MODERN DAY STONE SOUP:

SOCIAL WORKERS COMBATING THE OPIOID EPIDEMIC IN RURAL SETTINGS

6th Annual Social Work Conference
Presenter introductions

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Agenda

- Welcome
- Frame the opioid epidemic
- Evidence based practice for opioid intervention
- Rurality and Mental Health Services
- Rurality and Substance Use Services
- Wrap up
Learning Objectives

At the conclusion of this presentation, attendee’s will be able to:

- Explore national and local data trends related to the impacts of opioids on individuals/families
- Identify the role and skills of social workers employed in an integrated setting treating OUD
- Articulate the challenges and opportunities for social workers in addressing this challenge in rural settings
THE STORY OF STONE SOUP
As social workers we know a thing or two... so tell me

- What do we know about opioids?
- Why are they such a big deal?
HHS’s 5 Priorities

1. Improving access to treatment and recovery services;
2. Promoting use of overdose-reversing drugs;
3. Strengthening our understanding of the epidemic through better public health surveillance;
4. Providing support for cutting edge research on pain and addiction; and
5. Advancing better practices for pain management.
THE OPIOID EPIDEMIC BY THE NUMBERS

- **130+** People died every day from opioid-related drug overdoses
- **10.3m** People misused prescription opioids in 2018
- **47,600** People died from overdosing on opioids
- **2.0 million** People had an opioid use disorder in 2018
- **808,000** People used heroin in 2018
- **81,000** People used heroin for the first time
- **2 million** People misused prescription opioids for the first time
- **15,349** Deaths attributed to overdosing on heroin (in 12-month period ending February 2019)
- **32,656** Deaths attributed to overdosing on synthetic opioids other than methadone (in 12-month period ending February 2019)

**SOURCES**
1. 2019 National Survey on Drug Use and Health: Mental Health in the United States, 2018
2. NCHS Data Brief No. 329, November 2018
14 STATES
3 STATES
ALL OTHERS ARE NEUTRAL
EBP for Opioids

■ Medication Assisted Treatment
■ Professional Counseling
■ Case Management
■ Peer Support Specialist

■ In the context of an integrated approach
EBP for Opioids

- "Medication-assisted treatment (MAT) is the use of medications in combination with counseling and behavioral therapies, which is effective in the treatment of opioid use disorders (OUD) and can help some people to sustain recovery." – FDA, 2019

**FDA-approved buprenorphine products approved for the treatment of opioid dependence include:**

- Bunavail (buprenorphine and naloxone) buccal film
- Cassipa (buprenorphine and naloxone) sublingual film
- Probuphine (buprenorphine) implant for subdermal administration
- Sublocade (buprenorphine extended-release) injection for subcutaneous use
- Suboxone (buprenorphine and naloxone) sublingual film for sublingual or buccal use, or sublingual tablet.
- Subutex (buprenorphine) sublingual tablet
- Zubsolv (buprenorphine and naloxone) sublingual tablets

**FDA-approved methadone products approved for the treatment of opioid dependence include:**

- Dolophine (methadone hydrochloride) tablets
- Methadose (methadone hydrochloride) oral concentrate
EBP for Opioids

- Professional Counseling
  - CBT
  - DBT
- Group
- Individual
- Manualized Treatment
EBP for Opioids

Case Management
- Needs assessment
- Links with services
- Glue for the team

Peer Support Specialist
- Is in recovery
- Has lived experience to share
- Knows OUD IRL
EBP for Opioids

- Medication Assisted Treatment
- Professional Counseling
- Case Management
- Peer Support Specialist

- Literature calls for an integrated approach
- One stop shop
- One voice treatment that manages one another up; but is this realistic in rural communities?
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Rural Defined

- Urban cities with 50,000 or more residents
- Urban clusters, cities of more than 2,500 but less than 50,000.
- Approximately 97% of the U.S. is considered rural.
- Approximately, 1 in 5 Americans live in a rural area.
- Over 64% of rural Americans live east of the Mississippi.
- Nearly half (46.7%) of individuals living in rural America reside in the south.
Mental Health

- Rate is about the same in urban and rural areas
- Research Health Information Hub (2017), over 19% of individuals 18 and older in rural areas experience mental health issues.
- According to SAMHSA (2019), 47.6 million adults (18 and older) experienced a mental health issue within the previous year.
- Of those individuals, 11.4 million suffered a serious mental health issue such as suicide attempts in the previous year.
- Whitney and Peterson (2019) reported that 16.5% of children under the age of 18 have had at least one mental health issue in 2016.
- Further, they report that almost 50% of children who need mental health treatment do not receive services.
- According to SAMSHA (2019), 8.2 million youth 12 to 17 received mental health services in 2018. Nationally there is a mental health crisis.
Rural challenges to Mental Health Services – Shortage of Providers

- The ongoing shortage of professional mental health providers is well documented (Jensen & Mendenhall, 2018; Oetinger, Flanagan, & Weaver, 2014; Wilson, Knezevic, et al, 2018).

- Overall, according to Matthews et al (2017), less than 10% of health care practitioners provide services in rural areas. This lack of practitioners grows exponentially when you examine the availability of mental health providers.

- Over 80% of rural counties in the U.S. do not have a practicing psychiatrist (New American Economy, 2017).

- Further 47% of rural counties do not have a practicing psychologist versus only 19% of metropolitan counties. (Andrilla, Patterson, Garberson, Coulthard, & Larson, 2018).

- In addition, 81% of rural counties do not have a psychiatric nurse practitioner (Andrilla, Patterson, Garberson, Coulthard, and Larson, 2018).
Rural challenges to Mental Health Services – Shortage of Providers

- Only 20% of all social workers work in rural areas (Ohio University, nd).
- Hastings and Cohn (2013) reported that less than 50% of all rural counties had a master’s or doctoral level social workers.
- Due to the lack of trained mental health care professionals, individuals (if they seek treatment) do so from their primary physician.
  - Many of them are ill prepared to diagnosis individuals (Cohn & Hastings, 2013).
  - Physicians average 10 to 15 minutes with an individual.
Rural challenges to Mental Health Services – Geographic Dispersion

- 97% of America is rural
- Large geography agencies must services lowly populated areas.
- Much of rural America has less than 50 people per mile (Census Bureau, nd).
- The large land space coupled with the low density creates a barrier for service providers to reach clients and clients to reach service providers.
While each area may have access to part of the four-prong approach few if any have all four resources in their community (Galanter, Seppala, & Klein, 2016).

Approximately half of US counties have a physician who could prescribe buprenorphine (Rosenblatt, Andrilla, Catlin and Larson, 2014; Stein et al, 2015).

- Doctors are required to go through a rigorous process to be able to prescribe pharmacology.
- “Prescribing buprenorphine requires physicians to obtain a federal waiver, complete an eight-hour training, and meet other criteria” (Liebling, Yedinak, Green et al, 2016,18).

According to Rosenblatt, Andrilla, Catlin, and Larson (2014) only 2.2% of physicians in the United States had obtained the waiver to prescribe buprenorphine and the largest percentage of those were psychiatrist.

Lack of professional training and reimbursement difficulties compound the ability to access doctors for treatment (Liebling, Yedinak, Green et al, 2016).
Rural challenges to Opioid Care – Facilities

- Treatment facilities are few and far between often with limited access and fiscal resources for the opioid addicted individual.
- SAMSHA (2016) emphasized that lack of services was an availability barrier to accessing supportive therapies.
- “Rural counselors emphasized the lack of basic facilities attributable to inadequate funding” (Pullen & Oser, 2014, 895).
- Liebling, Yedinak, Green et al (2016) found that three most commonly reported barriers included waiting list, health insurance not approving enrollment and lack of ability to pay.
- “Rural areas often lack options for specialty substance abuse treatment programs – such as those tailored to women or racial minorities- which may discourage treatment utilization among vulnerable, underserved populations” (Pullen & Oser, 2014, 892).
- Couple this with the limited practitioners with specialization in opioid addictions, individual with opioid use issues often face limited options, which prohibit them from successful completion of opioid recovery (Bride et al., 2016).
Rural challenges to Opioid Care – Distance and Stigma

- Brems, Johnson Warner, and Roberts (2006) identified provider travel is often a barrier to accessing resources.
- Part of the issue with having to travel long distances are compounded by individuals living in rural areas may not have a driver’s license, a reliable car, or public transportation options (SAMSHA, 2016).
- Not having reliable transportation is often coupled with the stigma associated with services.
- As mentioned earlier, living in rural areas increases stigma that mental health services is a critical barrier. Couple with this stigma having to rely on family and friends is often avoided.
Discussion – Stone Soup

■ How do these findings compare to your experience?
■ What are some of the challenges you have faced in delivering MH care in rural settings?
■ What have you done to try and build coalitions in care delivery?
■ What are some next steps ideas that you can carry back to your agency to improve care in your area?