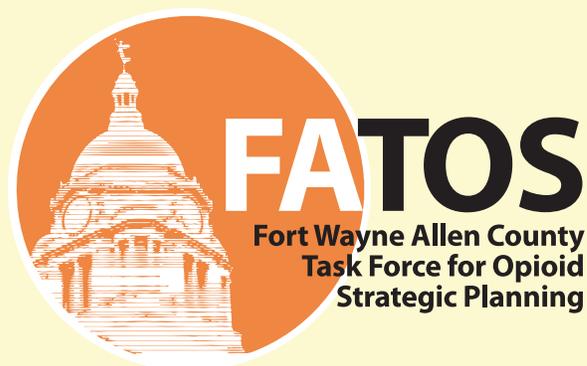


Prepared for the Fort Wayne Allen County Task Force  
for Opioid Strategic Planning (FATOS) and The Lutheran  
Foundation by the Purdue Fort Wayne Community  
Research Institute

# TURNING HOPE INTO ACTION:

## Evaluating the Opioid Crisis in Fort Wayne and Allen County

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May 23, 2018





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## EXECUTIVE SUMMARY

If you or a family member experienced opioid use disorder or opioid dependence, you don't need this report to tell you there's a problem here in Fort Wayne and Allen County. If your only knowledge comes from news reports, you may not know the scale of the problem so this document may be eye-opening. Either way, leaders in Fort Wayne and Allen County are working to limit improper use of opioids. There is reason for hope.

This report is a result of stakeholders convened by The Lutheran Foundation from December 2017 through March 2018 who are working to address the disease of opioid use disorder, specifically, and substance use disorder generally. It lists the good work now being done and the areas that need to be addressed as resources of time, talent and treasure become available. The IPFW Community Research Institute conducted interviews and reviewed outside sources to supplement the information gathered during the subcommittee process.

First and foremost, people in Fort Wayne and Allen County are interested in working together, across occupations and industries. Collaboration is already happening. Plus some of the solutions listed in this report could be implemented with existing staff and not many dollars. Others will require more people, money and time.

Although this effort had opioids as the central focus, many of the needed tools apply to substance use disorder. This work cannot be confined to people with opioid use disorder.

Using the state of Indiana's strategic plan on substance abuse as a guide, this report looks at the opioid crisis in four primary areas with the greatest need for each segment listed:

- 1. Prevention:** Education about opioids and developing resiliency skills with an emphasis on the school-age population and their parents.
- 2. Intervention:** Ability to seamlessly go from identifying misuse to entering treatment and recovery.
- 3. Treatment/Recovery:** Resources to expand services, especially for more mental health professionals.
- 4. Enforcement:** Expansion of existing treatment and recovery services for people in the criminal justice system.

Interestingly, the distinctions among the subcommittees started to collapse as they worked through this process. For example, a drug possession arrest could serve an intervention function to cause the offender to enter a treatment and recovery program.

One of the challenges of this project was merely staying on top of the news relating to opioids. It came fast and furious, from national media sources to the Indiana General Assembly. Legislative updates from this year's session are in this report.

While many reports get quickly shelved upon their completion, this work is just beginning. Although some measures of the opioid crisis are improving, like a reduction in the number of opioid prescriptions, others are worsening, such as the number of people dying from accidental opioid poisonings. Fort Wayne and Allen County is ready to turn hope into action when it comes to the opioid crisis.

# 1 INTRODUCTION AND BACKGROUND

In late 2017, The Lutheran Foundation engaged the Purdue University Fort Wayne Community Research Institute (CRI) to evaluate what is happening around the use and misuse of opioids in Allen County.

The Lutheran Foundation assembled a team of leaders with professional and personal experience to serve on the Fort Wayne Allen County Task Force for Opioid Strategic Planning (FATOS) and the respective subcommittees. Participants include representatives from mental health providers and both health systems, law enforcement, social service and non-profit agencies, the prosecutor's office, judiciary, public health, as well as community advocates with lived experience. A full list of participants is located in the appendix.

## 1.1 ORGANIZATION

Using "A Strategic Approach to Addressing Substance Abuse in Indiana" from Gov. Eric Holcomb's office as a guide,<sup>1</sup> FATOS organized four subcommittees:

1. Prevention,
2. Intervention,
3. Treatment and Recovery, and
4. Enforcement.

Subcommittee members were either existing FATOS members or served at the request of The Lutheran Foundation or CRI based on their professional or personal experience. CRI also conducted interviews with professionals on specific topics of interest to FATOS to ensure a broader assessment of the opioid crisis.

The subcommittees look like separate service areas on the surface. However, when the subcommittees convened in February and March, the distinctions quickly collapsed and started to overlap. For example, an arrest by the police department, which is an enforcement function, can be an intervention that gets someone misusing opioids into a treatment program through one of Allen County's problem-solving courts.

An effort separate from FATOS, led by Allen County Health Commissioner Dr. Deborah McMahan, is evaluating data collection around opioid and substance use, poisonings and deaths.

## 1.2 LANGUAGE IS IMPORTANT

Abuse. Addiction. Overdose. Junkie. Clean. Dirty. Habit. These have all been terms used to refer to people using and misusing substances in the past 50 years. However, medical and mental health professionals are moving away from these words and reclassifying how we talk about drug use to reduce stigma and make it person-first. Many mental health professionals now use "person with an opioid use disorder or substance use disorder" instead of user or addict.

The Office of National Drug Control Policy recommends these adjustments.<sup>2</sup>

<b>Words to avoid</b>	<b>Words to use</b>
Addict	Person with substance use disorder
Drug abuser	Person with substance use disorder
Drug problem, drug habit	Substance use disorder
Clean	Abstinent, not actively using
Dirty	Actively using
A clean drug screen	Testing negative for substance use

<sup>1</sup>This report is included in the Appendix.

<sup>2</sup>See "Changing the Language of Addiction" memorandum, Office of National Drug Control Policy. January 9, 2017.

A dirty drug screen	Testing positive for substance use
Former/reformed addict/alcoholic	Person in recovery, person in long-term recovery
Opioid replacement, methadone maintenance	Medication assisted treatment

This report, unless otherwise needed for context or by source material, uses person-first, stigma-reducing language.

### 1.3 SUBSTANCE USE DISORDER, OPIOID USE DISORDER DEFINITION

Substance use disorder (SUD) and opioid use disorder (OUD) are diseases of the brain and body. The fifth edition of the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM-5) reclassified the addiction to and dependence on substances, moving away from abuse and dependence and placing them into a single disorder in 2013.<sup>3</sup>

SUD is defined as having at least two symptoms from a list of 11 diagnostic criteria, creating a mild-to-severe continuum of the disorder. The criteria evaluate four areas: 1) impaired control such as using more of the substance than intended or spending significant time obtaining the substance, 2) social impairment including failure to fulfill obligations at work or at home or giving up social activities because of substance use, 3) risky use that creates immediate danger or worsening physical or psychological health and 4) pharmacological indicators of tolerance and withdrawal. The fourth area is not considered when patients are using opioids solely under appropriate medical supervision.

DSM-5 lists eight substances for SUD: alcohol, cannabis, hallucinogens, inhalants, opioids, sedatives/hypnotics/ anxiolytics, stimulants and tobacco. Caffeine, although having stimulating effects, is also listed as a substance that can cause withdrawal symptoms but does not qualify for SUD at this time.

Although dependence can be a symptom of SUD, physical dependence is distinct from the disorder. Dependence is characterized by the physical symptoms of withdrawal after repeated exposure to the substance. Physical dependence alone is not accompanied by SUD’s behavioral aspects like impaired control and social impairment.

### 1.4 WHY FOCUS ON OPIOID USE?

Opioids are not the top substance misused by the general public – that spot goes to alcohol.<sup>4</sup> Then why did The Lutheran Foundation and FATOS focus on opioids? It is because of the immediate risk of death posed by their use, whether they be prescription or illicit substances, and the public’s attention on this issue and the expectation that something needs to be done.

Many people with active OUD do not have the luxury of time because of a deadly drug supply, so they need systems and services ready to help them today. Based on anecdotal evidence from subcommittee members, people with OUD will use non-opioid drugs like synthetic marijuana if opioids are not readily available.

Additionally, the work to strengthen the systems to prevent, intervene and treat OUD specifically also apply to SUDs generally. Therefore this work will serve the larger SUD population. This report regularly references both OUD and SUD when appropriate and relevant.

### 1.5 OPIOIDS HAVE AN APPROPRIATE PLACE

It is not the position of FATOS or any of the subcommittees that prescription opioids should be removed from the market. Instead, they serve a very specific clinical need for select populations, including those with acute pain from surgery or severe injury and pain management for cancer and at the end of life. The key is for opioids to be prescribed and used appropriately.

<sup>3</sup>Diagnostic And Statistical Manual of Mental Disorders: DSM-5. Arlington, VA: American Psychiatric Publishing, 2013.

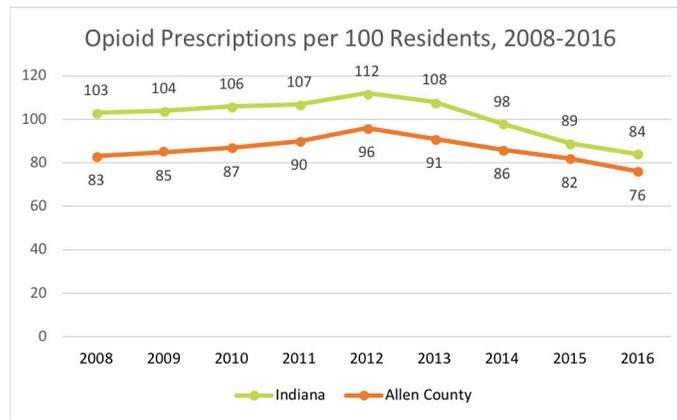
<sup>4</sup>Of the 21.5 million people with SUD in 2014, 17 million had alcohol use disorder. See Center for Behavioral Health Statistics and Quality. (2015). Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from <http://www.samhsa.gov/data/> on March 15, 2018.

## 1.6 DATA

The numbers help tell the story of the opioid crisis, but each number also reflects a person and a family affected by opioids.

Some good news is the opioid prescription rate is falling in both Allen County and Indiana, when looking at data from 2008 to 2016.<sup>5</sup> It peaked in 2012. Although Allen County is lower than the state's rate throughout, it is still above the 2016 national rate of 66.5 per 100 residents.<sup>6</sup> Furthermore, Indiana counties with larger populations including Marion, Lake and St. Joseph, usually had prescription rates lower than the state's so Allen is consistent with this pattern. One exception is Vanderburgh County, where Evansville is located, which was above the state rate during this eight-year period. The counties with the rates above the state average tended to be less populated such as Knox, Grant and Howard counties.

Table 1 Opioid Prescriptions per 100 Residents, 2008-2016



Source: Centers for Disease Control and Prevention, as calculated by Indiana Management Performance Hub

Looking at more recent Allen County data, physicians are improving their prescribing habits to reduce the amount opioids and other controlled substances being used in outpatient clinical practice.<sup>7</sup> From 2013 to 2017 there has been a two-thirds drop in the number of controlled-substances prescriptions. After converting the various opioids to morphine equivalents, which is a common reference measure, there has been a more than 40-milligram drop in the daily morphine equivalents prescribed to patients when comparing 2014 to 2017.

Bad news? The number of poisonings, fatal or not, is going up. Allen County had 74 fatal drug poisonings, regardless of substance, in 2016, creating a fatality rate of 19.98 per 100,000, according to Indiana State Department of Health statistics. This lower than the state's rate of 22.88 per 100,000. Males made up the majority of deaths at 62%, which is about the same as the state, and most are employed at the time of death, according to the Fort Wayne-Allen County Department of Health (Health Department).

Of those 74 fatalities, 53 involved an unidentified substance and 17 involved opioids. Heroin was not the cause of death for those. The large majority with an unspecified substance illustrate the need for better data collection and reporting because current practices may not be gathering complete information.

Because Allen County had fewer than 20 deaths from opioids annually from 2008 to 2016, statewide data provides a more statistically accurate trendline.<sup>8</sup> Just as prescriptions were going down, the number of deaths increased.

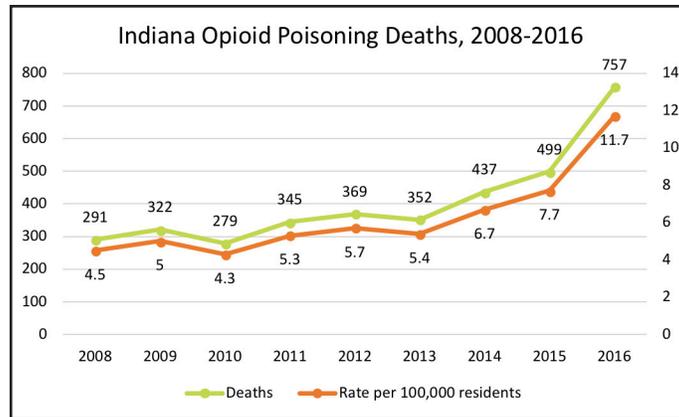
<sup>5</sup>Know the O Facts data as calculated using Centers for Disease Control and Prevention U.S. Prescribing Maps using retail pharmacy sample data. See <http://in.gov/recovery/1054.htm>.

<sup>6</sup>See Annual Surveillance Report of Drug-Related Risks and Outcomes. CDC National Center for Injury Prevention and Control (2018). Available at <https://www.cdc.gov/drugoverdose/pdf/pubs/2017-cdc-drug-surveillance-report.pdf>

<sup>7</sup>Information from an e-mail from Brian Henriksen, Ph.D., Fort Wayne Medical Education Program. March 20, 2018.

<sup>8</sup>Death rates of fewer than 20 people annually are considered unstable and unreliable and should be interpreted with caution, according to the map listed at <http://in.gov/recovery/1054.htm>. Accessed March 20, 2018.

Table 2 Indiana Opioid Poisoning Deaths, 2008-2016



Source: Centers for Disease Control and Prevention, as calculated by Indiana Management Performance Hub

The Health Department identified 126 fatal drug poisonings in 2017.<sup>9</sup> This makes for a more than 70% fatality increase between 2016 and 2017.

Looking at the demographics of those who died, the Health Department and the Fort Wayne Medical Education Program evaluated opioid fatalities from 2013 to 2017 using data from the Allen County Coroner's Office.<sup>10</sup> The majority of the deaths were middle-aged employed white males who died in a residence. More than 80% tested positive for controlled substances without a prescription and almost three quarters tested for opioids without a prescription when compared to prescription tracking data for the year before death from Indiana's prescription drug monitoring program.

On the enforcement front, the Fort Wayne Police Department (FWPD) seized more than 1,500 grams of fentanyl in 2017, compared to just 10.3 grams in 2016, creating an increase of more than 14,500%. The vice and narcotics unit seized more than 700 grams of heroin last year, an increase of more than 187% from 2016. Non-fatal drug poisoning cases investigated by FWPD increased by 49% from 2016 to 2017, going from just over 800 to 1,200.

Additional county-level data for all Indiana counties is available from the Indiana State Department of Health's County Profiles of Opioid Use and Related Outcomes report (2017).<sup>11</sup>

Since the prevention subcommittee identified the need to educate adolescents as a key strategy, it is worth evaluating local data on students' use of and perceptions on prescription drugs.

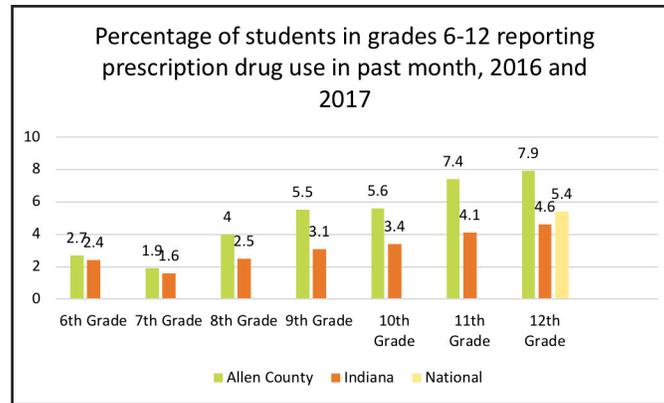
The Drug and Alcohol Consortium of Allen County released Indiana Prevention Resource Center (IPRC) statistics collected in 2017 from 6<sup>th</sup> through 12<sup>th</sup> graders in this county. About 5% of this population illegally used prescription medications in the past 30 days, which has shown an increase over 2015 and 2013 rates. Furthermore 22.6% perceived a slight or no risk to misusing prescription drugs, which as a 30% increase from the 2015 measurement. So as the numbers of deaths tied to opioids are going up, students' misuse of prescriptions is going up while the perceived risk is going down. Notably, Allen County's percentage exceeds the state at every grade level.

<sup>9</sup>Presentation by Allen County Health Commissioner Dr. Deborah McMahan at Drug and Alcohol Consortium of Allen County. March 9, 2018.

<sup>10</sup>Henriksen e-mail.

<sup>11</sup> A link to the report is located in Informational Resources.

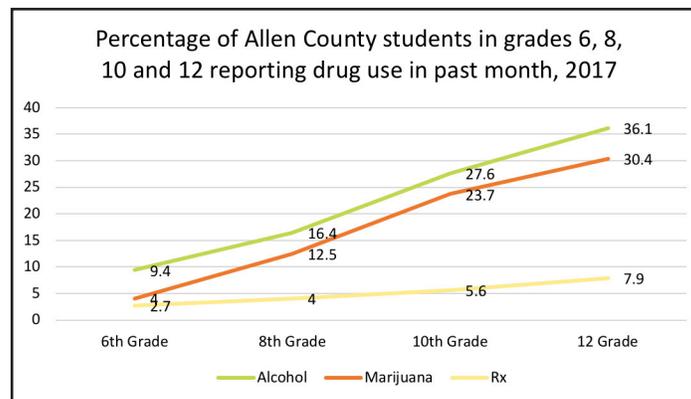
Table 3 Percentage of students in grades 6-12 reporting prescription drug use in past month, 2016 and 2017



Source: 2017 Indiana Prevention Resource Center Alcohol, Tobacco and Other Drug Use by Indiana Children and Adolescents Survey and 2016 Monitoring the Future Survey, courtesy of Allen County Drug & Alcohol Consortium

The rate of Allen County students using alcohol and marijuana far exceeds prescription drug misuse, according to 2017 data from IPRC. More than a third of 12<sup>th</sup> graders used alcohol and about 30% used marijuana in the past month. For 8<sup>th</sup> graders, more than 15% had used alcohol and more than 10% used marijuana. This is important because early adolescent substance use dramatically increases the lifelong risk of SUD.<sup>12</sup>

Table 4 Percentage of Allen County students reporting drug use in past month, 2017



Source: 2017 Indiana Prevention Resource Center Alcohol, Tobacco and Other Drug Use by Indiana Children and Adolescents Survey, courtesy of Allen County Drug & Alcohol Consortium

### 1.6.1 Need for more, better data

If what gets measured gets done, the opioid crisis needs more measurement.

A consistent theme in this process was the need for a more complete picture of the situation involving opioids. While many sources and agencies are tracking and reporting their work, there is a need for a more comprehensive compilation and evaluation of local data. Dr. Deborah McMahan, Allen County Health Commissioner, is convening a group separate from FATOS to look at this. Furthermore the new requirements for investigations of drug poisonings<sup>13</sup> will create a more standardized data set for one component of the situation.

The Lutheran Foundation is working with the Indiana Family and Social Services Administration's Division of Mental Health and Addiction (DMHA) to gather data from northeast Indiana on substance use. This data will play a role in determining DMHA Substance Use Prevention's use of block grant money.

<sup>12</sup>C. Jordan, S. Anderson. "Sensitive periods of substance abuse: Early risk for the transition to dependence," *Developmental Cognitive Neuroscience*, Vol. 25, pp. 29-44. June 2017.

<sup>13</sup>See 2018 Legislation section for Senate Enrolled Act 139.

## 1.7 STIGMA AND PUBLIC ATTITUDE

Another recurring theme was the stigma, shame or judgment associated with OUD and SUD. It shrouds the problem and affects both the person with OUD and SUD and their families and loved ones. It was acknowledged as a barrier to seeking treatment and recovery and isolates people from family, friends, neighbors and the larger community when they may need those the most.

The New England Journal of Medicine evaluated national public opinion polls taken in the past two years about opioids<sup>14</sup> that has value in understanding public perceptions.

Relevant findings to be applied for local efforts include:

- **Almost half knew someone** who had been **addicted to prescription pain medications**.
- **81 percent thought the problem of addiction** to prescription pain medication **was either a national emergency or a major problem** but falling short of national emergency. **Only 5 percent saw it as not a problem at all**.
- **63 percent thought the problem** of addiction to prescription drugs **had gotten worse from 2016 to 2017**.
- The **federal government bears more responsibility than state or local government in fighting the problem** of prescription drug misuse: 36 percent, 28 percent and 21 percent respectively; **and paying for programs** to address improper opioid use: 41 percent, 33 percent and 20 percent respectively.
- **Almost half believe the medical and mental health community have the most responsibility in fighting prescription drug abuse** with another 29 percent giving responsibility to the pharmaceutical company. **Only 12 percent thought it was law enforcement's**.
- **Doctors who inappropriately prescribe pain medications are mainly responsible** for prescription drug abuse **according to about a third of respondents**. **Second place goes to people who sell prescription pain medications illegally** at 28 percent. Only 10 percent identified people who take prescription pain medications as mainly responsible.
- **Respondents favored increasing pain management training for medical students and doctors** with 87 percent identifying it as either very or somewhat effective as well as 82 percent who thought monitoring prescribing habits would be very or somewhat effective.
- **More than a third thought reducing social stigma about drug addiction would be not too or not at all effective**.
- **Half thought** putting **warning labels** about OUD on prescription bottles **would be not too or not at all effective**.
- **Only 49 percent thought there was treatment** for prescription painkiller addiction **that was effective for a year or more**, leaving 34 percent not believing such and another 17 percent not sure.
- It was essentially **an even split between those who favored and opposed requiring insurers providing more extensive coverage for SUD**.
- **A solid majority**, specifically almost two thirds, **preferred those illegally possessing prescription pain medications to receive a treatment program without jail time**. Just over a quarter thought they should be incarcerated.

<sup>14</sup>RJ Blendon, JM Benson. Public Attitudes about Opioid-Abuse Epidemic. N Engl J Med 2018; 378:407-411.

These help FATOS understand where the efforts to date align with national priorities, such as engaging medical and mental health providers for treatment and recovery, and where they may need to do some additional work, like further reducing stigma.

## 2 NEEDED ACTION

Although more thoroughly discussed in each subcommittee section, here is a summary of the community's needs identified in this process.

### 2.1.1 Prevention

The prevention subcommittee recognized that much work needs to be done to educate the public about OUD and SUD in general and prevention tactics specifically.

Action items include:

- Education strategies directed at adolescents and their parents, guardians and other caring adults about the risks of opioids
  - Best-practice curricula for coping strategies and resiliency starting in pre-school or elementary school and continuing through the end of formal education
- Education strategies directed at people who have a history of drug misuse – including alcohol, opioids, and other drugs – especially if they started using at a younger age
- Community awareness of the risks of adverse childhood events (ACEs) and the associated increased risk of OUD and SUD
- Outreach to higher education institutions
- Education about the proper use, storage and disposal of opioid prescriptions
  - Increased awareness of drug takeback locations
  - Restricting access to legally prescribed opioids, especially for teens
- Decreased cost and increased distribution of naloxone (Narcan) for high-risk populations to prevent accidental opioid poisonings

### 2.1.2 Intervention

This subcommittee evaluated intervention at the systems and interpersonal levels as part of a system of care for people experiencing OUD or SUD and their families and loved ones.

Needs include:

- Ability to immediately connect someone with treatment and recovery services at the time of intervention
  - Walk-in touchpoints following an intervention to engage with treatment and recovery, perhaps with the ability to hold patients overnight until they can be seen by a doctor or therapist
- Education about the signs of OUD and SUD
- Strategies available online on how to conduct an intervention
- Intervention specialists trained on helping families AND loved ones intervene with someone experiencing OUD or SUD with funding to reimburse these services outside of an emergency department setting. Called by first responders or the emergency department at the time of care, these specialists could be part of a team that responds or follows up with a person or his or her family after an accidental poisoning to connect them with treatment and recovery services

- A medical-legal partnership with Indiana Legal Services to serve low-income people with OUD or SUD who experience civil legal problems like Medicaid denial, unsafe housing or the need for specialized driving privileges
- Addressing employee assistance programs and human resources “zero tolerance” policies when an employee independently requests assistance for SUD
- Engaging faith leaders to support intervention, treatment and recovery

### 2.1.3 Treatment and Recovery

As the population center for northeast Indiana, Fort Wayne and Allen County has many treatment and recovery options, but it can be difficult for patients to pay for the needed services plus the need outstrips the availability. Additionally there are many underserved populations for treatment and recovery services.

Needs include:

- More money to pay for OUD and SUD services, whether it be from private insurers or public programs
- More mental health professionals
- Better support for the families and loved ones of a person going through treatment and recovery
- More access to and payment for medication-assisted treatment
- More sober living facilities and other treatment and recovery options

### 2.1.4 Enforcement

The enforcement subcommittee, representing criminal justice and beyond, saw enforcement as a critical function to engage people with treatment and recovery while also serving a public safety role.

Needs include:

- More treatment and recovery services for people in the criminal justice system, especially for people at the Allen County jail
  - Expanding jurisdiction of problem-solving courts to surrounding counties
- A comprehensive plan for first responders treating people with OUD or SUD that isn’t the jail or emergency department, such as a mobile intervention team or options for people to voluntarily surrender at the police station without criminal penalty to be connected with treatment and recovery services
- Better enforcement against improper prescribers

## 3 SUBCOMMITTEES

The subcommittees met in February and March, each for a total of four hours. Treatment and recovery had a single meeting. The others met for two two-hour meetings. The first meeting involved a series of written questions and answers and group discussions specific to the content area. The second meeting, using what had been discussed at the first, looked forward to solutions with little to no cost and what could be done with additional funding.

## 4 PREVENTION SUBCOMMITTEE FINDINGS

Prevention goes beyond simply the prevention of OUD. It also includes minimizing unnecessary opioid use, preventing deaths from opioids and education to various audiences with specialized messages.

The Prevention Subcommittee identified that people often do not know the following:

- How OUD and SUD are diseases
- How OUD and SUD affects the brain
- How hard it is to stop using opioids
- How widespread OUD and SUD is
- Risks of misuse for prescription pain medication, especially with teenagers and young adults
- Signs of misuse
- How OUD and SUD affects people regardless of age, race, gender and income
- Available resources

Prevention messaging needs to be targeted to the following audiences:

- Parents
- Youth
- Patients
- Prescribers
- Dispensers
- Nurses and other non-prescribing health professionals
- Employers
- Schools, educators
- Clergy, religious leaders
- Legislators
- Media

While there is value in the general public knowing about prevention, the subcommittee listed the following populations as needing additional outreach (presented in no particular order):

- Youth
  - Especially those in conflict with their parents or those in families with limited English proficiencies
- People who have used opioids before
- People with a history of trauma and abuse
- People who started using substances at younger ages
- People who are not aware of the risks of OUD or SUD
- People with limited English proficiency
- People with chronic pain or chronic illness
- Seniors and the elderly
- Veterans

Because of the breadth of audiences and their specialized needs, there are many messages that need to be communicated. One key point needs to be raising awareness of opioids and their risks. While media reports on opioid use have increased in the past few years, people may not recognize their own need to understand the risks or spot signs of misuse in a child, spouse or other loved one.

Prevention messaging should consider two situations: 1) legally prescribed opioids and 2) opioids used recreationally but before the user experiences OUD.

For legally prescribed opioids, information needs to be conveyed about:

- SUD risks associated with opioids
- Safe use, storage and disposal by patients
- Prescribing habits, including fewer pills being distributed and starting with non-narcotic pain medications
- Managing pain without medication by recognizing not all pain can and should be avoided
- Using OUD, SUD screening tools before prescribing an opioid

For recreational opioid use, there needs to be:

- General education campaign about the risks, especially for teens and young adults
- Enforcement against dealers
- Securing legally prescribed medications
- Using proper medication disposal methods

Part of prevention comes from removing the supply of unused opioids. Allen County has six ongoing takeback locations as of March 2018. They are:

- Fort Wayne Police Department at the Rousseau Centre (downtown)
- Hometown Town Hall (northwest)
- New Haven Police Department (east)
- Indiana State Police Post (southwest)
- Walgreens, 6202 W. Jefferson<sup>15</sup>
- Walgreens, 6201 Stellhorn

Additionally, Walgreens in cooperation with TRIAD, Allen County, and Fort Wayne City Utilities hosts two drug takeback days each year at locations throughout Allen County.

Walmart announced in January it was going to distribute Dispose Rx with Class II opioid prescriptions,<sup>16</sup> yet it is not clear if that is being distributed presently in Fort Wayne and Allen County.

However the subcommittee saw the need for more visible and accessible takeback locations as well as disposal information provided at the time of pick-up, more education about medication disposal in general and working to reduce the number of pills prescribed as necessary to reduce the opioid supply coming from prescriptions.

The subcommittee looked at four groups and the roles they play in prevention:

1. Parents, families and caring adults
2. Prescribers and providers

<sup>15</sup>The W. Jefferson and Stellhorn locations were not listed on the Walgreens website as of March 8, 2018, but a phone call to the Jefferson location confirmed their presence.

<sup>16</sup>Dispose Rx is a powder that when mixed with water and medications turns the medication into an inert and biodegradable gel. See <https://news.walmart.com/2018/01/17/walmart-launches-groundbreaking-disposal-solution-to-aid-in-fight-against-opioid-abuse-and-misuse>

3. Schools and educators
4. Employers

A need for education across all groups, including education to and education from, was identified. Unique aspects to these groups are as follows.

#### **4.1.1.1 Parents, families and caring adults:**

This group provides support but needs awareness because many adults don't know what to look for such as addictive tendencies for or how to help. Additionally some parents and family members may be misusing opioids themselves, making them part of the problem.

Parents and guardians are in the unique position of being able to decline pain medications for their children, either from the prescriber or deciding not to fill a prescription until it is needed.

Adults also have an obligation to control access to opioids already in the home, specifically locking up pain medication that is used by another family member, or disposing it when no longer needed.

This subcommittee also found that there are unique dynamics of multicultural families that should be considered when crafting prevention strategies.

#### **4.1.1.2 Prescribers and providers:**

Prescribers are physicians, nurse practitioners, dentists or others healthcare providers with authority to write prescriptions for controlled substances. Providers in this context are pharmacists.

The subcommittee sought accountability from this group, including avoiding overprescribing and having consequences for those who do; patient education about use including managing access to prescriptions, storage and disposal; use of addiction screening tools; and knowing and using pain treatment alternatives to opioids.

Last year, the Indiana legislature limited first-time opioid prescriptions to a seven-day supply for adults in most circumstances.<sup>17</sup> Additionally, the Indiana Medical Licensing Board has protocols for prescribing controlled substances for chronic pain.<sup>18</sup>

In March, the American Dental Association (ADA) announced a new policy supporting opioid prescribing limits and continuing education.<sup>19</sup> Specifically it states the ADA supports 1) mandatory continuing education in prescribing controlled substances, 2) statutory limits of a seven-day supply of opioids for acute pain, and 3) dentists' use of prescription drug monitoring programs to deter misuse.

#### **4.1.1.3 Schools and educators:**

The subcommittee looked at this for both K-12 and higher education. Much like parents, families and caring adults, members noted the need for support and awareness. Additionally staff and faculty, with the right training, can help students develop skills like resiliency, coping and hazard avoidance. These skills need to be developed starting in elementary school and continued through the end of formal schooling, whether that be high school or higher education. SAMHSA has information about evidence-based behavioral health programs and practices available at <https://www.samhsa.gov/capt/tools-learning-resources/finding-evidence-based-programs>.

<sup>17</sup>Indiana Code § 25-1-9.7.

<sup>18</sup>See 844 IAC 5-6-1 through 5-6-10.

<sup>19</sup>See <https://www.ada.org/en/press-room/news-releases/2018-archives/march/american-dental-association-announces-new-policy-to-combat-opioid-epidemic>. Accessed April 2, 2018.

One existing local effort is through Fort Wayne-based McMillen Health. It has developed some substance- and opioid-related materials to educate both students and parents. “Pharm Crisis” is a one-session program for middle and high school students that was presented to more than 3,100 students in northeast Indiana in 2017, who showed a significant increase in knowledge after the class. Additionally McMillen Health developed a one-page handout to educate parents and guardians about the dangers of prescription and illicit opioids as well as a video<sup>20</sup> to educate parents.

McMillen Health CEO Holli Seabury notes that SAMHSA’s evidence-based curriculum often requires eight to 14 sessions yet most health teachers only get one semester to cover the full health-class curriculum and its many academic standards.<sup>21</sup> Therefore education efforts will need to be strategic in how to reach students and their parents.

Additionally the Drug and Alcohol Consortium of Allen County may be helpful in identifying evidence-based prevention and education programs and curricula to use in local classrooms, based on Allen County risk and protective factors.

Other possible tools for reaching student populations include:

- Expanding health-class curriculum using evidence-based models to engage community leaders, much like Junior Achievement
- Using behavioral screening tools designed for adolescents, namely CRAFFT or SBIRT
- Using random drug testing as a deterrent or intervention tool
- Engaging with existing communication channels that reach student audiences like Remedy Live

#### **4.1.1.4 Employers:**

Employers have the opportunity to exercise compassion for their employees, especially if they identify employees who may be moving toward OUD. One tool for employers is employee assistance programs (EAPs). Yet there is an inherent conflict between an employer’s desire to support and its duty to protect worker safety, especially if employees are driving, using equipment or put other employees or the public at risk.

One workplace option is the evidence-based Team Awareness training. It is a customizable worksite prevention training program that addresses behavioral risks arising from substance use disorder among employees and families.<sup>22</sup> Team Awareness has six components: 1) importance of prevention; 2) team ownership of policy as a useful tool to enhance safety and well-being for the workgroup; 3) stress and coping skills; 4) tolerance and how it can become a risk factor; 5) importance of appropriate help-seeking and help-giving behavior; and 6) access to resources for preventive counseling or treatment like EAP and 12-step programs.

Furthermore House Enrolled Act 1007-2018 creates best-practices guidelines for dealing with employees who test positive for substances and enter treatment as a result. See Section 8.3 for more information.

#### **4.1.2 Prevention Messaging Tools**

The channels to communicate prevention messages are broad. Some efforts are already underway. The Lutheran Foundation’s LookUp Indiana website at [lookupindiana.org](http://lookupindiana.org) includes information about opioid dependence as well as other mental health information and resources.

For prevention messaging to reach the desired audiences with the needed information, it would be best to be part of a coordinated, strategic campaign, whether this be on the local, regional, state or national level. Scattershot approaches, while able to be deployed quickly, often do not have the reach and duration to create

<sup>20</sup>See <https://vimeo.com/238611518>.

<sup>21</sup>E-mail from Holli Seabury. April 6, 2018.

<sup>22</sup>See <https://nrepp.samhsa.gov/Legacy/ViewIntervention.aspx?id=69>. Access April 11, 2018.

sufficient awareness and sustain changed behavior. Some of the campaign's tools could be social media efforts, public service announcements, online toolkits, newsletters and blogs, billboards, developing role models and peer influencers, and using rallies and other events to draw awareness.

As recommended by one subcommittee member, the Influencer Change Framework from the book "Influencer: The New Science of Leading Change" by Joseph Grenny et al is worth considering when developing the messaging and strategies. This model looks at the motivation and ability on the personal, social and structural levels and from there finding vital behaviors to create measurable results.

#### **4.1.2.1 Know the O Facts campaign**

Led by the Indiana Family and Social Service Agency (FSSA), the Know the O Facts website went live in January and presents information for Hoosiers to better understand opioid use disorder, learn key messages and to take the pledge to help reduce stigma. Although not designed to be a prevention strategy, it does provide a significant education function that meets many objectives from the prevention subcommittee.

The campaign focuses on communities where there are new opioid treatment programs being established, which includes Fort Wayne. It provides training and works with community-based partners and organizations, and engages them in outreach to their local communities. The federal 21<sup>st</sup> Century Cures Act is paying the \$500,000 cost for the first year.<sup>23</sup> Future efforts depend on funding.

The campaign's goals include: raising awareness of OUD and treatment, changing the way Hoosiers think, promoting effectiveness of medication assisted treatment and recovery, and knowing the physical signs of OUD. Three key messages are:

1. OUD is a disease.
2. There is treatment for a person with OUD.
3. Recovery is possible.

Addressing the opioid epidemic is not only a top priority for public health, it will also help build stronger communities and allow those with substance use disorders to lead healthier, more productive lives. FSSA will accomplish these goals through education, awareness and grass roots outreach. As each community understands more, FSSA hopes to decrease the stigma associated with OUD.

The intent is to disseminate key messages to communities statewide through local channels. By collaborating with local leaders including employers, each community will begin to understand and increase the use of stigma-reducing language.

#### **4.1.3 Funding**

Some of these efforts will require organization but little to no cost. Others will require a source of funding. There may be grant opportunities from government or private sources, which is why coordinated efforts on prevention are needed.

#### **4.1.4 Naloxone (Narcan)**

Indiana is one of 41 states where the opioid overdose antidote naloxone (brand name Narcan) is available without a prescription at local pharmacies, but cost may be a deterrent for people obtaining the medication, especially as the cost has increased over time. Since prevention goes beyond communication, working to reduce the expense of over-the-counter naloxone through grants or other funding is a strategy worth considering.

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<sup>23</sup>E-mails from Rebecca Buhner, FSSA. March 21-22, 2018.

On April 5, U.S. Surgeon General Jerome Adams issued an advisory on naloxone, encouraging those at risk of opioid poisoning or those who work with people taking high doses of opioids to know how to use the antidote and keep it within reach.<sup>24</sup> The advisory noted that the following people are at an elevated risk for opioid poisoning:

- *Misusing prescription opioids (like oxycodone) or using heroin or illicit synthetic opioids (like fentanyl or carfentanil).*
- *Having an opioid use disorder, especially those completing opioid detoxification or being discharged from treatment that does not include ongoing use of methadone, buprenorphine, or naltrexone.*
- *Being recently discharged from emergency medical care following an opioid overdose.*
- *Being recently released from incarceration with a history of opioid misuse or opioid use disorder.*

*It should be noted that, in addition to the above patient populations, patients taking opioids as prescribed for long-term management of chronic pain, especially those with higher doses of prescription opioids or those taking prescription opioids along with alcohol or other sedating medications, such as benzodiazepines (anxiety or insomnia medications), are also at elevated risk for an overdose.*

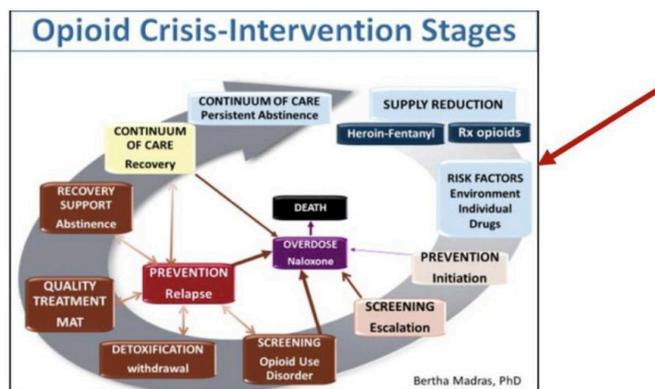
Adams, Indiana health commissioner prior to becoming surgeon general, recommends the public learn the signs of opioid poisoning, get trained to administer naloxone and talk to a physician or pharmacist about obtaining the medication.

## 5 INTERVENTION SUBCOMMITTEE FINDINGS

Intervention is the recognition of a problem and the change agent who can work to start the solution, as defined by the intervention subcommittee. It works on two levels: interpersonal and systematic, which can operate in tandem to create the change. In the context of the opioid crisis, intervention is a recognition of a problem and desire to enter into treatment and recovery. But it can be difficult to move from the desire to change to receiving services in Fort Wayne and Allen County.

It is helpful to look at intervention, treatment and recovery as a system of care with transition points between the elements.

Figure 1: Opioid Crisis-Intervention Stages from President’s Commission on Combating Drug Addiction and Opioid Crisis Final Report



Source: The President’s Commission on Combating Drug Addiction and the Opioid Crisis Final Report

<sup>24</sup> Surgeon General’s Advisory on Naloxone and Opioid Overdose. Issued April 5, 2018. See <https://www.surgeongeneral.gov/priorities/opioid-overdose-prevention/naloxone-advisory.html>. Accessed April 17, 2018.

Although treatment and recovery are evaluated in its respective section, brief explanations here are helpful. While the treatment and recovery subcommittee did not agree on a single definition of each, there was some consistency in seeing treatment as being the entry point while receiving professional care and having immediate needs met. Recovery may follow or happen concurrently with treatment and focuses on the long-term horizon, often using less structured systems like peer support.

The subcommittee identified problems with these transition points: going from intervention to treatment and transitioning from treatment to recovery. The most significant being that there can be a lack of immediate access to treatment. If a person identifies the substance use problem on a Friday afternoon but does not need or insurance will not pay for inpatient treatment, he or she has to wait until at least Monday morning or perhaps later in the week before he or she can see a specialist, therapist or counselor. See Section 5.1.3 for information about referrals.

Furthermore, people seeking treatment and their loved ones may not be familiar on how to engage with treatment and recovery services. Some programs specialize in certain populations, or insurance coverage may dictate what they can access.

Other challenges with intervention include:

- **Not knowing what to look for:** Do family members even know there is a problem? Very possibly not until it has crossed into full OUD or SUD and making the use disorder harder to treat than if it had been recognized earlier.
- **Lack of script:** Family members, employers or friends may not know what to say or do when they recognize there is a problem.
- **Chemical changes in the brain:** OUD or SUD can change a person's brain so this son, daughter or spouse is no longer thinking like they did before they used these substances.
- **Non-linear process:** It may take more than one intervention before someone enters treatment and recovery. Although some wait until the person has elected to enter treatment and recovery, motivational interviewing and similar tactics can elicit a desire to change and create the needed catalyst. Identifying substance dependence earlier, reducing shame and stigma associated with OUD and SUD, and creating accountability for opioid suppliers were also mentioned as areas of need in intervention.

### 5.1.1. Intervention tools

As has been a theme of this report, the distinctions between the subcommittees start to collapse, and that applies to intervention because the tools of intervention include enforcement mechanisms. For example, an arrest or a Child Protective Services investigation may instigate a person with OUD or SUD to access treatment and recovery services.

In sum, the subcommittee noted that intervention tools take many forms so long as it disrupts the status quo. It could be as simple as a conversation with a family member when opioid use is clearly creating problems or using an employee assistance program that identifies OUD or SUD. Or it could be the use of naloxone to avert a fatal poisoning where the patient then enters treatment. Naloxone or a prescription drug monitoring program, however, only truly serve intervention functions when the patient enters treatment and recovery as a result.

### 5.1.2. Syringe Services Program

Allen County is the only county in northeast Indiana and just one of eight authorized centers in the state to offer a syringe services program (SSP), often better known as a confidential needle exchange.

Operated by the Health Department one day a week, SSP offers a needle exchange and other supplies, free confidential SUD counseling, free wound care, free HIV and hepatitis C testing, referrals to treatment and sign-ups for health insurance coverage. In 2017, Allen County's SSP served more than 300 people, according to the Indiana State Health Department reports.

While not universally supported in the community, SSP uses evidence-based harm reduction principles.<sup>25</sup> The program is designed to reduce the transmission of hepatitis C and HIV and reduce their associated expenses. The on-site wound care is a cost-saving measure too, reducing the need for more expensive treatment if the wounds are not properly treated when less severe. Anecdotally, some SSP clients have been arrested for drug paraphernalia possession after visiting the site, although there is no information to believe law enforcement is directly targeting SSP clients.

### 5.1.3. 211 and OpenBeds referrals

On March 15, 2018, FSSA announced a partnership with the software company OpenBeds.net and Indiana 211, the free and confidential social service referral hotline. This combines OpenBeds' technology and 211's database to provide callers with real-time access to treatment and recovery services in the local community.

211 will make direct referrals for open beds in in-patient and residential treatment facilities for people experiencing opioid misuse.<sup>26</sup> Referrals are only made for opioids at this time, and the person calling must be the person seeking services. A family member or loved one can get general information, but the referral can only be given to a potential patient.

There are 14 trained OpenBeds navigators statewide, include four at Fort Wayne's call center. The navigators use a question-based assessment tool to identify the level of care the person needs as well as evaluating insurance coverage. If the caller's assessment indicates the need for in-patient or residential treatment, the navigator will submit the information to the provider while continuing to work with the caller to ensure he or she is connected with the provider. Many providers help those without insurance apply for coverage as part of the intake process. If the misuse is less severe, the caller will be provided with contact information for pertinent providers.

Additionally, providers can refer patients back to 211 to be connected with other social services agency for wrap-around services like job training.

FSSA also has a website listing licensed SUD treatment providers.<sup>27</sup> While it doesn't provide current openings or much more than a basic search-engine listing, it does offer a geo-location tool to locate a list of local providers with the ability to filter for specific services and populations served.

### 5.1.4. Intervention audiences

Like much of the information for OUD and SUD, intervention information can apply to anyone because of the reach of the disease. As identified by the subcommittee, intervention audiences include:

- People with OUD and SUD
- Family members of those with OUD and SUD
- Teens and young adults
- Vulnerable populations
- Lawmakers
- Faith leaders
- Mental health providers, particularly employee assistance programs
- Healthcare providers
- Employers
- Law enforcement
- Courts
- Social service agencies

<sup>25</sup>The Harm Reduction Coalition defines harm reduction as "a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs."

<sup>26</sup>Interview with Jaimie Farren, United Way of Allen County 211 director, March 20, 2018.

<sup>27</sup>See <https://secure.in.gov/apps/fssa/providersearch/home/category/as>. Accessed March 20, 2018.

### 5.1.5 Making intervention more effective

There are three ways to make intervention more effective, according to the subcommittee: 1) tactics, 2) systems and 3) personal relationships.

Tactics include personal stories and professional counseling or therapy. Within systems, it requires immediate access to treatment, insurance coverage, removing punitive aspects of enforcement if engaged via an arrest or Department of Child Services investigation. The subcommittee also expressed interest in 24- or 72-hour holds, either voluntary or involuntary, to engage the person with treatment services.

Intervention via personal relationships may take multiple forms and may require many attempts with the same person because the person needs to be ready to change. The relationship needs to show support but also stop enabling if that has occurred.

Needed resources include a better awareness of best practices, more training, more personnel prepared to serve as interventionists or case managers or provide religious support, and mandatory use of INSPECT before writing opioid prescriptions and being able to refer someone to treatment.

### 5.1.6 Intervention strategies and priorities

The Intervention Subcommittee found priorities that can be achieved with minimal costs and those could be implemented with additional funding.

Low- or no-cost intervention strategies mentioned were:

- Outlining how to get help for OUD or SUD, specifically engaging with treatment and recovery services
- Educational outreach teams like a speakers bureau to inform the public about signs of OUD or SUD, how to conduct an intervention, and available resources
- Developing intervention plans, scripts, tactics to be available online
- Involving clergy and faith leaders to support those with OUD and SUD and their families
- Education to the intervention audiences
- Intervention strategies that will require funding include:
  - A system or team, such as peer support, that guides a person from intervention through recovery
  - Walk-in touchpoints following an intervention to engage with treatment and recovery, perhaps with the ability to hold patients until they can be seen by a doctor or therapist
    - o A walk-in or storefront location to engage with treatment and recovery was a recurring idea
  - Intervention teams able to engage with people after a drug poisoning
  - Insurance coverage for services related to intervention

Although not directly evaluated in intervention subcommittee meetings, tactics like motivational interviewing or drug use screening assessments can serve as intervention strategies, especially when used by healthcare or mental health professionals. More information about these can be found in SAMHSA Tip 63 Medications for Opioid Use Disorder for Healthcare and Addiction Professionals, Policymakers, Patients and Families (2018)<sup>28</sup> and SAMHSA Tip 34 Brief Interventions and Brief Therapies for Substance Abuse (2012).<sup>29</sup> This is an area that should be considered in the work that follows this report.

Like prevention, funding sources for intervention may be a mix of government and private sources.

<sup>28</sup><https://store.samhsa.gov/product/SMA18-5063FULLDOC>

<sup>29</sup><https://store.samhsa.gov/shin/content//SMA12-3952/SMA12-3952.pdf>

## 6 TREATMENT AND RECOVERY SUBCOMMITTEE FINDINGS

Treatment and recovery is central in addressing OUD and SUD. However the path for each person and family looks different just as it does for people with other diseases.

Like with the other subcommittees, it is important to start with the definitions of treatment and recovery. The subcommittee members did not have consensus on what constitutes treatment and recovery – at least one member did not see a distinction – but some themes did emerge. There was also no consensus on whether treatment and recovery happen simultaneously or if a person transitions from one phase to the next.

For treatment, many subcommittee members saw it as a limited-term phase engaging with acute-level care from a more structured, professionalized setting. It often focuses on stopping use of the opioid or substance, including medically supervised withdrawal, formerly known as detox, either in an in-patient unit or intense outpatient treatment. Some members noted that a person may successfully complete treatment but never fully enter recovery.

Using a holistic approach, recovery looks beyond substance use to where the patient or client defines his or her goals, according to subcommittee members. In recovery, the person works toward and hopefully finds a productive, fulfilling life without substance use or dependence. This is usually long-term work of months and years, with fewer clinical services and more peer support services such as Narcotics Anonymous, Heroin Anonymous or Alcoholics Anonymous.

### 6.1.1. Desire for cooperation and building on successes

The subcommittee found a strong desire in collaboration and cooperation across sectors and service providers. There is a clear interest in working together to find solutions. Also the community's increasing awareness about the improper use of opioids opens opportunities to find solutions because this has been accepted as a problem.

Fort Wayne and Allen County have some effective programs that create ways to build on these successes. The subcommittee noted Allen County's award-winning problem-solving courts like Drug Court, the Syringe Services Program, existing peer support services and the breadth of addiction services providers.

### 6.1.2. Families of those in treatment and recovery

Families are in a critical position – positive or negative – for people in treatment and recovery but they are often removed and isolated from the process. It is positive when they are appropriately supportive but can turn negative if families have or continue to enable these behaviors. Family members may also have their own untreated substance use. Subcommittee members with the lived experience of treatment and recovery for themselves or as a family member said there were few resources for families. Providing resources and services for them is a key need that should be addressed in follow-up plans.

### 6.1.3. Employers' role with treatment and recovery

The subcommittee calls on employers to support employees going through treatment and recovery, using less disciplinary measures while also providing accountability. Employers need to see OUD and SUD as diseases and treat them as other medical conditions like heart disease or joint replacement. There is also potential for expanding the role of employee assistance programs, which are already in place for many workplaces, for treatment and recovery. Employers may need education on how to expand these roles.

### 6.1.4. Need for peer support

As demonstrated by sponsors in Alcoholics Anonymous, people who have successfully completed treatment or going through recovery for OUD and SUD can be a vital resource for those walking the same path. These relationships can be relatively informal, like a 12-step sponsor and the associated programs, or a trained mentor like a certified peer recovery coach. They may join the person with OUD or SUD early in the treatment and recovery process, helping the person identify choices for supportive services and look beyond immediate

treatment, or connect later in the recovery process.<sup>30</sup> There is much literature about these roles that go beyond the scope of this report, but the subcommittee believes that positive peer support, regardless of the form, is valuable and should be expanded.

### **6.1.5. Underserved populations for treatment, recovery**

The subcommittee identified underserved populations for treatment and recovery services, which will help plans resulting from this report better serve the entire community.

In no particular order, the groups were:

- Uninsured and underinsured people
- Low-income populations
- Jail population
- Minority populations
- Pregnant women
- Homeless population
- LGBT population
- People with chronic pain
- Elderly
- Rural populations
- Accidental poisoning revival patients

CRI also conducted interviews with local mental health professionals serving multicultural and African-American people with SUD.<sup>31</sup>

There is a general lack of cultural competency or awareness for multicultural patients and clients. Looking at immigrants and refugees, cultural differences but specifically the lack of clinicians who speak languages other than English or the lack of in-person translators for mental health services creates a significant barrier for SUD and mental health services overall. While phone translation is helpful in acute healthcare situations like the emergency department, it is deficient for mental health. Furthermore, there is no long-term formal recovery and support network for the multicultural community.

For the African-American community, some have a personal distrust of the medical system based on experience and a history of distrust and racism over generations. There are not many African-American mental health clinicians, counselors or therapists in Allen County, yet many African-Americans would like to see a provider of the same race. Additionally, African-Americans have reported feeling judged or looked down upon by their mental health professionals, causing them to leave treatment because they no longer saw the value to care.

Furthermore, some African-American pastors or lay faith leaders fail to see OUD or SUD as a medical condition but rather as a moral failing that can or should be solved through prayer alone rather than prayer and faith being part of a larger treatment and recovery plan.

#### **6.1.5.1 Ideas for better serving these groups**

As noted in other sections, subcommittee members thought reducing stigma around OUD and SUD would benefit these groups. These populations would also be served by structural changes to make care more available

<sup>30</sup>Center for Substance Abuse Treatment, What are Peer Recovery Support Services? HHS Publication No. (SMA) 09-4454. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009. Page 3. <https://store.samhsa.gov/shin/content/SMA09-4454/SMA09-4454.pdf>

<sup>31</sup>CRI Director Rachel Blakeman spoke with Irene Paxia, Ewelina Connelly and Josefina Cervantes from Amani Family Services February 26, 2018, and Janell Lane, LMHC, from Parkview Health System on March 8, 2018.

and affordable, including medication-assisted treatment. Although this is discussed further in the Enforcement Subcommittee section, there was also a desire to see less incarceration and more treatment for those convicted of drug crimes.

Specifically for the multicultural and African-American communities, all interviewees listed culturally competency training for mental health professionals as a good starting point, closely followed by getting people from these populations into these professional roles and working to identify how this schooling can be paid for.

### 6.1.6 Medication-assisted treatment

Medication-assisted treatment (MAT) is controversial, but the Treatment and Recovery Subcommittee and FATOS as a whole supports this evidence-based practice so long as the medication is part of a broader treatment strategy. Most members of the subcommittee believe it is underutilized locally, perhaps because of lack of number of physicians who can or will prescribe the medications or a stigma or lack of acceptance for people using MAT. Additionally, backing for the various medications used in MAT had varied support among subcommittee members.

Research on MAT indicates it improves outcomes for people with OUD as compared to counseling and therapy alone.<sup>32</sup> Not only does it reduce the illicit use of opioids and associated fatalities, but it serves a harm-reduction function.

MAT consists of three classes of prescription medication that control cravings, physical dependence and the effects of withdrawal. They work in different ways, either binding to the brain's opioid receptors (full or partial agonists) or blocking those receptors (antagonists).

When used properly, they stabilize patients but do not create a high or euphoria. MAT's stabilization should not be confused with addiction. MAT manages the physical dependence, allowing people to work on the other dimensions of their OUD.

The oldest MAT drug is methadone, a full agonist and Schedule II substance. It is usually dispensed daily at an on-site opioid treatment program (OTP) via an oral dose. Fort Wayne currently has one OTP, Center for Behavioral Health at 3910 Lima Road, but a second OTP, operated by Bowen Center, is scheduled to open May 29, 2018, in Fort Wayne.<sup>33</sup>

Buprenorphine, often better known by the brand names of Suboxone or Subutex, is a Schedule III partial agonist. Unlike the number of patients receiving opioid pain medications, the federal government restricts the number of patients to which a doctor or other licensed prescriber can prescribe buprenorphine at one time. Buprenorphine is often administered orally. However the U.S. Food and Drug Administration approved a once-monthly buprenorphine injection in November 2017.<sup>34</sup>

The third medication is the injectable antagonist naltrexone with the brand names of Vivitrol or Revia. It is usually administered once a month and physically blocks the effects of opioids. Naltrexone is not a controlled substance so there is no limit or restriction on who can prescribe it. But unlike methadone or buprenorphine, it requires patients to have fully withdrawn, somewhere between 5 and 10 days since the use of an opioid, when they start naltrexone. Additionally, naltrexone can manage alcohol dependence.

Naltrexone had the strongest level of support in the subcommittee, especially from those with the lived experience of treatment and recovery. Because naltrexone is not an opioid, it has no "street value" plus it is usually injected, offering the patient a full month without cravings. However it does require a patient to have fully withdrawn from opioid use so it has limited application in the broader patient base.

The agonists – methadone and buprenorphine – had more support from the subcommittee's clinicians, based on published research and their experience with patients or clients who successfully used the medications. People with lived experience were concerned about prescribing practices such as reluctance for tapering down dosages and diversion of buprenorphine to illicit use.

<sup>32</sup>The ASAM National Practice Guideline For the Use of Medications in the Treatment of Addiction Involving Opioid Use. American Society of Addiction Medicine. 2015. <https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24>

<sup>33</sup>FSSA Secretary Dr. Jennifer Walthall's comments. July 5, 2017. [https://www.in.gov/fssa/files/Walthall\\_OTP\\_remarks.pdf](https://www.in.gov/fssa/files/Walthall_OTP_remarks.pdf)

<sup>34</sup><https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm587312.htm>

Just as opioid pain medications were often prescribed without any supportive therapies like physical therapy to manage pain, the subcommittee was concerned that MAT could drift away from a comprehensive treatment program to being a therapy solely by pill. To be most effective, the medication needs to be one element of a treatment and recovery plan.

The cost of MAT, especially if not covered by insurance, can be a significant barrier to its use. The monthly cost of methadone at the Center for Behavioral Health exceeds \$400.<sup>35</sup> Vivitrol costs more than \$1,300 per injectable dose locally,<sup>36</sup> although Alkermes, Vivitrol's manufacturer, offers a co-pay savings program that can also be used by those without or not using insurance so out-of-pocket cost may be significantly lower.<sup>37</sup>

MAT still has a substantial stigma in the local community, including from medical professionals who do not specialize in addiction, the general public and those in recovery. For MAT to be more broadly used and accepted, the subcommittee emphasized the need to see MAT not as the easy way out of OUD but as a clinically effective treatment to allow people to work on the breadth of issues associated with their opioid or substance use. Using a disease analogy, some patients with high blood pressure find that they can manage their condition through lifestyle and diet modifications, while others find medication needed in addition to lifestyle adjustments. The same goes for people with OUD.

The Regional Mental Health Coalition of Northeast Indiana is working to increase availability of MAT locally. The coalition has strategies to persuade primary-care providers to offer buprenorphine or naltrexone as well as an MAT toolkit. It is also connecting primary care physicians who are interested in addressing OUD at MAT clinics by offering their medical services on a part-time basis.

### 6.1.7 Incorporating faith into treatment and recovery

Some members of the subcommittee also saw a need to better incorporate faith and spirituality into treatment and recovery plans. Originating from Alcoholics Anonymous, the 12 Step program uses a higher power, or God depending on the group,<sup>38</sup> as central to the recovery process, which has been meaningful to generations of people in recovery. Many local peer recovery groups use the 12-Step structure including Alcoholics Anonymous, Heroin Anonymous, Narcotics Anonymous and the Fort Wayne Rescue Mission. At least one group in Fort Wayne, Refuge Recovery, uses a Buddhist philosophy for recovery.<sup>39</sup> Whatever path of treatment and recovery a person with OUD or SUD uses, an evaluation of how to incorporate that person's faith and spirituality is an important component to achieve a holistic approach.

### 6.1.8. Areas of improvement

While good things are happening locally, there is room for improvement in treatment and recovery, according to the subcommittee.

One issue is capacity. As people become more aware of the problem, more people are seeking services. Thus there is a need for more credentialed mental professionals, especially people of color and those with language skills beyond English. Work is also being done in Allen County, as connected with SEA 510-2017<sup>40</sup> for an SUD pilot program, to increase the number of sober-living beds and increase the use of MAT. Telemedicine<sup>41</sup> is already authorized in Indiana, including mental health services and MAT coverage. It may be a way to increase access and capacity so long as reimbursement rates are sufficient as to avoid a financial penalty for providers who use this service.

As discussed above, there is a need for more MAT providers, especially those willing to prescribe naltrexone (Vivitrol), based on the preferences of subcommittee members for MAT that does not use opioid agonists. There may also be need for more licensed buprenorphine prescribers. Presently there are more than 30 credentialed

<sup>35</sup><http://centerforbehavioralhealth.com/treatment-center-indiana/> Accessed March 10, 2018.

<sup>36</sup><https://www.goodrx.com/vivitrol>. Accessed March 10, 2018.

<sup>37</sup>See <https://www.vivitrol.com/co-pay-savings-program>. This program does not apply to those using Medicare, Medicaid or other federal or state healthcare programs. Accessed April 23, 2018.

<sup>38</sup>Heroin Anonymous includes God in its Twelve Steps. [http://heroinanonymous.org/wp-content/uploads/2016/05/Reading\\_12-Steps.pdf](http://heroinanonymous.org/wp-content/uploads/2016/05/Reading_12-Steps.pdf) Accessed March 29, 2018.

<sup>39</sup>See <https://www.refugerecovery.org/meetings/?tsml-day=any&tsml-mode=me>. Accessed March 29, 2018.

<sup>40</sup>SEA 510-2017 is included in the appendix.

<sup>41</sup>See I.C. §§ 25-1-9.5, 27-8-34, 27-13-7-22, 12-15-5-11, 25-1-9.5-8. Indiana does not require reimbursement for telemedicine to match the reimbursement rate for in-person visits.

providers – consisting of physicians, physician assistants and nurse practitioners – in Allen County.<sup>42</sup> However information about patient loads and openings is not readily available.

### 6.1.9. Need for funding and payment

Treatment and recovery services typically come with a financial cost, but there are systemic, structural problems in payment, whether it be insurers or private pay, according to the subcommittee.

First and foremost, there needs to be more money to pay for more services, regardless of pay source. The subcommittee agreed that the entity paying for services can dictate the treatment plan rather than the patient's needs. Anecdotally, Indiana Medicaid patients often have access to more services than patients with private insurance. Although mental health parity is required by law<sup>43</sup> for most insurance plans, in practice it doesn't feel like treatment services are covered sufficiently.

There is also need for reimbursement for additional mental health licenses. Specifically, Indiana did not require reimbursement for licensed addictions counselor or family and marriage therapist when providing SUD services. However the state legislature responded this session.<sup>44</sup> Insurers will be required to reimburse for services provided by professionals with addiction counseling and family and marriage therapy licenses starting July 1, 2018.

## 7 ENFORCEMENT SUBCOMMITTEE FINDINGS

Enforcement may be the area with the broadest reach into the other subcommittees because it has intervention, treatment and recovery functions and can be a prevention mechanism too.

While enforcement agencies – police, prosecutor's office, judiciary, probation, jail – often have a punitive connotation, work by the Fort Wayne Police Department, county courts, Allen County Probation and Community Corrections are working to serve a rehabilitative role when possible. Leaders in this area are quick to point out that “we can't arrest our way out of this problem.”

Some of the concepts that emerged from this subcommittee were collaboration, the reactionary role of enforcement agencies, how enforcement has intervention, treatment and recovery purposes, and concerns about ability to enforce against overprescribing.

### 7.1.1. The purposes of criminal justice and opioids

Researchers recognize five purposes of the criminal justice system: 1) retribution or punishment, 2) deterrence, 3) incapacitation, 4) rehabilitation and 5) restoration (think restitution). The subcommittee believed that local efforts prioritize rehabilitation when the offender suffers from OUD or in some cases habilitation to put the offender in a better position than he or she was before. However an obligation to enforce the law still exists. The subcommittee saw value in punishment for dealers and crimes committed outside mere possession.

Incapacitation may offer some utility in the context of opioids and OUD. It could provide time to heal while incarcerated and address the underlying problems, if treatment and recovery services are available in the jail. However some subcommittee members noted that the lack of rehabilitation during incapacitation can create additional risk for accidental poisoning when the offender leaves and uses again.

### 7.1.2. Opioids larger than the criminal justice system

The subcommittee stated that misuse of opioids is larger than the criminal justice system. Looking at the problem from a purely economic and market perspective, there is significant demand for illicit opioids in the community, whether the need began with a prescription after surgery or it started from recreational use. Drugs

<sup>42</sup>The list of buprenorphine prescribers is available at <https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator>. Accessed March 19, 2018.

<sup>43</sup>See Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equality Act of 2008 as amended by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010. See also Comprehensive Addiction and Recovery Act of 2016.

<sup>44</sup>See House Enrolled Act 1007-2018 (Expanding mental health access).

are even present in the Allen County jail population.<sup>45</sup>

The subcommittee had no consensus on whether prescription or illicit opioids were the larger problem. It was fairly split between those who thought prescription opioids are often the entry point to using opioids, especially when pain is not properly addressed, and those who believed illicit drugs, especially fentanyl and carfentanil, are of more concern because of the greater potency. One notable success has been a reduction in the number of armed pharmacy robberies, which may be because of pharmacies modifying their own procedures to include time-delay safes.<sup>46</sup>

OUD and its SUD counterpart often are symptom of underlying mental health problems. People working in enforcement as well as treatment are seeing people who misuse opioids using whatever they can obtain – synthetic marijuana, methamphetamine, cocaine – when they start to withdraw from their opioids to prevent or mask the withdrawal symptoms. Plus, it's a race between illicit producers and the police with new drugs, especially synthetic marijuana variations or fentanyl, coming to market.

The intervention function of enforcement, such as an arrest, may have a diminished effect if the offender has not reached “rock bottom” or does not desire to change behavior. Some defendants eligible for drug court or other problem-solving courts elect to be incarcerated because they believe that will be an easier path.

Other enforcement obstacles were insufficient resources for staffing and funding, particularly when comparing Allen to surrounding counties because of the limited programming in outlying counties. Also, some were concerned about the mixed messages from the Syringe Services Program of public health vs. drug paraphernalia possession.

### 7.1.3. Expanding current roles and new programs

Enforcement subcommittee members want to expand their current roles with more resources. They would like to provide more treatment and offer a full continuum of care. They would like to follow up with people who have been treated for a poisoning and implement mobile intervention teams with emergency assistants, modeled on the successful FWPD Crisis Intervention Team. Additionally first responders indicated they would like an option of drug treatment facilities instead of the emergency department or jail.

Like the other subcommittees, this group saw the need for more people, money and in turn services to expand their current roles.

Programs that could be implemented in Fort Wayne and Allen County with the right resources are:

- A comprehensive strategy for first responders, judiciary, law enforcement, hospitals and mental health centers
- Expand or supplement the Crisis Intervention Team training and services to include substance use disorder for a mobile crisis assistance team (MCAT), which is currently being piloted in Indianapolis
- Police Assisted Addiction and Recovery Initiative (PAARI)<sup>47</sup>: Started in Massachusetts and now used in northwest Indiana, this program allows opioid users to voluntarily surrender at the police station and turn over drugs and paraphernalia without criminal charge and be connected with treatment services; a similar program in Michigan is Hope Not Handcuffs from Families Against Narcotics
- Jail Chemical Addiction Program: Currently used in Boone and Dearborn counties,<sup>48</sup> this intensive outpatient treatment program takes place within the jail
- Problem-solving courts expansion: Allen County has successfully implemented multiple problem-solving courts, like Drug Court and Veterans Court, and the intensive supervised HOPE probation, that could be expanded across jurisdictions because not all courts in northeast Indiana offer these services

<sup>45</sup><http://www.journalgazette.net/news/local/police-fire/20171121/sheriff-inmates-could-face-charges-in-jail-opioid-incident> Accessed March 14, 2018.

<sup>46</sup><http://www.pharmacytimes.com/news/recent-pharmacy-robbery-statistics> Indiana fell to the second-place spot in 2016, behind California. Well over half of Indiana's robberies in 2015 happened in Marion County from the same retailer.

<sup>47</sup>See <https://paarius.org/> and <http://www.familiesagainstnarcotics.org/hopenothandcuffs>

<sup>48</sup>See Boone County or Dearborn County JCAP. More information available here: <https://www.theindianalawyer.com/articles/46332-opioid-option>. Accessed March 19, 2018.

- Naltrexone injections prior to release: Some counties offer offenders an injection of naltrexone immediately prior to release from jail, which could be beneficial here to avert the concern about immediate opioid use upon release; some inmates already receive this if they are part of a treatment program but there is a need to expand this function
- Involuntary holds: There is interest in looking at expanding court-ordered 24- and 72-hour holds for people with acute opioid misuse to recognize “danger to self” beyond suicide; some states have statutory language that provides for involuntary admissions relating to SUD<sup>49</sup>

Other program expansions mentioned were social media surveillance of known criminals, more case managers in probation and community corrections, education and outreach especially to the public about the work currently being done, more coordination among agencies, more targeted enforcement against suppliers and prescribers, education for public defenders and other criminal defense attorneys about the problem-solving courts to help engage them in this process, and plans from the Attorney General’s office for interdisciplinary Highway Interdiction Teams to remove opioids and other illegal drugs from Indiana’s roadways.

Funding for these programs could come from additional appropriations from the state legislature as well as grant opportunities. User fees may also be an option when appropriate. Funding that could come from pending lawsuits may also be appropriate for enforcement functions connected to OUD and SUD.

#### 7.1.4. Needed legislation

Because of the formal legal structures in enforcement, there is a need for legislative changes to make these agencies more effective in addressing OUD and SUD. Two requests from the subcommittee are:

1. More treatment and associated funding for those in the criminal justice system, particularly Recovery Works
2. Extending the Lifeline law (Ind. Code § 7.1-5-1-6.5) to opioids that so that it provides immunity for those who call 911 for an accidental opioid poisoning

Coincidentally two requests made during the subcommittee process are on its way to becoming law: harsher penalties for those dealing drugs causing death (HEA 1359-2018) and additional data to and from coroners for deaths from accidental poisonings (SEA 139-2018).

## 8 OTHER MATTERS FOR CONSIDERATION

### 8.1 POPULATIONS WITH SPECIFIC NEEDS

Although OUD is not limited to a specific race, gender or socio-economic group, some populations require special attention.

#### 8.1.1. Minority, immigrant and refugee populations

As referenced in the treatment and recovery subcommittee, minority and multicultural populations have specific needs, including cultural awareness and services delivered in languages other than English. Ahmed Abdelmageed, PharmD; assistant dean of experiential education and community engagement at Manchester University’s College of Pharmacy, Natural and Health Sciences, noted at the recent Multicultural Council of Fort Wayne mental health symposium that “hyphenated Americans” like African-Americans and Muslim-Americans have a layer of complexity in healthcare settings.<sup>50</sup>

<sup>49</sup>Florida’s Marchman Act could be a model for Indiana. For more information, visit <http://www.dcf.state.fl.us/programs/samh/SubstanceAbuse/marchman/marchmanacthand03p.pdf>.

<sup>50</sup>Dr. Abdelmageed’s comments were made during the panel discussion of the Multicultural Council of Fort Wayne’s mental health symposium titled Addressing Trauma with Diverse Populations held March 16, 2018.

### 8.1.2. Children in families with improper opioid use

Indiana law permits court intervention if a child is born with fetal alcohol syndrome, neonatal abstinence syndrome or has any amount of controlled substance, including trace amounts, in child's blood, urine, umbilical cord tissue or meconium and the child needs care, treatment or rehabilitation but is not receiving those services and are unlikely receive such "without coercive intervention of the court."<sup>51</sup> If those criteria are met, the child is deemed a "child in need of services" (CHINS). A child is also a CHINS if the parents or guardians seriously impair or endanger the child.<sup>52</sup>

Although the Indiana legislature considered a law in 2017 that would have created a rebuttable presumption for court-intervention after prenatal substance exposure, it was ultimately removed.<sup>53</sup>

Allen Superior Court Judge Charles Pratt, who serves in the family relations division, is concerned that the legislature has limited the ability of the courts to serve an intervention function for parents or guardians who need to engage with treatment and recovery.<sup>54</sup> Furthermore, he is concerned that recent Indiana Court of Appeals decisions could limit court intervention for families where substance use is occurring, including prenatal exposure.<sup>55</sup>

In part because of the rebuttable presumption in I.C. § 31-34-12-4,<sup>56</sup> Pratt would like to see the family relations court hold parents with OUD and SUD accountable. This should not be interpreted as an automatic removal of children from the home. Rather, CHINS proceedings create an external incentive to get into and stay in a treatment and recovery program, according to Pratt. He recognizes additional CHINS cases will create a larger caseload but he would like to be more involved in this work.

Additionally, the Indiana Department of Child Services issued child welfare manuals effective at the beginning of this year about the frequency of drug screening.<sup>57</sup> Pratt is concerned that less screening is short-sighted.

Like his colleagues in the criminal division, Judge Pratt is interested in using the courts in the context of CHINS cases to help families engage in treatment and recovery. Pratt would like to be involved in future efforts resulting from FATOS' work.

### 8.1.3. Pregnant women

Another group is pregnant women actively using opioids. Babies born to women who used prescription or illicit opioids during pregnancy may be born with physical dependence on opioids and experience withdrawal after delivery, with symptoms like hyperirritability, tremors, excessive crying and diarrhea. This is clinically recognized as neonatal abstinence syndrome (NAS).<sup>58</sup> Clinical research indicates NAS is increasing.<sup>59</sup> NAS presents immediate concerns from neglect and abuse as a result of the withdrawal symptoms and developmental delays that may not appear for months or years. The use of opioid agonist MAT is recommended for pregnant women who would otherwise not stop using opioids. The Northeast Indiana Patient Safety Coalition's Neonatal Abstinence Syndrome Work Group is developing guidelines and a plan of care for infants exposed to prenatal opioids. These efforts should be included in future work to address people with OUD and SUD.

<sup>51</sup>I.C. § 31-34-1-10.

<sup>52</sup>I.C. § 31-34-1-1.

<sup>53</sup>See SEA 447-2017, which includes the prenatal exposure rebuttable presumption, and HEA 1006-2017, which does not. SEA 447-2017 signed into law April 26, 2017, which was superseded by HEA 1006-2017 on April 28, 2017.

<sup>54</sup>Interview with Judge Charles Pratt. March 19, 2018.

<sup>55</sup>See *In the Matter of S.M.*, 45 N.E.3d 1252, 1255-56 (Ind. Ct. App. 2015) (concluding that there was no evidence presented that infant H.G. was endangered when he was born with marijuana-positive meconium); *In re L.P.*, 6 N.E.3d 1019, 1021 (Ind. Ct. App. 2014) (an isolated use of methamphetamine, without more, does not support the conclusion of law that the child was a child in need of services); *A.M. v. Ind. Dep't of Child Servs. (In re S.M.)*, 45 N.E.3d 1252, 1256-1257 (Ind. Ct. App. 2015) (although meconium tested positive for marijuana, no evidence was provided that infant's needs were not being met).

<sup>56</sup>See *Ind. Dep't of Child Servs. v. J.D.*, 77 N.E.3d 801, 809 (Ind.Ct.App. 2017) (the rebuttable presumption concerns not only that child's physical or mental health is endangered, but also that child needs care, treatment, or rehabilitation that he is not receiving and is unlikely to be provided or accepted without the coercive intervention of the court).

<sup>57</sup>See Indiana DCS Child Welfare Policy Chap. 5 (General Case Management) Sec. 20 (Drug Screening in Permanency Case Management) and Chap. 4 Sect. 40 (Drug Screenings in Assessments).

<sup>58</sup>Kocherlakota, P. "Neonatal Abstinence Syndrome." *Pediatrics*. Vol. 134 Iss. 2. August 2014.

<sup>59</sup>Patrick, S.W. "Increasing incidence and geographic distribution of neonatal abstinence syndrome: United States 2009-2012." *Journal of Perinatology*. Vol. 35 650-655. 2015. NAS increased from 3.4 per 1,000 hospital births in 2009 to 5.8 per hospital births in 2012. Great Lakes states had a rate of 6.9 per hospital births in 2012.

## 8.2 THE IMPORTANCE OF FAITH AND FAITH LEADERS IN THE OPIOID CRISIS

The role of faith and faith leaders as it relates to opioids came up throughout this process. A person's faith often plays a central role in one's life, which can increase when facing OUD or SUD individually or with a family member or loved one. Naturally in times of crisis, people of faith look to the ordained or lay leadership of their houses of worship.

Though because of the stigma associated with OUD, SUD or other mental health diagnoses, it may be difficult to engage with these leaders. Additionally, faith leaders may not feel adept at navigating this issue with their members and congregants. For example, someone mentioned that a pastor didn't think he knew how to pray for someone with a substance use problem.

OUD and SUD isn't limited to people of one faith. Fort Wayne hosts the spectrum of the world's religions, including Catholicism, Protestant Christianity, evangelical Christianity, orthodox Christianity, Judaism, Islam, Buddhism and more. Thus plans to engage faith leaders need to honor the shared experience of religious worship while respecting faith traditions' individual belief systems.

## 8.3 2018 LEGISLATION

The Indiana General Assembly addressed issues of importance in the opioid crisis in this year's non-budget session. Specifically enacted bills, all signed into law by Gov. Eric Holcomb, looked at:

- **Use of prescription drug monitoring program (Senate Enrolled Act 221):** Phasing in prescribers' required use of INSPECT, Indiana's prescription drug monitoring program, at the time of opioid prescription, starting in 2019.
- **Investigation of overdose deaths (Senate Enrolled Act 139):** Requiring county coroners to obtain INSPECT records, test certain bodily fluids and report test results to the state and provide notice of death to the state with information relating to controlled substances.
- **Drug dealing resulting in death (House Enrolled Act 1359):** Making the manufacture or dealing of certain controlled substances resulting in a user's death a felony.
- **Expansion of mental health access (House Enrolled Act 1007):** 1) Establishing best-practice guidelines to assist employers with employees who agree to participate in a drug education and addiction treatment program including voluntary participation, informational resources and training for employers and data collection for an annual report. If employer and employee comply with certain requirements, employer is not liable for negligent hiring for employee's negligence of the employee and an employer's participation in the program is not admissible as evidence in certain civil actions. 2) Requiring insurers to pay for substance use disorder treatment provided by an addiction counselor or marriage and family therapist. 3) Creating up to nine additional opioid treatment programs.
- **Continuing medical education for controlled substance prescribers (Senate Enrolled Act 225):** Starting with licenses issued in 2019, prescribers applying for a new or renewed controlled substance license must have completed two hours of continuing medical education in the past two years about opioid prescribing and opioid misuse. This requirement sunsets in 2025.

Other bills relating to opioids were drafted but did not survive the 2018 legislative process.

### 8.3.1 Opportunities next session

The 2019 session will be a "long session" where the General Assembly will pass a two-year budget for the state of Indiana. Because of the intersection of budgetary considerations and the longer legislative time period, advocates for the issues addressed in this report should consider meeting with the local statehouse delegation and other state legislators interested in addressing opioid misuse this summer and fall to help them understand the need for action and funding in this corner of the state, with the intention for legislative response next year.

### 8.3.2 Needed federal legislation

Although FATOS and its subcommittees focused on local and state issues around opioid use, federal action is needed. Specifically there is a need to modify federal code<sup>60</sup> to remove a confidentiality provision that restricts disclosure of records without consent relating to substance use disorder from any federally assisted alcohol and drug abuse program to other healthcare providers.

## 8.4 TREATMENT REFERRALS

This is discussed in Section 5.1.3 about 211, OpenBeds.net and FSSA information.

## 9 CONCLUSION: WHERE WE GO FROM HERE

As noted in the Executive Summary, this report is the beginning not the end. Residents of Fort Wayne and Allen County should know that leaders are looking for solutions to the opioid crisis. Often the good work happening now gets little attention of media and the general public. Plus efforts at the national and state levels have positive local effects. We need to make sure the ideas collected during this process are further evaluated and implemented. Hope can become action.

There is also a need to look at the opioid crisis on a regional level. FATOS focused on Fort Wayne and Allen County in part because of the accelerated timeline, but this crisis does not recognize jurisdictional boundaries. The logical next step is to look at these areas across northeast Indiana, especially with how residents of those counties access services in Fort Wayne and what impediments exist. Many ideas suggested here can be implemented across geographies like prevention education.

### 9.1 NEXT STEPS

FATOS will reconvene to create Hope Into Action workgroups to address items from this report and those that were overlooked or came up after the subcommittee process. The intent is to structure workgroups based on audience. Potential workgroups include:

- Treatment and recovery: Providers and patients or clients
- Families: Those with family members with OUD or SUD or working to prevent OUD or SUD
- Schools and educators: K-12 and higher education
- Employers
- First responders: Police, fire and EMS
- Courts: The populations under court supervision and the people who work with them
- Underserved populations: Including people of color, non-English speakers, homeless

The Hope Into Action workgroups will develop workplans with action steps, emphasizing projects that can be completed yet this year with minimal cost but also those that will take resources of time and money.

Since FATOS members are experts in their respective fields, they are well-positioned to advocate for solutions to address opioid misuse. In the months to come, FATOS will reach out to the northeast Indiana statehouse delegation as well their federal counterparts to inform them of FATOS' work. Some problems identified here cannot be solved without legislative action.

Evaluating the opioid crisis on a regional level for northeast Indiana is also be a priority for 2018. This could take many routes, therefore it is premature to say precisely what that plan will be other than the need exists for

<sup>60</sup>See 42 CFR 2: Confidentiality of Substance Use Disorder Patient Records was passed with the intent in the 1980s to reduce the stigma and fear of prosecution for those seeking treatment of a substance use disorder. For more information visit <http://www.helpendopioidcrisis.org/>.

regional consideration.

## 9.2 REGIONAL MENTAL HEALTH COALITION EFFORTS

The Regional Mental Health Coalition (RMHC) has a significant number of efforts and projects underway that may serve as a vehicle for carrying out some of the subcommittees' recommendations. Some RMHC projects relating to opioids not already mentioned:

- Working with health systems to reduce opioid prescribing rates and increase medication-assisted treatment
- Changing Medicaid rules to avoid requiring prescribing opioids as the first-line treatment for pain
- Educating employers about mental and behavioral health, including opioid use
- Educating and connecting faith leaders to mental and behavioral health resources, including those about opioid use
- Expanding information about opioids on LookUpIndiana.org website
- Building students' resiliency skills and knowledge about drug risks in K-12 and higher education settings, including the Get Schooled tour for middle and high school students in northeast Indiana
- Developing better pathways to care for youth and their families relating to OUD and SUD

## 9.3 ALLEN COUNTY AS TEST SITE FOR STATEWIDE INITIATIVES

Going forward, Allen County is uniquely positioned to serve as a pilot or test site for statewide programs because of its mix of urban, rural and suburban localities.

It has a diverse cross-section of racial, ethnic and socioeconomic populations that represent the breadth of Indiana, from small town to large city. The FATOS process to date shows how leaders in Fort Wayne and Allen County across disciplines and industry sectors have the interest and ability to convene. Additionally, Allen County groups have already worked together for sober living facilities with SEA 510-2017.

## 9.4 FUNDING

All the interest and intent in the world does not print money. As discussed, some ideas need minimal funding. Others require significant expenditures, especially when it involves facilities, services, personnel, wages and benefits. Identifying particular funding sources was outside the scope of this project but some ideas suggested were federal block grants distributed directly to localities, a dedicated grant writer for these efforts, and other private and public grant sources, including those at the state and national level. Some services may be able to generate revenue through user fees. Locating funding sources, especially those with sufficient duration, will be an important component to the success of local efforts.

Indiana is also on track to receive additional federal funding to address problems resulting from opioids. In April, the U.S. Department of Health and Human Services announced \$10.9 million for Indiana in Opioid State Targeted Response Grants as part of the 21<sup>st</sup> Century Cures Act.<sup>61</sup> How this funding will be used had not been announced at the time of publication.

## 9.5 PARTNERING WITH EXISTING EFFORTS

Although tempting to start new initiatives to address the problems from this report, FATOS and The Lutheran Foundation should consider partnering with existing efforts to limit opioid use and increase access to treatment

<sup>61</sup>See <http://www.insideindianabusiness.com/story/37998648/federal-funds-to-fight-opioids>. Accessed April 25, 2018.

and recovery. Just as RMHC is working on some of these initiatives, other organizations like the Drug and Alcohol Consortium of Allen County, Northeast Indiana Regional Advisory Board and McMillen Health share similar goals and objectives. Collaboration could turn hope into action.

## 10 APPENDIX

### 10.1 FATOS MEMBERS

FATOS		
Marcia Haaff	Executive Director	The Lutheran Foundation
Andrea Schroeder	Community Advocate	
Angela Moellering	Chief Executive Officer	Lutheran Social Services
Beth Lock	Governmental Affairs	Allen County
Charles Clark	Senior Vice President	Parkview Behavioral Health
Connie Kerrigan	Director of Community Outreach	Parkview Behavioral Health
Danielle Barr	Manager	St. Joe Behavioral Health
Deb Morrone	Director of Public Safety Grants and Research	City of Fort Wayne
Dr. Deborah McMahan	Health Commissioner of Allen County	Fort Wayne-Allen County Department of Health
Elizabeth Embler	Community Advocate	
Jena Covell	Assistant Director – Allen County	Bowen Center
Joshua Gage	Community Advocate	
Katherine Korn	Community Advocate	
Captain Kevin Hunter	Vice & Narcotics	Fort Wayne Police Department
Kristina Johnson	Director of Community Initiatives	The Lutheran Foundation
Mary Pappas-Finch	Community Outreach Coordinator	St. Joe Behavioral Health
Megan Fisher	Regional Manager, Northern Indiana	Groups: Recover Together
Dr. Richard Ruhrold	Vice President of Clinical	Bowen Center
Shawn Fingerle	Director of Clinical Services	Parkview Behavioral Health
Tim Stelle	Community Advocate	
Judge Wendy Davis	Criminal Division Judge	Allen Superior Court

### 10.2 SUBCOMMITTEE MEMBERS

Prevention		
Andrea Schroeder	Community Advocate	
Connie Kerrigan	Director of Community Outreach	Parkview Behavioral Health
Irene Paxia	Executive Director	Amani Family Services
Jerri Lerch	Executive Director	Allen County Drug & Alcohol Consortium
Justin Calloway	Program Manager	Road to Recovery
Kristina Johnson	Director of Community Initiatives	The Lutheran Foundation
Mary Hess	Director of Health and Wellness	Fort Wayne Community Schools
Dr. Tracy Brooks	Assistant Professor of Pharmacy Practice	Manchester University

Intervention		
Angela Moellering	Chief Executive Officer	Lutheran Social Services
Connie Kerrigan	Director of Community Outreach	Parkview Behavioral Health
Captain Deborah Joyner	Detective Bureau	Fort Wayne Police Department
The Reverend Dr. Dennis Goff	Director of Ministry Programs	The Lutheran Foundation
Dr. Michael Stroncsek		Oral & Maxillofacial Surgery Associate
Michelle Savieo	Office Director	Department of Child Services
Susie Cisney	Director of Clinical Services	The Fort Wayne-Allen County Department of Health

Treatment/Recovery		
Angela Moellering	Chief Executive Officer	Lutheran Social Services
Brent Stachler	Clinical Director	The Rescue Mission
Cathi Counterman	Community Advocate	
Dr. Deborah McMahan	Health Commissioner of Allen County	Fort Wayne-Allen County Department of Health
Elizabeth Embler	Community Advocate	
Justin Calloway	Program Manager	Road to Recovery
Mary Pappas-Finch	Community Outreach Coordinator	St. Joe Behavioral Health
Megan Fisher	Regional Manager, Northern Indiana	Groups: Recover Together
Shawn Fingerle	Director of Clinical Services	Parkview Behavioral Health
Tei Ferguson	Director	Inspiration House
Tim Stelle	Community Advocate	
Toni Lovell	Vice President of Programs	The Rescue Mission

Enforcement		
Andrea Schroeder	Community Advocate	
Ben Goldsberry	First Responder	TRAA
Elizabeth Embler	Community Advocate	
Eric Zimmerman	Chief Probation Officer	Allen County Adult Probation
Judge Frances Gull	Criminal Division	Allen Superior Court
Jeff Stineburg	Deputy Prosecuting Attorney	Allen County Prosecuting Attorney's Office
Joshua Gage	Community Advocate	
Katherine Korn	Community Advocate	
Captain Kevin Hunter	Vice & Narcotics	Fort Wayne Police Department
Kim Churchward	Executive Director	Allen County Community Corrections
Mary Pappas-Finch	Community Outreach Coordinator	St. Joe Behavioral Health
Shawn Fingerle	Director of Clinical Services	Parkview Behavioral Health
Judge Wendy Davis	Criminal Division Judge	Allen County Superior Court

## 10.3 A STRATEGIC APPROACH TO ADDRESSING SUBSTANCE ABUSE IN INDIANA

State of Indiana, Governor Eric J. Holcomb

Jim McClelland, Executive Director for Drug Prevention, Treatment,  
and Enforcement

### A Strategic Approach to Addressing Substance Abuse in Indiana

#### 10.3.1 Vision

By accomplishing our mission, we will help people improve their lives and build stronger, healthier communities.

#### 10.3.2 Mission

With an initial focus on opioids, develop and implement a data-driven system focused on substance abuse prevention, early intervention, treatment, recovery, and enforcement that substantially reduces the prevalence of substance use disorder (SUD) in Indiana and helps those with SUD achieve recovery and become or return to being productive, contributing members of their communities.

#### 10.3.3 Overall Approach

We will coordinate, align, and focus the resources of Indiana state government and leverage the resources of other public sector entities and other sectors - including businesses, higher education institutions, health care systems, philanthropies, and not-for-profit organizations - to respond to the current opioid crisis and enhance the potential for timely responses to future crises resulting from substance abuse and addictions.

Toward that end, we will develop and implement complementary public health and public safety strategies that:

- Recognize substance use disorder as a chronic disease and incorporate prevention, treatment, and recovery systems accordingly, and
- Are designed to reduce the supply of and demand for illicit substances.

#### 10.3.4 Guiding Principles

- We will have a bias toward action and a strong sense of urgency.
- Systems we create – for government, for persons with SUD and their families, and for providers of services - will be data-driven, resilient, agile, and adaptable – evolving as learning increases and as the external environment changes.
- We will strive to incorporate innovation and continuous improvement to make optimal use of all resources to improve outcomes and impact.

- We will give preference to evidence-based programs and practices, while leaving room for promising innovative approaches.
- Where possible, we will give preference to locally-driven and implemented holistic, multidisciplinary approaches with and for persons with substance use disorders and their families.

### 10.3.5 Key High-level Outcome and Impact Indicators

- Number of persons with overdoses admitted to hospitals or emergency departments
- Deaths from overdoses
- Opioid prescription rates
- Number of babies born with Neonatal Abstinence Syndrome
- Percent of persons with substance use disorder who are in recovery and able to become or return to being productive, contributing members of their communities. (Note: Method of approximating this percentage to be determined.)

### 10.3.6 Executive Director for Drug Prevention, Treatment, and Enforcement

The Executive Director for Drug Prevention, Treatment, and Enforcement will:

- Provide overall leadership to accomplish the mission.
- Support, coordinate, and align the relevant work of various state agencies that directly or indirectly are involved in or affect substance abuse prevention, early detection and intervention, treatment and recovery, public safety and law enforcement efforts.
- Attract and leverage resources from entities outside state government to enhance the accomplishment of the mission.
- Encourage and support community-based collaborations aimed at prevention, treatment, recovery and enforcement.

Services will include:

- Leading the development and periodic review of strategic directions.
- Leading efforts to enhance the availability of accurate, timely data and actionable information to enhance the accomplishment of the mission.
- Identifying grant opportunities and coordinating responses.
- Attracting resources from other sectors to enhance accomplishment of the mission.
- Helping develop public policy to support and optimize accomplishment of the mission.

- Leading the development of a public awareness and education efforts to reduce stigma and help accomplish the mission.
- Developing and maintaining a highly user-friendly website with current information on a wide variety of relevant topics.
- Identifying and disseminating information on or providing links to effective programs and services.
- Arranging value chain and process improvement services to make best use of all resources to increase impact.

The Executive director of Drug Abuse Prevention, Treatment, and Enforcement, reports directly to the Governor of Indiana.

### 10.3.7 Major Strategies

1. Reduce the incidence of substance use disorder
  - a. Reduce the number of people who start using an addictive substance
    - i. Encourage the use of alternative pain management treatments and therapies and hospital-driven post-operative pain management protocols.
    - ii. Support improved, relevant education and training of prescribers and patients regarding pain medications and potential for addiction.
    - iii. Develop and implement a multi-year public awareness and education campaign regarding stigma, addiction, and recovery.
    - iv. Increase awareness of high Adverse Childhood Experience (ACE) scores as a risk factor, along with other risk and protective factors.
    - v. Identify and support the implementation of age-appropriate evidence-based addictive substance use and misuse prevention programs for children and youth. Encourage school-based programs that support positive peer relationships and social competence and evidence-based family strengthening programs. Monitor rates of alcohol and drug use among persons under age 18.
    - vi. Encourage increased opportunities (e.g. after-school, education, training, employment) - especially for high-risk populations and in high-risk areas.
    - vii. Promote healthy families.
  - b. Reduce the number of persons who become addicted to a legally prescribed substance.
    - i. Encourage implementation across disciplines throughout the state of new evidence-informed prescribing practices that reduce the duration and number of doses of opioid pain medication.

- ii. Encourage education and awareness efforts regarding safe use of legally prescribed substances.
    - iii. Continue to make INSPECT, Indiana’s prescription monitoring program (PDMP) more user-friendly and integrate it with electronic health record (EHR) systems. Support initiatives that encourage integration with all Indiana hospital systems, health information exchanges (HIE) and pharmacy dispensing software (PDS) systems. Encourage the use of INSPECT to inform clinical decision-making and support interventions with patients who may be abusing or misusing prescription medications contributing to the overdose epidemic.
    - iv. Encourage and support increased availability and awareness of “take back” opportunities.
  - c. Reduce the supply of illicit drugs
    - i. Support and encourage targeted law enforcement work focused on the supply chain for illicit substances, including interdiction efforts, reducing the drug supply chain, reducing impaired driving and pharmacy robberies.
    - ii. Support realignment of state law enforcement resources, as necessary, to better detect, disrupt, and dismantle drug trafficking organizations.
    - iii. Assist in coordination of efforts with local, state, and federal agencies, including coordinated approaches with neighboring states.
- 2. Reduce additional harm that can result from substance abuse
  - a. Increase survival rate of those who overdose
    - i. Expand access to and training in use of naloxone.
    - ii. Strive to connect those who overdose with treatment as soon as possible.
  - b. Encourage increased accessibility for persons addicted to intravenous drug use to syringe services programs to reduce the spread of infectious diseases such as HIV and HCV and to provide treatment information. Where possible, syringe services programs should be located close to treatment centers, and it is important that those who use such programs be able to do so without stigma or fear of arrest or prosecution.
- 3. Improve treatment of persons with SUD
  - a. Intervene as early as possible, ideally connecting individuals to treatment no later than the time of first arrest, first overdose, or first expression of a desire for help.
    - i. When treatment is not immediately available, encourage and support services that connect persons to a counselor/coach/other caring person who will stay in close touch with the individual at least until treatment is available.
    - ii. Encourage and support initiatives that provide counselors in emergency departments to establish a relationship with persons who have overdosed

and work to get them into treatment, or, where possible, begin treatment on-site.

- iii. Greatly improve access to effective, affordable treatment, with a preference for medication-assisted treatment (MAT) Add and/or expand treatment programs.
- iv. Obtain waiver to enable Medicaid to pay for residential treatment and recovery supports for SUD.
- v. Seek ways to augment the professional addiction treatment workforce, including increased use of trained paramedics, EMS workers, and peer recovery coaches.
  - 1. Support development of a program to train paramedics to provide follow up services for persons with SUD who have been released from treatment and who live in underserved areas.
  - 2. Explore increased training and licensure of recovery coaches.
  - 3. Review licensing requirements and payment policies based on licensure to determine if changes in public policy are needed.
- vi. Develop one or more pilot “hub and spokes” networks to provide a full array of services for a multi-county region. Rigorously evaluate and replicate positive and promising practices that fit the assets and needs of communities and their residents.
- vii. Encourage and support increased use of drug courts, diversion programs, and evidence-based treatment options for offenders with SUD. Identify, and seek to replicate, innovative practices being developed and used by local courts and local jails.
- viii. Encourage and support expansion and improvement of substance abuse treatment services within the corrections system, particularly at the time of entry.
- ix. Encourage and support stronger relationships between drug courts and corrections with community mental health centers or other addiction treatment providers to enhance the potential for successful re-entry into the community and reduce recidivism and the frequency of relapses.
- x. x. Support community-based recovery and long term wrap-around services, including recovery housing, to help persons in recovery become or return to being productive, contributing members of their communities. Seek to eliminate punitive policies that terminate services for people who relapse.
- xi. Increase the use of technology (e.g. telemedicine) to improve access to treatment services.
- xii. Use mobile teams to increase service availability.

- b. Develop and augment the ability of the Executive Director for Drug Prevention,

Treatment, and Enforcement to serve its stakeholders, including persons with SUD and their families, providers of services, and units of government. Develop robust systems to gather data from disparate sources and convert it into useful, actionable information for decision-making. Develop dashboards that enhance the ability to track progress and quickly identify problems. Develop a capability to use predictive analytics to help reduce the incidence and severity of future substance abuse problems and to identify where increases or shifts in resources would be advisable.

- c. Utilize the Healthy Hoosiers Foundation to facilitate the development of funds for appropriate purposes aligned with the goals of this strategic approach.
  - d. Explore potential project opportunities for graduate students in Public Health, Informatics, Social Work, and other disciplines.
4. Support and enhance substantial community-based collaborations aimed at prevention, treatment, and recovery. Encourage and support strengthening the infrastructure of communities (including county public health departments) to increase the capacity of communities to implement evidence-based prevention and treatment programs.
- a. Encourage and support community-based coalitions aimed at prevention, treatment, and recovery. Encourage significant involvement of community-based organizations, Purdue Extension, chambers of commerce and other organizations from the public, for-profit, and not-for-profit sectors.
  - b. Encourage improving the conditions within Indiana communities to strengthen equitable access to the social determinants of health to include, for example: improving economic and employment opportunities, improving literacy, increasing access to nutritional foods, improving access to quality education and skills training, etc.
  - c. Encourage and support strengthening the scope and capacity of the local public health department in each Indiana county and encourage each county health department to achieve national accreditation status. Encourage and support the substantial engagement of local health departments in opioid addiction treatment and prevention services, and strongly encourage health departments and hospitals to work together collaboratively.
  - d. Support workforce development initiatives to help ensure that communities have access to trained health professionals who engage in clinically appropriate addiction treatment and prevention services.

#### **10.4 SENATE ENROLLED ACT 510-2017: SUBSTANCE ABUSE PILOT PROGRAM**

SECTION 1. IC 33-33-2-46 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Sec. 46. (a) As used

in this section, “administrator” means the entity that enters into an agreement with the board of county commissioners of Allen County under subsection (e).

**(b)** As used in this section, “pilot program” refers to the substance abuse pilot program established under subsection (c).

**(c)** After June 30, 2017, and after approval of the Indiana commission to combat drug abuse, the board of county commissioners of Allen County may establish a four (4) year pilot program to assist participants in overcoming their substance abuse by providing:

**(1)** evidence based addiction treatment, including detoxification, medication assisted treatment, including a federal Food and Drug Administration approved long acting, nonaddictive medication for the treatment of opioid dependence; and

**(2)** assistance with developing a long term plan for sober living outside the pilot program.

**(d)** An individual is eligible to participate in the pilot program if the individual:

**(1)** is at least eighteen (18) years of age;

**(2)** is charged with a felony;

**(3)** is under the supervision of a court or community corrections program in Allen County, including:

**(A)** a problem solving court;

**(B)** a diversion program;

**(C)** community corrections;

**(D)** probation;

**(E)** home detention; or

**(F)** any other program involving community supervision as an alternative to commitment to the department of correction, if the program is approved by the court; and  
**(4)** is suffering from a significant substance abuse disorder and has been previously unable to remain sober.

**(e)** If the board of county commissioners of Allen County establishes a pilot program under subsection (c), the board of county commissioners of Allen County shall enter into an agreement with an entity with experience in administering community development programs.

**(f)** Mental health and addiction treatment services provided as part of the pilot program may be administered or subcontracted only by a provider certified by the division of mental health and addiction with expertise in providing evidence based mental health and addiction treatment services.

**(g)** The administrator shall provide a report to the legislative council before October 1, 2019, and before each October 1 of each year thereafter. The report must include the following:

**(1)** The number of persons successfully completing the pilot program.

**(2)** Estimated cost savings of the pilot program.

**(3)** Opportunities for replication.

**(4)** Recidivism rates of persons participating in the pilot program, including the following:

**(A)** A person’s new arrest or conviction that occurs while the person is participating

in the pilot program. **(B)** A person’s new arrest, conviction, or commitment to

the department of correction, not later than twelve (12) months after ending

participation in the pilot program. **(C)** A person’s new arrest, conviction, or

commitment to the department of correction, not later than twenty-four (24) months

after ending participation in the pilot program. **(D)** A person’s new arrest, conviction,

or commitment to the department of correction, not later than thirty-six (36) months

after ending participation in the pilot program.

**(h)** The report required by subsection (g) must be in an electronic format under IC 5-14-6.

**(i)** The administrator may not expend state money granted to the administrator for the pilot program unless the administrator has raised at least one dollar (\$1) of local funds for every one dollar (\$1) of state funds before July 1, 2018.

The administrator may not expend money granted to the administrator for the pilot program for a state fiscal year unless the administrator expends at least one dollar (\$1) of local funds for every one dollar (\$1) of state funds expended.

(j) The expenses of the pilot program may be paid from money appropriated to the administrator.

This section expires June 30, 2022.

## 10.5 PROVIDERS WITH BUPRENORPHINE PRESCRIBING AUTHORITY

This list of prescribers for buprenorphine within a 25-mile radius of 46802 was downloaded from the SAMHSA online database February 2, 2018.

First	Last	Deg.	Address	City	County	Zip	Telephone
Muhammod	Ahmad	M.D.	2418 Lake Avenue	Fort Wayne	ALLEN	46805	(260) 422-4757
Hary	Ailinani	M.D.	2512 East Dupont Road ste 200	Fort Wayne	ALLEN	46825	(260) 748-3650
Harold	Bacchus	M.D.	Med-I-Qwik, Inc. 1719 Cremer Avenue	Fort Wayne	ALLEN	46818	(260) 490-9150
Ryan	Bleck	D.O.	750 Broadway Suite 350	Fort Wayne	ALLEN	46802	(260) 423-2675
Brittany	Bower	NP	800 Broadway Suite 315	Fort Wayne	ALLEN	46802	(260) 489-6030
Lynnea	Carder	M.D.	1850 Wesley Road	Auburn	DE KALB	46706	(260) 927-0726
Julie	Chao	M.D.	10351 Dawson's Creek Boulevard Suite C	Fort Wayne	ALLEN	46825	(260) 387-7540
Sharon	Clevenger	NP	Indiana Center for CBT423 Airport North Office Park	Fort Wayne	ALLEN	46825	(260) 969-5583
Charles	Coats	M.D.	1330 North Coliseum Boulevard	Fort Wayne	ALLEN	46805	(260) 447-8982
Isaiah	Cruz	NP	3005 East State Boulevard	Fort Wayne	ALLEN	46805	(260) 267-9472
Omotayo	Fawibe		3005 East State Boulevard	Fort Wayne	ALLEN	46805	(413) 341-1787
Mark	Fisher	PA	2512 E Dupont Road Suite 200	Fort Wayne	ALLEN	46825	(260) 748-3650
Mario	Gomez	M.D.	2040 South Calhoun Street	Fort Wayne	ALLEN	46802	(260) 444-5695
Sitha	Kalapatapu	M.D.	St Joseph Medical Group, Inc.700 Broadway	Fort Wayne	ALLEN	46802	(260) 489-6030
Larry	Lambertson	M.D.	1909 Carew Street	Fort Wayne	ALLEN	46805	(260) 481-2700

Candace	Lemke	NP	2100 Goshen Road	Fort Wayne	ALLEN	46808	(260) 229-0883
Joseph	Long	M.D.	3005 East State Boulevard	Fort Wayne	ALLEN	46805	(574) 250-0945
Connie	Lubbehusen	PA	3005 East State Blvd	Fort Wayne	ALLEN	46805	(260) 267-9472
Connie	Lubbehusen	PA	3005 East State Blvd	Fort Wayne	ALLEN	46805	(260) 267-9498
Stephen	Lugo	MD	11123 Parkview Plaza Drive Suite 101	Fort Wayne	ALLEN	46845	(260) 425-6650
Don	Marshall	Jr., M.D.	1909 Carew Street	Fort Wayne	ALLEN	46805	(260) 481-2800x2
Don	Marshall	Jr., M.D.	3010 East State Boulevard	Fort Wayne	ALLEN	46805	(260) 471-0632
Don	Marshall	Jr., M.D.	5010 Southwood Avenue	Fort Wayne	ALLEN	46807	(260) 456-7266
Dorinda	Mosbrucker	NP	2512 East Dupont Road Suite 200	Fort Wayne	ALLEN	46825	(260) 748-3650
George	Moussally	NP	700 Broadway 6435 W. Jefferson Blvd, PMB109	Fort Wayne	ALLEN	46804	(602) 316-5944
Kevin	Murphy	MD	1720 Beacon Street	Fort Wayne	ALLEN	46805	(260) 373-8000
Bonnie	Pearson	NP	1909 Carew street	Fort Wayne	ALLEN	46805	(260) 481-2800
Kimra	Reed	NP	3005 E. State Boulevard	Fort Wayne	ALLEN	46805	(260) 267-9498
Andrew	Roberts	M.D.	6017 Stoney Creek Dr	Fort Wayne	ALLEN	46825	(260) 267-5159
Daniel	Roth	D.O.	2512 E Dupont Road Suite 200	Fort Wayne	ALLEN	46825	(260) 748-3650
Ruben	Singh	M.D.	Park Center Inc 909 East State Boulevard	Fort Wayne	ALLEN	46805	(732) 567-1330
Thomas	Straub	PA	2512 East Dupont Road Suite 200	Fort Wayne	ALLEN	46825	(260) 748-3650
Mahender	Surakanti	M .D.	800 Broadway Suite 208	Fort Wayne	ALLEN	46802	(260) 425-3204
Stephanie	Trice	NP	770 E. Dupont Road	Fort Wayne	ALLEN	46825	(866) 389-2727
Sarah	Turner	M.D.	2622 Lake Avenue	Fort Wayne	ALLEN	46805	(260) 425-3100
Thomas	Van Den Driessche	M.D.	3030 Lake Avenue Suite 32	Fort Wayne	ALLEN	46805	(260) 424-3134
Vijoy	Varma	M.D.	VA Northern Indiana Health Care System 2121 Lake Avenue	Fort Wayne	ALLEN	46805-5100	(260) 426-5431

## 11 INFORMATIONAL RESOURCES

With the scale of the opioid crisis in America, the amount of information publicly available can feel overwhelming. Below are some links to material that CRI reviewed during this process that has value to the general public, presented in no particular order.

[Treatment Improvement Protocol 63: Medications for Opioid Use Disorder](#) (SAMHSA, 2018): Free download designed for mental health and medical professionals but can be understood by informed lay readers. Goes far beyond MAT protocols to include many screening and diagnostic tools.

[Evidence-Based Practices Resource Center](#) (SAMHSA, 2018): Website provides links to materials and publications for clinicians, policy makers and the community for evidence-based practices related to opioids, OUD, substance use prevention, substance use treatment and recovery, and serious mental illness.

[Annual Surveillance Report of Drug-Related Risk and Outcomes](#) (Centers for Disease Control and Prevention, 2017): The first-of-its-kind report looking at opioid prescribing, drug use/misuse and SUD, nonfatal drug poisonings, drug poisoning mortality and CDC surveillance and prevention efforts.

[President's Commission on Combating Drug Addiction and the Opioid Crisis Final Report](#) (Office of the President, 2017): Summary of the commission chaired by Gov. Chris Christie, looking at federal funding, prevention, reimbursement for non-opioid pain treatments, and reduction of illicit opioid supply.

[President's Initiative to Stop Opioids Abuse and Reduce Drug Supply and Demand](#) (Office of the President, 2018): Issued after the subcommittees met and before the final FATOS meeting, this is presented without review and evaluation.

[The Opioid Epidemic: From Evidence to Impact](#) (Johns Hopkins Bloomberg School of Public Health, 2017): Looks at improving the safe use of prescription opioids and treatment of people with OUD.

[Un-burying the Lead: Public health tools are the key to beating the opioid epidemic](#) (Center for Health Policy at Brookings, 2018): Recommends furthering the final recommendations from the President's Commission on Combatting Drug Addiction and the Opioid Crisis that was released in November 2017.

[County Profiles of Opioid Use and Related Outcomes](#) (Indiana State Department of Health, 2017): Looks at statewide and county-level data from 2011 to 2015 on a range of medical data tied to improper opioid use including deaths, soft-tissue infections, infectious disease rates and endocarditis rates.

[The ASAM National Practice Guideline For the Use of Medications in the Treatment of Addiction Involving Opioid Use](#) (American Society of Addiction Medication, 2015): Designed for clinicians, this detailed guide explains medication-assisted treatment with considerations for special populations including pregnant women, adolescents, individuals in the criminal justice system, individuals with psychiatric disorders.

[Shatterproof's National Principles of Care](#) (Shatterproof, 2017): Shatterproof is a non-profit organization advocating for better care for people with substance use disorder. Their Substance Use Disorder Treatment Task Force created this model as a standard of care, which has been adopted by at least 16 insurers.