Journal of Rural Mental Health

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Online First Publication, January 25, 2024. https://dx.doi.org/10.1037/rmh0000259

AMERICAN PSYCHOLOGICAL ASSOCIATION

Journal of Rural Mental Health

ISSN: 1935-942X

https://doi.org/10.1037/rmh0000259

PROGRAM DESCRIPTION

Challenges and Opportunities for Rural Certified Community Behavioral Health Clinics

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In 2014, the Substance Abuse and Mental Health Services Administration's implemented a new pilot program to create Certified Community Behavioral Health Clinics (CCBHC) that would better integrate care and improve substance use disorder and behavioral health outcomes. However, no rural communities had been involved in the CCBHC pilot program. Our program was one of the first attempts at implementing the CCBHC model in a rural setting. Evaluation data, including a community needs assessment, an attestation confirming compliance with the CCBHC criteria, and collection of physical, behavioral, and substance use health outcomes at 6-month intervals, guided an ongoing assessment program. This was further aided by a community advisory board which partnered on programming, suggested interventions and guided data collection. Last, patient satisfaction surveys and interviews were conducted by an outside evaluator to identify any limitations or challenges not otherwise identified. Results indicate that delivery of substance use disorder treatment greatly increased. Access to mental health services, including crises services improved, care coordination expanded, formal partnerships increased, and community involvement was enthusiastic and growing. Nonetheless, securing sufficient workforce was difficult, and the stigma surrounding youth mental health treatment seemed to persist across implementation. The policy context of Utah's Mental Health Authority system created barriers not anticipated by the CCBHC federal model. Effective treatment of youth, workforce recruitment, and policy challenges unique to Utah's Medicaid model created barriers that will vary in their impact on other rural implementation sites. The former two concerns are likely to persist in other rural settings, though the latter may reflect challenges unique to this site.

Public Health Significance Statement

Certified Community Behavioral Health Clinics (CCBHCs) are a model designed by Substance Abuse and Mental Health Services Administration to incorporate the best practices of care delivery for substance use disorders and related treatments. Therefore, it is essential to develop the model to ensure it is effective in rural settings. This program is outlined here to give other rural care providers key lessons should they wish to implement a CCBHC in their community.

Keywords: stigma, substance use, community health, mental health, rural health care

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This project was funded by Substance Abuse and Mental Health Services Administration Grant 1H79SM083136-01. The authors acknowledge the partnership and support of their

continued

The Substance Abuse and Mental Health Services Administration (SAMHSA) began to promote a new gold standard for community care in 2014. This model, the Certified Community Behavioral Health Clinic (CCBHC), was funded by the Protecting Access to Medicare Act (Protecting Access to Medicare Act of 2014) representing one of the largest investments in mental health parity in the nation (U.S. Department of Health & Human Services, 2022a). CCBHCs are designed to cure systemic issues in care by providing comprehensive substance use disorder (SUD) and mental health treatment, including 24-hr crisis services, peer support offerings, and access to primary care (National Council for Mental Wellbeing, 2021). In addition to having these specific services, these clinics are required to be community-centered, with an active community advisory board. They must be embedded in a local safety net that includes law enforcement, Veterans Affairs centers, and youth programming. Last, the CCBHC model mandates culturally and linguistically appropriate interventions and services (U.S. Department of Health and Human Services, 2022b). When the program is implemented as designed, groups who may have fallen through the cracks of the system in the past instead become centered. The goal of capturing these clients is to reduce overall health care costs, improve health outcomes, and provide patient-centered, culturally and linguistically appropriate care. Each of these CCBHC services is sustainable because the improved care outcomes and efficiencies reduce costs of emergent services and ensure prevention is part of routine care models.

On a national level, SAMHSA leveraged its ability to provide funding to specific sites by launching a pilot study of how CCBHCs can be effective in eight states.[1] Their pilot trial demonstrated that this model has consistently provided positive client outcomes across multiple hospital settings. One report found that Oklahoma's, New York's, and Missouri's CCBHCs each saw reduced emergency department visits by 18–46% (National Council for Mental Wellbeing, 2021). In Oklahoma and New York, the number subsequently admitted to inpatient care declined by 20–69% across a 4-year implementation window (National Council for Mental Wellbeing, 2021). Readmissions dropped in both New York and New Jersey, and Missouri reported that of those with prior law enforcement involvement, 70% had no further involvement at 6 months (National Council for Mental Wellbeing, 2021). Six states emphasized that their involvement with the CCBHC program increased staffing and reduced long-standing workforce shortages, with particular emphasis on the increase in access to psychiatry, medication for opioid use disorder (MOUD), and peer support workers (National Council for Mental Wellbeing, 2021). In New Jersey alone, the number of clients receiving MOUD doubled, Missouri saw a 122% increase, and Oklahoma saw a 700% growth in clients served (National Council for Mental Wellbeing, 2021). States also reported substantially higher rates of follow-up care after hospitalization, outperforming statewide averages and other provider types on these and other quality measures (National Council for Mental Wellbeing, 2021). The robust evidence presented highlights the effectiveness of CCBHCs in urban settings but did

[1] The eight states were Minnesota, Missouri, New Jersey, New York, Nevada, Oklahoma, Oregon, and Pennsylvania, all of which piloted the program in a metropolitan area.

community collaborators without whom these efforts would not be possible. The authors gratefully thank Utah Support Advocates for Recovery Awareness, Four Corners Community Behavioral Health, Moab Valley Multicultural Center, Utah Navajo Health Systems, Moab Free Health Clinic, Grand County School District, and the members of their Community Advisory Board. The authors have no known conflicts of interest to disclose.

Sandra H. Sulzer played a lead role in conceptualization, funding acquisition, methodology, writing–original draft, and writing–review and editing and an equal role in project administration and supervision. Cristian Meier played a lead role in data curation, formal analysis, and validation, a supporting role in writing–original draft and writing–review and editing, and an equal role in methodology. Nara Bopp-Williams played a supporting role in data curation, investigation, project administration, and writing–review and editing. Paula Cook played a lead role in project administration and an equal role in supervision, writing–original draft, and writing–review and editing. Lauren Prest played a lead role in funding acquisition and project administration and an equal role in investigation, supervision, writing–original draft, and writing–review and editing.

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not provide any evidence about how to implement a CCBHC in a rural location.

Following the publication of pilot data from urban sites by SAMHSA, there have been subsequent rounds of grant funding for additional sites to create a CCBHC. Funding levels vary from 2 to 4 years, depending on the programmatic focus. For initial CCBHCs such as ours, we secured 2 years of funding in a competitive application process, wherein applicants established readiness to establish the model at a local site.

This article offers a discussion of how a CCBHC may function in one of the first rural settings in which the model has been implemented. As recipients of SAMHSA CCBHC funding, Moab Regional Hospital (MRH) offers an early view of how this grant can be implemented outside of an urban setting. While the requirements to create a CCBHC are identical everywhere, the challenges and character of rural health care shape the implementation of the model in ways worthy of discussion.

We will describe our experience in implementing a CCBHC in Moab, a rural town in Grand County, Utah with a population just over 5,000. The hospital "MRH" that implemented the CCBHC program primarily serves a catchment of approximately five counties (Carbon, Emery, Grand, Wayne, and San Juan), all of which are more geographically proximate to the area than to Salt Lake City. However, while proximate, clients utilizing services within the five-county catchment areas may have to drive up to 5 hr each way. These counties are all rural in nature (Economic Research Service U.S. Department of Agriculture, n.d.)[2] and include part of the Navajo reservation at the Southeastern corner of the state.

MRH had been interested in expanding mental health services for several years in response to community needs assessments that identified the severe need for expanding care. At the launch of the CCBHC, the local needs assessment identified "substance abuse" as the primary health concern of 72% local residents (National Rural Health Resource Center, 2016). Six months prior to CCBHC implementation, MRH started an outpatient-based opioid treatment program with the hire of an addiction psychiatrist. Prior to this, the hospital housed two licensed clinical social workers, who served primarily in mental health integration roles, and a master's level counselor who kept a panel of clients of all ages. Most of the medical interventions for mental health disorders had been provided either by primary care providers or a telehealth service through the local "Mental Health Authority" (MHA).[3] In Utah, a single Mental Health Authority (Utah Department of Human Services, n.d.-a) in a county or multicounty area has the exclusive ability to bill Medicaid for mental health services (Local Human Services Act, 2022). This model, unique to Utah, is intended to interface with its geographically disparate and predominantly rural geography. MHAs are required by statute to provide inpatient, residential, and outpatient care and services (Local Human Services Act, 2022). They also must offer 24-hr crisis care, psychotropic medication management, psychosocial rehabilitation, case management, community supports such as family support services and in-home care, consultation with other service agencies, and public education services and care for those who are incarcerated (Local Human Services Act, 2022).

Importantly, MHAs are not statutorily obligated to provide substance use treatment, which effectively separates these forms of care provision on a structural and policy level in the state. Furthermore, since MHAs are the only provider authorized to bill Medicaid for mental health services in a given area, other local providers who do provide SUD treatment services are only able to bill under substance use treatment to Medicaid. For patients who qualify for Medicaid, this means their care is inherently bifurcated between providers or that other local providers who treat comorbid conditions must self-fund any mental health care they offer. MRH is not the MHA for the tricounty region, which means they are unable to bill Medicaid for behavioral health services. For MRH, acute needs for hospitalization were typically diverted back to the community or occasionally boarded in the emergency room or medical floor. Prior to the implementation of the MRH CCBHC, there was limited interagency integration aside from informal communication common to small towns.

[2] Each county is rural as defined by the Office of Management and Budget, the Census Urban areas classification, and the USDA Business and Industry designations.

[3] In Utah, mental health authorities are authorized to exclusively serve a region for mental health needs and are the sole-allowable Medicaid provider for nonsubstance use–related mental health treatment.

Gaps in Rural Implementation of the CCBHC Model

Workforce shortages represent a major barrier to CCBHC implementation, particularly in rural areas. Even though mental health is frequently identified as a rural health priority (Gamm et al., 2010), nearly 75% of rural communities with populations from 2,500 to 20,000 lack a psychiatrist, and 95% lack a child psychiatrist (Gamm et al., 2010). The well-documented challenge of difficulty securing workforce (MacDowell et al., 2010) with geographic barriers to receiving specialist care (Hastings & Cohn, 2013) mean those living in rural communities often lack the access found in urban centers.

SUD treatment is also hampered locally due to insufficient access to MOUD. In Utah, opioid overdose deaths were 1.5 times higher in rural than urban counties across an 8-year period (DasGupta et al., 2020). And yet MOUD access inclusive of methadone clinics and buprenorphine prescribers were found predominantly along the urban corridors of the state (DasGupta et al., 2020). A similar pattern was found in rural Pennsylvania (Cochran et al., 2019). Ultimately, one third of rural Americans lived in a county without access to a buprenorphine provider, as compared to 2.2% of urban dwellers (Andrilla et al., 2019).

Stigma toward mental health and SUD treatment remains prevalent among providers and community members, presenting a cultural challenge that results in fewer persons accessing needed care. There is stigma generally toward harm reduction approaches even among health care providers (Madden et al., 2021; Sulzer et al., 2022). And there is evidence that stigma prevents physicians in rural areas from pursuing certification for buprenorphine (Andrilla et al., 2017). Rural leaders in two counties described their communities as having negative attitudes toward persons with mental illnesses (Johnsen et al., 1997). Older adults in rural areas expressed that they viewed pursuing mental health treatment with substantial stigma, except in the case of significant acute distress (Stewart et al., 2015). And there is a link between the strength of negative views toward people seeking professional help and a personal unwillingness to access care (Rost et al., 1993). Collectively, stigma presents a greater barrier to mental health and SUD care provision in rural areas, which makes sense to the extent that there are societal-wide stigmas toward these forms of care, and it is difficult to anonymously or privately seek treatment in a rural setting.

Geographic distances and lack of access to public transit are common features of rural locations. While urban patients may be able to utilize public transit or even walk to a local clinic, this is not feasible for a hospital that serves a five-county region, with long distances between care sites (DasGupta et al., 2020). Together, these data point toward unique experiences of rural clients suggesting CCBHC in rural areas must address additional client concerns that are experienced less often by urban CCBHC clients.

Method

Needs Assessment Data Collection Procedures

To bring MRH into compliance with CCBHC standards, a supplementary needs assessment was conducted in April and May of 2021. A comprehensive needs assessment is a standard requirement of CCBHC implementation. We used multiple sources of data to examine the cultural, linguistic, staffing needs, local resources, transportation, and income of the area. First, we conducted one focus group with local organizations and one focus group with residents to examine their perceptions related to the needs and resources of the community. Next, we used Google Maps to visualize the resource distribution in the area, specifically looking at health care, housing resources, social services, and SUD, treatment, and recovery services. Finally, we examined secondary data sources to examine transportation and income disparities by conducting a review of resources on Google, which was supplemented by feedback from the advisory board formed to inform the CCBHC.

CCBHC Model Implementation and Attestation Methods

The implementation period of the CCBHC took place across 2 years from 2020 to 2022 and as of this writing is 18 months into execution. The initial quarter of efforts included completing a

community needs assessment, establishing a community advisory board, and fulfilling attestation requirements for SAMHSA. The attestation outlined the required elements of a CCBHC and the hospital's efforts to achieve them. SAMHSA reviews each attestation to verify that a site is in compliance with CCBHC standards. MRH also participated in all required evaluation activities which included 6-month follow-ups on key mental and physical health measures, participant tracking and patient satisfaction surveys, much of which goes into a national database for SAMHSA to compare efficacy across sites. Locally, we had access to our own data for ongoing evaluation of the efficacy of the program.

CCBHC Evaluation Data Collection Procedures

The program evaluation was comprised of two survey instruments, which sought to examine the SAMHSA defined outcomes (e.g., housing, diagnosis) and clinical outcomes (e.g., depression, anxiety, use of drugs). Survey collection occurred at intake, and reassessment occurred every 6 months thereafter. The intake survey included the National Outcomes Measures survey instrument (provided by SAMSHA) and a project team-created survey using established clinical measures (e.g., Patient Health Questionnaire–9). The intake survey was administered in article form by a clinic nurse who had been trained on enrolling participants into the evaluation of the CCBHC. The survey was completed in person and took approximately 30 min to complete. The project team monitored when clients were eligible for reassessment, and a list of clients was provided to the clinic nurse to complete their reassessment using the same tools as the intake during an in-person appointment. Participants were able to decline participation in the evaluation and still receive all CCBHC services.

Institutional Review Board Statement and Informed Consent

The data collected in this article were exclusively for program evaluation as mandated by the funder and therefore exempt from Institutional Review Board Review and considered nonhuman subjects' research. Nonetheless, all participants in the needs assessment and evaluation of the CCBHC received informed consent documents and were provided the option to enroll (which identified consent to participate) or decline involvement in the evaluation and/or CCBHC. Participants were explicitly informed that care provision was not contingent upon completion of any surveys. Additionally, they were informed they could decline further involvement at any time or remove any previously collected data from program reporting.

Findings Including Successes and Key Challenges

Needs Assessment Results

The results of the needs assessment found several key findings, which were used formatively to implement the CCBHC. First, during the focus groups ($n = 10$) participants explained that while there were a good number of local resources that "it's definitely lacking." More specifically, they identified a need for additional staffing in skilled positions, which is often hampered by low local wages and high housing costs. Participants also identified the lack of local and regional travel supports, describing how no public or private travel was in operation. And they identified the need for additional training and availability of services related to cultural humility and translation services.

The results of the mapping component of the needs assessment found that there was a robust network of certain resources ($N = 37$). However, when further synthesizing the mapped results, it was clear that few services existed outside of the local area where MRH is housed. County residents had to travel into town to receive any services. Finally, the results of the secondary data analysis pointed toward a low median income: $51,557 at the county level versus $71,621 across the state (U.S. Census, 2020).

CCBHC Model Implementation and Attestation Results

Many aspects of the CCBHC were well aligned with care coordination and other goals already present at the hospital. However, the additional grant funding allowed for increased tracking of client outcomes and service use, staffing and

direct support for patients. Particular successes include formal partnerships with a Utah-based peer support agency and the local mental health authority, improving patient access to recovery advocacy, introducing transportation services, and crisis service delivery. The hospital also began offering a new van service to connect patients to care within Moab and in Salt Lake City, as needed. Additionally, the hospital was able to build a free-standing recovery center complete with opening a SAMHSA-certified opioid treatment program with daily dosing and wrap-around services for opioid use disorder, provision of medications for alcohol use disorder and tobacco use disorder, and contingency management for stimulant use disorder. Furthermore, involvement in the community advisory board was enthusiastic and resulted in a growing waitlist of future participants as residents rallied around the opportunity to improve care options in their community.

However, there were also challenges specific to the geographic context in which the CCBHC operated. These included policy-level barriers to care integration, persistent workforce shortages consistent with rural locations, and difficulty securing all of the supports needed to fully serve youth.

CCBHC Evaluation Results

Despite these particular challenges, preliminary results from the evaluation of the CCBHC suggested positive outcomes. During the 1st year of operation, MRH enrolled 122 adult clients and 10 youth clients into the CCBHC program evaluation. Only adult results will be reported here because of the small youth sample size. Overall, participants were most often diagnosed with a co-occurring disorder (68.3%; both a substance use and mental health disorder). On average, at intake adults had a generalized anxiety disorder–7 score of 6.59, which increased (to a nonstatistically significantly different amount) at the 6-month reassessment rate to 6.93 with scores indicating mild anxiety. Most often, participants were extremely confident about engaging in their recovery (57% intake; 68% 6-month reassessment). Finally, participants identified most frequently being abstinent from their drug of choice most days of the month (76% intake; 73% 6-month reassessment).

Our preliminary findings suggested that the overall provision of SUD care increased, and there was positive feedback from community advisory board members about developments such as the transportation services, increased access to integrated care, and peer supports. The shift to the CCBHC resulted in patients feeling their care was more consistent. One family member stated "having more care, and he doesn't feel like he is falling through the cracks. Personal attention. Consistency. He struggled with diagnosis for a longtime and feels like he has finally come to a good place and he is getting somewhere." Another patient said "[I] now have access to more services and diagnosis that I didn't have before. Had a consistency of care … feel better that I am getting regularly treated." The CCBHC model increased the number of services available, which otherwise might not be possible in a rural area. For example, the hospital may not have taken on the liability to implement a transportation system including a van and a driver for patients. One patient commented "Drive was awesome. This was a lifesaver!! Knowing now that we have a way to transport my mom has lifted so much weight off of us." Another patient said "Since I live alone with leukemia and a broken hip, your transportation is a god sent [sic]." The CCBHC also created better connections and relationships than previously existed, including a crisis services contract with the local mental health authority.

The implementation of the CCBHC was the first time that there has been rapid access to treatment in the region, which has unburdened access to family medicine, urgent care, and the emergency department. The availability of care has also been linked to a perceived reduction in care-provider burnout: It can feel hopeless to be unable to provide options or treatment to a patient in need. Having the recovery center as a place to route patients gives providers hope and a sense that they had options available. For patients who would not historically have been able to access treatment, this was a new opportunity. Similarly, having a crisis team who can be pulled in has opened up time for family medicine doctors who see back-to-back patients. The involvement of peer-led groups and peer-driven services has also increased including the creation of a women's group. However, there were also substantial challenges.

Policy-Level Barriers to Integrated Care

While CCBHCs are intended to fit seamlessly with Medicaid reimbursement and increase

effective billing as in the pilot states, that model did not match well with the state context of MRH. The MHA in this area is four corners community behavioral health, which serves three counties (Utah Department of Human Services, n.d.-b).

In the case of MRH, they were able to formally partner with the local MHA to increase care coordination with regard to crisis care services specifically. But self-funding some mental health treatments for substance use patients and dual diagnosis continued, in an effort to streamline care and reduce barriers to patients.

Difficulties in Workforce Recruitment

While other CCBHCs reported hiring an average of 117 new staff or a median of 43 in urban areas, MRH was able to fill far fewer positions (National Council for Mental Wellbeing, 2021). The hospital was able to hire for less than a dozen total new positions, including a full-time psychologist, two part-time telehealth psychiatric nurse practitioners, two counselors specialized in SUD, an emergency room case manager, a program director, and nursing staff for an opioid treatment program, three grant staff positions, and formalized paid partnerships for peer support and crisis services with nearby community partners. However, other positions remained unfilled for the duration of the initial 2-year granting period, including a full-time dedicated psychiatrist to serve youth. Furthermore, turnover common to rural job markets also led to three positions needing replacement during the same period.

Youth-Services Delays

Connected with the above two challenges, serving youth was particularly challenging during the initial roll-out of this CCBHC. The difficulty with hiring a youth psychiatrist and enrolling youth in services, compounded with the bifurcation of mental health and substance use treatment, COVID-19 and the unique challenges of stigma in a rural area all affected youth treatment. Despite an initial prediction that the program would be able to enroll 50 unique youth during the 1st year of service provision, only 10 youth were enrolled into CCBHC services by the end of the 1st year. Youth did receive some CCBHC services despite not being officially enrolled—meaning they accessed services, though they were not formally tracked within the program. On average, the CCBHC provided 22 youth services each month, which included both behavioral health and substance use treatment; however, most youth enrolled received mental health services only.

Discussion

Successes

While there were some challenges, the implementation of a CCBHC in rural Moab brought many positive outcomes to the community. The presence of entire clinic devoted exclusively to recovery has not only increased the amount of care available locally but also stands as a symbol of the importance and availability of treatment. It cannot be overstated that at the beginning of the grants period there was nothing where an entire facility now stands. In rural areas, the absence of services is so often palpable. This grant and model made a substantial difference for Moab and the surrounding areas. More than even access to care, the building has become a welcoming space. The waiting room of the recovery center has hot beverages, puzzles, and places for local residents to warm during winter months or cool off during summer, especially for those experiencing housing insecurity.

Furthermore, the care integration expectations of remaining CCBHC-compliant have broken down care silos. Essential meetings between various subspecialties to ensure successful implementation has improved care coordination and awareness of SUD treatment options. Well beyond the specific care outcome metrics, the CCBHC gave a unifying vision to the local community. And, since the model aligned so well with the needs identified locally, the project proceeded with substantial community investment and involvement. Establishing a community advisory board with a waitlist is unheard of, but the local enthusiasm for this program was substantial. It is easy to feel like rural areas have been forgotten; the CCBHC model made local residents rally instead around the possibility of hopeful changes. We would expect that similar positive ramifications would occur in other rural settings.

Beyond the positive implications of the rural implementation of the CCBHC model,

the challenges the community faced were largely structural in nature and may affect other rural sites.

Policy Challenges

The Mental Health Authority model in Utah prevents CCBHCs from fully operating as intended on a federal level. While the CCBHC program is intended to be flexible with state-governed Medicaid models, in Utah the MHA model bifurcates much of the care the CCBHC attempts to coordinate. While care coordination across agencies is possible, this workaround is likely to reduce some of the benefits of CCBHC implementation. We would expect to see more persons who fall through gaps because any barriers to treatment can be costly, especially during crises. Since much of the CCBHC model is designed to create a one-stop shop, medical home for care that integrates SUD, behavioral health and primary care treatments, Utah will be unable to fully execute those goals without altering its statutory language. Possible solutions include allowing CCBHCs to also serve as mental health authorities, transferring MHA to any qualified CCBHC in a given area, or improving statewide interoperability service agreements between entities so that patients receiving primary SUD treatment from another location can also receive all comorbid, Medicaid-eligible care from the same facility.

These changes are likely to be controversial: The MHA model is designed to eliminate competition in each area and theoretically achieve efficiencies by having one provider serve all patients. Each MHA receives annual earmarked funding from the state, giving them greater flexibility in treating complex patient populations (Behavioral Health Services Amendments, S.B. 41, 2022). The entities who currently receive those funds and depend upon them are unlikely to be advocates of sharing those funding streams or having them allocated differently to other agencies. At the same time, entities currently unable to bill for the Medicaid-eligible services they provide are likely to view access to Medicaid-billing as a crucial lifeline to long-term sustainability. Without it, they may need to turn patients away or offer substandard care. How to make these approaches fully self-sustaining in the future remains to be solved. In general, it is likely not sustainable for rural CCBHCs in a state with a model similar to Utah's to have to self-fund behavioral health care through donations or outside fundraising, instead of through care coordination and integration.

Workforce Recruitment

Workforce recruitment challenges are well documented in rural areas, but in this case, recruitment was also strained due to COVID-19. Many health care personnel were allocated to pandemic response, and at certain points, travel and other restrictions further impacted provider recruitment. With fewer providers overall in a rural location, the allocation of health professionals to pandemic responsiveness stretched resources even more substantially. It is difficult to untangle what proportion of the hiring challenges were due to rurality versus COVID-19, but the combined effect created substantial delays in filling all positions. Since the CCBHC model is designed to expand the number of providers, increase services, and introduce billing streamlining, this aspect of expansion will likely take longer to be fully realized in this context. As other rural communities strive to incorporate the CCBHC model they may need to plan for substantially longer implementation timelines, incorporating innovative strategies to compensate for inherent difficulties in rural workforce recruitment.

Youth Care

The challenges in enrolling youth in treatment were not anticipated by the team. To address the difficulties in enrolling youth into CCBHC services, the hospital took several additional steps to increase youth recruitment. The grants team worked closely with a therapist at the hospital to enroll youth who received behavioral health services. A second step taken was to provide two social workers on staff additional training on how to enroll youth clients by openly communicating with the parents by providing them with an overview of what the CCBHC is and what they would be asked to do if they decided to participate in the evaluation component. The team also proposed key changes for future years, including adding a youth member to the community advisory board, co-funding and partnering with an in-school counselor, and spending future years specifically focused on youth outreach. However, the delays likely

reflect larger social stigmas particularly linked to youth mental health (C. A. Heflinger & Hinshaw, 2010), and the social and environmental factors in rural areas that have been linked to the increases in drug use vulnerability (Dew et al., 2007).

There is evidence that greater perceived stigma toward youth behavioral health services is linked to parents being less willing to seek out care for their children (Polaha et al., 2015). It is also possible that stigma around behavioral health generally makes it less likely that signs of mental distress will be correctly identified (Mace et al., 2020). Identifying avenues to improve childhood access to care and early detection are essential since many mental health conditions persist into adulthood, so beginning an intervention sooner than later is crucial (Beauchaine & Hinshaw, 2008). Because there is evidence that families may face stigma if their child receives mental health care (C. Heflinger et al., 2014), it may be important to target educational programming toward parents in particular. If parents in rural areas faced less stigma or fear of blame for having a child with a mental health or substance use condition, they may be more likely to be advocates for care. If other organizations plan to create CCBHCs in rural areas, this is an area for proactive attention. Partnership with 4-H groups, youth centers, and increasing youth involvement in coalition work may all be strategies to consider employing in the future (Sulzer et al., 2020).

Program Limitations

Because the CCBHC model is new, this scholarship represents one of the earliest pieces documenting how the model functions and can contribute to rural substance use care. At this time, SAMHSA has conducted a pilot trial and collected substantial data from other recipients of this funding mechanism, but there have not been one or more controlled trials that show efficacy of this model over others. Interested parties should watch for forthcoming outcomes data published by SAMHSA and other grant recipients.

Conclusion

This article presents preliminary information about successes and challenges unique to implementing a CCBHC in a rural setting. While some aspects of implementation were likely specific to Utah, others, such as workforce recruitment and youth service challenges are more likely to generalize to other states. As future CCBHCs begin programming and outreach, it will be important for best-practice models to be shared across sites. The integration of SUD, mental health, and primary care services with peer support and crisis intervention requires a high level of coordination and dedication on the local level. In small communities, the presence of CCBHC funding and support may ultimately have more substantial and tangible impacts than in urban centers due to the relative absence of other resources. To this end, best practices for ensuring the long-term sustainability and success of this model may lead to more vibrant rural communities.

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Received November 4, 2022
Revision received September 20, 2023
Accepted November 17, 2023 ■