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STRENGTHENING RURAL BEHAVIORAL HEALTH SYSTEMS IN ARKANSAS: A SYSTEMS-ORIENTED REVIEW USING VETERANS TO EXAMINE BROADER SYSTEM CHALLENGES

JUSTIN WORKS[1], ANITA SEGO[2], STEPHANIE ROSE[3] & AMY TALLENTS[4]

1We are the 2; Department of Psychiatry Executive Director of Illinois Campus Cares Technical Assistance Center, Southern Illinois University School of Medicine Department of Health Sciences – Addiction Studies, University of Central Arkansas; 3Associate Professor, University of Central Arkansas; *Corresponding Author: Stephanie Rose, Department of Health Sciences – Addiction Studies, University of Central Arkansas, 201 Donaghey Avenue, Conway, Arkansas, 72034, Tel: 501-450-3194; Fax: 501-450-5515

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ABSTRACT

Rural Arkansas faces persistent behavioral health disparities, intensified by geographic isolation, workforce shortages, fragmented care systems, and limited access to specialized mental health and substance use services. Veterans living in rural communities often experience these barriers disproportionately because they frequently navigate multiple healthcare systems while facing elevated risks of suicide, substance use disorders, and co-occurring behavioral health conditions. This narrative review examines the behavioral health system factors that contribute to disparities in access, care coordination, and health outcomes across rural Arkansas using veterans as a population through which broader systemic challenges can be examined and understood. National literature is synthesized alongside Arkansas-specific policy documents, statewide surveillance reports, behavioral health system assessments, and findings from the Arkansas Veteran Well-Being Needs Assessment to identify barriers and opportunities for system improvement. Across the literature, behavioral health inequities consistently emerge from the interaction of workforce shortages, limited crisis response capacity, fragmented communication and care coordination, transportation barriers, cultural stigma, inadequate financing, and insufficient community-based infrastructure. Evidence further supports integrated behavioral healthcare, workforce recruitment and retention initiatives, expansion of community mental health and crisis services, telebehavioral health, strengthened data infrastructure, and cross-sector collaboration as key strategies for improving access and continuity of care. Arkansas has established a strong policy foundation through statewide behavioral health planning and investment in community- based services; however, significant opportunities remain to strengthen rural behavioral health systems, particularly for veterans and other underserved populations. A systems-oriented approach that integrates prevention, crisis response, coordinated care, workforce development, and continuous evaluation offers the greatest potential to reduce behavioral health disparities and improve long-term outcomes across rural Arkansas.

INTRODUCTION: The Complexity of Behavioral Health Inequities in Rural Communities

This paper examines the behavioral health system factors that contribute to disparities in access, care coordination, and outcomes across rural Arkansas while synthesizing national evidence with Arkansas-specific literature to identify evidence-based strategies for

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strengthening rural behavioral health systems. By integrating national research, Arkansas policy documents, statewide surveillance data, behavioral health system assessments, and findings from the Arkansas Veteran Well-Being Needs Assessment, this review identifies practical strategies that policymakers, healthcare organizations, and community stakeholders can use to strengthen behavioral health systems, improve care coordination, and reduce behavioral health disparities across rural Arkansas. The review addresses the following question: What behavioral health system factors contribute to disparities in access, care coordination, and health outcomes across rural Arkansas, and what evidence-based strategies does the literature identify for strengthening behavioral health systems in these communities?

Behavioral health disparities remain a significant public health concern in rural communities across the United States, where residents often face barriers to accessing timely, high-quality mental health and substance use services. Rural Arkansas exemplifies these challenges, with many communities experiencing provider shortages, transportation barriers, limited availability of specialty services, fragmented systems of care, and socioeconomic conditions that contribute to poorer health outcomes. These systemic issues contribute to delayed treatment, reduced continuity of care, and widening disparities between rural and urban populations. Addressing these disparities requires examining the behavioral health system as a whole rather than focusing solely on individual-level barriers. System-level factors—including workforce capacity, service availability, care coordination, funding structures, telehealth infrastructure, and collaboration among healthcare providers and community organizations—play a critical role in determining whether rural residents receive appropriate and effective behavioral healthcare. Understanding how these factors interact can help identify opportunities to improve access and strengthen service delivery.

Behavioral health disparities in rural communities represent a complex interaction of geographic, social, economic, cultural, and healthcare system factors. Although rates of mental illness are comparable between rural and urban populations, rural residents experience significantly greater barriers to receiving timely and appropriate behavioral healthcare. Limited provider availability, transportation challenges, stigma, socioeconomic disadvantage, and inadequate community resources contribute to persistent gaps in access and treatment (Stewart et al., 2021). These disparities are further exacerbated by workforce shortages, fragmented service delivery systems, insufficient crisis-response infrastructure, and inadequate support for behavioral health professionals (Burns et al., 2023; Hallett et al., 2024). Taken together, the literature demonstrates that improving rural behavioral health outcomes requires a comprehensive approach that addresses individual needs, community conditions, organizational barriers, and broader systemic inequities.

Although these disparities are often described in terms of limited access to care, workforce shortages, and other structural barriers, the broader literature suggests they also reflect how behavioral health systems are organized and coordinated. Addressing these challenges requires integrated systems of care that strengthen coordination among behavioral health, primary care, public health, and community-based organizations while promoting prevention, recovery, continuity across services, and reducing fragmentation throughout the behavioral health continuum (Drake & Bond, 2021; McGinty, 2023). These system-level approaches further suggest that sustainable improvements in behavioral health outcomes depend on collaboration

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among healthcare organizations, policymakers, and community stakeholders to build accessible, equitable, and recovery-oriented systems of care.

The National Institute on Minority Health and Health Disparities (NIMHD) Research Framework provides a useful model for understanding these interconnected factors by examining influences across multiple levels, including biological, behavioral, healthcare, sociocultural, and environmental domains (Stewart et al., 2021). Consistent with this framework, research examining rural healthcare access, criminal justice involvement among individuals with serious mental illness, behavioral health crisis care, and workforce retention emphasizes that disparities cannot be addressed through isolated interventions. Instead, sustainable solutions require integrated systems of care, increased investment, culturally responsive practices, and policies that strengthen community-based behavioral health infrastructure. The sections that follow synthesize national evidence with Arkansas-specific policy reports, surveillance data, and empirical observations to examine how system-level factors shape behavioral health access, care coordination, and outcomes within Arkansas's rural behavioral health system.

Rural Mental Health Disparities and Barriers to Access

Stewart et al. (2021) emphasize that rural mental health disparities result from the interaction of multiple factors rather than a single cause. Using the National Institute on Minority Health and Health Disparities (NIMHD) Research Framework, the authors explain that mental health outcomes are shaped by individual characteristics, interpersonal relationships, community environments, healthcare systems, and societal conditions. This multidimensional framework is particularly relevant for rural populations because barriers often accumulate and reinforce one another. Consistent with this perspective, broader rural behavioral health literature demonstrates that disparities arise from interconnected geographic, organizational, and socioeconomic barriers, including workforce shortages, transportation challenges, limited healthcare infrastructure, and fragmented service delivery (Morales et al., 2020; Coombs et al., 2022). Qualitative evidence from rural healthcare providers also suggests that organizational constraints, communication challenges, and community culture compound these structural barriers, limiting timely access to behavioral health services (Coombs et al., 2022). For example, a rural resident experiencing mental health concerns may face limited provider availability, transportation difficulties, insurance restrictions, stigma, and concerns about confidentiality within small communities (Stewart et al., 2021).

One of the most significant barriers identified is the shortage of behavioral health professionals. More than 60% of rural residents live in areas designated as mental health provider shortage areas, and many rural counties lack practicing psychiatrists entirely (Stewart et al., 2021). Although workforce development programs, such as loan repayment initiatives and the National Health Service Corps, have increased recruitment efforts, retaining behavioral health professionals in rural communities remains challenging. Emerging evidence suggests that workforce shortages are sustained by multiple organizational and system-level factors rather than recruitment challenges alone. Qualitative research within public behavioral health systems has identified low wages, documentation burden, inadequate administrative and physical infrastructure, limited career development opportunities, and chronically traumatic work environments as major contributors to workforce turnover and attrition, ultimately reducing

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access to behavioral health services (Hallett et al., 2024). These findings suggest that strengthening the rural behavioral health workforce requires policies that support provider retention through organizational investment, workplace support, and sustainable infrastructure in addition to recruitment efforts. Consistent with this systems-oriented approach, Stewart et al. (2021) recommend expanding innovative workforce models, including peer specialists, behavioral health aides, telehealth services, and integrated behavioral health within primary care settings to improve access in underserved rural communities.

Rural populations also experience unique behavioral health disparities based on age, identity, and social circumstances. Rural children experience higher rates of behavioral and developmental concerns while often having limited access to specialized pediatric mental health services. Older adults and veterans face increased vulnerability because of social isolation, stigma, and barriers to accessing appropriate behavioral healthcare, while older adults may also encounter limited availability of geriatric behavioral health services. Additionally, rural racial and ethnic minority populations experience disparities associated with poverty, discrimination, cultural mistrust, and limited access to culturally responsive services (Stewart et al., 2021). These disparities are further compounded by geographic isolation, transportation limitations, provider shortages, and broader social determinants of health that reduce the availability and continuity of behavioral healthcare across the lifespan, disproportionately affecting individuals with the greatest behavioral health needs (Morales et al., 2020; Harris & Gallant, 2023).

Suicide represents one of the most concerning consequences of rural behavioral health disparities. Rural suicide rates exceed urban rates, with particularly high risk among veterans, adolescents, young adults, and older adults. Contributing factors include social isolation, limited behavioral healthcare access, financial stress, firearm availability, and cultural expectations emphasizing independence and self-reliance that may discourage help-seeking (Stewart et al., 2021). The broader behavioral health systems literature suggests that effective suicide prevention requires more than expanding individual clinical services. Sustainable reductions in suicide risk depend on coordinated behavioral health systems that integrate prevention, timely crisis response, workforce capacity, care coordination, and continuity of care across the behavioral health continuum while strengthening collaboration among healthcare providers, public health agencies, and community organizations (Burns et al., 2023; McGinty, 2023).

Arkansas reflects many of the rural behavioral health challenges identified throughout the national literature while also illustrating how these barriers interact within a predominantly rural behavioral health system. Statewide assessments have documented behavioral health infrastructure gaps, geographic variation in service availability, workforce shortages, funding challenges, and opportunities to strengthen crisis services and care coordination across the Community Mental Health Center network (Guidehouse, Inc., 2024). Arkansas's statewide behavioral health planning efforts similarly recognize that improving behavioral health outcomes requires coordinated systems of care, expanded workforce capacity, strengthened prevention initiatives, and improved access to behavioral health services across rural communities (Arkansas Center for Health Improvement, 2025; Arkansas Department of Human Services, 2024). Empirical observations from the Arkansas Veteran Well-Being Needs Assessment further demonstrate how rural geography, fragmented service delivery, and limited

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access to timely, coordinated behavioral healthcare create barriers for individuals navigating multiple systems of care (Rose et al., 2026). Statewide surveillance also documents persistent geographic variation in suicide burden, reinforcing the need for continued investment in prevention, crisis response, workforce capacity, and coordinated systems of care across Arkansas's rural behavioral health system (Arkansas Department of Health [ADH], 2023). Together, these findings demonstrate that Arkansas's rural behavioral health disparities reflect interconnected limitations in workforce capacity, service availability, crisis infrastructure, and care coordination rather than isolated gaps within individual services.

Cultural Factors and Behavioral Healthcare Access

While workforce availability is a major concern, Coombs et al. (2022) demonstrate that rural healthcare access is also shaped by cultural values, healthcare experiences, and system-level barriers. Through interviews with rural healthcare providers in Montana, the researchers identified five themes influencing healthcare accessibility: rural identity and healthcare beliefs, the importance of cultural humility, fragmented communication systems, workforce limitations, and healthcare system priorities. These findings are consistent with broader rural behavioral health literature demonstrating that cultural beliefs, trust in healthcare providers, and prior healthcare experiences interact with structural barriers to influence when and how individuals engage with behavioral health services (Morales et al., 2020; Harris & Gallant, 2023). This interaction demonstrates that improving access requires attention to both the structural availability of behavioral health services and the cultural and relational factors that influence whether rural residents are willing and able to use them.

One of the key findings from Coombs et al. (2022) was the tension between rural cultural values and traditional healthcare models. Providers described many rural residents as valuing independence, self-reliance, and stoicism, which may contribute to delayed healthcare seeking. Concerns about stigma, negative experiences with healthcare providers, and fear of judgment often prevent individuals from seeking preventive or early intervention services. These findings align with Stewart et al.'s (2021) emphasis on stigma and sociocultural factors as significant contributors to rural mental health disparities. Similarly, Morales et al. (2020) argue that improving rural behavioral health outcomes requires addressing the social, cultural, and structural contexts that influence help-seeking behaviors rather than focusing solely on expanding service availability, while Harris and Gallant (2023) further demonstrate that trust and patient-provider relationships play a critical role in sustaining engagement with behavioral healthcare.

Coombs et al. (2022) also highlight cultural humility as an essential strategy for improving healthcare relationships. Providers reported that demonstrating empathy, respect, curiosity, and openness toward patients' experiences improved trust and engagement. However, many providers reported receiving limited formal training in cultural humility, requiring them to develop these skills through personal experience. This finding suggests that improving rural healthcare access requires not only increasing provider numbers but also strengthening provider preparation, particularly in cultural humility, to work effectively within diverse rural communities. These findings align with broader behavioral health systems literature emphasizing that workforce development should extend beyond clinical competencies to include communication skills, person-centered care, interdisciplinary collaboration, and

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organizational support that strengthen long-term engagement and treatment outcomes (McGinty, 2023).

Communication challenges represent another significant barrier. Rural healthcare systems frequently experience fragmented communication between hospitals, primary care providers, specialists, and behavioral health organizations. Inconsistent information sharing, incompatible electronic medical records, and delayed follow-up undermine continuity of care (Coombs et al., 2022). These organizational barriers mirror concerns identified by Hallett et al. (2024), who found that inadequate infrastructure and administrative inefficiencies contribute to workforce dissatisfaction and reduced quality of care. Similar concerns are reflected throughout the behavioral health systems literature, where fragmented communication and poor care coordination reduce continuity of care and limit the effectiveness of integrated behavioral health services across rural communities (Drake & Bond, 2021; McGinty, 2023).

Behavioral Health Workforce Shortages and Provider Retention Challenges

A consistent theme across the literature is that rural behavioral health disparities are closely linked to workforce shortages and persistent challenges in recruiting, developing, and retaining qualified behavioral health professionals. National evidence indicates that workforce shortages extend beyond insufficient numbers of behavioral health providers and reflect broader structural challenges involving provider distribution, recruitment, retention, and organizational capacity in rural communities (Stewart et al., 2021; Morales et al., 2020). Addressing these shortages therefore requires more than increasing the number of behavioral health professionals; it requires coordinated workforce development strategies that strengthen recruitment, professional preparation, retention, and organizational capacity within underserved communities (Baum & King, 2020). Building upon this broader perspective, Hallett et al. (2024) examined workforce attrition within Oregon's public behavioral health system and identified five primary contributors to turnover: low wages, documentation burden, inadequate infrastructure, limited career advancement opportunities, and chronically stressful work environments.

Low compensation was identified as one of the strongest contributors to workforce instability. Behavioral health professionals often require advanced education and specialized training but receive lower salaries compared with other healthcare professionals. Limited reimbursement rates and chronic underfunding restrict organizations' ability to provide competitive wages, benefits, and professional advancement opportunities (Hallett et al., 2024). These financial constraints are particularly significant in rural communities, where limited organizational resources and longstanding structural disparities restrict the ability to recruit and retain qualified behavioral health professionals (Morales et al., 2020). Financial limitations also restrict opportunities for workforce development, clinical supervision, and continuing professional education, making long-term retention increasingly difficult for rural behavioral health organizations (Baum & King, 2020). Consistent with these findings, McGinty (2023) argues that strengthening the behavioral health workforce requires sustained investment in workforce capacity and organizational infrastructure to ensure long-term system stability rather than relying solely on short-term recruitment efforts.

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Administrative burden further contributes to workforce burnout and turnover. Behavioral health professionals described excessive documentation requirements, complex billing processes, and insurance authorization procedures as reducing time available for direct client care. Rather than focusing primarily on therapeutic relationships, providers reported spending substantial time meeting administrative requirements, contributing to frustration and decreased job satisfaction (Hallett et al., 2024). These administrative demands reduce the time available for direct clinical services while increasing occupational stress, illustrating how organizational inefficiencies can affect both workforce retention and access to behavioral healthcare. McGinty (2023) similarly emphasizes that sustainable behavioral health systems require organizational infrastructure and workforce investments that support providers and strengthen the delivery of community-based behavioral health services.

Workforce shortages create additional challenges by increasing caseloads and responsibilities for remaining providers. Hallett et al. (2024) found that high client acuity, exposure to trauma, and insufficient organizational support contribute to chronic workplace stress and secondary traumatic stress. Similarly, Palomin et al. (2023) note that rural behavioral health professionals frequently assume multiple professional roles, practice beyond traditional specialty boundaries, and experience professional isolation because of limited workforce capacity, thereby further increasing occupational stress and contributing to provider burnout. This creates a cycle in which provider turnover increases workloads, which in turn contributes to additional burnout and attrition. This cycle demonstrates that workforce shortages function not only as an access problem but also as an organizational sustainability challenge, as declining workforce capacity can further destabilize the conditions necessary to retain remaining providers.

The findings from Hallett et al. (2024) complement Coombs et al. (2022), who found that rural healthcare providers frequently experience overwhelming workloads and limited resources. The broader literature demonstrates that workforce shortages cannot be addressed through recruitment efforts alone but instead require comprehensive strategies that strengthen professional preparation, retention, organizational infrastructure, leadership support, and sustained investment in the behavioral health workforce (Baum & King, 2020; McGinty, 2023). Long-term workforce stability depends on competitive compensation, supportive workplace environments, professional development opportunities, adequate infrastructure, and organizational policies that prioritize provider well-being. Strengthening workforce capacity is therefore essential to improving behavioral health access, sustaining continuity of care, and supporting resilient rural behavioral health systems.

Arkansas's behavioral health planning documents identify workforce capacity as one of the state's most significant barriers to improving behavioral healthcare, particularly within rural communities. Statewide assessments describe persistent recruitment and retention challenges, workforce shortages across Community Mental Health Centers, and the need for sustained investment in workforce development, supervision, and organizational infrastructure to expand behavioral health access (Guidehouse, Inc., 2024; Arkansas Center for Health Improvement, 2025). These priorities are reflected in Arkansas's strategic planning efforts, which emphasize strengthening the behavioral health workforce as a critical component of improving access, expanding community-based services, and supporting long-term system transformation (Arkansas Department of Human Services, Office of Substance Abuse and Mental Health, 2024). Overall, Arkansas's workforce priorities closely mirror the national literature,

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reinforcing that sustainable improvements in behavioral health access depend upon long-term investment in workforce recruitment, retention, development, and organizational capacity.

Behavioral Health Crisis Continuum and System Capacity

Behavioral health crisis systems have increasingly shifted from reliance on emergency departments and law enforcement toward a comprehensive, community-based crisis continuum designed to provide timely intervention, stabilization, and connection to ongoing care (Drake & Bond, 2021; McGinty, 2023). Within this evolving framework, Burns et al. (2023) examined whether behavioral health treatment facilities across the United States have adopted SAMHSA's recommended best practices for behavioral health crisis care (BHCC). Their findings demonstrate that crisis response capacity remains inconsistent, limiting access to timely intervention for individuals experiencing mental health emergencies. This variation in crisis capacity demonstrates that movement toward a community-based crisis continuum depends not only on adopting recommended practices but also on whether behavioral health systems have the organizational resources and infrastructure necessary to implement them.

Using data from 9,385 mental health treatment facilities, Burns et al. (2023) assessed implementation of six crisis care services: emergency psychiatric walk-in services, crisis intervention teams, onsite stabilization, mobile crisis response, suicide prevention services, and peer support. Only 6% of facilities implemented all six recommended services, demonstrating that comprehensive crisis systems remain uncommon nationwide.The limited adoption of the full continuum suggests that individuals experiencing behavioral health crises may encounter substantial variation in available services depending on the capacity of their local behavioral health system.

Mobile crisis response services were particularly limited, despite their importance in reducing reliance on emergency departments and law enforcement involvement. Burns et al. (2023) noted that mobile crisis programs require substantial staffing, transportation resources, and financial investment, making implementation challenging for many communities. These challenges are especially relevant for rural areas, where geographic distance and workforce shortages create additional barriers. McGinty (2023) also emphasizes that expanding community-based crisis services strengthens behavioral health systems by improving timely access to care while reducing reliance on emergency departments and other high-cost inpatient services.

Burns et al. (2023) found that organizations with stronger funding mechanisms, including certified community behavioral health clinics and grant-supported programs, were more likely to implement comprehensive crisis services. This finding reinforces the importance of sustained investment in behavioral health infrastructure, workforce capacity, and crisis system development. Across these sources, the literature suggests that effective crisis continuums require coordinated investments in workforce capacity, community-based services, sustainable financing, and cross-system partnerships to ensure individuals receive timely behavioral healthcare in the least restrictive setting (Burns et al., 2023; Drake & Bond, 2021; McGinty, 2023). Expanding crisis response systems, including services connected to the 988 Suicide and Crisis Lifeline, requires improved reimbursement structures, workforce expansion, coordinated systems of care, and strong community-based partnerships.

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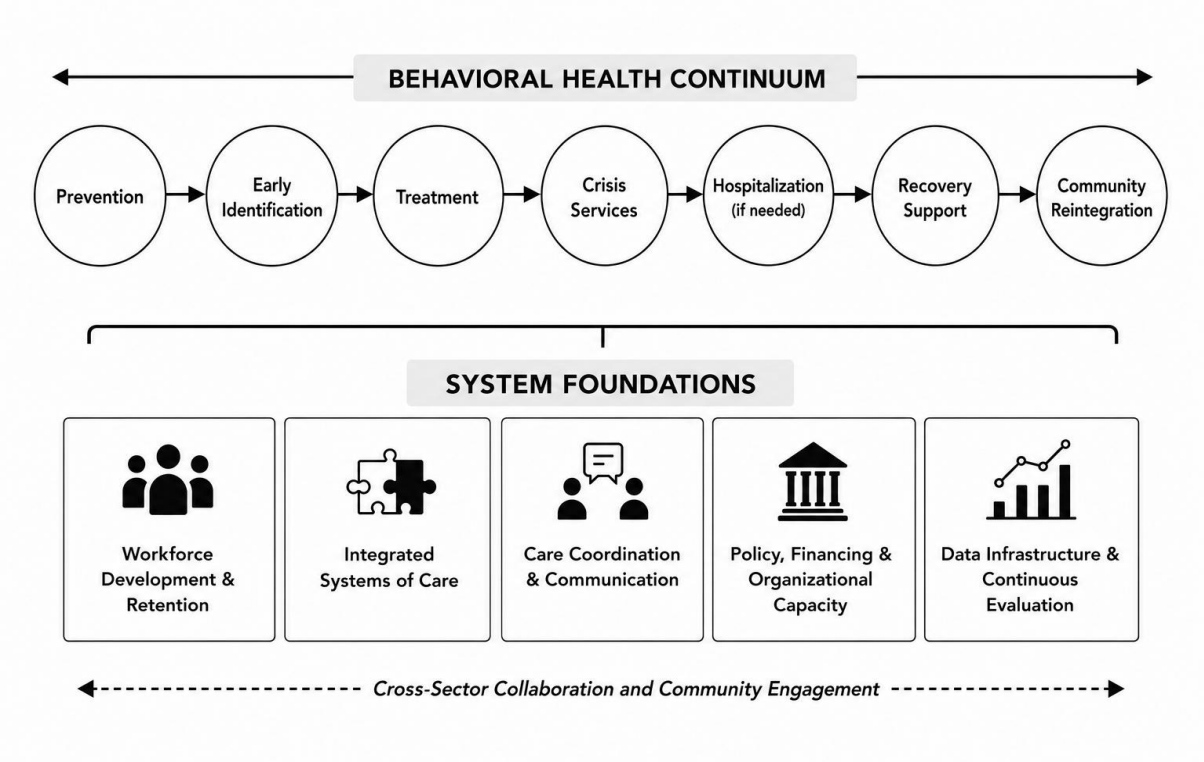
Arkansas has taken important steps toward strengthening its behavioral health crisis continuum through statewide initiatives that support Community Mental Health Centers, Certified Community Behavioral Health Clinics, workforce development, and regional collaboration to improve access to behavioral health and substance use treatment services, particularly in rural communities (Arkansas Center for Health Improvement [ACHI], 2025). The Arkansas Community Mental Health Center Study further identified opportunities to strengthen crisis stabilization services, emergency department coordination, care transitions, and Community Mental Health Center capacity to improve continuity of care across the state's behavioral health system (Guidehouse, Inc., 2024). Despite these efforts, empirical evidence demonstrates that fragmented care coordination, inconsistent emergency department practices, limited rural behavioral health capacity, and gaps in continuity of care continue to create barriers to timely crisis intervention across Arkansas's rural behavioral health system (Rose et al., 2026). Statewide surveillance documented 625 suicide deaths, including 111 veteran suicide deaths, and 2,313 emergency department visits for nonfatal suicide outcomes during 2023. These findings reinforce the ongoing demand for behavioral health crisis services in Arkansas and the need for sustained investment in prevention, crisis response, and coordinated systems of care (Arkansas Department of Health [ADH], 2023). Figure 1 synthesizes the literature reviewed throughout this manuscript into a conceptual framework illustrating how coordinated system-level foundations support the behavioral health continuum across rural communities.

Figure 1. Behavioral health continuum and system foundations for coordinated rural behavioral healthcare.



Note. Figure 1 presents a conceptual framework synthesized from the literature reviewed in this manuscript. The behavioral health continuum illustrates the progression from prevention through community reintegration. The system foundations represent the organizational and

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system-level capacities that support continuity of care across every stage. Together, workforce development and retention, integrated systems of care, care coordination and communication, policy, financing and organizational capacity, data infrastructure and continuous evaluation, and cross-sector collaboration strengthen access to care, coordination, and long-term behavioral health outcomes in rural communities.

Psychiatric Hospitalization, Continuity of Care, and Community-Based Alternatives

While effective crisis response is essential for stabilizing behavioral health emergencies, some individuals require short-term inpatient psychiatric hospitalization when community-based interventions are not sufficient to ensure safety or provide appropriate treatment. Contemporary behavioral health systems increasingly recognize that psychiatric hospitalization should function as one component of a broader continuum of care rather than an isolated intervention. Within this continuum, inpatient treatment is intended to provide stabilization, comprehensive assessment, treatment planning, and coordinated transition to community-based services that support long-term recovery and reduce avoidable readmissions (Clarke & Glick, 2020; Drake & Bond, 2021; McGinty, 2023). This approach places hospitalization within a coordinated system of care in which outcomes depend not only on inpatient treatment but also on the availability and continuity of services before admission and following discharge.

Rather than reflecting shortcomings of inpatient psychiatric care itself, the literature suggests that many challenges arise from fragmentation across the broader behavioral health system. Variability in admission practices, shortened lengths of stay, inconsistent discharge planning, and limited availability of community-based behavioral health services can weaken continuity of care following hospitalization and place greater reliance on emergency departments and crisis services (Clarke & Glick, 2020). In addition, behavioral health systems that lack coordinated transitions between crisis response, inpatient treatment, outpatient care, and recovery supports are less effective in promoting sustained recovery and reducing unnecessary hospitalization. The literature suggests that strengthening continuity of care across the behavioral health continuum is essential to improving long-term outcomes while ensuring that individuals receive treatment in the least restrictive setting appropriate to their needs (Clarke & Glick, 2020; Drake & Bond, 2021; McGinty, 2023).

Consistent with the national literature, Arkansas's behavioral health system faces growing demand for inpatient, crisis, and community-based behavioral health services while continuing to strengthen its coordinated continuum of care. Rather than emphasizing expansion of inpatient psychiatric capacity alone, statewide planning efforts focus on strengthening Community Mental Health Centers, regional collaboration, workforce development, integrated systems of care, and expanded access to community-based behavioral health services, particularly in rural communities (Arkansas Center for Health Improvement, 2025; Guidehouse, Inc., 2024). These initiatives recognize that improving behavioral health outcomes depends on coordinated transitions across inpatient, outpatient, crisis, and recovery services rather than on isolated treatment settings. The Arkansas Community Mental Health Center Study identified limited inpatient psychiatric capacity, increasing forensic utilization, and growing demand for behavioral health services as factors increasing reliance on Community Mental Health Centers to provide crisis stabilization, coordinate discharge planning, and support ongoing community-based treatment following hospitalization

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(Guidehouse, Inc., 2024; Treatment Advocacy Center, 2023). Taken together, the Arkansas literature suggests that improving behavioral health outcomes depends not only on maintaining appropriate inpatient psychiatric capacity but also on strengthening community-based infrastructure that promotes continuity of care before, during, and after hospitalization. These findings reinforce a systems-oriented approach in which inpatient psychiatric care functions as one component of an integrated behavioral health continuum supported by accessible crisis services, effective care coordination, and robust community-based treatment infrastructure (Arkansas Center for Health Improvement, 2025; Guidehouse, Inc., 2024; Treatment Advocacy Center, 2023).

Integrated Behavioral Health and Coordinated Systems of Care

Behavioral health systems increasingly recognize that improving outcomes requires coordinated care across primary care, specialty behavioral health, hospitals, and community-based organizations rather than delivery through fragmented systems. Integrated behavioral health has emerged as a systems-level strategy for improving access to behavioral healthcare by strengthening communication, care coordination, and continuity of care across providers and settings throughout the behavioral health continuum. Rather than functioning as separate specialty systems, integrated behavioral health emphasizes person-centered care in which primary care providers, behavioral health professionals, care managers, and community organizations work collaboratively to identify patient needs early, coordinate treatment, and support long-term recovery. The evidence reviewed suggests that integrated behavioral health improves access to care by reducing fragmentation while supporting earlier intervention, coordinated treatment, and continuity of care across healthcare settings (Dickinson et al., 2025; Kallenberg & Sieber, 2024; McGinty, 2023).

Integrated behavioral health extends beyond simply colocating behavioral health professionals within primary care practices. Contemporary models emphasize shared treatment planning, interdisciplinary teamwork, coordinated communication, population health management, and continuous follow-up that strengthen collaboration across providers and improve patient outcomes (Kallenberg & Sieber, 2024). Dickinson et al. (2025) similarly demonstrate that organizations implementing integrated behavioral health through structured quality improvement initiatives improved depression screening, behavioral health monitoring, care coordination, and team-based clinical workflows. Together, these studies suggest that successful integration depends not only on organizational structure but also on leadership commitment, standardized workflows, shared accountability, and sustained collaboration to support coordinated behavioral healthcare across multiple settings while reducing fragmentation between providers (Dickinson et al., 2025; Kallenberg & Sieber, 2024).

Implementing integrated behavioral health requires organizational and system-level transformation rather than isolated programmatic changes. The literature identifies workforce capacity, sustainable reimbursement models, leadership engagement, data sharing, practice redesign, and organizational readiness as essential components of successful behavioral health integration (Dickinson et al., 2025; Kallenberg & Sieber, 2024). These implementation challenges reinforce broader themes throughout the literature, demonstrating that improving behavioral health outcomes requires coordinated investment in workforce development, healthcare infrastructure, and cross-sector partnerships rather than isolated clinical

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interventions. Integrated behavioral health therefore represents both a model of care and a systems strategy that strengthens communication, continuity of care, and collaboration across behavioral health, primary care, hospitals, and community-based organizations while improving coordination throughout the behavioral health continuum (Drake & Bond, 2021; McGinty, 2023).

Arkansas's behavioral health planning efforts reflect the broader national movement toward integrated systems of care by emphasizing coordination among Community Mental Health Centers, primary care providers, hospitals, and community organizations. Rather than focusing on individual programs, statewide initiatives prioritize integrated service delivery, regional collaboration, workforce development, and expanded access to coordinated behavioral health and substance use treatment services, particularly within rural communities (Arkansas Center for Health Improvement, 2025). The Arkansas Community Mental Health Center Study similarly identifies opportunities to strengthen coordination across providers, improve care transitions, and enhance integration between crisis, outpatient, and community-based behavioral health services, thereby reducing fragmentation across the state's behavioral health system (Guidehouse, Inc., 2024). Despite these statewide priorities, empirical evidence demonstrates that limited rural behavioral health capacity, inconsistent care coordination, and fragmentation across service systems continue to create barriers to timely, coordinated behavioral healthcare (Rose et al., 2026). Across these Arkansas sources, the literature suggests that strengthening integrated behavioral health systems has the potential to improve communication across providers, streamline care transitions, reduce fragmentation, and expand timely access to behavioral healthcare throughout the state.

Serious Mental Illness, Criminal Justice Involvement, and the Need for Integrated Care

Serious mental illness (SMI) and criminal justice involvement are increasingly recognized as interconnected behavioral health systems challenges rather than issues attributable solely to psychiatric symptoms or criminal behavior. National evidence suggests that justice involvement often reflects broader failures in access to timely behavioral healthcare, crisis response, housing stability, substance use treatment, and other community-based supports designed to address behavioral health needs before they escalate (Bonfine et al., 2020; McGinty, 2023). Rather than occurring independently, these factors interact to increase the likelihood that individuals with serious mental illness enter the criminal justice system or encounter law enforcement instead of receiving coordinated behavioral healthcare. Collectively, the literature demonstrates that reducing justice involvement requires strengthening behavioral health systems that promote prevention, continuity of care, and coordinated community-based services rather than relying on crisis-driven or correctional responses.

Although interventions such as crisis intervention teams, mental health courts, and diversion programs have expanded treatment opportunities for justice-involved individuals, the literature suggests that these approaches often intervene only after individuals have already entered the criminal justice system. Bonfine et al. (2020) suggest that many diversion strategies remain limited because they focus primarily on psychiatric symptoms while giving less attention to the broader social and criminogenic factors that contribute to justice involvement, including housing instability, unemployment, trauma, substance use disorders, and limited social support.

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These findings align with McGinty (2023), who emphasizes that behavioral health outcomes are strongly influenced by social determinants of health, and with Morales et al. (2020), who suggest that improving behavioral health outcomes in rural communities requires expanding access to integrated community-based services that address structural barriers alongside behavioral healthcare. Together, these findings suggest that diversion alone is insufficient; sustainable reductions in criminal justice involvement depend upon behavioral health systems capable of addressing both clinical and nonclinical needs before crises occur.

This prevention-oriented perspective is reflected in Bonfine et al.'s (2020) recommendation to strengthen community behavioral health systems through the Sequential Intercept Model, particularly Intercept 0, which emphasizes prevention before individuals enter the criminal justice system. Rather than focusing exclusively on crisis response or post-arrest diversion, Intercept 0 prioritizes integrated behavioral healthcare, substance use treatment, housing assistance, employment support, trauma-informed care, and other community-based interventions that reduce the likelihood of justice involvement. These recommendations reinforce broader themes throughout the literature review, demonstrating that prevention, integrated behavioral health, and coordinated systems of care are more effective than fragmented, crisis-oriented approaches to care. Similarly, Drake and Bond (2021) suggest that community-based behavioral health systems are more effective than fragmented crisis-oriented approaches because they strengthen continuity of care across the behavioral health continuum, while McGinty (2023) emphasizes that sustained investment in prevention, workforce capacity, and cross-sector collaboration is essential for improving long-term behavioral health outcomes. In this context, the literature suggests that preventing justice involvement requires coordinated behavioral health systems that intervene early, strengthen continuity of care, and address behavioral healthcare, substance use disorders, and social determinants of health before crises escalate into involvement with law enforcement or the criminal justice system.

Arkansas's behavioral health planning efforts reflect this broader national emphasis on prevention, integrated systems of care, and coordinated community-based services. Statewide initiatives prioritize collaboration among Community Mental Health Centers, healthcare providers, community organizations, workforce development, and regional partnerships to strengthen behavioral health infrastructure and expand access to coordinated behavioral health and substance use treatment services, particularly in rural communities (Arkansas Center for Health Improvement, 2025; Guidehouse, Inc., 2024). Despite these statewide priorities, evidence from Arkansas demonstrates that fragmented systems of care, limited access to timely coordinated behavioral healthcare, and gaps in care coordination continue to create barriers to early intervention and continuity of care across the state's predominantly rural behavioral health system (Rose et al., 2026). The Arkansas literature supports the need to strengthen integrated behavioral health systems to improve continuity of care, expand early intervention, and reduce reliance on crisis and criminal justice systems through greater coordination across the behavioral health continuum (Arkansas Center for Health Improvement, 2025; Guidehouse, Inc., 2024; Rose et al., 2026).

Behavioral Health Policy, Financing, and System Transformation

Behavioral health system transformation requires more than expanding individual programs or implementing isolated clinical interventions. Increasingly, the literature recognizes that

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sustainable improvements in behavioral health outcomes depend on policy decisions, financing structures, governance, and organizational capacity that shape how behavioral health services are delivered across entire systems of care. Workforce development, crisis response, integrated behavioral health, and community-based treatment all require policy environments that support long-term investment, cross-sector collaboration, and sustainable implementation rather than short-term programmatic solutions (McGinty, 2023). National evidence suggests that behavioral health systems often struggle to implement evidence-based practices because financing mechanisms, reimbursement policies, and organizational structures frequently fail to support integrated, community-based models of care. McGinty (2023) argues that sustained progress in behavioral health depends on aligning public policy, healthcare financing, workforce investment, and organizational infrastructure to strengthen prevention, early intervention, and continuity of care. Similarly, Dickinson et al. (2025) demonstrate that successful implementation of integrated behavioral health requires organizational commitment, leadership engagement, standardized workflows, quality improvement initiatives, and sustained investment in interdisciplinary collaboration. Together, these findings reinforce that behavioral health policy functions as a systems-level mechanism that shapes whether evidence-based interventions can be implemented, coordinated, and sustained within communities.

Financing structures remain among the most significant determinants of behavioral health system capacity. Sustainable reimbursement models influence provider recruitment and retention, crisis response availability, implementation of integrated behavioral health, and access to community-based treatment services. Conversely, fragmented funding streams, administrative complexity, and inconsistent reimbursement can limit organizational flexibility, reduce workforce stability, and hinder the implementation of coordinated behavioral health systems (Dickinson et al., 2025; McGinty, 2023). These findings reinforce broader themes throughout the literature, demonstrating that strengthening behavioral health systems requires long-term investment in infrastructure, workforce development, information sharing, and organizational capacity rather than isolated funding initiatives or short-term grant programs.

Successful behavioral health system transformation therefore requires coordinated policy leadership that supports implementation across multiple sectors. Rather than focusing exclusively on expanding clinical services, effective behavioral health policy promotes governance structures that encourage collaboration among healthcare providers, behavioral health organizations, public health agencies, social service systems, educational institutions, criminal justice partners, and community organizations. Viewed across the literature, sustainable behavioral health improvement depends on policy environments that align financing, workforce development, integrated care, crisis response, and community-based services into coordinated systems capable of strengthening continuity of care across the behavioral health continuum (Dickinson et al., 2025; McGinty, 2023). This alignment is particularly important in rural communities, where limited resources and workforce capacity can magnify the effects of fragmented policies, financing structures, and service delivery systems.

Arkansas's behavioral health planning efforts reflect these broader national priorities by emphasizing long-term system transformation rather than the expansion of individual behavioral health programs. Statewide initiatives prioritize sustainable financing, workforce

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development, integrated systems of care, regional collaboration, and strengthening Community Mental Health Centers to improve behavioral health access across rural communities (Arkansas Center for Health Improvement, 2025; Guidehouse, Inc., 2024). Evidence from Arkansas demonstrates that fragmented systems of care, limited rural behavioral health capacity, and inconsistent coordination across providers continue to challenge the implementation of a fully integrated behavioral health system (Rose et al., 2026). Taken as a whole, the Arkansas literature suggests that meaningful improvements in behavioral health outcomes depend upon sustained policy commitment, coordinated financing strategies, and continued investment in workforce capacity, integrated systems of care, and community-based behavioral health infrastructure (Arkansas Center for Health Improvement, 2025; Guidehouse, Inc., 2024; Rose et al., 2026).

Behavioral Health Suicide Prevention, Surveillance, and Veteran Outcomes

Suicide prevention is increasingly recognized as a behavioral health systems responsibility rather than an intervention confined to individual clinical encounters. Effective prevention depends on a coordinated infrastructure capable of identifying risk early, responding rapidly during crises, reducing barriers to treatment, and maintaining continuity of care following emergency intervention. Within rural communities, these responsibilities are complicated by workforce shortages, geographic isolation, limited crisis capacity, stigma, and fragmented communication across healthcare and community systems. The broader literature therefore suggests that reducing suicide requires more than expanding crisis lines or clinical treatment alone; it requires coordinated prevention, crisis response, follow-up, and community-based supports across the behavioral health continuum (Burns et al., 2023; McGinty, 2023; Stewart et al., 2021).

A comprehensive suicide prevention infrastructure must operate across individual, organizational, community, and system levels. Early identification and intervention depend on accessible primary and behavioral healthcare, standardized screening practices, culturally responsive services, and a workforce prepared to recognize and respond to suicide risk. Crisis systems must also provide timely access to mobile response, stabilization, emergency psychiatric services, and coordinated transitions into ongoing treatment. Burns et al. (2023) demonstrate that comprehensive crisis capacity remains uncommon nationally, while McGinty (2023) emphasizes that sustainable prevention requires long-term investment in workforce development, community-based services, and cross-sector collaboration. Together, these findings indicate that suicide prevention effectiveness depends not only on whether services exist, but also on whether individuals can move successfully between prevention, crisis intervention, treatment, and recovery supports without becoming disconnected from care. Against this broader systems context, veterans provide an important lens through which broader behavioral health system conditions can be examined because many reside in rural communities, experience co-occurring behavioral health and substance use needs, and frequently receive services across public, private, community, and federal systems. Veteran suicide therefore offers a valuable perspective for understanding how fragmented access, delayed intervention, and inconsistent care coordination influence behavioral health outcomes among a population experiencing elevated suicide risk.

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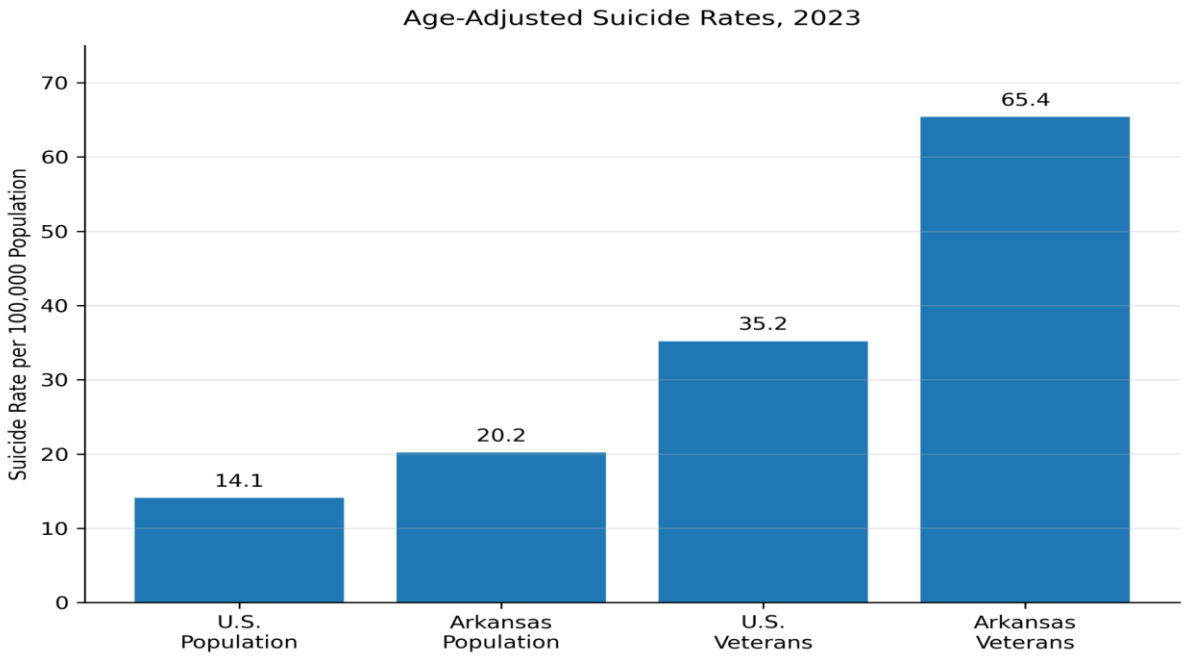
Arkansas has increasingly adopted a systems-oriented approach to suicide prevention by recognizing that effective prevention depends on coordinated behavioral healthcare rather than isolated crisis intervention. Across these planning efforts, the state's behavioral health planning documents emphasize strengthening prevention, early identification, crisis response, integrated behavioral healthcare, workforce development, community-based services, and care transitions as interconnected components of a comprehensive behavioral health continuum. Statewide initiatives further prioritize improving collaboration among Community Mental Health Centers, healthcare providers, public health agencies, emergency departments, veteran-serving organizations, and other community partners to strengthen continuity of care and reduce fragmentation across the behavioral health system (Arkansas Center for Health Improvement, 2025; Arkansas Department of Human Services, 2024; Arkansas Department of Human Services, Office of Substance Abuse and Mental Health [OSAMH], 2024; Guidehouse, Inc., 2024). These priorities reflect an understanding that suicide prevention outcomes depend on the capacity of multiple systems and organizations to coordinate interventions across prevention, crisis response, treatment, and recovery.

Statewide surveillance demonstrates why continued investment in this infrastructure remains necessary. Arkansas recorded 625 suicide deaths during 2023, including 111 veteran suicide deaths. The state's age-adjusted suicide rate was 20.2 per 100,000 population, substantially exceeding the national rate of 14.1 per 100,000. Among veterans, the age-adjusted suicide rate reached 65.4 per 100,000, illustrating the disproportionate burden experienced by Arkansas veterans. Emergency departments also treated 2,313 individuals for nonfatal suicide (intentional self-harm) outcomes, while considerable geographic variation in suicide mortality across counties further demonstrates persistent behavioral health disparities throughout the state (Arkansas Department of Health, 2023).

Figure 2. Age-adjusted suicide rates among the United States population, Arkansas population, United States veterans, and Arkansas veterans, 2023.



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Note. Figure 2 displays age-adjusted suicide rates per 100,000 population for the United States population (14.1), Arkansas population (20.2), United States veterans (35.2), and Arkansas veterans (65.4) during 2023. General population rates were reported by the Arkansas Department of Health using the 2000 U.S. standard population. Arkansas veteran rates were adjusted using the Veteran Population Projection Model 2023 standard population. National veteran rates were reported by the U.S. Department of Veterans Affairs.

The Arkansas Veteran Well-Being Needs Assessment provides an empirical perspective on how these broader system challenges affect individuals navigating behavioral healthcare outside a single coordinated system. Rather than identifying veterans as uniquely vulnerable, the assessment illustrates how fragmented care coordination, inconsistent emergency department practices, rural access barriers, and substance use intersect within a population that frequently interacts with multiple behavioral health systems (Rose et al., 2026). When considered alongside Arkansas's surveillance and statewide planning efforts, these findings demonstrate how system-level gaps can influence timely access to behavioral healthcare, continuity of care, and recovery following behavioral health crises. This convergence of empirical observations, surveillance data, and statewide planning priorities strengthens the case for addressing veteran suicide within the broader context of behavioral health system capacity rather than as an isolated population-specific concern.

The national and Arkansas literature suggests that effective suicide prevention depends on a behavioral health system capable of intervening before crises occur, coordinating care across multiple organizations, and sustaining recovery following emergency intervention. Arkansas has established a strong policy foundation for strengthening this continuum, yet statewide surveillance, planning documents, and empirical evidence indicate that opportunities remain to improve workforce capacity, crisis infrastructure, care coordination, and community-based behavioral health services, particularly in rural communities. Using the Arkansas veteran population as an empirical lens reinforces that suicide prevention is fundamentally a systems challenge requiring coordinated investment across the entire behavioral health continuum rather than reliance on downstream intervention after crises have already occurred.

Behavioral Health Data Infrastructure, Surveillance, and System Evaluation

Behavioral health system transformation depends not only on expanding services but also on the ability to evaluate whether those services improve access, coordination, quality, and outcomes across the behavioral health continuum. Contemporary behavioral health systems increasingly recognize that data infrastructure, surveillance, and continuous system evaluation are essential for identifying behavioral health needs, monitoring disparities, informing policy decisions, and guiding quality improvement across the continuum of care. Rather than serving solely administrative or reporting functions, behavioral health data systems provide the foundation for evidence-informed decision making by allowing policymakers, healthcare organizations, and public health agencies to assess system performance and identify opportunities for improvement (Dickinson et al., 2025; McGinty, 2023). This capacity is particularly important within rural behavioral health systems, where limited resources make it essential to identify service gaps and determine whether investments are reaching communities with the greatest needs.

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National literature further suggests that effective behavioral health surveillance extends beyond measuring disease prevalence or service utilization. Comprehensive data systems support evaluation of workforce capacity, crisis response, access to care, continuity of care, quality improvement, and implementation of evidence-based practices across healthcare settings. Dickinson et al. (2025) demonstrate that successful implementation of integrated behavioral health depends on ongoing performance measurement and continuous quality improvement, while McGinty (2023) argues that sustainable behavioral health reform requires data systems capable of evaluating whether policy investments produce meaningful improvements in population behavioral health outcomes. These findings demonstrate that surveillance and system evaluation are essential components of behavioral health governance rather than isolated public health activities.

Arkansas has increasingly incorporated surveillance and performance measurement into statewide behavioral health planning. The Arkansas Department of Health annually monitors suicide mortality, nonfatal suicide outcomes (intentional self-harm), demographic trends, and geographic variation to identify populations and communities experiencing disproportionate behavioral health burden (Arkansas Department of Health, 2023). Complementing these surveillance efforts, the Arkansas Acute Behavioral Health Event Dashboard provides statewide monitoring of emergency department utilization, inpatient behavioral health admissions, and other behavioral health indicators that assist state agencies and healthcare organizations in evaluating behavioral health system demand and service utilization. Together, these resources strengthen Arkansas's ability to identify service gaps, monitor emerging trends, and support evidence-informed planning across the behavioral health continuum.

Arkansas's strategic planning documents further recognize that surveillance alone is insufficient unless data are integrated into continuous system evaluation and quality improvement. The Roadmap to a Healthier Arkansas, the Office of Substance Abuse and Mental Health Strategic Initiatives Plan, and the Arkansas Community Mental Health Center Study each emphasize strengthening data sharing, performance measurement, accountability, and cross-sector collaboration to improve behavioral health planning, resource allocation, and organizational decision-making (Arkansas Department of Human Services, 2024; Arkansas Department of Human Services, Office of Substance Abuse and Mental Health, 2024; Guidehouse, Inc., 2024). Viewed across these statewide initiatives, there is an increasing emphasis on using behavioral health data not only to describe population needs but also to evaluate system performance, strengthen coordination among providers, and support long-term behavioral health system transformation. Integrating these functions can help state agencies and behavioral health organizations move from identifying disparities to evaluating whether specific policies and system investments are producing measurable improvements in access and outcomes.

Taken together, the national and Arkansas literature suggests that robust behavioral health data infrastructure is fundamental to strengthening rural behavioral health systems. Surveillance, performance measurement, and continuous system evaluation provide the information necessary to identify disparities, monitor implementation, strengthen accountability, and guide evidence-informed policy decisions. As Arkansas continues to expand behavioral health services, sustained investment in integrated data systems, cross-sector information sharing, and ongoing system evaluation will be essential for determining whether workforce investments,

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crisis system expansion, integrated behavioral healthcare, and other policy initiatives translate into measurable improvements in access, coordination, quality, and behavioral health outcomes across the state's predominantly rural behavioral health system.

Implications for Rural Behavioral Health Systems and Social Work Practice

The literature reviewed throughout this manuscript demonstrates that improving behavioral health outcomes in rural communities requires strengthening behavioral health systems rather than addressing individual barriers in isolation. Across the national and Arkansas literature, behavioral health disparities consistently emerge from the interaction of workforce shortages, fragmented systems of care, geographic barriers, cultural influences, limited crisis infrastructure, inadequate data systems, and broader social determinants of health. These interconnected findings reinforce that sustainable improvements in behavioral health access depend on coordinated organizational, community, and policy responses that strengthen the entire behavioral health continuum rather than on isolated clinical interventions. This systems perspective shifts the focus from addressing individual service gaps independently to strengthening the relationships among workforce capacity, service delivery, organizational infrastructure, and policy that shape access and continuity across rural communities.

For social workers and other behavioral health professionals, these findings highlight the importance of practice that extends beyond direct service delivery to include systems advocacy, interdisciplinary collaboration, and community partnership development. Effective practice within rural communities requires cultural humility, trauma-informed approaches, an integrated system of care, and attention to social determinants of health such as housing, employment, transportation, education, and poverty that influence behavioral health outcomes (Coombs et al., 2022; Morales et al., 2020; Stewart et al., 2021). As behavioral health systems continue to evolve, social workers are uniquely positioned to strengthen care coordination across healthcare organizations, Community Mental Health Centers, public health agencies, schools, criminal justice systems, and community organizations while advocating for equitable access to behavioral healthcare across rural communities. These roles position social workers to connect individual and community needs with organizational and policy-level efforts to reduce fragmentation and strengthen continuity across the behavioral health continuum.

The literature also demonstrates that strengthening rural behavioral health systems requires sustained investment in workforce development, organizational infrastructure, crisis response, integrated systems of care, and continuous system evaluation. National evidence consistently identifies workforce retention, interdisciplinary collaboration, leadership engagement, and organizational support as essential components of sustainable behavioral health systems (Dickinson et al., 2025; Hallett et al., 2024; McGinty, 2023). Arkansas's statewide planning efforts similarly prioritize workforce capacity, integrated care, regional collaboration, data-informed decision making, and the expansion of community-based behavioral health services as foundational strategies for improving behavioral health outcomes across the state's predominantly rural communities (Arkansas Center for Health Improvement, 2025; Arkansas Department of Human Services, 2024; Guidehouse, Inc., 2024). The alignment between national evidence and Arkansas's planning priorities suggests that these strategies are not independent areas of reform but interconnected components of the system capacity necessary to sustain behavioral health improvements over time.

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Ultimately, the literature suggests that achieving behavioral health equity within rural communities depends on coordinated investment across healthcare, behavioral health, public health, social service, education, and community systems. Sustainable improvement will require policies and organizational strategies that strengthen prevention, early intervention, crisis response, integrated care, continuity of care, and workforce sustainability while addressing the structural conditions that influence behavioral health access and outcomes. These findings provide important implications for policymakers, healthcare leaders, behavioral health professionals, and researchers seeking to strengthen rural behavioral health systems throughout Arkansas and other predominantly rural states.

CONCLUSION

Behavioral health disparities in rural communities result from the interaction of geographic, organizational, social, cultural, and policy factors that extend well beyond the availability of individual behavioral health services. Throughout this review, the national and Arkansas literature consistently demonstrates that workforce shortages, fragmented systems of care, limited crisis infrastructure, barriers to integrated behavioral healthcare, and inadequate coordination across organizations contribute to persistent inequities in behavioral health access and outcomes (Coombs et al., 2022; Hallett et al., 2024; McGinty, 2023; Stewart et al., 2021). These findings reinforce that improving rural behavioral health cannot be accomplished through isolated interventions or the expansion of individual programs alone. Instead, sustainable improvement requires coordinated behavioral health systems capable of providing prevention, early intervention, crisis response, treatment, recovery support, and continuous evaluation across the behavioral health continuum (Burns et al., 2023; Drake & Bond, 2021; McGinty, 2023).

The literature further demonstrates that strengthening rural behavioral health systems depends on long-term investment in workforce development, organizational infrastructure, integrated systems of care, community-based behavioral health services, and evidence-informed policy (Dickinson et al., 2025; Kallenberg & Sieber, 2024; McGinty, 2023). Effective behavioral health systems are characterized not only by the availability of services but also by their ability to coordinate care across healthcare providers, Community Mental Health Centers, hospitals, public health agencies, social service organizations, criminal justice partners, and community stakeholders. When effectively integrated, these system characteristics promote continuity of care, improve access to treatment, strengthen crisis response, and reduce fragmentation that can otherwise contribute to poorer behavioral health outcomes, particularly in rural communities (Bonfine et al., 2020; Burns et al., 2023; Drake & Bond, 2021). Their effectiveness therefore depends on sustained coordination and investment across the organizations and sectors responsible for delivering behavioral healthcare rather than on the strength of any single component of the system.

Arkansas provides an important case study for examining these broader behavioral health system challenges. Statewide planning documents, surveillance reports, and system assessments consistently identify workforce capacity, integrated systems of care, crisis services, data infrastructure, and cross-sector collaboration as priorities for strengthening behavioral healthcare across Arkansas's predominantly rural communities (Arkansas Center for Health Improvement, 2025; Arkansas Department of Human Services, Office of Substance

Abuse and Mental Health, 2024; Guidehouse, Inc., 2024). At the same time, empirical observations from the Arkansas Veteran Well-Being Needs Assessment illustrate how fragmented care coordination, inconsistent access to services, rural geography, and complex behavioral health needs intersect within a population navigating multiple systems of care (Rose et al., 2026). Although focused on veterans, these observations provide valuable insight into broader system-level challenges that affect behavioral health access and continuity of care throughout Arkansas.

Ultimately, this review demonstrates that strengthening behavioral health outcomes in rural Arkansas requires continued movement toward integrated, coordinated, and data-informed systems of care. Sustainable progress will depend on policies and organizational strategies that support workforce retention, strengthen Community Mental Health Centers, expand community-based behavioral health services, improve crisis response, enhance care coordination, and promote continuous system evaluation (Arkansas Center for Health Improvement, 2025; Arkansas Department of Human Services, 2024; Guidehouse, Inc., 2024; McGinty, 2023). As Arkansas continues to strengthen its behavioral health system, sustained collaboration among policymakers, healthcare organizations, Community Mental Health Centers, public health agencies, social service organizations, and community partners will be essential for ensuring that these investments translate into measurable improvements in behavioral health access, continuity of care, and long-term outcomes across the state's predominantly rural communities. By integrating national evidence with Arkansas-specific planning, surveillance, and empirical observations, this review contributes a systems-oriented perspective that may inform future research, policy development, and behavioral health system transformation aimed at improving access, equity, and long-term behavioral health outcomes across rural communities.

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