PREVENTION PERSPECTIVES

A Community Based Study of Opioid Use Behaviors in a Rural Indiana County

January 2016

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Acknowledgements

We would like to thank all those who assisted in the coordination of this research study: Scott County Partnership Inc., CEASE: Coalition to Eliminate the Abuse of Substances of Scott County, H2O: Hope to Others Ministries, and Scott County Health Department. We would especially like to thank the residents of Austin, IN who generously shared their experiences.

Suggested Citation

Howland, A.A., Benetti, M., & Zautra, N. (2016, January). *Prevention perspectives: A community based study of opioid behaviors in a rural Indiana county.* Prepared for CEASE of Scotty County and Indiana Division of Mental Health and Addiction.

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Background

The United States is in the midst of a growing substance abuse epidemic. Deaths in the U.S. from drug overdoses have increased by 137% since 2000, with a 200% increase in deaths involving opioids (including heroin and prescription pain medications).[2] The CDC estimates that the rise in opioid use, particularly prescription pain medications, is costing the U.S. roughly $55 billion annually with $5 billion in criminal justice costs, $25 billion in workplace productivity losses, and $25 billion in healthcare costs.[1, 10]

The consequences of this epidemic have been particularly troublesome for Indiana. It is estimated that the state ranks 12th in the U.S. in spent health care costs related specifically to opioid prescription pain medications, with an estimated figure of $640 million.[1,10] In 2013, roughly 30% of drug related deaths were caused by heroin and opioid prescription medication use.[7]

Most recently, Indiana caught national attention due to an HIV and Hepatitis C outbreak, in which all cases were caused by intravenous drug use of the opioid prescription medication Opana. A public health emergency was declared in the small, rural Southern Indiana town of Austin, situated in Scott County, which allowed for the county to establish a temporary syringe exchange program (SEP).[3, 4] Since that declaration, multiple laws and policies have been enacted to help reduce the impact of the health and substance abuse epidemics.[5, 13, 14] Indiana counties are now able to implement SEP's, so long as a public health emergency can be declared (specifically related to HIV or Hepatitis C). If requests are approved by the state, counties are able to operate these programs for up to one year with the option of making additional requests at the expiration of the one-year public health emergency declaration.[15, 17] As of January 2016, four counties have received approval for SEP's, including Scott, and nineteen other counties are in the process of requesting approval.[11]

Indiana Senate Bill 406, enacted in April 2015 allows for individuals to obtain and administer overdose intervention drugs, with certain provisions. [13,14] Indiana Executive Order 15-9 established the Governor's Task Force on Drug Enforcement, Treatment, and Prevention that is charged with gathering multi-sector stakeholders to "*assess the resources and programs available statewide, encourage collaboration among agencies and identify local models that may be extended to other areas of the state*".[5]

While Indiana has seen significant policy changes in response to the substance use issue, it is up to local communities to carry the torch forward. It is certainly necessary to focus attention on harm reduction, but attention must also be paid to treatment and prevention. Currently, it is estimated that only 5% of opioid-related healthcare costs are spent on substance use treatment, prevention, and research.[1, 10] It is imperative that communities not only focus on reducing the impact of the growing epidemic, but must also promote optimal health and wellness among all Indiana residents.

Methods

Study Design

This study is framed as a phenomenological study to describe the common meaning for several groups of individuals regarding their experience with intravenous drug use (IDU) within a single community to discover and prioritize current needs, identify strengths, and recommend potential next steps from the perspective of those most impacted by IDU (Crewell, 2013). In the case of Scott County the targeted groups included active intravenous drug users, persons in recovery from intravenous drug use, and family members of active users or persons in recovery. The goal was to develop a comprehensive description of the epidemic from the perspective of each of these groups of individuals including the common experiences or "what" was experienced and how these common experiences were contextualized by the different groups in terms of their individual perspectives, conditions, and situations through facilitated focus groups. Discussions lasted between 60 and 90 minutes and were audio-recorded and transcribed.

Sample

Consistent with a phenomenological study design, it is recommended that data from interviews or focus groups be collected from 5 to 25 participants who have all experienced a common phenomenon (Polkinghorne, 1989). The study's convenience sample included individuals present at and/or engaged in activities related to substance use harm reduction, treatment, and/or recovery provided by community churches, support and recovery groups, as well as health and social services pertaining to substance abuse harm reduction. The selection criteria for the study restricted participation to adult residents of Scott County, Indiana. In this study data were collected from 43 individuals who experienced the common phenomenon IDU as an active user (N=28), a person in recovery (N=9), or as a supportive family member (N=6).

Analyses

Transcriptions of semi-structured focus groups were analyzed using a phenomenological qualitative approach (Moustakas, 1994). Analyses were conducted using NVivo software which facilitate analyses within and across each group of individuals at each phase of analysis which include: 1) horizontalization, where researchers highlight significant statements that provide an understanding of how active users, persons in recovery, and family members experienced IDU; 2) theme development, where researchers develop clusters of meaning from significant statements in to themes; 3) textural description, where researchers use the developed themes to write a description of what individuals and groups experienced as a result of IDU, and finally; 4) a structural description of how specific individual and community conditions and contexts influenced these experiences within and between the three groups.

Findings

We conducted focus groups with a total of 43 men and women who fit the study criteria. Table 1 depicts the demographic characteristics of the sample. Among the focus group participants, the majority were white. All participants identified as having experience with intravenous drug use either personally or in relation to a close friend or loved one. A large number of those that participated in the focus groups, 22 participants, attended with their intimate partner or spouse, representing 11 couples.

Table 1: Characteristics of focus group study sample

	Focus Group Participants
Total number	43
Gender	
Male, *n* (%)	21 (48.8)
Female, *n* (%)	22 (51.2)

During initial coding by three individual researchers (horizontalization), 10 preliminary units of meaning were derived from significant participant statements across the three groups, resulting in the final development of the 6 comprehensive themes, described below.

Substance use related to experience of trauma

Traumatic experiences were connected with stories of substance use initiation. Several participants indicated unaddressed traumatic experiences and the associated feelings and memories as underlying causes of initial use and continued use:

> *I lost my brother, I lost my nephew on the same day. He killed his 5 year-old son. Before that my mom was murdered. Before that.. [mumbling] I didn't do nothing through all that. And all of the sudden, it's like one day I look up and everything went all to hell.*

Participants expressed a desire to "not feel". As one participant remarked:

> *Our feelings and our memories and just everything that goes through our mind for so long is out of our mind when we use—to cover it up. That's how we look forward to go back to. Because that's for so long, that's all we know. We don't want to think or feel.*

Using drugs intravenously to avoid traumatic memories and the associated feelings often results in chemical dependence:

> *Well you do it to change the way you feel. And you know you want to feel normal, you want to feel better, but then that changes what you do. Know what I mean, you're not yourself. Because when you get to that point that you're that sick you'll do a lot of things that you didn't think that you would do before just to again change the way you feel.*

To alleviate the horrific symptoms of chemical dependence on Opana, individuals behave in ways they later perceive to be shameful. As one participant remarked, *"I was so mad that I didn't care what I done at the time as long as I got what I needed I was fine. But as soon as I was done with it then I started feeling guilty".*

The perceived need to obtain Opana by any means necessary was described by another participant, "*We're gonna take what we can get so we don't get that sick on."*

Loss of relationships resulting from intravenous drug use and related behaviors

Individuals reported the loss of close relationships among friends and family members resulting from drug procurement incidents such as stealing and lying. Feelings associated with the loss of close relationships were particularly painful. One participant explained, *"And I was off the needle for 8 years and now my family pretty much disowned me and won't let me see my daughter. And all I want to do is get high and not think about all that."*

The need to obtain and use drugs eclipses all others:

> *It makes you very selfish, you know what I mean. You like you expect. You start expecting other people to do without their own needs because we do without. Like "well I'm not going to eat" because I'm trying to get the money to get high today. "I'm not going to eat today,. It's like, why should you? If you got money you should give it to me." Or say somebody loans you money and you pay it back to them. Then later that day you need some more money so you wanna think "they should loan it to me again because I know that they got it. And you know me, I paid them. Why don't they loan it to me again? That coulda been their bill money or anything, but you don't care.*

Consequences resulting from intravenous drug use and related behaviors vary widely in severity depending on the duration of drug use. As in the case of one participant:

> *For me everything was just stripped from me. My family was completely done. I had a job building bridges for 7 years, they was they were done you know. And I lost my daughter and my home, my vehicles. You know, no education, full of felonies.*

The consequences of use within family structures was particularly pronounced in that people felt at a certain point as if their family members wanted nothing to do with them:

> *Most of us I feel like have used and abused our family so much or manipulated them for so long that they're done. They're tired of it. They're tired of seeing us self-destruct. They love us, but they don't love us when we're high…. They don't' want to get hurt all over again.*

In some cases, participants perceived that their intravenous use of drugs was met with especially harsh rejection:

> *They hear us using the needle and they don't want to hear it, they don't want to see your ass, they don't want nothing to do with you.*

They can drink, it's not a problem. But once you put that needle in your arm you're on your own.

Entering treatment risks losing remaining relationships

Emotional stress of physically leaving an intimate partner relationship was another barrier expressed by participants who indicated they had few sources of support. Partners expressed concern over the safety and wellbeing of their significant other should they leave to enter treatment, *"He won't go to rehab unless he can go with me… they won't let you do that. But they got women and men, but they won't let nobody go in together".*

Although relationships between individuals using substances intravenously often promote continued drug use among partners, they also suppress the already limited access to treatment. Many perceive that entering treatment and abstaining from drug use would potentially compromise their relationship. As stated by one participant,

> *We are never apart. Ever. Every time I go to treatment they tell me to leave my husband, then every time I get out he's using. Of course he's using, I'm using too, but we're both trying to get out though. Why would I get a divorce?*

The possibility of losing even an unhealthy relationship is too great a risk to take for an uncertain treatment outcome. Further, participants described developing a relationship with their drug of choice that superseded all others and was so all encompassing that the idea of discontinuing use was overwhelming and seemingly impossible:

> *It's like any other relationship. I look at my drugs like a relationship and it's like I mean it can be your everything, you know what I mean. And you can love it, you can hate it. And it's kinda like being, I've never been really in a domestic violence situation, but I can kinda compare it to something like that. Where a woman can be so scared, you know, they don't want to be in the situation. They want to leave. But even as bad as that is, the fear of unknown. It's a lot harder to get sober than it was to just go and get high, you know. When you get down this low and you have nowhere to live or whatever. And you've gotta change everything. You have to make some major changes. Like you know say my husband don't want to get sober too. Then what do I do? I've got nowhere to go. Know what I mean. I've gotta change my [life]. Not just...that might mean getting a divorce or relocation. And how do you start from the bottom when you can't, you know, you got maybe charges against you, or this or that. You can't get people to hire you. And then if they did you wouldn't have a car to get there. You know, I mean you just you get overwhelmed with all the 'this is what I gotta do to' and you know it's just real easy to just run back to what you know. It just kinda holds you down.*

Challenges to entering treatment and recovery

One of the greatest barriers to entering substance use treatment is lack of or insufficient health insurance coverage. As one participant described, *"Well, a lot of the time: insurance.*

If you don't have really good insurance you're not going to get your child in to a good rehab or detox or whatever".

Mental health services are also limited due to insurance. As one participant described, *"Well I know that one of the places in town that they go for counseling won't even take insurance. Now how many people in these two communities are gonna be able to afford self-pay like that?"* Untreated mental illness contributes to substance use initiation, continuation, and relapse with or without engaging in treatment.

Available substance use treatment is perceived as difficult to access, often unaffordable, and insufficient in scope:

> *It's hard to find a good treatment plan. Anybody can find a 30-day plan. Residential, 30 days and then you're spit out. And there they go. And there's really no support, unless they really just, they gnaw and crawl and get... you know, they have to really want it so bad. It's just not, they don't have like a 'ok you're gonna get 30 days here in this little residential program or 6 months and then we're just going to spit you out into your community where you came from. And you're gonna be with the same old people doing the same old things'.*

The cost of maintaining medication assisted treatment was prohibitive:

> *When you go in they give you Suboxone, they started me on that, and once you get out they give you a 30 day supply. It's alright, but you have to go to a doctor, but you cannot find a doctor that easy. They're just not around. And the ones that are around want so much money $1500.*

Transportation and geographically removed treatment services were identified as barriers to recovery. As a small rural community there is no public transportation system. One participant described the transportation paradox, *"I mean I can call on somebody to get me a ride to go get high with somebody, but I can't get a ride to the social security office to get my social security card, so I can get a job."*

Extreme poverty and homelessness contribute to continued use and act as a barrier to engaging in treatment and recovery. Participants shared, *"There's no resources for people that's homeless. None."* In addition to no public transportation and no homeless services, the nearest grocery store is 5 miles away:

> *It's so bad in this town that the only grocery store that we had in this town closed down because they was going into debt for everybody going in and stealing so much in the store that they couldn't afford to keep their doors open. So now we don't even have a grocery store in this town.*

Beyond structural and systemic barriers to recovery, shame was another challenge to overcome. One participant described, "*It's a burden on your shoulders the things that you done to people.*" Facing consequences in regard to loved ones is especially challenging:

I think the hardest thing about recovery is you're finally sober and then you have to live with all the consequences, the people you've hurt, or maybe, I lived with people that I sold drugs to that never did drugs, but now are complete full blown addicts. I played a part in that, you know.

Feelings of shame, isolation and discrimination

All groups described experiencing stigma as a result of personal intravenous drug use or use by their loved ones. Parents experience shame in connection to their own enabling behaviors. As one parent described, *"I mean, you think you're helping them out. But until you know they're really hard core dope addicts, or whatever you want to call it, drug addicts. You want to help your child."* Parents felt isolated in their experiences related with their child's drug use:

I mean you know statistically there's more parents out there or spouses, but see I've been battling forever. My children are both addicts and their father was an addict. And I battled it with him. And I finally divorced him and then I started a worse battle than the spousal thing. I mean if you think it's bad with your spouse try it with your children. It's really bad... And they were both IV drug users and I just, there's just something about that I guess. I used to think that was just the worst of the worst.

Feelings of shame and isolation contributed to feeling inadequate as a parent:

Well there is shame. I mean I run into people that says "and my kids have masters degrees and they're working in New York. And they're doing this and this and this. What are your kids doing?" [WELL]... P11: Mine's in jail. (Participants together) Yeah. P14: Well like my son's probably overdosed 3 times... I mean he's survived, but I mean it's been a major ordeal for us all, but like I've had 2 children that have had a problem, but just one who's an intravenous user.

Perceived stigma of intravenous drug use contributed to feelings of hopelessness among family members. As on parent described, "*Well that's the thing, I think after awhile they get... the stigma is so much. That they just, they figure there's no reason to get clean, there's no reason to try to do right because they're just a pile of crap. They get told that everyday."*

Among those actively using drugs, stigma greatly impacted employment opportunities. As in the case of one participant, "*They all look at you like you're an IV drug user. Walk in anywhere and ask for a job. They'll look at you and say, "Sorry we're not hiring" even when they say they are hiring."* Although available job opportunities are severely limited in the community, participants perceived discrimination resulting from their status as a "user":

Even if you don't have a felony. Just if you have that certain background, being an addict or you know being a junkie or whatever, people discriminate. People are judgmental. And they're not wanting to, like if I was to walk in the Dollar Store and I was clean and I put in that application you know at least one of those bitches behind that counter is saying "don't hire her" you know "she's a junkie" or "she was a junkie."

Participants strongly felt that they were defined by their drug use and as such could not get help even if they had a strong desire to do so:

> *It's what you do, it's not who you are. And it's really hard not to define yourself when you got so many people pointing a finger at you, but like that's your only problem. And that's my main problem, is I actually wanted to get help, and I'm sure everybody in this room had some kind of problem of why they started using. So if you don't get to the root of that you ain't going to find somebody to help you with that you are not going to stop using.*

Reconciliation and hope for the future

Very little hope for the future was expressed among active users, although several volunteered to be representative examples of the consequences of drug use as a method of deterring youth from future use:

> *Just look at me. Use me as an example. If I was more educated about it when I was younger, I wouldn't do what I do, but the facts of it is. Cons and pros about it. I never got that growing up, I always thought it was cool. I guess they change it now. Reality check ya know. I taught my grandchild ever since he could learn about drugs, and now he knows. His parents are addicts too. It was just mostly education. Getting that path, a little bit of direction. You can't make anybody do anything. But at least you can give them that sense of direction.*

Fear about being forgiven and accepted is a barrier to change. As one participant described, *"It's a big step going back and facing what you done because you got this fear that you're not going to be liked anymore."*

Although hope for the future is minimal, people do desire a chance to reconcile and try to do better. As one participant remarked,

> *It's like you know going to church you know when you sin. A lot of people just give up you know. Don't give up. Just pray for forgiveness and go on you know cuz it's not over you know. You can always better yourself. You're better than you was yesterday.*

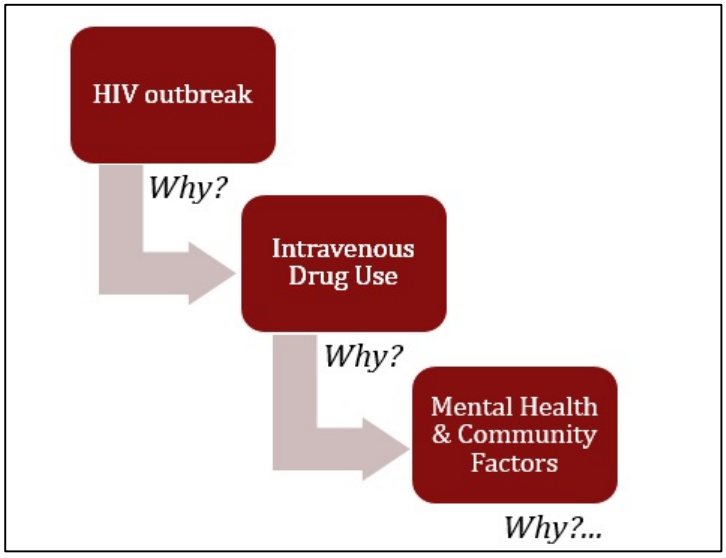
Discussion

Amidst a recent HIV/Hepatitis C outbreak and a growing opioid use crisis, it can be difficult to think about prevention. Millions of dollars and countless resources have been spent containing the outbreak and the opioid crisis, particularly within the criminal justice and child welfare systems, as well as on healthcare and substance abuse treatment. While focusing resources in this manner is important and necessary, a broader perspective is critical to examine the underlying causes of these problems as they are not only treatable, but preventable. It is equally critical to look at these issues through a public health lens and identify what actions to take to reduce the impact of harm, eliminate the risk of future problems, and to promote wellness in Indiana.

In order to comprehensively address and prevent substance use and the associated societal consequences, efforts to impact change cannot just be made at the individual or treatment level, but should also be targeted at the community and system levels. Most resources, albeit limited, are allocated towards treatment and rehabilitation; however, solely focusing on this *downstream* approach is limited in its effectiveness. Because resources for treatment and prevention are so limited, it is important to determine which approaches will make the most impact, and attempt to reach as many people as possible. These wider reaching approaches, or *midstream* and *upstream* approaches, attempt to effect and sustain community and systems change.[12]

To broaden towards *mid-* and *upstream* approaches it is necessary to examine the reasons why the epidemic occurred. By asking the question "Why?" we begin to examine the root causes of the epidemic and have a better understanding of the various pathways toward this problem. As root causes are examined and identified, solutions and points of intervention are revealed as well. The figure below shows one such pathway of root causes that were identified in our focus groups, and while they are specific to Scott County, may be translatable to other Indiana communities as well.

Figure 1: Examining Root Causes



For example, ask:

Why are people contracting HIV and Hepatitis C?

In Scott County, the root cause was intravenous drug use of prescribed opioid medications, both legally and illegally obtained.

Taking another step back, it is possible to explore the root causes of intravenous drug use:

Why are people injecting prescription and illegal drugs, resulting in opioid addiction and subsequent co-morbidities?

There are a myriad of factors that are associated with the pathways towards intravenous drug use and opioid addiction, however, three main root causes were identified in the focus groups: *mental health*, *relationships*, and *community factors*.

Mental health was related to low self-esteem, experiences of shame, diagnosable mental health disorders, as well as exposure to trauma and domestic violence as children and adults.

Relationships were central in that support networks were minimal. Relationships were damaged because of substance use, boundaries between loved ones were blurred and enmeshed, and a sense of community was longed-for amongst almost all participants.

Community factors pertained to limited access to food, shelter, transportation, and affordable healthcare.

Recent data also supports these causes, as the Robert Wood Johnson Foundation (RWJF, 2015) County Health Rankings report that Scott County fell to the bottom when compared to the other 91 counties. In 2015, Scott County ranked 92 in Length of Life, 91 in Quality of Life, and 91 in Social & Economic Factors.

These factors are also referred to as social determinants of health, which are, "*individual, neighborhood, and community resources and opportunities as well as hazards and toxic exposures*" (Jones, Jones, Perry, Barclay, & Jones, 2009; pg. 8). Examples of social determinants of health, as cited by the Secretary's Advisory Committee on Health Promotion and Disease Prevention Objectives for 2020 (2010), include:

- Access to quality healthcare
- Access to quality community services
- Adverse childhood experiences
- Education and job training
- Employment
- Food Security
- Housing
- Mental health
- Social Supports
- Transportation

The notion of addressing social determinants is supported by Koh, Oppenheimer, Massin-Short, Emmons, Geller, & Viswanath (2010) as they recommend to improve population health and wellness through integrated approaches that address social and economic factors, social support networks, physical and social environments, access to health services, as well as social and health policies.

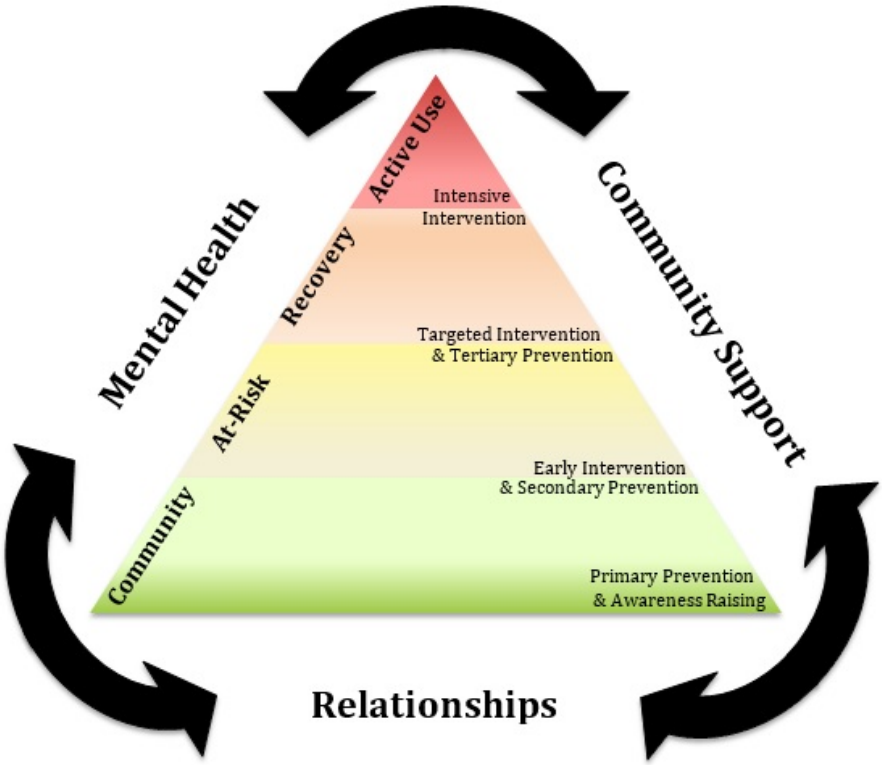
Mental health, relationships, and community factors are theorized in this study as critical points of intervention for communities. By addressing these underlying causes, communities can not only reduce the impact of substance use and prevent continued use, but can be strengthened as well.

The following section describes recommendations for how communities can initiate and target change efforts by leveraging their existing resources. Other resources are also provided to aid in efforts to reduce the impact of this epidemic, prevent future use, and promote wellness for all Indiana families.

Recommendations

Recommendations generated from study findings are framed by a conceptual model outlining a *Community Continuum of Supports*. The model is conceived as a comprehensive, public health approach to preventing and reducing harm from substance use through prevention and intervention activities that encompass the entire community and address the social, mental, and environmental conditions that affect health and wellness.

Figure 2: Community Continuum of Supports

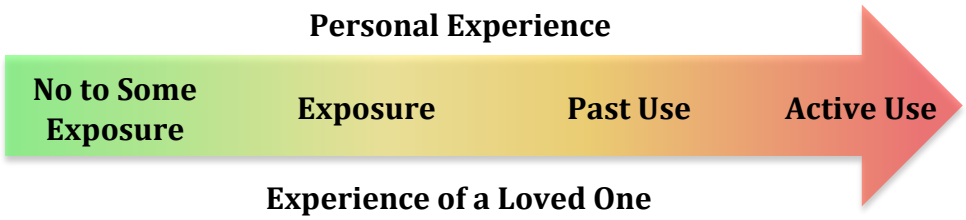


The three social determinants of health that were derived from the data as underlying causes – *mental health*, *relationships*, and *community support* – were present among all groups as both risk and protective factors. These determinants are also theorized to have a bidirectional relationship. For example a loss of community supports such as access to a grocery store compromises mental health which can subsequently impact relationships.

Because *mental health*, *relationships*, and *community support* are ubiquitous and interrelated, they surround the triangle model as key points of intervention that affect the health of all community members, regardless of their experience with substance use or addiction.

Therefore, the triangle section of the model has four tiers that encompass the entire spectrum of exposure to substance use: Active Use, Recovery (past use), At-Risk (exposure), and Community (no or some exposure). The term exposure is used to broadly focus the model on not only the individual's personal experience with substance use, but also the support systems of those individuals.

Figure 3: Experience and Exposure



The triangle also identifies the scope of activities recommended across the spectrum, moving from focused (i.e. intensive intervention) to broader (i.e. awareness raising) activities. While the tiers in this model are described categorically, these distinctions are arbitrary as the reality of substance abuse is fluid and ever changing. Relapse is known to be part of recovery, so a person may move between the recovery and active use tiers over time. We attempted to make this distinction by placing the recommended activities between each tier.

The rationale for each tier of the triangle, conceptualized within the framework of interrelated determinants that underlie the spectrum of exposure to substance use is detailed below. Examples of frameworks, interventions, and activities are provided within each tier for reference.

Active Use

Those who are experiencing opioid addiction require the most **intensive interventions** through rehabilitation, mental health treatment, support to reduce barriers to other community-level determinants of health, as well as harm reduction interventions such as syringe exchange programs. Family members of these individuals face hardships as well.

Focus group participants who were actively using reported having varying levels of experience with treatment. Many spoke of considering treatment, however, withdrawal symptoms appeared to be a significant barrier, as many reported spending most of their time seeking opioids to avoid feeling sick.

Those who had participated in treatment were often told to cut ties with significant others and friends who were also experiencing addiction, which is a common aspect of treatment. While the logic behind this is reasonable, participants felt that their significant others were the only resource or support they had. There was a common desire to engage in treatment

as a couple, but this is prohibited in current treatment programs. Participants felt that they would rather stay in the relationship and continue to use rather than face sobriety alone.

Many were also homeless or had unstable housing and were unable to get their basic needs met on a daily basis, often going hungry. It was explained that there is no grocery store in the community, and although there is a store about five miles away there is no available public transportation beyond a taxi service. Additionally, while a food pantry exists in the community, there are limited sources for cooked meals. Many participants expressed frustration with being offered boxed and canned food without an ability to prepare it.

Data also showed that family members of individuals actively using or in recovery felt shamed, isolated, and unsure of how to help loved ones. They cited a lack of available resources and supports for family members, as well as personal and structural barriers to existing supports.

The Substance Abuse and Mental Health Administration (SAMHSA, 2009) created a framework called Recovery-Oriented Systems of Care. This model is a comprehensive treatment and services approach that is inclusive of supporting individuals, families, and communities, as well as addressing the full range of social determinants that impact health. SAMHSA (2009; pgs. 8-9) describes the model as "*networks of organizations, agencies, and community members that coordinate a wide spectrum of services to prevent, intervene in, and treat substance use problems and disorders*" and "*is a shift from acute care methods to the broader adoption of chronic care strategies throughout systems of care*." Communities should explore the use of this model within their own contexts and to advocate for shifts in policy to help remove any barriers to implementation. Information about this model can be found in the Resource section on page 23.

Suggested Intensive Intervention Activities

Mental Health

- Access to quality and affordable opioid treatment programs
- Supported referrals to mental health professionals for on-going treatment
- Access to quality and affordable mental health professionals

Relationships

- Access to support groups for family members and friends
- Skill building (such as boundary setting) for family members and friends

Community Support

- Shelter and housing for homeless individuals
- Access to healthy and affordable food (local markets, kitchens, and pantries)
- Syringe exchange programs
- Education and access to overdose intervention treatments

Recovery

Those in recovery need similar supports to those in active use, but the intensity of those supports and services depends on the length of sobriety, as well as the level of opportunities and barriers to determinants of health**. Targeted intervention and tertiary prevention** activities such as, access to on-going, trauma-informed care, support this tier.

Many of the focus group participants had participated in some type of treatment, whether or not they were still maintaining sobriety. There was a consensus that 30-day rehabilitation programs were not particularly helpful because they did not provide much direction or support beyond the walls of the facility. It became clear that treatment is a complex and dynamic process, and is only effective with ongoing support. The focus group participants that had been to in-patient treatment programs were often referred to a mental health professional and some were provided with a 30-day supply of Suboxone, or buprenorphine, a medication that aids in mitigating withdrawal symptoms (Volkow, 2014). However, when they returned to their community, they faced many barriers to continuing treatment. Mental health supports were expensive and not easily accessible, prescriptions for medications were also expensive and many could not find doctors who were willing to prescribe the medication because of their history. Those who were able to find a doctor could not afford the healthcare fees.

There was also a stark awareness and recognition for the hurt past and active users had caused their loved ones and the damage they had done to themselves, and to face those realities without support felt insurmountable. Many also told stories of traumatic experiences and were unequipped with the skills to allow them to effectively heal from those experiences. The one central coping skill that had been developed was to use substances, which is a common cause for relapse.

Shame and stigma were common themes for family members as well. They expressed a fear of being perceived as a bad parent and placed blame on themselves, particularly if their family member was their child. Family members wanted to help their loved ones, but struggled with establishing boundaries and distinguishing between helping and enabling behaviors.

Suggested Targeted Intervention and Tertiary Prevention Activities

Mental Health

- Access to quality and affordable opioid treatment programs and mental health professionals
- Educational programs that build coping skills
- Trauma-informed treatment options

Relationships

- Access to support groups for recovery and family members of those in recovery
- Educational programs about co-dependency

Community Support

- Monitored and supported use of medication-assisted opioid treatment
- Opportunities for employment

At-Risk

Research shows that adverse childhood experiences or exposure to traumatic experiences can put people at risk for array of negative health outcomes (Felitti et al., 1998), including substance abuse. **Early intervention and secondary prevention** activities are critical for at-risk individuals, particularly for youth and young adults such as engagement in and support for positive activities and skill building.

Exposure to trauma was a common experience among focus groups participants, either in childhood or adulthood, particularly domestic violence and death of close loved ones. Mental health issues were prevalent, and the need for more accessible and affordable services was expressed. Family members reported that their children had untreated mental health issues early in life and felt that if resources had been available for their loved ones, substance use might have been prevented. Family members also cited that, looking back, they would have appreciated learning about risk factors and the early warning signs of substance use.

There is a large evidence-based for trauma-informed approaches to treatment and care. Organizations and agencies who treat or serve those who have experienced trauma must provide services in a way that promotes healing and avoids re-traumatization. Information about trauma and trauma-informed care can be found in the Resources section on page 23.

Research supports that *mental health*, *relationships*, and *community support* have an impact on youth at risk for negative outcomes. The U.S. Department of Health and Human Services, Administration for Children, Youth, and Families (ACYF, 2015) has found evidence supporting various skills, activities, and environments as protective factors for vulnerable populations. In 2015, ACYF released a factsheet detailing the ten protective factors with the strongest evidence mitigating negative outcomes among youth. Information can be found in the Resources section on page 23.

Suggested Early Intervention and Secondary Prevention Activities

Mental Health

- Targeted life skills training (self-regulation, relational, & problem solving skills)*
- Treatment for exposure to trauma (i.e. adverse childhood experiences)
- Organizational practices that avoid re-traumatization

Relationships

- Parenting support - Information on recognizing signs of use, red flags

Community Support

- Monitored and supported step down approach to reducing dependence on prescribed opioid medications
- Promotion of positive activities for youth*

**ACYF (2015) Protective Factors*

Community

Primary Prevention and Awareness Building activities represent the broadest level of supports for communities. These activities are aimed at the community-at-large, but should be emphasized for children and families. At minimum, people should feel safe, welcome, and supported in their communities. Supportive relationships and environments help to positively impact children and families. Efforts made to promote these characteristics in homes, schools, and neighborhoods strengthen communities and promote health and wellness.

Focus group participants discussed how their community had changed from when they were children. They remarked that growing up, there were more activities that engaged the entire community, they felt safe and protected in their community, and neighbors were supportive of one another. Participants described the current state of their community as drastically different; feeling isolated, unsafe, and unsupported.

Research supports that community development, family strengthening, and asset development promotes safety, health, and wellness as well as reduces the risk for negative outcomes. The Search Institute (1990) created a set of forty, evidence-based assets, or strengths, that support positive development for youth and communities. These assets focus on creating opportunities for youth to build their capacity and engage in positive activities as well as building youth skills and competencies. Information about the 40 Developmental Assets can be found in the Resources section on page 23.

Additionally, the Center for the Study of Social Policy created a Strengthening Families framework that promotes resilience and supports for families, particularly those with young children (Harper, 2014). The framework is comprised of five protective factors to support in families which are: *Parental Resilience*, *Social Connections*, *Knowledge of Parenting and Child Development*, *Social and Emotional Competence of Children*, and *Concrete Supports in Times of Need*. Information about the Strengthening Families framework can be found in the Resources section on page 23.

Suggested Primary Prevention and Awareness Building Activities

Mental Health

- Promoting social and emotional competence
- Screening and identification of symptoms/issues in children and adolescents
- Preventing adverse childhood experiences
- Access to quality and affordable mental health and health care providers

Relationships

- Parenting support to promote positive and effective parenting skills

Community Support

- Promoting developmental assets
- Access to healthy and affordable food
- Safe public spaces for community engagement and recreation
- Promoting alternatives to medicated pain management

Closing Thoughts

Not all communities have access to the same resources, nor the same quality of resources. Some communities experience more barriers, violence, substance use, homelessness, or poverty than others. These differences result in disparities, or inequities in health. Jones et al., (2009) help to provide an explanation of broader system-level issues at play that are underlying causes of these inequities, and are called the **social determinants of equity**; which are "*systems of power that determine the range of social contexts and the distribution of populations into those contexts.*" Particularly in the United States, the social contexts are the "*economic structure, which creates class structure through the means of private ownership and the means of production*". Keeping these larger societal issues in mind, we propose that communities are nonetheless able to build on what resources they do have. For instance, in Scott County community strengths include resilience, close-knit relationships, and active groups and coalitions that are committed to improving their community. People are the experts of their own lives and have the ability to leverage their resources in order to strengthen and support their communities.

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Resources

The Search Institute's 40 Developmental Assets
http://www.search-institute.org/research/developmental-assets

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http://www.in.gov/isdh/files/ISDH_SEP_Guidance_for_LHDs_-_FINAL_-_6-5-2015.pdf

Recovery-Oriented Systems of Care (ROSC) Resource Guide
http://www.samhsa.gov/sites/default/files/rosc_resource_guide_book.pdf

Strengthening Families Framework

http://www.cssp.org/reform/strengtheningfamilies

Indiana State Supervised Opioid Treatment Programs List

http://www.in.gov/fssa/dmha/files/OTP_Treatment_Centers_-_1-2012.pdf

Promoting Protective Factors for In-risk Families and Youth: A Guide for Practitioners.

https://www.childwelfare.gov/pubs/factsheets/in-risk/

National Child Traumatic Stress Network

http://www.nctsn.org/

Indiana Youth Institute

http://www.iyi.org/