

# **Behavioral Health – An Overview of the Current Climate of Behavioral Health in Rural America and the Available Resources**

Sara Afayee  
Helen Newton

Federal Office of Rural Health Policy

# Mission and Vision

## MISSION:

To inform leadership of FORHP, HRSA, and HHS on current and emerging issues in rural behavioral and mental health and facilitate the analysis of policy, practice, and related data.

## VISION:

To establish a framework for the Federal Office of Rural Health Policy to gather rural-relevant behavioral and mental health information, respond to requests, and track select rural disparities.

# HHS Behavioral Health Priorities

Secretary's Opioid Initiative

Integrating Primary Care/Behavioral Health Initiative

## FORHP's Behavioral Health Team

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**Vision:** To establish a framework for the Federal Office of Rural Health Policy to gather rural-relevant behavioral and mental health information, respond to requests, and track select rural disparities.

### Short Term (09/2015 – 12/ 2015)

### Long Term (01/2016 +)

#### Creation of Response Team:

#### Preparing the Response Team:

#### Acting and Collaborating the Response Team:

1.

Define the mental/behavioral health problem in rural

Develop an understanding of the evidence in rural

Add to rural evidence base as additional data is retrieved

2.

Identify programmatic leads

Establish an understanding of FORHP's programmatic investment

Develop a common set of performance measures specific to mental/behavioral health

3.

Develop actionable goals

Create a process for team request response

Utilizing process for team request response such that responses are valuable and efficient

# Objectives

- Understand key trends in behavioral health/mental health illness prevalence and access to treatment
- Know federal initiatives and priorities for behavioral health
- Understand innovation going on in this area and questions to consider for future projects
- Gain an understanding of behavioral health resources

# Definitions

- ***Mental Health:*** State of well-being in which every individual realizes his/her own potential, can cope with normal stresses of life, can work productively, and can make a contribution to the community
- ***Behavioral Health:*** All contributions to mental wellness including substances, their abuse, behaviors, habits, and other external forces

# What do we mean by behavioral health?

- The terms "behavioral health" and "mental health" are often used interchangeably.
- -It's a way of being inclusive. Behavioral health includes not only ways of promoting well-being by preventing or intervening in mental illness such as depression or anxiety, but also has as an aim preventing or intervening in substance abuse or other addictions.
- Community members and partners may use various terms, meet them where they are and inquire about the terms they use

<https://www.psychologytoday.com/blog/promoting-hope-preventing-suicide/200910/behavioral-health-versus-mental-health>

# Context for rural mental/behavioral health

## parallel universe ...

- Separate delivery system : mental health community health centers, substance abuse treatment centers, psychiatric inpatient units
- Different kinds of providers: mental health counselors, behavioral health counselors, social workers, psychologists, psychiatrists
- Different concepts of disease with different social implications: stigma, discomfort in disclosure

# Current Landscape on the Federal Level

- **President Obama's Plan Now is the Time**
  - January 16, 2013, to increase access to mental health services
  - SAMHSA has played a key role
  - Developing and funding new grant programs
  - Establishing the new [MentalHealth.gov](http://MentalHealth.gov) website
- **Secretary's Opioid Initiative**
  - **Opioid prescribing practices** to reduce opioid use disorders and overdose
  - The expanded use of **naloxone**, used to treat opioid overdoses
  - Expanded use of **Medication-assisted Treatment (MAT)** to reduce opioid use disorders and overdose

# Current Landscape on the Federal Level

## Continued...

- **Mental Health and Addictions Parity**
- The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 requires health plans to offer mental health and/or substance use benefits without imposing copayments, benefit limitations and other restrictions that are more stringent than those imposed on medical/surgical benefits.
- Parity was also included as a central component of the Affordable Care Act (ACA).
- The ACA extended parity protections to the small-group and individual market, Medicaid expansion plans and plans sold through states' health insurance marketplaces.
- Between MHPAEA and the ACA, now nearly all health plans must cover behavioral health services at parity with medical/surgical treatment.
- Together, the ACA and MHPAEA are expected to expand access to comprehensive mental health and addiction treatment benefits to more than [62 million Americans](#).
- For more history on parity, see the Health Affairs [Policy Brief](#) on Mental Health Parity.

# Objective #1.1:

- Understand key trends in rural mental health/behavioral health prevalence

# Rural populations have consistently slightly higher percentage of prevalence of mental illness in all categories

	Rural	Urban
Adults (18+) experiencing any mental illness (AMI)	19.5%	17.8%
Adults (18+) experiencing serious mental illness in the past year (SMI)	4.7%	3.9%
Adults (18+) experiencing serious psychological distress (SPD) in the past 30 days	5.7%	4.7%
Past year major depressive episode (MDE) among Adults (18+)	7.2%	6.6%

**Prevalence of Mental Illness (2010), Source : 2014 Update to Rural-Urban Chartbook,**

**UND**

# Suicide : A Rural Problem

The 2014 Update of the Rural-Urban Chartbook

**Data Table 19. Suicide rates among persons 15 years of age and older by sex, region, and urbanization level: United States, 2008-2010**

Region and urbanization level	Total		Males		Females	
	Rate	SE	Rate	SE	Rate	SE
	Deaths per 100,000 population					
All regions.....	14.9	0.0	24.5	0.1	6.1	0.0
Metropolitan counties:						
Large central.....	12.8	0.1	20.9	0.1	5.6	0.1
Large fringe.....	13.7	0.1	22.4	0.2	5.7	0.1
Small metro.....	16.1	0.1	26.3	0.2	6.7	0.1
Nonmetropolitan counties.....	18.9	0.1	31.1	0.2	7.0	0.1
Micropolitan.....	18.2	0.2	30.2	0.3	6.8	0.1
Non-core.....	20.0	0.2	32.6	0.4	7.4	0.2

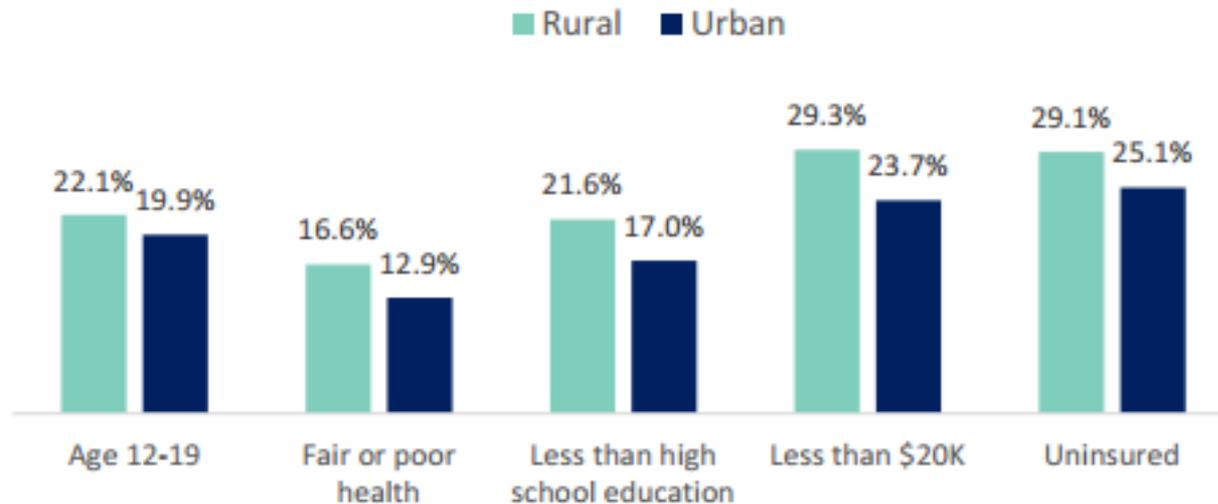
- Suicide rate increases with rurality
- Men have disproportionately higher rates of suicide
- The West has particularly high rates of suicide, 26.4 per 100,000 population (42.4 per 100,000 Men, 10.4/100,000 Women)

# Substance Use in Rural Populations

- Larger percentage of rural youth abuse alcohol (26% in 2010)
- Larger percentage of rural adults (18+) smoke tobacco vs. urban counterparts (27% vs. 18% in 2010)
- From 2008-2013, urban populations had slightly higher rates of opioid users (4.8% vs. 4.4%)

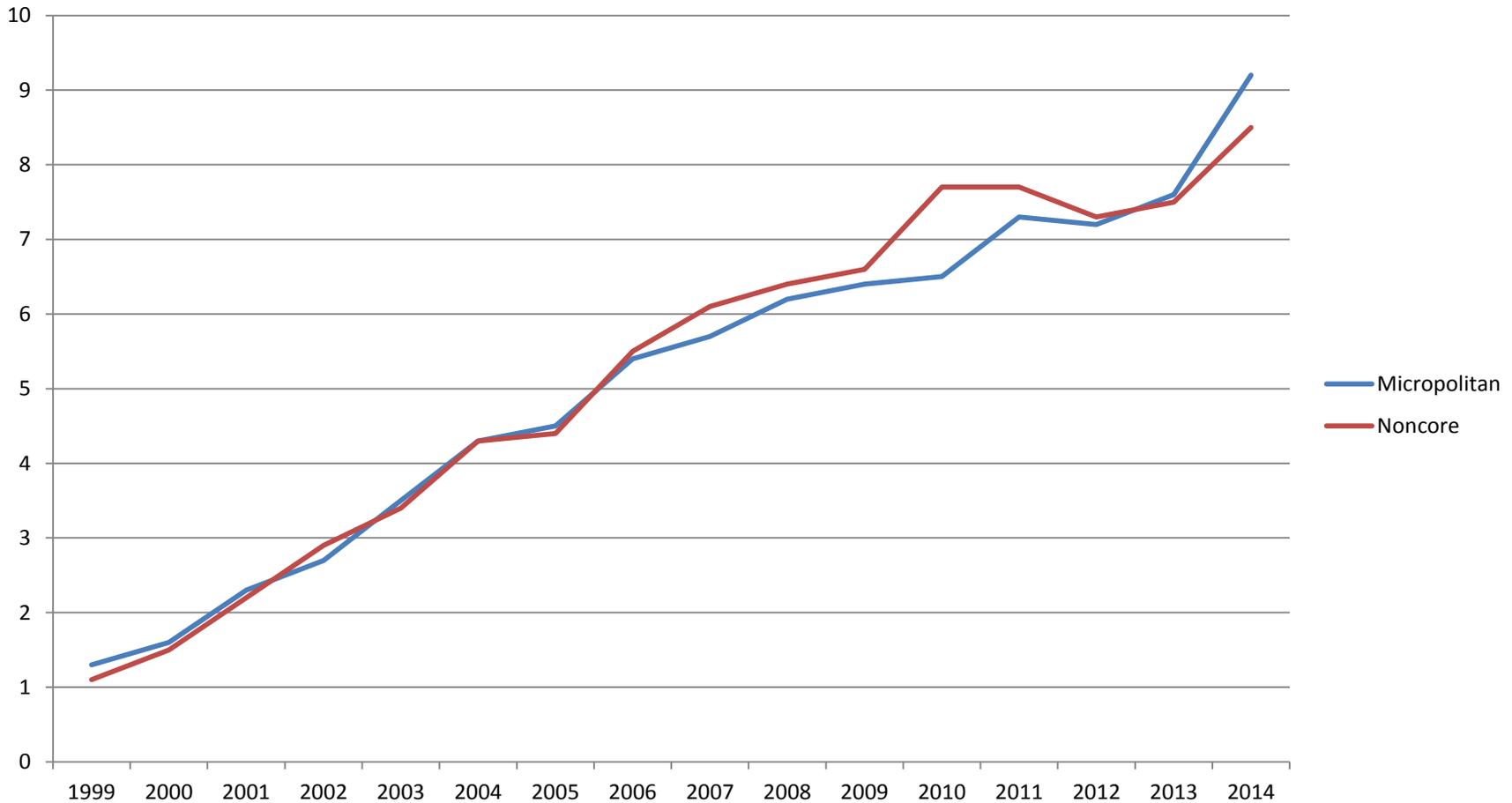
# Quick Look at Opioid Abuse in Rural Areas

Figure 1. Rural Persons Who Used Opioids in the Past Year Are More Likely to Have Socio-Demographic Vulnerabilities Than Urban Persons

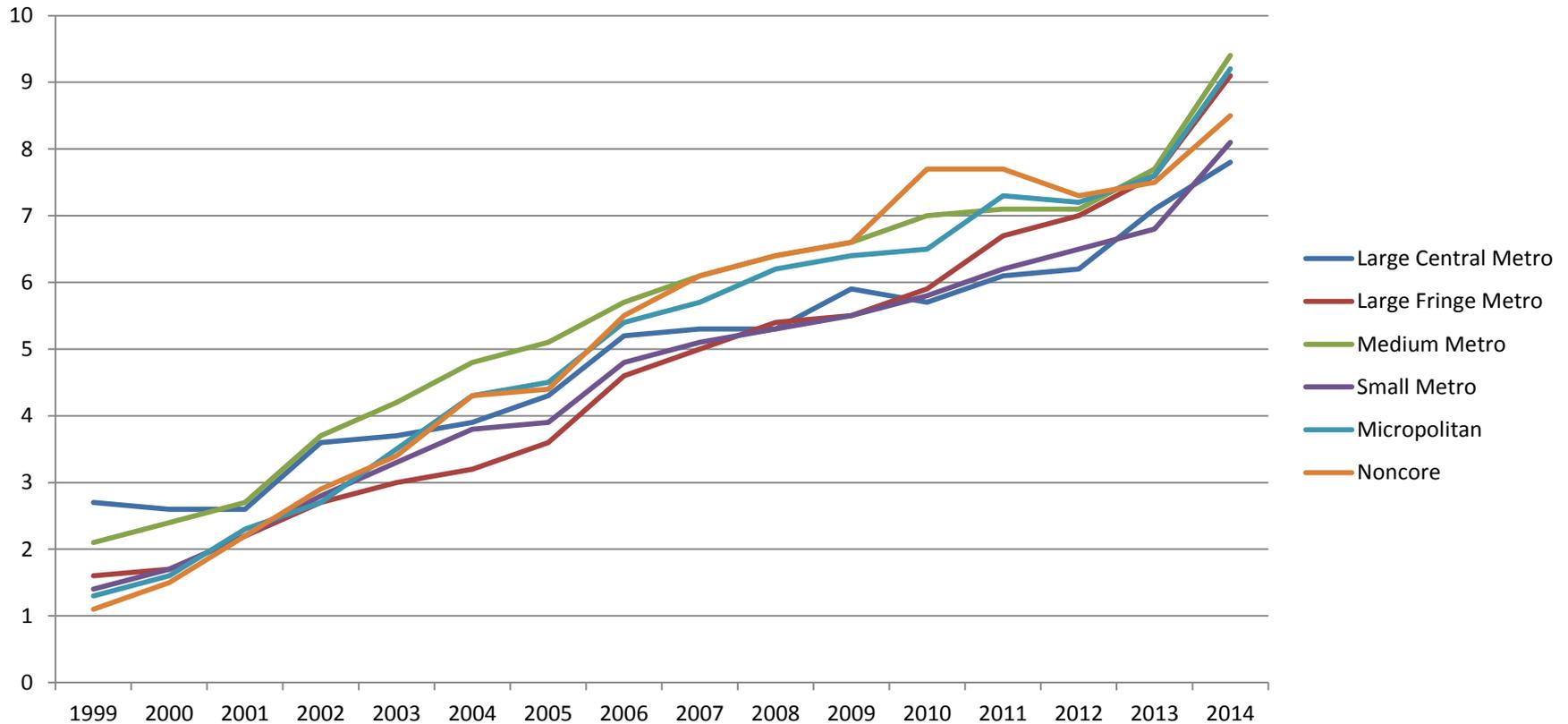


Data: National Survey of Drug Use and Health, 2008-13.  
Residence differences significant at  $p < .001$

# Increasing rate of death from opioid overdose in rural areas



# This trend in mortality is also true in urban areas



# State by state: Crude opioid overdose mortality rate (2014)

	>50% Rural	<50% Rural
Overdose Mortality >8.4% in 2014	<b>WV, NH, NM, OH, KY, UT, OK, ME, TN, NV, MO, WI, SC, MI, VT, AK, NC, CO, WA,</b>	<b>RI, MD, MA, CT, DE, DC</b>
Overdose Mortality Rate <8.4% in 2014	<b>IL, WY, PA, AZ, OR, GA, IN, KS, AL, MN, AR, LA, MT, IA, ID, SD, TX, HI, MS, ND, NE</b>	<b>VA, NY, NJ, FL, CA</b>

# Differences in those abusing opioids versus those dying from opioid overdose

- Young adults (12-29) dying, middle-aged adults (35-54) dying
- Users abuse heroin/prescription opiates equally, more fatal overdoses from prescription opiates in rural
- Rural middle aged women (45-54) dying at highest rates from prescription opiate overdose, (15.0% in 2014)

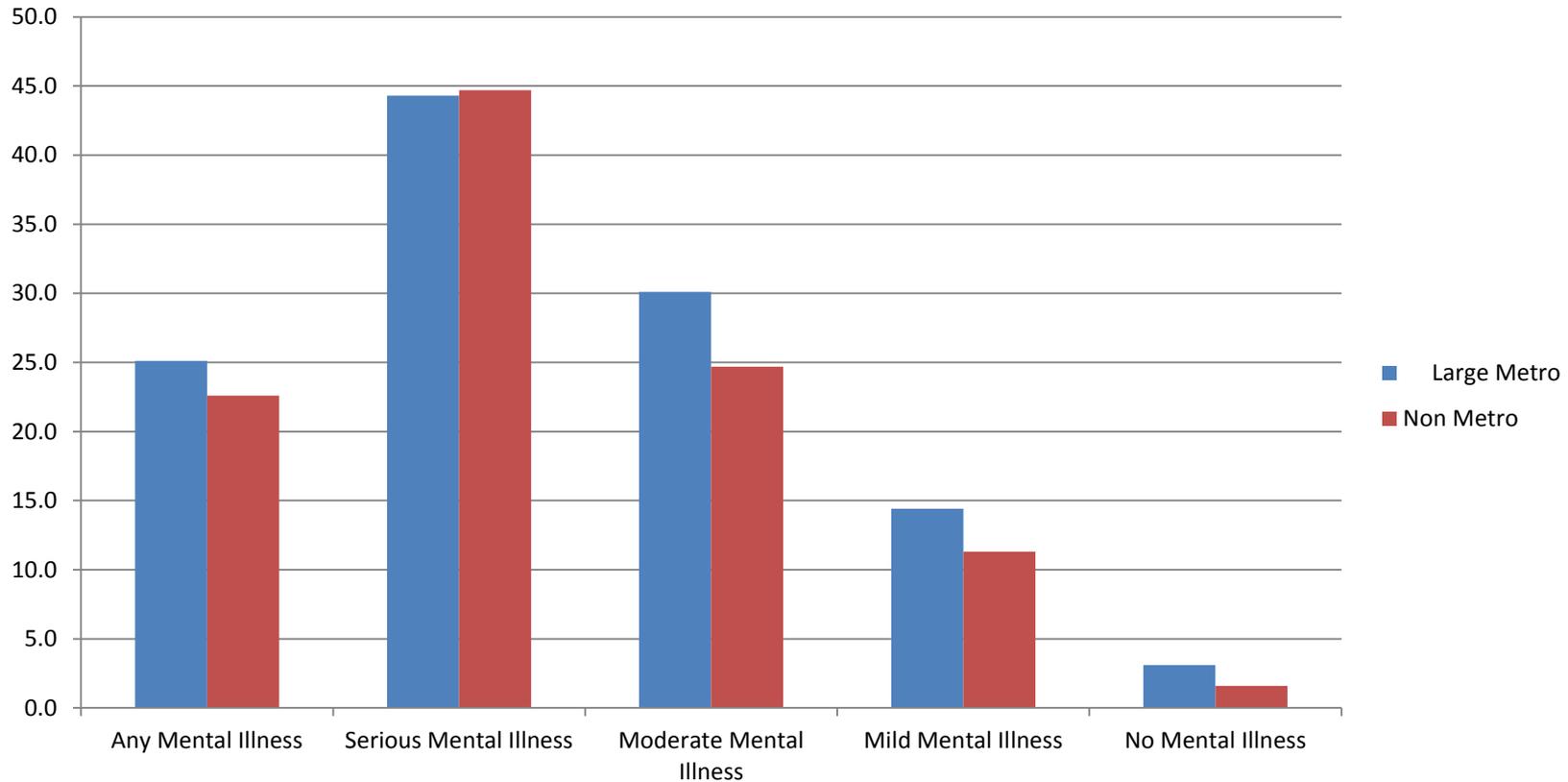
# Questions :

- Do these trends resonate with your community and your network process?
- Have you been able to create a sense of urgency using data such as this in your network development process?
- What gaps do you see in these trends?
- Does the work that you do address these gaps?

## Objective #1.2:

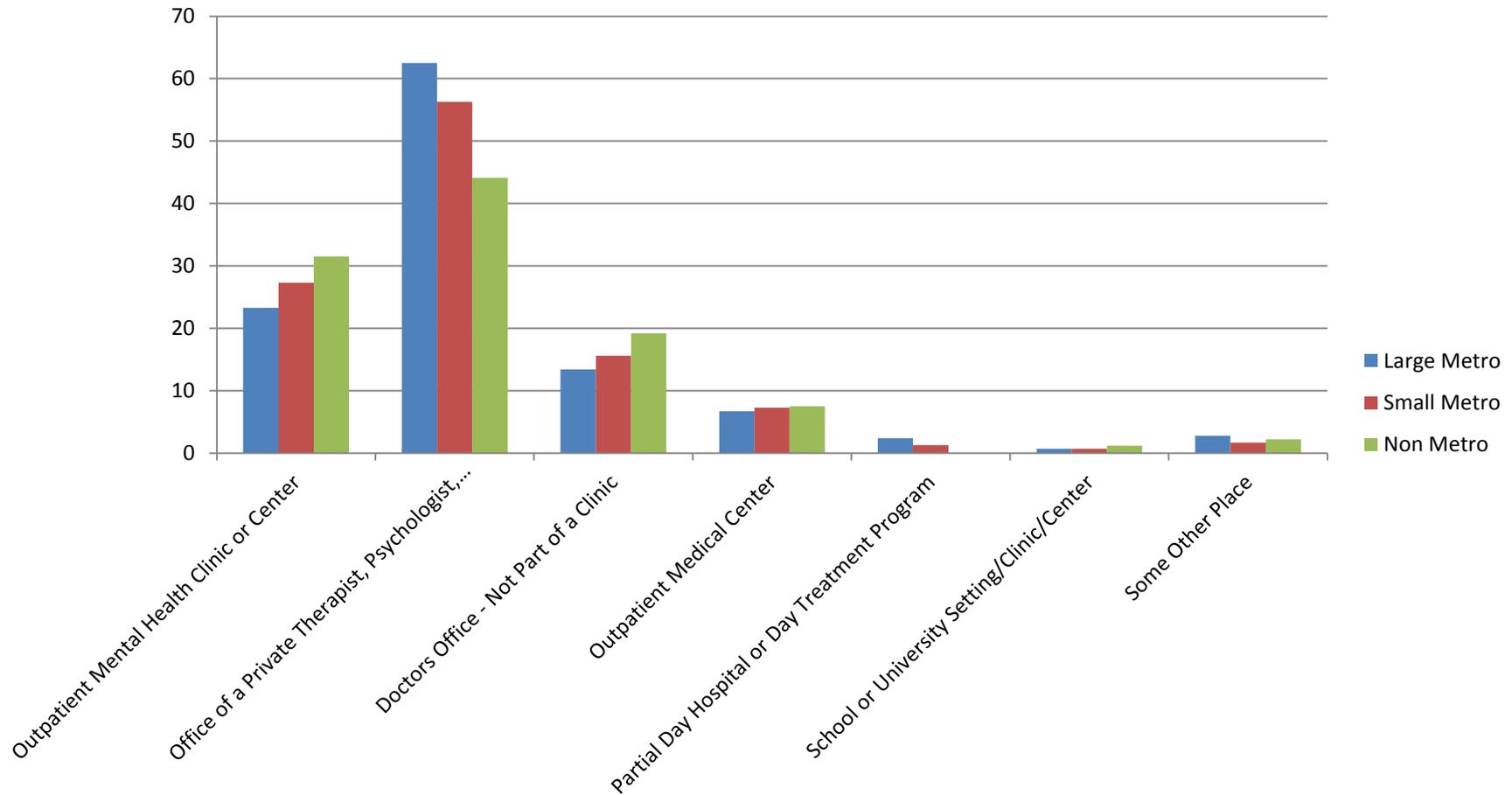
- Understand key trends in rural resident access to mental/behavioral health treatment

# Most rural patients receiving mental outpatient counseling have serious mental illness



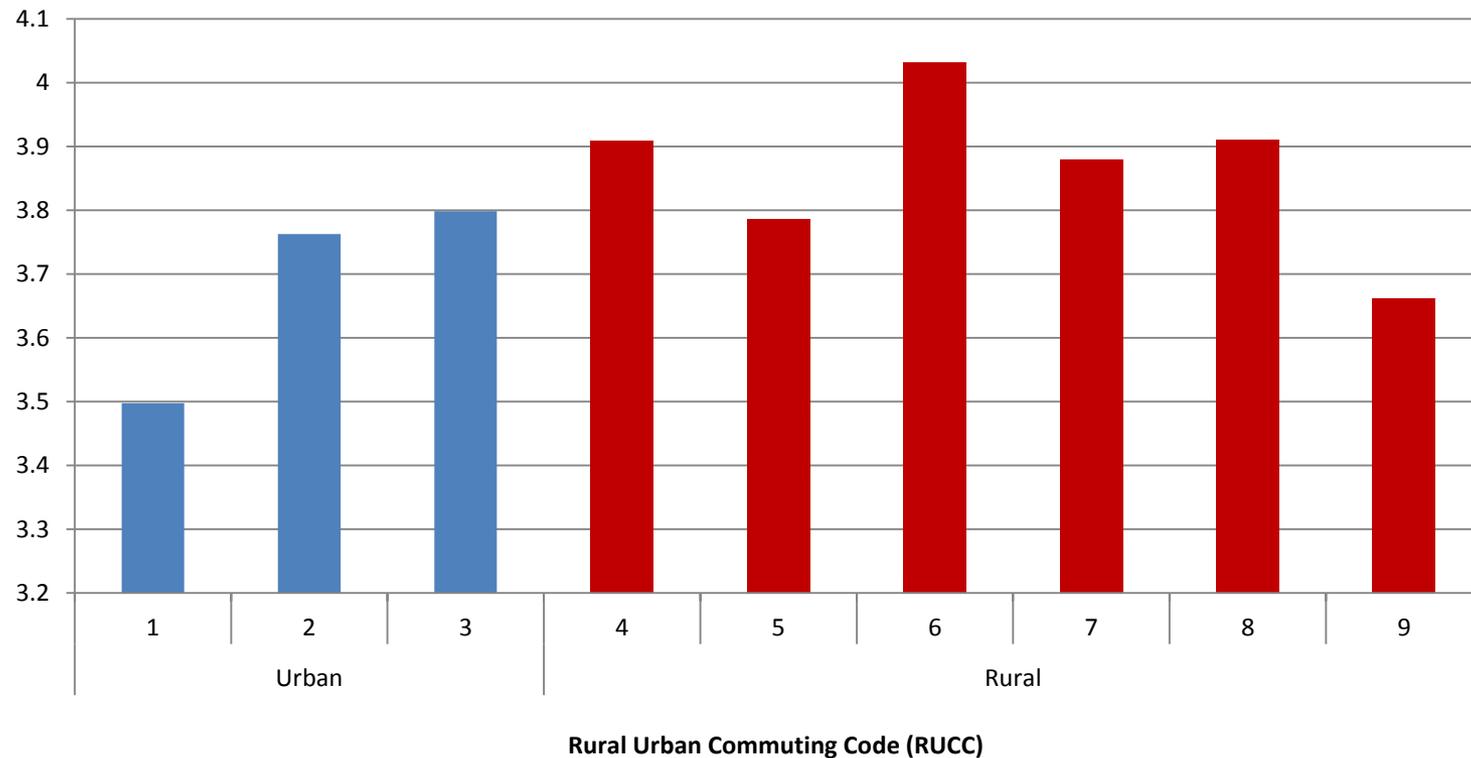
National Survey on Drug Use and Health: Table 1.25B – Received Outpatient Mental Health Treatment/Counseling in the Past Year (Persons Aged 18 and older), by Level Mental Illness , Geographic Characteristics, and Socioeconomic Characteristics: Percentages, 2013 and 2014

# Rural-urban differences in outpatient mental health treatment location



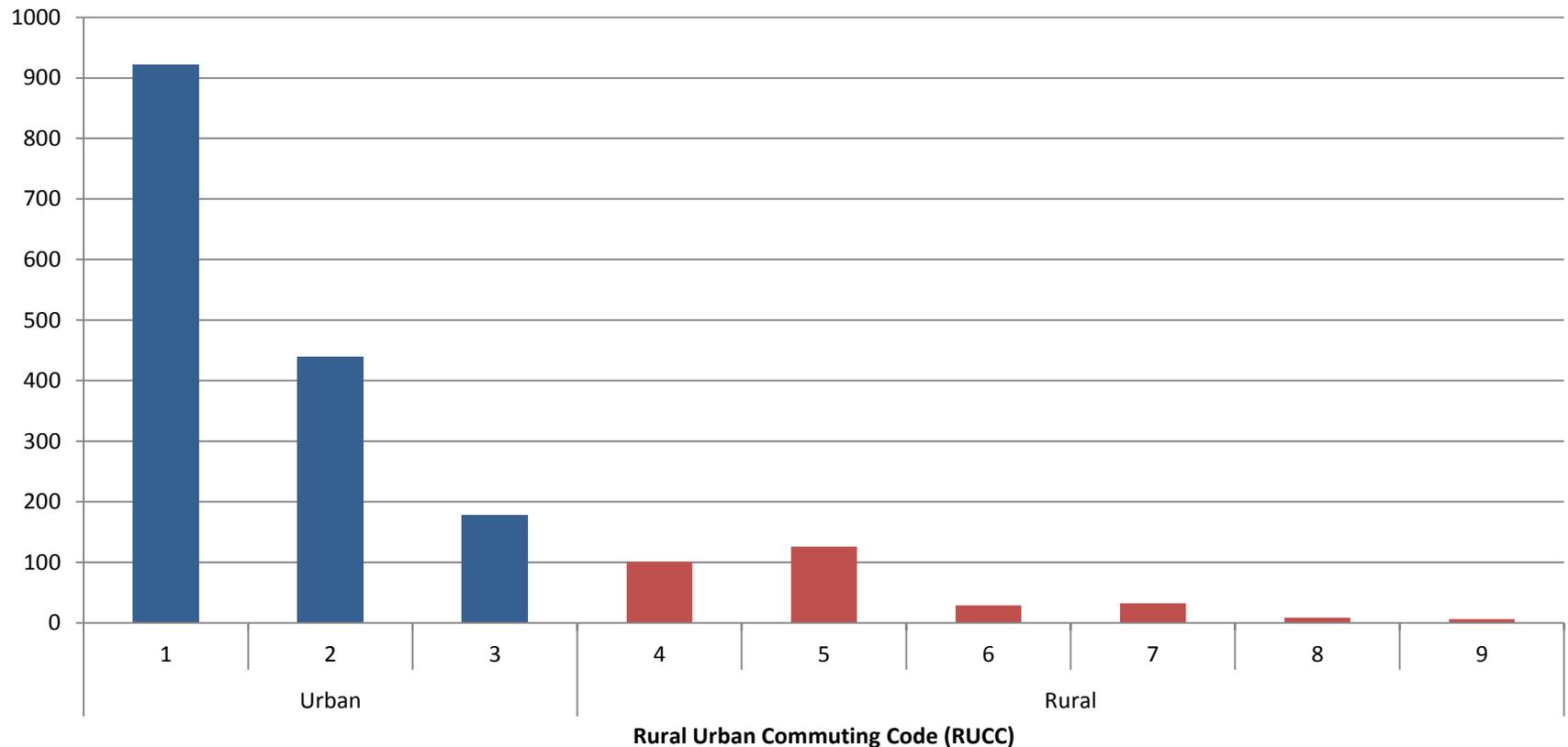
# Does supply meet demand? Days reporting poor/fair mental health status increases slightly with rurality

## Days Poor/Fair Mental Health per Month (mean)



# However, the supply of mental health providers is skewed towards the most urban counties

### # Mental Health Providers (mean)



# This is true of behavioral health provider and psychologist distribution as well

Rates per 100,000		
RUCC	Behavioral Health Providers	Psychologists
Urban		
1	148.4	29.0
2	142.2	23.3
3	129.3	19.7
Rural		
4	91.0	12.6
5	143.5	19.0
6	67.1	8.3
7	100.2	12.7
8	39.0	4.4
9	41.2	4.2

Source: Miller, B.F. et. al. (2014). Colocating Behavioral Health and Primary Care and the Prospects for an Integrated Workforce. *American Psychologist*. 69, 443-451.

Data: CMS National Plan and ProviderEnumeration System (NPPS), 2010 (using 2003 RUCC codes)

## Access to treatment for opioid use disorder for rural areas remains a challenge

- As of 2009, 82% of rural counties did not have detox centers
- As of 2010, only 3% of rural primary care physicians were waived to prescribe buprenorphine (important medication)
- Medication Assisted Treatment requires regular visits and coordination with additional counseling sessions – presents additional barriers for rural residents

# Questions

- Do these trends resonate with you and your community planning process?
- Is behavioral health workforce part of your network strategy?
- Are there specific issues that were not addressed in this presentation that you find to be a major barrier in access to treatment?

## Objective #2

- Understand innovation in this area and questions to ask for future projects

# Topics Heard from Grantees

- Integration of behavioral health into primary health care
- Reimbursement
- Workforce
- Opioid epidemic
  - 60 minutes segment:
    - <http://www.cbsnews.com/news/heroin-in-the-heartland-60-minutes>
- Suicide Rates
  - NY times article:
    - [http://www.nytimes.com/2015/11/03/health/small-towns-face-rising-suicide-rates.html?\\_r=0](http://www.nytimes.com/2015/11/03/health/small-towns-face-rising-suicide-rates.html?_r=0)

# Do you have a shared lexicon/language?

- Lexicon for Behavioral Health and Primary Care Integration, AHRQ April 2013
  - <http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf>

**Illustration: A family tree of related terms used in behavioral health and primary care integration**

See glossary for details and additional definitions

**Integrated Care**

Tightly integrated, on-site teamwork with unified care plan as a standard approach to care for designated populations. Connotes organizational integration involving social & other services. "Altitudes" of integration: 1) integrated treatments, 2) integrated program structure; 3) integrated system of programs, and 4) integrated payments. (Based on SAMHSA)

**Patient-Centered Care**

"The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care"—or "nothing about me without me" (Berwick, 2011).

**Coordinated Care**

The organization of patient care activities between two or more participants (including the patient) involved in care, to facilitate appropriate delivery of healthcare services. Organizing care involves the marshalling of personnel and other resources needed to carry out required care activities, and often managed by the exchange of information among participants responsible for different aspects of care" (AHRQ, 2007).

**Shared Care**

Predominately Canadian usage—PC & MH professionals (typically psychiatrists) working together in shared system and record, maintaining 1 treatment plan addressing all patient health needs. (Kates et al, 1996; Kelly et al, 2011)

**Collaborative Care**

A general term for ongoing working relationships between clinicians, rather than a specific product or service (Doherty, McDaniel & Baird, 1996). Providers combine perspectives and skills to understand and identify problems and treatments, continually revising as needed to hit goals, e.g. in collaborative care of depression (Unützer et al, 2002)

**Co-located Care**

BH and PC providers (i.e. physicians, NP's) delivering care in same practice. This denotes shared space to one extent or another, not a specific service or kind of collaboration. (adapted from Blount, 2003)

**Integrated Primary Care or Primary Care Behavioral Health**

Combines medical & BH services for problems patients bring to primary care, including stress-linked physical symptoms, health behaviors, MH or SA disorders. For any problem, they have come to the right place—"no wrong door" (Blount). BH professional used as a consultant to PC colleagues (Sabin & Borus, 2009; Haas & deGruy, 2004; Robinson & Reiter, 2007; Hunter et al, 2009).

**Behavioral Health Care**

An umbrella term for care that addresses any behavioral problems bearing on health, including MH and SA conditions, stress-linked physical symptoms, patient activation and health behaviors. The job of all kinds of care settings, and done by clinicians and health coaches of various disciplines or training.

**Patient-Centered Medical Home**

An approach to comprehensive primary care for children, youth and adults—a setting that facilitates partnerships between patients and their personal physicians, and when appropriate, the patient's family. Emphasizes care of populations, team care, whole person care—including behavioral health, care coordination, information tools and business models needed to sustain the work. The goal is health, patient experience, and reduced cost. (Joint Principles of PCMH, 2007).

**Mental Health Care**

Care to help people with mental illnesses (or at risk)—to suffer less emotional pain and disability—and live healthier, longer, more productive lives. Done by a variety of caregivers in diverse public and private settings such as specialty MH, general medical, human services, and voluntary support networks. (Adapted from SAMHSA)

**Substance Abuse Care**

Services, treatments, and supports to help people with addictions and substance abuse problems suffer less emotional pain, family and vocational disturbance, physical risks—and live healthier, longer, more productive lives. Done in specialty SA, general medical, human services, voluntary support networks, e.g. 12-step programs and peer counselors. (Adapted from SAMHSA)

**Primary Care**

Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. (Institute of Medicine, 1994)

Thanks to Benjamin Miller and Jürgen Unützer for advice on organizing this illustration

# Things to Consider

- Have you conducted an assessment (community assessment) to determine the need?
- Who else in your community is addressing this issue?
- What are the available resources?
- How are primary health and behavioral health interacting currently?
- What state level initiatives are available?
- Who are the champions in your community? In your State?
- Do you have people who identify as persons with lived experience as a part of your planning activities? Evaluation? Policy development?
- Have you ever considered using peer staff (recovery coaches, peer specialists, navigators, etc.)?

# Case Study: Grantees as a behavioral health convener

## **Granville Vance Public Health Department, *Oxford NC***

- Partnership with local mental health and substance abuse provider agencies
- Utilize agencies to conduct trainings and dispense naloxone to high risk populations
- Current metrics = 261 kits distributed, 16 reversals reported

# Think about your next proposal



- Can I find someone in my community to match?
- Do I want to pay my partners? Do I want to put them in my contractual section in budget?
- How will we determine who to take on? Caseload amount? Target audience?
- Serious mental illness versus mental health
- How can we connect to state-level activities?
- Do I have an indirect cost rate?
- Do I have a mental health/substance use provider as a partner? In a formal capacity?
- How do I build in sustainability efforts?
- Are we interested in tele-health? Tele-mental health?
- Have you considered inter-disciplinary teams? Co-location?
- Are there any contractual fees/services we will need?
- Do we have the workforce available?
- Do we have a network director? By-laws? Mission/vision?
- Do we want to build in educational events? Lunch and learns? CEUs?

**How do you build your work plan three years+ out?**

# Resources

# Resources : DATA

- [County Health Rankings 2016](#)
- [Behavioral Risk Factor Surveillance System \(BRFSS\)](#)
- [National Survey on Drug Use and Health \(NSDUH\)](#)
- [CDC WONDER](#)
- [Area Health Resource File \(AHRF\) 2014/2015](#)

# FORHP Funded Research



Center	Project	Status
WWAMI	Supply of Physicians Waivered to Treat Opioid Addiction in Rural America: Policy Options to Remedy Critical Shortages	Published in Annals of Family Medicine
WWAMI	Who Treats Opioid Addiction in Rural America? Quantifying the Availability of Buprenorphine Services in Rural Areas.	In Progress
WWAMI	The Supply and Distribution of the Behavioral Health Workforce in Rural America	In Progress
Maine	Rural Opioid Use: Prevalence and Characteristics	On Gateway
Maine	State and Local Efforts to Promote Prevention and Access to Treatment for Rural Opioid Users	In Progress
Maine	Implications of Rurality and Psychiatric Status for Diabetic Preventive Care Use among Adults with Diabetes	On Gateway
Maine	Implications of Rurality and Single Mother Status for Maternal Smoking	On Gateway
North Dakota	Use of Emergency Departments for Behavioral Health Related Care	In Progress

# SAMHSA Resources

- **SAMHSA Awards by States in FY 2014**
- <http://www.samhsa.gov/grants-awards-by-state/>
- **The National Network to Eliminate Disparities (NNED) in Behavioral Health**
- [http://nned.net/nned\\_overview/](http://nned.net/nned_overview/)
- **SAMHSA Surveys (Data)**
- [Emergency Department Data / DAWN](#)
- [Substance Abuse Facilities Data / NSSATS](#)
- [Mental Health Facilities Data / NMHSS](#)
- [Client Level Data / TEDS](#)
- [Population Data / NSDUH](#)
- **SAMHSA-HRSA Center for Integrated Health Solutions**
- <http://www.integration.samhsa.gov/>

# Resources: Toolkits

## SAMHSA:

- Opioid Overdose Reversal Toolkit
- Center for Integrated Health Solutions

<http://store.samhsa.gov/>

## FORHP:

- Rural Health Research Gateway

<https://www.ruralhealthresearch.org/>

- Community-Health Gateway:

- Behavioral Health Toolkit
- Addictions Toolkit
- Social Services Integration Toolkit

<https://www.ruralhealthinfo.org/community-health>

# Primary and Behavioral Health Care Integration (PBHCI) grant program



Purpose: To establish projects for the provision of coordinated and integrated services through the co-location of primary and specialty care medical services in community-based behavioral health settings.

Goal: To improve the physical health status of adults with serious mental illnesses (SMI) and those with co-occurring substance use disorders who have or are at risk for co-morbid primary care conditions and chronic diseases.

- Request for Application
  - <http://www.samhsa.gov/grants/grant-announcements/sm-15-005>
- Last Application Due Date: Friday, February 27, 2015
- Anticipated Number of Awards: 102
- Anticipated Award Amount: Up to \$400,000 per year
- Length of Project: Up to 4 years

# SAMHSA Resources

- **SAMHSA Awards by States in FY 2014**
- <http://www.samhsa.gov/grants-awards-by-state/>
- **The National Network to Eliminate Disparities (NNED) in Behavioral Health**
- [http://nned.net/nned\\_overview/](http://nned.net/nned_overview/)
- **SAMHSA Surveys (Data)**
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- [Population Data / NSDUH](#)
- **SAMHSA-HRSA Center for Integrated Health Solutions**
- <http://www.integration.samhsa.gov/>

# Thank you!

## Questions?