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Identifying and Addressing Barriers to Effective Substance Misuse Treatment in Rural Settings

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Those seeking treatment for opioid or substance use disorder (OUD/SUD) often face obstacles, which may be exacerbated in rural areas. Barriers to treatment, such as access, stigma, and policies that no longer reflect the current needs of clients seeking treatment for OUD/SUD, are well-documented. However, barriers once engaged in treatment that impact persistence are relatively unstudied. This study sought to understand the barriers related to effective treatment provision with clients in OUD/SUD treatment, particularly those in rural settings. This exploratory qualitative study consisted of two focus groups with 18 graduate social work and counseling psychology students completing a two-semester practicum at OUD/SUD treatment facilities. The student practitioners were trained in screening, intervention, and treatment services for SUD in rural and underserved locations. Participants reflected on the barriers for clients who sought OUD/SUD treatment and the subsequent impact on treatment efficacy. Three themes emerged, including *Substance Use Treatment and Criminalization Policies, Rurality, and COVID-Related Adjustments*. Mitigating barriers to OUD/SUD treatment, particularly in rural communities, is important to effectively address treatment needs. Understanding the ongoing support needed for clients to address barriers once engaged in treatment is critical to treatment persistence. Recognizing and addressing the identified barriers, particularly those with macro or community-level impacts, supports the client's harm reduction, treatment, and recovery needs to better position clients for successful outcomes.

Public Health Significance Statement

Identifying and addressing barriers to persistence in OUD/SUD treatment is of critical importance, particularly in rural communities where treatment resources may be limited, yet mortality rates rival those of urban communities. Recognizing and mitigating the identified barriers, particularly those with macro- or community-level impacts, reflects the harm reduction, treatment, and recovery emphasis of public health modeling.

Keywords: barriers to substance use disorder treatment, rural barriers to treatment, OUD/SUD treatment in rural settings

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Mortality associated with substance misuse exceeded 106,000 deaths annually last year in the United States, representing a 15% increase from the prior year (United States Children's Bureau, 2021). Adolescents have the fastest growing rates of increased mortality as overdose deaths for teens aged 14–18 years doubled from 2019 to 2021, with fentanyl accounting for the majority of those deaths (Jenkins et al., 2021). This mortality has a significant economic impact, with an annual cost of over $800 billion (Florence et al., 2021).

Substance misuse impacts all aspects of life, from physical and mental health to education and career to relationships (Ignaszewski, 2021). Despite the significant relational, social, and economic effects of substance misuse, barriers to treatment are extensive, particularly in rural settings where provider access may be limited. However, even when treatment is accessed, barriers to treatment persistence remain substantial, yet there is little empirical evidence documenting those barriers.

Substance Use Disorder Treatment Barriers

Barriers to utilizing opioid (OUD) or substance use disorder (SUD) treatments encompass a multitude of factors, including intra- and interpersonal, logistical, and environmental considerations. Transportation and financial obligations, fear of familial rejection due to use or due to seeking treatment, belief that recovery can occur without treatment, and shame or stigma regarding use all hinder participation in substance treatment (Adams & Volkow, 2020; Jegede et al., 2021; Tsai et al., 2019). Thus, barriers to accessing treatment include external systemic factors in combination with personal factors such as internalized stigma regarding use, which impact treatment-seeking behaviors, as well as treatment persistence.

The stigmas associated with OUD/SUD treatment are internalized not just by those seeking recovery but also by their families, communities, and treatment providers as well. For example, even when medical providers are trained in the efficacy of medication-assisted treatment (MAT), there is a reluctance by prescribing physicians in implementing MAT as a treatment protocol due to value-based perspectives regarding sobriety (Ober et al., 2017). Thus, provider values can also be a barrier to accessing OUD/SUD treatment.

Many barriers for clients are due to the significant consequences on their families. Women who are pregnant and currently using are afraid to speak with their medical provider regarding treatment for fear of losing their children (Ostrach & Leiner, 2019). For children entering the foster care system, 35% were a result of parental substance misuse (United States Children's Bureau, 2021). Of those in care as a result of parental substance misuse, nearly half are aged 5 years or younger (National Center on Substance Abuse and Child Welfare, 2019; United States Children's Bureau, 2021). Children in rural areas experience higher rates of foster care due to parental substance misuse, largely due to the insufficient relational capital or resources to be able to utilize kinship care, thus placing rural children at higher risk of foster care placement due to parental substance misuse (Brant, 2022).

Environmental Barriers

Rurality manifests barriers and hardships that are unique to the setting. OUD/SUD treatment programs in rural areas may be limited in availability or without sufficient providers to secure access to treatment (Browne et al., 2016). Additionally, mothers in rural areas have a significantly lower rate of seeking treatment than urban users (Ali et al., 2022), with higher overall rates of overdoses for women in rural areas than in urban locations (Spencer et al., 2022).

Rural areas may also be considered vulnerable targets. This is particularly true due to the rural workforce's common employment arenas requiring physically demanding positions where injuries are common; as a result, pharmacological corporations targeted these communities as prospective consumers (DeWeerdt, 2019; Keyes et al., 2014).

Additionally, rural communities often have political impacts regarding treatment that larger communities may not have. An example is that placing an MAT facility or sober living home in a rural community typically requires approval from the city council or governing board, whereas in a larger environment, a neighborhood may not be able to approve or deny a treatment facility (Deyo-Svendsen et al., 2020).

An additional barrier to OUD/SUD treatment is existing policies, particularly those criminalizing substance use. Drug-related changes in sentencing laws, rather than an increase in crime, have resulted in a significant rise in incarcerations (Ghandnoosh & Anderson, 2017), with almost half of those incarcerated serving sentences for drug offenses (Carson, 2021; Zeng, 2020). Policies to eradicate illegal substances have resulted in communities of

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color and lower socioeconomic statuses having higher incarceration rates (Jegede et al., 2021; Rouhani et al., 2022; Tyndall, 2019; Volkow, 2021). Drug of choice impacts the collateral damage that occurs; a common example is the differential sentencing for crack versus cocaine, with much more extensive sentencing penalties for crack despite no scientific difference in the impact of use (Goulian et al., 2022).

Criminalization policies often contribute to stigma around OUD/SUD, which negatively impacts access to treatment. Tyndall (2019) found that laws enforcing stiff penalties for substance possession result in public ambiguity regarding support for meaningful drug treatment policies, leading to stigmatizing substance misuse for not following societal rules.

The Present Study

While the literature documents multiple barriers to accessing treatment, less is known regarding barriers once in treatment for OUD/SUD, particularly in rural communities. This study sought to understand the barriers to treatment provision, persistence, and efficacy impacting clients in OUD/SUD treatment, particularly those in rural settings.

Method

Participants consisted of graduate social work and counseling psychology students placed in largely rural OUD/SUD settings for a two-semester internship as part of the Opioid Workforce Expansion Program, a Health Resources and Services Administration (HRSA) funded university training program. The key program aim was to increase the number of clinical social work (Master of Social Work) and counseling psychology practitioners trained in substance use screening, intervention, and treatment services, prioritizing rural or underserved areas. Participants completed internships at OUD/SUD treatment facilities and were trained in telemental health to offset barriers to accessing substance use treatment in rural communities.

Participants

Of 19 potential participants, 18 provided consent to participate in the focus groups at the end of a two-semester internship program. Participants were primarily graduate students in the Master of Social Work program (n = 15), while the remaining students were in counseling psychology, with two in the master's and one in the doctoral programs. Gender identities included 61% (n = 11) who identified as ciswomen, 33% (n = 6) as cismen, and 5% (n = 1) as nonbinary. Average participant's age was 30 (SD = 5.44), with most identified as Caucasian/White 83% (n = 15) and the remaining as African American/Black 5.55% (n = 1) and multiracial 5.55% (n = 1), and one participant also identifying as Hispanic. Most participants (n = 14, 77%) were from rural areas, and 13 (72%) indicated having a disadvantaged background. All but one were placed in a rural and/or medically underserved community as designated by HRSA, defined as a nonmetro county by the census or designated by a rural–urban commuting area code of four or higher as well as those counties with less than 35 people per square mile if coded as a two or three (Health Resources & Services Administration, 2022).

In the final week of the 9-month training, all participants were invited to participate in a voluntary, institutional review board approved (No. 54826) focus group through Zoom. Two focus groups were conducted and recorded in May of 2021, each lasting 1 hr on Zoom. Audio files were transcribed verbatim using https://Rev.com with pseudonyms replacing participant names.

Analysis

Data analysis employed Dedoose, a qualitative data analysis software, to facilitate the six-step thematic analysis process outlined by Terry et al. (2017). Using an inductive approach from a constructivist paradigm, thematic analysis allowed focus group data to inform the analysis rather than to impose a priori codes. The six steps are (1) familiarizing with the data, (2) generating codes, (3) theme development, (4) reviewing potential themes, (5) defining/naming themes, and (6) writing the report (Terry et al., 2017).

In step one, the second author conducted two focus groups and memoed potential themes. In step two, the first author used Dedoose to code the entire data corpus in units of two to four sentences to glean the main categories of discussion. In step three, the first author reviewed all codes to determine which coalesced together around categories, themes, and subthemes. In step four, the themes within this category initially included four themes with multiple subthemes each. The first

author memoed about these themes and selected relevant quotes to represent each subtheme. In step five, the definition process for each theme resulted in collapsing multiple subthemes into the larger themes. Development of this article is step six.

Results

Analysis of participant responses resulted in three themes related to the perceived barriers to OUD/SUD treatment in rural-based treatment facilities. Themes included *Substance Use Treatment and Criminalization Policies, Rurality, and COVID-Related Adjustments.*

Substance Use Treatment and Criminalization Policies

Policies are impacted by how policymakers perceive substance use, which has implications for organizational practices. As these mental health participants noticed the overlap in people experiencing SUDs and people involved in the criminal justice system, they began to observe the barriers some of the policies created to treatment persistence. Their awareness of the two types of policies—organizational and governmental—represented two subthemes: abstinence-only programs and probation policies.

Abstinence-Only Programs

The participants recognized that although they were exposed to various lenses on OUD/SUD treatment, including harm reduction and abstinence-only, the prevailing model in treatment organizations is abstinence-only. Policies derived from this lens presented barriers to treatment persistence. For example, Hunter discussed how abstinence-only policies impacted pregnant clients and their continued treatment, particularly for those involved with the Department of Community Based Services which has oversight of child protective services, *Using when you're pregnant, it's really common, and our patients won't say something about it because they're afraid of their Department of Community Based Services in court and all that. And that's a barrier to treatment.*

From this perspective, clients were unable to get the type of treatment that allows them to fully disclose their current substance use patterns because they feared their children could be taken away based on criminalization of substance misuse.

Kenneth also noted the intersection of organizational and legal policies:

> Policy is written in a way of a complete abstinence … the first failed drug test, you're out of here. And so, when you have that barrier for our clients, you sit and you dwell on what am I going to do as soon as that happens because you know it's going to happen. You know that there's going to be slip-ups. You know that life happens, stressors and things like that. And early on in recovery, you're trying to negate these instances of, are they going to get taken to jail?

While some participants discussed how the likelihood of going to jail for substance-related offenses decreased during the COVID-19 pandemic due to spacing needs in jails, others identified how continued OUD/SUD criminalization policies made it difficult for clients to relapse and continue in treatment. Thus, criminalization policies are a barrier to persistence in treatment due to fear of reprisal from the legal system—it is easier to drop out of treatment than to worry about treatment provision revealing use.

Probation Policies

Further highlighting the policies that presented barriers to OUD/SUD treatment, participants also reflected the way probation rules and law enforcement policies impacted the treatment experiences. Evelyn shared, "I've had a couple of incidents where a client will be in treatment, and the law enforcement will be outside the door trying to take them from treatment for just a small violation months ago." She noted that the incarceration possibilities made the treatment setting less confidential or safe for clients than intended. Allen described how the drug court policies prevented his client from being able to complete her treatment process, so his organization advocated for a new option in her drug testing times:

> I had a client recently that this happened to, and she kept missing drug tests, and then we were able to provide a separate one that wasn't through drug court that showed her innocence. She hadn't tested positive, but she continuously was missing these drug tests early in the morning because she worked night shift. As a single times parent, she had all these things she had to meet, and this poor woman kept getting knocked back down to phase one because she kept missing drug tests.

Through the drug court system's policies, the client's drug tests needed to occur during specific times that were difficult, given the client's other

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obligations. However, this was a barrier to her treatment persistence because she could not progress beyond the first phase of treatment without an official negative test.

Given the organizational policy barriers and legal barriers clients face, the misalignment of the support systems related to these policies is likely. Participants observed how money and funding impacted the treatment experience as barriers as well. Kenneth shared, *Anybody that works in substance use knows that our policies are not written in legislation to be successful for these individuals*. This myriad of policy-related barriers was observed across multiple treatment settings. Participants indicated the value of their professional roles to advocate for new policies to better facilitate substance use treatment persistence.

Rurality

The majority of participants ($n = 17$) were in rural and underserved areas. While rurality is a well-documented barrier to accessing treatment, rurality also impacts treatment once engaged. Participants identified three ways in which rurality presented a barrier to treatment efficacy: "brain drain," multiple/dual relationships, and inadequate access.

The perception that rural areas were less likely to attract and retain the most educated clinicians was a barrier to treatment observed by these mental health participants. Many of them identified as coming from rural backgrounds, and a part of their desire to return to their communities after graduation was to resist the "brain drain," or the flight of the most educated community members from rural areas. Olivia said:

> The interventions and treatments that are available in those areas aren't typically very good because of the fact that there are less clinicians with higher degrees and, therefore, have less training in certain subjects or interventions like CBT [Cognitive Behavioral Therapy] and DBT [Dialectical Behavioral Therapy] and all these different interventions that we learn the more education and experience you get. But because of the less of pay and lack of options … people might not be getting the treatment that they could be.

This perceived barrier to treatment was closely related to the likelihood of multiple relationships because the clinicians who were interested in working in rural areas were also likely to be from those same areas. Thus, wanting to serve within one's rural community meant they may be treating people they knew. For example, Lena had a former high school classmate participate in group treatment with her, but knew it was a barrier despite boundary setting:

> Every week is just like a coming home meeting. It's like she just relates everything to when we were in high school. We were really close, but we led really different lives, and I feel like it kind of gives the other clients maybe a wrong impression of me … I think it's been more of an issue for me than her maybe. But I don't think she realizes that it's an issue.

From Lena's perspective, having a prior relationship with clients presents a barrier in rural areas because it can compromise the clinician's reputation with other clients or divert the focus from the present to the past.

The third barrier related to rurality was a lack of consistent engagement in treatment. While much has been made of bringing high-speed internet to rural areas and the use of virtual means to increase access to treatment, the use of those measures is still limited. The increase in telehealth services provided during COVID-19 shifted that somewhat, but not completely. For example, Paris noted, "The lack of access to internet. The lack of access to actual phone service … Yeah, access is still limited." Similarly, Olivia said, "Some (services) just are not available in rural areas, as opposed to urban areas."

Access to treatment can also entail a variety of treatment modalities and the ability to provide adequate treatment differentiation, both of which can serve as barriers for treatment efficacy. Specifically, student providers observed that each client's circumstances, cultural identities, and treatment needs differed, but treatment protocol typically minimized individuation. As Kenneth noted, *I think my biggest takeaway was that treatment for substance use disorder is not cookie cutter … It's got to be adaptive. It's got to be tailored to the individual. And it's got to work with that individual*. Allen agreed, saying:

> If you're doing group work, you have multiple individuals with different levels of readiness for change. And you add that to, like you said, there's so many different avenues that people can take, so many different roads to recovery and in the group setting, that's one of the biggest challenges for me, has been getting everyone kind of on the same page to where the group is functioning and going in directions.

Both participants referenced the limitations that are present in many OUD/SUD treatment

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facilities, despite the best intentions. The treatment options they were asked to provide for clients may not have met everyone's needs because of the number of clients being served at once. As discussed in the final theme, OUD/SUD treatment facilities went to great lengths to mitigate the compounded accessibility issues during COVID-19. However, the uptake of telehealth impacted engagement which remained a barrier for treatment persistence.

COVID-Related Adjustments

The participants were interviewed during the COVID-19 pandemic, which presented multiple barriers to treatment persistence. These participants specifically noted telehealth and stimulus money as barriers that emerged during the pandemic. These treatment barriers were uniquely created or exacerbated by the social distancing mandates and economic incentives.

Telehealth Difficulties

Telehealth difficulties were reported consistently, with several participants highlighting the differences between treatment access and treatment engagement. Nora noted:

> We did notice even if they were present, participation was lower. They wouldn't necessarily be in front of the screen participating, or they might be multitasking, like trying to drive and go do something, or hanging out with their friends … It kind of wasn't taken as serious to a lot of people, when it was telehealth, as compared to when those same people would come into the office, it was totally different. Fully participate, no distractions.

Lena agreed, stating:

> But it's kind of like a double-edged sword. So, it's increased show rate, for the company. But I don't think it's been beneficial for every program. Because like, with our IOP [intensive outpatient] program, we might have like 30 people in a group, three days a week, and they're from various counties, and it's impossible to keep up with that many faces on the screen. A lot of times, they will check-in for attendance, and then they turn their mic off, turn their cameras off, and they check out. So as far as personal growth, I feel like COVID has affected that, because of the disconnect between the client and the clinician.

In both of these situations, the clinicians observed the number of clients who could and did show up for OUD/SUD treatment increased, but the engagement decreased overall. In addition to the reduced engagement, participants noted the lack of personal connection was a barrier to treatment efficacy. For example, Mark said:

> The problem that I had as a clinician, is the level of therapeutic services that you're able to provide … is limited, because there's a lot that we are taught to identify and to really read a person's body language that you just can't see a lot of the times. It's like they're able to hide behind the computer monitor.

Participants described limited personal connections with clinicians and peers, which meant they missed important communication between group members. Thus, limited communication in virtual therapeutic settings served as an interpersonal barrier to effective treatment.

Stimulus Money

An unexpected side effect of the COVID-19 pandemic that presented a barrier to treatment was the receipt of stimulus checks from the government. Jennifer said:

> I think the whole pandemic and the way that it's been handled has been the perfect storm of triggers for our clients. I work at the IOP [intensive outpatient], and something my clients told me is that not only were they isolated, not only were they bored, but they also have the stimulus checks coming in, which was a huge trigger for a lot of them. Just having that cash that nobody was keeping tabs on … that alone was really triggering for some of them.

Hunter observed a similar dynamic at his practicum site:

> All the mothers that I work with, they have at least one kid, some five or six. And so when we were getting the checks and it was per person, some of these women were getting five, $6,000. And they go from being homeless or in jail, in our treatment setting you get 28 days and then they walk out, they get their phone, their dealers were messaging them, sometimes ex boyfriends, things like that. And then they've got $6,000 to spend.

For some, stimulus checks were more money than many clients typically accessed. Economic support was a barrier to remaining in treatment because clients had funds to purchase substances, and the drug dealers in their communities were aware that most people received stimulus checks, so they were reaching out to sell drugs to them despite their being in treatment. Overall, by detailing these perceived barriers to effective OUD/SUD treatment, participants provided important insights into the ways treatment can be improved to ensure persistence.

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Discussion

While barriers to accessing treatment are well identified, these exploratory data indicate those same barriers persist even once in treatment and impact persistence and outcomes. Participants reflected on several barriers they perceived impacted OUD/SUD treatment, from initiation to completion and treatment efficacy and outcomes.

Rurality presented unique and persistent barriers for the clients these student providers served. The intimacy of rural communities can often present role conflicts as peers and family members seek treatment. The reputation of the clinician in the rural community can pose barriers. Many people who formerly used substances and are in recovery are motivated to help others have successful outcomes as well. But in rural communities, this can pose a particular issue if residents remember the former use rather than the current professional. Additionally, client presence in an agency setting can also influence perceptions about the provider and potentially limit access if prospective clients perceive treatment success based upon their knowledge of others who are attending with that same facility or clinician.

Cultural considerations for OUD/SUD treatment in rural communities should facilitate treatment based on individual needs. Relative assumed homogeneity in rural communities can be deceptive in not allowing aspects of diversity to be addressed. For instance, group therapy is a frequent choice of intervention in OUD/SUD treatment and can help support sobriety while also addressing isolation and stigma. However, in rural communities, due to limited numbers and overlapping relationships between clients, group treatment may be more generalized rather than able to specifically target individual needs or motivation for change. Tailoring treatment in a group setting is important but can be undermined by funding sources that prefer group treatment as a recovery tool due to the fiscal practicality (Steinberg et al., 2021).

An important consideration from these experiences is that some of the same barriers to accessing treatment remained barriers throughout treatment and subsequently impacted outcomes. For instance, telehealth helps mitigate limited access to treatment for those who have adequate internet or phone capacity, which is particularly important for clients in rural locales. However, telehealth also allows a decreased level of engagement during treatment as clients may not be actively attending to treatment through their audio or video. This simultaneous benefit with associated challenges creates reported provider ambivalence in the use of telehealth. Additionally, access to high-speed internet that allows video engagement is not always available nor affordable in rural areas, even through cell phones, which may not or may not have service in all areas. The barrier of accessing treatment is mitigated for those with access to telehealth but remains present as engagement, and thus outcomes may be impacted by the identified solution to the barrier.

Additionally, an incentive for participation in treatment was impacted by client-specific, ongoing needs such as employment, parenting, and economic impacts. One unanticipated deterrent on sustaining treatment was receiving stimulus checks during the COVID-19 shutdown, as many clients felt a sense of urgency to ensure the stimulus check was spent as they wanted rather than being spent by others who may have access to the funds. Clients also experienced pressure by dealers who tried to take advantage of the additional income, increasing stress and ready access for recidivism.

Another identified barrier to access and ongoing treatment was policy. Criminal justice policy, or lack thereof, is a significant barrier to accessing treatment and rarely contributes to the desired outcome of sobriety, even for court-mandated clients. Fear of reprisal, if use is known, can be a deterrent to accessing treatment. However, policies also continue to present barriers once in treatment. The lack of oversight of facilities such as sober living houses contributes to the recidivistic cycle of prison re-entry for formerly incarcerated individuals. Additionally, harsh penalties for substance possession are stigmatizing (Tyndall, 2019), while probation and parole policies do not allow for recidivism or relapse, which are common in OUD/SUD treatment (MacLean & Packer, 2019; Phelps et al., 2022). Child welfare policies have also resulted in a significant increase in children being placed in foster care due to parental substance misuse, with rural children (particularly infants and toddlers) being the most vulnerable (Sieger & Becker, 2020; United States Children's Bureau, 2021). However, these policies create a barrier to treatment as parents cannot effectively engage in treatment without fear of compromising their child's stability. Policy has not kept pace with

substance misuse treatment practices and remains a deterrent to care. Multidisciplinary approaches to treatment can help address some of these concerns as multiple professionals engage to support the recovery process.

Clinical Relevance

Mitigating barriers to OUD/SUD treatment persistence, particularly in rural communities, is important to effectively address treatment needs. Understanding the ongoing support needed for clients to address barriers once engaged in treatment is critical to treatment persistence and outcomes. Rural communities present with a unique culture that can impact access and outcomes of treatment. Many providers in a rural community are from that area, resulting in unique boundary testing—for instance, having a good friend from high school present for treatment or, especially for those practitioners in recovery, having a client be aware of former use by the clinician. These seeming boundary violations can also provide empathy and awareness, as well as the knowledge that recovery is possible, thus helping to reduce isolation. Navigating these boundaries so as to not impact outcomes or violate ethical principles is a vital aspect of clinical treatment which is important as providers who are from the rural community are often perceived as desirable in comparison to someone from outside of the community.

An additional consideration for clinical practice in rural OUD/SUD settings is the stigma that remains present even after entering treatment. While internalized stigma is common across all settings, rural communities can manifest that stigma in differing ways than in more urban settings. For instance, a community may oppose a MAT clinic or a harm reduction facility, despite the efficacy of the treatment approaches, due to the stigma associated with MAT's role in recovery. Similarly, having sober living facilities can depend on zoning laws and may face opposition from local residential neighborhoods, again, limiting access to therapeutic necessities like stable housing.

Finally, clinical implications reflect the complexities of life for clients. Clinicians must view the client holistically to allow the nuances that are present in everyday life to be acknowledged and supported in treatment. Practitioners must be aware of associated parenting responsibilities, employment, housing stability, criminal justice or other system involvement, and associated mental health needs to ensure treatment outcomes are met. Facilities that solely focus on sobriety may not address these concomitant needs. Therefore, ensuring treatment is individualized, even when conducted in group settings, is an important reminder. The use of multidisciplinary approaches can help address these concerns in support of the recovery process.

Limitations

One limitation of identifying barriers to effective OUD/SUD treatment is the use of the lens of the practitioner trainees, as barriers may not be perceived similarly by clients. Additionally, all participants were in a Southeastern, largely rural state where the majority of the counties are identified as having insufficient OUD/SUD providers. Finally, the experiences in these rural treatment settings may not be transferrable or ubiquitously true in other settings.

Conclusion

Mitigating barriers to OUD/SUD treatment, particularly in rural communities, is important to effectively address treatment needs, as many barriers impacting accessibility to treatment remain as barriers to treatment persistence. Simply navigating these barriers to enter treatment does not assuage them. Understanding the ongoing support needed for clients to address barriers once engaged in treatment is critical to treatment persistence. Current policies across system-involved clients, regardless of whether criminal justice or public child welfare systems, are not sufficient to support treatment persistence and may act as deterrents. Recognizing and addressing the identified barriers, particularly those with macro or community-level impacts, better positions clients for successful outcomes.

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