Mental Hygiene Goals and Objectives Form

Allegany County Mental Health Services (70620)

Certified: Robert Anderson (10/8/20)

Mental Hygiene Law, § 41.16 "Local planning; state and local responsibilities" states that "each local governmental unit shall: establish long range goals and objectives consistent with statewide goals and objectives." The Goals and Objectives Form allows LGUs to state their long-term goals and shorter-term objectives based on the local needs identified through the planning process and with respect to the State goals and objectives of each Mental Hygiene agency.

The information input in the 2020 Goals and Objectives Form is brought forward into the 2021 Form. LGUs can use the 2020 information as starting point for the 2021 Plan but should ensure that each section contains relevant, up-to-date responses.

Please indicate below if the overall needs of each disability population got better or worse or stayed about the same over the past year. Completion of these questions is required for submission of the form.

New To assist LGUs in the assessment of local substance use disorder (SUD) needs, OASAS Planning has developed a county-level, core-dataset of SUD public health data indicators. These reports are based on the recommendations of the Council of State and Territorial Epidemiologists and the regularly updated county-level datasets available in New York State. Each indicator compares county-level population-based rates to statewide rates. Reports for all counties are available in the County Planning System Under **Resources -> OASAS Data Resources -> Substance Use Disorder Key Indicators**

1. Overall Needs Assessment by Population (Required)

Please explain why or how the overall needs have changed and the results from those changes.

The question below asks for an overall assessment of unmet needs; however certain individual unmet needs may diverge from overall needs. Please use the text boxes below to describe which (if any) specific needs have improved, worsened, or stayed the same.

a) Indicate how the level of unmet **mental health service needs**, overall, has changed over the past year: ○ Improved ◉ Stayed the Same ○ Worsened

Please describe any unmet **mental health** service needs that have **improved**:

Clarity Wellness Community (Clarity), Allegany Arc (ARC) and Allegany Council on Alcohol and Substance Abuse (ACASA) work diligently to meet the needs of individuals. They work independently as well as collaboratively to maximize the use of scarce resources with in the county. They all address the level of unmet needs on a daily basis as well as a looking toward the furture. Clarity and ACASA offer walk-in appointments and make the 24-hour crisis hotline number available to the clients.

Please describe any unmet **mental health** service needs that have **stayed the same**:

Limited access to Child Psychiatry services remains an issue in the county, often forcing families to travel outside of the county for these services.

Please describe any unmet **mental health** service needs that have **worsened**:

As the COVID-19 pandemic continues, Clarity has recognized evolving needs from clients and the community in this rapidly changing time. Prolonged stress levels and changing social determinates of health have caused an increase in mental health and substance use symptoms.

b) Indicate how the level of unmet **substance use disorder (SUD) needs**, overall, has changed over the past year: ◉ Improved ○ Stayed the Same ○ Worsened

Please describe any unmet **SUD** service needs that have **improved**:

The Alcohol and Drug Subcommittee of the Allegany County Community Service Board serves as the local planning group. In 2017-18, the Allegany County Legislature [Legislator Judith Hopkins] created an Ad Hoc Committee on Heroin and Opioid use and prevention within the County. In late 2018, the Ad Hoc Committee combined with the CSB Substance Use Subcommittee providing even more community involvement. The Ad Hoc Committee developed the attached Strategic Sharpening Plan 2018-2019.

The Legislature voted to invest local funding for mini-grants awarded by the CSB as determined by the Subcommittee. These mini-grants provide seed money to local programs who address goals and objectives of the Strategic Sharpening Plan 2018-2019.

The current service matrix for Allegany County includes an OASAS licensed Outpatient clinic; Community Residential; Supportive Living; Vocational Rehabilitation; and Prevention Education programs. The Community is also fortunate to have private practitioners to provide outpatient treatment.

During the last year, local services improved with the addition of MAT and Peer Advocates. The local clinic provides these two programs. These two new services help to enhance the local service matrix and close some of the service gaps the County experienced in the past.

Please describe any unmet **SUD** service needs that have **stayed the same**:

Inpatient Rehabilitation beds. Allegany County does not currently have Inpatient Rehab beds within the County. This is a service the CSB and the County Legislature have identified as a local need. It is also supported by the Allegany County Heroin and Opiate Stratigic Plan (copy uploaded).

Please describe any unmet **SUD** service needs that have **worsened**:

The impact of Covid-19 on our clients on other members of our county has been an increase in substance use. The sale of alcohol has gone up and the number of Overdose for the first half of 2020 has gone up. We used EMS data, and it showed we had 20 Overdoses and 1 death for the first half of 2020. Covid-19 also hindered our ability to properly serve our clients during the shutdown. We were able to continue with telemed and telephonically for one on one sessions but we were not able to run groups.

c) Indicate how the level of unmet needs of the **developmentally disabled** population, overall, has changed in the past year:
○ Improved ◉ Stayed the Same ○ Worsened

Please describe any unmet **developmentally disability** service needs that have **improved**:

Allegany Arc works diligently to meet the needs of people with Developmental Disabilities every day in the midst of strict regulations and funding cuts. Allegany Arc has several goals to help ensure we are meeting the needs of people with Developmental Disabilities.

One is to increase the number of people directing their own services to 45. By continuing outreach and education, providing training on person-centered thinking and Personal Outcome Measures, educating staff, people receiving support, and families on informed decision-making and working with staff and families about dignity of risk and respecting each person's autonomy and self-determination. This is an ongoing process that Allegany Arc continues to focus on.

Allegany Arc is working on reducing the frequency of physical interventions. Our objectives are to establish agency-wide procedures for reporting and reviewing all incidents involving physical intervention and evaluating models such as the Six Core Strategies and Ukeru for feasibility, cost, and implementation. Allegany Arc continues to look into various programs and will examine what works best for our agency and the people we support.

Allegany Arc is increasing the percentage of people with I/DD supported by our agency who are engaged in integrated, competitive employment. We continue to increase job development activities and are increasing person-center-planning activities for people we support. Allegany Arc is heavily focused on this ongoing process.

Please describe any unmet **developmentally disability** service needs that have **stayed the same**:

Please describe any unmet **developmentally disability** service needs that have **worsened**:

The second section of the form includes; goals based on local need; goals based on state initiatives and goals based in other areas. The form allows counties to identify forward looking, change-oriented goals that respond to and are based on local needs and are consistent with the goals of the state mental hygiene agencies. County needs and goals also inform the statewide comprehensive planning efforts of the three state agencies and help to shape policy, programming, and funding decisions. For county needs assessments, goals and objectives to be most effective, they need to be clear, focused and achievable. The following instructions promote a convention for developing and writing effective goal statements and actionable objectives based on needs, state or regional initiatives or other relevant areas.

2. Goals Based On Local Needs

Please select any of the categories below for which there is a **high level of unmet need** for LGU and the individuals it serves. (Some needs listed are specific to one or two agencies; and therefore only those agencies can be chosen). When considering the level of need, compare each issue category against all others rather than looking at each issue category in isolation.

- **For each need identified you will have the opportunity to outline related goals and objectives, or to discuss the need more generally if there are no related goals or objectives.**
- **You will be limited to one goal for each need category but will have the option for multiple objectives.** For those categories that apply to multiple disability areas/state agencies, please indicate, in the objective description, each service population/agency for which this unmet need applies. (At least one need category must be selected).

Issue Category		Applicable State Agenc(ies)		
		OASAS	OMH	OPWDD
a)	Housing	☐	☐	☐
b)	Transportation	☐	☑	☑
c)	Crisis Services	☐	☑	☑
d)	Workforce Recruitment and Retention (service system)	☐	☐	☑
e)	Employment/ Job Opportunities (clients)	☐	☐	☐
f)	Prevention	☐	☐	☐
g)	Inpatient Treatment Services	☑	☐	☐
h)	Recovery and Support Services	☑	☐	☐
i)	Reducing Stigma	☐	☐	☐
j)	SUD Outpatient Services	☐	☑	☐
k)	SUD Residential Treatment Services	☐	☐	☐
l)	Heroin and Opioid Programs and Services	☑	☐	☐
m)	Coordination/Integration with Other Systems for SUD clients	☐	☐	☐
n)	Mental Health Clinic	☐	☐	☐
o)	Other Mental Health Outpatient Services (non-clinic)	☐	☐	☐
p)	Mental Health Care Coordination	☐	☐	☐
q)	Developmental Disability Clinical Services			☐
r)	Developmental Disability Children Services			☐
s)	Developmental Disability Student/Transition Services			☐
t)	Developmental Disability Respite Services			☐
u)	Developmental Disability Family Supports			☐
v)	Developmental Disability Self-Directed Services			☐
w)	Autism Services			☐
x)	Developmental Disability Front Door			☐
y)	Developmental Disability Care Coordination			☐
z)	Other Need 1(Specify in Background Information)	☐	☐	☐
aa)	Other Need 2 (Specify in Background Information)	☐	☐	☐
ab)	Problem Gambling	☐	☐	☐
ac)	Adverse Childhood Experiences (ACEs)	☐	☐	☐

(After a need issue category is selected, related follow-up questions will display below the table)

2b. Transportation - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

Allegany County is a rural county having 1034 square miles and 46,091 people. As a consequence, public transportation is limited. Public transportation is available; however, individuals often have long waiting times at stops when traveling. Bus stops are limited and it requires careful planning to ensure that one is going to make appointment times. There is an additional charge to get dropped off outside the established route that most individuals cannot afford. Public transportation hours are very limited and no services other than weekdays. This limits when individuals are able to attend appointments,

activities, and/or even meet basic needs such as shopping. Medicaid tranportation is not always reliable and does not address needs outside of medical and behavioral health.

Do you have a Goal related to addressing this need? (•) Yes ( ) No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)? (•) Yes ( ) No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Clarity Wellness Community was able to establish a robust network of telemental health services during the COVID-19 pandemic, which improved access to behavioral health services for some clients with previous transportation barriers. Clarity Wellness Community intends to continue to invest in its telemental health infrastructure so clients will still have this choice of service delivery once the pandemic subsides. Clarity will work to ensure that telemental health services are an option at main and sattelite locations. Although this does not address transportation barriers in the county as a whole, it is expected that it will help alleviate some of the burden.

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: Clarity will ensure current staffing plan includes licensed or permitted staff eligible to provide telemental health services beyond the pandemic emergency period.

Applicable State Agency: (check all that apply): ☐ OASAS ☑ OMH ☐ OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

2c. Crisis Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

Clarity operates a twenty-four hour crisis hotline [central triage] as well as providing emergency and walk-in appointments. When St. James closed its adolescent and adult behavioral health inpatient units, Reinvestment Money was provided to the counties in the catchment area. Allegany County through Clarity established Home Based Crisis Intervention [HBCI] and Intensive Intervention Services [ITS] in order to reduce hospitalizations and make appropriate treatment available on an outpatient basis. ARA received additional money from Finger Lakes PPS DSRIP to develop a mobile crisis team available during operating hours. This project did not result in a financially viable resource.

Do you have a Goal related to addressing this need? ( ) Yes (•) No

If "No", Please discuss any challenges that have precluded the development of a goal (e.g. external barriers):

The intended purpose of the Mobile Crisis Team was to provide immediate service to address the needs of individuals in crisis or at imminent risk of psychiatric crisis. In addition, to connect individuals to community based services and work to prevent similar events in the future. ARA developed and implemented such a mobile crisis team; however, due to lack of staffing* they were unable to continue with the service. In addition, during the period of time the Team was operating, utilization was low and did not support financial viability.

*please note previously reported difficulties in recruiting appropriate staff and steps taken to address the need.

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

Clarity developed and implemented a mobile crisis team however due to lack of staffing they were not able to continue to provide mobile crisis. In the short time they did offer mobile crisis utilization was low and data did not support fiscal viability. Previous data also supported the inability to fiscally support a mobile crisis team due to low utilization.

2d. Workforce Recruitment and Retention (service system) - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

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All behavioral health providers within the county struggle to attract and retain qualified staff whether it is licencensed professionals or direct care workers. They are often in competion with each other for hiring due to small workforce pool. With minimum wage increasing, it is even more difficult to hire employees.

Do you have a Goal related to addressing this need? (•) Yes ( ) No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)? ( ) Yes (•) No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Agencies have worked with their Boards and Human Resources Departments to develop plans regarding recruitment and maintenance of staff. Clarity revamped their salary schedule in order to attract more experienced workers. As this was only recently accomplished, results are not available for analysis.

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

Allegany Arc's Administration team is working with Human Resources closely to find better ways of attracting and retaining qualified staff for our programs including continual review of salaries and benefits.

Clarity Wellness has implemented the new salary scale which provides opportunity for growth for staff, for both compensation and continuing education. A new 3 month orientation process was developed to enhance training and to provide more support to new employees.

2g. Inpatient Treatment Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

OMH has instructed Article 31 clinics to begin evaluating and revamping infrastructure related to meeting the needs of clients with co-occuring mental health conditons and substance use disorders. Clarity has been involved with an initiative to implement best practices related to Opiate Use Disorders and Medication Assisted Treatment (MAT). Clarity has worked over the past year to obtain waivered prescribers for buprenorphine and has begun prescribing Naltrexone Extended Release Injections. Clarity has trained all staff on how to recoginze the signs of an overdose and how to administer Narcan.

Do you have a Goal related to addressing this need? (•) Yes ( ) No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)? (•) Yes ( ) No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Clarity will begin offering integrated substance use disorder treatment, including buprenorphine as a medication option to clients who have a co-occuring mental health condition and opiate use disorder.

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: Clarity will being providing induction and maintenance services for buprenorphine within the next 6 months.

Applicable State Agency: (check all that apply): [ ] OASAS [x] OMH [ ] OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

2h. Recovery and Support Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

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The Allegany County Heroin and Opioid report Developed by the Legislative Ad Hoc Committee was used to identify this goal. This group has put together the attached action plan to provide direction to obtain this goal. The attached "Strategic Sharpening Plan 2018-2019".identifies many SUD goals and objectives.

Based on the County plan we have added 1.5 FTE of Peer Advocate to our local provider. The Peer Advocates are in the process of completing their CERPA training.

Do you have a Goal related to addressing this need? (•) Yes ( ) No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)? (•) Yes ( ) No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Continue to expand different types of Recovery Support Services in Allegany County.

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: Complete the CERPA training for each peer advocate.

Applicable State Agency: (check all that apply): ☑ OASAS ☐ OMH ☐ OPWDD

Objective 2:

Applicable State Agency: (check all that apply): ☐ OASAS ☐ OMH ☐ OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

Due to a loss in funding we have had to reduce our Peer staff down to 1fte. We will continue to build on the one fte and look for other opportuinities for funding. The current rate of reimbustment is not high enoungh for the program to fully sustainable with out other funding.

2j. SUD Outpatient Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

Do you have a Goal related to addressing this need? ○ Yes ○ No

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

2l. Heroin and Opioid Programs and Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

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The Alcohol and Drug Subcommittee of the Allegany County Community Service Board serves as the local planning group. In 2017-18, the Allegany County Legislature [Legislator Judith Hopkins] created an Ad Hoc Committee on Heroin and Opioid use and prevention within the County. In late 2018, the Ad Hoc Committee combined with the CSB Substance Use Subcommittee providing even more community involvement. The Ad Hoc Committee developed the attached Strategic Sharpening Plan 2018-2019.

The Legislature voted to invest local funding for mini-grants awarded by the CSB as determined by the Subcommittee. These mini-grants provide seed money to local programs who address goals and objectives of the Strategic Sharpening Plan 2020-2021.
The current service matrix for Allegany County includes an OASAS licensed Outpatient clinic; Community Residential; Supportive Living; Vocational Rehabilitation; and Prevention Education programs. The Community is also fortunate to have private practitioners to provide outpatient treatment.

In 2018 the local 822 clinic added MAT services. Services were increased by twelve hours per week in 2020.

Do you have a Goal related to addressing this need? (•) Yes ( ) No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)? (•) Yes ( ) No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Increase local access to MAT services in the OASAS certified program. This will be accomplished by increasing the capacity of the MAT service and educating Behavioral Providers and consumers regarding the benefits of MAT.

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

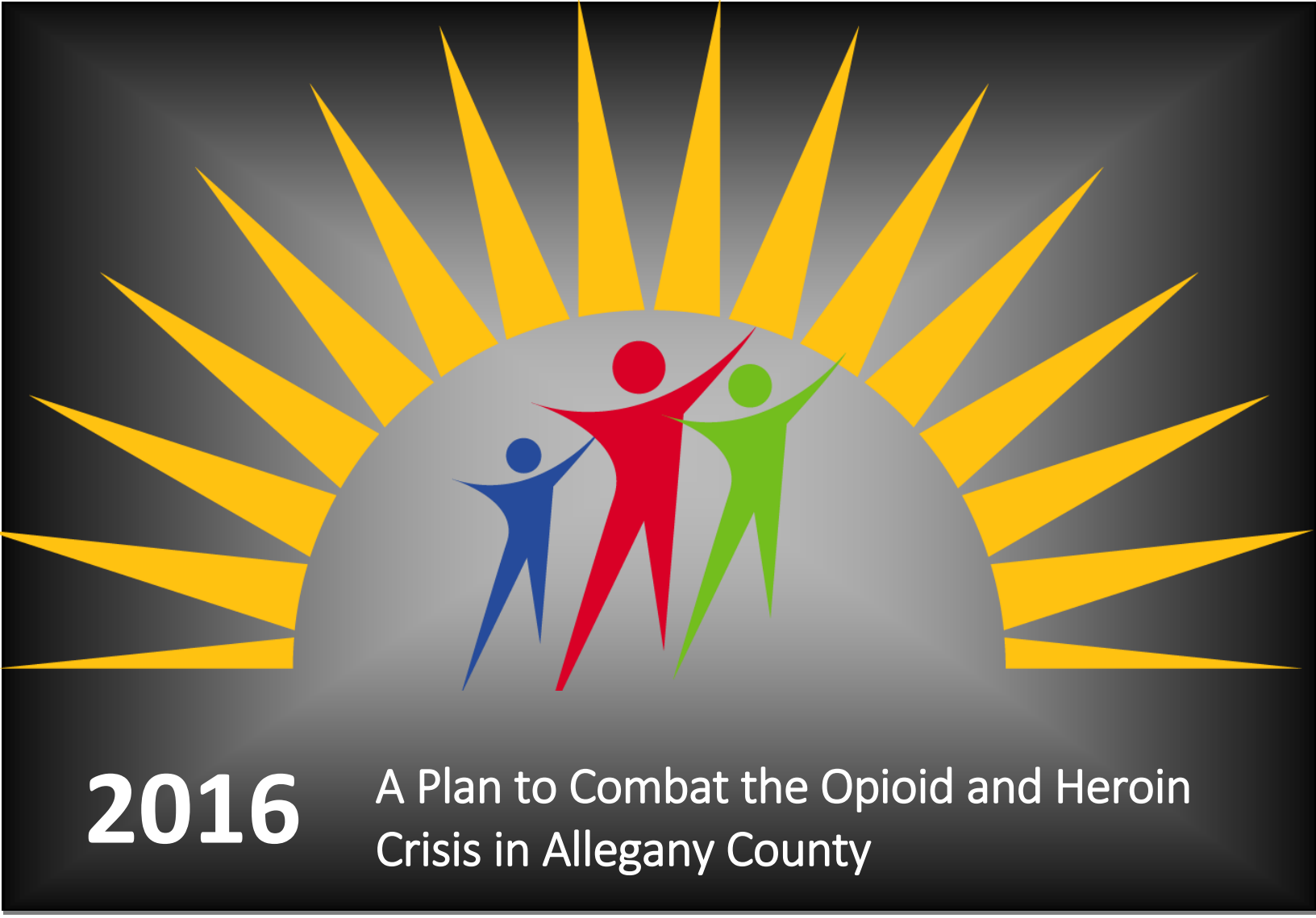
Objective 1: Hire a Physician to provide MAT in our clinic.

Applicable State Agency: (check all that apply): [x] OASAS [ ] OMH [ ] OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

The MAT program continues to grow in the clinic. We have added 12 more hours of physician time in the clinic over the last year. This is a very beneficial service for residents of Allegany County.



2016 A Plan to Combat the Opioid and Heroin Crisis in Allegany County

The purpose of this report is to outline a strategic planning process that will identifying community priorities and provide a strong foundation to build a framework to address heroin and opioid addiction.

It is our intention to align Allegany County with potential state and federal funding opportunities while investigating evidence-based and/or best-practice prevention, intervention and treatment programs and services to best meet the needs of our community.

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TABLE OF CONTENTS

Heroin and Opioid: A Rural Health Crisis

1 EXECUTIVE SUMMARY

Allegany County, like many of the rural, suburban and urban communities in New York State; has witnessed a shift in the current addiction environment where once thought an inner-city phenomenon, heroin is reaching an epidemic proportion on the national, state and local level. As a result, the Allegany County Board of Legislators has enacted the Allegany County Heroin and Opioid Committee to learn more about this public health crisis. The end result will be a strategic plan to combat the issue at the public policy level.

Following Governor Cuomo's launch of the New York State Heroin Task Force and its 2016 Heroin and Opioid Task Force Report entitled **Combatting the Heroin and Opioid Crisis**, Allegany County enlisted the assistance of Ardent Solutions to create its own strategic plan for combatting the heroin and opioid crisis facing many Allegany County residents and families.

This document will outline the current landscape and recommendations for prevention, treatment, recovery and enforcement at the local level as it relates to the state-wide action plan. It entails the collaborative work of a cross-section of key stakeholders, individuals in recovery, and family caregivers who have been torn apart by the heroin and opioid crisis due to overdose or those who have experienced serious health and social problems as a result of their addiction.

The work is committed to the development of a comprehensive plan that includes immediate, actionable steps to tackle the crisis from various angles. Findings from ad-hoc work groups, public policy research, key informant interviews, community surveys and focus groups have been analyzed and contribute to these conclusions.

Special thanks is extended to those who leant their support, time and resources during this process:

Allegany Council on Alcoholism and Substance Abuse, Inc.
Allegany County Board of Legislators
Allegany County Department of Health
Allegany County Department of Social Services
Allegany County Attorney's Office
Allegany County Probation Department
Allegany Rehabilitation Associates, Inc.
Wellsville Police Department
Members of Yorks Corners Mennonite Church Celebrate Recovery Group
Concerned citizens who are impacted by heroin and opioid addiction

On behalf of Ardent Solutions, Inc., thank you for the opportunity to contribute to this vital public health issue, and for providing us the opportunity to support Allegany County residents.

2 METHODOLOGY

Research methodology is the process used to gather and analyze data needed to answer the research questions guiding in this study. In examining the impact of the heroin and opioid epidemic on Allegany County, New York, Ardent Solutions, Inc., imposed the following strategies to determine the depth of the problem (Problem Statement), current approaches available to address the issue, and future opportunities to tackle the epidemic.

2.1 Key Questions

Both quantitative and qualitative data was gathered and analyzed to better understand key questions:

1. How prevalent is heroin and opioid use/abuse in Allegany County?

2. What is the current landscape for heroin and opioid prevention, treatment, recovery and enforcement?

3. What are the strengths, weaknesses, opportunities and threats for heroin and opioid prevention, treatment, recovery and enforcement?

4. What evidence-based strategies or best-practices are currently being implemented or could be implemented to address prevention, treatment, recovery and enforcement?

5. How can Allegany County strengthen its infrastructure to better combat the heroin and opioid epidemic?

2.2 Literature Review

Ardent Solutions, Inc. reviewed scientific literature findings, evaluated relevant material and synthesized the information from various sources. Over fifty (50) articles, journals, and websites were read to help inform this study. Public policy information was gathered and summarized to provide guidance for local advocacy strategies, while acknowledging state and federal policy that may dictate efforts.

2.3 Data

Quantitative Data: The purpose of quantitative research is to quantify data and generalize result from a sample to the population of interest, to measure the incidence of various views and opinions in a chosen sample, and sometimes followed by qualitative research which is used to explore some findings further.

Quantitative data including heroin and opioid use/abuse trends, social determinants of health associated with heroin and opioid use/abuse, community perspective of the problem, and identifying local assets for those engaged in a heroin or opioid addiction. Key data points included:

- Incidence, morbidity and mortality data
- Local agency utilization and enforcement data
- Implementation of a community survey

Qualitative Data: The purpose of qualitative research is to gain an understanding of underlying reason and motivations, to provide insights into the setting of a problem, generating ideas and/or hypotheses for later quantitative research, and to uncover prevalent trends in thought and opinion.

Qualitative data was gathered through Key Stakeholder Focus Groups. Individuals were identified as representatives from the Partners for Prevention Allegany County's Heroin and Opioid Task Force and the Allegany County Board of Legislator's Heroin and Opioid Sub-Committee. These individuals were selected for their expertise in the subject matter and experience; both professionally and personally.

Ardent Solutions, Inc., assembled three (3) groups of key stakeholders that were charged with the following:

Asset Mapping Assist in the development of key stakeholder meeting, key informant interviews, system mapping of the local care system based on prevention, treatment, recovery and enforcement; and develop an inventory of potential assets collaborators which are willing to cl for the common good to help identify gaps in services and systematic challenges.

Data Collection

Where achievable, local data will be gathered and analyzed to establish a timely snapshot and ongoing understanding of those at greatest risk for heroin and opioid abuse. This information will be used to set future project goals and objectives, elevate marketing efforts to those most vulnerable, and become our baseline for developing evaluation measures. Data points and contributing data sources will be identified through a small group process.

Community Engagement

Focus groups with caregivers and individuals affected by an opioid or heroin addiction would help shed light on the strengths and weakness of the current care model in Allegany County. Questioning routes will be designed to gain a better understanding on treatment access issues, input into prevention messaging strategies, opportunities to better engage individuals who use or abuse opioid and heroin into treatment, etc.

"It's time to give those who have overcome their addiction a voice."

Community Key Stakeholder

3 PUBLIC POLICY

3.1 Summary

The following is a summary of public policy (including legislation, resolutions, and other policies) and community initiatives regarding heroin and opioid prevention, treatment, recovery and enforcement around the country. When available, links are provided to the original legislation or resolution.

PUBLIC POLICY- Legislation

I. Opioid Abuse Prevention and Treatment Act of 2015 H.R. 3677 – 114th Congress
Sponsored: Rep. Bill Foster (D-IL) Introduced to House: October 1, 2015

1. Summary

This bill requires the Department of Health and Human Services (HHS) to award grants to states to develop a peer review process to identify and investigate questionable or inappropriate prescribing and dispensing patterns of drugs classified as schedule II or III under the Controlled Substances Act, which are drugs with an accepted medical use that have the potential to be abused and addictive.

This bill amends the Public Health Service Act to require HHS to establish grant programs to: (1) facilitate training to increase the capacity of health care providers to screen and treat patients to prevent drug abuse, and (2) develop continuing education criteria that allow health profession boards or state agencies to certify appropriate education for safe prescribing of schedule II or III drugs. The Health Resources and Services Administration must award grants to evaluate the prospect of state health professions boards expanding the authority of providers to prescribe drugs to treat drug abuse.

The Drug Enforcement Administration must request that practitioners registered to dispense controlled substances screen patients for potential drug abuse before prescribing a schedule II or III drug.

The Food and Drug Administration must consider whether naloxone (a prescription drug used to rapidly reverse an overdose of heroin or other opioids, which are drugs with effects similar to opium) should be available without a prescription.

HHS must convene or coordinate with an interagency working group to encourage states and local governments to increase opportunities for disposal of opiates (drugs derived from opium) and to reduce opportunities for abuse of opiates.

The Government Accountability Office must review federal opioid abuse activities and make recommendations to reduce opioid abuse and overdoses.

Legislative Link:
https://www.congress.gov/bill/114th-congress/house-bill/3677/text

II. Comprehensive Addiction and Recovery Act of 2016 S. 524 – 114th Congress

Sponsored: Sen. Sheldon Whitehouse (D-RI) Introduced to Senate: February 12, 2015
Public Law No. 114-198: July 22, 2016

TITLE I--PAIN MANAGEMENT BEST PRACTICES INTER-AGENCY TASK FORCE

1. Summary

(Sec. 101) This bill requires the Department of Health and Human Services (HHS) to convene a Pain Management Best Practices Inter-Agency Task Force to: (1) review, modify, and update best practices for pain management and prescribing pain medication; and (2) examine and identify the need for, development of, and availability of medical alternatives to opioids (drugs with effects similar to opium, such as heroin and certain pain medications).

TITLE II--COMPREHENSIVE OPIOID ABUSE REDUCTION ACT 2016

1. Summary

(Sec. 202) This bill amends the Omnibus Crime Control and Safe Streets Act of 1968 to authorize the Department of Justice (DOJ) to award grants to state, local, and tribal governments to provide opioid abuse services, including:

- enhancing collaboration between criminal justice and substance abuse agencies;
- developing, implementing, or expanding programs to prevent, treat, or respond to opioid abuse;
- training first responders to administer opioid overdose reversal drugs; and
- investigating unlawful opioid distribution activities.

(Sec. 203) DOJ's Office of the Inspector General must audit a number of DOJ grant recipients each year. Grants may not be awarded to nonprofit organizations that hold money in offshore accounts to avoid tax liability.

(Sec. 204) DOJ must award grants to state, local, and tribal governments to establish or expand programs for veterans, including veterans treatment courts, peer-to-peer services, and treatment, rehabilitation, legal, or transitional services for incarcerated veterans.

(Sec. 205) As an offset, this title amends the Justice Assistance Act of 1984 to eliminate existing authority for DOJ to award grants under the Emergency Federal Law Enforcement Assistance Program through FY2021.

(Sec. 206) The Family-Based Substance Abuse Treatment Program is expanded to include prison-based family treatment programs for pregnant women.

(Sec. 207) The Government Accountability Office (GAO) must report on how DOJ grant programs address substance use and substance use disorders among adolescents and young adults.

TITLE III--JASON SIMCAKOSKI PROMISE ACT (Promoting Responsible Opioid Management and Incorporating Scientific Expertise Act or the Jason Simcakoski PROMISE Act)

1. Summary

(Sec. 302) This bill directs the Department of Veterans Affairs (VA) to expand its Opioid Safety Initiative to include all VA medical facilities.

The VA must direct VA health care providers, before initiating opioid therapy, to use the VA's Opioid Therapy Risk Report tool, which must include: (1) information from state prescription drug monitoring programs, (2) a patient's most recent information, (3) information on controlled substances prescribed to a patient outside the VA, (4) the most recent time the tool was accessed by a VA health care provider regarding a patient, (5) the results of a patient's most recent drug test, and (6) the ability to determine whether a health care provider prescribed an opioid to a patient without checking information in the tool.

The VA must establish enhanced standards for urine drug tests before and during opioid therapy to help prevent substance abuse, dependence, and diversion.

The VA must use the Interdisciplinary Chronic Pain Management Training Team Program to provide education and training on pain management and safe opioid prescribing practices.

Each VA medical facility must designate a pain management team of health care professionals to coordinate pain management therapy for patients experiencing pain that is not related to cancer. The VA must establish standard protocols for the designation of pain management teams. The protocols must ensure that a health care provider without expertise or training in prescribing pain medications does not prescribe opioids unless the health care provider: (1) consults with a provider who has pain management expertise or who is on the pain management team; and (2) refers the patient to the pain management team for subsequent prescriptions and therapy.

VA health care providers to must provide information on prescriptions of controlled substances received by veterans to state prescription drug monitoring programs.

The VA must report on improving the Opioid Therapy Risk Report tool to allow for improved real-time tracking and access to data on certain clinical indicators, concurrent prescribing of opioids by VA health care providers, and mail-order opioid prescriptions.

The VA must: (1) maximize the availability to veterans of opioid overdose reversal drugs, such as naloxone; (2) equip each VA pharmacy with such medications for outpatient use; and (3) expand the Overdose Education and Naloxone Distribution program to ensure that veterans receiving VA health care who are at risk of opioid overdose may access such drugs and training on the proper administration of such drugs.

The VA must modify its patient record system to ensure that health care providers who access a veteran's record will be immediately notified about whether the veteran is receiving opioid therapy, has a history of substance use disorder or overdose, or is at risk of opioid abuse.

(Sec. 303) The VA and the Department of Defense (DOD) must ensure that the VA/DOD Pain Management Working Group: (1) includes a focus on specified practices, (2) coordinates with other working groups, (3) consults with other federal agencies, and (4) and consults with the VA and DOD regarding proposed updates to the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain.

The VA and DOD must update the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain.

(Sec. 304) The GAO must report on the VA's Opioid Safety Initiative and the opioid prescribing practices of VA health care providers.

The VA must report on the prescription of opioids to certain patients at each VA facility and notify Congress and investigate if a provider's or facility's prescription rate is inconsistent with safe care standards.

(Sec. 305) VA disclosure of certain information to a state prescription drug monitoring program in order to prevent misuse of prescription medicines by a veteran or dependent is made mandatory.

(Sec. 306) This bill amends the Veterans Access, Choice, and Accountability Act of 2014 to reduce the aggregate amount of awards and bonuses that may be paid by the VA in each of FY2017-FY2021.

TITLE IV--KINGPIN DESIGNATION IMPROVEMENT ACT of 2016

1. Summary

(Sec. 402) This bill amends the Foreign Narcotics Kingpin Designation Act to allow classified information to be submitted to a reviewing court ex parte (without all parties present) or in camera (in private) in a judicial review of a determination by the President that a foreign person is subject to sanctions as a significant foreign narcotics trafficker.

TITLE V--GOOD SAMARITAN ASSESSMENT ACT of 2016

1. Summary

(Sec. 503) The GAO must report on the Office of National Drug Control Policy's review of state and local Good Samaritan laws that exempt from criminal or civil liability any individual who administers an opioid overdose reversal drug or device (e.g., naloxone).

TITLE VI--OPEN ACT (Opioid Program Evaluation Act or the OPEN Act)

1. Summary

(Sec. 602) DOJ and HHS must each enter into an arrangement with the National Academy of Sciences to identify outcomes and develop metrics to evaluate: (1) the incidence of opioid abuse and illegal opioid distribution, and (2) the effectiveness of

department grant programs regarding opioid abuse. DOJ and HHS must each publish outcomes and metrics and require grant recipients to collect and report data. The National Academy of Sciences must publish the evaluations.

(Sec. 606) As an offset, this title reduces the authorization of appropriations for financial assistance under the Emergency Federal Law Enforcement Assistance program for FY2022.

TITLE VII--INFANT PLAN OF SAFE CARE IMPROVEMENT ACT

1. Summary

(Sec. 702) This bill amends the Child Abuse Prevention and Treatment Act to require the national clearinghouse for information relating to child abuse to maintain and disseminate information about requirements and best practices relating to the development of plans of safe care for infants born affected by illegal substance abuse symptoms, withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder.

(Sec. 703) The plan of safe care for such infants that is required for a state to receive a grant to improve its child protective services system must: (1) address the health and substance use disorder treatment needs of the infant and affected family or caregiver, and (2) specify a system for monitoring whether and in what manner local entities are providing services in accordance with state requirements.

(Sec. 704) Annual state data reports must include the number of such infants, the number for whom a plan of safe care was developed, and the number for whom referrals are made for services, including services for the affected family or caregiver.

(Sec. 705) HHS must monitor state compliance with child protective services system grant requirements.

TITLE VIII--NAS HEALTHY BABIES ACT

1. Summary

Nurturing and Supporting Healthy Babies Act or the NAS Healthy Babies Act
(Sec. 802) The GAO must report on:

- the prevalence of neonatal abstinence syndrome (NAS), which is the symptoms of withdrawal in a newborn;

- NAS treatment services for which coverage is available under state Medicaid programs;
- the care settings and reimbursement for NAS treatment;
- the prevalence of use of various care settings for NAS treatment under state Medicaid programs;
- any federal barriers to treating infants with NAS under state Medicaid programs; and
- its recommendations for improvements that will ensure access to NAS treatment under state Medicaid programs.

(Sec. 803) This bill amends title XIX (Medicaid) of the Social Security Act to exclude abuse-deterrent prescription drugs from the requirement that manufacturers of single-source or innovator drugs pay additional rebates to state Medicaid programs.

(Sec. 804) Under current law, the Centers for Medicare & Medicaid Services must use analytic technologies to identify improper Medicaid claims. The bill prohibits a state agency from using or disclosing such technologies except for purposes of administering a state Medicaid program or Children's Health Insurance Program (CHIP). State agencies must have adequate data security and control policies to ensure that access to such information is restricted to authorized persons for authorized uses.

(Sec. 805) The bill places $5 million in the Medicaid Improvement Fund to be available beginning in FY2021.

TITLE IX--CO-PRESCRIBING TO REDUCE OVERDOSES ACT of 2016

1. Summary

(Sec. 902) HHS may establish a grant program to support prescribing opioid overdose reversal drugs (e.g., naloxone) for patients at an elevated risk of overdose, including patients prescribed an opioid.

Grant recipients may use the funds to purchase opioid overdose reversal drugs, establish a program for prescribing such drugs, train health care providers and pharmacists, track patients and outcomes, offset patient cost sharing, conduct community outreach, and connect patients to treatment.

(Sec. 903) HHS may provide information to prescribers in federally qualified health centers and Indian Health Service facilities on best practices for prescribing opioid overdose reversal drugs for patients at an elevated risk of overdose.

(Sec. 904) This title amends the Public Health Service Act to reduce, as an offset, the authorization of appropriations for Centers for Disease Control and Prevention facilities for FY2018.

TITLE X--IMPROVING TREATMENT FOR PREGNANT AND POSTPARTUM WOMEN ACT of 2016

1. Summary

(Sec. 1002) Support for residential substance abuse treatment programs for pregnant and postpartum women is extended through FY2021.

(Sec. 1003) The Center for Substance Abuse Treatment must carry out a pilot program to make grants to state substance abuse agencies to support services for pregnant and postpartum women who have a primary diagnosis of a substance use disorder, including opioid use disorders. The Center for Behavioral Health Statistics and Quality must fund an evaluation of the pilot program.

(Sec. 1004) As an offset, this title reduces the authorization of appropriations for Centers for Disease Control and Prevention facilities for FY2017.

TITLE XI--VETERAN EMERGENCY MEDICAL TECHNICIAN SUPPORT ACT of 2016

1. Summary

(Sec. 1102) HHS must establish a demonstration program for states with a shortage of emergency medical technicians (EMTs) to streamline state requirements and procedures to assist veterans who completed military EMT training to meet state EMT certification, licensure, and other requirements.

TITLE XII--JOHN THOMAS DECKER ACT of 2016

1. Summary

(Sec. 1202) HHS must report on the availability of information regarding prescription of opioids after youth sports injury, including information on opioid use and misuse, injury treatments that do not involve opioids, and treatment for opioid addiction. The report must determine the extent this information is available to teenagers and adolescents who play youth sports, their families, youth sports groups, and health care providers.

Taking into consideration the findings of the report, HHS must develop and disseminate such information.

TITLE XIII--LALI'S LAW

1. Summary

(Sec. 1302) HHS may make grants to states that allow standing orders (documents that allow a person to acquire, dispense, or administer a prescription medication without a person-specific prescription) for opioid overdose reversal drugs (e.g., naloxone). Grants may be used for:

- developing standing orders for opioid overdose reversal drugs for pharmacies,
- encouraging pharmacies to dispense drugs pursuant to such a standing order,
- implementing best practices for prescribing opioids and prescribing and discussing with patients opioid overdose reversal drugs,
- developing training for prescribers to use in educating the public on administration of opioid overdose reversal drugs, and
- educating the public on the availability and public health benefits of opioid overdose reversal drugs.

States must report on pharmacies that dispense opioid overdose reversal drugs under a standing order and the number of pharmacists trained in educating the public on administration of opioid overdose reversal drugs.

(Sec. 1303) As an offset, this title reduces the authorization of appropriations for Centers for Disease Control and Prevention facilities for FY2017.

TITLE XIV--REDUCING UNUSED MEDICATIONS ACT of 2016

1. Summary

(Sec. 1402) This bill amends the Controlled Substances Act to allow a pharmacist to partially fill a prescription for a schedule II controlled substance (such as an opioid) if: (1)

such partial fills are not prohibited by state law, (2) a partial fill is requested by the patient or prescribing practitioner, and (3) the total quantity dispensed in partial fillings does not exceed the quantity prescribed. Such prescriptions may also be partially filled in accordance with existing Drug Enforcement Administration (DEA) regulations that permit partial fills when a pharmacist cannot supply a full quantity, a patient resides in a long-term care facility, or a patient is terminally ill.

The bill specifies time limits for filling the remaining portion of a partially filled prescription.

TITLE XV--OPIOID REVIEW MODERNIZATION ACT of 2016

1. Summary

(Sec. 1502) This bill amends the Federal Food, Drug, and Cosmetic Act to require the Food and Drug Administration (FDA) to refer new drug applications for opioids to an advisory committee before approval, unless the FDA finds that such a referral is scientifically unnecessary and not in the interest of protecting and promoting public health and the FDA notifies Congress of its rationale.

The FDA must convene an advisory committee on labeling opioids for pediatric use before approving any such labeling.

(Sec. 1503) As part of its evaluation of the Extended-Release/Long-Acting Opioid Analgesics Risk Evaluation and Mitigation Strategy, the FDA must develop recommendations regarding education programs for prescribers of opioids.

(Sec. 1504) The FDA must finalize the draft guidance entitled "General Principals for Evaluating the Abuse Deterrence of Generic Solid Oral Opioid Drug Products."

TITLE XVI--EXAMINING OPIOID TREATMENT INFRASTRUCTURE ACT of 2016

1. Summary

(Sec. 1602) The GAO must report on inpatient and outpatient treatment capacity, availability, and needs, including detoxification programs, clinical stabilization programs, transitional residential support services, rehabilitation programs, treatment programs for pregnant women or adolescents, and treatment through Indian health programs.

The report must include the barriers to real-time reporting of drug overdoses at the federal, state, and local level and ways to overcome those barriers.

TITLE XVII--OPIOID USE DISORDER TREATMENT EXPANSION AND MODERNIZATION ACT

1. Summary

(Sec. 1703) This bill revises the qualifications required for a practitioner to administer, dispense, or prescribe narcotic drugs for maintenance or detoxification treatment in an office-based opioid treatment program.

The bill expands qualifying practitioners to include licensed nurse practitioners and physician assistants who have expertise and prescribe medications for opioid use disorder in collaboration with or under the supervision of a qualifying physician if state law requires physician oversight of prescribing authority. Qualifying practitioners must comply with reporting requirements and have the capacity to provide all FDA-approved drugs for opioid use disorder.

HHS may change the maximum patient limit for qualifying practitioners. If HHS increases the limit, then a qualifying practitioner must obtain written consent from each patient regarding assessment and treatment.

HHS must update the treatment improvement protocol containing best practice guidelines for the treatment of opioid-dependent patients in office-based settings.

HHS may recommend revoking or suspending the registration of a practitioner who fails to comply with the requirements of the Controlled Substances Act.

(Sec. 1705) This section repeats section 1402.

TITLE XVIII--NATIONAL ALL SCHEDULES PRESCRIPTION ELECTRONIC REPORTING REAUTHORIZATION ACT of 2015

1. Summary

(Sec. 1802) This bill amends the National All Schedules Prescription Electronic Reporting Act of 2005 to include as a purpose of state prescription drug monitoring systems

ensuring access to prescription history information for the investigative purposes of law enforcement, regulatory, and state professional licensing authorities.

(Sec. 1803) The grant program for state prescription drug monitoring programs is extended through FY2020 and revised, including to:

- allow grants to be used to maintain and operate existing state prescription drug monitoring programs,
- require HHS to redistribute any returned funds among the remaining grantees,
- require a state to provide HHS with aggregate data and other information to enable HHS to evaluate the success of the state's program, and
- expand the program to include any commonwealth or territory of the United States.

The DEA, HHS, a state Medicaid program, a state health department, or a state substance abuse agency receiving non-identifiable information from a prescription drug monitoring database for research purposes may make that information available to other entities for research purposes.

A state receiving a grant must: (1) facilitate prescriber and dispenser use of the state's prescription drug monitoring system, and (2) educate prescribers and dispensers on the benefits of the system both to them and society.

Legislative Link:
https://www.congress.gov/bill/114th-congress/senate-bill/524/text

III. New York State Legislative Program Bill No.32; 12079 -01-6

1. Summary

Part A. Sec. 1. Amendment of NYS Education law adding new section 6509-d allowing for limited exemption from professional misconduct for individuals licensed under Title 8 otherwise prohibited from prescribing or administering drugs pursuant to his/her licenses, permission to administer an opioid antagonist in the event of an emergency.

Part B. Sec. 1. Amendment of Public Health law sites that the NYS Commissioner of Health will provide each county a monthly report, submitted every three months, of opioid overdose data for purposes of addressing the opioid epidemic.

Part C. Sec. 1. Amendment of Public Health law requiring hospitals to disseminate information regarding types of treatment and recovery services; including inpatient, outpatient, and medication-assisted treatment; how to recognize the need for treatment services, how to determine level of treatment; to individual with a documented substance use disorder or who appear to be at-risk for a substance use disorder during discharge planning.

Part C. Sec.2a. Every hospital shall develop, maintain and disseminate written policies and procedures for the identification, assessment and referral of individuals with documented substance use disorder as defined in section 1.03 of the mental health law.

Part C. Sec. 2b. Every hospital shall establish and implement training, within existing or in addition to current training programs, for all individuals licensed or certified pursuant to title 8 of the education law, who provide direct patient care for identification, assessment and referral of individuals with a documented substance use disorder or who appear to be at-risk for a substance use disorder.

Part C Sec. 2c. Every hospital shall inform an individual with a documented substance use disorder or who appear to be at-risk for a substance use disorder of treatment services that may be available to them through a substance use disorder services program; including at point of discharge, discharge from ED, admission, and/or commencement of treatment.

Legislative Link:
https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/GPB32_HeroinOpioidAbusePrevention_Bill_2.pdf

IV. New York State Legislative Program Bill No.33; 12080 -01-6

1. Summary

Amend public health law, in relation to providing training in pain management for certain individuals; to amend the insurance law, in relation to providing coverage for medically necessary inpatient services for the diagnosis and treatment of substance abuse disorder; to amend the public health law, the social service law, and the insurance law, in relation to limiting initial prescriptions re: acute pain, for opioids to a seven-day

supply; and to amend the mental hygiene law and the public health law, in relation to the dissemination of information by pharmacists to customers regarding controlled substances and counseling for individuals purchasing syringes.

Sec. 1. 3309-1, 2. Prescription pain medication awareness program to educate the public and health care practitioners about the risks associated with prescribing and taking controlled substance pain medications; including the development and implementation of a public health education media campaign to alert youth, parents and the general population about the risks associated with prescription pain medications and the need to properly dispose of any unused medications.

Sec. 1. 3309-3. Three-hours of approved course work and training in pain management, palliative care and addiction must be completed no later than July 1, 2017 and once within each three year period thereafter, for professionals licensed under Title 8 of the education law, registered under the federal controlled substances act and in possession of a registration number from the drug enforcement administration, and every medical resident who is prescribing under a facility registration number from the drug enforcement administration. Every person meeting said criteria on or after July 1, 2017 shall complete such course work or training within one year of such registration and once within each three year period thereafter. State leaders will establish standards and approve curriculum that includes, but is not limited to the following: state and federal requirements for prescribing controlled substances, pain management; appropriate prescribing; managing acute pain; palliative medicine; prevention, screening and signs of addiction; responses to abuse and addiction; and end-of-life care.

Legislative Link:
https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/GPB33_HeroinOpioidAbusePrevention_Bill_3.pdf

4 PREVENTION, TREATMENT, RECOVERY AND ENFORCEMENT SERVICES

4.1 Background

Prescription opioids are powerful pain-reducing medications that include prescription oxycodone, hydrocodone and morphine, among others, and have both benefits as well as potentially serious risks. These medications can help manage pain when prescribed for the right condition and when used properly. But when misused or abused, they can cause serious harm, including addiction, overdose and death. Typically pain medications can be administered by pill, but many report crushing prescription opioid pills to snort or inject the powder for a more rapid high.

Research indicates that for many, prescription opioids are a gateway to the illicit drug heroin. Heroin is an opioid drug that is synthesized from morphine, a naturally occurring substance extracted from the seed pod of the Asian opium poppy plant. Heroin usually appears as a white or brown powder or as a black sticky substance, known as “black tar heroin.”

According to the National Institute on Drug Abuse, heroin can be injected, inhaled by snorting or sniffing, or smoked. All three routes of administration deliver the drug to the brain very rapidly, which contributes to its health risks and to its high risk for addiction, which is a chronic relapsing disease caused by changes in the brain and characterized by uncontrollable drug-seeking no matter the consequences.

Scientists state that when heroin enters the brain, it is converted back into morphine, which binds to molecules on cells known as opioid receptors. These receptors are located in many areas of the brain (and in the body), especially those involved in the perception of pain and in reward. Opioid receptors are also located in the brain stem, which controls automatic processes critical for life, such as blood pressure, arousal, and respiration.

Heroin overdoses frequently involve a suppression of breathing. This can affect the amount of oxygen that reaches the brain, a condition called hypoxia. Hypoxia can have short- and long-term psychological and neurological effects, including coma and permanent brain damage.

After an intravenous injection of heroin, users report feeling a surge of euphoria (“rush”) accompanied by dry mouth, a warm flushing of the skin, heaviness of the extremities, and clouded mental functioning. Following this initial euphoria, the user goes “on the nod,” an alternately wakeful and drowsy state. Users who do not inject the drug may not experience the initial rush, but other effects are the same.

Researchers are also investigating the long-term effects of opioid addiction on the brain. One result is tolerance, in which more of the drug is needed to achieve the same intensity of effect. Another result is dependence, characterized by the need to continue use of the drug to avoid withdrawal symptoms. Studies have shown some deterioration of the brain's white matter due to heroin use, which may affect decision-making abilities, the ability to regulate behavior, and responses to stressful situations. In many cases, the fear of detoxification is a driving force behind continued use.

> *"Withdrawal is real. It is painful with great emotional and physical discomfort. It can last days. For many of our residents, it is happening in environments that are not equipped to handle the crisis; our local jail, local Emergency Departments, people's homes."*
>
> Concerned Key Stakeholder

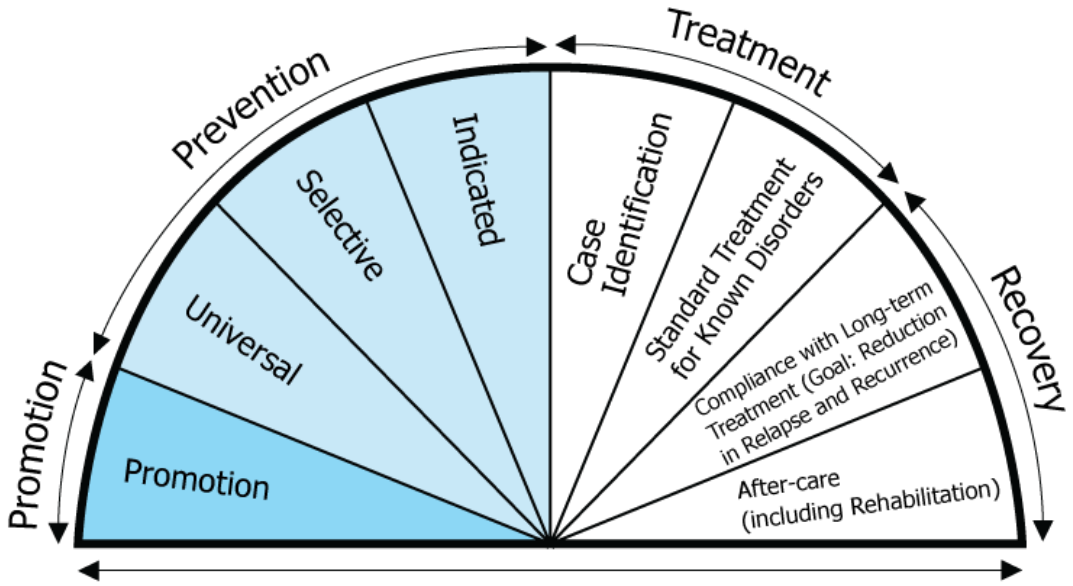
As reported by the Office of the New York State Comptroller in the report ***Prescription Opioid Abuse and Heroin Addiction in New York State*** (June 2016), heroin and pain medications in particular continue to top the list as the fastest rising addictions in the United States. While overdose deaths are the most dramatic and wrenching index of a much larger problem, there are immense human, societal, and fiscal costs associated with this epidemic. These include short-term and long-term health consequences, strain on and destruction of families, missed work, unemployment, crime and incarceration, as well as direct medical spending for emergency care and treatment. Research published in 2014 estimated the U.S. societal costs of prescription opioid abuse, including direct medical costs and indirect costs for caregivers, the workplace and the criminal justice system, at $55.7 billion in 2007, well before the nation's recent surge in prescription opioid abuse.

4.2 Prevention

Prevention of heroin and opioid drug abuse is a complex issue. Prevention strategies must balance messaging and activities that promote safe and effective prescription medication use, while educating the community about the risks and adverse effects of improper prescription medication use and the illegal use of heroin.

4.2.1 Prescription Drug Abuse Prevention

A comprehensive approach to behavioral health means seeing prevention as part of an overall continuum of care. The Behavioral Health Continuum of Care Model demonstrates this in the following diagram:



The Prescription Drug Abuse Prevention Plan expands upon the Administration's National Drug Control Strategy and includes action in four major areas to reduce prescription drug abuse:

Education is critical for the public and for healthcare providers to increase awareness about the dangers of prescription drug abuse, and about ways to appropriately dispense, store, and dispose of controlled substance medications.

Enhancement and increased utilization of prescription drug monitoring programs will help to identify "doctor shoppers" and detect therapeutic duplication and drug-drug interactions.

Proper Disposal through the development of consumer-friendly and environmentally responsible prescription drug disposal programs may help to limit the diversion of drugs, i.e. as most non-medical users often receive or steal the drugs from family and friends.

Law Enforcement agencies must have support and the tools they need to expand their efforts to shut down "pill mills" and to stop "doctor shoppers" who contribute to prescription drug trafficking.

Understanding risk-factors and identifying the highest-risk populations is essential to aligning prevention strategies, effective interventions, outreach efforts, and educational messaging. According to the Center for Disease Control, some risk factors that make people particularly vulnerable to prescription opioid abuse and overdose include:

- Obtaining overlapping prescriptions from multiple providers and pharmacies
- Taking high daily dosages of prescription pain relievers
- Having a mental illness or history of alcohol or other substance abuse
- Living in rural areas and having low income

Studies by the Substance Abuse Mental Health Services Administration's (SAMHSA) Center for the Application of Prevention Technologies Issues Brief entitled **Preventing Heroin Use: Facts, Factors, and Strategies** investigated Protective Factors that help buffer and protect against prescription drug misuse. Youth Protective Factors sited include:

- Having a long-acting opioid prescription, a lower dosage prescription, or only being prescribed Schedule III or IV opioids is associated with lower misuse, abuse, and dependence (Edlund et al., 2010; Sullivan et al., 2010).
- Committing to do well in school and achieving high school and college degrees are protective against prescription drug misuse and abuse (Collins et al., 2011; Arkes & Iguchi, 2008).
- Attending a prevention class is associated with less misuse (Ford & Rigg, 2015).
- Having greater perception of substance abuse risks prevents opioid misuse (Ford & Rigg, 2015)
- Youth who have a strong parental bond (Schroeder & Ford, 2012) and have parents who disapprove of misuse (Collins et al., 2011) are less likely to misuse prescription drugs.
- The presence of a Gay-Straight Alliance (GSA) in school protects sexual minority youth from misusing prescription drugs (Heck et al., 2014).
- Community norms against use is associated with lesser prescription drug misuse (Collins et al., 2011)

4.2.2 Heroin Prevention

The Center for Disease Control recognizes people most at risk for heroin addiction are:

- Those who are addicted to prescription opioids, cocaine, marijuana or alcohol
- Those enrolled in Medicaid or without insurance
- Non-Hispanic whites
- Males
- Those living in large metropolitan areas
- 18 to 25 years of age

As sited in the Substance Abuse Mental Health Services Administration's (SAMHSA) Center for the Application of Prevention Technologies Issues Brief entitled **Preventing Heroin Use: Facts,**

Factors, and Strategies, research suggests that dependence on, or abuse of, opioid pain relievers is the strongest risk factor for heroin abuse or dependence (Jones et al., 2015), with many heroin users reporting nonmedical use of opioid pain relievers prior to initiating heroin use (Jones, 2013; Muhuri, Gfroerer, & Davies, 2013). Because of this strong connection, it is important to consider risk and protective factors related to the nonmedical use of prescription drugs when assessing where and how to focus heroin prevention efforts.

Additional risk factors for heroin use include:

- Personality characteristics, such as cynicism, or a high level of anger toward self and others, are associated with heroin being the "drug of choice" (Suh et al., 2008).
- Early onset of tobacco and other drug use has been associated with past-year heroin use (Wu & Howard, 2007), heroin initiation (Martins et al., 2007), and opiate use (Storr et al., 2005).
- History of poly-drug use, especially combined inhalant and marijuana use, is linked to past-year heroin use (Wu & Howard, 2007).
- Having ever been in jail or a detention center is associated with past-year heroin use (Wu & Howard, 2007).
- Engaging in multiple delinquent behaviors (i.e., getting into serious fights at school or work, engaging in group fighting, carrying guns, selling illicit drugs, stealing, or attacking someone with intent to seriously injure) makes someone more likely to have engaged in past-year heroin use (Wu & Howard, 2007).
- Ability to access heroin-using social networks makes a person more likely to have used heroin in the past six months (Rudolph, Jones, Latkin, Crawford, & Fuller, 2011).
- Having experienced a history of child abuse (sexual, physical or emotional) is associated with heroin initiation, past-year heroin use (Nomura et al., 2012), and the number of years of lifetime heroin use (Malow et al., 2006).
- Dropping out of school, participating in delinquent behaviors, or having a history of foster care placements increases the chances of past-year heroin injection use (Wu & Howard, 2007)
- Experiencing depression or having a network of injecting drug users increases the likelihood of engaging in injection heroin use (Kuramoto, Bohnert, & Latkin, 2011).

Only one (1) Protective Factor was cited in the study:

- Having high IQ scores or high socioeconomic status is associated with less habitual heroin use (White et al., 2012)

4.2.3 Secondary Prevention

Secondary prevention aims to reduce the impact of the heroin and prescription drug abuse by halting or slowing its progress, encouraging strategies that prevent relapse, and implement programs to return people to their original health and function to prevent long-term problems; such as overdose.

As sited in the Substance Abuse Mental Health Services Administration's (SAMHSA) Center for the Application of Prevention Technologies Issues Brief entitled **Preventing Heroin Use: Facts, Factors, and Strategies**, research suggests heroin overdose risk factors include:

- Being homeless and having a long history of injection drug use increases the likelihood of experiencing a nonfatal heroin overdose during a lifetime (Sherman, Cheng, & Kral, 2007).
- Using heroin in a public space or residing in a large city has been associated with an increase in overdose death (Green, Grau, Carver, Kinzly, & Heimer, 2011).
- Recently injecting drugs, being incarcerated, poly-drug use, testing positive for hepatitis, or having witnessed an overdose increases risk of past-year-nonfatal overdose (Ochoa et al., 2005).
- Decreases in the cost of heroin and increases in availability are associated with increased heroin overdose hospitalizations (Unick, Roseblum, Mars, & Ciccarone, 2014).

4.2.4 Tertiary Prevention

Tertiary prevention aims to soften the impact of the ongoing addiction that has lasting effects on the individual, family and society. This is done by helping people manage their addiction long-term in order to improve as much as possible their ability to function, their quality of life and their life expectancy.

Often individuals require assistance and support for long-term sobriety by addressing other social determinants of health and well-being through recovery support. SAMHSA has delineated four major dimensions that support a life in recovery:

Health: overcoming or managing one's disease(s) or symptoms; for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem; and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being

Home: having a stable and safe place to live

Purpose: conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society

Community: having relationships and social networks that provide support, friendship, love, and hope

4.2.5 Children, Families, and School-Based Education

The Office of Alcoholism and Substance Abuse Services prevention strategies for children and families include the provision of accurate, age appropriate and culturally competent information, and educational curricula including social skills development. Environmental strategies for schools and communities include improving policies, regulations and their enforcement to reduce the availability of drugs and improve social norms. Counseling and Early Intervention services may also be provided to those identified at higher risk for substance abuse. These programs and strategies are implemented through a variety of activities, including classroom presentations, skill development workshops, community awareness events, and training sessions for professionals, parents, teachers, community leaders and others as appropriate.

All OASAS funded prevention services must address individual and/or family risk and protective factors and/or community level risk and protective factors which are predictive of substance abuse among youth, as identified by a local needs assessment. Target populations for recurring prevention services are children and youth ages 5-20 and those who directly impact youth (i.e., parents/family members). Young adults ages 21-25 may receive early interventions for substance use. Adult populations aged 21 and over may benefit from evidence-based environmental strategies, information awareness activities and community capacity building efforts such as prevention coalition trainings and technical assistance.

As of June 2016, New York State Department of Education announced the new ***Health Education Standards Modernization Supplemental Guidance Document: An Instructional Resource Packet for Heroin and Opioids*****.** Developed to assist school districts to meet requirements of modernizing health education instruction by including heroin and opioid content within the alcohol, tobacco, and other drugs curricula, paragraph a of subdivision 4 of section 804 of the Education Law, as amended by Chapter 181 of the laws of 2000, was amended in response to the increase in heroin and opioid abuse in New York and across the nation

(http://www.p12.nysed.gov/sss/documents/FinalNYSEDHeroin-OpioidsInstructionalResourcePacket6.16docx.pdf).

4.3 Treatment

As reported by the Office of the New York State Comptroller in the report ***Prescription Opioid Abuse and Heroin Addiction in New York State*** (June 2016), over the decade ending in 2014, the number and rate of treatment admissions for heroin use among New Yorkers aged 12 and older increased by over 20 percent. The number and rate of treatment admissions for prescription opioid abuse in New York nearly doubled over the period. Among New York

demographic groups tracked by federal data, white, males and individuals in the 21 to 30 age range had the highest treatment admission rates for use of both substances. Men accounted for majorities of heroin treatment admissions both in New York and nationally, including nearly three-quarters of those in the State during 2014, according to the most recent data.

Younger individuals are disproportionately represented in the group, with those aged 21-25 representing nearly 20 percent of the New York total and those aged 26-30, the next largest cohort. Still, heroin addiction strikes all ages, and racial and ethnic groups.

Dependent upon where the person is in their disease cycle, treatment options vary according to the most appropriate level of care and resources. Several variables influence what type of treatment a person receives. According to local experts the most pressing factors include:

- Locality of Programs and Services
- Availability of Beds
- Insurance Benefits and Personal Costs
- Insurance Approval; i.e. Level of Care

> *"Someone who needs inpatient or long-term care services are lucky to have 14 days approved by their health insurance carrier. This is simply not enough time!"*
>
> Concerned Key Stakeholder

The NYS Office of Alcoholism and Substance Abuse Services has defined treatment as the following:

I. CRISIS SERVICES

A. Medically Managed Withdrawal and Stabilization. Medically managed withdrawal and stabilization services are provided in a hospital setting and are designed for individuals who are acutely ill from alcohol-related and/or substance-related addictions or dependence, including the need for medical management of persons with severe withdrawal or risk of severe withdrawal symptoms, and may include individuals with, or at risk of, acute physical or psychiatric co-morbid conditions. This level of care includes the 48-hour observation bed. Individuals who have stabilized in a medically managed detoxification service may step-down to a medically supervised service within the same service setting or may be transferred to another service setting.

B. Medically Supervised Inpatient Withdrawal and Stabilization. This service is physician directed and staffed 24 hours a day 7 days per week with medical staff and includes 24 hour emergency medical coverage. Medically supervised withdrawal services provide: bio-psycho-social assessment, medical supervision of intoxication and withdrawal conditions; pharmacological services; individual and group counseling; level of care determination; and referral to other appropriate services. Medically supervised withdrawal and stabilization services are appropriate for persons who are intoxicated by alcohol and/or substances, who are experiencing, or who are expected to experience, withdrawal symptoms that require medical oversight. Individuals who have stabilized in a medically managed withdrawal service may step-down to a medically supervised outpatient service.

C. Medically Supervised Outpatient Withdrawal and Stabilization. Based on a medical and bio-psycho-social evaluation, providers of services otherwise certified by OASAS may provide outpatient medically supervised withdrawal services to clients who suffer moderate alcohol or substance withdrawal, do not meet the admission criteria for medically managed or inpatient medically supervised detoxification services, and who have emotional support and a home environment able to provide an atmosphere conducive to outpatient withdrawal leading to recovery. In addition to the general services required above, outpatient medically supervised withdrawal patients must be seen by a medical professional every day, engage in counseling services, have access to a 24 hour hotline with access to a medical professional that can provide consultation about acuity of symptoms of withdrawal, assessment of need for higher level of care, and other supports for patient and family. Outpatient withdrawal services can be provided under a separate certification as and Medically Supervised Outpatient Withdrawal Service or may be provided in an outpatient setting with the approval of the OASAS Medical Director that is documented as a designation on the outpatient certification as an ancillary withdrawal service (see below).

D. Ancillary Withdrawal Service. Ancillary withdrawal services are the medical management of mild or moderate symptoms of withdrawal within in an OASAS-certified setting. Medical staff monitor withdrawal symptoms. Providers must have a protocol for providing ancillary withdrawal services approved by the OASAS Medical Director. The protocol must include a physician director of the service, medication and counseling protocol for managing withdrawal and 24 hour emergency plan. Staffing will include a physician, physician extenders, registered nurse, and clinical staff. A treatment plan will include the medication protocol to achieve safe withdrawal management, clinical interventions to provide engagement, management of urges and cravings, addresses cognitive and behavioral issues and recovery supports.

E. Medically Monitored Withdrawal and Stabilization. This service can be provided in a free-standing community-based setting or as an additional service of a licensed chemical dependence inpatient or residential provider. This service treats clients who are intoxicated by alcohol and/or substances suffering from mild withdrawal complications or who are in danger of relapse. These services do not require physician direction or direct supervision by a physician and should provide a safe environment to complete withdrawal and secure referral to the next level of care. Medically monitored withdrawal services must provide: assessment; monitoring of symptoms and vital signs; individual and group counseling; level of care determination, and referral to other appropriate services. This level of service will be eliminated over time as all current and future programs will transition to Stabilization in Residential Services (for a description of this service, see below).

II. INPATIENT SERVICES

A. Inpatient Rehabilitation. OASAS-certified 24-hour, structured, short-term, intensive treatment services provided in a hospital or free-standing facility. Medical and individualized treatment services are provided to individuals with substance use disorders who are not in need of medical detoxification or acute care and are unable to participate in, or comply with, treatment outside of a 24-hour structured treatment setting. Individuals may have mental or physical complications or co-morbidities that require medical management or may have social, emotional or developmental barriers to participation in treatment outside of this setting. Treatment is provided under direction of a physician medical director and the staff includes nursing and clinical staff 24 hours 7 days per week. Activities are structured daily to improve cognitive and behavioral patterns and improve functioning to allow for the development of skills to manage chronic patterns of substance use and develop skills to cope with emotions and stress without return to substance use. People who are appropriate for inpatient care have co-occurring medical or psychiatric conditions or are using substances in a way that puts them in harm. Many experience decreases in ability to reason and have impaired judgment that interferes with decision making, risk assessment, and goal setting and need a period of time for these consequences of substance use to diminish.

III. OUTPATIENT SERVICES

A. Brief Intervention. Outpatient pre-admission service. This service is a one to three session brief intervention provided to people who do not meet the diagnostic criteria for admission to SUD services, but meet at least one criteria for an SUD based on DSM 5, or who have screened as high risk through an agency screening process. The intervention educates them about their substance use, alerts them to possible consequences, and motivates them to change their behavior. A brief intervention may follow a screening where some risky use has been identified, but the individual does not need or accept a referral to treatment.

B. Outpatient Clinic. OASAS-certified outpatient services have multi-disciplinary teams which include medical staff and a physician who serves as medical director. These programs provide treatment services to individuals who suffer from substance use disorders and their family members and/or significant others. Outpatient services may be delivered at different levels of intensity responsive to the severity of the problems presented by the patient. The length of stay and the intensity (as measured by frequency and duration of visits) will vary during the course of treatment. In general, persons are engaged in more frequent outpatient treatment visits earlier in the treatment process; visits generally become less frequent as treatment progresses. Treatment includes the following procedures: group and individual counseling; education about, orientation to, and opportunity for participation in relevant and available self-help groups; alcohol and substance abuse disorder awareness and relapse prevention; HIV and other communicable disease education, risk assessment, supportive counseling and referral; and family treatment. Procedures are provided according to an individualized assessment and treatment plan.

C. Outpatient Rehabilitation. OASAS-certified services designed to assist individuals with chronic medical and psychiatric conditions. These programs provide: social and health care services; skill development in accessing community services; activity therapies; information and education about nutritional requirements; and vocational and educational evaluation. Individuals initially receive services three to five days a week for at least four hours per day. There is a richer staff to client ratio for these services compared to other outpatient levels and these services are required to have a half-time staff person qualified in providing recreation and/or occupational services and a half-time nurse practitioner, physician's assistant, or registered nurse. Like medically supervised outpatient, outpatient rehabilitation services require a physician medical director and medical staff are part of the multi- disciplinary team. The clinical team includes credentialed alcohol and substance abuse counselors and other qualified health professionals. A treatment plan is required to address functional needs of the individual including cognitive, behavioral, employment, and interpersonal.

D. Problem gambling outpatient. Services that assist individuals who are affected by problem and pathological gambling including family members and/or significant others. These services may be provided in free-standing settings or may be co-located in chemical dependency clinics or other mental health settings. In general, persons are engaged in outpatient treatment up to a year and visits are more frequent earlier in the treatment process becoming less frequent as treatment progresses. Each problem gambling outpatient service provides the following: group and individual counseling, education about, orientation to and opportunity to participate in problem gambling awareness and relapse prevention, self-help groups and family treatment. In addition, financial counseling is provided either directly or through outside referral. Procedures are provided according to an individualized assessment and treatment plan.

E. Intensive Outpatient Service - An OASAS-certified treatment service provided by a team of clinical staff for individuals who require a time-limited, multi-faceted array of services, structure, and support to achieve and sustain recovery. Intensive outpatient treatment programs schedule a minimum of 9 service hours per week delivered during the day, evening or weekends. This service is provided in a certified outpatient clinic under the direction of a physician medical director. A team of clinical and medical staff must provide this service including credentialed alcohol and substance abuse counselors and other qualified health professionals. The treatment program consists of, but is not limited to: individual, group and family counseling; relapse prevention and cognitive and behavioral interventions; motivational enhancement; and the development of coping skills to effectively deal with emotions and environmental stressors.

IV. OPIOID TREATMENT SERVICES

A. Opioid Treatment Program (OTP). OASAS-certified sites where methadone or other approved medications are administered to treat opioid dependency following one or more medical treatment protocols as defined by 14 NYCRR Part 822 OTPs offer medical and support services including counseling and educational and vocational rehabilitation. OTPs also include the Narcotic Treatment Program (NTP) as defined by the federal Drug Enforcement Agency (DEA) in 21 CFR Section 13. A physician serves as medical director and physician and nursing staff assess each individual and approve the plan of care. Clinical staff provide individual, family and group counseling. Patients are prescribed and delivered medication assisted treatment which is expected to be long term medication management of a chronic disorder. Many patients are provided treatment over a lifetime similar to chronic management of diabetes or a heart condition.

V. RESIDENTIAL SERVICES

A. Intensive Residential Services. In addition to the procedures required of all chemical dependence residential services, intensive residential rehabilitative services provide the following additional procedures, either directly or by referral: vocational procedures such as vocational assessment, job skills training and employment readiness training; parenting, personal, social and community living skills training including personal hygiene and leisure activities. These services provide a minimum of 40 hours/week of procedures within a therapeutic milieu. Individuals appropriate for this service category include persons unable to comply with treatment outside a 24 hour setting as evidenced by recent unsuccessful attempts at abstinence or prior treatment episodes including unsuccessful outpatient treatment with substantial deficits in functional skills or in need of ongoing management of medical and/or psychiatric problems. For residential rehabilitation services that serve children, at least one direct care staff with training and experience in child care shall be identified.

B. Community Residential Services - These services provide a structured therapeutic milieu while residents are concurrently enrolled in an outpatient chemical dependence service which provides addiction counseling. Community residential services provide the following procedures either directly or by referral: vocational procedures such as vocational assessment, job skills training and employment readiness training; parenting, personal, social and community living skills training including personal hygiene and leisure activities. Individuals appropriate for this level of care include persons who are homeless or whose living environment is not conducive to recovery and maintaining abstinence.

C. Supportive Living. OASAS-certified programs that are designed to promote independent living in a supervised setting for individuals who have completed another course of treatment, are making the transition to independent living, and whose need for services does not require staffing on site on a 24-hour a day basis. These services provide a minimum level of professional support, which includes a weekly visit to the site and a weekly contact of the resident by a clinical staff member. These treatment services are for individuals who either require a long-term supportive environment following care in another type of residential service for an undetermined length of stay, or who are in need of a transitional living environment prior to establishing independent community living.

D. Stabilization Services in a Residential Setting. OASAS-certified providers of residential programs that provide medical and clinical services including: medical evaluation; ongoing medication management and limited medical intervention; ancillary withdrawal and medication assisted substance use treatment; psychiatric evaluation and ongoing management; and group, individual and family counseling focused on stabilizing the individual and increasing coping skills until the individual is able to manage feelings, urges and craving, co-occurring psychiatric symptoms and medical conditions within the safety of the residence. This service has a physician who serves as medical director, psychiatrist, nurse practitioner and/or physician assistants to provide and oversee medical and psychiatric treatment. Medical staff are available in the residence daily, but 24-hour medical/nursing services are not. There is medical staff available on call 24/7 and there are admitting hours 7 days per week.

E. Rehabilitative Services in a Residential Setting. Certified OASAS providers of residential programs which provide rehabilitative services for individuals who are stable enough to manage emotional states, urges and cravings, co-occurring psychiatric symptoms and medical conditions within the safety of a residential setting. This service requires a physician who will serve as medical director, nurse practitioner, psychiatrist and nursing staff on site daily and clinical staff provide monitoring for medical and psychiatric symptoms that are stable. Services include medical monitoring of chronic conditions including routine medication management and individual, group and family counseling focused on rehabilitation. The service requires a treatment plan to address functional needs including

personal and interpersonal functioning. The treatment program teaches individuals to manage self and interactions with others with increasing independence.

F. Reintegration Services in a Residential Setting. Certified OASAS providers of residential programs that provide reintegration services to transition from structured treatment environments to more independent living. This setting does not require a physician to serve as medical director and staff coordinate treatment services but do not provide direct clinical care. Most services are provided in the community and include clinical and social services. Individuals are provided a safe living environment with a high degree of behavioral accountability. Services include medical and clinical oversight of chronic but stable medical and psychiatric symptoms and conditions in a community treatment program including an outpatient Substance Use Disorder treatment program. Services also include: community meetings; activities of daily living (ADL) support; case management; and vocational support and clinical services to support transition to independent living. Reintegration services may be provided in a congregate or scatter-site setting.

G. Residential Rehabilitation Services for Youth (RRSY). In July 2007, all short-term and long-term RCDY programs began converting to a new residential service that includes the following enhanced staffing pattern: Medical Director, on-site medical staff, provision for psychological and psychiatric services and a community support specialist to help with case management and discharge planning. The staff to patient ratio is 1:8 and all programs are required to have a family therapist and/or a social worker with family therapy experience.

VI. RECOVERY SUPPORT AND HOUSING SERVICES

A. Recovery Support. Services available through community service providers including: recovery centers, recovery coaching, case management and mutual help groups. These supports include Home and Community Based (HCBS) services. Individuals are eligible for (HCBS) services if they meet the functional criteria and are enrolled in a Health and Recovery Plan (HARP). Individuals can also access: peer services through outpatient clinics and opioid treatment programs (OTP); a Recovery Center as a recovering member of the community; and housing supports through the case management associated with supportive housing. Recovery supports may enable a person who lacks social, emotional and community resources in the natural environment to maintain community based living if the additional supports help stabilize them and provide enough support to enable them to manage early recovery in an ambulatory setting.

B. Permanent Supportive Housing. Permanent Supportive Housing includes all housing with an expected length of stay beyond 24 months. OASAS' Shelter Plus Care, New York/ New York III and Upstate Permanent Supportive Housing Program are considered permanent housing. All of OASAS' permanent housing programs include rental subsidies

and provide access to supportive services which assist individuals and families to achieve greater independence and self-sufficiency. Permanent Supportive Housing can also lead to "turn-key", whereby the lease may be turned over to a tenant who has reached a level of income that is sufficient to assume full rental responsibility. OASAS provides opportunities for safe and affordable permanent supportive housing to homeless adults and families through rental subsidies and case managed supportive services. Permanent Supportive Housing may be organized as a scatter-bed setting in small clusters of 5-10 units in a building with case management and employment counseling services coming to the housing sites or as a congregate care setting in one building with one or several different special need populations.

5 OPIOID PREVENTION, TREATMENT, RECOVERY & ENFORCEMENT DATA

5.1 Background Enforcement Data

According to ***America's Addiction to Opioid: Heroin and Prescription Drug Abuse***, presented by Nora D. Volkow, M.D., the abuse of and addiction to opioids such as heroin, morphine, and prescription pain relievers is a serious global problem that affects the health, social, and economic welfare of all societies. It is estimated that between 26.4 million and 36 million people abuse opioids worldwide, with an estimated 2.1 million people in the United States suffering from substance use disorders related to prescription opioid pain relievers in 2012 and an estimated 467,000 addicted to heroin. The consequences of this abuse have been devastating and are on the rise. For example, the number of unintentional overdose deaths from prescription pain relievers has soared in the United States, more than quadrupling since 1999. There is also growing evidence to suggest a relationship between increased non-medical use of opioid analgesics and heroin abuse in the United States.

According to the American Society of Addiction Medicine ***Opioid Addiction 2016 Facts and Figures***, in 2014, adolescents ages 12-17; 467,000 adolescents were current nonmedical users of pain reliever, with 168,000 having an addiction to prescription pain relievers. An addition, an estimated 28,000 adolescents had used heroin in the past year, and an estimated 16,000 were current heroin users. An estimated 18,000 adolescents had a heroin use disorder in 2014. The prescribing rates for prescription opioids among adolescents and young adults nearly doubled from 1994-2007. Most adolescents who misuse prescription pain relievers were provided them for free by a relative or friend.

Furthermore, the American Society of Addiction Medicine estimated that heroin overdose deaths among women have tripled in the last few year. From 2010 through 2013, female heroin overdoses increased from 0.4 to 1.2 per 100,000. 48,000 women died of prescription pain reliever overdoses between 199-2010, and prescription pain reliever overdose deaths among women increased more than 400% from 1999-2010, compared to 237% among men. To explain this phenomena, experts state that women are more likely to have chronic pain, be prescribed pain relievers, be given higher doses, and use them for longer periods of time than men.

To address the complex problem of prescription opioid and heroin abuse, experts believe that we must recognize and consider the special character of this issue. Opioids not only negatively impact health and mortality, but also play a fundamental role in healing and reducing suffering from chronic and acute pain. We must strike the right balance between providing maximum relief from suffering while minimizing associated risks and adverse effects.

"There is a major difference between a physical addiction where a person uses opioids for medicinal purposes to control physical pain versus a psychological addiction where a person abuses opioids as a compulsion or perceived need."

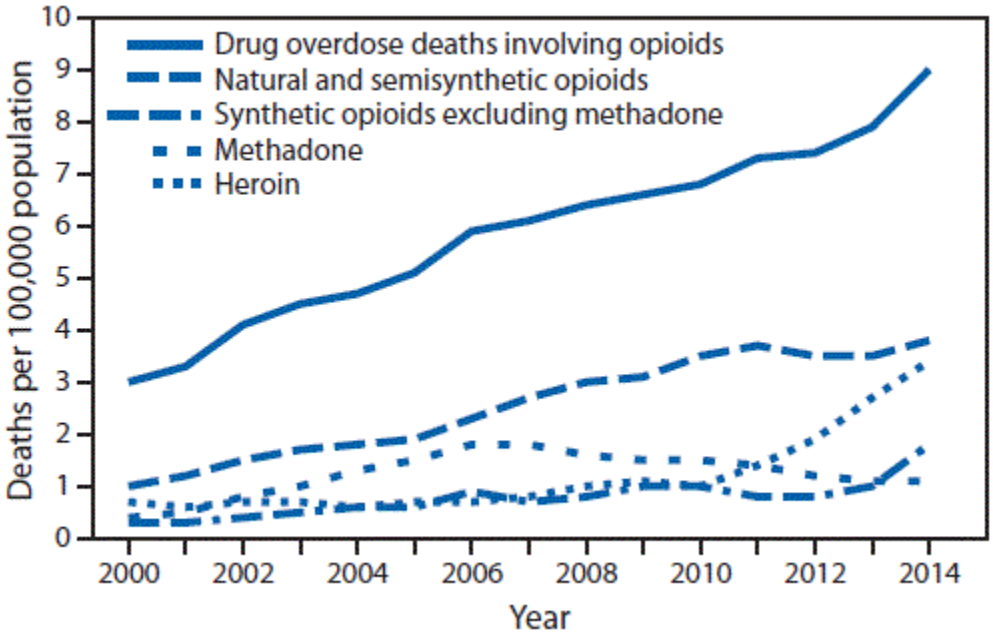
Concerned Key Stakeholder

Research indicates that several factors are likely to have contributed to the severity of the current prescription drug abuse problem. They include drastic increases in the number of prescriptions written and dispensed, greater social acceptability for using medications for different purposes, and aggressive marketing by pharmaceutical companies. These factors together have helped create the broad "environmental availability" of prescription medications in general and opioid analgesics in particular.

The ***America's Addiction to Opioid: Heroin and Prescription Drug Abuse*** report continues to illustrate this point, stating that the total number of opioid pain relievers prescribed in the United States has skyrocketed in the past 25 years. The number of prescriptions for opioids (like hydrocodone and oxycodone products) have escalated from around 76 million in 1991 to nearly 207 million in 2013, with the United States their biggest consumer globally, accounting for almost 100 percent of the world total for hydrocodone (e.g., Vicodin) and 81 percent for oxycodone (e.g., Percocet).

This greater availability of opioid (and other) prescribed drugs has been accompanied by alarming increases in the negative consequences related to their abuse. For example, the estimated number of emergency department visits involving nonmedical use of opioid analgesics increased from 144,600 in 2004 to 305,900 in 2008; treatment admissions for primary abuse of opiates other than heroin increased from one percent of all admissions in 1997 to five percent in 2007; and overdose deaths due to prescription opioid pain relievers have more than tripled in the past 20 years, escalating to 16,651 deaths in the United States in 2010.

Drug Overdose Deaths Involving Opioids by Type of Opioid – United States, 2000-2014



Source: National Vital Statistics System, Mortality File

In terms of abuse and mortality, opioids account for the greatest proportion of the prescription drug abuse problem. Deaths related to prescription opioids began rising in the early part of the 21st century. By 2002, death certificates listed opioid analgesic poisoning as a cause of death more commonly than heroin or cocaine.

The Center for Disease Control indicates that states with more opioid pain reliever sales tend to have more drug overdose deaths. Hence, the introduction of new legislation such as I-STOP effective August 27, 2013, requiring most prescribers to consult the Prescription Monitoring Program (PMP) when writing prescriptions for Schedule II, III, and IV controlled substances, was enacted to decrease the number of opioid prescriptions available. Yet, stakeholders feel that a shift has occurring toward greater use of heroin due to a limited supply of prescription opioids on the streets. As well, as demand increases for prescription opioids, costs rise leaving many addicted to turn to the less costly heroin.

According to Substance Abuse and Mental Health Services Administration Center for the Application of Prevention Technologies, the following national and state data sources are available to assist with monitoring, planning and evaluating prevention strategies:

National Data Sources for Heroin-Related Indicators

Date Source	Indicators	Level of Reporting	Link
National Vital Statistics System Mortality Data (NVSS-M)	# of deaths due to heroin overdose, dependence, and abuse	National, State, County	http://www.cdc.gov/nchs/nvss/deaths.htm
Treatment Episodes Data Sets (TEDS)	# of admissions involving heroin # of admissions involving Heroin as the Primary Drug	National, State	http://www.samhsa.gov/data/client-level-data-teds/reports
Uniform Crime Report (UCR)	# of arrests for robberies, burglaries, property, violent crimes, and drug law violations	National, State	https://ucr.fbi.gov/ucr
National Survey on Drug Use and Health (NSDUH)	Lifetime, past-year, and past-month use of heroin (age 12-17, 18-25, 26 or older) Perception of great risk associated with heroin, by age group Drove while under the influence of medication and/or drug	Nation, State	http://www.samhsa.gov/data/population-data-nsduh/reports
Monitoring the Future (MTF)	Lifetime, past-year, past-month use of heroin (among 8th, 10th, and 12 graders)	National, State	http://www.monitoringthefuture.org/

	Perception of harmfulness of heroin use		
Poison Control Centers	# of heroin-related overdose calls	Regional, State	http://www.aapcc.org/data-system/

5.1.1 Local Data

Although national data is prevalent, local data continues to be a challenge for planning and monitoring purposes. Most county-level data reported by national and/or state entities are less useful due to the indicator estimates available from them are often unstable or suppressed given the low case counts. Local providers are working diligently to capture key data points for better surveillance, yet data is often difficult to obtain in a timely and accurate manner.

Local Key Stakeholders identified the following data points and local resources as important for planning and monitoring:

- Hospital and Emergency Department Data
- Death Certificates or Autopsy Reports
- Prescription Drug Monitoring Programs
- Police Department Arrest Records
- Narcan Distribution/Use Reports
- School Safety and The Education Climate (SSEC) Data Reports
- Drug Court Data
- Risk and Protective Factor Survey Data
- Family Court Data- including Child Protective Services Filings
- Probation Department Data; including Pre-Sentencing and Planning Information
- Alcohol and Substance Abuse Service Provider Utilization Data
- Local Health Care Provider Prescribing Practices
- Maternal/Child Health Data for Neonatal Abstinence Syndrome (NAS)/Neonatal Opioid Withdrawal Syndrome (NOWS) - Neonatal Abstinence Syndrome (NAS) refers specifically to neonatal withdrawal from opioids. Common opioids that can lead to NAS include short acting opioids including hydromorphone, oxymorphone, morphine, oxycodone, codeine and heroin, and long acting opioids including methadone and buprenorphine. NAS describes a constellation of symptoms including CNS irritability, autonomic instability, and GI dysfunction. NAS occurs in 55-94% of infants exposed to opiates and varies in severity from mild to life-threatening. Clinical signs and symptoms of NAS depend on multiple factors including the type of opioid the infant was exposed to,

timing of exposure before delivery, maternal health, and maternal and infant metabolism.

5.1.2 New York State Department of Health

In accordance with the recommendations of New York State Heroin and Opioid Task Force Report and Governor's Cuomo's recently enacted legislation, the New York State Department of Health (NYSDOH) is providing opioid overdose information (deaths, emergency department (ED) visits, and hospitalizations) by county in a quarterly report. The reported cases are based on the county of the resident. Opioids include both prescription opioid pain relievers such as hydrocodone, oxycodone, and morphine, as well as heroin and opium. It is important to note that the report does not fully capture the burden of opioid abuse and dependence in New York State.

The New York State Department of Health also identifies that the report has some data limitations. Significant time lag in the electronic reporting of death certificates and patient information to the NYSDOH impact data completeness. For instance, due to factors like toxicology tests, overdose mortalities take time to be confirmed. As a result, the mortality numbers in this report may not reflect all deaths that have occurred within a given quarter.

Therefore, data provided in the report are not considered complete by the NYSDOH and should be used and interpreted with caution. Mortality, hospitalization, and ED quarterly data may change as deaths, hospitalizations, and ED visits are confirmed and reported. Subsequent reports may contain frequencies for a quarter which differ from the previous report as they reflect additional confirmations and updates. Additionally, due to the small frequencies, rates should be interpreted with caution. When rates are based on only a few cases, small changes in frequencies can produce large changes in the rates making it difficult to discern true changes from chance fluctuation.

The first of these reports was released in October 2016 entitled **New York State- County Opioid Quarterly Report for Counties Outside of New York City**. The purpose of the report is to support county-level decision making and planning.

6 ALLEGANY COUNTY STATE OF PREVENTION

6.1 Heroin and Opioid Prevention Assets

I. Allegany Council on Alcoholism and Substance Abuse, Inc. (ACASA)

Aligning with the NYS Department of Education standards, the Allegany Council on Alcoholism and Substance Abuse, Inc., Prevention Education Department, provides evidence-based or best-practice strategies when working with youth, adults and families. School-based programs include:

- **Here's Looking At You** (Grades K – 12)
  This curriculum is a research based, mixed-media prevention program focused on the gateway drugs of alcohol, nicotine, and marijuana. Here's Looking At You is designed to promote healthy norms, increase protective factors, and reduce risk factors that have been correlated with drug use. The program was developed around three components: giving students current and accurate information, teaching them social skills, and providing opportunities for them to bond with their school, their families, and their community.
- **Botvin's "Life Skills Training** (Grades 6-8)-
  Botvin *LifeSkills Training* (LST) is a research-validated substance abuse prevention program proven to reduce the risks of alcohol, tobacco, drug abuse, and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviors. This comprehensive and exciting program provides adolescents and young teens with the confidence and skills necessary to successfully handle challenging situations.
- **Too Good for Drugs**
  Social Emotional Learning concepts are infused with established theories of Social Development, Social Learning, and Normative Education to build protective factors and mitigate risk factors for substance abuse. A knowledge base of the negative health effects of substance use, including the misuse of prescription opioids and over-the-counter medications and electronic nicotine delivery systems.
- **Family Education**
  ACASA's Clinic provides multidisciplinary treatment to individuals living with alcoholism and other drug addiction. Through the process, family members and friends often feel helpless, confused, hurt and stressed. Recognizing the impact of opioid and heroin abuse on the family, ACASA facilitates a family education program to assist family members to better understand the addiction process, strategies to help the person living with an addiction without negative enabling, and the importance of positive enabling and self-care.

"Community and family education is critical so families know the signs and symptoms of heroin and opioid use. I had no idea what to look for. Spoons were disappearing and I'd find them in my loved-one's bedroom. Little did I know that that was a warning sign!"

Allegany County Concerned Mother

II. Ardent Solutions, Inc.

A. Chronic Pain Self-Management Program

Learning how to manage pain so that you can get on with living a satisfying fulfilling life can represent a daily challenge for those faced with chronic pain. The Chronic Pain Self-Management Program is a workshop given two and a half hours, once a week, for six weeks, in community settings such as senior centers, churches, libraries and hospitals. Workshops are facilitated by two trained leaders, one or both of whom are peers with chronic pain themselves.

B. STAMP Out Prescription Drug Misuse and Abuse Program

The *STAMP Out Prescription Drug Misuse & Abuse Program* is a resource from Ardent Solutions, Inc., in partnership with the University at Buffalo School of Pharmacy and Pharmacy Sciences, which educates seniors, caregivers, families, and community-based senior services providers about prescription drug misuse and abuse in older adults. Presentations, electronic monitors messaging, and handouts targeting older adults and caregivers in the community on ways to improve safe medication use.

III. Allegany County Department of Social Services

A. Preventative Services

When the Allegany County Department of Social Services Child Protective Services unit finds actual or potential child abuse or neglect, the Department strives to prevent future problems by providing services to the family. Such services generally include home visits and parenting information and assistance, with specialized instruction or assistance in other areas provided as needed. Services are provided by trained caseworkers from the Department of Social Services and partner agencies.

IV. Partners for Prevention in Allegany County (PPAC)

A. Town Hall Meetings

PPAC hosts Town Hall Meetings throughout Allegany County to educate communities about underage drinking and other key issues, including opioid and heroin abuse, with the purpose of mobilizing residents around prevention efforts.

B. Family Matters

Family Matters, a committee of PPAC, focuses on building family attachment emphasizing a strong family unit where enduring relationships are established and thrive. Family attachment builds strong connections between adults and children laying the foundation for lifelong emotional regulation and well-being leading to positive behaviors, self-confidence and healthy relationships with other.

C. School Nurses Network of Allegany County (SNNAC)

Since 2007, the School Nurses Network of Allegany County (SNNAC) has been collaborating to build a bridge of communication between school nurses and the local community.

V. Self-Help Groups

A. Narcotics Anonymous

Narcotics Anonymous is a global, community-based organization with a multi-lingual and multicultural membership. NA offers recovery from the effects of addiction through working a twelve-step program, including regular attendance at group meetings. The group atmosphere provides help from peers and offers an ongoing support network for addicts who wish to pursue and maintain a drug-free lifestyle. Narcotics Anonymous, is not meant to imply a focus on any particular drug; NA's approach makes no distinction between drugs including alcohol. Membership is free, and NA has no affiliation with any organizations including governments, religions, law enforcement groups, or medical and psychiatric associations.

The following table illustrates Narcotics Anonymous meeting across the Southern Tier that may be supportive for Allegany County residents:

NA Group Name	Day(s) of Week	Time	Location	Meeting Type
Sunday Night Clean & Serene	Sunday	7:30-9:00p.m.	First Baptist Church 133 South Union Street Olean, NY 14760	Open Open Discussion No Smoking
Soul Searchers	Sunday	7:00-8:30p.m.	Kinship House 30 Rumsey Street Bath, New York 14810	Basic Test Study Meeting It Works How & Why Tradition Study No Pets
	Sunday	1:30p.m.	Colonial Village 3974 Route 417, Lot 108 Allegany, NY 14706	N/A
Lost Dreams Awaken	Sunday	7:00-8:30p.m.	Noyes Hospital 44 Red Jacket Street Dansville, NY 14437	Basic Test Study Meeting It Works How and Why Traditional Study No Pets
	Sunday	7:00p.m.	Franklinville Free Methodist Church 41 South Main Street Franklinville, NY 14737	
Never Alone Never Again	Sunday Tuesday Saturday	7:00-8:00p.m.	First Lutheran Church 120 Chandler Street Jamestown, NY 14701	Open Basic Text Study Meeting No Smoking No Court Papers Signed
Our Choice	Monday* Thursday** Friday*** Saturday	7:00-8:00p.m. 11:00a.m.-Noon	WCA Hospital 2nd Floor Auditorium 207 Foote Avenue Jamestown, NY 14701	Open No Smoking Wheelchair Accessible *It Works How and Why Book Study **Candlelight Meeting *** Ask It Basket
Spiritual Footsteps	Monday	7:00p.m.	St. Tomas Church 122 Liberty Street Bath, NY 14810	N/A
	Monday	7:00p.m.	Trapping Brook House 3084 Trapping Brook Rd. Wellsville, NY 14895	Open
Time for a Change	Monday Friday	7:30-9:00p.m.	1st Baptist Church 133 Union Street Olean, NY 14760	Open No Smoking Wheelchair Accessible
Recovery Starts Here	Tuesday	7:00-8:30p.m.	Free Methodist Church 25 Franklin Street Dansville, NY 14437	Basic Text Open Discussion Living Clean Speaker Tradition Study

Back to Basics	Tuesday	7:00-8:30p.m.	Senior Center 20 Broadway Mall Hornell, NY 14843	Literature Open Discussion
Recovery on the Hill	Tuesday	7:00-8:30p.m.	St. Tomas Church 122 Liberty Street Bath, NY 14810	Basic Text Topic Basket Information Pamphlet Speaker
Recovery at Work	Tuesday Saturday	7:30-9:00p.m.	St. Stevens Church 109 Berry Street Olean, NY 14760	Open Open Discussion No Smoking
A Vision of Hope	Wednesday Wednesday	1:00-2:00p.m. 7:30-9:00p.m.	1st Baptist Church 133 Union Street Olean, NY 14760	Open No Smoking Wheelchair Accessible Step Working Meeting
Just for Today	Wednesday	7:00-8:00p.m.	The Relief Zone 5 Frew Run Frewsburg, NY 14738	Open Open Discussion No Smoking
	Wednesday Friday	11:30a.m. Noon	Allegany Council 5956 Airway Rd. Wellsville NY 14895	Open
	Thursday	8:00p.m.	United Methodist Church 79 Madison Street Wellsville, NY 14895	Basic Test Discussion/Participation Closed (Addicts Only)
Keeping It Green	Wednesday	7:00-8:30p.m.	St. Tomas Church 122 Liberty Street Bath, NY 14810	Basic Text Information Pamphlet Open Discussion Wheelchair Accessible No Smoking
Recovery on the Rez	Wednesday	7:30-8:30p.m.	Free Methodist Church 287 Center Street Salamanca, NY 14779	Open Open Discussion No Smoking
Unity of Action and Purpose	Thursday	7:30-9:00p.m.	Cornerstone Church 118 Brookview Avenue Olean, NY 14760	Open Basic Text Study Meeting No Smoking
The Nooner	Thursday	12:00-1:30p.m.	CASA Building 141 Main Street Dansville, NY 14437	Basic Text Wheelchair Accessible
	Thursday Saturday	8:00p.m. 7:00p.m.	ICS 24 Maple Avenue Wellsville, NY 14895	Open
Vision of Hope	Thursday	7:00-8:30p.m.	Free Methodist Church 60 Washington Street Hornell, NY 14843	Basic Text

Golden Links	Thursday	7:00-8:30p.m.	Ira Davenport Hospital Route 54 Bath, NY 14810	Step Study It Works How and Why No Pets No Smoking Security Camera
NA in Nunda	Thursday	7:00p.m.	United Methodist Church 26 East Street Nunda, NY 14517	N/A
Stairway to Serenity	Friday	7:00-8:30p.m.	Free Methodist Church 25 Franklin Street Dansville, NY 14437	Literature Speaker Open Discussion
Recovery at Work	Friday	7:00-8:30p.m.	St. Tomas Church 122 Liberty Street Bath, NY 14810	Living Clean Closed (Addicts Only)
	Friday	7:30p.m.	Lutheran Church Fassett Lane Wellsville, NY 14895	Closed (Addicts Only)
Saturday Night Live	Saturday	7:00p.m.	St. Tomas Church 122 Liberty Street Bath, NY 14810	N/A
New Beginnings	Saturday	7:00-8:30p.m.	Salvation Army 95 Seneca Street Hornell, NY 14843	It Works How and Why

Self-Help Groups may change overtime. To stay informed about Narcotics Anonymous meetings, visit: www.naws.org/meetingsearch/

B. Celebrate Recovery

Celebrate Recovery is a faith-based recovery program with foundations based on biblical scripture. The program is welcoming to anyone who wishes to overcome hurt, hang-ups, and habits. Meetings occur locally at the Yorks Corners Mennonite Church, 3350 County Road 29, Wellsville, New York 14895.

6.1.1 Enhancement Strategies

I. I-STOP/PMP – Internet System for Tracking Over-Prescribing- Prescription Monitoring Program

Effective August 27, 2013, most prescribers are required to consult the Prescription Monitoring Program (PMP) Registry when writing prescriptions for Schedule II, III, and IV controlled substances. The PMP Registry provides practitioners with direct, secure access to view dispensed controlled substance prescription histories for their patients. The PMP is available 24 hours a day/7 days a week via an application on the Health Commerce System (HCS) at https://commerce.health.state.ny.us. Patient reports will include all controlled substances that were dispensed in New York State and reported by the pharmacy/dispenser for the past six months. This information will allow practitioners to better evaluate their patients' treatment with controlled substances and determine whether there may be abuse or non-medical use.

6.1.2 Proper Disposal Strategies

I. Partners for Prevention in Allegany County (PPAC)

Partners for Prevention in Allegany County (PPAC) is a Drug-Free Communities Coalition of businesses, prevention specialists, youth, parents, law enforcement, civic volunteers, fraternal and religious organizations, governmental and elected leaders, healthcare professionals, school, media, veterans human service organizations and youth serving organizations. PPAC's mission: *We are coalition of concerned individuals who care about the health and wellness of our children, families, schools, and communities. We strive to reduce those risk factors that lead to alcohol and drug abuse, teen pregnancy, violence and school dropout. We are empowering Allegany County New York to collaboratively work together to create a healthy environment for our youth while encouraging positive change.*

A. Prescription Drug Take-Back Program Events

Collaborating with local law enforcement agencies, Prescription Drug Take-Back Initiative aims to provide a safe, convenient, and responsible means of disposing of prescription drugs, while educating the general public about the potential of abuse of medication.

B. Permanent Pill Drop Location:

Alfred State University Police, Theta Gamma House, 10 Upper College Drive, Alfred, NY 14802
Allegany County Sheriff's Office, 4884 State Route 19, Belmont, NY 14813
Cuba Police Department, 15 Water Street, Cuba, NY 14727
Fillmore Pharmacy, 10560 State Route 19, Fillmore, NY 14735
Jones Memorial Hospital, 191 North Main Street, Wellsville, NY 14895
Wellsville Police Department, 46 South Main Street, Wellsville, NY 14895

6.1.3 Law Enforcement

I. STOPP – Southern Tier Overdose Prevention Program

The Southern Tier Overdose Prevention Program (STOPP), a program of Southern Tier Health Care System, is a community-based opioid overdose prevention and Narcan distribution program supported by the New York State Department of Health and amfAR. Through its STOPP program, Southern Tier Health Care System provides free training in the use of Narcan and free Narcan kits to non-EMS firefighters, basic life support first responders, members of law enforcement and the friends and family members of those most likely to suffer an overdose from heroin and prescription opiates like oxycodone. STOPP was created to save lives.

Participants in Narcan training learn how to:

- Recognize the signs and symptoms of overdose
- Distinguish between different types of overdose
- Perform rescue breathing
- Call emergency medical services
- Administer intranasal Narcan

As of November 2016, the following entities have received STOPP training:

EMS	**Law Enforcement**
Andover Fire Department	Allegany County Sheriff's Office
Friendship Fire and Ambulance	

Additional individuals representing Allegany County health and human service agencies have attended training independently.

II. Partners for Prevention Allegany County (PPAC)

Partners for Prevention Allegany County's Environmental Strategies Committee addresses alcohol policy, and evidence-based strategies to reduce intoxication and the availability of alcohol, tobacco, marijuana, prescription drugs, and illegal drugs. The committee also works to change social norms around attitudes about behavior of alcohol and drug use. The committee, primarily composed of law enforcement representatives, implements the Allegany County Pill Drops, Underage Drinking Deterrence Initiative, Meth Busters campaign, Tips Training, and increases media awareness preventing drunk and drugged driving.

III. Police Assisted Addiction and Recovery Initiative (P.A.A.R.I)

Police Assisted Addiction and Recovery Initiative (P.A.A.R.I) is a national movement to support local law enforcement agencies to work with opioid addicts. Its purpose is to transition from arrest and punitive solutions to the opioid epidemic to a recovery enhanced model. P.A.A.R.I committed police department encourage opioid drug users to seek recovery, help distribute lifesaving opioid blocking drugs to prevent and treat overdoses, connect addicts with treatment programs and facilities, and provides resources to other police departments and communities that want to do more to fight the opioid addiction epidemic.

Western New York law enforcement agencies participating in P.A.A.R.I include:

- Amherst Police Department
- Buffalo Police Department
- Cattaraugus County Sheriff's Office
- Depew Police Department
- Erie County Sheriff's Office
- Gowanda Police Department
- Lancaster Police Department
- Buffalo-Niagara NFTA Transit Police Department
- Niagara Fall Police Department
- Salamanca Police Department

6.2 Prevention Strengths

1. The Council on Alcoholism and Substance Abuse, Inc., reports that Prevention Education Services are available to all Allegany County School Districts.

2. Social Media platforms; i.e. Facebook, Twitter, etc., are widely utilized by organizations to reach the community-at-large and segmented paid advertising to target audiences.

3. Non-traditional resources; i.e. faith-based organizations, worksites, etc., have joined efforts to prevent heroin and opioid use, abuse and addiction. Many support Narcotics Anonymous

(NA) Support Groups by hosting meetings, while others embrace those struggling with addiction through faith-based programs.

4. Although local law enforcement does not currently partner with the national Police Assisted Addiction and Recovery Initiative, many embrace supporting recovery as a means to end the opioid epidemic versus the traditional punitive strategies.

6.3 Prevention Challenges

1. Although NYS Department of Education has mandated modernization of health education standards to include opioid and heroin education, Common Core standards often overshadow health education in the classroom.

2. Funding continues to be flat lined for prevention education programs and eliminated for school-based supports; i.e. Resource Officers.

3. Stigma associated with heroin and opioid use and abuse, as well as addiction in general, often prevent individuals and families from asking for help.

4. Prescribers' messaging about prescription disposal may contradict safe medication disposal messaging. This may be due to costs of medications where patients are instructed to "hold on" to prescriptions rather than dispose of them in case they need them again in the future.

5. Screening is one strategy to help identify individuals at-risk for drug addiction and link him/her to early treatment. To be successful, healthcare professionals must commit to an evidence-based clinical tool and build skills/infrastructure. SBIRT (Screening, Brief Interventions, and Referral to Treatment) training has been offered through the Allegany Council on Alcoholism and Substance Abuse, Inc., with limited participation from the healthcare field.

6. Mandatory Drug Testing is a strategy that the judicial system implements to monitor drug activity in defendants with the ultimate purpose of reducing risks of pretrial and parolee misconduct. Yet, key stakeholders' report that results of mandatory drug testing, although logical in concept, often fail and are very costly to not only the system, but also to families.

"The system is being manipulated over and over. Mandatory drug testing is not taken seriously. Individuals will walk into an appointment at probation or with the courts and openly say I've been using. The only consequence is to send them back to jail. Or they circumvent services that would benefit the family unit to avoid testing."

Concerned Key Stakeholder

7. Sustainment of prevention efforts is a continuous battle. Measuring prevention strategies' impact on opioid and heroin use can be challenging. Funding is often focused on the high cost of treatment services.

8. Although key stakeholders and those in recovery understand the vital importance of naloxone or Narcan for the emergency treatment of a known or suspected opioid overdose, many question the lack of criminal consequences and feel it enables the addiction.

"There are no laws that require someone to enter into drug treatment or be assessed after they have been 'Narcanned'. Mental Health laws provide the option for involuntary treatment or a 72 hour hold and pick-up order if someone is deemed to be a risk to themselves or to others. It's ironic that a heroin overdose, or multiple heroin overdoses by the same person in the same day, is not legally deemed to be a risk."

Concerned Key Stakeholder

6.4 Prevention Opportunities

1. For individuals already using heroin, research suggests that risk reduction programs are vital. Strategies to prevent heroin overdose include:

- **The MORE Project** (Bowser, Jenkins-Barnes, Dillard-Smith, & Lockett, 2010). This program promotes harm reduction among current heroin users through street outreach, risk-reduction education, discussion sessions, and psychological counseling.

- **Overdose Education and Naloxone Distribution Programs** (OEND; Doe-Simkins et al., 2014; Green, Heimer, & Grau, 2008; Jones, Roux, Stancliff, Matthews, & Comer, 2014; Kerr, Kelly, Dietze, Jolley, & Barger, 2009; Walley et al., 2013). These programs expand education and access to antidotes that can reduce mortality from overdose.
- **Determining Cost-Benefits of Prevention Programs.** The cost-benefit of prevention services can assist providers in advocating for funds and demonstrate the importance of prevention in the continuum of service provision.
- **Pharmacy Collaborations.** According to the **National Safety Council**, nearly half of opioid painkiller users are unaware that these drugs are as addictive as heroin. Increasing health literacy appropriate information regarding opioid abuse at pharmacies can better inform patients about their potential risks for addiction. As well, the Academy of Pharmacy Practice and Management recognizes the pharmacists' essential role in opioid overdose prevention and advocates for greater collaboration. Pharmacists are ideally positioned to contribute to the following U.S. Department of Health & Human Services priorities to address opioid overdose, death, and dependence: improving prescribing practices, identifying high-risk individuals, ensuring access to medication-assisted therapy (buprenorphine and methadone), and expanding use of naloxone. McLaughlin, Bill, and Scott Brewster. "Opioid Overdose Prevention." Journal of the Merican Pharmacists Association. By Jeffrey Bratberg. Vol. 55:5. N.p.: JAPhA, 2015. 14-17. Sept.-Oct. 2015. Web. 7 Nov. 2016.

2. **Educational and Multicomponent Evidence-Based Programs** for prevention approved by the New York State Office of Alcoholism and Substance Abuse Services can be found on the NYS OASAS website (https://oasas.ny.gov/prevention/evidence/EBPSList.cfm).

3. **Addiction Prevention Campaigns** can assist providers to deliver prevention messaging across all segments of the population. Three notable NYS Campaigns that are available for local replication include:

Kitchen Table Toolkit: Developed to assist parents, teachers, counselors and the community with guidance on how to initiate conversations about heroin and opioid abuse. The information in the toolkit may also be applicable for alcohol and other drugs. Videos and guidance documents were developed to assist with a community forum or a personal conversation.

Talk2Prevent Parent Toolkit: Parental disapproval of underage drinking and drug use is the #1 reason kids choose not to drink or use drugs. This toolkit focuses on how to initiative conversations about alcohol use early and often.

Text2Talk Parent Toolkit: This toolkit provides parents and adults guidance on texting with teens to connect and continue communicating about alcohol and its risks.

4. Although **Mandatory Drug Testing** has shown to have limitations in the criminal justice system, studies suggest that randomized testing in schools and workplaces are a proactive prevention technique.

A. The Drug Free America Foundation, Inc. reports that schools who drug test provide students a reason to say "no" when approached to use drugs. Additional outcomes cited include:

- Random drug testing applies only to students who volunteer to participate in extracurricular activities such as athletics or, in some schools, to student drivers.
- Students who take leadership roles in the school community are role models and should be drug free.
- Random student drug testing occurs during a medically valid time to intervene because youth become addicted more easily than adults, and their recovery is more difficult.
- Most students don't use drugs and have a right to safe and drug-free learning environments. School administrators need reasonable tools to stop drug users and drug dealers from ruining school for everyone.
- Testing gives parents an opportunity for early intervention and treatment.

B. Drug use in the workplace have both financial and productivity consequences. According to the Drug Free America Foundation, Inc., a company can expect to experience higher absenteeism and more job-related accidents because of employees' drug use. In addition:

- A company can expect to experience higher absenteeism and more job-related accidents because of employees' drug use.
- Business owners lose an estimated $100 billion per year because of substance abuse.
- Employees who use drugs are only two thirds as productive as nonusers, and their use contributes to increased thefts, damaged equipment and other unnecessary costs in the workplace.
- According to the U.S. Department of Labor, one in five workers report that they have had to work harder, redo work or cover for a co-worker, or have been put in danger or injured as a result of a fellow employee's drinking.
- Small business owners are especially vulnerable because they often do not have an established drug-free workplace policy, do not require new employees to submit to drug testing prior to employment and have smaller financial reserves to expend if an employee causes a job-related accident or injury while impaired

Research of workplace drug testing effectiveness shows the following results:

- Employers have seen a decrease in workplace accidents, employee mistakes, absenteeism, and turnover after implementing testing.
- Businesses in many states may also qualify for a 5 percent discount or more on their workers' compensation premiums.
- Businesses that implement a drug free workplace policy improve the working environment, employee morale and customer satisfaction.
- Clear, consistent workplace substance abuse policies and employee drug education can: (1) create an informed workforce; (2) significantly reduce drug and alcohol abuse problems in the workplace; and (3) reach employees, their families, and their communities.

7 ALLEGANY COUNTY STATE OF TREATMENT

7.1 Asset Map

The following table provides an in-depth review of programs and services licensed through the Office of Alcohol and Substance Abuse Services (NYS OASAS) to provide various levels of treatment accessible to Allegany County residents. Referrals and assessments are required to determine eligibility and appropriate level of care. Insurance payers are notified of the patient's desire for treatment and determines whether the request is either denied or approved through submitted documentation.

Provider	Summary	Payment Type
Allegany Council on Alcoholism and Substance Abuse, Inc. 2956 Airway Road Wellsville, NY 14895	Alcohol and Drug Dependency Services including outpatient clinics in Wellsville and Cuba, NY, Community Residential Program for males, and Supportive Living Program for males.	Self-Pay Medicaid Medicare Private Health Insurance
Cattaraugus County Council on Addiction Recovery Services 201 South Union Street Olean, NY 14760	Alcohol and Drug Dependency Services including outpatient clinics in Olean, Gowanda, Machais, Salamanca, and Randolph, NY; Community Residential Program for males, and Supportive Living Program.	Self-Pay Medicaid Medicare Private Health Insurance
Alcohol and Drug Dependency Services 291 Elm Street Buffalo, NY 14203	Alcohol and Drug Dependency Services Detoxification drug rehab with a primary focus on Substance abuse treatment and drug rehab. Specializing in Residential short-term Sober Living (30 days or less), Residential long-term substance abuse treatment program Sober Living (more than 30 days).	Self-Pay Medicaid Medicare Private Health Insurance

Community Action Organization/Erie County Dart Program 1237 Main Street Buffalo, NY 14209	The Drug Abuse, Research & Treatment (DART) Program is a Methadone Maintenance Treatment Clinic serving Erie County.	Medicare Medicaid Private Insurance Self-Pay
Freedom Village for Veterans 291 Elm Street Buffalo, NY 14203	"Freedom Village" is a Veterans Treatment Center providing intensive chemical dependency treatment to men who have served in the military, incorporating specialized individual and family services for those who also may have post-traumatic stress disorder (PTSD) or mental health issues.	Medicare Medicaid Private Insurance Self-Pay
Lake Shore Behavioral Health, Inc. The Lighthouse Women's IR 232 Hempstead Avenue Buffalo, NY 14215	The Lighthouse provides a supportive recovery environment for pregnant and parenting women with children in need of a Residential Substance Abuse Treatment Facility	Medicare Medicaid Most Private Insurance Self-Pay
Horizon Village, Inc. 291 Elm Street Buffalo, NY 14203	Horizon Village Terrace House is a 31-bed inpatient residential, medically supervised treatment facility. We provide twenty-four hour care to men and women who need support, counseling, observation, nursing and medical care to achieve initial stabilization from drug and/or alcohol withdrawal.	Medicare Medicaid Private Insurance Self-Pay

Alcohol and Drug Dependency Services 107 Delaware Avenue Buffalo, NY 14202	Alcohol and Drug Dependency Services Detoxification drug rehab with a primary focus on Substance abuse treatment and drug rehab. Specializing in Residential short-term Sober Living (30 days or less), Residential long-term substance abuse treatment program Sober Living (more than 30 days). Outpatient drug rehab, Substance abuse day treatment program.	Self-Pay Medicaid Medicare Private Health Insurance
CAO/Drug Abuse Research and Treatment Program 1237 Main Street Buffalo, NY 14209	CAO/Drug Abuse Research and Treatment Program Detoxification drug rehab with a primary focus on Substance abuse treatment and drug rehab. Specializing in Outpatient Substance Abuse Treatment and Drug Rehab Program	Self-Pay Medicaid
City View Treatment Center Sheehan Memorial Hospital 425 Michigan Avenue Buffalo, NY 14203	City View Treatment Center Sheehan Memorial Hospital Detoxification drug rehab with a primary focus on Substance abuse treatment and drug rehab. Specializing in Residential short term drug rehab program sober living (30 days or less), Residential long term drug rehab treatment sober living (more than 30 days), Outpatient drug rehab, Partial hospitalization drug rehab/Substance abuse day treatment	Self- Pay Medicaid Medicare State Financed Insurance (other than Medicaid) Private Health Insurance Military Insurance (VA, TRICARE)

Erie County Medical Center 462 Grider Street Buffalo, NY 14215	Erie County Medical Center Detoxification drug rehab with a primary focus on Substance abuse treatment and drug rehab. Specializing in Residential short term drug rehab program sober living (30 days or less), Residential long term drug rehab treatment sober living (more than 30 days), Outpatient drug rehab, Partial hospitalization drug rehab/Substance abuse day treatment. Services include Detoxification and Methadone Detoxification	Self-Pay Medicaid Medicare State Financed Insurance (other than Medicaid) Private Health Insurance
VA Western NY Healthcare System 3495 Bailey Avenue Buffalo, NY 14215	VA Western NY Healthcare System Detoxification drug rehab with a primary focus on Substance abuse treatment and drug rehab. Specializing in Hospital inpatient drug program, Residential short term sober living (30 days or less), Residential long term sober living (more than 30 days), Outpatient drug rehab, Partial hospitalization drug treatment, Substance abuse day treatment. Services provided include detoxification, Methadone Maintenance, Methadone Detoxification.	Medicaid Medicare State Financed Insurance (other than Medicaid) Private Health Insurance Military Insurance (VA, TRICARE)
DePaul Addiction Services Detoxification Services 774 West Main Street Rochester, NY 14611	DePaul Addiction Services Detoxification Services Detoxification drug rehab with a primary focus on Substance abuse treatment	Self-Pay Medicaid Private Health Insurance Military Insurance (VA, TRICARE)

	and drug rehab. Specializing in Residential short term drug rehab program sober living (30 days or less), Residential long term drug rehab treatment sober living (more than 30 days), Outpatient drug rehab, Substance abuse day treatment. Services provided include substance abuse treatment, detoxification, Methadone Maintenance, Methadone Detoxification.	
Unity Chemical Dependency Outpatient 1565 Long Pong Road Rochester, NY 14626	Unity Chemical Dependency Outpatient Detoxification drug rehab with a primary focus on Substance abuse treatment and drug rehab. Specializing in Hospital inpatient drug rehab, Hospital inpatient substance abuse program, Outpatient drug rehab, Partial hospitalization drug rehab/Substance abuse day treatment. Services provided include substance abuse treatment and detoxification.	Self-Pay Medicaid Medicare State Financed Insurance (other than Medicaid) Private Health Insurance
Unity Chemical Dependency Adolescent Treatment Program	Unity Chemical Dependency Adolescent Treatment Program includes outpatient and residential care focused specifically on the adolescent.	Self-Pay Medicaid Medicare State Financed Insurance (other than Medicaid) Private Health Insurance
Hope Haven The Jerome Center 16 Bank Street, 2nd floor Batavia, NY 14020	Hope Haven is a 20 bed inpatient Chemical Dependency Unit that provides assessment, 24	Self-Pay Medicaid Medicare State Financed Insurance (other

	hour medical monitoring, recreational therapy, and recovery services.	than Medicaid) Private Health Insurance
Unity Health System Park Ridge Hospital, Inc. Chemical Dependency Building Rochester, NY 14626	Unity Health System Park Ridge Hospital, Inc., Detoxification drug rehab with a primary focus on Substance abuse treatment and drug rehab. Specializing in Outpatient Substance Abuse Treatment and Drug Rehab Program. Services provided include substance abuse treatment and detoxification.	Self-Pay Medicaid Medicare State Financed Insurance (other than Medicaid) Private Health Insurance
Veterans' Outpatient Clinic 465 Westfall Road Rochester, NY 14620	Veterans Outpatient Clinic Detoxification drug rehab with a primary focus on Mental health services and drug rehab. Specializing in Outpatient Substance Abuse Treatment and Drug Rehab Program. Services provided include substance abuse treatment and detoxification.	Self-Pay Private Health Insurance Military Insurance (VA, TRICARE)
Finger Lakes Addictions Counseling and Detoxification Rehab 28 East Main Street Clifton Springs, NY 14432	Finger Lakes Addictions Counseling and Detoxification drug rehab with a primary focus on substance abuse treatment and drug rehab. Specializing in Residential short-term drug rehab program sober living (30 days or less), Residential long-term drug rehab treatment sober living (more than 30 days), Outpatient drug rehab, and Substance abuse day treatment. Services	Self-Pay Medicaid State Financed Insurance (other than Medicaid) Private Health Insurance Military Insurance (VA, TRICARE)

	provided include substance abuse treatment and detoxification.	
Behavioral VA Healthcare Line 400 Fort Hill Avenue Canandaigua, NY 14424	Behavioral VA Healthcare Line Detoxification drug rehab with a primary focus on Mental health services and drug rehab. Specializing in Residential short-term drug treatment sober living (30 days or less), Residential long-term drug rehab treatment sober living (more than 30 days), Outpatient drug rehab, Substance abuse day treatment. Services include substance abuse treatment and Detoxification.	Self-Pay Private Health Insurance Military Insurance (VA, TRICARE)
WCA Hospital 207 Foote Avenue Jamestown, NY 14701	The WCA Inpatient Chemical Dependency Program functions as a sub-acute care, 13-bed, intensive inpatient facility.	Medicaid Medicare Most Private Insurance including Fidelis and Blue Cross Blue Shield Self-Pay
Renaissance Addiction Services 920 Harlem Road West Seneca, NY 14224	The Renaissance Addiction Services is a Substance Abuse, Opiate Addiction and Alcoholism Treatment Center for youth and adults. Services include medically assisted detox, buprenorphine detox and treatment, residential inpatient treatment, dual diagnosis/co-occurring disorders treatment, and trauma therapy.	Medicaid Self-Pay Commercial Insurances Private Insurances
Loyola Recovery Foundation, Inc. Loyola Detox Unit at the Bath	Loyola Recovery Foundation: Drug Treatment Center is a treatment center	Medicaid State Insurance other than Medicaid

VA Medical Center 76 Veterans Avenue Bath, NY 14810 Loyola Inpatient Rehab Unit 411 Canisteo Street, Floor 3 West Hornell, NY 14843 Loyola Outpatient Rehab Unit 411 Canisteo St., Floor 4 East Hornell, NY 14843	that focuses on detoxification and Methadone detoxification through a medically supervised withdrawal, inpatient hospitalization program, and outpatient rehabilitation. Special services catered to Veterans.	Self-Pay with Sliding Fee Scale Private Insurance
Inpatient Addiction Recovery Program 2 Coulter Road Clifton Springs, NY 14432	Clifton Springs Hospital and Clinic is an Inpatient Addiction Rehabilitation Program providing substance abuse treatment and Buprenorphine services.	Medicaid Medicare Self-Pay Private Insurance State Insurance other than Medicaid
Stutzman Addiction Treatment Center 360 Forest Avenue Buffalo, NY 14213	The Margaret A. Stutzman Addiction Treatment Center is a 33-bed, trauma informed, inpatient residential rehabilitation program. Special treatment services are available for women, pregnant women, and individuals living with a co-occurring mental health diagnosis, parents with children (PATch) Program, and trauma survivors.	Medicaid Medicare Private Insurance State Insurance other than Medicaid Self-Pay No one is turned away for inability to pay
Eastern Niagara Hospital, Inc. Reflections Recovery Centre 521 East Avenue Lockport, NY 14094	Reflections is an intensive, short-term alcohol and other drug 20-bed unit.	Medicaid Medicare Private Insurance State Insurance other than Medicaid Self-Pay Financial Assistance
St. Joseph's Hospital New Dawn STARS 555 St. Joseph's Boulevard	Saint Joseph's Hospital - New Dawn ARU is a treatment facility which	Medicare Medicaid State Insurance other than

Elmira, NY 14901	specializes in substance abuse services providing hospital inpatient detoxification.	Medicaid Military Insurance Access to Recovery (ATR) Voucher Private Insurance Self-Pay No one is turned away for inability to pay
John L. Norris Addiction Treatment Center 1732 South Avenue Rochester, NY 14620	The John L. Norris Addiction Treatment Center operates a 44-bed, inpatient, addiction treatment program with services available for those who are deaf and hard of hearing.	No individual will be denied access based on inability to pay

7.2 Treatment Strengths

1. Many programs and services provide treatment for co-occurring disorders simultaneously rather than concurrently; i.e. mental health and substance abuse dual diagnosis. This potentially decreases the patient's length of stay and addresses the person holistically.

2. Families and caregivers are not viewed as "collateral," but as a vital component of the recovery process. Providers, such as ACASA, welcome families and concerned residents for educational counseling sessions.

> *"Prevention, treatment and recovery services are not only needed for the abuser, but for the children and family too."*
>
> Concerned Family Member

7.3 Treatment Challenges

1. Health Insurance Portability and Accountability Act establishes national standards for confidentiality prohibiting sharing of health related information between providers without the direct consent of the patient. In some cases, HIPAA prevents continuity of care and perpetuates manipulation of the system.

2. Treatment Providers face workforce shortages that make it challenging to meet the high demands of those searching for help. According to the National Council on Alcoholism and Drug Dependence, Inc., recruitment and retention of qualified addiction treatment workers has long been an issue because of low pay, high burnout rate, and stigma attached to addiction. Turn-over is also an issue for clients who feel frustrated at the lack of continuity of care.

3. Many substance users report that they experience multiple barriers that produce significant challenges to linking with treatment services. Being on a waiting list is frequently mentioned as a barrier, leading some people to give up on treatment and to continue using. Typically the longer substance users have to wait to be admitted to treatment, the more likely they are to not follow through with treatment.

4. Law enforcement officials are developing approaches to traditional and community policing in response to greater possession and trafficking activities, drug-related homicides, and overdose deaths. Law enforcement play a pivotal role in opiate prevention efforts, but some feel that enforcement strategies may lead to greater problems; especially for those who are vulnerable and innocent becoming collateral damage in the war on opioid and heroin abuse. As well, informants may continue their opioid or heroin use to engage with dealers; hence delaying their entry into treatment.

> *"Unfortunately, for many people finding themselves in trouble with the law for heroin or opioid use or sales, law enforcement provides an alternative to jail time by making them an informant. Then, the individual wonders why other consequences occur. Their children are removed by Social Services because of an unsafe home environment. The children often become sexual or physical abuse victims at the hands of those their parents are trying to set-up for the police."*
>
> Concerned Key Stakeholder

5. Although the Affordable Care Act requires private insurance companies and Medicaid to cover substance use disorders, those seeking help are still at the mercy of payers. Patients are required to progress to higher levels of care based on their documented "failure" at lower levels of care. For example, individuals seeking in-patient care must demonstrate that they have "failed" at out-patient care first; which often leads the individual to feel abandoned, hopeless and frustrated.

"Insurance companies make people seeking help "fail out" of less costly treatment strategies to finally be approved for the most appropriate level of care. By the time that occurs, someone may no longer be ready for help or have overdosed."

Concerned Key Stakeholder

6. Allegany County's rural isolation and vast distance to addiction specialty centers is often a barrier to accessing hospital inpatient detoxification, inpatient residential rehabilitation, and medication-assisted opioid addiction treatment. Although state and federal funding allocations have increased to combat the heroin and opioid epidemic, most monies are flowed to urban centers leaving rural communities at the mercy of their urban counterparts.

"There are no local detoxification centers. When people are sent to the urban centers like Buffalo or Rochester, there is no guarantee that they will even be accepted. In fact, people are more likely to receive services if they just show up in the Emergency Department at the larger, urban hospitals rather than having a referral from a local provider."

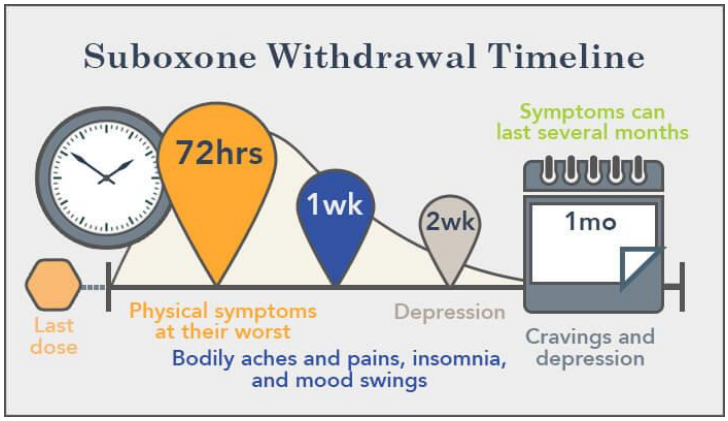
Concerned Key Stakeholder

7. Although state leaders report expanding program slots for substance use disorder by 2,335 in New York, Allegany County struggles to realize the positive impact of new legislation, regulations and funds. The Allegany Council on Alcoholism and Substance Abuse, Inc., reports that program slots do not equivalent to increased funding. The expectation is organizations like ACASA will see more patients with the same amount of funding by simply increasing the case load of already existing counselors.
8. Although transportation and distance to addiction specialty centers can be challenging, others recognize the need for some individuals entering recovery to distance themselves from the current environmental factors that help lead to addiction; home, work/school, peers, and family.

"Putting someone into treatment programs locally is often like providing them with a new drug source and supplier."

Concerned Key Stakeholder

9. Although medication-assisted opioid addiction treatment (MAT) shows significant outcomes for heroin and opioid abusers, medications such as Buprenorphine, Methadone and Suboxone have their own addictive qualities and problems, including withdrawal symptoms.



In Allegany County, only two (2) physicians are recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) as Buprenorphine Treatment physicians; Dr. Reed Haag and Dr. Pasquale Picco. Waiting lists to enter into local MAT practices are substantial due to regulatory practices dictating the number of patients/provider.

Some living in recovery have a different perspective on the use of MAT as a treatment strategy. It was described as an easy-out for those wish to continue to get high without dealing with the underlying root causes or consequences.

> *Subutex and Suboxone is a legal way of getting high. Easy to shoot up, easy to dissolve. Suboxone clinics are a Band-Aid and it's flooding our community with prescriptions. If you don't need a whole table, you can sell the rest on the street.*
>
> Individual Living in Recovery

7.4 Treatment Opportunities

1. **Workforce Strategies**. The U.S. Bureau of Labor Statistics estimates the number of jobs for addiction and behavioral-disorder counselors will rise 22 percent, from 94,900 to 116,200, between 2014 and 2024. In contrast, the number of jobs overall in the United States is expected to grow 6.5 percent during that period. Strategies to increase the availability of local addictions and behavioral-disorder counselors include the *Grow Your Own* method, rural student/resident experiences and rotations in addiction services, workforce ladder

programs supporting clinicians and mid-level providers to pursue advance degrees in the behavioral health field, and broadening the concept of "workforce" to include peers and ancillary providers.

2. **Opioid Treatment Programs.** Only federally authorized doctors and certified Opioid Treatment Programs who have completed appropriate training and the application process are allowed to prescribe medication-assisted opioid addiction treatment. Physician patient limits are set for 30 or 100 patients/approved provider. Physicians who have prescribed buprenorphine to 100 patients for at least one year can apply to increase their patient limits to 275 under new federal regulations.

3. **Recovery Training and Self-Help** (RTSH) is an evidence-based group aftercare program for individuals recovering from opioid addiction. RTSH is based on the principle that opioid addiction, regardless of a person's original reasons for using substances, stems from conditioning due to the reinforcing effects of repeated opioid use. RTSH is designed to deactivate addiction by teaching and supporting alternative responses to stimuli previously associated with opioid use. Program goals include reducing the occurrence and frequency of relapse and re-addiction and helping unemployed participants obtain employment. RTSH features 6 months of twice weekly meetings, regular weekend recreational activities, and a support network for clients. Each RTSH group is co-led by a professional therapist and a group leader in recovery. At one of the weekly meetings, the professional therapist delivers the Recovery Training (RT) curriculum, a preplanned series of didactic sessions that systematically addresses predictable threats to abstinence from illicit opiates. The second weekly meeting, a self-help session conducted by the group leader in recovery, is devoted to sharing experiences, discussing personal issues, addressing group business, and planning for weekend recreational and community service activities.

4. **Brief Negotiation Interview (BNI) with Emergency Department (ED)-Initiated Buprenorphine** is an evidence-based program that seeks to increase treatment for ED patients with severe opioid use disorders. Designed for use with ED patients 18 years of age or older who present with moderate-to-severe opioid use disorder, the program can be used in hospitals and other healthcare settings. It is designed to engage patients in treatment for opioid dependence and expand their access to medication-assisted treatment, and includes follow-up primary care management. Intended secondary effects include reductions in self-reported days of illicit opioid use and HIV-risk behaviors.

5. **Screening, Brief Intervention, and Referral to Treatment (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. Streamlining assessment in 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 quickly assesses the severity of substance use and identifies the appropriate level of treatment.

- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

6. **Recovery Coaching** is a peer-based recovery support service that is non-clinical and designed to engage others beyond recovery initiation through stabilization and into recovery maintenance. Similar peer interventions in clinical settings have been shown to improve engagement and retention of people seeking services. It is also known that long-term treatment and/or recovery outcomes are improved by assertive linkages to community-based recovery supports such as Recovery Coaching. Friends of Recovery New York (http://www.for-ny.org/recovery-coach-academy.php), in collaboration with NYS OASAS, and the Connecticut Community for Addiction Recovery (CCAR), coordinates the delivery of the CCAR Recovery Coach Academy (RCA) across New York State. Friends of Recovery NY offers the NYS Recovery Coach Academy in three formats: (1) 5-day, 30 hour Recovery Coach Training only; (2) The five-day Recovery Coach training with a concurrent Training of Trainers, Those who meet the requirements for the TOT meet 1 1/2 hours at the end of each training day plus a final half-day "Teach-Back:" for a total of 10 additional hours; (3) A two-day, 10-hour Training of Trainers for previously trained Recovery Coaches who meet the requirements for the TOT. Costs for training are based on the host site, but may be a barrier for those interested in attending.

7. The **New York State Delivery System Reform Incentive Payment Program** (DSRIP) is the state government's Medicaid reform waiver program with the purpose of reducing unavoidable hospitalization use by 25% in five years; hence reducing costs to the Medicaid system. Various strategies have been identified as key opportunities to achieve this goal. Those pertinent to this study include: Project 2.b.vi Transitional supportive housing services; 2.c.i Development of community-based health navigation services; 2.c.ii Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services; 2.d.i Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care; 3.a.i Integration of primary care and behavioral health services; 3.a.ii Behavioral health community crisis stabilization services; 3.a.iii Implementation of evidence-based medication adherence program (MAP) in community based sites for behavioral health medication compliance; 3.a.iv Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community -based addiction treatment programs; 4.a.i Promote mental, emotional and behavioral (MEB) well -being in communities; 4.a.ii Prevent Substance Abuse and other Mental Emotional Behavioral Disorders; 4.a.iii Strengthen Mental Health and Substance Abuse Infrastructure across Systems. Leveraging of DSRIP funds and establishing learning communities may assist local providers in efforts to foster improved systems for opioid and heroin addiction treatment and recovery efforts.

8. **Continuing Medical Education**. Evidence-based teaching and training for medical professionals on opioid and heroin addiction; including new prescribing practice legislation, brief clinical assessment strategies, and the overall addiction process; can help bridge a gap in knowledge and practice for those in the medical field. As revealed in the American Hospital Association's article **The State of Behavioral Health Workforce: A Literature Review**, currently, more than 50 percent of patients get treated for behavioral health issues by their primary care provider (PCP); however, most PCPs have not received adequate training in behavioral health. Continuing Medical Education on opioid prevention, treatment and recovery is available both on-line and in-person. In New York State, the NYS Department of Health AIDS Institute and Office of Alcoholism and Substance Abuse Services (OASAS) are recognized training service providers. Additionally, the University at Buffalo Jacobs School of Medicine and Biomedical Sciences will provide education with a multidisciplinary approach focused on training current and future health care providers in safe acute-pain management; to educate providers, patients and the community about the risks of opioid pain medications and how quickly addiction and subsequently, even fatalities, can occur when opiates are prescribed -- even for legitimate reasons.

8 ALLEGANY COUNTY STATE OF DATA

I. New York State Department of Health

The New York State Department of Health (NYSDOH) is provides opioid overdose information (deaths, emergency department (ED) visits, and hospitalizations) by county in a quarterly report. The following data report provides a snapshot in time and may not be absolute:

Allegany County: Opioid overdoses and rates per 100,000 population (Data as of August, 2016)

		Jan-Mar, 2015		Apr-Jun, 2015		Jul-Sep, 2015		Oct-Dec, 2015		2015 Total		Jan-Mar, 2016	
Indicator	Location	Number	Crude Rate	Number	Crude Rate	Number	Crude Rate	Number	Crude Rate	Number	Crude Rate	Number	Crude Rate
Deaths [1]													
All Opioid Overdoses	Allegany	1	2.1	0	0.0	0	0.0	0	0.0	1	2.1	1	2.1
	NYS Excl. NYC	328	2.9	181	1.6	174	1.5	81	0.7	764	6.8	126	1.1
Heroin Overdoses	Allegany	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
	NYS Excl. NYC	133	1.2	107	1.0	128	1.1	57	0.5	425	3.8	63	0.6
Overdoses Involving Opioid Pain Relievers [2]	Allegany	1	2.1	0	0.0	0	0.0	0	0.0	1	2.1	0	0.0
	NYS Excl. NYC	218	1.9	91	0.8	85	0.8	44	0.4	438	3.9	69	0.6
Outpatient Emergency Department Visits [3]													
All Opioid Overdoses	Allegany	s	s	6	12.6	7	14.7	s	s	22	46.4	11	23.2
	NYS Excl. NYC	940	8.4	1,240	11.0	1,269	11.3	1,022	9.1	4,471	39.8	1,556	13.8
Heroin Overdoses	Allegany	s	s	s	s	s	s	s	s	13	27.4	10	21.1
	NYS Excl. NYC	626	5.6	922	8.2	897	8.0	779	6.9	3,224	28.7	1,246	11.1
Opioid Overdoses Excluding Heroin [2]	Allegany	s	s	s	s	s	s	s	s	9	19.0	s	s
	NYS Excl. NYC	314	2.8	318	2.8	372	3.3	243	2.2	1,247	11.1	310	2.8
Hospitalizations [3]													
All Opioid Overdoses	Allegany	0	0.0	0	0.0	s	s	s	s	s	s	s	s
	NYS Excl. NYC	403	3.6	511	4.5	508	4.5	385	3.4	1,807	16.1	398	3.5
Heroin Overdoses	Allegany	0	0.0	0	0.0	s	s	0	0.0	s	s	s	s
	NYS Excl. NYC	141	1.3	158	1.4	156	1.4	161	1.4	616	5.5	193	1.7
Opioid Overdoses Excluding Heroin [2]	Allegany	0	0.0	0	0.0	s	s	s	s	s	s	0	0.0
	NYS Excl. NYC	262	2.3	353	3.1	352	3.1	224	2.0	1,191	10.6	205	1.8

[1] Indicators are not mutually exclusive. Decedents and patients may have multiple substances in their system. Thus, overdoses involving heroin and overdoses involving prescription opioid pain relievers will not add up to the overdoses involving all opioids.

[2] This indicator includes pharmaceutically and illicitly produced opioids such as fentanyl.

[3] Indicators related to hospitalizations and emergency department data used ICD-9-CM codes prior to Oct 1st, 2015. ICD-10-CM codes are used from Oct 1st, 2015 and thereafter. Changes should be interpreted with caution due to the change in codes used for the definition.

s: Data for indicators related to hospitalizations and emergency departments are suppressed for confidentiality purposes if there are less than 6 discharges.

II. Allegany Council on Alcoholism and Substance Abuse, Inc.

Local service providers may access utilization data reports via the New York State Office of Alcoholism and Substance Abuse Services entitled the ***Admission Item Statistical Report-Outpatient Services*.**

Reviewing Allegany Council on Alcoholism and Substance Abuse, Inc. Outpatient Clinic 2015 Year-End Statistics, heroin was reported as the Primary Substance for outpatient admissions in 20.3% of cases; an additional 19.6% reported "Other Opioid/Synthetic" as the Primary Substance for treatment. According to ACASA Administrators and the following tables, this is a major shift from past statistics where alcohol, marijuana, and cocaine topped the lists.

Allegany Council on Alcoholism and Substance Abuse, Inc. Clinic Admissions' Data

Allegany Council on Alcoholism and Substance Abuse, Inc. Clinic Gender	**2014**		**2015**		**2016 YTD**	
	Count	%	Count	%	Count	%
Male	274	80.4%	242	76.6%	231	79.7%
Female	67	19.6%	74	23.4%	59	20.3%
Total	341	100%	316	100%	290	100%

Allegany Council on Alcoholism and Substance Abuse, Inc. Self-Reported Prior Mental Health Hospitalization	**2014**		**2015**		**2016 YTD**	
	Count	%	Count	%	Count	%
Yes	149	43.7%	187	59.2%	56	19.3%

Self-Reported Primary Substance Upon Admission	2014		2015		2016 YTD	
	Count	Percentage	Count	Percentage	Count	Percentage
Alcohol	153	44.9%	129	40.8%	116	40.0%
Benzodiazepine	0	0	2	0.6%	1	0.3%
Buprenorphine	2	0.6%	3	0.9%	3	1.0%
Cocaine	5	1.5%	9	2.8%	9	3.1%
Crack	8	2.36%	2	0.6%	2	0.7%
Heroin	36	10.6%	64	20.3%	64	22.1%
Marijuana/Hashish	64	18.8%	28	8.9%	37	12.8%
Methamphetamine	5	1.5%	8	2.5%	7	2.4%
None	0	0	3	0.9%	0	0
Non-Prescription Methadone	0	0	0	0	2	0.7%
Other Amphetamine	0	0	2	0.6%	4	1.4%
Other Hallucinogen	0	0	1	0.3%	0	0
Other Opiate/Synthetic	59	17.3%	62	19.6%	43	14.8%
Other Sedative/Hypnotic	1	0.3%	0	0	0	0
Other Stimulant	1	0.3%	2	0.6%	0	0
Over-The-Counter	1	0.3%	0	0	0	0
OxyContin	6	1.8%	1	0.3%	2	0.7%
Total	341	100%	316	100%	290	100%

Allegany Council on Alcoholism and Substance Abuse, Inc. Clinic Principal Referral Source	2014		2015		2016 YTD	
	Count	%	Count	%	Count	%
Conditional Discharge Private Provider	0	0.0%	0	0.0%	1	0.3%
Conditional Discharge Out-of-State	1	0.3%	2	0.6%	3	1.0%
Conditional Discharge in New York State	100	29.3%	95	30.1%	78	26.9%
Drinking Driver Referral	9	2.6%	4	1.3%	3	1.0%
District Attorney	0	0.0%	0	0.0%	1	0.3%
Drug Court	6	1.8%	23	7.3%	33	11.4%
Employee Assistance Program	1	0.3%	0	0.0%	0	0.0%
Employer/Union (Non-EAP)	0	0.0%	0	0.0%	1	0.3%
Family Court	7	2.1%	9	2.8%	3	1.0%
Family, Friends, Others	2	0.6%	3	0.9%	8	2.8%
Health Care Provider	16	4.7%	11	3.5%	6	2.1%
Local Social Services District Treatment Mandate/Medicaid Only	2	0.6%	1	0.3%	0	0.0%
Local Social Services District Treatment Mandate/Public Assistance	10	2.9%	10	3.2%	3	1.0%
Local Social Services District Income Maintenance	0	0.0%	2	0.6%	1	0.3%
Local Social Services District Treatment Mandate/Child Protective Services	23	6.7%	20	6.3%	16	5.5%
Managed Care Provider	2	0.6%	0	0.0%	0	0.0%
Mental Health Provider	9	2.6%	5	1.6%	6	2.1%
Office of Children and Family Services	0	0.0%	0	0.0%	1	0.3%
Other	74	21.7%	63	19.9%	24	8.3%
Other Court	33	9.7%	22	7.0%	22	7.6%
Other Prevention/Intervention Services	1	0.3%	0	0.0%	0	0.0%
Other Social Services Provider	2	0.6%	1	0.3%	1	0.3%
Parole General	5	1.5%	11	3.5%	16	5.5%
Parole Release Shock	1	0.3%	0	0.0%	1	0.3%

Parole Release Willard	1	0.3%	0	0.0%	0	0.0%
Probation	20	5.9%	14	4.4%	49	16.9
School (Other than Prevention Program)	0	0.0%	1	0.3%	0	0.0%
Self-Referral	16	4.7%	19	6.0%	13	4.5%

Source: NYS Office of Alcoholism and Substance Abuse Services Admission Item Statistics Report

III. Southern Tier Healthcare System

The Southern Tier Healthcare System's **Southern Tier Overdose Prevention Program** (STOPP) tracks Narcan use and individuals trained to administer intranasal Narcan through their efforts. STOPP has the ability to extrapolate Allegany County specific data to track usage statistics and monitor trends.

As of November 4, 2016, STOPP has trained a total of one-hundred sixty (160) non-EMS firefighters (59), law enforcement (20), professional service providers (46), and friends/family (35). Through these efforts, they have distributed a total of one-hundred twenty-five (125) Narcan Kits in Allegany County; EMS providers (39), law enforcement (35), professional service providers (43), friends and family (8). Each Narcan Kit contains two (2) doses of Narcan.

Agencies and individuals who wish to participate in the STOPP training and distribution program are required to sign a contract with Southern Tier Health Care System, Inc. acknowledging that they have received the training and a Narcan Kit. In addition, the contract states that upon request of a replacement Narcan Kit, individuals are required to report usage data.

In 2015, a total of ten (10) cases were reported; in comparison to 2016 year-to-date of thirteen (13) cases. The following represents a breakdown of those who received Narcan through STOPP:

Age of Those Aided	**2015**	**2016 (YTD 11.4.16)**
Under 25	0	3
25-34	3	4
35-44	3	4
45-54	1	2
Over 55	3	0
Total	10	13
Substance Reported for Overdose	**2015**	**2016 (YTD 11.4.16)**
Heroin	2	9
Other Opioid	2	1
Data Unavailable	6	3
Total	10	13
Gender of Those Aided	**2015**	**2016 (YTD 11.4.16)**
Male	4	11
Female	6	2
Total	10	13
Agency Administered Narcan	**2015**	**2016 (YTD 11.4.16)**
EMS/Fire	10	12
Law Enforcement	0	1
Total	10	13

IV. Allegany County Probation Department

Pre-Plea/Sentencing Investigations data tallied by the Allegany County Probation Department spans portions of 2015-August 2016. Data is based on clients self-reporting status for drug use at time of arrest.

Allegany County Probation Department Adult Defendant Self-Reporting Drug Use

	Total	*Females*	*Male*
# of Defendants	153	34	119
Average Age	34	35	33
# Reporting Marijuana Use	112 (73%)	27 (79%)	85 (71%)
# Reporting Heroin Use	40 (26%0	15 (44%)	25 (21%)
# Reporting Other Drug Use	74 (48%)	20 (59%)	54 (45%)
# Reporting Use of All Three Drug Types	34 (22%)	14 (41%)	20 (17%)
Age Ranger for Sample		18-77	16-63

Allegany County Probation Department Adult Defendant Self-Reporting Treatment Services

	Total	*Females*	*Male*
# of Defendants	153	34	119
Allegany Council on Alcoholism and Substance Abuse, Inc.	56	12	44
Allegany County Department of Social Services	11	4	7

Allegany County Probation Department Adult Defendant Residency by Zip Code

	Total	*Females*	*Male*
Wellsville	39	8	31
Cuba	17	4	13
Scio/Allentown	11	1	10
Belfast/Caneadea	11	2	9
Belmont	12	4	8
Bolivar/Little Genesee/Richburg	10	2	8
Friendship	10	2	8
Fillmore/Houghton	8	2	6
Andover/Whitesville	4	0	4
Alfred-Almond	2	0	2
Angelica	1	0	1
Rushford	1	0	1
Out-of-County	20	5	15

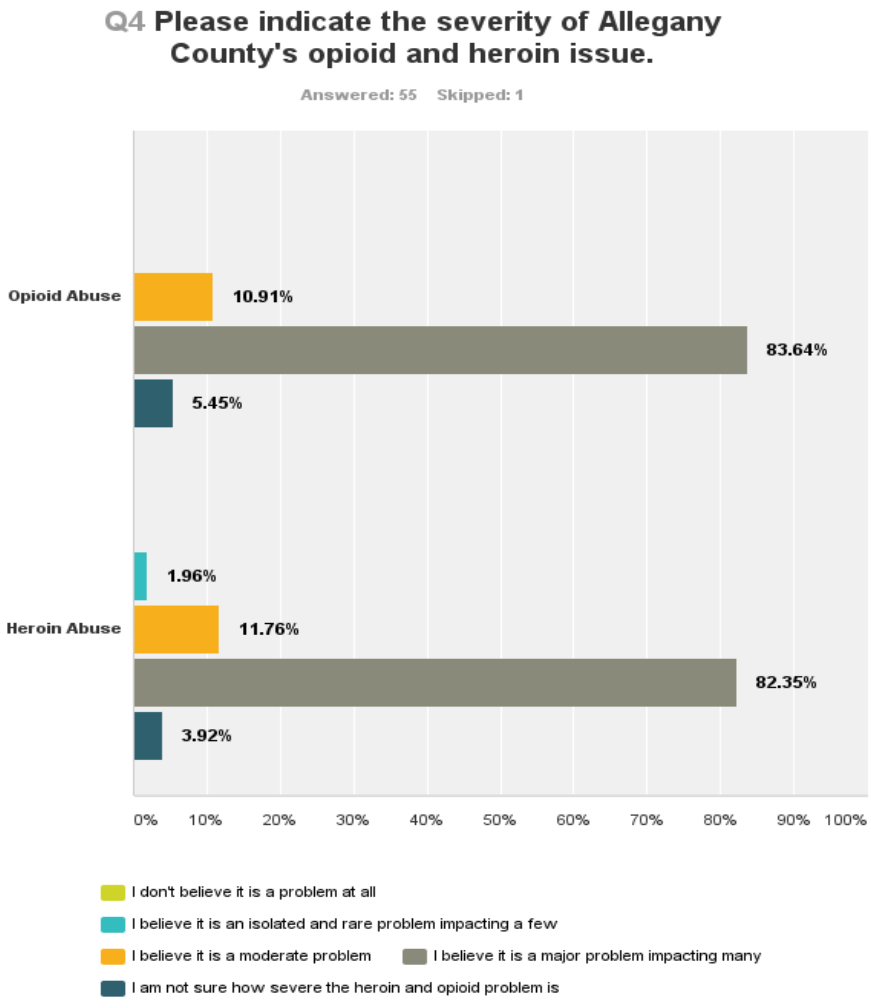
Allegany County Probation Department Youth Defendant Data

	Total	*Percentage*
Total Youth Screened	91	100%
# Youth Reporting No Alcohol or Drug Use	59	65.8%
# of Youth Reporting Alcohol Use	9	9.8%
# of Youth Reporting Marijuana Use	17	18.7%
# of Youth Reporting Cocaine/Crack Use	2	2.2%
# of Youth Reporting Prescription Drug Use	2	2.2%
# of Youth Reporting Unspecified Drug Use	2	2.2%

V. Allegany County Heroin and Opioid Community Survey

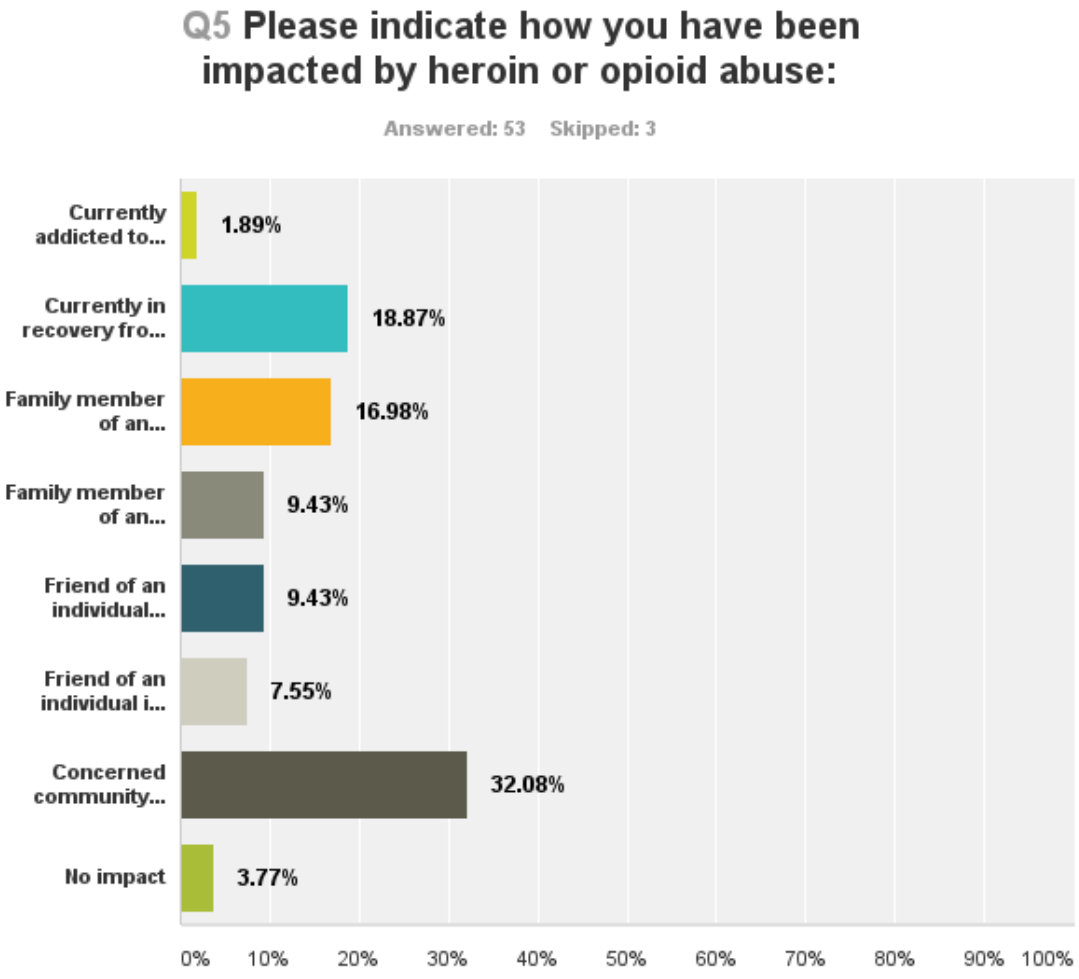
A total of fifty-six (56) community surveys were administered both on-line and as paper copies. Of those, two (2) were completed by individuals 18-25 years of age (3.64%), seven (7) were 26-35 years of age (12.74%), eighteen (18) were 36-49 years of age (32.73%), and twenty-eight were fifty (50) years and older (50%). When reviewing gender of respondents, twenty-one (21) were male and thirty-four (34) were female. Twenty-two (22 or 45.24%) were not currently caregiving for youth, nineteen (19 or42.24%) were parenting their own children in their own home, and one (1 or 2.38%) were caregiving for an adult child due to his/her opioid or heroin abuse. Results of the community are published throughout the survey as appropriate to tell the story of Allegany County's current heroin and opioid crisis.

When asked about the severity of the heroin and opioid crisis in Allegany County, respondents' opinions captured in the **Community Survey** demonstrated a high percentage of individuals felt that "opioid abuse and heroin abuse is a major problem impacting many" (83.64% and 82.35%) respectively.



Recognizing that community perspective to an issue emphasizes solidarity and social inclusion within the community to address a social problem. Persons who participate in the development of a solution to a problem creates a sense of responsibility and local knowledge and input is useful in every facet of a community-based initiative; such as addressing the heroin and opioid epidemic.

Understanding how community respondents are impacted by the heroin and opioid issue provides insight as to the level of knowledge and experience the sampling has. The following chart provides a breakdown of how **Community Survey** participants have been impacted by heroin or opioid abuse. Those directly impacted have a greater sense of urgency and may be a major asset to understanding the program, while those who are concerned may be allies in transforming the problem.



As well, maximizing natural influencers that make a difference in whether an individual will seek treatment and providing resources to these allies is imperative. **Community Survey** respondents were asked, "Thinking about heroin or opioid abuse, please indicate who you feel is influential in helping individuals seek treatment." The following influencers were cited:

Answer Options	Extremely Influential	Somewhat Influential	Not Influential At All
Parents	12	11	1
Spouse or Significant Other	10	15	0
Children	9	10	2
Faith Leader	12	9	3
Employer	5	9	7
Friends	12	11	2
Doctor or Other Healthcare Professionals	15	7	1
Counselor or Therapist	12	11	2
School Personnel	5	10	5
Law Enforcement Personnel	8	6	8
Judge or Other Court Personnel	13	7	4
Social Worker	7	8	8

When asked "what are the root causes for starting heroin or opioid use/abuse in Allegany County," the largest segment of **Community Survey** respondents indicated that addiction began with the use of a prescription pain medication (77.42%). Others (64.52%) stated that "experimentation with other illicit or legalized drugs or gateway drugs were a contributing factor. Some (54.84%) reported that opiates are "a less costly alternative to other drugs."

Additionally, other reasons cited included peer influence or peer pressure, lack of education about the impact and potential consequences of heroin and opioid use, lack of school prevention education, untreated mental illness, lack of constructive and healthy alternatives, and social determinants of health such as unemployment.

Additionally, when asked about effective prevention strategies, **Community Survey** participants were asked, "Looking back on you or your loved-ones addiction, please indicate what you feel providers and the community could have done to prevent the addiction (please check all that apply)."

The following provides a summary of the responses:

Looking back on you or your loved-ones addiction, please indicate what you feel providers and the community could have done to prevent the addiction (please check all that apply).		
Answer Options	**Response Percent**	**Response Count**
More Community-Based Prevention Messaging; i.e. Billboards, Radio Ads, Print Ads	46.4%	13
Less Accessibility to Prescription Pain Medications	75.0%	21
Greater Law Enforcement Consequences	46.4%	13
Increased Drug Testing; i.e. Workplace, Court Mandates, etc.	60.7%	17
Greater Access to Drug Education in Schools	60.7%	17
More Discussion with Healthcare Providers at Time of Prescribing Prescription Pain Medications	75.0%	21
More Discussion with Pharmacists at Time of Dispensing Prescription Pain Medications	60.7%	17

When asked "Recognizing Allegany County's limited resource, what communication strategies do you feel would most help individuals at-risk or impacted by heroin or opioid addiction (check all that apply)?" respondents cited the following:

Answer Options	**Response Percent**	**Response Count**
Radio	57.1%	24
Newspapers	23.8%	10
Billboards	47.6%	20
Websites	57.1%	24
Pamphlets or Brochures at Doctors' Offices	52.4%	22
Pamphlets or Brochures at Worksites	45.2%	19
Pamphlets or Brochures at Schools	54.8%	23
Fact Sheets at Pharmacies	52.4%	22
Pharmacy Consultations	47.6%	20
Electronic Monitors	26.2%	11
Physician Consultation	57.1%	24
Community Educational Programs	54.8%	23
Town Hall Meetings	38.1%	16

When **Community Survey** participants were asked what consequences they or their family member, friend or acquaintance has faced due to their opioid or heroin abuse, the following results were cited:

Answer Options	Impacted my life	Impacted my loved-one's life	Impacted my friend or acquaintance's life
Loss of job	5	15	15
Homelessness	2	6	12
Financial Hardship	13	18	14
School Problems (drop-out or expulsion)	0	9	8
Arrested	7	11	12
Probation	3	9	13
Drug Court	3	4	11
Mandated Substance Abuse Treatment	4	8	12
Loss/Potential Loss of Children by Court System	3	4	13
Loss of Driver's License	2	4	8
Divorce or separation from significant other	5	4	8
Loss of friends or acquaintances	11	14	14
Additional Mental Health Problems	6	15	13
Severe Withdrawal	9	12	15
Additional Physical Health Problems	5	10	11
Death	1	4	9

This information is significant for prevention messaging to paint a realistic picture of the burden of heroin and opioid addiction and may be helpful in prevention messaging.

To better understand what treatment and supports are most important to local individuals addicted to heroin and opioids, **Community Survey** participants were asked, "First, what forms of treatment are most important to individuals addicted to heroin and opioids in Allegany County? Second, please indicate whether the service is available or not for Allegany County residents?"

The following represents which services were deemed most important and whether the services are available locally:

Answer Options	Extremely Important	Somewhat Important	Not Important at All	Not Available Locally	Available Locally
Medication-Assisted Treatment	21	8	0	3	10
Behavioral Therapy	22	6	1	5	11
Detoxification Services	27	3	0	10	2
Peer Support Groups	17	11	1	6	9
Faith-Based Supports	16	10	3	4	9
On-line Support Groups	6	12	7	2	8
Inpatient Drug Treatment Facilities	23	6	0	14	6
Long-Term Residential Treatment Services	17	10	1	11	5
Outpatient Addiction Counseling	19	10	0	1	15
Family Counseling Services	20	7	2	5	10

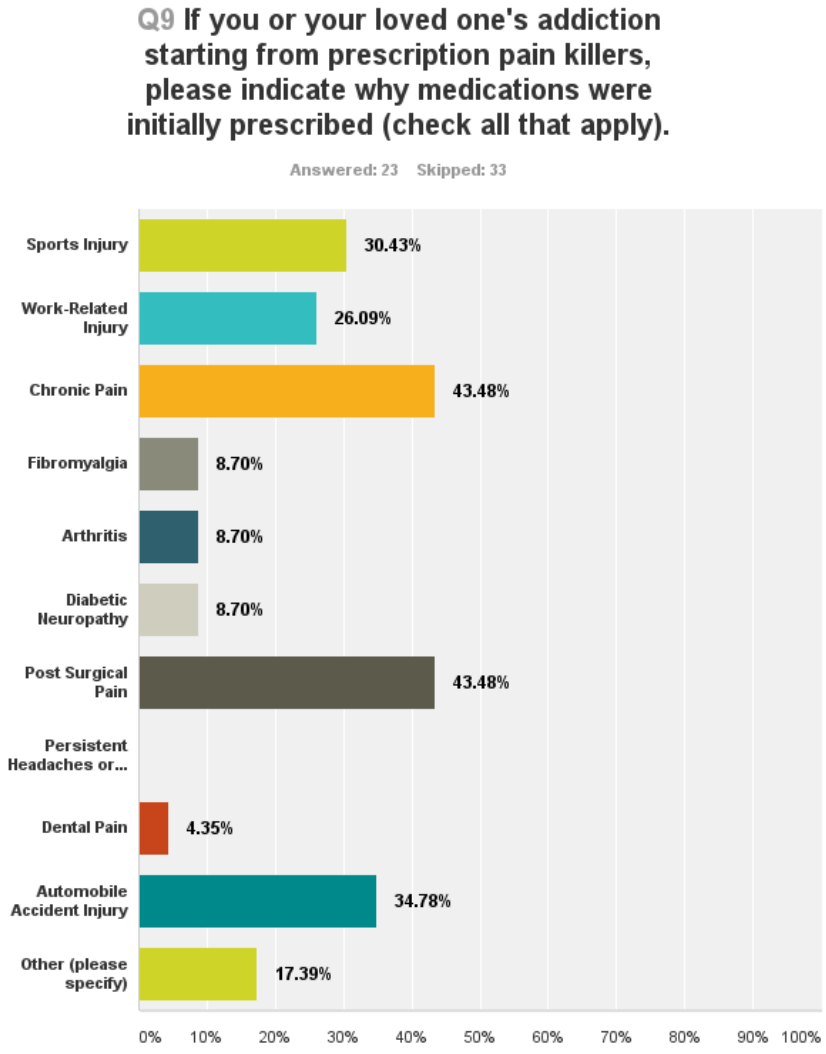
Additionally, **Community Survey** participants were asked, "First, what additional resources in Allegany County do you feel are most important in assisting individual in recovery from heroin or opioids avoid relapse (please check all that apply)? Second, please indicate whether these services are available locally."

The following responses were recorded:

Answer Options	Extremely Important	Somewhat Important	Not Important At All	Available Locally	Not Available
Housing Assistance Programs	16	9	2	10	5
Job Readiness Services	15	8	3	10	5
Food and Nutrition Assistance Programs	12	12	2	15	1
Temporary Cash Assistance Program	9	11	5	15	1
Pain Self-Management Workshops	21	5	1	3	9
Food Pantries	10	11	3	14	2
Public Transportation Services	16	8	2	15	1
Peer Advocacy Programs	11	13	2	6	6
Crisis Intervention Services	24	3	1	11	4
Service Coordination/Case Management Services	15	9	2	10	4
Employment Services	16	8	3	11	4
Financial Literacy Programs	10	12	3	10	4
Childcare Daycare Services	15	10	2	11	2
Pain Clinic	20	7	1	7	6

This information is important to note when planning future interventions and for agencies who need to invest in greater marketing and outreach efforts when providing services locally.

Understanding why prescription pain medications were originally prescribed to patients, which ultimately may have led to his/her opioid or heroin addiction, is vital in examining the connection between medical conditions, prescribing practices and opioid or heroin abuse. Community Survey respondents were asked, "if you or your loved one's addiction started from prescription pain killers, please indicate why medication were initially prescribed (check all that apply)." Twenty-three (23) respondents answered as follows:



When **Community Survey** respondents were asked, "Thinking about you or your loved-ones experience with heroin or opioids, do you feel mandatory drug testing is an effective way to reduce recurrent use?" overwhelmingly 77.78% responded "yes," but many questioned the integrity of the process. Others questioned whether individuals will seek much needed family support from governmental agencies if they mandatory testing is a pre-requisite for services.

Community Survey participants were asked to identify barriers in treatment and/or recovery for those living in Allegany County facing heroin and/or opioid addiction. The following represents their responses:

Answer Options	Treatment	Recovery
Services Are Not Available Locally	13	13
Unsure of What Services Are Available	21	20
Transportation	11	11
Lack of Insurance	19	15
Co-Pays Too High	15	11
High Insurance Deductibles	15	12
Insurance Limitations to Adequate Time in Treatment	19	16
Services Not Available in a Timely Manner	21	16
Stigma Associated with Addiction	18	17
Lack of Beds in Treatment Facilities	18	11
Rejection for Treatment by Insurance Carrier	16	11
Not Ready to Stop Using	24	20
Does Not Feel Treatment is Needed or is Unnecessary	24	18
Negative Effect on Employment	16	11

As well, **Community Survey** respondents were asked, "If you or your loved-one is currently in recovery for heroin or opioid addiction, please indicate what was the defining factor for seeking help (check all that apply). The following represents their responses:

Answer Options	Response Percent	Response Count
Work Issues or Loss of Job	17.6%	3
Court Mandate	70.6%	12
Legal Ramifications	52.9%	9
Decline in Health	17.6%	3
Loss of Children	29.4%	5
Loss of Friends	23.5%	4
Separation from Significant Other	23.5%	4
Overdose	41.2%	7

8.1 Data Strengths

1. Assessing the risk and protective factors that contribute to substance use disorders helps practitioners select appropriate interventions. The Allegany Council on Alcoholism and Substance Abuse, Inc., facilitates the Risk and Protective Factor Survey in grades 6, 8, 10 and 12, in the majority of Allegany County schools. This data can help identify trends that effect Allegany County youth, provide baseline data to measure interventions' success based on a decrease in risk factors and an increase in protective factors, and help strategize interventions based on community needs.

2. Although state-wide data is limited in both subject area and timeliness, it can assist Allegany County in determining how great the impact of heroin and opioid abuse truly is in comparison to other rural counties.

8.2 Data Challenges

1. The use of Narcan or Naloxone by the public to reverse the effects of an overdose of heroin or some types of painkillers, was made legal in 2016 through the Good Samaritan law. Beyond the Southern Tier Opioid Prevention Program efforts, Narcan is available at most pharmacies without a prescription and through public venues sponsored by the New York State Department of Health's Harm Reduction Coalition. Mass distribution permits greater access, but makes data collection nearly impossible outside of data available through STOPP.

To counter this issue, since January 2016 the Allegany County Sheriff has been collecting Narcan Use Data from local Police Departments and Emergency Medical Service Personnel. The purpose is to establish one central, local database for Narcan information. Unfortunately, this process has been challenging, may be a duplication of STOPP efforts with these two distribution points, and does not address the alternate distribution points.

2. Another challenge sited by stakeholders is the lapse in time between ordering an autopsy due to a suspicious death to the time the toxicology report is received from Rochester; which in many cases can take up to a year or more.

The Allegany County Department of Health is working to rectify this time lapse by contracting with Olean General Hospital to perform autopsies inclusive of toxicology reports resulting in a much fast turn-around.

3. Coroners often avoid reporting a heroin or opioid overdose as cause of death on death certificates to shield the family from shame or stigma. This is particularly evident in small, rural communities where coroners are part of the community and feel compelled to protect friends, family members, co-workers and neighbors.

4. Stakeholders representing law enforcement cite the perceived lack of legal consequences due to the Good Samaritan Law as a barrier for true data collection. Individuals who overdose

and seek medical intervention are not subject to arrest. This eliminates a critical data point while reducing law enforcements leverage in combatting this issue as a criminal act.

5. Data from the Allegany County Probation Department may identify repeat offender issues, which may be important in planning interventions, messaging, and treatment strategies. Yet, data is not stored electronically and takes considerable effort to gather and analyze.

6. Claims data through insurance carriers would be beneficial to understand the many key data points; i.e. number of prescribed pain medications, treatment costs, etc. Yet, this data is difficult to access by planners.

8.3 Data Opportunities

1. Streamlining local data reporting and analysis into one electronic system that is user-friendly would offer those working to fight the heroin and opioid crisis a readily available source for data to assist with strategic planning, reporting, evaluation, and grant writing.

9 REGIONAL EFFORTS

Due to the nature of living in a rural community, it is important to note the necessity for Allegany County to build relationships within the Western New York and Finger Lakes Regions and all across New York State and beyond. As more federal and state funds are allocated on the regional level; Allegany County must advocate for services and monies to support prevention, treatment, recovery and enforcement efforts.

Allegany County may also learn from the efforts of other rural communities who have demonstrated success in prevention, treatment, recovery and enforcement efforts as to replicate locally.

Rural providers and consumers must have a voice in state-wide initiatives advocating for policy that support local efforts, rather than hinder the passion and good work currently being delivered.

10 INFRASTRUCTURE

To be an effective agent of change, community coalitions must understand the unique problems and opportunities that exist in their areas, develop a strategic plan, and address the needs.

Using the key five steps of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Strategic Prevention Framework, Allegany County must:

1. Assess needs
2. Build capacity to address those needs
3. Plan strategically
4. Implement an effective program
5. Evaluate the outcome

As well, SAMHSA enlists the "Seven Strategies to Affect Community Change" in effective coalition work:

1. Provide Information
2. Enhance Skills
3. Provide Support
4. Enhance Access/Reduce Barriers
5. Change Consequences
6. Change Physical Design
7. Modify/Change Policies

An emerging practice where stakeholders from diverse sectors establish a common agenda, shared metrics, a structured process and a jointly funded infrastructure has been shown to be an effective strategy for combating public health issues where multiple sectors are required to make impact. All representatives should allocate resources to their best extent, share ownership over the vision and mission of the group, and champion efforts within their own organization and the community. Key stakeholder meetings, key informant interviews, asset mapping of the local care system based on prevention, treatment, recovery and enforcement; and an asset inventory of potential assets agencies are willing to pool for the common good of this cause will provide help to identify gaps in services and opportunities for moving the needle on this issue.

11 KEY FINDINGS

The following key findings are based on the 2016 Allegany County, New York, Heroin and Opioid Study conducted by Ardent Solutions, Inc. Conclusions are based on data analysis inclusive of:

1. Key Stakeholders input
2. Quantitative data collection and analysis
3. Contributions of those who have experienced the impact of heroin and opioid addiction
4. Legislation and policy review
5. Best-practice and evidenced based strategies from across the nation

This information may be used to determine priorities and potential interventions in the areas of Prevention, Treatment, Recovery and Enforcement aligning with the New York State Heroin and Opioid Task Force final report. Each potential project and/or solution concept should be measured for feasibility by those committed to combat the issue of heroin and opioid addiction in Allegany County according to the following factors:

Factors	**Statement for Ranking and Prioritization**
Risk	A significant percentage of the target audience (population at risk) is currently practicing a behavior that represents a serious risk to good health.
Impact	An alternate behavior exists that will reduce the risk in a way that has a lasting impact on the health problem, above and beyond current efforts.
Behavioral Feasibility	The defined target populations have a less risky alternative to their current behavior, and the barriers to the alternate behavior are low enough to allow them to adopt it.
Resource Feasibility	The resources available are sufficient to reach this audience segment and influence its behavior within the timeframe of the initiative.
Political Feasibility	Both my organization and the community will support; is there enough support internally, externally, and politically to make the change happen.

Only projects that are determined feasible should be pursued and/or developed into a working document with Specific, Measurable, Achievable, Timely and Realistic Goals and Objectives.

Although this report focuses strictly on the heroin/opioid epidemic, it is important to note that information contained may be adapted and broaden to positively impact all alcohol and substance abuse issues.

The following section provides general key findings for consideration. Specific examples and tools can be found throughout the document in the "Opportunities" sections.

Several themes and key findings thread throughout all areas of the report; including:

1. Addiction as a disease, not a moral failure. The distinction between cause and effect is important to those whose lives have been impacted by the epidemic where behavior has resulted in criminal justice system involvement. According to the National Council on Alcoholism and Drug Dependence, Inc.'s article **Alcohol, Drugs and Crime** published in June 2015; a*lcohol and other drugs are implicated in an estimated 80% of offenses leading to incarceration in the United States including domestic violence, driving while intoxicated, property offenses, drug offenses, and public-order offenses. The nation's prison population has exploded beyond capacity and most inmates are in prison, in large part, because of substance abuse:*

- *80% of offenders abuse drugs or alcohol.*
- *Nearly 50% of jail and prison inmates are clinically addicted.*
- *Approximately 60% of individuals arrested for most types of crimes test positive for illegal drugs at time of arrest.*
- *Four of every five children and teen arrestees in state juvenile justice systems are under the influence of alcohol or drugs while committing their crimes, test positive for drugs, are arrested for committing an alcohol or drug offense, admit having substance abuse and addiction problems, or share some combination of these characteristics.*
- *1.9 million of 2.4 million juvenile arrests had substance abuse and addiction involvement, while only 68,600 juveniles received substance abuse treatment.*

As stated in Scot N. DuFour's article entitled **Perpetuating the Cycle: Opioid Addiction and the Criminal Justice System** (2016) *The traditional response to the illegal use and possession of drugs, including opiates, in the United States is incarceration, but this response is wholly inadequate to address the issue of heroin addiction and may actually contribute to the problem by placing users in situations that promote opiate use. Several treatment options for opiate addiction have been found to be far more successful than traditional punitive punishment in reducing recidivism and the crime that has been well-documented as associated with heroin use. The government should follow the example of some other nations using the forced detoxification that is imprisonment to rehabilitate opiate users and thereby decrease heroin dependency and associated crime rates.*

Many whose lives have been impacted by the intersection of their drug use/abuse and the criminal justice system cite their arrest as a main influence for seeking treatment.

> *Your desire to use overrides the consequences ad then the jail cell door slams; you want to use to forget about what you did yesterday, unfortunately when you come to your senses you are locked up.*
>
> Individual Living in Recovery

The continued support for drug court is important as Allegany County looks for methods to reduce the heroin and opioid crisis. Drug courts see rehabilitation and treatment as the primary goal of the justice system in a way that sees the addiction as the root cause of the problems.

Finally, drugs exist in prisons and it is easy for the prisoners to continue their use while incarcerated so mere incarceration does not succeed like it should in preventing offenders from using drugs.

Research shows that there are options during incarceration involving treatment for heroin addict offenders. Australia and some countries in Western Europe provide treatment during incarceration aimed at reducing overdose deaths, the spread of HIV, and criminal recidivism (Mitchell et al., 2009). Knowing that the risk of drug usage remains during incarceration and the fact that there is a high rate of needle sharing in prison the World Health Organization recommends some form of opioid treatment in prisons especially because the sudden detoxification that can occur during incarceration can increase the risk of overdose death from the same dose the offender was using before incarceration (Mitchell et al., 2009).

Detoxification during incarceration through supervised medication assisted therapy may assist the prison system and the individual with the acuteness of withdrawal and opiate cravings. As well, there is also a documented increase in the percentage of released inmates who continue to seek treatment if they received some form of treatment while incarcerated (Mitchell et al., 2009).

It is important that sustainable funds be allocated for treatment options in the incarcerated population with the primary goal of addressing the addiction. Continued support of Allegany County's drug court should be a priority moving forward where consequences are not eliminated or ignored, but help is the primary function.

2. Elimination of stigma must be a priority. Only through awareness, education and encouragement is Allegany County going to end stigma; hence inspiring those who need treatment to get the help that they need to recover. Research confirms that the stigma to addiction- negative attitudes and labels targeting those with drug problems- is a significant reason people do not seek treatment. The broader definition and impact of scare tactics and negative messaging can perpetuate stigma and create an environment of fear creating barriers for those who may and want help.

Examples of anti-stigma campaigns include:

- New York State's Combat Heroin and Prescription Drug Abuse (https://combatheroin.ny.gov/),
- Massachusetts's State Without Stigma Campaign (*http://www.mass.gov/eohhs/gov/departments/dph/stop-addiction/state-without-stigma/*),
- New Hampshire's Anyone, Anytime NH Campaign (*http://anyoneanytimenh.org/downloads/*)

> *Society doesn't look at addiction as a disease; we are at "dis-ease' with ourselves. Growing and recovery is optional; you can go to the mandated meetings and be a wallflower; it is the step work that gets us well.*
>
> Individual Living in Recovery

3. Embrace the voice and promote the important role of those who have experienced opiate addiction in the fight against the crisis. Those in recovery and family caregivers offer a perspective that professionals can learn from strengthening Allegany County's efforts. Individuals in recovery should have an equal say and be viewed as experts in the subject area. Their experiences shed light on the strengths, weaknesses, threats and opportunities for prevention, treatment, recovery and enforcement.

Those in of us in recovery are so very fragile. We struggle to see value in ourselves, but opportunities to contribute to the solution, rather than always being seen as the problem, is significant. It gives hope when someone may be feeling hopeless.

Individual Living in Recovery

As well, the message from those in recovery demonstrates the win-win quality of inclusiveness. Providing those in recovery a purpose to make a positive impact on something that so negatively impacted their lives is life changing and re-affirming. Empowerment strengthens self-value in the recovery process.

You need to feel like you have value. Utilize survivors to help others through it, not just someone with a degree that talks down to you. The mistake is not to include people that have had that experience.

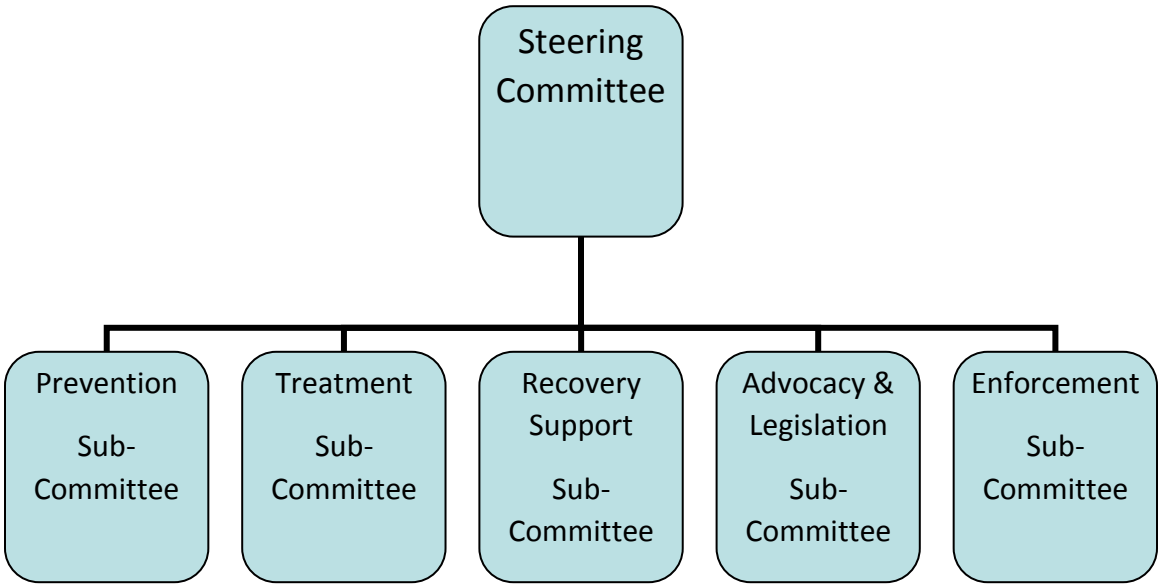
Individual Living in Recovery

4. Local, state and federal advocacy is imperative to the cause. So often urban centers overshadow rural needs. Advocacy for equitable resources and funding must be a priority moving forward. Banning rural communities together in regional, state-wide or national advocacy efforts helps carry the message further and stronger. As funds are released on regional levels often directed to population centers, rural communities must fight together to demonstrate unity and carry the message that our residents matter.

5. It is our recommendation that the Allegany County Partners for Prevention Heroin and Opioid Prevention Task Force join forces with the Allegany County Board of Legislators' Heroin and Opioid Ad-Hoc Committee to form a consolidated Coalition through the following infrastructure:

Steering Committee: A group of no more than thirteen (13) Key Stakeholders and concerned citizens who oversee efforts in the areas of prevention, treatment, recover, enforcement and advocacy.

Members from each of the sub-committees would elect two individuals to the Steering Committee to act as a liaison and communicate sub-committee progress on a shared work plan that spans across all sub-committees. Sub-Committees may utilize this report as a launching point to formulate a work plan to address key issues.



6. Information on heroin and opioid addiction should be shared with the community at-large including risk factors, signs and symptoms, and where to get services. The following populations where identified as highest risk for use and abuse and should be a priority for prevention education resources:

a. Males, 18-35
b. Youth
c. Pregnant and parenting women
d. Veterans who experience PTSD
e. Individuals and families who have experienced trauma due to domestic violence and childhood abuse,
f. Individuals in recovery who are at-risk for relapse
g. Individuals with an untreated mental health diagnosis
h. Those who actively are prescribed opioids as a pain management strategy

> *When there is untreated trauma, behavior, depression, feelings of no value – it plays out in life. Addiction becomes an option for an abused child. After people get into recovery and stay sober/clean for a while, you need to get 'under the hood' and deal with the untreated areas.*
>
> Individual Living in Recovery

Marketing, outreach and education campaigns should be tailored to specific populations (as listed above). Materials should be written at an appropriate literacy level and accessible in places that reach the targeted populations. Suggested sites include domestic violence shelters/programs, Veterans' services, worksites, pharmacies, schools, justice system, mental health facilities, physician practices, Emergency Departments, dental providers, etc.

Due to the high number of individuals who do not have access to an in-home computer and/or the high number of individuals wishing to maintain personal confidentiality and do not access information online on public computers, print materials should be the primary focus; with electronic communication such as websites and social media, as a complimentary communication strategy.

Narcotics Anonymous World Services has educational materials available on their website. We should flood the community including informing people where NA meeting are located. One pamphlet "Am I an Addict?" helps people look in the mirror and ask the tough questions.

Individual Living in Recovery

7. Strengthening medical professionals' knowledge and understanding of opioid addiction, alternative pain management strategies, and regulatory changes in prescribing practices, local and regional treatment options for referrals, and greater opportunities to join in local efforts is essential. Since research directly correlates prescription pain medicine as a gateway drug to other illicit opioids; including heroin and synthetic opioids, health care providers' have a major role and responsibility in ending this epidemic.

As well, medical professionals may perpetuate the addiction cycle by offering pain medications to those in recovery without considering the impact of re-introducing temptation and inviting relapse. For medical providers who are unaware of their patient's addiction history, this is a hurdle that must be overcome through improved communication, motivational interviewing practices, standardized assessments, and patient-doctor trust.

Are doctors educated about opioids in medical school? I'm an addict…seriously, don't offer me narcotics as my first choice for pain relief. Listen to me!

Individual Living in Recovery

8. Mandatory drug testing is viewed as a deterrent for continued use. Yet, individuals in recovery and key stakeholders both identified immense flaws in the system and opportunities for manipulation. Recommendations to improve this system include the following:

- **Randomized Testing:** Currently the system is described as relaxed and individuals can easily predict when testing will be required or refuse testing without consequence.
- **Impose Consequences:** If a test result is positive, there are no perceived or real consequences.
- **Improved Supervision of Urine Sample Catchment:** Urine sample catchment manipulation was cited as a major weakness. Supervision was described as non-existent.

9. Research indicates that wait time for admission into an inpatient or detoxification programs greatly impacts treatment success. Connecting individuals who self-refer directly with providers at their most vulnerable tipping point, prevents second-guessing and continued use/abuse. Long-waiting lists and requirements for people to fail out of lower levels of care, is a detriment to treatment. Recommendations included conducting a feasibility study for local medically supervised hospital or alternative setting detoxification services as a safe and accessible option.

> *For the opioid explosion, we need openings for detox beds. There's not enough places where people can go to safely detox. Crazy to have hospital and no detox beds. Some people want to kick and there isn't a place to do it. If people are involved with the courts, there should be leverage to recommend detox.*
>
> Individual Living in Recovery

10. Healthcare and behavioral health providers must provide person-centered care and individualized treatment plans when working with those living with an addiction.

> *My Aah-Ha moment… Can't treat everyone the same. What may work for someone, may not work for me; what works for me may put someone else back in addiction. People are fragile, there is nothing more important than when people listen – this can make a difference.*
>
> Individual Living in Recovery

11. Self-help support groups are critical for many people looking for support to stay sober. Yet, local self-help support groups were not always viewed as effective and were sometimes seen as a threat to an individual's recovery. It was strongly recommended to offer more non-court mandated support groups as a means of countering non-productive behaviors from those who are only present due to court requirements. Individuals living in recovery also requested that drug court and the probation department recognize alternative self-help groups; such as faith-based programs, as an approved resource.

AA is stale. I sometimes feel worse after attending a meeting because people are at different points of their recovery; some trying, but others aren't there with good intentions. Can be very detrimental to someone's recovery, especially someone on the edge.

Individual Living in Recovery

12. Offering of support groups for family and/or friends impacted by heroin/opioid is important. To our knowledge there are no current N/A family self-help groups.

13. Recovery Coaches were discussed as potential opportunities at both the key stakeholders meetings and in focus groups with individuals living in recovery. Recovery Coaches provide a dual purpose; provide support to an overwhelmed system and create a linkage between professionals and those in treatment.

Clinicians are educated people that look down on addicts; State Penn vs Penn State; they can read all they want, but don't get it. They don't walk in my shoes.

Individual Living in Recovery

14. The need for healthy alternatives and safe environments for individuals living in recovery was highly stressed as a local need. Recreational and socialization opportunities without the temptation of alcohol and/or other drugs was seen as a strategy to combat boredom, isolation and increase positive interactions.

We need to have a place where people can go, have coffee, play pool or board games; and know that they are in a safe environment …like a drug-free social club.

Individual Living in Recovery

15. Over the past several years, Resource Officers have been pulled from school districts due to budgetary cuts. It is recommended that school administrators and law enforcement work together to build opportunities for collaboration. Law enforcement can be a major asset to teachers, administrators, parents and youth.

16. To proactively promote overdose prevention and improve data gathering efforts, it is recommended that law enforcement and EMS agencies join the Southern Tier Overdose Prevention Program (STOPP) for training and monitoring purposes.

17. Local law enforcement agencies may wish to research various programs and activities that have proven to impact drug trafficking, drug violence and drug abuse. One methodology may be the Police Assisted Addiction and Recovery Initiative (PAARI) as cited in earlier portions of this report.

18. Local law enforcement and EMS have the opportunity to link families, loved ones and those participating in heroin and opioid use to treatment resources and education materials. Individuals who have received Narcan or who have administered Narcan to a friend or family member, but refuse transport for hospital evaluation, should be provided resources at the scene.

19. Continue to build knowledge of local and regional resources and advocate for equitable resources at the rural level.

20. Often healthcare is not determined by the healthcare provider or patient, but by financial entities paying for care. Advocacy should focus on patient rights and against the perceived conflict of interest of having insurance companies dictate treatment plans.

21. Advocate at the local community-level, state-wide and nationally regarding the need for greater post treatment supports.

Allegany County
Evalumetrics Youth Survey
(Risk and Protective Factor Survey)
2017

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ACASA

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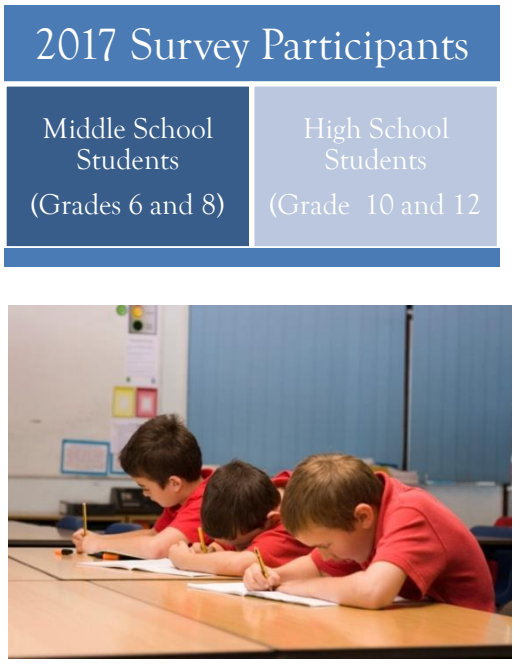
Evalumetrics Youth Survey
2017 Allegany County

INTRODUCTION

The Evalumetrics Youth Survey (EYS) was conducted in schools throughout Allegany County every odd-numbered year since1999 and most recently, in 2017. The EYS is based on the Risk and Protective Factor Model developed at the University of Washington by J. David Hawkins, Richard Catalano, and Janet Miller. The EYS asks students about several critical health risk behaviors such as substance use, violence and depression. The EYS also includes questions about students' attitudes toward and connection to school, family and community.

This report provides results for Allegany County Schools. Details of the student response sample for Allegany County are shown in appendix A.



Allegany County		
Grade	Females	Males
6th	179	224
8th	194	242
10th	194	179
12th	170	142
Total	737	787

Prevalence of Substance Use

Young peoples' use and abuse of alcohol, tobacco and other drugs remains a major concern for parents, health professionals, law enforcement and schools. Since the 1990's substance abuse prevention has developed evidence-based programs based on the Risk and Protective Factor Model. In the EYS, students were asked if, and how often they had used alcohol, tobacco, marijuana or other substances. Tables 1 (see Attachment I) shows the proportions of students (prevalence) who reported ever using, using in the 12 months prior to the survey and using in the 30 days prior to the survey. Alcohol, Marijuana and cigarettes are the most frequently used substances. Significant results include:

Drank Alcohol in Past 30 Days

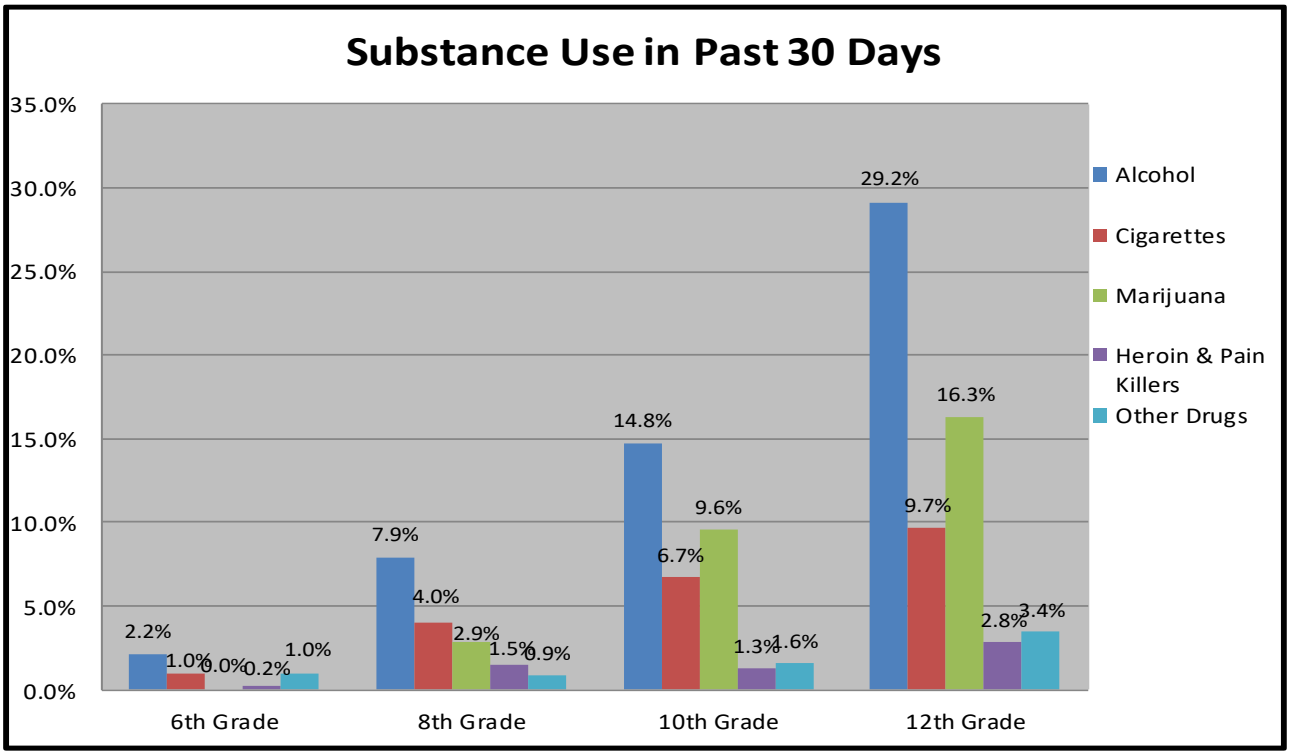
- 0.7% of 6th grade students reported drinking alcohol in the past 30 days.
- 1.8% of 8th graders drank in the past month.
- 6.7% of 10th graders drank at least once in the past 30 days.
- 16.9% of 12th graders drank alcohol at least once in the past month.

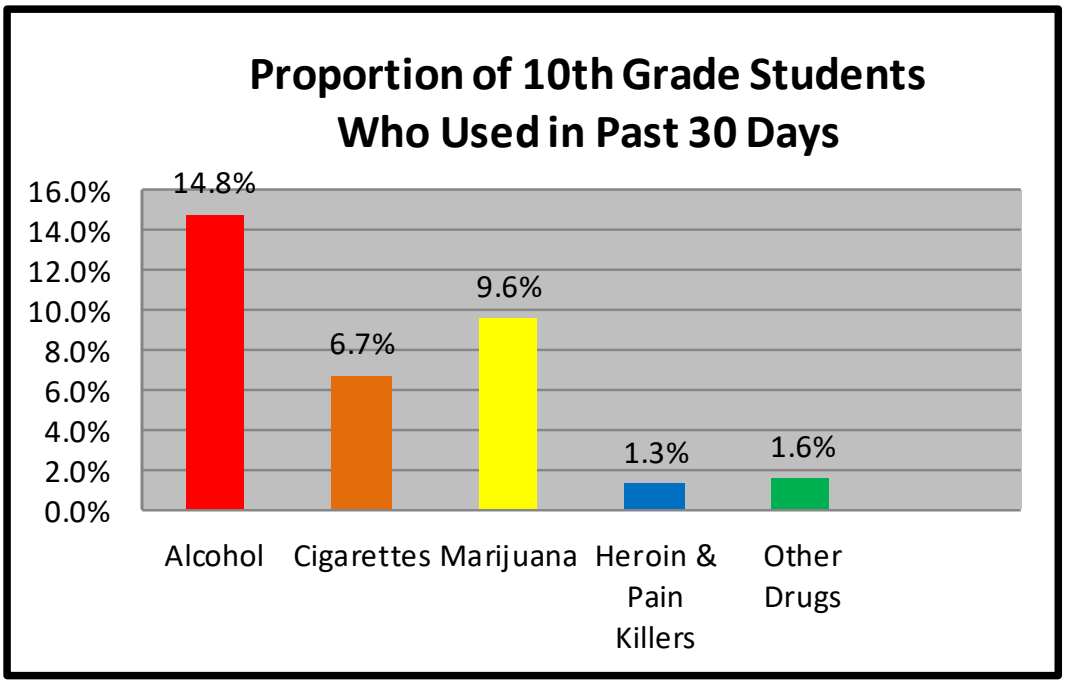
Smoked Cigarettes in Past 30 Days

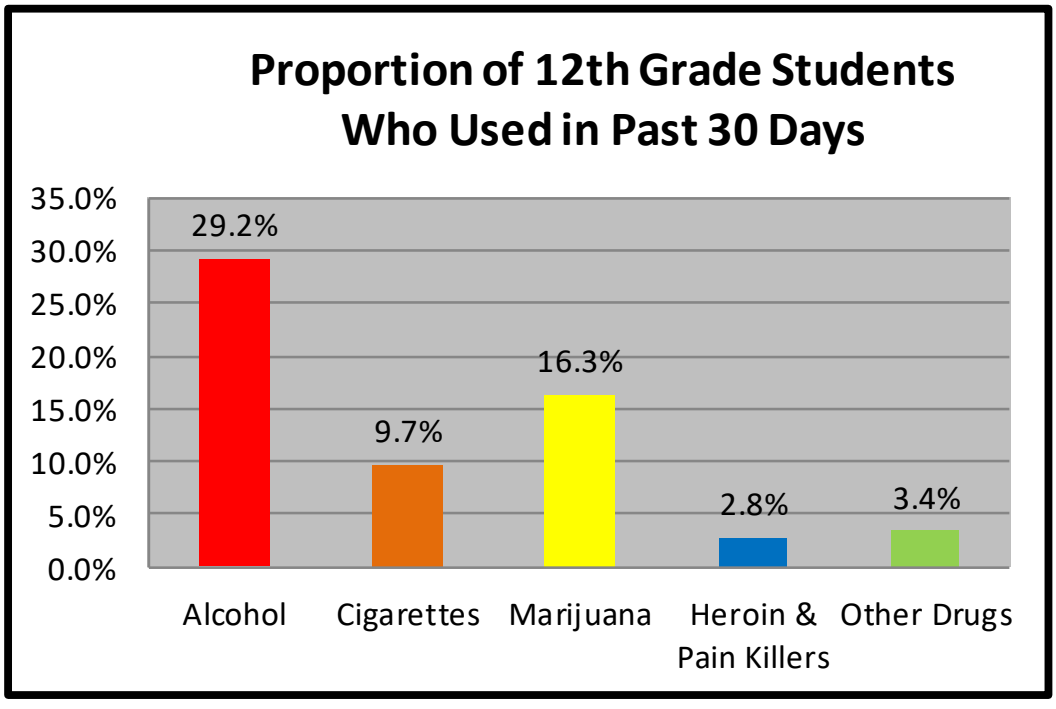
- 1.0% of 6th grade students reported smoking cigarettes in the past 30 days.
- 4.0% of 8th graders smoked cigarettes in the past month.
- 6.7% of 10th graders smoked cigarettes in the past 30 days.
- 9.7% of 12th graders smoked cigarettes in the past month.

Smoked Marijuana in Past 30 Days

- 0.0% of 6th grade students reported smoking Marijuana in the past 30 days.
- 2.9% of 8th graders smoked Marijuana in the past month.
- 9.6% of 10th graders smoked Marijuana in the past 30 days.
- 16.3% of 12th graders smoked Marijuana in the past 30 days.


Substance Use in Past 30 Days
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
2.2%
1.0%
0.0%
0.2%
1.0%
7.9%
4.0%
2.9%
1.5%
0.9%
14.8%
6.7%
9.6%
1.3%
1.6%
29.2%
9.7%
16.3%
2.8%
3.4%
6th Grade
8th Grade
10th Grade
12th Grade
Alcohol
Cigarettes
Marijuana
Heroin & Pain Killers
Other Drugs


Proportion of 10th Grade Students Who Used in Past 30 Days
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
14.8%
6.7%
9.6%
1.3%
1.6%
Alcohol
Cigarettes
Marijuana
Heroin & Pain Killers
Other Drugs


Proportion of 12th Grade Students Who Used in Past 30 Days
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
29.2%
9.7%
16.3%
2.8%
3.4%
Alcohol
Cigarettes
Marijuana
Heroin & Pain Killers
Other Drugs

Risk and Protective Factors

The Risk and Protective Factor Model was developed at the University of Washington by J. David Hawkins, Richard Catalano, and Janet Miller. The model was developed by reviewing two decades of research that identified a link between certain risk factors and several problem behaviors and between protective factors and avoidance of problem behaviors. A major strength of this model is that by implementing strategies to reduce factors that predict one problem, e.g. alcohol and other drug abuse, communities will likely reduce other negative behaviors, such as violence, delinquency, teen-pregnancy, gambling and dropping out of school.

While some risk factor prevalence might be low when compared to prevalence of use, it should be noted that risk factors are often predictors of future behavior. For example, the most common risk factor for 6th grade is Lack of Perceived Risk from Drug Use yet reported use of drugs by 6th graders is very rare [1].

Middle School Risk and Protective Factors - Table 2a (see Attachment 1) shows the proportion of 6th grade students who scored at or above the risk level on each factor scale. The table is sorted from the most prevalent risk factors to least common in 2017.

6th Grade Risk and Protective Factors

Note:
An "R" in ( ) means students were at risk from that Risk Factor.
A "P" in ( ) means students were at risk from lack of that Protective Factor.

Domains
-C=Community Domain
-F=Family Domain
-S=School Domain
-I/P=Individual/Peer Domain

The most prevalent factor among 6th grade students was Lack Opportunities for Prosocial Involvement in the Community (P1-C) with 18.8% scoring above the risk level.

Other prevalent factors include: Poor Family Discipline (R7-F) (16.6%); Lack Perceived Risks of Drug Use (P8-PI) (16.4%); and Lack Rewards for Prosocial Behavior in the Community (P2-C) (13.5%).

[1] ***Note: The survey does not measure all risk or protective factors. For example, poverty is a significant risk factor.***

Middle School Risk and Protective Factors- Table 2b (see Attachment 1) shows the proportion of 8th grade students who scored at or above the risk level on each factor scale. The table is sorted by the most prevalent risk factors to least common in 2017.

8th Grade Risk and Protective Factors

Note:
An "R" in ( ) means students were at risk from that Risk Factor.
A "P" in ( ) means students were at risk from lack of that Protective Factor.

Domains
-C=Community Domain
-F=Family Domain
-S=School Domain
-I/P=Individual/Peer Domain

The most prevalent factor among 8th grade students was Lack Opportunities for Prosocial Involvement in the Community (P1-C) with 28.4% scoring above the risk level.

Other prevalent factors include: Lack Rewards for Prosocial Behavior in the Community (P2-C) (20.3%); Family History of Antisocial Behavior (R9-F) (15.4%); and Sensation Seeking (R22-PI) (15.2%).

High School Risk and Protective Factors - Table 2c (see Attachment 1) shows the proportion of 10th grade students who scored at or above the risk level on each factor. The table is sorted by most common Risk Factors to least common in 2017.

10th Grade Risk and Protective Factors

Note:
An "R" in ( ) means students were at risk from that Risk Factor.
A "P" in ( ) means students were at risk from lack of that Protective Factor.

Domains
-C=Community Domain
-F=Family Domain
-S=School Domain
-I/P=Individual/Peer Domain

The most prevalent factor among 10th grade students was Lack Rewards for Prosocial Behavior in the Community (P2-C) with 27.2% scoring at or above the risk level.

Other factors were: Lack Opportunities for Prosocial Involvement in the Community (P1-C) (26.7%); Low Neighborhood Attachment (R1-C) (23.8%); and Family History of Antisocial Behavior (R9-F) (22.5%).

High School Risk and Protective Factors - Table 2d (see Attachment 1) shows the proportion of 12th grade students who scored at or above the risk level on each factor. The table is sorted by most common Risk Factors to least common in 2017.

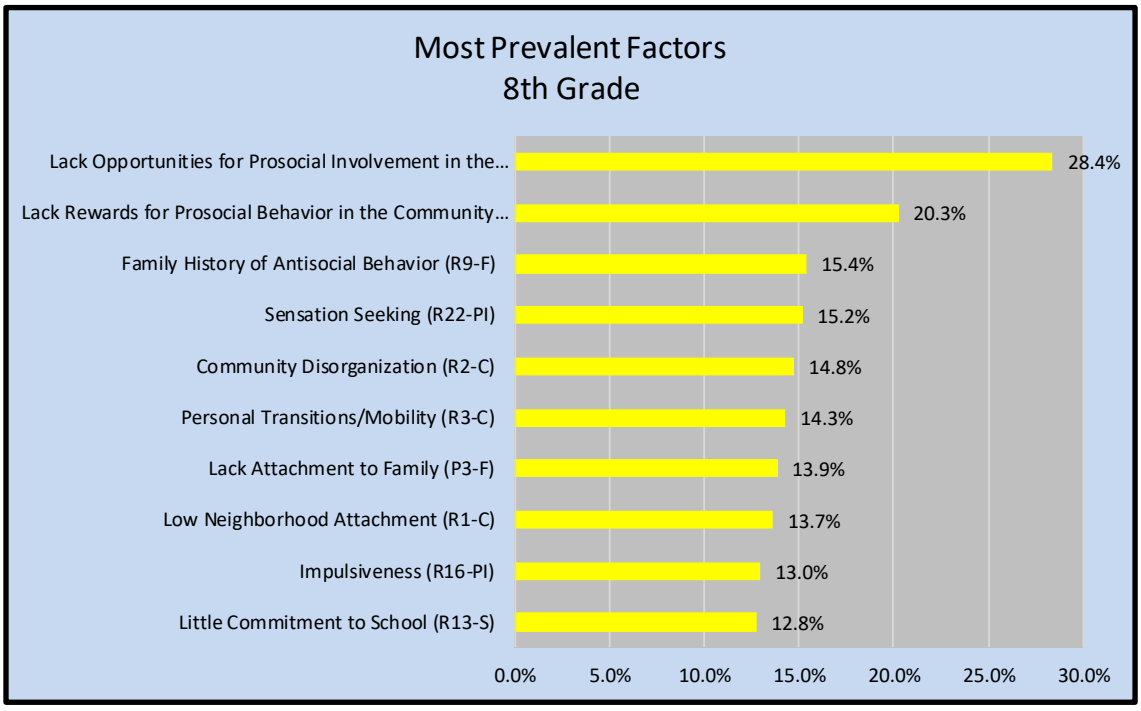
12th Grade Risk and Protective Factors

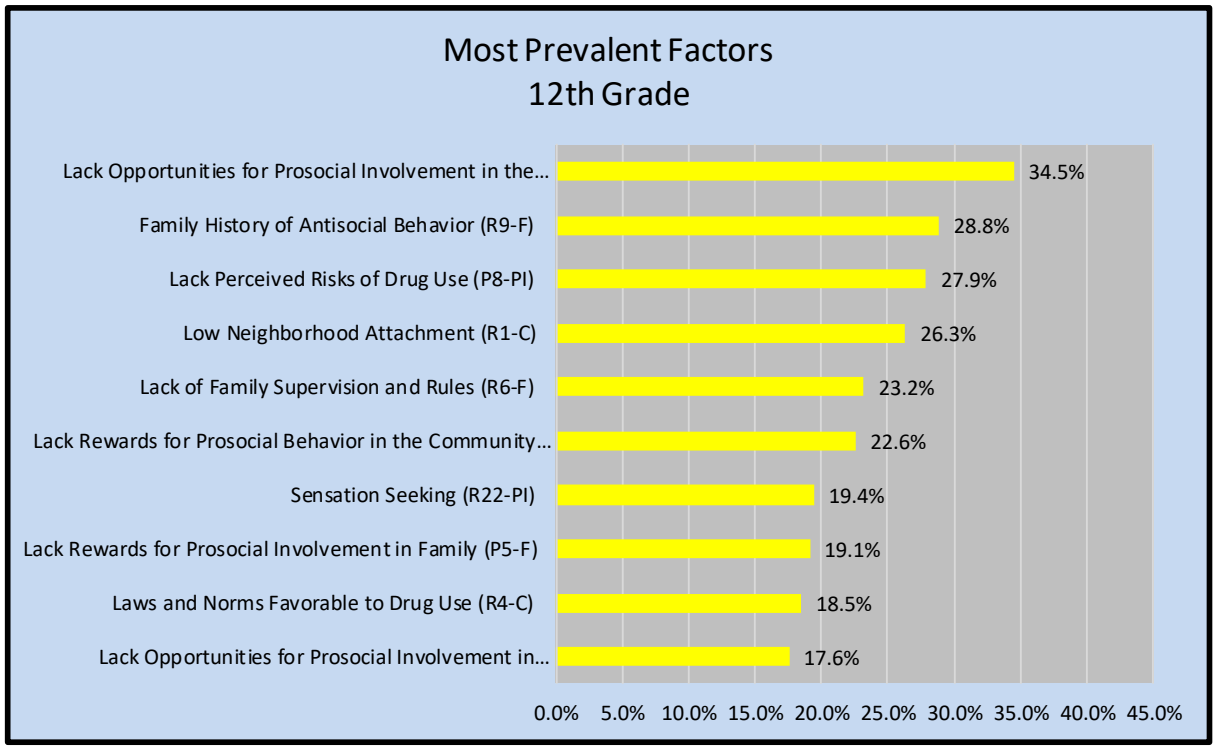
Note:
An "R" in ( ) means students were at risk from that Risk Factor.
A "P" in ( ) means students were at risk from lack of that Protective Factor.

Domains
-C=Community Domain
-F=Family Domain
-S=School Domain
-I/P=Individual/Peer Domain

The most prevalent factor among 12th grade students was Lack Opportunities for Prosocial Involvement in the Community (P1-C) with 34.5% scoring at or above the risk level.

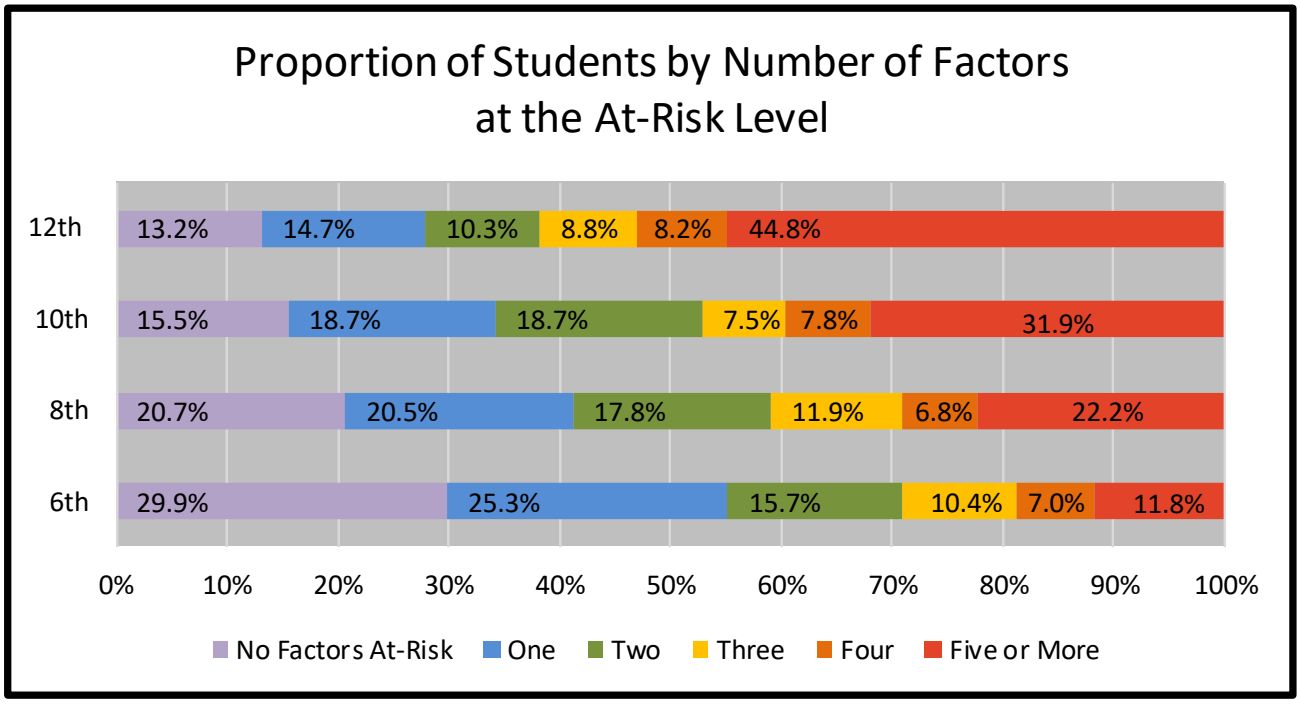
Other factors were: Family History of Antisocial Behavior (R9-F) (28.8%); Lack Perceived Risks of Drug Use (P8-PI) (27.9%); and Low Neighborhood Attachment (R1-C) (26.3%).


Most Prevalent Factors
8th Grade
Lack Opportunities for Prosocial Involvement in the...
28.4%
Lack Rewards for Prosocial Behavior in the Community...
20.3%
Family History of Antisocial Behavior (R9-F)
15.4%
Sensation Seeking (R22-PI)
15.2%
Community Disorganization (R2-C)
14.8%
Personal Transitions/Mobility (R3-C)
14.3%
Lack Attachment to Family (P3-F)
13.9%
Low Neighborhood Attachment (R1-C)
13.7%
Impulsiveness (R16-PI)
13.0%
Little Commitment to School (R13-S)
12.8%
0.0% 5.0% 10.0% 15.0% 20.0% 25.0% 30.0%


Most Prevalent Factors
12th Grade
Lack Opportunities for Prosocial Involvement in the...
34.5%
Family History of Antisocial Behavior (R9-F)
28.8%
Lack Perceived Risks of Drug Use (P8-PI)
27.9%
Low Neighborhood Attachment (R1-C)
26.3%
Lack of Family Supervision and Rules (R6-F)
23.2%
Lack Rewards for Prosocial Behavior in the Community...
22.6%
Sensation Seeking (R22-PI)
19.4%
Lack Rewards for Prosocial Involvement in Family (P5-F)
19.1%
Laws and Norms Favorable to Drug Use (R4-C)
18.5%
Lack Opportunities for Prosocial Involvement in...
17.6%
0.0% 5.0% 10.0% 15.0% 20.0% 25.0% 30.0% 35.0% 40.0% 45.0%

Overall Risk

The Risk and Protective Factor framework states that an individual student's likelihood of being involved in substance abuse, violence or other negative behavior increases relative to the number of factors from which the student is at-risk. Thus, an additional measure of overall risk in a community is the number of students reporting multiple factors beyond the at-risk level. Table 3 (see Attachment 1) shows the frequencies of the number of factors on which students scored above the risk level.



Bullying

Bullying and other violent behavior are a major concern for students, parents and school administrators. Several items in the Risk and Protective Factor Survey relate to bullying. Tables 4a and 4b (see Attachment 1) present responses to these items.

26.3% of 6th grade students said ***they had been bullied*** at least once in the 30 days prior to the survey.

7.0% of 6th grade students said ***they had bullied another student*** at least once in the 30 days prior to the survey.

16.7% of 8th grade students said ***they had been bullied*** at least once in the 30 days prior to the survey.

10.1% of 8th grade students said ***they had bullied another student*** at least once in the 30 days prior to the survey.

16.9% of 10th grade students said ***they had been bullied*** at least once in the 30 days prior to the survey.

13.5% of 10th grade students said ***they had bullied another student*** at least once in the 30 days prior to the survey.

14.6% of 12th grade students said ***they had been bullied*** at least once in the 30 days prior to the survey.

11.9% of 12th grade students said ***they had bullied another student*** at least once in the 30 days prior to the survey.

Depression

Teenage depression is a serious problem that affects every aspect of a teen's life. Left untreated, teen depression can lead to problems at home and school, drug abuse, and an overwhelming sense of sadness, despair, or anger. The survey included several items identical to the Centers for Disease Control and Prevention, Youth Risk Behavior Survey. The first of these asks students if they "feel depressed most of the time, even if you feel happy sometimes." Tables 5a – 5d (see Attachment 1) present responses to items related to depression and suicide ideation.

- 51.5% of 6th grade ***female*** students said that in the past year ***they felt depressed most of the time even if they felt happy some of the time***.
- 42.0% of 6th grade ***male*** students said that in the past year ***they felt depressed most of the time even if they felt happy some of the time***.

- 54.4% of 8th grade ***female*** students said that in the past year ***they felt depressed most of the time even if they felt happy some of the time***.
- 43.8% of 8th grade ***male*** students said that in the past year ***they felt depressed most of the time even if they felt happy some of the time***.

- 56.7% of 10th grade ***female*** students said that in the past year ***they felt depressed most of the time even if they felt happy some of the time***.
- 35.8% of 10th grade ***male*** students said that in the past year ***they felt depressed most of the time even if they felt happy some of the time***.

- 55.4% of 12th grade ***female*** students said that in the past year ***they felt depressed most of the time even if they felt happy some of the time***.
- 30.3% of 12th grade ***male*** students said that in the past year ***they felt depressed most of the time even if they felt happy some of the time***.

Suicide Ideation

The greatest concern about depression and other negative feelings is the possibility that a student might contemplate, plan or attempt suicide. Items from the Centers for Disease Control and Prevention, Youth Risk Behavior Survey were included in the survey to address these concerns.

3.9% of 6th grade ***female*** students said that at least once in the past year ***they made a plan to commit suicide***.

3.6% of 6th grade ***male*** students said that at least once in the past year ***they made a plan to commit suicide***.

12.9% of 8th grade ***female*** students said that at least once in the past year ***they made a plan to commit suicide***.

5.4% of 8th grade ***male*** students said that at least once in the past year ***they made a plan to commit suicide***.

14.9% of 10th grade ***female*** students said that at least once in the past year ***they made a plan to commit suicide***.

6.7% of 10th grade ***male*** students said that at least once in the past year ***they made a plan to commit suicide***.

14.7% of 12th grade ***female*** students said that at least once in the past year ***they made a plan to commit suicide***.

6.3% of 12th grade ***male*** students said that at least once in the past year ***they made a plan to commit suicide***.

Self-Injury

A recently recognized phenomenon among young people is intentional self-injury. Some teens have a difficult time balancing their conflicting feelings and some turn to harmful activities like drinking, using drugs, or self-injury. Intentional self-injurious behavior, through cutting or burning, is used as a mechanism for coping with emotional distress. Those who self-injure often are experiencing overwhelming feelings, like extreme anxiety or tension, and in the moment self-injury may seem to provide a feeling of escape or relief. These injuries are not a suicide attempts and often are interpreted as expressions of anger or psychological pain. Table 5e (see Attachment 1) presents responses to this item.

8.4% of 6th grade ***female*** students said that ***they had hurt themselves by cutting or burning when they were upset.***

12.1% of 6th grade ***male*** students said that ***they had hurt themselves by cutting or burning when they were upset.***

21.6% of 8th grade ***female*** students said that ***they had hurt themselves by cutting or burning when they were upset.***

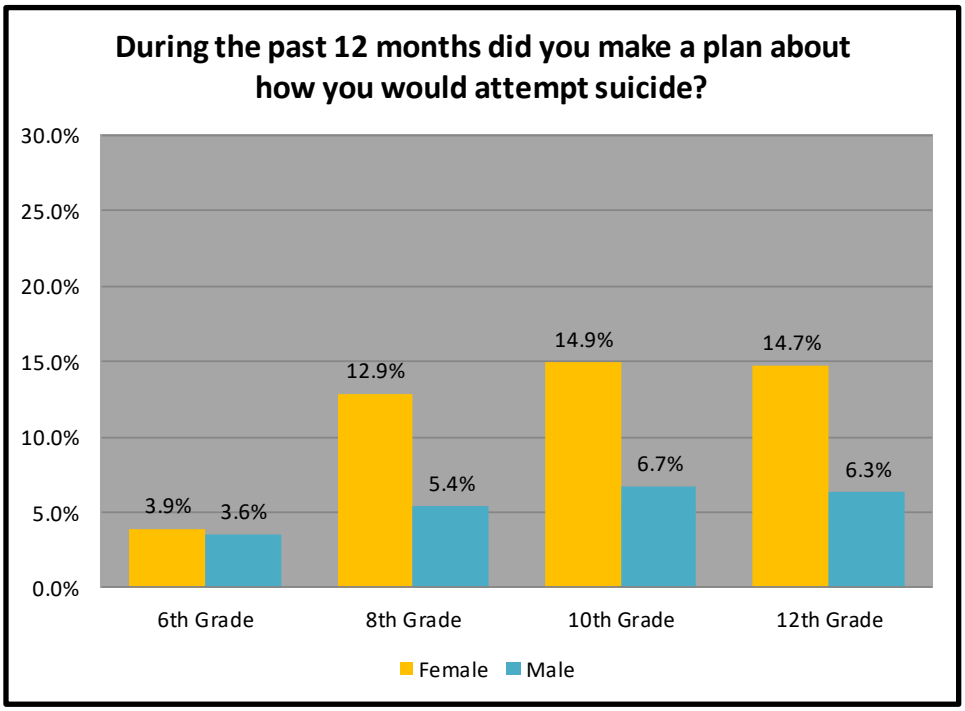
10.7% of 8th grade ***male*** students said that ***they had hurt themselves by cutting or burning when they were upset.***

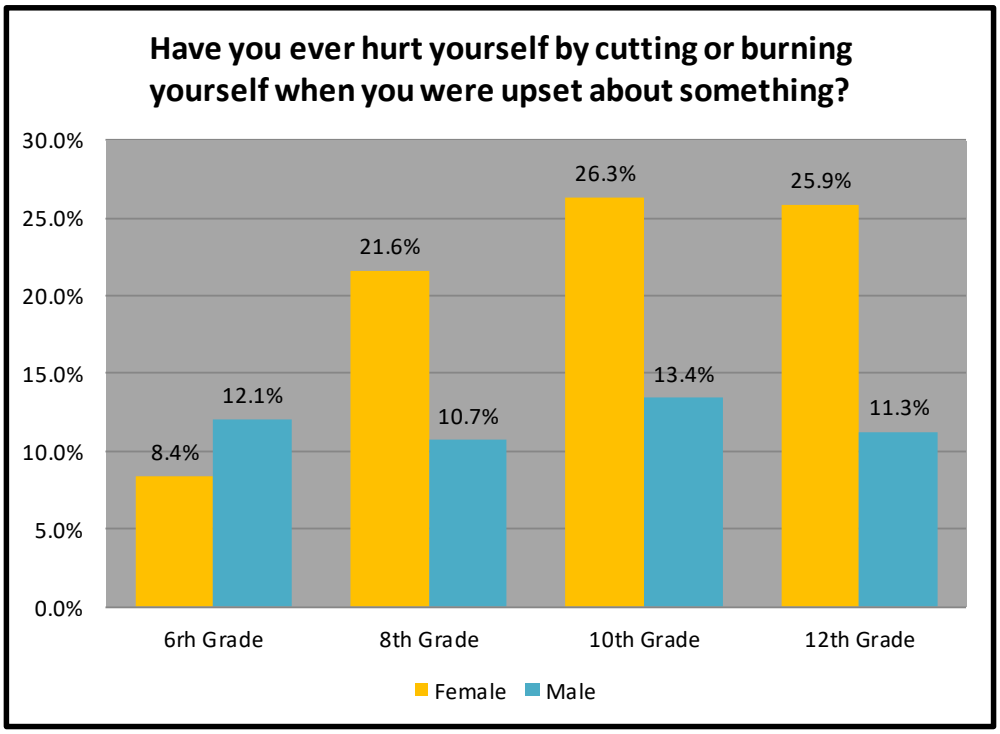
26.3% of 10th grade ***female*** students said that ***they had hurt themselves by cutting or burning when they were upset.***

13.4% of 10th grade ***male*** students said that ***they had hurt themselves by cutting or burning when they were upset.***

25.9% of 12th grade ***female*** students said that ***they had hurt themselves by cutting or burning when they were upset.***

11.3% of 12th grade ***male*** students said that ***they had hurt themselves by cutting or burning when they were upset.***


During the past 12 months did you make a plan about how you would attempt suicide?
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
3.9%
3.6%
12.9%
5.4%
14.9%
6.7%
14.7%
6.3%
6th Grade
8th Grade
10th Grade
12th Grade
Female
Male


Have you ever hurt yourself by cutting or burning yourself when you were upset about something?
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
8.4%
12.1%
21.6%
10.7%
26.3%
13.4%
25.9%
11.3%
6rh Grade
8th Grade
10th Grade
12th Grade
Female
Male

Adverse Childhood Experiences

Extensive research on trauma experienced by young people has led to the development of the concept of Adverse Childhood Experiences or ACE's. Adverse experiences include events that result from abuse, neglect and household dysfunction. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse. The 2017 EYS included a question about how many of the 11 most common ACEs the student had experienced. The survey did not ask about specific trauma. Table 6 shows the frequency of ACE scores. An ACE score of 2 or more is considered an at-risk level and has been shown to be related to many of the substance use and health risk behaviors included in the survey. More than one in 10 (11.3%) 6th grader and nearly one third (31.0%) of 12th graders reported an ACE score of two or more.

Allegany County

Evalumetrics Youth Survey 2017	**6th**	**8th**	**10th**	**12th**
How many Adverse Childhood Experiences?	**415**	**454**	**386**	**319**
None	45.3%	43.0%	36.8%	33.9%
1	25.5%	21.8%	18.7%	19.1%
2	11.6%	12.3%	12.7%	9.7%
3	3.4%	6.6%	9.6%	7.8%
4	2.7%	4.2%	3.9%	6.3%
5	1.2%	1.8%	4.9%	5.0%
6	1.4%	1.3%	1.8%	3.4%
7	0.0%	1.5%	1.6%	1.9%
8	0.2%	0.7%	0.8%	1.9%
9	0.7%	0.4%	0.0%	1.9%
10	0.0%	0.0%	0.5%	1.3%
11	1.7%	0.9%	1.3%	1.6%
More than two	11.3%	17.4%	24.4%	31.0%

ATTACHMENT 1

Risk and Protective Factor Survey

Results Tables

Prevalence of Substance Use

Allegany County

2017

Table 1.				
Allegany County				
Evalumetrics Youth Survey 2017	**Allegany County Schools**	**Allegany County Schools**	**Allegany County Schools**	**Allegany County Schools**
Reported Substance Use	**6th Grade**	**8th Grade**	**10th Grade**	**12th Grade**
Alcohol Use (except as part of religion) N=	**415**	**454**	**386**	**319**
Ever Used	9.9%	22.7%	46.9%	58.0%
Used in Past 12 Months	5.5%	16.1%	41.5%	54.5%
Used in Past 30 Days	2.2%	7.9%	14.8%	29.2%
>5 Drinks at Least Once in Past 30 Days	0.7%	1.8%	6.7%	16.9%

Allegany County				
Evalumetrics Youth Survey 2017	**Allegany County Schools**	**Allegany County Schools**	**Allegany County Schools**	**Allegany County Schools**
Reported Substance Use	**6th Grade**	**8th Grade**	**10th Grade**	**12th Grade**
Cigarette Use	**415**	**454**	**386**	**319**
Ever Used	4.6%	14.8%	26.9%	33.5%
Used in Past 12 Months	1.4%	6.2%	14.5%	29.8%
Used in Past 30 Days	1.0%	4.0%	6.7%	9.7%

Allegany County				
Evalumetrics Youth Survey 2017	**Allegany County Schools**	**Allegany County Schools**	**Allegany County Schools**	**Allegany County Schools**
Reported Substance Use	**6th Grade**	**8th Grade**	**10th Grade**	**12th Grade**
Marijuana Use	**415**	**454**	**386**	**319**
Ever Used	1.0%	7.9%	19.4%	35.7%
Used in Past 12 Months	0.5%	5.9%	15.8%	27.9%
Used in Past 30 Days	0.0%	2.9%	9.6%	16.3%

Allegany County				
Evalumetrics Youth Survey 2017	**Allegany County Schools**	**Allegany County Schools**	**Allegany County Schools**	**Allegany County Schools**
Reported Substance Use	**6th Grade**	**8th Grade**	**10th Grade**	**12th Grade**
Heroin & Prescription Pain Killers Use	**415**	**454**	**386**	**319**
Used in Past 12 Months	1.0%	2.0%	2.6%	3.4%
Used in Past 30 Days	0.2%	1.5%	1.3%	2.8%

Table 1-con't.				
Allegany County	Allegany County	Allegany County	Allegany County	Allegany County
Evalumetrics Youth Survey 2017	Schools	Schools	Schools	Schools
Reported Substance Use	6th Grade	8th Grade	10th Grade	12th Grade
Other Drug Use	415	454	386	319
Used ANY in Past 30 days	1.0%	0.9%	1.6%	3.4%
Cocaine	0.5%	0.4%	1.3%	1.3%
Cough/Cold Medicines	1.0%	0.9%	1.6%	1.6%
Crack	0.5%	0.7%	0.8%	0.9%
Ecstasy	0.5%	0.4%	0.8%	1.3%
Heroin	0.0%	0.7%	0.8%	0.9%
Inhalants	0.7%	0.4%	0.5%	1.3%
LSD/Psychedelic	0.2%	0.4%	0.5%	2.8%
Meth	0.5%	0.7%	0.3%	1.3%
Steroids	0.2%	0.4%	0.3%	1.3%
Uppers/Amphetamines	0.2%	0.4%	0.3%	1.6%
Pain killers such as Vicodin/Oxycontin	0.2%	0.9%	0.5%	1.9%
Other Prescription	0.0%	0.9%	0.5%	1.3%
Over the counter drugs	0.2%	0.9%	0.8%	0.6%
Other	0.2%	0.7%	0.3%	0.6%

Comparison to National Survey

8th Grade

Evalumetrics Youth Factor Survey Reported Substance Use Alcohol Use (except as part of religion) N=	Allegany County Schools 8th Grade 454	National 8th Grade
Ever Used	22.7%	22.8%
Used in Past 12 Months	16.1%	17.6%
Used in Past 30 Days	7.9%	7.3%
>5 Drinks at Least Once in Past 30 Days	1.8%	1.8%

Evalumetrics Youth Factor Survey Reported Substance Use Cigarette Use	Allegany County Schools 8th Grade 454	National 8th Grade
Ever Used	14.8%	9.8%
Used in Past 12 Months	6.2%	2.6%
Used in Past 30 Days	4.0%	2.6%

Evalumetrics Youth Factor Survey Reported Substance Use Marijuana Use	Allegany County Schools 8th Grade 454	National 8th Grade
Ever Used	7.9%	12.8%
Used in Past 12 Months	5.9%	9.4%
Used in Past 30 Days	2.9%	5.4%

Evalumetrics Youth Factor Survey Reported Substance Use Other Drug Use	Allegany County Schools 8th Grade 454	National 8th Grade
Used ANY in Past 30 days	0.9%	0.3%
Cocaine	0.4%	0.3%
Cough.Cold Medicines	0.9%	n/a
Crack	0.7%	0.2%
Ecstasy	0.4%	0.3%
Heroin	0.7%	0.2%
Inhalants	0.4%	5.4%
LSD/Psychedelic	0.4%	1.8%
Methamphetamine	0.7%	0.3%
Steroids	0.4%	0.3%
Uppers/Amphetamines	0.4%	1.7%
Pain killers such as Vicodin/Oxycontin	0.9%	n/a
Other Prescription	0.9%	n/a
Over the counter drugs	0.9%	n/a
Other	0.7%	n/a

10th Grade

Evalumetrics Youth Factor Survey Reported Substance Use Alcohol Use (except as part of religion) N=	Allegany County Schools 10th Grade 386	National 10th Grade
Ever Used	46.9%	43.4%
Used in Past 12 Months	41.5%	38.3%
Used in Past 30 Days	14.8%	19.9%
>5 Drinks at Least Once in Past 30 Days	6.7%	9.0%

Evalumetrics Youth Survey
2017 Allegany County

Evalumetrics Youth Factor Survey Reported Substance Use Cigarette Use	Allegany County Schools 10th Grade 386	National 10th Grade
Ever Used	26.9%	17.5%
Used in Past 12 Months	14.5%	4.9%
Used in Past 30 Days	6.7%	4.9%

Allegany County Evalumetrics Youth Factor Survey Reported Substance Use Marijuana Use	Allegany County Schools 10th Grade 386	Monitoring the Future National 10th Grade
Ever Used	19.4%	29.7%
Used in Past 12 Months	15.8%	23.9%
Used in Past 30 Days	9.6%	14.0%

Allegany County Evalumetrics Youth Factor Survey Reported Substance Use Other Drug Use	Allegany County Schools 10th Grade 386	Monitoring the Future National 10th Grade
Used ANY in Past 30 days	1.6%	0.4%
Cocaine	1.3%	0.4%
Cough.Cold Medicines	1.6%	n/a
Crack	0.8%	0.2%
Ecstasy	0.8%	0.5%
Heroin	0.8%	0.2%
Inhalants	0.5%	14.0%
LSD/Psychedelic	0.5%	1.0%
Methamphetamine	0.3%	0.2%
Steroids	0.3%	0.3%
Uppers/Amphetamines	0.3%	2.7%
Pain killers such as Vicodin/Oxycontin	0.5%	n/a
Other Prescription	0.5%	n/a
Over the counter drugs	0.8%	n/a
Other	0.3%	n/a

12th Grade

Allegany County Evalumetrics Youth Factor Survey Reported Substance Use Alcohol Use (except as part of religion) N=	Allegany County Schools 12th Grade 319	Monitoring the Future National 12th Grade
Ever Used	58.0%	61.2%
Used in Past 12 Months	54.5%	55.6%
Used in Past 30 Days	29.2%	33.2%
>5 Drinks at Least Once in Past 30 Days	16.9%	20.4%

Allegany County Evalumetrics Youth Factor Survey Reported Substance Use Cigarette Use	Allegany County Schools 12th Grade 319	Monitoring the Future National 12th Grade
Ever Used	33.5%	28.3%
Used in Past 12 Months	29.8%	10.5%
Used in Past 30 Days	9.7%	10.5%

Allegany County Evalumetrics Youth Factor Survey Reported Substance Use Marijuana Use	Allegany County Schools 12th Grade 319	Monitoring the Future National 12th Grade
Ever Used	35.7%	44.5%
Used in Past 12 Months	27.9%	35.6%
Used in Past 30 Days	16.3%	22.5%

Allegany County Evalumetrics Youth Factor Survey Reported Substance Use Other Drug Use	Allegany County Schools 12th Grade 319	Monitoring the Future National 12th Grade
Used ANY in Past 30 days	3.4%	0.9%
Cocaine	1.3%	0.9%
Cough.Cold Medicines	1.6%	n/a
Crack	0.9%	0.5%
Ecstasy	1.3%	0.5%
Heroin	0.9%	0.2%
Inhalants	1.3%	22.5%
LSD/Psychedelic	2.8%	0.8%
Methamphetamine	1.3%	0.3%
Steroids	1.3%	0.7%
Uppers/Amphetamines	1.6%	3.0%
Pain killers such as Vicodin/Oxycontin	1.9%	n/a
Other Prescription	1.3%	n/a
Over the counter drugs	0.6%	n/a
Other	0.6%	n/a

Risk and Protective Factors – Sixth Grade

6th Grade Students

Table 2a.

Year	Allegany County 2017
N=	415
Lack Opportunities for Prosocial Involvement in the Community (P1-C)	18.8%
Poor Family Discipline (R7-F)	16.6%
Lack Perceived Risks of Drug Use (P8-PI)	16.4%
Lack Rewards for Prosocial Behavior in the Community (P2-C)	13.5%
Personal Transitions/Mobility (R3-C)	11.6%
Sensation Seeking (R22-PI)	10.6%
Low Neighborhood Attachment (R1-C)	9.6%
Family Conflict (R8-F)	9.2%
Community Disorganization (R2-C)	8.7%
Lack Opportunities for Prosocial Involvement in Family(P4-F)	8.7%
Lack Rewards for Prosocial Involvement in Family (P5-F)	8.2%
Lack Opportunities for Prosocial Involvement in School (P6-S)	7.7%
Lack Attachment to Family (P3-F)	7.2%
Impulsiveness (R16-PI)	7.0%
Family History of Antisocial Behavior (R9-F)	6.0%
Rebelliousness (R14-PI)	5.8%
Lack of Family Supervision and Rules (R6-F)	5.5%
Little Commitment to School (R13-S)	5.3%
Favorable Attitudes Toward Antisocial Behavior (R18-PI)	4.6%
Lack Social Skills (P10-PI)	4.3%
Lack Rewards for Prosocial Involvement in School(P7-S)	4.1%
Antisocial Behavior (R17-PI)	3.1%
Rewards for Antisocial Involvement (R23-PI)	3.1%
Interaction With Antisocial Peers (R20-PI)	2.7%
Parental Attitudes Favorable to Antisocial Behavior (R11-F)	2.4%
Laws and Norms Favorable to Drug Use (R4-C)	1.9%
Lack a Belief in Moral Order (P11-PI)	1.9%
Parental Attitudes Favorable to Drug Use (R10-F)	1.4%
Favorable Attitudes Toward Drug Use (R19-PI)	1.2%
Perceived Availability of Drugs (R5-C)	0.7%
Friend Use Drugs (R21-PI)	0.0%

Risk and Protective Factors – Eighth Grade

Table 2b.

Year	Allegany County 2017
N=	454
Lack Opportunities for Prosocial Involvement in the Community (P1-C)	28.4%
Lack Rewards for Prosocial Behavior in the Community (P2-C)	20.3%
Family History of Antisocial Behavior (R9-F)	15.4%
Sensation Seeking (R22-PI)	15.2%
Community Disorganization (R2-C)	14.8%
Personal Transitions/Mobility (R3-C)	14.3%
Lack Attachment to Family (P3-F)	13.9%
Low Neighborhood Attachment (R1-C)	13.7%
Impulsiveness (R16-PI)	13.0%
Little Commitment to School (R13-S)	12.8%
Lack Perceived Risks of Drug Use (P8-PI)	12.6%
Lack Rewards for Prosocial Involvement in Family (P5-F)	11.7%
Lack Opportunities for Prosocial Involvement in School (P6-S)	11.5%
Poor Family Discipline (R7-F)	10.8%
Family Conflict (R8-F)	10.8%
Rebelliousness (R14-PI)	10.6%
Lack Opportunities for Prosocial Involvement in Family(P4-F)	9.3%
Lack of Family Supervision and Rules (R6-F)	8.4%
Favorable Attitudes Toward Antisocial Behavior (R18-PI)	8.4%
Lack Rewards for Prosocial Involvement in School(P7-S)	8.4%
Lack Social Skills (P10-PI)	7.9%
Laws and Norms Favorable to Drug Use (R4-C)	5.5%
Interaction With Antisocial Peers (R20-PI)	4.8%
Rewards for Antisocial Involvement (R23-PI)	4.8%
Parental Attitudes Favorable to Antisocial Behavior (R11-F)	4.4%
Parental Attitudes Favorable to Drug Use (R10-F)	4.0%
Lack a Belief in Moral Order (P11-PI)	3.5%
Antisocial Behavior (R17-PI)	3.3%
Perceived Availability of Drugs (R5-C)	3.1%
Favorable Attitudes Toward Drug Use (R19-PI)	2.6%
Friend Use Drugs (R21-PI)	1.8%

Risk and Protective Factors – Tenth Grade

Table 2c.

	Allegany County
Year	**2017**
N=	**386**
Lack Rewards for Prosocial Behavior in the Community (P2-C)	27.2%
Lack Opportunities for Prosocial Involvement in the Community (P1-C)	26.7%
Low Neighborhood Attachment (R1-C)	23.8%
Family History of Antisocial Behavior (R9-F)	22.5%
Sensation Seeking (R22-PI)	18.9%
Lack Attachment to Family (P3-F)	16.8%
Lack Opportunities for Prosocial Involvement in Family(P4-F)	16.8%
Lack Rewards for Prosocial Involvement in Family (P5-F)	16.6%
Little Commitment to School (R13-S)	14.2%
Lack Perceived Risks of Drug Use (P8-PI)	14.2%
Lack of Family Supervision and Rules (R6-F)	14.0%
Impulsiveness (R16-PI)	13.5%
Community Disorganization (R2-C)	12.4%
Personal Transitions/Mobility (R3-C)	12.4%
Rebelliousness (R14-PI)	11.1%
Laws and Norms Favorable to Drug Use (R4-C)	9.6%
Favorable Attitudes Toward Antisocial Behavior (R18-PI)	9.6%
Lack Rewards for Prosocial Involvement in School(P7-S)	9.6%
Poor Family Discipline (R7-F)	9.3%
Rewards for Antisocial Involvement (R23-PI)	8.8%
Family Conflict (R8-F)	8.5%
Friend Use Drugs (R21-PI)	8.0%
Parental Attitudes Favorable to Drug Use (R10-F)	7.8%
Favorable Attitudes Toward Drug Use (R19-PI)	7.8%
Interaction With Antisocial Peers (R20-PI)	7.5%
Perceived Availability of Drugs (R5-C)	7.3%
Lack Social Skills (P10-PI)	7.0%
Lack Opportunities for Prosocial Involvement in School (P6-S)	6.5%
Parental Attitudes Favorable to Antisocial Behavior (R11-F)	5.7%
Lack a Belief in Moral Order (P11-PI)	4.1%
Antisocial Behavior (R17-PI)	2.8%

Risk and Protective Factors – Twelfth Grade

Table 2d.

Year	Allegany County 2017
N=	319
Lack Opportunities for Prosocial Involvement in the Community (P1-C)	34.5%
Family History of Antisocial Behavior (R9-F)	28.8%
Lack Perceived Risks of Drug Use (P8-PI)	27.9%
Low Neighborhood Attachment (R1-C)	26.3%
Lack of Family Supervision and Rules (R6-F)	23.2%
Lack Rewards for Prosocial Behavior in the Community (P2-C)	22.6%
Sensation Seeking (R22-PI)	19.4%
Lack Rewards for Prosocial Involvement in Family (P5-F)	19.1%
Laws and Norms Favorable to Drug Use (R4-C)	18.5%
Lack Opportunities for Prosocial Involvement in Family(P4-F)	17.6%
Lack Attachment to Family (P3-F)	16.9%
Parental Attitudes Favorable to Drug Use (R10-F)	15.4%
Little Commitment to School (R13-S)	15.4%
Community Disorganization (R2-C)	14.7%
Poor Family Discipline (R7-F)	13.5%
Personal Transitions/Mobility (R3-C)	12.5%
Rebelliousness (R14-PI)	12.5%
Favorable Attitudes Toward Drug Use (R19-PI)	12.2%
Friend Use Drugs (R21-PI)	12.2%
Rewards for Antisocial Involvement (R23-PI)	12.2%
Impulsiveness (R16-PI)	11.9%
Lack Rewards for Prosocial Involvement in School(P7-S)	9.4%
Perceived Availability of Drugs (R5-C)	9.1%
Family Conflict (R8-F)	8.8%
Interaction With Antisocial Peers (R20-PI)	7.8%
Favorable Attitudes Toward Antisocial Behavior (R18-PI)	7.5%
Parental Attitudes Favorable to Antisocial Behavior (R11-F)	6.3%
Lack Opportunities for Prosocial Involvement in School (P6-S)	5.3%
Lack a Belief in Moral Order (P11-PI)	5.0%
Lack Social Skills (P10-PI)	4.7%
Antisocial Behavior (R17-PI)	4.4%

Overall Risk

Table 3.
Proportion of Students by Number of Factors at the At-Risk Level

Grade	Allegany County Schools 6th	Allegany County Schools 8th	Allegany County Schools 10th	Allegany County Schools 12th
N=	**415**	**454**	**386**	**319**
No Factors At-Risk	29.9%	20.7%	15.5%	13.2%
One	25.3%	20.5%	18.7%	14.7%
Two	15.7%	17.8%	18.7%	10.3%
Three	10.4%	11.9%	7.5%	8.8%
Four	7.0%	6.8%	7.8%	8.2%
Five or More	11.8%	22.2%	31.9%	44.8%

Bullying

Table 4-a Evalumetrics Youth Survey - 2017		Allegany County Schools 6th Grade	Allegany County Schools 8th Grade	Allegany County Schools 10th Grade	Allegany County Schools 12th Grade
In the past 30 days how many times did you verbally threaten or bully someone?	N=	415	454	386	319
None		82.0%	78.9%	75.6%	81.4%
Once		11.1%	11.0%	10.9%	6.8%
Twice		2.0%	3.4%	4.3%	4.4%
Three or more		5.0%	6.7%	9.2%	7.5%

Table 4-b Evalumetrics Youth Survey - 2017		Allegany County Schools 6th Grade	Allegany County Schools 8th Grade	Allegany County Schools 10th Grade	Allegany County Schools 12th Grade
In the past 30 days how many times were you threatened or bullied by someone?	N=	415	454	386	319
None		61.6%	69.6%	72.6%	76.3%
Once		12.1%	13.8%	10.5%	7.5%
Twice		7.7%	5.8%	5.2%	4.4%
Three or more		18.6%	10.8%	11.7%	10.2%

Table 4-c Evalumetrics Youth Survey - 2017	Allegany County Schools 6th Grade	Allegany County Schools 8th Grade	Allegany County Schools 10th Grade	Allegany County Schools 12th Grade
You see some students making fun of or saying cruel thing or pushing and threatening another student.	415	454	386	319
What would you most likely do?				
join the bullying	1.9%	2.0%	1.6%	2.8%
threaten or push the bully	15.7%	15.2%	14.0%	14.1%
tell the bully to stop	37.3%	30.8%	31.3%	34.5%
support the target after bullying is over	5.8%	4.8%	6.0%	4.4%
tell a teacher or adult	42.2%	28.9%	25.6%	26.0%
nothing	8.2%	9.9%	10.9%	10.7%

Behavioral Health Risk Behaviors

Table 5-a.
Evalumetrics Youth Survey
Allegany County

In the past year have you felt depressed or sad most days, even if you felt OK sometimes?	6th Grade		8th Grade		10th Grade		12th Grade	
	Females	Males	Females	Males	Females	Males	Females	Males
N	**179**	**224**	**194**	**242**	**194**	**179**	**170**	**142**
Strongly disagree	24.0%	26.3%	22.0%	24.0%	12.4%	25.7%	16.3%	25.4%
Disagree	24.6%	25.0%	23.6%	31.0%	30.9%	32.4%	28.3%	33.1%
Agree	29.9%	25.0%	30.2%	31.4%	28.1%	24.6%	28.9%	16.9%
Strongly agree	21.6%	17.0%	24.2%	12.4%	28.7%	11.2%	26.5%	13.4%
Agree/Strongly Agree	**51.5%**	**42.0%**	**54.4%**	**43.8%**	**56.7%**	**35.8%**	**55.4%**	**30.3%**

Table 5-b.
Evalumetrics Youth Survey
Allegany County

During the past 12 months did you make a plan about how you would attempt suicide?	6th Grade		8th Grade		10th Grade		12th Grade	
	Females	Males	Females	Males	Females	Males	Females	Males
N	**179**	**224**	**194**	**242**	**194**	**179**	**170**	**142**
Yes	3.9%	3.6%	12.9%	5.4%	14.9%	6.7%	14.7%	6.3%
No	96.1%	96.4%	87.1%	94.6%	85.1%	93.3%	85.3%	93.7%

Table 5-c.
Evalumetrics Youth Survey
Allegany County

During the past 12 months, how many times did you actually attempt suicide?

	6th Grade		8th Grade		10th Grade		12th Grade	
	Females	**Males**	**Females**	**Males**	**Females**	**Males**	**Females**	**Males**
N	**179**	**224**	**194**	**242**	**194**	**179**	**170**	**142**
None	97.2%	4.9%	91.2%	8.3%	91.2%	10.6%	93.5%	9.2%
1	2.2%	1.8%	3.6%	0.8%	4.1%	3.4%	4.1%	1.4%
2	0.0%	0.4%	3.1%	0.8%	3.1%	1.1%	1.2%	1.4%
3 or more	0.6%	0.4%	2.1%	1.7%	1.5%	1.7%	1.2%	0.7%
One or more	**2.8%**	**2.7%**	**8.8%**	**3.3%**	**8.8%**	**6.1%**	**6.5%**	**3.5%**

Table 5-d
Evalumetrics Youth Survey
Allegany County

During the past 12 months did any attempt result in injury, poisoning or overdose the had to be treated by a doctor or nurse?

	6th Grade		8th Grade		10th Grade		12th Grade	
	Females	**Males**	**Females**	**Males**	**Females**	**Males**	**Females**	**Males**
N	**179**	**224**	**194**	**242**	**194**	**179**	**170**	**142**
Yes	0.6%	0.9%	2.1%	1.2%	1.0%	1.7%	1.2%	0.7%
No	99.4%	99.1%	97.9%	98.8%	99.0%	98.3%	98.8%	99.3%

Table 5-e
Evalumetrics Youth Survey

Allegany County	6th Grade		8th Grade		10th Grade		12th Grade	
Have you ever hurt yourself by cutting or burning yourself when you were upset about something?	**Females**	**Males**	**Females**	**Males**	**Females**	**Males**	**Females**	**Males**
N	**179**	**224**	**194**	**242**	**194**	**179**	**170**	**142**
Yes	8.4%	12.1%	21.6%	10.7%	26.3%	13.4%	25.9%	11.3%
No	91.6%	87.9%	78.4%	89.3%	73.7%	86.6%	74.1%	88.7%

Appendix A

METHOD

The survey instrument was a self-report web-based form completed by students in a classroom setting. The sample for the survey was all 6th, 8th, 10th and 12th grade students in Allegany County Schools. Each Risk and Protective Factor is represented by one or more scale consisting of one or more item from the survey. Appendix B provides a data dictionary with the definition of each scale. Each student was given a score for each of the scales. Separate analyses were conducted for middle school (grades 6 &8) and high school (grade 10 & 12). Based on the distribution of scores for over 20,000 students in a 2001 survey in the five-county Finger Lakes region, standard scores (z-scores) were calculated by subtracting the mean score from each individual's score and dividing by the standard deviation.

Students with a standard score of 1 or greater on any risk factor were considered to be at-risk. A standard score of –1 or less on any protective factor was considered a lack of protection and therefore at-risk.

In addition to measuring risk and protective factors, the survey measures self-reported use of alcohol, tobacco, marijuana and other substances (prevalence). It also asked about students' behaviors related to bullying, depression, and self-injury.

SAMPLE

Each school was asked to arrange for distribution and completion of the surveys on a day and in a class-period of their choice. School staff supervised all surveys. In all cases, the survey is voluntary. Parents were notified about the survey and were given the option of having their child opt out of the survey without prejudice. Students were instructed not to put their name or any identifying information on the survey form.

Table 1

Allegany County

Grade	Females	Males
6th	179	224
8th	194	242
10th	194	179
12th	170	142
Total	737	787

Appendix B

Risk and Protective Factor Survey

Factor (Scale) Definitions

COMMUNITY: Low Neighborhood Attachment (R1)

I like my neighborhood.

If I had to move, I would miss the neighborhood I now live in.

COMMUNITY: Community Disorganization (R2)

How much do each of the following statements describe your neighborhood:

crime and/or drug selling.

fights.

lots of empty or abandoned buildings.

lots of graffiti.

COMMUNITY: Personal Transitions and Mobility (R3)

Have you changed homes in the past year?

How many times have you changed homes since kindergarten?

Have you changed schools in the past year?

How many times have you changed schools since kindergarten?

COMMUNITY: Laws and Norms Favorable to Drug Use (R4)

How wrong would most adults in your neighborhood think it was for kids your age:

to use marijuana.

to drink alcohol.

to smoke cigarettes.

If a kid drank some beer, wine or hard liquor (for example, vodka, whiskey, or gin) in your neighborhood would he or she be caught by the police?

If a kid smoked marijuana in your neighborhood would he or she be caught by the police?

If a kid carried a handgun in your neighborhood would he or she be caught by the police?

COMMUNITY: Perceived Availability of Drugs & Handguns (R5)

If you wanted to get some beer, wine or hard liquor (for example, vodka, whiskey, or gin), how easy would it be for you to get some?

IF You wanted to get some cigarettes, how easy would it be for you to get some?

If you wanted to get some marijuana, how easy would it be for you to get some?

If you wanted to get a drug like cocaine, LSD, or amphetamines, how easy would it be for you to get some?

If you wanted to get a handgun, how easy would it be for you to get one?

COMMUNITY: Opportunities for Prosocial Involvement (P1)

Which of the following activities for people your age are available in your community?

sports teams.

scouting.

boys and girls clubs.

4-H clubs.

service clubs.

COMMUNITY: Rewards for Prosocial Involvement (P2)

My neighbors notice when I am doing a good job and let me know.

There are people in my neighborhood who encourage me to do my best.

There are people in my neighborhood who are proud of me when I do something well.

FAMILY: Lack of Supervision and Rules (R6)

My parents ask if I've gotten my homework done.

My parents want me to call if I'm going to be late getting home.

Would your parents know if you did not come home on time?

When I am not at home, one of my parents knows where I am and who I am with.

The rules in my family are clear.

My family has clear rules about alcohol and drug use.

FAMILY: Poor Discipline (R7)

If you drank some beer or wine or liquor (for example, vodka, whiskey, or gin) without your parents' permission, would you be caught by your parents?

If you skipped school would you be caught by your parents?

If you carried a handgun without your parents' permission, would you be caught by your parents?

FAMILY: Family Conflict (R8)

People in my family often insult or yell at each other.

People in my family have serious arguments.

We argue about the same things in my family over and over.

FAMILY: Family History of Antisocial Behavior (R9)

Has anyone in your family ever had a severe alcohol or drug problem?

Have any of your brothers or sisters ever:

drunk beer, wine or hard liquor (for example, vodka, whiskey or gin)?

smoked marijuana?

smoked cigarettes?

taken a handgun to school?

been suspended or expelled from school?

About how many adults have you known personally who in the past year have:

used marijuana, crack, cocaine, or other drugs?

sold or dealt drugs?

done other things that could get them in trouble with the police like stealing, selling stolen goods, mugging or assaulting others, etc)

gotten drunk or high?

FAMILY: Parental Attitudes Favorable Toward Drug Use (R10)

How wrong do your parents feel it would be for <u>you</u> to:

drink beer, wine or hard liquor (for example, vodka, whiskey or gin) regularly?

smoke cigarettes?

smoke marijuana?

FAMILY: Parental Attitudes Favorable to Antisocial Behavior (R11)

steal anything worth more than $5?

draw graffiti, or write things or draw pictures on buildings or other property (without the owner's permission)?

pick a fight with someone?

FAMILY: Attachment (P3)

Do you feel very close to your mother?

Do you share your thoughts and feelings with your mother?

Do you feel very close to your father?

Do you share your thoughts and feelings with your father?

FAMILY: Opportunities for Prosocial Involvement (P4)

My parents give me lots of chances to do fun things with them.

My parents ask me what I think before most family decisions affecting me are made.

If I had a personal problem, I could ask my mom or dad for help.

FAMILY: Rewards for Prosocial Involvement (P5)

My parents notice when I am doing a good job and let me know about it.

How often do your parents tell you they're proud of you for something you've done?

Do you enjoy spending time with your mother?

Do you enjoy spending time with your father?

SCHOOL: Little Commitment to School (R13)

How often do you feel that the school work you are assigned

is meaningful and important? (#55)

How interesting are most of your courses to you? (#56)

How important do you think the things you are learning in school
are going to be for your later life? (#57)

Now, thinking back over the past year in school, how often did you...

Enjoy being in school? (#58a)

Hate being in school? (#58b)

Try to do your best work in school? (#58c)

During the LAST FOUR WEEKS how many whole days have you missed...

because of illness (#59a)

because you skipped or "cut" (#59b)

for other reasons (#59c)

SCHOOL: Opportunities for Prosocial Involvement (P6)

In my school, students have lots of chances to help decide
things like class activities and rules. (#60)

There are lots of chances for students in my school to talk with a teacher one-on-one. (#61)

Teachers ask me to work on special classroom projects. (#62)

There are lots of chances for students in my school to get involved in
sports, clubs, and other school activities outside of class. (#63)

I have lots of chances to be part of class discussions or activities. (#64)

SCHOOL: Rewards for Prosocial Involvement (P7)

My teacher(s) notices when I am doing a good job and lets me know about it. (#65)

The school lets my parents know when I have done something well. (#66)

I feel safe at my school. (#67)

My teachers praise me when I work hard in school. (#68)

PEER-INDIVIDUAL: Rebelliousness (R14)

I do the opposite of what people tell me, just to get them mad.

I ignore rules that get in my way.

I like to see how much I can get away with.

PEER-INDIVIDUAL: Impulsiveness (R16)

It is important to think before you act.

Do you have to have everything right away?

I often do things without thinking about what will happen.

Do you often switch from activity to activity rather than sticking to one thing at a time?

PEER-INDIVIDUAL: Antisocial Behavior (R17)

How many times in the past year (12 months) have you:

been suspended from school?

carried a handgun?

sold illegal drugs?

stolen or tried to steal a motor vehicle such as a car or motorcycle?

been arrested?

attacked someone with the idea of seriously hurting them?

been drunk or high at school?

taken a handgun to school?

PEER-INDIVIDUAL: Favorable Attitudes Toward Antisocial Behavior (R18)

How wrong do you think it is for someone your age to:

take a handgun to school?

steal anything worth more than $5?

pick a fight with someone?

attack someone with the idea of seriously hurting them?

stay away from school all day when their parents think they are at school?

PEER-INDIVIDUAL: Favorable Attitudes Toward Drug Use (R19)

How wrong do you think it is for someone your age to:

drink beer, wine or hard liquor (for example, vodka, whiskey or gin) regularly?

smoke cigarettes?

smoke marijuana?

use LSD, cocaine, amphetamines or another illegal drug?

PEER-INDIVIDUAL: Perceived Risks of Drug Use (P8)

How much do you think people risk harming themselves (physically or in other ways) if they:

Smoke one or more packs of cigarettes per day?

Try marijuana once or twice?

Smoke marijuana regularly? Take one or two drinks of an alcoholic beverage (beer, wine, liquor) nearly every day?

PEER-INDIVIDUAL: Interaction with Antisocial Peers (R20)

Think of your four best friends (the friends you feel closest to). In the past year (12 months), how many of your best friends have:

been suspended from school?

carried a handgun?

sold illegal drugs?

stolen or tried to steal a motor vehicle such as a car or motorcycle?

been arrested?

dropped out of school?

PEER-INDIVIDUAL: Friends' Use of Drugs (R21)

Think of your four best friends (the friends you feel closest to). In the past year (12 months), how many of your best friends have:

smoked cigarettes?

tried beer, wine or hard liquor (for example, vodka, whiskey or gin) when their parents didn't know about it?

used marijuana?

used LSD, cocaine, amphetamines, or other illegal drugs?

PEER-INDIVIDUAL: Sensation Seeking (R22)

How many times have you done the following things?

Done what feels good no matter what.

Done something dangerous because someone dared you to do it.

Done crazy things even if they are a little dangerous.

PEER-INDIVIDUAL: Rewards for Antisocial Involvement (R23)

What are the chances you would be seen as cool if you:

smoked cigarettes?

began drinking alcoholic beverages regularly,
that is, at least once or twice a month?

smoked marijuana?

carried a handgun?

PEER-INDIVIDUAL: Social Skills (P10)

You're looking at CD's in a music store with a friend. You look up and see her slip a CD under her coat. She smiles and says "Which one do you want? Go ahead, take it while nobody's around." There is nobody in sight, no employees and no other customers. What would you do now?

Ignore her
Grab a CD and leave the store
Tell her to put the CD back
Act like it's a joke, and ask her to put the CD back

It's 8:00 on a weeknight and you are about to go over to a friend's home when your mother asks you where you are going. You say "Oh, just going to go hang out with some friends." She says, "No, you'll just get into trouble if you go out. Stay home tonight." What would you do now? Leave the house anyway

Explain what you are going to do with your friends, tell her when you'd get home, and ask if you can go out
Not say anything and start watching TV
Get into an argument with her

You are visiting another part of town, and you don't know any of the people your age there. You are walking down the street, and some teenager you don't know is walking toward you. He is about your size, and as he is about to pass you, he deliberately bumps into you and you almost lose your balance. What would you say or do?

Push the person back
Say "Excuse me" and keep on walking
Say "Watch where you're going" and keep on walking
Swear at the person and walk away

You are at a party at someone's house, and one of your friends offers you a drink containing alcohol. What would you say or do?

Drink it
Tell your friend "No thanks, I don't drink" and suggest that you and your friend go and do something else
Just say "No, thanks" and walk away
Make up a good excuse, tell your friend you had something else to do, and leave

PEER-INDIVIDUAL: Belief in the Moral Order (P11)

I think it is okay to take something without asking if you can get away with it.

I think sometimes it's okay to cheat at school.

It is all right to beat up people if they start the fight.

It is important to be honest with your parents, even if they become upset or you get punished.

Allegany County Heroin and Opioid Abuse Ad-Hoc Committee Strategic Sharpening Plan 2018-2019

Prepared by:

Ardent Solutions
Network for Community Health

February 1, 2018

Contents

MISSION

The Allegany County Heroin and Opioid Abuse Advisory Board is an appointed ad-hoc legislative body that strives to influence, support and secure resources for communities, organizations, and individuals impacted by addiction. Our purpose is to ensure that appropriate prevention, treatment, and recovery assets are available to all Allegany County residents, while advancing policy and enforcement efforts at the local, state and federal level.

VISION

Collaboratively working together to create a safe and healthy Allegany County through alcohol and substance abuse/addiction-free living.

EXECUTIVE SUMMARY

Addiction to heroin or other opioids continues to be a critical public health concern for New York State residents and providers. Plaguing urban, suburban and rural communities; opioid addiction affects those who have overdosed, professional and informal caregivers, and those who have had serious health problems as a result of their addiction. Allegany County, New York is no exception.

As reported in the NYS Heroin and Opioid Task Force Report (June 2016), heroin overdose is now the leading cause of accidental death in the state. Between 2005 and 2014, upstate New York has seen an astonishing 222 percent increase in admissions to Office of Alcoholism and Substance Abuse Services (OASAS) certified treatment programs among those 18 to 24 years of age for heroin and other opioids. In all, approximately 1.4 million New Yorkers suffer from a substance use disorder.

In response to this epidemic, Allegany County, New York, underwent a thorough Community Needs Assessment to address the local opioid and heroin addiction crisis. This process was sponsored by the Allegany County Board of Legislators' Heroin and Opioid Ad-Hoc Committee and resulted in the 2016 Allegany County Heroin and Opioid Report (available at www.ardentnetwork.org).

With the approval of the 2016 Allegany County Heroin and Opioid Ad-Hoc Committee Report, workgroups were formed to synthesize the report findings and prioritize activities. As such, Ad-Hoc Committee members were joined by dedicated partners in the areas of Prevention, Treatment, Recovery, and Enforcement.

Over the course of 2017, members of the workgroup(s) and the Ad-Hoc Committee members have explored regional, state, and national efforts/models with the purpose of potential replication, began community discussions regarding the impact of heroin and opioid abuse, provided individuals living with heroin and/or opioid abuse a voice to share their story, and started to lay the foundation for a strategic plan moving toward greater implementation efforts.

This Strategic Plan was developed to reflect the myriad of issues and to be a guiding framework for action to address those issues. The Ad-Hoc Committee, working with individuals and organizations across our community, is committed to offering quality interventions. This document includes the following overriding strategic sharpening areas:

I: **Strategic Sharpening Planning Summary**
Report of the activities and consensus agreements from the Strategic Sharpening Planning process leading up to, including and following the facilitated strategic sharpening session on November 9, 2017.

II: **Strategic Sharpening Plan**
The overriding Plan aligning our Mission to strategic priorities, performance targets and strategies.

I. STRATEGIC SHARPENING PLANNING SUMMARY

A. April 2017 – December 2017 Summary

Utilizing the national Strategy to Address Opioid and Heroin Abuse, four workgroups were established to research, plan and implement tactics and strategies: Prevention, Intervention, Recovery, and Enforcement. The workgroups were made up of individuals from a cross-section of the community and organizations who brought their knowledge, expertise and ideas to the table around to address six (6) overriding strategies:

1. Reduce Access to Opioids
2. Improve Treatment of Addicted People and Enable Recovery
3. Minimize Desire to Misuse Opioids
4. Engage Healthcare Professionals to Address the Opioid Crisis
5. Expand Harm Reduction Practices with Opioid Misuse
6. Minimize People Starting to Misuse Opioid Drugs

Strategy 1. Reduce Access to Opioids

Activity 1. Assist in the Expansion of the Prescription Drug Take-Back & Disposal Program

a. Partnering with Partner's for Prevention in Allegany County (PPAC) and Allegany County Sheriff's Office, increased Prescription Disposal Sites from seven to eight with purchase of a Drop Box for the Jones Memorial Hospital Medical Practice (Bolivar Site) location
b. Increased Awareness with Allegany County Rx Drop Box Locations via Magnets with over 3,000 being distributed including outreach at the Allegany County Office for the Aging Senior Picnic, and through local pharmacies and agencies.
c. Implement the Homebound Rx Pick-Up Program through a collaboration with the Allegany County Sheriff's Office and the Allegany County Office for the Aging. A presentation was also given at the Allegany County TRIAD Senior Resource Alliance on Aging.

Activity 2: Educate the Community on Opioid Risks and Alternatives

a. Collaborating with staff and students of the Allegany-Cattaraugus County BOCES, workgroup members created the documentary Voices of Allegany County, illustrating the local, rural nature of the heroin and opioid crisis.
b. Securing private donations and local Service Club funding, a contract was established with Kingdom County Productions for three (3) viewings of The Hungry Heart documentary. Two Community Education Forums were held at the Wellsville David A. Howe Library (October 26, 2018) and Cuba-Rushford Central School (December 12, 2018). One additional event will be planned in the next three months (February-April 2018).
c. Various media outlets were utilized to support activities and initiatives of the Heroin and Opioid Ad-Hoc Committee and Workgroups; including, but not limited to press releases, social media, radio, public service announcements, and press coverage at all Ad-Hoc Committee meetings.

Activity 3: Expand and Enhance Chronic Pain Prevention and Management

a. Chronic Pain Self-Management Workshops were held from June 22 – July 27, 2017; and October 3 – November 14, 2017.

Strategy 2. Improve Treatment of Addicted People and Enable Recovery

Activity 1: Improve Social Integration of Recovering Addicts

a. Every September, SAMHSA sponsors Recovery Month to increase awareness and understanding of mental and substance use disorders and celebrate the people who recover. Many activities took place in September 2017 including: celebrating National Recovery Month Press Release, National Recovery Month Legislative Proclamation, Board of Legislators' Privilege of the Floor on September 25, 2017, Allegany Council on Alcoholism & Substance Abuse, Inc. Radio Spots, and Social Media Marketing
b. Celebrate Recovery is one of the seven largest addiction recovery support group programs. Over the course of this year, the Yorks Corners Mennonite Church continues to be a great resource with two new expansion sites at the Knights Creek Evangelical Church in Scio, New York and the Allegany County Sheriff's Office. Future expansion plans include the Cuba Cultural Center in Cuba, New York and the Houghton Wesleyan Church, Houghton, NY.

Activity 2: Reduce Stigma of Seeking Help with Substance Misuse

a. A collaboration with the Allegany County Suicide Prevention Coalition led to an expansion and incorporation of JustTellOne.org as a Local Anti-Stigma Campaign including: county-wide billboards; school and university outreach; posters, table tents, folders, agenda inserts; JustTellOne.org Servers of Hope Campaign in eight (8) local bars and taverns; table tents, posters, coasters; social media marketing; Andover Central School Open House tabling; SADD Conference tabling; and community and worksite health and wellness fairs.
b. Allegany County was recognized for efforts at the WNED Press Conference hosted by Erie County Mental Health Association for its implementation and commitment to the JustTellOne.org Anti-Stigma Campaign. From April – December 2017, a total of 40 individuals visited the JustTellOne.org website from Allegany County. JustTellOne.org awareness and marketing is a collaborative effort between the Prevention Workgroup and the Allegany County Suicide Prevention Coalition. A Servers of Hope with bar, restaurants and taverns; and school outreach are spreading information about this important resource.

Activity 3: Enable People Who Start Misusing Opioids to Quickly Quit

a. On May 25, 2017, CAReS provided an overview of the Recovery Coach model for the Recovery workgroup. Recovery Coaches is one strategy that has shown to be effective in engaging individuals into treatment and maintaining sobriety. Funding solicitations have been submitted to various local, state and federal entities without success.

Strategy 3. Minimize Desire to Misuse Opioids

Activity 1: Reduce Childhood Trauma and Become a Trauma-Informed Community

a. Ms. Vicki Grant, Commissioner of Social Services and Ms. Suzanne Krull, Cuba Cultural Center, participated in the 7-month Western New York Trauma Informed Care Champions Program; graduating in January 2018. Ms. Grant and Ms. Krull provided an Introduction of Trauma Informed Care in Addiction Services for the Treatment workgroup.

Strategy 4. Engage Healthcare Professionals to Address the Opioid Crisis

Activity 1: Increase Local Professional Development Training Offering Continuing Medical Education Credits Focused on Opioid Topics

a. On August 3, 2017, through a mini-grant from the Allegany County Area Foundation, the Prevention workgroup hosted Dr. Robert Wahler, representing the University at Buffalo School of Pharmacy and Pharmaceutical Sciences, to present Pharmacists' Response to Opioid Epidemic: Opioid Specific Counseling.
b. On August 2, 2017, the Allegany County Council on Alcoholism and Substance Abuse, Inc., presented Screening, Brief Intervention and Referral to Treatment (SBIRT) Training Support at Jones Memorial Hospital, Wellsville, New York.
c. On November 13, 2017, the NYSDOH Clinical Education Initiative from Mount Sinai Hospital presented Treatment for Hepatitis C: New Tests, New Drugs, and New Recommendations Training in Wellsville, New York.
d. On November 13, 2017, the NYSDOH Clinical Education Initiative from Mount Sinai Hospital presented Naloxone: Preventing Opioid Overdose in the Community.

Strategy 5. Expand Harm Reduction Practices with Opioid Misuse

Activity 1: Expand Programs to Reduce Needle-Transmitted Diseases Among Opioid Users

a. On August 24, 3017, Evergreen Health Services, a regional NYSDOH Syringe Exchange Program, provided an in-service and discussion at the Treatment Workgroup meeting to explore the potential expansion of their services to Allegany County. Due to costs and travel, Evergreen Health Services were unable to commit to this project at this time.
b. On November 22, 2017, the Prevention workgroup hosted Southern Tier Health Care System's Opioid Overdose Program to conduct a Naloxone community-based education session.

Strategy 6. Minimize People Starting to Misuse Opioid Drugs

Activity 1: Reduce Use of Gateway Drugs

a. The Prevention workgroup, collaborating with the Allegany Council on Alcoholism and Substance Abuse, Inc., introduced Tobacco 21 to the Allegany County Board of Legislators' Human Services Committee.
b. The Allegany Council on Alcoholism and Substance Abuse, Inc., partnering with the Allegany County Million Hearts Initiative, offered Tobacco Cessation programs during the months of February, March, and August 2017.

B. Regional Session October 2017

On October 26, 2017, the Allegany County Heroin and Opioid Ad-Hoc Committee invited regional leaders from Erie County to address local stakeholders as part of a Strategic Sharpening Session. Dr. Gale Burstein and County Executive Mark C. Poloncarz provided an update on the heroin and opioid crisis on a regional, state and federal level. As follow-up, Helen Evans, Ardent Solutions' Associate Director, provided a six-month review of workgroup activities and accomplishments.

A total of thirty-five attendees participated in the event. Key findings included:

- Heroin and opioid addiction continues to be a major priority and is acknowledged as a public health crisis across the nation
- Accurate data collection continues to be a challenge and must be addressed
- Local county government officials are encouraged to enact policy that protects the health and wellbeing of their constituents
- Local workgroup objectives and activities align with regional, state and federal approaches affirming local efforts

C. Allegany County Heroin and Opioid Ad-Hoc Committee Meeting

November 9, 2017

On November 9, 2017, the Allegany County Heroin and Opioid Ad-Hoc Committee joined together to review the current Strategies and Activities and plan for future endeavors.

Attendees:

- Judith Hopkins
- Tim O'Grady
- Melissa Biddle
- Jonathon Chaffee
- William Penman
- Brenda Rigby-Riehle
- Leslie Haggstrom
- Lori Ballengee
- Kevin Monroe
- Ravo Root

Absent/Excused:

- Ashley Buchholz
- Mona Carbone
- Marc Chamberlain
- Vicki Grant
- Chris Ivers
- Kevin LaForge
- Greg Muscato
- Christa Zenoski

Report

After the Planning Session(s), Helen Evans, Ardent Solutions, Inc. synthesized the notes taken by Megan Washer, Allegany County Clerk of the Board, to create a six-month work plan, which included the following strategic priorities:

1. Increase Advocacy Efforts to Enhance Rural Resources for Heroin and Opioid Initiatives
2. Reduce Access to Opioids
3. Engage Healthcare Professionals to Address the Opioid Crisis
4. Expand Harm Reduction Practices with Opioid Misuse
5. Enable People Who Start Misusing Opioids to Quickly Quit
6. To Improve Treatment of Addicted People and Enable Recovery
7. Minimize Desire to Misuse Opioids
8. To ensure sustainability of local efforts to address the heroin and opioid crisis.

D. Allegany County Joint Sub-Committee Meeting
January 26, 2018

Attendees:

Judith Hopkins
Sheriff Rick Whitney
Melissa Biddle
Jonathon Chaffee
William Penman
Carrie Whitwood
Leslie Haggstrom
JoAnne LaForge
Cheryl Ralyea
Theresa Moore
Terrance Rodgers
Robert Starks
Casey Jones
Helen Evans
Ann Weaver
Jeff Ciminesi
Jeff Luckey
Tracy Broshar
Gina Kocsis
Nancy Brinkwart
Kristine Fuller
Anita Baird
Probation Intern

On January 26, 2018, members of the Allegany County Heroin and Opioid Ad-Hoc Committee's Prevention, Treatment, Recovery and Enforcement workgroups held a joint-meeting to review the draft Strategic Sharpening Plan. The purpose was to provide input into the strategies, discuss potential projects/activities, and identify committed partners for the implementation phase. Members made recommended edits and additions to the draft Strategic Sharpening Plan that will be presented and formally approved at the next Ad-Hoc Committee.

II. STRATEGIC SHARPENING PLAN

Strategic Priority 1. To continuously reassess administrative structures to keep pace with changes in the environment while providing a sound infrastructure that supports the operation of the initiatives and to ensure sustainability of local efforts to address the heroin and opioid crisis.

Performance Target 1.1	Transition from the current Ad-Hoc Committee (temporary and short-term) to a long-term sustainable model.
Strategy 1.1.1	Identify potential models for the Allegany County Board of Legislators to adopt.
Strategy 1.1.2	Create a Transition Plan and timeline.
Strategy 1.1.3	Assist in the transition process.
Performance Target 1.2	Increase Advocacy efforts to enhance rural resources for heroin and opioid initiatives
Strategy 1.2.1	Develop a 2-page Policy Brief to demonstrate a concise overview of Allegany County's heroin and opioid issue and recommendations for regional, state, and federal support.
Strategy 1.2.2	Share the policy brief and voice concerns/needs with regional, state, and federal officials through advocacy visits. Enhance resources and commitment on a local level.
Strategy 1.2.3	Ensure the inclusion of the voice of someone who is in recovery.
Strategy 1.2.4	Develop Resolutions with Legislative approval to go to the State advocating for local resources, programs, etc., when appropriate.
Performance Target 1.3	Maintain and increase resources to support local efforts to address the heroin and opioid crisis.
Strategy 1.3.1	Continue to research funding opportunities to further efforts around identified strategies.
Strategy 1.3.2	Continue to outreach to community members and organizations to contribute time, energy and resources toward the effort.
Strategy 1.3.3	Continue to explore model programs and alternative strategies to meet the growing needs of those impacted by the heroin/opioid crisis.

Performance Target 1.4 Support advocacy issues related to other substance use disorders.

Performance Target 1.5 Define a solid data management strategy that will capture accurate and reliable data to help monitor and evaluate local efforts.

- Strategy 1.5.1 Continue to explore technology for Narcan distribution and usage to identify local community hotspots (ie: OD Map app).
- Strategy 1.5.2 Continue to monitor NYSDOH opioid and heroin data sets; recognizing potential inaccuracies (ie: timing of reporting).
- Strategy 1.5.3 Continue to work with local law enforcement and EMS to identify and implement efficient and effective data collection.

Performance Target 1.6 Continue to evaluate and monitor the heroin and opioid crisis to determine intervention(s) success and update strategies.

- Strategy 1.6.1 Continue to research regional, state, and national efforts that may be replicated in Allegany County.
- Strategy 1.6.2 Update the Allegany County Heroin and Opioid Report on an annual basis.
- Strategy 1.6.3 Provide quarterly reports to the Allegany County Board of Legislators and appropriate committees.

Strategic Priority 2. To build a strong, dedicated workforce of professionals and community individuals/stakeholders representing all sectors that can directly impact the heroin and opioid crisis in Allegany County through increased professional development and educational training, skill building, and best-practice strategies.

Performance Target 2.1 Engage physicians and health care practitioners through professional development training on safe pain management and prescribing practices to decrease the number of avoidable opioid prescriptions written in Allegany County.

- Strategy 2.1.1 Identify expert(s) or professional development opportunities in the field.
- Strategy 2.1.2 Secure Continuing Medical Education Credits (CME) via University of Buffalo.
- Strategy 2.1.3 Coordinate logistics of training event and complete evaluation.

Performance Target 2.2	Support local law enforcement in drug interdiction efforts.	
Strategy 2.2.1		Explore opportunities to financially support Advanced Roadside Impaired Driving Enforcement (ARIDE) training opportunities.
Strategy 2.2.2		Secure financial support for Drug Recognition Expert training opportunities.
Strategy 2.2.3		Secure financial support for overtime expenses accrued by law enforcement due to criminal investigations related to drugs.
Performance Target 2.3	Secure a healthcare practitioner and/or practice to employ local Opioid Medication Assisted Therapy (MAT) and/or improve access to regional Medication Assisted Therapy resources.	
Strategy 2.3.1		Identify a physician, nurse practitioner and/or physician assistant to apply to become a DATA-Waiver practitioner.
Strategy 2.3.2		Identify barriers for individuals to access MAT and assist in overcoming barriers.
Performance Target 2.4	Assist the local OASAS licensed agency to establish a Certified Peer Advocacy Program within Allegany County.	
Strategy 2.4.1		Identify funding to help support a Certified Peer Advocacy Program.
Strategy 2.4.2		Assist with any/all efforts necessary for program success.
Performance Target 2.5	Assist in recruitment and retention efforts, and public policy strategies, to help increase and/or retain the number of qualitied ATOD clinicians in the workforce.	
Strategy 2.5.1		Learn about workforce needs from licensed agencies and service providers.
Strategy 2.5.2		Assist in recruitment strategies (i.e.: grow your own, housing assistance, etc.).
Strategy 2.5.3		Provide vicarious trauma training and trauma-informed care programs for those working in the field.

Performance Target 2.6	Shift Allegany County to a Trauma Informed Community through systemic change and education.
Strategy 2.6.1	Educate the general public and all its sectors including but not limited to indivdiuals and families, government, human services, healthcare, education, law enforcement, business and faith communities about impacts of Adverse Childhood Experiences (ACEs) and other traumas.
Strategy 2.6.2	Promte a change in the paradigm of addressing trauma-related issues from the context of "what's wrong with you?" to "What's happened to you?".
Strategy 2.6.3	Engage with the WNY Trauma Coalition and the Institute for Trauma Informed Care to expand TIC training for Allegany County providers.
Strategy 2.6.4	Encourage a minimum of two (2) Allegany County Professionals to apply to become a member of the WNY Trauma Informed Care Champion Program beginning March 1, 2018.
Strategy 2.6.5	Encourage agencies/organizations to complete a TIC assessment.
Strategy 2.6.6	Encourage agencies/organizations to incorporate TIC culture through employee training, policy development, hiring practices, environment and consumer interactions.
Strategy 2.6.7	Encourage agencies/organizations to examine the evidence linking trauma and adverse childhood experiences to opioid additions. As a result said agencies may consider universal ACEs screening.

Strategic Priority 3. To increase awareness of, and access to, primary and secondary prevention efforts leading to a decrease in use, misuse and abuse of heroin and opioids, enable people who start misusing opioids to quickly quit, and expand harm reduction practices with opioid misuse.

Performance Target 3.1	Support Drug Take Back Program efforts to provide a safe, convenient, and responsible means of disposing of prescription drugs by partnering with PPAC, Allegany County Sheriff's Office and ACASA.
Strategy 3.1.1	Continue to support community awareness events/efforts and sub-promote associated activities in the same news releases, fliers, advertising where/when appropriate.

Strategy 3.1.2	Increase # of locations where deemed appropriate.
Strategy 3.1.3	Investigate opportunity to expand NYS Safe Sharp Collection Program in secure locations throughout Allegany County.
Strategy 3.1.4	Assist in promotion of Homebound Rx Pick-up Program.

Performance Target 3.2	Continue to educate community on opioid risks and alternative pain management options.
Strategy 3.2.1	Deliver a minimum of one (1) Community Education Forum utilizing the Voices of Allegany County/Hungry Heart format.
Strategy 3.2.2	Establish and promote the Voices of Allegany County Speaker's Bureau.

Performance Target 3.3	Expand and enhance chronic pain prevention and self-management services.
Strategy 3.3.1	Support evidenced-based Chronic Pain Self-Management workshops.
Strategy 3.3.2	Build an asset map of alternative pain management programs to be distributed to local physicians and community members.

Performance Target 3.4	Educate healthcare consumers on what to ask their doctor, dentist, etc.

Performance Target 3.5	Expand programs to reduce needle-transmitted diseases.
Strategy 3.5.1	Identify NYSDOH AIDS Institute Syringe Exchange Program(s).
Strategy 3.5.2	Determine potential for expansion into Allegany County and investigate requirements.

Performance Target 3.6	Reduce opioid overdose deaths through increased Naloxone availability.
Strategy 3.6.1	Support Registered Opioid Overdose Programs by hosing local training sessions.

Strategy 3.6.2 Expand awareness of the Good Samaritan Law to encourage people to seek out medical attention for an overdose or for follow-up care after naloxone has been administered.

Performance Target 3.7 Raise community awareness about the dangers of opioid addiction, sign and symptoms of misuse/abuse, and treatment resources.

Strategy 3.7.1 Draft, finalize and distribute educational materials that can be distributed in community settings and direct marketing sites.

Strategy 3.7.2 Utilize appropriate social media venues to share information.

Strategic Priority 4. To support long-term recovery for individuals struggling with heroin and opioid addiction and provide resources for those impacted by a loved-one's addiction.

Performance Target 4.1 Enact a community-based Recovery Coach Program to provide peer support to individuals seeking recovery from alcohol and other drugs to develop a recovery plan and initiate/sustain the person in their recover journey.

Strategy 4.1.1 Identify funding to support a Recovery Coach Program.

Strategy 4.1.2 Establish Recover Coach Program guidelines, policies and procedures. Seek a community-based organization to adopt the program and lead efforts.

Performance Target 4.2 Improve social integration and community connections for those living in recovery resulting in robust recovery-oriented services, opportunities for personal growth, and opportunities to positively contribute to the community.

Strategy 4.2.1 Create an asset map of current social support system(s) and sober community activities. Conduct a gaps analysis.

Strategy 4.2.2 Increase availability and frequency of social supports and activities utilizing current community infrastructure.

Strategy 4.2.3 Identify and address barriers that may prevent individuals from seeking social support from achieving success.

Strategy 4.2.4 Investigate model programs that have proven effective in rural communities.

Performance Target 4.3	Reduce stigma associated with opioid addition through a multicomponent stigma prevention campaign.
Strategy 4.3.1	Expand JustTellOne.org as an educational and awareness campaign that address addition-related stigma including the four-point approach recommended via 'Changing the Conversation' (Center for Substance Abuse Treatment 2000).
Strategy 4.3.2	Continue to collaborate with other coalitions to expand the JustTellOne.org campaigns (ie: Servers of Hope, Schools and Universities Campaigns, etc.).
Strategy 4.3.3	Support Celebrate Recovery as it is a stigma breaker and is open to anyone.
Performance Target 4.4	Build greater public acceptance and understanding that recovery is real and celebrate those who support individuals in recovery.
Strategy 4.4.1	Develop a holistic, integrated approach that maximizes already existing resources and promotes the addition of more groups to serve smaller population areas (ie: Celebrate Recovery, AA, NA, etc.).
Strategy 4.4.2	Plan and implement a Recovery Month Campaign.
Strategy 4.4.3	Cross-collaborate with other coalitions (Suicide Prevention Coalition, Partners for Prevention in Allegany County).
Performance Target 4.5	Increase caregiver resources and services for those impacted by a loved-one's addiction.
Strategy 4.5.1	Support a caregiver educational program for those wishing to learn about opioid misuse/abuse.
Strategy 4.5.2	Support a caregiver support group for individuals impacted by a loved-one's opioid misuse/abuse.
Strategy 4.5.3	Advocate for greater support for kinship caregivers due to opioid misuse/abuse.

Performance Target 4.6	Increase resource for families of people who are incarcerated and addicted.
Strategy 4.6.1	Develop a cooperative protocol to promote inmates attending and then transferring from Celebrate Recovery Inside to the regular Celebrate Recovery on the outside
Strategy 4.6.2	Build the skills of family members who can be a primary support for inmates on how to assist without enabling.
Strategy 4.6.3	Increase awareness and access to support resources for the family.

Performance Target 4.7	Identify opportunities to provide support and accountability for those in recovery by offering coordinated comprehensive services and efficient access to resources, including both mandated and non-mandated programs.

Acronym List

AA	Alcohol Anonymous
ACASA	Allegany Council on Alcohol and Substance Abuse
ACE	Adverse Childhood Experience
ARIDE	Advanced Roadside Impaired Driving Enforcement
ATOD	Alcohol, Tobacco and Other Drugs
CME	Continuing Medical Education credits
MAT	Medication Assisted Therapy
NA	Narcotics Anonymous
NYSDOH	New York State Department of Health
OD	Overdose
OASAS	Office of Alcoholism and Substance Abuses Services
PPAC	Partners for Prevention in Allegany County
SADD	Students against Destructive Decisions
SBIRT	Screening, Brief Intervention and Referral to Treatment
TIC	Trauma Informed Care
TRIAD	Older adult safety coalition consisting of oder adults representing each community in the County, the Office for the Aging, and law enforcement.

Allegany County
Evalumetrics Youth Survey
(Risk and Protective Factor Survey)
2019

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ACASA

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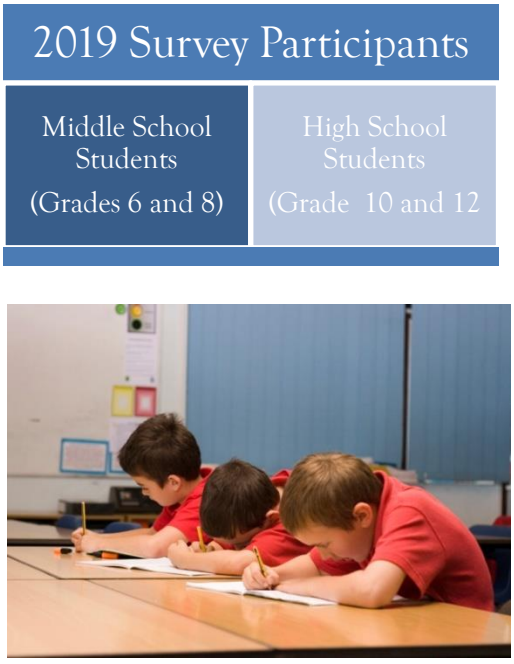
Evalumetrics Youth Survey
2019 Allegany County

INTRODUCTION

The Evalumetrics Youth Survey (EYS) has been conducted in schools throughout Allegany County every odd-numbered year since1999 and most recently, in 2019. The EYS is based on the Risk and Protective Factor Model developed at the University of Washington by J. David Hawkins, Richard Catalano, and Janet Miller. The EYS asks students about several critical health risk behaviors such as substance use, violence and depression. The EYS also includes questions about students' attitudes toward and connection to school, family and community.

This report provides results for Allegany County Schools. Details of the student response sample for Allegany County are shown in appendix A.



Allegany County

Grade	Females	Males
6th	213	207
8th	178	212
10th	163	201
12th	175	156
Total	729	776

Prevalence of Substance Use

Young peoples' use and abuse of alcohol, tobacco and other drugs remains a major concern for parents, health professionals, law enforcement and schools. Since the 1990's substance abuse prevention has developed evidence-based programs based on the Risk and Protective Factor Model. In the EYS, students were asked if, and how often they had used alcohol, tobacco, marijuana or other substances. Tables 1 (see Attachment I) shows the proportions of students (prevalence) who reported ever using, using in the 12 months prior to the survey and using in the 30 days prior to the survey. Alcohol, Marijuana and e-cigarettes are the most frequently used substances. Significant results include:

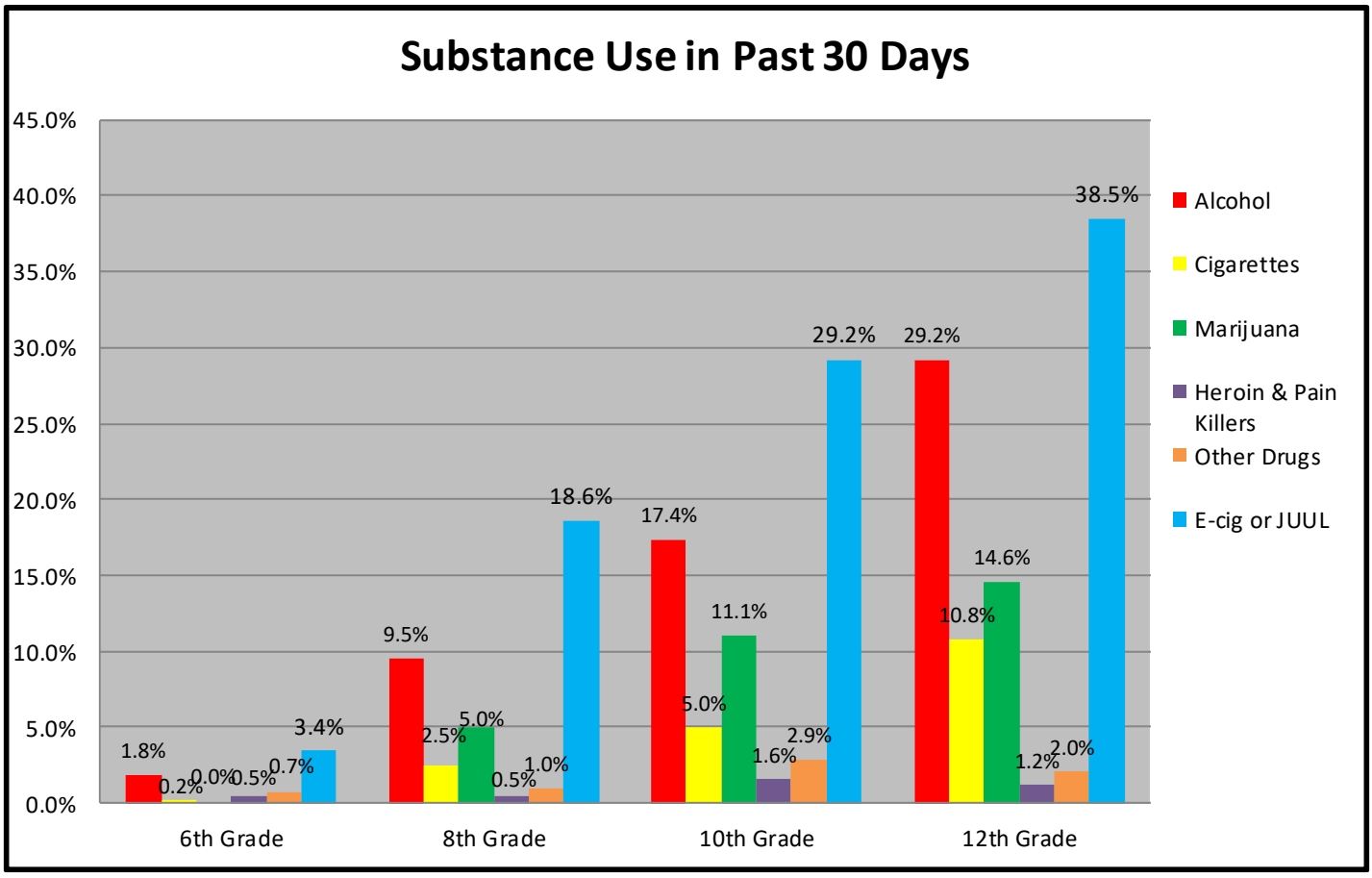
Alcohol Use in Past 30 Days
1.8% of 6th grade students; 9.5% of 8th graders; 17.4% of 10th graders; and 29.2% of 12th graders drank alcohol at least once in the past month.

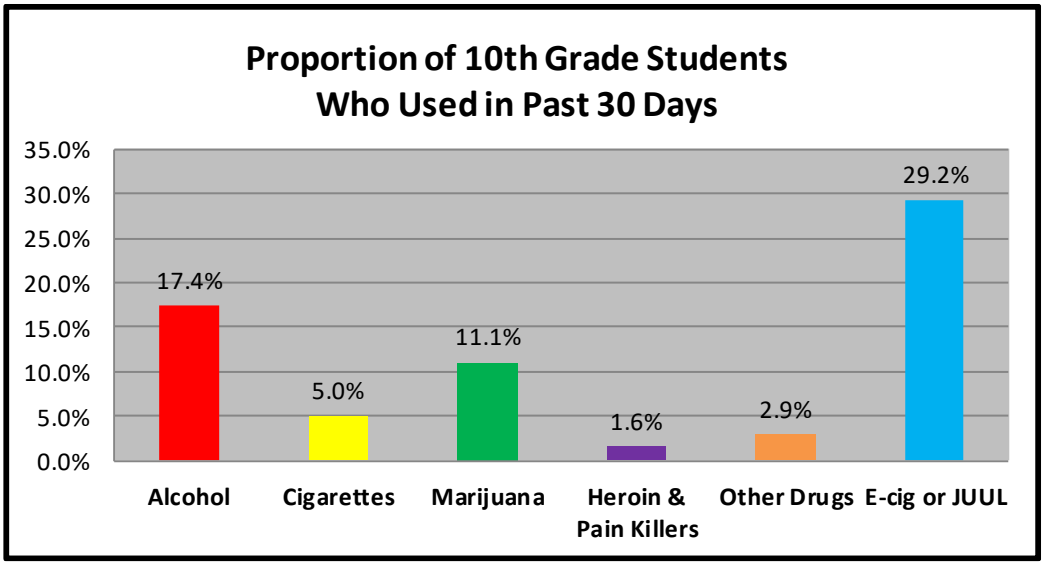
Smoked Cigarette in Past 30 Days
0.2% of 6th grade students; 2.5% of 8th graders; 5.0% of 10th graders; and 10.8% of 12th graders smoked cigarettes in the past month.

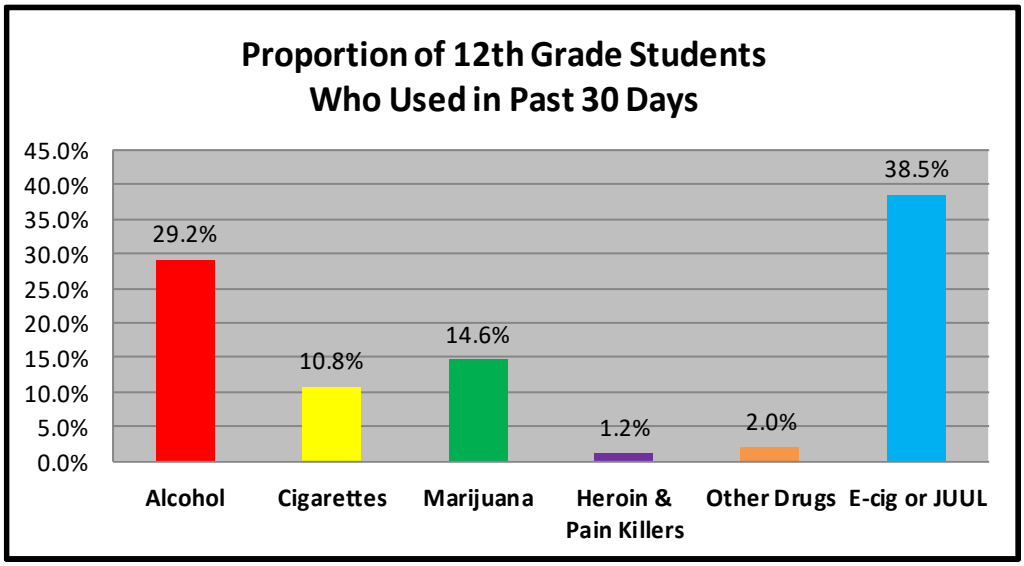
Used e-cigarette or JUUL in Past 30 Days
3.4% of 6th grade students; 18.6% of 8th graders; 29.2% of 10th graders; and 38.5% of 12th graders smoked cigarettes in the past month.

Marijuana Use in Past 30 Days
0.0% of 6th grade students; 5.0% of 8th graders; 11.1% of 10th graders and 14.6% of 12th graders smoked Marijuana in the past 30 days.

Evalumetrics Youth Survey
2019 Allegany County

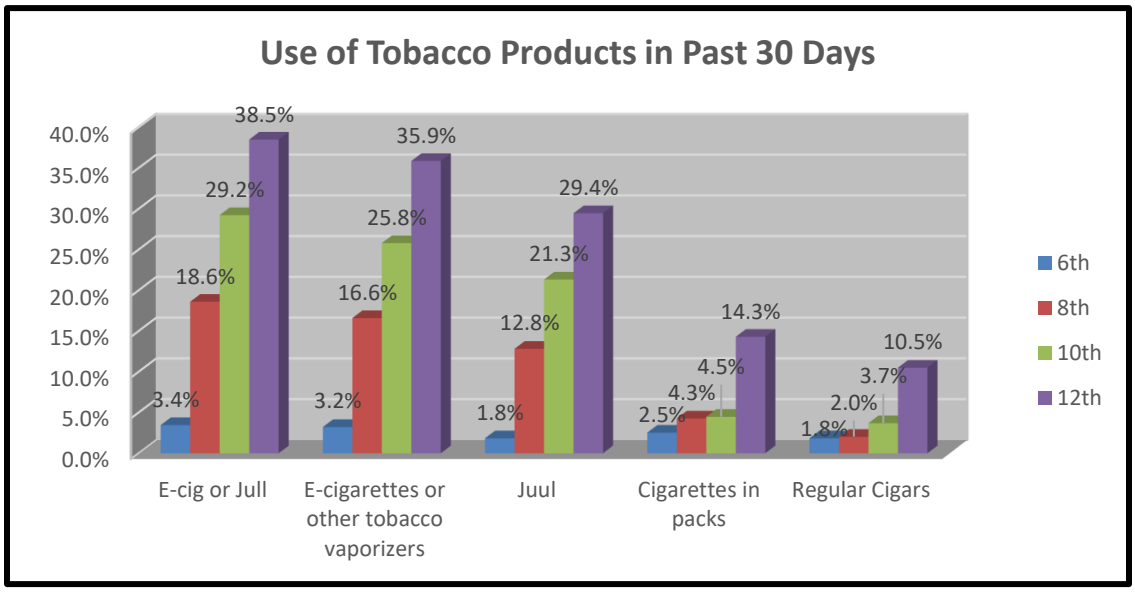



Proportion of 10th Grade Students
Who Used in Past 30 Days
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
17.4%
5.0%
11.1%
1.6%
2.9%
29.2%
Alcohol
Cigarettes
Marijuana
Heroin & Pain Killers
Other Drugs
E-cig or JUUL


Proportion of 12th Grade Students
Who Used in Past 30 Days
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
29.2%
10.8%
14.6%
1.2%
2.0%
38.5%
Alcohol
Cigarettes
Marijuana
Heroin & Pain Killers
Other Drugs
E-cig or JUUL

Use of Tobacco Products

While cigarettes have been decreasing in popularity, other tobacco products have gained popularity. In 2019, though one in 10 (10.8%) 12th grader reported smoking cigarettes, nearly four in 10 (39.7%) reported using at least one tobacco product. More than one in four (27.9%) 10th grader used one or more tobacco product. E-Cigarettes or other vaping devices, (e.g., JUUL) were the most commonly used tobacco products. More than one in three (35.9%) 12th grader used an E-cigarette or vaping device; more than one in four (29.4%) used a JUUL; and nearly four of 10 (38.5%) used one or the other or both.



Risk and Protective Factors

The Risk and Protective Factor Model was developed at the University of Washington by J. David Hawkins, Richard Catalano, and Janet Miller. The model was developed by reviewing two decades of research that identified a link between certain risk factors and several problem behaviors and between protective factors and avoidance of problem behaviors. A major strength of this model is that by implementing strategies to reduce factors that predict one problem, (e.g., alcohol and other drug abuse) communities will likely reduce other negative behaviors, such as violence, delinquency, teen-pregnancy, gambling and dropping out of school.

While some risk factor prevalence might be low when compared to prevalence of use, it should be noted that risk factors are often predictors of future behavior. For example, the most common risk factor for 6th grade is Lack of Perceived Risk from Drug Use yet reported use of drugs by 6th graders is very rare [1].

Middle School Risk and Protective Factors - Table 2a (see Attachment 1) shows the proportion of 6th grade students who scored at or above the risk level on each factor scale. The table is sorted from the most prevalent risk factors to least common in 2019.

6th Grade Risk and Protective Factors

Note:
An "R" in ( ) means students were at risk from that Risk Factor.
A "P" in ( ) means students were at risk from lack of that Protective Factor.

Domains
-C=Community Domain
-F=Family Domain
-S=School Domain
-I/P=Individual/Peer Domain

The most prevalent factor among 6th grade students was Lack Opportunities for Prosocial Behavior in the Community (P2-C) with 18.8% scoring above the risk level.

Other prevalent factors include: Lack Rewards for Prosocial Involvement in Family (P5-F) (23.0%); Poor Family Discipline (R7-F) (21.4%); and Lack Opportunities for Prosocial Involvement in the Community (P1-C) (19.1%).

[1] ***Note: The survey does not measure all risk or protective factors. For example, poverty is a significant risk factor.***

Middle School Risk and Protective Factors- Table 2b (see Attachment 1) shows the proportion of 8th grade students who scored at or above the risk level on each factor scale. The table is sorted by the most prevalent risk factors to least common in 2019.

8th Grade Risk and Protective Factors

Note:
An "R" in ( ) means students were at risk from that Risk Factor.
A "P" in ( ) means students were at risk from lack of that Protective Factor.

Domains
-C=Community Domain
-F=Family Domain
-S=School Domain
-I/P=Individual/Peer Domain

The most prevalent factor among 8th grade students was Lack Rewards for Prosocial Behavior in the Community (P2-C) with 21.9% scoring above the risk level.

Other prevalent factors include: Community Disorganization (R2-C) (19.6%); Sensation Seeking (R22-PI) (18.1%); and Low Neighborhood Attachment (R1-C) (16.6%).

High School Risk and Protective Factors - Table 2c (see Attachment 1) shows the proportion of 10th grade students who scored at or above the risk level on each factor. The table is sorted by most common Risk Factors to least common in 2019.

10th Grade Risk and Protective Factors

Note:
An "R" in ( ) means students were at risk from that Risk Factor.
A "P" in ( ) means students were at risk from lack of that Protective Factor.

Domains
-C=Community Domain
-F=Family Domain
-S=School Domain
-I/P=Individual/Peer Domain

The most prevalent factor among 10th grade students was Lack Rewards for Prosocial Behavior in the Community (P2-C) with 27.4% scoring at or above the risk level.

Other factors were: Sensation Seeking (R22-PI) (23.4%); Lack Opportunities for Prosocial Involvement in the Community (P1-C); and Low Neighborhood Attachment (R1-C) (22.1%).

High School Risk and Protective Factors - Table 2d (see Attachment 1) shows the proportion of 12th grade students who scored at or above the risk level on each factor. The table is sorted by most common Risk Factors to least common in 2019.

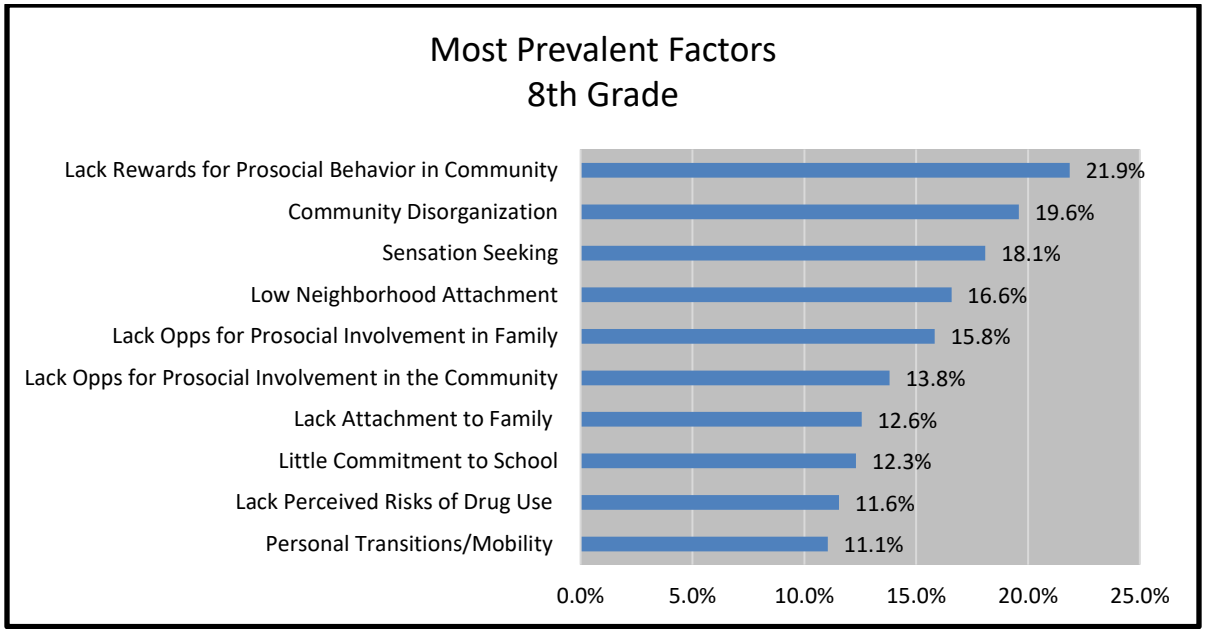
12th Grade Risk and Protective Factors

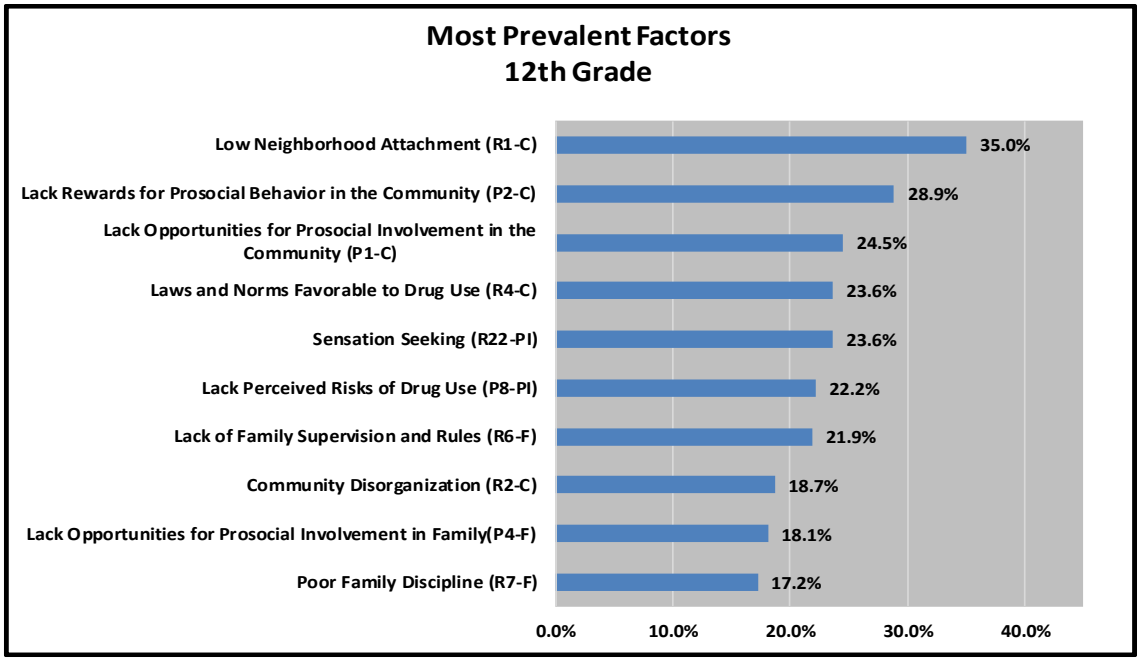
Note:
An "R" in ( ) means students were at risk from that Risk Factor.
A "P" in ( ) means students were at risk from lack of that Protective Factor.

Domains
-C=Community Domain
-F=Family Domain
-S=School Domain
-I/P=Individual/Peer Domain

The most prevalent factor among 12th grade students was Low Neighborhood Attachment (R1-C) with 35.0% scoring at or above the risk level.

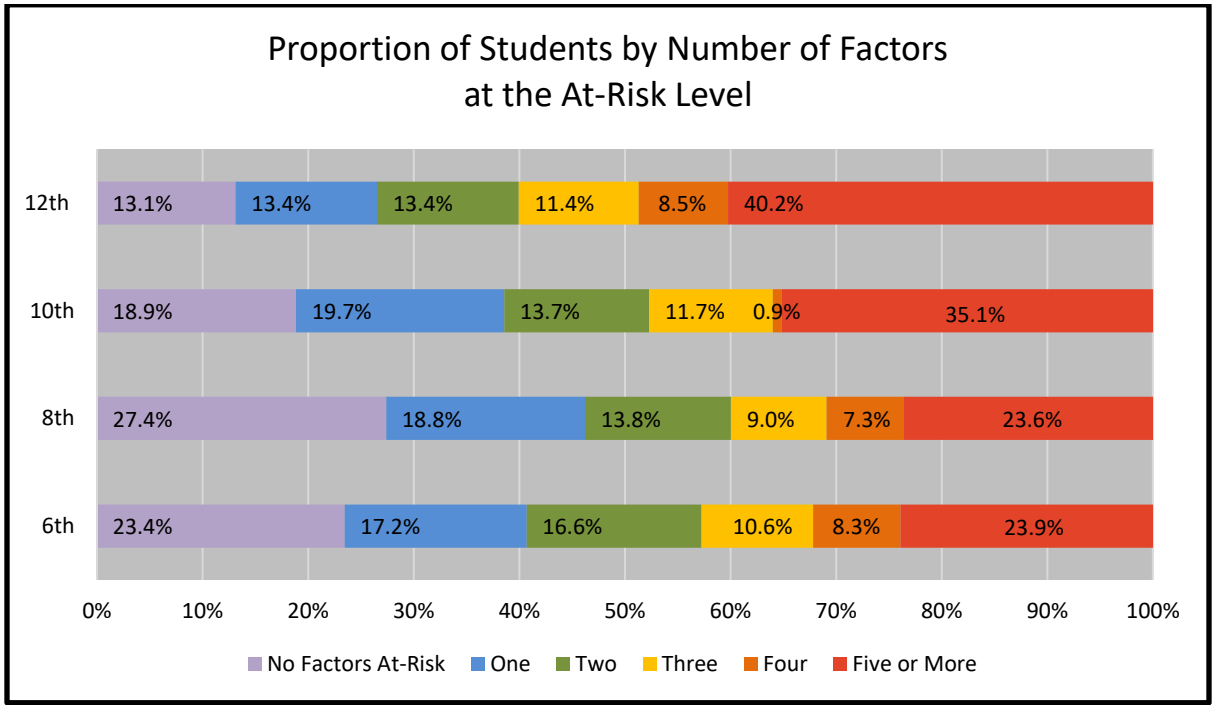
Other factors were: Lack Rewards for Prosocial Behavior in the Community (P2-C) (28.9%); Lack Opportunities for Prosocial Involvement in the Community (P1-C); and Laws and Norms Favorable to Drug Use (R4-C) (23.6%).


Most Prevalent Factors
8th Grade
Lack Rewards for Prosocial Behavior in Community
21.9%
Community Disorganization
19.6%
Sensation Seeking
18.1%
Low Neighborhood Attachment
16.6%
Lack Opps for Prosocial Involvement in Family
15.8%
Lack Opps for Prosocial Involvement in the Community
13.8%
Lack Attachment to Family
12.6%
Little Commitment to School
12.3%
Lack Perceived Risks of Drug Use
11.6%
Personal Transitions/Mobility
11.1%
0.0%
5.0%
10.0%
15.0%
20.0%
25.0%


Most Prevalent Factors
12th Grade
Low Neighborhood Attachment (R1-C)
35.0%
Lack Rewards for Prosocial Behavior in the Community (P2-C)
28.9%
Lack Opportunities for Prosocial Involvement in the Community (P1-C)
24.5%
Laws and Norms Favorable to Drug Use (R4-C)
23.6%
Sensation Seeking (R22-PI)
23.6%
Lack Perceived Risks of Drug Use (P8-PI)
22.2%
Lack of Family Supervision and Rules (R6-F)
21.9%
Community Disorganization (R2-C)
18.7%
Lack Opportunities for Prosocial Involvement in Family(P4-F)
18.1%
Poor Family Discipline (R7-F)
17.2%
0.0%
10.0%
20.0%
30.0%
40.0%

Overall Risk

The Risk and Protective Factor framework states that an individual student's likelihood of being involved in substance abuse, violence or other negative behavior increases relative to the number of factors from which the student is at-risk. Thus, an additional measure of overall risk in a community is the number of students reporting multiple factors beyond the at-risk level. Table 3 (see Attachment 1) shows the frequencies of the number of factors on which students scored above the risk level. More than four in 10 (40.2%) 12th grade student more than one in three (35.1%) 8th grade student scored at or above the risk level on five or more factors.



Bullying

Bullying and other violent behavior are a major concern for students, parents and school administrators. Several items in the Risk and Protective Factor Survey relate to bullying. Tables 4a and 4b (see Attachment 1) present responses to these items.

- 24.1% of 6th grade students said ***they had been bullied*** two or more times in the 30 days prior to the survey.
- 9.0% of 6th grade students said ***they had bullied another student*** two or more times in the 30 days prior to the survey.

- 20.4% of 8th grade students said ***they had been bullied*** two or more times in the 30 days prior to the survey.
- 13.6% of 8th grade students said ***they had bullied another student*** two or more times in the 30 days prior to the survey.

- 19.2% of 10th grade students said ***they had been bullied*** two or more times in the 30 days prior to the survey.
- 10.8% of 10th grade students said ***they had bullied another student*** two or more times in the 30 days prior to the survey.

- 12.5% of 12th grade students said ***they had been bullied*** two or more times in the 30 days prior to the survey.
- 11.4% of 12th grade students said ***they had bullied another student*** two or more times in the 30 days prior to the survey.

Depression

Teenage depression is a serious problem that affects every aspect of a teen's life. Left untreated, teen depression can lead to problems at home and school, drug abuse, and an overwhelming sense of sadness, despair, or anger. The survey included several items identical to the Centers for Disease Control and Prevention, Youth Risk Behavior Survey. The first of these asks students if they "feel depressed most of the time, even if you feel happy sometimes." Tables 5a – 5d (see Attachment 1) present responses to items related to depression and suicide ideation.

- 49.8% of 6th grade ***female*** students said that in the past year ***they felt depressed most of the time even if they felt happy some of the time***.
- 36.9% of 6th grade ***male*** students said that in the past year ***they felt depressed most of the time even if they felt happy some of the time***.

- 63.8% of 8th grade ***female*** students said that in the past year ***they felt depressed most of the time even if they felt happy some of the time***.
- 42.5% of 8th grade ***male*** students said that in the past year ***they felt depressed most of the time even if they felt happy some of the time***.

- 62.1% of 10th grade ***female*** students said that in the past year ***they felt depressed most of the time even if they felt happy some of the time***.
- 47.6% of 10th grade ***male*** students said that in the past year ***they felt depressed most of the time even if they felt happy some of the time***.

- 57.7% of 12th grade ***female*** students said that in the past year ***they felt depressed most of the time even if they felt happy some of the time***.
- 43.9% of 12th grade ***male*** students said that in the past year ***they felt depressed most of the time even if they felt happy some of the time***.

Suicide Ideation

The greatest concern about depression and other negative feelings is the possibility that a student might contemplate, plan or attempt suicide. Items from the Centers for Disease Control and Prevention, Youth Risk Behavior Survey were included in the survey to address these concerns. (see table 5b.)

17.4% of 6th grade ***female*** students said that at least once in the past year ***they made a plan to commit suicide***.

14.0% of 6th grade ***male*** students said that at least once in the past year ***they made a plan to commit suicide***.

29.2% of 8th grade ***female*** students said that at least once in the past year ***they made a plan to commit suicide***.

16.5% of 8th grade ***male*** students said that at least once in the past year ***they made a plan to commit suicide***.

28.2% of 10th grade ***female*** students said that at least once in the past year ***they made a plan to commit suicide***.

19.9% of 10th grade ***male*** students said that at least once in the past year ***they made a plan to commit suicide***.

20.6% of 12th grade ***female*** students said that at least once in the past year ***they made a plan to commit suicide***.

18.6% of 12th grade ***male*** students said that at least once in the past year ***they made a plan to commit suicide***.

Self-Injury

A recently recognized phenomenon among young people is intentional self-injury. Some teens have a difficult time balancing their conflicting feelings and some turn to harmful activities like drinking, using drugs, or self-injury. Intentional self-injurious behavior, through cutting or burning, is used as a mechanism for coping with emotional distress. Those who self-injure often are experiencing overwhelming feelings, like extreme anxiety or tension, and in the moment self-injury may seem to provide a feeling of escape or relief. These injuries are not a suicide attempts and often are interpreted as expressions of anger or psychological pain. Table 5e (see Attachment 1) presents responses to this item.

14.1% of 6th grade ***female*** students said that ***they had hurt themselves by cutting or burning when they were upset.***

14.0% of 6th grade ***male*** students said that ***they had hurt themselves by cutting or burning when they were upset.***

29.2% of 8th grade ***female*** students said that ***they had hurt themselves by cutting or burning when they were upset.***

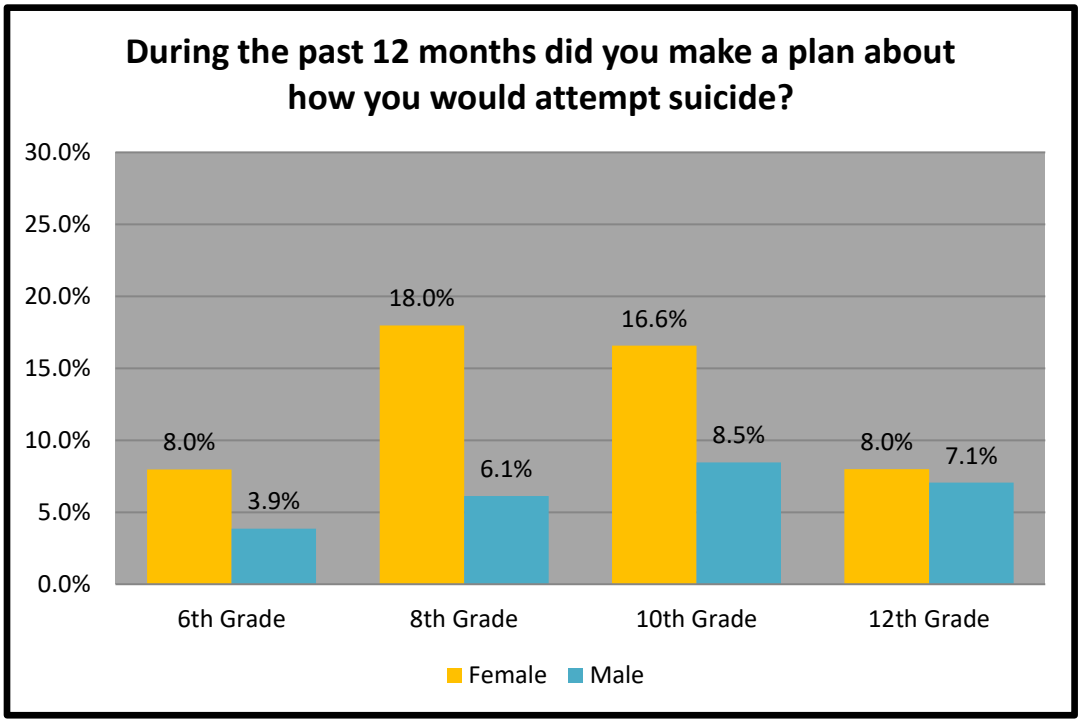
10.8% of 8th grade ***male*** students said that ***they had hurt themselves by cutting or burning when they were upset.***

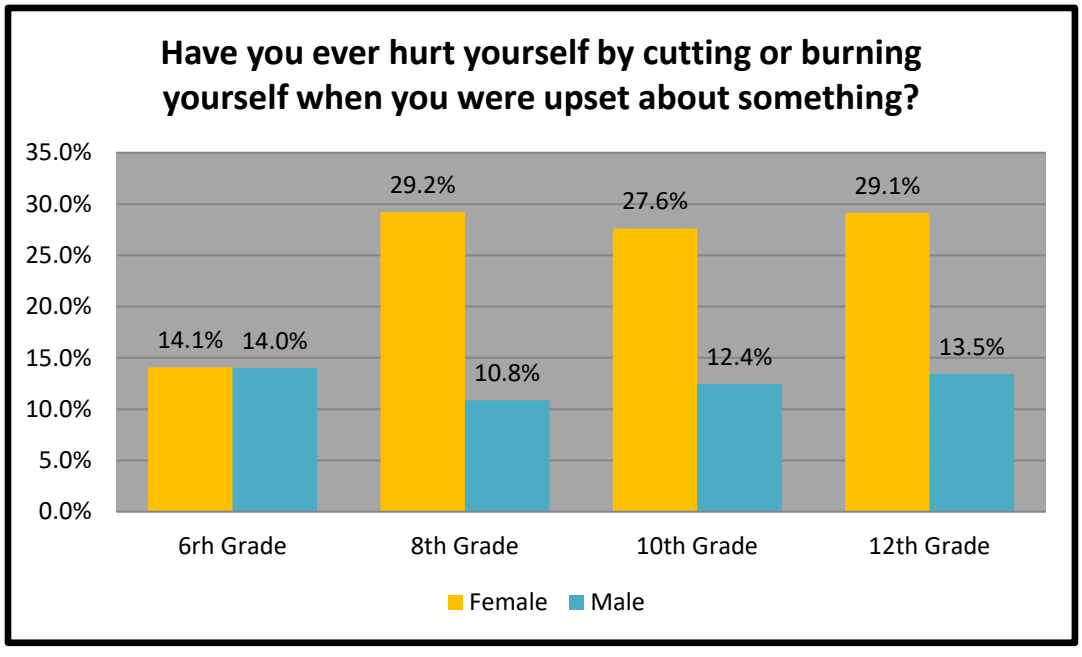
27.6% of 10th grade ***female*** students said that ***they had hurt themselves by cutting or burning when they were upset.***

12.4% of 10th grade ***male*** students said that ***they had hurt themselves by cutting or burning when they were upset.***

29.% of 12th grade ***female*** students said that ***they had hurt themselves by cutting or burning when they were upset.***

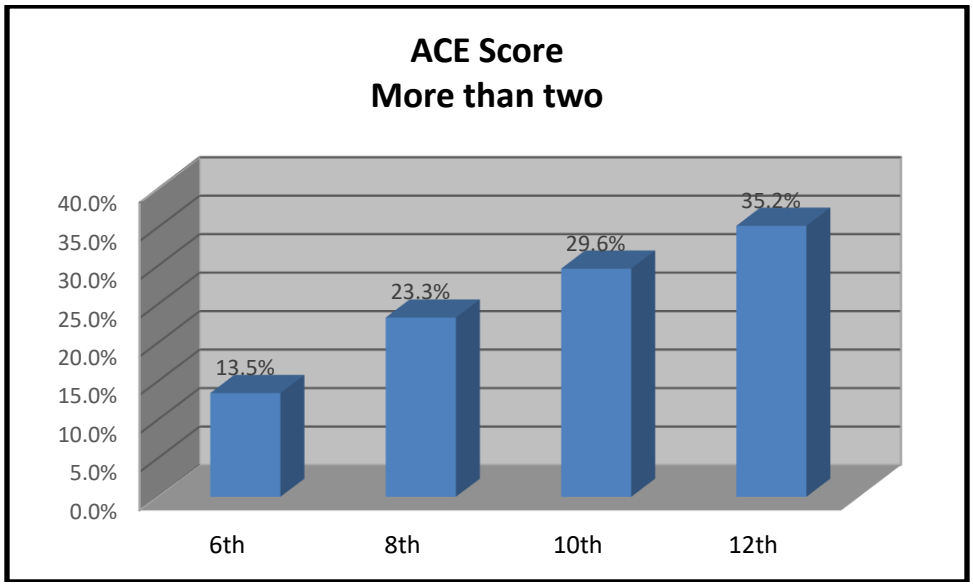
13.5% of 12th grade ***male*** students said that ***they had hurt themselves by cutting or burning when they were upset.***


During the past 12 months did you make a plan about how you would attempt suicide?
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
8.0%
3.9%
18.0%
6.1%
16.6%
8.5%
8.0%
7.1%
6th Grade
8th Grade
10th Grade
12th Grade
Female
Male


Have you ever hurt yourself by cutting or burning yourself when you were upset about something?
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
14.1%
14.0%
29.2%
10.8%
27.6%
12.4%
29.1%
13.5%
6rh Grade
8th Grade
10th Grade
12th Grade
Female
Male

Adverse Childhood Experiences

Extensive research on trauma experienced by young people has led to the development of the concept of Adverse Childhood Experiences or ACE's. Adverse experiences include events that result from abuse, neglect or household dysfunction. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse and academic failure. The 2019 EYS included a question about how many of the 11 most common ACEs the student had experienced. The survey did not ask about specific trauma. Table 6 shows the frequency of ACE scores. An ACE score of 2 or more is considered an at-risk level and has been shown to be related to many of the substance use and health risk behaviors included in the survey. More than one in seven (13.5%) 6th grader and more than one third (35.2%) of 12th graders reported an ACE score of two or more.



ATTACHMENT 1

Risk and Protective Factor Survey

Results Tables

Prevalence of Substance Use

Allegany County

2019

Table 1-a

Allegany County

Evalumetrics Youth Survey 2019 Reported Substance Use		Allegany County Schools 6th Grade	Allegany County Schools 8th Grade	Allegany County Schools 10th Grade	Allegany County Schools 12th Grade
Alcohol Use (except as part of religion)	N=	435	398	380	343
Ever Used		9.9%	28.6%	46.6%	58.6%
Used in Past 12 Months		5.1%	21.4%	37.9%	51.3%
Used in Past 30 Days		1.8%	9.5%	17.4%	29.2%
>5 Drinks at Least Once in Past 30 Days		0.5%	3.3%	7.1%	17.5%

Table 1-b

Allegany County

Risk and Protective Factor Survey 2019 Reported Substance Use	Allegany County Schools 6th Grade	Allegany County Schools 8th Grade	Allegany County Schools 10th Grade	Allegany County Schools 12th Grade
Cigarette Use	435	398	380	343
Ever Used	3.9%	10.8%	20.0%	35.9%
Used in Past 12 Months	0.7%	7.0%	12.4%	23.3%
Used in Past 30 Days	0.2%	2.5%	5.0%	10.8%

Table 1-c

Allegany County

Risk and Protective Factor Survey 2019 Reported Substance Use	Allegany County Schools 6th Grade	Allegany County Schools 8th Grade	Allegany County Schools 10th Grade	Allegany County Schools 12th Grade
Marijuana Use	435	398	380	343
Ever Used	1.1%	8.3%	25.8%	35.3%
Used in Past 12 Months	0.2%	7.0%	21.6%	29.7%
Used in Past 30 Days	0.0%	5.0%	11.1%	14.6%

Table 1-d-1

Allegany County Risk and Protective Factor Survey Reported Substance Use Other Drug Use	Allegany County Schools 6th Grade 435	Allegany County Schools 8th Grade 398	Allegany County Schools 10th Grade 380	Allegany County Schools 12th Grade 343
Ever Used Other Drug	1.4%	5.8%	8.4%	7.9%
Used ANY in Past 12 Months	1.4%	5.8%	8.4%	7.9%
Cocaine	0.2%	0.5%	2.1%	2.3%
Cough/Cold Medicines	0.7%	1.8%	4.2%	2.6%
Crack	0.2%	0.3%	1.3%	0.3%
Ecstasy	0.2%	0.3%	1.6%	0.9%
Heroin	0.2%	0.5%	1.3%	0.3%
Inhalants	0.2%	0.8%	1.6%	1.2%
LSD/Psychedelic	0.2%	0.5%	2.1%	1.7%
Meth	0.2%	0.3%	1.3%	0.3%
Steroids	0.2%	0.5%	1.3%	0.6%
Uppers/Amphetamines	0.0%	0.3%	1.3%	1.5%
Pain killers such as Vicodin/Oxycontin	0.5%	1.0%	2.1%	2.6%
Other Prescription	0.5%	1.8%	2.6%	2.6%
Over the counter drugs	0.2%	1.3%	2.4%	2.0%
Edible Marijuana (Gummys, brownies, cubes etc.)	0.2%	1.8%	2.6%	3.2%
Other	0.7%	1.0%	2.1%	0.9%

Table 1-d-2

Allegany County Risk and Protective Factor Survey Reported Substance Use Other Drug Use	Allegany County Schools 6th Grade 435	Allegany County Schools 8th Grade 398	Allegany County Schools 10th Grade 380	Allegany County Schools 12th Grade 343
Used ANY in Past 30 days	0.7%	1.0%	2.9%	2.0%
Cocaine	0.2%	0.0%	1.1%	1.2%
Cough/Cold Medicines	0.5%	0.5%	1.6%	1.7%
Crack	0.2%	0.0%	1.3%	0.3%
Ecstasy	0.2%	0.0%	1.1%	0.6%
Heroin	0.2%	0.3%	1.3%	0.3%
Inhalants	0.2%	0.3%	1.3%	1.2%
LSD/Psychedelic	0.2%	0.0%	1.3%	0.9%
Meth	0.2%	0.0%	1.1%	0.3%
Steroids	0.2%	0.0%	1.1%	0.3%
Uppers/Amphetamines	0.0%	0.0%	0.8%	0.6%
Pain killers such as Vicodin/Oxycontin	0.2%	0.3%	1.3%	1.2%
Other Prescription	0.2%	0.8%	1.3%	1.2%
Over the counter drugs	0.0%	0.5%	1.8%	1.2%
Edible Marijuana (Gummys, brownies, cubes etc.)	0.0%	0.5%	1.6%	1.2%
Other	0.5%	0.5%	1.3%	0.6%

Table 1-e

Risk and Protective Factor Survey Reported Substance Use Heroin & Prescription Pain Killers Use	Allegany County Schools 6th Grade 435	Allegany County Schools 8th Grade 398	Allegany County Schools 10th Grade 380	Allegany County Schools 12th Grade 343
Used in Past 12 Months	0.5%	1.3%	2.1%	2.6%
Used in Past 30 Days	0.5%	0.5%	1.6%	1.2%

Table 1-f

Allegany County

In the past 30 days did you use any of the following: (Check all that apply)

	6th	8th	10th	12th
N=	435	398	380	343
E-cig or JUUL	3.4%	18.6%	29.2%	38.5%
E-cigarettes or other tobacco vaporizers	3.2%	16.6%	25.8%	35.9%
JUUL	1.8%	12.8%	21.3%	29.4%
Cigarettes in packs	2.5%	4.3%	4.5%	14.3%
Regular Cigars	1.8%	2.0%	3.7%	10.5%
Cigarillos	0.5%	1.5%	3.4%	9.6%
Chewing tobacco	2.3%	3.8%	5.8%	9.0%
Small Cigars	1.6%	2.0%	3.4%	8.7%
Snuff/Pinch	1.1%	3.5%	4.7%	8.5%
Snus	0.9%	1.8%	2.4%	5.8%
Cigarettes roll-your-own	0.9%	1.5%	3.2%	5.0%
Pipe tobacco	0.5%	1.5%	2.9%	3.5%

Evalumetrics Youth Survey
2019 Allegany County

Table 1-g-1

Evalumetrics Youth Factor Survey 2019 Reported Substance Use Alcohol Use (except as part of religion) N=	Allegany County Schools 8th Grade 398	Monitoring the Future National 8th Grade	Allegany County Schools 10th Grade 380	Monitoring the Future National 10th Grade	Allegany County Schools 12th Grade 343	Monitoring the Future National 12th Grade
Ever Used	28.6%	23.5%	46.6%	42.2%	58.6%	58.5%
Used in Past 12 Months	21.4%	18.7%	37.9%	37.7%	51.3%	53.3%
Used in Past 30 Days	9.5%	8.2%	17.4%	19.7%	29.2%	30.2%
>5 Drinks at Least Once in Past 30 Days	3.3%	n/a	7.1%	n/a	17.5%	n/a

Table 1-g-2

Evalumetrics Youth Factor Survey 2019 Reported Substance Use Cigarette Use	Allegany County Schools 8th Grade 398	Monitoring the Future National 8th Grade	Allegany County Schools 10th Grade 380	Monitoring the Future National 10th Grade	Allegany County Schools 12th Grade 343	Monitoring the Future National 12th Grade
Ever Used	10.8%	9.1%	20.0%	16.0%	35.9%	23.8%
Used in Past 12 Months	7.0%	n/a	12.4%	4.2%	23.3%	7.6%
Used in Past 30 Days	2.5%	2.2%	5.0%	1.8%	10.8%	3.6%

Table 1-g-3

Evalumetrics Youth Factor Survey 2019 Reported Substance Use Marijuana Use	Allegany County Schools 8th Grade 398	Monitoring the Future National 8th Grade	Allegany County Schools 10th Grade 380	Monitoring the Future National 10th Grade	Allegany County Schools 12th Grade 343	Monitoring the Future National 12th Grade
Ever Used	8.3%	13.9%	25.8%	32.6%	35.3%	43.6%
Used in Past 12 Months	7.0%	10.5%	21.6%	27.5%	29.7%	35.6%
Used in Past 30 Days	5.0%	5.6%	11.1%	16.7%	14.6%	22.2%

Table 1-g-4

Evalumetrics Youth Factor Survey 2019 **Reported Substance Use** Other Drugs	**Allegany County Schools 8th Grade 398**	**Monitoring the Future National 8th Grade**	**Allegany County Schools 10th Grade 380**	**Monitoring the Future National 10th Grade**	**Allegany County Schools 12th Grade 343**	**Monitoring the Future National 12th Grade**
Used ANY in Past 12 Months	5.8%	n/a	8.4%	n/a	7.9%	14.3%
Cocaine	5.8%	0.8%	8.4%	2.6%	7.9%	3.9%
Cough. Cold Medicines	0.5%	2.8%	2.1%	3.3%	2.3%	3.4%
Crack	1.8%	0.4%	4.2%	0.6%	2.6%	0.9%
Ecstasy	0.3%	n/a	1.3%	n/a	0.3%	n/a
Heroin	0.3%	0.3%	1.6%	0.4%	0.9%	0.8%
Inhalants	0.5%	4.6%	1.3%	2.4%	0.3%	1.6%
LSD/Psychedelic	0.8%	0.9%	1.6%	2.0%	1.2%	3.2%
Methamphetamine	0.5%	0.4%	2.1%	0.4%	1.7%	0.3%
Steroids	0.3%	0.6%	1.3%	0.6%	0.3%	1.1%
Uppers/Amphetamines	0.5%	3.7%	1.3%	5.7%	0.6%	5.5%
Pain killers such as Vicodin/Oxycontin	0.3%	0.8%	1.3%	2.2%	1.5%	2.3%
Other Prescription	1.0%	n/a	2.1%	n/a	2.6%	4.2%
Over the counter drugs	1.8%	n/a	2.6%	n/a	2.6%	n/a
Other	1.0%	n/a	2.1%	n/a	0.9%	n/a

Table 1-g-5

Evalumetrics Youth Factor Survey 2019 **Reported Substance Use** Other Drugs	**Allegany County** **Schools 8th Grade 398**	**Monitoring the Future** **National** **8th Grade**	**Allegany County** **Schools 10th Grade 380**	**Monitoring the Future** **National** **10th Grade**	**Allegany County** **Schools 12th Grade 343**	**Monitoring the Future** **National** **12th Grade**
Used ANY in Past 30 days	0.5%	n/a	2.9%	n/a	2.0%	n/a
Cocaine	0.0%	0.3%	1.1%	6.0%	1.2%	1.1%
Cough. Cold Medicines	0.0%	n/a	1.6%	n/a	1.7%	n/a
Crack	0.3%	0.2%	1.3%	n/a	0.3%	n/a
Ecstasy	0.3%	n/a	1.1%	n/a	0.6%	n/a
Heroin	0.0%	0.1%	1.3%	n/a	0.3%	n/a
Inhalants	0.0%	1.8%	1.3%	1.0%	1.2%	0.7%
LSD/Psychedelic	0.0%	0.4%	1.3%	0.5%	0.9%	1.0%
Methamphetamine	0.0%	0.1%	1.1%	0.1%	0.3%	0.3%
Steroids	0.3%	0.3%	1.1%	0.4%	0.3%	0.8%
Uppers/Amphetamines	0.8%	1.8%	0.8%	2.4%	0.6%	2.4%
Pain killers such as Vicodin/Oxycontin	0.5%	n/a	1.3%	n/a	1.2%	n/a
Other Prescription	0.5%	n/a	1.3%	n/a	1.2%	4.2%
Over the counter drugs	0.5%	n/a	1.8%	n/a	1.2%	n/a
Other	0.0%	n/a	1.3%	n/a	0.6%	n/a

Risk and Protective Factors – Sixth Grade

Table 2a.

Year	Allegany County 2019
N=	435
Lack Rewards for Prosocial Behavior in the Community (P2-C)	34.0%
Lack Rewards for Prosocial Involvement in Family (P5-F)	23.0%
Poor Family Discipline (R7-F)	21.4%
Lack Opportunities for Prosocial Involvement in the Community (P1-C)	19.1%
Lack Perceived Risks of Drug Use (P8-PI)	19.1%
Lack Opportunities for Prosocial Involvement in School (P6-S)	17.0%
Lack Opportunities for Prosocial Involvement in Family(P4-F)	15.6%
Community Disorganization (R2-C)	14.7%
Laws and Norms Favorable to Drug Use (R4-C)	13.6%
Little Commitment to School (R13-S)	12.6%
Low Neighborhood Attachment (R1-C)	10.6%
Lack Rewards for Prosocial Involvement in School(P7-S)	9.4%
Family Conflict (R8-F)	8.7%
Personal Transitions/Mobility (R3-C)	8.5%
Impulsiveness (R16-PI)	8.3%
Lack of Family Supervision and Rules (R6-F)	7.8%
Lack Social Skills (P10-PI)	7.4%
Lack Attachment to Family (P3-F)	6.9%
Family History of Antisocial Behavior (R9-F)	6.0%
Parental Attitudes Favorable to Drug Use (R10-F)	5.3%
Rebelliousness (R14-PI)	5.3%
Favorable Attitudes Toward Antisocial Behavior (R18-PI)	4.6%
Antisocial Behavior (R17-PI)	4.1%
Parental Attitudes Favorable to Antisocial Behavior (R11-F)	3.7%
Rewards for Antisocial Involvement (R23-PI)	2.8%
Favorable Attitudes Toward Drug Use (R19-PI)	2.1%

Risk and Protective Factors – Eighth Grade

Table 2b. **Allegany County**

Year	2019
N=	398
Lack Rewards for Prosocial Behavior in the Community (P2-C)	21.9%
Community Disorganization (R2-C)	19.6%
Sensation Seeking (R22-PI)	18.1%
Low Neighborhood Attachment (R1-C)	16.6%
Lack Opportunities for Prosocial Involvement in Family(P4-F)	15.8%
Lack Opportunities for Prosocial Involvement in the Community (P1-C)	13.8%
Lack Attachment to Family (P3-F)	12.6%
Little Commitment to School (R13-S)	12.3%
Lack Perceived Risks of Drug Use (P8-PI)	11.6%
Personal Transitions/Mobility (R3-C)	11.1%
Family History of Antisocial Behavior (R9-F)	11.1%
Lack of Family Supervision and Rules (R6-F)	10.3%
Family Conflict (R8-F)	10.3%
Poor Family Discipline (R7-F)	10.1%
Impulsiveness (R16-PI)	9.8%
Rebelliousness (R14-PI)	9.0%
Lack Rewards for Prosocial Involvement in Family (P5-F)	8.5%
Parental Attitudes Favorable to Antisocial Behavior (R11-F)	7.8%
Favorable Attitudes Toward Antisocial Behavior (R18-PI)	7.5%
Lack Rewards for Prosocial Involvement in School(P7-S)	7.0%
Rewards for Antisocial Involvement (R23-PI)	6.8%
Lack Social Skills (P10-PI)	6.5%
Parental Attitudes Favorable to Drug Use (R10-F)	6.0%
Lack Opportunities for Prosocial Involvement in School (P6-S)	6.0%
Interaction With Antisocial Peers (R20-PI)	5.0%
Lack a Belief in Moral Order (P11-PI)	4.8%
Laws and Norms Favorable to Drug Use (R4-C)	4.0%
Favorable Attitudes Toward Drug Use (R19-PI)	3.5%
Friend Use Drugs (R21-PI)	2.8%
Antisocial Behavior (R17-PI)	2.5%
Perceived Availability of Drugs (R5-C)	1.3%

Risk and Protective Factors – Tenth Grade

Table 2c.

	Allegany County
Year	**2019**
N=	**380**
Lack Rewards for Prosocial Behavior in the Community (P2-C)	27.4%
Sensation Seeking (R22-PI)	23.4%
Lack Opportunities for Prosocial Involvement in the Community (P1-C)	23.4%
Low Neighborhood Attachment (R1-C)	22.1%
Community Disorganization (R2-C)	20.3%
Lack Opportunities for Prosocial Involvement in Family(P4-F)	17.6%
Lack of Family Supervision and Rules (R6-F)	15.8%
Lack Attachment to Family (P3-F)	15.8%
Little Commitment to School (R13-S)	15.5%
Personal Transitions/Mobility (R3-C)	14.5%
Family History of Antisocial Behavior (R9-F)	13.4%
Lack Perceived Risks of Drug Use (P8-PI)	13.4%
Rebelliousness (R14-PI)	13.2%
Lack Rewards for Prosocial Involvement in School(P7-S)	13.2%
Poor Family Discipline (R7-F)	12.1%
Impulsiveness (R16-PI)	11.8%
Laws and Norms Favorable to Drug Use (R4-C)	11.6%
Family Conflict (R8-F)	11.3%
Lack Opportunities for Prosocial Involvement in School (P6-S)	11.1%
Favorable Attitudes Toward Antisocial Behavior (R18-PI)	10.0%
Parental Attitudes Favorable to Drug Use (R10-F)	8.9%
Parental Attitudes Favorable to Antisocial Behavior (R11-F)	8.9%
Rewards for Antisocial Involvement (R23-PI)	8.9%
Lack Rewards for Prosocial Involvement in Family (P5-F)	7.6%
Interaction With Antisocial Peers (R20-PI)	7.4%
Favorable Attitudes Toward Drug Use (R19-PI)	7.1%
Friend Use Drugs (R21-PI)	6.8%
Perceived Availability of Drugs (R5-C)	6.3%
Lack a Belief in Moral Order (P11-PI)	5.5%
Antisocial Behavior (R17-PI)	4.7%
Lack Social Skills (P10-PI)	3.4%

Risk and Protective Factors – Twelfth Grade

Table 2d.

	Allegany County
Year	**2019**
N=	**343**
Low Neighborhood Attachment (R1-C)	35.0%
Lack Rewards for Prosocial Behavior in the Community (P2-C)	28.9%
Lack Opportunities for Prosocial Involvement in the Community (P1-C)	24.5%
Laws and Norms Favorable to Drug Use (R4-C)	23.6%
Sensation Seeking (R22-PI)	23.6%
Lack Perceived Risks of Drug Use (P8-PI)	22.2%
Lack of Family Supervision and Rules (R6-F)	21.9%
Community Disorganization (R2-C)	18.7%
Lack Opportunities for Prosocial Involvement in Family(P4-F)	18.1%
Poor Family Discipline (R7-F)	17.2%
Little Commitment to School (R13-S)	17.2%
Family History of Antisocial Behavior (R9-F)	16.9%
Parental Attitudes Favorable to Drug Use (R10-F)	16.3%
Lack Attachment to Family (P3-F)	15.7%
Favorable Attitudes Toward Drug Use (R19-PI)	13.7%
Friend Use Drugs (R21-PI)	12.8%
Rewards for Antisocial Involvement (R23-PI)	12.8%
Impulsiveness (R16-PI)	12.5%
Favorable Attitudes Toward Antisocial Behavior (R18-PI)	11.4%
Perceived Availability of Drugs (R5-C)	11.1%
Personal Transitions/Mobility (R3-C)	10.8%
Rebelliousness (R14-PI)	10.8%
Interaction With Antisocial Peers (R20-PI)	10.8%
Lack Rewards for Prosocial Involvement in School(P7-S)	10.5%
Family Conflict (R8-F)	10.2%
Lack Opportunities for Prosocial Involvement in School (P6-S)	9.0%
Parental Attitudes Favorable to Antisocial Behavior (R11-F)	7.6%
Antisocial Behavior (R17-PI)	7.3%
Lack Rewards for Prosocial Involvement in Family (P5-F)	6.4%
Lack a Belief in Moral Order (P11-PI)	4.7%
Lack Social Skills (P10-PI)	4.4%

Overall Risk

Table 3.
Proportion of Students by Number of Factors at the At-Risk Level

2019 Grade	Allegany County Schools 6th	Allegany County Schools 8th	Allegany County Schools 10th	Allegany County Schools 12th
N=	**435**	**398**	**380**	**343**
No Factors At-Risk	23.4%	27.4%	18.9%	13.1%
One	17.2%	18.8%	19.7%	13.4%
Two	16.6%	13.8%	13.7%	13.4%
Three	10.6%	9.0%	11.7%	11.4%
Four	8.3%	7.3%	0.9%	8.5%
Five or More	**23.9%**	**23.6%**	**35.1%**	**40.2%**

Bullying

Table 4-a.	Allegany County Schools	Allegany County Schools	Allegany County Schools	Allegany County Schools
EYS 2019	**6th Grade**	**8th Grade**	**10th Grade**	**12th Grade**
In the past 30 days how many times were you threatened or bullied by someone? N=	**435**	**398**	**380**	**343**
None	58.6%	66.1%	65.3%	78.4%
Once	11.7%	11.1%	8.9%	3.8%
Twice	6.9%	7.3%	3.9%	2.6%
Three or more	17.2%	13.1%	15.3%	9.9%
Two or More	24.1%	20.4%	19.2%	12.5%

Table 4-b.	Allegany County Schools	Allegany County Schools	Allegany County Schools	Allegany County Schools
EYS 2019	**6th Grade**	**8th Grade**	**10th Grade**	**12th Grade**
In the past 30 days how many times did you verbally threaten or bully someone? N=	**435**	**398**	**380**	**343**
None	77.9%	74.6%	77.1%	77.0%
Once	9.0%	9.8%	8.2%	8.2%
Twice	2.5%	5.5%	2.9%	3.5%
Three or more	6.4%	8.0%	7.9%	7.9%
Two or More	9.0%	13.6%	10.8%	11.4%

Table 4-c.	Allegany County Schools	Allegany County Schools	Allegany County Schools	Allegany County Schools
EYS 2019	**6th Grade**	**8th Grade**	**10th Grade**	**12th Grade**
You see some students making fun of or saying cruel thing or pushing and threatening another student.	**435**	**398**	**380**	**343**
What would you most likely do?				
join the bullying	1.6%	2.5%	3.2%	3.5%
threaten or push the bully	14.0%	15.6%	14.5%	10.5%
tell the bully to stop	31.7%	37.7%	38.9%	33.5%
support the target after bullying is over	6.9%	5.8%	6.8%	7.3%
tell a teacher or adult	34.0%	28.4%	21.1%	24.2%
nothing	6.7%	8.3%	11.6%	16.3%

Behavioral Health Risk Behaviors

Table 5-a.
Evalumetrics Youth Survey
Allegany County

In the past year have you felt depressed or sad most days, even if you felt OK sometimes?	6th Grade		8th Grade		10th Grade		12th Grade	
	Females	Males	Females	Males	Females	Males	Females	Males
N	213	207	178	212	163	201	175	156
Strongly disagree	25.6%	33.8%	13.0%	30.4%	12.4%	22.5%	11.9%	25.7%
Disagree	24.6%	29.3%	23.2%	27.1%	25.5%	29.8%	30.4%	30.4%
Agree	27.1%	23.2%	35.6%	25.1%	32.9%	32.5%	35.1%	32.4%
Strongly agree	22.7%	13.6%	28.2%	17.4%	29.2%	15.2%	22.6%	11.5%
Agree/Strongly Agree	**49.8%**	**36.9%**	**63.8%**	**42.5%**	**62.1%**	**47.6%**	**57.7%**	**43.9%**

Table 5-b.
Evalumetrics Youth Survey
Allegany County

In the past 12 months, did you think about or consider committing suicide?	6th Grade		8th Grade		10th Grade		12th Grade	
	Females	Males	Females	Males	Females	Males	Females	Males
N	213	207	178	212	163	201	175	156
Yes	17.4%	14.0%	29.2%	16.5%	28.2%	19.9%	20.6%	18.6%
No	82.6%	86.0%	70.8%	83.5%	71.8%	80.1%	79.4%	81.4%

Table 5-b-1.								
Evalumetrics Youth Survey								
Allegany County	6th Grade		8th Grade		10th Grade		12th Grade	
During the past 12 months did you make a plan about how you would attempt suicide?	Females	Males	Females	Males	Females	Males	Females	Males
N	213	207	178	212	163	201	175	156
Yes	8.0%	3.9%	18.0%	6.1%	16.6%	8.5%	8.0%	7.1%
No	92.0%	96.1%	82.0%	93.9%	83.4%	91.5%	92.0%	92.9%

Table 5-c.
Evalumetrics Youth Survey
Allegany County

	6th Grade		8th Grade		10th Grade		12th Grade	
During the past 12 months did you actually attempt suicide?	Females	Males	Females	Males	Females	Males	Females	Males
N	213	207	178	212	163	201	175	156
Yes	2.8%	2.4%	8.4%	5.7%	2.5%	8.5%	5.1%	3.8%
No	97.2%	97.6%	91.6%	94.3%	97.5%	91.5%	94.9%	96.2%

Table 5-d
Evalumetrics Youth Survey
Allegany County

During the past 12 months did any attempt result in injury, poisoning or overdose that had to be treated by a doctor or nurse?	6th Grade		8th Grade		10th Grade		12th Grade	
	Females	Males	Females	Males	Females	Males	Females	Males
N	213	207	178	212	163	201	175	156
Yes	0.5%	0.0%	3.4%	1.9%	2.5%	1.5%	1.7%	1.3%
No	99.5%	100.0%	96.6%	98.1%	97.5%	98.5%	98.3%	98.7%

Table 5-e
Evalumetrics Youth Survey
Allegany County

Have you ever hurt yourself by cutting or burning yourself when you were upset about something?	6th Grade		8th Grade		10th Grade		12th Grade	
	Females	Males	Females	Males	Females	Males	Females	Males
N	213	207	178	212	163	201	175	156
Yes	14.1%	14.0%	29.2%	10.8%	27.6%	12.4%	29.1%	13.5%
No	85.9%	86.0%	70.8%	89.2%	72.4%	87.6%	70.9%	86.5%

Table 6

Evalumetrics Youth Survey

Allegany County How many Adverse Childhood Experiences?	6th	8th	10th	12th
	435	**398**	**380**	**343**
None	50.4%	35.9%	36.7%	34.6%
1	23.2%	27.3%	21.3%	18.8%
2	13.0%	13.4%	12.4%	11.3%
3	5.2%	8.4%	9.4%	9.0%
4	3.5%	4.8%	5.9%	6.9%
5	2.6%	3.5%	4.0%	6.6%
6	0.7%	1.3%	3.5%	3.0%
7	0.5%	2.0%	2.2%	3.3%
8	0.2%	0.8%	1.6%	2.7%
9	0.0%	1.0%	1.3%	1.5%
10	0.2%	0.0%	0.8%	0.3%
11	0.5%	1.5%	0.8%	2.1%
More than two	**13.5%**	**23.3%**	**29.6%**	**35.2%**

Appendix A

METHOD

The survey instrument was a self-report web-based form completed by students in a classroom setting. The sample for the survey was all 6th, 8th, 10th and 12th grade students in Allegany County Schools. Each Risk and Protective Factor is represented by one or more scale consisting of one or more item from the survey. Appendix B provides a data dictionary with the definition of each scale. Each student was given a score for each of the scales. Separate analyses were conducted for middle school (grades 6 &8) and high school (grade 10 & 12). Based on the distribution of scores for over 20,000 students in a 2001 survey in the five-county Finger Lakes region, standard scores (z-scores) were calculated by subtracting the mean score from each individual's score and dividing by the standard deviation.

Students with a standard score of 1 or greater on any risk factor were considered to be at-risk. A standard score of –1 or less on any protective factor was considered a lack of protection and therefore at-risk.

In addition to measuring risk and protective factors, the survey measures self-reported use of alcohol, tobacco, marijuana and other substances (prevalence). It also asked about students' behaviors related to bullying, depression, and self-injury.

SAMPLE

Each school was asked to arrange for distribution and completion of the surveys on a day and in a class-period of their choice. School staff supervised all surveys. In all cases, the survey is voluntary. Parents were notified about the survey and were given the option of having their child opt out of the survey without prejudice. Students were instructed not to put their name or any identifying information on the survey form.

Table 1

Allegany County

Grade	Females	Males
6th	213	207
8th	178	212
10th	163	201
12th	175	156
Total	729	776

Appendix B

Risk and Protective Factor Survey

Factor (Scale) Definitions

COMMUNITY: Low Neighborhood Attachment (R1)

I like my neighborhood.

If I had to move, I would miss the neighborhood I now live in.

COMMUNITY: Community Disorganization (R2)

How much do each of the following statements describe your neighborhood:

crime and/or drug selling.

fights.

lots of empty or abandoned buildings.

lots of graffiti.

COMMUNITY: Personal Transitions and Mobility (R3)

Have you changed homes in the past year?

How many times have you changed homes since kindergarten?

Have you changed schools in the past year?

How many times have you changed schools since kindergarten?

COMMUNITY: Laws and Norms Favorable to Drug Use (R4)

How wrong would most adults in your neighborhood think it was for kids your age:

to use marijuana.

to drink alcohol.

to smoke cigarettes.

If a kid drank some beer, wine or hard liquor (for example, vodka, whiskey, or gin) in your neighborhood would he or she be caught by the police?

If a kid smoked marijuana in your neighborhood would he or she be caught by the police?

If a kid carried a handgun in your neighborhood would he or she be caught by the police?

COMMUNITY: Perceived Availability of Drugs & Handguns (R5)

If you wanted to get some beer, wine or hard liquor (for example, vodka, whiskey, or gin), how easy would it be for you to get some?

IF You wanted to get some cigarettes, how easy would it be for you to get some?

If you wanted to get some marijuana, how easy would it be for you to get some?

If you wanted to get a drug like cocaine, LSD, or amphetamines, how easy would it be for you to get some?

If you wanted to get a handgun, how easy would it be for you to get one?

COMMUNITY: Opportunities for Prosocial Involvement (P1)

In my community there are enough recreational activities for kids my age.

In my community there are enough recreational activities such as sports, clubs, fun events, that I can do if I want.

In my community there are recreational activities that I would like to do but I can't.

On average since the beginning of this school year, how many days each week did you participate in extra-curricular activity including: sports, music, clubs or after-school programs?

COMMUNITY: Rewards for Prosocial Involvement (P2)

My neighbors notice when I am doing a good job and let me know.

There are people in my neighborhood who encourage me to do my best.

There are people in my neighborhood who are proud of me when I do something well.

FAMILY: Lack of Supervision and Rules (R6)

My parents or the adults I live with ask if I've gotten my homework done.

My parents or the adults I live with ask want me to call if I'm going to be late getting home.

Would your parents or the adults I live with ask know if you did not come home on time?

When I am not at home, one of my parents or the adults I live with ask knows where I am and who I am with.

The rules in my family are clear.

My family has clear rules about alcohol and drug use.

FAMILY: Poor Discipline (R7)

If you drank some beer or wine or liquor (for example, vodka, whiskey, or gin) without your parents' permission, would you be caught by your parents or the adults I live with ask?

If you skipped school would you be caught by your parents or the adults I live with ask?

If you carried a handgun without your parents' permission, would you be caught by your parents or the adults I live with ask?

FAMILY: Family Conflict (R8)

People in my family often insult or yell at each other.

People in my family have serious arguments.

We argue about the same things in my family over and over.

FAMILY: Family History of Antisocial Behavior (R9)

Has anyone in your family ever had a severe alcohol or drug problem?

Have any of your brothers or sisters ever:

drunk beer, wine or hard liquor (for example, vodka, whiskey or gin)?

smoked marijuana?

smoked cigarettes?

taken a handgun to school?

been suspended or expelled from school?

About how many adults have you known personally who in the past year have:

used marijuana, crack, cocaine, or other drugs?

sold or dealt drugs?

done other things that could get them in trouble with the police like stealing, selling stolen goods, mugging or assaulting others, etc)

gotten drunk or high?

FAMILY: Parental Attitudes Favorable Toward Drug Use (R10)

How wrong do your parents feel it would be for you to:

drink beer, wine or hard liquor (for example, vodka, whiskey or gin) regularly?

smoke cigarettes?

smoke marijuana?

FAMILY: Parental Attitudes Favorable to Antisocial Behavior (R11)

steal anything worth more than $5?

draw graffiti, or write things or draw pictures on buildings or other property (without the owner's permission)?

pick a fight with someone?

FAMILY: Attachment (P3)

Do you feel very close to the adults in your family (mother/father/step parent etc.)?

Do you share your thoughts and feelings adults in your family (mother/father/step parent etc.)?

FAMILY: Opportunities for Prosocial Involvement (P4)

My parents give me lots of chances to do fun things with them.

My parents ask me what I think before most family decisions affecting me are made.

If I had a personal problem, I could ask my mom or dad for help.

FAMILY: Rewards for Prosocial Involvement (P5)

My parents or the adults I live with notice when I am doing a good job and let me know about it.

How often do your parents or the adults I live with tell you they're proud of you for something you've done?

Do you enjoy spending time with adults in your family (mother/father/step parent etc.)?

SCHOOL: Little Commitment to School (R13)

How often do you feel that the school work you are assigned is meaningful and important? (#55)

How interesting are most of your courses to you? (#56)

How important do you think the things you are learning in school are going to be for your later life? (#57)

Now, thinking back over the past year in school, how often did you...

Enjoy being in school? (#58a)

Hate being in school? (#58b)

Try to do your best work in school? (#58c)

During the LAST FOUR WEEKS how many whole days have you missed...

because of illness (#59a)

because you skipped or "cut" (#59b)

for other reasons (#59c)

SCHOOL: Opportunities for Prosocial Involvement (P6)

In my school, students have lots of chances to help decide things like class activities and rules. (#60)

There are lots of chances for students in my school to talk with a teacher one-on-one. (#61)

Teachers ask me to work on special classroom projects. (#62)

There are lots of chances for students in my school to get involved in sports, clubs, and other school activities outside of class. (#63)

I have lots of chances to be part of class discussions or activities. (#64)

SCHOOL: Rewards for Prosocial Involvement (P7)

My teacher(s) notices when I am doing a good job and lets me know about it. (#65)

The school lets my parents know when I have done something well. (#66)

I feel safe at my school. (#67)

My teachers praise me when I work hard in school. (#68)

PEER-INDIVIDUAL: Rebelliousness (R14)

I do the opposite of what people tell me, just to get them mad.

I ignore rules that get in my way.

I like to see how much I can get away with.

PEER-INDIVIDUAL: Impulsiveness (R16)

It is important to think before you act.

Do you have to have everything right away?

I often do things without thinking about what will happen.

Do you often switch from activity to activity rather than sticking to one thing at a time?

PEER-INDIVIDUAL: Antisocial Behavior (R17)

How many times in the past year (12 months) have you:

been suspended from school?

carried a handgun?

sold illegal drugs?

stolen or tried to steal a motor vehicle such as a car or motorcycle?

been arrested?

attacked someone with the idea of seriously hurting them?

been drunk or high at school?

taken a handgun to school?

PEER-INDIVIDUAL: Favorable Attitudes Toward Antisocial Behavior (R18)

How wrong do you think it is for someone your age to:

take a handgun to school?

steal anything worth more than $5?

pick a fight with someone?

attack someone with the idea of seriously hurting them?

stay away from school all day when their parents think they are at school?

PEER-INDIVIDUAL: Favorable Attitudes Toward Drug Use (R19)

How wrong do you think it is for someone your age to:

drink beer, wine or hard liquor (for example, vodka, whiskey or gin) regularly?

smoke cigarettes?

smoke marijuana?

use LSD, cocaine, amphetamines or another illegal drug?

PEER-INDIVIDUAL: Perceived Risks of Drug Use (P8)

How much do you think people risk harming themselves (physically or in other ways) if they:

Smoke one or more packs of cigarettes per day?

Try marijuana once or twice?

Smoke marijuana regularly? Take one or two drinks of an alcoholic beverage (beer, wine, liquor) nearly every day?

PEER-INDIVIDUAL: Interaction with Antisocial Peers (R20)

Think of your four best friends (the friends you feel closest to). In the past year (12 months), how many of your best friends have:

been suspended from school?

carried a handgun?

sold illegal drugs?

stolen or tried to steal a motor vehicle such as a car or motorcycle?

been arrested?

dropped out of school?

PEER-INDIVIDUAL: Friends' Use of Drugs (R21)

Think of your four best friends (the friends you feel closest to). In the past year (12 months), how many of your best friends have:

smoked cigarettes?

tried beer, wine or hard liquor (for example, vodka, whiskey or gin) when their parents didn't know about it?

used marijuana?

used LSD, cocaine, amphetamines, or other illegal drugs?

PEER-INDIVIDUAL: Sensation Seeking (R22)

How many times have you done the following things?

Done what feels good no matter what.

Done something dangerous because someone dared you to do it.

Done crazy things even if they are a little dangerous.

PEER-INDIVIDUAL: Rewards for Antisocial Involvement (R23)

What are the chances you would be seen as cool if you:

smoked cigarettes?

began drinking alcoholic beverages regularly,
that is, at least once or twice a month?

smoked marijuana?

carried a handgun?

PEER-INDIVIDUAL: Social Skills (P10)

You're looking at CD's in a music store with a friend. You look up and see her slip a CD under her coat. She smiles and says "Which one do you want? Go ahead, take it while nobody's around." There is nobody in sight, no employees and no other customers. What would you do now?

Ignore her
Grab a CD and leave the store
Tell her to put the CD back
Act like it's a joke, and ask her to put the CD back

It's 8:00 on a weeknight and you are about to go over to a friend's home when your mother asks you where you are going. You say "Oh, just going to go hang out with some friends." She says, "No, you'll just get into trouble if you go out. Stay home tonight." What would you do now? Leave the house anyway

Explain what you are going to do with your friends, tell her when you'd get home, and ask if you can go out
Not say anything and start watching TV
Get into an argument with her

You are visiting another part of town, and you don't know any of the people your age there. You are walking down the street, and some teenager you don't know is walking toward you. He is about your size, and as he is about to pass you, he deliberately bumps into you and you almost lose your balance. What would you say or do?

Push the person back
Say "Excuse me" and keep on walking
Say "Watch where you're going" and keep on walking
Swear at the person and walk away

You are at a party at someone's house, and one of your friends offers you a drink containing alcohol. What would you say or do?

Drink it
Tell your friend "No thanks, I don't drink" and suggest that you and your friend go and do something else
Just say "No, thanks" and walk away
Make up a good excuse, tell your friend you had something else to do, and leave

PEER-INDIVIDUAL: Belief in the Moral Order (P11)

I think it is okay to take something without asking if you can get away with it.

I think sometimes it's okay to cheat at school.

It is all right to beat up people if they start the fight.

It is important to be honest with your parents, even if they become upset or you get punished.

COMPLETE

Thursday, October 08, 2020 5:00:45 PM

Page 1

Q1

Contact Information

Name	**Robert W. Anderson, Ph.D.**
Title	**DCS**
Email	**robanders6@gmail.com**

Q2

LGU:

Allegany County Mental Health Services

Q3

a. Indicate how your local mental hygiene service system (i.e., mental health, substance use disorder and problem gambling, and developmental disability populations), overall, has been affected by the COVID-19 pandemic: Please specifically note, Any cross-system issues that affect more than one population; Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

Major issues reported by all providers include: Staffing problems, especially for residential services; Transportation, always a problem, is made more difficult and a bigger barrier by Covid-19 restrictions that limit number of passengers on buses and fewer buses operating; increase in medical risks since consumers are not seeking primary care; stressors and determinants of health are more intense and consumers are not able to access treatment as easily or frequently; Telehealth, while beneficial and helpful for some BH consumers, is not as therapeutic for many and did/does take some time to adjust and adapt for both therapists and clients; housing agencies have experienced difficulty accepting referrals and intakes.
The populations identified as needing Behavioral Health services have been disproportionately impacted by Covid-19. There have not been any discriminatory events reported regarding racial/ethnic groups. Services provided for consumers in the Mental Hygiene service system have not been as smoothly delivered. Travel, always an issue, has been even more of a barrier. Care managers have had to provide by leaving things on the front porch.

Q4

b. Indicate how your mental health service needs, overall, have been affected by the COVID-19 pandemic:Please specifically note, Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

Increase in anxiety and depression related to social determinates of health (housing, job loss, school changes, daycare, isolation.) Operating School satellites proved difficult in the spring, and even though are ready to open now, problems abound in meeting all needs. Lack of access to technology for some clients. Staffing issues. Anecdotally, increased suicide attempts in the community. Seems stressors are impacting people that don't traditionally access mental health services. More need for crises outreach.

Q5

c. Indicate how your substance use disorder (SUD) and problem gambling needs, overall, have been affected by the COVID-19 pandemic:Please specifically note, Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

The demand for services has increased on the outpatient side but our residential services have seen a decrease. No racial/ethnic groups have been disproportionately impacted. No one has complained of lack of services. Some increase in alcohol use disorder, relapse rates seem a little higher, limited access to community support groups (AA, NA, etc.) Some reluctance to participate in online forums that are similar.
Some children were more difficult to engage via telehealth.

Q6

d. Indicate how the needs of the developmentally disabled population, overall, have been affected by the COVID-19 pandemic:Please specifically note, Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

There is no indication of specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19,; and no significant differences between adult and children's services. Due to Covid-19 related staff illnesses and Covid-19 impact on schools, staffing is an even greater issue than previously.

Q7

a. Mental Health providers

No complaints regarding unavailability of educational materials, training, or difficulty revamping policies.

Q8

b. SUD and problem gambling service providers:

OASAS did a particularly positive job in keeping everybody up to date on Covid-19 issues and ways to cope.

Q9

c. Developmental disability service providers:

None at this time.

Page 2

Q10

a. Since March 1, 2020, how would you describe DEMAND for mental health services in each of the following program categories?

INPATIENT (State PC, Article 28/31 Inpatient, Residential Treatment Facilities)	**Increased**
OUTPATIENT (Clinic, ACT, Day Treatment, PROS, Continuing Day Treatment, Partial Hospitalization)	**Increased**
RESIDENTIAL (Support, Treatment, Unlicensed Housing)	**Increased**
EMERGENCY (Comprehensive Psychiatric Emergency Programs, Crisis Programs)	**Increased**
SUPPORT (Care Coordination, Education, Forensic, General, Self-Help, Vocational)	**Increased**

Q11

Respondent skipped this question

If you would like to add any detail about your responses above, please do so in the space below:

Q12

b. Since March 1, 2020, how would you describe ACCESS to mental health services in each of the following program categories?

INPATIENT (State PC, Article 28/31 Inpatient, Residential Treatment Facilities)	**Decreased**
OUTPATIENT (Clinic, ACT, Day Treatment, PROS, Continuing Day Treatment, Partial Hospitalization)	**No Change**
RESIDENTIAL (Support, Treatment, Unlicensed Housing)	**Decreased**
EMERGENCY (Comprehensive Psychiatric Emergency Programs, Crisis Programs)	**No Change**
SUPPORT (Care Coordination, Education, Forensic, General, Self-Help, Vocational)	**Decreased**

Q13

If you would like to add any detail about your responses above, please do so in the space below:

Due to some agencies transitioning to telehealth and working with less staff, access has taken longer at times (housing, DSS, etc.)

Q14

a. Since March 1, 2020, what number of mental health program sites in your county closed or limited operations due to COVID-19, apart from transition to telehealth?

2

Q15 **Respondent skipped this question**

If you would like to add any detail about your responses above, please do so in the space below:

Q16

b. What number of mental health program sites in your county remain closed or are offering limited services now, apart from transition to telehealth?

1

Q17 **Respondent skipped this question**

If you would like to add any detail about your responses above, please do so in the space below:

Q18 **N/A**

c. If your county operates services, did you maintain any level of in-person mental health treatment

Q19 **Respondent skipped this question**

If you would like to add any detail about your responses above, please do so in the space below:

Q20 **No**

d. As a result of COVID-19, are any mental health programs in your county closing operations permanently? If yes, list program name(s) and type(s).

Q21 **Respondent skipped this question**

If you would like to add any detail about your responses above, please do so in the space below:

Q22 **No**

e. Did any mental health programs in your county close due to workforce issues (e.g. staff infections, recruitment/retention issues)?

Q23

If you would like to add any detail about your responses above, please do so in the space below:

Respondent skipped this question

Q24

a. Apart from telehealth, during COVID-19, did your county or mental health providers within your county develop any innovative services or methods of program delivery that may be continued post-COVID? If yes, please describe.

Yes (please describe):
Telehealth

Q25

b. During COVID-19, did any mental health providers within your county form any partnerships with other providers that may be continued post-COVID? If yes, please describe.

Yes (please describe):
Partnerships already existed but were intensified. More frequent exchange of information and ideas.

Q26

a. During COVID-19, how many mental health providers within your county implemented existing continuity of operations plans?

2

Q27

If you would like to add any detail about your responses above, please do so in the space below:

Agencies implemented existing continuity of operation plans but needed to develop and amend plans to more directly address Covid-19 barriers. Clarity plan was developed within 24 hours of making decision to transition to remote services.

Q28

b. During COVID-19, how many mental health providers within your county did not implement existing continuity of operations plans?

0

Q29

If you would like to add any detail about your responses above, please do so in the space below:

Respondent skipped this question

Q30

c. During COVID-19, did your county LGU or Office of Emergency Management (OEM) assist any mental health providers in the development or revision of continuity of operations plans?

LGU

Q31

If you would like to add any detail about your responses above, please do so in the space below:

Respondent skipped this question

Q32

During COVID-19, what OMH guidance documents were beneficial to your disaster management process?

Program-level Guidance,

Telemental Health Guidance,

Infection Control Guidance,

Fiscal and Contract Guidance,

FAQs,

Please provide any feedback on OMH's guidance resources::

OMH provided guidance in all areas and the staff were accessible and helpful to address specific questions; especially fiscal and contract issues.

Page 3

Q33

1. Please indicate any needs for or issues with SUD and problem gambling prevention, treatment, and recovery providers acquiring Personal Protective Equipment (PPE), face masks, cleaning or disinfectant supplies, or similar materials related to the COVID-19 pandemic:

There were some difficulties obtaining PPE in the early stages of the Pandemic. That did not last long and the supply chain is now continuous.

Q34

a. How has COVID-19 affected the delivery of and demand for SUD and problem gambling prevention services in your county?

Closing of schools precluded providing most of the school based programing. Two schools were served via virtual programing. As the new school year begins, the Council is providing some services in person and virtually in the other schools.

Q35

b. How has COVID-19 affected the delivery of and demand for SUD and problem gambling recovery services in your county?

The Peer Advocate used telephonic means during the initial shut down. Now, services are both in person and telephonic. Clinical services went to telephonic during the initial shut down. The biggest impact was on our ability to provide Group treatment.

Q36

c. How has COVID-19 affected the delivery of and demand for problem gambling treatment services in your county?

Problem gambling was not impacted by Covid-19.

Q37

d. Since March 1, 2020, how would you describe DEMAND for SUD Treatment services in each of the following program categories?

INPATIENT	**No Change**
OUTPATIENT	**Increased**
OTP	**No Change**
RESIDENTIAL	**Decreased**
CRISIS	**No Change**

Q38 **Respondent skipped this question**

If you would like to add any detail about your responses above, please do so in the space below:

Q39

e. Since March 1, 2020, how would you describe ACCESS to SUD Treatment services in each of the following program categories?

INPATIENT	**Decreased**
OUTPATIENT	**Decreased**
OTP	**No Change**
RESIDENTIAL	**Decreased**
CRISIS	**No Change**

Q40 **Respondent skipped this question**

If you would like to add any detail about your responses above, please do so in the space below:

Q41

No

a. Apart from telehealth, during COVID-19, did your county or SUD and problem gambling service providers within your county develop any innovative services or methods of program delivery that may be continued post-COVID? If yes, please describe.

Q42

No

b. During COVID-19, did SUD and problem gambling service providers within your county form any partnerships with other providers that may be continued post-COVID? If yes, please describe.

Page 4

Q43

No

1. Has your county conducted analysis on the impact of COVID related to IDD services/OPWDD service system? If yes, please explain.

Q44

2. What are the greatest challenges your county will be facing over the next 12 months related to IDD services?

Staffing. Workforce is the most significant issue facing the IDD system in New York currently.

In 2012 Clarence J. Sundram, Governor's Special Advisor on Vulnerable Persons was tasked with examining the systems in place for the safety and protection of vulnerable people entrusted to the care of the state or community providers and offering recommendations for improvement. Sundram's report called for improvements in the working conditions for direct support staff members. Sundrum wrote, "Despite the difficulty of the job, direct support positions require at a minimum a high school diploma or equivalent. Perhaps reflective of this, such jobs are compensated poorly, with many workers living at or near the poverty level or forced to work multiple jobs to make ends meet. One might summarize the job description of the direct support worker as requiring the wisdom of Solomon, the patience of Job and the caring of Florence Nightingale. While much is said about the value of these direct support jobs, the traditional hallmarks of value are often missing - qualifying credentials, adequate pay, career ladders, attention to working conditions, adequate training, managerial and supervisory support and so on. Worse, when something goes wrong, the direct support worker is expendable, most often targeted for dismissal, justly or unjustly, especially in the private sector which generally lacks robust due process protections for employees."

Any initiative OPWDD could plan would be dependent on the ability of providers to recruit and retain a qualified workforce. This should be OPWDD's highest priority.

Q45

3. Is there data that would be helpful for OPWDD to provide to better information the local planning process? Please list by order of priority/importance.

No

Page 5

Q46

Please use the optional space below to describe anything else related to the effects of COVID-19 on Mental Hygiene service delivery that you were not able to address in the previous questions:

The impact of Covid-19 on the finances of the Mental Hygiene Services Delivery System are impossible to exaggerate. There has to be a way to address the disparity between financial support for State operated services and those operated by Counties or Private Agencies. The State is able to set rates in such a way that private providers are unable to bill for all services rendered. “Savings” are then available to the State.

At one time, it was argued that the more difficult clients were referred to State programs. That is no longer the case. State programs frequently refuse referrals and local agencies continue to provide treatment. Perhaps it is time to discontinue the three tiered service delivery system, which allows agencies to bill based more on costs than effectiveness of treatment.