

Findings and Recommendations of the Suffolk Heroin and Opiate Advisory Panel

A Report to the Suffolk County Legislature
and the Suffolk County Executive

December 2010

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Acknowledgements

The members of the Suffolk Heroin and Opiate Epidemic Advisory Panel thank the Suffolk County Legislature, especially Legislators Wayne Horsley, Lynne C. Nowick, Tom Muratore, DuWayne Gregory and Kate Browning as well as Suffolk County Executive Steve Levy for giving us the opportunity to serve the people of Suffolk County. We also thank Susan Eckert, aide to Legislator Nowick who helped organize our meetings and supported the process. Finally, we owe our thanks to those who came before the panel to share their personal experiences with addiction in hopes of making things a little easier for others who are struggling and those who follow in their footsteps.

I. Panel Purpose & Process

Suffolk County is in the midst of a crisis. More specifically, our communities, families and youth are in crisis as we do battle with a swift and powerful enemy: drug addiction. Addiction – especially among adolescents – is an age-old problem, yet heroin has upped the ante and highlighted some persistent challenges that must be addressed with renewed urgency if we are to reduce the misery and destruction. The current crisis is being fueled not only by powerful and inexpensive heroin, but also by a population who has been primed for heroin by their overexposure and reliance upon readily available prescription opiates. The Panel also recognizes the well-documented connection between the initial use of alcohol as an entry point to the use of drugs like marijuana, cocaine, heroin and other opiates. We know that substance abuse is preventable, that addiction is treatable and that recovery is possible. These recommendations provide an initial roadmap for making those goals more attainable in Suffolk.

A. Enabling Legislation and Panel Membership

Intro Resolution #413-2010, approved unanimously by the Suffolk County Legislature and signed by Suffolk County Executive Steve Levy on May 26, 2010, established the Heroin and Opiate Epidemic Advisory Panel. The enabling legislation was sponsored by Legislators Wayne Horsley, Lynne C.

Nowick, Tom Muratore and DuWayne Gregory. The Panel, comprised of the treatment professionals, prevention experts, school officials and health care professionals listed below, was charged with making recommendations about ways in which Suffolk County can “improve its response to heroin and opiates,” in terms of prevention, treatment and recovery support.

Panel members – all leaders in their respective fields - brought a diverse array of experiences and perspectives to the group, both personally and professionally. The energy, passion and dedication of each panel member was evident throughout the process that included listening to heartbreaking testimony about individuals and families who had fallen through the cracks, and coming to consensus on viable, achievable recommendations that would make Suffolk a healthier and safer place.

Panel Members include the following:

- Cari Besserman, Phoenix House of Long Island– **Panel Secretary**
- Elaine Economopolous, Horizons Counseling Center/Quality Consortium of Suffolk County
- Edward Ehmann, Smithtown Central School District/Suffolk County School Superintendents Association
- Arthur Flescher, Suffolk County Division of Community Mental Hygiene
- Kristie Golden, South Oaks Hospital
- Jack Hoffmann, Eastern Long Island Hospital – **Panel Vice Chair**
- Janine Logan, Nassau/Suffolk Hospital Association
- Pamela Mizzi, Suffolk County Prevention Resource Center
- Patrick O’Shaughnessy, St. Catherine of Siena Medical Center
- Jeffrey L. Reynolds, Long Island Council on Alcoholism & Drug Dependence – **Panel Chair**
- Lisa Lite-Rottmann, New York State Office of Alcoholism & Substance Abuse Services (OASAS)
- John Venza, Outreach House

B. Guiding Principles

The following guiding principles reflect a consensus among Panel members and formed the foundation for our discussions, deliberations and recommendations. There were many tenets that were "givens" for our group, yet are restated here for both emphasis and to increase awareness among lawmakers and community members. These principles, taken together with our recommendations form the basis for a pro-active response to substance abuse and addiction in Suffolk County.

- Addiction is a chronic disease which influences the biological, psychosocial, and spiritual facets of individuals and families. Left untreated, it is progressive and often fatal, which profoundly and negatively impacts the physical, psychological, social and spiritual quality of life for individuals and families.
- Prevention, screening, treatment and recovery support must be woven together and embedded in the fabric of our community.
- Substance abuse is preventable and success requires parents, schools, treatment providers, nonprofit organizations and communities to work together. All systems need to be fully engaged.
- Effective prevention programs promote and enhance protective factors, reverse and reduce risk factors, start early in childhood, are age-appropriate across the lifespan, culturally competent, community based and sustained.
- While it is Suffolk's *heroin* crisis that has brought the panel together, we believe that prevention programs and practices need to address all forms of substance abuse, including the underage use of tobacco and alcohol, the use of illegal drugs such as marijuana and cocaine, and the inappropriate use of legally obtained substances such as inhalants, prescription medications, and over-the-counter drugs.
- A well-considered and integrative approach to chemical dependency includes attention to problem gambling and other addictions.

- Individuals and families deserve a continuum of care that includes prevention, screening, pre-treatment, comprehensive treatment, continuing care, ancillary services and recovery support that is individualized, flexible, stage-matched and readily available on demand.
- There are many pathways to recovery, and because it is an intensely personal process, individuals should have full access to a variety of tools and services, including pharmacological interventions, 12-step programs and behavioral therapies.
- The County and the community must continue to work to eliminate the stigma and barriers to effective treatment associated with both addiction and mental health disorders.
- Individuals and families in recovery must be encouraged to function as partners in prevention and in the development of effective addiction services. Inclusion of their voices and experiences will make our systems of care more responsive and effective.
- Reducing the health consequences associated with substance use - including fatalities, overdose and infectious diseases such as HIV and Hepatitis C - is an important goal as we work towards abstinence.
- Providing sufficient resources for prevention, treatment and recovery-oriented services is a valuable and cost effective investment in the health, safety and well-being of all Suffolk residents.
- Health care professionals play an important role in addressing addiction and should have a clear understanding of the illness and available resources.
- Screening, brief intervention and referrals to treatment (SBIRT) should be incorporated into all medical encounters and into other settings, including schools.

C. Information Gathering Methods

1. Committee Meetings

The Panel met first on July 22, 2010 and continued meeting approximately twice per month through November 29, 2010. Each meeting was conducted

within either the Legislative building in Hauppauge or the Legislative Building/County Center in Riverhead. All meetings were open to the public and were facilitated using semi-structured discussion guides. Meeting recordings, minutes and/or transcripts can be obtained via the Suffolk County Legislature's website.

2. Data Gathering

The Panel collected and reviewed data sets focused on national, statewide, regional and local trends and indicators so as to come to a common understanding about the scope of the problems facing our community in context with other regions, particularly suburban areas. Trends in fatal overdoses, drug-related arrests, treatment admissions and other community indicators received significant attention from Panel members. Further, the group conducted an extensive literature review detailing best practices in prevention, addiction treatment and recovery support, again with an eye towards replicating programs or initiatives that have proven successful elsewhere.

3. Public Hearings & Written Testimony

Two Public Hearings to gather community input about strategies for addressing Suffolk's heroin and opiate crisis were held as follows:

Thursday, October 14, 2010

5:00pm - 7:00pm

Hauppauge Legislative Auditorium

725 Veterans Memorial Highway, Hauppauge

Wednesday, October 27, 2010

5:00pm - 7:00pm

Riverhead Legislative Auditorium

300 Center Drive, Riverhead

To accommodate as many speakers as possible, testimony was generally limited to three minutes per person and the public was encouraged to submit written

comments. Speaker sign-up commenced on-site at 4:30PM prior to each hearing and speakers were called in the order requests were received. Individuals were told that they could testify without disclosing their full name and could submit testimony anonymously to the panel via mail or email.

Outreach to encourage participation in the hearings was done using printed flyers, press releases sent to local newspapers, email blasts, and via social networking websites like Facebook. Approximately 50 individuals presented at each of these public hearings and participants included young people with addiction, people in recovery, parents of addicted teens, parents who have lost children to overdoses, treatment providers, school officials, students and concerned community members.

The Panel received written testimony from several individuals, including an incarcerated individual, parents impacted by addiction and an employee of the Suffolk County Sheriff's Department.

As the Panel submits these initial recommendations, we believe that each strategy we've prioritized herein is backed by identified needs in Suffolk County and evidence-based, established practices implemented here in our region or elsewhere.

II. Prevention Prepared Communities

A. Understanding Prevention and Current Efforts

As defined at the federal and state levels, prevention is a proactive, research-based process that focuses on increasing protective factors and decreasing risk factors that are associated with alcohol, drug abuse and problem gambling behavior in individuals, families and communities. Although prevention is important for all age groups, it is imperative to start with youth for many reasons. A developmental approach to prevention and reduction of underage drinking and drug use recognizes the importance of all the environmental and social systems

that affect adolescents as well as their own maturational processes and individual characteristics. Complex interactions among biological, social, cultural, and environmental factors also evolve as maturation proceeds. Thus for prevention programming to be most effective, it should be both evidence and developmentally based, culturally appropriate, comprehensive, integrated, and be initiated early. Prevention science demonstrates that lowering risk factors, increasing protective factors and implementing environmental strategies brings about a change in community attitudes, norms, and behaviors that drive alcohol other drug abuse. In essence, these efforts form a continuum designed to help children and adolescents make sound choices about drug and alcohol use. Scientific research provides the foundation for the design of interventions that accomplish these goals and the means for determining which interventions are effective.

A multitude of loosely connected prevention services and coalitions have existed in Suffolk County for decades. Some are coordinated by the County itself, some by the State and some by independent organizations, communities and schools. In 2009, through funding from both Suffolk County and the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the Suffolk County Prevention Resource Center was formed in cooperation with South Oaks Hospital. The Prevention Resource Center (PRC) was established to provide the necessary tools and technical assistance to communities in Suffolk County who are working to alleviate risk factors which have been recognized as negative local conditions responsible for challenging the quality of life for residents. The PRC has been charged with facilitating partnerships among schools, communities and prevention providers to focus on the provision of effective strategies to deal with alcohol, drug, and problem gambling and to make stronger connections among those putting forth the current efforts.

Certified and/or OASAS-funded Prevention Providers receive oversight from the OASAS Long Island Field Office, as well as by the Suffolk County Division of Community Mental Hygiene. Federal funding through the Drug Free Communities program supports several community and school-based coalitions

on Long Island, however, they are not fully integrated with the local prevention providers. Several schools have adopted evidence-based prevention programs such as “Too Good for Drugs,” “Protecting You/Protecting Me,” and “LifeSkills Training,” but few if any, are conducting them universally for all students in all grades. Practices vary widely and are often dependent on available resources, the interest of a school superintendent or individual teacher, or pressure from a Parent/Teacher Organization. A coordination of each of the things noted above would help to reduce the fragmentation of current prevention efforts on Long Island, and encourage more consistent practices across communities.

Most school districts have held “Heroin Forums” in the last 2-3 years. While there’s some variation, such forums usually last a couple of hours, include three or four presenters and attract only parents who are already committed to prevention and/or those in crisis and looking for help. While these public events help raise awareness and give motivated parents some additional insights, effective prevention is something more.

B. Evidence-Based Approaches

The term “evidence-based practice” (EBP) noted earlier refers to interventions for which systematic, empirical research has been conducted and provided evidence of effectiveness as an approach for specific problems and/or populations. At both the federal and state level, prevention EBPs are being promoted and professionals are being encouraged to adopt them and put the science into practice. Recent guidelines were released by OASAS requiring OASAS-funded prevention providers to move toward using EBPs in order to continue receiving funding into the future. A list of prevention EBPs can be viewed at the following link:

<http://www.liprc.org/site/EvidenceBasedPrograms.aspx>

and the panel supports the following prevention premises promulgated by the National Institute on Drug Abuse:

Prevention services should enhance protective factors and reverse or reduce risk factors. The risk of becoming a drug abuser involves the relationship among the number and type of individual, peer, family and community level risk and protective factors. The potential impact of specific risk and protective factors changes with age. For example, risk factors within the family have greater impact on a younger child, while association with drug-abusing peers may be a more significant risk factor for an adolescent. While risk and protective factors affect people of all groups, these factors can have a different effect depending on a person's age, gender, ethnicity, culture, and environment. Prevention programs should address all forms of drug abuse, alone or in combination, including the underage use of legal drugs, the use of illegal drugs, and the inappropriate use of legally obtained substances (e.g., inhalants), prescription, over-the-counter drugs. They should address the type of drug abuse problem in the local community, target modifiable risk factors, and strengthen identified protective factors and should be tailored to address risks specific to population demographics or characteristics, such as age, gender, and ethnicity, to improve effectiveness.

Environmental prevention strategies are focused on changing aspects of the environment that contribute to the use of alcohol and other drugs. Specifically, environmental strategies aim to decrease the social and health consequences of substance abuse by limiting access to drugs and alcohol and changing social norms that are accepting and permissive of substance abuse. They can change public laws, alter policies and practices to create environments, and enhance public awareness with an eye towards decreasing the incidence/prevalence of substance abuse.

Community-based prevention programs aimed at general populations at key transition points, such as the transition to middle school, can produce beneficial effects even among high-risk families and children. Such interventions do not single out risk populations and, therefore, reduce labeling and promote bonding to school and community. Community prevention programs that combine two or

more effective programs, such as family-based and school-based programs, can be more effective than a single program alone. Community prevention programs reaching populations in multiple settings—for example, schools, clubs, faith-based organizations, and the media—are most effective when they present consistent, community-wide messages in each setting. Community-based coalitions provide an effective means to frame, address and change substance abuse problems in neighborhoods.

School-based prevention services can be designed to intervene as early as preschool to address risk factors for drug abuse, such as aggressive behavior, poor social skills, and academic difficulties. Prevention programs for elementary school children should target improving academic and social-emotional learning to address risk factors for drug abuse, such as early aggression, academic failure, and school dropout. Prevention programs should be long-term with repeated interventions (i.e., booster programs) to reinforce the original prevention goals. Research shows that the benefits from middle school prevention services diminish without follow-up programs in high school.

Family-based prevention programs should enhance family bonding and relationships and include parenting skills; practice in developing, discussing, and enforcing family policies on substance abuse; and training in drug education and information. Family bonding is the bedrock of the relationship between parents and children. Bonding can be strengthened through skills training on parent supportiveness of children, parent-child communication, and parental involvement. Parental monitoring and supervision are critical for drug abuse prevention. These skills can be enhanced with training on rule-setting; techniques for monitoring activities; praise for appropriate behavior; and moderate, consistent discipline that enforces defined family rules. Information, drug education and drug testing training for parents and caregivers reinforces what children are learning about the harmful effects of drugs and opens opportunities for family discussions about the abuse of legal and illegal

substances. Brief, family-focused interventions for the general population can positively change specific parenting behavior that can reduce later risks of drug abuse.

Prevention works when individuals, families, schools, workplaces, and communities take action to promote emotional health and prevent and reduce mental illness and substance abuse. It takes a systemic, integrated approach and focused work along several domains, including individuals, schools and communities to be effective.

C. Issues Identified and Recommendations

RECOMMENDATION 1: Create and maintain a public education campaign to reduce the incidence of drug and alcohol use and problem gambling in the community and maintain a resource center for parents and professionals alike.

The Panel recognizes through public testimony and ongoing dialogue among members, that the general public lacks the necessary information about prevention, treatment and recovery. Educating parents and the community about drug and alcohol abuse, other addictive disorders and risk/protective factors in easy-to-understand language is imperative. Suffolk County should create a public awareness/education campaign (PSAs & advertisements) that is routinely broadcast across multiple media outlets – including print, television, radio and online.

RECOMMENDATION 2: Encourage and provide the support necessary to schools to adopt evidence-based substance abuse prevention services for all students K-12.

Research indicates that adolescent drug and alcohol consumption is a complex behavior influenced by many things such as:

1. Normal maturational changes that all adolescents experience (e.g., biological and cognitive changes, such as sexual development and differential maturation of specific regions of the brain, and psychological and social changes, such as increased independence and risk taking);

2. Multiple social and cultural contexts (i.e., the social systems) in which adolescents live (e.g., family, peers, and school);
3. Genetic, psychological, and social factors specific to each, and;
4. Environmental factors that influence the availability and appeal of alcohol and other drugs (e.g., enforcement of underage alcohol policies by schools and others, community support for enforcement of underage drinking laws, marketing practices, pricing, and the physical availability of alcohol).

Schools currently focus on the social and emotional health of youth, yet teachers often use prevention lessons that are less than comprehensive due to limited time to cover the subject matter and/or dated materials. Good prevention addresses risk and protective factors, is sustained and is woven into a school's culture. Bringing evidence-based models of prevention to schools should be fully funded through training for school personnel and prevention providers. A mechanism for them to access ongoing technical assistance in keeping to the fidelity of the scientific model should be in place as well. Training and technical assistance could be facilitated by OASAS directly or through local county government prevention services.

Schools are faced with the sometimes daunting task of educating many children who do not learn well within the typical milieu of the classroom and may resort to drugs and alcohol as coping mechanisms. Teacher and guidance education programs do not always cover creative ways to address students with special needs and faculty may become entrenched in operating within a system that can stifle innovation. This may be based on regulation, learning standards or budget constraints. A strengths-based approach, often used in treatment programs, is equally imperative for use in the school setting.

We encourage the use of SBIRT in health care settings, but also urge its implementation in school settings, particularly when school personnel can create direct linkages to organizations that offer information and referral services, treatment interventions, student assistance counselors or other clinical staff to

support needs that are identified in the screening process. Early identification and intervention is imperative to the proactive approach to ensuring a student's social and emotional health, as well as long-term academic success.

While young people spend a great deal of time in school, they spend more time at home and 100% of their time within our communities. Evidence-based programs delivered in community settings that strengthen family relationships, enhance parent-child communication and build parenting skills are a critical component of prevention efforts. These programs generally are, and should be tailored to specific community needs, delivered in a variety of settings to foster accessibility, sustained over time and should be delivered with cultural competence.

RECOMMENDATION 3: Acknowledge and address the misuse and diversion of prescription drugs.

It is well known that opioid misuse and addiction is a problem not unique to Suffolk County. Both the federal and state governments have begun to address this issue and make recommendations to effect change. Specifically, one of the most comprehensive plans was drafted by the College of Physicians and Surgeons in Ontario, Canada. These guidelines developed multiple recommendations to support effective, yet safe opioid prescribing practices, as well as suggest legislative changes to support a comprehensive revision in the way health care providers manage patients in pain both in the acute and chronic settings.

Opioid use and addiction are a complex process and it has been well documented in the medical literature here in the U.S. that many patients start down the addiction pathway after being exposed to prescription opioid analgesics. Due to opioid receptor down-regulation and tolerance, patients classically will require larger doses of opioid analgesics to manage their pain, which leads many providers to add long-acting opioids such as Oxycontin to their regimens. Once a patient receives this class of opioid, they often begin to develop signs of misuse and potential addiction. If prescription narcotics are no

longer available, many will turn to heroin to meet their addictive needs, as it is readily available and can be easily be inhaled as opposed to being injected.

This has led to near epidemics of heroin and opioid abuse throughout many counties and states in the United States, and unfortunately, Suffolk County is no exception. What is also quite clear is that there is lack of policies, educational mandates, clinical screening/testing, and use of meaningful electronic information to guide health care practitioners as to how to effectively, yet safely manage patients on opioid medications.

RECOMMENDATION 4: Support and encourage health care provider and consumer education as it relates to pain management, opioids and other prescription medications.

The Panel strongly suggests that ensuring adequate and ongoing training of medical providers treating patients in their private practice is a necessary step to ensure uniform and high-quality care for opioid dependence as well as other forms of chemical dependency and mental health disorders. Primary Care Physician involvement and behavioral health-integration is being heavily supported through evidence-based models of care. This should be strongly promoted in medical education programs and barriers removed to its implementation.

New York State should mandate at least one hour of Continuing Medical Education (CME) for all health care providers regarding the safe use of opioids and primary care Graduate Medical Education (GME) residencies should include opioid addiction/prescription abuse training in their residency curriculums.

Suffolk County should spearhead programs to effectively educate patients about dangers of opioid misuse, signs and symptoms of addiction and available resources. This might include sponsored trainings, health center practices and/or public service announcements.

RECOMMENDATION 5: Continue to co-sponsor unused prescription drug reclamations that include links to care.

Drug reclamations are critical to child safety and public health. Beyond the hundreds of pounds of medications that are collected during each event, the increased awareness about medication safety even among those who don't participate is important. Each of these drug reclamations should include a linkage to care for those wanting more information, addiction treatment or help for a family member.

RECOMMENDATION 6: Call on federal lawmakers to pass legislation requiring all pharmacies to accept unused and/or expired medications from consumers and to dispose of them safely.

Drug reclamation events are important, but accessibility can be limited. Pharmacies that dispense medications should be required to accept unused meds back from consumers. With a pharmacy in each community, they are readily accessible, experienced in handling medications, including controlled substances, and able to answer consumer questions.

RECOMMENDATION 7: Promote the use of technology to track prescriptions and health care records.

The Suffolk County Legislature should call on the New York State Department of Health to take immediate steps to insure tracking of ALL opioid prescriptions in real time with shared access among treating physicians, pharmacists and other health care providers. New York currently operates a federally-funded Prescription Drug Monitoring Program (PDMP) and like other state-run PDMPs nationwide, the program seeks to identify and deter drug/diversion, and facilitate and encourage the identification, intervention with and treatment of persons addicted to prescription drugs. We've been told, however, that the database is not updated frequently and that pharmacists – key players in this equation – don't have access to the information. Real-time access would help pharmacists determine a prescription's authenticity, whether it was

already filled by another pharmacy or physician, and whether the patient has engaged in "doctor shopping".

Additionally, as hospitals and other health care facilities move to implement shared Electronic Medical Records (EMR), a comprehensive drug monitoring system must be part of this system and federal funding – including Medicaid reimbursement - should be contingent on institutional compliance.

It may also be that the Suffolk County Department of Social Services, because of its involvement in Medicaid has both access to, and a concurrent fiscal interest in medical claims related to opioid medications. This should be investigated further.

RECOMMENDATION 8: Continue the distribution of free drug testing kits to parents and promote drug testing as a prevention and screening tool.

The Panel agrees that when used properly and in conjunction with other tools and supportive services, drug test kits can be helpful to parents looking for evidence of substance abuse. Periodic testing may also give young people a strategy for dealing with peer pressure (ie: "I can't try it; my parents test me regularly."). The Suffolk County Sheriff's Office and several Legislators routinely give away drug testing kits and the Panel encourages continuation of such distribution, particularly when done in connection with parent education seminars and linkages to treatment.

RECOMMENDATION 9: Support drug testing and SBIRT (Screening, Brief Intervention and Referral to Treatment) as routine parts of physicals and well visits conducted for those under the age of 18 in primary care settings.

At present time, primary care physicians and other health care professionals do not routinely test youth for drug use as part of annual wellness visits. In addition, primary care doctors often lack the information or resources to fully educate youth and parents about the dangers of drug and alcohol abuse. Medical providers should take a more active role in addressing adolescent

addiction and Suffolk County can set the stage for this by launching such a pilot program in its health centers. Parents would have the opportunity to opt-out of testing and SBIRT should be implemented in a way consistent with best practices (see further discussion of SBIRT and reimbursement mechanisms) in the next section. This further supports the evidence-based model of integrating physical and behavioral health care.

The Panel also took testimony from parents who turned to their pediatrician for help with their child's addiction, but were unable to obtain information or referrals. Accordingly, we encourage efforts to better train, engage and equip pediatricians with the resources and referrals necessary to guide parents in crisis.

RECOMMENDATION 10: Require and routinely conduct drug testing as part of sports physical requirements in schools.

Given that schools require sports physicals conducted by primary care physicians prior to a student's participation on a school team, this provides a unique opportunity to integrate drug testing into a routine exam without additional inconvenience or intrusion. Although the Panel recognizes that this will not always identify everyone with a drug problem (i.e. adolescents may stop using prior to the exam to show a "clean" result), it will surely identify some, it will offer an opportunity for parents, adolescents and physicians to have a dialogue about drug use and may serve as a deterrent to use. It will also offer youth a response when faced with peer pressure (i.e. "I can't use that, I need to have a drug test as part of my sports physical"). Schools that do not implement such a policy should be continuously educated about the benefits of such a protocol. Requiring drug test results as part of a health certification will not only allow timely intervention for substance abuse problems, but will also save the lives of students who might otherwise experience fatal consequences resulting from drug use and physical exertion.

RECOMMENDATION 11: Develop a strategic plan to monitor county-wide data related to population-level change in the prevalence and incidence of drug and

alcohol dependence & abuse beyond what currently exists and monitor savings associated with the change.

The Panel believes that current local data collection efforts at the school, precinct and township levels are not conducive to assessing population-level, environmental change in the County. Data collection efforts often differ by location and, thus, cannot be appropriately compared over time. Data collection efforts must be standardized and reported in a timely fashion so that all related trends can be monitored more readily. The Panel urges the Legislature to convene a group of statisticians and research experts to determine what data should be collected to provide the most useful information to the County for planning and evaluation purposes. This includes data collected by schools, communities, police departments, etc. All schools should be required to survey students using an OASAS-sanctioned survey at a minimum of every two years. Police precincts and Townships should be required to collect specific data related to measuring change beyond what is currently being gathered. The Panel also suggests the development of projections of cost savings resulting from interventions aimed at reducing consequences of alcohol and substance abuse. This should include the development of specific cost benefit ratios based on specified criteria.

RECOMMENDATION 12: Encourage townships to promote the value of community-based coalitions that work collaboratively with individual school districts and other adjacent communities to support the development of community-based models of prevention.

Community coalitions are the primary point for all prevention interventions to begin. Only a community as a whole can begin to direct schools, businesses, churches, and social organizations to address addiction through prevention and treatment. The Panel supports community coalitions as the starting point for all integrated systemic interventions within a neighborhood or specific area. A coalition can coordinate efforts all stakeholders to effectively address addiction through prevention and treatment.

RECOMMENDATION 13: Strengthen the existing statute and support the more active and effective use of the Social Host Law.

The goals of prevention interventions aimed at underage drug and alcohol use are to:

1. Change societal acceptance, norms, and expectations surrounding underage drinking and drug use, including that on college campuses.
2. Engage parents and other caregivers, schools, communities, all levels of government, all social systems that interface with youth, and youth themselves in a coordinated effort to prevent and reduce underage drinking and its consequences.
3. Prevent adolescents from starting to drink or use other drugs.
4. Promote an understanding of underage drug and alcohol consumption in the context of human development and maturation that takes into account individual adolescent characteristics as well as environmental, ethnic, cultural, and gender differences
5. Delay initiation.
6. Intervene early, especially with high-risk youth.
7. Reduce drinking, drug use and its negative consequences, when initiation already has occurred.
8. Identify adolescents who would benefit from interventions, including treatment and recovery support services.

Testimony at our public hearings, and a presentation made by Suffolk County Police Commissioner Richard Dormer, revealed a relatively small number of arrests for social host law violations. The Panel believes that there are obstacles to the full implementation of the Social Host Law and that the law itself is poorly understood. The panel encourages increased dialogue among law enforcement entities, including the District Attorney's office, in order to make the law fully and easily enforceable in all settings. It is suggested that the Suffolk County interpretation of the law be compared to other Counties in New York to ensure

that the usefulness of the law is made clear. The County is also encouraged to take a proactive approach by monitoring social media sites such as Facebook and Twitter for planned parties and intervening with parental notification prior to a party taking place. The Panel suggests that a concurrent dialogue take place among law enforcement agencies to examine other, similar laws and impediments to enforcement. Reporting to the Legislature annual statistics on the enforcement of such laws is also imperative to track the action being taken.

The Panel supports current efforts to increase the fines for social host law violations and to ensure that the law is fully applied in all settings, including parks and college campuses.

RECOMMENDATION 14: Recognize commercial merchants who get involved in prevention activities.

The Panel recognizes that business merchants can play a key role in creating prevention prepared communities. Small businesses are negatively impacted when fewer sales are made and can be tempted to sell alcohol or drug paraphernalia to adults and minors simply to maintain financial viability. In these cases, incentives for compliance with the law are not in align. A system should be established to acknowledge merchants for clean inspections and correct action, as well as a system to make reports of poor inspections available to the public. A further acknowledgement of a merchant's commitment can be demonstrated through a signed "pledge" that states their intent to follow the laws regarding not selling to minors as is used through the "Not on Your Life" (NOYL) prevention program.

RECOMMENDATION 15: Create a fair plan to utilize and equally distribute asset forfeiture dollars resulting from drug and alcohol related arrests/convictions to carry out prevention efforts throughout Suffolk County.

Asset forfeiture dollars are currently used for a variety of purposes in Suffolk County. A percentage of those funds should be re-directed to support prevention efforts in the County and be used to provide financial support for

school-based, evidence-based prevention approaches and technical assistance to implement them. Accounting and reporting on the use of the dollars should be made annually to the Legislature.

RECOMMENDATION 16: Develop a tax on all alcohol sales to support treatment and prevention services and ban all sales and displays of drug related paraphernalia.

A little over 10 years ago, a national survey funded by the Robert Wood Johnson Foundation, found that 82 percent of adults favored an increase of five cents per drink in the tax on beer, wine and liquor to pay for programs to prevent minors from drinking and expand alcohol treatment programs. In at least one state, the residents supported a ten cent increase. A number of states have implemented a tax on alcohol to support prevention and treatment, however, New York is not one of them. All 50 states and the District of Columbia levy some type of tax on alcoholic beverages. However, only some of the states use the tax revenues or other revenues from alcohol sales to fund needed alcohol treatment programs. A small tax on alcohol to support prevention and treatment should be considered for liquor merchants in Suffolk County.

Consideration has been made in a number of states, and bills brought before the State legislatures have passed that restrict or ban the sale of drug paraphernalia. This legislation has varied from location to location, but has focused on limiting the sale of things like pipes, bongs, paper for rolling and other items to only certain types of merchants. Manufacturers and distributors have often gotten around existing laws by putting labels on things that state the use of the product is for tobacco, even though it is widely know that certain items are used with illegal drugs as well. The idea to limit the sale to only certain types of merchants is an attempt to control this to the greatest degree possible. Suffolk County should explore these existing laws and consider legislation that limits the sale of anything that has a clear link to the use of illegal drugs.

RECOMMENDATION 17: Explore the use of the Suffolk County Police Department's drug-sniffing K-9 unit for school locker inspections.

The Suffolk County Police Department has successfully trained dogs to detect a variety of drugs in student lockers. This K-9 unit is specially trained to find and respond to the discovery of drugs and drug paraphernalia and offers schools yet another tool for combating substance abuse. School districts should be encouraged to learn more about this K-9 unit and decide based on individual circumstances, whether their skills can potentially be brought to bear in their buildings.

III. Access to Treatment and Addiction Services

A. Understanding Treatment and Current Efforts

Our knowledge of the altered physiological processes and structural changes in the brain underlying the development of addictive disease has increased markedly over the past several decades. Yet, there remains continued confusion about an issue of critical importance in understanding why heroin and other opioids have such a powerful grip on some users: the difference between physiological dependence and addictive disease.

Physiological dependence is characterized by the occurrence of a specific set of symptoms, known as withdrawal, which occur when an individual is prevented from using a particular drug that he or she has been taking regularly for an extended period of time. Physiological dependence develops following prolonged ingestion of opioid drugs irrespective of the purpose of this use. So, for example, it is not uncommon for individuals receiving extended opioid prescriptions for the management of pain to be physically uncomfortable when initially weaned off the medication. Yet, despite the development of dependence most individuals treated with narcotics for pain will not develop the complex illness of addiction.

Physiological dependence is time-limited; the symptoms diminish and eventually disappear with extended abstinence. Addiction, on the other hand, is a brain

disease “characterized by intense, and at times uncontrollable, drug craving and use that persist even in the face of devastating consequences”. Addictive disease is marked by its persistence and the repetitive resumption of drug use (relapse), even after extended periods of abstinence, i.e., in the absence of physiological dependence.

During the last twenty years brain imaging studies, along with other data, have revealed that chronic drug use causes alterations in neurochemistry, structure and metabolic function in areas of the brain that are critical for the performance of learned, goal-directed behavior and decision-making. These changes directly underlie the persistent difficulties abstinent addicts experience with craving and management of drug-related behaviors, and may also contribute to some of the other cognitive and emotional difficulties they experience in achieving and maintaining a sustained, productive and satisfying recovery.

Physiological dependence often co-occurs with addictive disease and has a powerful influence over behavior by the addict. It’s common for the drive to avoid withdrawal to serve as the primary motivation for drug seeking activities that may be dangerous, destructive, and demeaning. Yet, addressing only physiological dependence without consideration of the changes in brain structure and function associated with the development of addiction treats only a consequence of the loss of control suffered by the addict and doesn’t lead to lasting recovery.

Recognition that addictive disease is rooted in physiological and structural changes in the brain that alter function, perhaps permanently, does not negate the value of traditional “talk” therapies, social interventions or self-help. However, it does suggest that in some number of cases these approaches will have limited effectiveness. It also challenges the common assumption that the reason a given individual does not respond to these traditional approaches is rooted in his or her lack of motivation, or failure to “hit bottom.” Current research also suggests that the changes in brain structure and function which accompany drug use continue to evolve over the course of drug use, indicating that different therapeutic approaches are likely to be required at different points in the course of the disease.

Substance abuse treatment is an umbrella term for the processes of medical and/or psychotherapeutic treatment, for dependency on psychoactive substances such as alcohol, prescription drugs, and so-called street drugs such as cocaine, heroin or amphetamines, benzodiazepines, or other drugs. Generally, substance abuse treatment is an attempt by one or more people to cause the substance abuser to discontinue abusing drugs, alcohol or unhealthy behaviors.

Treatment includes a set of activities carried out by properly trained and certified professionals to intervene in and organize supports for alternative behaviors to reduce or eliminate the abusive use of psycho-active chemicals by persons. Treatment may be detoxification which is a medically supervised process by which an individual is slowly tapered off drugs where abrupt cessation could lead to seizure or death. Those substances are alcohol, benzodiazepines, or barbiturates. Medical detoxification occurs during the period immediately following the cessation of drug use when withdrawal symptoms are most intense. The duration of this period (often called the acute phase of withdrawal) for short-acting opioids like hydrocodone, oxycodone and heroin is typically 3-5 days. However, withdrawal symptoms are not limited to this acute phase; symptoms including disturbed sleep, irritability, sense of hopelessness, lack of energy, aches and pains and loose bowels may last for many weeks after cessation of use. Hospitalization stays for this detoxification process, though, are usually no longer than 5 days, leaving the individual extremely vulnerable and prone to relapse. Opiates do not require medically supervised withdrawal contrary to popular belief, nor is it appropriate to use detoxification simply to remove an individual from the community in which they are abusing substances. Detoxification is an intense medical service that is provided on a voluntary basis; a detoxification unit is not a "locked" hospital unit and patients can leave at their own will, even if it is against medical advice.

A treatment that often follows detoxification is inpatient rehabilitation which generally takes place over several weeks while the individual remains in the protected hospital environment. Inpatient rehabilitation provides the individual

with counseling, group sessions and education to assist them in stabilizing so that they can move on to, or return to outpatient treatment. These Post-detoxification, or short-term rehabilitation programs, may extend the inpatient stay to a total period of 3-4 weeks. However, most insurers do not pay for post-detoxification services the first time an individual seeks inpatient treatment, preferring less costly outpatient follow up care. Meanwhile, the power of opioid addiction is such the lower-grade withdrawal symptoms persist for extended periods after cessation of use (so-called residual or protracted withdrawal) and result in strong drug cravings for literally weeks and months.

Outpatient treatment is where an individual meets 1-5 times a week for varying lengths of time with a counselor in individual, group and family sessions. Longer residential programs are also available to adults and adolescents where they may live for months and receive an ongoing array of services and family interventions to support long-term recovery. In outpatient Medication Supported Recovery (formerly known as Medication Assisted Therapy or MAT), there are medications currently used, and others in development, which mitigate the persistent withdrawal, cravings, and relapse cycle of opioid addiction. While abstinence may be the preferred goal for many people, there is substantive evidence that chronic use of a variety of drugs, including opioids, produces significant changes in the structure and functioning of the user's brain that evolve over the course of drug use and may not be easily reversed. The type of treatment required may vary at differing stages of the disease and the recovery process and treatment effectiveness will vary from one individual to another.

The modern era of medication supported recovery (formerly known as medication assisted treatment or MAT) for opioid dependence began with the introduction of methadone replacement therapy in the early 1960's. There are presently four medications licensed for the treatment of opioid addiction: methadone, naltrexone, levo-alpha-acetylmethadol (LAAM) and buprenorphine. While still licensed, LAAM is no longer available and will not be discussed here. Each of the available medications differ on a number of levels including pharmacological, regulatory, social stigma and patient acceptance.

The provision of treatment services in Suffolk County is accomplished by a network of NYS OASAS-certified providers (a list of OASAS treatment providers can be viewed via the OASAS website) working alongside a number of other private organizations and multiple private practitioners who offer treatment services within their scope of practice. Treatment services range from inpatient hospital services to residential treatment to outpatient services and pre-treatment interventions. Certified and/or OASAS-funded organizations receive oversight from the OASAS Long Island Field Office, as well as by the Suffolk County Division of Community Mental Hygiene. Private Practitioners do not receive direct oversight from either the County or OASAS and utilization levels are not tracked. OASAS tracks a significant amount of data about service use among certified providers and produces annual reports regarding met and unmet needs by county. Treatment utilization rates within the private practice delivery system are not readily known, however, data is likely maintained by individual payer source.

Prior to entering treatment, some individuals require intervention services to help engage them in the treatment process. These services are generally provided by a variety of private practitioners and organizations that may not necessarily be involved in the provision of treatment, but instead provide ancillary services that facilitate treatment entry and support recovery.

A. Evidence-based Approaches

Evidence-based treatment is defined as using an approach that is based on a foundation of evidence or positive outcomes during and after treatment completion. With addiction treatment, there are a number of approaches that are considered evidence-based, however, not every approach is right for every person. For example, some treatment modalities are better for youth than adults, some are better for those with co-occurring disabilities such as mental illness, and should be taken into account when working with any particular group or population seeking treatment. Treatment needs to be readily available and easily accessible so that any hesitation about entering treatment on the part of the

drug-addicted individual is not complicated or confounded by an onerous process of admission. Most interventions emphasize that a person must be treated for an adequate period of time, depending on the individual's needs and associated problems. Recovery is a long-term, sometimes life-long process that cannot be expected to take place in three to five days or a "twenty-eight day program". As with any area of difficulty in our lives, time generally has the greatest influence in our overall success and health. The following government supported links:

(<http://www.nida.nih.gov/PODAT/Evidence2.html>
<http://www.drugabuse.gov/PODAT/Evidence.html>)

provide a listing of evidence-based approaches that are supported on a federal, state and local level. Treatment programs should be strongly encouraged to adopt these practices to ensure the greatest likelihood of treatment success for all those entering their doors.

c. Issues Identified and Recommendations

RECOMMENDATION 18: Explore the need for sub-acute adolescent crisis services.

It's unclear if Suffolk County needs adolescent detoxification beds but there's an apparent need for sub-acute care adolescent crisis services, particularly to address the initial 24-48 hours of initial intervention. The Panel is cognizant of the fact that a key impetus for its formation was to assess whether there are sufficient detoxification beds available for adolescents in need. Indeed, our region has lost dedicated medically managed detoxification beds in the last decade as hospitals such as St. Catherine of Siena in Smithtown and Southside Hospital in Bay Shore closed their units, however, some medically supervised beds were opened by other providers to offset the loss. None of these beds, however, were specifically designated for individuals under the age of 18 and there's little agreement as to exactly how many in this age group would benefit from, or be eligible for, this level of care. While anecdotal information suggests that the number of individuals – both adults and adolescents – seeking medically

managed detoxification services has increased in recent years, inpatient providers report often having empty beds.

The pertinent issue may be the confusion and misinformation associated with the nature and purpose of detoxification services. Treatment providers are often contacted by parents who are distraught as they witness the out-of-control behavior of their child. It's fully understandable that they seek an immediate treatment solution aimed at controlling behavior and ensuring medical safety. What's not fully understood, though, is that withdrawal from the entire range of opioid drugs is not generally life threatening and can be readily managed in less intensive (and costly) environments. Medically managed detoxification services that are provided in a hospital setting are appropriate for individuals who are physically dependent upon substances that can result in serious and potentially deadly seizures if abruptly stopped. The primary substances requiring closely monitored detoxification services are alcohol, benzodiazepines, and barbiturates.

To the frustrated and frightened parent, however, an inpatient detoxification placement sounds like an immediate, perfect answer. The substance-using youth is confined, out of the house, and finally receiving some form of "treatment." The panel does not disagree with the need for rapid intervention, but questions how many teens addicted to opioids actually require hospital-based detoxification services. The September, 2010 Service Need Profile released by New York State OASAS states that existing detoxification beds meet only 18.2% of projected community needs of Suffolk County adults. We suggest that a local needs assessment be initiated in an effort to verify whether or not true demand exists for this service and for which age range. A simultaneous discussion needs to occur related to insurance reimbursement issues related to detoxification services.

Education for the public and specifically for parents, about the limitations of detox, difference between detox and inpatient rehabilitation, and outpatient

options for supervised withdrawal might streamline the treatment entry process and decrease frustration.

Both the testimony provided and the professional experiences of several panelists support the need for a sub-acute care, non-hospital program perhaps modeled after the Talbot House crisis service operated by Catholic Charities. Talbot House features a short-stay (two weeks or less) inpatient model for adults with alcoholism who are pending transfer to an inpatient rehabilitation unit or stabilizing sufficiently to participate in outpatient care. Non-life threatening withdrawal symptoms are managed in this type of setting and an array of medical interventions, such as Suboxone induction, could be included as well. It is recommended that the possibility for funding sub-acute care crisis beds for adolescents in Suffolk County be explored with New York State OASAS.

RECOMMENDATION 19: Increase inpatient rehabilitation and residential services for adolescents.

The need for inpatient rehabilitation and intensive residential services for adolescents is more clear-cut with only a fraction of current needs being met. Families and addiction professionals report spending extended periods of time to enhance the treatment readiness of adolescents, only to watch that willingness disappear as the search for an available bed turns into days. Rehabilitation units that serve adults cannot easily incorporate youth due to various factors including age and safety concerns, nor would they necessarily be appropriately served in that milieu.

Given parents' quest for confinement and some "clean time" as detailed on the previous page, it make sense to explore creation of a temporary residence for adolescents where they could be placed for 24-48 hours, stabilized and assessed for treatment needs/readiness. This would serve as a cost-effective alternative to unnecessary emergency room visits, hospitalization and give families in crisis, some respite and peace of mind.

RECOMMENDATION 20: Improve and increase the availability of outpatient treatment services for youth and think creatively to make them more accessible to young people in need.

The Panel notes a significant difficulty in connecting adolescents with available services in their communities due to a variety of factors. OASAS data released in September suggests that only 43.6% of service demand is being met. As we recommend the creation of additional services and a public awareness campaign regarding what already exists, we also believe that such services should be created in a way that they are better integrated within the lives of adolescents. Parents at our public hearings raised issues of accessibility in terms of available hours, transportation troubles and other barriers to care. We are closely watching emergent partnerships between school districts and treatment providers and encourage creative collaboration that expands capacity and eliminates barriers to care. The integration of physical and behavioral health services in the primary care office would also increase access in a more comfortable and familiar setting.

RECOMMENDATION 21: Explore the viability of legislation for involuntary assessment and treatment and examine the current diversion process in Suffolk County.

The Panel is aware that all licensed substance abuse treatment is voluntary and OASAS-licensed units are not secure/locked. Often families are looking for a way to obtain help for a child, but are faced with the reality that the child must be agreeable to treatment and cannot be held in treatment against their will. Unfortunately, a child under the influence and grip of alcohol or drug addiction is not always aware of the problems they are having. Legislation such as the Marchman Act of Florida should be explored for viability and practical implementation in New York State.

Although PINS diversion is imperative to give youth every opportunity to be engaged in care and change behavior, data has not been fully analyzed or presented to evaluate recent outcomes of the various interventions. The Panel

strongly suggests that the Legislature convene a panel of experts and stakeholders to evaluate the effectiveness of the current PINS diversion system to determine if goals are being achieved in a meaningful way and ensure the diversion process is being utilized by schools and parents in the most effective and efficient manner to help youth in need.

RECOMMENDATION 22: Establish a comprehensive plan to expand outreach, education and supportive services for families impacted by addiction.

Though addiction is a family disease, our service delivery system – perhaps because of reimbursement rates and payment mechanisms - is largely focused on the identified patient. The recent publication and distribution of referral lists and resource guides for parents of addicted kids is an important step in the right direction. Still, families knee-deep in crisis are frequently unclear about treatment options, unsure about the level of care their child requires and experience difficulties navigating the system. Families, for example, frequently misunderstand the nature, purpose and duration of detoxification and often feel their child needs inpatient care to remove them from the negative environment in which they have become addicted, although this may not always be the best option.

Additionally, most addicted young people are resistant to treatment, leaving family members frustrated and confused. Suffolk County and OASAS should support the development of additional family-based services including psycho-educational workshops, professionally facilitated and/or organized parent support groups that address addiction as well as co-occurring disorders, family-focused counseling and therapy and planned family intervention services. OASAS regulations should be examined to ensure family interventions are supported, particularly when the adolescent has not yet engaged in treatment themselves. The Panel urges the Legislature to encourage state lawmakers to review insurance law to ensure coverage for this is a required benefit. Additionally, we recommend the creation of written educational materials to educate families about treatment options.

RECOMMENDATION 23: Support funding for ancillary services that facilitate treatment entry, ensure ongoing access to care and support recovery.

Getting adolescents into treatment can be a long road and maintaining one's recovery involves a lifetime's worth of work. Current payment mechanisms emphasize inpatient and outpatient treatment and funding for ancillary services like case management, transportation and recovery services remains scant. There is a great deal of expertise among the OASAS-certified programs in Suffolk County and a host of non-profit organizations that are capable of offering these ancillary services if given the appropriate funding. The Legislature should support and fund such services.

RECOMMENDATION 24: Push for enactment of a New York version of Pennsylvania's Act 106 of 1989 to improve access to care.

Insurance coverage denials remain a significant barrier to care for young people in need of treatment. Insurance approval is especially difficult to obtain for adolescents regardless of whether or not the benefit is in place, and requires frequent re-certification for continued treatment. Insurance companies routinely require patients to "fail" at outpatient treatment first before offering coverage for inpatient treatment, regardless of their drug of choice, duration of use or co-morbidities. When inpatient coverage is approved, initial approvals are short in duration – usually 7-10 days at best – which is contraindicated by what we know about chemical dependence treatment for youth, which generally requires longer periods of time for adolescents when compared to adults. More than one panel member recounted stories of individuals who were refused coverage for treatment by their parents' insurers, only to wind up incarcerated in the Suffolk County jail, highlighting a significant cost-shift from the private sector to Suffolk's taxpayers. Adolescents entering the juvenile justice system due to difficulties stemming from substance abuse are extremely common. It has been reported that approximately 75% of those presenting in the diversion programs in Suffolk County have a history of substance abuse or a substance use disorder.

Specific to heroin and opiate medication supported recovery (aka “MAT”) noted earlier, an intervention becoming more common, most third party payers, as well as Medicaid do not reimburse adequately. This serves as a significant barrier for many people interested in receiving this care.

The Pennsylvania Act 106 of 1989 requires most group health insurance plans to include coverage for addiction treatment. The only prerequisite for addiction treatment is certification and referral by a licensed physician or psychologist. A minimum standard of treatment authorization is required. The Consumer Guide to Pennsylvania’s Drug and Alcohol Insurance Law (Act 106 of 1989) explains the law’s provisions, which apply to most group insurance policies offered in the state of Pennsylvania, including Health Maintenance Organizations (HMO’s). The guide explains what an insurance company must pay for, details how to get help through an insurance company, and how to choose a treatment provider.

New York sorely needs this legislation and the Suffolk County Legislature should call on state lawmakers to craft and pass a bill that meets the needs of young people and their families.

RECOMMENDATION 25: Review County-funded services, foster collaboration among providers and encourage cooperation among all County departments.

Suffolk County currently funds a variety of addiction services that are provided by both county employees and contracted nonprofits. While the Division of Community Mental Hygiene conducts oversight of all services and manages nonprofit contracts, the service continuum has been developed incrementally and the time seems right to take a step back, review existing services and assess whether changes are necessary in order to fill service gaps. Moreover, as the County wrestles with a fiscal crisis that precludes significant funding increases, the time seems right to assess whether more coordination about treatment providers, particularly as it relates to service hours, cross-agency referrals and outreach efforts could increase capacity and promote efficiency. Long-funded programs should be reviewed and evaluated closely in the coming year to

determine if the priorities of the County have shifted, requiring funding priorities to change direction. When agencies close programs or cease operations, a coordinated process should occur to ensure that funds are re-allocated in a well-considered manner using established procurement procedures.

RECOMMENDATION 26: Pursue coordinated treatment and recovery methods and remove barriers to the implementation of these.

A greater integration of services specifically for the opioid using population across provider agencies is imperative to combat heroin and opioid drug dependency regulatory barriers to this should be eliminated. There are some long-standing examples of cooperation in this area: the relationship between the Suffolk County Division of Community Mental Hygiene and Phoenix House residential services where the County opiate treatment program will provide supervised withdrawal from methadone for patients being treated by Phoenix House; the willingness of Charles K. Post, the local State rehabilitation facility, as well as other local rehabilitation facilities to continue medication supported recovery (aka MAT) for individuals being treated for co-occurring chemical dependency problems. The Panel encourages greater integration of services for the opioid using population to include private physicians, particularly those prescribing buprenorphine (Suboxone). Initial efforts have been undertaken by the Suffolk County Division of Community Mental Hygiene Services to develop linkages between licensed treatment programs and private physicians, but more needs to be done in this regard.

RECOMMENDATION 27: Re-evaluate the criteria for Suffolk's Suboxone-To-Abstinence Program.

This innovative program appears to be underutilized by those under the age of 19 and the Panel recommends that Suffolk County consider alternative ways of utilizing this resource. One option is to raise the age limit to 25, but change the program's focus from comprehensive Suboxone treatment to one which is limited to medical stabilization, or induction. The greatest barrier to medication assisted care for many people involves the high cost

associated with this initial stage of the treatment process. Further, many providers lack proficiency in medical stabilization and are reluctant to take on that responsibility or perceived liability. Suffolk County, by virtue of its long history as a methadone treatment provider, is uniquely suited to serve this function and could provide this service at a reasonable fee since the expense for medication would be limited to the few days of stabilization and the staffing resources are already in place. Partner agencies could provide the initial comprehensive assessment and referral for Suboxone induction with the understanding that the individual will return to them for ongoing care.

RECOMMENDATION 28: Increase training opportunities and technical assistance for those treating opiate dependent individuals.

Some panelists and providers testifying at our public hearings highlighted the need for more extensive education and training of licensed providers of chemical dependency treatment services and nonprofit agency personnel, specifically in the screening, assessment and treatment of opioid dependent individuals. Support for this drug-specific increased training and monitoring of its progress could be led by OASAS via its regulation and oversight of licensed treatment services, contract management and professional credentialing. OASAS has taken steps along these lines and recently promulgated regulations requiring medical directors of licensed providers to be or become board-certified in addiction medicine.

Ensuring adequate and ongoing training of medical providers treating patients in private practices is likely to prove more difficult, but is nevertheless important to ensure uniform and high-quality care for opioid dependence as well as other forms of chemical dependency.

RECOMMENDATION 29: Ensure that treatment and recovery education and services are required as part of a school-behavioral health integration model, including both mental health and substance abuse services.

The need to reduce barriers to early intervention, treatment and ongoing recovery services was a clear theme throughout the Panel deliberations and is the focus of every federal and state agency. Encouraging the implementation of evidence-based models of prevention and treatment is in the forefront of each service delivery system, including integrated and co-located care, in-home services and reaching individuals in the environments they live work and educate themselves. Fully funded training should be made available to both healthcare and school professionals along with on-going technical assistance that encourages bringing evidence-based science into practice through a collaborative treatment and recovery approach. Require social and emotional curricula to be infused in all grade levels, integrating educational growth with mental health and behavioral health. With interest and cooperation from the schools, this education can be delivered by a variety of qualified non-profits with behavioral health expertise. Invite and encourage licensed providers to partner with schools to deliver services on-site. Emergency preparedness plans for drug epidemic response should be a part of every integrated model. Develop skill-based modules (ie: resistance to peer pressure) for existing health curricula. Demonstrate clearly the damage to the body and brain that is caused by drug and alcohol use. Furthermore, the new generation of communication technology has unlimited potential in terms of reaching youth and can be harnessed in addressing the Suffolk heroin epidemic and supporting a recovery-focused school community.

RECOMMENDATION 30: Offer Screening, Brief Intervention and Referral to Treatment (SBIRT) in Suffolk County health centers, thereby setting the stage for broader adoption by health professionals across Suffolk County.

According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), SBIRT is “a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma

centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.”

- Screening assesses the severity of a patient’s substance use and identifies the appropriate level of treatment.
- Brief Intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavior change.
- Referral to treatment provides links to care for those in need.

A key aspect of SBIRT is the integration and coordination of screening and treatment components into a system of services. This system links a community's specialized treatment programs with a network of early intervention and referral activities that are conducted in medical and social service settings.

It is important to note that reimbursement for SBIRT is available through commercial insurance CPT codes, Medicare G codes, and Medicaid HCPCS codes. Rates are included in the table below:

Commercial Insurance	CPT 99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	\$33.41
	CPT 99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	\$65.51
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	\$29.42
	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	\$57.69
Medicaid	H0049	Alcohol and/or drug screening	\$24.00
	H0050	Alcohol and/or drug service, brief intervention, per 15 minutes	\$48.00

It’s our understanding that clinical staff at Suffolk’s health centers currently administer the CAGE questionnaire to patients, which is to be applauded and suggests that the small modifications necessary to fully implement SBIRT may not be too unwieldy. Furthermore, the New York State Office of Mental

Health(OMH) has supported a number of demonstration projects state-wide, including one on Long Island, to implement various screening protocols in primary care offices specific to the geriatric population. This can easily be translated into working with pediatricians and is a current goal of OMH. Screening at the primary care level and connecting individuals to treatment is heavily supported, with integrated and co-located services being top priority.

RECOMMENDATION 31: Establish OASAS regulations that allow harm reduction techniques to be used with adolescents in outpatient treatment settings demonstrating this as an appropriate treatment objective.

NYS OASAS regulations require a treatment goal of abstinence for anyone entering a licensed treatment facility. This goal conflicts with best practices for engaging youth in treatment who often do not see occasional use of a substance as problematic. For example, an individual who uses heroin regularly might not see having a drink once in a while as a problem, yet complete abstinence from all substances is a required OASAS treatment goal. Providers are reviewed less favorably by OASAS if treatment does not result in complete abstinence at the time of discharge. The enforcement of abstinence as an end result of treatment frequently results in youth being "turned-off" to services and do not fully engage in care. A change in this OASAS regulation is imperative for better engagement of youth in treatment and the use of harm reduction techniques, as well as encourages existing professionals to learn evidence-based, harm reduction approaches. This change will not negate the primary objective of abstinence, but will allow providers to work with young people on an ongoing basis as they move through the complete process of recovery.

RECOMMENDATION 32: Re-evaluate OASAS regulations that penalize programs for under or over utilizing authorized slots or established capacity expectations.

The Panel is informed that providers are given specific capacity limits for inpatient and residential care. An approved number of beds are to be maintained in order to ensure access to the community, while being held to strict square

footage requirements. Data collection and survey results are often negative if a provider under-utilizes their capacity. In addition, if they over-utilize, they are penalized. This creates a difficult balance for providers that can further complicate the access-to-care process. Providers should be given some leeway in maintaining capacity goals, for example, 10-20% higher or lower than what is approved by OASAS would make access easier when community demand is high and would reduce the penalty when demand is low. This gives treatment providers the flexibility to meet community demands as they fluctuate without having the burden of going through a certification or waiver process. A precedent for this is in place for programs licensed by the New York State Office of Mental Health.

RECOMMENDATION 33: Address variations in school district policies that create differential educational opportunities for kids in treatment.

Some school districts pay for full-day classes run by programs like those at Eastern Suffolk BOCES while an adolescent is in residential treatment, while other districts pay for a tutoring service for two hours per day. This creates disparities among students and must be examined. Person-centered planning for students that have addictions, as well as students with other disabilities is imperative, allowing all to have equal access to education, social, emotional and vocational supports across a variety of settings. Proactive planning in the mainstream schools through activities like screening, prevention and treatment integration, rather than reactive at the time of a crisis, will ensure cost containment over the long run and will lead to better outcomes for young people through early identification.

RECOMMENDATION 34: Establish an immediate plan to address fatal overdoses.

The Panel recognizes that most drug overdoses are preventable through the following: (1) abstinence from drug use; (2) overdose prevention education for active drug users; (3) the provision of prompt medical care for those suffering overdose symptoms. As such, the Panel recommends that:

- Opioid overdose training efforts, including the provision of naloxone or “Narcan” be expanded to include drug and alcohol treatment providers, school personnel, law enforcement personnel, parents and drug users themselves.
- The New York State Legislature should pass “Good Samaritan” legislation, which would provide limited immunity from prosecution for low-level drug possession and alcohol offenses for those who call for medical assistance for themselves or someone else experiencing an overdose. Young people, afraid to call the police because they are impaired or have drugs in their possession, typically flee if there’s a medical emergency and without help, the patient dies. The Panel emphasizes that immunity should be limited and should not apply to drug dealers or traffickers. Additionally, immunity should only be granted when a good faith effort has been made to save a life.
- Given that many unintentional drug overdoses are attributable to changes in a user’s tolerance following a period of abstinence (forced or voluntary), we recommend that releasees from the Suffolk County Correctional Center be given printed overdose prevention materials as part of a discharge plan that also includes substance abuse treatment referrals.
- Because police officers are typically first responders to overdose scenes, even before ambulances, we recommend that all Suffolk County Police Department officers be trained in the administration of naloxone and furnished with kits that can be carried in sector cars.

The Panel reiterates its belief in the prevention, treatment and recovery continuum and we believe that keeping people alive through the reduction of fatal overdoses is a critical first step in enhancing public health.

RECOMMENDATION 35: Offer a one-time research grant to study level of care and length of stay data to examine trends in admissions, outcomes and recidivism in Suffolk County.

The Panel notes that there is a dearth of public research on recidivism rates and level of care outcomes in the new age of managed care. Insurance companies collect and use data to determine trends in beneficiary access to services, however this proprietary data is not easily accessible by public entities. Most treatment providers utilize some type of electronic records which maintain a wealth of information about treatment admissions, discharges and care denials. Few providers, however, employ statisticians that can objectively plan such a research project, analyze the data, control for variables and assess what is really happening in relation to treatment outcomes with shortened lengths of stay and denials of care. The study should include information gathering around admission requests and trends to provide information to demonstrate the need or lack of need for additional detoxification beds. A one-time grant project to collect and analyze appropriate data would provide Suffolk County with an objective analysis that could be shared statewide. Results could influence the regulation and delivery of care for decades to come. A standard procurement process should be pursued with a panel of research and treatment experts convened to review proposal submissions on behalf of the County.

IV. Relapse Prevention and Recovery Support

A. Understanding Recovery and Current Efforts

According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), recovery from alcohol and drug problems is defined as “a process of change through which an individual achieves abstinence and improved health, wellness and quality of life.” For too many young people in Suffolk, recovery from addiction remains elusive. National studies suggest that 60-80% of adolescents use drugs again within six months after finishing treatment, and almost 50% are using at prior rates or more within a year. The median time to drug relapse is 54 days or less than two months. It is, however,

important to understand that relapses during treatment often occur and are not unexpected. When an individual knows their drug use is being monitored they are less likely to use because of the potential consequence of being discovered, however, this, itself, does not prevent relapse. Monitoring use through urine screening can provide an early indication of a relapse, which could signal a possible need to adjust an individual's treatment plan to better meet his or her needs. Recovery and relapse prevention are not as simple as being drug-free or abstinent from use. The process of recovery is a life-long journey.

Some changes have emerged in the field of addiction recovery based on the latest scientific research and medical advances. There is a movement away from traditional hospital-based models of care and confrontational approaches to more recovery-oriented standards of care, however, the need for inpatient treatment is not negated by these trends for all people. The approach rests on the need to offer a person-centered intervention which develops recovery supports that embrace an individualized recovery process, in the individual's everyday environment. Certain types of evidence-based approaches to treatment, like motivational interviewing, harm-reduction and contingency management support the engagement of the individual, no matter where he or she is in the recovery process, and no matter how ready he or she is for a lifetime of abstinence.

B. Evidence-based Approaches

Although it is difficult to find evidence-based approaches specific to recovery separate from the actual treatment itself, there are emerging philosophies about how recovery can best be sustained over time. "Recovery management" is one of these approaches geared toward treating addiction in the same way other chronic or progressive illnesses are managed. Recovery management, like the disease management approach, is usually longer-term and is based in the individual's natural environment. It is nearly impossible to remove someone from the environment in which they live and work, thus, recovery needs to be built around this assumption. The belief is that this approach will improve results and to sustain recovery.

To further the recovery-focused mindset, a national focus on recovery oriented services includes treatment providers, schools and communities, and how each of these stakeholder groups interface with the individual and contribute to the recovery process. A Recovery Month website, sponsored by the federal government, provides nearly everything needed for each stakeholder to encourage a recovery approach in their locale. A number of organizations on Long Island have adopted a recovery-oriented approach, however, the Long Island community in general is not all in sync with recovery-minded beliefs. Perhaps this is due to deeply embedded and engrained traditional models of service delivery.

C. Issues Identified and Recommendations

RECOMMENDATION 36: Implement short-term residential programs to provide structure and support for early recovery.

The current opiate crisis has highlighted a number of gaps in the treatment/recovery continuum, including a lack of supportive transitional housing options for young people attempting to remain clean and sober. Very often young people, who because of their addiction have been ejected from the family household, may be lucky enough to complete an inpatient treatment program and after discharge wind up in unhealthy or unsafe living conditions that aren't supportive of their recovery. Suffolk County needs to explore the development of supportive sober living environments that can ease the transition back into an alcohol and drug-free life. A wide range of services including case management, onsite 12-step meetings and job placement help could be available for a 30-90 day period.

RECOMMENDATION 37: Support the recommendations contained within the May 2010 report issued by Suffolk's Welfare-to-Work program

Specifically, the Panel joins the Commission in: (1) urging the New York State Office of Alcoholism and Substance Abuse Services (NYS OASAS) to immediately assume regulatory responsibility for sober homes; (2) urging OASAS

and the Suffolk County Department of Social Services to enhance rental reimbursement rates for approved sober home operators; (3) urging the County, towns and municipalities to use all available legal remedies to crack down on operators who run unsafe sober homes, including withholding of rental payments and aggressive code enforcement.

RECOMMENDATION 38: Create relapse prevention and recovery support groups to protect our investment in treatment and reduce the likelihood of relapse.

Self-help groups are a key component of recovery for tens of thousands of Long Islanders, including a sizable population of young people. Hundreds of 12-step meetings exist across Suffolk County, however, few are geared toward adolescents. There are also a number of support groups for those with a variety of illnesses funded by a variety of sources, including Suffolk County, for example, mental illness, cancer, diabetes, etc, but few, if any, professionally facilitated relapse prevention support groups exist. Given their relatively low cost of operation and demonstrated benefits, we urge the development of additional recovery support groups, especially on the East End.

RECOMMENDATION 39: Ensure access to a greater number of sober options for socialization. Alcohol and drug-free sober dances and other community activities should be the norm, rather than an occasional novelty.

The panel believes that we need to take a more proactive approach to keeping young people occupied with positive activities. Building these protective factors is imperative to supporting a young person's positive decision making around not getting involved with substance use and gambling. Funding cuts to youth services at the Town and County levels as well as a reduction in private support has left kids with fewer activities that keep them engaged and safe. Organized sports, clubs, and community events provide meaningful alternatives to drinking and using drugs with friends. The Panel would like to see an expansion of sober options for socialization and simultaneously believes that we

must increase the market for such activities by having them be peer-designed and peer-led.

Finally, the Panel sees a clear need for Youth Bureaus in each town and encourages the Legislature to ensure schools work more closely with those Bureaus, as well as supports and encourages other positive youth programs such as after school programs and clubs, vocational endeavors, scouting programs and community service involvement.

RECOMMENDATION 40: Integrate recovery policies, protocols and services into school settings.

Young people spend a good percentage of their time in school, highlighting the importance of school districts incorporating a recovery focus into activities and policies. Schools should foster the development of self-help groups (AA, NA, Alanon) within their buildings, by donating space and making referrals. Social workers and counseling staff should work closely with students' families on a post-treatment re-entry plan. School personnel should develop closer relationships with local organizations that offer information and referrals, as well as treatment providers in order to facilitate timely and effective referrals to care, discharge planning and recovery management. This applies to both substance abuse and mental health providers, ensuring the needs of those students with co-occurring mental health concerns are met. Providers can support the school personnel once a student is identified as needing help, but relationships must be fostered and put into place for recovery to be fully supported. Schools can and should access the supports available in the community to help them meet the demands they face to better ensure a student's academic, social and emotional growth.

RECOMMENDATION 41: Encourage the development of Recovery Community Centers – gathering places and peer-led service centers for young people seeking or in recovery, and their family members.

While other regions of New York – including the Bronx, Brooklyn, Rochester and Oneonta - have recovery drop-in centers, none currently exist on Long Island. These centers serve as recovery hubs providing important support to young people, including 12-step meetings, social events, health and wellness activities, vocational and educational services and family support services. Our region sorely needs Recovery Community Centers.

RECOMMENDATION 42: Suffolk County should investigate the feasibility and if warranted, promote the development of a recovery school.

Many other states and major cities across the US have “recovery schools” – where students receive academic services, recovery support and continuing care and where being sober is the norm. Recovery Schools provide an environment that supports student’s new-found sobriety while simultaneously giving them the academic services necessary to succeed in the workplace. Recovery Schools are prepared through policies and protocols to address the needs of students in crisis, either through in-house staff or contracted services.

About recovery schools, Monique Bourgeois, Executive Director of the Association of Recovery Schools, says: *“Think about this: would an adult’s continuing care plan for recovery include returning to his or her favorite bar five days a week for six hours a day? If so, what are the chances that this adult would remain abstinent? In essence, this is what is being asked of students in recovery when they return to their previous academic settings. For some students, their previous academic settings are their bars.”*

Ensuring that a recovery school is accessed by only those that clearly need it though defined criteria should be established to ensure a person-centered approach is incorporated before a student is sent “out-of-district” unnecessarily. The Panel recognizes that balancing the need for these services with the imperative to, whenever possible, keep students within the milieu of their home district setting, should not be overlooked.

RECOMMENDATION 43: Integrate vocational rehabilitation services to a greater degree into treatment and mainstream school settings as part of the recovery process.

Those admitted to addiction treatment have high unemployment rates and a high need for vocational counseling. However vocational counseling, vocational and life skills training, and job-seeking skills training are limited in most treatment programs due to funding limitations. Too often we encounter young people whose recovery journey is detoured by their inability to find work, particularly in this economy. Those who start using alcohol and drugs at a young age – typically 14-16 – miss key educational opportunities and intellectual milestones, placing them at a significant disadvantage that can last a lifetime. Employment gives young people, as well as adults, daily structure, a sense of responsibility, fosters pride and enhances financial security. We need to give Suffolk’s young people the tools necessary to stay sober and become successful in all areas of their lives. Vocational and life-skills services incorporated into the mainstream high school and local community are imperative to a young person’s successful transition to adulthood, particularly if the student is in recovery. Person-centered planning is imperative for students with a history of addiction and treatment, and schools should ensure those with addictions get equal consideration during the CSE process or when making other educational accommodations. Students should not simply be sent out-of-district to an alternative program without regard to person-centered planning.

Furthermore, OASAS certified providers are currently required to report on certain vocational statistics and pursuits for those treated within an agency. These current reporting requirements do not adequately allow for, or encourage individuals in treatment, youth or adults, to be fully engaged in the vocational rehabilitation process. The Panel suggests that OASAS convene a panel of experts to review their current requirements related to vocational progress reporting to determine if other mechanisms might be more effective in achieving an end goal of employment.

RECOMMENDATION 44: Educate families about the recovery process from addiction and co-occurring mental illness.

Families need more information, psycho-social education and support about the recovery process and strategies for supporting a loved one in recovery. The siblings of addicted young people warrant particular attention. Just as families need more support and information when trying to access treatment for a loved one, they need more guidance about how best to support a family member in recovery. Families mired in a loved one's addiction frequently need to re-learn healthy coping behaviors and understand how best to relate to a loved one newly in recovery. Beyond the emotional components, families often have practical questions about whether or not to have alcohol in the home, how to address the re-appearance of friends and peers who may not be a healthy influence, and how to voice concerns about suspected relapse.

We also want to highlight the needs of siblings who have been impacted by a sibling's addiction. These children often become "forgotten" as the family remains laser-focused on the addicted child. They in turn, may slide into substance abuse as a coping mechanism for family stress or as a way of gaining equal attention. Educational materials and professionally facilitated support groups for family members should be considered for Suffolk County.

RECOMMENDATION 45: Urge the NYS Division of Human Rights to spearhead a renewed statewide effort to combat discrimination against people in recovery, educating both employees and employers about local, state and federal human rights laws.

Social stigma remains a key obstacle for individuals and families touched by addiction. Shame and embarrassment is a barrier to treatment, hampers prevention efforts and impedes recovery. Charged with combating discrimination and addressing bias, the NYS Division of Human Rights should work with the NYS OASAS to create and distribute multi-media educational materials addressing bias and discrimination against those with addiction. These statewide

efforts should be supported locally by the Suffolk County Human Rights Commission.

V. Other issues & Recommendations

RECOMMENDATION 46: Prevent HIV/AIDS, Hepatitis C and other infectious diseases among adolescent substance users.

We know that Long Island leads the nation in suburban HIV/AIDS cases and that the incidence of Hepatitis C has risen in recent years. While most young people using heroin start-out by snorting the drug, some look for a more efficient high and move on to injecting, which multiplies one's risk for a wide variety of health consequences, including HIV, Hepatitis C and other infectious diseases. As attention to HIV/AIDS has waned in recent years, it's easy to imagine an emergent wave of new cases directly related to adolescent drug use, both via unsafe injections and unsafe sex while impaired. Most printed HIV prevention materials are geared towards older, urban, chronic drug injectors. The Panel urges that a search for more relevant materials be conducted and obtained by the Suffolk County Department of Health for distribution. If the Suffolk DOH determines that no suitable materials exist, the creation of disease prevention and health promotion materials and messages that will reach young substance users should be pursued.

RECOMMENDATION 47: Require consumer participation on local planning bodies, committees and require County-funded nonprofits to detail how consumers - including adolescents - participate in program design and agency governance.

People in recovery and families impacted by addiction are an untapped resource for program development, outreach strategies and outcome evaluation. There should be designated slots on all local planning bodies for consumers and meetings should be held at a time and place conducive to their participation. Funded non-profit organizations should be queried as part of their regular

program reporting about their mechanisms for consumer input into program design/operations and overall agency governance.

RECOMMENDATION 48: All recipients of County funds should be required to educate their employees, volunteers and clients/participants about tobacco use, alcoholism, drug addiction, problem gambling and available community resources.

Receiving funds from Suffolk County already comes with several requirements. As we acknowledge substance abuse as our region's most serious public health threat, the County has a significant interest in ensuring that local residents know the signs/symptoms of addiction and where to get timely help.

VI. Summary & Conclusions

The Panel recognizes that many of our recommendations are beyond the purview of the Suffolk County Legislature. Still, the Legislature has been quite vocal in the past about urging the federal and state government to take action on a wide variety of issues. Moreover, we know that neither the Legislature nor the County Executive will be the sole readers of this document and we make these recommendations as a wide-ranging call to action.

It became more and more clear with each meeting that a community approach was at the forefront of what needed to be the target for Suffolk County. The task of aligning all stakeholders may seem daunting, but can be achieved with a coordinated effort over time. We cannot lose sight of the motivation we have in our communities or the strength we have as Suffolk County residents to make change happen. Complex change requires that multiple steps be taken and achieved in order to support progress. Stagnation and frustration can easily occur if even one piece of the puzzle is left without being addressed. These recommendations are goals which must be our focus, however, the Legislature must take into account that objectives cannot be met or achieved without planning and collaboration with all stakeholders. Please note that many prevention, treatment and recovery oriented recommendations have been made

by the federal and state governments and should be considered as a part of this report, although they are not referenced directly as a part of the Panel's local findings.

This Panel remains lawfully constituted through the first half of 2011 and will use the balance of our time together to make additional recommendations, support implementation of these recommendations and serve as a resource for County lawmakers.

Finally, we know that attention to our region's heroin crisis has already begun to wane and opportunities for change can be fleeting. Let's ensure that in the midst of so much devastation, we take the actions and make the changes necessary to be better prepared for the next drug that threatens the lives of our kids and families.