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Recovery Support Resources in Rural and Frontier Areas: A Call for Research and Action

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A profound shift is underway in the design of addiction treatment in the United States. The acute care model of biopsychosocial stabilization that dominated addiction treatment over the last four decades of the twentieth century is being revamped via the emergence of models of sustained *recovery management* (RM) and nesting this new approach to addiction treatment and recovery support within larger *recovery-oriented systems of care* (ROSC) (Kelly & White, 2011; White, 2008). RM and ROSC place great emphasis on the development and mobilization of indigenous community resources to support long-term recovery from individuals and families affected by alcohol and other drug (AOD) problems.

As interest in RM and ROSC has grown, questions have arisen about how to design and implement these new models of care and support with particular populations and within particular geographical and cultural contexts. This brief paper explores some of the questions that are arising related to the application of RM and ROSC within rural and frontier settings.

The State of Addiction Treatment and Recovery Support in Rural and Frontier Settings

Concern has existed for some time about alcohol and other drug problems in rural communities (Beltrame, 1978) and how treatment and post-treatment recovery supports can be best delivered within these environments (USDHHS, 1994). A brief review of the professional literature suggests a number of starting points for our discussion.

The Rural Context: The "rural" designation embraces areas with widely differing demographic, economic, and cultural characteristics, including wide variations in AOD-related attitudes and use patterns (Booth & McLaughlin, 2000). Comparing "urban/rural" rural areas (those rural areas containing one or more metropolitan communities) with those areas that have been designated as "very rural" or "frontier" reveal settings with widely differing risks and resiliencies (Fleming, 1994; Leukefeld, Clayton, & Myers, 1992). Rural communities do tend to share some

distinguishing characteristics: individualism, isolation, religiosity, cultural conservatism, distrust towards outsiders, economic distress, and out-migration of young adults (Schoeneberger, Leukefeld, Hiller, & Godlaski, 2006). The risk for substance use disorders in the rural context must be viewed within the growing economic disadvantage resulting from the loss of economic infrastructure, e.g., declines in rural farming, manufacturing, and mining (Schoeneberger, 2006; Schoeneberger et al., 2006). The resolution of substance-related problems must capitalize on the indigenous recovery capital that exists or that can be mobilized within rural areas.

> *We made it* [succeeded in developing an effective rural service delivery model] *because of a willingness to change, to engage the recovering community and the service system, and to work at keeping clear boundaries between ourselves and others. We saw the possibilities as greater than the problems*. (Henderson & Long, 1994)

Problem Prevalence: Living in a rural community is not a protective factor for the development of a substance use disorder (Johnson et al., 2008; Schifano, 2008; Thomas & Compton, 2007), particularly if that rural area includes an accessible medium to large city (Martino, Ellickson, & McCaffrey, 2008). Persons from rural communities tend to present with clusters of drug choices different than those seen in urban areas: alcohol, cannabis, methamphetamine, solvents, and prescription opioids such as Oxycontin (Gfroerer, Larson, & Colliver, 2007; Lambert, Gale, & Hartley, 2008; Stoops, Tindall, Mateyoke-Scrivner, & Leukefeld, 2005). The prevalence of AOD problems in rural communities equals or surpasses those experienced in urban communities (Cronk & Sarvela, 1997; Ruiz, Stevens, McKnight, Godley, & Shane, 2005), and rural youth may even begin AOD use earlier and enter addiction treatment with a greater degree of problem severity than their urban counterparts—particularly in alcohol use and alcohol-related risk behaviors (e.g., drinking and driving) and methamphetamine use (Booth, Kirchner, Fortney, Ross, & Rost, 2000; Hall et al., 2008; Lambert et al., 2008; Pruitt, 2009). The greater degree of problem severity at the time of help-seeking for people living in rural areas may reflect a greater period of delay before seeking help (Fortney & Booth, 2001).

Treatment Infrastructure: Addiction treatment infrastructure in many rural communities is characterized by the recent loss of long-tenured leaders, obstacles to clinical staff recruitment and retention (e.g., professional isolation, limited education/training resources, high caseloads, low salaries), underutilization of the latest clinical technologies, a lack of specialized services (e.g., for women, adolescents, people with AIDS, people with co-occurring disorders), and eroding and unstable funding (Anderson & Gittler, 2005; Clark et al., 2002).

Treatment Access: Barriers to addiction treatment in rural communities include problems related to multidimensional social stigma, lack of treatment availability, lack of payment resources—particularly private insurance, lack of transportation, child care, distrust of service professionals, lack of or exclusive reliance on family/partner/social support for recovery, lack of bilingual staff, lack of integration across service sectors, and perception of inadequate treatment quality by potential referral sources (Booth & McLaughlin, 2000; Metsch & McCoy, 1999; Sawyer, Gale, & Lambert, 2006; Yannessa, Reece, & Basta, 2007). In spite of similar prevalence of substance use problems, rural adults and youth are much less likely to be provided treatment for a substance use disorder than are adults and youth in urban communities (Borders & Booth, 2007; Pullman & Heflinger, 2009; Simmons & Havens, 2007), with some studies finding that drug users in urban areas were twice as likely to enter addiction treatment as drug users in rural areas (e.g., Metsch & McCoy, 1999). Some barriers to treatment entry that have been attributed to rural location may be more

accurately related to other factors, e.g., gender, race, poverty (Small, Curran, & Booth, 2010). Distance—to addiction treatment or a recovery support resource—is a particularly important predictor of access and retention (Beardsley, Wish, Fitzelle, O'Grady, & Arria, 2003).

Treatment Quality: Rural addiction treatment programs, like their urban counterparts, often fail to utilize evidence-based treatment methods (Bouffard & Smith, 2005). While this is reflective of the national state of addiction treatment rather than a uniquely rural issue, there may be particular barriers to disseminating evidence-based practices in rural treatment centers (e.g., professional isolation). Rural programs may have less adjunctive services, culturally specific services, and fewer services for other people presenting with special needs (Bouffard & Smith, 2005). Very little is known about whether and how addiction treatment has been adapted to the special needs of people in rural areas or the extent to which that treatment has been refined for women, adolescents, and other populations that may present with special needs (Booth & McLaughlin, 2000). Private addiction treatment centers in rural areas have added specialized services but are still less likely to offer specialized services for women than private programs located in urban communities (Knudsen, Johnson, Roman, & Oser, 2003). Linkages for post-institutional monitoring, recovery support, and if needed, early re-intervention are particularly weak for rural residents leaving institutional settings to return home to rural areas (Oser et al., 2009).

Treatment Outcomes: In spite of multiple obstacles to availability, access, and acceptance of addiction treatment in rural areas, individuals from these areas who are treated achieve outcomes comparable to those treated in urban communities (Hiller et al., 2007).

The Experience of Recovery in Rural Areas: Only recently have there been studies that sought to capture the lived experience of recovery in rural areas and to extract the implications of those experiences for the design and delivery of addiction treatment and related recovery support services (Grant, 2007).

Indigenous Recovery Support: Little attention has been given in the professional literature on the differences in availability of recovery support resources (e.g., recovery mutual aid meetings, clubhouses, and social activities; recovery homes; recovery advocacy organizations and activities) between urban and rural communities and the effects any such differences exert on long-term recovery outcomes.

Promising Areas of Future Innovation: Promising practices related to the delivery of addiction treatment and recovery support services in rural areas of the United States include:

- service planning on a regional basis that allows geographically contiguous rural areas to create and sustain recovery supports jointly that would be beyond the resources of each contributing partner (Fleming, 1994);
- delivery of addiction treatment services through rural satellites, co-location with existing health and social service resources and assertive outreach programs (White, 2009);
- delivery of addiction treatment services through training of medical or mental health specialists (particularly for women; Booth et al., 1999);
- delivery of services via bibliotherapy (letters, books, manuals, pamphlets);
- assertive models of case management that assure consistency and continuity of support—particularly for rural women (Kopelman, Huber, Kopelman, Sarrazin, & Hall, 2006; Passey, Sheldrake, Leitch, & Gilmore, 2007; Vaughn-Sarrazin, Hall, & Rick, 2000);
- telephone (including text-based interventions and smart phone applications), videoconferencing and Internet-based

treatment/support (including potential development of applications for iPad, Kindle and other E-reader platforms) (Finfgeld-Connett & Madsen, 2008; Kavanagh & Proctor, 2011; Miller, 2005);

- use of community organizer roles (versus clinical roles) to develop and mobilize indigenous recovery support resources within rural areas (White, 2009); and
- application of the concept of "community recovery" to the long-term resolution of AOD problems in rural areas (White, Evans, & Lamb, 2010; Willie, 1989).

Resilience and Recovery in Rural Areas

Two things are striking from the above brief review. First, rural areas have been viewed primarily through the lens of their deficits rather than their assets. Second, we know a lot more about addiction and addiction treatment in rural areas than we know about addiction recovery in these same milieus. The lack of focus on recovery in all addictions-related research and this absence extends to rural research. In 1996, a group of drug use(r) researchers interested in "rural and urban research and practice" met in Lexington, Kentucky, to formulate research questions related to AOD problems in rural areas. The meeting generated more than 60 important research questions—not one of which was specifically related to long-term recovery. In fact, the word *recovery* does not appear in the conference report (Leukefeld & Edwards, 1999).

Significant advantages could accrue from focusing on existing and potential recovery support assets in rural communities. The focus on indigenous recovery resource development closely aligns with the rural reliance on family, extended family, social networks, and indigenous institutions (e.g., churches, co-ops) to solve problems rather than relying on service professionals (Metsch & McCoy, 1999). Restricted and potentially diminishing access to professionally-directed addiction treatment may be overcome by people seeking recovery in rural communities via support from family, friends, primary care physicians, clergy and faith communities, work, school, and through local and online recovery support groups (Grant, 2007). And addiction recovery may provide a context for the recreation of community in response to the weakening of mutual identification and support that has long characterized rural areas but that has weakened in recent decades (Grant, 2007).

Shifting the lens through which we examine rural areas from a pathology or intervention (treatment) paradigm to a solution-focused recovery paradigm is hampered by the lack of recovery-focused research in rural areas. The goal for the future is addiction recovery support services in rural communities that are available, accessible, affordable, and acceptable. Achieving that goal will be greatly facilitated by answers to key questions related to the current state of addiction recovery in rural areas and on the design, delivery, and evaluation of recovery support services in rural communities. Below are some of the questions that would be part of this rural recovery research agenda.

Recovery and the Rural Context

- How are the changing demographics of rural areas (e.g., aging of the rural population, racial diversification, etc.) affecting needs of addiction treatment and recovery support services?
- How do social norms related to alcohol and drug use in rural areas affect availability of addiction treatment and recovery supports and the experiences of people seeking recovery within these areas?
- Do the obstacles related to stigma faced by people in recovery differ for people living in rural areas?

Prevalence of Recovery

- What is the prevalence of recovery within rural areas of the United States (e.g., what percentage of people in rural communities who meet lifetime DSM-IV criteria for a substance use disorder do not meet such criteria for the past year)?
- Does the prevalence rate (in remissions per 100,000 people meeting lifetime diagnostic criteria) vary by degree of rurality?
- What is the demographic/clinical profile of those who recover and those who do not recover within rural areas?
- How is the rate of recovery prevalence changing over time within rural areas?

Process of Recovery

- What are the factors most related to recovery initiation among people living within rural areas?
- What is the global health status of people in recovery within rural areas and how does this status change over the course of recovery? Are there particular recovery service/support needs of people in rural areas that are stage-dependent?

Barriers to Recovery

- What barriers to recovery are unique to rural areas?
- What are the most common mistakes made in attempting to deliver treatment and recovery support services to rural areas?
- What strategies have been proven to be most effective in overcoming barriers to recovery in rural areas?

Recovery Supports

- What is the degree of availability, accessibility, affordability, and varieties of addiction treatment and recovery support services in rural areas of the U.S.?
- What are the most effective strategies for elevating the use of evidence-based, recovery-focused treatment practices in rural areas?
- What is the availability of recovery mutual aid societies within rural areas, and are these resources increasing or decreasing?
- What are the choices of recovery mutual aid societies available to people living in rural communities (e.g., varieties of 12-Step fellowships; varieties of secular and religious alternatives to 12-Step fellowships; availability of specialty groups related to age, gender, sexual orientation, medication status, etc.)
- Does participation in known active ingredients of 12-Step programs (e.g., meeting participation, step work, service work) differ in rural and urban areas?
- What family recovery support services exist in rural areas?
- What recovery support institutions exist in rural areas beyond recovery mutual aid fellowships, e.g., recovery community organizations, recovery centers, recovery homes, etc.?
- What creative strategies are emerging to address the transportation needs of people seeking recovery support services in rural areas?
- Could family and friends within rural areas be trained to perform some of the functions now being delivered by recovery coaches in urban communities?
- What are the effects of telephone- and internet-based recovery

support services on long-term recovery outcomes among people living in rural areas, e.g., the Online Recovery Network of the Heartview Foundation in Bismarck, North Dakota?

- What are the effects of cultural revitalization approaches (e.g., methods used by White Bison) on long-term recovery outcomes within rural communities? How might such approaches be more widely replicated?

Intrarural Variations

- What differences exist related to the above questions across rural areas and by the degree of rurality?
- What differences exist related to the above questions within particular ethnic and cultural rural communities, e.g., Native American communities, migrant communities?
- How do the pathways and processes of addiction recovery differ within rural areas across special populations of residents, women, adolescents, people recovering from co-occurring disorders, people re-entering the community from prison, Native American communities, etc.?

A Starting Proposal

The incremental process through which science proceeds will make it very difficult to quickly extend pathology-focused and treatment-focused addiction research to encompass a focus on the pathways and processes of recovery—particularly studies focusing on recovery in rural areas of the United States. I am not expecting National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism funding for such research to appear on the horizon any time soon, but there are preliminary steps that could be taken. Recovery prevalence questions could be added to existing studies on the epidemiology of AOD use and AOD-related disorders that would shed light on the rural recovery prevalence question. Studies of post-treatment monitoring and support models pioneered in urban communities (Scott, Dennis, & Foss, 2005) could be tested for comparability of outcomes in rural communities. Additionally, there is a need to mine the growing base of experiential knowledge related to the delivery of recovery support services in rural areas through projects like the Center for Substance Abuse Treatment's Recovery Community Service Program (RCSP) and the Access to Recovery (ATR) program. Representatives from the RCSP and ATR programs (particularly those from designated rural and frontier states) could be brought together to capture their experience on key recovery-related questions and to formulate specific questions that could help shape a rural recovery research agenda. This could be accomplished through a centralized gathering or hosted in key rural regions via the Addiction Technology Transfer Network. It is time such preliminary steps were taken.

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