



Recommendations to Address the  
Heroin/Prescription Opiate Abuse  
in Orange County

Prepared by

Orange County Heroin/Prescription Opiate Abuse Task Force

For

County Executive, Steven M. Neuhaus

May 5, 2014

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## Introduction

The abuse and misuse of prescription drugs, especially painkillers (also known as opioids) is a growing problem in Orange County. While the category of opioids includes illegal drugs such as heroin, it also includes prescription medications used to treat pain such as morphine, codeine, methadone, and oxycodone. When used correctly, prescription drugs can be powerful adjuncts to a comprehensive pain management plan, but they pose serious health risks when abused. Unfortunately, misperceptions about their safety, increasing availability, and other motivations – including getting high and financial gain are driving the prevalence of painkiller abuse.

According to the Alcohol and Drug Abuse Council of Orange County, prescription and over-the-counter medications account for most of the illicit drugs commonly abused by high school seniors. Nearly 1 in 12 high school seniors reported non-medical use of Vicodin, 1 in 20 reported abuse of Oxycontin, and 7 in 20 said they obtained prescription narcotics from a friend or relative. Among those who abuse prescription drugs, high rates of other risky behaviors, including abuse of other drugs and alcohol, have also been reported.

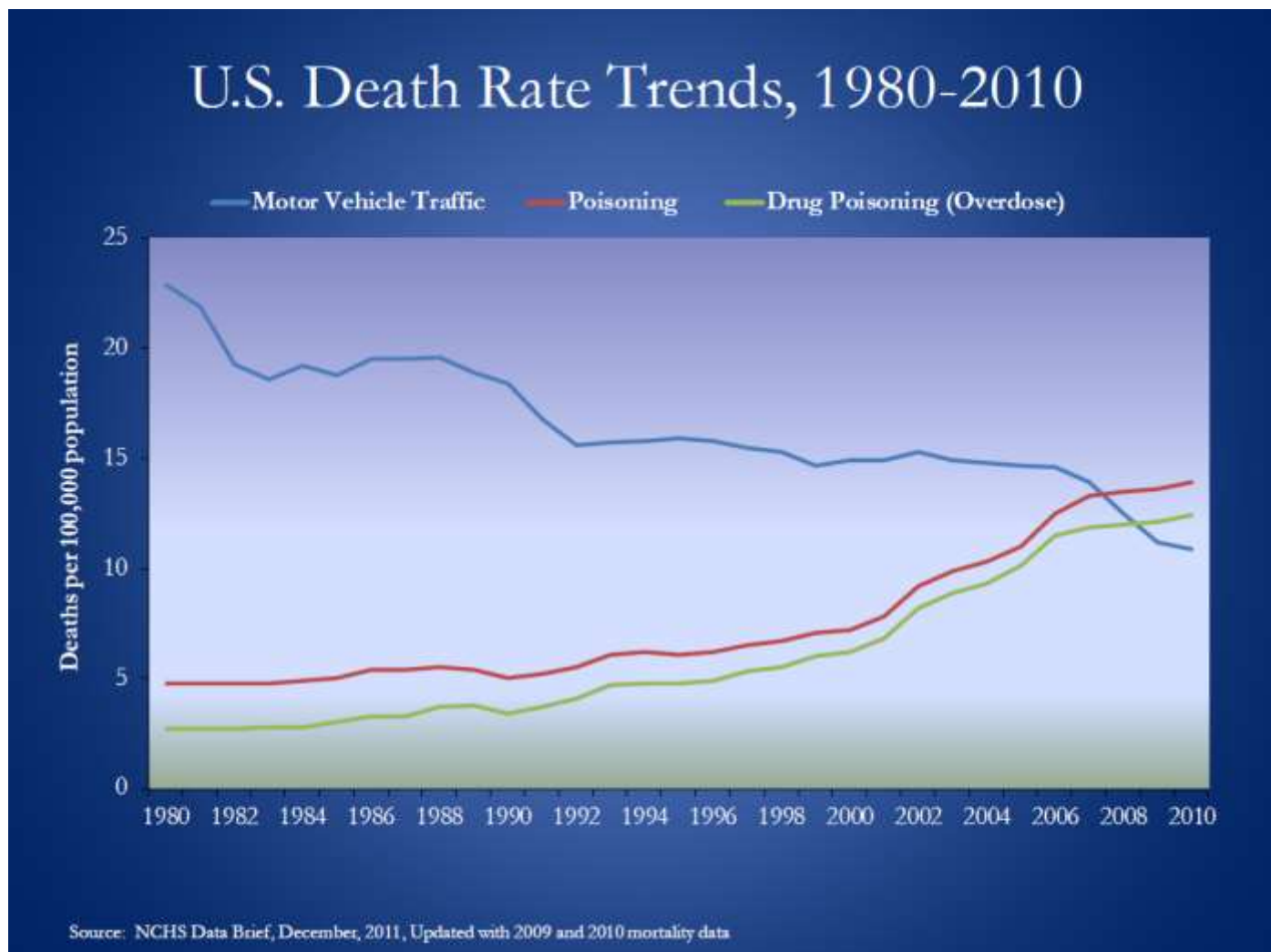
Abuse of drugs of any kind, even legal drugs, is not the type of problem that anyone wants to admit is occurring in their community, and certainly not one we'd imagine being prevalent in our still largely rural County. Unfortunately, it is in the data or perception from our clinics to our law enforcement, and, tragically, to our medical examiner's office, we are seeing a rise in the number of those affected. And, it's not just here. The Centers for Disease Control and Prevention has characterized prescription drug overdose as an epidemic, a term that reinforces the need for policy and program changes and a community-led response plan. (Prevention, 2011) Adding further to the concern of misuse, abuse and addiction is the connection between prescription painkillers and heroin use. With the crackdown on clinics that prescribe pain pills by the thousands, the implementation of the drug monitoring program in Internet System for Tracking Over-Prescribing - Prescription Monitoring Program NYS I-Stop, and pharmaceutical companies that have changed their formulas so the pills are more difficult to abuse, opiate addicts are turning to cheaper and more-plentiful heroin. NYS I-Stop being defined as a "real time" prescription monitoring registry to provide timely and enhanced information to practitioners and pharmacists which requires all prescriptions to be electronically transmitted thus improving safeguards for the distribution of specific prescription drugs that are prone to abuse." The National Survey on Drug Use and Health report in December 2013 indicated that the number of people abusing prescription painkillers has dropped steadily as heroin use has increased. (SAMHSA, 2013)

With that in mind, as well as our own data and experiences, we agreed it was necessary for a proactive approach to combat the problem by launching the Prescription Pain Killer Safety Task Force (Task Force). The Task Force is a multi-disciplinary approach to addressing this critical issue, bringing together representatives from a cross-section of programs and services that interact with prescription painkillers, including prescribers, pharmacists, hospitals and pain management clinics, schools, clinicians and addiction specialists, law enforcement, and the medical examiner's office. The goals of the Task Force were to look at the issue of prescription drug abuse from all angles and to develop a plan of recommended actions that

each Stakeholder, as well as parents and families, can put into place to reduce the incidence of abuse of prescription painkillers and opiate addiction.

### Background

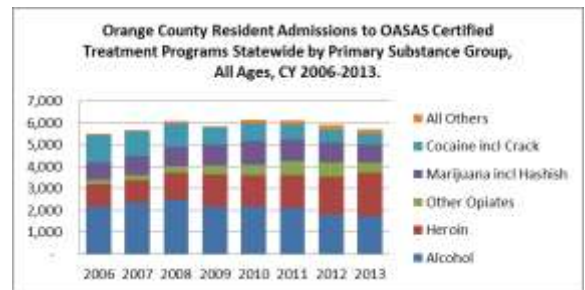
The Centers for Disease Control and Prevention (CDC) sounded the alarm in late 2011, when an analysis showed that in 2010, drug overdose deaths outpaced motor vehicle deaths. More than half of the drug overdose fatalities involved prescription drugs, and nearly three-quarters of those fatalities were because of opioid painkillers. Prescription drug - opioids include oxycodone (Percocet, Tylox, OxyContin), hydrocodone (Vicodin, Lortab), and methadone (Dolophine). Overall, according to the CDC, more than 12 million Americans reported using prescription painkillers for nonmedical purposes in 2010.



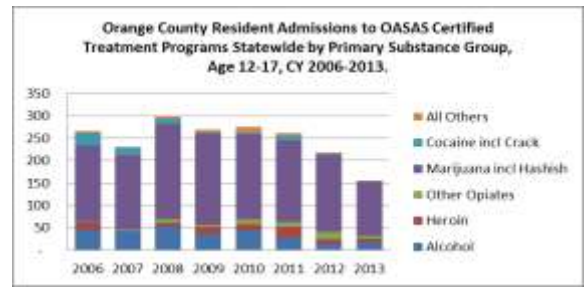
The NYS Office of Alcoholism and Substance Abuse Services (OASAS) data “Admission by Age and Primary Substance” graphs show a pattern that follows statewide and national trends, trends coupled with rising numbers of people seeking treatment for prescription drug addiction. The fastest growing trend indicated in the charts is admission to treatment for heroin. This increase in heroin addiction likely began with addiction to prescribed opiates.

**Orange County Resident Admissions to OASAS Certified Treatment Programs Statewide by Age and Primary Substance Group, CY 2006-2013.**

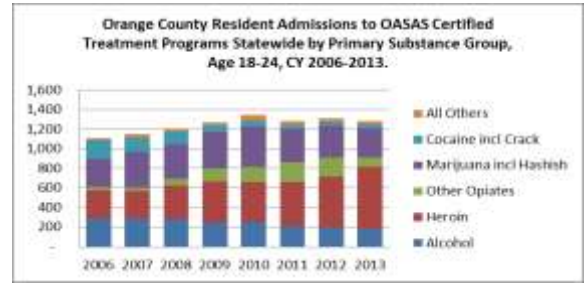
All Ages							
Year of Admission	Alcohol	Heroin	Other Opiates	Marijuana incl Hashish	Cocaine incl Crack	Other or Unknown	Grand Total
2006	2,173	1,027	212	773	1,239	82	5,506
2007	2,342	1,035	217	881	1,122	84	5,681
2008	2,468	1,241	306	880	1,063	111	6,069
2009	2,185	1,452	415	935	773	95	5,855
2010	2,172	1,433	488	1,060	829	157	6,139
2011	2,119	1,492	641	975	692	196	6,115
2012	1,816	1,708	658	902	590	224	5,898
2013	1,747	1,970	466	823	506	200	5,712



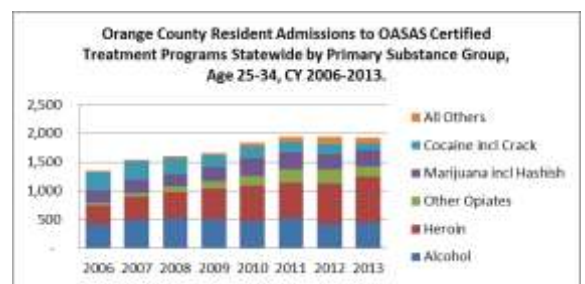
Age 12 thru 17							
Year of Admission	Alcohol	Heroin	Other Opiates	Marijuana incl Hashish	Cocaine incl Crack	All Others	Grand Total
2006	45	16	2	171	27	6	267
2007	42	1	2	167	17	2	231
2008	53	8	8	213	12	7	301
2009	37	14	6	203	4	6	270
2010	44	14	11	190	5	11	275
2011	29	22	11	182	12	6	262
2012	14	10	17	171	3	3	218
2013	18	7	6	123		1	155



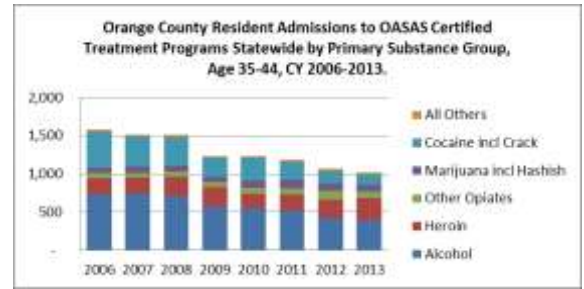
Age 18 thru 24							
Year of Admission	Alcohol	Heroin	Other Opiates	Marijuana incl Hashish	Cocaine incl Crack	Other or Unknown	Grand Total
2006	287	291	30	292	189	21	1,110
2007	289	278	34	369	148	21	1,149
2008	281	342	73	351	131	26	1,204
2009	246	420	132	373	73	27	1,271
2010	254	407	151	415	65	51	1,343
2011	210	447	207	333	41	47	1,285
2012	195	519	199	324	37	38	1,312
2013	183	629	102	291	42	38	1,285



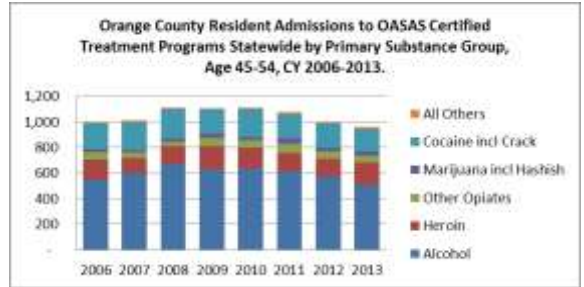
Age 25 thru 34							
Year of Admission	Alcohol	Heroin	Other Opiates	Marijuana incl Hashish	Cocaine incl Crack	Other or Unknown	Grand Total
2006	427	322	44	207	329	20	1,349
2007	497	398	69	228	332	19	1,543
2008	530	449	105	207	274	39	1,604
2009	514	527	129	248	207	36	1,661
2010	474	619	161	319	203	63	1,839
2011	524	614	240	293	185	88	1,944
2012	422	712	237	269	176	122	1,938
2013	450	794	188	275	123	101	1,931



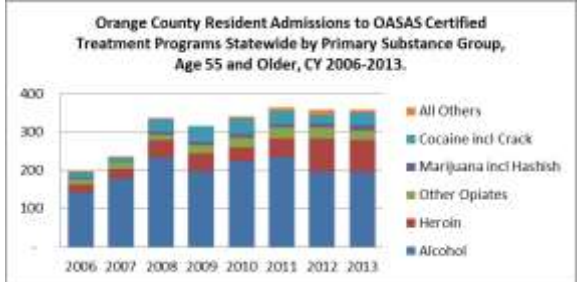
Age 35 thru 44							
Year of Admission	Alcohol	Heroin	Other Opiates	Marijuana incl Hashish	Cocaine incl Crack	Other or Unknown	Grand Total
2006	726	217	67	72	475	20	1,577
2007	736	214	55	93	399	15	1,512
2008	705	253	70	77	384	22	1,511
2009	560	266	63	68	255	19	1,231
2010	543	193	84	97	299	14	1,230
2011	512	212	86	108	237	30	1,185
2012	416	243	118	96	164	34	1,071
2013	393	283	92	86	134	34	1,022



Age 45 thru 54							
Year of Admission	Alcohol	Heroin	Other Opiates	Marijuana incl Hashish	Cocaine incl Crack	All Others	Grand Total
2006	547	158	57	26	203	12	1,003
2007	599	119	42	23	214	13	1,010
2008	667	142	36	25	228	13	1,111
2009	630	178	64	35	192	7	1,106
2010	633	163	57	29	217	12	1,111
2011	610	148	68	50	183	16	1,075
2012	572	137	58	33	187	13	1,000
2013	509	172	52	34	175	18	960



Age 55 and Older							
Year of Admission	Alcohol	Heroin	Other Opiates	Marijuana incl Hashish	Cocaine incl Crack	All Others	Grand Total
2006	141	23	12	5	16	3	200
2007	179	25	15	1	12	4	236
2008	232	47	14	7	34	4	338
2009	198	47	21	8	42		316
2010	224	37	24	10	40	6	341
2011	234	49	29	9	34	9	364
2012	197	87	29	9	23	14	359
2013	194	85	26	14	32	8	359





With increased use of prescription opioid analgesics for the treatment of pain, misuse also has increased, as have the use of medical services and deaths associated with opioid analgesics. There were 1,718 overdose deaths in New York in 2009 70 percent of which were because of opioids, including heroin and prescription drugs, reported by OASAS. According to the Orange County Medical Examiner’s Office, 9.34% of deaths investigated by the Medical Examiner’s office in 2012 were drug-related.

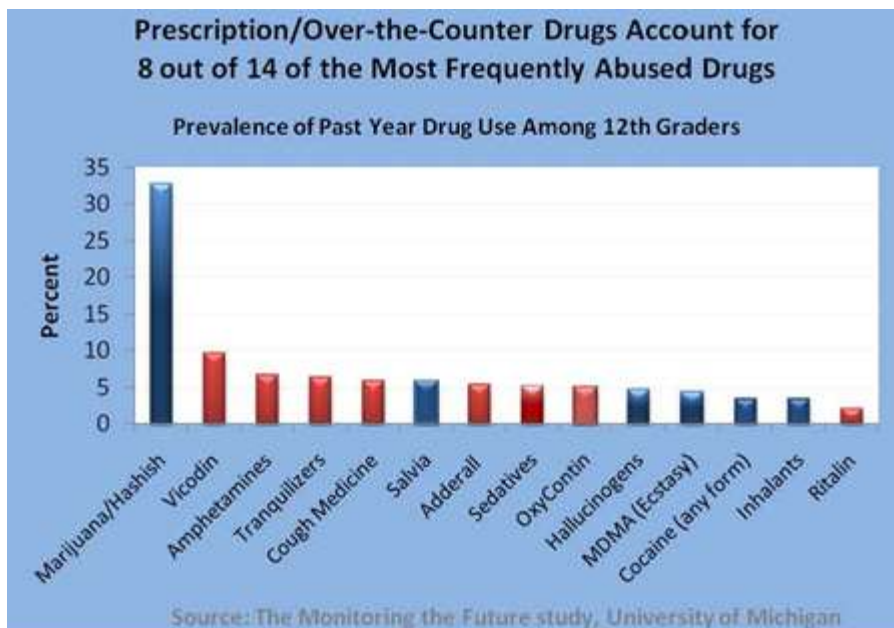
**ACCIDENTAL DRUG OVERDOSES, ORANGE COUNTY, 2008-2012**

<b>Year</b>	<b>Total</b>	<b>Average Age</b>	<b>Males (%)</b>	<b>Females (%)</b>
2008	38	38	76.4%	23.6%
2009	46	42	78.3%	21.7%
2010	46	41	58.7%	41.3%
2011	57	41	57.9%	42.1%
2012	53	43	66%	34%
<b>Total</b>	240	41	67.5%	32.5%

**MOST COMMONLY OCCURRING DRUGS IDENTIFIED IN ACCIDENTAL OVERDOSES, ORANGE COUNTY 2008-2012**

<b>Drug Name</b>	<b>Number of Positive Tests in Overdoses</b>	<b>Percentage in Total Number of Overdoses</b>
Morphine	59	24.6
Alprazolam	55	22.9
Oxycodone	53	22.1
Heroin	44	18.3
Cocaine	42	17.5
<b>Total</b>	253	

In the Centers for Disease Control and Prevention's June 2013 edition of *Morbidity and Mortality Weekly Report*, an annual survey of high school students showed that 20.7 percent of students had, at some point, taken a prescription drug without a doctor's prescription. According to the CDC, 55 percent of people who abuse prescription painkillers get them from a friend or relative for free, 11.4 percent paid the friend or relative and 4.8 percent stole them from a friend or relative. Just over 17 percent got them with a doctor's prescription.



2013

The multi-layered responses to this epidemic, including the national crack down on the prescription drug “pill mills” expansion of Drug Monitoring Programs - NYS I – Stop, drug take-back programs, education, and media attention has led to a decrease of about 5% in the number of narcotic painkiller prescriptions in 2013 as compared to 2012.

As we begin to have an impact on prescription opioid use, evidence is mounting to show that it is being replaced by another highly addictive opiate: heroin. Heroin is a common substitute for prescription pills, and it is available and cheaper than prescription drugs. Reported in Med Page February 2014, White House drug czar Gil Kerlikowske and Wilson Compton of the National Institute on Drug Abuse said that while overall heroin abuse and deaths remain rare, there are signals that the narcotic's popularity is growing. Kerlikowske also noted a recent study showing that 80% of new heroin users previously had used prescription painkillers recreationally.

It is clear that the multi-disciplined and multi-layered approach proposed by the Task Force in the following recommendations will be imperative to get a handle on this “opiate epidemic” that is dramatically reducing the quality of lives and resulting in death for many.

## **Recommendations to achieve measurable reductions in controlled prescription drug misuse, abuse and overdose using a comprehensive approach**

In accordance with the Association of State and Territorial Health Officials (ASTHO) President, Dr. Terry Cline’s challenge to “improve health outcomes and reduce the human and economic costs associated with prescription drug misuse, abuse and overdose” (Cline, 2013 - 2014 ASTHO's President's Challenge<sup>15</sup> by 15: Reduce Prescription Drug Abuse & Deaths 15% by 2015, 2013) and to “reduce the number of unintentional overdose deaths involving controlled prescription drugs 15 percent by 2015, the Task Force submits the following recommendation within the ASTHO Strategic Map framework,” as issued on September 20, 2013 during the annual ASTHO Meeting in Orlando, Florida.

### **A. Expand and Strengthen Prevention Strategies**

1. Promote and Implement Primary Prevention Strategies.
  - a. Promote use and provide training of SBIRT (Screening, Brief Intervention and Referral to Treatment) in primary care settings.
  - b. Raise greater awareness through public education campaigns and community forums.
  - c. Launch a media campaign promoting awareness, education, and risk connected with use of pain killers and heroin.
  - d. Expand school and community based surveys that look at risk and protective factors to be used as foundation for strategic planning for school and community-based prevention education.
  - e. Recommended use of evidence-based strategies and/or programs as listed in the National Registry of Evidence-Based Programs and Practices (NREPP) of the Substance Abuse Mental Health Services Administration (SAMHSA). NREPP is a searchable online database of mental health and substance abuse interventions. All interventions in the registry have met NREPP’s minimum requirements for review and have been independently assessed and rated for Quality of Research and Readiness for Dissemination.  
<http://www.nrepp.samhsa.gov/>
  - f. Expand community coalitions that include community members, parents, providers, school representatives, law enforcement, elected officials, and others to align with the Substance Abuse and Mental Health Services Administrator’s (SAMHSA) Prevention Framework recommendations on building local capacity. [Orange County Coalitions.pdf](#)
2. Support legislation that mandates CME training for all clinicians that prescribe controlled substances.
3. Support the Federal Drug Administration’s three key roles for prescribers in curtailing the U.S. opioid epidemic:

- a. Ensuring they have adequate training in opioid therapy;
  - b. Knowing the content of the most-current opioid drug labels (examples of the important information found in the labeling of two opioid drugs, OxyContin and Dolophine, are provided at the end of this document); and
  - c. Educating patients about the appropriate use of opioids, their potential risks, and proper disposal techniques.
4. Provide education for Prescribers using the guidelines developed by New York City Department of Health and Mental Hygiene “Preventing Misuse of Prescription Opioid Drugs,” <http://www.nyc.gov/html/doh/downloads/pdf/chi/chi30-4.pdf> that were informed by opioid prescribing guidelines in other jurisdictions. ([NYC Guidelines](#)) The New York City Department of Health and Mental Hygiene created these guidelines to help reduce the misuse of prescription opioid analgesics by establishing standards for prescribing from the Hospital Emergency Departments (ED). In developing the guidelines, the Health Department was cognizant of the need to preserve the vital role of the ED in treating patients with painful medical conditions. These guidelines are consistent with the City Health Information Bulletin on Opioid Prescribing, “Preventing Misuse of Prescription Opioid Drugs,” and are informed by opioid prescribing guidelines in other jurisdictions. They also incorporate input from a panel of New York City ED providers. The guidelines are not meant for patients in palliative care programs or with cancer pain. They do not replace clinical judgment in the appropriate care of patients nor are they intended to provide guidance on the management of patients while they are in the ED.

Guidelines for the management of patients discharged from an emergency department:

- a. Consider short-acting opioid analgesics for the treatment of acute pain only when the severity of the pain is reasonably assumed to warrant their use.
- b. Start with the lowest possible effective dose if opioid analgesics are considered for the management of pain.
- c. Prescribe no more than a short course of opioid medication for acute pain. Most patients require no more than three days.
- d. To assess for opioid misuse or addiction, use targeted history or validated screening tools. Prescribers can also access the New York State Controlled Substance Information (CSI) on Dispensed Prescriptions Program for information on patients’ recent controlled substance prescription history before prescribing controlled substances.
- e. Avoid initiating treatment with long-acting or extended-release opioid analgesics.
- f. Address exacerbations of chronic or recurrent pain conditions with non-opioid analgesics, non-pharmacological therapies, and/or referral to specialists for follow-up, all as clinically appropriate.

- g. Avoid when possible prescribing opioid analgesics to patients currently taking benzodiazepines and/or other opioids. Consider other risk factors for consequential respiratory depression.
- h. Attempt to confirm with the treating physician the validity of lost, stolen, or destroyed prescriptions. If considered appropriate, replace the prescription only with a one to two day supply.
- i. Provide information about opioid analgesics to patients receiving a prescription, such as the risks of overdose and dependence/addiction, as well as safe storage and proper disposal of unused medications.

## **B. Improve Monitoring and Surveillance**

1. Provide education and training to prescribers regarding guidelines for use and penalties for not following the drug monitoring program “I – Stop” that went into effect August 27, 2013. Most prescribers are required to consult the Prescription Monitoring Program (PMP) Registry when writing prescriptions for Schedule II, III, and IV controlled substances. The PMP Registry provides practitioners with direct, secure access to view dispensed controlled substance prescription histories for their patients. The PMP is available 24 hours a day/7 days a week via an application on the Health Commerce System (HCS) at <https://commerce.health.state.ny.us> Patient reports will include all controlled substances that were dispensed in New York State and reported by the pharmacy/dispenser for the past six months. This information will allow practitioners to better evaluate their patients' treatment with controlled substances and determine whether there may be abuse or non-medical use.
2. Support the sharing of drug monitoring systems across states – currently 16 states can share data across state lines.
3. We would like to see a State policy in place to address the issue of multiple prescriptions being filled and coincide with the new law that pharmacies are able accept unused prescriptions (pending federal law). For example, if a patient says a certain drug does not work and they are given another prescription for the same ailment, they can only get that second prescription filled after they return the first to the pharmacy. This helps address excess pills sitting in medicine cabinets.
4. Increase the use of clinical monitoring tool for functional improvement
  - a. Daily Living Activities Functional Assessment DLA -20

## **C. Expand and Strengthen Control and Enforcement**

1. Increase arrest and prosecution of individuals who sell and distribute these drugs illegally.
2. Explore the development of protocols for toxicology testing.

3. Drug Recognition Training (DRE) for law enforcement. Increased Drug Recognition Expert or Evaluator (DRE) Training - Seek grant funding opportunities to fund an Orange County training initiative.

- a. Drug Recognition Expert or Evaluator (DRE) Training: defined by the International Association of Chiefs of Police as training specific for law enforcement officers to identify people whose driving is impaired by drugs. The committee supported a request to identify more DRE trained Orange County Officers. Currently one STOP DWI staff member, and one State Police Officer are known to have the certifications. Requirements and training costs are significant and reflected below: Discussion reflected that each municipal police department would greatly benefit from having a DRE Officer available to promote training and awareness / discussion about the complexities of assessing driving under the influence of abused prescription medications.

The Drug Expert Certification (DEC) Program trains police officers and other approved public safety officials as drug recognition experts (DREs) through a three-phase training process:

1. Drug Recognition Expert Pre-School (16 hours)
  2. Drug Recognition Expert DRE School (56 hours)
  3. Drug Recognition Expert Field Certification (Approximately 40 – 60 hrs.)
- b. The training relies heavily on the Standardized Field Sobriety Tests (SFST's), which provide the foundation for the DEC Program. Once trained and certified, DREs become highly effective officers skilled in the detection and identification of persons impaired by alcohol and/or drugs. DREs are trained to conduct a systematic and standardized 12-step evaluation consisting of physical, mental and medical components.
4. Expand programs that aim to prevent medication misuse and abuse by providing a secure, environmentally safe means for residents to dispose of unwanted drugs.
    - a. The Orange County Sheriff's Department provides the Safe Scripts Prescription Drug Disposal Program. [OC Sheriff's Dept. Safe Scripts](#)
    - b. Encourage police departments to participate in the National DEA Drug Take Back program typically held twice a year during the months of April and October. The following link will provide you with information:  
[http://www.deadiversion.usdoj.gov/drug\\_disposal/takeback/index.html](http://www.deadiversion.usdoj.gov/drug_disposal/takeback/index.html)
    - c. Encourage police departments to develop a Prescription Drug Collection and Disposal Procedure and install secure drug disposal containers as a safe place for the

public to dispose of unwanted or unused medications. Include public outreach to senior housing, etc.

5. Include in all education / training for physicians and dentists the CDC prescribing recommendation:
  - a. For acute pain: If opioids are warranted, prescribe only short-acting agents - a 3-day supply is usually sufficient.
  - b. For Chronic noncancerous pain: Avoid prescribing opioids unless other approaches to analgesia have been demonstrated to be ineffective.
  - c. Avoid whenever possible prescribing opioids in patients taking benzodiazepines because of the risk of fatal respiratory depression.
6. Recommend all Emergency Room Electronic Medical Record prescribing data bases change the default for number of days prescribed from twenty or thirty days to three to five days.

#### **D. Improve Access to and Use of Effective Treatment and Recovery Supports**

1. Monitor and improve access to full continuum of treatment services – detoxification, inpatient rehabilitation, outpatient day rehabilitation, outpatient clinic service, methadone maintenance, community residential programs and supported housing. Improve service access via educating Health Home Care Coordinators and Peer Recovery Coaches.
2. Publicize treatment resource guide ([List of Treatment and Prevention Providers](#)).
3. Implement and expand the use of best practices intervention:
  - a. Promote the expansion of training - Focus on Integrated Treatment (FIT) - FIT is a comprehensive, evidence-based online training program that gives professionals the skills needed to provide the most effective approach to treating clients with co-occurring substance use and mental health disorders. By drawing upon numerous randomized controlled trials, FIT provides a state-of-the-art science approach to treatment.
  - b. NYS Department of Health, Medicaid Health Homes, are a care management model that serves individuals who have complex medical, behavioral, and long term care needs. Individuals with one or more chronic conditions, one of which can be substance abuse/addiction, are eligible for this care management service, with the goal to coordinate care and result in better outcomes.
  - c. Cognitive Behavioral Therapy (CBT)-promote capacity building and/or training of CBT strategies and interventions for the substance abusing client and/or co-occurring client throughout the public and private provider system.

- d. Trauma Informed Care (TIC) - promote and expand TIC throughout Orange County's provider network as well as cross-systems to build an informed system of organizations, programs, and services that understand the vulnerabilities or triggers of trauma survivors that can lead to abusing substances or triggers that can cause relapse.
- e. Promote use of Life Events Checklist and/or Post-Traumatic Stress Disorder (PTSD) checklist.
- f. Person-Centered Treatment (PCT) - also known as person-centered psychotherapy, person-centered counseling, and client-centered therapy. PCT is a form of talk-psychotherapy with the goal being to provide clients with an opportunity to develop a sense of self-actualization, where they can realize how their attitudes, feelings and behavior are being negatively affected.
- g. Provide Culturally Responsive Treatment – need to integrate culturally competent practice to engage and understand different cultures and ethnic communities and how each group may define health especially within the context of substance abuse. These practices need to be infused in practice, policy development and administration.
- h. Wellness Self-Management Plus (WSM+) - a curriculum-oriented program for adults with serious mental health problems. WSM+ has been designed to address both substance use and mental health in an integrated and recovery supportive manner.
- i. CAGE-AID - CAGE is derived from the four questions of the tool: Cut down, Annoyed, Guilty, and Eye-opener (*CAGE Source: Ewing 1984*). A quick drug and alcohol assessment tool for determining whether a patient may be currently abusing drugs or alcohol. It can be used to detect existing substance use problems prior to prescribing opioid therapy.
- j. Drug testing - Increase training on the role of drug testing in proper identification and treatment of prescription drug use and Heroin abuse. Identify high priority providers which include Primary Care Providers (using the Treatment Assistance Publication Series, TAP 32 "Clinical Drug Testing in Primary Care" published by SAMHSA). Other high priority targets for training on drug testing include behavioral health providers, Suboxone providers, emergency room physicians and pain management clinics. Address financial road blocks to obtaining drug testing in settings other than substance abuse programs such as in behavioral health clinics. Enhance drug testing services to include synthetic opiates. Educate providers to be aware of the strengths and limitations of their drug testing panel with an aim of reducing the incidence of prescription drug/opiate use that is undetected in standard drug screening panels.
- k. Housing Support - knowing there is a direct relationship between homelessness and addiction (SAMHSA, 2003) with roughly 60% of homeless individuals abusing drugs, promotion of cross-systems capacity building and complex capability development will be fostered throughout treatment providers and service delivery systems.



4. Implement overdose prevention and intervention strategies
  - a. Expand training and implementation of nasal or injectable Narcan (Naloxone) overdose antidote for use among all first responders including law enforcement, providers, and family members. The American Medical Association has recently sent a letter of support for federal legislation, the Stop Overdose State Act of 2013, which seeks to decrease drug overdose by expanding awareness and use of Naloxone, a receptor antagonist that potentially can prevent opioid overdose deaths. The bill also aims to improve epidemiological surveillance of overdose occurrences and establish a coordinated federal plan of action.
  - b. More extensive public education about overdose - signs of overdose, information about the Good Samaritan Law, and the importance of connecting people with treatment.
5. Expand utilization of treatment alternatives to incarceration:
  - a. TASC - Treatment Alternatives for Safer Communities – used at the post-plea, pre-sentencing level to offer eligible clients, non-violent offenders with drug related offenses, treatment instead of incarceration, thereby reducing recidivism and increasing public safety.
  - b. MASP - Misdemeanor Alternative Sentencing Program - used at the post-plea, pre-sentencing level to offer eligible clients with drug related offenses treatment instead of incarceration, thereby reducing recidivism and increasing public safety.
  - c. Make the best use of Drug Courts - A uniquely collaborative approach to treatment. Upon voluntary entry into court-supervised programs, appropriate non-violent addicted offenders become part of a dramatic intervention process. This process involves coordination between defense attorneys, prosecutors, treatment and education providers and law enforcement officials. Rules of participation are defined clearly in a contract agreed upon by the defendant, the defendant's attorney, the district attorney and the court. In Orange County the following courts are designated Drug Courts - Orange County Court, Middletown City Court, Newburgh City Court, and Orange County Family Juvenile Court.
  - d. Port Jervis Forensic Connections Project began in April 2014 - A Justice and Mental Health Collaborative initiative (funded by The Federal Department of Justice) - modeled after The Sequential Intercept Model, is a partnership between the Orange County Department of Mental Health, Orange County District Attorney's Office, County Department of Probation, Orange County Legal Aid Society, Rockland Psychiatric Center, Independent Living Inc., Bon Secours Community Hospital, Catholic Charities, Restorative Management, Inc., and Occupations, Inc. aimed at providing a mental health track for clients that are co-occurring, specifically targeting women. Clients who are

eligible and do not pose a public safety risk will be referred to the appropriate staff for a psychosocial/mental health assessment, while being supported by a Peer Partner. Case management, supervision, and community-based treatment, will be available to clients, who might otherwise be detained while their cases are being processed through court.

- e. Orange County Middletown Court Connections Program - The Orange County Mental Health Court Connections Program is designed to support the City of Middletown Court with a meaningful response to the problems posed by the defendants with mental illness in the criminal justice system. The City of Middletown Court addresses both the treatment needs of the defendant with mental illness and the public safety concerns of the community. In addition, the Connections Program gives the judges the resources necessary to consider effective alternatives to incarceration dispositions for defendants whose mental illness has contributed to their current criminal justice involvement and whose participation in the Connections Program will not create an increased risk to public safety. The Task Force recommends future expansion of this Program throughout Orange County.
  - f. Re-Entry Program - “Staying Out Project” (funded by New York State Division of Criminal Justice Services [DCJS]). A re-entry program lead by the Alcoholism and Drug Abuse Council of Orange County offered on a voluntary basis to inmates post-sentencing. Inmates would participate in evidenced-based programs while incarcerated, namely “Thinking for a Change-T4C” and “Ready Set Work.” A cognitive-behavioral approach designed by The National Institute of Corrections coupled with a focus on vocational rehabilitation. Inmates would also be met at the door of discharge by an assigned Case Manager and mentor to assist in their reentry into society, assisting with establishing follow-up appointments, facilitating transportation, access to treatment, thus reducing recidivism and increasing overall public safety.
6. Provide education about and access to medications assisted treatment to support recovery. Medication-assisted treatment for opioid addiction and dependence is much like using medication to treat other chronic illnesses such as heart disease, asthma or diabetes. Taking medication for opioid addiction is not the same as substituting one addictive drug for another. The most common medications used in the treatment of opioid dependence today are methadone, naltrexone, and buprenorphine (Suboxone).
- a. Methadone is an opioid and has been the standard form of medication-assisted treatment for opioid addiction and dependence for more than 30 years. Methadone for the treatment of opioid dependence is only available from federally-regulated clinics which are few in number and unappealing for most patients. In addition, studies show that participation in a methadone program improves both physical and mental health, and decreases mortality (deaths) from opioid addiction. Like Suboxone, when taken properly, medication-assisted treatment with Methadone

suppresses opioid withdrawal, blocks the effects of other problem opioids and reduces cravings.

- b. Naltrexone (Vivitrol) is an opioid blocker that is also useful in the treatment of opioid addiction. Naltrexone blocks the euphoric and pain-relieving effects of heroin and most other opioids. This type of medication-assisted treatment does not have addictive properties, does not produce physical dependence, and tolerance does not develop. Unlike methadone or Suboxone, it has several disadvantages. It does not suppress withdrawal or cravings. Therefore, many patients are not motivated enough to take it on a regular basis. It cannot be started until a patient is off of all opioids for at least two weeks, though many patients are unable to maintain abstinence during that waiting period. Also, once patients have started on naltrexone the risk of overdose death is increased if relapse does occur.
- c. In 2002, the FDA approved the use of the unique opioid buprenorphine (Subutex, Suboxone) for the treatment of opioid addiction in the U.S. Buprenorphine has numerous advantages over methadone and naltrexone. As a medication-assisted treatment, it suppresses withdrawal symptoms and cravings for opioids, does not cause euphoria in the opioid-dependent patient, and it blocks the effects of the other (problem) opioids for at least 24 hours. Success rates, as measured by retention in treatment and one-year sobriety, have been reported as high as 40 to 60 percent in some studies. Treatment does not require participation in a highly-regulated federal program such as a methadone clinic. Since buprenorphine does not cause euphoria in patients with opioid addiction, its abuse potential is substantially lower than methadone.

#### **E. Expand and Strengthen Key Partnerships and Collaborative Infrastructure**

1. Schedule regular meeting with the Task Force and work group targeting Recommendations A – D.
2. Incorporate the work of the Task Force with the developing Comprehensive Continuous Integrated System of Care (CCISC) initiative. CCISC will provide an umbrella framework for transformation that will include stakeholder’s input from all disability areas. The cross system Steering Committee will lead the development of our framework of agency self-assessment and work plans, identifying key staff to serve as “change agents”, and including additional key partners from other service systems such as social services, probation, law enforcement, schools, etc. The commitment to this CCISC will create lasting positive treatment outcomes to our collective populations with complex needs through shared value foundation and common language across service areas. The successful treatment outcomes, addiction recovery, increased hospital and rehabilitation diversion, reducing homelessness, arrests, and out of home placements for children, and successfully integrating care for multiple chronic care issues

is fully aligned with the triple-aim foundation of the Affordable Care Act. This system transformation will strengthen the delivery of services in Orange County.

**F. Secure / Align Resources and Infrastructure to Implement Comprehensive Approaches**

Use this County plan to coordinate activities, enhance communication among all stakeholders, focus our efforts, and develop collective strategies under one work plan.

**G. Use Data, Evaluation, and research to Inform Interventions and Continuous Improvement**

1. Development of Countywide Data workgroup - in collaboration with Orange County Department of Mental Health, Alcoholism and Drug Abuse Council of Orange County, Catholic Charities of Orange County, Orange County Youth Bureau, Orange County Health Department, and Orange-Ulster BOCES. Partner with State University of New York (SUNY) system to disseminate national recognized survey to measure perceptions, norms, usage rates, etc.
2. Enhance data monitoring and sharing - develop a data repository database to track heroin - and other drug-related overdoses, deaths, hospital admissions and crimes within our County to be shared amongst key county stakeholders and to be owned by one key stakeholder.

**Resources**

<http://store.samhsa.gov/product/opioid-overdose-prevention-toolkit/all-new-products/sma13-4742>

<http://www.nyc.gov/html/doh/downloads/pdf/chi/chi30-4.pdf>

[http://www.co.orange.ny.us/filestorage/1162/1372/Operation\\_Safe\\_Scripts\\_2012.pdf](http://www.co.orange.ny.us/filestorage/1162/1372/Operation_Safe_Scripts_2012.pdf)

<http://www.dec.ny.gov/chemical/63826.html>