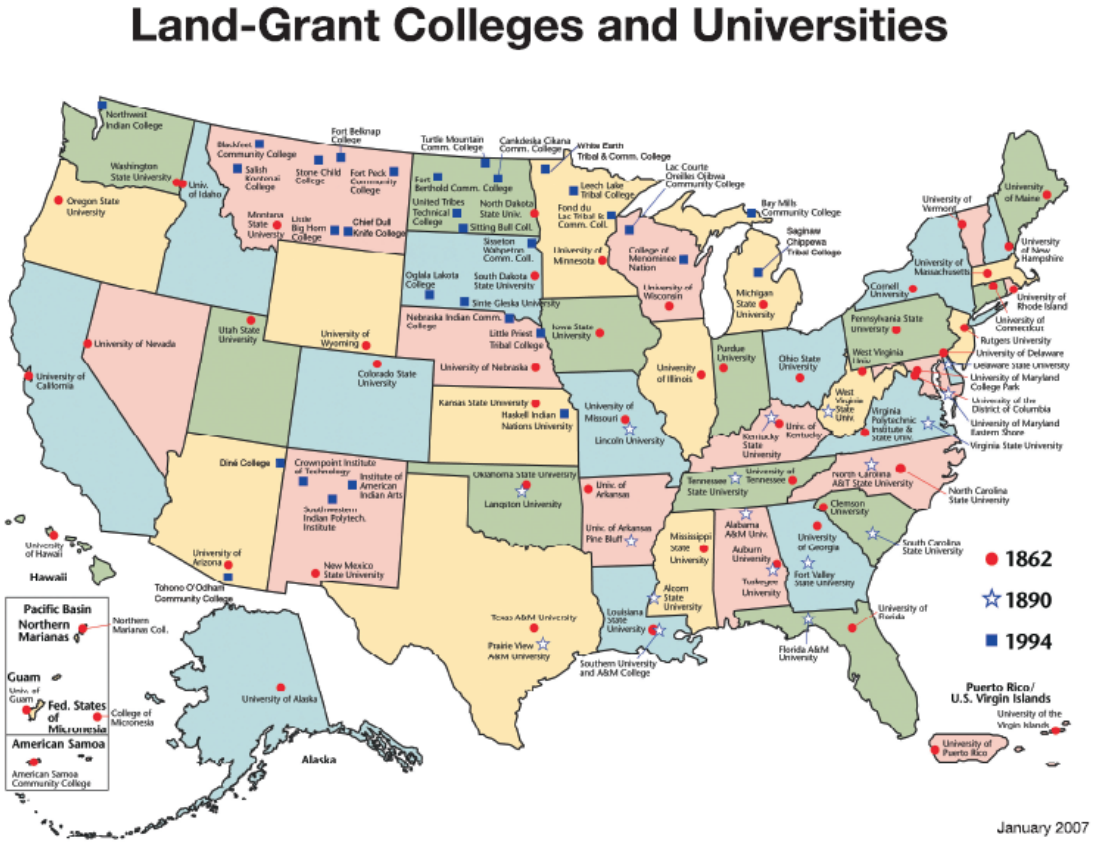
In addition to caring for aging parents and spouses, older rural women are caring for children of relatives when parents are unable to provide care. Census data indicate that well over 2.4 million grandparents provide care to grandchildren who are living with them. Additionally, caregiving can greatly impact workforce productivity. Increasing family caregiving responsibilities have collided with the smaller employed family to intensify pressures on caregivers. For example, caregiving demands often interfere with job responsibilities. Caregivers in minority households are more likely to be caring for their mother (42%) than those in non-minority households (25%) (National Alliance For Caregiving, 2005).The overall physical, emotional, and financial costs of caregiving are often collectively referred to as caregiver burden (Sherwood, et. al., 2005). A conservative estimate reports that 20% of family caregivers suffer from depression, twice the rate of the general population. Feelings of depression can become a serious problem for some caregivers. For women with limited resources in rural areas, the stress and burden associated with caring for children and elderly parents can have a significant impact on physical and mental health.

Extension's Role in Supporting Positive Mental Health

Health encompasses a broad array of issues. The Cooperative Extension Service (CES) works to address health issues by forming partnerships with others in the health community at the local, state, and federal levels. In particular, CES is an important player in the lives of rural Americans. Through university family and consumer programs and outreach efforts, CES helps individuals and families become resilient and healthy by teaching nutrition, food preparation skills, positive child care, family communication, financial management, and health care strategies.

The CES has a Responsibility to Rural Communities

The programs and resources discussed in this paper are products of the U.S. Department of Agriculture's (USDA) Cooperative State Research, Education and Extension Service (CSREES). CSREES is the federal partner in the CES, providing support through federal funding and through national program leadership to identify and address current issues and problems focused on agriculture, the environment, human health and well-being, and communities. In particular, CSREES supports research, education and extension programs in the Land-Grant University System. The most prominent among its many partners, this system is comprised of more than 100 colleges and universities. A land-grant college or university is an institution that has been designated by its state legislature or Congress to receive unique federal support. Within this system, CSREES works with individuals and families in rural communities to build prosperity through research, education, and extension, often through the USDA's Rural Regional Development Centers {http://www.nal.usda.gov/ric/ruralres/regional.htm}--with their many partners in the university system and in communities across the country. The scope of this network is shown in the map below:



Enhancing Physical and Mental Health

Through outreach efforts and partnerships with others in the health community CES health specialists work to address many of the physical and mental health concerns facing rural Americans at the local, state and national levels. For example, to increase access to nutrition and physical activity programs and health information by Americans two partnerships been established recently at the national level. The first with America On The Move® (AOM) (http://aom.americaonthemove.org/) focuses on good nutrition and regular physical activity. AOM is a national initiative dedicated to helping individuals and communities across the country make positive changes to improve health and quality of life. AOM inspires people of all ages to have fun, shows simple ways to become more active by engaging individuals through interactive media, and supports community involvement and behavior change. AOM emphasis, along with its community presence, (http://www.csrees.usda.gov/nea/food/part/health_part_aom.html) complements CES efforts to reach out to individuals, families, and communities to improve Americans' nutrition, health and fitness, and the environment so that it supports healthy food choices and physical activity The second with The Food and Drug Administration, Office of Women's Health (FDA OWH) (http://www.fda.gov/womens/) addresses health issues of women, their families, and caregivers. FDA OWH funds research and collaborates with national organizations, corporations, and Federal agencies to sponsor outreach and education efforts. In partnership with CSREES, it expands its outreach services to CES health educators; thereby, recognizing their role in providing health information to consumers across the life span. Printed materials are available from FDA OWH to CES specialists and others (http://www.csrees.usda.gov/nea/food/part/health_part_fda.html) on a variety of topics to include: heart disease, depression, lung cancer, menopause, HIV/AIDS, smoking and diabetes.

In addition, CES focuses on the many health issues and challenges faced by rural Americans and their families at the community and state levels. One such example is The Rural Health Initiative from Montana State University. Through outreach efforts, this Initiative is establishing a Rural Health Resources Program for rural Montanans. This program is designed to assist rural under-served, under-represented, vulnerable and special needs population and communities to improve their quality of life and daily functioning by providing technical assistance to local government and assisting needy communities in seeking out source of funding to address unmet health and social services (http://www.csrees.usda.gov/nea/food/pdfs/ruralhealth.pdf).

Improving Personal Finances

Through outreach efforts and consumer programs to improve the finances of rural Americans, financial management extension specialists and others have made use of the Transtheorectical Model of Behavior Change. First used for addictive behaviors in drug and alcohol interventions; it is now being applied to change financial behaviors (Procaska et al., 1992a, 1992b, 1994).

A recently introduced program to the system “Small Steps to Health and Wealth™ ” (http://www.rcre.rutgers.edu/sshw/) is based on the premise of changing behavior one

step at a time. This program is designed to motivate consumers to implement behavior change strategies that can work to either improve their health or their personal finances. In addition, through the Financial Security in later Life Initiative, Cooperative Extension seeks to help people improve personal financial behaviors leading to financial security in later life as well as enhance the capacity of local educators and their partners to deliver effective programs, and increase economic vitality and quality of life for families and communities. More information about this Initiative with useful tools for both consumers and educators are found at http://www.csrees.usda.gov/fsll.

Ensuring Adequate Housing

The goal of the CSREES Housing and Indoor Environment program is to contribute to the quality of life for consumers through sustainable housing programs including safe and affordable housing, air and water quality, and energy. CSREES works with other federal agencies, nonprofits, the private sector, and in coordination with our Land-Grant University System partners. Together, they provide research, education, and outreach programs for consumers and professionals in housing, health, and environmental fields to help them make accurate decisions about homes and the environment.

Cooperative extension provides housing and environment programs that can help rural communities including the following national programs: Healthy Indoor Air for America's Homes; Healthy Homes; Breast Cancer and Environmental Risk Factors; Housing Affordability/Counseling; and Universal design and visit ability.

Specific state examples of the above programs of interest for rural communities are "Rent Smart" and "Universal Design and Home Accessibility Program." Rent Smart is a teaching guide designed to be the core of a community tenant education program to help individuals develop the life skills necessary to become successful tenants. Developed by the University of Wisconsin-Extension, this outreach program is being used throughout the North Central States region and reached approx 4,000 tenants and landlords annually. Universal design is an approach to the design of products, services and environments to be usable by as many people as possible regardless of age, ability or situation. It strives to be a broad-based solution that helps everyone, not just those with disabilities. The Universal Design and Home Accessibility Program of Iowa State University provides definitions /descriptions for accessible, adaptable, visible and universal design; building and remodeling ideas; gadgets and gizmos to make everyday life easier; and laws and regulations and policies and standards to make building assessable.

Supporting Family Caregivers

Family caregiving is emerging as a major social and economic issue in the United States, impacting every area of family life. There is a growing demand for family strengthening programs that support caregivers and delay institutionalization of the aged and infirm. According to the National Advisory Committee on Rural Health and Human Services (2006), the utilization of caregiver support services can be expanded through increased outreach and education to diminish the stigma related to these services. There a number

of high quality family caregiving outreach and educational resources available through the CES. One example of an Extension program focused on caregiving issues is from University of Wisconsin Extension. Wisconsin Extension provides critical leadership to the Wisconsin Alliance for Family Caregiving, which helps family caregivers maintain their health and well-being and supports them in their caregiving roles and responsibilities. The Alliance provides education, resources and support to organizations and individuals who work with family caregivers, training class leaders and facilitators to use resources such as *Taking Care of You: Powerful Tools for Caregiving; Caregiving Relationships for People Who Care for Adults*; and *Caregiving Near Life's End.* The Alliance received grant funding to become non-profit organization and a website was established (http://www.uwex.edu/ces/flp/caregiving/), resulting in outreach to caregivers throughout the state. As a result family caregivers are connecting to new resources, getting help with daily tasks, using relaxation to cope, coping on a daily basis with stress, reporting not feeling as sad and using action plans.

A national example of Extension's role in family caregiving can be found in the eXtension Initiative. eXtension is a collaborative internet site where land-grant university faculty provide their expertise to produce new educational and information resources on a variety of topics. eXtension takes the Cooperative Extension System to a greatly expanded level by introducing millions of Americans to innovative, objective, research-based information and education. Through the power of the Internet, eXtension complements the work of Extension agents and educators already working in nearly every U.S. county. This emerging technology can greatly enhance CES' service to rural communities through a 24/7/365 Internet-based resource designed to provide access to objective, research-based programs solving real problems in real time. Content on the eXtension web site is created by groups of experts called Communities of Practice (CoP). Educators from all parts of the land-grant system work together to consolidate existing information from the land-grant system, create new materials, answer user questions, perform distance diagnostics, and interact with eXtension users through live chats and discussion groups.

A multi-state, multidisciplinary Family Caregiving Working Group has emerged to become an Extension Community of Practice, strategically collaborating to assist providers and educate caregivers on a variety of issues and challenges. The Family Caregiving CoP brings together experts from the fields of gerontology, human development, intergenerational relations, family resource management, nutrition, health, housing, agriculture, and community development working to support and educate caregivers and their families. For rural communities, the Family Caregiving CoP provides the best university research on caregiving topics to help educators and citizens improve the quality of their lives by making wise caregiving decisions.

CONCLUSIONS AND DISCUSSION

The information discussed here on the physical, mental and financial health of rural women confirms that social forces and resources are not evenly distributed between rural and urban areas. Opportunities were presented to help alleviate hardships associated with rural-urban inequality due to substandard rural housing, inadequate finances, and caregiver burden. The realization of these opportunities calls for a collaborative effort on the part of rural community agencies, services and systems to support the mental health and well-being of women and their families. This is best achieved through an integrated approach of research, education and practice as epitomized by the land-grant university system and its community and public health partners. Through its ongoing community-based participatory research activities and outreach efforts the land-grant university system via the CES can and does make a difference to the lives and health of rural residents and rural communities. Future efforts are needed to effectively promote this system to other organizations and institutions working in rural communities and to encourage collaborations for related research and community-based activities. Utilization of CES and the coming together with others will best serve the physical health, mental health and daily living needs of rural residents and has the potential to enhance rural communication and mental health services through improvements in technology and rural infrastructure.

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