National Report

Rural Substance Use Disorder Stigma and Treatment Needs

Center on Rural Addiction
UNIVERSITY OF VERMONT

Prepared by the UVM Center on Rural Addiction
Surveillance & Evaluation Core

September 2023

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Acronyms

HRSA: Health Resources & Services Administration

MOUD: Medications for Opioid Use Disorder

OUD: Opioid Use Disorder

RCORP: Rural Communities Opioid Response Program

SUD: Substance Use Disorder

UVM CORA: The University of Vermont Center on Rural Addiction

Executive Summary

The University of Vermont Center on Rural Addiction (UVM CORA) aims to expand substance use disorder (SUD) treatment capacity in rural communities by providing consultation, resources, and evidence-based technical assistance to healthcare providers and community partners. This national rural SUD stigma and treatment needs assessment explores SUD stigma as well as SUD treatment needs and barriers through the experiences and perspectives of rural practitioners.

In June 2023, the three Health Resources and Services Administration (HRSA) Rural Centers of Excellence on Substance Use Disorders (UVM CORA, the University of Rochester, and the Fletcher Group), conducted an online survey of practitioners affiliated with HRSA Rural Communities Opioid Response Program (RCORP) grant sites throughout the country. We invited 794 practitioners to participate and received 303 responses (response rate: 38%) including 257 practitioners in 42 states and Puerto Rico who reported directly serving patients at the time of the survey and were thus eligible to participate. These 257 eligible respondents included 147 practitioners in counseling roles (e.g., counselor, case manager) and 110 practitioners in clinical roles (e.g., physician, nurse practitioner). Of the practitioners in clinical roles, 75% were able to prescribe medications (e.g., MD, NP), 83% of whom reported currently prescribing medications for opioid use disorder (MOUD). Practitioners reported high comfort treating patients with opioid use disorder (OUD; mean=8.6; scale 0–10) and stimulant use disorder (mean=7.6). Among special populations with SUDs, practitioners reported the greatest comfort treating older adults (mean=8.1) and the least comfort treating adolescents (mean=5.5).

Overall, practitioner respondents reported experiencing positive emotions (i.e., low stigma) toward people with OUD (mean=61; scale 10–70[1]). Most practitioners (73%) *agreed* that MOUD are the most effective way to treat OUD. Similarly, most practitioners (72%) *did not agree* that MOUD replace addiction to one substance with another. While practitioners reported experiencing low stigma when interacting with people with OUD, they endorsed stigma as a top barrier to providing OUD treatment, with nearly half endorsing stigma among the top barriers to treating patients with OUD (48%) and to patients receiving OUD treatment (45%). The other most frequently reported barriers were time and staffing constraints (53%; practitioner barriers to providing OUD treatment), and time, transportation, housing, and other supports (83%; patient barriers to receiving OUD treatment).

Practitioners reported using both preferred (i.e., non-stigmatizing) and non-preferred (i.e., potentially stigmatizing) SUD terms[2] in clinical settings, with most non-preferred terms used by fewer than a quarter of practitioners. Our findings highlight opportunities for education in clinical settings to reduce stigma associated with OUD and OUD treatment. For more information about stigma and SUDs please visit recoverycenterofexcellence.org/stigma-collaboration.

[1] Brown SA. Standardized measures for substance use stigma. *Drug Alcohol Depend*. 2011;116 (1-3): 137-141. Affect Scale for substance use disorder; scale range: 10 (negative emotions/ high stigma – 70 (positive emotions/low stigma).

[2] For more information about preferred and non-preferred terms, please see the National Institute on Drug Abuse (NIDA)'s Words Matter.

Background

UVM CORA seeks to expand SUD treatment capacity in rural communities by providing consultation, resources, and evidence-based technical assistance to healthcare providers and community partners. With our national rural SUD stigma and treatment needs assessment, we explored rural practitioners' beliefs about SUDs and perspectives on SUD stigma as well as SUD treatment needs and barriers in rural areas.

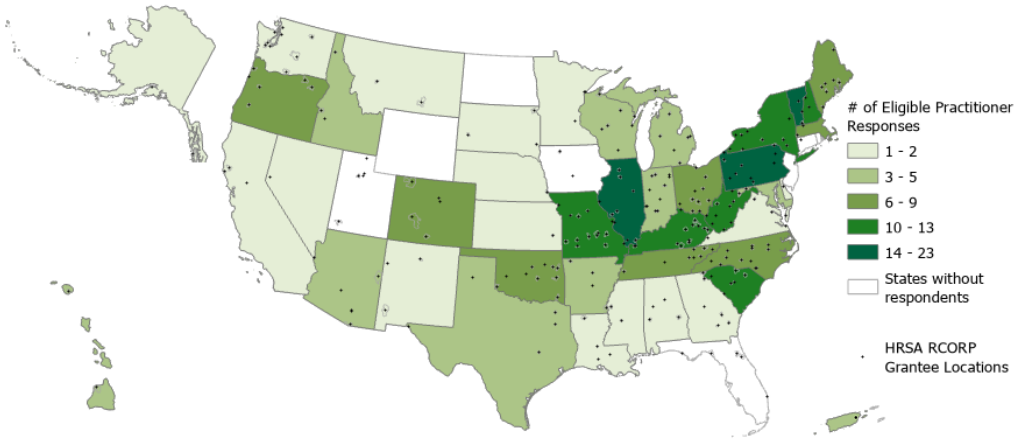
Areas addressed in the survey:

- Substance use concerns
- Barriers to SUD treatment
- Comfort treating SUDs
- Beliefs about SUDs and treatment
- Stigma toward people with SUDs
- Stigmatizing and non-stigmatizing language used in clinical practice

Methods

UVM CORA conducted an online needs assessment survey (June 1-30, 2023) in partnership with the two other HRSA-funded RCORP Rural Centers of Excellence (the University of Rochester and the Fletcher Group). We collected contact information for practitioners affiliated with HRSA RCORP grant sites throughout the country via contact surveys distributed to RCORP project directors. The needs assessment survey was distributed via email to 794 practitioners followed by weekly reminders throughout the duration of the survey. We received 303 survey responses (response rate: 38%), 257 of which were from practitioners currently working in roles directly serving patients and were thus eligible to participate. We received responses from 42 states and Puerto Rico (**Figure 1**).

Figure 1. Geographic Distribution of Practitioner Respondents



Practitioner Respondents

Demographics & Professional Roles

Practitioner respondents were primarily white (91%), non-Hispanic (94%), and female (75%), with a mean age of 46 (**Table 1**). Respondents included 147 practitioners in counseling roles (e.g., counselor, case manager) and 110 practitioners in clinical roles (e.g., physician, nurse practitioner; **Table 2**). Of the practitioners in clinical roles, 82 worked in roles able to prescribe medications (i.e., MD, DO, NP, PA), 68 of whom reported currently prescribing MOUD to patients **(Table 1)**.

Table 1. Practitioner Demographics

	Clinicians	Counselors	All
Practitioner respondents – n (%)	**110 (43%)**	**147 (57%)**	**257 (100%)**
Age – mean (range)	49 (28–77)	44 (23–68)	46 (23–77)
Female – n (%)	74 (67%)	118 (80%)	192 (75%)
White – n (%)	102 (93%)	131 (89%)	233 (91%)
Non-Hispanic – n (%)	104 (95%)	137 (93%)	241 (94%)
Prescribing Clinicians† – n (%)	82 (75%)	N/A	82 (32%)
Prescribing clinicians currently treating patients with medications for opioid use disorder – n (%)	68 (62%)	N/A	68 (26%)

† See **Table 2.** for clinical roles able to prescribe medications (i.e., prescribing clinicians).

Table 2. Professional Roles

Clinical Roles	110 (43%)	Counseling Roles	147 (57%)
Nurse Practitioner†	34 (13%)	Alcohol and Drug Counselor	45 (18%)
Nurse	19 (7%)	Mental Health Counselor	27 (11%)
Primary Care Physician†	19 (7%)	Recovery Coach/Peer Support	24 (9%)
Specialist Physician†	15 (6%)	Case Manager	20 (8%)
Physician Assistant†	12 (5%)	Social Worker	19 (7%)
Certified Nurse Midwife†	2 (1%)	Psychologist	5 (2%)
Paramedic	1 (<1%)	Other Counseling Role	7 (3%)
Pharmacist	1 (<1%)		
Other Clinical Role	7 (3%)		

† Clinical roles able to prescribe medications (i.e., prescribing clinicians)

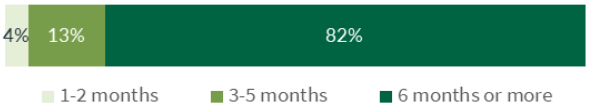
Practitioner Respondents
Work Settings & MOUD Treatment

Most practitioners (84%) worked in clinical settings, including 22% in SUD treatment settings, 21% in Federally Qualified Health Centers, and 16% in mental or behavioral health organizations (**Table 3**).

The median number of patients served by practitioners per week for all reasons was 50 for clinicians and 20 for counselors. Among clinicians who reported currently treating patients with MOUD, the median number of MOUD patients treated at any given time was 50 (*data not shown*).

Overall, practitioners currently treating patients with MOUD reported moderate difficulty (mean=5; scale 0–10) retaining patients in MOUD treatment and moderate concern (mean=6) about their patients not taking their MOUD as prescribed (*data not shown*). Most practitioners (82%) reported that their patients generally receive MOUD for six months or longer (**Figure 2**).

Figure 2. Average Duration of MOUD Treatment



Buprenorphine was the most frequently prescribed MOUD (99%) followed by naltrexone (74%) (**Table 4**).

Table 3. Work Settings

	n (%)
Clinical Settings	**217 (84%)**
SUD Treatment Setting	56 (22%)
Federally Qualified Health Center	54 (21%)
Mental or Behavioral Health Organization	40 (16%)
Rural Health Clinic	20 (8%)
Hospital	19 (7%)
Opioid Treatment Program	9 (4%)
Primary Care Practice	8 (3%)
Tribal Health Center	7 (3%)
Federally Qualified Health Center Look-Alike	3 (1%)
Other Clinical Setting	1 (<1%)
Community Settings	**40 (16%)**
Recovery Community Organization	9 (4%)
Local or State Health Department	7 (3%)
School System or Higher Education	6 (2%)
Emergency Medical Services	3 (1%)
Correctional Setting	3 (1%)
HIV and HCV Prevention Organization	1 (<1%)
Other Community Setting	11 (4%)
Total	**257 (100%)**

Table 4. MOUD Prescribed

	n* (%)
Buprenorphine	67 (99%)
Naltrexone	50 (74%)
Methadone	7 (10%)

* n=68 prescribing clinicians currently treating patients with Medications for Opioid Use Disorder (MOUD; see **Table 1**).

Note: MOUD are not mutually exclusive.

Comfort Treating SUDs

Overall, practitioners reported high levels of comfort (scale 0–10) treating patients with OUD (clinician mean=8.7; counselor mean=8.6; **Figure 3**). Practitioners reported moderate to high levels of comfort treating patients with stimulant use disorder (clinician mean=7.0; counselor mean=8.1; **Figure 3**). Practitioners who currently prescribe MOUD generally felt they had the training, experience, and support to induct patients on MOUD treatment (mean=8.5; *data not shown*).

When asked about special populations with SUDs, practitioners reported the most comfort treating older adults (mean=8.1) and the least comfort treating adolescents (mean=5.5; **Figure 4**).

Figure 3. Mean Level of Comfort (Scale 0–10) Treating Opioid Use Disorder and Stimulant Use Disorder

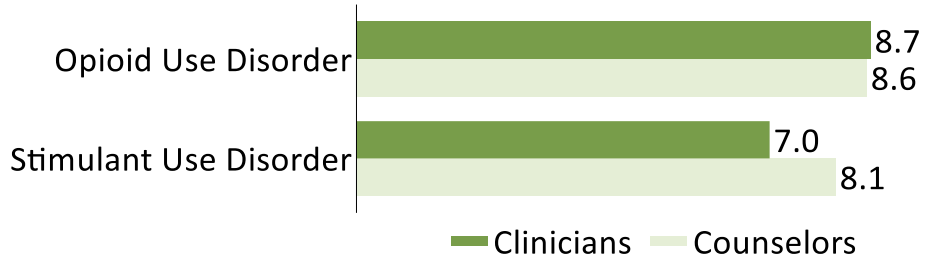
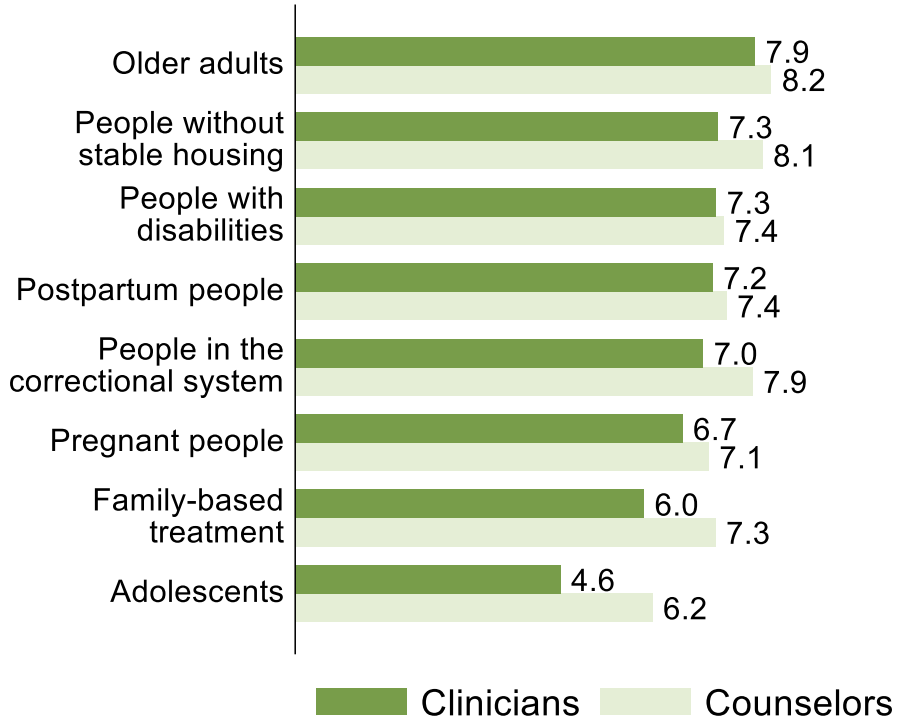


Figure 4. Mean Level of Comfort (Scale 0–10) Providing Substance Use Disorder Services to Special Populations



Practitioner Stigma

Overall, practitioner respondents reported experiencing positive emotions (i.e., low stigma) toward people with OUD (mean=61; scale 10–70; **Figure 5**) and toward people with stimulant use disorder (mean=59; **Figure 6**) as measured using the Affect Scale for SUDs, in which respondents rated 10 opposing emotion pairs on a 1–7 scale. Responses to each pair were summed for a score of 10–70 with 10 representing negative emotions (i.e., high stigma) and 70 representing positive emotions (i.e., low stigma). The Affect Scale has been validated to assess SUD stigma (Brown, 2011).[1]

Figure 5. Practitioner Affect Ratings When Interacting With A Person With Opioid Use Disorder

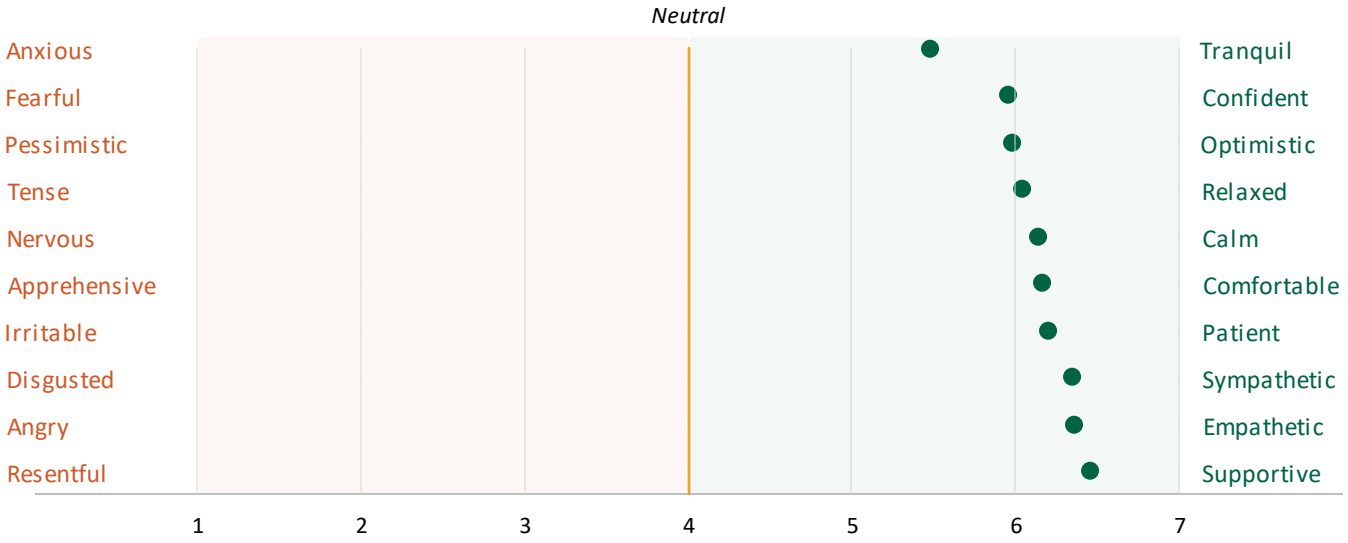
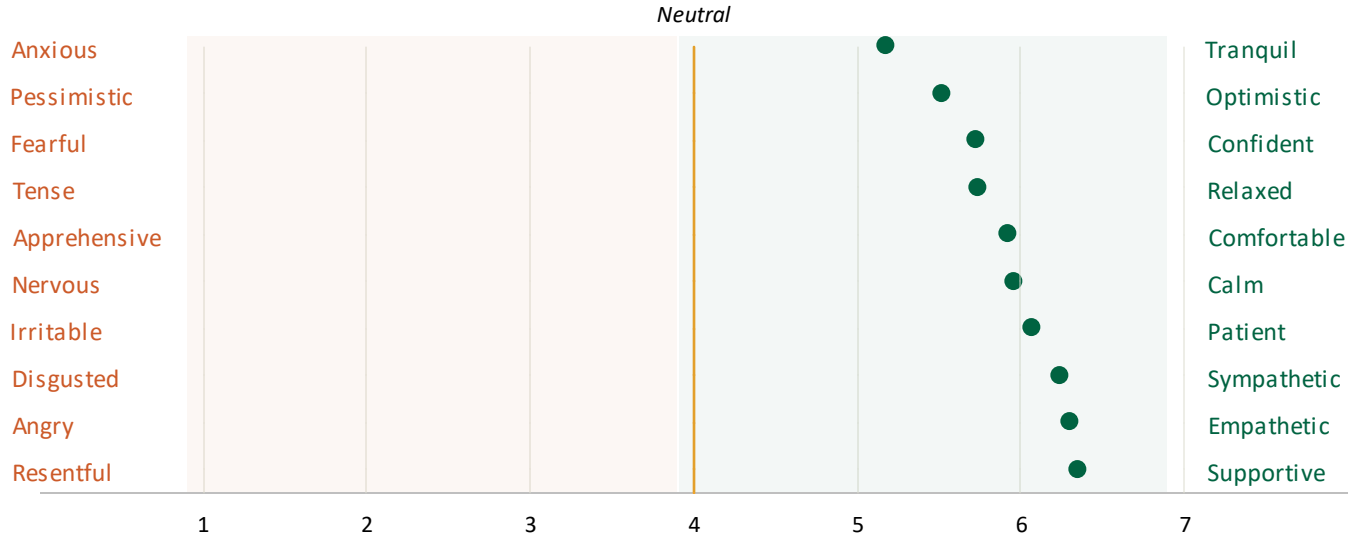


Figure 6. Practitioner Affect Ratings When Interacting With A Person With Stimulant Use Disorder



[1] Brown SA. Standardized measures for substance use stigma. *Drug Alcohol Depend.* 2011;116(1-3):137-141.

Use of Stigmatizing Language

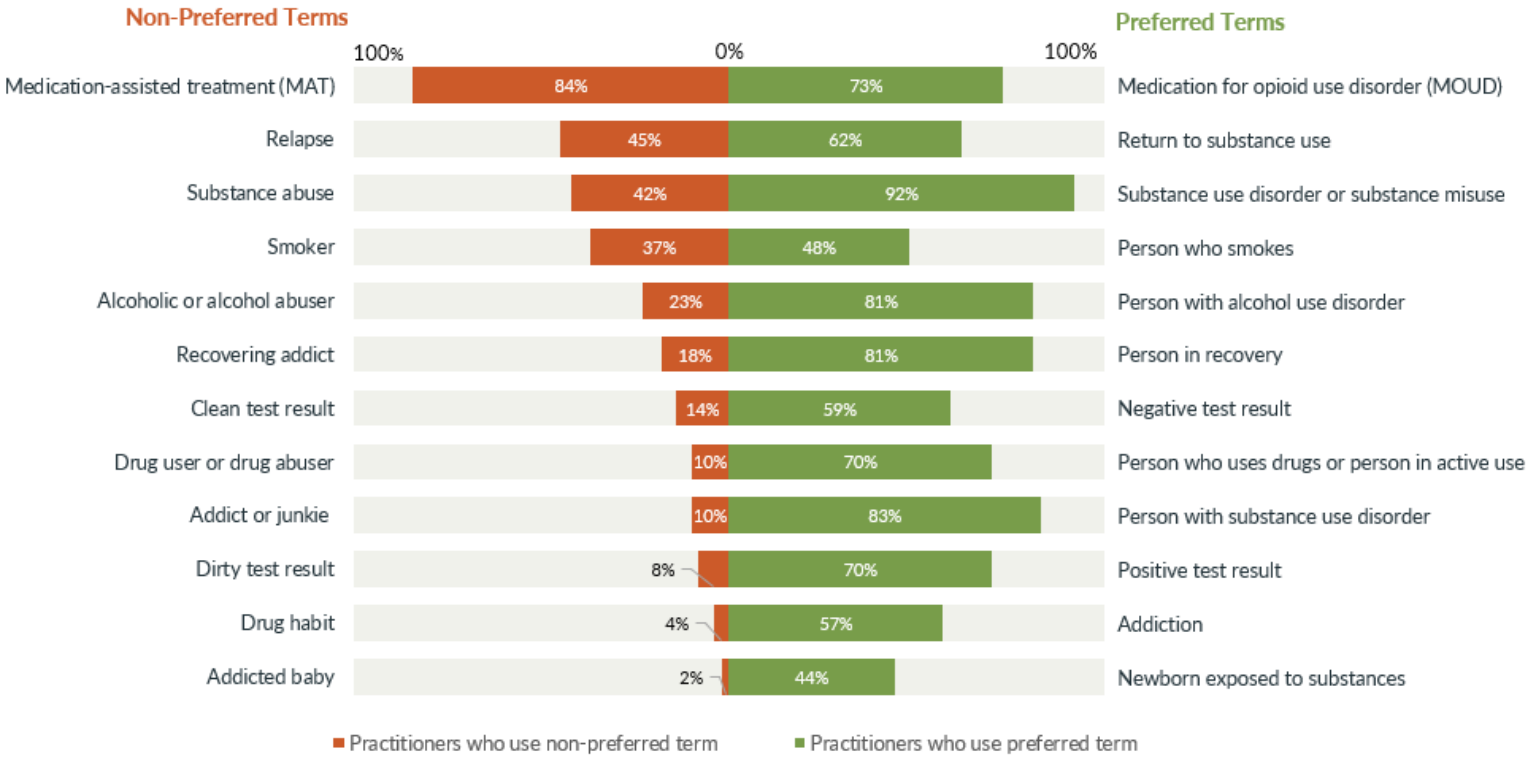
All Practitioners

Practitioners reported using both preferred (i.e., non-stigmatizing) and non-preferred (i.e., potentially stigmatizing) SUD terms in clinical settings. The most commonly used non-preferred term was "medication-assisted treatment (MAT)" (87%). While many people continue to use the term "MAT," in recent years the National Institute on Drug Abuse (NIDA) and others have recommended replacing it with "MOUD."[2] Other frequently used non-preferred terms included substance abuse or misuse (70%), and relapse (57%), although most non-preferred terms were used by fewer than a quarter of practitioners.

A greater proportion of clinicians (37%; **Figure 7**) as compared to counselors (19%; **Figure 8**) reported using the non-preferred term "smoker" in clinical settings ($p<0.01$), whereas a greater proportion of counselors (65%; **Figure 8**) than clinicians (45%; **Figure 7**) reported using the non-preferred term "relapse" in clinical settings ($p<0.01$).

Clinicians

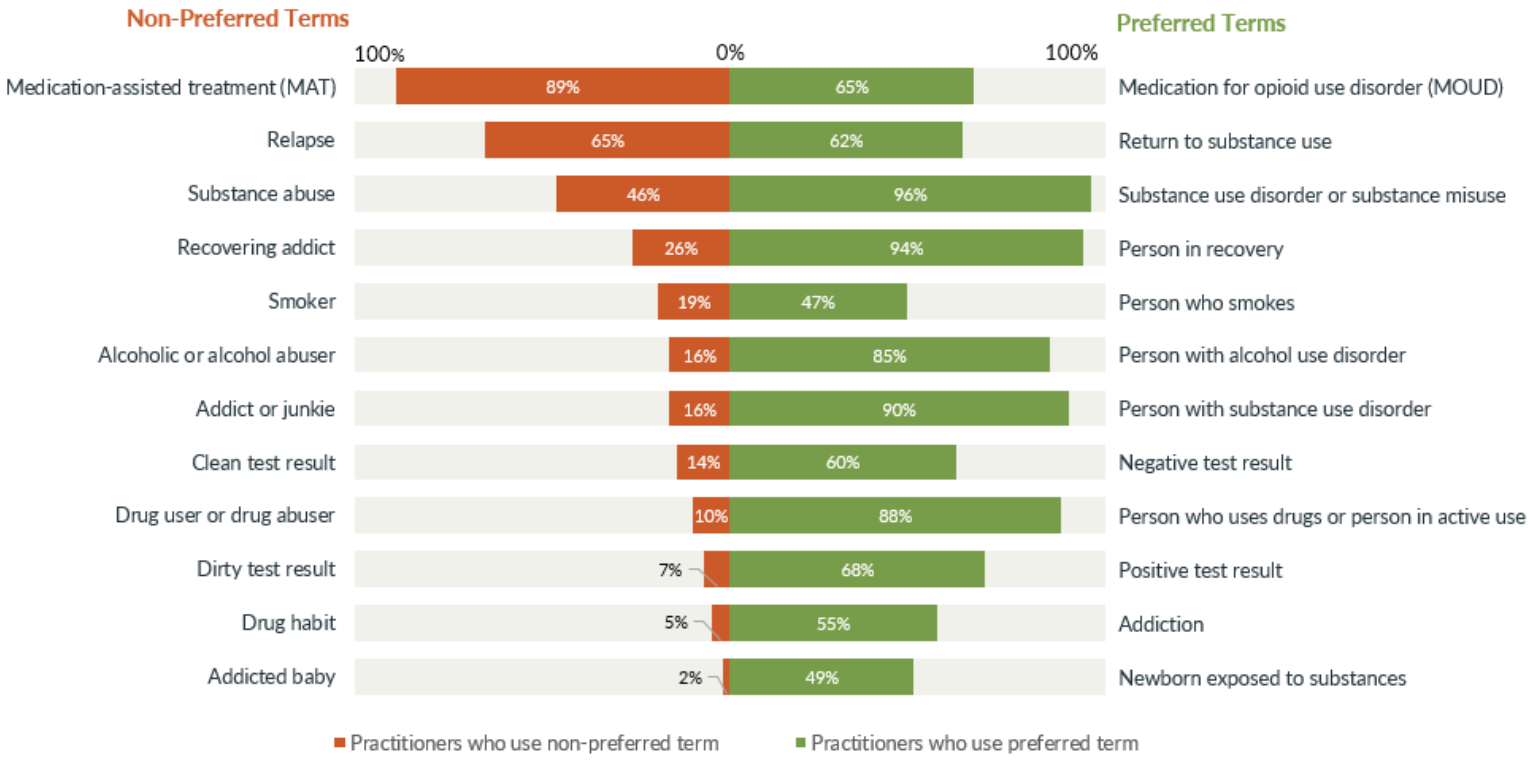
Figure 7. Proportion of Clinicians Who Report Using Preferred and Non-Preferred Terms in Professional Settings



[2] For more information about preferred and non-preferred terms, please see the National Institute on Drug Abuse (NIDA)'s Words Matter.

Use of Stigmatizing Language
Counselors

Figure 8. Proportion of Counselors Who Report Using Preferred and Non-Preferred Terms in Professional Settings



Some practitioners described practitioner stigma, including stigmatizing language and need for stigma reduction education and training, in their open-ended survey responses (see example quotes below).

> *"[A challenge is] seeing stigma and addressing it. Understanding my own bias and addressing that, changing my vocabulary."*

> *"[We need] stigma reduction courses for practitioners."*

Practitioner Beliefs

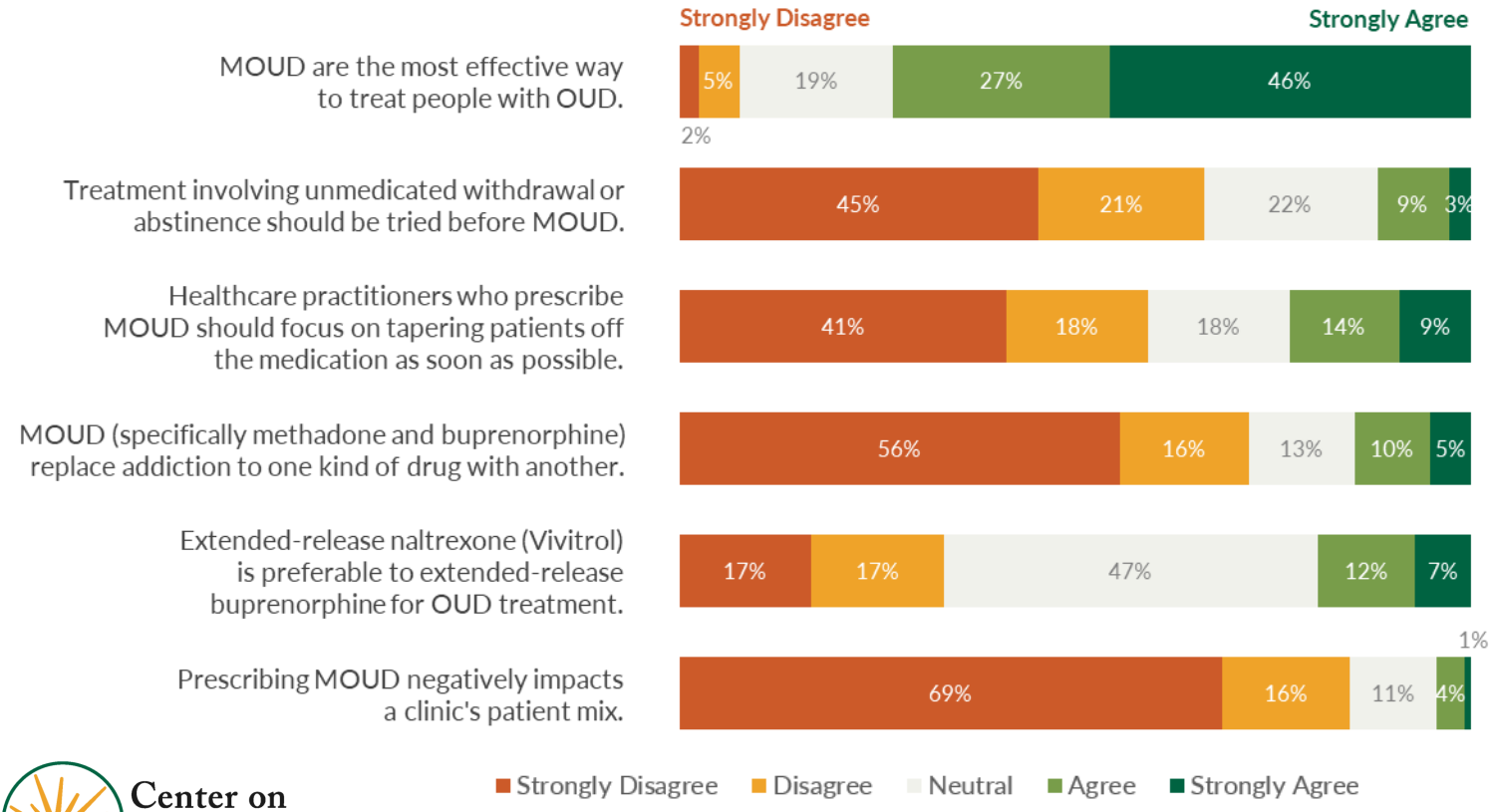
Medications for Opioid Use Disorder

Most practitioners *agreed* that MOUD are the most effective way to treat people with OUD (73%; **Figure 9**) and *disagreed* that treatment involving unmedicated withdrawal or abstinence should be tried before MOUD (66%). More than half of practitioners *disagreed* that MOUD prescribers should focus on tapering patients off MOUD as soon as possible (59%). Nearly half of practitioners *neither agreed nor disagreed* that extended-release naltrexone is preferable to extended-release buprenorphine for OUD treatment (47%).

While most practitioners *disagreed* that MOUD replace addiction to one kind of drug with another (72%; **Figure 9**), one in six *agreed* with this statement (15%). Some practitioners noted concerns about this belief in their open-ended survey responses (see example quote at right). A handful of practitioners *agreed* that prescribing MOUD negatively impacts a clinic's patient mix (5%).

> ***"[A challenge is] the stigma in our community and people not believing that MAT treatment can be successful. It seems to be a belief by our community that the person is just changing one addiction for another."***

Figure 9. Practitioner Beliefs About Medications for Opioid Use Disorder



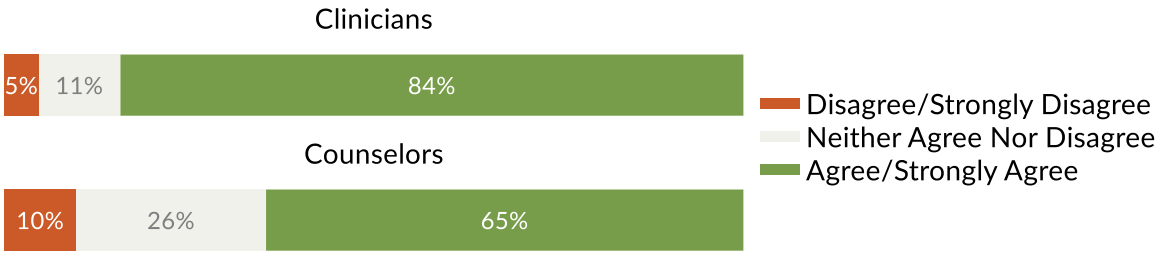
Practitioner Beliefs

Medications for Opioid Use Disorder

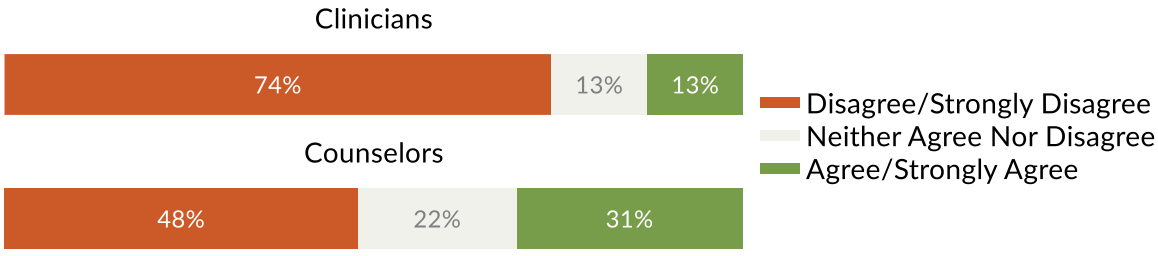
A greater proportion of clinicians than counselors *agreed* or *strongly agreed* that MOUD are the most effective way to treat people with OUD (84% vs. 65%; p<0.01; **Figure 10**) and *disagreed* or *strongly disagreed* that practitioners should focus on tapering patients off MOUD as soon as possible (74% vs. 48%; p <0.01) and that extended-release naltrexone is preferable to extended-release buprenorphine for OUD treatment (45% vs. 24%; p<0.01).

Figure 10. Significant differences between clinicians and counselors regarding beliefs about opioid use disorder.

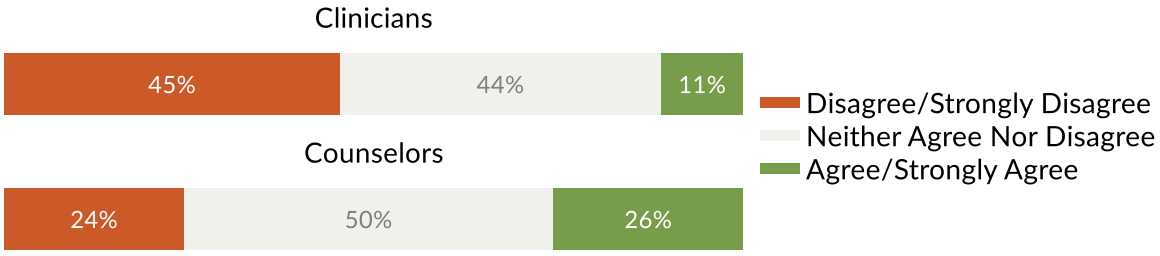
"MOUD are the most effective way to treat people with OUD."



"Practitioners should focus on tapering patients off MOUD as soon as possible."



"Extended-release naltrexone is preferable to extended-release buprenorphine for OUD treatment."



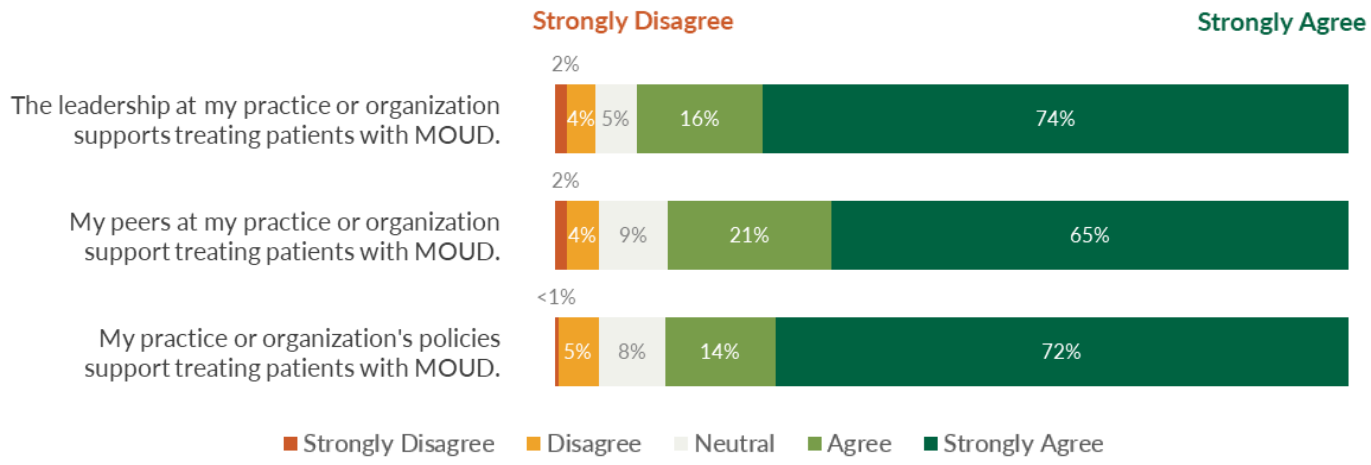
Practitioner Beliefs

Institutional Support for Treatment With MOUD

Practitioners generally reported institutional and peer support for treatment of patients with MOUD, with most practitioners *agreeing* or *strongly agreeing* that the leadership at their practice or organization supports treating patients with MOUD (90%), that their peers at their practice or organization support treating patients with MOUD (86%), and that their practice or organization's policies support treating patients with MOUD (86%; **Figure 11**). However, some practitioners expressed a need for additional institutional support in their open-ended survey responses (see example quotes at right and below).

> ***"[We need] hospital leadership to care about improving care for people who use drugs."***

Figure 11. Institutional Support for Opioid Use Disorder Treatment



> ***"[We need to] spread the knowledge about how easy it is to provide this therapy. I'm a [specialist], and I went into this field with worry and trepidation, only to realize how easy this is."***

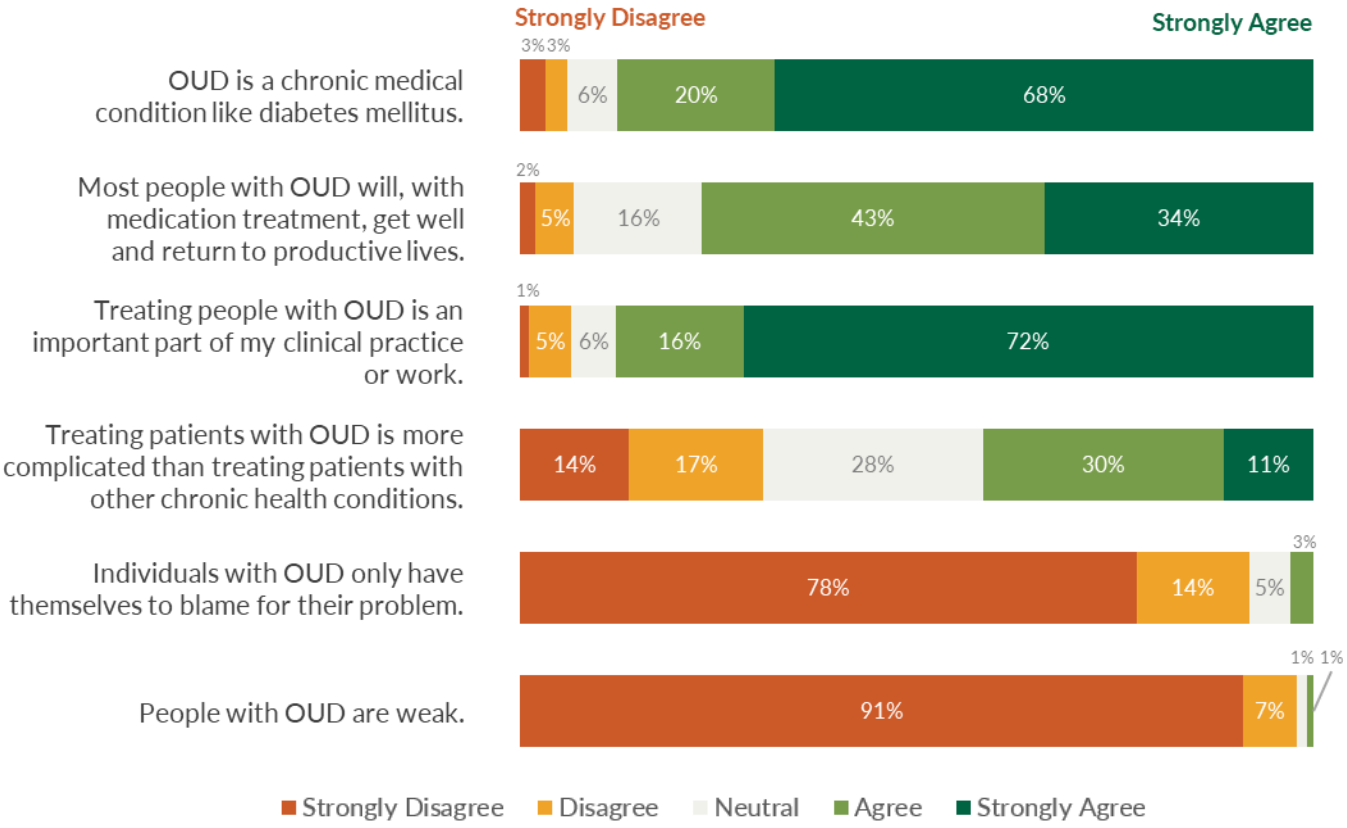
Practitioner Beliefs
Opioid Use Disorder

Most practitioners *agreed* or *strongly agreed* that OUD is a chronic medical condition (88%; **Figure 12**), and that most people with OUD will, with medication treatment, get well and return to productive lives (77%). Overall, practitioners reported that treating people with OUD is an important part of their clinical practice or work (88%).

Practitioners reported a range of beliefs regarding whether treating patients with OUD is more complicated than treating patients with other chronic health conditions, with 42% *agreeing*, 28% *neither agreeing nor disagreeing*, and 31% *disagreeing*.

Practitioners largely *disagreed* with the stigmatizing statements that individuals with OUD only have themselves to blame for their problem (92%) or are weak (98%), although a handful of respondents *agreed* with these statements.

Figure 12. Practitioner Beliefs About Opioid Use Disorder

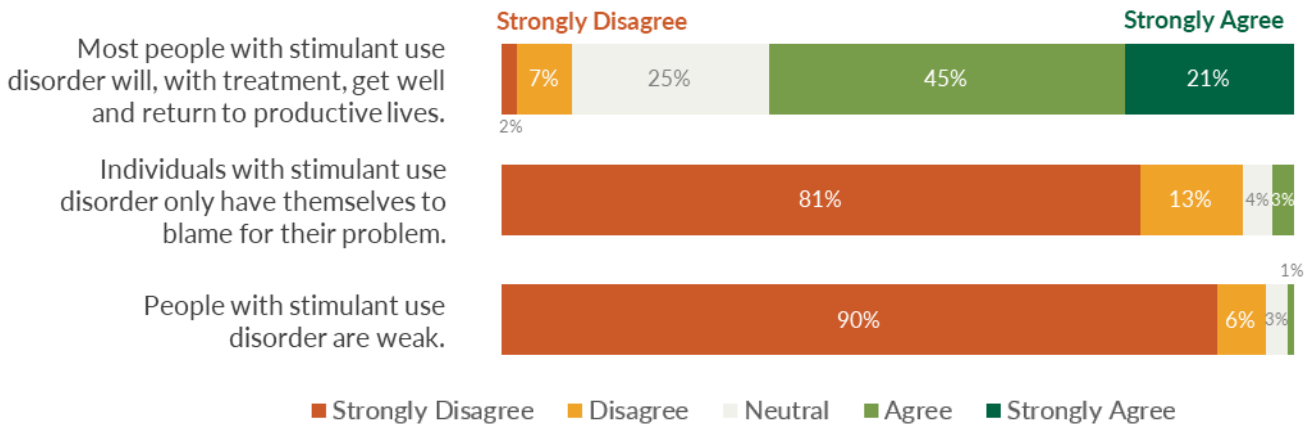


Practitioner Beliefs
Stimulant Use Disorder

Two thirds of practitioners *agreed* that most people with stimulant use disorder will, with medication treatment, get well and return to productive lives (66%; **Figure 13**).

Practitioners largely *disagreed* with the stigmatizing statements that individuals with stimulant use disorder only have themselves to blame for their problem (94%) or are weak (96%), although a handful of respondents *agreed* with these statements.

Figure 13. Practitioner Beliefs About Stimulant Use Disorder

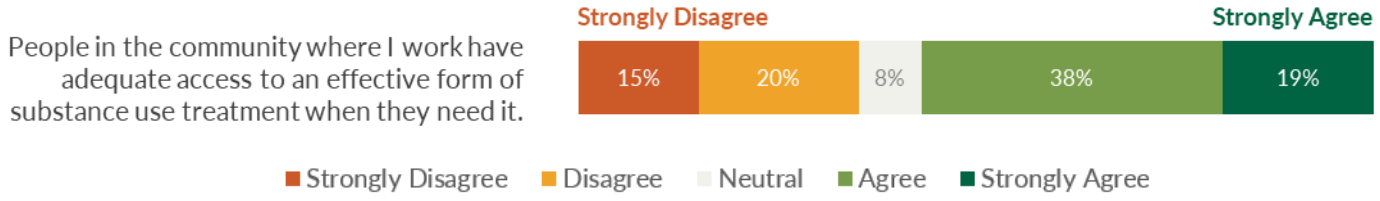


Practitioner Beliefs

Access to Substance Use Disorder Treatment

Over half of practitioners *agreed* that people in the community where they work have adequate access to an effective form of SUD treatment when they need it (57%; **Figure 14**).

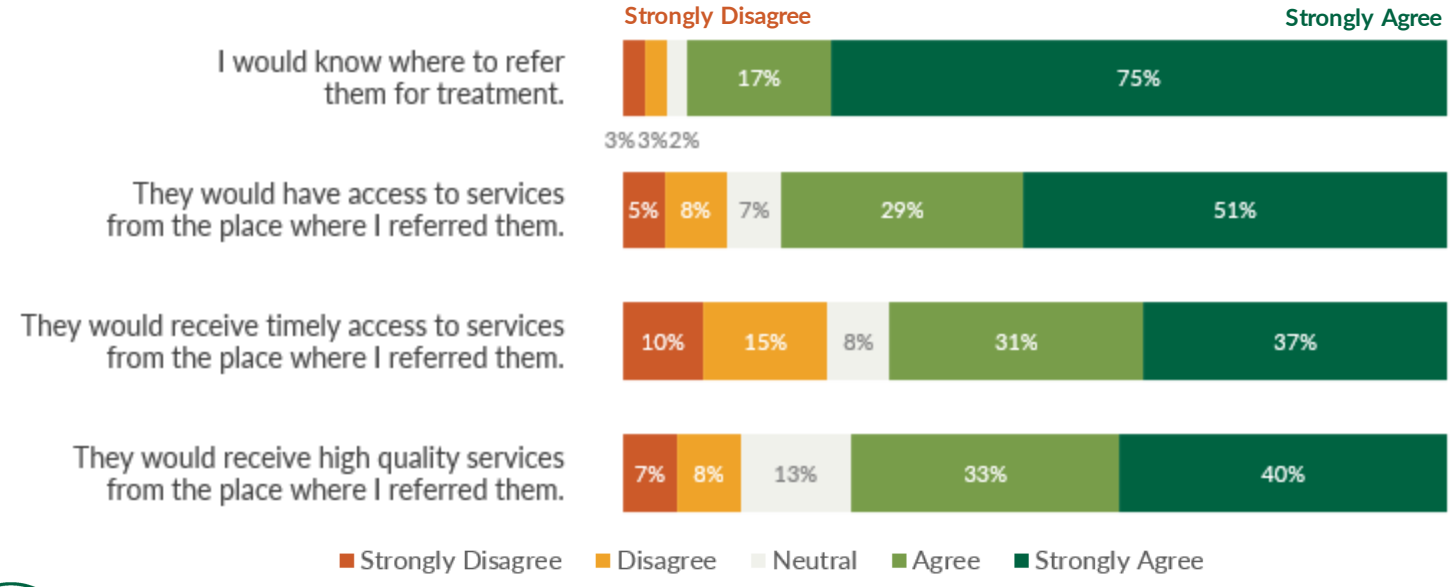
Figure 14. Practitioner Beliefs About Access to Effective Substance Use Disorder Treatment



Access to Opioid Use Disorder Treatment

Most practitioners reported knowing where to refer people for OUD treatment (92%) and *agreed* that patients would be able to access services (80%), would receive timely access to services (68%), and would receive high quality services (73%) at the location to which they were referred (**Figure 15**).

Figure 15. Practitioner Beliefs About Access to Opioid Use Disorder Treatment



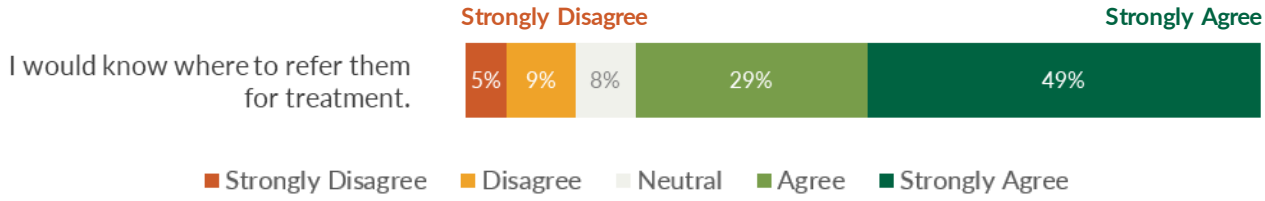
Practitioner Beliefs

Access to Stimulant Use Disorder Treatment

Three quarters of practitioners reported knowing where to refer patients for stimulant use disorder treatment (78%; **Figure 16**).

Figure 16. Practitioner Beliefs About Access to Stimulant Use Disorder Treatment

If a person came to me and confided that they were experiencing stimulant use disorder, I feel confident that:

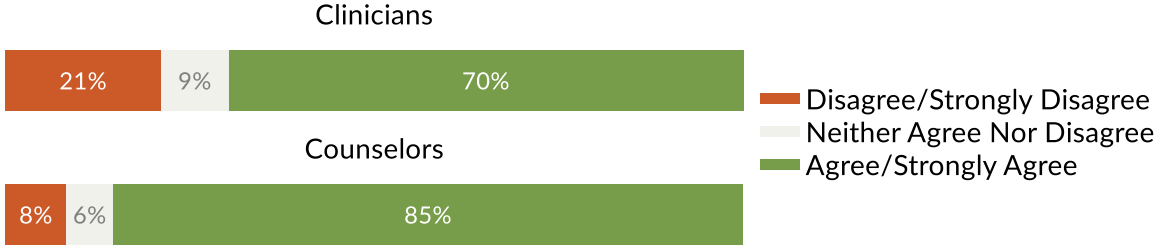


> *"[We need] more focus on stimulant use disorders... as this has become its own pandemic!"*

Clinicians Compared to Counselors

Overall, clinicians and counselors reported similar views regarding access to stimulant use disorder treatment (*data not shown*). However, a greater proportion of counselors than clinicians reported feeling confident that they know where to refer people experiencing stimulant use disorder for treatment (85% vs. 70%; p<0.01; **Figure 17**). Some practitioners expressed need for additional focus on stimulant use disorder treatment in their open-ended survey responses (see example quote above).

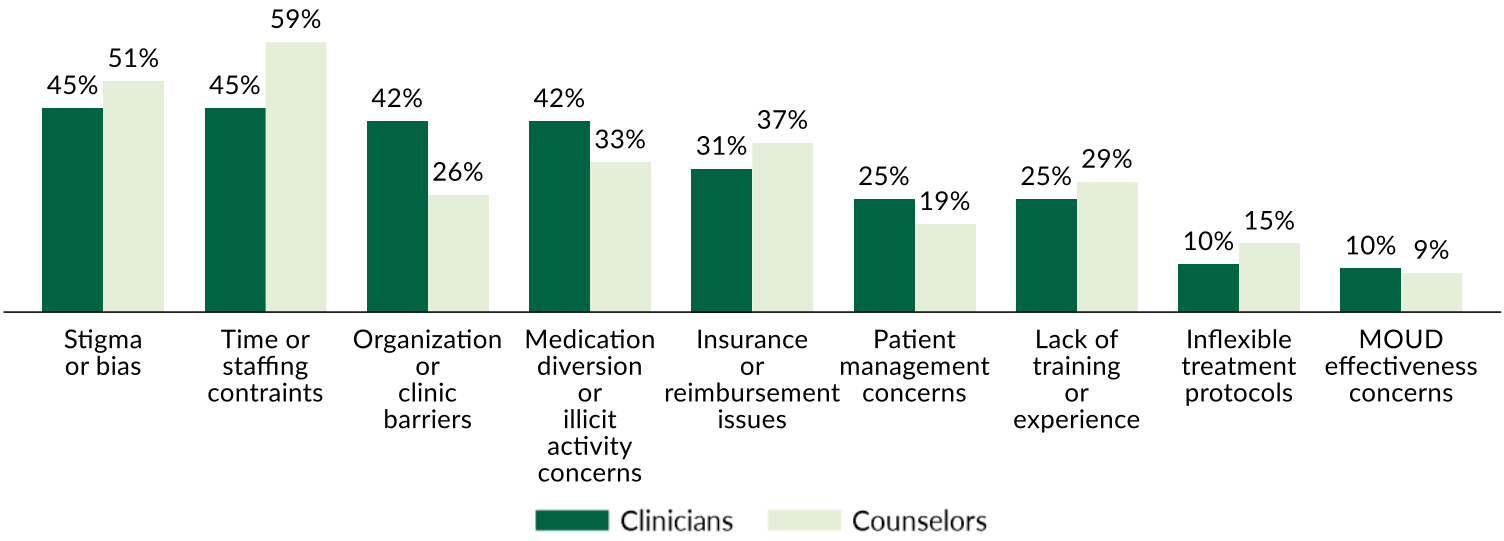
Figure 17. Clinician and counselor agreement that they know where to refer people for stimulant use disorder treatment.



Practitioner Barriers
To Treating Patients With OUD

Both clinicians and counselors ranked stigma and time or staffing constraints as top barriers to treating patients with OUD (**Figure 18**). A greater proportion of clinicians than counselors ranked organizational or clinic barriers as a top barrier (42% vs. 26%; p<0.01).

Figure 18. Practitioner Barriers to Treating Patients with Opioid Use Disorder



"We need...

... Counselors to help our patients with how they think and feel about the medication."

... More training of front office staff."

... Stigma reduction, education of addiction as a chronic health condition."

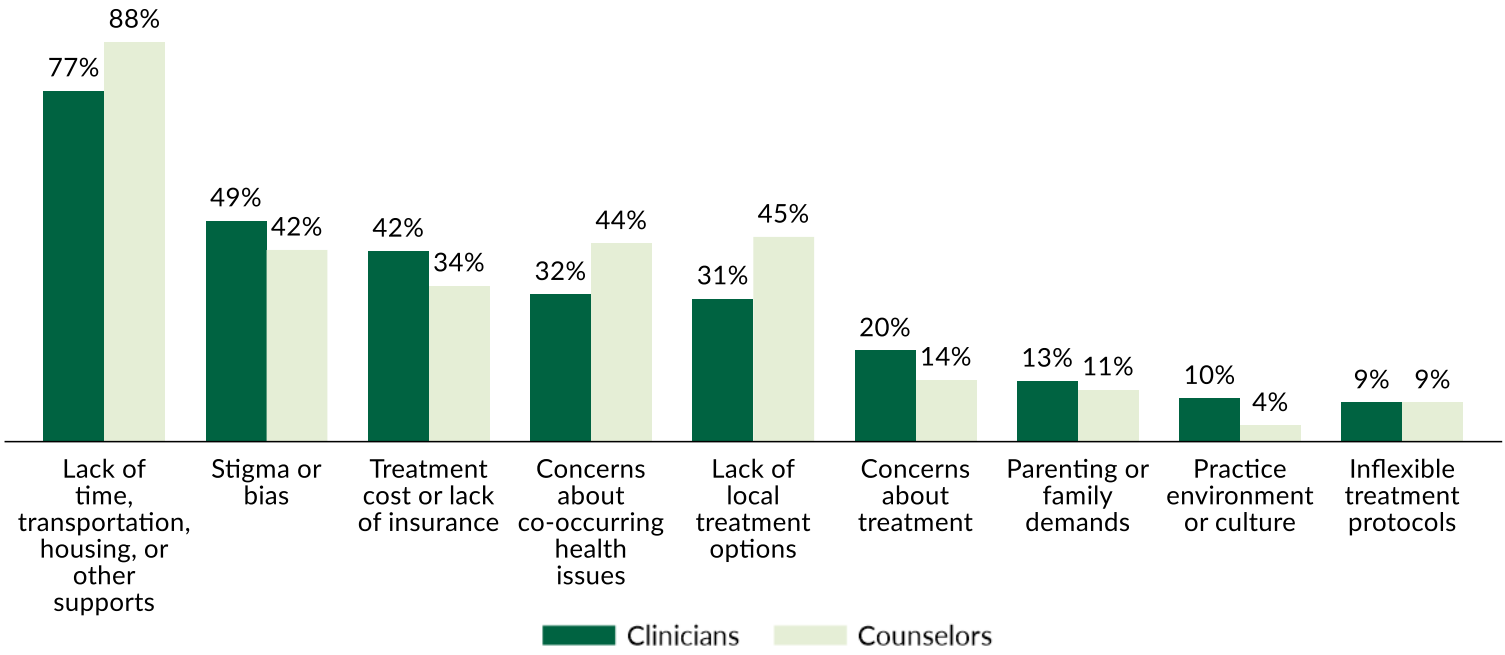
... A hotline for real time clinical support."

Patient Barriers

To Receiving OUD Treatment

Practitioners ranked access barriers (lack of time, transportation, housing, or other supports) and stigma or bias as the top barriers to patients receiving OUD treatment (**Figure 19**).

Figure 19. Practitioner-Identified Barriers to Patients Receiving Opioid Use Disorder Treatment



Unique Barriers for Rural Patients

"Scheduling with childcare and night shift jobs, sustained transportation, childcare."

"Risk of being discharged from program due to inconsistent participation in services."

"No public or private transportation, distance to services."

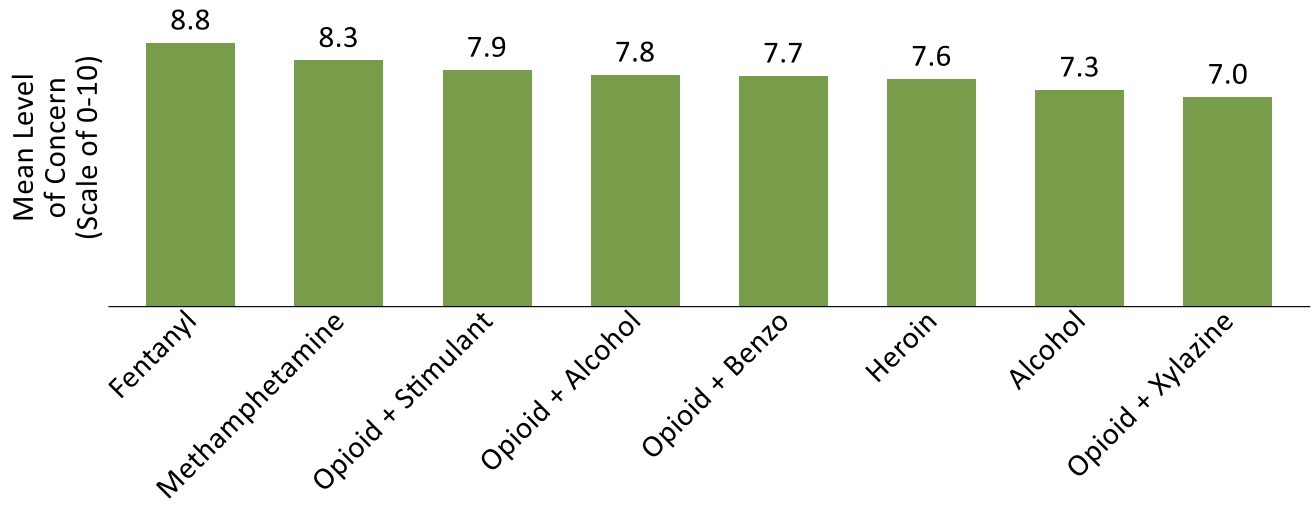
"Lack of Medicare and Medicaid providers and stigma from community."

Substances of Concern

Practitioners reported the greatest concern about use of fentanyl (mean=8.8; scale 0–10), methamphetamine (mean=8.3), and heroin (mean=7.6) among their patients (**Figure 20**). The substance combinations of greatest concern were opioids plus stimulants (mean=7.9), opioids plus alcohol (mean=7.8), opioids plus benzodiazepines (mean=7.7), and opioids plus xylazine (mean=7.0).

Additional substances of concern to practitioners (substances listed under "other" by ≥5 practitioners with a concern level of ≥7) included MDMA, counterfeit or pressed pills, kratom, xylazine, and laced or adulterated substances. Practitioners also noted substance concerns in their open-ended survey responses (see example quotes below).

Figure 20. Substances and Substance Combinations of High Concern (Level ≥ 7) to Practitioners



"[I am concerned about] individuals using a combination of several different street drugs without knowing exactly what substances these street drugs contain."

"Just general concern for polysubstance use of all kinds—so many possible combinations."

"The clients talk about a new drug called tranq [xylazine]."

"Teens are telling me they are getting marijuana laced with other things."

Practitioner Recommendations

Most Important Improvement to Increase OUD Treatment Access

"Providing ALL phases of treatment in a rural setting."

"Low-Barrier Care! Receiving OUD treatment should not be dependent on engagement in services (meaning, medication). Medication should not be discontinued due to less than perfect engagement in therapy/appointments. Many of our clients have significant barriers to access."

"Access to on-demand, reliable transportation; clinics within rural areas that are easily accessible and flexible with appointment times and scheduling."

"Stigma reduction, education of addiction as a chronic health condition."

"Increased ability to access MOUD and/or inpatient treatment the day the patient is ready for it."

"Access to harm reduction programs."

"Improving workforce conditions (caseloads, adequate supervision, salary, benefits, loan repayment) so that the system of care is stable and consistent in the delivery of services."

"A mobile unit to reach patients with transportation issues."

"Increasing access to services for all populations including adolescents. Removing those transportation barriers."

"Support for the logistical needs of parents/people responsible for caring for children."

"More resources getting established and providing care here in our community without having to transfer to other locations for treatment."

Acknowledgments

We would like to thank the many RCORP-affiliated practitioners who participated in UVM CORA's national substance use disorder needs assessment, whose valuable input will help us improve the support and resources we provide to rural communities. We would also like to thank the UVM CORA faculty, staff, and clinician advisors who provided helpful guidance as we developed the questions for this assessment.

Questions

Please visit **uvmcora.org** for more information or contact us at **cora@uvm.edu** with any questions.

Suggested Reference

University of Vermont Center on Rural Addiction (2023). *National Report: Rural Substance Use Disorder Stigma and Treatment Needs.* Retrieved from: www.uvmcora.org.

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This publication is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $17,032,587 with zero percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS or the U.S. Government.