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An APA and SAMHSA Initiative

Improving Behavioral Health Services for Individuals with SMI in Rural and Remote Communities

Executive Summary

August 2021

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Executive Summary

According to data from the 2018 National Survey on Drug Use and Health (NSDUH), the prevalence of serious mental illness (SMI) is slightly higher for rural adults ages 18 and over than for adults living in urban areas, with 5.8 percent of rural adults experiencing a serious mental illness (SMI) (e.g., major depression, bipolar disorder, schizophrenia) in the past year compared to 4.1 percent of urban adults (SAMHSA, 20 August 2019). This elevated rate of SMI for rural adults is greatly impacted by various barriers affecting rural and remote areas that limit the **availability**, **accessibility**, and **acceptability** of behavioral health services. The purpose of this report is to provide a resource for providers and policymakers working in rural and remote areas to improve the **availability, accessibility**, and **acceptability** of behavioral health care for individuals with SMI. The major barriers and opportunities related to these three elements are discussed throughout the report and summarized below. It is important to note that this document focuses on rural and remote populations. For the purpose of this report, the term *remote* includes both frontier and remote, defined by the Federal Register as areas characterized by a mix of low population size and high demographic remoteness. However, the authors are sensitive to indigenous perspectives on the use of frontier, as it has negative connotations of victimization from colonial settlement. In addition, the report does not aim to address the unique issues faced by indigenous populations being covered by various other projects underway at the Substance Abuse and Mental Health Services Administration (SAMHSA) and through the Indian Health Service that are designed to address these unique populations.

Barriers to the Availability of Mental Health Services for Individuals with SMI in Rural and Remote Areas

Rural and remote areas have greater shortages of specialty behavioral health workforce than urban and suburban areas. This chronic workforce shortage, particularly psychiatrists, in rural areas affects the ability of adults with SMI in rural areas to obtain timely, evidence-based, and high-quality mental health services. Due to the shortage of behavioral health specialists, primary care providers in rural areas often play a large role in the delivery of behavioral health services, but they may not have the knowledge, competency, or comfort to assess, treat, and manage SMI. In addition, individuals with SMI living in rural areas are more likely than urban/suburban individuals to rely on public financing (e.g., Medicaid, Medicare, and state-funded services) of mental health services. However, not all behavioral health providers participate in these public health insurance programs, and public and private health insurance plans frequently do not reimburse for the substantial travel time clinicians and peer specialists spend driving to provide mental health services to individuals living in rural and remote areas. The resulting lack of participation by these providers limits the availability and accessibility of services.

Barriers to the Accessibility of Mental Health Services for Individuals with SMI in Rural and Remote Areas

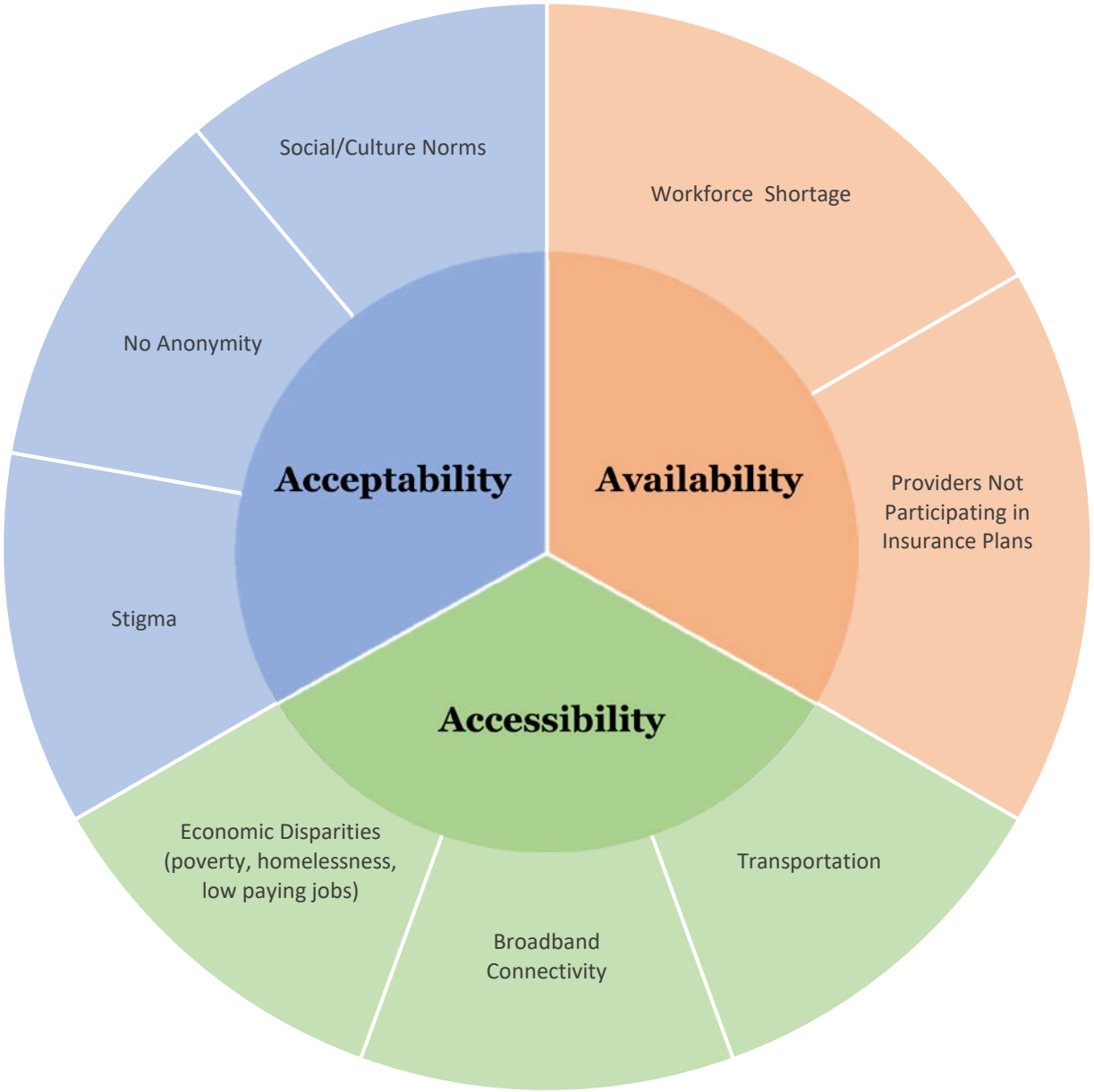
Individuals with SMI living in geographically dispersed areas have limited access to mental health services due to a wide array of transportation barriers. Transportation barriers in rural and remote areas may include the inability to secure reliable and cost-effective transportation, limited public transit, cost of gas for travel, wear on an individual's vehicle, geographic and inclement weather obstacles, and the extensive travel time to and from appointments that may necessitate taking time off from work. Taking time off may result in unpaid leave and/or difficulty and costs in arranging for child and family-care services. Minority rural populations may also face greater barriers accessing behavioral health services that are sensitive to race, ethnicity, culture, sexual orientation, and gender identity, due to a mostly homogenous behavioral health workforce that may not understand their unique needs. Further, limited or absent broadband connectivity, except in publicly available Wi-Fi locations, and the high cost to secure broadband connection, can hinder access to online mental health services. Finally, rural economic inequalities, including higher poverty rates among minority populations, low-earning wages, and homelessness, may impact mental health care access.

Barriers to the Acceptability of Mental Health Services for Individuals with SMI in Rural and Remote Areas

The effects of social stigma, as well as a local community's strong social norms and deeply rooted cultural values, may contribute to an individual's viewpoints and perception surrounding mental illness. For example, some rural residents may feel a strong need for self-sufficiency with the prescribed societal norm to "pull yourself up by your bootstraps." Further, rural and remote

areas are commonly described as tight-knit communities. The social stigma surrounding mental illness and the lack of anonymity experienced in small communities can be barriers to the acceptability of mental health services.

Barriers to Mental Health Services in Rural and Remote Areas



To overcome these barriers, federal agencies, states, localities, and organizations are working together to expand the **availability, accessibility,** and **acceptability** of behavioral health services for rural adults with SMI. Some of the key strategies highlighted below are examples of how rural and remote communities have mitigated some of the challenges of bringing equitable access to behavioral health services while also factoring in social determinants of health.

Strategies to Improve the Availability of Mental Health Services for Individuals with SMI in Rural and Remote Areas:
To address the chronic behavioral health workforce shortage, rural communities are bridging the mental health service delivery gap by working with other licensed and certified professionals (e.g., primary care physicians, nurse practitioners, and peer support specialists) and community providers (e.g., law enforcement, emergency medical services (EMS) technicians, and community health workers). Efforts include increasing these providers' knowledge and competency in recognizing and addressing the mental health needs of rural residents by:

- Expanding the knowledge and comfort level of rural primary care providers, enabling them to screen, evaluate, and treat mental health conditions in their patients through a tele-mentoring education model known as Project ECHO (Extension for Community Healthcare Outcomes);
- Training primary care providers to implement collaborative care and consultation with specialty mental health providers (e.g., psychiatrists) through three standard integrations of behavioral health and physical health frameworks—coordinated/collaborative care, co-located, and full integrated care—allowing primary care providers to manage the health of rural individuals while also providing an expansion in the mental health referral network;
- Offering psychiatric residents training and educational opportunities on clozapine and long-acting injectables to increase competency in these treatment modalities;
- Expanding the use of peer support specialists to enhance the rural behavioral health workforce and to normalize the need for mental health care and reduce stigma associated with SMI;
- Training EMS technicians, law enforcement, and community health workers to assess and screen for suicide risk; and
- Training, and then relying on, community members to provide crisis intervention and other behavioral health services.

The availability of evidence-based practices (EBPs) needs to be considered, but often basic needs are so acute and resources are so diminished that rural and remote communities build modified practices that work within their constraints. More research is needed on adaptations to EBPs in rural settings to demonstrate whether desired outcomes are achievable with modification, and whether programs (e.g., Individual Placement and Support and Assertive Community Treatment) should be monitored to measure the same outcomes (e.g., employment retention; days without hospitalization) to see if the tailored version results in similar outcomes in rural environments.

States can assist with evaluations and establish policies that will make more resources available for modified approaches and increase the availability of essential evidence-based services and supports, using the flexibility of Medicaid and State General Funds to assure appropriate rates are set to support evidence-based services.

For instance, clozapine is considered the "gold standard" evidence-based treatment for refractory schizophrenia and other similar conditions. Increasing access to clozapine can be achieved by psychiatrists collaborating via telepsychiatry with rural primary care providers to administer regularly scheduled blood draws and to mitigate some of the common side effects associated with clozapine. This collaboration ensures that individuals with refractory schizophrenia and other complex mental health conditions receive the best evidence-based treatment, with support from their primary care providers to co-manage their treatment.

Strategies to Improve the Accessibility of Mental Health Services for Individuals with SMI in Rural and Remote Areas
Efforts to bring mental health services and treatment opportunities directly to individuals increases an individual's convenient access to routine mental health services while also reducing barriers common in small communities (e.g., transportation barriers, limited Wi-Fi access). State agencies, local communities, and healthcare agencies are coming together to mobilize

mental health services in rural and remote regions in order to bring care to the patient, rather than the patient traveling to the service center.

The use of telehealth, including audio-only telemedicine, and tele-mental health services, has a range of benefits for individuals with SMI in rural and remote areas, including improving timely access to care that is otherwise not available in an individual's community. It provides anonymity, as well as convenience for individuals (by reducing extensive travel time to and from office visits and minimizing the need for time off from work and/or arranging for child/family-care services for appointments). Broadband infrastructure support is critical to ensuring that access to behavioral health services in rural and remote areas is comparable to that provided on a face-to-face basis in other settings.

Technology is also a valuable tool in rural and remote areas for connecting an individual with SMI in crisis to services, as well as for the first responders who are often the only people available to respond in a timely manner to a crisis. In addition to technology increasing access to crisis services, states and local communities are making efforts to provide timely access to crisis and suicide prevention services through centralized crisis hotlines, warmlines (including peer-run lines), mobile crisis response teams, and crisis receiving/stabilization centers. Access to crisis hotlines and peer-run lines that provide free and confidential services is an important resource for rural populations where mental health services are often limited, under-resourced, or often viewed as stigmatizing. Many states offer a peer warmline, given the wealth of research supporting the efficacy of warmlines in enhancing the recovery process beyond the clinical scope.

Strategies to Increase the Acceptability of Mental Health Services for Individuals with SMI in Rural and Remote Areas

Educating, training, and investing in mental health literacy, prevention, and early intervention in school-based initiatives have been shown to increase awareness about mental health symptoms, decrease the social stigma commonly associated with mental illness and substance use issues, and increase help-seeking behaviors in youth and young adults who have engaged in school-based mental health literacy programs. Youth-based mental health literacy initiatives are shifting the culture, reducing the social stigma commonly associated with mental illness, and promoting help-seeking behaviors.

The understanding and familiarity of cultural and social characteristics common in rural areas are important considerations when educating, promoting, and encouraging emotional and mental well-being to reduce mental health stigma and when inspiring help-seeking behaviors for mental health treatment. Working with community champions and familiar community leaders--including teachers, coaches, clergy members, business leaders, and primary care providers--to model positive mental health messaging, destigmatize mental illness, and openly talk about mental health and rural stress can increase the acceptability of mental health care.

Faith-based organizations are natural community support systems for bridging the mental health service gap in rural communities. Spiritual leaders are increasing their knowledge and capacity to serve the members of their congregation facing mental health challenges, enabling them to recognize when to connect individuals with a mental illness and/or their family members with a mental health professional.

Marketing suicide awareness campaigns where people are most at risk (e.g., gun shops, ranges) and where people can be reached discretely (e.g., posting suicide awareness flyers on the back of bathroom stalls) can serve to encourage people to reach out for help in times of need, and reduce the high rates of suicide found in rural and remote areas of the U.S.

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developing, implementing, financing, and sustaining behavioral health services for individuals with SMI living in rural and remote communities.

Strategies to Expand Mental Health Services in Rural and Remote Areas

Availability

- Training other licensed and certified professionals and community providers (e.g., primary care, clergy, community health workers, peer support specialists, first responders) to bridge the mental health service delivery gap.
- Expanding the use of peer support specialists to support an individual's treatment and recovery.
- Integrating behavioral health and physical health to provide whole health care.
- Increasing the availability of EBPs (adapted for rural/remote areas) by establishing financing mechanisms through Medicaid and State General Funds to assure appropriate rates are set to fully support evidence-based services.
- Offering psychiatry residency training at local and state universities in the benefits and prescribing of clozapine and long-acting injectables to increase competency in these treatment modalities.
- Ensuring clozapine utilization via telepsychiatry, using rural providers to administer blood draws & monitor for common side effects.

Accessibility

- Bringing mental health care directly to the client through mobile mental health treatment services.
- Using telehealth (including audio-only modalities), telemedicine (telepsychiatry), and tele-mentoring services (ex. collaborating with psychiatrists).
- Equipping individuals with SMI and first responders (law enforcement, EMS, paramedics) with internet-connected tablets (e.g., iPads) to connect individuals in crisis with a behavioral health specialist in a timely manner.
- Providing technology (tablets, Wi-Fi) to individuals with SMI to virtually connect with a mental health specialist.
- Certifying and training members of the local community to become crisis responders and secure transport drivers.
- Addressing economic inequalities (e.g., poverty rates, homelessness, low wages) by providing housing and other supports and embedding housing services with other support services.
- Increasing response to timely crisis and suicide prevention services through centralized hotlines, warmlines, and mobile crisis response teams, and training first responders to assess for suicide risk.

Acceptability

- Increasing mental health literacy through school-based initiatives to increase awareness, reduce social stigma, and promote help-seeking behaviors.
- Working with community champions and trusted community organizations (e.g., teachers, coaches, clergy, business leaders) who understand the local cultures and social norms to foster positive mental health messaging, destigmatize mental illness, and inspire help-seeking behavior for mental health services.
- Marketing suicide awareness campaigns at sites where people are most at risk (e.g., gun shops and gun ranges) and can be reached discreetly.

References

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