AMERICAN PSYCHOLOGICAL ASSOCIATION

Journal of Rural Mental Health

© 2023 American Psychological Association
ISSN: 1935-942X

2023, Vol. 47, No. 4, 221–231
https://doi.org/10.1037/rmh0000237

In Their Own Voice: Behavioral Health Care Delivery Barriers in Rural New York

Brett R. Harris[1, 2] and Katie C. Gallant[1]

[1] Department of Public Health Research, NORC at the University of Chicago, Bethesda, Maryland, United States

[2] Department of Health Policy, Management, and Behavior, University at Albany School of Public Health

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Rural areas are disproportionately impacted by mental health and substance use disorders, drug overdose, and suicide. Several environmental and service access barriers are linked to these disparities, yet little is known about facilitators and barriers to care delivery that may impact client outcomes. Our study sought to explore these facilitators and barriers from the perspective of service providers. We conducted a qualitative focus group study with 206 professionals with a vested interest in behavioral health in 16 rural counties across New York State between March 2020 and September 2021. We started focus groups in person and then transitioned to Zoom during the pandemic. We audio-recorded, transcribed, and analyzed focus groups for themes. Multiple themes related to the delivery of behavioral health services emerged including invested and collaborative provider networks as facilitators and limited workforce capacity, state policy and regulatory issues, and scarce funding as barriers. Specifically, participants described how the way funding is allocated puts rural areas at a disadvantage and does not provide them with the flexibility or resources necessary to address the unique and extensive needs of their communities. They also explained how strict service quotas contribute to stress, burnout, and turnover among service providers. Despite these challenges, they described significant investment, collaboration, and determination that helped them provide high-quality services with limited resources. Together, our findings uncovered new regulatory and policy-related contributors to behavioral health care disparities in rural areas and suggested developing and implementing community-specific, needs-based approaches that leverage community strengths and assets.

Public Health Significance Statement

This study uncovered several regulatory and policy-related contributors to behavioral health care disparities in rural areas, but also significant strengths and assets that can and should be leveraged for mental health promotion and suicide prevention. A strengths-based approach positions rural communities to take immediate action to address behavioral health morbidity and mortality.

Keywords: rural, behavioral health, behavioral health providers, behavioral health service delivery barriers, behavioral health funding and resources for rural areas

Supplemental materials: https://doi.org/10.1037/rmh0000237.supp

This article was published Online First June 15, 2023.

Brett R. Harris https://orcid.org/0000-0002-9426-4319

No external funding was received for this study. The authors would like to acknowledge the contribution of several individuals: Brooke Wyand for her assistance in conceptualizing this project, kickstarting the focus groups, and coordinating the project's transition from in person to virtual; Brianna Maher for her efforts in conducting focus groups and kickstarting the analysis; Nicole Fera, Abby Mariani, Giana Calabrese, Alejandra Puerta, Aishwarya Jadhav, Juliana Rich, and Catherine Choi for focus group facilitation, data collection, and/or data analysis; and the local mental hygiene directors and

continued

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Behavioral health morbidity and mortality—defined as illness and death associated with substance use, mental health, and suicide risk—have been on the rise for the past 2 decades. In 2021, drug overdose deaths surpassed 100,000 in the United States for the first time in a 12-month period, representing a 28.5% increase from the previous year alone (Centers for Disease Control and Prevention[CDC], 2021). The suicide rate increased by 36.8% between 2000 and 2018 (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2020) and by 4% between 2020 and 2021 alone (Curtin et al., 2022). Another 40.3 million Americans 12 years of age and older had a substance use disorder in the past year, 52.9 million Americans 18 years of age and older had a mental illness, 12.2 million had serious thoughts of suicide, and 1.2 million attempted suicide (Substance Abuse and Mental Health Services Administration, 2021).

Rural residents are disproportionately impacted by behavioral health-related morbidity and mortality. For example, in 2020, the suicide rate was significantly greater in rural compared to urban areas of the United States (19.1 vs. 12.6 per 100,000 population) and increased at a greater rate (52.5% vs. 25.1% between 1999 and 2020; Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2020). Unintentional drug overdose deaths, though increasing across the country, increased 840.6% between 1999 and 2020 in rural areas, from 2.5 to 23.9 per 100,000 population (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2020).

Unfortunately, there is a shortage of behavioral health professionals to address the disproportionate need in rural areas (Morales et al., 2020). In fact, as many as 65% of rural counties across the United States lack access to psychiatrists, with over 60% of rural residents living in what are considered mental health provider shortage areas (Andrilla et al., 2018; Health Resources and Services Administration, 2019). As a result, rural communities have limited service availability and long wait times, making it difficult to access behavioral health care when needed; residents are forced to travel long distances with limited travel options to access care (Hoeft et al., 2018; Morales et al., 2020).

Residents are also hesitant to seek behavioral health care due to the rural culture of self-determination and the heightened stigma created by the close-knit nature of rural communities (Harris et al., 2023; Schultz et al., 2021). Beyond access to care and help-seeking, rural residents face deep-rooted issues that contribute to poor mental health and suicide risk including high rates of poverty, financial and employment challenges, food insecurity, interpersonal violence, child abuse and neglect, and housing insecurity. These compounding factors lead rural residents into multiple service systems, creating additional challenges for both residents and service providers (Harris et al., 2023).

Though service access barriers are well studied in rural areas, the ability of providers and communities to effectively deliver services warrants further examination, as effective behavioral health interventions and treatments exist. Limited research has found that rural behavioral health providers struggle to provide effective care due to the severity of mental health and substance use among clients, the need for care to be culturally sensitive, and a lack of training options (Moore et al., 2010; Thomas et al., 2012). We undertook a qualitative focus group study of professionals with a vested interest in behavioral health to further explore the challenges faced by rural behavioral health providers and uncover issues and themes that may not have been identified in the existing literature. In this article, we present novel findings on service delivery barriers and suggest actionable programmatic and policy recommendations for improving care in the face of significant service access barriers.

Method

Participants

We conducted a qualitative focus group study with 289 rural residents and professionals in

their staff for championing our study and recruiting participants. A special thanks goes to the professionals who participated in our study and shared their stories, experiences, input, and feedback in the hopes of improving behavioral health services in rural communities across New York State and nationwide.

This article is based on data published in Harris et al. (2023).

Correspondence concerning this article should be addressed to Brett R. Harris, Department of Public Health Research, NORC at the University of Chicago, 4350 East-West Highway, 8th Floor, Bethesda, MD 20814, United States. Email: harris-brett@norc.org

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

16 rural counties in New York State between March 5, 2020, and October 1, 2021; 13 focus groups were with residents 18 years of age and older, and 19 were with professionals. Due to the focus on service delivery barriers, this article examines the professional subset of this larger study and includes conversations with 206 professionals with a vested interest in the behavioral health of residents. Participants were almost entirely of White race (n = 192, 93%), approximately 60% female (n = 124), were an average age of 50 (range: 26–74), and included health and behavioral health care providers, local government officials and employees, social service providers, law enforcement, first responders, school personnel, and clergy. Unique results of the larger study of professionals and residents—focused on service access barriers, environmental and cultural factors, and county success stories—are presented elsewhere (Harris et al., 2023).

To gain support from county leadership, we emailed all of the state's 25 rural local mental hygiene directors (LMHDs) to inform them of the project and request a videoconference to discuss details. We defined rural as counties with a designation of micropolitan (population 10,000–50,000) or noncore (population under 10,000) by the National Center for Health Statistics (Ingram & Franco, 2013). During these videoconferences, we explained the purpose of the project, who should participate, and what participation would entail. Sixteen LMHDs chose to have their counties participate in the project and agreed to help us recruit participants (64% participation rate among rural counties in New York State). Counties that participated were similar demographically to counties that did not (supplemental material S1).

Materials

We developed a facilitation guide that included the purpose of the study, the informed consent process, mental health resources, brief participant introductions, and a set of guided questions. The guided questions included a series of open-ended questions with subquestions and probes specific to professional participants; residents from our larger study were asked a different set of questions. The questions included:

1. How living and working in a rural community impacts the work you do, including what is specific and unique to your county.
2. How residents in your community cope with stress and what you do in your professional role to help them.
3. Your perceptions on whether residents see you or your organization as a resource to seek services or support for stress or behavioral health-related concerns and how you can encourage residents to seek your organization out when needed.
4. What is needed to improve the capacity of your community to address behavioral health and/or prevent suicide.
5. How to engage key invested parties that may be missing from the table.

Procedure

LMHDs coordinated recruitment efforts within their counties; we created flyers and recruitment emails to assist them. LMHDs reached out through a variety of channels to recruit professionals including county opioid and suicide prevention coalitions, local community services boards, schools, and directly to key invested parties including law enforcement, local government officials, and clergy. Our staff assisted with outreach to increase participation.

We conducted focus groups following procedures outlined by the CDC (2018). As qualitative researchers, we acknowledge that our prior experiences, assumptions, and beliefs may influence the research process; we selected a diverse team and implemented a debriefing process to mitigate these influences. Our staff consisted of research scientists, research associates, and student research assistants, with four based in rural communities and another four from urban and suburban areas representing racial/ethnic minority populations. The whole team came together to debrief after each session to discuss thoughts, preliminary takeaways, and differences of opinions. Our composition of staff allowed for a variety of perspectives in the facilitation, debrief, and analysis of focus groups.

Our team began conducting the focus groups in person early in the study and transitioned to Zoom for the safety of participants during the COVID-19 pandemic. Participants used a link embedded in our recruitment materials to register for the focus groups. We provided participants of the in-person focus groups a copy of the consent form when they arrived for the focus group and asked them to review and sign it prior to participating.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

We read the consent form to participants of the virtual focus groups during the introduction and asked them to confirm their consent prior to beginning the focus group.

Two to three research team staff were present during each focus group, one to two facilitators and one notetaker. The facilitator provided an introduction to the study and described the details of participating including what would be discussed, when and how to contribute to the conversation, and how long the session would last. Because the conversation could be challenging at times, the facilitator shared information for the National Suicide Prevention Lifeline and Crisis Text Line at the start of the session, and one staff person was prepared to assist participants in a breakout room if needed. All focus groups included five to 12 participants, lasted approximately 90 min, and were audio-recorded and transcribed by the research team. No incentives were provided for participation. All research protocols were approved by the NORC at the University of Chicago and the University at Albany Institutional Review Boards.

We conducted a thematic and content analysis guided by the work of Miles and Huberman (1994); our process convened the research team to incorporate diverse backgrounds and perspectives into the analysis. First, we created and selected codes to identify data that corresponded to our research goals and incorporated them into a codebook. We refined the codebook using an iterative process that included two research team staff testing the codebook on two transcripts and coming together as a research team to make revisions to the codebook as needed. Once the codebook was finalized, we assessed and ensured intercoder agreement by having another two staff code two of the same transcripts and reviewing the coded content as a research team to discuss and resolve discrepancies. The two staff then proceeded to split the transcripts and code them in Microsoft Word using open coding to organize the raw data by code. Next, the research team discussed the coded content, came to agreement on the categorization of data, and engaged in axial coding to link and connect the group of codes under higher order categories. The research team then engaged in selective coding to connect the categories and group the content into themes.

Results

Multiple themes related to the delivery of behavioral health services emerged including invested and collaborative provider networks as facilitators and limited workforce capacity, state policy and regulatory issues, and scarce funding as barriers.

Facilitators

Invested Provider Networks

Participants described a social connectedness and closeness within their communities that makes them personally invested in serving their clients. They reported how these clients are like family to them, and they take every effort to ensure they provide the highest quality services possible. Furthermore, they described going out of their way to devise and implement creative solutions to ensure their clients receive the services they need. One participant described how he and his colleagues brought services to their clients during the COVID-19 pandemic:

> We literally were meeting our clients underneath the gazebo in camping chairs. We tried in the most nontraditional ways to keep the human connection going, because we knew folks still needed the personal connection.

Participants explained other situations in which they had to be creative to serve hard-to-reach populations, even when it impacted their bottom line and resulted in opportunity costs for the organization. One participant described her organization's use of outreach teams to serve families at a distance from the nearest provider:

> A lot of our children and family services [are conducted by] outreach teams in the home environment. So, it requires different approaches, approaches that aren't always easy to figure out how to fund, approaches that take longer on your staff when they're traveling an hour to do a home visit. They do a half or a third of the work in a day that office-based clinicians do, so there's the management challenges of making that be successful.

Another participant described routine brainstorming and strategizing he and his colleagues use to reach the highest risk populations that choose to stay isolated:

> I think the most at-risk people and being able to reach them present something of an oxymoron, whether it's due to self-reliant culture or a history of hurt. We're talking about people that want to largely be left alone. So how do we de-isolate the person that wants to be left alone in order to not have them [die by] suicide? …

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

> They have to engage the community [with suicide prevention messaging] somewhere at these other places.

Participants reported how this investment, creativity, and determination coupled with a connection to the community and the families they serve make them better equipped to address significant behavioral health challenges, especially those passed down from generation to generation. One participant described how their persistence and the relationships they have built with clients and their families over time have helped them address the most difficult challenges:

> Because our agency works with children and adults, … we have seen family cultural patterns where this denial gets really embedded and is cyclical and that there are many layers … We have found that if we can stick it through and keep them engaged and develop a relationship over time, we can help them through it.

Participants emphasized that relationships and community investment are largely unique to rural areas and are critical to the delivery of high-quality behavioral health services in the face of limited resources.

Collaboration Among Providers

Participants described an ease of interorganizational collaboration, which is rare in urban communities. Because they know each other well and share many of the same clients, they explained that they can provide clients with individualized, high-quality wraparound services despite limited resources. Furthermore, because many of the providers have worked in multiple service organizations within their community over the course of their career, they explained how they are able to understand the inner workings of each organization and successfully navigate difficult cases, referrals, and warm handoffs. They said that it is as simple as picking up the phone to discuss and devise the best course of action for a client in a short period of time. One participant described collaboration in her county:

> We all work very collaboratively together, the different systems and agencies. When I speak with coordinators in different counties, they don't navigate the system like we do. So, being small we know each other, we know we can call up [an organization] and say, 'this is what's going on, can you help problem solve this case?' So, we all kind of have our go-to people to help think outside the box and get a little creative with solutions.

Participants went on to explain that collaboration has been increasing over the years and that they have been breaking down silos and identifying and successfully addressing issues that may have been missed or not fully addressed in the past. One participant explained a recent success:

> We had a conversation a few weeks ago about our low opioid overdose rates when we're seeing them skyrocket in [other] communities and it's in national headlines. We've worked really well together on early intervention, identification, access to services, and supporting access to wherever you are comfortable. Those things make a big difference when your provider system is working together for the overall benefit of the person.

Participants explained that this teamwork and success leave them feeling positive about their work in the face of significant challenges, resulting in staff continuity and longevity. One participant explained the impact of staff continuity and longevity on service delivery:

> In my experience, the people that work in these positions in our county stay in our county. [Some] move out, but a lot of them have been here for many years and are familiar with the culture and community, which positively impacts how services are delivered.

The determined, invested, and collaborative provider networks described by participants facilitate the delivery of high-quality behavioral health services to rural residents.

Barriers

Limited Workforce Capacity and Burnout

Participants overwhelmingly described workforce recruitment and retention as a significant barrier to the delivery of behavioral health services in their communities. First, participants explained how significant salary differentials between rural and urban service providers lead trained and educated clinicians to move out of the county for higher paying jobs. Then, they explained that limited staffing leaves them with large caseloads; these large caseloads lead to long wait times for appointments, suboptimal care, risk of burnout, and staff turnover. One participant explained:

> We have standard caseloads that are ranging from 100 to 130 individuals. It's way too many to provide good quality care, in my opinion … which ultimately, in turn, plays into these long waitlists.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Participants also described how the extensive needs of residents in their communities make it harder to provide high-quality care. Participants explained that many of their clients receive care within multiple service systems and that addressing these needs as part of their large caseloads is challenging and leads to compassion fatigue, vicarious trauma, and burnout. One participant explained how this work can impact their own mental well-being:

> We have our own trauma but then we take on others' trauma trying to help [others], and we need to learn ways to process and to cope with that so that it doesn't become our own.

Participants emphasized how these factors increase the likelihood of turnover and explained that turnover creates a lack of consistency for clients, makes it harder for them to develop a rapport with their provider, increases time on waitlists, and results in suboptimal behavioral health outcomes. One participant described this phenomenon as an inability to move forward:

> The staff turnover too, you connect with somebody and then you have a new clinician the next time you walk in the door, and, if this happens five times a year, you never really get to move forward, you're always stuck on that building relationship part.

Unfortunately, this lack of consistency leads to negative client experiences which in turn makes residents hesitant to seek care in the future.

Restrictive State Policies, Approaches, and Regulations

One of the most commonly discussed themes among participants involved restrictive state policies, approaches, and regulations. One regulation that was discussed across several focus groups was the strict service quotas the state places on provider organizations. Participants described how their organizations are required to serve a certain number of clients to maintain their state funding. However, they pointed out that, in order to meet these quotas, they are not able to spend the time that is needed to effectively treat their clients, particularly those with multiple systems involvement. One participant described this dilemma:

> There is a lot of pressure to maintain units of service, but what accounts for a unit of service is when the client is sitting in front of you. That does not account for all the complex issues outside of the session, so it's almost like you're being penalized for not meeting your units of service while trying to serve the whole person.

Participants went on to explain how the pressure created by state regulations leads to stress, burnout, turnover, and limited workforce capacity:

> [The state] says you're not doing enough because your units of service are down and [they're] going to pull your funding and positions. The staff are stressed out because they are working constantly. Then, it feels like they're getting this message that they're not working hard enough, so there is a lot of burnout and stress. People jump ship if a job opens up somewhere else, even if it is a pay cut, which nine times out of ten it's not because the pay here is really poor. So, we cannot attract new staff.

In addition, participants explained how low levels of reimbursement for services provided in rural areas make delivering care extremely difficult. Specifically, participants described how reimbursement is low for unlicensed providers, particularly under Medicaid, putting rural organizations with greater proportions of unlicensed providers at a disadvantage and creating the perception that rural providers are not valued.

Participants also described how the state's funding strategies and algorithms impact their ability to provide behavioral health services to residents. They specifically explained that state behavioral health funding is allocated based on population size, limiting the amount they receive. They went further and emphasized that, because of this algorithm, counties with the smallest populations and greatest needs get the least amount of funding. One participant explained:

> Some of the formulas do not help our communities at all. I just did a regional grant for our whole county, and it was $9,000. What [are we] supposed to do with $9,000 to offer 24/7 crisis services? It just doesn't make any sense. Just because their formulas are based on per person. So, what ends up happening is that the areas with the fewest people receive the least services, and they are probably some of the people that really need the most services.

Participants conveyed that, when they shared their concerns with the state over the funding algorithm, the state recommended they take a regional approach to pool funding across counties, an approach that was not well received across all focus group sessions. One participant described the shortcomings of this approach:

> They lump you all in so you are working in three counties, but being so rural, you are so far apart it may take you three hours to get from one end to the other. But they're providing you the same money, no matter where

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

> you're putting the services, if you know what I mean. It just does not make sense.

Other participants explained that this regional approach does not take into account the uniqueness of each county and that even bordering counties have access to and provide residents with different services and resources. In fact, they called the regional approach a "one-size-fits-all mandate" and described how it results in accommodations on the part of rural counties. One participant explained:

> The state just gives broad directives and expects the counties to implement X, Y, or Z, but they don't consider [how our county] is very unique compared to [the neighboring urban counties]. Some of the things they ask us to do are out of touch with reality, and it's really frustrating, because you're expected to do these things, but how do we do it when we don't have the resources, especially when they're unfunded mandates?

Beyond the amount of funding allocated to rural areas, participants described challenges related to how and where the funding is allocated. Participants emphasized that, even when the money is there, it is typically tied to specific downstream treatment services, which does not allow them to use it for prevention or early intervention services that meet the needs of their community. One participant, agreeing with his colleagues, explained:

> The funding that comes down through the provider systems is usually so very narrowly focused that it's really hard to figure out a way to make a great case to meet the needs of your community. I mean, it can be done, and we do it and we twist ourselves in pretzels to do it, but it's usually very narrowly focused, highly prescriptive, and it's prescriptive from a [state capitol] point of view, … not often with consideration of rural needs.

Participants emphasized the importance of a public health approach in rural areas that is not supported by the state or federal government but would result in better outcomes:

> If we were to consolidate and streamline and take more of a public health prevention agenda, we would be getting much better results than what we're getting now. We reduce this and then two years later, we're right back to square one with that, I mean, it's just the finger in the dike approach to the problem.

Instead, participants described constant budget cuts that force them to cut services and resources at the very center of a public health approach including those that help with natural stress relief. As a result, they explained that residents tend to cope with alcohol at local bars. Participants then lamented that policymakers do not understand the plight of rural areas and agreed that they should tell their stories so that policymakers better understand their challenges and adjust the way funds are distributed in the future:

> Sharing stories with policymakers and the state health department [will be critical]. We do community health assessments every three years, and I can tell you in the past, probably three or four cycles, our priority areas have not changed. It's chronic disease and mental health. But you never see the funding change.

Without funding allocated for their specific needs, participants explained that they would continue to face difficulties in addressing their communities' unique challenges.

Difficulty Competing for Funding

Participants frequently described their difficulty obtaining state, federal, and private foundation funding for behavioral health services and initiatives. The most commonly reported barrier was that their low population density makes it difficult to compete for funding, even when they have greater needs than their urban counterparts. One participant explained:

> Funding gets concentrated around large population areas and that's great for individuals who live in those areas of larger density, but for rural communities, it means that we are almost completely ignored when it comes to services and the ability to apply for competitive grants on the state or federal level. We as a community do a fantastic job of collaborating to bring as much critical mass as possible and a competitive grant environment, but unfortunately, we don't touch the numbers that [larger cities] do.

Participants also described a lack of consideration for unique rural community needs among funders as a major barrier. They explained that the current funding system is not cost-effective or sustainable because the typical 2–3-year awards do not allow communities enough time to make a lasting impact. In fact, they emphasized that, once the funding is gone, organizations are forced to discontinue services and seek a new funding source. Unfortunately, they explained that many communities do not have the capacity or experience to obtain additional grant funds to sustain services; they agreed that funding is awarded by those who write the proposal best rather than those who need it most. Without

funding, they emphasized that rural communities are limited in what they can do no matter how motivated they are. One participant explained:

> I think it all goes back to funding. The county wanted to do the Crisis Stabilization Center, but there was no funding. We talked about putting a peer on the mobile team like [the neighboring county] has, but there was no funding for that. So, a lot of it comes down to the money. We do have some great ideas, we all work really well together, and we're all trying, but we're very limited in what we can do. The ideas that we have can't come together because there is no money, and we're always the last to get the money.

Participants continued to emphasize their dedication and motivation to serve their communities but admitted their limitations without adequate funding.

Discussion

In this qualitative analysis of focus group data collected from professionals across rural New York, we explored key facilitators and barriers to the delivery of behavioral health services to residents in care. This study is the first to directly identify and link restrictive state and federal policies, regulations, and approaches as significant barriers to the delivery of behavioral health services in rural areas and to explore existing strengths and assets that can be leveraged in the face of limited resources. It is critical that we better understand these strengths and barriers so that we can devise recommendations that are advantageous for rural communities as they seek to address rising behavioral health morbidity and mortality.

Limited Workforce Capacity and Burnout

Participants in our study talked extensively about staff recruitment and retention challenges in their counties and how limited workforce capacity results in large caseloads, burnout, and lower quality services delivered to clients. This finding is strongly supported in research studies and reports and is widespread in rural areas across the country (Baum & King, 2020; Buche et al., 2017; Gale et al., 2019; Schultz et al., 2021). These studies and reports recommend incentives to increase the size of the workforce including higher salaries; flexible hours; additional residency slots; and loan repayment, pipeline, and relocation and resettlement programs (Baum & King, 2020; Buche et al., 2017).

Unfortunately, these recommendations are difficult to implement because they require states to prioritize rural areas and allocate funding specifically for these purposes. In New York State, for example, rural areas were not one of the populations prioritized in the governor's suicide prevention task force report in 2019 (New York State, 2019), and advocates continue to demand higher salaries for behavioral health professionals. Satisfaction, positively correlated with staff retention in the behavioral health field (Scanlan & Still, 2019), may be a more tangible goal with a more immediate impact. In our study, participants who spent their entire careers in the same county voiced satisfaction with their jobs because of several strengths including the collaborative and collegial nature of their work and the successes they have achieved. The results of our study suggest the importance of leveraging these strengths and imply that simply creating a virtual community of behavioral health professionals within and across rural counties to share successes and challenges may help improve satisfaction and reduce burnout and turnover.

Restrictive State Policies, Approaches, and Regulations

Limited workforce capacity is just one of many factors that have been linked to poor mental health in rural areas. Others include limited service availability and long waitlists, long travel distances and limited transportation, social isolation, heightened stigma, a rural culture of self-determination, poverty, a lagging economy, lack of jobs and unemployment, and substandard housing and homelessness (Harris et al., 2023). Participants in our study thoroughly described their efforts to address these contributors—including raising awareness, reducing stigma, promoting help-seeking, delivering crisis services, leveraging telehealth, providing job training programs, and building infrastructure—but explained that they do not have the funding or support needed to be successful. They pointed to restrictive state and federal policies, regulations, and approaches that, if modified, would help them better address the behavioral health needs of their residents.

Specifically, participants described how the way funding is allocated has a significant impact

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

on their ability to deliver behavioral health services. First, they explained that whether they receive funding at all is dependent on how many units of service they provide. They are held to strict service quotas, and the state threatens to pull their funding if they do not meet them. Participants from specific counties in our study struggled to meet these quotas due to the extensive needs of their clients, especially those with multiple systems involvement. This created stress, undervaluation, burnout, and turnover. Therefore, though burnout and turnover among rural providers are well-studied concepts (e.g., Gale et al., 2019; Schultz et al., 2021), our study identified a restrictive quota system as a contributor which suggests that the way service quotas are determined to be revised to address the unique needs of each county and population. Otherwise, turnover will continue to be a problem, organizations may suffer lost revenue, and clients will be more likely to receive suboptimal care (Scanlan & Still, 2019).

Second, participants explained that funding is allocated for very specific purposes—typically downstream such as crisis stabilization or opioid overdose reversal—which does not give them the flexibility to tailor services to meet the needs of their residents. Participants prefer taking a prevention approach, as they continue to see and address the same issues year after year. Unfortunately, funding is allocated for specific purposes at both the state and federal levels. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) has separate centers for mental health, substance use prevention, and substance use disorder treatment, and it is rare that grantees can use any one funding stream to jointly address substance use, mental health, and/or suicide risk. Furthermore, SAMHSA suicide prevention grants are typically more clinical-based and downstream, whereas the CDC's Comprehensive Suicide Prevention Program allows grantees to address multiple issues across a continuum using a public health approach. It is the funding stream that defines which services are provided, and participants in our study emphasized that the decisions are made from a central office rather than on the ground in rural communities. This suggests that funders consider more blended strategies and incorporate the voices of rural communities when they design funding programs.

Third, participants explained that the state's funding algorithm is based on population size, leaving them with limited funding to address significant needs. Unfortunately, the state's suggested way around this is partnering with neighboring counties to pool funding, an approach that participants emphasized does not account for the uniqueness of their counties and is not practical or useful. This suggests the importance of revising funding algorithms so that they are based on need rather than population size; this method of distributing funds may be more effective and result in higher quality, targeted behavioral health services for rural residents.

Difficulty Competing for Funding

Similarly, participants explained that their low population density makes it difficult to compete for state, federal, and private foundation funding. Our findings align with Atkins et al. (2021) who revealed that, after accounting for economic disadvantage, applications serving rural areas are less likely to be funded than applications serving urban areas. Atkins et al. (2021) explained this finding as an assumption on the part of funders that urban centers have higher levels of poverty than rural areas and that they will maximize impact and show results by funding densely populated areas.

In addition to low population size, participants in our study identified a lack of grant writing resources as another competitive disadvantage to obtaining grant funding. Headwaters Economics developed a rural capacity index to rank communities specifically on this stated disadvantage; our findings align with their recent analysis, which revealed that anywhere from 22% of communities in the Northeast to 75% of communities in the Midwest are designated as low capacity based on the staffing, resources, and expertise needed to successfully apply for funding, manage grants, and plan and maintain services (Hernandez, 2022). This suggests that, even when significant funding is made available for rural communities, many will not be able to access it due to lack of resources, underscoring the need for funders to adjust their strategies to promote equity. Alternative strategies may include shorter applications, technical assistance in the grant writing process, targeted rather than open calls for proposals, and foregoing competitive applications and awarding based on need (Atkins et al., 2021; Hernandez, 2022).

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Leveraging Strengths and Assets

Despite all these barriers, participants in our study demonstrated several strengths and assets that they leverage to provide high-quality behavioral health services to residents in their counties including investment, creativity, collaboration, and determination. In fact, their ability to collaborate and their investment in their community are unique to rural areas yet is rarely considered when designing policies and programs. Instead, most of the research, articles, and reports on rural behavioral health that inform policy and program design focus on deficits only (e.g., Bolin et al., 2015; Heflin & Miller, 2012), which limits the ability of policymakers, professionals, and the behavioral health field to devise and successfully implement both short- and long-term solutions. Identifying and elevating the strengths of the rural provider network is critical, as a strengths-based approach positions rural communities to take immediate action to address behavioral health morbidity and mortality.

Limitations

The results of this study should be interpreted in light of several limitations. First, our study was limited to a sample size of 206 professionals in rural areas of New York State which limits generalizability to rural areas across the country. However, our qualitative approach elicited a rich discussion that allowed us to explore and identify new themes related to service delivery that may not have been captured using a quantitative approach. The identified themes are applicable to other areas of the country and may be useful to a wide range of policymakers, administrators, and researchers. In addition, though we had good representation from rural New York, we did not have the perspective of six of the state's rural counties. Though the counties are similar demographically, it is possible that the counties that participated were more invested in behavioral health than those that did not, which may have biased the perspectives we present in this article. Furthermore, our participants were mostly of White race; though this is about the same proportion of White individuals in the overall population from which our participants were selected, we were limited on the perspectives we received from other races and ethnicities. Finally, due to the pandemic, most of the study was conducted via Zoom or by phone, depending on the participant's access to broadband. Regardless, the open and honest discussions that took place via Zoom were comparable to the discussions that took place in person.

Conclusion

Despite these limitations, our findings identified key facilitators and barriers to the delivery of behavioral health services in rural areas and uncovered new regulatory and policy-related contributors to behavioral health care disparities. Several recommendations stemmed from our findings that may help rural providers more effectively address the specific needs of their communities. These recommendations are significant, as many of the current recommendations and proposed solutions are difficult to implement without sufficient funding and support. Future research should compare and contrast the impact of policies, regulations, and approaches on rural areas across the country and should examine the extent of their impact on both service delivery and client outcomes.

References

Andrilla, C. H. A., Patterson, D. G., Garberson, L. A., Coulthard, C., & Larson, E. H. (2018). Geographic variation in the supply of selected behavioral health providers. *American Journal of Preventive Medicine*, *54*(6, Suppl. 3), S199–S207. https://doi.org/10.1016/j.amepre.2018.01.004

Atkins, R., Allred, S., & Hart, D. (2021). *Philanthropy's rural blind spot*. https://www.pinnacleprevention.org/uploads/9/0/3/3/90331111/spring2021-feature-atkins-blind-spot.pdf

Baum, N., & King, J. (2020). *The behavioral health workforce in rural America: Developing a national recruitment strategy project team*. University of Michigan School of Public Health, Behavioral Health Workforce Research Center. https://www.behavioralhealthworkforce.org/wp-content/uploads/2020/02/Recruitment-and-Retention-of-BH-Providers-Full-Report-2.2020.pdf

Bolin, J. N., Bellamy, G. R., Ferdinand, A. O., Vuong, A. M., Kash, B. A., Schulze, A., & Helduser, J. W. (2015). Rural healthy people 2020: New decade, same challenges. *The Journal of Rural Health*, *31*(3), 326–333. https://doi.org/10.1111/jrh.12116

Buche, J., Beck, A., Singer, P., Casemore, B., & Nelson, D. (2017). *Workforce factors impacting behavioral health service delivery to vulnerable populations: A Michigan pilot study*. University of

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Michigan School of Public Health, Behavioral Health Workforce Research Center. https://www.behavioralhealthworkforce.org/wp-content/uploads/2017/05/FA2P2_Vulnerable-Pop-BH-Serv-Del_Final-Report.pdf

Centers for Disease Control and Prevention. (2018). Data collection methods for program evaluation: Focus groups. *Evaluation Briefs*. https://www.cdc.gov/healthyyouth/evaluation/pdf/brief13.pdf

Centers for Disease Control and Prevention. (2021). *Drug overdose deaths in the U.S. top 100,000 annually*. https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm#:~:text=Provisional%20data%20from%20CDC

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2020). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. https://www.cdc.gov/injury/wisqars

Curtin, S. C., Garnett, M. F., & Ahmad, F. B. (2022). *Provisional numbers and rates of suicide by month and demographic characteristics: United States, 2021*. Vital Statistics Rapid Release; no. 24. https://www.cdc.gov/nchs/data/vsrr/vsrr024.pdf

Gale, J., Janis, J., Coburn, A., & Rochford, H. (2019). *Behavioral health in rural America: Challenges and opportunities*. https://rupri.org/wp-content/uploads/Behavioral-Health-in-Rural-America-Challenges-and-Opportunities.pdf

Harris, B. R., Gallant, K., & Mariani, A. (2023). *Mental health in rural New York: Findings and recommendations from a rural mental health listening tour with residents and professionals* (NORC Working Paper Series). NORC at the University of Chicago. https://sbirt.webs.com/Rural-NY-Listening-Tour-Report.pdf

Health Resources and Services Administration. (2019). *Designated health professional shortage areas statistics*. Bureau of Health Workforce, U.S. Department of Health and Human Services. https://data.hrsa.gov/topics/health-workforce/shortage-areas

Heflin, C., & Miller, K. (2012). The geography of need: Identifying human service needs in rural America. *Journal of Family Social Work*, *15*(5), 359–374. https://doi.org/10.1080/10522158.2012.719476

Hernandez, P. (2022). *A rural capacity map*. Headwaters Economics. https://headwaterseconomics.org/equity/rural-capacity-map/

Hoeft, T. J., Fortney, J. C., Patel, V., & Unützer, J. (2018). Task-sharing approaches to improve mental health care in rural and other low-resource settings: A systematic review. *The Journal of Rural Health*, *34*(1), 48–62. https://doi.org/10.1111/jrh.12229

Ingram, D. D., & Franco, S. J. (2013). *NCHS urban–rural classification scheme for counties. National Center for Health Statistics* (Vital Health Statistics, Publication No. 2014–1366, Series 2, No. 166 CS245991). Department of Health and Human Services. https://www.cdc.gov/nchs/data/series/sr_02/sr02_166.pdf

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis* (2nd ed.). Sage Publications.

Moore, T., Sutton, K., & Maybery, D. (2010). Rural mental health workforce difficulties: A management perspective. *Rural and Remote Health*, *10*(3), 1519. https://doi.org/10.22605/RRH1519

Morales, D. A., Barksdale, C. L., & Beckel-Mitchener, A. C. (2020). A call to action to address rural mental health disparities. *Journal of Clinical and Translational Science*, *4*(5), 463–467. https://doi.org/10.1017/cts.2020.42

New York State. (2019). *Communities united for a suicide free New York*. https://omh.ny.gov/omhweb/resources/publications/suicide-prevention-task-force-report.pdf

Scanlan, J. N., & Still, M. (2019). Relationships between burnout, turnover intention, job satisfaction, job demands and job resources for mental health personnel in an Australian mental health service. *BMC Health Services Research*, *19*(1), Article 62. https://doi.org/10.1186/s12913-018-3841-z

Schultz, K., Farmer, S., Harrell, S., & Hostetter, C. (2021). Closing the gap: Increasing community mental health services in rural Indiana. *Community Mental Health Journal*, *57*(4), 684–700. https://doi.org/10.1007/s10597-020-00737-x

Substance Abuse and Mental Health Services Administration. (2021). *Key substance use and mental health indicators in the United States: Results from the 2020 national survey on drug use and health*. https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf

Thomas, D., Macdowell, M., & Glasser, M. (2012). Rural mental health workforce needs assessment - a national survey. *Rural and Remote Health*, *12*(4), 2176. https://doi.org/10.22605/RRH2176

Received January 2, 2023
Revision received May 19, 2023
Accepted May 23, 2023 ■