
Statewide Aggregate Rural Health
Needs Assessment:
Mental Health and Wellbeing



NYS ASSOCIATION FOR
RURAL HEALTH

Acknowledgements

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Executive Summary

Rural communities across New York State face urgent and complex behavioral health challenges. High rates of depression, anxiety, suicide, and substance use converge with longstanding structural barriers such as provider shortages, limited inpatient capacity, fragile crisis services, transportation gaps, broadband limitations, and stigma. These challenges are not new, but they are intensifying and appear consistently across the 44 rural counties of New York in Community Health Assessments (CHAs), Community Health Improvement Plans (CHIPs), and Local Services Plans (LSPs).

The Statewide Aggregate Rural Health Needs Analysis (SARHNA) was developed by the New York State Association for Rural Health (NYSARH) to bring these county-level insights into a single framework. This report systematically synthesizes hundreds of pages of local planning documents to create a statewide picture of rural behavioral health.

Data were aggregated within the eight mental wellbeing and substance use priorities from the New York State Prevention Agenda: Anxiety and Stress, Suicide, Depression, Substance Misuse and Overdose Prevention, Tobacco/ E-cigarette Use, Alcohol Use, Adverse Childhood Experiences, and Healthy Eating. Additional cross-cutting themes were identified that impact access to care: Workforce Shortages, Service Gaps, and Infrastructure Challenges.

From this synthesis, accessibility emerges as the central and unifying theme. Residents across rural New York repeatedly report that even when services exist in theory, they are inaccessible in practice due to long wait times, lack of local providers, the absence of crisis stabilization or inpatient beds, transportation barriers, and unreliable broadband that limits telehealth. Accessibility is not only about whether a clinic or program exists on a map, but whether individuals and families can reliably reach and use services when they are most needed.

Key Findings

Mental Health Conditions: Depression and anxiety are top priorities in nearly every county. Adult prevalence rates range from 15 to 34 percent, and youth data are even more concerning. In counties such as Livingston, Ontario, and Madison, more than 40 percent of youth report feeling sad or depressed most days. Suicide mortality rates, particularly among teenagers and older adults, are significantly higher than state averages in many rural areas.

Substance Use and Overdose: The opioid and fentanyl crisis is identified as one of the most urgent issues statewide. Nearly every county lists overdose deaths as a top concern, with

fatalities often exceeding state averages. The COVID-19 pandemic worsened this crisis; Ulster County, for example, reported more than a 40 percent increase in overdoses between 2019 and 2021. While harm reduction programs, naloxone distribution, and peer recovery networks are expanding, treatment access remains inconsistent and medication-assisted treatment (MAT) capacity is limited.

Alcohol, Tobacco, and Vaping: Binge drinking and alcohol-impaired driving remain disproportionately high in rural counties. In the Mid-Hudson region, alcohol-related crashes exceed 50 per 100,000 population in some areas. Tobacco use among adults is significantly higher than statewide averages, and vaping among youth continues to rise, with nearly one in four students in some counties reporting recent e-cigarette use.

Trauma and ACEs: Adverse childhood experiences are consistently identified as foundational drivers of poor behavioral health. In many counties, more than 40 percent of youth report two or more ACEs. Trauma is strongly linked to depression, substance use, and suicide, yet trauma-informed practices remain uneven and underfunded across systems.

Workforce: Shortages in the behavioral health workforce represent a structural crisis. Many rural counties are designated as Health Professional Shortage Areas (HPSAs) or Mental Health Professional Shortage Areas (MHPSAs), with provider-to-population ratios far worse than the state average of 1:310. Ratios of 1:500 or more are common, with some areas approaching 1:1,000. Counties report widespread vacancies in psychiatry, nursing, clinical, peer support, and direct care roles. These shortages lead to long waitlists, interruptions in care, and closures of inpatient and detox programs.

Service Gaps: The clearest evidence of accessibility failure lies in inpatient behavioral health and crisis services. Families report months-long waits for psychiatric or substance use treatment beds. Pediatric psychiatric capacity is particularly limited, leaving children to board in emergency departments for days while awaiting placement. In counties like Greene, families must travel 40 to 100 miles for services. In Franklin, individuals with developmental disabilities and aggressive behaviors face some of the most limited placement options in the state.

Infrastructure Challenges: Lack of transportation and broadband infrastructure compound access issues. Residents without cars, or those living in areas without reliable transit, face major challenges in reaching care. Public transit is sparse, infrequent, and often stigmatized, with heavy impacts on older adults, people with disabilities, and low-income households. Broadband is equally critical: in Steuben, Livingston, and Chenango Counties, large shares of households

lack reliable access, making telehealth, remote learning, and basic digital engagement impossible.

Rural Complexity

The SARHNA analysis underscores that rural communities are not monolithic. Conditions and access barriers differ not only between counties but also within them. This variability demands localized strategies that account for both disparities and strengths at the sub-county level.

Demographic equity is not a separate concern but a defining feature of access. Poverty, age, disability, race and ethnicity, language, sexual orientation, and gender identity shape whether residents can locate services, afford them, and remain engaged. Youth and LGBTQ+ residents face particularly high risks of depression and suicidality. People with intellectual and developmental disabilities encounter severe gaps in crisis stabilization and respite care. Spanish-speaking families and other linguistic minorities often lack culturally competent providers. Counties are beginning to address these disparities through bilingual staffing, implicit bias training, targeted youth programs, and data systems that track outcomes for marginalized groups.

The findings of this report are clear: rural New York is experiencing a behavioral health crisis defined by accessibility. Yet the same communities facing the greatest barriers also hold the assets and partnerships necessary for solutions. By investing in evidence-based strategies, strengthening the behavioral health workforce, expanding inpatient and crisis capacity, improving infrastructure, and centering equity, New York State can help transform rural behavioral health from a story of shortage and inequity to one of resilience, innovation, and improved health for all.

Introduction: The Rural Reality

“There are not enough mental health services here across all types of needs. We only have one psychiatrist across the whole county. Our primary care physicians get nervous about prescribing medications... There isn’t anybody that you can consult in a timely fashion to prescribe the right medications or refer that person.” – Chenango County CHA

Imagine living in a small town in rural New York. The closest mental health provider is hours away. Public transportation is rare, and when it does exist, it’s inconvenient, stigmatized, and often inadequate. Families struggle when their loved ones need inpatient care or supportive housing, but available beds simply don’t exist. Parents of children with developmental disabilities describe heartbreaking choices when there is “nowhere to put their person” once they can no longer provide care.

This is not a distant scenario. It is the daily reality of thousands across New York’s 44 rural counties. Community Health Assessments and Local Services Plans paint this picture in strikingly consistent terms: depression, anxiety, suicide, substance use, and trauma all converge against the backdrop of a profound lack of access to services.

The Statewide Aggregate Rural Health Needs Analysis (SARHNA) was launched to provide a comprehensive and systematic picture of behavioral health needs across New York’s 44 rural counties. Rural health stakeholders have long recognized the urgent challenges facing these communities, including rising rates of depression, anxiety, suicide, and substance use combined with structural barriers such as provider shortages, transportation gaps, and housing instability. Yet, until now, no statewide framework has pulled together the diverse county-level planning documents that capture these realities in detail.

The SARHNA builds on the existing infrastructure of Community Health Assessments (CHAs), Community Health Improvement Plans (CHIPs), and Local Services Plans (LSPs). These documents are written by local health departments and county mental health agencies with input from hospitals, providers, and community stakeholders, and they represent the most comprehensive sources of county-level knowledge about health conditions, gaps in services, and community strengths. By systematically collecting and synthesizing these materials, the SARHNA identifies both the common challenges shared across rural New York and the distinct ways those challenges play out locally.

This initiative is more than an exercise in aggregation. It is a way of honoring the voices and perspectives of rural residents, providers, and leaders whose lived experiences are reflected in county plans. Their reports describe not only urgent needs but also the assets – such as faith communities, local coalitions, schools, peer networks, and civic organizations – that rural communities draw upon to respond to behavioral health crises. By bringing these diverse sources together, the SARHNA creates a unified, equity-centered picture of rural behavioral health in New York and lays the groundwork for actionable strategies that can strengthen systems of care.

Methods

Data Sources

The SARHNA draws upon existing county-level planning documents that represent the most comprehensive, locally generated accounts of rural health conditions, priorities, and gaps. Specifically, the analysis includes:

2022 – 2024 Community Health Assessments (CHAs): Conducted triennially by local health departments in collaboration with hospitals and health systems, CHAs provide a broad overview of health status, risk factors, and social determinants of health at the county level.

2022 – 2024 Community Health Improvement Plans (CHIPs): Also led by health departments, CHIPs translate CHA findings into action steps aligned with the New York State Prevention Agenda. They reflect local coalitions’ consensus on priority areas and interventions.

2024 – 2027 Local Services Plans (LSPs): Developed by county mental health departments and submitted annually to the New York State Office of Mental Health (OMH), the Office of Addiction Services and Supports (OASAS), and the Office for People with Developmental Disabilities (OPWDD), LSPs document needs, services, and outcomes in mental health, substance use, and developmental disability services.

All available CHAs, CHIPs, and LSPs from New York’s 44 counties classified as rural were collected and reviewed. Because these documents differ in structure, terminology, and level of detail, the SARHNA was designed to synthesize them through a transparent and systematic coding process. A full list of county documents used in this report can be found in [Appendix A](#).

Data Management and Organization

The research team, supported by the New York State Association for Rural Health (NYSARH), created a central repository for all documents. Files were catalogued by county, year, and document type. A data collection tool was designed to capture both quantitative indicators (e.g., prevalence rates, hospital admissions, mortality statistics) and qualitative content (e.g., identified needs, stakeholder quotes, narrative accounts of barriers and assets).

To ensure consistency, the tool included a preliminary set of broad categories or themes aligned with the NYS Prevention Agenda's priorities for Mental Wellbeing and Substance Use. These initial buckets included:

- Anxiety and stress
- Depression
- Suicide
- Substance use and overdose
- Tobacco and vaping
- Alcohol use
- Adverse childhood experiences (ACEs) and trauma
- Healthy eating and nutrition

New York State's 44 Rural Counties:

Allegany	Montgomery
Broome	Ontario
Cattaraugus	Orleans
Cayuga	Oswego
Chautauqua	Otsego
Chemung	Putnam
Chenango	Rensselaer
Clinton	Schenectady
Columbia	Schoharie
Cortland	Schuyler
Delaware	Seneca
Essex	St. Lawrence
Franklin	Steuben
Fulton	Sullivan
Genesee	Tioga
Greene	Tompkins
Hamilton	Ulster
Herkimer	Warren
Jefferson	Washington
Lewis	Wayne
Livingston	Wyoming
Madison	Yates

During analysis, additional categories were added iteratively to capture the diversity of experiences reported across counties. Examples include housing, transportation, broadband access, workforce shortages, and stigma. Within each bucket, data fields were structured to record outcomes, community needs, available assets, and equity considerations.

Analysis

Qualitative Data

The team employed qualitative analysis software (NVivo, MAXQDA, and CORAL AI) to systematically code text from the documents. Each county's CHA, CHIP, and LSP was reviewed

in full, and relevant content was assigned to one or more thematic buckets. Codes were applied to both explicit references (e.g., “youth suicide rates have increased”) and interpretive insights (e.g., “providers describe transportation as a barrier to care”).

The coding process followed an iterative, multi-step approach:

1. **Open Coding:** Initial review of documents to identify key themes, language, and categories.
2. **Theme Assignment:** Organization of findings into the established themes, with refinement as new themes emerged.
3. **Equity Tagging:** Each coded segment was reviewed for explicit or implicit references to equity, including disparities by age, gender, race/ethnicity, socioeconomic status, geography, or disability.
4. **Cross-County Comparison:** Once coding was complete, patterns were analyzed across counties to identify recurring themes, unique local challenges, and examples of resilience or promising practices.

Quantitative Data

Where counties reported quantitative indicators, these data were extracted into a spreadsheet aligned with the themes. Examples include prevalence of depression or anxiety, suicide mortality rates, opioid overdose deaths, and youth vaping prevalence.

Synthesis of Findings

The final synthesis process emphasized both challenges and assets. Alongside descriptions of shortages and gaps, counties frequently reported strengths such as strong coalitions, peer recovery programs, school-based supports, and faith or civic organizations working to reduce stigma and expand access.

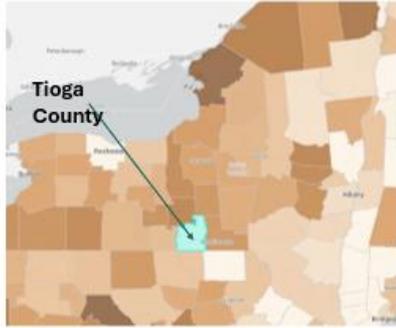
Equity and Rural Heterogeneity

Equity considerations were identified throughout the analysis. During coding and synthesis, the research team paid special attention to how behavioral health needs and access barriers differ by population subgroup, including youth, older adults, low-income households, and sexual and gender minorities.

The concept of rural heterogeneity – the recognition that health challenges vary not only between counties but also within them – guided the interpretation of findings. Sub-county data (e.g., by ZIP code) and community-level narratives were used to illustrate how health disparities manifest unevenly within rural spaces.

Rural Heterogeneity

Tioga County illustrates the complexity of mental distress in rural areas and serves as a clear example of rural heterogeneity, where health outcomes and needs vary significantly even within a single county.



On a statewide map, Tioga County looks relatively healthy, shaded lightly for mental distress.



But when you **zoom in by ZIP code**, a **different story emerges**— pockets of the county struggle with high distress while others fare better.

Data retrieved from CDC PLACES: Centers for Disease Control and Prevention. Interactive PLACES Map: Frequent Mental Distress. Centers for Disease Control and Prevention; 2024. Available from: <https://experience.arcgis.com/experience/22c7182a162d45788d952a236278ed85>

Although Tioga may appear relatively healthy when shaded lightly on statewide, county-level maps, the story shifts when data are viewed at the ZIP code level. Some areas reveal levels of frequent mental distress well above countywide averages, while others fare far better. This uneven geography demonstrates why county-level data alone can be misleading and why local context matters. It also illustrates how residents living just a few miles apart may experience dramatically different opportunities to maintain mental health and well-being.

Limitations

Several limitations should be acknowledged. First, county-level documents vary in their comprehensiveness and the extent to which they incorporate community voice. Some counties provide robust data and detailed narratives, while others offer only high-level summaries. Second, the lack of standardized reporting across CHAs, CHIPs, and LSPs limits direct comparisons. Third, the SARHNA relies on secondary data, which reflects the priorities and constraints of state and county planning processes. Despite these challenges, the systematic coding and aggregation approach allows for identification of broad, consistent themes and provides the most complete statewide portrait of rural behavioral health needs to date.

Findings

The SARHNA organizes findings from county-level planning documents into fourteen themes. These themes serve as the framework for understanding both the breadth and depth of behavioral health needs across rural New York. Each theme captures a cluster of related issues that emerged consistently across CHAs, CHIPs, and LSPs.

The themes reflect two types of information. Some represent direct behavioral health outcomes, including depression, anxiety, suicide, substance use, alcohol misuse, and tobacco/vaping. Others capture the structural and social drivers that shape those outcomes, such as housing, transportation, broadband access, workforce shortages, food insecurity, and adverse childhood experiences (ACEs). These categories illustrate how health conditions and access barriers intersect to create complex challenges in rural communities.

While each theme highlights a distinct area of need, there is significant overlap between themes. For example, many counties describe high rates of youth anxiety and depression alongside increases in vaping or alcohol use. Workforce shortages, transportation limitations, and broadband gaps appear across nearly every issue, demonstrating how structural barriers constrain prevention and treatment efforts. Similarly, trauma and ACEs cut across multiple themes, functioning as underlying drivers that influence both mental health and substance use.

Anxiety and Depression

"Mental well-being is essential to overall health. At any given time, almost one in five young people are affected by [Mental/Eating/Behavioral] disorders, including conduct disorders, depression and substance abuse."

- Chautauqua County CHA

Across rural New York, counties identify depression and anxiety as pressing and widespread concerns. These conditions affect adults and youth alike, often co-occurring and compounding the daily challenges of poverty, unstable employment, rural isolation, and limited health infrastructure.

Key Metrics:

Poor mental health (# days per month)¹

Frequent Mental Distress (% of population)¹

Depression (age adjusted rate per 100,000)¹

Rural County Data Table containing these metrics can be found in [Appendix B](#).

Adult Burden

Population-level indicators confirm that adult mental distress is both elevated and persistent. **Figure 1** shows the average number of poor mental health days reported per month, with most rural counties clustered between five and six days. This means that in a typical month, many adults in rural New York spend nearly a week experiencing significant mental distress. Counties such as Franklin, Cayuga, and Yates report averages at the higher end, above six days, while Putnam and Ontario trend lower, closer to five. The range illustrates the unevenness of mental health burden across the state, but the overall pattern is one of consistently high prevalence.

A related indicator – adults reporting 14 or more poor mental health days per month – further highlights the persistence of distress. As **Figure 2** illustrates, 15 to 20% of adults in many counties meet this threshold, effectively spending half the month in a state of poor mental health. Counties like Schoharie, Fulton, and Clinton show the highest percentages, with one in five adults reporting chronic distress at this level. These numbers reinforce what local health departments describe qualitatively: mental health concerns are not episodic for many rural residents but enduring conditions that shape daily life, employment stability, and family well-being.

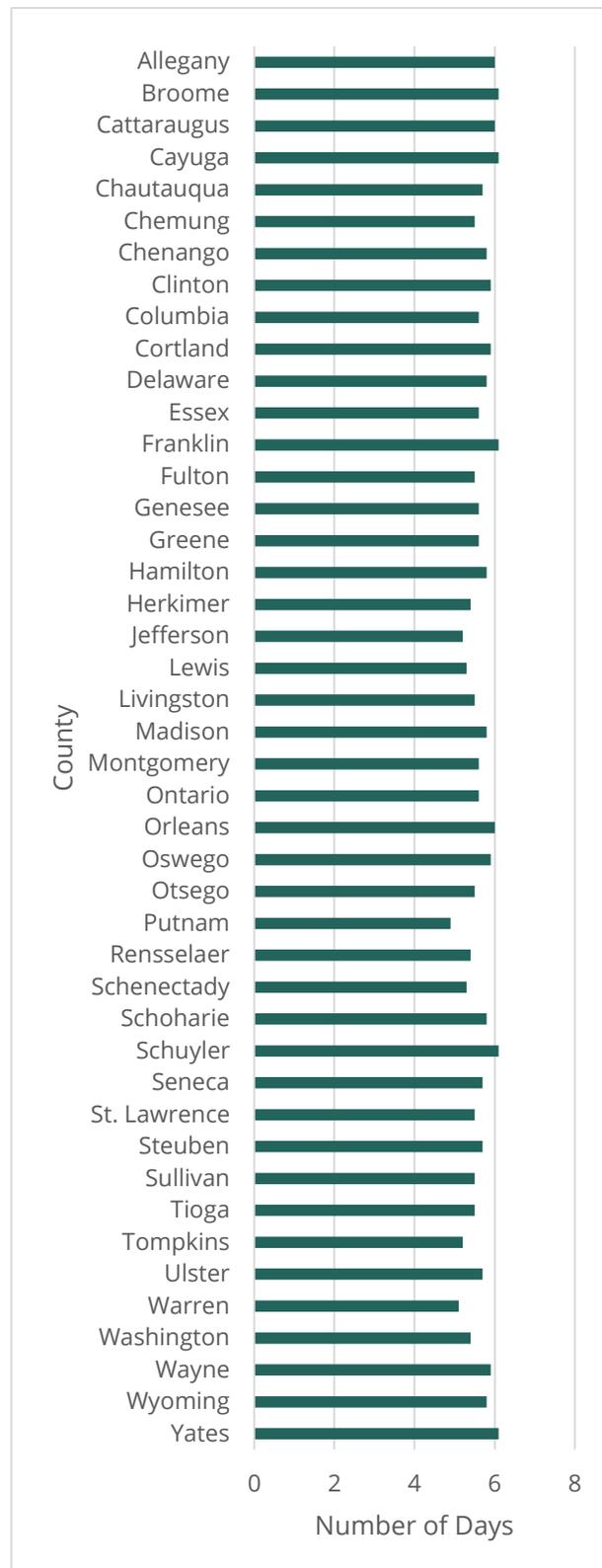


Figure 1: Average number of poor mental health days per month.¹

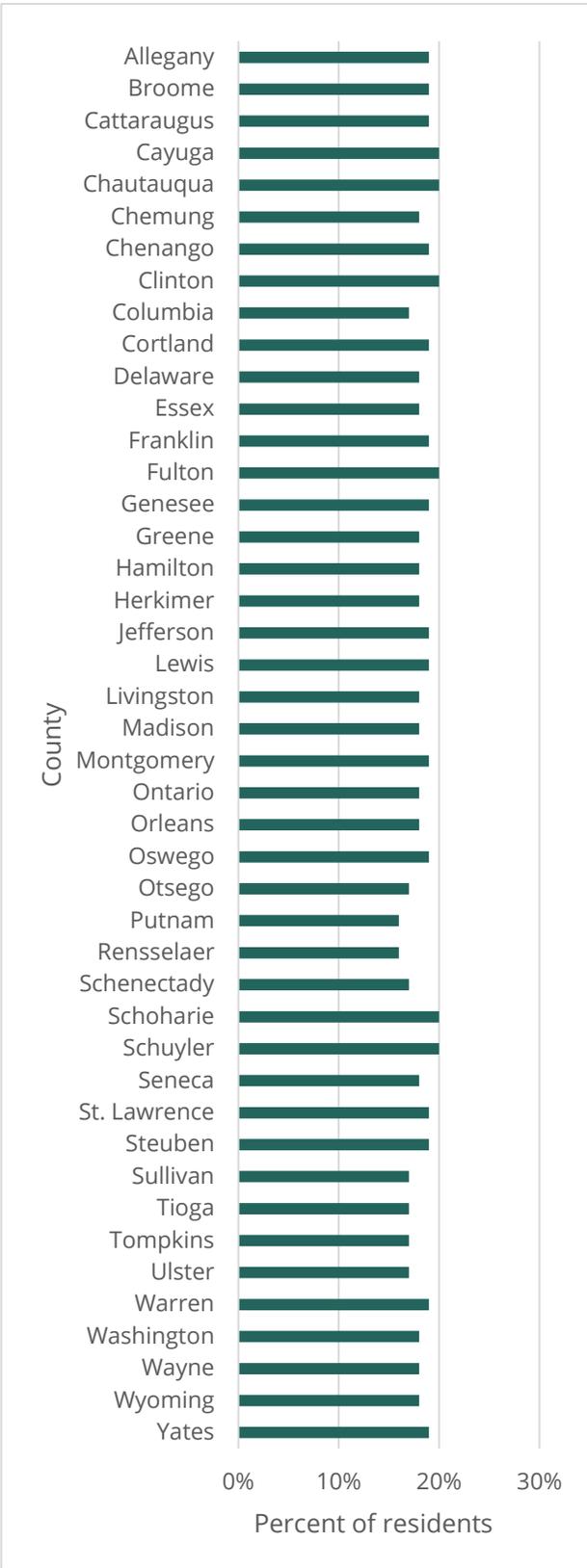


Figure 2: Percent of residents experiencing more than 14 poor mental health days per month.²

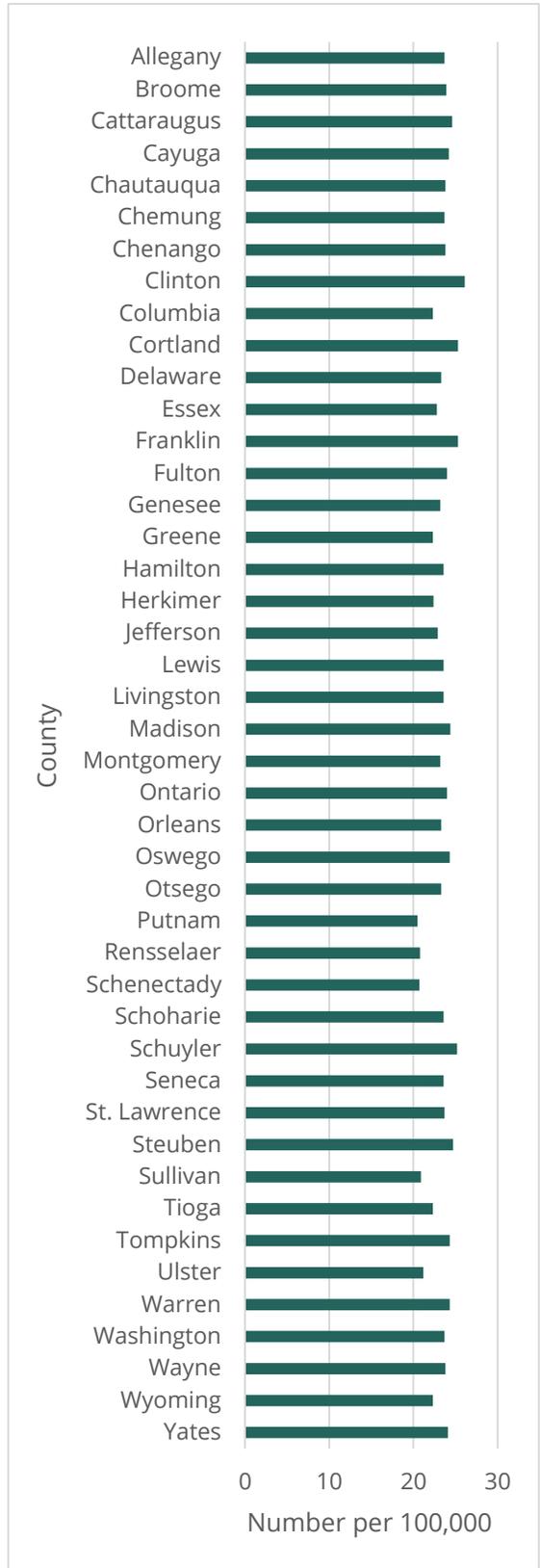


Figure 3: Age adjusted depression rate (per 100,000 residents).¹

Beyond days of distress, counties also report diagnostic data on depression and anxiety. Rates vary, but a consistent pattern emerges: 15–34% of adults report a diagnosis of depression or anxiety. For example, Chemung County reports that one-third of adults have a depression diagnosis, while in Wayne County, half of adults report persistent sadness. **Figure 3** illustrates these county-level variations, showing that while rates differ, every rural county documents a substantial burden of behavioral health conditions among rural residents.

Youth Burden

If adult data paint a picture of widespread and chronic distress, youth data reveal an even more alarming trajectory. In Livingston County, the share of young people reporting depression jumped from 22% to 35% within just a few years. In Ontario and Madison Counties, more than 40% of youth reported feeling sad or depressed most days, while in Seneca County, nearly one in five report suicidal ideation and close to 10% have attempted suicide. Even where diagnostic labels are not used, student surveys show consistent increases in reports of sadness, hopelessness, and anxiety, with counties describing a “new normal” of elevated youth distress.

Youth outcomes are particularly concerning because they often exceed adult rates, suggesting that the pipeline of need for behavioral health services will only grow over time. For instance, St. Lawrence County reports that while 23% of adults report depression, 27% of youth report two or more ACEs and experience elevated suicidal ideation. Similarly, Tompkins County identifies 29% of youth as feeling sad or hopeless most days - rates that surpass most adult prevalence benchmarks. This pattern underscores the generational dimension of rural distress: younger cohorts are entering adulthood with higher levels of depression and anxiety than the adults currently utilizing care.

Interpreting the Patterns

Taken together, the figures show a consistent and sobering reality: mental distress in rural New York is both widespread and intensifying. The data also highlight important variation. Some counties, like Putnam or Ontario, report lower averages of poor mental health days, while others such as Franklin, Cayuga, and Yates report significantly higher burdens. This heterogeneity reflects differences in demographics, economic conditions, local resources, and health infrastructure. Still, the overarching pattern is clear: across the rural landscape, mental health distress is not an exception but a defining feature of community health.

Key Takeaways: Anxiety and Depression in Rural New York Counties

Adults live with persistent distress: Most rural counties average 5–6 poor mental health days/month, with 15–20% of adults experiencing ≥14 days of distress.

High diagnostic burden: On average, about 25% of adults report depression or anxiety diagnoses, with sharp increases in counties like Steuben (+10 pts) and Schuyler (+8 pts).

Youth crisis is sharper: In several counties, 40%+ of young people report being sad or depressed most days, exceeding adult benchmarks and signaling growing generational need.

Rising trends, not isolated spikes: Counties across all regions describe worsening patterns of distress, with multiple years of increases documented in both adult and youth data.

Variation within a shared crisis: Some counties (e.g., Franklin, Yates, Cayuga) show the highest averages, but no county is untouched—mental distress is a structural feature of rural health.

Suicide

"Suicide not only results in significant impacts on family members, friends, and co-workers, suicide has a negative rippling effect on the community at large as well." - Delaware County LSP

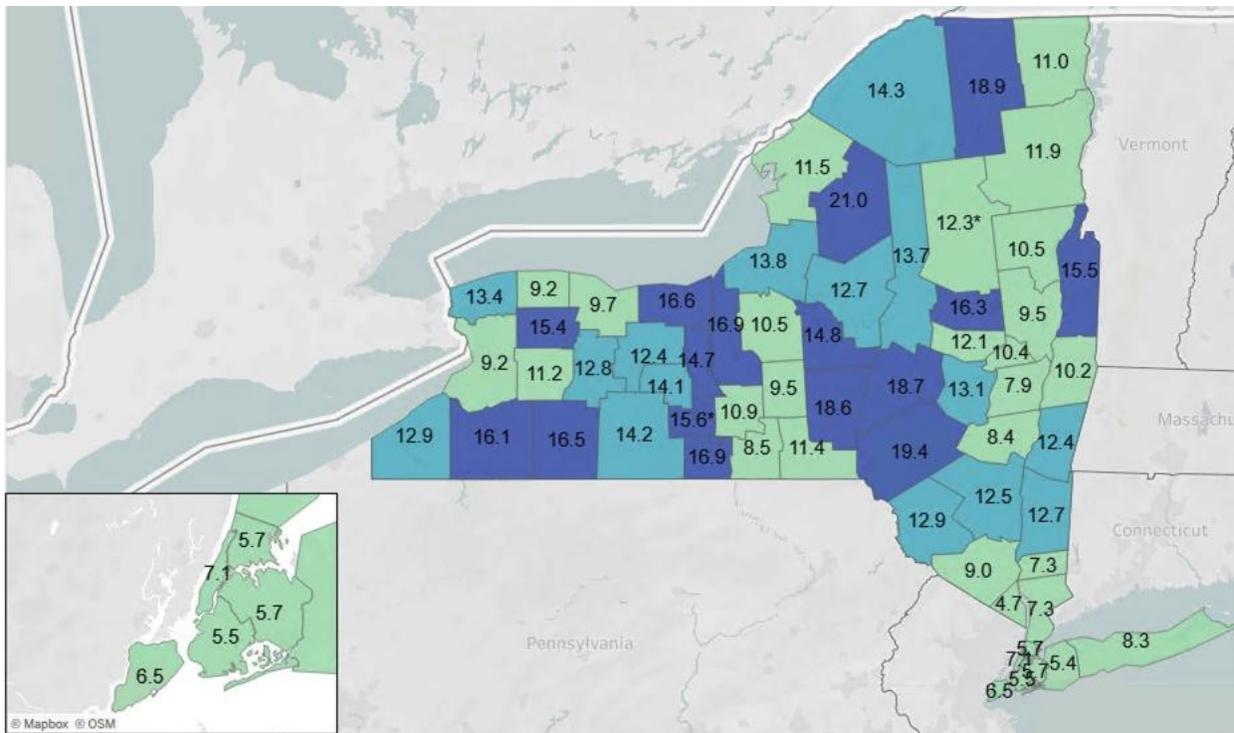
Suicide remains a significant and persistent public health concern in rural New York, with rates that often exceed state averages. **Figure 4** highlights 2022 suicide mortality by county, showing clusters of higher risk across the North Country, Southern Tier, and parts of the Hudson Valley. **Figure 5** provides detailed county-level suicide rates, many of which fall in the 7.3 to 21 deaths per 100,000 range – well above the state’s overall average.

The pattern is not only one of high baseline risk but also of variability. Some counties such as Delaware and Lewis report among the highest rates, while others such as Steuben or Tioga report lower but still concerning levels. Across regions, the trend is unmistakable: rural communities carry a disproportionate share of suicide mortality.

Key Metrics:

Suicide (Age adjusted rate per 100,000)³

Rural County Data Table containing these metrics can be found in [Appendix B](#)



Quartile (Q) Distribution

High Concern	Q4: 14.7 - 21
Moderate Concern	Q3: 12.4 - < 14.7
Low Concern	Q1 & Q2: 4.7 < 12.4

Figure 2: Age-adjusted suicide rate per 100,000 residents (2022).³

Age and Population Differences

Youth and older adults are identified as the groups at greatest risk. Among teenagers aged 15–19, suicide rates in several counties are significantly higher than statewide norms. These numbers can be misleading, as county-level youth mortality data can be unstable due to small sample sizes. To clarify, county youth mortality rates are based on few events, so they can jump with small changes. For example, in a county with 5,000 teens, moving from 1 to 3 deaths shifts the rate from 20 to 60 per 100,000 and may not reflect a true trend. Regardless, local health departments consistently describe adolescent suicide as a rising crisis. Bullying, sexual violence, child abuse, and untreated trauma are frequently mentioned as drivers of vulnerability.

Older adults are also at elevated risk. Counties such as Franklin, Sullivan, and Yates highlight high suicide rates among residents over 65, often linked to chronic illness, disability, social isolation, and loss of support networks. Local reports describe a “silent crisis” among seniors, one that is less visible than youth suicidality but equally urgent.

Contributing Risk and Protective Factors

Risk factors for suicide are multifaceted and overlap with broader behavioral health concerns. Economic hardship, unemployment, and unstable housing intensify distress in adults, while trauma exposure, family conflict, and school stressors shape youth vulnerability. Social isolation – a structural feature of rural life – cuts across age groups, amplifying risk for both adolescents and older adults.

Protective factors such as family connectedness, peer support, engagement in community networks, and timely access to care are consistently cited as mitigators; yet, these resources are unevenly distributed and many rural counties report insufficient infrastructure to sustain them.

Persistent Gaps in Crisis Response

Counties consistently describe limited access to crisis services. Mobile crisis units, 24/7 hotlines, and walk-in stabilization centers remain scarce, leaving emergency departments and law enforcement to manage many acute episodes. Long wait times for psychiatric evaluation and stigma around seeking care compound these challenges,

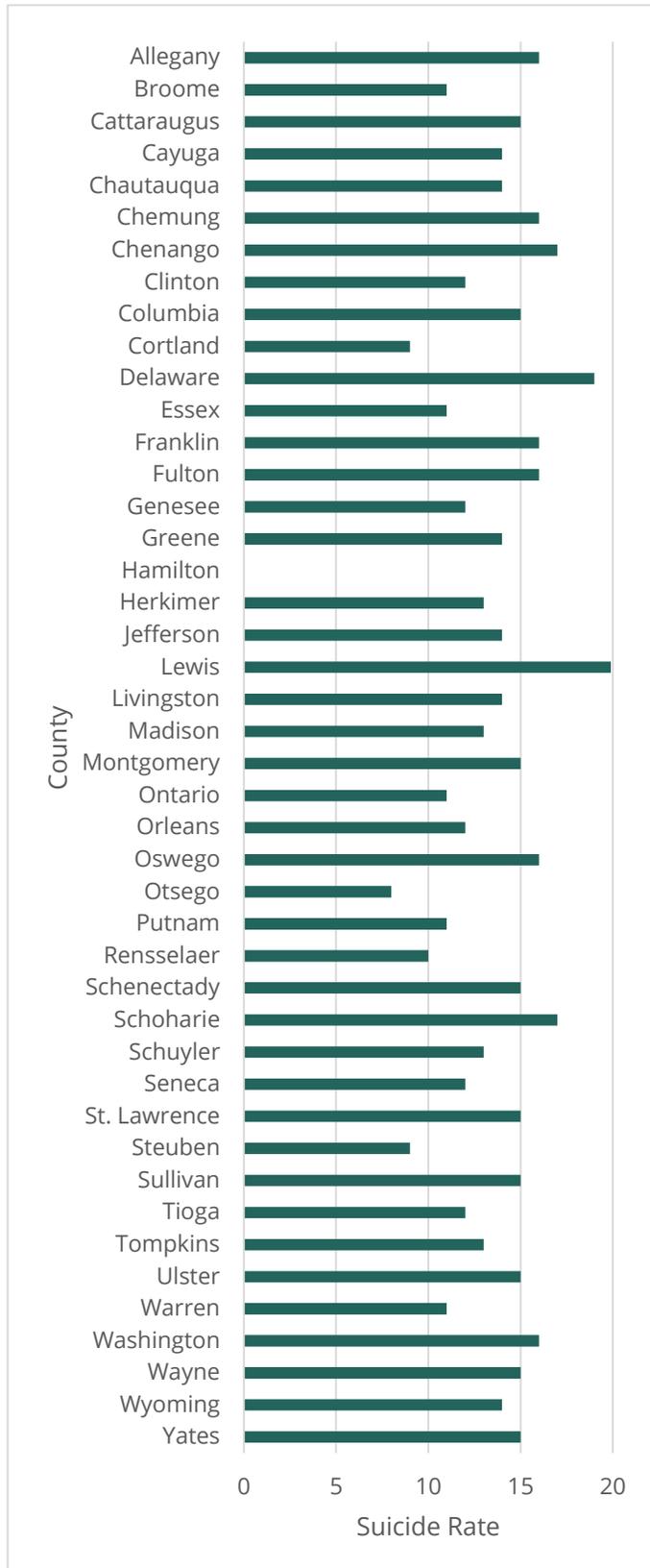


Figure 3: Suicide rate (per 100,000).³

leaving individuals at heightened risk without timely or appropriate intervention.

Structural Dimensions

County-level data and narratives make clear that suicide is not an isolated phenomenon but one deeply tied to structural determinants of health. Poverty, lack of transportation, workforce shortages, and limited service integration all intensify the problem. The persistence of high suicide mortality in rural New York underscores the need for both immediate crisis interventions and broader systemic change.

Key Takeaways: Suicide in Rural New York Counties

Above-average mortality: Many rural counties record suicide rates of 14–18 per 100,000, well above the state average.

Youth and older adult vulnerability: Adolescents face especially high risk, with local reports highlighting bullying, trauma, and untreated depression as key drivers. Older adults experience elevated suicide tied to social isolation, chronic illness, and loss of support.

Gaps remain: Family connectedness and peer/community supports are effective but not consistently available across counties. Mobile crisis and rapid-response services are insufficient in most areas.

Structural drivers: Suicide risk is compounded by poverty, limited behavioral health workforce, and long waits for care.

Substance Use

"The extent of substance use [is] inclining rapidly and these individuals do not have the resources available to break the cycle and be free from this tragic and debilitating illness. They continue their means of use and sales of substances to survive." - Chenango County CHA

Substance use is a common concern across rural New York, including drug, alcohol, and nicotine use. Counties describe high and rising overdose deaths driven by fentanyl, persistent binge drinking and impaired driving, and continued elevated rates of adult smoking alongside rapid growth in youth vaping. The burden is uneven by place and population, and the COVID-19 period intensified risk through isolation, disrupted services, and economic stress. Access

remains fragile because of workforce shortages, long travel distances to access treatment facilities, limited inpatient treatment options, and gaps in integrated care for co-occurring conditions.

Drug Use and Overdose

“Unintentional injury is now the leading cause of death in the United States for ages 1-44, and drug overdose is the leading cause of unintentional injury for ages 25-64. In 2017 more than 70,000 people died from a drug overdose, and of those deaths almost 68% involved a prescription or illicit opioid.”

- Broome County CHA

Drug use, particularly involving opioids and fentanyl, remains one of the most urgent behavioral health challenges across rural New York. Nearly every county identifies opioid-related deaths as a top priority, with overdose rates frequently exceeding state averages. Rates range widely, from 8.2 per 100,000 in Yates County and 11.3 in Lewis County to catastrophic levels in counties such as Sullivan (64), Broome (51.7), and Chautauqua (48.7). **Figure 6** reflects this struggle with overdose rates across New York counties. In many areas, opioid overdose deaths have risen sharply since 2010, with especially steep increases tied to synthetic opioids such as fentanyl. County reports confirm that fentanyl is now present most opioid-related fatalities, surpassing heroin or prescription pain relievers as the primary driver of mortality.

The COVID-19 pandemic intensified this crisis. Counties such as Ulster documented more than a 40 percent increase in overdoses and a doubling of opioid-related fatalities between 2019 and 2021. Other rural counties describe a similar acceleration during the pandemic years, with heightened isolation, economic stress, and disruptions to services amplifying risk and delaying treatment access.

Demographics of Risk

The crisis disproportionately affects adults aged 18 to 64, particularly males and non-Hispanic whites, though disparities across other groups are noted as well. In many rural counties, emergency department visits related to overdoses remain elevated, underscoring the strain on already limited health systems. Local reports also highlight geographic disparities: smaller and

Key Metrics:

Drug Overdose Rate (per 100,000 residents)⁴

Smoking (per 100,000 residents)¹

Binge Drinking (per 100,000 residents)¹

Alcohol-Impaired Driving Deaths²

Rural County Data Table containing these metrics can be found in [Appendix B](#).

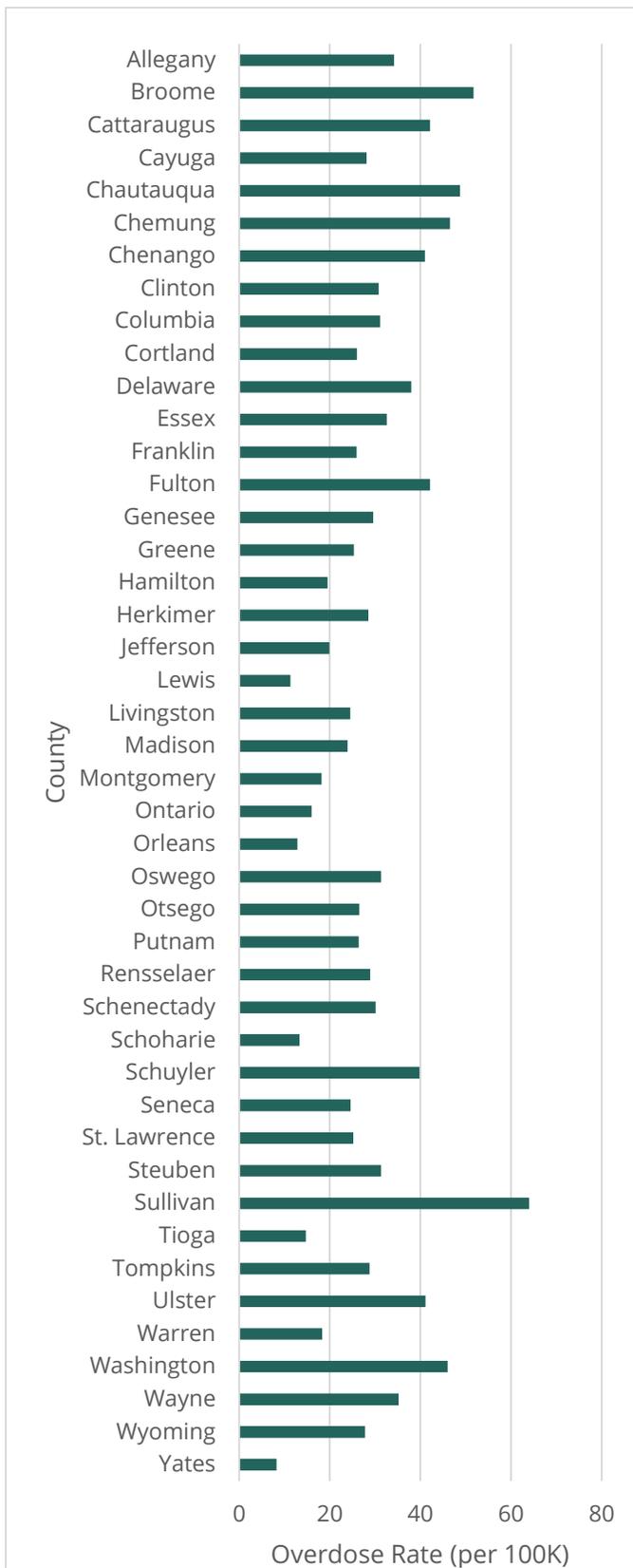


Figure 4: Overdose rate (per 100,000).⁴

more remote counties often have fewer hospital-based detox or stabilization units, leaving EDs as the only point of acute care.

At the same time, prescribing rates for opioid medications, though declining statewide since 2015, remain above average in many rural areas. Elevated prescribing, when combined with the influx of fentanyl and other synthetics into drug markets, contributes to an environment of sustained risk for misuse, overdose, and death.

Treatment Access and Gaps

Counties consistently describe the dual challenge of rising overdose deaths and limited treatment access. Many rural areas lack sufficient infrastructure for prevention, treatment, and recovery. Medication-Assisted Treatment (MAT) programs are particularly scarce in counties with the highest overdose rates, and where they do exist, programs often operate at capacity. Geographic barriers and transportation difficulties compound these gaps, with individuals traveling 30 miles or more for care, often across county lines.

Equally concerning is the limited availability of integrated treatment for co-occurring substance use and mental health disorders. County reports note that depression, anxiety, and trauma frequently intersect with substance use,

yet treatment programs are often siloed, leaving residents with fragmented care. Waitlists, workforce shortages, and stigma further delay access, leading to preventable relapses and, in many cases, repeat overdoses.

Structural Drivers and Ongoing Challenges

Structural barriers such as transportation gaps, limited housing, and workforce shortages, continue to drive overdose deaths upward. The compounding effects of poverty, unemployment, and rural isolation create conditions where recovery is fragile and relapse is common.

Counties repeatedly emphasize that substance use cannot be addressed in isolation. Instead, it must be understood as part of the broader behavioral health landscape – one deeply connected to co-occurring mental health conditions, housing instability, and social determinants of health. Without addressing these root causes, local stakeholders argue, overdose prevention and treatment efforts will remain insufficient.

The findings confirm that substance use in rural New York is both a public health emergency and a systemic challenge. Counties and community coalitions are working to expand harm reduction, treatment access, and recovery supports, but without stronger investment in infrastructure, workforce development, and integrated care, rural communities will continue to face rising overdose deaths and unmet needs for prevention and recovery.

Key Takeaways: Drug Use and Overdose in Rural New York Counties

Overdose mortality exceeds state averages: Multiple rural counties report rates above 30 per 100,000, with Sullivan, Ulster, and Broome among the highest.

Fentanyl dominates fatalities: Synthetic opioids now account for most overdose deaths, surpassing heroin and prescription painkillers.

COVID-19 accelerated the crisis: Counties like Ulster saw a 40% rise in overdoses and doubled fatalities between 2019–2021.

Treatment gaps persist: Many high-burden counties lack sufficient MAT programs and integrated behavioral health services; geographic barriers further delay care.

Systemic drivers remain unresolved: Poverty, housing instability, workforce shortages, and transportation barriers fuel ongoing overdose risk.

Alcohol Use

“Alcohol is the most-often identified gateway drug by people who misuse other substances such as prescription and illicit drugs. Preventing adolescents from using alcohol and other substances and supporting conditions or attributes that mitigate the risk factors associated with substance use are key strategies that can be used to prevent alcohol misuse.” - Essex County CHA

Scope of Alcohol Misuse

Alcohol misuse remains a persistent and significant behavioral health concern throughout rural New York. Counties consistently report elevated levels of binge drinking, impaired driving, and related harms, underscoring that alcohol use is not merely an individual choice but a population-level issue that affects public health, community safety, and economic well-being. Binge drinking, defined as consuming four or more drinks for women or five or more drinks for men on a single occasion, is notably prevalent among young adults but is also documented across a broad spectrum of ages and income groups. In many rural areas, binge drinking is normalized through cultural and social practices, and its consequences ripple far beyond those who engage in risky consumption.

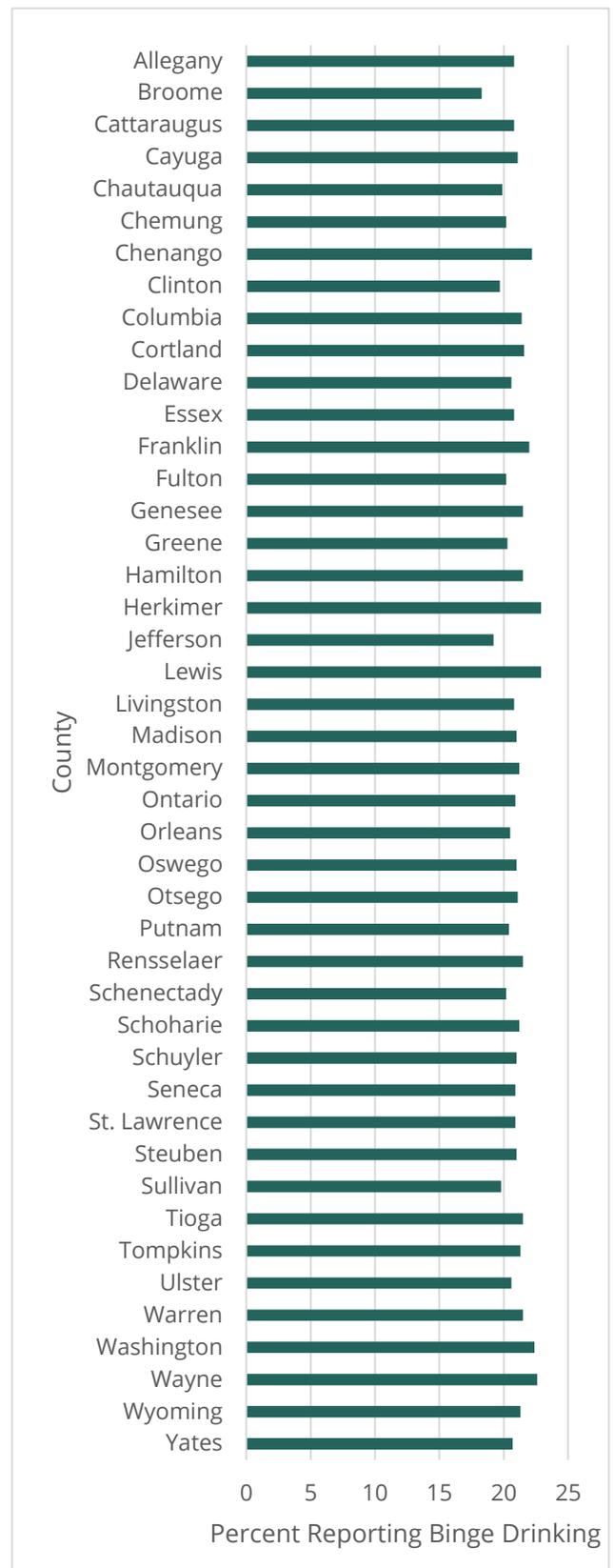


Figure 5: Percent of residents reporting binge drinking.¹

County-level data illustrate the widespread nature of binge drinking across rural New York (Figure 7). Most counties report prevalence rates clustered tightly between 20% and 22% of adults, with very few falling outside this range. For example, Sullivan County reports approximately 19.8%, while Rensselaer County is slightly higher at 21.5%, aligning closely with the rural average. Counties such as Essex (20.8%) and Washington (22.4%) also fall within this band, demonstrating how consistent binge drinking prevalence is across regions. Even counties on the lower end, like Clinton (19.7%) or Jefferson (19.2%), remain near the overall pattern.

Taken together, these figures show that binge drinking is not confined to isolated pockets of the state but represents a structural, statewide rural issue. With nearly every county falling within a narrow band of 20–22%, the data underscore how deeply binge drinking is embedded across demographics and geographies. Figure 8 illustrates the distribution of these rates across rural counties, reinforcing the ubiquity of this behavior.

Community-Level Consequences

The consequences of alcohol misuse extend far beyond the individual and deeply affect community safety and economic stability. Alcohol-impaired driving remains one of the leading contributors to motor vehicle injuries and fatalities in rural counties. Long travel distances on unlit roads, limited public transportation, and fewer law enforcement patrols exacerbate the risk of alcohol-related crashes. **Figure 8** reveals stark geographic variation, with clusters of rural counties reporting impaired driving death rates well above state averages.

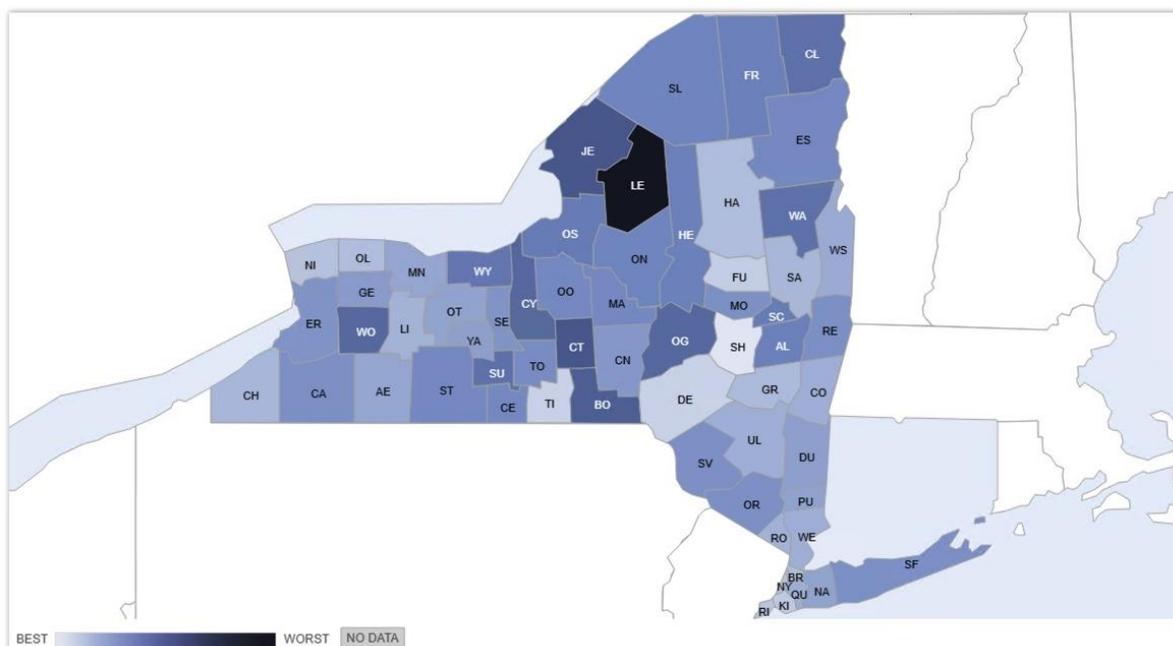


Figure 6: Alcohol-impaired driving fatalities, 2018-2022.¹

Putnam County is among the most concerning examples, with alcohol-related motor vehicle injury and death rates exceeding 50 per 100,000 population. Sullivan County reports rates of approximately 50.1 per 100,000, and Ulster County 44.8 per 100,000, placing both among the highest in the state. Clinton County also reports elevated rates of alcohol-related crashes at 55.2 per 100,000, highlighting that this problem extends to the North Country as well as the Hudson Valley. These figures demonstrate the ongoing difficulty of reducing alcohol-related traffic harms in rural areas, even as statewide fatality rates have declined.

The strain on emergency departments and healthcare systems from alcohol-related injuries is profound. Alcohol-related crashes and trauma cases require urgent, resource-intensive interventions, diverting limited staff and beds away from other needs. Beyond traffic injuries, excessive alcohol consumption contributes to liver disease, hypertension, and cancers, while also worsening mental health conditions such as depression and anxiety. Social impacts - including domestic violence, child neglect, and workplace absenteeism - add further economic strain, compounding the public health burden. Counties report that these broader harms reinforce cycles of instability that affect families, schools, and local economies.

Persistent Rural Burden

Despite statewide progress in reducing alcohol-impaired driving fatalities over the past two decades, rural counties continue to experience disproportionately high rates compared to urban areas. This uneven distribution underscores the unique challenges faced by rural populations, where geographic isolation, limited enforcement, and cultural acceptance of drinking converge to sustain high levels of harm. Counties such as Greene and Washington report alcohol-related crash and death rates well above state averages, despite overall statewide improvements.

Alcohol misuse also intersects with other behavioral health concerns, magnifying its impact. In Tioga County, for example, alcohol use is intertwined with broader substance use issues, compounded by limited provider availability, poverty, and transportation barriers. These social determinants deepen disparities and make recovery more difficult. Similarly, in Franklin County, alcohol misuse is reported alongside high rates of mental distress, suicide risk, and economic instability, illustrating how alcohol contributes to a web of interconnected challenges.

These intersections underscore that alcohol cannot be addressed as a stand-alone issue. Effective strategies must integrate alcohol misuse prevention and treatment into broader behavioral health frameworks that also address trauma, mental illness, and substance use

disorders. Counties increasingly call for trauma-informed approaches, expanded recovery supports, and structural investments that target the root causes of alcohol misuse, including poverty, transportation inequities, and cultural acceptance of risky drinking. Without these systemic changes, rural residents will continue to bear a disproportionate burden of alcohol-related harm, even as the state overall moves toward progress.

Key Takeaways: Alcohol-Impaired Driving Deaths and Binge Drinking in Rural New York Counties

Binge drinking affects 18–22% of rural adults, with prevalence highest among young adults but present across all groups.

Alcohol-impaired driving deaths remain elevated in rural counties, with some regions (e.g., Mid-Hudson, North Country) recording the state’s highest rates.

Community-level impacts include preventable injury, loss of life, and strain on emergency medical and healthcare systems.

Recovery services remain uneven, with rural residents facing gaps in alcohol use disorder treatment access.

Alcohol misuse intersects with other behavioral health issues, reinforcing the need for integrated approaches.

Tobacco and Vaping

“Smoking is the leading cause of preventable morbidity, mortality, and health expense in the U.S.” - Schenectady County CHA

Nicotine use in rural New York remains one of the most persistent and evolving public health challenges. While cigarette smoking has declined statewide over the past two decades, rural counties continue to report significantly higher rates than urban areas, with certain vulnerable populations facing especially steep disparities. At the same time, new products such as e-cigarettes and flavored vaping devices have rapidly shifted nicotine use patterns among adolescents and young adults, raising concerns about a new generation at risk of long-term dependence. Together, high adult smoking rates and rising youth vaping prevalence illustrate how rural communities are navigating both the legacy of tobacco use and the emerging risks of vaping, with consequences that cut across health, equity, and prevention systems.

Adult Smoking Trends

Adult smoking rates in rural areas are consistently above the statewide average of 12% (Figure 9). Many rural counties fall in the 16–19% range, underscoring the gap between rural and statewide prevalence.

These patterns are tightly linked to mental health. Individuals with depression, anxiety, and trauma histories are far more likely to use tobacco, and county stakeholders repeatedly describe smoking as a coping mechanism in communities where stress, isolation, and economic hardship are prevalent. Local surveys show that smoking rates climb to 45% among low-income adults and exceed 50% among residents with disabilities, populations that also report high levels of poor mental health and unmet behavioral health needs. In this way, tobacco use is not only a driver of physical illness but also a marker of deeper structural stressors affecting mental well-being.

Smoking worsens depression and anxiety symptoms, complicates recovery from substance use disorders, and reduces the effectiveness of psychiatric medications. Local health departments increasingly frame cessation as a behavioral health intervention, with the potential to improve mood, enhance resilience, and reduce relapse risk. Sustained investments in prevention, cessation programs, and trauma-informed approaches are therefore central not only to reducing chronic disease but also to strengthening rural behavioral health.

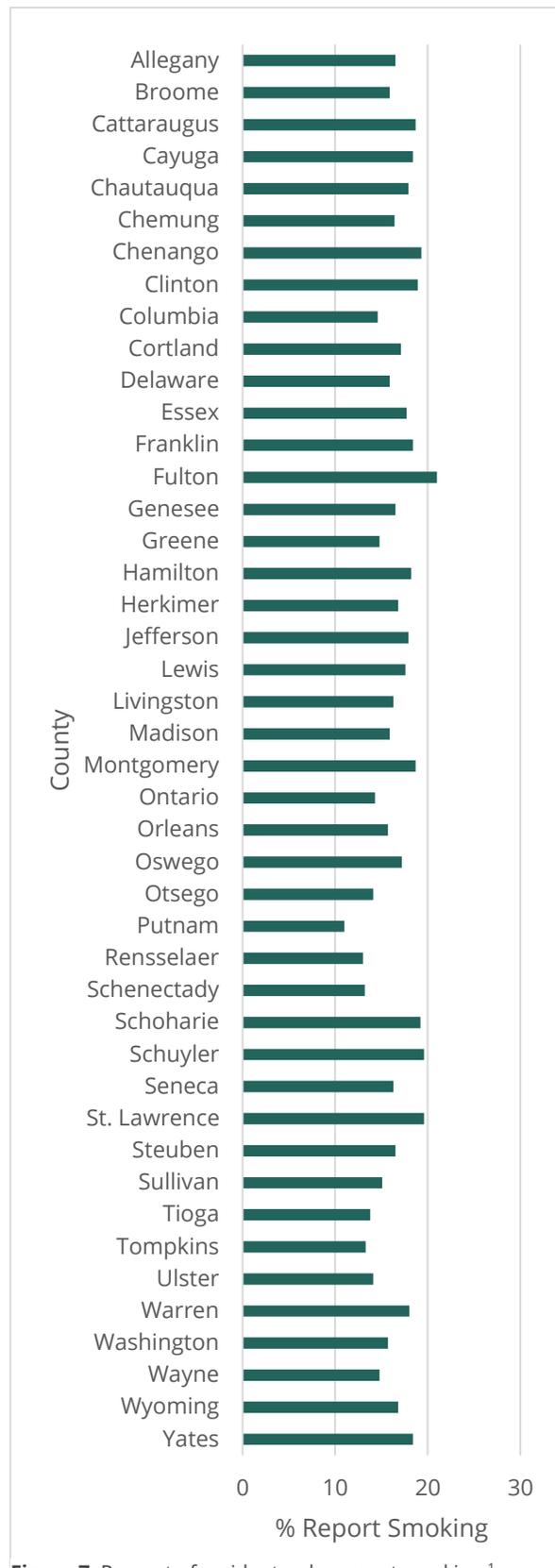


Figure 7: Percent of residents who report smoking.¹

Youth Vaping and Emerging Risks

In contrast to entrenched adult smoking, rural counties face a rapidly growing challenge in the form of youth vaping. Data from Broome and Otsego Counties show that nearly one in four high school students report using e-cigarettes within the past month, with Broome's rate climbing to 28.8%, well above state and national averages. This represents a generational shift in nicotine use: while traditional cigarette smoking has declined among youth, vaping has become the primary entry point.

Similar patterns emerge in Genesee, Orleans, and Wyoming Counties, where youth vaping prevalence has spurred targeted interventions aimed at cutting rates by as much as 16.6%. Stakeholders highlight the role of flavored products like JUUL in attracting adolescents, noting that vaping normalizes nicotine use and increases the likelihood of both lifelong dependence and eventual transition to combustible tobacco products. The developmental risks of nicotine exposure during adolescence heighten the concern, as vaping threatens to reverse public health gains made in reducing youth smoking.

Trends in adult smoking and youth vaping reflect structural vulnerabilities in rural areas, including socioeconomic disparities, limited access to cessation services, and environments where tobacco products remain accessible and normalized. While prevention programs, school initiatives, and statewide policy reforms are promising steps, counties underscore that reducing tobacco and vaping harms requires a comprehensive approach. Coordinated strategies that combine prevention, treatment, and policy enforcement—while addressing the social determinants that sustain nicotine use—are essential for reversing the tide of preventable illness and creating healthier, more resilient rural communities.

Key Takeaways: Tobacco Use and Vaping in Rural New York Counties

Adult smoking rates in several rural counties exceed 18%, higher than the statewide average of ~12%.

Nearly **one in four high school students report recent vaping**, with flavored e-cigarettes as common entry points.

Vaping normalizes nicotine use, increases addiction risk, and can act as a gateway to cigarette smoking.

Addressing both entrenched adult smoking and emerging youth vaping is essential to reducing preventable disease in rural NY.

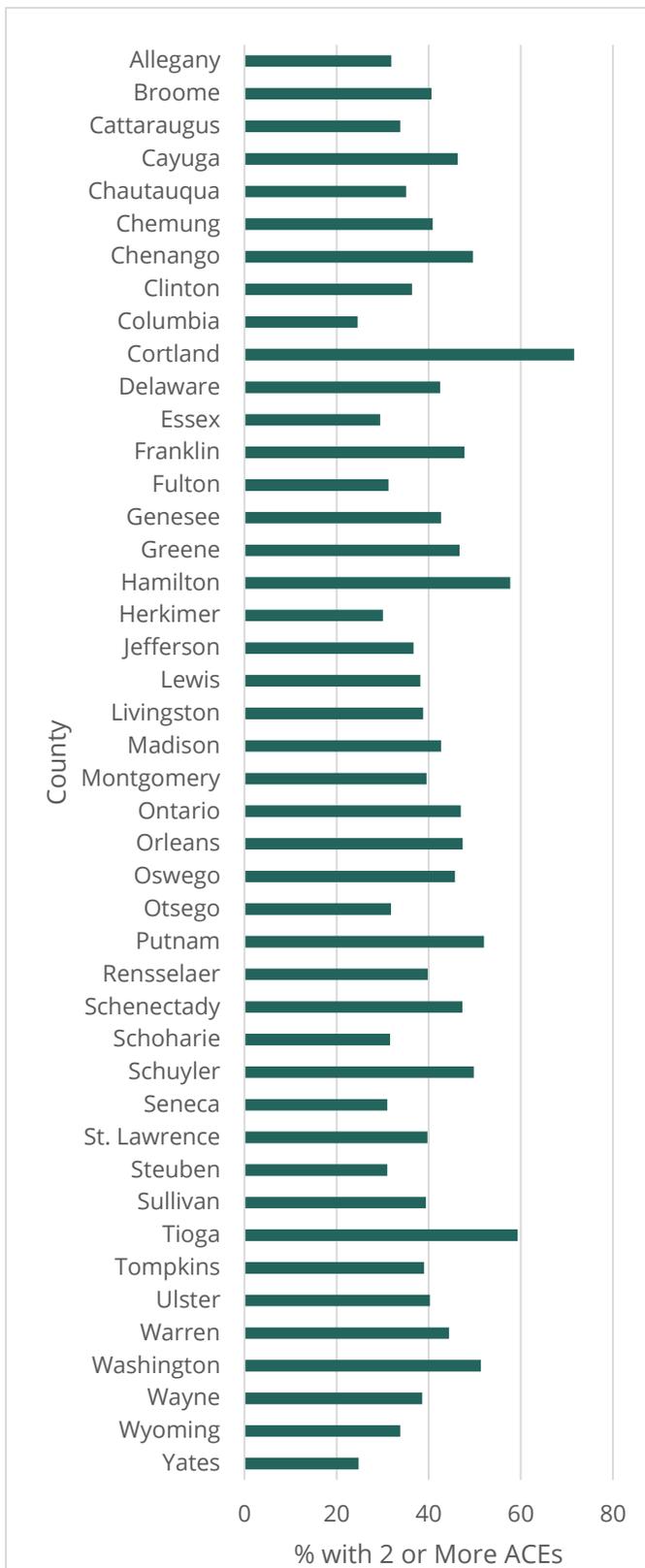


Figure 9: Percent of the population with 2 or more ACEs.³

fueling those conditions. This recognition has shifted the conversation: counties increasingly frame trauma as a structural determinant of health, shaped by environments of violence, instability, or inequity. This broader framing encourages solutions that extend beyond clinical care into social policy and community resilience.

Prevalence and Long-Term Impacts

ACEs are highly prevalent across rural and semi-rural communities, cutting across socioeconomic groups but disproportionately affecting families facing poverty, housing instability, and social isolation. Together, **Figures 10 and 11** demonstrate this stark reality. The widespread nature of trauma underscores its foundational role in shaping behavioral health outcomes. Early adversity is consistently linked to depression, anxiety, substance use, suicidal behavior, and chronic physical illness. In many counties, ACE exposure is nearly universal among individuals engaged in treatment, underscoring how deeply trauma shapes the behavioral health landscape.

Local data illustrate these patterns clearly. In Livingston County, an alarming three-quarters of residents report at least one ACE. In Ontario County, more than 40 percent of high school seniors report two

or more ACEs, strongly correlated with depression and suicidal ideation. Monroe County surveys show that 70 percent of youth report at least one ACE and one-third report two or more, with these youth at far higher risk of suicide attempts, substance use, and persistent sadness. Madison County reports child abuse and neglect rates higher than both state and national averages. In Clinton, Cortland, Seneca, and Wayne, ACE prevalence and child maltreatment indicators highlight trauma as a widespread, early-occurring, and severe problem across rural communities.

Quantitative analyses from Genesee, Orleans, and Wyoming Counties demonstrate a dose-response effect. In Genesee, residents with one ACE were nearly three times more likely to report poor physical health, and those with four or more ACEs were over five times more likely. In Orleans, four or more ACEs nearly tripled the odds of poor physical health and were strongly associated with worse mental health. In Wyoming, even a single ACE nearly quadrupled the odds of poor physical health, while four or more ACEs carried less incremental risk than in neighboring counties. Across all three counties, ACE exposure was tied to higher rates of smoking, binge drinking, and other substance use, compounding already elevated health risks.

Counties also emphasize the cyclical and intergenerational nature of trauma. Parents with high ACE scores are more likely to struggle with mental health and substance use themselves, contributing to unstable environments that perpetuate trauma in their children. Leaders note that trauma influences not only individual health but also school readiness, workforce participation, and economic stability, reinforcing cycles of disadvantage.

Barriers and Capacity Challenges

Although there is widespread recognition of trauma as a foundational driver of behavioral health and social outcomes, most counties report that their capacity to respond remains limited and uneven. A primary obstacle is the pervasive shortage of qualified behavioral health professionals.

Fragmented service delivery further complicates trauma response. Many counties report a lack of coordination between behavioral health providers, primary care, schools, and social services. Without integration, trauma-informed practices are inconsistently applied, leaving families to navigate disconnected systems. In Chenango County, the absence of integrated primary and behavioral health services is identified as a major barrier. Across rural regions, limited training opportunities for frontline staff in education, healthcare, and community organizations compound these gaps, resulting in patchy adoption of trauma-sensitive approaches.

Funding instability represents another major barrier. Trauma-informed care initiatives are often supported through short-term grants, leaving counties without reliable long-term resources to sustain programs once initial funding ends. Sullivan County notes that while prevention and intervention strategies are a priority, current goals are insufficient due to funding limitations. St. Lawrence County emphasizes that high staff turnover and ongoing system churn require constant retraining, consuming scarce resources and undermining continuity. Counties caution that this cycle of instability weakens progress, as investments in trauma-informed care repeatedly lose momentum when programs cannot be sustained.

Counties also report that trauma-informed work requires long-term commitment and policy-level change, not isolated projects. Without systemic reforms, trauma-informed care remains partial and unevenly applied. Counties consistently emphasize that trauma response must be institutionalized through stable funding streams, workforce development, cross-sector collaboration, and ongoing leadership commitment. Only then can trauma-informed approaches deliver the continuity, stability, and reach needed to address the deep and intergenerational impacts of ACEs across rural New York.

Key Takeaways: Trauma and ACEs in Rural New York Counties

Widespread prevalence: Local surveys show high exposure, with many youth and adults reporting multiple ACEs tied to depression, suicidality, substance use, and chronic illness.

Dose-response effect: Health outcomes worsen as ACE exposure increases. Even one ACE elevates risk, while four or more ACEs are strongly associated with poor physical and mental health.

Barriers to care: Workforce shortages, fragmented systems, limited training for frontline staff, and unstable funding undermine the consistency and sustainability of trauma-informed care.

Foundational driver and cross-sector issue: Trauma and ACEs are root causes of behavioral health challenges. Unaddressed trauma undermines recovery and fuels relapse.

Healthy Eating and Nutrition

“Poor nutrition and food insecurity are key social determinants of health that impact mental health and substance use treatment outcomes.” -

Chautauqua County CHA

Access to healthy and affordable food emerges across rural New York as both a health concern in its own right and a critical social determinant of behavioral health. Counties consistently report high levels of food insecurity, particularly among low-income households and families with children. Many rural residents face long travel distances to grocery stores, limited availability of fresh produce, and high reliance on convenience outlets where nutritious options are scarce. These challenges are closely tied to poverty, transportation limitations, and the absence of robust local food systems that can reliably supply affordable, high-quality foods. **Figures 12 and 13** illustrate prevalence of food insecurity across the state.

Key Metrics:

% of residents experiencing food insecurity¹

Rural County Data Table containing these metrics can be found in [Appendix B](#).

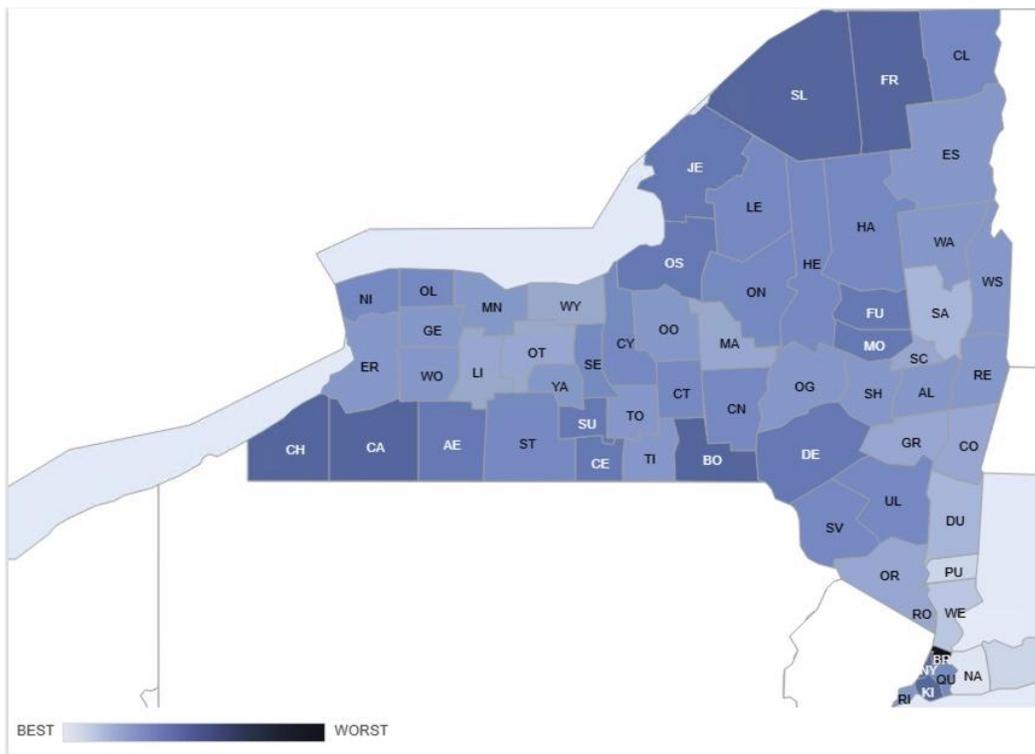


Figure 10: Percent of residents experiencing food insecurity (2022).¹

While food insecurity is not the most central finding in county needs assessments compared to issues like workforce shortages or overdose deaths, it remains an important theme. Stakeholders stress that food insecurity compounds other behavioral health challenges, reinforcing cycles of stress and limiting the effectiveness of prevention and treatment efforts.

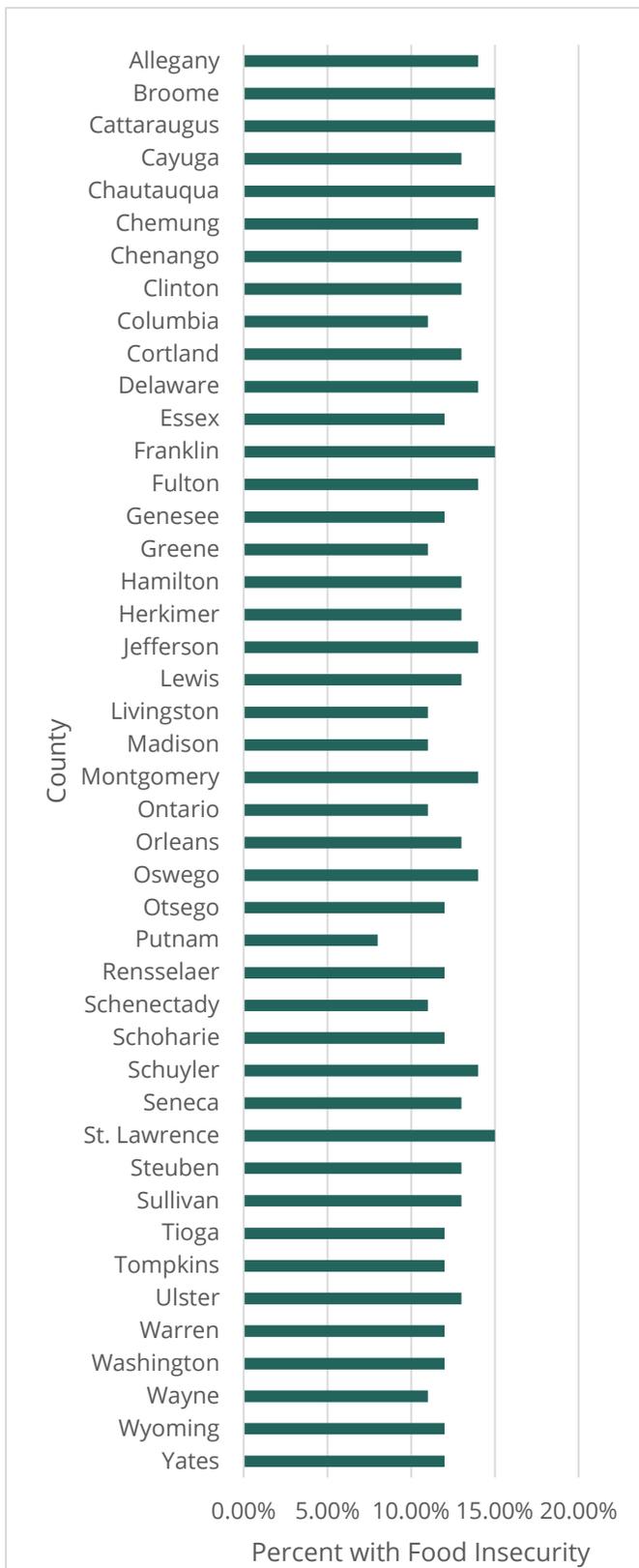


Figure 11: Percent of residents facing food insecurity (2022).¹

Counties emphasize that without stable access to nutrition, progress in other areas of behavioral health may be undermined.

Connections to Behavioral Health Outcomes

County assessments also highlight the clear connection between food insecurity and behavioral health. Families struggling to secure adequate nutrition face chronic stress, which compounds anxiety and depression and elevates the risk of poor outcomes across the life course. For children, food insecurity is linked to developmental and behavioral challenges that spill over into schools and social services. For adults, the daily stress of food scarcity contributes to feelings of hopelessness, complicates recovery from substance use disorders, and erodes overall well-being.

This relationship underscores that food insecurity is more than an issue of hunger. It shapes how individuals and families experience stress, how communities mobilize to meet needs, and how behavioral health systems respond. Counties increasingly view food access as a behavioral health intervention, one that can help reduce vulnerability and strengthen resilience.

Ongoing Challenges

Despite these promising practices, counties acknowledge persistent barriers.

Food assistance programs are often underutilized due to stigma, lack of awareness, or administrative hurdles. Transportation remains a limiting factor, preventing many rural residents from accessing either food outlets or food distribution sites. These themes mirror broader accessibility issues in the behavioral health system, reinforcing the interconnected nature of social determinants.

Counties also note that while food insecurity is widely recognized, it often receives less funding and policy attention compared to more acute behavioral health concerns. Stakeholders argue that sustained investment in transportation, economic opportunity, and local food systems is necessary to move from short-term relief to long-term stability.

Key Takeaways: Food Access and Nutrition in Rural New York Counties

Not central but significant: Food insecurity is not the top-ranked behavioral health issue, but it remains an important determinant that influences outcomes across mental health and substance use.

Persistent challenges: Limited grocery access, long travel distances, and poverty sustain high levels of food insecurity in many rural counties.

Behavioral health connection: Food insecurity compounds stress, depression, and recovery challenges, while children in food-insecure households face developmental and behavioral risks.

Need for systemic investment: Sustainable progress requires stronger investments in transportation, local food systems, and culturally appropriate food access.

Access to Care

As the themes are examined together, one issue consistently emerges as the central and unifying theme: **accessibility**. Counties describe behavioral health needs that are widespread and urgent, yet repeatedly note that services are difficult to reach, fragmented, or altogether absent. This lack of accessibility is not limited to one type of service or one segment of the population. It is the thread that runs through nearly every area of concern identified in the SARHNA.

Accessibility has multiple dimensions. At the most immediate level, it is defined by the presence of providers who can deliver care when and where it is needed. Many counties report that even when residents are motivated to seek help, they face long wait times, limited appointment

availability, or the absence of specialists in their community. Access is also shaped by geography: rural residents often live far from the nearest mental health clinic, recovery program, or crisis center, and the lack of transportation options makes these distances especially daunting. For others, the barrier is technological. Without reliable broadband, telehealth cannot fill the gaps left by provider shortages and geographic isolation.

Accessibility is about more than service availability: it also requires that services be usable and acceptable. Stigma around mental health and substance use continues to deter individuals from seeking care, particularly in smaller rural communities where anonymity is limited. Financial barriers, including lack of insurance coverage or high out-of-pocket costs, create additional obstacles. For families facing poverty, food insecurity, or unstable housing, behavioral health services may be inaccessible even when physically present.

In the following sections, this report describes barriers that underpin accessibility of services: workforce shortages, service gaps, and infrastructure limitations (including challenges associated with transportation and broadband).

Workforce

"Workforce recruitment and retention continues to be an issue across all three disability populations in Sullivan County. Sullivan County has a record high number of staff vacancies for all positions including clinical, health professionals, and paraprofessionals... Lack of staff continues to be at a crisis level of need." - Sullivan County CHA

Workforce shortages continue to be identified as the most pressing barrier to access to behavioral health care in rural New York. Across nearly every CHA), CHIP, and LSP, counties cite insufficient provider capacity as a top concern. Shortages affect the entire continuum of care, including psychiatrists, licensed clinicians, nurses, direct support staff, peer specialists, and home health aides.

Key Metrics:

Number of individuals served by one Mental Health Provider¹

Psychiatrists (per 100,000)¹

Licensed Mental Health Counselors (per 10,000)¹

Licensed Clinical Social Workers (per 10,000)¹

Rural County Data Table containing these metrics can be found in [Appendix B](#).

Mental Health Providers

Shortages of mental health providers have created a behavioral health system that cannot keep pace with community needs. Even where services may be available on paper, they may be functionally inaccessible due to vacant positions. As **Figure 14** shows, psychiatrist shortages are especially severe, with some counties reporting no child psychiatrists at all. **Figure 15** shows that licensed clinical social workers and mental health counselors are also difficult to recruit and retain, leading to long waits for therapy and psychiatric medication management. Nursing vacancies compound these problems, particularly in rural hospitals and community-based clinics where turnover is high and recruitment pipelines are limited.

Beyond licensed staff, counties face severe gaps in direct support roles that are essential for daily functioning and independence. Chronic shortages of home health aides, personal care aides, and staff serving individuals with developmental disabilities (OPWDD populations) are widespread. Low-wage, high-demand jobs with limited advancement drive chronic turnover and vacancies. The practical impact is reduced continuity of care and greater burdens on families, especially where institutional alternatives are distant or already overextended. Home care shortfalls limit the ability of older adults and people with chronic conditions to remain at home, forcing families to shoulder more care and increasing strain on facilities.

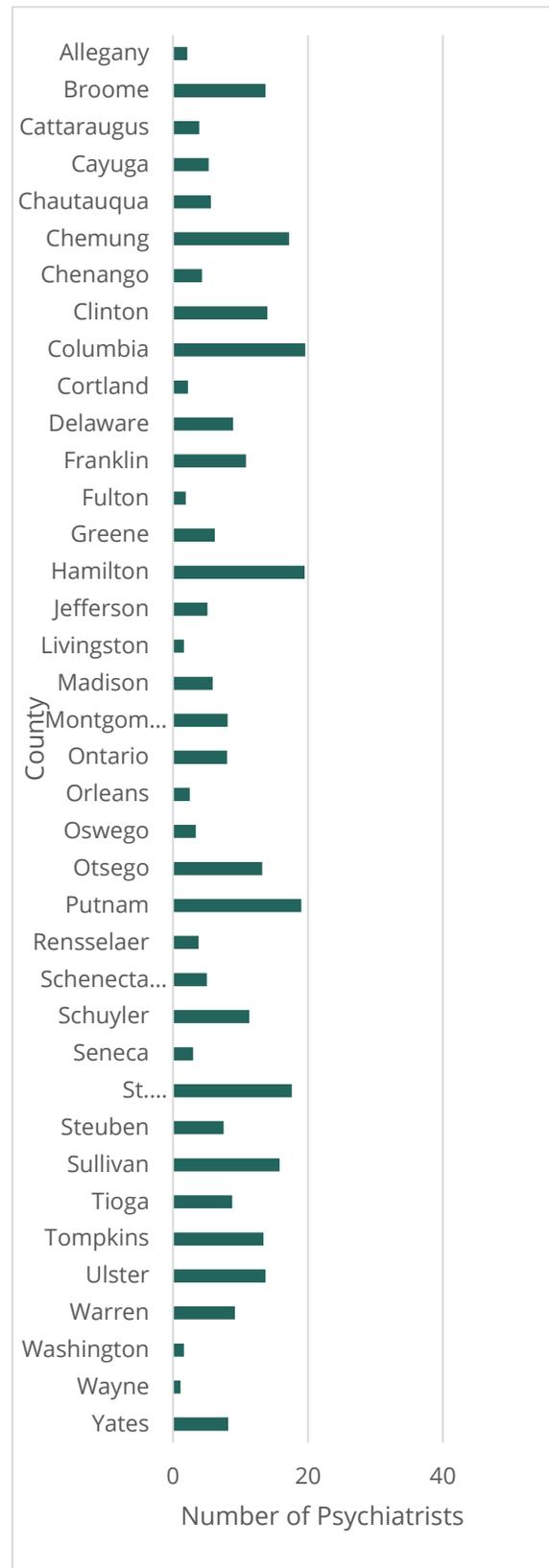


Figure 12: Number of psychiatrists per 100,000.¹

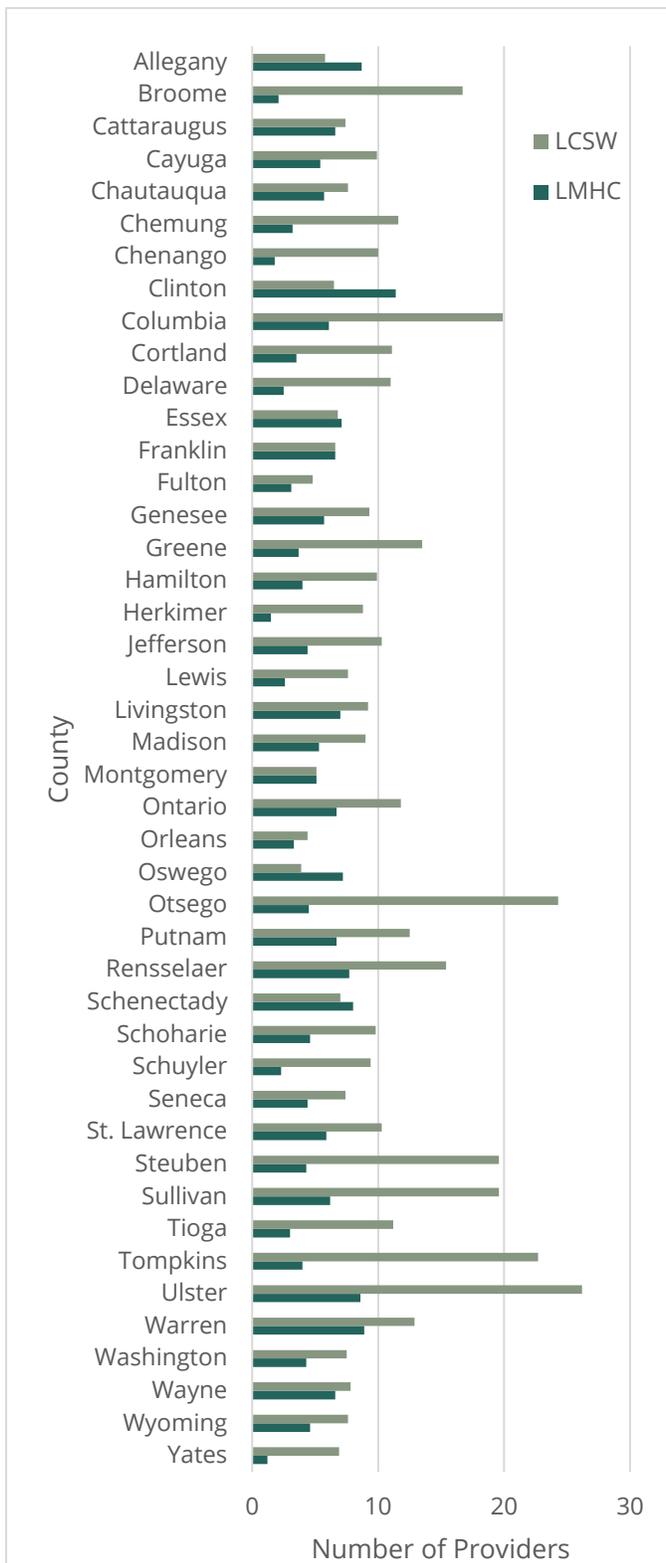


Figure 13: Number of Licensed Clinical Social Workers and Licensed Mental Health Professionals per 100,000.¹

These qualitative reports are confirmed by quantitative indicators of shortage. Many rural counties are formally designated as Mental Health Professional Shortage Areas (MHPSAs), with provider-to-population ratios far worse than the state average (**Figure 16**). While New York as a whole averages one mental health provider for every 371.5 residents, rural counties often report ratios of 1:500 or higher, with the most extreme reaching 1:1,690. These disparities highlight the scale of unmet need. Moreover, because the data reflect licensed providers rather than full-time, actively practicing clinicians, the true shortage is likely greater than reported. In the most underserved communities, each provider must serve hundreds more residents than the statewide norm, leading to overburdened staff, fragmented care, and delays that cascade across the system.

Designations and licensing data likely still understate the on-the-ground reality. County CHAs, CHIPs, and LSPs describe services paused or closed because vacancies could not be filled, children waiting months or years for therapy, and families unable to find psychiatric care within county borders. Turnover perpetuates cycles of disruption. Without a uniform system to track vacancies, turnover, or workforce development pipelines, the true scope of the crisis remains hidden.

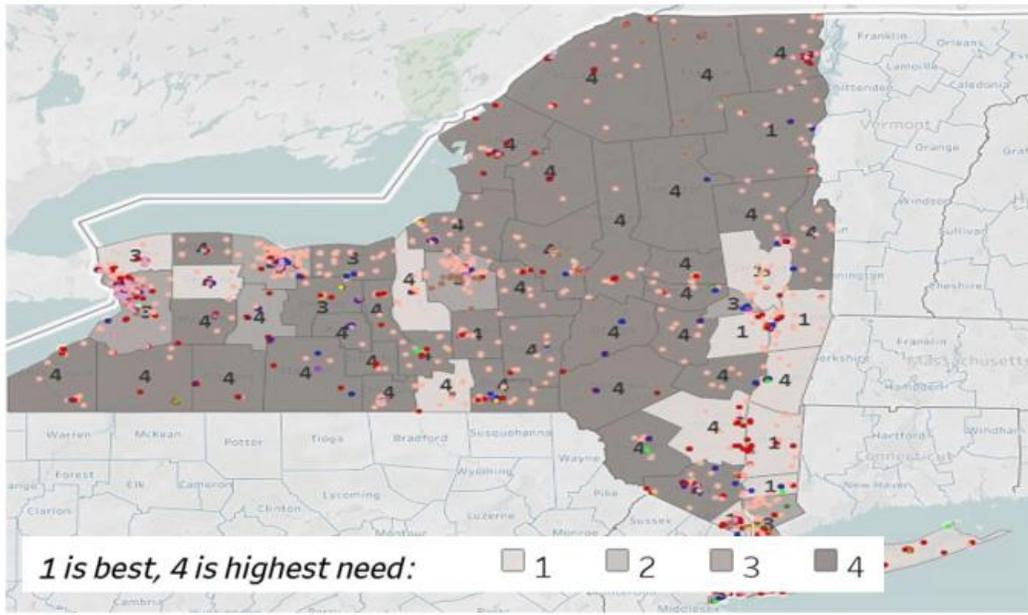


Figure 14: Designated Workforce Shortage Areas.⁶ Number indicates severity of Health Professional Shortage Area; shading indicates severity of Mental Health Professional Shortage Area.

Table 1: Positions with critical vacancies.

Category	Positions	Counties with Shortages
Nursing	Registered Nurses (RNs), Licensed Practical Nurses (LPNs)	Broome, Clinton, Essex, Franklin, Fulton, Hamilton, Montgomery, Saratoga, Warren, Washington, Schuylar, Schoharie, Delaware, Steuben, Jefferson, Chenango, Cayuga, Greene, Putnam
Specialized Clinician	Psychiatrists (esp. child), Licensed Clinicians (LCSW, LMHC, LMFT), Counselors, Psychologists	Hamilton, Livingston, Schuylar, Broome, Chenango, Delaware, Steuben, Franklin, Clinton, Essex, Fulton, Saratoga, Warren, Washington, Putnam, Greene, Cayuga, Jefferson
Direct Support	Direct Support Professionals (esp. OPWDD services)	Hamilton, Livingston, Schuylar, Schoharie, Broome, Delaware, Greene, Putnam, Warren, Washington, Steuben, Jefferson
Peer Workforce	Peer Specialists, Outreach Workers	Schoharie, Warren, Washington, Rensselaer, Putnam, Broome, Delaware, Steuben, Jefferson
Home Care	Home Health Aides, Personal Care Aides	Broome, Clinton, Essex, Franklin, Fulton, Hamilton, Montgomery, Saratoga, Warren, Washington, Jefferson, Delaware, Steuben

Direct Support Workforce

Counties consistently identify chronic shortages in direct support roles, including home health aides, personal care aides, and staff serving individuals with developmental disabilities (OPWDD populations). These positions are essential for safety, independence, and quality of life, yet they are low-wage, physically and emotionally demanding, and offer limited career advancement—conditions that drive high turnover and persistent vacancies.

Counties citing sustained shortages in OPWDD direct support professionals include Hamilton, Livingston, Schuyler, Schoharie, Broome, Delaware, Greene, Putnam, Warren, Washington, and Steuben. The practical impact is reduced continuity of care and greater burdens on families, especially where institutional alternatives are distant or already overextended.

Home care shortfalls are similarly widespread. Broome, Clinton, Essex, Franklin, Fulton, Hamilton, Montgomery, Saratoga, Warren, Washington, Jefferson, Delaware, and Steuben report home health aide and personal care aide vacancies that limit the ability of older adults and people with chronic conditions to remain at home. As direct support capacity erodes, families shoulder more care, facilities experience higher strain, and residents lose opportunities to maintain independence.

Peer Workforce

Counties highlight the peer workforce, peer specialists, recovery coaches, outreach workers, as a critical but underdeveloped component of behavioral health. Peers offer lived-experience, culturally competent support that often engages residents reluctant to use traditional services. Yet multiple counties (including Schoharie, Warren, Washington, Rensselaer, Putnam, Broome, Delaware, Steuben, and Jefferson) report difficulty recruiting and sustaining peer roles.

The barriers are consistent: limited training pipelines, inadequate compensation, and scarce professional development. Counties stress that, without targeted investment, peer programs that could bridge gaps, extend reach, and reduce pressure on licensed clinicians will remain too small and unstable to meet community need, despite being one of the most promising strategies for early engagement and recovery support.

Consequences for Access and Care

“Provider shortages in multiple sectors are causing excessive wait times. In some cases, patients have to wait 6 or 7 months to be seen by a provider.”

— St. Lawrence County CHA

Stakeholders consistently frame workforce shortages as foundational: they undercut every other aspect of behavioral health care. Even when communities have facilities, program models, or funding streams, the absence of staff prevents resources from being deployed. Initiatives collapse not because of lack of vision or funding but because positions remain vacant. Counties argue that without an adequate workforce, residents cannot access care no matter how motivated they are to seek it.

Table 2: Impacts of workforce shortages.

Aspect	Description	County Examples
Capacity Limits	Shortages reduce outpatient, inpatient, residential, and crisis services.	Long-term vacancies prevent opening beds or detox programs (multiple counties).
Delays & Waitlists	Lack of staff creates long waits and thus people in crisis cycle through ERs, increasing demands on hospitals.	Detox paused due to staffing (Sullivan). Limited residential for co-occurring disorders (Clinton).
Fragmented Care	High caseloads limit coordination and integrated treatment for SMI/SUD.	Facilities struggle to manage complex cases (Clinton, multiple counties).

Capacity Limits

Table 2 shows specific impacts of workforce shortages on access to care. Workforce vacancies significantly limit service capacity across rural New York, deeply affecting the availability and operation of essential behavioral health programs. Many counties report that detox units, crisis stabilization programs, and inpatient psychiatric beds remain closed or partially operational due to insufficient staffing, especially shortages of psychiatrists, licensed clinicians, nurses, and direct support staff. In Sullivan County, detox services have been paused entirely, leaving residents without a local option for withdrawal management. Crisis services in other counties operate with minimal staff coverage, often limited to business hours, forcing law enforcement and emergency departments to respond to behavioral health emergencies.

Programs frequently exist in name but cannot admit patients because there are not enough clinicians or nurses to staff them safely. These gaps ripple through the entire continuum of care, reducing outpatient options, overwhelming emergency services, and creating dangerous gaps at the inpatient level. Individuals in acute crisis are often diverted to emergency departments, which are not designed for ongoing behavioral health treatment. This mismatch between patient needs and available services prolongs distress for patients and families and

contributes to a cycle in which emergency rooms serve as the default point of care. Counties consistently emphasize that these capacity constraints are not temporary disruptions but long-term structural barriers that weaken system stability.

Delays and Waitlists

Capacity shortages feed directly into long delays and extensive waitlists for behavioral health services. These waits are not minor inconveniences but structural outcomes of an understaffed system. Across rural New York, county plans describe how delays prevent timely intervention, disrupt continuity of care, and force families to cycle through emergency departments when no other options exist. County plans reveal how these delays affect families in concrete ways. Services in multiple counties have been paused or suspended because essential staff could not be hired. Families often describe waiting months, sometimes years, before accessing therapy or psychiatric evaluations. This is particularly concerning for children, who may pass through critical developmental windows without appropriate care. In counties such as Chenango and Sullivan, parents report traveling hours for appointments, compounding the financial and emotional strain of a system already in crisis. **Table 3** provides a county-by-county summary of reported wait times and illustrates how shortages manifest in real-world service delays across rural New York.

Table 3: Examples of wait times as described by counties.

County	Service Type	Wait Time Details
Oswego	Pediatric MH	>3–5 days ED boarding; 320 cases in 2022
Chenango	Outpatient Clinic	5–10 days initial; ≤3 days high-risk; 6–8 weeks med eval
St. Lawrence	Behavioral Health	6–7 months wait for MH/SUD treatment
Sullivan	MH/SUD Services	Waitlists up to 2 years; detox paused
Greene	Respite (Children)	No overnight respite; long waits (months+)
Chenango	Psych Med Eval	6–8 weeks wait
Oswego	Psych Med Eval	Likely 6–8 weeks
Schoharie	MH Services	74.7% of those surveyed did not receive care due to “Too long of a wait to get an appointment”
Franklin	Inpatient for SMI	9.39 admits delayed per month

In Chenango County, outpatient mental health clinics report that initial appointments are generally scheduled within five to ten days, with high-risk individuals seen in three days or less. Yet residents then face waits of six to eight weeks for psychiatric medication evaluations. This gap between intake and follow-up care leaves individuals vulnerable and delays access to critical interventions. In St. Lawrence County, residents face average waits of six to seven months for both mental health and substance use disorder services. Families describe the frustration of waiting months while symptoms worsen, often leading to greater reliance on emergency departments as a stopgap measure.

In Sullivan County, residents report delays of up to two years for mental health and substance use disorder services. Detox programs have been suspended altogether due to staffing shortages, leaving residents without a local option for withdrawal management. For individuals in acute crisis, this absence of timely detox services significantly increases the risk of relapse, hospitalization, or overdose. In Oswego County, pediatric mental health presentations are increasingly managed in emergency departments. Children may be boarded for three to five days while awaiting inpatient transfer, with 320 such cases documented in 2022. Local data also suggest that psychiatric medication evaluations can involve waits of six to eight weeks, compounding delays for young people in crisis.

In Greene County, care for children is especially limited. Families report no access to overnight respite, and even day or community respite programs involve waits stretching for months or longer. This lack of stabilization options places additional burdens on families already coping with high stress. In Schoharie County, survey data demonstrate the extent of the problem. Among residents who sought services but did not receive them, 74.7 percent cited “too long of a wait to get an appointment” as the main reason. This underscores that delays are not just anecdotal but a measurable barrier to care. In Franklin County, inpatient treatment capacity is so constrained that an average of 9.39 admissions for serious mental illness are delayed each month. Families describe how delays prolong crises and leave loved ones without safe stabilization options.

The cumulative effect of these wait times is severe. Symptoms worsen during delays, relapse risk increases, and families are forced to rely on emergency departments that are not designed to provide sustained behavioral health care. Some residents disengage entirely when confronted with months- or years-long waits, widening the gap between need and treatment. Counties stress that these delays highlight a system that is structurally unable to deliver timely, appropriate intervention.

Key Takeaways: Workforce Shortages in Rural New York Counties

Persistent and pervasive barrier. Workforce shortages remain the most consistently identified challenge across CHAs, CHIPs, and LSPs, affecting every level of behavioral health care.

Psychiatric and clinical vacancies. Shortages of psychiatrists, especially child psychiatrists, leave many counties with no local specialty care. Licensed clinicians such as psychologists, LCSWs, LMHCs, and LMFTs are also difficult to recruit and retain, producing long waits for therapy and medication management.

Direct support and home care. Chronic vacancies in direct support professionals, home health aides, and personal care aides reduce continuity of care, place greater burdens on families, and limit older adults' ability to remain at home.

Peer workforce underdeveloped. Counties view peers and recovery coaches as promising for culturally competent support, but barriers such as limited training, inadequate pay, and scarce professional development leave programs too small and unstable to meet demand.

Consequences for access. Vacancies translate directly into program closures, months- or years-long waitlists, children boarding in EDs, and families traveling across counties for basic services. Even where facilities exist on paper, many remain closed in practice because positions cannot be filled.

Service Gaps

Counties consistently report structural gaps in behavioral health services that leave residents without timely or appropriate care. Limited inpatient capacity, workforce shortages, geographic isolation, and fragmented coverage produce delays, denials, and extended emergency department boarding. These are not temporary bottlenecks but enduring conditions that make stabilization unreliable, especially for children, adults with complex needs, and families with limited resources.

Key Metrics:

Number of Adult Inpatient Psychiatric Beds per County⁵

Number of Pediatric Inpatient Psychiatric Beds per County⁵

Inpatient Treatment Access

“Inpatient psych capacity for children and youth remains a challenge. Bed searches can take considerable time resulting in youth being held at the crisis unit for extended lengths.” – Rensselaer County LSP

Inpatient behavioral health care stands out as one of the most strained and least accessible parts of the system. Counties consistently describe conditions where psychiatric beds are scarce, workforce shortages prevent programs from operating at capacity, and long travel distances place extraordinary burdens on families. These barriers are not temporary fluctuations but enduring, structural features that leave many residents without stabilization during moments of acute crisis.

The consequences of this scarcity are visible in nearly every region. Youth remain boarded in emergency departments for days awaiting psychiatric placements, straining hospitals and compounding family distress. Adults with serious mental illness or co-occurring disorders cycle through repeated ED visits when admissions are denied, while the absence of crisis stabilization units forces law enforcement and emergency staff into roles for which they are ill-suited. Insurance barriers add another layer of restriction, with denials or limits on length of stay creating premature discharges even when beds are technically available.

Specialized populations face some of the steepest barriers. Franklin County reports long waits for individuals with developmental disabilities and aggressive behaviors, while Rensselaer and Sullivan counties note that residents with co-occurring conditions encounter paused admissions or prolonged delays. Pediatric psychiatric beds remain especially scarce, with counties like Greene and Oswego emphasizing the long travel times and inappropriate holding conditions families endure. These inequities fall hardest on those with limited transportation, financial resources, or social support, amplifying disparities across rural communities.

What emerges is not a story of isolated shortages but of structural inaccessibility. Inpatient treatment is constrained by the combined weight of facility scarcity, insurance restrictions, geographic isolation, and fragmented service systems. Counties stress that these converging factors have turned inpatient care into one of the clearest illustrations of how rural behavioral health infrastructure falls short—leaving residents, particularly children and those with complex conditions, without timely or appropriate stabilization when it is needed most.

Table 4: Total number of adult and pediatric inpatient psychiatric beds.⁵

County	Adult Psychiatric Beds (Community Hospitals)	Child/Youth Psychiatric Beds (Community Hospitals)
Cattaraugus	14	0
Clinton	18	12
Essex	12	0
Greene	0	0
Hamilton	0	0
Oswego	32	0
Schoharie	0	0
St. Lawrence	28	12
Tompkins	20	6
Warren	30	0
Wayne	16	0
Wyoming	10	0

Inpatient behavioral health treatment in rural New York operates under persistent, structural strain. Across counties, demand for stabilization services surpasses available capacity, producing delays, diversions, and denials of care. The scarcity of psychiatric beds, compounded by staff vacancies and geographic isolation, leaves individuals and families in vulnerable circumstances without timely or appropriate support. This crisis affects both youth and adults, cutting across mental health, substance use, and developmental disability services. Rather than episodic bottlenecks, the conditions described by counties point to a system where inpatient access is structurally unavailable, with harmful consequences that ripple throughout the behavioral health continuum.

Pediatric Psychiatric Scarcity and Family Burdens

Pediatric psychiatric bed scarcity is another dimension of the inpatient capacity gap. As shown in **Table 4**, many rural hospitals license only a handful of adult psychiatric beds and none for children or youth. For example, Oswego County has 32 adult beds but zero pediatric beds; Wyoming County has just 10 adult beds and none for youth; and Greene, Schoharie, and Hamilton Counties have no licensed inpatient psychiatric units at all. Even in counties that do

have some pediatric capacity, such as St. Lawrence (12 pediatric beds) or Clinton (12 pediatric beds), the numbers are extremely limited compared to the population in need. Statewide, just over 1,100 pediatric psychiatric beds exist, and they are heavily concentrated downstate rather than in rural areas.

The absence of local pediatric capacity translates into prolonged crises. Greene County reports that families must travel between 40 and 100 miles to locate inpatient services for children. In Rensselaer County, families endure prolonged “bed searches” that leave young people in crisis units far beyond clinically appropriate timeframes. Oswego County illustrates the same pattern, with children forced to wait in emergency departments for three to five days until a transfer becomes available. Without local beds, the first point of contact—whether a crisis unit or an emergency department—becomes a holding environment rather than a treatment pathway.

These conditions place extraordinary strain on families already navigating acute distress. Parents in Greene and Oswego Counties describe missing work, facing significant financial hardship, and enduring long-distance travel during moments of crisis. Rensselaer stakeholders emphasize the emotional toll of prolonged uncertainty, where a child is stabilized only superficially while a bed search drags on. The lack of pediatric resources not only delays care but amplifies trauma, as children remain in inappropriate or overstimulating settings without access to specialized psychiatric support. These burdens fall most heavily on families with limited income or transportation, underscoring structural inequities within New York’s inpatient system.

It is important to note that psychiatric inpatient bed counts are reported by the New York State Office of Mental Health through its Transformation Plan Status Reports and facility-level capacity tables. These reports provide statewide and hospital-level data but do not aggregate numbers at the county level. As a result, counties must rely on facility data and regional summaries, and there is no single public source that shows exact inpatient psychiatric bed counts by county.

Adults with Complex Needs

Adults with serious mental illness and co-occurring conditions also encounter dangerous gaps. Sullivan County highlights a growing number of individuals who are too compromised to be managed safely in outpatient care yet do not meet the rigid thresholds for hospital admission. Without intermediate stabilization options, these residents cycle through community settings unequipped to manage acute psychiatric needs. Schoharie County underscores the stakes of such gaps, reporting high rates of fatal overdoses alongside long inpatient wait times, with

many residents ultimately denied admission due to persistent bed shortages or restrictive insurance policies.

Franklin County documents the growing complexity of forensic cases, with 14 adult 730 evaluations in a single year and a rising trend in cases involving serious mental illness. Residents with developmental disabilities and aggressive behaviors face especially long waits for inpatient placement, as few facilities are able to accommodate them. Families report being left without safe alternatives while loved ones cycle between short-term community placements and emergency rooms unprepared for their needs. These examples reveal that adults with complex profiles are not only underserved but structurally excluded from stabilization options, reflecting systemic shortcomings in the design of inpatient behavioral health across rural counties.

Inpatient Care Constrained by Workforce Deficits

Underlying each county narrative is the workforce crisis that constrains inpatient access. Rensselaer County reports having to pause admissions to co-occurring disorder programs entirely due to staffing shortages, leaving individuals without continuity of care. Clinton County describes a surge in inpatient admissions that has overwhelmed its emergency departments, with limited staff available to manage increased demand. Delaware County also points to a mismatch between rising admissions and available personnel, illustrating how workforce strain translates directly into reduced capacity for both inpatient and crisis stabilization services.

The lack of psychiatrists, nurses, and specialized clinicians means that even when facilities exist, they often cannot operate at full strength. In some counties, programs sit idle not because physical space is unavailable but because staff vacancies prevent safe operation. Families in Rensselaer recount months-long waits for inpatient treatment of youth with co-occurring disorders, directly tied to staffing shortages. In Clinton and Delaware, the absence of trained professionals stretches remaining staff beyond safe limits, leading to longer waits in emergency rooms and delayed stabilization. These examples illustrate that workforce shortages are not ancillary but foundational, determining whether inpatient treatment is accessible at all.

Geographic Isolation and Systemic Access Barriers

Geographic isolation magnifies the problem of inpatient scarcity, particularly for rural families without reliable transportation. Greene County reports having no detoxification or rehabilitation facilities within its borders, forcing residents to travel significant distances for treatment. Pediatric psychiatric beds are absent within a 50-mile radius, creating prolonged periods of emergency department boarding while families wait for openings elsewhere. In Oswego County, the distance to specialized care combines with prolonged delays to create

unsafe conditions, as children remain in ER settings never intended for long-term psychiatric stabilization.

Travel itself becomes a structural barrier, particularly when families must make repeated trips for visitation or follow-up care. In counties like Greene, parents describe the financial strain of driving hours for short hospital visits, compounding the stress of having a child or adult relative in crisis. Residents without vehicles, including low-income households in Delaware and Chenango counties, face even greater challenges, as public transit is limited or nonexistent. Geographic isolation not only delays care but, in many cases, prevents families from pursuing it altogether. This reinforces patterns of inequity, where those with fewer resources face the steepest barriers to inpatient behavioral health access.

County-Level Illustrations of Inpatient Crisis

Sullivan County reports a rising number of individuals too ill for outpatient care but ineligible for hospital admission, leaving them without stabilization resources. Schoharie documents high fatal overdose rates and inpatient wait times so severe that local leaders describe them as “unimaginable.” Franklin notes the rise of forensic cases and the absence of placements for individuals with developmental disabilities and aggressive behaviors. Rensselaer’s co-occurring disorder programs have paused admissions entirely due to workforce shortages.

Greene County families routinely travel long distances for detox, rehabilitation, or child psychiatric care that does not exist locally, while Oswego reports children waiting days in emergency departments for scarce psychiatric beds. These county-level examples demonstrate that inpatient scarcity is not isolated but woven throughout the state’s rural regions. The repetition of similar conditions—delayed care, denied admissions, and prolonged boarding—underscores that the inpatient crisis is systemic and structural, not circumstantial.

Inpatient behavioral health treatment in rural New York is constrained by a complex interplay of workforce shortages, facility scarcity, insurance barriers, geographic isolation, and systemic fragmentation. These factors create structural inaccessibility rather than temporary capacity issues. The consequences are prolonged wait times, emergency department overuse, denied or premature discharges, and significant burdens on families, especially for pediatric and complex adult populations. Counties uniformly call for increased workforce investment, expansion of inpatient and intermediate care capacity, improved transportation and telehealth infrastructure, and integrated care coordination to alleviate this systemic crisis.

Key Takeaways: Inpatient Treatment Access in Rural New York Counties

Lack of inpatient treatment access. Counties report stabilization gaps for those too ill for outpatient care but not eligible for admission, denials tied to bed shortages or insurance, and the near absence of pediatric psychiatric beds. Families often travel 40–100 miles for treatment or wait through prolonged boarding in emergency departments.

Vacancies close or limit programs. Detox units, crisis beds, and inpatient programs often exist in name only, unable to operate due to unfilled positions. Families face months-long waits for evaluation or placement, and children are sometimes boarded in emergency departments for days awaiting transfer.

Rural conditions magnify barriers. Geographic isolation, lack of transportation, low wages, and thin professional networks make access unstable. Fragmentation across providers leaves residents with serious mental illness or substance use disorders cycling through disconnected services.

Crisis Services

“Crisis services for persons with complex needs or multiple systems involvement can also be very challenging. Crisis services are extremely limited. The Emergency Department becomes utilized for crises. If a situation is behavioral as opposed to clinical, the individual is returned home (medicated) to an unsafe environment. There are no respite options for families or providers.” - Sullivan County LSP

Crisis services across rural New York are among the most fragile and overburdened parts of the behavioral health system. Families and individuals experiencing acute psychiatric or substance use crises encounter systemic barriers that delay or block stabilization. These barriers appear in multiple forms: limited mobile coverage, overwhelmed hospital units, fragmented systems, and infrastructure that cannot keep pace with demand. The result is a fragile safety net that fails to provide timely or appropriate response when residents are in greatest need. **Table 5** captures some of the struggles reported by counties with respect to crisis response services.

Table 5: Challenges in access to crisis response services as described by the counties.

County	Crisis Response Struggle
Rensselaer	Average monthly youth crisis unit visits increased by 23% in 2023 versus 2022
Jefferson	Currently no 24/7/365 crisis response system
Chenango	One staff member provides crisis services across more than 600 square miles
Putnam	No mobile crisis team; law enforcement often tasked with crisis de-escalation
Delaware	Mobile Crisis Assessment Team has nearly 65% more adults receiving crisis services than children
Schenectady	Crisis Unit at Ellis Medicine has been overwhelmed due to inpatient bed closures and staffing closures

Counties stress that mobile crisis coverage is thin, inconsistent, and often unavailable outside of business hours. In Schoharie County, a single crisis worker covers 626 square miles during daytime hours, leaving evenings and weekends dependent on telehealth or 911. Putnam County has no mobile crisis intervention at all, meaning law enforcement is the default responder for psychiatric emergencies. St. Lawrence County reports that its mobile crisis team currently operates from 9 AM to 11 PM, with 96% of wellness checks performed by police. Families in Hamilton and Delaware Counties describe long waits or having no choice but to involve law enforcement during children’s psychiatric emergencies, situations that can be stigmatizing or escalate fragile crises rather than resolve them.

Even where services exist, data show clear imbalances. Delaware County’s Mobile Crisis Assessment Team (MCAT) handled about two-thirds more adult than child cases between 2019 and 2021, with telephone assessments rising sharply during the COVID-19 pandemic. In Rensselaer County, mobile crisis programs operate as a shared service across counties and have yet to recover to pre-pandemic service levels due in part to workforce shortages. Still, demand is climbing: average monthly visits to the children and youth Crisis Unit in Rensselaer rose 23% between 2022 and 2023, with ages 12–17 disproportionately represented in visits involving suicide. Recidivism among young people aged 12–21 also shows a slight upward trend, signaling persistent gaps in stabilization and follow-up.

Hospital-based crisis units are overwhelmed. In Schenectady County, Ellis Medicine’s crisis unit has been constrained by staffing shortages and periodic bed closures, producing overcrowding in emergency departments. Patients are often discharged prematurely or held for long periods

while inpatient placements are sought, compromising psychiatric care and reducing overall emergency capacity.

Capacity limits are compounded by the fragmentation of crisis services across New York's major behavioral health agencies. The Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS), and Office for People with Developmental Disabilities (OPWDD) each operate with distinct referral processes, eligibility criteria, and program mandates. This patchwork leaves individuals with co-occurring conditions stranded between agencies.

Franklin County families caring for loved ones with developmental disabilities and aggressive behaviors describe being turned away from multiple systems because no single agency claimed responsibility. Fulton and Montgomery Counties emphasize that managed care absorption has weakened community supervision while failing to build integrated referral pathways. Providers in these areas characterize the system as one where silos collide, with individuals stuck between competing bureaucratic requirements and agencies unwilling to coordinate. The result is that the residents with the most complex needs, such as those with developmental disabilities, co-occurring mental illness and substance use, or forensic involvement, are precisely the ones most likely to find themselves without meaningful crisis support.

Fragmented Care Beyond Crisis Response

Fragmentation appears within day-to-day crisis care and discharge planning. In Clinton County, staff working with clients with co-occurring disorders note that they are too overstretched to collaborate across specialties. Instead of coordinated care, crises are managed in episodic bursts: a hospitalization here, an emergency room visit there, with little continuity in between. Families are left to manage referrals, case planning, and follow-up largely on their own.

Outpatient access illustrates the depth of the gap. In one county, outpatient enrollment has risen since 2019, but wait times stretch from 9 to 21 weeks, and no provider offers same-day access. For residents with emerging crises, these waits push them toward emergency departments, ensuring that crisis services remain the entry point rather than the last resort. Families report frustration at being trapped in this cycle: initial stabilization in an ED, long waits for outpatient follow-up, and eventual relapse back into crisis.

Crisis Services Constrained by Workforce Deficits

While crisis services should be the focus, workforce shortages run underneath every example. Rensselaer County has suspended admissions to youth crisis programs due to staff vacancies. Sullivan County has paused detoxification services entirely, leaving residents without local withdrawal management. Franklin County providers report that respite beds, already scarce,

are routinely full and unavailable when crises occur. Even when counties launch new services, sustainability proves difficult. Livingston County stakeholders describe promising pilots that collapse within a few years when staffing pipelines dry up.

A Cycle of Scarcity and Instability

Together, these factors form a cycle that counties consistently describe. Limited coverage leaves nights and weekends unprotected. Hospital units absorb patients they cannot treat appropriately, creating backlogs for other medical emergencies. Fragmentation across agencies and providers ensures that individuals with complex needs receive inconsistent care, if any at all. Workforce shortages limit expansion or sustainability of programs, perpetuating the gaps. Rural residents in crisis thus encounter a repeating pattern: delayed stabilization, inappropriate interventions, and fractured pathways back to care.

Key Takeaways: Crisis Services in Rural New York Counties

Hospitals are overwhelmed. Schenectady's crisis unit faces staffing shortages and bed closures, while Oswego reports children boarded in emergency departments for three to five days. In Rensselaer, youth stabilization beds are often full, with admissions suspended at times.

Fragmentation leaves residents stranded. Franklin families caring for individuals with developmental disabilities and aggressive behaviors are repeatedly turned away. Fulton and Montgomery providers describe disjointed referrals and weakened case management under managed care.

Care coordination breaks down in practice. In Clinton, staff are too overextended to collaborate on co-occurring disorders, leaving families to navigate disconnected services that recycle crises instead of resolving them.

Workforce shortages compound instability. Rensselaer and Sullivan counties have suspended crisis and detox programs due to lack of staff, while Livingston reports that promising pilots collapse when staffing pipelines cannot be sustained.

Children and vulnerable groups bear the heaviest burden. Youth, families with limited resources, and individuals with developmental disabilities face unsafe waiting periods, inappropriate interventions, and repeated cycles through emergency settings

Infrastructure Challenges

In counties where workforce shortages already limit the number of available providers, the distance required to see those providers compounds the problem. Similarly, the absence of reliable broadband limits the ability of telehealth to offset travel demands. Counties emphasize that these overlapping barriers make accessibility not just a question of whether care exists, but whether it is physically and practically reachable.

Key Metrics:

Proportion of Residents without Vehicle Access¹

Proportion of Residents without Broadband Access¹

The sections that follow detail how rural residents experience transportation barriers, including long travel distances, limited public transit, and inadequate non-emergency medical transport. These findings highlight that improving accessibility requires not only growing the workforce but also ensuring that residents have reliable means of getting to the care that workforce provides.

Transportation

“Transportation is a major barrier causing missed appointments, delayed care, and treatment gaps, especially in rural areas with limited public transit and economic challenges.”

– Broome County CHA

Transportation consistently emerges in county assessments as one of the most significant barriers to access to behavioral health care. Even when providers are available and services exist, rural residents often cannot reach them. Distances between towns and treatment centers are long, public transit is scarce or nonexistent, and many households lack reliable personal vehicles. These conditions create situations where the very existence of services is irrelevant if residents cannot get to them.

Counties describe transportation barriers as a common reason why appointments are missed, treatment plans are interrupted, and individuals disengage from care altogether. For residents managing mental health or substance use disorders, the inability to travel for services translates directly into delayed treatment, worsening symptoms, and greater reliance on emergency care. Families report that transportation challenges often make it impossible to access pediatric or specialized services, forcing them to choose between long travel times or going without care.

Distance and Geographic Isolation

In rural New York, distance itself becomes a health determinant. Residents across many counties describe traveling long stretches of highway, often without public transit options, simply to reach basic behavioral health services. For routine care like therapy or psychiatric medication management, the time and cost of driving an hour or more each way can discourage consistent attendance. Families caring for children with behavioral health needs report that missing school and work for repeated long-distance appointments adds stress and financial strain.

These challenges become even more severe in emergencies. When crisis stabilization units or inpatient psychiatric facilities are located in distant urban centers, residents in acute distress face dangerous delays. Law enforcement and EMS often serve as the only means of transportation, but response times are lengthened by geography, and once transport is arranged, the travel itself can take hours. Counties like Broome, Delaware, and Chenango emphasize that geographic isolation directly translates into delayed crisis response, higher use of emergency departments for behavioral health, and poorer outcomes for residents already in vulnerable situations.

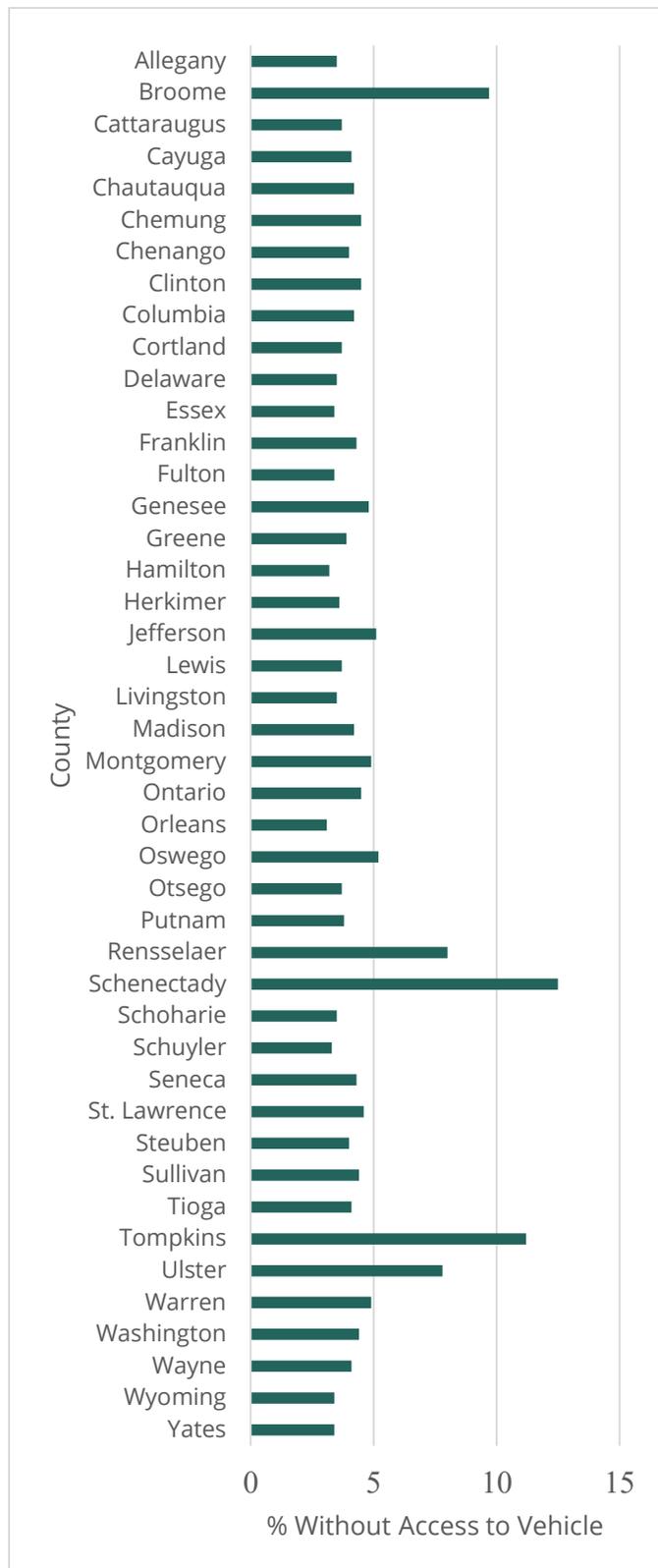


Figure 15: Percent of residents without access to a personal vehicle.¹

Private Transportation Issues

The populations most affected by vehicle shortages are also those with the greatest health needs. Low-income households face financial barriers not only to purchasing and maintaining vehicles but also to affording fuel for long-distance travel. Renters, younger residents, and seniors are disproportionately represented among those without cars, making them especially vulnerable to missed care. **Figure 17** illustrates that in many rural counties, between 4% and 8% of households lack access to a vehicle, with some counties such as Broome, Schenectady, and Tompkins exceeding 10%. Stakeholders in multiple counties emphasize that behavioral health patients who lack vehicles frequently miss appointments, cycle on and off waitlists, and disengage from treatment.

The consequences extend beyond healthcare. Without reliable vehicles, residents struggle to maintain employment, access grocery stores, or participate in community activities—all of which are linked to behavioral health. Counties note that lack of transportation isolates residents socially, worsens economic instability, and erodes protective factors that might otherwise buffer against mental illness or substance use. In this way, transportation insecurity becomes both a symptom and a driver of rural inequities: poverty reduces access to vehicles, while lack of vehicles perpetuates cycles of poverty, unemployment, and poor health.

Public Transportation Issues

Public transportation, where it exists, is limited, infrequent, and unreliable. Counties including Chenango, Columbia, Delaware, Sullivan, and Ulster describe systems with few routes, irregular schedules, and ongoing driver shortages. Residents report that buses may run only a few days a week or require advanced booking, making them unsuitable for crisis or urgent health needs. Even Medicaid-funded transportation is criticized as confusing, stigmatized, and unreliable; some residents report drivers failing to show up, leading them to forgo appointments entirely.

The burden of inadequate transit falls most heavily on vulnerable populations. Counties such as Cattaraugus, Lewis, and Wyoming note that low-income families, individuals with disabilities, and socially isolated residents experience the steepest barriers. Middle-aged adults balancing work and caregiving are also disproportionately affected. These barriers directly contribute to missed care, job instability, and heightened stress, worsening behavioral health outcomes.

Table 6 summarizes how counties describe these gaps, highlighting themes such as limited accessibility and reliability, barriers for vulnerable populations, the need for expanded coordination, and infrastructure improvements.

Table 6: Challenges with public transportation as described by the counties.

Theme	Key Issues	Counties / Region
Limited Accessibility & Reliability	Few routes, infrequent service, driver shortages; residents miss appointments & can't access food/work/school	Chenango, Columbia, Delaware, Sullivan, Ulster
Barriers for Vulnerable Populations	Disproportionately impacts low-income, disabled, rural, & socially isolated; middle-aged adults highly vulnerable	Cattaraugus, Lewis, Wyoming
Need for Expanded Services & Coordination	More bus lines, safer sidewalks, better Medicaid transport, collaboration among providers	Mid-Hudson Region, Livingston, Montgomery, Putnam, Ulster
Integration with Health Services	Mobility management programs connect clients with resources, but uptake remains low	Broome
Infrastructure & Planning	Need for Complete Streets, safer sidewalks, pedestrian crossings, biking/walking integration	Chemung, Finger Lakes Region, Herkimer, Mid-Hudson Region, Ulster

Impact on Behavioral Health Access

Transportation challenges directly undermine treatment continuity. Counties report that missed appointments are among the most common reasons for treatment disruption, especially in substance use programs where consistency is crucial. Missing even one or two sessions can reset recovery timelines and increase relapse risk. In mental health, no-shows often push residents to the bottom of already long waitlists, further delaying care.

In emergencies, transportation barriers are even more dangerous. When mobile crisis teams are unavailable locally or psychiatric beds are located hours away, families may wait extended periods for ambulances or law enforcement. Once transport is arranged, patients often face long rides to distant facilities. These delays can escalate crises, turning manageable episodes into life-threatening emergencies.

Counties consistently stress that transportation is not a side issue but a structural driver of health. Without reliable vehicles or robust transit, behavioral health access cannot be fully realized. Even where providers exist, residents cannot consistently reach them. Transportation gaps magnify other systemic challenges such as workforce shortages and poverty, making it impossible for rural communities to achieve equitable health outcomes.

Key Takeaways: Transportation Barriers in Rural New York Counties

Distance matters: Residents frequently travel over an hour for behavioral health services, delaying crisis response and complicating consistent care.

Vehicle access is unequal: Up to 9–10% of households in counties like Chenango, Delaware, and Herkimer lack cars, with higher rates among renters and low-income populations.

Transit systems are inadequate: Limited routes, infrequent schedules, and unreliable Medicaid transportation undermine health access.

Unequal burden: Low-income households, people with disabilities, and socially isolated residents face the steepest transportation barriers.

Structural determinant: Transportation insecurity amplifies rural inequities and must be addressed as a central component of behavioral health planning.

Broadband

“Broadband access is a super-determinant of health, influencing all access.” – Essex County CHA

Broadband access has emerged as one of the most critical determinants of access in rural New York. Reliable high-speed internet now defines whether residents can connect to behavioral health care, education, and employment opportunities in an increasingly digital world. County assessments consistently highlight broadband gaps as a pervasive challenge that compounds rural isolation and exacerbates disparities. Without adequate connectivity, residents cannot participate in telehealth, online schooling, remote work, or even basic information-seeking, leaving them further behind.

Counties describe broadband as a “super-determinant of health.” It is a foundational infrastructure that shapes access to every other service. Where access is limited, residents face both immediate consequences, such as being unable to attend virtual therapy, and longer-term barriers, such as reduced educational attainment and constrained job opportunities. **Figure 18** shows the extent to which rural New Yorkers face barriers to telehealth.

Across the Finger Lakes and Southern Tier regions, approximately eight percent of residents lack reliable broadband. In Steuben County, 14% of households are disconnected, and in

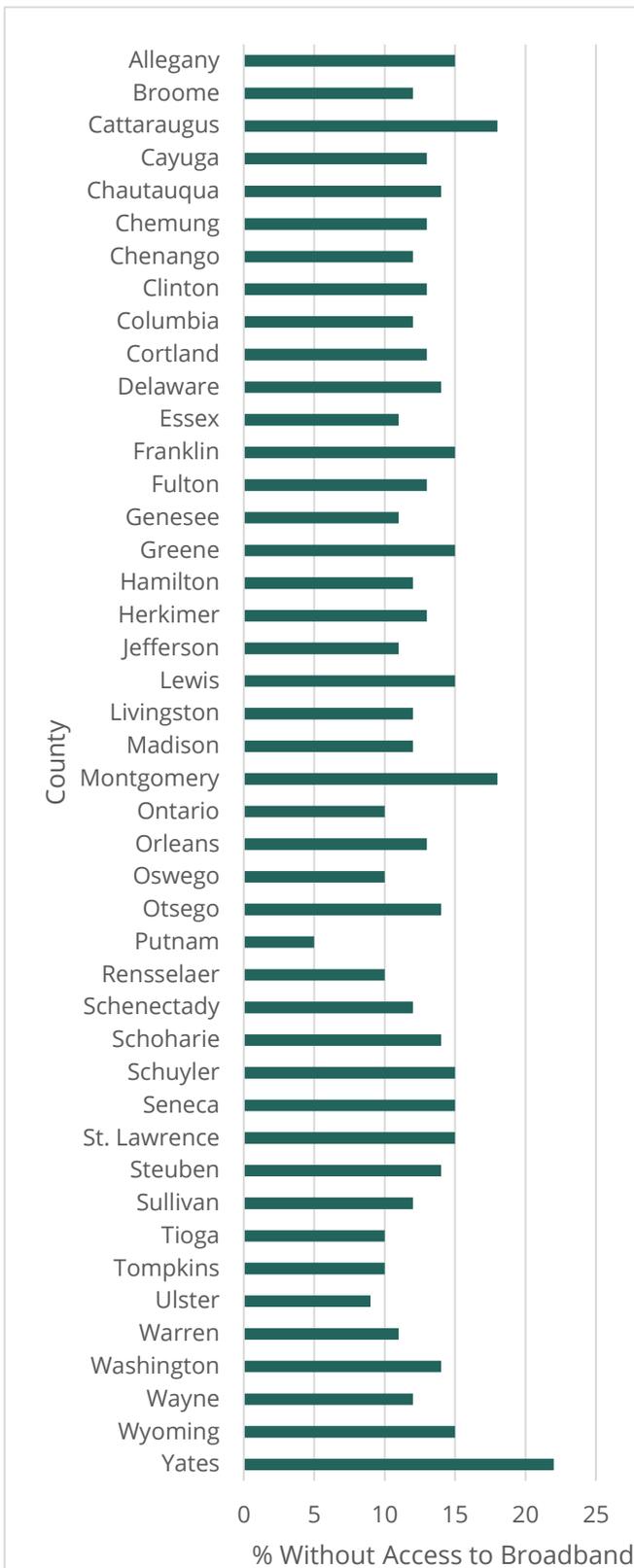


Figure 16: Percent of households without access to broadband internet.¹

Livingston, 12%. In Yates County, more than 20% of residents lack fixed, stable broadband service, compared to a statewide average of 9.8%. These gaps leave thousands of households without the ability to engage in basic online health, educational, and employment resources.

Disparities exist not just between but also within counties. Essex County illustrates this clearly: while towns near Lake Champlain and Lake Placid have strong coverage, southwestern areas remain almost completely offline. Schoharie County similarly reports that its most rural areas lack meaningful broadband, making telehealth, remote work, or online learning nearly impossible.

Counties in the Mid-Hudson region, including Sullivan, describe patchy coverage and slow speeds, even where service technically exists. These gaps undermine one of the most promising solutions to rural workforce shortages: telehealth. Without reliable internet, residents cannot access remote psychiatric services or virtual support groups, while providers struggle to implement electronic health records and offer continuity of care.

Socioeconomic Inequities in Access

Broadband gaps do not fall evenly. Households with lower incomes, less

education, or in more isolated geographies are far less likely to have reliable service. In Allegany County, leaders emphasize that broadband gaps intersect with poverty and housing insecurity, leaving disadvantaged families further cut off from opportunities to improve their circumstances. For children, this means falling behind in school;

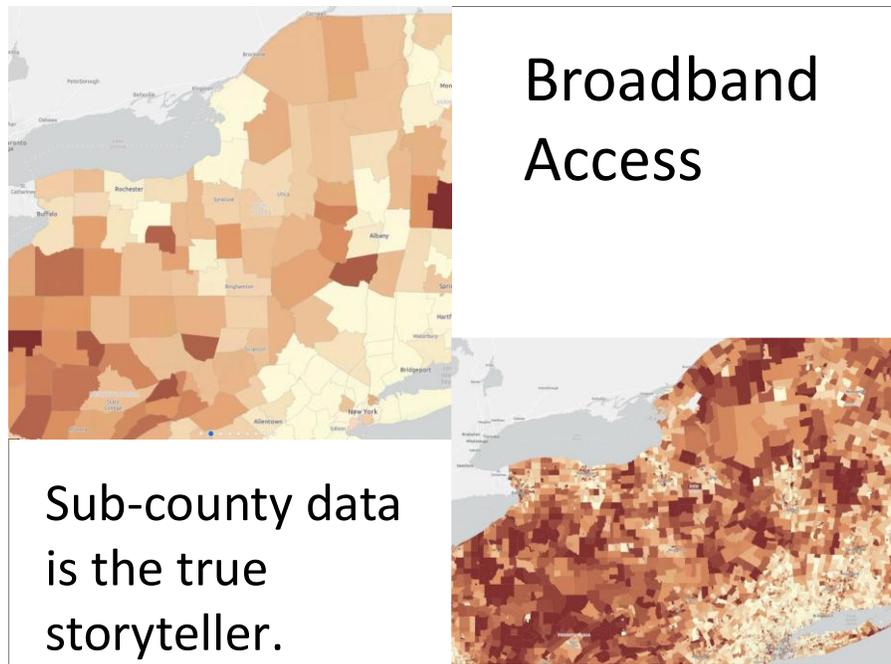
for adults, it means limited access to jobs, training, and healthcare.

The COVID-19 pandemic magnified these inequities. At a time when telehealth, online schooling, and remote work became lifelines, many rural households could not participate at all. In some counties, school districts resorted to distributing paper packets or Wi-Fi hotspots with limited reach, while behavioral health providers struggled to maintain therapy and support services for disconnected patients.

Consequences for Health Systems and Providers

Broadband gaps do not just affect households—they also impact the health system itself. Providers in rural clinics and community organizations often struggle with limited connectivity, undermining adoption of telehealth, secure health records, and cross-agency coordination. School-based counselors in rural towns report that unreliable internet prevents them from offering virtual sessions, forcing families to choose between long drives and no care at all. Even mobile crisis teams note that poor connectivity limits their ability to communicate and respond in real time.

Counties emphasize that broadband is no longer optional. Without it, rural systems cannot deliver timely care, and residents cannot access prevention or recovery supports. Addressing the digital divide is therefore essential to ensuring that telehealth fulfills its promise as a solution to rural behavioral health workforce shortages.



Counties stress the need for targeted infrastructure investments, stronger coordination among service providers, and community-level outreach. Efforts to expand broadband must reach not only population centers but also the most rural and underserved areas. Stakeholders also call for affordability measures, as many households that technically have access cannot afford subscription costs. Local leaders argue that only by making broadband universal and affordable can New York ensure that rural residents participate fully in health, education, and economic systems.

Key Takeaways: Broadband Access in Rural New York Counties

Super-determinant of health: Broadband access underpins behavioral health, education, and employment, shaping whether rural residents can connect to essential services.

Within-county disparities: Areas of Essex and Schoharie lack meaningful coverage even when neighboring towns are connected, creating patchwork access.

Socioeconomic divide: Lower-income, less-educated, and more isolated households are least likely to have broadband, compounding inequities.

System strain: Providers and schools also face unreliable connectivity, undermining telehealth, care coordination, and crisis response.

Demographic Equity Considerations

“Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, mental health...or other characteristics historically linked to discrimination or exclusion.” - Cortland County CHA

Access to behavioral health care in rural New York is uneven, shaped not only by provider shortages but also by income, age, disability status, race and ethnicity, language, and identity. County planning documents make clear that these demographic factors determine whether residents can locate services, understand how to use them, and remain engaged once enrolled. Equity is therefore not a parallel concern but a defining feature of access itself: who can get care, when, and under what conditions.

Poverty

Poverty consistently emerges as the strongest predictor of unmet behavioral health needs. Allegany County reports a child poverty rate of 25.8 percent and an overall poverty rate of 16.3 percent, while Franklin County identifies 43 percent of households as ALICE (Asset Limited, Income Constrained, Employed), unable to reliably afford basic necessities. In Delaware County, high poverty rates combine with workforce shortages to further limit access.

In multiple counties, residents describe delaying or forgoing care because of deductibles, copays, or providers unwilling to accept their insurance. In Chenango County, primary care physicians often hesitate to prescribe mental health medications without specialist support, while long wait times prevent timely appointments. Even when services are technically available, modest fees or insurance restrictions can force residents to disengage, leaving needs unmet.

Youth and Families

Children and adolescents face distinct inequities in mental health and substance use, shaped by socioeconomic status, sexual orientation, gender identity, and geography. Counties have responded by embedding supports in schools, where access is most immediate. Seneca County places OASAS-licensed staff in every district and operates satellite clinics to reduce barriers, while also training school staff through Youth Mental Health First Aid. Ontario County emphasizes school-based teams and parenting programs such as Triple P, targeting adolescents from lower-income households most at risk for depression. The county also uses youth survey data to guide interventions, though shortages in pediatric psychiatric beds and outpatient clinics make school-based services essential.

Cortland County's data reveal significant disparities among LGBTQ+ and transgender youth, prompting expanded social-emotional learning and prevention coalitions that build inclusive environments and connect students to culturally competent care. Ulster County likewise relies on school-based mental health services as critical access points, pairing them with crisis intervention teams and peer recovery supports to address service shortages. Madison integrates school services with suicide prevention and LGBTQIA+ coalitions, while Livingston links schools, law enforcement, and healthcare providers to strengthen crisis response and mental health education. Collectively, these efforts illustrate how counties are reducing inequities by tailoring services to marginalized youth and placing care within trusted community institutions.

Intellectual and Developmental Disabilities

Individuals with intellectual and developmental disabilities (I/DD) who also experience mental health or substance use challenges face some of the most complex barriers to care. In Franklin County, providers report severe difficulties securing inpatient placements for people with I/DD who exhibit aggressive behaviors, leaving families cycling between emergency departments and temporary community placements.

Greene County highlights critical shortages in respite care, especially overnight options for children with I/DD and co-occurring behavioral health needs. Without this support, caregiver strain escalates, leading to preventable hospitalizations and further destabilizing families. In Lewis County, long wait times and the absence of local inpatient treatment options mean families must travel long distances, adding financial and emotional burdens that disrupt continuity of treatment and recovery.

These county experiences show how the intersection of I/DD with mental health and substance use disorders compounds disparities in rural areas. Families encounter fragmented systems, workforce shortages, and limited service capacity, resulting in persistent gaps in crisis stabilization, treatment, and long-term support.

Race, Ethnicity, and Language

Racial, ethnic, and language disparities in mental health and substance use care persist across many counties, even in predominantly white rural regions. In Schenectady County, Black residents experience significantly higher hospitalization rates for mental health conditions than White residents. To reduce this gap, the county is investing in a new outpatient mental health facility in a lower-income neighborhood designed to expand access and provide more culturally appropriate care.

Chautauqua County highlights barriers for its growing Hispanic population, noting that The Chautauqua Center is the only site with Spanish-speaking staff at every level and formal medical translation. This linguistic capacity improves access to behavioral health treatment for Hispanic families who otherwise struggle to find providers.

Ulster County builds cultural and linguistic competence within its behavioral health system through Spanish-language gatekeeper trainings and incentives to recruit and retain bilingual staff. Putnam County employs Spanish-speaking health educators to support outreach and engagement with behavioral health resources, ensuring services are accessible to residents who might otherwise face language barriers. Tompkins County stakeholders emphasize systemic challenges, including a shortage of culturally responsive providers and insurance

barriers that disproportionately affect people of color, limiting timely access to treatment and contributing to ongoing disparities.

LGBTQ Residents

LGBTQ residents, particularly youth, consistently face elevated risks for depression, anxiety, substance use disorders, and suicide attempts. These disparities are compounded when services fail to provide affirming, culturally competent care.

In Cortland County, a dedicated LGBTQ center offers safe spaces and prevention programs aimed at reducing substance use and supporting positive coping strategies. The center also connects residents to behavioral health resources, though fears of stigma and discrimination continue to limit engagement. Tompkins County places equity at the center of its behavioral health system, collecting and analyzing data on disparities, embedding peer and family advocate roles, and training providers in cultural competence and implicit bias. In the Adirondack region, providers emphasize trauma-informed practices, inclusive policies, and partnerships with LGBTQ organizations to expand peer recovery services, reduce stigma, and ensure treatment environments are affirming.

Mental health and substance use disparities among LGBTQ residents cannot be reduced without intentional, affirming approaches. Progress is visible in prevention initiatives, peer-led programs, and provider training, but systemic barriers (e.g., fear of stigma, lack of specialized services, and uneven cultural competence) continue to undermine equitable access.

Measuring and Managing Equity

Some counties are moving beyond documenting disparities to embedding equity into planning and practice. Tompkins County publishes health equity indicators for minoritized populations to set a baseline for improvement. Essex County trains staff in trauma-responsive practices and normalizes screening and referral for families exposed to adversity. Ulster County incorporates implicit bias training and community engagement strategies into its Department of Mental Health. These steps demonstrate how counties are making equity a structural priority rather than a background concern.

Disparities in access are not abstract—they are lived realities with clear patterns across counties. Residents who struggle with cost, stigma, language, or culturally inappropriate care are the same residents most likely to miss appointments, lose continuity, and rely on emergency services as a last resort. County planning documents consistently demonstrate that equity is not an add-on but the framework through which access must be understood and addressed. Centering equity clarifies where rural systems should concentrate effort and

investment, ensuring that new capacity translates into real, usable care for those most at risk of falling through the cracks.

Key Takeaways: Demographic Equity Considerations in Access to Care in Rural New York Counties

Equity as access: Demographic factors like income, identity, and language determine who receives care and who is left out.

Poverty as barrier: Low income and underinsurance remain the strongest predictors of unmet behavioral health needs.

Youth at risk: LGBTQ+ and transgender students face higher rates of depression and substance use, making schools vital access points.

I/DD and co-occurring needs: Individuals with developmental disabilities experience severe gaps in crisis stabilization and long-term care.

Race, ethnicity, and language: Persistent disparities call for culturally competent and affirming behavioral health services.

Structural equity efforts: Counties are moving from documenting disparities to embedding equity through training, data, and systemic reforms.

Summary and Conclusion

The Statewide Aggregate Rural Health Needs Analysis (SARHNA) offers a detailed, system level picture of behavioral health conditions and access across rural New York State. Drawing on county Community Health Assessments, Community Health Improvement Plans, and Local Services Plans, it surfaces the patterns, disparities, and lived realities that define rural behavioral health today.

The findings confirm that mental health and substance use challenges are widespread and, in many places, worsening. Depression, anxiety, suicide, and opioid related overdoses are repeatedly flagged as urgent. Youth and older adults emerge as especially vulnerable, with high rates of adolescent depression and suicidal ideation alongside growing isolation among older residents. These conditions rarely exist alone; they overlap and compound, creating complex needs that strain already limited systems of care.

Accessibility stands out as the unifying theme. Many services exist in theory but are inaccessible in practice. Workforce shortages, including psychiatrists, licensed clinicians, nurses, direct support professionals, and peers, are the most pervasive constraint, driving long waits, staff burnout, and unstable programs. In some counties, wait times extend months or even years, leaving urgent needs unmet.

Inpatient capacity exposes these pressures most clearly. Pediatric psychiatric beds are scarce or absent across large regions, forcing children in crisis to board in emergency departments. Families often travel 50 to 100 miles for detoxification or psychiatric care. Adults with co-occurring conditions or developmental disabilities face admission denials due to a lack of specialized programs. The result is not just a system under strain, but one in which stabilization is often structurally unavailable.

Structural barriers magnify gaps. Transportation is a near universal hurdle, with long distances, thin public transit, and limited Medicaid rides that drive missed appointments and drop off, especially for people managing substance use disorders. Broadband limitations further restrict reliable telehealth; in several counties, sizable shares of residents lack adequate connectivity, cutting households off from virtual care.

Social and economic conditions shape outcomes throughout. Housing instability, food insecurity, poverty, and unstable employment are closely linked to poor behavioral health. Adverse childhood experiences and trauma are cited across nearly every county plan as foundational drivers with ripple effects across schools, workplaces, and families. Rural health is therefore inseparable from the broader social and geographic realities of rural life, and aggregate data can mask sharp differences by ZIP code even within a single county.

Community Partnerships are the operating system counties are building to close access gaps. Hospitals and public health teams align screening and referral so an emergency visit or a primary care check can lead to same day treatment. Crisis partners co schedule who responds when, debrief on a set cadence, and use shared forms so cases move without re-evaluation. Law enforcement, courts, and jails are becoming treatment gateways through CIT refreshers, jail to clinic referral lines, and diversion packets that carry medication and counseling plans through release and arraignment. Harm reduction partners shorten the window from overdose reversal to buprenorphine starts and mobile counseling. Schools embed clinicians and standardize referrals so guidance concerns become same week counseling without leaving campus. Primary care integrates behavioral health through SBIRT, embedded counselors, and warm electronic referrals to prevent front desk bouncing. Peers and family advocates provide continuity across settings, including evenings and weekends. Housing networks pair keys with

on site coaching, benefits navigation, and medication follow up. Shared dashboards, single directories, and overdose mapping reduce bad referrals and steer outreach. Joint workforce pipelines, including job fairs, practicums, and ride alongs, turn student interest into hires. Regional tables standardize forms, data dictionaries, and messaging so residents see the same process across county lines. Accountability is public, as coalitions set targets in the open, report progress, and copy what works next door. In short, counties are turning separate programs into a single front door and a dependable pathway through care.

Demographic equity is integral to this work, not a parallel concern but a defining feature of access. County documents show that income, place, age, disability status, race and ethnicity, language, and identity shape whether residents can find services, understand how to use them, and stay engaged. Low income is a consistent predictor of unmet need, with high poverty and ALICE rates, deductibles, copays, and limited acceptance of insurance pushing people out of care. Transportation gaps fall hardest on seniors, renters, and younger adults in places where clinics cluster in just one or two towns; vehicle access rates show how quickly weekly visits can become impossible. Youth face distinct risks, and several counties respond with school-based clinics, universal prevention curricula, and targeted supports for LGBTQ and transgender students. People with intellectual and developmental disabilities encounter additional barriers when appropriate inpatient or respite options are scarce. Language access matters in majority white rural regions too; Spanish speaking outreach, interpretation, and bilingual responder training are expanding where counties have documented gaps. Some counties are institutionalizing equity by tracking health indicators for minoritized populations, adopting trauma responsive practices, and embedding equity goals into department plans so effort and funding follow measured disparities.

In conclusion, the SARHNA project portrays rural behavioral health in New York as high need and high friction. Conditions converge against workforce shortages, long waits, fragmented pathways, and social inequities. It also documents a practical path forward that is already in motion. Communities are building an integrated operating system of partnerships that moves residents from first contact to care without stalls. When shared scripts, single referral channels, co response models, peers, housing supports, data transparency, and joint workforce pipelines line up, and when equity sits at the center, links become lifelines. The result is faster first visits, fewer repeat crises, and safer handoffs from emergency rooms and jails for rural New Yorkers.

Appendix A: Data Sources

List of County Documents

County	Community Health Assessment	Community Health Improvement Plan	Local Services Plan
Allegany	CHA	CHIP	LSP
Broome	CHA	CHIP	LSP
Cattaraugus	CHA	CHIP	LSP
Cayuga	CHA	CHIP	LSP
Chautauqua	CHA	CHIP	LSP
Chemung	CHA	CHIP	LSP
Chenango	CHA	CHIP	LSP
Clinton	CHA	CHIP	LSP
Columbia	CHA	CHIP	LSP
Cortland	CHA	CHIP	LSP
Delaware	CHA	CHIP	LSP
Essex	CHA	CHIP	LSP
Franklin	CHA	CHIP	LSP
Fulton	CHA	CHIP	LSP
Genesee	CHA	CHIP	LSP
Greene	CHA	CHIP	LSP
Hamilton	CHA	CHIP	LSP
Herkimer	CHA	CHIP	LSP
Jefferson	CHA	CHIP	LSP
Lewis	CHA	CHIP	LSP
Livingston	CHA	CHIP	LSP
Madison	CHA	CHIP	LSP
Montgomery	CHA	CHIP	LSP
Ontario	CHA	CHIP	LSP
Orleans	CHA	CHIP	LSP
Oswego	CHA	CHIP	LSP
Otsego	CHA	CHIP	LSP
Putnam	CHA	CHIP	LSP
Rensselaer	CHA	CHIP	LSP
Schenectady	CHA	CHIP	LSP
Schoharie	CHA	CHIP	LSP
Schuyler	CHA	CHIP	LSP
Seneca	CHA	CHIP	LSP
St. Lawrence	CHA	CHIP	LSP
Steuben	CHA	CHIP	LSP
Sullivan	CHA	CHIP	LSP

County	Community Health Assessment	Community Health Improvement Plan	Local Services Plan
Tioga	CHA	CHIP	LSP
Tompkins	CHA	CHIP	LSP
Ulster	CHA	CHIP	LSP
Warren	CHA	CHIP	LSP
Washington	CHA	CHIP	LSP
Wayne	CHA	CHIP	LSP
Wyoming	CHA	CHIP	LSP
Yates	CHA	CHIP	LSP

Additional Data Sources

1. University of Wisconsin Population Health Institute. (2025). *County Health Rankings & Roadmaps*. University of Wisconsin. Retrieved from <https://www.countyhealthrankings.org>
2. Centers for Disease Control and Prevention. (2024). *PLACES: Local Data for Better Health*. U.S. Department of Health and Human Services. Retrieved from <https://www.cdc.gov/places>
3. New York State Department of Health. *New York State Prevention Agenda Dashboard*. Retrieved from https://apps.health.ny.gov/public/tabvis/PHIG_Public/pa/reports/#county
4. New York State Department of Health. *New York State Opioid Dashboard*. Retrieved from https://apps.health.ny.gov/public/tabvis/PHIG_Public/opioid/reports/#county
5. New York State Office of Mental Health. *New York State Psychiatric Inpatient Bed Capacity*. June 2025. Retrieved from https://omh.ny.gov/omhweb/statistics/nys_psychiatric_inpatient_bed_capacity.pdf
6. New York State Office of Mental Health. *Needs Assessment Dashboard (Workforce and MHPSA Designations)*. Retrieved from <https://omh.ny.gov/omhweb/tableau/needs-assessment.html>

Appendix B: Data Tables

Table 1: Mental Health Metrics

County	Poor MH ¹ (days per month)	Frequent Mental Distress ¹ (% of population)	Depression ¹ (Age adjusted rate per 100,000)	Suicide ³ (Age adjusted rate per 100,000)
Allegany	6.0	19%	23.7	16.5
Broome	6.1	19%	23.9	11.4
Cattaraugus	6	19%	24.6	16.1
Cayuga	6.1	20%	24.2	16.9
Chautauqua	5.7	20%	23.8	12.9
Chemung	5.5	18%	23.7	16.9
Chenango	5.8	19%	23.8	18.6
Clinton	5.9	20%	26.1	11
Columbia	5.6	17%	22.3	12.4
Cortland	5.9	19%	25.3	9.5
Delaware	5.8	18%	23.3	19.4
Essex	5.6	18%	22.8	11.9
Franklin	6.1	19%	25.3	18.9
Fulton	5.5	20%	24	16.3
Genesee	5.6	19%	23.2	15.4
Greene	5.6	18%	22.3	8.4
Hamilton	5.8	18%	23.6	12.3
Herkimer	5.4	18%	22.4	13.7
Jefferson	5.2	19%	22.9	11.5
Lewis	5.3	19%	23.6	21
Livingston	5.5	18%	23.6	12.8
Madison	5.8	18%	24.4	14.8
Montgomery	5.6	19%	23.2	12.1
Ontario	5.6	18%	24	12.4
Orleans	6	18%	23.3	9.2
Oswego	5.9	19%	24.3	13.8
Otsego	5.5	17%	23.3	18.7
Putnam	4.9	16%	20.5	7.3
Rensselaer	5.4	16%	20.8	10.2
Schenectady	5.3	17%	20.7	10.4
Schoharie	5.8	20%	23.6	13.1

County	Poor MH¹ (days per month)	Frequent Mental Distress¹ (% of population)	Depression¹ (Age adjusted rate per 100,000)	Suicide³ (Age adjusted rate per 100,000)
Schuyler	6.1	20%	25.2	15.6
Seneca	5.7	18%	23.6	14.7
St. Lawrence	5.5	19%	23.7	14.3
Steuben	5.7	19%	24.7	14.2
Sullivan	5.5	17%	20.9	12.9
Tioga	5.5	17%	22.3	8.5
Tompkins	5.2	17%	24.3	10.9
Ulster	5.7	17%	21.2	12.5
Warren	5.1	19%	24.3	10.5
Washington	5.4	18%	23.7	15.5
Wayne	5.9	18%	23.8	16.6
Wyoming	5.8	18%	22.3	11.2
Yates	6.1	19%	24.1	14.1
Rural County Average	5.7	18.4%	23.4	13.6
NYS Average	4.9	12%	19.1	9.7

Table 2: Substance Use Metrics

County	Drug Overdose⁴ (per 100,000 residents)	Smoking¹ (per 100,000 residents)	Binge Drinking¹ (per 100,000 residents)
Allegany	34.2	16.5	20.8
Broome	51.7	15.9	18.3
Cattaraugus	42.1	18.7	20.8
Cayuga	28.1	18.4	21.1
Chautauqua	48.7	17.9	19.9
Chemung	46.5	16.4	20.2
Chenango	41.0	19.3	22.2
Clinton	30.8	18.9	19.7
Columbia	31.1	14.6	21.4
Cortland	26.0	17.1	21.6
Delaware	38.0	15.9	20.6
Essex	32.6	17.7	20.8
Franklin	25.9	18.4	22
Fulton	42.1	21	20.2
Genesee	29.6	16.5	21.5
Greene	25.3	14.8	20.3
Hamilton	19.5*	18.2	21.5
Herkimer	28.5	16.8	22.9
Jefferson	19.9	17.9	19.2
Lewis	11.3*	17.6	22.9
Livingston	24.5	16.3	20.8
Madison	23.9	15.9	21
Montgomery	18.2*	18.7	21.2
Ontario	16.0	14.3	20.9
Orleans	12.8*	15.7	20.5
Oswego	31.3	17.2	21
Otsego	26.5	14.1	21.1
Putnam	26.4	11	20.4
Rensselaer	28.9	13	21.5
Schenectady	30.1	13.2	20.2
Schoharie	13.3*	19.2	21.2
Schuyler	39.8*	19.6	21
Seneca	24.6*	16.3	20.9

County	Drug Overdose⁴ (per 100,000 residents)	Smoking¹ (per 100,000 residents)	Binge Drinking¹ (per 100,000 residents)
St. Lawrence	25.2	19.6	20.9
Steuben	31.3	16.5	21
Sullivan	64.0	15.1	19.8
Tioga	14.7*	13.8	21.5
Tompkins	28.8	13.3	21.3
Ulster	41.1	14.1	20.6
Warren	18.3	18	21.5
Washington	46.0	15.7	22.4
Wayne	35.2	14.8	22.6
Wyoming	27.8	16.8	21.3
Yates	8.2*	18.4	20.7
Rural County Average	29.8	16.7	21.0
NYS Average	32.5	12.0	20.0

Note: Overdose (*) indicates an unstable value due to data suppression.

Table 3. ACEs Metrics

County	2 or More ACEs³ (Percent of Population)
Allegany	31.9
Broome	40.6
Cattaraugus	33.8
Cayuga	46.3
Chautauqua	35.1
Chemung	40.9
Chenango	49.6
Clinton	36.4
Columbia	24.6
Cortland	71.6
Delaware	42.5
Essex	29.5
Franklin	47.8
Fulton	31.3
Genesee	42.7
Greene	46.7
Hamilton	57.7
Herkimer	30.1
Jefferson	36.7
Lewis	38.2
Livingston	38.8
Madison	42.7
Montgomery	39.5
NYS	41.9
Ontario	47
Orleans	47.4
Oswego	45.7
Otsego	31.8
Putnam	52
Rensselaer	39.8
Schenectady	47.3
Schoharie	31.6
Schuyler	49.8

Seneca	31
St. Lawrence	39.7
Steuben	31
Sullivan	39.4
Tioga	59.3
Tompkins	39
Ulster	40.3
Warren	44.4
Washington	51.3
Wayne	38.6
Wyoming	33.8
Rural County Average	41.1
NYS Average	41.9

Table 4. Food Insecurity Metrics

County	Food Insecurity (% of population)
Allegany	14
Broome	15
Cattaraugus	15
Cayuga	13
Chautauqua	15
Chemung	14
Chenango	13
Clinton	13
Columbia	11
Cortland	13
Delaware	14
Essex	12
Franklin	15
Fulton	14
Genesee	12
Greene	11
Hamilton	13
Herkimer	13
Jefferson	14
Lewis	13
Livingston	11
Madison	11
Montgomery	14
Ontario	11
Orleans	13
Oswego	14
Otsego	12
Putnam	8
Rensselaer	12
Schenectady	11
Schoharie	12
Schuyler	14
Seneca	13
St. Lawrence	15

Steuben	13
Sullivan	13
Tioga	12
Tompkins	12
Ulster	13
Warren	12
Washington	12
Wayne	11
Wyoming	12
Yates	12
Rural County Average	13%
NYS Average	13%

Table 5: Workforce Shortage Metrics

County	Population Served per 1 Mental Health Provider¹	Psychiatrists¹ (per 100,000)	Licensed Mental Health Counselor¹ (per 10,000)	Licensed Clinical Social Worker¹ (per 10,000)
Allegany	380	2.1	8.7	5.8
Broome	380	13.7	2.1	16.7
Cattaraugus	520	3.9	6.6	7.4
Cayuga	450	5.3	5.4	9.9
Chautauqua	520	5.6	5.7	7.6
Chemung	290	17.2	3.2	11.6
Chenango	520	4.3	1.8	10.0
Clinton	280	14.0	11.4	6.5
Columbia	400	19.6	6.1	19.9
Cortland	230	2.2	3.5	11.1
Delaware	630	8.9	2.5	11.0
Essex	490	x	7.1	6.8
Franklin	280	10.8	6.6	6.6
Fulton	380	1.9	3.1	4.8
Genesee	500	x	5.7	9.3
Greene	960	6.2	3.7	13.5
Hamilton	1690	19.5	4.0	9.9
Herkimer	1040	x	1.5	8.8
Jefferson	400	5.1	4.4	10.3
Lewis	470	x	2.6	7.6
Livingston	640	1.6	7.0	9.2
Madison	400	5.9	5.3	9.0
Montgomery	970	8.1	5.1	5.1
Ontario	330	8.0	6.7	11.8
Orleans	1300	2.5	3.3	4.4
Oswego	540	3.4	7.2	3.9
Otsego	440	13.2	4.5	24.3
Putnam	210	19.0	6.7	12.5
Rensselaer	480	3.8	7.7	15.4
Schenectady	350	5.0	8.0	7.0
Schoharie	630	x	4.6	9.8

County	Population Served per 1 Mental Health Provider¹	Psychiatrists¹ (per 100,000)	Licensed Mental Health Counselor¹ (per 10,000)	Licensed Clinical Social Worker¹ (per 10,000)
Schuyler	430	11.3	2.3	9.4
Seneca	410	3.0	4.4	7.4
St. Lawrence	400	17.6	5.9	10.3
Steuben	400	7.5	4.3	19.6
Sullivan	450	15.8	6.2	19.6
Tioga	550	8.8	3.0	11.2
Tompkins	220	13.4	4.0	22.7
Ulster	240	13.7	8.6	26.2
Warren	210	9.2	8.9	12.9
Washington	550	1.6	4.3	7.5
Wayne	800	1.1	6.6	7.8
Wyoming	380	x	4.6	7.6
Yates	840	8.2	1.2	6.9
Rural County Average	494.1	8.5	5.1	10.8
NYS Average	371.5	13.6	5.5	12.1