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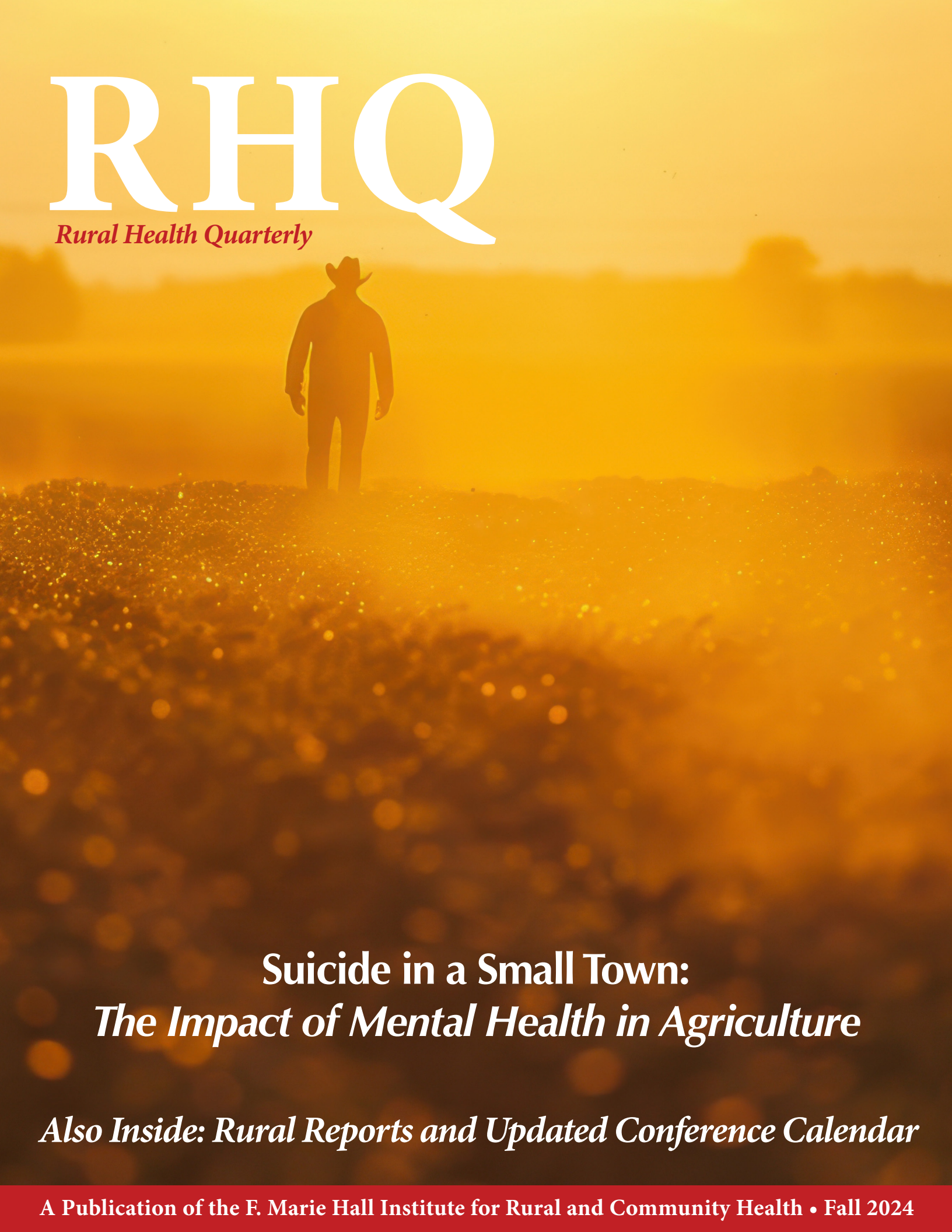
Rural Health Quarterly



Suicide in a Small Town:
The Impact of Mental Health in Agriculture

Also Inside: Rural Reports and Updated Conference Calendar

A Publication of the F. Marie Hall Institute for Rural and Community Health • Fall 2024

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Fall 2024

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CARE ACCESS

RURAL LIVING

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Rural Health Quarterly

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Rural Mental Health – A Crisis Wrapped in a Dilemma

BILLY U. PHILIPS, JR., PhD

PUBLISHER
Executive Vice President, Division of Rural Affairs, and Director, F. Marie Hall Institute for Rural and Community Health

"I don't believe it!" That's what I heard nearly everywhere that I went for days afterward. A funeral is often a big social event and a family reunion among West Texas people because the person being remembered is old, and their passing isn't that unexpected. Of course, there are notable exceptions, such as when fallen warriors were laid to rest having given all in one or another of our wars or when some sick soul decides to invade a school and shoot kids and their teachers. But this time, it was different when a seasoned old cowboy familiar with guns died from an 'accidental' shooting while cleaning a shotgun. "It happens," someone said, citing Earnest Hemingway's untimely demise. No one was buying that, and no one was saying what everyone thought, which was that it was a suicide. "Tough old cowboys don't do that!" That was the unspoken sentiment. Farmers are not immune, either.

About one-fifth of the U.S. population, or 60 million, lives in rural areas, and about 7.7 million people have a mental illness. That is very similar to the urban prevalence of mental illness. According to an article from the Office for Disparities Research and Workforce of the National Institute of Mental Health, however, rural populations experience significant disparities in mental health outcomes. Generally, this has been the pattern in many chronic conditions, and it persists for many reasons dealing with access to care, availability of services, affordability linked to more restrictive payment options, and acceptability related to small-town culture.

In thinking back, I realized that what I had read in the Rural Health Information Hub on the topic of rural mental health was right about several of the risk factors that were present in the case I described above. Old tough cowboys have been known to do some drinking and in this modern age of other drugs, some become addicted to substances in their own medicine cabinet or that of a well-intended neighbor or family member. Another risk is isolation and loneliness. West Texas covers half the landmass of Texas, and approximately half that landmass, or 131,000 sq. miles, is home to a growing population, with most of those 3.1 million people living in communities with a population of less than 5,000.

Many folks live more than an hour from the nearest mental health providers because almost all of West Texas counties are designated by the HRSA as Mental Health Workforce Shortage areas. Provider shortages put further strain on a system that is already overloaded. Transportation seems to be an age-old problem. Moreover, one thing you learn quickly when you grow up in a small rural community is that news travels faster than cars, and everyone knows something about everyone else's business. That's a bigger problem than might be appreciated in an urban area because it impacts things like stigma, mental health literacy, and culturally and linguistically responsive care.

When we consider the issues surrounding rural mental health disparities, we are left with a crisis wrapped in a dilemma and are faced with the best bad choice. With social media, we live in an age of too much information, and much of it is only partially true or patently false. There are no easy solutions. Yet, with all of this information, and now, with new tools like AI, the expectations are being poorly managed. There are so many risk factors and challenges to overcome. There's also an urgency that forces choices that are often not the most complete, but that can be afforded among all healthcare needs.

Back to my story about the tough old cowboy in my hometown. Back then and in that time and place, we had no less difficult choices. After his passing, our community came together to find solutions to gain the peace we desperately needed with such a loss. The pastors in the churches preached about mental illness and what to do about the spiritual crisis of suicide. The schools began teaching kids how to recognize early signs and ways to be more kindhearted. And there was a lot more talk around the barber and beauty shops about all the problems and what needed to be done. I remember a new family moving into town and it turned out that the mom was a social worker and the dad ran the senior center. In other words, we couldn't bring back our friend but we sure as heck were determined to do all we could to not have that happen again in our town. Nowadays, we have much more scientific and organized ways for communities to address mental illness. The Rural Health Information Hub offers two resources that address mental health and suicide prevention. They are the Mental Health in Rural Communities Toolkit and the Rural Suicide Prevention Toolkit.

Rural, small-town folks are somewhat accustomed to fending for themselves. Indeed, the most innovative solutions are often found in times of scarcity. We don't have enough time or money to do it all and there is no magic bullet for mental illness and suicide. Look at the challenge this way, if we need to fix a problem then we have to recognize it as a problem and we have to want to do something to fix it. Community-centric solutions are well known to be the only things that really do work and they often lead to the next step that will work. That is why I like toolkits – out in rural America – we often use a toolkit to fix things that need fixin'. Anyway, it's a start.

RURAL REPORTS

RURAL HEALTH REPORTING

FROM ACROSS THE NATION

AND AROUND THE WORLD

ALABAMA //

Clarke County's Grove Memorial Hospital recently converted to a Rural Emergency Hospital, signaling the closure of one of the area's last birthing units. Without the hospital's labor and delivery services, women will be forced to travel to Selma, Montgomery, Mobile, or Bay Minette.

al.com | 07.10.24

ALASKA //

The Della Keats precollege program, on hiatus since 2018, won a $1.3 million grant from the Indian Health Service, which will help provide healthcare professions outreach programming to students from kindergarten through high school. The grant is expected to fund the program for the remainder of the decade.

alaskabeacon.com | 07.08.24

ARKANSAS //

$9 million from various state sources was recently allocated to four rural hospitals. One source, the state's Rural Hospital Sustainability Program, was founded with the goals of strengthening rural communities, promoting economic development, and preserving access to healthcare.

kait8.com | 07.03.24

ILLINOIS //

The USDA Food and Nutrition Service, in conjunction with Full Plates Full Potential and the Illinois Public Health Institute, awarded the state $10 million in grants as part of the USDA's $100 million Healthy Meals Incentives Initiative, empowering schools to serve healthier meals.

usda.gov | 07.10.24

KANSAS //

A webinar was recently presented by Thrive Allen County, a Kansas nonprofit organization dedicated to rural revitalization. The webinar focused on the ways in which community-driven work in impoverished, underserved rural areas can improve local infrastructure, which, in turn, has the power to promote public health.

Thrive serves Allen County's 13,000 residents, about half of whom live in rural areas. "We pivot when necessary, which is often," said Lisse Regehr, Thrive's president and CEO.

dailyyonder.com | 07.11.24

AUSTRALIA

A platform for enhancing hospital communications, currently used in Sydney, will soon be implemented in rural and remote areas. This expansion, powered by eHealth NSW, seeks to improve communications for 70 ambulance stations and a dozen hospitals, better allowing paramedics and clinicians to provide diagnoses and share urgent information.

healthcareitnews.com | 07.12.24

CANADA

Canada's federal government plans to invest nearly $50 million toward improving healthcare workforce planning. This will include research on how healthcare workers might be best supported.

$22.5 million in funding will be dedicated to Health Workforce Canada to improve the accessibility of healthcare workforce data. $13 million will aid in expanding the National Registry of Physicians, while $330,000 will go toward improving physician licensing standards and processes.

hcamag.com | 07.12.24

CHINA

Ted Chaiban, UNICEF Deputy Executive Director, recently led a series of engagements targeted at building cooperation between the organization and its partners in China. These efforts are focused largely on providing children in "humanitarian situations" and other developing countries with services and supplies.

"This agreement is an exciting opportunity to bring improved health services to more children in African countries, through the power of collaboration," said Chaiban.

reliefweb.int | 07.17.24

KENTUCKY //

Four Kentucky counties—Breathitt, Jessamine, Lee, and Nelson—were recently certified as Recovery Ready Communities, having established addiction services for more than 122,000 residents. These services include peer support, mental health and addiction care, and assistance in finding employment.

kentucky.gov | 07.11.24

MONTANA //

The University of Montana received $1.8 million to partner with rural school districts in addressing the healthcare workforce shortage. Current programs include pre-apprenticeships and opportunities for high school students to earn college credits.

umt.edu | 07.15.24

NEW MEXICO //

The state's Department of Health has expanded treatment options for opioid use disorder, including medication-assisted treatment alongside existing mental health and harm reduction services. Outpatient treatment for the disorder, originally limited to clinics in Albuquerque, Las Cruces, and Roswell, is now offered in 30 public health offices across the state.

publicnewsservice.org | 07.15.24

NORTH CAROLINA //

The Centers for Medicare and Medicaid Services recently awarded the state's Department Health and Human Services $2.5 million to expand school-based behavioral health services. "Schools provide a unique opportunity to connect students with behavioral health services by reducing barriers like cost, transportation, and missed work for parents or caregivers," said Secretary Kody Kinsley.

witn.com | 07.18.24

OKLAHOMA //

A mobile cardiology clinic, founded in 2015, continues to provide services to 14 rural and Native American communities across the state. "We try to make our services easily accessible and develop lasting bonds with the communities we serve," said Dr. Jim Melton, a vascular surgeon who cofounded the program.

cardiovascularbusiness.com | 07.10.24

TEXAS //

Alongside the declaration of a Public Health Emergency, the Centers for Medicare and Medicaid Services announced additional resources and flexibilities in response to Hurricane Beryl. These provisions include special insurance enrollment opportunities, access to disaster toolkits, assistance in maintaning dialysis care, and more.

cms.gov | 07.12.24

DENMARK

Beginning in 2030, Denmark will tax livestock farmers for the greenhouse gases emitted by their cows, sheep, and pigs. Though this measure seeks to target a major source of methane emissions, no other country has instituted such a policy.

"We will take a big step...in becoming climate neutral [by] 2045," said Jeppe Bruus, Taxation Minister. According to the UN Environment Program, livestock account for approximately 32 percent of the methane emissions caused by humans.

health.wusf.usf.edu | 06.27.24

GERMANY

Researchers in Melpitz, Germany, recently discovered that wood- and coal-burning stoves contribute to significant levels of harmful air pollution, even in small rural areas. Smoke from sources like wood and coal contains polycylic aromatic hydrocarbons, which are known carcinogens.

thecooldown.com | 05.30.24

IRELAND

The Tech2Heal project at Atlantic Technological University in Donegal has been awarded €1.4 million to improve rural health. Researchers will examine work-life balance and find ways to address inequalities and enhance patient outcomes.

siliconrepublic.com | 06.26.24

Suicide in a Small Town: The Impact of Mental Health in Agriculture

AMBER C. PARKER

Amber C. Parker is Lead Writer at the F. Marie Hall Institute for Rural and Community Health.

We hear all of the time about the ongoing suicide epidemic that's gripping the U.S. veteran community, with an estimated 22 veterans taking their own lives every day. However, veterans are not the only group dealing with excruciatingly high suicide rates. America's farmers, ranchers, and others who work in agriculture are also in a deep crisis.

The CDC says the agriculture industry has the fourth highest suicide rate (44 deaths per 100,000 people) of any occupation group in the U.S. In general, rural residents have higher rates of depression, substance abuse, and completed suicide. While they're responsible for producing the nation's food and fiber, farmers are three and a half times more likely to die by suicide than the general population, according to the National Rural Health Association (NRHA). The farmer suicide rate may be even higher because many may disguise their suicides as farm accidents.

Regardless of location, there's a whole host of reasons someone struggles with mental health issues. Agriculture is largely influenced by factors that are out of the control of a single farmer or rancher. These include weather, livestock disease, pests, market prices, interest rates, and even work-related accidents. One study from researchers at the University of Georgia showed the top stressors for farmers are operating costs, commodity prices, and drought.

•

Depression and all mental illness are legitimate medical conditions but are often seen as a weakness or flaws. Much of the stigma is a result of this unwarranted shame, which only adds to the burden. To cope with the weight of their illness, many people may turn to drugs and/or alcohol. The addiction only adds to the problems.

National statistics show that adults in rural areas have higher rates of use for tobacco and methamphetamines, and the number of opioid users has grown in towns of every size. According to the CDC, opioid painkillers are prescribed for about 20% of farmers and farmworkers after they're injured and can't work. A recent study shows about 75% of farmers reported being directly affected by opioid misuse, addiction, or overdose either themselves, within their family, or among the community population. Almost 77% said they could easily access opioids without a prescription.

The high rate of gun ownership in rural areas may contribute to the higher suicide rate. The Pew Research Center found that nearly half, or 47%, of rural residents say they own a gun. Of all the ways to take your own life, firearms have the highest fatality rate with between 82.5% and 96.0% of all gun-related attempts being lethal. In 2020, CDC data show the rural gun death rate was 28% higher than that in urban areas. In Montana, in 2019, the suicide rate was twice that of the national rate, and about 60% of them involved a firearm. In addition, rural residents end up in the emergency room for nonfatal self-harm incidents at a higher rate than people in the cities.

•

Many people, urban and rural, struggle with depression and/or thoughts of suicide in silence. The work-life for farmers and ranchers is often spent isolated from others. They are independent and are more unlikely to ask anyone for help. A 2022 study in the American Journal of Industrial Medicine found that nearly half of all farmers who take their own lives are older than 65 years old. Researchers found older

farmers and ranchers were more likely to have physical health problems, while younger ones were more likely to have relationship problems.

Many farmers may feel that their stress or mental health challenges are their fault because their own life is wrapped into their role as a farmer. Some avoid asking for help simply out of fear. They think by asking for help, others will consider them weak and a failure. Some studies show many farmers are reluctant to seek mental health care, partly because they think therapists or doctors couldn't understand their lives.

As for many Americans, people who work in the agriculture industry may simply lack health insurance, and if they do have health insurance, it doesn't cover mental health.

Experts suggest limited access to mental health services and a reluctance to seek help could be associated with the elevated risk of suicide.

Increasing awareness of mental illness may be one way to overcome the stigma in rural communities. Experts say talking openly with others about lived experiences with mental health challenges helps to normalize the conversation and diffuse the stigma surrounding mental illness. The simple act of sharing stories can be an important first step for people to seek help for their own mental health challenges and encourage others to admit that they are struggling.

But finding help may be easier said than done. The National Institutes of Health says more than 60% of rural Americans live in designated mental health provider shortage areas. For many folks, telemedicine provides a lifeline that's not only convenient, it's also more private, especially in small towns where everyone seems to know everybody. It helps reduce the stigma and the shame of walking into a building where people know it's the therapist.

During recent town hall meetings in several rural West Texas counties, community leaders expressed the desperate need for more mental health providers, especially addiction counselors. For example, Comanche County, which is home to about 13,000 people, only had less than ten Licensed Chemical Dependency Counselors between 2017 and 2021. That's according to data from the Texas Department of State Health Services. In 2017, the county had five counselors and that number dipped to four in 2018. The county only had three addiction specialists in 2019, but the number increased to four in 2020 and 2021.

Like many rural communities throughout the U.S., Comanche County also does not have enough social workers to deal with people in need. In 2017, the county had only two Licensed Clinical Social Workers, but that number declined the following year to just one, and that held steady between 2019 and 2021. In the same years, Comanche County had only one Licensed Master Social Worker.

Comanche County had less than ten Licensed Professional Counselors between 2017 and 2021, going from seven for three years before dipping to just five in 2020 and down again to four in 2021. In the same years, the county only had one Licensed School Psychology Specialist to help the county's children and teens with mental distress.

While the Veterans Administration and Defense Department have set up programs to help our veterans struggling with mental illness, the U.S. Department of Agriculture has also created a helping hand. It's the Farm and Ranch Stress Assistance Network (FRSAN), and it's broken down into four regions. It's a resource farmers and ranchers can use to help deal with stressful times. It connects farmers, ranchers, and other agriculture workers to assistance programs and resources. Through funding from the program, state departments of agriculture, state extension services, and non-profits could establish helplines, provide suicide prevention training for farm advocates, and create support groups.

One study from the University of Georgia showed that any suicide prevention programs aimed at farmers need to be tailored to the unique characteristics of the farming life. It found that any program needs to include messaging that stresses "you're not alone" and the need to educate people close to farmers, including the spouses, ag extension agents, and other farmers.

Farming in America has been, and will continue to be, a high-stress profession that requires farmers and their families to be highly adaptable and resilient in the face of uncertainty.

If you or someone you know may be experiencing a mental health crisis, contact the National Suicide & Crisis Lifeline by dialing "988" or the Crisis Text Line by texting "HOME" to 741741. You can also call the AgriStress Helpline at 833-897-2474.

The Mahaska Health hospital in Oskaloosa, Iowa, includes a building built in 1928. The facility was expanded in the 1960s, during a rural-hospital building boom fueled by federal incentives. Such expansions coincided with the baby boom, during which hospitals handled a surge in births. The annual number of babies born to Mahaska County residents has dropped by more than half since the baby boom's height. *(TONY LEYS/KFF HEALTH NEWS)*

Rural Hospitals Built During Baby Boom Now Face Baby Bust

**TONY LEYS,
KFF HEALTH NEWS**

Tony Leys, rural editor/correspondent, is based in Des Moines, where he worked 33 years as a reporter and editor for the *Des Moines Register*. Tony was the *Register*'s lead health care reporter for more than 20 years and served four terms as a board member for the Association of Health Care Journalists. He is an alum of the University of Wisconsin-Madison and the Knight Science Journalism program at MIT.

OSKALOOSA, Iowa — Rural regions like the one surrounding this southern Iowa town used to have a lot more babies, and many more places to give birth to them.

At least 41 Iowa hospitals have shuttered their labor and delivery units since 2000. Those facilities, representing about a third of all Iowa hospitals, are located mostly in rural areas where birth numbers have plummeted. In some Iowa counties, annual numbers of births have fallen by three-quarters since the height of the baby boom in the 1950s and '60s, when many rural hospitals were built or expanded, state and federal records show.

Similar trends are playing out nationwide, as hospitals struggle to maintain staff and facilities to safely handle dwindling numbers of births. More than half of rural U.S. hospitals now lack the service.

"People just aren't having as many kids," said Addie Comegys, who lives in southern Iowa and has regularly traveled 45 minutes each way for prenatal checkups at Oskaloosa's hospital this summer. Her mother had six children, starting in the 1980s, when big families didn't seem so rare.

"Now, if you have three kids, people are like, 'Oh my gosh, are you ever going to stop?'" said Comegys, 29, who is expecting her second child in late August.

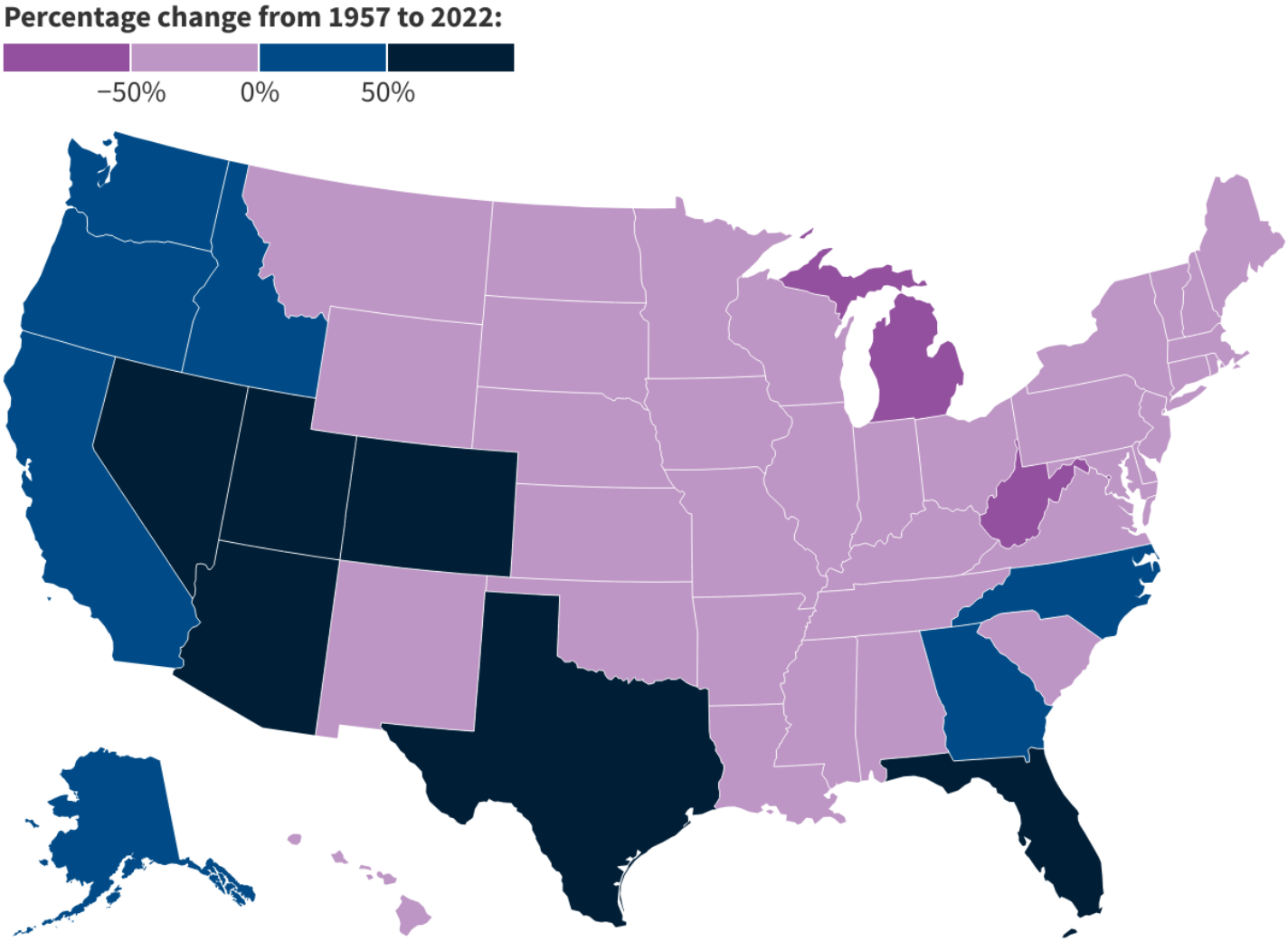
These days, many Americans choose to have small families or no children at all. Modern birth control methods help make such decisions stick. The trend is amplified in small towns when young adults move away, taking any childbearing potential with them.

Hospital leaders who close obstetrics units often cite declining birth numbers, along with staffing challenges and financial losses. The closures can be a particular challenge for

pregnant women who lack the reliable transportation and flexible schedules needed to travel long distances for prenatal care and birthing services.

Births Down in 37 States and DC Since 1957

The baby boom peaked in 1957, when about 4.3 million children were born in the United States. The number of births dropped to below 3.7 million by 2022, even though the overall U.S. population nearly doubled over that same period.



Source: U.S. Centers for Disease Control and Prevention
Credit: Lydia Zuraw/KFF Health News

The baby boom peaked in 1957, when about 4.3 million children were born in the United States. The annual number of births dropped below 3.7 million by 2022, even though the overall U.S. population nearly doubled over that same period.

West Virginia has seen the steepest decline in births, a 62% drop in those 65 years, according to federal data. Iowa's births dropped 43% over that period. Of the state's 99 counties, just four — all urban or suburban — recorded more births.

Births have increased in only 13 states since 1957. Most of them, such as Arizona, California, Florida, and Nevada, are places that have attracted waves of newcomers from other states and countries. But even those states have had obstetrics units close in rural areas.

In Iowa, Oskaloosa's hospital has bucked the trend and kept its labor and delivery unit open, partly by pulling in patients from 14 other counties. Last year, the hospital even managed the rare feat of recruiting two obstetrician-gynecologists to expand its services.

The publicly owned hospital, called Mahaska Health, expects to deliver 250 babies this year, up from about 160 in previous years, CEO Kevin DeRonde said.

"It's an essential service, and we needed to keep it going and grow it," DeRonde said.

Many of the U.S. hospitals that are now dropping obstetrics units were built or expanded in the mid-1900s, when America went on a rural-hospital building spree, thanks to federal funding from the Hill-Burton Act.

"It was an amazing program," said Brock Slabach, chief operations officer for the National Rural Health Association. "Basically, if you were a county that wanted a hospital, they gave you the money."

Slabach said that in addition to declining birth numbers, obstetrics units are experiencing a drop in occupancy because most patients go home after a night or two. In the past, patients typically spent several days in the hospital after giving birth.

Dwindling caseloads can raise safety concerns for obstetrics units.

A study published in JAMA in 2023 found that women were more likely to suffer serious complications if they gave birth in rural hospitals that handled 110 or fewer births a year. The authors said they didn't support closing low-volume units, because that could lead more women to have complications related to traveling for care. Instead, they recommended improving training and coordination among rural health providers.

Stephanie Radke, a University of Iowa obstetrics and gynecology professor who studies access to birthing services, said it is almost inevitable that when rural birth numbers plunge, some obstetrics units will close. "We talk about that as a bad event, but we don't really talk about why it happens," she said.

Radke said maintaining a set number of obstetrics units is less important than ensuring good care for pregnant women and their babies. It's difficult to maintain quality of care when the staff doesn't consistently practice deliveries, she said, but it is hard to define that line. "What is realistic?" she said. "I don't think a unit should be open that only delivers 50 babies a year."

In some cases, she said, hospitals near each other have consolidated obstetrics units, pooling their resources into one program that has enough staffers and handles sufficient cases. "You're not always really creating a care desert when that happens," she said.

The decline in births has accelerated in many areas in recent years. Kenneth Johnson, a sociology professor and demographer at the University of New Hampshire, said it is understandable that many rural hospitals have closed obstetrics units. "I'm actually surprised some of them have lasted as long as they have," he said.

Johnson said rural areas that have seen the steepest population declines tend to be far from cities and lack recreational attractions, such as mountains or large bodies of water. Some have avoided population losses by attracting immigrant workers, who tend to have larger families in the first generation or two after they move to the U.S., he said.

Katy Kozhimannil, a University of Minnesota health policy professor who studies rural issues, said declining birth numbers and obstetric unit closures can create a vicious cycle. Fewer babies being born in a region can lead a birthing unit to shutter. Then the loss of such a unit can discourage young people from moving to the area, driving birth numbers even lower.

In many regions, people with private insurance, flexible schedules, and reliable transportation choose to travel to larger hospitals for their prenatal care and to give birth, Kozhimannil said. That leaves rural hospitals with a

larger proportion of patients on Medicaid, a public program that pays about half what private insurance pays for the same services, she said.

Iowa ranks near the bottom of all states for obstetrician-gynecologists per capita. But Oskaloosa's hospital hit the jackpot last year, when it recruited Taylar Swartz and Garth Summers, a married couple who both recently finished their obstetrics training. Swartz grew up in the area, and she wanted to return to serve women there.

She hopes the number of obstetrics units will level off after the wave of closures. "It's not even just for delivery, but we need access just to women's health care in general," she said. "I would love to see women's health care be at the forefront of our government's mind."

Swartz noted that the state has only one obstetrics training program, which is at the University of Iowa. She said she and her husband plan to help spark interest in rural obstetrics by hosting University of Iowa residency rotations at the Oskaloosa hospital.

Comegys, a patient of Swartz's, could have chosen a hospital birthing center closer to her home, but she wasn't confident in its quality. Other hospitals in her region had shuttered their obstetrics units. She is grateful to have a flexible job, a reliable car, and a supportive family, so she can travel to Oskaloosa for checkups and to give birth there. She knows many other women are not so lucky, and she worries other obstetrics units are at risk.

"It's sad, but I could see more closing," she said. ●

KFF Health News is a national newsroom that produces in-depth journalism about health issues and is one of the core operating programs at KFF — the independent source for health policy research, polling, and journalism.

Obstetrician Taylar Swartz visits with patient Addie Comegys and her husband, Jeff Comegys. As she neared her due date, Addie Comegys would need to make the trip weekly for checkups at the hospital, which is bucking a national trend by maintaining labor and delivery services. *(TONY LEYS/KFF HEALTH NEWS)*

Jacqueline Benitez puts away groceries at her home in Bellflower, California. *(ALLISON DINNER/AP PHOTO)*

Food Stamps Go Further in Rural Areas—Until You Add Transportation Costs

SARAH MELOTTE

Sarah Melotte is a reporting fellow for *The Daily Yonder*.

The lower cost of groceries in rural areas means that federal nutrition benefits cover a greater share of food expenses there, but higher transportation costs erode any advantage rural families may have in stretching their food dollars, new research shows.

The nonpartisan nonprofit Urban Institute found that the average cost of a modestly priced meal is about 5% lower in nonmetropolitan (or rural) areas than in metropolitan ones.

Benefits from the Supplemental Nutrition Assistance Program (SNAP, formerly known as food stamps) cover about 85% of the cost of that meal in nonmetropolitan counties, while the benefit covered an average of 81% of the cost of the meal in metropolitan counties, the research showed.

But SNAP benefits don't go as far as people think in rural areas, according to a nutrition program advocate.

"The meal gap is profound throughout America, but rural America gets hit harder because the transportation cost to get the food is higher," said Salaam Bhatti, the director of SNAP programs at the nonprofit Food Research and Action Center (FRAC) in an interview with the Daily Yonder.

Nationally, SNAP covers an average of 84% of the total cost of a modestly priced meal.

The amount of SNAP benefits an individual receives is based on things like income and household size, not on other factors like transportation cost.

Lack of Transportation and Broadband Plague Food-Insecure Rural Americans

After Covid-era emergency allotments expired in February of 2023, low-income Americans continued to struggle with increasing food insecurity as federal benefit programs like SNAP slashed budgets and reinstated work requirements for recipients.

Data from the Economic Research Service (ERS) shows that rural people generally live farther from a supermarket compared to their urban counterparts. According to a 2010 ERS report (the most recent available), the median distance to a supermarket in rural areas was 3.2 miles, compared to 0.7 miles for urban residents.

Smaller populations in rural areas make operating a grocery store more difficult. According to the most recent USDA data, 76 counties had no grocery store at all in 2016, and about 82% of those counties were rural.

In addition to transportation barriers, lack of access to high speed internet in rural counties can exacerbate the burden of providing food for low-income families by making it harder to sign up for government benefits.

A Daily Yonder analysis of broadband data found that residents of rural Zip codes sometimes paid up to $25 more per month than their urban and suburban neighbors.

"Low-income families are working multiple jobs and juggling kids," Bhatti said. "[Transportation] eats up your car, your gas, but it also eats up your time."

SNAP Coverage Varies by Economic Industry

Although meal costs are generally less expensive in rural areas, some rural counties are the exception to the rule. In rural counties where recreation and tourism drive the local economy, for example, SNAP only covers about 80% of the total cost of a meal. The average cost of a meal for a low-income family in rural recreation counties is $3.57, 10 cents higher than the average cost of a meal in urban areas.

That's because recreation-dependent counties tend to have higher-than-average costs of living compared to other rural counties. In 2023, the average household income needed to support a family of four in rural recreation communities was $97,800, compared to $88,900 in other rural counties, according to a dataset compiled by the Economic Policy Institute.

The cost of a meal also varied across other economic types of counties in rural areas.

- In rural counties where government industries like federal prisons or public schools drive most of the economic activity, SNAP covered about 85% of the cost of a meal. (Average cost of a meal , $3.31 per person)

- In farming-dependent counties, SNAP covered about 86% of the total cost of a meal, on average. (Average cost, $3.27 per person).

- In rural counties where manufacturing was the predominant economic activity, SNAP covered about 88% of the total cost of a meal. (Average cost, $3.22 per person.)

- On average, SNAP covered 86% of the total cost of a meal in counties where mining and natural resource extraction was the primary driver of economic activity. (Average cost, $3.25 per person.)

- In rural counties where no particular industry dominated the local economy, SNAP covered about 87% of the total cost of a meal. (Average cost, $3.26 per person.)

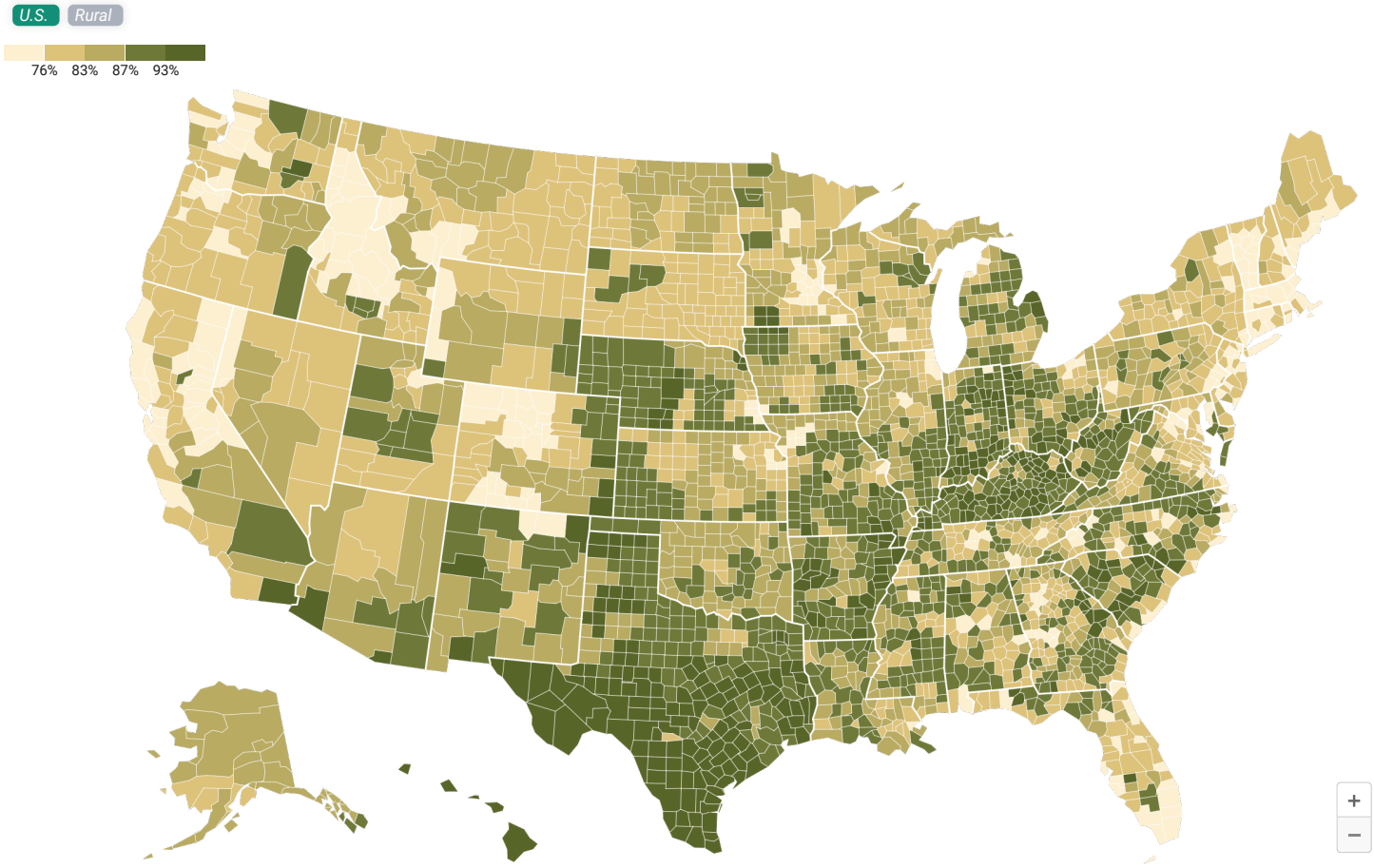
The county economic types are based on categories created by the Economic Research Service (ERS), a branch of the USDA.

This story was originally published in The Daily Yonder. *For more rural reporting and small-town stories visit dailyyonder.com.*

Does SNAP Cover the Cost of a Meal?

SNAP coverage is measured by the average cost of a modestly-price meal divided by the maximum SNAP alottment for the fiscal year 2024.

Click on the rural tab to see rural figures.



Map: Daily Yonder / Sarah Melotte • Source: Urban Institute • Get the data • Created with Datawrapper

Average Percentage of a Meal SNAP Alottments Cover in Rural Counties

SNAP coverage is measured by the average cost of a modestly-price meal divided by the maximum SNAP alottment for the fiscal year 2024.

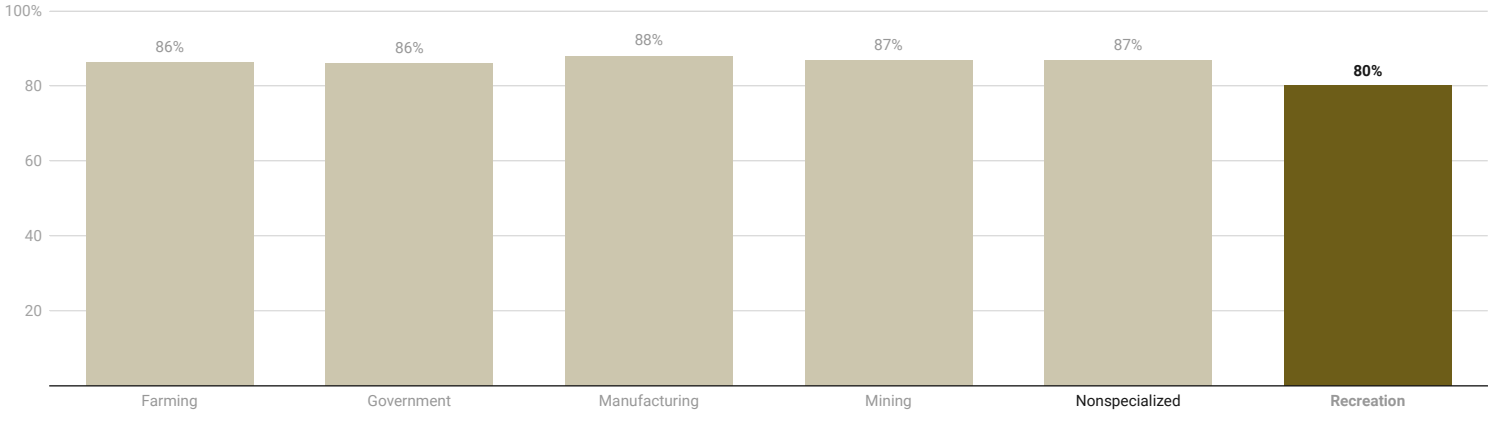


Chart: Daily Yonder / Sarah Melotte • Source: Urban Institute • Get the data • Created with Datawrapper

In Rural Texas, ERs Are Facing a Growing Mental Health Crisis

LIZA KALININA, TEXAS COMMUNITY HEALTH NEWS

Liza Kalinina is a graduate student at Texas State University and an intern with Texas Community Health News, a collaboration between the School of Journalism and Mass Communication and the university's Translational Health Research Center.

For 24/7 mental health support in English or Spanish, call the Substance Abuse and Mental Health Services Administration's free help line at 800-662-4357. You can also reach a trained crisis counselor through the Suicide and Crisis Lifeline by calling or texting 988.

Across the state, rural hospitals face a shortage of mental health care providers, with over 60% of rural counties designated as provider shortage areas by the Health Resources and Service Administration.

At the same time, the number of people experiencing mental health crises has increased, and these patients are often forced to seek care in the emergency room of rural hospitals, where they face long waits for treatment and use resources that are needed by patients with critical conditions.

Terry Scoggin, CEO of the Titus Regional Medical Center (TRMC), says his and other rural hospital ERs are the primary place where mental health patients are taken despite the fact that ER doctors are not trained to treat mental health conditions.

"The emergency department is a very hectic, chaotic, life-and-death area. It's not the best environment for a mental health person or person with drug overdose," Scoggin said.

Emergency rooms are a last resort for rural mental health

Situated in rural northeastern Texas, near the Arkansas border, Titus County has one psychiatrist and four licensed clinical social workers to serve 33,000 people in Titus and the surrounding counties. Accounting for population, that's about two-thirds fewer providers than are present in the rest of the state, according to the Texas Department of State Health Services.

Titus' mental health providers also care for patients in surrounding counties that have even fewer resources.

"We have one psychiatrist in the five counties that we support. So that gives you an idea of the lack of opportunities," said Scoggin.

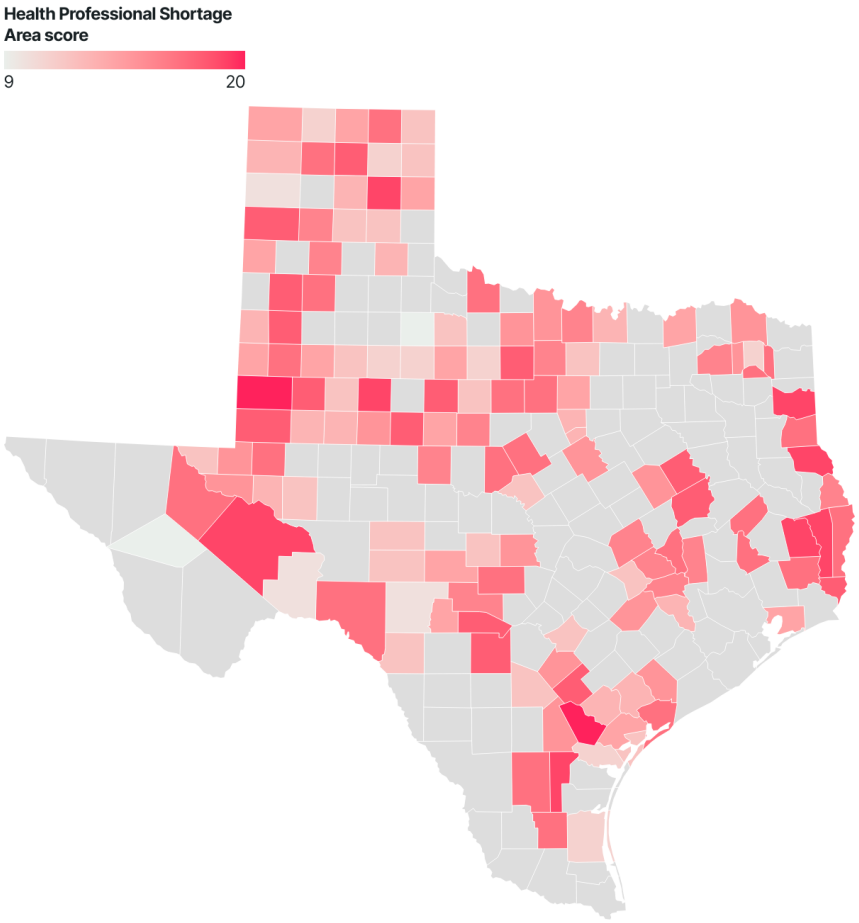
Without preventative care, people experiencing mental health crises in rural counties like Titus end up in the ER. Some are brought there after a public disruption. Others are brought by relatives.

Once in the ER, patients can spend days or even weeks waiting to be screened by a local mental health authority before they can be discharged or transferred. For patients at the Titus hospital, where there's no psychiatrist on staff, that's the Mount Pleasant Mental Health Clinic, which serves four counties and struggles to keep up with patient screenings.

In Titus, patients with mental health needs would typically be transferred to Terrell State Hospital, but the waits there are long, too.

Many rural Texas counties lack the needed number of mental health care workers.

The Health Resources & Services Administration's Health Provider Shortage Area score indicates the priority of providing additional workers to the area, with higher numbers indicating greater priority.



Source: Health Resources & Services Administration (2024)

> TEXAS COMMUNITY HEALTH NEWS

"Terrell stays full. That is just the way it is, that's not us, that's Terrell," said Rachelle Sills, director of the Mount Pleasant Mental Health Clinic. According to Sills, her team calls Terrell every day when they're trying to transfer a patient, sometimes waiting as long as 14 days for an opening.

Kathy Griffis is the vice president of clinical operations and chief nursing officer at Titus Regional Medical Center. She worries for patients with mental health conditions — but also for her staff, who sometimes deal with violent patients during extended stays in the ER.

Brittany Bacak, a licensed clinical social worker, said that the isolation mental health patients experience while waiting in the ER can exacerbate their symptoms, leading to violence toward staff.

"When you put a client in a room, and you tell them that they have to stay in that room and they can't leave that room for multiple days, people get agitated, right?" said Bacak, a lecturer at the School of Social Work at Texas State University who spent eight years working in Texas emergency rooms in both rural and urban hospitals in Bastrop, San Marcos and Austin prior to teaching.

Telehealth in ERs could reduce violence and get patients more timely care

Concerned with the long waits experienced by mental health patients in rural ERs and the associated danger to staff, Griffis worked with colleagues at Baylor University Medical Center and St. Luke's Health in Lake Jackson to explore the use telehealth to help ER doctors treat mental health patients who end up in their department.

A year later, the state legislature allocated $7.4 million over two years to fund telepsychiatry consultations for rural hospitals, based on the work of Griffis and her colleagues.

A pilot program was launched in March in Titus and Knox counties. Texas Tech psychiatrists contracted by Texas Health and Human Services are available to rural hospitals seven days a week, 10 hours a day, enabling ER physicians to start treating mental health patients in the ER within the first 24 hours.

"Now we can at least get a diagnosis, a prescription, and possibly a discharge back into society and not a discharge to another hospital," said Scoggin.

Sills, at the Mount Pleasant Mental Health Clinic, welcomes the program because it will reduce workload and help move patients to a more appropriate care setting in less time.

"We are such a high-crisis, high-volume clinic here that I think the local psychiatrists (through telemedicine) will really help the ER in maybe moving some of those people faster, whatever that means, getting them to another place or being able to advise them," Sills said.

Griffis hopes to demonstrate the program's efficacy and secure future funding, but the challenges of providing mental health care in rural areas extend beyond the ER. Due to provider shortages, accessing ongoing mental health care in rural communities is a challenge, even for those with private health insurance.

"I think we've got to relook at the infrastructure in our community for mental health," Scoggins said.

Titus Regional Medical Center in Mt. Pleasant. (BEN TORRES/*TEXAS TRIBUNE*)

FALL 2024 CONFERENCE CALENDAR

Check out our list of rural health conferences, and let us know if you're hosting one so we can help spread the word. Email us at RHQ@ttuhsc.edu.

2024 TORCH/TARHC Fall Conference
September 23-26
Kalahari Resort and Conventions
Round Rock, TX

2024 South Dakota Indigenous and Integrative Health Summit
September 24
Arrowwood Resort and Conference Center at Cedar Shore
Oacoma, SD

22nd Annual Rural Health Clinic Conference
September 24-25
Sheraton Kansas City Hotel at Crown Center
Kansas City, MO

Radically Rural Summit 2024
September 25-26
Keene, NH

2024 Washington Rural Network Prevention Conference
September 25-26
Yakima Conference Center
Yakima, WA

23rd Annual Critical Access Hospital Conference
September 25-27
Sheraton Kansas City Hotel at Crown Center
Kansas City, MO

2024 Kentucky Rural Telehealth Summit
September 26
WKU Knicely Center
Bowling Green, KY

2024 NTCA Fall Conference
September 29-October 2
JW Marriott
Indianapolis, IN

2024 Annual Appalachian Translational Research Network (ATRN) Summit
September 30-October 1
Southwest Virginia Higher Education Center
Abingdon, VA

2024 Annual Colorado Rural Health Conference
October 2-4
Omni Interlocken Hotel
Broomfield, CO

2024 Annual Oklahoma Rural Health Conference
October 2-4
River Spirit Hotel & Casino
Tulsa, OK

41st Annual Oregon Rural Health Conference
October 2-4
Riverhouse on the Deschutes
Bend, OR

2024 Georgia Faith in Rural Health Summit
October 4
Mercer University
Macon, GA

9th Annual National Summit on Social Determinants of Health
October 6-8
Hilton Inner Harbor
Baltimore, MD

2024 NARHC Fall Institute
October 7-9
Amway Grand Plaza and Devos Place
Grand Rapids, MI

2024 Wisconsin Healthcare Workforce Summit
October 8
Wilderness Resort
Wisconsin Dells, WI

2024 Kentucky Immunization Summit
October 9
Embassy Suites Newtown Pike,
Lexington, KY

2024 North Country Leadership Summit
October 9-10
Lake Placid Conference Center, Lake Placid, NY

11th Annual Kentucky Viral Hepatitis Conference
October 10
Embassy Suites Newtown Pike,
Lexington, KY

2024 Annual Association of Programs for Rural Independent Living (APRIL) Conference
October 11-13
Hyatt Regency McCormick Place,
Chicago, IL

2024 Annual National PACE Association Conference
October 13-16
Manchester Grand Hyatt, San Diego, CA

2024 Annual Grantmakers in Aging Conference
October 15-18
Westin Book Cadillac, Detroit, MI

2024 Annual Iowa Community Health Conference
October 16-18
Iowa Event Center, Des Moines, IA

2024 Annual Shaping Our Appalachian Region (SOAR) Summit
October 17-18
Pikeville, KY

2024 Annual National Association for Home Care and Hospice Conference and Expo
October 20-22
Tampa Convention Center
Tampa, FL

2024 Transforming Community and Rural Healthcare Symposium
October 21-22
Mayo Civic Center
Rochester, MN

2024 Annual National Association of Development Organizations Training Conference
October 21-24
New Orleans Marriott
New Orleans, LA

3rd Annual Texas Rural Health Conference
October 23-24
University of Texas at Arlington
Arlington, TX

11th Annual Kentucky Rural Behavioral Health Symposium
October 26
Center for Health Education and Research
Morehead, KY

2024 Annual American Public Health Association Meeting and Expo
October 27-30
Minneapolis Convention Center
Minneapolis, MN

81st Annual National Congress of American Indians (NCAI) Convention
October 27-November 1
MGM Grand
Las Vegas, NV

2024 Annual Iowa Rural Health Association Conference
October 28
Drake University Olmsted Center
Des Moines, IA

2024 Annual National Association of Community Health Centers Financial, Operations Management/IT Conference & Expo
October 28-29
Hilton Union Square
San Francisco, CA

2024 Annual Maryland Rural Health Conference
November 3-5
Crowne Plaza
Annapolis, MD

2024 Annual New England Rural Health Conference
November 6-7
Mystic Marriott Hotel
Groton, CT

2024 Missouri Rural Health Association Conference
November 6-7
The Lodge at Old Kinderhook
Camdenton, MO

2024 Louisiana Rural Health Summit
November 7
Le Pavilion at Parc Lafayette
Lafayette, LA

2024 Annual Midwest Rural Agricultural Safety & Health (MRASH) Conference
November 7-8
ISU Alumni Center
Ames, IA

2024 Annual Rural Health Association of Utah Conference
November 13
Dixie Convention Center
St. George, UT

32nd Annual West Virginia Rural Health Conference
November 13-15
The Resort at Glade Springs
Daniels, WV

2024 Annual Illinois Critical Access Hospital Network (ICAHN) Conference
November 14
I Hotel and Conference Center
Champaign, IL

2024 West Virginia Health Equity Summit
November 15
The Resort at Glade Springs
Daniels, WV

2024 Annual Rural Health Voice Conference
November 19-20
Southwest Virginia Higher Education Center
Abingdon, VA

27th Annual South Carolina Rural Health Conference
November 19-21
Hyatt Regency
Greenville, SC

2024 Annual Tennessee Rural Health Association Conference
November 20-22
Marriott Downtown
Knoxville, TN

2024 National Conference on EMS
November 20-23
Harrah's Waterfront Conference Center
Atlantic City, NJ

2024 22nd Annual IRHA Public Policy Forum
November 21
Embassy Suites
Plainfield, IN

26th Annual Kentucky Rural Health Association Conference
November 21-22
WKU Knicely Center
Bowling Green, KY

2024 Annual Conference on Advancing School Mental Health
December 5-7
Hyatt Regency
Orlando, FL

2024 Annual National Healthcare Coalition Preparedness Conference
December 10-12
Rosen Shingle Creek Hotel
Orlando, FL

18th National Indian Nations Conference
December 10-13
Agua Caliente Band of Cahuilla Indians Reservation
Palm Springs, CA ●

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