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Opportunities for Identifying and Addressing Unhealthy Substance Use in Rural Communities: A Commentary on Cucciare et al (2017)

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ABSTRACT: Unhealthy substance use is a public health problem facing rural communities across the United States. Unfortunately, numerous challenges including stigma, perceived need for care, and perceived accessibility of substance use treatment serve as barriers to many rural adults using substances in obtaining the care they need. It is therefore important to examine whether accessing health care options other than substance use treatment is associated with improved substance use. In a recent study published in the *American Journal of Drug and Alcohol Abuse*, we explored whether use of outpatient medical care (OMC) was associated with reductions in substance use among rural stimulant users over a 3-year period. Overall, the results showed that, among rural adults using stimulants, those with at least one OMC visit had fewer days of alcohol, crack cocaine, and methamphetamine use over time. However, most participants reported not having any use of an OMC over the 3-year period, suggesting the need for identifying innovative opportunities to provide substance use help for persons living in rural settings. In this commentary, we discuss opportunities for detecting and addressing unhealthy substance use in retail clinics, via clergy and pharmacists.

KEYWORDS: Rural substance use, retail clinics, clergy, pharmacy-led interventions

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Introduction

In our prior study, Cucciare et al,[1] examined whether having at least one outpatient medical care (OMC) contact was associated with reductions in substance use among rural adults using stimulants over a 3-year period. Our results showed that rural adults using stimulants, reporting at least one OMC contact (compared with no contacts), had fewer days of alcohol, crack cocaine, and methamphetamine use over time. Moderators of this effect included employment-related problems for alcohol use, psychiatric severity for crack cocaine use, and educational attainment for methamphetamine use, suggesting that contact with an OMC may be particularly beneficial for rural adults using stimulants with poorer functioning. In our study, we also emphasized the potential importance of OMC including primary care, family medicine, and community health clinics in identifying and intervening on substance use in this population. Indeed, general practitioners and family physicians are often more available than specialty care providers in rural communities,[2] making them a relatively accessible provider for adults using stimulants.

Acceptable care options for seeking substance use help, including OMC, are important given negative views held by many substance users toward the availability and effectiveness of substance use treatment.[3] Stigma, low perceived need for treatment and perceived access to care are barriers to seeking substance use treatment in rural communities[3] even when substance use treatment is geographically accessible. These potential barriers to formal substance use care suggest a need for having additional care options in this population. Furthermore, in Cucciare et al,[1] 62% of adults using substances, at baseline, reported not having an OMC contact in the prior 12 months, and the percentage of individuals not receiving OMC was stable (ranging from 62% to 66%) over the 3-year study period.[1] This finding highlights the importance of continuing to look for innovative opportunities to screen for and address unhealthy substance use in rural adults using substances. This commentary discusses opportunities for detecting and addressing unhealthy substance use in retail clinics, via clergy and pharmacists. We also present some of the challenges that exist in implementing screening, counseling, and referral efforts in these settings.

Retail Clinics

When compared with urban communities, access to OMC such as primary care is less available in rural communities. In 2008, rural counties in the United States had on average 62.0 primary care physicians per 100 000 residents, compared with 80 primary care physicians for the same number of residents in urban counties.[4] Retail clinics offered by retailers such as Walmart, Walgreens, and CVS provide an opportunity to increase access to OMC clinics in many rural communities. Walmart clinics are currently available in Georgia, South

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Carolina, and Texas.[5] Walgreens has more than 400 retail clinics across the United States,[6] and CVS "minute clinics" are also available in select states across the country.[7] Retail clinics provide a broad scope of services including wellness and preventative care, health screenings, primary acute care, management of chronic medical conditions, and referral to specialty care. Services are highly accessible (low-cost, multiple pay options, allow walk-ins) and can be accessed through large networks of retail stores across the United States. Retail clinics have the potential to be an important context for providing OMC[8] to rural adults using substances who may have difficulty accessing OMC available in more traditional primary care clinics and/or substance use treatment.

Retail clinics are an opportunity to identify substance use, provide counseling, and facilitate linkage to more intensive substance use help when needed. Well-established models of screening, brief intervention, and referral to treatment[9] could be implemented in these settings, offering a less stigmatizing care context to discuss substance use with a provider. Prior research suggests rural adults using drugs prefer care settings that offer a way to preserve their anonymity, which can be difficult in rural communities.[10] Retail clinics offer an opportunity to avoid the stigma associated with having one's car seen in a treatment center parking lot or being observed walking through the door of a local substance use treatment provider. Unfortunately, current availability of retail clinics in some regions of the United States (eg, Walmart retail clinics are currently available in only 3 Southern States) limits their potential to offer this type of care for rural substance users across the United States. Also, the financial model of retail clinics is at least partly predicated on providing care to large volumes of individuals, which can conflict with giving providers the time needed to conduct relatively lengthy counseling and referral activities. Retail clinics are likely to continue to expand throughout the United States which may address the availability challenge. However, studies are needed to identify viable financial models that can help incentivize retail clinic providers' to engage in these activities with patients living in rural communities.

Clergy

Given their widespread availability, clergy could serve important roles in identifying and addressing unhealthy substance use among rural adults using substances. With more than 400 000 ministers, priests, and rabbis actively serving across the United States, clergy are a highly visible and trusted source of support for many people.[11] Clergy are often seen as deeply committed to their congregation and in their willingness to honor a person's confidentiality, making them an important source of support. Clergy delivered screening and counseling for unhealthy substance use may reduce common barriers (eg, perceived access and need for care, stigma) to seeking mental health services, especially among those with low income as clergy do not typically charge fees, require insurance, or require extensive paperwork to access services. Also, the frequency with which clergy interact with their congregation makes them well-positioned to observe behavioral changes in people over time.

Clergy-based counseling for unhealthy substance use is feasible and desirable for many individuals and perhaps more so for some people than seeking substance abuse or mental health treatment. In the United States, about 15% of individuals reporting to seek some form of lifetime help for unhealthy substance use reported seeking clergy services.[11] Among a US sample of people with a probable mental health problem including unhealthy substance use, 20% reported receiving counseling from a pastor in the prior year.[12] Furthermore, Cucciare et al[1] found that among persons using stimulants and not reporting an OMC contact at baseline, 40.5% reported that religion was an important part of their life, 24.66% reported that they were very religious, and 24.03% reported that they regularly attended (monthly or weekly) church (data not reported in the original manuscript). Also, regular church attendance is strongly associated with receiving past-year counseling by clergy among persons with a probable mental health problem including unhealthy substance use.[12] Together, these findings suggest that clergy are a commonly sought-out source of support for people with unhealthy substance use and may be especially helpful for those not interested or able to seek other types of substance-related help.

Clergy have the potential to play a vital role in identifying unhealthy substance use, providing counseling, and helping to link people to more intensive care when needed. To our knowledge, to date, no studies have been conducted testing the effectiveness of clergy-based screening, brief intervention, or referral efforts for persons using drugs or alcohol. Prior studies have focused on testing comprehensive, multiyear faith-based interventions to reduce substance use in adolescents,[13] improving substance use outcomes among women in residential substance abuse treatment programs,[14] and testing the feasibility of implementing substance use prevention efforts within the church.[15] Studies are needed to demonstrate whether screening and counseling efforts and models for linking substance users in need of more intensive care to services can be effectively implemented in the church setting and delivered by clergy. This area of research is especially needed given that while some clergy may have years of experience counseling persons with mental health or substance use problems, others may have little to no experience. Another important consideration is that clergy might also experience inner conflict between their faith and what approach to take to best help an individual dealing with substance use issues. Therefore, research studies describing how to implement effective models (eg, specifying needed training, oversight, and support) for screening, counseling, and linking persons with unhealthy substance use to care in religious settings are critical to fully realizing the potential of clergy in this role.

Pharmacists

The accessibility of pharmacists and their knowledge of commonly abused substances, including prescription medications,

make them a practical yet underutilized provider for conducting substance use screening, intervention, and referring to care in the community. For many people living in rural areas, pharmacists may be the only or one of the few health care providers that they come into contact with on a regular basis. Regular contact with people in their community creates an opportunity to develop relationships with customers and identify changes in behavior of those individuals over time. Rural pharmacists currently report providing more public health services than their urban counterparts such as disease state management, identifying health risks in the community, working with community partners to address health problems, and referring patients to other health professionals,[16] and many express a willingness to take on more responsibilities related to unhealthy substance use counseling and intervention[16,17] making them well-positioned to help identify, counsel, and link rural substance users to needed care.

Several studies show that pharmacist-led interventions can improve patient health outcomes. One recent study found that rural persons receiving a one-time pharmacy-led educational intervention on diabetic retinopathy (DR) led to 79% of patients electing to receive DR screening.[18] A large study of more than 1400 rural and urban patients receiving a pharmacist-led intervention (brief counseling and pharmacotherapy) for tobacco cessation showed quitting success rates on par with interventions delivered by other health care professionals.[19] Another study of 200 pharmacies in the United Kingdom showed that a pharmacy-led intervention for smoking cessation consisting of one-to-one counseling up to 12 weeks including help with decisions about appropriate pharmacotherapy was less effective than specialist-based group services of similar length and content (18.6% vs 35.5% quit rates at 4 weeks post baseline)[20] but had the advantage of reaching more people. However, a one-time brief (10-minute) pharmacy-led intervention for reducing harmful drinking had no effect on drinking outcomes when compared to leaflet-only control condition.[21] The authors of the study suggested that insufficient training in brief intervention was a likely factor in explaining the findings. Although potential exists for pharmacists to improve health outcomes of rural users of substances, improving their level of training in interventions for unhealthy substance use is likely needed to optimize their potential to help this population.

To address this challenge, numerous pharmacy schools offer specific training in rural health.[22] This training includes courses in public health and health disparities that could integrate skills for screening for unhealthy substance use, brief counseling, and strategies for helping to link patients in need of more intensive care to community resources. Additional challenges to pharmacists widening their scope of practice to include screening and counseling for unhealthy substance use are not having appropriate facilities (eg, lack of office space or private areas) and not having the time needed to devote to these activities. For example, some pharmacists, especially those working in rural communities, may be the only pharmacist available during the day to help customers. This may leave little to no time to spend screening, counseling, or educating persons using substances on helpful resources in the community. Therefore, needed are studies to identify effective models of pharmacist-delivered substance use–related screening and counseling, and how to best implement such models in "real-world" rural pharmacy settings, to effectively overcome these challenges.

Conclusions

Findings from Cucciare et al[1] suggest that for some rural substance users, especially those who may experience a lack of availability of substance use treatment or find it unacceptable, OMC including primary care, public health, or community health clinics may be helpful in reducing their substance use. However, as shown in their study, Cucciare et al[1] found that most rural users of stimulants did not connect to an OMC over the 3-year period suggesting a need to continue to look for innovative opportunities to offer substance use–related health care services to this population. Because of their availability in rural communities, "big box" retail clinics, churches, and pharmacies provide a currently underdeveloped opportunity for improving the availability of screening and brief counseling and linkage of rural substance users living in rural settings to more intensive substance use care when needed. It is important to note that we are not suggesting these settings replace the need for more resources to support specialized drug and alcohol support programs in rural communities. Instead, we aim to point out that for some individuals engaging in unhealthy substance use, these settings may offer some advantages over more formal substance use treatment including being highly accessible, avoiding or reducing stigma associated with care seeking, being low or no cost, and being highly trusted and able to build on established relationships with people living in rural communities. Notably, several challenges to realizing the potential of retail clinics, clergy, and pharmacists remain including identifying sources of financial support needed to effectively implement screening, counseling, and linkage to care efforts in these settings. Furthermore, studies are needed to demonstrate effective models for implementing substance-related screening, intervention, and referral efforts in these settings to help "pave the way" to fully realize these opportunities.

Author Contributions

All authors contributed meaningfully to the concept or design of the work and/or drafted or revised the article, and approved the version to be published.

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