Mental Health Systems in Rural and Remote Areas during COVID-19

NASMHPD Commissioners Meeting

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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.

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Mental Health during COVID-19

- Current data does not seem to indicate large differences in impact in mental health across rural and non-rural areas, but a more detailed understanding may be possible as more data becomes available.
- There were not statistically significant differences in outcomes reported between urban and rural respondents, though at the time of a June 2020 CDC survey, people in rural areas reported fairing slightly better on average compared to urban counterparts across the items being measured
- CDC reported national data collected between August 2020 and February 2021 which indicated that the percentage of adults experiencing symptoms of anxiety or depression increased from 36% to 42% without breaking out data for rural areas.
- A survey of rural adults in December 2020 echoed these findings: 56% of rural adults said that they were personally experiencing more mental health challenges than a year ago.
- Initially, death rates from COVID-19 were higher in urban areas, but by Summer 2020, rural rates of COVID-19 deaths had surpassed urban areas. Now, urban populations are being vaccinated at higher rates that rural populations, which may result in higher levels of spread in impact in rural areas going forward compared with urban areas.
- Drug overdose deaths rose by close to 30% in the United States in 2020
- Suicidal ideation has increased, yet, suicides declined or stayed the same during the COVID-19 pandemic. This may change over time.

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Access and Workforce

- People in rural areas may access mental health services at similar rates to other areas of the United States, but they do not have equivalent access to intensive or specialty services.
- 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
- 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.
- 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.
- An examination of one state system showed that evidence-based programs (EBPs), such as Assertive Community Treatment (ACT), Supported Employment, Supportive Housing, and Multisystemic Therapy, were less likely to be offered in rural areas and staff in rural areas were less likely to be trained in EBPs in rural areas compared with urban areas

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Access and 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
- Sudden withdrawal of already limited mental health and primary care workforce in rural communities reduced access during COVID-19
- COVID-19 led to a massive natural experiment in the rapid and widespread implementation of tele-behavioral health care.

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American Indian/Alaska Native Communities

- As of April 2021, AI/AN people in the United States experienced the highest death rate from COVID-19 compared with other racial and ethnic groups and were 2.4 times as likely to die from COVID-19 compared with whites.
- Many tribes were able to institute innovative and forward leaning public health measures and have also led in vaccine distribution, initially achieving higher rates of vaccination than other racial and ethnic groups
- For each of these conditions, AI/AN individuals experience higher rates than national averages across racial and ethnic groups. Nationally, AI/AN individuals 18 years and older were less likely to receive mental health services (13.9 %) compared with the national rate (16.1 percent). AI/AN people also had the highest rate of suicide among racial and ethnic groups in 2019, at 22.5 per 100,000 compared with a national rate of 13.9 per 100,000

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Telehealth

- Responding to the need to provide socially-distanced services, health systems rapidly shifted to telehealth service
- Temporary legal and regulatory flexibilities were enacted to enable the provision of telehealth services
- A study that analyzed half of all private insurance claims in the United States from February of 2020 to April of 2020 found a 2900% increase in mental health telehealth claims
- Another study that examined a national sample of commercial and Medicare advantage claims from January to June 2020 found that telehealth accounted for 56.8% of total psychiatry visits, 50.8% of social work visits, and 49.1% of psychology visits during this period
- In general, and in rural areas specifically, it offers a more convenient way for people to access many mental health services. In addition to direct service delivery, telehealth may be used to support consultation with other providers, such as primary care providers or less specialized behavioral health care providers, so may be a way of bolstering the capacity of the existing workforce in rural and remote areas.

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Rural Telehealth Challenges

- Because many of these changes designed to respond to the pandemic are temporary, mental health systems and providers face a lot of uncertainty and may have to adapt to a new regulatory and policy environment as COVID-19 rates decline
- Whereas there was a general acceptance of telehealth prior to COVID-19, rural communities had a harder time rapidly expanding use due to technology barriers, such as:
  - Lack of access to broadband or limited bandwidth
  - Poor cellular coverage
  - Limitations in individuals' phone plans that limit the number of minutes or amount of data that they can use; and
  - Lack of access to necessary technology
- Will a Congressional infrastructure bill help increase access to broadband and technology?

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Crisis Services

- There is not a one-size-fits-all model for crisis in rural/remote areas
- Crisis services capacity and availability varied by rural community pre-pandemic and was strained during peak outbreaks
- Data is unclear about outcomes and defaults to law enforcement
- Leveraging partnerships with area first responders to strengthen crisis response abilities and incorporating technologies like telehealth to make the best use of available resources in developing and delivering crisis care
- Supporting 24/7 access in rural/remote communities is difficult due to financial viability and workforce capacity necessitating nuanced approaches and partnerships with first responders and others
- Increased use of telehealth in crisis is positive, but still a barrier in rural areas with limited broadband access

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Takeaway Points

- At the time of this paper, much information is anecdotal.
- Emergence of Delta variant is prolonging affects of pandemic in communities, including rural communities.
- Sudden withdrawal of already limited mental health and primary care workforce in rural communities reduced access during COVID-19, especially face to face.
- As of April 2021, AI/AN people in the United States experienced the highest death rate from COVID-19 compared with other racial and ethnic groups and were 2.4 times as likely to die from COVID-19 compared with whites.
- COVID-19 led to a massive natural experiment in the rapid and widespread implementation of tele-behavioral health care.
- Whereas there was a general acceptance of telehealth prior to COVID-19, rural communities had a harder time rapidly expanding use due to technology barriers
- Supporting 24/7 access in rural/remote communities is difficult due to financial viability and workforce capacity necessitating nuanced approaches and partnerships with first responders and others

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Recommendations

- Quickly ending telehealth flexibilities created to respond to the COVID-19 pandemic would likely be disruptive to mental health care systems and those being served. Policymakers should try to learn from experiences during the pandemic to develop systems that encourage the appropriate role for telehealth, without reflexively reverting to the pre-pandemic status quo.
- Developing the rural mental health workforce should be a continued priority. Efforts to train and recruit mental health professionals in rural and remote areas should be combined with service adaptations and supports like remote consultation to fully leverage existing workforce capacity.
- There should be a more concerted effort to examine behavioral health surveillance, facility, and claims data by urbanicity, including stratification of data from more remote areas, to understand the impact of COVID-19 on systems and people in rural and remote areas.
- There is a need for service model innovation and adaptation in rural and remote areas, especially to meet the needs of people with intensive and complex mental health needs. This work should be attentive to different population groups, including AI/AN populations.
- Funding should be made available through federal and state pandemic relief and infrastructure packages.

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