STORIES *from* SULLIVAN

HOW A RURAL COMMUNITY RESPONDS TO THE OPIOID EPIDEMIC

Patricia Strach
Katie Zuber
Elizabeth Pérez-Chiqués
Photos by Kyle Adams

Rockefeller Institute of Government

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A billboard near Fallsburg, New York

CONTENTS

1. Pathways to Addiction 3
2. The Invisible: The Forced Displacement of Poppy Growers in Mexico 13
3. Rural Challenges 17
4. Sullivan County, 1982 23
5. Fighting Back 26
6. Spillovers 33
7. #MeToo in the Wake of Addiction 37
8. A Family Disease 40
9. What Can State and Federal Officials Do to Help in the Opioid Crisis? Listen. 44
10. When Battling Addiction, Is Jail Time the Problem or the Only Solution? 45
11. The Other Family Separation Crisis 53
12. Deaths of Despair or Access to Healthcare? 63
13. Combating the Opioid Epidemic Is Not Just about More Services — It's about Access to the Right Services 71
14. The Illusion of Services 76
15. Seven Things That Everyone on the Frontlines of the Opioid Crisis Should Know 87
16. Five Myths of the Opioid Crisis 93
17. So Far from God 102
18. Stigma Kills 107

FOREWORD

In mid-2017 the team at the Rockefeller Institute of Government began discussing one of the most pressing problems facing the nation: opioid misuse. Reports of overdoses and the human and social toll of the opioid crisis were daily occurrences. As a result, the issue was seared into the public consciousness.

However, we noticed something peculiar from the reports: The more policymakers responded with new programs to address the crisis, the death rate only grew. There was a policy disconnect.

It wasn't the first time our society grappled with an opioid crisis, but the size and scale of the current crisis was different. In every state, rural, suburban, and urban communities, rich and poor, people of diverse racial and ethnic backgrounds were all dealing with how to respond to the crisis.

The capacity to respond to the crisis also was different. I was struck by the fact that a rural West Virginia community had the highest opioid death rate in the nation. Putting aside the chicken-or-egg root causes of the crisis, this community was already struggling — adding an opioid crisis to respond to was almost unthinkable. But, like West Virginia, New York also had many pockets of rural communities struggling as well.

Communities like Sullivan County. To note, Sullivan County is a place of strong, diverse communities and natural beauty. I grew up in the area and still have family there. But the opioid crisis has hit the community hard — and they are fighting back.

To examine this response, and the policy disconnect, is why our research team, led by our Director of Research Dr. Patricia Strach, sprang into action. Although there were a number of important studies on the opioid crisis, our goal was to embed our team in a community ravaged by the crisis in order to gain a richer understanding of the root causes of the crisis in order to target effective solutions. It wasn't only about numbers and statistics. It was about reaching out to the community — families, health and treatment providers, law enforcement, individuals in recovery, activists, and many others — to build a grassroots perspective and understanding. From there, we could develop recommendations for policymakers that could stem the tide.

What was just an idea of a study in mid-2017 became Stories from Sullivan. It was a unique way to provide evidence-based research to a broad community of policymakers, researchers, and the general public. We did not have a traditional thesis that we were testing. Our team went with an open mind. As important, we presented our findings as we went — a process we called "research in real time."

More than two years later, more than 100 interviews, hundreds of meetings and calls, numerous drafts, reams of analysis, and a never-wavering commitment to solving the crisis, we are happy to present our initial report. **There's more to be done, but the Rockefeller Institute of Government team has presented a road map to solve this crisis.**

This will be one of the Rockefeller Institute's more important contributions to practical policy research, and for that the Stories from Sullivan team deserves tremendous credit, including: the core research team of Drs. Patricia Strach, Katie Zuber, and Elizabeth Pérez-Chiqués; the communications team led by Communications Director Kyle Adams, Michele Charbonneau, Michael Cooper, and Alexander Morse; and Chief of Staff Heather Trela for making sure the project was fully supported without a hitch. Of note is the photography throughout the report by Kyle Adams, which brilliantly captures the essence of what was happening on the ground. Finally, I want to thank our guest contributors Kevin Haworth for his shared experience of growing up in Sullivan County, and Angélica Ospina-Escobar for her comparative pieces from Mexico. These important contributions demonstrate that we are interconnected and facing similar issues, no matter the geography or political current of the day.

This report is essential reading for policymakers, press, researchers, and the general public to understand not only how to effectively address the opioid crisis, but also how to dig deeply into a pressing public policy matter in order to understand the problem and provide evidence-based solutions. This study is groundbreaking not only for its recommendations, but for its mold-breaking research process. Too often research is presented as black and white. More often it is shades of gray. Our team successfully presents this complicated picture with clarity, honesty, and deep understanding.

Jim Malatras
President
Rockefeller Institute of Government
June 2019

ABOUT SULLIVAN COUNTY

Nestled in the Catskill Mountains, a mere 90 miles northwest of New York City (but beyond the public transportation lines to get people to and from there), lies Sullivan County, New York. With houses dotting picturesque lakes and views of the valleys beyond, it's easy to imagine Sullivan in the early twentieth century as "a place of wellness" where tuberculous patients came to recover, or in its heyday in the 1950s and 1960s as a vacation destination. New Yorkers, desperate to get out of the congested city in the humid summer months, flocked to Sullivan's resorts. As one provider explained, the "county was the Las Vegas of the East. Literally, this was the place to come to see Frank Sinatra." But, like much of upstate New York and many rural communities across the country, Sullivan's major industries including both tourism and agriculture have faltered. When resort hotels like Kutsher's, the Concord, and Grossinger's closed, people in the county lost access to well-paying jobs. Local shops, like those lining the main street of South Fallsburg, are now vacant and boarded up.

Sullivan County has 78,000 residents spread across a thousand square miles. It does not have a single Starbucks and just one Walmart, which we were told is the only place to buy essentials, like underwear, in the county. We provide these details not only for context about what Sullivan is like, but also for readers to understand how assumptions we may have about how to address problems may not work in places that are so different from where many of us (researchers and policymakers alike) live and work.

INTRODUCTION

In rural communities like upstate New York's Sullivan County, where the bus runs twice a week and cab fare is expensive, people who need substance-abuse treatment often have a hard time getting to it.

A few years ago, one public official in the county wanted to show state officials how vital transportation is to addressing access, especially in a county the size of Rhode Island. She started by inviting them to Sullivan County. Instead of meeting in a conference room, she took them for a drive.

"I tried to really give them a visual," she said. "They were shocked that it took an hour to get from one end of the county to the other, and that's just straight."

It's clear that America has an opioid problem. In conversations with people on the frontlines of the epidemic, however, it is not so clear that lawmakers in Albany or Washington DC, understand the realities of the crisis — like the challenges of accessing services in remote rural communities.

This disconnect between the communities fighting opioids on a day-to-day basis and lawmakers devising solutions in the state's Capitol weakens the response to the opioid crisis. How can we expect state and federal officials to craft relevant solutions to a problem we don't fully understand?

In an effort to bridge this disconnect between local communities and lawmakers, the Rockefeller Institute of Government is conducting an in-depth study of the opioid crisis in Sullivan County, a rural community located 100 miles northwest of New York City.

Readers will follow the project as it happens — what we call "research in real-time."

By talking to community members, public officials, medical experts, and activists, we seek a better understanding of the causes and effects of the opioid epidemic not just in Sullivan County, but in similar communities across the country.

In short, we ask:

+ **What does the opioid problem look like in a small, rural community?**
+ **How has the community responded?**
+ **What do people on the ground need from government to address it?**

In essence, this project looks at how government works by examining its response to a public health crisis. How do different levels of government — state, federal, and local — work together to address the situation? Are the policy solutions really addressing needs on the ground? How are governmental agencies and departments working or not working together in response?

Our work combines aggregate data analysis with on-the-ground research in affected communities to provide insight into what the opioid problem looks like, how communities respond, and what kinds of policies have the best chances of making a difference.

PART 1

Fallsburg, New York

Pathways to Addiction

HOW THE US DEVELOPED AN OPIOID PROBLEM

How did opioids become a problem in the United States? It's a question that many people are asking and that most newspapers purport to know the answer to, at least if you read the headlines. Opioids became a problem in the early 1990s when big pharmaceutical companies tried to boost profits by pushing the sale of painkillers. People eventually got hooked, but when they lost access to prescription medications they turned to heroin as a cheaper, more accessible alternative.

This is a common story told about the origins of America's opioid epidemic, and it is probably a story you've heard once or twice before. But does it really tell the whole story?

In an effort to answer that question, we traveled to Sullivan County, which has one of the highest opioid death rates of any county in New York State, to consult with community members, public health officials, and the families of people struggling with addiction. Although many people agreed that prescription drugs and the pharmaceutical companies are largely to blame for the current crisis, this narrow focus on painkillers ultimately obscures other parts of the story we heard about legitimate injuries, recreation, and self-medication. In short, it misses the broader

sociocultural and economic changes that have coalesced alongside a shift in physicians' prescribing practices to lead America down the road to addiction. In this blog, we unpack the national narrative surrounding the opioid crisis in the United States, and then adjust it to account for what we heard on the ground in Sullivan County.

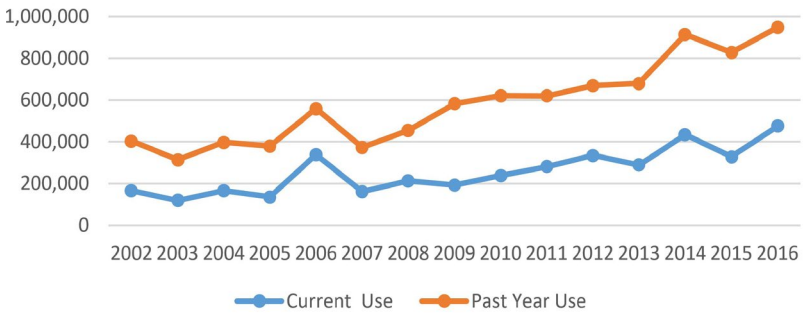
HOW DID OPIOIDS BECOME A PROBLEM?

THE NATIONAL NARRATIVE

Americans moved from prescription opioids to heroin and now fentanyl.

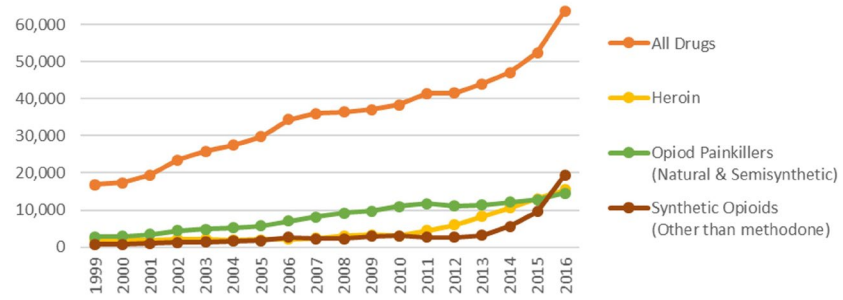
Nearly every account of the opioid crisis in America begins in the early 1990s, when large pharmaceutical companies sought to boost profits by increasing the sale of prescription opioids. Indeed, while many doctors feared the addictive properties of drugs designed to minimize pain, companies like Purdue Pharma set out to change physicians' prescribing habits by aggressively marketing and promoting their drugs. As early as 1995, the Food and Drug Administration approved Purdue Pharma's pain reliever OxyContin, and other opioids like it, for the purpose of treating moderate-to-severe pain lasting over extended periods of time.[1] Although organizations like the Agency for Health Care Policy and Research believed that such drugs could be used to improve long-term treatment of cancer pain, companies like Purdue hired hundreds, if not thousands, of sales representatives to push the drug on primary care physicians — physicians who treated conditions other than cancer

Heroin Use among People Aged 12 or Older, 2002-16



SOURCE: Rockefeller Institute analysis of data from the 2016 National Survey on Drug Use and Health.

Number of Drug Overdose Deaths in the United States, 1999-2016



SOURCE: Rockefeller Institute analysis of data from the 2016 National Survey on Drug Use and Health.

Note: Current use indicates those individuals who reported using heroin in the past month, whereas past year use represents any individual who reported using heroin within that year.

1 *Prescription Drugs: OxyContin Abuse and Diversion and Efforts to Address the Problem*, Report to Congressional Requesters GAO-04-110 (Washington, DC: United States General Accounting Office, December 2003), https://www.gpo.gov/fdsys/pkg/GAOREPORTS-GAO-04-110/pdf/GAOREPORTS-GAO-04-110.pdf.

including arthritis, injuries, and chronic back pain.[2] Their efforts paid off. By 2001, sales of OxyContin exceeded $1 billion annually, and the drug became "the most frequently prescribed brand-name narcotic medication for treating moderate-to-severe pain in the United States."[3]

Consistent with what has been described as a "coordinated, sophisticated, and highly deceptive marketing campaign," designed to convince "doctors, patients, and others that the benefits of using opioids to treat chronic pain outweighed the risks," the sale of prescription opioids skyrocketed in the United States.[4] Between 1999 and 2010, sales of opioid pain relievers nearly quadrupled, fueling an increase in the number of opioid-related deaths.[5] During the same 11-year period, opioid-related deaths climbed steadily from 8,050 in 1999 to 21,089 in 2010 and beyond. By 2016, estimates from the Centers for Disease Control and Prevention indicate that between 1999 and 2016 opioids claimed the lives of more than 350,000 Americans.[6]

Alarmed by the growing number of deaths, state and federal officials sought to restrict access to painkillers,

According to research published in *Addictive Behaviors*, an increasing number of people are experimenting with heroin as their first opioid, rather than transitioning from painkillers to heroin, as the dominant narrative would suggest.

or so the narrative continues. In 2016, Massachusetts became one of the first states to limit the duration of first-time opioid prescriptions to seven days.[7] In little over a year, the National Conference of State Legislatures found that 23 states enacted similar legislation, with prescribing limits ranging anywhere

2 Patrick Radden Keefe, "The Family That Built an Empire of Pain," *New Yorker*, October 30, 2017, https://www.newyorker.com/magazine/2017/10/30/the-family-that-built-an-empire-of-pain.
3 *Prescription Drugs: OxyContin Abuse and Diversion and Efforts to Address the Problem*.
4 *County of Sullivan vs. Purdue Pharma L.P., et al.*, Supreme Court of the State of New York, Sullivan County, Index No. 2017-961, June 7, 2017, http://webapps.co.sullivan.ny.us/docs/cmgr/pr/y_2017_m_06_d_08-Summons-and-Complaint.pdf.
5 "Vital Signs: Overdoses of Prescription Opioid Pain Relievers — United States, 1999-2008," *Morbidity and Mortality Weekly Report (MMWR)* 60, 43 (2011): 1487-92, https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm?s_cid=mm6043a4_w%20-%20fig2.
6 "Data table for Figure 1. Age-adjusted drug overdose death rates: United States 1999-2016," https://www.cdc.gov/nchs/data/databriefs/db294_table.pdf, in Holly Hedegaard, Margaret Warner, and Arialdi M. Miniño, *Drug Overdose Deaths in the United States, 1999-2016*, NCHS Data Brief No. 294 (Washington, DC: National Center for Health Statistics, December 2017), https://www.cdc.gov/nchs/data/databriefs/db294.pdf.
7 Office of the Massachusetts Governor, "Governor Baker Signs Landmark Opioid Legislation into Law," press release, March 14, 2016, https://www.mass.gov/news/governor-baker-signs-landmark-opioid-legislation-into-law.

from three to 14 days. Prescription drug monitoring programs (which seek to improve opioid prescribing) and dosage limits (which penalize healthcare providers who prescribe patients more than a certain amount of opiates) are two additional examples of state-level interventions designed to control the supply of opiates. For its part, the federal Drug Enforcement Administration (DEA) announced in October 2016 that it would reduce the manufacture of almost every opioid pain medication in the United States by a minimum of 25 percent.[8] Although many people celebrated these supply-reduction efforts as a necessary first step in the war against opioids, others warned about their effects on people already struggling with addiction. Indeed, for the men, women, and teenagers already dependent on prescription opiates, limited access to painkillers created a new problem — finding more money to buy more expensive pain pills on the street, or tracking down a cheaper, more accessible alternative. For many, the solution was heroin.[9]

A rise in the use of heroin seems to bear this out. According to *The National Survey on Drug Use and Health*, heroin use in the United States has steadily increased since 2007, with only a few exceptions. Because heroin consumption is not as common as the use of other illicit drugs, the survey includes estimates for both current (past month) and past year use. Throughout 2016, an estimated 948,000 people aged 12 or older used heroin (see figure on page 5). Although this figure was comparable to the estimates reported in 2014 and 2015, it was still higher than the estimates reported each year between 2002 and 2013.[10] Not surprisingly, the number of heroin-related deaths has also climbed. "Between 2002 and 2013, the rate of heroin-related overdose deaths nearly quadrupled," with more than 15,000 deaths occurring in 2016 alone.[11]

Although heroin claimed the lives of more people in 2016 than in any of the previous 15 years, fentanyl — which is a powerful synthetic opioid that is "fifty to one hundred times more potent than morphine" — proved even more deadly.[12] Over the past several years, the rate of overdose deaths involving fentanyl and other synthetic opioids doubled from 9,580 deaths in 2015 to roughly 19,400 in 2016, making fentanyl the deadliest opioid now available in the United States (see "Number of Drug Overdose Deaths in the United States, 1999 - 2016" on page 5).

8 United States Drug Enforcement Administration, "DEA Reduces Amount Of Opioid Controlled Substances To Be Manufactured In 2017," press release, October 4, 2016, https://www.dea.gov/divisions/hq/2016/hq100416.shtml.

9 Theodore J. Cicero, Matthew S. Ellis, and Zachary A. Kasper, "Increased use of heroin as an initiating opioid of abuse," *Addictive Behaviors* 74 (November 2017): 63-6, https://www.researchgate.net/publication/317131906_Increased_use_of_heroin_as_an_initiating_opioid_of_abuse.

10 Rebecca Ahrnsbrak et al., *Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health* (Rockville: Substance Abuse and Mental Health Services Administration (SAMHSA), September 2017), https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm.

11 "Today's Heroin Epidemic," Centers for Disease Control and Prevention, last viewed July 7, 2015, https://www.cdc.gov/vitalsigns/heroin/index.html.

12 "What is fentanyl?," Centers for Disease Control and Prevention, last updated August 29, 2017, https://www.cdc.gov/drugoverdose/opioids/fentanyl.html.

So what explains this move from prescription painkillers to heroin and now fentanyl? The common explanation outlined above is that cracking down on prescription opiates has shifted the market to more dangerous drugs like fentanyl. As one senior Vox news reporter put it: "If you go after opioid painkillers, people will eventually go to heroin. If you go after heroin, they'll eventually go to fentanyl. And if you go after fentanyl, they might resort to some of its analogs, like carfentanil."[13] Admittedly, this logic makes sense. It assumes that whenever individuals lose access to prescription painkillers they are forced into the streets to buy stronger, cheaper alternatives. However, this explanation is too simplistic for understanding the complexities of the current opioid crisis. Although the increasing number of deaths does raise questions about the utility of supply-reduction efforts, this common narrative concerning the transition from painkillers to heroin and now fentanyl fails to account for a variety of other factors that have contributed to the current opioid crisis. These include rapid increases in heroin production; changes in the distribution strategies of drug traffickers; and broader patterns of drug addiction throughout the United States.

CHEAP HEROIN FLOODS THE MARKET

With respect to the supply-side economics of addiction, a substantial increase in the availability of heroin has created new opportunities to abuse it. As the DEA observed in its *2017 National Drug Threat Assessment*: "Rapid increases in heroin production in Mexico since 2015 have ensured a reliable supply of low-cost heroin, even in the face of significant increases in user numbers.... This increase was driven in part by reduced poppy eradication in Mexico and Mexican organizations' shift to increased heroin trafficking."[14] What this means in the context of the United States is that more people have access to heroin than ever before. According to research published in *Addictive Behaviors*, an increasing number of people are experimenting with heroin as their first opioid, rather than transitioning from painkillers to heroin, as the dominant narrative would suggest.[15] In 2005, less than 10 percent of people who were dependent on opioids used heroin first. However, a decade later, that number increased to a third, making heroin "the leading drug for new opioid initiates." As one observed, a dealer-driven increase in supply "gave more people new opportunities to try heroin even if they weren't addicted to painkillers."

Changes in the way drug traffickers are doing business have also contributed to the rising number of deaths, particularly with respect to the sale of fentanyl. While prescription fentanyl — which takes the form of patches or lozenges — is sometimes diverted

13 German Lopez, "How fentanyl became America's leading cause of overdose deaths," Vox, updated December 21, 2017, https://www.vox.com/science-and-health/2017/5/8/15454832/fentanyl-carfentanil-opioid-epidemic.

14 *2017 National Drug Threat Assessment* (Washington, DC: U.S. Department of Justice, Drug Enforcement Administration, October 2017), https://www.dea.gov/sites/default/files/2018-07/DIR-040-17_2017-NDTA.pdf.

15 T.J. Cicero, M.S. Ellis, and Z.A. Kasper, "Increased use of heroin as an initiating opioid of abuse," *Addictive Behaviors* 74 (November 2017): 63-6.

Jared Levine is recovering from an opioid addiction. The hardest part, he said, is aftercare. If you're not on probation, it's more difficult because there is no one watching you.

from healthcare facilities, it is more common for powdered forms of the drug to be illicitly manufactured in China and Mexico and then smuggled into the United States.[16] Once here, powdered fentanyl is mixed into heroin, oftentimes without the buyer's knowledge, or pressed into counterfeit pills resembling Xanax, Oxycodone, and other opioid medications. When used as a cutting agent in heroin, fentanyl "looks like heroin, is packaged in the same baggies or wax envelopes as heroin, and displays similar stamps or brands as heroin."[17] From a dealer's perspective, the logic is simple. By mixing fentanyl with other adulterants including sugar, dealers can sell less heroin for the same price and oftentimes with the same effect. In fact, the DEA has observed that an increasingly large amount of fentanyl is being sold as heroin, even when there is no heroin in the product.

Although most people who are exposed to fentanyl are unaware that it was used to cut heroin, there is some anecdotal evidence to suggest that others actively seek the drug. When we asked folks in Sullivan County about whether people know they are being sold fentanyl, one retired probation officer told us that some people go looking for it. When a death occurs, rather than alert people to avoid a particular dealer, it signifies to

16 *2017 National Drug Threat Assessment.*
17 Ibid.

buyers the drug's potential potency. "If it does kill somebody they run down the road and get more," he explained. The DEA alluded to a similar phenomenon in its *2017 National Drug Threat Assessment*. According to the federal government's leading drug agency, public health warnings intended to notify "the community that a particular heroin stamp is known to contain fentanyl" can actually cause "some users to go in search of it." Still, the DEA believes that the vast majority of heroin users who are exposed to fentanyl actually have no desire to take the drug.[18]

Beyond the supply-side economics of drug addiction outlined by the DEA, we spoke to folks in Sullivan County about what they believed was driving the epidemic. Surprisingly, their answers didn't revolve around drug cartels in Mexico or the profits to be made by selling fentanyl. Instead, their responses were rooted in the small, rural community in which they lived. In fact, the only person to mention illegal drug markets in Mexico or China was a county-level official who told us that the federal government was failing in its responsibility to stop drugs at the border. In describing the federal government's "lackluster response" to the opioid epidemic, he pointed out that opioids — unlike marijuana — cannot be grown legally in the United States. "The great poppy fields of Sullivan County aren't fueling this issue," he reassured us. Still, the vast majority of people we spoke to talked less about foreign drug markets than about the realities of why people in rural communities turn to opioids in the first place.

By night, the Evergreen Apartments complex in Monticello is known as a hotspot for drug-related activity.

FROM A BIRD'S-EYE VIEW TO A WORM'S-EYE VIEW: PATHWAYS TO ADDICTION IN SULLIVAN COUNTY

Although we spoke to a variety of people in the fields of public health, law enforcement, and even families struggling with addiction, they pointed us in the direction of three main pathways to addiction — legitimate injuries, recreational use, and self-medication.

LEGITIMATE INJURIES

When asked about the different pathways to addiction, several people told us that friends and family members were prescribed opiates following a physical injury at school or work — for example, a high school student who was prescribed painkillers after suffering a football injury; a young woman who had her wisdom teeth removed; or a middle-aged man who slipped and fell at work. Because men and women of all ages are susceptible to these types of injuries,

18 Ibid.

the sentiment in Sullivan County is that opioid addiction "does not discriminate" — that it threatens young and old, rich and poor, urban and rural communities alike. However, some respondents, many of them public health officials, expressed concern that middle-aged people and the elderly are at a particularly high risk for opioid use. "It's not just young people," one official told us. "A lot of people think that it's the 18-to-24-year-olds. What we're really finding is it's predominantly more in the 30-and-40-year-olds."

National statistics bear these findings out. Between 1999 and 2014, the CDC found that prescription overdose rates were highest among people aged 25 to 54 years old.[19] Listening to the folks in Sullivan County, many people feel that prescribing practices themselves obscure the dangers of taking prescription medications to manage pain-related injuries. In the paraphrased words of one respondent — it starts off with a prescription, then leads to a problem. It's not cocaine, which you buy from the street. It's not marijuana, which comes from an illegal source. The rationalization is that it's from a doctor. People don't realize its impact.... Once you're hooked, you're hooked.

RECREATIONAL USE

Despite growing concern over opioid use among middle-aged Americans, there was considerable speculation regarding the pathways to addiction among those who use drugs recreationally. Oftentimes, though not always, these discussions focused on teenagers who are allegedly stealing painkillers from their parents' medicine cabinets. According to Aleta Lymon, former director of prevention and training at the old Recovery Center in Monticello, young people are gaining access to prescription drugs by going to pharm parties in Sullivan County. "They're taking the medicine from their medicine cabinets at home, and they're going to parties, and they're dumping all these meds into bowls," she told the *Times Herald Record*.[20] After talking with several people about opioid use in Sullivan County, such concerns appear rooted in the belief that drugs have increasingly come to define youth culture in the United States. Thus, one parent and community organizer told us about songs like "Rockstar," which glamorize "poppin' pillies" and other forms of drug use. Kids, she explained, are looking for more ways than ever to get high, whether that's by huffing glue or mixing prescription cough syrup with soda and Jolly Ranchers (the so-called purple drank or sizzurp, named after the ingredient used to make it). Still, the notion that kids are doing what they've always been doing, namely partying with drugs to have fun, was prevalent in many of the conversations we had about young people. While it remains to be seen whether, and to what extent, changes in American youth culture precipitated the current opioid crisis, one thing is certain — the drugs available to young people are becoming both increasingly deadly and available.

19 "Prescription Opioid Overdose Data," Centers for Disease Control and Prevention, last updated August 1, 2017, https://www.cdc.gov/drugoverdose/data/overdose.html.

20 Leonard Sparks, "Task force plans prescription-drug disposal days," *Times Herald-Record* recordonline.com, May 27, 2012, http://www.recordonline.com/article/20120527/NEWS/205270322.

SELF-MEDICATION

While pill parties and the purple drank conjure up images of teens acting irresponsibly and out of control, it is clear that young people turn to opioids for other reasons. Of the three women we spoke with whose children struggled or are struggling with addiction, two indicated that their daughters were ostracized at school because they didn't fit in. The use of heroin among these young women was not a form of acting out, or even the result of a dependency on painkillers. Instead, it was a form of self-medication. According to one parent: "My daughter she was bullied in school and I think that's part of the reason why she started." For others, opioids helped their children cope with anxiety, depression, and other co-occurring mental health disorders. Thus, another parent indicated that her daughter, now in recovery, was never prescribed painkillers. In fact, she never even smoked cigarettes. Yet once her daughter discovered that marijuana could help reduce her anxiety, it was only a matter of time before she started using alcohol, and eventually heroin, to cope with her mental health issues. This is not to say that all people with mental health disorders use drugs to self-medicate their symptoms, or vice versa. Indeed, the causal relationship between mental health and substance-use disorders is still unclear.

However, the number of people with co-occurring disorders is significant. In 2016, an estimated 8.2 million adults aged 18 or older (3.4 percent of all adults) experienced co-occurring mental health and substance-use disorders, even though only about half received either mental health care or substance-use treatment.[21]

Research on the rising morbidity and mortality of middle-aged white Americans indicates that teenagers are not alone in using opioids to self-medicate. In a now-famous study, researchers Anne Case and Angus Deaton found a surprising increase in midlife mortality among non-Hispanic whites living in the United States due to drug overdoses, suicides, and chronic liver diseases. In interpreting their data, Case and Deaton have argued that these so-called "deaths of despair" may be linked to declining wages, limited job opportunities, and fewer marriages.[22] In other words, failure to fulfill societal expectations has led to higher rates of suicide, drug use, and other risky behaviors, particularly among middle-aged white Americans. In Sullivan County, which is 73 percent white, the effects of joblessness and other "collateral issues," as they were described to us, can be seen driving through town.[23] As one service provider described it:

> If you were to drive over Route 52 to go to ShopRite, it's not uncommon — if you keep your eyes open — to see people walking over that overpass with a baby carriage, holding the baby in their arms, with everything they own in

21 Rebecca Ahrnsbrak, et al., *Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health* (Rockville: Substance Abuse and Mental Health Services Administration (SAMHSA), September 2017), https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015/NSDUH-FFR1-2015.pdf.

22 Anne Case and Angus Deaton, *Mortality and Morbidity in in the 21st Century*, Brookings Papers on Economic Activity (Washington, DC, Brookings Institution, Spring 2017): 397-476, https://www.brookings.edu/wp-content/uploads/2017/08/casetextsp17bpea.pdf.

23 "Sullivan County, NY," Census Reporter, accessed June 26, 2018, https://censusreporter.org/profiles/05000US36105-sullivan-county-ny/.

Jill Neails, a resident of an affordable housing complex in Monticello, helps tend a community garden in a space once known as an open-air drug market.

> the carriage.... Now put it this way. I'm going to be brutally honest with you. If I was in that position, I'd probably shoot dope too. I would boot up and bang off in a heartbeat if I felt that hopeless.

In Sullivan County, like many other rural communities throughout the United States, townspeople have watched as industries died, wages diminished, and jobs evaporated. Yet many people remain. In this setting, people don't just use drugs because they want to experiment or have fun, although some of them do. In this setting, people depend on drugs to numb the reality of an otherwise painful existence. Absent an understanding of how these broader, socioeconomic forces feed into the cycle of addiction, any response to the opioid crisis will be inadequate at best.

CONCLUSION

Sullivan County isn't much different from other communities ravaged by the opioid epidemic. An increasing number of people are dying but there's very little anybody can do to stop it, or at least that's what most people told us. Thus, when researchers, journalists, and politicians ask the question about how opioids became a problem, it is imperative that we speak to the people who face down this epidemic every day in their communities. Indeed, a national narrative that begins and ends with pharmaceutical companies and aggregate data misses the human element of addiction and the multitude of pathways to get there.

"The displaced" of Guerrero, from Cuartoscuro Archivo

PART 2

The Invisible: The Forced Displacement of Poppy Growers in Mexico

After interviewing dozens of people in rural Sullivan County about the opioid epidemic, it's clear that the people on the frontlines cleaning up the problem are not the ones who created it. As one person in Sullivan told us, the great poppy fields of Sullivan County are not feeding the problem. So, what is? Where does heroin come from? In this piece, Angélica Ospina-Escobar and Juan Camilo Pantoja-García provide insight into the state of Guerrero, and the impoverished rural communities in Mexico that produce heroin. Caught between poverty, a government that prohibits poppy production, and the violence of drug cartels who want control over poppies, farmers must choose to grow poppies or leave their homes. *Translated by Elizabeth Pérez-Chiqués.*

ABOUT THE AUTHORS

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DESPITE THE ENORMOUS RESOURCES that the Mexican state dedicates to campaigns to eradicate poppy crops, practical results have been disappointing. Between 2006 and 2015, poppy production in Mexico increased by 422 percent, from 12,355 to 64,495 acres.[1] The case of the state of Guerrero, located in the south of the country, is paradigmatic because even though Guerrero has been targeted by much of the eradication efforts (33,908 acres were destroyed between 2014 and 2017), the state was the leading producer of poppy during these years.[2]

Considering the negative effects that poppy producers face, including forced internal displacement, it is worth considering why they assume both the risks and the burdens of engaging in an activity that turns them into criminals in the eyes of the state. The difficult socioeconomic conditions experienced by these communities generate favorable conditions for the development of illegal economies because they cannot find other viable alternatives to satisfy their basic needs. The farmers in Guerrero's mountains face the dilemma between emigrating and cultivating poppy to survive.

"WE PLANTED POPPY OUT OF NECESSITY, NOT BY CHOICE"

In 2015, 67 percent of the population of the state of Guerrero was poor,[3] 23 percent lived in conditions of extreme poverty,[4] and 44 percent in moderate poverty.[5] The municipality of Leonardo Bravo is classified as highly marginalized with 87 percent of the population below the poverty line, 33 percent are extremely poor, and 54 percent are moderately poor.[6] Conditions of scarcity created favorable conditions for Guerrero to become a central state in supplying the demand for the poppy flower, and to become a processing and transit zone for the drugs derived from this plant — 18 of the 31 rubber laboratories in the country that were dismantled between 2010 and 2015 were in Guerrero.[7] Therefore, it is not unsurprising that, according to some estimates, 80 percent of the people of Guerrero's mountains supplement their income with the cultivation of poppy.

They also plant avocado, peaches, corn, beans, and peanuts, and have small businesses. However, as the growers themselves say, the geographical characteristics of Guerrero's highlands, together with the historical lack of

1 *World Drug Report 2018* (Vienna: Research and Trend Analysis Branch, Division for Policy Analysis and Public Affairs, United Nations Office on Drugs and Crime (UNODC), June 2018), https://www.unodc.org/wdr2018/prelaunch/WDR18_Booklet_2_GLOBAL.pdf.

2 Ibid.

3 A person is in a situation of poverty when their income in insufficient to satisfy their basic needs, and when they have a deficiency in one of six indicators, including access to health services, education lag, access to housing, and access to food. See Coneval (2019), "Medición de la pobreza--Glosario," https://www.coneval.org.mx/Medicion/Paginas/Glosario.aspx.

4 A person is in a situation of extreme poverty when they have three or more deficiencies, of six possible, within the Social Privation Index and which, moreover, is below the minimum welfare line. People in this situation have such a low income that, even if they dedicate it completely to the acquisition of food, they could not acquire the necessary nutrients to have a healthy life (as defined by Coneval 2019, "Medición de la pobreza—Glosario").

5 "Medición de la pobreza multidimensional y Gasto en Ramo 33: Indicadores a nivel municipal, 2010 y 2015 — Guerrero," PowerPoint presentation, Centro de Estudios de Finanzas Púbicas (CEFP), January 2018, http://www.cefp.gob.mx/publicaciones/presentaciones/2018/pbr/Guerrero.pdf.

6 Ibid.

7 *World Drug Report 2018*.

public investment in infrastructure such as roads and irrigation systems, make it difficult for any crop other than poppies to be profitable enough for these farmers. As Yuritzia López Gómez, a leader of the poppy grower communities in Guerrero, observed:

> The process of poppy harvesting lasts three to four months,[8] tell me what could be a profitable crop for farmers that had that harvesting time and that would have buyers for their product. Where, in addition to that, we have an infrastructure in roads that is very deteriorated … when the product already goes down to the city, it comes shaken, the avocado arrives as guacamole.

Because of the number of annual harvests (up to three), the little water that it requires, and the ease with which it grows in the highland soil, the poppy is a crop that allows farmers to access the income necessary to cover basic needs such as buying medicine or getting medical tests — services that should be public, but that the state does not guarantee. The United Nations has recognized that the problem of poppy cultivation is not only a matter of security, but is intimately linked to the development of the cultivating communities.

However, poppy cultivation does not always guarantee a secure income. Between 2000 and 2016, Guerrero experienced a boom in poppy cultivation due to, among other things, an 88 percent fall in coffee prices.[9] The price of opium gum has also fallen, from between 15 and 20 thousand pesos per kilo until 2018 (between $790 and $1,000 in US dollars) to 3 and 5 thousand pesos in 2019 (between $158 and $263).

In addition, the illegal nature of this crop, which turns into criminals those who are dedicated to its production, throws farmers into a situation of marginalization, not only judicially, but also politically and socially. As the leader of the poppy growers explained, there are many misconceptions and stigma surrounding these communities:

> Poppy has turned — within our state, Guerrero — in the economic sustenance for at least 1287 communities … you think of Guerrero, well, they produce opium gum, they [surely] have big houses, big cars and more, you go there and you realize that's not the case…. And on top of that society demonizes them by saying "poppiers" ("amapoleros"), when they do not even know … how they are living in that region.

State presence in these communities has been basically limited to military operations, which have exacerbated the problems of their already fragile economies. The Mexican federal government's strategies to decrease the presence and strength of criminal organizations throughout the republic had the unintended effects of splitting

8 In contrast, the cultivation of avocado requires, in addition to abundant water, manure, and fertilizers, five years to have a harvest and other plants such as peaches only have one harvest season per year.

9 Romain Le Cour Grandmaison, Nathaniel Morris, and Benjamin T. Smith, "No More Opium for the Masses: From the U.S. Fentanyl Boom to the Mexican Opium Crisis: Opportunities Amidst Violence?," Network of Researchers in International Affairs (NORIA), 2019, https://www.noria-research.com/app/uploads/2019/02/NORIA_OPIUM_MEXICO_CRISIS_PRO-1.pdf.

existing cartels, multiplying the number of criminal organizations operating in the state, and profoundly altering the structure of organized crime in Guerrero. In 2005 the Sinaloa cartel was the only organization operating in the state of Guerrero, but by 2016 there were no less than 50 criminal organizations operating in the state.[10] These smaller criminal organizations lack the logistical capacity for international drug-trafficking operations of the larger cartels, and supplement their income with other, more violent, criminal activities, such as kidnapping and extortion, which require greater territorial control over the communities where they operate.[11]

"IF WE LEFT OUR COMMUNITIES IT IS BECAUSE WE DID NOT WANT TO DIE."

Guerrero is the second most-affected state in terms of population by the phenomenon of forced internal displacement in the Republic. This is a problem that, although it has been downplayed in Mexico, has continued to increase in tandem with the escalation of violence related to the illegal production and trafficking of drugs. The case of Guerrero, however, is not an isolated one. Forced internal displacement is a phenomenon that has been increasing in the country over the last 10 years. Official data recognize that, between 2002 and 2017, almost 330,000 people, mostly farmers, were displaced.[12] In 2017 alone, 20,390 displaced persons were reported, with the state of Guerrero having the second largest number of documented cases in Mexico. However, these figures are likely an underestimate because there are no official registration mechanisms in Mexico to account for the displaced population, nor a legal framework that recognizes internal displacement as a serious violation of human rights and that offers remedies.

The forced displacement of poppy farmers by organized crime reveals the fragility of the existing order in rural territories, with little visible presence of the state and where the search for survival is the engine that drives individuals to cultivate an illicit plant as well as leave their belongings when an armed group violently takes over their territories. Poppy growers are the weakest link in the heroin trafficking chain and face, in state abandonment, multiple forms of violence, starting with poverty.

ACKNOWLEDGMENTS

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10 Rogelio Agustín Esteban, "Se disputan Guerrero 50 bandas criminales," *Milenio*, January 22, 2016, https://www.milenio.com/policia/se-disputan-guerrero-50-bandas-criminales.

11 Victor Manuel Sánchez Valdés, How to Reduce Violence in Guerrero, "Building Resilient Communities in Mexico: Civic Responses to Crime and Violence" Briefing Paper Series (Washington, DC: Mexico Institute, Woodrow Wilson International Center for Scholars, and San Diego: Justice in Mexico, University of San Diego, September 2015), https://www.wilsoncenter.org/publication/how-to-reduce-violence-guerrero.

12 Brenda Gabriela Pérez Vázquez, Lígia de Aquino Barbosa Magalhães, and Montserrat Castillo Portillo, *Episodios de Desplazamiento Interno Forzado Masivo en México Informe* 2017 (Mexico City: Comisión Mexicana de Defensa y Promoción de los Derechos Humanos, (CMDPDH), 2018), http://www.cmdpdh.org/publicaciones-pdf/cmdpdh-informe-de-desplazamiento-interno-masivo-en-mexico-2017.pdf.

PART 3

Rural Challenges

NESTLED IN THE CATSKILLS, Sullivan County has a striking natural topography: beautiful mountains and houses dotting picturesque lakes. It's no wonder why, in its heyday, New York City's residents flocked to Sullivan to escape the summer heat.

Like many upstate communities, however, major industries have left. The agriculture and tourism industries that drove Sullivan's economy have declined substantially, and the prevalence of drugs has increased. Today, like many places, opioids are common. Even though Sullivan is a relatively small county of 78,000 people, it has one of the highest opioid death rates of any county in New York.[1]

A 2017 Rockefeller Institute report found that more than 3,000 New Yorkers died from drug overdoses in 2015, a number that has steadily grown over time.[2] Although no part of the state is left untouched by the opioid problem,

1 Jim Malatras, *By the Numbers: The Growing Drug Epidemic in New York* (Albany: Rockefeller Institute of Government, April 2017), http://www.rockinst.org/wp-content/uploads/2017/11/2017-04-20-By_numbers_brief_no8-min.pdf.

2 Ibid.

the effects are most stark in upstate communities. For example, between 2010 and 2015, the Bronx saw a 57 percent increase in drug-related deaths, while Onondaga County saw a 145 percent increase, and Erie County a more than 250 percent increase.

State policymakers have shined a light on the opioid problem with both executive and legislative task forces and a broad package of reforms — reducing the amount of opioids a doctor can prescribe, eliminating insurance barriers for treatment, and increasing the number of treatment beds in New York.

Even with good intentions, statewide reforms mandating particular kinds of behavior can still have a disparate impact on the state's very different regions. What works in New York City — with its extensive infrastructure and robust economy — may not work in upstate areas without these advantages. Or, what works in urban centers like New York City, Albany, or Buffalo, may not work in rural counties like Sullivan because rural areas face a different set of challenges than urban or even suburban areas.

Ruins of The Pines resort in Monticello. Above, a farm in western Sullivan County.

WHY ARE OPIOIDS SO HARD TO COMBAT?

In our discussions with policymakers, health officials, community activists, and providers in Sullivan, we heard common themes, likely similar in many other places: it's hard to get appropriate treatment; there is little or no support for housing and jobs; and wraparound services are nonexistent. But we also heard of problems distinct to rural places like Sullivan: All of the above problems are exacerbated by a lack of services and a lack of transportation.

ACCESS TO APPROPRIATE TREATMENT

In New York City, lack of access to treatment services might mean plenty of doctors and facilities, but some that will take a patient unable to pay. In rural areas like Sullivan, some services are just not available: There are no detox beds in the county's premier hospital and service providers rely heavily on outpatient treatment. We heard over and

over again about a lack of both treatment beds in qualified medical facilities and even just beds to sleep in at night. Getting a bed of any kind requires a wait.

Families, providers, health officials, and activists noted that the model of care has shifted and long-term treatment facilities are closing. As one county health official told us: "There is no long-term treatment programs anymore, the eighteen to twenty-four months do not exist. Do I understand it? Yes,... I do understand the six to nine month, and so on and so forth. There's just no ifs, ands, or buts about it." Treatment was most often at outpatient facilities, but outpatient rehabilitation is especially hard in rural counties that lack public transportation.

The county — a thousand square miles, roughly the same size as Rhode Island — runs just two bus routes and only on Thursdays and Fridays.

HOUSING AND JOBS

We heard over and over again how people addicted to opioids had difficulty finding housing and jobs, even after they completed treatment. For all of the empty resorts peppering the county, there are few housing options for addicts who have completed recovery programs. They go back to the same environments that maintained or even fed their addictions. Low-income individuals, for example, are housed in motels known for cockroaches and drug deals. As a lawyer explained to us, once people with addictions finish a program, they are forced back to the place that got them started and they relapse: "Aftercare treatment is homelessness."

People who have addictions or who have criminal records (often because of their addictions) have a difficult time finding and maintaining steady employment. Although many of the best resort jobs dried up when the tourism industry died down, the county did bring in a new casino to the area, which opened in February. But even here, local residents wondered how many local people would be hired, especially given constraints on the skills they have, the addictions they are combating, and the criminal records that follow them.

WRAPAROUND SERVICES

For people who have successfully completed treatment programs, there are no wraparound services to help them find housing and jobs and to navigate the complex healthcare system. Instead, they are left to fend for themselves. For example, we heard about a senior citizen who suffered a stroke and applied for Medicaid, but the process of applying for Medicaid can take up to three months. "He has a beat-up car, can't afford an inspection," but his only option was to drive to Poughkeepsie for rehabilitation "because not a single provider between here and there will take his insurance."

WHY IS IT HARD IN RURAL AREAS?

Rural areas, like Sullivan, have a small population spread out over a large geographic area. The very basic services that urban and suburban residents take for granted, like transportation and communication infrastructure, are missing in rural areas. Other essential services, like education and emergency medical services, are spread out over a large area, making them more expensive to provide. When combined with poverty, the problem can feel insurmountable.

Almost every person we spoke with said that transportation is an issue. According to one community member, "transportation and poverty are powerful." They create a barrier to just about everything from buying fresh food to seeking out appropriate medical care to finding and maintaining a job. The county — a thousand square miles, roughly the same size as Rhode Island — runs just two bus routes and only on Thursdays and Fridays. Lack of transportation makes it difficult for people who suffer from addiction to get the services they need.

People suffering from substance-use disorders may not have access to cars. Medicaid will pay for taxis to medical appointments, but it does not pay for transportation for other necessities, like trips to the pharmacy or grocery store. Even if they do have cars, lack of transportation means that someone who is on drugs and wants or needs to get somewhere may drive while under the influence.

A health official explained that there are not enough treatment facilities in the county and, with no real public transportation, a traditional system does not work. There aren't enough beds, certainly. But there aren't enough doctors (only two psychiatrists in the county), not enough dentists, and not enough social workers. For people who live outside the center of the county —

the triangle composed of Monticello, Liberty, and Fallsburg — it's three times as hard. Health officials and providers are well aware of the problem, but not as sure about the solutions, such as telemedicine or mobile clinics. Although they need a presence in the far reaches of the county, doing so takes resources from the already stressed services provided in Liberty and Monticello.

Because of the large geographic size of the county and the lack of meaningful transportation, many services in Sullivan become, like healthcare, hard to get: basic necessities, work, or even daycare. According to one education official: "Transportation has a big impact on workforce.... I know there are people who have, they have to take a cab to work and they will pay $15 to go two and a half miles, but it's [snowing] ... and they might only be making $9 an hour or $8 an hour or something.... And I think that's harder here.... Even within Monticello, people take cabs and it's really expensive."

As a lawyer explained to us, once people with addictions finish a program, they are forced back to the place that got them started and they relapse: "Aftercare treatment is homelessness."

Left: A mobile home community in Monticello. Facing page: The Heritgae Inn in Monticello.

WHAT CAN WE LEARN FROM SULLIVAN COUNTY?

Like many counties in New York State and across the nation, Sullivan County has an opioid problem. And, like many counties, the opioid problem is hard to combat when individuals lack access to services they need.

However, unlike urban and suburban areas, rural areas have particular challenges. First, lack of access in rural areas does not mean having services but not being able to afford them; rather, many services are just not available. Second, rural areas have a small population spread out over large geographic areas. Transportation is an issue for meeting basic needs like healthy food, healthcare, and work. County officials and service providers struggle with how to use limited resources to meet these complex needs, either finding ways to bring people to centralized services or finding ways to get services out to the far reaches of the county. Either way, existing resources are stretched thin as it is, and it is not clear how to expand to meet the growing challenges.

Additionally, rural areas have been hard hit economically. When industry leaves, there are not a lot of alternatives. Two health officials explained in rural areas, "When it's bad, it's really bad." We heard this sentiment often. Rural areas are slower to recover from economic downturns. Even with the new casino, they have fewer people who are qualified and able to work in it.

PART 4

Sullivan County, 1982

Guest author Kevin Haworth grew up in Sullivan County, New York. Here, he recounts his experience through the lens of today's growing opioid epidemic, which has ravaged the county and places like it across the country. His first-hand account reveals how, in rural communities like Sullivan, poverty and expansive geography combine to shape the experiences of young people. In short, it shows how decades of decline left countless communities vulnerable to the onslaught of addiction.

THE FIRST TIME I SAW SOMEONE SMOKE POT, it was in the back row of a school bus that had just crossed the line dividing Ulster County from Sullivan.

I was 12 years old. Each day, I took a school bus for 45 minutes from home to the local high school, weaving through a series of small towns along Route 209 to a slightly bigger town where the school sat. At the end of the day, we did the same ride in reverse, working our way through one-store and no-store towns and along rural roads that followed streams or ran alongside forests with signs for hunters.

This wasn't the suburbs. No one got dropped off in front of their house. Instead, the bus rode down what passed for the main arteries in towns like Spring Glen or Phillipsport.

Schoolkids would disembark in bunches at drop-off points and then walk far down gravel roads, the thin capillaries that lead to old farmhouses and simple ranch homes and trailers all over Sullivan County.

I spent 10 years of my childhood in Sullivan County, from age seven to high school graduation. The time covered the end of the 1970s and most of the 1980s. The end of the famous Borsht Belt resorts felt inevitable even then, though a few of the old hotels hung on. As a teenager, I worked each summer at the Nevele, just over that county line where the school bus ran. Crowds still came for the belt-busting meals and the summers at the pool, but each summer there were more empty chairs on the lawn and fewer guests to entertain.

The Stardust Lounge rolled the spotlights each night, though the entertainment was far from cutting edge. (One old Catskills comedian, playing to his mostly Jewish crowd, opened each set with a groaner about the then-King of Jordan and enemy of Israel: "King Hussein? They should call him King Whonuts!")

Back then, Sullivan County felt like two worlds: the mythical past of the Borsht Belt and the day-to-day rural poverty that made up reality for most of the kids who lived in my corner of the county. They were children of men who worked at the tanning factory (which closed), the sawmill (which closed), the local auto mechanic. Or their parents were teachers who tried to educate children up and out of the county.

As the incident in the school bus suggests, Sullivan County was like many places then in regards to drugs: kids smoked pot in parked cars, or in woodsy hideaways, or in abandoned bungalows. Our parents smoked too, downstairs after they thought the kids were asleep, or in their woodshops or tool-scattered garages, or peacefully on their screened-in back porches. They drank, too, and unlike pot that felt like a real danger. Until Mothers Against Drunk Driving made its voice heard in the 1980s and the state police started cracking down on DWIs, being able to steer home after working your elbow at the local bar was considered a basic life skill.

> Much has changed in that time, but the fundamental dynamic of too much space and too little money has not. I am lucky that opioids had not arrived to Sullivan County when I was a teenager.

What's different now? The hotels are gone, definitively, and they're not coming back. But the hotels and bungalow colonies always masked the lack of investment in other industries, the absence of colleges and universities, the limited opportunities available to most daily residents. Vacationers would come up to the Catskills for a few months each year, enjoying the fresh air and unspoiled natural resources. When they left at the end of the summer, not much had changed for the people who lived

there the rest of the year. The winter was always longer than the summer in Sullivan County.

All of this has made for a particularly vulnerable area for opoids to reach, and a stubborn place from which to rid them. Previous pieces in this series have pointed out just how isolated and disconnected many towns in the county are from each other, and how far they are from the kinds of services cities and suburbs take for granted. Growing up in Sullivan County, I lived this truth.

A brief story will illustrate what I mean. One summer day, when I was 11, my friends and I decided we wanted to go to the mall. Our parents were working, or taking care of the house, or just had no free time for a spur-of-the-moment trip for idle shopping. It just wasn't done.

So we hopped on our bicycles, cheap ten-speeds that were hand-me-downs or bought secondhand from older kids. There were three of us, ages 11, 14, and 15. We set off mid-morning to ride to the nearest town with the kinds of stores you could wander through. It was 17 miles away.

To get there — Middletown, New York, in Orange County — we pedaled up forbidding roads that killed our legs and then down at neckbreaking speeds. There is no 17 miles of relatively flat ground anywhere in the Catskills. There probably isn't even five miles. It was a long ride, and for most of it we had to ride our bikes on the shoulder of Route 17, the major highway that connects the Catskills to New York City. When tractor trailers flew by, our bikes shuddered from the concussion of the wind. As the youngest, I trailed behind my two friends, straining to keep up with their pace. About halfway there, my friend's bike hit a loose spot of asphalt. The skinny tire kinked, the bike pitched forward, and he went sprawling into the highway. I watched as he scrambled out of the way of a car that had come speeding around the corner. We tested the bike for fitness and continued on.

It took most of the day to get to our destination. When we arrived, we wandered through a department store for about a half hour, thumbing records in the music section. We had no money. Then we turned around and rode all the way home again. It was a trip born of desperation, of trying to make the world feel a little bit smaller, more conquerable, for one afternoon.

Thirty-six years later, a boy living on my road in Summitville, New York, would find himself just as far from the mall, just as far from the high school. Much has changed in that time, but the fundamental dynamic of too much space and too little money has not. I am lucky that opioids had not arrived to Sullivan County when I was a teenager. There were a lot of hours and days to fill for me, for everyone else. We might have filled them very differently.

My two children were born in Ohio, not New York, but many of the conditions of their birthplace remind me of my childhood. They were born into a thriving college town where I was teaching, but the lively college is only a button on the great green coat of Appalachia, another place of isolation and entrenched poverty. The opioid crisis is there, too. The stories from Sullivan County are only the start.

Kevin Haworth is a National Endowment for the Arts Fellow in Creative Writing and the author of four books, including the novel The Discontinuity of Small Things and the essay collection Famous Drownings in Literary History.

Sandra Oxford, a citizen-activist in Sullivan County, at a new community garden in Monticello.

PART 5

Fighting Back

IT'S NO SECRET that upstate, rural communities like Sullivan County have been hit especially hard by the opioid epidemic, even though the phenomenon is by no means confined to these areas. In 2016, 14 deaths were attributed to opioid use in Sullivan County, and the problem is continuing to grow. According to early estimates for 2017, as many as twenty-seven residents died of a drug overdose in the county last year.

Although no one is sure exactly how to solve the opioid problem in Sullivan County, doing nothing is not an option. What the response looks like, however, depends on whom you ask and where they work. To get a better feel for what the local fight against opioids looks like, we spoke to a range of people in Sullivan County about their experiences. What came into focus was a multifront battle fought along the lines of crisis management, treatment and recovery, and prevention.

CRISIS MANAGEMENT

Upon recognizing an extensive need for resources and awareness, community organizers and public officials sponsored Narcan trainings throughout Sullivan and Orange Counties.

Narcan, which is a medication used to reverse opioid overdose, "is a prefilled, needle-free device that requires no

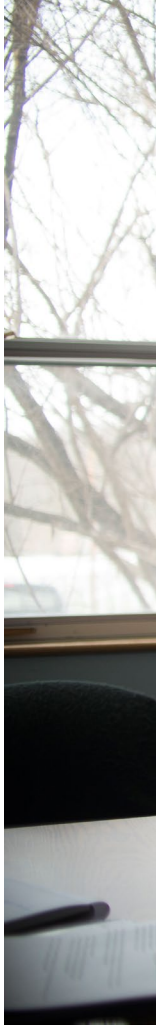
assembly and is sprayed into one nostril while patients lay on their back." Between January and December 2017, the Sullivan County Public Health Department trained 246 people to dispense Narcan, Catholic Charities an additional 244, and the Greater Pine Bush Partnership another 300. It's amazing, one organizer told us, how many lives a single training can save.

But not everyone is as enthusiastic about administering Narcan in this way. In fact, we heard about growing frustration among first responders who are concerned that Narcan doesn't just save lives, it also enables an addiction. Indeed, it is not uncommon for police officers, EMS workers, and family members to revive the same person multiple times — even in the same day. In response to the argument that Narcan offers little more than a safety net for risky behavior, one public health administrator pointed out during a meeting of the Opioid Epidemic Task Force that, although the county can't mandate substance-use treatment, people at least need to be alive to get there. From this perspective, Narcan gives public health professionals another chance to intervene, and people struggling with addiction another chance to seek treatment.

A second, yet related, approach to crisis management in Sullivan seeks to cut off immediate access to opioids in the county by removing drugs from people's homes. The Prescription Drug Abuse Prevention Task Force thus organizes Take Back Days in partnership with the local Sheriff's Office. According to Public Health Director Nancy McGraw, the purpose of these events is to prevent prescription drugs from "falling into the wrong hands and being abused or sold on the streets."

On any given Take Back Day, people with unwanted pills can drop them off at a temporary collection site, no questions asked, and the Sheriff's Office will transport them to Poughkeepsie for incineration. The county hopes to obtain its own incinerator soon so transport to Poughkeepsie becomes unnecessary. In addition to numerous Take Back Days sponsored throughout the year, permanent drop boxes have been installed at the following local police stations: Liberty, Fallsburg, and Monticello, as well as the lobby of the Department of Family Services building. As a result of these combined efforts, more than 1,700 pounds of unwanted medication have been removed from Sullivan County.

For its part, the Sullivan County Sheriff's office has made a concerted effort to identify and arrest the leaders of



Sullivan County Narcan Training by Speciality Area, 2017

Initial Law Enforcement	26
Refresher Law Enforcement	48
Firefighters	65
School Personnel and Students	29
County Employees	11
Nursing and Medical Professionals	11
EMS Providers	37
911 Call Center Workers	18
County Commissioner Refresher	1
2017 Total Trained by Sullivan County Public Health	**246**

Sullivan County Public Health Director Nancy McGraw in her office in Liberty.

major drug trafficking organizations. In 2014, for example, as a result of two teenage overdose deaths in Livingston Manor, Sullivan County Sheriff Michael Schiff[1] launched an investigation into the drug's supplier. In less than a year, a partnership between the Sullivan County Sheriff's office, the New York City Police Department, and multiple federal agencies led to the arrests of five members of a Bronx-based drug trafficking network and the seizure of nearly $5 million (26 pounds) of heroin. In addition to takedowns and investigations, the county is considering adopting a program like Wallkill Cares,[2] which allows people in the neighboring town of Wallkill to request treatment for substance-use from the police in Orange County.

Although county-level officials and organizers are coming together to combat opioids in any way possible, many people believe that the problem is only getting worse. Indeed, with so much time and energy being invested in crisis management, some of the more expensive solutions, like medical treatment and prevention, seem even further out of reach. "It's like treating

1 United States Drug Enforcement Administration, "Major Heroin Supply Chain From New York City To Upstate Counties, Long Island Dismantled: Five Arrested, $5 Million In Heroin, $115,000 Cash And Two Guns Seized," press release, May 29, 2015, https://www.dea.gov/divisions/nyc/2015/nyc052915.shtml.

2 "Wallkill Cares Program," Town of Wallkill Police Department, accessed June 26, 2018, http://www.wallkillpd.org/128-community-spotlight/111-wallkill-cares-program.html.

A volunteer with Catholic Charities conducts community outreach in Liberty, New York.

someone for a burn when they're still in the fire," one public health administrator told us — we're "treating the problem upside-down."

TREATMENT AND RECOVERY

Ironically, in a place overrun by vacant rooms and abandoned beds, remnants of the luxurious hotels, bungalow colonies, and boarding rooms of the past, one of the greatest challenges facing Sullivan County is limited access to drug-treatment facilities and housing. Although two hotels — Paul's Hotel in Swan Lake and the Grand Hotel in Parksville[3] — were purchased and converted into adult residential facilities by Samaritan Daytop Village, both were closed in the early 2010s after the comprehensive human services organization filed for Chapter 11 bankruptcy.[4] The Daytop facilities were generally reserved for New York City patients; still, it is difficult to comprehend why the number of drug treatment facilities would decline as the number of opioid deaths skyrocketed.

Sullivan County is not alone in watching its long-term treatment facilities close down. As the Substance Abuse and Mental Health Services Administration observed, long-term residential treatment, which can have lengths of stay anywhere from 12 to 18 months, is "relatively uncommon."[5] Quite frankly, some people in the community are

3 Martin Boris, "The Catskills at the End of World War II," in *In the Catskills: A Century of Jewish Experience in "The Mountains,"* ed. Phil Brown (New York: Columbia University Press, 2002): 42-54.

4 Leonard Sparks, "Daytop Village to close Swan Lake treatment facility," *Times Herald-Record* recordonline.com, February 12, 2014, http://www.recordonline.com/article/20140212/news/140219934.

5 "Treatments for Substance Use Disorders," Substance Abuse and Mental Health Services Administration (SAMHSA), last updated June 13, 2018, https://www.samhsa.gov/treatment/substance-use-disorders.

convinced that long-term care is rare because it's exorbitantly expensive. "If we're really committed then why aren't people getting services," exclaimed one frustrated member of the Sullivan County Opioid Epidemic Task Force at a recent meeting. "Why aren't we paying for it?!"

Still, people in the public health community offer an alternative explanation, which is that the model of care has changed. While putting a person in long-term treatment might help them achieve sobriety, it does not always equip them with the tools they need to successfully navigate challenges at home. "Long-term treatment programs closed because they weren't successful," one public health administrator said, though not everybody agrees.

For people seeking treatment in Sullivan County, one option available to them is Catholic Charities, a comprehensive human services organization with a chemical dependency clinic in Monticello, in the heart of Sullivan County. In addition to providing medically supervised detox and withdrawal programs, Catholic Charities offers intensive day rehabilitation services; residential programming for men and women; and community-based supportive housing apartments. Surprisingly, the detox center at the public hospital closed a few years ago. "They were never at full census," explained one public health administrator, after the hospital changed its admission criteria to include physical withdrawal. "If you've ever encountered an addict, they are not going to let themselves go through physical withdrawal because it's so uncomfortable, especially for opiates, it's unbearable.... So their census began to deplete, and it wasn't cost effective. It's very high cost to run a detox center in a hospital."

> With so much time and energy being invested in crisis management, some of the more expensive solutions, like medical treatment and prevention, seem even further out of reach. "It's like treating someone for a burn when they're still in the fire," one public health administrator told us.

For those on the other side of treatment, the process of recovery begins. According to one public health administrator, more needs to be done to prevent people from relapsing in recovery. Drawing a comparison between the safe environment of a long-term treatment facility and the challenges people face back home, she expressed frustration over her inability to mandate patient participation in Alcoholics Anonymous (AA), which was deemed a "religious activity" by the federal Court of Appeals. "We can't

Kevin Greff and Julie Pisall are among the founders of the Kingfisher Project, which aims to raise awareness about heroin addiction after the death of Pisall's daughter in 2014.

mandate AA/NA [Narcotics Anonymous] which is driving me crazy, because of the legality," she explained:

> I think the field actually lost it when they stated that AA/NA was a religious affiliation and that we couldn't make people go, 'cause we were more successful when they had that buffer, if that makes sense, they had a safety net. Now they have to find it on their own. We can suggest it. Some people still do it. The majority of them don't, you know.... So without being able to mandate some kind of buffer to help them and support them through the process while they are out there, I think a lot of them trip and fall.

Instead of mandating participation in Narcotics Anonymous, public health administrators can connect individuals to a licensed peer recovery coach. In addition to developing a recovery plan, these coaches assist clients by putting them in touch with a wide variety of services and acting as a personal guide and mentor. The program, known as Friends for Recovery, circumvents some of the bureaucratic red tape found in hospitals. "HIPAA [the Health Insurance Portability and Accountability Act] impairs self-help groups," one peer recovery coach told us. "It squashes the intimacy between recovering addicts." By comparison, Friends of Recovery, which emphasizes holistic healing and other spiritual principles, creates a place where people can talk openly about their problems and build fellowship.

In addition to peer recovery coaches, the county is working with local organizations to start a support group for those who lost loved ones to overdose.

PREVENTION

In light of the growing death rate, people in Sullivan County recognize the need for something more than just treatment. "We need treatment, we absolutely need it," one provider explained. "But the word

treatment is what it is — it's treatment. It's not a cure. Prevention is a cure. It's an absolute cure."

Growing recognition of the need to stop drug addiction before it starts has led to a range of responses directed at prevention. Hindering these efforts, however, is a lack of resources. Although treatment in Sullivan County remains vastly underfunded, there are even fewer dollars earmarked for prevention. The State Targeted Response (STR) grant awarded to Catholic Charities is a perfect example of this disparity in funding. In September 2017, Governor Andrew Cuomo announced that Catholic Charities Community Services of Orange and Sullivan would receive a $2 million grant to enhance access to prevention, treatment, and recovery services. However, little more than a $100,000 was set aside to deliver an afterschool, evidence-based prevention program known as Too Good for Drugs.[6] Although the program seeks "to promote life skills" and "resistance to the use of illegal drugs," schools have difficulty freeing up staff for trainings and integrating the program into an already cramped curriculum.[7]

In the absence of money, community organizers have done what they can to raise awareness. In February 2017, the Tri-County Community Partnership (formerly the Greater Pine Bush Partnership) launched its "Have a Slice" campaign to encourage parents to talk to their kids about drugs. Eight pizzerias participated, placing stickers on pizza boxes with facts about drug use that could be used as conversation starters. Numerous panel discussions and events have also been held to educate the community about drug and alcohol use. In October 2017, the Sullivan County Drug Abuse Task Force sponsored a public health conference at Bethel Woods entitled "Local Solutions to a National Opioid Crisis." In addition to covering such topics as the "biology of substance-use disorders" and "medication-assisted treatment," elected officials, public health experts, and law enforcement officials discussed ways of working together to end the opioid problem. In a community strapped for cash, something as simple as a conversation can go a long way.

CONCLUSION

The fight against opioids in Sullivan County is carried out not only in police stations and hospitals but around the kitchen table. Although many people expressed concern that the opioid problem is growing, the inability to contain the spread of opioids has less to do with a lack of resolve in the county than a lack of resources. Even though a permanent solution remains elusive, folks in Sullivan County continue to hold the front-line.

6 "Catholic Charities Receives More than $2 Million in Federal Funding To Fight Opioid Crisis in Sullivan and Ulster Counties," catholiccharitiesny.org, September 18, 2017, https://catholiccharitiesny.org/news/catholic-charities-receives-more-2-million-federal-funding-fight-opioid-crisis-sullivan-and.

7 *Too Good for Drugs*, What Works Clearinghouse (WWC) Intervention Report (Washington, DC: U.S. Department of Education, September 14, 2006), https://ies.ed.gov/ncee/wwc/Docs/InterventionReports/WWC_Drugs_091406.pdf.

PART 6

Spillovers

Opioids' effects on families, social services, and schools

ROCKEFELLER INSTITUTE'S ANALYSIS of aggregate data shows that opioid use is growing, deadly, and especially difficult across New York State, but the numbers are particularly troubling upstate. These data don't show, however, exactly who in the community is affected by opioid use and how they are affected. We asked policymakers, health officials, providers, and activists in Sullivan County about how opioids have an impact on their communities. As we expected, they told us the sheer quantity of drug overdoses has a huge impact on the public health and criminal justice systems. What we didn't anticipate, but heard often, were the spillover effects on families, social services, and schools.

FAMILIES

Opioid use can be, in the words of one parent, "devastating" to families. We spoke with four mothers whose teenage and adult children battled addiction. In our discussions, we heard how expensive, time-consuming, and emotionally exhausting addiction is for family members. It puts stress on relationships with other family members. The stress, guilt, and anxiety can break

up marriages. One expert described living with an addict as "walking on eggshells."

Even for families with resources, like education and jobs, it can be difficult for parents to navigate the complex system to get help for their children with addictions. One mother, a teacher, explained to us how her insurance wouldn't pay for residential rehabilitation for her daughter, only outpatient treatment. But her daughter was homeless and didn't have any other options. Although she had to delay retirement, this mother acknowledges that she is lucky because her daughter received a scholarship to a long-term residential facility in Arizona, and she could afford to pay nearly $100,000 for 18 months of private rehabilitation out of state. But, she asked, "Who has that kind of money?" Parents of children with addiction say their own health suffers and work is much more difficult.

Even for families with resources, like education and jobs, it can be difficult for parents to navigate the complex system to get help for their children with addictions.

SOCIAL SERVICES

Foster care is another area that is affected by the increasing opioid problem. According to National Public Radio (NPR), the number of children in foster-care is skyrocketing, in some places doubling. In New York State, foster care placements have declined substantially since the 1990s, in part driven by a large decrease in New York City. Still, in Sullivan County, the number of children in foster care is up from a low of 48 children in foster care in 2009 to 82 in 2016. According to one county official, normal action plans just aren't available because "mom and dad are both on drugs and the kids require placement." Child Protective Services is dealing with these kinds of cases and is overwhelmed finding homes for and placing children, let alone the additional cost, estimated at a million dollars.

Although better than unsafe environments, foster care can disrupt children's lives. Children in foster care "can't get access to … their driver's license because they're in foster care, can't go to work, get working papers cause they're in foster care.… You know, sleepovers, the typical things that kids do, is limited in that service." Local officials try mightily to make their lives as "normal" as possible and to keep them in their schools with friends, but parents' opioid use is — at best — disruptive for children.

In the end, there just aren't enough services of all kinds for children of parents with addiction. One county health official explained that addiction can be traumatic for a child who has "watched their parent get taken out in handcuffs, or watched their parent and

walked in a room, and they're stoned out of their mind, or I can just imagine what a child is seeing." These children need resources: psychiatrists, social workers, trial workers, guidance counselors, foster families, and medical doctors. Yet, Sullivan County has a hard time attracting people to fill these positions. People in Sullivan explained that the pay is low, the work is hard, and the potential for official reprimand is high.

The epidemic is also straining the county. Already meager resources are spread even thinner. Caseworkers have dozens of files, and state funding is based on "units of service," i.e., time spent with clients, not the quality of care they provide. A 60-minute visit in the office or clinic would count as one unit of service, but social workers do not get compensated for the coordination they must perform among all of the other actors. "[W]hen you talk about a child, you have a social worker … the trial worker…. You have the guidance counselor in the school. They might be on probation in the community. You have a medical doctor that might be treating them for something else. You have the parent. You know, so you have a multitude of service providers that you're supposed to be coordinating care with…. We do a sixty-minute unit of service with the client sitting here, but yet I have to call parole. I have to call the school. There's the care coordination component and we don't get credit for that. How do we get paid for that?"

The epidemic is also straining the county. Already meager resources are spread even thinner. Caseworkers have dozens of files, and state funding is based on "units of service," i.e., time spent with clients, not the quality of care they provide.

SCHOOLS

Although opioid deaths are highest among New Yorkers age 45 to 54, the effects of opioid use by grandparents and parents has an effect on schools, as does the smaller (but growing) number of youth who use opioids. One former school resource officer noted that Sullivan County's schools are impressive for what they do offer, like access to psychologists. But guidance counselors who reach out to kids who are troubled can't always mitigate the problems associated with bullying and the self-medication that comes from it.

The cost of treating opioid addiction — through county programs, Medicaid, Medicare, private insurance, or out-of-pocket costs — is so high that many people push for prevention to avoid problems. During the 1980s and 1990s, schools adopted the Drug Abuse Resistance Education (D.A.R.E.)

The Sullivan County Government Center in Monticello

program, which encouraged students to "just say no" to drugs. D.A.R.E. was originally developed in Los Angeles by police officers and teachers to reduce drug, tobacco, and alcohol use by youths, as well as to improve relations with police. Although D.A.R.E. programs were adopted across the country, there was little evidence that it actually worked. Schools stopped using it.

Now, prevention advocates are looking for alternatives to be used in its place, like "Too Good for Drugs," a program targeted by grade level that teaches healthy lifestyle choices (including not using drugs). Still, schools in Sullivan — like New York State more generally — are overwhelmed with requests for teachers to do a lot more than simply teach the basics. One teacher explained that for prevention programs to work, teachers have to really believe in them and not see them as just another thing they have to do. And they have to resonate with students. She gave the example of a school art teacher who planned events for students, enabling them to express and share their work. One student called her the "antidrug teacher," for her ability to create a program that was meaningful for students. "Three-fourths of them would roll their eyes at a drug program," she explained.

When we think about the opioid problem, we think about people with addictions and treating those addictions. But the effects of opioid addictions spill over past those people who are addicted and into their families, the social services in a community, and to schools. Policies and programs to address opioid addiction also need to take into account the needs of these other important institutions.

PART 7

Monticello, New York

#MeToo in the Wake of Addiction

RESEARCH ON ABUSE AND DRUG TREATMENT overwhelmingly focuses on how childhood abuse causes trauma and how individuals use drugs as a way to deal with it. Women are more likely than men to have experienced sexual and physical abuse,[1] and women who have experienced sexual violence are five times more likely to misuse prescription opioids.[2] But women and men don't just use drugs because of trauma caused by sexual assault. They are also more vulnerable to sexual assault because of their addictions.

Research shows that rape commonly occurs with drug or alcohol usage, especially for young adults. A study

1 Virginia Gil-Rivas, Robert Fiorentine, and M. Douglas Anglin, "Sexual Abuse, Physical Abuse, and Posttraumatic Stress Disorder among Women Participating in Outpatient Drug Abuse Treatment," *Journal of Psychoactive Drugs* 28, 1 (1996): 95-102.

2 Lauren Jessell et al., "Sexual Violence in the Context of Drug Use Among Young Adult Opioid Users in New York City," *Journal of Interpersonal Violence* 32, 19 (2017): 2929-54.

82% of Women
43% of Men

EXPERIENCE FREQUENT PROPOSITIONS FOR SEX BECAUSE OF THEIR ADDICTIONS.

39% of Women
24% of Men

HAVE EXCHANGED DRUGS OR MONEY FOR SEX.

on opioid use among young adults in New York City found that women who use opioids were perceived at greater risk for sexual violence because they were often disoriented or unconscious. Further, the study found that opioid users are often seen as "unworthy of sexual respect and as readily willing to sell sex for drugs or money."

The numbers back up this idea. Both women (82%) and men (43%) report frequent propositions for sex, often by strangers, because of their addictions. And both women (39%) and men (24%) have exchanged drugs or money for sex. But women experience this more often and more severely than men. Forty-one percent of women and 11 percent of men report being forced to have sex without their consent when they were using drugs. One mother in Sullivan County, where we are studying the opioid problem on the ground,[3] told us: "It's very different to be a woman and to be in the addiction cycle because of that." It "takes your self, it continues to eat away at your self esteem."

Another mother told us about her daughter, Tina, who was living with an addict, panhandling for money. The only way he let her get out of panhandling was if she had sex with him. Tina's mother tells us that wasn't at all like her daughter, who is fastidious about her body and is gay.

It isn't just dealers or other users who take advantage of opioid users. It's also the very individuals who are supposed to be helping them. According to media reports, doctors in Atlanta, Detroit, Chicago, and San Diego have prescribed opioids in exchange for sexual favors, and, in at least one case, prescribed opioids and then demanded sexual favors to refill prescriptions once women were addicted.[4]

3 "Stories from Sullivan," Rockefeller Institute blog, various dates, http://rockinst.org/stories-from-sullivan/.

4 See Mark Winne, "Doctor accused of trading prescription drugs for sex; 44 arrested in massive bust," WSB-TV Atlanta, updated March 1, 2018, https://www.wsbtv.com/news/local/doctor-accused-of-trading-prescription-drugs-for-sex-44-arrested-in-massive-bust/709268909; L. L. Brasier, "Doctor faces prison time for trading drugs for sex," *USA Today*, updated September 28, 2015, https://www.usatoday.com/story/news/nation-now/2015/09/26/doc-headed-prison-trading-prescriptions-sex/72880934/; Marwa Eltagouri, "Ex-doctor gets almost 6 years for Craigslist sex-drugs scheme," *Chicago Tribune*, August 5, 2014, http://www.chicagotribune.com/suburbs/oak-park/chi-craigslist-sex-drugs-doctor-20140805-story.html; Dana Littlefield, "Doctor gets federal prison for prescribing pain pills in exchange for sex," *San Diego Union-Tribune*, March 6, 2017, http://www.sandiegouniontribune.com/news/courts/sd-me-thota-sentencing-20170306-story.html.

A bulletin board at a women's treatment center in Sullivan County.

In our discussions in Sullivan County, we heard how one young woman was offered drugs in exchange for sex by a doctor at the treatment center where she was seeking help. Her mom explained, "the doctor … was soliciting women for sex, when they would go to get Suboxone from him … not uncommon. There's a guy up here … too, was doing the same thing. I saw a text one time from that doctor to my daughter … it's this, the whole thing with women who are addicts and the trading of sex, and the soliciting of sex."

This young woman did not want to report the doctor for fear that she would see him at the local Shoprite grocery store and for fear that she wouldn't be able to get the treatment she needs. In rural counties, like Sullivan, where there are only four doctors licensed to dispense medication assisted treatments, like Suboxone, what happens when there is one fewer?

Like the young woman in Sullivan, opioid users rarely report sexual propositions and assaults. There are almost no consequences for perpetrators. The stigma of drug use means that drug users often blame themselves and feel that others will not believe them, contributing to what the authors of the New York study describe as "a drug using culture with few social consequences for perpetrators of sexual violence and little support for those who are victimized."

Opioid users rarely report sexual propositions and assaults. There are almost no consequences for perpetrators. The stigma of drug use means that drug users often blame themselves and feel that others will not believe them.

PART 8

A Family Disease

"IT'S HELL," ONE MOTHER TOLD US, DESCRIBING HER SON'S HEROIN ADDICTION.

Over the past 15 years, Sam has been in and out of treatment, in and out of jail, and back and forth to medical appointments. She told us that it is "impossible" to succeed after addiction, and even harder in rural areas. Who will take him to probation meetings? Who will take him to doctor's appointments? He has no car and there is no public transportation. She doesn't give him money, but she does buy food for him and help with his rent. "Some people might say I'm enabling," she says, but there is no playbook on what to do when your child has a substance-use disorder and few resources to help guide the way.

Above: Julie Pisall cofounded the Kingfisher Project, a radio program that aims to raise awareness of heroin addiction, after her daughter's death in 2014.

Although much of the conversation about addiction focuses on the individuals — how opioids affect the brain or if a "bed" is available for detox or treatment — a peer recovery specialist described addiction to us as a "family disease." According to a national survey conducted by the 2004

Faces & Voices of Recovery Campaign,[1] more than two-thirds of American families have been touched by addiction. What does this mean for families? And, where can they go to get help?

Addiction is "devastating" for families. It creates stress, anxiety, and disagreement between family members. According to Sullivan County District Attorney Jim Farrell, people with substance-use disorders may betray their families by stealing from them. They may lie to them too. While parents can feel exploited, they still worry about their kids. But continued support for children with addictions can lead to conflict with other family members. "They're constantly telling me why do I do it, you know, he's never going to change. I do it because of my son and … I'll do it until I cannot" do it anymore.

Feelings of guilt and loneliness stem from the stigma of addiction. Most of the mothers we spoke to didn't want to be identified; they didn't want to shine a light on their children (we use pseudonyms to protect their identities). Parents struggle, feeling that they might have done something wrong, they might be bad parents. They feel shunned "by the entire universe."

Early one night at a forum on opioids in Liberty, a mother raises her hand. She, too, has been dealing with her son's addiction for more than a decade. She, too, doesn't know what to do. She is frustrated. Facilities treat individuals with opioid addictions, she says, but they don't provide help, support, or therapy for families. Where can she go for help?

Families need support. But it can feel as if the system is designed to punish them. Sam is on probation: How's he going to get there, his mother asks. They've taken away his license, and he doesn't have a car anyway. She either has to take off work to get him to his appointments or he does not live up to the terms of his

Maryland, Rhode Island, and Vermont implemented a health home model for people with substance-use disorders. Health homes are not physical "homes" for people to live, but rather an administrative structure that allows states to provide coordinated care for high-need, high-cost Medicaid beneficiaries with chronic health needs.

1 *The Faces & Voices of Recovery Campaign Raises Awareness About Recovery from Addiction* (Princeton: Robert Wood Johnson Foundation, last updated December 13, 2012), https://www.rwjf.org/en/library/research/2009/07/the-faces---voices-of-recovery-campaign-raises-awareness-about-r.html.

Woodbourne Correctional Facility in Woodbourne, New York. For parents of children with substance-use disorders, jail is not always the worst option — it means a drug-free environment, housing, and regular check-ins after release.

probation and goes back to jail. "Who's being punished?" his mother asks. "My son is, of course, because you're not giving him the tools to ever make it out." But she's been living in the wake of addiction for years.

Without the proper supports, parents in this situation feel like they are "left to their own devices." Libby has been involved with opioids for more than a decade, and her mom describes the public, private, and nonprofit services available to families as a "big blanket with a lot of holes." There are no standard protocols across different agencies and the rules are contradictory. When asked where families can go for help, mothers we spoke to said there isn't one place.

Family support groups can help. "My mother started going to Al-Anon and Nar-Anon support groups and she started talking about what was going on," one person in recovery told us. "She stopped hiding it and took a step forward, and with that she learned a lot," Surprisingly, her involvement in the group and the information she obtained also helped her son. "A lot of my manipulative behaviors that I was trying were no longer successful. I think in the long run that did help me. I had to finally kind of face the music for some of my stuff." Still, such meetings aren't for everyone. A friend took Libby's mom to an Al-Anon meeting. "It was terrible," she explained. Some people say that Al-Anon doesn't "fit" opioid problems, and it doesn't fit young people. What works for one family in Sullivan County doesn't necessarily work for another.

Although there are many services in Sullivan County for people with addictions, families we spoke to were

frustrated with the red tape. It's hard to find help, and parents say they can't give up just because an agency turns them away. Tammi, for example, has been battling addiction for years. When she tried to get out of an exploitative relationship, she called her mom for help. Together they looked into a women's shelter. It was 3:30 on a Friday and social services didn't want to have anything to do with them. Tammi's mom echoed a common complaint: What was she supposed to do? Where was she supposed to go? She had set boundaries: her daughter couldn't live with her while she was using, but Tammi's mom couldn't send her daughter back to a bad situation and agencies weren't going to help.

Jail isn't always the worst option. The mothers we spoke to told us how, after decades of drug use and decades of navigating a complex system, they have learned to leverage the criminal justice system to help their children. Going to jail, for example, means their children will have little care (no detox, for example) and will come out with a record, making it hard to get a job. But it also will prevent their children from using and it will give them housing (however bedbug ridden) and regular check-ins afterwards. Libby's arrest "saved her life." But it didn't stop the addiction.

Child Protective Services (CPS), too, can be leveraged both to motivate drug-using parents as well as to provide appropriate care for young grandchildren. CPS requires parents with addictions to work out plans for the continued care of their children. It gives authority to other members of the family to provide adequate care for the young. Libby's mom was glad CPS got involved, "because now they are going to write a safety plan where they can't have their own child until they … are doing all the things in the safety plan."

Is this really the best that we can do? There are alternative, more comprehensive models of care. Maryland, Rhode Island, and Vermont implemented a health home model for people with substance-use disorders. Health homes are not physical "homes" for people to live, but rather an administrative structure that allows states to provide coordinated care for high-need, high-cost Medicaid beneficiaries with chronic health needs. Health homes cover the costs of six core services: care management, care coordination, health promotion, transitional care and follow-up, individual and family support, and community services.

New York State already has health homes for high-needs populations, especially people living with HIV. But it has not expanded it to people with substance-use disorders. Even if health homes were to provide care for substance-use disorders, it is unclear how the range of necessary services would reach rural areas, like Sullivan.

In our trips to Sullivan County we've talked with many mothers, women who bear the disproportionate burden of caring both for their children who have opioid addictions and for their grandchildren who are affected by addiction. Although the particulars of their stories are different, they describe a similar problem: opioid addiction is a family disease without adequate family supports.

Barbara Gref cofounded the Kingfisher Project, a radio program that aims to raise awareness of heroin addiction.

PART 9

What Can State and Federal Officials Do to Help in the Opioid Crisis? Listen.

THE OPIOID PROBLEM HAS HIT UPSTATE NEW YORK and its rural areas particularly hard. We've written both about the demographics most likely to use opioids[1] and the spillover effects on families, social services, and schools.[2] In Sullivan County, it seems as though opioids affect nearly everyone, and nearly everyone has a stake in what happens. Yet, community members feel they are working harder than ever and still falling further and further behind.

1 Jim Malatras, *By the Numbers: The Growing Drug Epidemic in New York* (Albany: Rockefeller Institute of Government, April 2017), http://rockinst.org/wp-content/uploads/2017/11/2017-04-20-By_numbers_brief_no8-min.pdf.

2 Patricia Strach, Katie Zuber, and Elizabeth Pérez-Chiqués, "Part 5. Spillovers," Rockefeller Institute of Government blog, April 6, 2018, http://rockinst.org/blog/stories-from-sullivan-spillovers.

Although we asked, repeatedly, what state and federal officials could do to help, people in Sullivan County most often said they wanted officials to understand the problem from their point of view.

Over breakfast at a local diner, community members explained that even though awareness is growing, they see the problem getting worse. For example, the county's premier hospital, Catskill Regional Medical Center (formerly Harris Hospital), does not have a detox center. In fact, the number of available treatment beds has shrunk even as the opioid problem has grown. A community activist noted that people in Sullivan are inundated. It's a sentiment that we heard a lot: People in Sullivan are working hard, but they can't keep up.

In our visits to Sullivan we heard several people compare the opioid problem to the AIDS epidemic of the 1980s and 1990s, which created fear and had no easy solutions. Like AIDS, the current opioid problem is out of control. It's spreading. And, to those on the ground, it feels as though there's nothing anybody can do to stop it. People in Sullivan believe that addressing the opioid problem means, like AIDS, focusing on both prevention and crisis management.

According to one county health official, it feels as if they are "just spinning [their] wheels." They really need to address (1) reentry into the community (after treatment or the criminal justice system) and (2) the availability of opioids. Otherwise, "nothing's going to change." We've heard over and over again how insurance doesn't cover the cost of treatment. As a result, long-term programs are closing, shortening the length of stays, or reducing what they provide. "[I]t becomes, really, the responsibility of the community providers to fill in the gaps, and we don't have the resources. And that's what it comes down to, we just don't have all the resources."

When we asked one mother what she wanted policymakers to know, she tells us she's given up on them. This mother, with political bumper stickers on her car and signs in her yard, doesn't have faith in officials for the most pressing problem in her life: her daughter's addiction.

It isn't that the county doesn't want to do more; it can't do more. A provider explained, "the county itself doesn't seem to have the resources, nor sufficient infrastructure, to keep its attention focused on social-determinant, health-related issues."

What can state and federal officials do to alleviate the burden? We asked folks in Sullivan that question. Given the common feeling of being overwhelmed

Catskill Regional Medical Center in Harris, New York.

and inundated, we were surprised by the response. Local community members want more resources, for certain. But more than that, they want to be heard. They feel government doesn't understand the problems they face.

Sullivan County lacks physicians and facilities to treat people with opioid addiction, housing and jobs to keep addicts from relapsing, and wraparound services to navigate the system. A lack of transportation, along with poverty, make the opioid problem particularly difficult to solve.

Local officials and service providers have extensive experience with state and federal regulations, but they see them as often hindering, rather than helping, them. As a county health official explained to us, the state is very good at handing down directives based on studies done in labs. However, there is a disconnect between what the community provides and what the state sees.

Federal rules, too, can seem to people on the frontlines as hindrances. For example, federal HIPAA rules, which protect patient privacy, have admirable goals.[3] However, the effect is to make coordinating care in offices that handle multiple health issues much more difficult. A provider explained to us how, at one point, two sides of the same clinic were treating the same person for the same set of problems related to addiction but couldn't talk to one another.

Local actors do not have much faith in other levels of government to help them. When asked if local government and other organizations think they can go to the state and get money from the state, a service provider responded: "No.... you're not living in the real world when you think that way." This provider

3 "HIPAA for Professionals," HHS.gov, last reviewed June 16, 2017, https://www.hhs.gov/hipaa/for-professionals/index.html.

explained, "You can walk through the streets and see [local elected officials].... So there's more of a connection that way. And we've got to look each other in the eye." He contrasted the personal, responsive relationship community members have with local officials to the relationship they have with state officials, who are located farther away, and federal officials, who are not seen as invested in the community, noting that he was thinking of putting one official's picture on the side of a milk carton saying "have you seen this guy?"

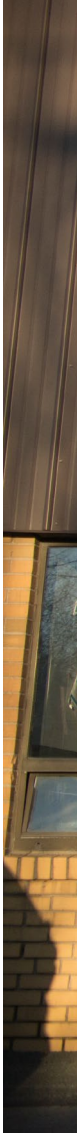
A community advocate told us how she focuses not on government but on hope. Opioid addiction can seem very dark, and the reality is that parents lose their children. She doesn't shy away from that. But there's also hope, and people need that. They need more than the numbers, more than empty words from political officials. When we asked one mother what she wanted policymakers to know, she tells us she's given up on them. This mother, with political bumper stickers on her car and signs in her yard, doesn't have faith in officials for the most pressing problem in her life: her daughter's addiction.

Certainly, people in Sullivan could use more resources, and they often said as much. They don't have what they need in terms of infrastructure to handle the primary problem (people with drug addictions), let alone the secondary effects on families, foster care, and schools.[4] They think that policymakers are throwing money at cities. They encounter all kinds of government agencies: OMH, OASAS, SSDI, Medicaid. But these agencies make it difficult to get help, rather than facilitate it. When we heard suggestions of what government can do, it was to get out the way. Local government officials and nonprofit providers said they'd like fewer regulations that make it difficult to do their jobs.

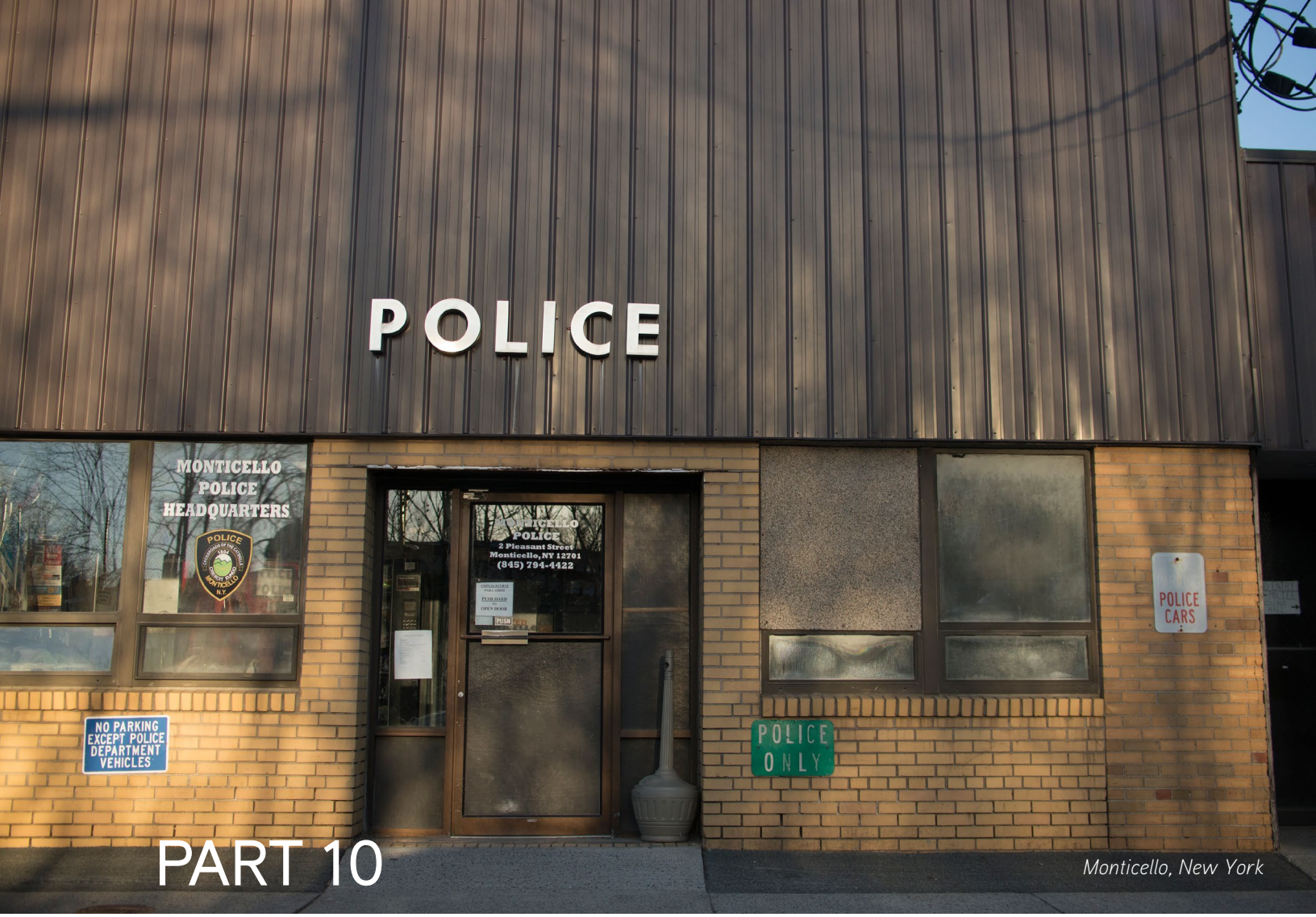
People in the community seem to think that other levels of government don't "get" them. They feel left behind. They worry about the future. They do not want to be the photo op for a politician's campaign, and they don't want to be lectured by public officials who may have never met a person addicted to opioids, let alone work or live with them day in and day out.

This sentiment is not unique to Sullivan County. When we asked an addiction specialist who works for a public facility in a different state what she wanted officials to know, she responded that addicts and the people who work with them "are worth it." She choked up as she explained, "we are worth spending the money on. We are worth spending time. We are throwing [addicts] away. We throw them away. They are someone's father, someone's son. I'm tired of us throwing them away. I'm tired of them being treated as though they don't matter."

People on the ground want engagement. They want people in high positions to understand them and the problem they face. They want public officials to care.



4 Patricia Strach, Katie Zuber, and Elizabeth Pérez-Chiqués, "Part 7. A Family Disease," Rockefeller Institute of Government blog, May 29, 2018, http://rockinst.org/blog/stories-from-sullivan-a-family-disease.



PART 10

Monticello, New York

When Battling Addiction, Is Jail Time the Problem or the Only Solution?

THE OPIOID CRISIS HAS PRECIPITATED A SEA CHANGE in the way people think and talk about substance use — from criminal behavior that must be prosecuted to a disease requiring medical treatment. At the same time, growing recognition of the failure to stop drug addiction through "tough on crime" policies has intensified support for alternatives to incarceration, ranging from drug treatment courts[1] and

1 Prijnett S. Flores et al., *An Analysis of Drug Treatment Courts in New York State* (Albany: Rockefeller Institute of Government, May 23, 2018), https://rockinst.org/wp-content/uploads/2018/05/5-23-18-Drug-Court-Report.pdf.

safe injection sites[2] to legalization[3] of the drugs themselves. Despite the widely shared belief that we can't arrest our way out of the opioid crisis, questions still remain about whether and to what extent jail is ever the solution. For some families, the answer is not so obvious.

Despite increased awareness of opioid use as a public health problem rather than a law enforcement issue, some — although not all — public officials have doubled down on the existing "tough on crime" approach. At the federal level, policymakers have been widely criticized for reinstating harsh mandatory minimum sentences[4] for nonviolent drug offenders and considering the strengthening of penalties[5] for trafficking in fentanyl. Similar legislation imposing a ten-year minimum sentence on first offenders who make, sell, or transport illicit opioids and authorizing law enforcement to charge drug dealers with homicide has been considered in states like Arizona[6] and New York,[7] respectively. While supporters believe

Despite increased awareness of opioid use as a public health problem rather than a law enforcement issue, some — although not all — public officials have doubled down on the existing "tough on crime" approach.

such laws are necessary to deter dealers and increase the cost of drugs, critics[8] respond that they exacerbate racial disparities in the criminal justice system

2 William Neuman, "De Blasio Moves to Bring Safe Injection Sites to New York City," *New York Times*, May 3, 2018, https://www.nytimes.com/2018/05/03/nyregion/nyc-safe-injection-sites-heroin.html.
3 Heather Trela, *Clash of Laws: The Growing Dissonance between State and Federal Marijuana Policies* (Albany: Rockefeller Institute of Government, January 25, 2018), https://rockinst.org/issue-area/clash-laws-growing-dissonance-state-federal-marijuana-policies/.
4 U.S. Department of Justice, Office of the Attorney General, "Memorandum for All Federal Prosecutors: Department Charging and Sentencing Policy," May 10, 2017, https://www.justice.gov/opa/press-release/file/965896/download.
5 German Lopez, "Senate Republicans' new plan for the opioid crisis: the same old war on drugs," Vox, April 12, 2018, https://www.vox.com/policy-and-politics/2018/4/12/17226680/senate-republicans-opioid-fentanyl-bill.
6 Antonia Noori Farzan, "Arizona Proposing Harsher Sentences for Heroin, Despite Evidence They Don't Work," *Phoenix New Times*, February 6, 2018, https://www.phoenixnewtimes.com/news/arizona-considers-mandatory-minimum-sentences-for-heroin-fentanyl-opioids-10108927.
7 Bethany Bump, "New approach to drug crime gains national attention," *Times Union*, May 6, 2018, https://www.timesunion.com/local/article/New-approach-to-drug-crime-gains-national-12890220.php.
8 Marc Mauer, "Viewpoint: The impact of mandatory minimum penalties in federal sentencing," *Judicature* 94, 1 (2010): 6-8, 40, https://www.sentencingproject.org/wp-content/uploads/2016/01/Judicature-Impact-of-Mandatory-Minimum-Penalties-in-Federal-Sentencing.pdf.

Albany County Sheriff Craig Apple discussed the shifting role of law enforcement in the opioid crisis at the Rockefeller Institute of Government's forum "Combating the Opioid Crisis," on June 27, 2018.

and, ultimately, fail to reduce crime. In fact, while it is argued that such laws are aimed at big-time drug dealers, a recent investigation by *The New York Times*[9] revealed that friends, family members, and spouses are regularly prosecuted for sharing drugs with each other. In other words, stringent drug laws do not always operate as intended.

While the debate over charging and sentencing policies is likely to continue, a closer look at the opioid crisis in Sullivan County suggests that, for many families struggling with addiction, jail may be less of a deterrent to opioids than it is an option of last resort. While many of the people we spoke to agreed that the current crisis requires a public health response, the criminal justice system has played a pivotal, and unexpected, role in addressing the opioid problem.

Generally speaking, law enforcement officials wield considerable power over the lives of people with substance-use disorders. Indeed, they are often the ones to decide whether a drug offender will be arrested and sent to jail, offered entry into drug court, or fast-tracked into treatment. Whatever their decision, the outcome for addicted men and women can mean the difference between life and death — between going to prison, gaining access to treatment, or returning

9 Rosa Goldensohn, "They Shared Drugs. Someone Died. Does That Make Them Killers?," *New York Times*, May 25, 2018, https://www.nytimes.com/2018/05/25/us/drug-overdose-prosecution-crime.html.

to the streets. As the opioid crisis intensifies, both law enforcement officials and families struggling with addiction have harnessed the criminal justice system to meet the growing demand for treatment.

In Sullivan County, some families have leveraged the criminal justice system to keep their loved ones alive. One mother we spoke to said she had no other alternative but to ask the district attorney to keep her son in jail after he overdosed on heroin. **"I called them and said – please, you need to keep my son in jail because if you don't he'll be dead.... [I]t was the only way to save his life."** Sadly, she is not alone. Another mother we spoke to, whose daughter was caught stealing, threatens to press charges if she leaves rehab. "This is terrible," she told us. "We're not really blackmailing but leveraging her into treatment with this threat. And it very well could be a bona fide threat."

When individuals suffering from opioid addiction refuse treatment, law enforcement officials have similar tools at their disposal. Under the county's drug treatment court program, individuals who are arrested on drug-related charges have the choice between going to jail or going to treatment. Initially, District Attorney Jim Farrell did not believe in the effectiveness of forced treatment. "[W]hen I started this business twenty-two years ago, I did not believe … you could force someone into treatment and it'd be successful," he explained. But now his thinking has changed: "[W]hen you are in treatment, even by force, even by threat of going to jail, and someone shares something in a group about the way that they affected their sister, or their mother, or their grandmother and it hits somebody, that person, then, may see the light." In the end, the opioid crisis has forced law enforcement officials like Farrell to reconsider their role in the war against drugs. "I went into this job to put bad people behind bars," he explained. "I'm not here to be a social worker. But … my job has taken me into the drug court arena where we try to get people help."

While many of the people we spoke to agreed that the current crisis requires a public health response, the criminal justice system has played a pivotal, and unexpected, role in addressing the opioid problem.

While many of the people we spoke to agreed that the current crisis requires a public health response, the criminal justice system has played a pivotal, and unexpected, role in addressing the opioid problem.

Although court-ordered supervision can facilitate recovery, few services are available once people exit the criminal justice system. "The hardest part of all is aftercare," said one person in recovery. "There's really nothing, if you're not on probation that is."

Ironically, while law enforcement officials can compel people into

treatment, hospital workers cannot. Indeed, substance use rehab outside of jail or prison is purely voluntary. As one social worker explained: "If we have somebody that's coming in that's not identifying as depressed, is not identifying with anxiety, does not have a history of bipolar disorder … insurance will not authorize their treatment." It's a problem we've heard a lot about in Sullivan County — while individuals with severe mental illness can be committed to a facility if they are a harm to themselves or others, people with substance-use disorders cannot, even though their addiction may be more deadly than depression.

While jails can minimize exposure to harm by keeping people off the streets, they are not a substitute for treatment. As one mother explained, her son "went right from getting high…. in the parking lot to going to jail. No detox, no medication, no doctor." Still, as the number of drug rehabilitation facilities has diminished, jails and prisons[10] sometimes offer the only treatment available. In Sullivan County, a credentialed alcohol and substance-use counselor has been installed at the local jail and they are considering the use of Vivitrol to treat people with opioid addiction.

As the opioid crisis intensifies, law enforcement officials have started developing alternatives to incarceration. In Chatham,[11] for example, when an afflicted person asks a police officer for help with his or her addiction, the officer is required to treat the request as a typical "call for service." Under the Chatham Cares 4 U initiative, the town's part-time police force must determine what type of treatment individuals need and whether they have insurance, find an appropriate treatment bed, and bring them there. Since the program began in July 2016, at least 180 people[12] addicted to drugs have asked for help, 80 percent[13] were placed in treatment within 24 hours, and over half remained off drugs after leaving treatment.

While jail may not be a solution to the opioid problem, the coercive power of the criminal justice system can still be leveraged to save lives. For this reason, jails must be equipped to meet the needs of people with substance-use disorders. However, more needs to be done so that incarceration is not the only option for families struggling with this disease.

10 Sam Quinones, "Addicts Need Help. Jails Could Have the Answer," *New York Times*, June 16, 2017, https://www.nytimes.com/2017/06/16/opinion/sunday/opioid-epidemic-kentucky-jails.html.

11 Jeanette Wolfberg, "County hears details of Chatham Cares 4 U program," *The Columbia Paper*, March 22, 2017, https://www.columbiapaper.com/2017/03/county-hears-details-chatham-cares-4-u-program/.

12 Joel Tyner, "Legislator says police chief has a solution to opioid crisis: Column," Poughkeepsie Journal, April 27, 2018, https://www.poughkeepsiejournal.com/story/opinion/valleyviews/2018/04/27/legislator-says-police-chief-has-solution-opioid-crisis-column/545245002/.

13 Lynzi DeLuccia, "'Chatham Cares 4 U' helps residents fight drug abuse," WRGB Albany 6 News, April 11, 2018, https://cbs6albany.com/news/local/chatham-cares-4-u-helps-residents-fight-drugabuse.

PART 11

Sullivan County, New York

The Other Family Separation Crisis

"How do you sustain a community where kids are no longer with parents?"

— Sullivan County official on the effects of the opioid crisis

ADULTS MAY BE THE ONES MISUSING DRUGS, but children are the opioid epidemic's greatest collateral damage. In Sullivan County, we've heard stories of loss — of parents losing their children to drugs, but also of children losing their parents. We've heard of children witnessing their parents' deaths and witnessing their parents being revived, sometimes multiple times. Of children being separated from their families and from their communities.

Children of parents with substance-use disorders are at an increased risk

of experiencing maltreatment.[1] The U.S. Department of Health and Human Services has estimated that rising rates of drug-related hospitalizations and drug overdose deaths are related to rising child welfare caseloads — an increase of 10 percent in a county's drug-related hospitalizations and overdose death rates has been estimated to lead to an increase in foster care placement rates of 2.9 and 4.4 percent, respectively.[2]

After a decade of out-of-home placement reductions, the US foster care population has been growing, from 396,966 in 2012 to 437,465[3] children in out-of-home care during 2016, an increase that has been attributed, mostly anecdotally, to the opioid crisis.[4] Researchers have estimated the number of children removed because of parental substance or alcohol use rose from 14 percent to 34 percent[5] between 1998 and 2016. Roughly 35 percent of children whose parental rights were terminated

The consequences for children might be even more acute than in prior drug epidemics. Opioid dependency among adults living in households with children is increasing. In fact, 40 percent of new opioid-dependent adults are estimated to live in households with children.

1 Linda C. Mayes and Sean D. Truman, "Substance Abuse and Parenting," in *Handbook of Parenting, Volume 4: Social Conditions and Applied Parenting*, ed. Marc H. Bornstein (Mahwah: Lawrence Erlbaum Associates, 2002); Rebecca G. Mirick and Shelley A. Steenrod, "Opioid Use Disorder, Attachment, and Parenting: Key Concerns for Practitioners," *Child and Adolescent Social Work Journal* 33, 6 (2016): 547–57.

2 Laura Radel et al., *Key Findings from a Mixed Methods Study*, ASPE Research Brief (Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, March 7, 2018), https://aspe.hhs.gov/system/files/pdf/258836/SubstanceUseChildWelfareOverview.pdf

3 *Preliminary Estimates for FY 2016 as of October 20, 2017,* The AFSCARS Report No. 24 (Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, n.d.): 1-6, https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport24.pdf.

4 Cory Morton and Melissa Wells, "Behavioral and Substance Use Outcomes for Older Youth Living With a Parental Opioid Misuse: A Literature Review to Inform Child Welfare Practice and Policy," *Journal of Public Child Welfare* 11, 4-5 (2017): 546-67, https://www.tandfonline.com/doi/abs/10.1080/15548732.2017.1355866; Nancy K. Young, *Examining the Impact of the Opioid Epidemic. Testimony before the United States Senate Committee on Homeland Security and Governmental Affairs* (Lake Forest: Children and Family Futures, April 22, 2016), https://www.hsgac.senate.gov/imo/media/doc/Testimony-Young-2016-04-22.pdf.

5 U.S. Administration for Children and Families, "Number of children in foster care continues to increase," press release, November 30, 2017, https://www.acf.hhs.gov/media/press/2017/number-of-children-in-foster-care-continues-to-increase.

in 2012 had been removed for parental alcohol or drug abuse.[6]

The consequences for children might be even more acute than in prior drug epidemics. Opioid dependency among adults living in households with children is increasing. In fact, 40 percent of new opioid-dependent adults are estimated to live in households with children.[7] Moreover, parents involved in the child welfare system who use opioids are less likely than other drug users to retain custody of their children.[8] Finally, there has been a substantial increase during the past 15 years of in utero exposure to opioids in mothers involved in the child welfare system.[9]

Although, nationally, drug overdose hospitalizations and drug overdose deaths are related to increased child welfare caseloads and although, nationally, people on the frontlines (judges, caseworkers) describe a sharp increase in foster care placements due to opioids, we do not have solid data that demonstrate it. In New York State, the overall number of children in foster care has dropped significantly between 1995 and 2017. So, what can the numbers tell us? What happens to children during the opioid epidemic? What is the potential impact on foster care and, more importantly, what impact does foster care have on children?

THE RELATIONSHIP BETWEEN DRUG USE AND FOSTER CARE PLACEMENTS

Numbers do not lie, but they may not necessarily tell the whole story either. Mark Courtney, a University of Chicago expert on foster care, suggests that we can learn lessons about the effect of opioids on foster care by looking at previous drug epidemics. Looking at the past shows that there is not a direct correlation between drug use and foster care. Instead, how county officials, families, and judges respond to parents who use drugs determines how many children are placed into foster care, how many homes are available to care for them, and how much all of this will cost the county.

FIRST, how county officials respond to drug use will have an impact on foster care numbers. Approximately one in five children entering foster care is an infant. Counties in New York State have a great deal of leverage in how they treat mothers who give birth to children with opioids in their system. Screening mothers and their babies for the presence of opioids and treating positive tests as evidence of child abuse or neglect — as was often the case with crack cocaine — will result in much higher foster care placements.

6 Only higher for children removed for neglect. See Sid Gardner, *State-Level Policy Advocacy for Children Affected by Parental Substance Use* (Lake Forest: Children and Family Futures, August 2014), http://childwelfaresparc.org/wp-content/uploads/2014/08/State-Level-Policy-Advocacy-for-Children-Affected-by-Parental-Substance-Use.pdf; "Number of children in foster care continues to rise," Administration for Children & Families (ACF), November 30, 2017, https://www.acf.hhs.gov/media/press/2017/number-of-children-in-foster-care-continues-to-increase).

7 L.R. Bullinger and C. Wing, "Trends in opioid abuse and dependency in households with children," unpublished paper, 2017.

8 Martin T. Hall et al., "Medication-Assisted Treatment Improves Child Permanency Outcomes for Opioid-Using Families in the Child Welfare System," *Journal of Substance Abuse Treatment* 71 (September 2016): 63-7.

9 Gregory Bushman et al., "In Utero Exposure to Opioids: An Observational Study of Mothers Involved in the Child Welfare System," *Substance Use & Misuse* 53, 5 (2018): 844-51.

SECOND, the availability of other family members to provide foster care for children will have an impact on foster care placements. During the late 1980s and early 1990s, crack cocaine strained the foster care system, leading to placements with family rather than unrelated foster homes. Although biological families are supposed to be paid like other, unrelated foster families, they sometimes serve as guardians unofficially or in exchange for benefits for the children, like TANF, Medicaid, food assistance, or electronic benefits transfer (EBT).

THIRD, how courts view opioid misuse can have a significant impact on foster care placements, too. Judges have authority to place children in the care of another family member and to demand evidence-based high-quality treatment. Judges can also take children away from their parents and place them in foster care with an unrelated family, having a potentially huge impact on foster care numbers (and a county's budget).

THE COSTS OF FOSTER CARE

Foster care generally is very costly: it strains county budgets; it has lifelong effects on children who are a part of the system; and it tears apart the fabric of communities.

Foster care strains county budgets. The costs[10] of foster care provision are substantial, running about $21,535 per year for each child in a regular foster care placement, and up to $81,441 for institutional placements (FY 2011 estimates). The average annual cost of placing a child in foster care in New York State is $51,943 (in FY 2017[11]), which is more expensive than tuition at Harvard.

Foster care generally is very costly: it strains county budgets; it has lifelong effects on children who are a part of the system; and it tears apart the fabric of communities.

But, unlike Harvard, where students get the benefit of high spending in a rewarding experience, money barely trickles down to children in foster care. Monthly payments[12] (to foster families or homes) in Upstate New York ranges from $552 for infants to $2,016 for children with conditions such as HIV.

Foster care also has far-ranging, long-term social costs and lifelong consequences for children. Children in

10 Gerard Wallace and Ryan Johnson, *New York State - Child Welfare Costs and Kinship Services* (Delmar: New York State Kinship Navigator, n.d.), http://www.nysnavigator.org/pg/professionals/documents/NewYorkStateChildWelfareCostsandKinshipCare.pdf.

11 *FY 2017 Executive Budget Financial Plan* (Albany: NYS Division of the Budget, 2016), https://openbudget.ny.gov/historicalFP/fy1617archive/eBudget1617/financialPlan/FinPlan.pdf.

12 "Administrative Directive," NYS Office of Children and Family Services, August 24, 2017, https://www.ocfs.ny.gov/main/policies/external/OCFS_2017/ADFs/17-OCFS-ADM-11.pdf.

foster care are an extremely vulnerable population. They are at higher risk for experiencing adverse life outcomes, such as homelessness, higher rates of teenage pregnancy, and lower earnings.[13] Additionally, children in foster care are more likely to drop out of school and to experience substance-use problems themselves.[14] They exhibit higher rates of behavioral, emotional, and health problems, which not only result from the experiences that led to their placement, *but from the experience of the foster care system itself*.[15]

AN INCREASED NUMBER OF PLACEMENTS, DIFFERENT TYPES OF PLACEMENTS, OR BOTH?

A recent ASPE Research Brief found that people in communities on the frontlines perceive the number of children in foster care as increasing due to opioid use in their families and believe it is more difficult to find placement for these children, echoing our own interviews in Sullivan County.[16] Officials in Sullivan County identified the family and child welfare services, in particular, as one of the areas that has been hardest hit by the far-reaching "tentacles" of the opioid crisis. They expressed not only concern, but alarm, regarding the devastating effect that the epidemic was having on families; on the family structure; and, ultimately, on the county's social fabric. One official noted communities are going from "single parent families, to no parent families."[17] If something is not done, he warned, "you are not going to have a family structure at some point in the next decade … kids aren't going to have even just single parents any more, it's going to be foster parents or being placed in a facility for their … younger ages."[18]

Communities on the frontlines perceive the number of children in foster care as increasing due to opioid misuse in their families and believe it is more difficult to find placement for these children.

Officials explained how county expenditures for child protective services and foster care have sky-rocketed. According to data from the Sullivan County budget, county foster care costs have nearly tripled, from $551,895 in 2017 to $1,592,895 in 2018,[19] while federal funds for foster care decreased from $1,550,000 to $1,300,000 during the same period. Although capped funds allocated to Sullivan County through the state's Foster Care Block Grant increased

13 Mark E. Courtney, Sherri Terao, and Noel Bost, *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Conditions of Youth Preparing to Leave State Care* (Chicago: Chapin Hall Center for Children at the University of Chicago, 2004), https://www.chapinhall.org/wp-content/uploads/Midwest-Study-Youth-Preparing-to-Leave-Care.pdf; Joseph J. Doyle, Jr., "Child Protection and Child Outcomes: Measuring the Effects of Foster Care," *American Economic Review* 97, 5 (2007): 1583–610.

14 Mark E. Courtney et al., *Foster Youth Transitions to Adulthood: Outcomes 12 to 18 Months After Leaving Out-of-Home Care* (Madison: School of Social Work, University of Wisconsin-Madison, 1998).

15 Scott Cunningham and Keith Finlay, "Parental Substance Use and Foster Care: Evidence from Two Methamphetamine Supply Shocks," *Economic Inquiry* 51, 1 (2013): 764-82; Doyle, Jr., "Child Protection and Child Outcomes."

16 Radel et al., *Substance Use, the Opioid Epidemic, and the Child Welfare System.*

17 Interview # 11_12012017.

18 Interview # 23_03152018.

19 County of Sullivan 2018 Adopted Budget Detail (Monticello: Sullivan County Office of the County Manager, n.d.), http://webapps.co.sullivan.ny.us/docs/omb/CountyofSullivanAdoptedBudget_2018_Detail.pdf..

Sullivan County Foster Care Costs and Federal Funding, 2017 and 2018

	2017	2018	% Change
Sullivan County foster care costs	$551,895	$1,592,895	188.62%
Federal funds for foster care	$1,550,000	$1,300,000	-16.13%

SOURCE: County of Sullivan 2018 Adopted Budget Detail (Monticello: Sullivan County Office of the County Manager, n.d.), http://webapps. co.sullivan.ny.us/docs/omb/CountyofSullivanAdoptedBudget_2018_Detail.pdf.

between 2017 and 2018 by $111,008, the brunt of rising costs falls to the county or, as one public official put it: "[O]nce you've hit your cap, you're done. So if you have a hundred kids and that's your cap, and all of a sudden you have 200, that's all local cost, there's no other federal, state money for that."[20] In addition to the financial costs of counties, local officials talked about the increased complexity and severity of the cases, including babies being born addicted and having to remove them "directly as newborns and a couple of days old."

It wasn't clear at the start of the epidemic that the effect on children would be so dramatic. But local officials describe this threat to the community's social fabric as "eye-opening." It "kind of made it more real, not that it wasn't real, but it kind of made it more that this is really, really getting serious now … it magnified the issue locally for us. And it's not just the budget, I mean, we can deal with the numbers. But I think it became the social fabric of the community … how do you sustain a community where kids are no longer with parents?"[21]

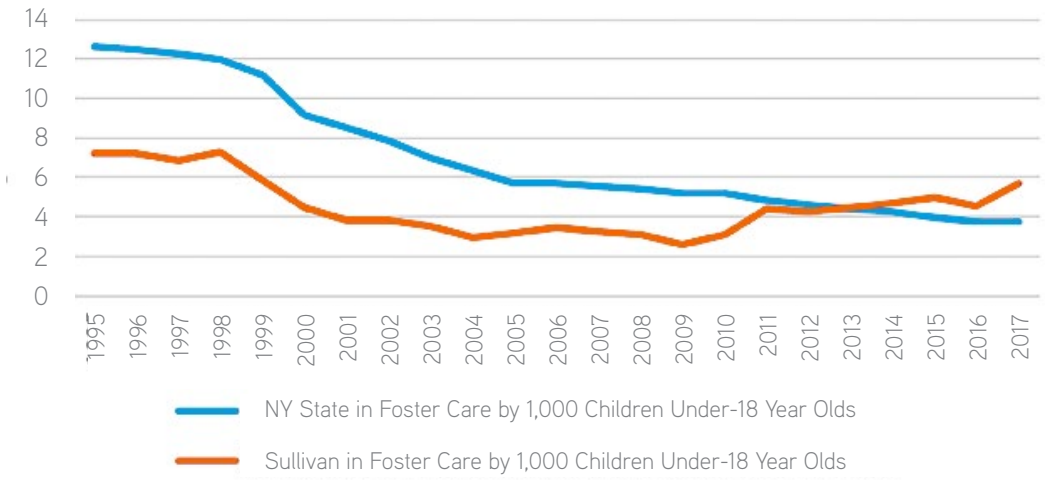
The number of children in foster care in the state of New York has decreased overall, from 37,000 in 2003 to 17,500 in 2017, but places like Sullivan County, which are hardest hit by the opioid epidemic, say they are seeing an increase and intensification of cases. Foster care numbers in Sullivan have been ticking upwards since 2009.

According to officials, the general scarcity of resources for addiction services, for mental health services, and for family and child services, coupled with the small number of foster care providers in the county, and its large geography, have resulted in increased numbers of children placed into foster care in the last two years. In 2017 alone, 47 children entered foster care in Sullivan County, with 100 children in foster care on the last day of 2017: a rate of 5.7 per 1,000 children under the age of 18, higher than the statewide rate of 3.7.

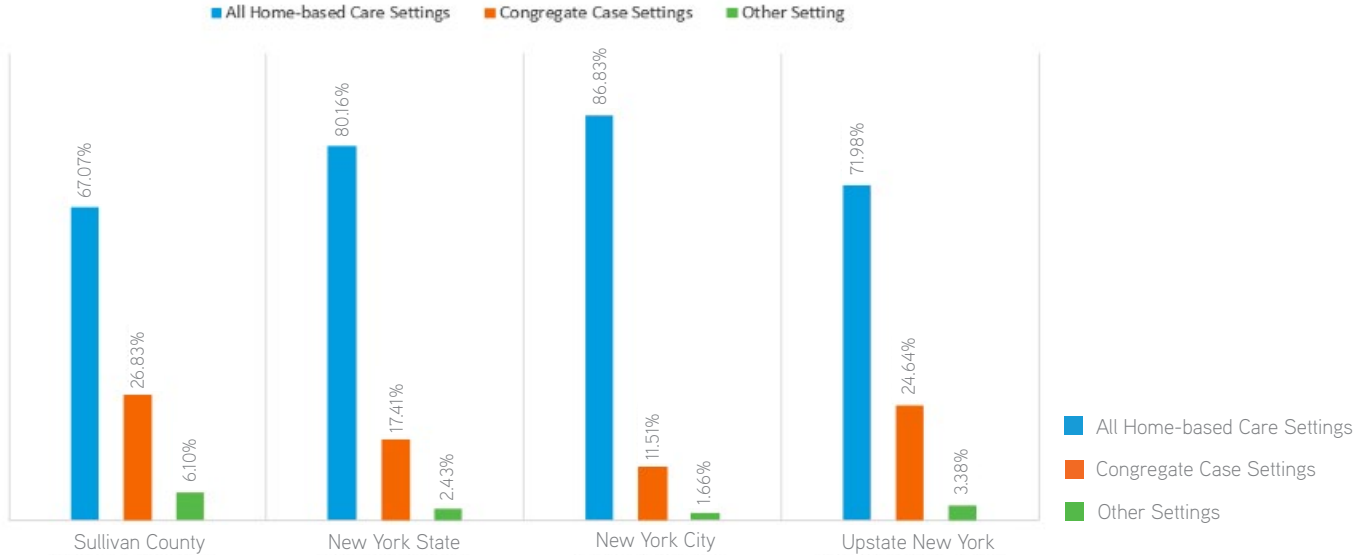
In addition to the increased rate in both foster care entries and children in foster care, there have been changes in the type of placements, which may account for the increased costs experienced by the county. In 2017, Sullivan County children spent 34,438 days in foster care; only 1.5 percent of the days were in approved relative homes, the least costly type of placement, while 60.9 percent were in foster boarding homes and 22 percent in institutions, which are the costliest type of placement. By comparison, in 1995, more children were placed in relatives' homes (4.8 percent),

20 Interview # 23_03152018.
21 Interview # 23_03152018.

Rates of Children in Care on the Last Day of the Year, 1995-2017



Percent of Children Living in Foster Care by Setting Type on December 31, 2016



more children were placed in foster boarding homes (80 percent), and fewer were placed in institutions (9.8 percent).

In general, Sullivan County children are placed more often in group-home settings. For example, of the 82 Sullivan children in care on the last day of 2016, two-thirds (55) were placed in home-based care settings, like placement with relative or in foster care; a quarter (22) were placed in congregate care settings, like group homes; and one in 20 (5) were placed in other settings. In comparison, the percentage in home-based-care settings at the statewide level was much higher, and congregate care (institutions) and other settings were lower.

Children in Sullivan County are also spending more time in foster care. In 2017, they spent an average of 269 days in foster care, the highest number in our data (in 1995, the average was 208, and the lowest during the 1995-2017 period was 177 in 2005).[22]

22 "Monitoring and Analysis Profiles (MAPS), Aggregate Data," New York State Office of Children and Family Services, accessed August 6, 2018, https://ocfs.ny.gov/main/reports/maps/defaultAgg.asp.

They are also being placed out of Sullivan County. Even though county officials "try like hell" to keep children in their communities, more children are being placed out of county and even out of state. Nationally, the ASPE[23] research reports difficulty in finding foster homes because children are in care longer (keeping existing foster homes full), in placing siblings together, and in finding local placements. Multigenerational substance-use may also play a role in finding family members to take in children.[24] As a Sullivan County official explained, "[I]n our case, we don't really have a lot of foster care providers, so they are getting shipped to Pennsylvania, Massachusetts. So it's really almost destroying, in some respects, the whole family structure. The kids are just, they're not … even if they are fostered in the county they are being fostered hundreds of miles away somewhere."[25]

Of the total Sullivan County children in foster care during 2016 (132), 40 percent (53) were placed out of county and 2 (1.5 percent) were placed out of state. This has serious repercussions in terms of the possibility of achieving family reunification, which often depends on the availability of intensive family-centered services, and increases the probability of children lingering in the foster care system for prolonged periods of time. It further increases the trauma that often characterizes the foster care experience, causing total disruption in the child's life — loss of parents, friends, and community.

Foster care is not only disruptive, it can also be unsafe. The rate of indicated maltreatment reports *while* in foster care for children in Sullivan County was 19.22[26] (per 100,000 care days), higher than the statewide rate of 15.93, and the Upstate rate of 13.8. Foster care is designed to be a measure of last resort and, often, a life-saving intervention. Nonetheless, the effects of receiving poor foster care services can be harmful to children, families, and communities; for children to experience maltreatment while in the foster care system is a massive failure of our foster care system.

WHAT COMMUNITIES SAY THEY NEED

When specialized care is needed — to treat addictions, to provide for the mental health of children in families affected by addiction, or finding families/facilities to place children — already scarce local resources may be stretched too thin. In rural areas there is a small pool of potential foster families to begin with. Unlike their urban counterparts who have resources to scale, rural communities cannot build group homes to house children who need care. The irony is that rural counties, with few resources, may end up paying more: housing children in group homes because they

23 *Substance Use, the Opioid Epidemic, and the Child Welfare System: Key Findings from a Mixed Methods Study*, ASPE Research Brief (Washington, DC: U.S. Department of Human Services, March 7, 2018), https://aspe.hhs.gov/system/files/pdf/258836/SubstanceUseChildWelfareOverview.pdf.

24 Radel et al., *Substance Use, the Opioid Epidemic, and the Child Welfare System*.

25 Interview # 23_03152018.

26 *2016 Bright Spots Data Package* (Albany: NYS Office of Children and Family Services, September 2017), https://ocfs.ny.gov/main/cfsr/data/brightspots/2016-Bright-Spots-Complete.pdf.

can't find foster families and housing them out of county because they don't have the ability to place them closer.

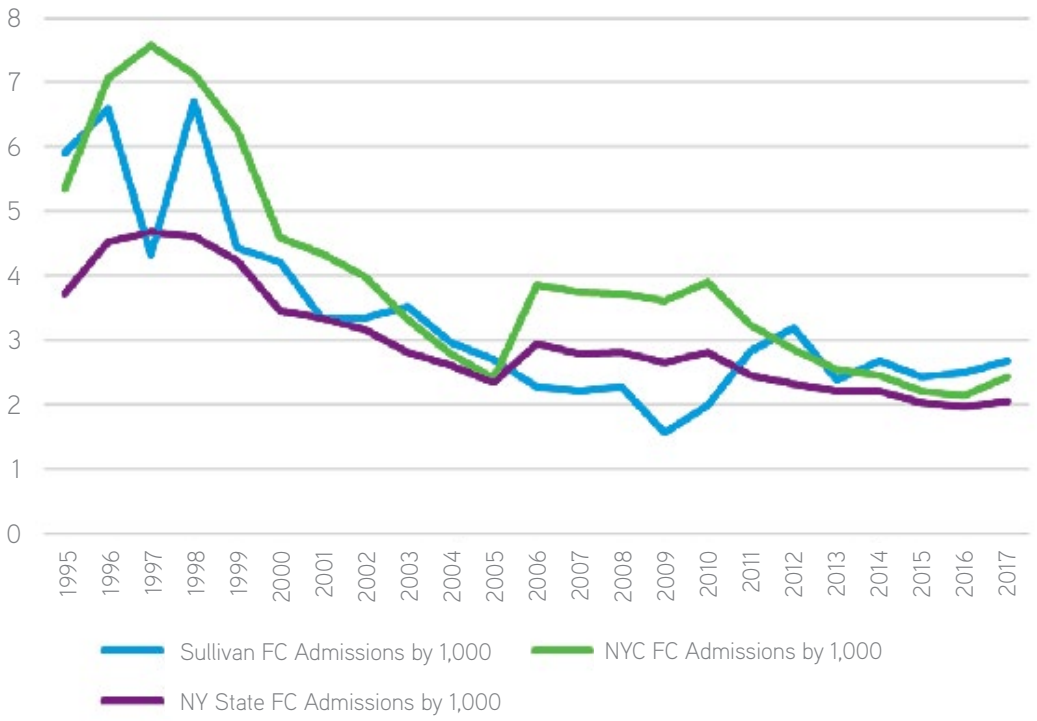
As one Sullivan County official explained when asked about the resources they needed, "… I guess more funding for foster care, because if we can't, if we are not going to create beds or create more places to put people, we need more funding to kind of help place kids as their parents are having issues." He further explained that if the opioid addiction problem was effectively addressed, the strain on the foster care system would be reduced.

There is a need for increased specialized resources to address the trauma that families and children suffer as a consequence of parental substance-use, including social workers and mental health professionals. Current personnel on the frontlines say they are overwhelmed with high caseloads and insufficient resources to address the needs of this population. And, more importantly, there is a need for good *in-county* foster homes to provide a loving and supportive environment for children to heal and thrive; to give the child's life a semblance of stability and normalcy. As one county administrator noted:

> If I'm taking a child out of a home, I want to make it as normal as possible for them in that transition, and, you know, kids go to birthday parties, they have sleepovers, they go out to Chuck E. Cheese. That doesn't happen in a lot of our foster cares, I'm not saying in all of them. But again, they also live on limited resources and are taking in kids out of the goodness of their heart and giving them a safe home. So, I'm not knocking them. But sometimes it's just — it needs more than just a safe home, to feel normal.[27]

27 Interview # 19_01182018.

Foster Care Admissions per 1,000 Under-18 Years Old



A bail bonds and process service on Broadway in Monticello, NY.

CONCLUSION

Even though adults are the ones with addictions, a closer look at foster care suggests that children may be paying the price. Foster care is expensive and — even with good placements — the effects can be far-reaching. Experts do not know whether the disconnect between national data, which does not show a sharp and sudden spike in foster care placements, and interviews with local officials, who say that they are overwhelmed, is due to a lag in the data (the reporting hasn't caught up to the reality) or if there is something else going on, such as a similar number of children in foster care but more difficulty in finding suitable placements for them. A closer look at Sullivan County shows just how far-reaching the problem can be.

If you are interested in becoming a foster or adoptive parent in Sullivan County, please contact the Sullivan County Department of Family Services at (845) 292-0100 ext. 2292 or (845) 292-0100 ext. 2389.

PART 12

Catskill Regional Medical Center
Harris, New York

Deaths of Despair or Access to Healthcare?

OPIOIDS ARE A PROBLEM IN RURAL COMMUNITIES. Prescription opioid use first surfaced in rural America, it is concentrated in rural states, and rural states have the highest rate of drug overdose deaths. It's clear that opioids are a problem in rural communities. But it's not clear why. Some say it's the economy and culture of rural areas, which have more manual labor jobs and fewer resources to combat the problem.

In a now famous study, Anne Case and Angus Deaton found a surprising increase in midlife mortality among whites living in the United States due to drug overdoses, suicides, and chronic liver diseases.[1] Case and Deaton

1 Anne Case and Angus Deaton, "Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century," *Proceedings of the National Academy of Sciences* 112, 49 (2015): 15078-83.

described these "deaths of despair" as potentially linked to declining wages, limited job opportunities, and fewer marriages.[2] In other words, failure to fulfill societal expectations has led to higher rates of suicide, drug use, and other risky behaviors for one population in particular: middle-aged, non-Hispanic, white Americans with a high-school education. Sociologist Andrew Chernoff explains[3] that it isn't just that these people might be doing poorly, but they may be comparing themselves unfavorably to a higher standard they cannot meet. White men with high-school educations may look back and see that they are not doing as well as their fathers, while, Chernoff says, African American men may see themselves doing better.

There's no doubt that communities, like Sullivan, have experienced tough times. People might even describe a sense of despair. One mother we spoke to explained: "there's no hope anymore. We always lived with the idea that we were going to have our home, our jobs … both my boys are college educated and continued to live at home until they were married because they needed not only their income but their wives' income to support a home." Another recent transplant told us that people in Sullivan "see no hope, they feel that they've been lied to, or they feel that there's been so many false starts since the heyday of the hospitality industry." And a third: "If you look at the county as if it was a person … and you are going to diagnose that person. The county would be diagnosed depressed, anxious, traumatized, alright? But probably traumatized first."

The real problem with deaths of despair is that it is an effective soundbite — it takes a complicated problem and gives all of us a simple way to understand it. But it isn't necessarily at the root of rural opioid misuse, and it doesn't necessarily lead to the right policy solutions.

But while they describe a community that has seen years of economic marginalization and has been traumatized as a result, it's not clear exactly how that translates to opioid use. Case and Deaton[4] themselves claim opioid use adds "fuel

2 See also Alex Hollingsworth, Christopher J. Ruhm, and Kosali Simon, *Macroeconomic Conditions and Opioid Abuse*, NBER Working Paper 23192 (Cambridge: National Bureau of Economic Research, revised March 2017), http://www.nber.org/papers/w23192.pdf.

3 Andrew J. Cherlin, "Why Are White Death Rates Rising?," *New York Times*, February 22, 2016, https://www.nytimes.com/2016/02/22/opinion/why-are-white-death-rates-rising.html.

4 Anne Case and Angus Deaton, *Mortality and Morbidity in the 21st Century*, Brookings Papers on Economic Activity (Washington, DC: Brookings Institution, Spring 2017): 397-476, https://www.brookings.edu/wp-content/uploads/2017/08/casetextsp17bpea.pdf.

Volunteers are building a community garden in public housing complex in Monticello to improve local diets and quality of life.

to the fire" for the larger demographic pattern of increasing white mortality for a very specific population (45- to 54-year-old non-Hispanic whites with a high school degree), but that hasn't stopped others[5] from explaining opioid overdoses more generally as deaths of despair. It's an easy answer sidestepping difficult questions. Why do some people in rural communities turn to opioids while others in similar circumstances do not? How do we know that urban areas (or subpopulations within urban areas) don't similarly feel despair? Why does despair affect white Americans when — contrary to Andrew Chernoff — Michelle Alexander's *The New Jim Crow*[6] suggests that many black Americans do not see a story of relative progress, comparing themselves favorably with

5 Jennifer S. Vey, *Addiction by design: Place, isolation, and deaths of despair* (Washington, DC: Brookings, August 1, 2018), https://www.brookings.edu/blog/the-avenue/2018/08/01/addiction-by-design-place-isolation-and-deaths-of-despair/?utm_campaign=Brookings%20Brief&utm_source=hs_email&utm_medium=email&utm_content=64942205.

6 Michelle Alexander, *The New Jim Crow: Mass Incarceration in the Age of Colorblindness* (New York: The New Press, 2012).

the past? Are Native Americans'[7] overdoses, second only to those of white Americans, deaths of despair too? Can we describe urban drug overdoses as deaths of despair? Were prior drug epidemics — crack/cocaine, methamphetamines, or heroin — also due to despair? When is drug use not about despair?

When diseases like yellow fever and cholera wreaked havoc in nineteenth-century cities, killing tens of thousands of Americans at a time, experts attributed them to "miasma" or bad air. Yellow fever and cholera, however, aren't transmitted by bad air but by mosquitoes (yellow fever) and polluted water (cholera). Nineteenth-century cities were filthy places, and, no doubt, a stench hung over them. But, as noxious and unhealthy as it was, the stench didn't cause these diseases to spread any more than the level of despair hanging over rural counties causes opioid overdoses. There has to be a mechanism or a vector for it to infect individuals.

Deaths of despair is a better soundbite than causal mechanism. As one person on the frontlines explained, "No one goes out saying they want to be a drug addict. But people try things, people do things … and depending on [their] experience or how many times they try something, and their genetic makeup and their history, determines whether or not they continue to have a problem." People we spoke to offered many reasons why an individual might turn to drugs: adverse childhood experiences, trauma, bullying, boredom, mental health, stupidity, brokenness and pain, kids just being kids, and, yes, economic hardship.

Physicians in rural areas prescribe more opioids than physicians in urban areas. Physicians also prescribe opioids more readily to white Americans than to Hispanic or black Americans.

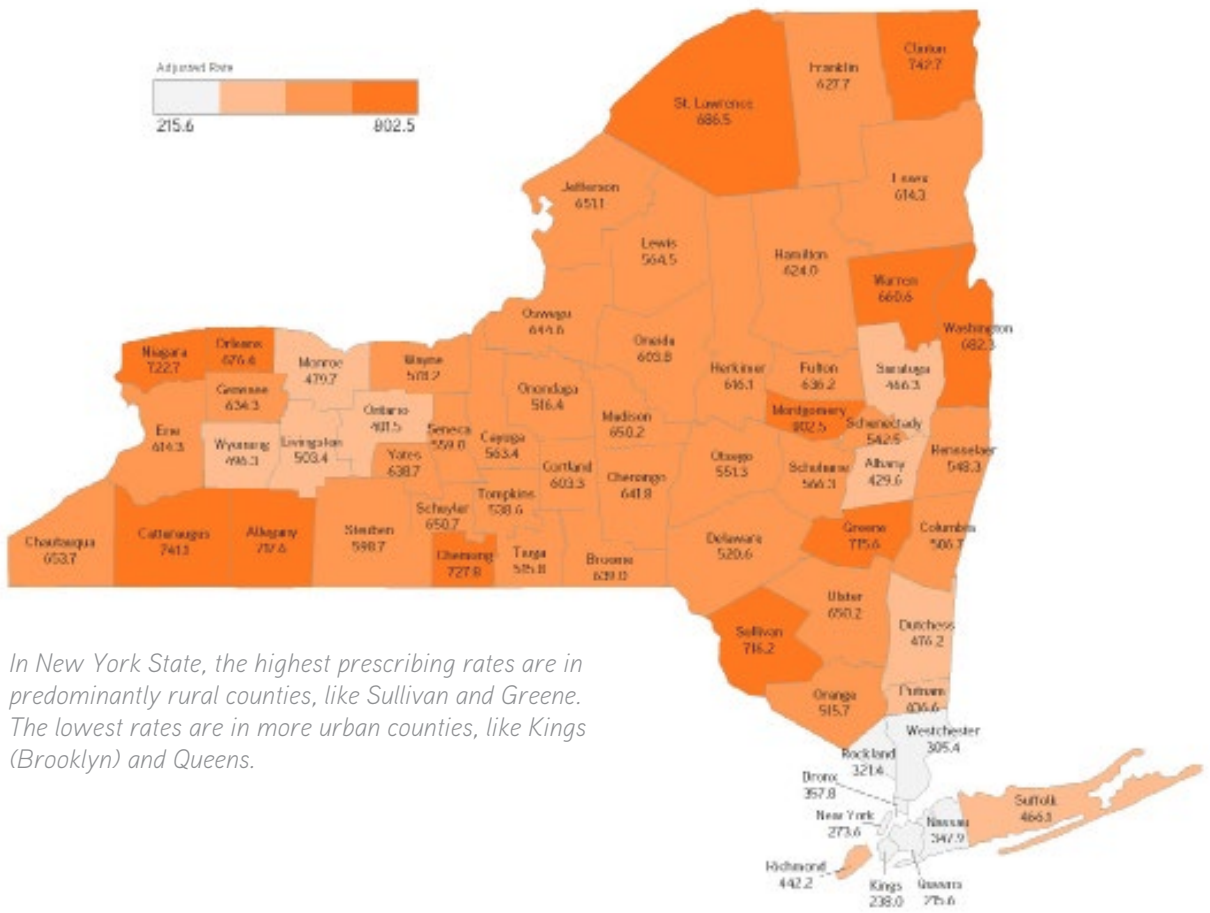
But to misuse opioids, individuals must have a way to get them first. Scholarly research shows that access to opioids varies a lot, and prescribing rates may hold the clue to current disparities between urban and rural communities. What if access to particular kinds of healthcare makes people sick?

Physicians in rural areas are much more likely to prescribe opioids.[8] In New York State, the highest prescribing rates are in the most rural areas and the lowest rates are in the most urban, even though these urban areas have medical centers

7 National Indian Health Board, "Testimony of the National Indian Health Board to the Committee on Energy and Commerce, Health Subcommittee: Legislative Hearing on Opioid Public Health and Prevention Efforts, March 22, 2018," https://docs.house.gov/meetings/IF/IF14/20180321/108049/HHRG-115-IF14-Wstate-BohlenS-20180321-U2.pdf.

8 Ameet Sarpatwari, Michael S. Sinha, and Aaron S. Kesselheim, "The Opioid Epidemic: Fixing a Broken Pharmaceutical Market," *Harvard Law & Policy Review* 11 (Summer 2017): 463-84, https://harvardlpr.com/wp-content/uploads/sites/20/2017/07/SarpatwariSinhaKesselheim.pdf.

Age-Adjusted Opioid Analgesic Prescription Rate Per 1,000 Residents, 2017
(Adjusted to 2000 US Population)



In New York State, the highest prescribing rates are in predominantly rural counties, like Sullivan and Greene. The lowest rates are in more urban counties, like Kings (Brooklyn) and Queens.

that draw patients from across the state and country for treatment. Sullivan County, for example, has an age-adjusted prescription rate of 716.2 per 1,000 people, while Queens County in New York City has a rate of only 215.6.

People we spoke to on the frontlines in Sullivan County often pointed to high prescription rates as a problem. A local pharmacist told us he's never dispensed so many controlled substances in his life. The district attorney explained:

> I think we are back to heroin in large part because of … our prescription patterns. And if it's true that 700 in a thousand are being prescribed those very, very serious painkillers in this county, woooh, we have an issue, and we are not alone, there's many other counties where the prescription practices are equally as egregious. How can 700 out of a 1,000 people need that?

He's right. Sullivan is not alone. There are ten counties in the 680+ prescriptions per 1,000 people category just in New York State.

Shouldn't physicians be prescribing opioids at similar rates? It turns out that physicians do not receive much education or training in pain

Main Street in Fallsburg, New York

management and safe-practices for opioid prescribing.[9] In fact, in the 1990s, organizations like the American Pain Society, the American Academy of Pain Management, the American Medical Association, and the Federation of State Medical Boards recommended reducing patient pain, including using opioids for chronic pain management.[10] And, pharmaceutical companies, like Purdue, engaged in extensive marketing and created lucrative incentives for doctors to prescribe pain medication.

Still, physicians vary in systematic ways. For example, physicians from higher-ranked medical schools prescribe fewer opioids than physicians from lower-ranked medical schools, even when taking location and patient population into account.[11] Rural areas, which have a hard time attracting professionals (lawyers, doctors, nurses, social workers, educators) may get doctors whose training is qualitatively different from doctors who are attracted to urban areas.

Once legitimate prescription opioids enter a community, they often get diverted to others in a community. According to a 2015 study, a 10 percent

9 Karen O. Anderson, Carmen R. Green, and Richard Payne, "Racial and Ethnic Disparities in Pain: Causes and Consequences of Unequal Care," *Journal of Pain* 10, 12 (2009): 1187-1204, http://www.med.umich.edu/anes/mpost/pub09/anderson2009jpain.pdf.

10 Sarpatwari, Sinha, and Kesselheim, "The Opioid Epidemic."

11 Molly Schnell and Janet Currie, *Addressing the Opioid Epidemic: Is There a Role for Physician Education?*, NBER Working Paper 23645 (Cambridge: National Bureau of Economic Research, revised November 2017), http://www.nber.org/papers/w23645.pdf.

increase in prescription opioids under Medicare Part D coverage for elderly leads to a 7 percent increase in opioid-related deaths and a 14 percent increase in treatment admissions rates *for populations ineligible for Medicare*.[12] For rural areas with very high prescription rates already, this is an alarming fact. Physician-prescribed opioids lead to higher overdose death rates for people who were not prescribed opioids.

Physicians, generally, in rural areas prescribe more opioids than physicians in urban areas. Physicians also prescribe opioids more readily to white Americans than to Hispanic or black Americans. Some researchers have noted that white Americans have higher opioid overdose rates, but white Americans also have greater access to healthcare and greater access to prescription opioids within the healthcare system.[13]

By comparison, Hispanic Americans and black Americans are less likely to be treated for pain and less likely to be prescribed medication.[14] Meghani et al. found that Hispanic Americans were as likely to be prescribed some sort of pain medication, but 22 percent less likely than their white counterparts to receive opioids. Black Americans were 22 percent less likely to receive pain medication of any kind, and 29 percent less likely to receive opioids than white Americans for similar conditions.[15]

> If despair is the problem, we can basically throw our hands up because policy solutions are few and far between.

Why do physicians prescribe more opioids to white Americans? Does it have something to do with pain thresholds? It turns out the more likely reason may have something to do with physicians' assessment of a patient. For types of pain that require physician discretion to evaluate, stereotypes and preconceptions are more likely to come into play. When physicians prescribe for nonsurgical/trauma pain (e.g., backache or migraine rather than back surgery or an accident) Hispanic Americans are *30 percent less likely to receive opioids*, and black Americans are *34 percent less likely* than white Americans for similar conditions.[16] Physicians often underestimate the severity of nonwhite patients' pain.[17] Hispanic Americans report feelings of discrimination and lack

12 David Powell, Rosalie Liccardo Pacula, and Erin A. Taylor, *How Increasing Medical Access to Opioids Contributes to the Opioid Epidemic: Evidence from Medicare Part D*, NBER Working Paper 21072 (Cambridge: National Bureau of Economic Research, April 2015), http://www.nber.org/papers/w21072.pdf.

13 See, for example, Helena Hansen and Julie Netherland, "Is the Prescription Opioid Epidemic a White Problem?," *American Journal of Public Health,* 106, 12 (2016): 2127-9.

14 Carmen R. Green et al., "The Unequal Burden of Pain: Confronting Racial and Ethnic Disparities in Pain," *Pain Medicine* 4, 3 (2003): 277-94; Salimah H. Meghani, Eeeseung Byun, and Rollin 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, 2 (2012): 150-74.

15 Meghani, Byun, and Gallagher, "Time to Take Stock."

16 Ibid.

17 Anderson, Green, and Payne, "Racial and Ethnic Disparities in Pain."

of understanding from doctors when they express they are in pain.[18]

Which brings us back to deaths of despair. If despair were at the root of opioid use, then, yes, the least well-off communities should have the highest overall death rates. The least well-off within these communities should be disproportionately affected, too, and yet that's not the case. Opioid overdose deaths affect a broad range of people, from law enforcement to star students. Economist Christopher Ruhm found little support for the deaths of despair hypothesis, arguing instead that patterns for sex and age "suggest that changes in the drug environment may be an important determinant of rising drug mortality."[19] Opioids, especially street drugs like heroin and fentanyl, are prevalent, inexpensive, and extremely deadly. In Ruhm's analysis, it's access to a growing supply of more lethal drugs that leads to overdose deaths.

Yes, it is possible that despair plays a role in opioid use. But it's likely that despair plays a role in addiction of all types. For despair to explain the current opioid epidemic, it needs to explain the blunt differences between rural and urban areas, as well as patterns within a community and between different types of communities: why white and Native Americans are affected more than Hispanic or black Americans; why men more than women; and why now.

The real problem with deaths of despair is that it is an effective soundbite — it takes a complicated problem and gives all of us a simple way to understand it. But as easy as it is to look at rural communities and point to despair, it isn't necessarily at the root of rural opioid misuse, and it doesn't necessarily lead to the right policy solutions. In fact, if despair is the problem, we can basically throw our hands up because policy solutions are few and far between.

If Ruhm is right, and access to opioids is the problem, the scope of blame and responsibility is much more specific. The same people and organizations that got us into this crisis would have to take responsibility for getting us out. We'd have to take a look at how and for what conditions the U.S. Food and Drug Administration approved particular drugs, how these drugs were marketed, and how physicians prescribed them. We'd have to understand the role federal and state agencies had in regulating these processes. We'd have to figure out how doctors prescribed opioids for nonpalliative care in the first place, and why they are allowed to opt out of (and indeed are limited in) providing medication-assisted treatment to get people off.

Powerful national and state actors have good reason to support the deaths of despair explanation. It lets everyone involved in increasing access to opioids off the hook, and it leaves under-resourced county health officials holding the bag for cleaning it up.

18 Nicole A. Hollingshead et al., "The Pain Experience of Hispanic Americans: A Critical Literature Review and Conceptual Model," *Journal of Pain* 17, 5 (2016): 513-8.

19 Christopher J. Ruhm, *Deaths of Despair or Drug Problems?*, NBER Working Paper 24188 (Cambridge: National Bureau of Economic Research, January 2018): 6.

PART 13

Combating the Opioid Epidemic Is Not Just about More Services — It's about Access to the Right Services

WHY ARE SO MANY PEOPLE DYING?

Overdose deaths don't affect populations equally. In the United States, opioid overdose death rates are highest in rural communities. In a previous analysis, we discussed some of the reasons why opioid use has become such a problem in rural communities. Contrary to the popular narrative that social and economic deterioration in rural communities account for the current crisis (the so-called "deaths of despair" hypothesis), we suggest, instead, that access to physicians who readily

PHOTO: The Kingfisher Project's Sky Lantern Release (http://jeffersonvilleny.com/sky-lantern-release/) in Jeffersonville, New York, in November 2017, commemorated those whose lives have been affected by narcotics and opioid addiction.

prescribe opioids in rural areas may hold the clue to current disparities between urban and rural drug use.

But how opioid misuse becomes a problem is only one part of the puzzle as to why death rates are so high. The other piece is what prevents local governments from making significant progress to stem the tide.

We went down to rural Sullivan County to learn more from people on the frontlines. Certainly, rural communities — like Sullivan — do not have the resources or support they need to deal with a problem of this magnitude. The county's hospital does not have a detox unit and there are only a handful of drug rehabilitation facilities. Ironically, as the crisis in Sullivan worsened, more facilities closed. Services that other New York State residents might take for granted — access to specialized medical care, public transportation, available and affordable housing — just aren't there, creating a real barrier for county leaders trying put an end to the crisis.

Do rural communities face greater burdens? And do they have fewer resources to address them? We decided to find out by looking at neighboring Orange County to see if it was any more successful in the ongoing fight against opioid use. We discovered that, while Orange County typically has more resources and infrastructure to deal with the problem, it — like many other counties — struggles to get ahold of opioid use and overdose deaths as heroin and fentanyl become more readily available.

Sitting just a few miles to the southeast, Orange County ranks higher on measures of population, income, and health than Sullivan. Its population is nearly five times larger, and more than three quarters of its population live in urban areas.

> While Orange County benefits from greater resources and infrastructure, there is no indication of the epidemic slowing down here either. Despite every effort to the contrary, the overdose death rate in both Sullivan and Orange counties continues to climb.

Socioeconomic and health indicators suggest that suburban counties like Orange have greater capacity to deal with the opioid problem. Indeed, people in Orange make more money (median income $71,910, compared to $52,027 in Sullivan County) and fewer live in poverty, even though the unemployment rate is comparable across both counties. In the Robert Wood Johnson Foundation's annual ranking of county health by state, Orange generally ranks in the top third, much higher than Sullivan.

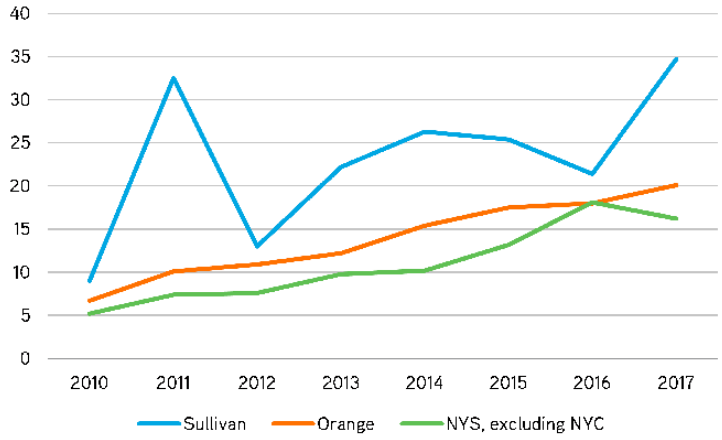
At the most basic level, the sheer size of government in Orange is bigger. The District Attorney's Office,[1] for example, employs 12 investigators, 19 clerical workers, and 45 assistant district attorneys compared to the eight assistant district attorneys in Sullivan County.[2] Orange also employs an epidemiologist who develops public health assessments and countywide improvement plans.

Orange has a larger revenue stream as well. In 2017, the county collected $279.6 million[3] in sales tax, which helps fund the local government and its 42 towns, villages, and cities. Sullivan, by comparison, took in just under $40 million.

While Orange County benefits from greater resources and infrastructure, there is no indication of the epidemic slowing down here either. Despite every effort to the contrary, the overdose death rate in both Sullivan and Orange Counties continues to climb. In Sullivan, the number of opioid-related deaths in 2017 was nearly four times higher than the number of deaths in 2010. For Orange, it was nearly three times higher than in 2010.

Even though Orange and Sullivan are differently resourced communities, their experiences with the opioid epidemic are at times indistinguishable. In both counties, we heard about staffing shortages and the difficulty of hiring well-qualified addiction specialists:

Overdose Deaths Involving Any Opioid, per 100,000 People 2010-17



SOURCE: Rockefeller Institute analysis of "Opioid-related Data in New York State," https://www.health.ny.gov/statistics/opioid/.

"There aren't enough of them and they are poorly trained," said one provider in Orange. As in Sullivan, Orange County also experiences difficulty getting people into treatment, connecting families to services, and dealing with state agencies. "We're desperate," one public health official told us in Orange County. "We're desperate, as so many other communities are, to get a handle on this."

Why isn't a county with greater resources and infrastructure able to move the needle on overdose death rates? The answer may have less to do with local governments than with the nature of the drug itself. As one Orange County official observed: "We really felt like we were getting a pretty good handle on it. We thought we were managing the number of deaths and doing a great

1 "About the Office," Orange County, New York, accessed August 31, 2018, https://www.orangecountygov.com/265/About-the-Office.
2 Michael Randall, "Sullivan panel OKs request to fill 3 assistant DA jobs; 2 more approvals needed," *Times Herald-Record*, August 3, 2017, https://www.recordonline.com/news/20170803/sullivan-panel-oks-request-to-fill-3-assistant-da-jobs-2-more-approvals-needed.
3 "Local Sales Tax Growth in 2017 Highest in Four Years," Office of the New York State Comptroller, January 2018, https://www.osc.state.ny.us/localgov/pubs/research/local-sales-tax-growth-2017-highest-in-four-years.pdf.

Posters on a bulletin board at the Monticello Police Department.

deal of work … and then fentanyl hit the streets."

Fentanyl is a synthetic opioid[4] 50 times more potent than heroin and 100 times more potent than morphine. A single dose of fentanyl as small as two grains of salt can be fatal, yet drug traffickers[5] are using it at an alarming rate to cut heroin and boost profits — oftentimes without the buyer's knowledge. Making matters even worse, the likelihood of overdosing on heroin or fentanyl is higher than for other drugs because tolerance for opiates diminishes very quickly. As one addiction specialist explained to us, if people who are incarcerated for several days get out and use opioids at the same level they used before incarceration, they are at a much higher risk of dying than if they were using marijuana or cocaine. "So, that's something that's very different about this particular drug cycle," he pointed out. "[I]t's the lethality that makes this what it is."

In short, the lethality and increased production of synthetic opioids make it nearly impossible for local communities, both rural and suburban alike, to get ahead of the problem. However, the policies put in place by state and federal

4 Centers for Disease Control and Prevention, "Synthetic Opioid Overdose Data," last updated December 19, 2018, https://www.cdc.gov/drugoverdose/data/fentanyl.html.

5 U.S. Drug Enforcement Administration, "DEA Releases 2017 National Drug Threat Assessment: Prescription opioid abuse poses deadly threat," press release, October 23, 2017, https://www.dea.gov/press-releases/2017/10/23/dea-releases-2017-national-drug-threat-assessment.

lawmakers do not always help these communities in the ways they are intended. Even though policymakers have increased access to treatment beds and invested dollars in alternatives to incarceration, local governments still struggle to find qualified staff. "This is the frustration of the treatment programs," one provider told us. "They keep expanding access to treatment but you can't find a nurse practitioner to prescribe Buprenorphine. Programs fight over them because they're so minimal. So how do you get good results if you can't staff a freaking program?"

As in Sullivan, Orange County also experiences difficulty getting people into treatment, connecting families to services, and dealing with state agencies. "We're desperate," one public health official told us in Orange County. "We're desperate, as so many other communities are, to get a handle on this."

WHAT CAN WE DO ABOUT IT?

People on the frontlines of the opioid epidemic are frustrated. They feel like they are working harder and harder but still falling behind. Parents are angry, telling us if opioid use and overdose deaths are truly a national epidemic, then policymakers ought to treat them that way.

To make a meaningful difference, local governments across the state will need not just more resources, but the right kind of resources. For example, both government and nonprofit providers have a hard time hiring and retaining qualified staff. On the one hand, they aren't able to pay enough. But, on the other, there's a shortage of people with the degrees, training, and experience required (often by law) to do the job. More money would likely ease the problem, but it wouldn't necessary solve it. And other, more targeted solutions that incentivize people to get specialized degrees in counseling, nursing, or social work and training in psychiatry (especially child psychiatry) could also help.

Even in counties with more services, admission criteria at treatment centers and length-of-stay restrictions, which limit insurance to 30 days of treatment, make it difficult for people to access services even when beds are available — creating the illusion of services without effectively addressing the problem.

If we are serious in our commitment to ending the opioid crisis, then state and federal policymakers must listen to what local communities are up against and target their investments accordingly.

A mural on Broadway in Monticello, New York

PART 14

The Illusion of Services

FROM THE FIRST DAY WE SET FOOT IN SULLIVAN COUNTY, we've heard about people who want help but can't get it. Just about everybody we've talked to — parents, social workers, treatment providers, local officials, people in recovery — is frustrated. Many tell a similar story about a lack of available treatment beds. A county official summed the problem up this way: "it's waiting lists and/or you are getting shipped out somewhere.... [T]o me that's a big problem, just the lack of beds."

But, at the same time local officials and families on the frontlines say there are no beds, New York State's Office of Alcoholism and Substance Abuse Services (OASAS) treatment locator tool shows plenty of open slots: at the time of thsi writing 74 opportunities within 50 miles of Monticello, NY (the heart of Sullivan County). "I get emails every day from providers 'We have beds, we have beds, we have beds,'" one addiction specialist told us. "Sullivan County has beds.... That's not the problem."

Beds on paper are often hard to access in person: people who show up at the emergency department are turned away; people who try to get into treatment facilities find there is no one there to answer the phone; and people who want

medication-assisted treatment find few doctors who will treat addiction (and those that do aren't accepting any more patients). It's hard for a person seeking services, but it's also hard for providers who want to do more but can't.

The computer system may be right that there are plenty of treatment beds, but those beds aren't always available to people who need them — a disconnect that we call the "illusion of services." Why are services so hard to access? And what can we do about it?

LACK OF MEDICALLY SUPERVISED DETOX

People who are addicted to opioids and seek treatment may go to the hospital emergency department for help. Under federal law,[1] hospitals are required to provide appropriate medical care for "emergency medical conditions," where the absence of medical care could be expected to place the health of the individual in serious jeopardy or serious impairment to bodily functions. Withdrawal is not necessarily considered an emergency medical condition, and many doctors do not believe that detoxification requires a hospital-level of care. In 2008, New York State enacted new guidelines[2] for detoxification, shifting to community-based care for withdrawal. Catskill Regional, Sullivan County's only hospital, for example, does not detox. Only one hospital between Orange and Sullivan Counties does.

Almost everyone we spoke to talked about the lack of long-term treatment options, with lengths of stay lasting approximately six to 12 months. In Sullivan, two residential facilities closed in the early 2000s, just as the crisis intensified.

Hospitals treat addiction under a medical model of care, where individuals have to experience physical withdrawal before they are admitted. Essentially, people who come to the emergency department for help are sent home unless they are experiencing, as one hospital social worker described, very painful symptoms: "shakes, dilated [pupils], sweats, whole body aches, severe body aches, restlessness … body twitching, like their legs will twitch or their arms will twitch, is a sign.… Typically, they are nauseous, they're vomiting, they have diarrhea." But, most people leave the hospital before they reach that point.

1 "Emergency Medical Treatment & Labor Act (EMTALA)," Centers for Medicare & Medicaid Services, last modified March 26, 2012, https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html.

2 "Medically Managed Detoxification Reform," NYS Office of Alcoholism and Substance Abuse Services, accessed October 13, 2018, https://www.oasas.ny.gov/admin/hcf/mmdreform.cfm.

A member of a treatment center in Sullivan County discusses her recovery efforts with Stories from Sullivan researchers.

People who have more complicated cases do have a greater likelihood of being admitted to a hospital, such as patients with comorbid medical conditions — e.g., diabetes, hypertension, pregnancy; with suicidal/homicidal/psychotic states; with no capacity for informed consent; or in danger of seizure or *delirium tremens* (DTs).[3]

Healthcare providers also know they have a greater chance of getting people into detox if they present co-occurring mental health and substance-use disorders, because they can "capture them on the inpatient unit," where they can stabilize people on medications and then transition them to rehab. However, insurance generally won't pay for an

Even when beds are available, or insurance will pay, admission criteria can make it difficult for people to access services.

3 These criteria are based on guidelines issued by the Substance Abuse and Mental Health Services Administration (SAMHSA). Cited in *Evidence-based Practices in Drug and Alcohol Treatment and Recovery* (Scottsdale: Magellan Health, June 2016), https://www.magellanprovider.com/media/32436/su-monograph.pdf.

Several motels around Sullivan County, like this one, are used for outpatient housing.

inpatient mental health stay without an Axis 1 diagnosis, like schizophrenia or other clinical disorders. And substance-use rehabilitation is purely voluntary. According to one hospital social worker, "[w]e encourage. We educate. We support. But, if they say they want to leave, they can leave. There's no regulatory standard that says you have to be held here against your will."

Although federal flexibility allows physicians at hospitals to treat addiction in cases of emergency using medications like buprenorphine, and although a state waiver[4] allows hospitals to expand the number of beds they use to treat addictions, hospitals still turn patients away.

Even though many doctors do not believe that detoxification requires inpatient care, hospitals do not always help patients access community-based services. Instead, prospective patients are often told to leave and come back when the symptoms get worse. The head of a nonprofit explained the experience of one man his organization worked with:

> A gentleman … late at night on a weekend, called our peer engagement specialist. [H]is wife wanted him to go to the hospital, so, we're pretty upfront because if he's not in withdrawal, if he's not experiencing

4 "DAL 18-05 - Time Limited to Provide Detoxification Services in Excess of Bed/Patient Days Thresholds," NYS Department of Health, March 2, 2018, https://www.health.ny.gov/professionals/hospital_administrator/letters/2018/2018-03-02_dhdtc_dal_18-05_waiver_detox_services.htm.

withdrawal symptoms they are not likely going to take him. And we ask folks, have you been in withdrawal before, have you experienced any negative consequences when you stopped using alcohol, when you stopped using opiates? We kind of ask them, because if they don't meet the admission criteria, which has nothing to do with treating addiction — it has to do with health — if they don't meet that, they are not going through an emergency room, and they're not getting into a hospital bed. So, his wife was at home alone with this husband who was drinking.... And had a child who was in bed asleep, couldn't take him to the hospital, and she called an ambulance.... The next thing you know, it's now two or three o'clock in the morning, my peer engagement specialist gets another phone call, now the guy is in the parking lot at the hospital, so, in my mind that should never happen, that should never, ever happen.

Unlike other chronic diseases or medical conditions, standard protocols for treating people with substance-use disorders are not widely known, broadly available, or consistently implemented. "[I]f the guy went with a chest pain, would he have been discharged to the parking lot," this man wondered. "[H]e came in an ambulance, and there was no family member there, what would they do with him if he was a cardiac patient, or some other patient?"

We may not appreciate how hard it is for a person with a substance-use disorder to say, "I'm ready."

More than half of US counties lack physicians who can prescribe buprenorphine,[5] leaving 30 million people without access to medication-assisted treatment. With severe shortages of doctors, mental health professionals, and other addiction specialists, community supports are primarily available in urban and well-resourced communities. But people who want help can still get turned away.

In the meantime, some people require inpatient detox. Opiate withdrawal is dangerous and, in some cases, deadly.[6] People with co-occurring conditions[7] like heart disease, diabetes, epilepsy, and liver failure are at greater risk during withdrawal. But the persistent vomiting and diarrhea associated with opioid withdrawal may result in dehydration, elevated blood sodium, and heart failure, even for people without other medical complications.

5 Roger A. Rosenblatt et al., "Geographic and Specialty Distribution of US Physicians Trained to Treat Opioid Use Disorder," *Annals of Family Medicine* 13, 1 (2015): 23–6.

6 "Editorial: Yes, people can die from opiate withdrawal," *Addiction* 112 (2016): 199-200, https://onlinelibrary.wiley.com/doi/epdf/10.1111/add.13512.

7 Herbert Duber et al., "Identification, Management, and Transition of Care for Patients with Opioid Use Disorder in the Emergency Department," *Annals of Emergency Medicine* 72, 4 (2018), https://www.researchgate.net/publication/325567654_Identification_Management_and_Transition_of_Care_for_Patients_With_Opioid_Use_Disorder_in_the_Emergency_Department.

Lorie, a nurse who lives in Sullivan County, frequently confronts addiction in her job.

Doctors, social workers, and treatment providers are often frustrated by what they cannot do. One hospital social worker explained how hard it is to be the bad guy and tell patients to come back to the hospital when their symptoms are worse, and she described their (often angry) reaction: "'I'm homeless, no car, where do you want me to go, it's winter, what am I supposed to do?' and those are valid points! Like, what are they supposed to do?"

RESTRICTIONS ON INPATIENT REHABILITATION SERVICES

Almost everyone we spoke with talked about the lack of long-term treatment options. In Sullivan, two residential facilities closed in the early 2000s. But — unlike many rural communities — the county still has a community residence program in Monticello, a residential program for youth in Fallsburg, and another for women with infants and toddlers in Barryville.

Even though options for residential treatment exist in Sullivan, length-of-stay restrictions can make it difficult for people to utilize those services. Insurance typically does not pay for residential treatment beyond 30 days. Therefore patients (and their families) must often pay for long-term care out of pocket. One mother estimates she spent $95,000 dollars on 18 months of rehab for her daughter in another state, while another says she paid tens of thousands of dollars a month. Needless to say, most families don't have that kind of money.

Even when beds are available, or insurance will pay, admission criteria can make it difficult for people to access services. Generally, we heard about people being turned away if they:

- Require medically supervised detox — because withdrawal is often accompanied by unpleasant and potentially fatal side effects, rehabs typically refer out for detox.
- Fail to meet age and sex requirements for beds — male-only beds are not available to women, for example, and others are reserved for adults only.
- Exhibit a co-occurring disorder for which they are prescribed benzodiazepines — treatment facilities turn people away when they are on medication for a mental health disorder, even though co-occurring mental health and substance use disorders are common.

These obstacles are exemplified by the story of one mother whose daughter was turned away from the same facility not once, but three times — the first time because her daughter was on antidepressants; the second time because she needed to detox from fentanyl; and the third time because she was detoxed using methadone (not Suboxone). Ironically, a representative from the same facility expressed frustration over their inability to fill 10 empty beds.

Finally, people are also turned away if facilities lack the appropriate staff to oversee and manage beds. As one study noted, "while there are many impediments to accessing care, the absence of a workforce[8] that is of sufficient size and adequately trained is a significant factor." Behavioral health providers have difficulty recruiting and retaining a competent workforce,[9] achieving workforce diversity, and assuring that the workforce delivers safe and effective services. What few people there are who specialize in addiction services are hard to hire, and county governments and nonprofits can't compete with for-profit providers who can afford to pay higher salaries. So while a bed might be available, if there are insufficient staff to run it, the bed sits empty.

RESTRICTIONS ON MEDICATION-ASSISTED TREATMENT

Sometimes, the discussion of beds doesn't mean actual, physical beds but outpatient treatment options, what are more precisely referred to as "treatment slots." Although the promise of slots is that they are more readily available, patients have trouble accessing medication-assisted treatment, designed to treat opioid addiction, from doctors as well.

It's far easier to prescribe opioids than the medication-assisted treatment to help people stop using them. Physicians, dentists, veterinarians, physician assistants, nurse practitioners, and nurse midwives in New York can prescribe opioids, but medication-assisted

8 Mark Olfson, "Building The Mental Health Workforce Capacity Needed to Treat Adults With Serious Mental Illnesses," *Health Affairs* 35, 6 (June 2016), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2015.1619..

9 Mark Smith and Angela F. Jury, *Workforce Development Theory and Practice in the Mental Health Sector* (Hershey: IGI Global, 2017).

treatment[10] (methadone, buprenorphine, or naltrexone) requires specialized clinics, trainings, and authorization. Methadone is available only through highly regulated treatment programs, which patients have to visit daily at the beginning. Buprenorphine can be prescribed in physicians' offices, but it requires a DEA waiver, which includes an eight-hour training for doctors and an additional 16 hours of online training for physicians' assistants and nurse practitioners. In addition to limiting which medical personnel can provide medication-assisted treatment, there are limitations on how many patients they can treat. During the first year of buprenorphine certification, physicians can have up to 30 patients under treatment at one time. After a year, they can apply to have the number increased to 100, then 275.[11] While the number may appear sizable, there is no comparable patient limit for prescribing opioids. In Sullivan, this means that most doctors, dentists, and vets can prescribe opioids, but only nine physicians are licensed to provide buprenorphine.

Limited access to medication-assisted treatment is not a Sullivan problem or even a New York State problem. It's a problem across the country. In 2016, less than 4 percent of physicians were waivered to prescribe buprenorphine in the US.[12] It's not much better now. Of the 55,000 physicians[13] who can prescribe buprenorphine in the US, 72 percent are 30 Patient Certified, 20 percent are 100 Patient Certified, and 8 percent are 275 Patient Certified.

Even if every physician prescribed at the limit, there would still be more patients than slots. But most physicians do not prescribe to the limit.[14] Less than half (1,465 out of 3,143) of US counties have a physician who can prescribe buprenorphine, leaving 10 percent of the population (more than 30 million people) without a single prescriber of medications for addiction treatment — the overwhelming majority (21 million) in rural areas.[15]

STAFFING SHORTAGES

Many parts of the country also lack mental health professionals, leaving people needing help in a real bind. A 2009 study found that more than three-quarters of US counties had a severe shortage of mental health workers.[16] Those shortages are

10 Arthur Robin Williams, "Responding to the Opioid Epidemic and Expanding Access to Quality Treatment," *Psychiatric Times* 35, 5 (May 18, 2018), https://www.psychiatrictimes.com/cme/responding-opioid-epidemic-and-expanding-access-quality-treatment.

11 "Apply to Increase Patient Limits," U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration (SAMSHA), last updated February 9, 2017, https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management/increase-patient-limits.

12 Sarah E. Wakeman and Josiah D. Rich, "Barriers to Medications for Addiction Treatment: How Stigma Kills," *Substance Use & Misuse* 53, 2 (2018): 330–3.

13 "Practitioner and Program Data," U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration (SAMSHA), accessed October 3, 2018, https://www.samhsa.gov/medication-assisted-treatment/training-materials-resources/practitioner-program-data.

14 Christopher M. Jones et al., "National and State Treatment Need and Capacity for Opioid Agonist Medication-Assisted Treatment," *American Journal of Public Health* 105, 8 (2015): e55–63.

15 Rosenblatt et al., "Geographic and Specialty Distribution of US Physicians."

16 Kathleen C. Thomas et al., "County-Level Estimates on Mental Health Professional Shortage in the United States," *Psychiatric Services* 60, 10 (2009): 1323-8, http://www.oregonhwi.org/resources/documents/countylevelMHshortage.pdf.

unevenly distributed. Eight-five percent of federally designated mental health personnel shortage areas are in rural locations.[17] Rural counties and high-poverty areas also have the most severe shortages for child psychiatrists. With only two child psychiatrists in the Sullivan/Orange area, we heard time and time again about the years-long waiting list for an appointment.

It is not just doctors, physicians, assistants, and psychiatrists who are needed. It is social workers, Credentialed Alcoholism and Substance Abuse Counselors (CASACs), and nurse practitioners. Half of agencies specializing in substance use say they have difficulty filling open positions, primarily because of a lack of qualified applicants. Turnover is high (19 percent nationally, but 40 percent in some reports)[18] because "addiction counselors move among vacant positions in the field or leave the field altogether because of its low wages and benefits and heavy caseloads, as well as the stigma associated with both having addictions and working with people who do."[19] Unable to offer a competitive salary, Sullivan County had difficulty filling five vacancies, including four social work positions and a CASAC. "Our pay-scale here in Sullivan County is not very good," one government official observed. And you "can't get something out of a dry well."

From providers, we have also heard about the impossible bind they are in: reimbursement rates are too low — often they don't cover the costs of what they're required to provide, let alone structural improvements they want to make to their facilities. "I'm expected to provide a specific amount of units of service," one provider explained (a unit of service in this case is 60 minutes of therapy). But units of service do not take into account the work that social workers and others must do in coordinating a patient's care and social service needs (e.g., with parole, foster care, etc.).

People are knocking on doors only to be turned away. If we are serious in our fight against opioids, then our approach must be altered.

MISSED OPPORTUNITIES

We may not appreciate how hard it is for a person with a substance use disorder to say "I'm ready." Withdrawal is physically painful, and recovery is a lifelong task. But people who are addicted to opioids can be more afraid of withdrawal than death, and the root causes of their addiction still persist even when they achieve sobriety. According to one person in recovery, "I didn't care if I woke up. I would have

17 Michael A. Hoge et al., "Mental Health And Addiction Workforce Development: Federal Leadership Is Needed To Address The Growing Crisis," *Health Affairs* 32, 11 (2013): 2005–12.
18 Ibid, citing *Evidence-based Practices in Drug and Alcohol Treatment and Recovery*.
19 Hoge et al., "Mental Health And Addiction Workforce Development."

welcomed it at one point. Death is not a motivating factor to stop using because how much worse could your life get.... Withdrawal is frightening. The physical symptoms, they're bad.... Once you get past that, it won't go away. You think that it just goes away once you stop taking the drug but there's always some underlying issue that's going to come up. There's always going to be something else to address."

Turning away people who want help is a missed opportunity to save a life. Opiate withdrawal may lead to morbidity or even death, and there's a high probability taking another dose of illicit opioids will be lethal. When someone asks for help, as the head of a nonprofit explained, "we need a way to respond to that, quickly." Yet, people on the frontlines feel caught between a rock and a hard place. They cannot provide the help they may want to. They cannot force insurance companies to pay for treatments they think will be best. They cannot make people with substance use disorders get treatment. One psychiatrist explained the difficult part is getting the person to say "I'm ready."

What happens if we make it easier to seek treatment? If we are going to strengthen our response to the opioid crisis, then solutions should be based on the assumption that people addicted to opioids are doing everything to avoid that incredibly painful experience of withdrawal and the understanding that recovery is a lifelong process.

POLICY SOLUTIONS

Opioid overdoses kill more than 40,000 Americans[20] a year, more than 3,000 of which are New Yorkers. In previous analyses, we showed the collateral damage addiction causes families and communities. We've asked how to stem the tide. One crucial step is ending the illusion of services and making sure that services offered on paper are accessible in person. Here are some places to start:

1. **Make access easy and open.** Every community needs a place where people with substance-use disorders can get help, whether that point of entry is a hospital emergency department or a stand-alone clinic, where they won't be turned away.
2. **Achieve parity in protocols for treating people with substance-use disorders and other life-threatening conditions.** Opioid withdrawal can be dangerous because its symptoms cause dehydration and desperation. Even more problematic, the next dose of a controlled substance, especially illicit opioids, could be a person's last dose. If there's one factor that distinguishes opioids from other drugs, it's their lethality. Getting people to treatment and making sure they have what they need to get better is imperative if we're to make progress on this problem.
3. **Help treatment providers meet their staffing needs.** If treatment beds are available, but nobody is there

20 "Opioid Overdose Deaths by Age Group," Henry J. Kaiser Family Foundation, accessed October 3, 2018, https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-age-group/?dataView=0&currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22new-york%22:%7B%7D%7D,%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

to answer the phone or do intake, it's as if the bed didn't exist at all. Treatment providers have trouble hiring qualified doctors, nurses, CASACs, and social workers. It's hard work. The pay is not good. Positions stay empty for a long time and, even when they are filled, turnover is high. Finding a way to incentivize people to get the required education, take a job, and stay in it is essential for providing necessary services.

4. **Pay providers reasonable reimbursement rates to cover the costs of services.** When reimbursement rates for some conditions and services are generous and others are not, hospitals, doctors, and medical professionals gravitate to more lucrative fields in the most desirable locations. If we want to make sure people get the treatment they need, it cannot be a money-losing endeavor.

5. **Incentivize medication-assisted treatment.** If it's easier and more lucrative to prescribe opioids than the medication to treat substance-use disorder, should we be surprised that people become addicted and cannot find help? Even though medication-assisted treatment is the standard of care for the treatment of opioid addictions, there is still pushback[21] from physicians, patients, and their families who think that it is substituting one drug for another. There aren't enough doctors who can prescribe medication-assisted treatment. Those doctors who do cannot accept enough patients. And these doctors aren't located in the communities (often rural) that need them most.

The illusion of services can be more frustrating than having no services at all. In the case of the latter, it's clear what is not available and what people do not have access to. But it is exasperating to people on the frontlines of the opioid epidemic to see services that are supposedly available be just out of reach.

CONCLUSION

People in rural communities like Sullivan have a difficult time accessing services, but it is not just because there are so few treatment options. In fact, New York actually does pretty well in providing treatment when compared to other states. Roughly 10 percent of the nation's opioid treatment programs are located in New York (or 130 total facilities). Still, certain practices and procedures make it difficult for people to receive treatment, even when they are ready to ask for help. The perception that there are no services in places like Sullivan may not be wholly accurate.

However, people are knocking on doors only to be turned away. If we are serious in our fight against opioids, then our approach must be altered. The solution is not necessarily to continue adding more treatment beds, but rather to make sure people have immediate access to the ones already there. In short, the first step should be to make sure what we promise on paper we deliver in person.

21 Nora D. Volkow et al., "Medication-Assisted Therapies — Tackling the Opioid-Overdose Epidemic," *New England Journal of Medicine* 370, 22 (2014), https://www.nejm.org/doi/full/10.1056/NEJMp1402780.

PART 15

Seven Things That Everyone on the Frontlines of the Opioid Crisis Should Know

Det. Sgt. Guy Farina of the Town of Montgomery Police Department is a drug recognition expert and law enforcement liaison for Hope Not Handcuffs - Hudson Valley.

OUR PREVIOUS ANALYSIS[1] INTRODUCED THE "ILLUSION OF SERVICES," or the disconnect between opioid treatment services that appear on paper and people's actual ability to access them in person. We highlighted several obstacles to access, including the lack of medically supervised detox, length-of-stay restrictions, and regulations that make it easier to prescribe opioids than medication-assisted treatment.

But how do we end this illusion of services?

1 Patricia Strach, Katie Zuber, and Elizabeth Pérez-Chiqués, "Stories from Sullivan: The Illusion of Services," Rockefeller Institute of Government blog, October 3, 2018, https://rockinst.org/blog/stories-from-sullivan-the-illusion-of-services/.

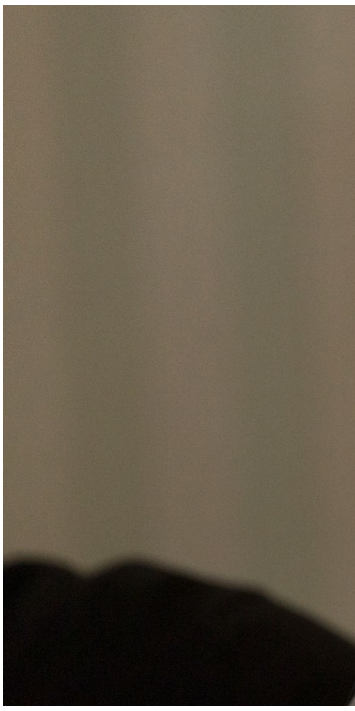
Part of the answer will be complex policy changes. But part of the answer is making sure we're all on the same page: sharing information about accessibility, existing laws, and new research. We talked with Rob Kent, legal counsel for New York State's Office of Alcohol and Substance Abuse Services (OASAS). Afterwards, we identified seven solid takeaways that everyone on the frontlines of the battle against opioid use should understand.

1. THERE'S NO GUARD AT THE FRONT DOOR.

Everyone who wants to get treatment should be able to get it.

+ **Not every individual requires inpatient detox, but even if patients are not presenting physical withdrawal symptoms, they should be connected to adequate services:** Under New York State's Public Health Law, if a hospital does not provide substance use disorder services, "then it shall refer individuals in need of substance use disorder services to and coordinate with substance use disorder service programs that provide behavioral health services." Furthermore, when a person with a substance use disorder is discharged, "the hospital shall inform the individual of the availability of the substance use disorder treatment services that may be available to them" (Public Health Law, section 2803-u[2]). As Mr. Kent observed, discharging people into a parking lot, or telling them to come back when the symptoms are worse, is not considered an adequate referral. The Department of Health's website[3] lists hospital patients' rights in New York State, while the ER Survival Guide provides advice to individuals who have been turned away.
+ **Insurance companies cannot require patients to get prior authorization for inpatient or outpatient substance-use treatment in certified OASAS facilities:** New York State eliminated[4] insurance prior authorization requirements in 2016.
+ **It is illegal for an insurance company to tell individuals that they must fail at outpatient treatment before they will cover inpatient treatment:** "Fail First" policies, also known as "Step Therapy" protocols, are insurance policies that begin with the most cost-effective therapy and move to other, more costly therapies only if

2 Laws of New York, Public Health Law Article 28, §2803-U, "Hospital substance use disorder policies and procedures," https://www.nysenate.gov/legislation/laws/PBH/2803-U.
3 "Patients' Bill of Right," in "Your Rights as a Hospital Patient in New York State - Section 2," NYS Department of Health, revised January 2018, https://www.health.ny.gov/publications/1449/section_2.htm#patients.
4 NYS Department of Financial Services, Insurance Circular Letter No. 13 (2018), RE: Preauthorization for Substance Use Disorder Treatment, September 19, 2018, https://www.dfs.ny.gov/insurance/circltr/2018/cl2018_13.htm.



Above: Catskill Regional Medical Center in Harris, New York. Right: A woman at a treatment center in Sullivan County discusses addiction and recovery.

necessary. Chapter 512[5] of the Laws of 2016 includes protections for patients who are required to use step-therapy protocols and a process for appealing them. Patients who wish to file a complaint[6] related to health insurance companies should contact the New York State Department of Financial Services at (212) 480-6400 or toll-free at (800) 342-3736.

+ **Treatment facilities cannot turn patients away because patients cannot afford to pay:** Every OASAS-certified treatment facility in the state is required to take patients seeking help. OASAS has prepared a list of questions[7] for patients to ask when they have been denied admission to a treatment program.

+ **Under the Mental Hygiene Law, inpatient[8] and outpatient[9] treatment facilities cannot turn patients away based solely on their:**

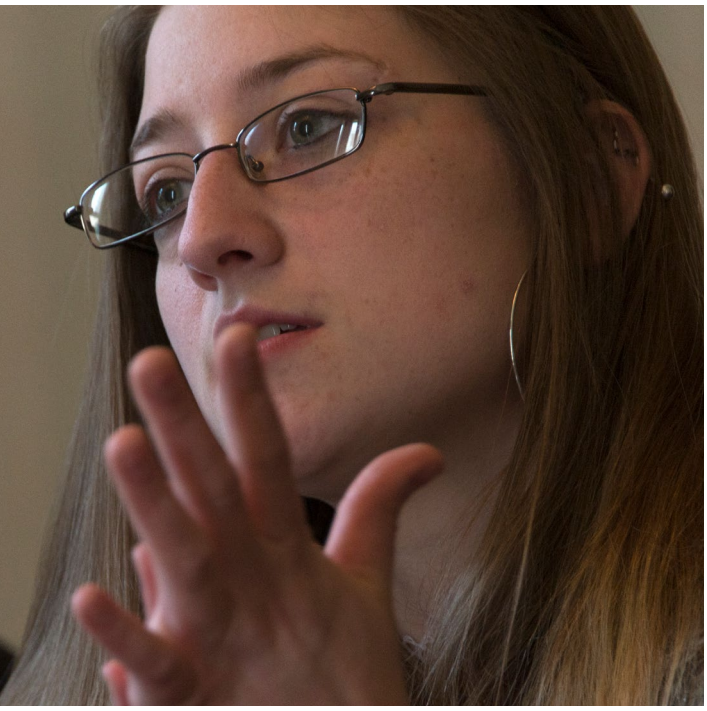
5 "Questions and Answers on Step Therapy Legislation (Chapter 512 of the Laws of 2016)," NYS Department of Financial Services, updated May 2, 2017, https://www.dfs.ny.gov/insurance/health/step_therapy_legislation_qa.htm.

6 "Consumer Complaint," NYS Department of Financial Services, accessed December 21, 2018, https://www.dfs.ny.gov/complaint.

7 *Questions to ask when you are denied admission to a treatment program,* (Albany: NYS Office of Alcoholism and Substance Abuse Services, n.d.), https://oasas.ny.gov/CombatAddiction/documents/UnabletoPayMemo.pdf.

8 *Part 820: Residential Services* (Albany: NYS Office of Alcoholism and Substance Abuse Services, n.d.), https://www.oasas.ny.gov/regs/documents/Part820ResidentialServices.pdf.

9 *Part 822: General Service Standards for Chemical Dependence Outpatient (CD-OP) and Opioid Treatment programs (OTP)* (Albany: NYS Office of Alcoholism and Substance Abuse Services, n.d.), https://www.oasas.ny.gov/regs/documents/822.pdf.



- prior treatment history;
- referral source;
- pregnancy status;
- history of contact with the criminal justice system;
- HIV and AIDS status;
- physical or mental disability;
- lack of cooperation by significant others in the treatment process; or
- medication-supported recovery for opioid dependence prescribed and monitored by a physician, physician's assistant, or nurse practitioner.

OASAS encourages[10] providers to complete mental health screenings to ensure appropriate care, but current law does not explicitly preclude denial of addiction services based on a patient's use of antidepressants or other medications designed for treating co-occurring mental health disorders.

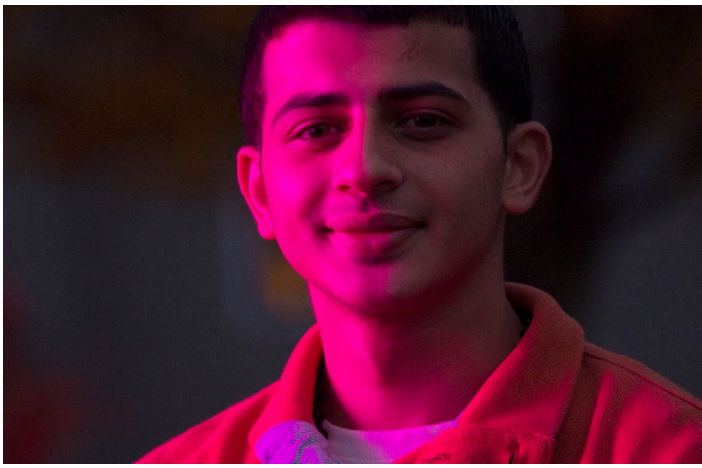
2. THERE'S NO PRESET LIMIT ON THE TIME SOMEONE SPENDS IN TREATMENT.

If an insurance company denies treatment because it believes treatment is not medically necessary, patients can appeal this decision. Even for New Yorkers who have insurance with a 14-day limit, if a patient's request for additional treatment days is denied, the patient can appeal. *Insurance companies must pay for treatment during the appeals process.* Failure to appeal a denial of care means the patient effectively agrees with that decision. To learn more, see a video on the appeals process.[11]

3. STATE LAW PERMITS SERVICES FOR FAMILY MEMBERS TOO.

- Families are crucial for helping individuals find stability and recovery. OASAS encourages providers to engage families and family support as "standard practice." Because privacy laws can obstruct family involvement, the advocacy and support group Friends of Recovery – New York recommends carrying a signed HIPPA form[12] at all times and obtaining a healthcare proxy.

10 "Co-Occurring Disorders," NYS Office of Alcoholism and Substance Abuse Services, accessed December 21, 2018, https://www.oasas.ny.gov/treatment/cod/index.cfm.
11 "Appeals Process," YouTube video, 2:19, "NYS OASAS," February 26, 2016, https://www.youtube.com/watch?v=Od9YMS07zHM&feature=youtu.be.
12 "HIPAA Sample Forms for OASAS Certified Treatment Providers," NYS Office of Alcoholism and Substance Abuse Services, accessed December 21, 2018, https://www.oasas.ny.gov/hipaa/forms/hipaa_forms_home.cfm.



Above: Members in recovery at Dynamite Youth Center in Fallsburg, New York. Facing page, bottom: Staff members at Dynamite Youth prepare for a group session.

- Outpatient programs can provide services to family members to help them support a loved one's recovery, address their own emotional stress dealing (past or present) with a loved one's substance-use disorder, and learn strategies to encourage recovery.
- For more detail about how providers can bill for a family visit, see FAQ for Family Treatment.[13]

4. HOSPITALS CAN MAKE A DIFFERENCE IN THIS FIGHT IF THEY PRESCRIBE EMERGENCY BUPRENORPHINE IN THE EMERGENCY DEPARTMENT.

Although physicians who prescribe medication-assisted treatment must obtain authorization from the Drug Enforcement Administration, the "three-day rule"[14] allows practitioners to administer medication-assisted treatment for a maximum of 72 hours to relieve acute withdrawal symptoms

13 *FAQ on Delivering and Billing for Family and Significant Other Services in an OASAS Certified Setting* (Albany: NYS Office of Alcoholism and Substance Abuse Services, n.d.), https://rockinst.org/wp-content/uploads/2018/12/FAQ-for-Family-Treatment.pdf.

14 "Emergency Narcotic Addiction Treatment," U.S. Department of Justice, Diversion Control Division, accessed December 21, 2018, https://www.deadiversion.usdoj.gov/pubs/advisories/emerg_treat.htm.

while arranging for treatment. Research suggests that "risk of recurrent use, overdose and death is high if patients are withdrawn from, or do not receive, effective long-term medication treatment."[15]

5. PATIENTS DON'T "COMPLETE" TREATMENT FOR SUBSTANCE-USE DISORDER; INSTEAD, HEALTH PROFESSIONALS SHOULD ADJUST THE INTENSITY OF SERVICES AS PATIENTS' NEEDS EVOLVE.

Substance-use disorder is a chronic disease, and treating it is a lifelong process. Most patients go through treatment a number of times before they stabilize. The type of services individuals receive, e.g., intensive outpatient services versus residential/inpatient services, should reflect individual needs.

6. PEOPLE WITH SUBSTANCE-USE DISORDERS DO RECOVER, AND THEY LEAD PRODUCTIVE LIVES.

Despite the scary statistics, substance-use disorder is not a death sentence.

While we know that in 2016 more than 66,500 people entered treatment in New York State, anonymity makes it difficult to get an accurate count of the people who are now living in recovery.[16] Even when treatment is successful, people can be reluctant to publicize the fact that they've completed a program. Getting people in recovery to come out and say they've benefited from treatment is part of a broader movement to raise awareness around substance-use disorders.

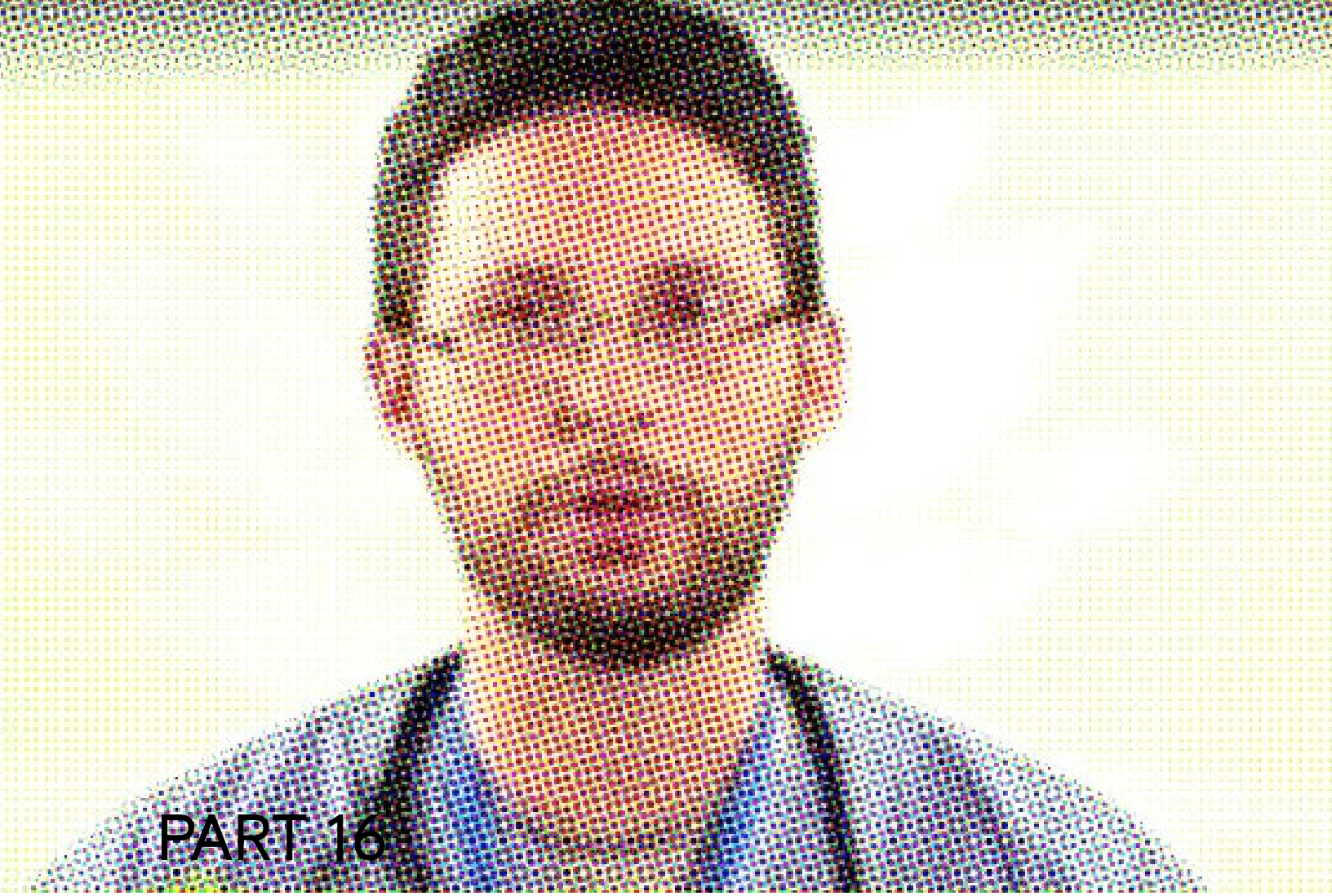
7. OASAS WANTS TO HEAR FROM YOU.

If you are a provider who is struggling to meet New York State requirements, or if you believe that OASAS regulations stand in the way of providing treatment to people in your community, Mr. Kent wants to hear from you. Contact OASAS at: legal@oasas.ny.gov.

If you are a patient, or family of a patient, who is unsure of your rights or believe that you have been unfairly denied services, contact OASAS Patient Advocacy Services at: 1-800-553-5790.

15 Peter D. Friedmann and Joji Suzuki, "More beds are not the answer: transforming detoxification units into medication induction centers to address the opioid epidemic," *Addiction Science & Clinical Practice* 12, 1 (2017): 29, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5688652/pdf/13722_2017_Article_92.pdf.

16 *New York State — Opioid Annual Report* (Albany: NYS Department of Health, October 2017), https://www.health.ny.gov/statistics/opioid/data/pdf/nys_opioid_annual_report_2017.pdf



PART 16

Five Myths of the Opioid Crisis

DID YOU KNOW THAT YOU CAN DIE FROM OPIATE WITHDRAWAL?

WE DIDN'T.

When we first started this project in November 2017, we had little knowledge of opioids beyond the basic understanding that they were responsible for the current public health crisis. As political scientists, we wanted to know how opioids affect local communities and what government was doing about it.

To date, we have conducted more than 100 interviews with doctors, nurses, social workers, lawyers, peer advocates, activists, people in recovery, and more. We've listened to people talk about the challenges[1] rural communities face —

1 Patricia Strach, Katie Zuber, Elizabeth Pérez-Chiqués, "Stories from Sullivan: Rural Challenges," Rockefeller Institute of Government blog, March 13, 2018, https://rockinst.org/blog/stories-sullivan-rural-challenges/.

like limited transportation and fewer treatment options — and how people navigate their way around them — for example, by leveraging the criminal justice system[2] to get loved ones into treatment.

We've learned a lot just by talking to people in their communities, but, like us, many people still have questions about what kinds of treatment are the most effective and where to go for help. "What is the cutting-edge research showing?" one person asked. In this analysis, we consult both the research and the law to debunk five myths about opioid-related treatment in New York State.

MYTH #1
YOU CAN'T DIE FROM OPIATE WITHDRAWAL.

When people dependent on opioids go to the hospital for detox, they're often turned away on the grounds that withdrawal won't kill them. "There's no real danger coming off of heroin," one hospital social worker explained. However, "[w]hen it's alcohol and benzos … chances are we are probably going to admit."

When people suddenly decrease or stop consuming either alcohol[3] or benzodiazepines[4] — psychiatric medications commonly prescribed to treat anxiety and depression — they are at risk for experiencing life-threatening seizures and delirium tremens. For this reason, patients dependent on these substances are typically admitted to the hospital for detoxification, whereas people dependent on opioids are not. This tendency to underestimate the dangers of opiate withdrawal and turn people away results from the common misperception that "no one dies" from it.[5]

Contrary to popular wisdom, death from acute opiate withdrawal is uncommon but not unprecedented. Withdrawal symptoms may include nausea, fever, sweating, vomiting, diarrhea, and hypertension, among others. If left untreated, persistent vomiting and diarrhea can result in heart failure caused by hypernatraemia (elevated blood sodium levels), as well as severe dehydration.[6] Patients with comorbid conditions, such as coronary artery disease, congestive heart failure, HIV,

2 Patricia Strach, Katie Zuber, and Elizabeth Pérez-Chiqués, "Stories from Sullivan: When Battling Addiction, Is Jail Time the Problem or the Only Solution," Rockefeller Institute of Government blog, July 5, 2018, https://rockinst.org/blog/stories-from-sullivan-when-battling-addiction-is-jail-time-the-problem-or-the-only-solution/.

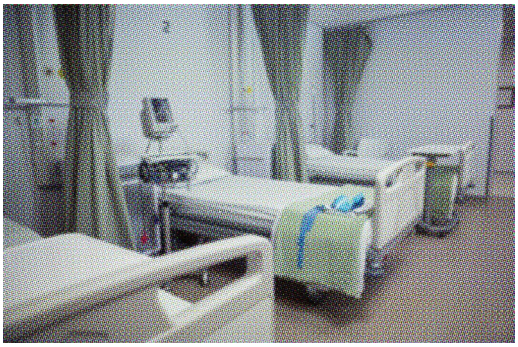
3 Ankur Sachdeva, Mona Choudhary, and Mina Chandra, "Alcohol Withdrawal Syndrome: Benzodiazepines and Beyond," *Journal of Clinical & Diagnostic Research* 9, 9 (2015), VE01-7, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4606320/.

4 Jonathan Brett and Bridin Murnion, "Management of benzodiazepine misuse and dependence," *Austrailian Prescriber* 38, 5 (2015): 152-5, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4657308/,

5 Theodore Dalrymple, "Withdrawal from heroin is a trivial matter," *Spectator*, January 7, 2009, https://www.spectator.co.uk/2009/01/withdrawal-from-heroin-is-a-trivial-matter/.

6 Shane Darke, Sarah Larney, and Michael Farrell, "Yes, people can die from opiate withdrawal," *Addiction* 112: 199-200, https://onlinelibrary.wiley.com/doi/full/10.1111/add.13512.

or liver failure, are also at increased risk of death.[7] Aside from the physical complications of opiate withdrawal, the desperate actions people take to relieve their symptoms (such as buying more illicit opioids) are also life threatening. Failure to monitor and treat the symptoms of opiate withdrawal can (and does) result in death.[8]



MYTH #2
HOSPITALS CAN'T PROVIDE DETOXIFICATION SERVICES BECAUSE THEY DON'T HAVE A DETOX UNIT.

Given the risks associated with opioid withdrawal, hospitals play a key role in saving lives. Oftentimes people present at emergency departments either seeking detoxification by their own free will, or, more commonly, following an overdose reversal with Narcan. Between 2016 and 2017, emergency room visits for opioid overdoses increased by nearly 30 percent.[9] A psychiatrist at one hospital estimates that they see two to three overdoses a day, some even in the parking lot. But, like most hospitals, they don't have a certified detoxification unit. Instead, when people wake up from an overdose in the emergency department, most of them just leave. "[W]e encourage, we educate, we support," explained one hospital social worker. "But once they say they want to leave they can leave. There's no regulatory standard that says you have to be held here against your will."

Under the New York State Mental Hygiene Law, a certificate is required for hospitals to operate a detoxification unit.[10] A "unit" is defined as "the provision of chemical dependence withdrawal and stabilization services in excess of 5 beds, or greater than 10 percent of overall patient days."[11] Consequently, hospitals are reluctant to admit patients for detoxification services unless they hold the requisite certificate, otherwise they risk reimbursement.

Because the refusal to admit for detox is "a missed opportunity that could potentially have fatal consequences," the New York State Office of Alcoholism

7 Herbert C. Dube et al., "Identification, Management, and Transition of Care for Patients With Opioid Use Disorder in the Emergency Department," *Annals of Emergency Medicine* 72, 4 (October 2018): 420-31, https://www.annemergmed.com/article/S0196-0644(18)30352-4/fulltext,

8 Scott North, "Lawsuit contends staff ignored inmate's peril before she died," *HeraldNet*, August 4, 2016, https://www.heraldnet.com/news/lawsuit-against-snohomish-county-focuses-on-inmates-death/.

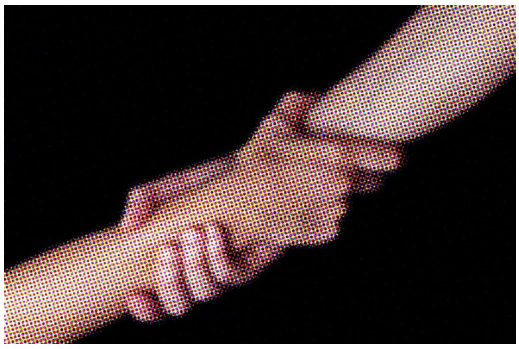
9 Alana M. Vivolo-Kantor et al., "Vital Signs: Trends in Emergency Department Visits for Suspected Opioid Overdoses — United States, July 2016 – September 2017," *Morbidity and Mortality Weekly Report* 67, 9 (2018): 279-85, https://www.cdc.gov/mmwr/volumes/67/wr/mm6709e1.htm?s_cid=mm6709e1_w.

10 Laws of New York, Mental Hygiene Law Article 32, §32.05, "Operating certificate required," https://www.nysenate.gov/legislation/laws/MHY/32.05.

11 Laws of New York, Mental Hygiene Law § 19.09, 19.15, 19.40, 22.09, Part 816, "Chemical Dependence Withdrawal and Stabilization Services," https://www.oasas.ny.gov/regs/documents/816.pdf.

and Substance Abuse Services (OASAS) issued a time-limited waiver in March 2018 authorizing hospitals to run more than five detox beds without first obtaining a certificate.[12] The only stipulation is that hospitals are asked to send an email to OASAS notifying the agency of their intent to expand detoxification services. Under the existing waiver, every medical/surgical bed in a hospital can be used to provide detoxification services, and hospitals can receive reimbursement for them. The waiver, which was initially set to expire on December 31, 2018, was recently extended to December 31, 2019.[13] However, only six hospitals have contacted OASAS regarding their intent to take advantage of this opportunity.[14] They are:

+ Cortland Regional Medical Center (Cortland)
+ Flushing Hospital Medical Center (Queens)
+ UPMC Chautauqua at WCA (Jamestown)
+ Joseph's Medical Center (Yonkers)
+ Jamaica Hospital Medical Center (Queens)
+ Auburn Community Hospital (Auburn)



MYTH #3
PEER ENGAGEMENT SERVICES CANNOT BE BILLED TO MEDICAID.

Expanding detoxification services is one part of the overall effort to improve access to addiction treatment in New York State. Increasing peer-support services is another. A comprehensive review of the research found that peer recovery support can lead to "reduced relapse rates, increased treatment retention, improved relationships with treatment providers and social supports, and increased satisfaction with the overall treatment experience."[15] However, a common misconception among drug treatment providers and hospitals is that they cannot bill for these services.

Part of the confusion stems from the fact that different types of peer workers exist: e.g., certified addiction recovery coaches (CARC), peer-engagement specialists, and sponsors. Yet, only

12 "DAL 18-05 - Time Limited Waiver to Provide Detoxification Services in Excess of Bed/Patient Days Thresholds," NYS Office of Alcoholism and Substance Abuse, March 2, 2018, https://www.health.ny.gov/professionals/hospital_administrator/letters/2018/2018-03-02_dhdtc_dal_18-05_waiver_detox_services.htm.

13 "DAL 18-19 - Time Limited Waiver to Provide Detoxification in Excess of Bed/Patient Days Thresholds EXTENDED," NYS Office of Alcoholism and Substance Abuse Services, December 24, 2018, https://www.oasas.ny.gov/legal/documents/detoxwaiver-DAL18-19.pdf.

14 "Opinion of Counsel," NYS Office of Alcoholism and Substance Abuse Services, accessed February 7, 2019, https://www.oasas.ny.gov/regs/nyslaws.cfm.

15 Sharon Reif et al., "Peer Recovery Support for Individuals With Substance Use Disorders: Assessing the Evidence," *Psychiatric Services* 65, 7 (2014): 853-61, https://www.ncbi.nlm.nih.gov/books/NBK263204/.

REQUIREMENTS	CERTIFIED RECOVERY PEER ADVOCATE	CERTIFIED ADDICTION RECOVERY
Certification Board	New York Certification Board	New York Certification Board
Training	**46 hours of training** Recovery Advocacy : 10 hours Mentoring & Recovery: 10 hours Recovery & Wellness: 10 hours Ethics for Peer Professionals: 16 hours	**60 hours of training** Recovery from Addiction: 20 hours Recovery Coaching: 20 Hours Recovery Education: 5 hours Ethical Responsibility: 15 hours
Examination	Required	Not required
Other	**500 Hour Work Requirement** 500 hours of work experience as a volunteer, CRPA provisional, or CARC, including 25 hours of supervision by a qualified supervisor	**Annual Renewal Requirement** 6 hours of Addiction Recovery Coaching including at least 1 hour of NYCB approved ethics
Reimbursable	Yes	No

the services provided by certified recovery peer advocates (CRPA) are reimbursable under Medicaid.[16] A certified recovery peer advocate is someone who is in recovery themselves, or has a close family member in recovery. CRPAs help people with substance-use disorders navigate the obstacles of getting into treatment and support people when they return home. Under existing regulations, CRPAs must be supervised by a credentialed or licensed clinical staff member. However, confusion about whether and how much to bill for peer-support services can deter providers from utilizing them.

In billing for services, licensed clinicians must develop a treatment plan that includes the clinical reasons for peer-support services, establish goals for treatment, and identify next steps. For their part, peer advocates must provide a note for each visit, including the duration and overall purpose of the service. The format for billing and reimbursement is a fee-for-service model. For additional information on how to become a CRPA or bill for services, see this guidance document[17] and toolkit[18] published by OASAS.

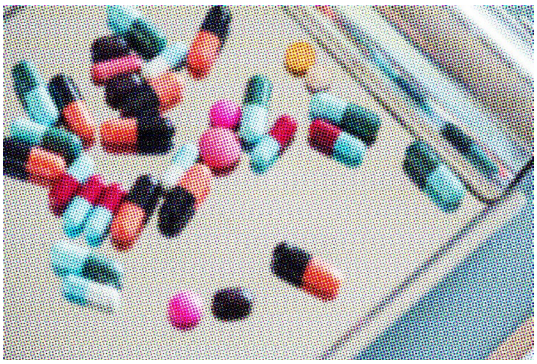
It's worth noting that while financial considerations weigh heavily on the minds of providers, still other concerns exist. Some agencies, for example, worry about liability and whether a signed consent form is necessary for peer advocates to be in the room. Still others don't fully understand what

16 "Re: Clarifying the role of certified recovery peer advocates, recovery coaches and interventionists for providers and consumers of addiction services," NYS Office of Alcoholism and Substance Abuse Services, November 10, 2017, https://www.oasas.ny.gov/regs/documents/Clarifyingtheroleofecertifiedrecoverypeeradvocates.pdf.

17 "Peer Support Services in Outpatient Clinical Settings," NYS Office of Alcoholism and Substance Abuse Services, 2017, https://www.oasas.ny.gov/ManCare/documents/PeerSupportServicesGuidanceFINALDraft2017.pdf.

18 *Peer Integration and the Stages of Change ToolKit*, (Albany: NYS Office of Alcoholism and Substance Abuse, May 2018), https://www.oasas.ny.gov/recovery/documents/PeerIntegrationToolKit-Final2.pdf.

CRPAs do. "Many of the staff are confused about the role of CRPAs," one training director explained. "They need to know that the CRPAs are there for very specific duties and that they shouldn't be used to do anything clinical. They shouldn't be sent to go get coffee and lunch for the staff [or] … to do all of the filing. They have a very specific duty and the staff need to be educated just like the CRPAs need to be educated."



MYTH #4
MAT IS SUBSTITUTING ONE DRUG FOR ANOTHER.

Beyond detoxification and peer-support services, hospitals can administer medication-assisted treatment (MAT). MAT is nothing new in the United States. Pilot studies testing methadone maintenance for heroin addiction, for example, began in 1964, followed by formal Food and Drug Administration (FDA) approval in 1972.[19] When used properly, methadone reduces cravings for opioids without causing euphoria, suppresses the symptoms of withdrawal, and blocks the effects of heroin.[20]

The FDA has since approved two additional medications for preventing opioid relapse including buprenorphine (e.g., Suboxone[21] which is taken daily in pill form) and naltrexone (e.g., Vivitrol[22] which requires a monthly shot). Buprenorphine is a "partial opioid agonist," which means that it mimics "full agonists" (such as oxycodone, fentanyl, and heroin) by *attaching* to opioid receptors in the brain. However, it does so imperfectly. Partial attachment eases withdrawal symptoms and reduces drug cravings without causing the same euphoric effect as full agonists (see the helpful guide for patients from the Women's College Hospital[23]). Typically, doctors will start patients on Suboxone during the early stages of withdrawal in order to minimize the painful symptoms that can lead to relapse.

Naltrexone, by comparison, is an "opioid antagonist," which means that it blocks opioid receptors in the brain and prevents people from feeling the effects of taking opioids. Unlike Suboxone, people who take extended-release antagonists like Vivitrol must complete detoxification first. A new study comparing buprenorphine to naltrexone found that, because naltrexone requires going through full withdrawal, people have a substantially

19 Herman Joseph, Sharon Stancliff, and John Langrod, "Methadone Maintenance Treatement (MMT): A Review of Historical and Clinical Issues," *Mount Sinai Journal of Medicine* 67, 5 & 6 (2001): 347-64, https://pdfs.semanticscholar.org/ae14/39e284a4b5fc299306f2a8991b493b36edf4.pdf.

20 "Part A: Questions and Answers Regarding the History and Evolution of Methadone Treatment of Opioid Addiction in the United States," *Methadone Research Web Guide* (Bethesda: NIDA International Program, n.d.), Part A-1 — A-11, https://www.drugabuse.gov/sites/default/files/pdf/parta.pdf.

21 "Opioid dependence treatment," Suboxone.com, accessed February 7, 2019, https://www.suboxone.com/.

22 "Help Reinforce Your Recovery," Vivitrol.com, accessed February 7, 2019, https://www.vivitrol.com/.

23 "Starting Beprenorphine Therapy: A Guide for Patients," Women's College Hospital, January 5, 2018, https://www.womenscollegehospital.ca/assets/pdf/MetaPhi/Buprenorphine%20book%2018.01.05.pdf.

more difficult time getting started on the medication.[24] However, once over the "induction hurdle," naltrexone and buprenorphine exhibit similar effects. For example, results indicate that the opioid relapse rate for naltrexone was approximately 52 percent, compared to 56 percent for buprenorphine. These findings are consistent with other studies[25] and extensive literature reviews[26] showing that MAT significantly reduces the chances of opioid-related relapse and even death.

Despite the known benefits of MAT, its use is controversial. Perhaps the most common objection is that medication-assisted treatment amounts to little more than the substitution of one drug (methadone, buprenorphine, or naltrexone) for another (oxycodone, hydrocodone, heroin, and fentanyl). Thus, opponents argue that the goal of treatment should not be to put people on medication but instead to abstain from all substances. "The thinking that created the problem shouldn't solve the problem," said one women in recovery at a New York Summit. "Yet people are pushing for solutions run by the pharmaceutical companies."

In contrast to the abstinence-only approach, proponents of medication-assisted treatment argue that it is necessary to save lives. "We are not treating a drug with a drug," explained one addiction specialist. "We are treating a substance-use disorder with a medication."

Amid growing acceptance of the disease model[27] of addiction, supporters often liken MAT to other prescribed medications (such as taking insulin for diabetes). However, the potential for diversion and misuse is real. Studies show that people can misuse buprenorphine by injecting or snorting the crushed tablets,[28] while others sell it on the street to make a profit.[29] Thus, the most effective MAT programs typically combine medication-assisted treatment with intensive drug-monitoring activities, therapeutic counseling, and vocational resources and referrals.[30]

While it is unlikely that the treatment community will reach a consensus on MAT anytime soon, the road to recovery is long and varied. Perhaps the best we can do, then, is to respect people's decisions about what kinds of treatment work best for them. "It's your recovery," one counselor explained. "You are the one who drives the train."

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24 Joshua D. Lee et al., "Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X:BOT): a multicentre, open-label, randomised controlled trial," *The Lancet* 391, 10118 (2018): P309-18, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)32812-X/fulltext?elsca1=tlxpr.

25 Hilary Smith Connery, "Medication-Assisted Treatment of Opioid Use Disorder: Review of the Evidence and Future Directions," *Harvard Review of Psychiatry* 23, 2 (2015): 63-75, https://pdfs.semanticscholar.org/959c/e3caf1fe3bed9da973bc8a1530a9ead497b1.pdf.

26 Catherine Anne Fullerton et al., "Medication-Assisted Treatment With Methadone: Assessing the Evidence," *Psychiatric Services* 65, 2 (2014): 146-157, https://ps.psychiatryonline.org/doi/pdfplus/10.1176/appi.ps.201300235.

27 Jeanette Kennett, Steve Matthews, and Anke Snoek, "Pleasure and Addiction," *Frontiers in Psychiatry* 4, 117 (2013), https://www.frontiersin.org/articles/10.3389/fpsyt.2013.00117/full.

28 Michelle R. Lofwall and Sharon L. Walsh, "A Review of Buprenorphine Diversion and Misuse: The Current Evidence Base and Experiences from Around the World," *Journal of Addiction Medicine* 8, 5 (2014): 315-26, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4177012/.

29 "CESAR FAX Special Series: Buprenorphine June 13, 2011 — September 12, 2011," *CESAR FAX* 20, 22-34 (2011), http://www.cesar.umd.edu/cesar/pubs/20110915%20buprenorphine%20cesar%20fax.pdf.

30 *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction: A Treatment Improvement Protocol TIP 40* (Washington, DC: U.S. Department of Health and Human Services, 2004), https://www.naabt.org/documents/TIP40.pdf.

MYTH #5
HIGH-QUALITY TREATMENT IS OUT-OF-STATE TREATMENT.

Over the past year, we've spoken to several parents who sent their children out of state for addiction treatment, or at least considered the option. Oftentimes, these decisions were rooted in the perception that long-term treatment is inaccessible or that local facilities offer substandard care. Throughout the course of our interviews, overreliance on outpatient care (often caused by insurance restrictions), outdated treatment facilities, inferior halfway housing, and the lack of wraparound services were all cited as powerful disincentives to seek addiction treatment locally.

By comparison, the alleged benefits of traveling out of state are enticing: people can seek treatment anonymously; remove themselves from known triggers in their environment; or pursue special treatment options that aren't available locally, e.g., flotation tank therapy.[31] The fact that some of the most widely advertised facilities are "nestled in the hills of Malibu, California"[32] or the beautiful southwest deserts of Arizona[33] doesn't hurt either. Oceanfront property, serene desert landscapes, and plush backyards dotted with barbeque grills appeal to most people, suffering from addiction or not.[34]

While luxury residences and tranquil getaways sound and look appealing, treatment fraud is a real issue.[35] No doubt, credible rehabs exist outside New York State. However, others are exploitative. For example, unscrupulous providers will pay "lead generators" $50 dollars for a single referral, with the understanding that they can reap $40,000 or more in insurance claims.[36] The now infamous "man-in-blue" ad, featuring a bearded young man in blue scrubs wearing a stethoscope (pictured on page 94), is emblematic of the deceptive marketing techniques used to lure patients. Sponsored by the Addiction Network, a 24-hour call center based in Southern California, the ad promises free consultation and referral services. However, the agency does not verify whether a provider is reputable. Instead, callers are "automatically routed to a rotating list of treatment centers, which prepay to receive a set number of calls per month."[37]

31 "Flotation Tank Therapy In Addiction Treatment," Anaheim Lighthouse, January 9, 2018, https://anaheimlighthouse.com/blog/flotation-tank-therapy-in-addiction-treatment/.
32 The Canyon, https://thecanyonmalibu.com/traveling-out-of-state/.
33 Sabino Recovery, https://www.sabinorecovery.com/your-stay/.
34 Beachside Rehab, https://www.beachsiderehab.com/inpatient-treatment-program/.
35 "When it comes to rehab referrals, beware of broken promises," NYS Office of Alcoholism and Substance Abuse, accessed February 7, 2019, https://oasas.ny.gov/treatment/StopTreatmentFraud.cfm.
36 David Segal, "A Doctor With a Phone and a Mission," *New York Times*, December 27, 2017, https://www.nytimes.com/interactive/2017/12/27/business/drug-addiction-ads.html.
37 Ibid.

While luxury residences and tranquil getaways sound and look appealing, treatment fraud is a real issue.

The so-called "Florida model" has come under attack due to its not-so-obvious shortcomings. While luxury rehabs do an excellent job getting people in the door (paying for expensive advertising, promising cutting-edge treatment, and offering free one-way plane tickets), "they don't have the natural connections … to the community services that are essential for continued recovery." As one provider put it, for-profit entities "take people out of their communities, bill insurance, run the insurance dry," and then turn people out without first connecting them to aftercare services at home.

Despite the difficulties people can have accessing treatment,[38] New York State has one of the largest drug treatment systems in the United States. In 2016, there were 279,744 admissions to New York State substance use treatment programs. By comparison, the next two largest state programs admitted 152,548 (California) and 95,414 (Maryland) people, respectively.[39] When asked why so many New Yorkers continue seeking treatment elsewhere, one residential provider explained that it was because local nonprofits lack the resources needed to compete on the market for drug treatment, even though they offer more comprehensive care; e.g., residential treatment followed by outpatient treatment in or close to people's community of origin. "It's one of the best kept secrets in New York State," he explained, "that there is treatment available."

CONCLUSION

At a time when many people to turn to the internet for answers to questions about drug treatment, separating fact from fiction is crucial to informed decision making and action. Indeed, the simple fact that people can and do die from opioid withdrawal should prompt more hospitals to reexamine their admission criteria and take advantage of the time-limited waiver to expand detoxification services. Getting informed, learning about different treatment options, and understanding the rules and regulations that govern access to care are necessary steps in dispelling the myths that prevent people from getting the treatment they deserve.

38 Patricia Strach, Katie Zuber, and Elizabeth Pérez-Chiqués, "Stories from Sullivan: The Illusion of Services," Rockefeller Institute of Government blog, October 3, 2018, https://rockinst.org/blog/stories-from-sullivan-the-illusion-of-services/.

39 *Treatment Episode Data Set (TEDS) 2016: Admissions to and Discharges from Publicly Funded Substance Use Treatment* (Washington, DC: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2018), https://www.samhsa.gov/data/sites/default/files/2016_Treatment_Episode_Data_Set_Annual.pdf.

PART 17

So Far from God

As part of our Stories from Sullivan series, we talked to experts across the border in Mexico to understand what the opioid epidemic looks like there, and how their government addresses opioid dependency. In this analysis, Professor Angélica Ospina-Escobar shows what opioid dependency looks like in Mexico and how policies in Mexico that limit access to methadone harm treatment and recovery efforts. Text and photos by Professor Angélica Ospina-Escobar.

TAN LEJOS DE DIOS, Y TAN CERCA DE LOS ESTADOS UNIDOS

"So far from God and so close to the United States," is a phrase that is repeated in Mexico to express how the social, economic, and health crises facing the United States have a counterpart in Mexico. What is the Mexican correlate of the opioid crisis in the United States? Has the prevalence of heroin use changed over time? Are we facing a future scenario of over-mortality in people dependent on heroin due to the presence of fentanyl?

When examining the data available in the National Epidemiological Surveillance System of Addictions, it turns out that

Above: A heroin user in a buying-selling-using location in Hermosillo, Sonora.

these official data on drug use in Mexico do not allow us to outline a clear trend regarding heroin use in the country. For example, national addiction surveys show that, while in 1988 the national prevalence of once-in-life heroin use was 0.01 percent, in 2011 it rose to 0.2 percent, remaining at that level until 2017, the date of the last national survey of drug use.[1] On the other hand, the National Survey on Drug Consumption in Public Primary, Secondary and High School Students[2] reports a prevalence of heroin once in life use among young people between 12 and 19 years old of 0.9 percent, which suggests an increase in heroin use in the juvenile population.

The data available from public addiction treatment centers, however, show decreasing trends in the volume of people seeking treatment for the problematic use of heroin. Thus, while in 1994 the percentage of people seeking help for heroin dependence was 13.3 percent, in 1999 it fell to 8.8 percent; in 2007 it was 10.5 percent, and for 2016 the proportion was 3.4 percent. It is noteworthy that, while in the 1990s only the northwestern region of the country reported cases of problematic heroin use, as of 2005 it is a situation reported in all 32 states of the Mexican Republic.

With respect to the trajectories of drug initiation, from the total of individuals receiving in-patient services in non-governmental treatment centers from 1994 to 2016, only between 1 and 7 percent reported heroin as a starting drug. Regarding drug-related

1 J.A. Villatoro et al., *Encuesta Nacional de Consumo de Drogas, Alcohol y Tabaco (ENCODAT) 2016-2017: Reporte de Drogas* (Ciudad de México: INPRFM, 2017).

2 J. Villatoro-Velázquez et al., *Encuesta Nacional de Consumo de Drogas en Estudiantes 2014: Reporte de Drogas* (Ciudad de México: INPRFM, 2015).

mortality, deficiencies in the mortality data do not allow for the accurate identification of drug-related deaths, nor for the accounting of changes in drug-related mortality over time. In general, the mortality reported by official sources of heroin overdose in Mexico is around 0.1 percent and has remained relatively stable at that level for about two decades. In contrast, violence consistently appears as the leading cause of death in this population, which means that what kills people dependent on heroin in Mexico is not the substance itself, but a hostile context that discriminates and marginalizes this population.

By 2015, it was estimated that there were 141,690 opioid users in Mexico.[3] Of these, 44 percent were concentrated in the cities of Tijuana, Ciudad Juárez, and Hermosillo. The states of Baja California — whose capital is Tijuana — and Chihuahua, where Ciudad Juárez is located, are the states with the highest prevalence of heroin use nationwide as reported in 2017 (0.3 percent and 0.2 percent, respectively).

These data suggest that Mexico is far from having epidemic levels of problematic heroin use and that it is rather a situation concentrated in specific regions of the country. In this scenario, offering systems of care to users with problematic heroin use in cities with a higher prevalence of consumption would be an efficient and cost-effective strategy to not only provide treatment and expand healthcare to this population, but also prevent the emergence of new consumers and collect epidemiological data on the trajectories and dynamics of drug use, as well as the health conditions of this population. Additionally, establishing systems of care would aid in further exploration of the local drug markets. This would improve the ability to monitor the appearance of new substances such as fentanyl and its effects on the health conditions of populations with problematic drug use and their buying-selling-using dynamics.

Given the emergence of the opioid crisis in the United States, the adjustment of better mechanisms for epidemiological surveillance of drug use is necessary in Mexico. This means having better and more expansive approaches to user populations from a human rights perspective. Politically, this means that we must begin to consider drug users as members of society regardless of their drug use.

THE MALILLA: THE OPIOID CRISIS AND THE INTENTIONAL POLICY OF PAIN IN MEXICO

> *The malilla* [slang Spanish word for withdrawal syndrome] *is the worst thing that can happen to you, I really do not wish it upon anyone, not even my worst enemy. You tremble, your belly becomes a knot, you can't pass anything, not even water. Your bones hurt, you can't walk, nor think, nor sleep, from the pain you feel, you only think about having a fix* [using heroin]*. You sweat nonstop, everything turns around and in addition, you suffer from insomnia.... It's ... It's really uncontrollable, it's something very strong, very, very "gacho"* [bad, ugly]*. That's why when you want to break*

3 Centro Nacional para la Prevención y el Control del VIH y el Sida, "Tamaño estimado de población HSH y UDIS en las ciudades prioritarias de propuesta Ronda 9," CENSIDA 2010,

away from the Shiva [heroin], *you need something to help you. That's why we turn to methadone. The problem is that, if you stop taking the methadone, it also hits with withdrawal symptoms, the same or even worse as with the Shiva, there is no way out….*

— Ivan, 35 years old, Hermosillo

Paco has been heroin dependent since he was 15 years old. At 19, after several admissions to treatment, he began a substitution treatment with methadone.

Methadone is the only medication available in Mexico that can treat the symptoms of opioid withdrawal syndrome. This syndrome is a physiological response to the cellular adaptations of the permanent stimulation that opioids generate in the central nervous system. The intensity and severity of the symptoms depend on the type and amount of substance consumed. In the first phase, symptoms include piloerection, heavy sweating, generalized pain, muscle spasms, bone pain, tachycardia, hypertension, tremors, irritability, motor agitation, anorexia, and insomnia. At an advanced stage, symptoms include paresthesia, fever, colicky abdominal pain, nausea, vomiting, diarrhea, and hyperglycemia.[4] It is medically acknowledged that opioid withdrawal syndrome can cause death.

Using methadone does not necessarily mean that people struggling with opioid addiction stop using drugs, but it is a harm-reduction strategy that helps decrease the frequency and intensity of heroin use and, with this, people manage to better perform their roles within their families, jobs, schools, etc. Additionally,

Above: Used syringes discarded on a street in a neighborhood north of Hermosillo, Sonora. Needle-exchange programs aim to take used syringes out of circulation to prevent exposure by nonuser residents. Below: "Here is where dreams become nightmares," border wall in Playas de Tijuana, Baja California.

4 F.J. Alzate García, "El síndrome de abstinencia por opioides," *Cuadernos de Psiquiatría*, 49 (2012): 19-25.

it is an effective measure to reduce the risks of HIV infection, Hepatitis C, and death from an overdose.

Thanks to methadone, Paco had found a job in a grocery store near his house, with which he financially supported his two daughters and his partner. Under methadone treatment, Rosario, a street resident in Mexico City with HIV and a dependence on heroin, achieved adherence to antiretroviral treatment. Thanks to that, she had reached viral suppression in December of last year. That is to say, Rosario not only enjoyed excellent health conditions, but, having an undetectable level of HIV in her system, she also did not transmit the virus to other people. Through the services of the Condesa Clinic, the public HIV clinic in Mexico City, Rosario had also managed to access a temporary shelter system and hold temporary jobs, all of which contributed to the improvement of her health conditions.

Although methadone can be used successfully to treat opioid-use disorder and decrease the spread of infectious diseases, the government limits its usage, preferring an abstinence-based strategy. Limiting access to medication, however, can make drug use and disease worse, not better.

LACK OF MEDICATION

The government imposes limits on the production of the medicine itself. According to information available from the Comisión Federal para la Protección contra Riesgos Sanitarios [Federal Commission for the Protection against Sanitary Risks] (Cofepris), only one laboratory in the country is authorized to produce methadone, but it has restrictions on importing the supplies needed as raw material. According to an informant from this laboratory, importing these supplies can take up to nine months, once the corresponding permits have been granted. Once the raw materials enter the country and are transported to the laboratory, a civil servant from Cofepris must open the package. No one other than Cofepris personnel can open the package containing the raw materials, as these are classified as Schedule I controlled medications, which are the most restricted. These bureaucratic procedures, in addition to a very limited demand for the product — given the small size of the heroin-dependent population in Mexico — makes methadone a low-priority medication, despite the suffering its absence creates in individuals suffering from opioid addiction.

LACK OF ACCESS

Although methadone is an essential medicine included in the basic supplies list of the health sector in Mexico since 2017, it is not available – except for honorable exceptions – in most public hospitals, so it is very difficult to access. And it is not available throughout the country. Only Tijuana and Ciudad Juárez have public clinics that offer methadone treatment. Along with these two public clinics, there are four private institutions that provide methadone treatment in Tijuana, Ciudad Juárez, Nogales, Mexicali, Nuevo Laredo, Zapopan, and Mexico City.

This focused provision of methadone treatment contrasts with the reports of the national surveillance system on drug use, which highlights the existence of heroin dependents in almost all the

Memorial for missing or murdered women in Ciudad Juárez, Chihuahua.

states throughout the national territory. It is noteworthy that while in the 1990s only the northwestern region reported cases of problematic heroin use, as of 2005 it is a situation reported in the 32 states of the Republic.

Even though the physical dependence generated by methadone is medically acknowledged, in recent years private clinics that offer this drug have been shutting down without following up on the people who were under treatment. In 2015, the methadone clinic in Hermosillo, Sonora closed. In 2017, two clinics were closed in Ensenada, Baja California, and in December 2018, the clinic in Mexico City was closed. In January 2019 the methadone clinics in Ciudad Juárez, Chihuahua, and Mexicali were declared in short supply and stopped providing the service. In all cases, the closure was made unexpectedly and there was no contingency plan to guarantee the welfare of the patients, some of whom had been in treatment for years.

EFFECTS OF LIMITING METHADONE

At first, patients like Paco and Rosario thought that the closing of the clinics where they received services would be temporary. In the past, the establishments would run out of the medication and be closed for a couple of days. However, this time the situation remains unsolved without any authority acting on the matter to ensure access to this essential medication.

Given the physical dependence that methadone produces, its shortage exposes individuals to conditions of unnecessary suffering and constitutes a serious violation of their human rights. In the context of state indolence and faced with the severity of the malilla, the individuals return desperately to the use of injected heroin as a way of mitigating the physical pain caused by their dependence. This strategy will, in the long term, not only deepen their

Leaving the penitentiary of Hermosillo, Sonora, where many detainees are in for drug possession. The watchtower can be seen on the right side of the photo. There is no methadone program in the prison. On the other hand, when there is no heroin in the streets, the only place where you can buy it is in prison. Behind these transactions are many families who are trying to keep their loved ones alive.

problematic drug use patterns, but also put them at greater risk of early death.

Thus, three years after the closure of the methadone clinic in Hermosillo and two years after the closure of the Ensenada clinics, the lack of services to the heroin-dependent population continues. Anecdotally, we've heard of a spike in deaths, however, there are no official records.

Rosario has not returned to the Condesa clinic in Mexico City for her antiretroviral treatment; she has disappeared from the radar of those who were guiding her through her antiretroviral treatment and now they can only helplessly think that they lost a patient with an excellent prognosis, who will surely die anonymously in the cold streets of the city. Paco reinjected heroin two months after the closing of the Hermosillo clinic. Currently, he spends around $1,500 Mexican pesos [around $80 USD] daily to purchase the drug, an amount of money that guarantees the practice of illicit activities and the dismantling of his mother's house. He lost his family and faces a precarious health situation, as his veins have collapsed, and he suffers from Hepatitis C. Paco isn't the only one suffering from this dependence; his entire family, who watch helplessly as he deteriorates day by day, suffers too. This dependence affects two girls under the age of 10, who were left without a father, and his partner who, at 25, is now the head of the family.

The limited access to methadone can be understood as part of a state policy that privileges abstinence as the only treatment option for substance-use disorders in general, and heroin dependence in particular. This preference for abstinence programs is reflected by the ongoing methadone shortages and in the fact that no public entity has stepped up to ensure the supply of this medicine in the cities where private clinics have abruptly cut off their supply, thus leaving individuals who had been receiving services for their heroin dependence to their own fate at the mercy of the organized crime that controls the local drug markets.

In the case of heroin addiction, privileging abstinence as the only treatment option is denying the medical condition of withdrawal syndrome and subjecting people struggling with heroin addiction to unnecessary physical suffering. This denial of the public supply of methadone appears as a de facto policy in which the user is punished for his addiction, exposing him to pain. But pain does not cure dependence; on the contrary, pain dehumanizes and dishonors their lives and those of their families, and strips them of their dignity. In the end, once they have gone through this slow and painful process of social death, they will eventually die physically too, confirming the prophecy of "drugs = death." However, it is not the drugs that kill; it's the indifference of state institutions and the social stigma against drugs and drug users that ultimately seals their fate.

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PART 18

Stigma Kills

Monticello native Jared Levine is an author who is in recovery.

IN DECEMBER 2018, two economists published a discussion paper calling attention to the "unintended consequences" of naloxone, a lifesaving medication designed to reverse an opioid overdose.[1] In it, the authors contend that increased availability of naloxone incentivizes high-risk drug use by reducing the likelihood of death. Moreover, they contend, expanding access to the medication results in more crime because "some opioid abusers are saved by naloxone" and they "steal in order to fund their addictions."

Even though subsequent scholars have called into question the data used to

1 Jennifer L. Doleac and Anita Mukherjee, *The Moral Hazard of Lifesaving Innovations: Naloxone Access, Opioid Abuse, and Crime*, IZA Discussion Paper No. 11489 (Bonn: IZA Institute of Labor Economics, April 2018), http://ftp.iza.org/dp11489.pdf.

A client at a recovery center in Sullivan County discusses his journey through addiction.

support the authors' claims,[2] the notion that life-saving interventions encourage people to use drugs by creating a safety net is nothing new. Early studies in the 1990s found that needle-exchange programs reduced the incidence of HIV infection.[3] However, policymakers expressed concern that investing in such programs would encourage drug use by increasing the availability of needles. Applying a similar logic to opioids, some have argued that making Narcan readily available reduces both the stigma and the risk that attaches to illicit drug use, and that stigma itself is socially beneficial to the extent that it prevents drug use.

Contrary to the argument that stigma deters socially unacceptable behavior, it is evident from our research that stigma, in fact, kills.

2 Richard G. Frank, Keith Humphreys, and Harold A. Pollack, "Does Naloxone Availability Increase Opioid Abuse? The Case For Skepticism," *Health Affairs* blog, March 19, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180316.599095/full/.

3 *Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy,* GAO/HRD-93-60 (Washington, DC: United States General Accounting Office, March 1993), https://www.gao.gov/assets/220/217594.pdf.

Contrary to the argument that stigma deters socially unacceptable behavior, it is evident from our research that stigma, in fact, kills. Even though opioids are changing the way we think and talk about addiction, stigma — or negative attitudes towards people with substance-use disorders that result in social devaluation and discrimination — has real human consequences. In this blog, we examine the stigma surrounding addiction and discuss its implications for people with substance-use disorders. Not only does stigma affect the delivery of healthcare services and treatment to persons with substance-use disorders, it isolates family members and undercuts prevention efforts.

We've heard numerous concerns that people on medication-assisted treatment are made to feel unwelcome in the 12-step community due to the belief that they are trading one drug for another.

STIGMA AND HEALTHCARE DELIVERY

Despite growing acceptance of addiction as a brain disease, stigma is pervasive.[4] For example, Ohio Sheriff Richard K. Jones forbade his deputies from carrying Narcan. "I'm not the one that decides if people live or die," he told the *Washington Post*.[5] "They decide that when they stick that needle in their arm."

Although the sheriff misconstrues addiction as a willful choice, he is not alone. Even as we met people who carried Narcan in their cars or on their persons, we heard about first responders who believe that naloxone only enables addiction[6]; pharmacies that refuse to stock Narcan[7]; and disturbing social-media campaigns that disparage the lives and human worth of people with substance-use disorders.

A systematic review of the biomedical and psychological literature found that health workers also hold negative attitudes towards patients with substance-use disorders.[8] While some report feeling ill-equipped to treat patients due to inadequate education

4 Jeffrey M. Jones, "Americans With Addiction in Their Family Believe It Is a Disease," Gallup News Service, August 11, 2006, https://news.gallup.com/poll/24097/Americans-Addiction-Their-Family-Believe-Disease.aspx.

5 Cleve R. Wootson, Jr., "Why this Ohio sheriff refuses to let his deputies carry Narcan to reverse overdoses, *Washington Post*, July 8, 2017, https://www.washingtonpost.com/news/to-your-health/wp/2017/07/08/an-ohio-countys-deputies-could-reverse-heroin-overdoses-the-sheriff-wont-let-them/?utm_term=.0608ab1e5d24.

6 Interview # 36_05252018.

7 Interview # 04042018.

8 Leonieke C. van Boekel et al., "Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review," *Drug and Alcohol Dependence* 131, 1-2 (2013): 23-35.

and training,[9] others feared for their safety or expressed distrust as a result of patients' behaviors.[10] "People do lie, cheat, steal, [and] manipulate … to not be sick," one recovery coach explained.[11] But such behaviors must be treated as symptoms of a disease rather than a character flaw.

Health professionals who specialize in addiction,[12] treat fewer patients,[13] or have personal experience with addiction[14] typically have more positive attitudes towards patients with substance-use disorders. However, stigma still affects the delivery of healthcare services. Research shows, for example, that patients who perceive discrimination by health officials are more likely to drop out of treatment,[15] and to receive suboptimal care[16]; e.g., shorter nurse visits or task-oriented rather than patient-centered nurses. Anecdotally, in Albany we heard about a mom who overheard nurses chanting "one more day, one more day" prior to her son's discharge; about "demoralizing code" that doctors write to one another "saying we need to get this person out"; and about health professionals withholding medication-assisted treatment and making patients wait for it.[17] The

Stigma prevents policymakers from developing solutions that could have a positive effect in favor of putting Band-Aids on the symptoms.

9 C. Deans, "Caring for clients with dual diagnosis in rural communities in Australia: the experience of mental health professionals," *Journal of Psychiatric and Mental Health Nursing* 12 (2005): 268-74.
10 Rosemary Ford, "Interpersonal challenges as a constraint on care: The experience of nurses' care of patients who use illicit drugs," *Contemporary Nurse* 37, 2 (2011): 241-52.
11 Interview # 10162018a.
12 Gail Gilchrist et al., "Staff regard towards working with substance users: a European multi-centre study," *Addiction* 106, 6 (2011): 1114-25.
13 Lin Ding et al., "Predictors and Consequences of Negative Physician Attitudes Toward HIV-Infected Injection Drug Users," *Archives of Internal Medicine* 165, 6 (2005): 618-23.
14 Christopher Russell, John B. Davies, and Simon C. Hunter, "Predictors of addiction treatment providers' beliefs in the disease and choice models of addiction," *Journal of Substance Abuse Treatment* 40, 2 (2010): 150-64.
15 Loren Brener et al., "Perceptions of discriminatory treatment by staff as predictors of drug treatment completion: utility of a mixed methods approach," *Drug and Alcohol Review* 29, 5 (2010): 491-7.
16 Sue Peckover and Robert G. Chidlaw, "Too frightened to care? Accounts by district nurses working with clients who misuse substances," *Health and Social Care in the Community* 15, 3 (2007): 238-45.
17 Interview # 10162018a.

Annette Kahrs, president of Tri-County Community Partnership, works with local law enforcement agencies on Hope Not Handcuffs - Hudson Valley, a collaborative program to improve access to addiction treatment services.

effect is dehumanizing, demoralizing, and disempowering for people with substance-use disorders.[18]

Stigma, and the accompanying fear of repercussion, is particularly harmful for pregnant women and their children. At a meeting of nine women in recovery, nearly all participants said they would be reluctant to tell their doctors they were using if they were pregnant due to fear of being jailed or having their kids taken away.[19] Nurses, too, expressed concern that pregnant women forego prenatal care out of fear of being caught. "If mom tests positive as an outpatient, we'll have a conversation," one nurse explained at a local task force meeting, "but we'll never see her again. She knows that if she stays we'll test her for drugs."[20]

STIGMA AND ACCESS TO MEDICATION-ASSISTED TREATMENT

Medication-assisted treatment (MAT) is also stigmatized, which, in turn, makes staying in recovery even more challenging. According to Dr. David A. Patterson Silver Wolf, associate

18 J. Curtis and L. Harrison, "Beneath the surface: collaboration in alcohol and other drug treatment. An analysis using Foucault's three modes of objectification," *Journal of Advanced Nursing* 34, 6 (2001): 737-44.
19 Field Notes_180711.
20 Field Notes_180711.

professor at Washington University, stigma serves as a powerful disincentive for doctors to become certified to prescribe buprenorphine. "Physicians whose practices focus on patients with opioid use disorder don't have to worry about their 'brand' being harmed because it is tied to this treatment and this patient population," he wrote in STAT.[21] "But a typical primary care physician in Manhattan or suburban Atlanta or rural Nevada might worry about the potential trouble that patients with addictions might cause in their waiting rooms." Indeed, a recent survey of licensed physicians in the United States found the top-cited reason for not being waivered to prescribe MAT was not wanting to be inundated with requests for buprenorphine.[22]

STIGMA AND RECOVERY

People on MAT are stigmatized in other ways. For example, we've heard numerous concerns that people on medication-assisted treatment are made to feel unwelcome in the 12-step community due to the belief that they are trading one drug for another. "Narcotics Anonymous, not big fans of people on medication," one addiction specialist told us.[23] "They're ostracized for not being clean, they're told they're not allowed to share or speak at the meeting … so they end up not having that community support to their recovery." Even though

21 David A. Patterson Silver Wolf, "Do business concerns keep doctors from treating opioid addiction?," STAT, March 29, 2019, https://www.statnews.com/2019/03/29/medication-assisted-therapy-lags-strictly-business/.

22 Andrew S. Huhn and Kelly E. Dunn, "Why Aren't Physicians Prescribing More Buprenorphine?," *Journal of Substance Abuse and Treatment* 78 (July 2017): 1-7.

23 Interview # 72_07132018.

Thomas Bosket (above and at left), cofounder of ENGN, discusses the organization's community-building work, including art-based approaches to addiction and recovery.

many people have expressed great appreciation for Narcotics Anonymous as a recovery organization, others report feeling ashamed, confused, hurt, and even angered due to their medication status. [24]

Loved ones can also be resistant to the idea of medication-assisted treatment. "[F]amily members don't want them to take it," the addiction specialist said.[25] "If they have to take it, they want them off it as quickly as possible," because they, too, believe it's "treating a drug with a drug."

Stigma can also silence people in recovery. "[P]eople have a skewed perception of what someone with a substance-use disorder looks like," one peer recovery coach explained, "what they behave like, what they're entitled to, whether or not we know them, want to have them in our families.... [W]e all know people in recovery, we just don't know that we know them because we've all kept our mouths shut for so long."[26] Her colleague agreed. "[T]he more people come out and say, 'I am a person in recovery. I am a teacher, a doctor, your neighbor, your friend.' The more normalized it becomes."[27]

STIGMA AND PREVENTION

Finally, stigma can undermine efforts to prevent drug use before it even begins. For example, one provider who trains educators in school-based prevention strategies indicated that teachers are sometimes resistant to the idea. "You can't necessarily get folks to agree with the project that you are trying to do," he explained.[28] "We have difficulty sometimes with ... individual classroom teachers and their personal biases ... making it challenging for our trainers to deliver their message for kids."

HOW STIGMA KILLS

Stigma makes it harder to promote good health and it limits access to treatment, recovery, and prevention. It causes people to point fingers at the wrong culprit. When loved ones exhibit the symptoms of addiction, such as stealing or lying, parents worry that their actions will be interpreted as a reflection of

24 William L. White, *Narcotics Anonymous and the Pharmacotherapeutic Treatment of Opioid Addiction in the United States* (Philadelphia: Philadelphia Department of Behavioral Health and Intellectual disAbility Services and Chicago: Great Lakes Addiction Technology Transfer Center, 2011), http://atforum.com/documents/2011NAandMedication-assistedTreatment.pdf.

25 Interview # 72_07132018.

26 Interview # 10162018a.

27 Interview # 10162018b.

28 Interview # 72_07132018.

poor parenting. They feel alone and even responsible for what happened to their children. "We were derelict parents," one mom explained. "Trying to live through the guilt of trying to understand what happened to our son and … at the same time be shunned by the entire universe … [U]p until this point we've kind of lived in a bubble."[29]

When treatment is inadequate, or people relapse, stigma also results in the individual being blamed rather than a failed system. According to Sherry Daley, director of government affairs at the California Consortium of Addiction Programs and Professionals, friends and relatives may doubt their loved ones when they say something is wrong with a treatment program due to years of relapse and manipulative behavior. "They're going to say, 'Wow, you screwed it up again,'" she told *Mother Jones*.[30]

But, as we've shown, there are real barriers to accessing care[31] and the people who need it most are at the greatest risk for abuse.[32]

The argument that naloxone incentivizes drug use, and the accompanying idea that stigma is socially beneficial, is dangerous not only because it is flawed, but because it can perpetuate the problem: limiting healthcare, treatment, recovery, and prevention efforts. It puts the blame on people with substance-use disorders and burdens their families with keeping shameful secrets.

The truth is that substance-use disorders are common (in 2017, an estimated 30.5 million Americans aged 12 or older used an illicit drug, including 3.2 million people who used prescription drugs)[33] and, until we address the problem head on, they will continue to be common. Stigma silences those people who need help the most: doctors who are reluctant to provide care; pregnant women who forego conversations with medical professionals about the substances they are dependent on; parents who refrain from talking about their children, and school-age children who aren't able to talk about their parents. Stigma prevents policymakers from developing solutions that could have a positive effect in favor of putting Band-Aids on the symptoms. If we don't change attitudes around addiction, we risk kicking the can down the road and potentially creating even bigger problems to address in the future: babies born addicted to heroin; families torn apart and traumatized; and children removed from their homes.

29 Interview # 31_04242018.

30 Julia Lurie, "'Mom, When They Look at Me, They See Dollar Signs,'" *Mother Jones*, March/April 2019, https://www.motherjones.com/crime-justice/2019/02/opioid-epidemic-rehab-recruiters/.

31 Patricia Strach, Katie Zuber, and Elizabeth Pérez-Chiqués, "Stories from Sullivan: The Illusion of Services," Rockefeller Institute blog, October 3, 2018, https://rockinst.org/blog/stories-from-sullivan-the-illusion-of-services/.

32 Patricia Strach, Katie Zuber, and Elizabeth Pérez-Chiqués, "Stories from Sullivan: #MeToo in the wake of Addiction," Rockefeller Institute blog, May 14, 2018, https://rockinst.org/blog/stories-from-sullivan-metoo-in-the-wake-of-addiction/.

33 Jonaki Bose et al., *Key Substance Use and Mental Health Indicators in the United States: Results from the 2017 National Survey on Drug Use and Health* (Rockville: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, September 2018), https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHFFR2017/NSDUHFFR2017.pdf.

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