We paid a brief visit to eastern Kentucky, June 11–13, to listen and learn about the opioid epidemic there: its trajectory; evolving public health efforts to prevent and treat addiction; and actions to address the rising law enforcement challenges associated with illicit drug trafficking. The knowledge gained will inform future activities by the Center for Strategic and International Studies (CSIS), an independent Washington-based policy institute. Our expert hosts at Operation UNITE (Unlawful Narcotics Investigation, Treatment, and Education), especially its president and CEO Nancy Hale, assisted by the district office of Representative Harold Rogers (R-KY), headed by District Director Karen Kelly, were exceedingly generous and gracious guides, for which we are most grateful. We were also very fortunate to be joined on this trip by Dr. Julia Zur, senior policy analyst and an expert on the opioid epidemic based at the Kaiser Family Foundation in Washington, D.C. Her insights were highly valuable both during the trip and in shaping this brief report.

We returned from Kentucky with five powerful impressions.

First is the truly exceptional nature of the epidemic itself.

This epidemic, a sweeping, ferocious threat to Kentucky society, is unlike any other health emergency America has experienced. It is a deep and long crisis—not a short temporary emergency—that has been two decades in the making, against which Kentuckians have struggled for years. It has achieved daunting scope and scale. In 2015, Kentucky tied Ohio for the third-highest rate of death due to drug overdose in the United States with a rate of 29.9 overdose deaths per 100,000 people. In 2015, there were 21 (reported) opioid overdose deaths per 100,000 people in Kentucky. Opioid misuse, abuse,
We have a cultural and a chemical problem.

It is the first epidemic rooted in modern medicine: the overuse, misuse, and abuse of prescription opioids, propelled by clinical and industrial practices. Today we are witnessing a fast-evolving, highly fluid epidemic that has become a hybrid, in which heroin, methamphetamine, fentanyl, and other illicit substances (atop prescription drugs) increasingly fuel addiction, overdoses, and death. Each drug that emerges as a new driver of the epidemic changes the equation and requires multiple adjustments in approach.

This epidemic aggressively exploits and compounds preexisting weakness and vulnerabilities of society: deep poverty, apathy, and isolation; other forms of substance abuse and dependence; corruption; a stagnant or declining local economy; and weak institutions of governance. Its perniciousness rests also on stigma and shame.

Second is the considerable progress under way.

UNITE and its many partners have demonstrated the profound power and influence of local action. Multi-sectoral community and county initiatives have acquired enduring capacity, proven their resilience, become indispensable, and inspired others. The Louisville Courier-Journal and other Kentucky-based media have been highly impactful in spotlighting corruption and illicit drug markets, including diversion of prescription medications, and in pressing to overcome woefully insufficient access to treatment and prevention. Public knowledge has deepened, and there has reportedly been substantial reduction in stigma. State action has also proven invaluable: the much-improved Kentucky All-Schedule Prescription Electronic Reporting (KASPER) system to monitor prescriptions; the impressive emerging drug court system; major legislation to change prescribing practices and advance a public health approach; and changes in policing, including use of naloxone, an overdose reversal medication.

Third is the centrality of Medicaid expansion.

At the federal level, Medicaid expansion in Kentucky has been the single-most powerful tool to expand access to treatment, aided by the flow of additional resources and programs under the 21st Century Cures Act and Comprehensive Addiction and Recovery Act (CARA). Of the more than 400,000 Kentuckians who gained health insurance statewide under the Patient Protection and

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Affordable Care Act (ACA), over 82,000 live in the 5th Congressional District. The uninsured rate in Kentucky’s 5th Congressional District decreased from 17.4 percent in 2012 to 5.7 percent in 2015. This was the third-largest reduction in the rate of uninsured in the entire United States following Medicaid expansion.

Inversely, a significant reduction in access to Medicaid prevention and treatment services—with no viable alternative—will undermine progress to date and set in motion a dangerous regression.

Fourth are the multiple, conspicuous gaps.

The epidemic retains a fierce, devastating power. Kentucky is still far from bending the curve and truly controlling the epidemic. That elusive moment cannot be reached until glaring shortfalls—in medical training and practice, data, treatment facilities, prevention in schools (where there is no uniform curriculum on the epidemic), recovery programs, and local law enforcement—are systematically addressed.

Law enforcement is understaffed and underpaid, overwhelmed by the drug-related crime that dominates Kentucky’s local and state police caseloads. We were unable to meet with the Knox County Sheriff because, 20 minutes prior to our scheduled meeting, two of the six total officers patrolling the 400-square mile county were shot by a methamphetamine dealer. The police face acute cross-pressures: officers and judicial officers who shorten sentences for drug offenders are criticized by drug offenders’ neighbors for being too easy on crime. At the same time, officers who press for felony convictions are viewed as excessively harsh on the mentally ill. And far too often, treatment is simply not available. The wait can be months long, while both those entering treatment and those in recovery often lack transport.

There remains an acute shortage of transitional housing and professional post-rehabilitation support. Without halfway houses to assist with sobriety and employment, people recovering from addiction often return to the same circumstances under which their addiction flourished. There are promising inchoate telework opportunities that may eventually be coordinated with transitional housing, but quality internet access along with better transport will need to be available.

A significant percentage of Suboxone, a legal opioid substitute and popular form of medication-assisted treatment, is diverted in Kentucky into illicit channels, including rogue clinics operating

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Operation UNITE—A Mature Community Model

Operation UNITE (Unlawful Narcotics Investigation, Treatment, and Education) is a household name and highly valued brand in the 30 counties it serves in eastern Kentucky. From its inception in 2003, UNITE has partnered with local actors to address critical gaps. Responding initially to a law enforcement need, Congressman Hal Rogers founded UNITE with a Department of Justice grant. In subsequent years, UNITE contributed to the arrest of 210 drug dealers, the then largest drug roundup in Kentucky history; it created a drug tip line still used to this day; and it helped form 30 drug courts in partnership with the Administrative Office of the Courts. From 2004 onwards, UNITE has provided information about treatment options and vouchers for treatment to those in the 5th District. Even though Kentucky’s treatment facilities have risen from two in 2003 to 26 today, there is still a significant need, addressed systematically by UNITE, to facilitate entry into addiction treatment and subsequently into recovery programs.

In recent years, UNITE has given high priority to another emerging critical gap: prevention and education of children. In one county, 50 percent of children live with grandparents or great-grandparents. “We [in eastern Kentucky] have lost one, maybe two generations,” said Nancy Hale, CEO of Operation UNITE. In its facilitation role, UNITE offers a suite of prevention programs to schools that do not have the financial or technical capacity to deliver these services. UNITE has facilitated the entry of AMERICORPS volunteers into schools, and secured a (now-expired) grant to pay for drug counselors in schools. Structuring prevention programs around sports and outdoor activities, such as basketball in the case of the “Shoot Hoops Not Drugs” program and fishing in the case of “Hooked on Fishing Not Drugs,” has achieved significant levels of student participation. Antidrug messaging permeates these programs, with short lectures between sports drills and skill lessons. Children serve as crucial liaisons between UNITE and difficult-to-reach families and communities. At UNITE school clubs and Camp UNITE, a weeklong summer camp, children ages 5 to 18 gain a peer-support group, with whom they can discuss the challenges of living with family members’ addictions, and learn that they have a responsibility to address drug addiction in their communities. A mobile prevention initiative called “On The Move” consists of a classroom in a bus and helps UNITE educate children in remote areas.

To pay for these myriad activities, UNITE integrates federal, state, and private grants. It is inherently difficult to demonstrate a causal link between UNITE’s activities and drug addiction rates. That said, “a KASPER (Kentucky All-Schedule Prescription Electronic Reporting) System trend analysis conducted by the state Office of the Inspector General showed a 4.4 percent reduction in all controlled substances prescriptions from 2003–2005 in the UNITE service area, with 14 counties experiencing a state-high 9.7 percent decrease.” Pre- and post-tests reveal significant changes in knowledge and attitudes after students experience “On The Move.” UNITE is currently partnering with Kentucky University to analyze this age-disaggregated data.

In 2007, President Bush labeled UNITE’s community-based approach to combating drug misuse and addiction a model for the nation. Nine other states are currently working to replicate UNITE. In 2012, UNITE also launched the National Rx Drug Abuse & Heroin Summit, the largest annual conference addressing the American opioid epidemic. The 2017 summit, attended by 2,500 people, featured providers, researchers, advocates, law enforcement, pharmacists, and educators. Past Rx Summits have featured President Obama, the U.S. Surgeon General, the director of the Centers for Disease Control and Prevention (CDC), and the director of the National Institute on Drug Abuse (NIDA).

Several factors account for UNITE’s success in mobilizing people around the opioid epidemic. The active, sustained leadership and support of Congressman Hal Rogers has been the sine qua non of UNITE’s achievements over the past 14 years. Strong leadership drawn from the ranks of seasoned educators and cultivated from within UNITE’s ranks has also been critically important, fostering an entrepreneurial spirit that has spurred many innovative pilot programs funded from diverse sources. Accelerated implementation and rising community support has rested on UNITE’s carefully cultivated alliances with school districts, law enforcement officials, community groups, and the medical community. UNITE has systematically tapped local knowledge and earned the respect of its partners.
temporarily out of hotels.\textsuperscript{7} This has damaged the reputation of this form of treatment and exposed the need for far more careful oversight and management.

To varying degrees, almost every facet of the epidemic suffers from incomplete and poor-quality data. Many overdose and drug-related deaths are ruled car accidents, suicides, or violent crime, masking the true impact of opioids. The lack of data on nonfatal opioid overdoses further obscures the epidemic’s severity. Much more research and much better data are needed on treatment efficacy and the impact of prevention programs.

Fifth is the pressing need for a coherent, unified strategy.

Efforts remain highly fragmented, their sustainability uncertain. Arguably most important in this regard, \textit{long-term success requires a major external infusion of resources}, predictably over many years and across many sectors, and \textit{the articulation of a long-term vision} to guide investments and move beyond ad hoc, siloed approaches.

Local action alone will not suffice. There simply are not adequate fiscal resources and human and institutional capacities available at the community, county, or state level to meet urgent multiple needs. And if such external flows do materialize, that step will bring with it demands for heightened coordination, oversight and accountability, and calls for far better metrics and data, along with expanded research.

Closing Thoughts

Much about the opioid epidemic in eastern Kentucky remains uncertain, subject to unfolding debates over the correct course of action.

Police and judges alike, we heard, struggle with how to strike the correct balance between ensuring the accountability of drug offenders—to the law and to the victims of theft and violence—versus creating effective and reliable pathways from addiction to treatment to recovery.

Providers of care are actively debating the relative merits of medication-assisted treatment (MAT) versus abstinence approaches. Many individuals with whom we spoke regarded the diversion and abuse of Suboxone as a significant driver of the opioid crisis. Though many object to MAT in principle, viewing it as substitution of one opioid for another, most pointed to their concerns over the practical implementation challenges: there is almost a complete lack of counseling and support to ensure proper usage in those prescribed Suboxone. Vivitrol, an opioid blocker rather than substitute, has more widespread support among treatment providers and law enforcement, but its relatively high cost limits its accessibility.

The debate over Medicaid appears divided and a source of confusion. A judge and the owner of rehabilitation facilities argued that Medicaid expansion was responsible for improved access to treatment services and predicted that many treatment facilities would go out of business in the event of Medicaid rollback. Few others we interviewed made the direct connection between Medicaid and expanded treatment. Some went so far as to call Medicaid expansion counterproductive, as the 30-day residential treatment it covers is too short to be effective and puts graduates at greater risk of overdose, due to their lack of post-rehabilitation support and decreased drug tolerance. Increased access to treatment under Medicaid, some argued, actually contributed to the epidemic by providing increased access to prescription opioids, such as Suboxone. These perceptions seemed to be rooted in both practical and political concerns.

Some aspects of Kentucky’s opioid epidemic are peculiar to the history, culture, economy, and governance of the Commonwealth of Kentucky, but many lessons are broadly applicable to the national opioid epidemic. Southeastern Kentucky has achieved much with relatively modest resources, a source of pride and experience that can benefit others. Its residents, however, still feel the region is marginalized and neglected, with inadequate federal attention to address its conspicuous gaps.

Ultimately, any solution to the opioid epidemic in Kentucky will be built upon a coherent, reliable, multiyear national strategy that better integrates public health approaches with law enforcement. Both are essential, both have serious deficiencies at present, and both can be systematically improved with sufficient political will, resources, and a smart blueprint for action.