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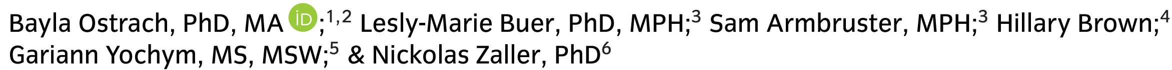
COMMENTARY

COVID-19 and Rural Harm Reduction Challenges in the US Southern Mountains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Overdose deaths and some other consequences of substance use and its criminalization are greater in rural areas, particularly Appalachia[1,2] and other parts of the Mountain South. With health care shortages and underfunding of social services in rural areas[3] and in the South predating COVID-19-related disruptions, rural Harm Reduction[4] [i] programs are more likely to lack sufficient resources.[5] A recent study[6] focused on mostly urban sites in northern states documented challenges syringe access programs (SAPs) faced in supply distribution early in the COVID-19 pandemic. Our experiences in the Mountain South suggest challenges to rural and southern SAPs are even more pronounced.[ii]

Recent data show greater and faster-increasing COVID-19 rates in Appalachia and the South[7] compared to other areas. Given inadequate rural health care infrastructure,[8,9] SAPs are an important link between people who use drugs (PWUD) and health care, including overdose prevention and infection control. Trust between Harm Reduction providers and PWUD[10-13] is especially important given COVID-19 and the recent protests against police violence. PWUD are reluctant to call first responders for fear of arrest, particularly where being at the scene of a fatal overdose can result in murder charges.[14] Such fears are likely now compounded by the additional dangers of being transported to a hospital or jail where novel coronavirus risks are heightened. SAPs and other community structures to which PWUD turn for supplies and information need support now more than ever.

Resource gaps facing community-based Harm Reduction organizations in the Southern Mountains are compounded by a lack of reliable data about overdose, infectious diseases, and other indicators of need. Based on our fieldwork, gaps are substantial in the South and in rural areas, yet are key to demonstrating need and obtaining funding.[10-13,15]

Prior to COVID-19, rural patterns of use included more methamphetamines (meth), alone or with opioids.[16-18] From our direct work with people who use drugs and test the meth they use with fentanyl test strips, we know fentanyl has increasingly entered the meth supply in parts of the Mountain South where we work (Western North Carolina, East Tennessee, Central Arkansas) in recent years. This dynamic increases risks not only for overdose but also for more severe COVID-19 illness.[19] Others have emphasized, including in this journal, catastrophic effects the pandemic could have on overdose rates, especially in rural areas.[20] In the context of COVID-19-driven border control, less meth is available in the United States; what is available is more contaminated with fentanyl—increasing overdoses among meth users nationally.[21] In some regions where we work, we also see prices increasing for some substances.

This is a dangerous combination for our SAP participants in the Mountain South. During the pandemic, many face a drug supply contaminated with greater quantities of fentanyl. With disruptions to the supply chain of meth and other substances, rural participants must obtain

substances with which they are less familiar and that may be more expensive. People who generally use meth may buy heroin, or vice versa, further increasing overdose risks. Stay-at-home orders, physical distancing, and rapidly increasing COVID-19 rates in our respective states mean PWUD may feel pressured to obtain substances from people they do not know well,[19] eliminating the protective factor of a known and trusted drug provider.[22] Simultaneously, PWUD may be more likely to use alone—another risk factor for overdose.

A crucial role Harm Reduction providers play during the pandemic is engagement with participants. Community-based Harm Reductionists are adept at providing outreach to the most vulnerable. Given the constellation of overlapping risks for severe COVID-19 complications and overdose, resources must be allocated to support existing Harm Reduction services in areas of highest overdose, so they are better equipped to respond to intensifying risks.

The Harm Reduction Coalition issued guidelines at the outset of COVID-19,[19] urging mobile distribution of greater quantities of safer injecting supplies and naloxone, within distancing and hygiene recommendations. SAPs were encouraged to provide COVID-19 recommendations to participants: increased handwashing; minimizing supply sharing; preparing their own drugs; awareness of the increased likelihood of overdose; avoiding distribution sites if symptomatic; stocking up on supplies and drugs in case of shortages; preparing for withdrawal; and considering getting a prescription for buprenorphine products, even short term, to prevent symptoms of withdrawal or overdose in the case of drug supply disruption. Such recommendations positioned SAPs as a primary source of public health information for PWUD.

There is more that rural SAPs could do with adequate resources and legislative support to operate legally and be mobile. Free COVID-19 testing could be part of mobile distribution in areas with few testing sites. Some SAPs offer face masks, hand sanitizer, and gloves—where we work, only SAPs with public funding or that receive donated equipment are able to do so. The research community can partner with local SAPs to help collect meaningful data to better understand how the pandemic affects PWUD. Current NIDA Director Volkow recently urged researchers to be proactive in conducting rapid research with PWUD at high risk for COVID-19 complications.[23]

COVID-19 has negatively affected Harm Reduction services in the Mountain South. In some places certain programs or services were suspended at the start of the pandemic, including HIV and hepatitis C testing at several syringe access programs in East Tennessee and Western North Carolina, and naloxone and safe injecting supply distribution at an SAP run by the Eastern Band of Cherokee Indians tribal health service. While some programs adapted quickly to new environments, most saw a decrease in service availability. For example, Choice Health Network Harm Reduction in Knoxville, Tennessee, suspended services for 2 weeks in late March and early April in order to plan a service delivery model that protected participants as well as staff. As of June, the program has reached pre-COVID-19 numbers in terms of the amount of naloxone kits, syringes, and other supplies distributed. In Asheville, North Carolina, the Steady Collective moved to an all-mobile supply distribution model, successfully making naloxone, fentanyl test strips, and safe injecting supplies available to regular participants near all of their regular distribution sites without interruption. The Steady Collective also began distributing COVID-19-specific items based on participant requests and known risks, including oral hygiene kits, hand sanitizer, elderberry syrup, and more bottled water. Specific to the increased risk of overdose during the pandemic, they attempted to distribute breathing barriers out of concern people would be reluctant to give rescue breaths when reversing an overdose, but quickly ran out. Moreover, the inability to distribute at fixed-site locations constrained their normal capacity to offer personalized wound care by the staff clinician. Outreach workers with the North Carolina Harm Reduction Coalition (NCHRC) in rural Western North Carolina counties already worked from a fully mobile model and continued to serve syringe access participants. However, COVID-19 restrictions halted detention center-based linkage to care efforts that had just begun, as well as ongoing overdose prevention training with incarcerated county residents. Case management for NCHRC's law enforcement-assisted diversion program in rural Western North Carolina was challenged by pandemic-related restrictions on in-person intakes, resulting in lost contact with people referred for diversion who would normally be sought out directly in often hard-to-reach places and who might not have reliable phone or Internet access. Though PWUD may be less likely to have consistent phone or Internet access anywhere, lack of cellular and digital infrastructure in rural areas[24,25] further compounds pandemic challenges.

While we have seen increases in overdose morbidity and mortality in East Tennessee and intensification of lack of health care access and increased demand for supplies among PWUD in Western North Carolina, we have also found profound and committed methods of engagement with program participants as well as with additional community-based organizations. Bonds between Harm Reduction programs and local mutual aid groups have intensified, as all attempt to meet the needs of the unsheltered, immunocompromised, unemployed, and PWUD. Current public health emergencies highlight the mutual aid practiced for decades among PWUD[26] due

to lack of public and private support. This mutual aid occurred among PWUD prior to COVID-19 and continues now in different formats. The disruption of a trusted drug supply and constraints on the ability to use with others who could readily administer naloxone when needed demonstrates the intense, inherent mutual aid among PWUD. This pandemic provides yet another chance to document and find actionable ways to support it.

In the rural Mountain South, fentanyl was increasingly present in meth prior to the pandemic; this appears to be worsening. COVID-19 increases overdose risks for rural PWUD—highlighting the importance of local, community-based Harm Reduction and mutual aid. The pandemic intensifies the need for increased distribution of naloxone and fentanyl test strips, while lack of legislative support and public funding for organizations that provide the most effective Harm Reduction services hamper the effectiveness and reach of evidence-based responses. Collection of and access to reliable data on overdose morbidity and mortality and other indicators would help in advocacy for additional resources. In this critical moment, local community responses to the needs of PWUD have been constrained. Yet, communities have also adapted, and more so in rural areas where SAPs were already under-resourced and spread thinner to cover more ground.

Notes

i. We intentionally capitalize the term "Harm Reduction" to indicate an approach to the work grounded in full application of the Principles of Harm Reduction, and in keeping with an ongoing conversation in the movement about the difference between "capital H, capital R" Harm Reduction versus "little h, little r" harm reduction that uses some elements and strategies without implementing the larger spirit.

ii. "With health care shortages and underfunding…"

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