

A Call to Action

Louisville
Heroin and Opioid
Response Summit



United States Attorney's Office
Western District of Kentucky
Report and Recommendations



Photograph by Rob Metzger Photography

Friends and Community Stakeholders:

March 24, 2017

The heroin and opioid crisis ravaging Louisville is a crisis of addiction – a condition described by medical and treatment professionals as a substance use disorder. Untreated substance use disorders are causing overdoses, overdose deaths, family pain and dysfunction, property crime, violent crime, jail overcrowding, loss of economic productivity, and overtaxing of public resources and healthcare systems. Arguably, the heroin and opioid crisis is Louisville’s most significant public safety and public health crisis: we lose almost three times more residents to overdose than we do to homicide.

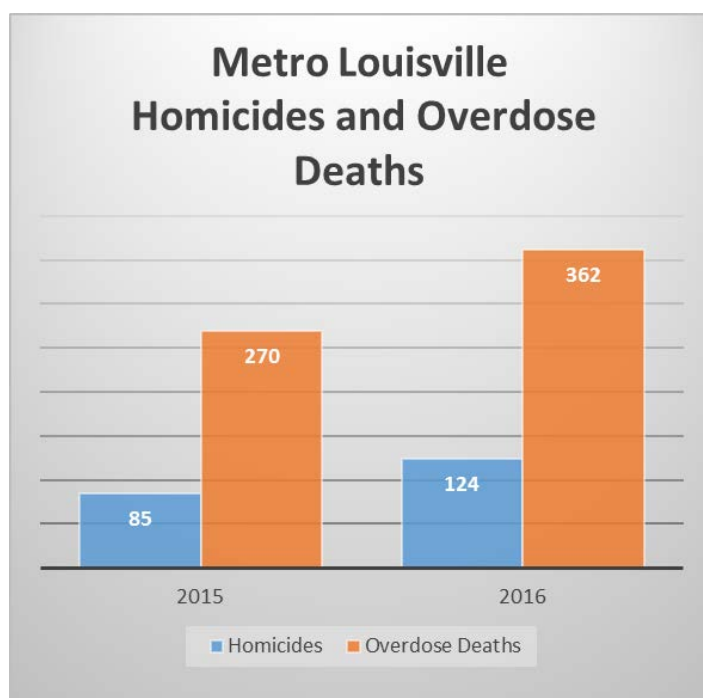
In December 2016, the United States Attorney’s Office co-hosted the Louisville Heroin and Opioid Response Summit with the Drug Enforcement Administration and the University of Louisville School of Medicine. The twofold purpose of the Summit was to (1) create a forum where professionals working on the heroin and opioid epidemic could learn about the broad range of local efforts to address the crisis, and (2) develop recommendations for improved strategies. This report summarizes the observations and recommendations developed at the Summit.

Planning and preparation for the Summit was itself a revelation. We began by inviting Louisville-area stakeholders across a broad range of disciplines – law enforcement, first responders, public health, healthcare, addiction treatment, education – to participate in a single meeting to develop the broad outlines for the Summit program. Much to our surprise, many of the professionals working on the heroin and opioid problem every single day had never come together to share information. We began to have glimpses of other surprising problems: hundreds of addicts seeking treatment turned away from treatment facilities every month due to a shortage of community (i.e., free) detox and treatment beds; overdose data often publicly unavailable for months after the incidents; purportedly identical data sets developed by different agencies varying by wide margins; and basic information concerning overdoses escaping uncollected.

The initial stakeholders meeting was followed by a series of more focused meetings, each of these limited to particular domains: law enforcement, criminal justice and first responders; treatment and recovery; and prevention and education. At these following meetings, we made deeper dives into Louisville-area successes and frustrations. We learned of ambitious and impactful programs. We found uncomfortable tension between some treatment providers offering traditional abstinence programs and providers who offered medication-assisted therapies or MAT. Within the treatment community, we saw immensely impactful programs working in strange isolation from one another, with little collaboration. And at every turn, we made the acquaintance of ferociously dedicated people in government agencies and nonprofit organizations working valiantly to tackle the crisis.

With assistance from our working groups, we selected panelists to represent the various response sectors in Louisville. During multiple panel preparation meetings, we collaborated to identify the most important information to be shared at the Summit, information about area impacts, programs, initiatives, needs and shortfalls.

Despite our focus on local issues, we began to hear a pervasive drumbeat of universal principles about addiction in all our discussions: addiction is a chronic brain disease that disrupts brain reward circuitry; stigma surrounding addiction discourages sufferers from seeking treatment; repeated relapse must be expected along the road toward recovery; long-term recovery succeeds best with access to open community support services; and teenage substance use of any kind strongly correlates with the development of substance use disorders. We came to realize we would need speakers who would educate our Summit audience about these universal principles and point toward the best evidence-supported approaches to treatment, prevention and enforcement.



We succeeded in recruiting an ideal complement of speakers. Mark Jorrich, M.D., an addiction treatment specialist from Louisville, explained the neurobiological basis for the current scientific understanding of addiction as a chronic, but treatable brain disease. Ivana Grahovac, a recovering heroin addict herself, compellingly described the social support required by addicts to pursue and maintain recovery. New Jersey State Trooper Captain Juan Colon came to describe New Jersey's centralized Drug Monitoring Initiative, which collects, analyzes and

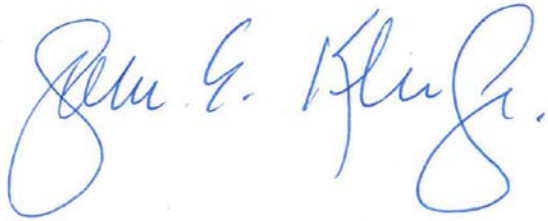
disseminates almost every possible bit of information available statewide about heroin and opioids, with information contributed by the public safety, public health, treatment, and healthcare sectors. And Robert DuPont, M.D., former Director of the National Institute on Drug Abuse and former White House Drug Czar, a national leader with more than 50 years of experience in drug policy and treatment, shared his visions for responding to existing addictions and preventing new ones. Dr. DuPont insists our most effective response lies in a collaboration between criminal justice and treatment, where criminal probation programs move addicts into treatment and recovery. Prevention, he explained, must focus on teenagers to promote a paradigm of teenage health as avoiding any chemicals – alcohol, marijuana, tobacco, other drugs – to stimulate brain reward mechanisms.

With the Summit now behind us, it is clearer than ever we have a great deal more work ahead of us. Our deep immersion into the full range of law enforcement, public health, treatment, recovery, prevention and healthcare responses to the heroin and opioid problem generated the recommendations we offer at the conclusion of this report. We have come to understand the public response – and especially the government response – has been profoundly inadequate to address the urgent demands of this crisis. Our good intentions – and reliance upon intuitive solutions – will not suffice. Overcoming the heroin and opioid crisis – reversing the effects of the current scourge and preventing ongoing crisis – will require an informed understanding of proven, evidence-based solutions and a commitment of significantly greater resources. We simply must do more, especially more to fund treatment, recovery and prevention programs.

The best news from our Summit is that we all have new partners to work with. We have new relationships with the army of professionals battling to make a difference, and we fully expect unprecedented collaboration across all involved disciplines as we implement recommended next steps. We are grateful, too, for our partnerships with the University of Louisville School of Medicine, the DEA 360 Strategy and CADCA, Community Anti- Drug Coalitions of America.

Only two things can defeat us in our battle against this epidemic: a lack of commitment and a failure to collaborate. A serious and sustained commitment to resolve this crisis will bring us the resources we need, and our collaboration will broaden our impact immeasurably.

To our fellow Louisvillians who work to help those impacted, to stop the dealers, to keep our community healthy, you have my deepest respect and gratitude. Let's continue on together, and we will succeed.



John E. Kuhn, Jr.
United States Attorney for the Western District of Kentucky



Summit Sponsors: U.S. Attorney John E. Kuhn, Jr.; DEA Special Agent in Charge Timothy Plancon; University of Louisville School of Medicine Dean Toni M. Ganzel, M.D.; DEA-360 Community Outreach Chief Sean T. Fern; and CADCA Chairman, General Arthur T. Dean.



DRUG ENFORCEMENT ADMINISTRATION
LOUISVILLE DISTRICT OFFICE

Partners and Friends:

On behalf of the United States Drug Enforcement Administration, I want to thank you for your participation and vital support of the Louisville Heroin and Opioid Response Summit. The summit was a main component of DEA's ongoing 360 Strategy, in which we are advocating a multi-pronged approach in combating the ongoing heroin, fentanyl, and opioid abuse epidemic.

We know that fighting this epidemic is not a simple task. The summit brought together experts and leaders from the fields of treatment and recovery, prevention, and law enforcement to further strengthen our invaluable professional relationships and partnerships as we continue the ongoing battle to reduce opioid abuse in Louisville and the surrounding communities. These relationships will be instrumental in strengthening community organizations as we position ourselves to provide long-term help and support in reducing all future drug use.

I am extremely grateful to all of our partners in the summit as we continue to move forward to make this community a safer and healthier place for everybody. Please continue to count on the DEA's dedication to work hard in the community, raising awareness of the dangers of all opioid misuse, while simultaneously working to eliminate the often violent drug trafficking organizations that are fueling the cycles of addiction.

Again, thank you for your concern for the community as we continue to work together and develop strategies to reduce the epidemic of opioid abuse.

Warmest regards,

A handwritten signature in dark ink, appearing to read "Tim J. Plancon", with a stylized flourish at the end.

Timothy J. Plancon
Special Agent in Charge
U.S. Drug Enforcement Administration
Detroit Field Division
Kentucky - Michigan - Ohio



Toni M. Ganzel, MD, MBA
Dean of the School of Medicine
Professor of Otolaryngology

Colleagues:

It was a pleasure and honor to host so many of you at the Heroin and Opioid Response Summit in December as we continued our discussion on opioid use and abuse. Obviously, this is a topic of significant concern to all of us.

During our time together, many of you brought forward innovative ideas on how we can collectively work together to address what truly is a major health and societal concern. Our combined and collaborative efforts are for the development of new strategies in this arena.

This report on the summit digests the discussion to the salient points raised in December. It establishes the landscape we face and thoughts on how to adjust that landscape to what we hope to achieve. Some of the ideas already are being acted upon and/or refined.

I look forward to our next round of discussions where we can talk about progress and next steps.

Sincerely,

A handwritten signature in black ink that reads "Toni M. Ganzel". The signature is written in a cursive, flowing style.

Executive Dean
UofL Health Sciences Center

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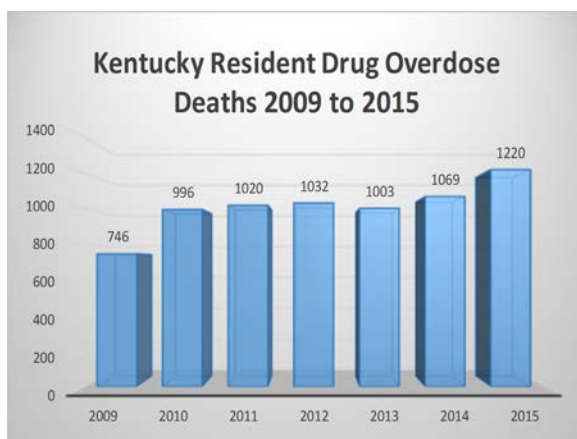
TABLE OF CONTENTS

Louisville Heroin and Opioid Response Summit

REPORT AND RECOMMENDATIONS

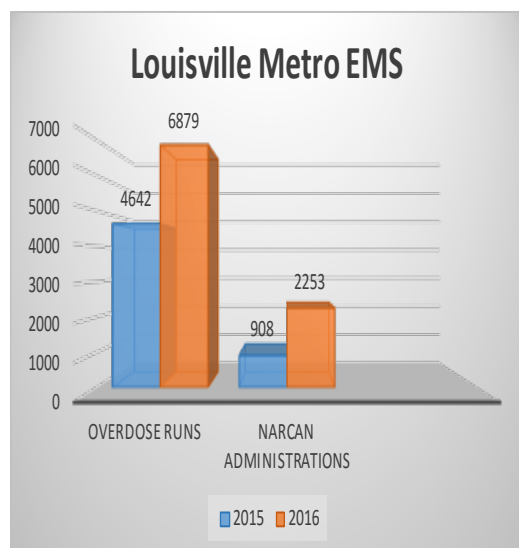
Introduction, United States Attorney John E. Kuhn, Jr.	i
Messages from Co-Sponsors	
Special Agent in Charge Timothy Plancon, DEA	iv
Dean Toni M. Ganzel, M.D., University of Louisville School of Medicine.....	v
Important Facts	2
The Science of Addiction, Treatment and Recovery	4
PANEL: Public Health, Prevention and Education	6
Centralized Data Collection, Analysis and Sharing.....	10
PANEL: Law Enforcement & First Responders.....	12
Linking Criminal Justice and Health to Promote Recovery	17
PANEL: Treatment & Recovery.....	19
The Journey of Recovery	24
Call to Action.....	25
Sources and Resources.....	32

Important Facts



Jefferson County Overdose Deaths By Drug Type

Primary Substance	2015	2016
Heroin	134	119
Fentanyl	39	176
Heroin and Fentanyl	17	56
All Opiates	218	304
All Drugs	270	362



Louisville has seen a significant spike in the number of overdoses and emergency calls for help.

- In January 2017, Louisville Metro EMS responded to an average of 22 overdose calls each day, totaling 695 overdose calls for the month – a 30 percent increase compared to January 2016.
- By February 2017, Louisville Metro Police reported a 173% increase in overdose scenes compared to the first two months of 2016.
- According to EMS, overdose calls for help come from every zip code; and overdose runs increased by 2,237 from 2015 to 2016.

Recent Jefferson County Heroin Seizures:

47 pounds of heroin – January 2017
 13.2 pounds heroin and \$1 million – June 2016
 4 pounds heroin and \$180,000 – February 2017

Heroin is in a class of opium derivatives and semi-synthetic substitutes that includes Morphine, Methadone and Fentanyl. Prescription pain pills are also opioids and produce effects similar to heroin.

80% of Americans using heroin reported first misusing prescription opioids.

Heroin is a Schedule I narcotic with no currently accepted medical use. It is an opioid drug made from the Asian opium poppy plant and can be a white powder, a brown powder or a black sticky substance ("black tar Heroin"). Heroin is 4 to 5 times more potent than Morphine.

Fentanyl is a synthetic or man-made opioid that is 50 to 100 times more potent than Morphine. Fentanyl is often mixed with Heroin by drug traffickers, thereby increasing the risk of overdose.

Carfentanyl is an opioid 10,000 times more potent than Morphine. It is used as an elephant tranquilizer but occasionally sold as Heroin, creating a high risk of overdose.



Powder form Heroin is often mixed with other drugs including Cocaine and Fentanyl

*Addicts
inject, snort, or smoke
heroin.*



Lethal dose of Heroin v. Fentanyl

- **55,000 + OD Deaths in 2015 - more than all homicides and traffic deaths COMBINED: 15,696 Murders; 35,092 Traffic Fatalities.**
- 144 drug overdose deaths occur every day in the United States, and 63% of those are caused by Heroin or pharmaceutical opioids.
- 12.5 million Americans misused prescription pain medications in 2015.
- The CDC attributes a 72% increase nationwide in overdose deaths, from 2014 to 2015, to opioids including Heroin and Fentanyl.
- In 2015, Kentucky had the third highest death rate due to drug overdose at 29.9 per 100,000.
- Over \$400 billion is spent in healthcare costs per year for substance abuse treatment.
- 20.8 million Americans (7.8%) have substance abuse disorders, but only 2.2 million (10.4%) received any type of treatment.

The Science of Addiction

Dr. Mark Jorrich, M.D., specializes in treatment and addiction and serves as the Medical Director of the MORE Center in Louisville and the Medical Director of Behavioral Health Group Opiate Treatment Clinic in Lexington, Kentucky. Dr. Jorrich also currently serves as the President of the Kentucky Society of Addiction Medicine. At the Louisville Heroin and Opioid Response Summit, Dr. Jorrich explained current medical and scientific thinking about addiction and described the array of treatment options for opioid use disorder.

Addiction Defined

Simply put, addiction is a chronic brain disease. Like other diseases, it has its roots in biology, and it causes anatomical and physiological changes in the brain. The disease of addiction is preventable and treatable, but – if untreated – it can last a lifetime.

Mental health professionals refer to the disease of addiction as substance use disorder. Substance use disorder is defined as a chronic, neurobiological disease characterized by a lack of control over drug use, compulsive drug use, craving, increasing drug tolerance and continued use despite serious harm. Repeated substance use and resulting addiction cause functional brain changes and a disorder of normal brain reward systems, leading to an inability to abstain from substances despite negative consequences.

Both genetic and environmental factors contribute to the development of substance use disorders. Genetic influences are so strong that addiction is often described as a family disease. While some genes appear to increase susceptibility to addiction, other genes may have a protective effect. Important environmental influences increasing risk of addiction are drug use by peers, the availability of drugs, drug-using partners, and a history of victimization.

Treatment Options

Treatment for addiction can take place in a multitude of settings: residential long-term facilities (including halfway houses and group homes), residential short-term facilities, partial hospitalization, intensive outpatient programs, outpatient medication and counseling, and inpatient detoxification. It is important to understand that while detoxification and the management of withdrawal symptoms is an important step for many treatment protocols, detoxification is not in itself a “treatment” for addiction.



Dr. Jorrich compared an MRI scan of the brain of a long-term drug user to an MRI scan of the healthy brain of a non-drug user. The two scans show markedly different activity levels of brain activity.

There is a multitude of treatment protocols for opioid use disorder as well: abstinence-based or 12-step programs, and medically assisted treatments (MAT). Cognitive behavioral therapy can be used to support all treatment protocols. Abstinence-based programs have helped millions achieve recovery and are especially effective with young persons and persons with a lower level of dependence. MAT includes a variety of medications with varying pharmacological mechanisms, and all have been shown by research to be effective in reducing relapse rates for prolonged periods. At this juncture, MAT primarily employs one of three drug types, either Methadone, Naltrexone, or Buprenorphine/naloxone.

Methadone is a slow-acting, long-lasting opioid agonist that stimulates opioid receptors in a non-euphoric manner, at a far lower intensity than heroin and other opioids. Methadone is closely managed by a physician in a dedicated clinic with the goal of managing cravings and helping the patient become functional. Naltrexone is an antagonist used to deter abuse by blocking the ability of opioids to attach to receptors and stopping the effect of opioids. Buprenorphine/naloxone also deters abuse by limiting the effect of opioids, although not blocking the opiates completely. Not every MAT protocol may be suitable for an individual patient with specific characteristics and needs, and addiction physicians can assist with informed, appropriate treatment selections.

No single treatment is appropriate for everyone. Because substance use disorder has biological, psychological and social components, good treatment as well as successful recovery require a continuum of care – holistic, integrated and multifaceted. To the fullest extent possible, those in treatment should seek to understand all available treatment options before choosing a particular program.

“Addiction is a primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm and craving.”

Mark Jorrich, M.D.



Mark Jorrich, M.D., speaking during the Heroin and Opioid Response Summit on December 1, 2016 in Louisville.

Panel: Public Health, Prevention, and Education

Educating the Medical Community

Toni Ganzel, M.D., Dean of University of Louisville School of Medicine, discussed how the medical school and physician education had responded to the growing realization that prescribing practices for prescription opioids had contributed to the development of substance use disorders. Dr. Ganzel observed that four out of five heroin users began their opioid use with prescription painkillers. She called for a continuum of improved education beginning in the early stages of the medical school curriculum and continuing into practice. In fact, the University's School of Medicine was one of 75 medical schools that had committed to incorporating the CDC guidelines on prescribing opioids (issued in March 2016) into their curriculum.


Dr. Ganzel discussed some of the historical difficulties with prescription pain medications. She explained that patient pain had once been identified as "the fifth vital sign." Healthcare professionals placed a heavy reliance upon patients' self-reported pain assessments. Best practices for chronic pain management were not widely understood, and the emphasis on pain control led to long-term opioid prescriptions.

Now the medical school actively teaches its students about the physiological basis of pain, the pharmacological mechanisms of opioids and other pain medication, and the distinction between acute and chronic pain. UofL medical students are taught to evaluate pain as part of a functional assessment rather than relying entirely upon a self-reporting of pain. They are also encouraged to prescribe non-opioid medication and recommend non-pharmacological therapy for pain management. They learn, too, about the mechanisms of addiction, principles of treatment and recovery, and the fundamental precept that addiction is a chronic disease, not a character flaw.

"Addiction is a powerful, powerful disease of brain reward and we need to understand that, to acknowledge it, and to understand the signs and symptoms of addiction, to understand the principles of prevention and recovery, and need to do our part in caring for these patients with compassion, hope and excellence."

Dr. Toni Ganzel,

Dean of UofL School of Medicine



Knowledge
Skills
Attitude

Practicing Physicians

Evidence based treatment for acute vs. chronic pain, including opioids, non-opioids and non-medication treatment

- HB1 training and KASPER reporting
- CDC guidelines & checklists regarding dosing, harm reduction, setting functional treatment goals
- Diagnose and refer/treat addiction
- Teach, mentor and model that addiction is a chronic disease, not a character flaw

Medical residents who study in specialized programs at UofL following medical school receive additional training concerning pain, pain management, opioids and addiction. Similarly, practicing physicians are also required to continue to learn about pain management and opioid risks. As a condition of medical licensure, Kentucky state law now requires physicians to complete courses on a regular basis concerning opioid prescribing.

The City Response: One Love Louisville

Panelist Patty Gregory, co-chair of Louisville's Substance Abuse Work Group, an outgrowth of the Mayor's Safe and Healthy Neighborhoods, reported on some of the City's numerous programs and initiatives addressing prevention and substance misuse. The Substance Abuse Work Group is a collaborative body with members from law enforcement, emergency response agencies, schools, pharmacies, corrections, syringe exchange programs and public health. Under the umbrella of One Love Louisville in the Office of Safe and Healthy Neighborhoods, the city has received multiple grants for prevention education and naloxone kits. The Work Group advocates for more extensive drug prevention in schools and supports drug free community programs in the PAL Coalition neighborhoods of Portland, Algonquin and Old Louisville as well as in Shawnee and with Youth Alliance. Ms. Gregory stated that research demonstrates that every dollar spent on prevention saves between \$10 to \$20 dollars in future costs such as treatment services. Despite these savings, Kentucky remains one of the few states that does not mandate prevention education in its schools.

According to the U.S. Surgeon General's November 2016 Report, *Facing Addiction*, every dollar spent on evidence-based intervention can save \$58 in later costs.



The Louisville Metro Syringe Exchange Program (LMSEP) began in 2015 and quickly expanded to serve four locations. In FY 2016, 3,865 were served; of those, 1,812 were returning, and 239 were referred to drug treatment. The program operates to eliminate the spread of blood-borne diseases including HIV and Hepatitis C among those who inject drugs. The program specifically targets adults ages 18 to 25.

Drug Education in the Schools

Representing Jefferson County Public Schools (JCPS), Brandy Wood, a certified drug and alcohol counselor, and Dr. Katy Zeitz, JCPS Achievement Area Superintendent, explained that JCPS does not have a system-wide drug and alcohol education and prevention program. Counselors do, however, arrange for substance education and prevention in some schools. JCPS does have an active and responsive intervention program, with counseling services available at every school level. School staff and teachers receive training to identify and refer students who may need services. Four assessment counselors are available for

service at all middle and high schools throughout the school district with each counselor assigned approximately 12

schools each. Referrals typically come from assistant principals, school counselors, and parents. JCPS counselors engage both the student and parents, exploring treatment options if appropriate. Counselors provide ongoing support and can act as a liaison for families, the school, and treatment providers.

Dr. Leisa Schulz, Superintendent of Catholic Schools of the Archdiocese of Louisville, described a more comprehensive drug education and prevention program within the parochial school system. Each of the nine parochial high schools in Louisville provide heroin and opioid awareness education to their students. All schools, from kindergarten through Grade 12, receive age-appropriate drug and alcohol education. Parents of freshmen in high school receive training about adolescent drug and alcohol use. Two of the high schools, Trinity and Bethlehem (in Bardstown, Kentucky), have adopted random drug testing programs for students.

The Catholic school system also has intervention programs in place. Students are assessed if suspected of drug use, and treatment and counseling are pursued in lieu of punishment. Families are intensively engaged as part of the response protocol.

Data Collection and Analysis Efforts

An enormously important component of a fact-driven public health response to the overdose crisis is data collection and analysis. Ashley Webb, Director of the Louisville Metro Poison Control Center, explained that the Poison Center not only responds to calls for accidental poisoning, but also functions as part of a local, statewide and national data collection and monitoring network. Though based in Louisville, the Poison Center collects data from the entire state of Kentucky concerning all instances of poisoning, including overdoses. That data is uploaded every 8 minutes to a database maintained by the Center for Disease Control (CDC).

Within the state, the Poison Control Center works closely with health departments, healthcare providers, law enforcement and first responders to provide near real-time information concerning threats from potentially toxic substances or the adulteration of drugs. Recently, Poison Center staff noted multiple hospital visits by patients having atypically strong reactions to a single Percocet tablet; their work led to the identification of counterfeit Percocet tablets containing Fentanyl, a highly potent synthetic opioid. Ms. Webb noted that the Poison Center's surveillance system is only as good as the data it receives. There remain significant gaps in the consistency of reporting from healthcare providers, including hospitals.

The Kentucky Injury Prevention Research Center (KIPRC) is a collaborative venture between the Kentucky Department for Public Health and the University of Kentucky. While not itself engaged in primary data collection, KIPRC does engage in extensive secondary data analysis. The Center receives information concerning injuries from a broad range of sources including statewide data systems, public agencies and private enterprises such as hospitals. Representing KIPRC, Dr. Dana Quesinberry explained that analysis of data relating to injuries leads to better informed policies, interventions and programs for injury prevention – including overdoses. Unfortunately, KIPRC wrestles with data collection challenges, including extended reporting delays from some sources and receipt of data in unidentified formats. Dr. Quesinberry emphasized that more current and more comprehensive data is needed to better target and evaluate the effectiveness of interventions and policies.



Panel led by Dr. Joann Schulte, Director, Louisville Public Health and Wellness; seated from left: Dr. Toni Ganzel, Dean, UofL School of Medicine; Dr. Dana Quesinberry, Health Policy and Program Evaluator, KIPRC; Patty Gregory, Co-Chair, Mayor's Substance Abuse Task Force; Dr. Leisa Schulz, Superintendent of Catholic Schools, Archdiocese of Louisville; Dr. Katy Zeitz, Achievement Area Superintendent, JCPS; Brandy Wood, Counselor, JCPS; Ashley Webb, Director Kentucky Poison Control Center.

*"Better data leads to better targeting, more effectiveness of interventions, policies and programs."
-- Dr. Dana Quesinberry, Kentucky Injury Prevention and Research (KIPRC)*

Common Prescription Opioids

OxyContin and Percocet are two frequently prescribed opioids used to treat pain. Both are narcotics containing the active ingredient Oxycodone. The molecular structures of Heroin and Oxycodone are almost identical. These prescription opioid narcotics come from the same place Heroin does – the opium poppy. Oxycodone and other legally prescribed opioids mimic the effects of Heroin on the body and mind and often are used interchangeably by many who are addicted.

Commonly Prescribed Opioids by Name

- Codeine (Only Available In Generic Form)
- Fentanyl (Actiq, Duragesic, Fentora)
- Hydrocodone (Hysingla Er, Zohydro Er)
- Hydrocodone/Acetaminophen (Lorcet, Lortab, Norco, Vicodin)
- Hydromorphone (Dilaudid, Exalgo)
- Meperidine (Demerol)
- Methadone (Dolophine, Methadose)
- Morphine (Astramorph, Avinza, Kadian, Ms Contin, Ora-Morph Sf)
- Oxycodone (Oxycontin, Oxecta, Roxicodone)
- Oxycodone and Acetaminophen (Percocet, Endocet, Roxicet)
- OxyCodone and Naloxone (Targiniq ER)



Despite having only 4.6% of the world's population, the United States consumes more than 80% of all prescription opioids. The United States consumes 83% of all Oxycodone and 99% of all Hydrocodone.

Centralized Data Collection, Analysis, and Sharing

As New Jersey faced a growing heroin and opioid epidemic with ever-increasing overdoses, overdose deaths and criminal activity driven by addiction, the state's leaders needed empirical data to inform the public safety and public health response. Intelligence and data existed in agencies and organizations throughout the state, but data collection was not comprehensive; the discrete silos containing the information that was collected were not consolidated; various data sets were not correlated or compared; and information was often not disseminated for many months after its collection. In short, the situation was very similar to that in Kentucky today.

“Intelligence led policies answered the question: ‘How can you implement effective policies if you don't know the scope of the problem?’” -- New Jersey State Police Captain Juan Colon

Drug Monitoring Initiative

New Jersey recognized it was imperative to gather all relevant data in one central place, analyze all data sets against one another, then disseminate the information and analysis on a nearly real-time basis. To meet these needs, the New Jersey State Police (NJSP) Fusion Center developed the New Jersey Regional Drug Monitoring Initiative (DMI). The success of the DMI has led to its recognition as a “recommended best practice” by the Office of National Drug Control Strategy. According to NJSP Captain Juan Colon, who helped develop the new system, the DMI's collection and analysis capabilities have enabled New Jersey to better understand heroin and opioid supply and demand; to identify problem drugs, problem locales, and problem people; and quickly deploy targeted health and prevention resources.

The data collected by the DMI is sourced from both law enforcement and health domains: information about fatal overdoses, non-fatal overdoses, drug arrests, naloxone administrations, drug seizures, shootings, gun recoveries, treatment center admissions, ER visits, forensic lab results, toxicology results, urinalysis results,

and information from the prescription drug monitoring program (equivalent to Kentucky's KASPER system). Layered into this data is incident-location and residential information to identify localized drug use patterns and to develop mapping of drug-incident data.

Virtually every agency and organization touched by the drug epidemic contribute – and receive – information. Partners include DEA, HSI, AHIDTA, NJSP, local law enforcement, academia, public health agencies, hospitals, healthcare providers, treatment centers, forensic labs, medical examiners, probation departments, poison control centers as well as a multitude of state agencies.

Once information is received, it is analyzed intensively, then openly shared back to contributors within days – not months – after receipt. A range of reports are generated on a regular basis. Data is continually monitored for patterns that show localized activities, developing threats, trending drug characteristics, identified health risks, or any other pattern potentially requiring a public health or law enforcement response. When appropriate, the DMI issues timely advisories

and alerts. Partners may also request focused data, analysis or reports to meet particular needs. Captain Colon explains: “We push all of the information we receive back out to our partners to insure they’re giving us a nickel, but we’re giving them back a dollar.”

To build a system like the New Jersey DMI, Captain Colon recommends the following steps:

- Identify the information requirements of investigative and public health professionals
- Identify the essential data sets needed to meet the information requirements
- Identify the data sources
- Build partnerships with source entities that gather essential data
- Minimize points of collection in central nodes or repositories
- Automate the information collection process

Executing these steps was no easy task, but Captain Colon maintained that building the system was not an expensive undertaking, saying, “We started with two people and zero dollars.”

The logistical and legal impediments to data sharing include the sensitivity of law enforcement and health information, technological issues, trust across disciplines, and incentivizing noncompulsory data sharing. But these challenges can be resolved: law enforcement information is de-sensitized to an “Official Use Only” level, health information is de-identified, and collaborative relationships between executives encourage resolution of logistical problems.

The DMI model of centralized data collection, analysis and sharing insures that data drives decisions and improves the responsiveness of the public health and safety sectors. New Jersey offers its support to any state interested in developing a similar program.



Panel: Law Enforcement and First Responders

The controlled substances behind the heroin and opioid crisis are primarily heroin, prescription opioid pain medications diverted for unlawful use, and illegally produced synthetic opioids, especially fentanyl and related analogues. All of these substances are used by people with opioid addictions, and all of them have caused countless overdoses and overdose deaths.

Diversion of Prescription Opioids

Most people using illegal opioids start by misusing prescriptions: data shows that 80% of heroin users began with prescription opioids. According to DEA Assistant Special Agent in Charge Tom Gorman, prescription painkillers originate in the United States, where prescribing practices have made them far more prevalent than in any other nation. For example, although the United States has only 5% of the world's population, it consumes 99% of the world's hydrocodone, a common opioid painkiller. Because of the prevalence of prescription opioids, 53% of the people using these drugs for nonmedical purposes obtain them from medicine cabinets, a friend or family member.

Prescription pills are also trafficked by regional U.S.-based drug organizations that obtain pills in bulk from rogue healthcare organizations or by using teams of “patients” that obtain prescriptions under false pretenses. Most of the regional trafficking organizations delivering pills in bulk to the Louisville area are based in Detroit, Atlanta, Chicago and Eastern Kentucky. Drug cartels based in Mexico are *not* involved in distribution of prescription pills; indeed, those cartels consider pills to be a product that competes with the heroin and nonmedical synthetic opioids they distribute.

Heroin Distribution Networks

Most of the heroin that makes its way to Louisville is extracted from heroin poppies grown primarily in Mexico and, in decreasing amounts, in Columbia. The synthetic opioid fentanyl is manufactured in China, then shipped primarily to Mexico – or manufactured in Mexico from precursors produced in China. In Mexico, fentanyl is most commonly mixed with heroin or pressed into pills before shipment to the United States. Fentanyl is 50 times more potent than heroin.

Heroin and fentanyl are shipped from Mexico to the United States by various competing cartels, which mostly transport the heroin in vehicles or by individuals who have ingested sealed packages containing heroin. Most of these drugs destined for Louisville will travel one of a handful of routes: either to a regional drug trafficking organization in Detroit, Chicago or Atlanta and then to a Louisville trafficking group, or directly from California to Louisville.

Panelist Tom Schardein with the Louisville Metro Police Department (LMPD) discussed the path drugs take in arriving in Louisville. Once in Louisville, the drugs are distributed by networks of associated individuals. The drugs may pass from the originating trafficker atop a pyramid through multiple levels of dealers before being sold to an end user. The dealers may work directly for a high-level trafficker, or may essentially function as independent contractors or businesses that either pay for drugs in advance, or, frequently, that have the drugs “fronted” – advanced on credit, with an expectation of repayment once the drugs are sold.

On the street, drugs are often trafficked by users who are selling drugs to support their own habit. Although the trafficking addict is certainly being compensated for his drug dealing, he is not as a rule in the business primarily for profit, as is the case with higher-level local traffickers.

As lead supervisor of the narcotics major case platoon for LMPD, Sgt. Schardein explains that the local trafficking organizations in Louisville are typically dealing in a multitude of controlled substances, most of which come from Mexico from the same source cartels, by the same routes, as heroin and fentanyl. The typical higher level traffickers in Louisville will have some combination (or all) of the following for sale: heroin and opioids, methamphetamine, cocaine, marijuana and prescription pills.

With access to this wide range of drugs, street level traffickers will often provide customers buying one drug type a “free sample” of another drug in an effort to expand their market. This multi-drug market also reflects the demands from multi-drug users. Toxicology reports from overdose deaths demonstrate the vast majority of overdose victims have ingested multiple controlled substances, not simply a single drug.

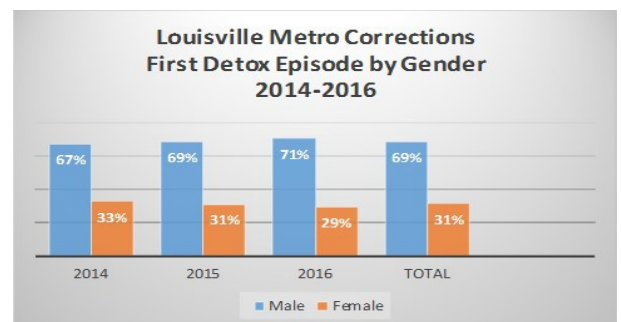


Heroin and U.S. currency seized at a tire distribution center in Louisville on October 30, 2015

Opioid User Demographics

Law enforcement officials and first responders report that heroin and opioid use includes every demographic and is prevalent in every zip code in Jefferson County. Still, some groups seem to be impacted more heavily than others. Statewide Kentucky data shows that most overdose deaths occur in persons aged 45 to 54. In Jefferson County, Metro Corrections records show that 71% of jail detainees undergoing detoxification for the first time were men in 2016. Metro Corrections reports that 9,916 inmates underwent detox protocols in 2016, with 6,115 inmates detoxifying from opiate use.

Unfortunately, broader data reflecting the demographics and location of heroin and opioid use is neither comprehensive nor reliable. In recent years, data from heroin and opioid overdose deaths has served as a representative proxy for information about all heroin and opioid users.



Impact on Resources

The surge in heroin and opioid use and trafficking has heavily impacted law enforcement agencies. Enormous investigative resources are directed at disrupting and dismantling trafficking groups by LMPD, DEA, FBI, ATF, the Jefferson County Sheriff's Office, Shively Police Department, Jeffersontown Police Department and other local agencies. Moreover, law enforcement must direct additional responsive and investigative resources to crimes committed by addicts to support their drug habits, such as thefts, burglaries, street robberies, business robberies, and home invasions. Groups involved in drug trafficking are also responsible for much of the gun violence in Louisville, sometimes in activity stemming directly from drug trafficking (protecting turf, robbing one another of drugs or cash) or in unrelated ways arising generally from the violent gun culture typically associated with drug activity.

“Every day of the year, the jail has between 60 to 80 incarcerated persons on a detox protocol.”

*Steve Durham
Assistant Director
Louisville Metro Corrections*

Law Enforcement and Emergency Responders: Working Together

LMPD officers also respond to every call for ambulance services related to an overdose. They respond in order to provide protection for EMS or Fire Department personnel from possible dangerous criminal activity. Moreover, all personnel responding to drug scenes are put at risk of toxic exposure to opioids. The highly potent synthetic opioids such as fentanyl and carfentanyl can be absorbed through the skin or inhaled, potentially causing an overdose. Indeed, some law enforcement agents and officers have overdosed when collecting evidence. Because of this, officers respond to all overdose calls in pairs so that one can aid the other if required.

They also carry the opioid antidote Naloxone, not only to help overdose victims recover from overdose, but also to use on a fellow officer in the case of exposure. The same concerns have led DEA to adopt new protocols requiring agents to carry Naloxone.

Louisville's emergency services have also expended enormous resources responding to overdoses. In 2016, Metro Louisville EMS executed nearly 7,000 overdose runs. This figure does not include overdose runs by other EMS services operating in Jefferson County nor overdoses where patients are treated at emergency rooms after arriving by private vehicle.

Overdoses create a huge burden for area healthcare providers and organizations. Every hospital emergency room throughout Jefferson County typically handles multiple overdoses per day. As the potency of heroin and opioids have increased, emergency responders and emergency room doctors have had to significantly increase the dosage of Naloxone because lower doses of Naloxone are ineffective. Even when a dose is sufficient to revive a victim, Naloxone's effects do wear off more quickly than opioid levels subside, and victims can re-sedate and even succumb to overdose even after receiving Naloxone.

Due to the risk of re-sedation, Dr. Robert Couch, former President of the Greater Louisville Medical Society, stressed the importance for overdose victims to be seen at a hospital even after a Naloxone administration by EMS or police. However, Louisville Metro EMS Deputy Chief Col. Diane Vogel reported that most overdose victims revived with Naloxone are not interested in additional medical attention; instead, they are typically angry that their high has been interrupted – despite being saved from a potentially lethal overdose. Once they are revived from an overdose and reach decisional capacity, they have the legal right to refuse more medical care and often do refuse. Information about substance use treatment is offered to friends and family who may accompany an overdose victim, but the victims themselves are rarely interested.

2016	Metro Louisville EMS Only
Overdose Runs	Narcan Administrations by Patient
January 524	93
February 402	99
March 627	282
April 512	143
May 715	316
June 641	217
July 516	129
August 524	146
September 613	235
October 530	169
November 519	145
December 756	279
Totals: 6879	Totals: 2253

The Jefferson County Criminal Justice Response

The criminal justice system within Jefferson County has developed extensive programs to respond to the heroin and opioid epidemic. The Office of the Commonwealth's Attorney strives to punish traffickers and to assist users in obtaining treatment. As part of the Heroin Rocket Docket program developed by the Commonwealth's Attorney and the County Attorney, every criminal case involving heroin charges is triaged by three prosecutors. If they determine the defendant is trafficking for profit, the case is advanced to Circuit Court for full felony prosecution. If the defendant is assessed to be an addict whose conduct is related to his addiction, the defendant's case may be disposed of with a conditional discharge that imposes a requirement that the defendant obtain drug treatment as a condition of his release.

While there is no monitoring of these defendants, they are required to show proof of treatment. Those addicts with more extensive criminal histories who appear to require more enhanced supervision are referred to an intensive drug treatment court conducted in Jefferson District Court.

The Civil Court Intervention Option: Casey's Law

The state court system offers another court intervention option pursuant to a Kentucky statute known as Casey's Law. That law provides a mechanism by which a court may compel an addict to obtain treatment. Under this law, a civil proceeding may be initiated by a family member or friend of an addict by filing a petition in District Court. Upon a showing that the respondent is addicted, is a danger to him/herself and others, and needs treatment, the court may order the respondent to undergo two medical evaluations. If the medical providers support treatment, the court may order the respondent to undergo treatment under penalty of contempt, that is, under threat of jail if the respondent does not comply.

Casey's Law does require petitioners to certify they will be financially responsible for treatment, but District Court Judge Stephanie Pearce Burke explained at the Summit that respondents can be steered to free or low-cost treatment options if ability to pay is a problem. She stated that she believed families would be filing hundreds of these petitions every month if they fully understood the value and effectiveness of the Casey's Law procedure.

Innovative Diversion Program: LEAD

Jamie Allen of the Louisville Metro Criminal Justice Commission reported to the Summit about another significant, innovative diversion program for addicts being considered for implementation in Louisville. The program, known as Law Enforcement Assisted Diversion or LEAD, originated in Seattle where it was tremendously successful, with 58% of participants experiencing no re-arrest. Following a harm reduction model, LEAD empowers officers to forego arresting low level drug offenders and addicts in favor of a referral to a LEAD case manager. The case manager assesses the participants for their immediate needs, including housing, medicine assisted treatment, and trauma care. The harm reduction approach does not require abstinence, but rather safer or managed drug use at first, with encouragement for participants to pursue treatment when they are ready. The LEAD program has not yet been funded in Louisville, but evidence demonstrates such a pre-arrest diversion program has much promise.



Panel led by U.S. Attorney John E. Kuhn, Jr. Seated from left: Jamie Allen, Public Protection Coordinator, Louisville Metro Criminal Justice Commission; Steve Durham, Assistant Director, Louisville Metro Corrections; Sgt. Tom Schardein, Supervisor Narcotics Unit, LMPD; Thomas Gorman, Assistant Special Agent in Charge, DEA; Col. Diane Vogel, CEO, Louisville EMS; Frank Dahl, Assistant Commonwealth Attorney; Dr. Robert Couch, Chair, Greater Louisville Medical Society; and Judge Stephanie Pearce Burke, Jefferson County District Court.

Linking Criminal Justice and Health to Promote Recovery

Dr. Robert I. DuPont is a national leader in drug policy and treatment. He was the first Director of the National Institute on Drug Abuse and the second White House Drug Czar, serving under two Presidents. He later became the founding President of the Institute for Behavior and Health, Inc., which has the simple but focused mission to reduce the use of illegal drugs. To this day, he not only develops drug policy but also treats substance use disorder as a practicing psychiatrist.

Dr. DuPont advocates three main points: (1) Criminal justice and health must work in concert to enhance treatment effectiveness; (2) Because nearly all substance use disorders can be traced to adolescence substance use, prevention efforts must target teenagers to encourage a paradigm of health which includes complete abstinence from all chemicals used to stimulate brain reward or pleasure; and (3) The goal of treatment is sustained recovery, and treatment success should be measured by a five-year standard.

Hope vs Standard Probation

Randomized control study of HOPE showed that over a one-year period, HOPE probationers were:

- 55% less likely to be arrested for a crime
- 72% less likely to use drugs
- 61% less likely to skip appointments with supervisory officer
- 53% less likely to have their probation revoked
- HOPE probationers on average were sentenced to 48% fewer days of incarceration than the standard probation group

Criminal Justice Can Effectively Promote Treatment and Recovery

Dr. DuPont believes one of the ways to stop the drug epidemic is to use the criminal justice system to promote treatment and recovery. Drug treatment courts have proliferated, and today more than 3,000 programs exist across the country with varying specialty focuses such as controlled substances, DUI, veterans or juvenile offenders. The treatment court model generates very good outcomes: 84% of graduates avoid re-arrest within the first year of completion, with 75% success at the two-year graduation mark. Moreover, drug courts are six times more likely to keep offenders in treatment long enough for them to get better.

Dr. DuPont also promotes court-managed supervision programs that compel abstinence. As a successful exemplar, Dr. DuPont pointed to Hawaii's Opportunity Probation with Enforcement (HOPE) program. Participants in HOPE are subjected to frequent and random drug tests with swift and certain sanctions for any violation. Positive drug tests, missed probation appointments or missed drug tests typically result in immediate, limited jail time. As the accompanying graphic shows, the HOPE program correlates not only with far less drug use, but also with substantially reduced incarceration and recidivism for participants. Because five million people are currently on parole or probation, and 85% of those have substance abuse problems, the HOPE model is highly scalable. Dr. DuPont argues that compulsory treatment is both

effective and humane. Passivity – failing to intervene – leaves the drug user vulnerable and erodes the quality of life in the community. The humane thing to do, he urges, is to intervene. Families, in particular, can help with leverage toward treatment.

Youth Abstinence Is Necessary For Health

Dr. DuPont’s research demonstrates that most addictions begin in adolescence: most adults who have abstained from any substance misuse by the age 21 are highly unlikely to begin illicit drug use in adulthood. We must, he insists, normalize abstinence for young people – abstinence from *all* chemicals that stimulate the brain: alcohol, marijuana, tobacco and other drugs.

Dr. DuPont believes we must develop a new cultural paradigm where complete abstinence is understood as vital for health. Conversely, adolescent use must be understood as destructive, potentially disrupting normal brain structure and function. The key to leverage is the family, but all of our social, cultural and public institutions can promote abstinence as an integral part of positive health.

Sustained Recovery is the Ultimate Goal

The goal of treatment is sustained recovery. Recovery means abstinence *and* being a different, better person who has ended the selfishness induced by drug dependence. Recovery, he explains, is not a short-term treatment program, but a lifetime challenge.

Dr. DuPont insists we must end the “conflict” between MAT (medication assisted therapy) and abstinence (12-step) treatment programs. He points out that some treatment programs such as nationally recognized Hazelden have combined MAT with abstinence-based programs.

He observes that all of these treatment modalities have helped users into recovery. What we lack, however, is a universal standard by which to measure success for sustained recovery. Dr. DuPont recommends the adoption of a five-year recovery standard as the benchmark for measuring the efficacy of all treatment programs whether MAT or abstinence-based.

“We cannot arrest our way out of this epidemic. We cannot treat our way out of this epidemic. Linking law enforcement and treatment make prevention, treatment, and recovery work.”

Dr. Robert DuPont

Panel: Treatment and Recovery

Intersection of Treatment and the Criminal Justice System

Because many users of illicit drugs eventually have an encounter with the criminal justice system, Louisville Metro Corrections has had to fashion a number of jail-based programs to cope with – and assist – the incarcerated addict. According to Steve Durham, Assistant Director of Metro Corrections, the county's jail on an average day is helping 60 to 80 persons through detoxification, providing medical treatment and support while inmates suffer through withdrawal symptoms. While detoxification is a necessary first step toward treatment, many detainees are released through their court proceedings before receiving any drug treatment or even completing detoxification. Unfortunately, most of those addicts return immediately to drug use upon released.

Those who remain in jail following detoxification are steered toward a Metro Corrections program called PACT – Pathway Advocacy Alliance for Community Treatment. PACT is a state-funded program that provides treatment services to addicts while incarcerated. The program includes the administration of Vivitrol injections to initiate medicine-assisted treatment (MAT).

Another program – FACT, or The Familiar Faces Action and Community Transition Program – addresses the reality that many inmates are released without resources to support recovery. FACT provides services to repeat offenders who are often homeless. These so-called “familiar faces” are linked with community resources before they are released, given clothing, medicine and toiletries and provided a “warm hand-off” to a facility to continue their recovery.

Finally, Metro Corrections is pursuing a Pay for Success/Social Impact Bond to obtain private funding for drug treatment from local service providers for released inmates. It is hoped that the additional drug treatment from this program will promote recovery and reduce recidivism.

*“We would rather help
someone than jail someone.”*

*Steve Durham
Assistant Director
Louisville Metro Corrections*

The Economic Benefit of Treatment:

According to the U.S. Surgeon General's November 2016 Report, *Facing Addiction*, every dollar spent on substance use disorder treatment saves \$4 in healthcare costs and \$7 in criminal justice costs.

Drug Court Intervention

In Louisville, the Jefferson County District Court operates a drug court treatment program. Jefferson County District Court Judge Eric Haner explained that his Drug Treatment Court provides intensive supervision and treatment management for its participants, who are typically nonviolent drug offenders. Participants pass through four phases, each requiring varying degrees of sobriety, engagement in employment and participation in counseling or support groups such as Narcotics Anonymous or Alcoholics Anonymous. On average, participants require 23 months to complete the program. Successful graduation requires the participant to remain drug-free for at least one year and meet all other drug court requirements.

Drug Court participants submit to random drug screenings a minimum of three times per week. This model is aligned with the approach advocated by featured speaker Dr. Robert DuPont, who described highly successful programs where treatment is coupled with frequent testing and swift and certain sanctions for positive tests.



Honorable Eric J. Haner meets with a Drug Court Diversion participant at Jefferson County District Court.

Judge Haner emphasized, too, the cost-effectiveness of the Drug Court. While the cost of incarcerating an individual for one year is \$20,047, the cost of drug court participation for the same period is only \$6,069.

Adult Drug Court Statistics

Detox	2014	2015	2016
Benzodiazepine	2,077	2,713	2,898
Alcohol	1,709	2,597	3,485
Opiates	4,290	5,055	6,115
Total Detox	6,100	7,893	9,916

DRUG COURT SUCCESS:

Two years after completing the Drug Court program, graduates had a recidivism rate of 20%. By comparison, persons on probation for similar offenses who did not participate in Drug Court had a recidivism rate of 57.3% two years after their probation period ended.

Kentucky Administrative Office of Courts

Reducing Harm, Providing Compassion

Recognizing that users who are not ready for treatment nevertheless have significant unmet needs, Russ Read, a founder of the Kentucky Harm Reduction Coalition, stressed the value of helping users deal with the most pernicious collateral consequences of substance abuse. He emphasizes that offering hope, compassion and respect along with practical assistance to those battling addiction not only minimizes harm, but also is effective in steering users into treatment. The Kentucky Harm Reduction Coalition distributes Naloxone kits to heroin and opioid users to enable them to reverse potentially deadly overdoses. Thus far, the Coalition has distributed more than 3,000 kits across the Commonwealth, more than half of those in Jefferson County. The Coalition also actively participates in the successful needle exchange program sponsored by the Metro Public Health and Wellness Department. Research has demonstrated that such programs reduce the transmission of AIDS without increasing rates of injection drug use. An additional benefit, as noted by panel moderator, Scott Hesselstine of Centerstone, is that individuals involved in needle exchange programs are 5 times more likely to eventually seek treatment and enter recovery programs. Finally, the Coalition also actively works to educate both users and the general public about addiction and to destigmatize the disease since stigma and shame are significant barriers to treatment.

Barbara Carter, a panelist and Program Specialist with Public Health and Wellness's Office of Addiction Services, advised that this Office works toward improving the city's response to the addiction epidemic in a number of ways. The Office plans to build a coalition of treatment providers within Louisville to solicit innovative ideas for responses and solutions to the drug problem and will pursue grant funding to support promising initiatives. The Office is also working with the University of Louisville's Kent School of Social Work to assemble a coalition of students to develop effective outreach addressing drug misuse within the student population.

“Harm reduction deals with hope, compassion and respect...”

*Russ Read,
Kentucky Harm Reduction*

In another role, the Office of Addiction Services works to identify groups with unmet treatment needs through evaluation and outcomes research. One such group is post-partum women. While pregnant, they are a priority population for treatment services, but following childbirth, these same women lose their special status for access to treatment. Termination of treatment increases the chances of relapse, putting the women, their children and their families at risk.

Treatment Resources in Louisville

Within the Louisville area, there are many treatment facilities and programs. Both in-patient and out-patient programs are available, although any recovery from heroin or opioids requires an initial detoxification. Some programs offer medication assisted therapy (MAT), some are based upon a traditional abstinence-based twelve-step model, and some combine the two treatments. Cost varies dramatically; some programs are strictly private pay, while others are subsidized with grants or donations. Some will accept Medicaid reimbursement; others will not accept Medicaid or simply cannot due to a Medicaid rule known as the IMD (Institutions for Mental Disease) exclusion, which does not allow Medicaid payment for inpatient addiction treatment services in facilities with more than 16 beds.

The Treatment and Recovery Panel included representatives from some of the largest treatment providers within the recovery community. Centerstone, a national non-profit organization providing substance abuse treatment and mental health services, has multiple locations in Jefferson and surrounding counties. Centerstone offers inpatient detoxification and rehabilitation as well as intensive outpatient programs, for both adolescents and adults.

Centerstone treats heroin and opioid use disorders with MAT combined with behavioral therapies, including integration of 12-step programs.

The Healing Place is a long-term, residential recovery center providing food, clothing and shelter as well as addiction treatment to more than 700 homeless men and women each day. The organization provides residential detoxification, an intermediate two-week “Off the Streets” residential program, followed by a recovery program. The Healing Place employs a twelve-step program model, urging clients to accept a spiritual recovery. Relying heavily on private donations, The Healing Place is able to provide treatment at no cost. Unfortunately, the heavy demand for detoxification beds overwhelms the organization’s capacity, and approximately 400 persons seeking detoxification and treatment are turned away every month. Facilities are being expanded to approximately double the detox bed capacity, but those additional beds will not suffice to meet the current level of need.

Volunteers of America operates a range of programs for high-need populations, including specialized addiction recovery services that target particular groups. In separate programs, the organization offers residential addiction recovery for men with substance use and co-occurring disorders (Shelby Men’s Recovery Center), men leaving correction facilities (Halfway Back), veterans (Veterans Addiction Recovery), and substance-dependent women who are pregnant or have young children (Freedom House). Freedom House has celebrated 135 babies born to drug-free women between 2015 and 2016.

The University of Louisville is another important resource within the recovery community. Dr. Erica Ruth, the Director of the University’s Addiction Psychiatry Training Program, oversees a clinic that offers MAT, behavioral therapy and other psychiatric services to addicts. She notes that substance use disorders often co-occur with other mental health disorders, and these patients with co-occurring disorders require a range of intensive treatment available at her clinic.

“I just think we are at the beginning of really having a true recovery-oriented system of care here in Louisville.

* * *

Being able to address and treat the whole person is essential, and that’s why multiple pathways to recovery are essential.”

*Scott Hesseltine,
V.P. of Addiction
Services, Centerstone*

Barriers to Treatment

Despite the widespread presence of treatment providers in the Louisville area, access to treatment remains an enormous problem. All panelists agreed that insurance coverage issues – whether an individual’s lack of any health insurance altogether or insurance policies’ limitations regarding coverage for treatment – create enormous difficulties for persons seeking treatment. And with relapse a common outcome of treatment, with many addicts requiring treatment services multiple times before achieving long-term recovery, the inability to pay becomes for many an insurmountable obstacle to recovery.

The Surgeon General’s November 2016 report, *Facing Addiction in America*, reports that 7.8 percent of the population – 20.8 million people – met the diagnostic criteria for a substance use disorder in America in 2015. But only 10.4 percent of that group – 2.2 million – received any type of treatment. While many of the 18.6 million persons with substance use disorders are not seeking treatment, many fail to obtain treatment simply due to access problems. Certainly, this is the sad situation in Louisville.



Moderator Scott Hesseltine, V.P. of Addiction Services, Centerstone; Hon. Eric J. Haner, Jefferson County District Court; Steve Durham, Assistant Director, Louisville Metro Corrections; Patrick Fogarty, former Director of Business Development and Mission, The Healing Place; Russ Reed, Co-founder, Kentucky Harm Reduction Coalition; Barbara Carter, Program Specialist for the Office of Addiction Services, Louisville Public Health and Wellness; Courtney Wallace, Senior Director, Addiction Recovery Services, Volunteers of America; Dr. Erika Ruth, Director of UofL School of Medicine Outpatient Addiction Services; and Chris Wood, Director, Counseling Center, Southeast Christian Church.

The Journey to Recovery



“ It’s not what happened in treatment that determines whether a person will make it through the rest of their life sober, abstinent, and healthy, but...what meets that person, on a family level, on an employment level, on an education level, that they will be able to access at regular intervals of care, that will scaffold and support a person into being able to protect and manage their reeccovery for the rest of their life. ”

*Ivana Grahovac,
Facing Addiction, Inc.*

Ivana Grahovac, a champion of support for youth prevention and recovery, is currently the Director of Advancement for Facing Addiction, Inc. Previously she worked as the Executive Director of Transforming Youth Recovery and Executive Director of Austin Recovery.

When Ms. Grahovac speaks about addiction, prevention, treatment and recovery, she speaks with an authority and passion forged in the crucible of her personal heroin addiction and annealed by her journey to recovery. The heroin addiction that began in college drove her into a dark descent and through a cycle of treatment relapse. Describing those years, Ms. Grahovac tells of being overwhelmed by shame, self-loathing and hopelessness, with no meaningful vision of any purposeful life for the recovering addict. Finally, secluded in a Michigan jail cell, she experienced a transformative moment of intense clarity, a personal spiritual epiphany that she could find wholeness through an abstinence-based recovery.

When Ms. Grahovac then completed another treatment program (her sixth), she returned to her family’s home and found stability with local recovery support networks. However, when she left home to enroll at the University of Michigan, she suddenly found herself without open, accessible support resources; feeling alone and adrift in the college culture of inebriation and substance misuse, she even began to consider drinking or using drugs again. Fortunately, she was able to connect with a few students in recovery, then reached out to the entire University community to see if others were interested in joining a recovery-oriented student group. The response was overwhelming, and the group developed into the school-sponsored University of Michigan Collegiate Recovery Program. Her involvement in the program was the first step in Ms. Grahovac fulfilling a promise she made to herself after her own treatment experience: that she would help others in recovery.

Ms. Grahovac’s reflections about her experience have led her to profound insights about the nature and importance of recovery, treatment, intervention and prevention.

- She believes that a community’s open embrace of recovery is critically important in encouraging addicts toward recovery. For addicts burdened by shame and devoured by their disease, community acceptance demonstrates there is hope after addiction and a prospect for a full, healthy, fulfilling life.
- Though treatment is a necessary step toward healing, she believes emphatically that treatment alone does not determine whether a person succeeds with sustained recovery. Instead, she maintains, broad cultural acceptance and support – from families, schools, healthcare, employers and communities – is critical to protecting and sustaining lifelong recovery.
- Youth recovery programs provide a highly effective intervention framework that can prevent worsening addiction and save young people from the worst consequences of the downward spiral of addiction. Ms. Grahovac urges greater investment in visible, viable, accessible, fun communities and programs where students in recovery can find one another and have a genuine school experience.

A Call to Action

An effective strategy to overcome the heroin and opioid epidemic requires an intensified commitment in the areas of treatment, prevention and enforcement:

- Addiction treatment should be available for all persons seeking treatment.
- Prevention programs built upon evidence-based principles should be offered in all schools.
- Education outreach to the general public concerning opioid risks, addiction, and treatment should be expanded.
- Law enforcement should improve and intensify efforts to eliminate the supply of heroin, fentanyl, opioid analogues and diverted pharmaceuticals.
- All sectors working on and affected by the heroin and opioid problem should collaborate to share data and information even if not mandated to do so.
- Kentucky should establish a comprehensive, centralized drug data collection, analysis and sharing system.
- Recovery support programs and systems should be developed in schools and throughout the community.

RECOMMENDATIONS FOR IMPROVED TREATMENT AND RECOVERY SUPPORT

In Louisville, the biggest shortfall in helping those with a substance use disorder is a lack of access to addiction treatment. Every month, The Healing Place turns away 400 persons seeking detoxification and treatment because they do not have a sufficient number of community beds, that is, beds available for free. More treatment beds are needed for low-income persons.

While there is often available capacity in both MAT (medication-assisted treatment) and abstinence facilities, the vast majority of those options require payment by either private insurance or patients themselves. But private insurance inevitably limits payment for these services; indeed, the share of substance use disorder financing from private insurance has declined dramatically over the last three decades. Moreover, the path of addiction has led many addicts to a point where they have no health insurance or means to pay. Families sometimes bear the significant expense, but most addicts relapse multiple times, requiring multiple rounds of treatment, and the cycle often exhausts families' capacity or willingness to pay for repeated treatment.

Although Medicaid does pay for treatment, that funding option has not resolved the access problem. The expansion of Medicaid eligibility under the Affordable Care Act not only provided coverage for healthcare but

also significantly broadened access to substance abuse treatment for a population in which substance use disorders occur at higher rates. Unfortunately, many persons with opioid use disorder descend into so deep a level of dysfunctionality that they often fail to obtain Medicaid coverage despite being eligible. Further limiting access through the Medicaid system is a law (the "IMD exclusion" pertaining to "Institutions for Mental Disease") that prevents Medicaid from paying for medically necessary addiction treatment in any facility larger than 16 beds, thus eliminating access to larger facilities.

IMPROVING ACCESS

Louisville – as well as Kentucky and the federal government – must commit more resources to improve access to treatment. Relying upon nonprofit organizations to provide free care will simply not suffice to fill the enormous gap. Our public institutions must contribute far more to deal with this deadly epidemic. The enormous human, social and financial costs of addiction more than offset the costs of more expansive treatment funding.

Access to substance abuse treatment through the Medicaid system should be expanded, not restricted. Currently, 1.3 million people receive mental health and substance abuse treatment under the Medicaid expansion. Given the proven 11 to 1 financial return on treatment expenditures, public support for treatment simply must continue, in some form or other, at the broadest, most inclusive level possible. If Medicaid coverage is to be curtailed, another mechanism for public treatment funding should unquestionably replace it.

As a separate matter pertaining to Medicaid, the IMD exclusion should be terminated for substance abuse treatment facilities in a manner that avoids any unintended consequence that the exclusion was originally intended to avoid. While we turn away hundreds of addicts every month who are seeking treatment, it is unconscionable that we allow treatment beds to lie empty in larger facilities because they are unable to accept Medicaid reimbursement due to the exclusion.

Another model that might be explored by both public and nonprofit entities is a simple voucher system to pay for treatment. From 2005 through 2016, Operation UNITE, a nonprofit organization combating substance use disorders primarily in southeastern Kentucky, has provided over \$13 million in vouchers to enable 4,069 individuals to enter treatment programs. A government-funded voucher system, where *any* person (or, alternatively, any person without means to pay) who suffers from a substance use disorder can obtain a voucher to pay for treatment at an evidence-based, appropriately accredited program, could meet the rising treatment demand through the currently existing infrastructure of treatment facilities.

SUPPORTING RECOVERY

Our cultural history has not been kind to those suffering from addiction. For most of modern history, addiction has been heavily stigmatized. We viewed addicts as moral failures, lacking willpower and character. Addicts

saw themselves through a lens of shame and hid their dependencies from the world as best they could.

We now know better. Medical science has helped us understand how certain drugs such as opioids affect the brain, change it, and lead to uncontrollable, diseased dysfunction. We understand that addiction is – plainly – a disease.

It is important that the modern scientific conception of addiction as a brain disease be widely understood and accepted. There should be no shame in suffering from a disease.

Yet we know that even today the chief obstacles to both treatment and recovery is the benighted stigma that still attaches to addiction. Our city should redouble its efforts to build a compassionate, supportive, community-wide environment that supports everyone in recovery and that celebrates and affirms the ennobling experience of living in recovery.

Successful treatment will ideally lead to *sustained recovery* – a life of productive, healthy, sober living. But abstention from drugs and alcohol can be challenging in our society, especially for persons whose social engagements have generally involved substance use. Given the growing number of persons with substance use disorder, our public agencies and private enterprises should develop more recovery-support institutions, associations and programs. We need systems and structures woven into our community that will support and sustain recovery. Other cities have invested in support by building recovery centers for those in recovery to socialize, network, celebrate, and receive ongoing support such as twelve-step meetings.

Our schools can do more to support recovery, too. Every area university and college should create visible, viable, accessible, fun communities where students in recovery can easily find one another and have a genuine college experience free from alcohol and drugs. Some large cities have established recovery high schools, mentored by college students in recovery. Louisville should evaluate the need for similar programs here.

RECOMMENDATIONS FOR IMPROVED PREVENTION AND EDUCATION

Prevention efforts must broaden and intensify, targeting not only the general public, but also students, their families, and the healthcare professions.

PROFESSIONAL EDUCATION

Healthcare professionals are currently wrestling with an important reassessment of their role in contributing to addictions, largely as a result of prescribing practices built upon previously accepted pain management protocols.

Medical schools such as the University of Louisville School of Medicine deserve accolades for responding to the opioid and heroin epidemic by developing programs to teach all medical students about pain management, responsible opioid prescribing, and practices to reduce addiction risks. Another bright spot is Kentucky's prescription drug monitoring program (PDMP), KASPER, which has received national recognition as one of the most effective PDMPs in identifying patient misuse of prescription drugs.

Intensifying physician education efforts are underway at a national and statewide level. In March 2016, the CDC took the unprecedented step of issuing guidelines to aid doctors in prescribing opioids. Pursuant to a state law, the Kentucky Board of Medical Licensure now mandates that all physicians licensed in Kentucky obtain continuing regular, repeated medical education concerning prescription opioids.

These important provider education efforts should be continued and expanded. The omnipresence of substance use disorders should lead medical schools and licensure bodies to require not only more information about pain and prescribing practices, but about addiction itself. As the brain disease model of addiction has gained wide acceptance, education about the nature and treatment of addiction should no longer be the exclusive province of specialized psychiatrists and addiction counselors, but of all healthcare professionals – to include physicians of all

specialties, nurse practitioners, physician assistants, nurses, pharmacists, and dentists. A better understanding of substance use disorders will better prepare healthcare professionals to recognize, refer and respond to those suffering from addictions.

TEACHING OUR YOUNG PEOPLE

We must promote a paradigm of youth abstinence as the ideal of health. We must educate parents so they understand that an attitude of tolerance for even occasional or experimental substance use puts their children at risk for serious, debilitating and life-threatening addictions. We must embrace and encourage a universal cultural standard that is consistent with the findings of research and neuroscience, and the new normal must be the avoidance of *all* substances that stimulate the brain for pleasure until the age of full majority – age 21. Health requires adolescent abstinence: no alcohol, tobacco, marijuana or other drugs.

Our schools must implement evidence-based drug awareness and drug use prevention programs at every school and at every level of academics. While some school systems in Jefferson County do have drug education programs, others have abandoned such programs, focusing instead on targeted intervention resources for children who are using substances. While evidence-based intervention is important and effective, it does not substitute for a comprehensive, universal drug education program for all school-aged children.

PUBLIC AWARENESS EFFORTS

We must do more to educate the general public about the biological basis of substance use disorders, the threats posed by opioids and substance use disorders, and the array of resources available for addicts and their families. Because stigma surrounding addiction discourages addicts from seeking treatment, we must promote a universal acceptance of the concept that addiction is a brain disease, a medical condition that must be treated like any other disease.

As addicts spiral into self-destruction, their families, friends and partners are typically overwhelmed by a sense of helplessness. In fact, however, they are not helpless: they may pursue civil court proceedings pursuant to Casey's Law to compel addicts to attend treatment programs. While many families may fear undertaking the financial responsibility for treatment, the judges in Jefferson County who handle these cases are very sensitive to petitioners' ability to pay and can steer addicts to free or lower cost options. Because Casey's Law is so seldom used, our public awareness efforts must include education about this available legal procedure. We must urge those close to addicts to use Casey's Law far more frequently.

Families in addiction crisis often experience problems locating treatment facilities, determining whether to pursue MAT or abstinence or a combination thereof, sorting through costs, insurance coverage and payment options. While a number of websites offer information and assistance with these issues, those seeking treatment would benefit from more guidance and support in finding the best treatment program fit. The Louisville-area community of treatment programs should consider collaboratively developing and staffing a central treatment clearinghouse that would assist those seeking treatment based upon individual needs, treatment preferences, insurance, and other financial resources.

Our community must also continue efforts to make the public aware of the life-saving potential of Naloxone and needle exchange programs. Naloxone can reverse the

effects of a heroin overdose, and clean needles can protect the intravenous drug user from exposure to HIV and Hepatitis.

STRATEGIES FOR PUBLIC EDUCATION

To disseminate all of this important information, every possible medium and communication vector should be harnessed. Short videos or audio recordings can be created by public agencies and nonprofit organizations, then carried by television, radio and online media. A series of town hall meetings held in multiple locations throughout Jefferson County and surrounding communities will provide area residents an opportunity to learn about heroin and opioid addiction from live speakers and to interact with subject matter experts.

PREVENTING ABUSE OF PRESCRIPTION OPIOIDS AT HOME

Since 4 out of 5 heroin users report beginning opioid use with prescription painkillers, we must improve our community's efforts to remove unused prescription drugs from the home, thereby reducing the risk these drugs might be misused. As the Prevention and Education panelists observed, school-aged children, from middle school through high school, are often home alone, especially after school from the hours of 3 p.m. to 7 p.m. Drugs left unsecured in a medicine cabinet or drawer put our children at risk.

Twice a year, on National Prescription Drug Take-Back Days, DEA offers the public a safe, convenient, and responsible means of disposing of prescription drugs by establishing collection sites where drugs can be dropped off for disposal. While the initiative nets literally tons of unused drugs each Take-Back Day, convenient and safe prescription drug disposal should be available year round. We recommend secure disposal boxes be established throughout Jefferson County, perhaps in area pharmacies, with regular and appropriate destruction of discarded pharmaceuticals.

RECOMMENDATIONS FOR LAW ENFORCEMENT AND CRIMINAL JUSTICE

There is much effective and focused work under way in the law enforcement and criminal justice system. The response of Louisville Metro Corrections in implementing detox protocols and a multitude of treatment tracks has been exemplary. The drug treatment courts in Jefferson County District Court follow an evidence-based model proven to be effective. Nevertheless, there is room for change and improvement in some areas of law enforcement and criminal justice.

One possible improvement would be to intensify and expand collaborative efforts such as joint federal-local task forces that can bring federal financial and investigative resources to assist the skilled and experienced detectives of LMPD. Coordination between federal and state prosecution authorities (the U.S. Attorney's Office and the Office of the Commonwealth's Attorney) provides a broad range of powerful charging and sentencing options for heroin and opioid traffickers. The overdose prosecution initiative, a partnership between DEA, LMPD and the U.S. Attorney's Office, with funding provided by the federal OCDETF program, is one of a number of federal-local collaborations that promises to generate increased federal prosecutions and lengthy sentences for traffickers selling drugs that lead to overdoses and overdose deaths.

Jefferson County's Heroin Rocket Docket has been developed to steer traffickers to Circuit Court for prosecution and addicts toward treatment. The addicts are required to show proof of treatment, but there is no monitoring of these defendants' drug use. As Dr. Robert DuPont emphasized, the criminal justice system offers an unparalleled opportunity to effectively steer justice-involved addicts into treatment and recovery. The HOPE program in Hawaii achieved immensely successful results with frequent drug testing of probationers and with quick and certain sanctions for positive drug tests. We encourage the Heroin Rocket Docket to implement a

HOPE-modeled program where the addicts in the conditional discharge program are not merely directed to obtain treatment, but also frequently drug-tested with clear and certain sanctions. Program effectiveness could be evaluated by comparing drug use and recidivism outcomes between a randomly selected group in a monitored program to an unmonitored group.

We recommend that the LEAD program, the pre-arrest diversion pathway evaluated by the Jefferson County Crime Commission, be implemented. The program has met with great success in Seattle, reducing the negative impact of addiction through harm reduction efforts.

Police could also assist addicts in finding treatment were LMPD to institute a program similar to the Angel Program in Jeffersontown Police Department. Unfortunately, LMPD's willingness to engage in an Angel Program is only one part of the equation; success requires an immediate availability of treatment beds, and until Louisville's community treatment capacity is expanded, such a program may be unworkable.

Laboratory testing of controlled substances seized by law enforcement can be improved in multiple ways. Turnaround times from submission to report should be reduced; alternatively, a highly responsive system for getting fast reports for priority seizures should be created. Our testing laboratories must be equipped to identify particular opioid analogues and the latest designer synthetics. Comprehensive qualitative and quantitative analysis is needed to broaden the intelligence value of lab work. Such testing, along with analysis of adulterants can be a valuable tool in linking separate seizures that might otherwise appear unrelated.

RECOMMENDATIONS FOR COLLABORATIVE DATA COLLECTION AND DISSEMINATION INVOLVING PUBLIC HEALTH AND PUBLIC SAFETY DOMAINS

Many agencies, local and statewide, in both the public safety and public health domains, are working to improve the collection and sharing of data and intelligence related to the heroin and opioid epidemic. KIPRC, the Kentucky Office of Drug Control Policy, KASPER (Kentucky's Prescription Drug Monitoring System), the Kentucky State Police, Appalachia HIDTA, Louisville Metro EMS, Louisville Metro Public Health and Wellness, Louisville Poison Control, Louisville Metro Corrections and LMPD have all dedicated resources to collecting data and intelligence. Driving these efforts is a fundamental and compelling principle: an informed response to the heroin epidemic requires empirical data from both the public health sector and law enforcement domain.

Currently, with many agencies, the data that is collected is only available months after receipt. Even more concerning is the lack of consistent and reliable data. In fact, in obtaining local and state information to use for our Heroin and Opioid Response Summit, we found that the values of purportedly identical data sets varied widely from agency to agency, and we came to realize that some agencies unwittingly maintain, use and disseminate unreliable data concerning overdoses, overdose deaths and other information related to the opioid crisis.

Despite the laudable progress made by many of the agencies collecting data on the heroin and opioid problem, the Commonwealth still lags well behind other states with respect to the scope, responsivity and collaboration of data collection and sharing. Unlike states such as New Jersey, Kentucky has no comprehensive, centralized system where data sets from virtually every entity, agency and enterprise engaged with heroin and opioid issues are assembled, analyzed and correlated.

Kentucky should work toward building a data collection, analysis and sharing program similar to New Jersey's Drug Monitoring Initiative. We should begin to collect data from this nonexclusive list: local, state and federal law enforcement; first responders; healthcare providers including physicians and hospitals; KASPER (Kentucky's prescription drug monitoring system); addiction treatment providers; academic institutions; corrections agencies such as jails; probation offices; laboratories that test seized controlled substances and tissue samples for toxicological analysis; courts and public health departments.

Pertinent data that should be collected includes, at minimum:

- Information about fatal and nonfatal overdoses, including date, time and location of overdoses, demographic information about victims, toxicology lab results for fatal overdoses, laboratory results for seized substances, naloxone administration
- Information about heroin and opioid seizures by law enforcement, including qualitative and quantitative analysis of seized drugs, packaging, appearance, location of seizure
- Information about arrests involving heroin or opioids
- Information from healthcare providers concerning heroin or opioid use
- Information from treatment facilities concerning demographic information about clients, substances used by clients
- Information from needle exchange programs
- Urinalysis results from probation positives
- Prescribing information from KASPER
- Information from Poison Control Centers

Quite clearly, much of this information is highly sensitive or even protected by law, but the data collection can be structured to alleviate these concerns. For example, health information can be “de-identified,” which means that identifying personal information is scrubbed from the information fed into the central system. Similarly, law enforcement data would be de-sensitized from a law-enforcement-sensitive level to an official-use-only level, thus assuring that information will not compromise any active investigations.

Once collected, the centralized data must be analyzed, with information from separate data sets correlated to identify threats to public health or safety; drug use and distribution trends; and other patterns. The raw data is available to and shared with participating agencies on a nearly real-time basis; findings and reports are regularly disseminated; and specific analysis and reports may be requested by any participant. The system should have the capacity to make data available days – not months – after receipt.

There are many complex components to the logistics of data collection, storage, management and analysis for a comprehensive, centralized system such as this. It will take time to create such a system. Mostly, however, it will require wide-ranging partnerships and collaboration across many disciplines. We must recognize that shared information is critical to an effective response to this crisis and that the benefits to ourselves and our community will far exceed our investment. If we work together across disciplines, professions and broad domains, there is absolutely no reason we cannot create a comprehensive data sharing initiative.

* * *

“Only two things can defeat us in our battle against this epidemic: a lack of commitment and a failure to collaborate. A serious and sustained commitment to resolve this crisis will bring us the resources we need, and our collaboration will broaden our impact immeasurably. Together, we can build a healthier community and bring this destructive chapter to an end.”

United States Attorney John E. Kuhn, Jr.

SOURCES and RESOURCES

Local and Statewide Data Sources for this Report:

Louisville Metro Department of Corrections
Louisville Metro Emergency Services
Louisville Metro Police Department
Kentucky Medical Examiner's Office
Kentucky Administrative Office of Courts

Federal Data Sources for this Report:

Center for Disease Control (CDC)
Drug Enforcement Agency (DEA)
U.S. Surgeon General's Report, *Facing Addiction*, 2016

For more information, visit these websites:

Centers for Disease Control (CDC): www.cdc.gov/drugoverdose/opioids
Community Anti-Drug Coalitions of America (CADCA): www.cadca.org
DEA Outreach: www.dea.gov/prevention/360-strategy/360-strategy
Department of Justice Drug Courts: www.nij.gov/topics/courts/drug-courts
Kentucky Injury Prevention Research Council: www.mc.uky.edu/kiprc
Kentucky Office of Drug Control Policy: <http://odcp.ky.gov>
National Institute on Drug Abuse: www.drugabuse.gov
Partnership for Drug-Free Kids: <http://drugfree.org>
Surgeon General's Report: <https://addiction.surgeongeneral.gov>

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