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The Geography of Need

Rural behavioral health in America:
What public evidence and Care Solace care-navigation data
reveal about burden, barriers, and opportunity

CARE SOLACE DATA & IMPACT INSTITUTE
Applied research & analytics

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The distance between "I need help" and "I have an appointment"

Everyone agrees rural America has a mental health problem. The provider shortages are well-documented. The statistics are stark. The policy briefs keep arriving. And yet, for most rural families, the experience of trying to get care hasn't meaningfully changed.

The reason is deceptively simple. Rural behavioral health has primarily been treated as a supply problem — not enough providers in not enough places. That framing is true as far as it goes. But it misses the harder question: what happens after someone decides to seek help?

In communities where the nearest psychiatrist is two counties away, where everyone knows everyone, where a missed day of work means a missed paycheck, and where "just call this number" often leads to a voicemail that's never returned — the problem isn't just that providers are scarce. It's that the *entire pathway from need to care* is fragile. One broken link — a wrong number, a full caseload, a three-month wait, a transportation gap — and the whole thing collapses.

This is the *conversion gap*: the distance between knowing you need help and actually sitting in front of someone who can provide it. In rural America, that gap is where the system fails.

> *Rural mental health is an access problem before it is a referral problem.*

This paper draws on three sources of evidence. The first is public research: federal workforce data, CDC mortality statistics, and recent peer-reviewed findings that together describe the scope and severity of rural behavioral health disparities. The second is Care Solace's de-identified care navigation data: 45,974 rural service requests that reveal, in operational detail, what people are actually seeking when they reach for help. The third is the new federal policy landscape—particularly the $50 billion Rural Health Transformation Program (RHTP), which creates an unprecedented opportunity to close the conversion gap at scale.

Together, these sources tell a consistent story. Rural demand is rising, broad-based, and clinically complex. It frequently arrives entangled with food, housing, and healthcare access needs, and it is disproportionately concentrated among adolescents. The data doesn't just describe a crisis. It describes a design problem — one that can be solved, with the right infrastructure, and one that $50 billion in new federal investment is specifically designed to address.

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A system built for everywhere except here

The numbers paint a clear picture. HRSA estimates that 137 million Americans - roughly 40 percent of the population - live in a Health Professional Shortage Area (HPSA) for mental health. As of the most recent Q1 FY2026 reporting period, 6,807 mental health HPSAs covered those 137 million Americans, and nearly 62 percent of those shortage designations (4,212) were rural, affecting more than 30.5 million people.[2][3]

But shortage designations only capture part of the story. The workforce gap is not evenly distributed across provider types. Rural counties are more likely to lack psychiatric nurse practitioners, psychologists, social workers, and licensed counselors. This means when someone in a rural community needs support beyond basic counseling, the options narrow fast.[2] A March 2026 study in JAMA Network Open found that roughly 80 percent of rural counties have no practicing psychiatrists at all.[7]

The gravity of the situation is best captured by its most devastating metric: the loss of life. In 2022, the CDC reported a suicide rate of 20.0 per 100,000 in rural communities, significantly outstripping the 13.4 recorded in urban areas—a 49% gap.[5] The data revealed a clear trend: suicide rates were consistently lower in regions with robust insurance coverage, reliable broadband access, and higher income levels.[5]

Recent figures confirm this disparity is not shrinking:

- Entrenched Inequality: Provisional 2024 CDC data and 2026 county-level analyses show the rural-urban divide persists at 40–50%, with rates in non-metropolitan areas remaining nearly double those of large urban counties.[12][13]
- A Diverging Trend: A 2026 study found that rural suicide mortality reached 28.69 per 100,000, compared to 20.20 in urban counties.[12]
- National Context: This rural increase occurred even as overall national suicide rates experienced a modest decline, highlighting a crisis that is increasingly concentrated in America's rural heartland.[12]

The failure to provide adequate mental health access isn't just a social issue; it is a massive economic drain. On a national scale, untreated mental illness is projected to cost the U.S. economy $477.5 billion in 2024, with cumulative losses expected to reach nearly $14 trillion by 2040. [14]

In rural areas, these costs manifest in a more localized and devastating way:

- Schools: Forced to act as frontline mental health providers without the necessary funding or staff.
- Emergency Rooms: Becoming the default destination for crises that could have been prevented with outpatient care.
- Employers: Grappling with diminished workforces and lost productivity in regions already struggling with labor shortages.

Ultimately, these rural systems are left to absorb the financial and operational weight of care that was never delivered in the first place.

> *Tele-behavioral health matters in rural markets — but the data now show that even dramatic telehealth expansion has not closed the conversion gap. The pathway from "I need help" to "I have an appointment" still breaks at the same fragile links.*

National survey data underscores a widening divide. Between 2019 and 2022, symptoms of anxiety and depression increased nationwide, with rural adults bearing a disproportionately higher burden.[4] While many hoped the rise of remote telehealth care would level the playing field, *JAMA Psychiatry* found that psychotherapy usage actually grew faster in urban areas than in rural ones between 2018 and 2021, even during the teletherapy expansion that many hoped would close the gap.[6]

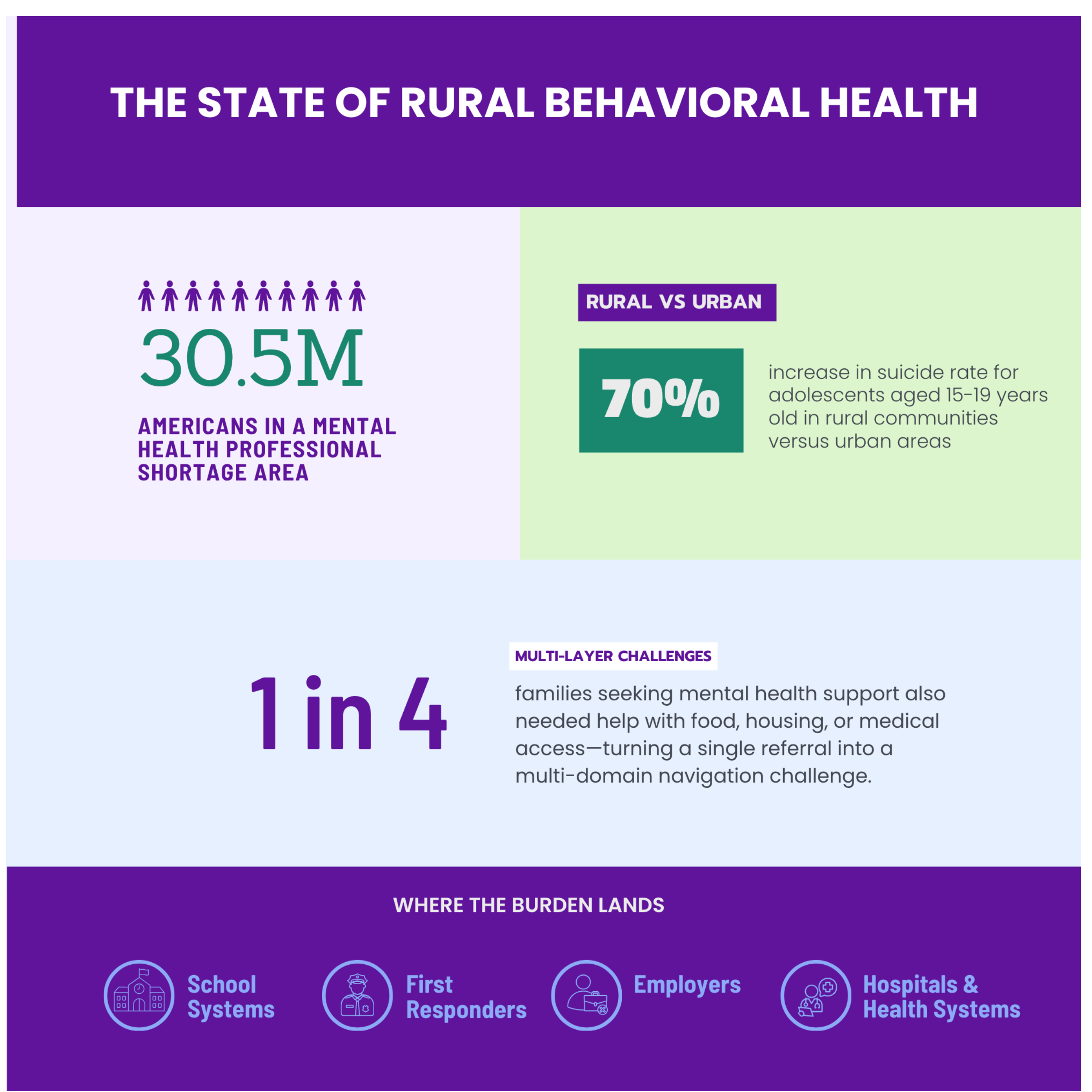
The limitations of the digital shift became even clearer in a March 2026 *JAMA Network Open* study, which highlighted that while telehealth served as a vital tool, it failed to equalize care or solve the complex navigation problem inherent in rural healthcare.

The critical realities evidenced:

- Minimal Growth: Even among mental health specialists who heavily adopted telehealth, the share of rural patients increased by only about 0.9 percentage points.[7]
- Relocation vs. Access: Most of that minor increase was attributed to existing urban patients relocating to rural areas, rather than the system reaching new rural residents.[7]

Rural youth face the sharpest end of these disparities.

Adolescents aged 15–19 in rural counties experience suicide rates approximately 70 percent higher than their urban peers, and only an estimated 20–30 percent of rural adolescents with major depressive episodes receive treatment—compared to nearly 50 percent in urban areas.[15] These are not marginal differences. They describe a system that is failing the population most in need of early intervention.



$50 billion and a question of design

The policy environment has moved beyond recognition of the problem. HRSA continues youth-focused behavioral health workforce investments through RCORP-Pathways, and USDA's Distance Learning and Telemedicine program remains active.[8][9][10] But the scale of what is now possible has shifted dramatically.

In July 2025, the One Big Beautiful Bill Act (Public Law 119-21) authorized the Rural Health Transformation Program (RHTP)—a $50 billion, five-year initiative administered by the Centers for Medicare & Medicaid Services. All 50 states received awards in December 2025, with first-year allocations averaging $200 million per state (ranging from $147 million to $281 million). Funds of $10 billion per year will flow from FY2026 through FY2030.[16]

The RHTP explicitly prioritizes the very systems and critical realities evidenced in this report.. States must use funds for three or more approved categories, which include: supporting access to mental health and substance use disorder treatment services; recruiting and retaining clinical workforce talent in rural areas; providing training and technical assistance for technology-enabled care delivery; promoting consumer-facing, technology-driven solutions; and developing innovative care models that bring services closer to rural residents.[16]

> *Behavioral health is not a side note in state RHTP plans. It is a central investment theme.*

States are directing funds toward integrated behavioral health in primary care, school-based mental health programs, mobile crisis teams, telehealth hub infrastructure, and workforce pipeline development. Multiple state plans specifically identify adolescent mental health, co-occurring social needs, and care coordination as priority areas—precisely the demand patterns visible in Care Solace's data.[17]

The question is no longer whether rural behavioral health will receive investment. It is whether that investment will fund systems that close the conversion gap—or repeat the pattern of adding capacity at the edges without solving the navigation problem in the middle.

CARE SOLACE DATA

45,974 rural help-seekers inform reality

Public research describes the landscape. But it rarely captures what the access problem looks like at the point of contact — the moment a parent calls for help, a school counselor submits a referral, or a young adult searches for a therapist they can actually see. That's where Care Solace's data adds something different. De-identified care-navigation records reflect real demand — what surfaces when people try to turn need into action. And the rural signal is unmistakable.

> *Consider the rural parent whose 15-year-old son's anxiety referral also flags food insecurity and a three-month psychiatry wait. Without navigation, the pathway collapses. With a care-coordination model, the family receives a same-week virtual psychiatry appointment and a food-pantry connection—closing two gaps in one handoff.*

45,974
Rural Care Navigation Requests

11.3X
Growth in Rural Volume, 2020 to 2023

56.3%
Rural Requests Flagged for Anxiety

14.6%
Flagged for Suicidal Ideation / Self-Harm

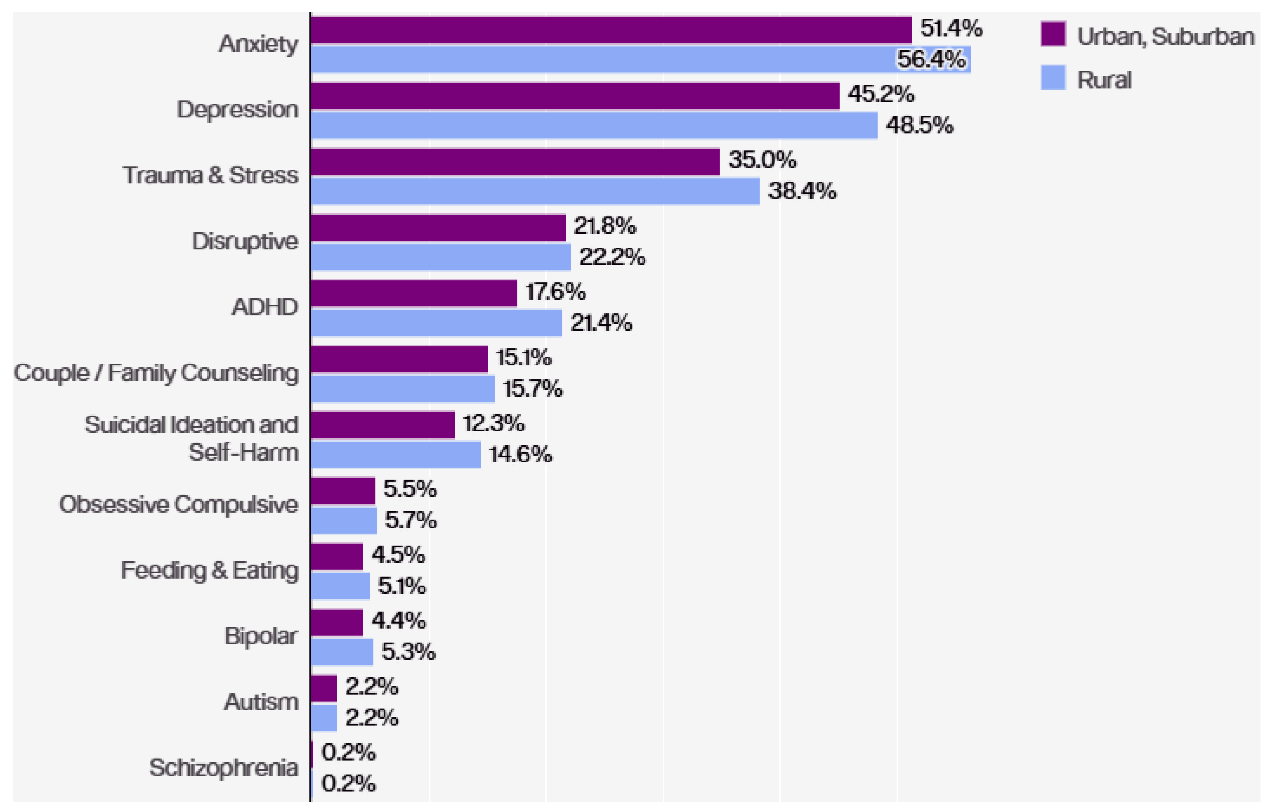
The burden is broad — not narrow

Across nearly every major clinical category, rural requests outpace urban and suburban ones. Anxiety: 56.3% vs. 51.5%. Depression: 48.6% vs. 45.3%. Trauma and stress: 38.6% vs. 35.0%. ADHD: 21.1% vs. 17.5%. Suicidal ideation and self-harm: 14.6% vs. 12.3%.[1]

This isn't a story about one diagnosis driving rural demand; It's about elevated need across the board, arriving with greater clinical complexity and fewer local options to absorb it.

Rural help-seeking skews toward higher clinical burden

Share of distinct Care Solace service requests by concern category, 2020–2026.



Interpretation note. Percentages reflect the share of distinct search IDs within each cohort associated with a given category. Categories are non-mutually exclusive. Data reflect help-seeking and navigation demand rather than population prevalence.

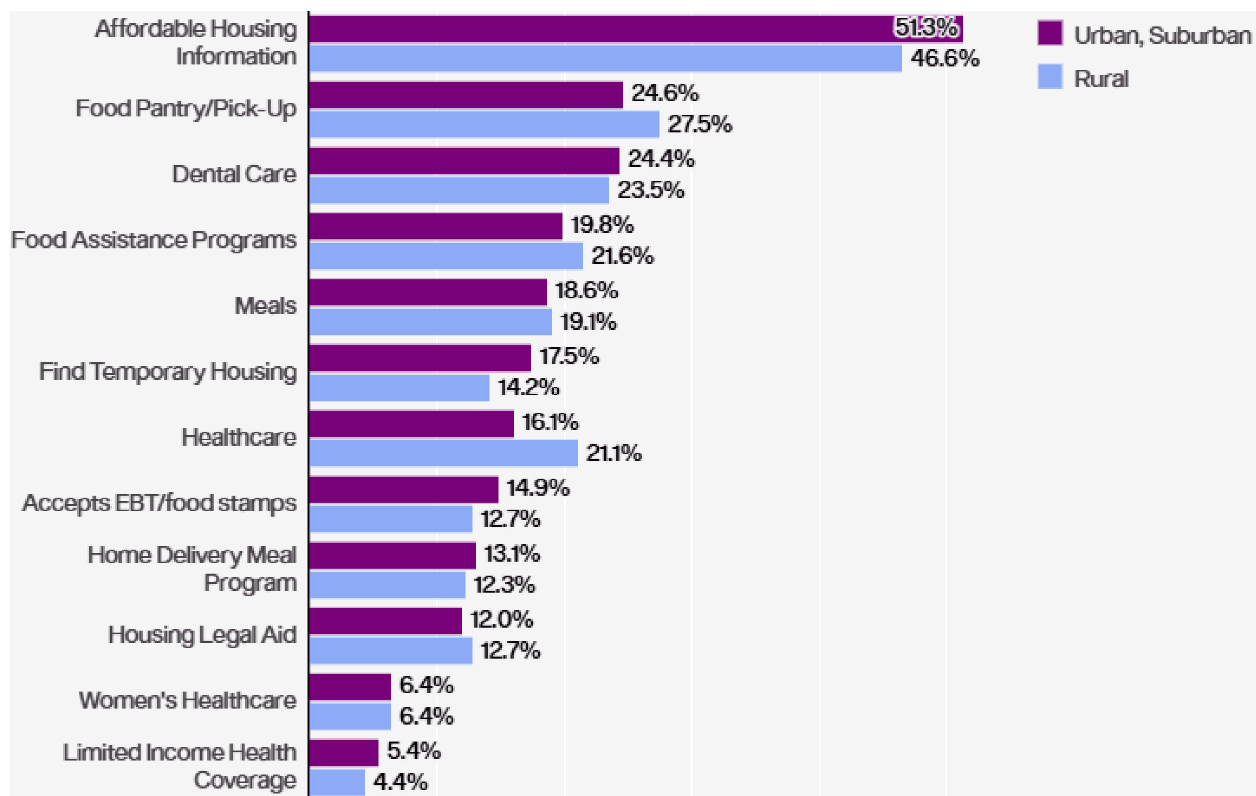
Need doesn't arrive alone

One of the most striking insights from Care Solace data is that rural behavioral health needs almost never exist in a vacuum. Instead, they arrive intertwined with logistical and practical hurdles—barriers to access that urban healthcare systems often take for granted.

Rural requests more frequently involve healthcare assistance (22.2% vs. 16.2%), food pantry support (27.5% vs. 24.6%), and dental care (24.9% vs. 24.0%). The pattern extends across food assistance programs, temporary housing, and other social-service categories.[1] In rural requests, roughly 1 in 4 families seeking mental health support also needed help with food, housing, or medical access—turning a single referral into a multi-domain navigation challenge.

Rural requests more often carry social service and care navigation needs

Selected service/support categories; percentages are non-mutually exclusive.



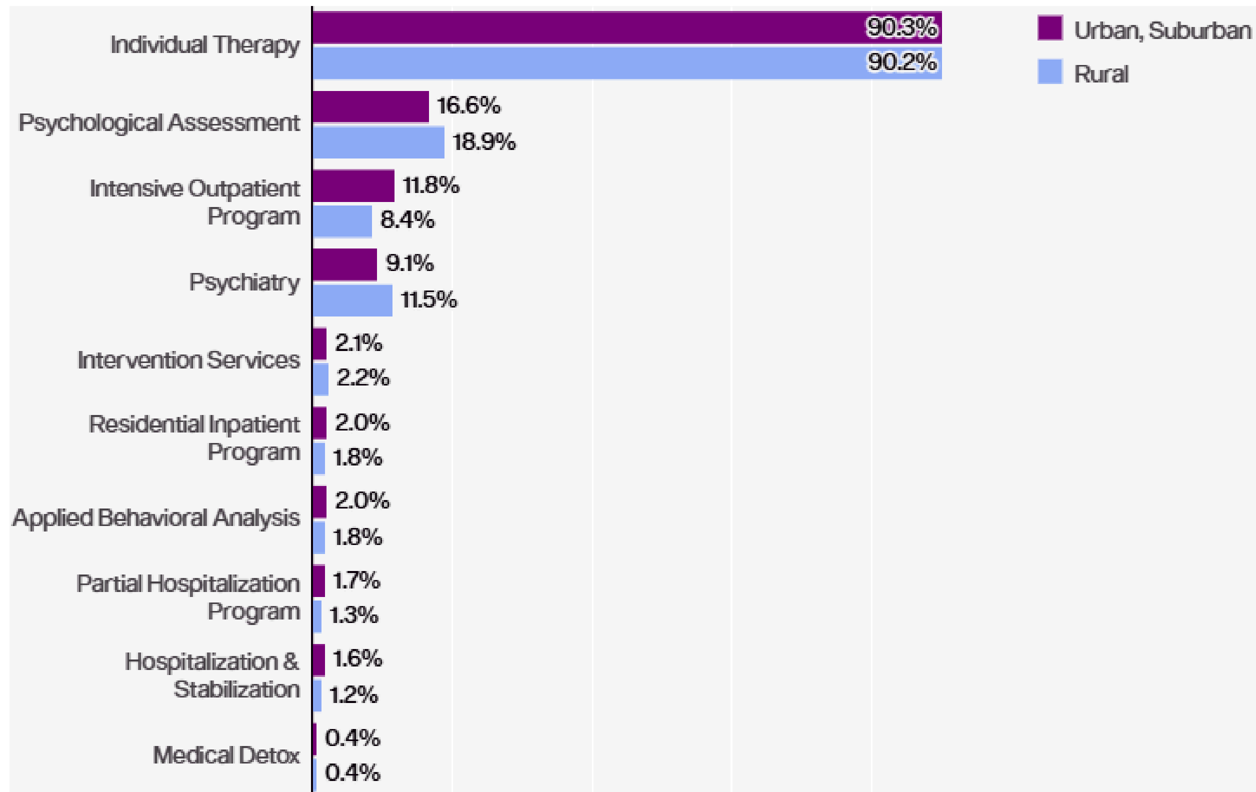
This matters because it reframes the problem. A rural behavioral health strategy that only thinks about therapy appointments will miss the family that also needs help with healthcare navigation, food access, and dental care. In rural communities, access failure in one domain compounds difficulty in every other.

Specialty care and adolescents: where the gap bites hardest

Individual therapy dominates requests in both rural and non-rural settings, at roughly 90%. But rural demand over-indexes on the two hardest service types to fill in thin markets: psychological assessment (18.7% vs. 16.5%) and psychiatry (11.4% vs. 9.1%).[1] These are precisely the services most likely to encounter months-long waits and the widest geographic mismatch between where people live and where providers practice.

Specialty needs surface more often in rural demand

Rural requests over-index on psychiatry and psychological assessment.

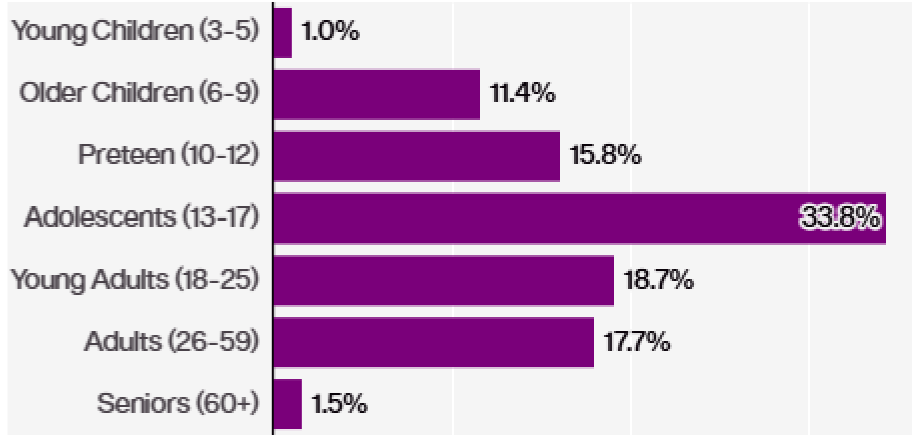


The demographic data brings the urgency of this crisis into sharp focus. Adolescents aged 13–17 constitute the largest segment of rural assistance requests at 33.8%, with young adults aged 18–25 following at 18.6%. Collectively, more than half of all rural individuals seeking help are under the age of 26.[1]

This concentration of demand among the youth is a critical alarm for the healthcare system, especially when viewed alongside broader national trends:

- Mortality Disparity: Rural youth suicide rates are 70% higher than those of their urban peers.[15]
- Treatment Gap: Despite the higher risk, rural youth receive treatment at roughly half the rate of urban youth.[15]

The high volume of adolescent requests in this data is far from incidental; it represents the system's most pressing and personal signal for immediate intervention.



Age profile of rural Care Solace service requests with demographic data.

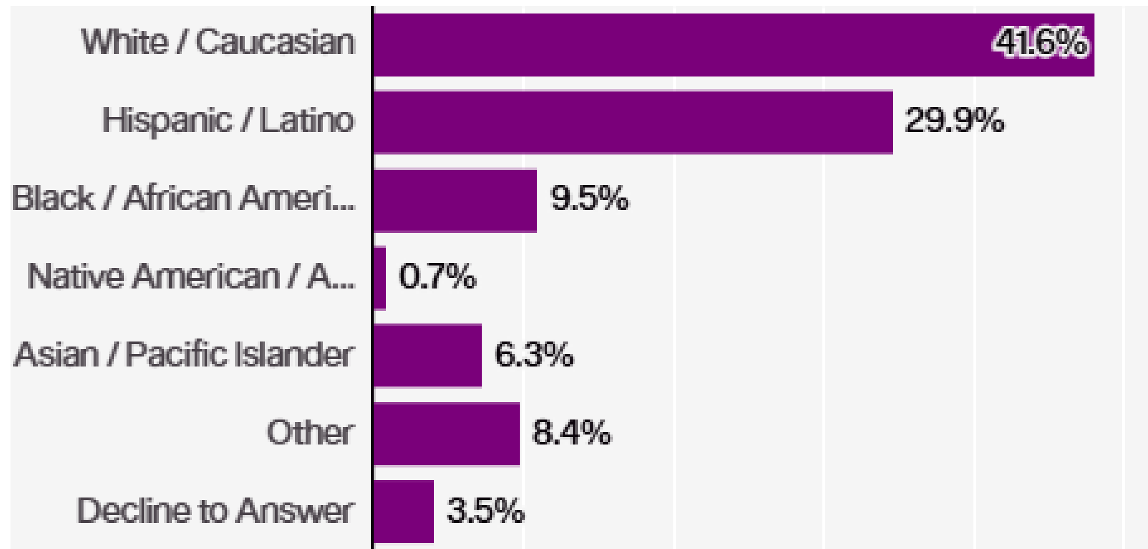
The gender and ethnic breakdown of rural assistance requests highlights a diverse demographic of need. According to recent data:

- Gender: Females represent the majority of rural requests at 56.4%, followed by males at 41.8%, and non-binary individuals at 1.8%.[1]
- Based on the demographic data, we see a diverse cross-section of rural communities seeking support, with the largest volume of requests coming from White/Caucasian and Hispanic/Latino individuals.

The ethnic profile of rural help-seekers is distributed as follows:

- White / Caucasian: 41.6%
- Hispanic / Latino: 29.9%
- Black / African American: 9.5%
- Asian / Pacific Islander: 6.3%
- Native American / Alaska Native: 0.7%
- Other / Multiple Backgrounds: 8.4%
- Declined to Answer: 3.5%

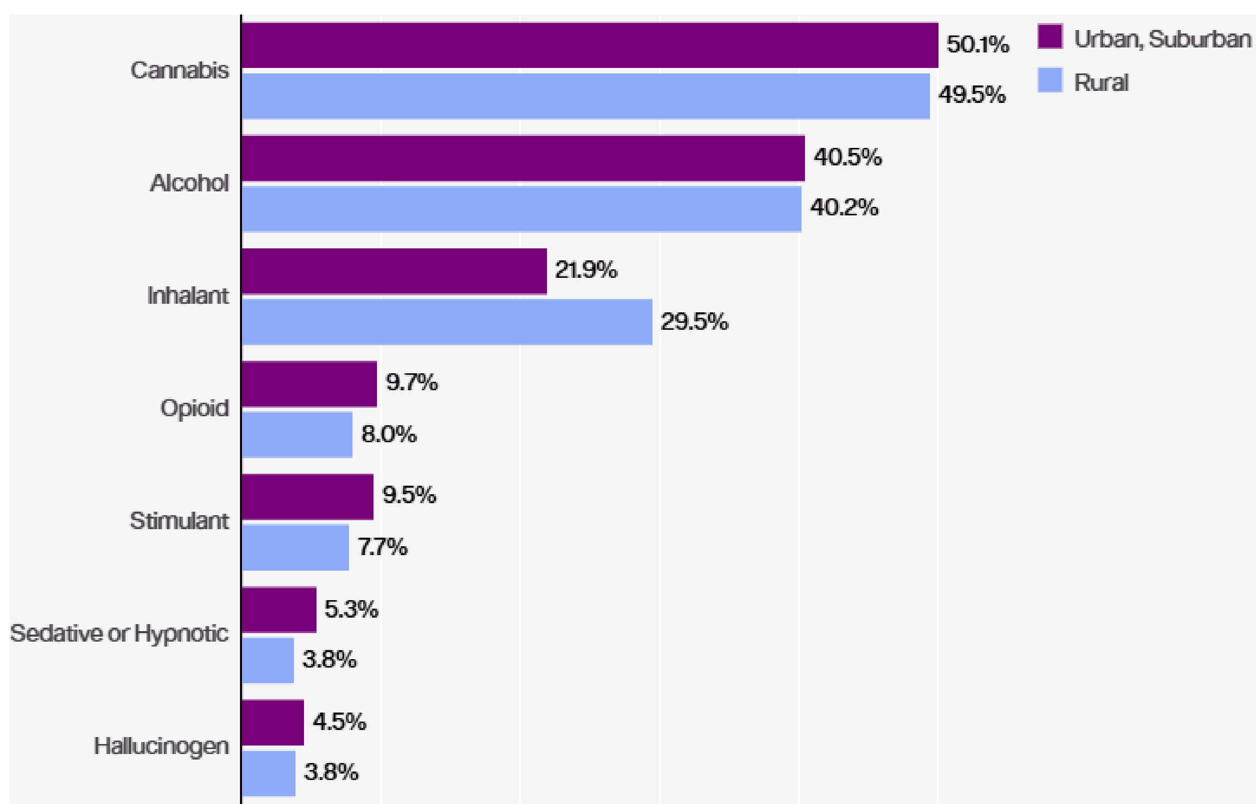
These figures highlight that the mental health crisis in rural America is not a monolithic experience; it spans across cultural and ethnic lines, requiring a nuanced and inclusive approach to care delivery.



Substance patterns: a different profile

Cannabis and alcohol are the most common substance-related concerns in both rural and urban groups, with nearly identical rates. But the divergence is notable on inhalants: 29.4% of rural substance-related requests vs. 21.8% urban/suburban — consistent with research linking inhalant use to younger populations and limited substance access. Opioid-related requests are slightly lower for rural help-seekers in this data (8.1% vs. 9.7%), though rural opioid mortality remains well-documented elsewhere.[1]

Substance-related concerns by rural flag



IMPLICATIONS

Where the burden lands

When someone in a rural community can't advance from need to care, the cost doesn't vanish. It shows up somewhere else.

Audience	How the gap shows up
School systems	Elevated counseling loads, rising absenteeism, heavier family navigation burdens, and delayed care for students and staff.
Municipalities & counties	Pressure on first responders and crisis systems, fragmented post-referral handoffs, and no visibility into whether residents actually complete care.
Employers	Absenteeism, retention challenges, and untreated need quietly eroding workforce stability in already thin labor markets.
Hospitals & health systems	Referral bottlenecks, ED strain, readmissions risk, and limited step-down options when local specialty capacity is scarce.

The common thread across all of these settings is the same: a referral that doesn't convert to care isn't a referral. It's a missed opportunity. Rural-serving institutions need to move toward models that go beyond measuring whether a handoff was made and begin tracking whether the person on the other end actually connected to care—even when complete visibility is difficult to achieve.

FRAMEWORK

Five principles for rural behavioral health that work

After coordinating care across all 50 states and processing tens of thousands of rural requests, five design principles consistently separate approaches that work from those that look good on paper. Each maps directly to approved uses of RHTP funds—providing states with a ready-made framework for deploying investment where it will close the conversion gap, not just add capacity at the margins.

Closing the rural access gap: key challenges and the care coordination advantage

Key Challenge	Care Coordination Advantage
✔ Diversity of Modality	In rural areas, many families either prefer or require in-person care. Navigate all modalities to deliver the right care and not just an available digital slot.
✔ Solve for the "Whole Population"	Provide a sustainable path for families' specific financial reality - Medicaid, private insurance and the uninsured.
✔ Optimize RHTP Infrastructure vs. Adding Competition	Drive those in need to your state's new RHTP infrastructure, ensuring school based centers and rural hubs are being fully utilized and supported.

Rural communities face structural challenges that directory-based referral models cannot solve. Care coordination addresses modality diversity, whole-population coverage, and RHTP infrastructure optimization.

1. Navigation, not just information

A directory is not a solution. It's a starting line that most people never cross. In rural settings, people need help narrowing options, confirming availability, checking insurance fit, and staying engaged through the handoff to a booked appointment. A referral that leads to a voicemail is a dead end with a name attached. Human-powered care coordination—where a real person navigates complexity on behalf of the family and tracks the process through to provider match—represents a fundamentally different model than posting a list and hoping someone follows through.[11]

RHTP alignment: Innovative care models (Category I); consumer-facing technology-driven solutions (Category C).

2. Hybrid local + virtual pathways

The most resilient rural models don't choose between in-person and telehealth. They combine local trust with regional or virtual reach, coordinating all three layers as one system. The 2026 telehealth evidence confirms that pure virtual expansion fails to generate meaningful new rural patient relationships. Coordinated hybrid models—where virtual capacity supplements a thin but present local system—succeed where standalone telehealth does not.[7]

RHTP alignment: Technology-enabled care delivery (Category D); IT advances (Category F); telehealth hub infrastructure.

3. Privacy-aware engagement

In small communities, the decision to seek mental health care carries social weight that urban systems rarely must account for. When the receptionist at the clinic is also your neighbor, anonymity matters. Access pathways need to offer discretion, human support for those who want it, and self-service options for those who don't. Systems that provide both a 24/7 multilingual human companion and a confidential self-service option reduce dropout and engage populations that would otherwise never surface in referral data.

RHTP alignment: Behavioral health access (Category H); innovative care models (Category I).

4. Payer realism and social-needs integration

Rural access strategies must work across Medicaid, Medicare, commercial insurance, and sliding-scale options—because the payer landscape in rural communities is rarely uniform. And because behavioral health demand often arrives bundled with food, housing, and healthcare access needs, solutions must be built for that complexity, not around it. Care Solace's data show that roughly one in four rural families seeking mental health support also need help in at least one other social-service domain.[1]

RHTP alignment: Provider payments across payer types (Category B); prevention and chronic disease management (Category A).

5. Measurement that captures follow-through

The metrics that matter go beyond awareness: provider matches, appointment confirmation, time-to-care, and post-appointment satisfaction. The industry standard today—counting referrals made, website visits, or hotline calls—tells you whether people know you exist. It tells you very little about whether anyone got care. The aspiration is full closed-loop measurement from first contact to confirmed treatment. No system achieves that perfectly, but the organizations that build toward it—tracking each stage of the care pathway and following up after the match—generate meaningfully better data than those that stop at the point of referral. RHTP itself requires states to report on performance metrics and demonstrate measurable progress, making this trajectory not just a best practice but a programmatic requirement.[16]

RHTP alignment: Evidence-based, measurable interventions (Category A); CMS performance reporting requirements.

> *Rural communities don't need an urban model transplanted into their geography. They need access systems designed for their reality — low density, high consequence, practical friction, and a need for trusted support from start to finish.*

ALIGNMENT WITH THE RURAL HEALTH TRANSFORMATION PROGRAM

From systemic goals to day-one impact

The launch of the RHTP creates an historic opportunity to close the very conversion gap this paper describes. With $50 billion now flowing to states, the question is not whether rural behavioral health can be addressed, but whether states will invest in systems that actually convert need to care. The figure below maps RHTP's five systemic goals to the infrastructure states envision building—and to the day-one care coordination capabilities that can accelerate results while long-term capacity comes online.

RHTP Systemic Goal	Infrastructure Build (States' Visions)	Day-One Care Solace Impact
Sustainable Access	Improve efficiency by helping rural facilities coordinate operations and share resources.	**Instant Connectivity:** While new physical walls are being built, families have a hand to hold to navigate the current providers in their zip code.
Workforce Development	Strengthen recruitment and retention efforts for rural physicians and nurses.	**Protect the Healer:** Offload the administrative "referral hunting" from rural doctors, reducing burnout and restoring their capacity to focus on medicine.
Innovative Care Models	Develop Community Health Hubs and hub-and-spoke models to coordinate regional care.	**The Human Safety Net:** Provide a 24/7 multilingual resources to ensure patients actually navigate between those hubs without falling off the care line.
Tech Innovation	Expand telehealth, digital health tools, and AI to deliver efficient care.	**Introduce a Cultural Concierge:** 24/7/365 multilingual support can solve for insurance, transportation and language barriers in real-time.
Systemic Cost Avoidance	Long-term reduction in ER boarding and high-cost crisis admissions.	**Accelerate the "Save":** By reducing wait times to days, catch and support families in the early intervention window before a crisis occurs.

RHTP systemic goals mapped to state infrastructure visions and Care Solace's day-one care coordination impact. Care Solace provides immediate navigation, multilingual support, and outcome-oriented tracking while states build long-term infrastructure.

This mapping illustrates a critical point: states do not need to wait for new facilities to open, new providers to be trained, or new technology platforms to be deployed before rural residents see benefits. Care coordination infrastructure—navigation, multilingual support, insurance and transportation problem-solving, and provider matching with post-match follow-up—can operate on day one, using the existing provider landscape more effectively while long-term RHTP investments mature.

For state RHTP administrators, the implications are direct. Navigation infrastructure satisfies multiple approved uses of funds simultaneously. It advances behavioral health access (Category H), supports innovative care models (Category I), promotes technology-driven consumer-facing solutions (Category C), and generates the measurable outcomes data that CMS requires for continued funding and performance scoring.

CONCLUSION

The geography of need is clear

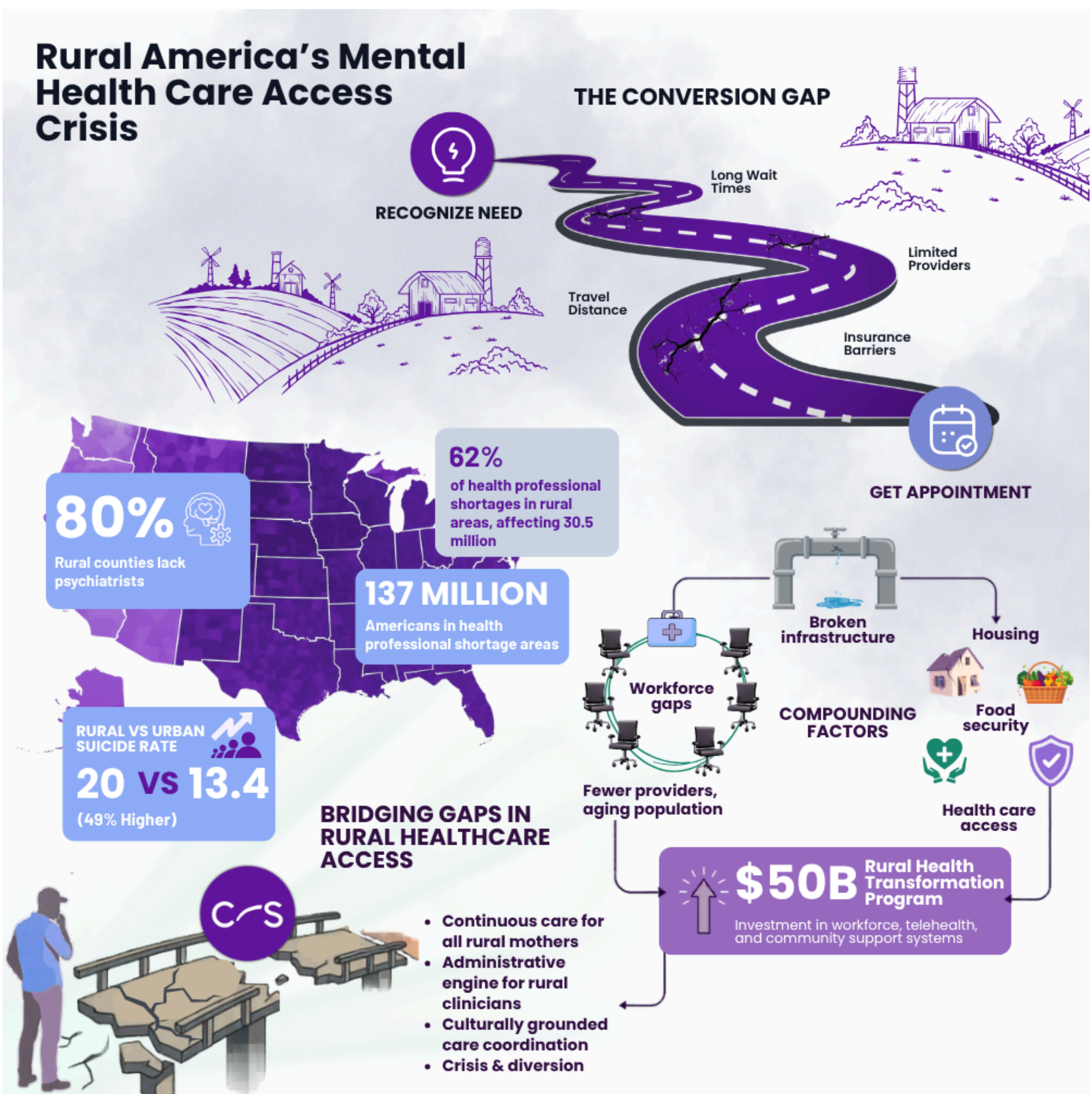
The data—public, federal, and from Care Solace's own platform—point to the same conclusion: rural behavioral health is not a problem of awareness. Communities, schools, employers, and families in rural America know the need is there. What they lack is a reliable pathway from recognizing that need to reaching care.

The Rural Health Transformation Program has changed the resource equation. With $50 billion flowing to all 50 states over five years, the funding question is answered. But funding alone has never been the constraint. The conversion gap persists because the systems between a person's first call for help and their first appointment are fragile, fragmented, and unmeasured. Closing that gap requires navigation infrastructure—not just referral lists.

The evidence in this paper, combined with Care Solace's operational experience matching tens of thousands of rural individuals to care, provides a proven framework for RHTP-funded initiatives. States that prioritize navigation infrastructure, hybrid delivery, privacy-aware engagement, and outcome-oriented measurement will move beyond documenting disparities and deliver measurable improvements in rural mental health access and outcomes.

Care Solace operates in this space every day. We match individuals with licensed mental health and substance use providers in all 50 states, through a verified network of 700,000+ providers and a team of multilingual Care Companions available 24/7/365. Our data tells us that rural demand is real, rising, and complex. Our field experience tells us it can be met—with the right design.

> *The geography of need is clear. The infrastructure to match it is now funded. The question is whether we'll build systems that actually close the gap—from first call to first appointment.*



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About the Care Solace Data & Impact Institute

The Data & Impact Institute is the applied research and analytics function of Care Solace. It translates care-navigation data, public research, and field insight into practical intelligence for the communities Care Solace serves.

About Care Solace

Care Solace is a human-powered, technology-enabled care coordination company helping communities connect people to mental health care, substance use treatment, and social services in all 50 states. Care Solace reports supporting more than 31 million people, partnering with 1,000+ institutions, maintaining access to 700,000+ verified providers, and achieving 83% first-match satisfaction.[11]

For more information, visit caresolace.org/rhtp

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