Rural Behavioral Health Services

Bruce Lubotsky Levin and Ardis Hanson

Introduction

Health and behavioral health care in America have come under increasing scrutiny during the last half of the twentieth century and beginning of the twenty-first century from a vast array of stakeholders, including consumers, providers, employers, community leaders, policymakers, administrators, educators, as well as lawmakers at the state and federal levels of government. Proposals for national and state health care reform have been encouraged, in part, by the need to control the rising costs of health and behavioral health care and to address the obstacles and inequities in accessing health and behavioral health services. Although the United States Congress passed major comprehensive health care reform legislation in 2010 with the Patient Protection and Affordable Care Act (ACA, PL 111–148), significant health care initiatives (particularly in association with entitlement programs) have been proposed and implemented by various individual states.

Historically, individuals who live in rural and frontier areas in America have significant and often times distinct health and behavioral health care needs, but have experienced numerous obstacles in obtaining these services. These numerous challenges include the lack of accessible services (e.g., social isolation, significant geographical distances, and inhospitable climates), a general scarcity of resources and

B. L. Levin (✉)
Department of Child and Family Studies, College of Behavioral and Community Sciences, University of South Florida, Tampa, FL, USA

Behavioral Health Concentration, College of Public Health, University of South Florida, Tampa, FL, USA
e-mail: levin@usf.edu; levin@health.usf.edu

A. Hanson
Research and Education Unit, Shimberg Health Sciences Library, University of South Florida, Tampa, FL, USA
e-mail: hanson@health.usf.edu

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the absence of a human services infrastructure, severe shortages of service providers, the absence of service specialization (availability of services), the inappropriate organization of services based upon urban (metropolitan) delivery system models, and inefficient communication (including diversity of languages and sub-cultures) to disseminate information and coordinate care.

These rural health care delivery barriers become even more complex with the provision of rural (and particularly frontier) behavioral health services, since behavioral health services delivery has historically faced problems of stigma (among health providers, consumers, and employers), poor integration with physical (or somatic) health services, unique language and cultural challenges to treatment, as well as substantial reliance on public sector funding.

This chapter presents an overview of the major challenges in the provision of rural behavioral health services in the United States. It also identifies what we see as the most important issues facing rural behavioral health services delivery in the foreseeable future.

Defining Rural and Frontier Areas

Rural America encompasses 97% of the land area of the United States and contains 60 million residents (19% of the U.S. population) (Ratcliffe, Burd, Holder, & Fields, 2016). Furthermore, 10 states in the United States have 40% or more of their population who live in rural or frontier areas.[1] The most rural populations of America are spread across almost 2500 counties heavily concentrated in the South and the Midwest.

Factors contributing to the decrease in rural America include migration of young adults to more urban areas, fewer births, increased mortality among working adults, an aging population, and re-classification of previously rural areas to urbanized and urban areas (Cromartie, 2017).

Basing its definition upon residential population density and land-use characteristics, the U.S. Census Bureau defines rural as "all population, housing, and territory not included within an urbanized area or urban cluster" (Ratcliffe et al., 2016, p. 3). The Census Bureau defines territory within tracts, which may contain both rural and urban areas, and its Rural-Urban Commuting Area Codes characterize the nation's Census tracts. Since the U. S. rural population abides in housing subdivisions on the edge of urban centers, in densely settled small towns, and in sparsely populated or remote areas, rural categories can be classed as mostly urban, mostly rural, or completely rural.

The Census Bureau also uses other measures to assist others in understanding the socioeconomic diversity of rural America. These include the Rural-Urban Continuum Codes, Urban-Influence Codes, Natural Amenities Scale, and the ERS

[1] (Maine (61%), Vermont (61%), West Virginia (51%), Mississippi (50%), Montana (44%), Arkansas (43%), South Dakota (43%), Kentucky (41%), Alabama (40%), and North Dakota (40%).

Typology Codes. Of especial interest to behavioral health are the ERS Typologies Codes, which examine six policy-relevant class areas (education, employment, persistent poverty and persistent child poverty, population loss, and retirement destination) in addition to six economic dependence categories (Cromartie, 2017). This can make understanding rural issues challenging.

To further complicate matters, there is no standard, universally used definition for frontier and remote (FAR) areas. While a FAR is commonly defined as six or fewer people per square mile, there are other factors that also may define an area as a FAR. In addition to population density, other factors include distance from a specific service point or a population center, travel time, availability of paved roads, and seasonal changes that may affect access to services. In 2007, the National Center for Frontier Communities (2007) created a consensus definition using a weighted matrix that utilized density (persons per square mile), distance (miles to supermarket), and travel time (minutes to supermarket). Building upon this model, the Office of Rural Health Policy (ORHP) and the U.S. Department of Agriculture (USDA) developed the Frontier and Remote Areas (FAR) methodology, which uses ZIP-code-level frontier and remote area (FAR) codes to assist with policy and research (Economic Research Service, 2017). The FAR methodology utilizes travel time to nearby urban areas (population centers) to create a four-level categorical schema. The levels are based on access to high order services (level one), low order services (level four), and intermediate order services (levels two and three). Section 10324(B1-II) of the ACA defines a "Frontier State" where "at least 50 percent of the counties in the State are frontier counties…counties in which the population per square mile is less than 6" (p. 841).

Rural Behavioral Health Services

Historically, health and behavioral health services have been largely concentrated in large, urban areas of America. Hence, the basic organizational models for health and behavioral health services delivery have been based upon urban at-risk populations. The same can be said of professional and graduate education and training programs for health and behavioral health practitioners, many of which evolved in major metropolitan universities and hospitals. Few graduate training programs have concentrations in rural behavioral health, separate certification, or other credentialing programs.

There is significant variability and heterogeneity in rural environments throughout the United States. Every rural community is unique, with its own at-risk populations as well as its underlying economic, historical, political, cultural, and social structures, collectively contributing to diverse patterns of health and behavioral health problems. Population characteristics and the economic base in the rural Southwest will differ significantly when compared to population characteristics in rural Appalachia, Northern New England, the South, the Great Plains, or in the Frontier West. Moreover, no single systems delivery model of rural health and

behavioral health services could be expected to serve all rural and frontier areas in the United States, just as there is no single systems delivery model for urban health and behavioral health services.

Collectively, rural populations in America have unique characteristics that impact issues of accessibility, availability, and acceptability of health and behavioral health services. Issues include sociodemographic differences (e.g., income, poverty, and education), geographic differences (distance to care), cultural differences (rural vs. urban), and perceptual differences (e.g., stigma surrounding mental illnesses).

Hospitals in rural areas tend to be smaller, older facilities that serve a higher proportion of unemployed, lower income, uninsured, or publicly insured individuals compared to urban hospitals (Phillips & Moylan, 2017). Hence, rural areas often have disproportionate populations dependent upon Medicare and Medicaid programs (Foutz, Artiga, & Garfield, 2017). Nearly two-thirds of uninsured people in rural areas live in a state that did not implement the ACA Medicaid expansion. Since uninsured or underinsured rural individuals are disproportionally affected by state decisions to not implement the expansion option, they may have fewer affordable coverage options to obtain care early (prevention) or until they are in a crisis mode (Newkirk & Damico, 2014).

More basic problems, such as insufficient transportation, electricity, water, and communication systems, have only complicated the process of providing and using rural health and behavioral health services.

Investment in health infrastructure is critical to improving quality of care and reducing disparities in the delivery of care to rural Americans (Seigel, 2018). This investment is critical to care for the number of rural residents who suffer from mental illnesses, alcohol abuse, and substance use disorders.

Epidemiology

Rural populations have historically experienced increased rates of alcohol abuse, substance use, child and spousal abuse, and depression. However, one of the basic problems facing the rural behavioral health services research field involves the estimation of the prevalence of behavioral disorders in individuals who live in rural and frontier areas as well as subsequent rural versus urban prevalence comparisons. The lack of definitive conclusions and study findings have been attributed, in part, to the variability in definitions (of both rural/urban areas and of behavioral disorders), sampling design (including potential differences in the age, ethnicity, and/or racial characteristics of the population), measurement (e.g., treated prevalence versus true prevalence), source of data, and the type of instrument utilized in rural behavioral health studies. Studies on mental illnesses may or may not include substance use disorders or co-occurring disorders. Studies may fail to address what level of severity is being examined (mild, moderate, or serious) and whether the population is being examined over a 12-month period or a lifetime.

Of the total percent of adults identified with a mental disorder in the United States, for example, it is estimated that 40.4% experienced mild disorders, 37.3% experienced moderate disorders, and 22.3% experienced serious mental disorders (Bagalman & Napili, 2018). Estimates of 12-month prevalence of mental illnesses are 24.8% among adults and estimates of 12-month prevalence of mental illnesses including substance use disorders among adults are 32.4% (Druss et al., 2009). However, these estimates may not always differentiate among rural, urban, or sub-urban populations or areas.

SAMHSA reports almost 20% (over 6.5 million) of residents living in non-metropolitan counties suffered from one or more behavioral health problems during 2016 (Center for Behavioral Health Statistics and Quality, 2017). Symptoms related to anxiety disorders, trauma, cognitive disorders, behavioral disorders, and psychotic disorders are often comparable to urban residents (CBHSQ, 2017), however, suicide rates in rural areas have surpassed urban suicide rates (Ivey-Stephenson, Crosby, Jack, Haileyesus, & Kresnow-Sedacca, 2017).

In addition, the highest per capita rates of complex co-occurring disorders (COD) were found in rural areas (Somers, Moniruzzaman, Rezansoff, Brink, & Russolillo, 2016). Further, rural residents who are female, poor, elderly, belong to a cultural, racial, or ethnic minority, or who are unemployed have an increased likelihood of experiencing behavioral health problems (Bardach, Tarasenko, & Schoenberg, 2011; Burholt & Scharf, 2014; Cummings, Wen, Ko, & Druss, 2013, 2014; Tjaden, 2015; Wielen et al., 2015).

The stress of ranching and farming has been a major problem in selected rural areas of America. The threat of losing family land, a home, a family, experiencing severe weather problems, and the constant preoccupation with uncertain crop production creates major stressors on many ranch and farm families. Accidents, equipment problems, social isolation, and irregular cash flow can produce unhealthy emotional reactions, often in association with behavioral and/or somatic disorders. Added stress and depression, suicidal tendencies, and substance abuse all increase the probability of already above average work-related accidents and contribute to the exacerbation of physical health conditions.

Obstacles to Services Delivery

The number of obstacles rural residents face in obtaining behavioral health services results in increased disparities compared to urban residents. It is well-established the need to implement adequate services in non-metropolitan areas was and remains a critical national behavioral health imperative (Roberts, Battaglia, & Epstein, 1999; Seigel, 2018; Wilson, Bangs, & Hatting, 2015). The availability of behavioral health services and service providers, the accessibility to services, the acceptability of these services to rural residents, and the utilization and costs of specialty services remain critical factors in rural behavioral health services delivery.

Rural American families have difficulty managing multiple health care needs due to a number of structural reasons. These challenges include: higher numbers of individuals without health care insurance or who are underinsured; fewer primary and specialty providers; time, geography, and transportation challenges; and community and employment disenfranchisement (Barker, Londeree, McBride, Kemper, & Mueller, 2013; Chavez, Kelleher, Matson, Wickizer, & Chisolm, 2018; Monnat & Beeler Pickett, 2011; Weinhold & Gurtner, 2014).

Rural poverty and persistent rural poverty are problematic. Across all four regions of the United States (Northeast, Midwest, South, and West), poverty rates were consistently higher for those living in rural areas (Semega, Fontenot, & Kollar, 2017). Further, persistent poverty, defined as a poverty rate of 20% or greater for at least four consecutive decades, is primarily a rural phenomenon, and 301 (85.3%) counties experiencing persistent poverty in the USA are rural (Economic Research Service, 2018). These structural barriers exacerbate the social determinants of health for rural populations (National Advisory Committee on Rural Health and Human Services, 2017).

It is not surprising the overall availability and volume of behavioral health services, programs, and providers increases with the population density of a community or area. Thus, the growth of behavioral health services in rural areas remains limited. Residents of rural jurisdictions face significant health challenges, including some of the highest rates of risky health behaviors and worst health outcomes of any at-risk population in the country.

In the next four sections, we borrow the framework of availability, accessibility, affordability, and acceptability, first developed by Bushy and still relevant today, at the level of national rural policy (Bushy, 1997; Wilson et al., 2015). *Availability* examines staffing or service shortages which often limit the receipts of services. *Accessibility* looks at coordination of services across the many sectors of the health, behavioral health, and social service systems and transportation to those service providers and/or facilities. *Affordability* involves the costs of care, such as direct and indirect costs, and affording insurance that covers one's needs. *Acceptability* addresses the persistent discrimination, perception, and stigma attached to the receipt of or need for behavioral health services.

Availability (Facilities and Staffing)

Rural America has suffered from continual shortages of available behavioral health and supportive services that, in turn, have restricted the array of behavioral health services in rural areas. The availability of specialty behavioral health services has been partially dependent upon the existence and availability of professionally trained behavioral health providers. The Health Resources and Services Administration uses Health Professional Shortage Areas (HPSAs) to define areas with shortages of primary medical care, dental, or mental health providers and may be geographic in nature (e.g., county or service area), population (e.g., low income,

Medicaid eligible), or facilities (e.g., federally qualified health center). The Federal definition for mental health HPSA requires the population-to-provider ratio must be at least 30,000–1 (20,000 to 1 if there are unusually high needs in the community). Mental health designations may qualify for designation based upon three criteria: (1) the population to psychiatrist ratio, (2) the population to core mental health provider (psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists) ratio, or (3) the population to both psychiatrist and core mental health provider ratios (Bureau of Health Workforce, 2018).

Over 60% of rural areas in the United States have been designated as federal mental health professional shortage areas (MH HPSAs). Of the 5119 MH HPSAs in the United States as of December 2017, there were 2718 rural MH HPSAs and 467 Partially Rural MH HPSAs across the ten HRSA regions. The total number of MH practitioners needed to remove the HPSA designation are 5985 and 2257, respectively. To achieve target ratios of 10,000:1, an additional 5985 practitioners would be required.

Unfortunately, the sparseness of rural populations as well as geography limit both the number of behavioral health providers as well as the diversity of behavioral health specialists in rural areas. In turn, these shortages in behavioral health providers as well as services significantly impact the organization and delivery of rural behavioral health services. There are proportionately fewer behavioral health

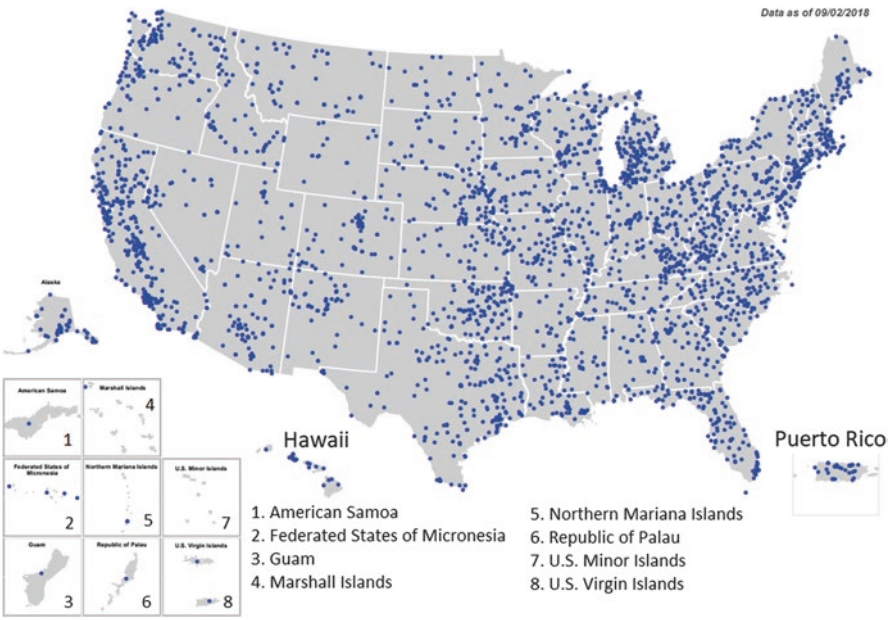

Fig. 1 HRSA Health Professional Shortage Area (HPSAs) facilities – mental health. Used with permission. Retrieved from the HRSA Map Gallery https://data.hrsa.gov/maps/map-gallery [ExportedMaps/HPSAs/HGDWMapGallery_HPSAs_MH_Facilities.pdf]

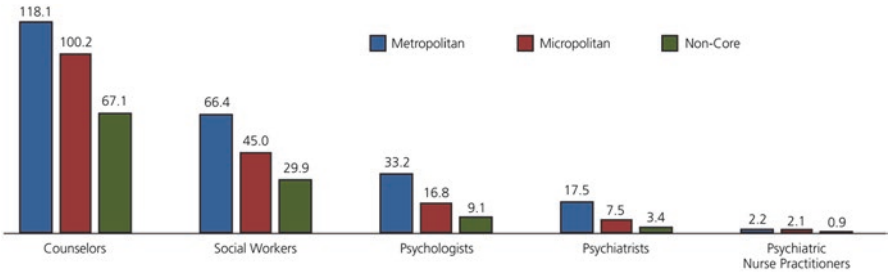

Fig. 2 Behavioral health providers per 100,000 population in U.S. Counties by Urban Influence Category. Used with permission of the WWAMI Rural Health Center, University of Washington (Larson, Patterson, Garberson, & Andrilla, 2016). Note: Micropolitan and Non-Core are rural designations

providers (psychologists, social workers, and counselors) living in rural areas, regardless of education and training levels (Figs. 1 and 2).

With the rise of integrated health and behavioral health care, 40% of primary care physicians were geographically co-located with behavioral health providers in urban areas compared with co-located primary and behavioral health providers in isolated rural areas (22.8%) and in frontier areas (26.5%) (Miller et al., 2014). Although physicians often provide behavioral health care in the absence of behavioral health specialty providers, there are concerns by physicians they may not be trained sufficiently to diagnosis or treat mental or substance use disorders. A survey of family medicine physicians in rural Montana reported a number of self-limitations in behavioral health services delivery, including lack of confidence or competence and inadequate knowledge or training (Robohm, 2017).

Even rural health clinics struggle to provide mental health services (Harris et al., 2016; Kosteniuk et al., 2014; Wright, Damiano, & Bentler, 2015). A survey of Iowa rural health centers reported difficulty hiring and retaining physicians (80%), physician assistants, and nurse practitioners (both 50%), with referrals to specialists being common. With the implementation of the ACA, almost 60% of respondents also anticipated an increase in the size of their patient load; however, only 19% believed they had the human, financial, and material resources necessary to respond to those challenges (Wright et al., 2015).

Despite continuing efforts to recruit, staff, and retain rural behavioral health professionals from social work, psychology, psychiatry, and psychiatric nursing, efforts at meeting the special needs of these behavioral health professionals have been

isolated and have focused on relatively few geographic areas in rural and frontier areas of the United States.

Accessibility (Coordination of Care and Community and Social Supports)

Rural residents often live farther away from health care resources and providers and therefore must travel farther to obtain needed services (Meit et al., 2014). With only a quarter of rural and frontier primary and behavioral health care providers co-located, there is an increased need for coordination of hospital, provider, and community-based services for persons with mental and substance use disorders. Since patients receiving care in the specialty mental health sector are much more likely to receive adequate care than patients receiving care in the general medical sector only, rural individuals often receive poorer quality care (Agency for Healthcare Research and Quality (AHRQ), 2017).

Emergency Room as Primary Care

It is not uncommon for individuals living in rural areas to travel hundreds of miles to seek inpatient behavioral health care because of the absence of emergency/24 h behavioral health services in their rural communities as well as the stigma still attached to the treatment of mental illnesses. While approximately 30% of rural individuals identified a hospital, emergency room, or clinic as a source of ongoing care (AHRQ, 2017), 12% of rural residents use the emergency room (ER) for behavioral health treatment (Schroeder & Leigh-Peterson, 2017). Approximately 75% of rural residents present at the ER with a primary diagnosis of a mental disorder and approximately 60% present with a primary diagnosis of a mental or substance use disorder were more likely to be on public insurance. In addition, approximately 25% of rural elderly present to the ER with a mental health problem (Schroeder & Leigh-Peterson, 2017).

The requirement to drive so far away to receive care and not be able to receive referrals for continuity of care in one's local communities reduces rural residents' ability to have consistency in care, follow-up, and provider. Further, rural behavioral health providers and agencies, often over-extended with large client caseloads, may not have the time or expertise to seek additional or supplemental support for needed programs, especially outside of their standard service area(s) or case management partnerships, or for complex, co-occurring disorders (Mowbray, McBeath, Bank, & Newell, 2016; Nover, 2014). Mowbray et al. (2016) describe the challenges of coordinating behavioral health and social services to rural corrections-involved populations.

Integrated Care Coordination

There remains heterogeneity in the organizational models of behavioral health services delivery. For example, while some states and communities organize behavioral health services together with substance abuse services in a single agency, other states have separate agencies for behavioral health and substance abuse services. In addition, selected states house behavioral health and substance abuse services in an umbrella human services agency.

Nevertheless, the scarcity of rural behavioral health services and rural behavioral health providers together with continual changes in the organization, financing, and delivery of health and behavioral health services (through provider networks and managed care) provides strong incentives for linking or integrating behavioral health services with primary health care. Models include integrated provider teams and collaboration and partnerships between behavioral health services and other human services organizations through co-locations, site visits, shared facilities, and joint staff activities. One benefit of integrated care is the "medical cost offset effect", or the decrease in medical care utilization and costs after the introduction of an integrated behavioral health component within a comprehensive health care program, which can assist with the coordination of care for complex co-morbid conditions (Cummings, O'Donohue, & Cummings, 2009).

Individuals with serious mental illness are at an increased risk for developing co-morbid chronic physical illnesses. The CalMEND Pilot Collaborative to Integrate Primary Care and Mental Health Services was an attempt to address the needs of this population (Nover, 2014). Focused on quality assurance, intra- and inter-agency teamwork, and access to adequate primary care for this population, the CalMEND Pilot showed it was able to improve collaboration among the six CPCI pilot partnerships by unifying primary care and behavioral health providers. It focused on team-driven care with the design, development, and running of effective care teams, implementing clinical workflows supportive of integrated care, and improved care management among persons with complex, co-occurring disorders (Nover, 2014). For additional reading on the integration of physical and behavioral health care, see Chapter "Integration of Primary Care and Behavioral Health" in this volume.

Safety Net Clinics

There are numerous challenges common to safety net clinics. These include limited access to specialists for Medicaid and uninsured patients, difficulty communicating with external providers, and payment models with limited support for care integration activities (Derrett et al., 2014). A study of clinicians in 150 safety net primary

care clinics in Washington State, primarily Federally Qualified Health Centers or Rural Health Clinics, found that most respondents believed the integrated health/behavioral health program was beneficial (Williams, Eckstrom, Avery, & Unützer, 2015). Rural respondents approved of the flexibility of the program when planning care. However, social service limitations (e.g., housing or transportation services) were identified more often as program limitations and a lack of awareness of program resources by other team members (Williams et al., 2015).

Telehealth, e-Health, and m-Health

Considering many of the challenges in accessibility for residents of rural and frontier areas, telehealth and emerging e-/m-health technologies may be able to surmount these barriers. In their retrospective review of Medicare data, Mehrotra et al. (2017) found the number of telemental health visits not only grew on average 45.1% annually but by 2014, there were 5.3 and 11.8 telemental health visits per 100 rural residents with mental illnesses. Residents who received telemental health services tended to be younger, have disabilities, and live in poorer communities.

Also, states with telemedicine parity laws and regulatory environments had significantly higher utilization than other states. In their review of Medicaid data in the 22 states with telehealth reimbursement, Douglas et al. (2017) found the highest utilization of telemedicine (95%) was predominantly used to treat persons with behavioral health diagnoses. Patients were more likely to live in a rural area with a managed care plan, have an aged, blind, and disabled criteria, and be males 45–64 years of age. Douglas and colleagues also determined that reimbursement alone was not enough to drive the use of telemedicine; it is critical to more closely examine state-specific reimbursement and licensure policies on telemedicine.

These studies, with others, illustrate the challenges and issues involved in licensing, liability, and accreditation when it comes to the provision of mental health and substance use services. For example, when six states in the nation allowed telemental health counseling across state lines with full and reciprocal privileges, but due to the states' interpretation of Medicare/Medicaid rulings on telehealth reimbursement, providers receive unequal reimbursement for services rendered.

Health care professionals have to address limitations in scope of practice, difficulties with in-state and interstate credentialing, lack of portability of practitioner licenses, remote prescribing, not to mention immunity and liability issues that may occur when dealing with emergency or crisis events. However, there is progress being made. Since 2016, more states have addressed these key regulatory questions. For example, Arkansas, Hawaii, Indiana, Louisiana, and Maine established regulations that allow patient relationships and evaluations to be established via real-time audio and visual telehealth technologies (Epstein Becker Green, 2017).

Affordability (Individual and System)

Affordability involves the costs of care, and for many that centers on the affordability of health insurance. For others, affordability also examines system issues that affect affordability of care, such as provider reimbursement, which affect availability of services and resources.

Historically, individuals living in rural areas were more likely to have their mental health services paid for by public insurance and less likely paid by private insurance than individuals living in more urban areas. Today, rural individuals with serious or persistent mental illnesses (SMI/SPMI) still remain more likely to have their mental health services paid by public insurance. They were also more likely to pay out-of-pocket costs compared to individuals with SMI living in urban areas (Harman, Fortney, Dong, & Xu, 2010).

With the implementation of the Patient Protection and Affordable Care Act in 2010 and Medicaid expansion, there have been more opportunities for rural individuals to obtain health coverage for behavioral disorders. However, states that did not accept Medicaid expansion created significant gaps in coverage as households, with incomes between 18% and 99% of the federal poverty level (FPL) were ineligible for Medicaid or to enroll in the health insurance exchange (HIE) marketplace. Rural residents were less likely than urban residents to use the Marketplace.

In states, such as Texas, there were 1,101,000 adults in the insurance gap, accounting for almost a quarter of all uninsured persons in Texas (Gong, Huey, Johnson, Curti, & Philips, 2016, 2017). The gap was significantly higher in rural East and South Texas and in Texas as a whole. One-third of the enrollees previously had private or employer-based insurance before enrollment into the Marketplace. By 2014, the number of uninsured adults was reduced by 710,000, with two-thirds of the enrollees in the Marketplace (Gong et al., 2016, 2017). In rural Wisconsin, enrollments in public insurance led to substantial increases in outpatient visits but not mental health visits (Burns et al., 2014).

How individuals chose health insurance plans may be related to a number of factors, including comprehension of insurance terminology and language, numeracy, consistency of options across choices, and the number of available plans. Hence, the ability of an individual to choose an affordable option may depend upon improving the consumer's ability to comprehend the intricacies of health insurance (Barnes, Hanoch, & Rice, 2015, 2016).

Interventions designed to improve rates of mental health treatment, such as the collaborative care models, are usually based on private payers, such as managed care organizations which are less likely to operate in rural areas. However, in addition to shortages of providers, third party payers have placed restrictions on both the delivery and reimbursement of behavioral health services. For rural behavioral health settings, this has primarily affected Medicare and Medicaid entitlement programs. Although licensed behavioral health practitioners from various disciplines may be reimbursed for behavioral health services, physicians continue to receive

supervisory and medication authority, legal responsibility, and accountability for behavioral health treatment, despite the severe shortage of physicians trained and/or interested in behavioral health treatment in rural areas. Furthermore, the particular behavioral health providers who are "approved" to deliver behavioral health services vary in terms of the health and behavioral health service settings, states, and funding sources. This has been particularly important with the introduction of new health care strategies and developing provider networks in rural areas in America.

Acceptability (Values, Traditions, Culture)

Acceptability refers to the provision of behavioral health services in a way that is compatible with the values of the populations at-risk. Rural values, attitudes, and traditions may limit the utilization of behavioral health services. Given the racial, ethnic, and cultural diversity among rural populations, acceptability of behavioral health services may be difficult to achieve for a number of reasons, including: established self-care practices; specific behavioral health etiologic beliefs; the lack of knowledge about behavioral health services, gatekeeping, and treatment for these services; and the location of behavioral health treatment settings.

Acceptability of rural behavioral health services may also be influenced by the urban education and training orientation of behavioral health providers. How practitioners learn to work with rural populations potentially affects the establishment of trust during the construction of the behavioral health provider-consumer relationship. This relationship directly impacts the success of rural behavioral health outreach and aftercare programs. If the rural behavioral health outreach providers are viewed as community outsiders, then the helping relationship will not be established. Thus, careful recruiting and retaining of behavioral health professionals for work in rural areas is critical in planning and implementing rural behavioral health programs.

Community acceptability is also critical for the survival and effectiveness of rural behavioral health programs (Bushy, 1997). To help ensure that a program is acceptable by a population at-risk for behavioral disorders, a community needs assessment should be conducted prior to the planning and implementation of a new rural behavioral health program. The collection and thorough understanding of cultural data is critical so that the provision of rural behavioral health services will be made available in a manner consistent with the cultures of at-risk populations.

Behavioral health providers should consider a number of factors for a rural behavioral health needs assessment initiative, including: population density; travel; time and work-related issues; customs, values, and traditions related to behavioral health services; and patterns of natural events. Thus, behavioral health programs will not thrive unless personal, employment, cultural, and enviro-behavioral factors are taken into consideration.

Implications for Behavioral Health

The shortage of rural behavioral health professionals, the limited availability of behavioral health services, and the relative dependence upon government entitlement programs for the financing of rural and frontier behavioral health services has contributed to significant problems for rural communities. These problems include: rural residents not receiving needed behavioral health services; rural individuals not receiving timely behavioral health services, potentially increasing the cost, duration, and level of behavioral health care; and the provision of treatment for behavioral disorders in service settings far from the home community.

The Rural Healthy People 2020 survey found that mental health and mental disorders remain the fourth most often identified rural health priority (Bolin et al., 2015). Many of the basic service delivery issues and challenges in the organization and delivery of rural behavioral health services have not been addressed effectively or consistently by policymakers and legislators.

Two decades ago, Roberts et al. (1999) concluded the "implementation of adequate services in non-metropolitan areas is a critical national health imperative." The California Rural Health Policy Council (1998) defined the ideal rural health care delivery system as addressing three components. First, the system would integrate fully locally defined health- and prevention-related services. Second, it would incorporate broad community engagement and collaboration. Finally, strategic planning would be locally driven with measurable outcomes for the community.

More recent recommendations, such as the emphasis on (re)building rural infrastructure from the National Rural Health Association (Seigel, 2018), again reinforce what behavioral health providers, consumers, advocates, and researchers have known for some time: although health care in the United States is generally viewed by most in society as a right (of citizenship), behavioral health care is not a part of that right.

Nevertheless, the era of tremendous change in health and behavioral health care will continue in the foreseeable future. While challenges remain in addressing severe shortages in rural behavioral health providers as well as building successful models of rural managed behavioral health services delivery, we see a strategic rural focus on the following key elements in behavioral health services delivery:

1. continued consumer and family involvement in program, policy, and clinical decision making and outcomes (MacDonald-Wilson, Schuster, & Wasilchak, 2015; Nelson, Barr, & Castaldo, 2015);
2. integration models that address patient centeredness and normative aspects of care across functional, organizational, professional and service components within integrated primary care/mental health programs (Bachrach, Boozang, & Davis, 2017; Bird, Lambert, Hartley, Beeson, & Coburn, 1998; van der Klauw, Molema, Grooten, & Vrijhoef, 2014), and,
3. clinical, service provision, cultural, and management competence (or rural practice expertise) of rural behavioral health providers, especially in the adoption and implementation of evidence-based practices (Dotson et al., 2014; Weaver, Capobianco, & Ruffolo, 2015).

Through public and private services delivery partnerships, coalitions of consumers and providers, integration of health and behavioral health providers and services, telecommunication technologies, and targeted as well as experiential education and training programs for practitioners, rural and frontier communities have the potential of building stronger, more vital behavioral health services.

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