The early signs of the opioid epidemic hit community health centers and medical provider’s in the late 1990’s and early 2000’s. It began with patients with unspecified pains that could only be quelled with powerful pain pills; patients with unrealistic demands for opioid prescriptions beleaguered providers. By the time the Kentucky General Assembly passed HB 1 in 2012, regulating the prescription of controlled substances and requiring the use of KASPER, opioid addiction had ingrained itself across our state and country. Many unable to get opioid prescriptions had moved on to heroin, and the pace of the epidemic was not slowing in any measurable way. People from all walks-of-life were addicted and dying.

The Family Health Centers, Inc. (FHC), a community health center with eight locations in Louisville-Jefferson County, saw the growing need for substance use services. “When we first began exploring the idea of expanding substance use services to all our clinical locations, there were a lot of emotions that came forth among our staff,” stated Bill Wagner, CEO of FHC. “This epidemic had affected their families and friends. This wasn’t just a public health crisis, for many this was personal.” FHC’s Phoenix Health Care for the Homeless center located on Muhammad Ali Boulevard already had a Certified Alcohol and Drug Counselor for their patient population, but the growing need in the community demanded a larger response. In 2016, Family Health Centers won a competitive grant award through the Health Resources and Services Administration (HRSA) to provide direct substance use services to individuals with opioid or alcohol addiction. “We had experience providing substance use services to our homeless patients, but the need for more services had become overwhelming,” said Wagner. “Our approach to addiction services needed to fit our primary care model. It needed to be integrated with our medical services and go beyond behavioral health and support services.”
Family Health Center’s substance use program combines medication assisted treatment with substance use workers to provide assessments, motivational interviewing, case management, and ongoing support to patients engaged in recovery. FHC prescribes Naltrexone to patients who have already been through detox and are currently in recovery. Naltrexone, commercially known as Vivitrol, is a monthly shot or daily pill that blocks the effects of opioids and alcohol and is used to prevent relapse. “When evaluating the kind of substance use program that would work for our primary care setting, two reasons we chose to offer Vivitrol is that it is non-addiction forming and it can be administered once a month,” stated Dr. Jim Jackson, Chief Medical Officer at FHC. “People weren’t going to come to us to abuse this medicine and there is no street value to it. Furthermore, we think it is much more realistic for our patients, who may struggle with transportation or other issues, to come to an appointment once a month rather than weekly or daily.”

FHC accepts internal and external referrals for patients. Patients establish care with medical providers, who prescribe and monitor the Vivitrol, and LCSW substance use workers who provide counseling, motivational interviewing and linkages to additional services as needed. “There are many people who are coming from rehabilitation programs, detox centers, or the justice system who may be motivated to stay clean, but need extra help,” says Robin Goodman, LCSW, head of the Substance Use Program at the Family Health Centers. “Vivitrol helps people maintain their sobriety and gives them that extra time and clarity they need to reorganize and rethink their lives. The medication assistance is the easy part of the program. The hard part for people is working on the things about themselves that may have contributed to their addictions in the first place, or puts them at risk for relapse. That is why our program includes both the medication and the behavioral health support.” In addition, FHC assists eligible patients with signing up for health insurance and provides its services on a sliding-fee-scale. Grant funds can assist with the cost of Vivitrol for patients who are in the process of applying for or having their insurance reinstated.

FHC’s substance use program first involved educating the medical providers about Vivitrol and how the pro-
gram would operate. “This was an obstacle for many of our medical providers to overcome. Treating patients with addiction was new for many of us and there was a lot of trepidation initially,” stated Dr. Jackson. “At first providers came on board slowly, but I think as they began to see the benefits of medication assisted treatment and saw the need in their own patients, then we were able to bring more providers on board willing to prescribe Vivitrol.”

Working with patients with substance use disorders can be slow and frustrating work. Many relapse, many are never seen again, but there are those who emerge from their addictions and their transformations are revitalizing. “I care for a woman, who when I first saw her was straight out of jail, and was doing her court mandated Vivtrol follow-up. She was living in a women’s shelter, and appeared disheveled, almost lost,” stated Paula Minervino, APRN with FHC. “When I saw her again a few months later, she was a different person. When I walked into her room she was sitting upright, her hair was fixed, she was put together, and most of all she was smiling. As I talked with her, she told me she had gotten a job, had her own apartment and had gotten custody of her daughter back. She was excited to be drug free and getting her life back together. The experience has shown me that when you treat someone for their substance use disorder, helping someone not only treats the addiction, but also gives them back their life, their families, and a sense of self-worth.” Dr. Larry Fineman, Internal Medicine physician at FHC added, “If you had hypertension, I would lower your blood pressure. If you had diabetes, I would control your sugar. If you had an addiction, I would give you the opportunity for a better tomorrow. For these diseases, we have Lisinopril, insulin, Vivitrol and additional therapies for other diseases that present themselves. At Family Health Centers, we are fortunate to have those medications and colleagues who can help support and monitor these treatments.”

Today, Family Health Centers provides substance use services at all eight FHC locations. In 2018 Debi Bennett, LCSW was brought on as the Community Liaison for Substance Use Services to help educate community providers and ease patient’s transition into the FHC substance use program. “People are often looking for additional support in their recovery, but may not know how to navigate our health care system to find the ongoing services that fits their needs,” says Ms. Bennett. “My role is to let people know that Family Health Centers is an option in their treatment and how to access us.” Individuals interested in learning more about the Family Health Centers substance use program can contact 502-772-8118.

**Family Health Centers, Inc. (FHC)** is a not-for-profit community health center who provides access to high quality primary and preventive health care services regardless of the ability to pay. Caring for Louisville since 1976, Family Health Centers serves more than 43,000 individuals annually. Our services include adult primary care, pediatrics, women’s health, dental, behavioral health, substance use treatment, laboratory, radiology, pharmacy, health education, and programs and services for refugees and the homeless. Learn more at [www.fhclouisville.org](http://www.fhclouisville.org).
Addressing Opioid Dependency in Kentucky: A Health and Social Justice Scholars Community Project

by: Diane Zero, third-year PhD student, UofL School of Public Health & Information Sciences

The Centers for Disease Control and Prevention (2018) reported for 2016, the overdose epidemic expanded geographically across the United States, with overdose deaths increasing in all races and ethnicities examined for men and women 15 years of age and older. The National Safety Council (2019) found the probability of dying from an overdose (1:96) is now higher than the probability of dying in a motor vehicle accident (1:103).

In the U.S., Kentucky is among the states most effected by the opioid epidemic. Between 1999 and 2016, the state’s rate of overdose-related deaths increased from 4.9 per 100,000 people to 33.5 per 100,000 (National Center for Health Statistics, 2018). The community of Louisville recognizes the severity of the opioid epidemic, along with need for the city to take effective action. In the city’s 2018 Community Needs Assessment, 64% of resident respondents identified substance abuse as the biggest problem facing the community, and 62% saw substance abuse as the community’s number one issue to focus on (Louisville Metro Department of Health and Wellness, 2018).

To address this epidemic, quality treatment options for individuals with substance use disorders must be accessible, affordable, and easily identifiable by those in need of care. The Louisville Metro Department of Health and Wellness (LMHW) and the University of Louisville Department of Health Promotion and Behavioral Sciences have been working in partnership to address this need since last June.

As part of this work, Health and Social Justice Scholar Diane Zero and Sam Rose, LMHW Community Health Coordinator are developing a community guide to quality evidence-based services and programs for substance use disorder treatment, for use by individuals with substance use disorders and their families. In the development phase, design of the guide will be informed by in-depth interviews and focus groups with stakeholders in the community. Once complete, there are plans to distribute the guide in the community through an awareness and marketing campaign. Look for more information on this exciting project in the coming months.
It’s Time for a “Truth” Campaign for Marijuana: A Call to Action
by: Camille A. Robinson, MD, MPH
Postdoctoral Clinical Research Fellow in Adolescent Medicine, Johns Hopkins University

Walking into the school-based health center at the urban high school I have consulted at for the past 3 years, I am reminded from the smell in the hallways that... marijuana is a part of my patient’s lives in some shape or form. Fast forward to adolescent clinic that afternoon... it seems that a majority of my patients are using marijuana multiple times per day. They are quickly able to list off reasons for using marijuana, including, “it helps me sleep”, “it helps me cope with stress”, “it’s natural/from the earth”, “it’s not addictive”, “it’s not bad for you”, “it makes me feel good/better”, and the list goes on. Some have reported being arrested for possession and/or distribution of marijuana, but that has not yet deterred them from continued use. Some say that their parents, family members, and friends all use it. Most report extremely complex social lives related to living in economically depressed and oppressed neighborhoods, thus complicating my intervention efforts. Why does this matter in the era of increasing legalization? Two major reasons: 1) youth perception of the harmful effects of marijuana is decreasing and 2) marijuana use has harmful effects on adolescents and the developing adolescent brain. Furthermore, the negative impact of marijuana use may disproportionately affect low-income, urban youth of color as these youth may face other vulnerabilities that cumulatively alter their trajectory as they transition into adulthood.

First, while the annual national U.S. prevalence of adolescent marijuana use has declined since peak use in the late 1990s, perceived risk has continued on a steep decline since the mid-2000s in the Monitoring the Future study. This decreased perceived risk is troubling as the potency of available marijuana in today’s market has significantly increased with a ratio of tetrahydrocannabinol ([THC], the psychoactive ingredient in marijuana) to cannabidiol from 14 times in 1995 to 80 times in 2014. An increase in vaping marijuana has also been reported since the introduction in 2017 of a vaping marijuana question in the Monitoring the Future study. Furthermore, more than a quarter of students in 8-12th grades that have used marijuana in the past year reported vaping marijuana. These are concerning trends in adolescent marijuana use that we must address to ensure a healthy adolescent and young adult population.

Secondly, it is well established that adolescent brain development and maturation, particularly that of the prefrontal cortex, extends into the mid-20s. The developing adolescent brain is also more vulnerable to the effects of substance use and earlier substance use initiation is associated with substance use disorders in adulthood. Specifically, studies on adolescent marijuana use have shown associations with poorer cognitive functioning and mental health (including depression, anxiety, and psychosis). Furthermore, there has been a dose-response found between increasing marijuana use and lower
cognitive functioning. However, marijuana use may alter the developing brain in ways that are not yet fully understood which are different from normal development or whether any changes are reversible. Thus, additional neuroimaging and longitudinal studies are needed which is where the Adolescent Brain Cognitive Development (ABCD) study comes into play. The ABCD is the largest long-term study of brain development in the U.S. (the study will follow 9-10 year old children until young adulthood) and is studying the effects of substance use on brain development as well. The first round of data was just released in 2018 and we look forward to its findings.

Concerningly, our adolescents are flooded with pro-marijuana messages, ranging from city billboard ads advertising medical marijuana to social media posts. This has become especially prevalent in the era of legalization of both medical and recreational marijuana for adults and a topic that has even made it into the 2020 U.S. presidential debates. A study of 7,000 randomly sampled tweets revealed that pro-marijuana tweets outnumbered anti-marijuana tweets by more than 15 times and pro-marijuana tweeters were found to be younger (<20 years old) and a greater proportion was African American compared to the average Twitter population. Similar data was found on Instagram. In fact, browse the Instagram account of Snoop Dogg, a rap artist/celebrity who has 33.9 million followers with over 41 thousand posts (as of July 2019), and you will find daily videos or photos of him smoking or promoting marijuana. You can also easily find YouTube videos on how to vape marijuana or dab (highly concentrated THC oil in a process that uses butane to extract the THC).

In contrast, a broad-based and national public health campaign is missing for marijuana use prevention. However, we can learn from the experiences in tobacco prevention. Since 2000, the Truth Initiative has launched a campaign to raise awareness of the harmful effects of tobacco and is specifically geared towards youth. The campaign has been associated with a decreased risk of smoking initiation and an increase in anti-smoking attitudes for adolescents between the ages of 12 and 17. Similar findings have been shown in the young adult population even though the campaign is geared towards those under 18 years of age. The “Truth” Campaign was relaunched in 2014 taking into account the increase in popularity of social media and vaping/e-cigarettes with the message of ending youth tobacco use. Once again this campaign is showing effectiveness at changing tobacco-related attitudes, intentions, and behaviors among adolescents and young adults. In response to the opioid epidemic, the “Truth” website has even added opioids to informational messages despite the campaign’s original aim of tobacco prevention. However, marijuana is missing from these discussions, despite marijuana now being more prevalent than cigarette smoking among adolescents. The closest informational website for teens is the NIDA for Teens website (https://teens.drugabuse.gov/drug-facts/marijuana) which unfortunately does not have a large social media presence. Additionally, the American Academy of Pediatrics
(AAP) has published resources that focus on how providers can discuss marijuana with youth, parents, and policy makers.11-13

While the national discourse debates whether to legalize marijuana for adults, one message we must make clear is that marijuana use is not safe for adolescents and their developing brain. Finally, we as providers, public health practitioners, and community members cannot ignore the powerful messages our adolescents receive on a regular basis and we are uniquely positioned to prevent and intervene on adolescent marijuana use using novel methods, especially social media campaigns. However, we must be aware that changing perceptions of the harmful effects of marijuana for adolescents will not be solely enough for those adolescents using marijuana to cope with the daily stress of living in economically depressed and oppressed neighborhoods. For these adolescents, we will need to supplement our messages with political advocacy for investment in mental health treatment and communities.

References
NAMI Louisville is the local affiliate of the National Alliance on Mental Illness. We work with over 5,000 local individuals and family members who suffer with serious mental illness, many who have family members with a dual diagnosis of mental illness and addiction or substance use disorder. We have seen firsthand the devastation that the combination of these illnesses can have on both the individual and their entire family.

Historically there has been a tendency for substance use disorder to be viewed separately from mental health issues such as trauma. In truth, however, they are so extensively overlapped that it is often impossible to tell them apart as individual or separate problems. Healthcare providers are now becoming aware of this intersecting relationship between mental health, substance use, violence, injury, and trauma, and finding that it makes better sense to consider them together than apart.

Statistically 1 in 5 individuals will seek care each year for mental health related treatment. People with mental illnesses are known to be twice as likely to have a substance use problem than those who do not exhibit mental health conditions. Furthermore, people with a substance use problem are three times more likely to also be experiencing a co-occurring mental illness. They are innately intertwined, with one making it much more likely that you will be experiencing the other. Therefore, we must seek treatments that see the duality of these illnesses.

Some mental health conditions are all too commonly associated with a particular addiction. For example, twenty-one percent of individuals experiencing alcoholism also have a co-occurring anti-social personality disorder. Continued use of cocaine can lead to anxiety disorders, paranoia, and insomnia. Many individuals who suffer from PTSD are prescribed an opiate to deal with the consequences of the trauma, such as pain or sleep issues. A consequential addiction then develops, and the long-term use of heroin can result in the inability to experience happiness with the drug leading to depression in users.

When a user begins abusing a substance it is often to alleviate the negative affect of a symptom associated with a mental illness, known as self-medication. Over time they may develop a substance use problem as they continue to use the drug for its perceived benefit. In addition, the use of certain drugs may exacerbate the expression of mental illness when used over extended periods of time. Alcohol use is known to cause symptoms of anxiety and depression, and cannabis use is associated with the increase in symptoms for those who suffer from schizophrenia.

No matter the age or sex of the family member, when a dual-diagnosis exists within a family the entire family suffers. The family, in our current society, remains the primary source of attachment, nurturing, and socialization for humans. Each family and each family member are uniquely affected by the individual using substances including but not limited to having unmet developmental needs, impaired attachment, economic hardship, legal problems, emotional distress, and sometimes violence being perpetrated against him or her. For children there is also an increased risk of developing a substance use disorder themselves.

Thus, treating only the individu-
al with the active disease of addiction is limited in effectiveness. Social work education and training emphasizes the significant impact the environment has on the individual and vice versa. The utilization of evidence-based family approaches has demonstrated superiority over individual or group-based treatments. Treating the individual without family involvement may limit the effectiveness of treatment for two main reasons: it ignores the devastating impact of substance use disorders on the family system leaving family members untreated, and it does not recognize the family as a potential system of support for change.

The impact will vary depending on the role and gender that the individual with the substance use disorder has in the family. For example, if an adolescent child is identified as having a substance use disorder, this will affect the family differently than if a parent has the addiction. While men act more quickly in seeking treatment, women are more likely to misuse substances and more rapidly progress from initial use to developing an addiction.

Other factors that need to be weighed into the treatment include a family’s attitudes and beliefs, education, the age of the family members, and perhaps most importantly understanding that as individuals within the family work to heal, or when and if the dynamic of the group shifts, the entire group is affected by these changes.

Abuse and neglect can leave children in need of support and left with their own traumas to deal with as children of a parent with a substance use disorder. Parents of adult children often find themselves enabling their adult child by bailing them out of jail, allowing them a free place to live or taking care of their neglected children.

Every single person in an addict’s immediate family (and at times extended family) is affected in some way by the individual’s substance abuse. Addiction impacts a family’s finances, physical health and psychological wellbeing. If young children are a part of the family, their ages must also be factored into the effect of substance abuse. The same can be said for older adults who have adult children. The severity of addiction and the type of substance dependence also factor into the overall impact of addiction on a family.

As a family navigates around the individual with a substance use disorder, they will attempt to find balance and their roles may shift to accommodate the unstable environment. Several roles have been identified and found within the family structure as it attempts to balance, the enabler, the hero, the scapegoat, the mascot, the lost child and the addict. When these roles are established during childhood, they become behavioral patterns that continue to play out and evolve throughout adulthood.

While continuing to navigate the complexities of a dual diagnosis it is important to factor in any relationships that can be found. It appears that individuals who grow up in a home with substance abusing parents are more likely to experience some sort of domestic, or sexual abuse leading to trauma, which will then make these same individuals more likely to abuse drugs or alcohol themselves, continuing the cycle.

Breaking this cycle is the goal of NAMI’s educational classes. By bringing the entire family into the healing of their family member they become part of the healing process. As family members learn about local resources and use effective communication tools, they are better able to support their family members needs as they attempt to not only recover from their mental illness but to overcome their addiction. We tell our families that they need to remember to take care of themselves during these trying times but to never lose hope that their family member will recover as fully as possible and come to lead a productive life. If you or anyone you know is in need of family support for mental health conditions or substance use disorder please have them go to the NAMI Louisville website at www.namilouisville.org or call our local office for resources at 502-588-2008. Participation in one of our family educational classes or support groups is often a lifesaving turning point for healing a family torn apart by the duel diagnosis of mental illness and substance use disorder.

References:
Kentucky Opioid Use - Where are we nationally? How did we get here?
How are we doing now?
by: Karen W. Krieger, MD, MEd, FAAFM, AAHIVM(S), Health Sciences Center Office of Diversity and Inclusion Director of Health Equity, Professor of Family and Geriatric Medicine

Kentucky, historically, has the worse health or near worst health outcomes in a variety of health indicators in the US. The NIH National Institute on Drug Abuse released 2017 data in May of 2019 for Opioid-involved overdose deaths per 100,000 persons and Opioid Prescriptions per 100 persons in the United States. (https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state). Kentucky was #8 in numbers of opioid-involved overdose deaths at 27.9 per 100,000 persons in 2017 and #7 in the US for opioid prescriptions at 86.8 per 100 persons in 2017. Compare this to Hawaii with the best performance at 3.4 opioid-involved overdose deaths per 100,000 persons and 37.4 opioid prescriptions per 100 persons during the same time period.

Nationally, 70,237 drug overdose deaths occurred in 2017. Opioids, mainly synthetic opioids (other than methadone), are currently the main driver of drug overdose deaths. Synthetic opioids are a class of drugs that are designed to provide pain relief, mimicking naturally occurring opioids such as codeine and morphine. Opioids were involved in 47,600 overdose deaths in 2017 (67.8% of all drug overdose deaths). In 2017, the states with the highest rates of death due to drug overdose were West Virginia (57.8 per 100,000), Ohio (46.3 per 100,000), Pennsylvania (44.3 per 100,000), the District of Columbia (44.0 per 100,000), and Kentucky (37.2 per 100,000). States with statistically significant increases in drug overdose death rates from 2016 to 2017 included Alabama, Arizona, California, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Michigan, New Jersey, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, West Virginia, and Wisconsin.” https://www.cdc.gov/drugoverdose/data/statedeaths.html

The following charts document levels of pain killer prescriptions in the US in 2012
Opioids are prescribed for moderate to severe pain from surgery, injury, or certain health conditions like cancer. Their use includes risks such as misuse, addiction, overdose, and death. Individuals with previous substance abuse disorders, mental illness, and familial substance abuse histories can be predisposed to the above risks. From 2006-2012 the distribution and manufacture of synthetic opioids from US companies flooded the US markets with approximately 76 billion opioid pills. Currently, many of these companies are involved in court proceedings, or have lost court proceedings, with judgements in excess of $500 million. As states proceed with cases against pharmaceutical companies this amount is expected to exponentially increase. Monday, August 26, 2019 the Boston Globe Media News website STAT announced it had won a 3.5 year legal battle as the Ky. Supreme Court mandated the release of Purdue Pharmaceutical OxyContin files. The public will now be able to review new information about how Purdue Pharma aggressively promoted OxyContin in Kentucky and what the executives knew about addiction risks. This past March, the Sadler family, owners of Purdue Pharma, and the company agreed to pay $270 million to settle a lawsuit brought by the state of Oklahoma. [https://www.statnews.com/2019/08/26/kentucky-supreme-court-allows-release-of-purdue-oxycontin-records/](https://www.statnews.com/2019/08/26/kentucky-supreme-court-allows-release-of-purdue-oxycontin-records/)

In 2010 the Prescription Drug Overdose: Boost for State Prevention (Prevention Boost) program originated out of the CDC’s (Center for Disease Control) Injury Center.
The program equipped five state health departments (Kentucky, Oklahoma, Tennessee, Utah, and West Virginia) with resources and scientific assistance to prevent prescription drug overdoses. Funding was provided to advance three key areas:

1. Maximizing the use of PDMPs (Prescription Drug Monitoring Programs)
2. Improving public insurance mechanisms to protect patients
3. Evaluating policies to identify preventions that works

In 2011 and 2012 respectively, Ohio and Kentucky mandated clinicians to review prescription drug monitoring program (PDMP) data and implemented pain clinic regulation. In these states, Morphine Milligram Equivalents (MME) per capita decreased. This decrease was 62% in Kentucky counties from 2010 to 2015. Kentucky’s program is called KASPER—the Kentucky All Schedule Prescription Electronic Reporting system for monitoring controlled substance use. It was designed to assist medical providers and pharmacists in providing medical care with controlled substances. It is also an investigative tool for law enforcement and regulatory agencies to assist with authorized reviews and investigations. Medical providers and pharmacists can review opioid prescriptions in morphine milligram equivalents to help assess patient safety.

Accounting for physician responsibility in curtailing the opioid epidemic in Kentucky, the Kentucky Board of Medical Licensure maintains a website of resources for prescribing and substance abuse screening and treatment resources: [https://kbml.ky.gov/prescribing-substance-abuse/Pages/default.aspx](https://kbml.ky.gov/prescribing-substance-abuse/Pages/default.aspx). The site provides links to medical providers concerning:

2. Professional standards for prescribing and dispensing controlled substances [https://kbml.ky.gov/hb1/Documents/Summary%20of%20KAR%209%20201%20Kar%20201%20KAR%209%20260.pdf](https://kbml.ky.gov/hb1/Documents/Summary%20of%20KAR%209%20201%20Kar%20201%20KAR%209%20260.pdf)
Recommendations for medical provider prescribing guidelines include obtaining family history genotypes of substance abuse disorders, formal psychosocial assessments, and the use of tools and contracts for evaluating addictive risk to patients and subsequent patient risk monitoring. These mechanisms and such programs as KASPER have led to a recent announcement of a decline in drug overdose deaths in the state of Kentucky. The Kentucky Office of Drug Control Policy in its annual report released August 1, 2019, reported a decrease in Kentucky overdose fatalities of 15% in 2018. This is the first decrease in Kentucky in overdose fatalities since 2013. The 2018 number was 233 deaths less than the record high total of 1,565 deaths in 2017. Kentucky was one of 37 states demonstrating a decrease of overdose fatalities. Nationwide, the probationary death rate decreased by 5.1% for the first time in decades.

**Overdose deaths in Kentucky**

Links to Kentucky Treatment Resources are listed on the Kentucky Board of Medical Licensure’s website, as well as, governances and state laws. Treatment resources include; *Find Substance Abuse and Mental Health Treatment Your Road to Recovery*, SAMHSA (Substance Abuse and Mental Health Services Administration - US government site, *Find Treatment Database*, The AGAPE Center Listing of Kentucky Treatment Centers, Kentucky Drug Rehab 101 Listing, Kentucky Substance Abuse Treatment Service Provider Directory, and the Kentucky Opioid Treatment Programs.

Current preventive and treatment activities in Kentucky this year include the University of Kentucky’s $87 million federal grant to reduce opioid deaths. The grant awarded over 4 years aims to reduce opioid deaths in 16
Kentucky counties by 40% in 3 years. Kentucky, ranking 5th in US opioid deaths, secured the federal monies with plans to concentrate efforts in the highly affected counties of Fayette, Jessamine, Clark, Kenton, Campbell, Mason, Greenup, Carter, Boyd, Knox, Jefferson, Franklin, Boyle, Madison, Bourbon and Floyd. These counties had 764 deaths in 2017, with all but 1/3 involving Fentanyl, a synthetic opioid. The total populations of these 16 counties represent more than 40% of Kentucky’s population.

Locally, in May, 2019, Louisville Metro joined Camden County, NJ; Chesterfield County, VA; Clackamas County, OR; Cook County, IL; Cumberland County, MW, Durham County, NC; Eaton County, MI, Hudson County, NJ, Ingham County, MI, and Lewis and Clark County MT in expanding medication assisted treatment for opioid use disorder in jails by providing guidance on how to overcome barriers in providing opioid treatment. This national program will include staff training, creation of treatment guidelines, managing administration of medications, and educating jail staff about addiction.

In another new Louisville area initiative, Renew Recovery has collaborated with Anthem Blue Cross Shield in Kentucky and St. Matthews Community Pharmacy to offer an in-home drug treatment program. This pilot program will allow participants to receive treatment in their homes for 1-2 months then transition to an outpatient model lasting up to 2 years. The recovery team approach includes a psychiatrist, recovery coach, and medication-assisted treatment. This novel approach will involve a telehealth component and virtual reality technology to incorporate educational and motivational content. The program will be a covered benefit for eligible Anthem members, but copayments and deductibles may apply. And finally, let us not forget the long standing Louisville Area of Narcotics Anonymous peer support meetings. There are meetings places, dates, and times for those fighting addiction and those living with individuals experiencing addiction. Louisville Area of Narcotics Anonymous also supports a 24/7 help line. Visit their website at https://www.nalouisville.net/.

Good luck to all Kentuckians and their families struggling with this epidemic and the medical providers entrusted with their care.

References
In March of 2018, Louisville Metro Public Health and Wellness released “Coming Together for Hope, Healing, and Recovery,” the city’s ten-point plan to address substance misuse. The plan’s goals focus on addressing the social determinants of health that influence health outcomes around prevention, harm reduction, access to treatment, and recovery support. Primary among these root causes are education, social capital, housing, employment, criminal justice involvement, and access to health services. At least one community partner volunteered to be a champion for each goal and committed to work together with the Health Department to achieve their goal.

Successes of the plan so far have included the formation of a county-wide coalition around youth prevention and promotion, the addition of two mobile syringe exchange sites, the distribution of over 2000 units of Narcan to syringe exchange participants, the full implementation of a peer support program in the U of L hospital, and the passage of state legislation increasing the availability of expungements for drug-related charges. Efforts around creating quality metrics, regulating the operation of recovery residences and increasing job placement for people in recovery are also making headway.

Building on the successes of the first year of implementing the substance use disorder plan and the expansion of the Center for Health Equity, the Office of Addiction Services has begun to revise the plan to more explicitly address health disparities and include key performance indicators that reflect this equity focus. For example, our Syringe Exchange Program has identified a dramatic racial disparity in the utilization of their services by race, despite relatively similar rates of intravenous drug use across races. As a result, our new goal around syringe services aims to not only increase general access to services, but to explicitly aim to improve services to communities of color that have historically been disenfranchised by both the medical establishment and local government (particularly law enforcement). The team recognizes that the lack of trust resulting from the past mistreatment of these communities requires us to adapt our approach and partner with additional community partners to ensure that our services are available not only equally, but equitably.

Other areas of the revised plan that were not included in the original plan include an increased commitment to suicide reduction among people who inject drugs, greater linkage to services for mental and physical health for people with substance use disorders, and more opportunities for diversion from the criminal justice system. The department will continue to monitor the needs of the community through ongoing changes in the usage rates of substances, the resources available to serve these needs, and the political capital and community engagement necessary to carry out these initiatives. Check out our website for more details!
The Effects of Addiction on Families
by: Karen W. Krigger, MD, MEd, FAAFM, AAHIVM(S), Health Sciences Center Office of Diversity and Inclusion Director of Health Equity, Professor of Family and Geriatric Medicine

According to the National Institute on Drug Abuse’s 2017 statistics the abuse of tobacco, alcohol, and illicit drugs costs the US more than $740 billion annually in costs related to crime, lost work productivity, and health care. Data for this amount was gathered from drug usage, emergency room data, prevention and treatment programs as well as, other research findings (https://www.drugabuse.gov/related-topics/trends-statistics).

While the monetary effects are staggering, the impact of the alcohol and drug addiction are equally as devastating on family dynamics affecting all members in the home environment and the extended family structure, such as grandparents. The family member with the disease of addiction is often unpredictable and compulsive creating an atmosphere of negativity, anxiety, emotional pain, stress, and mistrust through physical, emotional, and mental abuse. Arguments, confusion, and conflict become the normal state within the household. Communication becomes more difficult as family members become guarded. The affected individual is unfocused, forgetful, or distracted as their energies and resources are geared toward their addiction.

As many as 1 in 5 children may live in homes with addictions. These children are 3 times more likely to be neglected, and/or physically or sexually abused. These family experiences can create delays in learning and development and lead to lifelong mental and emotional disorders. There is a higher incidence in dangerous substance use in these children as they develop a false belief that “everyone” takes drugs or drinks.

Children living in an environment in which methamphetamine is used and/or made are at an increased risk of injury or death due to exposure to the highly flammable, corrosive materials used in the manufacture of the drug. Their exposure may create chronic symptoms of cough, skin rashes, red or itchy eyes, agitation, inconsolable crying, irritability, and vomiting. Children can also accidentally ingest the harmful substances in their environments. These children are also exposed to illegal activities. Aging parents of adult children with substance abuse disorders may maintain inappropriate dependent relationships with their children missing the opportunities for their children to mature into stable, self-sufficient adults.

Family dynamics in addiction scenarios create familial roles such as the enabler who is often the non-addicted spouse or older child taking care of the things the addicted individual leaves undone such as paying the bills or getting the children to school; the hero who overachieves and often takes on responsibilities exceeding their developmental stage; the scapegoat, the child who habitually misbehaves in home and school which may lead to trouble with the law in adulthood; the mascot who uses humor or comedy to defuse tense situations; the lost child who is isolated from other members of the
family and has trouble developing relationships as a result; and the **addict**, who may or may not feel shame and remorse concerning their actions.

Children of drug abusing or alcoholic parents may present to their primary care medical providers with vague symptoms of abdominal pain, fatigue, and generalized pain appearing as psychosomatic illness. Their histories and presentations may include accidental injury, different types of abuse with manifestations of poor communication, under-socialization, and neglect. It is important for practitioners to recognize the signs and symptoms and to be advocates for the child, family and community. The National Association for Children of Addiction ([https://nacoa.org/professionals/primary-care-providers/](https://nacoa.org/professionals/primary-care-providers/)) provides on-line tools for health care professionals to accomplish these tasks.

**References:**


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**Announcements**

- **2019 Research!Louisville**
  - **When:** September 10-13, 2019
  - **Where:** Kosair Charities Clinical Translational Research Building
  - [Click here for a schedule of events.](#)

- **Muhammad Ali Humanitarian Award Winners Panel**
  - The Muhammad Ali Institute for Peace and Justice at the University of Louisville is excited to partner with the Muhammad Ali Center to bring three of their Muhammad Ali Award Winners to campus. This panel discussion, led by our Muhammad Ali Scholars, will explore the work of each of these humanitarians as well as what fuels their passion. Please join us as University of Louisville students get a first look into the award winners before the Muhammad Ali Center’s event on September 12th.
  - **When:** September 11, 2019, 12:00-1:30pm
  - **Where:** Brandeis School of Law, Room 275
  - *For information on future events hosted by the Muhammad Ali Institute for Peace and Justice please [click here.](#)*

- **Redlining Louisville: The Racist Origins of Real Estate, Planning and Wealth**
  - Joshua Poe, M.A., a nationally recognized city planner, data journalist, community organizer and movement geographer will explore the legacy of structural discrimination through federal housing policies and the far-reaching impact they have had on social determinants of health and economics.
  - **When:** September 12, 2019, 12:00-1:00pm
  - **Where:** Kosair Charities Clinical Translational Research Building, 101/102
  - *Lunch will be provided for the first 100 attendees.*
HEALTH SCIENCES CAMPUS
OFFICE OF DIVERSITY & INCLUSION

HUB@HSC OPEN HOUSE

A celebration of Community, Inclusion & Belonging

FRIDAY SEPTEMBER 13, 2019 | NOON-1:00
HSC INSTRUCTIONAL BLDG ROOM 120
500 SOUTH PRESTON STREET, 40202

Greetings from President Neeli Bendapudi

Light Refreshments

Ice Cream from Louisville Cream

Questions?
Email: hscodi@louisville.edu
Welcome to the 2019-20 LGBT Health Certificate Series! Go to our website for links to the videos and quizzes to earn credit. Register here: http://bit.ly/LGBTHSC or scan the QR

To earn a Certificate: Attendance required at four sessions total over the 2019-20 academic year (ending March 30th) and one Patient Simulation session (fall or spring). Participants may attend sessions in person or they will be posted to youtube 2 weeks after presentation. FREE lunch with RSVP!

FALL SESSIONS
Spring Sessions Announced in December

Variations in Sex Development and Intersex Conditions: Shifting Paradigms
September 5, Thursday
11:30am Lunch, 12-1pm; Med School Room B102
Speaker: Suzanne Kingery, MD
This module will explore the most common etiologies resulting in variations of sex development and help develop and apply sensitive language for discussing variations of sex development with affected individuals, their families and practitioners.

Gender-Affirming Surgery: What Healthcare Providers Should Know
September 24, Tuesday
11:30am Lunch, 12-1pm; CTR123
Speaker: Jon Witten, MD
This module will demonstrate effective communication on gender-affirming surgical options, information on differences in anatomy and physiology before/after surgery (with photos) and discuss pre-post operative concerns.

Pride Keynote Session: Meeting the Health Needs of Bisexual Patients
October 23, Wednesday
11:30am Lunch, 12-1pm; Kornhauser Auditorium
Speaker: Robyn Ochs
This module explores what it means to be bisexual, and will help providers prepare to meet the needs of their bisexual patients, highlighting disparities faced by bisexual people, challenging negative messages and stigma that surround the bisexual community and suggesting best practices for care.

Fall Patient Simulation Session
Required for Certificate. Another offered in Spring.
November 19, Tuesday
5:30pm—8:00pm; CTR 101-102
Patient Simulations offer an interactive approach to learning in which LGBTQ community members role play patient encounters with participants and offer feedback.
LGBT HEALTH CERTIFICATE

Variations in Sex Development and Intersex Conditions: Shifting Paradigms
Speaker: Suzanne Kingery, MD (she/her/hers)
Thursday, September 5th
Lunch: 11:30 am Lecture: 12:00-1:00 pm
500 S Preston st. Medical Instructional B Building, Room 102

RSVP required to receive a lunch!

We are excited to announce the first certificate session of the 2019-2020 season.

This module will explore the most common etiologies resulting in variations of sex development and help develop and apply sensitive language for discussing variations of sex development with affected individuals, their families, and practitioners.

Join us! This will be a space to ask questions and learn.

Please register here: http://bit.ly/LGBTHSC or via the QR code

You will receive credit towards the LGBT Health Certificate!
Pride Keynote: Dominique Jackson
October 3 @ 7:00 pm - 9:00 pm

An Evening with Dominique Jackson, actress from the hit FX series, POSE. Presented by UofL LGBT Center & Student Activities Board (SAB); October 3, 7:00 PM, UofL Student Actives Center, Ballroom, FREE and open to the public with Eventbrite registration.