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Assessment # 10

Strategies for the Delivery of Behavioral Health Crisis Services in Rural and Frontier Areas of the U.S.

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Strategies for the Delivery of Behavioral Health Crisis Services in Rural and Frontier Areas of the U.S.

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The Substance Abuse and Mental Health Services Administration's (SAMHSA) *National Guidelines for Behavioral Health Crisis Care* (referred to from here as "*National Guidelines*"), outlines the necessary services and best practices to deliver an effective crisis continuum. A comprehensive crisis service array includes three essential types of services: 1) centralized crisis lines that assess a caller's needs and dispatch support, 2) mobile crisis teams dispatched as needed in the community, and 3) crisis receiving and stabilization facilities that are available to "anyone, anywhere, anytime".[1] Data from the National Association of State Mental Health Program Directors Research Institute (NRI) indicate that nearly 98 percent of state mental health authorities (SMHAs) offer at least one of the crisis services recommended in the *National Guidelines*.[2] Of those, 82 percent of SMHAs offer 24-hour crisis hotline services, 86 percent of SMHAs offer mobile crisis response, and 90 percent offer crisis stabilization beds (either less-than 24 hours, or more-than 24 hours).[3]

While it is promising that the vast majority of states offer some level of crisis care to its citizens, it is unknown how widely available these services are, especially in rural and frontier areas, and whether they adhere to the best practices as 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 frontier areas where a lack of awareness, workforce shortages, distance to travel and transportation issues, cultural differences and the stigma associated with behavioral health, sustainability challenges, and availability of broadband internet services may present additional barriers to the delivery of comprehensive behavioral health crisis services in all locations.

According to the 2010 U.S. Census, 20 percent of the U.S. population, or approximately 60 million people, reside in rural and frontier areas of the United States, and their need for crisis services is comparable, or perhaps even greater, when compared to the need identified in urban areas.[4] Data from SAMHSA's 2018 National Survey on Drug Use and Health (NSDUH) show that 18.9 percent of adults aged 18 and older living in completely rural areas experienced a mental illness in the past year, compared to 18.6 percent of adults in urban areas.[5] 2018 NSDUH data also show that 2.5 percent of adults living in completely rural areas experienced a co-occurring substance use disorder and any mental illness in the past year, compared to 3.7 percent of adults in large metro areas.[6] Although rates of mental illness and substance use are comparable between rural and urban areas, the rates of serious mental illness (SMI) are higher in rural areas, with 5.8 percent of adults experiencing an SMI in the past year, compared to 4.1 percent of adults aged 18 and older in urban areas.[7] Additionally, while suicide rates among adults have risen since 2007 across the U.S., according to data from the Centers for Disease Control (CDC), 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.[8] Studies also show that youth in rural areas have nearly twice the risk for suicide than do their urban counterparts.[9] The divergence between suicide rates in rural and urban areas may be partially attributable to the prevalence of firearms in rural states, which

accounted for half of all suicides during the same period. Additionally, the availability of behavioral health services when in crises in rural and frontier areas is significantly limited when compared to urban areas. Multiple studies have shown a chronic shortage of mental health professionals in rural areas, and a tendency for providers to practice in more urban areas. These two factors underscore the need for a robust array of behavioral health crisis services in rural and frontier areas.[10]

The purpose of this paper is to understand the challenges associated with the delivery of comprehensive behavioral health crisis services in rural areas, and recognize the strategies and opportunities pursued by state authorities and local providers to enhance access and the availability of these important services in rural and frontier areas of the U.S. In addition, the opportunities and challenges presented by the COVID-19 pandemic are incorporated throughout.

A review of the literature was conducted to identify the most pressing challenges facing states and localities, as well as strategies used in the delivery of behavioral health crisis services in rural and frontier areas of the U.S. To ensure that only meaningful and relevant information is included, the author limited her research to include peer-reviewed journal articles and U.S. governmental reports published between 2010 and 2020. However, given the rapid advancements in technology, and the ever-changing needs and priorities associated with the COVID-19 pandemic, some news articles are referenced as well. To understand firsthand how these challenges affect the delivery of crisis services in rural areas and the strategies employed to overcome these challenges, the author and colleagues from the National Association of State Mental Health Program Directors Research Institute (NRI) and RI International conducted a series of seven structured telephone interviews with state, local, and non-governmental representatives from five states: Alaska, Colorado, Nebraska, New Mexico, South Carolina, and Tennessee (multiple entities from Alaska and Nebraska were interviewed for this paper). For the purposes of this report, the author relies on the U.S. Census Bureau's definition of rural, which is an area encompassing all population, housing, and territory with a population outside of an urban area with fewer than 2,500 individuals. The U.S. Census defines Frontier as an area with a population density of fewer than two people per square mile.[11]

This paper is divided into seven sections. The first five sections discuss the challenges and opportunities related to particular barriers to crisis service delivery in rural areas, including workforce, distance to travel and transportation, sustainability, and the use of technology and broadband access. These sections are followed by a section discussing additional effects the COVID-19 pandemic is having on the delivery of behavioral health crisis services in rural and frontier communities, and the implications each of these challenges and opportunities have for policy makers.

Behavioral Health Crisis Workforce in Rural Areas

As of September 2018, the Health Resources and Services Administration (HRSA) designated 2,672 Mental Health Professional Shortage Areas in rural areas.[12] The primary factor HRSA uses to designate Mental Health Professional Shortage Areas is "the number of health professionals relative to the population with consideration of high need," with a minimum of one provider to 30,000 residents (or 20,000 if there are higher than usual needs in a given community).[13] Data from the 2014 American Community Survey show that just 1.6 percent of the nation's psychiatrists practice in rural areas, which is on average nearly 47,000 residents per each rural psychiatrist.[14] Data from the American Medical Association show that nearly 60 percent of all counties in the U.S. do not have a single psychiatrist.[15] Compounding the issue is that many of the counties without a psychiatrist are clustered together, making it even more difficult for individuals to access psychiatric care quickly in case of an emergency.[16] Workforce shortages and retention issues were identified as a significant barrier to providing quality crisis care in each of the seven phone interviews conducted for this report. Several states, including Alaska and Colorado, are implementing or considering unique methods to reduce limitations to the delivery of behavioral health crisis services brought on by behavioral health workforce shortages in rural and frontier areas. Highlights of these unique methods are provided below.

<u>Alaska</u>

In the late 1960s, the Alaska Native Tribal Health Consortium (ANTHC) initiated the Community Health Aide Program to respond to the tuberculosis epidemic and the rise in infant mortality rates in tribal villages across the state. This program trained citizens with no experience in health care to provide basic health services and respond to the needs of individuals in rural and tribal areas across the state. The program was so successful that it was used as a model to implement the Behavioral Health Aide Program in 2008, which is a multi-level provider model that trains citizens on how to provide therapeutic services, respond to behavioral health crises, and support the general mental health and wellbeing of individuals in rural and tribal communities.[17] Support for the program was garnered through a number of newspaper articles and publications that recognized the significant mental health and substance use issues in the community, and noted that the state and local villages did not have adequate resources to respond to the need. (Owens, Chipp, personal communication, July 1, 2020).

Behavioral Health Aides (BHAs) are employed by their regional tribal health organizations; citizens interested in becoming a BHA need to be 18 years of age or older, and have earned a high school diploma or equivalent. There are four levels of BHA certification, including BHA-I, II, III, and Behavioral Health Practitioners. Potential BHAs often receive training from the ANTHC, who operates the only BHA Training Center in Alaska and works closely with the Community Health Aide Program Certification Board. Most training offered through the BHA Training Center are typically facilitated using a blend of distance-delivered technology; making the transition of courses that are usually held in-person relatively seamless

in response to COVID-19. Once certified, BHAs are qualified to provide and bill for various Medicaid services based on their level of certification, including SBIRT (Screening, Brief Intervention and Referral to treatment); tobacco cessation; and individual, group, and family psychotherapy. All BHAs are supervised by licensed clinicians who are able to assist BHAs in connecting individuals in crisis to higher levels of care, as needed (Owens, Chipp, personal communication, July 1, 2020).

BHAs are often the first to identify when someone is experiencing a crisis, and are the first to respond to traumatic events in the communities they serve. Alaska has found the BHA program to be effective at utilizing available human resources in communities that may otherwise not have an adequate supply, or any supply, of licensed behavioral health providers. BHAs serve multiple roles on the recommended crisis continuum, including answering emergency call lines and responding to crises in the community (similar to a traditional mobile crisis response team). These efforts help with the implementation of crisis services in rural and tribal areas. BHAs are notified of crises in the community in multiple ways, including a general awareness of crisis events in the community, monitoring patients and clients who have been identified as having serious mental illness, referrals that come through the general behavioral health department, collaboration with external behavioral health providers regarding aftercare needs for their clients who are returning home, or through referrals from Community Health Aides. To further highlight the essential role BHAs have in the continuum of care, Alaska's recently approved 1115 waiver clearly identifies BHAs as qualified provider types to deliver necessary services, including crisis response (Owens, Chipp, personal communication, July 1, 2020).

BHAs serve in multiple roles within the context of their position; this, coupled with the roles associated with being a member of a small community, can lead to high rates of burnout. During our interview with the ANTHC, it was noted that it is not unusual for BHAs to receive a "knock on the door at 2:00 am because they are known and trusted advisors in the community" (Owens, Chipp, personal communication, July 1, 2020). The multiple roles, the often indistinguishable boundaries between personal relationships and professional responsibilities, and the need to be constantly on-call to their communities can be confusing, exhausting, and lead to burnout, which ultimately leads to a high rate of turnover among BHAs. To reduce burnout and mitigate turnover, one of the largest tribal organizations in the state holds weekly teleconference calls specifically for BHAs to provide emotional support. During these calls, BHAs share stories to connect with and support one another, share traditional stories that connect to the types of cases they are serving and focus on their own wellbeing and mental health. (Owens, Chipp, personal communication, July 1, 2020).

The BHA program is financed through compact funding from the Indian Health Service (IHS), although the funding is limited. To increase resources to support the program, the ANTHC follows a fee schedule for courses delivered through the

ANTHC BHA Training Center for aspiring BHAs, and has applied for several grants to fill the gaps (Owens, Chipp, personal communication, July 1, 2020).

In July of this year, the IHS announced the expansion of the Community Health Aide Program, including the BHA program, to tribes in the contiguous U.S.[18] This effort will increase the ability of tribal communities that typically reside in rural and frontier areas to deliver physical health, behavioral health, and specifically behavioral health crisis services to individuals in their own communities. In addition to being available to tribes in the contiguous U.S., the Behavioral Health Aide Program makes available for a fee technical assistance to other communities interested in implementing a similar model.

Colorado

Currently Colorado requires there be at least one mobile crisis response team in each of the seven behavioral health regions of the state, and the teams need to be able to respond to a crisis within two hours of a crisis call. Each region has met the minimum obligation for number of teams; however, there are multiple mobile crisis response teams in the concentrated urban areas of the state, and only one crisis stabilization unit walk-in center and a few mobile crisis response team serving the entire Western Slope of the state, making it difficult for mobile crisis teams to adhere to the two-hour response guideline.

To improve crisis response times, Colorado is considering a model similar to, but less sophisticated than, the BHA Program in Alaska. The state has heard from communities in rural areas that there are concerned citizens who want to help respond to crisis situations, but they just do not know the most appropriate way to help. Rather than training citizens to be certified BHAs, the state is exploring training bachelor's-level providers or peers to carry a tablet to an individual in crisis that would be used to connect the individual to a skilled or licensed professional via telehealth services. Unfortunately, the COVID-19 pandemic has delayed any progress in these programs, and future budgetary decisions may determine whether these programs will be able to be established.

Distance to Travel and Transportation to Crisis Services

Distance to travel, limited or no public transportation, and a lack of infrastructure are significant barriers to individuals in need of crisis services. These factors also limit an individual's ability to access other behavioral health services and community supports that minimize the need for crisis services in the future. These barriers often result in long waits for mobile crisis teams to respond, reliance on first responders to transport individuals to care, and a reluctance to call for help in the first place. Also, when individuals have to travel far to receive appropriate levels of care, they are often removed from their communities, and forced to navigate their crisis alone, without the support of their families and friends.

As recommended in the *National Guidelines,* states can adjust their mobile crisis team response times to accommodate for geographic distances in rural and frontier

areas. In line with this recommendation, all of the states interviewed for this report indicated that they have relaxed their response-time requirements for mobile crisis teams when answering calls in rural and frontier areas. However, this does not change the need for an individual in crisis to receive a timely response.

Many smaller communities rely on their local law enforcement officers and other first responders to transport individuals experiencing a crisis to care. In all 50 states and the District of Columbia, police are authorized to initiate a psychiatric hold for an individual who appears to pose a risk to themselves or others.[19] However, this legal authority often creates an over-reliance on law enforcement to respond to crises, especially in rural and frontier areas where behavioral health workforce resources are limited. The *National Guidelines* recommend not involving police unless alternate behavioral health first responders are unavailable, "or the nature of the crisis indicates that emergency medical response (EMS) or police are most appropriate". [20]

An example provided by one state during the interviews for this report is that the state has an Emergency Protective Custody Statute that mandates officers bear the responsibility for deciding if someone meets the criteria for immediate harm to self or others. In these instances, officers may have to transport an individual more than two hours one way to make sure they are admitted into treatment. Because of legal issues and risks of harm to the officer and individual, the individual being transported must be restrained and transported in the back of the locked police car. This approach can create stressful situations for an individual in crisis that can exacerbate their symptoms, and serve to drain the resources of small law enforcement agencies in rural communities.

An electronic behavioral health bed registry that can be accessed online is helpful to individuals and law enforcement in rural areas when they need to access higher levels of care. A bed registry can be used to identify an appropriate nearby available inpatient psychiatric hospital bed. This will avoid a situation where a person might be turned away after traveling a long distance when a bed is not available at a crisis stabilization unit. Through its Technology Transfer Initiative (TTI) project, SAMHSA is currently funding 23 states to establish or enhance crisis bed registries to reduce this barrier.

Alaska, Colorado, and South Carolina shared their experiences about the impact transportation barriers have on their delivery of crisis services, as well as some of their unique approaches to overcome these barriers to effectively deliver crisis services to individuals in rural and frontier areas.

<u>Alaska</u>

An extreme example demonstrating the effect transportation barriers have on the accessibility of behavioral health crisis services is the lack of available transport for individuals experiencing a psychiatric emergency in remote areas of Alaska. Many of Alaska's villages rely on ferries, airplanes, and seaplanes paid for by the SMHA to

transport individuals experiencing a behavioral health crisis to a designated evaluation team. Alaska's SMHA funds an on-call staff, available 24 hour a day, seven days a week to secure transports with contracted providers who are specially trained in transporting individuals in crisis. In addition, the SMHA funds all costs of transporting individuals to Designated Evaluation and Treatment (DET) hospitals. Transportation delays are also caused due to inclement weather and the challenges of getting in or out of Alaskan villages. Due to COVID-19 and the challenges associated with commercial airlines availability, the SMHA has funded an increasing number of private charters to bring individuals in crisis into a DET as soon as possible.

Prior to the COVID-19 pandemic, the SMHA relied on two airlines, Alaska Air and RavnAir, to transport individuals in rural, frontier, and remote areas to receive appropriate care (McLaughlin, Raymond, Girmscheid, personal communication, June 22, 2020). Since Marcy 2020, Alaska Airlines has significantly reduced flights, and has begun laying off employees in August 2020. The state's other airline, RavnAir has also been significantly affected by the current pandemic. RavnAir experienced a 90 percent decline in bookings and revenue resulting from the COVID-19 pandemic, which forced RavnAir into bankruptcy in April 2020, limiting the available transport options for individuals experiencing a mental health crisis, and exacerbating the inequities in access to mental health services during the pandemic.[21] Alaska's Medicaid plan does not reimburse for expenses related to transport for a psychiatric emergency (McLaughlin, Raymond, Girmscheid, personal communication, June 22, 2020). The SMHA staff noted that even when two airlines were available to transport individuals experiencing a psychiatric emergency, it would often take several days to arrange for air transport from the remote villages. This is in stark contrast to when someone needs transport for a physical health emergency funded by Medicaid, when air transport would be arranged within hours. This barrier may lead to individuals who are deemed a risk to themselves or others being boarded in less-than-appropriate settings, including local jails because other treatment options (e.g., crisis stabilization units) are unavailable, until they can safely be transported to an appropriate level of crisis care.

<u>Colorado</u>

To reduce the reliance on law enforcement to transport individuals to crisis stabilization or other inpatient facilities, Colorado proposed legislation to pilot a program to train and certify members of the community in rural areas to become secure transport drivers. The proposed program would be sponsored through a partnership between the state's Medicaid authority and the public utilities commission. The program would train drivers in de-escalation techniques, and would use funds to secure and enhance a fleet of vehicles to make them safe for drivers to transport individuals in crisis. Unfortunately, funding for this pilot program in two rural areas of the state has been cut due to budget cuts resulting from COVID-19; however, one program has been allowed to continue in southeast Colorado after a provider and the Administrative Service Organization reallocated budgets to allow it to continue.

South Carolina

South Carolina offers mobile crisis response teams in all 46 of its counties, where master's-trained clinicians are available to respond to crises 24 hours a day, seven days a week. In Charleston County, a highly populated and large county, the mobile crisis response team only received, on average, five calls per month from local law enforcement and EMS. After discussions between the county and the EMS teams, it was revealed that EMS did not reach out to the mobile crisis response teams because it often took too long for the mobile crisis teams to respond. It was easier and faster for EMS to transport the individual in crisis to an emergency room, which is usually not the most appropriate setting, unless the individual in crisis was also experiencing a medical emergency. A partnership between the state and the EMS program in Charleston County was formed. Now when EMS is called to respond to a psychiatric emergency, they first evaluate whether the crisis is medical or psychiatric in nature. If medical, the ambulance will transport the individual to the appropriate level of care; if psychiatric, the EMS crew calls their supervisor to respond in an SUV. Once the supervisor responds, the ambulance is sent back out into service, and the supervisor connects the individual in crisis through the VIDYO telehealth app on their tablet to the mobile crisis response team. The mobile crisis response team is then able to evaluate and triage the crisis virtually, and can make recommendations on next steps. Service is immediate and allows for more appropriate use of EMS time and resources, and reduces the number of referrals to emergency departments in the county. It reduces the need for mobile crisis teams to travel long distances to reach a crisis, and allows individuals in crisis to receive services quickly. Since this program has been implemented, the county has experienced an increase in calls from EMS to mobile crisis from five to nearly 85 per month, and the county has seen a 58 percent decrease in ED use for individuals in psychiatric emergencies. (Bank, Blalock, personal communication, July 7, 2020).

Cultural Differences and Stigma Associated with Behavioral Health

According to a study out of Wake Forest University, the most commonly reported barrier to treatment among individuals in rural areas is the personal belief that "I should not need help".[22] Additionally, it is easier to seek help anonymously in large urban areas. According to Dennis Mohatt, the Vice President of the Behavioral Health Program and Director of the Western Interstate Commission for Higher Education (WICHE), "your neighbors don't have a clue in a city if you're going to get some help. But everybody [in a small town] will know if your pickup truck is parked outside of the mental health provider's office." Nebraska's Region 3, as well as Alaska's BHA program echoed this sentiment.

In the community served by Region 3, which consists of 22 primarily rural counties, there is a mindset among the farming and ranching communities that "you get back on the horse," and that whatever is bothering you will pass and is not something to take seriously (Reynolds, personal communication, June 17, 2020). This lack of awareness of mental health issues, as well as the stigma associated with serious mental health conditions, including depression, is reinforced by the primary care physicians serving in the area who often do not evaluate for or diagnose symptoms

of depression. Within the community there is a disconnect between the physical and mental health symptoms of the body that leads to a lack of mental health diagnoses and referrals to appropriate treatment. When these symptoms are overlooked for too long, in the worst cases they can lead to higher rates of suicide. Compounding the stigma in these communities, suicides are often not reported by the medical examiner as a cause of death on death certificates. Rather, death certificates indicate cause of death as a car accident or accidental overdose so as to not bring embarrassment to the family of the deceased (Reynolds, personal communication, June 17, 2020).

To combat this stigma, representatives from the Region often present at conferences for young ranchers. During these presentations, Region 3 staff share information about behavioral health and wellbeing, and promote the availability of behavioral health and crisis services in the area.

Additionally, the recommendations for centralized crisis hotlines made in the *National Guidelines* may also be more difficult to implement in rural areas due to beliefs in rural communities that people in the city would have no way to relate their problems. A study by the Pew Research Center found that "many urban and rural residents feel misunderstood and looked down on by Americans living in other types of communities [and that] people in other types of communities don't understand the problems people face in their communities".[23] This affects the use of the centralized crisis hotline in Colorado by individuals in rural and frontier areas.

During the phone interview with Colorado's Office of Behavioral Health, it was noted that there is reluctance among both individuals in need of care and law enforcement officers in smaller communities to call into an anonymous state crisis hotline number. The reluctance is fueled by a sense of resentment that someone "in the big city would actually know about my life and my problems? Why do they think they can fix this?" This leads to more after-hour emergency calls to local community providers, which are often already overburdened, when the Colorado Crisis Services Hotline could just as easily direct the caller to appropriate care and dispatch appropriate crisis services (Lee, personal communication, July 1, 2020).

Higher utilization of the centralized hotline can relieve the pressure of rural providers who are already overburdened with other responsibilities. During the interview with the ANTHC, a former provider in a remote village shared his story about being the only clinician available to answer crisis calls in the community during a six-month period. During this period, he had to be constantly available and in reach of his phone, even while trying to spend time with his family. While the actual number of crisis calls he received was low, he did experience many misdials. A centralized call center that is promoted and utilized across the state could help absorb some of these misdials, and alleviate some of the pressure on rural providers.

To encourage the use of the statewide hotline, New Mexico waived the state's unfunded requirement for local providers to operate their own emergency call capability. The only thing required of the providers is a memorandum of understanding with the statewide call center (Lindstrom, Wynn, personal communication, June 9, 2020).

Sustainability

Crisis services in rural and frontier areas face sustainability challenges in order to provide quality crisis care to "anyone, anywhere, anytime," when the population size and demand for services may not fully support the overhead and staffing requirements of the programs, especially for crisis receiving and stabilization facilities.

Many states fund their crisis services with state general revenue funds, especially for those services provided in rural and frontier areas of the state. Prior to its implementation of the Medicaid Section 1115 waiver, all of Alaska's crisis services were paid for through state general revenue funds and funds from the Indian Health Service for services provided to tribal villages (McLaughlin, Raymond, Girmscheid, personal communication, June 22, 2020). Even with the new Medicaid Section 1115 waiver for crisis services, the state will continue to rely on general revenue funds for building infrastructure and supplementing costs of care that cannot be covered by Medicaid (McLaughlin, Raymond, Girmscheid, personal communication, August 4, 2020).

Tennessee approaches this challenge by implementing a "firehouse model" to fund services provided by mobile crisis teams and crisis stabilization units. In this approach, crisis services are paid for on a per-member, per-month basis, based on the number of members in a particular catchment area at the time rates are established, not based on the number of people receiving services. Thus far, it has allowed for the sustainability of crisis services in rural areas of the state.

The changes implemented by the Centers for Medicare and Medicaid services in response to the COVID-19 pandemic have been incredibly helpful to states in providing crisis services to individuals in rural and frontier areas. A lack of broadband access in these areas limits an individual's ability to connect remotely to telehealth services, creating a greater demand for telephonic interventions, which are typically not reimbursed by Medicaid. However, as of March 1, 2020, under the CARES Act in response to COVID-19, CMS has waived the requirements for video technology and now allows the use of audio-only equipment to furnish a variety of services described under 42 CFR § 410.78(a)(3).[24] In addition to the flexibility for telephonic interventions, CMS has also relaxed some rules related to the qualifications an individual needs to be reimbursed for telehealth services. Prior to the emergency declaration, only certain providers were able to bill Medicaid for the provision of telehealth services. During the emergency declaration, all providers eligible to bill Medicaid for their professional services may now also bill for the telehealth services they provide.[25]

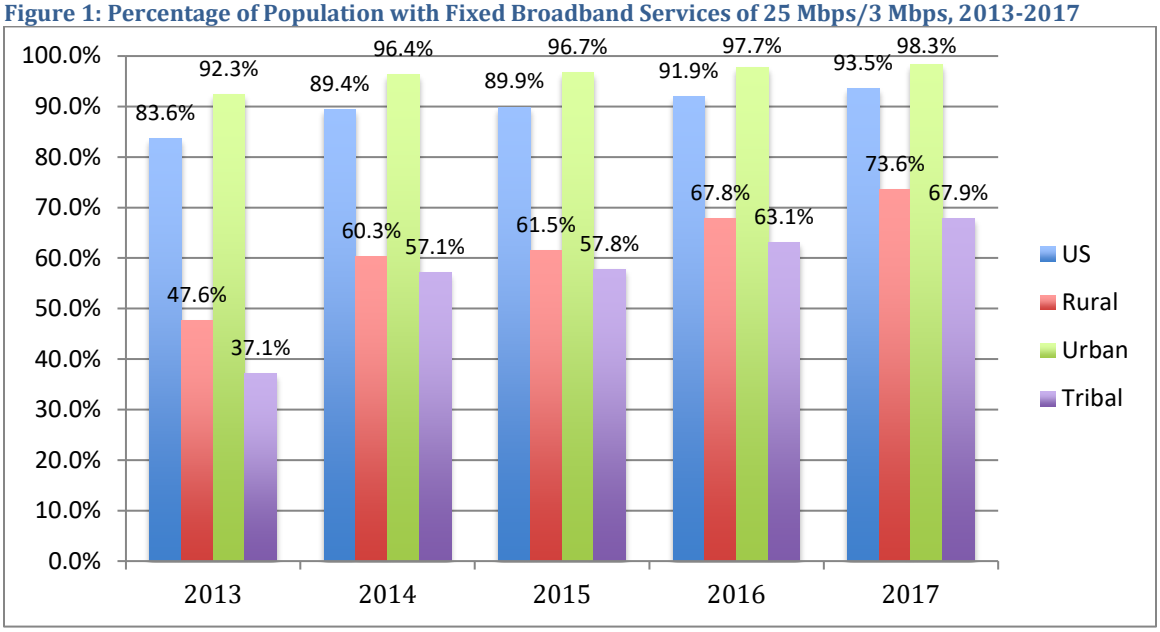
These flexibilities allow states to better serve individuals in rural and frontier areas, and increase access to crisis services for these populations. Each state interviewed for this report expressed appreciation for these changes, and advocated they be made permanent, beyond the public health crisis.

Use of Technology and Broadband Access

As described in the sections above, technology offers exciting opportunities to deliver sustainable crisis services to individuals in rural and frontier areas of the U.S. However, the infrastructure to support these methods is often lacking in less densely populated areas of the country. Inconsistent broadband connectivity in rural and frontier areas was identified as an area of need during each of the seven phone interviews conducted for this report.

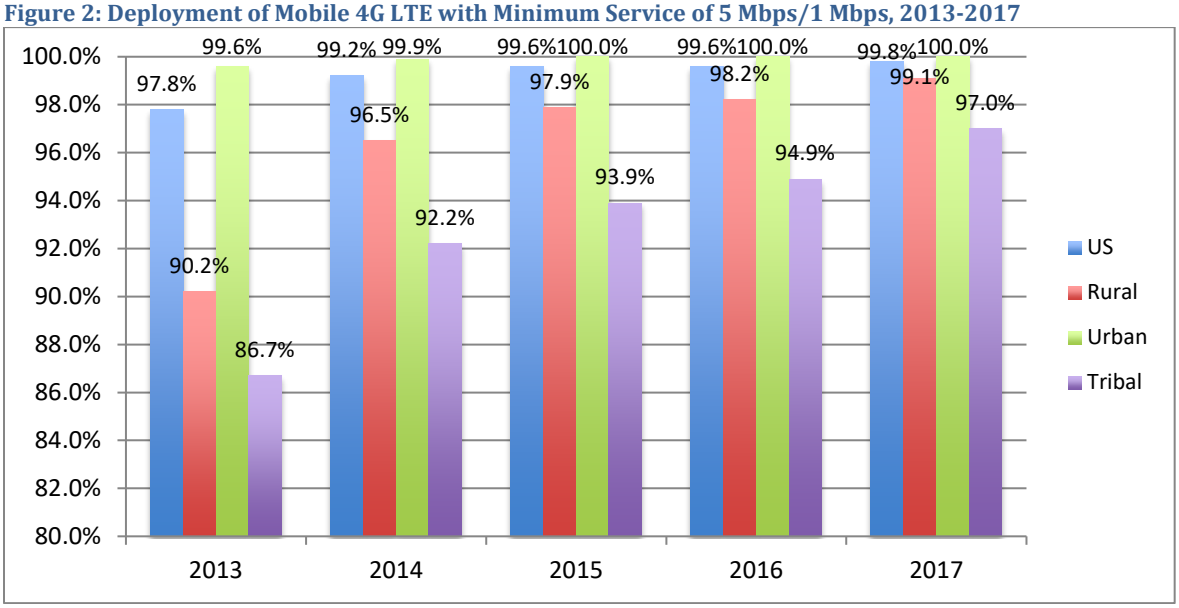
According to the Federal Communications Commission (FCC), the minimum fixed-broadband requirement is 25 Mbps download speed and 3 Mbps upload speed.[26] Data from the FCC show that this minimum level of broadband access has significantly expanded across all areas of the U.S., including rural and tribal areas, since 2013, although access in rural and tribal areas still lags behind urban connectivity. See Figure 1.[27]

Figure 1: Percentage of Population with Fixed Broadband Services of 25 Mbps/3 Mbps, 2013-2017



In addition to calculating rates of fixed broadband availability across the U.S., the FCC also monitors the availability of cellular technology. The minimum performance benchmark for mobile services is 4G LTE, within minimum speeds of 5 Mbps download, and 1 Mbps upload.[28] This level of mobile access is more widely available across all areas of the U.S., including rural and tribal areas, than fixed broadband services. See Figure 2.[29]

Figure 2: Deployment of Mobile 4G LTE with Minimum Service of 5 Mbps/1 Mbps, 2013-2017



While broadband connectivity, both fixed and mobile, is improving, and appears to be available throughout both rural and urban areas of the U.S., the experiences of individuals living in these areas may not align with the information available from the FCC. According to a 2018 Bloomberg report, the FCC's connectivity map (available online[i]), which maps the availability of broadband access by address, is inaccurate because it relies on Census blocks to calculate connectivity at a given address. Within Census blocks, which tend to cover small areas in urban communities and large tracts of land in rural areas, the availability of broadband can vary quite a bit. According to the report, "just because your closest neighbors have broadband doesn't guarantee you'll have any".[30] While the FCC purports that 21.3 million Americans lack access to broadband connectivity, research from BroadbandNow estimates that the number of Americans without broadband access is closer to 42 million, when taking into account the disparities within Census blocks.[31] The FCC data also do not consider limitations accessing broadband services due to the associated costs, and inability of some individuals to afford these services.

Not only does a lack of reliable broadband access limit the availability of telehealth services in rural and frontier areas, it also affects the perception of safety of mobile crisis response teams in rural and frontier areas. As discussed above, there are not enough mobile crisis teams to serve the entire Western Slope in the State of Colorado. This geographic area has mountainous terrain and can experience significant weather events, especially in the winter. Mobile crisis response teams are often reluctant to travel in these conditions, especially at night, when connectivity may be unavailable or inconsistent. To reassure members of the

[i] The FCC's Connectivity Map is available online at https://broadbandmap.fcc.gov/#/

mobile crisis teams that they should be able to reach help, should it be needed, the Office of Behavioral Health is sharing a map of broadband and cellular coverage with the mobile crisis teams. Additionally, mobile crisis teams across the state are exploring the idea of setting up mobile crisis "pop-up shops" in grocery stores and libraries in communities with better broadband coverage. The mobile crisis teams market to individuals that they can meet them closer in the community than an individual would have to travel to reach a crisis stabilization unit, while utilizing available broadband services. While this is not a perfect solution because the mobile crisis teams are not meeting individuals where the crisis is occurring, it is a compromise to help maximize the safety and wellbeing of the community, and sense of security of the mobile crisis teams.

Staff from South Carolina's SMHA pointed out that COVID-19 is highlighting the need for expanded broadband connectivity across all areas of the state, and SMHAs across the U.S. can partner with other agencies, including departments of education, to lobby their legislatures for expanded broadband connectivity.

Other Effects of COVID-19 on Crisis Services in Rural & Frontier Areas

The COVID-19 pandemic has restricted state budgets to pursue innovative programs, such as the transportation program and citizen response program in Colorado. It has also reduced the availability of transportation services in Alaska through decreased availability of air transport, compounded by the bankruptcy filing by RavnAir. In addition to these limitations, COVID-19 has also forced the closure or delayed opening of critical crisis services in rural and frontier areas of the U.S.

South Carolina's SMHA indicated that while mobile crisis response services did not cease during the pandemic, the state did have to temporarily close one crisis stabilization unit because the building is small and the space is not conducive to social distancing. Given utilization rates of other crisis stabilization units in the state, it is likely that demand for this unit would have increased during the pandemic; the crisis stabilization unit in Charleston experienced three times as many walk-ins between May and June than it had in previous years. Prior to COVID-19, South Carolina planned to expand its crisis stabilization services in four additional counties; however, the pandemic has delayed these efforts, and future progress is unknown due to budgetary restraints. Hospitals in the four counties where the crisis stabilization unit program was set to expand are funding partners of the initiative; however, given the financial hardships hospitals are facing as a result of the pandemic, they may no longer be able to financially support this initiative.

In Alaska, BHAs have realized an increase in demand for services since the COVID-19 pandemic began, because reportedly, baseline symptoms of anxiety among community members has increased, particularly in smaller communities that may not have centralized water and sanitation, and for those who have multi-

generational families living in one home. When COVID-19 began to spread across the U.S., many villages completely closed their borders to the rest of the state, allowing no transportation in or out, with the exception of cargo deliveries. Borders were closed, in part, due to historic trauma caused by the 1925 diphtheria outbreak and tuberculosis epidemic that decimated the populations of small villages (McLaughlin, Raymond, Girmscheid, personal communication, August 4, 2020). This isolation not only raises the collective feelings of anxiety of the community, but also limits the ability to access necessary care, unless robust telehealth services are available.

In addition, the COVID-19 pandemic has served to further exacerbate health disparities between rural and urban areas, which can heighten anxieties further in the face of a pandemic. Rural communities are disproportionately affected by an array of serious health issues, including heart disease, cancer, and stroke, which put individuals at higher risks of significant health consequences brought on by COVID-19, and can further strain limited resources in rural hospitals and health facilities.[32]

Implications for Policy Makers

Although the majority of states offer at least one of the recommended crisis services prescribed in the *National Guidelines,* it would be prudent for SMHAs to review where these services are available, and whether or not they meet the best practices guidelines recommended for their implementation. Based on the interviews for this report, although many states offer statewide crisis hotlines, they may not be used effectively in all areas of the state, especially rural areas, and most states do not use GPS technology to efficiently identify geographic location and dispatch the nearest support. Most states also provide mobile crisis response teams and crisis receiving and stabilization facilities; however, in many states these services are concentrated in urban areas, resulting in extended travel and wait times for individuals in need in rural and frontier areas of the states. States should also consider implementing an electronic bed registry system, if one is not already available, to facilitate access to available psychiatric inpatient and other treatment beds that provide appropriate levels of care closest to an individual's home. An evaluation of a state's crisis system could identify areas where additional services are needed and improvements can be made. The need for expanded promotion of these services was also identified. A review of service utilization could help SMHAs identify areas to more effectively promote their behavioral health crisis services.

The COVID-19 pandemic has highlighted the inequities between the delivery of crisis services in rural and frontier areas and urban areas of the U.S., and the related budget cuts faced by states are forcing the postponement or elimination of innovative programs designed by states to better serve individuals in rural and frontier areas. However, the pandemic has also served to underscore the need for broadband to access telehealth services and has identified opportunities for sustainable telehealth expansion. Behavioral health policy makers have an opportunity to unite with other stakeholder groups (including education and physical health) to advocate for expanded broadband coverage in rural areas.

Following the current emergency health crisis, states should work with CMS to make permanent some of the flexibilities afforded to providers in the delivery of telehealth services during the pandemic.

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