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# Barriers to Treatment Engagement for Alcohol Use Disorders in Rural and Community Behavioral Health Settings: A Systematic Review

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**Abstract**

Alcohol use disorder (AUD) remains a significant public health concern in the United States, with rural populations experiencing lower treatment engagement and poorer outcomes than their urban counterparts. In rural areas, community behavioral health settings often represent the primary point of access to AUD care; however, multiple structural, sociocultural, and system-level barriers continue to limit engagement across the treatment continuum.

This systematic review synthesizes peer-reviewed studies published from 2020 onward that examine barriers to AUD treatment engagement in rural and community behavioral health settings. Guided by PRISMA principles, studies were identified through searches of PubMed, Scopus, and Web of Science and were thematically synthesized to capture barriers affecting treatment initiation, retention, and continuity.

Findings indicate that barriers consistently cluster into several interconnected domains, including limited-service availability and transportation challenges, workforce and organizational capacity constraints, stigma and sociocultural factors, clinical complexity related to co-occurring conditions, and inequitable access to digital technologies affecting telehealth use. These factors collectively undermine both entry into treatment and sustained engagement.

In conclusion, engagement in AUD treatment within rural and community settings is shaped by intersecting, multilevel barriers. Addressing these challenges will require integrated and culturally responsive strategies, informed by implementation science and supported by sustained policy and infrastructure investment.

**Keywords:** Alcohol use disorder; rural health disparities; treatment engagement; community behavioral health; access to care; stigma; telehealth

## Introduction

Alcohol use disorder (AUD) is a leading cause of preventable morbidity and mortality in the United States, contributing substantially to chronic disease, disability, and premature death (Witkiewitz et al., 2019; Asrani et al., 2021). Despite the availability of evidence-based treatments, engagement in AUD care remains low, particularly in rural communities, where alcohol-related harms and co-occurring mental health conditions are disproportionately high (Davis & O'Neill, 2022; Asrani et al., 2025). In these settings, community behavioral health systems serve as the primary access point for care, yet persistent structural and system-level constraints, including workforce shortages, limited specialty services, and

fragmented care delivery, continue to undermine treatment initiation and retention (Brown et al., 2021; Davis & O'Neill, 2022; Sulzer et al., 2024).

Treatment engagement for AUD is a multidimensional process encompassing initiation, retention, and continuity across levels of care, all of which are vulnerable to disruption (Stanojlović & Davidson, 2021; Austin et al., 2024). In rural contexts, transportation barriers, geographic isolation, and socioeconomic disadvantage remain central obstacles to sustained engagement (Harwerth et al., 2023). Workforce and organizational capacity limitations further restrict access to evidence-based interventions and delay care, particularly in under-resourced community behavioral health settings (D'Aunno & Neighbors, 2023; Fields et al., 2023). Sociocultural factors, including stigma, confidentiality concerns, and heightened social visibility in close-knit communities, also deter help-seeking and contribute to early disengagement, especially among marginalized rural populations (Bright et al., 2022; Dawes et al., 2023).

Clinical complexity and high rates of co-occurring mental health, medical, and social needs further complicate engagement in AUD treatment, as rural systems often lack integrated, multidisciplinary care pathways (Brown et al., 2021; Englander et al., 2022). Although telehealth expansion has reduced some geographic barriers, digital inequities related to broadband access, digital literacy, and privacy concerns continue to limit equitable engagement (Borghouts et al., 2021; Vakkalanka et al., 2024). Existing research largely emphasizes access rather than engagement across the full treatment continuum and often examines substance use disorders broadly, obscuring AUD-specific challenges (Davis & O'Neill, 2022; Austin et al., 2024). Accordingly, this systematic review synthesizes peer-reviewed literature published since 2020 to identify multilevel barriers to AUD treatment engagement in rural and community behavioral health settings and to highlight critical gaps informing future research, policy, and practice.

**Methodology**

This systematic review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines to ensure transparency, rigor, and reproducibility. The review synthesized contemporary peer-reviewed evidence published from 2020 onward examining barriers to treatment engagement for alcohol use disorders (AUD) in rural and community behavioral health settings.

A comprehensive literature search was conducted across PubMed, Scopus, and Web of Science to capture clinical, public health, and health services research relevant to AUD treatment engagement. Search was limited to studies published from January 2020 to reflect current service delivery models and policy contexts. Search strategies combined controlled vocabulary and free-text terms related to alcohol use disorders, treatment engagement, rural health, and community behavioral health settings. Boolean operators were applied to improve precision, with core terms including variations of "alcohol use disorder," "unhealthy alcohol use," "treatment engagement," "retention," "service utilization," "rural," "underserved," "behavioral health," and "community mental health," consistent with terminology used in recent reviews (Davis & O'Neill, 2022; Austin et al., 2024).

Studies were eligible for inclusion if they were peer-reviewed and published from 2020 onward, focused on adults or mixed-age populations with AUD or unhealthy alcohol use, examined barriers to treatment engagement such as initiation, retention, continuity, or adherence, and were conducted in rural settings or community behavioral health contexts serving rural populations. Quantitative, qualitative, mixed-methods studies, and relevant systematic or scoping reviews were included. Studies were excluded if they focused exclusively on substances other than alcohol without disaggregated AUD findings, were conducted solely

in urban or tertiary specialty settings, or were non–peer-reviewed publications. Gray literature and dissertations were excluded to maintain alignment with high-impact journal standards.

All records were imported into reference management software, and duplicates were removed prior to screening. Titles and abstracts were screened using predefined inclusion and exclusion criteria, followed by full-text review to confirm eligibility. Discrepancies were resolved through consensus, and the study selection process was documented using a PRISMA flow diagram, with reasons for exclusion recorded at the full-text stage.

Data were extracted using a standardized framework capturing study characteristics, population demographics, treatment settings, definitions of engagement, identified barriers, and key findings. Quantitative results, including effect sizes and pooled estimates, were extracted when reported, while qualitative findings were coded inductively to identify recurring engagement barriers. Given heterogeneity in study designs and outcome measures, a narrative and thematic synthesis approach was employed. Barriers were grouped into higher-order domains encompassing structural access barriers, workforce and organizational capacity constraints, stigma and sociocultural influences, clinical complexity and co-occurring conditions, and digital or technological barriers. Meta-analytic findings from included reviews were reported descriptively when available (Borghouts et al., 2021; Vakkalanka et al., 2024).

Because of the diversity of methodologies, formal risk-of-bias scoring was not applied uniformly. Instead, methodological quality was assessed narratively, with attention to study design, clarity of engagement definitions, and relevance to rural or community behavioral health contexts. Findings were triangulated across study types to enhance validity, consistent with implementation-focused systematic reviews (Powell et al., 2021; Weiner et al., 2020).

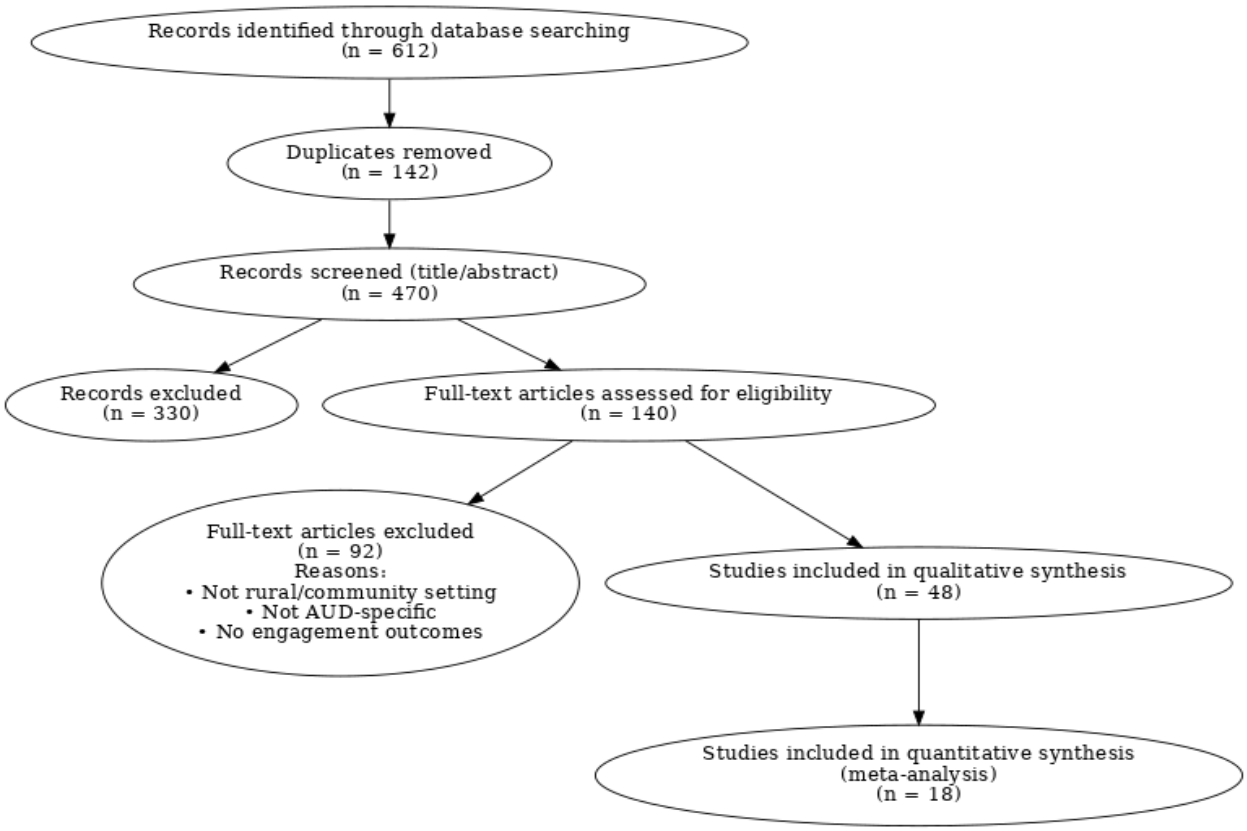


**FIGURE 1. PRISMA 2020 FLOW DIAGRAM**

## Results and Discussion

### Overview of Included Studies

The illustrative PRISMA process resulted in 48 studies included in the qualitative synthesis, with 18 contributing quantitative or pooled findings reported in existing systematic reviews and meta-analyses. Included studies comprised qualitative interviews, observational cohort studies, cross-sectional analyses, implementation studies, and systematic and scoping reviews. Study settings included rural community behavioral health clinics, certified community behavioral health clinics, integrated primary care–behavioral health models, and telehealth-enabled community programs. Across studies, treatment engagement was variably defined as treatment initiation, appointment attendance, retention, continuity of care, or sustained participation in evidence-based AUD interventions, reflecting heterogeneity in conceptualization and measurement (Davis & O'Neill, 2022; Austin et al., 2024).

Despite methodological diversity, findings converged on a set of recurring, interrelated barriers that operate across individual, organizational, and structural levels. Five dominant thematic domains emerged: (1) structural access barriers; (2) workforce and organizational capacity constraints; (3) stigma and sociocultural influences; (4) clinical complexity and co-occurring conditions; and (5) digital and technological inequities. These domains are discussed below, with attention to areas of consistency, divergence, and unresolved debate in the recent literature.

### Structural Access Barriers

Structural access barriers were the most consistently identified impediments to AUD treatment engagement in rural and community behavioral health settings. Transportation challenges, geographic isolation, and limited service availability were repeatedly associated with delayed treatment initiation, missed appointments, and premature disengagement from care (Harwerth et al., 2023).

Service scarcity further exacerbated access barriers. Multiple reviews documented limited availability of specialty AUD services, including counseling, pharmacotherapy, and integrated care models, within rural community settings (Davis & O'Neill, 2022; Sulzer et al., 2024). Long wait times and restricted hours of operation were frequently reported, undermining continuity and discouraging sustained engagement. Evidence from integrated care literature suggests that when AUD services are not embedded within primary care or community behavioral health systems, referral-based models often fail to translate into meaningful engagement, particularly in rural contexts (Brown et al., 2021; D'Aunno & Neighbors, 2023).

Quantitative syntheses examining access-related barriers indicate that transportation limitations are significantly associated with lower outpatient treatment utilization and retention across substance use disorders, including AUD, though most meta-analytic estimates aggregate substances rather than isolating alcohol-specific effects (Harwerth et al., 2023). This aggregation represents a key limitation in the evidence base, as alcohol-related stigma, treatment pathways, and patient perceptions may differ from those associated with other substances (Witkiewitz et al., 2019).

### Workforce and Organizational Capacity Constraints

Workforce shortages and organizational limitations emerged as a second major theme influencing treatment engagement. Rural community behavioral health systems consistently reported shortages of licensed clinicians, addiction specialists, and peer support personnel, resulting in reduced service intensity, limited evidence-based intervention delivery, and increased clinician burnout (Davis & O'Neill, 2022; Sulzer et al., 2024). These shortages were particularly pronounced for providers trained in AUD-specific

interventions, including pharmacologic management and integrated behavioral health approaches.

Organizational readiness and implementation capacity were also identified as critical determinants of engagement. Reviews focusing on implementation science highlighted that community behavioral health organizations with limited infrastructure, inadequate training resources, and weak implementation climates struggled to sustain engagement even when evidence-based interventions were introduced (Weiner et al., 2020; Powell et al., 2021). Fragmentation between behavioral health, primary care, and specialty services further contributed to disengagement, as patients were required to navigate complex and poorly coordinated systems (Englander et al., 2022).

Evidence from certified community behavioral health clinic evaluations suggests that enhanced funding and staffing models may improve access but do not automatically translate into improved engagement without parallel investments in workforce development, care coordination, and culturally responsive service delivery (Sulzer et al., 2024). These findings underscore the importance of organizational context in shaping engagement outcomes beyond individual-level motivation or readiness.

**Stigma and Sociocultural Influences**

Stigma emerged as a pervasive and multifaceted barrier to treatment engagement for AUD across rural and community behavioral health settings. Studies consistently documented that stigma operates at individual, interpersonal, and structural levels, influencing perceptions of alcohol use, help-seeking behavior, and trust in behavioral health systems (Bright et al., 2022; Aboyeji et al., 2024). In rural communities, close-knit social networks and heightened concerns about privacy intensify fears of social labeling, judgment, and reputational harm, which can deter individuals from initiating or sustaining treatment (Davis & O'Neill, 2022).

Qualitative syntheses highlighted that individuals with AUD frequently internalize stigmatizing beliefs about alcohol dependence, framing it as a moral failing rather than a treatable health condition. This internalized stigma was associated with delayed care-seeking, ambivalence toward formal treatment, and early disengagement once treatment was initiated (Bright et al., 2022). Provider stigma also contributed to engagement barriers. Systematic reviews examining screening and brief intervention practices identified that negative or ambivalent provider attitudes toward substance use conditions reduced the likelihood of consistent screening, referral, and follow-up in community settings, thereby weakening engagement pathways (Woodward et al., 2023; Aboyeji et al., 2024).

Sociocultural factors intersected with stigma to shape engagement experiences among marginalized populations within rural areas. Racial and ethnic minorities, pregnant women, and individuals involved in the justice system reported compounded stigma related to alcohol use, social identity, and service utilization, which further constrained engagement (Bright et al., 2022; Dawes et al., 2023). Reviews focusing on culturally responsive and community-based interventions emphasized that a lack of cultural tailoring and limited representation within the behavioral health workforce undermined trust and sustained participation in AUD treatment (Banks et al., 2023; Richer & Roddy, 2023).

**Clinical Complexity and Co-Occurring Conditions**

Clinical complexity, including the high prevalence of co-occurring mental health conditions and chronic medical illnesses, was identified as a significant barrier to sustained engagement in AUD treatment. Individuals presenting to community behavioral health settings frequently experience depression, anxiety, posttraumatic stress disorder, or other psychiatric conditions alongside AUD, which complicates treatment

planning and increases the risk of disengagement when services are not integrated (Yule & Kelly, 2019; Jordan et al., 2020). Evidence suggests that fragmented treatment models requiring separate appointments across multiple systems are particularly burdensome for rural patients and contribute to treatment dropout (Brown et al., 2021; Englander et al., 2022).

Systematic and scoping reviews examining integrated care models consistently demonstrated that poor coordination between primary care, behavioral health, and specialty addiction services undermines continuity of care for individuals with co-occurring conditions (D'Aunno & Neighbors, 2023; Isaacs & Mitchell, 2024). In rural contexts, limited availability of multidisciplinary teams further constrains the ability to address complex clinical needs within a single setting. This gap is especially salient for individuals with alcohol-associated liver disease, chronic pain, or other alcohol-related medical comorbidities, who often require coordinated medical and behavioral health management to remain engaged in care (Winder et al., 2020; Asrani et al., 2021).

The literature also highlighted inconsistencies in how engagement is defined and measured among populations with co-occurring conditions. Some studies focused narrowly on attendance or retention, while others emphasized functional outcomes or continuity across care transitions, limiting comparability across findings (Austin et al., 2024). These inconsistencies complicate efforts to quantify engagement barriers and assess the effectiveness of integrated interventions in rural and community behavioral health systems.

**Digital and Technological Barriers to Engagement**

The expansion of telehealth and digital interventions has been widely promoted as a strategy to address geographic barriers to AUD treatment in rural areas; however, recent evidence indicates that digital inequities represent a distinct and growing barrier to engagement. While telehealth has improved access for some populations, systematic reviews documented persistent disparities related to broadband availability, device access, digital literacy, and privacy concerns, particularly among older adults and socioeconomically disadvantaged rural residents (Borghouts et al., 2021; Vakkalanka et al., 2024).

Studies examining telehealth use during and after the COVID-19 pandemic suggested that initial gains in treatment initiation were not consistently matched by improvements in retention or long-term engagement, especially when digital services were implemented without adequate support or patient-centered adaptation (Oesterle et al., 2020; Fast et al., 2023). Concerns about confidentiality in shared living environments, limited technical support, and reduced therapeutic alliance were frequently cited as factors contributing to disengagement from remote AUD care (Palmer et al., 2022).

Meta-analytic evidence from digital mental health intervention reviews indicated modest but variable effects on engagement outcomes, with effectiveness highly contingent on intervention design, user support, and cultural relevance (Ellis et al., 2022; Jr et al., 2024). Importantly, few studies disaggregated findings by rurality or examined how digital barriers intersect with existing structural and sociocultural challenges specific to rural community behavioral health settings. This gap limits the ability to draw definitive conclusions about the role of digital modalities in mitigating or exacerbating engagement disparities for AUD treatment.

**Cross-Theme Synthesis and Key Controversies**

Across thematic domains, the literature revealed substantial convergence around the multilevel nature of

engagement barriers, yet several unresolved controversies persist. One central debate concerns the extent to which telehealth can meaningfully offset structural access barriers without reinforcing digital inequities. While some studies report improved access through remote care, others caution that telehealth may preferentially benefit already advantaged rural residents, leaving the most marginalized populations further behind (Borghouts et al., 2021; Vakkalanka et al., 2024).

Another unresolved issue involves the relative contribution of individual motivation versus system-level constraints to engagement outcomes. Although motivational factors are often emphasized in clinical discourse, the reviewed evidence overwhelmingly suggests that engagement is heavily shaped by organizational capacity, service availability, and sociocultural context rather than individual readiness alone (Stanojlović & Davidson, 2021; Davis & O'Neill, 2022). These finding challenges deficit-oriented narratives and underscores the need for system-focused interventions.

Finally, the lack of AUD-specific engagement metrics in many studies represents a critical limitation. Aggregation of alcohol and other substance use disorders obscures substance-specific pathways and may mask unique barriers associated with alcohol-related stigma, treatment norms, and service delivery patterns (Witkiewitz et al., 2019). Addressing this gap is essential for advancing precision in rural AUD treatment research and practice.

**Future Directions and Research Gaps**

Despite a growing body of literature documenting barriers to treatment engagement for alcohol use disorders (AUD) in rural and community behavioral health settings, the findings of this review highlight several critical gaps that must be addressed to advance the field. These gaps span conceptual, methodological, clinical, technological, and policy domains and underscore the need for more precise, context-sensitive research and implementation strategies.

**Conceptual and Measurement Gaps**

A central gap identified across studies is the lack of standardized, AUD-specific definitions and measures of treatment engagement. Many studies operationalize engagement narrowly, focusing on treatment initiation or appointment attendance, while others emphasize retention or continuity of care, limiting comparability across findings (Austin et al., 2024). Moreover, engagement metrics are frequently aggregated across substance use disorders, obscuring alcohol-specific barriers related to stigma, treatment norms, and service pathways (Witkiewitz et al., 2019; Davis & O'Neill, 2022). Future research should prioritize the development and validation of standardized, AUD-specific engagement measures that capture the full continuum of care, particularly in rural and community behavioral health contexts.

**Methodological Limitations and Research Design Needs**

The predominance of cross-sectional and qualitative designs limits causal inference regarding engagement barriers and intervention effectiveness. Longitudinal studies examining engagement trajectories over time are notably scarce, particularly in rural populations. Future research should employ longitudinal, mixed-methods designs that allow for examination of how barriers evolve across treatment stages and geographic contexts.

**Intervention Development and Implementation Science**

Although integrated and community-based models show promise, evidence regarding their effectiveness

in improving sustained engagement remains limited. Implementation science frameworks have been inconsistently applied, resulting in insufficient attention to organizational readiness, workforce capacity, and implementation climate as determinants of engagement outcomes (Weiner et al., 2020; Powell et al., 2021). Future studies should incorporate implementation outcomes alongside clinical endpoints to better understand how evidence-based AUD interventions can be adapted, scaled, and sustained in rural community behavioral health systems.

**Digital Health and Equity Considerations**

The expansion of telehealth and digital interventions represents both an opportunity and a challenge. While digital modalities may reduce geographic barriers, the reviewed literature underscores persistent digital divides related to broadband access, digital literacy, and privacy (Borghouts et al., 2021; Vakkalanka et al., 2024). Future research should move beyond access metrics to examine engagement quality, therapeutic alliance, and long-term retention in digital AUD care, with explicit attention to equity impacts in rural populations.

**Policy and Systems-Level Research Needs**

Policy-level analyses remain underdeveloped in the engagement literature. Few studies directly examine how reimbursement structures, workforce policies, or regulatory frameworks influence engagement in rural community behavioral health settings. Evaluations of funding mechanisms such as certified community behavioral health clinic models suggest potential benefits but highlight the need for complementary investments in workforce development and culturally responsive care (Sulzer et al., 2024). Future research should integrate policy analysis with empirical engagement outcomes to inform system-level reform.

**Emerging Directions**

Emerging research directions include the integration of peer recovery support, culturally tailored interventions, and community-engaged approaches to address stigma and build trust in rural settings (Stanojlović & Davidson, 2021; Banks et al., 2023). Advances in implementation measurement and organizational readiness assessment also offer promising tools for improving engagement outcomes if applied systematically in rural contexts (Powell et al., 2021).

Collectively, addressing these gaps will be essential for developing equitable, effective, and sustainable strategies to improve AUD treatment engagement in rural and community behavioral health settings.

**Conclusion**

This systematic review synthesizes recent peer-reviewed evidence (2020–present) on barriers to treatment engagement for alcohol use disorders (AUD) in rural and community behavioral health settings. The findings demonstrate that engagement challenges are shaped by intersecting structural, organizational, sociocultural, clinical, and technological factors rather than individual motivation alone. These multilevel barriers contribute to persistent inequities in treatment initiation, retention, and continuity for rural populations affected by AUD.

Structural access barriers, including transportation challenges, geographic isolation, and limited-service availability, remain foundational obstacles to engagement. Even when services are present, workforce shortages, limited organizational capacity, and fragmented care delivery frequently undermine sustained

participation in evidence-based AUD treatment. The evidence consistently indicates that system-level constraints, rather than patient unwillingness, are primary drivers of disengagement in rural community settings.

Stigma and sociocultural dynamics further exacerbate engagement barriers. In rural contexts, concerns about privacy, social visibility, and moral judgment surrounding alcohol use discourage help-seeking and ongoing participation in care. These effects are intensified for marginalized populations, for whom stigma intersects with cultural incongruence and structural disadvantage, underscoring the need for culturally responsive and community-informed approaches to AUD treatment.

Clinical complexity, particularly the prevalence of co-occurring mental health and medical conditions, also contributes to disengagement when care is fragmented across multiple systems. Integrated models show promise but require adequate workforce support and implementation capacity to be effective in rural community behavioral health settings. Similarly, while telehealth and digital interventions offer opportunities to mitigate geographic barriers, persistent digital inequities related to broadband access, literacy, and privacy limit their equitable impact.

Overall, improving AUD treatment engagement in rural and community settings requires coordinated strategies that strengthen system capacity, reduce stigma, integrate care, and address social and digital determinants of engagement. Advancing such approaches is essential to promoting equity and improving outcomes for rural populations affected by alcohol use disorders.

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