Report to Tri-County Board of Recovery and Mental Health Services

Mental Health Inequity Community Assessment

ILLUMINOLOGY

EXECUTIVE SUMMARY

The 2022 Tri-County Board of Recovery and Mental Health Services (TCB) Community Assessment provides several key takeaways for consideration as TCB continues its mental health equity planning efforts.

Existing data encourages further exploration of mental health inequities.

Existing data suggest that adults in the Tri-County area struggle with mental health disorders and problem or binge drinking. Additionally, while rates of opioid use and accidental overdose are not necessarily at their peak, they are still significant. Analysis of differential rates of experiencing mental and behavioral health problems in subgroups of residents is not as well developed as such analysis in public health, however evidence exists to suggest that at least in some counties, women are more likely to be diagnosed with a mental health disorder while men are more likely to binge drink or die from accidental overdose. Finally, all three counties in the Tri-County area are federally designated Mental Health Professional Shortage Areas.

Conversations about mental health inequity should continue.

Some local experts didn't have a solid definition of Mental Health inequity – this is not surprising since it's a relatively new concept. However, many local experts were already thinking about this topic and could define it, and either on its own or by extrapolating their knowledge of inequities in public health or other fields to this topic. Finally, some local experts seemed hesitant to discuss the concept, perhaps for fear of offense as they think of inequities mostly in terms of racial groups. Giving them language (and confidence) in discussing these topics would be helpful.

The assessment suggests children and residents with lower socioeconomic status (SES) are most likely to experience mental health inequities.

Local experts were most likely to identify children and residents with lower SES as the groups of people most likely to experience mental health inequities. This was due to rising levels of mental health challenges (especially anxiety and depression) in younger residents and the barriers to treatment that residents with fewer financial resources face, namely transportation difficulties and less flexible work arrangements that make it harder to regularly participate in mental and behavioral health services.

People who are not white were also identified as a group that may face these inequities.

The Tri-County Area seems to have ample drug treatment resources but lacks general mental health capacity.

Like many other fields, those in the mental health arena report struggling to find and retain talent. This may be exacerbated by the rural nature of the communities in the Tri-County area, which could be one attribute that detracts individuals from taking jobs there or which makes it easier for other employers to tempt them away elsewhere. The lack of mental health professionals has several implications, including longer wait times for intake or treatment and more difficulty finding specialized care (including care for residents with dual developmental and mental health diagnoses). Perhaps due to increased funding because of the opioid epidemic, local experts see more resources for drug treatment within the area.

The Tri-County Area has strengths that can be leveraged.

Many local experts said they felt a strong sense of community in their counties. They also indicated residents and professionals alike are willing to pitch in to solve problems. They find residents are willing to lend taxpayer support to problems if the case is well made. Finally, they see high levels of collaboration between professionals in their community along with open lines of communication. These are all assets which can be leveraged in the mental health equity planning process.

Some characteristics of the Tri-County Area could make the work harder.

Like many rural areas throughout the state and country, the Tri-County area suffers from a lack of safe, affordable transportation options. Additionally, as a Mental Health Profession Shortage Area, there is a deficit of qualified mental and behavioral health providers, meaning residents need to travel even further distances for treatment. Although transportation (both inside and outside the county) is available through a variety of social service agencies, the need to schedule in advance may make this difficult, especially for residents in crisis. Out-of-town placements also reduce patient compliance and inhibit their ability to access social support. Finally, some suggest that

the area's conservative attitudes may make stigma reduction and acceptance of individuals who struggle with mental and behavioral health challenges more difficult.

Best practices for reducing Mental Health Inequity focus on helping the community understand inequities, integrating existing services and resources, and attracting and retaining skilled mental health professionals.

Best practices for reducing mental health inequities in rural areas can be grouped into five categories: (1) laying the groundwork by honestly and openly discussing mental health inequities and training the community to understand and feel comfortable addressing them, (2) leveraging technology to extend service delivery through telemedicine, (3) integrating healthcare by including mental health services with primacy care and leveraging community resources to take advantage of formal and informal assistance networks, (4) improving the existing workforce by training allied professionals (law enforcement, EMS, etc.) in best practices for responding to mental and behavioral health needs, and (5) prioritizing the recruitment and retention of mental health professionals while taking into consideration the unique challenges that rural areas face in this effort.

There are specific strategies that TCB could consider to reduce Mental Health Inequities

Local experts provided suggestions for specific activities TCB could take to reduce these inequities, namely, more outreach and education (both to community members and professionals) helping to expand the number, type, operating hours, and location of treatment options available to local residents, supporting the recruitment and retention of mental health service providers, and assisting with transportation and childcare needs. At least one expert strongly recommended the foundation of other FQHCs which can draw federal funds into the area to finance these improvements and improve coordination of care.

COMMUNITY ASSESSMENT RESEARCH METHODS

To assist TCB with its mental health inequity planning, OnPointe and Illuminology used a hybrid research methodology consisting of three primary components: (1) a review of secondary data; (2) in-depth interviews with local experts; and (3) a review of best practices. Together, these three methods paint a rich portrait of the context in which TCB operates, the mental health inequities that may be present, and potential strategies for reducing those inequities.

Secondary Data Review

To begin, Illuminology reviewed findings from a search of publicly available data, as well as from information provided by TCB and the members of the TCB's Mental Health Inequity Workgroup. Data sources included:

- 2015 Darke Community Health Assessment
- 2015 Darke Community Health Improvement Plan
- 2020 Darke County Community Health Assessment
- 2021 Darke County Community Health Needs Assessment
- 2017 Miami Community Health Improvement Plan
- 2017 Miami County Community Health Assessment
- 2019 Miami County CHIP Annual Report
- 2021 Miami County Community Health Assessment
- 2022 (draft) Shelby Community Health Improvement Plan
- Ohio Mental Health & Addiction Services
- Ohio Automated Rx Reporting System
- Ohio Health Department
- Ohio Department of Natural Resources
- America's Health Rankings Annual Report 2021
- CDC National Center for Health Statistics

Illuminology extracted key research findings for this report and provided a full database of all indicators to TCB for future use.

In-depth interviews with local experts

To better understand the local context in which those individuals who face mental and behavioral health challenges live, Illuminology collaborated

with members of TCB's Mental Health Inequity Workgroup to identify groups of people within the Tri-County area who may face mental health inequities. Then, also in collaboration with this workgroup, Illuminology and TCB identified individuals who serve or otherwise have knowledge of the experiences of the populations identified. These potential groups of people who may experience mental health inequities included:

- Non-White residents
- Economically disadvantaged residents
- Uninsured / under-insured residents
- Members of the LGBTQ+ community
- Residents who live in more rural areas
- Younger residents
- Residents with physical or developmental disabilities
- Residents who may not be well-integrated into the larger community, including small pockets of Hispanic, Somali, Japanese, Chinese, and Eastern European people who work in the Tri-County area, as well as some isolated religious groups

Brad Reed introduced Illuminology researchers to approximately 37 local experts and provided a link at which invited individuals could schedule a time to complete a 45-minute discussion with Amanda Scott. Interviews were successfully conducted with more than 25 individuals, representing 20 organizations in the Tri-County area. The organizations represented were primarily governmental agencies (e.g., county offices of the Ohio Department of Job and Family Services, county Boards of Developmental Disabilities, Sheriff's departments, EMS) and non-profit organizations (e.g., United Way affiliates, Community Action Agencies, universities). A full list of individuals (and the organizations they represented) can be found in Appendix A.

A robust research methodology, including a review of secondary data, in-depth interviews with local experts, and a best practices scan were used to generate input into the Mental Health Inequity planning process.

These interviews explored local experts' overall understanding of mental health inequity, sought to identify populations within the Tri-County service area that might experience mental health inequities and flesh out why such inequities might occur,

and generated a list of assets, potential weaknesses, and specific policy or action recommendations for TCB to consider as it continues the planning process. The discussion guide used for these interviews can be found in Appendix B.

Literature Search & Best Practice Review

As a capstone to the research process, Illuminology conducted a literature search to identify best practices for reducing mental health inequities, especially in a rural context. Internet searches were used to identify sources. These were reviewed by research assistants and are summarized later in the document. A list of the titles of all literature considered for inclusion can be found in Appendix C.

LOCAL CONTEXT

The Tri-County area consists of Darke, Miami, and Shelby counties, with a total population of just over 206,000 people, according to the Census.[1] All three counties include metropolitan centers amid wider swathes of rural areas. The Tri-County area is largely White and the demographics of the three counties that make up the area are fairly similar. Notably, Darke County is more White than the other two counties, while Shelby County's Black population is the largest, percentage-wise, but is still quite small at 2.5%.

Table 1. Basic Demographic Characteristics of the Tri-County Area

Demographic Characteristic	Darke	Miami	Shelby	Tri-County area
Gender	(pop, 51,387)	(pop, 106,074)	(pop, 48,610)	(pop, 206,071)
Male	49.7%	49.5%	50.3%	49.8%
Female	50.3%	50.5%	49.7%	50.2%
Age				
Under 18	23.7%	23.1%	24.9%	23.7%
18 to 34	18.3%	19.0%	19.8%	19.0%
35-54	24.3%	25.3%	24.7%	24.9%
55-74	25.0%	24.7%	23.7%	24.5%
75 and older	8.8%	7.9%	6.9%	7.9%
Race				
White only	97.2%	93.3%	93.7%	94.4%

[1] Data source: 2020 American Community Survey, five-year estimates

Demographic Characteristic	Darke	Miami	Shelby	Tri-County area
Black only[2]	.7%	1.9%	2.5%	1.8%
Other race only	.8%	1.8%	1.5%	1.5%
More than one race	1.2%	3.0%	2.4%	2.4%

Local experts were aware of these demographics, in general. For instance, when asked to think about mental health inequities in the County, most noted the lack of racial diversity. Additionally, several interviewees commented on the "aging out" of the population, noting that many adults were moving away from the area for better economic opportunities.

SECONDARY DATA INDICATORS OF POTENTIAL MENTAL HEALTH INEQUITIES

A review of secondary data suggests that mental and behavioral health are a concern in the Tri-County area, though data located are mostly insufficient for identifying potential mental health inequities. Table 2 presents indicators for which data are available for all three counties.[3] Data may have been obtained from any of the sources listed previously. In each case, the most recent data point for each county is used; this may differ by county depending on the data sources that were located.

Table 2. Mental and Behavioral Health Indicators in the Tri-County Area

Indicator of Mental and Behavioral Health	Darke (pop, 51,387)	Miami (pop, 106,074)	Shelby (pop, 48,610)	Ohio
Residents reporting frequent mental distress	16.4%	Nearly 16%	17%	15.3%
Average days per month mental distress is reported	3.0	At least 5.0	5.4	5.2
Accidental drug overdose deaths / 100,000 people	37.0	21.8	35.8	47.2
Fentanyl related overdose deaths / 100,000 people	30.5	18.9	20.6	N/A
Suicide deaths / 100,000	15.1	15.0	14.0	13.8

[2] "Black only" refers to all people who self-identify as Black; "Other race only" refers to all people who do not self-identify as either White only or Black only. These terms are used here and throughout per Census convention.

[3] A full database of health statistics reviewed will be provided (in Excel format) to Tri-County.

Indicator of Mental and Behavioral Health	Darke (pop, 51,387)	Miami (pop, 106,074)	Shelby (pop, 48,610)	Ohio
people				
Percent of adults who drink excessively / binge drink	18.7	19.0	20.0	21.0
Percent of driving deaths that involved alcohol	37.5	36.8	34.0	33.0
Percent of children living in poverty	17.0	11.0	12.0	17.0
Designated as a Mental Health Professional Shortage Area?	Yes	Yes	Yes	N/A
Ratio of mental health providers to residents	1,381:1	840:1	1,100:1	380:1

Some differences were noted between residents within the counties in the sources located, though these were rare. Gender was the most commonly reported difference:

- In Miami County, women are more than twice as likely to be diagnosed with a mental health disorder (Among respondents to the 2017 CHA, 12.7% of women vs. 5.9% of men reported receiving such a diagnosis).
- In Darke County, men were more likely than women to experience accidental drug overdose (36.6 men per 100,000 adults 20 years of age or older vs. a rate of 22.4 for women, according to their 2020 CHA).

A few other differences were also noted:

- Older residents were significantly more likely to binge drink in Miami County according to their 2017 CHIP.
- In Darke County, residents' poverty status differed based on their race – 51.8% of Black residents and 31.8% of American Indian / Alaskan Natives were living in poverty, compared to 13.2% of White residents, according to their 2015 CHA.

All three counties are in a geographically defined **Mental Health Professional Shortage Area** as designated by the Health Resources and Services Administration, part of the Federal Health and Human Services Administration. This indicates there is less than one psychiatrist per 30,000 people in the area; for instance, there are no psychiatrists in Darke County. One 2021 estimate of the rural MSA containing Darke

County suggested that at least 34% of mental health needs in the county were unmet.

Similarly, in Miami County, a provider survey conducted in 2017 indicated that access to the following services was a moderate to serious problem in the county:

- Substance abuse treatment for youth (cited by 75.9% of providers)
- Mental health care for children aged 17 and under (cited by 73.9% of providers)
- Substance abuse treatment for adults (cited by 68.3% of providers)
- Mental health care for adults (cited by 61.1% of providers)

A review of data provided by the Ohio Department of Mental Health and Addiction Services indicates all three counties offer the same types of crisis services, including crisis intervention teams, a crisis hotline or call center, detoxification services, level 1 acute inpatient psychiatric care, mobile crisis teams, peer crisis support services, and short-term acute residential treatment. In-depth interviewees indicated crisis services may be (poorly) filling the vacuum of mental health services. Citing long waits for counseling and clinical services and lack of options in the community, they said many individuals ended up in crisis and eventually sought more emergent, urgent care at facilities of this type.

Darke, Miami and Shelby counties have officially been designated as Mental Health Professional Shortage Areas by the Federal government. Local providers also cite shortages in staff and services.

UNDERSTANDING AND IDENTIFYING MENTAL HEALTH INEQUITIES

The beginning of the in-depth interviews focused on local experts' understanding of mental health inequities as well as their observations of the inequities that might be present in the Tri-County area.

Awareness of Mental Health Inequities

Although many local experts were not aware of the specific term "mental health inequity," they were able to apply other public health-related concepts to the term. Local experts' definitions included:

- *There is the ability for some individuals to have first, a better ability to handle mental health behaviors (nature / nurture). Some folks just seem to have more resiliency. [It's also] access… There are still some demos in the population, there*

is the perception that there is not help for them or they can't get the help they need. The ability for all clients to access services and treatments that are needed.

- *Inequity means that services are not being provided fairly for everybody. Equality and equity [are] not always the same thing.*
- *Could mean access to services. Could mean not understanding the community that potentially could benefit from the services.*

Notably, some local experts had no idea what the term meant or had incomplete or inaccurate definitions. For instance, one local expert interpreted it to mean differences within mental health treatment and approaches for different types of diagnoses: "I think of barriers to access for certain types of disorders. So, looking at the readily accessible nature of treatment for PTSD or borderline personality disorder. As opposed to more 'standard' mental health disorders."

After the local experts' own definition was explored, a working definition was provided to them for use during the rest of the interview:

> *Behavioral health inequities refer to differences in outcomes and access to services related to mental health and substance misuse which are experienced by groups based on their social, ethnic, and economic status.*

Identification of Tri-County Residents Who May Face Mental Health Inequities

Local experts were also asked to think of any groups of people they encounter as part of their professional or personal life who may be at risk for experiencing mental health inequities. In some interviews, local experts were hesitant to name or discuss different groups of people. This seems to stem in part from an acknowledgment that mental and behavioral health issues can impact anyone at any time. However, there also seemed to be a tendency to be hesitant about misspeaking or overgeneralizing. Local experts would say things like "I don't want to stereotype" or "each individual situation is different." It's possible that a fear of saying the wrong thing about some groups of people may have made it harder for local experts to communicate honestly about differences they have observed, for fear of blaming the victim. **Equipping people with the language and**

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Not all local experts hesitated to discuss the topic, and some became more comfortable during the discussion. In the end, many of the groups identified by the Tri-County Mental Health Inequity Workgroup were noted. Table 3 shows a full list of responses provided by interviewees, along with a rough count of how many local experts mentioned them.

Table 3. Residents of the Tri-County Area Who May Face Mental Health Inequities

	Number of mentions
Children and adolescents	12
SES	11
Racial / ethnic identities other than White	9
LGBTQ+	7
Homeless individuals	4
Residents with disabilities	3
Gender	2
Immigrants or refugees	2

Children and adolescents. Children and adolescents were the most commonly identified group of residents who may be facing mental health inequities. In most cases, these discussions were focused around increasing rates of mental health issues in younger residents, especially anxiety and depression. Local experts also theorized about a lack of basic coping skills, perhaps as an after-effect of the COVID-19 pandemic. Additionally, some local experts saw a breakdown in adults' ability or willingness to parent as part of the problem. Representative comments include:

Younger residents may be facing anxiety, depression, and other mental and behavioral health disorders more frequently. They may also be more open about such issues.

- *Probably our greatest underserved population is teenagers and under… There's a tremendous need among young people for resiliency, coping mechanisms. Kind of astounding to me the things they struggle with… Their struggle is real, I*

don't mean to downplay it. Other populations seem to be able to deal with some of those struggles, but younger people not as much.

- *A lot of the young people I deal with don't have two parents at home who care for them…. they've raised themselves. They need a parent who loves and cares for them and wants the best of them. The breakdown of the family means the lack of constant coaching, mentor perspective, setting boundaries, and guardrails early in life.*
- *Students are struggling. Our young people – a lot of what we're seeing is anxiety and depression… A lot of them are not in any physical location – doing online stuff from home…A lot of people who should be here [on campus], getting the personal connections aren't. That creates an even bigger challenge and trying to help. We… have very well adjusted, upper to middle class students – all the resources in the world. And they are also still struggling with this – they have no motivation to get out of bed, not turning in assignments, etc…The pandemic had an impact that I'm not sure we're going to fully understand for a very long time.*

Additionally, some local experts said they thought the perception that younger residents are struggling may be driven, at least partially, by their willingness to be more open about those struggles. This could be caused by stigma reduction, as discussed later in this report.

Lower SES residents. The second most identified group of residents are those who have lower SES, especially residents living in poverty. They noted that this is driven by several factors, including a lack of transportation, which is problematic in a rural setting; more intense stigma; being underinsured or uninsured; and having lives that do not lend themselves to being proactive about their mental and behavioral health. This may include work schedules that do not allow taking time off and difficulty affording childcare. Representative comments include:

Lower SES residents face significant barriers to achieving optimal mental and behavioral health including reduced access to transportation and childcare.

- *A lot of our clients are low-income individuals. It wouldn't surprise me if it's inequitable there. For a lot of reasons. I think there is stigma, people not believing it, not being able to afford it. A whole host of societal reasons for that. Education, or lack thereof often goes hand in hand with that. There are resources there for people, but sometimes lack of awareness is a big deal. We have programs here, for instance, vaccines for children and infants,*

even if they are free… it's not a priority. That's been my whole career here it's been difficult to engage with people.

- *For lower SES families – access is difficult. They are trying to work and may only be able to do telehealth. Many places don't have good after-hours access. They may be missing work to try to get their kids into services, and their kids have to miss school.*
- *Who has more mental health issues? On the higher end of the wealth gap, I'm not going to know you have mental health issues – you can access services and cover the costs. Wealthier people also get help sooner – noticed over the last three weeks, not the last six months. Poor people put it off because they are hoping it will get better, they talk themself out of stuff because they know it's something that will take them under.*

Homeless residents could potentially be combined with this category. They seem to face a unique set of barriers to access, including more severe diagnoses that are more resistant to treatment, struggles with self-worth that make it hard to engage in therapy or treatment, and comorbid disorders – both mental health and addiction diagnoses, for example.

Non-White Residents. Several local experts noted the racial homogeneity of the Tri-County area, but others acknowledged the need to attend to racial and ethnic differences. Representative comments include:

- *We are 92% Caucasian. Students of color are usually student athletes, living away from home for the first time. They are the ones I worry about the most. They are taught to be strong, be fit, don't admit weakness, and that winning is everything. They also already feel like they stand out and are under a microscope. When male athletes started reaching out, I knew we had a turned a corner, both in terms of need and in terms of outreach.*
- *We don't have a significant amount of disparity at the population level we are a homogenous population – 98 percent White. In our rural community it's kind of difficult to pinpoint specific demographics.*
- *The community as a whole is rather homogenous.*

"We need to do a very good job of demonstrating our commitment to awareness and working within the value system of other people. Talking about and showing our beliefs of non-discrimination"

--Local expert

Some local experts indicated they did pick up on hesitancy on the part of non-White clients or felt providers could be doing more to serve these residents:

- *90 percent of our families are White; we don't get a lot of non-White families. The ones we have are not as open to services. They seem to be more closed, don't want people in their homes.*
- *People working in the system kind of get it but are we really equipping the system well enough to help, for instance, the African American community? There is less community support to follow up with mental health concerns – there may be more stigma, it may harder to talk to some people with different racial identities – there is a higher barrier to entry.*

At least one local expert placed this on the shoulders of providers:

- *I think sometimes in a more rural county, finding treatment that effectively addresses diversity for historically marginalized populations can be tricky… Within racial groups, the barriers to treatment vary from person to person. For some people there is a hesitation to reach out to services from providers who are not the same ethnic identity. Sometimes that's affected by the historical nature of the marginalization. Miami is predominantly a White European county so it's harder to find providers who might have that same lived experience that someone from one of those populations might want out of a provider. One of the primary issues that I've seen with people is that their lived experience in this County is that many White people are discriminatory, and they come to this agency and it's filled with White people. The receptionist is White, the intake worker is White, and many providers are White. We need to do a very good job of demonstrating our commitment to awareness and working within the value system of other people. Talking about and showing our beliefs of non-discrimination.*

LGBTQ+. Several local experts indicated a lack of providers that might be "best fits" for residents who do not identify as heterosexual, CIS-gendered individuals. Local experts indicated a need to find more providers who are competent and comfortable working with these populations.

- *Finding providers who are responsive to the needs of the LGBTQ+ population is something that can be difficult at times.*
- *Depending on gender identity, it can be hard to find appropriate options for care.*

- *This population spans across racial, ethnic backgrounds. Making sure we have a welcoming, inclusive environment is extremely important. Making sure we're recognizing that the name that's on their SS card might not be their preferred name. Being aware and conscious of their preferred gender pronouns, and making sure that as an agency, as a system, we're addressing people in that manner. We're not misgendering or using dead names.*

Note regarding literature review results. Each of the potential groups identified by local experts was echoed by the literature review on mental health equity in a rural context.

BARRIERS TO POSITIVE MENTAL AND BEHAVIORAL HEALTH

Most local experts did not identify specific barriers for different groups of residents, beyond those discussed in the prior section. That said, general barriers to seeking and successfully completing treatment were documented. These are shown in Table 4.

Table 4. Barriers to Mental Health Equity Identified by Local Experts

	Number of mentions[4]
Transportation	18
Stigma	10
Need for specific type of provider	6
Insurance	5
Lack of Child Care	2
Lack of social support	1

[4] Note that four barriers (transportation, stigma, insurance coverage, and availability of appropriate providers) were probed on if not specifically mentioned.

Transportation. It probably is not surprising to note that transportation is seen as a barrier to care in a rural area. Local experts noted that while some options are available in some areas, it sometimes requires advance notice to arrange, which may not work for some residents or in crisis situations. While an increase in telehealth services has helped, not all parts of the Tri-County area have reliable Internet access to support this type of therapy and some mental and behavioral health issues may be more effectively treated in a face-to-face environment.

Transportation is critical for access in rural communities. Advance scheduling requirements may reduce the utility of publicly funded options.

A subset of local experts says their case managers can assist clients in scheduling transportation, either with residents' Medicaid card or with free or low-cost transportation options in the community. Nonetheless this remains the most common barrier cited.

Role of stigma. While nearly half of local experts indicated the stigma attached to mental and behavioral health disorders might have a negative impact on seeking or completing treatment, many others indicated they believed the role of stigma was diminishing, particularly among young people. Representative comments include:

While stigma may have declined, especially for mental health issues and among young people, it remains a barrier for some, potentially including older residents, non-White residents, and for addiction issues.

- *Regarding stigma… if we were to have respected people in the community be very clear about the fact that they struggle, it might help. But that's a hard conversation and I'm not sure how well received that would be in this community. The idea that you buck up and take care of your business is still out there.*
- *Stigma is big. Sad to say… there are anti-discrimination laws about mental health, but I hear story after story of people losing their jobs because of mental issues.*
- *Stigma around mental health and helping – when I'm working with our families, one thing I try to do is help them see that it's beneficial and it's a positive step to take – to talk about things that are troubling you.*

- *Might have the insurance but not want to ask for help. I'm not sure all communities are as comfortable speaking about mental health or seeking help. There is this idea that we are going to take care of this as a family… We're in a very conservative county. Darke is even more conservative.*

Some local experts did tie stigma to two health inequities – notably differences by racial identity and gender:

- [In response to the question if stigma is still a problem] *Particularly among Black men – illness in any shape or form especially something painful or something impedes their ability to function in the world.*
- *I would probably say men, because I think they have the perception that they have to be the strong one, can't show weakness.*

Finally, some local experts indicated they thought the role of stigma had substantially declined in recent years, especially around mental health:

- *As far as drug abuse and mental health, there's definitely been a bit of a decline in general in stigma. When we first started distribution of Narcan, we had a little bit of pushback, now there are absolutely no issues with that all.*
- *I think it's always been there, but we have potentially eliminated the stigma – feel better asking for help.*
- *Definitely think stigma has declined among young people.*
- *Stigma does affect people but it's not one of the primary barriers that I see. As a society we're getting better at recognizing stigma and combatting it – after the opioid epidemic people started to recognize how those issues cut across society. Similar to what you would see anyplace else.*

Need for specific type of provider. Local experts did express problems finding some specific type of providers, especially for people who are dually diagnosed (i.e., with both developmental delays and mental or behavioral health concerns). They also identified services for kids who are sexually abused or younger kids (aged 3 – 5 or nonverbal) as particularly difficult to find.

Role of insurance. Many local experts indicate insurance is not an issue right now, perhaps due to Medicaid expansion. They caution this could change if that expansion is rolled back. Representative responses include:

- *Insurance does not seem to be as big of a barrier for us. Medicaid / Medicare expansion might have helped.*
- *We're pretty well covered now, but that will change when they do the unwinding from pandemic expansion.*
- *We definitely did a good job of utilizing Medicaid expansion. We collaborate well to insure, at least at the family level that - when kids are involved, families are more likely to get on the radar (Childrens' services, schools, etc.). Definitely well above average in using state dollars to get kids into special residential care settings.*
- *We still have some uninsured, but it's not as much as a lot of people think. We have people who can help people navigate the ACA marketplace, help them get enrolled.*

Additionally, some local experts indicated that residents still have difficulty navigating the systems required to secure insurance or access their benefits:

- *Insurance definitely plays a role in what type of facility will take you. Facilities choose who they want to take at intake and depending on your insurance, that can deter somebody from being able to receive services (Medicaid vs. others, for instance).*
- *So right now, it's open enrollment. It's a mess, it's hard to understand even if you're well-functioning. The last people that joined my church were functionally illiterate. Many companies require online. Many don't have access to a computer or don't have internet access or don't know how to use it.*
- *Insurance is really hard to figure out – does it cover, does it not cover? It takes a long time to go through billing cycles…. You might find out you have no coverage for 6 – 7 appointments.*

These barriers were echoed in the results of the literature review. As Table 5 shows, five major categories of barriers to mental health equity in rural communities were uncovered. Specific challenges in **blue** are those that were also identified by local experts. Commonalities between the two sources included: poverty, uninsured / underinsured status, difficulty recruiting and retaining mental healthcare professionals, lack of inpatient mental health services, transportation issues, and stigma.

Table 5. Barriers to Mental Health Equity in Rural Communities from Literature Review

Category	Specific challenge
Financial challenges	**Poverty**
	More likely to be uninsured or underinsured
	Less likely to have health insurance that covers mental health issues
	More likely to have public (i.e., Medicaid) insurance than private, which could cause reimbursement issues
	More likely to have health insurance network inadequacies and limited options for healthcare coverage
Workforce challenges	Nonexistent or insufficient specialized mental healthcare workforce because of: - insufficient demand for services to support ongoing costs of services - **difficulty recruiting and retaining mental healthcare professionals due to lower pay, lack of employment opportunities for spouses, burdensome workload, prior authorization requirements which divert time away from providing healthcare, need to function as a generalist regardless of specialization, insufficient professional resources and support services, lack of supervision, barriers to professional training and development, and feelings of isolation** - rural clinics' prioritization of primary care and chronic disease management over specialized care
	Most rural mental healthcare is provided by primary care physicians, EMS techs, or lay caregivers with no behavioral health specialization, so many people are not diagnosed or are misdiagnosed
	Rural mental healthcare providers tend to have lower levels of education and expertise than their urban counterparts and often lack training in care of the severely mentally ill
	Resistance to referrals among rural residents due to insufficient providers, long waiting lists, and inadequate follow-up
Infrastructure challenges	General lack of mental health facilities; those that do exist in rural areas tend to be state psychiatric hospitals
	Frequent lack of local inpatient mental health services and day treatment programs
	Greater distance from providers/transportation issues

Category	Specific challenge
	Lack of widespread access to broadband, which limits both the ability of planners to acquire demographic data necessary to identify disparities and the ability of patients to access healthcare through telehealth
	Often the only mental healthcare available is offered by local general hospitals with psychiatric units, but rural hospitals have been shutting down
Cultural challenges	**Stigma**
	Fear of loss of privacy or confidentiality
	Lack or inadequacy of mental health knowledge among rural citizens
	Mistrust of behavioral healthcare professionals and/or culture of self-reliance
	Lack of training in how to care for rural patients in a culturally competent/appropriate way; communication barriers and biases

STRATEGIES FOR ADDRESSING BARRIERS TO POSITIVE MENTAL AND BEHAVIORAL HEALTH IN THE TRI-COUNTY AREA

Local experts were asked to provide suggestions for specific actions that TCB could take to attempt to reduce mental health inequities. Table 6 shows the suggestions provided by local experts.

Table 6. Strategies for Reducing Mental Health Inequities Suggested by Local Experts

Strategy	Number of mentions[5]
Education / training / outreach	14
Need for more accessible locations	5
More community / residential treatment options	5
Help recruiting or retaining providers	5
Transportation assistance	4
Translation assistance	3

[5] Note that four barriers (transportation, stigma, insurance coverage and availability of appropriate providers) were probed on if not specifically mentioned.

Strategy	Number of mentions[5]
More convenient / extended appointment hours	3
Child / respite care	3
Bullying / school interventions	3
Establish additional FQHCs	1

The educational/ outreach piece contains a number of related suggestions, including helping the community better understand mental and behavioral health issues and the resources available to buffer them, as well as the need for breaking through issues of distrust, especially in non-White communities. Local experts suggest that community events (common before Covid but now less so) that happen in the places (e.g., churches) where harder to reach residents gather, and creative approaches that gain attention (a MH fair called "I Ain't Crazy!", for instance) might be most successful. As one expert put it, *"Look at culturally competent healthcare. What ports over? Make provision for, what might that look like? It might look like community healthcare. It might look like… pre-Covid, every month on the first Wednesday of the month we would have the Miami County free clinic come do blood pressure checks and diabetes testing. Maybe we need mental health professionals to come in once a month. We're looking at between 30-40 people every day for lunch."*

Local experts also provided suggestions that echoed the barriers they saw in the community: better transportation options, more locations, and hours other than traditional business hours.

Finally, one local expert advocated strongly for the establishment of other Federal Qualifying Health Centers, noting, "*There is an opportunity in this community to establish a FQHC… Think of all the things you could bring underneath that – MH was part of our FQHC. You could come into the health department and go to the social worker, go to the dentist. You could also have satellite locations… the amount of funding that can go into those is large. Money is constantly coming down from the federal government."*

The literature review provided additional suggestions for TCB's consideration. Once again, these strategies echo the data collected in the interviews with experts, either in terms of specific strategies recommended

or those implied by research findings. These strategies tend to be higher-level steps that TCB could encourage.

Table 7. Strategies for Reducing Mental Health Inequities from Literature Review

Category	Specific strategies/notes
Lay the groundwork	The first step is to recognize, reduce, and **openly discuss mental healthcare inequities**. This includes collecting standardized demographic and language data so that subgroups and inequities can be identified, as well as identifying shortages and planning for facilities and telehealth systems that will allow for the recruitment and training of more local providers.
Leverage technology	This can take the form of telehealth, telemental health, DMHIs (digital mental health interventions), etc.
Integrate healthcare	Either provide mental/behavioral health services in the same location as primary healthcare services, or create links between primary healthcare providers and mental/behavioral health specialists to aid the former in providing higher quality mental healthcare
Leverage community resources/create innovative partnerships	Innovative rural partnerships could **tap existing rural resources such as churches, barbers, social and legal service providers, and governmental entities to work with behavioral health professionals to provide services**. The wraparound model, which integrates formal services and interventions, community services, and interpersonal support and assistance from patient social networks, has been shown to help bridge the gap in behavioral health services often noted between urban and rural youth. Local resources such as lay caregivers can be mobilized to provide residential support and health-related care, while members of patients' social networks can be drawn on to provide needed services to those whose access to healthcare services is limited due to geographic and transportation barriers. Social service providers can engage in individual and systems advocacy by expanding their services to help their clients deal with practical and logistical issues such as navigating the criminal justice system, protecting their housing rights,

Category	Specific strategies/notes
	and securing funding to prevent them from becoming homeless. The coordination of services could be facilitated in various ways, from clinical homes to integrated service agency models to intensive case management.
Improve existing workforce	Workers already providing other forms of healthcare in rural communities could receive rudimentary or advanced behavioral health training, depending on their previous training status; for example, such training could be offered to EMS providers, who are often the first responders to rural behavioral health crises but who frequently lack behavioral health training. Rural behavioral health providers could also be trained in Culturally and Linguistically Appropriate Services (CLAS) and CLAS practices could be used in the future hiring of rural behavioral health providers so that culturally appropriate care is provided to rural community members. This could not only provide better care overall but could also reduce the stigma associated with seeking help for mental health issues within certain subgroups, thus increasing the utilization of existing behavioral healthcare services.
Prioritize recruitment & retention	Various strategies could be employed **to improve the recruitment and retention of behavioral healthcare providers in rural communities**. Rural communities could take advantage of residency programs that prepare healthcare providers for working in rural settings, such as the Advanced Nursing Education - Nurse Practitioner Residency program funded by the Health Resources and Services Administration. Public-academic partnerships between the psychiatry department at a major university and a rural area's public mental health system could be set up so that graduates from the academic program complete their residency in the rural area; rural residency programs that last multiple years could also be established. Rural-connected individuals could be recruited into graduate training programs in the mental health disciplines, and rural health-focused didactic and experiential training could be offered to mental health

Category	Specific strategies/notes
	graduate students. Finally, rural communities could offer perks to retain their behavioral healthcare workforce, including higher pay, long-term contracts and a guaranteed salary, hardship pay, family housing, state tax waivers, and medical loan repayment.

ASSETS FOR MENTAL HEALTH EQUITY PLANNING

Local experts identified assets that TCB could potentially leverage when conducting its planning process. The two most common attributes mentioned were a strong community identity that is caring and good collaboration and communication among community partners. Table 8 shows all assets identified by local experts.

Table 8. Assets Identified by Local Experts

Asset	Number of mentions[6]
Community Collaboration / partnerships	15
Caring / giving communities	6
Court programs	3
Small size (less demand for services)	1
Homeless shelter	1

[6] Note that four barriers (transportation, stigma, insurance coverage and availability of appropriate providers) were probed on if not specifically mentioned.

APPENDIX A: IN-DEPTH INTERVIEWS: LOCAL EXPERTS & ORGANIZATIONS

- **Scott Barr**- Director, Shelby County United Way
- **Jeanine Bensmen**- Infant/Toddler & Homebase Coordinator, Council on Rural Services (CORS)
- **Jessica Chambers**- Dean of Student Engagement, Edison State Community College
- **Tonya Clark**- Supervisor, Darke County Board of Developmental Disabilities
- **Pastor Kima Cunningham**- Richards Chapel United Methodist
- **Karen Eberle**- Program Assistant, OSU Extension, Miami County
- **Chuck Gee**- Site Manager, TCN Behavioral Health Services
- **Brian Green**- Supervisor, Miami County Board of Developmental Disabilities
- **Chad Hollinger**- Fire Chief, Sidney Department of Fire and Emergency Services
- **Terry Holman**- Health Commissioner, Darke County General Health District
- **Bruce Jamison**- Chief of Police, Edison State Community College
- **Doug Metcalfe**- Executive Director, SafeHaven, Inc.
- **Kara Pleiman**- Lieutenant/Jail Administrator, Shelby County Sheriff's Office
- **Dennis Propes**- Health Commissioner, Miami County Public Health
- **Steven Pulfer**- Director, Shelby County Department of Job & Family Services
- **Pamela Riggs**- Health Commissioner, Sidney-Shelby County Health Department
- **Diann Rodrigues**- Early Intervention Collaborative Representative, Shelby County Family and Children First Council
- **Roseanne Scammahorn**- Educator, Family and Consumer Sciences, OSU Extension, Darke County
- **Renee Thuma**- Program Specialist, Miami County Community Action Council
- **Bonnie VanGorden**- Director, Miami County Department of Job & Family Services

APPENDIX B: IN-DEPTH INTERVIEWS: DISCUSSION GUIDE

Tri-County MHEI Planning
In-depth interviews

Objective: To better understand the experiences and needs of people in the county who may be experiencing mental health inequities, as identified by the work group and by a review of data about the Tri-County area.

Intro: Hi! My name is Amanda Scott and I'm working with the Tri-County Board of Mental Health in their Equity and Inclusion planning process. As part of that work, we're speaking with people like you to better understand the needs and experiences of people who may face mental health and substance use disorders.

Thank you so much for making time for me in your busy schedule.

Great! Let's get started.

Q1. To begin, what do you think are the greatest mental health and substance use disorders issues facing people in Miami, Darke, and Shelby counties?

Q2. I'd like to understand how you think about mental health inequities. What does that term mean to you?

a. IF NECESSARY: Thank you for that. For the purposes of our conversation today, this is the definition I'd like to use:

   Behavioral health inequities refer to **differences in outcomes and access to services related to mental health and substance misuse which are experienced by groups based on their social, ethnic, and economic status**.

Q3. Now let's combine those two questions. When it comes to the mental health and substance use disorders you identified, who do you think is differentially impacted by those issues?

a. IF NECESSARY: Let's take the issues one by one to make this a bit easier, in your experience, who in your community is more likely to experience [INSERT ISSUE]? REPEAT FOR EACH ISSUE.
b. IF THE GROUP FOR WHICH THE R WAS RECRUITED IS NOT SPECIFICALLY MENTIONED: As I understand it you work with residents who [INSERT DESCRIPTION OF GROUP]. Do you think members of this group are more or less likely to experience mental health and substance use disorders, or not so much? Why or why not?

Q4. How are they differentially impacted?

a. Do you think they are more likely to experience mental health and substance use disorders? Or experience them more acutely? Or something else?

Q5. And taking a step further back… What do you think drives these inequities? What are the forces facing Miami, Darke, and Shelby County residents that lead to these differential experiences?

a. IF NECESSARY: Probe specifically on the role of:
    i. Insurance (lack of coverage, lack of MH coverage, lack of awareness of coverage, lack of providers who take coverage)
    ii. Stigma
    iii. Availability of behavioral health care providers
        1. Are available providers of the right type?
        2. How culturally appropriate are the services available?
    iv. Transportation

Q6. As someone who works with residents who might be facing these challenges, what do you think might help "level the playing field" so that positive mental and behavioral health is more attainable for all residents in the county?

a. To put that question differently, if you were in charge of eliminating mental health inequities, what steps might you take to try to do so?
    i. What specific changes would you make to help eliminate these inequities?
    ii. What specific policies or actions could TriCounty Mental Health Board take?
b. What things about Miami, Shelby, and Darke Counties would make it easier to reduce mental health inequities?
c. What things about Miami, Shelby, and Darke Counties would make it harder to reduce mental health inequities?

Q7. Thank you so much for your time. Is there anything else you think we should know as we continue this planning process?

a. Would it be ok for me to reach out to you if other questions come up as we do this work?

APPENDIX C: LITERATURE REVIEWED

Publication title
A call to action to address rural mental health disparities
A new emphasis on telehealth - how can psychologists stay ahead of the curve and keep patients safe?
A path forward: Mental health and the U.S. pandemic response
A quick start guides to behavioral health integration for safety-net primary care providers
A review of mental health approaches for rural communities: Complexities and opportunities in the Canadian context
A unified vision for transforming mental health and substance use care (CEO Alliance for Mental Health)
Achieving mental health equity
Advancing equity in mental health: An action framework
Management of mental disorders in rural primary care - a proposal for integrated psychosocial services
Behavioral health equity for all communities: Policy solutions to advance equity across the crisis continuum
Behavioral health implementation guide for the national standards for culturally and linguistically appropriate services in health and health care
Barriers to mental health treatment in rural older adults
Bringing equity into the fold: A review of interventions to improve mental health
Behavioral health service delivery for vulnerable populations
Building capacity to enhance behavioral health equity
Center for Psychiatric Rehabilitation - Alternative approaches to mental health care
CMS framework for health equity 2022-2032
Community input and rural mental health planning: Listening to the voices of rural Manitobans
Community interventions to promote mental health and social equity
Community partnering for behavioral health equity: Public agency and community leaders' views of its promise and challenge
COVID-19, structural racism, and mental health: policy implications for an emerging syndemic
Equity of care - a toolkit for eliminating health care disparities
Falling through the cracks: Gaps and barriers in the mental health system for America's disadvantaged children
Funk et al. (2008) - Integrating mental health into primary healthcare
Grant, Bender Simmons, & Davey (2018) - Three nontraditional approaches to improving the capacity, accessibility, and quality of mental health services: an overview
Growing older: Providing integrated care for an aging population
Health care reform and rural mental health: severe mental illness
Health equity, diversity, and inclusion council year in review, July 2021
Health equity, diversity, and inclusion readiness toolkit
Health equity, diversity, and inclusion readiness workbook
HHS health equity action plan
HHS rural action plan

Publication title
Human resource issues in rural mental health services
Improving behavioral health equity through cultural competence training of health care providers
Improving the mental health functioning of youth in rural communities
Integrating social justice advocacy into mental health counseling in rural, impoverished American communities
Transition to a Clubhouse Model- An Approach to Mental Health Recovery
Key Informant Perspectives on Rural Social Isolation and Loneliness
Kozhimannil & Henning (2018) - Racism and Health in Rural America
Mental health and mental disorders - a rural challenge: A literature review
Mental health services for rural elderly: Innovative service strategies
Ohio Department of Mental Health and Addiction Services Strategic Plan 2021-2024
Policy approaches to advancing health equity
Promoting behavioral health equity through implementation of The Incredible Years within primary care
Promoting health and behavioral health equity in California
Promoting health equity through understanding disparities
Resolving key barriers to advancing mental health equity in rural communities using digital mental health interventions
What is rural adversity, how does it affect wellbeing and what are the implications for action? [Rural adversity, wellbeing, implications for action]
Rural mental health ecology: A framework for engaging with mental health social capital in rural communities
Rural mental health overview - rural health information hub
SAMHSA national guidelines for behavioral health crisis care. Best practice toolkit
Telemental health through a racial justice and health equity lens
The role of public health in addressing racial and ethnic disparities in mental health and mental illness
Using e-health to enable culturally appropriate mental healthcare in rural areas
Watanabe-Galloway et al. (2015) - Recruitment and retention of mental health care providers in rural Nebraska: Perceptions of providers and administrators
Workforce capacity for reducing rural disparities in public mental health services for adults with severe mental illness