NATIONAL CONFERENCE OF STATE LEGISLATURES

Increasing Access to Rural Behavioral Health
June 4, 2021

Plan for Today’s Webinar

• National Landscape
• State Actions: Suicide and Overdose Prevention
• State Actions: Behavioral Health Workforce
Increasing Access to Rural Behavioral Health

National Conference of State Legislatures

Shawnda Schroeder, PhD, MA
Associate Director of Research and Evaluation
Research Associate Professor
Center for Rural Health
University of North Dakota
School of Medicine & Health Sciences

Andy McLean, MD, MPH
Clinical Professor and Chair
Department of Psychiatry and Behavioral Science
University of North Dakota
School of Medicine & Health Sciences
Land Acknowledgement Statement

Today, the University of North Dakota rests on the ancestral lands of the Pembina and Red Lake Bands of Ojibwe and the Dakota Oyate - presently existing as composite parts of the Red Lake, Turtle Mountain, White Earth Bands, and the Dakota Tribes of Minnesota and North Dakota. We acknowledge the people who resided here for generations and recognize that the spirit of the Ojibwe and Oyate people permeates this land. As a university community, we will continue to build upon our relations with the First Nations of the State of North Dakota - the Mandan, Hidatsa, and Arikara Nation, Sisseton-Wahpeton Oyate Nation, Spirit Lake Nation, Standing Rock Sioux Tribe, and Turtle Mountain Band of Chippewa Indians.

Disclaimer and Funding Statement

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At the time of this presentation, Tom Codette served as acting SAMHSA Assistant Secretary. The opinions expressed herein are the views of Dr. Shawnda Schroeder and do not reflect the official position of the Department of Health and Human Services (DHHS), or SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this presentation is intended or should be inferred.

The work of the Mountain Plains MHTTC is supported by grant H79SM081792 from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.
The MHTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Inviting to individuals participating in their own journeys
- Strengths-based and hopeful
- Person-first and free of labels
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Healing-centered/trauma-responsive
- Consistent with our actions, policies, and products


Mountain Plains Mental Health Technology Transfer Center

Provide free training, resources, and technical assistance to individuals serving persons with mental health disorders in HHS Region 8.

We belong to the Technology Transfer Center (TTC) Network, a national network of training and technical assistance centers serving the needs of mental health, substance use and prevention providers. The work of the TTC Network is under a cooperative agreement by the Substance Abuse and Mental Health Service Administration (SAMHSA).
Mental Health in Rural Communities

Data and Resources

- Rural Health Information Hub (RHHub)
- Rural Health Research Gateway
- Substance Abuse and Mental Health Services Administration
- Centers for Disease Control and Prevention
- Health Resource Service Administration
- PEW Research Center
- Western Interstate Commission for Higher Education – Behavioral Health Program
- National Council for Behavioral Health
Unmet Need for Care

- Among the 51.5 million adults aged 18 or older in 2019 with past year AMI, 26.0 percent (or 13.3 million people) perceived an unmet need for mental health services in the past year, which was higher than the percentage in each year from 2008 through 2018.
- Among the 13.1 million adults aged 18 or older in 2019 with past year SMI, 47.7 percent (or 6.2 million people) perceived an unmet need for mental health services in the past year, which was higher than the percentages in most years from 2008 through 2018.

Rural Barriers to Mental Health Services

Availability
Accessibility
Acceptability
Rural Barriers to Mental Health Services

Availability

County-Level Estimates of Mental Health Professional Shortage in the United States reports that higher levels of unmet need for mental health professionals exist in counties that were more rural and had lower income levels.
Rural Barriers to Mental Health Services

Availability: During a Global Pandemic (COVID-19)

• Fewer providers working, or working fewer hours/home schooling children, adapting to work from home.
• Increased need and demand which impacts availability.
• CDC guidelines influencing how in-person visits need to occur and time spent with patient(s) which impacts availability.

Rural Barriers to Mental Health Services

Accessibility

Rural residents may have limited access to mental healthcare due to cost of services, insurance coverage, lower behavioral health awareness which allows mental health concerns to go unrecognized and/or untreated, and the remote nature of living rural may require residents to travel long distances to receive services.
Rural Barriers to Mental Health Services

Accessibility: During a Global Pandemic (COVID-19)

- At-risk patients concerned about visiting available providers or traveling to see providers limits accessibility.
- Tele-mental health not an accessible option for all rural residents due to limited broadband, access to smart devices, and comfort utilizing technology
  - 58% of rural residents believe access to high speed internet is a problem in their area – in contrast to 13% in urban areas and 9% in suburbs
- Need to be mindful of the myriad of changes to tele-health practices and billing

Acceptability

Rural residents are likely to experience self-stigma, fear or embarrassment related to seeking out mental healthcare due to internal beliefs. When implementing rural mental health programs, community members and mental health care providers should consider how stigma may impact access and use of mental health services among rural residents. Lower health literacy and not recognizing the signs of various mental health issues can also serve as barriers to behavioral healthcare access in rural areas.
Rural Barriers to Mental Health Services

Acceptability: During a Global Pandemic (COVID-19)

- Not recognize symptoms as mental health concern, but result of quarantine or physical distancing.
- May downplay feelings and concerns.
- Ongoing experience of self-stigma, fear or embarrassment related to seeking out mental healthcare due to internal beliefs.

Legislative Options

- State Licensing Compacts
- Scope and Practice Issues
- Interface of Corrections and Behavioral Health
- Funding for Creative Practices utilizing Community Strengths
  - (Paramedics, Peers, Faith Based Organizations, Collaborative Care)
- 211 and 988 (7/2022)
- Speak Out on Stigma
Loan Forgiveness and Workforce Initiatives

- State, Federal and Private Loan Forgiveness Programs
- HPSA (Health Professional Shortage Areas—note earlier slide)
- Telebehavioral health:
  - 3rd party payers
  - Parity
  - Loan Forgiveness issues

Interdisciplinary Education
Funding for Research

- Prevention
- Telebehavioral Health
- New Models of Care

Ask yourself:
To how many “communities” do I belong?

Religious
Family
Social
Civic
City
Neighborhood

And many others...
Traits of Successfully Resilient Communities:

• Strong Leadership
• Engagement of members
• Wise use of resources
• Attention to psychosocial issues

Norris et al

Additional Resource

Preventing Suicide In Rural America: Policy Options from the CDC

https://www.cdc.gov/ruralhealth/suicide/policybrief.html

Policy options and other strategies for addressing factors leading to suicide in rural areas include:

- Improve Access to Mental and Behavioral Health Services
- Reduce Stigma in Communities
- Increase Connectedness with Peer Norm Programs
- Work with Communities to Reduce the Risks for Suicide

Suicide is preventable. This brief will explore policy options for suicide prevention and provide examples of programs used in or that can be adapted for rural settings.
Thank you!

Shawnda Schroeder, PhD
Associate Director of Research & Evaluation
Center for Rural Health
University of North Dakota School of Medicine & Health Sciences
Shawnda.Schroeder@UND.edu

Andy McLean, MD, MPH
Clinical Professor and Chair
Department of Psychiatry and Behavioral Science
University of North Dakota
School of Medicine & Health Sciences
What I’ll Share

1. Overview of Suicide and Substance Use in Rural America
2. Strategies to Prevent Suicide in Rural America
3. Increasing Access to Substance Use Treatment
What are Deaths of Despair?

• US life expectancy fell between 2016-17.
• Overdose deaths and suicide deaths drove this trend.
• Other causes of death falling.
• Life expectancy rebounded in 2018 and 2019, but impact of COVID-19 likely to be high.

Deaths by Drugs, Alcohol and Suicide, 2016

- 28.5–29.9 deaths per 100,000 (1 state)
- 30.0–39.9 deaths per 100,000 (13 states)
- 40.0–49.9 deaths per 100,000 (18 states)
- 50.0–83.1 deaths per 100,000 (18 states + D.C.)

Death by Suicide is Increasing

Suicide rates rose across the US from 1999 to 2016.

- Increase 38 - 58%
- Increase 31 - 37%
- Increase 19 - 30%
- Increase 6 - 18%
- Decrease 1%

Suicide Rates at the County Level, United States 2008-2014

Opioid Overdose Deaths by State
COVID-19 and the Opioid Epidemic

- Overdose deaths were already rising in early 2019.
- COVID-linked stressors likely made things worse.

Source: (Commonwealth Fund)

National Suicide Hotline Designation Act of 2020

Key Details for States

- The Legislation and Federal Communications Commission allow for a 2-year transition.
  - Allows for widespread network changes and to provide time to prepare for an expected increase in calls.
- Shorter, 3-digit number intended to be easier to remember.
- Builds off existing infrastructure of the National Suicide Prevention Lifeline.
- Allows states to impose a surcharge to support local call centers.
  - Similar to funding model in place for “911” calls.
- Does not currently include the ability to text “988.”
- Hotline will also include the Veterans Crisis Line.
States Considering 988 Legislation

- In 2021:
  - 17 states introduced 26 bills
  - Idaho, Kentucky, Utah and Virginia, have enacted legislation
- States have taken different actions:
  - Nebraska’s LB-247 (pending)
  - Utah’s SB-155

Lifeline Considerations for Rural States

Mobile Crisis Units
- Utah’s SB-31 – Utah Mobile Crisis Outreach Team Act
- California’s AB-988 (pending) establishes mobile crisis support teams to respond to certain calls.

Other Ideas
- Colorado’s “Safe 2 Tell” Program
  - SB-79 revised the program and allowed for students to make reports by phone, the program’s website and via the program’s app.
- Utah’s “Safe UT” Program
  - SB-175 created the SafeUT program, a statewide service that provides real-time crisis intervention to youth through live chat and a confidential tip program.
- Student ID Cards
  - Maryland’s HB-466 (pending) and Indiana’s SB-19 (pending).
Veterans in Rural Communities

- 44% of veterans returning from Iraq and Afghanistan live in rural zip codes.
- Stigma especially strong in military.
- Challenges working through Department of Veteran’s Affairs (VA).
  - Services may not be close by.
  - May have limited access to behavioral healthcare.

Policy Considerations for States

○ Telehealth Options

○ Veteran Specific Suicide Prevention Training
  - Arkansas’ SB-027 ensures that the suicide prevention hotline employs individuals who have experience working with veterans.
  - Washington’s HB-2411 expands the types of health providers required to undergo suicide prevention training, including access to lethal means training, to include marriage therapists, certain social workers and other mental health care providers.

○ Access to Lethal Means
  - Delaware’s HB-055 (pending) would establish the Delaware Gun Shop Project to develop and distribute suicide prevention materials to gun shops, firing ranges and other businesses. The Project would work in coordination with other successful programs in other states and industry representatives like the National Shooting Sports Foundation.
  - Utah’s HB-390 created a Suicide Prevention Education Program to fund suicide prevention activities by federally licensed retail firearms dealers that includes information on crisis intervention resources and how to identify persons who may be suicidal.
Rural SUD Flexibilities

- DEA relaxed telehealth restrictions:
  - No initial in-person assessment required
  - Waivered prescribers can prescribe via video or telephone
  - Providers can use less secure tech platforms (but not public-facing ones)
- Restrictions on Medicare reimbursements for telehealth waived
- Restrictions on receiving medications relaxed: Meds can be delivered by parties other than licensed clinicians and through indirect means like doorstep lockboxes.

Example Legislation

### SUD Treatment
- New Jersey’s AB-3843 mandates that telemedicine services should be treated the same as in-person visits and paid at the same rate as in-person services.
- Minnesota’s HB-105 include allowing initial evaluations and prescriptions to be completed through a telehealth visit and increasing the number of take-home doses of MAT medications a provider can prescribe.
- Vermont’s HB-742 authorized certain health professionals to renew a patient’s existing buprenorphine prescription without requiring an office visit.

### Naloxone and Overdose Prevention
- New Hampshire’s HB-1639 creates an opioid abatement trust fund, allowing the fund to reimburse the state and any political subdivision within the state for any portion of the cost of administering naloxone.
- Pennsylvania’s HB-2387 provides $947,000 for the state’s naloxone reentry tracking program for high risk individuals.
- Virginia’s HB-29 appropriates $1,600,000 to purchase and distribute naloxone kits to treat emergency cases of opioid overdose or suspected opioid overdose.
State Actions: Behavioral Health Workforce

Sydne Enlund, Policy Specialist
National Conference of State Legislatures
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○ Work with individuals who suffer from substance use disorders (SUDs)
○ SUDs can include alcohol, opioids and other substances
○ Work in a variety of settings including:
  • Inpatient and outpatient facilities
  • Sober living homes
  • Hospitals
  • Various community organizations

Who are Addiction Counselors?

What’s in a Name?

○ Licensed Addiction Counselor (Colorado)
○ Certified Alcohol and Drug Counselor (Idaho)
○ Certified Addictions Therapist (Mississippi)
○ Licensed Chemical Dependency Counselor (Ohio)
○ Substance Use Disorder Counselors (Utah)
Credentialing Addiction Counselors

- Credentialing requirements
  - Education
  - Training
- “Credential” can be a certification or a license
- Wide variations from state to state

Education Required for Addiction Counselor Credentialing

![Credentialing Requirements Chart]

- High school diploma or higher required
- Associate’s degree or higher required
- Bachelor’s degree or higher required
- Information not currently available

What Does Credentialing Mean?

**Ohio**
- Licensed Chemical Dependency Counselor
- Associate’s degree
- 2,000 hours of experience

**Nevada**
- Certified Alcohol and Drug Abuse Counselor
- Bachelor’s degree
- 4,000 hours of experience

**New Hampshire**
- Master Licensed Alcohol and Drug Counselor
- Master’s degree
- 3,000 hours of experience
○ Services delivered by a person with similar life experiences and previous behavioral health challenges (e.g., substance misuse, mental health condition, etc.)

○ May help someone seek treatment and mentor them while in treatment and recovery

○ Can be, but not limited to, parents, partners, friends, spouses, total strangers and who have appropriate experience and perspective to the person.

○ Also known as recovery coaches

Who are Peer Support Specialists?

Credentialing Peer Support Specialists

○ Certification/training requirements can be:
  ○ Outlined in state law
  ○ Led by a state agency
  ○ Established by a third-party organization

○ Employed by treatment and recovery programs

○ Currently reimbursed by Medicaid in 39 states

![Credentialing Peer Support Specialists Diagram]
Why Use Peer Support Specialists?

- Using peer support specialists can improve recovery outcomes
- Peer support specialists have been shown to:
  - Reduce symptoms and hospitalizations
  - Increase social support and participation in the community
  - Decrease lengths of hospital stays and costs of services
  - Improve well-being, self-esteem and social functioning
  - Encourage more thorough and longer-lasting recoveries

2021 Enacted Legislation

- **Arkansas S 607**: Medicaid Program Peer Support Specialist
  - Peer support specialists must obtain certification from an accredited organization approved by the Arkansas Alcohol and Drug Abuse Coordinating Council
- **Kansas H 2208**: Licensure by the Behavioral Sciences Regulatory Board
  - Reduces the number of required hours of face-to-face contact with clients
- **Kentucky S 166**: Alcohol and Drug Counselors
  - Creates licensure requirements for additional types of alcohol and drug counselors
- **Minnesota H 2128**: Health Care, Human Services and Licensing
  - Outlines scope of practice for certified peer support specialists
- **Montana S 166**: Licensed Addiction Counselors
  - Revises licensing and education requirements for addiction counselors
- **Washington H 1311**: Substance Use Disorder Professional Certifications
  - Allows people participating in apprenticeship programs to receive a substance use disorder professional certification
Scope of Practice Policy Website

- HRSA-funded project launched in February 2017.
- Designed to educate state policymakers about scope of practice issues related to non-physician health care providers.
- Legislative tracking, state-specific information and 18 interactive policy maps
- ScopeofPracticePolicy.org

Reach out anytime!

Sydne Enlund
Policy Specialist

Email
sydne.enlund@ncsl.org

Phone
303.856.1401
Questions?

Kelly Hughes, Program Director, Access, Costs and Coverage, Health Program, NCSL

Thank You!

Kelly.Hughes@NCSL.org