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Barriers to Substance Abuse Treatment in Rural and Urban Communities: A Counselor Perspective*

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INTRODUCTION

Substance abuse in rural and urban areas is a major public health concern. Despite the threat that untreated substance abuse presents to individual health and well-being, as well as the health and well-being of the broader community, there remain significant barriers to substance abuse treatment (Appel, Ellison, Jansky, & Oldak, 2004; Pringle, Emptage, & Hubbard, 2006). While some treatment facilities benefit from a greater availability of resources necessary for client success, others have comparably fewer options to offer those entering treatment. The disparity between needed and available services can put those on the front lines – namely, substance abuse treatment counselors – at a disadvantage as they attempt to negotiate client needs within less than ideal contextual realities. These counselors are in a unique position to identify barriers to treatment in their communities. This study therefore qualitatively examines barriers to providing effective substance abuse treatment, comparing the perceptions of rural and urban counselors and drawing insights from their experiences working in these differing contexts.

Barriers to Treatment in Rural & Urban Contexts

Barriers to substance abuse treatment have been well researched, especially as they relate to different treatment contexts. Initially, research focused predominantly on the challenges of working in urban areas, where the treatment needs often outweighed the availability of services (Schoeneberger, Leukefeld, Hiller, & Godlaski, 2006). While research indicates substance abuse treatment in urban areas is complicated by a lack of funding and the challenges of working with heterogeneous clients, many concerns once thought to be specifically urban – such as concentrated poverty and the availability and use of drugs – are no longer endemic solely to urban contexts (Schoeneberger et al., 2006; Pruitt, 2009). In some ways, urban treatment facilities are advantaged when compared to those in rural areas, as research indicates that urban areas offer a more diverse array of options for substance abuse treatment, suggesting that they may be better able to meet the diverse needs of clients (Hutchinson & Blakely, 2010; Oser et al., 2011). Specifically, treatment facilities in urban areas are more likely to provide auxiliary services essential for successful outcomes than rural facilities (i.e. detoxification and mental health services), and urban counselors have more resources for specific types of clients (i.e. minorities, women, HIV-positive

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populations; Arora et al., 2011; Fortney & Booth, 2001; Borders & Booth, 2007; SAMSA, 2011).

Given the growing substance abuse treatment needs of rural areas, focus has shifted to the challenges of delivering treatment in rural contexts (Schoeneberger et al., 2006; Oser et al., 2011). When considering treatment needs, as with health care needs more broadly, rural areas continue to be disproportionately disadvantaged with a lack of basic services and underutilization of available services when compared to urban contexts (Hutchinson & Blakely, 2010; Clay, 2007; Pringle et al., 2006; Borders & Booth, 2007). Exacerbating the problem of fewer facilities, rural clients are more geographically dispersed with fewer public transportation options (Gamm, 2004; Sung, Mahoney, & Mellow, 2011). As research indicates that shorter travel distances are associated with longer stays and greater completion rates in substance abuse treatment, this has unfortunate implications for rural counselors and clients (Beardsley, Wish, Fitzelle, O'Grady, & Arria, 2003; Fortney, Booth, Blow, Bunn, & Cook, 1995). Further, research indicates that compared to urban contexts, rural areas often lack options for specialty substance abuse treatment programs – such as those tailored to women or racial minorities – which may discourage treatment utilization among vulnerable, underserved populations (Knudsen, Johnson, Roman, & Oser, 2003; Oser et al., 2011). Additionally, treatment-seeking in rural areas may also mean a lack of anonymity, since there are fewer facilities and a higher probability of recognition in group-based meetings (Hutchinson & Blakely, 2010; Sexton, Carlson, Leukefeld, & Booth, 2008). Despite these findings, there have been calls by researchers to further investigate system and environmental factors that can serve as barriers to the use and success of substance abuse treatment in rural areas (Oser et al., 2011).

Counselor Perceptions of Barriers to Treatment

Though research examining barriers to substance abuse treatment predominantly focuses on aspects identified by clients, a more limited body of research addresses substance abuse counselors' perceptions of barriers to effective care. A study conducted in 2003, for example, surveying substance abuse treatment agency directors and clinical staff indicated a lack of available opportunities for continuing education and training, low salaries, and long hours are considerable barriers to recruiting and retaining qualified staff, and delivering effective care to clients (Gallon, Gabriel, & Knudsen, 2003). Participants of the study also cited the stigma associated with the substance abuse and the subsequent lack of respect for the profession as major barriers preventing counselors from entering and remaining in the field (Gallon et al., 2003). In addition to the findings of this study, other research examining counselor perceptions of the substance abuse treatment field indicate that poor funding, heavy caseloads, a lack of time for one-on-one care, excessive paperwork, and other bureaucratic demands result in the delivery of less than optimal treatment to clients as well as occupational burnout (Knudsen, Ducharme, & Roman, 2006; Appel et al., 2004; Bienecke, Shepard, Tetreault, Hodgkin, & Marckres, 2001). It is not surprising then that many of those working as substance abuse counselors describe the work as “a calling” and “the toughest job you’ll ever love” (Gallon et al., 2003).

Additionally, other research drawing on qualitative interviews conducted with rural providers of health care has found that those working in rural areas must confront a variety of unique challenges – such as maintaining confidentiality, establishing trust, limited resources, and isolation – suggesting that rural context may exacerbate the already challenging work of substance abuse treatment (Chipp et al., 2011). While limited research has confirmed the challenges of delivering substance abuse treatment in rural contexts, further research focusing on rural substance abuse treatment providers using a detail-rich qualitative approach is needed to understand the unique challenges of working in rural contexts (Chipp et al., 2011; Johnson, Brems, Warner, & Roberts, 2006).

Study Purpose

The purpose of this study is to compare rural and urban substance abuse counselors' perceptions of barriers to providing effective substance abuse treatment services. Despite what is known about barriers to substance abuse treatment, further research is needed to understand providers' perceptions of organizational and community barriers to treatment. This research draws on the essential perspective of those working in the liminal space between treatment organizations and clients. In this location, counselors are privy to the organizational challenges associated with delivering services, while also being intimately connected to the recipients of these services. Drawing on the insights of counselors as they negotiate daily challenges, this research builds on previous studies examining rural or urban barriers by simultaneously comparing findings from rural and urban counselors within a single state, working at state-funded treatment sites (Borders & Booth, 2007; Pringle et al., 2006; Gamm, 2004; McKenzie & Bushy, 2004). By collecting data on both rural and urban substance abuse treatment providers, this research allows for a more direct comparison between the two contexts. The contributions of the current study may serve to inform targeted efforts to improve the accessibility and efficacy of treatment.

METHODS

Participants

Data were collected from 28 substance abuse counselors in four focus group sessions conducted in 2008. Two sessions included counselors working in rural substance abuse treatment facilities and two included counselors working in urban facilities. The counselors were recruited from a regional conference for continuing education using IRB approved flyers distributed in conference sessions and an informational booth.

Volunteers were screened to assess their eligibility. Eligibility was limited to counselors working in Kentucky state-funded substance abuse treatment programs. Counselors were asked to report the county where they worked to determine whether they would be in an urban or rural focus group session. The USDA's Economic Research Service (ERS) rural-urban continuum codes (RUCC's) were used to classify the counties as either urban or rural based on county population and adjacency to metropolitan areas. The nine rural-urban continuum codes – where 1 represents the most urban and 9 represents the most rural counties – were divided into metropolitan (i.e. RUCC codes 1, 2, and 3) or non-metropolitan

(i.e. RUCC codes 4 through 9) following ERS's guidelines suggesting that non-metropolitan areas (i.e., RUCC 4 or greater) can be considered rural.

Procedures

Prior to the focus group, the facilitator obtained informed consent. Counselors were provided with food and compensated \$50 for their participation. Of the 28 participants, 18 worked in urban counties and 10 were employed in rural counties (64% and 36%, respectively). Eighteen of the participants were female (64%). Matching Kentucky's racial distribution, approximately 11% of participants were African American (N=3) while the remaining participants were white. The focus groups lasted 60-90 minutes and took place in a private room, concluding upon saturation of the discussion prompts. Focus groups were audio-recorded and moderated by the second author with the aid of a script.

The focus groups were allowed to evolve organically, but were guided by similar prompts. The sessions and prompts were designed to collect detailed qualitative data regarding a variety of topics. The relevant question prompts for this study include:

- What are the greatest obstacles that counselors have to overcome?
- What organizational resources do you think improve clients' treatment outcomes?
- Do you think there are any differences between rural and urban counselors? Do these impact clients' substance abuse treatment outcomes?

Content Analysis

The data collected during the focus groups was transcribed following the sessions. Counselor participants were de-identified and specific demographic information was not included in the transcriptions. To identify themes within the transcripts, both authors used line-by-line coding (Miles & Huberman, 1994; Bradley, Currey, & Dever, 2007). This method of qualitative content analysis was the most suitable for isolating counselors' perceptions of barriers to effective treatment. After initial, open coding was conducted, focused coding was used to extend the detail of the initial themes identified (Corbin & Strauss, 1990; Lofland, Snow, Anderson, & Lofland, 2006). Because memoing was used at each stage of the content analysis, connections to the existing literature and theoretical extension regarding perceptions of barriers to effective treatment were possible (Charmaz, 2001). After this entire process was carefully conducted, differences and similarities between the rural and urban contexts could be identified with greater precision than would have been allowed without coding. Themes not identified by both the authors were excluded from the analyses, yielding four major themes with several sub-themes under each theme. Rural and urban differences were identified in the sub-themes. Quotes are included to illustrate findings.

RESULTS

The focus groups informing these results were a rich source of information regarding counselors' perceptions of barriers to effective substance abuse treatment. Though counselors commented on a wide range of challenges they experienced in their work, four

main themes developed. Spanning both rural and urban contexts, counselors identified inadequate funding, client transportation difficulties, bureaucratic challenges, and a lack of interagency collaboration as major problems preventing the effective treatment of clients. These themes and the accompanying subthemes that emerged in the focus group sessions are displayed in Table 1. This table denotes which subthemes emerged within both rural and urban focus groups, as well as the subthemes which emerged in the rural or urban focus groups only.

Inadequate Funding

Perhaps the most ubiquitously present barrier across both rural and urban focus groups was the lack of funding for substance abuse treatment. Manifesting in a variety of ways, counselors emphasized that underfunding creates challenges for meeting basic client needs, as well as attracting and retaining qualified counselors. Several subthemes directly attributed to insufficient funding were expressed by both urban and rural participants, while additional subthemes emerged only in the urban or rural focus groups.

Regardless of treatment setting, focus group participants emphasized the importance of educational resources – for counselors and clients alike – and the difficulty accessing and providing these resources given budgetary constraints. For counselors, accessing continuing education was cited as essential for learning skills critical to their performance with clients. As one urban counselor suggested,

Funding is a big key too, because if you want the professionalism and you want the training and you want the experience...If I've got to go to a training and pay for it myself, but then you want to use that experience that I bring back to the table, of course I'm interested in professional development for myself, but you're benefiting from it as well. Or there is a wealth of knowledge here in books and resources but if it's coming out of my pocket totally and the funding is here and I can't afford it, then it makes a whole 'nother story.

Having to pay out-of-pocket for education, which benefits not only counselors themselves but also the institutions they work for and the clients they serve, can be a major disincentive for counselors. A rural counselor echoed these sentiments, suggesting that limited funds for educational resources fail to cover basic necessities, alluding to the trickle-down impact this can have on clients:

And the resources, having that...my professional fund yearly is gone already. We get it in July and it's gone. You know to buy additional books for yourself, paying your yearly fees for your LCSW, CADC, and whatever else is going on. Having that material for education...of course we can't bill under educating, however, that information for the clients is very important too.

In addition to impeding counselors' access to continuing education, a lack of funding also hampers rural and urban clients' access to educational resources. Regardless of where they practice, counselors agreed that providing educational materials to facilitate client recovery is a challenge given the lack of financial resources. One rural counselor stated plainly, "I struggle where I am at in coming up with resources to put in the hands of my clients to learn

from and to use...” An urban counselor expressed the same problem in greater detail: “I remember when I first started in the community mental health center; there was no workbooks, nothing. I had to supply everything, reading materials and stuff for my clients, because the emphasis wasn’t on providing materials for clients.” These statements demonstrate that for all counselors, the lack of financial support for treatment programs and the subsequent lack of educational opportunities for themselves and their clients are considerable barriers and having to finance the purchase of such resources from their own salary is not perceived as a sustainable or fair solution by counselors.

Just as clients directly and indirectly benefit from the financial and other resources provided to counselors and facilities, a lack of funding and resources can be detrimental to their success. Though this is an obvious conclusion, results of this study further reveal that both rural and urban counselors perceive that funding challenges may disproportionately affect rural counselors and their clients. As one rural counselor suggested, “They [urban treatment programs] have more options. We’ve got no options ... But again, if we had more funding sources, that would give us more options of what we could do with them.” Even a counselor working in a relatively populated area and participating in the urban focus group suggested that, relative to the state’s most populous city, their facility’s resources were limited: “Just speaking in relation to living in a small community and working in a small community versus like living in Louisville and all that, I think the financial factor plays a big part. In the urban areas such as the Louisville metropolitan area or whatever, they have more resources available and they have funding, just more of everything.”

Despite the several subthemes common to the rural and urban focus groups regarding inadequate funding, the urban and rural focus groups also yielded findings unique to each context. Specifically, in the urban focus groups, counselor participants emphasized the challenges associated with meeting the needs of non-English speakers, the lack of technological resources, and the heavy caseloads and understaffing directly attributable to a lack of funding. As one counselor stated when prompted regarding the most significant barriers to effective treatment, “The obvious barrier is language – I mean, we have a lot of clients who don’t speak English and it is hard to get interpreters and then, how are you going to pay for the interpreter? And if the client doesn’t show up and the interpreter does, then you get billed for that...” Urban participants also expressed a longing for more technological resources in the workplace, stating a desire for every counselor “to have a computer at their desk.” Such technological resources would undoubtedly be helpful to urban counselors, since results indicate that they tend to experience a considerable amount of strain associated with heavy caseloads and understaffing. As one urban counselor elaborated,

...there are a limited number of skilled trained professionals who are out there who are providing these services and we have this bumper crop of new folks who are coming in all the time and learning and leaving and that kind of thing. So I think from a resource perspective that is another resource that we can’t take advantage of because we can’t pay them enough to stay. So you can’t pay people enough to retain them in this field and work with the clients that we work with and that’s a barrier, to me.

Similar sentiments were expressed by other urban counselors, like one participant who suggested quite simply, "...staffing and caseloads, if you can increase the staff, you can lower the caseloads and provide better services." This commentary indicates that urban counselors confronted with a high volume of clients, ill-equipped with the resources to manage such caseloads, feel particularly constrained in their ability to deliver effective substance abuse treatment services.

While urban counselors may feel the impacts of a lack of funding most keenly because they are overburdened by the volume and diversity of their clients, rural counselors emphasized the lack of basic facilities attributable to inadequate funding. Results reveal that the conditions of substance abuse treatment facilities in rural areas are less than ideal for facilitating recovery. From "leaky roofs" to more serious problems, the basic infrastructure necessary for providing substance abuse services in rural areas seem to be deficient, thwarting counselors' ability to meet with clients: "And that is one of the things that frustrates me is I go in there day in and day out and I am thinking – the air conditioning in the summer is not adequate, the heating in the winter is not adequate...Just physical plant and treatment environment. I am not saying we need to build Radisson's necessarily, but at least have 3 or 4 sofas around." Though most counselors were adamant that positive results with motivated clients could still be achieved despite outdated, somewhat dilapidated facilities, undoubtedly more adequate funding could address these basic concerns and improve outreach to clients.

Transportation Challenges

Though data indicates a lack of funding is the most looming concern for counselors in both rural and urban settings, participants also cited client transportation difficulties as a major concern. In rural communities, where public transportation is scarce and individuals often live considerable distances from treatment facilities, it is not unexpected that arranging transport would present a challenge. Results indicate that both rural and urban counselors recognize the client challenges associated with getting to rural treatment facilities. From the perspective of urban counselors, the expense of getting to treatment in rural areas given rising fuel prices is particularly problematic: "Transportation is a big issue in a rural area, especially right now, with the gas prices continuing to rise. It's virtually impossible...it's always been an excuse you know, at times, but now it's...they simply cannot afford to make it out." Surprisingly, urban counselors also expressed similar attitudes regarding the challenges of transportation in their own communities:

Barriers to outpatient treatment many times are transportation. We have poor show rates for substance abuse clients primarily because they can't get there...well, I shouldn't say primarily, but in many cases because they can't get there. And you know, they don't have the resources and the car is broken down or whatever, and there just is not the same availability of funds and transportation and things like that, that help them to make it and be successful.

Focus group findings suggest that while some counselors may see such difficulties as an "excuse", the rising cost of fuel and the lack of financial resources of many clients may make transportation a very real challenge.

Like urban participants, rural counselors also highlighted the logistical difficulties associated with getting their clients to treatment facilities. However, unlike urban counselors, those in rural areas provided a slightly more nuanced account of the problem – directly citing client distance from treatment centers and the problems of relying on family or friends for transportation. As one rural counselor suggested:

And transportation...is the number one problem for many of the folks we have. They no longer have a driver's license; they abused that privilege and lost it. They can't get to 12 step meetings, they can't get to work, they can't get an IOP or any kind of counseling session, and they live 20 miles away from wherever. Without public transportation these people are having to rely on rides from other family members who have been enabling or using with them, or friends who have been enabling or using with them.

This response demonstrates that transportation is not just a logistical problem, but a social problem as well. Though it is unlikely that all friends and family members are substance users, relying on those who may or may not be supportive of an individual's choice to enter treatment is problematic. Even turning to someone supportive for transportation may be an unviable long-term solution: "The recovery community is rather small, and once they have been there awhile they know they can count on each other. If I have a flat tire someone will come pick me up, once, maybe twice. But as far as being able to rely on someone else for a ride for the next 5 years or even 1 year, that can be a little more difficult." In all, though the frustrations regarding client transportation difficulties were expressed by both urban and rural participants, the results of this study provide further evidence that rural treatment settings have additional, more persistent, and more severe transportation challenges.

Bureaucratic Challenges

According to participants in both urban and rural settings, bureaucratic tasks are also a barrier to delivering substance abuse treatment services. Findings indicate that counselors invest considerable time navigating bureaucratic obstacles which delay client entry into treatment programs and reduce the amount of time counselors can spend providing therapeutic services. Results demonstrate that for both rural and urban counselors, excessive paperwork is a major bureaucratic challenge that can have important effects on client outcomes. Within a rural focus group, a counselor cited paperwork as a reason for feeling "time-challenged", stating that it ultimately contributes to burnout within the profession. These views are further illustrated by statements made within the urban counselor sessions. As one urban counselor suggested, paperwork coupled with other extraneous non-counseling duties has promoted a shift in the entire approach taken to managing clients:

The number of tasks too, because we keep tacking on more and more little things, like ok, now we are doing a grant so we need this, this, and this as paperwork, and then now we are accessing this grant so we need this, this, and this...So there's a lot of that and I think that it gets in the way because they are busy trying to get statistics and I am busy trying to get statistics together and less time that I have for my clients. And so then I have to pick and choose which client is the most in crisis so now I have shifted from a proactive preventative approach to more of a crisis intervention approach.

Ultimately tied to the aforementioned lack of funding and inadequate hiring, findings indicate that counselors in both rural and urban contexts feel that they are expected to take on a greater number and variety of tasks. This creates a less than optimal treatment environment, reducing the overall time that counselors can spend with clients and increasing the stressfulness of their positions.

Further, both rural and urban counselors emphasized that delays getting clients into treatment – especially in rural areas – can undermine successful outcomes. Such delays, which can be linked to a lack of facilities in rural areas, are also partially attributable to the time constraints counselors experience due to excessive paperwork and other bureaucratic aspects of their positions. As one rural counselor stated, “...one of the biggest gaps in treatment is that it is such a personal issue for them to finally have someone...to be able to talk with them on an individual one-to-one basis. But, systemically that doesn’t exist because, well, we will give you an appointment in 3 weeks and then you can sit here and wait for a few hours and then we can see you or we are gonna cancel your appointment.” Further, as urban focus group participants emphasized, the delays delivering services in rural areas that are tailored to individuals with co-morbid conditions, like mental health disorders, are even longer. These statements emphasize that multiple demands on counselor time prevent them from establishing effective rapport with clients while also delaying client entry into treatment.

In addition to excessive paperwork and treatment entry delays, urban counselors emphasized a lack of case management as a major bureaucratic challenge further complicating their role providing services. Results from the urban focus groups indicate that even urban counselors, who admittedly have more resources and options for clients than rural counselors, feel ill-equipped to meet some client’s needs: “I would like to see more case management services for substance abusers. We have women’s case management, but we don’t have general case managers like they do for the chronically mentally ill.” Compounding obstacles tied to the lack of funding, namely the lack of educational resources necessary for counselors to learn new skills, the lack of specialty case management services within urban facilities suggests that counselors may be thrust into positions they feel unprepared to handle effectively. These findings demonstrate that, at least from the perspective of counselors working on the front lines, bureaucratic challenges can have significant impacts on counselor efficacy and client outcomes.

Lack of Interagency Cooperation

Finally, the lack of interagency cooperation was cited by rural and urban counselors as a major barrier to client success. On the whole, the counselor participants indicated that effective treatment requires not only substance abuse counseling, but also a variety of other complimentary services such as supervised detoxification and mental health services. Arranging these services requires communication among a network of facilities and providers. A rural counselor further explained that services can be arranged, but that networks connecting clients to services need to be further developed:

In Hazard, there is no detox program within 100 miles. Networking, I mean for us networking works very well...when networking works it works very well because

we don't have a detox program at the residential facility, so in order to detox somebody we have to refer them to another one, and with the IOP groups that I work with, making referrals to the appropriate agencies is very helpful when it works out. Some of that is interagency communication that actually needs to be worked on as well.

Though urban counselors may already benefit from having greater access to more facilities, they too experienced the frustration associated with having to arrange detoxification and other services for their clients: "...in our experience at the center and in our organization and then talking to other resources, detox...there is so much prescription medication – our facility is a non-medical facility, well there's just a whole lot of things we can't do."

Providing mental health services to rural and urban clients ultimately requires cooperation with other agencies and facilities, necessitating strong ties to these facilities. For rural counselors, limited facilities that serve a considerable geographic area make networking client access a challenge: "And there is one particular mental health facility that covers several counties, that's our main referral source. We're limited where we're at with referral sources, and linkages to other agencies." Findings indicate that urban counselors also struggle to provide effective mental health resources. An urban counselor supplied the following description of the problem:

Like, I have clients who are actively suicidal but drug and alcohol must be treated first, but yet, they are gonna continue to be suicidal while they're on detox, so you're flipping back and forth trying to figure out...and they do, they flop back and forth between the hospital and then they're there four or five days and then they come back to detox for two or three days and they have another suicidal ideation and then they go back.

In both rural and urban contexts, counselors repeatedly emphasized the lack of continuity in treatment services; stated differently, there was clear evidence that counselors perceived there was not a "continuum of care". A continuum of care is a tailored, tiered approach in which a client may seamlessly move through the treatment levels based on their progress (Oser, Knudsen, Staton-Tindall, Taxman, & Leukefeld, 2009; McKay et al., 2002). For example, a client may receive detoxification services (if needed) followed by an appropriate level of care (e.g., residential or outpatient) with subsequent aftercare services (e.g., participation in support groups such as AA or NA). This was most clearly articulated by an urban participant: "There is no continuum of care, there's no 'Ok, you got out of detox, now you are going right into this'. I mean, out of detox this day, and later on this day you're going to see this therapist or whoever. There's nothing really like that."

Given that rural and urban counselors in this study indicated limited service availability and an unclear process for accessing services, it is not surprising that counselors working in both contexts also cited that their clients improvised to gain access to such services. Counselors in rural and urban areas even cited a similar strategy among their clients: feigning suicidal intentions to acquire detoxification services. One of the rural counselors also working at a psychiatric hospital suggested, "...they have to come in and lie and say they are suicidal...so

they'll come in and we'll treat the withdrawal symptom and get them detoxed." An urban counselor went so far as to identify the practice as commonplace:

And there's nowhere for them to go if they have no insurance for that [detoxification, medical services] – nothing. ...they can go there [to the hospital] and tell them they are suicidal, which they really are not, but they are in grave pain and at their wits' end maybe, but they have to say something like that in order to get in. And we hear that every day.

Though desperation for relief from withdrawal symptoms may be the immediate cause generating these innovative strategies, it is a fundamental lack of effective collaboration between service providers that intensifies this desperation and forces clients and counselors to consider difficult choices.

Despite the several common subthemes identified by urban and rural counselors regarding the lack of interagency collaboration, two subthemes unique to rural counselors emerged. Specifically, rural counselors cited the challenge of meeting clients' housing needs, as well as facilitating access to basic dental and medical services. Meeting basic needs, it was argued, is necessary if clients are to focus on substance abuse treatment:

What I would like to see is working with the medical community, to include dentists. Because right now people come in with methamphetamine and you know cocaine, and their teeth are rotting right out of their mouth, and they are in pain. I would like to see us working more, and finding dentists and doctors who can help us keep the patient focused on treatment by meeting their needs.

As another rural counselor reiterated, "...just basic needs of healthcare, transportation, housing – it's hard to think about your mental or emotional health when you have nothing. You don't know where you are going to sleep...it's the hierarchy of needs." With the previously discussed findings regarding rural treatment facilities suggesting a lack of basic facilities as well as a lack of funding to improve this situation, these findings indicate these dire conditions extend to the basic living situations of rural clients as well.

DISCUSSION

The counselors participating in this study identified four key barriers to successful client outcomes: lack of funding, client transportation challenges, difficulties of bureaucracy, and the absence of interagency cooperation. Overall, though it is well established that there is a fundamental lack of substance abuse treatment services in rural areas, the results of this study suggest that even among urban counselors there is recognition of the special constraints experienced by those providing substance abuse treatment services in rural contexts (Hutchinson & Blakely, 2010). Though both rural and urban counselors feel the strain of these four barriers, it appears that they experience them in unique ways, such that measures to improve access, use, and outcomes of substance abuse treatment should incorporate local knowledge and characteristics. Just as research suggests that drug prevention programs are most effective when community-based and personalized, results of this study indicate that treatment programs work best when they too are tailored to contextual environments (Brown, Hill, & Giroux, 2004).

This study extends what is known about the challenges of rural and urban substance abuse treatment provision. As already suggested, extant research indicates that a lack of resources and funding limit the services such facilities can provide (Sung et al., 2011; Gallon et al., 2003). As this research demonstrates, a lack of basic facility resources – including suitable spaces for treatment activities and climate controlled buildings – present a considerable problem for rural counselors. Though further evidence is needed, it is likely that this is partially the result of the concentrated poverty in the rural areas where study participants worked. While these findings may not extend to all rural communities, the concerns of substance abuse counselors from rural Kentucky participating in this research may be representative of treatment providers from other economically depressed rural areas.

Similarly, the difficulty meeting the needs of non-English speakers expressed by urban participants in this research represents a novel contribution. Though dealing with diverse populations is common in urban facilities, counselors in this study felt ill-prepared to meet the needs of non-native English speakers in their communities. Despite the availability of translators, the difficulty in scheduling and maintaining appointments makes utilizing such services challenging for the urban counselors in this study. Further research is needed to determine how the delivery of substance abuse treatment services for non-native English speakers could be enhanced in urban and other areas where such services are needed.

The results of this study also build upon the existing literature examining the transportation difficulties experienced by rural substance abuse treatment clients. Specifically, while some of the transportation challenges identified in previous research are supported by findings of the current study, additional details are also revealed (Gamm, 2004; Sung et al., 2011). For example, though past research has documented client transportation difficulties in rural areas, results of this study indicate that even in urban areas where treatment facilities and public transportation are more available it may present a barrier to effective substance abuse treatment (Sung et al., 2011; Gamm, 2004; Beardsley et al., 2003). Further, while it is well established that rural areas often have few public transportation options with treatment facilities serving large geographic areas, this research demonstrates that rural clients may face additional difficulties as they attempt to coordinate transportation to treatment. Because such alternatives – like relying on family members and friends for rides– require individuals supportive of treatment-seeking and recovery, they may be untenable in rural communities where insular norms discourage the identification of problematic patterns of substance use and help-seeking. The findings of this study suggest that though transportation problems occur in both rural and urban areas, they are more pronounced and diverse in rural areas, warranting important consideration by practitioners hoping to encourage treatment in such communities. Ultimately, the widespread lack of reliable transportation poses a serious problem for individual recovery efforts and, more broadly, the public health of rural communities.

Relatedly, rural participants in this study emphasized the impact family ties may have on treatment. According to rural counselors, the family context of rural clients may be a contributing factor to their substance use, subverting efforts to recover:

...when they go through treatment, especially residential, most of eastern Kentucky is family oriented and they are close-knit families. And when that client leaves treatment, 9 times out of 10 they are going back into the same situation they came out of. And so that is going to really lower their chances of staying in recovery.

While support from family and friends can encourage entry into treatment and sustained sobriety, it is clear that in rural communities where substance abuse may have become an unfortunate family legacy, it can present a major barrier to treatment interventions. It is evident from this study that tailoring treatment to rural areas must include recognition of client-level barriers to effective treatment experiences – like transportation challenges, disadvantaged socioeconomic status, and close familial ties that may facilitate, rather than discourage, substance use.

Results also support previous findings that suggest the heavy caseloads and excessive paperwork of treatment providers may interfere with their ability to deliver services to clients (Howell & Chasnoff, 1999). In all, this research provides further experience-based insights from providers into the organizational, community, and client characteristics that impact the delivery and efficacy of substance abuse treatment services. Importantly, this research illustrates how bureaucratic challenges associated with the substance abuse counseling profession shape the services counselors are able to provide. Supported by previous research, participants indicate that excessive paperwork and delays getting clients into treatment present challenges for delivering services (Bienecke et al., 2001). Concerns regarding the delays getting clients into treatment were particularly acute among the rural counselors in this research. Clearly, fewer overall treatment facilities contribute to these delays, but it is likely strong connections to family among rural clients may influence preferences to wait for treatment closer to home. While such concerns are not unique to rural populations, they may impact decisions to enter treatment in ways that do not affect those seeking treatment in urban areas where options are more numerous and diverse.

Finally, in addition to these contributions, this research reveals key insights about the extreme measures some clients engage in to access services – regardless of rural or urban context. As previous work suggests, substance abuse treatment facilities often lack the full range of services needed by clients, which can result in problems arranging mental health and other services, as well as continuity of care issues (Arora et al., 2011; Fortney & Booth, 2001; Borders & Booth, 2007; SAMSA, 2011). While this study's findings support those assertions, they also reveal the improvisation clients engage in to access needed services – such as feigning suicidal ideation to receive supervised detoxification. According to the rural counselors in this study, it appears that their clients are particularly in need of a variety of services, such as substance abuse group therapy sessions tailored to women, as well as dental and general medical services. Rural counselors also noted that housing and other wrap-around services are needed, but often unavailable. While the lack of services available in rural areas when compared to urban areas – including fewer free or reducing cost services provided by public health clinics, university hospitals, and other non-profit agencies – will likely remain an ongoing challenge for those working to coordinate their delivery, greater interagency cooperation could enhance the availability of these resources. This suggestion is by no means a solution to larger problems like the underfunding of substance abuse

treatment programs, but it could be a strategic way providers might better utilize available resources in rural communities.

Limitations

Despite the important findings of this study, there are some limitations that should be considered. First, because counselors participating in this study are employed at state-funded treatment centers, results may not represent barriers encountered by substance abuse counselors working at private or other facilities. Such facilities may have a different client base than state-funded centers, resulting in exposure to different factors that shape client outcomes. However, it is expected that many of the barriers identified, especially those associated with rural treatment contexts, have relevance for other counselors, regardless of their funding sources. Additionally, because this research is focused on identifying broad rural-urban trends, no quantitative data was collected on specific counselor characteristics. However, it was clear from the discussion within the focus group sessions that counselors had a wide array of educational backgrounds, up to a doctorate, and a variety of years of experience.

Furthermore, the sample used in this research limits the applicability of the findings. First, study participants were self-selected, introducing a possibility of bias into the results, and were from Kentucky, a region with well-documented substance abuse problems. While the trends of prescription drug abuse make this area ripe for research regarding substance abuse treatment, they may also mean that counselors experience unique barriers to treatment not present in all rural or urban areas. Further, because rural areas have considerable cultural and other differences, future research would benefit from more nuanced definitions of rural treatment contexts. Specifically, examining experiences of substance abuse counselors in the rural Southwestern United States and the rural Mississippi Delta Region might provide a better sense of the unique constraints associated with different rural contexts.

Finally, the data used in this study are five years old, and given that state policies can shift dramatically in just a single year, it is possible that this study's findings may differ from current trends. Unfortunately, the annual substance abuse budget for Kentucky's Behavioral Health Department has gone largely unchanged for the past ten years, despite worsening trends of abuse and dependence. Therefore, it is likely that the themes of this manuscript remain relevant into the present.

Conclusions

Overall, the data informing this research indicate that community and cultural factors make treatment in rural areas particularly challenging. Though the importance of these factors cannot be undersold, one of the rural counselors made the provocative suggestion that the work of substance abuse counselors and their rural clientele are intentionally undervalued by policy makers and funding agencies:

There is an undercurrent of intentionality, the more people you talk to on the street the more you will hear this, this isn't by accident that this stuff happens. Let's keep them down in the mountains...nobody has made in eastern Kentucky more than a

half-hearted effort to really intervene in the disease process that is going on. They took substance abuse dollars, put it into the faith based community where it has not been spent, and cut the programs in each of the communities by that much. And I don't think any of that is by accident. I don't think that I am undervalued by accident. I think my clients are supposed to die.

Though these sentiments were met with resistance by some of the other rural counselors, the powerful words represent an undercurrent of frustration common to many of the rural participants. Overcoming these sentiments will only be possible if the treatment environment in rural Kentucky improves. This environment encompasses multiple levels, including a need for community and family recognition of substance abuse problems, as well changes within state-funded treatment facilities. To be effective, these changes must result in offering more diverse services and enhanced cooperation between agencies to meet client needs.

Ultimately, the results of this study suggest that rural counselors must meet the challenges of working with fewer resources in a context less conducive to recovery. Further, with problems of illicit drug use common in rural America, these key barriers may have even more dire consequences for rural substance abuse counselors and clients (Warner & Leukefeld, 2001). Given the difficulty of simply getting rural clients "in the door" of treatment programs – where they lack anonymity and have limited treatment options – working toward reducing the impact of these factors is a critical goal. Overall, this research suggests that an important component of improving treatment outcomes among rural clients is the recognition of unique cultural characteristics key to establishing client-counselor rapport and continued treatment. Improved substance abuse treatment among rural populations may also mean recognizing and strategizing how to deal with the layers of contextual factors that problematize recovery, including family histories of substance abuse and community contexts that encourage continued use.

REFERENCES

- Appel PW, Ellison AA, Jansky HK, Oldak R. Barriers to Enrollment in Drug Abuse Treatment and Suggestions for Reducing Them: Opinions of Drug Injecting Street Outreach Clients and Other System Stakeholders. *The American Journal of Drug and Alcohol Abuse*. 2004; 30:129–153. [PubMed: 15083558]
- Arora S, Kalishman S, Dion D, Som D, Thornton K, Bankhurst A, Boyle J, et al. Partnering urban academic medical centers and rural primary care clinicians to provide complex chronic disease care. *Health Affairs*. 2011; 30:1–9.
- Beardsley K, Wish ED, Fitzelle DB, O'Grady K, Arria AM. Distance traveled to outpatient drug treatment and client retention. *Journal of Substance Abuse Treatment*. 2003; 25:279–285. [PubMed: 14693257]
- Bienecke RH, Shepard DS, Tetreault J, Hodgkin D, Marckres J. Substance abuse providers' assessment of the Massachusetts Behavioral Health Program: Year 6. *Administration and Policy in Mental Health*. 2001; 28:443–457. [PubMed: 11804011]
- Borders TF, Booth BM. Research on rural residence and access to drug abuse services: where are we and where do we go? *Journal of Rural Health*. 2007; 23:79–83. [PubMed: 18237329]
- Bradley EH, Curry LA, Dever KJ. Qualitative Data Analysis for Health Services Research: Developing Taxonomy, Themes, and Theory. *Health Services Research*. 2007; 42:1758–1772. [PubMed: 17286625]

- Brown EJ, Hill MA, Giroux SA. A 28-day program ain't helping the crack smoker" - perceptions of effective drug abuse prevention interventions by north central Florida African Americans who use cocaine. *Journal of Rural Health*. 2004; 20:286–295. [PubMed: 15298105]
- Charmaz, K. Qualitative Interviewing and Grounded Theory Analysis. In: Holstein, JA.; Gubrium, JF., editors. *Analytic Strategies*. Thousand Oaks, CA: Sage; 2001.
- Chipp C, Dewane S, Brems C, Johnson ME, Warner TD, Roberts LW. "If Only Someone Had Told Me..." Lessons from Rural Providers. *The Journal of Rural Health*. 2011; 27:122–130. [PubMed: 21204979]
- Clay R. Rural substance abuse: overcoming barriers to prevention and treatment. *Substance Abuse and Mental Health Service Administration Newsletter*. 2007; 15:1–5.
- Corbin JM, Strauss A. Grounded theory research: procedures, cannons, and evaluative criteria. *Qualitative Sociology*. 1990; 13:3–21.
- Fortney J, Booth BM. Access to substance abuse services in rural areas. *Recent Developments in Alcoholism*. 2001; 15:177–197. [PubMed: 11449741]
- Fortney JC, Booth BM, Blow FC, Bunn JY, Cook CAL. The effects of travel barriers and age on the utilization of alcoholism treatment aftercare. *The American Journal of Drug and Alcohol Abuse*. 1995; 21:391–406. [PubMed: 7484987]
- Gallon SL, Gabriel RM, Knudsen JRW. The toughest job you'll ever love: A Pacific Northwest Treatment Workforce Survey. *Journal of Substance Abuse Treatment*. 2003; 24:183–196. [PubMed: 12810139]
- Gamm LD. Mental Health and Substance Abuse Services Among Rural Minorities. *The Journal of Rural Health*. 2004; 20:206–210. [PubMed: 15298094]
- Howell EM, Chasnoff IJ. Perinatal Substance Abuse Treatment: Findings from Focus Groups with Clients and Providers. *Journal of Substance Abuse Treatment*. 1999; 17:139–148. [PubMed: 10435262]
- Hutchinson, L.; Blakely, C. *Rural Healthy People 2010: A companion document to health people 2010*. Vol. Vol. 2. College Station, TX: Southwest Rural Health Research Center; 2010. Substance abuse trends in rural areas: a literature review.
- Johnson ME, Brems C, Warner TD, Roberts LW. The need for continuing education in ethics as reported by rural and urban mental health care providers. *Professional Psychology: Research and Practice*. 2006; 37:183–189.
- Knudsen HK, Ducharme LJ, Roman PM. Counselor emotional exhaustion and turnover intention in therapeutic communities. *Journal of Substance Abuse Treatment*. 2006; 31:173–180. [PubMed: 16919745]
- Knudsen HK, Johnson JA, Roman PM, Oser CB. Rural and urban similarities and differences in private substance abuse treatment centers. *Journal of Psychoactive Drugs*. 2003; 35:511–518. [PubMed: 14986881]
- Lofland, J.; Snow, D.; Anderson, L.; Lofland, L. *Analyzing social settings: A guide to qualitative observation and analysis*. Belmont, CA: Thomson & Wadsworth; 2006.
- McKay JR, Donovan DM, McLellan T, Krupski A, Hansten M, Stark K, Geary K, Cecere J. Evaluation of full vs. partial continuum of care in the treatment of publicly funded substance abusers in Washington State. *American Journal of Drug & Alcohol Dependence*. 2002; 28:307–329.
- McKenzie R, Bushy A. Rural minority and multicultural preventive care, primary care, and mental health issues: Challenges and opportunities. *Journal of Rural Health*. 2004; 20:191–192. [PubMed: 15298092]
- Miles, MB.; Huberman, M. *Qualitative Data Analysis: A Sourcebook of New Methods*. Vol. Vol. 2. Beverly Hills, California: Sage Publications; 1994.
- Oser CB, Knudsen HK, Staton-Tindall M, Taxman F, Leukefeld C. Organizational-level correlates of the provision of detoxification services and medication-based treatments for substance abuse in correctional institutions. *Drug and Alcohol Dependence*. 2009; 103:S73–S81. [PubMed: 19108957]

- Oser C, Leukefeld C, Tindall M, Garrity T, Carlson R, Falck R, Wang J, Booth B. Rural drug users: factors associated with substance abuse treatment utilization. *International Journal of Offender Therapy and Comparative Criminology*. 2011; 55:567–586. [PubMed: 20463206]
- Pringle JL, Emptage NP, Hubbard RL. Unmet needs for comprehensive services in outpatient addiction treatment. *Journal of Substance Abuse Treatment*. 2006; 30:183–189. [PubMed: 16616161]
- Pruitt LR. The forgotten fifth: rural youth and substance abuse. *Stanford Law & Policy Review*. 2009; 20:259–304.
- Schoeneberger ML, Leukefeld CG, Hiller ML, Godlaski T. Substance abuse among rural and very rural drug users at treatment entry. *The American Journal of Drug and Alcohol Abuse*. 2006; 32:87–110. [PubMed: 16450645]
- Sexton RL, Carlson RG, Leukefeld CG, Booth BM. Barriers to formal drug abuse treatment in the rural south: a preliminary ethnographic assessment. *Journal of Psychoactive Drugs*. 2008; 40:121–129. [PubMed: 18720660]
- Substance Abuse and Mental Health Services Administration (SAMHSA). The N-SSATS report: differences and similarities between urban and rural outpatient substance abuse treatment facilities. Center for Behavioral Health Statistics and Quality (Ed.). 2011; Vol. 2011 <http://www.oas.samhsa.gov/2k11/242/242UrbanRural2k11Web.pdf>.
- Sung HE, Mahoney AM, Mellow J. Substance abuse treatment gap among adult parolees: prevalence, correlates, and barriers. *Criminal Justice Review*. 2011; 36:40–57.
- Warner BD, Leukefeld CG. Rural-urban differences in substance use and treatment utilization among prisoners. *The American Journal of Drug and Alcohol Abuse*. 2001; 27:265–280. [PubMed: 11417939]

TABLE 1

Counselor Identified Barriers to Effective Substance Abuse Treatment, Major Themes and Subthemes

Themes	Lack of Funding	Transportation	Bureaucratic Challenges	Lack of Interagency Cooperation	
<i>Subthemes</i>	Difficult meeting needs of non-English speaking clients	Challenges getting to treatment facilities, especially in rural areas ¹	Lack of case management	No continuum of care	
	Lack of technological resources – i.e. computers			Lack of detoxification facilities	
	Heavy caseloads and understaffing			Lack of mental health services	
	Fewer treatment options for rural clients ¹		Excessive paperwork	Delays getting clients into treatment in rural areas ¹	Clients must improvise to access treatment services
	Lack of educational resources for clients				Challenges meeting housing needs of clients
	Limited continuing education opportunities for counselors				
	Lack of good facilities (e.g., building resources)				Client distance from treatment centers

* Dark grey boxes represent subthemes from **urban** focus groups ONLY; white boxes represent subthemes from **rural** focus groups ONLY; light grey boxes represent subthemes present in **BOTH** rural and urban focus groups

¹ Both rural **and** urban counselors recognize that there are fewer treatment options, as well as challenges and delays getting clients into treatment in rural communities.