# Barriers to Opioid Use Disorder Care in Polk County

Prepared for Polk County Behavioral Health & Disability Services Department
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## Background and Purpose

This report synthesizes findings from the analysis of six focus groups conducted with 42 individuals with lived experience of opioid use disorder (OUD) in Polk County, Iowa, in the spring of 2026. Participants represented three subpopulations: individuals residing in a minimum-security correctional facility, individuals engaged in community-based medication-assisted treatment (MAT), and individuals in community reentry following justice involvement. The focus groups were facilitated and transcribed by Rebel Healthcare and analyzed by Iowa State University's Public Science Collaborative using open coding and applied thematic analysis methods.

The analysis has been condensed into a summary of the barriers that prevent people with OUD from accessing and remaining in care. We report two types of barriers. The first are barriers explicitly named by participants (manifest), including directly stated obstacles such as clinic hours, housing discrimination, or fear of arrest. The second kind of barriers are those that participants experience but often can't fully explain, are consistent across many individuals' experiences, or are implied by their accounts (latent). These often point to the social environments that shape behavior in ways that either support or detract from the recovery potential of people with OUD. Both types of barriers warrant consideration for policy and program development. Addressing manifest barriers without addressing latent barriers risks producing minor improvements that leave the underlying problems with the system intact.

The report concludes with a community action framework to inform the translation of our findings into actionable recommendations for Polk County Behavioral Health and Disability Services and its community-based partners.

## Manifest Barriers to OUD Care

Manifest barriers were identified through direct participant statements about the obstacles they encountered when seeking, accessing, or remaining in treatment. Six categories of manifest barriers emerged in one or more of the three study sites.

### 1. Fear of Criminalization When Disclosing Need

The most consistently mentioned barrier was the expectation that disclosing substance use to a probation or parole officer, or requesting treatment while under supervision, would result in incarceration rather than treatment. Multiple participants described having asked for help and been sent directly to jail without a treatment referral. Other participants echoed the broader belief that being honest about a return to use would result in punitive actions, rather than treatment. This barrier blocks the act of disclosing a need for a service.

> *"As soon as you tell your parole officer here that you need help, they're going to lock you up. So nobody here gets help. But in New York, even after I relapse, I'll just tell my parole officer, 'You know, I relapsed,' and she'll give me help... I don't have fear of getting incarcerated until I come back here." — Corrections participant*
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> *"I've asked for help twice. And they sent me straight to the county without even sending me anywhere for help." — Corrections participant*

## 2. Operational Barriers to Treatment

Participants described specific operational features of MAT clinics that either prevent or interrupt access. This included things like multi-day induction delays during which they continued using, dosing hours limited to early-morning windows that conflict with employment, inconsistent Saturday hours, providers not being available, leading to same-day appointment cancellations, and biopsychosocial intake requirements imposed during active withdrawal.

MAT is an evidence-based form of treatment that participants describe as difficult to access for a variety of reasons. Barriers that limit or block access to MAT negatively impact a narrow window of openness to treatment and frequently leave people to suffer harmful withdrawal symptoms that are themselves a barrier to treatment. The window of readiness to change is described as brief and fragile. A responsive, user-centered system of care that dynamically adapts to user feedback by changing operating procedures might address this barrier.

> *"It takes three days…before they even dose you for the first time. What did they expect you to do? Just keep using those three days? Which I did keep using, until I got [dosed]." — MAT participant*
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> *"I went to Cobra, got turned away, and I was so close to saying fuck it and just leaving. …I was withdrawing so bad, to the point where if I didn't get anything that day, I was going to leave." — MAT participant*
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> *"Had it not been for Thrive and I would have been at home, I wouldn't have waited four or five hours to see the doctor, to see the nurse. I would have said, fuck it. I'm on probation." — MAT participant*

## 3. The Long Arm of Felony Conviction

Felony records systematically exclude individuals from housing, employment, and benefits programs, creating interconnected instabilities that can make treatment engagement and maintenance nearly impossible. Participants described being denied apartments despite meeting income requirements, being passed over for employment after successful interviews, and being disqualified from food assistance programs when enrolling in vocational training.

> *"I have a burglary charge, which keeps me from getting a lot of apartments. A lot of people in [half- and three-quarter houses] are taking up beds because they just cannot afford a place to live at that point in time." — Community participant*
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> *"I signed up for MIG welding through vocational training. But if you're in vocational training, you cannot get food stamps. It'll disqualify you. I surely cannot afford food for my two kids — 16 and 17 — plus myself, enough food that they're going to be able to eat like they should." — Community participant*

The housing barrier manifests in two ways. First is the immediate crisis of having nowhere to go after release from corrections or discharge from treatment. The second is that for people with a felony record, rental options are often limited for years or decades, regardless of recovery progress. Both barriers push individuals into environments where active use is prevalent and unavoidable, thereby increasing the risk of return to use. One participant's observation that people with felony records occupy sober-living beds because they cannot secure housing shows how one problem leads to another…fewer sober beds. Beyond its function as a barrier to recovery, the housing gap is actively consuming treatment capacity that could otherwise serve people at earlier stages of need.

## 4. Transportation

Transportation was named as a chronic barrier to MAT clinic attendance, meeting participation, medical appointments, and court dates by participants in all focus group discussions. The transit mismatch specific to one Polk County health care facility, requiring a bus and then a 45-minute walk, was cited by participants as eliminating that option. Within the Des Moines metro, participants described long, multi-leg commutes (e.g., a pre-dawn bus followed by a long walk) to reach jobs, appointments, and MAT, and described depending on sponsors, peers, and program shuttles to make it work.

> *"The bus doesn't go to [facility]. You have to catch a bus and then walk like 45 minutes. …Nobody on my program is going to have to hop a bus and then walk 45 minutes to get there." — Corrections participant*
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> *"Transportation is a big issue. I bet anybody you talk to [in sober living], that's their worst problem. You can't go to a job interview…a lot of people don't want to hire you unless you have transportation." — Community participant*

The transportation barrier has the potential to compound across the day, week, and month in ways that can make recovery harder. Chronic transportation barriers make getting to OUD care more difficult, and they also make daily living, and job, housing, and relationships more difficult to maintain. Participants' transportation stories suggest that transportation is more **a problem of route design** than a scarcity of resources (e.g., no license, no car, no money for bus pass).

### 5. Absence of Grief and Trauma Support

The accounts recorded in the focus group discussions make clear that grief is an active, recurring driver of use escalation that reactivates at unpredictable intervals, and that MAT alone does not address. Many participants named traumatic grief as either a direct cause of escalating use or a pivotal turning point in their recovery. Despite this, grief support was routinely unavailable or inaccessible unless participants actively sought it out from specialty providers. No participant described receiving proactive grief support as part of MAT intake or ongoing care.

> *"If I can get my grief under control, I think I can take my Suboxone and be happy. It's just when I'm alone, that grief creeps in, and I don't have no way to express it." — MAT participant*
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> *"My twin brother, I'm two minutes older than him, overdosed on fentanyl. They Narcan'd him five times to bring him back to life."— Corrections participant*
>
> *"My daughter called somebody else Dad. I'm in here getting high, running around, hustling, playing cards, doing nothing. Somebody else is raising my kids. I can't keep doing that to them. I can't keep doing that." — Corrections participant*

One participant's explicit plan to arrange a grief therapist before leaving residential treatment, self-initiated without any clinical prompt, illustrates both the gap in standard care and the degree to which participants themselves understand what they need when systems don't offer it. The gap between the prevalence of grief (and trauma) as a primary driver of substance use and relapse *and* the absence of grief support in routine care can be closed, or at least reduced.

### 6. Stigma in Institutional Encounters

Participants described systematic mistreatment in emergency departments, jails, and clinics that function as a direct barrier to care-seeking. In participants' telling, emergency departments refused to treat alcohol withdrawal seizures because alcohol was involved, jail staff mocked visible withdrawal symptoms rather than summoning medical assistance, and methadone clinics allowed visibly intoxicated clients to collect take-home doses. For people with an OUD, these experiences are internalized in ways that make getting treatment and other forms of care more difficult.

> *"I'm withdrawing from alcohol...I'm starting to hallucinate, and I'll never forget hearing the COs out at the desk be like, 'Oh, she's just tweaking.'...I didn't get to see a nurse for the two days of withdrawing and convulsing and hallucinating, and I was banging on that window...They just passed it off until I actually fell over and hit my head in the cell, before I got to see a nurse." — Community participant*
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> *"I was lying, cheating, and swindling that clinic every way I could for eight years...They're coming in here letting me get away with murder. So if they don't care, why would I care?...Obviously they know I'm drunk, they're giving me a boatload of methadone to go home with. They don't care if I go home and OD or not. I'm cash to them." — MAT participant*

There are two very different but complementary strategies to address system-level stigma. The first is education and programs aimed at people who work in medical, justice, and related institutions. The goal would be to effect attitude and behavioral change across these large institutions. The second is programs aimed at people with OUD. Here we might consider resilience training, coping strategies, and institutional navigator support.

## Latent Barriers to OUD Care

Latent barriers are the deep signals and subtle meanings that underlie the words people use to describe their experiences. Unlike manifest barriers, they may not be directly named by participants as problems or experiences. Instead, they are implied by how focus group participants share accounts of their experiences. Below, we share five latent barriers that, according to participants, produce harmful outcomes or constitute barriers to care.

**Latent Barrier 1: Help-Seeking**

The systems nominally designed to support recovery are structured in ways that make honest disclosure of need dangerous. Participants across all focus groups described *performing wellness* to avoid punishment, hiding relapse from probation officers, and concealing withdrawal symptoms in medical settings. This is a rational adaptation to a system in which disclosure triggers punishment rather than help. It is unlikely that this conflict can be addressed by improving any single program or institution. It will likely require changes across the system of care and to the incentive structure of supervision, medical care, and social services. If people can't distinguish between need-disclosure without also self-incriminating, they are less likely to seek care until their situation becomes a crisis.

**Latent Barrier 2: Cascade Effects**

Participants don't experience housing, employment, legal status, MAT access, family relationships, and mental health as separate problems to be addressed by siloed systems. People often both perceive and experience them as a single sequence of connected events, often fatalistically too. A dosing schedule conflict causes a missed appointment that triggers a take-home revocation. A take-home revocation creates a recurring transportation problem that costs a job and leads to missed rent payments. Losing housing might then require a temporary stay with a substance-using family member, which contributes to a relapse and probation violation. Settlement investments that address only one link in this chain often fail to produce measurable improvements because the remaining links preserve the original crisis. Effective investment should account for interrelated risk factors and the precarious lives of many people with an OUD.

**Latent Barrier 3: Environmental Context**

Participants consistently read the physical and relational environment of treatment settings as evidence of how they are regarded. Wall color in institutional contexts, numbered client identifiers, staff who allow visible intoxication without comment, and clinics that are open for ninety minutes on Saturday often leave people who use drugs to feel like they are just a case to be processed, rather than a person in need of help. This communication occurs whether or not any individual staff member is intentional about it, because it is a structural feature of the system rather than interpersonal behavior that can be educated away. Participants describe live plants, natural light, a staff member who remembers a client's name without checking a number, and clinic hours that accommodate employment as humanizing and supportive to recovery. These environmental signals can influence treatment experience and outcomes because when participants feel seen as human beings, they tend to stay, and when they feel processed, they tend to leave.

**Latent Barrier 4: System Literacy**

Navigating the OUD treatment and justice systems requires extensive, specialized, and complex knowledge that is neither publicly available nor uniformly distributed in the population. The mental health probation track, for example, which converts violations into case planning rather than incarceration, was successfully used by one participant but was unknown to another in the same focus group and to the facilitator. The capacity to document recovery activity and present it to a sentencing judge, which kept one participant out of prison, was self-developed through prior system experience and is not taught anywhere. The knowledge of how institutions function and how to activate them in one's own interest (system literacy) is a resource that the current system distributes by chance or exposure, rather than by design. People with more extensive system contact have greater knowledge of it, while those with less system exposure have fewer options because they have less institutional knowledge to work with.

**Latent Barrier 5: Structure and Control**

Participants describe a need for, and resentment of, external structure such as supervision schedules, sober living rules, dosing requirements, and probation conditions. What distinguishes the structure participants experience as *supportive* from the structure they experience as *controlling* is its orientation rather than its strictness. A consistent and explained structure that is connected to the participant's own recovery goals is experienced by participants as rational and helpful, whereas a structure that is opaque, arbitrary, or punitive is perceived as control. The question is not how much structure to impose, but what kind, and with what level of explanation. In ideal conditions, institutions are viewed as working with participants toward common goals.

## Recommendations

The table below offers a few ideas for translating 'barrier findings' into the kinds of specific actions that Polk County Behavioral Health and Disability Services and community-based partners might consider.

| Recommendation | Action Ideas |
|---|---|
| **Same-day MAT access protocol** | Establish an intake process that separates same-day dosing from biopsychosocial and life history assessment. Encourage funded clinics to document median time-to-first dose and consider a benchmark such as a 24-hour target. |
| **Peer recovery coach deployment in MAT settings** | Coaches carry system-navigation knowledge and serve as recovery capital brokers. Hire and compensate 1- 2 peer recovery coaches at each clinic site and consider embedding coaches in the dosing queue. |
| **Transportation coordination** | Expand shuttle infrastructure modeled on Kingdom Living's existing route (see also Rediscover transportation model in Clinton, IA). Coordinate with MAT clinics to align shuttle timing with dosing windows. Provide transit passes as a standard element of the MAT program. Journey map the client/user experience to inform transportation coordination re-design. |
| **Trauma and grief group integration** | Add a structured grief support group as a standard program offering, rather than a specialty referral, and screen all new enrollees for traumatic loss. |
| **Environmental audit of all funded clinic spaces** | Develop a brief environmental checklist (natural light, plant life, comfortable seating, named rather than numbered client identification, non-institutional color) and encourage funded clinics to meet minimum standards. |
| **Safe-to-disclose pilot with probation and parole** | Advocate for and pilot a treatment-first diversion protocol in which relapse disclosure to a probation officer triggers a treatment referral rather than automatic incarceration. Strong documentation of outcomes can inform statewide expansion. |
| **Mental health probation track expansion** | Audit current eligibility criteria and referral rates for the mental health probation track. Document the proportion of OUD-involved defendants who are eligible but not enrolled. Advocate with pre-trial services for enhanced screening and referral for all OUD-documented defendants. |
| **System literacy curriculum for peer coaches** | Document the system-navigation knowledge of experienced recovery coaches and peer support specialists (housing applications, MAT enrollment, probation track options, sentencing documentation) and formalize it into a curriculum that peer coaches deliver as part of the intake process. |

## Conclusions

The barriers documented in this report were described by more than 40 individuals as they shared their personal experiences with systems of care and justice. One participant described watching eight friends die of fentanyl in a single year and then being told that his parole officer would send him to jail if he disclosed a relapse. Another described being given fentanyl in surgery against her documented wishes, then being denied MAT services to address the resulting withdrawal, then being told she had no legal recourse because of her history. And a third has been in and out of Polk County jail for sixteen years and is now building a recovery support network large enough to change that trajectory.

These and other accounts converge on the idea that **the barriers to OUD care in Polk County lie within the systems of care intended to provide it, as much as in the individuals who need it.** Many of the barriers reported here represent specific, concrete opportunities to improve care and outcomes, such as targeted investments and either new programs or modifications to existing ones. Our analysis also identifies structural factors that can make accessing care more difficult. The recommendations we have proposed span a range of institutions, from treatment centers to justice systems, and include quick wins, low-cost interventions, and larger-scale, system-level changes that take time, resources, and coordination. Focusing on quick wins first, and building the collaborations necessary for system-level changes second, can build momentum.

What focus group participants ask for is neither novel nor unrealistic. They ask for a clinic that will see them the day they walk in. A probation officer who will help them get treatment rather than send them to jail for needing it. A place to live where a felony conviction will not prevent them from renting. A space that treats them like a person rather than a number. It is helpful to remind ourselves that what people with a history of harmful substance use are asking for is reasonable. And in practical terms, **these requests are achievable, and the settlement funds that make them possible are available now.**

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*In keeping with conventions for the analysis and interpretation of personal narratives, we did not attempt to verify the stories and perspectives shared in the focus groups. The value of these data is in what they tell us about the experiences and narratives commonly shared among people with opioid use disorder in Iowa. We recommend these narratives be paired with perspectives from care providers, administrative records, and other data to provide a holistic picture of how to best reduce OUD prevelance and harms.*