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What is a rural opioid risk and policy environment?

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The current US opioid epidemic differs from past drug epidemics in multiple ways. Rural communities that had little or no prior experience with heroin were affected and ill-prepared for the mass introduction of prescription opioids and the subsequent arrival of illicit opioids, including fentanyl. Longstanding methamphetamine production and use in these regions has enabled polydrug use that includes heroin, fentanyl, methamphetamine and other substances (Allen et al., 2019). Lessons learned from urban epidemics are useful but it is clear that research, policy and program planning in rural areas require novel approaches that consider local drug-related risk, social and policy environments (Rhodes, 2002).

Rural areas remain largely distinct in terms of infrastructure and health outcomes (Anderson, Saman, Lipsky & Lutfiyya, 2015), even though definitions of rural can be somewhat elastic <https://www.ruralhealthinfo.org/am-i-rural> and urban/suburban distinctions have increasingly become blurred (Landis, 2015). The NIDA/CDC/SAMHSA/Appalachian Regional Commission-funded Rural Opioid Initiative <https://grants.nih.gov/grants/guide/rfa-files/RFA-da-17-014.html> that serves as the background for this paper permitted small metropolitan areas, micropolitan areas and areas meeting one or more federal definitions of rural. The sites include small de-industrialized cities, former mining towns, and small trading hubs and their hinterlands in Illinois, Kentucky, Massachusetts, New Hampshire, North Carolina, Ohio, Oregon, Vermont, West Virginia, and Wisconsin; several sites are contributing to this special issue. The authors of this paper are the NIDA Science Officer for the project (R.A.J.) and an ex-officio investigator who serves as Chair of the project's Executive Steering Committee (H.H.), who together visited all of the project sites. The paper will briefly review our observations regarding unique features of rural risk, social and policy environments that affect research, policy and program planning.

Many aspects of macro-level drug use risk and policy environments are shared by rural and metropolitan areas because of the state-level policies that guide local planning and financing of behavioral and public health services and regulate harm reduction activities. Rural areas' low population sizes and densities lead to scarcities in funding and services, making it useful to consider local macro environments separately from those at the state level. We observed

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scarcity even where state-level policy and economic environments permitted a range of harm reduction services. Local decision makers often are unable to raise revenue from general funds or property tax levies to supplement the basic services supported by state and federal funds and may lack infrastructure necessary to compete for special initiatives managed by states, creating disadvantaged policy environments. Local rural social environments become important for policy making because decisionmaking circles may be small due to low population sizes and long-lived residence, and the relevant sectors may interact differently than in metropolitan areas. For example, law enforcement may hold power over health commissioners' decisions. Non-profit sectors usually are limited in scope and often reliant on decisions regarding public funding to shape what is available. These aspects of local rural macro-environments impede the creation of enabling environments for translating evidence-based practices into services, and augment urban-rural disparities (Jones, 2019).

Scarcity of resources in local macro-environments severely restricts access to the full range of effective health and social services. These services usually are clustered in a region's largest economic hub, and very limited or non-existent public transport means that residents depend on access to personal vehicles in good repair. Medication for opioid use disorder (MOUD) may be unavailable or only available through specialty clinics and, in some cases, is limited to naltrexone. Buprenorphine training for providers has had minimal success, with most waived providers choosing not to provide this service, demonstrating the limits of policy interventions. High prevalence of polydrug use that includes methamphetamine complicates matters because of the lack of evidence-based pharmacotherapy or other scalable treatments for stimulant use disorders. Drug-free treatment and aftercare programs, typically for-profit, are filling service gaps in many communities and often actively oppose MOUD and harm reduction approaches. Macro-level policy factors at the state level also interact with macrosocial, -policy or -physical environments at the local level. State-level Medicaid restrictions coupled with limited numbers of specialty care or primary care providers experienced in treating hepatitis C create other barriers, and poor broadband coverage can rule out telemedicine as a feasible alternative. Harm reduction services may exist but be unable to tailor their delivery and hours of operation to the actual needs of the community. Syringe access may take place in a health department or free clinic one or two mornings a week, in some cases wholly relying on volunteer staff. Chain pharmacies under standing orders permitting naloxone or syringe sales without a prescription may refuse to dispense these, invoking "pharmacist's discretion". In more remote areas, laboratory services may be unavailable, hindering diagnosis, treatment monitoring and research requiring biospecimens.

Familiar features of physical and policy risk environments like marginal housing and homelessness are common in rural areas, either hidden away in protected forest lands or highly visible in municipal parks. Social micro-environments akin to shooting galleries and settings that combine drug dealing and couch surfing also are present. Outreach to such drug use areas or homeless encampments of the kind that exists in urban areas tends to be rare, and shelters or other support services only exist in larger, better resourced rural towns.

Rural people who use drugs (PWUD) tend to remain more connected to families of origin than those in urban areas, and drug use networks may be located among kin (Young, Rudolph and Havens (2018), creating rather distinct micro-social environments. This can

provide social capital, but combined with the kind of fixed social identities that develop in small places, may augment stigma and make it difficult to seek services and re-establish oneself after recovery. Collectively or individually, providers may be discouraged from offering office-based MOUD over concerns that it will affect the image of their practice or disturb their other patients. The labeling of MOUD as replacement of one addiction with another and the belief that needle exchange fosters drug use have stigmatized and often blocked these services in rural communities, reflecting norms across a variety of micro social environments including PWUD, providers, and community leaders. The smallness of places and scarcity of services for all kinds of basic needs compound drug use stigma. High rates of disability coupled with poverty in rural areas impacted by the opioid epidemic mean that people with other chronic conditions also struggle to afford adequate health care, and may resent resources devoted to OUD (Kearney, Jones, Bell, Swinker & Allen, 2018).

Despite the conditions that can create or perpetuate stigma toward drug users, social micro environments may provide assets to create enabling environments for reducing drug-related harms. The small size of rural communities and the long tenure of residents may generate social capital and collective efficacy that support implementation of evidence-based practices to address opioids and their consequences. Where we saw full-time syringe services in a health care setting, it reflected the commitment of people with longstanding ties to the local community and the broader public health establishment. Key individuals, including PWUD, often take critical steps in addressing risk environments, who have stepped up to fill the gap in syringe access, naloxone distribution and safe use education through their network connections. The most flexible mobile syringe services we saw resulted from the long-lived commitment of someone whose HIV activism and service led them to harm reduction work. Personal, family connections to PWUD often provided the basis for local politicians, business people, law enforcement and other “natural leaders” to emerge. Outsiders seeking to build on this goodwill need to recognize the importance of building local relationships, avoid assumptions about local people, recognize the risks and commitments they make, and affirm the necessity of local solutions to create rural environments that enable effective ways to reduce opioid use and its consequences.

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References

Allen ST, O’Rourke A, White RH, Schneider KE, Kilkenny M, & Sherman SG (2019). Estimating the number of people who inject drugs in a rural county in appalachia. *American Journal of Public Health*, 109, 445–450. 10.2105/AJPH.2018.304873. [PubMed: 30676803]

- Anderson TJ, Saman DM, Lipsky MS, & Lutfiyya MN (2015). A cross-sectional study on health differences between rural and non-rural U.S. counties using the county health rankings. *BMC Health Services Research*, 15, 441. 10.1186/s12913-015-1053-3. [PubMed: 26423746]
- Jones CM (2019). Syringe services programs: An examination of legal, policy, and funding barriers in the midst of the evolving opioid crisis in the U.S. *International Journal of Drug Policy*, 70, 22–32. [PubMed: 31059965]
- Kearney GD, Jones K, Bell RA, Swinker M, & Allen TR (2018). Climate change and public health through the lens of rural, eastern North Carolina. *North Carolina Medical Journal*, 79, 170–177. 10.18043/ncm.79.5.270. [PubMed: 29735621]
- Landis JD (2015). Tracking and explaining neighborhood socioeconomic change in U.S. metropolitan areas between 1990 and 2010. Philadelphia: Penn Institute of Urban Research <https://www.penniur.upenn.edu/uploads/media/PennIUR-Policy-BriefLandis.pdf>.
- Rhodes T (2002). The ‘risk environment’: A framework for understanding and reducing drug-related harm. *International Journal of Drug Policy*, 13, 85–94.
- Young AM, Rudolph AE, & Havens JR (2018). Network-based research on rural opioid use: an overview of methods and lessons earned. *Current HIV/AIDS Reports*, 15, 113–119. 10.1007/s11904-018-0391-2. [PubMed: 29457200]