CATTARAUGUS COUNTY
BOARD OF HEALTH

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Public Health
Prevent. Promote. Protect.
Cattaraugus County
Health Department
Established 1923

MINUTES
July 5, 2017

The 857th meeting of the Cattaraugus County Board of Health was held at The Point Restaurant, 800 East State Street, Olean, New York on July 5, 2017.

The following members were present:

Dr. Joseph Bohan	Theresa Raftis
Dr. Zahid Chohan	James Snyder
Sondra Fox, RN	Kathryn Cooney Thrush, BSN, NP
Richard Haberer	

Also present were:
Kevin D. Watkins, MD, MPH, Public Health Director
Eric Firkel, County Attorney
Robert Neal, Legislator
Donna Vickman, County Legislator
Paul Schwach, MD, Clinic Physician
Gilbert Witte, MD, Medical Director
Rick Miller, Olean Times Herald
Dave Porter, Hearing Officer
Raymond Jordan, Sr. Public Health Sanitarian
Debra Lacher, Secretary to Public Health Director
Thomas Lecceadone, Administrative Officer
Patti Williams, Supervising Public Health Nurse
Eric Wohlers, Director of Environmental Health

The meeting was called to order by Dr. Bohan. The roll was called and a quorum declared. Mr. Snyder made a motion to approve the minutes of the Board of Health (BOH) meeting held on June 7, 2017, it was seconded by Kathryn Cooney Thrush and the motion was unanimously approved.

DIRECTORS REPORT: Dr. Watkins reported that Cattaraugus County will be showcased in the upcoming National Association of County and City Health Officials (NACCHO) 2017 Conference next week in Pittsburgh, Pa. One of the plenary speakers, Michael Meit, will speak on Public Health Revolution, Bridging Clinical Health and Population Health, and in his presentation he will include the beginnings of public health as reported in Cattaraugus County starting in1923.

Dr. Watkins stated he wanted to return back to a February Board meeting discussion that focused on considering a lawsuit against the big four pharmaceuticals (Johnson & Johnson, Purdue Pharma, Janssen Pharmaceuticals and Teva Pharmaceuticals USA) that misrepresented opioids to providers. He explained that Purdue Pharma, developer of OxyContin, an opioid analgesic, received approval by the Food and Drug Administration (FDA) on December 12, 1995 to distribute this drug. It hit the market in 1996. In its first year, OxyContin accounted for $45 million in sales for Purdue Pharmaceuticals. By 2000 the revenue sales balloon to $1.1 billion, an increase of well over 2,000 percent in a span of just four years. This was a new painkiller in an age where synthetic opiates like Vicodin, Percocet, and Fentanyl had already been competing for decades in doctors' offices and pharmacies for their piece of the market share of pain-relieving drugs. The drug-maker. Purdue Pharma, launched OxyContin with a bold marketing claim: One dose relieves pain for 12 hours, more than twice as long as any generic opioid medication. Company sales reps persuaded doctors to expand their use of opioids beyond treating cancer pain by pushing the notion that OxyContin posed a lower threat of abuse and dependence to patients than other, faster-acting painkillers. Doctors started prescribing OxyContin for everything from backaches to fibromyalgia, and the drug became the top-selling long-acting opioid for more than a decade. Hence, ten years later, Purdue Pharma profits increased its sales from 1.1 billion to $3.1 billion.

In the meantime, there was the continual complaints by patients for the need of a rescue medication in between the 12 hour because the effects of the drug wore off. To reduce introducing additional pain meds, and because reports indicated that OxyContin posed a lower threat of abuse and dependence, some physicians used OxyContin on a q8h schedule rather than the q12h interval, as recommended by FDA. Because of the cost of this drug, insurance companies refused to pay for a q8h interval. Purdue sales reps who spent their days visiting doctors to talk up OxyContin heard repeatedly that the drug didn't last up to twelve hours as described. If a doctor complained that OxyContin didn't last, Purdue reps explained to doctors that they should increase the strength of the dose rather than the frequency. Sales reps reminded doctors there is no ceiling on the amount of OxyContin a patient can be prescribed. A 10mg dose, the lowest dosage could be max to an 80mg dose every twelve hours. The remarkable commercial success of OxyContin, however, started to increase the rates of abuse and addiction. Drug abusers learned how to simply crush the controlled-release tablet and swallow, inhale, or inject the high-potency opioid (oxycodone) from the OxyContin for an intense morphine-like high. Opioids started turning up at pill parties (pharming), during arrest, and missing from the medicine cabinets. Opioids became the street drug of choice and were in high demand. Hence robberies of pharmacies were on the rise.
Weaning patients who were now addicts off these drugs became problematic as rehab facilities became over-crowed and patients found pain management clinics unsuccessful. When the availability of opioids became more difficult to acquire, patients/addicts turn to heroin to satisfy their cravings. Hence the third epidemic of heroin use and the rise in heroin-opioid deaths.

Dr. Watkins stated that annually, in the US, $55 billion in health and social costs related to prescription opioid abuse is being spent and of that $20 billion in emergency department and inpatient care for opioid poisonings is appropriated.

He stated that in NYS, $1.25 million dollars is being spent in health and social costs related to prescription opioid abuse each year. Handouts were provided to all in attendance that showed a state by state analysis.

He explained that looking at the years of potential life lost (YPLL) in Cattaraugus County due to heroin-opioid abuse can be the best indicator for whether the Board should recommend to the legislators to move forward in a lawsuit against the major pharmaceutical companies that misrepresented opioids to providers. In Cattaraugus County, deaths due to opioid abuse are as follow: 2013 (1), 2014 (1), 2015 (11), 2016 (10), and so far in 2017 (11). He added that the 2016 and 2017 death data is provisional. He stated that as of date, the YPLL in Cattaraugus County due to heroin/opioid abuse is 1,360. He went on to say that this is 1,360 years of potential income lost to the community and 1,360 years of potential social and economic stability lost for this community. He stated that the average income for the county is $41,000 and with potentially 1,360 YPLL, that is potentially $55,760,000 lost to the community. He remarked that other county departments that have time and effort dealing with heroin-opioid users include, Community Service (195) Clinic, Department of Social Services (123) Children displaced from home, County Jail (153) Inmates, and Probation (140) Probationers.

Dr. Watkins informed the Board that throughout the US, lawsuits are being filed against these pharmaceutical companies for deceptive practices; in New York, Broome County, Erie County, Nassau County, Niagara County, Orange County and Suffolk County have pursued legal action against these pharmaceutical companies and it appears that more counties will also file lawsuits. He stated that working with the county attorney he was informed that several legal firms would like to work on behalf of Cattaraugus County to join this wave of lawsuits being filed.

Dr. Witte asked if there would be a cost to hire one of these law firms. Attorney Firkel stated that the cost to the county if successful would be a contingency fee. Attorney Firkel did state that there could be some litigation fees incurred as well. After an in depth discussion by the Board, Sondra Fox made a motion to support a recommendation to the county legislators to work with one of these law firms to pursue legal actions against these pharmaceutical companies for deceptive practices, the motion was seconded by Kathryn Cooney Thrush. A vote was taken with (6) ayes, and (1) nay by Dr. Bohan.

Dr. Watkins updated the Board on the El Mariachi Board Order docket #16-050. Mr. Feria-Bautista has settled the $2,000.00 fine, but he was not able to pass the servesafe exam. Dr. Watkins informed the Board Mr. Feria-Bautista was granted another three month permit with a stipulation that he or a manger pass the servesafe exam before the permit expires. Pictures and a copy of the inspection report from June 28th were handed out to those in attendance. He stated that overall the restaurant appears to be in much better condition and moving in a direction where the department can reduce its monitoring frequency.

Dr. Bohan brought up for discussion the possibility of including in the Cattaraugus County Sanitary code the requirement of any restaurant that has repeat violations to have the manager take a food handler training course as a condition of their fine. Dr. Watkins responded that currently in NYS, (2) counties (Monroe and Chautauqua) requires as part of their sanitary code that all restaurant facilities must have a manager complete a food manager certification course and that Cattaraugus County is contemplating the same policy. Mr. Snyder asked if a brand new restaurant was opening would they be required to pass the course before a permit was issued. Dr. Watkins stated that yes, it would be a requirement prior to receiving a permit. He went on to say that he will bring to the September BOH meeting a resolution to have the Board add this provision (requiring all permitted restaurant facilities to complete a food manager certification course) to the Cattaraugus County Sanitary Code.

Dr. Watkins informed the Board that Susan Andrews will be retiring at the end of the month. Her work with the department has been unmeasurable and her replacement will have large shoes to fill. He added that this has been a rough year for the department as the department have had (8) retirements this year and all were long term employees. Dr. Bohan added his congratulations and thanks to Susan for her work in the department.

NURSING DIVISION REPORT: Patti Williams informed the Board that for reportable communicable diseases in June there were (2) cases of salmonella investigated, (1) case of campylobacter, (21) cases of chlamydia (14 were female and 7 were male), (4) cases of gonorrhea (1 individual had both gonorrhea and chlamydia), and (1) person was started on the post exposure rabies prophylaxis.

Nursing staff went out on a joint visit with the Seneca Nation of Indians (SNI) to investigate an elevated lead level case. The lead level was 8ug/dl (normal $\leq$ 9ug/dl-NYSDOH guidelines) the department guidelines requires remediation at or above a level of 15ug/dl, but the SNI chooses remediation at all levels; the child's own home was not affected but the exposure occurs while visiting the grandparent's home. Remediation will take place by the landlord of this home.

The homecare census as of July 3rd is (307). This census is a 7% decrease as compared to a three year 2014-2016 average, and a 13% decrease in June admissions compared to a three year 2014-2016 average. The department is also seeing an increase in requests for records from insurance companies. The department is in the process of hiring two nurses, to replace two who are retiring later this month. There are (26) lead patients, (13) maternal child health, and (19) Medicaid Obstetrical Maternal Services (MOMS) patients being followed by the department.

Dr. Watkins stated that the Center of Disease Control and Prevention (CDC) advises that any lead level above 5ug/dl should be of concern. Currently any levels reported between 5-9ug/dl the Health Department sends materials out to the parents of these children to warn them of the potential hazardous materials in the home that may lead to higher lead levels in children. Any level above 9ug/dl initiates a visit from our staff to their home as a precaution. The department feels that no lead level is safe and awaits the State to adopt CDC's current recommendations.

ENVIRONMENTAL DIVISION REPORT: Mr. Wohlers reported that mosquito surveillance resulted in only (41) mosquito's being trapped last week on the west side of the department's surveillance area, and (5) mosquitos being trapped on the east side; several sites have reported no mosquitos. Two mosquito pool batches were sent to the state for arboviruses testing.

The Community Development Block Grant (CDBG) has (3) water projects under contract, and has (1) water project and (1) septic system out to bid. Advertising seems to be working, as a steady stream of applicants are applying to the program, and the department is seeing referrals from other county agencies.

This is the time of year when rabies exposures are most prevalent, (25) specimens have been submitted to the state lab for testing however, only (1) positive raccoon has been identified. Between the Olean and Little Valley offices, to date, over (100) animal bites have been reported.

The state is scheduling a Basic Environmental Health program, which is a an introductory training program designed to equip entry level environmental health personnel with the basic knowledge, skills and abilities needed to develop competency in their initial and future duties, in Western New York in September. The department will enroll the two newest staff in this program.

This time of year is busy with inspections of children's camp programs, specifically making sure that camps follow the new regulations that have been put in place to accommodate campers with disabilities. In addition, medical and safety plans must be updated, including background checks on all staff.

Donna Vickman reported that she has had calls from constituents regarding the invasive wild parsnip that is overtaking fields, she asked if Mr. Wohlers had any information regarding this situation. Mr. Wohlers replied that he will contact Department of Environmental Conservation (DEC) to see if there is any information on this particular plant and whether any advice is suggested for those having this invasion.

ENFORCEMENT REPORT: Mr. Porter reported on the following enforcement case held on June 13, 2017:

DOCKET #17-012

Respondent: Ms. Alice Ferguson, R & R Dude Ranch, 8940 Lange Road, Otto, NY 14766 Violation 10NYCRR Sec.5-1.72 (c) (1) Respondent failed to submit complete daily records for the operation of the non-community public water supply for the month of April 2017 to the Cattaraugus County Health Department (CCHD) office by the 10th day of the following month.

Public Health Sanitarian: Chris Ann Covert, Public Health Sanitarian appeared for Cattaraugus County Health Department and was sworn in.

Respondent: Did not appear after having been properly served.

Recommendation: That the respondent pay a $200.00 fine on or before July 31, 2017. A $10.00 per day per diem will be assessed for every day not in compliance.

A motion to accept the recommendation was made by Mr. Haberer, seconded by Ms. Raftis, and unanimously approved.

Dr. Watkins reminded everyone that there will not be a BOH meeting in the month of August.

There being no further business to discuss, a motion to adjourn was made by Dr. Chohan, and seconded by Mr. Haberer and unanimously approved.

Respectfully submitted,

Kevin D. Watkins, M.D.

Kevin D. Watkins, M.D., M.P.H.
Secretary to the Board of Health

CATTARAUGUS COUNTY HEALTH DEPARTMENT

Established 1923

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Public Health
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Kevin D. Watkins, M.D., MPH, *Public Health Director*

Gilbert N. Witte, M.D.
Medical Director

Thomas P. Lecceadone
Administrative Officer

COUNTY OF CATTARAUGUS
STATE OF NEW YORK
ENFORCEMENT LIST

Hearing Officer: David Porter

Administrative Hearing 8-8-2017

DOCKET #17-015

Respondent: Cecil Gayton, Hillview Village Lot 10, 3880 Pennsylvania Road, Hinsdale, NY 14743 Violation sanitary code of the Cattaraugus County Health District Part 14.8.1 the Respondent stored more than ten (10) tires at his business on Oregon Road without a method to preclude the accumulation of rain water and the creation of a public health nuisance and failed to correct the violation by disposing of the waste tires by a compliance date prescribed by the health department.

Public Health Sanitarian: Richard Dayton, Public Health Sanitarian appeared for CCHD and was sworn in.

Respondent: Did not appear after having been properly served.

Testimony of Richard Dayton:

a.) Enf.-1 read and affirmed to be true respondent was offered a stipulation and a $50.00 civil compromise identified as P.E. #1.

b.) Proof of service was provided by Mr. Dayton and identified as P.E. #2.

c.) First complaint came from code enforcement for City of Olean September 29, 2016 concerning waste tires at respondent place of business, The Recycle Center.

d.) Field visit on September 29, 2016 at respondent's place of business, The Recycle Center. Employee of The Recycle Center was informed that the tires had to be removed properly within six months. This was a verbal instruction.

e.) On 3-20-17 visit to see if tires were removed at The Recycle Center, tires still present. Picture taken identified as P.E. #3.

f.) Letter to respondent dated 3-23-17 notice of sanitary code violation at respondents The Recycle Center, a very explicit letter with ramifications identified as P.E. #4.

g.) Field visit 6-29-17 tires still on premises. Picture taken identified as P.E. #5 spoke to Cecil Gayton via phone instructing him to pick up the hearing notice and stipulation while visiting The Recycle Center.

Hearing Officer Findings: The respondent is in violation of the sanitary code of the Cattaraugus County Health District Part 14.8.1.

Recommendation: 1.) That the $50.00 civil compromise be changed to a $100.00 fine to be paid on or before September 30, 2017 for failure to fix the violation part 14.8.1.

2.) The waste tires at The Recycle Center must be removed and properly disposed of by September 30, 2017.

3.) Any future tires stored on the premises of The Recycle Center must adhere to Part 14.8.1 of Cattaraugus County Sanitary Code.

4.) Failure to not pay the fine and removal of waste tires by September 30, 2017 will result in a $10.00 per day per diem until in full compliance.

Health Care Costs from Opioid Abuse: A State-by-State Analysis

MATRIX GLOBAL ADVISORS, LLC

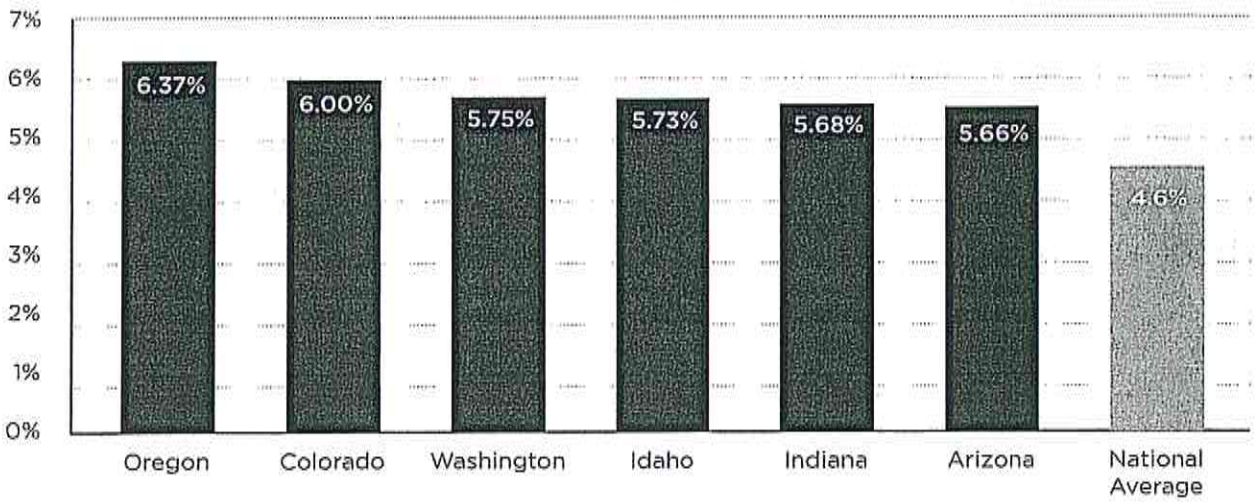
April 2015

The Centers for Disease Control has called prescription painkiller abuse an epidemic. U.S. health care costs attributable to the abuse of prescription painkillers (otherwise known as opioids) totaled an estimated $25 billion in 2007. Given the substantial differences among states in the level of opioid abuse, population size, and the cost of health care services, state-level cost estimates of the impact of opioid abuse are important for understanding and addressing the epidemic. Furthermore, given that many effective strategies for tackling this epidemic may be locally devised and implemented, state-specific estimates are essential for policymakers. The analysis presented here offers the first such estimates.

This analysis allocates the national estimate of the health care cost of opioid abuse among the 50 states and the District of Columbia, taking into account variations in state population, abuse rates, and cost of care. The analysis offers estimates of total health care spending from opioid abuse within a state as well as per-capita health care spending. For a summary of results for every state, see the Appendix.

2.1 million Americans have a substance abuse disorder involving prescription opioids.

STATES WITH HIGHEST OPIOID ABUSE RATES
(2010-2011)



Source: *SAMHSA 2013.*

TOP 10 STATES: TOTAL HEALTH CARE COSTS FROM OPIOID ABUSE

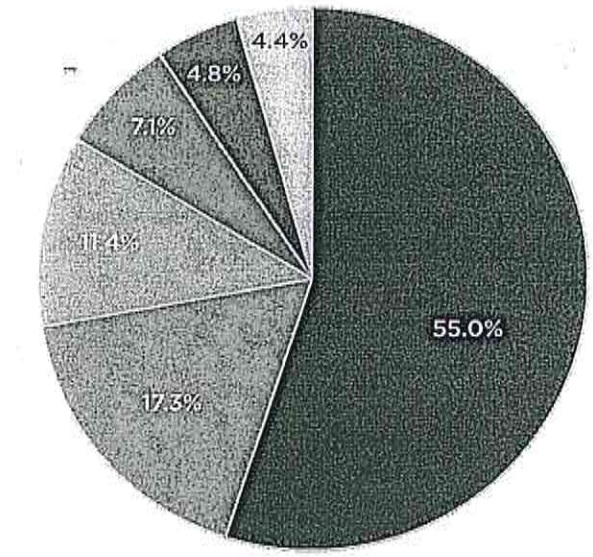
TOP 10 STATES: PER-CAPITA HEALTH CARE COSTS FROM OPIOID ABUSE

BACKGROUND

Opioid abuse is at the pinnacle of prescription drug abuse in the United States. According to the National Institute on Drug Abuse, 2.1 million Americans had a substance abuse disorder involving prescription opioids in 2012; opioid overdose deaths more than tripled between 1990 and 2010; and between 2004 and 2008, emergency room visits related to opioid abuse more than doubled *(Volkow 2014)*.

The majority of people who abuse opioids (55 percent) are given them by a friend or relative *(CDC 2011)*. See Chart 1 for a breakdown of sources of prescription opioids that end up being abused.

CHART 1: SOURCE OF ABUSED PRESCRIPTION PAINKILLERS



Source: *CDC 2011.*

DATA AND METHODOLOGY

Recently published research estimates that aggregate health care costs in the United States attributable to opioid abuse totaled $25 billion in 2007 *(Birnbaum et al. 2011)*. We constructed a model to allocate this estimate by state. To provide an accurate state-by-state breakdown of the total health care cost associated with opioid abuse, it is important to account for three factors that can vary substantially from state to state:

1) population,
2) cost of health care, and
3) the rate of opioid abuse.

In constructing the model, we incorporated state population data from the U.S. Census Bureau *(2014)*. For the cost of health care, we used hospital adjusted expenses per inpatient day *(Kaiser Family Foundation 2014)*. We chose this as a proxy for the cost of health care in a state because the majority of health care spending associated with opioid abuse is attributable to inpatient care *(White et al. 2011)*. Finally, for opioid abuse rates, we used the percentage of nonmedical use of prescription pain relievers by people 12 or older, as reported in the National Survey on Drug Use and Health *(SAMHSA 2013)*.

Incorporating these three factors in the model ensures that the total cost is distributed proportionally across states according to the relevant variations.

It should be noted that the state-by-state estimates are conservative for several reasons. The national estimate of health care costs attributable to opioid abuse is itself conservative, as described by Birnbaum et al. *(2011)*. In addition, this estimate relates to 2007, and the opioid epidemic has worsened substantially since then *(Volkow 2014)*.

DISCUSSION

The $25 billion estimate on which the state analysis is based represents total health care costs associated with opioid abuse. According to Birnbaum et al. *(2011)*, this cost is almost entirely (approximately 95 percent) attributable to excess medical and drug costs. Substance abuse treatment, prevention, and research account for the remaining 5 percent of the total health care burden.

Beyond health care costs, other significant economic burdens are associated with opioid abuse. These include costs related to criminal justice, estimated at $5 billion nationally, and lost workplace productivity, estimated at $25.5 billion *(Birnbaum et al. 2011)*. In total, opioid abuse imposes an estimated $55 billion in societal costs annually.

SOURCES

Birnbaum, Howard G., Alan G. White, Matt Schiller, Tracy Waldman, Jody M. Cleveland, and Carl L. Roland. 2011. "Societal Costs of Prescription Opioid Abuse, Dependence, and Misuse in the United States," *Pain Medicine* 12, no. 4 (April): 657–67.

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U.S. Census Bureau, Population Division. 2014. Table 1. Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2014. December.

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White, Alan G., Howard G. Birnbaum, Matt Schiller, Tracy Waldman, Jody M. Cleveland, and Carl L. Roland. 2011. "Economic Impact of Opioid Abuse, Dependence, and Misuse," *American Journal of Managed Care* 3(4): e59–e70.

ABOUT MGA

Matrix Global Advisors is a Washington, DC–based economic policy consulting firm. More information about MGA is available at www.matrixglobaladvisors.com. This report was prepared for Partnership for Drug-Free Kids.

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APPENDIX

SUMMARY OF RESULTS: STATE ANALYSIS OF HEALTH CARE COSTS ASSOCIATED WITH OPIOID ABUSE

State	Health Care Costs from Opioid Abuse	% of Abuse-Related Health Care Costs	Per-Capita Health Care Costs from Opioid Abuse
California	$4,262,705,505	17.1%	$110
Texas	$1,963,623,647	7.9%	$73
New York	$1,255,668,294	5.0%	$64
Florida	$1,246,526,068	5.0%	$63
Ohio	$1,075,753,413	4.3%	$93
Washington	$976,839,152	3.9%	$138
Illinois	$887,402,938	3.5%	$69
Pennsylvania	$873,738,730	3.5%	$68
Michigan	$829,955,719	3.3%	$84
Arizona	$698,537,803	2.8%	$104
New Jersey	$683,667,371	2.7%	$76
Indiana	$650,271,374	2.6%	$99
Oregon	$614,523,965	2.5%	$155
Colorado	$593,705,700	2.4%	$111
Massachusetts	$584,278,745	2.3%	$87
North Carolina	$582,486,663	2.3%	$59
Virginia	$546,523,496	2.2%	$66
Maryland	$451,018,165	1.8%	$75
Georgia	$447,129,259	1.8%	$44
Missouri	$440,176,029	1.8%	$73
Tennessee	$422,584,957	1.7%	$65
Wisconsin	$408,893,103	1.6%	$71
Minnesota	$375,689,480	1.5%	$69
South Carolina	$323,266,895	1.3%	$67
Louisiana	$296,901,908	1.2%	$64
Connecticut	$294,149,772	1.2%	$82
Oklahoma	$266,976,223	1.1%	$69
Kentucky	$262,000,618	1.0%	$59
Nevada	$238,241,309	1.0%	$84
Utah	$237,756,799	1.0%	$81
Alabama	$234,480,306	0.9%	$48
Arkansas	$205,529,321	0.8%	$69
New Mexico	$192,777,015	0.8%	$92
Idaho	$156,577,944	0.6%	$96
Kansas	$148,623,448	0.6%	$51
Mississippi	$141,709,137	0.6%	$47
Iowa	$121,049,678	0.5%	$39
Delaware	$109,439,642	0.4%	$117
Rhode Island	$108,354,005	0.4%	$103
New Hampshire	$107,993,141	0.4%	$81
West Virginia	$99,567,256	0.4%	$54
Nebraska	$97,527,060	0.4%	$52
Maine	$92,736,966	0.4%	$70
Hawaii	$84,803,596	0.3%	$60
Alaska	$69,448,831	0.3%	$94
DC	$62,588,368	0.3%	$95
Montana	$49,737,028	0.2%	$49
Vermont	$38,109,065	0.2%	$61
North Dakota	$33,219,499	0.1%	$45
South Dakota	$27,820,116	0.1%	$33
Wyoming	$26,915,476	0.1%	$46
Total	**$25,000,000,000**		

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The Promotion and Marketing of OxyContin: Commercial Triumph, Public Health Tragedy

| Art Van Zee, MD

I focus on issues surrounding the promotion and marketing of controlled drugs and their regulatory oversight. Compared with noncontrolled drugs, controlled drugs, with their potential for abuse and diversion, pose different public health risks when they are overpromoted and highly prescribed. An in-depth analysis of the promotion and marketing of OxyContin illustrates some of the associated issues.

Modifications of the promotion and marketing of controlled drugs by the pharmaceutical industry and an enhanced capacity of the Food and Drug Administration to regulate and monitor such promotion can have a positive impact on the public health. (*Am J Public Health.* 2009;99:221–227. doi: 10.2105/AJPH.2007.131714)

CONTROLLED DRUGS, WITH their potential for abuse and diversion, can pose public health risks that are different from—and more problematic than—those of uncontrolled drugs when they are overpromoted and highly prescribed. An in-depth analysis of the promotion and marketing of OxyContin (Purdue Pharma, Stamford, CT), a sustained-release oxycodone preparation, illustrates some of the key issues. When Purdue Pharma introduced OxyContin in 1996, it was aggressively marketed and highly promoted. Sales grew from $48 million in 1996 to almost $1.1 billion in 2000.[1] The high availability of OxyContin correlated with increased abuse, diversion, and addiction, and by 2004 OxyContin had become a leading drug of abuse in the United States.[2]

Under current regulations, the Food and Drug Administration (FDA) is limited in its oversight of the marketing and promotion of controlled drugs. However, fundamental changes in the promotion and marketing of controlled drugs by the pharmaceutical industry, and an enhanced capacity of the FDA to regulate and monitor such promotion, can positively affect public health.

OxyContin's commercial success did not depend on the merits of the drug compared with other available opioid preparations. The *Medical Letter on Drugs and Therapeutics* concluded in 2001 that oxycodone offered no advantage over appropriate doses of other potent opioids.[3] Randomized double-blind studies comparing OxyContin given every 12 hours with immediate-release oxycodone given 4 times daily showed comparable efficacy and safety for use with chronic back pain[4] and cancer-related pain.[5,6] Randomized double-blind studies that compared OxyContin with controlled-release morphine for cancer-related pain also found comparable efficacy and safety.[7–9] The FDA's medical review officer, in evaluating the efficacy of OxyContin in Purdue's 1995 new drug application, concluded that OxyContin had not been shown to have a significant advantage over conventional, immediate-release oxycodone taken 4 times daily other than a reduction in frequency of dosing.[10] In a review of the medical literature, Chou et al. made similar conclusions.[11]

The promotion and marketing of OxyContin occurred during a recent trend in the liberalization of the use of opioids in the treatment of pain, particularly for chronic non–cancer-related pain. Purdue pursued an "aggressive" campaign to promote the use of opioids in general and OxyContin in particular.[1,12–17] In 2001 alone, the company spent $200 million[18] in an array of approaches to market and promote OxyContin.

PROMOTION OF OXYCONTIN

From 1996 to 2001, Purdue conducted more than 40 national pain-management and speaker-training conferences at resorts in Florida, Arizona, and California. More than 5000 physicians, pharmacists, and nurses attended these all-expenses-paid symposia, where they were recruited and trained for Purdue's national speaker bureau.[19(p22)] It is well documented that this type of pharmaceutical company symposium influences physicians' prescribing,

even though the physicians who attend such symposia believe that such enticements do not alter their prescribing patterns.[20]

One of the cornerstones of Purdue's marketing plan was the use of sophisticated marketing data to influence physicians' prescribing. Drug companies compile prescriber profiles on individual physicians—detailing the prescribing patterns of physicians nationwide—in an effort to influence doctors' prescribing habits. Through these profiles, a drug company can identify the highest and lowest prescribers of particular drugs in a single zip code, county, state, or the entire country.[21] One of the critical foundations of Purdue's marketing plan for OxyContin was to target the physicians who were the highest prescribers for opioids across the country.[1,12–17,22] The resulting database would help identify physicians with large numbers of chronic-pain patients. Unfortunately, this same database would also identify which physicians were simply the most frequent prescribers of opioids and, in some cases, the least discriminate prescribers.

A lucrative bonus system encouraged sales representatives to increase sales of OxyContin in their territories, resulting in a large number of visits to physicians with high rates of opioid prescriptions, as well as a multifaceted information campaign aimed at them. In 2001, in addition to the average sales representative's annual salary of $55 000, annual bonuses averaged $71 500, with a range of $15 000 to nearly $240 000. Purdue paid $40 million in sales incentive bonuses to its sales representatives that year.[19]

From 1996 to 2000, Purdue increased its internal sales force from 318 sales representatives to 671, and its total physician call list from approximately 33 400 to 44 500 to approximately 70 500 to 94 000 physicians.[19] Through the sales representatives, Purdue used a patient starter coupon program for OxyContin that provided patients with a free limited-time prescription for a 7- to 30-day supply. By 2001, when the program was ended, approximately 34 000 coupons had been redeemed nationally.[19]

The distribution to health care professionals of branded promotional items such as OxyContin fishing hats, stuffed plush toys, and music compact discs ("Get in the Swing With OxyContin") was unprecedented for a schedule II opioid, according to the Drug Enforcement Administration.[19]

Purdue promoted among primary care physicians a more liberal use of opioids, particularly sustained-release opioids. Primary care physicians began to use more of the increasingly popular OxyContin; by 2003, nearly half of all physicians prescribing OxyContin were primary care physicians.[19] Some experts were concerned that primary care physicians were not sufficiently trained in pain management or addiction issues.[23] Primary care physicians, particularly in a managed care environment of time constraints, also had the least amount of time for evaluation and follow-up of patients with complicated chronic pain.

Purdue "aggressively" promoted the use of opioids for use in

TABLE 1—Distribution of OxyContin, Oxycodone (Excluding OxyContin), and Hydrocodone per 100 000 Population: Virginia, West Virginia, and Kentucky, 2000

	Distribution in Grams per 100 000 Population		
State and County	OxyContin	Oxycodone (Excluding OxyContin)	Hydrocodone
Virginia			
Dickenson	25 801	2 777	16 692
Lee	23 398	6 232	8 445
Buchanan	19 138	3 235	15 996
Scott	18 328	4 946	12 274
Roanoke City	17 856	2 808	7 201
Tazewell	17 135	3 482	27 714
Winchester City	15 242	6 764	14 057
Manassas City	14 735	5 920	5 511
Fauquier	14 396	6 935	4 434
Wythe	14 236	3 165	8 812
Kentucky			
Cumberland	22 113	1 486	8 148
Perry	20 996	6 145	27 413
Harlan	19 359	3 121	10 141
Leslie	18 221	4 017	16 925
Whitley	13 438	3 410	19 532
Greenup	13 222	5 151	44 872
McCreary	12 573	3 026	12 996
Clinton	12 517	2 911	14 892
Bell	11 739	3 118	26 037
Clay	11 563	3 260	21 093
West Virginia			
Pocahontas	17 318	3 605	17 651
Raleigh	16 813	5 959	8 718
Berkeley	16 299	5 254	5 009
Logan	16 153	2 224	22 950
McDowell	15 770	3 200	24 235
Greenbrier	15 752	2 539	12 380
Mercer	15 040	3 306	21 175
Hancock	13 465	4 327	8 831
Harrison	12 409	3 407	12 658
Cabell	11 665	3 608	13 018
US average	3 750	1 761	5 083

Source. Office of Diversion Control, Drug Enforcement Administration.[67]
Note. Data are for the counties or independent cities with the highest quantities of opioids (in grams) prescribed in each of the 3 states.

the "non-malignant pain market."[15(p187)] A much larger market than that for cancer-related pain, the non–cancer-related pain market constituted 86% of the total opioid market in 1999.[17] Purdue's promotion of OxyContin for the treatment of non–cancer-related pain contributed to a nearly tenfold increase in OxyContin prescriptions for this type of pain, from about 670 000 in 1997 to about 6.2 million in 2002, whereas prescriptions for cancer-related pain increased about fourfold during that same period.[19] Although the science and consensus for the use of opioids in the treatment of acute pain or pain associated with cancer are robust, there is still much controversy in medicine about the use of opioids for chronic non–cancer-related pain, where their risks and benefits are much less clear. Prospective, randomized, controlled trials lasting at least 4 weeks that evaluated the use of opioids for chronic, non–cancer-related pain showed statistically significant but small to modest improvement in pain relief, with no consistent improvement in physical functioning.[24–38] A recent review of the use of opioids in chronic back pain concluded that opioids may be efficacious for short-term pain relief, but longer-term efficacy (>16 weeks) is unclear.[39]

In the long-term use of opioids for chronic non–cancer-related pain, the proven analgesic efficacy must be weighed against the following potential problems and risks: well-known opioid side effects, including respiratory depression, sedation, constipation, and nausea; inconsistent improvement in functioning; opioid-induced hyperalgesia; adverse hormonal and immune effects of long-term opioid treatment; a high incidence of prescription opioid abuse behaviors; and an ill-defined and unclarified risk of iatrogenic addiction.[40]

MISREPRESENTING THE RISK OF ADDICTION

A consistent feature in the promotion and marketing of OxyContin was a systematic effort to minimize the risk of addiction in the use of opioids for the treatment of chronic non–cancer-related pain. One of the most critical issues regarding the use of opioids in the treatment of chronic non–cancer-related pain is the potential of iatrogenic addiction. The lifetime prevalence of addictive disorders has been estimated at 3% to 16% of the general population.[41] However, we lack any large, methodically rigorous prospective study addressing the issue of iatrogenic addiction during long-term opioid use for chronic nonmalignant pain.[42]

In much of its promotional campaign—in literature and audiotapes for physicians, brochures and videotapes for patients, and its "Partners Against Pain" Web site—Purdue claimed that the risk of addiction from OxyContin was extremely small.[43–49]

Purdue trained its sales representatives to carry the message that the risk of addiction was "less than one percent."[50(p99)] The company cited studies by Porter and Jick,[51] who found iatrogenic addiction in only 4 of 11 882 patients using opioids and by Perry and Heidrich,[52] who found no addiction among 10 000 burn patients treated with opioids. Both of these studies, although shedding some light on the risk of addiction for acute pain, do not help establish the risk of iatrogenic addiction when opioids are used daily for a prolonged time in treating chronic pain. There are a number of studies, however, that demonstrate that in the treatment of chronic non–cancer-related pain with opioids, there is a high incidence of prescription drug abuse. Prescription drug abuse in a substantial minority of chronic-pain patients has been demonstrated in studies by Fishbain et al. (3%–18% of patients),[53] Hoffman et al. (23%),[54] Kouyanou et al. (12%),[55] Chabal et al. (34%),[56] Katz et al. (43%),[57] Reid et al. (24%–31%),[58] and Michna et al. (45%).[59] A recent literature review showed that the prevalence of addiction in patients with long-term opioid treatment for chronic non–cancer-related pain varied from 0% to 50%, depending on the criteria used and the subpopulation studied.[60]

Misrepresenting the risk of addiction proved costly for Purdue. On May 10, 2007, Purdue Frederick Company Inc, an affiliate of Purdue Pharma, along with 3 company executives, pled guilty to criminal charges of misbranding OxyContin by claiming that it was less addictive and less subject to abuse and diversion than other opioids, and will pay $634 million in fines.[61]

Although research demonstrated that OxyContin was comparable in efficacy and safety to other available opioids,[11,63] marketing catapulted OxyContin to blockbuster drug status. Sales escalated from $44 million (316 000 prescriptions dispensed) in 1996 to a 2001 and 2002 combined sales of nearly $3 billion (over 14 million prescriptions).[19]

The remarkable commercial success of OxyContin, however, was stained by increasing rates of abuse and addiction. Drug abusers learned how to simply crush the controlled-release tablet and swallow, inhale, or inject the high-potency opioid for an intense morphinelike high.[64] There had been some precedence for the diversion and abuse of controlled-release opioid preparations. Purdue's own MS Contin had been abused in the late 1980s in a fashion similar to how OxyContin was later to be; by 1990, MS Contin had become the most abused prescription opioid in one major metropolitan area.[65] Purdue's own testing in 1995 had demonstrated that 68% of the oxycodone could be extracted from an OxyContin tablet when crushed.[66]

Opioid prescribing has had significant geographical variations. In some areas, such as Maine, West Virginia, eastern Kentucky, southwestern Virginia, and Alabama, from 1998 through 2000, hydrocodone and (non-OxyContin) oxycodone were being prescribed 2.5 to 5.0 times more than the national average. By 2000, these same areas had become high OxyContin-prescribing areas—up to 5 to 6 times higher than the national average in some counties (Table 1).[67] These areas, in which OxyContin was highly available, were the first in the nation to witness increasing OxyContin abuse and diversion, which began surfacing in 1999 and 2000.[23]

From 1995 to 2001, the number of patients treated for opioid abuse in Maine increased 460%, and from 1997 to 1999 the state had a 400% increase in the number of chronic hepatitis C cases reported.[68] In eastern Kentucky from 1995 to 2001, there was a 500% increase in the number of patients entering methadone maintenance treatment programs, about 75% of whom were OxyContin dependent (Mac Bell, administrator, Narcotics Treatment Programs, Kentucky Division of Substance Abuse, written communication, March 2002). In West Virginia, the first methadone maintenance treatment program opened in August 2000, largely in response to the increasing number of people with OxyContin dependence. By October 2003, West Virginia had 7 methadone maintenance treatment clinics with 3040 patients in treatment (M. Moore, Office of Behavioral Health Services, Office of Alcoholism and Drug Abuse, West Virginia, written communication, March 16, 2004). In southwestern Virginia, the first methadone maintenance treatment program opened in March 2000, and within 3 years it had 1400 admissions (E. Jennings, Life Center of Galax, Galax, Virginia, written communication, March 12, 2004).

With increasing diversion and abuse, opioid-related overdoses escalated. In southwest Virginia, the number of deaths related to opioid prescriptions increased 830%, from 23 in 1997 to 215 in 2003 (William Massello III, MD, assistant chief medical examiner, Office of Chief Medical Examiner, Western District, Virginia Department of Health, written communication, January 12, 2007). The high availability of OxyContin in these 5 regions seemed to be a simple correlate of its abuse, diversion, and addiction.

With the growing availability of OxyContin prescriptions, the once-regional problem began to spread nationally. By 2002, OxyContin accounted for 68% of oxycodone sales.[69] Lifetime nonmedical use of OxyContin increased from 1.9 million to 3.1 million people between 2002 and 2004, and in 2004 there were 615 000 new nonmedical users of OxyContin.[70] By 2004, OxyContin had become the most prevalent prescription opioid abused in the United States.[2]

The increasing OxyContin abuse problem was an integral part of the escalating national prescription opioid abuse problem. Liberalization of the use of opioids, particularly for the treatment of chronic non–cancer-related pain, increased the availability of all opioids as well as their abuse. Nationwide, from 1997 to 2002, there was a 226%, 73%, and 402% increase in fentanyl, morphine, and oxycodone prescribing, respectively (in grams per 100 000 population). During that same period, the Drug Abuse Warning Network reported that hospital emergency department mentions for fentanyl, morphine, and oxycodone increased 641%, 113%, and 346%, respectively.[71] Among new initiates to illicit drug use in 2005, a total of 2.1 million reported prescription opioids as the first drug they had tried, more than for marijuana and almost equal to the number of new cigarette smokers (2.3 million).[72] Most abusers of prescription opioids get their diverted drugs directly from a doctor's prescription or from the prescriptions of friends and family.[73]

In terms of illicit drug abuse, prescription opioids are now ahead of cocaine and heroin and second only to marijuana.[72] Mortality rates from drug overdose have climbed dramatically; by 2002, unintentional overdose deaths from prescription opioids surpassed those from heroin and cocaine nationwide.[74] Nationally, as well as regionally, the high availability of OxyContin and all prescription opioids was correlated with high rates of abuse and diversion.

THE FOOD AND DRUG ADMINISTRATION

Under the Food, Drug, and Cosmetics Act and implementing regulations, the FDA regulates the advertising and promotion of prescription drugs and is responsible for ensuring that prescription drug advertising and promotion are truthful, balanced, and accurately communicated. There is no distinction in the act between controlled and noncontrolled drugs regarding the oversight of promotional activities. Although regulations require that all promotional materials for prescription drugs be submitted to the FDA for review when the materials are initially disseminated or used, it is generally not required that these materials be approved by the FDA prior to their use. The FDA has a limited number of staff for overseeing the enormous amount of promotional materials. In 2002, for example, 39 FDA staff members were responsible for reviewing roughly 34 000 pieces of promotional materials.[19] This limited staffing significantly diminishes the FDA's ability to ensure that the promotion is truthful, balanced, and accurately communicated.

In 1998, Purdue distributed 15 000 copies of an OxyContin video to physicians without submitting it to the FDA for review, an oversight later acknowledged by Purdue. In 2001, Purdue submitted to the FDA a second version of the video, which the FDA did not review until October 2002—after the General Accounting Office inquired about its content. After its review, the FDA concluded that the video minimized the risks from OxyContin and made unsubstantiated claims regarding its benefits to patients.[19]

When OxyContin entered the market in 1996, the FDA approved its original label, which stated that iatrogenic addiction was "very rare" if opioids were legitimately used in the management of pain. In July 2001, to reflect the available scientific evidence, the label was modified to state that data were not available for establishing the true incidence of addiction in chronic-pain patients. The 2001 labeling also deleted the original statement that the delayed absorption of OxyContin was believed to reduce the abuse liability of the drug.[19] A more thorough review of the available scientific evidence prior to the original labeling might have prevented some of the need for the 2001 label revision.

CONCLUSIONS

OxyContin appears to be as efficacious and safe as other available opioids and as oxycodone taken 4 times daily.[11,63] Its commercial success, fueled by an unprecedented promotion and marketing campaign, was stained by escalating OxyContin abuse and diversion that spread throughout the country.[2,75] The regions of the country that had the earliest and highest availability of prescribed OxyContin had the greatest initial abuse and diversion.[23,67] Nationally, the increasing availability of OxyContin was associated with higher rates of abuse, and it became the most prevalent abused prescription opioid by 2004.[2]

Compared with noncontrolled drugs, controlled drugs, with their potential for abuse and diversion, pose different public health risks when overpromoted and highly prescribed. Several marketing practices appear to be especially questionable.

The extraordinary amount of money spent in promoting a sustained-release opioid was unprecedented. During OxyContin's first 6 years on the market, Purdue spent approximately 6 to 12 times more on promoting it than the company had spent on promoting MS Contin, or than Janssen Pharmaceutical Products LP had spent on Duragesic, one of OxyContin's competitors.[19] Although OxyContin has not been shown to be superior to other available potent opioid preparations,[11,63] by 2001 it had become the most frequently prescribed brand-name opioid in the United States for treating moderate to severe pain.[19] Carefully crafted limits on the marketing and promotion of controlled drugs would help to realign their actual use with the principles of evidence-based medicine.

Physicians' interactions with pharmaceutical sales representatives have been found to influence the prescribing practices of residents and physicians in terms of decreased prescribing of generic drugs, prescribing cost, nonrational prescribing, and rapid prescribing of new drugs.[76] Carefully crafted limits on the promotion of controlled drugs by the pharmaceutical sales force and enhanced FDA oversight of the training and performance of sales representatives would also reduce over- and misprescribing.

Although there are no available data for evaluating the promotional effect of free starter coupons for controlled drugs, it seems likely that the over- and misprescribing of a controlled drug are encouraged by such promotional programs and the public health would be well served by eliminating them.

The use of prescriber profiling data to influence prescribing and improve sales is imbedded in pharmaceutical detailing. Very little data are publicly available for understanding to what extent this marketing practice boosts sales. One market research report indicated that profiling improved profit margins by as much as 3 percentage points and the initial uptake of new drugs by 30%.[77] The use of prescriber profiling data to target high-opioid prescribers—coupled with very lucrative incentives for sales representatives—would seem to fuel increased prescribing by some physicians—perhaps the most liberal prescribers of opioids and, in some cases, the least discriminate. Regulations eliminating this marketing tool might decrease some potential overprescribing of controlled drugs.

The public health would be better protected if the FDA reviewed all advertising and promotional materials as well as associated educational materials—for their truthfulness, accuracy, balance, and scientific validity—*before* dissemination. Such a change would require a considerable increase in FDA support, staffing, and funding from what is currently available. Public monies spent on the front end of the problem could prevent another such tragedy.

The pharmaceutical industry's role and influence in medical education is problematic. From 1996 through July 2002, Purdue funded more than 20 000 pain-related educational programs through direct sponsorship or financial grants,[19] providing a venue that had enormous influence on physicians' prescribing throughout the country. Particularly with controlled drugs, the potential for blurring marketing and education carries a much higher public health risk than with uncontrolled drugs. At least in the area of controlled drugs, with their high potential for abuse and diversion, public health would best be served by severing the pharmaceutical industry's direct role and influence in medical education.

Marketing and promotion by the pharmaceutical industry have considerably amplified the prescription sales and availability of opioids. A number of factors have contributed to the marked growth of opioid abuse in the United States, but one factor is certainly the much increased availability of prescription opioids.[78] The public interest and public health would be better served by a redefinition of acceptable and allowable marketing practices for opioids and other controlled drugs. ■

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Organization:	Address:	Phone Number:	Contact:
Clinic Services:			
Allegany Council on Alcoholism	Cuba, NY	585-968-1482	
Chautauqua Center, The	319 Central Ave Dunkirk, NY	716-363-6050	
Chautaqua County Chemical Dependency Clinic	73 Forest Ave Jamestown, NY	716-483-6996	
Council on Addiction Recovery Services -CAReS	201 South Union Street Olean, NY	716-373-4303	
Counseling Services:			
Abbott Corners Addictions Services OP1	2107 Spruce St North Collins, NY	716-822-7117 ext. 232	Marie Bage
Abbott Corners Addictions Services OP1	3176 Abbott Rd Suite 500 Orchard Park, NY	716-822-2117	
Chautaqua County Chemical Dependency Services	200 E 3rd St 5th Floor Jamestown, NY	716-661-8374	
Council on Addiction Recovery Services-CAReS	201 South Union Street Olean, NY	716-373-4303	
PROS Dunkirk (Personalized Recovery Oriented Services)	51 East Third St Dunkirk, NY	716-366-7660	
PROS Jamestown (Personalized Recovery Oriented Services)	800 East Second St Jamestown, NY	716-661-1510	
The Resource Center	200 Dunham Ave Jamestown, NY	716-483-2344	
Drop Box Services:			
Drug Drop Boxes Health Community Alliance Building	1 School St Suite 100 Gowanda, NY		
Drug Drop Boxes Cattaraugus County Building	303 Court Street Little Valley, NY		
Drug Drop Box Olean City Building	101 East State Street Olean, NY		

Drop Box Services:			
Drug Drop Boxes Cattaraugus County Building	1 Leo Moss Drive Suite 4010 Olean, NY		
Drug Drop Box Salamanca Police Station	1 Barrett Drive Salamanca, NY		
Hotline Services:			
A AAA 1 Abuse & Addiction Helpline	708 Foote Ave Suite 114 Jamestown, NY	716-980-1418	
Crisis Hotline Business Hours 8:00AM-5:00PM MWRF Crisis Hotli Hotline Business Hours 10:00AM-7:00PM Tues.	201 South Union Street Olean, NY	1-866-851-5033	
Crisis Hotl Hotline-After Hours (24 Hours a day)	515 Main Street Olean, NY	1-800-339-5209	
Inpatient Services:			
Bradford Regional Medical Center/Recovery Systems *(Must have dual diagnosis)*	116 Interstate Pkwy Bradford, PA	800-466-2583 814-362-8319	
Horizon Village Terrace House (Detox & Inpatient Services)	291 Elm St Buffalo, NY	716-854-2444	
WCA Hospital - Inpatient Chemical Dependency Program	207 Foote Ave Jamestown, NY	716-664-8620	Andrew O'Brien
Narcan Training Services:			
Southern Tier Overdose Prevention Program (STOPP) NARCAN TRAINING	1 Blue Bird Square Olean, NY	716-372-0614	Abbe Kahm Prevention Coord.
CVS Pharmacy Dispense Naloxone with Standing Order	415 North Union Street	716-372-5889	
Rite Aid Pharmacy Dispense Naloxone with Standing Order	81 West Main Street Gowanda, NY	716-532-4114	
Rite Aid Pharmacy Dispense Naloxone with Standing Order	265 North Union Street Olean, NY	716-373-2716	
Rite Aid Pharmacy Dispense Naloxone with Standing Order	9 Broad Street Salamanca, NY	716-945-1095	
Rite Aid Pharmacy Dispense Naloxone with Standing Order	12208 State Route 16 Yorkshire, NY	716-492-2511	

Outpatient Services:			
Allegany Council on Alcsm & SA Outpatient	2956 Airway Rd Wellsville, NY	585-593-1920 ext. 722	Deborah Lewis
Behavioral Health Therapy Universal Primary Care	135 N Union Street Olean, NY	716-375-7500	
Chautauqua County Alc & Sub Abuse Svc OP	501 West Third St Jamestown, NY	716-664-3608	Carol Wright
Chautauqua County Alc & Sub Abuse Svc OP1	324 Central Ave Dunkirk, NY	716-366-4623	Peggy Erickson
Council on Addiction Recovery Services Outpatient	1 School St Gowanda, NY	716-373-4303 ext. 509	Jene Gardner
Council on Addiction Recovery Services Outpatient	9824 Route 16 Machais, NY	716-373-4303 ext. 509	Jene Gardner
Council on Addiction Recovery Services Outpatient	201 South Union St. Olean, NY	716-373-4303	
Council on Addiction Recovery Services Outpatient	100 Main St Salamanca, NY	716-373-4303 ext. 509	Jene Gardner
Council on Addiction Recovery Services Outpatient	356 Main St Randolph, NY	716-373-4303 ext. 509	Jene Gardner
Family Health Medical Services	320 Prather Ave Jamestown, NY	716-338-0022	
Horizon Boulevard Addiction OP	1370 Niagara Falls Blvd Tonawanda, NY	716-833-3708	
Horizon Union Losson Addiction OP	2563 Union Rd Suite 800 Cheektowaga, NY	716-668-7622	
Seneca Strong	938 RC Hoag Drive Salamanca, NY	716-945-8413	
South Towns Counseling Center Outpatient	27 Franklin St Springville, NY	716-662-2040	Julie Gutowski
Spectrum Human Services - Wyoming Outpatient	34 N Main St Warsaw, NY	716-662-2040	Julie Gutowski
TLC Health Network	100 Memorial Dr Gowanda, NY	716-532-8900	

Outpatient Services:			
TLC Health Network Outpatient	33 N Main St Cassadaga, NY	716-595-3355	Wendy Luce
TLC Health Network Outpatient	7020 Erie Rd Derby, NY	716-951-7321	Wendy Luce
Tri-County Chemical Dependency	33 N Main St Cassadaga, NY	716-595-3355	
WCA Hospital - Outpatient	51 Glasgow Ave Jamestown, NY	716-664-8620	Andrew O'Brien
WCA Hospital - Outpatient	338 Central Ave Dunkirk, NY	716-363-0018	
PAARI Services:			
Police Assisted Addiction Recovery Initiative (PAARI)	27 East Main St Gowanda, NY	716-532-2020	
Residential Services:			
Alcohol & Drug Abuse Services	120 Chestnut St Port Allegany, PA	814-642-9541	
Alcohol & Drug Abuse Services (Residential Short-Term)	118 Chestnut St Port Allegany, PA	814-642-9522	
Alcohol & Drug Abuse Svc Incorporated	2 Main St Suite 605 Bradford, PA	814-362-6517	
Alcohol & Drug Abuse Svc Inc - Kane	9 Field St Kane, PA	814-837-7691	
Council on Addiction Recovery Services (Community Residential)	1351 Olean Portville Rd Westons Mills, NY	716-373-0057 ext. 205	Keith Woods
Delta Village Treatment Center (25 Bed Facility for 18-28 yr. olds)	6301 Inducon Drive E. Sanborn, NY	716-731-2030 716-638-9222	Megan Gorski
Freedom Village (Veterans)	6301 Inducon Drive E. Sanborn, NY 14132	716-731-2030 716-638-9222	
Horizon Village (Adults)	6301 Inducon Drive E. Sanborn, NY 14132	716-731-2030 716-638-9222	
Kids Escaping Drugs (Renaissance Addiction Services RRSY)	920 Harlem Rd Buffalo, NY	716-827-9462 ext. 302	Robin Clouden

Residential Services:			
Margaret A. Stutzman Addiction Center	360 Forest Ave Buffalo, NY	716-882-4900	Barbara Conner
Trapping Brook (Supportive Living)	3084 Trapping Brook Rd Wellsville, NY	585-593-1920 ext. 701	Tina Wilson
Turning Point House (Intensive Residential)	9136 Sandrock Rd Eden, NY	716-992-4972	MaryBeth McCormick
Respite House Services:			
Eagle's Nest	Jamestown, NY	1-844-421-1114 716-260-0301	Kirsten Vincent
Support Group Services:			
Addiction Response Ministry (Faith based service)		716-222-0299	addictionresponseministry.com
Al-Anon/Alateen - Support Group	511 E 2nd St Jamestown, NY	716-484-1544	
CARES - Olean	201 South Union St Olean, NY	716-373-4303	
Chautauqua Area Service Committee of Narco (CASCNA) Support Group	PO Box 2026 Jamestown, NY	716-240-5983	
Council on Addiction Recovery Services (Supportive Living)	207 S Union St Olean, NY	716-373-4303 ext. 509	Jene Gardner
Seneca Strong Ongoing Support Outreach Program	983 RC Hoag Drive Salamanca, NY	716-945-8413	
Substance Abuse Intervention Tuesday 5:30PM - 6:45PM	201 S Union Street Olean, NY	716-373-4303	CARES
Substance Abuse Intervention Wednesday 5:45PM - 7:00PM	1100 Homer Street Olean, NY	716-307-2520	The Pentecostals of Olean Bob Lent / Coordinator
Website:			
http://recoveryincattco.weebly.com			

* Dual Diagnosis (Psychiatric disorder and substance abuse disorder)