Roundtable Discussion on Behavioral Health in Rural Communities

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Overview

• Behavioral health needs in the US have never been higher
• Thinking about levers to impact “access” to behavioral health services for rural communities
• Focus on:
  1. Integrated behavioral health services
     • Primary Care Services
     • Schools/School-based health centers
  2. Tele-behavioral health
     • Increasingly larger role, especially for rural areas
  3. Treating Opioid Use Disorders
     • Medications for Opioid Use Disorders
     • Peer Recovery Models
     • Harm Reduction Models
Why should we care about behavioral health?

- Behavioral health challenges impact every family and community--- directly and indirectly
Behavioral Health Need is High

Pandemic Causes Spike in Anxiety & Depression

% of U.S. adults showing symptoms of anxiety and/or depressive disorder*

- 2019
- Jun 2020
- Dec 2020
- Jun 2021
- Dec 2021

Symptoms of anxiety disorder:
- 31.7%
- 26.1%
- 26.5%
- 8.1%

Symptoms of depressive disorder:
- 30.2%
- 21.6%
- 21.4%
- 6.5%

Symptoms of anxiety or depressive disorder:
- 36.0%
- 30.4%
- 30.7%
- 10.8%

* Based on self-reported frequency of anxiety and depression symptoms. Derived from responses to Patient Health Questionnaire (PHQ-2) and the Generalized Anxiety Disorder (GAD-2) scale.

Sources: CDC, NCHS, U.S. Census Bureau
Behavioral Health Need is High

Figure 3
Share of Parents Reporting Worsening Mental Health For Their Children Ages 5-12, October-November 2020

- Overall Worsening of Mental or Emotional Health: 22.1%
- Elevated Symptoms of Depression: 4.4%
- Elevated Symptoms of Anxiety: 6.3%
- Elevated Symptoms of Psychological Stress: 9.2%

But behavioral health problems were growing even prior to the pandemic.

Figure 2

Percent of High School Students Who Seriously Considered Attempting Suicide in the Past Year, 2009-2019

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>13.8%</td>
</tr>
<tr>
<td>2011</td>
<td>15.8%</td>
</tr>
<tr>
<td>2013</td>
<td>17.0%</td>
</tr>
<tr>
<td>2015</td>
<td>17.7%</td>
</tr>
<tr>
<td>2017</td>
<td>17.2%</td>
</tr>
<tr>
<td>2019</td>
<td>18.8%</td>
</tr>
</tbody>
</table>

Serious Mental Illness in the Past Year: Among Adults Aged 18 or Older; 2008-2020

Results from the 2020 National Survey on Drug Use and Health
Youth Behavioral Health by Rural/Urban Status

Results from the 2016-2019 National Survey of Children’s Health (NSCH); 2018 National Survey on Drug Use and Health

<table>
<thead>
<tr>
<th></th>
<th>ADHD</th>
<th>BEHAVIORAL PROBLEMS</th>
<th>DEPRESSION</th>
<th>ANXIETY</th>
<th>SUBSTANCE MISUSE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Urban/Suburban</td>
<td>Rural</td>
<td>Total</td>
<td>Urban/Suburban</td>
</tr>
<tr>
<td>Youth Mental Health by Urban/Rural</td>
<td>9.5</td>
<td>8.5</td>
<td>5.6</td>
<td>9</td>
<td>4.1</td>
</tr>
<tr>
<td>Youth Mental Health by Urban/Rural</td>
<td>9.8</td>
<td>9.5</td>
<td>5.6</td>
<td>9.4</td>
<td>4.1</td>
</tr>
<tr>
<td>Youth Mental Health by Urban/Rural</td>
<td>12</td>
<td>10.5</td>
<td>5.6</td>
<td>10.2</td>
<td>3.8</td>
</tr>
</tbody>
</table>
Mental Health and Substance Misuse Commonly Co-Occurs

Results from the 2020 National Survey on Drug Use and Health

Substance Use: Among Adults Aged 18 or Older; by Mental Illness Status, 2020
Rate of Overdose Deaths Continues to Rise

Figure 1. National Drug-Involved Overdose Deaths*
Number Among All Ages, by Gender, 1999-2020

*Includes deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as coded in the International Classification of Diseases, 10th Revision. Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2020 on CDC WONDER Online Database, released 12/2021.
Figure 2. Urban–rural differences in age-adjusted rates of drug overdose deaths, by jurisdiction of residence: 2019

NOTES: Drug overdose deaths were identified using international Classification of Diseases, 10th Revision underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. Age-adjusted death rates were calculated using the direct method and the 2000 U.S. standard population. Decedent’s county of residence was classified as urban or rural based on the 2013 NCHS Urban–Rural Classification Scheme for Counties. Access data table for Figure 2 at: https://www.cdc.gov/nchs/data/databriefs/db403-tables-508.pdf#2
Mental Health Services Received in the Past Year: Among Adults Aged 18 or Older with Any Mental Illness in the Past Year; 2008-2020

Results from the 2020 National Survey on Drug Use and Health

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>18 or Older</td>
<td>40.9</td>
<td>40.2</td>
<td>42.4</td>
<td>40.8</td>
<td>41.0</td>
<td>44.7</td>
<td>44.7</td>
<td>43.1</td>
<td>43.1</td>
<td>42.6</td>
<td>43.3</td>
<td>44.8</td>
<td>46.2</td>
</tr>
<tr>
<td>18 to 25</td>
<td>30.3</td>
<td>32.0</td>
<td>32.6</td>
<td>32.9</td>
<td>34.5</td>
<td>34.7</td>
<td>33.6</td>
<td>32.0</td>
<td>35.1</td>
<td>38.4</td>
<td>37.3</td>
<td>38.9</td>
<td>42.1</td>
</tr>
<tr>
<td>26 to 49</td>
<td>41.4</td>
<td>40.8</td>
<td>43.3</td>
<td>41.1</td>
<td>42.0</td>
<td>43.5</td>
<td>44.2</td>
<td>43.3</td>
<td>43.1</td>
<td>43.3</td>
<td>43.9</td>
<td>45.4</td>
<td>46.6</td>
</tr>
<tr>
<td>50 or Older</td>
<td>45.2</td>
<td>42.8</td>
<td>45.1</td>
<td>43.6</td>
<td>42.4</td>
<td>50.5</td>
<td>49.9</td>
<td>48.3</td>
<td>46.8</td>
<td>44.2</td>
<td>45.8</td>
<td>47.2</td>
<td>48.0</td>
</tr>
</tbody>
</table>
Received Any Substance Use Treatment in the Past Year: Among People Aged 12 or Older Who Had a Substance Use Disorder in the Past Year; 2020

Results from the 2020 National Survey on Drug Use and Health
Children with mental health disorders who did not receive care

Note: Based on data from the 2016 National Survey of Children’s Health.
Results from the 2008 and 2016 National Survey on Drug Use and Health

<table>
<thead>
<tr>
<th>Reason for Not Receiving Mental Health Services</th>
<th>2008</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Could not afford cost</td>
<td>23</td>
<td>26</td>
</tr>
<tr>
<td>Thought could handle the problem without treatment</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Did not know where to go for services</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>Did not have time</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>Concerned about being committed/having to take medicine</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>Health insurance does not pay enough for mental health services</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Concerned about confidentiality</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Might cause neighbors/community to have negative opinion</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Health insurance does not cover any mental health services</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Treatment would not help</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Some other reason</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Might have negative effect on job</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Did not feel need for treatment at the time</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Did not want others to find out</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>No transportation/inconvenient</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

Source: 2008 and 2018 National Survey on Drug Use and Health. Note: Response categories are not mutually exclusive; respondents could indicate multiple reasons for not receiving mental health services.
COVID-19 Effect on Mental Health Services: Among Adults Aged 18 or Older Who Received Services; Quarter 4, 2020

Results from the 2020 National Survey on Drug Use and Health
## What does access mean for behavioral health services?

<table>
<thead>
<tr>
<th>Dimension of Access</th>
<th>What does this look like?</th>
<th>Levers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Availability</strong></td>
<td>Overall shortage of behavioral health providers</td>
<td>• Educational training grants</td>
</tr>
<tr>
<td><em>Demand compared to supply</em></td>
<td></td>
<td>• Loan repayment programs</td>
</tr>
<tr>
<td><strong>Accessibility</strong></td>
<td>Maldistribution of behavioral health providers</td>
<td>• Tele-behavioral health</td>
</tr>
<tr>
<td><em>Geographic relationship between the services &amp; the people in need</em></td>
<td></td>
<td>• Integrated behavioral health in CHCs and schools</td>
</tr>
<tr>
<td><strong>Accommodation</strong></td>
<td>Difficulty knowing how to get into services (24% do not know where to receive care)</td>
<td>• Care coordination</td>
</tr>
<tr>
<td><em>Ease of navigating behavioral health services</em></td>
<td></td>
<td>• Service referral lines</td>
</tr>
<tr>
<td><strong>Acceptability</strong></td>
<td>Stigma and bias continue to impact behavioral health service use</td>
<td>• Tele-behavioral health</td>
</tr>
<tr>
<td><em>Perception of behavioral health services</em></td>
<td></td>
<td>• Integrating health services into trusted health delivery and school settings</td>
</tr>
<tr>
<td><strong>Affordability</strong></td>
<td>Cost of care is the strongest predictor of the likelihood of receiving behavioral health treatment</td>
<td>• Payment policy</td>
</tr>
<tr>
<td><em>Cost of care</em></td>
<td></td>
<td>• MH insurance parity</td>
</tr>
</tbody>
</table>
Behavioral health workforce shortages in rural communities are endemic.
Integrated Behavioral Health

• Movement away from siloed care
• Co-locating behavioral health services into primary health care providers
  — Creating a team with close communication as needed and integrated treatment plan
• Universal screening and assessment for behavioral health, close connection to provide brief interventions or refer and coordinate with specialty mental health services
Integrated Behavioral Health may be maldistributed in rural communities

How do we support integrated behavioral health?

- Workforce training and education programs in integrated behavioral health
- Behavioral health screening in pediatric health settings (e.g., Mandated part of care in Massachusetts)
- Supporting Community Health Centers, which have the infrastructure to support integrated behavioral health
School-Based Mental Health

• Schools play a critical role in improving child mental health and well-being
  — Standardized screening & coordination to services
  — Embed behavioral health providers
  — Train teachers and administrators

• Aligning state educational system with state mental health systems

• Partner with Community Health Centers to deliver school-based mental health services
Tele-behavioral health

Figure 1
Share of outpatient visits delivered by telehealth, 2019-2021

- Mental health and substance use disorder visits
- Other outpatient visits

SOURCE: KFF and Epic Research analysis of Cosmos data
More than half of behavioral health services delivered in rural settings were via tele-behavioral health

Figure 3
Share of outpatient visits delivered by telehealth, by patient characteristics, March-August 2021

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Mental health and substance use disorder</th>
<th>Other outpatient care visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-18</td>
<td>32%</td>
<td>6%</td>
</tr>
<tr>
<td>19-64</td>
<td>38%</td>
<td>5%</td>
</tr>
<tr>
<td>65+</td>
<td>34%</td>
<td>5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Male vs. Female</th>
<th>Mental health and substance use disorder</th>
<th>Other outpatient care visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>38%</td>
<td>5%</td>
</tr>
<tr>
<td>Male</td>
<td>33%</td>
<td>5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urban vs. Rural</th>
<th>Mental health and substance use disorder</th>
<th>Other outpatient care visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>55%</td>
<td>6%</td>
</tr>
<tr>
<td>Urban</td>
<td>35%</td>
<td>5%</td>
</tr>
</tbody>
</table>

SOURCE: KFF and Epic Research analysis of Cosmos data
Tele-behavioral health in rural settings

- Repercussions of video-only requirements
  - Lack of broadband internet
- In-person visit requirements of CMS will resume after the public health emergency ends
  - Need to build connections between behavioral health providers and health providers
- Lack of reimbursement and payment parity will be an issue for behavioral health services
  - Current state legislation to require parity for private payors is a patchwork
Treating Opioid Use Disorders

Medications for Opioid Use Disorders

Peer Recovery Models

Harm Reduction Models
Medications for Opioid Use Disorders

• Also called, Medication Assisted Treatment (MAT), is an effective treatment for Opioid Use Disorders

• Methadone and Buprenorphine are the most common MOUDs
  — Methadone distributed in Opioid Treatment Programs (OTPs) which are highly restricted
  — Buprenorphine can be distributed in office-based clinics like a family medicine doctor or in emergency rooms making it easier to access this treatment
MOUD is an effective treatment for preventing overdose deaths

For the few who receive medication for opioid use disorder (MOUD) or residential treatment after detox, mortality was reduced over the next 12 months.

RETROSPECTIVE POPULATION COHORT, MASSACHUSETTS PUBLIC HEALTH DATA WAREHOUSE (2012-2014)

<table>
<thead>
<tr>
<th>30,681 patients admitted to a facility for medically managed opioid withdrawal (detox)</th>
<th>Most patients received no further treatment in the month after discharge from detox</th>
<th>All-cause mortality rate with relative risk reductions</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Treatment (65%)</td>
<td>[Diagram showing 65% of patients]</td>
<td>2 of 100 people who received no treatment were dead at 1 year, ↓ 37%</td>
</tr>
<tr>
<td>Residential (17%)</td>
<td>[Diagram showing 17% of patients]</td>
<td>↓ 66%</td>
</tr>
<tr>
<td>MOUD (15%)</td>
<td>[Diagram showing 15% of patients]</td>
<td>↓ 89%</td>
</tr>
<tr>
<td>MOUD + Residential (3%)</td>
<td>[Diagram showing 3% of patients]</td>
<td></td>
</tr>
</tbody>
</table>

But buprenorphine waivered providers are maldistributed
Supporting MOUD

• Increase the number of providers who can deliver MOUD
  — Training and education grants
  — Loan repayment
  — Within already existing health structures like emergency departments and health centers

• During the pandemic MOUD was able to be delivered via tele-health which increased access—unclear next steps on availability of this service for virtual care

• Increasing training and knowledge to the community on MOUD
Peer Recovery Models are widely supported by State Medicaid Programs.
Supporting Peer Recovery Models

• Must be delivered by a certified peer provider

• Costs, length of training, testing, and continuing education requirements prohibit the expansion of this model

• Partnering with agencies to provide scholarships and/or pay for the certification process, ease requirements to support entry into this position

• Train health systems to deploy this model
Harm Reduction Models

• Harm reduction is a proactive and evidence-based approach to reduce the negative personal and public health impacts of behavior associated with alcohol and other substance use at both the individual and community levels.

• Harm reduction organizations incorporate a spectrum of strategies that meet people “where they are” on their own terms, and may serve as a pathway to additional prevention, treatment, and recovery services.
Example of Harm Reduction Program Success

• One example of harm reduction is naloxone (commonly known as Narcan)

• Naloxone is a medicine that rapidly reverses an opioid overdose

• State naloxone laws allow the prescribing and dispensing of naloxone to substance users or to lay administrators (including nonmedical first responders, potential overdose bystanders, and family and friends of opioid users)

• Good Samaritan laws offer immunity from legal prosecution to those who seek emergency help for someone overdosing
Supporting Harm Reduction Programs

• Stigma and bias continue to prevent use of harm reduction strategies
  — Federal movement on funding harm reduction specifically

• Training and education on harm reduction strategies are needed

• We can look to the success of naloxone distribution to leverage support for newer models
  — e.g., Syringe Access Programs
  — Screen and connect to physical health care services for secondary health issues
Thank you!

• Please email with questions  
  BRIANNA_LOMBARDI@med.unc.edu

• go.unc.edu/Workforce