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Barriers to Community Treatment for Opioid Use Disorders among Rural Veterans

RESEARCH

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ABSTRACT

The Veterans Health Administration (VHA) has instituted several national initiatives to increase access to medication for opioid use disorder (MOUD). throughout rural America. The expansion of the MISSON Act's community care model may prove beneficial, but barriers still constrain widespread community treatment for veterans. The present study illuminates several previously unidentified barriers facing community-based providers who aim to provide MOUD to rural veterans. The primary means of data collection for this study included in-depth interviews with fifty-three non-VHA MOUD providers, thirty-one staff at non-VHA community-based organizations serving veterans, and five VHA behavioral health employees affiliated with the Montana VHA's substance use disorder program. Staff at non-VHA community-based organizations serving veterans refer veterans to the VHA for MOUD and express a low literacy level about non-VHA MOUD providers. VHA employees favor the VHA for MOUD and lack a network of collaboration with providers at non-VHA community care clinics. Attitudinal and structural barriers constrain veterans' treatment options within community settings by creating a vacuum of care in the community, whereby all veterans are funneled to the VHA for MOUD. In Montana, only 6 veterans receive MOUD from non-VHA providers, and this reliance on the VHA's MOUD program constrains access to treatment and the quality-of-care veterans receive.

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The Veterans Health Administration (VHA) is the largest integrated health and addiction treatment provider in the United States (Post et al., 2010; Trafton et al., 2013; VHA, 2008; Wyse et al., 2018). Despite its size, prior research has found that the VHA struggles to meet the demand for medication for opioid use disorder (MOUD), with some studies finding that only one third of veterans in need of MOUD receive it (Finlay et al., 2016; Oliva et al., 2013; Trafton et al., 2013; Wyse et al., 2018). One reason for the lack of treatment being received has been variable prescribing rates across VHA facilities, as some clinic providers prescribe to fewer than 10% of their patients diagnosed with opioid use disorder (OUD; Oliva et al., 2012). A second reason for low rates of MOUD utilization is the ongoing provider shortage within the VHA: over a 6-month period from 2017–2018, only 2% of the VHA's 72,272 medical providers prescribed buprenorphine, and among those who did, most did so below their capacity (Valenstein-Mah et al., 2018). This lack of prescribing is especially pronounced in rural areas, where veterans are overrepresented (Holder, 2017) and less likely than their urban counterparts to receive MOUD (Rubin, 2020).

Recognizing the importance of behavioral healthcare and the gap in utilizing MOUD, the VHA has instituted several national initiatives to improve the quality of behavioral healthcare and access to MOUD, especially among rural veterans (Gordon et al., 2011). First, the VHA funded a telemental health network whereby prescribers at "hub" VHA medical centers can treat veterans at distant "spokes," such as rural, primary care focused community-based outpatient clinics (CBOCs; Brunet et al., 2020; US Government Accountability Office [US GAO], 2019). This effort has had some success, as approximately half of the veterans enrolled in VHA healthcare, who are receiving MOUD, rely on the CBOC network for access to treatment (Oliva et al., 2013).

Second, the MISSION Act enabled the VHA to expand access to mental health and substance use disorder (SUD) treatment expertise at non-VHA facilities, especially in rural and frontier areas (Post et al., 2010). The MISSION Act's purpose is to establish permanent community care programs for veterans to receive services from the Act's approved, non-Veteran Affairs (VA) medical "community care providers" (VA MISSION Act, 2018). Considering the current opioid crisis and the disproportionate prevalence of OUD among veterans, the MISSION Act aims to improve access to behavioral healthcare, especially by increasing access to MOUD in rural communities without a VHA hospital or CBOC facility.

Third, the Stepped Care for Opioid Use Disorder Train the Trainer (SCOUTT) Initiative's primary goal is to, "Increase MOUD prescribing in VHA primary care, mental health, and pain clinics by training providers working in those settings on how to provide MOUD and to facilitate implementation by providing an ongoing learning collaborative" (Gordon et al., 2020, p. 227). This initiative's reliance on the stepped care model enables patients with a chronic disease to initiate care at specialty care facilities for SUD, and once stable, "step down" to a lower intensity of treatment offered in a primary care, mental health, or pain clinic setting (Gordon et al., 2020). This model is intended to reduce stigma as a barrier to treatment initiation by providing access to MOUD within primary care environments and extending MOUD to rural patients in a CBOC setting.

Prior studies suggested that these initiatives have improved access to MOUD for veterans, as half of the veterans enrolled in VA healthcare who receive MOUD do so through the CBOC system (Oliva et al., 2013). In community, non-VHA settings, MOUD admissions increased significantly from 2011 to 2016 for both urban and rural veterans, with the increases in admissions being greater for rural veterans (Turvey et al., 2020). Following Turvey et al.'s (2020) call to examine veterans in community, non-VHA settings, the present study develops logical hypotheses, rather than statistical inferences, for why community-based providers who aim to prescribe buprenorphine to veterans living in a rural state see little demand for their services. The national trends of increased utilization of MOUD among rural veterans identified by Turvey et al. (2020) are not emblematic of what occurred in Montana—where less than 1% of patients prescribed buprenorphine at State Targeted Response (STR) and State Opioid Response (SOR)-funded, non-VHA facilities were veterans (Green & Filteau, 2019). We examine this unique case and explore how localized barriers impede veterans' access to MOUD at nine non-VHA facilities. To do this, we collected qualitative data via interviews with employees at the Montana VHA, staff at community organizations serving veterans, and providers at STR/SOR sites to understand how the VHA's model of care and the referral networks, through which veterans access MOUD serve as mutable barriers to the efficacy of the VA's MISSION Act in rural and frontier areas.

STUDY CONTEXT

Montana has one of the highest per capita veteran populations in the US; over 1 in 10 (10.3%) residents are veterans (US Census, 2019). Montana veterans use VHA healthcare more frequently (nearly 39%) than veterans in other states (29%), placing strain on a healthcare system with only one VA hospital (National Judicial Opioid Task Force [NJOTF], 2019; US VA, 2014). The Substance Abuse and Mental Health Services Administration's (SAMHSA) *2018 National Survey on Drug Use and Health: Veterans* identified veterans as a high-risk population that non-VHA, state-

funded, MOUD sites should prioritize for treatment (McCance-Katz, 2018). A recent US Government Accountability Office (2019) report suggested that the Montana VHA's SUDs program struggles to meet the healthcare and treatment demands placed on it. The report also highlighted the importance of creating an active referral network between the VHA and non-VHA community providers.

METHODS

To increase outpatient MOUD services, SAMHSA administered funding through the STR and SOR programs to mitigate the opioid crisis by increasing access to the three FDA-approved medications (buprenorphine, methadone, naltrexone) for prevention, treatment, and community recovery (McCance-Katz, 2018). Over a 3-year period, Montana was awarded STR and SOR funds to increase prescribing capacity across the state of Montana. ***Figure 1*** below shows the spatial distribution of these state-funded MOUD sites, as well as the locations of VHA clinics with and without a DATA 2000 waivered provider.

Data collected through the Government Reporting and Results Act (GPRA) system show that from 2017–2020, Montana's nine STR and SOR MOUD sites, depicted in ***Figure 1***, served a total of 1,145 patients, of which six self-identified as veterans (Green & Filteau, 2019). These sites were intended to increase access to MOUD for all Montanans, including veterans enrolled in Montana VHA's SUDs program. In addition to capacity for treatment at STR and SOR funded sites, the VHA system in Montana has three DATA 2000 waivered providers statewide: one at the VHA hospital in Helena, one at the CBOC in Missoula, and one at the CBOC in Kalispell.

DATA GATHERING

This study was part of a broader evaluation of STR and SOR funding in Montana: Montana's Department of Public Health and Human Services identified veterans as a special population of concern, and this study sought to illuminate the barriers veterans face when accessing substance abuse treatment within the state. The study was submitted to Western Internal Review Board for approval and received an exempt status (Approval #: 13093595).

The primary means of data collection for this study

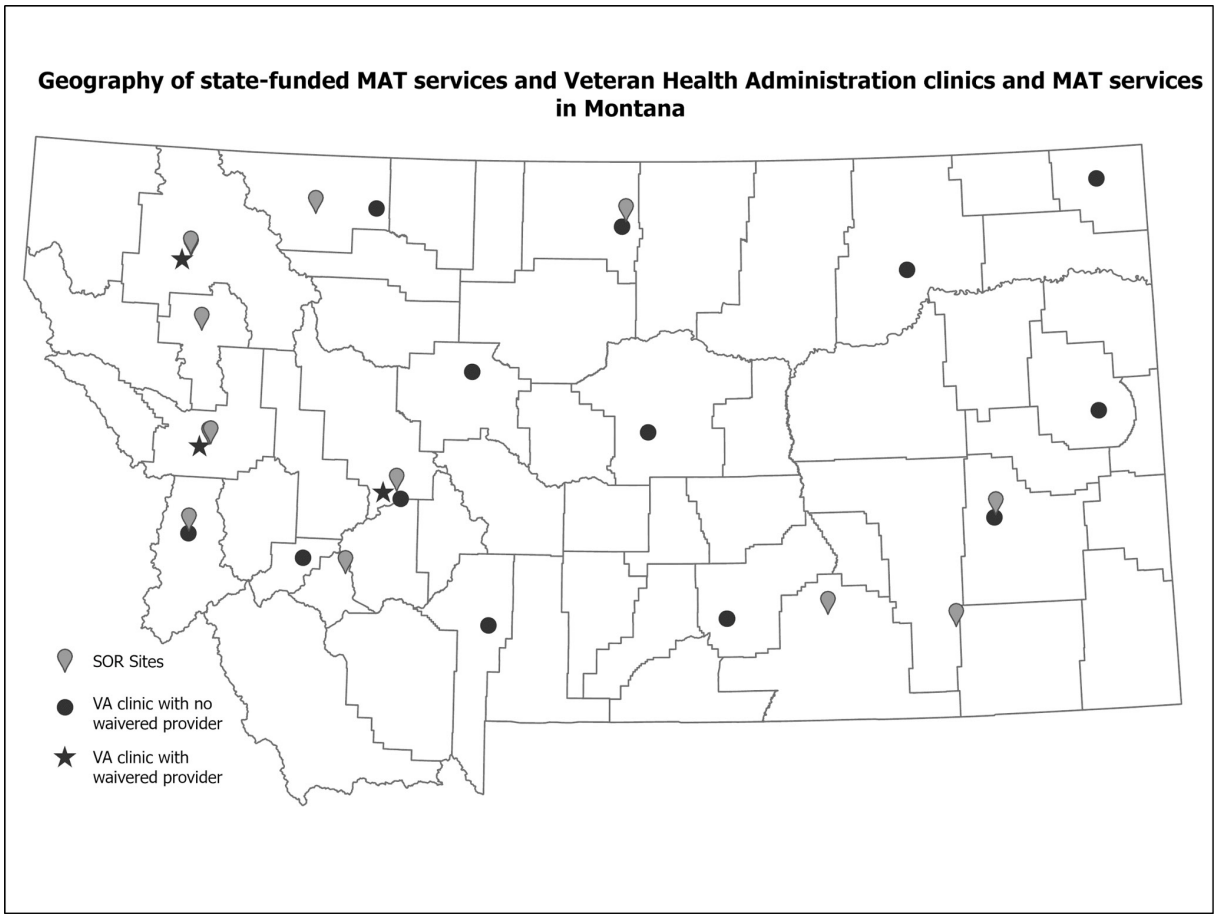

Figure 1 Map of SOR and VHA MOUD Services.

* Figure created by authors.

included in-depth interviews with staff at community organizations serving veterans, employees on the Montana VHA's behavioral health team, and STR/SOR MOUD providers across the state of Montana. Researchers contacted participants within these categories using a formal recruitment email and followed up by phone when necessary. When the respondent did not reply to any of these efforts, they were marked as "no response." Interviewers obtained verbal consent for interviews before proceeding. Because of COVID-19 precautions, interviews were conducted over the phone or via web-based video call services, and with each participant's consent the interviews were audio recorded. All interviews were conducted confidentially, and all data in this report is reported anonymously.

We completed 62 interviews with a total of 89 participants and ended data collection once saturation was reached within each category: when the information gleaned no longer provided new themes or theoretical relevance to the category (Creswell, 2007; Glaser & Strauss, 1967). ***Table 1*** specifies the number of participants within each category.

DATA ANALYSIS

Data were analyzed using initial and focused coding (Saldaña, 2009). First, a deductive coding guide was created by two researchers from themes raised during the interviews. Initial coding allowed coders to "remain open to all possible theoretical directions indicated by … the data" (Charmaz, 2006, p. 46). Through initial coding we identified themes associated with (a) the VHA's model of care, (b) VHA and non-VHA collaboration, (c) community-based referrals for MOUD, and (d) literacy among staff at community-based organizations of non-VHA MOUD. The analysis team then expanded the coding guide to encompass more specific details and patterns within each respondent category. Using focused coding, we then constructed categories and reorganized important themes as they emerged from the data (Glaser, 1978; Saldaña, 2009). Here are the emergent focused codes within each of the four initial codes:

- VHA model of care
  - VHA model of care
  - SOR perceptions of VHA
  - Wait time for care
- Collaboration between VHA and non-VHA providers
  - Barriers to collaboration
  - Well-functioning collaborative relationships
- Community-based referrals for MOUD
  - From the VHA to non-VHA providers
  - From non-VHA organizations to non-VHA providers
- Literacy among staff at community-based organizations of non-VHA MOUD
  - High
  - Low

The interview recordings for this study were transcribed

RESPONDENT CATEGORY	TYPES OF RESPONDENTS	NUMBER OF RESPONDENTS
VHA	• Behavioral health leadership • MOUD providers	5
Non-VHA community-based organizations	• Homeless veteran homes • Veteran services in higher education • Social workers • Veteran drug courts • Veteran prerelease services • Behavioral health providers and • executives • Medical health providers • AA/NA directors • VFW • American Legion • Wounded Warriors projects • US Senate Staffers	31
STR/SOR providers	• Physician assistants • Nurses • Care coordinators • Administrators • Peer support specialists	53

Table 1 Respondent Profiles.

Note: MOUD = Medication for Opioid Use Disorder. AA = Alcoholics Anonymous. NA = Narcotics Anonymous. VFW = Veterans of Foreign Wars.

verbatim and analyzed in NVivo Qualitative Software (QSR International Pty Ltd., 2020).

FINDINGS

VHA MODEL OF CARE

During our interviews, we asked the Montana VHA's behavioral health team to describe their SUD program and their perceptions as to why STR/SOR providers report so few veterans enrolling in their programs. A VHA behavioral health executive explained:

> We have the main facility and hospital in Fort Harrison, Montana, and then we have 14 clinics across the state. We have mental health or substance abuse staff in eight of those clinics, but we do telehealth services to the rest of those facilities. We have outpatient substance abuse treatment at most of our larger clinics—so, Billings, Bozeman, Great Falls, Helena, Missoula, and Kalispell. We have opioid replacement treatment through Suboxone. Currently we have three providers that are actively prescribing. All methadone treatment is done through contract—we don't have any methadone treatment at our facility. We also have a 24-bed residential unit at our treatment facility in Fort Harrison. And 12 beds are for PTSD and 12 beds are for substance abuse treatment. So especially when you look at substance abuse treatment at the VA, the goal would be that we try to provide those services in house if we can. Then we look at getting care in the community.

The Montana VHA prioritizes a model of care that enrolls veterans in their substance abuse program instead of making community referrals. Providers at the VHA prescribed buprenorphine (Suboxone), and as several other participants confirmed, the Montana VHA prefers keeping veterans within their health system for substance abuse treatment. The Montana VHA refers veterans to non-VHA providers, but this only occurs when the VHA does not offer a service or treatment, such as methadone.

Another member of the behavioral health leadership team at the Montana VHA succinctly stated why veterans do not use STR/SOR programs: "Because they get [MOUD] at the CBOC facilities and the VA [in Helena]. So, I mean, there's no point in sending them out [to the community]." This member of the VHA's behavioral health leadership team added: "I would say we try to keep as many within the VA system as we can just because we know veterans, that's our population. We know how to treat them effectively. We like to keep the veterans here." VHA staff noted that their literacy with veterans' health and their confidence in providing quality care and services are reasons they keep veterans within the VHA system. These reasons also help to explain why STR/SOR sites did not see a higher demand for MOUD services among veterans even though they are a high-priority population for the grant program. The VHA behavioral health team confirmed that the VHA provides MOUD services to veterans and the VHA's model of care prioritizes treating veterans within their network, rather than referring them to non-VHA facilities.

PERCEPTIONS OF VHA MODEL OF CARE AMONG SOR STAFF

Several SOR providers noted that veterans are a difficult population to serve due to the VHA's model of care. Despite being a high-risk, high-priority population for SAMHSA, SOR staff perceived that the VHA prefers to keep their MOUD treatment within the VHA's network of care. One behavioral health service director stated:

> For the veterans' stuff, that's been a little bit different, and I don't totally understand the VA system, and how they do things, but a lot of times on the SUD side, it feels like they prefer to keep that in house a little bit. So we don't get a ton of veterans, they end up going to like, over to Helena or their inpatient piece of things. So we don't have as much interaction on that side of things, just because their funding can sometimes dictate where they receive services.

This participant described the VHA's preference for keeping veterans within the VHA's network of care and touches on the reimbursement piece associated with the Mission Act: when veterans live in close enough proximity to the VHA's SUDs program, they are bound by the community care program to attend that treatment first. A medical director at a SOR program echoed the previous participant:

> I have no opposition and I don't see that there's any barriers for us actually taking [veterans] on. I'm just wondering how many of them are still … I know, in [town], I think a lot of them still get their care up at Fort Harrison. They go up there, I think, because of the cost of care and ease of care and their ability to plug in there. They just kind of stay away from anything local and just use those resources.

This medical director confirmed the perception of the behavioral health services director quoted above: the VHA prioritizes their own healthcare system, rather than referring veterans to community resources. As a care coordinator

stated: "The VA, they have some services here in [town], but then their MOUD patients go through the VA in Helena." SOR Providers perceived the VHA prioritizes the Fort Harrison VHA hospital over the CBOC facilities within local communities.

WAIT TIME FOR CARE

While laudable, the Montana VHA's preference to treat veterans within their healthcare system resulted in long waits and an overworked staff. One member of the VHA behavioral health leadership team discussed wait times:

> If somebody came in, and they wanted to see somebody, like, say, that day, we would meet with them. We have hours that we meet with people face-to-face. And, so, from 11 [a.m.] to 12 [p.m.] and 3 [p.m.] to 4 [p.m.], we will either call people or see them face-to-face and help them get connected to services. And then in that consult, we put in a referral to the doctor. What we do is within 30 days. So, we get them connected within 30 days, which is a pretty small window, and it's not the expectation of the private sector, but here at the VA, we try to do the best service possible.

This participant stated that the VHA aims to initiate treatment within 30 days of when a veteran presents to staff and assumes that this timeframe is shorter than what veterans would experience at non-VHA, community-based facilities. With only three DATA 2000 waivered providers within the Montana VHA, MOUD providers raised concerns about the potential 30-day wait period for treatment. For example, one VHA provider stated: "Just today, the guy I saw waited for a month and a half for an intake. He has a $900 per month opioid habit and a $10 or $50 copay for community care was too much for him. So that's what we're dealing with." In contrast to the 30-day wait period that the VHA cannot always uphold, a recent report by the Montana Primary Care Association documented that most SOR sites initiate MOUD same day from when a patient presents, with 2 weeks being the longest recorded wait time (Green, 2021). One provider described how the wait time between when a veteran presents with addiction and when the induction process begins affects admission:

> People who present need help immediately, not next week or next month. I would love to have immediate access to services because next week you're back on the needle or dead. Let's just say on Monday a guy presents, [and I say] "Well, yeah, I have an opening on Thursday at 9:30 [AM]." Do you honestly think he's going to say, "Oh, yeah, great, see you at 9:30 [AM] on Thursday?" No way! He's going to go back out and use.

In this provider's experience, the inability to do prompt inductions limits the effectiveness of the VHA's MOUD program. When asked about the addiction services offered by the VHA, every participant described the VHA's care as exceptional; however, VHA staff disagreed about how easily and timely veterans gain access to that care. VHA healthcare providers expressed displeasure with the wait times between when a veteran presents to staff with an addiction and when they eventually receive care. This VHA MOUD provider described the workload:

> This is a good program, we're doing good work, but it could be better: we need easier access, Narcan distribution, and a walk-in clinic. We [the VHA] are providing better care than anyone in the community, but access, access to care is the problem. [Veterans] have a problem getting the care. Fifty percent of my clinic is [*sic*] [veterans] with OUD, I have 80 patients total with OUD and SUD. [Interviewer: How do you manage this demand?] I overbook whenever I can—I do whatever I can do to get people in, or we send them to the Fort [VHA Hospital].

This participant described the negative effects from so few VHA providers who prescribe buprenorphine: providers are overwhelmed with demand for addiction services and instead of providing immediate care, providers must refer veterans to care outside their communities and even out-of-state. The "Fort," which the previous participant mentioned, is over 300-miles away from this provider's clinic. The lack of MOUD prescribing within the VHA potentially overwhelms providers, creates gaps in care, and leads to long-distance referrals for patients. In addition, relying on a model of care that prioritizes treatment within the VHA, rather than collaborating with non-VHA treatment facilities, may negatively affect the quality of the treatment experience for Montana's veterans.

COLLABORATION BETWEEN VHA AND NON-VHA PROVIDERS

Despite the challenges facing VHA staff and structural opportunities for community-based care, there is little communication between the Montana VHA and non-VHA MOUD programs. In one interview, two non-VHA behavioral health executives discussed communication between their organizations and the VHA as:

> [Behavioral Health Executive A:] Rare. We've had people call from the VA or other veteran services to inquire about things, but as far as really facilitating

> a true referral that included payment sources… very, very rare.
>
> [Behavioral Health Executive B:] Yeah. I'd have to agree with that. There's almost no communication between local agencies and the VA. To go back to your question. I still want to kind of, not to beat a dead horse, but it's almost like it's an insurance issue. The ones that do not have benefits, they end up in our locations because we exist to serve Medicaid type clientele. And so, they may end up in the programs and then they have access to getting inpatient, peer support, case management, all the things that we provide. But the insurance is a big stopper. If they do have [VA] benefits, they really don't get into the system, they just get into VA.

This dialogue demonstrates that staff at non-VHA community care clinics and staff at the VHA lack a strong network of collaboration. However, according to GPRA data and SOR providers, there are a few veterans accessing care at non-VHA, SOR MOUD programs throughout Montana. Participants in this study attributed this to the expansion of the community care program through the VA's MISSION Act. One health director stated:

> And veterans, veterans billing roles have really become a lot more relaxed in the last couple of years, as far as veterans being able to choose to get their care in health centers. It's going to be a choice for them now… really about educating that community, and what the capacity is for where they're living to be able to get those services.

A nurse stated:

> We're able to see them. We only have two, three [veterans]? We only have a couple of people that are veterans [as patients], but we haven't really had any issues with them coming in and seeing us, and getting their medications paid for and things like that. […] I'm not really sure how that coverage crosses over, but they have been seeing us instead of going to the VA.

These participants explained that the community care program enables veterans to choose whether they receive MOUD care at the VHA or non-VHA community care providers, such as SOR programs. They also tout the new billing structure, authorized by the MISSON Act, as integral to promoting this treatment. Overall, staff at SOR programs were eager to treat veterans, even if veterans could not afford the treatments. One Behavioral Health Director stated: "We would never decline a veteran service if they did want to get on the MOUD program." Despite their willingness to treat veterans, SOR programs prescribe to a total of six veterans across the state, and only one program discussed receiving referrals from the VHA, but just for mental health counseling. When asked, "What's your experience with veterans receiving services through you rather than through the VA? How does that get decided and managed?", a waivered provider stated:

> The way it's decided, I think, is at the discretion of the VA. So they just send people over and then we engage them from care at that point. I don't know that we've ever really sent anyone back to the VA. And then the level of engagement they get just depends on when they come in. Typically, they meet with a therapist first, who goes through a really big history, gets an idea of what their needs are. We put those pieces in place. And then when I see them, we try and fine tune that. And then, it's kind of an evolving process, how they're functioning, what their needs are, where they're at.

This SOR clinic is geographically isolated from Montana's more populated areas and located in the same town as the CBOC provider who describes being overwhelmed with veterans suffering from SUDs—half of whom have OUD. Coupled with the experience of the CBOC provider, and the fact that this SOR clinic only serves one MOUD patient, this area needs additional MOUD support to tackle the demand for treatment. It is, however, unclear if the VHA tried to refer veterans to this provider's MOUD program and the provider refused, or if the VHA only referred patients to the clinic for mental health counseling.

COMMUNITY-BASED REFERRALS FOR MOUD

Like the VHA staff, every participant working at a community organization stated that they would refer veterans to the VHA for MOUD. We asked the following question to understand where participants would refer veterans for MOUD: "If I were a veteran who confessed to you that I was struggling with opioid addiction, where would you refer me for treatment?" One member of the criminal justice system stated:

> Okay. If you were a veteran that gets full benefits, I would definitely direct you to the VA. If you were a veteran that might not have the benefits, it might take a while for you to get benefits with different processes and finding the DD-214 and all that stuff, and getting that stuff squared away. So if you might need more emergent assistance, I might refer you to a different place in the community, such as the

> Helena Indian Alliance or Boyd Andrews Community Services or PureView, to go and get an evaluation. And then my expectation would be that you would sign a release of information so that I can make sure that you're going and doing what you're supposed to do and follow the recommendations of the professional.

The VHA serves as this participant's primary source of referral for veterans, a common sentiment among staff at community organizations that serve veterans. Two additional quotes from staff working with veterans in the community echoed this sentiment:

> [Veterans Nonprofit A:] Yeah. So definitely, the first referral I would make is to the VA. If you weren't enrolled in the VA healthcare system, then I would probably refer you over to [a non-VHA local provider]. And then, I don't know...
>
> [Veterans Nonprofit B:] I would probably initially refer you to the VA. I would probably call out there to people that I know that can tell me which is the best person for this person to contact about that.

When staff at community-based organizations serving veterans refer veterans seeking MOUD only to the VHA, it creates a single pathway for care, rather than reflecting the broader access that can also be gained at non-VHA facilities within the state. As the primary referral option among staff at community-based organizations, veterans are funneled into VHA care and have not been presented with opportunities for care at non-VHA treatment programs. The stature of the VHA in Helena, as well as the recognition that they specialize in healthcare for veterans by staff at community organizations, further legitimizes the VHA's single prominence in the community and throughout the state, a role that all policy shifts have tried to minimize in efforts to increase access to care for veterans.

HIGH VERSUS LOW LITERACY AMONG STAFF AT COMMUNITY-BASED ORGANIZATIONS OF NON-VHA MOUD

There is variation in the level of awareness of non-VHA MOUD facilities among community organizations, as six of the 31 staff members at community organizations demonstrated knowledge of non-VHA, MOUD facilities. One executive at a state funded, non-SOR treatment facility noted:

> What programs exist? We have quite a number of state approved programs in Helena. I think there's nine. And so, they vary in size. There's the Helena Indian Alliance. There's various smaller programs that have a counselor or two that are working that are state approved. So, at last count that I was aware of... there's nine state-approved programs folks can access.

This participant demonstrated a high level of literacy about non-VHA treatment programs in the community, as does this director of a homeless shelter:

> There's Boyd Andrews [... but] you have to be cleaned up in order to go, so it's difficult. You have to be clean, off drugs, in order to go. So it's difficult. There's the Leo Pocha Clinic, it's a Native American clinic that works really well, if you're willing to go, but most of our vets just aren't willing to go get help.

These participants offered a few non-VHA behavioral healthcare options for veterans within the community. Most participants were unable to demonstrate this level of literacy. In fact, most participants were unable to identify any non-VHA program that provided substance abuse treatment in their communities. It should be noted that demonstrating knowledge of a non-VHA program does not mean that someone would refer prospective patients to that program; even participants with a knowledge of non-VHA substance abuse treatment providers deferred to the VHA's treatment program.

For staff at community organizations familiar with serving veterans, the VHA was the only widely known substance abuse treatment program providing MOUD, and thus became their default option when referring veterans for treatment. Further, literacy among staff about non-VHA facilities was exceedingly low. For example,

> [Interviewer:] Do you know of any other [treatment programs outside the VHA] that just exist in the community?
>
> [Veterans Non-Profit Director:] I'm trying to think. No, I don't think there is another one in Helena, actually.

Other respondents, such as this case manager, echoed the previous participant: "So my knowledge isn't extensive in [MOUD] programs, but I absolutely believe in them because I have seen them work in many of the different recovery areas I've been in."

Participants were willing to help connect the veterans they work with to care and believed in MOUD but had little knowledge about options for veterans outside the VHA. The lack of literacy among participants became especially apparent when one interviewer posed a question about the

SOR substance use treatment program in Helena, and the interviewer was asked to explain the community's available MOUD treatment options. After hearing this explanation, a social services director stated: "Well, see, and that's what I mean. I'm with an organization that knows a lot about the resources here, and I didn't even know that existed." The lack of knowledge about addiction treatment services outside the VHA was stark, and participants were often eager to learn about the available resources for veterans. The low literacy level among staff at veterans-centered community organizations results in fewer resources for veterans. When an interviewer asked a case manager "How much do you know about the MOUD treatment options in your community?", she responded:

> I don't. That's part of why I'm very interested in talking with you. [Veterans] believe that they have to receive their help through the VA, and don't recognize they can access community resources or state resources. Lack of knowledge, even like you're seeing with me, even people who are assisting them in getting into recovery or getting help or getting housing, and if we don't know a lot of the basics, how on earth are they going to when they're struggling with addiction?

This participant spoke to how the low literacy level among community support staff serves as a barrier to veterans receiving addiction treatment services outside the VHA. The case manager above agreed to the interview primarily to garner more information about the treatment options available at non-VHA facilities in her community.

DISCUSSION

The state of Montana and MOUD sites that received STR/SOR funding identified veterans as a priority population for MOUD, yet only six patients served by STR/SOR providers self-identify as veterans. The present study seeks to illuminate barriers facing the expansion of the community care model for veterans with OUD in a rural, frontier state.

Initial research suggests rural veterans lack access to MOUD in community care settings due to a shortage of medical professionals (Finlay et al., 2016; Gordon et al., 2020; Jones et al., 2009; Oliva et al., 2011); however, as ***Figure 1*** demonstrates, Montana's nine SOR sites cover most of the state, and evaluation data shows that they have capacity to take on more patients (Green & Filteau, 2019). The present study highlights that staff at the Montana VHA prioritize a model of care internal to the VHA, rather than referring veterans to community care providers who specialize in MOUD. Despite calls to expand the community care model nationwide (Blanco et al., 2020; Turvey et al., 2020), VHA staff in this study report a preference for VHA behavioral health and MOUD, which may explain why the community care model has not been widely adopted by the Montana VHA (Gordon et al., 2020).

The preference to provide MOUD within the VHA bodes well for expanding the CBOC and SCOUTT models of care, which aim to increase tele-prescribing and MOUD within VHA primary care, mental health, and pain clinics (Brunet et al., 2020; Gordon et al., 2020; US GAO, 2019). Military culture, which socializes its members to care for members of one's own unit and prioritize self-sufficiency, may explain this phenomenon (Westphal et al., 2015). However, research documents that positive socialization within the military context can create challenges for veterans as they transition to civilian life (McCormick et al., 2019). Similarly, the present study explicates that the attitudinal commitment among VHA staff to the VHA's model of care may also affect the VHA's willingness to collaborate with non-VHA providers, which may negatively affect veterans' access to treatment. Future research should examine the relationship between structural and attitudinal barriers to implementing the community care model. For instance, behavioral healthcare staff in rural areas face structural barriers such as understaffing, time constraints, limited resources, and too few providers (Andrilla & Larson, 2017; Barry et al., 2008; Filteau et al. 2021; Jones et al., 2009; Rosenblatt et al., 2015; Sigmon, 2014), but when states mitigate these structural barriers—as witnessed in Montana with the implementation and expansion of the SOR grant program—the lingering attitudinal barrier among VHA staff that their network is the only option for quality behavioral healthcare may constrain expansion of the community care model and veterans' access to MOUD treatment.

Attitudinal barriers also emerged among staff at community organizations serving veterans who referred patients to the VHA for substance use treatment. The attitudinal preference for VHA MOUD existed in conjunction with a structural barrier which further constrained the potential for referrals: staff at community-based organizations demonstrated a lack of literacy about non-VHA providers specializing in MOUD. The preference for VHA care among participants in this study may create a vacuum whereby all MOUD treatment funnels to the VHA, potentially exacerbating the VHA's inability to provide quality care to all potential patients due to the demand for MOUD. For example, Brunet et al. (2020) find a lack of addiction treatment nursing support and knowledge, and a lack of staff buy-in or knowledge of MOUD treatment within the VHA. Other research finds stigma, as well as a lack of time and resources at the VHA, inhibits MOUD treatment

(Gordon et al., 2011; Wakeman & Barnett, 2018).

The disproportionate amount of time, space, training, and staff it takes to treat SUDs, versus other mental health conditions, constrains the quality and amount of treatment available to veterans within the VHA (Najavits et al., 2010; Zubkoff et al., 2016). By referring all veterans to the VHA, staff at community-based organizations inundate the VHA's behavioral healthcare team with veterans seeking MOUD and likely decrease the quality of care veterans receive. Future research should continue to explicate the attitudinal and structural barriers that constrain referrals for treatment of OUD at non-VHA community care programs specializing in MOUD.

LIMITATIONS

The goal of this study is to understand the barriers to veterans accessing substance abuse treatment through state and community resources. We studied a single case and, thus, are providing logical inferences rather than statistical representation (Small, 2009). The main limitation of this study is the sample's focus on Montana's VHA medical network and community-based organizations that primarily serve veterans in Helena. Interviewers did recruit staff from community organizations across the state, but most work in the state's capital, and although they spoke about broader, state-wide patterns, much of their focus was on Helena. Given the focus on state-approved treatment providers and the state-wide approach taken by the Montana VHA, future studies should examine the generalizability of these findings in rural states with VHA systems that serve geographically dispersed veterans with a low density of providers.

IMPLICATIONS AND CONCLUSIONS

This study identifies a set of three structural and attitudinal barriers that, if addressed, may ensure and increase access to MOUD for veterans. First, staff at community-based organizations serving veterans express a preference for VHA MOUD, and second, they also lack literacy about non-VHA community-based providers specializing in MOUD. If veterans' advocates are unaware of or reluctant to refer veterans to community-based care, it will exacerbate the demands placed on VHA staff and inhibit access to treatment for veterans. Third, the VHA in Montana struggles to meet the demand of their patients and many SOR sites are approved community care providers that have additional capacity to treat patients, especially veterans. Increasing public knowledge of SOR programs and their ability to treat veterans becomes paramount to expand access to care for veterans suffering from OUD and other behavioral health disorders. Lastly, staff at the Montana VHA report treating patients, rather than referring veterans to community care providers who specialize in MOUD, and bridging this divide will ensure veterans receive expedited, quality care. Addressing these three interrelated dynamics will aid the MISSION Act's goal in supporting rural veterans' access to MOUD.

ADDITIONAL FILE

The additional file for this article can be found as follows:

Veterans Interview Questions. Our interview guide. DOI: *https://doi.org/10.21061/jvs.v7i3.262.s1*

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COMPETING INTERESTS

The authors have no competing interests to declare.

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REFERENCES

Andrilla, H., Coulthard, C., & **Larson, E.** (2017). Changes in the supply of physicians with a DEA DATA waiver to prescribe buprenorphine for opioid use disorder (Data Brief #162). WAMI Rural Health Research Center.

Barry, D. T., Bernard, M. J., Beitel, M., Moore, B. A., Kerns, R. D., & **Schottenfeld, R. S.** (2008). Counselors' experiences treating methadone-maintained patients with chronic pain: A needs assessment study. *Journal of Addiction Medicine, 2*(2), 108–111. DOI: *https://doi.org/10.1097/ADM.0b013e31815ec240*

Blanco, C., Ali, M. M., Beswick, A., Drexler, K., Hoffman, C., Jones, C. M., Wiley, T. R. A., & **Coukell, A.** (2020). The American opioid epidemic in special populations: Five examples. *NAM Perspectives*. DOI: *https://doi.org/10.31478/202010b*

Brunet, N., Moore, D. T., Lendvai Wischik, D., Mattocks, K. M., & **Rosen, M. I.** (2020). Increasing buprenorphine access for veterans with opioid use disorder in rural clinics using telemedicine. *Substance Abuse*, 1–8. DOI: *https://doi.org/10.1080/08897077.2020.1728466*

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. SAGE.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). SAGE.

Filteau, M. R., Kim, F. L., & **Green, B.** (2021). It's more than just a job to them: A qualitative examination of patient and provider perspectives on medication-assisted treatment for opioid use disorder. *Community Mental Health Journal*. DOI: *https://doi.org/10.1007/s10597-021-00824-7*

Finlay, A. K., Harris, A. H., Rosenthal, J., Blue-Howells, J., Clark, S., McGuire, J., Timko, C., Frayne, S. M., Smelson, D., Oliva, E., & **Binswanger, I.** (2016). Receipt of pharmacotherapy for opioid use disorder by justice-involved US Veterans Health Administration patients. *Drug and Alcohol Dependence*, *160*, 222–226. DOI: *https://doi.org/10.1016/j.drugalcdep.2016.01.013*

Glaser, B. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory*. The Sociology Press.

Glaser, B. G., & **Strauss, A. L.** (1967). *The discovery of grounded theory: Strategies for qualitative research*. Aldine Publishing. DOI: *https://doi.org/10.1097/00006199-196807000-00014*

Gordon, A. J., Drexler, K., Hawkins, E. J., Burden, J., Codell, N. K., Mhatre-Owens, A., Dungan, M. T., & **Hagedorn, H.** (2020). Stepped Care for Opioid Use Disorder Train the Trainer (SCOUTT) initiative: Expanding access to medication treatment for opioid use disorder within Veterans Health Administration facilities. *Substance Abuse, 41*(3), 275–282. DOI: *https://doi.org/10.1080/08897077.2020.1787299*

Gordon, A. J., Kavanagh, G., Krumm, M., Ramgopal, R., Paidisetty, S., Aghevli, M., Goodman, F., Trafton, J., & **Liberto, J.** (2011). Facilitators and barriers in implementing buprenorphine in the Veterans Health Administration. *Psychology of Addictive Behaviors: Journal of the Society of Psychologists in Addictive Behaviors, 25*(2), 215–224. DOI: *https://doi.org/10.1037/a0022776*

Green, B., & **Filteau, M. R.** (2019). *State Targeted Response (STR) to the Opioid Crisis Grant final evaluation*. Montana Addictive and Mental Disorders Division. DOI: *https://doi.org/10.36855/STR2019*

Holder, K. A. (2017). *Veterans in rural America: 2011–2015, American Community Survey Reports, ACS-36*. US Census Bureau. *https://www.census.gov/content/dam/Census/library/publications/2017/acs/acs-36.pdf*

Jones, C. A., Parker, T. S., Ahearn, M., Mishra, A., & **Variyam, J.** (2009). *Health status and health care access of farm and rural populations* (Economic Information Bulletin No. 57). Economic Research Service, United States Department of Agriculture. *https://www.ers.usda.gov/webdocs/publications/44424/9371_eib57_1_.pdf*

McCance-Katz, E. F. (2018). 2018 national survey on drug use and health: Veterans [PowerPoint slides]. SAMHSA. *https://www.samhsa.gov/data/sites/default/files/reports/rpt23251/6_Veteran_2020_01_14.pdf*

McCormick, W. H., Currier, J. M., Isaak, S. L., Sims, B. M., Slagel, B. A., Carroll, T. D., Hammer, K., & **Albright, D. L.** (2019). Military culture and post-military transitioning among veterans: A qualitative analysis. *Journal of Veterans Studies*, 4(2), 287–298. DOI: *https://doi.org/10.21061/jvs.v4i2.121*

Najavits, L. M, Norman, S. B., Kivlahan, D., & **Kosten, T. R.** (2010). Improving PTSD/substance abuse treatment in the VA: A survey of providers. *The American Journal on Addictions*, *19*(3), 257–63. DOI: *https://doi.org/10.1111/j.1521-0391.2010.00039.x*

National Judicial Opioid Task Force. (2019). *Promising strategies in providing opioid use disorder treatment to rural, frontier and other underserved communities*. National Center for State Courts. *https://www.ncsc.org/__data/assets/pdf_file/0019/17614/oud-txt-in-rural-areas-final.pdf*

Oliva, E. M., Harris, A. H., Trafton, J. A., & **Gordon, A. J.** (2012). Receipt of opioid agonist treatment in the Veterans Health Administration: Facility and patient factors. *Drug and Alcohol Dependence*, *122*(3), d 241–246. DOI: *https://doi.org/10.1016/j.drugalcdep.2011.10.004*

Oliva, E. M., Maisel, N. C., Gordon, A. J., & **Harris, A. H.** (2011). Barriers to use of pharmacotherapy for addiction disorders and how to overcome them. *Current Psychiatry Reports*, *13*(5), 374–381. DOI: *https://doi.org/10.1007/s11920-011-0222-2*

Oliva, E. M., Trafton, J. A., Harris, A. H., & **Gordon, A. J.** (2013). Trends in opioid agonist therapy in the Veterans Health Administration: Is supply keeping up with demand? *The American Journal of Drug and Alcohol Abuse*, *39*(2), 103–7. DOI: *https://doi.org/10.3109/00952990.2012.741167*

Post, E. P., Metzger, M., Dumas, P., & **Lehmann, L.** (2010). Integrating mental health into primary care within the Veterans Health Administration. *Families, Systems & Health: The Journal of Collaborative Family Healthcare*, *28*(2), 83–90. DOI: *https://doi.org/10.1037/a0020130*

Rosenblatt, R. A., Andrilla, C. H. A., Catlin, M., & **Larson, E. H.** (2015). Geographic and specialty distribution of US physicians trained to treat opioid use disorder. *Annals of Family Medicine, 13*, 23–26. DOI: *https://doi.org/10.1370/afm.1735*

Rubin, R. (2020). Rural veterans less likely to get medication for opioid use disorder. *JAMA*, *323*(4), 300. DOI: *https://doi.org/10.1001/jama.2019.21856*

Saldaña, J. (2009). *The coding manual for qualitative researchers*. Sage.

Sigmon, S. C. (2014). Access to treatment for opioid dependence in rural America: Challenges and future directions. *JAMA Psychiatry*, *71*(4), 359–360. DOI: *https://doi.org/10.1001/jamapsychiatry.2013.4450*

Small, M. L. (2009). 'How many cases do I need?': On science and the logic of case selection in field-based research. *Ethnography*, *10*(1), 5–38. DOI: *https://doi.org/10.1177/1466138108099586*

Trafton, J. A., Greenberg, G., Harris, A. H., Tavakoli, S., Kearney, L., McCarthy, J., Blow, F., Hoff, R., & **Schohn, M.** (2013). VHA mental health information system: Applying health information technology to monitor and facilitate implementation of VHA uniform mental health services handbook requirements. *Medical Care*, *51*(3 Suppl. 1), S29–S36. DOI: *https://doi.org/10.1097/MLR.0b013e31827da836*

Turvey, C. L., Lund, B. C., Jones, D., & **Arndt, S.** (2020). Community treatment for opioid use disorders in urban and rural veterans. *The Journal of Rural Health: Official Journal of the American Rural Health Association and the National Rural Health Care Association*, *36*(2), 167–176. DOI: *https://doi.org/10.1111/jrh.12406*

US Census Bureau. (2019). Montana Vet Statistics. Retrieved October 4, 2021, from *https://www2.census.gov/library/visualizations/2015/comm/vets/mt-vets.pdf*

US Department of Veterans Affairs. (2014). State Summaries: Montana. Retrieved October 4, 2021 from *https://www.va.gov/vetdata/docs/SpecialReports/State_Summaries_Montana.pdf*

US Government Accountability Office. (2019). VA health care: actions needed to improve oversight of community-based outpatient clinics. *https://www.gao.gov//assets/700/691221.pdf*

VA MISSION Act of 2018. s. 2372 — 115th Congress: VA MISSION Act of 2018.

Valenstein-Mah, H., Hagedorn, H., Kay, C. L., Christopher, M. L., & **Gordon, A. J.** (2018). Underutilization of the current clinical capacity to provide buprenorphine treatment for opioid use disorders within the Veterans Health Administration. *Substance Abuse*, *39*(3), 286–288. DOI: *https://doi.org/10.1080/08897077.2018.1509251*

Veterans Health Administration. (2008). *Uniform mental health services in VA medical center and clinics* (Handbook VHA 1160.01). Office of Mental Health Services.

Wakeman, S. E., & **Barnett, M. L.** (2018). Primary care and the opioid-overdose crisis–Buprenorphine myths and realities. *The New England Journal of Medicine*, *379*(1), 1–4. DOI: *https://doi.org/10.1056/NEJMp1802741*

Westphal, R. J., & **Convoy, S. P.** (2015). Military culture implications for mental health and nursing care. *Online Journal of Issues in Nursing*, *20*(1), 4. DOI: *https://doi.org/10.3912/OJIN.Vol20No01Man04*

Wyse, J. J., Gordon, A. J., Dobscha, S. K., Morasco, B. J., Tiffany, E., Drexler, K., Sandbrink, F., & **Lovejoy, T. I.** (2018). Medications for opioid use disorder in the Department of Veterans Affairs (VA) health care system: Historical perspective, lessons learned, and next steps. *Substance Abuse*, *39*(2), 139–144. DOI: *https://doi.org/10.1080/08897077.2018.1452327*

Zubkoff, L., Shiner, B., & **Watts, B. V.** (2016). Staff perceptions of substance use disorder treatment in VA primary care–mental health integrated clinics. *Journal of Substance Abuse Treatment*, *70*, 44–49. DOI: *https://doi.org/10.1016/j.jsat.2016.07.011*

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