

NASMHPD Update

NASMHPD

Supporting Excellence in Behavioral Health
60 YEARS



WASHINGTON

1.38
Crisis Jam
DAY IN THE
LIFE...
TEEN
CRISIS LINE

88 Crisis Jam
SYSTEMS
ENGINEERING
PIPER

IDAHO

WYOMING

NORTH
DAKOTA

SOUTH
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EP. 39
988 Crisis Jam
ALL
NATIONS
NE

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KENTUCKY

PENNSYLVANIA

WEST
VIRGINIA

CONNECTICUT
YOUTH
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CRISIS

SOUTH
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ARKA
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MIS
SIS
SIPPI

LABAMA
CRISIS
SYSTEM

FEAT. WENDY
POWERED
GEORGIA

911 AUSTIN
& INTEGRAL
CARE

72
88 Crisis Jam
MOBILE
CRISIS
IN
ALASKA

88 Crisis Jam
MARYLAND
MISSION

PUERTO RICO
Puerto Rico
988 System

New Jersey Is
a PADS Registry

Crisis Response
Battling
Addiction

Massachusetts Slides
Fill Frontline Gap

88 Crisis Jam
PSYCHIATRIC
GUARDING

VERMONT

VERMONT

Armstrong on Race, Mental Health
Work Is Not the Answer

Oklahoma's 988 Marketing Gets Creative

A Social Worker's Substance Use and
Journey

88 Crisis Jam
MOBILE
CRISIS
ARIZONA

88 Crisis Jam
COLORADO
CRISIS
HUB

EP. 147
88 Crisis Jam
INNOVATING
CRISIS
CARE
IN UTAH

on How COVID-19 is an Opportunity for
Mental Health Crisis Prevention and

EP. 39
988 Crisis Jam
ALL
NATIONS
NE

EP. 89
88 Crisis Jam
MY FARM WAS UNDER
AND I WAS DROWNING

Trace Terrell and
Crisis Lines

Montana Is Redesigning Crisis Services in a Rural
Area

EP. 141
988 Crisis Jam
BRIDGE
CENTER
OR
JES

KID'S
CRISIS
UNIT
AND

88 Crisis Jam
EP. 43
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FEAT. KIM
BOSWELL
988 Crisis Jam

Jydra Leitman
988 Crisis Jam

arissa Aguilera

Charlotte
Lamborne

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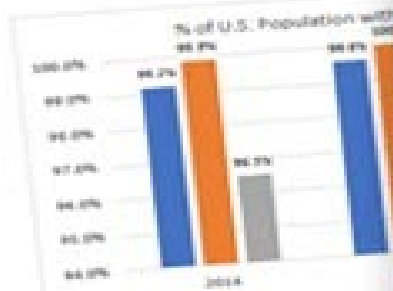


Improving Behavioral Health Services for Individuals with SMI in Rural and Remote Communities

August 2021

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While broadband connectivity, both fixed and mobile, is available in most areas of the U.S., the actual availability of broadband services is inaccurate because it relies on Census data that does not cover small areas in urban communities significantly. As the report says, "Just in the rural south, west, and Alaska have..." (Ferguson, R., 2015).

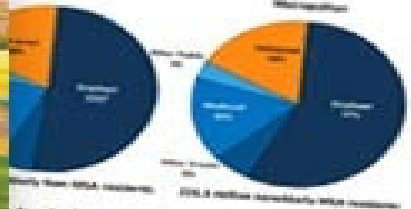
The maps developed by the FCC and the National Telecommunications Commission (Federal Communications Commission) show that the rural south, west, and Alaska have...



Opportunities exist for policymakers to use the CARES (Coronavirus) Act to address the issues caused by the pandemic. The CARES Act designates \$150 billion to cover...

and Remote Areas

Residents were more likely to have public coverage than metropolitan residents.



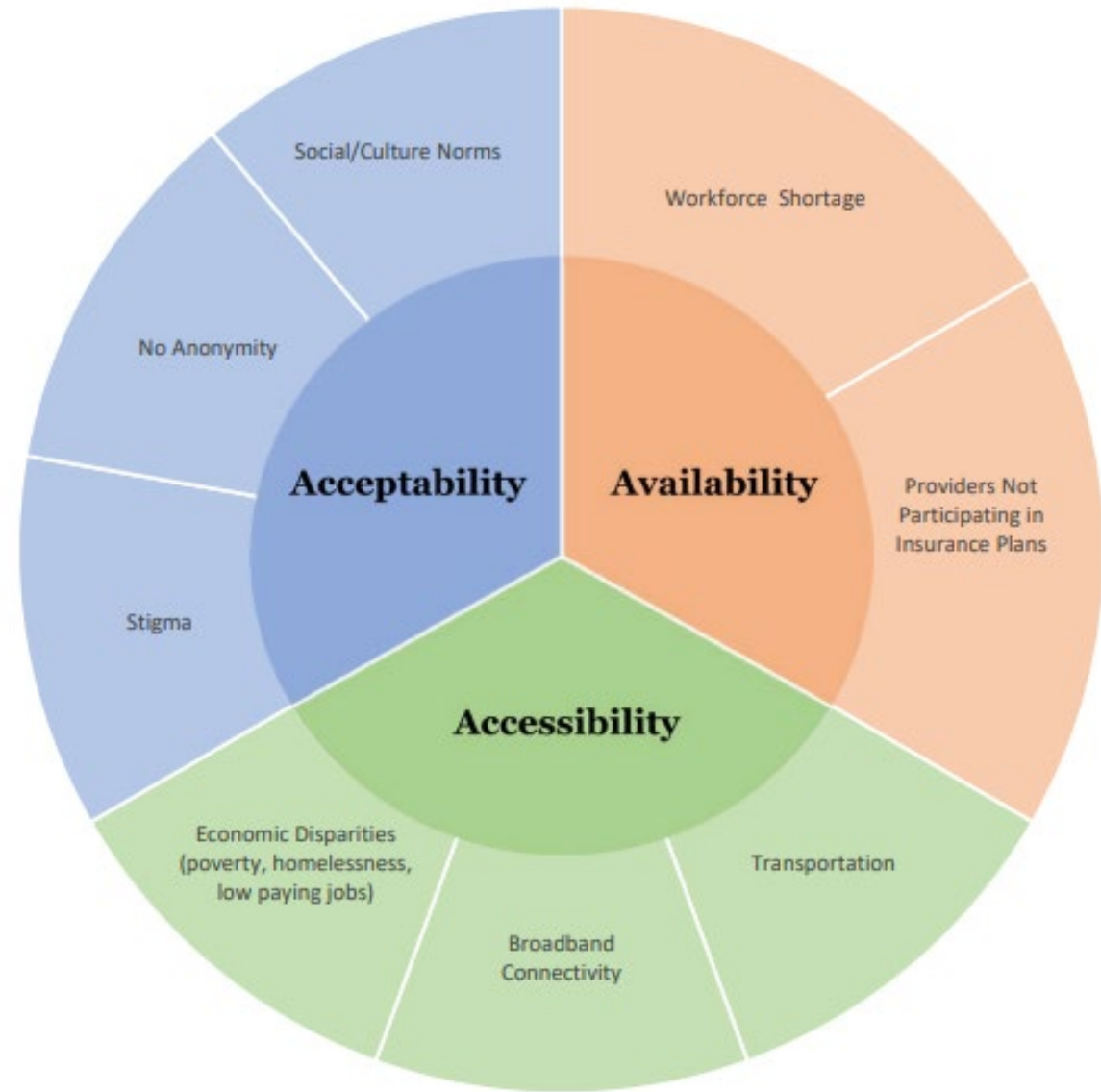
for Policymakers:

Residents with mental illness in rural areas have fewer behavioral health services than in urban and suburban settings. Rural areas are also more likely to rely on Medicaid, Medicare, and state-funded services.

Can use the flexibility of Medicaid and federal funds to secure appropriate rates to support evidence-based services and improve behavioral health workforce (p. 10).

Rural advocates can work together with state insurance commissioners to support the [Federal Mental Health Parity and Equity Act \(MHPAEA\)](#), Pub. L. 110-343, enacted under that Act and that private insurance plans provide comparable reimbursement rates for behavioral health services.

Barriers to Mental Health Services in Rural & 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

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.

Strategies to Expand Mental Health Services in Rural & Remote Areas

Increasing Access to Crisis Services

SAMHSA's [National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit](#) (National Guidelines) outlines the necessary services and best practices to deliver an effective crisis continuum of care, and recommends a comprehensive crisis service array that includes three essential services: 1) 24/7 crisis call centers that assess a caller's needs and dispatch support, 2) mobile crisis response teams dispatched as needed in the community, and 3) crisis-receiving and -stabilization facilities that are available to "anyone, anywhere, anytime" (SAMHSA, 24 February 2020). The majority of states (98%) offer at least one of these services: 82 percent of SMHAs offer 24-hour crisis hotline services, 86 percent offer mobile crisis response, and 90 percent offer some kind of crisis-receiving and -stabilization beds (for either less than or more than 24-hours) (NASMHPD Research Institute, 2015/2020).

While it is promising that the vast majority of states offer some level of crisis care to their citizens, little is known about how widely available these services are in rural and remote areas, and whether they adhere to the best practices prescribed in the National Guidelines. Ensuring all components are available to "anyone, anywhere, anytime" is an ambitious goal, and is especially challenging in rural and remote areas where a lack of awareness, workforce shortages, distance to travel and transportation issues, cultural differences and stigma, sustainability challenges, and availability of broadband access present additional barriers to the effective delivery of these services.

According to the National Guidelines toolkit, the



Key Lessons for Policymakers:

- » Use the national implementation of 988 as a national suicide prevention and mental health hotline number to assure that evidence-based and culturally appropriate call centers are available to individuals in rural areas.
- » Help local stakeholders (e.g., law enforcement providers, EMS, others) collaborate to create coordinated crisis response system that allow those closest to an individual in crisis to respond first and immediately connect individuals in crisis via technology to mobile crisis response team and/or transport the individual to the nearest most appropriate setting for their needs.

Key Lessons for Providers:

- » Be creative with co-location. What is frequently missing for law enforcement in rural areas is a place to take someone other than jail when

Addressing Suicide Risk Factors and Improving Suicide Response

According to the Centers for Disease Control and Prevention (CDC), suicide rates among adults across the U.S. have risen since 2007. The rate of suicide among individuals in rural counties increased at a rate 6.1 times faster than the rate in urban counties between 2007 and 2015 (CDC, 2018). The alarming divergence between suicide rates in rural and urban areas may be partially attributable to the higher prevalence of firearms in rural areas, which accounted for half of all suicides during the same timeframe.

The risk of suicide associated with social determinants of health has strongly been linked to economic factors related to educational attainment, homelessness, and poverty. Emerging research shows that a higher educational level is a protective factor against suicide. Phillips and Hempstead (2017) found that males with a high school education level or equivalent were two times as likely to die by suicide as their college-educated counterparts (Phillips & Hempstead, 2017).

Another factor contributing to suicide rates may be the limited accessibility of behavioral health services in rural areas when compared to urban areas, especially those integrated with primary care. A population at particular high risk of death by suicide in rural and remote areas is veterans, who have a 41% (deployed) to 61% (non-deployed) increased risk of suicide when compared to the general U.S. population. Suicide among military veterans is nearly twice as high in the "western U.S. and rural areas" where veterans "must drive 70 miles or more to reach the nearest Veterans Affairs (VA) medical center" (Veterans Affairs, 2018; Yen, 2017).

In addition, a 2019 study found that U.S. veterans and nonveterans with a history of homelessness were more likely to attempt suicide (74.5 percent and 72.1 percent, respectively)



Key Lessons for Policymakers:

- » Develop and support public awareness campaigns that normalize behavioral health and the need for treatment.

Key Lessons for Providers:

- » Conduct outreach to community connectors—including faith-based leaders, gun shop owners, and firing range owners—to conduct trainings in how to identify the signs and risks of suicide.
- » Market suicide awareness campaigns where people are most at risk (e.g., gun shops and ranges), and where people can be reached discretely (e.g., posting flyers and suicide awareness information on the back of bathroom stalls).

RURAL PEER SUPPORT LEARNING COMMUNITY

Education and resources to help you support people in rural and remote communities.

Third Tuesday of each month at 4 pm ET via Zoom

[Register here](#)

Open to peers and individuals with lived experience.