

Summary

Behavioral Health in Rural America: Challenges and Opportunities **Rural Health Policy Research Institute** **December 2019**

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Although all sectors of society are affected by behavioral health disorders (BHDs), the prevalence of many diagnoses and unmet needs is unequally distributed based on several factors such as place of residence, sub-population within society, etc. Rural areas present a particular challenge when it comes to the availability of prevention, diagnosis, treatment, and recovery services, so particular attention to rural areas is paramount.

I. The Prevalence of Behavioral Health Disorders and the Rural Context

The three core factors pertaining to addressing behavioral health (BH) in rural areas are defined as the prevalence of BHDs, access to care, and social factors affecting both of the former. Social factors include rural-urban geography, socioeconomic conditions, high-risk populations, and rural culture(s). Access depends on the “4 As and an S”: accessibility, availability, acceptability, affordability, and stigma. Prevention focuses on reducing the onset of conditions and minimizing the effects of existing conditions; treatment focuses on addressing BHDs and providing care; and recovery focuses on re-integrating people emerging from BHDs into everyday life.

The Prevalence of Mental Health Conditions

The overall prevalence of mental health conditions (MHCs) is comparable across urban and rural areas; however, the prevalence of specific conditions (i.e., suicidality and depression) is not. For example, from 2013-2015, there was a 10% higher suicide rate in rural areas than in urban areas. The suicide rate is also growing faster in rural areas; from 2001-2015, the suicide rate increased by 14% in rural areas compared to 10% in urban areas. The higher rural suicide rates may be attributed to limited access to mental health (MH) services, higher rates of substance use, greater availability of firearms, and reduced access to healthcare services. Different rural sub-populations also face variations in MHCs based on socioeconomic status, veteran status, sex, and race. The downstream effects of the severity of MHCs in rural areas exacerbate illness and have social consequences including family tension, increased homelessness, increased unemployment, increased incarceration, decreased productivity, and increased strain on healthcare services.

Rural Substance Use Disorders

Alcohol, the most commonly used substance across the country, is more prevalent among rural 12-20 year olds than urban 12-20 year olds. Binge drinking and driving under the influence are also more common in rural areas. The use of illicit, such as opioids and methamphetamines, and prevalence of downstream effects is also growing more rapidly in rural areas. The overdose

death rate in rural areas grew by 325% between 1999-2015 and surpassed the overdose death rate in urban areas in 2015.

Factors Contributing to Rural Behavioral Health Needs

Rural-urban behavioral health disparities are largely related to socioeconomic disparities (i.e., more poverty, higher unemployment, and less insurance in rural areas) between the two environments. Rural residents also tend to face greater stigma, higher rates of chronic illness, increased hopelessness, and lower education rates than their urban counterparts.

Rural Sub-populations at High Risk

Women (particularly pregnant women), adolescents, children, veterans, minority racial and ethnic populations, elderly populations, and people with co-occurring conditions are particularly vulnerable to MHCs and substance use disorders (SUDs) in a rural context.

II. Access to Behavioral Health Services

Accessibility

Rural people face added challenges (shortages of behavioral health providers, limited specialty services, and long travel distances) to accessing behavioral health services as compared to their urban counterparts, and achieving equal access for rural people will require creative strategies such as regionalizing systems of behavioral health care, encouraging the integration of behavioral health and acute medical care medical services, expanding telehealth, and implementing team-based systems of care.

Availability

An appropriately trained behavioral health workforce is required for services to be available. According to a previous study, rurality and per capita income were the two most reliable predictors of mental health workforce shortages; shortages in rural areas can be attributed to underfunding of behavioral health services, low salaries, limited reimbursement, high case loads, and limited supporting services. As such, rural areas need to maximize use of their scarce local resources by expanding workforces, implementing team-based care approaches, using community workers, and finding alternative ways to deliver care. Medication-assisted treatment (MAT) is also limited in rural areas; in 2017, 60% of rural counties did not have a physician qualified to prescribe buprenorphine for opioid use disorder (OUD). Criminal justice systems in rural areas also report high levels of MHCs in their incarcerated populations but inadequate resources to address them.

Acceptability

Acceptability is linked to stigma; a lack of anonymity in rural areas discourages people from seeking care for MHCs. As such, it is necessary for rural areas to facilitate the integration of behavioral health services into primary and acute care services. Acceptability is also tied to

cultural sensitivity; it is essential for behavioral health providers to be attuned to the unique cultural and clinical needs of the populations that they serve.

Affordability

Rural residents have a higher likelihood of being uninsured, are less likely to be insured through an employer, and are more likely to receive Medicaid than urban people. About 2/3 of rural uninsured individuals live in states that did not expand Medicaid under the Affordable Care Act. Rural people covered by private insurance are more likely than urban people to have high deductibles and are less likely to have a health savings account. Providers also contribute to the problem; for example, some behavioral health providers may not participate in provider panels for commercial health plans, and some (especially OUD treatment programs) may offer their services on a cash-only basis.

Stigma

Social misconceptions, stereotypes, prejudices, misinformation, and a lack of anonymity are all issues in rural communities that stigmatize MHCs and behavioral health disorders and also discourage people from seeking treatment.

Facilities

Rural people often do not have access to behavioral health treatment facilities; those who do typically have less choice and must travel a longer distance than their urban peers. Of the 595 active psychiatric hospitals in the United States, only 73 are in rural areas; of the 1,054 acute care hospitals that operate prospective payment-exempt psychiatric units, only 232 are in rural areas. Approximately 80% of substance use treatment centers can be found in urban areas. As such, telehealth is a promising tool for expanding behavioral health treatment services in rural areas. Barriers to telehealth adoption and utilization include reimbursement challenges, a lack of high speed internet access, cross-state licensure issues, and challenges pertaining to incorporating telehealth into clinical care settings.

Rural-Urban Differences in the Use of Behavioral Health Services

Rural residents are generally less likely to make use of office visits and more likely to receive medications for their behavioral health conditions. They are also generally less likely to receive treatment for their diagnoses than their urban counterparts. Rural people are more likely to seek help through primary care providers, hospitals, schools, the criminal justice system, and faith-based organizations. However, travel distance presents a significant barrier to accessing services of any kind. Despite other types of challenges (provider supply, reimbursement rates, practice patterns, etc.), integration of behavioral health services into general medical care is a promising solution for access challenges. Increased behavioral health training (i.e., MAT training) for healthcare providers is a necessary component of this integration.

III. Developing Comprehensive Behavioral Health Service Systems

A community-wide response involving different stakeholders is necessary for implementing comprehensive strategies for prevention, treatment, and recovery in rural areas.

Community Engagement

Community engagement is the first step toward recruiting necessary stakeholders. Broad-based coalitions have been proven to enhance local behavioral health services significantly. Project Vision based in Rutland, Vermont is an example. Since 2012, it has engaged more than 100 local, state, and federal stakeholders and has reported reductions in drug-related crimes, increases in treatment options, and the development of recovery programs in its target area(s).

Prevention

The implementation of evidence-based prevention strategies can address and minimize individual and societal costs of behavioral health disorders (BHDs); they should address the needs of high-risk populations and the general population, and they must be adapted to the unique needs of each community. Successful strategies that rural communities may consider include laws, regulations, and community education to reduce harmful alcohol use; laws and regulations to reduce access to lethal means of suicide; school-based social and emotional learning programs to prevent the onset of BHDs in children and adolescents; community-based parenting programs; training programs to help gatekeepers identify people with mental illness; broad-based coalitions; and/or needle/syringe exchange programs. The Fostering Futures Project in Wisconsin provides an example of a prevention strategy. In a coordinated effort between a local clinic and a local school district, the Fostering Futures Project has witnessed an increase in behavioral health service utilization, a decrease in school suspensions/expulsions, a decrease in substance use rates, a decrease in teen births, an increase in staff understanding of trauma issues, an increase in graduation rates, and an improvement in student health measures.

Treatment

Treatment must be evidence-based, coordinated/integrated, and tailored to each individual. As discussed earlier, integration of behavioral health and primary care is key, and the most common model of this integration puts specialty behavioral health providers into primary care settings. Integration can incorporate referral agreements, shared space arrangements, contractual agreements, and employment arrangements. In this model, primary care providers are responsible for screening for BHDs and the prescription of medications, while counselors and psychologists provide counseling and psychotherapy. More recently, the integration of MAT into primary care settings has gained traction. Cherokee Health Systems in Tennessee is an example of a rural integrated service; it embeds behavioral health consultants (i.e., psychologists, clinical social workers, etc.) into primary care teams, and coordination of care is facilitated through shared electronic health records. Regionalization of services depends on linkages between local providers and specialty behavioral health providers; an example is the hub-and-spoke model of MAT for OUDs. The spokes are local service providers who are MAT-qualified,

and the hubs are larger specialty providers who offer consultative support and act as a referral source for patients with more complex needs. Washington State and West Virginia have implemented hub-and-spoke networks for MAT delivery in rural areas. Telebehavioral health is a final option for expanding access to behavioral health care in rural areas, as it can improve access to evaluation and diagnosis, case consultation, treatment, medication management, continuing care, and provider education. The Wyoming Trauma Telehealth Treatment Clinic for survivors of domestic violence and sexual assault is an example; doctoral students from the University of Wyoming provide services under the supervision of psychologists.

Recovery

Recovery is supported by good relationships, financial security, satisfying work, personal growth, affirming living environments, culture or spirituality, and resilience to stress/adversity. Community education programs aimed at reducing stigma are the first step toward developing a supportive environment for recovery programs, and support for recovery may take the form of self-help groups, peer support, recovery support services, and/or recovery centers. The Personal Helpers and Mentors (PHaMs) service and the Vermont Recovery Network are examples of community-based recovery programs. Peer recovery programs, often involving the use of peer-recovery coaches to help clients, implemented in rural areas include the Centra Wellness Network, the Marquette Peer Recovery Drop-In Center, and START – Sobriety Treatment and Recovery Teams. The Marquette Peer Recovery Drop-In Center in Michigan’s Upper Peninsula offers peer mentoring/coaching, connection to resources, recovery groups, and social activities for individuals recovering from substance use disorders.

IV. Policy Options to Address Behavioral Health Disorders

Increased policy attention and the mobilization of local resources have worked together produce promising strategies and approaches to the expansion of behavioral health services in rural areas. There are four broad, interrelated areas where focused policies are needed. All of these areas depend on each other for their success.

Promote Rural Community Engagement

Policy strategies for promoting community engagement include the following:

- Leveraging existing and new federal and state incentives, technical assistance, and funding to encourage collaborative community engagement to address social and economic drivers of behavioral health disorders; combatting stigma; undertaking education programs; engaging stakeholders; rationalizing use of scarce resources; developing prevention, treatment, and recovery services; and connecting to regional systems of care.
- Using state and local resources and organizations to disseminate information on successful rural prevention, treatment, and recovery strategies and support the adaptation of these programs to fit unique local needs.
- Using state and local resources and organizations to support rural community education aimed at reducing stigma, promoting awareness that behavioral health disorders are

preventable and treatable, and informing residents about existing behavioral health resources.

- Helping local communities and regions explore alternative sources of support for local, regional, and state efforts to improve behavioral health service systems, including philanthropic and foundation funding, hospital-community benefit resources, in-kind contributions, sharing of resources, and the use of settlement funds that may result from suits against the pharmaceutical industry.

Support Development of Local and Regional Behavioral Health Services

Policy strategies for developing systems of care at the local and regional level include the following:

- Requiring local and state behavioral health agencies and organizations to assess local and regional gaps in services, unmet needs, the adequacy of service systems, and available resources to expand access to services.
- Encouraging and providing technical assistance to local, county, and state behavioral health agencies to plan and develop regional prevention, treatment, and recovery services.
- Using existing federal and state programs to create incentives to develop regional systems of behavioral health care that minimize unproductive competition, conserve scarce resources, provide access to specialty services, support local service delivery, and develop a financially sustainable service system.
- Encouraging states to invest in regional evidence-based prevention, treatment, harm reduction, and recovery programs.

Reform Behavioral Health Regulatory and Payment Policies

Strategies for regulatory and payment policy reform can lead to the expansion of coverage for behavioral health disorders and can support innovative care delivery system models by the following:

- Encouraging the integration of behavioral health and primary care services.
- Promoting the delivery of behavioral health services by Federally Qualified Health Centers, Rural Health Clinics, school-based clinics, and rural hospitals.
- Expanding the use of telehealth technology to facilitate access to treatment and recovery services.
- Modernizing telehealth policies to expand the use of technology to improve prevention, enhance access to care, and promote recovery.
- Funding the use of peer recovery workers.
- Supporting access to affordable health care coverage by improving the functioning of state health insurance markets, reducing regulatory burdens, and expanding Medicaid.

Expand the Behavioral Health Workforce and Create Incentives for Rural Practice

Policy strategies for expanding rural behavioral health workforces include the following:

- Exploring federal and state reimbursement and scope-of-practice regulations to expand the pool of reimbursable providers.

- Revising Medicare reimbursement policies to cover an expanded array of behavioral providers such as master's-trained counselors, marriage and family therapists, and peer support counselors.
- Encouraging the use of peer recovery and community health workers by creating training programs and developing payment policies to encourage their integration into behavioral health teams.
- Developing and funding more effective rural recruitment and pipeline programs.
- Expanding scholarship and loan repayment options to encourage rural behavioral health practice.
- Using technology to support supervision and collaboration among rural providers to reduce isolation and burnout.

Reference

Rural Health Policy Research Institute. (2019). *Behavioral Health in Rural America: Challenges and Opportunities*. Retrieved from <http://webcache.googleusercontent.com/search?q=cache:4KANxWDjY74J:www.rupri.org/wp-content/uploads/Behavioral-Health-in-Rural-America.pdf+&cd=1&hl=en&ct=clnk&gl=us>