Welcome!

The Nevada Opioid Center of Excellence (NOCE) is dedicated to developing and sharing evidence-based training and offering technical assistance to professionals and community members alike. Whether you're a care provider or a concerned community member, NOCE provides resources to support those affected by opioid use.

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Empowering Rural Communities: Overcoming Barriers to Substance Use Treatment

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Presenter Disclaimer

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Objectives:

- Discuss key barriers to SUD treatment in rural communities, including stigma, transportation, and provider shortages.
- Highlight innovative rural programs and models that improve access to prevention, treatment, and recovery services.
- Share practical tools and resources for building local capacity and partnerships.
- Inspire attendees to take action and advocate for sustainable, community-based solutions.

Understanding the Rural Landscape

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Substance Use in Rural Communities

- Substance use and misuse have long been prevalent in rural areas.
- Rural adults have higher rates of use for tobacco and methamphetamines, while opioid use has grown in towns of every size.
- Rural adolescents and young adults use alcohol at higher rates and are more likely to engage in high-risk behaviors, like binge drinking or driving under the influence, than their urban counterparts.

Reference:

RHIHub- Substance Use and Misuse in Rural Areas - https://www.ruralhealthinfo.org/topics/substance-use

Rural and Urban Substance Use Rates in the Past Year

(ages 12 and older, unless noted)

Substance Use	Non-metro	Small metro	Large metro
Alcohol use by youths aged 12-20	30.9%	28.4%	25.3%
Binge drinking (alcohol) by youths aged 12 to 20 (in the past month)	11.2%	8.5%	6.3%
Cigarette smoking	22.5%	17.3%	14.5%
Smokeless tobacco use	6.0%	3.6%	2.4%
Marijuana	21.0%	22.4%	22.5%
Illicit drug use	24.3%	25.5%	25.8%
Misuse of opioids	3.6%	2.6%	2.6%
Cocaine	1.2%	1.2%	1.7%
Hallucinogens	2.6%	3.1%	4.1%
Methamphetamine	1.7%	0.7%	0.7%
Inhalants	0.8%	0.9%	1.3%

Source: Substance Abuse and Mental Health Services Administration (SAMHSA), Results from the 2024 National Survey on Drug Use and Health: Detailed Tables.

Emerging Concerns

- Fentanyl contamination in counterfeit pills is driving a rise in overdose deaths, even though overall drug use is not increasing.
- Overdose deaths among teens more than doubled from 2019 to 2023, largely due to fentanyl-laced substances.
- Delta-8 THC, a psychoactive cannabis compound, was newly tracked in 2023—11.4% of 12th graders reported using it.

Sources:

- More teens than ever are overdosing. Psychologists are leading new approaches to combat youth substance misuse; By Zara Abrams; APA. March 1, 2024; Vol. 55 No. 2 - https://www.apa.org/monitor/2024/03/new-approaches-youth-substance-misuse
- Teens, Drugs, and Overdose: Contrasting Pre-Pandemic and Current Trends – KFF Health News - Nirmita Panchal and Sasha Zitter: Oct 15, 2024 - https://www.kff.org/mental-health/issue-brief/teens-drugs-and-overdose-contrasting-pre-pandemic-and-current-trends/

Factors Contributing to Substance Use in Rural Areas

- Poverty.
- Unemployment.
- Low educational attainment.
- Greater sense of stigma.
- Having a close friend or family member with a SUD or living in a home environment that supports drug or alcohol abuse.
- Experiencing substance misuse from an early age.
- Peer pressure.
- Lack of treatment services available.
- Past traumatic experiences.

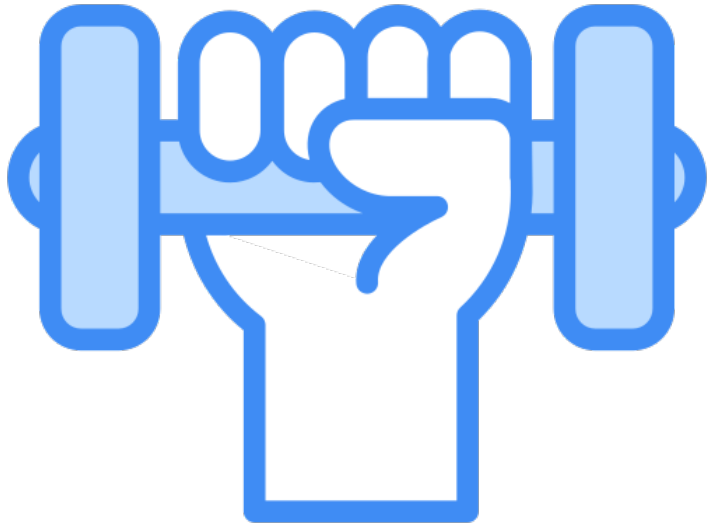
Resource: https://www.addictioncenter.com/addiction/rural-substance-abuse/

Unique Challenges of Rural Communities

- Limited access to healthcare.
- Educational barriers.
- Economic limitations.
- Population declining and aging.
- Limited public services.

Unique Strengths of Rural Communities

- Strong community ties.
- Connection to nature and land.
- Resilience and self-sufficiency.
- Lower cost of living.
- Cultural richness and tradition.
- Safety and quality of life.



Protective Measures That Can Reduce Risks

- Education and awareness programs.
- Accessible mental health and SUD services.
- Community engagement and mentorship.
- Parental involvement and family support.
- Youth recreational activities.
- Policy and law enforcement support.
- Economic and employment opportunities.
- Telehealth and mobile health services.

Resource: Rural Community Action Guide (ONDCP) - https://www.usda.gov/sites/default/files/documents/rural-community-action-guide.pdf

Key Barriers to Treatment Access in Rural Areas

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Geographic and Transportation Barriers

LONG DISTANCES AND LACK OF LOCAL TREATMENT CENTERS.

LIMITED PUBLIC TRANSPORTATION.

COSTS AND TIME BURDENS.

Shortage of Providers and Treatment Facilities

- Lack of trained addiction-specialist providers.
- Few clinics offering evidence-based treatments.
- Long waitlists and limited hours.

Reference:

Stopka TJ, Estadt AT, Leichtling G, Schleicher JC, Mixson LS, Bresett J, Romo E, Dowd P, Walters SM, Young AM, Zule W, Friedmann PD, Go VF, Baker R, Fredericksen RJ. **Barriers to opioid use disorder treatment among people who use drugs in the rural United States: A qualitative, multi-site study**. *Soc Sci Med.* 2024 Apr;346:116660. doi: 10.1016/j.socscimed.2024.116660. Epub 2024 Feb 13. PMID: 38484417; PMCID: PMC10997882.

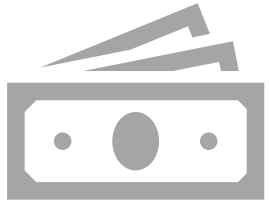
Stigma, Confidentiality, and Social and Cultural Barriers

Stigma around substance use and treatment.

Confidentiality concerns.

Cultural resistance or limited awareness of MAT.

Structural and Policy-Level Barriers



Insurance and cost hurdles.

Systemic treatment model constraints.

Limited integration within primary care.

Individual and Interpersonal Challenges

Fear of withdrawal or life disruption.

Employment and family obligations.

Social networks & exposure to substance use.

Why Rural Areas Are Disproportionately Affected

- Rural residents are much less likely to have access to evidence-based OUD treatments.
- A systematic review concluded that the most reported barriers in rural contexts are:
  - lack of clinics/providers (availability),
  - provider-level challenges (e.g., negative attitudes, inadequate training),
  - and transportation & cost issues (accessibility).
- Because rural populations often include older adults, veterans, Indigenous populations, and people with lower socioeconomic status — who may each face systemic disadvantages — these barriers intersect to create a "layered" burden.

Resources:

- Shedding Light on Rural Health Challenges – East Tennessee State University - https://www.etsu.edu/etsu-news/2023/05-may/etsu-norc-rural-patients-face-greater-challenges-sud-treatment.php?utm_source=chatgpt.com
- Lister JJ, Weaver A, Ellis JD, Himle JA, Ledgerwood DM. A systematic review of rural-specific barriers to medication treatment for opioid use disorder in the United States. Am J Drug Alcohol Abuse. 2020 May 3;46(3):273-288. doi: 10.1080/00952990.2019.1694536. Epub 2019 Dec 6. PMID: 31809217.
- Marie J, Sociodemographic Disparities in Access to Medication-Assisted Treatment (MAT) in Rural America. 2025, J Addict Res Ther 16: 742.

Impacts and Consequences

- Many people with opioid use disorder in rural areas go untreated or receive insufficient treatment.
- There is a higher reliance on court-ordered or forced inpatient treatment rather than voluntary, evidence-based care.
- Treatment dropout or failure is more likely due to logistical difficulties (transportation, schedule conflicts), stigma, or lack of local resources.
- Over time, untreated or under-treated OUD contributes to higher overdose rates, health complications, and community decline — especially in places already struggling economically.

Cultural & Faith Considerations in Rural OUD Treatment

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Strong Influence of Faith Communities

- Faith leaders often act as first points of support in rural communities, sometimes more than medical professionals.
- Many individuals may seek help through pastors, churches, or prayer groups, which can complement or sometimes substitute for clinical care.
- Some faith traditions promote abstinence-only approaches, which may conflict with evidence-based treatments like medication-assisted treatment (MAT).
- Religious stigma may exist around addiction, viewing it as a moral failing or spiritual weakness rather than a medical condition.

Norms Around Self-Reliance and Privacy

- Rural culture often emphasizes self-sufficiency, resilience, and “handling problems on your own,” which can discourage people from seeking treatment.
- Concerns about community visibility (“everyone will know I’m going to treatment”) are amplified in small towns, especially where faith communities are closely interconnected.

Stigma Shaped by Cultural and Religious Values

- Addiction may be framed as a character flaw, sin, or poor personal choice rather than a chronic health disorder.
- This can lead to:
  - Shame about seeking help.
  - Fear of judgment within faith communities.
  - A desire to “fix it privately,” delaying treatment.

Cultural Beliefs About Medication-Assisted Treatment (MAT)

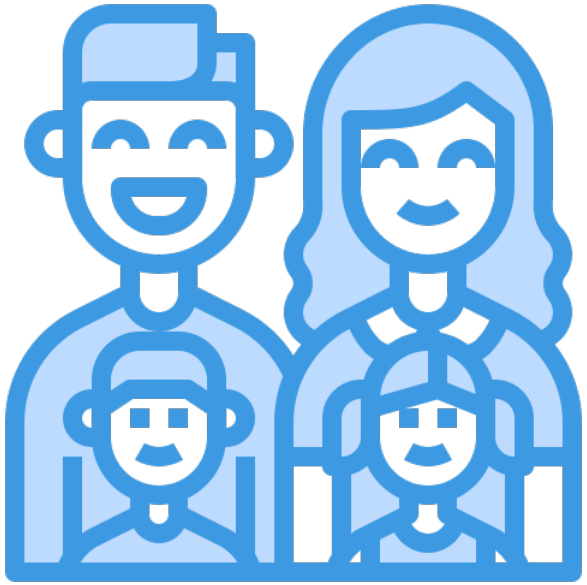
- In some rural or conservative communities, medications like methadone, buprenorphine, and naltrexone are misunderstood or seen as “replacing one drug with another.”
- Cultural or faith-based preferences for complete abstinence may make MAT appear incompatible with morally or spiritually acceptable recovery approaches.
- Some individuals prefer faith-based recovery programs, which may not incorporate MAT or mental-health counseling.

Community Attachment and Collective Identity

- Rural identity emphasizes tight-knit social networks, tradition, and valuing one's reputation—all of which can affect treatment decisions.
- Concerns about disrupting family roles, church involvement, or community responsibilities can deter individuals from entering residential treatment or frequent clinic visits.

Role of Families and Intergenerational Dynamics

- Family units often play an outsized role in rural areas.
- Cultural expectations may lead families to:
  - Encourage private or faith-based management of addiction.
  - Discourage formal treatment that could bring stigma.
  - Prioritize maintaining family reputation over seeking help



Different Cultural Groups in Rural Areas

- **Indigenous communities**: historical trauma, distrust of medical systems, preference for traditional healing practices.
- **Appalachian communities**: values of self-reliance, resistance to outside institutions, high stigma around mental health and addiction.
- **Rural Latino communities**: language barriers, cultural emphasis on family honor, and limited culturally competent services.

Faith-Based Support Can Be a Strength

- Churches often provide community support, recovery ministries, and social stability.
- Integration of spirituality with evidence-based treatment can improve engagement.
- Faith leaders can influence community attitudes positively when they are educated about addiction as a medical condition.

What Needs to Change

- Expand availability of OTPs and MAT-trained providers in rural areas; integrate MAT into primary care and rural health clinics.
- Increase transportation support — mobile treatment units, telehealth (where internet access permits), funded travel or shuttle services for patients.
- Reduce stigma through community education, promoting confidentiality, providing alternatives to abstinence-only models, and encouraging culturally sensitive care.
- Address policy and funding barriers: improve insurance coverage for OUD treatment, ensure Medicaid or public insurance supports MAT and recovery services, and support rural clinics financially.
- Develop flexible, low-threshold treatment options (e.g., take-home medication, flexible scheduling, telehealth behavioral therapy) to better fit rural residents' lives.

Innovative Solutions to Improve SUD and Opioid Treatment Access in Rural Areas

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Mobile Treatment Units - "Clinics on Wheels"

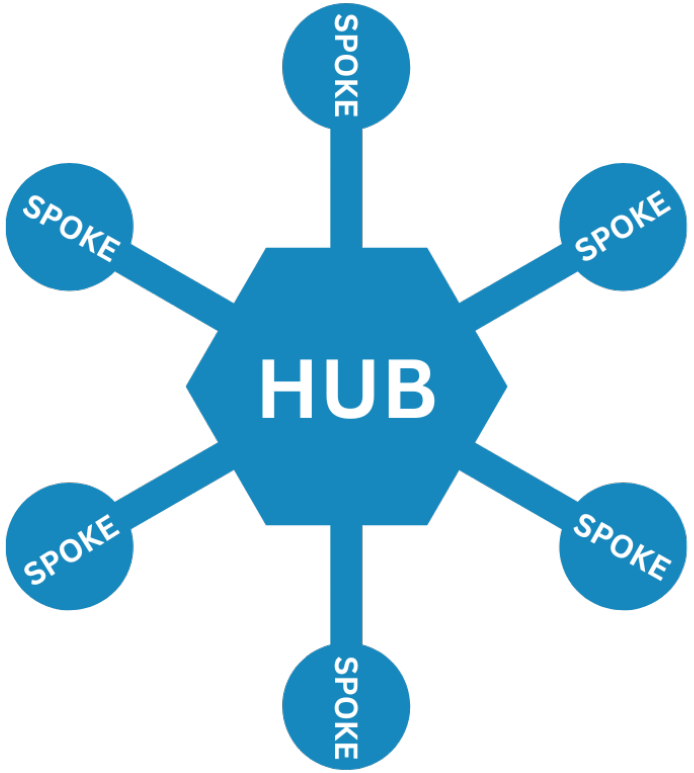
- Bring MAT (buprenorphine, methadone), counseling, and prevention supplies directly to remote communities.
- Reduce transportation burdens and reach people who otherwise wouldn’t travel long distances.
- Can be paired with telehealth evaluations or digital check-ins.

Telehealth Expansion for MAT and Counseling

- Offers remote medication management, therapy, peer support, and case management.
- Particularly impactful where stigma or lack of local specialists is a barrier.
- Works well when combined with:
  - Relaxed tele-prescribing policies.
  - Low-bandwidth platforms for areas with poor internet.
  - Phone-based (not video) appointments.

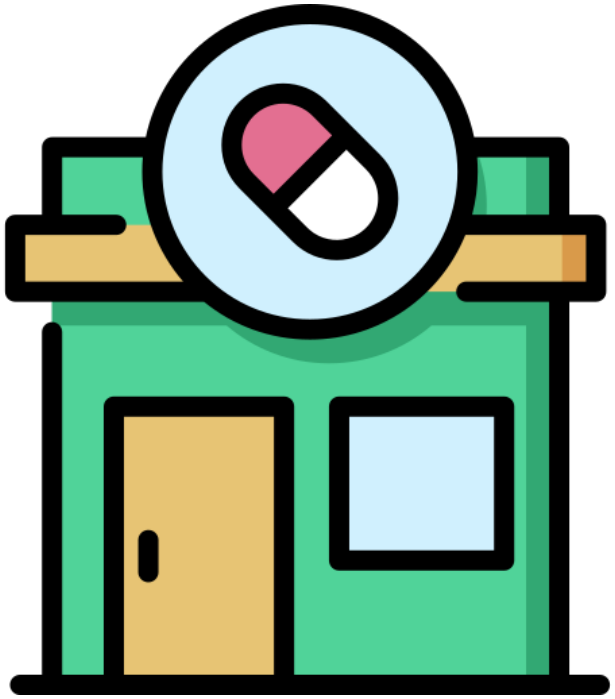
Hub-and-Spoke Models (Successful in Vermont and Expanding Elsewhere)

- Hub: centralized expert treatment center with addiction specialists and intensive care.
- Spokes: local primary care clinics, rural health centers, or pharmacies that provide ongoing MAT.
- Expands reach without needing a specialized clinic in every community.



Rural Pharmacies as Treatment Access Points

- Pharmacists can deliver:
  - Buprenorphine initiation and follow-up.
  - Medication management.
  - Overdose education and naloxone distribution.
- Useful in towns with no addiction specialists or hospitals.



Training Non-Specialist Providers-"Task Sharing"

- Equip rural primary-care providers, nurse practitioners, PAs, and even EMS personnel to:
  - Screen for OUD.
  - Provide brief counseling.
  - Initiate and maintain MAT (with supervision).
- Helps overcome major provider shortages.

Peer Recovery Coaches / Community Health Workers

- Peers can work in:
  - ERs.
  - Jails.
  - Mobile units.
  - Primary-care clinics.
- Provide culturally relevant support, reduce stigma, and help with care navigation.
- Especially effective in tight-knit rural communities.

Faith-Based & Culturally Aligned Partnerships

- Train pastors, church groups, and spiritual leaders on OUD as a medical condition.
- Create faith-supported but evidence-based recovery pathways.
- Helps align treatment with rural cultural norms of spirituality, community, and privacy.

Low-Threshold Treatment Programs

Reduce rules & barriers to entry, such as:				
Walk-in hours.	Same-day MAT initiation.	Flexible attendance requirements.	Reduced urine-screen frequency.	Non-punitive policies.

These are crucial for people with unreliable transportation or work/family responsibilities.

Integrated Care Models

- Combine services one location:
  - Primary care.
  - Mental health.
  - Prevention services.
  - Substance use treatment.
- Reduces stigma and makes treatment feel like ordinary healthcare.

Jail-to-Community MAT Continuity Programs

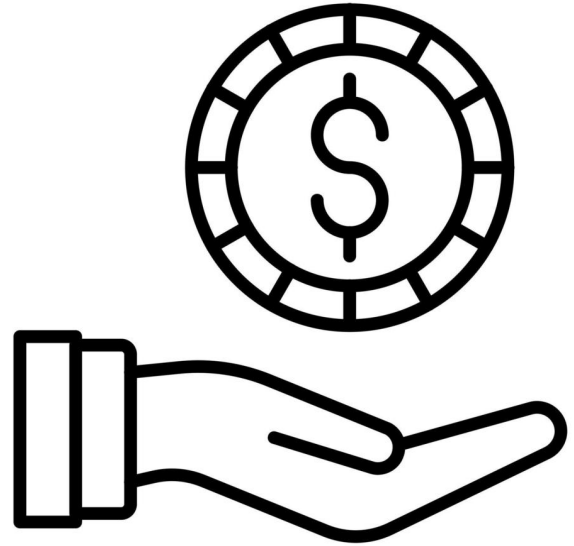
Initiate MAT in jails, then provide coordinated handoff upon release.

Important in rural counties where jails are major points of contact.

Reduces overdose risk after release—a high-risk period.

Economic Supports

- Address financial and social barriers directly:
  - Transportation vouchers.
  - Gas cards or ride-share partnerships.
  - Treatment scholarships.
  - Job-training programs integrated into recovery.



Recovery Housing and Sober-Living in Rural Areas

- Provide safe, supportive housing close to services.
- Can incorporate workforce development, peer support, and life-skills training.
- Helps people avoid relapse triggers in environments with high substance exposure.

Community Education and Anti-Stigma Campaigns

- Use local radio, churches, schools, and local leaders to shift attitudes.
- Emphasize “addiction is a treatable chronic disease,” not a moral failing.
- Reduce fear of judgment and increase willingness to seek help.

Integrate OUD Treatment into Non-Healthcare Settings

- Innovative access points include:
  - Fire stations.
  - Libraries.
  - Rural community centers.
  - Food pantries.
  - Schools.
  - Agricultural extension offices.
- Treatments “meet people where they are,” especially in areas with no clinics.

Prevention Services that Link to Treatment

- Naloxone distribution.
- Fentanyl test strips.
- Drug-checking services.
- Safe disposal sites.
- These build trust and serve as gateways to treatment.

What Works Best in Rural Areas

- The most effective rural strategies tend to combine services:
  - Telehealth + local pharmacies.
  - Mobile units + peer workers.
  - Faith-based partnerships + stigma reduction.
  - Flexible (low-threshold) MAT policies.
  - Task sharing among general healthcare providers.
- These approaches address the unique geography, culture, and resource constraints of rural communities.

Implementation Plan: Improving Rural SUD/OUD Treatment Access

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1. Establish Leadership and Partnerships (Month 0–1)

- Actions:
  - Form a Rural Opioid Response Steering Committee (public health, hospital, EMS, sheriff's office, faith leaders, people with lived experience).
  - Conduct a brief needs assessment using overdose data, treatment gaps, and community input.
  - Select priority areas: MAT expansion, mobile care, telehealth, stigma reduction, etc.
- Tools/Resources:
  - HRSA RCORP Needs Assessment Templates.
  - ODMAP (overdose data).
  - Rural Health Information Hub (community assessment tools).

2. Expand Treatment Access Through Telehealth and Local Providers (Month 1–6)

- Actions:
  - Recruit local primary-care providers, NPs, and PAs to deliver MAT.
  - Provide PCSS and ECHO training for buprenorphine prescribing.
  - Partner with a tele-MAT provider to cover gaps, evenings, weekends.
  - Set up private spaces in clinics, libraries, or community centers for telehealth visits if internet access is limited.
- Tools/Resources:
  - PCSS (free MAT training & mentorship).
  - State Telehealth Resource Center.

3. Launch Mobile Outreach or Expand Transportation Solutions (Month 2–8)

- Actions:
  - Deploy a mobile clinic (or shared regional unit) to deliver MAT, naloxone, screening, and referrals.
  - If mobile unit not feasible, implement transportation supports: gas cards, ride-share partnerships, or community volunteer driver programs.
- Tools/Resources:
  - Harvard Mobile Health Map Start-Up Toolkit
  - USDA Community Facilities Grants (vehicles)
  - MAT Implementation Guides

4. Build a Peer Recovery Workforce (Month 2–10)

- Actions:
  - Recruit and train peer recovery coaches from the local community.
  - Embed peers in ERs, primary care, mobile units, courts/jails.
  - Establish warm handoff protocols for overdose survivors and people released from jail.
- Tools/Resources:
  - State Peer Recovery Specialist Certification Programs.
  - PEER SUPPORT Toolkit
  - ATTC Educational Packages for Opioid Use Disorders – Peer Support Workers

5. Integrate Treatment in High-Impact Settings (Month 4–12)

- Actions:
  - Start or expand MAT in jails, with continuity of care upon release.
  - Implement universal screening in ERs and primary care.
  - Partner with pharmacies to dispense buprenorphine and provide naloxone.
- Tools/Resources:
  - Prison/Jail Medication Assisted Treatment Manual.
  - SAMHSA TIP 63 (MAT Implementation).
  - MAT Resources for FQHC Providers.

6. Engage Faith & Community Leaders (Month 3–12)

- Actions:
  - Train pastors, church groups, and community influencers on addiction as a medical condition.
  - Establish faith-supported recovery groups (Celebrate Recovery, SMART Recovery).
  - Use churches as stigma-free spaces for telehealth, groups, or peer support.
- Tools/Resources:
  - HHS Faith-Based Opioid Partnership Toolkit

7. Implement Overdose Prevention (Month 1–12)

- Actions:
  - Distribute naloxone widely (EMS, fire, law enforcement, libraries, churches).
  - Offer fentanyl test strips and harm-reduction education through mobile outreach.
  - Connect prevention program participants to MAT through warm handoffs.
- Tools/Resources:
  - Prevention Coalition toolkits.
  - Overdose Prevention and Response Toolkit.
  - Local public health supply chains.

8. Monitor Progress & Adjust Strategies (Quarterly)

- Actions:
  - Track metrics:
    - MAT starts
    - Overdose reversals
    - Treatment retention
    - Number of telehealth/mobile visits
    - Jail-to-community MAT continuity
    - Etc.
  - Review data quarterly with steering committee and adjust strategies.
- Tools/Resources:
  - Epi Info,
  - Prescription Drug Monitoring Programs (PDMPs)
  - Opioid Use Disorder Treatment Evaluation Framework

12-Month Outcomes (Expected)

By end of year one, the community should expect to achieve:

- Increased number of MAT prescribers (telehealth + local).
- Mobile treatment or transportation access in high-need areas.
- Consistent peer recovery presence in ER/jail/clinic settings.
- Wider naloxone coverage and reduced overdose deaths.
- Reduced stigma through faith and community engagement.
- Strong foundation for long-term sustainability and expansion.

Resources

- HRSA RCORP Needs Assessment Templates - https://bphc.hrsa.gov/compliance/site-visits/site-visit-protocol/needs-assessment
- ODMAP (overdose data) - https://www.hidtaprogram.org/odmap.php
- Rural Health Information Hub (community assessment tools) - https://www.ruralhealthinfo.org/toolkits/rural-toolkit
- PCSS (free MAT training & mentorship) - https://pcssnow.org/
- State Telehealth Resource Center - https://www.hrsa.gov/telehealth/telehealth-resource-centers
- Harvard Mobile Health Map Start-Up Toolkit - https://www.mobilehealthmap.org/
- USDA Community Facilities Grants (vehicles) - https://www.rd.usda.gov/programs-services/community-facilities/community-facilities-direct-loan-grant-program
- MAT Implementation Guides - https://www.nycourts.gov/LegacyPDFS/courts/problem_solving/opioid/Medication-4OpioidUseDisorder/MAT%20Implementation%20Guide%20and%20Checklist.pdf
- State Peer Recovery Specialist Certification Programs - https://www.mcboard.org/online-training-for-peers/
- PEER SUPPORT Toolkit - https://dbhids.org/wp-content/uploads/2024/02/PSToolkit-2023.pdf
- ATTC Educational Packages for Opioid Use Disorders – Peer Support Workers - https://attcnetwork.org/opioid-educational-package-peer-support-workers/

- Prison/Jail Medication Assisted Treatment Manual - https://www.rsat-tta.com/Files/RSAT_Prison_Med_Treat_FINAL.pdf
- Jail-based medication-assisted treatment: promising practices, guidelines, and resources for the field - https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf
- SAMHSA TIP 63 (MAT Implementation) - https://library.samhsa.gov/sites/default/files/pep21-02-01-002.pdf
- MAT Resources for FQHC Providers - https://www.nvpca.org/mat-resources-for-fqhc-providers
- HHS Faith-Based Opioid Partnership Toolkit - https://www.hhs.gov/sites/default/files/the-opioid-crisis-practical-toolkit.pdf
- Prevention Coalition toolkits - https://www.samhsa.gov/technical-assistance/sptac/toolkit
- Overdose Prevention and Response Toolkit - https://www.cdc.gov/overdose-prevention/media/pdfs/2024/04/SAMHSA-overdose-prevention-response-toolkit.pdf
- Epi Info - https://www.cdc.gov/epiinfo/pc.html
- Prescription Drug Monitoring Programs (PDMPs) - https://www.cdc.gov/overdose-prevention/hcp/clinical-guidance/prescription-drug-monitoring-programs.html
- Opioid Use Disorder Treatment Evaluation Framework - https://www.qualityhealth.org/bree/wp-content/uploads/sites/8/2025/01/OUD-evaluation-framework_DRAFT-V2.1.pdf

Thank You

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