NCSL's Rural Health Regional Roundtable – Western States

Behavioral Health

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What is Rural?

- 97% of the country's land mass is rural and 19.3% (60 million) of the population lives there.
- Urban areas make up only 3% of the entire land area of the country but are home to more than 80% of the population.
- Rural and remote areas across the United States are varied in terms of their populations, geography, and the mental health systems that serve them.
- Rural areas span all regions across the continental United States as well as Alaska and Hawaii. There are also rural areas in U.S. territories like Puerto Rico. Rural demographics also vary considerably.
- In many rural areas, there are significant American Indian, Alaska Native, or Pacific Islander populations.
- Some rural areas have sizable populations of migrant workers and Latino populations, others have large black or African American populations, such as rural areas in the south, whereas others are predominately white.

Mental Illness in Rural Communities

- Over half (56%) of adults with a mental illness (27 million) receive no treatment.
- Although the overall prevalence of mental health conditions is similar across rural and urban areas, the prevalence of some conditions, such as suicidality and depression, differ. For example, the difference in suicide rates among rural and urban residents is particularly alarming: in 2013-2015, the suicide rate was 55 percent higher in rural areas than in large urban areas. Rural areas also experienced higher increases in suicide rates over time.
- There are also variations within some rural sub-populations and communities in the rates of depression, suicidality, disease burden, and mental distress, including among women, low-income children, veterans, non-Hispanic Blacks, American Indian/Alaska Natives (AI/ANs), and LGTBQ.
- The reasons for higher rates of suicide in rural areas include limited access to MH services, high levels of SU, greater availability of firearms, community and social stressors, and reduced access to timely health care and emergency medical services.
- A May 2020 survey found that mental health conditions tripled during the peak of COVID stay-at-home orders in April 2020, compared with two years earlier. That percentage spiked to more than 41% in 2021.

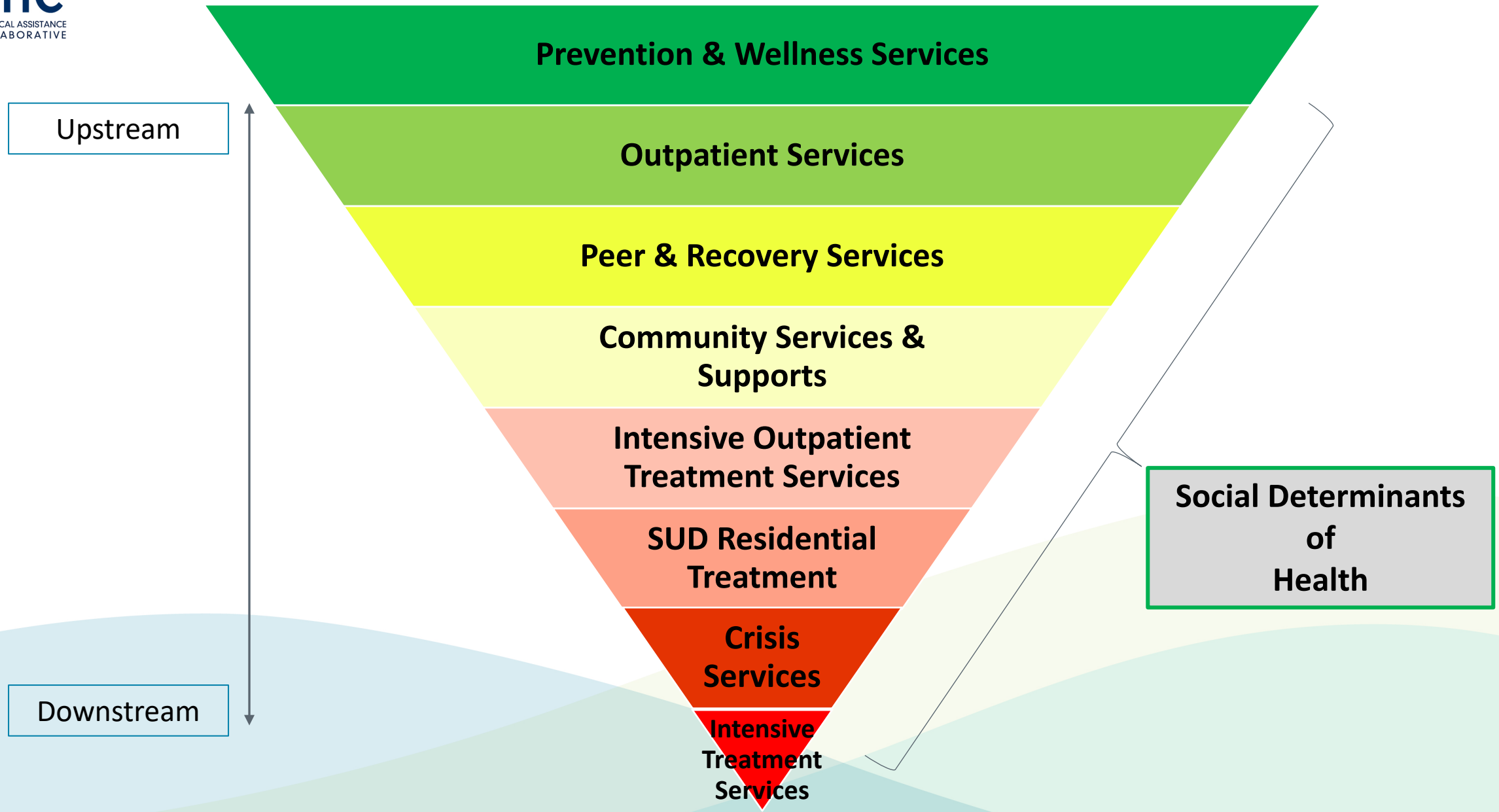
Substance Use in Rural Communities

- According to the 2021 National Survey on Drug Use and Health, 94% of people aged 12 or older with a substance use disorder (40+ million) did not receive any treatment.
- In 2021, according to the Centers for Disease Control and Prevention (CDC), 107,622 died of overdoses—a 15% increase over the 93,145 in 2020—and there are still over 102,000 deaths in the 12-month period ending in June 2022.
- COVID-19 also exacerbated the opioid crisis, with overdose deaths rising 30% from 2019 to 2020.
- The overdose death rate is higher in rural areas than in urban areas.
- Alcohol is the most commonly used substance nationally, with higher use rates among rural 12 to 20 year olds than their small and large metro area peers.
- Rural youth have 35% greater odds of having misused prescription opioids in the past year than their urban peers.
- Young adults aged 18-25 who live in remote rural areas misuse methamphetamine at almost twice the rate as those who live in urban areas.

Policy Framework – Public Health

- Prevention
- Early Intervention
- Treatment
- Recovery Supports

Core Elements of the Behavioral Health System



Current Topics in Behavioral Health

Downstream Topics

- 988 and Crisis Services
- Law Enforcement and Criminal Justice
- Hospital Beds
- Outpatient Commitment
- Opioids and Overdoses
- Homelessness

Upstream Topics

- Workforce shortages
- Medicaid coverage, state general funds, and managed care
- Certified Community Behavioral Health Clinics (CCBHC)
- Suicide Prevention
- Children's Behavioral Health, Schools, EPSDT
- *Olmstead* and Title II of the Americans with Disabilities Act, Litigation
- Integration of mental health, substance use, and primary care
- Racial Equity

Access to Behavioral Health Services in Rural Communities

- People in rural areas do not have equivalent access to intensive or specialty behavioral health services, including EBPs such as Assertive Community Treatment (ACT), Supported Employment, Supportive Housing, and Multi-systemic Therapy
- Data from 2010 to 2019 prior to COVID-19 showed that people in non-metropolitan counties were significantly less likely to receive outpatient treatment than individuals in large or small metropolitan counties and significantly more likely than people in large metropolitan areas to receive prescription medication without other forms of treatment
- This lack of access to specialized services for rural areas extends to other service systems. Veterans who have received mental health services from the Veterans Health Administration are much less likely to receive specialized care, including care for SMI, in rural areas.

Access to Behavioral Health Services in Rural Communities

- Prescribing capabilities for MATs are also limited in rural areas: about 60% of rural counties in 2017 did not have a physician who could prescribe buprenorphine for opioid use disorders (OUDs).
- Around 14% of behavioral health treatment facilities in the U.S. are in rural communities, and less than half of these specialize in addiction treatment.
- According to data from 2012–2014 National Ambulatory Medical Care Survey, 29% of physician office visits related to mental health in non-metropolitan areas were made to psychiatrists and 54% were made to primary care physicians, compared to 55% and 32% nationally.

Behavioral Health Workforce

- Rural and remote areas have widespread shortages of mental health professionals. More than 25 million people in rural areas, almost half the rural population, live in Health Resources and Services Administration (HRSA) designated mental health professional shortage areas
- The reasons for these shortfalls are complex and include chronic underfunding of the BH safety net, historically low salary levels, high case-loads, low reimbursement rates, and limited reimbursement for supporting services such as care coordination, community BH workers, and peer recovery workers.
- Many providers choose not to participate in insurance networks.

Beyond Behavioral Health Conditions

- Rural areas have a higher proportion of families living below the poverty level, more unemployment, and a greater percentage of residents who have public insurance or are uninsured than do urban areas. These characteristics are all risk factors for BHDs.
- Rural residents are more likely to be uninsured or underinsured, less likely to be insured through an employer, and more likely to receive Medicaid than are urban residents.
- Where residents have lower incomes and less access to affordable employer-sponsored coverage, approximately two-thirds of the rural uninsured population live in states that did not expand Medicaid.
- Among those covered by private insurance, rural residents are more likely than urban residents to have a high deductible health plan and less likely to have an associated health savings account.
- Rural individuals also experience a greater sense of stigma, a higher sense of isolation and hopelessness, lower education rates, and higher rates of chronic illnesses.
- Access to affordable housing and transportation are significant barriers and stressors.

Housing and Behavioral Health

- Housing stability and location can significantly affect health care costs, access, and outcomes.
- Health care spending is often higher for people experiencing homelessness or living in substandard housing.
- Rural homeless individuals and families are more likely than urban homeless individuals and families to be doubled-up with friends or families, living in vehicles, or living in substandard housing (which is one reason that rural homeless populations are often undercounted).
- A 2009 study of the impact of permanent supportive housing in rural Maine found that, for every homeless person placed in permanent supportive housing, there was an average per person cost savings of $2,751.19 Much of that savings came from a reduction in costs of mental health services and health care services, as well as reduced incarceration costs.20
- Those living in substandard but stable housing and those living in doubled up situations do not qualify as homeless under the HUD definition of homeless.
- TAC Priced Out Report – housing is out of reach for people with disabilities on Supplemental Security Income (SSI)

Takeaways for Rural Behavioral Health

- Improve ***access*** to “upstream” services (Prevention, Early Intervention, Treatment & Recovery; Core Components) while ensuring a safety net exists.
- Think beyond licensed clinical professionals to incl. Peers/PWLE, Community Health Workers, Paraprofessionals, Family Members
- Think beyond “Behavioral Health” treatment to Social Determinants of Health (SDoH). Improving overall quality of life can improve behavioral health outcomes.
- Need to expand and adapt the evidence-base in rural communities.
- Integrated Care, Hub and Spoke Models, Telehealth; with consultation available
- School-based programs with behavioral health
- Medicaid is critical, but will not pay for all services. Braided funding.

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