



National Advisory Committee On Rural Health and Human Services



Families in Crisis: The Human Service Implications of Rural Opioid Misuse Policy Brief July 2016

***Editorial Note:** During its spring 2016 meeting in Beaufort, South Carolina, the National Advisory Committee on Rural Health and Human Services discussed the unique rural challenges related to opioid use disorder and the experiences of families in crisis. During its site visit the Committee heard from residents, service providers, and stakeholders about the challenges to providing human services to families struggling with addiction. This brief is informed by those experiences, and conversations.*

RECOMMENDATIONS

- 1. The Committee recommends the Secretary develop a 2018 budget request to expand Medication Assisted Treatment to include Rural Health Clinics, Community Mental Health Centers and Critical Access Hospitals (see page 8).*
- 2. The Committee recommends the Secretary develop a 2018 budget request to support a rural demonstration project extending community mental health worker programs to shortage areas in recognition of limited capacity to address opioid misuse in isolated communities (see page 8).*
- 3. The Committee recommends the Secretary work with Congress to designate rural as a special population under the Substance Abuse Prevention and Treatment Block Grants (see page 9).*
- 4. The Committee recommends the Secretary ensure that all U.S. Department of Health and Human Services research on opioid abuse, overdose and treatment include rural-urban data cuts nationally and regionally to better inform policy and resource allocation (see page 9).*

INTRODUCTION

Nonmedical prescription opioid misuse is a fast growing public health problem and primary cause of unintentional deaths nationwide, particularly in many rural areas of the country. According to the Centers for Disease Control and Prevention (CDC), everyday 44 people die of a prescription drug related overdose.¹ The opioid crisis is multifaceted and affects communities nationwide. When the costs are calculated they exceed \$55 billion annually.²

During its spring meeting, the human service subcommittee of the National Advisory Committee on Rural Health and Human Services examined the impact and implications of opioid misuse on

¹ The U.S. Opioid Epidemic. The U.S. Department of Health and Human Services. (2015). <http://www.hhs.gov/opioids/about-the-epidemic/>

² Birnbaum, H. G., et al. "Societal Costs of Prescription Opioid Abuse, Dependence, and Misuse in the United States." *Pain Med* 12.4 (2011): 657-67.

rural families. Substance Use Disorder (SUD)³ not only puts individuals at risk of overdose and death, but can present a crisis situation for families. Addictions often create interpersonal problems for all family members: conflict between partners, conflict with children, emotional trauma, and adverse health risks. The Committee is also concerned about the implications for related impacts on employment and economic viability for rural families affected by the opioid crisis.

While opioid use disorder is a national epidemic, when it hits rural areas, the challenges increase given a limited health and social service infrastructure. Without access to evidence based treatment such as Medication Assisted Treatment (MAT)⁴, support services for long term recovery, and continuing technical assistance for health providers and professionals; addiction can slowly throw families into crisis.

BACKGROUND

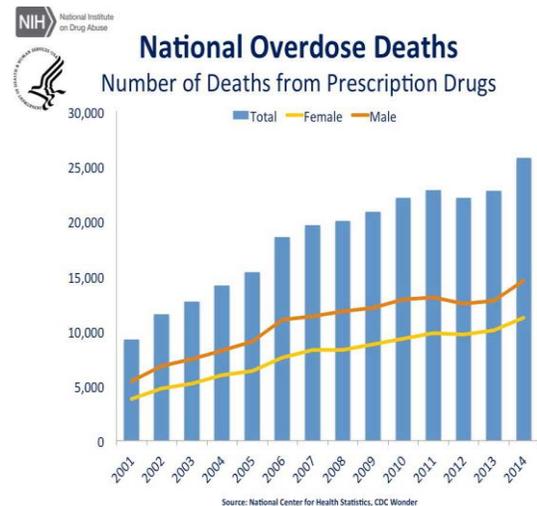
THE OPIOID EPIDEMIC A NATIONAL PROBLEM WITH RURAL DIFFERENTIALS

More people died from drug overdoses in 2014 than any year on record. The majority of drug overdose deaths (more than six out of ten) involve an opioid.⁵ Since 1999, the rate of overdose deaths involving an opioid has nearly quadrupled.⁶

Fatal opioid overdose in rural areas have increased at unprecedented rates from 2012-2014 and now are as high as or higher than rates in all metro areas.⁷ The alarming increase in fatal opioid overdose rates over the past two years has created concern among federal, state, and local health care providers, law enforcement officials, and policy makers.

Current Opioid Abuse Trends in Rural Communities

In 2014, opioids were involved in 28,647 deaths in the United States. Half of those deaths were from prescribed opioids.⁸ Rural communities have been particularly hard hit. Consider the following:



³ Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. <http://www.samhsa.gov/disorders/substance-use>

⁴ <http://www.samhsa.gov/treatment/substance-use-disorders#opioid>

⁵ Rudd, R. A., et al. "Increases in Drug and Opioid Overdose Deaths--United States, 2000-2014." *MMWR Morb Mortal Wkly Rep* 64.50-51 (2016): 1378-82.

⁶ Centers for Disease Control and Prevention. "Vital Signs: Overdoses of Prescription Opioid Pain Relievers--- United States, 1999--2008." *MMWR Morb Mortal Wkly Rep* 60.43 (2011): 1487-92.

⁷ Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2014 on CDC WONDER Online Database, released 2015. Data are from the Multiple Cause of Death Files, 1999-2014, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Retrieved from <http://wonder.cdc.gov/mcd-icd10.html>.

⁸ *Ibid.*

- Use of naloxone is 22% higher in rural.
- Drug related deaths are 45% higher in rural areas.
- Opioid-related overdose deaths have increased over the past 15 years in both rural and urban areas, with exponential increases in rural areas from 2013-2014.
- Rural states are more likely to have higher rates of overdose death, particularly from prescription opiate overdose.
- Men in rural areas are using more opioids than women in rural areas but more women are dying from opioid overdose.⁹
- Between 2005 and 2011, non-medical use of pain relievers among persons age 12 and older was higher in urban counties than rural and this trend continued into 2011-12 among adults, however, multiple studies document a higher prevalence rate among specific vulnerable rural populations, particularly among youth, women who are pregnant or experiencing partner violence, and persons with co-occurring disorders.¹⁰

Couple those metrics with the challenges that are unique to rural areas such as access to care, fewer providers and fewer insured. Rural areas also tend to have higher risk occupations that are physically demanding and prone to injury, for which opioids may be prescribed for treatment. Rural primary care providers are less likely to have received waivers¹¹ to prescribe buprenorphine in rural communities¹².

Of particular interest to the Committee is the fact that many rural opioid users were more likely to have socio-economic vulnerabilities that might put them at risk of adverse outcomes. Limited educational attainment, poor health status, being un-insured, and low-income are all socio-economic factors related to substance use disorder. These socio-demographic identifiers of rural opiate users have potential implications for family outcomes ranging from adverse experiences decreased family earning potential, limited professional employment, encounters with law enforcement and the involvement of child welfare services.¹³

⁹ *Ibid.*

¹⁰ Lenardson, J. D., J. A. Gale, and E. C. Ziller. (2016). *Rural opioid abuse: Prevalence and user characteristics*. (PB 63-1). Portland, ME: University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center, February 2016.

¹¹ <http://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management>

¹² Rosenblatt, R. A., et al. "Geographic and Specialty Distribution of Us Physicians Trained to Treat Opioid Use Disorder." *Ann Fam Med* 13.1 (2015): 23-6.

¹³ Lenardson, J. D., J. A. Gale, and E. C. Ziller. (2016). *Rural opioid abuse: Prevalence and user characteristics*. (PB 63-1).

INDIANA CASE STUDY

Drug abuse can quickly overwhelm the resources of a small town with devastating effects, as is the case in Austin, Indiana in 2014 .

Two years ago, an outbreak of HIV infection spread rapidly among a network of persons who inject drugs (PWID) in the small rural community of Austin in Scott County, southeastern Indiana. More than 194 people were infected, out of a population of 4,200. The lifetime cost of treating the HIV patients, as well as those with hepatitis C, could approach \$100 million, the Centers for Disease Control and Prevention (CDC) estimates. This outbreak strained the local public-health system and highlighted the potential threat confronting other rural areas overrun by heroin and prescription painkillers.

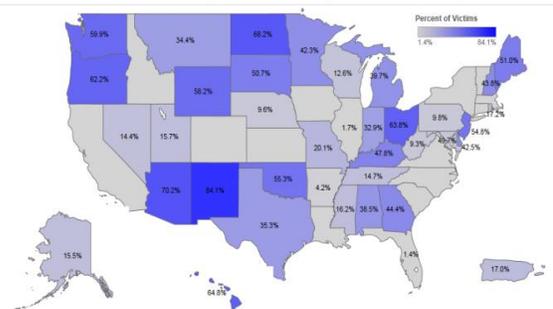
The situation in Austin, Indiana also illustrates the impact this epidemic can have on an economically challenged portion of the community. One out of five residents live below the poverty line, and less than 10 percent of adults hold a college degree. Many rural communities lack residential treatment. Austin is no different, where those waiting for a treatment bed must travel to nearby communities and wait-times can be up to eight weeks. Many who seek treatment are at higher risk of relapsing due to financial burdens and a shortage of supportive services within the county.

Since the Austin Outbreak, the CDC has identified 220 counties across the U.S. where similar conditions create vulnerability to eruptions of HIV and hepatitis C. Of the 220 counties most are rural with 56% in Kentucky, Tennessee and West Virginia, the Appalachian region hardest-hit by the opioid crisis. The remainder are scattered across 23 other states, from California to Maine.

Substance Abuse and Child Welfare

The Committee is concerned that the opioid crisis could exacerbate child abuse and neglect given that we're seeing a link nationally. State child welfare systems have reported that they are experiencing an increase in families coming to their attention with substance use problems impacting their ability to safely parent.¹⁴ Overall, the percent of victims from FY 2012 to FY 2014, with the risk factor designation of parental drug abuse has increased from 19.8% to 25.5%. However, within this group, the percent of infants with the risk factor designation of parental drug abuse has increased 8.1% (from 25.7% to 33.8%).¹⁵

Percent of Infant Victims with Parental Drug Abuse Risk Factor Reported FY 2014 (NCANDS)



¹⁴ Kamp, J., and A. Campo-Flores. "Parents' drug Abuse Strains Child-Welfare Agencies." *The Wall Street Journal*. Jan. 12, 2016 2016. Retrieved from <http://www.wsj.com/articles/parents-drug-abuse-strains-child-welfare-agencies-1452538476>

¹⁵ Child Welfare Information Gateway. (2016). Child maltreatment 2014: Summary of key findings. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

According to the National Incidence Study on Abuse and Neglect (NIS), except for educational neglect, the incidence of all categories of Endangerment Standard maltreatment was higher in rural counties than in urban counties and similar patterns also emerged in rates of most categories of Harm Standard maltreatment. Rural children had a nearly 2 times higher rate of overall Harm Standard maltreatment and nearly 2 times higher rate of overall Endangerment Standard maltreatment. Whether this reflects better coverage of maltreated children in the rural counties or higher rates of actual maltreatment in rural communities is not clear. Nor is it clear how other factors, such as socioeconomic status and family size differences, may contribute to these metropolitan status differences.¹⁶

The role of Federal Block grants

To fund systems of care and delivery of human services, behavioral health, and substance abuse treatment and prevention, States rely on a number of HHS block grant programs administered through the Substance Abuse and Mental Health Service Administration (SAMHSA) and Administration for Children and Families (ACF). That means states, rather than HHS, have broad discretion over how to allocate funding. Unfortunately, little tracking is done to see how states allocate funding between rural and urban areas.

Substance Abuse Prevention and Treatment Block Grant (SABG)

The Substance Abuse Prevention and Treatment Block Grant, administered by SAMHSA is distributed by formula to all States and Territories. It is the cornerstone of States' substance abuse prevention, treatment, and recovery systems.

An independent study¹⁷ of the SABG released in June 2009, found that the program was effective in: producing positive outcomes as measured by increased abstinence from alcohol and other drugs, increased employment, decreased criminal justice involvement, and other indicators; Improving states' infrastructure and capacity; fostering the development and maintenance of state agency collaboration; and promoting effective planning, monitoring, and oversight.

However while serving as a critical supplement to state substance use disorder (SUD) treatment efforts, over the last 10 years, SABG funding has not kept up with health care inflation, resulting in a 26% decrease in the real value of funding by FY 2015.¹⁸ To the extent rural families' access to substance abuse is dependent on block grants this does create the concern that this may negatively affect rural families facing an opioid crisis.

¹⁶ Sedlak, A.J., et al. (2010). *Fourth National Incidence Study of Child Abuse and Neglect (NIS-4): Report to Congress, Executive Summary*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families. Retrieved from

http://www.acf.hhs.gov/sites/default/files/opre/nis4_report_exec_summ_pdf_jan2010.pdf

¹⁷ Center for Substance Abuse Treatment and Center for Substance Abuse Prevention. *Independent Evaluation of the Substance Abuse Prevention and Treatment Block Grant Program: Final Evaluation Report*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009. Retrieved from <http://www.samhsa.gov/sites/default/files/grants/sapt-bg-evaluation-final-report.pdf>

¹⁸ *Substance Abuse Prevention and Treatment (SAPT) Block Grant*. National Association of State Alcohol and Drug Abuse Directors, Inc. February 2016. Retrieved from <http://nasadad.org/wp-content/uploads/2015/02/SAPT-Block-Grant-Fact-Sheet-2016-1.pdf>

Community Mental Health Services Block Grant (MHBG)

The MHBG program provides funds and technical assistance to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and 6 Pacific jurisdictions. Grantees use the funds to provide comprehensive, community-based mental health services to adults with serious mental illnesses and to children with serious emotional disturbances and to monitor progress in implementing a comprehensive, community-based mental health system.

The Social Services Block Grant (SSBG)

The Social Services Block Grant, Administered by the Administration for Children and Families, enables each state or territory to meet the needs of its residents through locally relevant social services; SSBGs support programs that allow communities to achieve or maintain economic self-sufficiency to prevent, reduce or eliminate dependency on social services. SSBGs fund a variety of initiatives for children and adults including daycare, protective services, case management, health related services, transportation, foster care, substance abuse, housing independent/transitional living, and employment services.

The services provided by state and local agencies under the SABG, MHBG, and SSBG account for key funding streams of rural human service providers that make up formal and informal networks supporting the care of individuals and families struggling with substance use disorder.

In the Committee's work over the past 10 years, stakeholders in multiple states have noted that allocated block grant funding may not always go to the areas of greatest need and often is concentrated in urban and suburban areas. The Committee recognizes that any change in allocation formulas would require a statutory change. **The Committee recommends** the Secretary work with Congress to designate rural as a special population under the Substance Abuse Prevention and Treatment Block Grants.

Barriers to Treatment and Services

SAMHSA's [Mental Health Report 2010](#) reports that states with proportionally large rural populations compared to urban populations have greater shortages of mental health providers and fewer facilities to provide treatment services. Although family doctors, psychologists, social workers, and pastors may be available in rural areas for delivering basic substance abuse services or social support, facilities available in rural areas that provide comprehensive substance abuse treatment services may be limited.

According to the 2014 *Substance Use & Misuse* article, [Barriers to Substance Abuse Treatment in Rural and Urban Communities: Counselor Perspectives](#), rural areas lack basic substance abuse treatment services as well as the supplemental services necessary for positive outcomes. Detoxification (detox) services, for example, provide the initial treatment for patients to minimize any medical or physical harm caused by substance abuse. The vast majority (82%) of

rural residents live in counties that do not have detox services.¹⁹ Often, local law enforcement or emergency departments provide the initial detoxification services.

In addition, patients may need more advanced treatment services depending on the stage of their illness that could necessitate the need for inpatient, intensive outpatient, and/or residential care not available in rural areas. The absence of these treatment services locally results in clients having to travel long distances to receive the proper care; greater distance to receive substance abuse treatment often results in lower completion rates of substance abuse treatment programs.²⁰

Discussion and Recommendations

During the meeting, the Committee heard from Bob Toomey the Director of South Carolina's Department of Drugs, Alcohol and other Substances (DAODAS). As Director of DAODAS, Mr. Toomey emphasized the critical role that state government's play in mitigating the negative, economic and social consequences of substance abuse on individuals, families, and communities. A key mission at the state level is to support the network of providers who deliver services to individuals with a substance use disorder (SUD). Addiction, like any other chronic disease, is treatable. However, there is a great need to develop rural specific treatment models that meet the needs of individuals and families dealing with a SUD. For families struggling with a SUD this requires intensive coordination of service providers of care for a family in crisis.

ON DEMAND TREATMENT IS VITAL TO RECOVERY

In South Carolina, every county has basic outpatient services contracted with the state's Department of Alcohol and Other Drug Abuse Services to provide treatment on demand, which is vital to intervention.

Mike Dennis, Executive Director of the Tri-County Commission on Alcohol and Drug Abuse, has seen the dire need for intervention in his rural South Carolina community. For three-and-a-half years, the Dawn Center in Orangeburg has offered buprenorphine, a medication used to treat addiction, in its outpatient programs. Currently, the center has 30 outpatients using the drug. Dennis said that detox facilities were not keeping patients long enough to fully detox and recover, leaving them more susceptible to overdose after being discharged.

"The longer we can get them engaged in services, the greater the likelihood they are to recover," said Dennis. Staff works closely together with social service agencies, including vocational rehabilitation services and mental health agencies to make sure every possible need is met for people in treatment. In addition, their own professional staff provides case management and counseling in order to help change thinking and behavior in the treatment of opioid abuse and in relapse prevention.

¹⁹ Lenardson, J., M. Race, and J. Gale. *Few and Far Away: Detoxification Services in Rural Areas*. Portland, ME: University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center, 2009. Retrieved from <http://muskie.usm.maine.edu/Publications/rural/pb41/Rural-Detox-Brief.pdf>

²⁰ Pullen, E., and C. Oser. "Barriers to Substance Abuse Treatment in Rural and Urban Communities: Counselor Perspectives." *Subst Use Misuse* 49.7 (2014): 891-901. <http://doi.org/10.3109/10826084.2014.891615>

Towards Creating a Stronger Treatment System for Opioid Use Disorders

While an important goal of treatment is to help individuals break addiction, treatment does not equal recovery. Access to treatment services for individuals with an identified SUD is critical to support long term recovery, it's also important for the stability their families. According to 2014 federal data, at least 89 percent of people who met the definition for a drug use disorder didn't get treatment.²¹ This can increase the likelihood of involvement from child welfare agencies, and the potential disruption of families through placement of children in foster care.

Ensuring that rural residents have access to treatment and long-term support services are critical for keeping families together. While research demonstrates that MAT supported recovery programs have led to a reduction in overdose deaths related to opioids, there remains a shortage of MAT facilities and providers in rural communities.²² The Committee believes policy makers must consider, plan, and fund adequate support services within communities for those receiving treatment to avoid having to refer patients out, placing them far away from family or putting them at risk of having to be away from their jobs. **Therefore, the Committee recommends** the Secretary develop a 2018 budget request to expand Medication Assisted Treatment to Rural Health Clinics, Community Mental Health Centers and Critical Access Hospitals.

The Role of Support Services

Many rural communities have inadequate capacity to connect individuals and families to the resources they need. **The Committee calls for technical assistance to support continuing education for rural health and human service providers on pain management and substance use disorders.**

Care Coordination and Mental Health Workers to address current Shortages in rural communities

The Committee supports coordination between general medical practitioners, specialty addiction treatment, and human service providers as another vital element in creating strong treatment systems. To facilitate service integration, **the Committee recommends** the Secretary develop a 2018 budget request to support a rural demonstration project extending community mental health worker programs to shortage areas in recognition of limited capacity to address this issue in isolated communities. By integrating services, treatment plans and care management strategies; providers can better address the health and human service needs of individuals to support long term recovery.

Increasing the Availability of Treatment Programs

Investments in locally staffed treatment centers are critical for vulnerable rural communities. The Committee commends the efforts of Secretary Vilsack, the White House Rural Council, and the U.S Department of Agriculture (USDA) who announced the availability of \$1.4 million through USDA's Rural Health and Safety Education grant program, which are expanding to support outreach to prevent opioid abuse in rural communities. As of November 2015, USDA's Rural Development Community Facilities program has provided more than \$213 million to 80 projects

²¹ *Benefits of Medicaid Expansion for Behavioral Health. ASPE Issue Brief.* Washington, DC: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. March, 2016. Retrieved from <https://aspe.hhs.gov/sites/default/files/pdf/190506/BHMedicaidExpansion.pdf>

²² Dick, A. W., Pacula, R. L., Gordon, A. J., Sorbero, M., Burns, R. M., Leslie, D. L., & Stein, B. D. (2015). Increasing Potential Access to Opioid Agonist Treatment in U.S. Treatment Shortage Areas. *Health Affairs (Project Hope)*,34(6), 1028–1034. <http://doi.org/10.1377/hlthaff.2014.1205>

in 34 States to develop or improve mental health and substance use disorder treatment facilities in rural areas.

The Health Resources and Services Administration (HRSA) through the Bureau of Primary Health Care's Substance Use Treatment Expansion Award, provided almost \$18 million of the nearly \$94 million awarded to 51 Health Centers who are located in rural zip codes.

In addition, the Federal Office of Rural Health Policy was authorized by Congress to fund the Rural Opioid Overdose Reversal Grant Program (ROOR). The ROOR program funded 18 grants at \$100,000 each, to form rural community partnerships to address this issue in rural communities. The partnerships are comprised of local emergency responders and other entities involved in the prevention and treatment of opioid overdoses and focus on the purchase and placement of emergency devices used to rapidly reverse the effects of opioid overdoses, for training on recognizing the signs of opioid overdoses, and the proper use of the devices. To date, approximately 600 people have been trained in the administration of naloxone and almost 2,000 devices have been purchased with 40 successful overdose reversals reported. The ROOR program has been included in the President's budget proposal for FY 17 at \$10M and, if appropriated, would continue this work and strongly emphasize the need to refer patients to an appropriate treatment center. These investments in health infrastructure will support communities to address substance use disorder well into the future.

Research Recommendations

Addressing the impact of opioid abuse, overdose and treatment in rural areas will require better data to drive future policymaking. The initial analysis shows clear rural disparities but further research is needed as not all programs take geographic differences into account. **The Committee recommends** the Secretary ensure that all U.S. Department of Health and Human Services research on opioid abuse, overdose and treatment include rural-urban data cuts nationally and regionally to better inform policy and resource allocation.

Conclusion

Ongoing prescription opioid misuse and heroin abuse pose a threat to the future of rural America. As many rural and tribal communities grapple with the challenges of geographic isolation, outmigration, poverty and lack of opportunity, opioid misuse and the associated community impacts put rural families at risk. In any community, widespread drug abuse inhibits the growth of industry, increases the difficulty in attracting new residents, and creates bleak futures for current residents.

The Department of Health and Human Services must ensure that policy measures are designed to empower rural health and human service providers to adequately respond to the needs of individuals in treatment and also the needs of their families in crisis. This is a vital step to creating systems of care that better serve the needs of rural communities.