

**Lake Cumberland Area Response to Opioids in Rural Communities
Planning Consortium**

Community Needs Assessment Report

Prepared by Nolo Consulting, LLC



A D A N T A
COMMUNITY MENTAL HEALTH CENTER



This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling \$200,000.00 with zero percentage financed with non governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.

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EXECUTIVE SUMMARY

Background

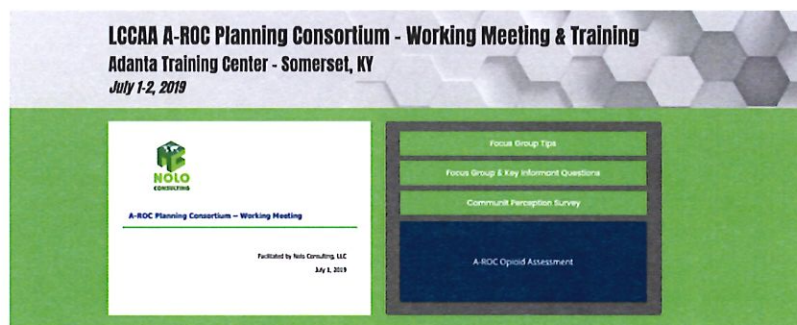
In January 2019, Lake Cumberland Community Action Agency, Inc. (LCCAA) responded to a funding opportunity issued by the U.S. Department of Health & Human Services, Health Resources & Services Administration for the Rural Communities Opioid Response Program. The funding opportunity's overall goal is to reduce the morbidity and mortality associated with opioid overdoses in high-risk rural communities by strengthening the organizational and infrastructural capacity of multi-sector consortium to address prevention, treatment, and/or recovery needs. In May 2019, LCCAA was awarded \$200,000.00 to for this endeavor and the Lake Cumberland Area Response to Opioids in Rural Communities (A-ROC) Planning Consortium was created. In addition to LCCAA, A-ROC's core members are Adanta Community Mental Health Center, Lake Cumberland District Health Department, and Lake Cumberland Area Development District.

During the summer of 2019, A-ROC contracted with [Nolo Consulting](#) to lead a process to collect information for secondary sources and facilitate qualitative approaches to collect data: administering perception interviews and completing focus group surveys across the 10-county area to fully engage diverse groups and communities.

Part I of the report includes a comprehensive review of most recent and relevant data themes and indicators that have an effect on the work of A-ROC's Planning Consortium and its strategic planning process. Part II focuses on the public views on substance abuse, these are diverse and often difficult to change. The significance of collecting individual perceptions from community focus groups is that perception influences opinion, judgment, understanding of a situation, meaning of an experience, and how one responds to a situation. Based on the information we collected in focus groups, the A-ROC Planning Consortium will be able to identify community needs and opportunities, as well as to plan educational and strategic activities in prevention, treatment and recovery. The main goal was to identify various community perceptions about opioid use and abuse, provide insight as to why these perceptions are held and to help improve a consortium planning process. A-ROC strategic and effective messages to improve health prevention communications require a better knowledge of diverse perceptions to support hundreds of community members in a 10-county area.

We encourage consortium members, community leaders and those that participated in the report's data collection process to read and review the **electronic version of the report which contains hyperlinks**, survey questions, local resources list and interactive maps in order to get a complete report and better understanding of the study.

The report and other resources can be found at the A-ROC Consortium web portal, created by Nolo Consulting.



The link to the A-ROC Consortium portal is: <https://www.noloconsulting.com/lccaaky2019>.

Consortium Members

Lake Cumberland Community Action Agency



Lake Cumberland Community Action Agency, Inc. is a private, non-profit entity incorporated October 31, 1973 to serve the 10-county Lake Cumberland area. Community Action Agencies (CAAs) were established under the Economic Opportunity Act of 1964 to fight America's War on Poverty to help people to help themselves in achieving self-sufficiency. LCCAA is the service area's largest

community-based organization assisting over fifteen thousand (15,000) people annually in the ten-county Lake Cumberland area that are either unemployed or under-employed. This low-income population has been excluded from economic and social opportunities which could help them in attaining self-sufficiency and improved living conditions. LCCAA provides the tools and encouragement to empower low-income people to confront and overcome those obstacles. LCCAA provides a wide array of services to assist with self-sufficiency including the Community Services Block Grant; Low Income Home Energy Assistance Program (LIHEAP); comprehensive early childhood educational and supportive services to 644 children and families through Head Start/Early Head Start/Migrant & Seasonal Head Start; Community Collaboration for Children; Emergency Food & Shelter Program; Medicaid Home & Community-Based Waiver services; and many others.

LCCAA Mission Statement is "LCCAA is committed to improving the health and welfare of the less fortunate through a variety of services and community partnerships to ensure self-sufficiency and economic stability." This Mission Statement embodies the nationally-adopted Promise of Community Action Community Action by which is: "Community Action changes people's lives, embodies the spirit of hope, improves communities, and makes America a better place to live. We care about the entire community, and we are dedicated to helping people help themselves and each other."

LCCAA is 110% percent committed to acting as an agent in change catalyst embodied in the Lake Cumberland Area Response to Opioids in Rural Communities (A-ROC) Planning Consortium. LCCAA sees first-hand through the various programs we administer the destruction caused by this epidemic. As the Lake Cumberland area's "boots on the ground" social service provider, LCCASA committed to our efforts to stand with the Lake Cumberland community to fight the war against opioids.

Adanta



The Adanta Group Community Mental Health Center was formed 1966. The CMHC's were mandated by President John F. Kennedy. Adanta is a private, non-profit organization providing community-based mental health; substance abuse; developmental and intellectual disability; alcohol, tobacco and other drug prevention; and sexual assault resource services.

Services are provided in the following Kentucky counties through local Adanta offices: Adair, Barren, Casey, Clinton, Cumberland, Green, McCreary, Pulaski, Russell, Taylor, Wayne, and Woodford.

The Adanta Group, a contractor with the Department of Community Based Services, provides behavioral health services with state and federal funds. Adanta accepts Medicaid, Medicare, and private insurance, and provide behavioral health services to individuals in need regardless of the ability to pay. Adanta enhances lives by promoting recovery and wellness through person-centered care.

Mission: Adanta is dedicated to establishing and maintaining a standard of excellence in providing community behavioral health care and developmental services to the citizens of the service areas in order to enhance the quality of life for those in need of such care and the family members of those saved. Adanta enhances lives by promoting recovery and wellness through person-centered care. **We exist to Enhance Lives.**

Adanta is committed to providing serves to individuals with a substance abuse issue. The Opioid crisis is on the forefront in Kentucky. Adanta provides Prevention to area businesses, schools, and anyone that ask for information. Adanta has trained staff in evidence-based programs such as the Matrix Model. Adanta has expanded services to include providing Nurturing Families group – many of which is dealing with the opioid crisis and peer support services and helping during needle exchange. Adanta is involved with Plan of Safe Care groups at Lake Cumberland Regional Hospital. Of recent, Adanta is placing Narcan at all thier locations and encouraging staff to be trained to administer if the need exists. Adanta researches daily for available grant opportunities to increase awareness, encourage prevention, or treatment.

Lake Cumberland Health Department



Lake Cumberland District Health Department originated on June 18, 1971. William P. McElwain, M.D., Commissioner of Health, sent out a memorandum announcing the establishment of the first District Health Department in the State of Kentucky namely, the Lake Cumberland District Health Department. The creation of this new legal entity joined Clinton, Cumberland, McCreary, Pulaski and Wayne counties into a District on July 1, 1971. In 1982 the counties of Adair, Casey, Green, Russell and Taylor joined the district bringing the total member counties to 10. The area covered by the LCDHD is approximately 3,613 square miles with a population of approximately 200,000. Somerset is the largest city in the 10-county area with a population of approximately 11,400 (2000 Census). The LCDHD is governed by a 30-member board of directors with representation from each county's local board of health. The board is comprised of county judge executives, physicians, nurses, dentists, veterinarians, engineers, optometrists and citizen members. The board employs an executive director and medical director to manage the day-to-day operations of the department. At LCDHD's peak, it had approximately 300 staff members employed in the 10 county health centers and administrative offices located in Somerset. With the challenges of the down-turned economy, LCDHD now operates with about 200 employees.

LCDHD Mission Statement: The Lake Cumberland District Health Department prevents illness and injury, promotes good health practices, and assures a safe environment to protect and improve the health of our communities.

LCDHD has established Harm Reduction/Syringe Exchange Programs. LCDHD's Harm Reduction Syringe Exchange Program (HRSEP) has been modeled after successful programs throughout the country. It uses a cost-effective approach with best practices for disease prevention by utilizing existing staff and health centers already set up for providing services to this population. The program is open to anyone who uses injectable drugs. Exchange of needles and rapid HIV testing will be provided anonymously; however, other health services, such as blood tests for hepatitis C, HIV, STD's, pregnancy tests, and immunizations will be provided confidentially.

LCDHD has also received grants to focus on helping those caught up in the legal system due to drug-related issues to receive case management to decrease their chances of relapse. The Lake Cumberland District Health Department is partnering with a consortium of area doctors, mental health facilities, and detention centers to reduce morbidity and mortality related to Opioid Use Disorder (OUD). The

Rural Health Opioid Program (RHOP) offers case management to those who live in the Lake Cumberland area at risk for OUD.

Lake Cumberland Area Development District



Lake Cumberland Area Development District, Inc. (LCADD) was established in 1969 and an office for the agency opened in the basement of the old Doctor Lawrence Hotel building in Jamestown, Ky. A professional staff was hired and a Board of Directors, composed of locally elected officials and citizens from Adair, Casey, Clinton, Cumberland, Green, McCreary, Pulaski, Russell, Taylor and Wayne counties, was put into place to govern the agency. This new regional

planning agency paved the way for an important long-term cooperative effort among local civic and governmental leaders within the 10-county area. The agency provided a forum for officials to discuss and deal with common problems affecting their counties, to set and accomplish major objectives and to take advantage of opportunities that could not be achieved alone. In short, the agency enabled local leaders to plan for both the growth of their communities and the region. By 1983, the growing agency needed more office space, so it moved to its current location on Lakeway Drive in Russell Springs.

LCADD's core values include: **FAIRNESS** - This agency is dedicated to being fair, impartial, and equitable in everything we do. **CREDIBILITY** - This agency is dedicated to being honest, ethical, and trustworthy at all times. **EXCELLENCE** - This agency is dedicated to being the best that we can be in all things, striving always to make our region a better place to live and work. **Responsibilities of Agency, Board & Staff.** **Identify** needs within the region and proactively promote and/or implement programs to address those needs. **Actively foster and promote regionalism;** organize and/or participate in regional forums. Increase public awareness of Lake Cumberland Area Development District and the services offered by the agency. **Conduct** yourself in a manner which promotes and maintains agency credibility. **Promote cooperation and coordination** between and among Board of Directors, committees, sister agencies, staff, and citizens within the region.

LCADD Mission Statement: The mission of the Lake Cumberland Development District is to provide a regional forum to local governments and citizens in order to identify issues and opportunities and to then provide leadership in planning and implementing projects and programs to improve the quality of life within the district.

The Lake Cumberland ADD has developed an initiative with various local jails within the 10-county area to assist inmates in overcoming barriers encountered upon release from incarceration; these barriers include securing housing, food, clothing, transportation, and jobs. Referrals for substance abuse rehabilitation are also offered to inmates.

Opioid Use Disorder: History

The opioid epidemic in Kentucky is not an isolated crisis, but one that can be seen across state lines, spanning across countries, continents, and even centuries. Although the causes of the current crisis may be unique to our generation, the medicinal use of opioids – and opioid-related addiction, overdoses, and death – has been part of the human story ever since the Greeks first began to record their history.

In Greek mythology, it was believed that the poppy plant originated from the tears of the goddess Aphrodite. Both the Greeks and the Egyptians worshiped opium poppy, and the “Father of Medicine” himself, Hippocrates, discovered that some diseases could be helped by opium. However, even then, other physicians noted that if not handled carefully, the use and abuse of opium could have catastrophic results.ⁱ



Centuries later, in the early 1800s, [Friedrich Serturmer](#), a German scientist and pharmacist, discovered a way to extract from the opium poppy the key ingredient that could deliver pain relief: the alkaloid. Serturmer, who knew of the poppy’s mythological origin, called the alkaloid “morphine,” naming it after the Greek god Morpheus.ⁱⁱ From this discovery, scientists in Germany then developed oxycodone which, while still addictive, offered the promise of fewer adverse side effects than morphine.ⁱⁱⁱ

When the Civil War began, hospitals and doctors in the United States started importing opioids to treat soldiers who had developed infections or been wounded on the battlefield. So many soldiers consequently developed addiction to the substance that the opioid epidemic of that generation was dubbed the “Army Disease.”^{iv}

As years progressed, scientists continued to develop opium-derived drugs, attempting to remove the addictive quality of the substance while maintaining the positive properties associated with it. As a result, codeine and heroin were created. The scientist who developed heroin, Heinrich Dresser, after testing it

on animals, humans, and himself, came to the erroneous conclusion that he had achieved his goal of creating a non-addictive opioid medication.

In the [Boston Medical and Surgical Journal](#), he stated that heroin “possesses many advantages over morphine...There’s no danger of acquiring a habit.”^v In the late 19th century, the German company Bayer began selling heroin to treat common ailments such as menstrual pain, pneumonia, and other respiratory illnesses and marketed heroin as cough suppressant for children.^{vi}



Am. J. Ph. 7 [December, 1901]

BAYER Pharmaceutical Products

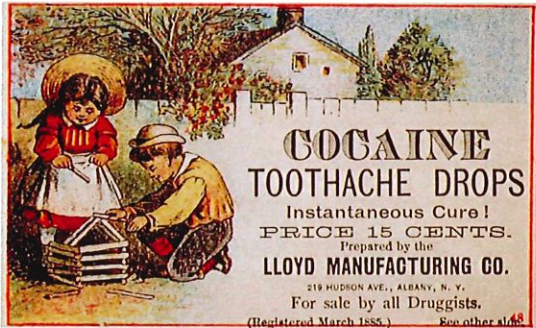
HEROIN—HYDROCHLORIDE

is pre-eminently adapted for the manufacture of cough elixirs, cough balsams, cough drops, cough lozenges, and cough medicines of any kind. Price in 1 oz. packages, \$4.85 per ounce; less in larger quantities. The efficient dose being very small (1-48 to 1-24 gr.), it is

The Cheapest Specific for the Relief of Coughs
(In bronchitis, phthisis, whooping cough, etc., etc.)

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Sole Agents
P. O. Box 2100 40 Stone Street, NEW YORK



As more opioids were imported to the United States, throughout the end of the 19th century and into the beginning of the 20th century, the number of Americans experiencing addiction grew to the tens of thousands. Women, specifically, were targeted by doctors who prescribed them opioids to treat pain associated with menstrual cramps and complications arising from ovarian and uterine medical conditions.^{vii}

By the early 1900s, the epidemic was so severe that Congress was pressed to take action. In an attempt to provide regulation of the products used to create the drugs, Congress supported the [Harrison Narcotics Tax Act](#). Additionally, attempting to protect the food and medicine that Americans were consuming, Congress created a bureau that would eventually evolve into the Food and Drug Administration (FDA).^{viii}

Over the years, the ingredients contained in opioid medications continued to evolve. Oxycodone was combined with aspirin, which had been created in 1899, to generate Percodan. Percodan was approved by the FDA in the 1950s and later, acetaminophen and oxycodone were used to create Percocet. As these drugs continued to be marketed and prescribed, the cases of addiction increased – so much so that by 1962 it was reported that “doctors had prescribed nearly 36 million Percodan” in the state of California alone.^{ix} In the 1980s the first president of the [American Pain Society](#), Dr. Russell Portenoy, joined other doctors in suggesting that opioids were the answer for millions of Americans experiencing pain that had gone untreated. It is worth noting that funding for the American Pain Society, which suggested that health care providers incorporate pain as the new “fifth vital sign” (along with blood pressure, temperature, heartbeat, and breathing), was funded in part by drug makers.^x

Despite nearly two centuries of historical accounts of opioid addiction and deaths related to opioid overdose, by the 1990s pharmaceutical companies still promoted the use of opioids as pain medication, claiming that patients could not become addicted. In many communities, over-prescribing by doctors and pharmacists became common practice, and hundreds of thousands of patients who were originally prescribed opioids as treatment for pain symptoms became addicted to the substances. When local, state and federal authorities began to shut down “pill mills” in an attempt to lessen the flow of opioids, people who had become addicted turned increasingly to heroin use in 2010, and fentanyl in 2013.^{xi}

Today, in the United States, 11.4 million individuals, age 12 and older, or 4.2 percent of the population, misuse opioids. Of these, 11.1 million misuse prescription pain relievers, 886,000 are heroin users, and 562,000 use both prescription pain relievers and heroin.^{xii} Given these figures, is imperative to leverage resources and work together to bring hope to communities experiencing the impacts of opioid use disorder.



DEFINITION: The term “pill mill” is typically used to describe a doctor, clinic, or pharmacy that is prescribing or dispensing controlled prescription drugs inappropriately.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3030470/>

PART I: COMMUNITY PROFILE

10-County Assessment Area

Kentucky is located in the East South-Central region of the United States, bordered by West Virginia, Virginia, Tennessee, Missouri, Illinois, Indiana, and Ohio. Its official name is the Commonwealth of Kentucky; its nickname is the “Bluegrass State.” Kentucky has a total area of 40,408 square miles, which makes it the 37th largest state. With a population of more than 4.4 million, Kentucky is the 24th most densely populated state in the country.



Figure 1: Kentucky Topography

The state has five distinct geographical regions: the Cumberland Plateau in the east, the (North-Central) Outer Bluegrass Region, the South-Central and Western Pennyroyal Plateau (also known as the Mississippi Plateau), the Western Coal Fields and the (West) Jackson Purchase (Fig 1). Kentucky is divided into 120 counties. Pike County is the largest county, while Jefferson County is the most populous. The state capital is the city of Frankfort, located northwest of Lexington.

The A-ROC Planning Consortium covers a 10-county region located in the Central, Southern region of the state; see Table 1.

County	Area	County seat	City name(s)
Adair County	407 sq mi	Columbia	Columbia city
Casey County	446 sq mi	Liberty	Liberty city
Clinton County	198 sq mi	Albany	Albany city
Cumberland County	306 sq mi	Burkesville	Burkesville city, Marrowbone CDP
Green County	289 sq mi	Greensburg	Greensburg city, Summersville CDP
McCreary County	428 sq mi	Whitley City	Pine Knot CDP, Stearns CDP, Whitley City CDP
Pulaski County	662 sq mi	Somerset	Burnside city, Eubank city (partial), Ferguson city, Science Hill city, Somerset city
Russell County	254 sq mi	Jamestown	Jamestown city, Russell Springs city
Taylor County	270 sq mi	Campbellsville	Campbellsville city
Wayne County	459 sq mi	Monticello	Monticello city

CDP = Census Designated Place = concentration of population defined by the U.S. Census Bureau for statistical purposes only.

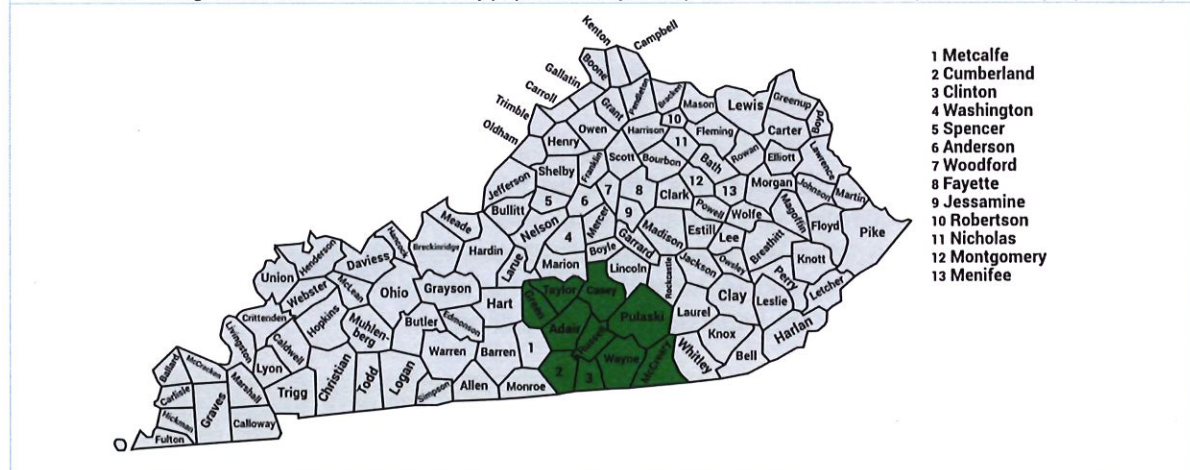


Table 1: A-ROC Service Area

Population Growth and Change

Based on the 2010 Census, the total population of Kentucky was 4,339,367, up 7.4 percent from 4,041,769 in 2000. Census estimates from 2017 indicate that Kentucky's population grew by an additional 2.6 percent (compared with 5.5 percent for the United States) from 2010 to 2017, reaching more than 4.4 million residents. Table 2 and Figure 2 illustrate the population change in the 10-county assessment service area.

2010-17 Population Change

Source: U.S. Census

	Total Population (2010 Census)	Population Estimate (July 1, 2017)	Percent Change
United States	308,745,538	325,719,178	5.5%
Kentucky	4,339,367	4,454,189	2.6%
Adair County	18,656	19,485	4.4%
Casey County	15,955	15,750	-1.3%
Clinton County	10,272	10,276	0.0%
Cumberland County	6,856	6,706	-2.2%
Green County	11,258	11,065	-1.7%
McCreary County	18,306	17,465	-4.6%
Pulaski County	63,063	64,449	2.2%
Russell County	17,565	17,775	1.2%
Taylor County	24,512	25,472	3.9%
Wayne County	20,813	20,716	-0.5%

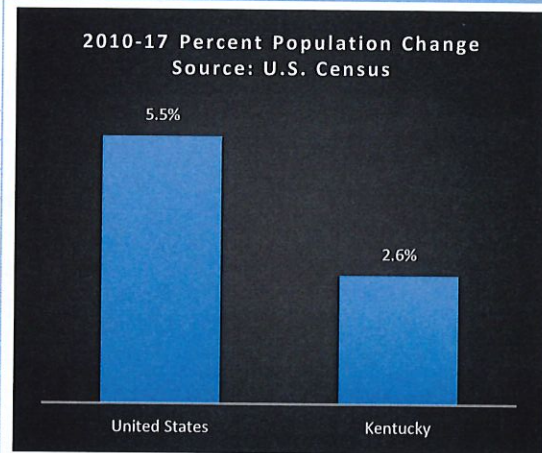


Table 2: Population Change (2010-17)

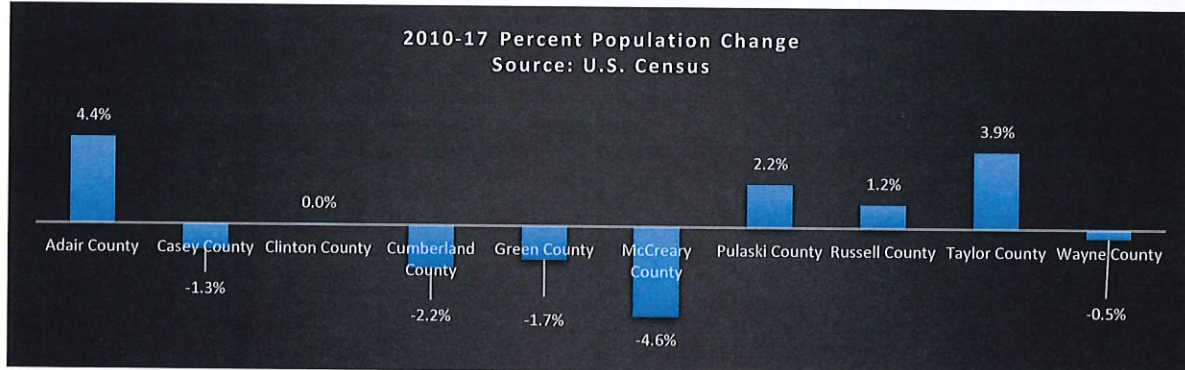


Figure 2: Population Change (2010-17)

Racial and Ethnic Characteristics

Based on 2017 population estimates, more than four out of five residents in Kentucky are white, 87.8 percent; 8.4 percent are black/African American, 1.9 percent identify as having two or more races, and 1.6 percent are Asian (Fig 3).

In each of the service area counties, the population is also predominantly white, ranging from 91.4 to 97.2 percent. McCreary and Taylor Counties have the highest black/African American populations, at 5.7 and 5.2 percent, respectively. The biracial population ranges from 1.1 to 2 percent.

The U.S. Census Bureau considers race and ethnicity to be two separate and distinct concepts.

What is race?

The Census Bureau defines race as a person's self-identification with one or more social groups. An individual can report as White, Black or African American, Asian, American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, or some other race. Survey respondents may report multiple races.

What is ethnicity?

Ethnicity determines whether a person is of Hispanic origin or not. For this reason, ethnicity is broken out in two categories, Hispanic or Latino and Not Hispanic or Latino. Hispanics may report as any race.

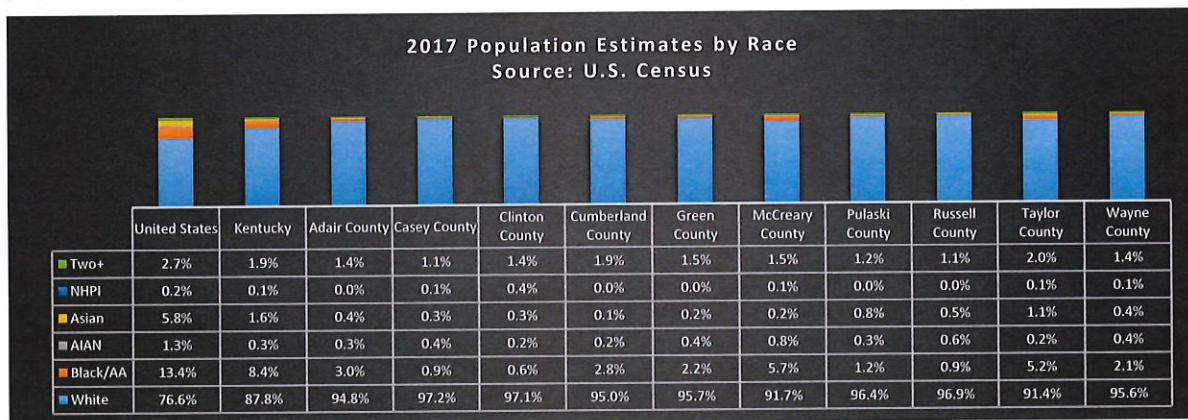


Figure 3: Population Estimates by Race (2017)

In Kentucky only 3.7 percent of the population is Hispanic/Latino (Table 3). Russell and Wayne Counties have the highest Hispanic/Latino populations in the A-ROC's region, 3.7 and 3.3 percent, respectively.

2017 Population Estimates: Hispanic/Latino

Source: U.S. Census

United States	18.1%
Kentucky	3.7%
Adair County	1.9%
Casey County	3.0%
Clinton County	2.9%
Cumberland County	1.3%
Green County	1.8%
McCreary County	2.7%
Pulaski County	2.5%
Russell County	3.7%
Taylor County	2.6%
Wayne County	3.3%

Table 3: Hispanic/Latino Population (2017)

"White" refers to a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

"Black or African American" refers to a person having origins in any of the Black racial groups of Africa.

"American Indian or Alaska Native" refers to a person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

"Asian" refers to a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

"Native Hawaiian or Other Pacific Islander" refers to a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

"Some Other Race" includes all other responses not included in the White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander race categories described above. Respondents reporting entries such as multiracial, mixed, interracial, or a Hispanic or Latino group (for example, Mexican, Puerto Rican, Cuban, or Spanish) in response to the race question are included in this category.

"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

Poverty

The [U.S. Department of Health and Human Services](#) issues the Federal Poverty Guidelines in the [Federal Register](#) annually. The Poverty Guidelines for a family of four in 2019 is \$25,750. Research suggests that a family of four requires at least double that amount to make ends meet.^{xiii} The measurement only accounts for the family's annual gross income; it does not include other aspects of economic status such as housing, debt, assets, or property. The calculation used today was originally developed in the 1960s based on the amount of money spent by families on food. The poverty level was reached by multiplying that dollar amount (money spent by families on food) times three. Today, families not only spend approximately one-seventh of their annual income on food, but the cost of childcare, transportation, and health care have increased drastically over the past 50 years (Fig 4).^{xiv}

Persons in Family/Household	Poverty Guidelines
1	\$12,490
2	\$16,910
3	\$21,330
4	\$25,750
5	\$30,170
6	\$34,590
7	\$39,010
8	\$43,430
For families/households with more than 8 persons, add \$4,420 for each additional person.	

Figure 4: 2019 Federal Poverty Guidelines

Poverty in Kentucky. Per the 2017 [Small Area Income and Poverty Estimates \(SAIPE\)](#), 17.1 percent of the population in Kentucky lives in poverty (more than 738,000 individuals), and 22.1 percent of children, ages 0-17, live in poverty (more than 218,000 children) (Table 4). In the 10-county assessment area, the poverty rate for the population overall is higher than Kentucky, ranging from 18.2 percent (Taylor County) to 34.4 percent (McCreary County); the poverty rate for children, ages 0-17, is also higher than Kentucky, ranging from 25.6 (Taylor County) to 45.6 percent (McCreary County).

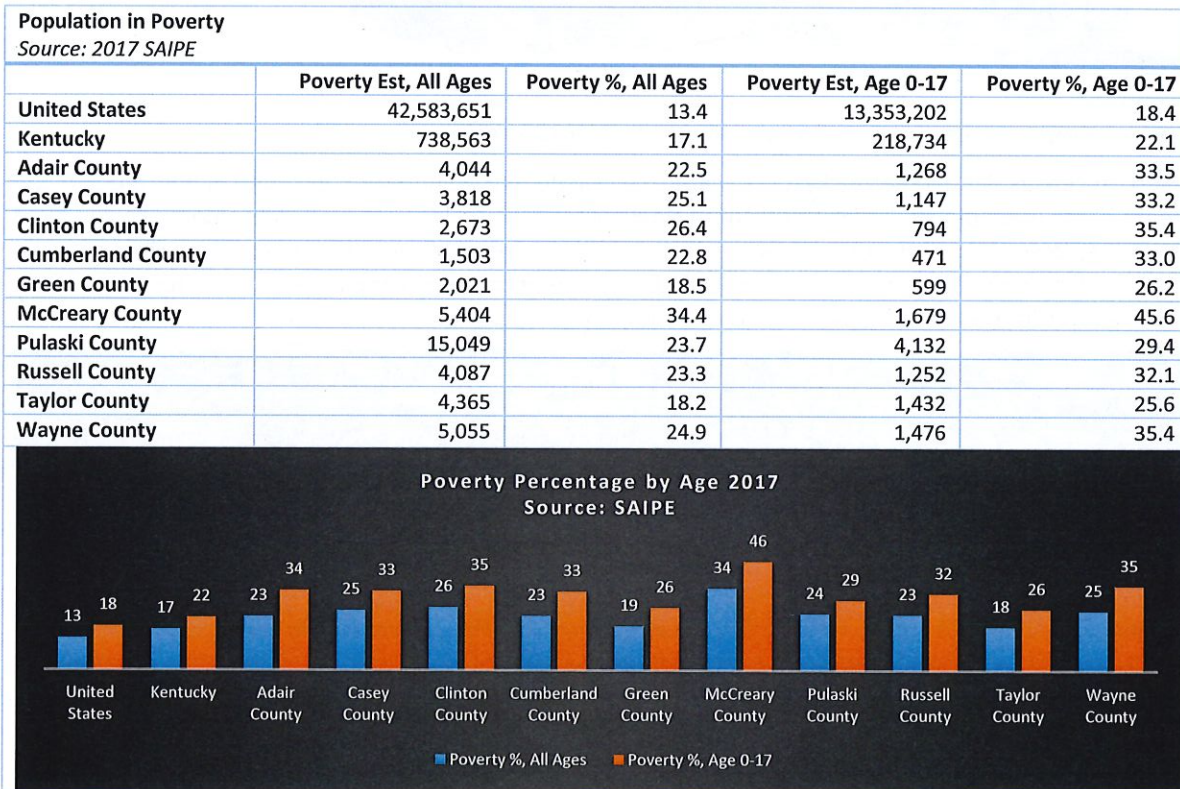


Table 4: Poverty (2017)

Unemployment

Per the U.S. Department of Labor, Bureau of Labor Statistics, the unemployment rate in Kentucky (not seasonally adjusted) in July, 2019 was 4.3 percent.^{xv} July, 2019 unemployment rates in the A-ROC service area ranged from 4.2 (Cumberland County) to 7.3 (McCreary County) (Fig 5).

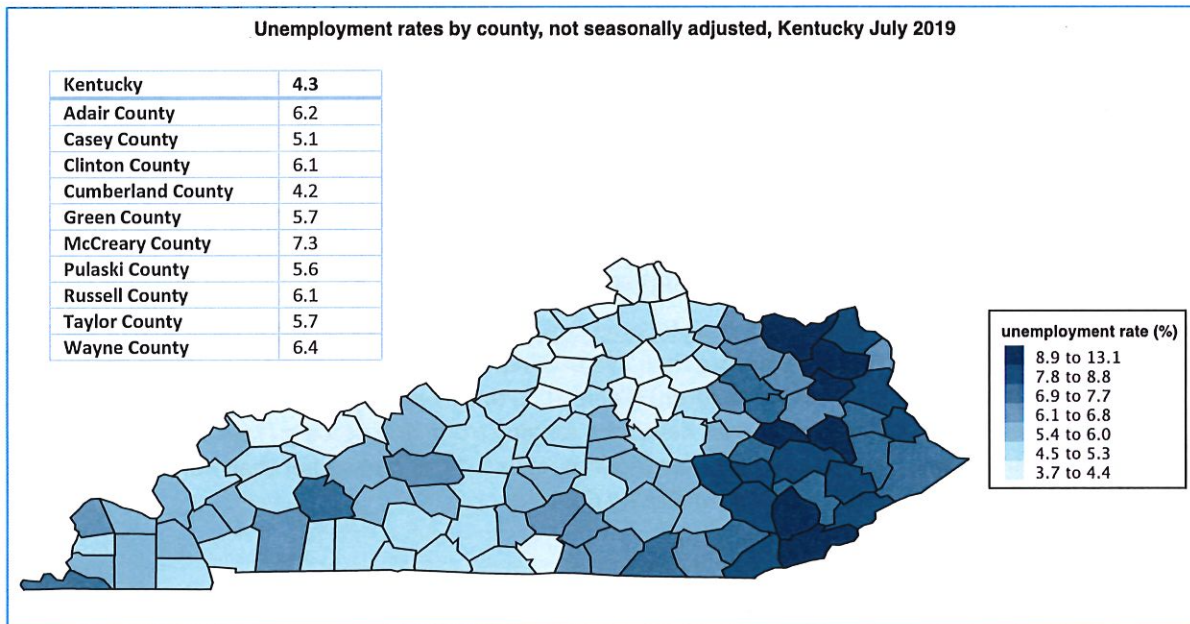


Figure 5: Unemployment Rates by County, Not Seasonally Adjusted (July 2019)

Based on census data, in Kentucky 17 percent of all single female householders with children under the age of 18 are unemployed and 4.1 percent of single male householders with children under the age of 18 are unemployed (Fig 6). In the A-ROC service area, between 13.7 and 30.1 percent of single female householders with children under the age of 18 are unemployed. Unemployment rates for single male householders in the A-ROC service area range from 0 to 24.2 percent.

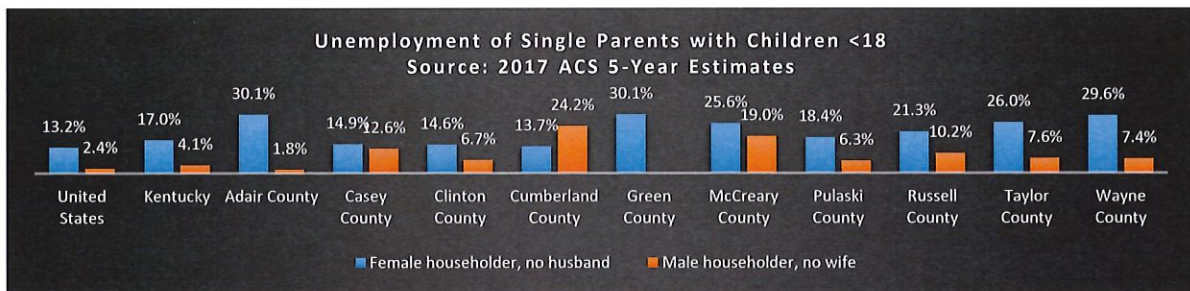


Figure 6: Unemployment of Single Parents with Children <18 (2017 ACS 5-Year Estimates)

ARTICLE: Long-term unemployment linked to increase in neonatal abstinence syndrome

"Babies born after being exposed to opioids before birth are more likely to be delivered in regions of the U.S. with high rates of long-term unemployment and lower levels of mental health services," according to a study from researchers at Vanderbilt University Medical Center and the RAND Corporation.

<https://medicalxpress.com/news/2019-01-long-term-unemployment-linked-neonatal-abstinence.html>

(More information on neonatal abstinence syndrome is found in the [Maternal and Prenatal Exposure](#) section)

Educational Attainment (Adults)

In the United States and Kentucky, approximately 87.3 and 85.2 percent of the adult population over age 25, respectively, is at minimum a high school graduate; in the 10-county assessment area, between 71.7 and 84.2 percent of the adult population over age 25 has a high school degree or higher (Fig 7). The percentage of the adult population with a bachelor's degree in the United States and Kentucky is 30.9 and 23.2 percent, respectively. Within the 10-county assessment area, between 7.6 and 18.8 percent of the adult population hold a bachelor's degree or higher.

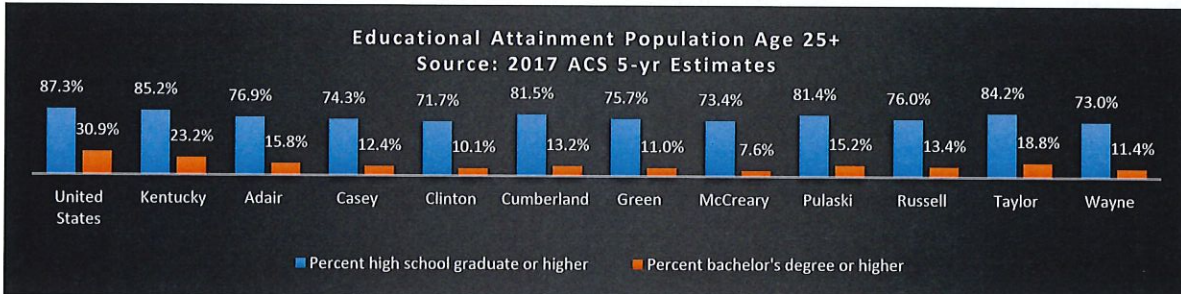


Figure 7: Educational Attainment Population Age 25+ (2017 ACS 5-Year Estimates)

Health Insurance

Per data collected from the [Kentucky Health Facts](#), 6 percent of the population under age 65 in Kentucky lacks health insurance. In the A-ROC service area, this number is between 6.2 percent (Pulaski and Taylor Counties) and 8.2 percent (Casey County) (Fig 8).

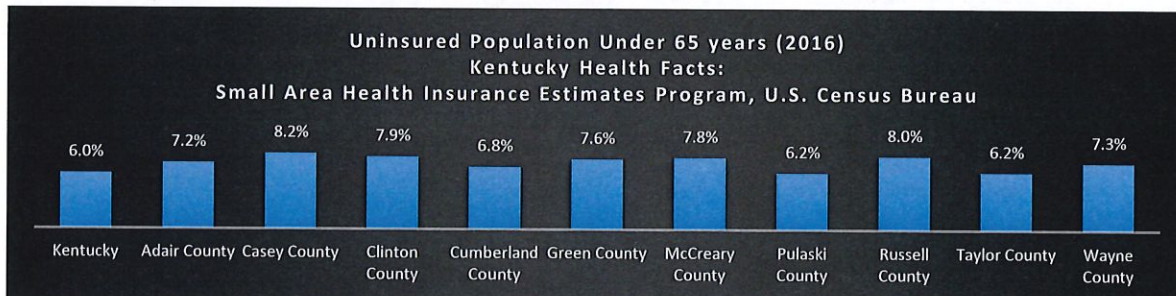


Figure 8: Uninsured Population Under 65 years (2016)

Health Literacy Levels

The University of North Carolina at Chapel Hill created an interactive website, illustrating and reporting on the health literacy of all states and counties in the United States, breaking down the data by block groups. The website offers "an interactive, searchable, national map of health literacy estimates for 216,864 census block groups in the United States. There are usually between 600 and 3,000 people living in a census block group. The health literacy estimates on this site range from 177 to 280, with higher numbers indicating higher health literacy. Individuals living in communities with low literacy estimates may be more likely to have problems reading and understanding basic health information, like a pamphlet about a medical condition. Those

DEFINITION: Census blocks, the smallest geographic area for which the Bureau of the Census collects and tabulates decennial census data, are formed by streets, roads, railroads, streams and other bodies of water, other visible physical and cultural features, and the legal boundaries shown on Census Bureau maps. Census data for these areas serve as a valuable source for small-area geographic studies.

living in neighborhoods with higher literacy scores may be able to understand basic health information, but could have difficulty with more complex text, such as documents describing medication side effects or insurance coverage.^{xvi}

Figure 9 illustrates the Health Literacy levels in the state of Kentucky. Please click [here](#) access the interactive mapping system. Table 5 provides a list of the top census blocks in each of the counties, with the lowest health literacy scores and percent of the population classified as having basic or below basic health literacy levels.

Health literacy is the ability to obtain, process, and understand information needed to make health decisions. Health literacy is not only a reflection of an individual's skills and abilities, but also how well health systems provide information and services. <http://healthliteracymap.unc.edu/>

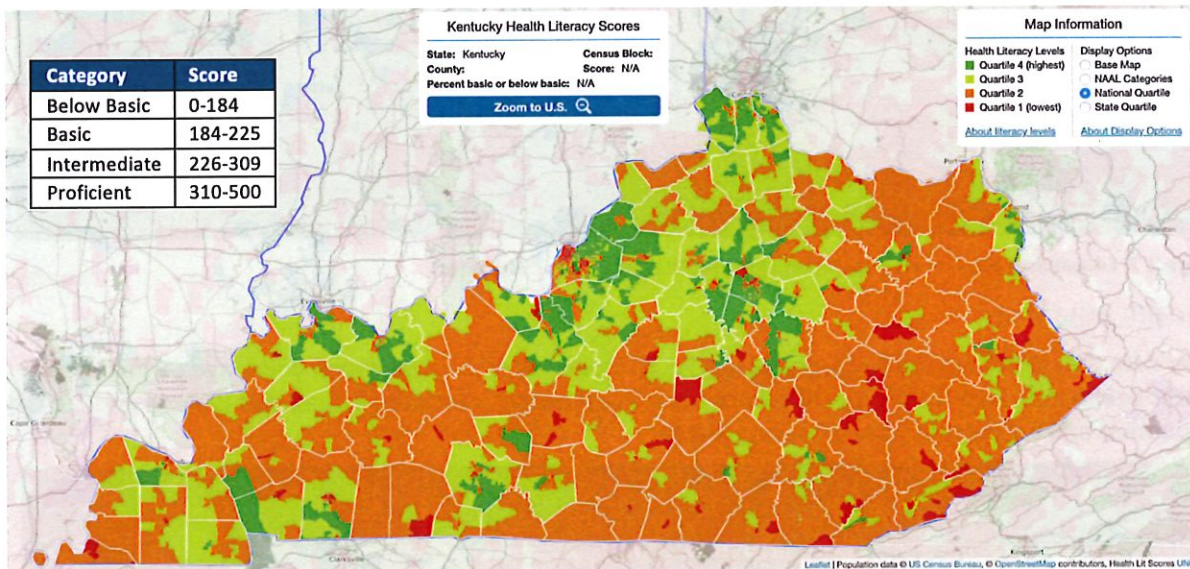


Figure 9: Kentucky Health Literacy Scores

Health Literacy Scores: Census Blocks within A-ROC Service Area with Lowest Scores

Source: <http://healthliteracymap.unc.edu>

	Census Block Group	Score	Percent Basic / Below Basic
Adair County	0019704012	226.8	48%
Casey County	0459501001	234.9	41%
Clinton County	0539702022	232.4	43%
Cumberland County	0579501005	230.6	44%
Green County	0879302003	236.7	40%
McCreary County	1479604005	229.5	46%
Pulaski County	1999306001	234.3	42%
Russell County	2079604004	235.8	41%
Taylor County	2179205006	220.1	52%
Wayne County	2319202003	230.6	44%

Table 5: A-ROC Service Area: Health Literacy Scores

DEFINITIONS

- Adults with **Below Basic** health literacy skills may be able to locate information in simple text (e.g., the time of their next clinic visit from an appointment slip) but would struggle with information in more complex documents.
- Adults with **Basic** health literacy skills are able to locate multiple pieces of information in a document but may have difficulty interpreting or applying this information (e.g., determining whether their body mass index is in a healthy range).
- Adults with **Intermediate** health literacy skills can often understand and apply medical information to their specific health context but may have difficulty navigating multiple complex texts (e.g., consent forms or health insurance documents) or drawing inferences from health materials.
- Adults with **Proficient** health literacy skills are able to use a table to calculate an employee's share of health insurance costs.

Prevalence of Opioid Use



In September of 2018, the [Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#), released a report titled: *Key Substance Use and Mental Health Indicators in the United States: Results from the 2017 National Survey on Drug Use and Health*. Based on this report, 11.4 million individuals, age 12 and older, or 4.2 percent of the population, misuse opioids in the United States, of which 11.1 million misuse prescription pain relievers, 886,000 are heroin users, and 562,000 use both prescription pain relief and heroin (Fig 10).^{xvii}

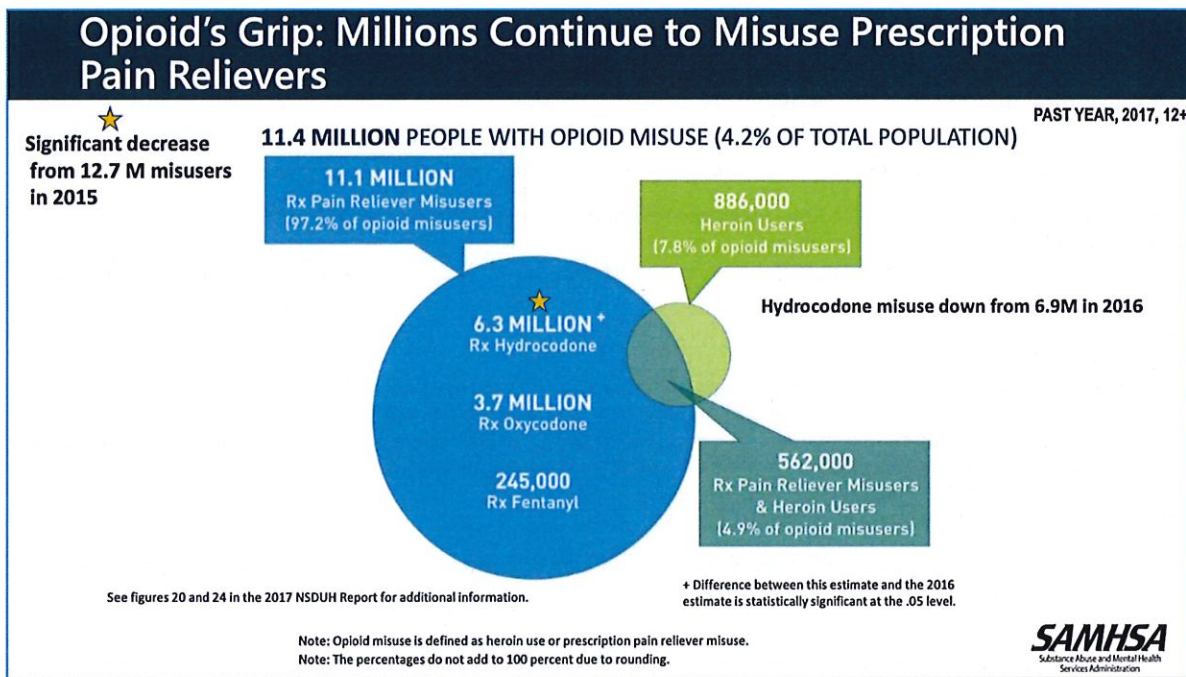


Figure 10: Opioid Misuse in the United States (2017)

The SAMHSA Center for Behavioral Health Statistics and Quality reports on national and state statistics through its [National Survey on Drug Use and Health \(NSDUH\)](#). Based on the combined 2016/2017 report, of the 11.2 million individuals, age 12 and older, who reportedly misused pain relievers in the United States during that timeframe, 160,000 were in Kentucky (1.4 percent of the total) (Table 6). The majority of individuals who reportedly misused pain relievers were over the age of 26 (8 million in the United States and 114,000 in Kentucky).

In Kentucky approximately 4.6 percent of the population, age 12 and older, misuse opioids, compared with 4.2 percent of the population in the U.S.

Pain Reliever Misuse: Estimated Numbers (in Thousands) (2016 and 2017 NSDUHs)

Source: SAMHSA

	12 or Older Estimate	12-17 Estimate	18-25 Estimate	26 or Older Estimate
Total U.S.	11,297	824	2,457	8,016
Kentucky	160	12	35	114
KY as % of U.S.	1.4%	1.5%	1.4%	1.4%

NOTE: Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

Table 6: Pain Reliever Misuse (2016 and 2017)

The NSDUH report also indicates that 917,000 individuals, age 12 and older, in the United States used heroin in the past year, of which 14,000 were in Kentucky (1.5 percent of the total population) (Table 7).

Heroin Use in the Past Year: Estimated Numbers (in Thousands) (2016 and 2017 NSDUHs)

Source: SAMHSA

	12 or Older Estimate	12-17 Estimate	18-25 Estimate	26 or Older Estimate
Total U.S.	917	13	220	683
Kentucky	14	0	3	10
KY as % of US	1.5%	-	1.4%	1.5%

NOTE: Estimated numbers appearing as 0 in this table mean that the estimate is greater than 0 but less than 500 (because estimated numbers are shown in thousands).

Table 7: Heroin Use (2016 and 2017)

In the United States, 1.7 million individuals, age 12 and older, were diagnosed with *Pain Reliever Use Disorder* (and addiction to pain medication), of which 30,000 were in Kentucky (1.7 percent of the total) (Table 8). In Kentucky, individuals diagnosed with *Pain Reliever Use Disorder* between the ages of 18 and 25 make up 1.9 percent of the total *Pain Reliever Use Disorder* diagnosed in the United States.

Pain Reliever Use Disorder in the Past Year: Estimated Numbers (in Thousands) (2016 and 2017 NSDUHs)

Source: SAMHSA

	12 or Older Estimate	12-17 Estimate	18-25 Estimate	26 or Older Estimate
Total U.S.	1,715	125	315	1,275
Kentucky	30	2	6	22
KY as % of US	1.7%	1.6%	1.9%	1.7%

NOTE: Pain Reliever Use Disorder is defined as meeting criteria for pain reliever dependence or abuse. Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

NOTE: Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

Table 8: Pain Reliever Use Disorder (2016 and 2017)

Figure 11 below, from the [2017 NSDUH](#), illustrates the source where pain relievers were obtained for the most recent misuse.

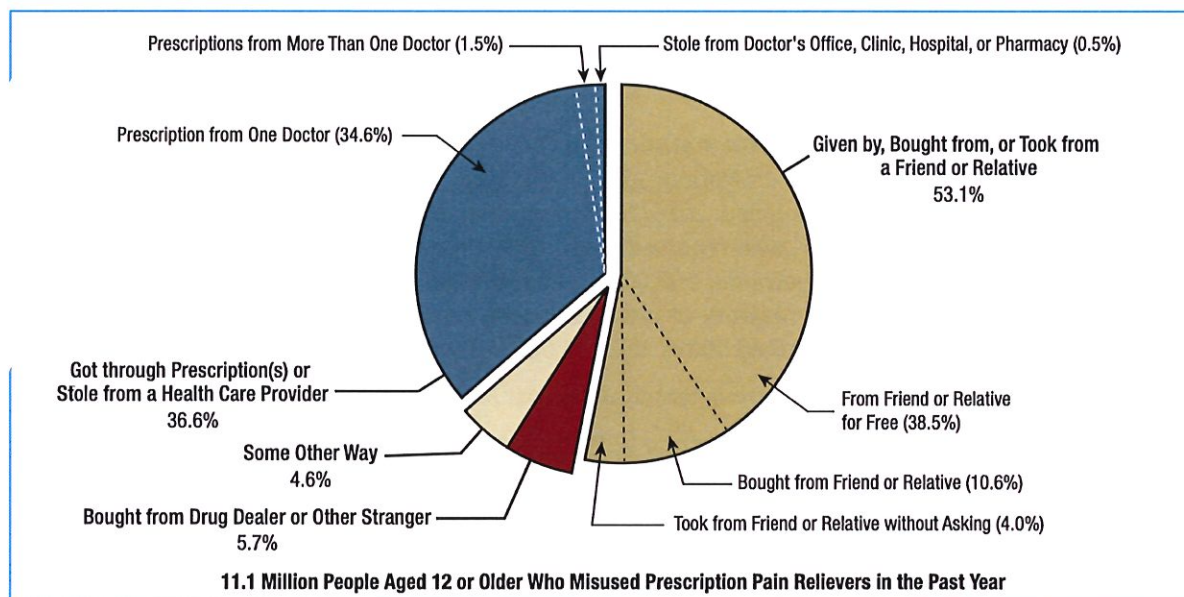


Figure 11: Source of Pain Reliever (2017 NSDUH)

Opioid Prescriptions

According to data gathered from the [Centers for Disease Control and Prevention](#) (CDC), the overall national opioid prescribing rate increased steadily from 2006, peaking in 2012 at more than 255 million and a prescribing rate of 81.3 prescriptions per 100 persons.

In 2007, the overall prescribing rate in Kentucky was 130.8 prescriptions per 100 people; the rate of opioid prescriptions dispensed per 100 persons in 2017 was 86.8.^{xviii} Although a significant decrease, Kentucky continues to have higher rates of opioid prescriptions dispensed per 100 people than most other states in the U.S. (Fig 12).

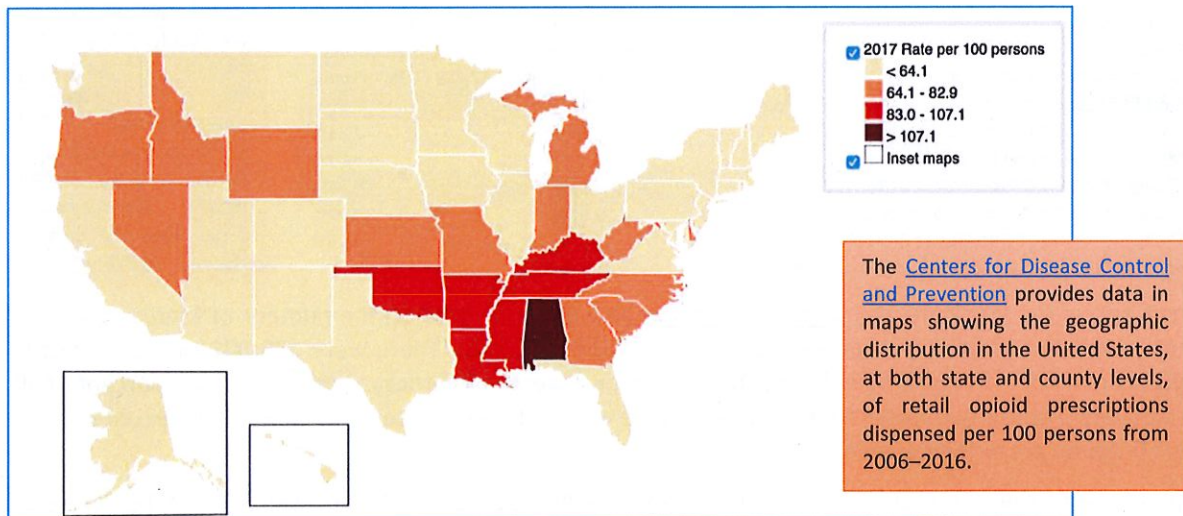


Figure 12: Opioid Prescription Rates (2017)

In the A-ROC service area, the highest opioid prescription rates in 2017 were seen in Cumberland County, with a rate of 148.6 prescriptions per 100 people. Notably however, prescription rates decreased in eight of the 10 service area counties (including Cumberland County), with the exception of Casey and Clinton Counties. In Casey County the prescription rate in 2017 was 86.1 per 100, up from 74.7; **the prescription rate in 2017 in Clinton County was 131.6 per 100, up from 1.4 per 100 in 2007** (Table 9).

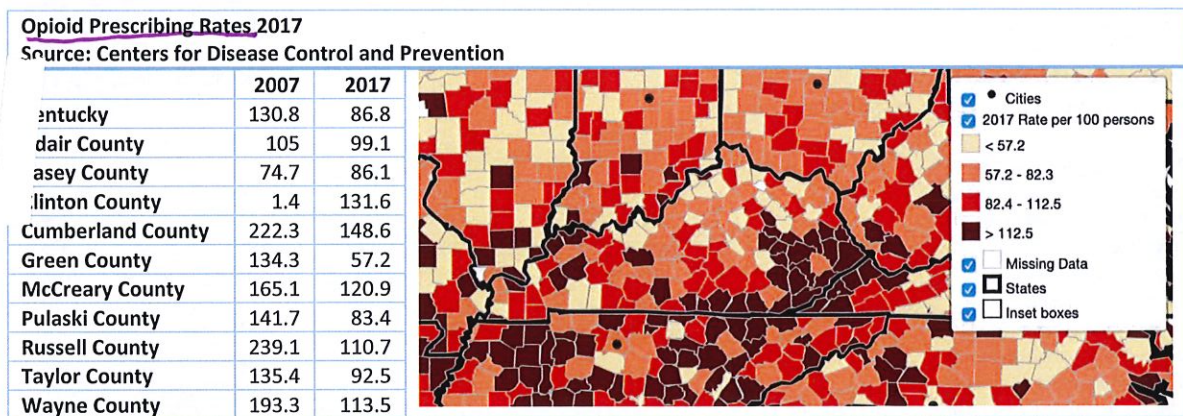


Table 9: Opioid Prescription Rates (2007 and 2017)

Opioid Prescribers and Prescription Claims

Based on data collected from the [Centers for Medicare and Medicaid Services](#), in 2017 there were more than 31 million Medicaid opioid claims in the United States, of which 533,521 (1.7 percent) were in Kentucky. At 4.57 percent, the opioid prescribing rate in the United States was higher than in Kentucky, which was 3.81 percent (Table 10). The change in Medicaid's opioid prescribing rate from 2013 to 2017 was -2.11 percent in the United States and -2.39 percent in Kentucky.^{xix}

Medicaid Opioid Prescribing Rates (2017)		
Source: Centers for Medicare and Medicaid Services		
	United States	Kentucky
Opioid Claims	31,095,607	533,521 (1.7% of total)
Fee-for-Service Opioid Claims	8,730,499	15,692 (0.2% of total)
Managed Care Opioid Claims	22,365,108	517,829 (2.3% of total)
Opioid Prescribing Rate	4.57%	3.81%
Fee-for-Service Opioid Prescribing Rate	4.58%	2.31%
Managed Care Opioid Prescribing Rate	4.57%	3.89%
Change in Opioid Prescribing Rates (2013-17)	-2.11%	-2.39%
Change in Fee-for-Service Opioid Prescribing Rate	-1.94%	-0.77%
Change in Managed Care Opioid Prescribing Rate	-2.25%	-2.59%

Table 10: Medicaid Opioid Prescribing Rates (2017)

The data reflect Medicaid prescription drugs prescribed by health care providers. Medicaid is a state-federal partnership that spent approximately \$68 billion on prescription drugs in 2017. U.S. retail prescription drug spending was about \$333 billion.

The [Centers for Medicare and Medicaid Services](#) also provides data on the number of Medicare Part D prescribers and claims by state and county. In the United States, there were 488,001 Medicaid Part D opioid prescribers in 2017, of which 6,907 (1.4 percent) were in Kentucky. Approximately 1 percent of all urban Part D opioid prescribers in the United States were in Kentucky, compared with 3.9 percent of rural Part D opioid prescribers (Table 11).^{xx}

Opioid claims reached more than 74 million in the United States in 2017, of which 1.6 million were in Kentucky (2.2 percent of the total). Similar to the proportion of urban and rural prescribers, rural opioid claims represent a higher proportion in the state of Kentucky (5.7 percent) compared to urban opioid claims (1.4 percent).

In contrast to the Medicaid prescribing rates, the Medicare Part D opioid prescribing rates are higher in Kentucky than in the United States, 5.28 percent and 5.05 percent, respectively. The Medicare Part D opioid prescribing rate change from 2013 to 2017 was -0.75 percent in the United States and -0.93 percent in Kentucky.

Medicare Part D Opioid Prescribing Rates (2017)		
Source: Centers for Medicare and Medicaid Services		
	United States	Kentucky
Part D Opioid Prescribers	488,001	6,908 (1.4% of total)
Urban Part D Opioid Prescribers	420,174	4,270 (1.0% of total)
Rural Part D Opioid Prescribers	67,306	2,607 (3.9% of total)
Opioid Claims	74,104,230	1,639,196 (2.2% of total)
Urban Opioid Claims	60,218,168	851,256 (1.4% of total)
Rural Opioid Claims	13,802,209	786,757 (5.7% of total)
Opioid Prescribing Rate	5.05%	5.28%
Urban Opioid Prescribing Rate	5.03%	5.58%
Rural Opioid Prescribing Rate	5.16%	4.99%
Change in Opioid Prescribing Rates (2013-17)	-0.75%	-0.93%
Change in Urban Opioid Prescribing Rate	-0.71%	-0.97%
Change in Rural Opioid Prescribing Rate	-0.90%	-0.91%

Table 11: Medicare Part D Opioid Prescribing Rates (2017)

The data reflect Medicare Part D prescription drug claims prescribed by health care providers. Approximately 70% of Medicare beneficiaries have Medicare prescription drug coverage either from a Part D plan or a Medicare Advantage Plan offering Medicare prescription drug coverage. In 2017 Medicare Part D spending was \$155 billion, while U.S. retail prescription drug spending was about \$333 billion.

Tables 12 and 13 provide detailed information on the Medicare Part D opioid prescribers and prescribing rates in 2017. Adair, Clinton, and Wayne Counties each reported an opioid prescribing rate of more than 5 percent. Casey and Clinton Counties reported an opioid prescribing rate change of more than -4 percent from 2013 to 2017.

Medicare Part D Opioid Prescribing Rates (2017) <i>Source: Centers for Medicare and Medicaid Services</i>					
	Adair County	Casey County	Clinton County	Cumberland County	Green County
Part D Opioid Prescribers	14	12	11	13	9
Urban Part D Opioid Prescribers	0	0	0	0	0
Rural Part D Opioid Prescribers	14	12	11	13	9
Opioid Claims	7,065	3,370	6,332	2,941	1,359
Urban Opioid Claims	0	0	0	0	0
Rural Opioid Claims	7,065	3,370	6,332	2,941	1,359
Opioid Prescribing Rate	5.01%	3.05%	5.82%	3.38%	2.24%
Urban Opioid Prescribing Rate	0.00%	0.00%	0.00%	0.00%	0.00%
Rural Opioid Prescribing Rate	5.01%	3.05%	5.82%	3.38%	2.24%
Change in Opioid Prescribing Rates (2013-17)	-1.62%	-4.16%	-4.30%	-2.45%	-1.75%
Change in Urban Opioid Prescribing Rate	0.00%	0.00%	0.00%	0.00%	0.00%
Change in Rural Opioid Prescribing Rate	-1.62%	-4.16%	-4.30%	-2.45%	-1.75%

Table 12: Medicare Part D Opioid Prescribing Rates (2017)

Medicare Part D Opioid Prescribing Rates (2017) <i>Source: Centers for Medicare and Medicaid Services</i>					
	McCreary County	Pulaski County	Russell County	Taylor County	Wayne County
Part D Opioid Prescribers	20	96	18	36	25
Urban Part D Opioid Prescribers	0	0	0	0	0
Rural Part D Opioid Prescribers	20	96	18	36	25
Opioid Claims	3,063	18,801	5,011	6,579	8,168
Urban Opioid Claims	0	0	0	0	0
Rural Opioid Claims	3,063	18,801	5,011	6,579	8,168
Opioid Prescribing Rate	3.16%	2.94%	3.73%	2.94%	5.50%
Urban Opioid Prescribing Rate	0.00%	0.00%	0.00%	0.00%	0.00%
Rural Opioid Prescribing Rate	3.16%	2.94%	3.73%	2.94%	5.50%
Change in Opioid Prescribing Rates (2013-17)	-2.25%	-2.39%	-0.74%	-0.99%	-1.40%
Change in Urban Opioid Prescribing Rate	0.00%	0.00%	0.00%	0.00%	0.00%
Change in Rural Opioid Prescribing Rate	-2.25%	-2.39%	-0.74%	-0.99%	-1.40%

Table 13: Medicare Part D Opioid Prescribing Rates (2017)

Who's Eligible for Medicare Part D?

Eligibility for Medicare Part D is not open to everyone. You must meet certain criteria to enroll in a Medicare Part D plan. Below are examples of some of the qualifying categories:

- You are age 65 or older
- You have a qualifying disability for which you have been receiving Social Security Disability Insurance (SSDI) for more than 24 months¹
- You have been diagnosed with End-Stage Renal Disease (permanent kidney failure requiring a kidney transplant or dialysis)
- You are entitled to Medicare Part A and/or enrolled in Medicare Part B

Article: Trends and Patterns of Opioid Analgesic Prescribing: Regional and Rural-Urban Variations in Kentucky (2012-15)

The adjusted models showed the Kentucky Appalachian region retained a significantly higher rate of residents with opioid analgesic prescriptions per 1,000 residents (30% higher than Central Kentucky and 19% higher than Kentucky Delta regions).

<https://www.ncbi.nlm.nih.gov/pubmed/29664203>

Tracking the Opioid Epidemic in the U.S. (Washington Post)

Newly released data reveals where 76 billion pain pills went.

The nation's largest drug companies have paid more than \$1 billion in fines to the Justice Department and Food and Drug Administration over opioid-related issues. Those firms have settled for millions of dollars in state lawsuits, whose terms have, until now, kept key information about the size and scope of the epidemic out of the public's grasp.

After a lengthy legal battle, investigative reporters [Scott Higham](#) and [Steven Rich](#) gained access to a database that reveals what each company knew about the number of pills it was shipping and dispensing, and when they were aware of those volumes – year by year, town by town.

They say the companies allowed the drugs to reach the streets of many communities, despite indications that those pills were being sold in apparent violation of federal law and diverted to the black market.

<https://www.washingtonpost.com/podcasts/post-reports/seven-years-76-billion-pain-pills--tracking-the-opioid-epidemic-in-the-us/>

In July 2019 the *Washington Post* released an article and data visualization tool, [Drilling into the DEA's pain pill database](#), giving the public access to information on the number of pills that were distributed into all states and counties in the United States, including information on the manufacturers, distributors and pharmacies that controlled the flow of pills. Based on this data, more than 1.9 billion prescription pain pills were supplied to the state of Kentucky between the years of 2006 to 2012 (Fig 13). Value-Med Inc., in the town of Paintsville (located in Johnson County) received 10.4 million pills over the course of seven years. The majority of pills supplied in Kentucky were manufactured by Actavis Pharma, Inc. (893 million pills); the largest distributor was AmerisourceBergen Drug (437 million pills).

- From 2006 to 2012 there were **1,901,662,933** prescription pain pills supplied to **Kentucky**.
- **437,401,815** of the pills were distributed by **AmerisourceBergen Drug** and **893,507,858** were manufactured by **Actavis Pharma, Inc.**
- **VALUE-MED INC, PAINTSVILLE** pharmacy received the highest number of pills.



Figure 13: Pain Pills Supplied to Kentucky (2006 – 2012)

Of the 1.9 billion pain pills supplied to Kentucky between 2006 and 2012, 92 million were supplied to the 10 counties in the A-ROC service area. The majority of pills were supplied to Pulaski County (29 million), followed by Clinton County (10 million). **It is notable that Clinton County received 11.2 percent of all pills supplied to the A-ROC service area, while the county makes up only 4.9 percent of the region's total population.**

Prescription Pain Pills Supplied (2006-2012)				
Source: DEA (via Washington Post)				
	Total Pills Supplied from 2006-2012	Percent of Total Pills Prescribed in A-ROC Service Area	Population Estimates 2017	Percent of Total Population Estimates in A-ROC Service Area
Adair County	6,542,540	7.1%	19,485	9.3%
Casey County	3,991,840	4.3%	15,750	7.5%
Clinton County	10,308,280	11.2%	10,276	4.9%
Cumberland County	4,110,370	4.5%	6,706	3.2%
Green County	3,087,100	3.3%	11,065	5.3%
McCreary County	7,701,172	8.4%	17,465	8.4%
Pulaski County	29,044,240	31.5%	64,449	30.8%
Russell County	9,247,680	10.0%	17,775	8.5%
Taylor County	9,208,550	10.0%	25,472	12.2%
Wayne County	8,986,268	9.7%	20,716	9.9%
Total A-ROC Service Area	92,228,040		209,159	

Table 14: Prescription Pain Pills Supplied (2006-2012)

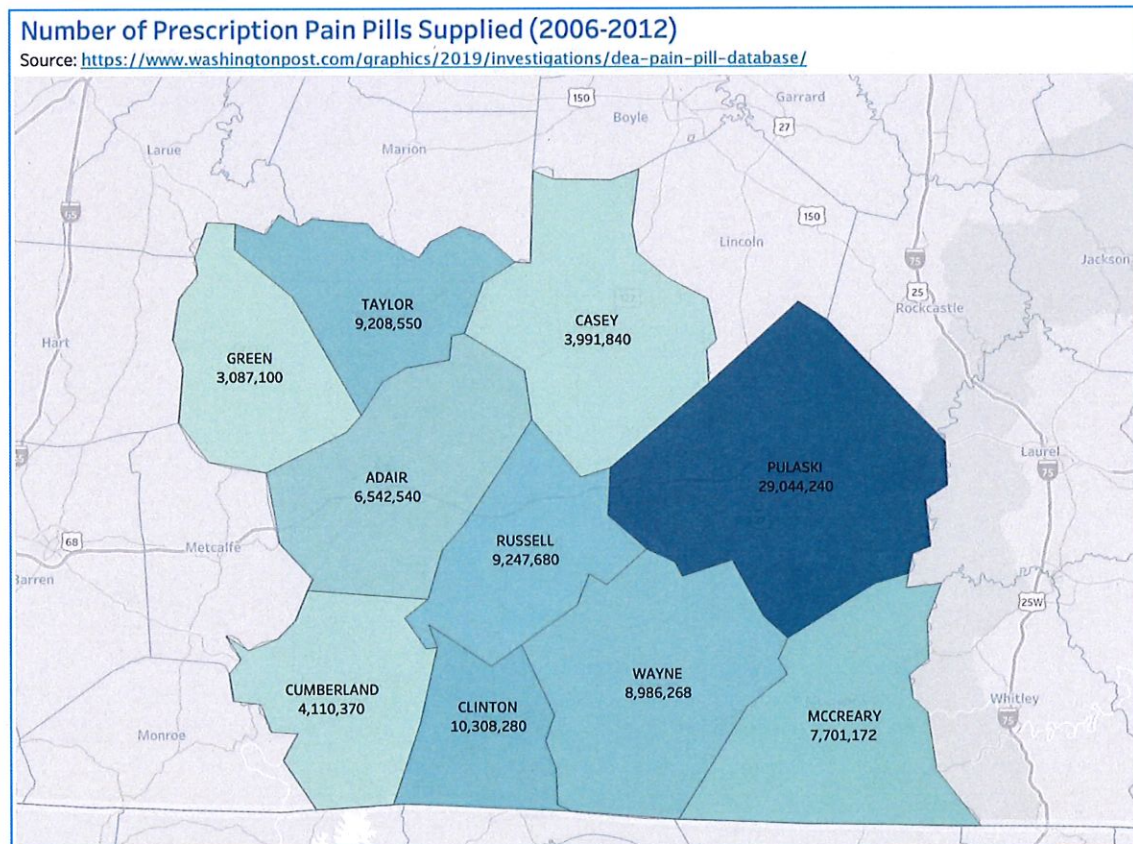


Figure 14: Prescription Pain Pills Supplied (2006-2012)

Using 2017 population estimates, the 10-county service area received enough pain pills over the course of seven years for each person in the area to have 63 pills, per person, per year (Table 15). **Estimates for Clinton County indicate that they received enough pills over the course of seven years for each person to have 143 pills, per person, per year.**

Prescription Pain Pills Supplied Per Person (2006-2012)				
Source: DEA (via Washington Post)				
	Total Pills Supplied from 2006-2012	Population Estimates 2017	Number of Pills Per Person	Number of Pills Per Person, Per Year
Adair County	6,542,540	19,485	336	48
Casey County	3,991,840	15,750	253	36
Clinton County	10,308,280	10,276	1,003	143
Cumberland County	4,110,370	6,706	613	88
Green County	3,087,100	11,065	279	40
McCreary County	7,701,172	17,465	441	63
Pulaski County	29,044,240	64,449	451	64
Russell County	9,247,680	17,775	520	74
Taylor County	9,208,550	25,472	362	52
Wayne County	8,986,268	20,716	434	62
Total A-ROC Service Area	92,228,040	209,159	441	63

Table 15 Prescription Pain Pills Supplied Per Person (2006-2012)

Note: The *Washington Post* data visualization tool calculation of pills per person, per year is slightly higher for each county.

Manufacturers

The top five manufacturers of pain pills in Kentucky and the 10-county service area were Actavis Pharma, Inc., SpecGX, LLC, Par Pharmaceutical, Amneal Pharmaceuticals, LLC and Purdue Pharma LP. Table 16 lists the top 15 manufacturers of pills that were distributed to the 10-county service area, each contributing 100,000 to 53 million pills.

Manufacturers of Prescription Pain Pills Supplied (2006-2012)

Source: DEA (via Washington Post)

	ADAIR	CASEY	CLINTON	CUMBERLAND	GREEN	MCCREARY	PULASKI	RUSSELL	TAYLOR	WAYNE	A-ROC Service Area
Grand Total	6,542,540	3,991,840	10,308,280	4,110,370	3,087,100	7,701,172	29,044,240	9,247,680	9,208,550	8,986,268	92,228,040
Actavis Pharma, Inc.	4,592,100	2,544,900	7,215,400	3,270,200	1,762,900	4,476,300	15,902,240	5,652,400	2,815,000	5,049,000	53,280,440
SpecGX LLC	1,240,100	713,700	333,000	225,100	646,900	869,900	7,834,400	1,501,900	3,631,800	2,161,300	19,158,100
Par Pharmaceutical	463,440	401,760	2,349,580	414,020	479,800	1,890,140	3,134,590	1,514,080	2,197,050	1,086,520	13,930,980
Amneal Pharmaceuticals LLC	83,800	188,400	77,200	12,300	97,100	200,500	556,900	237,500	232,700	186,200	1,872,600
Purdue Pharma LP	72,200	26,480	101,900	76,300	34,300	56,760	516,020	159,000	142,800	95,068	1,280,828
KVK-Tech, Inc.	13,700	22,700	36,900	18,500	1,700	38,300	376,900	22,000	20,400	48,200	599,300
UCB, Inc.	14,200	14,800	68,400	44,700	26,100	45,422	103,600	22,000	36,700	68,000	443,922
West-Ward Pharmaceuticals Corp.	900	39,700	8,600	2,700	1,400	51,500	54,000	40,700	9,100	117,000	325,600
Forest Laboratories, Inc.	7,100	2,200	21,100	3,600	1,200	8,200	114,600	25,600	9,300	65,400	258,300
Teva Pharmaceuticals USA, Inc.	12,300	2,800	11,700	6,200	10,100	8,400	97,400	15,000	29,000	15,000	207,900
Mylan Pharmaceuticals, Inc.	3,000	5,400	42,700	1,400	17,000	19,600	36,500	30,700	36,000	9,500	201,800
Endo Pharmaceuticals, Inc.	4,200	1,500	1,900	8,000	600	11,500	74,200	2,700	24,900	20,300	149,800
Sun Pharmaceutical Industries, Inc.	19,400	23,700	10,100	10,000	3,200	2,200	42,900	1,600	10,700	24,900	148,700
Ethex Corporation	3,200	400	4,000	1,900	500	11,400	72,200	6,400	6,500	5,200	111,700
AbbVie Inc.	9,500	100	13,700	2,100	2,200	7,400	36,500	5,700	1,000	25,500	103,700

Table 16: Manufacturers of Prescription Pain Pills Supplied (2006-2012)

Article: Little-known makers of generic drugs played central role in opioid crisis, records show.

<https://www.washingtonpost.com/investigations/little-known-generic-drug-companies-played-central-role-in-opioid-crisis-documents-reveal/2019/07/26/95e08b46-ac5c->

Distributors

The top five distributors of pain pills in Kentucky were AmerisourceBergen Drug, Cardinal Health, Walgreen Company, McKesson Corporation and Kroger. The top five distributors of pain pills in the 10-county service area were AmerisourceBergen Drug, Smith Drug Company, McKesson Corporation, Cardinal Health, and H.D. Smith Wholesale Drug. Table 17 lists the top 10 distributors of pills to the 10-county service area, each contributing 1.8 to 16.5 million pills.

Distributors of Prescription Pain Pills Supplied (2006-2012)											
Source: DEA (via Washington Post)											
	ADAIR	CASEY	CLINTON	CUMBERLAND	GREEN	MCCREARY	PULASKI	RUSSELL	TAYLOR	WAYNE	A-ROC Service Area
Grand Total	6,542,540	3,991,840	10,308,280	4,110,370	3,087,100	7,701,172	29,044,240	9,247,680	9,208,550	8,986,268	92,228,040
AMERISOURCEBERG EN DRUG CORP	1,448,900	102,100	6,148,190	432,500	1,138,340	366,100	4,692,720	1,865,900	382,400		16,577,150
SMITH DRUG COMPANY	1,075,130	15,700	1,008,000	102,800	68,360	5,781,550	3,877,500	2,738,740	332,640	511,700	15,512,120
MCKESSON CORPORATION	1,180,060	1,096,960	120,700	15,800	955,900	180,100	2,816,700	1,385,820	2,811,770	1,604,660	12,168,470
CARDINAL HEALTH	233,120		1,022,520	1,765,070		181,512	6,158,910	357,330	688,250	952,690	11,359,402
H. D. SMITH WHOLESALE DRUG	595,370	2,200,160	687,210	1,454,570	144,460	6,500	406,800	385,660	281,970	1,016,800	7,179,500
KROGER LIMITED PARTNERSHIP I							2,299,410	896,700	2,252,600	987,200	6,435,910
WALGREEN CO							3,585,300				3,585,300
RITE AID MID- ATLANTIC		326,020		35,500	614,170	641,800	610,470	785,350		493,350	3,506,660
WAL-MART PHARM WAREHOUSE #1	757,400						1,371,100		903,300	471,700	3,503,500
ANDA PHARMACEUTICALS INC	422,200	26,700	1,000	3,300	15,000	5,400	385,100	320,400	246,900	423,000	1,849,000

Table 17: Distributors of Prescription Pain Pills Supplied (2006-2012)

Lake Cumberland Area Response to Opioids in Rural Communities (A-ROC) Planning Consortium
Opioid Crisis Community Needs Assessment: PART I: Community Profile

Pharmacies of Prescription Pain Pills Supplied (2006-2012)
Source: DEA (via Washington Post)

	ADAIR	CASEY	CLINTON	CUMBERLAND	GREEN	MCCREARY	PULASKI	RUSSELL	TAYLOR	WAYNE	A-ROC Service Area
PREScription SHOPPE	1,302,600									1,302,600	1,302,600
KROGER PHARMACY L-901										1,290,740	1,290,740
DYER DRUG CO			1,181,230							1,181,230	1,181,230
WAL-MART PHARMACY 10-0665									1,158,960	1,158,960	1,158,960
KROGER PHARMACY L-403									1,152,030	1,152,030	1,152,030
RX DISCOUNTh PHARMACY #8						1,037,930				1,037,930	1,037,930
KROGER PHARMACY L-757							1,026,480			1,026,480	1,026,480
KROGER PHARMACY L-900								1,017,100			1,017,100
WESLEY DRUG CO		998,350									998,350
HEALTH FIRST PHARMACY PSC					986,350						986,350
PAMIDA PHARMACY #22		979,720									979,720
KING PHARMACY, INC							923,150				923,150
K MART PHARMACY #7255							842,400				842,400
GREENSBURG DISCOUNTh PHARMACY					842,320						842,320
LAKESHORE PHARMACY							804,760				804,760
CENTRAL DRUG CENTER INC									772,100	764,900	772,100
WAL-MART PHARMACY 10-1234									745,570		745,570
MEDICINE CENTRE PHARMACY											726,760
MORGAN'S MEDICINE, PLLC.				726,760							726,760
RUSSELL SPRINGS PHARMACY								722,100			722,100
WALMART PHARMACY #10-569	714,500										714,500
LAKE CUMBERLAND PHARMACY, LLC								707,850			707,850
CERTACARE INC	643,250										643,250
WAYNE KWIKSCRIPT INC										631,000	631,000
NANCY, PHARMACY							581,150				581,150
FRED'S PHARMACY # 1664			554,600								554,600
PROFESSIONAL PHARMACY LLC							547,830				547,830
GOFORTH PHARMACY LLC							530,400				530,400
SOMERSET PHARMACY INC						434,200	471,000				471,000
WYNN EXPRESS PHARMACY											434,200
CERTACARE PHARMACY			330,760					49,000			379,760
THE MEDICINE SHOPPE	376,980										376,980
DAFFRON DRUG INC											360,410
EASTRIDGE-PHELPS PHARMACY LLC									332,640		332,640
FRED'S PHARMACY #2019					328,860						328,860

Lake Cumberland Area Response to Opioids in Rural Communities (A-ROC) Planning Consortium
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Pharmacies

In Kentucky the top five pharmacies that received the highest number of pills were Value-med Inc., Paintsville; P C A Corrections, Louisville; Little & Waddle Inc., Prestonsburg; DBA Medicine Cabinet Pharmacy, Paintsville; and Walgreen Co., Louisville. In the 10-county service area, the top five pharmacies that received the highest number of pills were Shearer Drug, Rite Aid of Kentucky, Inc., Medicine Shoppe, Walgreen Co. and F and H Drugs Inc. Over the course of seven years, they received a combined 23.2 million pills. Table 18 lists all pharmacies in the service area and the number of pills that were received by each.

Pharmacies of Prescription Pain Pills Supplied (2006-2012)
Source: DEA (via Washington Post)

	ADAIR	CASEY	CLINTON	CUMBERLAND	GREEN	MCCREARY	PULASKI	RUSSELL	TAYLOR	WAYNE	A-ROC Service Area
SHEARER DRUG			6,778,550								6,778,550
RITE AID OF KENTUCKY, INC.		454,060			786,300	824,300	894,420	1,355,540		704,620	5,019,240
MEDICINE SHOPPE							4,173,350				4,173,350
WALGREEN CO.							3,666,500				3,666,500
F AND H DRUGS INC										3,604,900	3,604,900
WEST SOMERSET PHARMACY INC							3,169,960				3,169,960
CAPPS PHARMACY INC				3,106,950							3,106,950
DAUGHERTY'S DRUG STORE						2,898,480					2,898,480
CENTURY PHARMACY									2,567,530		2,567,530
KENTUCKY CVS PHARMACY, L.L.C.	83,100					2,453,422	1,528,930		854,030		2,466,060
BURGESS DRUG STORE INC #2											2,453,422
PROFESSIONAL PHARMACY OF SOMERSET, LLC						2,323,190					2,323,190
WAL-MART PHARMACY 10-0689							2,278,560				2,278,560
KROGER PHARMACY L-745							2,008,790				2,008,790
GRIDER DRUG #2, LLC								1,713,500			1,713,500
JAMESTOWN VALU-RITE PHCY INC								1,634,230			1,634,230
KROGER PHARMACY L-369									1,624,590		1,624,590
COLUMBIA PHARMACY		1,579,290									1,579,290
HILL'S PHARMACY INC			1,516,010								1,516,010
PLYLES PHARMACY INC		1,490,660									1,490,660
SCIENCE HILL DRUG							1,471,100				1,471,100
DYER DRUG											
CENTURY PHARMACY, INC.			1,463,140					1,352,590			1,463,140
SOUTH CREEK DRUG										1,345,918	1,345,918
GRIDER DRUG #1								1,332,250			1,332,250

Lake Cumberland Area Response to Opioids in Rural Communities (A-ROC) Planning Consortium
 Opioid Crisis Community Needs Assessment: [PART I: Community Profile](#)

Pharmacies of Prescription Pain Pills Supplied (2006-2012)

Source: DEA (via Washington Post)

	ADAIR	CASEY	CLINTON	CUMBERLAND	GREEN	MCCREARY	PULASKI	RUSSELL	TAYLOR	WAYNE	A-ROC Service Area
CROWLEY'S PHARMACY										283,780	283,780
COLLEGE DRUGS INC							256,100				256,100
KMART PHARMACY								246,330			246,330
GRIDER DRUG - KEY VILLAGE								245,780			245,780
LAKER DRUG								223,000			223,000
WAL-MART PHARMACY 10-0569	215,500										215,500
SMITH PHARMACY INCORPORATED				196,460							196,460
NANCY PHARMACY							144,800				144,800
JAMES MEDICAL PHARMACY	136,660										136,660
CORNER DRUG STORE INC					74,910						74,910
EASTRIDGE-PHELPS PHARMACY, LLC					68,360						68,360
RITE AID OF KENTUCKY, INC				47,600							47,600
FRED'S, PHARMACY #1189				32,600							32,600
HOMETOWN PHARMACY OF WHITLEY CITY INC						29,500					29,500
PAMIDA PHARMACY, #22		24,000									24,000
PERRY, H A MD						23,100					23,100
MEDICINE SHOPPE LONG TERM CARE							17,600				17,600
HOSPICE OF LAKE CUMBERLAND							10,100				10,100
SHOPKO PHARMACY #2718		9,200									9,200
J & J FOODS							8,700				8,700
LANGDON ST. HEALTH MART PHARMACY							8,300				8,300
GREEN RIVER PHARMACY		8,200									8,200
GROSS, RICK D MD							2,500				2,500
PRICE, JOHN ROGERS MD		2,300									2,300
ALDERDICE, BEN B DMD, SR.							1,280				1,280
WADE, C LESLIE DVM								1,000			1,000
RICHARDSON, MARLENE K DMD									600		600
HAYS, PHILIP EDWARD DVM									300		300
PERRY, LARRY ELBERT MD						200					200
BURKETT, BRUCE GENE DVM							200				200
ANDREW, JAMES KEITH DVM									200		200
HISATAKE-BUMGARDNER, TAMARA M. DVM							100				100
MOSLEY, FRANCINE R, MD						40					40

Table 18: Pharmacies of Prescription Pain Pills Supplied (2006-2012)

Distribution Over Time

Figure 15 below illustrates the number of pills that were manufactured, distributed and received over the seven-year period by the top three manufacturers, distributors and pharmacies.

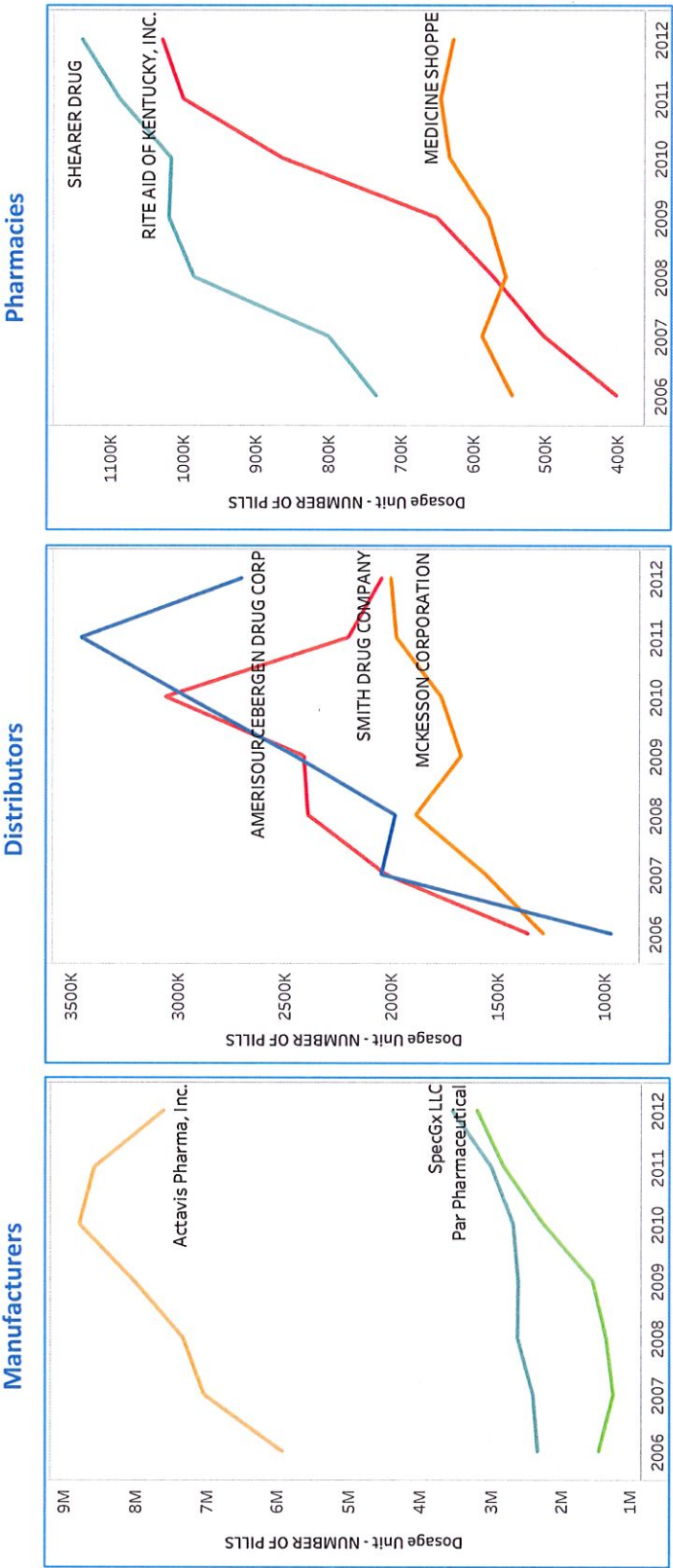
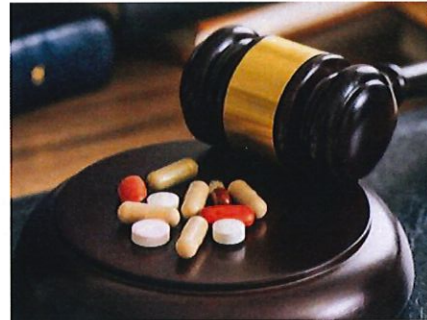


Figure 15: Distribution Over Time

Lawsuits and Settlements

Many of the top manufacturers, distributors and sellers of opioids to Kentucky are currently involved in multiple pending lawsuits and some settlements around the country. In fact, according to a [Courier Journal](#) article in September 2019, thirteen Kentucky hospital systems and their hospitals "have banded together to sue opioid manufacturers, distributors and sellers," claiming more than 40 businesses have used "a false narrative marketing scheme" that understated the risks associated with opioids and "precipitated the crisis."^{xxi} These Kentucky hospitals have joined 300 hospitals from across the country that have filed lawsuits against these companies.



Companies including [Actavis Pharma](#), [Purdue Pharma](#) and [Walgreens](#), who are among the top manufacturers, distributors and pharmacies in Kentucky, are also being sued in U.S. District Court in Ventura County, California, for their role in the opioid crisis there for many of the same reasons.^{xxii}

Per an NPR report in August, around 2,000 cities, towns and counties across the country are "participating in a massive multidistrict civil lawsuit against the opioid industry for damages related to the abuse of prescription pain medication. The defendants in the suit include drug manufacturer Mallinckrodt, wholesale distributors McKesson and Cardinal Health, and pharmacy chains CVS and Walgreens."^{xxiii}

Both Ohio^{xxiv} and Oklahoma^{xxv} have recently won multi-million-dollar settlements against large manufacturers and distributors such as Teva and Purdue Pharmaceuticals, Johnson & Johnson, McKesson, Mallinckrodt LLC and SpecGx LLC.

Health Effects of Opioid Use

Inpatient Hospitalizations and Emergency Department (ED) Visits



The [Kentucky Injury Prevention and Research Center](#) (KIPRC) is a partnership between the Kentucky Department for Public Health and the University of Kentucky's College of Public Health; its mission is to increase knowledge and awareness of injury prevalence in Kentucky. In addition to collecting data on occupational safety and health, as well as injury profiles, the KIPRC reports on drug-related inpatient hospitalizations and emergency department (ED) visits for a variety of drugs including cocaine, cannabis, sedatives, antidepressants and others (see [link](#) for details by county).

Tables 19, 20 and 21 report on inpatient hospitalizations and ED visits due to nondependent abuse of drugs, drug dependence and acute drug poisoning.

Nondependent Abuse of Drugs

In 2018 almost 60,000 instances of inpatient hospitalization or ED visits were recorded in Kentucky for nondependent abuse of drugs (excluding overdoses), of which almost 10,000 (17 percent) were opioids (Table 19). In the A-ROC service area, 2,334 instances of inpatient hospitalization or ED visits were recorded for nondependent abuse of drugs, of which 331 (14 percent) were opioids. Green and Russell Counties report the highest proportion of nondependent abuse of opioid drug-related inpatient hospitalizations and ED visits, 28 and 20 percent, respectively.

DEFINITION: Nondependent abuse of drugs: Includes cases where a person, for whom no other diagnosis is possible, has come under medical care because of the maladaptive effect of a drug on which she/he is not dependent and that she/he has taken on his own initiative to the detriment of her/his health or social functioning.

<http://www.centralx.com/diseases/icd278.htm>

Drug-Related Inpatient Hospitalizations and Emergency Department Visits (2018)												
Nondependent Abuse of Drugs (Excluding Overdoses)												
Source: Kentucky Injury Prevention and Research Center												
	Kentucky	Adair County	Casey County	Clinton County	Cumberland County	Green County	McCreary County	Pulaski County	Russell County	Taylor County	Wayne County	A-ROC Service Area
Any substance	59,970	167	207	68	39	75	248	844	131	418	137	2,334
Amphetamine abuse	16,022	66	104	28	11	25	87	350	31	149	42	893
Cannabis abuse	17,986	66	82	19	8	20	53	280	30	114	43	715
Cocaine abuse	6,342	12	*	0	*	6	*	18	*	55	*	**
Hallucinogen abuse	152	0	0	0	0	0	*	*	0	*	0	**
Opioid abuse	9,942	25	24	9	7	21	40	113	26	47	19	331
(Total and percent of total)	17%	15%	12%	13%	18%	28%	16%	13%	20%	11%	14%	14%
Sedative, hypnotic or anxiolytic abuse	1,737	10	*	0	*	0	9	24	6	8	5	**
* Count of at least one but fewer than five was suppressed.												
** Unable to determine due to suppressed data.												

Table 19: Nondependent Abuse of Drugs (Excluding Overdoses) (2018)

Drug Dependence

During the same calendar year, 2018, more than 22,000 instances of inpatient hospitalization or ED visits were recorded in Kentucky for drug dependence (excluding overdoses), of which almost 16,000 (70 percent) were opioid-type dependences (Table 20). In the A-ROC service area, 656 instances of inpatient hospitalization or ED visits were recorded for drug dependence, of which 444 (68 percent) were opioid-type dependences. McCreary and Wayne Counties reported the highest proportion of opioid-type-dependence-related inpatient hospitalizations and ED visits, 79 and 74 percent, respectively.

Drug-related Inpatient Hospitalizations and Emergency Department Visits (2018)												
Drug Dependence (Excluding Overdoses)												
Source: Kentucky Injury Prevention and Research Center												
	Kentucky	Adair County	Casey County	Clinton County	Cumberland County	Green County	McCreary County	Pulaski County	Russell County	Taylor County	Wayne County	A-ROC Service Area
Any substance	22,390	45	42	19	10	16	102	187	49	144	42	656
Amphetamine and other psychostimulant dependence	3,057	8	8	*	*	*	23	26	5	32	*	**
Cannabis dependence	1,655	6	*	*	0	*	19	16	*	25	0	**
Cocaine dependence	853	*	*	0	0	0	*	*	*	16	0	**
Hallucinogen dependence	15	0	0	0	0	0	0	0	0	0	0	0
Opioid-type dependence	15,755	32	28	13	5	11	81	128	34	81	31	444
(Total and percent of total)	70%	71%	67%	68%	50%	69%	79%	68%	69%	56%	74%	68%
Sedative, hypnotic or anxiolytic dependence	3,081	*	*	*	*	*	10	21	*	6	*	**
* Count of at least one but fewer than five was suppressed.												
** Unable to determine due to suppressed data.												

Table 20: Drug Dependence (Excluding Overdoses) (2018)

ARTICLE: United States Emergency Department Visits Involving the Accidental Ingestion of Opioid Pain Relievers by Children, Aged 1-5

Source: Substance Abuse and Mental Health Services Administration (SAMHSA)
 Drug Abuse Warning Network

- According to the Drug Abuse Warning Network (DAWN), in 2011 an estimated 4,321 emergency department (ED) visits involved accidental ingestion of opioid pain relievers by children, aged 1 to 5. The number of ED visits increased 200.7 percent from 1,437 visits in 2004 to 4,321 visits in 2011; however, the number of ED visits was stable between 2009 and 2011.
- Combined 2004 to 2011 DAWN data show that an estimated 22,174 ED visits involved accidental ingestion of opioid pain relievers by children, aged 1 to 5. An estimated 5,977 of these ED visits involved hydrocodone products (Vicodin; Lortab), and 4,365 involved Oxycodone products (OxyContin; Percocet). About 5,222 visits involved buprenorphine (Subutex; Suboxone), a medication used to treat opioid addiction.
- Combined 2004 to 2011 DAWN data show that among ED visits involving accidental ingestion of opioid pain relievers by children, aged 1 to 5, 85 percent involved opioids only; additional drugs were involved in the remaining 15 percent of these ED visits.
- Combined 2004 to 2011 DAWN data show that among children, aged 1 to 5, taken to the ED for accidental ingestion of opioid pain relievers, 71 percent were treated and released; 16 percent were admitted to the hospital for inpatient care, and 11 percent were transferred to another health care facility.

https://www.samhsa.gov/data/sites/default/files/report_3398/ShortReport-3398.html

Acute Drug Poisoning

In 2018 almost 17,000 instances of inpatient hospitalization or ED visits were recorded for acute drug poisoning (overdose), of which more than 2,500 (15 percent) were opioids other than heroin (Table 21). In the A-ROC service area, 606 instances of inpatient hospitalization or ED visits were recorded for acute drug poisoning (overdose), at least 79 were due to opioids other than heroin, but due to suppressed data a final count is not available. In Green County, 32 percent of all inpatient hospitalizations and ED visits due to acute drug poisonings were due to opioids other than heroin.

Drug-related Inpatient Hospitalizations and Emergency Department Visits (2018)												
Acute Drug Poisoning (Overdose)												
Source: Kentucky Injury Prevention and Research Center												
	Kentucky	Adair County	Casey County	Clinton County	Cumberland County	Green County	McCreary County	Pulaski County	Russell County	Taylor County	Wayne County	A-ROC Service Area
Any substance	16,795	45	57	9	15	25	43	204	46	123	39	606
Antidepressants	1,224	*	*	0	0	*	*	20	6	*	6	**
Benzodiazepines	1,482	9	5	0	*	5	8	22	5	7	6	**
Cocaine	279	0	*	0	0	0	0	0	0	*	0	**
Heroin	3,988	*	*	0	*	0	0	13	*	21	*	**
Opioids other than heroin (Total and percent of total)	2,511 15%	9 20%	8 14%	* **	0 0%	8 32%	10 23%	26 13%	6 13%	12 10%	* **	** **
Other specified and unspecified drugs	7,965	27	41	7	13	14	24	129	29	80	21	385
* Count of at least one but fewer than five was suppressed.												
** Unable to determine due to suppressed data.												

Table 21: Acute Drug Poisoning (Overdose) (2018)

Comorbid Infectious Diseases

Records of inpatient hospitalization or ED visits in Kentucky for patients with a drug overdose, abuse or dependence with various comorbid infectious diseases indicates that in 2018, 12,013 were for hepatitis C, 1,394 were for hepatitis A, 1,098 were for endocarditis, and 756 were for HIV (Table 22).

DEFINITION: Comorbidity:
 The simultaneous presence of two chronic diseases or conditions in a patient.

In the A-ROC service area, Pulaski County recorded the highest number of patients with a drug overdose, abuse or dependence with hepatitis C (170) and endocarditis (10). Taylor County recorded the highest number of patients with a drug overdose, abuse or dependence with hepatitis A (14) and tied with Pulaski County on the number of patients with a drug overdose, abuse or dependence with HIV (5).

Drug-related Inpatient Hospitalizations and Emergency Department Visits (2018)
 Comorbid Infectious Disease and Drug Overdose, Abuse or Dependence
 Source: Kentucky Injury Prevention and Research Center

	Kentucky	Adair County	Casey County	Clinton County	Cumberland County	Green County	McCreary County	Pulaski County	Russell County	Taylor County	Wayne County
Drug overdose, abuse or dependence with endocarditis	1,098	*	0	*	0	0	*	10	0	*	*
Drug overdose, abuse or dependence with hepatitis A	1,394	0	*	0	0	0	*	6	0	14	0
Drug overdose, abuse or dependence with hepatitis C	12,013	10	10	9	*	*	57	170	10	59	34
Drug overdose, abuse or dependence with HIV	756	0	0	*	0	0	0	5	0	5	0

*Count of at least one, but fewer than five suppressed

Table 22: Comorbid Infectious Disease and Drug Overdose, Abuse or Dependence (2018)

DEFINITIONS

Endocarditis: Infection of the hearts lining, usually involving the heart valves.

Hepatitis A: Highly contagious liver infection caused by the hepatitis A virus.

Hepatitis C: Infection caused by a virus that attacks the liver and leads to inflammation.


ARTICLE: Common Comorbidities

People with substance use disorders are at particular risk for developing one more primary conditions or chronic diseases. When primary conditions simultaneously co-occur with substance use disorders, they are referred to as comorbidities.

<https://www.samhsa.gov/medication-assisted-treatment/treatment/common-comorbidities>

Drug Overdose Deaths

COMMONWEALTH OF KENTUCKY
JUSTICE & PUBLIC SAFETY CABINET



2018 Overdose Fatality Report
KENTUCKY OFFICE OF DRUG CONTROL POLICY

John C. Tilly, Secretary
Justice & Public Safety Cabinet
Van Ingram, Executive Director
Office of Drug Control Policy

Substance abuse, particularly the diversion and abuse of prescription drugs, along with heroin and illicit fentanyl, remains one of the most critical public health and safety issues facing Kentucky. Over the past decade, the number of Kentuckians who die from drug overdoses has steadily climbed to more than 1,000 each year, exacting a devastating toll on families, communities, social services, economic stability and growth.

In an effort to reverse the trend, the Commonwealth has implemented a number of program and policy initiatives, including, but not limited to, the statewide use of prescription drug monitoring programs, expanded availability of substance abuse treatment opportunities, and the enactment of laws (House Bill 1 from the 2012 Special Session and House Bill 217 from the 2013 Regular Session) specifically addressing the availability of prescription medications. Senate Bill 192 in the 2015 session increased penalties for traffickers and included a number of harm-reduction measures aimed at reducing overdose deaths.

According to the [2018 Overdose Fatality Report](#), in 2018, 1,247 Kentucky residents died due to a drug overdose, a 15 percent decrease from the 1,477 fatalities counted in 2017. The majority of overdose deaths were for those ages 35-44, followed by 25-34 and 45-54. The top five counties for resident overdose deaths (age-adjusted by capita) were Boyd, Madison, Kenton, Clark and Campbell Counties. Table 23 illustrates the number of drug overdose deaths by decedent's county of residence. Within the A-ROC service area, the number of overdose deaths increased in Russell County and decreased in Casey, Cumberland, Pulaski, and Wayne Counties from 2017 to 2018.

Count of Drug Overdose Deaths			
Source: KY Office of Drug Control Policy			
	2017	2018	Age Adjusted Drug Overdose Mortality Rate (2018)
Adair County	<5	<5	Suppressed
Casey County	6	5	Suppressed
Clinton County	<5	<5	Suppressed
Cumberland County	<5	0	0.0
Green County	<5	<5	Suppressed
McCreary County	<5	<5	Suppressed
Pulaski County	13	10	16.65
Russell County	<5	6	Suppressed
Taylor County	8	8	Suppressed
Wayne County	5	<5	Suppressed

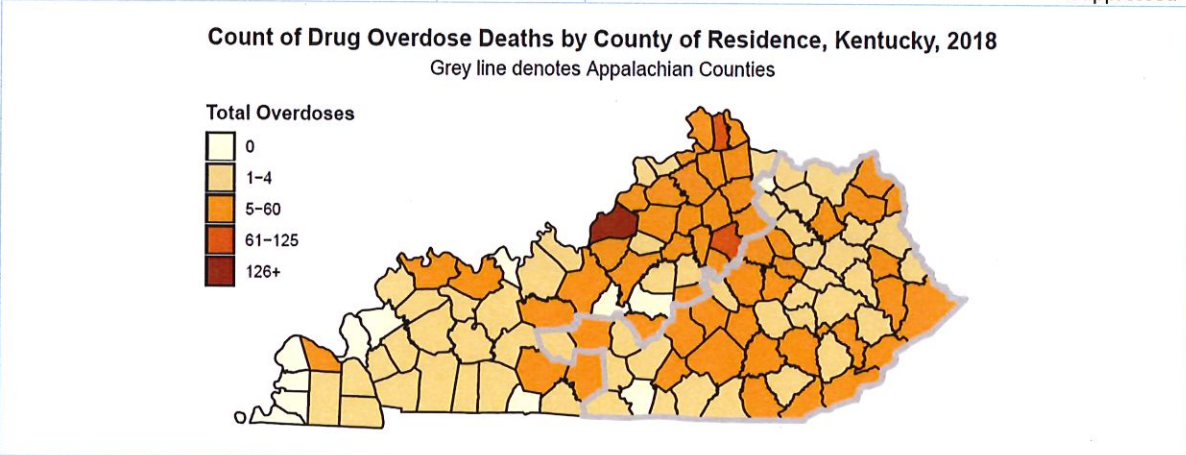


Table 23: Drug Overdose Deaths (2017-18)

Opioid Overdose Mortality Rate

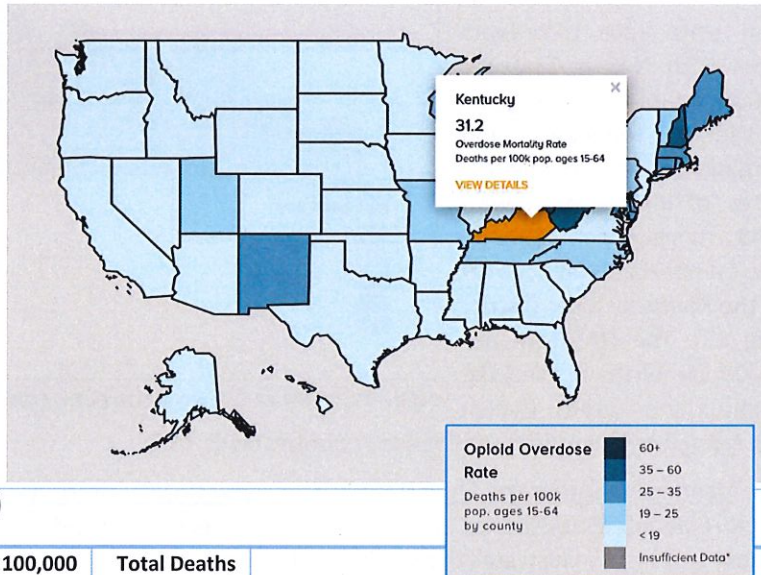
The [National Opioid Research Center \(NORC\) at the University of Chicago](#) is an objective, non-partisan research institution that delivers reliable data and rigorous analysis to guide critical programmatic, business, and policy decisions. Since 1941, NORC has conducted groundbreaking studies, created and applied innovative methods and tools, and advanced principles of scientific integrity and collaboration. Today, government, corporate, and nonprofit clients around the world partner with NORC to transform increasingly complex information into useful knowledge.

NORC has created an interactive data tool reporting on the drug overdose mortality rates by state and county.

1. <https://opioidmisusetool.norc.org>: This resource reports on data for all states and counties
2. <http://overdosemappingtool.norc.org>: This resource reports on data for states and counties in Appalachia

Data Source	
Opioid Overdose Mortality Rate	CDC NCHS NVSS – Multiple cause of death data – (2008-2012; 2013-2017)
Age-adjusted mortality rate for population, aged 15 to 64. Underlying cause-of-death codes: X40-X44, X60-X64, X85, and Y10-Y14. Multiple cause-of-death codes: T40.0, T40.1, T40.2, T40.3, T40.4, T40.6.	
*Note: There are variations in reporting across states for the ICD-10 codes on contributing causes. Therefore, these estimates should be used with caution.	

Based on 2013-17 data reported on the mapping tool, the opioid overdose mortality rate per 100,000 in the United States was 16.4, while the rate in Kentucky was 31.2. In the A-ROC service area, the actual opioid overdose mortality rate per 100,000 was calculated for Pulaski County (18.2) and Russell County (41.9). The crude mortality rate was calculated for six of the counties. Total deaths were suppressed for four of the 10 counties in the service area.



Opioid Overdose Mortality Rate (2013-17)

Source: NORC at the University of Chicago

	Deaths Per 100,000 Population (Ages 15-64)	Total Deaths
Adair County	<14.3*	Suppressed
Casey County	22.3*	11
Clinton County	55.9*	18
Cumberland County	Insufficient Data	Suppressed
Green County	Insufficient Data	Suppressed
McCreary County	<15.1*	Suppressed
Pulaski County	18.2	33
Russell County	41.9	24
Taylor County	23.5*	19
Wayne County	16.7*	11

*For counties with fewer than 10 recorded deaths over the five-year period, the number of deaths is suppressed. However, we calculated the maximum crude mortality rate, which is provided above.

Note: There are variations in reporting across states for the ICD-10 codes on contributing causes. Therefore, these estimates should be used with caution.

Figure 16: Opioid Overdose Mortality Rate (2013-17)

Maternal and Prenatal Exposure

Neonatal Abstinence Syndrome (NAS)

NAS or neonatal opioid withdrawal syndrome (NOWS) may occur when a pregnant woman uses drugs such as opioids during pregnancy. A recent national study revealed a fivefold increase in the incidence of NAS/NOWS between 2004 and 2014, from 1.5 cases per 1,000 hospital births to 8 cases per 1,000 hospital births. This is the equivalent of one baby born with symptoms of NAS/NOWS every 15 minutes in the United States. During the same period, hospital costs for NAS/NOWS births increased from \$91 million to \$563 million, after adjusting for inflation.

<https://www.drugabuse.gov/opioid-summaries-by-state/kentucky-opioid-summary>

The [2016 Neonatal Abstinence Syndrome \(NAS\) in Kentucky](#) report states that the number of newborns per 1,000 with NAS increased 24-fold since 2001, from 46 in 2001 to 1,115 in 2016.^{xxvi}

The state rate of infants born with NAS is 23.3 per 1,000 infants. The regions bordering Tennessee and Virginia report the highest rates of infants born with NAS, ranging from 62.9 in the Cumberland Valley to 69 in the Kentucky River district (Fig 17). The NAS rate per 1,000 live births in the Lake Cumberland area (which encompasses the A-ROC service area counties) was 34.7.

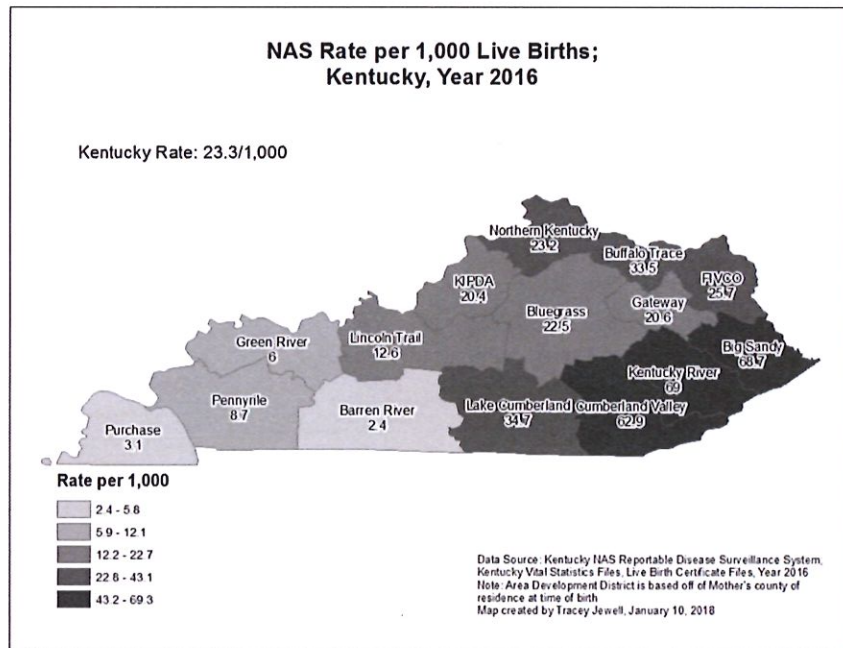


Figure 17: NAS Rate per 1,000 Live Births (2016)

The [Vanderbilt Center for Child Health Policy and RAND Corporation](#) has created an interactive tool to explore neonatal abstinence syndrome rates in select states and counties in the United States. Figure 18 below graphically illustrates the significant NAS rate increases in Kentucky from 2009 to 2015. In 2009 the mean NAS rate per 1,000 hospital births was 10.66; this rate increased to 43.79 in 2015.

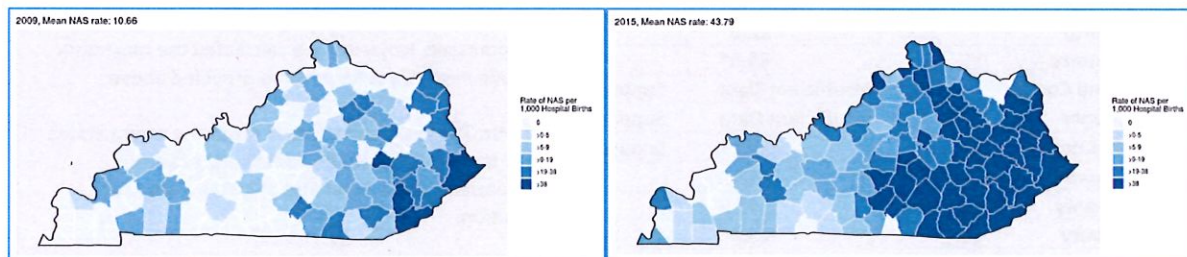


Figure 18: NAS Rates by County (2009 and 2015)

Based on data collected, the NAS rates per 1,000 births in the A-ROC service area in 2015 ranged from 0 in Clinton County to 81.34 in McCreary County (Table 24).

Neonatal Abstinence Syndrome Rates (2015)	
<i>Source: Vanderbilt Center for Children Health Policy and RAND Corporation</i>	
McCreary County	81.34
Russell County	75.83
Taylor County	62.89
Pulaski County	61.50
Casey County	52.98
Adair County	43.48
Green County	29.41
Wayne County	27.78
Cumberland County	14.29
Clinton County	0

Table 24: NAS Rates (2015)

DEFINITION: Neonatal Abstinence Syndrome (NAS): A group of conditions caused when a baby withdraws from certain drugs he's exposed to in the womb before birth.

ARTICLE: Infants with Prenatal Substance Exposure.

Each year, an estimated 15 percent of infants are affected by prenatal alcohol or illicit drug exposure. Prenatal exposure to alcohol, tobacco, and illicit drugs has the potential to cause a wide spectrum of physical and developmental challenges for these infants. There is also potential for ongoing challenges in the stability and well-being of infants who have been prenatally exposed, as well as their families, if substance use disorders are not addressed with appropriate treatment and long-term recovery support. The intersection of pregnancy and substance use creates a need for a collaborative approach among medical, substance use, child welfare, and early childhood providers to address the multifaceted needs of the mother, infant, and family. Coordinated services and early intervention for pregnant women with substance use disorders and their infants are critical in preparing families for optimal bonding, health, and well-being.

<https://ncsacw.samhsa.gov/resources/substance-exposed-infants.aspx>

Inpatient Hospitalizations and Emergency Department (ED) Visits: NAS

In 2018, 1,181 instances of inpatient hospitalization or ED visits were recorded for neonatal abstinence syndrome in Kentucky (Table 25). In the A-ROC service area, at least 86 inpatient hospitalization or ED visits were recorded for neonatal abstinence syndrome, of which 25 (29 percent) were in Pulaski County and 22 (26 percent) were in Taylor County.

Drug-Related Inpatient Hospitalizations and Emergency Department Visits (2018)	
Neonatal Abstinence Syndrome	
<i>Source: Kentucky Injury Prevention and Research Center</i>	
Kentucky	1,181
Adair County	11
Casey County	13
Clinton County	Not reported
Cumberland County	*
Green County	6
McCreary County	9
Pulaski County	25
Russell County	16
Taylor County	22
Wayne County	8

* Count of at least one but fewer than five was suppressed.

Table 25: Neonatal Abstinence Syndrome (2018)

March of Dimes

Can opioids cause problems for your baby during pregnancy and after birth?

Yes. Using opioids during pregnancy may cause problems for your baby, including:

- **Miscarriage.** This is when a baby dies in the womb before 20 weeks of pregnancy.
- **Preterm labor and premature birth.** Preterm labor is labor that starts too early, before 37 weeks of pregnancy. Preterm labor can lead to premature birth. This is when your baby is born before 37 weeks of pregnancy. Babies born early may have more health problems at birth and later in life than babies born full term.
- **Birth defects,** including **heart defects** and **spina bifida.** Birth defects are health conditions that are present at birth. Birth defects change the shape or function of one or more parts of the body. They can cause problems in overall health, how the body develops, or in how the body works. Spina bifida is the most common **neural tube defect** (also called NTD). Neural tube defects are birth defects of the brain and spinal cord.
- **Fetal growth restriction** (also called growth-restricted, small for gestational age and small for date). This means a baby doesn't gain the weight she should before birth.
- **Low birthweight** (also called LBW). This is when a baby is born weighing less than 5 pounds, 8 ounces.
- **Neonatal abstinence syndrome** (also called NAS). NAS is when a baby is exposed to a drug in the womb before birth and goes through withdrawal from the drug after birth. NAS is most often caused when a woman takes opioids during pregnancy. NAS can cause serious problems for a baby, like being born too small and having breathing problems. Even if you use an opioid exactly as your health care provider tells you to, it may cause NAS in your baby. So tell your prenatal care provider about any opioid you take, even if it's prescribed to you by another health care provider. If another health care provider prescribes you an opioid, make sure she knows you're pregnant.

Low Birthweight Babies

Between 2012 and 2016, according to KentuckyHealthFacts.org, 9 percent of all births in Kentucky had a low birthweight. In the A-ROC service area, between 7 and 11 percent of births were babies with low birthweight (Fig 19).

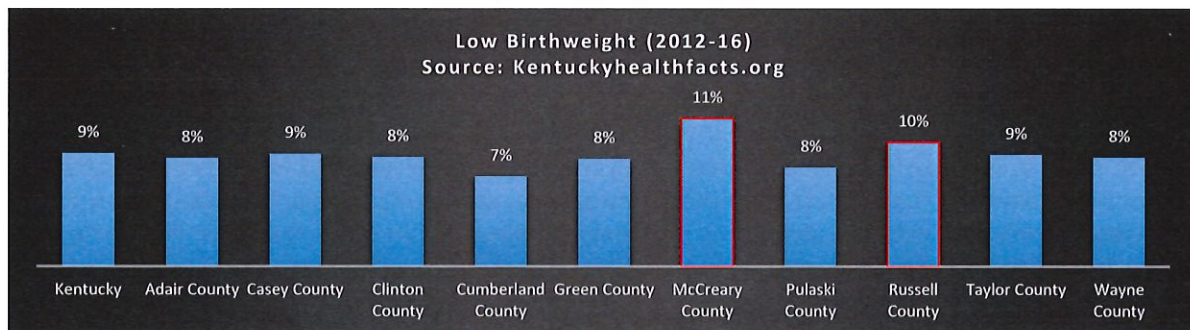


Figure 19: Low Birthweight (2012-16)

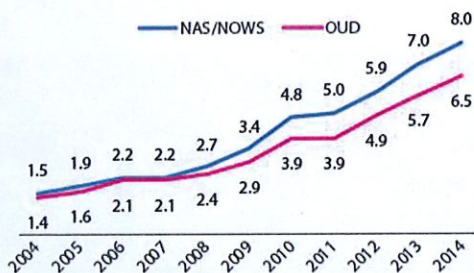
DRAMATIC INCREASES IN MATERNAL OPIOID USE DISORDER AND NEONATAL ABSTINENCE SYNDROME

Opioid use during pregnancy can result in a drug withdrawal syndrome in newborns called **neonatal abstinence syndrome**, or **neonatal opioid withdrawal syndrome** (NAS/NOWS), which causes **costly** hospital stays. A recent analysis showed that an estimated **32,000** babies were born with this syndrome in the United States in 2014, a more than **5-fold increase** since 2004.

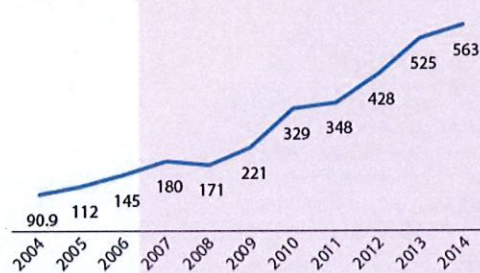


**EVERY ~ 15 MINUTES,
 A BABY IS BORN SUFFERING
 FROM OPIOID WITHDRAWAL.**

**NAS/NOWS and Maternal
 Opioid Use Disorder on the Rise**
 Rates per 1,000 Hospital Births



**Growing Hospital Costs for
 Treatment of NAS/NOWS**
 Inflation-Adjusted U.S. Dollars (millions)

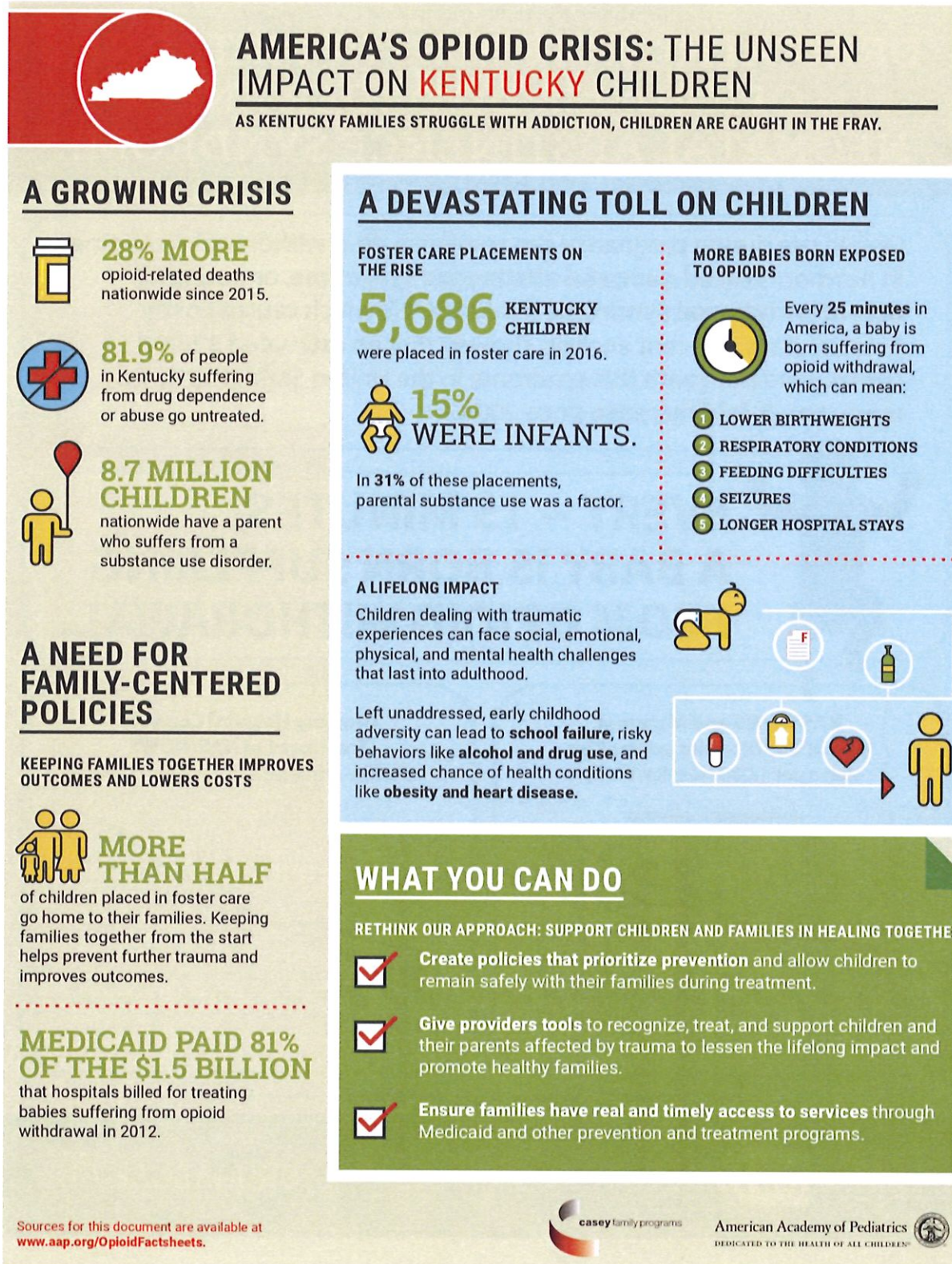


Honein et al. Pediatrics 2019, Winkelman et al. Pediatrics 2018, Haight et al. MMWR 2018.

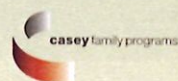


National Institute
 on Drug Abuse

DRUGABUSE.GOV



Sources for this document are available at www.aap.org/OpioidFactsheets.



American Academy of Pediatrics
 DEDICATED TO THE HEALTH OF ALL CHILDREN®

Mental Health Clinician Shortage, Long-Term Unemployment associated with Neonatal Abstinence Syndrome*

*Neonatal Abstinence Syndrome (NAS) is a withdrawal syndrome experienced by some opioid-exposed infants after birth.

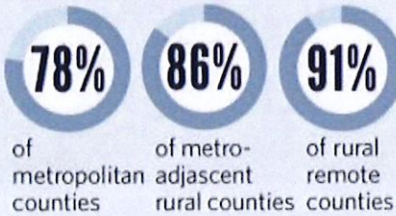


Based on
 county-level
 data from
8 states



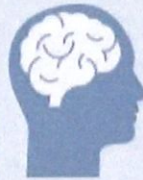
Rates of NAS
 increased from
3.2 to 14.5
 per 1000 hospital births
 from 2009-2015

MENTAL HEALTH



IN OUR STUDY
 had a
 shortage of mental
 health providers

Counties with a
 shortage of mental
 health providers
 were associated with
 higher rates of NAS



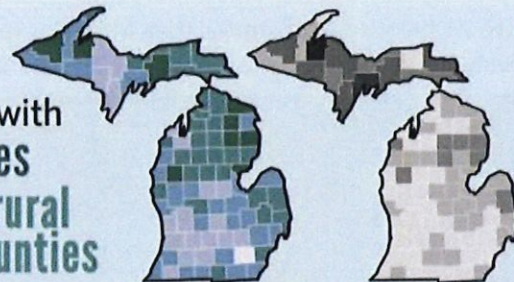
Adjusted IRR, 1.17

ECONOMIC FACTORS

From 2009-2015
 the 10-year
 unemployment
 rate increased
 from **6.5%**
 to **8.2%**

and was
 associated with
 higher rates
 of NAS in rural
 remote counties

Adjusted IRR, 1.34



UNEMPLOYMENT RATE
 10-year moving average

RATE OF NAS
 per 1000 hospital births

>4-6 >12

0 >100



In rural
 remote
 counties,
 a higher proportion
 of manufacturing jobs
 WAS ASSOCIATED WITH
 higher rates of NAS

Adjusted IRR, 1.06



County
 macroeconomic
 conditions affect
 rates of NAS,
 especially in
 rural counties

POLICYMAKERS
 should consider
 economic
 development
 as a HEALTH
 INTERVENTION

Patrick, S.W., Fanerly, L.J., Dick, A.W., Scott, T.A., Dudley, L., Stein, B.D. (2019) Association Among County-Level
 of Economic Factors, Clinician Supply, Metropolitan or Rural Location, and Neonatal Abstinence Syndrome.
 Journal of the American Medical Association, XXX, doi:10.1001/jama.2019.10000

Supported by The National Institute on Drug Abuse & The National Institute for Health Care Management
 @VUMCchildpolicy • To explore NAS in your county, visit www.childpolicy.org/nas



VANDERBILT
 Center for
 Child Health Policy



Socioeconomic Effects of Opioid Use

Impact on Workforce

In Kentucky, on average the labor force comprises 2 million individuals, of which approximately 1.8 to 1.9 million are employed. Based on data collected from the [Bureau of Labor Statistics](#), the unemployment rate over the past 10 years has dropped steadily from its peak in 2010, at 10.6 percent, to a rate of 4.2 percent in 2019 (Fig 20).

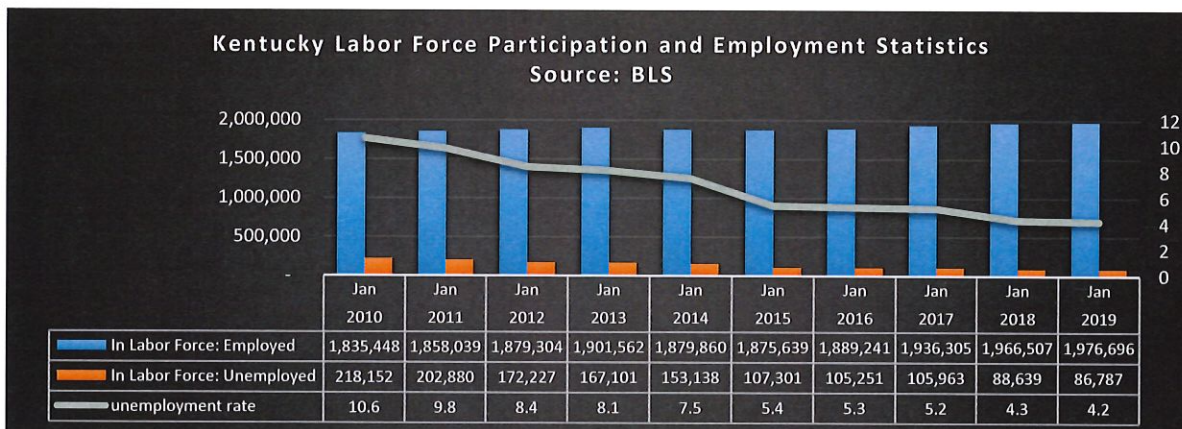


Figure 20: Kentucky Labor Force and Employment Statistics (2010-19)

Figure 21 below demonstrates that while the total labor participation rate (employed and unemployed individuals) dipped below 2 million in 2015 and 2016, since then it has steadily increased.

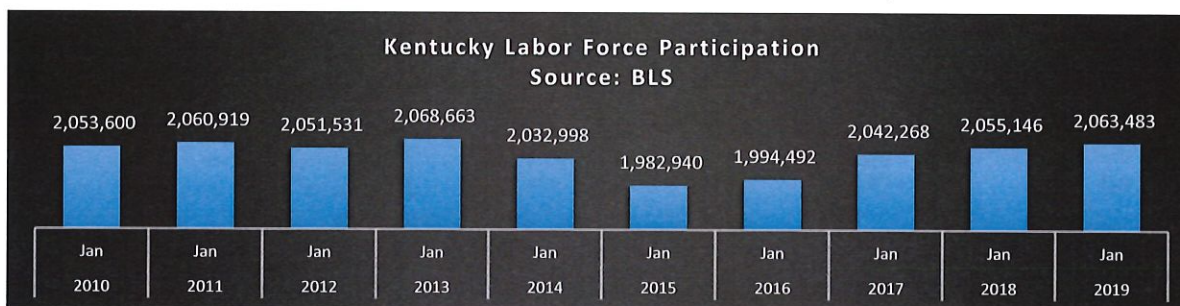


Figure 21: Kentucky Labor Force Participation (2010-19)

A recent study completed by the [University of North Carolina at Chapel Hill Kenan-Flagler School of Business](#) in March 2019 found that the opioid epidemic greatly impacts employment by pulling eligible workers out of the labor force, causing employers and companies to turn to technology and automatization to compensate for the lack of available and qualified workers.^{xxvii} The study found that the increase in automation was greater in companies and firms that rely more heavily on low-skilled workers, a group of individuals most impacted by the opioid crisis.

In their paper, [Opioids and the Labor Market](#), researchers Dionissi Aliprantis and Mark E. Schweitzer found that there is a negative link between opioid prescriptions and labor force participation, meaning that areas with higher opioid prescriptions show a reduction in labor force participation.^{xxviii}

Business struggles.

The opioid crisis is undermining businesses in multiple ways, including compromised workplace safety, lower productivity, higher turnover and lost institutional knowledge, said Rachael Cooper, senior program manager of Opioid Use Harm Prevention at the National Safety Council.

Employees who misuse opioids may compromise workplace safety in manufacturing, construction and other industries, but even if employees take opioids as prescribed, they can be impaired, she said, because the drugs slow a patient's central nervous system and reaction time.

<https://insiderlouisville.com/economy/opioid-crisis-harming-businesses-few-have-answers/>

One industry hit particularly hard by the opioid epidemic is the construction industry. Barclays Research found that the risk of developing an addiction to opioids is six times higher for employees who work in construction than for individuals in other industries. The types of daily tasks associated with the construction industry increase the risk of injury, and it has become common practice for opioids to be prescribed to treat the pain associated with these injuries. However, as construction workers return to workday after day, it is often difficult for their bodies to sufficiently heal and for pain to naturally subside. Resultantly, opioid-related pain management can seem like the only option for some whose jobs require the physical strain of manual labor. Construction workers, not wanting to lose their jobs and needing for pain to be manageable in order to keep working, find themselves in a cycle that, for many, leads to opioid addiction. Moreover, when a worker experiencing pain can only get through a workday by managing it with the use of opioids, this can pose additional dangers. With reaction times reduced and central nervous systems compromised, those operating machinery or engaged in other potentially dangerous tasks while under the influence of opioids are in danger of further injuring themselves or other workers.^{xxix}

People are dying.

They're dying across the country — an average of more than 130 people a day amid the deadliest U.S. drug epidemic in the modern era. But the fast-spreading opioid crisis has taken an especially large toll in Kentucky, where Ford Motor Co. has nearly 14,000 workers at two of its biggest assembly plants.

It's just a matter of statistics, UAW Local 862 President Todd Dunn says, that the casualties include some of those workers and their families.

"When you look at the Kentucky Truck Plant, you basically have two aircraft carriers' worth of people," Dunn told *Automotive News*. "There's not one person that's not touched in some way or another from opioid use, opioid death, suicide or overdose."

More help preventing and treating opioid misuse is high on the UAW's agenda for this year's contract negotiations with the Detroit 3.

"The issue demands that we get involved, and it demands that we set an example of combating it in a positive way — the union and the company," UAW Vice President Rory Gamble, whose granddaughter died of an opioid overdose in January, told *Automotive News*. "We have to grab this thing and address it now."

<https://www.autonews.com/automakers-suppliers/treating-deadly-opioid-epidemic-top-concern-uaw>

Medical Cost

According to an analysis conducted earlier this year by [Premier Safety Institute](#), the opioid crisis has cost the medical industry upward of \$1.94 billion in annual hospital costs. Many of these costs are directly and indirectly related to patient care, including naloxone use for overdoses, emergency room visits, subsequent inpatient care costs, and the increased risk of acquiring other diseases which require longer-term medical care. The majority of these costs are disproportionately covered by government programs, such as Medicare and Medicaid.^{xxx}

Furthermore, according to [Altarum](#), a nonprofit health research and consulting institute, the crisis could cost an additional \$500 billion by 2020. Their assessment is that “greatest cost comes from lost earnings and productivity from overdose deaths – estimated at \$800,000 per person, based on an average age of 41 among overdose victims.” However, per their study, individuals not only lose in the form of wages and productivity but also in healthcare costs and even death. The private sector loses through productivity and health care costs, and federal, state and local governments also lose through health care costs and a multitude of social and public services.

According to [Kentucky Health News](#) and the [Lexington Herald-Leader](#), in April of this year, “the cost of opioid-related treatment at the University of Kentucky rose 733 percent, and the number of opioid patients rose 481 percent.” Hospital treatment costs for opioid-related medical issues went up more than 700 percent from 2009-2018, with an estimated cost of \$7.6 million. Additionally, patients with diagnoses such as hepatitis C increased 481 percent, at a cost of \$63.3 million. Again, the burden of this has fallen mainly on Medicaid and Medicare. Linda Blackford, writing for the *Lexington Herald-Leader* states, “figures from the Kentucky Cabinet for Health and Family Services show that 63,000 Kentucky Medicaid patients were diagnosed with opioid use disorder in 2018. The agency estimates the annual per capita cost to treat each of those patients tops \$15,000. Using a conservative estimate, that’s almost \$1 billion a year from federal and state coffers. The federal government pays 75 to 80 percent of the cost.”^{xxxi}

Crime Rates

According to the [Crime in Kentucky Report issued by the Kentucky State Police](#), more than 280,000 crimes were reported in 2017, of which more than 66,000 crimes (23 percent) were drug/narcotic offenses.^{xxxii} Taylor County reported the highest number of drug/narcotic offenses in 2017 with 267. Cumberland County reported the highest proportion of drug/narcotic offenses, at 67 percent (Table 26).

Crime in Kentucky, Commonwealth of Kentucky 2017 Crime Report: Kentucky State Police			
	Total	Drug/Narcotic Offenses	
		Total	Percent of Total
Kentucky	282,360	66,157	23%
Adair County	235	129	55%
Casey County	61	18	30%
Clinton County	229	123	54%
Cumberland County	60	40	67%
Green County	108	50	46%
McCreary County	313	116	37%
Pulaski County	58	18	31%
Russell County	362	166	46%
Taylor County	697	267	38%
Wayne County	118	44	37%

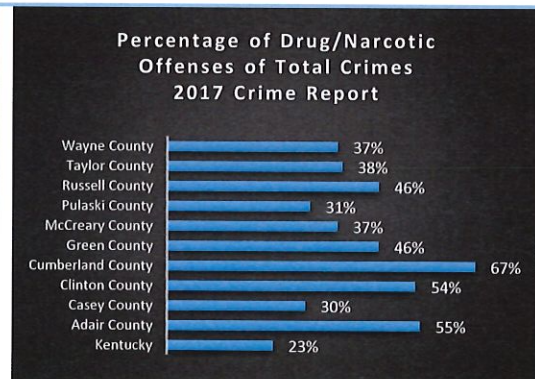


Table 26: Number of Reported Crimes by Type of Crime (2017)

Effects of Opioid Use on Child Welfare

Child Abuse and Neglect

In 2018, 68 percent of child victims of abuse or neglect in Kentucky were documented as having a substance abuse risk factor, up from 67 percent in 2017. Figure 22 illustrates the upward trend of substance abuse as a risk factor in abuse/neglect cases from 2014 to 2018.^{xxxiii}

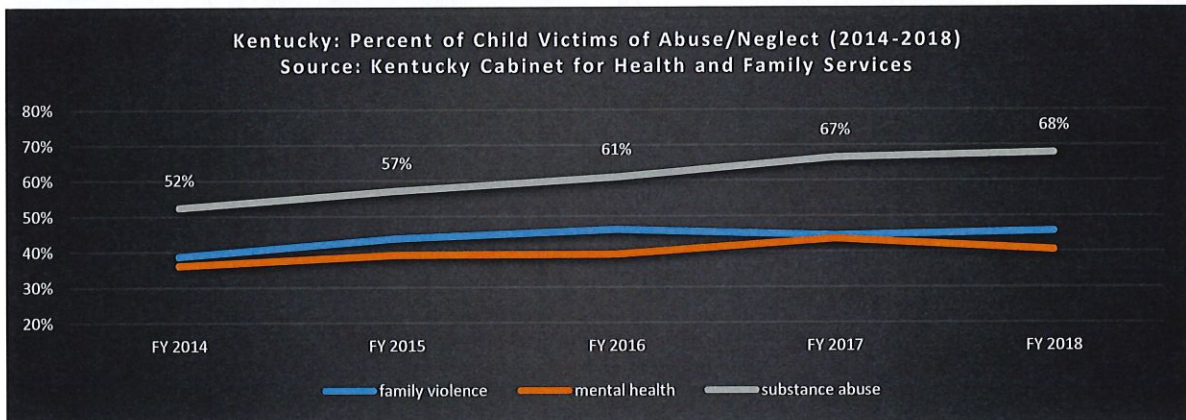


Figure 22: Percent of Child Victims of Abuse/Neglect by Risk Factor (2014-18)

Annie E. Casey Foundation: Kids Count Data Center

Definitions: Percent of child victims of neglect, physical abuse or sexual abuse that had alcohol or substance abuse, mental health, or family violence issues as a present risk factor in their case.

Data Source: Kentucky Cabinet for Health and Family Services, Department for Community Based Services.

Footnotes: Each substantiated case could have more than one risk factor present. Percentages for the state as a whole reflect the county average for a given risk factor.

In A-ROC service area, between 50 percent (Adair County) and 79 percent (Green County) of child victims of abuse/neglect were documented to have a substance abuse risk factor. All counties experienced an increase in the child victims of abuse/neglect with a substance abuse risk factor from 2016 to 2017. All counties, with the exception of Taylor County, experienced a decrease of child victims of abuse/neglect with a substance abuse risk factor from 2017 to 2018 (Fig 23 to 27).

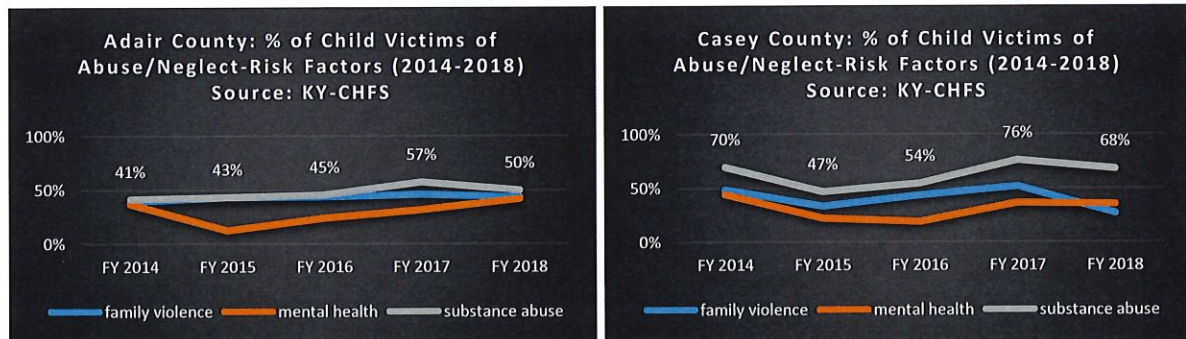


Figure 23: Adair and Casey Counties: Percent of Child Victims of Abuse/Neglect by Risk Factor (2014-18)

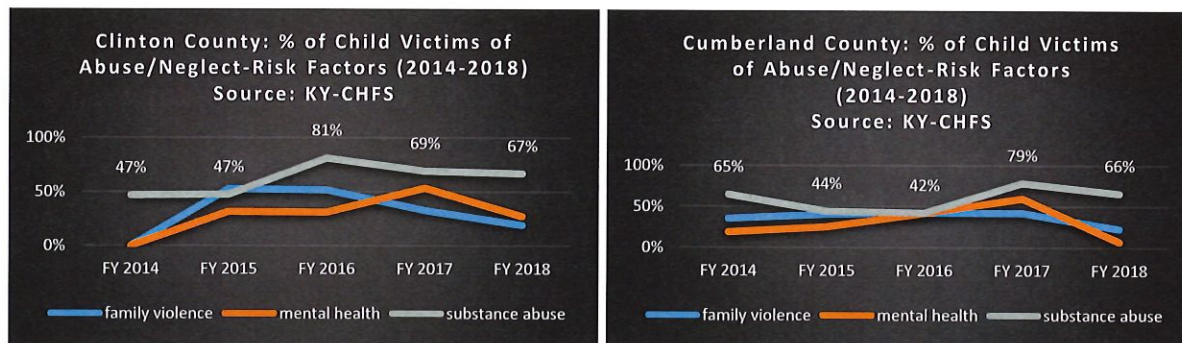


Figure 24: Clinton and Cumberland Counties: Percent of Child Victims of Abuse/Neglect by Risk Factor (2014-18)

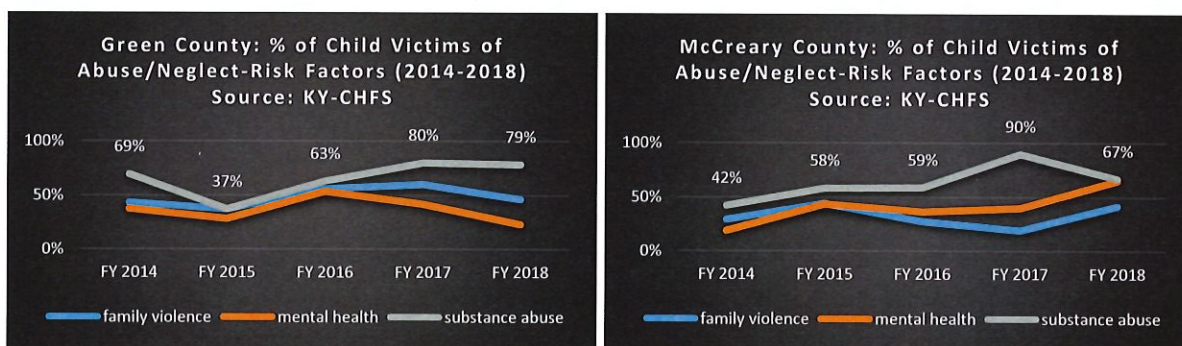


Figure 25: Green and McCreary Counties: Percent of Child Victims of Abuse/Neglect by Risk Factor (2014-18)

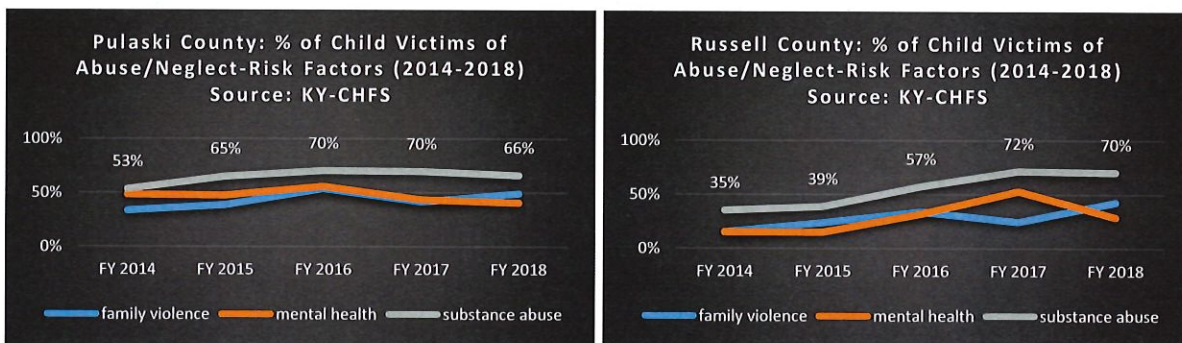


Figure 26: Pulaski and Russell Counties: Percent of Child Victims of Abuse/Neglect by Risk Factor (2014-18)

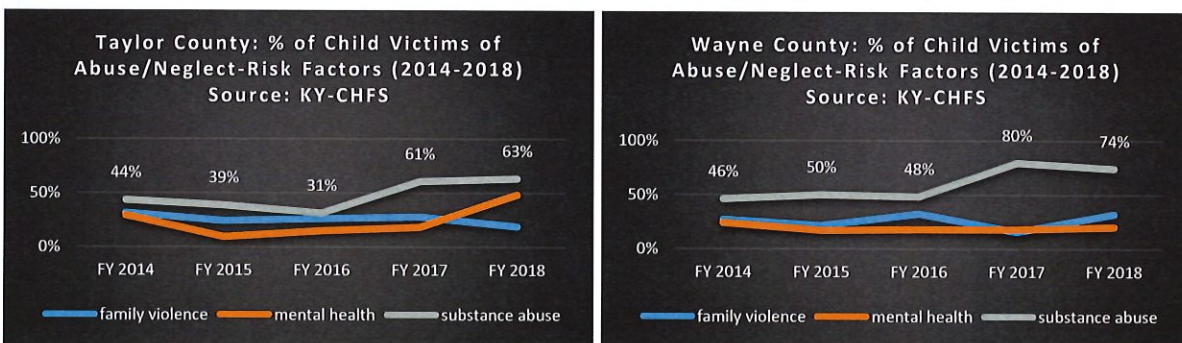


Figure 27: Taylor and Wayne Counties: Percent of Child Victims of Abuse/Neglect by Risk Factor (2014-18)

Foster Care

[The Opioid Epidemic's Effect on Kentucky Children & How You Can Help](#)

Kentucky Foster Care and the Opioid Epidemic

From 2012 to 2015, the percentage of removals of children from their homes that cited parental substance use as a contributing factor increased 13 percent (from 28.5 percent in 2012 to 32.2 percent in 2015). Compared with all other reasons for children being removed from the home, this was the largest percentage increase. Additionally, Kentucky has reported an increase in children entering foster care faster than they are leaving. The numbers speak volumes, as there are now more than 8,000 children in foster care in Kentucky, compared to 6,000 children four years ago.

Kentucky has the highest rate of children placed in kinship care in the country. While it's important to keep children in foster care with relatives and other familiar caregivers whenever safely possible, the opioid crisis has made this more difficult to accomplish. This is because opioids can affect entire neighborhoods and families when introduced to a region, making kinship care difficult to achieve. The result is a much greater need for people willing to become foster parents. Foster parents provide a safe, loving home for a child while his/her parents overcome challenges and learn healthy skills so the child can safely return home.

70,000 children in Kentucky aren't living with their parents. The opioid crisis has compounded this number even more. Child homelessness in Kentucky is the highest in the nation, largely due to the number of opioid overdoses. After Harlan County in eastern Kentucky was devastated by the recession, many turned to opioids. Opioid addiction hasn't abated, and now the county reports 26 percent of children as homeless.

<https://kentucky.kvc.org/2017/02/20/the-opioid-epidemics-effect-on-kentucky-children-how-you-can-help/>

Based on U.S. Census data, 1.7 percent of all children under age 18 in households in the United States is a foster child and/or in homes where they are unrelated to the householder, a total of 1.2 million children. In Kentucky more than 23,000, or 2.3 percent, of children under age 18 are either foster children or otherwise unrelated to the head of household. In the A-ROC service area, Pulaski and Russell Counties report the highest proportion of children under age 18 as foster children or otherwise unrelated to the head of household, 2.8 and 2.7 percent, respectively.

Population Under 18 Years in Households

Source: 2017 ACS 5-Year Estimates

	Total	Foster child or other unrelated child		Total	Foster child or other unrelated child
United States	73,356,237	1,257,366	Green County	2,347	26
Kentucky	1,008,766	23,690	McCreary County	3,924	79
Adair County	3,788	69	Pulaski County	14,261	399
Casey County	3,537	68	Russell County	3,994	106
Clinton County	2,249	0	Taylor County	5,650	70
Cumberland County	1,466	27	Wayne County	4,566	72

Percent of Children < 18 in Households: Foster Child/Other Unrelated Child Source: 2017 ACS 5-Year Estimates

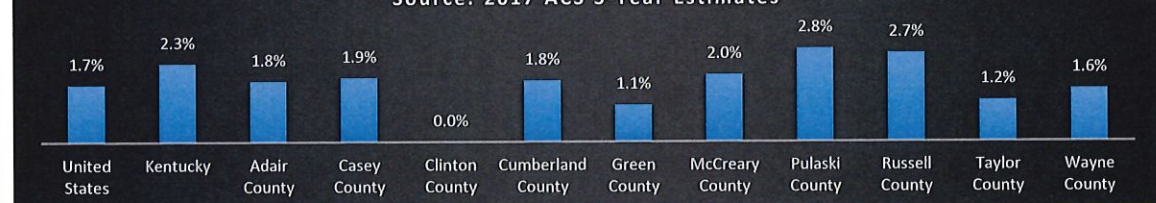


Figure 28: Foster Child/Other Unrelated Child in Household (2017 ACS 5-Year Estimates)

NOTE: The U.S. Census data reports a significantly lower number of foster or unrelated children than the [KVC Kentucky](#) article above. This census data is an average of five years and may not include children counted in the study above. Census data is included in order to compare geographic locations to one another.

Based on data collected from the [Annie E Casey Kids Count](#) database, provided by the [Kentucky Cabinet for Health and Family Services, Department for Community Based Services](#), the rate per 1,000 children ages 0-17 in foster care due to abuse or neglect in Kentucky was 47.3 (from 2016-18). Within the A-ROC service area, McCreary County reported the highest rate of children in foster care, 90.9 per 1,000 children ages 0-7 while Green County reported the lowest rate, 28.8 (Table 27).

Children in foster care (3-year) in Kentucky (2016-18) (Rate per 1,000 children ages 0-17)* Source: Annie E Casey Kids Count	
Kentucky	47.3
McCreary County	90.9
Pulaski County	60.5
Russell County	54.2
Adair County	49.3
Clinton County	47.7

Children in foster care (3-year) in Kentucky (2016-18) (Rate per 1,000 children ages 0-17)* Source: Annie E Casey Kids Count	
Wayne County	40.4
Taylor County	36.3
Cumberland County	29.6
Casey County	29.0
Green County	28.8

Table 27: Children in foster care (3-year) (2016-18)

*NOTE: Out-of-home care includes placements with licensed foster homes with relatives or unrelated caregivers, or institutional placements such as group homes and residential treatment facilities. Data are collected to reflect the county of the case manager's office. The numerator for the rate calculation is the sum of three years of data. The denominator for the rate calculation is the midpoint year child population estimate.

The Kids Count database also reports on the number of children in out-of-home care by year. In Kentucky, there were more than 17,000 children out-of-home care, up from almost 15,891 in 2017 and 14,592 in 2016. The number of children in out-of-home care increased from 2016 to 2018 in Adair, Clinton, Pulaski and Russell Counties (Table 28).

Children in Out-of-Home Care in Kentucky Source: Annie E Casey Kids Count			
	2016	2017	2018
Kentucky	14,592	15,891	17,362
Adair County	37	61	98
Casey County	42	34	27
Clinton County	31	33	47
Cumberland County	15	12	16
Green County	17	31	19
McCreary County	106	126	113
Pulaski County	150	210	514
Russell County	57	62	99
Taylor County	68	63	76
Wayne County	56	40	77

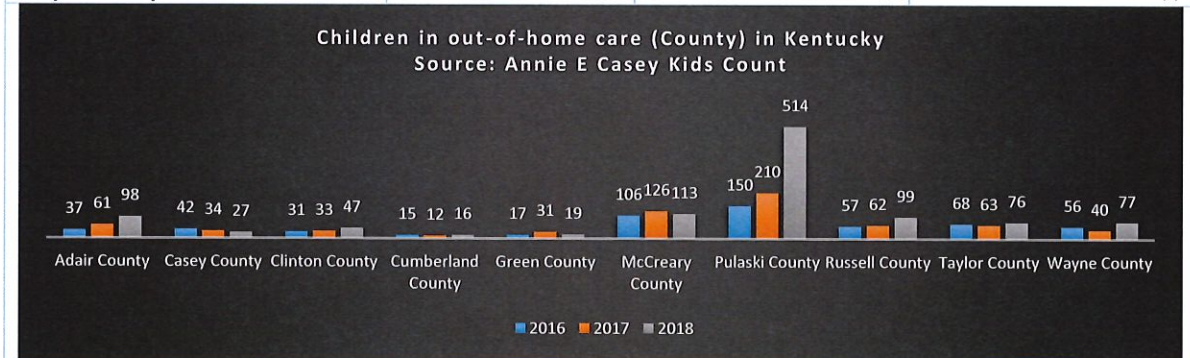


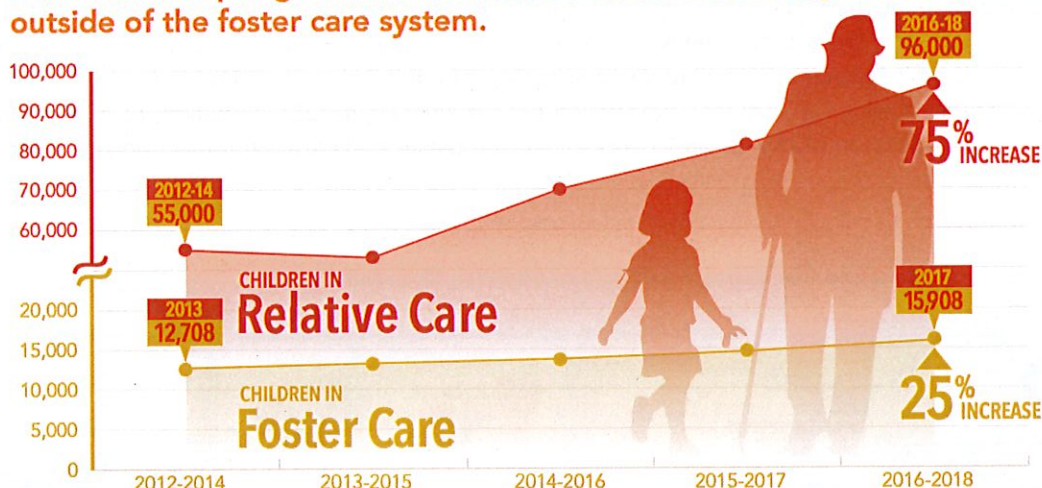
Table 28: Children in out-of-home care in Kentucky



Family & Community

All children need safe homes and loving families to thrive. When children cannot remain in their parents' care – due to parental substance abuse or incarceration, the military deployment or death of a parent, or experiencing child maltreatment – grandparents and other relatives often step up to raise them. This has become even more true as the addiction crisis permeates Kentucky.

The number of Kentucky children in foster care has reached a record high, with even steeper growth in the number of children being raised by relatives outside of the foster care system.

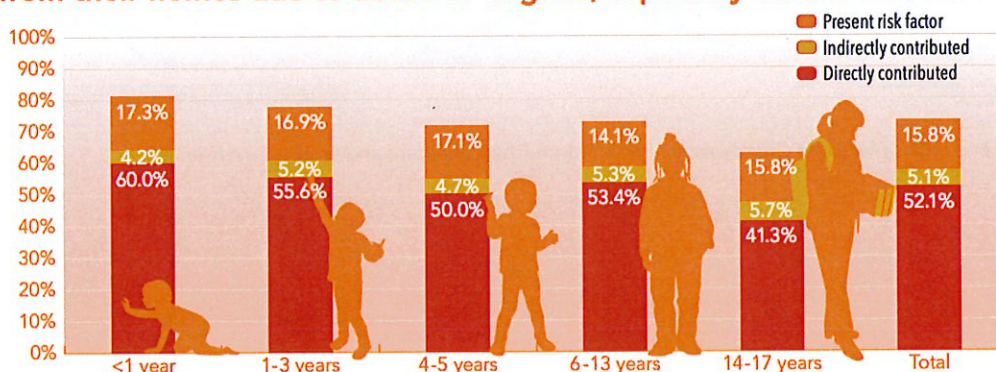


Number of Kentucky Children in Foster Care, 2013 to 2017, and in Relative Care, 2012-2014 to 2016-2018

Note: Relative care data exclude children living with relatives licensed as foster parents.

SOURCES: Kentucky Department for Community Based Services and U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

Substance abuse is a major factor for over half of children being removed from their homes due to abuse or neglect, especially infants and toddlers.



Percent of Kentucky Children in Out-of-Home Care Due to Child Abuse or Neglect in Which Substance Abuse Directly or Indirectly Contributed to the Maltreatment, or Was a Risk Factor Present in the Household, by Age Group, September 2017-August 2018

SOURCE: Kentucky Department for Community Based Services.

Kentucky and A-ROC Service Area

In Kentucky more than 104,000 grandparents live with their grandchildren (under age 18), of which 53.3 percent are responsible for the care of their grandchildren (Table 29). In the 10-county assessment area, more than 5,500 grandparents live with their grandchildren (under age 18), of which more than 3,100, between 35.6 and 84.6 percent, are responsible for their care.

Grandparents Living with and Responsible for Own Grandchildren Under Age 18							
Source: 2017 ACS 5-Year Estimates							
	Living with	Responsible for			Living with	Responsible for	
United States	7,269,685	2,582,410	35.5%	Green County	90	32	35.6%
Kentucky	104,124	55,525	53.3%	McCreary County	501	424	84.6%
Adair County	335	168	50.1%	Pulaski County	1,830	1,014	55.4%
Casey County	346	201	58.1%	Russell County	568	351	61.8%
Clinton County	349	226	64.8%	Taylor County	776	420	54.1%
Cumberland County	214	125	58.4%	Wayne County	512	220	43.0%

Grandparents Responsible for Own Grandchildren												
Source: 2017 ACS 5-yr Estimates												
United States	Kentucky	Adair County	Casey County	Clinton County	Cumberland County	Green County	McCreary County	Pulaski County	Russell County	Taylor County	Wayne County	
64.5%	46.7%	49.9%	41.9%	35.2%	41.6%	64.4%	15.4%	44.6%	38.2%	45.9%	57.0%	
35.5%	53.3%	50.1%	58.1%	64.8%	58.4%	35.6%	84.6%	55.4%	61.8%	54.1%	43.0%	
■ Responsible ■ Not Responsible												

Table 29: Grandparents Living with and Responsible for Own Grandchildren (2017 ACS 5-Year Estimates)

The number of grandchildren under the age of 18 living with a grandparent householder in Kentucky is 93,614 (9.3 percent of all children under age 18) (Table 30). Approximately 40 percent of those children are under the age of 6; 34 percent are between the ages of 6 and 11, and 26 percent are between 12 and 17 (Table 28). In the A-ROC service area combined, almost 4,800 grandchildren under the age of 18 live with a grandparent householder (between 3.3 and 17.6 percent of total children under age 18). In the A-ROC service area, between 31 and 64 percent of all grandchildren living with a grandparent householder are below age 6.

Age of Grandchildren Living with Grandparent Householder					
Source: 2017 ACS 5-Year Estimates					
	Total Children Under 18	Total Grandchildren Living with Grandparent Householder	Grandchildren Living with Grandparent by Age		
			< 6 years	< 6 to 11 years	12 to 17 years
United States	73,356,237	5,781,786 (7.9%)	2,602,670	1,839,993	1,339,123
Kentucky	1,008,766	93,614 (9.3%)	37,712	31,789	24,113
Adair County	3,788	202 (5.3%)	129	41	32
Casey County	3,537	375 (10.6%)	128	152	95
Clinton County	2,249	237 (10.5%)	119	96	22
Cumberland County	1,466	239 (16.3%)	87	82	70
Green County	2,347	77 (3.3%)	25	18	34
McCreary County	3,924	691 (17.6%)	237	229	225
Pulaski County	14,261	1,483 (10.4%)	559	546	378
Russell County	3,994	584 (14.6%)	183	267	134
Taylor County	5,650	600 (10.6%)	315	116	169
Wayne County	4,566	348 (7.6%)	157	88	103

Table 30: Age of Grandchildren Living with Grandparent Householder (2017 ACS 5-Year Estimates)

Health Worker Shortages

Based on the [County Health Rankings and Roadmap](#), in 2018 there was one primary care physician per 1,510 residents, one dentist per 1,560 residents and one mental health provider per 520 residents in the state of Kentucky (Table 31). Casey County reported the highest number of residents per one mental health provider, 1,440 to 1 followed by McCreary County, 1,250 to 1. Only Pulaski County has a better ratio of total population to mental health providers than the state of Kentucky, at 350 to 1.

Providers-to-Population Ratio (2018)			
Source: County Health Rankings and Road Map			
	Primary care physicians	Dentists	Mental health providers*
Kentucky	1,510:1	1,560:1	520:1
Casey County	15,810:1	7,910:1	1,440:1
McCreary County	3,580:1	17,510:1	1,250:1
Wayne County	1,570:1	3,410:1	1,200:1
Russell County	2,520:1	3,540:1	1,110:1
Green County	Not reported	2,770:1	690:1
Taylor County	1,500:1	3,170:1	630:1
Cumberland County	1,690:1	2,250:1	610:1
Clinton County	2,540:1	5,090:1	570:1
Adair County	3,810:1	6,430:1	550:1
Pulaski County	1,330:1	1,390:1	350:1

*Mental health providers are defined as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and mental health providers that treat alcohol and other drug abuse, as well as advanced practice nurses specializing in mental health care.

Table 31: Providers-to-Population Ratio (2018)

Health Professional Shortage Areas (HPSAs)

The [Health Resources and Services Administration](#) (HRSA), provides data on health care programs that provide health care to people who are geographically isolated, economically or medically vulnerable. One of the datasets reports on Health Professional Shortage Areas, or HPSAs. An HPSA can be a geographic location, a population group or facility experiencing a shortage of health care professionals. The three categories measured within HPSAs are dental health, mental health and primary care. HPSAs are measured on a scale of 0 to 25 (for primary care and mental health) and 0 to 26 for dental health; a higher score indicates a greater need.^{xxxv} Based on data collected from the HRSA, as of October 2019, all counties within the Lake Cumberland Catchment Area (encompassing all 10 A-ROC service area counties) have an HPSA designation for mental health, with a score of 18 (Table 32).

Health Professional Shortage Areas, Data Pull October 2019			
Source: Health Resources and Services Administration			
Discipline	HPSA Name	Designation Type	HPSA Score
Dental Health	Cumberland County	Geographic HPSA	8
Dental Health	McCreary County	Geographic HPSA	23
Mental Health	Lake Cumberland Catchment Area (all 10 counties)	Geographic HPSA	18
Primary Care	Casey County	Geographic HPSA	14
Primary Care	Clinton and Wayne Counties	Geographic HPSA	10
Primary Care	Cumberland County	Geographic HPSA	12
Primary Care	Green County	Geographic HPSA	12
Primary Care	McCreary County	Geographic HPSA	18

Table 32: Health Professional Shortage Areas

Figure 30 illustrates the scoring method used to determine a Mental Health HPSA.

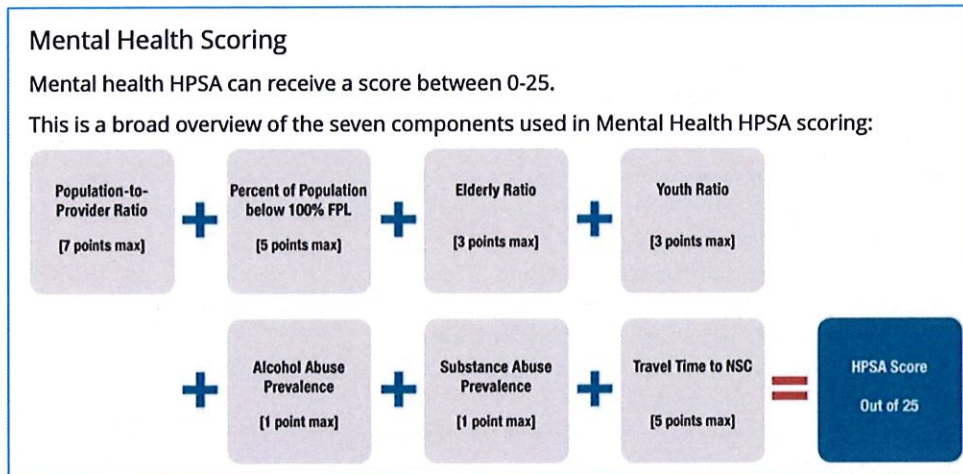


Figure 30: Mental Health HPSA Scoring

Medically Underserved Areas (MUAs)

The HRSA also reports on Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs), which reflect populations with a lack of access to primary care services. MUAs are measured by an Index of Medical Underservice Score (IMU), with a score range of 0 to 100 (0 represents completely underserved). Areas with IMUs below 62 qualify as an MUA or MUP. Based on data collected, all 10 counties in the A-ROC service area have a score below 62, with Taylor County reporting the highest score at 59.1, followed by McCreary County, scoring 58.9.^{xxxvi}

Medically Underserved Areas, Data Pull October 2019 Source: Health Resources and Services Administration	
Service Area Name	Index of Medical Underservice Score
Casey County	53.5
Cumberland County	53.8
Green County	56.5
Wayne County	57.0
Pulaski County	58.0

Medically Underserved Areas, Data Pull October 2019 Source: Health Resources and Services Administration	
Clinton County	58.3
Russell County	58.7
Adair County	58.8
McCreary County	58.9
Taylor County	59.1

Table 33: Medically Underserved Areas

Figure 31 illustrates the scoring method used to determine a Medically Underserved Area or Medically Underserved Population.

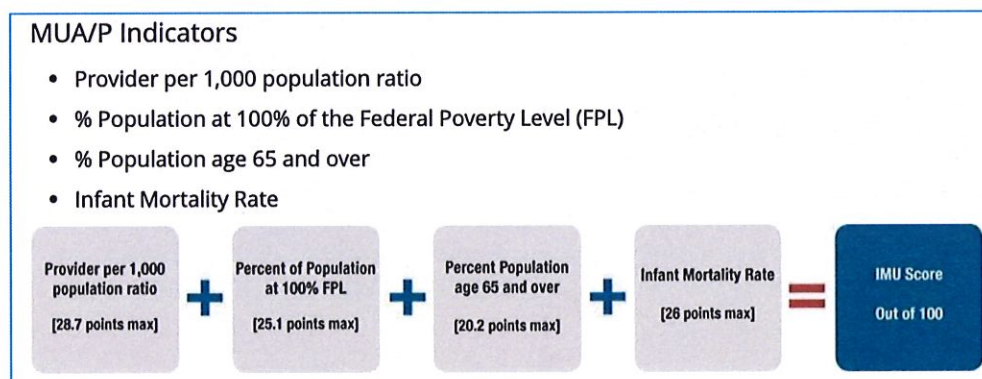


Figure 31: MUA/MUP Scoring

Types of Designations

We use **Health Professional Shortage Area (HPSA)** designations to identify areas, population groups, or facilities within the United States that are experiencing a shortage of health care professionals.

- **Geographic HPSAs** have a shortage of services for the entire population within an established geographic area.
- **Population HPSAs** have a shortage of services for a specific population subset within an established geographic area. Frequently Designated Population HPSAs include Medicaid-eligible, low-income, migrant farmworker, Native American/Alaskan Native, people experiencing homelessness.
- **Facility HPSAs.** Facility HPSAs include three categories:
 - Other Facility (OFAC) Public or nonprofit, private medical facilities serving a population or geographic area designated as an HPSA with a shortage of health providers.
 - Correctional Facility Medium- to maximum-security federal and state correctional institutions and youth detention facilities with a shortage of health providers.
 - State Mental Hospitals State or county hospitals with a shortage of psychiatric professionals (mental health designations only).
- **Automatic Facility HPSAs (Auto-HPSAs).** Some facilities do not have to apply for a designation. They are automatically designated as HPSAs by statute or through regulation. These include:
 - **Federally Qualified Health Centers (FQHCs)** Health centers that provide primary care to an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.
 - All **organizations receiving grants under Health Center Program** Section 330 of the Public Health Service Act are FQHCs.
 - **FQHC Look-A-Likes (LALs)** Community-based health care providers that meet the requirements of the [HRSA Health Center Program](#), but do not receive Health Center Program funding.
 - **Indian Health Facilities** [Federal Indian Health Service \(IHS\)](#), tribally run, and Urban Indian health clinics that provide medical services to members of federally recognized tribes and Alaska Natives.
 - **IHS and Tribal Hospitals** Federal Indian Health Service (IHS) and tribally run hospitals that provide inpatient and outpatient medical services to members of federally recognized tribes and Alaska Natives.
 - **Dual-funded Community Health Centers/Tribal Clinics** Health centers that receive funding from tribal entities and HRSA to provide medical services to members of federally recognized tribes and Alaska Natives.
 - **CMS-Certified Rural Health Clinics (RHCs) that meet National Health Service Corps (NHSC) site requirements** Outpatient clinics located in non-urbanized areas which CMS certifies as RHCs and meet [NHSC Site requirements](#) including accepting Medicaid, CHIP, and providing services on a sliding fee scale.

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs). MUAs and MUPs identify geographic areas and populations with a lack of access to primary care services.

- **MUAs** have a shortage of primary care health services for residents within a geographic area such as:
 - a whole county;
 - a group of neighboring counties;
 - a group of urban census tracts; or
 - a group of county or civil divisions.
- **MUPs** have a shortage of primary care health services for a specific population subset within an established geographic area. These groups may face economic, cultural, or linguistic barriers to health care. Some examples include: people experiencing homelessness, low-income, Medicaid-eligible, Native American, migrant farmworkers.

Based on data provided by the A-ROC Planning Consortium team, in the A-ROC service area, there are a total of four psychologists, seven psychiatrists, 219 Licensed Professional Clinical Counselors (LPCC), 43 Licensed Clinical Social Workers (LCSW) and 49 Certified Social Workers (CSW). [Click for a comprehensive list of providers with addresses and phone numbers.](#) Additionally, there are a reported 28 licensed substance disorder providers, of which two offer peer support (Table 34).

Existing OUD Workforce							
Source: A-ROC Planning Consortium							
*Obtained from Substance Abuse and Mental Health Services Administration Website							
**Obtained from Kentucky Cabinet for Health and Family Services Provider Directory Website							
County	Number of Mental Health Providers**					Number of Licensed Substance Use Disorder Providers*	Number of Licensed Substance Use Disorder Providers that Offer Peer Support*
	Psychologist	Psychiatrist	LPCC	LCSW	CSW		
Adair	0	0	45	3	4	8	1
Casey	0	0	3	3	3	1	
Clinton	0	0	11	1	1	2	
Cumberland	0	0	2	3	1	1	
Green	0	0	7	1	2	1	
McCreary	0	0	9	1	0	1	
Pulaski	1	6	77	27	11	9	2
Russell	0	0	26	2	7	1	
Taylor	3	1	20	1	16	3	1
Wayne	1	0	19	2	4	1	
Totals	4	7	219	43	49	28	4

Table 34: Existing OUD Workforce

PART II: COMMUNITY FEEDBACK

"If wisdom were offered me on the one condition that I should keep it shut away and not divulge it to anyone, I should reject it. There is no enjoying the possession of anything valuable unless one has someone to share it with." — Seneca

In an opening meeting held on July 2, 2019, Nolo Consulting facilitated a participatory and inclusive process where A-ROC stakeholder agencies (LCCAA, LCADD, LCDHD, and Adanta) discussed and provided feedback on the following subjects: general perceptions of the Consortium members about the opioid crisis, the community and the culture; identification of local secondary data sources; identification of key experts and leaders to be contacted as informers for the study; identification of data gaps; discussion of primary data sources available to organize focus group interviews; and discussion on how and who will engage the target population. During the July working meeting, a set of common qualitative questions were identified, and these guiding questions eventually became the foundation of the various data collection instruments used by agencies and leaders to administer focus group surveys, key informant conversations, and a general public perception survey. A-ROC members' ultimate purpose for the qualitative, primary data collection study was to authentically seek and incorporate the voices and perspectives of people in the 10-county area.

Part Two of the report presents findings of the three approaches used to collect information on perceptions about opioid use and abuse using a Focus Groups approach that targeted local, community-level populations such as parents, youth groups, incarcerated individuals, recovery groups, law enforcement, EMT, firefighters, and other service providers from all 10 counties. These focus groups were complemented with key informant interviews conducted by Nolo Consulting's team and by a general public survey distributed in the area. Copies of the focus groups, key informant interviews (with physicians, pharmacists, judicial system professionals) and the general public survey are included in the attachment and A-ROC Consortium's web portal. In addition to the questions, instructions on how to conduct Focus Groups Interviews, Do's and Don'ts, data findings and local resource list are also included in the A-ROC Consortium web portal in order to serve participating agencies in following and calibrating their actions accordingly based on information collected from the community. The link to the A-ROC Consortium portal is: <https://www.noloconsulting.com/lccaaky2019>.

Focus Groups Responses and Analysis

Focus Groups were held in community venues such as schools, churches, community centers, and other locations. Focus Groups were facilitated by local leaders and consortium members who have long-term relationships with prevention, treatment and recovery activities in the region. Consortium members were key to the Focus Group process since they will also participate in strategic planning activities following the focus group interviews and community assessment analysis.

Focus groups formed, and interviews completed, according to the date of completion, included the following groups:

1. Celebrate Recovery Focus Group at Russell Springs United Methodist Church, conducted on August 22, 2019;
2. Emergency Medical Technician, Fire Department, and Emergency staff and professionals from Casey Co, Russell Co, Pulaski Co., conducted on August 23, 2019;
3. Celebrate Recovery Focus Group, completed at Somerset Baptist Center, August 27, 2019;
4. Celebrate Recovery Focus Group, completed at Burkesville Center on August 29, 2019;
5. Celebrate Recovery Focus Group, completed at Columbia on September 3, 2019;
6. Incarcerated Male Inmates Focus Group at the Adair County, Kentucky Jail, conducted on September 12, 2019;
7. Incarcerated Female Inmates at Russell County, Kentucky Jail, conducted on September 13, 2019
8. Law Enforcement officials focus group from Casey, Russell, Adair, and Clinton Counties (participants included Sherriff's office, City Police Department, and Kentucky State Police), conducted on September 20, 2019; and,
9. Law Enforcement Focus Group (Pulaski and Clinton Counties, Kentucky State Police, Sheriff's Department, Police officers represented) conducted on September 3, 2019.
10. Treatment Providers Focus Group (Adair County, Russell County, Taylor County), conducted on September 10, 2019;
11. Treatment Providers Focus Group (Russell County, Pulaski County, Wayne County), conducted on September 12, 2019;
12. Pulaski County High School Youth Focus Group, conducted on October 17, 2019.

In the summary of focus group responses, general statements are included that offer a synopsis of the collective sentiment expressed by the different focus groups that participated. Specific individual answers (*in italics*) that provided insights from individual participants are also included.

EMT / Fire Department / Emergency

Overall, the feedback from these participants supports improving and growing efforts to educate children (early and often), more information about availability of resources to help people that need treatment and creating support systems that eliminate the stigma associated with drug use and addiction. These participants are very aware of the many problems that families are facing daily due to the crisis and talked about actual consequences, like higher number of younger residents becoming homeless, lack of care by many in the community due to judgment and biases, and the supply of the drugs that appeal to some people that want to make money selling drugs to those that are addicted. Most expressed disappointment with county leadership's work on this issue, quality and quantity of treatment places available, and the lack of information available about resources. There is consensus about the importance of removing the stigma and shame associated with Opioid Use Disorder (OUD) among these providers.

Individuals' responses to Focus Group questions are below:

- 1) What are your general feelings about opioid use and addiction in the county/region?
 - *How the physicians are handling patients, cutting them off too early or continuing to write "scripts."*
 - *Provide more oversight to physicians – no resolution to the problem till this occurs.*
 - *Same with Emergency Room – attend only when certain doctors are on call.*
 - *Following doctors, doctor shopping.*
 - *Happening across the region.*
- 2) How did you first hear about opioid use and addiction as a problem for our community?
 - *Ambulance runs on same person in the same week or same day = problem.*
 - *Addresses of known users that come up on calls.*
 - *More than one overdose call per shift.*
 - *Increase of homelessness in younger generation. Mostly 18-29 years old. Started with drug problem in family, then kicked out.*
 - *Increase in the last four years and continues to increase yearly.*
- 3) What is something that you think would deter people from using opioids?
 - *Got to be willing to stop using. Regardless of education.*
 - *Know the back story. Know what the root of the problem is and start from there.*
 - *Starts with pain management. Peer pressure.*
 - *Family life (Foster care families).*
 - *Schools 1st – 6th grade – living with grandparents because of parent abuse.*
 - *Mild concern to children when they witness the overdose in family.*
 - *Have to educate kids – early.*
 - *More support systems in the community that include education. Even if the user doesn't attend – the family can still receive the education to be their support.*
 - *Need community centers similar to that of the aging centers for kids to go to.*
 - *More access to resources available.*
 - *Child activities.*
 - *Educate providers on the resources.*
 - *Jail not safest place to send people – can get more drugs there than on the street.*
 - *Jail – can get all the education and counseling they want.*
 - *Where in the night can they go for safe/dry place to stay.*
 - *Show that someone cares and no one is judging them.*

- *Need couple of days to be removed from the environment.*
 - *Have no self-esteem – low morale.*
- 4) What are the significant differences between rural and urban areas regarding drug prescription and use?
- *No division – same path.*
 - *Know Dr.'s in each county that are part of the problem.*
 - *Oversight of medical group – [KASPER](#) – so inundated, over-logged, Federal government to expand KASPER system. (KASPER is a controlled substance prescription monitoring system designed to be a source of information to assist practitioners and pharmacists with providing medical and pharmaceutical patient care using controlled substance medications.)*
 - *Hospital hoppers. Can't research, just want to get them out the door.*
 - *Get patient discharged without a fuss.*
 - *More available to pain clinics in urban areas.*
 - *More clinics, more available, more drugs. Patient not taking – selling to someone else. A lot to do this to provide for family.*
- 5) How do you stay informed about the opioid prevention, treatment and recovery services that are available in the county? *Possible follow-up: How well does the county leadership, agencies and government keep the community informed?*
- *Not well C- grade.*
 - *Financial – Counties rural – Every Tax \$ accounted for.*
 - *[ASAP](#) – Keeps this group educated and community educated.*
 - *County leadership – uneducated on issues.*
 - *Don't know and also a blind eye to problem – blinders on.*
 - *No one wants to deal with it – huge problem.*
 - *[Lake Cumberland Break Away Project](#) - Provide required education classes to meet Drug Court requirements, etc.*
 - *No backing from county government.*
 - *Adair – "Gateway town" due to Cumberland Parkway, Louisville, Campbellsville.*
 - *"Mexican Mafia" from Louisville. These are groups from state prisons (not Mexico), and the State Police are scared of them.*
 - *Open meetings - public meetings. Be active, let public see them (advocates), and the press is always in attendance.*
 - *Educate on data on their specific county.*
 - *Advertising on social media.*
 - *Elections every two and four years, officials running for re-election will rise up and address drug issue during campaign.*
 - *Open records data, from EMT to county judges.*
 - *National Runs Sheets by EMT.*
 - *Hospital ER needs to collect data.*
 - *Fact finding – strength in numbers.*
 - *(Officials) Need to ride with a cop and EMT or just out by themselves to see for themselves.*
 - *Awareness campaign – to community level.*
 - *Until people in a position to change things see it for themselves, the statistics won't matter.*
 - *"Out of sight, out of mind," until it happens to their own.*

- *They are reactive and not proactive.*
 - *Danville Home – for those as soon as they leave the jail - provides support, job training, etc.*
- 6) Describe the quality of opioid prevention services in the county. Talk about your experiences.
- *Low Quality of prevention services.*
 - *Former buddies start back in their life.*
 - *No family support – shunned – bad kid – embarrassed.*
 - *“Friends” get them back in their habits.*
 - [Narcotics Anonymous](#) and [Celebrate Recovery](#).
- 7) From your expertise, what area is lacking to address the opioid crisis?
- *Education and Information.*
 - *Officials not on board.*
 - *Not enough info on TV.*
 - *Not enough visual information.*
 - *Social media.*
 - *Local ER and EMS need to get info. on resources – handouts.*
 - *Resource guide for law enforcement, ER, EMS etc.*
- 8) Please give us your perspective on how we can work as a community to effectively address the opioid crisis.
- *Education.*
 - *More facilities.*
 - *Understand needed support.*
 - *Not judge.*
 - *Look at it as a community.*
 - *Know the resources.*

Law Enforcement

Law enforcement are first respondents for prevention, education, and support to individuals and families. It is many times overwhelming because many residents' expectations may be asking for more than they can do, and the resources are also limited. These professionals feel responsible to provide the best information about resources, which is not always available. Lack of resources takes up law enforcement time and makes drug problem worse. Participants in the focus group agree that this is a problem for all members of the community, and that the majority of the problems they face are drug related. Law enforcement officers are well-aware of those services that are effective and those that are not working as well (some of the individual answers are specific about agencies and programs that work that they rely upon.) Law enforcement informants confirm that there is a huge need for more treatment units and centers in the area. Law enforcement officials share a high level of involvement and commitment to find solutions and help the community. Education, treatment, and enforcement, some of the ways they demonstrate commitment and action include: "sitting on boards and being part of the community, in positive interaction with the community, dealing with families of the addict and showing compassion, and educating families of the addict."

Several law enforcement participants would like to see more done by leaders from the area, supporting more treatment facilities, staying current about the issues, and getting more involved in solutions.

The following are individual responses to a Focus Group interview conducted on September 20, 2019. **The participants included Sheriff's office, City Police Department, and Kentucky State Police from Casey, Russell, Adair, and Cumberland Counties:**

- 1) What role does law enforcement play in terms of opioid misuse (both heroin and prescription opioids)?
 - *Enforcement, prevention.*
 - [Angel Initiative](#) - Kentucky State Police check people into treatment.
 - *Success for court-ordered rehab is nowhere near the same as voluntarily entering into rehab.*
 - *Can't force into rehab-they have to want to.*
 - *Meth/heroin rarely get prison time.*
 - *Parents call, wanting law enforcement to take child somewhere for treatment.*
 - *Drugs in jails.*
 - *Cycle - same families, generational, "normal to the families."*
 - *Child wants out of the family but nowhere to go, no help for low-income families.*
 - *Drug Court is harder than they are willing to commit to. Many get out because they think it is easy treatment and to get by and avoid jail sentence.*
- 2) What roles would you like law enforcement to play?
 - *Have places-resources.*
 - *Be able to give someone a solid answer about a resource, not just pass the buck.*
 - *Disappointing not being able to help – discouraging.*
 - [Casey's Law petition](#)-good resource.
 - *People in the community expect government to provide whatever they need government to provide, including law enforcement.*
 - *Think police is a fix-all.*
 - *Hospital, providers, etc., don't want to do anything and leave the law to deal with it.*
 - *Be able to get help for those who really want it.*
 - *Law is the first contact and often know family's experiences and what's going on*

- 3) What has your experience been with people with substance use disorder?
- *Very broad.*
 - *More mentally ill threatening suicide and mostly drug-induced mental illness.*
 - *Kids doing same thing now as parents - cycle of use starts again.*
 - *Very few people going to Eastern State Hospital are mental - its drug use.*
 - *Lots of children being diagnosed with Autism, but it's the family drug use - child being born addicted.*
 - *Some going to jail when they need to be in other facilities.*
 - *Adanta refusing to do anything if on drugs they have to be medically cleared, saying they can't do a proper evaluation because they are under the influence.*
 - *"Babysitting" for 10 hours until they can get evaluated.*
 - *Ties up resources; once in custody for mental illness, they are in police custody just like an arrest, and evaluations and waiting can take hours.*
 - *Lack of resources takes up law enforcement time and resources - makes drug problem worse.*
 - *First-time user going into areas seeking drugs with no patrol/police presence.*
- 4) What do you feel is the most prevalent concern in our community related to substance abuse?
- *Everyone is a victim.*
 - *85% - 90% of people in jail is drug related.*
 - *Stealing, domestic violence, theft - all drug-related crimes.*
 - *Pulls county financial resources; jail is biggest drain of county budgets.*
 - *No way to get ahead of the problem.*
 - *Problem with legal drugs being prescribed.*
 - *Kentucky - highest state for over-prescribing doctors.*
 - *When do doctors become accountable?*
 - *[Suboxone](#) clinics are the biggest drug dealers.*
 - *Suboxone is supposed to wean by doctor, but people in clinics never get weaned off the medication.*
 - *Addicts say it's harder to get off suboxone than other drugs.*
 - *Over-prescribing.*
 - *People go to clinics, say they have drug problem, take 2 pills and sell 18.*
 - *Increase in Suboxone - highly sought after.*
 - *Employment problems – drug-related.*
 - *Majority of problems – drug-related.*
 - *Industry won't come into communities.*
 - *Need to streamline services/resources.*
 - *500-bed facility would fill up in 6 months.*
 - *Thefts, safety, costs, bribery, counterfeit money.*
- 5) What would you like the community to know about substance abuse that they probably do not realize?
- *Doesn't just affect that person, but the community - all families have been affected.*
 - *Awareness out-of-sight, out-of-mind.*
 - *More awareness in the community.*
 - *Convey the real problem to the community.*
- 6) If funds were available where do you think money could be spent and make the most impact?
- *Facilities to help.*
 - *Simple, straight process to get people help.*

- *Rural communities don't want treatment facilities in their community - fear they will bring more problems.*
 - *Awareness in schools.*
 - *More manpower - boots on the ground.*
 - *Simple resources.*
 - *Too much time sitting and waiting for a response.*
 - *So much time on the addicted, not enough time on the pushers - will continue to be a problem.*
 - *Dealers being put in drug court - waste of resources.*
- 7) How do you stay informed about the opioid prevention, treatment and recovery services that are available in the county? *Possible follow-up:* How well does the county leadership, agencies and government keep the community informed?
- *Word-of-mouth.*
 - *Working.*
 - *Trial and error.*
 - *[ASAP](#) does a lot - needs more funding.*
 - *Don't have enough people to devote-no manpower.*
 - *School resource officer - good source.*
 - *ASAP, very active.*
 - *Law always plays some role, but not primary role; can't carry the burden.*
 - *Need more education in health classes.*
 - *Prevention specialist in schools.*
- 8) Describe the quality of opioid prevention services in the county. Talk about your experiences.
- *None.*
 - *Police presence.*
 - *Patrolling being in the area.*
 - *ASAP ([Kentucky Agency for Substance Abuse Policy](#))*

The following are the individual responses to a Focus Group interview conducted on September 3, 2019. The participants included Sheriff's Department, City Police Department, and Kentucky State Police from Pulaski and Clinton Counties:

- 1) What role does law enforcement play in terms of opioid misuse (both heroin and prescription opioids)?
 - *Enforcing the laws that apply to drugs.*
 - *Getting people, the help (treatment) they need.*
 - *Cause and effect of drugs*
 - *[Sky Hope](#) the women are thankful for getting help.*
 - *Narcan-everyone carries it helps save lives.*
 - *Show support to the community and substance users*
 - *Law supportive doing fund raisers to help.*
 - *Mediator and liaison for families*
 - *Law enforcement can help find treatment outside of Casey's Law.*
 - *Not enough resources to help*
 - *Prescription -money makers*
 - *Suboxone worse than drugs*
 - *Meth labs have decrease and moved to importing*
 - *Education doing a better job educating schools and kids.*
 - *Drug court positive and negative- the dealers are sentenced to Drug court and not users, the dealers aren't using drugs.*
- 2) What roles would like law enforcement to play?
 - *Education, treatment, and enforcement*
 - *Sky Hope, sitting on boards and being part of the community.*
 - *Positive interaction with the community*
 - *Humanization of police officers*
 - *Dealing with families of the addict showing compassion.*
 - *Families of the addict needs to be educated.*
- 3) What has your experience been with people with substance use disorders?
 - *Drugs are different today from years ago.*
 - *Everyone has some experience with an addict*
 - *Drug use doesn't affect just poor people, now it affects every class, race, etc.*
 - *Stigma and seeking help*
 - *People are more open going to get help and don't care if others know.*
 - *Families are going through the addiction and are victims.*
- 4) What do you feel is the most prevalent concern in our community related to substance abuse?
 - *Kids*
 - *Accessibility*
 - *Prevalence*
 - *Hep-C-health issues*
 - *Hurts tourism, for example, people on streets asking for money*
 - *Limited workforce*
 - *Other crimes associated with drugs (theft, domestic violence).*

- *Residual effects of drugs*
 - *Changing laws of drug charges from felonies to misdemeanors-decriminalization of substance abuse.*
 - *Criminals have knowledge of the system and know what to say to avoid jail.*
 - *No fear of being imprisoned*
- 5) What would you like the community to know about substance abuse that they probably do not realize?
- *How quickly they can become addicted to opioids and Meth.*
 - *Kids think they can experiment with drugs and not get addicted.*
 - *TV glamorizes alcohol and drugs and kids don't see the ugly picture.*
 - *Drugs has been normalized in some communities.*
 - *Outcome of addiction (jail, treatment, death).*
 - *What it does to the people physically, socially and emotionally.*
 - *Self-esteem issues*
 - *Parent's at a loss of what they can do can see destruction.*
 - *Have resources to help the public.*
 - *Casey's Law is being used more*
 - *Treatment facilities expert advice*
 - *Mothers coming and wanting to put child in jail rather than see them use or die.*
- 6) If funds were available where do you think money could be spent and make the most impact?
- *Having funding and moneys for staff to assist the public and get into treatment ([Angel Program](#)).*
 - *Families not having insurance can't get help*
 - *Money must be spread out for education, enforcement, and treatment*
 - *Interventions for incarcerated people-jail programs*
 - *Education start at Pre-school all through school or at a level they can understand.*
 - *Slow input of addiction by early education.*
 - *Law enforcement budgets are limited spend most budget buying drugs.*
 - *Financial resources to fight the problems*
 - *Just Say No Campaign was effective*
 - *Legalizing marijuana encourages kids that drugs are okay.*
- 7) How do you stay informed about the opioid prevention, treatment and recovery service that are available in the county? How well does the county leadership, agencies and government keep the community informed?
- *Don't think they here enough about treatment facilities from leaders and agencies.*
 - *Behind the times*
 - *Never hear anything*
 - *Not wanting to get involved*
- 8) Describe the quality of opioid prevention services in the county. Talk about your experiences.
- *Stigma of recovery centers.*
 - *The person hitting rock bottom and seeking help.*
 - *Looking for a way out of addiction.*
 - *Officers burnout and limited resources.*
 - *Police departments not notified when an overdose occurs because doctors don't want to call it in.*

- *ER doctors should be required by law to report all overdoses.*
- *Reporting overdoses help law enforcement track the drugs and the sellers.*
- *Small communities' overdoses get covered up.*
- *Narcan is an available resource*
- *Narcan is used daily*
- *Treatment needs to be at least one-year vs the 30 days or 6-month programs.*
- *See relapse at the 6-month mark of treatment*

Families Affected by OUD (Opioid Use Disorder)

The insights and feedback from families affected by OUD and recovery group participants reveal frustration and fatalistic perceptions. There is acknowledgement of a situation that seems to be out of control, with not much support from leadership and/or programs to address this shared, prevalent, problem. The group speaks about the support systems they are using to stay informed, get the support they need for themselves and do their best to support family members as caregivers. Most support education of children early, establishing proactive community outreach and breaking labels that make the problem worse to help in recovery and treatment. One of the participants summarized how the area or leaders could have prevented or assisted in the treatment of OUD: *"(Build) a place where I could have gone for help without it destroying my life and my reputation. Somewhere that I could just go and say, 'I think I have a problem' and not have to be concerned about the repercussions of that confession in the community and people's view of me."*

Individuals' responses to Focus Group questions are below:

- 1) What are your general feelings about opioid use and addiction in the county/region?
 - *It's out of control.*
 - *Not enough is being done.*
 - *I was extremely alarmed when I found employers are having a hard time getting employees who can pass a drug screen.*
 - *Doctors don't care to overdose patients.*
 - *Not good.*
 - *Out of control — ODs, death, suicide.*
 - *Rampant.*
 - *Epidemic.*
 - *Out of control.*
 - *Horrible — widespread.*
 - *People using at younger age.*
 - *Not as bad as it used to be — price got so high.*
- 2) How did you first hear about opioid use and addiction as a problem for our community?
 - *When I went to work for a drug testing company.*
 - *When we moved to Adair County and found out it was the drug capital.*
 - *When I started using my friend base grew rapidly because everyone wanted the drugs.*
 - *Working in the school system and seeing the parents of students.*
 - *Working in the court system.*
 - *When my son failed a drug test.*
 - *When I decided to get clean and sober.*
 - *Active addiction.*
 - *My job at manufacturing company in the County in the New Hire Dept. - I see drug test results.*
 - *Good friend battling addiction was put on opioids, which caused relapse and messed his life up.*
 - *Family members — deceased wife, son in prison.*
 - *UNITE — moved to Somerset in '06 — sister executive administrator in UNITE but had family members using — every family has someone.*
 - *Worksite (construction) — late 90's — everybody was doing it.*
 - *Using — twice.*
 - *I found out the hard way — withdrawal was horrible.*

- *My brother went through it.*
- 3) What is something that you think would deter people from using opioids?
- *Stop offering [Suboxone](#) — it is only trading one addiction for another.*
 - *Education — we don't even realize the problem until we see those around us spiraling out of control.*
 - *Jesus Christ!*
 - *Community outreach.*
 - *Education.*
 - *Drs. prescribe something different — opioids not as first choice.*
 - *Prayer— people to get real with themselves.*
 - *Change doctor prescribing habits — restrict access.*
 - *Limit number of pills given — wean off appropriately.*
 - *Education — Doctors and pharmacists talk about it, as well as former addicts*
- 4) What are the significant differences between rural and urban areas regarding drug prescription and use?
- *Prescriptions are easier to get in the urban areas.*
 - *People I see in my work doing drug testing say that it is easier to get drugs on the street here than anywhere else they have been.*
 - *I was told by someone recently that they saw more drugs in Russell County in two months than they did in eight years in Chicago*
 - *The bigger the city, the easier access. It would help if there was more to do (in rural area).*
 - *Urban missions are more prominent — rural population is more spread out and mission outreach is limited.*
 - *No difference.*
 - *Easier to conceal in big cities.*
 - *Increased use in urban areas is due to availability, larger population and it's cheaper.*
 - *More use in cities — walk-in pain clinics.*
 - *Word of mouth in cities — addicts know the doctors who easily prescribe.*
- 5) How do you stay informed about the opioid prevention, treatment and recovery services that are available in the county? *Possible follow-up: How well does the county leadership, agencies and government keep the community informed?*
- *Celebrate Recovery.*
 - *Drug Court.*
 - *Word-of-mouth.*
 - *I don't really know.*
 - *Social media.*
 - *Church — social media — friends.*
 - *Community — Alcoholics Anonymous, Narcotics Anonymous — would help to have one place for information.*
 - *Leadership happens more from the community than from the leaders.*
 - *All I see is the [drug take-back](#).*
 - *I agree 100% (with previous comment that the leadership happens from the community).*
 - *What we hear in the media is always the negative, not the positive.*
 - *UNITE coalition meets every month.*

- *We attend multiple Celebration Recovery programs.*
 - *I see nothing done to inform the community.*
 - *Drug Court and jail are the only options to stay informed.*
 - *Leadership does not inform at all.*
 - *Seems like leadership wants the problem.*
 - *Local forum held with Extension Office — no public access to forum.*
- 6) Describe the quality of opioid prevention services in the county. Talk about your experiences.
- *Drug Court is a farce with unreasonable demands.*
 - *Programs in front of Judicial Plaza, Ministers Coalition.*
 - *Subpar, mostly, just pamphlets.*
 - *Participants don't even know if we have any.*
 - *I was recently in a group where they talked about having used some grant money for prevention to do some billboards, but no one even notices the billboards.*
- 7) What is the most frustrating issue for you in dealing with a loved one who struggles with OUD?
- *Being around a user when I'm trying to get clean.*
 - *Denial — they are oblivious to the issue.*
 - *They don't think they have a problem.*
 - *The sense of hopelessness.*
 - *Society's quickness to just write them (users and addicts) off.*
- 8) What resources would have been beneficial to your loved one to prevent or assist in treatment of OUD?
- *Education at a young age.*
 - *Shorter prescription terms following a medical procedure — only prescribe a couple of days' worth of pills instead of 90 pills.*
 - *More observation of patients after a few days of prescription medication.*
 - *A place where I could have gone for help without it destroying my life and my reputation. Somewhere that I could just go and say, "I think I have a problem" and not have to be concerned about the repercussions of that confession in the community and people's view of me.*

Incarcerated Individuals and Those Fighting Addiction

Key informants revealed that information and education about opioids and the fatal and/or tragic consequences of use and abuse is the most important and immediate action that the community needs to take to deter people from using opioids. Several of the individual statements about what and why to communicate strong messages included: *"Talk about the consequences of addiction; no one starts with the thought to be a drug addict; Stop sugar coating the problem; Need more awareness about the effects on the family's lives; I never hear consequences of addiction; It is a monster that never leaves you; You will be leaving the real world to go into the drug world; We need a face of addiction (to make an impact)."*

Male key informants do not think that geographical location (rural vs. urban) makes much of a difference regarding access to opioids. Many describe the strategies and methods used to get the drugs. Many argued that it is probably easier to hide or not to see the availability in rural areas, but most people know where to go and how to obtain it. Many feel it is easier to get drugs than to get prevention and treatment services. One participant describes the prevention services area: *"No one willing to help, so go back to what you know best,"* and another participant stated, *"Don't know where to go for help."*

Regarding what the community can do to prevent others from being incarcerated because of the opioid epidemic, key informants agree that education must start early. One of the most heartfelt comments received was the following: *"Show/explain/educate how addiction affects your family. I put my family through hell and my daughter is addicted now."*

Male Individuals' responses to Focus Group questions are below:

- 1) What factors led you to opioid addiction?
 - Family, being around it all my life. Only time not around it is in jail. Many people in my family use.
 - Started at a young age - recreational use.
 - Addictive personality - drinking, pot.
 - Had a bad car wreck, doctor giving me 60 pills every month.
 - Abused a legitimate prescription from doctor; wasn't taking as prescribed.
 - Death of a best friend.
 - Get hurt or trauma by something and used.
 - Death of my grandfather.
 - Started using to be more social, to be cool - became my identity; 15 years later, using heroin and meth.
 - Peer pressure.
 - Small-town environment, nothing to do, no recreation for the kids.
 - Father passed away.
 - Easy access - got from doctors.
 - Abuse as a child; trauma - several inmates experienced trauma as a child.
 - Didn't know how to cope.
- 2) What message would you give to community members regarding addiction?
 - Start working with young kids.
 - Get involved with your kids.
 - Help kids deal with trauma at a young age.
 - More open relationships and discussion with kids.
 - If out of jail, I would be doing Meth.
 - Don't condemn talk.

- *Band-Aids are not a solution; it makes things worse.*
 - *Lose family, all the important things.*
 - *Understand addiction, stop judgment. Be more aware instead of judging.*
 - *"Say no," doesn't work. It is not understanding the depth of the problems.*
 - *It's a disease just like cancer and we need help to recover.*
 - *Stop judging.*
 - *At first, it's a choice, but then becomes a disease.*
- 3) What would make the biggest impact in decreasing opioid addiction in our community?
- *Doctors not prescribing for every little issue (toothaches), and patient not using the drug but selling it.*
 - *Easily giving out.*
 - *Deal with pain; more pain management. Pain is part of life.*
 - *If pills are being prescribed, the problem won't go away.*
 - *Doctors crack down on opioids, then heroin will take over.*
 - *Pain pills are addictive - no one wants to be sick.*
 - *More awareness about addiction.*
 - *More rehab places.*
 - *Some rehabs located in worst part of town and close to the dealers.*
 - *More support and education for families on how deep addiction goes.*
 - *Families want to help, but just enable.*
 - *Educate families on how deep addiction goes.*
- 4) What are your general feelings about the opioid use and addiction in the county/region? and How did you first hear about opioid use and addiction as a problem for our community?
- *90s - early 2000s.*
 - *Florida pipeline; going to Florida taking van loads, going to get pain medication, then to Maryland to get pain medication.*
 - *In Bowling Green in 2015 heroin hit; 2018 meth flooded in.*
 - *Wayne County, heroin is on the rise.*
 - *Everyone I went to school with and played sports with; some are dead and I am only 43 years old.*
 - *Didn't realize the problem until two years ago; worse than I thought*
 - *Scared about the younger generation and my kids - pray every day that my kids don't become addicted.*
 - *Monster that never leaves you.*
 - *Doctors prescribing medication to young children for anxiety is starting the addiction.*
 - *Easy access to pills.*
 - *It's killing people.*
 - *Sad - tearing families apart.*
 - *It is a never-ending cycle.*
 - *Feelings of guilt about passing addiction on to children.*
 - *Never-ending cycle – generational.*

- 5) What is something that you think would deter people from using opioids?
- *If you want it, you know where to go to get it.*
 - *You know what to look for and the kind of people.*
 - *Cities just more people*
 - *More potent in the cities.*
- 6) What are the significant differences between rural and urban areas regarding drug prescription and use?
- *More plentiful in the cities.*
 - *Drug dealers from other states; more people more money.*
 - *Heroin more dangerous in big cities.*
 - *Know where to go.*
 - *More substance abuse treatment programs.*
 - *Self-pay facilities are better, get better help than state funding programs*
 - *Got to want it- for yourself.*
- 7) How do you stay informed about the opioid prevention, treatment and recovery services that are available in the county? *Possible follow-up:* How well does the county leadership, agencies and government keep the community informed?
- *Not well.*
 - *Need more facilities-sober living.*
 - *Do intervention for the homeless.*
- 8) If there were dollars to spend fighting the opioid crisis, what would make the biggest impact? What is needed most?
- *More facilities-sober living facilities.*
 - *Jobs.*
 - *Get in treatment quicker.*
 - *Show/explain/educate how addiction affects your family; I put my family through hell & daughter's addicted now.*
 - *Show signs of addiction-symptoms.*
 - *Educate families about addiction*
 - *Support groups for addicts*
- 9) What impact has the opioid epidemic had on you and your family as to why you are incarcerated?
- *Destroyed.*
 - *My first marriage.*
 - *Destroyed everything, I had lost my wife and haven't seen my kids and missed birthdays.*
 - *Stole, lied, and cheated from my family - siblings mad at me.*
 - *Parents done with me.*
 - *Missed my two boys growing up; been in treatment twice*
 - *No memories of my kids growing up; daughter an addict.*
 - *Pain, misery and grief.*
 - *Lost it all.*

10) What do you feel the community could do to prevent others from being incarcerated because of the opioid epidemic?

- *Catch them young - scared straight.*
- *Start at 8-9 years old.*
- *Get involved.*
- *Have sober fun.*

Some of the common themes expressed by female inmates identify mental health as the key reason associated to the addiction for most, psychological stress and the need to cope. These suggested that the access to drug is high but education, awareness, rehab places and families' ability to help is limited and not available from many residents in the area who are dealing with early sign of addiction and later recovery. Another perception provided by participants focus on the need for community leaders and members to understand the addiction, stop judgment and stigmatizing people dealing with dependency and recovery.

Female Individuals' responses to Focus Group questions are below:

1) What factors led you to opioid addiction?

- *Father passed away.*
- *Easy access - got from doctors.*
- *Abuse as a child; trauma - several inmates experienced trauma as a child.*
- *Didn't know how to cope.*

2) What message would you give to community members regarding addiction?

- *Band-Aids are not a solution; it makes things worse.*
- *Lose family, all the important things.*
- *Understand addiction, stop judgment. Be more aware instead of judging.*
- *"Say no," doesn't work. It is not understanding the depth of the problems.*
- *It's a disease just like cancer and we need help to recover.*
- *Stop judging.*
- *At first, it's a choice, but then becomes a disease.*

3) What would make the biggest impact in decreasing opioid addiction in our community?

- *More awareness about addiction.*
- *More rehab places.*
- *Some rehabs located in worst part of town and close to the dealers.*
- *More support and education for families on how deep addiction goes.*
- *Families want to help, but just enable.*
- *Educate families on how deep addiction goes.*

4) What are your general feelings about the opioid use and addiction in the county/region? and How did you first hear about opioid use and addiction as a problem for our community?

- *Scared about the younger generation and my kids - pray every day that my kids don't become addicted.*
- *Monster that never leaves you.*
- *Doctors prescribing medication to young children for anxiety is starting the addiction.*
- *Easy access to pills.*

- *It's killing people.*
 - *Sad - tearing families apart.*
 - *It is a never-ending cycle.*
 - *Feelings of guilt about passing addiction on to children.*
 - *Never-ending cycle – generational.*
- 5) What is something that you think would deter people from using opioids?
- *Started using - always knew had a problem.*
 - *Suboxone and Methadone - trading one addiction for another.*
 - *Got addicted to Suboxone, worse than pills.*
 - *Was given [Subutex](#) while pregnant; was supposed to be easier on baby. Doctor didn't inform me about the risk, and baby was born addicted to Subutex.*
 - *Awareness education.*
 - *Talk about the consequences of addiction.*
 - *No one started with the thought to be a drug addict.*
 - *Make it harder to get pills and needles.*
 - *Accountability; make sure really seeing counselor - easy to forge sheets & no one calls.*
 - *Face facts; stop sugar-coating the problem.*
 - *Doctors need to be held accountable for prescribing the medication.*
 - *Need more awareness about the effects on the families; lives are lost.*
 - *Never hear consequences of addiction.*
 - *Need a face to addiction.*
 - *Hear more about vaping, but not narcotics.*
- 6) What are the significant differences between rural and urban areas regarding drug prescription and use?
- *Easy access.*
 - *Go to big city and out of state if not available.*
 - *Use fake identification (ID) from another state to get pills*
 - *Doesn't matter where you are at.*
 - *Use internet to get pills online.*
 - *Had pills delivered to P.O. Box.*
- 7) How do you stay informed about the opioid prevention, treatment and recovery services that are available in the county? *Possible follow-up: How well does the county leadership, agencies and government keep the community informed?*
- *Don't stay informed.*
 - *Not informed.*
 - *No advertisement.*
 - *Don't know where to go for help.*
 - *No newspaper ads, billboards.*
 - *Need more treatment centers.*
 - *No one willing to help, so go back to what you know best.*
 - *Fear of arrest by police.*

- 8) If there were dollars to spend fighting the opioid crisis, what would make the biggest impact? What is needed most?
- *Education.*
 - *Transitional resources-transitional living.*
 - *Help pick life back up - learning how to live.*
 - *Daily living skills resources.*
 - *Housing.*
 - *Jobs.*
 - *Transportation.*
 - *More education on signs and symptoms of addiction.*
- 9) What impact has the opioid epidemic had on you and your family as to why you are incarcerated?
- *Broken family.*
 - *Leaving the real world to go into the drug world.*
 - *Children away from parents.*
 - *Children angry.*
 - *Not just hurt yourself but those around you.*
 - *Children grow up without parents.*
 - *Affects everyone.*
 - *Kids thinks it is cool, parents going to jail.*
 - *I was a good mother until the disease took over.*
- 10) What do you feel the community could do to prevent others from being incarcerated because of the opioid epidemic?
- *Reach out to them.*
 - *Offer resources and education.*
 - *Hear people's stories.*
 - *Awareness in schools - elementary.*
 - *Reduce the stigma of what the addict is.*
 - *Doesn't discriminate.*
 - *Can't cure it by yourself - have to have help.*
 - *Must have treatment and understanding.*

Treatment Providers

Treatment providers that participated in the focus groups offered very concrete and practical alternatives and solutions with a community-based focus. Some of the most noteworthy included: advocating for change at the local level, supporting proactive education of residents about addiction, concentrating on simple messages and addressing ignorant beliefs like “why can’t you just quit.” These informants support starting grassroots efforts to help others understand that it is not a moral issue. Other recommendations regarding solutions included: offering addicts an opportunity to voice what they think, the area needs more peer support specialist and or someone in the community appointed to inform others about community resources. These professionals restated educational recommendations proposed by others that participated in the study as well as the importance of increasing services, providers and resources: the need host open forums and workshops once per month; increase treatment providers, qualified clinicians, and recruit psychiatrist; and, increase transportation options so people can’t get to treatment appointments.

The following include individual responses from Focus Group Questions of Treatment Providers from Adair County, Russell County, Taylor County, completed on September 10, 2019.

- 1) What lead you to choose the field of addiction treatment to practice in?
 - *In mental health if they didn’t have an addiction someone with them did (20 years of experience).*
 - *Started in prison setting with substance abuse program*
 - *Personal story-sister committed suicide had alcohol issues and went to work at regional prevention center at Adanta and become a CADC (Certified or Licensed Certified Alcohol and Drug Counselor)*
 - *Married to an alcoholic lost his battle worked in correction and then substance abuse program.*
- 2) How do people obtain prescription opioids?
 - *Physicians*
 - *Buying off the streets*
 - *Family members*
 - *Trading stuff one prescription for something else they want*
 - *Doctor shopping*
 - *Stealing prescription pads from doctors’ offices*
- 3) What message would you give to community members regarding addiction?
 - *Small town think where hidden and its right here very real.*
 - *It’s here in our face its real.*
 - *People move into a dry town and think it’s okay.*
 - *Need to face it*
 - *Advocate for change*
 - *Not “why can’t you just quit”*
 - *Educate yourself on addiction*
 - *Family education*
 - *Not a respecter of person or social standing*
 - *Health wellness and intervention*
 - *Family must stay healthy (it’s a family disease).*
 - *Many kinds of addictions*
 - *Can’t happen to me mindset*
 - *Opioid use down (meth) use up*

- *Generational users' way of life*
 - *Education about what addiction is and educating people that you may be addicted*
 - *Making marijuana legal makes addicts think it's okay to use.*
 - *More injection*
 - *Education from doctors when they prescribe*
 - *Grass root effort*
- 4) What are your general feelings about the opioid use and addiction in the county/region? And How did you first hear about opioid use and addiction as a problem for our community?
- *Scary, lots of overdoses*
 - *You don't know what you're getting or taking anymore*
 - *IV use afraid of needles in lakes and on streets*
 - *Contaminated community*
 - *Females, pregnancy, and domestic violence*
 - *Heart wrenching worrying*
 - *Clinicians have to keep selves healthy*
- 5) What is something that you think would deter people from using opioids?
- *Addicts need to voice what they think*
 - *Not one answer*
 - *Peer support specialist*
 - *Support mental health services*
 - *Underlying trauma needs to be addressed if not just adding to the problem*
 - *Create more resources*
 - *Intervene and stop the issues not just medicate*
 - *Start getting clean increase confidence and find employment*
 - *Educate employers on recovery*
 - *Employment support*
 - *Probation and parole have changed attitude to help with treatment rather than look people up.*
 - *Drug court*
 - *[Vivitrol](#) has some success but not a cure all.*
 - *MAT (Medication Assistance Treatment) more success if meet with counselor*
 - *Prevention and education*
- 6) What are the significant different between rural and urban areas regarding drug prescription and use?
- *All bad*
 - *Cities hidden more*
 - *Rural more transparent*
 - *Urban more resources and programs*
 - *More providers in urban areas*
 - *Rural slower to catch on to prescription use*
 - *Rural area good ole boy-trust the people.*

- 7) How do you stay informed about the opioid prevention, treatment and recovery services that are available in the county? How well does the county leadership, agencies and government keep the community informed?
- *Constantly looking for resources which are limited*
 - [SAMSHA](#) Substance Abuse and Mental Health Services Administration
 - *Evidence base practice*
 - *Alert each other about resources*
 - *New trends for treatment and new treatment*
 - *Needs to be someone in the community people can go to for services/someone appointed to tell about community resources.*
 - *I don't know that I have ever went to a community leader for anything*
 - *Need more detox in the area, if people are hurting, they don't want to drive to Corbin, or Lexington.*
 - *Resource guide per county*
- 8) If there were dollars to spend fighting the opioid crisis, what would make the biggest impact? What is needed most?
- *Resources to reach the people*
 - *Peer support specialist*
 - *Mentor programs for when a person gets clean to help get a job.*
 - *Employees giving incentive for employer to stay clean.*
 - *Criminal charges being removed from job application*
 - *Transportation system-uber system to get people to treatment, jobs, meetings*
 - *Helping get criminal charges expunged from records.*
 - *Educating employers about changes and parole vs probation.*
 - *Education and educating teachers about warning signs of use and withdrawal symptoms.*
 - *Education about the darker side of addiction*
 - *Split money with treatment, and resources*
 - *Peer support is what addict wants someone that has been in their shoes.*
 - *Ads are more graphic but still don't see the face of addiction.*
 - *Multi umbrella approach*
- 9) How do you network with other service providers to address the opioid epidemic in the 10-county region?
- *Referring to other services*
 - *Connect with agencies with peer support.*
 - *Just now utilizing Casey's Law*
 - *Consult with each other network together with different areas.*
 - *Connecting the client for all their needs to other services*
 - *Misinformation about Casey Law-obstacles, legal system learning what they can do, and family is financial responsible for treatment.*
 - *Trainings is a place to network*
 - [Al-Anon](#)
 - *List of free treatment providers for Casey's Law*
 - *Some judges and attorneys not on board because not educated*

10) What trends or patters have you identified as related to the opioid epidemic?

- *More Meth*
- *Less opioids*
- *Both*
- *Buying on the streets*
- *Increase in IV use for heroin*
- *More Trafficking*
- *More needle exchange programs-large numbers of needles switches.*
- *More leniency for marijuana use*
- *Narcan training for families*
- *Argument of how many times to intervene with Narcan.*

The following include individual responses from Focus Group Questions of Treatment Providers from Russell County, Pulaski County, Wayne County/Kentucky represented, completed on September 12, 2019.

1) What lead you to choose the field of addiction treatment to practice in?

- *Tug to work with prevention after working with families and children dealing with a lot of trauma.*
- *Worked with families with history of opioid and meth taking over entire families using.*
- *Personally, addicted after a prescription in rehab for 2 years and clean for 3 years went back 1st hand, love helping and now at Sky Hope.*
- *Case Management background seeing all the families you work with talking to them about substance abuse coming from a small rural area Meth taking over cultural of whole families using children using.*

2) How do people obtain prescription opioids?

- *Off the streets to ease pain*
- *Peer pressure and friends*
- *Dr. Shopping (the practice of visiting multiple physicians to obtain multiple prescriptions for otherwise illegal drugs, or the medical opinion that one wants to hear.)*
- *Florida Pipeline ([reference](#))*
- *Easy to go out of state-go to another doctor to get opioids*
- *Doctors increasing dosage after client has been on medication for years*

3) What message would you give to community members regarding addiction?

- *You can recovery*
- *No resources, no money*
- *Price tag can't afford to get help you can there are programs that will pay for your child to go to rehab or state will pay*
- *Stop judging start healing.*
- *Not our county but it is our county*
- *Denial*
- *Keep an open mind-support them maybe it will get better*

4) What are your general feelings about the opioid use and addiction in the county/region? And How did you first hear about opioid use and addiction as a problem for our community?

- *Work for state and saw things happening in our community, saw a lot of addiction and avoidance*
- *Media-someone arrested for trafficking and drug use*
- *Aware when I was younger friends using drugs, lost friends to heroin overdose.*

- *Started going to funerals of my classmate's half of my graduation class gone because of drug use (methadone/Xanax).*
- 5) What is something that you think would deter people from using opioids?
- *Been sober for five years going to doctor for issues and doctors still what to prescribe something with codeine tell them I am in recovery they don't care prescribe anyway.*
 - *People take it because doctor knows better than they do.*
 - *Remind doctors of your recovery*
 - *Doctors need to be more cautious.*
 - *Relapse happens and people give up on people.*
- 6) What are the significant different between rural and urban areas regarding drug prescription and use?
- *Everywhere you go*
 - *Just the same as here as in the Lexington no difference*
 - *People go across county lines to get it.*
 - *Users go to other counties because of shame*
 - *More help for someone*
 - *Urban users come to rural areas and vice versa.*
- 7) How do you stay informed about the opioid prevention, treatment, and recovery services that are available in the county? How well does the county leadership, agencies and government keep the community informed?
- *Wellness Coalition, meetings, interagency meetings, media and different affiliations.*
 - *Read a lot*
 - *Community involvement*
 - *Stay connected/plug-in*
 - *Working with groups and getting information*
 - *Need open forums 1 once per month or workshops*
 - *Not enough awareness*
 - *People think it's a moral issue-they can quit if they want to.*
 - *Not a fan of Suboxone*
 - *County officials not supportive*
 - *Families don't know about Casey's Law or angel initiative or how it works.*
 - *Government waited to late-everything is a crisis not just opioid (Fentanyl, Suboxone, Opioids etc.)*
 - *Need more peer specialist*
 - *Not enough treatment providers*
 - *Not enough psychiatrist*
- 8) If there were dollars to spend fighting the opioid crisis, what would make the biggest impact? What is needed most?
- *More advertisement/better Help ADS*
 - *Education on signs and symptoms of addiction*
 - *More money and pay for providers (reimbursement for services).*
 - *More awareness of the disease portion of addiction*
 - *Transportation- people can't get to me for treatment, to groups, DUI class etc.*
 - *More qualified clinicians.*

9) How do you network with other service providers to address the opioid epidemic in the 10-county region?

- *Find Help Now KY.org*
- *Google*
- *Word of mouth*
- *Calling*
- *Keep a file in my office of resources and update it one per year.*

10) What trends or patterns have you identified as related to the opioid epidemic?

- *Mixing heroin/Oxycodone/alcohol (whiskey, vodka).*
- *Police seem to be more aggressive to arrest individuals for drinking.*
- *Meth is a source of income-sold and used- poor communities' way to feed their families.*
- *Socially acceptable behavior-generational*
- *Eastern KY no jobs people sell drugs to take care of family and kids it's a way of living.*
- *Cocaine making a come back*
- *Meth and fentanyl on the rise*

Youth and Teens

The youth that participated in the focus groups included a total of eight students: three from 10th grade, one from 11th grade, and four 12th graders from Pulaski County High School. Most students favor more prevention education in the school setting because it is the most effective. They want to know what this epidemic is doing to their community and school, also want to receive more data about age groups' use, addiction rates and school use. Students want to know why other people are using, and they prefer to learn more from people's stories rather than theoretical or scripts. Students that participated have direct connection with the opioid epidemic, yet the level of knowledge about resources, information and what services are available is not adequate.

Individual responses to Focus Group questions are below:

- 1) What are your general feelings about opioid use and addiction in the county? And, how did you first hear about opioid use and addiction as a problem for our community?
 - *Parents who work in law enforcement and medical field - have heard on multiple occasions.*
 - *Others were not aware, but have observed citizens who are "on something," or have had strangers come to homes and restaurants who are "on something."*
 - *Unaware of issues within the school itself, unlike other substances.*
 - *Hear about problems on news. Loss of coal industry "economy" has contributed to increased use.*
- 2) What do you think are some reasons students in your school might try using drugs?
 - *Kids see parents using to "relax," which makes it acceptable, and kids learn from observation.*
 - *Peer pressure and lack of observation of negative consequences.*
 - *Kids use to relieve the pressures of school.*
 - *"Not the drug dealer in the 'trench coat'."*
 - *Lack of drug testing, especially among non-athletes.*
 - *Perception that it is tough to get caught since use is minimal.*
 - *Kids that have low perspective of prospects for a quality life.*
 - *It's what mom and dad do.*
- 3) How do you think they get the drugs?
 - *Family prescriptions and steal the pills.*
 - *If you see the right kid, you just ask them.*
 - *Older friends who may have graduated. Older relatives seem to be the most common method.*
 - *Old, unused prescriptions laying in the back of the medicine cabinet.*
- 4) What about pills compared to alcohol? Which is more dangerous? Why?
 - *Pills are more dangerous because you can overdose. Don't really know how much you are taking.*
 - *Alcohol is more accessible for teens, which can lead to intolerance and social acceptance.*
 - *Alcohol use is more public/social. Prescription is more of a hidden issue.*
 - *Teens can easily access alcohol.*
 - *People know their limits with alcohol, and everyone's limits are different.*
 - *"A lot of adults drink."*
- 5) Have you had education related to drugs and alcohol and the risks? Describe the things you have been told.

- *We have heard that drugs are bad, but not since freshman year. Have heard the message but nothing in the past 2-3 years.*
 - *Parents preach moderation in adults when it comes to alcohol.*
 - *The message has been heard "over and over," "feel like beating a dead horse."*
- 6) What is something that you think would deter people from using opioids?
- *TGFD (Too Good for Drugs High School Kit) was good but nothing since freshman year.*
 - *Occasional speaker.*
 - *Posters have so much info that they cannot decipher it all. Tired of the same old thing and will not stop or pay attention to posters with info*
 - *Sharing personal stories; make the problem real. All agreed that personal stories are more effective than a Power Point with a script.*
 - *Same videos every year; kids stop paying attention.*
 - *Realize that time constraints may limit the use of personal speakers.*
 - *They want fresh info.*
 - *Outside of school, there is very little that is going to convince me to stop using.*
- 7) What specific instances are you aware of with youth and opioid epidemic?
- *Close friend or family member who has struggled.*
 - *Rx control from the doctors. Educate to stop handing out pain pills like candy.*
 - *Treat acutely, not chronically.*
 - *Educate people about what is happening to their own bodies. The anti-smoking campaign ads have a positive impact. "Who wants to smoke after seeing those ads?"*
 - *Some shared experiences about grandparents caught up, when it just started as a simple pain treatment that evolved into addiction.*
 - *Dad, who is a doctor shared general observations about opioids and the misuse problems.*
 - *Family with law enforcement officer who has shared information.*
- 8) What do you feel would be helpful to know about opioid epidemic, and who do you feel would be appropriate to educate you on it?
- *Very little info available from the "Average Joes." Tend to shrug off info from parents, but instead, they tend to grasp information from "experts."*
 - *Need to know what this epidemic is doing to our community.*
 - *More stats about age groups and school use. These things have an impact on use of other substances. Want to know why other people are using.*
 - *People stories.*
 - *Churches sharing messages of hope. New people in recovery, not just those who are 'recovered,' but who are just getting started.*
 - *Ladies Center residents have provided inspirations. "Beyond Scared Straight" has taught us what can happen as a consequence of use from those who are living it. And how quickly it can happen.*
- 9) Do you know about opioid prevention services in the county? What services and programs do you know about?
- Notetaker message: "Several looks of bewilderment. The group had difficult time recalling anything."
- *Recovery Center*
 - *TGFD*

Key Experts and Informant Interview Questions and Responses

Purpose of interviewing key informants from the area is to validate various community perceptions about opioid use and abuse through key experts and leaders. Some key experts can provide insight for the Area Consortium as to why these perceptions are held and to help improve a consortium planning process. A key informant is a proxy for her or his associates from a group, a profession or an organization. Key informant interviews are in-depth interviews of a select group of experts, identified by A-ROC members, who are most knowledgeable about the issue. They often are very useful as part of the planning process and needs assessment. These are particularly helpful to supplement survey findings, particularly for the interpretation of survey results.

The following open-ended questions served as guiding questions to encourage key informants with different expertise and roles to move to higher levels of thinking and to help us generate additional questions and information that can support the work of the Consortium.

A. Pastors / Clergy

1. What are some specific things that could be done to impact the addiction issue in the surrounding communities?
2. Would you and your congregation be willing to get more involved in addressing addiction in our area? If yes, how? If no, why not?

B. Courts/Probation

1. What do you feel would make a difference in addressing the opioid crisis in our area? Please elaborate and explain why you think it would work.
2. When grants are received to address the opioid crisis in our area, how do you feel is the best way to spend those dollars that would make a difference?

C. Pharmacist

1. Which drugs are most commonly overprescribed and possibly misused? and/or What medications are you most aware of that are a problem in the community? Can be combined with questions:
2. What are the top changes that could be made to make a difference?
3. What are some changes you think are necessary and could impact substance abuse?

D. Physicians

1. What are some factors that contribute to prescription drug abuse in this community? Heroin?
2. Who are the people most affected by opioid misuse?
3. What can you recommend addressing the opioid misuse in our community?

The following is a summary of the insight and input provided by seven key informants representing physicians, pharmacists, pastors and court system professionals. The following comments and perceptions from key informants we interviewed are not in any particular order. Names and titles of the participants are kept anonymous in order to share all points of view and messages and get a complete picture of the professional's views.

- *Twenty-five year ago, the opioid push in the area was to prescribe pain medication to cancer patients.*
- *Not only the drug companies are to blame for opioid addiction.*

- Last generation changed the culture from spiritual to secular, no hope and no fulfillment; seeking quick fixes.
- Also, idle hands, no work, may increase the predisposition for addiction.
- There is more publicity about the rural abuse of opioids, but I do not see the difference between rural vs. urban access or use of opioids.
- Drug companies have received an unfair bad rap recently, but I was never pressured by a pharma representative to prescribe more opioids.
- Many doctors are well-trained and not stupid. However, there are some accepted, research references that became the standard of care that justified the prescription of oxycodone.
- Responsible doctors are not willing to risk their careers. There are Medical Board reviews.
- The biggest impact or solution is to come to face our Savior; that is the ultimate solution for many.
- As a physician, I have no feedback or knowledge of opioid prevention services.
- Opioid use is going down.
- There is a socioeconomic connection to addiction; the problem is an addiction problem, rather than the drug itself or the type of drug.
- I think that Adverse Childhood Experiences (ACEs) is the number one factor, socioeconomic, that will have a tremendous impact on future drug use and health conditions.
- There are many lies coming from the drug companies about the drug effects.
- We have a limited number of behavioral scientists in the region and Primary Care doctors, who are responsible for control and therapy.
- Rehabilitation and social workers are needed. Payment to social workers must increase in order to have them become part of the solution.
- It seems like drug habits are more likely to be formed when individuals are in an environment that offers no alternative or competing ways to meet their desires.
- People are product of their environment, more than we like to think. By acknowledging this, we can have more compassion for one another, but more importantly, we can begin helping one another by providing people with as many opportunities as possible for learning alternative ways to meet their needs. We can eradicate the problem of [lack of] self-discipline.
- Address and focus on Adverse Childhood Experiences (ACE). [Adverse childhood experiences predict opioid relapse during treatment among rural adults.](#)
- Do genotyping.
- Find better ways to attack pain with prevention. Prescribe less opioid. Nurse Practitioners do not need to prescribe it.
- Leadership in the area does not get it; they see the people as the problem.
- Primary care physicians do not have as many resources to lobby, and they are losing political influence power.
- There is peer pressure among youth and younger adults.
- One positive approach to the solution and reduction is to communicate more with people. People do communicate with one another and can be used as reliable messengers.
- People share prescriptions back and forth.

It has been proposed that testing (genotyping) for genetic variants may assist in tailoring drug selection and drug dosing for an individual based on their gene composition for drug metabolism which could lead to early selection and optimal dosing of the most effective drugs, while minimizing treatment failures and toxicities.

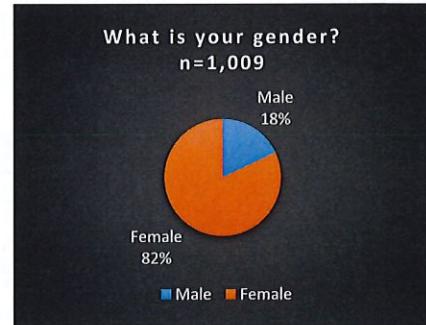
- *An addicted brain does not know the drug.*
- *We are all affected, the whole community is challenged, not just a few.*
- *There are less people seeking employment due to disability, pain, drug abuse.*
- *In a community with limited resources, there is a push-and-pull effect that affects many. The better informed are less affected by these forces.*
- *One of the challenges is the lack of mental health services and advocacy, limited drug education in schools.*
- *One important solution to the opioid action among leadership is to have more counties involved to build a bigger effort – size matters.*
- *Educating health professionals and the public about appropriate use*
- *Implementing prescription-drug monitoring programs.*
- *Developing prescription opioids that incorporate abuse-deterrent technologies.*
- *I was surprised to hear that some high school students were given Narcan shots to take home.*
- *People want help, but they prefer it in isolation in order to protect family. It is important to help them bring their issues out in the open.*
- *The focus was first cancer patients, then doctors used it for other reasons and didn't know about the consequences to prescribe it for other reasons and to many more people. I do not think that doctors have overprescribed; it is rare to have that problem in the area.*
- *The process of treatment and recovery needs to work. There are so many people addicted, treatment is long-term and necessary for many. If it is not available, they will select the alternative. But trying to get them to treatment is many times impossible, cost is too high (\$10,000 private) – places making money, and people cannot afford or able to pay.*
- *People are so afraid; they are not going to call people by name that are benefiting from it. People in power may appear to be unaware of the problem, but many think they are just part of the problem or they profit from the epidemic and crisis.*
- *Create more senior-focused (over 65 population) treatment centers.*

Community Perception Survey About Opioid Use and Abuse

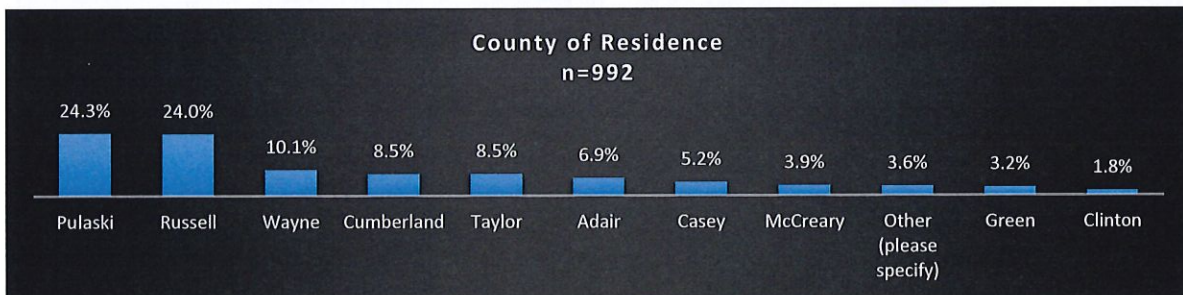
As part of the assessment, a [community perception survey](#) was distributed to members in the 10-county service area. A total of 1,009 responses were received and analyzed, of which 82 percent were female respondents and 18 percent were male respondents.

What is your age?	
Answered	957
Average	45.5
Mean	43.4
Mode	50.0
Range	18 - 88

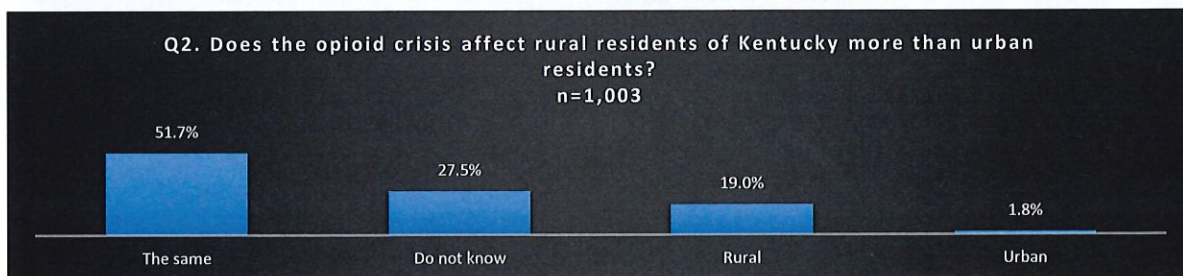
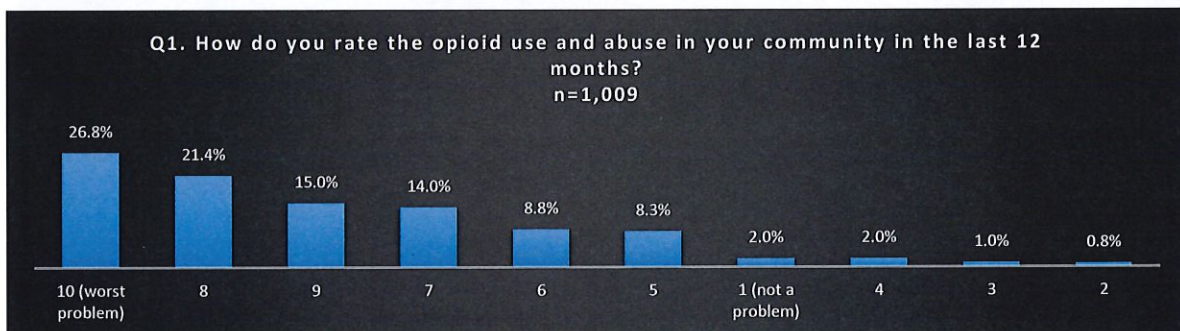
Approximately 95 percent of respondents completed the question regarding their age; the average age of respondents was 45.5, the youngest respondent was 18, the oldest was 88.

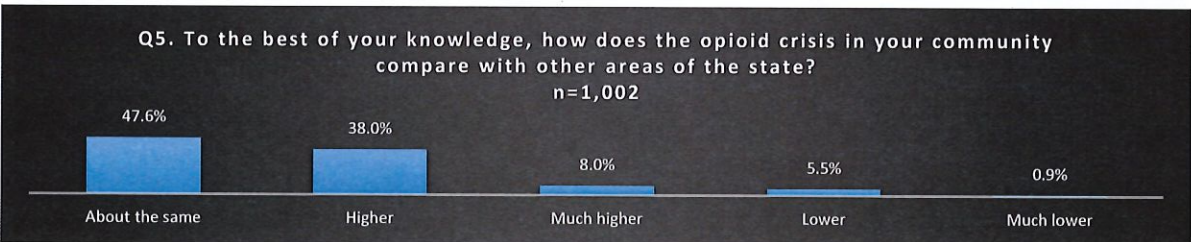
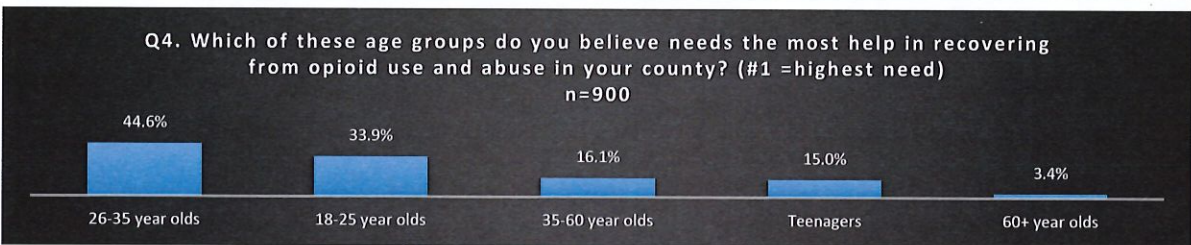
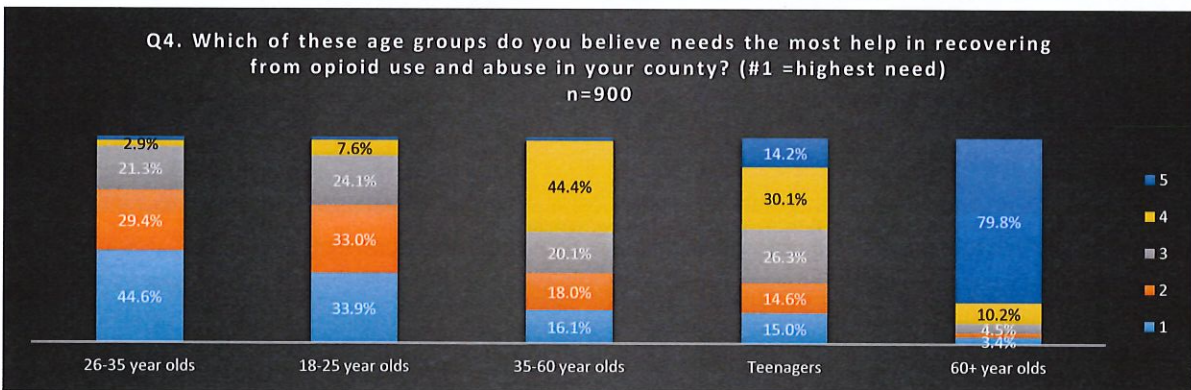
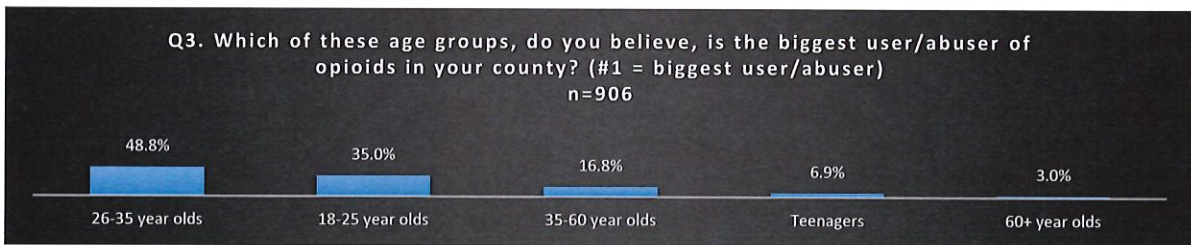
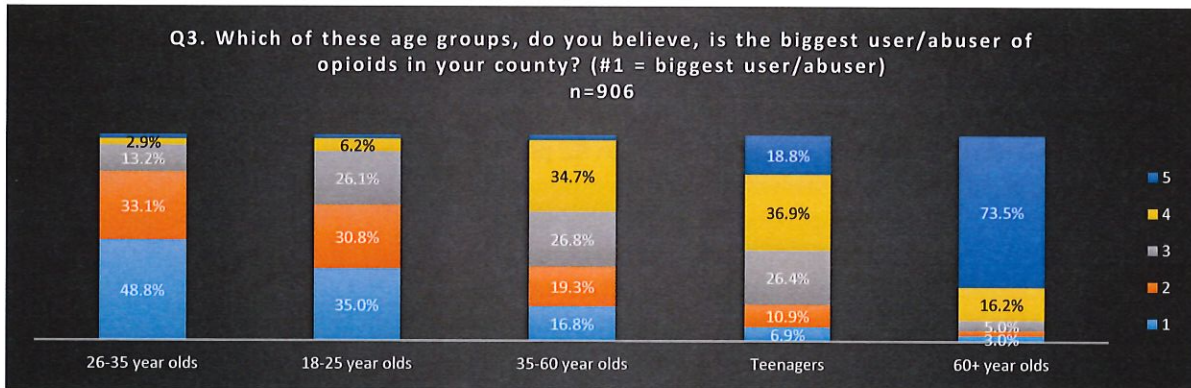


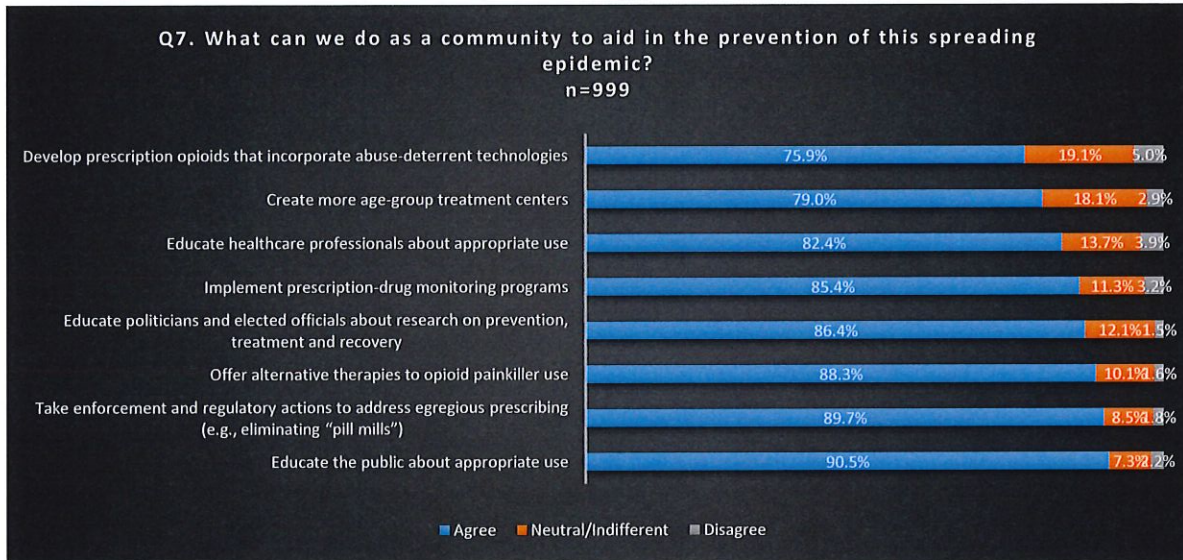
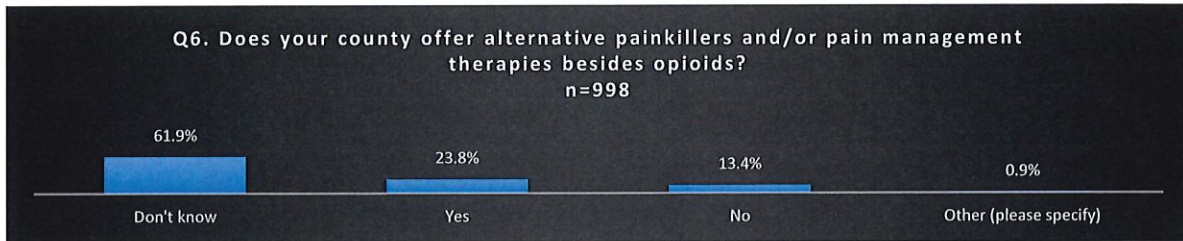
Approximately half of the respondents were from Pulaski County (24.3 percent) and Russell County (24.0 percent). In addition to the counties listed in the figure below, 3.6 percent of respondents included other counties of residence: Allen, Anderson, Barren, Bell, Boyle, Clay, Fayette, Hardin, Knott, Knox, Laurel, Lincoln, Madison, Marion, Nelson, Owen, Rockcastle and Warren.



Following are the answers to the questions included in the community perception survey:







See [Appendix C](#) for additional qualitative answers to this question.

Q8. What can we do as a volunteer to aid in the prevention of this spreading epidemic?

Just over half of all survey respondents answered this question with 513 individual comments. For answers and findings this question, please refer to the [Consultants Conclusions and Observations](#) section.

See [Appendix C](#) for additional qualitative answers to this question.

PART III: CURRENT INITIATIVES, PROGRAMS, RESOURCES AND BEST PRACTICES

The specific factors impacting the Kentucky population are unique to the local community. However, very few regions of the United States have gone unscathed by the current opioid epidemic. By studying the methods other organizations have employed to combat opioid use disorder in their own communities, the A-ROC Planning Consortium can learn from the experiences and research conducted by other professionals in this field and develop actionable plans that take into account methods that have proven successful in other parts of the country.

Included below are articles, case studies, best practices and other resources to take into consideration when developing a strategic plan to address opioid use disorder prevention, treatment and recovery in the community.

Prevention

While it is critical to leverage resources to address the treatment of individuals who are currently experiencing addiction to opioids and the abuse, misuse, overdoses and death that can result, prevention of future addiction in community members who are not experiencing addiction is imperative. Below are brief descriptions and links to prevention-related resources.

General Prevention of Opioid Use Disorder

Resource: Centers for Disease Control and Prevention – Prevent Opioid Use Disorder

Link: <https://www.cdc.gov/drugoverdose/prevention/opioid-use-disorder.html>

Overview: This resource enumerates a variety of strategies for preventing addiction and reducing the risk of exposure to opioids, including State prescription drug laws and prescription drug monitoring programs.

Resource: Health Policy Review – Reframing the Prevention Strategies of the Opioid Crisis: Focusing on Prescription Opioids, Fentanyl, and Heroin Epidemic

Link: <http://accurateclinic.com/wp-content/uploads/2018/08/Reframing-the-Prevention-Strategies-of-the-Opioid-Crisis-Focusing-on-Prescription-Opioids-Fentanyl-and-Heroin-Epidemic-2018.pdf>

Overview: Offering a 3-Tier Approach to curb opioid abuse, as well as a review of the evolution of the opioid epidemic, consideration of the failure of oversight in the pharmaceutical industry and reframing of prevention strategies.

Resource: Kentucky Injury Prevention and Research – Overdose Prevention Program

Link: <http://www.mc.uky.edu/kiprc/programs/kdopp.html>

Overview: Kentucky Drug Overdose Prevention Program - Provides County Profiles on Drug Overdose Hospitalizations and Deaths.

Resource: Centers for Medicare & Medicaid Services – Opioid Prescribing Rate

Link: <https://cmsoeda.maps.arcgis.com/apps/MapSeries/index.html?appid=735f83ac6e984d6fade11b241d295585>

Overview: This is an interactive, web-based resource that visually presents opioid prescribing rates within Medicare Part D by geography. Communities can use the tool to understand regional variation, target resources, and develop solutions for the opioid crisis.

Resource: Article – Addressing Host Factors: Primary, Secondary and Tertiary Prevention of Opioid Dependence

Link: https://link.springer.com/chapter/10.1007/978-3-319-47497-7_11

Overview: This suggests a tiered action plan using primary, secondary and tertiary data to prioritize prevention methods / models.

ACEs (Adverse Childhood Experiences), Early Childhood Intervention, and Youth Education

Resource: Addiction and Attachment – A Complex Relationship (paper)

Link: <https://pdfs.semanticscholar.org/e81d/968c6c6cf6cd6a0d4c023a19d73659f59e98.pdf>

Overview: ACEs are the most significant predictor of addiction in adults. Therefore, to prevent opioid addiction in the future, it is necessary to bring aid to children experiencing ACEs now.

Resource: Kentucky Office of Drug Control Policy – 2018 Drug Use Prevention Curriculum Resource Guide

Link: [https://odcp.ky.gov/Reports/KY-ODCP%20Drug%20Prevention%20Program%20in%20the%20Schools%20Recommendation%20final%20\(ADA\)_asm.pdf](https://odcp.ky.gov/Reports/KY-ODCP%20Drug%20Prevention%20Program%20in%20the%20Schools%20Recommendation%20final%20(ADA)_asm.pdf)

Overview: Information about prevention education for youth; prevention programs in Kentucky schools, and Kentucky prevention resources.

Adult Education

Resource: Journal of Emergency Nursing – A Quality Improvement Project to Improve Education Provided by Nurses to ED Patients Prescribed Opioid Analgesics at Discharge

Link: <https://www.sciencedirect.com/science/article/abs/pii/S009917671730377X>

Overview: Teach nurses and other health care professionals about how they can best educate patients regarding the proper use of opioids and the risk of addiction.

Resource: Centers for Disease Control and Prevention – Interactive Training Series

Link: <https://www.cdc.gov/drugoverdose/training/online-training.html>

Overview: An Online Training Series for Healthcare Providers, complete with 11 modules, including Treating Chronic Pain Without Opioids, Communicating with Patients, Dosing and Titration, and Opioid Use During Pregnancy.

Case Studies & Best Practices

Resource: American Society for Clinical Pharmacology and Therapeutics - Public Health Policy Strategies to Address the Opioid Epidemic

Link: <https://ascpt.onlinelibrary.wiley.com/doi/full/10.1002/cpt.992>

Overview: Reduce prescribing to reduce opioid fatality rate; a look at a state that was successful in its efforts to curb the opioid crisis in their area. Oregon successfully reduced opioid prescribing by 20 percent and reduced the opioid fatality rate by 30 percent. This journal entry includes action steps taken to achieve these results.

Resource: Awareness, Education and Collaboration: Promising School-Based Opioid Prevention Approaches

Link: <http://www.esc-cc.org/Downloads/SAMHSA%20Opioid%20Brief.pdf>

Overview: Risk factors and paths to opioid access, mental health and opioid misuse, recommendation to engage youth as activists in their communities.

Resource: Science Direct – Moving Opioid Misuse Prevention Upstream: A Pilot Study of Community Pharmacists Screening for Opioid Misuse Risk

Link: <https://www.sciencedirect.com/science/article/abs/pii/S1551741118302195>

Overview: Recommends that since pharmacists are the gatekeepers between patients and opioids, pharmacists are in an ideal position to screen for opioid misuse, and to educate patients about safe use.

Reduce the Stigma of Addiction and Change the Narrative

Resource: U.S. National Library of Medicine National Institutes of Health - Addiction as an Attachment Disorder: Implications for Group Therapy

Link: <https://www.ncbi.nlm.nih.gov/pubmed/11191596>

Overview: This article substantiates why group therapy is the treatment of choice for addiction and notes the importance of creating a culture in which the stigma of opioid addiction is removed to ensure people who need help feel comfortable asking for help.

Resource: American Journal of Health Promotion – Breaking the Silence and other Prevention Lessons from the Opioid Epidemic

Link: <https://journals.sagepub.com/doi/full/10.1177/0890117118764695>

Overview: Recommendation to assist people experiencing opioid addiction in gaining access to help by changing the narrative about recovery and treatment and removing the stigma around addiction.

Treatment and Recovery

Listed below are opioid-related treatment and recovery resources.

Treatment & Recovery Resources for Patients and Families

Resource: United for Recovery

Link: <http://www.unitedforrecovery.org/>

Overview: This is a nonprofit founded in Bardstown, Kentucky. The mission is to save and restore lives through education, prevention, and recovery support for individuals, families and communities impacted by substance abuse disorder.

Resource: Find Help Now Kentucky

Link: <http://www.findhelpnowky.org/>

Overview: Use this website to find an addiction treatment facility that is taking new clients right now. They work with hundreds of facilities across the state to bring up-to-date and accurate information about their treatment offerings and availability.

Resource: Office of Drug Control Policy – Treatment and Recovery

Link: <https://odcp.ky.gov/Pages/Treatment-Resources.aspx>

Overview: The new Kentucky Help Call Center provides referrals across the state to both public and private treatment providers. Kentuckians struggling with a substance use disorder, either themselves or within their families, can call 1-833-8KY-HELP (1-833-859-4357) toll-free to speak with a specialist about their treatment options and available resources.

Resource: Lake Cumberland Breakaway Project

Link: <https://lcbproject.org/>

Overview: The Lake Cumberland Breakaway Project is a group of community volunteers working to give those struggling with addiction a place to go when they have no place, to provide a central helpline of available resources and to assist in the education of youth. Their mission is to provide resources for abstinence-based recovery programs, addiction awareness education, and job assistance for the community.

Resource: National Institute on Drug Abuse – Advancing Addiction Science

Link: <https://www.drugabuse.gov/patients-families>

Overview: Treatment and prevention resources for patients and families.

Resource: Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants

Link: <https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054>

Overview: This Clinical Guide provides comprehensive, national guidance for optimal management of pregnant and parenting women with opioid use disorder and their infants. The Clinical Guide helps healthcare professionals and patients determine the most clinically appropriate action for a particular situation and informs individualized treatment decisions.

Housing

Resource: Recovery Kentucky – Specialized Housing

Link: <http://www.kyhousing.org/Specialized-Housing/Pages/Recovery-Kentucky.aspx>

Overview: Recovery Kentucky was created to help Kentuckians recover from substance abuse, which often leads to chronic homelessness.

Life-Saving Solutions

Resource: Buprenorphine Practitioner Locator

Link: <https://www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator>

Overview: This interactive map allows you to find practitioners authorized to treat opioid dependency with buprenorphine by state.

Resource: Naloxone (brand name Narcan) at Walgreens

Link: <https://www.walgreens.com/topic/pharmacy/naloxone.jsp?o=acs>

Overview: Walgreens' campaign educates teens about opioid abuse. Naloxone (brand name Narcan) is an opioid antidote that can reverse an overdose. It is now available without a prescription at select Walgreens pharmacies across the United States.

Resource: Health and Human Services – Better Availability of Overdose-Reversing Drugs

Link: <https://www.hhs.gov/opioids/about-the-epidemic/hhs-response/better-overdose-response/index.html>

Overview: In April 2018, the Surgeon General released an Advisory on Naloxone and Opioid Overdose that emphasized the importance of access to naloxone for patients, health care practitioners, families, friends, and community members.

Research-Based Scientific Solutions

Resource: National Institutes of Health HEAL Initiative

Link: <https://heal.nih.gov/>

Overview: Launched in April 2018, the NIH HEAL Initiative is an aggressive, transagency effort to speed scientific solutions to stem the national opioid public health crisis.

Resource: NIH Principles of Drug Addiction Treatment: A Research-Based Guide

Link: <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/preface>

Overview: Outlining the principles of effective drug addiction treatment, including evidence-based approaches to drug addiction treatment.

Medication-Assisted Treatment (MAT)

Medication-assisted treatment (MAT) is the use of medications with counseling and behavioral therapies to treat substance use disorders and prevent opioid overdose. MAT is primarily used for the treatment of addiction to opioids such as heroin and prescription pain relievers that contain opiates. The prescribed medication operates to normalize brain chemistry, block the euphoric effects of alcohol and opioids, relieve physiological cravings, and normalize body functions without the negative effects of the abused drug. [Medications used in MAT](#) are approved by the Food and Drug Administration (FDA), and MAT programs are clinically driven and tailored to meet each patient's needs. Combining medications used in MAT with anxiety treatment medications can be fatal. Types of anxiety treatment medications include derivatives of Benzodiazepine, such as Xanax or valium.

Opioid Dependency Medications - Methadone, buprenorphine, and naltrexone are used to treat opioid dependence and addiction to short-acting opioids such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone. People may safely take medications used in MAT for months, years, several years, or even a lifetime. Plans to stop a medication must always be discussed with a doctor.

Methadone. Methadone tricks the brain into thinking it's still getting the abused drug. In fact, the person is not getting high from it and feels normal, so withdrawal doesn't occur. Learn more about [methadone](#).

Buprenorphine. Like methadone, buprenorphine suppresses and reduces cravings for the abused drug. It can come in a pill form or sublingual tablet that is placed under the tongue. Learn more about [buprenorphine](#).

Naltrexone. Naltrexone works differently than methadone and buprenorphine in the treatment of opioid dependency. If a person using naltrexone relapses and uses the abused drug, naltrexone blocks the euphoric and sedative effects of the abused drug and prevents feelings of euphoria. Learn more about naltrexone.

<https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat>

Certified MAT Centers

Tables 35 and 36 list the MAT centers in Kentucky, delineating between the centers located in the A-ROC service area and the balance of centers located in the state of Kentucky. Of the 24 certified MAT centers in Kentucky, only one is located in the A-ROC service area, Crossroads Treatment Center of Somerset in Pulaski County (Table 35).

Program Name	DBA	Street	City	State	Zip Code	Phone
Crossroads Treatment Center of Somerset	N/A	607 Clifty Street	Somerset	KY	42503	(606) 485-4730

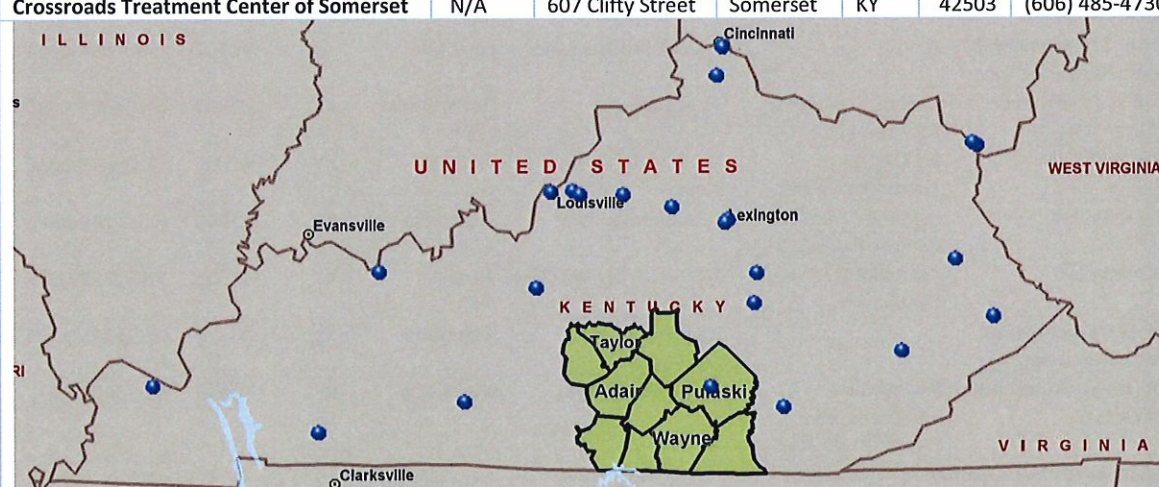


Table 35: A-ROC Service Area: Certified MAT Centers

Program Name	DBA	Street	City	State	Zip Code	Phone
ULTIMATE TREATMENT CENTER	ULTIMATE CARE MEDICAL SERVICES LLC	3655 WINCHESTER AVENUE	ASHLAND	KY	41101	(606) 393-4632
Crossroads Treatment Center of Ashland,		1220 Greenup Avenue	Ashland	KY	41101	(606) 393-1165
BHG Berea Treatment Center	BHG XXXV	1000 Ace Drive	Berea	KY	40403	(859) 756-5006
Center for Behavioral Health Kentucky, Inc.		1990 Louisville Road, Suite 110	Bowling Green	KY	42101	(270) 782-2100
BHG XXXIV, LLC	BHG Corbin Treatment Center	967 South Hwy. 25 West	Corbin	KY	40702	(606) 526-9348
NKY Med Clinic, LLC		1717 Madison Avenue	Covington	KY	41011	(859) 360-0250
Metro Treatment of Kentucky, LP	Covington Metro Treatment Center	1450 Madison Avenue	Covington	KY	41011	(859) 444-4499
E-Town Addiction Solutions, LCC		2645 Leitchfield Road, Suite 104	Elizabethtown	KY	42701	(270) 234-8180
Center for Behavioral Health Kentucky, Inc.		2225 Lawrenceburg Road, Building C	Frankfort	KY	40601	(502) 352-2111
BHG XXVI, LLC	Kentucky Treatment Centers-Hazard	48 Independence Drive	Hazard	KY	41701	(606) 487-1646
Western KY Medical, LLC		609 Hammond Plaza	Hopkinsville	KY	42240	(270) 887-8333
Crossroads Treatment Center of Northern Kentucky, PSC		1974 Walton Nicholson Pike	Independence	KY	41051	(864) 527-3145
Crossroads Treatment Center of Louisville		1700 Cargo Court	Jeffersontown	KY	40299	(502) 749-6764
BHG XXXV, LLC	dba BHG Lexington Treatment Center	455 Park Place	Lexington	KY	40511	(859) 276-0533
New Vista	Medication Assisted Recovery	201 Mechanic Street	Lexington	KY	40507	(859) 977-6080
Methadone Opiate Rehabilitation and Education Center	The MORE Center	1448 South15th St.	Louisville	KY	40210	(502) 574-6414
Center for Behavioral Health Kentucky, Inc.		1402-A Browns Lane	Louisville	KY	40207	(502) 894-0234
Daviess Treatment Services, LLC	Daviess Treatment Services, LLC	3032 Hwy 144	Owensboro	KY	42303	(270) 685-5030
BHG XXXIII, LLC	BHG Paducah Treatment Center	2705 Olivet Church Road	Paducah	KY	42001	(270) 443-0096
BHG XXIV, LLC	Kentucky Treatment Centers-Paintsville	628 Jefferson Ave.	Paintsville	KY	41240	(606) 789-6966
BHG XXV, LLC	Kentucky Treatment Centers-Pikeville	368 South Mayo Trail	Pikeville	KY	41501	(606) 437-0047
Center for Behavioral Health Kentucky, Inc.		1018 Ival James Boulevard	Richmond	KY	40475	(859) 575-1323
CRC Health Treatment Clinics, LLC	Shelbyville Comprehensive Treatment Center	213 Midland Blvd.	Shelbyville	KY	40065	502-647-0154

Table 36: Kentucky: Certified MAT Centers

Buprenorphine Practitioners

Table 37 provides a list of practitioners authorized to treat opioid dependency with buprenorphine. ^{xxxvii}

County	Name	Address	City	State	Zip Code	Telephone Number
Adair	Dr. Viorel Boborodea	803 Burkesville St	Columbia	KY	42728	270-318-3399
	Dr. Martha Burton	805 Burkesville St	Columbia	KY	42728	270-384-0233
	Susan Bradshaw / Sandra Popplewell (NPs)	1463 Campbellsville Road	Columbia	KY	42728	270-384-9934
	Dr. Mary Dene, Dr. Donald Weidler and Dr. Robert Shipp					
Casey	Dr. Robin Atwood	84 Hustonville Street	Liberty	KY	42539	606-706-7473
	Dr. Imad Haddad	112 Liberty Square	Liberty	KY	42539	606-787-5044
Pulaski	Dr. Nicholas Zinn	305 Langdon Street	Somerset	KY	42503	215-588-8869
	Dr. Viorel Boborodea	850 Hail Knob Road Ste B	Somerset	KY	42503	270-318-3399
	Dr. Richard Van Dam	2441 S. Highway 27	Somerset	KY	42501	606-219-6680
	Dr. Alan Myers	349 Bogle Street	Somerset	KY	42503	606-485-4611
	Mark Martin / Joann Carroll (NPs)	341 Bogle Street Ste A	Somerset	KY	42503	606-677-0201
	Dr. Ibraiz Iqbal	104 Hardin Lane Ste B	Somerset	KY	42503	606-677-1112
	Dr. Dennis Anciro and Dr. Gionvannie Eugenion	754 S Highway 27	Somerset	KY	42501	606-677-6787
	Dr. Ashok Lakhiani	1112 South Hwy 27, Ste B	Somerset	KY	42501	606-679-6251
	Dr. James Wilson	100 Hardin Lane Suite 3	Somerset	KY	42501	866-755-4258
	Dr. John Garner	660 Lakeway Drive	Russell Springs	KY	42642	270-858-3003
Russell	Dr. Robert Bertram	92 Joe Petty Drive	Russell Springs	KY	42642	866-755-4258
	Dr. John Garner	1846 Old Lebanon Road	Campbellsville	KY	42718	270-789-1022
Taylor	Cynthia Phillips / Kathleen Stevens / Manada Shepperd (NPs)					

Table 37: Buprenorphine Practitioners

Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder

Opioid overdoses cause one death every 20 minutes. Medication-Assisted Treatment (MAT)—a combination of psychosocial therapy and U.S. Food and Drug Administration-approved medication—is the most effective intervention to treat opioid use disorder (OUD) and is more effective than either behavioral interventions or medication alone. MAT significantly reduces illicit opioid use, compared with nondrug approaches, and increased access to these therapies can reduce overdose fatalities. However, MAT is often unavailable to those in need of it because of inadequate funding for treatment programs and a lack of qualified providers who can deliver these therapies.

<https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder>

Task Forces

Title/Type: *National City-County Task Force on the Opioid Epidemic*

Objective(s):

- Explore how cities and counties collaborate to address the opioid epidemic.
- Explore how local leaders can build on these collaborations to improve outcomes in local communities.
- Increase awareness, elevate proven solutions, disseminate guidance and solutions to city and county officials.

Kentucky Involvement: Judge Gary Moore of Boone County, KY is the Co-Chair.

Source/Link: <http://opioidaction.org/report/>
<https://www.ket.org/opioids/legislators-create-task-force-opioid-abuse/>
<https://www.naco.org/national-city-county-task-force-opioid-epidemic>

Title/Type: *South Louisville Task Force on Opioids*

Objective(s): Study the opioid abuse epidemic in south Louisville and develop recommendations to state and local government and the community-at-large.,

Kentucky Involvement: Targeting specific districts in south Louisville (State Representatives McKenzie Cantrell and Joni Jenkins).

Source/Link: <https://insiderlouisville.com/health/drug-epidemic/south-louisville-legislators-convene-task-force-on-opioid-crisis/>
<https://www.facebook.com/events/lynnhurst-united-church-of-christ/south-louisville-task-force-on-opioids/2068664306740593/>

Medical Facilities, Educational Institutions, and Other Resources

Hospitals

Table 38 provides a list of hospitals in the A-ROC service area, notable is that there is no hospital in McCreary County. For a comprehensive list of all hospitals in the state of the Kentucky please visit: <https://chfs.ky.gov/agencies/os/oig/dhc/Pages/hcf.aspx>

County Location of Provider	Name	Address	City	State	Zip	Phone Number
Adair County	T.J. Health Columbia	901 Westlake Drive	Columbia	KY	42728	270-384-4753
Casey County	Casey County Hospital	187 Wolford Avenue	Liberty	KY	42539	606-787-6257
Clinton County	The Medical Center at Albany	723 Burkesville Rd	Albany	KY	42602	606-387-8000
Cumberland County	Cumberland County Hospital	299 Glasgow Road	Burkesville	KY	42717	270-864-2511
Green County	Jane Todd Crawford Hospital	202-206 Milby Street	Greensburg	KY	42743	270-932-4211
McCreary County	There are no hospitals currently in this county					
Pulaski County	Lake Cumberland Regional Hospital	305 Langdon Street	Somerset	KY	42503	606-679-7441
Russell County	Russell County Hospital	153 Dowell Road	Russell Springs	KY	42642	270-866-4141
Taylor County	Taylor Regional Hospital	1700 Old Lebanon Road	Campbellsville	KY	42718	270-465-3561
Wayne County	Wayne County Hospital	166 Hospital Street	Monticello	KY	42633	606-348-9343

Table 38: Hospitals

Health Departments

Table 39 provides a list of all county health departments in the A-ROC service area.

Name	Address	City	State	Zip	Phone Number
Adair County Health Department	801 Westlake Drive	Columbia	KY	42728	270-384-2286
Casey County Health Department	199 Adams Street	Liberty	KY	42539	606-787-6911
Clinton County Health Department	131 Foothills Avenue	Albany	KY	42602	606-387-5711
Cumberland County Health Department	226 Copper Lane	Burkesville	KY	42717	270-864-1232
Green County Health Department	220 Industrial Park Rd	Greensburg	KY	42743	270-932-4341
McCreary County Health Department	119 Medical Lane	Whitley City	KY	42653	606-376-2412
Pulaski County Health Department	45 Roberts Street	Somerset	KY	42501	606-679-4416
Russell County Health Department	211 Fruit of the Loom Dr	Jamestown	KY	42629	270-343-2181
Taylor County Health Department	1880 N. Bypass Rd.	Campbellsville	KY	42718	270-465-4191
Wayne County Health Department	39 Jim Hill Service Road	Monticello	KY	42633	606-348-9349

Table 39: Health Departments

Medical Clinics

Table 40 provides a list of medical clinics in the A-ROC service area accepting uninsured/self-pay (on a sliding scale) and/or Medicaid patients. Research was conducted using: <https://www.freeclinics.com/>, as well as individual county websites

County Location of Provider	Name	Address	City	State	Zip	Phone Number
Adair County	T.J. Health Columbia Clinic	902 Westlake Drive	Columbia	KY	42728	270-384-0451
	T.J. Health Columbia-Primary Care	810 Jamestown Street	Columbia	KY	42728	270-384-4764
	Adair Family Medical Center	937 Campbellsville Road	Columbia	KY	42728	270-384-2777
Casey County	Casey Family Medical Center	376 Randolph Street	Liberty	KY	42539	606-787-6246
Clinton County	Clinton Family Medical Center	606 Burkesville Rd	Albany	KY	42602	606-387-4251
Cumberland County	Cumberland Family Medical Center	360 Keen Street	Burkesville	KY	42717	270-864-2889
Green County	Greensburg Healthcare	2680 Campbellsville Rd	Greensburg	KY	42743	270-299-2222
	Greensburg Family Medical Center	1911 Campbellsville Rd	Greensburg	KY	42743	270-932-2424
	Green County Primary Care (Clinic of hospital)	310 Industrial Park Road	Greensburg	KY	42743	270-299-2286
McCreary County	McCreary Family Medical Center	69 S. Main Street	Whitley City	KY	42653	606-376-7399
Pulaski County	Women's Care of Lake Cumberland	333 Bogle Street	Somerset	KY	42503	606-678-2807
Russell County	Russell Family Medical Center	404 Steve Drive	Russell Springs	KY	42642	270-866-3161
	Wellness on Wheels Preventative Oral Health Primary Care Services	404 Steve Drive	Russell Springs	KY	42642	270-858-6655
	Jamestown Healthcare	1417 N. Main St	Jamestown	KY	42629	270-343-2597
	Family Practice Associates of Russell County	124 Dowell Road	Russell Springs	KY	42642	270-866-2440
	Primary Care Associates of Russell County	92 Joe T. Pettet Dr.	Russell Springs	KY	42642	270-866-8881
Taylor County	Taylor Regional Care Center	67 Kingswood Drive	Campbellsville	KY	42718	270-465-3812
Wayne County	Wayne County Hospital's Rural Health Clinic	166 Hospital Street	Monticello	KY	42633	606-340-3251

Table 40: Medical Clinics

Mental Health/Behavioral Health Clinics

Table 41 provides a list of mental health/behavioral health clinics in the A-ROC service area accepting uninsured/self-pay and/or Medicaid patients.

Count(ies) Served	County Location of Provider	Name	Address	City	State	Zip	Phone Number
Adair County	Adair County	Adanta Group	200 E Frazier Ave	Columbia	KY	42728	270-384-4719
Casey County	Casey County	Adanta Group	322 Middleburg Street	Liberty	KY	42539	606-787-9472
Clinton and Cumberland Counties	Clinton County	Adanta Group	101 Adanta Circle	Albany	KY	42602	606-387-7635
Green County	Green County	Adanta Group	521 Old Hedgenville Rd	Greensburg	KY	42743	270-932-3226
McCreary County	McCreary County	Adanta Group	90 Medical Lane	Whitley City	KY	42653	606-376-2466
Pulaski County	Pulaski County	Adanta Group	259 Parkers Mill Road	Somerset	KY	42501	606-679-7348
Russell County	Russell County	Adanta Group	119 Herriford Curve Rd	Jamestown	KY	42629	270-343-2551
Taylor County	Taylor County	Adanta Group	250 Water Tower Bypass	Campbellsville	KY	42718	270-465-7424
Wayne County	Wayne County	Adanta Group	735 West Columbia Ave	Monticello	KY	42633	606-348-9318
Community Based Interventions in Clinton County (606-387-0567) and Wayne County (606-343-0216)							

Table 41: Mental Health/Behavioral Health Clinics

Outpatient Substance Abuse/Opioid Treatment Clinics

Using the search engine: <https://findhelpnowky.org/>, outpatient substance abuse/opioid treatment clinics were located for each of the A-ROC service area counties, see table 42.

County Location of Provider	Name	Address	City	State	Zip	Phone Number
Adair County	SperoHealth	341 Office Park Dr	Columbia	KY	42728	270-380-1601
	Adanta Group	200 E Frazier Ave	Columbia	KY	42728	270-384-4719
Casey County	Adanta Group	322 Middleburg Street	Liberty	KY	42539	606-787-9472
Clinton County	Adanta Group	101 Adanta Circle	Albany	KY	42602	606-387-7635
	Community Based Interventions	104 Washington Street	Albany	KY	42602	606-387-0567
Cumberland County	Serenity Counseling Services	301 Keen St	Burkesville	KY	42717	
Green County	Adanta Group	521 Old Hedgenville Rd	Greensburg	KY	42743	270-932-3226
McCreary County	Adanta Group	90 Medical Lane	Whitley City	KY	42653	606-376-2466
Pulaski County	Adanta Group	259 Parkers Mill Road	Somerset	KY	42501	606-679-7348
	SperoHealth	349 Bogle Street Suite B	Somerset	KY	42501	606-485-4611
	Buckhorn Children and Family Services	99 Office Park Dr	Somerset	KY	42501	606-668-1114
Russell County	Adanta Group	119 Herriford Curve Rd	Jamestown	KY	42629	270-343-2551
	Serenity Counseling Services	130 Wilson St	Russell Springs	KY	42642	270-864-1625
Taylor County	Adanta Group	250 Water Tower Bypass	Campbellsville	KY	42718	270-465-7424
Wayne County	Adanta Group - Monticello	735 West Columbia Avenue	Monticello	KY	42633	606-348-9318
	Community Based Interventions	80 Rolling Hills Blvd	Monticello	KY	42633	606-343-0216

Table 42: Substance Abuse/Opioid Treatment Clinics

Note: Search option filter(s) used: Treatment Type = Outpatient

Closest Residential Treatment Facilities

Using the search engine: <https://findhelpnowky.org/>, each county name was entered and the top/closest residential treatment facility was identified; table 43 illustrates the five closest residential treatment facilities available to residents of the A-ROC service area.

County Location of Provider	Name	Address	City	State	Zip	Distance in miles from A-ROC Service Area Counties
Taylor County	The Healing Place of Campbellsville (Not accepting patients as of 11/15/19)	105 Hiestand Farm Rd	Campbellsville	KY	42718	Adair County (19) Cumberland County (40) Green County (12) McCreary County (40) Taylor County (0)
Pulaski	SKYHope Recovery (program for women)	77 Union Street	Somerset	KY	42501	Casey County (23) Clinton County (38) Pulaski County (0) Russell County (26) Wayne County (26)
Pulaski	Lake Hills Oasis (program for men)	125 Jordans Way	Somerset	KY	42501	Casey County (24) Clinton County (41) Pulaski County (0) Russell County (29) Wayne County (28)

Table 43: Residential Treatment Facilities

Note: Search option filter(s) used: Treatment Type = Residential: Short or Long-Term

Closest Medical Detox Centers

Using the search engine: <https://findhelpnowky.org/>, each county name was entered and the top/closest medical detox center was identified; table 44 illustrates the four closest medical detox centers available to residents of the A-ROC service area.

County Location of Provider	Name	Address	City	State	Zip	Distance in miles from A-ROC Service Area Counties
Whitley / Knox County	Baptist Health-Trillium Center	1 Trillium Way	Corbin	KY	40701	Clinton County (59) McCreary County (25) Russell County (52) Wayne County (43)
Warren County	Rivendell Behavioral Health Hospital	1035 Porter Pike	Bowling Green	KY	42103	Cumberland County (589)
Hardin County	Stepworks Recovery Centers - Elizabethtown (Crowne Pointe)	1111 Crowne Pointe Drive	Elizabethtown	KY	42701	Adair County (53) Green County (35) Taylor County (39)
Jessamine County	Stepworks Recovery Centers - Nicholasville	151 Coconut Grove Drive	Nicholasville	KY	40356	Casey County (44)

Table 44: Medical Detox Centers

Note: Search option filter(s) used: Treatment Type = Detox: Medical

Closest Inpatient Rehab Facilities

Using the search engine: <https://findhelpnowky.org/>, each county name was entered and the top/closest inpatient rehab facility was identified; table 45 illustrates the three closest inpatient rehab facilities available to residents of the A-ROC service area.

County Location of Provider	Name	Address	City	State	Zip	Distance in miles from A-ROC Service Area Counties
Hardin County	Lincoln Behavioral Health System	3909 S. Wilson Road	Radcliff	KY	40160	Casey County (65) Green County (42) Taylor County (46)
Montgomery County	Shepherds Shelter	236 Bridgett Dr	Mount Sterling	KY	40353	McCreary County (99) Pulaski County (74)
Russell County	Russell County Hospital Medical Stabilization (3 to 5 day inpatient detox program)	153 Dowell Road	Russell Springs	KY	42642	Adair County (14) Casey County (20) Clinton County (23) Cumberland County (25) Green County (31) McCreary County (41) Pulaski County (30) Russell County (0) Taylor County (23) Wayne County (24)
Warren County	Rivendell Behavioral Health	1035 Porter Pike	Bowling Green	KY	42103	Adair County (59) Clinton County (71) Cumberland County (59) Russell County (73) Wayne County (86)

Table 45: Inpatient Rehab Facilities

Note: Search option filter(s) used: Treatment Type = Inpatient

Figure 32 illustrates the locations of the closest residential treatment, medical detox and in-patient rehab facilities in relation to the A-ROC service area counties.

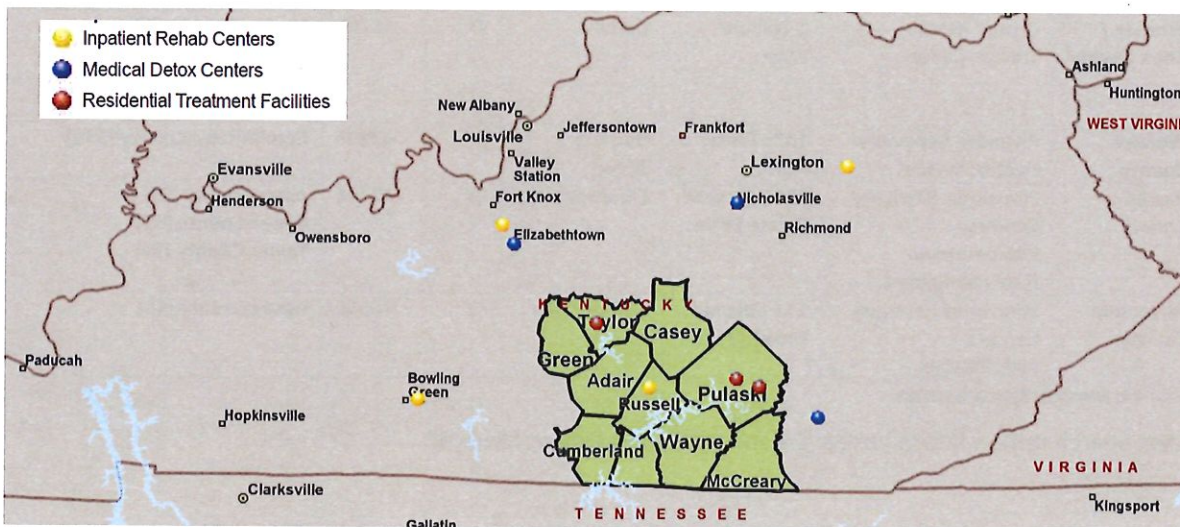


Figure 32: Closest Treatment Facilities to A-ROC Service Area

Needle Exchange Programs

Based on data collected from the [Kentucky Cabinet for Health and Family Services](#), there are currently 69 Syringe Service Program (SSP) sites operating in 58 KY counties (Fig 33).

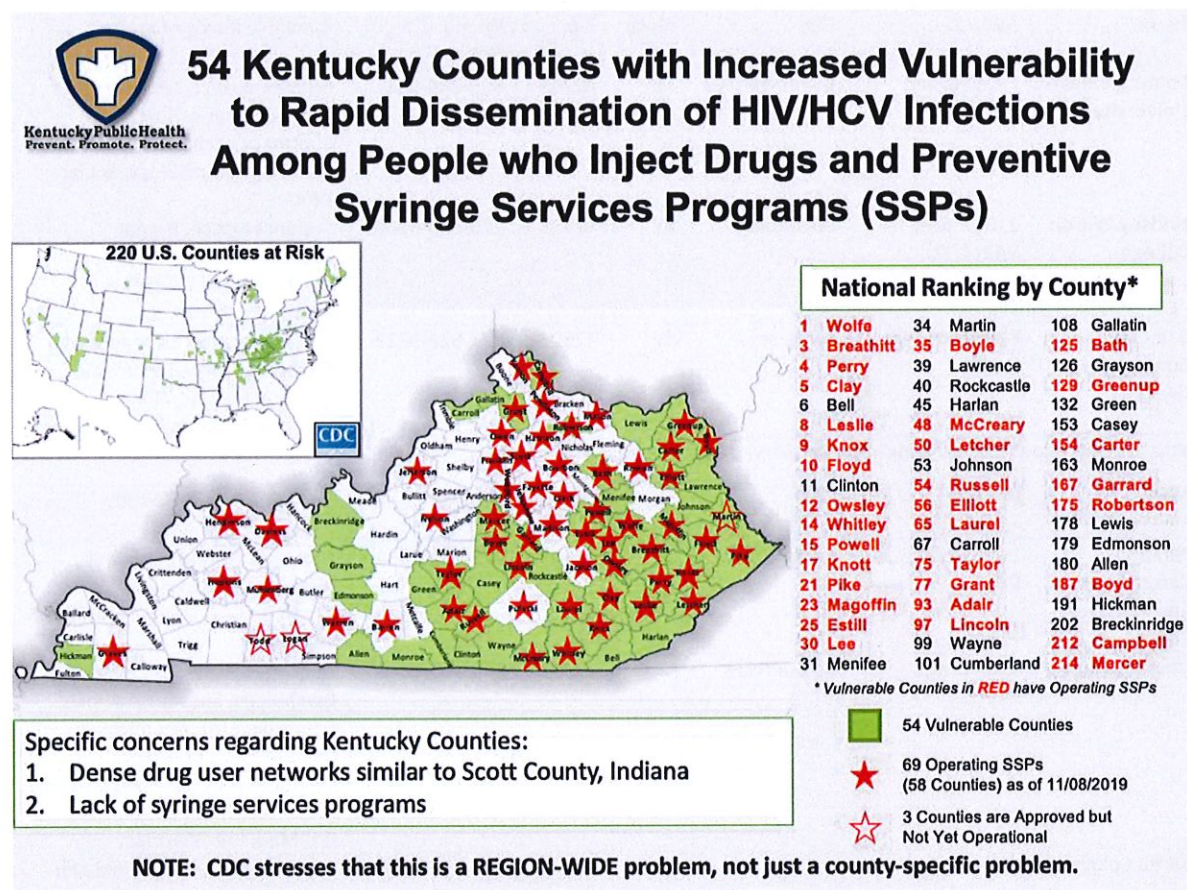


Figure 33: KY Syringe Services Programs (SSPs)

Nine out of the ten A-ROC service area counties are categorized as vulnerable counties, however **only five have Syringe Services Programs (SSPs)**. All SSPs in the five counties are located in the county health departments, with limited days and hours of operation for the program (Table 46).

Name	Address	City	State	Zip	Times
Adair County Health Department	801 Westlake Drive	Columbia	KY	42728	MWF 3-4:15
McCreary County Health Department	119 Medical Lane	Whitley City	KY	42653	W 8 – 4pm
Pulaski County Health Department	45 Roberts Street	Somerset	KY	42501	M-F 8 – 4pm
Russell County Health Department	211 Fruit of the Loom Dr	Jamestown	KY	42629	M-F 1-4pm
Taylor County Health Department	1880 N. Bypass Rd.	Campbellsville	KY	42718	MTRF 1-4pm

Table 46: Syringe Services Programs (SSPs)

Educational Institutions

Tables 47 and 48 provide list of education institutions with fields of study relevant to the study, only three of the institutions listed are in the A-ROC service area (Table 47).

Name	Address	City	State	Zip	Phone Number	Available Fields of Study
Campbellsville University	1 University Drive	Campbellsville	KY	42718	800-264-6014	Criminal Justice, Marriage and Family Therapy, Nursing, Pharmacy Technician, Pre-Pharmacy, Psychology, Social Work
Lindsey Wilson College	210 Lindsey Wilson St.	Columbia	KY	42728	270-384-8100	Criminal Justice, Human Services & Counseling, Psychology, Nursing, Pre-Pharmacy, Pre-Med,
Somerset Community College	808 Monticello Street	Somerset	KY	42501	877-629-9722	Criminal Justice, Emergency Medical Services-Paramedic, Practical Nursing, Nursing, Pharmacy Technology,

Table 47: Educational Institutions in A-ROC Service Area

Name	Address	City	State	Zip	Phone Number	Available Fields of Study
Ashland Community and Technical College	1400 College Drive	Ashland	KY	41101	606-326-2000	Nursing Assistant, Criminal Justice, Health Science Technology, Nursing, Pharmacy Technology
Union College	310 College Street	Barbourville	KY	40906	800-489-8646	Nursing & Health Sciences, Psychology, Substance Abuse Counseling-MS, Chemical Dependency Counselor Certification (CDCC-fully online), Social & Behavioral Sciences, Pre-Med, Pre-Pharmacy
Berea College	101 Chestnut St.	Berea	KY	40404	859-985-3000	Psychology, Nursing, Child and Family Studies
Western Kentucky University	1906 College Heights Blvd.	Bowling Green	KY	42101	270-745-0111	Psychological Studies, Public Health, Social Work, Clinical Mental Health Counseling, Addictions Education Certificate
Thomas More University	333 Thomas More Parkway	Crestview Hills	KY	41017	859-341-5800	Nursing, Psychology, Criminal Justice
Centre College	600 West Walnut St.	Danville	KY	40422	859-238-5200	Psychology, Pre-Nursing, Pre-Social Work, Pre-Pharmacy, Pre-Med, Pre-Physician Assistant
Elizabethtown Community and Technical College	600 College Street Rd	Elizabethtown	KY	42701	270-769-2371	Criminal Justice, Emergency Medical Services Technology, Health Science Technology, Human Services-Psychiatric Mental Health Technician Cert. & Substance Abuse Recovery Coach Cert., Nursing, Nurse's Aide
Gateway Community	500 Technology Way	Florence	KY	41042	859-441-4500	Criminal Justice, Emergency Medical Services Technology-Paramedic, Human Service-

Lake Cumberland Area Response to Opioids in Rural Communities (A-ROC) Planning Consortium

Opioid Crisis Community Needs Assessment: *Part III: Current Initiatives, Programs, Resources and Best practices*

Name	Address	City	State	Zip	Phone Number	Available Fields of Study
and Technical College						Substance Abuse Recovery Coach Certificate, Nursing
Kentucky State University	400 East Main Street	Frankfort	KY	40601	502-597-6000	Psychology, Nursing, Criminal Justice, Social Work
Georgetown College	400 East College St.	Georgetown	KY	40324	800-788-9985	Nursing Arts, Pre-Med, Pre-Pharmacy, Psychology, Public Health, Social & Criminal Justice,
Northern Kentucky State University	Nunn Drive	Highland Heights	KY	41099	859-572-5100	Child Mental Health Counseling, Criminal Justice, Nursing, Health Science, Psychological Studies, Social Work
Hopkinsville Community College	720 North Drive	Hopkinsville	KY	42241-2100	270-707-3700	Nursing, Criminal Justice, Human Services
Transylvania University	300 North Broadway	Lexington	KY	40508	859-233-8300	Psychology, Pre-Med, Pre-Pharmacy, Pre-Physician Assistant, Pre-Public Health
University of Kentucky	100 Funkhouser Building	Lexington	KY	40506	859-257-2000	Nursing, Social Work, Public Health, Pre-Med, Psychology, Pharmacy, Medical School, Dental School
Bellarmine University	2001 Newburg Rd	Louisville	KY	40205	502-272-8000	Criminal Justice, Nursing, Psychology, Pre-Pharmacy,
University of Louisville		Louisville	KY	40292	800-334-8635	Criminal Justice, Nursing, Public Health, Social Work, Counseling & Human Development, Alcohol and Drug Counseling, Medical School, Dental School
Midway University	512 East Stephens St	Midway	KY	40347	800-755-0031	Criminal Justice, Nursing, Psychology (Alcohol & Drug Abuse Counseling concentration), Pre-Med, Pre-Physician Assistant, Pre-Pharmacy,
Morehead State University	150 University Blvd.	Morehead	KY	40351	800-585-6781	Child Development, Chemical Dependency Counseling Minor, Community Support Services, Counseling, Criminology, Criminal Justice, Nursing, Physician Assistant, Psychology, Social Work,
Murray State University	102 Curris Center	Murray	KY	42071	800-272-4678	Clinical Mental Health Counseling, Clinical Psychology, Criminal Justice, Nursing, Public and Community Health, Social Work,
Kentucky Wesleyan College	3000 Frederica St.	Owensboro	KY	42301	800-999-0592	Criminal Justice & Criminology, Health Sciences, Nursing, Psychology, Pre-Pharmacy, Pre-Med, Pre-Physician Assistant,
University of Pikeville	147 Sycamore Street	Pikeville	KY	41501	606-218-5250	Criminal Justice, Nursing, Social Work, Psychology, Osteopathic Medicine

Name	Address	City	State	Zip	Phone Number	Available Fields of Study
Eastern Kentucky University	521 Lancaster Avenue	Richmond	KY	40475	859-622-1000	Nursing, Child and Family Studies, Psychology, Emergency Medical Care, Mental Health Counseling, Public Health, Police Studies, Social Work
University of the Cumberlands	6178 College Station Drive	Williamsburg	KY	40769	877-713-8767	Public Health, Human Services, Psychology, Criminal Justice, Pre-Med, Pre-Pharmacy, Pre-Physician Assistant
Asbury University	One Macklem Drive	Wilmore	KY	40390	859-858-3511	Clinical Psychology, Pre-Nursing, Psychology, Social Work,

Table 48: Educational Institutions

Other Databases and Resources

Opioids Safety – Tools and Resources

<https://www.premiersafetyinstitute.org/safety-topics-az/opioids/tools-and-resources/>

USDA Opioid Resources

<https://www.usda.gov/topics/opioids/resources-map>

Covering Opioids with Data

<https://docs.google.com/document/d/1NDjd-7I2GfENPFRqMi5cT63Q6KRzWsvTHohbXESTnHq/edit>

Measuring the Toll of the Opioid Epidemic Is Tougher Than It Seems

<https://www.propublica.org/article/measuring-the-toll-of-the-opioid-epidemic-is-tougher-than-it-seems>

CONSULTANT OBSERVATIONS AND IMPLICATIONS

Perception plays an important role in our life but sometimes we ignore the fact that the way we perceive things might not be the way things are. Our beliefs, culture and many other biases come in the way when looking at an event and trying to understand it. Wrong perceiving of a situation might sometimes lead to negative emotions and interfere with how or what we are willing to do to change conditions. Perception will also play a role in fixing the opioid crisis we face in our country. There are many key players we need to engage in the solution, including pharmaceutical companies, patients and advocates, physicians and medical professionals, service providers, family members, elected officials and adolescents.

The **perception** we construct becomes our reality. For example, there are many studies that prove that physicians care about what patients want and research shows that U.S. doctors consider patient expectations and preferences as key factors in whether to formally recommend pain medications.^{xxxviii} Drug makers know this, and pharmaceutical companies spend billions of dollars a year on advertising their drugs on television and other popular media. That advertising has had a dangerous influence on prescribing practices for all kinds of drugs, not just opioids. Perception-based marketing may and has influenced patients, their families, and physicians. In 2015 the American Medical Association (AMA), one of the largest professional organizations for physicians in the nation, called for a total ban on these kinds of commercials.^{xxxix} AMA was unsuccessful.

Other similar examples are playing out across the nation, and public health officials are forced to combat preconceived notions about what addiction is, and what it takes to address it. Examples of perceptions they must address include:

- "People with addiction are often blamed and told it is their responsibility to 'fix it' themselves, and stigma colors people's thinking about the right thing to do."
- "Stigma is the single largest reason why we don't have these programs everywhere they are needed."
- "There's really no other health condition that we either address through the use of the criminal justice system as a primary means of engagement, or through ignoring the science and the evidence around what works."
- Many times, people do not believe in "evidence" because it is inconsistent with their underlying opinion about the situation.

Although the impacts of the opioid epidemic are far-reaching, the future is by no means bleak. Community members, organizations, churches, government agencies, nonprofits and countless others have devoted time, resources, and personal emotional investment into addressing the causes of opioid misuse, offering treatment to those who seek help, and working to prevent opioid use disorder in the future.

For the past four months, A-ROC and Nolo Consulting's team focused on collecting and analyzing over a thousand perception responses and statements from a variety of stakeholders and diverse community groups in Kentucky's A-ROC counties. These are essential because it is not always enough to just present secondary data in order to overcome perceivable characteristics or social stigmas. Based on the responses and perceptions collected from participants, our team identified seven major categories that can help consortium members build a shared plan under an organized structure and create a united and strategic plan of work to address the current opioid crisis. After reviewing these seven categories and themes, leaders and advocates like A-ROC Planning Consortium will need to continue to make the case for more vigorous education campaigns, support medical interventions (even those that may be controversial),

expand advocacy efforts in isolated communities, and urge for policy solutions to address opioid abuse, always underscoring what is at stake.

These seven categories encompass the hundreds of individual perceptions collected from county residents and an emphasis on these may help tailor solutions that are culturally relevant and timely to help lessen the influence of opioid use disorder. Also included in [Appendix C](#) are complete individual responses without edits to capture all reactions, ideas, suggestions and provide an actual indication of the frequency of the responses.

1. Community Outreach Activities: Education and a Focus on Early Intervention

The most repeated responses, over 350 answers, identified education, raising awareness, organizing community members, developing relationships that would gain buy-in, putting together a taskforce (composed of critical service providers, for example, pharmacists) and a having a focus on educating children as the key activities to address the epidemic. Many responses also complemented the finding from the focus group sessions conducted across the region, agreeing that **“engaging the community in dialogue and educating them could be a significant preventative strategy.”** Some examples from the surveys are: *“Be willing to be a messenger to help others learn about the education of the drug crisis and the length of time it takes to recover”*; *“Advocate for the re-creation of the/a Civilian Conservation Corps similar to the work relief program from the 1930's but with a new focus of removing individuals from harmful personal environments and teaching them skills related to the conservation and development of natural resources owned by the state and federal government.”*; and, *“Train a certain group of people to be educated and experienced in recognizing when someone is under the influence so as to ensure they are highly educated and not abusing them themselves and then work out some type of system where these people can notify authorities. This who abuse, do not become concerned about being careful about going and buying the substances but those who sell them are usually very careful and will carry 2-3 disposable phones, carry backpacks and have certain characteristics about them.”*

2. Expanding Access and Funding for Therapy Treatment and Recovery

The second highest responses include expanding access and funding for more treatment and recovery. Selected responses included: *“Create more rehab opportunities for the poor”*; *“establish a local sub/methadone clinic”*; *“Make mental healthcare more accessible and comprehensive”*; *“Support programs that are addressing the issue, i.e. Celebrate Recovery. Need faith-based involvement to support recovery efforts”*; and *“Make sure the children of anyone fighting an opioid addiction get into a program to help them as early as possible.”*

3. Law Enforcement and Punishment of Users

A few responses encourage tougher laws, monitoring, enforcement, improvement in the court system and punishment. Some of the responses include: *“Go after the drug pushers and keep them in jail stop just giving them a slap on the wrist and do something to them as well as the users. Drug Court is a good option!”*; and, *“We can’t, but if the judges stopped the revolving door system & we had a legal system more like President Reagan recommended in the 80s there wouldn’t be as big a problem. We blame everyone & everything but the person who chooses to do drugs. We need to stop making excuses for people & they need to face the legal consequences of their actions.”*

4. Physician and Prescription Focus

Responses from participants centered on to the reduction of prescriptions, monitoring doctors and other comments against prescription drug companies. Some of the secondary data we reviewed showed that opioid prescription distribution in the A-ROC area, based on the rates reported from 2007 to 2017, was not based on a coherent standard and reveal plenty of county-to-county inconsistencies. Also,

there is evidence of a “push” for a higher prescription of opioid pain medications in rural areas by different drug companies and a higher rate of opioid prescription in Kentucky as compare to the US for Medicare Part D. Some of the responses include: *“As parents, not use opioids ourselves and NOT allow the doctors to give them to our children for pain relieve after surgery. Both my daughter and son were given scripts after wisdom teeth extraction and I wouldn't fill them. They used ibuprofen for pain and swelling which worked fine.”*; and, *“Pharmacies with high narcotic sales speak up about doctors with reputation to prescribe and this really shows.”*

5. Policy Focus

Two examples include these statements: *“Devote your time in changing the laws.”*; *“Stronger laws and jail time needs to be longer to get them detox and then set up programs out of state away from their homes. I think that would help to have it away from the place they are used to getting their drugs.”*

6. Expand Research and Explore/Support Socio-Economic Alternatives

Ideas and perceptions examples include: *“Find out what local communities are already doing and build upon those efforts rather than making new programs”*; and *“Recruit businesses that pay a living wage to hire locals. Work to make affordable housing available to all who need it.”*

7. Cultural Beliefs

Some of the comments from a few respondents regarding how to help prevent the opioid epidemic included: *“Need a faith-based community at the forefront. People need Jesus and so many times they are filling hurts with “stuff” to cover the hurt”*; and, *“Show concern, love, and compassion to those in need.”*

APPENDICES

Appendix A: Focus Group Instructions, Do's and Don'ts for Focus Group Interviews, Consent Form

Appendix B: Community Perception Survey About Opioid Use and Abuse

Appendix C: Community Perception Survey About Opioid Use and Abuse: Q7 and Q8

Appendix A: Focus Group Instructions, Do's and Don'ts for Focus Group Interviews, Consent Form



July 25, 2019

TO: Lake Cumberland Area Response to Opioids in Rural Communities Planning Consortium
FR: Nolo Consulting, LLC, Dr. H Nolo Martínez (nolomartinez@gmail.com)
RE: Focus Group Template and General Information

What is A-ROC Planning Consortium: Lake Cumberland Community Action Agency, Inc. (LCCAA) formed a multi-sector, opioid response planning consortium in the rural 10 county Lake Cumberland service area. LCCAA is partnering with Lake Cumberland Area Development District (LCADD), Lake Cumberland District Health Department (LCDHD), and ADANTA - the Regional Mental Health/Mental Retardation Board. All four entities are domestic non-profit community-based organizations serving the 10-county rural service area. The overall goal is to reduce the morbidity and mortality associated with opioid overdoses in high-risk rural communities by strengthening the organizational and infrastructural capacity of multi-sector consortiums to address prevention, treatment, and/or recovery needs. The consortium is called A-ROC and the members are and Lake Cumberland Community Action Agency, Inc. (*A-ROC Lead Applicant Agency*).

Focus Group Purpose: A-ROC will conduct community-level Focus Groups that are comprised of groups from the 10-county area communities. Groups will include, among others: parents, teens, incarcerated individuals, service providers (like law enforcement officials, fire fighters, health providers, elected officials, pharmacists) **to identify various community perceptions about opioid use and abuse and provide insight as to why these perceptions are held and to help improve a consortium planning process.**

Increasing utilization and appeal of substance abuse services requires understanding public perceptions of substance abuse. The public views on substance abuse is diverse and many times difficult to change. Helpful and effective messages and strategic to improve health prevention communications are needed to support hundreds of community members in the 10-county area. The significance of collecting individual perceptions from community focus groups is that perception influences opinion, judgment, understanding of a situation, meaning of an experience, and how one responds to a situation. Based on the information we collect, the A-ROC Planning Consortium will be able to identify community needs and opportunities as well as to plan educational and strategic activities in prevention, treatment and recovery.

Before conducting any focus groups, it is important to decide what information you would like to obtain from your qualitative methods. Below are some sample perception questions you may use. Remember, these are only suggestions – feel free to adjust, discard or add any questions to adapt your qualitative methods to your specific community.

Quick Tips:

- Always provide definitions for terms so that you and your participants are on the same page. (For example, **Opioids** definition = are a class of drugs that include the illegal drug heroin,

synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone (OxyContin®), hydrocodone (Vicodin®), codeine, morphine, and many others.)

- Start with 1 – 2 warm-up questions to build rapport. These are easy, fact-seeking questions.
- Use 5 – 7 core questions to obtain in-depth information and 1 – 2 wrap-up questions to allow respondents to share final thoughts.
- Either use a recorder or have a second person taking notes and debrief immediately.

Focus Groups are held in community venues such as schools, churches, community centers, and other locations. Focus Groups are facilitated by local leaders and consortium members who have long term relationship with prevention, treatment and recovery activities in the region. Consortium members will be engaged in the Focus Group process as well as the strategic planning activities that follow the focus group interviews.

FOCUS GROUP QUESTIONS (Please add the two or three group specific questions you have)

1. What are your general feelings about the opioid use and addiction in the county/region?
2. How did you first hear about opioid use and addiction as a problem for our community?
3. What is something that you think would deter people from using opioids?
4. What are the significant different between rural and urban areas regarding drug prescription and use?
5. How do you stay informed about the opioid prevention, treatment and recovery services that are available in the county? *Possible Follow up:* How well does the county leadership, agencies and government keep the community informed?
6. Describe the quality of opioid prevention services in the county. Talk about your experiences.
7. GROUP SPECIFIC QUESTION
8. GROUP SPECIFIC QUESTION

Additional suggestions (optional):

- What is something you would like to learn more about?
- What words or phrases come to mind when you think of the opioid epidemic in the area?
- When, how, and where do people use opioids?
- What, in your own experience, are the reasons of opioid use/addiction?
- What, in your own experience, are the consequences of opioid use/addiction?
- What solutions have other communities used to reduce opioid use and abuse?
- What are the barriers that prevent most community members to be more active in your prevention education programs?
 - *Follow up:* Do you have any ideas on how to build opioid education advocacy leader groups among all communities in the county?
- How much of a challenge is it to have an impact on decisions regarding opioid prevention at the local (county), regional or state level?
- What are your ideas about the possibility or opportunity to work with other community members to support each other and improve prevention education programs in your county?

- *Probe:* Do you think it is possible? Yes, or No. If the answer is no, why not? If the answer is yes, describe how or what experiences you have in cases when parents and community members are working together.

Review: Do's and Don'ts for Focus Group Interviews

A focus group interview can be quite useful for qualitative research if we approach them properly. It can be an effective way to get started on a project. Getting a group of parents together to discuss ideas can be extremely helpful. Focus groups can provide you with a cost-effective way of testing your initial assumptions, beginning to identify relevant topics, exploring ideas, and acquiring the data you need to create a plan to guide program development. Here is a quick list of dos and don'ts that can help you prepare for your session:

1. Recruit Participants from a Variety of Backgrounds.

One of your goals is to identify relevant community groups. You might find that certain ideas resonate strongly with some participants, but don't interest other participants at all.

2. Don't Recruit Participants Who Are Too Similar or Too Different.

It's important that focus-group participants have something in common for you to get useful information about a topic you're exploring.

3. Don't Lose Control of a Focus-Group Session.

If a discussion gains too much momentum, it can take on a life of its own and get away from you, so you might spend 20 minutes talking about something that is completely unrelated to your research goals. To avoid this happening, exercise control over a session, and don't be afraid to stop people if they wander too far off topic or take too much time with their responses. But do this by saying something like, *"I'm really interested in what you're saying, but we need to get us back to the main topic of our discussion because our time is limited."*

4. Do Encourage Conversation Between Participants During a Session

Sometimes people find talking in a group to be intimidating, so it can take a little encouragement to get participants to open up. To facilitate everyone's participation, set the tone for a session by taking the time to chat with each participant before launching a discussion of your planned topics. Introduce yourself and volunteer some information about a personal experience to let participants get a feel for who you are.

It is good to do a round of introductions, and really pay attention to what each person says. Follow up each introduction with thoughtful questions that show you really care about who a person is and what he or she has to contribute. If one person seems more comfortable with open communication, begin the session by chatting with that person to set an example of the kind of communication you want, then transition to another participant who might not be quite as talkative. By making this transition, you'll show more reserved participants that their thoughts and opinions are equally important to you and that they can communicate with you and the group in the same way as more gregarious participants.

5. Don't Go Too Deeply into Any Given Topic

Your goal in a focus group is to properly frame your questions rather than trying to arrive at definitive answers. You'll likely find that some of your questions turn out to be less important than you anticipated, while others that you hadn't considered to be pivotal turn out to be more important than you thought. Don't feel pressured to leave a focus-group session with all of the data you need to guide your team's design decisions. Instead, try to leave each session with a firm understanding of your information needs. This can be extremely valuable because it can help you to avoid spending significant resources investigating topics that are unimportant. It can also help you to identify important issues that could seriously hamper your product's success if you do not address them properly through additional research.

1. Have 2 note takers in the room to record as much information as possible.
2. Make sure to audio record the 50 to 60-minute session.
3. Before the session, make sure to distribute the Consent Form. You may have time to read it out loud and ask each to sign it and collect before starting the focus group.

Regards,

Dr. Nolo Martínez

Nolo Consulting LLC.

LOGO OF A-ROC HERE

Focus Group Participant/Interviewee Consent Form

I understand that Lake Cumberland Area Response to Opioids in Rural Communities Planning Consortium (A-ROC) and partner agencies are trying to understand and identify **various community perceptions about opioid use and abuse and provide insight as to why these perceptions are held and to help improve a consortium planning process**. I am willing to help with the study. I understand that I can help by sharing my views and experiences as I answer to the questions. This study should take about 40 to 50 minutes of my time.

I am taking part because I want to. I have been told that I can stop at any time, and I do not have to answer any questions if I do not want to. No one will know my answers except the A-ROC Planning Consortium Executive Team and the people I tell my answers. By helping with this study, I will help offer input about community efforts, services and help bring about change for our community.

I can contact A-ROC Program Director, Ms. Marlene Taylor, at <phone number> or at <email address>.

Parent's/Guardian's Name: _____

Signature of Parent/Guardian: _____

Date: _____ Time: _____ (AM/PM)


Address: _____ Zip Code: _____

Agency conducting the survey interview: _____

Make sure to give a copy of this consent form to the participant!

Self-discipline is much more of an environmental problem than an individual one. An individual can change beliefs and behavior through education, the resources available for education are presented by the environment. Furthermore, the habits that an individual develop to meet their desires are in large part product of what is available in the environment. A study by neuroscientist Carl Hart found that when meth addicts were given a choice between \$5 dollars and 50 milligrams of meth, addicts took the \$5 dollars half of the time. When they increase the amount to \$20 dollars, they almost never took the drug. The research found that drug addicts are rational decision makers and will choose not to take the drug when there are alternative reinforcers. It seems like drug habits are more likely to be formed when individuals are in an environment that offers not alternative or competing ways to meet their desires. People are product of their environment more than we like to think. By acknowledging this we can have more compassion for one another, but more importantly we can begin helping one another by providing people with as many opportunities as possible for learning alternatives ways to meet their needs we can eradicate the problem of self-discipline.

Appendix B: Community Perception Survey About Opioid Use and Abuse



This Project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department for Health and Human Services (HHS) as part of an award totaling \$200,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.

Community Perception Survey Opioid Use and Abuse

1. How do you rate the opioid use and abuse in your community in the last 12 months? (Please circle one answer)

1 (not a problem)	2	3	4	5	6	7	8	9	10 (worst problem)
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2. Does the opioid crisis affect rural residents of Kentucky more than urban residents? (Please circle one answer)

Rural	Urban	The Same	Don't know
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3. Which of these age groups, do you believe, is the biggest user/abuser of opioids in your county? (Rank from 1 to 5 (1 = biggest user/abuser))

_____ Teenagers _____ 18-25 year olds _____ 26-35 year olds _____ 35-60 year olds _____ 60+ year olds

4. Which of these age groups do you believe needs the most help in recovering from opioid use and abuse in your county? (Rank from 1 to 5 (1 = biggest user/abuser))

_____ Teenagers _____ 18-25 year olds _____ 26-35 year olds _____ 35-60 year olds _____ 60+ year olds

5. To the best of your knowledge, how does the opioid crisis in your community compare with other areas of the state? (Please circle one answer)

Much higher	Higher	About the same	Lower	Much lower
-------------	--------	----------------	-------	------------

6. Does your county offer alternative painkillers and/or pain management therapies besides opioids?

_____ Yes _____ No _____ Don't know Other (please specify): _____

7. What can we do as a community to aid in the prevention of this spreading epidemic?

	Agree	Neutral/Indifferent	Disagree
Educate healthcare professionals about appropriate use			
Educate the public about appropriate use			
Educate politicians and elected officials about research on prevention, treatment and recovery			
Implement prescription-drug monitoring programs			
Take enforcement and regulatory actions to address egregious prescribing (e.g., eliminating "pill mills")			
Develop prescription opioids that incorporate abuse-deterrent technologies			
Offer alternative therapies to opioid painkiller use			
Create more age-group treatment centers			

8. What can we do as a volunteer to aid in the prevention of this spreading epidemic?

Demographic Information

Male / Female (please circle your answer)	Age: _____	County of Residency: _____
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Appendix C: Community Perception Survey About Opioid Use and Abuse: Q7 and Q8

Q7. What can we do as a community to aid in the prevention of this spreading epidemic?

1. Community Outreach Activities: Education, Focus on Early Intervention (<i>awareness, proactive dissemination of information, ACE, GenoTyping, children, form Community Coalitions, institutionalize a Together-effort a Nexus Group, more Homeless Shelter, Implement Dreamland Book Youth focus</i>)
1. Book Dreamland tells the story!
1. Create opportunities for recovering users to engage in the community in a meaningful way so they have a purpose and are motivated to get well and stay well
1. don't know what "pill mills" mean. pill mill (plural pill mills) (idiomatic) A clandestine operation where a medical worker illicitly offers prescription medication to patients in exchange for bribes.
1. Educate our way out of the problem for future generations by teaching students the dangers.
1. Educate students early and often
1. Educate the public on coping skills, mental health and trauma recovery and make mental healthcare more accessible.
1. Had a hard time deciding on question # 4! I think all of the age groups need help.
1. I think a lot of the problem is the fact that parents are not placing expectations on their children and then want the community to take care of the problems after they have failed as an adult.
1. reward the section of society that is clean and sober stop wasting resources
1. start explaining the risk of opioid abuse and misuse to teenagers before they start taking drugs.
1. Support the children who are affected by he opiod use of their parents to stop the cycle
1. The most effective way to discourage abuse and help recovering addicts will be to foster a strong community of citizens who lead by example of not partaking and have enough emotional intelligence to be cooperative rather than competitive. Meeting people where they are and leading a way out. Highlighting recovered addicts while making recovery feel reachable to the majority of constituents.
1. We need an individual/group to become the nexus for everyone to come together in the battle against this epidemic.
1. We need to work with supporting familys and have education in schools on how to be a parent, budget, car maintance, how finances work.

Broad Category = Community Outreach Activities: Education, Focus on Early Intervention + Subcategory

1. **Community Outreach Activities: Education, Focus on Early Intervention**
2. **Expanding Access Therapy Treatment and Recovery**
3. **Law Enforcement and Punishment of Users**
4. **Physician and Prescription Focus**
5. **Policy Focus**
6. **Research and Explore**
7. **Cultural and Religious Action**
12. include WHOLE family programs in treatment - to show enablers how to quit being enablers

2. Expanding Access Therapy Treatment and Recovery

2. comprehensive rehab centers that include therapy and also workforce support to connect them with jobs
2. Encourage referrals to rehab centers instead of incarceration. Also, making rehab centers more accessible for those without insurance.
2. Get to the root of the problem and see why they are using. Most users have something they are numbing. Rehabs just get them clean. We need more counseling as a nation! Also, look at how many states have legalized medical marijuana and how it helps those coming off opioids. Deaths down by hundreds of thousands. Check out article by Dr. Sanjay Gupta on opioid use vs marijuana.
2. Having a grant or funding to help pay for the treatment.
2. Healthcare professionals know the appropriate use but yet they continue to over-prescribe.
2. Incorporate more Physical Therapy in place of the painkillers, don't offer refills on scripts
2. Interview people with problem and make sure they really want to get clean/ send to treatment
2. Make treatment more accessible. Open more sober living houses.
2. More treatment and recovery centers
2. More treatment facilities...affordable..
2. Not necessarily age-group related, just more involved treatment centers
2. not sure if teenagers with a problems should all be grouped together. They may need more individual help, but definitely needs help. where
2. Offer treatment that actually gets them off of it rather than just substituting suboxine addiction.
2. sober living facilities
2. Stop incarcerating addicts. Treat them instead.
2. Treat the sources of addiction with Adverse Childhood Experience focused on in schools
2. We need more access & focus on affordable treatment & recovery
2. would like to see homeless shelter and halfway homing for families and departing inmates

Broad Category = Expanding Access Therapy Treatment and Recovery + Subcategory
1. <i>Community Outreach Activities: Education, Focus on Early Intervention</i>
2. <i>Expanding Access Therapy Treatment and Recovery</i>
3. <i>Law Enforcement and Punishment of Users</i>
4. <i>Physician and Prescription Focus</i>
5. <i>Policy Focus</i>
6. <i>Research and Explore</i>
7. <i>Cultural and Religious Action</i>
26. Genetic testing to understand predispositions to medication metabolism.

3. Law Enforcement and Punishment of Users (drug courts, colonized and let them die)
3. Allow law enforcement the ability to take more action against problem and stop letting the offenders out of jail the next day or same day. When someone is found with the drugs in their system or on them repeatedly, they should have to perform hard labor and not just be allowed to sit in a jail cell. Make them work to pay for keeping them in jail. Make them hold a job or go back to jail and work for their upkeep.
3. Drug Court but need something before they get this far
3. Harsher punishment for repeat offenders on usage and prescribing. Take away entitlements for users and licensing for doctors who fraudulently prescribe.
3. help people without insurance
3. Make the punishment so harsh people will stay away from them
3. More drug enforcement
3. Support drug courts.

Broad Category = Law Enforcement and Punishment of Users + Subcategory
1. <i>Community Outreach Activities: Education, Focus on Early Intervention</i>
2. <i>Expanding Access Therapy Treatment and Recovery</i>
3. <i>Law Enforcement and Punishment of Users</i>
4. <i>Physician and Prescription Focus</i>
5. <i>Policy Focus</i>
6. <i>Research and Explore</i>
7. <i>Cultural and Religious Action</i>
34. Stop the clinics where all these people are going to get them!!!
345. Hold users more accountable for the using of over use of the opioids and the medical providers that over prescribed these medications, mandatory drug screens for all people who work at any job and or receives any Government assistance randomly. Workers would call at anytime and send for a drug screen before they get the next assistance check. Develop a system that will inform other pharmacies, and medical providers anywhere of individuals who are prescribed pain killers/Opioids along with dates and amounts

4. Physician and Prescription Focus (more accountability, prescription frequency, overprescribing)
4. A huge reason for this pill epidemic is doctors over prescribing. I think that these doctors should have their licences taken away. They completely over prescribe on opioids to boost their numbers for insurance payouts. Also, making marijuana legal/decriminalized will help the epidemic. We can prescribe marijuana for alot of what we prescribe opioids for.
4. Crack down on Dr's that prescribe opioid's and get patients addicted
4. Do not prescribe them unless patient has a critical/fatal medical issue. Use other means besides opioids. We have more pain tolerance than most let on like they have.
4. DO NOT prescribe TOO MANY pills for extended time!!!
4. Hold those accountable that over prescribe the medications and those caught with them make them serve a sentence that will clean them up, make them think about what they are doing and office assistance when they are released so that they do not go back to that lifestyle
4. I believe doctors give the drugs to freely and push drugs on people that don't actually need them. I have a cousin that the doctors give 4 xanax, 2 muscle relaxers and 2 pain pills a day. He is so zonked out he cant even function but he believes he needs them because the doctor gives them to him. I have another cousin the same way! Thats a ridiculous amount of medicine for anyone to function. Neither of them realize how much that medicine is affecting them and think they actually need more and are buying more in the street! It's too easily accessible so all this above sounds great but unless its out of reach it will always be a problem. It has to start from the top with federal laws passed against the drug companies, the rest is just a waste of time. And this needle program is just ridiculous! Again, it's enabling drug addiction instead of taking care of the problem.
4. It isnt an opioid epidemic it is a meth epidemic that has caused elderly and disable ppl to be treated like criminals. The meth users ste still getting there meth but im now consider a drug addict for going to suboxone because it was only choice besides meth there is . I need my anxiety and pain meds back im 60 uro disabled that eill die soon yo heart attack or panic attack suboxone helps pain it is opioid but my nerves shot cant take it much longer
4. STOP allowing the continual sale month after month
4. the doctors that prescribe it put them in jail monitoring
41. When people come in for a pill count (pharmacy or doctor's office) verify all the markings on the pill are THE SAME. Post flyers about ways to get help without trading one drug for another.

5. Policy Focus (change: federal, state, local, agency driven policies)

5. Change procedures with CPS (Child Protective Services) that when a report is made about a KNOWN user/abuser parent that appropriate action is taken instead of making excuses as to why they can't do anything.

Broad Category = Policy Focus + Subcategory

1. *Community Outreach Activities: Education, Focus on Early Intervention*
2. *Expanding Access Therapy Treatment and Recovery*
3. *Law Enforcement and Punishment of Users*
4. *Physician and Prescription Focus*
5. *Policy Focus*
6. *Research and Explore*
7. *Cultural and Religious Action*

51. Pass legislation to hold physicians accountable for the over-prescription of opioids and other painkillers.

Q8. What can we do as a volunteer to aid in the prevention of this spreading epidemic?

1. Community Outreach Activities: Education, Focus on Early Intervention (*awareness, proactive dissemination of information, ACE, GenoTyping, children, form Community Coalitions, institutionalize a Together-effort a Nexus Group, more Homeless Shelter, Implement Dreamland Book Youth focus*)

1. Advertise
1. advocate
1. Advocate and educate more
1. Advocate for prevention
1. Advocate for the re-creation of the/a Civilian Conservation Corps similar to the work relief program from the 1930's but with a new focus of removing individuals from harmful personal environments and teaching them skills related to the conservation and development of natural resources owned by the state and federal government.
1. As a person in recovery for opioid addiction and having been a professional person, we have to find a way to lessen the stigma associated with addiction and give people a means to ask for help without fear of their life being destroyed even further because they asked for help. I know that I would have sought help before the drugs had caused so much damage to myself and my family had there been a safe place to just simply admit that I had a problem. We have to understand that not all persons who struggled with opioid addiction are in some back alley. There are professional people that you encounter everyday in our community that are struggling and trying to stop on their own - it just isn't quite that easy to do.
1. Ask abusers to talk to people
1. Assist in educating the public.....
1. Awareness
1. Awareness activities and activities that make accessing treatment easier.
1. Be available
1. Be aware of the issue and educate as well as be aware of what programs are available to refer those who need help that we may come across to.
1. Be more informative
1. be more informed
1. Be more involved and speak out about the effects they have and how quickly the grip of addiction gets on you
1. be more visible in the community and let families of addicts know about help that is available
1. Be proactive
1. BE THERE FOR OUR FAMILIES
1. be there to listen & help where needed
1. Be vocal
1. Be willing to be a messenger to help others learn about the education of the drug crisis and the length of time it takes to recover.
1. Become educated about opioid and push for some form of monitoring programs to monitor the issuance of this drug.
1. Become proactive in identifying a potential for addiction and taking action by educating oneself to see the signs and to find a way to prevent that path
1. Becoming more involved with youth. Educating members in our community. Awareness campaigns and acknowledgement of there being a problem. Involve all resources - community action agencies, churches, healthcare professionals, schools, community leaders.
1. Bring about more awareness
1. By getting involved more with the young people and do more volunteer work or some sort of sports
1. care for one another be willing to listen and learn
1. Come together to brainstorm and think of ways to resolve it but not add to it.
1. Continue to partner with families in helping provide information about local support organizations
1. Continue to spread knowledge, maintain soberly, prayer, educate others, share experiences, strength and hope.
1. Counseling and helping/educating those who come forward.
1. Educate and communicate.

1. Community Outreach Activities: Education, Focus on Early Intervention <i>(awareness, proactive dissemination of information, ACE, GenoTyping, children, form Community Coalitions, institutionalize a Together-effort a Nexus Group, more Homeless Shelter, Implement Dreamland Book Youth focus)</i>
1. Educate and keep open mind
1. Educate and monitor. Have more successful awareness and prevention programs such as DARE involved. The problem is families are using drugs, and this is what the children are growing up in as a norm. They need lots of education to plant a seed.
1. educate children
1. Educate community
1. Educate educational centers and schools about the risk of opioid use and addiction.
1. Educate everyone about treatment.
1. Educate healthcare and kids
1. Educate more x2
1. educate more on the types of drugs people are using, its not just meth or dope.
1. Educate more people o how to help treat alcoholic/addicts
1. Educate on the dangers of the drug
1. Educate others
1. Educate our children at an early age on the effects!
1. Educate our community about the epidemic and what can be done to help hinder the spread.
1. Educate our neighbors and community members
1. Educate our parents to start the conversations at home
1. educate ourselves
1. Educate ourselves and others around us
1. Educate ourselves on the cause and effect of addiction and stop viewing addiction as choice and not a disease.
1. Educate ourselves, be advocates and speak out
1. educate people
1. Educate people and help them
1. Educate people and offer help
1. educate people more
1. educate people on it, the effect x3
1. Educate people on other pain management
1. Educate people on the effects of drug use on their children.
1. Educate people you come in contact with.
1. Educate start at lower age bracket, community involvement,
1. Educate the community x2
1. Educate the people using. We also need more support groups.
1. educate the public x2
1. Educate the public about treatment the problem and the solution
1. Educate the public, get involved with community efforts to prevent, and educate addicts to recovery.
1. educate them more on the effect it has on their families.
1. Educate x23
1. Educate, Educate, Educate Do not sugar coat it!
1. Educate, Educate, Educate
1. Educate, offer alternative activities especially to teens and young adults
1. Educate, offer appropriate treatment
1. educate, put out brochures, flyers, have public speech's with people who have overcome it speak. Do not judge them but try to understand them and help them find a way out.
1. Educate, support groups for opioid users and support groups for families.
1. Educate, take time to listen, don't just send to jail cause they have a drug problem.
1. Educating parents/community members about the risk of prescription opioids leading to opioid use. Also, any type of prevention efforts.
1. Education & Resource can help lead prevention efforts. But this epidemic is beyond just prevention, our community needs to embrace those in recover with as much/or more effort as they do with prevention. They many people we already have in recover in our community can be of great resource with helping educate others on the truth of this epidemic. Peoples personal experiences hit home more for me than and news story, or boring educational form of statistics. We also need to embrace the ones in recovery so that they don't return to their old lifestyle. We need to educate them, employee them and housing assistance without bias judgement of their past. We have to create a educated community that is recovery strong!
1. education and recovery tools
1. Education at early age
1. Education for diet and exercise to reduce inflammation and encourage healthy lifestyle choices.
1. Education in the school systems on what these drugs do to the brain and about addiction in general.
1. Education in the schools at a early age.
1. Education of the public

1. Community Outreach Activities: Education, Focus on Early Intervention <i>(awareness, proactive dissemination of information, ACE, GenoTyping, children, form Community Coalitions, institutionalize a Together-effort a Nexus Group, more Homeless Shelter, Implement Dreamland Book Youth focus)</i>
1. Education within our schools on opioid addiction. Educate the public through Health Departments or other state or local government agencies, medical professionals
1. Education x 17
1. Education. Informing people of the dangers. Finding ways to assist treatment centers.
1. Encourage and assist in education about dangers, alternatives, and treatment
1. Encourage community leaders to have forums to discuss the issue. Include healthcare providers, teachers/educators, law enforcement and politicians to deliver the message. People in the community are aware of the problem but they don't like to talk about it. This does not make it go away.
1. Fund programs and involve community stakeholders as partners to create a plan to address the problem.
1. Get educated and become involved
1. Get information out
1. Get involved x 5
1. Get involved as a community to promote economic development, which brings living wage jobs, affordable housing, and the sense of family back to our communities
1. Get rid of Adanta to start with
1. Get the information out about recognizing the abuse and how to treat it.
1. Get the word to the officials and public.
1. Give educational seminar
1. Give information to the parents about it
1. Go into Public Schools and Work Places more- sadly it's in the Work Place more prominently.
1. go public
1. Have awareness meetings in high schools and libraries.
1. have classes on how addictive opioids are also.
1. Have meeting (AA and NA).
1. have more community events and attend community events related to prevention
1. Have more knowledge on it that is available to the community.
1. Have those conversations with family, friends, and co-workers
1. Help educate
1. Help Educate the public x 2
1. Help educate us
1. help educate, offer assistance without judgement
1. help get the word out about treatment options.
1. help out with events and help encourage people to attend
1. Help them become more aware of what it does to them and the family.
1. Help with education of the community and healthcare providers
1. Help, have conventions so often on certain day that the community provides
1. Honest patrol officers. Doing their job and not offering telling on others like children. Get out and do their jobs correctly and find out themselves. Better education for youngsters.
1. I believe education is key! Educating everyone on the dangers, signs and treatment options. I genuinely believe that many addicts begin simply by being over prescribed medication.
1. I feel educating the public that addiction can happen to anyone and erasing those stereotypes of what an addict is.
1. I feel that doc & SCC in stat need more education
1. I honestly don't know much about this epidemic except what is on the news. I don't know anyone with this problem. It's not something you can readily observe in someone at the super market. But, I believe it is a choice like any other addiction. I have zero sympathy for people who knowingly abuse meds of any kind. I'm against all these citizen-funded programs and such. If someone OD's, then the problem is solved. We shouldn't spend money on these people when there are so many bigger issues that don't deal with people choosing to be addicts.
1. I WOULD HELP IF I COULD IN ANYWAY I CAN
1. inform
1. inform others of what we know
1. Inform the community about the effects of opioid addiction and how to see signs of abuse.
1. information and presentations in the community
1. Informative and spread education to community
1. Just try to make as many people aware of the damages that this epidemic really does cause.
1. Keep educated ourselves for others
1. Keep informed and share with others
1. Keep the conversation going
1. knowledge and prevention
1. Let me know. Spread the word via community events, Facebook, Instagram.

1. Community Outreach Activities: Education, Focus on Early Intervention <i>(awareness, proactive dissemination of information, ACE, GenoTyping, children, form Community Coalitions, institutionalize a Together-effort a Nexus Group, more Homeless Shelter, Implement Dreamland Book Youth focus)</i>
1. let people know it is big problem talk more about it.
1. Let people know what it can do to families
1. listen, help, love x2
1. MAKE IT KNOWN THAT THERE IS A BETTER WAY TO COPE WITH REALITY THAN TO DRUG YOUR FEELING.
1. Mentor and be examples for the children in our communities
1. more community involvement
1. more education in schools
1. more meetings, reach out and be more involved
1. More truthful training programs aimed at youth. Show them the real effects of opioid addiction.
1. Offer education in the schools
1. Offer forums, mtgs, education, psycho education, supports, media campaigns, increase/educate others about wellness and benefits to counterbalance the disease within our State and communities so people can for better about themselves and not abuse self
1. offer more information on the dangers of opioid
1. Offer support, treatment, resources and educate
1. Participate in educational efforts to combat the opioid crisis.
1. participate in programs that are trying to help
1. partner with existing groups
1. Plan and implement information sessions.
1. Post flyers and statistics.
1. Present speakers at the lunches and after-hours educate the members on what to look for.
1. Prevention and Education
1. Programs to educate about the hazards
1. Promote awareness in schools.
1. Provide education early in schools
1. Provide programs in schools to educate
1. Raise awareness
1. raise awareness in the community
1. reach out to those in addiction and offer hope educate the public regarding addiction
1. Recognize we have a drug problem then provide support to user and encourage them to get help
1. Run educational commercials on TV stations and on radio. Have guest speaker segments on morning radio show.
1. School age education programs
1. Schools are very important...get the message out to the younger people prior to their getting the opportunity to try a drug
1. Seminars on effect and destruction of pain killers
1. Send home an appropriate note to parents just in case they need information to help them out.
1. Set a good example and "be there" so support people.
1. share information
1. Share information about treatment options. And share information about the problem in order to deter use.
1. share knowledge
1. Share stories, vote for needle sharing sites
1. Show compassion and grace to those who want help: connect them with resources to live better lives through affordable housing, job placement opportunities, community volunteerism.
1. Show concern for all and let them know that lots of people have the problem, not just them. We care for all.
1. Speak at schools, events. Take statics to show kids and pictures showing the affects of drug use.
1. speak out x2
1. Speak to people about our families that have gone through this and let them know how it hurts everyone.
1. speak up x2
1. speak out and rally together
1. Spread current and correct information
1. spread the message of recovery
1. Spread the message, educate people-let them know there is a solution.
1. Spread the word about recovery steps
1. START EDUCATING @EARLY AGE
1. Stay informed.
1. stay involved with the community and resources ie drug court, journey to recovery, celebrate recovery
1. talk openly be supportive
1. talk to everyone about drug addiction
1. TALK TO FAMILIES
1. talk to our kids about it

1. Community Outreach Activities: Education, Focus on Early Intervention (<i>awareness, proactive dissemination of information, ACE, GenoTyping, children, form Community Coalitions, institutionalize a Together-effort a Nexus Group, more Homeless Shelter, Implement Dreamland Book Youth focus</i>)
1. Talk to people, educate everyone we can
1. Talk to teens
1. talk to the users offer information on where to get help
1. talk to young people more
1. teach more about it
1. Tell people to take pain meds as little as possible and try other methods because they are addictive
1. Train a certain group of people to be educated and experienced in recognizing when someone is under the influence so as to ensure they are highly educated and not abusing them themselves and then work out some type of system where these people can notify authorities. This who abuse, do not become concerned of being careful about going and buying the substances but those who sell them are usually very careful and will carry 2-3 disposable phones, carry back packs and have certain characteristics about them.
1. Try to find ways for people to get help without fear of repercussions.
1. Try to educate, but also work with those folks who are using the drug to help them find ways to stay off the drug.
1. Try to engage teenagers and young adults in more activities to occupy their time....More Education for parents.
1. Try to talk to then and offer them help like rehab AA and NA
1. Utilize those in recovery / who have experience in the community to show that there is life after drug abuse.
1. We can be a voice to help aid in the prevention.
1. We can help educate the public about appropriate use of opioids and help educate our politicians and elected officials about research on prevention, treatment and recovery
1. We have a wonderful program at our hospital that drs need to know about. One of our hospital drs works to keep patients OUT of the program. Says he doesn't believe in it. He is a HUGE hindrance to folks getting help.
1. with help to seek treatment
1. Educate our employees/clients about correct/appropriate use of pain medicine, as well as how to recognize and understand opioid abuse and how to report observations safely and confidentially.
1. Education in schools...not sure what but whatever is being taught now is not helping...
1. Watch out for signs in our youth, teachers watch for children with signs of neglect
1. We could give information about classes to help with the sickness.

Broad Category = Community Outreach Activities: Education, Focus on Early Intervention + Subcategory
1. Community Outreach Activities: Education, Focus on Early Intervention 2. Expanding Access Therapy Treatment and Recovery 3. Law Enforcement and Punishment of Users 4. Physician and Prescription Focus 5. Policy Focus 6. Research and Explore 7. Cultural and Religious Action
12. Carry the message of recovery
12. Educate and rehabilitate.
12. Educate the public. Offer alternatives. Handouts and literature given out.
12. Education to patients on alternative treatments for pain management: such as heat/ice/TENS/massage/chiro/PT
12. education with home health agencies
12. Education, Increase resources within the community
12. find alternative and educate people on the alternatives.
12. Hold community forums to involve stakeholders and partner with the community, gra programs to control risk of public health issues, inpatient detox facilities, fund outpatient and partial hospitalization programs, encourage patients to enter treatment by providing childcare and eliminating other barriers.
12. I believe we need to address the mental health and well being of the young elementary children and all the way up to high school in our community. Teaching these children how to cope with unfortunate events that take place in their lives that they have no control over. Making therapies more attainable for youngsters. Regular counseling as an added class in health. I think a mental health professional should meet with every single student throughout school years to take the stigma away from viewing mental health therapy as negative. I believe addressing mental health and well being in a persons early years through consistent counseling in coping and life skills will better equip youngsters with healthier lifestyle choices when they are faced with being offered drugs.
12. I think as a community we should develop more places for people to talk about their addictions. Such as AA and NA meetings. I also think that the community should hold county wide events to explain why it is such an epidemic and if anyone needs help give them resources closer to home, such as rehabs and other things so they don't feel as if our community doesn't care because most rehabs are out of county.
12. increase public awareness of the problem advocate for treatment options
12. increasing awareness, trying to intervene before it starts, provide assistance with recovery
12. Make sure we are spreading information and treatment options to the public about the crisis.
12. Meetings with community partners to have a plan of attack. Send more to treatment than jail, get them educated.

Broad Category = Community Outreach Activities: Education, Focus on Early Intervention + Subcategory	
12.	Offer help and resources to the addiction community. I dont know if there are any or not in Pulaski, but we should have detox centers, recovery group homes, and recovery programs that help people who also arent in jail. We should teach kids more in school about what drugs do to you, rather than just "Drugs are bad, dont take them". Besides that quote i made, there isnt much drugs education in the pulaski school system.
12.	Offer to help friends and family with this issue too get clean
12.	Start at helping before the person becomes an addict. This starts before they become an addict
12.	to do more rally's bring more recovery
12.	Volunteer at a treatment center
12.	We as human beings are going to have to treat people that they have worth and a purpose.
12.	Work together with Health services to get treatment facities affordable for the low income people to get help.
13.	Don't be an enabler, educate people, bring awareness, make people accountable for their actions
134.	Educate and enforce regulatory action to address prescribing.
14.	Educating physicians is definitely important.
15.	Go into the schools and educate of what really happens with these drugs and over using, mandatory classes that focus on how the use of these and all drugs can effect you and your future.
154.	Educate politicians, prescribers, and individuals.
16.	Educate the public, assist in providing jobs, start young.

2. Expanding Access Therapy Treatment and Recovery	
2.	Add in screening for HCV and HIV
2.	Continue to monitor and develop strategies and programs to treat and prevent.
2.	Create more rehab opportunities for the poor.
2.	demand resources to help families, reach out to people
2.	Developing sober living houses in each county would be greatly beneficial.
2.	Drug abuse counseling
2.	Drug Counseling
2.	Encourage and provide better alternatives for the addicts of a better future for them and their families.
2.	Encourage groups such as Celebrate Recovery, Help financially with drug treatment centers, Legalize everything and use the monies to help recovery programs
2.	find more resources to help combat opioid crisis
2.	funds
2.	Get them help
2.	GIVE RESOURCES
2.	Have more recovery in places that need it most
2.	have pain clinics in the county
2.	help
2.	Help break the cycle of tradition, people need to understand that you have to work to survive. If people have to work, they wont have time to abuse drugs.
2.	Help by starting/supporting more recovery options(Celebrate Recovery, NA meetings,etc)
2.	Help others get clean and treatment.
2.	Help others recover
2.	Help out those that one knows is in need of help.
2.	Help people coming out of recovery get employment.
2.	Help those in recovery to get industry certifications and/or job skills that can make them more marketable employees once they are advanced in their recovery.
2.	If local treatment options were available, this would be a great start.
2.	Increasing access to treatment centers and treatment facilities where parents can have their children there with them
2.	Just help families be able to recover because it's not only the attics issue it's the family as well
2.	Keep doing needle exchange
2.	local methodone clinic
2.	local sub/methodone clinic
2.	local suboxone clinics and rehabs
2.	Make mental healthcare more accessible and comprehensive.
2.	make resources and support groups for users as well as families who are affected by this epidemic
2.	Make sure the children of anyone fighting an opioid addiction get into a program to help them as early as possible.
2.	More centers to work with the addiction
2.	more facilities
2.	more programs
2.	more recovery centers and sober living

2. Expanding Access Therapy Treatment and Recovery
2. More rehab centers for addicts, with the stipulation requiring participants to be in the program 9 mos. to a year.
2. more rehabs
2. More support groups for families.
2. More treatment centers x3
2. More treatment facilities
2. More treatment options need to be available even while they are incarcerated.
2. NA/AA meetings
2. not do needle exchange help put them into drug programs
2. offer a suboxone or methadone clinic
2. Offer alternative choices.
2. Offer drug counseling?
2. offer help when needed
2. offer mental health services
2. Offer more help!
2. Offer really good counseling and mentoring support
2. offer recovery not jail and pills not addictive ones that is how it starts
2. open a sub/methadone clinic
2. open more treatment centers
2. Open needle exchange to lower disease & local rehab facilities and suboxone clinics
2. Open or offer a rehab here in the community that maybe does not cost a lot because money for these things have been an issues in my family.
2. open pain clinic
2. open pain clinic in this county
2. Pain clinics
2. Recovery programs-local
2. Rehab
2. Set up support groups.
2. start 12 step programs
2. Stop treating this as a moral issue, and start talking about the need of affordable, quality treatment & recovery centers
2. sub clinic
2. suboxone clinic
2. support groups for those impact not just those addicted.
2. Support programs that are addressing the issue, ie Celebrate Recovery. Need faith-base involvement to support recovery efforts.
2. Support programs to help recovering users.
2. Support those in recovery by reducing discrimination in employment and housing
2. Those who really need meds should get them. They should be subject to pull count and drug screening regular.
2. Treatment Centers x2
2. Treatment not prison sentences, activities for people so they don't resort to drugs.
2. TRY TO GET ASSISTANCE TO THOSE WE ENCOUNTER WITH A PROBLEM
2. We need more long term and evidenced based treatment centers with transitional services.
2. We need more long term treatment options. We need to encourage the government to push insurance to support alternative therapies for pain management.
2. we need non profit age appropriate treatment centers

Broad Category = Expanding Access Therapy Treatment and Recovery + Subcategory

1. Community Outreach Activities: Education, Focus on Early Intervention
2. Expanding Access Therapy Treatment and Recovery
3. Law Enforcement and Punishment of Users
4. Physician and Prescription Focus
5. Policy Focus
6. Research and Explore
7. Cultural and Religious Action
21. Fight for more treatment centers, use of Vivitrol or other assistance. Somehow addicts need to be forced to go into treatment, or a program that will help. Need programs for those in jail and when they exit. Publicize help and programs. Use money for something besides research. This started 30 years ago. We should be able to treat now, not continue research.
21. Help convince folks you know struggling with addiction to get help. Notify local authorities of suspected abuse.
21. help to seek treatment
21. Listen to them
21. offer more services to teens and the forefront
21. Work with groups that are active in promoting recovery.

Broad Category = Expanding Access Therapy Treatment and Recovery + Subcategory
1. Community Outreach Activities: Education, Focus on Early Intervention
2. Expanding Access Therapy Treatment and Recovery
3. Law Enforcement and Punishment of Users
4. Physician and Prescription Focus
5. Policy Focus
6. Research and Explore
7. Cultural and Religious Action
21. listen to people
213. Make donations to treatment centers. Work in Operation UNITE Coalitions. Report suspected abuse and illegal sale of drugs.
216. Stop enabling the addicted with other harmful medications to get addicted to and needles when they need. Set up more community activities for addicts. Make them feel like they are still a part of the community and we care about them bettering themselves. Shame will hold an addict back from trying to seek help. There are a lot of natural ways to treat addiction. I believe more research on alternative treatment options would be a popular, smart, and successful route.
24. Reach out to physical therapy providers, and personal trainers that are certified in pain recovery therapeutic movements to coordinate with physicians through an innovative program to use nutrition and exercise therapy to facilitate constituents in resolving the actual pain problem to prevent the trigger for misuse and relapse.
26. Once someone has gotten clean there should be comprehensive programs that help them stay that way. Job and educational opportunities would go a long way.

3. Law Enforcement and Punishment of Users (drug courts, colonized and let them die)
3. Encourage stricter laws and punishment
3. Go after the drug pushers and keep them in jail stop just giving them a slap on the wrist and do something to them as well as the users. Drug Court is a good option!
3. Keep the corruption out of the courthouse.
3. Report
3. Report any misuse
3. report misuse
3. Report suspected problems
3. Report the ones that sell
3. We can't, but if the judges stopped the revolving door system & we had a legal system more like President Reagan recommended in the 80s there wouldn't be as big a problem. We blame everyone & everything but the person who chooses to do drugs. We need to stop making excuses for people & they need to face the legal consequences of their actions.

Broad Category = Law Enforcement and Punishment of Users + Subcategory
1. Community Outreach Activities: Education, Focus on Early Intervention
2. Expanding Access Therapy Treatment and Recovery
3. Law Enforcement and Punishment of Users
4. Physician and Prescription Focus
5. Policy Focus
6. Research and Explore
7. Cultural and Religious Action
31. Have a way to submit people you believe are selling or using to have in a base so police can see locations and observe, that is secure. Education needs to begin by 6th grade on saying no and why. Not just an assembly program.
31. If there was a "hotline" we could call to report people (especially those with children) and not just the police, that would be helpful.
34. Bust the ones selling them illegal.
34. Petition proper authorities to monitor doctors and those who are prescribing these painkillers. They should be prosecuted with the stiffest penalties available.
34. Stop all doctors and dentists from prescribing pain killers. If someone is in that much pain they should be hospitalized and given IV pain management for 2-3 days maximum...then take tylenol or advil for pain relief...and not sent home with an addictive prescription of narcotic drugs that will likely be abused!
34. stop doctors who aren't pain clinics from writing pain killers
34. Stop slapping them on the wrist, protect the public non users from these junkies, the addicts get too much coddling and the rest of us have to deal with them bumming and sleeping in public areas, they sell their bodies for the junk and it's disgusting.
345. Keep dealers in prison ! STOP drug trafficking ! Reduce the number of drugs Federal programs mail out automatically to elderly or low income. 100s of pills (3-4 a day x 30 days) are mailed to an individual, they keep part and sell the rest for added income !!! Make them accountable for each pill they take. Random count of medication !! This is big area of drugs being sold.
3452. Enforce rules in place for providers writing the medication, make stricter rules for prescribing opioids. Make patients meet so many criteria before allowing them to receive them, and enforce urine drug screens, kasper, etc. Also-every county needs a detox facility. Some of these patients have nowhere to go for help.
35. harsher punishment for drug dealers!

37. Drug Monitoring programs and rely on our Police/State to continue help protect and seize. Offer help to those who need it. Ask the Lord above to help!

4. Physician and Prescription Focus (more accountability, prescription frequency, overprescribing)

- 4. As parents not use opioids ourselves and NOT allow the drs to give them to our children for pain relieve after surgery. Both my daughter and son were given scripts after wisdom teeth extraction and I wouldn't fill them. They used ibuprofen for pain and swelling which worked fine.
- 4. Cut down on the number of prescriptions written,
- 4. make it much harder to obtain these drugs
- 4. Make less accessible to get
- 4. Methodone
- 4. Monitor
- 4. Monitor doctor prescription writing
- 4. monitoring more
- 4. Pay more attention to the doctors.
- 4. Pharmacies with high narcotic sales speak up about doctors with reputation to prescribe and this really shows
- 4. Prescribe pain killers only when seriously needed instead of just for headaches and prescribe only for short periods of time.
- 4. Recognize it not the epidemic. Meth is. Ppl need their pain meds and anxiety meds back. Pain meds can be monitored anything. Just get ppl help soon i have three heart attack already and ruptured an aortic anyserym due to withdrawls from xanax. And there was nothing in place then to help only suboxone now and ot eill be the new epidemic om five years
- 4. stop enabling and make each person responsible for there own medication. monitor to make sure they are taking according to their Doctors orders.
- 4. Stop prescribing them
- 4. STOP sending 100+ pills to individual on Federal program (3-4 pain pills x30 days). Low income/ elderly are selling pills !! Find a way to check the pill count!! This is nuts, Government is supporting the addiction
- 4. Stop using drugs
- 4. Talk to big Parma about discontinuing the drugs that are causing the epidemic
- 4. The prescription drug companies need to be affected financial for the problems they have created for financial gain.
- 4. We need to hold doctor's responsible for their prescribing of opiates.

Broad Category = Physician and Prescription Focus + Subcategory

- 1. *Community Outreach Activities: Education, Focus on Early Intervention*
- 2. *Expanding Access Therapy Treatment and Recovery*
- 3. *Law Enforcement and Punishment of Users*
- 4. *Physician and Prescription Focus*
- 5. *Policy Focus*
- 6. *Research and Explore*
- 7. *Cultural and Religious Action*

- 41. Host intake/destroy medication days or bins for population and advertise; Educate youth in particular, since they may be experimenting with, or have an addicted family member; Introduce more options for alternatives to pain.
- 41. Offer treatments that are not pharmaceutical, but are affordable. Early childhood education, education in the schools as soon as Kindergarten, create systems of care where agencies are working together
- 41. Publicize the names/locations of those guilty of egregious prescribing. Help families of addicts so that one doesn't sink the whole ship.
- 41. Stop the illegal prescription doctors, stop medical maintenance and share our messages of recovery.
- 41. Work to decrease the amount of methadone, etc. that are prescribed to assist users. It appears that these are highly addictive as well, further perpetuating the abuse and addiction cycle. Educate lawmakers in order to bring attention and change to this issue.

5. Policy Focus (change: federal, state, local, agency driven policies)

- 5. Devote your time in changing the laws.
- 5. Drug test more public employees more often.
- 5. drug test weekly
- 5. Implement Drug test to those on welfare! Like Florida!
- 5. Push out politicians to make changes
- 5. Stop Opiate Lobbyists from paying off politicians like Mitch McConnell
- 5. Stronger laws and jail time needs to be longer to get them detox and then set up programs out of state away from their homes. I think that would help having it away from the place they are used to getting their drugs .

Broad Category = Policy Focus + Subcategory
1. Community Outreach Activities: Education, Focus on Early Intervention
2. Expanding Access Therapy Treatment and Recovery
3. Law Enforcement and Punishment of Users
4. Physician and Prescription Focus
5. Policy Focus
6. Research and Explore
7. Cultural and Religious Action
517. Call our legislators, undo the stigma associated with dependency, pray
53. Make weed legal stop giving them out
534. More strict enforcement and penalties. Both of abusers and prescribers.
54. Get the pharmaceutical companies to reduce the cost of Naloxone to add to the opioid medications to inhibit the high and reduce the risks of overdose.
54. Regulate doctors, doctors are keeping the drugs in the community. Over prescribing.
54. Stop giving meds all together and limit the prescription. and we should enforce drug laws and not let anyone walk away.

6. Research and Explore (best practices, find out what successful locations are doing, individual perceptions (faith based, salvation, volunteering)
6. Determine the community source of the access to opioids - i.e. egregious or illegal distribution and eradicate by all means possible. If we can't determine the source, then treating the "symptoms" will have only minimal results.
6. Find out what local communities are already doing and build upon those efforts rather than making new programs
6. I disagree with this problem because politicians do not need to be involved in the work of a doctor. Because of this, those of us who desperately need the medication have a harder time getting it and are made to feel like we are drug addicts.
6. know what to look for
6. More employment opportunities
6. offer more social activities as a community to occupy teens
6. Our population has become addicted to drugs which has led to the deterioration of family and job force. Jails aren't even a place now where people can get and stay clean.
6. Pay close attention to family members
6. People need to work and have a purpose to get in the morning not just hang out all day and get paid to do it.
6. People that I know that have been impacted start via pill mill or selling. Our local dr and practitioners are good at not over prescribing now. With selling they make so much money then try it getting hooked. Families must have support. Once you hit rock bottom how can they pull out? An acquaintance hit rock bottom. Homeless. Found a job with a old friend. Can't get a license because has no perm address. Can't rent a hotel room without a license. How can they overcome
6. Recruit businesses that pay a living wage to hire locals. Work to make affordable housing available to all who need it.
6. Scheduled lock boxes to decrease starting the abuse after a prescribed need, such as surgery

Broad Category = Research and Explore + Subcategory
1. Community Outreach Activities: Education, Focus on Early Intervention
2. Expanding Access Therapy Treatment and Recovery
3. Law Enforcement and Punishment of Users
4. Physician and Prescription Focus
5. Policy Focus, and
6. Research and Explore
7. Cultural and Religious Action
61. Help with research or grassroots efforts.
61. Reach out more, speaker meetings.

7. Cultural and Religious Action (faith based, salvation-driven)
7. don't know; some can prob not be helped
7. Encourage people to get jobs instead of being drug addicts. I have no patience for these people. Not sure how someone gets addicted when taking a medication AS PRESCRIBED. It's stupid, lazy abusers that get into trouble with this stuff. Trying to turn them around is useless until they see how pathetic they are and WANT to change.
7. Join together pray
7. Lead people to Jesus! He is the only answer!
7. Love people
7. Need Faith-based community in the forefront. People need Jesus and so many times they are filling hurts with "stuff" to cover the hurt.
7. PRAY
7. Pray and teach them the love of Jesus
7. Prayer x 2
7. Really not for sure they will find a way to use even if we try to help by social media

7. Cultural and Religious Action (faith based, salvation-driven)
7. Show concern, love and compassion to those in need
7. spread the message of hope, strength, and love
7. Tell people about Jesus and that He loves them!
7. Try to stay healthy, exercise regularly. Pray

Broad Category = Cultural and Religious Action + Subcategory
1. Community Outreach Activities: Education, Focus on Early Intervention
2. Expanding Access Therapy Treatment and Recovery
3. Law Enforcement and Punishment of Users
4. Physician and Prescription Focus
5. Policy Focus, and
6. Research and Explore
7. Cultural and Religious Action
71. BRING GOD BACK TO OUR COMMUNITIES!! (Schools, hospitals, organizations, etc.) Volunteer time in our schools, nursing homes, community clean up.....START taking pride in our community!!

END NOTES

- ⁱ Drugs Kill More American than Guns and Cars. Kentucky was ground zero from the start. Louisville Courier Journal. January 28, 2018, Updated April 19, 2018, <https://www.courier-journal.com/story/news/investigations/2018/01/28/kentucky-ground-zero-opioid-epidemic/1069608001/>
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- ^{iv} Ibid
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- ^{xviii} Centers for Disease Control and Prevention <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html>
- ^{xix} Medicaid State Opioid Prescribing Mapping Tool https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/OpioidMap_Medicaid_State.html
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- ^{xxi} 13 Kentucky Health Systems Sue Pharmacies, Drug Makers Over the Opioid Crisis <https://www.courier-journal.com/story/news/local/2019/09/05/kentucky-health-systems-suing-pharmacies-over-opioid-crisis/2224197001/>
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<https://www.census.gov/content/dam/Census/library/working-papers/2019/demo/sehsd-wp2019-04.pdf>

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xxxvii Buprenorphine Practitioner Locations, <https://www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator#XcCiMo48eUo.mailto>

xxxviii Comparison of Opioid Prescribing Patterns in the United States and Japan: Primary Care Physicians' Attitudes and Perceptions
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Community Needs Assessment Plan

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This outlines details of our consulting services to support the Lake Cumberland Community Action Agency, Inc. (LCCAA) in completing a comprehensive community assessment of the current 10-county service area, in order to support the Lake Cumberland Area Response to Opioids in Rural Communities (A-ROC) Planning Consortium to develop a strategic plan to support families affected by Opioid Use Disorders (OUD).

This proposal is intended as an informative reference plan and description of our methodology. The final outline and specific indicators to be collected will be developed in conjunction with you team and core members of the consortium. This consulting plan, including information, are the property Nolo Consulting, LLC.

A-ROC Planning Consortium Proposal Deliverables

What:

1. Complete in-depth, comprehensive **analysis** of community needs identifying:
 - **Prevention** - opportunities and gaps
 - **Treatment** - opportunities and gaps
 - **Recovery** - opportunities and gaps
2. Including resources available like:
 - Access to care
 - Federal resources

- State resources
- County and Local resources available for leveraging

HOW and WHEN to collect and analysis: from June – October 15, 2019

June 2019:

1. Start with reviewing literature about the reason for the increase in use of opioids, then review/studies articles on the incidence and prevalence of the situation in Kentucky. Include research and resources that focus on best practices tried or implemented in the area.
2. Breakdown what **prevention** methods, strategies, education and resources are the most common in the survey and focus group design).
3. Assess the provider services by county (complement and expand data findings Table 7; page 11 on the proposal)
4. Identify all OUD related initiatives in the 10-county area (including statewide sponsored; June and ongoing.)
5. Find if there is demographic data from **Ky help call center, referral hotline, findhelpnow** (beds available) from 10 county area (page 10 of the proposal) that we can obtained to analyze (June and ongoing, via video conference and phone interviews.)

July 1-2, 2019 at Adanta Training Center, 130 Southern School Road, Somerset, KY:

6. **Initial organizing meeting** (*face to face*) with the consortium include meeting with LCCAA, LCADD (find data about community outreach activities), LCDHD, and Adanta. Topics for discussion:
 - Data available,
 - What are data needed, missing or not available during proposal design?,
 - Primary data sources available,

- How to engage the target population?,
 - A-ROC Planning Consortium will strive to keep all interactions in the context of the area's cultural values,
 - Help facilitate discussion about ideas/plans to cover over the 10-county area, scheduling and identify data collection facilitators among Consortium members,
 - Facilitate a *"How to implement and conduct a Focus Group Interview session?"* with Consortium members.
7. Identify (follow up with interview, include findings on final database of resources) the "most" experts for each of the 10 counties to analysis of the area's resources and gaps in prevention, treatment and recovery. (July and ongoing, via video conference and phone.)
 8. Question/interview service providers listed on the grant page 9-10 of the LCCAA's plan proposal. Purpose to validate data findings plus confirm and verify. (July and ongoing, via video conference and phone.)
 9. Start development and design of interview questions with a focus on the Prevention/Treatment/Recovery process. Greatest focus will be on the prevention questions. (July and ongoing, via video conference and phone.)

August 2019:

10. Develop a final draft of the Comprehensive Community Needs Assessment Tools, pilot test instruments. KEY INFORMANTS, FOCUS GROUPS, SURVEYS.
11. Design focus groups, identify target audiences, and schedule FG and interviewers.
12. Conduct and complete local, community-level assessments on **perception** about opioid use and abuse using Focus Groups and/or surveys, of individual segments of the target population of all 10 counties, including:
 - Parents,

- Teens,
- Incarcerated individuals,
- Law enforcement, and
- Elected officials including Judge/Executives.

Note: We will use Consortium members to administer, take notes and record the Focus Groups and disseminate survey assessments. This will guarantee better results based on the communication and culturally appropriate messages during the interview sessions. It is also critical to have Strategic Planning members present to understand first-hand the feedback and insights from the different target communities.

13. Discuss when to bring additional A-ROC Planning Consortium members and determine what role these members will have in the collection of information:

- Primary care providers;
- Faith community members;
- Early childhood education providers;
- Judicial system professionals,
- Law enforcement,
- Family Resource/Youth Service Center representatives,
- Local Education Agencies (LEAs);
- OUD workforce members

September 2019:

14. Schedule data analysis and reporting time

October 2019:

15. Delivery final community assessment report and findings.

