Ulster Coalition Against Narcotics

UCAN

Report to the Ulster County Legislature

244 Fair Street
Kingston, NY 12401

September 15, 2015

UCAN

CONTENTS

EXECUTIVE SUMMARY

Heroin is a highly addictive narcotic, with users representing a variety of ages, races and other backgrounds. Fatal overdose, the contraction of Hepatitis C and/or HIV and addiction and dependence are among a plethora of negative side effects that can result from heroin use. In addition to physical danger, heroin use threatens a user's social ties often straining family bonds, friendships and professional relationships.

Across the nation, heroin abuse has been increasing at dangerously high rates in recent years. In 2013, there were 89,269 cases of heroin and prescription opiate treatment admissions in New York State alone, an increase from 63,793 in 2004. During this same time period, the drug also disproportionately impacted New Yorkers ranging in age from 18 to 24. Nationally, as many as 467,000 people were reportedly abusing heroin or suffering from heroin dependence in 2012. [1]

There is no doubt that we are in the midst of an epidemic. Citizens of our county, state and nation are dying. Our response must be strong. It demands a partnership, a true working relationship between the medical community, law enforcement, the judiciary, insurers, providers, health and human services agencies, elected officials, and the public.

With each tragic death, there are hospital stays, emergency department visits, missed work, unemployment increases, and vastly untold amounts of human suffering. The facts are staggering. The Administrative Director of the Upstate New York Poison Center reported in April 2014 for the Joint Senate Task Force on Heroin and Opioid Addiction that 70% of drug arrests in Ulster County were for heroin or opioids, up 30% from a few years ago. [2]

According to the Federal Government, "the economic costs of drug use are enormous: In 2007 alone illicit drug use cost our Nation more than $193 billion in lost productivity, healthcare, and criminal justice costs. But the human costs are worse. Nationwide, drug-induced overdose deaths now surpass homicides and car crash deaths in America."[3]

Governor Cuomo's New York State Combat Heroin and Prescription Drug abuse acknowledges that Heroin addiction and prescription opioid abuse are persistent national problems that reach deep into communities across New York and most heavily affect young adults.

[1] https://www.governor.ny.gov/news/governor-cuomo-and-legislative-leaders-announce-agreement-package-bills-combat-heroin-opioid
[2] http://www.nysenate.gov/files/Joint_Senate_Heroin_Addiction_Task_Force_Final_Report_5-27-14.pdf
[3] https://www.whitehouse.gov/ondcp/drugpolicyreform

EXECUTIVE SUMMARY

It is evident according to panelists at the Harvard TH Chan School of Public Health "…. opioid abuse needs to be treated as a disease, with the understanding that support and continuing care are crucial to recovery, and no tolerance for stigmatization."[4]

As Michael Botticelli, Director of the National Drug Control Policy (ONDCP) said, "We don't predicate saving someone's life from other diseases based on their compliance with treatment. We save their lives because their lives are worth saving." Families suffering from opioid abuse, he concluded, need to know "there is hope and life and joy on the other side of addiction."

It is time to educate the public and offer the help to those that need it. "Addiction is a complex disease. There are no easy or quick solutions, nothing short of a comprehensive approach to this opioid epidemic will turn the tide of overdose deaths and reduce the harms that opioids are inflicting upon individuals, families and our communities."[5]

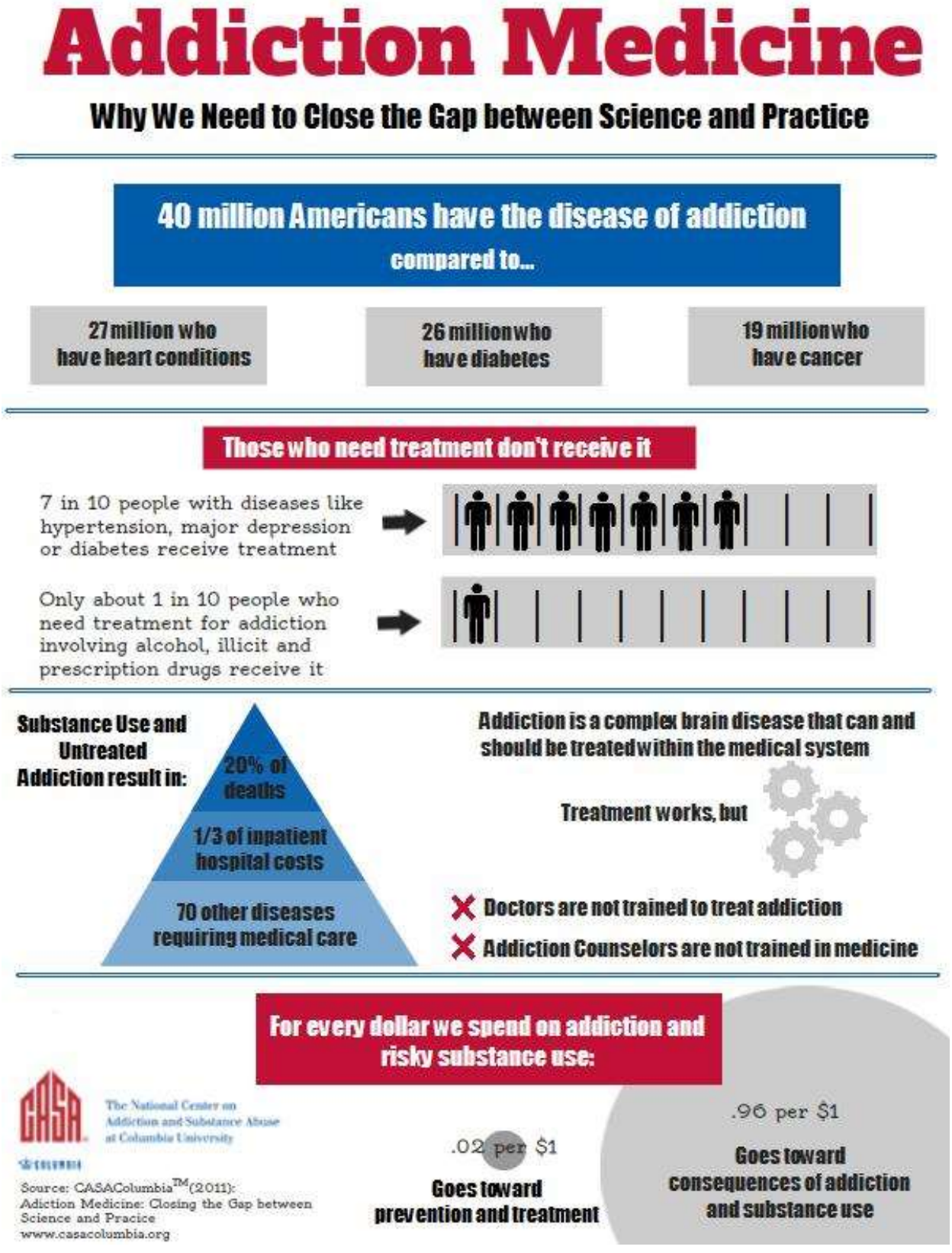
Further Director Botticelli shared, "The consequences have been painfully clear. In 2013, one American died every 12 minutes from an overdose, most involving opioids, which include prescription pain medicines and heroin. A substance use disorder is a chronic disease that can be prevented and treated, and from which recovery is possible."

Nora Volkow, Director of the National Institute on Drug Abuse stated, "In all my years as a physician I have never, ever met an addicted person who wanted to be an addict." And she made it clear that in her opinion, "If we embrace the concept of addiction as a chronic disease where drugs have disrupted the most fundamental circuits, that enable us to do something that we take for granted—make a decision and follow it through—we will be able to decrease the stigma, not just in the lay public, but in the health care system, among providers and insurers. So that patients with mental illness do not have to go through obstacles to obtain the evidence-based treatments, so that they don't have to feel that shame, they don't have to feel inferior, and perhaps we will be able to feel empathy for a patient suffering from a disease we call addiction."[6]

The Ulster Coalition Against Narcotics (UCAN), formed by passage of Resolution 371 in October, 2014 was created to, "… study ways in which to identify how individuals can be helped, identify other ways to prevent abuse, and identify ways in which to protect the public from opiate drug abuse in Ulster County …" We have embraced this charge and desire to offer hope and a path toward recovery for those suffering with the disease of Substance Use Disorder. After many months of meetings, discussions and deliberations, we offer you this report containing 12 recommendations for your consideration, and, we hope, action.

As ONDCP Director Botticelli stated, "We can't afford to wait."

[4] http://news.harvard.edu/gazette/story/2015/05/opioid-abuse-a-main-street-scourge/
[5] MA.Gov recommendations of the Governor's opioid working group
[6] http://www.drugabuse.gov/about-nida/noras-blog/2015/06/addiction-disease-free-will


Addiction Medicine
Why We Need to Close the Gap between Science and Practice
40 million Americans have the disease of addiction
compared to...
27 million who have heart conditions
26 million who have diabetes
19 million who have cancer
Those who need treatment don't receive it
7 in 10 people with diseases like hypertension, major depression or diabetes receive treatment
Only about 1 in 10 people who need treatment for addiction involving alcohol, illicit and prescription drugs receive it
Substance Use and Untreated Addiction result in:
20% of deaths
1/3 of inpatient hospital costs
70 other diseases requiring medical care
Addiction is a complex brain disease that can and should be treated within the medical system
Treatment works, but
Doctors are not trained to treat addiction
Addiction Counselors are not trained in medicine
For every dollar we spend on addiction and risky substance use:
.02 per $1
Goes toward prevention and treatment
.96 per $1
Goes toward consequences of addiction and substance use
The National Center on Addiction and Substance Abuse at Columbia University
Source: CASAColumbia™(2011): Adiction Medicine: Closing the Gap between Science and Pracice
www.casacolumbia.org

UCAN MISSION STATEMENT

TO HELP AND PROTECT THE PUBLIC FROM HARMFUL EFFECTS OF OPIOIDS, WHETHER MEDICATION OR ILLICIT, BY STUDYING HOW TO DEVELOP OR IMPROVE APPROACHES TO PUBLIC EDUCATION, PREVENTION AND USAGE REMEDIATION AND PRESENTING ITS FINDINGS TO THE ULSTER COUNTY LEGISLATURE FOR FURTHER ACTION.

ADOPTED BY UNANIMOUS VOTE OF UCAN MEMBERS AT THE MARCH 18, 2015 MEETING.

FILED WITH THE CLERK OF THE ULSTER COUNTY LEGISLATURE ON MARCH 19, 2015.

SECURE, SAFE, SOBER HOUSING

UCAN recognizes that secure, safe, sober housing on the continuum of care is a critical part of recovery for many struggling with Substance Use Disorder (SUD.) Sober homes offer SUD sufferers a place free from their daily triggers and promote an environment of healing.

Unfortunately, in New York only state funded homes are regulated; leaving many of these alleged safe havens unregulated and unsafe. Many recovery homes are purely money driven and, indeed, dangerous for the vulnerable individuals within. Failing a drug screen is not grounds for immediate eviction in state regulated homes. Regrettably, lives have been lost because of such actions in unregulated sober homes.

The magnitude of this issue was documented in a May 30, 2015 NY Times story titled "A Choice for Recovering Addicts: Relapse or Homelessness - Virtually unnoticed and effectively unregulated, a system of housing known as "three-quarter" homes profits off the poor and desperate in New York City." [1]

The report highlighted, "Three-quarter houses, also known as "sober" or "transitional" homes, have multiplied in the past decade, catering to poor people in treatment for substance and alcohol abuse, homeless people desperate to avoid shelters, and mentally ill people with nowhere else to go. For a bunk bed, operators usually charge residents either the monthly $215 housing allowance for people on public assistance, or about $300 a month for people on disability.

Tenants are crammed into bedrooms, as many as eight to a room. The ramshackle homes are often infested with bedbugs and rodents. Bunk beds block exits. Because they are not regulated, they are often centers of the very kind of drug activity they purport to avoid."

After The Times published its investigation on May 30, 2015 the city formed an emergency task force, inspected 64 of the homes and moved out more than 200 tenants in overcrowded homes, mainly to hotels. The task force is now working on helping those tenants find permanent housing.

Three-quarter houses filled a housing gap for people leaving prison or inpatient treatment programs. Without an increase in the state-set housing allowance or a tightening of regulations for these houses, advocates worry that the underground industry will continue.

In Suffolk County, N.Y. a pilot program is underway implementing standards of safety in sober/recovery homes. Suffolk County Legislator Kate Browning, who chairs the Sober

[1] http://www.nytimes.com/2015/05/31/nyregion/three-quarter-housing-a-choice-for-recovering-addicts-or-homelessness.html?_r=0

SECURE, SAFE, SOBER HOUSING
(CONTINUED)

Home Oversight Board, which has been tasked with overseeing the pilot program, says that rampant heroin use has further decayed an already lacking housing system. "Unregulated homes have become a plague on our community. People cannot find safe options where they can get clean, leading to tragic consequences," Browning said.

Without regulation, Browning says such houses have become increasingly unsafe, at best continuing a cycle of addiction and at worst directly leading to dire medical consequences, such as the heroin overdose of one of her constituents in an unregulated property.

The Suffolk County pilot program, which is administered in partnership with the state Office for Alcoholism and Substance Abuse Services (OASAS), provides significantly increased funding for each tenant: a flat $995.70 for each of the 45 individuals currently enrolled in the program, as opposed to the $475 room and board entitlement available to the county's Department of Social Services clients outside of the program.

Similar legislative action was taken in Massachusetts and Florida in 2015, also to specifically address regulation and safety of sober homes.[2]

Therefore, it is the recommendation of UCAN that the Ulster County Legislature adopt a resolution calling upon New York State to immediately enact standards of care for sober homes and/or recovery residences or to empower counties to take action through Local Law.

There being no state or local standards at the present time, UCAN further recommends that the Ulster County Legislature adopt a policy establishing a standards based certification process for any sober home operating within Ulster County.

[2] MA Governors recommendation of the opioid working group, THE FLORIDA SENATE 2015 SUMMARY OF LEGISLATION PASSED Committee on Children, Families, And Elder Affairs

OMBUDSMAN

Through numerous testimonials UCAN has found that many individuals suffering from Substance Abuse Disorder (SUD) as well as their families have been unsuccessful in finding treatment options and navigating complicated insurance regulations and requirements. Unfortunately, delays in obtaining necessary care can, and has, lead to lives lost and families devastated.

Determining treatment needs is further exacerbated by the varying level of addiction of each person with SUD, the existence of co-occurring disorders, lack of insurance, unwillingness of insurer to cover cost for treatment, uncertainty of the presence of SUD, fear, quality and availability of treatment, and more. Ulster County currently lacks a dedicated system to expedite access to care and to ensure support to those with SUD and their families seeking information within Ulster County.

The New York State Office Alcohol and Substance Abuse Services (OASAS) has implemented the HOPE hotline for support with alcoholism, drug abuse and problem gambling. HOPEline services include connection to masters level clinicians who are professional, well-trained and knowledgeable, crisis and motivational interviewing for callers in need, referrals to more than 1,500 local prevention and treatment providers, 48 hours call back to those who wish to be contacted, Multi-lingual services, and informational materials.

While the HOPEline is a wonderful resource, it is not local and does not account for the County's local supportive services that may be readily available. An Ulster County ombudsman could act as an "ear to the ground" for needs within the recovery community, as a conduit among recovery organizations and the community at large. The Ulster County SUD ombudsman would require knowledge of SUD and its treatment and recovery paths in evidenced based treatment and would liaison with NYS OASAS, Substance Abuse and Mental Health Services Administration (SAMHSA), NYS Attorney General's office, and neighboring counties.

A dedicated SUD ombudsman will also help to increase points of entry to treatment, eliminating the need for individuals to access other levels of care only through acute treatment services (ATS) and clinical stabilization services (CSS.) This strategy was one of the recommendations of the Massachusetts' "Governor's Opioid Working Group" issued in June, 2015.[1] This recommendation included funding for patient navigators and case managers to ensure a continuum of care and provide a mechanism to manage capacity more efficiently and be able to better meet the demand for treatment.

[1] http://www.mass.gov/eohhs/images/dph/stop-addiction/recommendations-of-the-governors-opioid-working-group.pdf

OMBUDSMAN (CONTINUED)

As for treatment coverage parity, it is still common to see insurance companies ignore or try to avoid honoring it. NY State Attorney General Eric Schneiderman said, "Mental health and addiction recovery treatments must be regarded the same as other health insurance claims." He continued by saying, "We will continue to take on those who ignore the law and reinforce the false and painful stigma often associated with these ailments." An Ulster County SUD ombudsman, with the support of the Ulster County government, could act as an advocate on behalf on individuals for insurance equality and partner with Attorney General Schneiderman to ensure compliance with coverage rules and regulations.

U
C
A
N

Therefore, it is the recommendation of UCAN that the Ulster County Legislature support the assignment of an ombudsman tasked with providing guidance on how to obtain alcohol and substance abuse treatment, assistance with navigating insurance regulations and requirements, and build community awareness. UCAN further recommends that this service be widely advertised to the general public and made known to medical and mental health services professionals.

MEDICATION DROP BOXES

UCAN has found that unused portions of prescription medications pose a serious health and safety risk to individuals and families, especially school aged youth.

→ Over 50% of prescription drug abusers got them from family or friends.[1]

→ Over 67% of 12th graders who abused prescription narcotics, such as Vicodin® or OxyContin®, were given the drugs by a friend or relative. [2]

→ 22% of 12th graders who abused prescription narcotics took the drugs from a friend or relative without asking. [3]

→ In 2013, 6.5 million people aged 12 and older used prescription drugs non-medically.[4]

→ The number of emergency department visits due to medication poisoning for children under age five increased 30% from 2001 to 2008, and child self-exposure to prescription products accounted for 55% of the emergency room visits.[5]

→ Abuse of prescription pain medications is leading to an increase in opiate overdoses, but in the past opiate overdoses were most often due to heroin use. Abuse of prescription pain pills is a growing problem with a growing number of fatalities.[6]

→ In 2011, nonmedical use of prescription drugs among youth and young adults ages 12 - 25 was the second most prevalent illicit drug use category, with marijuana being first.[7]

→ CASAColumbia reports that allowing pharmacies to take back drugs is an important step in curbing prescription drug abuse, particularly among teens. Most teens who abuse prescription drugs get them from their own home, or the home of a friend. This has made restricting teen access to prescription drugs especially difficult.[8]

---

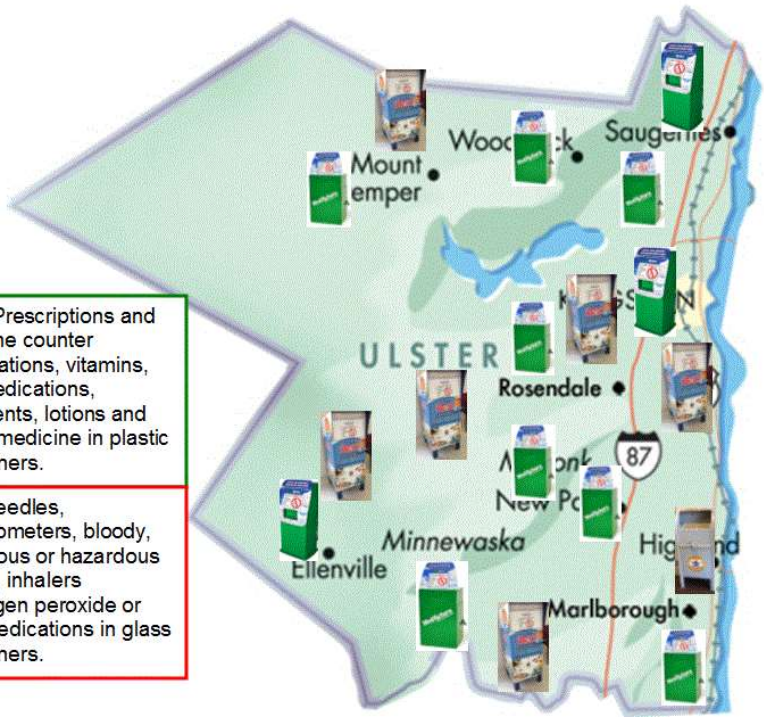
[1] 2012 National Survey on Drug Use and Health: Summary of National Findings, Substance Abuse and Mental Health Services Administration (September 2013)
[2] "Monitoring the Future National Survey Results On Drug Use, 1975–2012" National Institute on Drug Abuse
[3] "Monitoring the Future National Survey Results On Drug Use, 1975–2012" National Institute on Drug Abuse
[4] 2013 National Survey on Drug Use and Health: Summary of National Findings, Substance Abuse and Mental Health Services Administration (September 2014)
[5] "The Growing Impact of Pediatric Pharmaceutical Poisoning," The Journal of Pediatrics, (February 2011)
[6] "Epidemic: Responding to America's Prescription Drug Abuse Crisis" (PDF), Office of National Drug Control Policy, April 2011
[7] http://combatheroin.ny.gov/sites/default/files/resources/1004_MedicineCabinetSafe_factsheet_final_2014.pdf
[8] http://www.casacolumbia.org/the-buzz-blog/drug-enforcement-administration-finally-allows-pharmacies-take-back-drugs

MEDICATION DROP BOXES (CONTINUED)

Until recently, a person who wanted to responsibly dispose of unused prescriptions had few options: pharmacies could not take them, law enforcement officers could not take them and flushing them down the toilet is hazardous to wildlife and the environment. The only viable opportunity came twice a year at DEA prescription take-back programs.

The Secure and Responsible Drug Disposal Act of 2010, which US Senator Charles Schumer cosponsored, required the Drug Enforcement Agency (DEA) to establish regulations that would allow pharmacies and community organizations the opportunity to become authorized collectors of left-over prescription drugs. Last year the DEA finalized those rules, allowing a pharmacy to register with the DEA and put a drop box at their facility for people to dispose of old prescriptions.

Ulster County Permanent Medication Disposal Boxes



Yes: Prescriptions and over the counter medications, vitamins, pet medications, ointments, lotions and liquid medicine in plastic containers.

No: Needles, thermometers, bloody, infectious or hazardous waste, inhalers hydrogen peroxide or any medications in glass containers.

DISPOSAL LOCATIONS

In 2014 the Resource Recovery Agency, in cooperation with the Ulster County Sheriff's Office and the New York State Department of Health provided prescription medication disposal drop boxes at the Resource Recovery Agency, the County Law Enforcement Center in Kingston, the Ulster County Community College, the four substations of the County Sheriff's Office and at local Police Departments.

UCAN

Therefore, it is the recommendation of UCAN that the Ulster County Legislature establish a policy to provide safe and convenient containers for the residents of Ulster County to dispose of unused prescribed medications in cooperation with the Department of Health and local pharmacies.

METHADONE MAINTENANCE

UCAN has identified insufficient availability of the Ulster County Methadone Maintenance treatment program as a substantial obstacle to providing county residents suffering from opioid specific Substance Use Disorder (SUD) with opportunities to achieve recovery. A plan to address this unmet need for Methadone and addiction support within the county is needed.

As reported by the Ulster County Health Department to the NYS Office of Alcohol and Substance Abuse Services (OASAS), NYS Office of Mental Health (OMH), and the NYS Office for People with Developmental Disabilities (OPWDD), "In substance use arena all providers report an increase in opiate addiction and an increase in utilization of out patient Substance Use services. Ulster County also has a waiting list for methadone and suboxone services."[1]

In the same report the Ulster County Department of health identified the following as service needs and gaps, "Ulster County has no outpatient detox services and additional methadone maintenance slots and suboxone providers are needed. There is limited licensed sober housing available." Further, the department stated that, "Substance abuse and other risk indicators in Ulster County are generally higher than comparable counties in NY State."

An overview of 5 meta-analyses and systematic reviews, summarizing results from 52 studies and 12,075 opioid-dependent participants, found that when methadone maintenance treatment was compared with methadone detoxification treatment, no treatment, different dosages of methadone, buprenorphine maintenance treatment, heroin maintenance treatment, and L-aacetylmethadol (LAAM) maintenance treatment, methadone maintenance treatment was more effective than detoxification, no treatment, buprenorphine, LAAM, and heroin plus methadone.[2]

Designated Methadone treatment locations in Ulster County should develop a plan to readily adjust to the number of patients in need ("on demand") and to ensure that those within Ulster County requesting Methadone Treatment are not turned away or wait-listed. To continuously evaluate treatment availability, the Health Department should acquire timely statistics on the number of people in treatment and those people waiting for treatment due to a shortage of access.

Additionally, an expansion of services must be evaluated. Individuals with SUD often suffer from other mental health disorders. An increased level of screening for co-occurring mental health issues should be conducted during methadone maintenance treatments. Mental health

[1] http://www.clmhd.org/img/pdfs/brochure_mii48drjzi.pdf
[2] Amato, Davoli, Perucci, et al., 2005, http://www.drugabuse.gov/sites/default/files/pdf/partb.pdf

METHADONE MAINTENANCE (CONTINUED)

counseling, referrals for continued care, coordination with County Health Department and local detox should all be considered before an individual is wait listed or turned away. Naloxone, or NARCAN kits should be distributed and/or made available to patients who are wait listed and information about the Good Samaritan law should be provided.

The following is excerpted from "Methadone Maintenance Treatment (MMT): A Review of Historical and Clinical Issues" published in The Mount Sinai Journal of Medicine, October/November 2000:
"The Institute Of Medicine and the National Institutes of Health have reviewed the issues surrounding Methadone Maintenance Treatment. The agencies have concluded that opiate addiction is a medical disorder and that methadone maintenance with relevant ancillary services is the most effective treatment for opiate addiction. Both agencies stressed the need to expand the program to treat the hundreds of thousands of untreated heroin users nationwide. To increase accessibility to treatment, both agencies recommend the expansion of methadone maintenance, the training of more health personnel, the easing of regulations on federal, state and local levels to permit the opening of new programs, and the development of new models of treatment. However, effective medical and political leadership is necessary to reduce the social stigma surrounding addiction and methadone treatment in order to effectively implement these changes."[3]

UCAN

Therefore, it is the recommendation of UCAN that the Ulster County Legislature adopt a policy calling for Methadone treatment services conducted through the Ulster County Department of Health be expanded to 7 days per week.

UCAN further recommends that the County Legislature call upon the Ulster County Department of Health to evaluate possible actions that will expand the Methadone Maintenance treatment program and reduce the number of patients on the Methadone treatment wait list, including the promotion of outpatient services in private medical practices for lower risk qualifying individuals.

[3] HERMAN JOSEPH, PH.D.1, SHARON STANCLIFF, M.D.2, AND JOHN LANGROD, PH.D.3
https://www.drugpolicy.org/docUploads/meth347.pdf

HARM REDUCTION

UCAN understands that responding to the Heroin/Opioid epidemic that is plaguing the county, state and nation will require a multi-faceted approach. Of the programs offered and multitude of research conducted and shared, the concept of harm reduction has been repeated and emphasized.

According to the National Institute of Health, "Drug use is a public health problem associated with high mortality and morbidity, and is often accompanied by suboptimal engagement in health care. Harm reduction is a pragmatic public health approach encompassing all goals of public health: improving health, social well-being and quality of life. Harm reduction prioritizes improving the lives of people who use drugs in partnership with those served without a narrow focus on abstinence from drugs. Evidence has shown that harm reduction oriented practice can reduce transmission of blood-borne illnesses, and other injection related infections as well as preventing fatal overdose."[1]

Michael Botticelli, Director of the White House Office of National Drug Control Policy (ONDCP), while a panelist at the Harvard TH Chan Public School of Health stated, "Approximately 18 billion opioid pills were dispensed in 2012 … enough to give everyone in the US over 18,075 pills." Regrettably the problem doesn't stop there. He continued, "Four out of five heroin users who started recently started with prescription pain pills … The ripple effects include new cases of HIV, AIDS, and hepatitis C."

"Needle-exchange programs are effective tools to fight the spread of infectious disease and steer heroin users into treatment" according to Michael Botticelli. "They've been demonstrated to reduce not only infectious disease but also create an opportunity for people to get care and provide a transition into treatment for people in the community," he said. "The programs also reduce the risk that law enforcement officers will become infected if they are accidentally stuck by a needle", he added.

Locally, Hudson Valley Community Services, Inc., headquartered in Westchester County, provides comprehensive harm reduction services. As HVCS Executive Director Andrea Straus stated in their 2015 Annual Report, "We're committed to connecting any Hudson Valley resident with or at high risk for chronic disease to the healthcare and support services they need to have a better quality of life. Though our slate of service areas grows, we're committed to helping end HIV/AIDS in our region, too. It's a daunting task, but if we work together as a team—all of us—we can accomplish great things."[2]

[1] http://www.tandfonline.com/doi/abs/10.1080/10550887.2015.1059651
[2] http://www.hudsonvalleycs.org/wp-content/uploads/2013/10/HVCS_AnnualReport2015.pdf

HARM REDUCTION (CONTINUED)

"Several studies have found that needle exchanges dramatically cut the rate of HIV transmission among injection drug users without increasing the rate of illegal drug use", said William Schaffner, an infectious disease expert at the Vanderbilt University School of Medicine in Nashville. He continued, "Needle exchanges also give public health workers a chance to educate drug users and provide other health services. That's important because people addicted to drugs may not get medical care."[3]

In New York in 1992, 52% of newly diagnosed AIDS patients were injection drug users. Ten years later, after the implementation of needle-exchange programs, only 3% of new HIV cases were injection drug users, according to the New York State Department of Health AIDS Institute.

One of the fastest-spreading recorded US outbreaks of HIV since the inception of the epidemic is now occurring in southeastern Indiana, and it is being driven by injection drug use, specifically, abuse of the opioid painkiller Opana (oxymorphone). Sadly, this outbreak was preventable, given all that we know about HIV and its links to opioid addiction, yet adequate treatment resources and public health safeguards were not in place.

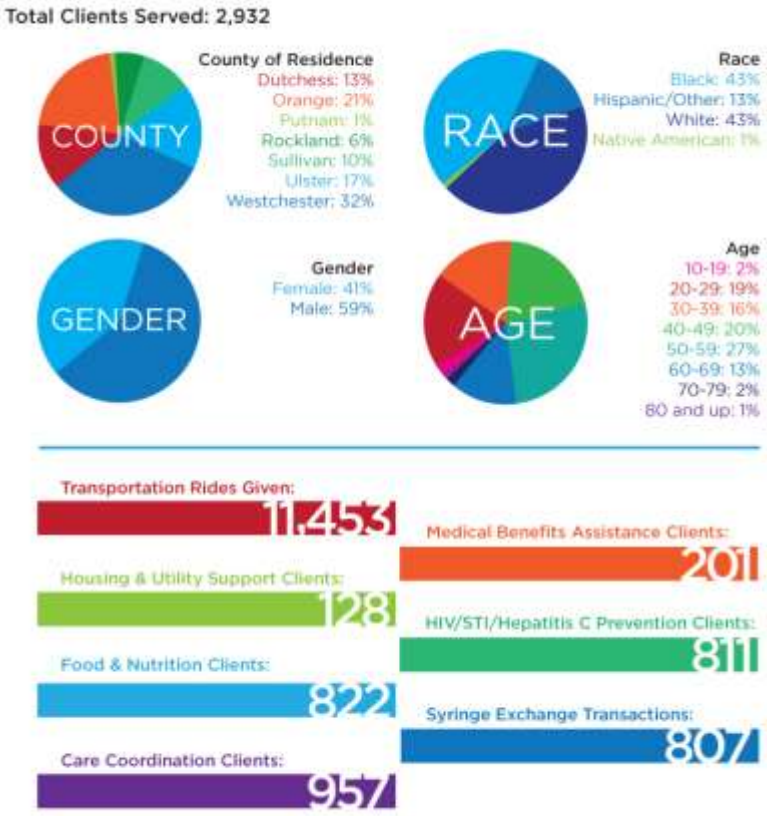
The Indiana HIV outbreak should be a wake-up call that we cannot become complacent about HIV. Even though effective antiretroviral treatments have greatly reduced the morbidity and mortality from the disease and trials for an HIV vaccine are underway, addicted populations, who are often hard to reach with treatment and other interventions, continue to be vulnerable because of stigma and lack of healthcare resources, thus enabling the virus to spread. We must redouble our efforts to address the underlying problems of opioid abuse for all Americans so that we can shut the door on HIV, once and for all.

The Center of Disease Control (CDC) reports that substance use, abuse, and dependence has been closely associated with HIV infection since the beginning of the epidemic. Although injection drug use (IDU) is a direct route of transmission, drinking, smoking, ingesting, or inhaling drugs such as alcohol, crack cocaine, methamphetamine ("meth"), and amyl nitrite ("poppers") are also associated with increased risk for HIV infection. These substances may increase HIV risk by reducing users' inhibitions to engage in risky sexual behavior. Substance use and addiction are public health concerns for many reasons. In addition to increasing the risk of HIV transmission, substance use can affect people's overall health and make them more susceptible to HIV infection and, in those already infected with HIV, substance use can hasten disease progression and negatively affect adherence to treatment.[4]

[3] http://www.usatoday.com/story/news/2015/05/07/drug-use-increases-hepatitis/70907318/
[4] http://www.cdc.gov/hiv/riskbehaviors/substanceuese.html

HARM REDUCTION (CONTINUED)

Similar to Substance Use Disorder (SUD), injection drug use is often viewed as a criminal activity rather than a medical issue that requires counseling and rehabilitation. Stigma related to drug use may prevent people who inject drugs (PWID) from seeking HIV testing, care, and treatment. Studies have shown that PWID treated for substance abuse are more likely to start and remain in HIV medical care, adopt safer behaviors, and take their HIV medications correctly than those not receiving such treatment.



HUDSON VALLEY COMMUNITY SERVICES, INC

Hudson Valley Community Services, Inc. currently provide valuable Harm Reduction services to some of Ulster County's most vulnerable residents.

[5]

UCAN

Therefore, it is the recommendation of UCAN that the Ulster County Legislature aggressively support and promote the activities of Hudson Valley Community Services, Inc. in Ulster County and the myriad harm reduction services they provide.

[5] http://www.hudsonvalleycs.org/wp-content/uploads/2013/10/HVCS_AnnualReport2015.pdf

SUD TREATMENT PILOT

UCAN acknowledges that many individuals incarcerated in County jails and state prisons suffer from Substance Use Disorder (SUD). While Medication Assisted Treatments (MATs) are widely regarded as the most effective treatment method for SUD, it is overwhelmingly absent in today's prison system.

According to CASAColumbia, "Overdose death rates from opioid drugs have increased significantly over the past 14 years, largely due to tremendous increases in the prescribing and consequent availability of addictive painkillers. Certain populations, especially individuals involved in the criminal justice system, are particularly vulnerable to overdose. In fact, one study found that drug overdose was the leading cause of death for those who left prison and rejoined their community."[1]

The criminal justice system is a prime target for any serious effort to address addiction in our communities. 70% of prisoners tested in New York upon arrest were positive for drugs, about 10% of those were for heroin. Treatment in most places is merely forced detox, and generally not medication-assisted. The medication generally controls any physical dependence issues, and allows the patient to engage in recovery activity. Without treatment during incarceration, even with referral to treatment upon discharge, the people reentering society have up to 79% recidivism rate at 3 years, as opposed to 31% in those treated. Treatment while incarcerated also has been shown to lead to follow-up in outpatient treatment.

A 2013 Huffington Post article reported that the Kentucky drug courts' promotion of abstinence-based treatment was associated with many overdose deaths in Northern Kentucky that took place shortly after those with opioid addiction left jail or participated in the state's abstinence-based treatment plan. Fortunately, two law firms have collaboratively taken emergency action against the state of Kentucky on behalf of Stephanie Watson, a woman involved in the justice system, who is forbidden from taking any medication prescribed by her doctor to treat her opioid addiction at the risk of having her bond revoked and being sent to jail. The lawsuit questions the court's ability to impede on doctor-patient relationships and prohibit medical care. It also argues that the ban on medication to treat opioid addiction for those involved in the criminal justice system is unconstitutional and violates the Americans with Disabilities Act, as well as the Rehabilitation Act of 1973.

The lawsuit is not seeking any financial compensation, aside from court and attorney costs. Instead, it seeks to require Kentucky to allow people like Watson and others in the criminal justice system to receive medical treatment for a disease, in this case opioid addiction.

[1] http://www.casacolumbia.org/the-buzz-blog/treating-opioid-addiction-criminal-justice-system

SUD TREATMENT PILOT (CONTINUED)

Federal mandates have recently prohibited drug courts that receive federal assistance from refusing medication-assisted treatment for justice-involved individuals with addiction. States that continue this practice may be at risk of being denied federal funding. This push has caused Kentucky, whose drug courts receive a substantial amount of federal grants, to rethink their position on medication-assisted drug treatment for justice-involved individuals, although a definitive reversal of policy has yet to be made.

Another promising step is the introduction of the Comprehensive Addiction Recovery Act of 2015.[2] This is a federal initiative that attempts to address the addiction treatment gap in criminal justice settings. It does so by allowing the federal government to provide grants to state and local governments to encourage them to provide medication-assisted treatment for opioid addiction.

The second-largest area of federal and state spending on the consequences of addiction and risky use is costs linked to adult and juvenile corrections and the courts. 85% of all inmates in the adult corrections system are substance involved and 65% of inmates (nearly 1.5 million) have addiction involving alcohol or drugs other than nicotine. By the time young people enter the juvenile justice system, 78% are substance involved, and 44% meet clinical criteria for addiction involving alcohol and drugs other than nicotine.[3]

It is estimated that about one-half of State and Federal prisoners abuse or are addicted to drugs, but relatively few receive treatment while incarcerated. Initiating drug abuse treatment in prison and continuing it upon release is vital to both individual recovery and to public health and safety. Various studies have shown that combining prison- and community-based treatment for addicted offenders reduces the risk of both recidivism to drug-related criminal behavior and relapse to drug use—which, in turn, nets huge savings in societal costs.

A 2009 study in Baltimore, Maryland, for example, found that opioid-addicted prisoners who started methadone treatment (along with counseling) in prison and then continued it after release had better outcomes (reduced drug use and criminal activity) than those who only received counseling while in prison or those who only started methadone treatment after their release.

UCAN supports the conclusion of Sarah E. Wakeman MD & Josiah D. Rich MD, MPH, "Treatment, particularly pharmacotherapy for opioid use disorders, saves lives, reduces crime, and is cost-effective. Nationally, there is a clear evidence base for pre-release pharmacotherapy with linkage to community treatments. Internationally, there is experience,

[2] https://www.govtrack.us/congress/bills/114/s524
[3] http://www.casacolumbia.org/the-buzz-blog/treating-opioid-addiction-criminal-justice-system

SUD TREATMENT PILOT (CONTINUED)

evidence, and precedent for maintenance treatment within corrections. Incarceration should be utilized as an opportunity for engagement, treatment initiation, and linkage to care. Just as important is reexamining our policies on drug use and addiction. Drug courts offer a promising opportunity to shift from incarceration to treatment. However, stigma and misunderstanding about the evidence-base for agonist maintenance treatments is of tremendous concern as are the implications of judges and other drug court officials making medical decisions without the training or expertise to do so."[4]

Therefore, it is the recommendation of UCAN that the Ulster County Legislature, in cooperation with the Ulster County Sheriff, establish a Substance Use Disorder treatment pilot program, including entrance screening and Medication Assisted Treatments (MATs), at the Ulster County Jail for the treatment of incarcerated individuals.

[4] Sarah E. Wakeman MD & Josiah D. Rich MD, MPH (2015): Addiction Treatment within U.S. Correctional Facilities: Bridging the Gap between Current Practice and Evidence-based Care, Journal of Addictive Diseases, DOI: 10.1080/10550887.2015.1059217, http://dx.doi.org/10.1080/10550887.2015.1059217

DRUG COURT

UCAN supports the National Association of Drug Court Professionals (NADCP) and the White House Office of National Drug Control Policy (ONDCP) in their opinion of the importance of a well-run Drug Court and its effectiveness in reducing recidivism.

The criminal justice system can refer drug offenders into treatment through a variety of mechanisms, such as diverting nonviolent offenders to treatment; stipulating treatment as a condition of incarceration, probation, or pretrial release; and convening specialized courts, or drug courts, that handle drug offense cases. These courts mandate and arrange for treatment as an alternative to incarceration, actively monitor progress in treatment, and arrange for other services for drug-involved offenders.

According to the NADCP, in 20 years since the first Drug Court was founded, there has been more research published on the effects of Drug Courts than on virtually all other criminal justice programs combined. The scientific community has put Drug Courts under a microscope and concluded that Drug Courts work. Better than jail or prison. Better than probation and treatment alone. Drug Courts significantly reduce drug use and crime and are more cost-effective than any other proven criminal justice strategy.[1]

Drug court programs have a tangible effect on criminal recidivism. A study funded by the Department of Justice examined re-arrest rates for drug court graduates and found that nationally 84 percent of drug court graduates have not been re-arrested and charged with a serious crime in the first year after graduation, and 72.5 percent have no arrests at the two year mark.

→ The most rigorous and conservative scientific "meta-analyses" have all concluded that Drug Courts significantly reduce crime as much as 45 percent more than other sentencing options.

→ Nationwide, for every $1 invested in Drug Court, taxpayers save as much as $3.36 in avoided criminal justice costs alone. When considering other cost offsets such as savings from reduced victimization and healthcare service utilization, studies have shown benefits range up to $27 for every $1 invested.

→ Drug Courts are six times more likely to keep offenders in treatment long enough for them to get better.

[1] http://www.nadcp.org/learn/do-drug-courts-work

DRUG COURT (CONTINUED)

→ Children of Family Drug Court participants spend significantly less time in out-of-home placements such as foster care, and family re-unification rates are 50% higher for Family Drug Court participants.[2]

Ulster County's Drug Court system has the potential to be a leader in the utilization of alternatives to incarceration. With support from other services in the County such as reintegration services, job training, housing, treatment within the system, and Medication Assisted Treatments (MATs) made available through medical direction, Ulster County can be a model for other counties in New York State to follow.

Therefore, it is the recommendation of UCAN that the Ulster County Legislature commission a review of its Drug Court system by an independent professional, such as NADCP, to evaluate the court for utilization, efficiency and effectiveness.

UCAN further recommends that the County Legislature establish a policy requiring timely data collection and analysis to assist in ongoing evaluation.

[2] http://www.nadcp.org/learn/do-drug-courts-work

NARCAN DISTRIBUTION

UCAN believes that saving lives of individuals suffering from substance abuse disorder will be best achieved through treatment and recovery. Unfortunately, lives are being lost every day due to Heroin and Opioid overdoses.

Naloxone is a medication that temporarily reverses an Opioid based drug overdose by allowing a person to start breathing again on his or her own. It can be delivered via a nasal spray or injection. Naloxone, distributed commonly as NARCAN, is simply administered, safe and extremely effective. It is not a drug that can be abused. Teaching people how to respond to an overdose is straightforward and can be taught quickly.

The clear benefits of the anti-overdose drug Naloxone are well documented nationally, in New York State and here in Ulster County. Already numerous lives have been saved with NARCAN by Ulster County Sheriff's Deputies, local Law Enforcement Officers and fire and EMS personnel. Directly arming those individuals at high risk with Naloxone will further decrease the number of deaths due to opioid intoxication and increase the odds of survival of an overdose.

Incarcerated individuals with substance abuse disorder are arguably at the highest risk for overdose upon release from jail/prison. Withdrawal from opioids leads to lower tolerance and a greatly increased risk of post release overdose death, particularly in the first two weeks after incarceration. Assessing prisoners on exit from the system, and providing them with a NARCAN kit may have the effect of modifying any future use, and/or saving the life of the released prisoner or someone he or she comes in contact with.

New York State has launched an exciting pilot program at New York City's Queensboro Correctional Facility, in which all individuals being released will be offered a NARCAN kit and given training in overdose recognition and response. Expansion of this pilot throughout the State's prison system is anticipated.

This new initiative builds on groundbreaking work that has been happening in a few other parts of the country, including in San Francisco and Rhode Island. The Harm Reduction Coalition's DOPE (Drug Overdose Prevention and Education) Project has been part of the work in San Francisco and Rhode Island and, more recently, a program funded by the New York City Department of Health and Mental Hygiene in which family members and others visiting inmates at Rikers Island are given a similar training along with NARCAN.

The first training took place at the Queensboro facility on February 5, 2015. "The first training was very moving" says Harm Reduction Coalition's Medical Director, Sharon Stancliff. Inmates shared stories of overdoses among people close to them and deepened their understanding of the risks of overdose in reentering the community.

NARCAN DISTRIBUTION (CONTINUED)

When told of this initiative, formerly incarcerated and ex-heroin user Brian Thompson said, "I have experienced first-hand friends dying from drug overdoses upon release from custody. With the lack of effective drug treatment programs in prisons, naloxone overdose training makes perfect sense. In one brief minute, untold agony and misery for family and friends suffering the loss of a loved one can be avoided."

As well as the Harm Reduction Coalition, the collaboration behind this pilot includes the New York State Department of Corrections and Community Supervision (DOCCS) and the New York State Department of Health (NYSDOH). Both State agencies have enthusiastically embraced the pilot and have moved with impressive speed and creativity.

In a press release issued by the State, Dr. Carl Koenigsmann, Deputy Commissioner and Chief Medical Officer at the Division of Corrections and Community Supervision (DOCCS) said, "DOCCS is committed to maintaining the health and safety of those in our custody and helping those leaving our custody help themselves and others. This project, in conjunction with New York State Department of Health and the Harm Reduction Coalition, will enable us to reach people who desperately need help."

Dr. Howard Zucker, Acting New York State Health Commissioner said, "Drug overdoses are one of the greatest threats facing the health and well-being of individuals recently released from prison. Through this groundbreaking training pilot, these individuals will have the knowledge and skills necessary to not only protect themselves, but to save the lives of others when they come home."

U
C
A
N

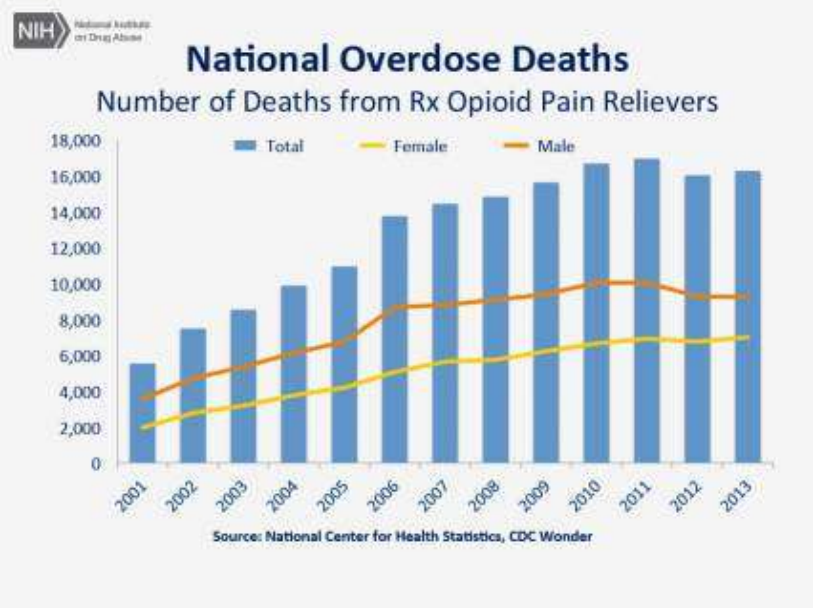
Therefore, it is the recommendation of UCAN that the Ulster County Legislature support funding in the Ulster County Sheriff's 2016 Budget to provide for the distribution of NARCAN kits to individuals identified as at risk for post release Heroin/Opioid use.

Should the Legislature decide against funding the distribution of NARCAN kits, UCAN recommends that, at a minimum, inmates be provided information on how to obtain a kit and training.

NARCAN DISTRIBUTION

Death due to overdose is not limited to Heroin or illegal Opioids. Far too many overdose deaths are the result of the use, and not necessarily abuse, of Opioid based prescription pain medication.

A lot of the work has been done to limit the potential abuse of prescription drugs with the implementation of I-STOP, which, among other things, changed hydrocodone from a Schedule 3 medication allowing for refills to a Schedule 2 medication that does not. This is now being adopted on the federal level. Additionally, the Prescription Monitoring Program (PMP) has made it difficult for individuals to use multiple doctors, although it has not necessarily reduced the size of prescriptions dispensed. The mandatory reporting of medications dispensed by pharmacists within 24 hours, as well as the mandate that prescribers check the PMP, has focused attention on the issue.



National Overdose Deaths—Number of Deaths from Rx Opioid Pain Relievers. The figure above is a bar chart showing the total number of US overdose deaths involving opioid pain relievers from 2001 to 2013. The chart is overlayed by a line graph showing the number of deaths by females and males. From 2001 to 2013 there was a 3-fold increase in the total number of deaths. Rx Opioid Pain Relievers include: other opioids, methadone, and other synthetic narcotics.

As previously stated in this report, Naloxone is a medication which has the ability to immediately reverse a life-threatening opioid overdose. Most commonly distributed as NARCAN, it has been used to save multiple lives in Ulster County and hundreds more across the state and nation.

NARCAN DISTRIBUTION (CONTINUED)

In Rhode Island there is a collaboration between pharmacists and physicians to allow pharmacists to distribute naloxone kits to anyone who is at risk, or even anyone who requests one. In Ulster County this might even be taken farther, to say that anyone who is prescribed an opioid with a morphine-milligram equivalent over 100, should be offered a kit, as well as risk information. A prescription of that size carries an approximately 9-fold risk of overdose death compared with one of 20 mg morphine-equivalent.

In addition to patient safety, UCAN was concerned about access to a NARCAN kit to every member of the household to protect in the event that a prescription pain killer was taken by someone other than the patient, either accidentally or intentionally.

Therefore, it is the recommendation of UCAN that the Ulster County Legislature support funding in the Ulster County Health Department's 2016 Budget – to liaison with local pharmacies to coordinate and provide for the distribution of NACAN kits with certain Opioid based medications.

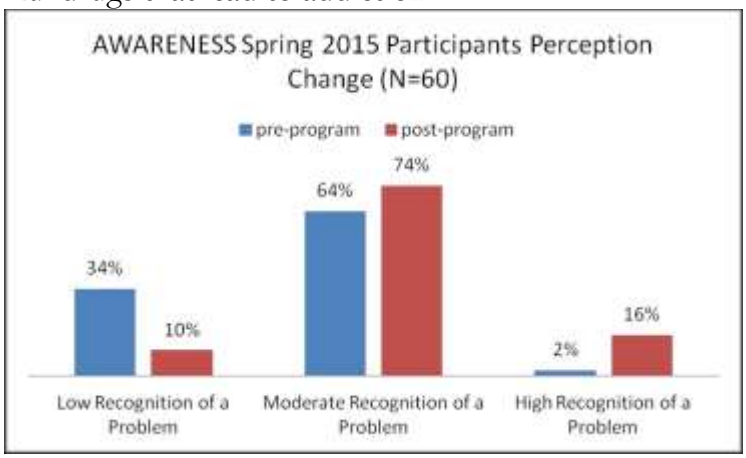
Should the Legislature decide against funding the distribution of NARCAN kits in pharmacies, UCAN recommends that, at a minimum, individuals be provided information on how to obtain a kit and training when prescriptions are filled.

AWARENESS

For many children experimentation can quickly turn into a problem of misuse and addiction. By utilizing early intervention AWARENESS teaches youth who are ticketed with Marijuana and Alcohol offenses what addiction is.

The National Institute on Drug Abuse (NIDA) recognizes behavioral treatment as one of the three current models of recovery and treatment programs. The NIDA states that behavioral treatment can be achieved through individual therapy, family therapy, and motivational interviewing.[1] Based on motivational interviewing, Dr. Ken Winters and his colleagues (2006) developed an evidence-based brief early intervention program, "Brief Intervention for Adolescent Alcohol and Drug Use". AWARENESS collaborates with Dr. Winters in utilizing this program, with minor adjustments.

In addition, AWARENESS utilizes the power of group activity and team bonding as a method for participants to identify their own issues and ultimately begin the process of behavioral change. By having people who have overcome their own addictions and misuse guide those still struggling, AWARENESS creates a supportive, non-judgmental and nurturing environment. 90% of the youth participants in 2014/2015 identified a need to change their behavior in reducing and working towards ceasing their use instead of moving toward more powerful drugs that lead to addiction.[2]



"Adolescents' abuse of prescription drugs often involves the use of opiates and opioids. In a national survey, the Centers for Disease Control found that 17.8% of students had taken prescription drugs without a doctor's prescription at least once in the course of their lifetime (CDC, 2014b). This same survey found that 2.2% of students reported having used heroin at least once in their lifetime. Prescription opiates had the most current use; almost 6% of respondents report using prescription opiates in the past 30 days, an increase from 2012. 3%

[1] http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment

[2] Analysis by Hongyan Cui, Ph.D, Western Michigan University, College of Education and Human Development

AWARENESS (CONTINUED)

have used heroin in the past 30 days; almost 6% have ever used heroin or opiates (figure 1.) Initiation to these drugs begins in later adolescence: 37% of users were over 14 when they first used opiates; 30% first tried them before the age of 11 (figure 2.)[3]

Figure 1

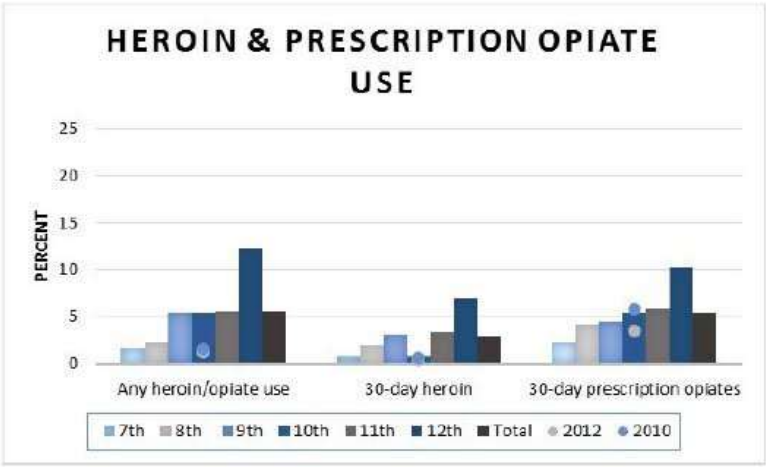
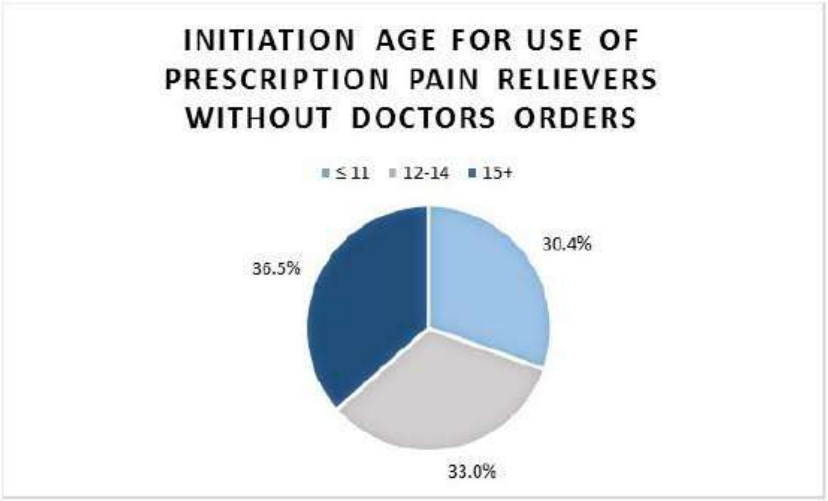


Figure 2



Respondents report greater use of prescription rather than non-prescription opiates.

37% of respondents were 15 or older when they first used opiates; 30% first tried them before the age of 11."

UCAN

Therefore, based on the appropriations in the 2015 Adopted Budget it is the recommendation of UCAN that the Ulster County Legislature continue to fund the AWARENESS program at or above current levels in their 2016 Budget – Contract Agency.

[3] http://ulsterpreventioncouncil.org/wp-content/uploads/2015/04/Ulster-County-Full-Report-1.pdf

PUBLIC SERVICE ANNOUNCEMENT

UCAN identified public education as an integral factor in community level action in the battle against Heroin and Opioid use, abuse and overdose. Sharing information with and educating the public about the disease of Substance Use Disorder (SUD) will lessen the stigma and offer support and understanding as well as access to care.

The office of the ONDCP states "Throughout much of the last century, scientists studying drug abuse labored in the shadows of powerful myths and misconceptions about the nature of addiction. When science began to study addictive behavior in the 1930s, people addicted to drugs were thought to be morally flawed and lacking in willpower. Those views shaped society's responses to drug abuse, treating it as a moral failing rather than a health problem, which led to an emphasis on punitive rather than preventative and therapeutic responses."[1]

Today, thanks to significant advances in neuroscience, our Nation's responses to drug abuse have begun to change. Groundbreaking discoveries about the brain have revolutionized our understanding of drug addiction, enabling us to respond more effectively to the problem.

Americans who suffer from addiction are more neglected than individuals with any other condition where medical treatment options are currently available.

→ 15.9 % of Americans (40.3 million) have the disease of addiction - more than have heart disease (20.7 million), diabetes (25.8 million) or cancer (19.4 million).

→ 31.7% (80.4 million), while not addicted, engage in use of addictive substances in ways that threaten health and safety (risky users).

→ More than 20% of deaths in the United States are attributed to tobacco, alcohol and to other drug use.

→ Substance use and addiction are the largest preventable and most costly public health and medical problems in the US.

→ 40 million Americans ages 12 and older have addiction involving nicotine, alcohol or other drugs, a disease affecting more Americans than heart conditions, diabetes or cancer.

→ Another 80 million people engage in risky use of addictive substances in ways that threaten public health and safety, but do not meet the clinical criteria for this disease.

→ The earlier substance use starts, the greater the risk of addiction[2]

[1] https://www.whitehouse.gov/ondcp/drugpolicyreform

[2] The National Center on Addiction and Substance Abuse at Columbia University (CASA Columbia).

PUBLIC SERVICE ANNOUNCEMENT (CONTINUED)

Ulster County communities must be informed about the facts surrounding the disease of addiction and the stigma born of the lack of awareness of the facts. This decades old stigma has caused real harm and is a barrier to individuals seeking help. Stigma significantly contributes to the poor physical and mental health of those suffering from the disease of SUD.

Additionally, parents must be given the tools they need to be able to identify risk factors and harms associated with substance use. They need to be informed about medication safety practices in their homes, dangers of Opioid based pain management medications (themselves and their kids), the Good Samaritan law and programs available for prevention, treatment and recovery.

Besides parents, coaches, athletes, employers and businesses should all be educated on the risks of Opioid based pain medications, substance use and addiction, the Good Samaritan law, best practices for responding to substance use and recovery, referral information, and overdose prevention.

Therefore, based on the appropriations in the 2015 Adopted Budget it is the recommendation of UCAN that the Ulster County Legislature support funding in the Department of Health's 2016 Budget dedicated to the creation of Public Service Announcements aimed at raising awareness of Substance Use Disorder, breaking the stigma of addiction and providing information on resources available in Ulster County.

UCAN further recommends that Ulster County continue the relationship established with Professor Bray and the students in the SUNY New Paltz Film Department and contact them when commissioning the creation of any Public Service Announcement.

URGENT

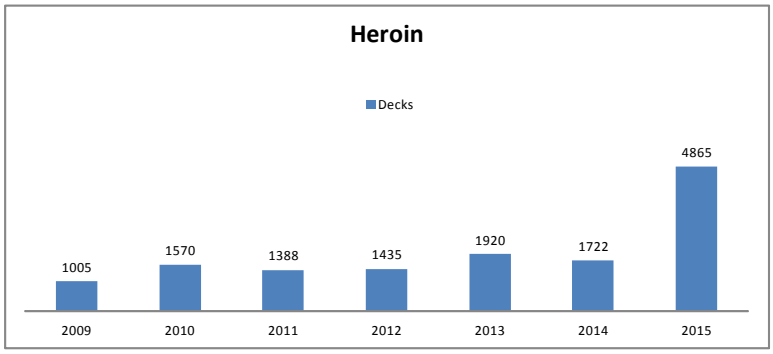
UCAN recognizes that one of the greatest obstacles to combatting this Heroin and Opioid epidemic is the availability of these drugs in our communities, especially to our youth. Ulster County is in a unique position to surmount this obstacle through our Ulster Regional Gang Enforcement Narcotics Team - URGENT.

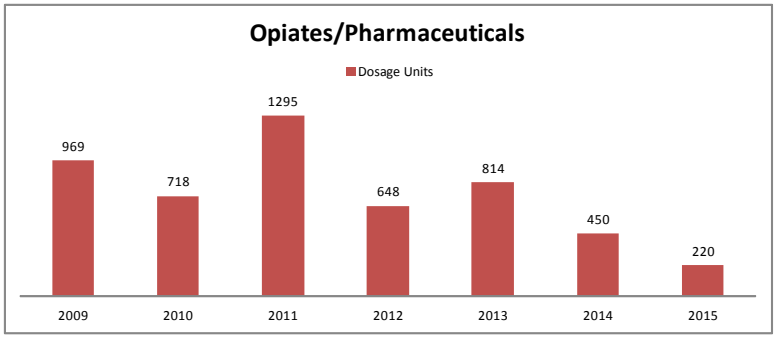
Since its inception, this inter agency task force has had a proven record of successful enforcement activities in Ulster County. The amount of Heroin removed from our streets by URGENT has increased fourfold since 2009. Conversely, the number of Opiates has decreased, making it even more evident that Heroin has become a serious issue in our community.

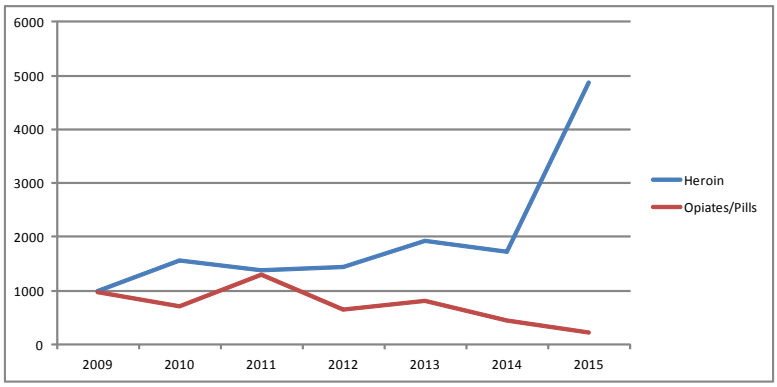
ULSTER REGIONAL GANG ENFORCEMENT NARCOTICS TEAM
U.R.G.E.N.T.
Ulster County Law Enforcement Center
380 Boulevard
Kingston, New York 12401

Area Code 845	
URGENT (Main)	334-5732
URGENT (Secondary)	340-3589
URGENT Tips Hotline	340-3570
URGENT Fax	338-2313
URGENT Supervisor	340-5757
URGENT Supervisor	384-6232

URGENT STATS FOR:
6 Year Trend 2009 - (July) 2015







URGENT (CONTINUED)

In 2015 alone 4,865 decks of Heroin and 220 dosage units of pharmaceuticals have been seized by URGENT. With the support of US Senator Schumer and County Executive Hein, Sherriff Van Blarcum has applied for federal High Impact Drug Traffic Area (HIDTA) designation.

Recognized for our central location halfway between New York City and Albany, Ulster County is a valuable tool in efforts to sever a major drug trafficking artery in New York State. URGENT has successfully collaborated on numerous missions resulting in thousands of pounds of drugs being kept off of not only Ulster County's streets, but out of many communities in Central and Upstate New York. If granted, HIDTA status will allow Ulster County access to additional resources to further assist in keeping our communities clean.

U
C
A
N

Therefore, based on the appropriations in the 2015 Adopted Budget it is the recommendation of UCAN that the Ulster County Legislature support an increase in the Ulster County Sheriff's 2016 Budget - URGENT Division to aid in their efforts.

COALITION MEMBERS

COALITION MEMBERS

Louis M. Klein, Esq., Chairman

Carl Belfiglio, Ulster County Legislator – District 8
Elizabeth Berardi, Safe Sober Living
Ray Bryant, County Resident, Accord
D. Holley Carnright, Ulster County District Attorney
Cheryl DePaolo, Director, Ulster Prevention Council
David B. Donaldson, Ulster County Legislator – District 6
Dr. Stacia Felicello, Chambers Elementary School
Dr. Raymond Harvey, Institute for Family Health
Tom Kadgen, County Resident, Saugerties
Les Kalmus, County Resident
John Parete, Ulster County Legislature Chairman
Robert Parete, County Resident, Stone Ridge
Marie Shultis, Director, AWARENESS
Mary Wawro, Ulster County Legislator – District 1

EDUCATION & PREVENTION SUBCOMMITTEE

Dr. Stacia Felicello, Chair
Carl Belfiglio
Elizabeth Berardi
Ray Bryant
D. Holley Carnright
Cheryl DePaolo
Marie Shultis
Hai-Ping Yeh

TREATMENT & INTERVENTION SUBCOMMITTEE

Tom Kadgen, Chair
Elizabeth Berardi
Cheryl DePaolo
Judy Hakam
Dr. Raymond Harvey
Marie Shultis

OTHER DISTINGUISHED CONTRIBUTORS

Professor Gregory Bray, Ph.D, Assistant Professor, Media, SUNY New Paltz
Judy Hakam, County Resident, Stone Ridge
Heidi Haynes, Representative, NYS Senator George Amedore
John Quigley, Representative, NYS Senator George Amedore
Will Raphaelson, Representative, NYS Assemblyman Kevin Cahill
Danny Savona, Representative, NYS Senator George Amedore
Steven Siriani, SUNY New Paltz Student
Hai-Ping Yeh, Social Worker, Kingston Consolidated School District

Resolution No. 371 October 21, 2014

Establishing the Ulster County Coalition Against Narcotics

Referred to: The Public Health and Social Services Committee (Chairman Lopez and Legislators Allen, Belfiglio, Litts and Provenzano), and The Law Enforcement and Public Safety Committee (Chairman Briggs and Legislators Gregorius, Loughran, Maio, and Ronk)

Legislators Carl Belfiglio, John Parete and Mary Wawro and Legislator Lopez offer the following:

WHEREAS, heroin and opioid abuse have become an alarming problem across the nation, including within communities across Ulster County; and

WHEREAS, in 2013, there were 89,269 admissions for heroin and prescription opioid abuse treatment in New York State alone, an increase from 63,793 in 2004. During this same time period, New Yorkers ages 18 to 24 had the largest increase in such admissions; and

WHEREAS, nationally, nearly half a million people were reportedly abusing heroin or suffering from heroin dependence in 2012; and

WHEREAS, heroin abuse is a public health crisis in the State of New York, and in Ulster County which represents a frightening share of heroin victims; and

WHEREAS, heroin is a highly addictive narcotic, with users representing a variety of ages, races and other backgrounds. Heroin and opioid addiction impacts families in every corner of Ulster County; and

WHEREAS, fatal overdose, the contraction of Hepatitis C and/or HIV, and addiction and dependence are among the negative side effects that can result from heroin use; and

WHEREAS, in June 2014, Governor Cuomo signed into law a legislative package to combat this epidemic, which includes expansion of opioid overdose training and increased availability to naloxone, a medication which reverses an opioid overdose; and

WHEREAS, there is a need to equip and train law enforcement, EMS and the health community with the tools they need to save lives, and to ensure the proper use of naloxone; and

WHEREAS, Ulster County desires to supply more information about warning signs of heroin and opioid abuse and misuse; now, therefore be it

Resolution No. 371 October 21, 2014

Establishing the Ulster County Coalition Against Narcotics

RESOLVED, that the Ulster County Coalition Against Narcotics is hereby created to study ways in which to identify how individuals can be helped, identify other ways to prevent abuse, and identify ways in which to protect the public from opiate drug abuse in Ulster County; and, be it further

RESOLVED, that the Coalition shall consist of 15 members who shall be appointed by the Chairman of the Legislature; and, be it further

RESOLVED, that the Coalition members should include elected officials, law enforcement officials, members of the District Attorney's office, members of the mental health community, school officials, members of local fire departments, EMS, medical staff, members of the drug abuse treatment community, concerned members of the general public, and any other organization with knowledge of opiate abuse; and, be it further

RESOLVED, that the Ulster County Coalition Against Narcotics shall submit a written report of its findings and recommendations to the County Legislature no later than six months after its first meeting for consideration, review, and appropriate action, if necessary; and, be it further

RESOLVED, that the members of the Ulster County Coalition Against Narcotics shall serve without compensation other than for actual and necessary expenses with appropriations made therefore, unless other provided by resolution of the County Legislature, pursuant to Section C-16 of the Ulster County Charter and Section A2-11 of the Administrative Code,

and move its adoption.

ADOPTED BY THE FOLLOWING VOTE:

AYES: 23 NOES: 0

Passed Committee: Public Health and Social Services on October 6, 2014

Passed Committee: Law Enforcement and Public Safety on October 6, 2014

FINANCIAL IMPACT:
NONE

Resolution No. 371 October 21, 2014

Establishing the Ulster County Coalition Against Narcotics

STATE OF NEW YORK
ss:
COUNTY OF ULSTER

This is to certify that I, the undersigned Clerk of the Legislature of the County of Ulster have compared the foregoing resolution with the original resolution now on file in the office of said clerk, and which was adopted by said Legislature on the 21st Day of October, 2014, and that the same is a true and correct transcript of said resolution and of the whole thereof.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of the County of Ulster this 22nd Day of October in the year Two Thousand and Fourteen.

|s| Victoria A. Fabella
Victoria A. Fabella, Clerk
Ulster County Legislature

Resolution No. 259 July 21, 2015

Authorizing A Sixty (60) Day Extension For Reporting To The Ulster County Legislature The Findings And Recommendations Of The Ulster County Coalition Against Narcotics

Referred to: The Public Health and Social Services Committee (Chairman Lopez and Legislators Allen, Belfiglio, Litts and Provenzano), and The Law Enforcement and Public Safety Committee (Chairman Briggs and Legislators Fabiano, Provenzano, Ronk and Wishnick)

Legislators Carl Belfiglio, David Donaldson, John Parete, and Mary Wawro offer the following:

WHEREAS, pursuant to Resolution No. 371, dated October 21, 2014, the Ulster County Legislature delegated the authority to the Ulster County Coalition Against Narcotics to study ways in which to identify how individuals can be helped, identify other ways to prevent abuse, and identify ways in which to protect the public from opiate drug abuse in Ulster County; and

WHEREAS, pursuant to Resolution No. 371 of 2014, the Ulster County Coalition Against Narcotics was to submit a written report of its findings and recommendations to the County Legislature no later than six months after its first meeting for consideration, review, and appropriate action, if necessary; and

WHEREAS, the review and assessment of intervention, treatment, education and prevention resources within Ulster County were identified as the principle focus of the coalition, thus an Intervention and Treatment sub-committee and an Education and Prevention sub-committee were formed to assist with the research and investigation, with an eye towards forming policy recommendations; and

WHEREAS, the sub-committees have met frequently, individual members have attended state and national conferences on the subject matter, members recently testified at a June 2, 2015 hearing of the State Senate Task Force on Heroin and Opioid Addiction examining the issues facing communities in the wake of increased heroin abuse; and

WHEREAS, on June 17, 2015 the coalition met with the Commissioner of the Ulster County Department of Health to discuss services currently provided in Ulster County; and

WHEREAS, due to the volume and complexity of the subject matter, and the ongoing meaningful discussions that the Coalition has been conducting, it is now necessary to request an extension of sixty (60) days for the submission of said report; now, therefore be it,

Resolution No. 259 July 21, 2015

Authorizing A Sixty (60) Day Extension For Reporting To The Ulster County Legislature The Findings And Recommendations Of The Ulster County Coalition Against Narcotics

RESOLVED, that the Ulster County Coalition Against Narcotics is hereby authorized a sixty (60) day extension to September 15, 2015 to report its findings and recommendations to the Ulster County Legislature at the regularly scheduled meeting to be held on Tuesday, September 15, 2015 at 7:00 PM in the Legislative Chambers, 244 Fair Street, 6th Floor, County Office Building, Kingston, NY,

and move its adoption.

ADOPTED BY THE FOLLOWING VOTE:

AYES: 22 NOES: 0
(Absent: Legislator Maio)

Passed Committee: Public Health and Social Services on July 6, 2015

Passed Committee: Law Enforcement and Public Safety on July 6, 2015

FINANCIAL IMPACT:
NONE

STATE OF NEW YORK
ss:
COUNTY OF ULSTER

I, the undersigned Clerk of the Legislature of the County of Ulster, hereby certify that the foregoing resolution is the original resolution adopted by the Ulster County Legislature on the 21st Day of July in the year Two Thousand and Fifteen, and said resolution shall remain on file in the office of said clerk.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of the County of Ulster this 23rd Day of July in the year Two Thousand and Fifteen.

|s| Victoria A. Fabella
Victoria A. Fabella, Clerk
Ulster County Legislature

ULSTER COUNTY LEGISLATIVE NEWS

ULSTER COUNTY NEWS INFORMATION
OFFICE OF ULSTER COUNTY LEGISLATURE
244 FAIR STREET
KINGSTON, NEW YORK, 12401

PHONE: 845.340-3900
FAX: 845.340.3651
www.co.ulster.ny.us
www.ulstercountyny.gov

FOR IMMEDIATE RELEASE

May 19, 2014

ULSTER COUNTY LEGISLATIVE PRIORITY: HEROIN AND OPIOID OVERDOSE EPIDEMIC

(KINGSTON, NY) "Heroin is becoming main stream. It is taking lives unnecessarily, ruining families and leaving individuals hooked on it for life, according to District Attorney D. Holley Carnright. These comments were made at a stakeholder chat on the growing epidemic of heroin and opioid use and overdoses in Ulster County. Legislative Chairman John Parete recently hosted this first of a series of chats to bring to light the insidiousness of the disease.

Mr. Richard Muellerleile, President of the Ulster County EMS Council, stated, in 2013, the 38 certified EMS units in Ulster County were "dispatched for 363 overdose calls" with an average of 351 calls for the previous three years.

As the founder of the Narcan overdose response program at the City of Kingston Fire Department, EMS Director Chris Hyatt reported "Since the initiation of the program, on the 7th of April, we have had to use it six times and three lives have been saved as a result."

"There is a lack of public knowledge and awareness regarding this epidemic. Public education is the primary step to addressing this problem," noted Mr. Muellerleile.

District Attorney D. Holley Carnright commented, "Today heroin does not have a dangerous label attached to it like it did back in the 70's. As people shift from pharmaceuticals to heroin, it has become too much of a main stream product. We are finding people of all ages and from all segments of our community who are addicted to heroin. I believe it is time to bring back the Madison Avenue type ad campaign to educate people regarding the devastating and potentially lethal consequences of heroin use".

Former SUNY New Paltz Police Chief Ray Bryant noted, "When we had Hollywood on our side, they helped us to make it look ugly. People sometimes look at the DA and law enforcement's anti-drug messages suspiciously."

Ulster County Sheriff Paul Van Blarcum reiterated, while law enforcement's role is the enforcement of laws, "we are also here to save lives. They changed the Good Samaritan law. If your friend overdoses, and even if there is heroin or drugs laying around, help him or her. Don't be afraid."

Legislator Carl Belfiglio, District 8 from the Town of Esopus, summed up this stakeholder chat saying, "This is a call to arms. Risky behaviors, like experimenting with drugs, can have a lifetime of community impacts. There are concrete and lasting activities that we can be doing right now, to stem the tide."

Chairman Parete has enlisted the assistance of former Legislative Chairman Louis Klein to guide this important Legislative priority through the many obstacles. Mr. Klein said that he was "more than happy to help in any way he can to help Ulster County save lives."

##

ULSTER COUNTY LEGISLATURE

JOHN R. PARETE
Chairman 845-340-3693

DAVID B. DONALDSON
Vice Chairman 845-340-3900

DONALD J. GREGORIUS
Majority Leader 845-340-3900

KENNETH J. RONK
Minority Leader 845-340-3900

P.O. Box 1800
KINGSTON, NEW YORK 12402
Telephone: 845 340-3900
FAX: 845 340-3651

VICTORIA A. FABELLA
Clerk 845-340-3666

CAPPY B. WEINER
CHRISTOPHER RAGUCCI
Counsel 845-340-3900

ERICA K. F. GUERIN
Minority Counsel 845-340-3900

Legislative Colleagues,

During my county address in March I spoke about a growing epidemic of Heroin use and death due to overdose in our communities. One of the budget items that I will be working on this year is establishing dedicated funding for our police departments and EMTs so that they have the training to administer, and the supply on hand of, the Heroin antidote Naloxone. Unfortunately, Heroin is flowing throughout our communities. In addition to working to stop that flow, we have to be prepared to help those who fall victim to it. Terribly, it's our young adults who are the most prevalent victims right now.

NYS Attorney General Eric Schneiderman also recognized this disturbing trend and introduced his Community Overdose Prevention (COP) Program in April. Just yesterday the Daily Freeman announced the State Legislature's passage of Assembly Bill A8285 and Senate Bill S4588 to boost the availability of the antidote drug for heroin overdoses. I applaud the Attorney General and the State Legislature for recognizing this serious danger and taking real steps to address it. Unfortunately the Attorney General's program is strictly available to Law Enforcement Agencies because of its funding source and the State Legislation only establishes a pilot program "through which the Commissioner of Health will make Naloxone available to up to 30 public high schools throughout the state and to trained police officers upon request."

I have heard from our local, firefighters and EMS providers that there is nothing more disturbing than the thought of coming upon an overdose victim, knowing you could help them, but can't because you don't have the proper equipment to save their life. In this case the equipment needed is the drug Naloxone and the training to administer it. We need to arm our front line rescue workers with Naloxone so we can save, and then help, those who have fallen victim to this deadly drug.

I believe we have a crisis on our hands for our young adults age 18 and over, but particularly those at the very vulnerable ages of 18 - 21. I believe some of the laws enacted decades ago with the good intent to help young adults stay clean of substances may in fact be driving them to more dangerous ones. Instead of being able to go to a controlled, monitored environment like

a nightclub to dance all night, or a bar to have a drink or two legally, they have been forced in to their friends basements or the farmers' fields where they can take or drink or shoot up whatever they can get their hands on completely away from any type of monitoring.

When a tab of Heroin, for $5, is cheaper than a six pack of beer, folks, we have a problem.

I am grateful for the opportunity to use this bully pulpit to express my concern for these young adults and appreciate you taking the time to read this. This is something that families talk about all the time at their kitchen tables. Although I believe that this problem needs to be addressed at a statewide level, I know we can do something to start fighting this epidemic right here and right now.

I welcome your thoughts on this important endeavor and look forward to working with you to address this serious issue.

Kindest regards,

John R. Parete
Chairman, Ulster County Legislature

ULSTER COUNTY LEGISLATURE

JOHN R. PARETE
Chairman 845-340-3693

DAVID B. DONALDSON
Vice Chairman 845-340-3900

DONALD J. GREGORIUS
Majority Leader 845-340-3900

KENNETH J. RONK
Minority Leader 845-340-3900

P.O. Box 1800
KINGSTON, NEW YORK 12402
Telephone: 845 340-3900
FAX: 845 340-3651

VICTORIA A. FABELLA
Clerk 845-340-3666

CAPPY B. WEINER
CHRISTOPHER RAGUCCI
Counsel 845-340-3900

ERICA K. F. GUERIN
Minority Counsel 845-340-3900

April 9, 2014

Honorable Eric Schneiderman, NYS Attorney General
Office of the Attorney General
The Capitol
Albany, NY 12224-0341

Dear Attorney General Schneiderman,

I write to commend you on your Community Overdose Prevention (COP) Program. I share your concerns about the dramatic increase of heroin abuse and spoke about the severity of the problem when I addressed the County Legislature in March.

I know that Ulster County Sheriff Paul VanBlarcum is having his officers participate in your program and has offered his office's assistance to our local Police Chiefs as well. I am contacting you with the hope that you will consider expanding your program to other first responders as well. Specifically, I believe that our area volunteer EMS and Fire Departments would benefit greatly from your program.

Please let me know if there is anything that I or the County Legislature can do to help you in your fight to combat this growing epidemic. I look forward to hearing from you.

Sincerely,

John R. Parete, Chairman
Ulster County Legislature

ULSTER COUNTY LEGISLATURE

JOHN R. PARETE
Chair 845-340-3699

DAVID B. DONALDSON
Vice-Chair 845-340-3699

DONALD J. GREGORIUS
Majority Leader 845-340-3900

KENNETH J. RONK
Minority Leader 845-340-3900

P.O. Box 1800
KINGSTON, NEW YORK 12402
Telephone: 845 340-3900
FAX: 845 340-3651

VICTORIA A. FABELLA
Clerk 845-340-3666

CAPPY WEINER
Counsel 845-340-3900

CHRISTOPHER RAGUCCI
Counsel 845-340-3900

ERICA GUERIN
Minority Counsel 845-340-3900

May 16, 2014

The Honorable Andrew M. Cuomo
Governor of New York State
NYS State Capitol Building
Albany, NY 12224

Dear Governor Cuomo:

I write to thank you for your activities to bring communities together to discuss the battle against the heroin and opioid addiction epidemic that is plaguing our country. I am glad that you are a member of the Joint Senate Task Force on Heroin Opioid Addiction and look forward to the resulting legislative solutions.

On May 13th, I hosted an Ulster County discussion on the topic with similarly distinguished panelists as you had at your forum on May 9th. Ulster County Sheriff Paul VanBlarcum, Ulster County District Attorney D. Holley Carnright, Ulster County EMS Council President Rich Mullerliele, former SUNY New Paltz Police Chief Raymond Bryant, City of Kingston Fire Department Lt. Christopher Hyatt, Former Legislative Chairman Louis Klein and other concerned citizens all contributed valuable insights on the issue.

Our panelists identified two key areas where we feel that State attention could yield immediate results. The first is for State Aide for the purchase of the intranasal naloxone kits for EMS and Fire Departments. While Attorney General Schneiderman's Community Overdose Prevention (COP) Program was an amazing jump start for Law Enforcement agencies, we need to get this proven lifesaving antidote into the hands of all of our first responders. Second, is to have the New York State Health and Education Departments bring back the "Madison Avenue" type ad campaign to alert adults and children alike to the devastating and potentially lethal consequences of heroin use.

I have enclosed a copy of the press release about the Ulster County conversation and look forward to further discussions with you regarding a State-County collaboration on this very important public health and safety need.

Kindest regards,

John R. Parete, Chairman
Ulster County Legislature

ULSTER COUNTY LEGISLATURE

JOHN R. PARETE
Chairman 845-340-3693

DAVID B. DONALDSON
Vice Chairman 845-340-3900

DONALD J. GREGORIUS
Majority Leader 845-340-3900

KENNETH J. RONK
Minority Leader 845-340-3900

P.O. Box 1800
KINGSTON, NEW YORK 12402
Telephone: 845 340-3900
FAX: 845 340-3651

VICTORIA A. FABELLA
Clerk 845-340-3666

CAPPY B. WEINER
CHRISTOPHER RAGUCCI
Counsel 845-340-3900

ERICA K. F. GUERIN
Minority Counsel 845-340-3900

May 28, 2014

The Honorable Andrew M. Cuomo
Governor of New York State
NYS State Capitol Building
Albany, NY 12224

Dear Governor Cuomo:

As the Chairman of the Ulster County Legislature, I have been made aware of rapidly developing heroin problem in our county. Our law enforcement leaders, including our District Attorney and Sheriff, have made it extremely clear that we have a crisis on our hands. However, they believe, as I do, that the public does not appreciate the depth of the problem or the inherent dangers it presents. These law enforcement leaders believe that a clarion call from them will not be taken as seriously as the problem warrants.

Sometimes opportunity is created by a tragedy. Recently, the son of two of Ulster County's most prominent and respected residents, died of a drug overdose. We have been informed that his mom is willing to join our effort to create community awareness of the severity of the problem and the depth of the crisis. But even that's not enough.

I have recently appointed a committee comprised of community leaders, concerned citizens and representatives of government agencies to develop a countywide approach to this crisis. I have enclosed some materials from our meeting held earlier this month. Its mission is to complement the efforts of our law enforcement professionals. It is in that regard that I write.

I believe that a directive from you, to our schools, to develop and present educational programs for students and parents alike, regarding the crisis at hand and the inherent dangers it presents, would insure the dissemination and comprehension of potentially life-saving information. It could also help us develop a dialogue at the local and even countywide level.

Sincerely,

John R. Parete, Chairman

JRP:jem Enclosures

OASAS Improving Lives.
NEW YORK STATE
OFFICE OF ALCOHOLISM & SUBSTANCE ABUSE SERVICES
Addiction Services for Prevention, Treatment, Recovery

Governor
Andrew M. Cuomo

Commissioner
Arlene González-Sánchez, M.S., L.M.S.W.

June 11, 2014

John R. Parente, Chairman
Ulster County Legislator
P.O. Box 1800
Kingston, NY 12402

Dear Chairman Parente:

I am in receipt of your May 28th letter to Governor Cuomo sharing your thoughts on the rapidly developing heroin problem in our country, and more personally, in your county.

I applaud your interest in and enthusiasm to address this very dangerous issue. The Governor is very much aware and concerned about these issues affecting so many New Yorkers. OASAS has a statewide prevention infrastructure of 183 providers and over 170 coalitions that work at the community level to address such issues as they arise. Our provider network is working with many schools and other institutions across the state on this very serious issue.

Just today, the Governor announced a Statewide initiative to combat heroin use. Major components of this initiative are strategies to raise awareness of the consequences of heroin usage at our SUNY and CUNY campuses.

In a related effort, OASAS is working with the State Education Department and the Department of Health to develop and distribute appropriate materials to further educate young people to the dangers of heroin and opioid addiction.

Though our providers are in many schools, we at OASAS cannot dictate to the autonomous school districts that they develop and deliver such educational programming to all of their students. That suggestion would have to come from the NY State Education Department. Should you wish to pursue your proposal with the State Education Department you may want to contact Commissioner John King at 89 Washington Avenue, Albany, New York 12234. Actually, every district has local control through their individual school boards. Each Board therefore would need to approve such a change in their curriculum delivery.

Allow me to suggest two immediate ideas that you may find to be effective for your County. The first is to contact your local prevention providers and discuss with them their current access to the schools in your County. Cheryl DePaolo from Family Services Inc. and Colleen Young from the Onteora Central School District are the Prevention Directors in your area: Ms. DePaolo can be reached at 845 458-7406 or cdepaolo@familyservicesny.org and Ms. Young can be reached at 845 657-2354 or cyoung139@hvc.rr.com. Secondly, you can also offer your time and influence to the local school districts.

Again, we at OASAS thank you for your interest and commitment to your community. Please keep me informed as to your progress.

Sincerely,

Mary Ann DiChristopher
Acting Associate Commissioner
Division of Prevention & Housing

ULSTER COUNTY LEGISLATURE

JOHN R. PARETE
Chair 845-340-3699

DAVID B. DONALDSON
Vice-Chair 845-340-3699

DONALD J. GREGORIUS
Majority Leader 845-340-3900

KENNETH J. RONK
Minority Leader 845-340-3900

P.O. Box 1800
KINGSTON, NEW YORK 12402
Telephone: 845 340-3900
FAX: 845 340-3651

VICTORIA A. FABELLA
Clerk 845-340-3666

CAPPY WEINER
Counsel 845-340-3900

CHRISTOPHER RAGUCCI
Counsel 845-340-3900

ERICA GUERIN
Minority Counsel 845-340-3900

June 3, 2014

Senator John Bonacic
New York State Senate
201 Dolson Avenue, Suite F
Middletown, NY 10940

Dear Senator Bonacic:

I write to thank you for your activities to bring communities together to discuss the battle against the heroin and opioid addiction epidemic that is plaguing our country. I am glad that you are a member of the Joint Senate Task Force on Heroin Opioid Addiction and look forward to the resulting legislative solutions.

On May 13th, I hosted an Ulster County discussion on the topic with similarly distinguished panelists as you had at your forum on May 9th. Ulster County Sheriff Paul VanBlarcum, Ulster County District Attorney D. Holley Carnright, Ulster County EMS Council President Rich Mullerliele, former SUNY New Paltz Police Chief Raymond Bryant, City of Kingston Fire Department Lt. Christopher Hyatt, Former Legislative Chairman Louis Klein and other concerned citizens all contributed valuable insights on the issue.

Our panelists identified two key areas where we feel that State attention could yield immediate results. The first is for State Aide for the purchase of the intranasal naloxone kits for EMS and Fire Departments. While Attorney General Schneiderman's Community Overdose Prevention (COP) Program was an amazing jump start for Law Enforcement agencies, we need to get this proven lifesaving antidote into the hands of all of our first responders. Second, is to have the New York State Health and Education Departments bring back the "Madison Avenue" type ad campaign to alert adults and children alike to the devastating and potentially lethal consequences of heroin use.

I have enclosed a copy of the press release about the Ulster County conversation and look forward to further discussions with you regarding a State-County collaboration on this very important public health and safety need.

Kindest regards,

John R. Parete, Chairman
Ulster County Legislature

JOHN J. BONACIC
SENATOR, 42ND DISTRICT

CHAIR
COMMITTEES ON
JUDICIARY
RACING, GAMING & WAGERING

DEPUTY REPUBLICAN CONFERENCE LEADER
FOR STATE/FEDERAL RELATIONS

THE SENATE
STATE OF NEW YORK

COMMITTEES
ALCOHOLISM
BANKS
CHILDREN & FAMILIES
CULTURAL AFFAIRS, TOURISM, PARKS & RECREATION
FINANCE
HOUSING, CONSTRUCTION & COMMUNITY DEVELOPMENT
MENTAL HEALTH
RULES

July 28, 2014

John R. Parete, Chairman
Ulster County Legislature
PO Box 1800
Kingston, NY 12402

Dear John,

Thank you for your recent letter where you share two key areas that came up during an Ulster County discussion on the heroin epidemic. The first suggestion was state aid for the purchase of intranasal naloxone kits for EMS and Fire Departments, and the second suggestion was creating a "Madison Avenue" ad campaign to alert adults and children to the devastating consequences of heroin use.

Please know that last month, the NYS Senate passed a legislative package of bills to combat the heroin epidemic and among them were bills specifically regarding naloxone, and drug awareness in the media:

- SB 7661 which allows for school districts, BOCES programs, charter schools, and other educational entities may possess and administer naloxone for heroin overdoses, and that they will be protected by the Good Samaritan law.

- SB 7649 which provides for naloxone kits be distributed through an opioid overdose prevention program.

- SB 7654 which requires the OASAS and the DOH to establish the Heroin and Prescription Opioid Pain Medication Addiction Awareness and Education Program to utilize social media, and mass media to reduce the stigma associated with drug addiction. It will also increase the public's knowledge of the dangers of drug abuse, signs of addiction, and relevant programs and resources.

Additionally, the Governor has pledged state money to put Narcan in the hands of law enforcement through the Community Overdose Prevention Program (COP). EMS organizations currently purchase naloxone as part of their day to day supplies, and firefighters are given kits once they have completed a Narcan training program.

(con't)

ALBANY OFFICE: ROOM 509 LEGISLATIVE OFFICE BUILDING, ALBANY, NY 12247 (518) 455-3181
DISTRICT OFFICE: 201 DOLSON AVENUE, SUITE F, MIDDLETOWN, NY 10940 (845) 344-3311
SATELLITE OFFICE: 111 MAIN STREET, DELHI, NY 13753
EMAIL: BONACIC@NYSENATE.GOV

If I can be of any further assistance, please do not hesitate to contact my office.

Sincerely,

JOHN J. BONACIC
State Senator

JJB/mj

ULSTER COUNTY LEGISLATURE

JOHN R. PARETE
Chair 845-340-3699

DAVID B. DONALDSON
Vice-Chair 845-340-3699

DONALD J. GREGORIUS
Majority Leader 845-340-3900

KENNETH J. RONK
Minority Leader 845-340-3900

P.O. Box 1800
KINGSTON, NEW YORK 12402
Telephone: 845 340-3900
FAX: 845 340-3651

VICTORIA A. FABELLA
Clerk 845-340-3666

CAPPY WEINER
Counsel 845-340-3900

CHRISTOPHER RAGUCCI
Counsel 845-340-3900

ERICA GUERIN
Minority Counsel 845-340-3900

June 3, 2014

Senator William Larkin
New York State Senate
1093 Little Britain Road
New Windsor, NY 12553

Dear Senator Larkin:

I write to thank you for your activities to bring communities together to discuss the battle against the heroin and opioid addiction epidemic that is plaguing our country. I am glad that you are a member of the Joint Senate Task Force on Heroin Opioid Addiction and look forward to the resulting legislative solutions.

On May 13th, I hosted an Ulster County discussion on the topic with similarly distinguished panelists as you had at your forum on May 15th. Ulster County Sheriff Paul VanBlarcum, Ulster County District Attorney D. Holley Carnright, Ulster County EMS Council President Rich Mullerliele, former SUNY New Paltz Police Chief Raymond Bryant, City of Kingston Fire Department Lt. Christopher Hyatt, Former Legislative Chairman Louis Klein and other concerned citizens all contributed valuable insights on the issue.

Our panelists identified two key areas where we feel that State attention could yield immediate results. The first is for State Aide for the purchase of the intranasal naloxone kits for EMS and Fire Departments. While Attorney General Schneiderman's Community Overdose Prevention (COP) Program was an amazing jump start for Law Enforcement agencies, we need to get this proven lifesaving antidote into the hands of all of our first responders. Second, is to have the New York State Health and Education Departments bring back the "Madison Avenue" type ad campaign to alert adults and children alike to the devastating and potentially lethal consequences of heroin use.

I have enclosed a copy of the press release about the Ulster County conversation and look forward to further discussions with you regarding a State-County collaboration on this very important public health and safety need.

Kindest regards,

John R. Parete, Chairman
Ulster County Legislature

ULSTER COUNTY LEGISLATURE

JOHN R. PARETE
Chair 845-340-3699

DAVID B. DONALDSON
Vice-Chair 845-340-3699

DONALD J. GREGORIUS
Majority Leader 845-340-3900

KENNETH J. RONK
Minority Leader 845-340-3900

P.O. Box 1800
KINGSTON, NEW YORK 12402
Telephone: 845 340-3900
FAX: 845 340-3651

VICTORIA A. FABELLA
Clerk 845-340-3666

CAPPY WEINER
Counsel 845-340-3900

CHRISTOPHER RAGUCCI
Counsel 845-340-3900

ERICA GUERIN
Minority Counsel 845-340-3900

June 3, 2014

Senator Cecilia Tkaczyk
New York State Senate
42 Crown Street
Kingston, New York 12401

Dear Senator Tkaczyk:

I write to thank you for your sponsoring of legislation to redirect savings from the closure of correctional facilities to a fund designed to support 90-day addiction treatment programs. As we both know, there is much to be done to address the growing problem of substance abuse involving heroin and other opioid narcotics.

On May 13th, I hosted an Ulster County discussion on the topic with distinguished panelists from Ulster County. Ulster County Sheriff Paul VanBlarcum, Ulster County District Attorney D. Holley Carnright, Ulster County EMS Council President Rich Mullerliele, former SUNY New Paltz Police Chief Raymond Bryant, City of Kingston Fire Department Lt. Christopher Hyatt, Former Legislative Chairman Louis Klein and other concerned citizens all contributed valuable insights on the issue.

Our panelists identified two key areas where we feel that State attention could yield immediate results. The first is for State Aide for the purchase of the intranasal naloxone kits for EMS and Fire Departments. While Attorney General Schneiderman's Community Overdose Prevention (COP) Program was an amazing jump start for Law Enforcement agencies, we need to get this proven lifesaving antidote into the hands of all of our first responders. Second, is to have the New York State Health and Education Departments bring back the "Madison Avenue" type ad campaign to alert adults and children alike to the devastating and potentially lethal consequences of heroin use.

I have enclosed a copy of the press release about the Ulster County conversation and look forward to further discussions with you regarding a State-County collaboration on this very important public health and safety need.

Kindest regards,

John R. Parete, Chairman
Ulster County Legislature

ULSTER COUNTY LEGISLATURE

JOHN R. PARETE
Chair 845-340-3699

DAVID B. DONALDSON
Vice-Chair 845-340-3699

DONALD J. GREGORIUS
Majority Leader 845-340-3900

KENNETH J. RONK
Minority Leader 845-340-3900

P.O. Box 1800
KINGSTON, NEW YORK 12402
Telephone: 845 340-3900
FAX: 845 340-3651

VICTORIA A. FABELLA
Clerk 845-340-3666

CAPPY WEINER
Counsel 845-340-3900

CHRISTOPHER RAGUCCI
Counsel 845-340-3900

ERICA GUERIN
Minority Counsel 845-340-3900

June 3, 2014

Assemblywoman Claudia Tenney
New York State Assembly
LOB 426
Albany, NY 12248

Dear Assemblywoman Tenney:

I noted the Assembly's joint Alcoholism and Drug Abuse, Health, and Codes Committee's Roundtable to discuss a comprehensive approach to the opiate and heroin crisis held in Albany on May 12th and NYC on June 5th. I look forward to continuing the discussion toward the development a multi-prong strategy to fight this epidemic.

On May 13th, I hosted an Ulster County discussion on the topic with similarly distinguished panelists as you had at your roundtables. Ulster County Sheriff Paul VanBlarcum, Ulster County District Attorney D. Holley Carnright, Ulster County EMS Council President Rich Mullerliele, former SUNY New Paltz Police Chief Raymond Bryant, City of Kingston Fire Department Lt. Christopher Hyatt, Former Legislative Chairman Louis Klein and other concerned citizens all contributed valuable insights on the issue.

Our panelists identified two key areas where we feel that State attention could yield immediate results. The first is for State Aide for the purchase of the intranasal naloxone kits for EMS and Fire Departments. While Attorney General Schneiderman's Community Overdose Prevention (COP) Program was an amazing jump start for Law Enforcement agencies, we need to get this proven lifesaving antidote into the hands of all of our first responders. Second, is to have the New York State Health and Education Departments bring back the "Madison Avenue" type ad campaign to alert adults and children alike to the devastating and potentially lethal consequences of heroin use.

I have enclosed a copy of the press release about the Ulster County conversation and look forward to further discussions with you regarding a State-County collaboration on this very important public health and safety need.

Kindest regards,

John R. Parete, Chairman
Ulster County Legislature

ULSTER COUNTY LEGISLATURE

JOHN R. PARETE
Chair 845-340-3699

DAVID B. DONALDSON
Vice-Chair 845-340-3699

DONALD J. GREGORIUS
Majority Leader 845-340-3900

KENNETH J. RONK
Minority Leader 845-340-3900

P.O. Box 1800
KINGSTON, NEW YORK 12402
Telephone: 845 340-3900
FAX: 845 340-3651

VICTORIA A. FABELLA
Clerk 845-340-3666

CAPPY WEINER
Counsel 845-340-3900

CHRISTOPHER RAGUCCI
Counsel 845-340-3900

ERICA GUERIN
Minority Counsel 845-340-3900

June 3, 2014

Assemblyman Peter Lopez
New York State Assembly
45 Five Mile Woods Road
Catskill, NY 12414

Dear Assemblyman Lopez:

I noted the Assembly's joint Alcoholism and Drug Abuse, Health, and Codes Committee's Roundtable to discuss a comprehensive approach to the opiate and heroin crisis held in Albany on May 12th and NYC on June 5th. I look forward to continuing the discussion toward the development a multi-prong strategy to fight this epidemic.

On May 13th, I hosted an Ulster County discussion on the topic with similarly distinguished panelists as you had at your roundtables. Ulster County Sheriff Paul VanBlarcum, Ulster County District Attorney D. Holley Carnright, Ulster County EMS Council President Rich Mullerliele, former SUNY New Paltz Police Chief Raymond Bryant, City of Kingston Fire Department Lt. Christopher Hyatt, Former Legislative Chairman Louis Klein and other concerned citizens all contributed valuable insights on the issue.

Our panelists identified two key areas where we feel that State attention could yield immediate results. The first is for State Aide for the purchase of the intranasal naloxone kits for EMS and Fire Departments. While Attorney General Schneiderman's Community Overdose Prevention (COP) Program was an amazing jump start for Law Enforcement agencies, we need to get this proven lifesaving antidote into the hands of all of our first responders. Second, is to have the New York State Health and Education Departments bring back the "Madison Avenue" type ad campaign to alert adults and children alike to the devastating and potentially lethal consequences of heroin use.

I have enclosed a copy of the press release about the Ulster County conversation and look forward to further discussions with you regarding a State-County collaboration on this very important public health and safety need.

Kindest regards,

John R. Parete, Chairman
Ulster County Legislature

ULSTER COUNTY LEGISLATURE

JOHN R. PARETE
Chair 845-340-3699

DAVID B. DONALDSON
Vice-Chair 845-340-3699

DONALD J. GREGORIUS
Majority Leader 845-340-3900

KENNETH J. RONK
Minority Leader 845-340-3900

P.O. Box 1800
KINGSTON, NEW YORK 12402
Telephone: 845 340-3900
FAX: 845 340-3651

VICTORIA A. FABELLA
Clerk 845-340-3666

CAPPY WEINER
Counsel 845-340-3900

CHRISTOPHER RAGUCCI
Counsel 845-340-3900

ERICA GUERIN
Minority Counsel 845-340-3900

June 3, 2014

Senator James Seward
New York State Senate
41 So. Main Street
Oneonta, NY 13820

Dear Senator Seward:

I write to thank you for your activities to bring communities together to discuss the battle against the heroin and opioid addiction epidemic that is plaguing our country. I am glad that you are a member of the Joint Senate Task Force on Heroin Opioid Addiction and look forward to the resulting legislative solutions. I wholeheartedly agree with you that we need to develop a multi-prong strategy to fight this epidemic.

On May 13th, I hosted an Ulster County discussion on the topic with similarly distinguished panelists as you had at your forum on May 8th. Ulster County Sheriff Paul VanBlarcum, Ulster County District Attorney D. Holley Carnright, Ulster County EMS Council President Rich Mullerliele, former SUNY New Paltz Police Chief Raymond Bryant, City of Kingston Fire Department Lt. Christopher Hyatt, Former Legislative Chairman Louis Klein and other concerned citizens all contributed valuable insights on the issue.

Our panelists identified two key areas where we feel that State attention could yield immediate results. The first is for State Aide for the purchase of the intranasal naloxone kits for EMS and Fire Departments. While Attorney General Schneiderman's Community Overdose Prevention (COP) Program was an amazing jump start for Law Enforcement agencies, we need to get this proven lifesaving antidote into the hands of all of our first responders. Second, is to have the New York State Health and Education Departments bring back the "Madison Avenue" type ad campaign to alert adults and children alike to the devastating and potentially lethal consequences of heroin use.

I have enclosed a copy of the press release about the Ulster County conversation and look forward to further discussions with you regarding a State-County collaboration on this very important public health and safety need.

Kindest regards,

John R. Parete, Chairman
Ulster County Legislature

ULSTER COUNTY LEGISLATURE

JOHN R. PARETE
Chair 845-340-3699

DAVID B. DONALDSON
Vice-Chair 845-340-3699

DONALD J. GREGORIUS
Majority Leader 845-340-3900

KENNETH J. RONK
Minority Leader 845-340-3900

P.O. Box 1800
KINGSTON, NEW YORK 12402
Telephone: 845 340-3900
FAX: 845 340-3651

VICTORIA A. FABELLA
Clerk 845-340-3666

CAPPY WEINER
Counsel 845-340-3900

CHRISTOPHER RAGUCCI
Counsel 845-340-3900

ERICA GUERIN
Minority Counsel 845-340-3900

June 3, 2014

Assemblyman Frank Skartados
New York State Assembly
154 North Plank Road, Suite 2
Newburgh, NY 12550

Dear Assemblyman Skartados:

I noted the Assembly's joint Alcoholism and Drug Abuse, Health, and Codes Committee's Roundtable to discuss a comprehensive approach to the opiate and heroin crisis held in Albany on May 12th and NYC on June 5th. I look forward to continuing the discussion toward the development a multi-prong strategy to fight this epidemic.

On May 13th, I hosted an Ulster County discussion on the topic with similarly distinguished panelists as you had at your roundtables. Ulster County Sheriff Paul VanBlarcum, Ulster County District Attorney D. Holley Carnright, Ulster County EMS Council President Rich Mullerliele, former SUNY New Paltz Police Chief Raymond Bryant, City of Kingston Fire Department Lt. Christopher Hyatt, Former Legislative Chairman Louis Klein and other concerned citizens all contributed valuable insights on the issue.

Our panelists identified two key areas where we feel that State attention could yield immediate results. The first is for State Aide for the purchase of the intranasal naloxone kits for EMS and Fire Departments. While Attorney General Schneiderman's Community Overdose Prevention (COP) Program was an amazing jump start for Law Enforcement agencies, we need to get this proven lifesaving antidote into the hands of all of our first responders. Second, is to have the New York State Health and Education Departments bring back the "Madison Avenue" type ad campaign to alert adults and children alike to the devastating and potentially lethal consequences of heroin use.

I have enclosed a copy of the press release about the Ulster County conversation and look forward to further discussions with you regarding a State-County collaboration on this very important public health and safety need.

Kindest regards,

John R. Parete, Chairman
Ulster County Legislature

ULSTER COUNTY LEGISLATURE

JOHN R. PARETE
Chair 845-340-3699

DAVID B. DONALDSON
Vice-Chair 845-340-3699

DONALD J. GREGORIUS
Majority Leader 845-340-3900

KENNETH J. RONK
Minority Leader 845-340-3900

P.O. Box 1800
KINGSTON, NEW YORK 12402
Telephone: 845 340-3900
FAX: 845 340-3651

VICTORIA A. FABELLA
Clerk 845-340-3666

CAPPY WEINER
Counsel 845-340-3900

CHRISTOPHER RAGUCCI
Counsel 845-340-3900

ERICA GUERIN
Minority Counsel 845-340-3900

June 3, 2014

Assemblyman Kevin Cahill
New York State Assembly
Governor Clinton Bldg., Suite G-4
1 Albany Avenue
Kingston, NY 12401

Dear Assemblyman Lopez:

I noted the Assembly's joint Alcoholism and Drug Abuse, Health, and Codes Committee's Roundtable to discuss a comprehensive approach to the opiate and heroin crisis held in Albany on May 12th and NYC on June 5th. I look forward to continuing the discussion toward the development a multi-prong strategy to fight this epidemic.

On May 13th, I hosted an Ulster County discussion on the topic with similarly distinguished panelists as you had at your roundtables. Ulster County Sheriff Paul VanBlarcum, Ulster County District Attorney D. Holley Carnright, Ulster County EMS Council President Rich Mullerliele, former SUNY New Paltz Police Chief Raymond Bryant, City of Kingston Fire Department Lt. Christopher Hyatt, Former Legislative Chairman Louis Klein and other concerned citizens all contributed valuable insights on the issue.

Our panelists identified two key areas where we feel that State attention could yield immediate results. The first is for State Aide for the purchase of the intranasal naloxone kits for EMS and Fire Departments. While Attorney General Schneiderman's Community Overdose Prevention (COP) Program was an amazing jump start for Law Enforcement agencies, we need to get this proven lifesaving antidote into the hands of all of our first responders. Second, is to have the New York State Health and Education Departments bring back the "Madison Avenue" type ad campaign to alert adults and children alike to the devastating and potentially lethal consequences of heroin use.

I have enclosed a copy of the press release about the Ulster County conversation and look forward to further discussions with you regarding a State-County collaboration on this very important public health and safety need.

Kindest regards,

John R. Parete, Chairman
Ulster County Legislature

LOUIS M. KLEIN
Attorney-at- Law
61 Lipton Street
Kingston, New York 12401

June 3, 2014

Hon. Egidio F. Tinti
Chief, City of Kingston Police Department
1 Garraghan Drive
Kingston, New York 12401

Re: Heroin/Opioid Addiction and Overdose
Prevention Discussion Group

Dear Chief Tinti:

John Parete, the Chairman of the Ulster County Legislature, recently asked me to chair and/or facilitate the above-referenced discussion group. Participants include a wide array of government officials, EMTs, and community leaders, including Sheriff Van Blarcum, District Attorney Carnright, Legislator Parete and Legislator Belfiglio. To date, we have had only one brief discussion.

We fervently hope that you will see your way clear to join us in our effort to identify steps that the Ulster County Legislature might take to combat the ever-increasing problem of Heroin/ Opioid Addiction and overdose prevention. Although it would be fantastic if you would personally become a part of our discussion group, if you cannot see your way clear to do that, we would welcome working with your designee.

Although, at present, we are only functioning as a discussion group, as I understand it, Legislature Chairman Parete intends to have the group, or some part of it, remain in effect in order to participate in the implementation of its recommendations.

If you have any concerns or questions which you would like addressed, please feel free to contact me by phone at (H) 338-8767 or (C) 853-4229, or personally.

Respectfully yours,

Louis M. Klein

Cc: Hon. John Parete

LOUIS M. KLEIN
Attorney-at- Law
61 Lipton Street
Kingston, New York 12401

October 23, 2014

Honorable D. Holley Cranright
District Attorney, Ulster County
284 Wall Street
Kingston, New York 12401

Re: Heroin/Opioid Addiction and Overdose Prevention
Discussion Group - UCAN

Dear Holley,

I am happy to report that our group is making great progress in our endeavor to combat the Heroin and Opioid use epidemic plaguing Ulster County. Our monthly meetings continue to be informative and productive.

At our October 22nd meeting students from SUNY New Paltz presented a rough cut of a PSA they are working on in collaboration with the UCAN Subcommittee on Education and Prevention. During the post preview discussion coalition members agreed that some personal testimonials could leave a power impact on the viewer. At one of our initial meetings you offered to help us select appropriate recovering addicts. If you feel that you could still facilitate such a testimonial, I would like to forward your contact information on to Mr. Steven Sirianni, the New Paltz student coordinating the PSA project. Your interest and participation in our coalition is truly appreciated and offers a degree of legitimacy and professionalism to the group.

Additionally, at the October 21st session of the Ulster County Legislature Resolution Number 271, officially establishing the Ulster County Coalition Against Narcotics, was passed. It is my hope that you will agree to continue to serve as a member of the Coalition.

If you have any concerns or questions which you would like addressed, please feel free to contact me by phone at (H) 338-8767 or (C) 853-4229, or personally.

Respectfully yours,

Louis M. Klein

Cc: Hon. John Parete

ULSTER COUNTY COALITION AGAINST NARCOTICS
C/0 **Ulster County Legislature**
244 Fair Street
P.O. Box 1800
Kingston, New York 12401
(845) 340-3800

March 25, 2015

To: All Town and Village Clerks and Town and Village Boards

Dear Ladies and Gentlemen:

During the latter part of last year, the Ulster County Legislature, by Resolution number 371, established the Ulster County Coalition Against Narcotics. Thereafter, I was appointed the Chairman of said Coalition by Legislature Chairman John Parete.

As I am sure you know, heroin and opioid abuse has become an alarming problem across the nation. It has become a public health crisis in New York State and within Ulster County's communities, as well. Since our federal and state government has cracked down on the abuse of prescriptive drugs, in many areas heroin has become the drug of choice. Today it often costs more to purchase a pack of cigarettes than an individual dose of heroin.

Our Coalition, comprised of District Attorney Holley Carnright, County Legislators, members of the drug abuse treatment community, an education administrator, members of the EMS community and concerned members of the public, was established to advise the Legislature of ways to identify and supply appropriate treatment for heroin and opiate abusers, as well as of ways to facilitate prevention of opioid abuse. One of our principal purposes is to inform the public throughout Ulster County of the existence of an opioid crisis in Ulster County and to enlist its support in our County's quest to abate, if not resolve the problem.

We know that some of our communities have groups with similar objectives operating within their borders. If you are among them, we would appreciate it if you would inform their representatives about us and that we welcome their participation in our mission and enlist their support of our efforts. We urge them to contact us.

Thank you for your anticipated cooperation.

Respectfully yours,

Louis M. Klein, Chairman
Ulster Coalition Against Narcotics

ULSTER COUNTY COALITION AGAINST NARCOTICS
C/O ULSTER COUNTY LEGISLATURE

P.O. Box 1800
KINGSTON, NEW YORK 12402
Telephone: 845 340-3900
FAX: 845 340-3651

April 2, 2015

Hon. Assemblywoman Linda B. Rosenthal
Assembly District 67
Chair: Alcoholism and Drug Abuse Committee

Hon. Assemblywoman Rosenthal,

The Ulster County Coalition Against Narcotics was created late last year in response to the growing heroin resurgence in our area. Since the Senate's Heroin Task Force has made it abundantly clear that the heroin epidemic is a state wide problem, we request your attention to the following.

One of the issues that we have identified as troublesome is the extended time that addicts have to wait for methadone treatment. Therefore our sub-committee respectfully requests that you look into this matter as we find delays in providing treatment for addicts to be counter intuitive.

We believe that active addicts are a danger to themselves, their families, and the public at large; to say nothing of the enormous drain on public funds that continual opioid use creates by:

Criminal activity leading to incarceration and criminal justice costs

Emergency Services costs in responding to overdoses

Hospitalizations and Emergency Room events

Contracting and transmitting long term needle borne diseases like HIV and Hepatitis C

Familial neglect thereby creating costs to Children's Protective Services and Family Courts

We hold that the aforementioned costs far exceed those of expanding methadone treatment programs

We have made a similar request to Senator Amedore, the chair of the Senate's Drug and Alcohol Abuse Committee

Thomas Kadgen,

Chair: Intervention and Treatment Sub-Committee
Ulster County Coalition Against Narcotics

ULSTER COUNTY COALITION AGAINST NARCOTICS
C/O ULSTER COUNTY LEGISLATURE

P.O. Box 1800
KINGSTON, NEW YORK 12402
Telephone: 845 340-3900
FAX: 845 340-3651

April 2, 2015

Hon. Senator Amedore, NYS District 46
Chairman NY Senate Drug & Alcohol Abuse Committee
Co-Chair NYS Senate Heroin Task Force

Hon. Senator Amedore,

The Ulster County Coalition Against Narcotics was created late last year in response to the growing heroin resurgence in our area. Since the Senate's Heroin Task Force has made it abundantly clear that it is a state wide problem and that you assigned your staff to audit our meetings, our sub-committee decided against creating a memorializing resolution and has opted to contact you directly.

One of the issues that we have identified as troublesome is the extended time that addicts have to wait for methadone treatment. Therefore our sub-committee respectfully requests that you look into this matter as we find delays in providing treatment for addicts to be counter intuitive.

We believe that active addicts are a danger to themselves, their families, and the public at large; to say nothing of the enormous drain on public funds that continual opioid use creates by:

Criminal activity leading to incarceration and criminal justice costs

Emergency Services costs in responding to overdoses

Hospitalizations and Emergency Room events

Contracting and transmitting long term needle borne diseases like HIV and Hepatitis C

Familial neglect thereby creating costs to Children's Protective Services and Family Courts

We hold that the aforementioned costs far exceed those of expanding methadone treatment programs

In closing we would like to acknowledge and relay our appreciation for your concern for our county

A similar request has been sent to the Chair of the Assembly's Alcohol and Drug Abuse Committee, Linda Rosenthal.

Thomas Kadgen,

Chair: Intervention and Treatment Sub-Committee
Ulster County Coalition Against Narcotics

ULSTER COUNTY LEGISLATURE

JOHN R. PARETE
Chair 845-340-3699

DAVID B. DONALDSON
Vice-Chair 845-340-3699

DONALD J. GREGORIUS
Majority Leader 845-340-3900

KENNETH J. RONK
Minority Leader 845-340-3900

P.O. Box 1800
KINGSTON, NEW YORK 12402
Telephone: 845 340-3900
FAX: 845 340-3651

VICTORIA A. FABELLA
Clerk 845-340-3666

CAPPY WEINER
Counsel 845-340-3900

CHRISTOPHER RAGUCCI
Counsel 845-340-3900

ERICA GUERIN
Minority Counsel 845-340-3900

June 4, 2015

Assemblyman Joseph Lentol
New York State Assembly
Legislative Office Building, 632
Albany, NY 12448

Joe

Dear Assemblyman Lentol:

I write to thank you for your leadership in introducing Assembly Bill A02962, An act to amend the criminal procedure law, the civil practice law and rules and the executive law in relation to the possession of opioid antagonists. There is no doubt that the heroin epidemic we are facing must be fought on many fronts. The passage of this legislation will undeniably result in lives being saved and more individuals suffering from the disease of addiction being identified and provided with the services they need to start recovery.

It was almost exactly one year ago to the day that I wrote to State Senate and Assembly members representing Ulster County asking for state action that would help us in our battle locally. Since that time the County Legislature formed the Ulster Coalition Against Narcotics (UCAN) to continue the discussion and develop recommendations on policies the County Legislature could adopt to address Heroin and Opioid use and abuse. Coalition members include such distinguished individuals and professionals as our District Attorney, County Sheriff, County Legislators, a doctor from the Institute for Family Health who administers Methadone and Suboxone treatment, a school administrator, Mrs. Elizabeth Berardi who was invited to testify at the recent State Senate Heroin Task Force hearing on June 2nd, and many others. They are a great group who take this issue seriously and donate their free time to offer their professional advice.

I had an opportunity to discuss your interest and commitment to this issue with your staff and have relayed that I and the members of the UCAN would be more than happy to offer our support and advocacy to you on future legislation you might introduce on this serious issue. On behalf of UCAN and the Ulster County Legislature, thank you for introducing legislation that provides real, tangible assistance to the people who are on the front lines of this battle every day.

Kindest regards,

John R. Parete, Chairman
Ulster County Legislature

A02962 Summary:

BILL NO A02962A

SAME AS No same as

SPONSOR Lentol (MS)

COSPNSR Cymbrowitz, Gottfried, Weprin, Abinanti

MLTSPNSR

Add S60.48, CP L; add S4519-a, CPLR; amd S841, Exec L

Relates to the possession of opioid antagonists and receipt into evidence.

A02962 Actions:

BILL NO A02962A

01/20/2015 referred to codes
04/22/2015 reported
04/23/2015 advanced to third reading cal.190
05/27/2015 amended on third reading 2962a
06/01/2015 passed assembly
06/01/2015 delivered to senate
06/01/2015 REFERRED TO CODES

A02962 Votes:

A02962A 06/01/2015 145/0

Abbate	Y	Clark	ER	Gantt	Y	Kim	Y	Morelle	Y	Richard	Y	Stec	Y		
Abinant	Y	Colton	Y	Garbari	Y	Kolb	Y	Mosley	ER	Rivera	Y	Steck	Y		
Arroyo	Y	Cook	Y	Giglio	Y	Lalor	Y	Moya	Y	Roberts	Y	Stirpe	Y		
Aubry	Y	Corwin	Y	Gjonaj	Y	Lavine	ER	Murray	Y	Robinso	Y	Tedisco	Y		
Barclay	Y	Crespo	Y	Glick	Y	Lawrenc	Y	Nojay	Y	Rodrigu	Y	Tenney	Y		
Barrett	Y	Crouch	Y	Goldfed	Y	Lentol	Y	Nolan	Y	Rosenth	Y	Thiele	Y		
Barron	Y	Curran	Y	Goodell	Y	Lifton	Y	Oaks	Y	Rozic	Y	Titone	Y		
Benedet	Y	Cusick	Y	Gottfri	Y	Linares	Y	O'Donne	Y	Russell	Y	Titus	Y		
Bichott	Y	Cymbrow	Y	Graf	Y	Lopez	Y	Ortiz	Y	Ryan	Y	Walker	Y		
Blake	Y	Davila	Y	Gunther	Y	Lupardo	Y	Otis	Y	Saladin	Y	Walter	Y		
Blanken	Y	DenDekk	Y	Hawley	Y	Lupinac	Y	Palmesa	Y	Santaba	Y	Weinste	Y		
Borelli	Y	Dilan	Y	Hevesi	Y	Magee	Y	Palumbo	Y	Schimel	Y	Weprin	Y		
Brabene	Y	Dinowit	Y	Hikind	Y	Magnare	Y	Paulin	Y	Schimmi	Y	Woerner	Y		
Braunst	Y	DiPietr	Y	Hooper	Y	Malliot	Y	Peoples	Y	Seawrig	Y	Wozniak	Y		
Brennan	Y	Duprey	Y	Jaffee	Y	Markey	ER	Perry	Y	Sepulve	Y	Wright	Y		
Brindis	Y	Englebr	Y	Jean-Pi	Y	Mayer	Y	Persaud	Y	Silver	Y	Zebrows	Y		
Bronson	Y	Fahy	Y	Johns	Y	McDonal	Y	Pichard	Y	Simanow	Y	Mr Spkr	Y		
Brook-K	Y	Farrell	Y	Joyner	Y	McDonou	Y	Pretlow	Y	Simon	Y				
Buchwal	Y	Finch	Y	Kaminsk	Y	McKevit	Y	Quart	Y	Simotas	Y				
Butler	Y	Fitzpat	Y	Katz	Y	McLaugh	Y	Ra	Y	Skartad	Y				
Cahill	Y	Friend	Y	Kavanag	Y	Miller	Y	Raia	Y	Skoufis	Y				
Ceretto	Y	Galef	Y	Kearns	Y	Montesa	Y	Ramos	Y	Solages	Y				

A02962 Memo:

BILL NUMBER:A2962A

TITLE OF BILL:

An act to amend the criminal procedure law, the civil practice law and rules and the executive law, in relation to the possession of opioid antagonists

PURPOSE:

To promote the use of opioid antagonists to combat and prevent drug-related overdoses.

SUMMARY OF SPECIFIC PROVISIONS:

Section 1 of the bill adds a new section 60.47 to the criminal procedure law to prohibit the introduction of possession of an opioid antagonist to any trial, hearing, or proceeding pursuant to sections 220.03, 220.06, 220.09, 220.16, 220.18, or 220.21 of the penal law for the purpose of establishing probable cause for an arrest or providing any person's commission of such offense. This section also defines the term opioid antagonist.

Section 2 of the bill adds new section 4519-a to the civil practice law and rules to prohibit the introduction of possession of an opioid antagonist in any trial, hearing, or proceeding pursuant to subdivision 1 of section 231 and paragraph 3 of subdivision b of section 233 of the real property law or subdivision 5 of section 711 and subdivision 1 of section 715 of the real property actions and proceedings law as evidence that the building or premises are being used for illegal trade, manufacture, or other illegal business.

Section 3 of the bill adds a new subdivision 7-b to section 841 of the executive law to take such steps as necessary to ensure that police and peace officers receive appropriate instruction regarding section 60.47 of the criminal procedure law.

Section 4 of the bill provides for the effective date.

JUSTIFICATION:

Opioid antagonists, such as naloxone, have been in existence since the 1960s and have helped in preventing numerous heroin and opiate overdose-related deaths in emergency situations. Recent legislation and actions by law enforcement and chemical dependence prevention and treatment providers have increased the availability of naloxone to those with addiction to heroin and opiates. At hearings and roundtable discussions held by the Assembly, chemical dependence prevention and treatment providers, physicians, drug policy experts, and law enforcement all cited the importance of the availability of opioid antagonists in preventing overdose-related deaths. Although medical treatment is required after an opioid antagonist is administered, its use and possession should not be discouraged amongst those who need it most. By prohibiting the possession of opioid antagonists as evidence in court of possession of controlled substances, this bill would help to encourage people to obtain and possess opioid antagonists and continue to save lives.

PRIOR LEGISLATIVE HISTORY:

A.10015-A of 2014

FISCAL IMPLICATIONS:

None.

EFFECTIVE DATE:

This act shall take effect in 60 days and shall apply to all cases pending on such date.

THE SENATE
STATE OF NEW YORK
ALBANY 12247

Tuesday
8:30 - appt

JOINT TASK FORCE ON HERION AND OPIOID ADDICTION

SENATOR GEORGE A. AMEDORE, JR.
CO-CHAIR
ROOM 802
LEGISLATIVE OFFICE BUILDING
ALBANY, NEW YORK 12247
518-455-2359

SENATOR TERRENCE P. MURPHY
CO-CHAIR
ROOM 817
LEGISLATIVE OFFICE BUILDING
ALBANY, NEW YORK 12247
518-455-3111

SENATOR ROBERT G. ORTT
CO-CHAIR
ROOM 815
LEGISLATIVE OFFICE BUILDING
ALBANY, NEW YORK 12247
518-455-2024

May 8, 2015

Peter Nekos
187 Spillway Rd
West Hurley, NY 12491

Joe
I will
June 2 off
if possible

Dear Mr. Nekos:

The New York State Joint Senate Task Force on Heroin and Opioid Addiction, co-chaired by Senator George Amedore, Senator Terrence Murphy and Senator Robert Ortt will host a public hearing in Albany to solicit input on the rise in the use of heroin and opioids and to evaluate what state measures may be needed to further reduce drug abuse in New York.

The Hearing will address the following questions:

- What specific recommendations do you have for raising awareness, treatment options, preventing addiction and informing people about the dangers of heroin and opioid abuse?
- What state or local actions must be taken to ensure law enforcement has the tools to prevent potential drug-related crimes, avoid negative community impacts and keep heroin off the streets?

Senator George Amedore, Senator Terrence Murphy, Senator Robert Ortt cordially invite you to provide testimony at the hearing to be held at 6:00 P.M. on June 2, 2015 at SUNY Albany, D'Ambra Auditorium, Life Sciences Research Building, 1400 Washington Avenue, Albany, NY 12222. Upon your RSVP we will coordinate the time of your testimony.

To RSVP, please contact Brendan Lovullo at lovullo@nysenate.gov or (518) 455-2561.

“The Public Health Implications of Heroin and the Federal Response to the Opioid Overdose Epidemic”

Tuesday July 28, 2015
10:00 a.m.
2141 Rayburn House Office Building

Statement of
Michael P. Botticelli
Director of National Drug Control Policy

Chairman Sensenbrenner, Ranking Member Jackson Lee, and members of the Subcommittee, thank you for this opportunity to address the public health issues surrounding heroin in the United States and the Federal response.

As you know, the Office of National Drug Control Policy (ONDCP) was established in 1988 by Congress with the principal purpose of reducing illicit drug use, manufacturing, and trafficking; drug-related crime and violence; and drug-related health consequences. As a component of the Executive Office of the President, our office establishes policies, priorities, and objectives for the Nation's drug control programs and ensures that adequate resources are provided to implement them. We also develop, evaluate, coordinate, and oversee the international and domestic anti-drug efforts of Executive Branch agencies and ensure such efforts sustain and complement state and local drug policy activities.

At ONDCP, we are charged with producing the *National Drug Control Strategy* (*Strategy*), the Administration's primary blueprint for drug policy, along with a national drug control budget. The *Strategy* is a 21st century plan that outlines a series of evidence-based reforms that treat our Nation's drug problem as a public health challenge, not just a criminal justice issue. It is guided by what science, experience, and compassion demonstrate about the true nature of drug use in America.

The considerable public health and safety consequences of nonmedical prescription opioid and heroin use underscore the need for action. Since the Administration's inaugural 2010 *National Drug Control Strategy*, we have deployed a comprehensive and evidence-based strategy to address opioid use disorders and overdose deaths due to heroin use and prescription opioid misuse. The Administration has increased access to treatment for substance use disorders, expanded efforts to prevent overdose and has coordinated a Government-wide response to the consequences of nonmedical prescription drug use. We also have continued to pursue actions against criminal organizations trafficking in opioid drugs. This statement focuses largely on the Administration's public health policy interventions to address opioid drug abuse, as well as those of our Federal, state and local partners, including professional associations that are involved with opioid prescribing or the prevention and treatment of opioid misuse. The statement of the Drug Enforcement Administration (DEA) for this hearing will discuss supply and law enforcement approaches.

Trends and Consequences of Opioid Use

Opioids – a category of drugs that includes heroin and prescription pain medicines like oxycodone, oxymorphone and hydrocodone – are having a considerable impact on public health and safety in communities across the United States. According to the Centers for Disease Control and Prevention (CDC), approximately 120 Americans on average died from a drug overdose every day in 2013. Of the nearly 44,000 drug overdose deaths in 2013, opioid pain relievers were involved in over 16,200, while heroin was involved in over 8,200. Overall, drug overdose deaths now outnumber deaths from gunshot wounds (over 33,600) or motor vehicle crashes (over

32,700)[1] in the United States.[2] Moreover, overdose deaths related to opioid pain relievers and heroin are undercounted as around one quarter of death certificates do not list the drug responsible for the fatal drug overdose,[3] and until recently standards did not exist for death investigation reporting, and adoption of these standard is not universally practiced.[4]

The diversion and nonmedical use of prescription opioid medications has been of serious concern at the national, state, and local levels for over a decade. Increases in admissions to treatment for substance use disorders,[5] drug-related emergency department visits,[6] and, most disturbingly, overdose deaths[7] attributable to nonmedical prescription drug use place enormous burdens upon communities across the country. Heroin, in contrast, until very recently has been used at much lower rates, possibly because historically its use was generally via injection, which often was necessitated by its low purity. As heroin purity increases, heroin can be smoked or snorted.[8] Research shows that price reductions (resulting from greater availability) are closely related to overdose hospitalization rates; every $100 decrease in the price of heroin per pure gram results in a 2.9 percent increase in the number of overdose hospitalizations.[9]

In 2013, over 4.5 million Americans ages 12 and older reported using prescription pain relievers non-medically within the past month.[10] This makes nonmedical prescription pain reliever use more common than use of any category of illicit drug in the United States except for marijuana. Approximately 289,000 Americans reported past month use of heroin in 2013.[11] Heroin use remains relatively low in the United States when compared to other drugs; however, the increase in the number of people using the drug in recent years – from 373,000 past year users in 2007 to 681,000 in 2013 – is troubling.[12] These figures likely undercount the number of users, as national household surveys do not track all heroin-using populations such as homeless users. At least one community with a high level of chronic drug users among its homeless

[1] Fatality Analysis Reporting System (FARS) Encyclopedia Available at: http://www-fars.nhtsa.dot.gov/Main/index.aspx
[2] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death, 1999-2013 on CDC WONDER Online Database, released 2015. Extracted by ONDCP from http://wonder.cdc.gov/mcd-icd10.html on January 30, 2015.
[3] See http://s3.documentcloud.org/documents/1151267/heroin-project-2014-study-on-overdose-deaths.pdf
[4] Goldberger BA1, Maxwell JC, Campbell A, Wilford BB. Uniform standards and case definitions for classifying opioid-related deaths: recommendations by a SAMHSA consensus panel. J Addict Dis. 2013;32(3):231-43. doi: 10.1080/10550887.2013.824334.
[5] Substance Abuse and Mental Health Services Administration. *Treatment Episode Data Set (TEDS) 2001-2011, National Admissions to Substance Abuse Treatment Services*. U.S. Department of Health and Human Services. [2013]. Extracted April 2013.
[6] Substance Abuse and Mental Health Services Administration. *Drug Abuse Warning Network, 2011: National Estimates of Drug-Related Emergency Department Visits*. U.S. Department of Health and Human Services. [May 2013]. Available: http://www.samhsa.gov/data/2k13/DAWN2k11ED/DAWN2k11ED.htm#5.2
[7] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death, 1999-2013 on CDC WONDER Online Database, released 2015.
[8] Stöver HJ1, Schäffer D. SMOKE IT! Promoting a change of opiate consumption pattern - from injecting to inhaling. Harm Reduct J. 2014 Jun 27;11:18. doi: 10.1186/1477-7517-11-18. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4094754/
[9] Unick G1, Rosenblum D, Mars S, Ciccarone D.Addiction. The relationship between US heroin market dynamics and heroin-related overdose, 1992-2008.2014 Nov;109(11):1889-98. doi: 10.1111/add.12664. Epub 2014 Aug 4.
[10] Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Detailed Tables*. Department of Health and Human Services. [November 2014]. Available: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabsPDFWHTML2013/Web/HTML/NSDUH-DetTabsSect7peTabs1to45-2013.htm#tab7.3b
[11] Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Detailed Tables*. Department of Health and Human Services. [November 2014]. Available: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabsPDFWHTML2013/Web/HTML/NSDUH-DetTabsSect7peTabs1to45-2013.htm#tab7.3A
[12] Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Detailed Tables*. Department of Health and Human Services. [November 2014]. Available: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabsPDFWHTML2013/Web/HTML/NSDUH-DetTabsSect7peTabs1to45-2013.htm#tab7.2A

population, Baltimore, revises their heroin count by 10 percent to adjust for heroin use among its homeless population.[13]

Nonetheless, the trend for increases in heroin users shown in the National Survey on Drug Use and Health (NSDUH), a household-based survey from the Substance Abuse and Mental Health Services Administration (SAMHSA), comports with other indicators, including recent reporting from the National Institute on Drug Abuse's (NIDA) Community Epidemiology Work Group, which found that a number of U.S. cities, including Atlanta, Baltimore, Boston, Chicago, Cincinnati, Denver, Miami, Minneapolis, San Diego, Seattle, and St. Louis, indicated increases in heroin use. In addition, heroin remained at relatively stable but high levels in Detroit, New York City, and Philadelphia.[14] DEA also reports an over 300 percent increase of heroin seizures at the Southwest border from 2008 to 2013.[15]

A recent report from CDC and FDA using NSDUH public-use data[16] shows a significant increase in heroin use from 2002 to 2004 and from 2011 to 2013. Rates remained highest among males, persons aged 18 to 25 years, persons with annual household incomes below $20,000, persons living in urban areas, and persons with no health insurance or with Medicaid; however, rates increased significantly across almost all study groups. Moreover, the greatest increases in heroin use occurred in demographic groups that historically have had lower rates of heroin use, doubling among women and more than doubling among non-Hispanic whites. The rates of individuals who developed abuse or dependence on heroin, a near doubling during the decade-long study period, with a 35.7 percent increase during 2008–2010 alone, emphasize the addictive nature of this drug. This increase parallels the sharp increase in heroin-related overdose deaths reported since 2010.

This report also indicates that individuals who use heroin also use other drugs. People with past year abuse of or dependence on alcohol, marijuana, cocaine, or opioid pain relievers were at increased risk for past year heroin abuse or dependence. In 2013, 59 percent of the 8,257 heroin-related overdose deaths in the United States involved at least one other drug.[17] Data presented in this report indicate the relationship between heroin and opioid pain relievers, as well as the relationship between heroin and cocaine, are particularly strong. In fact, past year abuse or dependence on opioid pain relievers was the strongest risk factor for past year heroin abuse or dependence. These results, coupled with prior research on heroin use trajectories, underscore that heroin use has its roots in, and often exists alongside, other forms of substance misuse.

Research illustrates that heroin use today is one of the later steps in most personal drug use trajectories. An analysis of NSDUH data shows that 21,000 people nationally began using

[13] Baltimore Mayor's Heroin Treatment & Prevention Task Force Report http://health.baltimorecity.gov/sites/default/files/Mayor%20Heroin%20Treatment%20Prevention%20Task%20Force%20Final%20Report%20July%2013%202015.pdf

[14] National Institute on Drug Abuse. Highlights and Summaries from January 2014 Reports. Available: http://www.drugabuse.gov/about-nida/organization/workgroups-interest-groups-consortia/community-epidemiology-work-group-cewg/highlights-summaries-january-2014-reports

[15] National Seizure System, El Paso Intelligence Center, extracted January 25, 2014.

[16] Jones CM, Logan J, Gladden RM, Bohm MK. Vital Signs: Demographic and Substance Use Trends Among Heroin Users - United States, 2002-2013. MMWR Morb Mortal Wkly Rep. 2015 Jul 10;64(26):719-25 Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6426a3.htm?s_cid=mm6426a3_w

[17] CDC. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2014. Available at http://wonder.cdc.gov.

heroin when 12 to 17 years old, 66,000 people began using when 18 to 25 years old, and 82,000 began when 26 years and older.[18] Past-year heroin users were most likely to be in the 26 and older demographic. A second study of treatment seekers found the average age of treatment seekers to be around 23, and 75 percent of these began by using prescription opioids first.[19] While the increases in overdose deaths among young people is disturbing, and pediatricians and doctors caring for people under the age of 25 need to be engaged on this issue, practitioners who treat adults normally past the typical age for developing substance use disorders need to monitor their patients for possible heroin use.

The nonmedical use of opioids translates into serious health consequences. In 2013 alone, approximately 1.9 million Americans met the diagnostic criteria for abuse of or dependence on prescription pain relievers, with heroin accounting for approximately 517,000 people with past-year abuse or dependence; both figures represent significant increases from just a decade earlier.[20] For the duration of this statement, the terms "opioid use disorder" and "heroin use disorder" will be used to describe people who meet the criteria for abuse and dependence, since the terminology in the Diagnostic and Statistical Manual, Fifth Edition (DSM 5), the U.S. standard for classifying mental health disorders, no longer makes a distinction between abuse and dependence.

Although only about 15 percent of people who have not used heroin in the past year believe it would be fairly or very easy to obtain, approximately 81 percent of people who have used it in the past year hold that belief.[21] Most Americans of all ages perceive great risk in using heroin once or twice a week.[22] Disturbingly, approximately 20 percent of people 12 to 17 years old do not believe using heroin once or twice weekly is harmful (compared to only 5 percent of people 26 or older).[23]

Beyond the many lives taken by fatal overdoses involving these medications, prescription opioids are associated with significant burden on our healthcare system. In 2011 alone, the last year for which these data are available, 1.2 million emergency department (ED) visits involved the nonmedical use of prescription drugs.[24] Of these 1.2 million ED visits, opioid pain relievers accounted for the single largest drug class, accounting for approximately 488,000 visits. This is nearly triple (2.8 times) the number of ED visits involving opioid pain relievers just 7 years

[18] R.N. Lipari and A. Hughes. The NSDUH Report: Trends in Heroin Use in the United States: 2002 to 2013. (2015). Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Rockville, MD. http://www.samhsa.gov/data/sites/default/files/report_1943/ShortReport-1943.html Available at linked to on 7-19-2015.
[19] Cicero TJ, Ellis MS, Surratt HL, Kurtz SP.The changing face of heroin use in the United States: a retrospective analysis of the past 50 years. JAMA Psychiatry. 2014 Jul 1;71(7):821-6. doi: 10.1001/jamapsychiatry.2014.366.
PMID: 24871348 available at http://archpsyc.jamanetwork.com/article.aspx?articleid=1874575
[20] Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Detailed Tables*. Department of Health and Human Services. [November 2014]. Available: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabsPDFWHTML2013/Web/HTML/NSDUH-DetTabsSect7peTabs1to45-2013.htm#tab7.40A
[21] R.N. Lipari and A. Hughes. The NSDUH Report: Trends in Heroin Use in the United States: 2002 to 2013. (2015). Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Rockville, MD. http://www.samhsa.gov/data/sites/default/files/report_1943/ShortReport-1943.html Available at linked to on 7-19-2015.
[22] R.N. Lipari and A. Hughes. The NSDUH Report: Trends in Heroin Use in the United States: 2002 to 2013. (2015). Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Rockville, MD. http://www.samhsa.gov/data/sites/default/files/report_1943/ShortReport-1943.html Available at linked to on 7-19-2015.
[23] *Ibid*.
[24] Substance Abuse and Mental Health Services Administration. *Drug Abuse Warning Network, 2011: National Estimates of Drug-Related Emergency Department Visits*. U.S. Department of Health and Human Services. [May 2013]. Available: http://www.samhsa.gov/data/2k13/DAWN2k11ED/DAWN2k11ED.htm#5.2

earlier in 2004 (173,000). Among specific opioid drugs in 2011, oxycodone accounted for the largest share (31%) of ED visits; there were 100,000 more visits involving oxycodone in 2011 than in 2004, an increase of 263 percent. Heroin was involved in nearly 258,000 visits in 2011. Increases in hospitalizations for prescription opioid overdose within a community actually predicts subsequent year heroin overdose,[25] indicating that not only do people tend to migrate to heroin if it is available, but also entire communities may shift usage habits.

Similar trends concerning growth in heroin use are reflected in the country's specialty substance use disorder treatment system. Data show a more than double increase in the past ten years of treatment admissions for individuals primarily seeking treatment for prescription opioid use disorder, from 53,000 in 2003 to 127,000 in 2011. Heroin treatment admissions remained flat over the same time period, yet accounted for 285,451 admissions in 2012.[26] Although all states have not yet reported specialty treatment admission data for 2013 and 2014, the trend in those states that have is that many more people are seeking treatment for heroin use than in the past.[27] In contrast, the percentage of people seeking treatment for prescription opioid use disorder has declined. Not every state, however, has experienced this decline. In some states with particularly intransigent prescription opioid misuse problems (for example, Tennessee), treatment admissions remain higher. In some states with historically high heroin treatment admissions (for example, New York), prescription opioid treatment admissions began an upward climb only in the late 1990s and at much lower levels.

There has been considerable discussion around potential connections between the non-medical use of prescription opioids and heroin use. There is evidence to suggest that some users, specifically those with a serious prescription opioid use disorder, will substitute heroin for prescription opioids. Heroin is cheaper than prescription opioids. A SAMHSA report found that four out of five recent heroin initiates had previously used prescription pain relievers nonmedically. However, only a very small proportion (3.6%) of those who recently had started using prescription drugs nonmedically initiated heroin use in the following five-year period.[28] Preventing the initiation of nonmedical opioid use nevertheless can help reduce the pool of people who may resort to heroin initiation later on because a large proportion of heroin users begin with abusing opioid pain relievers, even if this is a small subset of overall nonmedical opioid users.

We also know that substance use is often progressive, with some users rapidly escalating their use frequency, dosing, potency of drug and using through routes other than oral administration (e.g., sniffing, smoking or injecting) to achieve greater euphoria. Because the body rapidly develops tolerance to most effects of opioids and because withdrawal from opioids

[25] Unick GJ, Rosenblum D, Mars S, Ciccarone D. Intertwined epidemics: national demographic trends in hospitalizations for heroin- and opioid-related overdoses, 1993-2009. PLoS One. 2013;8(2):e54496. doi: 10.1371/journal.pone.0054496. Epub 2013 Feb 6. PMID: 23405084.
[26] Substance Abuse and Mental Health Services Administration. *Treatment Episode Data Set (TEDS) Substance Abuse Treatment Admissions by Primary Substance of Abuse, United States* [2002 through 2012 – Table 1.1a]. U.S. Department of Health and Human Services. [July 2014]. Available:
http://www.samhsa.gov/data/sites/default/files/2002_2012_TEDS_National/2002_2012_Treatment_Episode_Data_Set_National_Tables.htm
[27] Substance Abuse and Mental Health Services Administration. *Treatment Episode Data Set (TEDS) Substance Abuse Treatment extracted 6/2/2015 (Source Cala TIC Presentation Primary Drug Treatment Admissions.*
[28] Substance Abuse and Mental Health Services Administration. *Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States*. Department of Health and Human Services. [August 2013]. Available:
http://www.samhsa.gov/data/2k13/DataReview/DR006/nonmedical-pain-reliever-use-2013.pdf

exerts the opposite effect (e.g., severe pain and gastrointestinal distress) regardless of whether the drug used is a relatively weak opioid like codeine or a stronger one like heroin, a vicious cycle can develop, where a user must keep using to avoid the severe flulike and depressive symptoms associated with withdrawal. We know from survey data that as an individual's nonmedical use of prescription opioids becomes more frequent or chronic, that person is more inclined to purchase the drugs from dealers/prescriptions from multiple doctors, rather than simply getting them for free from a friend or relative.[29] Qualitative data indicates as tolerance, dependence, or craving increases, users tend to obtain more opioid sources and at times will select lower cost alternatives such as heroin as a way to meet and afford escalating opioid needs.[30,31,32] Research also suggests that the same dealers who deal in illicit pills often also supply heroin.[33]

The Administration's Response

Since 2009, the Obama Administration has deployed a comprehensive and evidence-based strategy to address: (1) excessive and dangerous opioid prescribing for pain and its consequences; and (2) illegal importation and sales of heroin. These efforts have expanded as surveillance has revealed an uptick in deaths related to the laboratory-created synthetic drug fentanyl and its analogs.

The following discussion identifies the efforts in each of these areas as experts believe they are all important for addressing heroin and the public health of people and communities heroin impacts.

Efforts to Stem the Prescription Opioid Crisis

President Obama's inaugural *National Drug Control Strategy*, released in May 2010, labeled opioid overdose a "growing national crisis" and laid out specific actions and goals for reducing nonmedical prescription opioid and heroin use.[34]

[29] Unpublished estimates from Substance Abuse and Mental Health Services Administration, *National Survey on Drug Use and Health*. 2009-2012, March 2014.

[30] Lankenau SE, Teti M, Silva K, Jackson Bloom J, Harocopos A, Treese M. Initiation into prescription opioid misuse amongst young injection drug users. Int J Drug Policy. 2012 Jan;23(1):37-44. doi: 10.1016/j.drugpo.2011.05.014. Epub 2011 Jun 20. PMID: 21689917 available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3196821/

[31] Lankenau SE1, Teti M, Silva K, Bloom JJ, Harocopos A, Treese M.J Patterns of prescription drug misuse among young injection drug users.Urban Health. 2012 Dec;89(6):1004-16. doi: 10.1007/s11524-012-9691-9. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3531346/

[32] Sarah G. Mars, Philippe Bourgois, George Karandinos, Fernando Montero, Daniel Ciccarone. "Every 'Never' I Ever Said Came True": Transitions from opioid pills to heroin injecting Int J Drug Policy. Author manuscript; available in PMC 2015 March 1.Published in final edited form as: Int J Drug Policy. 2014 March; 25(2): 257–266. Published online 2013 October 19. doi: 10.1016/j.drugpo.2013.10.004 available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3961517/pdf/nihms533727.pdf

[33] Sarah G. Mars, Philippe Bourgois, George Karandinos, Fernando Montero, Daniel Ciccarone. "Every 'Never' I Ever Said Came True": Transitions from opioid pills to heroin injecting Int J Drug Policy. Author manuscript; available in PMC 2015 March 1.Published in final edited form as: Int J Drug Policy. 2014 March; 25(2): 257–266. Published online 2013 October 19. doi: 10.1016/j.drugpo.2013.10.004 available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3961517/pdf/nihms533727.pdf

[34] Office of National Drug Control Policy. *2010 National Drug Control Strategy*. Executive Office of the President. [2010]. Available: http://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/ndcs2010.pdf#page=49

Nonmedical use of prescription drugs still represents the bulk of illicit opioid use in America, and pharmaceutical opioids are responsible for the majority of opioid-related deaths. Our response to this public health emergency focuses on preventing the diversion and nonmedical use of prescription drugs, decreasing the number of Americans dying from opioid overdose every day, and expanding access to effective treatment, health care, and services for people with opioid use disorders.

In April 2011, the Administration released a comprehensive *Prescription Drug Abuse Prevention Plan (Plan)*,[35] which created a national framework for reducing prescription drug diversion and misuse. The *Plan* focuses on: improving education for patients and healthcare providers; supporting the expansion of state-based prescription drug monitoring programs; developing more convenient and environmentally responsible disposal methods to remove unused and unneeded medications from the home; and reducing the prevalence of pill mills and doctor shopping through targeted enforcement efforts.

The Administration has made considerable progress in all four areas of the *Plan*. To start, much progress has been made in expanding available continuing education for prescribers. Managing patients' pain is a crucial area of clinical practice, but research indicates that health care practitioners receive little training on pain management or, safe opioid prescribing.[36,37] Ten states (Connecticut,[38] Delaware,[39] Iowa,[40] Kentucky,[41] Massachusetts,[42] New Mexico,[43] Ohio,[44] Tennessee,[45] Utah,[46] and West Virginia[47]) have passed legislation mandating education for prescribers, and we strongly encourage other states to explore this as an option.

At the Federal level, the Department of Health and Human Services (HHS) has implemented education requirements for its agency health care personnel, including professionals serving tribal communities through the Indian Health Service (IHS), those working with underserved populations through the Health Resources and Services Administration (HRSA), and personnel attending to biomedical research trial participants at the Clinical Center of the National Institutes of Health (NIH). Similar efforts have been implemented by the Bureau of Prisons and the Department of Defense (DoD). The Department of Veterans Affairs (VA) is making training available to clinicians although it is not currently required.

[35] Office of National Drug Control Policy. *Epidemic: Responding to America's Prescription Drug Abuse Crisis* [2011] Available: http://www.whitehouse.gov/sites/default/files/ondcp/issues-content/prescription-drugs/rx_abuse_plan.pdf
[36] Mezei, L., et al. Pain Education in North American Medical Schools. *The Journal of Pain*. 12(12):1199-1208. 2011.
[37] U.S. Government Accountability Office. *Prescription Pain Reliever Abuse*. [December 2011]. Available: http://www.gao.gov/assets/590/587301.pdf
[38] CONN. GEN. STAT. § 20-10b (2015), *available at* http://www.cga.ct.gov/2015/ACT/PA/2015PA-00198-R00HB-06856-PA.htm
[39] 24 DEL. CODE ANN. § 3.1.1, *available at* http://regulations.delaware.gov/AdminCode/title24/Uniform%20Controlled%20Substances%20Act%20Regulations.pdf.
[40] IOWA ADMIN. CODE r. 253-11.4 (2011), *available at* https://www.legis.iowa.gov/docs/ACO/chapter/07-22-2015.653.11.pdf.
[41] 201 Ky. Admin. Reg. 9:250 (2013), *available at* http://www.lrc.ky.gov/kar/201/009/250.htm.
[42] MASS. GEN. LAWS ch. 94C, § 18(e) (2011), *available at* https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXV/Chapter94c/Section18.
[43] N.M. ADMIN. CODE § 16-10-14 (2012), *available at* http://164.64.110.239/nmac/parts/title16/16.010.0014.htm.
[44] OHIO REV. CODE ANN. § 4723.482
[45] TENN. CODE ANN. § 63-1-402 (2013), *available at* http://www.tn.gov/sos/acts/108/pub/pc0430.pdf.
[46] UTAH ADMIN. CODE r. 58-37-6.5 (2012), *available at* http://le.utah.gov/xcode/Title58/Chapter37/58-37-S6.5.html?v=C58-37-S6.5_1800010118000101.
[47] W. VA. CODE § 30-1-7A (2011), *available at* http://www.legis.state.wv.us/wvcode/ChapterEntire.cfm?chap=30&art=1&section=7A.

The Administration developed and has made available free and low-cost training options available for prescribers and dispensers of opioid medications via several sources, including SAMHSA and NIDA. The Food and Drug Administration (FDA) now requires manufacturers of extended-release and long-acting (ER/LA) opioid pain relievers to make available free or low-cost continuing education to prescribers under the Risk Evaluation and Mitigation Strategy (REMS) for these drugs.

These efforts alone, however, cannot address the dearth of critical and necessary opioid prescriber training as it is an optional program. From 2010 to 2013, overdose deaths involving prescription opioids have decreased – but only by 2 percent.[48] We must do more to ensure all prescribers have the tools they need to prevent nonmedical prescription drug use. The Administration continues to support policies that mandate a continuing education requirement for prescribers, as outlined in the *Plan*, potentially linked to their registration to prescribe with the DEA.

In March, HHS announced a comprehensive, evidence-based initiative aimed at reducing opioid dependence and overdose. Among the three priority areas of the initiative are efforts to train and educate health professionals on safe opioid prescribing, including the development of prescribing guidelines for chronic pain by the CDC.

FDA has also taken a number of steps to help safeguard access to opioid analgesics while reducing risks of non-medical use and overdose. In April 2013, FDA approved updated labeling for reformulated OxyContin that describes the medication's abuse-deterrent properties. These properties are expected to make the drug more difficult to inject or abuse nasally.[49] In September 2013, ONDCP joined the FDA to announce significant new measures to enhance the safe and appropriate use of ER/LA opioid analgesics.[50] FDA required class-wide labeling changes for these medications, including modifications to the products' indication for pain severe enough to require daily, around-the clock, long-term opioid treatment and for which alternative treatment options are inadequate, warnings around use during pregnancy, as well as post-market research requirements. FDA also announced that manufacturers of ER/LA opioids must conduct further studies and clinical trials to better assess risks of misuse, addiction, overdose, and death. And in December 2013, FDA announced its recommendation that DEA reschedule hydrocodone combination products from Schedule III to Schedule II of the Controlled Substances Act; in August 2014, DEA issued a Final Rule implementing this recommendation, which became effective in October 2014.[51]

[48] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death, 1999-2013 on CDC WONDER Online Database, released 2015. Extracted by ONDCP from http://wonder.cdc.gov/mcd-icd10.html on January 30, 2015.
[49] "Determination That the OXYCONTIN (Oxycodone Hydrochloride) Drug Products Covered by New Drug Application 20–553 Were Withdrawn From Sale for Reasons of Safety or Effectiveness." Federal Register 78:75 (April 18, 2013) p. 23273. Available: http://www.gpo.gov/fdsys/pkg/FR-2013-04-18/pdf/2013-09092.pdf
[50] Food and Drug Administration. "ER/LA Opioid Analgesic Class Labeling Changes and Postmarket Requirements – Letter to ER/LA opioid application holders." Department of Health and Human Services. [September 2013]. Available: http://www.fda.gov/downloads/Drugs/DrugSafety/InformationbyDrugClass/UCM367697.pdf
[51] 21 CFR Part 1308 Schedules of Controlled Substances: Rescheduling of Hydrocondone Combination Products from Schedule III to Schedule II. DEA. Final Rule. Available at http://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-19922.pdf

The Administration is also educating the general public about the dangers of opioid use. ONDCP's Drug-Free Communities (DFC) Support Program currently funds 680 community coalitions to work with local youth, parent, business, religious, civic, and other groups to help prevent youth substance use. Grants awarded through the DFC program are intended to support established community-based coalitions capable of effecting community-level change. All DFC-funded grantees are required to collect and report data on past 30-day use; perception of risk or harm of use; perception of parental disapproval of use; and perception of peer disapproval of use for four substances, including prescription drugs.

The second area of the Administration's *Plan* focuses on improving the operations and functionality of state-administered Prescription Drug Monitoring Programs (PDMPs). PDMP data can help prescribers and pharmacists identify patients who may be at-risk for substance use disorders, overdose, or other significant health consequences of misusing prescription opioids. State regulatory and law enforcement agencies may also use this information to identify and prevent unsafe prescribing, doctor shopping, and other methods of diverting controlled substances. Aggregate data from PDMPs can also be used to track the impact of policy changes on prescribing rates. The Prescription Behavior Surveillance System, funded by CDC and FDA, is developing this surveillance capacity for PDMPs. Research also shows that PDMPs may have a role in reducing the rates of prescribing for opioid analgesics. For example, states where PDMPs are administered by a state health department showed especially positive results.[52]

In 2006, only twenty states had PDMPs. Today, the District of Columbia has a law authorizing a PDMP, and forty-nine states have operational programs.[53] The state of Missouri stands alone in not authorizing a PDMP. Kentucky[54], New Jersey,[55] New Mexico[56], New York[57], Oklahoma[58], and Tennessee[59] all require their prescribers to use their state's PDMP prior to prescribing in certain circumstances. In Tennessee, where the requirement to check the PDMP went into effect in 2013, there was a drop in the number of high utilizers of opioid pain relievers from the fourth quarter of 2011 to the fourth quarter of 2013.[60]

Building upon this progress, the HHS Office of the National Coordinator for Health Information Technology (ONC) and SAMHSA are working with state governments and private sector technology experts to integrate PDMPs with health information technology (health IT) systems such as electronic health records. Health IT integration will enable authorized healthcare providers to access PDMP data quickly and easily at the point of care. CDC is evaluating the SAMHSA grantees to identify best practices and determine the impact of the integration efforts.

[52] Brady, JE, Wunsch, H, Dimaggio, C, Lang, BH, Giglio, J, and Li, G. Prescription drug monitoring and dispensing of prescription opioids. Public Health Reports 2014, 129 (2): 139-47. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3904893/pdf/phr129000139.pdf
[53] National Alliance of Model State Drug Laws. (2014). Status of State Prescription Drug Monitoring Programs (PDMPs). Retrieved from http://www.namsdl.org/library/16666FCC-65BE-F4BB-A2BBAD44E1BC7031/.
[54] Kentucky 201 KAR 9:260. 2012. Available at http://www.lrc.ky.gov/kar/201/009/260.htm
[55] P.L. 2015, c.74 (N.J. 2015), *available at* http://www.njleg.state.nj.us/2014/Bills/AL15/74_.PDF
[56] New Mexico Register. 16.12.9.9. November 15, 2012. Available at http://www.nmcpr.state.nm.us/new-mexico-register/prev_issues/prev_issuesxxiii/xxiii21/16.12.9amend
[57] New York 3343-A. 2012. Available at http://law.justia.com/codes/new-york/2012/pbh/article-33/title-4/3343-a
[58] Oklahoma 3251. 2010. Available at http://www.oklegislature.gov/cf_pdf/2009-10%20FLR/hflr/HB3251%20hflr.pdf
[59] Tennessee 2253. 53-10-310. 2012. Available at http://www.tn.gov/sos/acts/107/pub/pc0880.pdf
[60] Tennessee Department of Health Controlled Substance Monitoring Database Committee. Controlled Substance Monitoring Database 2014 Report to the 108th Tennessee General Assembly, February 1, 2014. Page 5. Available at http://health.tn.gov/statistics/Legislative_Reports_PDF/CSMD_AnnualReport_2014.pdf Linked to 9-04-2014

The Department of Justice's (DOJ) Bureau of Justice Assistance (BJA) is also supporting expanded interstate sharing of PDMP data, which is especially important. Currently, at least thirty states have some ability to share data. PDMP administrators are working to better integrate these systems into other health IT programs. In FY 2014, BJA made fifteen site-based awards for states to implement or enhance a PDMP program or strategy to address non-medical prescription drug use, misuse and diversion within their communities. Since inception of the grant program in FY 2002, grants have been awarded to forty-nine states and one U.S. territory. In recent years, the grant program included tribal participation, and gave support to states and localities to expand collaborative efforts between public health and public safety professionals. For example, according to Maryland's Department of Health and Mental Hygiene, [61] the state used its grant funding to form local overdose fatality review (OFR) teams comprised of multi-agency, multi-disciplinary stakeholders who review information on individuals who died from drug and alcohol related overdose. The OFR teams meet monthly to review medical examiner and other data such as substance use disorder treatment records. They identify overdose risk factors, missed opportunities for prevention/intervention, and make policy recommendations. These teams work on both prescription opioid and heroin overdose deaths. Currently the PDMP cannot disclose its information directly to the fatality review teams but there is a proposal to change this law so the review team can request data directly. This is an excellent example of how the PDMP expansion can be useful in understanding and addressing what for some can be the second stage of opioid use disorders, heroin use.

In February 2013, the VA issued an Interim Final Rule authorizing VA physicians to access state PDMPs in accordance with state laws and to develop mechanisms to begin sharing VA prescribing data with state PDMPs. The interim rule became final on March 14, 2014.[62] Since then, the VA has developed and installed software to enable VA pharmacies to transmit their data to PDMPs. As of April 2015, 67 VA facilities were sharing information with PDMPs in their respective states. VA providers have also begun registering and checking the state databases. However, the VA does not currently require prescribers to check the PDMP prior to prescribing.

While PDMP reporting is not required by IHS facilities, many tribes have declared public health emergencies and have elected to participate with the PDMP reporting initiative. Currently, IHS is sharing its pharmacy data with PDMPs in 18 states,[63] and IHS is in the process of negotiating data-sharing with more states.[64] As these systems continue to mature, PDMPs can enable health care providers and law enforcement agencies to prevent the non-medical use and diversion of prescription opioids.

[61] Maryland Department of Health & Mental Hygiene. (2014). Overdose Fatality Review in Maryland. Harold Rogers PDMP National Meeting. Retrieved from http://www.pdmpassist.org/pdf/PPTs/National2014/2-04_Baier.pdf. Accessed on 4-22-2015.
[62] Disclosures to Participate in State Prescription Drug Monitoring Programs, 78 Fed. Reg. 9589 (Feb. 11, 2013); 79 Fed. Reg. 14400 (Mar. 14, 2014).
[63] Indian Health Service. (2014). Prescription Drug Monitoring Programs: Indian Health Service Update. Harold Rogers PDMP Annual Meeting. Retrieved from http://www.pdmpassist.org/pdf/PPTs/National2014/2-14_Tuttle.pdf.
[64] Cynthia Gunderson, Prescription Drug Monitoring Programs & Indian Health Service, Barriers, Participation, and Future Initiatives, Presentation at Third Party Payer Meeting, December 2012. http://www.pdmpexcellence.org/sites/all/pdfs/Gunderson.pdf.

The third pillar of our *Plan* focuses on safely removing millions of pounds of expired and unneeded medications from circulation. Research shows that approximately 53 percent of past year nonmedical users of prescription pain relievers report getting them for free from a friend or relative the last time they used them, and for approximately 84 percent of these, that friend or relative obtained the pain relievers from one doctor. An additional 15 percent bought or took them from a friend or relative.[65] Safe and proper disposal programs allow individuals to dispose of unneeded or expired medications in a safe, timely, and environmentally responsible manner.

From September 2010 through September 2014, the DEA partnered with hundreds of state and local law enforcement agencies and community coalitions, as well as other Federal agencies, to hold nine National Take-Back Days. Through these events, DEA collected and safely disposed of more than 4.8 million pounds of unneeded or expired medications.[66] DEA has scheduled its next National Take-Back Day for September 26, 2015.

In addition, DEA published a Final Rule for the Disposal of Controlled Substances, which took effect October 9, 2014.[67] These new regulations expand the options available to securely and safely dispose of unneeded prescription medications. They authorize certain DEA registrants (manufacturers, distributors, reverse distributors, narcotic treatment programs, retail pharmacies, and hospitals/clinics with an on-site pharmacy) to modify their registration with the DEA to become authorized collectors. Collectors may operate a collection receptacle at their registered location, and anyone can distribute pre-printed/pre-addressed mail-back packages that go to mail-back program operators. Retail pharmacies and hospitals/clinics with on-site pharmacies and law enforcement to include Veterans Health Administration (VHA) and DoD police officers may operate their own disposal collection receptacles. In addition, long-term care facilities that offer disposal collection receptacles must partner with either a retail pharmacy or a hospital/clinic with an on-site pharmacy to operate collection receptacles in their facilities. Any person or entity may partner with law enforcement to conduct take-back events. Additionally, VHA is offering drug take back options to Veterans.[68]

ONDCP and DEA have engaged with Federal, state, and local agencies, and other stakeholders to increase awareness and educate the public about the new rule. In November 2014, ONDCP, DEA and the Alameda County California Superintendent's office hosted a webinar for community agencies to explain the new rule and discuss how local ordinances might define or fund disposal programs. Over 800 people registered for the program, and 436 viewed it live.[69] ONDCP and DEA will engage with Federal partners as well as with state and local entities to develop and implement a plan to develop disposal programs nationwide.

[65] Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings*. Department of Health and Human Services. [September 2014]. Available: http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.htm#2.16

[66] Drug Enforcement Administration. "DEA and Partners Collect 309 Tons of Polls on Ninth Prescription Drug Take-Back Day." Department of Justice. [November 5, 2014]. Available: http://www.dea.gov/divisions/hq/2014/hq110514.shtml

[67] Disposal of Controlled Substances, 79 Fed. Reg. 53519 (Sep. 9, 2014). Available: https://www.federalregister.gov/articles/2014/09/09/2014-20926/disposal-of-controlled-substances

[68] Veterans Health Administration. "Joint Fact Sheet: DoD and VA Take New Steps to Support the Mental Health Needs of Service Members and Veterans." [August 26, 2014]. Available at: http://www.va.gov/opa/docs/26-AUG-JOINT-FACT-SHEET-FINAL.pdf. Accessed on 12-01-2014.

[69] Office of National Drug Control Policy. "Website Blog Watch: Webinar DEA Final Rule on Disposal of Controlled Substances." Available at: https://www.whitehouse.gov/blog/2014/11/17/watch-webinar-dea-s-final-rule-disposal-control-substances. Accessed on 4-15-2015

The *Plan's* fourth pillar focuses on improving law enforcement capabilities to reduce the diversion of prescription opioids. Federal law enforcement, to include our partners at DEA, is working with state and local agencies across the country to reduce pill mills, prosecute those responsible for improper or illegal prescribing practices, and make it harder for unscrupulous registrants including pharmacies to remain in business. An unintended consequence of law enforcement efforts against pharmaceutical suppliers can occur when major enforcement actions happen, patients receiving medicines for legitimate conditions from those providers or pharmacies may be abandoned. Without being tapered off their opioid regimens they will experience withdrawal which can be profoundly disabling and is only alleviated by an opioid.[70] It is not known how many patients have resorted to heroin in these circumstances, but without coordination between law enforcement to ensure enforcement activities do not interrupt legitimate patient care, we are concerned about unintended consequences.

All of these efforts under the *Prescription Drug Abuse Prevention Plan* are intended to reduce the diversion, non-medical use, and health and safety consequences of prescription opioids. The Administration has worked tirelessly to address the problem at the source and at an array of intervention points. This work has been paralleled by efforts to address heroin trafficking and use, as well as the larger opioid overdose problem facing this country.

Efforts to Stem the Heroin Crisis:

Heroin was added to Schedule I of the controlled substances list in 1914, and efforts to address heroin use and trafficking have been reflected annually in our *National Drug Control Strategy*. Opium poppy, from which heroin is derived, is not grown in the United States, and manufacturing is based outside of the country, primarily in Mexico for U.S. sales. Drug seizure data suggest a great deal of heroin has been flowing into the United States in recent years, primarily from Mexico but also from South America.

Pharmaceutical opioids activate the same receptors in the brain as heroin, a reason why users can switch from one to the other and avoid withdrawal. Approximately 18 billion opioid pills were dispensed in 2012,[71] enough to give every American 18 years or older 75 pills.[72] Plentiful access to opioid drugs via medical prescribing and easy access to diverted opioids for nonmedical use help feed our opioid crisis. In fact, as discussed above, the majority of new users come to heroin with experience as nonmedical prescription drug users.[73] Prior to today's opioid epidemic, heroin largely had been confined to urban centers with larger heroin using populations. Many communities and states that have never had a heroin use problem are now dealing with this epidemic, as Vermont Governor Shumlin discussed in his 2014 *State of the State* address.

In 2012 ONDCP held an interagency meeting focused on heroin, as many agencies were concerned that prescription opioid users might migrate to heroin. The interagency prescription

[70]American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington VA, American Psychiatric Association. 2013. Page 541.
[71] IMS Health, National Prescription Audit, 2012
[72] Estimate presented by Thomas Frieden during oral presentation at Preventing Prescription Drug Overdose: New Challenges, New Opportunities. National RX Drug Abuse Summit, Operation Unite. Atlanta GA. April 8, 2014.
[73] Muhuri, P.K., Gfroerer, J.C., Davies, MC. SAMHSA CBHSQ Data Review. Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States. August 2013.

drug working group formed a research group to examine the nature of the transition from prescription opioids to heroin, and CDC and SAMHSA have increased their focus on this issue, developing additional analyses to help track and publicize the issue.[74,75]

In May 2015, the Administration held its inaugural meeting of the Congressionally-mandated interagency Heroin Task Force. This Task Force is co-chaired by ONDCP Deputy Director for State, Local and Tribal Affairs Mary Lou Leary and U.S. Attorney for the Western District of Pennsylvania David Hickton and includes Federal agency experts from law enforcement, medicine, public health and education. The Task Force report will highlight emerging evidence-based public health and public safety models for law enforcement engagement in activities that promote solutions to reduce demand or decrease spread of disease.

The *National Drug Control Strategy*'s efforts also include pursuing action against criminal organizations trafficking in opioid drugs, working with the international community to reduce cultivation of poppy, identifying labs creating dangerous synthetic opioids like fentanyl and acetyl-fentanyl and enhancing border efforts to decrease the flow of these drugs into the country.

Treatment, Overdose Prevention, and Other Public Health Efforts

The public health consequences of nonmedical opioid and heroin use are often similar if not identical. Most notably, in both cases, some proportion of individuals escalate use and eventually develop a chronic opioid use disorder requiring treatment. The low rate of cases referred to treatment by medical personnel in the face of such a dangerous epidemic suggests that providers may ignore or miss the problems of nonmedical prescription opioid use and heroin use among their patients. The extent of the opioid use problem requires that health care providers work in tandem with law enforcement to address the issue.

People who escalate use are vulnerable to begin injecting, and this behavior dramatically increases their risk of exposure to blood-borne infections, including human immunodeficiency virus (HIV) and hepatitis C. It is noteworthy that in the latest HIV outbreak in rural Indiana, it was intravenous use of the strong prescription opioid oxymorphone, not heroin, which accounted for most of the cases. Since the first patient in the outbreak was identified in January 2015, 174 people have tested positive for HIV. To combat the spread of HIV, Indiana instituted an emergency syringe services program, among other efforts to expand treatment for HIV and opioid use disorders. The Administration continues to support a consistent policy that would allow Federal funds to be used in locations where local authorities deem syringe services programs to be effective and appropriate. Studies show that comprehensive prevention and drug treatment programs, including syringe services program, have dramatically cut the number of new HIV infections among people who inject drugs.

[74] R.N. Lipari and A. Hughes. The NSDUH Report: Trends in Heroin Use in the United States: 2002 to 2013. (2015). Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Rockville, MD. http://www.samhsa.gov/data/sites/default/files/report_1943/ShortReport-1943.html Available at linked to on 7-19-2015

[75] Jones CM, Logan J, Gladden RM, Bohm MK. Vital Signs: Demographic and Substance Use Trends Among Heroin Users - United States, 2002-2013. MMWR Morb Mortal Wkly Rep. 2015 Jul 10;64(26):719-25. PMID: 26158353

Nonmedical use of opioids like heroin can produce overdose including fatal overdose especially when used in conjunction with other sedatives including alcohol and anti-anxiety medicines. People who have stopped using for a period of time, such as those who were in treatment, have been medically withdrawn, or have been incarcerated, are especially at risk of overdose because their tolerance has worn off but they use amounts similar to those prior to cessation. When used chronically by pregnant women, both prescription opioids and heroin can cause withdrawal symptoms in newborns upon birth, and if these opioids are withdrawn during pregnancy, fetal harm may result.

For these reasons, it is important to identify and treat people with prescription opioid use disorder quickly, ensure they are engaged in the most effective forms of evidence-based treatment, and make lifesaving tools like the overdose reversal antidote naloxone widely available. Fortunately, the treatments for heroin and prescription opioid use disorder are the same. The standard of care is behavioral treatment plus stabilization on one of three FDA-approved medicines, often called medication-assisted treatment (MAT). MAT may be tapered in time to produce abstinence, but a health care provider must make the decision that is right for his or her patient regarding whether to cease a medication.

The Administration continues to focus on vulnerable populations affected by opioids, including pregnant women and their newborns. From 2000 to 2009 the number of infants displaying symptoms of drug withdrawal after birth, known as neonatal abstinence syndrome (NAS), increased approximately threefold nationwide.[76] Newborns with NAS have more complicated and longer initial hospitalizations than other newborns.[77] Newly published data shows the problem nearly doubled from 2009 to 2012.[78] Additionally, the study showed that 80 percent of the cost for caring for these infants was the responsibility of state Medicaid programs during this time.

The Administration is focusing on several key areas to reduce and prevent opioid overdoses from prescription opioids and heroin, including educating the public about overdose risks and interventions; increasing access to naloxone, an emergency opioid overdose reversal medication; and working with states to promote Good Samaritan laws and other measures that can help save lives. With the recent rise in opioid-involved overdose deaths across the country, it is increasingly important to prevent overdoses and make antidotes available.

It is important to note in some cases traffickers are combining heroin with the synthetic lab-produced opioid fentanyl or an analog, presumably as a way to increase user perception of

[76] Epstein, R.A., Bobo, W.V., Martin, P.R., Morrow, J.A., Wang, W., Chandrasekhar, R., & Cooper, W.O. (2013). Increasing pregnancy-related use of prescribed opioid analgesics. Annals of Epidemiology, 23(8): 498-503. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/23889859.
[77] Patrick, S., Schumacher, R.E., Benneyworth, B.D., Krans, E.E., McAllister, J.M., & Davis, M.M. (2012). Neonatal abstinence syndrome and associated health care expenditures: United States, 2000-2009. Journal of the American Medical Association, 307(18): 1934-40. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/22546608.
[78] Patrick, SW, Davis, MM, Lehman, CU, Cooper, WO. Incresing incidence and geographic distribution of neonatal abstinence syndrome: United States 2009-2012. Journal of Perinatology (2015): 1-6 online publication, April 30, 2015; doi:10.1038/jp.2015.36

product strength and thus user experience.[79] Fentanyl can produce overdose rapidly in naïve users and in such cases naloxone may be insufficient remedy for fentanyl or its analogs.[80]

The Administration is providing tools to local communities to deal with the opioid drug epidemic. In August 2013, SAMHSA released the *Opioid Overdose Prevention Toolkit*.[81] This toolkit provides communities and local governments with material to develop policies and practices to help prevent opioid-related overdoses and deaths. It contains information for first responders, treatment providers, and those recovering from opioid overdose. In July 2014, Attorney General Holder issued a Memorandum urging Federal law enforcement agencies to identify, train and equip personnel who may interact with victims of an opioid overdose,[82] and in October 2014, the Attorney General announced the launch of the Department of Justice's *Naloxone Toolkit* to support law enforcement agencies in establishing a naloxone program.[83] In August 2014, the Administration announced that DoD was making a new commitment to ensure that opiate overdose reversal kits and training are available to every first responder on military bases or other areas under DoD's control.[84] And earlier this month, the Indian Health Service announced its own toolkit for use with American Indian and Alaskan Natives a population who has disparate rates of past year non-medical prescription pain reliever use (6.9 percent vs. 4.2 percent in the rest of the population).[85]

The Administration continues to promote the use of naloxone by those likely to encounter overdose victims and for them to be in the position to reverse the overdose, especially first responders and caregivers. The Administration's FY 2016 Budget requests $12 million in grants to be issued by SAMHSA to states to purchase naloxone, equip first responders in high-risk communities, and provide education and the necessary materials to assemble overdose kits, as well as cover expenses incurred from dissemination efforts. Profiled in the 2013 *National Drug Control Strategy*, the Quincy Massachusetts Police Department has partnered with the State health department to train and equip police officers to resuscitate overdose victims using naloxone. The Department reports that since October 2010, officers in Quincy have administered naloxone in more than 382 overdose events, resulting in 360 successful overdose reversals.[86] In the past year, we have witnessed an exponential expansion in the number of police departments that are training and equipping their police officers with naloxone. They now number in the hundreds.

[79] Notes from the field: increase in fentanyl-related overdose deaths - Rhode Island, November 2013-March 2014. Mercado-Crespo MC, Sumner SA, Spelke MB, Sugerman DE, Stanley C; EIS officer, CDC. MMWR Morb Mortal Wkly Rep. 2014 Jun 20;63(24):531. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6324a3.htm

[80] Zuckerman M, Weisberg SN, Boyer EW. Pitfalls of intranasal naloxone.Prehosp Emerg Care. 2014 Oct-Dec;18(4):550-4. doi: 10.3109/10903127.2014.896961. Epub 2014 May 15. Available at linked to on.

[81] Substance Abuse and Mental Health Services Administration. Opioid Overdose Prevention Toolkit. Department of Health and Human Services. [August 2013]. Available: http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA13-4742

[82] Department of Justice, Office of Public Affairs. "Attorney General Holder Announces Plans for Federal Law Enforcement Personnel to Begin Carrying Naloxone." [July 31, 2014]. Available at http://www.justice.gov/opa/pr/attorney-general-holder-announces-plans-federal-law-enforcement-personnel-begin-carrying linked to 10-18-2014

[83] Department of Justice, Office of Public Affairs. "Remarks by Attorney General Holder at the International Association of Chiefs of Police Annual Conference." [October 27, 2014]. Available at: http://www.justice.gov/opa/speech/remarks-attorney-general-holder-international-association-chiefs-police-annual-conference

[84] http://www.va.gov/opa/docs/26-AUG-JOINT-FACT-SHEET-FINAL.pdf

[85] SAMHSA. National Survey on Drug Use and Health. The CBHSQ Report, June 2015.Nonmedial use of prescription pain relievers varies by race. http://www.samhsa.gov/data/sites/default/files/report_1972/Spotlight-1972.html linked to on 7-19-2015.

[86] Quincy (Massachusetts) Police Department Reporting. Email received 3/15/15.

Extraordinary collaboration is taking place in rural and suburban communities such as Lake County, Illinois. As part of the Lake County Heroin/Opioid Prevention Taskforce, the Lake County State's Attorney has partnered with various county agencies, including the Lake County Health Department; drug courts; police and fire departments; health, advocacy and prevention organizations; and local pharmacies to develop and implement an opioid overdose prevention plan.[87] Since July 2014, the Lake County Health Department has trained more than 34 police departments, 27 of which are carrying naloxone. As of February 2015, the Lake County Health Department had trained 828 police officers and 200 sheriff's deputies to carry and administer naloxone, and more departments have requested this training.[88]

Prior to 2012, just six states had any laws which expanded access to naloxone or limited criminal liability. Today, 35 states[89] and the District of Columbia have passed laws that offer criminal and/or civil liability protections to lay persons or first responders who administer naloxone. Twenty-four states[90] have passed laws that offer criminal and/or civil liability protections for prescribing or distributing naloxone. Thirty-three states[91] have passed laws allowing naloxone distribution to third-parties or first responders via direct prescription or standing order. ONDCP is collaborating with state health and law enforcement officials to promote best practices and connect officials interested in starting their own naloxone programs. The odds of surviving an overdose, much like the odds of surviving a heart attack, depend on how quickly the victim receives treatment. Twenty-five states[92] and the District of Columbia have passed laws which offer protections from charge or prosecution for possession of a controlled substance and/or paraphernalia if the person seeks emergency assistance for someone that is experiencing an opioid induced overdose. As these laws are implemented, the Administration will carefully monitor their effect on public health and public safety.

The Affordable Care Act and Federal parity laws are extending access to mental health and substance use disorder benefits for an estimated 62 million Americans.[93] This represents the largest expansion of treatment access in a generation and could help guide millions into successful recovery. The President's FY 2016 budget request includes $11 billion for treatment, a nearly seven percent increase over the FY 2015 funding level.

It is essential to identify and engage people who use prescription opioids non-medically early because the risks of being infected with HIV or hepatitis C increases dramatically once someone transitions to injection drug use. It is much less expensive to treat a person for just a substance use disorder early using evidence-based treatment, rather than to treat a person with a substance use disorder and provide lifetime treatment for HIV or a cure for hepatitis C.

[87] Office of the State's Attorney, Lake County, Illinois, Michael G. Nerheim. "Call to Action Lake County Opioid Prevention Initiative." [May 29, 2013]. Available at: http://lcsao.org/news/press-releases
[88] Lake County Health Department Reporting. Email 2/19/15.
[89] CA, CO, ID, OR, UT, WA, AZ, NM, OK, GA, KY, LA, MS, NC, TN, VA, WV, CT, DE, MA, MD, ME, NJ, NY, PA, RI, VT, IL, IN, MI, MN, MO, OH, SD, and WI.
[90] CA, CO, ID, UT, AZ, NM, GA, MS, NC, TN, VA, WV, CT, MA, NJ, NY, PA, VT, IN, MI, MN, OH, SD, and WI.
[91] CA, CO, ID, OR, UT, WA, AZ, OK, GA, KY, LA, MS, NC, TN, VA, WV, CT, DE, MA, MD, ME, NJ, NY, PA, VT, IL, IN, MI, MN, MO, OH, SD, and WI.
[92] AK, CA, CO, UT, WA, NM, FL, GA, KY, LA, NC, WV, CT, DE, MA, MD, NJ, NY, PA, RI, VT, IL, IN, MN, and WI.
[93] Berino, K., Rosa, P., Skopec, L. & Glied, S. (2013). Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans. *Research Brief.* Assistant Secretary for Planning and Evaluation (ASPE). Washington, DC (Citation: Abstract of the Brief found at http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm)

Medication-assisted treatment should be the recognized standard of care for opioid use disorders. Research shows that even heroin users can sustain recovery if treated with evidence-based methods. Studies have shown that individuals with opioid use disorders have better outcomes with maintenance MAT.[94] Yet for too many people, it is out of reach. For instance, only 26.2 percent (3,713) of treatment facilities provided treatment with methadone and/or buprenorphine.[95] Treatment programs are too often unable to provide this standard of care, and there is a significant need for medical professionals who can provide MAT in an integrated health care setting.

Medicines for opioid use disorder containing buprenorphine are important advancements that have only been available since Congress passed the Drug Addiction Treatment Act of 2000 (DATA 2000). They expand the reach of treatment beyond the limited number of heavily regulated Opioid Treatment Programs that generally dispense methadone. Also because physicians who have taken the training to administer the medicines are allowed to treat patients in an office-based setting, it allows patient care to be integrated with mainstream medicine. Injectable naltrexone offers similar advantages but only to patients who have been abstinent from opioids for 7-10 days. Special training required by DATA 2000 for prescribing buprenorphine is not required for injectable naltrexone.

We need to increase the number of physicians who can prescribe buprenorphine, when appropriate and the numbers of providers offering injectable naltrexone. Of the more than 877,000 physicians who can write controlled substance prescriptions, only about 29,194 have received a waiver to prescribe office-based buprenorphine. Of those, 9,011 had completed the requirements to serve up to 100 patients. The remainder can serve up to 30. Although they are augmented by an additional 1,377 narcotic treatment programs, far too few providers elect to use any form of medication-assisted treatment for their patients.[96] Injectable naltrexone was only approved for use with opioid use disorders in 2012, and little is known about its adoption outside specialty substance use treatment programs but use in primary care and other settings are possible. To date only about 3 percent of U.S. treatment programs offer this medicine for opioid use disorder.[97] Education on the etiology of opioid abuse and clinician interventions is critical to increasing access to treatments that will stem the tide of opioid misuse and overdose.

And there are some signs that these national efforts are working with respect to the prescription opioid problem. The number of Americans 12 and older initiating the nonmedical use of prescription opioids in the past year has decreased significantly since 2009, from 2.2 million in that year to 1.5 million in 2013.[98] Additionally, according to the latest Monitoring the

[94] Weiss RD, Potter JS, Griffin ML, McHugh RK, Haller D, Jacobs P, Gardin J 2nd, Fischer D, Rosen KD. Adjunctive Counseling During Brief and Extended Buprenorphine-Naloxone Treatment for Prescription Opioid Dependence: A 2-Phase Randomized Controlled Trial Published in final edited form as: Arch Gen Psychiatry. 2011 December; 68(12): 1238–1246.
[95] SAMHSA. *National Survey of Substance Abuse Treatment Services (N-SSATS): 2012 -- Data on Substance Abuse Treatment Facilities* (December 2013).
[96] Personal communication (email) from Robert Hill (DEA).
[97] Aletraris L1, Bond Edmond M1, Roman PM1., Adoption of injectable naltrexone in U.S. substance use disorder treatment programs. J Stud Alcohol Drugs. 2015 Jan;76(1):143-51.
[98] Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Detailed Tables*. Department of Health and Human Services. [November 2014]. Available: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabsPDFWHTML2013/Web/HTML/NSDUH-DetTabsSect7peTabs1to45-2013.htm#tab7.36A

Future survey, the rate of past year use among high school seniors of OxyContin or Vicodin in 2014 is its lowest since 2002.[99]

However, while all of these trends are promising, the national data cited earlier concerning increases in emergency department visits, treatment admissions, and overdoses involving opioids bring the task ahead of us into stark focus. Continuing challenges with prescription opioids, and concerns about a reemergence of heroin use, particularly among young adults, underscore the need for leadership at all levels of government.

Conclusion

We continue to work with our Federal, state, local, and tribal partners to continue to reduce and prevent the health and safety consequences of nonmedical prescription opioid and heroin use. Together with all of you, we are committed partners, working to reduce the prevalence of substance use disorders through prevention, increasing access to treatment, and helping individuals recover from the disease of addiction. Thank you for the opportunity to testify here today, and for your ongoing commitment to this issue. I look forward to continuing to work with you on this pressing public health matter.

[99] The Monitoring the Future study. *Narcotics other than Heroin: Trends in Annual Use and Availability – Grades 8, 10, and 12*. University of Michigan. [December 2014]. Available: http://www.monitoringthefuture.org/data/14data/14drfig11.pdf

Facing the Hudson Valley's Heroin Problem

A heroin epidemic has taken hold of the Hudson Valley — and it's killing our kids

BY LEANDER SCHAERLAECKENS

Aimee Austin with a picture of her daughter, Cara Kudrenetsky, who died from a heroin overdose in 2012, a month before her 18th birthday

PHOTOGRAPH BY MICHAEL POLITO

Cara Kudrenetsky, the daughter gone too soon, lives on in the ink etched into her mother's forearm: a heart with a peace sign in it. Above it are Cara's name and her birth and death dates: 7.29.95 - 8.27.12. Cara had drawn a heart just like it once, only in hers, the heart was broken. Cara's mother, Aimee Austin, a speech and language pathologist at BOCES in Poughkeepsie, had mended it for the tattoo, hoping that her own heart would eventually do the same after her daughter's tragic death from a heroin overdose.

Heroin is not new. In fact, nearly a century before the illicit drug became the rockstar downer of choice in the '60s and '70s, it was developed and sold over the counter by Bayer as a fin-de-siècle alternative to "addictive" pain meds like morphine. Unfortunately, it wasn't long before heroin addicts abounded — but the drug wasn't banned until 1924.

Today, heroin is making a comeback, particularly among teens and young adults. Not just underprivileged teens living in the inner cities, not just kids from broken homes or with drug-addicted parents. Heroin, once the scourge of cities and the purview of young urban males, has come to suburbia (according to a study published last year in *JAMA Psychiatry*, 90 percent of today's users are white and 75 percent live outside of

urban areas). It's come to the middle class; to the rich; to the children of educated, affluent professionals; to fresh-faced cheerleaders and track stars who, in a different time, may have smoked a couple of blunts now and then as a coming-of-age rebellion. Heroin has come to the Valley. And it's killing our kids.

Related: Meet the Dutchess County Drug Task Force

This epidemic is frighteningly prevalent among teens and young adults. Law-enforcement officials point out that families often struggle to spot the signs of it. "You need to identify it in your kids early and get a handle on it," says East Fishkill Police Chief Kevin Keefe. "Get it at the top of the spiral. When they get to me, it's probably too late."

Young people between the ages of 18 and 24 are especially at risk. In fact, according to a Youth Risk Behavior Survey (YRBS), the percentage of New York State high school students who reported using heroin increased from 1.8 percent in 2005 to 4 percent in 2011. In addition, according to the New York State Office of Alcohol and Substance Abuse Services (OASAS) and its Combat Heroin initiative, there was a *222-percent* increase in New York State heroin treatment-center admissions in Upstate New York between 2004 and 2013.

In Dutchess County alone, the number of drug-overdose deaths has exploded from nine in 2000 to 79 in 2013, according to Kari Reiber, MD, the county's commissioner of health. Of the 262 overdose deaths in the county in the past five years, more than 80 percent were opioid-related. "Since 2009," Dr. Reiber says, "There are more accidental overdose deaths per year than motor vehicle deaths in Dutchess County."

Of course, the heroin crisis isn't just local. A national study by the Centers for Disease Control found that the death rate from heroin overdoses doubled across 28 states, including New York, from 2010 to 2012, from 1.0 to 2.1 per 100,000. The total number of deaths increased from 1,779 to 3,635, whereas deaths related to opioid pain relievers decreased from 6.0 to 5.6. Prescription pills are still killing far more people than heroin — both locally and nationally — but with the crackdown on the former, the trend is shifting to the latter.

> "There are more accidental overdose deaths per year than motor vehicle deaths in Dutchess County"

But why? Why the resurgence of a drug that the bourgeois once found so vile — or at least never talked about? One reason is that today's heroin, unlike the heroin of decades past, is cheap. *Really*cheap. In fact, a stamp-bag of heroin (roughly one hit) can cost as little as $5. Compare that to the street price of one OxyContin, which, since crackdowns on "doctor shopping" in recent

years (including the implementation of the state-wide Internet System for Tracking Over-Prescribing program in late August 2013), can be $80 or more. The low cost of heroin coupled with the fairly recent street-scarcity and expense of prescription painkillers — and the reformulation of certain prescription meds by pharmaceutical companies to make them less crushable, and therefore less snortable and injectable — has meant that many users are moving from pills to heroin just because it's easier. Back in the day, 50 years ago, the vast majority of heroin users — 80 percent, according to the *JAMA Psychiatry* paper — used heroin from the start of their drug abuse. In contrast, a large number of today's heroin users transitioned from prescription painkillers when they became too expensive or stopped being effective. "The better controls of prescription drugs correlated with the rise of heroin," says Keefe. "We're tightening our grip on prescription abuse but what's slipping through our fingers is heroin."

It's not just cheap and accessible, though. It's very pure — and more dangerous than ever. The mix of affordability, accessibility, and opiod-induced euphoria makes heroin particularly appealing to cash-strapped, pleasure-seeking teens and young people who, by virtue of their youth, rarely have a sense of their own mortality. Despite its ostensible affordability, though, that wash of euphoria actually comes at a very high price. The number of "bad batches" has risen sharply. As heroin has boomed, so have the number of enterprising operators, hoping to maximize profit by cutting the heroin with sedatives and other drugs. Fentanyl, a synthetic opioid used to manage severe pain (it's often prescribed in the form of transdermal patches, like Duragesic, to treat cancer pain), is one of those drugs. Fentanyl is estimated to be from 50 to 100 times more potent than morphine and five to 15 times stronger than heroin. Unfortunately, it's impossible to tell from looking at a bag whether or not it's laced, so using, even once, is tantamount to a game of Russian roulette. Even if you don't get a bad batch, you're still in real danger. "With continued usage, tolerance goes up, so increased amounts are needed," explains Mario Malvarosa, MD, an addiction specialist at the Lexington Center for Recovery in Poughkeepsie. And more heroin means an increased risk of overdose. "There are side effects, and one of them is respiratory depression." Essentially, many people die of overdose when their bodies "forget" to breathe.

Addicts fear withdrawal. Kicking heroin induces powerful cravings and wretched side effects. "When you suddenly stop, there are withdrawal symptoms which are usually the opposite of what the person was experiencing," says Dr. Malvarosa. The symptoms include nervousness, jitters, muscle aches and pains, chills, tremors, diarrhea, vomiting, and excessive salivation.

Unfortunately, it's impossible to tell from looking at a bag whether or not it's laced, so using, even once, is tantamount to a game of Russian roulette

In the old days, "treatment" meant a visit to the free methadone clinic. Today's treatment programs are much more comprehensive. Many take insurance, and many offer crisis intervention services. But, though you may not find many of today's young heroin-addicted Valley residents standing in line

nodding off outside the free clinic, you will find that their addictions are very real and as dangerous — if not more so — than those of 50 years ago. Today, the many treatment options for heroin and opioid addiction include hospital-run and independent outpatient programs, intensive in-patient rehab centers and detox programs, and dual-diagnostic treatment (which can include treatment for addiction plus cognitive behavioral therapy [CBT] for co-existing mental or emotional disorders, such as anxiety, depression, and other conditions). And yes, there are some private rehab facilities that look more like country clubs than drug-treatment centers, for those who can afford it.

But heroin is different than many other drugs that have been abused by teens and young adults in recent decades. Heroin is generally not used by those wanting to party. While it does produce a high, and is frequently the next — and, sadly, often the last — step in a long line of other drugs that may start with a "gateway" drug like prescription painkillers, it is also sought by kids looking for an escape, relief from depression, anxiety, or other emotional pain, and, because of the inherent shame heroin use bears, teens often snort or shoot it alone.

In Cara Kudrenetsky's case, depression was an ongoing problem. The second of Aimee Austin's five children, Cara was in a DARE (Drug Abuse Resistance Education) program in elementary school and, as a teenager, she liked to draw and take pictures. She had a knack for going into her bedroom, plastered with posters of Kings of Leon and Jimi Hendrix, with brown hair and reemerging with blue or pink hair. She loved to cook and hoped to attend the Culinary Institute of America after she graduated high school. Her dream was to open a vegan restaurant in New York City, even though she could never resist a burger.

"She was beautiful," says her mother, Aimee. But she didn't feel beautiful. She felt ugly and had low self-esteem. She struggled with her weight and thought she wasn't popular. Even after she managed to lose 70 pounds by improving her diet and exercising, she didn't feel much better. "For some reason she had this void that she needed to fill."

Related: The Warning Signs of Heroin Addiction

When Cara was 15, she was prescribed Ambien to help her sleep while she was sick. Her mother gave her the whole bottle to administer to herself, only to find Cara staggering out of the bathroom and jabbering incoherently one day. It wasn't long before Aimee started finding pieces of drinking straws around the house. She didn't realize that her daughter was crushing and snorting her pills until she found a straw with some white powder next to it. Other than that, Cara was good at hiding her highs.

One day, Aimee came home to find her kitchen a mess, with batter on the ceiling, flour and cooking utensils everywhere — and Cara nowhere in sight. When Cara did return, she was incoherent. Another time, her mother found a couple of white pills on Cara's bed that turned out to be OxyContin. She lectured her daughter about the dangers of drugs, but Cara cried about her body and her lack of friends. Pretty soon, Cara was stealing her mother's prescription pills from her drawer. "They have the

commercials on TV, ‘Lock up your prescriptions,’ ” Aimee reflects. “But of course they weren’t talking to me; they were talking to everyone else.”

Cara asked a counselor at her school for help. Her mom took her to a treatment facility, which turned her away because their insurance wouldn’t cover it. So Aimee took her daughter to a mental-health hospital, where she was given psychotropic drugs for four days and then released. She was told to take her to another facility in Westchester but had no way of getting her there regularly. Without intervention, Cara kept using. She was alone in her room a lot, getting high before meeting friends.

Cash started disappearing from wallets in the house. Aimee’s childhood piggy bank, once hefty with spare change, suddenly felt awfully light. Cara worked at a nearby Subway and she babysat. She had plenty of money to buy drugs.

While there are many treatment options, many are finding it difficult to access them, argues Elaine Trumpetto, executive director of the Council on Addiction Prevention and Education (CAPE) in Dutchess County. In 2013, 89,269 people were admitted to treatment facilities for heroin and prescription opioid addictions in the state, up 40 percent from 2004, according to Governor Cuomo’s office. Although state laws require treatment programs to provide services to those who can’t pay and there is financial aid available, CAPE says getting into rehab is complicated. And given the number of heroin users, the need is overwhelming. In 2011, a National Institute on Drug Abuse survey concluded that 4.2 million Americans who were at least 12 years old had used heroin at least once in their lives. It is believed that 23 percent of users become addicts. Heroin is more likely to send someone to rehab than any other hard drug — twice as likely as crack, and more than four times as likely as cocaine.

Related: Council on Addiction Prevention and Education (CAPE) Educates Locals On Drug Abuse

---

“This disease that we’re facing, the prevalence of overdose and addiction, can be prevented,” Trumpetto says. “Addiction is a preventable disease. The economic devastation that this costs families, counties, our states and our nation is monumental. You’ll consistently be funding enforcement and treatment if you don’t get in front of the problem and invest in prevention. You’re going to repeat this cycle over and over again.” Prevention is a better bargain for society as a whole. For every dollar spent on it, $12 to $18 is saved on treatment, according to the Department of Health’s Center for Substance Abuse Prevention.

“Treatment is a short-term solution,” Trumpetto says. “Prevention is a long-term vision.”

Until Cara died, the summer of 2012 had been the family's best ever. She seemed to have stopped taking pills. She had a boyfriend whom the family adored, and her relationship with him was blossoming. She appeared to be happier than ever. The whole family barbecued and enjoyed each other's company. They all went to the Jersey Shore; for the first time since she was a young child, Cara felt comfortable enough with her weight to go to the beach. They all went to a music festival in a big RV they rented. Michael, the oldest boy, had taken up the guitar and joined a band. They made a few appearances on the main stage of The Chance Theater in Poughkeepsie, and the family would all go watch. "I remember Cara smiling a lot," Aimee says. "She wanted to live. There's no doubt in my mind she wanted to live." She was maturing quickly. She seemed to have gotten a handle on her demons.

PHOTOGRAPH BY MICHAEL POLITO

Her boyfriend, though, was using drugs, and Cara would get angry at him for it — because, Aimee assumed, she had gotten clean and wanted him to as well. But Cara would overdose not long thereafter. "She painted a picture that I wanted to see, who maybe she even wanted to be," says Aimee. "But that wasn't what was happening. You never can believe the child. They'll tell you everything is fine. And you want to believe everything is fine because it's easier. You want them to be well." A week before Cara passed away, Aimee found another straw. She suspected it had been Michael's.

> "You never can believe the child. They'll tell you everything is fine. And you want to believe everything is fine because it's easier"

Aimee got home at 1 a.m. on a Monday. She had gone to Florida with her eldest daughter, Teresa, to look at a college. She checked on Michael, who was asleep. Cara's door was closed, so she thought she'd let her sleep, too. She didn't know that Cara's boyfriend was in her downstairs bedroom with her. Aimee awoke the next morning and went through her routine with her youngest son, having breakfast and getting dressed. That's when the boyfriend came storming up the stairs, screaming that

Cara was unconscious and foaming at the mouth. Aimee ran down. Cara lay in her bed, motionless. They called 911 and put her on the floor and started CPR, as instructed. Aimee begged for her to cough back to life. She didn't. When the paramedics arrived, they tried reanimating her with a defibrillator. They couldn't. Cara had gone into cardiac arrest and would never regain consciousness. She was declared dead moments after arriving at the hospital. The medics never administered Narcan because they didn't know there was heroin in her system. The boyfriend insisted they had only smoked weed. But the toxicology report was clear. Aimee was taken aback when the police asked her about heroin. To her, heroin belonged with inner-city junkies. She didn't even know what it looked like.

It had happened quickly, as it often does with heroin. Less than a year from the time her mother realized she was taking prescription pills, Cara was dead, just days before her senior year of high school would begin. When they cleaned out her room, the family found a small baggie of heroin. In the back of her drawers, they found many more empty baggies. Texts on Cara's phone to her boyfriend mentioned "powders."

Michael is now older than his sister was when she died. They were close. He didn't know she was using heroin, and he blames himself. It's been hard on him, on all of them. "We've fallen apart," says Aimee. "It's very hard to piece your family back together." She hasn't done much to Cara's room. She has started speaking about her at forums on addiction. "It wasn't the dream I had at all for my daughter to be the poster child for a heroin overdose," she says. "But Cara's dead and that's the end of the story, really. Her story is over. But there are other people's stories that can have a happy ending."

http://www.timesunion.com/local/article/State-shifts-heroin-epidemic-fight-6479573.php

State shifts heroin epidemic fight

New programs, more beds and money on agenda

By Paul Grondahl Updated 10:57 am, Wednesday, September 2, 2015

IMAGE 1 OF 10

New York State Office of Alcoholism and Substance Abuse Services Commissioner Arlene Gonzalez-Sanchez addresses those gathered for a press event held by State and local officials to discuss the health risks and dangers of underage drinking, on Wednesday, June 10, 2015, in Albany, N.Y. (Paul Buckowski / Times Union archive)

BUY THIS PHOTO

Albany

Responding to criticism that her agency was not doing enough to fight a spike in heroin addiction and fatal overdoses, the commissioner of the state Office of Alcoholism and **Substance Abuse Services** is rolling out new programs, adding residential treatment beds and spending an additional $10 million in state funding as part of a redoubled heroin response.

"There's not one fix to the heroin epidemic. We're taking a multiprong approach," OASAS Commissioner **Arlene Gonzalez-Sanchez** told the **Times Union** in a wide-ranging interview last Tuesday that was taped by WMHT as part of an upcoming collaboration between the newspaper and public TV station on heroin coverage.

The new programs include a $1 million medication-assisted treatment program in Utica and $250,000 to create two new positions, a family-support navigator that offers guidance on treatment options for addicts' families and a peer advocate on call in a hospital emergency department to connect patients to addiction treatment after an overdose. OASAS works on its programs in conjunction with state **Department of Health** officials.

Gonzalez-Sanchez repeatedly defended the efforts of her agency, whose highest-profile effort to date had been a series of billboards, public service announcements and a public-awareness program of the ravages of heroin addiction on its website, **www.combatheroin.ny.org**.

The state also operates a toll-free, 24-hour confidential hot line, 1-877-8-HOPENY (1-877-846-7369) and links to its services on the website.

"I don't want to paint a rosy picture," she said. "We still face a lot of challenges. It might seem like we're not doing enough, but New York state still leads the way and other states look to us. I'm on a national board for addiction treatment, and New York is still the

model for patient-centered, family-focused treatment services."

Despite calls by advocates and parents of heroin addicts for more treatment beds, many communities around the state have rebuffed proposals with a not-in-my-backyard stand.

"There's a lot of NIMBY-ism in front of us and it has not been easy to site these programs," Gonzalez-Sanchez said. The agency faced especially fierce opposition in Buffalo, where there was a 500-person waiting list for methadone maintenance treatment. The state added 200 methadone slots, and the expanded operation has run smoothly without the level of complaints anticipated.

There was also push-back in Albany, she said, when **Hope House** doubled its capacity and this spring opened a second 20-bed adolescent residential-treatment facility at its Livingston Avenue complex on the edge of Arbor Hill.

The agency operates 12 addiction-treatment centers around the state, and they provide addiction treatment services to about 250,000 people annually.

In the past decade, admissions for heroin and prescription opioid-abuse treatment increased 136 percent statewide, from 63,793 admissions in 2004 to 89,269 in 2013. The largest increases were in the 18-to-24 age group and the geographic regions of upstate (222 percent increase) and Long Island (242 percent increase).

Deaths from heroin overdose surged in New York state from 215 in 2008 to 478 in 2012. The percentage of heroin deaths doubled from 13 percent to 26 percent of the 1,848 drug overdose deaths statewide in 2012. Deaths from heroin overdoses across the nation also escalated 175 percent between 2010 and 2014.

Although there is often a waiting list in many communities, including Albany, there are open treatment beds on most days around the state. OASAS is working to put real-time availability of treatment beds with a locator map on its website so addicts and their families can access openings even if they are not centrally located for the patient.

OASAS has about 750 employees and a $600 million annual budget. In addition to adding $10 million in state funding each of the past two years to combat heroin and opiate addiction, Gov. **Andrew Cuomo** signed into law last year a legislative package that included insurance reforms, enhanced treatment options and programs to help families of addicts navigate a patchwork of federal, state and local services.

"A lot of the complaints we hear from parents come down to not knowing how to negotiate the system," Gonzalez-Sanchez said. "In many cases, it's not a problem of access, but in not knowing how to apply for it."

One success OASAS likes to tout is training more than 75,000 people on the use of naloxone nasal spray, also known by the brand name of Narcan, which has led to more than 1,800 reversals of life-threatening heroin and opioid overdoses.

The commissioner and OASAS' general counsel, **Robert Kent**, sought to put an end to a widespread complaint by parents and providers regarding a "fail-first" requirement of some insurance companies. The legislative package signed into law last year curtailed a common practice among insurance companies that an addict had to prove unsuccessful at staying drug-free while receiving less intensive, outpatient services before being approved for costlier and more intensive, residential treatment. Parents and providers also criticized the inconsistency of insurance company determinations of "medical necessity," the basis of many coverage decisions.

"We have leverage now because of the legislation and we won't approve any fail-first insurance companies," Kent said. OASAS rejected a handful of insurance companies as a result and they are not included on the state's locator map of state-approved firms.

"We've met with insurance and managed-care companies, they understand the law, and they are complying," Kent said. "If families hear of a fail-first policy, they should call us. We will put a stop to that."

Kent said he's concerned about state residents who relocated to Florida for addiction treatment and got taken advantage of.

"We've heard horror stories," Kent said. "Families mortgaged their homes and emptied their bank accounts to pay for treatment in Florida. They came back to New York still in need of treatment with complaints about their bad experience."

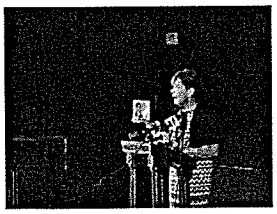
Despite a focus on heroin, addiction continues to be the leading problem and it consumes nearly half of OASAS resources.

"Every addiction is a priority for me, not just heroin," she said. "We can't forget about people struggling with alcohol, cocaine, prescription pills, synthetics and other drugs. We're not here to sugarcoat the heroin problem. It's a critical issue and we're trying to address it."

pgrondahl@timesunion.com • 518-454-5623 • @PaulGrondahl

Overdose scourge: Community gathering notes 'epidemic'

Megan Brockett, mbrockett@pressconnects.com | @PSBMegan *5:46 a.m. EDT September 1, 2015*



(Photo: MEGAN BROCKETT / Staff Photo)

As community members, officials and health and human service providers filed into the Tri-Cities Opera Center on Monday, many stopped to take a small silver ribbon from a box in the lobby.

The ribbons, they were told, are meant to commemorate those who have died from overdoses and to raise awareness about drug-related deaths and injuries.

At Monday's press conference at the Clinton Street opera house, held on International Overdose Awareness Day, guests were asked wear their silver ribbons to help start a conversation about the issue.

"Today, we want to commemorate and honor individuals lost in Broome County to the opioid epidemic," Carmela Pirich, executive director of the Addiction Center of Broome County, said. "(And) we want to offer hope to anybody struggling with addiction."

Close to 50 people gathered at the Tri-Cities Opera Center for the event, where several speakers remarked on the progress made locally to help those struggling with opiod addiction, but said that more must be done.

Broome County Legislator Jason Garnar was among the speakers who called for more funding for services to help people battling addiction.

Garnar told the group gathered at the opera house that he has had two close family members addicted to heroin. He said he worried at first about what people would think and wondered how it could have happened to someone close to him.

But Garnar and others at Monday's event said part of the challenge is beating the stigma surrounding addiction to get help for those who need it.

It's important for families with loved ones struggling from addiction to know they don't have to be ashamed, he said.

"We're all going through this together; we're all going through this as a community," Garnar said. "What I've found out is there are so many people here who are willing to help."

But those people, and the services they offer, need more funding, Garnar said.

Penny Stringfield, a board member of the Addiction Center of Broome County, echoed Garnar's call for more financial support for addition programs and treatment.

Stringfield's son, Johny, died of a heroin overdose in February at the age of 24.

He died the same day he returned home from rehab after insurance prevented him from staying in the program any longer, Stringfield said.

"Yes, there (are) treatment (programs) available here, but there is such a lack of services, and there are so many holes right now," Stringfield said.

Last year, 39 people died from overdoses last year in Broome County, where 13 percent of residents have substance use disorders, according to the Addiction Center of Broome County.

Nationwide, 1 in 3 families are impacted by substance use, with 22 million Americans suffering from addition, the release said.

International Overdose Awareness Day, held each year on Aug. 31, aims to raise awareness and reduce the stigma of drug-related death and injury, according to overdoseday.com (http://www.overdoseday.com/).

At the Binghamton opera house on Monday, Stringfield urged those in the audience to wear their silver ribbons all day and to tell people why when they asked about them.

Her speech ended on a final plea:

"Work very hard ... with your elected officials to understand this is something we desperately need funding for," she said.

Follow Megan Brockett on Twitter @PSBMegan (https://twitter.com/PSBMegan).

Local services

The Addiction Center of Broome County: (607) 723-7308

Fairview Recovery Services: (607) 722-8987

Fairview Addiction Crisis Center: (607) 722-4080

New Horizons (UHS): (607) 762-3232

Lourdes grief counseling/DORS group: 877-9LOURDES

Read or Share this story: http://press.sn/1EytzjM

Tuesday, September 1, 2015

HOME

Ulster County officials get look inside Northeast trauma center

LAKE KATRINE – Narcotics overdoses are becoming an increasing factor in brain injury cases nationwide, according to a fact-finding tour made by Ulster County legislators Monday night in Lake Katrine.

Members of the Health and Human Services Committee teamed up with Ulster County Coalition Against Narcotics (UCAN) to tour the insides of the local trauma center.

County officials, including some legislators, among a group touring the NCRBI

It looks like just another looming rectangular building on the outskirts of Tech City, but the 205,000-square-foot Northeast Center for Rehabilitation and Brain Injury represents the largest facility of its kind in the entire world.

Each day, patients in this 280-bed nursing home struggle to recover basic motor skills and body functions. Some 180 are severely brain injured, with about 40 on ventilators, administrators told the group. And nearly seven percent got there from drug overdoses – a sharply increasing trend.

"We're seeing the stark realities of traumatic brain injuries, surviving a heroin overdose, lives that are changed forever," noted Legislator Carl Belfiglio, whose wife AnnMarie works as an occupational therapy coordinator at Northeast.

Belfiglio explained that he was prompted to take the tour after reading news reports about problems at Golden Hill nursing home in Kingston, formerly owned by the county. He said the committee should compile current ratings on every local facility.

While the facility is not under direct oversight of the county legislature, a large majority of its patient population is covered under Medicaid, due to the younger age of its growing number of drug overdose victims. UCAN Chairman Lou Klein is expected to deliver a report to the legislature on the narcotics impact.

County Legislator Craig Lopez, who is wheelchair-bound, wanted to see the parallel between a brain injury facility and physical injury center.

"I was in an accident when I was 18 years old," Lopez said. "That was nearly 22 years ago. I spent three months at Westchester Medical Center and then I went to a rehab center for six months. The parallel I see between this one and Kessler is that I think the ultimate goal is to facilitate people back into the community and it's nice to know that it doesn't appear to be a permanent type facility, but more of a progressive facility to get people back into their communities."

Facility administrator Seth Rinn criticized the state rating system, which includes an annual survey, staff analysis, and a 17-point quality measures review. The factors are boiled down into a simple five-star rating system devised by federal regulators, which overlooks important aspects of specialized care institutions like Northeast.

"We have a large population that are on anti-psychotic and anti-anxiety medications. In a typical nursing home, those kind of medications are frowned upon. In our environment, it's very different, these medications are used as a therapeutic component, building their cognitive abilities," Rinn said.

Northeast was established in the late 1990s by Anthony Salerno. After his death in 2008, the facility nearly lost its CMS certification due to violations. It is currently owned by NCRNC, LLC of Spring Valley, under Efraim Steif.

Saturday
August 8, 2015

HOME

Click for weather forecast

Narcan revives another victim of drug overdose

CONNELLY – Ulster County Sheriff's deputies revived a man who was found unconscious, unresponsive and not breathing at 11:30 a.m. on Friday in a Connelly residence.

Officers responded to a 911 call of a 30-year-old man in cardiac arrest as the result of a reported heroin overdose.

Deputies administered several doses of Narcan resulting in the man beginning to breathe and regain consciousness. Emergency medical services personnel arrived and transported him to the emergency room for evaluation.

Deputies were assisted at the scene by State Police, Esopus Volunteer Ambulance Squad and Mobile Life Support Services.

HOME

National Institute on Drug Abuse
The Science of Drug Abuse & Addiction

Methadone maintenance in prison results in treatment retention, lower drug usage following release

Print

Science Spotlight

May 29, 2015

Treatment is the Key

A new NIDA-funded study shows that, among people incarcerated for six months or less, those who received continued methadone maintenance while imprisoned were more likely to obtain follow up drug treatment than those who underwent detoxification from methadone while in jail. The findings show that one month after release, participants who continued to receive doses of methadone while incarcerated were more than twice as likely to obtain treatment at a community methadone clinic after their release, compared to those who went through tapered methadone withdrawal. In addition, in the month following their release, opioid use was lower among the methadone maintenance patients (8 percent), versus the tapered withdrawal group (18 percent). Because of the high risk of relapse and fatal overdose that often occurs among inmates following release from prison, the study results emphasize the importance of connecting this population to follow-up treatment and retention.

To view the abstract of the article published in *The Lancet*, go to: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)62338-2/abstract. To learn more about criminal justice and drug abuse, go to http://www.drugabuse.gov/related-topics/criminal-justice-drug-abuse.

For more information, contact the NIDA press office at media@nida.nih.gov or 301-443-6245.

Contact:
NIDA Press Office
301-443-6245
media@nida.nih.gov

About the National Institute on Drug Abuse (NIDA): The National Institute on Drug Abuse (NIDA) is a component of the National Institutes of Health, U.S. Department of Health and Human Services. NIDA supports most of the world's research on the health aspects of drug abuse and addiction. The Institute carries out a large variety of programs to inform policy and improve practice. Fact sheets on the health effects of drugs of abuse and information on NIDA research and other activities can be found at http://www.drugabuse.gov, which is now compatible with your smartphone, iPad or tablet. To order publications in English or Spanish, call NIDA's DrugPubs research dissemination center at 1-877-NIDA-NIH or 240-645-0228 (TDD) or email requests to drugpubs@nida.nih.gov. Online ordering is available at https://drugpubs.drugabuse.gov. NIDA's media guide can be found at http://www.drugabuse.gov/publications/media-guide/dear-journalist, and its easy-to-read website can be found at http://www.easyread.drugabuse.gov.

About the National Institutes of Health (NIH): NIH, the nation's medical research agency, includes 27 Institutes and Centers and is a component of the U.S. Department of Health and Human Services. NIH is the primary federal agency conducting and supporting basic, clinical, and translational medical research, and is investigating the causes, treatments, and cures for both common and rare diseases. For more information about NIH and its programs, visit www.nih.gov.

NIH. . .Turning Discovery Into Health®

This page was last updated May 2015

NIH...Turning Discovery Into Health®

How heroin claimed the life of a cop's daughter

A retired Albany police officer talks of the hellish experience of watching her daughter lose her fight with drug addiction

By Paul Grondahl
Updated 7:02 am, Monday, October 27, 2014

Colonie

When Patty Farrell discovered the lifeless body of her 18-year-old daughter, Laree, on that terrible spring morning, dead of a heroin overdose in her upstairs bedroom in the tidy bungalow they shared, shock turned to grief and gave way to a flood of emotions.

"I was so sad at first, and then I got angry because I felt betrayed," Farrell said. "I trusted her and believed she had stopped using and she played me. That's how powerful heroin is. If it killed my daughter, who was really strong, it can kill anyone."

Farrell, 51, who is divorced and raised her daughter as a single parent, retired in 2008 after 20 years as an Albany police officer, including a decade as a detective. She now works for the state. Her law enforcement career made Farrell streetwise and savvy about the drug culture and criminal activity. It did not matter against an insidious, deadly drug.

"My heart just breaks when I hear about kids using heroin," she said. "It's poison and it only takes once. And there's no happy ending with heroin."

Her daughter had injected heroin for just four months, bracketed around one month of residential treatment at an out-of-state rehabilitation facility. Counselors, family and friends thought the rehab was successful.

The same day she returned home, however, Laree relapsed, shot up that night in her bedroom and never woke up. She died March 16, 2013, five days before her 19th birthday.

A framed poem she wrote in rehab hangs on her bedroom wall; it's titled "Free Your Demons."

It concludes: "Once the demons are gone,/They won't be missed./Time heals everything./You can come back from this."

Farrell hopes to educate and raise awareness by sharing her daughter's heartbreaking story. She has spoken at legislative hearings and public forums on the recent scourge of heroin addiction in the Capital Region. She pleaded for expanded treatment for addicts, tougher penalties for dealers, increased investigations and heightened vigilance by overly trusting parents.

Farrell said the package of legislation signed by Gov. Andrew Cuomo in June was a good start in combating the surge in heroin and opioid use — including requiring insurance companies to

cover "medically necessary" treatment and a $25 million investment from the state — but it did not go far enough.

Farrell was disappointed that "Laree's Law," a bill sponsored by Sen. Neil Breslin, D-Bethlehem, that would have increased penalties for drug dealers when a particular sale leads to a fatal overdose, was left out and failed to win passage.

Farrell vowed to keep fighting for Laree's Law.

"I feel Laree pushing me to do more," Farrell said. "Someone dies of an unintentional drug overdose in this country every 19 minutes. I refuse to give up on this."

Laree Farrell-Lincoln was a golden girl, with wavy blond hair, wide green eyes, a dazzling smile and a carefree spirit that radiated confidence. She grew up just off Central Avenue, near Colonie Center. "You could hear her laugh a block away," her mother said.

She was a cheerleader, played softball and had an inner brightness that illuminated the halls at Colonie Central High School. She was a straight-A student who started kindergarten at 4, vaulted ahead a grade and graduated from high school at 16 with an advanced Regents diploma.

"Laree (pronounced luh-REE) was the most intelligent girl I ever knew," said Jessie Kowalski, her best friend since seventh grade. "We just clicked. She was like my other half. I lost my heart and soul when she died."

Kowalski had her friend's name and the date of her birth and death tattooed on her back.

The details of Laree's addiction — when she started using heroin, where she got her drugs and how she supported her habit — remain shrouded in mystery.

"She got involved with the wrong people," Kowalski said. "Heroin is all over Colonie. She was ashamed of it and hid it from me. She didn't want to let me see that part of her."

Farrell said her daughter was a natural leader who had a wide circle of friends at Roessleville Elementary School, Sand Creek Middle School and Colonie High. "She always stuck up for the underdog," her mother said.

She graduated with honors and enrolled at Hudson Valley Community College, but lost interest in academics and for the first time in her life seemed adrift and uncertain of her future. She worked at a sandwich shop and ice cream parlor. Her father, Herb Lincoln, bought her a VW Jetta, her first car. She paid for insurance and gas. She chafed at the strict rules laid down by her mom.

"We butted heads quite often," Farrell said.

In October 2012, Laree told her mother that she had been using heroin for about a week and she was sick, scared and desperate. Farrell was shocked. She knew her daughter had abused

alcohol and smoked marijuana, but not in the extreme. Their pediatrician had no experience treating heroin addiction and her daughter ended up in the detox unit of St. Peter's Hospital in Albany. She was treated with Suboxone, a drug that suppresses withdrawal symptoms and cravings for heroin. She checked herself out of detox the following day. "I can do it on my own," she said.

But it became clear she was not kicking her addiction. She lost 30 pounds over the next three months, looked strung out, stopped showering and keeping up her appearance and had the glazed, nodding look of a heroin high. "I was begging her to get into an inpatient rehab and she was fighting me," Farrell said.

In January 2013, Laree said she wanted to get clean for real this time and asked for her mother's help once more. Farrell's health insurance covered just two nights at St. Peter's detox, but a staff member successfully argued for a third night. Two doctors lobbied on her daughter's behalf and got her admitted to Mountainside, a private treatment facility in Canaan, Conn. Farrell's insurance covered 80 percent of the 28-day residential program.

"She had a horrible withdrawal, but she really seemed to turn a corner and she said it had saved her life," Farrell said. She found comfort in the facility's strict regimen of work assignments, group therapy sessions, meditation, exercise and counseling.

Farrell visited her daughter and saw improvements. Her counselor said she had progressed to the point where she could be transferred to a less restrictive halfway house in Connecticut, a "sober house" that she would share with three other young women battling drug addiction.

Her mother picked her up on Valentine's Day, they drove back to Colonie, visited her grandparents and packed up her car with bedding and household supplies. Her daughter planned to get a job and would need a car. Farrell waved goodbye as Laree drove her Mazda away from their house, supposedly headed for Connecticut.

"She never got there," Farrell said. "I got a call from a staff member who said she never showed up. She bought some heroin in Colonie and got high."

She was disqualified from the halfway house and arrived home a few days later. "She was a mess," Farrell said. "She hated herself, but the addiction was stronger than she was. We were back in hell."

Since Farrell worked during the day, she had her daughter stay with Farrell's parents, who provided around-the-clock supervision. The arrangement seemed to work. She attended 12-step meetings daily, gained weight, took care of her appearance again and seemed to turn a corner.

After several weeks, Farrell allowed her daughter to return home. The two made plans to go to the St. Patrick's Day parade, a happy tradition.

That afternoon, somebody dropped off Laree at the workplace of her best friend, Kowalski. She planned to spend the night at Kowalski's house in Latham, but told her friend she was too tired and asked to be dropped off at her mother's house.

Mother and daughter talked and had a bowl of ice cream. It seemed almost like old times with the daughter she knew before heroin. "Be sure you get me up early in the morning," she told her mom. "I want to do my hair and makeup."

She kissed her mother good night.

Her mother yelled up the stairway to her daughter's bedroom at 7:15 the next morning to wake her up. There was no answer. Farrell climbed the narrow stairway, stepped through the open doorway and found her daughter cold and unresponsive in bed. She called 911. Paramedics worked on Laree for about 90 minutes, but she was gone.

"In a way I feel it was my fault because I should have been with her that night and instead she somehow bought heroin and shot up at home," Kowalski said.

She told Kowalski heroin gave her "a state of euphoria," she said. "I never knew her to have depression. I don't know why she needed heroin, but it's a disease and no matter how much she wanted to stop, she couldn't," Kowalski said.

Laree told her best friend and mother that she started using heroin because her boyfriend was a recovering heroin addict who spoke about the drug in terrifying tones and how much it had once controlled his life. "She was a very stubborn person and she always had the inner strength to quit things when she decided it was time," Farrell said. She had quit drinking and smoking cigarettes cold turkey. She thought she could do the same thing after trying heroin, her mother said.

Even a street-smart former cop was clueless about heroin's reach. "There's a whole heroin world out there none of us knows about," she said. "It's a tight-knit community of users. Laree knew where to get it in Colonie, but she never told me where. She kept that secret. She went to the nearby CVS to buy her syringes."

Farrell later discovered her daughter had stolen a rarely worn emerald ring and pawned it, cashed in U.S. Savings Bonds given to her as a child and sold off a video game system and games to get cash to buy heroin.

"It was four months of hell after she started using heroin," Farrell said. "She wanted to get clean. We all tried to help her quit, but the drug was too powerful."

For the past 19 months, Farrell has channeled her grief into action, speaking out against heroin and creating a memorial garden in the backyard. Laree's father, family and friends helped install an angel fountain, stone retaining walls and a bench, along with figurines of Laree's beloved peacocks and a heart-shaped granite marker with a picture of mother and daughter.

Farrell placed a dozen pictures of Laree around her living room. She commissioned jewelry that incorporated some of her daughter's ashes. She got a tattoo on her forearm of a peacock and the words, "For all eternity."

It has not filled the hole in her heart. Farrell is comforted, though, by the companionship of the pets her daughter loved, Maxi the cat and Harley, a German shepherd.

"No matter how painful it is, I'll keep talking about heroin and how my daughter died," Farrell said. "We can't turn away from it and try to sweep it under the rug. We have to remove the stigma."

Farrell saved a final Mother's Day card her daughter gave her. When she is feeling low, she reads what her daughter wrote:

"The rest of my life will consist of proving to you how much I appreciate you and show you I can be an amazing daughter. I love you with all my heart. For all eternity. Love, Laree."

pgrondahl@timesunion.com • 518-454-5623 • @PaulGrondahl

Gmail by Google

Jay Mahler <mahler.jay@gmail.com>

Fwd: Fw: GOVERNOR CUOMO LAUNCHES "COMBAT HEROIN" CAMPAIGN

1 message

Krista <ksimera@aol.com> Mon, Sep 22, 2014 at 2:25 PM
To: Jay Mahler <mahler.jay@gmail.com>

GOVERNOR CUOMO LAUNCHES "COMBAT HEROIN" CAMPAIGN

Campaign Features PSAs, Dedicated Website, and Social Media Awareness Efforts

Governor Andrew M. Cuomo today launched "Combat Heroin," a campaign designed to inform and educate New Yorkers about the risks of heroin and prescription opioid use, the signs of addiction, and the resources available to help.

"Heroin and opioid addiction has impacted families in every corner of our state and stolen the lives of too many New Yorkers – but today we're taking another step forward in the fight against this serious epidemic," Governor Cuomo said. "The Combat Heroin campaign will get the word out about the dangers of this illegal drug use, as well as the treatment and support services that are available to those who need help. Just like this year's new law that expanded access to treatment and anti-overdose medication, this campaign is comprehensive and designed to save lives. I urge anyone who knows someone in need of help to reach out today."

Heroin and opioid abuse have become an alarming problem in communities across New York State and the nation. In 2013, there were 89,269 admissions for heroin and prescription opioid abuse treatment in New York State alone, an increase from 63,793 in 2004. During this same time period, New Yorkers ages 18 to 24 had the largest increase in such admissions. Nationally, nearly half a million people were reportedly abusing heroin or suffering from heroin dependence in 2012.

In June 2014, Governor Cuomo signed into law a legislative package to combat this epidemic. The package included insurance reforms, new models of care to divert people into community-based treatment and to support people after they have completed treatment, allowing parents to seek assessment of their children through the PINS diversion services, and expansion of opioid overdose training and increased availability to naloxone, a medication which reverses an opioid overdose.

A critical element of the legislative package requires the New York State Office of Alcoholism and Substance Abuse Services to develop and implement a public awareness and education campaign. The Office of Alcoholism and Substance Abuse Services, the NYS Department of Health, and the NYS Office of General Services' Media Services Center have worked together to create a multifaceted media campaign which includes a new website that is easy to navigate and is targeted toward parents, adults, and young people who are seeking help and information concerning heroin and opioid abuse and misuse.

The website, which can be found at this link: http://combatheroin.ny.gov/, includes information about warning signs of heroin and opioid abuse and misuse, access to Office of Alcoholism and

Substance Abuse Services treatment providers, and guidance to help parents talk to their children and healthcare professionals talk with their patients.

The campaign also includes four public service announcements and video messages, available on the above-linked website, from New Yorkers talking about the impact of heroin and other opioids on their lives.

Linda Ventura, founder of Thomas' Hope and a Suffolk County mother who lost her son to a heroin overdose, said, "I am proud to have been part of the call for legislative change in NYS to help eradicate the opiate and heroin epidemic. Governor Cuomo's campaign to address this insidious epidemic and to educate and direct families afflicted with this disease is welcomed and appreciated."

Susan Salomone, co-founder of Drug Crisis in our Backyard and a Putnam County mother who lost her son to a heroin overdose, said, "This is the first step in stemming the tide of overdoses that are occurring in New York State. Thank you Governor Cuomo and the legislature for your acknowledgement of this as an epidemic, a disease, and your commitment to raise awareness of the critical nature of legal opiates and heroin."

Cortney Lovell of Young People In Recovery - New York, said, "The Combat Heroin campaign is a wonderful example of what's possible when the community recognizes a crisis, unites together to find a solution and then takes meaningful steps to make a change. With the support of Governor Cuomo, our legislators, and our state offices, this campaign will increase awareness of the invaluable resources available throughout New York State. I'm grateful to share in the message that not only is the disease of addiction prevalent, but that there is hope through recovery."

Tatiana, a young person from New York City in long term recovery, said, "Heroin and Opiate-based narcotics almost took my life. Recovery is real and has given me true freedom. This campaign is a powerful tool that will create awareness and make a difference in the lives of the people suffering."

Anne Constantino, CEO of Horizon Health Services/Horizon Village in Western New York, said, "The heroin epidemic in WNY has been devastating. We are grateful to the Governor for his leadership in the fight to educate the public and to bring resources and hope to struggling families. With aggressive actions we can save lives."

Kevin M. Connally, Executive Director of Hope House Inc. in Albany, said, "Although heroin has been a problem for many years, the fact that today we are seeing teenagers who are using heroin and many are even injecting it, is extremely troubling. Use of heroin is affecting people of all ages, races and socioeconomic status. I applaud Governor Cuomo and his actions to combat the heroin epidemic."

Outreach President Kathy Riddle said, "The opiate / heroin epidemic in New York State is ravishing our families, schools and communities. Education, intervention and treatment can save lives and prevent future innocent victims and devastated families. I applaud Governor Cuomo for his leadership to include a public awareness campaign to raise awareness on this issue."

Bill Bowman, Executive Director of the Alcohol and Substance Abuse Council of Jefferson County, said, "We applaud the Governor's decision to launch the Combat Heroin Public Awareness Campaign. Jefferson County, like most counties in New York State, is experiencing a severe heroin epidemic with an associated rise in drug arrests, increase in related crime, overdose calls to first

responders, and overdose deaths. By bringing the reality this epidemic clearly in the eyes of New Yorkers, promoting prevention and how to access help, the Combat Heroin Campaign will surely save many lives."

Jennifer Faringer, MS.Ed., CPPg, Director of DePaul's National Council on Alcoholism and Drug Dependence-Rochester Area, said, "DePaul's National Council on Alcoholism and Drug Dependence-Rochester Area fully enthusiastically supports the efforts of NYS OASAS and Governor Cuomo in their efforts to raise awareness around the risks of Opioids. Opioid abuse, stemming often from the misuse/abuse of prescription pain medications impacts the lives of NYS's youth, their families and our communities! Working together in partnership we can make a difference in the lives of New Yorkers for a healthier and safer NYS!"

In addition to the Combat Heroin campaign, other initiatives being implemented include:

- SUNY and CUNY will promote the Combat Heroin campaign on college campuses and train campus police and emergency personnel on the use of naloxone.
- The 12 Office of Alcoholism and Substance Abuse Services Addiction Treatment Centers will continue to train New Yorkers on the use of naloxone. Addiction Treatment Center staff have already trained more than 3,200 people.
- Expand naloxone training for first responders including police officers, firefighters, sheriffs' deputies and emergency services. Approximately 1,100 law enforcement officers have already received the life-saving training.
- Working with community providers to train persons throughout New York State likely to witness an overdose, including professional staff, drug users and their families on overdose prevention and the use of naloxone. To date, over 170 agencies have been enrolled, 15,000 persons trained, and in excess of 1,000 overdoses reversed.
- Create more prescription medication disposal sites across the state for New Yorker's to safely dispose of prescription medications. Department of Health has established a statewide medication drop box program. Drop boxes are also available year round at State Police Troop Headquarters in Batavia, Unadilla, Canandaigua, Latham, East Farmingdale, Ray Brook, Oneida, Middletown and Salt Point.

People or families who need help with substance abuse can call the toll-free Office of Alcoholism and Substance Abuse Services HOPEline at 1-877-846-7369 to speak with a trained medical professional. HOPEline staff can answer questions and help people find treatment 24 hours a day, seven days a week. All calls are confidential.

To help combat heroin and prescription opioid abuse and misuse, visit www.combatheroin.ny.gov (#CombatHeroin).

###

Additional news available at www.governor.ny.gov
New York State | Executive Chamber | press.office@exec.ny.gov | 518.474.8418

Schumer says Ulster County needs additional help with heroin +VIDEO

By James Nani
Times Herald-Record
Published: 5:02 PM - 07/01/14
Last updated: 5:16 PM - 07/01/14

KINGSTON -- U.S. Sen. Charles Schumer urged Tuesday for Ulster County to be designated a major drug trafficking area by the White House in the wake of an increase in heroin related seizures and crime.

Speaking at the Ulster County Law Enforcement Center, Schumer said he has sent a letter to the head of the federal Office of National Drug Control Policy to designate the county a federal High Intensity Drug Trafficking Area.

Schumer said the federal intelligence, coordination, funds and supplies would help stem the heroin epidemic before it mirrors the crack-cocaine problems of the 1980s.

"About 15 to 20 years ago, crack began rearing its ugly head in the east and frankly, not enough was done and it got its tentacles into our society," Schumer said. "We don't want that to happen again."

Schumer specifically pointed to heroin seizures in Ulster County that he said have tripled since 2007, and drug-related arrests that are on pace to increase by more than 25 percent this year, compared to 2013.

The designation of a High Intensity Drug Trafficking Area would allow Ulster County access to greater intelligence-sharing coordination among federal, state and local police, plus additional drug use prevention and drug use treatment.

Ulster Sheriff's Department Detective Sgt. Dirk Budd, who heads the Ulster Regional Gang Enforcement Narcotics Team, said the sheriff's office had made efforts to gain the federal designation for about six years. Though U.R.G.E.N.T. currently works with the U.S. Department of Homeland Security, Budd said the FBI typically does more work within the Capitol Region. The new federal designation could concentrate the agency's efforts down into Ulster County, the southern-most area of the U.S. attorney's federal jurisdiction.

Budd said it could also get other local police agencies on board to share information and work together if resources are coming from the federal level.

Ulster County Executive Mike Hein said his office is preparing the application. County Sheriff Paul Van Blarcum said the effort would have a difference.

"Today, our team just got bigger," Van Blarcum said.

>

By Amy Neff Roth

Print Page

June 06. 2014 6:00AM

Officials: Number of heroin users at jail a sign of growing epidemic

More and more admitted heroin users are ending up in Oneida County jail.

Over the last 15 months, 245 have entered the jail, which normally houses about 500 to 540 inmates, Oneida County Sheriff Robert Maciol said.

"That's a staggering number," he said.

More and more admitted heroin users are ending up in Oneida County jail.

Over the last 15 months, 245 have entered the jail, which normally houses about 500 to 540 inmates, Oneida County Sheriff Robert Maciol said.

"That's a staggering number," he said.

That's the kind of number that has grabbed the attention of public officials, substance abuse treatment providers, health care providers, police departments and other nonprofit agencies involved in substance abuse. They've banded together to develop strategies to prevent addiction and to help those already addicted to heroin.

The latest endeavors:

-- Maciol, state Sen. Joseph Griffo, R-Rome and Oneida County Executive Anthony Picente highlighted some of those efforts at a news conference Thursday.

-- Rome Memorial Hospital sponsored an educational session on heroin abuse Thursday evening.

-- And a state task force on heroin and opioid addiction, on which Griffo sat, released its report last week.

Griffo said he was struck by the scope of the problem after attending an April task force forum in Utica and reading testimony from other forums.

"This is truly a problem that is hitting every society class, every geographical region and it's because of the availability and the access and the cost, the price," he said. "I knew it was a serious issue, but I think the magnitude and how pervasive it was, was kind of surprising and disappointing at the same time."

Abuse of prescription opioid painkillers has been on the rise for years. But now that the state has tightened access to painkillers, many users have switched to heroin.

Here are some of the ways the county is fighting back:

-- The Oneida County Opiate Task Force formed in January to find ways to fight heroin. Made up of representatives from government, law enforcement, nonprofit agencies and the community, it already has produced a county resource guide.

-- The Sheriff's Office has applied for a $4,500 state grant to equip the county's 39 front-line deputies with kits so they can administer the drug naloxone to reverse the effects of an opioid overdose. Deputies sometimes are the first to arrive on the scene, particularly in a rural area.

-- The county and local agencies are working together to reach more community members with naloxone training.

-- The state task force recommended passage of 25 bills targeting education, treatment and law enforcement.

Judith Reilly, community program director of the Center for Family Life and Recovery in Utica, said many of the 25 bills being backed by a legislative task force on heroin fit in well with work done by the center, such as putting drug prevention programs in schools, raising public awareness, promoting pharmaceutical take-back programs and limiting prescriptions for acute pain.

The bills also address the fact that people need all kinds of help to recover and promote "wrap-around" services covering all aspects of the person's life, including employment, peer support, health care, financial services and child care.

The task force's plan also puts money into these programs.

"That's good, that's really good," she said.

Follow @OD_Roth on Twitter or call her at 792-5166.

Fighting Heroin Addiction

Here's what some local groups have to say about heroin:Heather Nower, program director, Community Recovery Center at Rome Memorial HospitalWhat's happening: 34.6 percent of patients last year admitted to using opiates (heroin or painkillers) as their primary or secondary drug, compared to only 16.8 percent in 2009.Treatment roadblocks: Too few doctors prescribing suboxone – an opioid that weans patients off other opioids – because each doctor can only see so many patients. Patients who find a doctor sometimes have trouble getting to the office. Hard to get insurers to approve inpatient treatment even for patients who really need it.Wil Murtaugh, deputy executive director, ACR HealthWhat it's

doing: Program to distribute naloxone – heroin "antidote" – and train community members in nine counties with 66 names on waiting list. Waiting for state approval to start syringe exchange program in Utica to prevent spread of HIV and hepatitis C.Program roadblock: Governor hasn't signed bill letting agencies distribute naloxone without having a doctor present.Dan Broedel, director, Midstate Regional Emergency Medical Services CouncilWhat it's doing: Training EMTs and other first responders to administer naloxone.Success: Eight basic life support agencies trained so far and more requesting training every week.Tom Zinger, emergency department nurse manager, Faxton St. Luke's HealthcareWhat's happening: ER seeing more heroin users, perhaps two or three a week.What it's doing: Admitting those who meet criteria and referring all to ER social workers who can line up treatment and other services.

http://www.uticaod.com/article/20140606/NEWS/140609621

Print Page

The New York Times

July 18, 2013

Heroin in New England, More Abundant and Deadly

By KATHARINE Q. SEELYE

PORTLAND, Me. — Heroin, which has long flourished in the nation's big urban centers, has been making an alarming comeback in the smaller cities and towns of New England.

From quaint fishing villages on the Maine coast to the interior of the Great North Woods extending across Maine, New Hampshire and Vermont, officials report a sharp rise in the availability of the crystalline powder and in overdoses and deaths attributed to it. "It's easier to get heroin in some of these places than it is to get a UPS delivery," said Dr. Mark Publicker, an addiction specialist here.

Here in Portland, better known for its laid-back vibe and lively waterfront, posters warn of the dangers of overdose. "Please," they say: "Do Not Use Alone. Do a Tester Shot" and "Use the Recovery Position" (which is lying on one's side to avoid choking on vomit).

The city, like many others across the country, is experiencing "an inordinate number of heroin overdoses," said Vern Malloch, assistant chief of the Portland Police Department. "We've got overdose deaths in the bathrooms of fast-food restaurants. This is an increase like we haven't seen in many years."

Heroin killed 21 people in Maine last year, three times as many as in 2011, according to the state's Office of Substance Abuse and Mental Health Services. New Hampshire recorded 40 deaths from heroin overdoses last year, up from just 7 a decade ago. In Vermont, the Health Department reported that 914 people were treated for heroin abuse last year, up from 654 the year before, an increase of almost 40 percent.

"Heroin is our biggest problem right now," said Capt. Scott Tucker of the Rutland, Vt., police.

One reason for the rise in heroin use is the restrictions on doctors in prescribin
tightened supply of pain pills, and physical changes that made them harder to
for a quick high, have diverted many users to heroin, which is much cheaper a
Dr. Publicker, president of the Northern New England Society of Addiction Me
some doctors in the region had been overprescribing painkillers, which can be

heroin. A federal study in 2011 showed that the treatment admission rate for opiate addiction was higher in Maine, and New England, than elsewhere in the country, though communities everywhere are reporting problems.

"We had a bad epidemic, and now we have a worse epidemic," Dr. Publicker said. "I'm treating 21-, 22-year-old pregnant women with intravenous heroin addiction."

Yet the rise in heroin abuse here predated the restrictions on painkillers, leading some officials to blame the simple law of supply and demand. Distributors in New York see a wide-open market in northern New England, where law enforcement can be spotty and users are willing to pay premium prices. A $6 bag of heroin in New York City fetches $10 in southern New England but up to $30 or $40 in northern New England, law enforcement officials said. The dealer gets a tremendous profit margin, while the addict pays half of what he might have to shell out for a prescription painkiller.

"If the market is flooded with low-priced, high-grade heroin, a significant population is addicted," Captain Tucker of Rutland said. "That's the free market."

Heroin is one of the most addictive drugs in the world. About a quarter of everyone who tries it becomes dependent on it. Users can quickly develop a tolerance, prompting them to seek more and more until the pursuit takes over their lives and, often, leads to ruin.

Theresa Dumond, 23, who lives on the streets of Portland, said she sells her body three times a day to support her heroin habit. She lost custody of her two young children about a year ago ("I can't keep track"), and their father died.

"I've lost everything," she said as she and a companion, Jason Lemay, 26, walked to an abandoned train tunnel, littered with old needles and trash, to shoot up. "The heroin numbs the pain and makes you not care about life," she said.

Her only concern now is scoring more heroin. She pays no attention to food and sleeps where she is or in a shelter.

Once deep inside the train tunnel, she helped Mr. Lemay inject a needle into one of his legs — he had no good veins left in his arms — and then jabbed a needle into her own arm. "It's the best feeling ever," she said. "It's the warm rush."

With more people becoming addicted, officials in New England are bracing for the likely consequences: more burglaries so addicts can support their habits and heavier demands on health, welfare and law enforcement services. Novice users are more likely to share needles, leading to an expected increase in infections like H.I.V. and hepatitis C.

Maine is the first state that has limited access to specific medications, including buprenorphine and methadone, that have been proven to be effective in treating addiction, a step taken to save money. Many here worry that such restrictions are likely to make things worse and lead to more fatalities.

For now, emergency responders are busier than ever.

"We used to have just two or three overdose calls a week," said Terry Walsh, Portland's deputy fire chief, who oversees emergency medical services. "Now we're seeing two, three, four a day."

Most of the heroin reaching New England originates in Colombia and comes through Mexico, federal law enforcement officials said. The number of seizures along the border jumped sixfold in 2011 from 2005. But enough is getting through to major distribution centers in the Northeast, including Philadelphia and New York, that it is flowing steadily into northern New England, often through Lowell, Lawrence and Holyoke, Mass. In May, six people were arrested in connection with a $3.3 million heroin ring in Springfield, Mass., and Holyoke, where investigators seized 45,000 single-dose bags.

The purity of the heroin varies widely, which law enforcement officers say is partly responsible for the increase in deaths, and bad batches have been reported throughout the region. Even an experienced user might not be prepared for the strength of a particular bag. And because heroin reaches the brain so quickly — and witnesses hesitate to call for help immediately — overdoses are often fatal.

Lourdes Watson-Carter, 34, who lived in a small town near here, had been a heroin addict for several years, according to her family and friends. They said her addiction led her to prostitute herself to pay for her next fix.

After her most recent term in prison, for drug trafficking, her friends and family thought she was clean. She was even preparing to go back to school in cosmetology and hairdressing and hoped she might regain custody of her young son.

But one night last month, Ms. Watson-Carter injected some very pure heroin, according to her father, Michael Watson, a retired Amtrak police officer, who lives in Maryland.

"She was taking the same amount she would usually take, but it was so concentrated and pure that she overdosed," he said. By the time an ambulance arrived, she may have been brain dead; he received conflicting reports. She caught pneumonia a few days later and then died.

Her death was especially awful, her father said, because he thought she was finally turning her life around. "But I knew I was going to get that call someday," he said. "You try to prepare

yourself for it, and you think you can handle it. But you don't handle it very well."