THE RESPONSES OF RURAL SCHOOLS AND COMMUNITIES TO THE
OPIOID EPIDEMIC IN WESTERN PENNSYLVANIA

A Dissertation in
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by
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ABSTRACT

I examine in this dissertation, using a three article format, how rural districts, communities, and superintendents made sense of and responded to the current opioid epidemic in western Pennsylvania. I conducted extensive fieldwork in rural western Pennsylvania, an area heavily affected by the recent opioid crisis, over the 2017-2018 school year. I examine how economic and educational policies affected the capacity of districts in this region to respond to the opioid crisis and its effects (e.g., the effects of parental substance use disorders on students). I further analyze the ways local residents applied moral valuations associated with rurality and drug addiction to make sense of their own and their community’s responsibility in supporting those addicted to opioids, and how these moral valuations in some instances limited collective resolve to address this crisis. Having examined the broader and local contexts that structure district and local responses to this crisis, I explore the skills and strategies that superintendents have used to work within their contextual opportunities and constraints to implement district responses to this epidemic that support all students. I conclude with a discussion of the policy, theory, and educational practice implications of this research.
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Chapter 1

Introduction

In the minds of many that lived there, the small, rural town where I grew up was a bucolic, tight-knit, and safe place. Parents and community leaders believed that the town’s rurality protected the community and its youth from what were considered the “urban” dangers of crime and drug use. However, during my years growing up in this place and in the years after I left, hidden under this local narrative was rampant opioid use and addiction. People I played lacrosse with, dated, and spent much of my adolescent life with, became addicted to heroin and prescription pain killers. A few of these friends luckily are in recovery today, often after a defining event such as overdose or arrest. Others continue to use today, while others sadly lost their lives from overdose or suicide.

Through these hometown relationships, I have seen how addiction to opioids can completely reshape a person’s life. I also understand how addiction and its effects travel through family and friend networks. As a former elementary teacher and mentor, I also appreciate how drug addiction in the home affects a child’s intellectual and social-emotional development. Together, these experiences provided me with a particularly situated knowledge of opioid addiction and its effects, but also a desire to support efforts that would combat this significant public health threat. I came to the Pennsylvania State University with the goal to better understand how schools and educators can respond to this crisis and the ways students impacted by this epidemic may be better supported.

The opioid epidemic is national in scope and as a social problem is deeply structural, going well beyond the individual user. That is, the “opioid epidemic” or the “opioid crisis” is not
simply a crisis of the drug itself, but the logical conclusion of an array of social, economic, political, and institutional developments. Scholarship has conclusively found, for example, that higher rates of opioid overdose deaths are more likely to occur in areas experiencing economic underdevelopment and distress, regional economic change, and in communities historically dependent upon industries like energy extraction, manufacturing, and other labor market sectors that involve physical labor—many of these places rural (Keyes, Cerdá, Brady, Havens, & Galea, 2014; Monnat, 2018, 2019; Monnat & Rigg, 2018). Research has also demonstrated how the rise of the opioid crisis was associated with regulatory policy-making connected to the pharmaceutical industry that created the conditions by which places across America became literally flooded with opioid pharmaceuticals, creating whole new cohorts of people addicted to opioids and burgeoning new social and health problems (Inciardi & Cicero, 2009; Quinones, 2016). As a social problem in America, opioid addiction is deeply structural and as such it resists easy solutions and “quick fixes.” It is, however, at the individual level where this crisis is most immediately and intimately felt.

Despite my dissertation’s focus on local school districts and educational leaders, it would be grossly unfair and a fundamental misreading of this health crisis to suggest that its solution ultimately lies at the local level. It does not. This is especially the case given the extent to which many of the places most affected by this epidemic are also under-resourced and have limited political, institutional, and fiscal resources to draw upon. Effective solutions to this health crisis, therefore, ultimately have to address the structural conditions that gave rise to this epidemic in the first place. However, this does not mean that local communities or schools can or should sit passively by as they are ravaged by this health crisis. This dissertation, while not ignoring or discounting the macro-structural features of this crisis, is focused on this very question of local agency and, specifically, how local places and schools respond to this pressing social problem.
The Opioid Epidemic

The opioid epidemic is a serious national health issue. Between 1999 and 2017 over 210,000 people died from prescription opioid overdose (Center for Disease Control [CDC], 2018a). In 2018, nearly 500,000 persons reported that they used heroin in the past year (CDC, 2018b). As can be seen in Figure 1-1, rates of opioid overdose are particularly high in counties in the Northeast, Southwest, and in the Appalachian region. These regions have experienced high rates of opioid overdose since the early 2000s, but rates of opioid overdose have also begun to rise in other regions of the country such as the Midwest (CDC, 2018a). Pennsylvania, specifically, has historically had and currently has one of the highest standardized opioid overdose mortality rates in the country. Between 1999 and 2015 9,668 Pennsylvania residents died from heroin or prescription painkiller overdose (CDC, 2018a). In 2018, Governor Tom Wolf declared the opioid epidemic a statewide emergency (Governor Wolf, 2018).

Figure 1-1: U.S. county opioid overdose rates 2015 (Economist, 2017).

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1 The opioid epidemic, although grabbing national attention, is not the only drug use related issue affecting urban and rural communities. Methamphetamine and cocaine rates of use have risen, and have spiked in some counties where opioid related deaths have declined (Levy, 2019; Morris, 2018).
The opioid epidemic, although a statewide concern, has had a particularly profound effect on impoverished rural communities in western Pennsylvania (Figure 1-2; Drug Enforcement Agency [DEA], 2017). Those who live in western Pennsylvania often experience challenging economic conditions (e.g., poverty, high rates of unemployment, etc.) as a result of prolonged economic decline across the region (Chiang, 2004; U.S. Census Bureau, 2018). These communities and residents have also acutely experienced the devastating effects of this opioid crisis (DEA, 2017). After 16 opioid overdoses occurred in Washington County in one day, David J. Hickton, former U.S. Attorney for Western Pennsylvania, stated “we can’t accept this like we are accepting it…We just can’t go on like this” (Bernstein, 2015, np). How to address this health crisis in rural western Pennsylvania is a serious and perplexing issue.

![Figure 1-2: Map of Pennsylvania county age-adjusted standardized opioid mortality rates, per 100,000 people, 1999-2015 (CDC, 2018a).](image)
While drug use issues are often associated with urban areas, many rural communities experience high rates of drug overdose (CDC, 2018a; Keyes et al., 2014). Rates of drug overdose mortality are increasing at a faster rate in rural counties than urban, and a greater proportion of rural adolescents today engage in prescription pain killer misuse than urban (Monnat & Rigg, 2015; Rigg, Monnat, & Chavez, 2018; Stewart, Cao, Hsu, Artigiani, & Wish, 2017). In part these rates are high because conditions in many rural places (e.g., poverty, economic decline, etc.) coincide with high rates of opioid overdose, but also because rural places often lack a breadth of health care and drug treatment options where those addicted to opioids may receive effective care (Keyes et al., 2014; Roehrich, Meil, Simansky, Davis, & Dunne, 2007).

While rural America is a fundamentally diverse spatial category, in the past fifty years, many rural communities experienced prolonged economic contraction (Slack, 2014). Industries that were common in rural areas, such as manufacturing and natural resource extraction, have shed workers (Brown & Schafft, 2019). Many industries now common in rural areas (e.g., service sector or corrections) are marked by unstable and low wage employment (Lichter & Brown, 2011; Slack, 2014). As a result, in many rural places poverty, unemployment, and community distress are common (Keyes, et al., 2014; Monnat, 2018). In these places of loss and decline many people struggle to survive, and many also leave their local rural communities to seek out opportunities elsewhere. However, not all rural communities experience the same economic struggles. In rural America, poverty is often spatially concentrated and is especially persistent in pockets of the rural South and rural Appalachia (U.S. Department of Agriculture, 2019).
Health and well-being are also largely stratified between places, and healthy and unhealthy persons are often spatially segregated. Individuals in economic distress are likely to have poorer health than those persons who are economically stable. Places with high rates of poverty and unemployment are, in turn, likely to have populations with higher rates of health issues and exhibit various indicators of poor health (Berry, 2014). Rural health is, specifically, “subject to the same sets of restructuring, institutionalization, globalization, and geographic differentials that influence other aspects of rural life” (Berry, 2014, p. 671). Many rural people, furthermore, struggle with their personal health after years of “back-breaking” labor in labor-intensive industries (i.e., farming, mining, etc.) that once thrived in rural areas (Inciardi & Cicero, 2009; Keyes et al., 2014). As Inciardi and Cicero (2009) note, “many adults in these rural areas tend to suffer from chronic illnesses and pain syndromes, born out of hard lives of manual labor in perilous professions” (p. 106).

Rural places, furthermore, often lack a strong health care infrastructure that can support local health. Rural people often struggle to access affordable, diverse, and preventative health care services for various health concerns (Berry, 2014). Rural hospitals have been increasingly consolidated or closed, and there is a widespread shortage of physicians across rural America (Berry, 2014; Brown & Schafft, 2019). Mental health care providers are also underrepresented in rural places (Berry, 2014). In rural areas, pain patients are typically served by local physicians and not pain specialists, who may be able to better manage and treat pain without the use of prescription opioids (Keyes et al., 2014). In many rural communities, absent of an effective health care infrastructure and at the time appropriate state regulations, unregulated “pill mills” flourished in the 1990s and early 2000s, organized by a business model of profits rather than a model of treatment and care (Quinones, 2016).
The opioid epidemic cannot be disconnected from the modern economy and policies, which have largely acted on rurality as “a peripheral, relatively unimportant and ‘empty’ geography or historical artefact” (Corbett, 2014, p. 3). The opioid epidemic has had its greatest impact on communities where economic and community distress are high (Monnat, 2018, 2019). Rural places also often lack the health infrastructure that can address rising opioid misuse and addiction. In rural places where poverty rates are high, opioid misuse and addiction are rampant, and there are inadequate health services and support, the increasingly complex health needs of the local population may not be met.

**The Role of the Rural School**

In rural places, schools can support local health through health education and school-based health services (Blackstock, Chae, Mauk, & McDonald, 2018; Colby et al., 2013). The rural school, furthermore, is often central to local civic and social life, and because of this educators and educational leaders have a unique capacity to organize and energize collective responses to local problems (Tieken, 2014). Furthermore, previous research has found that social capital and the presence of community integrating institutions, such as churches, can support local health (Rigg et al., 2018; Yang, Jensen, & Haran, 2011). Therefore, rural schools in their “integrative and interactive roles” can support community cohesion and, thereby, strengthen community protective health factors (Schafft, 2016, pp. 144). However, our current education system tends to disincentivize educators and educational leaders from serving community needs,
in part because of policies and mandates that prioritize “high stakes” accountability (Schafft, 2016).

Many rural districts across the country face this unprecedented health issue, which has real and immediate implications for students, schools, and local communities. While the roots of this crisis are macro-level and deeply structural, at the same time local rural schools, institutions defined by their proximity to local community, may still play important roles in addressing this pressing local social problem (Schafft, 2016; Tieken, 2014). Rural schools serve important community health roles, yet how schools respond to opioid addiction and other health crises has been given relatively little attention. There has, in turn, been little prior research on the impact of the opioid epidemic on rural schools and the role that rural schools play in addressing a health crisis. My dissertation research addresses this empirical and theoretical gap.

**The Research**

The purpose of my dissertation research was to examine and explain how local educational leaders, districts, and communities in western Pennsylvania’s have responded to the opioid epidemic. I hope this work can provide guidance to educators and leaders struggling with the very real realities of local opioid misuse and addiction. Again, broader macro changes are needed, which this research points to, but I also hope to support through this research the work of local educators and residents as they struggle to respond to this epidemic on the ground. I review

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2 The predominant view of accountability established by current educational policies, refers to holding schools, teachers, and leaders accountable for student success on standardized assessments. This view of accountability competes with holding schools accountable to their local community’s educational priorities and values.

3 Other researchers have, however, discussed the important role of rural schools and education for health promotion and addressing health crises in other countries (Jordanova et al., 2015; Onyango-Ouma, Aagaard-Hansen, & Jensen, 2005).
below the research I conducted in rural western Pennsylvania school districts before discussing the positionality I took in this work.

**Research Overview**

I conducted fieldwork in western Pennsylvania school districts over the 2017-2018 school year. The data analyzed in this dissertation were gathered in two stages. I first collected qualitative data across twelve rural districts before conducting an in-depth study of two rural districts. The research presented in Chapters Two and Three come from case studies of Buchanan and Durbin District. I examine in these chapters the unique district (Chapter Two) and community (Chapter Three) responses to this crisis that occurred in these contexts. The data presented in Chapter Four are from interviews, fieldnotes, and documents gathered by fieldwork in the twelve rural districts where research was initially conducted.

I entered the field interested in understanding how schools, communities, and educational leaders have responded to the opioid crisis in western Pennsylvania. I was put in contact with a few superintendents in the region by a colleague of mine, who is a former Pennsylvania district leader. I was able to recruit four superintendents into study participation from these initial introductions. I then used snowball sampling from these four participants to recruit and interview another eight rural superintendents. I drove often to these twelve rural districts in the months after initial interviews with superintendents to gather field data. I spent a considerable amount of time in local town stores and libraries and also attended public meetings held in these districts’ communities. I, for instance, went to various school board meetings across districts. I wrote fieldnotes on each experience in the field. I also gathered numerous community or district

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4 All place, district, and participant names have been replaced with pseudonyms.
specific documents while in these districts, such as newspaper articles or district policy documents.

I after initial data collection and analysis selected two districts from this initial sample of twelve rural districts to study in depth through case study methods (Yin, 2018). These districts were selected for further study because their characteristics were representative of other “landscapes of despair” communities (Monnat & Brown, 2017, see Burfoot-Rochford, Chapter Two) and each district framed the opioid crisis differently (see Burfoot-Rochford, Chapter Three). I contacted Durbin and Buchanan superintendents for permission to conduct my research in their districts. I was granted school board approval to conduct this research in Buchanan District after I presented my study to the school board and a formal vote passed. In Durbin, the superintendent contacted the school board on my behalf and I was granted approval to conduct my research in the district without a formal board vote.

I emailed teachers and staff in each district, after being granted approval, recruitment materials. I interviewed those teachers that expressed immediate interest in talking to me after initial emails were sent out. I asked participants, after conducting interviews, if they could pass on my contact information to others in the district who may be willing to talk to me. I interviewed a total of forty-one district staff and faculty members using these recruitment strategies across districts. I also directly reached out to a drug awareness community action group in Durbin District and interviewed the leaders of this organization. I spent a considerable amount of time in these two districts. I wrote fieldnotes on my experiences in these districts, and gathered countless documents specific to Durbin and Buchanan communities and schools while in the field. Data collection stopped when additional data did not further clarify or expand the findings that were specific to the study’s research questions.
What I Brought With Me

I was an outsider of the communities I studied. I am, however, not outside this issue. Because of my experiences with this issue, I was an active participant in this research and made connections with my participants and their experiences. I was not a detached observer, but “participant who maintains a dialogue with the subjects themselves, filtering that dialogue through an understanding of the macro-level forces at play…[and] the theoretical ideas through which experiences are being interpreted” (Sherman, 2009, p. 14). I also because of this focus on reflexivity and dialogue brought my research findings back to study participants in the form of school board presentations or direct member checks.

I was, further, invested in this research in developing knowledge that would ultimately inform and, thereby, support effective school and community responses to this issue. This dissertation is, therefore, focused on policy and practice. I am, further, careful in the presentation of my research that I foreground the broad structures that have encouraged the growth of the opioid epidemic and also shaped responses to the opioid crisis, so that this dissertation does not serve to “blame” those places or residents struggling with this health issue. I do focus on the agency of actors in this research, but to highlight ways that places and people can act on those macro and mezzo-structures that have limited their capacity for effective local responses to this crisis.

I had entered the field, furthermore, with an understanding of how economic and educational policies at times converge to limit the capacity of local rural schools and educators to become involved in community improvement efforts (Schafft, 2016). I applied this understanding to the research questions and analysis, focused on district responses to this crisis, that are explored in the case study of Buchanan and Durbin District presented in Chapter Two. The analysis presented in Chapter Two was, therefore, largely deductive. I also assumed, based
on my reading of previous research on rural educational leadership (Colby et al., 2013; Howley, Howley, Rhodes, & Yahn 2014), that rural superintendents were likely to play some role in addressing this health crisis in both their districts and local communities. I did not know when I entered the field what role that was, but this line of thinking directed my research and resulted in the research questions and findings examined in Chapter Four. The case studies of Durbin and Buchanan District communities presented in Chapter Three, however, arose through an iterative inductive data analysis process. I initially observed in Buchanan and Durbin Districts that although opioid overdose mortality rates and community demographics were relatively similar across districts, residents between these districts talked about the opioid crisis differently. I, in an attempt to understand these differences, continually connected data and data codes to various literatures and social theories (i.e., deviance and social problem frames), collected further district data specific to my developing understandings, and revisited analysis as new theories or ideas were applied and/or rejected by the data. I discuss the conclusions of this inductive analysis in Chapter Three. I provide a more detailed overview of these chapters below.

Dissertation Overview

This dissertation is structured as three separate, analytically independent articles that consider educational leader, community, and district responses to the opioid epidemic in rural western Pennsylvania. In Chapter Two I examine the impact of the opioid epidemic on rural students in Durbin and Buchanan District, as well as the broader educational and economic policies that limited the capacity of these districts to respond to this crisis. I begin this chapter with a broader discussion on the public health functions of schools and those factors that may limit the ability of schools to take on public health roles (Blackstock et al., 2018; O’Malley,
Rural districts may, specifically, be challenged to address local needs associated with the opioid crisis because of their typically limited local financial and health resources that could be used to support school-based health efforts. The concentration of poor health and poverty in communities impacted by this crisis, as discussed, may further create inherent challenges for local schools to support student well-being and local health. Furthermore, rural educators may face institutional pressures to attend to student output on state tests instead of focusing on broader issues of student and community health. Educational policy and public discourse may discourage educational leaders and educators from addressing public health crises if those efforts are not clearly aligned with the public school mission of academic preparation and thought to be outside of the institutional domain of the school.

In Buchanan and Durbin districts, poverty rates are high and many residents struggle to provide for themselves and their families. Research participants described their communities as depressed and district residents as economically struggling. In these districts, many students also experienced various academic, social, and health effects from heroin and/or prescription opioid use in the home—specifically parents’ substance use disorders, deaths of immediate family members, and children being placed in foster care and/or raised by grandparents. The schools and educators in these districts, however, were largely unable, and in some cases unwilling, to meet increasingly complex student social, health, and emotional needs. In many districts, student services, such as guidance, had been cut in response to shrinking budgets. Buchanan and Durbin teachers also felt unable to address non-academic needs of students as their attention was largely directed towards student success on state tests. Many educators also discussed how they felt that it was not the responsibility of the school to address home or community issues, and that these issues were outside of the purview of how they framed the institutional function of the
school (e.g., educative rather than health-related). I conclude this chapter with a discussion of how schools, and educational policy, may inadvertently reinforce spatial health disparities.

Chapter Three examines how residents in Durbin and Buchanan District made sense of and constructed the opioid epidemic as a moral issue. In the previous chapter I focus predominantly on districts and schools and the agency of institutions in responding to this crisis, and in this chapter I focus specifically on the rural community and community action. This chapter, furthermore, explores in more depth the community context and perspectives of the opioid crisis, by applying a moral economies lens (Sherman, 2009) to further understand the limited community responses to this crisis across Durbin and Buchanan districts.

I explore in this chapter how place-embedded moral economies and discourses influence how local people frame the opioid crisis and come to understand what responses to this health issue are seen as appropriate. I find that the unique moral calculus that residents in Buchanan and Durbin Districts used to frame drug use and users, informed by perceived rural, local, and drug “addict” identities, shaped how these residents defined the opioid problem and proposed solutions to its impact. In both communities residents morally “othered” the opioid crisis and those affected by this epidemic from the local community, pushing the crisis outside the local place. In Durbin and Buchanan Districts, however, the moral axes that residents used to “other” this issue and disembed it from the local identity were different. I conclude this chapter with a discussion on the need to account for problem frames and morality when understanding the reasons for and shape of collective actions.

In Chapter Four, specifically, I examine the agency and actions of superintendents in rural western Pennsylvania as local opioid misuse and addiction posed increasingly urgent challenges in their districts. In many of the twelve districts initially studied, superintendents struggled to find community support for school initiatives that would target the opioid epidemic
and its effects. A few superintendents faced outward resistance to expanding drug prevention and education efforts in their districts by their school boards. I discuss how these leaders worked with their boards to develop a suitable response to this crisis, and the challenges that these superintendents experienced when pushing back against community perceptions of the opioid crisis. I draw attention to how superintendents may act on their “zone of tolerance” (Boyd, 1982) to expand their capacity to respond to this opioid crisis with or without community support. The research presented in this chapter also draws specific attention to how community perceptions of the crisis come to change (e.g., an opioid overdose of a community insider), and what this means broadly for superintendent-school board interactions. I conclude this chapter with a discussion on how rural leaders may manage, attend to, or alter community perceptions of place and drug addiction when seeking support to expand drug education and prevention efforts in their districts.

Chapter Four draws on many of the ideas presented in Chapters Two and Three. While the previous chapters give an in depth look at the district and community amidst this crisis, this chapter foregrounds what local actors can really do about this crisis with the understanding that there are both institutional and community restrictive factors. This chapter while also providing new insights about changing community contexts and what this means for the agency of rural superintendents, hopes to provide a direction forward for how leaders and educators can act on and work within their unique rural community/school contexts to implement needed district responses to the opioid epidemic. Again, responses to this crisis need to be broad, but this chapter discusses how superintendents can begin to prepare the community and school to respond effectively to this crisis, when proper support is made available.

In Chapter Five, I conclude this dissertation with a discussion of how practitioners, researchers, and policy-makers may more effectively and equitably support local responses to address this crisis. The three articles in this dissertation explain the unique processes by which
responses to this epidemic differed across western Pennsylvania. The opioid epidemic is a national issue that has been stirred by various economic and social policies. I discuss, specifically, in this chapter the various state and national policies that have limited the capacity of certain schools to respond to this crisis. I propose steps that policymakers should take to curb the further growth of this crisis, and support those schools and communities that are affected. I hope that broader social and political attention is given to not only how this epidemic has had serious effects in many communities, but that not every local place and/or school has had an equal capacity to respond effectively to this health crisis. While I focus my attention on the policies and broad actions that created the conditions that this crisis has grown from, I also discuss in this conclusion the ways rural leaders, educators, and students can act on and improve local health. I discuss how these local actors can utilize the agency that they have, which has been limited by outside policies as discussed, to develop responses to this health crisis. It is not the sole responsibility of local schools and communities to resolve this issue, but as this issue is experienced on the ground local actors need some direction on how to combat this crisis.


Chapter 2

Public Health, “Landscapes of Despair,” and Rural Schools: The Local Challenges of Addressing the National Opioid Crisis

Abstract

Deaths caused by prescription painkillers and heroin misuse are at epidemic levels in many rural communities across the country. In this study, I analyze data gathered from interviews and fieldwork conducted in two rural districts in western Pennsylvania, a region highly affected by the recent opioid epidemic. In these "landscapes of despair" local schools and educators struggle to respond to complex student issues associated with the opioid crisis, as local conditions and state educational policies limit their capacity for action in this arena. I discuss in this article the role of education in public health and the steps that policymakers can take to ensure that students have equal access to health education and supports in schools.

Introduction

The opioid epidemic is a nationwide health crisis. In 2016, more than 45,000 people in the United States died from opioid overdose (Center for Disease Control and Prevention [CDC], 2018a). From 1999 to 2016 prescription opioid overdose deaths increased by 400 percent (CDC, 2018a). In 2017, nearly 494,000 persons reported that they had used heroin in the last year, and
over 15,000 died from heroin overdose (CDC, 2018b). The effects of this epidemic on U.S. youth are also significant as adolescent opioid overdose rates have more than doubled since 1999 (CDC 2018a; Curtin, Tejada-Vera, & Warmer, 2017) and heightened national opioid misuse and addiction rates are associated with recent increases in child service home removals (Meinhofer & Angleró-Diaz, 2019).

Historically, public education has been called upon to address various public health issues or concerns, from childhood obesity to tobacco use (see U.S. Department of Health and Human Services, 2001, 2007, 2010). In the 1980s in response to the AIDS crisis, many political and health leaders, and educational organizations lobbied for greater sex education in public schools (Rothman, 2014). Today, lunch programs feed students in schools, school nurses provide medical services, and schools teach health curricula that are not specific to academic subjects but healthy lifestyles. Many of these school based health efforts are also mandated by state and federal governments. Because students spend often “about six hours a day approximately 180 days per year during a critical period of their development [in school], school[s] are in a unique position to help improve the health status of children and adolescents nationwide (Brener et al., 2017, p. 1). Education and schools impact student health and may, therefore, together play an important role in addressing the opioid epidemic.

There is, however, little uniform guidance from state or national leaders on how best to meet student health needs in schools. Multiple school-based health models (e.g. “The Whole School, Whole Community,” “Whole Child”), intervention systems (e.g. multi-tiered systems of support), and teaching techniques (e.g. mindfulness practices) are used to support student health. However, these various health supports and interventions are not broadly implemented (Brener et al., 2017; Dulaney, Hallam, & Wall, 2013; Meiklejohn et al., 2012). The allocation of funds by states and the federal government to target student health needs in schools and, specifically,
student mental health, have also been generally uneven, which has resulted in ad hoc patchworks of local, state and federal funding, and hence, inconsistent and often inadequate social and health services in schools (O’Malley, Wendy, & Pat, 2018). Health education and school-based health services are, as a result, not uniform nor equal across public schools (Brener et al., 2017; Zajacova & Lawrence, 2018). Furthermore, school-based health interventions have broadly struggled to close “the gap in health status between different social and economic groups in society” (Nutbeam, 2000, p. 260). The manner by which students are able to access and receive adequate health supports in schools, however, has real implications for their academic success and future well-being (Cohen & Syme, 2013; Hahn & Truman, 2015).

In this multi-case study, I examine how the interaction of institutional characteristics of the school and external characteristics of the community shape school district responses to the opioid crisis in rural western Pennsylvania. Between 2010 and 2015 5,342 Pennsylvanians died from opioid overdose (CDC, 2018a). In 2017, Pennsylvania Governor Tom Wolf stated, in support of increased drug education in state schools, “we will take the fight against heroin and opioid abuse to the next level— the classroom, where education plays a key role in prevention” (Governor Wolf, 2017, para. 2). The state, with support from Governor Wolf, has recently mandated that opioid specific drug education be included in all public-school health curricula (Pennsylvania Department of Education, 2018). Despite a greater emphasis on the importance of education in addressing this epidemic (see Baker, 2019), the efforts of schools amidst this crisis in Pennsylvania and nationally are, however, relatively unknown. In this study, I examine the institutional and community factors that influence the ability of rural

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5 At the time of this study, the newly mandated district requirements for opioid specific education had not been finalized. Districts were in the process of developing plans for how to address this mandate as this study took place. All Pennsylvania school districts must now have opioid specific education in place.
districts in western Pennsylvania to take on public health roles and responsibilities amidst this worsening health crisis.

I conducted extensive fieldwork and interviewed forty-one educators in Durbin and Buchanan District, two rural western Pennsylvania districts, over the 2017-2018 school year. These districts face both economic challenges and high rates of opioid overdose and can be considered “landscapes of despair”— areas that have disproportionally experienced chronic economic under-development and attendant social and health consequences (Monnat & Brown, 2017). My research was guided by the following research questions:

1) How have rural youth, communities and schools been affected by opioid misuse and addiction?

2) How has the capacity of the local school district as an institution to respond to the opioid crisis and its effects been shaped externally by community economic health?

3) How has the capacity of the local school district as an institution to respond to the opioid crisis and its effects been shaped internally by structural and cultural characteristics of the school district institution?

In this paper, I discuss how rural western Pennsylvania students are affected by the opioid epidemic, and the internal and external factors that enhance or constrain districts’ capacity to combat the effects of local opioid misuse and addiction. While it is challenging to clearly delineate the layers of policies and processes that shape both the local communities of western

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6 District names have been replaced with pseudonyms.
7 In this paper I focus on opioid use, misuse (i.e. overdose), and addiction. I am conscious of how terms like drug “abuser” and “addict” depicts a certain image of individuals who have substance use disorders (e.g., addiction as a personal choice or an individual defined by their condition). I stay away from the term opioid “addict” (as this is not person first language), but when it is used in this piece I am capturing the language used by respondents so this language is quoted.
Pennsylvania and their schools, I attempt to pinpoint and contextualize the external community characteristics and internal institutional structures that have closely shaped local responses to this growing health crisis. I conclude this article with a broader discussion on the role of public education in addressing public health issues and the specific policies and conditions that undermine the ability of local schools to support student health in “landscapes of despair” (Monnat & Brown, 2017).

**Schools, Communities, and Health**

The spatial stratification of economic opportunity in this country has led to vast disparities in educational funding and opportunity between schools (Biddle & Berliner, 2002; Berliner, 2006). In underfunded schools, educators and leaders often face inherent challenges as educational policy demands contrast the real experiences and needs of students in impoverished urban (Anyon, 2005) and rural contexts (Schafft, Killeen, & Morrissey, 2010; Schafft, 2016). The research presented in this article further adds to this body of scholarship by examining how the unintended consequences of economic and educational policies converge in schools to exacerbate health disparities between places.

**The Opioid Epidemic**

In the 1990s, prescription opioids were commonly diverted and liberally prescribed, at times through “pill mills,” as many states lacked adequate drug monitoring programs (Rigg, March, & Inciardi, 2010; Quinones, 2016). In 1996, OxyContin was released—advertised at the time as a safer low addictive drug alternative to other opioids such as morphine. In turn, OxyContin began to flood into both licit and illicit drug marketplaces (Quinones, 2016; Van Zee, 2009). It was later discovered that, after its release, the maker of Oxycontin, Purdue Pharma, had
suppressed information that detailed the drug’s addictive properties (Armstrong, 2019; Van Zee, 2009). Rates of prescription opioid misuse and addiction, ultimately, spiked in the late 1990s in rural Maine, the Rust Belt, the Mountain West, and Appalachia (Inciardi & Cicero, 2009; Van Zee, 2009). In the past few years, more than one thousand municipal, county, and state lawsuits were filed against Purdue Pharma, the maker of OxyContin, for its role in the growth of the opioid crisis (Schott, 2019).

In the early 2010s, increased regulation of prescription opioids, a “pendulum swing” in prescription practices, along with the reformulation of OxyContin to be abuse deterrent, created the conditions for a rapid rise in heroin misuse and addiction in this country (see Figure 2-1) (Unick, Rosenblum, Mars, & Ciccarone, 2013; Keyes, Cerdá, Brady, Havens, & Galea, 2014; Paulozzi, Kilbourne, & Desai 2011). Many addicted to prescription opioids turned to heroin as it became more readily available in local drug markets and was often cheaper than opioid pills (Mars, Bourgois, Karandinos, Montero, & Ciccarone, 2014). However, a large proportion of persons addicted to opioids today initiated use with heroin, as drug markets became increasingly saturated with heroin in the early 2000s (Quinones, 2016; Rigg & Monnat, 2015). Recently, overdose deaths from powerful synthetic opioids—such as fentanyl and carfentanyl—have risen precipitously, due to their potency and, in turn, their ease to conceal in transport, as small amounts are highly valued (Drug Enforcement Agency[DEA], 2017, see Figure 2-1).
The opioid epidemic and its effects are, however, predominantly concentrated in specific U.S. regions. Many of the highest county rates of opioid overdose are found in the Appalachian region, New England, and in the Southwest. However, rates of opioid overdose are also beginning to grow in the Midwest (Monnat, 2018; Rigg, Monnat, & Chavez, 2018). Those areas of the country where opioid mortalities from overdose are particularly high, high levels of poverty, suicide, and family distress are also more likely to be present (Monnat, 2018). The average population educational attainment level in those counties’ with high rates of opioid overdose is also lower than those with low rates of opioid overdose (Richardson, Charters, King, & Harper, 2015). Those communities and regions the most affected by the opioid epidemic, therefore, face various economic, social, and health hardships.

“Landscapes of Despair”

The opioid crisis is not a rural or an urban issue, but it is an issue for many communities situated at the political and economic margins. Vast spatial inequalities tied to political and
economic processes push capital and opportunities into certain places, and not others. The inability of some local places to thrive in a neo-liberal driven market is inevitable, as not all places (often rural and inner cities) have the same capital, political power, or spatial positioning in which to benefit or sustain in a global economy (Schafft, 2016). Rural space, specifically, “in the context of modern capitalist states…is either a peripheral, relatively unimportant and ‘empty’ geography or historical artefact” (Corbett, 2014, p. 3).

Neoliberal economic policies, focused on deregulation and global economic competition, have undermined the viability of many domestic industries (e.g. natural resource extraction and manufacturing) (Brown & Schafft, 2019). “Good jobs” in these industries in rural places were largely replaced with “bad jobs” in the service sector, that offer little in the way of economic stability (Brown & Schafft, 2019; Sherman, 2009; Slack, 2014). The experiences of rural places are not economically consistent nor monolithic, but unemployment and underemployment is nonetheless higher in non-metro counties than metro (Jensen & Jensen, 2011) and many rural U.S. counties and regions experience high and persistent rates of poverty (U.S. Department of Agriculture, 2019).

Previous research has found that “deaths of despair”— deaths from drug overdose, suicide, or alcohol use— are related to personal and locally shared downward mobility, economic decline, and social isolation, especially among white working class males (Case & Deaton, 2017). Individuals experiencing adverse economic circumstances (e.g., poverty, unemployment, etc.) typically experience poor personal health (e.g., low life expectancy, heart disease, etc.) (Berry, 2014; Kemp, 2019; Monnat & Pickett, 2010). A spatial concentration of social and economic stressors, in turn, often lead to higher rates of poor health indicators within
these distressed places—these “landscapes of despair” (Monnat & Brown, 2017). Rural places, specifically, often lack a breadth of social and health services, because of the broader politics and economies of health care, leading to underserved rural populations and a lack of health supports in those places most in need (Berry, 2014; Blackstock, Chae, Mauk, & McDonald, 2018).

Devolution, the retraction of state and federal support in local governance, has, furthermore, “placed additional responsibilities on rural local governments historically disadvantaged by weak fiscal capacity and low tax bases” (Lobao, 2014, p. 550). From devolution, a market-based distribution of state and national grants and dollars, and cuts made to federal public health funding, many municipalities and districts struggle to access resources that may benefit community health efforts (Lobao, 2014; O’Malley et al., 2018; McKillop & Illakkuvan, 2019). The concentration of poverty, unemployment, and poor health in certain rural communities has the potential to weaken the capacity of local people and places to resolve these very issues (Monnat & Rigg, 2018). Therefore, in “landscapes of despair,” where the opioid epidemic has had its greatest effect, the ability to mount effective efforts to fight the rise of local opioid misuse and addiction may be limited, and especially in the context of state and national-level policies that promote devolution.

Rural Schools and the Opioid Crisis

The role that schools play and have played in addressing this crisis, and the experiences of educators in these “landscapes of despair,” are relatively unknown. Education, in terms of

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8 The term “landscapes of despair” was coined by Dear and Wolch (2014) to describe the settlement of at risk populations (e.g., disabled, homeless, and individuals with mental health needs), after national deinstitutionalization efforts in the 1960s and 1970s, in specific urban “ghettos” where community based services were prevalent. I, however, use this concept/metaphor as Brown and Monnat (2017) do to represent a concentration of both poor health and negative economic indicators in certain places—i.e., a spatial aggregation of “deaths of despair” and their associated factors (Case & Deaton, 2017).
attainment, has a positive effect on individual health (Cohen & Syme, 2013; Hahn & Truman, 2015). The health trajectories of students are also affected by various school factors that are both specific to learning healthy behavior (e.g., drug education), but also schooling broadly (e.g., academic rigor of the curriculum, teacher and peer relations) (Shears, Edwards, & Stanley, 2006; Zajacova & Lawrence, 2018). In addition, schools often serve community health functions (e.g., health promotion initiatives), and in some rural and urban places even provide direct health care to local residents (Blackstock et al., 2018; Wade et al., 2008). In the rural context, where health services and other community institutions are often scarce, the rural school may play a vital role in addressing the local effects of this national health crisis.

Rural schools, however, often have access to only limited resources in which to pull from to develop programs or initiatives that would support student and community health (Blackstock et al., 2018; O’Malley et al., 2018). Rural communities tend to have weak tax bases, which limits district funding (Johnson & Howley, 2015) and, in turn, puts added pressure on educational leaders to do “more with less” (Tekniepe, 2015, p. 2; Howley, Howley, Rhodes, & Yahn, 2014). In districts experiencing budget reductions, resources (e.g., time, funds, or personnel) for non-academic services (e.g., health education or counseling) are often the first to be cut or stretched (Howley, Howley, Hendrickson, Belcher, & Howley, 2012; Johnson & Howley, 2015; O’Malley et al., 2018).

Federal and state educational policies and their underlying logic, furthermore, often serve to narrow teachers’ attention to student academic outcomes, assessed through standardized testing, at the expense of attention to broader student issues like personal health (Daly, 2006; Rooney, 2015; Schafft et al., 2010; Schafft, 2016). As Biddle, Mette, and Mercado (2018) note:
Pressure to produce gains in testing may encourage educators to retreat toward the goals and objectives of the institution, rather than seeing schools as part of a larger community ecology with an obligation to the wellbeing of both community and school. (p. 3)

Therefore, state and national mandates and policies may limit the capacity, and desire, of rural educators and districts to address the opioid epidemic and its local health effects. The unintended consequences of various economic and educational policies, and their underlying logics, may, as this literature review suggests, create inherent challenges for certain places to resolve local health issues. As this study finds, schools in these “landscapes of despair” may reproduce community disadvantage and health disparities between places.

**Data, Methods, and Sites**

A multi-case study design was used for this research project (Yin, 2018). Because rural schools are entrenched in their local communities and the broader public education landscape (Schafft, 2016), any understanding of how rural districts and educators respond to this epidemic is “likely to involve important contextual conditions pertinent to [the] case” (Yin, 2018, p. 15). A case study design affords this empirical connection to context. I discuss below the communities where this multi-case study was conducted as well as the data collection and analysis methods used in this research.

**Sites**

In 2018, Pennsylvania Governor Tom Wolf declared the opioid epidemic a statewide emergency, after over 2,500 commonwealth residents died from opioid overdose in 2017 (CDC, 2018a; Governor Wolf, 2018). Western Pennsylvania counties, as can be seen in Figure 2-2, have been particularly affected by this epidemic and high rates of opioid overdose. Opioid overdose
rates across the state are also growing at faster rate in rural counties than in urban (DEA, 2017). Durbin and Buchanan District are in two of the highest opioid overdose mortality rate counties in the state.

Buchanan and Durbin District were selected for study because their local characteristics were more so representative of the contexts under study (i.e., “landscapes of despair”). Buchanan and Durbin Districts are both classified as rural by the National Center for Education Statistics. These districts and their communities experienced massive economic and population decline as a result of local mines, factories, and other industries closing or leaving western Pennsylvania. The unemployment and poverty rates in each districts’ community populations are higher than state averages (U.S. Census Bureau, 2018). A high percentage of the local population in these districts are also disabled, which is in part because each district population is older and

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9 These districts were also selected as local residents across districts shared divergent perspectives on the opioid crisis and individuals addicted to opioids. Specifically, in Buchanan District residents largely viewed this health crisis as confined to urban places or a problem for community outsiders alone. In Durbin District, on the other hand, residents defined drug addiction as a moral failure of the deviant “addict.” I conducted a comparative case study of these observed differences, the factors that led to these differences, and the effects of these community perspectives in Chapter Three.

10 The National Center for Education Statistics (2017) classifies districts as rural if in a Census defined rural territory.
has a large proportion of senior residents, i.e. over the age of sixty-five (U.S. Census Bureau, 2018). Therefore, as the local Buchanan and Durbin communities were similar, this research provides a particularly important look at the role of education in these “landscapes of despair.”

**Data Collection**

Durbin and Buchanan District superintendents aided in the selection and recruitment of study participants within their respective districts. I used snowball sampling as I recruited and interviewed additional participants. I interviewed a range of district personnel including principals, grade level teachers, paraprofessionals, nurses, and counselors. In total I interviewed forty-one district educators and leaders: sixteen in Buchanan District and twenty-five from Durbin District. While I interviewed other western Pennsylvania residents in this research, I do not include these interview data in this analysis as these participants lived outside these districts or were unable to speak to the processes under study (i.e., how local conditions and institutional logics of local school districts shaped district responses to the opioid crisis). I concluded data gathering in these two districts when additional interviews produced diminishing insights on the key topical areas of the study (Yin, 2018).

A semi-structured role-specific interview protocol was used in all interviews. Interview questions elicited respondents’ understanding of the effects of the opioid epidemic and also the district responses addressing this health issue (see Appendix). In Buchanan and Durbin District, I conducted two group interviews (with a total of nine participants), four pair interviews (six participants), and twenty-eight individual interviews. Interviews lasted on average forty-five minutes in length, although ranging from as an hour and a half to twenty-five minutes. Interviews were audio-recorded and then transcribed. Participants were largely natives to the local area and all participants were white and most were female.
I gathered various forms of data that were specific to these school districts and their responses to the opioid crisis as a means to develop a deeper understanding of the cases studied (Yin. 2018). I attended school board meetings, local action group meetings, and community events in both Durbin and Buchanan District, and recorded through fieldnotes (Emerson, Fretz, & Shaw, 2011) how local residents and educators talked about the epidemic and the formal and informal responses that were considered to combat this health crisis. Fieldnotes and available district documents, such as school board meeting notes, newspaper articles, or written district policies, were analyzed with interview data. I used data collected from these field sources to check the validity of the findings that arose through interview analysis, and vice versa. I also conducted member checks with various participants, which provided further data and validated or challenged developing study findings.

**Data Analysis**

I analyzed data through coding and memoing on the various factors that participants understood to shape their own and their districts’ capacity to respond to this health issue (i.e., restricted by time, accountability demands, funding, etc.) (Saldaña, 2016). These initial codes were thematically organized as either factors that shaped district response to the opioid crisis that were external or internal to these school districts. I analyzed within these categories how these factors connected with one another, within the data, and how these factors came to directly shape responses to the crisis (e.g., poverty, opioid crisis, student mental health, budgets, cuts to mental health programs).

I also continually compared data and the presentation of concepts/processes/codes within the data across districts, looking for similarities and differences across contexts (Yin, 2018). This data comparison allowed for a clearer definition of the conceptual themes that began to emerge in analysis (e.g., the many effects of limited local budgets had on district responses to this crisis).
I also compared data across interview type and participants’ district position. Data and analysis, however, consistently showed that these districts experienced many of the same internal and external constraints that had limited their ability to effectively respond to this opioid crisis. I discuss the consistent themes that arose, and were supported, through data analysis in the following sections.

Findings

I discuss below how local opioid addiction and misuse affected the well-being and academic lives of students in these districts, and how this crisis compounded local issues of mental and physical health. I then go on to discuss how local school and community conditions, in particular as they relate to local economic decline in these areas, challenged the ability of schools and educators to address student health needs, speaking to the second research question. Finally, addressing my third research question, I examine below how broader educational policies deterred the ability, and desire, of district educators to become engaged in efforts to address this crisis and its effects. This research illustrates how schools affected by the opioid crisis may not have the local resources to meet students increasingly complex health needs and that educators may be limited in their capacity to address student health concerns by state educational policies.

The Effects of the Opioid Epidemic- “Landscapes of Despair”

The effect of the opioid epidemic on local rural schools and communities in western Pennsylvania were for many participants not easily disentangled from other perceived local problems, such as poverty, changing family dynamics, and community disengagement. As a Durbin District teacher stated, “the jobs aren’t here, there’s a certain level of poverty, and you
also have this opioid addiction problem at the same time. You have all this stuff mixed together.”

Many participants described their communities as depressed. Educators also noted that community decline had, in turn, affected district demographics and overall student well-being, as a Durbin principal explained:

I have seen that in the first three years of my employment here we had pockets of kids that were struggling. You had your middle, you had your higher performing kids, kids who came from a stable two-family home, you know just your typical, their parents work they take them, they do things. The past three years it is not even a gradual it has been like it just fell off of a cliff.

Many participants believed that the mental health of the student body generally had worsened in recent years. In Buchanan District two students died by suicide in the same week the year prior to my fieldwork. The general community distress made it challenging for participants to separate out what they saw as the distinct effects of the opioid epidemic on the local area. However, participants largely believed that the growth of local opioid misuse and addiction in the past few years had further undermined local welfare, while further complicating educators work with students.

Most participants did not think that student opioid use was a rampant issue, although participants did provide examples of student marijuana, alcohol, and illicit prescription medicine use in each district. Participants noted, however, that parent and community member opioid misuse and addiction were growing problems. As a Buchanan District teacher discussed, parental drug overdose had become a serious issue:

A couple years ago I had a class where I had four parents die within a little bit…I had students whose parents had died from drug overdose. And so that’s really hard. And I had
one in particular who lost a mother and a father, within a year to drug overdose. So I think it is a really hard thing.

The death of a parent or the involvement of student families with Children and Youth Services due to substance use issues in the home, participants noted, led to custody issues and at times grandparents taking guardianship over grandchildren. Participants also shared that many of those grandparents who gained child custody struggled to meet the complex health needs of their grandchildren, as these students had been deeply affected by parental drug use.

Generally, educators explained how parental drug use, either known because of local arrests or word of mouth, had observable effects on their students in school. As a teacher at Durbin discussed, the effects of family substance use had a direct impact on her students’ well-being:

They were having issues with a dad using heroin and a kid going to the bathtub finding their dad passed out with a needle in his arm. I mean just seeing that obviously, you are talking about some major trauma but obviously then if a parent then dies from an overdose, now you are talking about a middle school or elementary kid or a high school kid dealing with the death of a parent, which is never easy no matter what age you’re at. And, it’s the trauma from it, I think is absolutely massive, now you start talking about kids seeing those types of things and it changes their behavior, their socio-emotional wellness becomes questionable then and it’s, the impacts are absolutely just massive. And it occurs, I don’t want to say regularly but it happens frequently in our community.

Participants noticed that those students whose parents or family members suffered from opioid addiction often suffered from anxiety and depression, which negatively impacted their academic success and behavior in school. A teacher at Durbin gave an example, “I have a student whose parents got divorced because mom and dad were involved in using drugs, and also from what I
understand, selling them. Mom was caught selling heroin at her job…[The son] is [now] in therapy.” In other instances, participants described how it was a challenge to get affected students to focus on daily school work, as often they lacked sleep, the appropriate care, or struggled daily with their mental health. Those students who experienced personal struggles due to home substance use were as a result often academically below grade level. As a teacher at Durbin explained:

The kids what they are facing at home just the mere fact that they got themselves out of bed that day and got themselves here into school, that’s a big deal for them. And, you know, if you have a kid whose parents have passed out or whatever and they got their little brother and sister up and out with breakfast and everything and the fact, when they get to school the first thing on their mind is not learning about government and economics. You know, they are worried about did my little sister get on the bus today? What am I going to find when I get home?

These students often struggled in school, which participants also believed caused further anxiety and depression, and continued cycles of despair.

**State, Regional and Community Characteristics Shaping School Responses to the Opioid Crisis**

In this section I explore how the institutional capacity of the local school to respond to the opioid crisis has been shaped by external community conditions. The key factors that shaped and/or constrained school response in these districts were limited budgets and personnel, which were caused by increased charter enrollments in each district, unfunded state mandates, and local economic decline. With limited budgets and shrinking staffs, Buchanan and Durbin District struggled to meet the increasing health needs of students impacted by the opioid crisis.
In Durbin and Buchanan districts, participants noted that financial restraints made it challenging for each district to expand current health services and education. There were many factors that limited district budgets. Participants noted, for one, that in the last five years district dollars had increasingly gone to fund student tuitions to cyber charter schools. As a district leader noted:

And if you look at the funding, heck we pay $500,000 a year to cyber charters. And they dictate what we pay. It’s not you are getting $6,500 for a kid from the state, you pass that $6,500 along. It’s you get $6,500 for a regular ed kid or a special ed kid and they charge you $8,000 and $9,000 for a regular kid. And then if the kid has an IEP it is 20. They are charging you three or four times what you are getting reimbursed.

Educational leaders in these districts also discussed how various unfunded state mandates had further restricted district discretionary funds. The local budgets in these districts, however, were primarily limited by low local tax bases. In each of these districts, school funds depend heavily on state and federal revenues.

Limited local budgets restricted the monies that could be put towards drug education and mental health services, but also led to staffing cuts in each district. As a teacher explained in reference to Buchanan district, “[The district] does try to do something, but there’s only so much that they can do with their means and [the] staff that we have here.” Some community members, furthermore, directly resisted increased school spending, as associated tax increases would make more precarious their local livelihoods. A local resident at a school board meeting at Buchanan District stated that if the school board approved tax increases, to support a larger school budget, he would be unable to sustain his farm. In Buchanan District taxes were not raised and a district guidance counselor position was furloughed as a result. In response to furloughing this position a parent protested:
The number of children that have lost one or even both parents in our district is increasing every year…A large percentage of our students have been removed from their homes and are now being raised by grandparents…They deserve all the support we can offer.

The district argued that by furloughing this position it would create a more “effective and efficient educational program.”

The tightening of budgets and resulting cuts to staff often put added pressure on educators to fulfill more demands. As a teacher at Buchanan teacher noted:

I feel like our staff has been cut short. Once someone retires or leaves, they’re not rehiring, but we’re still expected to fill those positions of students or teachers that have left. Class sizes are getting larger. There’s less teachers…and everyone just feels stressed out by it, and really feeling the pressure.

In Durbin and Buchanan districts, guidance counselors explained that because of reductions to the district support staff they have increasingly taken on additional roles and responsibilities that were not focused on supporting student mental health. As a guidance counselor discussed:

My job has become very administrative. And not by anyone’s fault, but like I do all the scheduling, I do all this. I do the gradebook stuff. Not that guidance counselors haven’t done that, whenever I was first here I had a secretary who did that… I am [as a result] more of a crisis [counselor], like if something is happening they come to see me… I used to do groups, I don’t do that anymore, just for time.

The ability of guidance counselors to conduct health services had become increasingly restricted, as student mental health needs at the same time had expanded. As an elementary principal at Durbin noted, however, worsening student health had led to the hiring of new school nurse:
We had to hire another nurse due to the fact that our parents are not taking them to the doctors, they use us as their nurse as their doctor, so the amount of kids that were going through the nurses office just skyrocketed. And it became they are really just not taking them to the doctor they are using my nurse.

In adding this nurse, because of extreme need, district monies were, however, moved away from other areas, further complicating the district’s limited budget.

**Educational Policy and The Responsibility of Schools to Serve Local Health Needs**

In this section I explore how the capacity of the local school and educators to respond to the opioid crisis has been shaped internally, through the school institution, by national, state, and local education policies, cultures, and beliefs. Educators felt restricted/limited in their ability to respond to this crisis because of heightened accountability demands, but many also felt that it was not the responsibility of teachers and schools to address student health. In focusing their attention on academic outcomes alone, most educators did little to address students’ growing health needs.

In 2013, Pennsylvania adopted rigorous state standards, the Pennsylvania Core, aligned to the Common Core national standards. The state has since aligned student and school assessments to these standards. The results from state assessments, as a result of Act 82 passed in 2012, are also now part of teacher and principal standardized state evaluations (Pennsylvania Department of Education, 2013). The performance by these districts on state assessments were similar, and overall student performance in each district were close to state averages. Teachers and administrators discussed how it was challenging to fit health and/or drug education into the districts’ standardized curricula, however, because of the prominent attention in each district to tested subjects:
Because everybody is so focused on teaching to the standards and teaching to the tests. The PSSA [Pennsylvania System of School Assessment] rules everything… I think just finding time to put it in. Where do you put it? The kids don’t necessarily have a health class. They have gym. They have social sciences. Where do you put it? What do you take away from to provide that?

Many teachers also explained that students whose health had been further compromised by local opioid misuse and addiction often got lost in the standardized curriculum. As a Buchanan teacher explained:

That becomes a vicious cycle, that, I’m glad that you are trying to provide guidance counseling and everything else for this student, but now you’ve pulled them from this class every week for the last three weeks…so now they’re struggling to keep up with our class.

Teachers also explained that they felt overwhelmed managing the ever-increasing complex home lives of their students as well as the numerous administrative and accountability demands asked of them. The attention that teachers gave to tests and the standardized curriculum, provided little room for them to take on and become involved with additional drug prevention and/or health education efforts in and outside their classrooms. Moreover, teachers in these districts did not feel able, or in some cases willing, to take steps to address issues associated with local drug misuse and addiction.

Many educators stated that they did not feel that it was necessarily their responsibility to address local opioid misuse and addiction and its effects. As a Buchanan teacher noted, “Do we need to become the center for, ‘this is where I get help because my mom has a drug issue or I have a drinking problem?’ That’s not what the school is supposed to be.” It was clear in these districts, and in this quote, that many teachers held onto the belief that education and community
well-being were unrelated or should remain separate. Educators, generally, described that the many social services now provided by the local school, had complicated the purpose of schooling. As a Durbin teacher noted:

We’re in charge of making sure that they have a breakfast and a lunch. We send food home with kids over the weekend. We make sure they have coats…If we’re taking on the parental role, it’s hard because then you start mixing morals in with it.

Teachers further explained that many non-academic responsibilities had become recently attached to schooling and their positions. As a teacher at Durbin district noted:

I am not just the teacher. I am a teacher, but I also am the parent. I am the disciplinarian, [and] apparently, I am now the body guard because when there is an issue or a fire drill I am the first one out the door in case it is a trap…I am triage, I am a nurse…It’s overwhelming.

Other non-academic efforts, teachers discussed, also became prominent foci in their districts as well, such as suicide-prevention. The non-academic functions that these schools are purposed with, many educators generally felt resistant to address. However, other educators believed it was imperative to address the needs of the whole child in the classroom and school, including their health. A few educators also believed it was necessary for the school to support parents in need, as a guidance counselor at Durbin District stated, “I would hope that parents see us as a resource and that we are wanting to help.” This sentiment, however, was not shared across all participants, and many believed that the broad culture in the school district was not directed towards those conversations.

Most teachers also felt unprepared to address students health needs, as this was not a focus of their training or a part of their previous experience in schools. As a Buchanan teacher considered:
I think it’s now becoming a part where I feel like you have to be their guidance
counselor. Well, they have so much anxiety outside of school with this. “Okay, but, so
now you’re not performing in my class.” I don’t know how to mesh those two together.
How am I supposed to take whatever your mental health issue is that I was not trained to
deal with and teach you math? You still have to know the math stuff. I know how to
teach you the math stuff. I don’t know how to fix your mental health issue.
Teachers discussed how they tried to do their best to address the personal issues that students
brought into the classroom, but were hesitant to have hard conversations with students for fear of
not doing what was right or best for these students. Teachers were often encouraged by their
administrators to send students with health issues to the nurse or guidance counselor—who were
themselves largely overwhelmed. Teachers in these districts also discussed that they lacked
access to quality training on supporting student health, especially student health issues related to
the opioid epidemic. As a Buchanan teacher noted:

   Once upon a time this was a drug addict, but now they can be somebody white collar…We
   have been trained from that perspective, but not necessarily how to deal with the kids in
   the classroom who are going through it and what we can do to help the community to try
to stop it.

Many educators felt unprepared or unable, and some resistant, to respond to the opioid epidemic
and its effects on students. Educators, guidance counselors, and nurses across these districts
ultimately struggled to meet the growing health needs of students that had been caused by the
opioid epidemic.
Discussion

Many rural youth, communities, and schools are greatly affected by the opioid epidemic. Participants provided numerous examples of how parental substance use affected children, and how these effects manifested in the school. The opioid epidemic, however, was one of the many issues facing both Durbin and Buchanan District. Poverty, unemployment, and limited economic opportunities had negatively affected local students and their communities prior to the onset of the opioid epidemic. The opioid crisis had, however, compounded problematic local conditions and further worsened the health and well-being of many local youth. In western Pennsylvania, recent data suggests that opioid overdose rates are leveling off (Prose, 2019). The data from western Pennsylvania is encouraging, but rates of methamphetamine and cocaine use and sale have risen in the state at the same time as opioid overdose rates declined (Levy, 2019). The opioid crisis, and drug use broadly, is intimately connected to a host of other pressing and interconnected social, economic, and health issues and inequalities.

The conditions of the local communities surrounding these districts shaped each school district’s ability to respond to this epidemic. It was challenging for these districts to expand drug education programming and/or add student health services because of limited district funds. The small institutional scale of each district also led guidance counselors, largely responsible for school-based counseling, to take on administrative duties, which took time away from the services that they could provide to students in need. These non-academic services, in response to tightening local budgets, were also the first to be cut. Low tax bases and local poverty, associated to poor health, in turn, made it challenging for districts to serve student health concerns.

In these districts, where guidance counselors and nurses struggled to address rising student health concerns, teachers also felt unable to address student emotional needs. Educators
felt overwhelmed balancing the many health and academic needs of students while also attempting to meet institutional demands. Teachers’ attention to state tests and standards undermined their capacity to serve local health. It was evident that the purpose of schooling embedded in the minds of teachers, focused on academics alone, also served to keep their attention away from issues related to student health. These teachers, therefore, felt internal institutional and cultural pressures to remain focused on student academic outcomes. However, some teachers expressed more expanded views of schooling and education, but had been unable to gain the supports or training that would allow them to better address student health needs.

The inability of districts to support those students whose home lives are more complex because of the opioid epidemic may, in turn, reproduce negative local conditions. Without needed health support and at times facing academic failure as a result of the standardized curriculum, those students impacted by this crisis may be at a higher risk for future poverty and substance use (Keyes et al., 2014; Lichter & Graefe, 2011; Shears, Edwards, & Stanley, 2006). Therefore, schools in these contexts of despair may not have the tools or resources to address student needs, which may worsen current and future local health. This research highlighted this cyclical process and the potential for negative local conditions to be reproduced by the inability of the school district to support student and local health. Not all schools and communities may have appropriate capacity to address complex local issues, such as the opioid crisis, which may maintain or exacerbate spatial health disparities.

**Conclusion**

In Pennsylvania, many state-promoted initiatives and policies have widened economic disparities between communities in the state. In 2006, billed by politicians as an economic
panacea, Marcellus Shale natural gas extraction began to occur in western Pennsylvania. However, the economic benefits from this industry's growth were not widespread (Hardy & Kelsey, 2015) and many low-income residents experienced increased housing insecurity as a result of gas extraction buildout (Schafft, McHenry-Sorber, Hall, & Burfoot-Rochford, 2018). The charter school movement in Pennsylvania has also had an uneven effect across school districts in the state. The number of students leaving for cyber charter schools in Pennsylvania is higher in resource poor districts, and, therefore, financially struggling districts regularly use a substantial proportion of their limited resources for charter tuitions (Mann & Baker, 2018). The recently revised state school funding formula in Pennsylvania, furthermore, has thus far not reduced the spending disparities between schools, which it intended to address (Behrman, 2019). Policymakers in Pennsylvania must evaluate how resources to combat the opioid epidemic are distributed between schools and communities, and how policies or state economic initiatives maintain, or worsen, various economic, social, and health inequities that exist across the state.

The separation of public health from the purpose of schooling may also deny the real health disparities that schools reinforce. In districts where poverty rates are high, and often student scores on standardized assessments are low, the effect of accountability demands on educators is often intensely felt (Berliner, 2006; Rooney, 2015). In rural and urban places of poverty, students may be in greater need of health supports, but educators may feel particularly coerced to keep their focus on educational outcomes. More research is needed which explore the public health functions and capacities of schools within the current educational policy landscape. The current Every Student Succeeds Act advances school attention to student wraparound services (O’Malley et al., 2018), so it is important that future research consider how health services in this new policy context are implemented equitably across schools. Those economically marginalized places, suffering from associated health concerns, and their schools,
that are affected by the economic organization of education, may both inherently struggle to
resolve the health and education issues associated with this crisis. It is, therefore, also essential
that state and federal funds are directly allocated for school-based health efforts in those districts
most affected by this crisis.

It is imperative that attention be given broadly to how federal and state policies produce
these “landscapes of despair,” and undermine local residents and educators capacity to address
various health issues. The negative effects of many economic and educational policies (e.g.,
poverty, teaching to the test) converge in rural schools.\footnote{11} I believe that education and schools
needs to thrive in rural places for these communities to be able to effectively address local
problems. I would encourage national and state policymakers to support the community
development efforts of schools to address challenging local conditions, through direct financial
provisions and training, while also easing those educational policy mandates that disadvantage
rural schools and undermine students’ attachments to place. The antecedents of this crisis (e.g.,
concentrated poverty) in rural places also must be addressed by policy efforts and state
interventions (e.g., rural community development efforts). It is, however, paramount that
policymakers evaluate how economic logics embedded in schooling, the practices of the state,
and in health care, have concentrated negative economic and health conditions in certain places
while at the same time undermined the capacity of the educators and residents in these places to
address these same negative conditions.

\footnote{11} Opioid overdose rates are high in urban areas (Monnat, 2018). Urban places and schools also experience negative
effects from various educational and economic policies (Anyon, 2005). Future research should consider the capacity
of urban schools to address this crisis, from their positioning also at the margins of the educational and economic
landscape.
References


Chapter 3

Opioids and the Moral Economies of Rural Community: Local Framings and Responses to a Social Crisis

Abstract

I examine in this study how local residents in rural western Pennsylvania, an area heavily affected by the recent opioid epidemic, understood the effects of the opioid crisis on their rural places and positioned those addicted to opioids within local moral economies. I conducted two years of fieldwork in two rural school districts (Buchanan and Durbin) in western Pennsylvania. I found that despite pronounced evidence of the multiple impacts of opioid addiction locally, there have paradoxically been limited local responses to this issue in these districts. The prevailing view of local residents in these communities was that those addicted to opioids were undeserving of community support, although the moral bases of these justifications varied between districts. I find that the unique moral economies present in each district, formed by residents’ reconciliation of local conditions and identities with broader moral discourses (i.e., the moral rural and the immoral drug “addict”), ultimately, circumscribed the range of possible responses to the opioid crisis that each local community felt were needed. This study adds to scholarship on moral economies by further developing the logics of moral economies. I conclude this paper with a discussion on the need for broader collective actions that challenge moralizing depictions of drug addiction.
Introduction

The rise of progressive era reforms efforts in the early 1900s pushed political and social attention to the issues of urban vice (i.e., prostitution, crime, and drug use) in this country. In this progressive vein, and in conjunction with the temperance movement, the amoral image of the “junkie” became established, in which opioid addiction was “framed as a morally enslaving condition that trapped the unwary” (Acker, 2002, p. 7). At the time, opioids were not illegal to use, buy, or sell in the United States, but these social regulation movements, and the amoral depiction of the perverse “addict” that they wielded, encouraged the enactment of various state and federal policies that increased regulation on opioids and their use (Acker, 2002). The common characterization of the drug “addict” has evolved over time, incorporating now psychological and pharmacological descriptions, but many of the deviant representations of drug use and user that were common at the turn of the 20th century remain normative today (Acker, 2002; Linnemann & Wall, 2013).

Rural, in contrast, is considered moral space. Rural places are often portrayed as the “antithesis of the modern urban world—more moral, virtuous, and simple” (Brown & Kandel, 2006, p. 4; Enticott, 2003; Woods, 2010). Rural people are, furthermore, often attributed with moral qualities associated with strong work ethics and communitarian values. Drug use in rural areas has, in turn, historically received little national attention given the prevailing (misplaced) assumption that rural communities, relative to urban, are void of crime and drugs (Acker, 2002; Somerville, Smith, & McElwee, 2015). When rural drug use has garnered broader media or political attention, rural drug problems are typically depicted as caused by urban invaders or the rural poor—seen as “outside community, outside law, outside reason, [and] outside bourgeois conventionality” (Linnemann & Wall, 2013, p. 9; Netherland & Hansen, 2016; Somerville et al.,
Many rural people, despite these representations, are today addicted to heroin and/or prescription opioids.\textsuperscript{12}

The current opioid epidemic is an unprecedented national and rural health crisis. Between 1999 and 2016 more than 350,000 persons died from opioid misuse nationwide (Center for Disease Control [CDC], 2018a). From 2010 to 2016 heroin overdose deaths increased five-fold (CDC, 2018b). Rural rates of opioid overdose are, furthermore, increasing at a faster rate than urban, and some of the highest county level opioid overdose rates are concentrated in impoverished rural areas (Keyes, Cerdá, Brady, Havens, & Galea, 2014; Monnat, 2018; Rigg, Monnat, & Chavez, 2018). Rural adolescents are also more likely than their urban counterparts to misuse prescription opioids (Monnat & Rigg, 2015). Many rural citizens have had to contend with the realities of this crisis and its effects on their local communities.

In rural places, however, health services and supports are often scarce (Berry, 2014). Because of limited access to health resources, rural people struggling with substance use disorders often must depend heavily on family or community support, in terms of social or economic capital, in treatment and recovery (Fox, Blank, Rovnyak, & Barnett, 2001; Moody, Satterwhite, & Bickel, 2015). In resource poor rural communities, however, local residents may not feel that those addicted to opioids are deserving of limited community assets, specifically, if considered to be lacking moral standing in the community (Burton, Garret-Peters, & Eason, 2011; Sherman, 2009). How local residents morally appraise those addicted to opioids (i.e., as undeserving or deserving of community support) may, therefore, come to impact how communities broadly act to address the local effects of this opioid epidemic.

\textsuperscript{12} In this paper I focus on opioid use, misuse (i.e. overdose), and addiction. I am conscious of how terms like drug “abuser” and “addict” depicts a certain image of individuals who have substance use disorders (e.g., addiction as a personal choice or an individual defined by their condition). I stay away from the term opioid “addict” (as this is not person first language), but when it is used in this piece I am capturing the language used by respondents so this language is quoted.
I examine in this study how residents in rural western Pennsylvania, an area heavily affected by the recent opioid epidemic, understood the effects of the opioid crisis on their rural places and positioned those addicted to opioids within local moral hierarchies. I conducted extensive fieldwork in 2017 and 2018 in two rural school districts (Durbin and Buchanan District) in western Pennsylvania. I interviewed a total of forty-three educators and community members across these two districts and supplement this interview data with fieldnotes and documents gathered while in the field. My research examined the following research questions:

1) How do rural residents in western Pennsylvania morally position themselves in relation to the opioid epidemic and its effects?

2) How and why do particular moral interpretations of the opioid crisis and its effects in rural western Pennsylvania communities become dominant?

3) How do local moral economies affect the potential for collective action to address this health crisis in rural western Pennsylvania?

Despite pronounced evidence of the multiple impacts of opioid addiction locally, there has paradoxically been a limited response to this crisis in both Durbin and Buchanan communities. This not only appears to contradict local lived experience of opioid misuse and addiction, but may also hinder future state interventions that might reasonably mitigate this health crisis which can literally become a matter of life or death. I examine in this research how community members in these districts applied a situated moral calculus to explain the causes, effects, and needed community responses to this crisis. This research finds that residents negotiated their local realities, identities, and certain moral discourses to morally evaluate those affected by the opioid crisis. In Buchanan District residents morally othered those addicted to opioids through a

13 All place, district, and participant names have been replaced with pseudonyms.
lens of rural *community* where in Durbin residents othered those addicted to opioids through *individual* moral definitions of drug addiction. These processes differed between districts because of the ways this epidemic and its effects intersected with local moral economies. I conclude this paper with a discussion on the logics of moral economies and the need for broader collective actions that target this crisis and challenge moralizing frames of drug addiction.

**Rural Moral Economies**

Morality is “both the particular doctrine of thought, feeling, and action that most people in a given social world agree upon and consider proper” (Burton et al., 2011, p. 101). Individuals often evaluate themselves and others by what is collectively understood to be morally right (or more morally right) and wrong (Burton et al., 2011; Sherman, 2006, 2009). There are a variety of characteristics or qualities that are considered moral, such as honesty, altruism, personal responsibility, etc. Morality is, however, socially constructed; there is no inherent moral doctrine or code that all acts or behaviors can be judged against, but numerous contested, evolving, and situated moral standards that groups or individuals use to evaluate actions or actors (Boucquey, 2017; Paniagua, 2014; Wolford, 2005).

Morality, furthermore, can be the basis of symbolic value and boundaries, whereby, groups or individuals attribute themselves with moral worth and “other” outsiders in moral terms. Specifically, “upholding moral standards allows individuals in low social status position to gain empowerment by raising their status at the symbolic level, thereby, attenuating their low social status” (Lamont, Schmalzbauer, Waller, & Weber, 1996, p. 37). Moral lines and discourses are also used as a symbolic means to police and uphold various social boundaries (Lamont & Molnar, 2002). Moral judgments, for instance, “such as lazy, hard-working,
trustworthy, and criminal are often used as criteria for distinguishing one individual or group of people from others as a basis for liking, assessing social worth, giving support, and relegating rewards” (Burton et al., 2011, p. 99).

The symbolic valuing of morality gives rise to moral economies. In moral economies, local people assess who is and who is not deserving of finite community resources based on placed moral evaluations of residents and their actions. Morality, in turn, “become(s) a type of symbolic capital, a symbolic boundary marker than can be traded for other real and symbolic forms of capital, such as economic rewards or social ties” (Sherman, 2006, p. 8). In turn, communities are more likely to allocate their collective resources (e.g., time, money, energy, etc.) to resolve a local issue, if that problem creates unjust local conditions in terms of situated moral standards and/or effects persons with credited local moral value (Scott, 1977; Thompson, 1971).

Moral economies, however, are not based from a “single, coherent ideology but rather a conglomeration of ideas drawn from social, cultural, religious, and psychological sources” (Sherman, 2006, p. 7). Local people, for instance, often pull from moral values embed in religious or political thought to develop their own, and evaluate others’, moral lives (Sherman, 2006, 2009). Rural residents, specifically, often appropriate, apply, or practice representations attributed to rural people (e.g., hardworking, honest, etc.) and the rural community (e.g., tight-knit, bucolic, etc.), which also impacts rural people’s moral assessments of local actions and actors (Woods, 2010; c.f., Enticott, 2003; Sherman, 2009; Somerville et al., 2015). As local moral economies are collectively shared and enacted, they are also influenced by place identities, boundaries, histories, and power structures (Sherman, 2009, p. 15).

Economic, social, and cultural changes (e.g., economic decline, immigration, outmigration, etc.) in rural communities can, however, lead to modifications in local moral
economies (Boucquey, 2017; Burton et al., 2011; Paniagua, 2014). Sherman (2006, 2009), for example, found that the local moral economy of a rural northern California town changed as local economic opportunities contracted (c.f. Sherman & Sage, 2011). In this rural community, residents established new bases for moral demarcations that better applied to the community’s current conditions (Sherman, 2006, 2009). As Sherman (2009) states, adaptations to the local moral hierarchy, “helps to create and enforce new behavioral norms, which, although based in pre-existing moral understandings, nonetheless present new interpretations of morality specific to the community’s present needs” (p. 187). However, as rural change is often uneven (Burfoot-Rochford & Schafft, 2018; Schafft, McHenry-Sorber, Hall, & Burfoot-Rochford, 2018) there may exist multiple and opposing moral economies within a single context, often differentiated by social position or group identity (Boucquey, 2017; Paniagua, 2014).

I examine in this research how the opioid crisis and those affected fit within the unique local moral economies observed in Durbin and Buchanan, and how this served to shape local responses to this crisis in these places. I foreground in this research how residents in rural western Pennsylvania, specifically, borrowed from broader constructions of rurality and drug addiction to morally other the opioid crisis and the local “junkie.” I, however, also discuss the often multiple and evolving local moral discourses that residents used to value and label those people affected by the opioid crisis as unworthy of community support. I find that residents across these districts used different moral basis in which to evaluate those effected by the opioid crisis, but in both districts local residents determined that those addicted to opioids were undeserving of community support or aid.
Data, Methods, and Sites

I used a case study approach to explore how residents responded to the local effects of the opioid crisis in both Durbin and Buchanan District (Yin, 2018). I focused this research in school districts because rural schools are central community institutions (Tieken, 2014) and rural educators are, in turn, particularly sensitive to local community issues (Schafft & Biddle, 2014). I examine in this comparative case study, specifically, how residents in Durbin and Buchanan assessed the moral standing of those locally addicted to opioids and how this evaluation, ultimately, affected community resolve to address this crisis. A comparative case study design is particularly well suited to examining differences in social processes, and the bases of variance, between two like contexts (Yin, 2018).

Durbin and Buchanan District

In 2017, Pennsylvania had the third highest drug overdose mortality rate in the country (CDC, 2018a). From 2010 to 2017 over 10,000 commonwealth citizens died from opioid overdose (CDC, 2018a). In 2018, Pennsylvania Governor Tom Wolf declared the opioid epidemic a statewide emergency (Governor Wolf, 2018). Rural areas in Pennsylvania, like nationally, also have faster growing rates of opioid overdose than urban (Drug Enforcement Agency [DEA], 2017). Rural counties in western Pennsylvania, specifically, have some of the highest drug overdose mortality rates in the state (DEA, 2017).
I selected Durbin and Buchanan districts for study because of their location within high overdose mortality rate counties in western Pennsylvania, seen in Figure 3-1, and the unique ways residents in each district community constructed meanings around this crisis. Residents in these districts used different moral bases to “other” opioid addiction and “addicts,” which became clear through initial field experiences in the region. In each district some school-based efforts had been made to address this crisis, which I explore elsewhere (see Burfoot-Rochford, Chapter Four), but collective action to address this crisis locally had yet to be galvanized. Therefore, comparison across districts allowed for the analysis of how unique moral economies in each district came to shape local understandings of the opioid crisis and may have also led to equally meager support for community efforts to target the local opioid crisis across districts.

Durbin and Buchanan districts have each a single campus where all local K-12 students are served. The district schools and offices were located in the largest town in each district, but each district also served students from surrounding small towns. Participants believed that, despite these districts encompassing multiple towns, district boundaries represented the borders of the local place (see Tieken, 2014). As respondents noted, each district was the “hub” of the
surrounding community. These districts are both classified as rural by the National Center for Education Statistics.\(^{14}\)

Durbin District is near an urban center, but has similar economic and demographic characteristics to that of the more remote Buchannan District (U.S. Census Bureau, 2018). The physical character and culture of Durbin is deeply defined by its coal mining history. Buchanan although dependent on natural resource extraction is more agrarian, and many of the town names in the district are agriculture based (e.g., Cornville, Farmington, etc.). The communities in Durbin and Buchanan both experienced prolonged economic decline and population loss in the past three decades. The populations of the communities surrounding Durbin and Buchannan District are older, with a large population of seniors, and residents are predominantly Non-Hispanic white (U.S. Census Bureau, 2018). These districts are located in adjacent counties and their town centers are roughly thirty-five miles apart.

**Data Collection**

I integrated various data sources, gathered through various collection methods, in the examination of local resident experiences with the opioid crisis in Durbin and Buchanan District (Yin, 2018). I spent extensive time in both districts in 2017 and 2018. I attended school board meetings, community events, and local meetings in each district. I wrote fieldnotes focused on how residents talked about the opioid epidemic and the various local events related to local drug use in these communities (i.e., local arrests or known drug overdoses) (Emerson, Fretz, & Shaw, 2011). I also gathered documents in each district related to the effects of the opioid epidemic on the local area, as well as collected any local editorials, articles, or publications from local

\(^{14}\) The National Center for Education Statistics (2017) classifies districts as rural if in a Census defined rural territory.
organizations related to the opioid crisis. I also conducted forty-three interviews with district employees and local residents while conducting district fieldwork.

I requested and was granted approval to conduct this research in Buchanan and Durbin by each districts’ respective school board. I initially sent out a recruitment letter to all staff and faculty in Durbin and Buchanan District, which in both districts led to multiple contacts and interviews. I then used snowball sampling to recruit additional study participants. I, further, provided my contact information to each person interviewed for them to pass on to other prospective participants. I interviewed twenty-six educators and community members from Durbin District and seventeen from Buchanan District. I conducted two group interviews (with a total of nine participants), four pair interviews (eight participants), and twenty-six individual interviews.

I interviewed various district personnel, e.g., principals, grade level teachers, paraprofessionals, nurses, and counselors. While the majority of interviews were conducted with educators, I also interviewed two members from the organization Communities Against Drugs in Durbin District. District personnel and these community action group members were equally entrenched in their local communities and, therefore, able to give accounts of the local effects of the opioid crisis and community reactions to local opioid addiction. Twenty-eight participants, at the time, lived in Durbin or Buchanan district or graduated from the district. Most participants grew up in western Pennsylvania. All participants were white and most were female.

I used a semi-structured interview protocol for each interview (see Appendix). I asked participants questions specific to the effects of the opioid epidemic on their local community and their beliefs regarding how best to address this issue. I also asked questions in these interviews about the local community and the character of the local place, so as to better understand each
district’s local identity and moral economies. Interviews were audio-recorded and then transcribed.

**Data Analysis**

I analyzed how respondents and the community more broadly made sense of the effects of this epidemic on their local place and talked about local opioid users. I conducted content analysis of transcripts, fieldnotes, and documents to examine how these communities broadly framed this crisis. While the research questions detailed above ultimately directed the analysis of this research study, analysis was inductive. In initial interviews with respondents clear differences in how each district’s residents understood the opioid crisis arose (i.e., the opioid problem is an outsider issue vs. the opioid crisis is a rampant concern). I, in turn, through data analysis sought to understand the basis for these differences, and how different understandings of the opioid crisis that existed between Buchanan and Durbin came to direct local responses to this crisis across these communities.

I developed initial codes based on the broad differences that emerged in analysis of interview and fieldnote data (e.g., community outsiders, widespread problem, etc.). I looked for patterns within these general codes and relationships between and within these concepts. I centered this initial analysis on how residents defined and talked about local opioid “addicts.” In analysis, and the finite coding that resulted, divergent community level definitions in each district of the opioid “addict” began to take form (Saldaña, 2016). I wanted to examine the basis for these district disparities and their effects on local social interactions, but at the time of this initial analysis did not have a clear analytical framework to examine these variances. I applied various broader concepts or frameworks to the data in analysis (e.g., social problems, problem frames, deviance), but each was not explanatory of the data collected. I ultimately, applied a
moral economies framework to the data, which provided an expounding analysis of the data collected.

I, specifically, measured through coding and memoing, the moral “values” and “value” (codes) that residents in these communities attached to those locally addicted to opioids. I also used comparisons between districts to further clarify the findings that were specific to each community (Yin, 2018). I used various data points (i.e., from fieldnotes, transcripts, etc.) to both challenge and support each research finding. I, specifically, analyzed the moral discourses Durbin and Buchanan residents used to rationalize their local moral evaluations (e.g., rural community or drug “addict”) and what effect these evaluations had on local responses to the opioid crisis (e.g., undeserving of community aid, stigma management). I did this through the development of conceptual coding matrices (using NVivo software), whereby, I began to connect codes together in a matrix so to develop a composite of how residents both understood and considered responses to this issue in each district. I compared these composite coding matrices (specific to problem definition and solution) between districts, but also pulled in outside research and theory to understand the conceptual bases (e.g., the “addict” or rural place) of these unique district moral frameworks.

In this chapter, I examine how Durbin and Buchanan District residents morally framed the opioid crisis, morally positioned those addicted to opioids, and how this affected problem-solving regarding this local issue. I examine how residents in these communities drew from various moral discourses (e.g., rural, local identity, and drug addiction) in which to label local drug use and addiction and distance themselves from this crisis and its effects. In each district, however, the ways residents morally framed this crisis and its effects differed. I below consider each research question within the contexts of each district. I examine each district separately as it affords the opportunity to examine the basis for, and effects of, the divergent views on this issue.
that existed across contexts. I conclude this analysis by discussing how residents across these districts differed in how they morally positioned themselves in relation to this crisis (Research Question One) and how different moral discourses were applied by residents to evaluate individuals addicted to opioids across these contexts (Research Question Two), but despite these differences residents in both districts believed it was not their responsibility to address the opioid crisis and its effects (Research Question Three).

**Durbin District**

I provide below a basic overview of the limited economic opportunities in Durbin District communities before I go on to address Research Question One, and examine the unique ways that residents in Durbin District morally positioned their communities in relation to the opioid crisis. I highlight in this discussion the specific community moral boundaries that served to justify residents isolation and exclusion of community outsiders who had been credited with the local effects of the opioid crisis. I then, in response to Research Question Two, go on to discuss the ways a local community action group attempted to challenge this local framing of the opioid crisis. I discuss throughout this section how residents in Durbin felt that those addicted to opioids were undeserving of community support.

**The Durbin Community**

Durbin District communities have experienced pronounced economic decline and population loss since the early 2000s (U.S. Census Bureau, 2018). Many businesses in the small downtown of Durbin have been closed and many storefront windows are boarded up. The town is also surrounded by many closed factories and coal mines, that had once provided jobs for many residents in Durbin District. A respondent further described:
There aren’t really any big business in or extremely close to Durbin. I know that when my grandparents grew up in this town there was Durbin Plant, which was a nuclear power plant facility that a lot of people were employed at. The Foundry was more of a job where a lot of people went to that… I think those are definite challenges, just [diminished] job opportunities.

Many had left the local area to move to more populated centers, like Pittsburgh, where jobs were more readily available. As a teacher described, “I like to say like 2008, like 2009, when the recession started hitting, a lot of people lost their jobs and a lot of people moved to other places to get jobs.” As residents left the local area, real estate demand and prices dropped, which led to the development of new rental properties in the area (i.e., transitions from home owners to home renters). Many of these new rental properties now serve low-income residents. In 2017, however, of the roughly the ten percent of the local population who had lived in a different residence the year prior to their current residence in Durbin, half came from towns in the same county (U.S. Census Bureau, 2018). Therefore, although many understood newcomers as coming from outside the community many came from nearby places and some were residents moving back to the area (see Schafft, 2005). As a teacher added, “But you tend to have children in and out, like through a little revolving door, especially with the neighboring districts. We tend to hold on to [their] files because we know they are coming back around.”

**The Moral Rural**

Many described Durbin as “a nicer, safer place” than other communities in the region. As a teacher described, “I love it. It’s a small town. Everybody knows everybody. There really is that community spirit and feel.” In the minds of participants Durbin is a small rural town and many believed that the opioid epidemic was not a prominent local issue. Respondents felt that their community was largely protected from the ills of opioid addiction and misuse, in part a
factor of its rurality. The common sentiment about the opioid crisis was “Oh, no, not here.” A respondent who claimed that the opioid epidemic was not a local problem stated:

I would think [the opioid crisis is] in the larger city areas, just from watching the news and hearing what you see on television. We had an in-service earlier this year about that, about opioids. I remember thinking, I’m like, “that’s crazy that this hasn’t impacted us more than maybe what it’s impacting other places.”

Residents, further, believed that because children and families were more supported in the local area—the local community was “tight-knit”—drug use in the community would be less likely to occur. As a teacher noted, “It’s either harder to hide or else it doesn’t happen as much maybe because you have a family-like community—a support system.” Events that did occur in the local community related to this crisis (e.g., arrests or overdoses) and other local social problems were often framed as contrary to the local identity and the attributes of those in the local place. A common reaction to “abnormal” events (e.g., a local murder or opioid overdose) was, “You’d never expect anything this horrible to happen here. This is a good neighborhood. This ain’t no Pittsburgh.”\(^{15}\) Many participants believed that those affected by this crisis were found in other places that lacked the same moral value and standing as Durbin.

The limited local economic opportunities in the area and recent housing changes had led to a mixed local population of newcomers and old-timers. “I think a lot of our population is either two things in Durbin,” a community member related, “It’s either the transient people that

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\(^{15}\) This quote was from a local resident, captured in a local newspaper, who was responding to a recent local murder of a community resident by a family member. This quote comes from a regional news publication that picked up and wrote on this more extreme event. There are no local newspapers in either Durbin or Buchanan and both places have access to the same regional media sources. While newspapers and the media broadly often influence how local problems are framed (Linnemann & Wall, 2013; Netherland & Hansen, 2016), the effect of the media on local residents’ understanding of the opioid crisis would be consistent between districts as each had the same access to media content. Therefore, the effects of the media on local residents understanding of the opioid crisis could not explain residents’ divergent definitions of the opioid “addict” observed between districts.
live there, like in the low-income housing, or it’s people that have lived there forever.” These community outsiders many believed did not share community values.

It is hard because there is not necessarily a pride from the home, that we are Durbin, type of thing. It is a lot of, we are here for now. If we need to move tomorrow because I am not with this guy anymore…so there is not that setting roots here.

For those participants who were aware of the effects of the opioid epidemic or were concerned of its potential local effect, many would attribute this issue to newcomers to the area. A teacher noted, “I notice a lot of people new moving in our street, my street, other people’s streets that you know you can almost tell or notice that that kind of activity is going on.” Drug use, residents in Durbin believed, was simply one defining characteristic of transient low-income residents.

Respondents, further, connected the opioid epidemic and opioid addiction to poverty and poor home conditions that were synonymous with this transient population, as a teacher described:

This sounds bad, though. I think a lot of people around here don’t work, and it’s a poor area, so there’s cheap rent. We have a lot of renters, not home owners. I just think a lot of it has to do with that…I think uneducated, lack of finances, lack of good jobs. Then it’s the cycle.

At times this negative perception of low-income outsiders, respondents connected to their unwillingness, and not an inability, to take on a responsible job. As a resident noted:

I was taught that there was consequences to everything, you are not always going to be the best, you don’t always have to be a winner, but you have to learn to behave appropriately and if you don’t follow rules or don’t listen then there are consequences. And that’s life. I think some of our parents in the community today, I don’t know, I just feel like that drive is not there, that ability to want to get out of bed and go to work, do what you need to do to take care of yourself, take care of your kids. It is not there.
In this district, community residents largely conflated characteristics of individuals addicted to opioids with the “undeserving poor” who were already positioned outside the moral and social boundaries of the community.

The Not Moral Rural Community

In 2014 a community action group, Communities Against Drugs, was formed in response to rising concerns of crime and drug sale in the local community. The leader stated, however, that, “A lot of people don’t believe a small town like Durbin has a drug problem.” This group is largely made up of community residents who had been directly affected by the opioid epidemic (e.g., people in recovery from opioid addiction or parents of children addicted to opioids). The members of this organization were long-standing community members, not transient newcomers. In 2018, the organizer of Communities Against Drugs said that not much progress had been made in refuting the common community perception that drugs and crime were not issues in Durbin. As he explained:

You take the churches such as this one here, this one is 90 percent elderly, they know they are helping us. They let us work out of here. That is their contribution, they don’t want to hear it. They are old people they don’t believe that drugs are here as much as they say on the news because its Durbin, it may be in Pittsburgh, it may be in [nearby urban center], but they don’t believe it is here.

This group, although made up of community members affected by this crisis, was considered by many to be working to resolve an issue that was not in Durbin or was not a Durbin issue. The way that members of the Communities Against Drugs group framed the opioid problem was not salient to the moral perspectives of residents in Durbin, and because of this the group largely struggled to garner collective support of their efforts. In some ways, the group’s efforts to push information seen as counter to the community image, isolated the group, as a resident described
their efforts, “‘Hey, can we talk about the drug problem that may be increasing in our community.’ That’s not a fun conversation that people want and then by pushing the issue then you become the bad guy.” Membership in this group had decreased steadily since 2016. In 2019, this action group, ultimately, disbanded.

Residents in Durbin District understood the opioid crisis as an issue external to their local community. The problems of opioid addiction were attributed by residents to community outsiders, and often urban outsiders, who were seen to lack the moral standing of those who were part of the Durbin rural community. For those in the community who had been affected by the crisis and attempted to draw community attention to the need to address this crisis, their messages were largely “othered” and discounted by the community broadly. The social boundaries, and moral justifications of these social boundaries, that existed in this district, limited any support for community aid of those effected by the opioid crisis.

**Buchanan District**

I examine in this section how residents in Buchanan District morally positioned themselves, and not their communities, in relation to the opioid crisis and local individuals with opioid use disorders. I highlight in this discussion the individual moral discourses that residents used to justify the local social exclusion of those addicted to opioids. In response to Research Question Two, I also go on to describe how a local resident attempted to challenge negative moral views of drug addiction that existed in the community. I discuss below how residents in Buchanan felt that those addicted to opioids were undeserving of community support, addressing Research Question Three.
The Buchanan Community

Buchanan District is rural and remote. The schools and local churches in the district are the main venues of social interaction and activity for residents. An old coal mine exists near the district campus and large trucks regularly haul waste coal from this mine to a nearby plant passing by the small district campus. While some residents are employed locally in the mining and manufacturing industry, many local mines and mills are closed. As a teacher noted the change in employment opportunities, “I would say most of my friends [used] to be either working in the mills or in a coal mine or something, and we don’t see that anymore as much.” There are only a few small businesses in the area, and many residents work on local farms or commute to jobs in more populated towns in the region. The population in the district, as a result of shrinking economic opportunities in the area, declined by ten percent from 2009 to 2017 (U.S. Census Bureau, 2018). In Buchanan local transiency was increasingly common, as it was in Durbin.

Respondents described local residents in Buchanan District as conservative, “very family oriented, Christian, hardworking, good people.” The local community participants defined as tightknit and where “neighbors look out for each other.” However, respondents also noted that the community had changed in recent years. As a respondent discussed, “With me, growing up, it was so easy... There was no fear, actually. I’m not kidding. You didn’t have to lock your doors... Now, you have to lock your doors.” In this district, there was a general consensus that as local poverty had risen, long-standing residents left, the local population became more transient, and people began to retract to more private lives, Durbin was no longer the safe bucolic space that those who grew up in the area believed that it used to be.
Drug Addiction and Morality

The opioid epidemic, all participants noted, had a serious effect on the local Buchanan community. A teacher described the recent effects of the opioid epidemic, “—just this week there was a death in the community from it. It just happens.” Many participants from this district had family members or friends that had passed away from drug overdose. The overdose of a former graduate, who also worked at the Buchanan High School, however, was the common event that respondents used to describe the impact of this epidemic on the local area. A teacher explained the overdose of this former student/employee:

I think that he’s the one person that still gets talked about, because he was also a student. I think the people—I think the teachers here looked at him as more of a student than an employee. He was still very young when he passed away. During his time here, he was well liked by everybody. He was very talented. He was just a very unique individual, with just so many areas of interest that he connected to everybody. Every teacher, he could connect to, and every student, he could connect to. The fact that he was loved by so many people, I think, is the reason that we’re able to continue talking about him.

The death of this former employee that everyone felt “connected to” participants believed had led to broader awareness of the opioid crisis and its local effects. The general consensus of respondents was that the community was aware of the issue, it was a part of the community. As a teacher noted, local issues associated with drug addiction and misuse were just part of the community, “It just seems like it’s a common thing. I think, community-wise, drugs in general, they’re here more than they used to be.”

Respondents believed, however, that people in the local community held negative perceptions of drug “addicts,” despite the awareness that this crisis affected a wide range of local individuals. Residents often saw opioid addiction as a personal decision and problem. A school
board member stated in reference to a resident’s recent overdose, “He should have known better. He shouldn’t have been taking those drugs.” A district leader stated that suicide and drug overdose were often treated in similar ways in the Buchanan community:

They think that overdosing is committing suicide in a sense, so that is not honored in any way either. And here if someone commits suicide you cannot honor them in any way. We had a student that died of cancer, that flower up there with the yellow ribbon on, he was honored at the football game….we wore the yellow ribbons, they brought yellow roses up for him put them in a basket to give to his mother. But if someone commits suicide it is not the same.

Residents generally believed that it wasn’t a community responsibility to support those suffering from an addiction, as their conditions were caused by poor personal choices.

Many residents also attempted to hide local drug addiction and use, to avoid the negative “addict” or drug user label. As a district administrator noted, “I know that there was an OD, just back on this road here…that wasn’t a heart attack and that is what the lady said her husband had, but it wasn’t. So people are still hiding it, they aren’t coming out and saying what it was in a lot of cases too.” Residents attempted to hide family or friend substance use because of a concern “about what people are going to say. What are people going to talk about at church on Sunday?... [It will] look bad upon us because we have been in the community forever.” A teacher added, “Again, I think it’s the stigma. I think it’s that some people think that if you’re an addict that you’re a bad person... I think that some people choose to keep quiet about drug use, because they don’t want there to be this negative light shined on this person.” The four obituaries of individuals who had recently died from drug overdose in this community, that I became aware of in my fieldwork, did not include any reference to their cause of death.
Many respondents in Buchannan District believed that dealing with opioid addiction was a responsibility of law enforcement, and that punishment was the needed response to opioid use and sale. As a teacher succinctly stated, “Punish the addicts, they break the law." Another teacher added, “What is going to make it stop. I just don’t feel that there is enough punishment…It just seems like the law sucks when it comes to drugs.” Because of this focus on the punishment of the individual, residents had ascribed responsibility for addressing this crisis to law enforcement, and not the community broadly. A principal further added, community support was given to those affected by the drug addiction or misuse of a family member, seen largely as innocent, but not the individual addicted to opioids:

When we had the one parent that passed away. You go down to the funeral home and there is lots of people. And everybody is like, not shocked that it happened, but focusing on the kids. How can we help the kids out? But really the focus should have been earlier, if you all saw this what this parent was like, do something or say something. Those are, some of that stuff, some people want to keep that obviously confidential. Nobody wants to come out and air their dirty laundry.

Opioid misuse and addiction were largely seen as a personal moral failing, that the community had no responsibility to address.

These community perceptions of drug addiction and local values led to little support for those affected by the opioid crisis and limited collective conversations on how to address the opioid crisis broadly. As an elementary principal noted:

Then again, we had another death in our community just about a year—just about a year ago now that was pretty impactful….It happened, but it was treated in a taboo way. We don't want to talk about it. Walls go up. It’s a bad thing. There’s shame involved and all that kind of stuff. When it happens, of course, everybody’s somber. Oh my gosh, this
happened. Then as far as reaction and what has been done, I would say I don’t think it’s left that big of an impact because in my mind, not a lot has changed. We don’t talk about things differently.

There were some immediate steps taken by the school to address this crisis (e.g. a community awareness night) after the death of the former student/employee discussed, but both school and community efforts to draw attention this issue were largely unsupported locally and, in some cases, resisted. A Buchanan music teacher, for instance, wanted to write a piece of music in memoriam of the deceased student/employee, but the community and administration contested this effort. The superintendent received emails from community members protesting the commemoration of the deceased, after information was released that the music teacher planned to write this piece. The teacher was eventually directed to not conduct this piece, as he stated, because it was a topic that, “We’re not supposed to talk about.”

**Is Drug Addiction Immoral?**

Mrs. Tanner, a Buchanan District paraprofessional, attempted to bring attention to this issue and garner support for collective responses to this crisis in the district. Mrs. Tanner, whose son was in recovery from an opioid addiction, described her sons’ path to addiction:

He had knee surgery, and those strong pills, those pain pills. Yeah. Little did I know then, to refuse those pain pills. They felt really, really good. Yeah. Then when you’re paying $60 a pop on the street where you’re gonna pay $8 for a bag of heroin.

As she stated, however, the community generally acted on and perceived “addicts”, and her own son as, “They are junkies. They’re no good. Throw them in jail. Throw away the key.” This educator, however, worked with various residents in private, as many reached out to her to help organize supports for family members suffering from substance use disorder. These
conversations occurred in private as, Mrs. Tanner stated, because these residents wanted to protect their family members from the “junkie” label.

Mrs. Tanner also stated that she had been unsuccessful in bringing resources from a local action group into the local community, even finding little in the way of support from those residents who reached out to her in private for support. Mrs. Tanner provided the following illustrative example of a recent local discussion she was involved in to transform a closed high school building in a nearby town into a rehab:

People threw a fit. A fit, because this rehab was goin’ in there, and these people were no good and na, na, na, na. But yet, if you park your car in the driveway of this high school and sit and look across the street to this trailer court you could watch drug dealers going. The people that want to go to rehab that are in this rehab, they’re not gonna hurt you. It’s the people across the street. Do you see what I mean?

Mrs. Tanner and respondents generally described that although local residents were aware of the effect of the opioid epidemic locally, it was not a problem the community wanted to engage with as those addicted to these drugs were morally unworthy of community support. Despite these efforts by Mrs. Tanner, the message that she represented did not resonate with the way local residents believed that opioid use and users should be acted on.

Residents in Buchanan District understood opioid addiction as an individual issue, caused by the poor and immoral choices of the individual addicted. Buchanan residents sought to distance themselves from those addicted to opioids and, at times, actively conceal family or friend opioid addiction for fear of community label. The views of opioid addiction utilized by residents to describe, and distance themselves from, the effects of this crisis were often morally based and negative. In Buchanan, residents didn’t feel that those addicted to opioids were deserving of community aid, but punishment, and, therefore, little collective support was given
to efforts to combat or treat local opioid misuse and addiction. Mrs. Tanner and her efforts to reframe the definition of opioid addiction shared locally were ineffective, as they countered the beliefs of drug addiction shared by most community residents.

**Discussion and Conclusion**

It was clear in this study that rural and local identities as well as broader understandings of drug addiction influenced how residents in these communities morally positioned themselves in relation to the opioid epidemic and its effects. In Durbin, residents saw the opioid issue as only affecting *groups* (i.e., community outsiders/newcomers) with low moral standing. In Buchanan, residents saw opioid addiction as an *individual* (i.e., the drug “addict”) moral problem. This research, therefore, suggests that individuals or groups may not be able to uniformly access a range of moral discourses to base their personal or collective moral standing on. Buchanan residents could not distance themselves from “urban problems” or isolate the effects of opioid crisis to community outsiders alone, as it was clear that this issue had impacted many residents’ friends, family members, and a much admired community insider. Therefore, the opioid crisis caused residents in these districts to reconcile how their local conditions connected, or not, to local identities and broader moral discourses.

The counter views of the opioid crisis that existed in each community (i.e., it is a rural issue and/or that drug addiction is not a moral failure) were considered locally to be illegitimate. The local residents who attempted to respond to this crisis, Mrs. Tanner and members of the Durbin action group, lacked the moral standing, because of their association with opioid addiction, to have their voices and experiences validated. As McHenry-Sorber and Schafft (2015) note, “hegemonic narratives become exceptionally difficult for the excluded group to
reframe, not only because of the narrative’s implicit assumed legitimacy, but also because conflicts are thereafter framed through the discursive lens of othering” (p. 735). This research suggests, however, that the viewpoints of an excluded group may be “othered” in different ways depending on the structure of local moral narratives (i.e., a based on characterizations of a group or individuals). It is important that researchers continue to critique how, and in what ways, local moral economies serve to exclude, and justify the exclusion, of those most in need of community support.

The ways that residents framed this crisis across these communities did not command a collective response. This research, therefore, adds to the literature on collective inaction, and the unique ways that local persons choose not to act to adverse negative local conditions (see Neumann, 2016). The local understandings of this crisis differed across districts, but those affected by the opioid crisis were determined to be unworthy of community aid in both Durbin and Buchanan. Poverty, unemployment, and economic distress are often high in those communities where the opioid crisis has had its greatest impact (Monnat, 2018). The form of moral economies in those communities challenged with the effects of this health crisis, therefore, may influence if, and how, local people support, through allocation of limited local resources, local initiatives that address this issue.

The unique discourses that residents pulled from to develop their moral economies (i.e., undeserving poor or deviant drug “addict”) also affected local social interactions in these districts. In Buchanan, residents actively hid friend or family member opioid addiction for fear of community stigma. In this district, those addicted to opioids were expelled from the community when they became labelled as an “addict,” and, specifically, attributed with the unique immoral qualities that residents had attached to this label. In Durbin, on the other hand, community outsiders were labelled as drug “addicts,” but this was just one of many labels attached to this
group, such as “transient” or “lazy.” Therefore, this research shows that the moral discourses that residents pull from, and have access to, to morally position themselves within local social hierarchies may also affect labelling and processes of stigma management in these contexts. The Buchanan community as a whole experienced a damaged rural identity, whereby, residents felt a “movement away from a preferred and sometimes idealized kind of local community” (Burton et al., 2011, p. 105). More research is needed which explores the moral work of individuals in rural communities with “spoiled” identities (Goffman, 1963).

The opioid epidemic is an unprecedented health crisis. The effects of the opioid epidemic are likely to be lasting as many communities struggle to resolve the very profound effects of local opioid addiction and overdose. I showed in this study how the opioid crisis was understood and responded to locally across two rural communities in western Pennsylvania. I, however, do not propose that responses to this crisis must occur at the local level alone or that somehow it is these, or other, local communities fault that opioid addiction and misuse continue to be social problems. The political, economic, and health factors that supported the growth opioid crisis in western Pennsylvania generated from outside the boundaries of these two communities (Quinones, 2016). There is currently a nationwide effort to hold accountable drug manufactures and doctors for their role in the opioid crisis (Stickler, 2019). It will be important that future research consider how evolving understandings of the causes of the opioid epidemic, that frame the crisis as an unjust systematic issue and not alone individual, influence situated moral economies and, in turn, local actions to address this crisis. It is important that through these efforts, however, that broader sentiments or beliefs that vilify the “undeserving poor” are also questioned. It is important state inventions and social campaigns (e.g., policies, awareness promotions, etc.) target the moral beliefs that have allowed residents in these communities to see this issue as an outsider problem or a problem that is specific to the morally corrupt opioid
“addict.” The only moral issue that should be considered in developing responses to this crisis is that people, no matter who they are or thought to be, are dying and more could be done to prevent these deaths.
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Chapter 4
Heroin, Prescription Opioids, and Rural Superintendents: Understanding Rural District and Superintendent Responses to the Opioid Epidemic in Western Pennsylvania

Abstract

The number of deaths caused by the use of heroin or prescription pain killers nationwide has increased annually over the past decade with some of the most rapid growth occurring in the nation’s most rural areas. This qualitative study examines the responses of districts and superintendents to this growing health crisis in twelve rural school districts in western Pennsylvania, an area heavily affected by the recent opioid epidemic. I analyze how superintendents in these rural districts worked with their local school boards and communities to develop educational or local programming to address opioid misuse and addiction. I find that the capacity of superintendents to respond to the opioid crisis in their districts was at times limited by local perspectives of place and drug addiction, which justified limited support for district efforts to target this crisis. This research, however, also finds that the capacity of educational leaders to respond to this crisis expanded when community perspectives changed, typically after a defining community event that stirred public support for responses to this crisis. However, despite these constraints or supports for leadership action, district responses to this crisis predicated on the ability of superintendents to successfully act on and within their unique zone of tolerance. I find that the ability of rural superintendents to navigate and alter local perspectives is vital to the implementation of district efforts to respond to this crisis.
Introduction

The opioid epidemic has had a profound effect on many communities across the country. Between 1999 to 2016 more than 350,000 people died from opioid misuse (Center for Disease Control and Prevention [CDC], 2018a). Heroin overdose deaths alone increased five-fold from 2010 to 2016, and more than 15,000 individuals died from heroin misuse in 2016 (CDC, 2018b). Despite the common perception that drug use and sale are urban problems, rural opioid misuse and addiction are serious national public health concerns (Noonan, 2012). Drug overdose mortality rates are currently increasing at a faster rate in rural counties than urban, and rural adolescents engage in greater prescription painkiller misuse than their urban counterparts (Monnat & Rigg, 2015; Rigg, Monnat, & Chavez, 2018; Stewart, Cao, Hsu, Artigiani, & Wish, 2017). Because of these trends, there is a growing need to address the opioid crisis in many rural places.

Rural schools, because of a common scarcity of health supports and institutions in rural places (Berry, 2014), may play an important role in combating this health crisis. Rural schools directly affect student health through health education, nurse services, and school counseling (Blackstock, Chae, Mauk, & McDonald, 2018; O'Malley, Pat, & Wendt, 2018). Rural schools also "impart a strong sense of local identity and shared purpose, and act as important sites of local civic engagement" and activism in rural places (Schafft, 2016, p. 139; Tieken, 2014). Educational leaders in rural places, in turn, often function as both institutional and community leaders (Tieken, 2014; Tekniepe, 2015). The actions of rural educational leaders to address this

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16 In this paper I focus on opioid use, misuse (i.e. overdose), and addiction. I am conscious of how terms like drug “abuser” and “addict” depicts a certain image of individuals who have substance use disorders (e.g., addiction as a personal choice or an individual defined by their condition). I stay away from the term opioid “addict” (as this is not person first language), but when it is used in this piece I am capturing the language used by respondents so this language is quoted.
crisis may be, therefore, vital to rural youth and community health. The ability of rural superintendents, specifically, to navigate and/or act on their specific "zone of tolerance" (Boyd, 1982) may be critical to the implementation of district responses to this health crisis in rural places.

In this study, I explore how twelve rural school districts and superintendents in western Pennsylvania responded to the ongoing opioid crisis. In 2018, Pennsylvania Governor Tom Wolf declared the opioid epidemic a statewide emergency after more than 2,500 state residents died from opioid overdose in 2017 (CDC, 2018a; Governor Wolf, 2018). In rural western Pennsylvania, specifically, opioid overdose mortalities have been particularly pronounced (Drug Enforcement Agency [DEA], 2017). I collected data in twelve rural districts in this region over the 2017-2018 school year through field observations, documents, and interviews with superintendents. This study was guided by the following research questions:

1. What do district superintendents in rural communities hit hard by the opioid epidemic see as the opportunities and constraints that shape their work with their local school board in the development of district responses to this health crisis?

2. How have rural superintendents navigated and acted on their zone of tolerance in their efforts to implement district responses to the opioid epidemic?

This research contributes to the field of educational leadership by exploring the range of factors that influence educational leaders' and district actions amidst a health crisis. As this research reveals, the range of responses by rural districts in western Pennsylvania to the opioid epidemic were the result of various conflicts, compromises, and agreements that occurred between rural superintendents and their respective communities and school boards. This research suggests ways that rural educational leaders can be responsive to and critically engage with those local rural narratives, politics, identities, and boundaries that frame - or reject - the opioid crisis as a
local community or educational issue. This study also highlights the ways educational leaders can work within or act on their "zone of tolerance" (Boyd, 1982) to garner, or circumvent the need for, local support for district initiatives to combat this health crisis. In conclusion, I discuss the need for broader policy responses to this crisis.

**Rural Superintendents’ Zone of Tolerance in an Opioid Epidemic**

Rural superintendents work within a unique “zone of tolerance” when developing, proposing, and implementing district practices and policies (Boyd, 1982; Budge, 2006). A zone tolerance refers to the range of educational policy decisions and changes that a local community is willing to support and that an educational leader is given discretion to work within (Boyd, 1982; Grooms, 2017). Educational leaders that advocate for district policies and practices that are viewed to be outside of the locally established zone of tolerance are, in turn, likely to face community and school board opposition (Boyd, 1982; Budge, 2006). However, there are “no formalized boundaries for a zone of tolerance, and it varies according the community as well as to the issue under consideration” (Grooms, 2017, p. 947). The ability of rural western Pennsylvania superintendents to effectively act within and act on their zone of tolerance may determine if responses to the opioid crisis occur in these districts. I discuss below rural school boards and hegemonic understandings of rural drug use, before discussing how rural superintendents may be able to act on the local political and social environments within which they work.

**The Rural Context**

In rural places local narratives, boundaries, and collective identities are often evolving negotiated “projects,” as “groups struggle to define themselves in terms of particular versions of
'rural’ or ‘local’ life” (Groenke & Nespor, 2010, p. 52). In rural places, this negotiation of community often occurs within the local school district and through the political and civic forum it provides (McHenry-Sorber & Schafft, 2015; Youngblood-Jackson, 2010). The school district, furthermore, often reproduces local boundaries, narratives, and identities as school board members often support those district policies or practices that align with locally held values, histories, and perspectives on the purposes of education (McHenry-Sorber & Provinzano, 2017; McHenry-Sorber & Schafft, 2015; Rey, 2014;). In turn, those students or residents who are considered to be community insiders, compared to those viewed as community outsiders, are more likely to have their needs addressed in board decision-making and in district policies or practices (Youngblood-Jackson, 2010). The school district can, therefore, foster the “reproduction of the community hierarchical social system” (Salamon, 2003, p. 150). Rural local narratives, identities, and boundaries, however, do evolve as the makeup, experiences, and conditions of rural communities change over time (Sherman, 2009; Woods, 2010). In many rural places, the previous stable features of the local community, whether economic or social, have deteriorated, which stripped “away many of the identity-building resources that were traditionally available” for local rural citizens (Groenke & Nespor, 2010, p. 66; Sherman, 2009). The priorities of school boards, and the makeup of boards themselves, can consequently change when local communities become more diverse (Alsbury & Whitaker, 2006; Howley et al., 2005; Salamon, 2003). Furthermore, immediate board support for certain district initiatives may be found in times of public crises, specifically, when local and broad events draw attention to the immediate need for school responses to mounting social issues (e.g., school safety efforts after national school shootings) (Kingdon, 2003). The contested and evolving local environments of rural districts, in turn, structures the zone of tolerance that educational leaders work within (Howley, Howley, Rhodes, & Yahn 2014; McHenry-Sorber & Budge, 2018; Oakes,
Welner, Yonezawa, & Allen, 2005), and are likely to also frame school board and superintendent discussions on how best to respond to the opioid crisis in local rural districts.

**Rural Drug Use**

Drug addiction has been constructed as a moral failing, a failing of control, and a psychological weakness, and many of these frames remain normative today and are central to the narratives used to characterize drug users. These broad definitions of drug addiction affect how ordinary people understand and respond to those who use opioids and other drugs, and have also structured the design of our modern national and state drug policies (Acker, 2002; Linnemann & Wall, 2013; Linnemann & Kurtz, 2014). In rural areas, the “addict” narrative is often used to rationalize the social sanctioning of those suffering from substance use disorders within local places (Sherman, 2009; Somerville, Smith, & McElwee, 2015).

Drug misuse, addiction, and sale are predominantly framed as urban problems, as “the bucolic aesthetics of rurality are at variance with the urban based aesthetics of crime” (Somerville et al., 2015, p. 220). For this reason many people don’t identify rural areas as especially criminogenic places. Rural people are, furthermore, often attributed with behaviors or values (e.g., hard-working, moral, and self-sufficient) that contrast with those stereotypically attributed to drug users (e.g., amoral, selfish, and out of control) (Keyes, Cerdá, Brady, Havens, & Galea, 2014; Somerville et al., 2015; Sherman, 2009). Whether these definitions and understandings of rural drug use are realized in local places or not, they often influence how local rural people respond to issues associated with local drug use (Linnemann & Kurtz, 2014; Sherman, 2009; Somerville et al., 2015). Therefore, these broad portrayals of the “addict” and rural drug use are also likely to influence how community and school board members make sense of the opioid crisis and its effects in rural western Pennsylvania districts.
Rural Superintendents

Rural superintendents, whose jobs are dependent upon school board support, are often, “expected to act within the accepted dominant values and norms of the community, in effect charged with upholding the traditional power structures that can create inequity” (McHenry-Sorber & Provinzano, 2017, p. 608; Tekniepe, 2015). However, at times educational leaders must act against dominant community values or board priorities when those values or priorities run contrary to the mission of the education institution or otherwise run counter to administrative judgments regarding best practices (Klar & Brewer, 2014; McHenry-Sorber & Budge, 2018). Rural superintendents can use various leadership strategies to act on their zone of tolerance and expand the “area within which a local community will allow policy to be changed and developed” (Oakes et al., 2005, p. 287).

Educational leaders can work to disrupt those community or school board perspectives that create roadblocks for leaders in their attempts to implement and find support for responsive equitable school/district practices. Educational leaders can, for instance, provide a platform for diverse local voices in times of school/district decision making, so that the needs of the whole community are represented in institutional practices and policies (Tieken, 2014). Rural educational leaders can also serve as brokers of social networks within their communities, connecting diverse newcomers to longstanding local residents and their networks (Shiffman, 2019). Principals and superintendents can also organize professional development opportunities for community and school board members that attempt to broaden awareness of issues experienced by marginalized others in the local community (Holme, Diem, & Welton, 2014). Rural superintendents in western Pennsylvania may, therefore, have real agency in influencing local perspectives on the opioid epidemic and, thereby, also generating public support for district responses to this health crisis. I examine in this study the factors that shaped district leaders’
capacity to respond to this crisis and, in addition, how rural superintendents in western Pennsylvania worked with, and at times against, their respective boards and local communities to develop and implement responses to the growing opioid crisis.

**Data, Methods, and Sites**

Data used in this article were collected as part of a larger qualitative study examining how rural districts have responded to the opioid epidemic in western Pennsylvania. The sample of districts at the focus of the study included twelve rural districts in western Pennsylvania. These districts were identified as rural using the National Center for Educational Statistics classifications. In Pennsylvania, between 1999 and 2015, 9,668 people died from heroin or prescription painkiller overdose (CDC, 2018a), and a large portion of these overdose deaths occurred in western Pennsylvania, see Figure 1. Numerous youths have, furthermore, experienced the negative effects of raised rates of parental substance use disorders and opioid overdose death across Pennsylvania (Brundage, 2019; Meinhofer & Angleró-Díaz, 2019).

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17 The National Center for Education Statistics (2017) classifies districts as rural if in a Census defined rural territory.
Sites

The communities found in the twelve western Pennsylvania rural districts studied were predominantly small, defined by farming and natural resource extraction, historically coal and, more recently, natural gas extraction. The rural districts studied in southern Pennsylvania have a distinct coal mining history and character, which was, however, not as evident in the northern districts. The districts in this sample were geographically large; one of the districts studied served students from nine municipalities covering a land area of over 250 square miles. The majority of these districts had a single elementary, middle, and high school and many of these districts had all schools on a unified campus.

<table>
<thead>
<tr>
<th>Districts (pseudonyms)</th>
<th>District Student Population</th>
<th>Economically Disadvantaged Percent of District Enrollment</th>
<th>Non-Hispanic White Percent of District Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barre</td>
<td>1,500</td>
<td>50</td>
<td>95</td>
</tr>
<tr>
<td>Buchanan</td>
<td>1,000</td>
<td>45</td>
<td>95</td>
</tr>
<tr>
<td>Crown</td>
<td>1,500</td>
<td>55</td>
<td>80</td>
</tr>
<tr>
<td>Durbin</td>
<td>1,200</td>
<td>55</td>
<td>90</td>
</tr>
<tr>
<td>Fanton</td>
<td>1,200</td>
<td>45</td>
<td>95</td>
</tr>
<tr>
<td>Foster</td>
<td>1,900</td>
<td>30</td>
<td>95</td>
</tr>
<tr>
<td>Gainesville</td>
<td>600</td>
<td>55</td>
<td>95</td>
</tr>
<tr>
<td>Grain</td>
<td>700</td>
<td>45</td>
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<tr>
<td>Mountain</td>
<td>1,400</td>
<td>50</td>
<td>95</td>
</tr>
<tr>
<td>Nottingham</td>
<td>1,200</td>
<td>45</td>
<td>95</td>
</tr>
<tr>
<td>Pleasant</td>
<td>900</td>
<td>65</td>
<td>95</td>
</tr>
<tr>
<td>White</td>
<td>1,500</td>
<td>65</td>
<td>80</td>
</tr>
</tbody>
</table>

*Note:* Data from the Pennsylvania Department of Education (2018a) and National Center for Education Statistics (2017).
1. District figures are rounded so to protect the anonymity of districts. Student populations are rounded to the nearest hundred, where student demographic percentages are rounded to the nearest five percent figure. In the case of districts with non-Hispanic white population percentages that were close to 100%, I rounded their percentage to 95% so to not be misleading of population breakdown.
2. “This data element indicates the percent of students who are considered economically disadvantaged in the district based on October Student Snapshot enrollment. It equals the number of students identified as economically disadvantaged in the district divided by total district enrollment. It is at the discretion of the District to determine if a student is economically disadvantaged. Poverty data sources such as Temporary Assistance for Needy Families cases, census poverty, Medicaid, children living in institutions that are neglected or delinquent, those supported in foster homes or free/reduced price lunch eligibility may be used” (Pennsylvania Department of Education, 2016, np).
Table 1 provides detailed information on each district studied. The local population demographics of Foster and White District,\(^{18}\) as can be seen in Table 1, differ from those of the other ten districts. The characteristics of these twelve districts and their differences are, however, largely representative of the region. Local overdose deaths and opioid death rates by district do not appear in Table 1, because overdose data are not measured at the school district level. In addition, drug overdose data are often under reported in rural areas (Lindemann, 2017). These districts, however, are found in counties with some of the highest overdose rates in the state. In 2016, for instance, Greene (49) Fayette (43), Armstrong (59), Cambria (65), and Indiana County (50) all experienced higher rates of drug overdose deaths, per 100,000 residents, than the state aggregate rate (36.5) (DEA, 2017).

**Data Collection**

I conducted interviews and fieldwork in these twelve rural districts over the 2017-2018 school year. I used a variety of methods to recruit district superintendents into this study. I was initially put in contact with four superintendents from western Pennsylvania by a colleague of mine who is a former district leader from the region. I interviewed these four superintendents and used snowball sampling from these initial contacts to recruit and interview an additional eight rural superintendents in western Pennsylvania. I did reach out to other rural superintendents in the region but did not receive responses to recruitment emails.

The superintendents who participated in this study were all originally from western Pennsylvania. These superintendents had primarily spent their entire careers in the area, although many had moved between western Pennsylvania districts as they progressed through the ranks of

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\(^{18}\) All place, district, and participant names have been replaced with pseudonyms.
teacher, principal, and superintendent. A few of these superintendents had even graduated from the districts that they now lead. The length of time that these superintendents had been in their current position ranged from six months to six years and all had been working in education for at least fifteen years. Two of the twelve superintendents interviewed had recently retired but were talked out of retirement by a nearby district school board in dire need of a superintendent. One superintendent was the acting superintendent for the district (Barre), formerly the assistant superintendent, as the previously sitting superintendent was on leave. All superintendents interviewed were white and ten of the twelve superintendents interviewed were men.

In each interview, I asked superintendents how the opioid epidemic had affected their students and communities, how they engaged the community with this issue, and how the community and district responded, or not, to youth and local opioid use. I focused in these interviews on eliciting from superintendents how they understood their capacity for timely responses to this health crisis. Interviews were semi-structured, which gave room for further probing on the constraints and opportunities that leaders experienced as they attempted to respond to this crisis. Each superintendent, however, was asked questions related to their district responses to this crisis and community support for these initiatives. Interviews took place in each superintendents’ office. Interviews lasted typically forty-five minutes to an hour, but with a range of thirty-five to seventy-five minutes in length. In a few instances, I also asked follow up questions of superintendents after interviews, via email, if further clarification to the statements made in an interview were needed. Interviews were audio-recorded and then transcribed. Fieldnotes were also written after each interview and each experience in the field.

I also attended district and community events when possible (e.g., district trainings, school board meetings, drug awareness group meetings, etc.) and wrote detailed fieldnotes on these experiences and the observations made while in these districts (Emerson, Fretz, & Shaw,
2011). District level documents such as board meeting notes, newspaper articles, and district handbooks were also included in analysis. Through documents and in observations of school board meetings, I tracked school board policy decisions and debates that were specific to this health issue. I captured community and district interactions in fieldnotes, which afforded me the opportunity to infer what local school boards and communities considered meaningful and important (Emerson, Fretz, & Shaw, 2011). I, for instance, attended a community training on Naloxone administration and examined how community members talked about the overdose reversal drug and opioid misuse generally. I also wrote fieldnotes and collected documents that were specific to school board and superintendent interactions, often gathered by attending school board meetings, and how local community members talked about or gave support to district drug prevention programs in board meetings, in local newspapers, and in the community broadly.

**Data Analysis**

Fieldnotes, interview transcripts, and documents were initially coded with concepts inherent in the research questions and also found in the literature reviewed above, e.g., school board-superintendent relationships and school board perspectives. I organized data by research question initially and then began to develop and organize data further by core themes that emerged through analysis within each organized data block. As data were analyzed and new themes or understandings arose, codes were reformed and then again re-applied to the data (Saldaña, 2016). The subheadings below represent the major themes that were identified from data analysis. Analysis occurred through coding and recoding, but also through ongoing analytic memoing, which engaged the data collected and emerging themes with the study’s research questions (Bogdan & Biklen, 2006). I continued to develop more finite codes under each theme, which helped me to add detail and nuance to the processes by which leaders understood and acted on their capacity to respond to this health crisis in their districts.
I also compared data across districts, which allowed me to capture the range of factors that served to shape superintendents’ work with their respective school boards. I also compared data collected in superintendent interviews with data collected through fieldnotes to, further, validate study findings. I, in addition, compared themes, and presentation of the themes within the data, between those districts with different community demographics. I found through this comparison that the themes and findings identified below were consistent between all districts.

**Constraints and Opportunities for Response**

In some districts, community awareness and willingness to act on the opioid epidemic was high, and in others, the concern about opioids was “generally not on their radar.” Several superintendents mentioned that their school board actively avoided any discussion of the threat posed by local and youth opioid use. In some districts, however, discussions about drug use and addiction resulted in debate among school board members. When the topic of local opioid use, misuse, and addiction was discussed in the local community or by the local school board, residents often described this issue as an urban problem, an issue for community outsiders, or a problem caused by deviant drug “addicts.” These perspectives served to limit the local support afforded to superintendents to implement or expand district programming that would address this crisis. In some districts, however, the effects of the opioid crisis came to challenge local perspectives of this crisis, the local place, and opioid addiction, which, in turn, afforded superintendents increased support for district initiatives that they proposed that would address this crisis.
An Outsider Problem

Community apathy about the issue, as some superintendents acknowledged, rested on the belief that drug use and addiction were seen as issues that affected other—often urban—communities rather than their own. As the Pleasant superintendent noted, “There are some people who think ‘This is [a] rural…[place], our kids aren’t doing that. That’s not here.’ If you talk about something like cocaine, ‘Oh that is a big city drug that is not happening here.’” Resistance and apathy towards this crisis, ultimately, undermined the efforts of superintendents to engage with the community about this growing issue. As the superintendent at Mountain District explained, “the best laid programming would probably hit a deaf ear, because it’s not depicted [here] that we have a drug problem.”

In a few cases where community awareness to local opioid issues was relatively high, local community members perceived the problem to be caused by outsiders bringing drugs into the local area. As the White superintendent explained:

The opioid epidemic has been rapid in our community and surrounding communities. There have been robberies of lifelong residents’ homes, deaths in the streets, and vehicles surrounding our schools and strangers walking throughout the community at all hours…The community and residents are angry and frustrated with the change in the atmosphere and the change in the population that has moved into the community. In other cases, denial that opioid use and opioid dependency represented communitywide problems rested on the misplaced idea that only certain types of people get involved with drugs. As the Nottingham superintendent related:

First, some people still deny that, “No it is not in our school district. It is every place else, but it is not here.” And then when it’s like it’s here, and you think it can only happen to a kid that is not doing well in school or something. But I have seen it at all levels.
Superintendents, furthermore, believed that gaining support for opioid prevention and education in the community was difficult because many parents believed that drug problems only affected certain families. As the superintendent at Foster District noted, “There is straight up denial and disengagement, or lack of engagement I should probably say, just because it doesn’t affect me. My family is good.” In some districts, therefore, public support or demand for extending drug education and prevention programs was non-existent, because the issue had been pushed to the margins of the local community or outside the community entirely.

In 2014, PA General Assembly Act 139 made it legal for schools in Pennsylvania to have and use Naloxone, a medication which reverses the effects of opioid overdose. Through Act 139, a standing prescription to the drug was also made available to all schools in the Commonwealth (Governor Wolf, 2015). The policies and procedures for administering Naloxone were to be written and approved by local districts. Statewide, a recent report found that roughly half of Pennsylvania school districts had Naloxone on hand, as reported by school nurses (McDonald, Pinto-Martin, Compton, Parikh, & Meisel, 2020). Two of the twelve districts studied did not have Naloxone on hand in district schools at the time of the study, while a few districts had Naloxone on site but it was managed by the school resource officer. In all districts, however, the policies to be written and the decision to have Naloxone at the district led to community conversations about opioids, opioid use, and the responsibility of the local school in serving those who may be using opioids.

In their deliberations with local school boards about Naloxone, superintendents often encountered complex local narratives about opioid use and addiction. Some community and school board members believed that the availability of Naloxone would only encourage student use of opioids. The superintendent at Pleasant District suggested that Naloxone (Narcan the brand name) was perceived by some as protection against the consequences of drug use, a
protection the school should not be providing. The superintendent asked rhetorically, “if we have Narcan, are we seen as supporting that and saying look you might overdose, but we will get you out of it, or should there be a consequence?”

In addition, Naloxone was resisted or rejected in a few districts because making it available would be an admission by the board that the community had an opioid problem. As the Fanton superintendent, who pushed for Naloxone in his school district found, “I think if they [school board members] publicly say that they are having this policy, they admit there is a problem and I don’t think they want to admit that…I think they are trying to protect the area, [from] the stigma.” This superintendent further explained that after gaining approval for Naloxone he was still struggling to get this prescription from a local doctor. He believed that certain interested parties in the community were trying to subvert the board’s decision by lobbying the doctor to refuse the district’s prescription for Naloxone. The Naloxone policy in Fanton was actually rescinded weeks after the initial interview with this superintendent, only to be reapproved months later. As this section suggests, superintendents at times faced local resistance to the district actions that they proposed to address this crisis, like having Naloxone in the district. It was clear that board perspectives of rural place, that placed drug issues in urban places, and drug addiction, that defined drug addiction as largely immoral, served to frame the conversations that these leaders had with their respective boards. These local perspectives, ultimately, restricted the capacity of leaders (i.e., their zone of tolerance) to implement district responses to this crisis.

How ‘Catalyst Events’ Shifted Public Perceptions

Drug use has been a problem in western Pennsylvania for years, but the recent opioid epidemic and the increasing number of overdose fatalities in the state has brought about larger public concern. As the Gainesville superintendent noted, it was “hard [for local residents] to even
believe, but there is heroin in almost every little community out there even the small rural communities. It was hard to believe that it’s here, but it was.” With a local death, it was more difficult for community members to place drug problems outside of their community. A local overdose death in some cases led to more immediate public support for school prevention and educational initiatives to address the growing opioid threat. In some cases after a community overdose the local school board demanded that responses to this crisis occur, while in others superintendents brought forward and found local support for plans to expand drug education or mental health services in response to this crisis. In Crown District this was the case, as the superintendent discussed:

I think that when the kid passed away that helped us, it was a year and a half, two years ago. You can’t put a blanket over [it], you can’t cover it up, and you can’t deny it… I just think it was the perfect storm, because this just started to get pretty bad… And just hearing from kids talk about things like this…It really hits home. When you see adults pass away, ehhh, that was your [choice] then, but when it is teenagers, or kids…if it’s somebody that they know, somebody that they are close with, in their generation, then it hits them pretty hard. Then it is an opportunity to crack the door, open the door a little.

The Crown superintendent consolidated public support to implement responses to this crisis in his district. In this district, and others, the opioid overdose of a community resident created an opportunity for superintendents to propose and find support for responses to the opioid crisis. However, as the superintendent at Mountain District further expressed, without a defining event, such as a student death, it was unlikely that any constructive district response would be made, as he stated maybe public support for these initiatives would come if, “we had a platform where our QB OD’ed.”
Board support of district responses to this issue were at times predicated on the local overdose death of someone “close, somebody that everybody knows.” As the Buchanan superintendent reported, two years earlier the district had responded to the death of a young community member employed by the school district, “we had some training following that only because there were so many people that were very close to him. Former students, current students, he was a popular kid, he was involved in a lot of stuff here.” A school board member in this district that I talked to identified this death as a defining community moment. In contrast, another former student who passed away from drug overdose in Buchanan District did not receive the same widespread concern and attention:

They’ll talk about it because one of the board members nephews overdosed and was in the hospital. She talked about it and she was probably more open about it but nobody else wanted to add to the conversation, or say not even, “How is he?” It’s just like, “he should have known better. He shouldn’t have been taking those drugs they are only bad for you. He deserves to be in the hospital.” I mean that’s the way they think.

The Grain superintendent also noted, that because drug use now affected a wider range of people in the community greater attention was being given to the problem, “you have certain families that you know that alcohol and drugs take place and you’re not going to change that mindset. But when other families start getting impacted by it and you see what is going there. I think that’s the biggest change.” As is evident in this quote, public support was at times predicated on the opioid epidemic having an effect on people that were seen as “regular” community citizen and not the assumed traditional opioid “addict.” As local perspectives of drug addiction were challenged by the known overdose of a community resident, superintendents would find support for district initiatives that sought to address this crisis. However, as this latter section suggests local support depended upon who in the community had been affected by this crisis, as earlier local patterns of
substance use had done little to directly challenge board perspectives of place and drug addiction.

**Superintendents and School Boards in an Opioid Epidemic**

All twelve rural districts had drug education and prevention programming in place at the time of the study. A few districts had expanded their drug education or health programming in direct response to the epidemic (e.g., Botvin Life Skills and Discovery Education Operation Prevention), while others kept longstanding drug education programs virtually unchanged. Some superintendents on their own initiative had recently organized trainings for teachers, administrators, and staff on this growing health crisis. A few school districts also showed students the film *Chasing the Dragon*, an FBI-produced video about opioids and drug use. Overcoming local resistance or apathy to expand drug education and prevention within each district was often predicated on catalyst events, as described, but importantly also how superintendents worked with their local school boards and local communities. Often, district responses to this epidemic hinged not on the extent of local opioid misuse and addiction, but also the ability of superintendents to successfully work within and act on their zone of tolerance as they developed, proposed, and implemented district responses to this crisis.

**Leaders Working In and On Their Local Context**

In some districts school-board superintendent relationships supported the ability of superintendents to go against community perspectives of the opioid crisis and implement unsupported initiatives that would address the effects of this crisis. In Foster District the superintendent was able to implement numerous drug prevention and education programs even despite general community apathy towards the opioid crisis. As he stated, “I think that maybe,
the lack of overt comments or yelling or screaming or anything else, public or otherwise, is probably pretty representative of the fact that everybody I think is pretty satisfied with what we have got going on.” In Nottingham District, the superintendent was able to add numerous drug awareness programs because, as she said, the school board was “very supportive” of her and her leadership. These superintendents described that these positive board relationships had been dependent on how these leaders had communicated and built “trust” with their boards over time.

At times, superintendent-school board dynamics deterred the ability of superintendents to go against board policy or sentiment. Pleasant and White superintendents felt that they had little discretion to go against board perspectives. In each of these districts, as the board did not readily support district initiatives to address this crisis little to no response to this epidemic occurred. In White District, specifically, the newly hired superintendent said that because he was new to the district he had been directed by the board to address immediate financial and academic interests. As he stated, “For me, just getting started there were so many other irons in the fire, and this sounds awful to say this particular situation (the opioid crisis) is one that we are going to deal with as the need escalates.” In Pleasant, although the superintendent did provide some information to his board on the issue, he did not feel able to challenge their perspectives on opioid addiction. As the Pleasant superintendent stated in reference to not having Naloxone on site:

Me as a superintendent, I am not because I kind of follow their lead. I serve at their discretion… Me personally… I wish we had Narcan. I think it is the right thing to do morally, professionally… I think it is the right thing to do. But like I stated earlier, I serve at the mercy of the board.

In Pleasant District the superintendent resigned at the end of the school year. The extent to which superintendents were given discretion to against board sentiment or local perspectives, was
largely dependent on the relationships that these leaders had built with their respective boards over time.

At times, when local support for district responses to this crisis was lacking, superintendents believed that they needed to be, “forceful in trying to get the programs implemented [and] get the word out there.” A few superintendents who found little in the way of support for efforts to expand drug education or mental health services in their respective district would go outside their district for aid. In Grain District, for instance, funding for the evidence based guidance program that the district implemented was funded by a local business, a partnership that had been developed by the superintendent. In Foster District, grants that the superintendent had applied for, independent of board direction, funded many of the health programs implemented in the district. With limited financial resources across these districts and school board apathy towards this crisis, accessing outside resources made responding to this crisis possible in these districts.

When school boards were less sympathetic to efforts to respond to the opioid epidemic, leaders, also brought information to school board meetings or to parent meetings about local opioid use in an attempt to shape local perspectives and, thereby, encourage community and district responses to the issue. In many districts superintendents brought information to the school board about the opioid epidemic and its local impact, which spurred in some cases board support for responses to this crisis (e.g., an information night in Mountain District). As the Gainesville superintendent stated, talking about the issue publicly allowed residents to become aware of the many individual issues that existed locally, “Because we all had stories or experiences, or we all know people who were using drugs, but we just think it is someone we know it’s not someone you know. But when you start bringing awareness to it and you start talking about it, you realize it is more common than what you thought.” In Nottingham the
superintendent also provided a platform for the mother of a former student who passed away from opioid overdose to talk about her son’s struggles with addiction, as she stated:

His mother, we arranged a school presentation, his mother was not a well-educated women, I had never heard her speak before, but she wanted to say something to the community or to the other students. We filled our auditorium there were people standing in the back, through her whole presentation you could have heard a pin drop. And we had all ages in there, we had young like middle school kids, high school kids, parents, community members, and I am telling you everybody really took everything to heart.

District leaders would also share information about the opioid crisis with the community through district-community communication avenues (e.g., newsletters or calendar emails). These leaders often shared resources with their communities about the opioid crisis and drug addiction collected from local social service and law enforcement agencies, or accessed through their professional networks.

In conversations with local residents and school board members, superintendents also attempted to directly challenge the assumptions that the opioid epidemic did not affect their district. As the Foster superintendent further explained, superintendents believed it was also necessary to challenge local perspectives of drug “addicts”:

I try to tell people it’s not all bad kids that have a problem, it might be your straight A kid, it might be the athlete who ended up breaking his arm or breaking his leg and took pain pills and now has an issue. It might be the valedictorian that has an issue. It’s not always that kid that is considered the problem kid.

If there was not a clear concrete event like a former student overdose, many superintendents attempted to shift or challenge local assumptions about drug use and users. Superintendents believed that by sharing information about the opioid epidemic that was local specific and that
accurately described the effects of the opioid epidemic, they would encourage boards to “have ownership, understand, and [become] aware….and [be] more driven to do more.”

In cases where there was limited board support for and even resistance to efforts to target this crisis, like having Naloxone in district schools, superintendents were put in a position whereby they had to go directly against board sentiment to implement responses that they felt necessary. In Fanton District, for example, the superintendent regularly advocated to have Naloxone stocked in his district and was vocal about the need for this policy in school board meetings and in the community. This superintendent also told a local reporter, and it was published in a local paper, that he had been unable to follow the school’s policy because he had been undermined in his attempt to get Naloxone in the district. In doing so, this superintendent sought to expand support for this effort by bringing local conversations on Naloxone out into the open. His tireless efforts eventually led to Naloxone being stocked at the district.

**Discussion**

In these districts local narratives, boundaries, and identities shaped school board perspectives of the opioid epidemic, which, in turn, shaped district responses to this health crisis. When school board members saw the opioid crisis as an issue for other communities or not a school issue, superintendents found little in the way of support for efforts to address the opioid crisis (e.g., stocking Naloxone or expanding drug education). In some districts, therefore, board perspective that the opioid crisis was not a local problem (whether this was real or imagined) was a barrier for those superintendents interested in implementing district efforts to address the opioid crisis (i.e., restricting their zone of tolerance). Local opioid related events, however,
instead of being a basis for board resistance to new policies or practices that would address the opioid epidemic, served often to encourage responses to this health crisis.

In all districts, superintended-school board relationship served to either limit or enhance the zone of tolerance that these leaders were afforded in their efforts to respond to this crisis in their respective districts. In some cases, superintendents did not feel that they were able to go against board sentiment, to initiate efforts that would target local opioid misuse and addiction without public support. White and Pleasant District superintendents, for instance, felt unable to implement responses to this crisis without public support. In other districts, like Nottingham, superintendents were able to leverage positive relationships with their boards to implement district drug education efforts, even when these initiatives were not a community priority. In these districts where school board-superintendent relationships were strong and superintendents were given greater discretion to act, the policy and practices that these superintendents implemented, ultimately, reflected a local vision of community and schooling that was not widely accepted (e.g., the opioid epidemic is here and the district is responsible for addressing it).

In some districts superintendents attempted to change or challenge local perspectives of the drug “addict” and also local narratives, identities, and boundaries. A few district leaders worked to alter local views of the opioid crisis, by providing information to board and community members on this epidemic and its local effects. The superintendent in Nottingham District, for instance, gave a platform for a mother affected by this crisis to share her story with the local community, which functioned to expand residents’ awareness of the opioid problem and knowledge of drug addiction. The efforts of these superintendents to transform or alter local perspectives of the rural community and drug addiction, in some cases, shifted leaders’ zone of
tolerance, and these leaders, in turn, were afforded greater leeway to act on this opioid crisis within their districts.

In 2017, the Pennsylvania legislature passed a new school code bill (Act 55) that included provisions to mandate that school districts put in place opioid specific drug education programming starting in the 2018-2019 school year (Pennsylvania Department of Education, 2018b). While superintendents interviewed were aware of this new mandate, it had, at the time of the study, not yet led to concrete school board discussions or district actions. Many superintendents also expressed concern that they would not be readily able to meet this mandate, often because of concerns over the availability of sound evidence based drug education programming focused on opioid misuse and addiction. It will, therefore, be important that future research examine how state level education policy responses specific to this epidemic come to impact the unique zone of tolerance that superintendents are afforded as they attempt to respond to this health crisis in their local districts. However, new policy guidelines may not disrupt the normative beliefs of local district stakeholders observed across these communities (see Holme et al., 2014; McHenry-Sorber & Provinzano, 2017), which ultimately dictated superintendents’ capacity to respond to this issue across these districts.

Conclusion

This research found that although these places were experiencing a similar crisis, the response to this crisis differed between districts. This study specifically found that the capacity of districts to act against this crisis were predicated on changes in the local community, district leaders efforts to shape local perspectives of the opioid crisis, and/or superintendent-school board relationships. It was clear in these districts that as the local context changed, and a
realization that the opioid epidemic was an internal issue, leaders were afforded greater discretion to act against this crisis. Leaders also attempted to shape local perspectives of the opioid crisis as a means to expand their capacity to act against this epidemic and its effects. Many superintendents also leveraged their relationships with their boards to implement responses to the crisis that they felt necessary but were not board supported. It is extremely concerning that district responses to the opioid crisis, as shown in this research, may be dependent on factors that are in no way connected to local opioid addiction and overdose death. This research also found that public support for district responses to the opioid epidemic was at times predicated on this crisis having an impact on local residents seen as non-typical drug users. This is highly problematic in that it suggests that certain community residents substance use disorders may not lead to a district response while others may. Educational leaders must, therefore, always work to understand and respond to the needs of all community members, and especially those needs or local issues that don’t garner collective attention.

While there has been increased attention within the field of rural education research to critical educational leadership (McHenry-Sorber & Budge, 2018; Rey, 2014), the specific strategies that rural leaders can use to expand their agentic capacity to do this type of work are underdeveloped. This research has highlighted a few strategies by which rural educational leaders can work to expand their capacity to conduct critical like leadership. Leaders who brought information to their school boards on the opioid crisis at times stirred local support for efforts to combat this crisis within their districts. A few rural superintendents in this study also capitalized on the attention given to this issue after local overdose deaths occurred. Other superintendents leveraged their relationships with their boards, to implement district practices that better served the current needs of all students and families. And finally, a few superintendents applied for and received outside grants to support their district health efforts,
which largely circumvented a need for board support for these initiatives. More research is, however, needed which explores how rural educational leaders act within and on their zone of tolerance to practice critical leadership in unique and changing contexts.

Educational leaders must be driven to implementing district practices or policies that serve the needs of all students, even when local beliefs or politics may be a barrier for doing so. Educational leaders, furthermore, need to be prepared to respond to “shifting needs in…local contexts” (Furman, 2012, p. 195) and know how to be adapt their leadership practices so to ensure that their schools and districts remain socially just as their local contexts shift (Alsbury & Whitaker, 2006). Educational leaders must continually assess how local and rural narratives, identities, and boundaries are changing and how they are used to resist local changes or marginalize certain local voices and needs. It is also important for leaders to consider how through changes, inclusive district policies and practices may become more supported (e.g., their zone of tolerance expanded or policy windows created as local narratives, identities, and narratives are altered). More research is needed that explores how local and national perspectives of drug use and users change as this epidemic spread, how these perceptions are informed by spatial, racial, gender, and class assumptions, and how these evolving and contested perceptions come to affect school responses to this issue.

While there has been increased attention within the field of rural education research to critical educational leadership (McHenry-Sorber & Budge, 2018; Rey, 2014), the specific strategies that rural leaders can use to expand their agentic capacity to do this type of work are underdeveloped. This research has highlighted a few strategies by which rural educational leaders can work to expand their capacity to conduct critical like leadership. Leaders who brought information to their school boards on the opioid crisis at times stirred local support for district efforts to combat this crisis and, thereby, expanded their zone of tolerance to act on this
issue. A few rural superintendents in this study also capitalized on the attention given to this issue after local overdose deaths occurred. Other superintendents leveraged their relationships with their boards, to implement district practices that better served the current needs of all students and families. And finally, a few superintendents applied for and received outside grants to support their district health efforts, which largely circumvented a need for board support for these initiatives. More research is, however, needed which explores how rural educational leaders act within and on their zone of tolerance to practice critical leadership in unique and changing contexts.

Finally, effective solutions to this crisis must address the structural conditions that give rise to this crisis in the first place. Concentrated poverty, economic decline, and limited economic opportunities are all strongly and directly associated with opioid overdose death (Monnat, 2018). Educational and economic policies that support, rather than limit, the capacity of rural people and leaders to address the on the ground issues that this crisis has created must be, therefore, promoted. However, this does not mean that local communities can or should sit by passively as they are ravaged by the opioid crisis. Without suggesting a radical devolution and “go it your own” approach whereby local schools and educators are tasked with yet one more daunting social role, I argue that as a key institution in rural communities, rural schools are well placed to provide leadership and direction to local agency around the opioid crisis. Rural educational leaders can and should play an important role in supporting those youth and local community members who have been affected by this terrible health crisis.
References


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Chapter 5
Conclusion

In 2007, two of my former high school peers died: one hung himself in rehab and the other died by purposeful overdose from prescription opioids. In 2009, two individuals from my graduating class were released from prison after each served four years for heroin trafficking. In 2014, a former friend was arrested for heroin sale. In 2016, my ex high school girlfriend overdosed from heroin for a second time. These overdoses, deaths, and arrests are what often are focused on when we talk about the opioid crisis. However, as I have discussed, these deaths, arrests, and overdoses are not simply individual incidents tied together by a class of drugs, but were enabled by the unscrupulous business practices of pharmaceutical companies along with state policies that allowed opioid prescription to be largely unregulated in the 1990s, limited economic opportunities for entire communities, and restricted access to health supports for those most in need (Berry, 2014; Monnat, 2018; Quinones, 2016; Van Zee, 2009). That is the “opioid crisis” is far more than a crisis of substance misuse and addiction, but a structural crisis of marginalization and disempowerment of particular people and places, coupled with government deregulation in capitulation with corporate agendas. Without attention to the broader antecedents of this crisis, many communities will continue to struggle with opioid addiction and other associated social problems.

This dissertation focused on the political, economic, and cultural contexts that shaped the responses of districts, communities, and superintendents in rural western Pennsylvania to the opioid epidemic. I examined in Chapter Two how educational and economic policies together limited the capacity of rural districts to respond to this health crisis. I explored, in this chapter, how rural western Pennsylvania districts struggled to address student mental health concerns,
associated with parental substance use disorders, given their restricting local tax bases and a narrow institutional focus on academic preparation. I analyzed in Chapter Three the unique moral calculus that local rural western Pennsylvania residents used to understand local opioid addiction and their responsibility for addressing its effects. I discussed, in Chapter Three, the ways residents in Durbin and Buchanan District positioned this crisis and those suffering from an opioid addiction within situated moral economies and how these local moral valuations weakened collective resolve to combat the opioid problem. In Chapter Four, I examined the enabling factors and constraints superintendents experienced as they attempted to act on this crisis within their roles as district administrators. I discussed in Chapter Four the local perspectives of the opioid crisis examined in previous chapters (i.e., characterizations of drug addiction), but emphasized the ways superintendents in rural western Pennsylvania were able to constructively act on these perspectives and, thereby, expand their agentic capacity to respond to this epidemic. In this concluding chapter I review this research’s broad implications for policymakers, practitioners, and researchers.

**Research Implications**

The findings presented in this dissertation are potentially limited by the researcher positionality that I entered the field with. I was very clear with participants, both in my correspondence and my informal conversations, about my experiences with the opioid crisis. This positionality, therefore, may have caused participants to share perspectives with me that aligned to my own. The findings from this research, furthermore, speak to processes that were observed over the 2017-2018 school year alone. There are theoretical implications from this research that I discuss throughout this dissertation, that do have widespread significance, but I do
not claim that each dissertation articles’ findings are representative or can be extrapolated. I believe that many of the research implications that I discuss for educational practice (e.g., leadership strategies) are transferable, but will need to be adapted based on the unique time and context in which they are applied. While there are limitations to this research, and more research around this topic is still very much needed, this study provides an important look into the structural challenges that many rural schools, communities, and local actors face in their efforts to respond to this crisis. I discuss below, specifically, the ways that policymakers, researchers, and educational practitioners can better support the well-being of those rural schools and communities affected by this opioid crisis.

**Federal and State Actions**

The opioid epidemic, and responses to this crisis, cannot be detached from the policies that have created uneven economic conditions and political power across space (Berry, 2014; Monnat & Rigg, 2018; Monnat, 2018). In many states, policymakers have taken steps to address the impacts of the opioid epidemic. However, despite state and national efforts to increase the availability of Narcan (Ramm, 2019), disrupt drug trafficking (Drug Enforcement Agency [DEA], 2018), expand drug addiction treatment in rural places (Health Resources & Service Administration [HRSA], 2019), and hold accountable pharmaceutical companies for their role in the opioid crisis (Schott, 2019), the community level risk factors for opioid misuse and addiction are often given little political attention.

President Trump as part of his recent budget allocated 1.8 billion dollars to support state initiatives that combat the opioid epidemic. The president’s strategy to address the opioid crisis, however, is largely focused on opioids and individual actors, and not those economic, health, and political factors that initially sparked nationwide increases in opioid overdose and addiction. The roll back of the Affordable Care Act, supported by the president, has, for instance, now made it
harder for many citizens to get drug and mental health treatment covered by insurance (Ehley, 2019). The economic policies and tax cuts that the president has also supported have increased economic bifurcation and cut many of the social safety nets for citizens in poverty (Casey & Dutta-Gupta, 2019). President Trump’s recent trade war with China, in addition, has damaged the domestic agriculture industry, which will have a lasting negative impact on many rural local economies (Telesz, 2019; Van Osdol, 2019). While some surface efforts by the president have been made to address the outcomes of the opioid epidemic, the economic and political policies that he has thus far supported have not benefited those disenfranchised and marginalized citizens, that his candidacy was supported by, who have also experienced the worst of the opioid crisis (see Monnat & Brown, 2017).

In January 2020, Governor Tom Wolf announced the launch of “Reach Out PA: Your Mental Health Matters” an inter-agency collaboration that seeks to reduce barriers for mental health treatment in the state (Murphy, 2020). While this initiative does not address many of the broad factors that encouraged the growth of the opioid crisis in the region, it is important that this effort acknowledges the relationship between the opioid crisis, stigma, and spatial disparities of health service access across Pennsylvania. While I believe these efforts and the Rural Communities Opioid Response Program (see HRSA, 2019) are excellent steps, I would encourage state legislatures to develop and propose policies that will significantly enhance health services and supports (not specific to drug treatment or mental health alone) in impoverished rural and urban areas.

19 In 2018, now presidential candidate Elizabeth Warren proposed the CARE Act, modeled after the 1990 CARE Act that worked to combat the HIV/AIDS epidemic. The CARE Act would allocate 100 billion dollars over ten years in support of local and state efforts that expand drug treatment and harm reduction strategies. Bernie Sanders was a cosponsor of the bill, and both candidates have said that they would continue support for this initiative if elected as president (Lopez, 2019).
This research also highlighted that educational leaders who were able to access and leverage state and professional assets had some success in implementing needed health programs in their districts. The state should better coordinate rural district and agency partnerships, so that the ability of superintendents to access available grants or trainings specific to student health is not simply dependent on the capacities and connections of leaders alone. There are various efforts to connect rural educators and share resources between rural schools, such as the California Rural Ed Network (Romney, 2018) and the Pennsylvania Association of Rural and Small Schools [PARSS] (PARSS, 2019). These network efforts should be financially encouraged through direct state funding and coordination efforts. It is essential that health professionals are also integrated into these rural education networks.

In Pennsylvania, a few municipalities have also approved various local harm reduction operations (e.g., needle exchanges, medication assisted treatment centers, etc.) to combat the effects of the opioid crisis. In Philadelphia, local efforts are currently underway to open the country’s first safe injection site (Allyn, 2019). This effort also just passed a major legal hurdle, when U.S. District Judge Gerald McHugh ruled that “allowance of some drug use as one component of an effort to combat drug use will not suffice to establish a violation of” the U.S. Controlled Substance Act and the so called “crack house statute” (E. PA District Court, 2019, p. 56; Feldman, 2020). The nonprofit group Safehouse is currently waiting for a declaratory judgement to be issued so that their proposed safe injection site will be permitted by law, but this decision is likely to be appealed (Feldman, 2020). I believe that harm reduction strategies in concert with prevention and treatment initiatives and, most importantly, broader efforts to address the social, economic, and political factors that stimulated the growth of this crisis, need to be supported widely at the state and federal level.
Research, Rural Communities, Rural Schools and Opioids

In Buchanan District residents largely identified local problems including local opioid addiction with community newcomers. The local social boundaries established in Buchanan, allowed residents to maintain their understanding of their place, even as it was understood to be increasingly occupied by urban outsiders (whether this was in fact true or not). In Buchanan, residents who were addicted to opioids were viewed locally as contradicting the image of the rural place and the shared values of local rural residents. Those addicted to opioids in Buchanan were, in turn, practically and discursively excluded from the community and, thereby, prohibited from receiving community aid. The experiences of residents in Buchanan highlight the ways that the discursive and material dimensions of rural community produce a framework of belonging that functions to both reinforce the symbolic boundaries of the community and act as a mechanism of exclusion for those deemed as “outsiders” (Woods, 2010).

In Durbin, however, residents did not feel that their place was safe and bucolic or that this opioid crisis was somehow outside their rural community. This dissertation, therefore, draws attention to an uneven rural geography (Woods, 2010), whereby, changing community conditions are often experienced differently and have differential effects on residents’ understandings of place across different rural areas. This research finds that this place differentiation occurred in these communities because of the unique ways residents in these districts negotiated local identities and power relations with their everyday experiences, even as community conditions were relatively similar across Buchanan and Durbin District. The different processes of place-making that occurred in each district, ultimately, influenced local responses to this health crisis, and may also affect how these places understand and experience change in the future (Burfoot-Rochford & Schafft, 2018).
In Durbin District residents, furthermore, understood their place as having qualities similar to that of urban places (e.g., crime, poverty, etc.). This place was still rural in the minds of residents, but these understandings were detached from the moorings of traditional representations of rural space. I introduced this idea in Chapter Three, but future research must consider how places like Durbin come to understand their own rurality in the face of conditions that separate their community from other rural places. It is, further, important that research consider how these places and their experiences come to be, “fed back into the collective imagination, refining and modifying the [rural] (Woods, 2010, p. 16). The representations of the opioid epidemic and its effects in rural places by the media and by politicians challenge some traditional representations of rural people and places, while leaving others intact (Linnemann & Wall, 2013; Netherland & Hansen, 2016). The lived experiences of residents in Durbin District with the opioid epidemic (e.g., local crime, drug overdose death) also counters traditional representations of rural community (e.g., crime and drug free). Therefore, further attention must be given to how the opioid epidemic has come to affect discursive representations, material realities, and the everyday lives of rural places.\(^{20}\)

It is further necessary that research and researchers continue to focus on what responses to the opioid crisis are working. There are, as I discussed, various state level efforts under way that attempt to respond to the local effects of the opioid crisis. It is essential that the effectiveness of these state or regional efforts are continually assessed through research. There are also

\(^{20}\) Halfacree (2006) states that space is both defined and then reproduced in the trialectic relationship between these different elements (i.e., discursive representations, material realities, and the everyday lives). This research suggests that the opioid epidemic created a dissonance between these different elements of rural space, as in Durbin everyday lives of the rural did not align with broader depictions of rural space. This dissonance, according to Halfacree (2006), may cause definitions of rural space to not be reproduced and, thereby, create changes to how rural space is understood, acted upon, and lived in. However, as this and other research suggests rural places are often discursively disconnected from various social problems by framing those problems as inflicted upon the rural place or caused by the local “undeserving poor.” (Linnemann & Wall, 2013; Somerville, Smith, & McElwee, 2015). Therefore, across rural communities different understandings of not just place but space may exist, which may have confounding effects on broader understandings of rural space.
numerous communities that have high rates of poverty, unemployment, and family distress, but where opioid overdose deaths are not high. It would be important for research to consider what qualities of these outlying communities have been protective factors against local opioid misuse and addiction.

It is also important that future research consider how educators, educational leaders, and districts respond to other social problems. In many rural places methamphetamine and cocaine use are on the rise (Levy, 2019; Morris, 2018). Individuals addicted to methamphetamines or cocaine are, however, typically attributed with characteristics that are different than those attributed to people suffering from an opioid addiction. These divergent definitions are related to the effects that these drugs have on the user, but also how these drugs and those addicted to these drugs have been generally portrayed (Acker, 2002; Linnemann & Wall, 2013). It becomes necessary, therefore, to consider how broad definitions and portrayals of individuals addicted to methamphetamines or cocaine may, in turn, inform the work of school districts faced with rising local drug use. The opioid epidemic has also led to thousands of deaths. Methamphetamine and cocaine crises, on the other hand, often do not cause widespread death, which may draw broad moral concern. It is important, therefore, that future research continue to critique the ways different social problems are framed and how these frames serve to encourage, or not, local actions to resolve these issues.

This research has also highlighted how local moral economies and situated moral evaluations of the opioid “addict” at times served to limit community resolve for collection action in response to this crisis. In Durbin and Buchanan District, by not responding to this crisis the districts’ local youths are at a higher risk for future substance use (Lichter & Graefe, 2011). It, therefore, is necessary for future research to consider how local moral economies may be both protective and risk factors for student substance use and, in turn, what schools and educators can
realistically do to shape local moral economies. There has been a bevy of research on the moral dimensions of educational leadership (Stefkovich & Begley, 2007) and, in addition, current educational leadership standards require that principals and superintendents, “provide moral direction for the school” (National Policy Board for Educational Administration, 2015). However, little is known about the ability of educational leaders to provide moral direction for their local community, especially, in contexts where local moral beliefs may need to be questioned. While this is an important area for future research, I believe educational leaders can begin to take on this type of moral community work by leading in the civic engagement of students and residents (see Stone, 2001) and modeling and practicing a clear moral code focused on student success (see Stefkovich & Begley, 2007) and community welfare.

**Rural Schools, Educational Leaders, and Educators**

Rates of opioid overdose death and addiction, and increasing rates of methamphetamine and cocaine use (Levy, 2019; Morris, 2018), are likely to remain high in many rural areas without broader attention to the policies that affect rural conditions and schools, but also without local action. I don’t place blame on schools or communities for their limitations, but understand that without on the ground responses to this crisis in concert with mezzo- and macro-level policy efforts this epidemic is likely to continue. Rural schools, furthermore, are an important arena for collective action and a context where local identities can be questioned and reconstructed (Tieken, 2014). Rural schools can also support local well-being, through direct service outreach and educational efforts in their local places (Schafft, 2016). It is important, therefore, that rural schools and educators do what they can to address this crisis and, specifically, disrupt barriers for collective and effective initiatives that target this epidemic.

In Chapter Four I highlighted ways that rural educational leaders can expand their capacity to respond to community issues in their district that they feel are important (in this case
the effects of the opioid crisis). It is essential that superintendents are proactive and begin to act on or shape those school board perspectives (e.g., moralizing framings of drug addiction) that may become a basis of support for exclusionary school policies or practices in the future (see Youngblood-Jackson, 2010). In Chapter Four, I presented some of the strategies that leaders can use to act on their local contexts, such as information sharing, developing and leveraging school board relations, and providing a platform for diverse local voices. This community leadership work may go beyond the conventional responsibilities of the superintendent. However, as this research has shown, many of the issues that students face are not easily resolved in the school or district alone and, furthermore, the capacity of district leaders to address student issues are often dependent on the agency they are afforded within their unique institutional and community context. It, therefore, is essential that superintendents positively act on their local places so they may better support all students.

It is important that educational leaders, however, continue be aware of, and assess, their constraints and unique contexts so that their leadership actions are informed, equitable, and, thereby, effective. It is important that programs that prepare educational leaders, therefore, foreground critical leadership (Furman, 2012), focus on how leaders can expand their agentic capacity (their zones of tolerance), and require prospective leaders to frequently practice assessing change in local and institutional contexts. These leadership capacities are all the more valuable today as U.S. schools becomes much more diverse and our current national political and social landscape has become more contentious. This research can provide a starting point for prospective educational leaders to begin interacting with these important ideas.

It is also necessary that educators and students leverage rural school-community relationships to implement district or school initiatives that will have a positive impact on local places and people. Rural educational leaders can work closely with local businesses,
municipalities, and organizations to foster school partnerships that are focused on community
development (Budge, 2006). Rural educators can also use various place-based pedagogies that
attend to and enrich students’ ties to their local places, and also engage students in efforts that
support community health (Bartholomaeus, 2013; Bowers, 2008). It is important that rural
educational leaders, educators, residents, local institutions, and students come together around
resolving real community issues and inequalities.

As I highlighted in Chapter Three, however, local residents in these western Pennsylvania
communities largely labelled locals addicted to opioids as undeserving of community aid. It is
essential, therefore, that educational leaders and educators ensure equitable access to the
resources that the local school and its community partnerships creates and distributes (e.g., social
capital or health resources). Rural schools and leaders can aid in the development of community
social ties that enhance the capacity of local places to collectively resolve local issues (Tieken,
2014; Wilkinson, 1991). For instance, as I cited in Chapter Four, some superintendents gave a
platform for community members affected by the opioid crisis to share their stories with local
residents. Rural educators and educational leaders must, therefore, safeguard an inclusive shared
school space, that brings together diverse local residents around shared school purposes and
community issues.

I also believe that all schools must work to directly strengthen student protective factors
against substance use. The community risk factors for student substance use that existed in many
of the rural communities studied will not be immediately resolved, even if broad policy efforts to
improve rural community health occur. Therefore, rural educators in these places should teach
students resiliency skills, support students’ prosocial connections, encourage restorative
practices, and support the academic and social success of all students (Perkins & Borden, 2003;
Shears, Edwards, & Stanley, 2006). The school, educators, and educational leaders in these
places should also encourage positive student social ties and civic engagement efforts that support a more cohesive and involved community support system for all students.

The rural, furthermore, is often seen as “vulnerable, disadvantaged, under threat and disappearing, either suggesting a politics of defense to maintain the stability of its boundary or a politics of abandonment to celebrate its demise” (Bell, Lloyd, & Vatovec, 2010, p. 5). Rural space and places are often assumed to serve specific economic functions (e.g., agriculture, natural resource extraction, rural tourism, secondary production, dumping grounds, or spaces of consumption) or, alternately, judged to lack economic utility in a global market and, thereby, space to be largely abandoned or disinvested in (Corbett, 2007; Lichter & Brown, 2011). Rural education, however, must directly question and challenge these economic portrayals and, “read hope, rather than despair, in the current rural condition” (Edmondson, 2003, p. 104).

It is important that all students understand that rural space has value both in its current material and ideological form. Rural space is attributed with many ideas, some of which are negative, but others that place social and moral value in rural places. Rural lands also hold natural and aesthetic resources, which are great. It is possible that value may not be seen in rural life if viewed through an economic lens, but:

If we consider meaningful everyday life as made, rather than consumed, it is human capacities, orientations, and tendencies rather than human possessions that we need to think about as resources. Rural villagers, then, have no fewer resources at hand than do urban dwellers. (Raution & Lanas, 2010, p. 233)

Rural educators need to ask students to critically evaluate how they understand success—as this term is socially constructed and in its social definition is often infused with economic purposes. This point is not to detract from the arguments made earlier that various policies, business practices, and state efforts have undermined the well-being of many rural places and that broader
economic and educational changes are needed, but to simply highlight that rural places often have positive qualities that are not considered in schools and, within, the hegemonic framing of a “good life.”

**Final Thoughts**

*I had two early stints, in the early 90s, with head injuries, football and you’re not smart enough and your doctor’s not monitoring you to ween you off as your body heals, so I was taking 6 to 10 Vicodin a day with a fentanyl patch and I knew nothing about it. Then your body heals and the pain doesn’t go away. It is there, [but] the pain problem is in this pill bottle. You go to the doctor, you are injured, you take a pill, your headache goes away, you can walk, your leg’s not hurting, you can finish your day at work because you got to pay your bills for your family. I don’t get out of bed and do a whole lot for myself, I mean we do, we live and we have fun, but we do things for people. So you will do whatever to sacrifice yourself to continue the quality of life for the people around you....I got to go to work [so I took these pills].

The problem is parents...are the biggest generational abusers of that. You know they are not the heroin people or coke people or the crack people, they were the working people that all of a sudden got injured. Then of course it becomes, if the doctor cuts you off tomorrow you’re not just superman, you’re going to turn to heroin or whatever else there is. And next thing you know kids get involved because dad or mom is so pulled down from it... whether it started out for all the right reasons and turned into all the wrong reasons your life starts to fall out of balance and it’s easy to do that. – Dr. Wilkins, superintendent

The “opioid crisis” is a reductive expression for the array of causal factors that led to increased opioid overdose and addiction rates across the country. The opioid crisis is a symptom of greater social, political, and economic processes of marginalization, which have not only led many places and people to struggle to survive, but undermined the ability of many communities to resolve the issues that they experience. In focusing on the outcomes of this crisis alone (e.g., opioid overdose deaths, sale, or addiction) political attention has thus far been focused on drug treatment, prevention, or punishment. This narrow policy focus does little to address many of the causes of this crisis. Furthermore, in focusing on opioids alone, the problems of this epidemic are
often framed in deviant terms, which not only further conceals the causes of this social problem but can justify punitive or non-responses to this health issue.

The quotes that introduced this section come from a superintendent I interviewed in rural western Pennsylvania, Dr. Wilkins. Dr. Wilkins became dependent on opioids not because of a deviant immoral lifestyle, but because doctors had prescribed him narcotics with little concern for their addictive properties. He did not take opioids because he was part of a “lazy underclass,” but took opioids, like many in his community, because he believed he had to choose between taking these drugs or not being able to support his family. He kept taking these drugs as he became trapped in cycles of pain and dependency. I saw similar but also different paths to opioid addiction in my hometown, but, like Dr. Wilkins, all of these stories of addiction were somehow tied to the economic, health, and political contexts that these individuals lived in. Those addicted to opioids are victims not of an opioid crisis but a political and economic crisis of structural inequality and de-regulation that has, ultimately, made it harder for many people today to live happy, healthy, and sustainable lives in their local places.

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I used here a pseudonym to protect the confidentiality of this superintendent. Dr. Wilkins is no longer using opioids.
References


Appendix

Educational Leader Protocol

To the participant:
Thank you for talking with me today. My name is Ian Burfoot-Rochford and I am a PhD Candidate from Penn State University working on my dissertation. The reason that I have asked to talked to you today is that I believe that you may be able to help me better understand how schools and communities have been impacted by and are responding to the opioid epidemic in Pennsylvania.

As I explained already, what you say here will be kept confidential. The information that you share with me today will be added to what other people have told me about education and the opioid epidemic here in Pennsylvania. All identifying information will be removed from the written transcript of this interview.

I’d like to start by asking you some basic background questions.

1. RESPONDENT BACKGROUND
1. How long have you worked in education? _______ Yrs.
2. How long have you worked in your current position? _______ Yrs.
3. Do you currently live in the community that you work in? Yes / No
4. Did you grow up in this area? Yes / No

2. SCHOOL AND COMMUNITY
1. Can you tell me a little about the communities that your district serve?
   - What are the people like that live here?
   - What are some of the main economic industries in this community?
2. What changes, if any, have you noticed in these communities in the last ten years?
3. Can you tell me a little bit about your schools in this district?
- What are your students like? Where do they often go after graduating from this district?
- What are your teachers like? Where do your teachers often come from?
- What are some things that your school is currently working on?
- What is the faculty here proud of?

4. How would you describe the relationship between the schools in your district and the communities they serve?
   - Are school events well attended by the community?

3. EDUCATIONAL LEADERSHIP
5. How do these communities, and their community members, affect your work as a superintendent?
   - Can you talk a little about your school board and your relationship with the board?
   - What responsibilities do you take on in the local community?

6. I know that there are many different policies that impact schools and schooling in Pennsylvania today, from state accountability policies to state tax acts. I also know that each policy has different demands, which create different responsibilities for you in your day to day work. I am not going to discuss each policy with you today, but what are some of the general challenges that you face when attempting to implement federal, state, or local policies or initiatives in district? How do these policies affect your day to day work in schools and communities?

7. How do you try to balance community values or needs with the demands created by these policies?

4. UNDERSTANDING THE OPIOID EPIDEMIC-
   The next questions that I am going to ask you will be about opioid use and abuse in your local area. Opioids are a class of drugs that includes prescription pain killers, such as OxyContin, Morphine, and Vicodin, and also heroin. In the past ten years, opioid related deaths, arrests, and drug treatment have dramatically increased statewide. These recent dramatic increases in negative opioid related outcomes, have been declared an opioid epidemic by state leaders.

8. What effect, if any, has the opioid epidemic had in your district’s local communities?
   - When did this issue first become noticeable?
   - What do you see as some of the root causes of this epidemic locally?
   - Who has been the most impacted?
(If none, where has the opioid epidemic had an effect?)

9. How do local community members view this issue?
   - If it is talked about, where? When?
   - How has the community responded to this issue? (Why do you think there has been no response? What are the challenges to organizing a community response to this issue?)
- What do you think would need to happen for the communities in this district to be driven to organize action against local opioid, use, abuse, and addiction?
- How has the community interacted with the school on this issue?

10. What effect, if any, has the opioid epidemic had on your district’s schools and students?
- What factors, either at home or in the community, do you think puts students at risk for using and abusing opioids in this local area?

11. How is the opioid epidemic talked about in your schools?
- Do teachers talk about this issue? Do you talk about this as a whole staff?
- Are there different views about this problem within your school? (Do you feel that there is consensus on the issues of the problem and what they can do? Is there a common definition of addiction shared by school personnel?)
- How might you start having these conversations with your staff?

5. RESPONDING TO THE OPIOID EPIDEMIC
12. What do you think the role of the school should be in addressing this issue?

13. What is happening in your schools currently that addresses issues of youth substance use?
- What programs are run in your school which work to prevent youth substance use? (If none, what are some of the challenges faced in trying to do so? What would an optimal drug prevention/education program look like in your mind?)
- What resources are available in your district, school, or community that can be used, or are used, to combat drug use in your schools or their local communities?

14. What, specifically, do you think superintendents can do to address issues of local and youth opioid use and abuse? What do you feel is your responsibility as educational leader in addressing local opioid use and abuse?

15. How can state policymakers better support local community efforts to combat local opioid use, abuse, and addiction? How can state policymakers better support local schools in addressing these issues?

End of Interview
Teacher/Nurse/Guidance Interview Protocol

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<tr>
<th>Interviewer:</th>
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<td>Interviewee ID:</td>
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To the participant:
Thank you for talking with me today. My name is Ian Burfoot-Rochford and I am a PhD Candidate from Penn State University working on my dissertation. The reason that I have asked to talked to you today is that I believe that you may be able to help me better understand how schools and communities have been impacted by and are responding to the opioid epidemic in Pennsylvania.

As I explained already, what you say here will be kept confidential. The information that you share with me today will be added to what other people have told me about education and the opioid epidemic here in Pennsylvania. All identifying information will be removed from the written transcript of this interview.

I’d like to start by asking you some basic background questions.

1. RESPONDENT BACKGROUND
   1. How long have you worked in education? \[____ Yrs.\]
   2. How long have you worked in your current position? \[____ Yrs.\]
   3. Do you currently live in the community that you work in? \[Yes / No\]
   4. Did you grow up in this area? \[Yes / No\]

2. SCHOOL AND COMMUNITY
   1. Can you tell me a little bit about your school? (What are some of the core values or characteristics that define <school name>? How does it differ from other schools in the area?)

   2. Can you tell me a little about the local community that the school serves? (What are some of the values or characteristics that you believe define this local community? What are the students like? What are the parents like?)

   3. How would you describe the relationship that the school has with the local community that it serves? How does the local community, its values or its characteristics, effect the school in which you work?
4. What changes, if any, have you noticed in the local community in the last ten years? How have these changes impacted the school? How have these changes impacted your work in the school?

3. THE COMMUNITY AND THE OPIOID EPIDEMIC - The next questions that I am going to ask you will be about opioid use and abuse in your local area. Opioids are a class of drugs that includes prescription painkillers, such as Oxycontin, Morphine, and Vicodin, and also heroin. In the past ten years, opioid related deaths, arrests, and drug treatment have dramatically increased statewide. These recent dramatic increases in negative opioid related outcomes, have been declared an opioid epidemic by state leaders.

5. What affect, if any, has the opioid epidemic had on your school’s local community and its residents? (How has this changed over time?)

*If no affect skip to question 13*

6. Who in this community has been the most affected by opioid use, abuse, and addiction?

7. What do you see as some of the causes or reasons that some community residents have begun to use and abuse opioids?

8. How is the opioid epidemic talked about or viewed in your school’s local community? How is drug addiction viewed in the local community?

4. THE SCHOOL AND THE OPIOID EPIDEMIC

9. How has the use of heroin and prescription painkillers by local citizens, and possibly students, impacted the daily life of your school? (How does this problem manifest itself in the school or in your classroom?)

10. How is local drug use, abuse, and addiction talked about in your school? (When and where do these conversations occur? What is the content of these conversations? Who is talking?)

11. Do employees in this school share a common definition of drug addiction? How is drug addiction defined generally by employees of this school/district?

12. What trainings are available to teachers to learn about opioid addiction and drug prevention?
13. Who is responsible for implementing this school’s drug education program? What does the drug education program in this school look like? (i.e. When and where is drug education taught? What is taught? etc.)

14. What federal, state, or local resources are available to your school to run and teach an effective drug education program in this school? What are the challenges to implementing an effective drug education program in this school?

15. How else does this school work to prevent or address student or community drug use? What are the challenges in trying to do so?

16. What do you think the role of the school should be in addressing or combatting local opioid, use, abuse, and addiction?

17. How can state policymakers and leaders better support or help schools and communities that have been affected by the opioid epidemic?

End of Interview
To the participant: Thank you for talking with me today. My name is Ian Burfoot-Rochford and I am a PhD Candidate from Penn State University working on my dissertation. The reason that I have asked to talked to you today is that I believe that you may be able to help me better understand how schools and communities have been impacted by the opioid epidemic in Pennsylvania.

As I explained already, what you say here will be kept confidential. The information that you share with me today will be added to what other people have told me about education and the opioid epidemic here in Pennsylvania. All identifying information will be removed from the written transcript of this interview.

I’d like to start by asking you some basic background questions.

1. RESPONDENT BACKGROUND

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
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<tbody>
<tr>
<td>1. What is your current position?</td>
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<td>2. How long have you worked at your current position?</td>
<td>_______ Yrs.</td>
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<td>3. How long have you worked in or lived in this county?</td>
<td>_______ Yrs.</td>
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2. BACKGROUND

5. Can you first tell me a little bit about the work that you do here at (organization name)?

6. Does your organization provide services or run programs which focus on drug prevention, treatment, or care in this area? If so, can you speak about these services and programs?

7. Can you now tell me a little about the communities that your organization serves?
THE COMMUNITY AND THE OPIOID EPIDEMIC- The next questions that I am going to ask you will be about opioid use and abuse in your local area. Opioids are a class of drugs that includes prescription pain killers, such as OxyContin, Morphine, and Vicodin, and also heroin. In the past ten years, opioid related deaths, arrests, and drug treatment have dramatically increased statewide. These recent dramatic increases in negative opioid related outcomes, have been declared an opioid epidemic by state leaders. I am going to first ask you some questions about the opioid epidemic’s effect on your school’s local communities and then go on to ask you some questions about how this epidemic has affected your school.

8. What effect, if any, has the opioid epidemic had in your school’s local communities?
   - When did this issue first become noticeable?
   - What have you seen as some of the precipitating factors that have supported this problems growth in this area?
   - What do you see as some of the root causes of this epidemic locally?
   - Who has been the most impacted by this epidemic?

9. How do local community members view this issue?
   - If it is talked about, where? When?
   - How is drug use and addiction generally viewed in this community?
   - How is alcohol and marijuana use viewed in this community?

10. How has the community responded to this issue? (If no, Why do you think there has been no response?) What are the challenges to organizing a community response to this issue? What do you think would need to happen for the communities in this district to be driven to organize action against local opioid, use, abuse, and addiction?)
    - How has the community interacted with your organization on this issue?

11. What are some the challenges that individuals recovering from opioid addictions face in this local community as they work to get off and stay off these drugs? (What are some of the general challenges opioid addicts face when seeking out drug treatment?)

5. SCHOOL AND SOCIAL SERVICE AGENCIES
12. What relationship, if any, does your organization have with local schools? What relationship would your organization like to have with schools? What districts do you work with?

13. What challenges does your organization face in trying to work with schools?
14. What do you think the role of the school should be in addressing or combatting local opioid, use, abuse, and addiction?

END OF INTERVIEW
Ian Burfoot-Rochford  
Ph.D. Educational Leadership  
The Pennsylvania State University  
Iub121@psu.edu

EDUCATION

<table>
<thead>
<tr>
<th>Institution</th>
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<tbody>
<tr>
<td>Pennsylvania State University</td>
<td>Ph.D., Educational Leadership</td>
<td>University Park, PA 2020</td>
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<tr>
<td>University of Vermont</td>
<td>B.S., Elementary Education</td>
<td>Burlington, VT 2010</td>
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PEER-REVIEWED ARTICLES


NATIONAL PEER-REVIEWED CONFERENCES


