

Access and Quality of Mental Health Services in Rural and Urban America

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KEY FINDINGS

- **Access to Mental Health Facilities:** Nearly 18% of large rural and over 40% of small/isolated rural Zip Code Tabulation Areas (ZCTAs) were located at least 30 minutes from any type of mental health care facility compared to less than 10% of urban ZCTAs.
- **Digital Divide Exacerbating Access:** Both rural and urban ZCTAs located more than 30 minutes away from the nearest mental health facility have a higher proportion of households *without* access to essential telecommunication devices.
- **Quality of Rural Mental Health Facilities:** Rural facilities generally demonstrate better performance compared to urban facilities in terms of continuity of care measures and lower rates of physical restraint and seclusion usage.

INTRODUCTION

Rural mental health and behavioral health

One in five adults and one in six youths experience mental illness each year, and geographic variations exist.^{1,2} Rural residents are more likely than urban residents to experience mental health disorders, or more importantly, serious mental illness — “serious functional impairment that substantially interferes with or limits one or more major life activities.”² In 2019, nearly a quarter of rural residents, about 6.5 million individuals reported having mental illness.²

In addition to higher rates of mental illness, rural areas also face significant challenges with substance use and misuse. Mental health and substance use disorders often coexist, exacerbating each other’s impact on individuals’

well-being if left unaddressed. Individuals combating mental illness often rely on alcohol and tobacco as coping mechanisms.^{3,4} In 2020, 19.2% of non-metropolitan residents smoked compared to 14.4% of metropolitan residents leading to 75% more tobacco smokers per capita in non-metropolitan areas than metropolitan areas.⁵ In 2021, 60.4% U.S. adults in non-metropolitan areas reported alcohol use whereas 68.0% of small-metropolitan and 69.3% of large-metropolitan U.S. adults reported alcohol use indicating a small difference in the substance preference between locations based on rurality.⁶ These substance use patterns can contribute to the development of additional mental health disorders further exacerbating mental health challenges in the United States.^{7,8}

Rural-urban disparities in access to outpatient and inpatient mental health services

Mental health conditions require timely and appropriate treatment. Untreated conditions can result in substance use disorders, unemployment, homelessness, suicide, incarceration, deterioration of physical health, shorter lifespan, and increased co-occurrence of chronic diseases such as diabetes, obesity, epilepsy, cancer, and cardiovascular disease.⁸ However, rural residents face provider shortages at a far greater rate than those who reside in urban areas.⁹ As of March 2025, over 122 million individuals, including 29.3 million residents in rural areas and 53.5 million residents in partially rural areas, live in Mental Health Professional Shortage Areas with nearly 6,202 additional mental health practitioners needed to remove shortage designations.¹⁰ Provider shortages in rural communities have resulted in fewer outpatient mental health visits per year among rural residents.¹¹ The shortfall in visits, particularly among individuals receiving medication, raises access to care concerns. Among Medicare beneficiaries with mental health disorders, telehealth visits improved outpatient care access from 2010 to 2017, but overall urban-rural disparities remain.¹²

The COVID-19 pandemic has increased the need for comprehensive mental health policies to address the mental healthcare workforce, the financing of mental healthcare delivery, and unmet need for mental healthcare among vulnerable populations.¹³ Additionally, the rapid expansion of telehealth services during the COVID-19 pandemic has shaped access to mental health care, a topic explored in more detail later in this brief. Continued reforms in U.S. mental health care should be anchored in evidence-based research and practice. Mental health researchers, practitioners, and advocates would welcome data-driven policy solutions to improve mental healthcare access. Therefore, the purpose of this brief is to document a more recent trend of mental health care access and quality in urban and rural communities.

METHODS

Data Sources & Analysis

Using multiple publicly available national datasets, we profiled the extent of disparities in mental health access and care quality by residence rurality. Both SAMHSA Behavioral Health Treatment Facility Locator and American Hospital Association (AHA) survey data were used to identify mental health care facilities and hospital-based psychiatric units with and without telehealth capacity (Table 1). Services were characterized by residential, inpatient, and outpatient service settings per facility in the locator. Descriptive analyses were used to identify associations between rural/urban communities and selected mental health domain indicators.

Table 1. Facility Data Sets in the Study

Data Set	Year	Facility Included	Facility Excluded
SAMHSA Behavioral Health Treatment Facility Locator	2019	<ul style="list-style-type: none"> • Psychiatric hospitals • General hospitals with a separate inpatient substance use and/or psychiatric unit • State hospitals • Veterans Affairs medical centers • Certified community behavioral health clinics • Partial hospitalization or day treatment facilities • Outpatient facilities provide outpatient substance use and/or mental health services to ambulatory clients (e.g., Federally Qualified Health Center [FQHC]) • Residential treatment centers • Multi-setting mental health facilities • Community mental health centers • Other types of residential treatment facilities[†] 	<ul style="list-style-type: none"> • Department of Defense (DoD) military mental health treatment • Individual private practitioners or small group practices not licensed as a substance use and/or mental health clinic or center • Jails or prisons

AHA	2020	<ul style="list-style-type: none"> Complete universe of hospitals (both parent and subsidiary hospitals) in the United States limiting to those with psychiatric units and/or psychiatric consultation/liaison services 	<ul style="list-style-type: none"> Analysis included only those hospitals that were not in the SAMHSA data and that had either psychiatric units or psychiatric consultations/liaison services
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Notes: † Other types of residential treatment facilities include those that are not licensed as psychiatric hospitals primarily offering customized mental health treatment programs in a residential setting. These types of residential treatment centers are designed to serve a general population and are not limited exclusively to either children or adults.

The main sources of secondary data for this analysis are presented in Table 2. Using the 2019 ZCTA-level American Community Survey (ACS), we derived all residents in each ZCTA area (17,523 urban, 4,737 large rural, and 9,775 small rural or isolated ZCTAs; Table 2) and calculated travel distances from each residential ZCTA centroid (hereafter, residential proximity) to the nearest outpatient and inpatient mental health care facilities in road miles and minutes across all urban and rural ZCTAs. To identify differences in inpatient psychiatric facility quality of care, we used Inpatient Psychiatric Facility Quality Reporting (IPFQR) data at the facility level in January-December 2019 and first two quarters of 2020.

Table 2. Mental Health Domain Measures and the Corresponding Data Sources

	Settings	Measures	Data Sources	Year
Access	Outpatient Care	Residential proximity to the nearest specialized outpatient mental health care settings	SAMHSA BH Locator; ACS data	2019
	Inpatient Care	Residential proximity to the nearest inpatient psychiatric unit	AHA Annual Survey; ACS data	2020
	SUD treatment setting	Residential proximity to the nearest facility offering substance use treatment	SAMHSA BH Locator; ACS data	2020
Quality	Inpatient	<ul style="list-style-type: none"> Hours of physical restraint use Hours of seclusion use Patients discharged on multiple antipsychotic medications with appropriate justification Transition record with specified elements received by discharged patients Timely transmission of transition record Screening for metabolic disorders Follow-up after hospitalization for mental illness 30-day all-cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility Medication continuation following inpatient psychiatric discharge 	CMS IPFQR	2015-2019

RESULTS

Spatial Access to Mental Health Facilities

Figure 1 illustrates the geographic availability of rural and urban mental health facilities by facility services type. Out of the total of 32,021 Zip Code Tabulation Areas (ZCTAs), 6,466 ZCTAs (20.2%) — where approximately 13,630,336 individuals reside, accounting for 4.2% of the U.S. population — require travel times exceeding 30 minutes to reach any type of mental health care facility. Specifically, 19,644 ZCTAs (61.3%) are located more than 30 miles away from mental health facilities offering outpatient services, 16,062 ZCTAs (50.1%) are more than 30 miles away from facilities providing inpatient services (as depicted in Figure 1C), and 20,538 ZCTAs (64.1%) are situated more than 30 miles away from crisis intervention services (as depicted in Figure 1D). The Midwest and West census regions exhibit the highest prevalence of ZCTAs with a lack of mental health facilities within a 30-mile radius. Small rural ZCTAs, across all mental health facility types, demonstrate the longest median driving times to access care, averaging 26.2 minutes to any mental health care facility, 64.3 minutes to an outpatient facility, 51.7 minutes to an inpatient facility, and 66.8 minutes to a crisis intervention team (as detailed in Table 3). In contrast to urban ZCTAs, the majority of large rural and small rural ZCTAs have distances exceeding 30 miles to reach all types of mental health facilities with 2,739 (57.8%) and 8,179 (83.7%), respectively, requiring more than 30 minutes of travel time to access inpatient psychiatric units.

Figure 1. Locations of Mental Health Facilities by Setting or Services

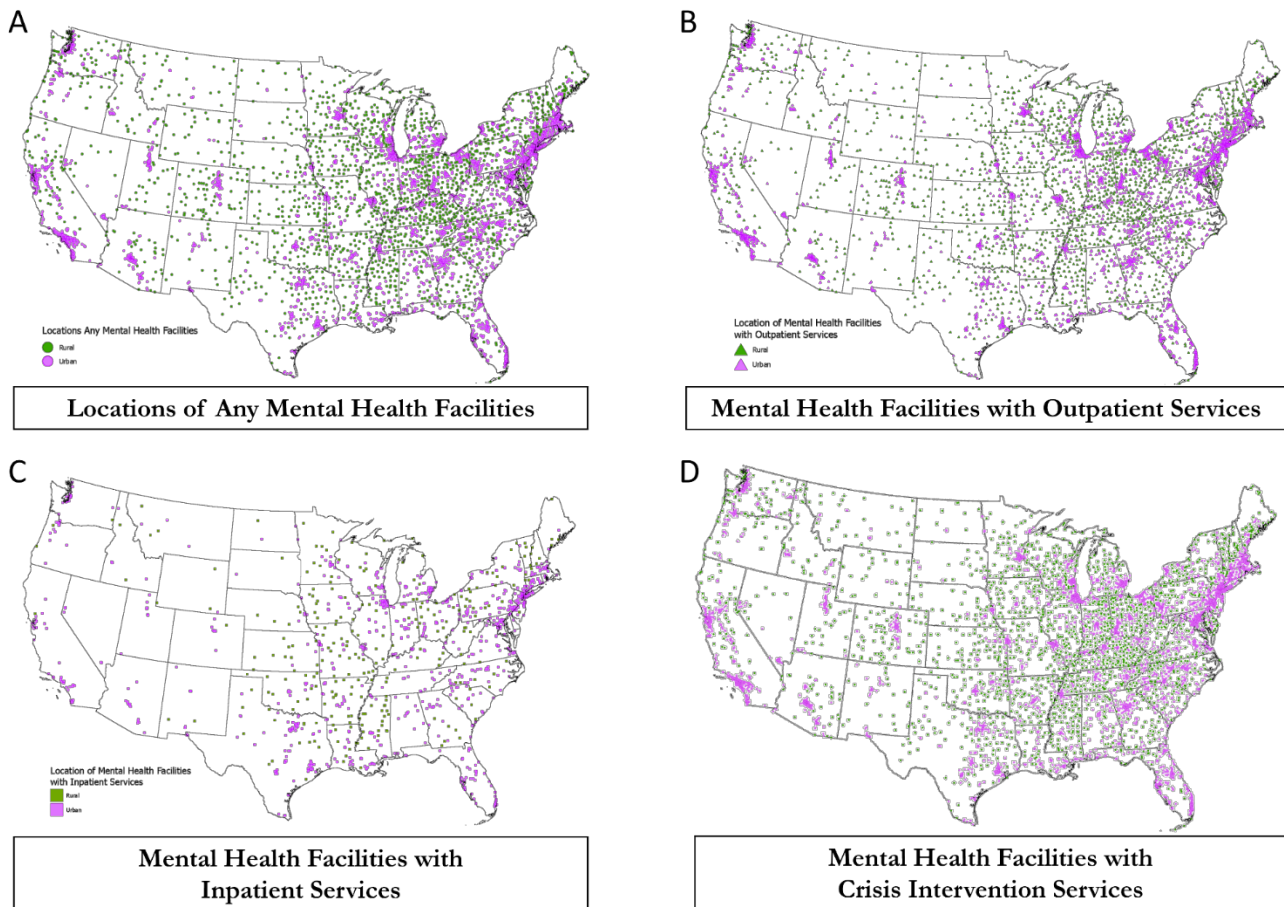


Figure 2. Driving time to any mental health facility and digital health access across ZIP-Code Tabulation Areas in the United States

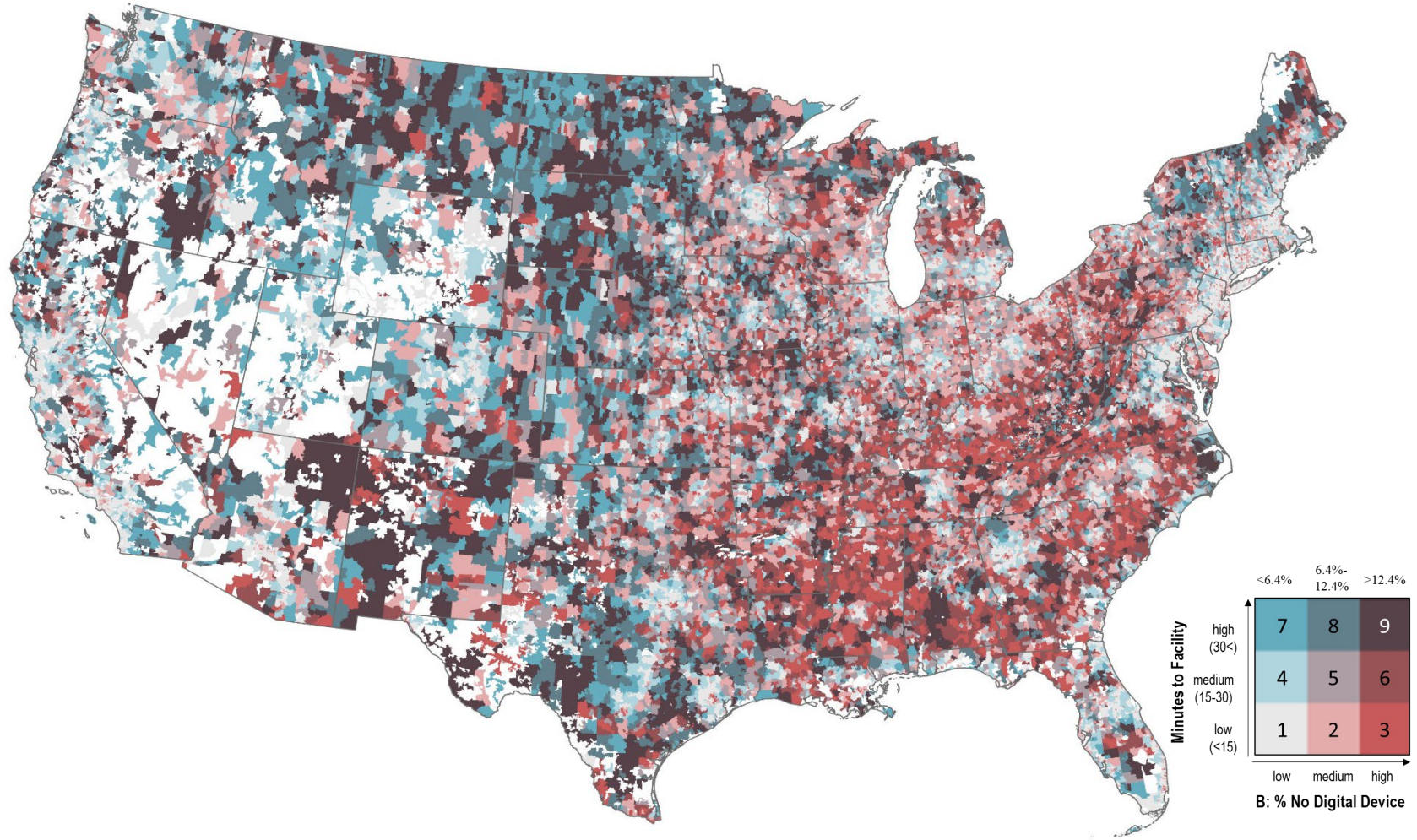


Table 3. Driving Time in Minutes from ZIP Code Tabulation Area (ZCTA) Centroids to Mental Health Facilities by Rurality, 2019-2020

		Urban (n=17,523)	Large Rural (n=4,737)	Small Rural or Isolated (n= 9,775)	P value
Driving time to the nearest mental health facility:					
	Median (IQR)	13.2 (7.7, 20.85)	18.4 (11.7, 26.4)	26.2 (16.9, 34.0)	<.001
Any mental health facility	Number % of ZCTAs > 30 minutes	1,653 (9.4)	829 (17.5)	3,984 (40.76)	<.001
	Median (IQR)	25.9 (14.5, 48.2)	48.4 (29.7, 75.2)	64.3 (40.7, 104.2)	<.001
Any mental health facility with outpatient services	Number % of ZCTAs > 30 minutes	7,655 (43.7)	3,535 (74.6)	8,454 (86.5)	<.001
	Median (IQR)	21.4 (13.7, 32.6)	33.5 (22.3, 50.3)	51.7 (35.8, 78.4)	<.001
Any mental health facility with inpatient services	Number % of ZCTAs > 30 minutes	5,144 (29.4)	2,739 (57.8)	8,179 (83.7)	<.001
	Median (IQR)	28.1 (15.8, 50.05)	52.6 (32.3, 80.6)	66.8 (42.6, 107.0)	<.001
Any mental health facility with crisis intervention services	Number % of ZCTAs > 30 minutes	8,229 (47.0)	3,708 (78.3)	8,601 (88.0)	<.001

Notes: IQR=interquartile. P <.001 calculated from Dunn's multiple comparison tests of equality-of-populations ranks based on Bonferroni tests.

Digital Divide Exacerbating Access to Mental Health Facilities

In 2019, the travel burden to any mental health facility increased with residential rurality (Table 3). There were 3,984 (40.76%) small or isolated rural communities where local residents had to drive more than 30 minutes to reach the nearest mental healthcare facility (P value < 0.001), compared to 829 (17.5%) in large rural communities, and 1,653 (9.4%) in urban communities. As noted earlier, while telehealth and digital interventions hold promise for improving mental and behavioral health outcomes, their success is frequently contingent upon the availability of adequate technological infrastructure (e.g., broadband connectivity and telecommunication equipment). However, in ZCTAs located more than 30 minutes away from the nearest facility (Figure 2), a significantly larger proportion of households lacked access to essential technological resources. Specifically, 759,954 households (14.7%) did not have computers, 1,448,886 households (28.0%) did not have smartphones, 2,491,417 households (48.2%) did not have tablets, and 1,295,290 households (25.0%) did not have broadband subscriptions. In contrast, in ZCTAs within 15 miles of a psychiatric facility, the percentages were considerably lower: 8,521,842 households (9.3%) lacked computers, 17,681,067 households (19.3%) lacked smartphones, 36,654,985 households (40.0%) lacked tablets, and 15,335,834 households (16.8%) lacked broadband subscriptions.

By residence rurality, compared to urban areas, large rural and small/isolated rural areas were more likely to lack digital tools including *no computers* (11.0% in urban, 15.8% in large rural, and 16.9% in small/isolated rural), *no smartphones* (22.5% in urban, 29.9% in large rural, 33.0% in small/isolated rural), and *no broadband subscription* (19.3% in urban, 26.5% in large rural, and 27.8% in small/isolated rural; all p<.001).

Table 4. ZIP Code Tabulation Area (ZCTA) Characteristics, 2019 American Community Survey, by Rurality

	Urban		Large Rural		Small or Isolated Rural		P values
	17,523		4,737		9,775		
Total ZCTAs	271,197,521		28,236,543		22,766,229		
Total Population	Mean	SD	Mean	SD	Mean	SD	
Population Demographic characteristics							
% Age ≥65 years	17.7	9.7	20.1	10.3	22.9	12.1	<.001
% Married	50.8	13.5	52.6	13.3	55.1	13.5	<.001
% Female	50.4	5.6	49.6	7.1	49.3	7.0	<.001
Race and ethnicity							
% Non-Hispanic White	80.2	21.2	87.7	17.7	89.2	17.8	<.001
% Non-Hispanic Black	10.0	17.2	6.5	15.5	4.2	12.5	<.001
% Hispanic	8.7	10.7	5.4	8.8	4.9	8.4	<.001
% Non-Hispanic Asians	3.4	6.7	0.6	1.4	0.5	1.6	<.001
% Non-Hispanic Indigenous / Alaska Native	0.8	4.7	1.5	6.8	2.7	11.4	<.001
Household Characteristic							
Total Households	100,281,059		10,808,621		8,950,508		<.001
<i>Socioeconomic Characteristics</i>							
% 200% below Federal Poverty Level	29.7	16.8	36.0	16.1	36.3	16.5	<.001
Median household income	43,039	14,898	35,156	8,641	34,999	9,292	<.001
% Uninsured	7.9	6.9	9.1	8.3	9.2	8.5	<.001
% Unemployed	5.1	5.0	5.2	5.8	5.2	7.5	.26
<i>Household Occupancy</i>							
% Households with more than 1 occupant per room	2.6	4.4	2.3	4.0	2.2	4.3	<.001
<i>Household Digital Access</i>							
% No computer	11.0	9.2	15.8	11.4	16.9	11.8	<.001
% No tablet	42.3	14.0	49.6	14.0	51.8	14.5	<.001
% No smartphone	22.5	11.9	29.9	13.5	33.0	14.3	<.001
% No broadband subscription	19.3	12.8	26.5	14.5	27.8	14.6	<.001

Notes: SD=standard deviation. Data obtained from the 2015-2019 American Community Survey. P values were calculated using one-way analyses-of-variance (ANOVA) adjusted for multiple comparisons based on Bonferroni tests. The American Community Survey classified all desktops, laptops, tablets, and smartphones, along with selected computing technologies such as smart home devices and single board computers, as computers based on responses received through write-ins.

Facility Characteristics of Psychiatric Units by Rurality, 2019

Among the 1,644 hospitals with inpatient psychiatric capability in 2019, approximately 76% were located in urban areas, while 16% were situated in large rural areas, and 8% were located in small or isolated rural areas. In comparison to the urban inpatient psychiatric facilities, rural facilities exhibited significant differences in several key aspects. Specifically, rural hospitals were more likely to function primarily as general medicine and surgery hospitals rather than specialized psychiatric hospitals. Additionally, rural facilities had a higher prevalence of being publicly owned rather than

privately owned (both with $p < 0.001$). In terms of capacity, rural hospitals had fewer beds compared to their urban counterparts. They were also less likely to be accredited, serve as teaching hospitals, provide alcohol or drug dependency services, or have affiliations with larger healthcare systems.

Rural-Urban Differences in Psychiatric Care Quality

Rural facilities demonstrated superior quality score performance compared to urban facilities in 2019, exhibiting higher scores on continuity-of-care measures and lower rates of physical restraint and seclusion usage. Throughout the study period, rural facilities consistently outperformed urban facilities in transition record management, physical restraint use, and seclusion use. However, there was substantial variation in the quality scores of inpatient psychiatric care across facilities. Low-performing facilities provided only 47% of patients with detailed discharge information and transmitted only 31% of patient records in a timely manner for post discharge visits while high-performing facilities achieved rates of 97% and 92%, respectively. Notably, urban facilities exhibited greater variation in quality compared to small or isolated rural facilities.

Alcohol Brief Interventions

The introduction of the IPFQR program has yielded positive outcomes in the delivery of alcohol interventions within both rural and urban healthcare facilities during hospital stays and at discharge (Table 5). Encouragingly, urban communities have made significant progress and are closing the gap with large rural and small/isolated rural communities. Specifically, in urban facilities, the alcohol intervention rate during the hospital stays rose from 79% in 2016 to 90% in 2019 compared to stable rates in small/isolated rural facilities which rose from 91% in 2016 to 92% in 2019. Furthermore, the rate of alcohol interventions at discharge increased from 65% in 2017 to 75% in 2019 in urban facilities. The rate in small/isolated rural facilities increased from 70% in 2017 to 83% in 2018 but fell to 78% in 2019.

Tobacco Cessation Interventions

Following the implementation of the IPFQR program, both rural and urban healthcare facilities have shown improvements in their provision of tobacco cessation interventions during hospital stays and at discharge. Notably, small/isolated rural facilities have increased their tobacco cessation intervention rate during hospital stays from 80% in 2015 to 94% in 2019 (Table 5). Similarly, the intervention rate at discharge witnessed a substantial increase, rising from 50% in 2016 to 81% in 2019.

Transition of Care and Patient Restraint Use

Small or isolated rural units performed better compared to urban units on timely transmission of transition records (mean marginal difference 522.5, 95% CI 56.3–38.8). Physical restraint or seclusion use was less likely in rural than in urban units (OR 50.6, 95% CI 50.5–0.8).

Follow-up Care

Notable disparities of the quality of psychiatric care between rural and urban areas were observed during the period from 2015 to 2019. Specifically, facilities situated in small or isolated rural ZCTAs experienced a greater decline in the average rates of 30-day follow-up care decreasing from 60.7% in 2015 to 48.8% in 2019. In comparison, urban facilities demonstrated a smaller decrease declining

from 54.6% to 49.2% during the same period. Similar trends were also observed for 7-day follow-up rates. Furthermore, there was a reduction in the proportion of patients being discharged while prescribed multiple antipsychotic medications across all units with appropriate justification between 2016 and 2018.

Table 5. Facility Performance on Tobacco and Alcohol Interventions, 2019, by Rurality

Measure	Median Facility-level Annual Performance (%)					% change (baseline to 2019)
	2015	2016	2017	2018	2019	
Tobacco Intervention During Hospital Stay						
Urban	73	84	87	87	88	3.4
Large rural	78	89	90	93	90	6.1
Small or isolated rural	80	90	90	90	94	3.1
Tobacco Intervention at Discharge						
Urban	-	46	57	59	65	4.0
Large rural	-	58	67	69	69	4.6
Small or isolated rural	-	50	66	74	81	7.1
Alcohol Intervention During Hospital Stay						
Urban	-	79	88	90	90	3.3
Large rural	-	83	90	93	92	5.6
Small or isolated rural	-	91	90	91	92	3.5
Alcohol Intervention at Discharge						
Urban	-	-	65	73	75	4.4
Large rural	-	-	68	76	72	8.4
Small or isolated rural	-	-	70	83	78	9.6

DISCUSSION

Access to Mental Health Facilities

Access to mental health facilities is a significant concern in the United States. Approximately 20.2% of ZCTAs with a population of over 13 million people require travel over 30 minutes to reach a mental health care facility. The Midwest and West census regions were identified as having the highest prevalence of ZCTAs lacking mental health facilities within a 30-minute drive. Small rural areas experience longer median driving times to access outpatient (64.3 vs. 25.9 minutes) or inpatient (51.7 vs. 21.4 minutes) mental health care compared to urban areas.

The persisting challenge of accessing mental health care, particularly in rural and remote areas, highlights the need for targeted and sustained efforts to address these access disparities.

Collaborative care models, which integrate mental health services into primary care settings, have demonstrated potential in making mental health services more accessible.¹⁴ Indeed, prior systematic literature review of Collaborative Care Models has shown significant improvements in medication use, patient satisfaction, reduced emergency psychiatric visits, and mental health quality of life for patients with depression or anxiety.¹⁵ However, the initial implementation of mental health parity laws that require health insurance plans to provide equal coverage for mental health services has led to an increased use of mental health specialty services over primary care services.¹⁶ These data, along with our findings on substantial geographic disparities in mental health care access facing rural

isolated communities, reveal a patchwork of access to these services. While parity laws aim to improve affordability, addressing these geographic gaps in access may require additional strategies such as provider capacity building and incentives for the integration of behavioral health care into primary care settings in these underserved rural communities.

Rural hospital closures and shrinking psychiatric beds¹⁷⁻¹⁹ present additional challenges in the current mental health care landscape.²⁰ Between 2010 and 2024, 150 rural hospitals closed with many others reducing inpatient psychiatric services.¹⁷⁻¹⁹ The discontinuation of rural hospitals and psychiatric units exacerbates the already pressing issue of limited access to essential mental health services particularly in rural and underserved areas. To address rural hospital closures, Congress has allowed Critical Access Hospitals and small rural hospitals to convert to Rural Emergency Hospitals, as established under Section 125 of the Consolidated Appropriations Act 2021, in exchange for ending inpatient hospital services. Rural Emergency Hospitals must offer emergency and observation care and may offer other outpatient services based on the needs of their community. Therefore, Rural Emergency Hospitals cannot help address access to inpatient psychiatric treatments for rural individuals experiencing severe mental illness.

To address access to acute mental health care, SAMHSA launched the 988-crisis-hotline that provides immediate support to individuals in mental health emergencies.²⁰ While the hotline represents a critical entry point to care access, its rapid implementation has highlighted the persistent gaps in the availability of mental health infrastructure. The surge in call volume has underscored the limited capacity of the current community-based mental health services. Addressing these compounded challenges will need an extensive effort to enhance the mental health workforce and reimbursement structures to expand and optimize community-based interventions such as telepsychiatry services.

Digital Divide Hinders the Promise of Telehealth or Telepsychiatry in Rural Communities

The digital divide exacerbates the challenges of accessing mental health facilities in remote areas. ZCTAs located further away from the nearest mental health facility had more households lacking access to essential telecommunication resources such as computers, smartphones, tablets, and broadband subscriptions. This digital divide further compounds the difficulties faced by individuals in rural communities limiting their ability to access telehealth services and other digital mental health resources. While telemedicine and telepsychiatry have emerged as innovative solutions to bypass geographical barriers, thereby improving access to mental healthcare services^{21,22} particularly in rural areas,¹² it is essential to recognize that these are not substitutes for inpatient psychiatric programs. The role of telehealth is complementary, aimed at bridging gaps in access rather than replacing the comprehensive care provided by inpatient psychiatric services.

Our findings that rural areas have longer drive times and lower digital access via digital devices and broadband subscriptions are particularly salient given recent policy changes to telehealth utilization catalyzed by COVID-19. To facilitate the use of needed mental health services in a rapidly changing health care environment, state-level policies like payment parity for telehealth services and Medicaid reimbursement for audio-only telehealth services were adopted within the United States. Specifically for mental health care, compacts like the Psychology Interjurisdictional Compact (PSYPACT)²³ and the Interstate Medical Licensure Compact (IMLC)²⁴ allow participating states to enable psychiatrists

to practice across state lines via telehealth improving the shortages of mental health professionals in states where rural and frontier area residents had to travel substantially further for mental health care.²¹ In fact, rural areas have the potential to benefit most from these policy adoptions. In a 2023 study looking at whether policy adoption increased the odds of mental health treatment facilities offering telehealth services, rural counties were found to have significantly greater likelihood of having a treatment facility that offered telehealth services compared to the urban facilities.²² This shows the effectiveness of telehealth expansions on increasing availability of mental health services in rural America.²⁵ However, despite the increased supply availability of telehealth or telepsychiatry services, rural residents faced significant barriers to effective telehealth uptake for mental health care both before and during the COVID-19 pandemic when telehealth services expanded rapidly nationwide. At the end of December 2020, 27% vs. 34% of rural vs. urban veterans received video telehealth services for mental health care.²⁵ This rural-urban telehealth uptake disparity is aligned with our findings that rural residents are less likely to have broadband connections or digital devices. Increasing telehealth supply without parallel investments in digital infrastructure and literacy initiatives might be insufficient to reach individuals in need of services.²⁶

Public policy has tried to address some technical aspects of the digital divide, especially broadband gaps, through the Department of Agriculture (USDA) and the Federal Communications Commission's (FCC's) Rural Digital Opportunity Fund (RDOF).²⁷ Although more recent policy changes may be increasing access beyond what we could measure with our dataset, the 2021 Infrastructure Act marked a shift in funding magnitude for broadband expansion. The Act provisions for broadband infrastructure were larger than those of the FCC and USDA, the primary sponsors of broadband capacity before this Act implementation.²⁸ Notably, the Affordable Connectivity Program, included in the Infrastructure Act, provides subsidies to help low-income families with the cost of broadband connectivity.²⁹ The Act's Broadband Equity, Access, and Deployment (BEAD) program, with over \$42 billion allocated, dwarfs the funding of the FCC and USDA programs combined.³⁰ This significant federal commitment, along with affordability initiatives like the now-expired Affordable Connectivity Program, shows ongoing efforts to bridge the digital divide. Our findings highlight the need for continued research to monitor the impacts of these investments aimed at closing gaps in broadband subscription and access particularly in rural areas.

Inpatient Psychiatric Care Quality

With regard to the quality of inpatient psychiatric care, our study found rural mental health facilities generally demonstrate superior performance compared to urban facilities on continuity of care and reduced use of physical restraints and seclusion. Less variations in care quality exist in rural facilities than in urban facilities. Key quality improvement programs, including the IPFQR program, evidence-based practices and treatment guidelines,³¹ and comprehensive staff training and education programs,²³ have been implemented to enhance clinical skills and promote patient safety. Emphasis has been placed on patient-centered care, approaches to individualized treatment plans, and shared decision-making.³² Regular monitoring and evaluation of care quality indicators have been undertaken to identify areas for improvement. It is encouraging to see an improving trend in tobacco cessation interventions during hospitalization and at discharge especially in small rural facilities. However, substantial variation remains highlighting the need to address barriers in lower-

performing facilities and maintain consistent, evidence-based, and patient-centered practices through ongoing quality monitoring particularly in screening, brief intervention, and referral to treatment (SBIRT) for alcohol use disorders. However, the high variation across inpatient psychiatric facilities, as indicated in our findings, suggests that identifying the barriers and facilitators in the low performing facilities is imperative to maintain consistent implementation of evidence-based practices and treatment guidelines across all inpatient psychiatric units. Continuous monitoring and evaluation of care quality indicators are crucial for identifying areas that need interventions to reduce variations in care quality and foster patient-centered approaches.

Limitations

This cross-sectional study examined availability of mental health facilities and the inpatient quality during 2015-2020 and did not capture changes and developments over time after a certain year.³⁵ A reliance on self-reporting facility capacity for crisis intervention services and telehealth services leads to potential bias due to the dependence on a respondent's ability to recall past events and experiences accurately.³⁶ Furthermore, the lack of standardization of what constitutes a brief intervention may result in some institutions reporting positively that a "brief intervention" was performed whereas a different institution performing identical behavior may not consider a "brief intervention" to be conducted.³⁷ Finally, only having quality measures from inpatients provides an incomplete representation of the broader population as an inpatient setting and patient population is vastly different to the setting and population of outpatients in need of psychiatric care.³⁶

CONCLUSIONS

The study underscores the disparities in mental health access and care faced by individuals in rural communities. It emphasizes the need for comprehensive strategies to address the challenges of access, the digital divide, and variations in care quality. Over the past decade, significant federal initiatives, such as increased funding for Health Centers to include behavioral health services,^{38,39} the introduction and expansion of Certified Community Behavioral Health Clinics (CCBHCs),^{40,41} and the extension of Medicare coverage for telehealth services,⁴² have aimed to bridge access gaps. These efforts raise critical questions about their effectiveness in addressing rural access disparities. Additionally, the ongoing national push to integrate behavioral health with primary care warrants further investigations of its implementation rate in rural and urban communities. Addressing these rural disparities in access to mental health care and the digital divide requires targeted interventions, stakeholder collaborations, and continued assessments of policy impacts to optimize resource allocations for mental health services and outcomes for individuals in rural areas ultimately promoting overall well-being in these communities.

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