Targeting High-Need, High-Minority Geographies: Improving Access to Behavioral Health Care

Introduction

Integrated behavioral health or primary care behavioral health, is "*care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse [sic] conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.*"[1]

Preliminary analyses suggest that regions with high levels of poor mental health and larger minority populations have less access to mental health services.[2] This is consistent with literature on disparities in mental health access for minority populations who also have less access to substance use treatment services.[3] Minority populations are also less likely to have health insurance, face higher barriers to accessing primary health care services, and have fewer behavioral health professionals practicing in close proximity to primary care providers in their neighborhoods.[4-5] This research identifies priority areas for addressing racial disparities in access to behavioral health care. Specific aims include identifying high-need areas based on poor mental health and race and exploring primary care, mental health, and integrative behavioral health care capacity in these areas.

The Problem

It is well documented that minority populations have less access to behavioral health services.[3,6] While minority populations have lower prevalence of major depressive disorders, minorities are more likely to have chronic, long-term mental health issues.[7] The prevalence of serious mental disorders has increased over the past decade, [8] along with increases in substance use and mental health issues as a result of the COVID-19 pandemic. Further, all races and ethnicities have experienced increases in opioid-related mortality over the past few years, though minority populations have experienced the most dramatic increase.[10]

Physical and mental health co-morbidities are higher among minority populations.[11] A recent analysis from the Robert Graham Center found that Black populations have higher rates of any mental illness (AMI) and two or more chronic conditions compared to other whites and other racial or ethnic minorities.[12] Black populations with co-morbidities are also less likely to receive mental health treatment.[13-14]

In summary, we know that minorities have less access to behavioral health and primary care services and have higher rates of behavioral health co-morbidities. This, along with the documented benefits of integrative behavioral health, highlight the importance of integrating primary and behavioral health care for improving equity in access to care. Improving these equity issues requires targeted approaches to identify priority areas and explore integrated behavioral health care capacity in these areas.

Our Innovation

We used geographic information systems (GIS) to identify areas with the greatest mental health needs that also had the largest Black populations, while exploring integrative behavioral health capacity in these areas.

Data were integrated from a variety of sources, including the Centers for Disease Control and Prevention (CDC) PLACES dataset,[15] the American Community Survey,[16] the SAMHSA Behavioral Health Services Locator,[17] and the National Provider and Plan Enumeration System (NPPES).[18] We used a co-location mapping approach to identify Black priority counties – defined as those in the highest quintile for poor mental health and the highest quintile for percentage of Black populations. Substance Abuse and Mental Health Services Administration (SAMHSA) integrative primary care facilities and primary care and mental health providers were then mapped onto these areas. Finally, we compared the behavioral health capacity of Black priority counties with other high mental health need counties that had the largest percentage of white populations (highest quintile).

Figure 1: Mental Health Priority Counties

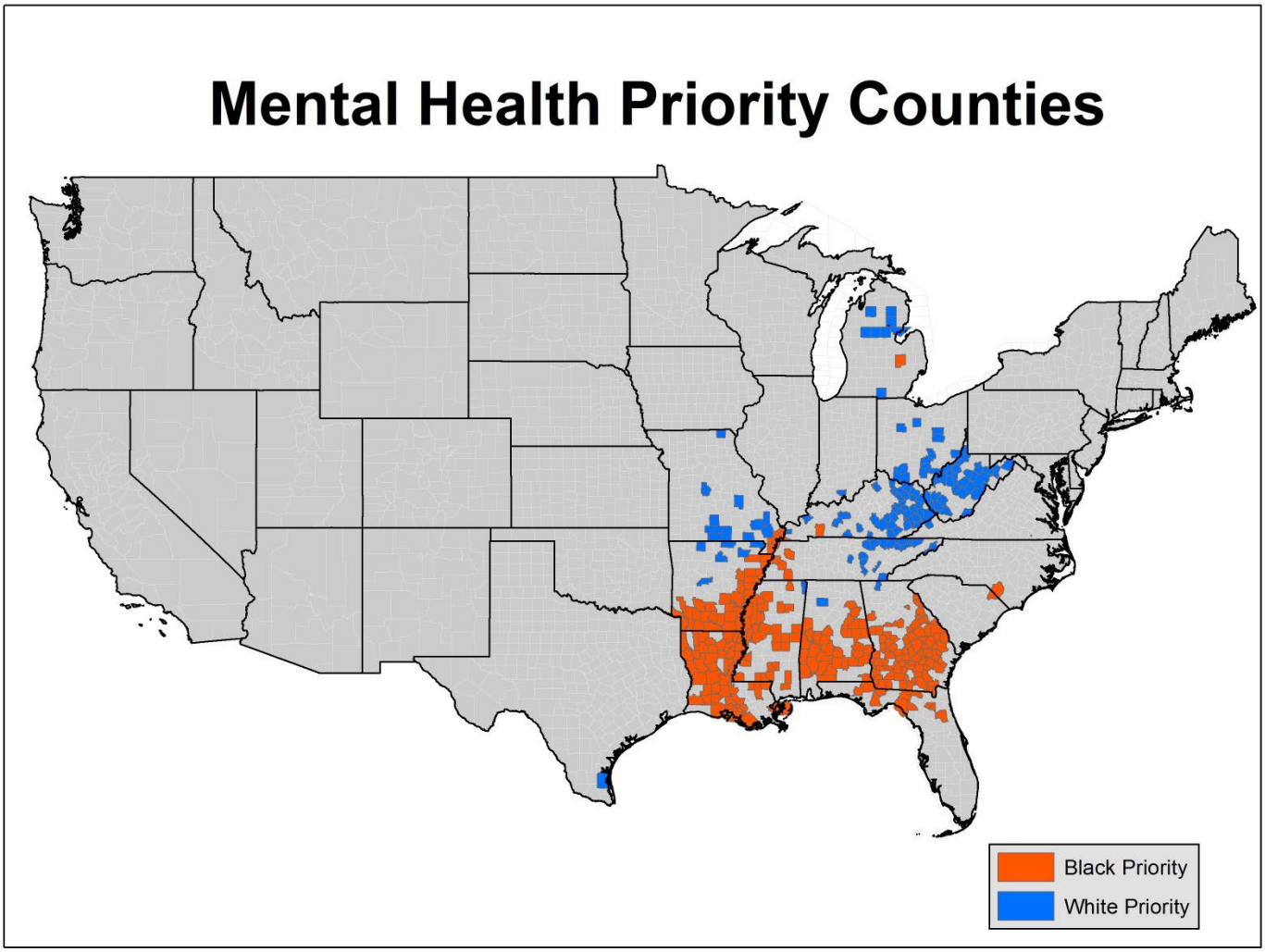

Figure 1 displays the location of 245 Black priority counties – those with poor mental health and larger Black populations. These counties are concentrated in the southeast and Mississippi Delta region, and almost 9 in 10

of these counties are located in five southern states (Georgia [82], Louisiana [44], Mississippi [33], Alabama [32], and Arkansas [29]). Further, Black priority counties are located primarily in non-metropolitan areas, with almost 1 in 5 in the most rural areas.

Also displayed are the location of 133 white priority counties – those with poor mental health and larger white populations. These counties are located primarily in the Appalachia and the Ozarks (Missouri and Arkansas) regions. Roughly 9 in 10 white priority counties are located in four neighboring states within the Appalachia region (Kentucky [39], West Virginia [32], Tennessee [18], and Ohio [13]). White priority counties are located primarily in non-metropolitan areas [80%), with more than 1 in 3 of these counties in the most rural areas.

Table 1 displays access to care, demographics, and health-related characteristics of priority counties. In addition to having higher rates of poverty, unemployment, and other challenges related to social determinants of health, Black priority counties have less access to co-located primary care and mental health providers (IBH practices) and integrative primary care facilities when compared to white priority counties. No differences exist between the two groups for primary care and mental health access to care measures, but both priority county groups have significantly less access when compared to the national average. Black priority counties have significantly higher rates of hypertension, obesity, diabetes, and physical inactivity. In general, white priority counties have significantly smaller populations, are more likely to be located in rural areas, and have significantly higher rates of smoking and smoking-related poor health outcomes (e.g., COPD, asthma).

Table 1: Characteristics of Priority Counties

	Black Priority Counties	**White Priority Counties**	**All**
# of Counties	245	133	3,143
Access to Care			
IPC Facilities per 100K***	1.2	2.5	2.3
IBH Practices per 100K***	2.5	4.5	4.7
PCP per 100K	3.8	3.7	5.2
MH per 100K	10.3	11.1	14.9
% Uninsured***	12.4	8.5	9.7
Demographics			
Population**	31,168	21,145	103,305
Median Age***	39.5	43.5	41.4
% Age 65+***	17.4	19.9	18.8
% Under Age 18**	22.6	21.7	22.3

Table 1, cont.: Characteristics of Priority Counties

	Black Priority Counties	White Priority Counties	All
Race/Ethnicity			
% White Alone***	56.8	97.1	82.9
% Black Alone***	38.8	0.8	9.1
% Hispanic**	4.1	2.2	9.4
% Non-White***	43.2	2.9	17.1
SDOH			
% Unemployed**	7.9	7.0	5.3
% Poverty***	24.3	20.8	15.1
% Single Female HH***	36.6	17.7	19.5
% Rural***	65.4	83.3	58.4
Mental Health			
% Depression***	22.6	27.4	21.2
% Frequent Mental Health Distress	19.1	19.7	15.4
Health Behaviors			
% Binge Drinking*	14.6	14.1	17.0
% Smoking***	24.3	26.6	19.7
% No Physical Activity***	38.9	36.5	30.5
Health Outcomes			
% Fair or Poor Health**	28.3	27.3	21.1
Chronic Conditions			
% High Blood Pressure***	43.1	40.7	34.7
% High Cholesterol***	34.5	35.8	32.1
% Diabetes***	15.5	12.8	11.7
% Obesity**	40.5	39.4	35.5
% COPD***	10.0	12.0	8.0
% CHD***	8.3	9.1	7.0
% Asthma***	10.6	10.8	9.6

This research integrates multiple data sources and uses a co-location mapping approach to highlight disparities for Black populations in accessing mental health care services and the potential for increasing integrative behavioral health in high-need areas.

Next Steps

In addition to exploring co-location mapping methods to identify integrative behavioral health capacity for other minority population groups, future research will identify peer comparison counties that can be targeted for in-depth, qualitative research.

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Authors
Michael Topmiller, PhD, Mark Carrozza, MA, Jennifer Rankin, PhD, Jessica McCann, MA, Jene Grandmont, MA, and Morgan Walker, MS

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