Orange County Heroin Task Force
Draft Meeting Minutes
October 14, 2015 1pm – 3pm

Welcome Comments: Major Jacobs and Sheriff Demings provided opening remarks to begin the meeting at 1pm. Mayor Jacobs thanked everyone for attending the third meeting of the Orange County Heroin Task Force. I continue to be impressed with the amount of work and collaboration at the subcommittee meetings where so much of the work is being done. I would encourage the task force members that if you are not part of a subcommittee to please consider joining one. We have a full agenda today so I would like to call on Ms. Burkett for the Task Force Roll Call and the Sheriff for welcome comments.

Task Force Roll Call: Carol Burkett provided the roll call with the following Task Force members in attendance:

- Honorable Teresa Jacobs, Orange County Mayor & Co-Chair
- Honorable Jerry L. Demings, Orange County Sheriff & Co-Chair
- Honorable Fred Lauten, Chief Judge, Ninth Judicial Circuit
- Honorable Jeff Ashton, State Attorney, Ninth Judicial Circuit
- Dr. Ademola Adewale, Florida Hospital
- Danny Banks, Special Agent in Charge, FDLE, Orlando Region
- Joe Cocchiarella, Interim Director, MBI
- Dr. Michael Deichen, UCF Health Services
- Dr. Maribeth Ehasz, UCF Vice President, Student Development and Enrollment Services
- Dr. Jeff Goltz, Vice President, Valencia College School of Public Safety.
- Dr. Douglas Hardy, Clinical Director, NICU, Winnie Palmer Hospital
- Bryan Holmes, OCPS Protective Services Department (representing Dr. Barbara Jenkins, Superintendent)
- Chief Brett Meade, UCF Police Department
- Deputy Chief Rob Pigman, Orlando Police Department (representing Chief John Mina)
- Dr. George Ralls, Deputy County Administrator, Orange County Public Health & Safety
- Chief Cornita Riley, Orange County Corrections
- Director Phil Scarpelli, DCF Substance Abuse & Mental Health
- Dr. Kevin Sherin, Department of Health for Orange County
- Dr. Joshua Stephany, Interim Medical Examiner, District Nine
- Dr. Josef Thundiyil, Orlando Health Emergency Medicine

The Sheriff mentioned that we continue to see several overdoses each day that EMS is responding to. Most cases we believe are related to Heroin overdoses. All across Florida we are seeing an uptick in heroin cases. We applied for a federal grant to combat heroin abuse and use but we did not receive the funding. The limited dollars available went to the northeastern states that are experiencing a heroin epidemic like Maine and Vermont. I believe the work of this task force is going to prove very beneficial to the citizens of Orange County.

Approval of Minutes: A motion was made by Chief Judge Lauten to approve the minutes and a second by Sheriff Demings. Minutes approved by all Task Force members.

Special Remarks: Mayor Jacobs introduced Mr. David Siegel who is providing great awareness regarding this issue and his advocacy for naloxone. I know you brought a special guest with you today for introductions. Mr. Sieigel said his first mission is to have random drug testing in all middle and high schools and colleges and my second mission is to make naloxone a household word. On October 4th, I was in Washington, D.C. with the Facing Addiction Rally. We had thousands of people in the Washington Mall and numerous speakers (Steven Tyler, Sheryl Crowe, and Congressman Patrick Kennedy) in the fight against drug addiction. I met a lady who spoke about her daughter and explained how she came home one night and her daughter was tired and went to sleep. The mother called 911 when she couldn't wake her up and she died from an overdose. Mr. Siegel introduced his guest speaker, Heather Thomson, Associate Director of Medical Science with Kaleo Pharmaceuticals.

Presentation: Life Threatening Opioid-Induced Respiratory Depression and Overdose: Addressing an Unmet Medical Need: Presentation Agenda: 1) Epidemiology of life-threatening opioid-induced respiratory depression and overdose; 2) the SAMHSA toolkit identifies at-risk patient populations; 3) Early intervention is crucial, and 4) Naloxone and Evzio auto injector.

- Death rate by all drug poisoning is now greater than vehicular collisions in the US
- Discussed the rise in abuse of prescription opioids and heroin from 2004-2013
- Discussed opioid induced respiratory depression
- At-risk populations identified by SAMHSA – taking high doses of opioids; receiving rotating opioid medication regimen; discharged from emergency medical care following opioid intoxication or poisoning; at high-risk for overdose because of legitimate medical need for analgesia coupled with a suspected or confirmed history of substance abuse; completing mandatory opioid detoxification or abstinence programs; recently released from incarceration and a past user for abuse of opioids.
- Four populations at-risk for life threatening OIRD and Overdose – medical use of prescription opioids, non-medical use of prescription opioids, non-medical use of prescription opioids by third-party and heroin users
- Risk Mitigation Strategies- HCP Development Tools, Counseling, Identifying Patients At-risk, Identifying Misuse During Treatment, National DEA Take Back Days
- Additional Considerations
- Reviewed Signs of Opioid Overdose
- Immediate Intervention is Critical with Life-Threatening OIRD
- Addressing the Unmet Need – Existing Constraints (naloxone was developed for medically supervised settings, glass vial syringe systems were built for medical professionals, vial/syringe needle requires training on proper aseptic and manual administration technique
- Meeting the Unmet Need – Develop a product that can handle the demands of a non-medical/community setting, maximum ease of use for bystander administration; minimize training and expertise required for proper use in stressful situations by bystanders.
- Naloxone expanded access is recommended
- Evzio Auto-Injector – only FDA approved naloxone for emergency therapy in settings where opioids may be present including the home.
    - Take-home auto-injector with visual and voice instructions to make it easy to use by family members and caregivers with little or no training
    - Proven injectable route of administration and user never sees needle before, during or after auto-injection.

- Evzio is an opioid antagonist indicated for the emergency treatment or known or suspected opioid overdose as manifest by respiratory and/or central nervous system depressions. Evzio is intended for immediate administration as emergency therapy in settings where opioids may be present
- Evzio is not a substitute for emergency medical care.
    - Questions – Mayor Jacobs asked if naloxone was good for any opiate for any kind of patient. Naloxone is used for opioid dependence and alcohol dependence.
    - What is the price for the auto-injector and is it covered by insurance. Commercial insurance requires a co-pay of $17 average; we have also donated product to law enforcement and provided special pricing for educational institutions.
    - Chief Meade asked about the shelf life for police to carry naloxone. She indicated there are multiple formulations of naloxone to include nasal which requires a controlled temperature.
    - Dr. Ralls - Is there a self-pay cost if someone who has no insurance? Without knowing exactly what it is it's probably hundreds of dollars but it's like an epi-Pen (very comparable pricing).
    - Dr. Ehasz – Can you provide examples of higher educational institutions that are utilizing it for first responders and teachers. We are having conversations with different entities with group homes, educational institutions, infirmary, a couple with security, a couple for the dorm and everyone is looking at the best model for their population.
    - Chief Meade - Is there a way to determine naloxone is still good. We are considering the product for officers to carry and we have a humid environment. What is the shelf life? There are multiple formulations of naloxone and build it yourself nasal kits in a controlled temperature. The naloxone in the auto-injector was built for a wide array of temperatures. The shelf life on these is 2 years.
    - Sheriff Demings - You indicated the opioid induced depressed state is four minutes - is that the average or the maximum amount of time. Heather - when the brain is without oxygen you will gradually start to lose brain cells. The most important cells you lose are memory & executive function in the cerebral cortex. The good news is that when someone is suffering from an overdose and doesn't breathe fine and then stops; it's a gradual slide which is about an hour. So the window for response time may be a little broader. Sheriff - part of my concern is an abuser who uses this as a security blanket. The risk factors are still pretty high, if the person uses, this is not a safety measure for them. We see on a daily basis from Fire personnel with a number of saves but frankly, many of the cases the person does not survive. We have to balance all of that when we have this conversation. Heather - The encouraging part, the harm reduction community has tried to collect as much data as possible. It turns out that when someone is saved from naloxone, they tend to seek treatment and abuse less frequently. Whether it helps get them into the healthcare system we need more studies and data collection.
    - Judge Lauten: If response time is critical, Mr. Siegel has raised this a little bit. We would like first responders and law enforcement to have it but we need the user to have it. By the time there's a call and response it may be too late. Heather - We are finding very rapid uptake with take-home naloxone. Even the ones in treatment know they are at risk. Overwhelming

majority of overdoses is witnessed and there is someone there to summon help.

Subcommittee Updates:

Danny Banks, Special Agent In Charge, FDLE & Co-Chair of the Law Enforcement Subcommittee provided the update: We had a second meeting last week with great attendance and we accomplished a lot of things. We have five stated objectives and we have seen exceptional activity among all partners on joint details. The State Attorney's Office was at our meeting and we reviewed a lot of the arrests which were possession or sale and delivery (low level arrests). Orange County Corrections put these numbers together and in 2014, we saw the highest number of heroin-related arrests (676) since we began measuring the issue. This year, we are already at 683 which re-emphasizes our problem and that law enforcement is also doing a great job of making arrests. The committee talked about working with the courts and what we as law enforcement can do so we don't have to re-arrest someone. The Law Enforcement Subcommittee is working with Education and Prevention Subcommittee to look for opportunities to decrease the repeat offenders. We had a lot of discussion and I commend Orange County Corrections and Linda Brooks that talked about sentencing and drug probation and parole. We talked about some of the programs that do work and we want to work with our partners to ensure that we look for sentencing or court mandated programs that will help these individuals not be repeat offenders. We are very enthusiastic about this approach as we go into the Subcommittee Co-Chairs meeting. We are planning a seminar scheduled in January which is a multi-pronged cooperative effort with the Education and Prevention Subcommittee. The event will be held at the Valencia College School of Public Safety and the seminar is titled "From the Poppy Plant to Recovery." I would like to give credit to the Sheriff's Office and Orlando Police Department for spearheading that opportunity. The cooperative effort we have in Orange County is not consistent everywhere across our state. The value of this task force and the Law Enforcement Subcommittee is that we have municipal, state and federal entities all sitting together talking about enforcement actions. When you add to that the presence of the state attorney and corrections, we see a lot of value that we can bring to this task force as we look for solutions.

Dr. Maribeth Ehasz, Vice President, UCF Student Development and Enrollment Services & Co-Chair of the Education and Prevention Subcommittee provided the update: We had our second meeting and it was an excellent discussion. We have very committed members from agencies, education and law enforcement at the table. We are all working together to understand what is out currently out there and how we can make it easier for the public and parents to get help. We have broken down our subcommittee into sub-workgroups. The first is Social Media/Marketing – we have two launches to use social media and outreach efforts working with education and curriculum workgroup on a couple of themes. The first launch is to address the family, friends and current users and to simply the information on the signs and symptoms and how to reach out for support. We have worked with student groups at all levels on this effort. We have a working title "Being a Hero" Everyone Can Be A Hero by Calling 911. The second sub-workgroup is Education and Curriculum and I see Sharon Warner in the audience. She and her group, who is trying to synthesize the information, see what's available and bringing together in a simplified form. One the recommendation is one website that will include videos, social media, informational downloads, etc. The two sub-workgroups met additionally because there is some much overlap with their tasks so they met again and we should have something to show very soon. The Adult Training sub-workgroup; you've heard from the Law

Enforcement Subcommittee and this should be an excellent opportunity for law enforcement as well as other partners to work together on this issue. The fourth sub-workgroup is the Community Education Plan with the charge to bring everything we're learning into one comprehensive document and one comprehensive plan and reach out to neighborhood organizations, PTA's, Rotary and civic organizations, and faith-based groups to really spread the message. We already have information developed - long and short versions of presentations and the group is also talking about a Speakers Bureau. It's not enough to know there's information out there but for others to obtain the information. The fifth sub-workgroup is Collegiate Recovery Group for colleges to provide support for students after they've been through recovery. They are contacting other institutions across the country such as Texas Tech, University of Texas at Austin, Alabama, University of Florida, and Ohio State to see what they are doing and best practices. We have a recovery program at UCF that we are starting and opening very soon. We will have a special area for students to be together and we will have more information from that group.

Mayor Jacobs: Can you tell me the number of municipalities that are participating in the Law Enforcement Subcommittee Discussion. Director Banks indicated that we had increased attendance at the last meeting with the Chief of Ocoee attending and many others agencies. The Mayor asked if Carol was sending the notice out to all law enforcement agencies so they have the opportunity to participate. Carol indicated that she was.

Dr. Kevin Sherin, Director of the Health Department for Orange County and Co-Chair of the Healthcare Subcommittee provided the update. We had a second meeting last week and went over some of objectives in great depth about data, Naloxone distribution and education and training aspects that concern the healthcare community. We talked about data that will led to outcome tracking; we would look at emergency departments, hospitals, NAS, medical examiner's data, treatment systems data and coordinate with law enforcement on their arrests data, jail data which we have quite an intake system there, and we would like to look at utilization of Naloxone and methadone from our pharmacies. The health department would not require the data because it's not a reportable event; this would be voluntary on opioid and heroin overdoses, but we would like to look at more than deaths. We would like to see treatment referral data; we need to see improvements in this area. We continue to look at our EMS system with Naloxone but we are not looking at law enforcement to carry naloxone because of our robust system. We do want to implement the new emergency responder act as it pertains to caregivers and families. Most of the overdoses we see occur in the home so it would be nice to have a take-home kit. In the university setting, we would discuss having it available through the RA's; it would look like a caregiver similar to an epi-pen. We looked at some of the issues in Rhode Island and developing a collaborative agreement with Walgreens pharmacy like many other states are doing which would make the product over the counter without a prescription. We are looking at the Florida Statute and working with the Florida Board of Pharmacy to see if the collaborative agreement is possible. The naloxone kits could be considered price gauging, how we make it available to those that don't have insurance. Our goal is to have Naloxone viewed as the epi-pen for this disease. Distribution of Naloxone at the ED, jail and treatment facilities where's there is a handoff for the caregiver and family member. We are looking at the logistics to make this happen and how to write the prescription. Education and training – we have a lot of individuals that need to be trained to consist of nurses, residency training programs for physicians, EMS training needs with certain nuisances, pharmacy training needs and practicing physicians (approximately 2,000) Florida College of

Emergency Physicians has a mobile training unit with capability to develop the training needs via webinar. We will work with American Academy of Pediatrics and Family Physicians and all primary care providers so they know how to deal with it in their practices. Community education needs for families. We talked about other training needs such as nurses in the high school level need to have a level of awareness about signs and symptoms but also trained in SBIRT as well. Education on opioid and pain practices are needed. Website link for national guidelines which are due out in January is http://m.enterprisenews.com/article/20151006/NEWS/151007508/SHARED/st_refDomain=t.co&st_refQuery=/v6bqAxpFpd

Prescription Drug management system, which is E-FORSCE in Florida. It would be helpful if someone can assist the physician in busy practices so the information can be utilized. We talked about best practices in some other states such as Washington State and Massachusetts which have reduced overdoses with Naloxone. There's also a Good Samaritan that predates this. Florida law is robust in protecting people doing the right thing in an overdose situation. We also heard about the pilot program with Florida Hospital in Altamonte and Aspire which arranges for referral to the treatment system. We need to develop data systems, training systems and systems of care for these individuals. I also have links on from waivers systems to get access to these medications. Finally we touched on primary care prevention programs with community wide campaigns. There was a primary prevention campaign with peers years ago and kids going away on lock-ins on these anti-drug messages. We are front and center with the heroin epidemic and let's deal with this head on.

Best Practices for PDMP
http://pdmpexcellence.org/sites/all/pdfs/COE_BriefinOnBestPractices_final_april_2012.pdf
Buprenorphine waiver:
http://www.samhsa/gov/medication-assisted-treatment/buprenorphine-waiver-management
http://www.needymeds.org/drug_list.taf?
http://buprenorphine.samhsa.gove/SAMHSA_reports.html
https://www.naabt.org/buprenorphine-cost.cfm
http://www.naabt.org/newsletter/jun2011

Director Phil Scarpelli, Department of Children and Families, Substance Abuse and Mental Health Administration and Co-Chair of the Treatment Subcommittee provided the update. We've heard a common and resounding theme about education and awareness. We honed in on a lot of discussion and we've got to figure out a way and means for repository for treatment services for citizens. Why reinvent the wheel but engage our 211 partners that provide that existing service. Much of the community knows the vast array of services that are provided. We want to talk about dialogue for those family members who engage 211 for services. We want to assist them on any training needs, possibly a script that would help navigate and give prescriptive guidance for resources. Along with community awareness and education, the issues on medication-assisted treatment are very much unknown. We need to continue our practices on community education and awareness but not vetted through 211 but more of a grass roots level. The issue on expanding the knowledge base on Vivitrol and Naloxone was stated by previous committee updates as well. The fact that the availability and the knowledge of efficiencies and prescriptive nature in the medical community needs much more knowledge and infusion in the community. I think the sum total of the task force efforts on education and

awareness not only to consumers but family members and the extended community is the path that needs to be taken and we will report on our engagement with 211.

Mayor – one commonality is communication and think as we move forward let's think Carol how we have one cohesive way to communicate this information.

Presentation: Naloxone "The Law and Promising Practices"
Mayor Jacobs introduced Dr. Josef Thundiyil, Orlando Health Medical Toxicologist and Emergency Medicine who provided the presentation on "Naloxone – The Law and Promising Practices."
In listening to the subcommittees and one of the important discussions is Naloxone which plays a vital role in reducing overdoses. Many of these practices have not been around very long so we are identifying promising practices and each one is unique to that community. Brief history – naloxone has been around for 40-50 years. In fact, the World Health Organization listed it as an essential medicine because it works very well. If you've seen it given to someone, it's amazing to see them revived. Naloxone is called Narcan which is trade and generic name. The drug wears off within an hour so it's important that they seek medical attention in emergency department because they may go into respiratory arrest. Narcan is not a controlled substance and it has not abuse potential. The only risk is those addicted to opiates; the withdrawal can be uncomfortable. It requires little to no training with the Evizo device and all EMS units carry Naloxone in Orange County. If you look at CDC reports, it has shown about 644 Naloxone programs exist in US and have saved about 26,000 lives from 1996 to 2014. Traditionally, we give it through IM injection but I think for the lay public it's hard to imagine giving a shot. But the Evizo device, you do not see the needle and it talks to you. There's another device that gives it intranasal like an allergy medicine.

I want to acknowledge this concern about our EMS personnel trained to use naloxone and whether it's available. We have an incredible EMS system and I interface with them every day in my work as an emergency physician. We have 2100 EMS personnel and we cover 1.3 million in population with 120,000 hospital transports a year. Every single unit carries narcan and they are trained on how to use it. To put that in perspective to a city like Boston, similar population they have about 200 EMS units, so even though we have a bigger area we have a lot more units that allow us quick access. You can see from the graph that our EMS personnel use the drug annually 1200-1500 times a year. Not all of those administrations are for heroin overdoses but many are for people that are confused or altered. Here's a graph on narcan usage based on zip codes.

Let's talk about limitations – public safety have the drug and are trained to use, healthcare providers know how to use the drug especially in acute care, but what about the 3-5 minutes someone has where they may develop a brain injury. Getting it in the hands of the general public and in schools, people like family, friends or bystanders. Some of the obstacles are the legal repercussions. People wonder will I get in trouble not just laypeople but prescribers. What if I administer naloxone and someone has a bad outcome – what are the criminal or civil liabilities. From a prescriber standpoint, I want to prescribe to a heroin user but the person may be unconscious so the family member or friend will need to give it to the user but the family member needs the prescription. As a prescriber, can I prescribe to a third party and what the limitations are? We looked around the country and what laws exist and how we fit into this. You will see about 10 maps in a row. This first map is a good introductory map which shows Naloxone access and Good Samaritan access. We

are one of 37 states that have Naloxone that can be prescribed which passed this year. Next slide, we are one of 24 states where prescribers have immunity from criminal liability and 24 states where prescribers are immune from civil liability. Additionally, we are one state that can prescribe to a third party prescriber. Dr. Sherin mentioned that we could give it to members in a school system or an RA in a dorm. This allows us to bypass it such as family member, friend or close associate. The next map shows that we do not have a standing order for Naloxone. In certain states, people can go to a pharmacy and they've had it prescribed before and they can go get it at any point. Additionally, laypeople are not entirely immune from criminally liability, although they are immune from civil liability. There are several opportunities we have with third party prescribing but there are a few areas that are limited that we may make a legislative push for.

Opportunities for Naloxone: Some of the promising practices - several studies have suggested people released from the ER, Jail and Treatment Centers are at very high-risk for overdose deaths. In the initial 30 days, there risks are 10 to 100 times higher and some of that is due to their loss of tolerance. We will go through examples of four cities and states and the practices they've employed. Rhode Island assembled a consortium of emergency physicians, health department and treatment providers and began identifying high-risk patients and discharging them with a Naloxone rescue kit. The patient watched a video on how to administer it. In addition, when a recovery coach was available they would follow-up with patient to gain entry in a rehab program. Funding for coaches came from the Rhode Island State Department of Behavioral Healthcare. A couple of keys steps - need to have funding for Naloxone kits and stakeholders from the community must be involved. I bring this up because we already have something in place in which some hospitals as a pilot program such as Florida Hospital and the nurse navigator program. We are identifying people at high-risk for referral and get them into treatment. When we look at Baltimore Maryland which is considered the epi-center for heroin, it's estimated in some places that one in ten residents are actively using heroin. If we look at their deaths, they reached over 100 deaths in the first quarter compared to the 90 deaths we've seen for the year. People in Baltimore who sought care recently came from jails and hospitals. So they started training inmates at detention centers and prescribing and dispensing naloxone from that position. They also went in to the community to high risk areas and are actively prescribing and teaching people how to use narcan. The City of Baltimore also starting using the Evizo injector which Ms. Thomson spoke to us about. We looked at the prices for these devices which cost as much as $575, but as Heather pointed out there are other ways to get this covered through insurance and co-pays. Kaleo Pharma donated over 3,000 Evizo kits to Baltimore to get them stated in the community.

Another example is Durham County Detention Center – first county detention center in the south to distribute naloxone kits to those released from jail that are high-risk. Surveys from the Naloxone training and education inside the jail indicated that one in ten had been a victim of an overdose, about 1/3 witnessed an overdose and ¾ after this training wanted narcan and felt comfortable using narcan. The fourth county or actually this is throughout the state of California, the Tarzana Treatment Centers took a different approach and they started distributing narcan when exiting rehab. But as you can imagine this is very controversial; what message are we giving people. They really looked at it from a very practical standpoint. Addiction is part of a continuum and there is also risk of relapse which is highly associated with death. Abstinence for each and every person is the goal but harm reduction is a very key component.

Dr. Sherin mentioned the National Association of School Nurses which issued a position statement in which they believe narcan should be part of an emergency plan and they should facilitate access and referral to families at risk of addiction. Here are some other cites and cities that have started programs.

Expanding Access to Pharmacies: This is an area that looks very promising. Walgreens and CVS have collaborative agreements in 12 other states where there are able to distribute narcan directly to a patient which takes out the person going to a physician to get the prescription. Carol contacted the Florida Board of Pharmacy to discuss this and currently we do not have a collaborative agreement and possibly Florida law will not allow us to do it. This is not a controlled substance but it does require a prescription. I agree with Mr. Siegel and his shared vision that every single household should have narcan in their medicine cabinet. Currently, there's not a push to make this over-the-counter, however using this model like other states it would bypass having to obtain a prescription. In our committee, we talked about free distribution to high-risk groups to such as the jail, ER, and treatment centers. Part of this requires ongoing education from public safety and family and friends. The data indicates that over half of the deaths are occurring in the home and place of residence. We need to reach the family members and friends and educate them how to use it. In our committee, we talked about a webinar or community education forums on how to use narcan for family and friends. Then the other promising area that I have not seen other counties use is a bridging therapy. There's a drug out there called Naltrexone which is a sister drug to Naloxone. The drug is known as Vivitrol and it stays in the persons system for 28 days. This is promising because the risk of overdose is the highest in first 30 days, not just loss of tolerance but people getting back on their feet. The downside is the injection costs about $1,200. In 2014, FADAA starting to provide several million dollars in grant money to the Department of Children and Families and Department of Corrections to help reimburse providers selected to provide the treatment and injection of Vivitrol. As I conclude here, we have to remember addiction and use of heroin is part of a continuum. We are looking at it in three separate groups, those that don't use or have begun to use, those in the throes of addiction and those that are using and want to quit. Non-users - we need prevention through education; Users – we need to educate their family and friends about narcan; and Users Ready to Quit – we need to make sure there's a helping hand to help them quit.

In conclusion, Naloxone is a life saving antidote and critical to reducing mortality and its important for us to discuss widen access and availability. The other warning, Naloxone is not a panacea, it's important to reduce mortality but as a community if our only goal is to reduce mortality then I don't think we are doing a purely successful job. We have to look at other issues such as prevention, education and rehabilitation in the process.

Mayor commented: thank you for the closing comments, while our focus at this meeting is on naloxone this is only a portion of what were talking about. It's a relatively small portion but crucial part of it but if we can't keep them alive then we can't help them break the addiction cycle. If the prevention isn't there and the treatment isn't there then we are not doing our jobs.

Joe Cocchiarella -Law Enforcement Subcommittee we talked about how we come into contact with addicts that are ready for rehab and treatment. We've heard about the number of beds that are available in the community as low as 32-40. I would be interested in

hearing more information about the availability. Naloxone can help us save mortality but rehabilitation saves lives and their future.

Mayor asked about the number of beds available. Director Scarpelli – we don't count for the sum total of bed availability because the funding goes to the uninsured. The providers that we contract with are challenged with bed availability. We do need to look at sum total and what matches the demand. We need to look at what's the capacity and what's the demand. We've heard pretty low estimates, only a few dozen for all of Central Florida.

Dr. Ralls – It may be helpful for the next agenda to move the focus in that direction. The treatment part is where we are going to struggle. Director Scarpelli – can you look at the capacity issue for the next subcommittee.

Sheriff – I look at all of those incidents reported to law enforcement. On a daily basis, the majority we respond to are incidents where individuals are located in the bathrooms of local fast food restaurants; we had one individual on the side of the road with the needle still in his arm. We also find people in cars at traffic lights slumped over and we are finding them in their homes. Looking at this on a daily basis, what we are responding is finding them in the public behind the convenience stores, as we need to make Naloxone available in the community. It's these places where individuals are dialing 911 because we have such a short response time (4 minutes) even those places I named, convenience stores, restaurants their personnel are finding these individuals, time is of the essence and this has to be a part of the dialogue. I'm sure our subcommittee will talk more about this.

Mayor – We may need a legislative fix and then the reality is the cost of having it available everywhere. We need statistics behind where we are encountering people overdosing that would help us. We know whose coming through our jails but we need to have a better idea of where the overdoses are taking place. Carol mentioned that Deputy Murray, OCSO mentioned retailers as a part of the education plan that we need to reach out to.

Public Comment: Mr. Siegel – I'm so happy you're talking about Naloxone because you will be saving thousands of lives. It comes in a shot or spray. The spray is only 70% effective because you could have a blockage in your nose. The shot is 100% effective. When a doctor gives a prescription for an opioid he should also give you a prescription for Naloxone. This opens up a conversation to talk about how addictive pain medication can be. Naloxone should be in every medicine cabinet and every restaurant, bar and every addict should carry one in their pocket. One of my goals is go to the Florida Medical Board and have them direct doctors on this practice; maybe the doctors on the panel would be better to go to the Florida Medical Board and ask them to give a prescription for Naloxone when the give a controlled pain medication. The price will drop once it becomes a household name and in every medicine cabinet especially if it becomes an over-the-counter product. I'm sure communities like ours can get with Kaleo on free Naloxone and discounted pricing for our community.

Mr. Jose Colon – I'm so proud we have this task force and what I want to say comes from the streets. Heroin is the worst thing that can happen; I come from Puerto Rico and I've seen friends dying because of this drug. When God put us together he sees his own people crying. In certain areas we have the problem, combinations of Cocaine and Heroin together and how do we treat those. I go to those places so I can tell you what I see. 75% does not know what Naloxone is and they can't afford it. I didn't event know Naloxone existed. Let's

talk about how doctors prescribe pills and end up in the drug dealer's hand. These people will kill you if you try to stop a million dollar business. We take it to the lower level and get input from the street. We don't need the epidemic here in Orange County; we can do this together but we need more street knowledge with health officials not law enforcement that can talk to them about Naloxone. We have a lot of heroin going from Semoran to homeless camps.

Mayor asked Jose Colon – how did you hear about the meeting today. I was in my office and I heard about the meeting on the news. I was feeding a homeless camp and I saw the heroin usage jump on a segment. To see how it came from kids for them it's easier to use pills and then they abuse the prescriptions which are killing are youth.

Mayor spoke about the homeless initiative, that as we communicate about this issue we are not going to be reaching them so that's an important message to take away. Dr. Sherin – we do need outreach on the intel Mr. Colon provided. We have people that work in the community that get to those folks with outreach. The issue of the Puerto Rican community, we need to make sure we are using the right outlets.

Jo-Anne Stone - I have my own private practice and I operate several half-way houses and I'm also a person in long-term recovery for the past 21 years. If you are looking for someone to help you with these issues, I'm willing to help. I had gentlemen in my half-way house six months ago they found him with a needle in his arm. If we had narcan, we could have saved his life. There's a lot of shame with addiction; I'm proud of who I am and I've worked hard for it. Question - Did you not have narcan in your facility because you were not aware of it? I had heard about it but I didn't know how to get it; I wasn't informed. You would not have been able to receive it six months ago because it was recently approved by the legislature. But we have no mechanism in place to let you know how you can obtain it. We also received a sample kit like the one you have at the Facing Addiction Rally. The other thing we need to remind everyone, if you're an addict it's not about pride but fear from law enforcement if you're asking for it.

Judge Lauten – now you can get this drug, so is it about affordability or getting the prescription. I would be the one to get the prescription. Will they give it to me in my name and can I use my insurance? Does anyone have an answer to that question? Dr. Ralls commented that the prescription can be written to the third-party but insurance is a different story. Mayor - Education is critically important on this issue because if we don't have all the answers then the community will not have the answers.

Karen Sessions – I commend the Mayor for convening this Task Force. One of the cities in Sarasota County recently adopted their law enforcement to carry Naloxone. What needs to be put in place for our law enforcement to carry the drug? We do have an efficient EMS response but minutes are critical in this regard. As the task force gives recommendations, in co-prescriptions this is a state issue and this also affects the elderly with opioid abuse with pain management. If we do have a recommendation with the state licensing board that physicians take up. At out last meeting, as we talked about where the different police departments and Sheriff is providing narcan to all officers. I know UCF PD is moving forward but there was some reservation about whether it was a cost effective means with the quick response by EMS. I would like more stats to see if EMS is not responding because you're finding them in distress before EMS arrives. Sheriff - every example that I mentioned, EMS was there before we arrived; all of these were EMS calls.

Perspective of medicine cabinets, UCF takes the leading role and we look at what works for Orange County.

Allison Walsh – Advanced Recovery System – very disappointed that we lost the grant. Any additional information as a community that we can assist in fundraising that can roll out additional programs. Sheriff – we are going to be vigilant to look for additional grant opportunities, there was limited funding from the Federal government provided at that time and Florida is new to this issue compared to states up north. That does mean in the future that we will not be successful in obtaining additional grant dollars. There will be recommendations that will come from the subcommittees and whether or not local law enforcement will carry narcan or not is being discussed now in the committees. Dr. Thundiyil alluded to a number of issues relating to cost factors and does it make sense for us to do that here because of our EMS system. In many locations across the country there are unique reasons as to why they are doing it; this is still under review. Allison - when we look at other initiatives, education and awareness and all of that costs money, you need to know that you have a dedicated community behind you. The lack of beds is always a concern and an issue. For those that need assistance they are few and far between. We are opening 93 beds in the next couple of weeks as well as 60 beds of sober housing but that's not enough. Central Florida needs more resources. I didn't hear reference this time regarding discussions with the Police Department in Massachusetts. They gather donated scholarship beds around the community and when people come into their police department they connect them with treatment. Chief Rob Pigman - I know Chief Mina spoke to the Chief in Gloucester and they are doing great things. They are a smaller community but I don't know the result as far as moving forward but I know the Chief is looking at those ideas.

Announcements & Closing Comments: Carol provided a brief update on the recent DEA Take Back Day. This is an opportunity to thank law enforcement for their great work regarding Take Back Day when they collected over 1800 pounds of unwanted and unused medications in four hours on September 26th. The Mayor announced the next meeting will be held on November 11th at 9am.