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KEY FACTS and RECENT and EMERGING TRENDS IN RURAL SUBSTANCE USE

State Agriculture and Rural Leaders

2016 Legislative Agriculture Chairs Summit

Denver, CO

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Data Source: National Survey on Drug Use and Health; Substance Abuse & Mental Health Services Administration

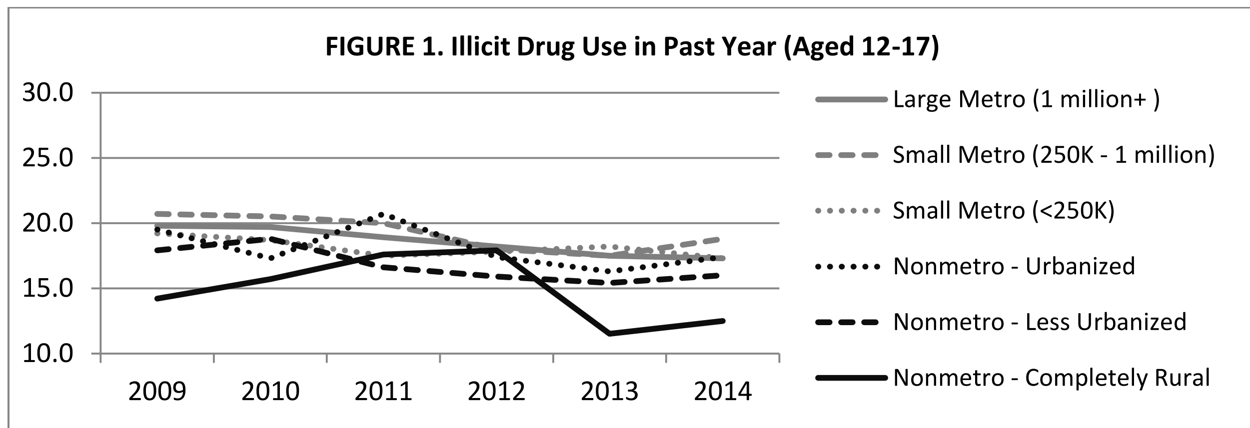
RURAL DRUG ABUSE - KEY FACTS and TRENDS

RURAL YOUTH

- Rural youth (aged 12-17) are more likely than urban youth to smoke cigarettes, drink alcohol, binge drink, and misuse prescription opioids.
- Rural youth perceive substance use as less risky compared to urban youth.
- Illicit drug use among youth has trended downward in metropolitan areas, but prevalence is more sporadic in nonmetropolitan areas.

TABLE 1. Illicit Drug Use in Past Year (Aged 12-17)

	2009	2010	2011	2012	2013	2014
Large Metro (1 million+ population)	19.8	19.7	18.9	18.2	17.5	17.3
Small Metro (250K - 1 million)	20.7	20.5	20.0	18.0	17.5	18.8
Small Metro (<250K)	19.2	18.7	17.5	17.8	18.2	17.3
Nonmetro - Urbanized	19.5	17.3	20.7	17.4	16.3	17.4
Nonmetro - Less Urbanized	17.9	18.8	16.6	15.9	15.4	16.0
Nonmetro - Completely Rural	14.2	15.7	17.6	17.9	11.5	12.5



RURAL ADULTS

- Rural adults (aged 18+) are more likely than urban adults to smoke cigarettes and begin smoking as children.
- Binge drinking and intoxicated driving are more common in rural versus urban areas.
- Drug use is most common among "emerging adults" (ages 18-25).

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TABLE 2. Illicit Drug Use in Past Year (Aged 18-25)

	2009	2010	2011	2012	2013	2014
Large Metro (1 million+)	37.1	36.3	36.4	38.5	37.7	37.5
Small Metro (250K - 1 million)	36.5	36.2	35.4	35.3	34.9	35.5
Small Metro (<250K)	37.9	34.4	33.4	35.8	34.5	34.8
Nonmetro - Urbanized	34.0	35.5	36.4	32.9	32.6	35.7
Nonmetro - Less Urbanized	30.0	26.4	27.8	26.9	30.6	30.3
Nonmetro - Completely Rural	31.8	25.2	24.1	22.8	23.7	24.6

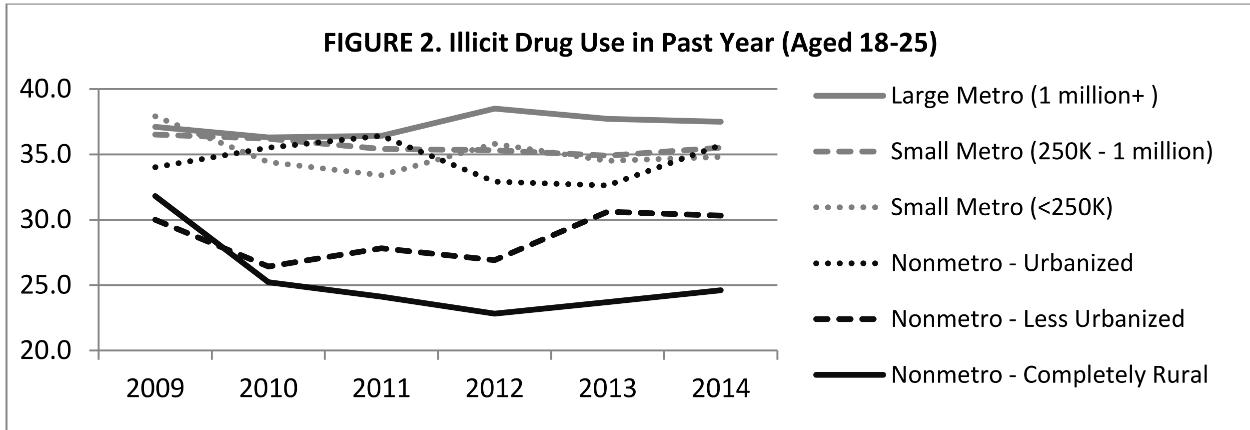
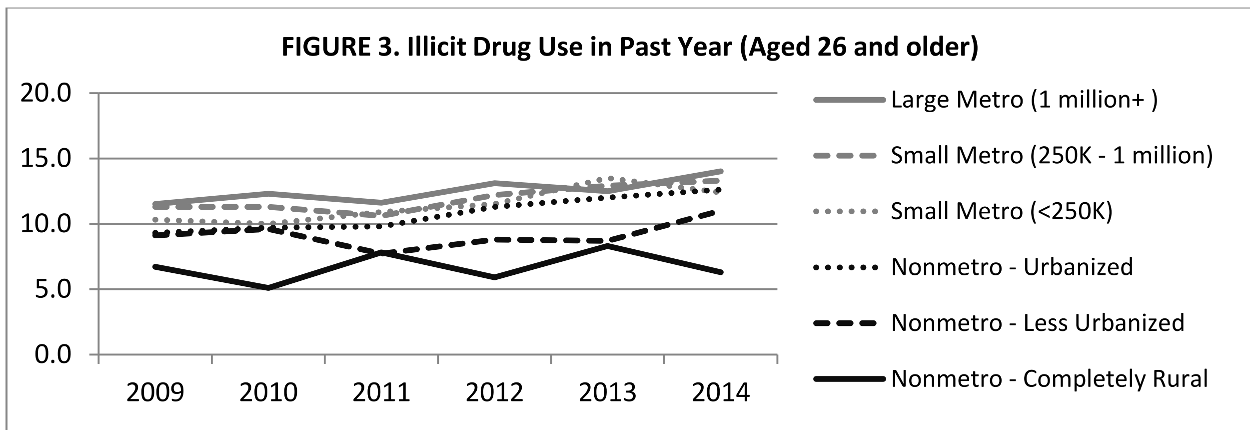


TABLE 3. Illicit Drug Use in Past Year (Aged 26 and older)

	2009	2010	2011	2012	2013	2014
Large Metro (1 million+)	11.5	12.3	11.6	13.1	12.5	14.0
Small Metro (250K - 1 million)	11.3	11.3	10.6	12.2	12.9	13.3
Small Metro (<250K)	10.3	10.0	10.9	11.5	13.5	12.4
Nonmetro - Urbanized	9.3	9.7	9.8	11.3	12.0	12.6
Nonmetro - Less Urbanized	9.1	9.6	7.7	8.8	8.7	11.0
Nonmetro - Completely Rural	6.7	5.1	7.8	5.9	8.3	6.3



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THE OPIATE EPIDEMIC

- Prescription opioid abuse is trending downward, but it is being replaced by heroin.
- Prescription opioid abuse is a gateway to heroin use – 80% of adults who have ever used heroin have also abused prescription pain relievers at some point in their lives.
- The demographic characteristics of prescription opioid and heroin users are converging. White women are the fastest growing group of heroin users.
- Heroin is easy to find in small towns. In most places, heroin is cheaper than beer.
- Most addicts interchange heroin and prescription pain relievers based on availability.
- Most rural residents do not get the prescription pills they abuse from dealers. Instead, they get them from friends/family and/or directly from physicians. Rural residents are more likely than urban residents to report that they obtained the pills they abuse directly from a physician.
- Rural residents utilize emergency department services more frequently than their urban counterparts. Opioids are more liberally prescribed in emergency departments.
- The most commonly abused prescription opioids include codeine (often sold as Tylenol w/Codeine), hydrocodone (often sold under brand names Vicodin, Lortab, Lorcet), and oxycodone (often sold under brand names OxyContin, Percocet, and Roxicodone).
- About a third of youth who abuse prescription opioids also use other illicit drugs and abuse other prescription medications.
- Nearly a third of adults who abuse prescription opioids first started abusing prescription opioids in youth (between ages of 12 and 17).
- Adults in manual labor occupations are at increased risk of prescription opioid misuse.

TABLE 4. Non-Medical Use of Prescription Pain Relievers in Past Year (Aged 12-17)

	2009	2010	2011	2012	2013	2014
Large Metro (1 million+)	6.1	5.8	5.6	5.0	4.4	4.1
Small Metro (250K - 1 million)	6.8	7.1	6.5	5.9	4.7	5.3
Small Metro (<250K)	8.7	6.3	5.9	5.9	6.0	4.8
Nonmetro - Urbanized	8.2	8.0	5.9	5.2	5.2	7.4
Nonmetro - Less Urbanized	5.8	6.0	6.5	5.8	4.3	5.2
Nonmetro - Completely Rural	4.5	2.1	6.5	6.4	3.5	3.9

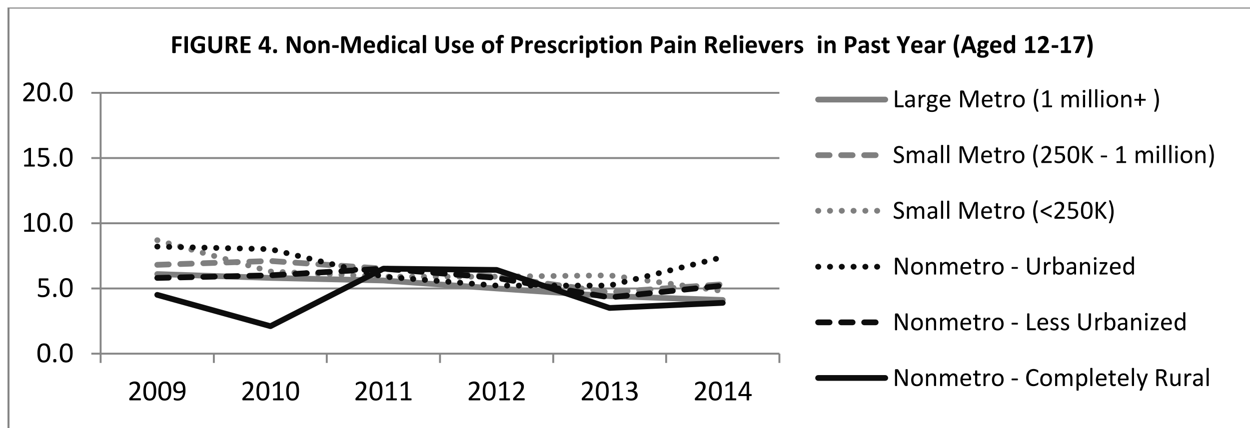

FIGURE 4. Non-Medical Use of Prescription Pain Relievers in Past Year (Aged 12-17)

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TABLE 5. Non-Medical Use of Prescription Pain Relievers in Past Year (Aged 18-25)

	2009	2010	2011	2012	2013	2014
Large Metro (1 million+)	11.3	10.5	9.3	10.4	8.7	7.8
Small Metro (250K - 1 million)	12.8	12.2	10.6	10.3	9.3	8.1
Small Metro (<250K)	13.0	12.1	10.4	10.3	8.8	8.3
Nonmetro - Urbanized	13.1	12.0	11.0	8.5	9.6	7.1
Nonmetro - Less Urbanized	11.9	9.5	9.9	9.5	7.9	8.1
Nonmetro - Completely Rural	10.7	11.5	6.4	9.0	6.9	5.3

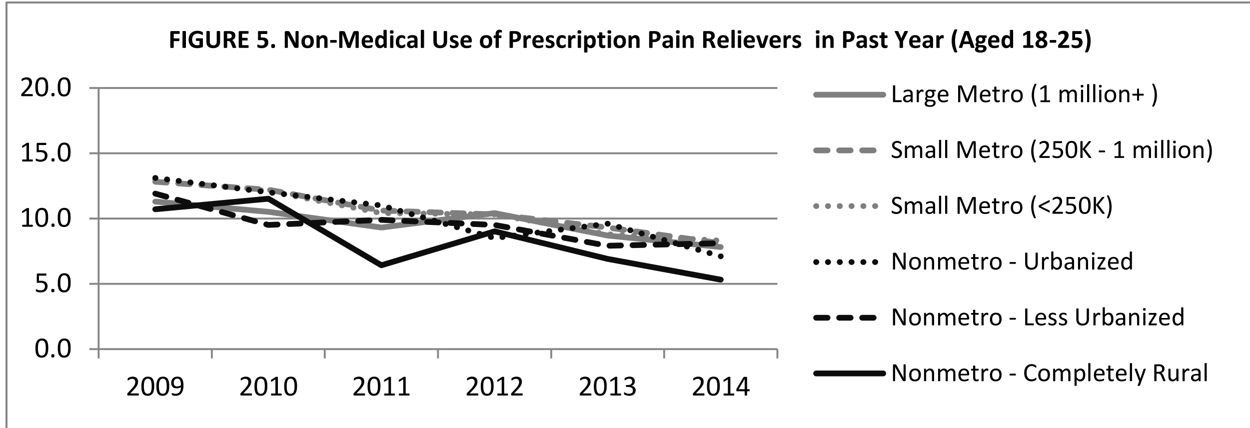
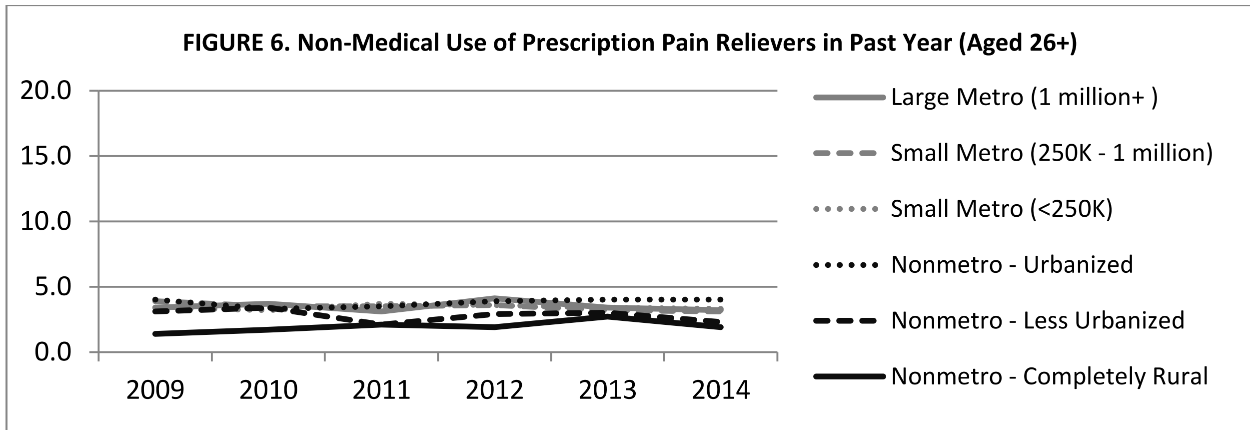


TABLE 6. Non-Medical Use of Prescription Pain Relievers in Past Year (Aged 26 and older)

	2009	2010	2011	2012	2013	2014
Large Metro (1 million+)	3.4	3.7	3.1	4.1	3.4	3.2
Small Metro (250K - 1 million)	3.9	3.5	3.5	3.6	3.2	3.1
Small Metro (<250K)	3.4	3.2	3.7	3.6	3.4	3.3
Nonmetro - Urbanized	4.0	3.3	3.5	3.9	4.0	4.0
Nonmetro - Less Urbanized	3.1	3.4	2.1	2.9	3.0	2.3
Nonmetro - Completely Rural	1.4	1.7	2.1	1.9	2.7	1.9



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THE STUBBORN RURAL METHAMPHETAMINE PROBLEM

- Methamphetamine is a blue collar drug and its production and addiction are enduring problems in rural areas.
- Methamphetamine accounts for the largest percentage of drugs identified from law enforcement seizures.
- The wholesale price of meth is declining.

EMERGING DRUG TRENDS

- **OPIATES**
  - Surge in overdose deaths due to heroin laced with synthetic fentanyl (an opioid 30-50 times more potent than heroin)
  - Increased abuse of Methadone and Suboxone (designed to treat opiate addiction)
  - Increase in babies born with opiate addiction
  - Abuse of Zohydro (a powerful new prescription painkiller) may be the next major opioid epidemic. Zohydro is a potent, extended-release version of hydrocodone without anti-abuse formulation. It can be crushed, chewed, mixed with alcohol, snorted, and injected for full potency.

- **CANNABINOIDS**
  - Increasing overdoses from synthetic cannabinoids (spice, K2), especially in south and northeast
  - THC puppy chow (adding THC oil to powdered sugar/Chex cereal mixture)

- **SYNTHETIC DRUGS ("Designer Drugs")**
  - Flakka (synthetic bath salt, acts as cross between cocaine and meth, sometimes known as "gravel")
  - Pump-It Powder (marketed as enhanced plant vitamin, legal substance, produces effects more powerful than cocaine and meth, popular in Midwest and Plains states, sold in gas stations and head shops)

- **DRINKS**
  - Purple Drank (mixture of sprite, jolly ranchers, and codeine).
  - Anti-energy drinks ("extreme relaxation beverages")
  - Lemon Drop (homemade hallucinogenic made by mixing painter's solvent with over-the-counter cough syrup, and powdered lemonade)

DISCUSSION: What emerging drug trends have you seen in your community?

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WHAT'S DRIVING RURAL DRUG PROBLEMS?

1. Increasing economic deprivation and unemployment create a stressful and hopeless environment that increases drug abuse risk.
2. Tight kinship and social networks allow faster diffusion of drugs.
3. Outmigration of upwardly mobile young adults from rural areas increases economic deprivation and creates an aggregation of young adults at greater risk.
4. The increased sale of prescription opioids in rural areas led to greater availability for nonmedical use through diversion. Crackdowns and increasing prices opened a window for a heroin market.
5. Most physicians (especially rural physicians) are not trained in pain management and may prescribe opioids too liberally. Physicians must now also contend with the moral/ethical issue of continuing to prescribe opioids versus cutting off patients who are at risk of transitioning to heroin.
6. Lack of treatment facilities in rural areas prohibits the intensive and consistent treatment required to kick addiction.

STRATEGIES TO COMBAT RURAL DRUG PROBLEMS

PREVENTION

1. Reduce unnecessary and over-prescribing of pain reliever narcotics.
2. Restrict pain reliever prescribing to youth except in extreme cases.
3. Improve parent and youth education on the risks and consequences of drug abuse with a focus on the most addictive and dangerous drugs.
4. Develop abuse-deterrent and non-addictive formulations of prescription pain relievers.
5. Increase access to livable-wage employment opportunities and skills-based apprenticeship and trade training in rural areas.
6. Incentivize upwardly mobile youth to remain in rural communities or return to rural areas after college completion.
7. Invest in comprehensive longitudinal data collection and analysis to facilitate prediction of emerging drug trends, causes, and proposed solutions.

TREATMENT

1. Develop innovative treatment modalities, including home-based treatment and comprehensive case-management that focuses on the mental health, economic, family, and community causes of drug abuse.
2. Make opiate abuse-resistant treatment options more affordable and more widely available.
3. Partner with business leaders and unions to provide treatment options and incentives for workers in manual labor occupations.
4. Increase use of family drug courts to link teen criminal offenders to mental health and substance abuse treatment.

DISCUSSION: There is no one-size-fits-all approach. What has worked in your community? What strategies have been less effective?

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RECOMMENDED READING

Sam Quinones. 2015. *Dreamland: The True Tail of America's Opiate Epidemic*. Bloomsbury Press. http://www.bloomsbury.com/us/dreamland-9781620402511/
Over the past fifteen years, enterprising sugar cane farmers in the small county of Xalisco on the west coast of Mexico have created a unique distribution system that has brought black tar heroin--the cheapest, most addictive form of the opiate, two to three times purer than its white powder cousin--to the veins of people across the United States. Communities where heroin had never been seen before have become overrun with it. Local police and residents are stunned: How could heroin, long considered a drug found only in the dense, urban environments along the East Coast, and trafficked into the United States by enormous Colombian drug cartels, be so incredibly ubiquitous in the American heartland? Who was bringing it here and why were so many townspeople suddenly eager for the comparatively cheap high it offered? Acclaimed journalist Sam Quinones weaves together two classic tales of American capitalism in Dreamland--young men in Mexico, independent of the drug cartels, in search of their own American Dream via the fast and enormous profits of trafficking cheap black tar heroin to America's rural and suburban addicts; and Purdue Pharma, determined to corner the market on pain with its new and expensive miracle drug, Oxycontin, extremely addictive in its own right. Quinone illuminates just how these two stories fit together as cause and effect.

John Temple. 2015. *American Pain: How a Young Felon and His Ring of Doctors Unleashed America's Deadliest Drug Epidemic*. Lyons Press. http://www.lyonspress.com/book/9781493007387
The king of the Florida pill mills was American Pain, a mega-clinic expressly created to serve addicts posing as patients. American Pain's doctors distributed massive quantities of oxycodone to hundreds of customers a day, mostly traffickers and addicts who came by the vanload. American Pain chronicles the rise and fall of this game-changing pill mill, and how it helped tip the nation into its current opioid crisis, the deadliest drug epidemic in American history. The narrative swings back and forth between Florida and Kentucky, and is populated by a gaudy and diverse cast of characters. This includes the incongruous band of wealthy bad boys, thugs and esteemed physicians who built American Pain, as well as penniless Kentucky clans who transformed themselves into painkiller trafficking rings. It includes addicts whose lives were devastated by American Pain's drugs, and the federal agents and grieving mothers who labored for years to bring the clinic's crew to justice.

- Monnat, Shannon M. and Khary K. Rigg. 2015. "Examining Rural/Urban Differences in Prescription Opioid Misuse among U.S. Adolescents." *Journal of Rural Health*. http://onlinelibrary.wiley.com/doi/10.1111/jrh.12141/abstract.
- Rigg, Khary K. and Shannon M. Monnat. 2015. "Comparing Characteristics of Prescription Painkiller Misusers and Heroin Users in the U.S." *Addictive Behaviors* 51:106-112. http://www.ncbi.nlm.nih.gov/pubmed/26253938
- Rigg, Khary K. and Shannon M. Monnat. 2015. "Urban vs. Rural Differences in Prescription Opioid Misuse among Adults in the United States: Informing Region Specific Drug Policies and Interventions." *International Journal of Drug Policy* 26:484-491. http://www.ncbi.nlm.nih.gov/pubmed/25458403

RECOMMENDED VIEWING

Oxyana. 2013. http://oxyana.com/about.html
Tucked in the Appalachian mountains of Southern West Virginia, Oceana, is a small, once thriving coal-mining town that has fallen victim to the fast spreading scourge of prescription painkiller Oxycontin. As the coal industry slowly declined and times got tough, a black market for the drug sprung up and along with it a rash of prostitution, theft and murder. Soon its own residents had nicknamed the town Oxyana and it began to live up to its reputation as abuse, addiction and overdoses became commonplace. Oxyana is a harrowing front line account of a community in the grips of an epidemic, told through the voices of the addicts, the dealers and all those affected.

The OxyContin Express. 2009. https://www.youtube.com/watch?v=wGZEvXNqzkM

South Florida, the "Colombia of prescription drugs", was home to a bustling pill pipeline that stretches from the beaches of Ft. Lauderdale to the rolling hills of Appalachia. "The OxyContin Express" features intimate access with pill addicts, prisoners and law enforcement as each struggles with a growing national epidemic.

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