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Addressing the Opioid Crisis in Clinton

Addressing Stigma and Access to Treatment

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School of Planning and Public Affairs

The University of Iowa
IOWA INITIATIVE FOR SUSTAINABLE COMMUNITIES

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List of Key Acronyms

Term	Meaning
CJS	Criminal Justice System
COD	Co-occurring Disorders
CRUSH	Community Resources United to Stop Heroin
CSAC	Clinton Substance Abuse Council
DART	Drug Abuse Response Team
DEA	U.S. Drug Enforcement Administration
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
ED	Emergency Department
FDA	U.S. Food and Drug Administration
MAT	Medicated Assisted Treatment
OUD	Opioid Use Disorder
RCO	Recovery Community Organization
SAMHSA	Substance Abuse and Mental Health Services Administration
SUD	Substance Use Disorder

Executive Summary

The opioid epidemic has emerged as a critical public health issue in communities across the United States, including in Clinton, Iowa. Public concern combined with large, multi-state legal settlements with pharmaceutical companies have created an opportunity for communities like Clinton to explore policy options for addressing opioids. Opioid use disorder (OUD) is a substance use disorder (SUD) characterized by a chronic pattern of opioid misuse. SUDs can have devastating effects on individuals, their families, and their communities as it can lead to health problems, job insecurity, financial hardship, and death.

The opioid crisis is a complex issue with a multitude of problems and systems contributing to the magnitude and severity of the issue. In Clinton, the systems that allow opioid problems to proliferate include education, healthcare, criminal justice, housing, and economic development. Demographic characteristics such as gender, race, age, socioeconomic status, and criminal history also contribute to the complexity of the SUD problem in Clinton. In our initial research and data collection phase, the lack of treatment access and the presence of stigma surrounding OUD/SUD emerged as underlying themes that worsen the OUD situation in Clinton. Treatment access refers to the availability, affordability, and quality of healthcare services available to people with OUD and SUD. Stigma refers to the negative attitudes, beliefs, and stereotypes that people hold about individuals who suffer from OUD and SUD.

This report seeks to identify and evaluate evidence-based policy options to address the barriers associated with treatment access and stigma in Clinton. The beginning of this report contextualizes the national opioid epidemic and the state of the opioid epidemic in Iowa. The report then discusses addressing social stigma and access to treatment, followed by a section focused on the background of the problem. The third and fourth sections discuss methods employed to understand the problem in Clinton, including analysis of stakeholder interviews. The concluding section discusses **ten policy recommendations for Clinton to address the opioid crisis**, including:

1. Implement public training sessions on OUD and SUD for community members.
2. Implement organizational training sessions on OUD and SUD for healthcare providers, law enforcement and EMS, and other professional communities.
3. Expand peer-support services.
4. Open a peer-support services community center that provides services specifically for OUD and SUD.
5. Expand capacity to better disseminate services.
6. Expand mental health programming through the Iowa Community Mental Health Services Block Grant.
7. Create an intercity bus route to expand access to more services in Davenport.
8. Use the opioid settlement money to fund more community beds for detox and addiction services.
9. Make naloxone more available and accessible in the community.
10. Spread awareness of the FDA's elimination of buprenorphine "X-waiver"

DEIJ Statement

Central to the team's efforts to address the opioid crisis in Clinton is a commitment to diversity, equity, inclusion, and justice (DEIJ). The team understands that people suffering from OUD or SUD come from all walks of life and represent diverse backgrounds. In general, the opioid crisis disproportionately affects certain communities, including those in rural areas, low-income households, people of color, LGBTQIA+ individuals, and people with disabilities. The team acknowledges that systemic inequities contribute to the opioid epidemic and that these disparities must be addressed to effectively combat the problem. The team is also aware that the opioid epidemic not only affects those struggling with addiction but also their families, friends, and the broader community. This team is committed to collaborating with community partners to advocate for policies and programs that create a safe, supportive, and inclusive environment for all people impacted by the opioid epidemic. The opioid epidemic is complex, and we believe that a collective and equitable approach will create meaningful and lasting change for the Clinton community.

Topic and Significance

Communities across the United States are responding to the impacts of the opioid epidemic, namely the increased incidence of opioid use disorder (OUD). Physicians often prescribe opioids to relieve pain, but the highly addictive nature of these drugs can cause a person to develop physical dependence over time.[1] This physical dependence is characterized by OUD or, more broadly, substance use disorder (SUD). Once ingested, opioids activate the opioid receptors in the brain that block the body's pain signals. Examples from the opioid class of drugs include morphine, oxycodone, codeine, hydrocodone, heroin, and fentanyl.

The Three Waves of the Opioid Epidemic in the United States

Between 1999 and 2019, opioid overdose deaths in the U.S. increased from 3 per 100,000 people to 16 per 100,000 people.[2] The beginning of the opioid epidemic can be traced back to the 1990s when the Food and Drug Administration (FDA) approved Purdue Pharma's pain management drug OxyContin.[3] The first wave of the opioid epidemic occurred from 1999 to 2010 with physicians overprescribing opioids. This practice created a population addicted to these pain relievers. Heroin defined the second wave from 2010 to 2013 with U.S. overdose deaths involving heroin increasing by 286% between 2002 and 2013.[4]

The third wave of the opioid epidemic began in 2013 and continues today. The introduction of synthetic opioids, fentanyl especially, is the main driver of this current phase of the epidemic. Pharmaceutical fentanyl is a synthetic opioid that is approved for treating pain. However, most of the harm caused by this third wave is linked to fentanyl that is illegally manufactured and distributed.[5] Fentanyl is 50 times more potent than heroin and 100 times stronger than morphine.[6] Synthetic opioid-related deaths increased by 56% from 2019 to 2020 and accounted for 82% of all U.S. opioid-related deaths in 2020.[7]

State of the Opioid Epidemic in Iowa

Fentanyl's role in the opioid crisis is having a profound impact on the state of Iowa. Fentanyl accounted for 83% of all opioid-related overdoses in 2021. As seen in Figure 1, the number of opioid-related deaths in Iowa has steadily increased since 2018.[8]

The federal government made a policy change in December 2022 that has the potential to reverse this trend in Iowa and expand treatment options in the state. Buprenorphine is a drug used in Medication Assisted Treatment (MAT) to help people reduce or quit their opioid use. In 2017, there were only 1.7 buprenorphine-waivered physicians per 100,000 people in Iowa.[9] This was the lowest rate in the U.S. The bipartisan Mainstreaming Addiction Treatment Act of 2023—signed by President Biden on December 29, 2022—eliminated the need for physicians to obtain a waiver from

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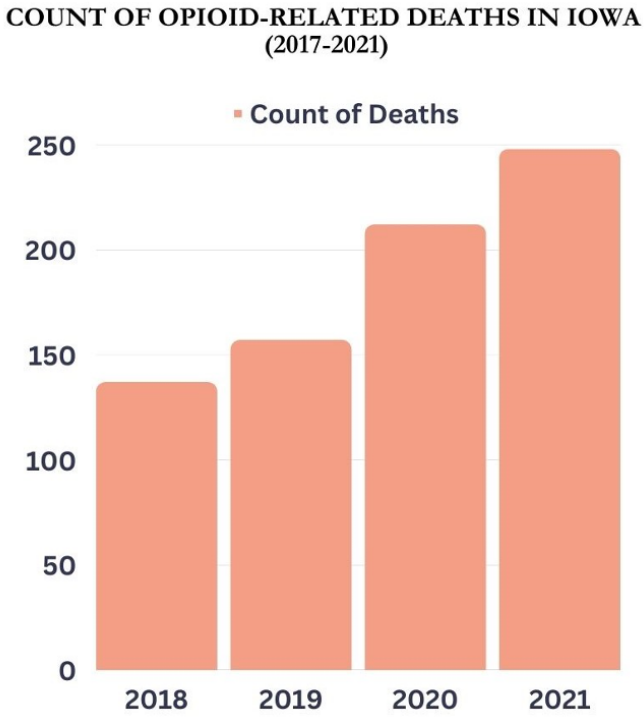
[1] "Opioids." *Opioids | Johns Hopkins Medicine*, 19 Oct. 2022.
[2] "Understanding the Epidemic." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 17 Mar. 2021.
[3] Koh, Howard. "What Led to the Opioid Crisis-and How to Fix It." *News*, 24 Feb. 2022.
[4] Jones, Mark R et al. "A Brief History of the Opioid Epidemic and Strategies for Pain Medicine." Pain and therapy vol. 7,1 (2018): 13-21. 6
[5] "Fentanyl." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 1 June 2022.
[6] "Fentanyl." DEA.
[7] "Synthetic Opioid Overdose Data." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 6 June 2022.
[8] "Prescription Monitoring Program" Prescription Monitoring Program | Iowa Board of Pharmacy, 2021.
[9] Knudsen HK. The Supply of Physicians Waivered to Prescribe Buprenorphine for Opioid Use Disorders in the United States: A State-Level Analysis. J Stud Alcohol Drugs, July 2015.

the U.S. DEA to prescribe buprenorphine.[10] The removal of the "X-waiver" barrier allows Iowa physicians to treat OUD with buprenorphine and bypass the burden of seeking approval to do so.

Figure 1: Count of Opioid Related Deaths in Iowa



Source: Iowa Board of Pharmacy, 2021

[10] Linas, B. S., & Linas, B. P. (2023, February 14). *The X-waiver for Buprenorphine prescribing is gone. it's time to spread the word*. STAT. Retrieved April 23, 2023, from **https://www.statnews.com/2023/02/14/x-waiver-buprenorphine-prescribing-gone-spread-the-word/**

Goals: Addressing Social Stigma and Access to Treatment

During the 2022 fall semester, the team identified the issues of social stigma and limited access to treatment and recovery services as the scope of its Capstone project. Exploring these two dimensions as possible barriers to successfully addressing the opioid crisis in Clinton informed the team's recommendations to bring about sustainable change.

The World Health Organization defines stigma as "a mark of shame, disgrace, or disapproval that results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society."[11] In the case of OUD and other SUDs, public stigma poses a significant barrier to treatment. The availability and accessibility of effective treatment services for OUD is influenced by public opinion.[12] Research shows that social stigma, discrimination, and policy attitudes about OUD contribute to which treatment options a community provides.[13] Stigma among healthcare professionals is also a major factor, as stigmatizing attitudes can damage the health and well-being of people with substance use disorder as it interferes with the quality of care they receive in clinical settings.[14] Stigma against people with OUD and SUD is not confined to the healthcare industry, as any caregiver that interacts with or provides services to people with OUD and SUD can hold stigmatizing attitudes.[15]

Stigma and access to treatment are interrelated issues that contribute to the ability of a community to effectively respond to addressing the prevalence of SUDs. Access refers to the "ability to obtain healthcare services such as prevention, diagnosis, treatment, and management of diseases, illness, disorders, and other health-impacting conditions."[16] Barriers to access can manifest in many forms such as limited hours, long wait times, lack of transportation, low health literacy, lack of healthcare professionals and facilities, overall poverty of individuals, and lack of insurance.[17] Therefore, to adequately respond to the issue, stigma and access and their relationship to each other must be considered.

[11] Cheetham, A., Picco, L., Barnett, A., Lubman, D. I., & Nielsen, S. (2022). The impact of stigma on people with opioid use disorder, opioid treatment, and policy. *Substance abuse and rehabilitation*, 1-12.

[12] Adams, Z. W., Taylor, B. G., Flanagan, E., Kwon, E., Johnson-Kwochka, A. V., Elkington, K. S., ... & Aalsma, M. C. (2021). Opioid use disorder stigma, discrimination, and policy attitudes in a national sample of US young adults. *Journal of Adolescent Health*, *69*(2), 321-328.

[13] Ibid.

[14] Stone, E. M., Kennedy-Hendricks, A., Barry, C. L., Bachhuber, M. A., & McGinty, E. E. (2021). The role of stigma in US primary care physicians' treatment of opioid use disorder. *Drug and alcohol dependence*, *221*, 108627.

[15] Matsos, S. (2022, April 28). *Stigma of addiction: Johns Hopkins Medicine*. Stigma of Addiction | Johns Hopkins Medicine.

[16] "Health Care Access" *Center for Health Ethics- University of Missouri School of Medicine.*

[17] Ibid.

Background

Opioid Use Disorder and Treatment Options

What is OUD?

In addition to being the cause of many overdose deaths, opioids can also lead to the development of opioid use disorder (OUD). OUD is a chronic disorder characterized by a pattern of opioid use leading to problems of distress and two symptoms outlined in the Diagnostic and Statistical Manual of Mental Disorder, 5th Edition (DSM 5-TR).[18] The American Medical Association (AMA) estimates that between 3 to 19 percent of people who take prescription pain medications develop an addiction to them.[19] OUD can disrupt relationships with friends and family, harm performance at work, and result in long-term health and legal consequences.[20]

Medication Assisted Treatment

To treat OUD, Medication Assisted Treatment (MAT) is gaining popularity among healthcare professionals as an effective measure for treating OUD. "MAT is the use of medications, in combination with counseling and other therapeutic techniques, to provide a 'whole patient' approach to the treatment of opioid use disorder."[21] By replacing opioids with other medications (e.g., methadone, buprenorphine, naltrexone) that can reduce the likelihood of relapse or overdose, MAT is an evidence-based strategy to tackle the nation's opioid epidemic. Communities like Clinton are investing in this treatment because of its effectiveness and saliency.

Naloxone

In addition to MAT, naloxone is an imperative treatment in the fight to save lives. Naloxone is a drug that reverses opioid overdoses and is approved by the FDA. Naloxone can reverse an overdose caused by heroin, fentanyl, and prescription opioid medications.[22] If administered to a person experiencing an overdose, naloxone can rapidly reverse the overdose and save the person's life. With fentanyl being the top contributor to overdose deaths, widespread access to naloxone is a key component to saving lives and providing treatment to those suffering from OUD.

Punitive Action

Outside of healthcare-based solutions, punitive action has also been employed by communities across the United States. In the U.S. prison system, the largest population of inmates are those who are incarcerated for drug offenses.[23] Though U.S. drug laws are efficient at punishing more serious offenders, these same laws give long sentences to low-level offenders. In 2009, the U.S. Sentencing Committee found that the use of punitive action as a deterrent for drug-affiliated recidivism is ineffective as only 11% of those incarcerated for drug charges are considered high-threat individuals.[24]

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[18] "What Is a substance use disorder?" *Psychiatry.org - What Is a Substance Use Disorder?*
[19] "Opioid Use Disorder." *Psychiatry.org - Opioid Use*.
[20] "Opioid Use Disorder." *Yale Medicine*, Yale Medicine, 26 Oct. 2022.
[21] National Center on Substance Abuse and Child Welfare. "Medication-Assisted Treatment." *National Center on Substance Abuse and Child Welfare*.
[22] "Lifesaving Naloxone." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 25 Jan. 2023.
[23] *BOP Statistics: Inmate Offenses*. Accessed 25 Feb. 2023.
[24] Belenko, Steven, et al. "Treating Substance Use Disorders in the Criminal Justice System." *Current Psychiatry Reports*, vol. 15, no. 11, Nov. 2013.

Punitive action policies that aim to reduce recidivism are more effective when linked with treatment. Eighty-five percent of the U.S. prison population struggles with either SUD or OUD, yet only 5% receive treatment.[25] Inserting treatment into the criminal justice system (CJS) has the potential to enhance the effectiveness of drug-related sentences. Diversion models used within the CJS are shown to reduce recidivism, and legally mandated treatment is shown to improve program retention.[26] The following models can help link the CJS with treatment:

- *Diversion to treatment:* First time offenders offered to have their cases put on hold to attend treatment. Successful treatment outcomes lead to case dismissals. These cases are always operated and controlled by the district attorney.[27]
- *Jail-based Treatment:* Despite the time-constraint of treatment in a jail setting, incarcerated individuals can be referred to intervention services or community resources.[28]
- *Prison-based Treatment:* Treatment is provided in centers within prisons through therapeutic communities (TCs).[29]
- *Treatment in Community-based Corrections:* The use of probation and parole to address substance and alcohol abuse in a community. This model of treatment is not uniform as only 1 to 9 percent of people in any drug-related programming receive this type of treatment.[30]
- *Drug Courts:* Refers offenders to long-term substance abuse and case management services. Drug courts utilize incentives and sanctions to enforce these requirements.[31]

Punitive action is only effective in deterring drug use if additional services are provided to those who suffer from SUD or OUD. The use of wraparound services—services that cater to all social needs—would reduce drug use following release instead of only during the incarceration period. In a 2021 case study performed at the University of Massachusetts Medical School, the use of wraparound services termed MISSION-CJ (Maintaining Independence and Sobriety through Systems Integration, Outreach and Networking-Criminal Justice) reduced the number of nights individuals with OUD spent in jail and reduced opioid use and mental health symptoms.[32] Components of these MISSION-CJ wraparound services included critical time intervention case management, dual recovery therapy, peer support, educational and vocational support, trauma-informed care, and risk-need-responsivity treatment. These treatments were administered jointly through a case manager and peer support specialist with lived experience.[33]

Harm Reduction

Harm reduction is an intervention technique that aims to reduce the negative externalities of certain behaviors, including (but not limited to) substance and opioid abuse.[34] While abstinence is

[25] Abuse, National Institute on Drug. "Criminal Justice DrugFacts." *National Institute on Drug Abuse*, 1 June 2020.
[26] Belenko, Steven, et al. "Treating Substance Use Disorders in the Criminal Justice System." *Current Psychiatry Reports*, vol. 15, no. 11, Nov. 2013.
[27] Ibid.
[28] Ibid.
[29] Ibid.
[30] Ibid.
[31] Ibid.
[32] "Study Shows MISSION Wraparound Services Boost Outcomes for Drug Court Clients." *UMass Chan Medical School*, 14 July 2021.
[33] Ibid.
[34] Logan, Diane E., and G. Alan Marlatt. "Harm Reduction Therapy: A Practice-Friendly Review of Research." *Journal of Clinical Psychology*, vol. 66, no. 2, 2010, pp. 201–14.

the only fail-safe method to stave off the negative effects of substance and opioid abuse, the core concept of harm reduction is to meet people where they are and provide incremental steps.[35] Some key features of harm reduction include reducing risk and harmful behaviors. Harm reduction is a public health framework that is underpinned by values of pragmatism and humanism.[36]

Harm reduction models exist on a spectrum, and support for one harm reduction technique does not equate to support for all of them. Harm reduction strategies exist for a multitude of behaviors and manifest different solutions for each.[37] For example, harm reduction techniques that address a youth drinking problem may include a roundtable discussion of good-Samaritan laws or how to drink in moderation. This same model looks different in the realm of substance abuse.

Some harm reduction techniques that stave off the negative effects of opioid use include opioid substitution, needle exchange programs, safe injection sites,[38] outreach programs, education and information, and naloxone distribution.[39] Opioid substitution programs have been developed for drugs such as heroin, oxycodone, and morphine. These programs utilize pharmacotherapy—the treatment of a disease through medication—to reduce the risks associated with illicit opioid use.[40] These programs decrease illicit opioid use, the risk of HIV, criminal activity, and opioid-related deaths. Needle exchanges have existed since the 1980s and were developed to stop the spread of bloodborne diseases. Forty-five studies from 1989-2002 have shown that these programs are effective, safe, and efficient. Some countries such as Spain, Norway, Germany, and Canada have implemented safe injection sites where individuals with SUDs have their drugs administered by nurses in a sterile environment. These programs also reduce bloodborne diseases and overdose deaths by regulating the illicit use of intravenous substances at the ground level.[41]

Outreach programs focus on reaching out to those suffering from SUD or OUD and provide them with information about behavioral risks and link them to community resources.[42] These outreach programs may include targeted interventions and allow for dissemination within hard-to-reach populations. Evidence from these programs shows they have reduced needle sharing and other types of risky behaviors.[43]

Peer Recovery & Support

Peer recovery services are a best practice for SUD/OUD and many cities have implemented these services in their communities, including Cedar Rapids, Iowa, through CRUSH of Iowa Recovery Community Center. Peer recovery services are administered by people who have personally experienced addiction and are in recovery.[44] A peer mentor can provide valuable insights into the challenges and successes of addiction and recovery and help welcome people into the

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[35] Ibid.
[36] Ritter, Alison, and Jacqui Cameron. "A Review of the Efficacy and Effectiveness of Harm Reduction Strategies for Alcohol, Tobacco and Illicit Drugs." *Drug and Alcohol Review*, vol. 25, no. 6, 2006, pp. 611–24.
[37] Logan, Diane E., and G. Alan Marlatt. "Harm Reduction Therapy: A Practice-Friendly Review of Research." *Journal of Clinical Psychology*, vol. 66, no. 2, 2010, pp. 201–14.
[38] Ibid.
[39] Ritter, Alison, and Jacqui Cameron. "A Review of the Efficacy and Effectiveness of Harm Reduction Strategies for Alcohol, Tobacco and Illicit Drugs." *Drug and Alcohol Review*, vol. 25, no. 6, 2006, pp. 611–24.
[40] Logan, Diane E., and G. Alan Marlatt. "Harm Reduction Therapy: A Practice-Friendly Review of Research." *Journal of Clinical Psychology*, vol. 66, no. 2, 2010, pp. 201–14.
[41] Ibid.
[42] Ritter, Alison, and Jacqui Cameron. "A Review of the Efficacy and Effectiveness of Harm Reduction Strategies for Alcohol, Tobacco and Illicit Drugs." *Drug and Alcohol Review*, vol. 25, no. 6, 2006, pp. 611–24.
[43] Ibid.
[44] US Department of Health and Human Services. *What-Are-Peer-Recovery-Support-Services.* 2009.

recovery community. Peer recovery services help individuals stay connected to recovery services as it provides a critical link between formal treatment programs and ongoing recovery efforts within the recovery community. Having a sense of community and shared purpose can be a powerful motivator for individuals in recovery from SUD/OUD.[45]

Peer recovery services are flexible in that they are tailored to meet the specific needs of the individual in recovery. Because recovery looks different for different people, peer recovery services allow individuals to receive the treatment that is best for them at the level of support that is necessary. There are initiatives and programs across the U.S. that aim to increase the number and quality of peer recovery services.[46]

The Peer Recovery Center of Excellence (PRCOE) is a federal initiative launched by the Substance Abuse and Mental Health Services Administration (SAMHSA) to support the development and implementation of peer recovery services in communities across the U.S. PRCOE provides support and resources to organizations that provide peer recovery services and works to promote a broader understanding of the role of peer support in recovery.[47] Iowa is part of region seven within the PRCOE system along with Kansas, Missouri, and Nebraska. Iowa and Kansas do not currently have any Recovery Community Organizations (RCOs), but there are four RCOs in Missouri and two in Nebraska.

Organizations with the RCO designation share common attributes such as being a peer-led organization that provides support and resources for individuals in recovery from SUD and their families. RCOs are run by individuals in recovery and promote long-term recovery and quality of life improvements for those in recovery. RCOs also work to reduce the stigma associated with SUDs and advocate for a more positive understanding of SUD and recovery.

Political Dimensions of the Problem

A 2022 Bipartisan Policy Center survey found that 61% of Americans consider the misuse of opioids in the U.S. to a be a major public health emergency, and 58% think Congress is not doing enough to combat the opioid crisis.[48] Further, according to a 2021 Pew Research Center survey, the share of Americans who say drug addiction is a major problem in their local community *declined* by 7% from 2018 to 2021. This data contrasts with the *increasing* rate of fatal overdoses from 21.7 to 28.33 per 100,000 people during that same time span.[49] The reason for this disparity is unclear, but the salience of other issues such as the economy and the COVID-19 pandemic may be overshadowing the severity of the opioid epidemic.

Both Republicans and Democrats recognize the importance of addressing the opioid epidemic. Republicans tend to prioritize initiatives that focus on addressing illicit drug trade, while Democrats tend to prioritize holding pharmaceutical companies accountable.[50] However, both parties have expressed support and taken action to expand naloxone availability and increase funding for drug courts. Drug courts—like the one in Clinton County—provide an alternative to incarceration for individuals with OUD/SUD.

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[45] Ibid

[46] *Peer Recovery CoE.*

[47] Ibid

[48] "Views on the U.S. Opioid Crisis: A BPC-Morning Consult Poll." *Bipartisan Policy Center*.

[49] Odabaş, Meltem. "Concern about Drug Addiction Has Declined in U.S., Even in Areas Where Fatal Overdoses Have Risen the Most." *Pew Research Center*, Pew Research Center, 31 May 2022.

[50] Stoke, Daniel C. and Agarwal, Anish K. "Partisan Politics and the Opioid Epidemic: A Social Media Analysis" *University of Pennsylvania Leonard David Institute of Health Economics,* 21 May 2021.

Government Action

On October 16, 2017, the U.S. Department of Health and Human Services (HHS) declared that the opioid crisis presents a public health emergency.[51] On December 22, 2022, HHS renewed the determination that "a public health emergency exists nationwide because of the continued consequences of the opioid crisis".[52] Additionally, in September 2022, the Biden administration provided $1.5 billion to U.S. states and territories to address the opioid crisis. The Iowa Department of Health and Human Services (Iowa HHS) received $9 million in state opioid response money as part of the allocation.[53] As of April 2023, Iowa HHS has not announced its plans for spending that money.

State of Iowa Opioid Settlements

As part of a multi-state lawsuit, the State of Iowa settled claims that certain prescription drug companies and pharmaceutical distributors engaged in misleading and fraudulent conduct in the marketing and sale of opioids and failed to detect or prevent diversion of the drugs. The State of Iowa allocated the settlement money across its 99 counties. Clinton County will receive payment totaling $1,124,293.98 over the next 17 years. The County is required to use these funds for activities to remediate the opioid crisis and treat or mitigate OUD and related disorders through prevention, harm reduction, treatment, and recovery services.[54]

Clinton County Settlement Allocation

Clinton will receive funds from two settled claims: $913,448.13 from Amerisource Bergen, Cardinal, and McKesson (FY 2023-2039) and $210,845.84 from Janssen between (FY 2023-2032) for a combined total of $1,124,293.98.[55] At the time of the report, Clinton County has not yet announced its plan for these funds

Community Profile: Clinton, Iowa

Clinton sits on Iowa's eastern border along the Mississippi River, northeast of the Quad Cities and southeast of Dubuque. Clinton is the county seat of Clinton County and had an estimated population of 23,434 in July 2021 according to the U.S. Census Bureau.[56] As Table 1 illustrates, Clinton's median household income ($50,154) is lower than the state median income ($65,429). Clinton residents also attain fewer bachelor's degrees than the state average; 20 percent of Clinton residents have a bachelor's degree compared to Iowa's 29.7%. Clinton has a slightly higher percentage of people under 65 without health insurance at 7.8% compared to Iowa's 5.8%. There is also higher percentage of people in Clinton experiencing poverty (17.8%) compared to the rest of the Iowa (11.1%).

Table 1: Clinton, Iowa vs. Iowa Demographic Data

[51]Davis, Julie Hirschfeld. "Trump Declares Opioid Crisis a 'Health Emergency' but Requests No Funds." *The New York Times*, The New York Times, 26 Oct. 2017.
[52] "Declarations of a Public Health Emergency." *List of Public Health Emergency Declarations*.
[53]. Robin Opsahl, Iowa Capital Dispatch December 7. "Iowa Legislators Will Enter 2023 Session with $19 Million in Opioid Settlement Funds." *Iowa Capital Dispatch*, 8 Dec. 2022./
[54] "Opioid Settlement Information." *Iowa State Auditor*.
[55] "Opioid Settlements." *Iowa Attorney General*.
[56] U.S. Census Bureau. (2022, July 1).

Demographic	Clinton, Iowa	Iowa
Total Population	24,434 people	3,197,689
Age		
Persons under 18 years	20.9%	23.1%
Persons 65 years and older	19.6%	17.7%
Race and Hispanic Origin		
White alone	89.1%	90.1%
Black or African American	5.1%	4.3%
American Indian and Alaska Native	0.5%	0.6%
alone	0.6%	2.8%
Asian alone	4.6%	6.7%
Hispanic or Latino	4.4%	2.1%
Two or More Races		
Housing		
Owner-occupied housing unit rate	68.4%	71.6%
Median value of owner-occupied units	$103,800	$160,700
Education		
High School graduate or higher	88.6%	92.8%
Bachelor's Degree of Higher	20.0%	29.7%
Health		
With a disability, under 65 years	13.4%	8.1%
Persons w/o health insurance, under 65 years	7.8%	5.8%
Income and Poverty		
Median Household Income	$50,154	$65,429
Persons in Poverty	17.8%	11.1%

Source: US Census Bureau, American Community Survey, 2022

In the 2022 elections, most Clinton residents voted Republican in the U.S. Senate (Grassley) and House (Miller-Meeks) races. At the state level, Clinton County's two Iowa House representatives (Determan and Mommsen) and its Iowa Senator (Cournoyer) are Republicans. At the County level, six out of eight supervisors are Republican while one official does not have a political affiliation. The City of Clinton has a mayor-council form of government. The mayor is the chief executive officer and is responsible for overseeing the day-to-day operations of the city. There are eight members of the City Council, including the mayor.

Treatment Providers in Clinton

There are numerous organizations in Clinton working to address the opioid crisis and the prevalence of SUD. Clinton Area Substance Abuse Council (CSAC) is a leading organization that collaborates with community partners and the city to develop strategies for addressing the abuse of

opioids and other substances. CSAC is a nonprofit organization that supports community efforts to prevent and treat substance abuse. CSAC is the only comprehensive substance abuse treatment agency in Clinton as of March 2023 when Life Connections—a mental health and substance abuse services organization—closed their substance abuse division. Due to the limited number of providers in the city, the average wait time to get a scheduled assessment with CSAC is three to four weeks (as of 2020).

Additionally, there is only one primary healthcare provider for every 1,840 residents in Clinton compared to the Iowa average of one primary provider for every 1,360 residents.[57] Mental healthcare access in rural Iowa is also a struggle to attain. In Clinton, there is one mental healthcare provider for every 1,000 residents compared to the Iowa average of one mental healthcare provider for every 820 residents.[58]

Community Resources United to Stop Heroin (CRUSH+) and the Drug Abuse Response Team (DART) are two auxiliaries of CSAC that provide services to people with OUD. CRUSH+ consists of community members who seek to increase awareness of SUDs and addiction and expand treatment options. The goal of DART is to identify, educate, treat, and prevent opioid abuse through a multidisciplinary team.

MercyOne Clinton, a nonprofit healthcare organization, opened the Medication Assisted Treatment (MAT) Clinic in October 2019. The MAT Clinic only operates from 1:00-5:00pm on Wednesdays. Currently, the clinic serves twenty-three patients on a weekly, biweekly, or monthly basis. 57% of patients are male, 43% are female, and the age range is 25-65. In the 3.5 years since the MAT Clinic opened, 51 people are no longer receiving services for various reasons.

The Clinton County Resource Center is an innovative addition to the Clinton community in that it allows direct access from the county jail to the county resource center – simply a hall's walk away. The logic here is that individuals being held in jail can often benefit from community resources upon release – if they choose to seek them out. The Clinton County Resource Center was a collaborative effort between Clinton County's sheriff, attorney, judge, and corrections officers that aimed to fill in the systemic gaps they encountered when trying to help people improve their opportunities in life.

Other Limited Services

Clinton currently has no supply of low barrier shelter options for individuals struggling to find or maintain a safe, reliable shelter away from the physical influence of drugs. The Victory Center, a local church, provides shelter for those in need, but there are many barriers associated with this option. Finally, the City of Clinton has and distributes hotel vouchers to those in need, but this is not a cost-effective, sustainable alternative.

There is also a lack of local administrative capacity to staff a local Social Security Office in Clinton. Since there is no physical office in town, qualified individuals seeking benefits and services must call and wait on the phone for extended periods of time to set up benefits. The lack of administrative capacity extends to submitting applications for and securing Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI).

[57] "Community Needs Assessment Clinton, Iowa" *MercyOne*

[58] Huisenga, Kristin. "Documentation of Rural Challenges."

Methodology

The team employed various methods to collect data relevant to the two components of the project scope: stigma and treatment access. Data collection took place in two phases. The first phase consisted of literature reviews and case studies, and the second phase consisted of stakeholder interviews. Literature reviews and case studies are important tools for understanding opioid use disorder (OUD) and substance use disorder (SUD) based on the best available research and information. These data collection methods identify existing programs and policies and contribute to the development of evidence-based policy recommendations. Stakeholder interviews were conducted to understand attitudes towards people with OUD and SUD and to identify existing barriers to treatment in Clinton. The information collected from literature reviews, case studies, and stakeholder interviews was essential to developing policy recommendations for this report.

Literature Reviews and Case Studies

The team conducted background research to learn about the context of the opioid addiction crisis in the U.S. and in Iowa. Preliminary literature reviews contributed to team knowledge about OUD, SUD, MAT, and naloxone; the debate surrounding punitive action versus harm reduction treatment approaches; and the relationship between stigma and treatment access. The goal of these literature reviews and case studies was to understand the existing evidence surrounding issues within the project scope of examining access and stigma. The team consulted a variety of different sources such as new articles, case-studies, academic papers, reports, and books.

Stakeholder Interviews

The team conducted interviews with various professionals in Clinton who have a stake in the opioid crisis or in the community's polysubstance abuse problem. Stigma is a personal and complex topic, and interviews provide a space for participants to share their perspectives and experiences. The interviews consisted of open-ended questions that allowed interviewees to share their own perspectives of issues related to opioids. Based on the answers to the interview questions, the team assessed if and how stigma presents in the Clinton community and identified barriers to accessing treatment.

Initially, our project co-leads introduced us to seven stakeholders who work in fields connected to substance use. The team also utilized a snowball method wherein we asked interviewees for additional stakeholders with whom we could talk. To comply with the Institutional Review Board's (IRB) standards for academic research, we did not speak with anyone who was actively living with a substance use disorder. The interviews were conducted in-person or over video call and lasted between 30 minutes to one hour.

In advance of each interview, the team sent the interviewee a list of general questions that were common to every interview. We also asked additional questions to learn about the interviewee's expertise or to elaborate on responses. The standard interview questions were:

1. Which organization are you affiliated with and what is your role?
2. What challenges do you face in your job/role?
3. What are the challenges that your clients/patients face?
4. What problems do you see with treatment access here in Clinton?
    a. Do you see these problems firsthand?
5. What problems do you see with stigma here in Clinton?

6. Do you have access to any data that you think would be useful for our research?
7. If you had a magic wand, and you could make any one thing happen to address the opioid problem in Clinton, what would it be?

To analyze the results of the stakeholder interviews, the team highlighted responses to questions that were similar to other interviewees' responses; this helped to identify the most frequently shared concerns about Clinton's opioid and substance abuse problems.

Findings and Discussion

In total, the Opioid Capstone team interviewed 12 local and expert stakeholders who are connected to the broader opioid crisis and substance abuse problems in Clinton. These interviews were conducted between February and April 2023. A list of each interviewee's organization, role, profession, and sector is provided in Table 2.

The conversations with the 12 stakeholders provided local context to the current state of the Opioid Epidemic in Clinton, Iowa. Five common themes emerged from these interviews: (1) increased demand for SUD/OUD treatment and recovery services; (2) barriers to treatment; (3) stigma as a barrier to treatment access; (4) innovation in building administrative capacity; and (5) the interconnected professional network in the community. While there are areas of improvement the community can make, these interviews also highlighted the assets and strengths already existing within Clinton. This section will highlight the findings from the interviews and provide a discussion of how these themes relate to addressing stigma and access as it relates to the providing services and resources to people with OUD and SUD.

Table 2: Interviewee Organization, Roles, and Profession

Organization	Role	Profession	Sector
7th Judicial District, Department of Correctional Services	Employee	Public Management	Public
Cedar Rapids CRUSH+	Peer Recovery	Substance Abuse Treatment	Nonprofit
Clinton Area Substance Abuse Council	Employee	Substance Abuse Prevention & Treatment	Nonprofit
Clinton County	Administration of Justice	Elected Official	Public
Clinton County	Administration of Justice	Elected Official	Public
Clinton Fire Department	Firefighter/Paramedic	Firefighter/Paramedic	Public
Clinton Police Department	Corporal	Law Enforcement	Public
Clinton Police Department	Lieutenant	Law Enforcement	Public

Life Connections	Provider	Mental Health / Substance Use Counseling	For Profit
Life Connections	Provider	Mental Health / Substance Use Counseling	For Profit
MercyOne Clinton	Provider	Behavioral Healthcare	For Profit
University of Iowa Hospitals & Clinics Addiction and Recovery Collaborative	Provider	Healthcare/Academia	Public

Theme 1: Increased demand for SUD/OUD services

Providers of substance abuse treatment spoke about the challenges that arise from the high demand for treatment services. Each interview also mentioned the importance of addressing mental health services and SUD *together*. In Clinton, the supply of services does not meet the increasing demand. Bridgeview and Community Health Care are the only two local providers for mental health services, and the interviewees spoke about how this is not enough to meet the demand of people needing services. For those seeking substance abuse treatment and recovery services, Clinton Substance Abuse Council is the only organization providing these services with the closure of Life Connections in March 2023. Additionally, one member of the Clinton Fire Department (CFD) spoke about how they felt their job did not allow them enough time to adequately serve community members who struggle with OUD/SUD.

The interviewees discussed that many of the people with SUDs are seeking and/or receiving multiple services. In Clinton, people with SUD have a history of interacting with a few or all of the following organizations: MercyOne, the Clinton County Resource Center, the City of Clinton Police Department, the City of Clinton Fire Department, mental health services, substance abuse and treatment services, housing services, and the criminal justice system. This places a demand on not only treatment and recovery services, but other social and community services as well. For instance, of the clientele served at the Clinton County Resource Center, most people (~75%) have substance-use disorder(s), and 1 in 2 clients are seeking housing services. Additionally, with the Resource Center being housed in the Clinton County Jail, there are also many clients with a history of interacting with the criminal justice system. For Clinton County in 2022, there were 228 substance-use related criminal cases. The City of Clinton reported 73 drug related arrests. Increased demand for SUD/OUD informed the policy recommendations by emphasizing the importance of proposing recommendations that are multi-dimensional and address many facets of the issue.

Theme 2: Barriers to treatment

Transportation

Professionals in Clinton identified multiple barriers that prevent individuals from accessing addiction treatment and recovery services. To access addiction treatment services, individuals must be able to move from their point of reference to the location where services are provided. Most individuals actively struggling through addiction do not have the financial means necessary to meet their own transportation needs. The Clinton Sheriff's Office is aware of the demand for increased transportation services, and they are currently serving as the only pickup and drop-off service

available for Clinton residents that are involuntarily committed to the hospital for mental health services or SUD/OUD treatment.

Healthcare

Healthcare is another barrier to treatment identified through the interviews. With 84% of Life Connection's clientele receiving and utilizing Iowa Medicaid benefits to access SUD/OUD programming and services in Clinton; this indicates a necessity for the State of Iowa to economically incentivize private investment in SUD/OUD programming and treatment. This rural public health crisis (increased SUD/OUD) can be avoided with proper public policy interventions. Iowa Medicaid has not updated fee schedules in this service sector for a decade and it is placing an increasingly large and stifling economic burden on the ability of private, local providers to step in and help be a part of the solution within their own communities. Another challenge that stakeholders identified was the lack of a reliable detox center. MercyOne Clinton has the capacity in its emergency department (ED) to treat SUD, OUD, and mental health conditions.

Comorbidity

The comorbidity, or simultaneous presence of two or more diseases or medical conditions in a patient, of SUD/OUD and mental health diagnoses is high. This comorbidity functions as a barrier to individuals seeking to access SUD and OUD treatment services. There are two local mental healthcare providers in the community of Clinton. These providers include Bridgeview Community Mental Health Center and Community Health Care. Neither of these local mental healthcare providers refer individuals for more intensive services. Clinton residents struggling with mental health diagnoses are effectively barred from receiving the level of care they can, should, and need to access to do their part in maintain a healthy community. Common barriers to treatment access in Clinton are listed in *Table 3: Barriers to Access.*

Table 3: Barriers to Treatment Access

Current barriers to accessing services:	Why can't it be easily fixed?	Outcomes:
• Demand for transportation	• Expensive and inconsistent	• People fall through the cracks and cannot access services.
• Comorbidity of SUD, OUD and mental health	• Self-medicating due to lack of access	• People's health conditions worsen while addiction increases.
• Demand for referral services to more intensive treatment	• Lack of administrative capacity	• Community is stuck trying to support people without the necessary resources.
• Increased crime and death rates (for people with mental health and SUD/OUD)	• Requires intersectional, interdisciplinary collaboration across multiple stakeholders.	• Individuals arrested for SUD/OUD and mental health related crimes are removed from state benefits (after 28.5 days in jail)

	• Trend towards criminalization of SUD/OUD	
• Stigma*	• Stigma around recreational drug usage and addiction (i.e. "Just say no")	• Social stigma surrounding drug usage and addiction is maintained and perpetuated.
• No supply of low barrier shelter in town	• Expensive and political NIMBYism	• Individuals struggling with addiction are forced to find shelter in local networks – often those same networks where they purchased drugs.
• No Social Security office in town	• Lack of administrative Capacity	• People who are eligible for benefits are less likely to apply for and receive assistance.
• Increased local population suffering with SUD/OUD	• Requires multiple systems collaborating	• More people are struggling and falling through the cracks of more systems

**All Barriers to Access were collected from Interviews*

Theme 3: Stigma as a barrier to treatment access

The stigma held by healthcare providers in Clinton creates a barrier to treatment access for those who seek treatment on their own accord. Professionals broadly shared the challenges associated with the newness of addiction treatment services and programming during a time of high community need. To address these challenges, stakeholders reported that they are working to increase recruitment, expand educational programs and physical programming space, and collaborate with community partners. They also explained how the stigma held by Clinton healthcare providers has an effect of reducing the actual and perceived levels of addiction treatment in the community. Criminal stigma is also present in Clinton. Populations aligning with the description of individuals committing increased rates of crime necessarily face increased social stigma from law enforcement and law-abiding society members. Criminal stigma does not end on the street, and in fact it follows individuals seeking addiction and mental health treatment and services into the healthcare facilities

they are asking for help. Table 4 illustrates the presence of stigma in Clinton at the individual (social stigma) and organizational levels, and in general.

Table 4: Types of Stigmas Identified in Interviews (Quotes)

Social-Stigma	Organizational Stigma	General Stigma
- "Back door versus front door release of inmates. Nobody from the front side of the building sees these people. So many times, they saw people draped around the place & knew they would be back soon." - "We have another place for you to go when you are getting out of [jail]." - "Buy-in from some judges [helped] move the public defender office next door to the Resource Center." - "[A] mental health advocate in the jail meets with inmates to help [with] mental health."	- "People with substance use disorder are treated negatively by healthcare providers." - "It's common for concerns to be minimized." - "People are given a label and treated accordingly—especially for illicit drugs." - "People like to complain about people with substance use disorders without taking action to help." - "Subconsciously—when people with addiction or mental health issues come into the ED, that is automatically assumed to be the problem. [For example] one patient with [a] meth addiction said her family automatically thinks she is using no matter what."	- "I believe that most people want to be kind and compassionate and want to provide good care to patients. But we have laws and policies and culture and attitudes that are embedded, and so we can end up perpetuating stigma without even realizing it. For example, **there are pervasive attitudes that a person who uses drugs should not be a parent. While this is changing to some degree, we have taken children away from parents who use substances instead of providing treatment to the parent. Everyone loses in these situations.** We need to have policies and procedures that direct the resources needed to keep families together and support them in the process of recovery."

**All quotes were collected from interviews*

Theme 4: Innovation in building administrative capacity

In addition to high levels of stigma, there are also many aspects of bureaucratic red tape within public administration that has frustrated agents within the local systems aiming to help improve outcomes. This has led to many actors in Clinton finding innovative solutions. Access to SUD/OUD services and treatment in Clinton is decentralized. There are many systems, programs, authorities, and organizations interacting with individuals amid their struggle with use disorders. Many interviewees expressed frustration at the ways in which bureaucratic justice and public administration systems are intentionally designed to place a tremendous burden on criminals returning to society. Which has led stakeholders across multiple sectors to come together to discuss potential solutions that can be implemented soon.

The team learned through visiting the Clinton community that its opioid stakeholders are receptive to and eager for innovative ideas and suggestions for local interventions that can mitigate negative outcomes of OUD and SUD. The work these local professionals perform within their roles is often interdisciplinary and overlapping. Through the interviews, current practices that highlight

innovation in building administrative capacity in the criminal justice system emerged. This includes: the county jail serving as a de facto mental health institute, moving the public defender's office next door to the county resource center, and having a mental health advocate meet with inmates to help determine mental health. Additionally, stakeholders identified the importance and added-value that an increase in peer-support and mentorship services could have on the Clinton community.

Theme 5: Interconnected professional network

Through interviews with Clinton stakeholders, the team discovered that the interviewees knew one other and were familiar with each other's work. These stakeholders were eager to provide suggestions for additional people to add more context, different perspectives, and new expertise to the interview process. This existing network is a resource and essential asset that Clinton already is and should continue to utilize when addressing the opioid crisis.

Additionally, various stakeholders are currently working together to come up with solutions for the community. DART is one example of an interdisciplinary approach as CSAC and the City of Clinton Police Department work closely together to identify, educate, treat, and prevent drug abuse, addiction, and fatalities within Clinton. This collaboration across various stakeholders is a tremendous asset to the community and shows the commitment of Clinton to make progress towards providing resource and services to those with SUD and OUD in the community.

Discussion: Stigma and Access

The interviews the team conducted with stakeholders confirmed the importance of approaching the issue under the stigma and access dimensions. Many of the problems centered around accessing SUD/OUD treatment and recovery services are connected to stigma. For example, interviewees agreed that "it takes courage to take the first steps towards recovery." In addition to this self-stigma, most SUD/OUD clients seeking treatment and services are court-mandated, meaning they must comply with sobriety check-ins from the justice system. This engagement with the punitive justice system continues to exacerbate internal, external, and general stigma associated with SUD/OUD treatment.

Stigma is a large barrier between accessing local programming and recovery services, in addition to healthcare treatment and services. Therefore, it is reasonable to fully consider how and why the different aspects of stigma interact in the ways they are presenting within the Clinton community. Regional providers indicated that "there are not enough clinics and clinicians who treat opioid use disorder. Some who do provide treatment use outdated, punitive or stigmatizing practices. We need more low-barrier entrance points to care scattered around the state. Every week I meet people who must travel a long distance for care or who have had negative experiences with the healthcare system in the past."

Recommendations

The following section highlights several promising strategies to decrease stigma and/or improve access to treatment and recovery services. Some recommendations require up-front investments while others cost less but require community members to work together in new ways. The recent availability of settlement funds suggests that both sets of strategies may be within reach for Clinton.

1. Implement public training sessions on OUD and SUD for community members.

These training sessions should be free to the public and administered by a group of people that are in recovery themselves, substance use professionals, and mental health professionals. Education across all levels will be imperative to addressing stigma and educating people on the impacts of SUD and OUD. It is recommended that Clinton Substance Abuse Council take the lead in organizing and designing these trainings as they have the experience and personnel to adequately deliver these training sessions for community members. Also, the training should be held at a public location accessible by public transportation routes, such as the Clinton Public Library. To get the community to attend these training sessions, multiple organizations can team-up to sponsor the events and provide incentives to people for attending. These trainings should be a part of a series where each session focuses on one topic. Topics for the series include:

- signs and symptoms of OUD and SUD
- risks and consequences of OUD and SUD
- recognizing and responding to an opioid or substance use-related emergency
- specialized training on administering naloxone
- supporting individuals in recovery from opioid or substance use disorders
- addressing personal stigma.

2. Implement organizational training sessions on OUD and SUD for healthcare providers, law enforcement and EMS, and other professional organizations.

Organizational training sessions must be tailored to specific organizations' needs. In Clinton, organizational training should be offered to healthcare providers, law enforcement and EMS, and other community organizations. These training sessions should focus on how to identify and address OUD and SUD-related stigma with their respective organizations and provide resources and support to those affected. Each training should be tailored to fit the organization's needs and address how stigma materializes in their daily operations.

It is recommended that CSAC be responsible for working with different community organizations to hold trainings as they have the experience and personnel to adequately deliver these training sessions for various organizations. Additionally, these organizational training sessions should have an evaluation and certification process that recognizes individuals and organizations that meet certain standards of excellence in OUD and SUD training and care. This evaluation will assess the knowledge, skills, and attitudes of professionals who successfully complete the training.

3. Expand peer-support services.

Peer support services can be effective for addressing SUD by providing supportive and non-judgmental space for individuals to share their experiences, be around positive role models, and access affordable and accessible resources. Peer support services are provided by people who have experienced OUD/SUD themselves and have first-hand knowledge of the challenges that come with addiction. Peer recovery services can include peer-led support groups, peer recovery coaches, and Peer Recovery Centers.

3a. Peer-led support groups: These groups are led by individuals who have experienced substance use disorders themselves and can provide a space for people to support each other in their recovery journeys.

3b. Peer recovery coaches: Peer recovery coaches are individuals who have received training in support of others in their recovery from substance use disorder. Coaches can provide one-on-one support and guidance, in addition to connecting individuals with resources and services that aid in their recovery.

4. Open a peer-support services community center that provides services specifically for OUD/SUD.

The team recommends that the City of Clinton create an extension center of the Clinton County Resource Center. These two centers should work closely together to provide services to people with OUD and SUD addiction and those in recovery. How these two centers differ is through their services. The Clinton County Resource Center should continue existing in its current form of being an entry point for referring and connecting people to a variety of services.

Currently, the Clinton County Resource Center provides resources in mental health, physical health, substance use, housing/shelter, medication, accessing benefits, employment, transportation, computer/phone access, and general support. While the Clinton County Resource Center focuses on referring and connecting people to services, this proposed branch location should focus on providing peer-support services.

Peer-recovery centers are community-based centers that provide a range of services and support for individuals with addiction and those in recovery. These centers are typically run by people in recovery themselves and can be a valuable resource for individuals looking for support and connection. Services include peer-support groups, educational workshops, and social activities. By implementing the features of recommendation #3 into the center, the new center will provide a place for people to not only receive peer-support services, but other services as well.

In addition to being an evidence-based practice supported by research and current best practices, many of the stakeholders the team interviewed, identified the desire of a peer recovery center for Clinton. A peer support recovery center is appropriate for Clinton as it not only improves access to services but can also address stigma. The team recommends Clinton follow the framework established by the Peer Recovery Center of Excellence (PROCE) initiative and become a Recovery Community Organization (RCO). RCOs have been successful in many communities across the United States at bridging the gap between services and connecting people in recovery to resources.

RCOs emphasize the role of community in the recovery process and support recovery by fostering a sense of community that is committed to long term recovery. The target audience for an RCO are people with substance use disorder, their friends and family, and people in recovery. In Clinton, there are a group of individuals, such as CRUSH+ who are committed to implementing

more peer support services. These individuals are in recovery themselves and want to build a community that fosters long-term recovery initiatives.

Services and elements that should be incorporated at the Resource Center include:

- a user-friendly and welcoming facility located in downtown Clinton
- involvement of the families of people struggling with SUD/OUD
- public training on OUD and SUD stigma
- increased Narcan accessibility and training
- Crisis Intervention Training
- training for organizations about OUD and SUD stigma
- peer recovery support services
- physical and mental health activities such as yoga, exercise programs, and physical and mental health programs
- vehicle fleet to transport people to appointments, interviews, and other services.

5. Expand Capacity to Better Disseminate Services.

The need for more capacity in Clinton can be seen through the administrative burden that exists for individuals seeking treatment and services. Administrative burden is when the access to governmental services is barred in part by the learning, process, or psychological burdens of applying for/seeking help. These administrative burdens can be mitigated through resource folders and the hiring of a social services specialist.

5a. Resource Folders: Resource folders would be folders given to those leaving jail or drug court and would be filled with information on various services, from treatment centers and programming to social services available to them. This information is already available at the Clinton Resource Center and therefore the only costs would be the purchasing of folders. Directly providing these folders also mitigates barriers to access for those who do not feel comfortable in the county courthouse.

5b. Social Services Specialist: The City of Clinton should use the opioid settlement money to contract out a social work to come to the Clinton Resource Center once a week to help individuals apply for/get back on social services. Through our interviews we discovered that being in jail for 29.5 days means that social services are cut off, and there are barriers for this population to get these services back. By providing a specialist to work with these individuals, Clinton could ensure that those who need services are able to receive them. The average base salary for a social worker in Iowa is $47,529 a year,[59] meaning the cost per hour would be approximately $22. If the social worker were contracted to come for one full day a week, the yearly cost (at $22/hour) would be $6,864.

6. Expand mental health programming through the Iowa Community Mental Health Services Block Grant.

With the closure of the addiction treatment branch of Life Connections in March 2023 there is a new gap in services for those suffering from OUD and SUD. Therefore, expansion of services through the community mental health center, Bridgeview (or other mental health providers deemed

[59] *Social worker salary in Iowa*. (n.d.). Retrieved April 9, 2023.

suitable at the city's discretion), is needed to offset this new service gap. The state of Iowa receives $5.5 million in federal funding a year to address mental health in the state.[60] Services aimed at addiction treatment are permissible under this grant in accordance with Part B of the Title XIX of the Public Health Service Act, through which funding is authorized.[61] The planning step for this grant are as follows:

> ***1. Assess the strengths and organizational capacity of the service system to address specific populations:*** The current strengths of Clinton when facing OUD and SUD is the goals of involved stakeholders: to provide more services to those suffering from addiction. This unification of views was solidified by the round-table discussions that resulted in the creation of the Clinton Resource Center. The organizational capacity of Clinton for this issue is therefore high, with many stakeholders having identified and worked together on this issue before.
>
> ***2. Identify the unmet service needs and critical gaps within the current system:*** Through our interviews we have discovered some limitations to capacity in mental health services aimed at addiction. First, that Medicaid scheduling for mental healthcare in Iowa has not been updated to allow for sustainable services; and second, that there is a lack of staff at Bridgeview, barring access for more individuals to receive treatment.

After these steps are taken, the community must then set up performance indicators to measure the success of programming and create planned expenditures. Other necessary information, such as state health disparities and environmental factor plans are included in the grant with the required information from the state already filled out. The link to the grant can be found in Appendix 3.

7. Create an intercity bus route to expand access to more addiction services in Davenport.

Due to the gaps in services found for mental health in Clinton, expansion of transportation to other communities would allow for higher access. The creation of an intercity bus route from Clinton to Davenport would allow for citizens to easily access Davenport for health services. This would also provide a service to the whole community allowing for higher mobility, as Davenport has bus routes to Iowa City, Des Moines, and Chicago. The following steps would need to be completed to create this bus route:

- Intercity Bus Assistance Program Project Proposal: the form necessary to apply to this project can be found **here**
- Authorizing Resolution
- Labor Protection Agreement
- Certifications and Assurances
- Minority Impact Statement

[60] *Community Mental Health Services Block Grant, Iowa Department of Health and Human Services.*
[61] Ibid.

8. Use the opioid settlement money to fund more community beds for detox and addiction services.

During our interviews within the community, we learned that the main provider for detox, MercyOne, only had 3 beds available and these were often underutilized. The opioid settlement money provided to the City of Clinton should be used to expand the number of beds provided to the community by at least 2. The average cost of a standard hospital bed frame is $4,500, so the initial capital cost would be around $9,800, plus the cost of mattresses. The expansion of these beds would allow for more treatment and healthcare access in Clinton.

9. Make naloxone more available and accessible in the community.

The affordability of naloxone and the stigma surrounding the purpose of carrying naloxone are barriers to accessing this life-saving drug. The City of Clinton and Clinton County should explore ways to increase the availability of free naloxone in the community so that this remedy is easily accessible by people with OUD or bystanders to an overdose event. It should be noted that individuals with a current opioid prescription for a legitimate health concern can be at risk for an overdose even if they do not experience OUD. The list below details specific recommendations for expanding naloxone availability:

1. Stock naloxone for emergency use at local government buildings: This practice would increase the likelihood that naloxone can be accessed nearby during an overdose event. Individuals at risk of an overdose may not be able to access naloxone on their own due to affordability or stigma, so nearby access can ensure that doses are available in an emergency. The relatively small cost of purchasing a few naloxone doses to have on hand at facilities with public use can make the drug accessible to people who cannot afford it on their own.

2. Partner with pharmacies to provide more free naloxone to the community: More doses in the hands of community members increases the likelihood that someone can administer naloxone during an overdose event. Free distribution sites should include government buildings (other than the police station) to reduce the stigma that people may experience at pharmacies. The newly approved over the counter (OTC) version of Narcan may be a cheaper option for local governments to purchase.

3. Train more government employees to recognize the signs of an overdose and administer naloxone: These trainings would require minimal effort as naloxone is most commonly available in the form of a nasal spray. Government employees have a duty to serve the public, and they should be prepared to intervene if they are in a position to help someone who is experiencing an overdose.

10. Spread awareness of the FDA's elimination of buprenorphine "X-waiver".

The Clinton community has historically limited access to MAT options. The MercyOne MAT Clinic only operates one day per week and before the "X-waiver" requirement was lifted in December 2022, there were only two physicians in Clinton who had obtained the waiver and could

prescribe buprenorphine.[62] According to SAMHSA, buprenorphine can reduce cravings and withdrawal symptoms, decrease the likelihood of opioid misuse, and enhance safety in the event of an overdose.[63] Now that any physician can freely prescribe this MAT drug, the next step is to get the word out and encourage Clinton practitioners to treat OUD. The City of Clinton and Clinton County should utilize communication channels to increase awareness of buprenorphine accessibility among the public and the medical community.

Evaluation of Recommendations: 4 E's

A short evaluation of our recommendations is provided in Figure 2 to the left, denoted by number. The definitions for these evaluation lenses are provided below:

Equity: Fairness, justice, and equity in services and policy within the management and institutions serving the public.

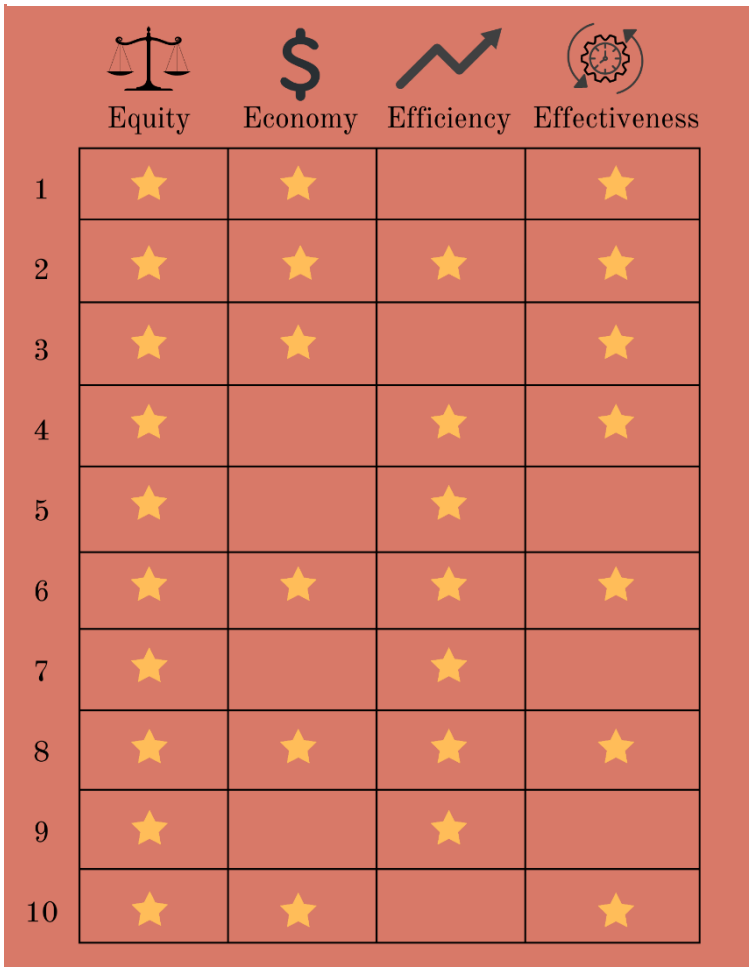
Economy: Managing resources to get the desired level of service for the least amount of cost.

Efficiency: Providing public services so the greatest output/results are gained through the least amount of input possible.

Effectiveness: Successfully producing the desired result or accomplishing a set of goals.

The use of these lenses to evaluate our recommendations is due to these values being highly integrated in public affairs and policy. This evaluation is provided to visualize the costs and benefits of each recommendation by these standards.

Figure 2: Recommendation Evaluation



62 Substance Abuse and Mental Health Services Administration. (2023). *Buprenorphine Practitioner Locator*. SAMHSA.
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Appendix 1: Opioid Settlement Money

The overall lump sum of money that Clinton County will receive from the opioid settlement is $1,224,293.98. This money can be used to fund any activities to remediate the effects of the opioid epidemic and any related disorders. This money comes from two sources: the distributors (AmerisourceBergen, Cardinal, McKesson) and the manufacturer (Janssen and Mallinckrodt). Below are the yearly cycles of distribution.

Table 5: Mallinckrodt Payout

	Payment 1 (2023)
Clinton County	$8,278.73

Data Source: Iowa AuditorAppendix 1 cont.

Table 6: Janssen Payout

	Payment 1 (2023)	2 (2023)	3 (2023)	4 (2023)	5 (2023)	6 (2027)	7 (2028)	8 (2029)	9 (2030)	10 (2031)	11 (2032)	County Total
Clinton County	$13,950.96	$32,547.88	$26,050.60	$39,999.69	$44,335.40	$7,912.77	$7,912.77	$7,912.77	$10,074.33	$10,074.33	$10,074.34	$210,845.84

Data Source: Iowa Auditor

Table 7: Distributor Payout

	Payment 1 (2023)	2 (2023)	3 (2024)	4 (2025)	5 (2026)	6 (2027)	7 (2028)	8 (2029)	9 (2030)	10 (2031)	11-18 (2032-39)	County Total
Clinton County	$39,021.79	$41,009.99	$41,009.99	$51,329.82	$51,329.82	$51,329.82	$51,329.82	$60,370.05	$60,370.05	$60,370.05	$50,747.12	$913,448.13

Data Source: Iowa Auditor

Appendix 2: Deinstitutionalization, Co-occurring Disorder, and Interactions with the Criminal Justice System

The rise in interactions between individuals with substance use disorders, mental illness and the criminal justice system (CJS) can be attributed to the deconstruction of mental health supports on a federal level in the United States. Deinstitutionalization refers to the systematic degradation of mental health systems and started during the civil rights period. This occurred due to the incorporation of diverse groups into mainstream society and was informed by three beliefs: 1) that mental hospitals were cruel and inhumane, 2) hope that new medication would become a "cure," and 3) the desire to save money. These beliefs were unfounded, as the deterioration of mental health services meant that those who needed them were relegated to poor social environments, the use of medication has never become a cure, and underfunding meant low community capacity to deal with these rising problems. Federally, these changes were codified by the Omnibus Budget Reconciliation Act of 1981, which stopped funding for community mental health centers/nursing homes that were meant to replace the old system of mental hospitals. This made mental health less available to those who are impoverished or severely mentally ill, leading to the dependence on the criminal justice system to maintain social order.

The dependence on the CJS to maintain social order means that those who are mentally ill found themselves in this system, with prison and jail surveys consistently finding higher rates of mental illness than in the general population. Before deinstitutionalization, those released from mental hospitals had lower arrest rates than the general populace, so the rise in interactions can therefore be connected back to the lack of replacement programming. This lack of programming means that those who are mentally ill experience homelessness and drug culture more often than those without, which can lead to a substance use disorder (SUD) and higher interaction with the CJS. In a national sample, it was found that sever mental illness in arrests could be explained by SUD involvement, and that SUD can lead to higher recidivism as well.

The higher dependence on illicit substances or alcohol in the mental illness population can be attributed to the self-medication theory. The self-medication theory proposes that the use of drugs and alcohol is a coping mechanism, caused in part by the lack of mental health access. Fifty-five percent of those with COD (serious mental health issues and SUD) receive no treatment, and only 7.4% of those with COD receive treatment for both.

Appendix 3: Community Mental Health Services Block Grant

Information about the Community Mental Health Services Block Grant can be found on the Iowa Department of Health and Human Services website at this link: **https://hhs.iowa.gov/mhds-providers/providers-regions/block-grant**. After the planning steps are made the following information can be filled out:

- Planning Tables

a. Table 1: Priority areas and Annual Performance Indicators
b. Table 2: State Agency Planned Expenditures
o Environmental Factors and Plan
c. Healthcare System, Parity and Integration **(Required)**
d. Health Disparities (Requested)
    a. Iowa Demographic Summary on pp 68 of FY 2022-23 Community Mental Health Block Grant Application and Plan
e. Innovation in Purchasing Decisions (Requested)
f. Evidence Based Practices for Early Intervention to Address Early Serious Mental Illness (ESMI) **(Required)**
    a. Questionnaire for this section is already completed by the state
g. Person Centered Planning (PCP) **(Required)**
    a. Questionnaire for this section is already completed by the state
h. Program Integrity **(Required)**
i. Tribes (Requested)
j. Statutory Criterion for MHBG **(Required)**
    a. Questionnaire for this section is already completed by the state
k. Quality Improvement Plan (Requested)
l. Trauma (Requested)
m. Criminal and Juvenile Justice (Requested)
n. Crisis Services **(Required)**
    a. Questionnaire for this section is already completed by the state
o. Recovery **(Required)**
    a. Questionnaire for this section is already completed by the state
p. Community Living and the Implementation of Olmstead (Requested)
q. Children and Adolescent M/SUD Services **(Required)**
    a. Questionnaire for this section is already completed by the state
r. Suicide Prevention **(Required)**
    a. Questionnaire for this section is already completed by the state
s. Support of State Partners **(Required)**
    a. Questionnaire for this section is already completed by the state
t. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application **(Required)**
    a. Questionnaire for this section is already completed by the state

Appendix 4: Findings Challenges and Themes

Challenges

Table 8: Professional Challenges by Sector and Organization

Organization	Workplace Sector	Challenges
Justice	Public	Unreliable detox center
Justice	Public	Unreliable detox center
Healthcare	Private	Stigma in client treatment
Behavioral Health	Private	Outdated Medicaid pay scale for services
Law Enforcement	Public	Helping reduce stigma & CIT (Crisis Intervention Training) across the Department
First Responder	Public	Increased number of people struggling with SUD/OUD
Addiction Recovery	Public	Newness of treatment & programming for addiction

Table 9: Key Themes from Interviews

Innovation in Building Administrative Capacity	Interconnected Social, Professional Network Already in Place	Stigma as Barrier to Access Treatment and Recovery Services	Increased Demand for SUD/OUD Treatment and Recovery Services
- County jail serving as de facto mental health institute	- Inter-governmental collaborations between county & city law enforcement	- Self-Stigma	- SUD/OUD Rapidly increasing and creating negative effects in the larger community (crime & death rates)
- Buy in from some judges - moved public defender office next door to the Resource Center	- D.A.R.T. (Public, non-profit partnership) (Drug Abuse Response Team)	- External stigma	- Drug Court - Trying to prevent recidivism & get people well, drug free & working in the community
- Mental health advocate in the	- Creation of County Resource	- General stigma	- All professional interviewees

jail meets with inmates to help determine mental health	Center & mental health advocate in county jail		conveyed most of their SUD/OUD clients are court mandated to seek and adhere to a recovery program