WESTERN**POLICYBRIEF**
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USING HOMES TO IMPROVE BEHAVIORAL HEALTH OUTCOMES IN THE RURAL WEST

By Brandn Green, JG Research and Evaluation

"Continued efforts to link housing, and a varied understanding of housing to care and need, may provide one strategy to help those working to improve outcomes for members of their rural communities."

SUMMARY

- Housing is intertwined with well-being and health. For those who have a behavioral health condition, housing can be unstable, uncertain, and hopefully, a location for recovery. In this brief, the varied ways that housing interacts with behavioral health are presented and placed within the current policy context of Medicaid expansion.

RECOMMENDATIONS

- In states that have expanded Medicaid, use the Health Home in innovative ways to deliver culturally appropriate behavioral health care in rural places.
- In states that have not expanded Medicaid, view the housing and health nexus as an opportunity to reduce costs and improve patient outcomes.

INTRODUCTION

Home. This simple concept elicits some of our most fundamental attachments and commitments. Home does not necessarily correspond to housing. Housing is more complicated, as it reflects the intersection of the personal and the bureaucratic. All housing in the United States is structured by government. In this way, housing is one of the few political topics that touches us all, even those without one.

Substance use disorders and mental illness effect 55.9 million Americans. The overlap of housing and behavioral health is an emerging area of scholarly research and policy priorities. In states that have expanded Medicaid and are using innovative funding structures to provide housing as a health intervention, the overlap offers potential return on investment and improved health outcomes for members of our communities.

BEHAVIORAL HEALTH OF RURAL GEOGRAPHIES

The prevalence of substance abuse and mental illness are comparable across rural and urban geographies. A rural resident, however, is less likely to utilize behavioral health care, is less likely to remain in treatment once a treatment program is initiated and is more likely to live in a medically underserved area than his or her urban counterpart. Practical challenges for accessing behavioral health care extend beyond care system capacity, as the distances to care in many rural places, and the associated stigma and social proximity of small communities, act as disincentives for the pursuit of mental health care.

HOUSING AND BEHAVIORAL HEALTH CARE

Housing integrated with mental health services and health delivery could become an essential component for improving rural behavioral health care systems. Rural residents are much more likely to receive their mental health care directly from a primary care physician, even when the primary care physician is without any professional training in mental health (Williams et al., 2015). If we extend this observation, could it be that behavioral health care in the home setting might even further benefit rural residents?

Mobile health programs, where emergency medical technicians provide basic care to frequent utilizers within their homes, have been shown to lower cost burdens within local emergency responder systems. Considering how to provide behavioral health care, medication maintenance for substance use disorders and pharmacological supports for individuals with mental illness, using a similar model has potential to improve patient outcomes and efficiencies in care delivery.

An understanding of the home as a location of care is one of five models for how housing overlaps with behavioral health and emotional well-being. The following summaries integrate perspectives from researchers, federal agencies, and policy makers who have been working on housing and behavioral health within rural settings.

HOUSING AS CARE

The most direct way housing overlaps with behavioral health is as the location where one receives treatment or mental health care. In a range of settings, including but not limited to residential treatment centers, transitional living spaces, institutions and in-home care, the concept of home is mobilized as the setting for behavioral health care. Often, these settings have a mixture of formal and informal strategies connecting patients' continued access to housing with continuation with treatment.

HOUSING AS FAMILY

Healthy families are foundational to healthy mental health development and the acquisition of healthy substance utilization behaviors. If the physical structure of the home is unsafe or if the loss of a home occurs during childhood, the developmental process is negatively affected. In the most severe situations of danger, child and protective services remove the child from the home, thereby protecting him or her from the adverse impacts of the family system.

Emotional danger exists in a home where there is abuse, partners engaging in adverse substance usage or when informal caretaking exacts an emotional tone on household caregivers. In these scenarios, the home may become a place to flee and avoid. The trauma enacted within the home may adversely impact the mental health of the individual who may, in response, increase or change the nature of their substance usage. Rural settings add an additional layer of geographic isolation to the home that may exacerbate or create mental illness in situations of trauma.

HOUSING AS DANGER

The physical characteristics of the home, be they lead paint, rickety stairs or a lack of sunlight, present a wide array of physical danger when the quality of the home is substandard. These risks might be heightened in rural contexts where ramshackle housing is more likely to remain classified as usable property, rather than being condemned, due to a lack of oversight and difficulty in viewing rural properties. In the ways that physical danger enhances stress, it runs the risk of having a deleterious effect on mental health. Exposure to environmental hazards might create or exacerbate mental illness, especially in children.

HOUSING AS DISTRESS

A systematic review of all studies examining the impact that home foreclosures had on mental health found that those with a personal experience of home foreclosure had higher levels of depression, anxiety, alcohol use, psychological distress and suicide (Tsai, 2015). Extending foreclosure beyond the home and to property, including farm land, the effects of economic downturns and mental health crises remind us of the 1980s farm crisis and the suicide clusters of farmers. The home itself and the stress associated with trying to keep the home exacerbate preexisting mental health conditions and tend to worsen substance usage patterns.

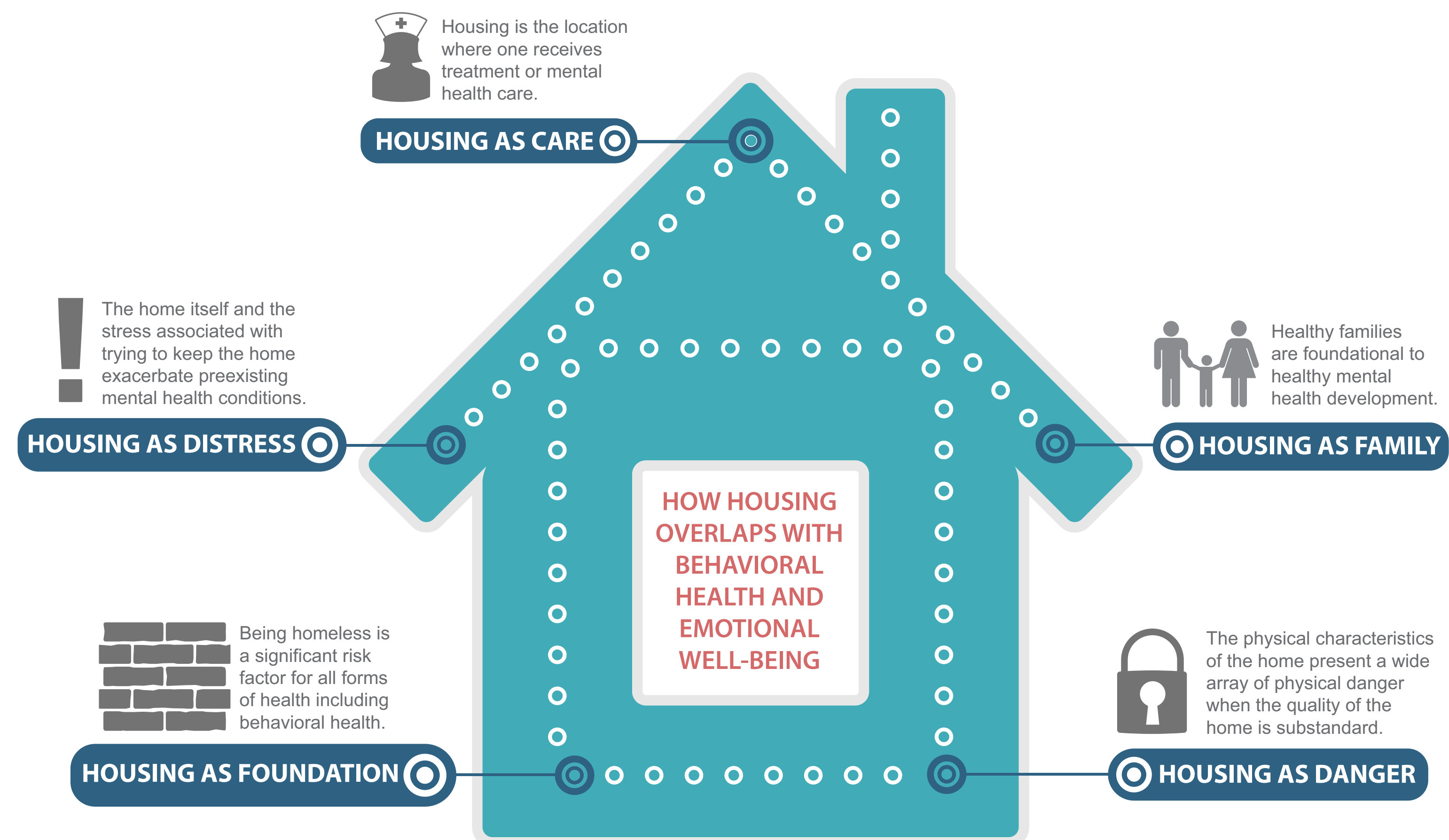
In times of financial hardship, mental wellbeing and an increased likelihood to engage in adverse substance abuse behavior can be exacerbated by a lack of behavioral health care. Conceptualizing housing as the primary source of emotional distress, when it reflects personal need, shifts the nature of psychological care beyond counseling and includes, for example, advising patients about debt relief options. At a time of dairy price fluctuations and the possibility of variable agricultural commodity prices, anticipating how and where to deliver debt counseling, relief options, and linkages to mental health services could prevent a repeat of the 1980s farm crisis.

HOUSING AS FOUNDATION

Being homeless is a significant risk factor for all forms of health including behavioral health. The concept of the Housing First model is to provide housing to the homeless before asking them to participate in substance abuse treatment programs. The state of New Mexico was the first state to orient their attempt to address homelessness around the provision of housing. This model has been implemented in a wide range of locations and is receiving wide-spread support among federal and state agencies tasked with providing care for the homeless.

Permanent supportive housing provides the same undesignated length of stay and provides support services for individuals with a diagnosed Serious Mental Illness (SMI) who receive disability. Concerns exist about the level of funding that is provided for these individuals, as a recent analysis has concluded that there is not a single housing market in the United States where an individual on disability could find affordable housing when affordable housing is defined as 30% of overall household income.

For vulnerable populations, be they homeless, transitioning out of an institutional setting or veterans, the pursuit of housing and the need to negotiate between shelters and doubled-up living arrangements while navigating the public assistance system can result in extended periods of uncertainty and housing insecurity. In this situation, especially in rural communities, where transportation costs and arrangements can be harder to manage, Housing First models have begun to highlight how stable, reliable, no-strings-attached housing is necessary for wellbeing. It is the foundation upon which an individual can move toward independent living and mental health.



POLICY IMPLICATIONS

States vary greatly in both the ways they manage specific federal programs and in the extent to which they have developed state-specific supported funding for housing programs (TAC, 2014).

Medicaid reimbursement structures are set by states with waiver authority and reimbursement mechanism options provided by the Centers for Medicare and Medicaid Services (CMS). CMS provides general instruction and outlines how three broad goals are supported for housing those with behavioral health needs: individual transition housing services, individual housing and tenancy sustaining services. There are also often state-level housing services. In addition to these options, health homes can be developed for individuals with serious mental illness. As of the end of State Fiscal year 2017, the only states in the Western region to have implemented health homes had been New Mexico and Washington state (KFF, 2018). California recently reported the opening of the first health home in the state located in San Francisco.

Health homes are mechanisms for coordinating care for people with chronic conditions, including the presence of one serious and persistent mental health condition. Rural health clinics can provide the care that is covered by health home reimbursements, including comprehensive case management, care coordination, and a whole person approach to improving outcomes. Service delivery in rural areas will be complicated by distance and a potential lack of medical professionals; however, reimbursements can cover virtual teams and the broad integration of expertise toward care provision. It is worth examining how linkages with primary care providers in rural settings, where behavioral health care and chronic disease care is most often occurring within rural communities, can link to the funding reimbursement structure of the health home for states that have expanded Medicaid.

CONCLUSION

Behavioral health care systems can best provide culturally appropriate care in rural settings by recognizing that challenges are produced by the benefits of rural life. Housing systems that enhance behavioral health in the rural context must reflect rural preferences while providing care in line with the current state of the science. New models for reimbursement to the newly covered Medicaid populations may offer opportunities for turning the tide on behavioral health outcomes, which in many rural communities have not improved and have in fact declined over the past twenty years throughout the United States. Continued efforts to link housing, and a varied understanding of housing to care and need, may provide one strategy to help those working to improve outcomes for members of their rural communities.

ABOUT THE AUTHOR

Brandn Green (brandng@gmail.com) is co-owner and principal researcher for JG Research and Evaluation. His integration of rural sociology with social epidemiology began in his first professional appointment at Bucknell University where he directed a program focused on the social dimensions of the environment. Dr. Green attended Bucknell University as an undergraduate, completed a Masters of Divinity degree at Wake Forest University, and a PhD in Rural Sociology and the Human Dimensions of Natural Resources and the Environment at Pennsylvania State University.

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