COMPANION GUIDE

EVIDENCE-BASED BEST PRACTICES FOR RURAL BEHAVIORAL HEALTH ACCESS

A NYSARH Implementation Guide

NYS ASSOCIATION FOR
RURAL HEALTH

This companion guide is designed to help rural counties and community partners quickly identify a small number of high-impact strategies to improve access to mental health and substance use disorder services. It serves as an entry point to the full Implementation Guide, which provides detailed program descriptions, implementation steps, cost estimates, funding pathways, and technical assistance resources.

Rather than presenting every possible option, this guide focuses on the most effective and feasible starting points. Rural communities often operate with limited staff, funding, and infrastructure. The goal is to select a manageable set of strategies that align with local needs and can be implemented successfully, rather than attempting system-wide transformation all at once.

How to Use This Guide

Begin by identifying the most pressing behavioral health challenges in your community using SARHNA findings, county planning documents, and local data. Most counties will find that a small number of barriers drive most unmet need, such as workforce shortages, long wait times, or gaps in crisis response.

From there, use the **Programs by Priority Barrier** table to locate programs that directly address those barriers. Many strategies serve multiple functions. Telehealth, for example, can expand workforce capacity, reduce wait times, and address geographic isolation simultaneously.

As you consider options, use the **Program Complexity and Timeline** table to match each program to your county's current capacity. Some strategies can be implemented relatively quickly using existing systems, while others require new partnerships or longer-term planning. It is generally most effective to begin with two to five strategies that can be implemented successfully within the next 12 to 24 months.

Finally, confirm that each selected strategy has a clear path to sustainability. Programs supported by Medicaid reimbursement, state initiatives, or multi-year federal funding are more likely to be maintained over time.

Use the **Quick-Start Recommendations** at the end of this guide as a starting point, then refer to the full Implementation Guide for detailed planning and execution.

Understanding Evidence and Complexity

Evidence strength reflects how rigorously a program has been evaluated:

- **Highest:** Multiple randomized controlled trials (RCTs), meta-analyses, or Cochrane reviews with consistent positive outcomes across populations and settings
- **High:** Strong research base with documented rural effectiveness; published evaluations; recognized by federal evidence clearinghouses
- **Moderate:** Promising practices with strong early evidence; pilot data or program evaluations with positive outcomes in rural or comparable settings

Implementation complexity reflects what it takes to put a program into practice. Programs are rated along a general spectrum (Low, Medium, High) based on resource requirements, partnerships, timeline, and funding complexity.

Higher complexity does not mean more important. In many cases, lower-complexity programs are the most effective starting point and can be launched while groundwork is laid for more intensive investments.

PROGRAMS BY PRIMARY BARRIER

Primary Barrier	Programs to Review
Workforce shortages	Collaborative Care Model; Peer Recovery Support Services; Rural Mental Health Workforce Pipeline Programs; Telehealth and Telepsychiatry Suite
Geographic isolation and transportation	Mobile Medication Units; COTIs and Mobile Treatment Vans; ACT and Flexible ACT; Community Paramedicine; Telehealth Suite
Long wait times	MATTERS Network; CA Bridge Program; 24/7 Open Access Centers; Vermont Hub and Spoke Model; RCORP Consortiums
Crisis infrastructure gaps	Crisis Now Model (988 + Mobile Crisis + Stabilization Centers); SPOA and Regional Crisis and Step-Down Capacity
Youth mental health crisis	School-Based Mental Health Centers; Screening, Brief Intervention, and Referral to Treatment (SBIRT); Prevention Resource Centers; Youth Clubhouses
Overdose deaths	Harm Reduction Programs and Syringe Services Programs; Data-Driven Overdose Surveillance; HEALing Communities Model
Co-occurring mental health and substance use	Certified Community Behavioral Health Clinics (CCBHCs); Cross-Walk Program
Housing instability and poverty	Permanent Supportive Housing; Recovery Residences; Rural Outreach Center (ROC) Model; Recovery-Oriented Systems of Care (ROSOC) and Whole Person Care
Fragmentation and coordination gaps	AmericaServes / NYServes Coordinated Referral Networks; Regional Behavioral Health Networks; SPOA; Recovery Community Centers and Recovery Community and Outreach Centers
Stigma and engagement failures	NAMI Family-to-Family; Family Support Navigators
Older adult suicide and isolation	Social Support Programs for Isolated Older Adults

PROGRAM COMPLEXITY AND TIMELINE

Program	Complexity	Timeline
CA Bridge Program	Low	3–6 months
NAMI Family-to-Family	Low	3–6 months
Peer Recovery Support Services (CRPAs)	Low	3–6 months
Prevention Resource Centers	Low	3–6 months
SBIRT	Low	3–6 months
Social Support Programs for Isolated Older Adults	Low	3–6 months
Telehealth and Telepsychiatry Suite	Low	3–6 months
Collaborative Care Model (CoCM)	Low to Medium	6–12 months
Data-Driven Overdose Surveillance with Public Dashboards	Low to Medium	3–6 months
Family Support Navigators	Low to Medium	6–12 months
Harm Reduction and Syringe Services	Low to Medium	3-6 months
MATTERS Network	Low to Medium	3–6 months (if joining existing network)
Recovery Community Centers	Low to Medium	6–12 months
School-Based Health and Mental Health Centers	Low to Medium	6–12 months
24/7 Open Access Centers	Medium	12–18 months
COTIs and Mobile Treatment Vans	Medium	6–12 months
Community Paramedicine Behavioral Health Programs	Medium	6–12 months
Cross-Walk Program	Medium	6–12 months
Mobile Medication Units (MMUs)	Medium	6–12 months
Recovery Residences	Medium	6–12 months
Rural Outreach Center (ROC) Model	Medium	6–12 months
Youth Clubhouses	Medium	6–12 months
AmericaServes and NYServes	Medium to High	6–12 months
Crisis Now Model (988 + Mobile Crisis + Stabilization)	Medium to High	12–24 months
ROSOC and Whole Person Care	Medium to High	12–24 months
Rural Mental Health Workforce Pipeline Programs	Medium to High	12–24 months
ACT and Flexible ACT	High	12–18 months

Program	Complexity	Timeline
CCBHCs	High	12–24 months
HEALing Communities Model	High	12–24 months
Permanent Supportive Housing (PSH) for SUD	High	12–24 months
RCORP Consortiums	High	12–24 months
Regional Behavioral Health Networks	High	12–24 months
SPOA and Regional Crisis and Step-Down Capacity	High	12–24 months
Vermont Hub and Spoke Model	High	12–24 months

High-Impact Options by Primary Barrier

The following sections provide brief descriptions of the highest-impact programs according to the primary barrier they address as indicated in the *Implementation Guide* (some programs may address more than one barrier.) Use this section to build your initial shortlist before consulting the full guide for detailed planning.

Workforce Shortages

Workforce shortages affect nearly every aspect of behavioral health care in rural communities. Rather than relying solely on recruitment, effective strategies focus on extending the reach of existing providers and building alternative support systems.

1. Collaborative Care Model (CoCM)
Evidence: Highest | Complexity: Low to Medium
Embeds behavioral health support within primary care, allowing a single psychiatric consultant to support multiple practices. Backed by more than 80 RCTs and reimbursable through Medicaid and Medicare. One of the most impactful and sustainable starting points for most rural counties.

2. Peer Recovery Support Services (PROS) and Certified Recovery Peer Advocates (CRPAs)
Evidence: High | Complexity: Low
People with lived experience provide outreach, navigation, coaching, and harm reduction. Peers improve engagement with populations that avoid traditional services and can often be implemented at low cost.

3. Rural Mental Health Workforce Pipeline Programs
Evidence: High | Complexity: Medium to High
University partnerships create supervised training placements in rural schools and clinics, with pathways to convert interns into permanent staff. Clinicians trained in rural settings are significantly more likely to remain there.

4. Telehealth and Telepsychiatry Suite

Evidence: High to Highest | Complexity: Low

A suite of seven models that extend specialist access across rural geographies, from Project ECHO peer learning networks for providers, to direct telepsychiatry for patients, to school-based and nursing home models, among others. Can be implemented relatively quickly and integrated into primary care, schools, hospitals, or community settings.

Geographic Isolation and Transportation Barriers

Distance and lack of transportation remain major obstacles to care. Programs that bring services directly to individuals are often the most effective response.

5. Mobile Medication Units (MMUs)

Evidence: High | Complexity: Medium

State-licensed mobile opioid treatment programs traveling regular routes to underserved communities. Critical for individuals who would otherwise need to travel daily for methadone dosing.

6. Centers of Treatment Innovation (COTIs) and Mobile Treatment Vans

Evidence: High | Complexity: Medium

Broader than mobile medication units, these vans provide MOUD, counseling, peer support, transportation assistance, and insurance navigation, reaching people not accessing brick-and-mortar clinics.

7. Assertive Community Treatment (ACT) and Flexible ACT

Evidence: Highest | Complexity: High

Multidisciplinary teams provide intensive services in clients' homes and communities. Flexible ACT is specifically designed for rural areas with smaller team sizes. Consistent reductions of 50% or more in hospitalization rates.

8. Community Paramedicine Behavioral Health Programs

Evidence: Moderate to High | Complexity: Medium

EMS providers conduct post-overdose follow-ups, suicide risk checks, and rapid treatment referrals. Uses an existing geographically distributed workforce that already reaches every rural address.

Long Wait Times

Delays in accessing care lead to worsening conditions and missed opportunities for early intervention. Immediate access models are critical.

9. 24/7 Open Access Centers

Evidence: High | Complexity: Medium

Walk-in assessment and referral centers with no appointment needed. Eliminates the intake bottleneck that delays treatment for months and creates an immediate entry point into care.

10. MATTERS Network (Medication for Addiction Treatment and Electronic Referrals)
Evidence: High | Complexity: Low to Medium
A statewide rapid referral network guaranteeing next-day MOUD appointments from emergency departments, correctional facilities, and law enforcement. Joining the existing network is one of the fastest, lowest-cost interventions available.

11. CA Bridge Program (Hospital-Based MOUD Access)
Evidence: High | Complexity: Low
A free training and protocol model enabling hospitals to initiate buprenorphine in the emergency department and connect patients to outpatient follow-up within 24 to 72 hours. Converts a high-risk moment into immediate treatment engagement.

12. Vermont Hub and Spoke Model
Evidence: Highest | Complexity: High
Distributes MOUD capacity across regional specialty centers (hubs) and community settings such as primary care practices (spokes), allowing patients to be treated closer to home. Vermont achieved the highest MOUD treatment capacity in the United States using this model.

13. RCORP Consortiums
Evidence: High | Complexity: High HRSA-funded multi-county consortia that pool resources to expand MOUD access, build the workforce, implement telehealth, and develop care coordination across counties. Addresses long wait times indirectly by expanding local treatment capacity over time rather than creating an immediate access point; counties with urgent gaps should prioritize MATTERS and CA Bridge first.

Crisis Infrastructure Gaps

In many rural communities, law enforcement or emergency departments serve as default responders to mental health crises. Clinical alternatives are urgently needed.

14. Crisis Now Model (988 + Mobile Crisis + Stabilization Centers)
Evidence: High | Complexity: Medium to High
A three-component integrated system: a 988-connected regional call hub, 24/7 mobile crisis teams, and short-term stabilization facilities. These components work together as a unified system rather than separate programs. Mobile crisis teams are often the most feasible first step.

15. Single Point of Access (SPOA) and Regional Crisis and Step-Down Capacity
Evidence: Moderate to High | Complexity: High
A centralized intake system with one phone number for all intensive services, combined with regional crisis beds shared across counties. Eliminates the experience of making dozens of calls and provides high-acuity services no single county could sustain independently.

Youth Mental Health Crisis

Youth mental health needs continue to increase while access remains limited. Schools are the most accessible point of contact for struggling youth.

16. School-Based Health and Mental Health Centers

Evidence: Highest | Complexity: Low to Medium

Behavioral health clinicians provide counseling and therapy directly inside schools, removing all transportation barriers and reducing stigma. The most common and sustainable model embeds an FQHC- or hospital-employed clinician within the school building, enabling Medicaid billing.

17. Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Evidence: Highest | Complexity: Low

Universal substance use screening with brief intervention and referral to treatment. Feasible within existing staff and visit structures, using free OASAS training statewide. Enables early intervention before use escalates to disorder.

18. Prevention Resource Centers (OASAS)

Evidence: High | Complexity: Low

OASAS-funded regional centers provide schools with evidence-based prevention curricula, technical assistance, and data collection support, free of charge. A fast, low-resource way to build upstream prevention infrastructure.

19. Youth Clubhouses

Evidence: Moderate | Complexity: Medium

Non-clinical drop-in centers offering peer support, recreation, and skill-building in a substance-free environment. Fills the gap between school-based clinical services and formal treatment, particularly during higher-risk after-school and weekend hours.

Opioid Use and Overdose Deaths

Rural communities continue to face high rates of overdose, often driven by fentanyl and limited access to treatment.

20. Harm Reduction Programs and Syringe Services

Evidence: Highest | Complexity: Low to Medium

Syringe exchange, naloxone distribution, fentanyl test strips, safer use education, and peer outreach to active users. Prevents overdose deaths, reduces HIV and hepatitis C transmission, and builds the trust that often leads to treatment engagement. Legal in New York State and supported by OASAS funding.

21. Data-Driven Overdose Surveillance with Public Dashboards

Evidence: Moderate to High | Complexity: Low to Medium

Real-time dashboards tracking overdoses and related indicators, enabling targeted naloxone placement, outreach, and coalition planning. Foundational infrastructure for effective community response.

22. HEALing Communities Study Model and Healing Cayuga

Evidence: Highest | Complexity: High

A structured coalition-based initiative coordinating evidence-based strategies through county government, a university partner, and local providers. Cayuga County documented a 41% reduction in non-fatal overdoses and a 61% reduction in fatal overdoses using this model.

Co-Occurring Mental Health and Substance Use Disorders

Fragmented treatment systems create barriers for individuals with co-occurring conditions, who are often too complex for standard programs but do not meet criteria for inpatient admission.

23. Certified Community Behavioral Health Clinics (CCBHCs)

Evidence: Highest | Complexity: High

State-certified clinics providing comprehensive, 24/7 integrated behavioral health services (e.g., mental health, substance use disorder, crisis response, and primary care screening) to anyone regardless of ability to pay. Require significant organizational investment but offer the most comprehensive integrated care model available.

24. Cross-Walk Program

Evidence: Moderate | Complexity: Medium

Embeds a behavioral health specialist directly within a primary care practice to treat co-occurring substance use disorder and depression in a single, trusted setting.

Housing Instability and Poverty

Housing instability undermines treatment engagement and recovery. Without stable housing, individuals cannot reliably maintain medication regimens or build the routines that support recovery.

25. Permanent Supportive Housing (PSH)

Evidence: Highest | Complexity: High

Rental subsidies with intensive case management for homeless or housing-unstable individuals with a history of substance use disorder. Research shows 90% or higher housing retention rates, along with reduced hospitalizations and emergency department use.

26. Recovery Residences (Certified Sober Living)

Evidence: High | Complexity: Medium

Peer-run certified sober living homes that fill the critical step-down gap between residential treatment and independent living. OASAS provides grants of up to $75,000 for property improvements, and ongoing operating costs are largely covered by resident fees.

27. Rural Outreach Center (ROC) Model

Evidence: Moderate to High | Complexity: Medium

A holistic support model addressing root causes of poverty through care coordination, therapy, budgeting assistance, employment support, housing help, and food assistance. Developed by The Rural Outreach Center, a nonprofit in Western New York.

28. Recovery-Oriented Systems of Care (ROSOC) and Whole Person Care
Evidence: High | Complexity: Medium to High
Intensive care coordination for high-need adults who are frequent users of emergency departments and correctional facilities. Addresses housing, income, food, healthcare, and behavioral health simultaneously.

Fragmentation and Coordination Gaps

Rural systems are often fragmented, requiring individuals to navigate multiple disconnected agencies and leaving providers without coordinated referral pathways.

29. AmericaServes and NYServes Coordinated Referral Networks
Evidence: Moderate to High | Complexity: Medium to High
A centralized coordination center and shared technology platform (Unite Us) routing referrals across housing, employment, legal services, and behavioral health, with closed-loop tracking to confirm needs are met. Originally developed for veterans and military families through IVMF at Syracuse University, but applicable to broader community populations.

30. Regional Behavioral Health Networks | *Evidence: Moderate to High | Complexity: High*
Regional coordination entities that convene providers and facilitate multi-county planning for shared priorities such as telepsychiatry contracting, workforce recruitment, and crisis response. In New York State, these most closely resemble Behavioral Health Independent Practice Associations (BH IPAs).

31. Recovery Community Centers and Recovery Community and Outreach Centers
Evidence: Moderate | Complexity: Low to Medium
Peer-led, non-clinical spaces providing recovery support, mutual aid, workforce development, and linkage to treatment. Create accessible, community-based entry points into the behavioral health system.

Stigma and Engagement Failure

Stigma and distrust prevent many high-need individuals from accessing services through traditional channels. Peer-based and community-based models are the most effective response.

32. NAMI Family-to-Family
Evidence: High | Complexity: Low
A free, eight-session education program for family members supporting a loved one with mental illness, peer-delivered by trained family members with lived experience. Reduces caregiver distress and improves treatment engagement. Low-resource and easy to scale in rural areas.

33. Family Support Navigators
Evidence: Moderate to High | Complexity: Low to Medium
Specialized navigators helping families understand addiction, navigate the treatment and insurance systems, and address coverage denials. Addresses a critical gap given the frequency of insurance denials for substance use disorder treatment.

Older Adult Suicide and Isolation

Older adults in rural communities face elevated risks of isolation, depression, and suicide, yet are among the least likely to seek out mental health services.

34. Social Support Programs for Isolated Older Adults
Evidence: Moderate | Complexity: Low
An integrated set of strategies that bring mental health outreach and screening to older adults through programs they already use, e.g., community paramedicine wellness checks, Meals on Wheels depression screening by trained staff, volunteer friendly visitor programs, and telehealth-accessible mental health services at senior centers.

Quick-Start Recommendations

BY TOP PRIORITY BARRIER

Top Priority	Start Here
Crisis Infrastructure Gaps	Crisis Now Model (beginning with mobile crisis teams)
Fragmentation and Coordination Gaps	AmericaServes / NYServes Coordinated Referral Network
Geographic Isolation and Transportation	Telehealth & Telepsychiatry Suite · Mobile Medication Units or COTIs
Housing Instability and Poverty	Recovery Residences
Long Wait Times	MATTERS Network · CA Bridge Program
Older Adult Suicide and Isolation	Social Support Programs for Isolated Older Adults · Nursing Home Telepsychiatry (within the Telehealth & Telepsychiatry Suite)
Opioid/Overdose Deaths	Harm Reduction Programs and Syringe Services Programs · Data-Driven Overdose Surveillance with Public Dashboards
Stigma and Engagement Failure	Peer Recovery Support Services · Recovery Community Centers
Workforce Shortages	Collaborative Care Model
Youth Mental Health Crisis	School-Based Mental Health · SBIRT

BY IMPLEMENTATION CAPACITY

Capacity Level	Recommended Starting Points
Low capacity (limited staff and funding)	SBIRT; Peer Recovery Support Services; Join existing networks (MATTERS, Prevention Resource Centers); Telehealth & Telepsychiatry Suite
Moderate capacity	Collaborative Care Model; School-Based Mental Health; Harm Reduction Programs & Syringe Services Programs; Mobile Crisis Team (within Crisis Now model)
High capacity	CCBHC development; Vermont Hub and Spoke Model; RCORP Consortium; Crisis Stabilization Centers (within Crisis Now model)

BY COUNTY SIZE

County Size	Recommended Starting Points
Very small (fewer than 30,000 residents)	Join regional partnerships (e.g., RCORP, Regional Behavioral Health Networks); Collaborative Care Model (CoCM); Telehealth & Telepsychiatry Suite; Peer Recovery Support Services
Small to medium (30,000–100,000 residents)	Collaborative Care Model (CoCM) and School-Based Health & Mental Health Centers; SBIRT; Harm Reduction Programs & Syringe Services Programs; Mobile Crisis Team (within Crisis Now model)
Larger (more than 100,000 residents)	CCBHC development; Vermont Hub and Spoke Model; Crisis Now

Sustainability Considerations

Regardless of which programs you select, build sustainability into program design from the start. Programs that collapse after a grant cycle leave communities worse off than before.

Prioritize Medicaid reimbursement. The most sustainable programs are those that generate ongoing Medicaid revenue. Collaborative Care Model billing codes, school-based mental health, telepsychiatry, peer services, and CCBHC Prospective Payment System rates all provide sustainable funding streams.

Diversify funding from the start. Combine federal grants, state funding, Medicaid, hospital community benefit funds, and local sources to reduce dependence on any single stream.

Avoid programs dependent solely on short-term grants unless you have a sustainability plan in place before launch, including Medicaid billing and local funding sources.

Document outcomes. Data on reduced emergency department use, reduced hospitalizations, and improved recovery outcomes makes the case for continued investment from payers, county government, and funders.

Key Medicaid-reimbursable programs include the Collaborative Care Model, school-based mental health services, telepsychiatry, peer services, and CCBHCs. Key multi-year federal funding sources include RCORP, SAMHSA grants, and HRSA grants. Key state-supported ongoing programs include OASAS Prevention Resource Centers and OMH mobile crisis expansion funding.

Note: For detailed implementation guidance, cost estimates, funding sources, technical assistance contacts, and references, refer to the full implementation guide: *Evidence-Based Best Practices for Rural Behavioral Health Access: A NYSARH Implementation Guide*.