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Rural communities' challenges in accessing treatment services

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TAKEAWAYS

Despair is not killing rural Americans, easy access to opioids and lack of treatment is.

Existing infrastructure to treat addiction is not located where the problem has hit hardest.

Opioids have a broad effect on communities, including on foster care, schools, and the labor force.

People in local communities often feel forgotten—they want their government officials to listen to them and understand the problems they are facing.

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The following three articles explore how the opioid crisis is hindering human services programs in meeting their objectives. Patricia Strach, Elizabeth Pérez-Chiqués, and Katie Zuber describe the challenges of accessing treatment services in rural communities; Pamela Petersen-Baston details individual and systems barriers to addressing the opioid crisis; and Randi Walters and Brandi Stocksdale present Maryland's challenges in serving families struggling with substance use disorder.

In an effort to help state and federal lawmakers understand the day-to-day realities of the opioid crisis, including the challenges of accessing services in remote rural communities, we are conducting an in-depth study of the opioid crisis in three communities in New York State: a rural county (Sullivan), a suburban county (Orange), and an urban county (Queens). So far, we have conducted more than 170 interviews with law enforcement officers, lawyers, judges, doctors, nurses, social workers, government officials, activists, family members, and people in recovery, as well as state and some federal officials across the three areas. Our research is ongoing, and we hope to expand to more state and federal officials. We anticipate another 40 interviews, concluding in 2021. In this article, we focus in particular on rural Sullivan County, located 90 miles northwest of New York City (but with little public transportation access to the city).[1] Sullivan has one of the highest opioid-related overdose death rates of any New York county. Our research questions include:

- What does the opioid crisis look like in the local community?
- How has the community responded?
- What do people on the ground need from the government to address the crisis?

Access to opioids

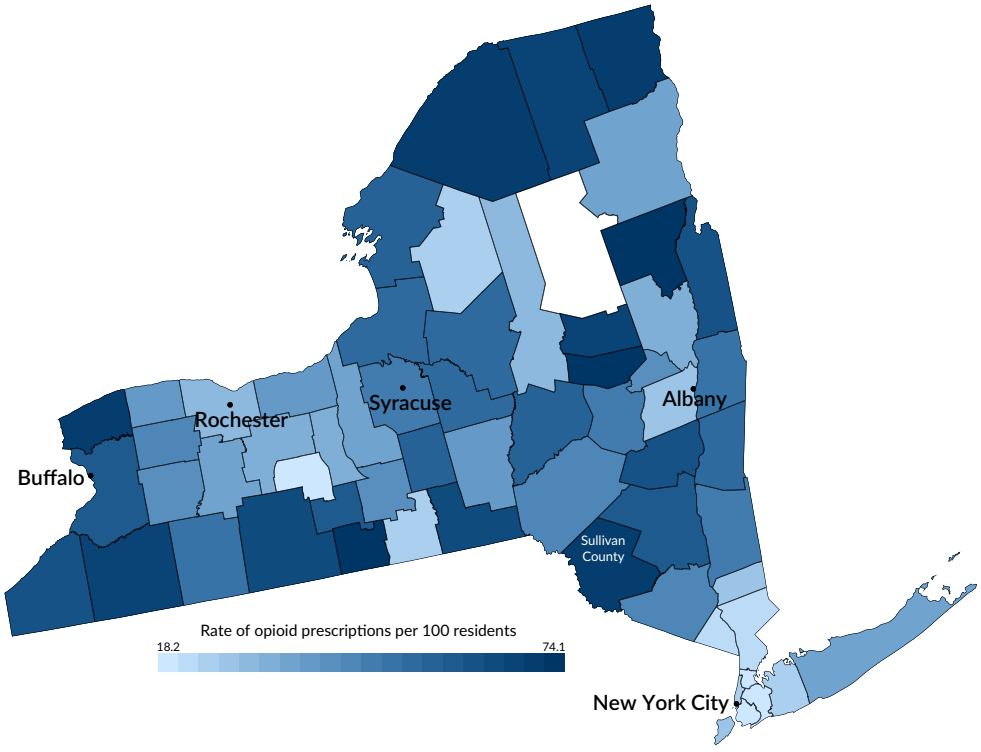
Opioid use is disproportionately more common among white, rural Americans, though national data indicate that drug overdose deaths in suburban and urban communities have now surpassed those in rural communities.[2] The media narrative around the opioid crisis has primarily been one of "deaths of despair." According to this perspective, people living in small and economically depressed communities turn to drugs as a means of escape. This narrative, however, makes it too easy to write off communities rather than taking the time to understand and address how the opioid crisis has evolved in these communities. We wanted to look in more detail at the mechanisms through which drugs get into communities and affect particular groups of people. We found that rather than a black cloud of despair, rural communities have easy access to opioids but lack access to treatment.

Both white Americans and those living in rural areas have had greater access to opioid prescriptions than non-whites and those living in urban areas. Access to prescription drugs—and specifically prescription opioids—among white Americans is partly explained by the fact that they have greater access to

healthcare than their non-white counterparts. In addition, white Americans receiving care are prescribed pain killers at a higher rate than non-white Americans. A 2012 study found that while Hispanics in the United States were as likely as non-Hispanic white Americans to be prescribed some type of pain medication, they were 22 percent less likely to receive opioids. African Americans were 22 percent less likely to be prescribed *any* pain medication compared to white Americans, and 29 percent less likely than white Americans to receive opioids for similar conditions.[3] For types of pain that require physician discretion to evaluate (such as backache or migraine, as compared to back surgery or an accident) the rates are even higher; African Americans were 34 percent less likely to receive opioids for similar conditions.[4] The Centers for Disease Control and Prevention has documented that physicians in rural areas are much more likely to prescribe opioids compared to physicians in urban areas, potentially due to higher rates of injury.[5]

These patterns hold true in New York State where prescription rates are much higher in rural areas than in urban areas (Figure 1). The rates shown in the figure are from 2018, after opioid prescription rates had declined from their 2012 peak.[6] Still, a great deal of variation between counties remained. For example, the 2018 opioid prescription rate in urban Queens County was 18.6 prescriptions per 100 people, compared to 59.0 in rural Sullivan County. The differences in prescribing rates may be explained by varying practices by doctors in each location and by differences in the populations they serve. As discussed above, prescribing varies by race and Sullivan County is majority white (72 percent), while Queens County is majority non-white (white population is 25 percent).[7]

Figure 1. Access to prescription opioids tends to be higher in more rural counties in New York.



Source: U.S. Centers for Disease Control and Prevention, U.S. County Prescribing Rates, 2018.

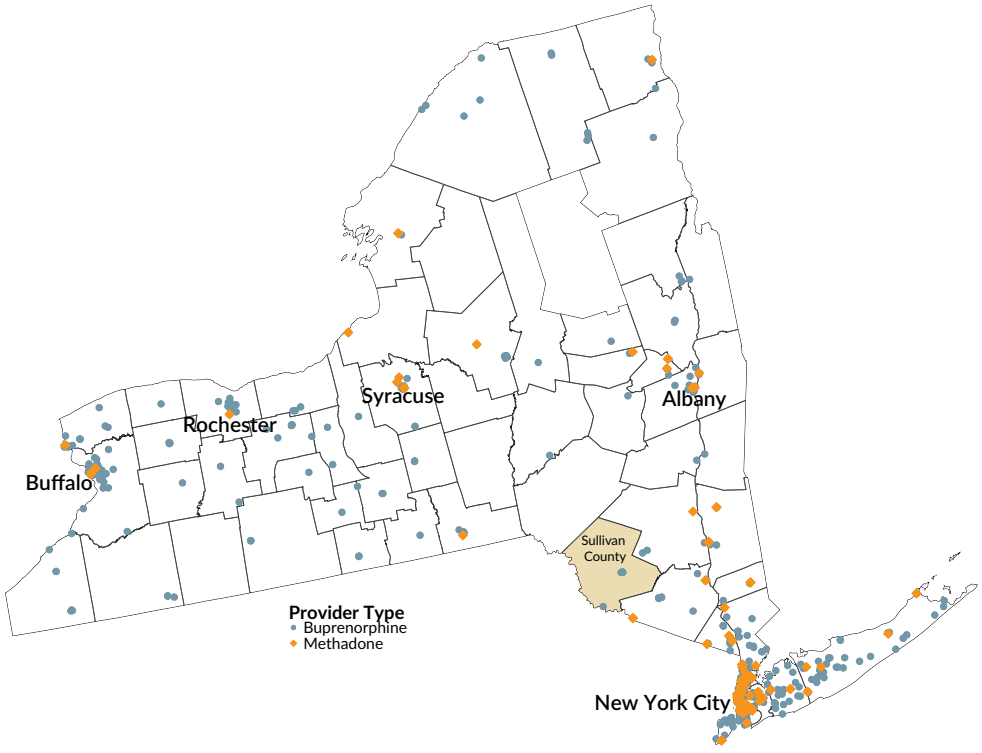
Rural challenges

The challenges raised in our discussions with policymakers, health officials, community activists, and providers in Sullivan are similar to those in many areas of the country; it is difficult to obtain appropriate treatment for opioid-use disorder, and even when an individual is able to successfully complete treatment, there are few wraparound services available to help them find housing and employment. However, these problems are exacerbated in rural areas like Sullivan, where both services and transportation are lacking.

Access to treatment

While accessing appropriate treatment is often a challenge, the particular issues that limit access vary. In an urban area like New York City, the primary challenge is often financial; services are generally available, but those who need them may not be able to pay. In a rural area like Sullivan County, however, some treatment services are simply not available at any price. Figure 2 shows the locations of treatment options in New York State. Sullivan, a county of 1,000 square miles, has three in-patient treatment options within the county, several buprenorphine practitioners who provide outpatient services, and no methadone clinics. Yet, even these listed options are not always available in practice.[8] A recent article found that most doctors on the federal provider database had no available appointments, and those that did have appointments had wait times exceeding two weeks.[9]

Figure 2. Medication-assisted treatment options in New York State tend to be clustered around metropolitan areas.



Note: A single dot may represent more than one provider of the same type in the same location.

Source: Substance Abuse and Mental Health Services Administration Treatment Locator, Accessed July 19, 2019.

Because it is far enough away from New York City, but close enough to be accessible, Sullivan County has more options than other rural communities. Very few inpatient treatment facilities exist in rural areas of the state, with service providers relying primarily on outpatient treatment. These services, which may be available only during business hours, could be virtually inaccessible to those who work or have childcare issues.

While our study is being conducted in New York State, geographic variability in access to treatment exists nationwide. For example, more than half of all U.S. counties lack physicians who can prescribe buprenorphine—a medication used to block the effects of opiate withdrawal—leaving 30 million people without access in these mostly rural communities.[10] Buprenorphine is an effective treatment for opioid use disorder and can be provided in office-based settings, but physicians must obtain a waiver from the Drug Enforcement Administration in order to prescribe it.

Transportation

Almost every person we interviewed in Sullivan County identified lack of transportation as a critical issue. Sullivan County, home to 78,000 people, is approximately the same size as the state of Rhode Island. However, the county has only two daily bus routes. Transportation is particularly challenging for those who do not have a valid driver's license or access to a car. While Medicaid will pay for taxis to medical appointments, it does not pay for transportation for other necessities, like going to and from work or to the pharmacy or grocery store. Ironically, we learned that the lack of transportation does not disrupt the flow of drugs into these communities. As one mother observed, "we can't get a pizza delivery, but we can get a heroin delivery."

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Post-treatment services

People who successfully complete a drug treatment program further struggle with accessing post-treatment services. To stay in recovery most need help securing and keeping safe housing and stable employment. Unfortunately, in remote rural areas like Sullivan, these post-treatment services are also lacking.

Finding safe housing is particularly challenging for those who complete drug treatment. As a lawyer explained to us, once people with addictions finish a program, they are typically forced back into the same communities they came from and they relapse: "aftercare treatment is homelessness." People in recovery are "thrown back into the street, thrown back into their parents' house, they're just thrown back into the same place they were, but without the right tools . . . to succeed." Those completing treatment thus often end up in the same communities—and the same conditions—that they came from, increasing their likelihood of relapsing.

People who have addictions (and possibly criminal records, often because of their addictions), frequently have difficulty finding and maintaining steady employment in any environment, and these issues are likely exacerbated in rural communities. The agricultural and tourism industries that once drove Sullivan's economy have declined substantially,

leaving few jobs that pay a living wage. For some, transportation issues may put these few good jobs even further out of reach.

Capacity to provide needed services

A final challenge that rural communities face is a lack of capacity—through resources and infrastructure—to provide needed services. Even if local officials have the will to address the problem of drug addiction in their community, including spillover effects on areas such as foster care (see text box), they often lack an effective way to implement a solution. Local officials with whom we spoke noted that they are at a severe disadvantage when applying for competitive state grants, because the number of people to be served may be below the grant threshold and because they do not have professional grant writers to make their case.

This lack of capacity can be illustrated when considering the issue of inpatient treatment. From our very first day of doing interviews, we heard about "beds" from grassroots organizers who told us "there are no beds," to a state official who said, "getting a bed is a wait." However, the state has a database showing that the physical capacity exists to treat more than a thousand people in an inpatient setting. While these treatment slots may be technically available, they are in practice inaccessible to people who need them, due in part to staffing shortages. Half of all agencies specializing in treating substance use disorder say they have difficulty filling open positions, primarily due to a lack of qualified applicants. Shortages of treatment professionals is a problem across the United States, but it is especially challenging in rural areas that lack physicians, social workers, credentialed alcohol and substance abuse counselors, nurse practitioners, and support staff. If an inpatient treatment slot is available but there is no receptionist to answer the phone, then the bed will go unfilled.

People in local communities want to be heard

We asked all of our interviewees: "What do you want state and federal policymakers to know?" The answers we heard surprised us. While people did note the need for additional resources, they spent the most time talking about how they wanted to be heard and understood. One provider, referring to state and federal officials, said:

Foster care:

When discussing how to address the opioid epidemic, policymakers often frame it around the people with addictions and treating those addictions. However, the implications of those addictions spill over and affect families, schools, and communities. As such, policy and program strategies must consider effects in these other areas. A prime example is the child welfare system. One of the most challenging aspects of opioid addiction, to both families and the systems designed to support them, is the removal of children from the home in the context of parental drug abuse.

As the opioid epidemic has developed, the number of children removed from home and placed in foster care has been growing. Nationwide, the number of children in foster care rose about 10 percent from 2012 to 2018 after a decade of decline.[1] Rural Sullivan County has seen an even more dramatic rise in foster care placements over the same time period. In 2012, there were only 75 children in foster care in the county, but by 2018 there were 122, an increase of over 60 percent. However, Sullivan County's experience stands in contrast with the rest of New York State; foster care placements declined during this same time period in both New York City and Upstate New York.[2]

While a causal link between opioid use disorder and the rise in foster care rates has not been established, child welfare data show that substance use is a challenge for many parents in that system. For example, in 2017, more than a third of children placed in foster care nationwide had parental drug use listed as a reason for removal.[3] In addition, the rate of children entering foster care due to parental drug use rose each year from 2011 to 2017, up to 131 per 100,000 children in the U.S.[4] Finally, studies have shown that parents who use opioids are less likely than other drug users to retain custody of their children.

Increases in foster care placements affect not only family well-being, but also government budgets. Children in foster care have higher rates of behavioral, emotional, and health issues, both because of the family circumstances that put them into the foster care system in the first place and as a result of the system itself.[5] Foster care is also expensive. Increases in foster care placements lead to increased costs for counties, straining their already tight foster care budgets. For example, in New York State, the average annual cost for a child in foster care was over $56,000 in fiscal year 2010–2011.[6]

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[1] https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/afcars

[2] https://www.acf.hhs.gov/cb/resource/trends-in-foster-care-and-adoption

[3] https://www.childtrends.org/one-in-three-children-entered-foster-care-in-fy-2017-because-of-parental-drug-abuse

[4] https://www.childtrends.org/one-in-three-children-entered-foster-care-in-fy-2017-because-of-parental-drug-abuse

[5] J. J. Doyle, "Child Protection and Child Outcomes: Measuring the Effects of Foster Care," *American Economic Review* 97, No. 5 (December 2007): 1583–1610; M. E. Courtney and A. Dworsky, "Early Outcomes for Young Adults Transitioning from Out-Of-Home Care in the USA." *Child & Family Social Work* 11, No. 3 (2006): 209–219.

[6] G. Wallace and R. Johnson, New York State - Child Welfare Costs and Kinship Services, New York State Kindship Navigator, Rochester, NY, n.d. available at: http://www.nysnavigator.org/pg/professionals/documents/NewYorkStateChildWelfareCostsandKinshipCare.pdf

> The information that's down here, the people that are in the trenches, doesn't get up there. It just doesn't. And then they make decisions based on a disconnect. And then people scream loud enough and in 10–20 years we come back around and are having the same argument all over again. If that makes sense. So, besides the obvious, I really think they need to turn off their brains, turn on their ears.

Another provider in an urban area told us:

> People are suffering. People are hurting.…Walk into one of these rat den buildings that they rent out in Newburgh. And say "if I had to live there every night, what would it be like for me?" You know. How easy would it be to get up and look for a job if I…have rats and cockroaches…where I have to put cotton balls in my kid's ears so a roach doesn't crawl into their ear and get stuck there. You know, see what people live through, not with [a] camera, by yourself. Go out with one of my caseworkers one day. And see what they have to do in a day to help families.

People in local communities felt forgotten by their state and federal officials. As one mother observed, "If it's a crisis, why don't you treat it like one?"

Conclusion

The opioid epidemic is deadly, and it is particularly devastating for rural communities. Overdose deaths are explained primarily not by a cloud of despair hanging over communities, but by concrete mechanisms such as physician prescription patterns and a lack of treatment options. To better address the opioid crisis, policymakers must address the concrete challenges that communities face in order to connect people in need to appropriate treatment.■

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[1]This article draws on the both the presentation by Patricia Strach and Elizabeth Pérez-Chiqués at the September 2019 poverty research and policy forum, *Human Services Programs and the Opioid Crisis*, and on P. Strach, K. Zuber, and E. Pérez-Chiqués, *Stories from Sullivan: How a Rural Community Addresses the Opioid Crisis*, Volume 1, Rockefeller Institute of Government, June 27, 2018. Available at: https://rockinst.org/issue-area/stories-from-sullivan-vol-1/

[2]S.H. Woolf, and H. Schoomaker, "Life Expectancy and Mortality Rates in the United States, 1959–2017." *JAMA* 322, No. 20 (2019): 1996–2016.

[3]S. H. Meghani, E. Byun, and R. M. Gallagher, "Time to Take Stock: A Meta-Analysis and Systematic Review of Analgesic Treatment Disparities for Pain in the United States," *Pain Medicine* 13, No. 2 (February 2012): 150–174.

[4]S. H. Meghani, E. Byun, and R. M. Gallagher, "Time to Take Stock."

[5]M. C. Garcia et al., "Opioid Prescribing Rates in Nonmetropolitan and Metropolitan Counties Among Primary Care Providers Using an Electronic Health Record System—United States, 2014–2017," *Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report* 68, No. 2 (January 18, 2019); G.E. Metcalf and Q. Wang, "Abandoned by Coal, Swallowed by Opioids," NBER Working Paper No. w26551, National Bureau of Economic Research, 2019. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3504435.

[6]Opioid prescription rates rose steadily from 2006 to 2012, peaking at a national average of 81.3 prescriptions per 100 people. The rate then declined from 2012 to 2017, to 58.7 prescriptions per 100 people. See https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html, accessed February 4, 2020.

[7]U.S. Census Bureau, "2018 American Community Survey 5-Year Estimates," Table DP05.

[8]P. Strach, K. Zuber, and E. Pérez-Chiqués, "Why Policies Fail: The Illusion of Services in the Opioid Epidemic." *Journal of Health Politics*, Policy, and Law 45, No. 2 (2020): 341–364.

[9]L. Flavin, M. Malowney, N.A. Patel, M.D. Alpert, E. Cheng, G. Noy, S. Samuelson, N. Sreshta, and J. W. Boyd, "Availability of Buprenorphine Treatment in the 10 States with the Highest drug Overdose Death Rates in the United States." *Journal of Psychiatric Practice* 25, No. 1 (2020): 17–22.

[10]R. Rosenblatt, C. H. A. Andrilla, M. Catlin, and E. H. Larson, "Geographic and Specialty Distribution of US Physicians Trained to Treat Opioid Use Disorder," *Annals of Family Medicine* 13, No. 1 (2015): 23–26.

Sources & Methods

Type of analysis: Qualitative

Data source: Interviews with law enforcement officers, lawyers, judges, doctors, nurses, social workers, government officials, activists, family members, and people in recovery.

Type of data: Interviews

Unit of Analysis: Counties

Sample definition: Three counties in New York State: Sullivan County (rural); Orange County (suburban); and Queens County (Urban, in New York City).

Time Frame: Study began in 2017 and is ongoing.

Limitations: This is a qualitative analysis, and the results are not necessarily representative of the entire population.