

1 NEW YORK STATE JOINT SENATE TASK FORCE
2 ON HEROIN AND OPIOID ADDICTION

3
4 ROUNDTABLE DISCUSSION

5 TO EXAMINE THE ISSUES FACING COMMUNITIES
6 IN THE WAKE OF INCREASED HEROIN AND OPIOID ABUSE

8
9 SUNY Oneonta
10 Hunt Union Ballroom
108 Ravine Parkway
Oneonta, New York 13820

11 February 23, 2016
12 12:00 p.m. to 2:00 p.m.

13 PRESIDING:

14 Senator James L. Seward, Sponsor

15 Senator Terrence Murphy, Chair

16 Senator George Amedore, Jr., Co-Chair

17 Senator Fred Akshar
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SPEAKERS:

Brian Burns
Judge, Adult or Criminal Family Treatment Court
Otsego County

John Muehl
District Attorney
Otsego County

Joe McBride
District Attorney
Chenango County

Richard Devlin
Sheriff
Otsego County Sheriff's Office

Craig DuMond
Undersheriff
Delaware County Sheriff's Office

Mike Covert
Police Chief
Cooperstown Police Department

Kelly Liner
Interim Executive Director
Friends of Recovery of Delaware and Otsego counties

Noel Clinton-Feik
Co-owner
Crossroads Inn

Joseph Yelich
Superintendent
Oneonta City Schools

Jason Gray
Paramedic
Chief of Sidney EMS

1 SPEAKERS (Continued):

2 Matthew Jones
3 Director of clinical operations
4 Bassett Medical Center, Emergency Department

5 Dr. James Anderson
6 Medical Director, Behavioral-Health Integration
7 Bassett Medical Center

8 Celeste Johns
9 Chief of Psychiatry
10 Bassett Medical Center

11 Sheryl DeRosa
12 Program Coordinator, Alcohol and Drug Abuse Services
13 Chenango County Behavioral Health

14 Ruth Roberts
15 Director of Community Services
16 Chenango County

17 Noreen Hodges
18 Council on Alcoholism and Substance Abuse
19 Schoharie County

20 Mary Rose Rosenthal
21 Alcohol and Drug Abuse Council
22 Delaware County

23 Chris Compton
24 Director
25 County Alcohol and Drug Abuse Services

 Susan Matt
 Director of Community Services
 Otsego County

 Julie Dostal
 Executive Director
 LEAF Council on Alcoholism and Addictions

1 SENATOR SEWARD: We're going to get started.

2 Apologize for a short delay.

3 We have a good group out this afternoon, and
4 I really appreciate everyone's participation.

5 I'm Senator Jim Seward, and I'm very proud to
6 represent this region in the New York State Senate.

7 And, I want to welcome everyone to this
8 roundtable of the Senate Task Force on Heroin and
9 Opioid Addiction.

10 You know, it was in this very room, just
11 about two years ago, in April of 2014, we had a
12 similar gathering. And since that time two years
13 ago, a number of steps have been taken to deal with
14 this epidemic, which has -- let's face it, it's torn
15 lives, families, and, in some cases, whole
16 communities apart.

17 And shortly after the 2014 meeting, and the
18 other 17 forums that were held around the state at
19 that time, a comprehensive report was issued by the
20 Task Force, and a host of new bills were approved,
21 and later signed into law by the Governor.

22 Now, a key piece of that package was my
23 legislation that expanded the insurance coverage for
24 the diagnosis and treatment of substance-use
25 disorder.

1 Now, that went actually into effect less than
2 a year ago, in April of 2015, and we're still
3 looking at the impact of what that legislation can
4 do.

5 But whenever someone makes that decision,
6 that life-altering decision, to seek treatment, we
7 need to do all we can to ensure that treatment is
8 available. We may not get a second chance.

9 And, overall, as a result of the work in
10 2014, we at the state level, in conjunction with
11 many local efforts, have enacted a multi-prong
12 strategy, you know, education and prevention; access
13 to treatment; tougher laws, particularly directed at
14 those who prey on the addicted.

15 But, let's face it, there's still much more
16 work that needs to be done, and that's why we are
17 here together today.

18 We have an outstanding gathering of local
19 stakeholders to discuss the situation as it exists
20 today.

21 And I'm very pleased to be joined today by
22 two of our Task Force Co-Chairs:

23 Senator George Amedore from the Schenectady
24 area, as well as Senator Terrence Murphy from
25 Westchester County.

1 Another one of our Co-Chairs,
2 Senator Robert Ortt from Western New York, is unable
3 to be with us today, but he's represented by
4 Kevin Crumb here today.

5 Kevin, if you would just (motioning)... thank
6 you for being here.

7 Also, we're delighted that the newest member
8 of the New York State Senate, just elected last year
9 in a special election, our neighbor to the south,
10 Senator Fred Akshar is here with us today as well.

11 You know, the focus of today's session, this
12 is an opportunity for us to discuss what is
13 happening in this area, what's working in the battle
14 against heroin and drug addiction, and, also, to
15 identify what gaps in service remain, and to help us
16 determine what we can do at the state level to help
17 fill those gaps.

18 So those are the two thoughts I'd like -- as
19 we get into the discussion part of our program,
20 those are the two things we would like to hear from
21 you:

22 What's happening today?

23 And what gaps remain, and what more we can do
24 to be helpful to the local efforts to combat this
25 addiction?

1 And with that, I would like to invite our
2 Co-Chairs and my colleagues to make brief opening
3 marks.

4 First, Senator Murphy.

5 SENATOR MURPHY: Sure.

6 First of all, thank you so much,
7 Senator Seward, for putting on just an amazing forum
8 here today. It is an honor and a privilege to be
9 here and see so many professionals around the table
10 here.

11 And, just a quick, thank you, to the
12 students.

13 This is an incredible opportunity for us
14 to -- for you guys to listen, and for us to see what
15 you guys need. You're the ground game.

16 You're the ground game.

17 So this is really important that you guys are
18 here. I thank you for being here.

19 But, as the Co-Chair of the New York State
20 Task Force, along with, like Senator Seward said,
21 with Senator Amedore and Senator Ortt, it is --
22 I had the privilege of going to New Orleans this
23 past summer, on the national conference of state
24 legislators; specifically, with the pain management
25 and the opioid abuse.

1 And, we're not alone here in New York State,
2 I'll let you know that.

3 There was 13 other states that were there,
4 and we are doing some really good stuff. We just
5 need to do more.

6 And that's why we hold these forums, to
7 figure out what else we need to do. Like the
8 Senator said, what gaps we need to fill.

9 Just recently, I'm going to say, actually,
10 Thursday, this past Thursday, I had in my district,
11 in my hometown, a 26-year-old male overdosed and
12 died.

13 Went to the wake last night.

14 11 days earlier, previously, we had a
15 significant bust of a 20-year-old female; \$30,000
16 cash, 562 bags of heroin.

17 This is what's going on, and this is why we
18 will continue to hold these Task Force meetings
19 around New York State till we get it right.

20 And it is an honor and a privilege to be
21 here.

22 And I'd just like to thank Senator Seward for
23 the invitation of allowing me to come up here and
24 participate.

25 So, I am all ears.

1 Thank you.

2 SENATOR SEWARD: Thank you, Senator Murphy.

3 Senator Amedore.

4 SENATOR AMEDORE: Well, Senator Seward, thank
5 you so much for hosting this roundtable and this
6 forum.

7 For all of the guests and every -- all of the
8 speakers at the table here, thank you for your time
9 and your dedication to an issue that we have in the
10 state of New York which I believe is a true crisis.

11 It's a crisis on our hand, and there's an
12 epidemic with a high heroin use and opiate
13 overprescription and -- in pain management that is
14 creating this crisis that we have in New York.

15 I'm Senator George Amedore, and I represent
16 the 46th Senate District, which consists of
17 Schenectady, Montgomery, Albany, Greene, and Ulster
18 counties; it's a five-county area.

19 And I have the good fortune to be the
20 Chairman of the Alcoholism & Substance Abuse
21 Standing Committee in the State Senate, as well as
22 Co-Chair with two good friends of mine,
23 Senator Murphy and Senator Ortt on the Task Force of
24 Heroin and Opiate Addiction.

25 And we, literally, have gone around this

1 state, last year, as well as in prior years, our
2 Senate Conference has gone around, and we've had a
3 whole host of roundtables, as well as Task Force
4 meetings, to really understand, firsthand, the
5 issues, and what we're facing; what law enforcement,
6 what DAs, what health providers, what sheriffs,
7 what I believe the parents, most importantly, are
8 facing, with this crisis.

9 And, no question, that someone who is bound
10 with this addiction, it's very hard for them to
11 shake or overcome, and it takes us all, together, to
12 help fight this crisis.

13 And I am so glad to see in the audience
14 friends of all of ours, and that's the Friends of
15 Recovery who is here, because part of the
16 multi-prong approach that we -- that Senator Seward
17 talked about, with advocacy and education, with law
18 enforcement, with in treatment, is the approach of
19 recovery, and how we can do a much better job in
20 maintaining and keeping people in the recovery stage
21 of life, and the support services that are needed
22 for those individuals, so that we can overcome and
23 eradicate this problem.

24 So, thank you, SUNY Oneonta, as well as
25 Senator Seward for your hosting, and for this very

1 important topic being discussed today.

2 Thank you.

3 SENATOR SEWARD: Thank you, Senator Amedore.

4 And next, Senator Akshar.

5 SENATOR AKSHAR: Well, good afternoon,
6 everyone.

7 I'm Senator Fred Akshar. I'm the newest
8 member of this great Majority Conference, as well as
9 a new member of the Heroin Task Force.

10 Thank you to everybody who is sitting around
11 the table.

12 I think these types of roundtables are
13 critically important to finding a solution to this
14 issue.

15 It's a community issue that requires a
16 community response, and I think that this is --
17 these forums and these events that we're having
18 today are a perfect example of folks coming
19 together.

20 So, Senator Seward, thank you for hosting
21 this.

22 SUNY Oneonta, thank you for allowing us to
23 have this here.

24 And I, too, want to reiterate what my
25 colleagues have said: I thank each of you sitting

1 around this table for your willingness to
2 participate in this, and help us find solutions to
3 this issue.

4 Thank you.

5 SENATOR SEWARD: Thank you very much.

6 What we would like to do next is, we'll go
7 around the table, and if everyone would just simply
8 introduce themselves, and also just mention your
9 role in being with us today.

10 We'll start with you, Judge Burns.

11 JUDGE BRIAN BURNS: Thank you.

12 My name is Brian Burns. I'm an Otsego County
13 judge. I preside over the adult or criminal family
14 treatment court in Otsego County.

15 Back in 2001, I opened a family treatment
16 court for parents dealing with addiction issues,
17 whose children were either in foster care as a
18 result or in danger of being in foster care.

19 DA JOHN MUEHL: I'm John Muehl. I'm the
20 Otsego County District Attorney. I'm responsible
21 for prosecuting all the crimes in the county.

22 I've also been a member of the Otsego County
23 Drug Treatment Court since January 1st of 2004.

24 DA JOE McBRIDE: My name is Joe McBride. I'm
25 the Chenango County DA.

1 I've been involved with the drug court in our
2 county since its inception, under Judge Sullivan,
3 I believe many, many years ago. I believe it was
4 one of the first in Upstate New York.

5 I'm also involved in our county organization
6 on what we -- our heroin task force.

7 I'm also -- I have -- my staff and myself are
8 involved with the drug-court area.

9 And, obviously, I'm involved in the
10 prosecutions of all criminal matters, including drug
11 matters, in Chenango County.

12 Thank you.

13 SHERIFF RICHARD DEVLIN: Richard Devlin,
14 Otsego County Sheriff.

15 Not only we do deal with the law-enforcement
16 side of this, we have the correctional side of
17 housing inmates that are addicted and have
18 underlying medical conditions.

19 So we deal with a lot of different aspects of
20 this drug crime.

21 LT. DOUG BRENNER: Doug Brenner, Lieutenant,
22 City of Oneonta Police Department.

23 Part of my job is to collect stats and notice
24 trends in crime, and trying to address those.

25 And we have seen it, of course, in the

1 opiate-addiction areas, and so I'm active in the
2 opiate task force here, to try and find some
3 solutions.

4 UNDERSHERIFF CRAIG DuMOND: Hi. My name is
5 Craig DuMond. I'm the current undersheriff of the
6 Delaware County Sheriff's Office.

7 And on behalf of Sheriff Mills, I chair the
8 Delaware County Drug Task Force, as well as the
9 drug-enforcement unit of our office.

10 CHIEF MIKE COVERT: My name is Mike Covert.
11 I'm the Cooperstown Police Chief.

12 I started the P.A.A.R.I. program, for "Police
13 Assisting Addicts Toward Recovery Initiative," and
14 we have 43 that have started this program so far.

15 KELLY LINER, RN: I'm Kelly Liner. I'm the
16 interim executive director at Friends of Recovery of
17 Delaware and Otsego counties.

18 We are a 501(c) not-for-profit recovery
19 organization.

20 We run the Turning Point Recovery Community
21 Center here in Oneonta and Delhi.

22 And, we promote addiction recovery and --
23 through advocacy, education, and peer-support
24 services.

25 NOEL CLINTON-FEIK: Good morning. I'm

1 Noel Feik, and I'm one of the co-owners of the
2 Crossroads Inn.

3 We provide transitional supportive housing to
4 individuals coming from rehab, prison, or jail.

5 SUPT. JOSEPH YELICH: My name is
6 Joseph Yelich. I'm the Superintendent of the
7 Oneonta City Schools.

8 I'm here to continue to promote
9 multi-jurisdictional partnership that provides both
10 response to the concerns, but a model for
11 intervention on the front end.

12 When you see this problem manifest itself in
13 adults, you have to understand that they have
14 children, and those children are at school.

15 And it may be our own students that are in
16 crisis and need significant support.

17 So the city schools and the board of
18 education and my office are committed to creating
19 and maintaining those partnerships that would help
20 with that process.

21 JASON GRAY: My name is Jason Gray. I'm a
22 paramedic, and chief of Sidney EMS.

23 Sidney EMS is a small not-for-profit
24 ambulance service that's responsible for responding
25 to not only your typical medical emergencies, but

1 seeing a significant increase in the response to
2 heroin and opioid overdoses.

3 I'm responsible for overseeing the operation,
4 training of staff, and looking for trends in how we
5 can try to help, and collaborate with our other
6 local partners, in stopping this program.

7 DR. MATTHEW JONES: Matthew Jones. I am the
8 director of clinical operations at the
9 Bassett Medical Center, in the emergency department.

10 DR. JAMES ANDERSON: I'm
11 Dr. James Anderson. I'm the medical director of
12 behavioral-health integration at Bassett, as we are
13 working on the DSRIP project (the Delivery System
14 Reform Incentive Payment.)

15 As part of behavioral-health integration, and
16 as one of our DSRIP projects, we are working on a
17 withdrawal management project that is focused fairly
18 significantly on the problem that we're all here
19 today to discuss: heroin and opioid addiction.

20 Specifically, right now, we are working to
21 try to build and implement a medication-assisted
22 treatment, or "MAT" program, based out of our
23 primary-care offices, to try to step up and do as
24 much as we can to take a role in dealing with this
25 difficult issue.

1 DR. CELESTE JOHNS: I'm Celeste Johns. I'm
2 the chief of psychiatry at Bassett Medical Center,
3 and I've been at Bassett for more than 26 years.

4 I am a district delegate to the
5 Medical Society for the State of New York.

6 And, recently, I also took on the part-time
7 role of being medical director and direct treatment
8 provider at the Otsego County Addiction Recovery
9 Services here in Oneonta.

10 SHERYL DeROSA: I'm Sheryl DeRosa. I'm the
11 program coordinator of alcohol and drug abuse
12 services at Chenango County Behavioral Health.

13 I've been a member of the Chenango County
14 Drug Court team for the past three years, and, you
15 know, we just work to provide treatment, recovery,
16 and prevention services in the community.

17 RUTH ROBERTS: Hi. My name is Ruth Roberts.
18 I'm the director of community services in
19 Chenango County.

20 I'm responsible for the planning and
21 oversight of -- for services for the three
22 disability areas: mental health, substance abuse,
23 and developmental disabilities.

24 As a community partner, I think it's
25 important for me to say that this is a complex

1 problem that we're dealing with.

2 Many behavioral-health conditions tend to be
3 complex. It requires multiple partners, and those
4 relationships at the community level.

5 And, there's no other way to do it than to
6 get together, like we're doing today, and, also, of
7 course, include those family members, and the
8 individuals themselves who are struggling with the
9 conditions, and to come up with real, viable
10 solutions.

11 So, thank you.

12 I'm glad I'm here.

13 NOREEN HODGES: I'm Noreen Hodges from the
14 Schoharie County Council on Alcoholism and Substance
15 Abuse. I have been there since 2013.

16 As a prevention agency, we have increased
17 high-schoolers' belief that drugs can be harmful, by
18 72 percent.

19 We go into every school and every grade and
20 teach those skills and coping mechanisms and
21 knowledge to, hopefully, prevent someone using drugs
22 and alcohol in the first place.

23 And we survey that every two years, and we
24 have a good measure of success.

25 We started an orientation program for drug

1 court, because we found that the AA rooms were
2 somewhat becoming disruptive by people being in the
3 AA rooms, mandated through drug courts. So, we
4 wanted to open their eyes to what an opportunity
5 AA can really be in their recovery.

6 I chair our Schoharie County Opiate Task
7 Force. We'll be showing the "Hungry Heart."

8 We're speaking to doctors, encouraging the
9 Suboxone medication certification.

10 We just started our P.A.A.R.I. program in
11 Cobleskill. We had our first person come in
12 yesterday morning.

13 I was just talking to Police Chief from
14 Cooperstown.

15 We have 10 ANGELS trained to sit with that
16 person while they're are waiting to get into
17 treatment in a 24- to 48-hour window.

18 I know Cooperstown has had a good measure of
19 success, so, fingers crossed, Cobleskill will have
20 that as well.

21 I'm also a state-certified recovery-coach
22 trainer and SBIRT, or, screening, and brief
23 intervention, for youth and for adults, so we can
24 get them help sooner and faster.

25 And I'm also a DSRIP project chair --

1 co-chair.

2 MARY ROSENTHAL: I'm Mary Rosenthal from the
3 Alcohol and Drug Abuse Council of Delaware County.

4 We are a prevention education agency, same as
5 Noreen.

6 We also do referral information, workshops.

7 We also are big in the recovery support
8 services. We have a recovery coach employed by us.

9 I would like to see that get funded, maybe,
10 through the State, somehow, so that we could
11 increase how many we can have, because it's very
12 important for the recovery coaches to be part of
13 someone in, especially early recovery, helping them,
14 assisting them, along their road to recovery.

15 I'm a member of the Delaware County Drug Task
16 Force, and I'm also a member of the Delaware County
17 Drug Court.

18 CHRIS COMPTON: Hi, everyone.

19 My name is Chris Compton, the director of
20 County Alcohol and Drug Abuse Services.

21 We are a medically-supervised outpatient
22 treatment program.

23 I'm also a member of Delaware County
24 Opiate Task Force, as well as a member of the
25 Drug Treatment team and Family Treatment Court team.

1 SUSAN MATT: My name is Susan Matt. I'm the
2 Otsego County Director of Community Services, so
3 I oversee the three disability areas that my
4 colleague Ruth identified.

5 Otsego County also runs clinical services.

6 We have an integrated service area, and we
7 have been actively focusing on the treatment of
8 adolescents since 2010. We see about 50 kids a year
9 who struggle with addiction, and have really been
10 seeing that consistently.

11 We also just are very happy to receive the
12 Clubhouse Grant that OASAS awarded, and excited that
13 that will also enhance our ability to do services
14 for the kids.

15 We're also very happy that we now have a
16 formal working relationship with our health-care
17 partner, Bassett, and that's really added a
18 tremendous amount, both through the DSRIP initiative
19 and through Dr. Johns, and the conversations that
20 are ongoing, on how do we work together in
21 addressing this chronic illness for everyone?

22 JULIE DOSTAL: Good afternoon.

23 I'm Julie Dostal. I'm the executive director
24 of the LEAF Council on Alcoholism and Addictions.

25 I'm also the chair of the Otsego County

1 Opiate Task Force, which is a group of about
2 30 individuals -- professionals, people in recovery,
3 schools, medical professionals -- that are working
4 together to address the opiate issues in
5 Otsego County.

6 LEAF is a council on alcoholism, like my
7 colleagues Mary and Noreen.

8 And we work in the schools and in the
9 community to try to prevent an addiction before it
10 starts.

11 SENATOR SEWARD: Well, thank all very much
12 for joining us here today.

13 And I also want to thank everyone in the
14 audience.

15 Certainly, our SUNY Oneonta classes, thank
16 you for being here, as well as so many community
17 members who are vitally interested in this important
18 topic.

19 The only downside is that we -- there's not
20 room at the table for everyone, because, certainly,
21 everyone's view point is important.

22 And we will be having, among the participants
23 here today, you know, a -- our format is kind of a
24 roundtable discussion.

25 But if anyone at the table or anyone in the

1 audience has any written remarks that you have with
2 you today, that you would like to submit, we will
3 gladly accept them.

4 Or, if, at a later date, you would like to
5 submit some written comments to the Task Force,
6 certainly, submit those to my office right here in
7 Oneonta, and we will see that the Task Force
8 receives copies of those written comments.

9 Now, we are limited today to two hours in
10 terms of our program.

11 I know we got started a little late, so we'll
12 end a little bit late, but we are limited to
13 two hours because of the fact that the Task Force
14 has a similar forum later today out in Penn Yan, and
15 that's gonna take a little bit of travel time.
16 There are no straight roads between Oneonta and Penn
17 Yan.

18 But with that, let's get started with our
19 roundtable discussion.

20 I'm not sure where to start, but I think I'll
21 start here with Julie and Susan to -- I would like
22 to, first, let's talk about, from those individuals
23 who are directly involved in working with those who
24 are addicted, in terms of:

25 What type of services and treatment are

1 currently available?

2 What gaps and voids still remain in this
3 region of state?

4 What treatment programs: inpatient,
5 outpatient, other options?

6 We'd like to hear about, let's talk about,
7 what's happening today in treatment?

8 And, what more needs to be done, and, how we
9 can be helpful.

10 JULIE DOSTAL: Well, thank you very much, and
11 welcome, Senators.

12 And thank you, Senator Seward for inviting,
13 for making it possible for me to speak at this
14 forum.

15 Glad to be here.

16 I guess what I start right on the ground
17 with, we're prevention, and we work to try to
18 prevent a problem before it ever starts; prevent an
19 addiction before it ever starts.

20 And, a couple of the things that we are
21 actively involved with, and that is the
22 Otsego County Opiate Task Force. That group is
23 working hard, we are on the ground.

24 We started after the forum last time that you
25 were in town, and this group has been busy since

1 then, and we have been working on issues, such as
2 housing, such as trying to connect people to
3 recovery resources.

4 One of the things that we're working on with
5 the task force is a website and an ad design called
6 "Recovery Seek."

7 You can look us up at recoveryseek.org.

8 There is a very rudimentary website up there
9 where we can get people help if they need to find
10 help immediately.

11 People were not knowing where to go for
12 resources, and we're going to get that out there,
13 and get it really robust, so that people can find
14 resources.

15 The other thing that we're doing actively in
16 working on this particular issue is being quite
17 involved in the DSRIP process, and in working with
18 our partners in the medical community, to try to
19 address some of the issues around opiate addiction.

20 Otherwise, we're doing prevention. We're
21 busy in the schools, we're busy in the community,
22 we're working with kids, we're working with
23 families.

24 And, that's what we're doing in the
25 community.

1 So that's the active stuff that we're doing.

2 Where we see some needs, is that next?

3 Is that what you'd like to hear next?

4 SENATOR SEWARD: Yes.

5 JULIE DOSTAL: Okay. Then let me go right
6 into that.

7 So I want you to know that, in the best of
8 all worlds, we do work to stop addiction before it
9 starts.

10 So, before I really go into the local
11 conditions that get in our way, I want to speak
12 about a larger issue that really gets in the way of
13 prevention sometimes.

14 We can't prevent one addiction while being
15 double-minded about the harms associated with all
16 addictions.

17 And the opiate crisis is bad. It's terrible.

18 According to the CDC, it killed approximately
19 25 New Yorkers last year, and that's not acceptable.

20 It warrants a full-court press and receives
21 much public attention.

22 Also according to the CDC, there are about
23 4,000 New Yorkers who die yearly from
24 alcohol-related causes.

25 It warrants a full-court press, but the

1 commodity responsible for such harm has been
2 elevated to the status of economic strategy.

3 It sends a mixed message, and addiction is
4 addiction.

5 Whether it's to a legal substance or an
6 illegal substance, just think how many New Yorkers
7 we might save if the same public full-court press
8 were applied to a substance which causes more harm
9 and creates more costs than opiates.

10 So I just wanted to put that on the table.

11 With the opiate task force, we work really
12 hard, and there are a couple of things that we've
13 identified, and we talk about this as we get
14 together.

15 First, a large number of residents needing
16 treatment have only been successful in finding that
17 treatment out of state.

18 While administrative roadblocks, paperwork,
19 insurance companies, and lack of bed availability
20 make it nearly impossible to find treatment
21 in-state, we should not have to send our loved ones,
22 our friends, and our family to Arizona, California,
23 Florida, or North Carolina to find lifesaving
24 treatment.

25 With a state as rich in resources as

1 New York State, we ought to be able to find
2 resources in New York State.

3 Housing and transportation for those needing
4 sober environments in their recovery are either
5 extremely limited or are laden with mounds of
6 paperwork and rules.

7 Individuals can end up right back where they
8 got high in the first place, and this is no way to
9 start supports and to support recovery.

10 In this, I would like to give a big shout-out
11 to Crossroads which is a place that is working in
12 our community.

13 Treatment on demand is necessary for people
14 struggling with opiate addiction.

15 The window of opportunity to welcome a person
16 with addiction through the door of recovery is very
17 small; yet, we're treating addiction like it's
18 someone else's problem.

19 Would we send any other medical patient in
20 acute distress out the door with just a phone
21 number, or, possibly, an appointment in two weeks?

22 No, we would not.

23 And why is the often fatal addiction -- fatal
24 disease of addiction handled differently?

25 And, finally, prevention.

1 Statewide media campaigns and informative
2 websites are but a small piece of the prevention
3 puzzle.

4 New York State has the finest, most active
5 prevention system in the entire country.

6 We are the experts that you have paid for and
7 supported.

8 Use us.

9 It doesn't make sense to spend prevention
10 money in a centralized way when conditions on the
11 ground vary from village to village, county to
12 county, upstate to downstate.

13 I submit to you that the prevention experts
14 who know the ground truth to their community can be
15 the experts who can target local conditions much
16 better than a broad-brush media campaign.

17 Please consider this as you look to
18 solutions.

19 Thank you for your time and your
20 consideration, and hearing my testimony.

21 We are heartbroken in our area.

22 Too many are suffering.

23 Too many are dying.

24 And too many families are impacted in an
25 extremely negative way.

1 You have the power to make the difference,
2 and we respectfully ask that you do.

3 The staff of LEAF are always available for
4 additional information and expert consultation, and
5 it would be our honor to do so.

6 Thank you.

7 SENATOR SEWARD: Susan, did you have anything
8 to add in terms of what's happening locally?

9 SUSAN MATT: Sure. I'm going to kind of come
10 from two perspectives.

11 One is, the county director, I oversee, and
12 see, how mental-health issues are addressed, and
13 addiction issues, but, also, I have over 30 years in
14 the treatment arena.

15 I've been a clinical social worker for
16 30 years, and have worked, and had the privilege to
17 work, with people who struggle with addiction and
18 their families.

19 The approach that I'm promoting for us is
20 really a broad-brush prevention agenda, looking at,
21 really, people that are at risk.

22 I believe a child who struggles with
23 depression, who's been a victim of violence, is at
24 risk for suicide, addiction, multiple problems,
25 jail, incarceration, all the research support that.

1 So we are really looking at a broad-brush,
2 trauma-informed community.

3 That's where I think we've had conversations
4 and are interested in going, of how do we really
5 raise all of our youth up to being healthy and
6 functional and members of society.

7 On the treatment side, I think there's many
8 challenges, and I practice in an urban area.

9 There are many challenges to the rural areas,
10 is economy of scale, that there's things like the
11 housing initiatives that come out, work for a model
12 of 25 beds.

13 25 beds don't work in the rural communities,
14 you know, so we need housing models and housing
15 options that will work.

16 We have them on the mental-health side, we
17 have stipends on the mental-health side, that give a
18 lot of flexibility. But we don't have them for
19 people in recovery.

20 And I see all the things that we have for
21 people who struggle with mental illnesses, and we do
22 not have them for people who struggle with
23 addiction.

24 You know, we don't have care management, we
25 don't have housing, we don't have a lot of services

1 that we have for people who struggle with mental
2 illness.

3 I think the other piece on the treatment
4 side, and this has gone on forever, is that we treat
5 addiction so differently than we treat other chronic
6 illnesses.

7 There is no chronic illness in which you get
8 half the treatment you need.

9 You know, if a doctor says you need 10 doses
10 of chemotherapy, we don't say, Here, here's five,
11 good luck.

12 I mean, it's just crazy and insane the way we
13 treat this illness, and it's taken its tolls over
14 every years.

15 And I think we really need to be pushing that
16 it be treated as -- on an equal level and equal
17 footing and as an equal chronic illness, as
18 everything else.

19 And I think some of the legislation has been
20 instrumental. You know, I think the parity laws,
21 the insurance stuff, the no -- removing the, you
22 know, you have to fail first.

23 I mean, who says that?

24 You don't say that to any other person who
25 has a chronic illness, but we say it to addiction.

1 I think the other things in addition, you
2 know, what we struggle with in treatment is
3 certainly access.

4 You know, none of our beds are local, so
5 there are at least an hour to an hour and a half
6 away.

7 Even though there's a bed, and I know there's
8 a new-bed availability that will tell us right now
9 how many beds are out there, getting that person
10 from the emergency room at Bassett to that bed is
11 where the rubber meets the road, and that's where
12 there's a breakdown and no supports in that
13 happening.

14 I mean, it's transportation, it's insurances,
15 it's all of those things.

16 Our average is four to seven days into a
17 residential program; and, yet, Chief Covert will
18 share with you, he's getting people into treatment
19 in 24 to 48 hours in Florida.

20 Something is wrong with this picture when law
21 enforcement is having better success in getting
22 people into treatment -- now, they're all going out
23 of state -- than we as treatment providers can get.

24 Something is broken with the system.

25 And I think families have been saying that,

1 and we really need to listen, that we need to have a
2 system that is available, that is accessible, that
3 we can find ways to get people from A to B.

4 People, when they're ready to seek treatment,
5 their life is usually a disaster. They don't know
6 if they have Medicaid or Medicare, whatever. They
7 don't -- haven't really thought about it.

8 So, there's a lot of things that take work to
9 help them to get ready and to put those things in
10 place.

11 I think the other things with treatment is,
12 you know, we have a shortage of skilled
13 professionals, we have a shortage on the medical
14 side.

15 We've struggled. Our clinic went two years
16 without a medical provider.

17 And this is the first time we're actually
18 prescribing Suboxone, now that we have Dr. Johns
19 there.

20 So, it was a huge uphill battle.

21 We could get doctors from upstate to come
22 down, which was six hours; four hours' travel, for
23 two hours of clinical service, and that becomes
24 cost-prohibitive for us.

25 So we need -- we need treatment that is

1 funded at a sustainable, reasonable way.

2 I believe that's one reason why we have a
3 shortage of treatment, is that it's underfunded.
4 It's not paid for at a reasonable rate.

5 And no one goes into it expecting to make
6 money. We just expect to break even, and be able to
7 cover our costs.

8 So when we're paying for this expertise, and
9 then we have poor insurance reimbursement or poor
10 payment, you just can't do it.

11 And our clinic was certainly on the brink of
12 having to make the decision that we weren't meeting
13 our regulations and we may have to close.

14 So, I think the regulations have been a
15 barrier.

16 I know OASAS has been working on those, but,
17 we need to look at what has gotten in the way of
18 developing a service system.

19 Why isn't there more private providers at the
20 table here?

21 We talk about the public as the last resort?
22 It's the only resort.

23 So what has happened, that there's no
24 private-sector development in this area?

25 I mean, there is a huge need for it, but

1 there's not private-sector development. And that's
2 a good business question to be looking at.

3 SENATOR SEWARD: Thank you, Susan.

4 I know DSRIP has been mentioned a couple of
5 times, and I know that's really kind of directing
6 where we're going in terms of the delivery system in
7 this region. And Bassett does cover all of the
8 counties who are involved here at the table.

9 Dr. Anderson or Dr. Johns, would you want
10 to comment, in terms of additional treatment
11 availability in the region, is that being looked at
12 in terms of through the DSRIP process? And what
13 plans may be in the offing there?

14 DR. JAMES ANDERSON: I'll take the first
15 crack at this.

16 We are working right now, I think that
17 Dr. Dostal very eloquently talked about the
18 importance of having treatment ready on demand,
19 through a short window, when a person is struggling
20 with addiction, is in that period that they are
21 ready and able to accept treatment.

22 With this in mind, and also recognizing, as
23 Sue Matt points out, that we have a shortage of
24 providers, particularly a shortage of medical
25 providers, taking those two things together, we are

1 working on building a model of office-based
2 treatment for opioid addiction -- opioid and heroin
3 addiction; specifically, trying to set up, not just
4 getting our physicians set up with an X license,
5 which is absolutely essential to be able to
6 prescribe Suboxone, but, certainly not sufficient,
7 but making sure that entire clinics are prepared,
8 from the physicians, to the nursing staff, to
9 absolutely having behavioral-health available.

10 It is medication-assisted treatment.

11 It is not just treatment with medication.

12 So having counseling available in addition to
13 prescription medications, like buprenorphine, like
14 Suboxone, are essential.

15 We are working right now on -- knock on
16 wood -- we are working on a proposal with some of
17 our colleagues over in Massachusetts, to be a part
18 of a large national grant that would give us funding
19 and training to set up this infrastructure in a
20 number of our primary-care clinics.

21 That's down the road, that's aspirational.

22 That has not happened, yet.

23 We are working towards it, but that's our
24 goal.

25 In terms of what might be helpful to move

1 this effort forward, not only this specific effort
2 to build a program for medication-assisted
3 treatment, but our overall goal of trying to make a
4 significant impact in this epidemic. There are a
5 couple of things that I have identified that seem as
6 though they might be useful.

7 We mentioned that, in order to be able to
8 provide Suboxone, we need medical providers that are
9 willing to do it.

10 Well, certainly, they have to be willing to
11 do it. They also have to be legally allowed to do
12 it.

13 As it stands right now, a provider can
14 provide as -- this is a little bit of hyperbole --
15 there are very few barriers in terms of how much
16 hydrocodone, how much Percocet, a provider can
17 prescribe.

18 When a provider wants to try to deal with
19 this problem, that I often say that we in medicine
20 have been benevolently complicit in its creation, we
21 have to jump through hoops in order to be able to
22 get access to this medication.

23 We have to go through -- I think this is a
24 wonderful act that it's available -- we have to get
25 a data waiver, the Drug Addiction and Treatment Act,

1 in order to get an X number to be able to provide
2 Suboxone.

3 So, that's doable, but that creates an extra
4 barrier for already very busy providers to even have
5 the option on the table to use this medication as a
6 part of treatment.

7 So that's one barrier that I suggest that we
8 might look at.

9 Even with the data-waiver program, as it is
10 put in right now, our physicians are eligible to get
11 that waiver.

12 Our advanced practice clinicians -- our nurse
13 practitioners, our physician assistants -- are
14 ineligible to even get into a position that they are
15 able to provide Suboxone.

16 That is a potential barrier.

17 It seems that having it be more challenging
18 to provide the medication to treat addiction than
19 the medications that, down the road for many of
20 these folks, are leading to addiction, that's a
21 problem.

22 And I guess the last thing that I would say,
23 particularly as we are looking to expand these
24 office-based treatment centers for
25 medication-assisted treatment, one thing that we are

1 very cognizant of as we are setting these up, making
2 sure that we are not only helping our patients, but
3 we are in compliance of the law, is looking at
4 CFR 42, Part 2, which governs recordkeeping as it
5 pertains to substance-abuse treatment, that the law
6 was put in place with absolutely important
7 intentions.

8 We know the stigma that is around addiction.

9 This law is put in place to protect the
10 confidentiality of patients who are going forward to
11 get addiction treatment, and that's absolutely
12 essential.

13 But as we are building these office-based,
14 these primary-care-based medication-assisted
15 treatment programs to meet the need that we know is
16 there for on demand treatment, for treatment in a
17 short window, to bringing treatment to where
18 patients are at, we have to make sure that we have
19 clearly written legislation that let's our providers
20 know that, as they do this important work, that they
21 are safe from legal repercussions, while also making
22 sure that patients are assured that their records
23 are not being widely publicly available.

24 I don't know if that's what you folks were
25 looking for, but, thank you for bringing me here.

1 SENATOR MURPHY: Could you repeat that
2 legislation, the chapter number? Is that federal?
3 Is that state?

4 That's federal?

5 DR. JAMES ANDERSON: Yes, federal.

6 It's CFR 42, Part 2.

7 The other law that I referenced was a
8 2000 act, the Drug Addiction Treatment Act, or, the
9 Data Act, which allows the use of Schedule III to V
10 drugs for treatment of addiction.

11 SENATOR MURPHY: Okay.

12 SENATOR SEWARD: You mentioned -- you were
13 mentioning medication-assisted treatment.

14 That would be, you're referring to outpatient
15 treatment?

16 DR. JAMES ANDERSON: Yes, Senator.

17 SENATOR SEWARD: Is there any -- is there any
18 plans, in terms of inpatient treatment options, in
19 this region?

20 SUSAN MATT: I think the issue with inpatient
21 goes back and -- goes back to the reinforce -- the
22 payment for it.

23 I mean, we've had this discussion, why don't
24 we have some local beds?

25 And the issue is, sustainability, as well as

1 the availability of the medical staff, to work with
2 the inpatients.

3 There are conversations that go on pretty
4 regularly about this, because we do have some empty
5 beds locally, and we've talked about what we can do
6 about them.

7 But, they have to be sustainable.

8 You know, hospitals shouldn't have to take a
9 loss to provide this service.

10 SENATOR SEWARD: Dr. Johns, I know you
11 wanted to speak to that.

12 DR. CELESTE JOHNS: I think I was actually
13 going to say very much the same thing, that what we
14 would be reimbursed for doing would be a critical
15 question.

16 You know from the past, that just sustaining
17 a psychiatric unit in this part of Central New York
18 costs more than we get reimbursement for.

19 There is not reimbursement for inpatient
20 detox in a medical hospital, such as Bassett, and
21 there is very specific skills and training that go
22 into doing both detox and rehabilitation;
23 particularly, inpatient rehabilitation.

24 The long and short of it is that, it is --
25 there is -- the availability is not sufficient in

1 our area, on any level.

2 And, certainly, if we make it through that
3 part, if someone with an addiction problem makes it
4 through those steps, there is still not at all
5 enough long-term outpatient maintenance treatment.

6 And I did want to say, at this juncture, that
7 we need to recognize that we are dealing with a
8 chronic, relapsing illness.

9 I deeply believe that we need to have
10 effective medical treatments.

11 I believe that that includes Suboxone,
12 Vivitrol, many other agents, that we can use, and
13 abuse.

14 I know that my law-enforcement partners don't
15 want to see a lot more Suboxone flooding the
16 streets, and so I also deeply believe that the
17 treatment that we give has to be done very
18 carefully, it has to be done with support services,
19 including counselors.

20 And then that comes back to your question:
21 Are we going to be doing it in the hospital, or are
22 we going to do it in our medical center?

23 We're siloed.

24 Most of our clinics are Department of Health,
25 as opposed to being licensed by Office of Mental

1 Health or by OASAS.

2 So, we may want to provide treatment in our
3 Cobleskill clinic, but we may not be able to even
4 get reimbursement to have a counselor in that clinic
5 who can provide the supportive treatment to help
6 somebody change their life and change their
7 lifestyle.

8 That's regulatory reform that we desperately
9 need.

10 I think I'll stop here.

11 SENATOR SEWARD: Those are good points for
12 us.

13 I wanted to call on Chief Covert.

14 I know you've been -- I've been reading about
15 and hearing about, you've implemented a rather
16 innovative program there in Cooperstown.

17 And if you could describe, briefly, your
18 experience, and, particularly, in obtaining
19 treatment options for those who show up at your door
20 and say, I would like to get into treatment.

21 CHIEF MIKE COVERT: Well, one of things with
22 the P.A.A.R.I. program, it was started in
23 Gloucester, Massachusetts, by Chief Campanella, who
24 had people dying from overdoses, and he didn't know
25 what to do with it.

1 So he reached out to his friends and
2 constituents, and they came up with this program.
3 And then he reached out to the medical community and
4 rehab centers throughout the United States, to say,
5 What can we do?

6 One of the things that we have in
7 New York State is, most of the people that I deal
8 with say that they have insurance, and they proudly
9 say, I have Medicaid, I have Fidelis.

10 That doesn't do anything for us.

11 It doesn't work for out-of-state, it doesn't
12 work for in-state.

13 In-state, if you have a broken arm, for
14 example, you get it put into a cast, and you have it
15 for 6 to 8 weeks in the cast so it heals.

16 The brain takes a long time to heal from this
17 disease.

18 And one of the things that we're doing is,
19 we're having these detox centers or rehab centers in
20 New York State that only treat people, at the most,
21 14 days to 28 days, and that's after failing several
22 times.

23 It's not long enough for them to heal, so
24 they relapse, and they continue the program again.

25 A lot of it takes four to seven days just to

1 get an appointment, and then when your appointment
2 comes, you go to outpatient and you get treated
3 there for a half-hour visit, \$50 co-pay, and you go
4 home. Come back in two weeks.

5 The problem is, is that, when we do that, you
6 know, it just doesn't work with the program, because
7 it takes so long to heal.

8 We need more programs, more facilities, in
9 New York State that are willing to take other
10 things.

11 We need to have Medicaid step up to the
12 plate, possibly, and provide real insurance.

13 If you have a heart attack, you go to the
14 emergency room, they send you to ICU. They take you
15 down to critical-care unit, down to the medical
16 floor, ship you to rehab, at Sunnyview, or some
17 other place. And then after two weeks out there, or
18 three weeks out there, or a month, then they ship
19 you back to outpatient, and after a year, they
20 declare that you're cured, and you stop taking your
21 Plavix and everything else.

22 With outpatient, you go in there with a
23 disease, such as an overdose, you go, in our case
24 here, with Bassett, we go to the emergency room,
25 crisis, released. Four to seven days you may get an

1 appointment, and then you're an outpatient.

2 If you fail the outpatient, you fail again at
3 outpatient, you fail again, you may have come back
4 to crisis two or three times and been dealt with
5 there again.

6 And then, finally, they'll say, Okay. Well,
7 you can take 14 days rehab, or 28 days.

8 But it's still not enough.

9 The program that we started, the P.A.A.R.I.
10 program, we have over 253 rehab centers throughout
11 the United States that we can draw from.

12 I have used just several -- a few of them,
13 but they're in almost every state. I believe
14 40 states total.

15 And with that, we can turn around and contact
16 the placement coordinator, who not only looks at
17 them -- as an example -- I have to back up for a
18 second.

19 When I talk to a person that calls me, their
20 window of opportunity is that moment when he calls
21 me.

22 To have a drug addict call a police chief and
23 tell him, "I have a drug problem, I need help," it
24 goes against everything that they've ever known.
25 They're paranoid, they're schizophrenic, they're

1 worried about the police.

2 And when they call me, you know that they're
3 at the bottom where they need help.

4 If I leave a phone message and don't come
5 back to it until the next day, I don't -- I lose
6 that person. They never call back. They never
7 answer the cell phone. And it's is done.

8 I have called six of them so far, all week
9 long, that left messages when I was out sick, and
10 I can't get ahold of them.

11 With this, if we can turn around and get
12 those people the help that they need when they need
13 it, these placement coordinators drop Medicaid, they
14 get Obamacare in other states, such as Arizona,
15 Florida, California, and they pay for that.

16 They call the families and they ask the
17 families to pay for those monthly payments of
18 insurance, and then they get them shipped out there.

19 It's a one-way ticket.

20 They fly out to California, they fly down to
21 Florida. They go to the rehab center, that picks
22 them up right at the airport, and they take them
23 there.

24 The cost, without insurance, is, roughly,
25 \$29,800 a, month on average.

1 With that, I've gotten where I can have
2 clinics that will dual-diagnose people, because most
3 of the people, I ask interviews -- in interviews,
4 when I talk to these people, "What's your drug of
5 choice?"

6 They tell me, reluctantly, heroin, or
7 opiates.

8 And then when I ask them, I said, "How long
9 you have been doing this?" they'll tell me how many
10 years.

11 I ask them how much they're using, so I can
12 get an idea of how much we're taking off the street
13 for the demand.

14 And then in the process of that, I ask them,
15 I said, "Well, what started you on heroin?"

16 Out of the 43 people that I've dealt with so
17 far that are in the program, only 2 of them started
18 heroin right off the bat and said, Let's do heroin.

19 One was on his 21st birthday, he did it with
20 five of his friends. Three of his friends are now
21 deceased from overdoses. And he asked for help.

22 But, the rest all started from opiates as
23 painkillers administered by hospitals for injuries
24 that they attained back when they were 13, 14, 15,
25 16 years of age, and that it continued through that

1 process, that once the medicine stopped, they
2 weren't able to afford buying it on the street
3 because of I-STOP, which was a great program.

4 They can't get fake prescriptions anymore.

5 They can't buy pills on the street because
6 they're too expensive, when you can buy heroin, in
7 our area, it's \$25 a packet; down in the Newburgh
8 area, it's \$15 a packet; and down in Woodstock,
9 I was getting people there that were buying it for
10 \$10 a packet.

11 All right?

12 So, the commodity is out there that's cheaper
13 than buying pills.

14 And at first they would snort it. And then,
15 finally, when the drug didn't work for them anymore,
16 they started injecting.

17 Some of my people are using 25 packs a day.

18 If you think of that as even \$20 a packet,
19 that's \$500 a day, times 7 days a week.

20 That's \$3500 a week that they're stealing
21 from the community, or stealing from their family,
22 their friends. Lifesavings are being taken away
23 from the families, when he you hear the back stories
24 and the horror stories.

25 And the family -- I have ANGELS that come

1 into this program that I use as volunteers. And
2 I had ten of them, came right in and said, We want
3 to volunteer, we want to help.

4 But I found out that the family members
5 wanted to help.

6 They have a loss, that they don't know what
7 to do anymore.

8 And when they come in, they whisper about
9 this. It's not about, Can I talk you to privately?
10 and they start talking about heroin.

11 And I talk to them out loud about heroin, and
12 they look at me and say, Oh, my god, I've never
13 talked about this before.

14 It's a skeleton in their closet.

15 And when you look at it, everybody has
16 skeletons in their closet; it's just a matter of how
17 big your closet is.

18 And with that, we all know addicts, but we
19 don't talk about it.

20 So I started my program on Thanksgiving,
21 because I wanted it when all the family members were
22 sitting around the table at Uncle Jim's house, and
23 Sally -- Cousin Sally is in her bedroom, Well,
24 where's Cousin Sally?

25 Everybody in the room knows that

1 Cousin Sally's an addict, but nobody talks about it.

2 "Oh, she's in her bedroom, she doesn't feel
3 good today;" because she's in there shooting up.

4 And with that, I wanted the families to talk,
5 because grandma and grandpa can afford to pay for
6 the insurance. They can pay for the flight to get
7 out there.

8 And if they can't afford it, and they can't
9 pay for it, they can at least talk to them and say,
10 a thing like, first of all, I try and get them out
11 of state here when they go to this program, because
12 I get them away from their frenemies.

13 And I use the term "frenemies" because their
14 friends and family that enable them look the other
15 way and tell them -- don't tell them that it's wrong
16 to do this, don't say no. Or, they're enemies who
17 turn around and keep trying to give them the drug.

18 So I try and send them out of state.

19 In Upstate New York, if you're gonna start
20 your life over, my choice of going to a place to
21 start over would be a place where I wake up every
22 day and it's sunny.

23 [Laughter.]

24 CHIEF MIKE COVERT: So I send them to
25 California, and I send them to Florida.

1 They have the most rehab centers that are
2 available with open beds.

3 I talked to one yesterday, he had 10 beds
4 available out of 14 that he has in his place.

5 They're residential centers. They're set in
6 residential areas in Florida, California.

7 I had a girl call me up the next day after
8 she was sent out to Florida -- or, to California.
9 She woke up on Laguna Beach, and she looked out, and
10 she goes, My god, this is beautiful. I'm on the
11 ocean.

12 Her neighbor was a movie star.

13 And she was amazed that she was placed there,
14 and that we could actually get her there and get her
15 some help.

16 It takes a long time for these people to
17 heal, so we don't -- can't do 30-day stints of this.
18 It doesn't work.

19 I'm trying to get most of the people in
20 95-day, 90-day centers, with 90-day outpatient. And
21 I do that out there, and they pay for the
22 insurances.

23 The hangups that we have, is not having
24 money.

25 Let's face it, addicts don't have jobs, for

1 the most part. Addicts don't have money, they don't
2 have insurance.

3 Yes, they get Medicaid because they work with
4 the County and the County systems, so everybody gets
5 Medicaid.

6 It doesn't help.

7 With that, the last thing is, is that, if we
8 can get more places in New York, get more funding
9 with Medicaid to open up that door for funding,
10 I think that we could solve a lot of the problems
11 here.

12 Our hospitals are -- hands are tied.

13 I dealt with the subject yesterday at
14 Bassett.

15 Morphine pills.

16 And, he's there, he asked for help; but, yet,
17 he gets admitted. The first thing was, we were
18 going to arrest him because we -- he had so many
19 drugs on him. We found his prescriptions.

20 And if we admit the person, there's not much
21 they can do, other than find a place to place them.

22 That's the sad part, because people want to
23 stay home. They don't want to leave.

24 And we can't do that in New York State.

25 SENATOR SEWARD: Chief, just briefly, the --

1 you mentioned there are 350 treatment centers?

2 CHIEF MIKE COVERT: 253.

3 SENATOR SEWARD: 253.

4 Are any of those in New York State?

5 I know you like to go for the -- more
6 sunshine.

7 CHIEF MIKE COVERT: One -- one -- two of
8 them. Right?

9 Two.

10 Both want insurance, so they have to have PPO
11 insurance.

12 SENATOR SEWARD: Uh-huh.

13 And these, Florida, California, Arizona,
14 facilities, are they privately --

15 CHIEF MIKE COVERT: They are privately-owned.

16 SENATOR SEWARD: -owned.

17 CHIEF MIKE COVERT: And if you have PPO
18 insurance, like Blue Cross/Blue Shield, or whatever,
19 I can get them there within 24 hours.

20 If they have to get insurance, it's either
21 the 1st of the month or the 15th of the month to get
22 them their insurance, so that they become,
23 quote/unquote, residents of that state.

24 They get rid of their Medicaid and they take
25 on Obamacare, which those states allow it for rehab.

1 SENATOR SEWARD: I see.

2 SENATOR MURPHY: So we have nobody
3 in-network?

4 CHIEF MIKE COVERT: Nobody.

5 OFF-CAMERA SPEAKER: Well, they deliberately
6 use the out-of-network benefits.

7 So if they were in-network and a
8 New York State provider, they would get \$100.
9 They're getting \$650 for that same service.

10 Right, they're going through the back door to
11 go into -- through the out --

12 SENATOR MURPHY: So, to my point, they're not
13 allowed to be. They don't want to be a provider --

14 OFF-CAMERA SPEAKER: Right, right, right.

15 SENATOR MURPHY: -- so we have no
16 New York State providers.

17 OFF-CAMERA SPEAKER: Yes. Exactly.

18 SENATOR MURPHY: Gotcha.

19 CHIEF MIKE COVERT: And that's our problem.

20 OFF-CAMERA SPEAKER: And just to speak to the
21 bed availability, you know, the Governor rolled it
22 out, it went on. There were six beds, male beds, at
23 Conifer Park in the morning, and they were taken
24 within a half an hour.

25 And that was just -- and I just looked in

1 Schenectady to Albany.

2 So -- and there were, like, one or two other
3 beds available.

4 OFF-CAMERA SPEAKER: And that's if the
5 providers update the system.

6 OFF-CAMERA SPEAKER: Right.

7 SENATOR AKSHAR: Has anybody found that
8 problematic?

9 It's been a topic of discussion in my
10 district, with some people providing services
11 that -- that the new clearinghouse is not being kept
12 up to date, and the information provided is not
13 accurate.

14 Has anybody had any dealings with that?

15 OFF-CAMERA SPEAKER: I'm also getting
16 feedback that it's not very user-friendly.

17 I think, right now, it's done by county.

18 And I think it would be more useful if it was
19 done by ZIP code, and, also, we're able to narrow in
20 on what type of bed you were looking for.

21 And it's a little difficult to find. It's on
22 the Department of Health website.

23 I think the easier access, and a little more
24 friendly use, would be good update.

25 RUTH ROBERTS: I hear mixed information about

1 the bed availability across the state.

2 I often hear that there are beds, there are
3 beds open, and that, quite frankly, we have
4 providers across the state who are at risk
5 financially, because they're not operating at full
6 capacity.

7 We're in Chenango County. And, by the way,
8 we're not part of the Bassett DSRIP. We're part of
9 Care Compass, which is led by UHS. And,
10 unfortunately, they did not choose to focus on
11 substance abuse. They chose only to really focus on
12 the mental health in their projects.

13 But, I'm told that New Horizons, which is
14 operated out of UHS, inpatient, which we do referral
15 out of folks to, is operating, generally, at a
16 60 percent capacity.

17 So, I understand, and getting people into
18 treatment during that particular window of
19 opportunity, absolutely.

20 And I share the same concerns that Sue
21 expressed earlier: How is it possible that folks
22 can, you know, have access in such an expedient
23 manner, compared to going through the traditional
24 treatment-provider system that we have set up?

25 Something is really wrong, and something

1 needs to be fixed.

2 On the other hand, we have to look at, how
3 are we supporting those providers that do exist in
4 the state?

5 And, if we really are setting up a system
6 where they cannot operate business, then we're going
7 see more and more of them go away, because most
8 businesses can't continually operate with a deficit
9 like that.

10 So, I'm going kind of take an opportunity now
11 to talk about some things that we've already talked
12 about.

13 But, you know, I started out by saying, this
14 needs to be a multi-prong approach, and the first
15 order of business is prevention.

16 Prevention, prevention.

17 And I think we have to be willing to step
18 back and look at our communities, and ask those
19 questions:

20 How well are we doing in terms of growing
21 healthy people?

22 How well are we doing in terms of growing
23 healthy children, supporting families, making sure
24 that families have what they need, the resources
25 they need, so that there is some connected tissue

1 within the community, so that when problems do come
2 up, and they will come up, that there will be those
3 built-in protective factors that will allow families
4 and children and people to remain healthy?

5 And then we've got to be able to address
6 those situations where people desperately need help.

7 And, certainly, the heroin epidemic is an
8 example of that, and it needs to be now, so -- and
9 it's about keeping people alive.

10 That's how small that window of opportunity
11 is.

12 And so once we navigate all the quagmire of,
13 how do we keep people alive, and how do we get --
14 how do we access treatment? then we -- also, we're
15 not done.

16 We have to also then consider, what kind of
17 community is that individual returning to?

18 And that individual isn't, like, operating in
19 a vacuum.

20 They have friends, they have families, they
21 often have children, and all of that has to be
22 considered.

23 When you look at the environments that an
24 addict, who has probably been in and out of the
25 jail, multiple times, in and out of inpatient rehab,

1 multiple times, for a number of the reasons that
2 we've already talked about, so they're coming back
3 to the community, and, where can they live? What
4 resources exist?

5 We need safe and sober, clean, housing
6 options for individuals that are coming out of these
7 very expensive, high-level, high-end inpatient
8 settings.

9 And then we need to, as communities, have
10 roads to recovery.

11 You know how hard it is for an addict to get
12 a job?

13 Do you know how hard it is, when they go in
14 and they apply for an employment, when they finally
15 get to that point in their recovery where they're
16 ready to invest in some type of job or vocational?

17 It's very difficult.

18 We then create all sorts of barriers for
19 them.

20 So, even if the addict is able to get from --
21 from getting off the streets, getting off the drugs,
22 going through treatment, and coming back out into
23 the community, in some ways, they're just starting
24 in terms of recovery.

25 So I think, you know, it's -- we have to

1 look, micro, at all of the moving parts, and we also
2 have to not lose sight of the bigger picture.

3 And, you know, I believe, you know,
4 government has a role in this, but don't think for a
5 second that government is going to fix all this, or
6 should they.

7 You know, this requires, you know, a
8 collective action, and what's sometimes called a
9 "collective impact model."

10 You know, everybody has skin in the game.

11 Everybody has a part in the solution here.

12 SENATOR SEWARD: Thank you, Ruth.

13 I just want to point out, you made some
14 excellent points.

15 I -- you know, I continue to sponsor and push
16 legislation that would provide a -- some tax credits
17 to employers who hire an individual who is a --
18 graduated from a drug court, or successfully
19 completed a -- you know, the judicial diversion
20 program, or something of that sort.

21 RUTH ROBERTS: Thank you. I appreciate that.

22 SENATOR SEWARD: Because that's -- you know,
23 that's a key point in terms of helping someone start
24 over, in terms of their lives.

25 This has all been very good comments, and we

1 want to hear from everyone, but I wanted to
2 specifically turn our attention to some of our
3 law-enforcement officials.

4 We have our county judge, who -- Judge Burns,
5 who I must say, we were just chatting earlier, a few
6 years ago, when we were each being sworn in for our
7 new terms, Judge Burns, really, for the first time,
8 a few years ago, openly, even at that kind of joyous
9 occasion, on a New Year's Day, he talked about the
10 heroin problem in Otsego County, and, it's serious,
11 it's widespread, and we needed to get on top of it.

12 And I appreciate that, Judge.

13 And, also, we have our two district attorneys
14 here, as well as other law enforcement.

15 And I wanted to hear from all of you, in
16 terms of what your thoughts were, in terms of, you
17 know, the current laws on the book:

18 Are they helping?

19 Are they hurting?

20 What measures, you know, would you like to
21 see, to better assist you in doing your work, both,
22 in dealing with this from a-law enforcement point of
23 view, but also moving people toward a life of
24 recovery?

25 DA JOE McBRIDE: Senator, we'd like to defer

1 to the judge, to make sure we don't have any future
2 problems in his courtrooms.

3 [Laughter.]

4 SENATOR SEWARD: Use the mic there.

5 JUDGE BRIAN BURNS: Thank you, Joseph.

6 Very briefly, some of the numbers which
7 I find startling:

8 Up until about 2005 in Otsego County, we
9 averaged about five felony indictments a year for
10 those involved with opiates or heroin.

11 By 2012, we're averaging over 50 people a
12 year.

13 One or two, maybe three, kids in foster care
14 back in 2005, due though their parent's use of
15 opiates. By 2012, 2013, we were up over 20.

16 So the impact on the community, both
17 financially and in terms of human costs, has been
18 enormous, and particularly with the kids in foster
19 care, to generational.

20 And the response from the courts, and the
21 district attorney's offices, really started before
22 this specific problem, but it was a recognition that
23 much of the substance-use-disorder issue should be
24 treated as a public-health issue, not as a
25 criminal-law issue.

1 And the treatment courts were started as
2 partnerships, and it's not just in our county, in
3 Chenango County, but in every county in the state.
4 And the treatment courts are partnerships between
5 the courts, legal counsel, law enforcement,
6 treatment providers, and I absolutely include both
7 mental-health and substance-use-disorder treatment
8 providers in that.

9 Local colleges, like this college, local
10 human-service agencies, and our county Catholic
11 Charities, Opportunities for Otsego, LEAF, a real
12 multi-disciplinary community-based approach to this
13 problem.

14 The laws that have been passed in response to
15 this system, some have been enormously helpful.

16 There's a judicial diversion law now, and
17 through that, and our prior efforts, we've diverted
18 close to 500 people in 15 years.

19 These are non-violent felons, and just a
20 quick word on that.

21 Dr. Dostal's dealing with these folks
22 before the onset of the full addiction, she's
23 involved with preventive services.

24 By the time they come to me, they are
25 adjudicated non-violent felons, or, people whose

1 children have been removed, or about to be removed,
2 and placed into foster care because of their
3 involvement with criminal justice system.

4 The increase in crime I think has been
5 significant, and I say non-violent crime.

6 But, the burglaries, the grand larcenies, the
7 forgeries, all of those things, have made a
8 significant impact on our community.

9 And the drug-court philosophy is, if we can
10 break this cycle of addiction, we can promote public
11 safety and help take care of our neighbors at the
12 same time.

13 The diversion laws which the Legislature
14 passed allow us to do that, and address some of the
15 other issues that were raised, such as, to help
16 eliminate the stigma of a felony conviction when
17 trying to get a new job.

18 As a judge, if somebody successfully
19 completes an intensive treatment program, I can wipe
20 out that felony conviction. I can go back in time
21 before they even came to me and get rid of certain
22 misdemeanor convictions as well.

23 That helps the reentry process.

24 One of the most important changes in the law
25 that I believe is made in the last few years, is a

1 recognition by the Legislature that this epidemic
2 doesn't happen in a vacuum.

3 It's not just hospitals were providing
4 painkillers.

5 There is a segment of our society that
6 manufactures and distributes masses -- massive
7 amounts of heroin, and this poison is killing people
8 in our community.

9 And a few years ago, the Senate passed a
10 major drug trafficker law, which enhanced or made
11 longer sentences for those kingpins; those
12 manufacturing and distributing things.

13 Not the street-level dealers, many of whom
14 are selling a bag of heroin, and their pay is they
15 get to keep a bag of heroin; but to turn law
16 enforcement and the courts' efforts towards the
17 major traffickers.

18 That's been a significant, I think,
19 improvement.

20 I'm not sure if this district attorney has a
21 distinction of the first two major-trafficker
22 convictions in the state, but, certainly, among
23 them, and that was based on investigations done by
24 Sheriff Devlin's individuals.

25 But these are the people who are really

1 responsible for bringing this into our community.

2 In terms of resources, I absolutely think
3 additional treatment, inpatient beds, detox
4 facilities, the ability to provide meaningful
5 long-term treatment, is essential, but it should not
6 come at the cost of diverting resources away from
7 law enforcement, away from the court system, and
8 really attacking this at the supply side.

9 And I just -- I don't want to lose sight of
10 that as well, because I think that's a significant
11 factor in this problem, the enormous money that can
12 be made.

13 And, again, from my perspective, these people
14 are predators, and they're taking away people's
15 money, their health, and their very lives.

16 And I applaud the efforts of the Legislature
17 to really turn the focus on those individuals who
18 are the major traffickers.

19 SENATOR SEWARD: Thank you.

20 There certainly is a big difference from,
21 someone who is addicted, and someone who is
22 profiting on the addiction of others.

23 JUDGE BRIAN BURNS: Absolutely.

24 SENATOR SEWARD: Any other comments from our
25 law enforcement?

1 DA JOHN MUEHL: I would comment on what you
2 just commented on, Senator.

3 When I first took office, our major drug in
4 Otsego County was cocaine, and cocaine dealers were
5 generally in it to make money.

6 And we talked, and we treated them, pretty
7 much as dealers: They get caught, they were
8 convicted, and they were sent to prison.

9 And at some point, and I think Judge Burns
10 helped me change my mind a little bit, and I don't
11 tend of be very warm and fuzzy, but --

12 [Laughter.]

13 DA JOHN MUEHL: -- I got to the point where
14 I saw that a lot of our -- what we would consider a
15 dealer here in Otsego County, with heroin, was
16 really not a dealer.

17 It was somebody who was being taken advantage
18 of by someone who was a dealer. They would convince
19 them to sell for them or mule for them, a carry, and
20 do their bidding for them, and pay them in heroin.

21 One of the biggest, the first kingpin, and it
22 was the first kingpin and conviction, and I'm not
23 sure that we -- it's a distinction for our county,
24 certainly, but, it was the first major-trafficker
25 conviction in New York State, after a jury trial, it

1 was in Otsego County, and the guy's name was
2 Jose Rodriguez. And he was the first heroin dealer
3 I had ever encountered.

4 And I first prosecuted him in 2005, and we
5 sent him to prison for 2 1/2 years, and he got in
6 shock, and he got out. And then he thought he would
7 run his whole organization from New York City, and
8 he did.

9 If you wanted heroin in Otsego County, and he
10 sold over 90 percent of all heroin in Otsego County,
11 you called him in the Bronx, and he would say, Okay.
12 You go meet somebody at Wal-Mart at -- you know, in
13 10 minutes, and they'll be there.

14 And then he would send his mule with the
15 drugs.

16 So it was a three-year -- three- and
17 four-year operation, between the Sheriff's Office,
18 Otsego County -- the Otsego County Sheriff's Office
19 and Oneonta City Police, in order to catch enough of
20 these people and roll them and turn them and get
21 them to testify against Jose Rodriguez, who got over
22 40 years in state prison, after trial, and deserved
23 every day of it.

24 I complain still, at times, because I put
25 people in prison, and -- or, the judge puts them in

1 prison, but I prosecute them, and I give them
2 five years. And the next day I walk down the
3 street, and there they go down the street, and I
4 say, What's going on here? I mean, how did they get
5 out and -- you know, in no time?

6 I think that -- and I'm not saying it's this
7 part of the State Legislature, but I think that
8 there's been a lot of concern, over years and years,
9 that district attorneys overstep their bounds, and
10 people are worried about the Rockefeller drug laws,
11 et cetera, et cetera.

12 And I think if you were to go back and look
13 at how people are actually treated, that people are
14 getting more time now than they were under the
15 Rockefeller drug laws, because, district attorneys,
16 I believe, most of them, use their discretion, and
17 we only put the people who really deserve to be in
18 prison for a long time in prison for a long time.

19 And at times now, if I have somebody that
20 I really believe is a big dealer and I don't have a
21 lot on them, I can't get a lot of time on them.

22 But, for the most part, with the major
23 trafficker we do it.

24 And these smaller people that are dealing,
25 I now treat differently, and now we steer much more

1 towards treatment than we do to prison, because,
2 they aren't selling because they want to make money;
3 they're selling because they have a drug habit.

4 And sending them to prison doesn't do any --
5 doesn't help anything.

6 It's simply -- it simply prolongs them from
7 just -- they're just going to get out and start
8 again.

9 So, it's a huge difference of how we treat
10 heroin than how we used to treat, or still do treat,
11 other drugs that aren't nearly as addictive.

12 DA JOE McBRIDE: Thank you, Senator.

13 My towns, I'm going to give you the update
14 from Chenango County.

15 We are a small rural town, and we don't have
16 the two colleges that you have in the beautiful
17 Cooperstown that you have here in Otsego County, but
18 we do have the problems of our own.

19 I checked with our officers and our public
20 officials before I came over here today, I checked
21 with the Sheriff's Department, and they estimated
22 there were approximately 10 deaths due to heroin in
23 our county last year.

24 I talked to our City Police Department, and
25 he informed me that, the good news, that the heroin

1 arrests for 2015 were actually down, and that we had
2 done a good job at fighting the influx of heroin in
3 our particular county.

4 But even with the arrests and prosecutions
5 down, three-quarters of our drug-court people are in
6 drug court because of use and abuse of heroin.

7 So what we've done, just like John said, we
8 don't have the scale that they have over here, but
9 when we see people from out of town coming into our
10 community to sell dope, we find them, we target
11 them, and we remove them.

12 And the word's out, that if you come to
13 Upstate New York, if you come to my county, or you
14 come to Otsego County, and you get caught selling
15 dope, you're gonna go to prison for a long time.

16 We've also taken a view with the people who
17 are selling dope for their personal, you know,
18 addiction. They're viewed a different way. We try
19 to get the people into drug court.

20 We have a very conservative community.

21 So if I tell everyone that I want to give
22 everybody a hug to get them out of drug addiction,
23 I'm going be out of office very soon.

24 But, if I can say, listen, we are going to
25 give these people the opportunity to prove

1 themselves to everyone in our community, we're going
2 to give them a hand, we're going to put them on the
3 right road, and we're going to give them the
4 opportunity to work their way back in the community.

5 How does that help me?

6 It keeps them out of our county jail for a
7 year. It keeps them out of state prison.

8 And no matter when they come back from state
9 prison, if I ship them, they're always coming back.

10 So we're trying to give them the services
11 that they can need to change their life up-front.

12 And that's what we've been doing, not only in
13 our county, but throughout the state.

14 That being said, there are very serious
15 issues.

16 I talked to Public Health today. They told
17 me, three years ago, there were two to five cases of
18 hep C in our community.

19 There are now 230.

20 I don't know what the math is there, but
21 that's a crisis.

22 That means there's a lot more people using
23 needles, having health issues.

24 And from the people in that world, and
25 I don't expect to know those numbers, that is a

1 phenomenal cost to the community to deal with the
2 hep C crisis, more than incarceration, more than the
3 lifetime cost of help.

4 We need to focus on keeping our people safe
5 and healthy.

6 The next, I spoke to our drug-court
7 coordinator, who does most of the work.

8 People here today are on our drug-court team,
9 and they do -- they -- I can't make it to every
10 meeting, I try to get staff there as much as I can.

11 But I came down to Jim Everhart (ph.), who's
12 our director, and said, I'm going to this meeting
13 today. What would you like me to speak about?

14 And he said, You know what, Joe? The biggest
15 problem we have, is when our people need services,
16 there are roadblocks to getting in.

17 Whether there is a bed in New Horizons or
18 not, the guy, if he's in jail, he's not eligible for
19 service. If he's out of jail, well, he's not
20 addicted and he's not in crisis.

21 Well, he just got of jail.

22 Those people aren't getting in.

23 And a lot of times, in my experience, and
24 then I'll let someone else speak, is that heroin is
25 the worst drug we've ever had.

1 They can be in jail for nine months. Used to
2 be, you'd get the cocaine people, even the crack
3 people, if they were removed from the drug for a
4 certain period of time, most of them, the light
5 turned on, the light bulb was there, "This is
6 killing me."

7 My experience with the people who are
8 addicted to heroin, is they get out, and no matter
9 what the time, if you don't provide them the
10 services they need, you don't get them a place to
11 live, away from their enemies, their frenemies, then
12 there is absolutely no chance of success, and, they
13 are very likely to overdose and die, because they go
14 back into a world where they haven't been using a
15 narcotic drug, they ingest it in their body, and
16 many times in our county, we've had the 24-hour
17 overdose. Immediately released from jail and, boom,
18 that they've died from the overdose.

19 That's the 30-second version of what's going
20 on.

21 It's not just in Chenango County or
22 Otsego County. It's all over state. And if
23 everybody works together, and if we get people in.

24 And the last thing is, we have a young man
25 who was a heroin addict in our county, who went down

1 to Florida, and he opened his own rehab center, and
2 we send our kids there.

3 And that's because of money.

4 He was a kid, he didn't have a college
5 education. He got certified, and whatever he needs
6 in Florida, and he's able to do there, because of
7 the lack -- I don't want to say lack of regulation,
8 but we can't tie our hands here.

9 And everybody who's trying to do something
10 good, make it unprofitable for the hospital, can't
11 get involved in providing the service.

12 We need to find a way to provide that
13 service.

14 If they can do it in California, in Malibu,
15 we can do here in Upstate New York.

16 Thank you, and that's all I have.

17 SENATOR SEWARD: Thank you, Joe.

18 And our men in uniform here, who are on the
19 front lines every day, are on the streets, I'd like
20 to hear your perspective, in terms of, you know,
21 what laws are on the books today that are working,
22 and if there's anything you need from us.

23 SHERIFF RICHARD DEVLIN: Undersheriff, I'm
24 going to start with you, because you're doing a lot
25 of active cases.

1 UNDERSHERIFF CRAIG DuMOND: Thank you,
2 Sheriff.

3 First of all, I'd just like to say again,
4 thank you, Senator Seward, for hosting this, and
5 bringing us all together, because, you know, we've
6 said all over the place, we're not going to arrest
7 our way out of this situation. It's going to take a
8 collaborative approach.

9 And, you know, I can't agree with the
10 panelists more that have spoken today, Judge Burns,
11 both our DAs, they're -- I mean, you just want to
12 say that, there's is no other way to say it, they're
13 right on the money, when it comes to the problems
14 that we face.

15 So I'm not going to get into, you know, our
16 support of the treatment services. It's clearly
17 there.

18 We definitely need better treatment services,
19 more available treatment services, if we're going to
20 make a difference.

21 We currently look at this as two different
22 tracks, as has been talked to today: You have your
23 addicts, and you have your businessmen, and you
24 can't treat one like the other, either way.

25 So, your addicts, you really need to -- you

1 need to get them the services that they need to
2 bring them back to being productive members of
3 society.

4 And, the dealers, you need to hammer, no way
5 about it.

6 And what we're seeing a little bit is a
7 manipulation on both sides, and I'm going to bring
8 up a couple of things that I think might be helpful.

9 We have a very successful drug court in
10 Delaware County, as we do in the counties
11 surrounding us. It works very well.

12 We think that we're -- again, we're very
13 conservative in our approach to who are the people
14 we send to drug court.

15 The diversion laws are great; however, you
16 know, I think it was DA Muehl that brought up the
17 Rockefeller drug laws.

18 A lot of that stuff, there was some baby --
19 there were some babies that got thrown out with the
20 bathwater on that.

21 And, we need to bring back some minimum
22 sentences in regard to some of these businessmen
23 drug dealers, so that the courts and the district
24 attorneys, the prosecutors, have the teeth and the
25 tools they need to really give these people the

1 punishment they deserve, because they do.

2 They're ruining our communities, they're
3 victimizing people; they really are.

4 They're taking advantage of our weakest, the
5 most vulnerable populations within our counties, and
6 they're, literally, victimizing these people.

7 A couple of weeks ago, I arrived on the scene
8 of a significant operation, that we took down a meth
9 house in the village of Walton. And the first thing
10 I saw when I got out of my car was a 12-year-old boy
11 carrying his 3-year-old sister out of the house.

12 And it's heartbreaking.

13 And it is -- this isn't something that we're
14 just seeing randomly. This is something we're
15 seeing on a regular basis.

16 The other thing that's -- that's -- I would
17 feel neglectful if I didn't mention it, is the
18 majority of these people that we're arresting,
19 whether it be the addicts we're arresting for the
20 petty offenses or the dealers, the people that we're
21 arresting, 9 out of 10, if not more, are on public
22 assistance.

23 Okay?

24 And, I believe there's some welfare reform
25 that needs to happen within New York State, and that

1 could be beneficial in helping us to address these
2 problems.

3 First of all, let's talk about the first
4 track: the treatment.

5 If we brought back the urine screen -- or,
6 I shouldn't say if we brought back.

7 If we implemented urine screening within our
8 public-assistance population, again, our poor and
9 impoverished citizens who are being victimized by
10 these dealers, we may be able to catch some of these
11 families, we may be able to catch some of these
12 individuals, before it's too late.

13 We may be able to get them in beginning
14 stages of their addictions, become -- before they
15 become full-out drug addicts, and start committing
16 offenses and crimes to support their habits.

17 This may be helpful. It may be something we
18 can do to address these things in the early stages,
19 a more preventative piece.

20 The second thing, as far as the businessmen,
21 because let me -- I'm sorry, let me back up.

22 Because, these victims are losing everything.

23 They're losing their families, and we heard
24 about the increased foster care.

25 We have significant increased foster care.

1 It's devastating their lives, and it's
2 generational, as the DA said.

3 The businessmen, why do we have repeat drug
4 offenders on public -- or, repeat businessmen,
5 felons, who have been receiving prison sentences on
6 multiple occasions, coming out and getting
7 public-assistance benefits?

8 Especially the repeat felons, why are the
9 taxpayers, in any way, supplementing the lifestyle
10 of repeated felons who are destroying our
11 communities of the hard-working taxpayers who are
12 struggling to maintain these communities?

13 Maybe we should bring back fingerprint
14 screening, which is something we took away not too
15 long ago, and deny public assistance to those felon
16 businessmen.

17 The cost-savings realized could be applied to
18 treatment services we so desperately need, and
19 enhance the enforcement efforts on the
20 law-enforcement side.

21 So, I mean, I think this is just a piece that
22 needs to be looked at.

23 It was mentioned a bunch of times here today,
24 we need to look at all facets. We can't focus just
25 on one. We need to look at everything.

1 And I truly believe that welfare reform needs
2 to be looked at as well, as part of addressing this
3 problem.

4 SENATOR SEWARD: Thank you.

5 Any other comments, law enforcement?

6 LT. DOUG BRENNER: I just -- in my capacity
7 here, I try to look at the overall health and safety
8 of the community.

9 And with that, I've noticed trends and
10 problems before, and one of them is, of course, why
11 we're here talking about it.

12 And I have -- today, I can reiterate what
13 everyone else already said. That was some of the
14 points I mark here, I'm checking off as people say
15 it.

16 There's one thing that was mentioned once,
17 and I think that maybe it should be brought about
18 again.

19 There was, of course, passed, is the I-STOP
20 regulation. That was to try and stop the multiple
21 issuance of opiate prescriptions.

22 Sometimes I think that maybe there ought to
23 be an "I-Don't-Start."

24 [Laughter.]

25 LT. DOUG BRENNER: Because it seems as though

1 these prescriptions come out a little too quick, a
2 little too fast, and a little too young.

3 Chief Covert mentioned 41 out of 43 of his
4 people went in, all started with prescription
5 medications.

6 I've had instances to see where children, as
7 young as 8 years old, are getting prescription
8 hydrocodone.

9 And I'm not -- and there has been -- stats
10 have come up and said, that if they start a
11 prescription opiate before the age of 15, they're
12 70 percent more likely to become an addict.

13 I'm not sure if that's something legislation
14 could talk about, could look into, could regulate,
15 but I think it's a discussion that needs to be had.

16 The only other thing I can really throw out
17 there, and it's been brought up once or twice again,
18 is post-treatment housing and employment, because,
19 in the end, I think you really, really have to
20 provide hope.

21 SENATOR SEWARD: Yes.

22 SENATOR MURPHY: Chief, is it?

23 LT. DOUG BRENNER: No, Lieutenant.

24 SENATOR MURPHY: Lieutenant, are you finding
25 more of -- when you go into an area, more of a

1 prescription Oxycontin/oxycodone, or are you finding
2 the bags of heroin?

3 Because we have found out that, you know, a
4 lot of the bags are being cut with the fentanyl, and
5 that's, you know, used in anesthesia.

6 But are you finding more pill form or more
7 actual heroin bags?

8 LT. DOUG BRENNER: Before I-STOP legislation
9 we found pills.

10 Since I-STOP legislation, now we find bags.

11 SENATOR MURPHY: Gotcha.

12 OFF-CAMERA SPEAKER: If you talk, if you
13 speak to, I interview dozens of low-level street
14 deals, what we call the "low-level street dealer,"
15 and ask how they got addicted to opioids, and they
16 all will say, prescription pain pills, prescription
17 pain pills.

18 SENATOR MURPHY: 1,000 percent, the forum
19 I went down in New Orleans, number-one reason, was
20 the over-prescription of Oxycontin/oxycodone.

21 You have good kids that are going in for a
22 simple shoulder surgery, or going for a tooth
23 extraction. They go in, and get a 60 count of
24 Oxycontin, use 2 of them, the parents don't know
25 what to do.

1 If the other kids come in, their friends come
2 in, and they actually steal it out of the medicine
3 cabinet.

4 They're stealing it from our veterans.

5 They're stealing it from our seniors.

6 They're going in and they're randomly looking
7 through all the medicine cabinets and getting these
8 medications.

9 DA JOE McBRIDE: The success of the one-stop
10 program has created a major heroin problem.

11 I mean, I don't see the volume of pills, and
12 correct me if I'm wrong, if anyone does anymore,
13 that we did four years ago.

14 So, we solved one problem, and we got another
15 one to deal with.

16 DR. MATTHEW JONES: (Inaudible) you know, if
17 you look at the numbers, it appears that there's
18 been success with it.

19 But I will tell you, practicing, I feel very
20 much that it is something that we're not seeing, the
21 drug-seeking behaviors.

22 And, interestingly, patients now are aware of
23 it, and actually will understand it. So if you get
24 into this conversation with them and you bring it
25 up, you know, they'll back off immediately and say,

1 Hey, no problem. I don't want to create any issues.

2 You know, I think, you know, just -- I really
3 just want to -- I agree very much with everybody
4 who's discussed, you know, creating, you know, local
5 treatment programs that are real-time. You know,
6 meaning, that when I have a patient in the emergency
7 department, I think Chief Covert hit the nail on the
8 head when he said, you know, you've got a moment
9 that you can make a difference.

10 And, to be able to pick up the phone and
11 start that treatment process for a patient would be
12 hugely helpful to us.

13 You know, we get different kinds of patients
14 in the emergency department. Some come in, you have
15 a conversation with them -- maybe they're there for
16 a sore throat, you have a conversation with them,
17 and they're very open to getting treatment.

18 You know, and this is, you know, a patient
19 that needs specific resources, that I can try to go
20 through our social worker, but they're overworked.
21 They're dealing with the mental-health side of it,
22 and trying to find them the kind of help that they
23 need.

24 You know, probably the most troubling, and
25 the most, you know, difficult patients to take care

1 of with, are those that come in more under the
2 auspice of an intervention.

3 You know, they're there with family members,
4 there's a lot of anxiety, there's a lot stress,
5 both, on the patient side, the family side.

6 And, you know, there's very much back to the
7 sense of, you know, this is something that, if you
8 don't strike now, you're going to miss an
9 opportunity to make a huge difference in somebody's
10 life.

11 And, again, we don't have a mechanism to get
12 those patients the help that they need immediately.

13 You know, so, if I could advocate for one
14 thing, or one gap, in care that we provide right
15 now, is really having programs.

16 And I would defer, you know, to the experts
17 as to what those programs look like, but, you know,
18 they need to be local, they need to be real-time;
19 meaning, I can pick up the phone and say, It's a
20 done deal.

21 It needs to be a pull system.

22 You know, I refer to that as, you know, the
23 number of hoops that you have to jump through to get
24 one of these six beds that almost always are
25 taken -- and I don't mean to say that there's just

1 six beds -- but they're an hour away, and we'll talk
2 to you tomorrow, and send us this, and they have to
3 be that, and you have to do this test.

4 So, you know, it -- it -- I -- somebody
5 brought up earlier, the notion of having a navigator
6 that navigates or is an advocate for these patients.

7 You know, I was going to call it a
8 "coordinator," but, if there was somebody locally,
9 or at the hospital level, you know, that we could
10 pass off patient information, and they had the
11 ability to get these patients -- you know, I could
12 hand off, and I knew this patient was going to get
13 where they need to be, and then, we could establish
14 those programs to get them there, I think that would
15 be hugely helpful.

16 You know, I got off track a bit.

17 The other thing that I just want to mention,
18 you know, what, you know, we started doing, I'm
19 going to guess about a year and a half ago, you
20 know, back, the I-STOP, again, I think has been very
21 helpful.

22 We -- the emergency physicians, with the
23 primary-care physicians who actually see, you know,
24 this is -- this is probably a multi-times daily
25 issue for them; whereas, in the emergency

1 department, you know, to some degree, I'm going to
2 guess, four or five time as week we're seeing these
3 patients.

4 But having a conversation about coordinating
5 the medications that we're writing out of the
6 emergency department.

7 So, you know, I would have to imagine the
8 primary-care physicians find it, you know, somewhat
9 disrespectful, in that they establish these
10 programs, they work very hard with their patients --

11 And when say "programs," the program with
12 that specific patient, that they're going to get the
13 medications that they've discussed.

14 -- and then they come to the emergency
15 department, and, you know, they get, you know,
16 60 hydrocodone, or whatever it may be, which is
17 totally against what a doctor has worked very hard
18 with their patient.

19 So we want to coordinate, you know, what
20 we're prescribing, not to infringe on that
21 relationship or that agreement or the well-being of
22 the patient.

23 And, it was great, in that we came up with
24 some prescribing guidelines.

25 And, again, you can never go to any one

1 clinician and say, "You can't do this," because
2 circumstances always vary.

3 But, you know, the guidelines, you know,
4 really focused on substitutes for opiates, looking
5 at the non-steroidal anti-inflammatories, which are
6 wonderful medications when they're used properly.

7 And the other thing we really looked at is
8 curtailing the length of the prescriptions that
9 we're writing, which I-STOP does wonderfully.

10 You know, it gives you that, you know,
11 less-than-five-day out, which I think is -- there's
12 no reason why, somebody brought up an example, an
13 ED physician should be writing somebody for 60 pain
14 pills.

15 I mean, that's just -- you know, we're acute
16 care. Our job is to acutely take care of the pain
17 issue and get them to a specialist.

18 So we came up with these guidelines, which,
19 you know, along with the I-STOP, has been hugely
20 helpful, in that it -- you know, I think it
21 empowered, or our ED physicians felt empowered, now
22 that they had something, from an institutional
23 level, that we could -- we could -- or, they
24 individually could refer back to and say, Look, this
25 is what we do. It's not what I'm doing, I'm not the

1 bad guy.

2 And it is -- you know, we started this
3 project, we looked at these patients coming through.
4 And the goal is to go back and look at, you know,
5 how -- has this been successful?

6 Are we getting the patients back to where
7 they need?

8 And are the prescriptions coming from the
9 folks that originally wrote it?

10 Do they have one provider, essentially, that
11 are -- that are prescribing the medication?

12 SENATOR SEWARD: Thank you, Dr. Jones.

13 And, did -- did you have a comment as well,
14 Celeste?

15 DR. CELESTE JOHNS: I have a comment on
16 something that we, actually, to my surprise, has not
17 been brought up yet, one more missing link, and it's
18 the drug-disposal availability.

19 How do question get rid of the excess pills?

20 I remember, when I broke my wrist, I got
21 60 Percocet.

22 Doesn't everybody?

23 [Laughter.]

24 DR. CELESTE JOHNS: And my son, my teenaged
25 son, walked into the bedroom and said, Wow, mom, you

1 know how much I could get for those?

2 Oh, my god.

3 They were gone. They were -- they were in my
4 septic system, somewhere.

5 But it's very hard to get rid of -- it's very
6 hard to get rid of opioid pills.

7 And there is a lot of room for legislative
8 action, and for funding, in terms of having drug
9 manufacturers, hospitals, drug stores, have secure
10 ways to take back and destroy medications.

11 SENATOR SEWARD: I know -- I was there, at
12 the City Police Department, there is a disposal
13 facility there.

14 I'm not sure, are there others around the
15 area?

16 SHERIFF RICHARD DEVLIN: We have one at the
17 Sheriff's Office.

18 I am not sure (inaudible) Delaware.

19 OFF-CAMERA SPEAKER: We do.

20 SHERIFF RICHARD DEVLIN: We get between 70 to
21 100 pounds a year of prescription drugs.

22 SENATOR SEWARD: They tend to be at
23 law-enforcement locations because of the -- they
24 have to be under guard.

25 RUTH ROBERTS: But if there could be some

1 mechanism to make that part of the culture of the
2 medical community, and for those individuals, like
3 care coordinators or case managers that might be in
4 and out of a patient's life, perhaps home.

5 I mean, when you think about the aging, or
6 the geriatric, population, typically, they're on
7 multiple medications because there are comorbid
8 conditions, and, medications change.

9 How often does an elderly person go to a
10 doctor, and then go to -- go right back, and they're
11 always tweaking and changing.

12 And so, after a while, that medicine cabinet,
13 or the cabinet in the kitchen, is brimming full of
14 prescription medications, and then makes them
15 vulnerable for those break-ins and those burglaries.

16 But if it could just become part of our,
17 like, culture, our conversation, you know, in terms
18 of, you know, the medications that were previously
19 prescribed, you know, making sure that there's a
20 safe way to dispose of those.

21 SENATOR SEWARD: Good point.

22 We had mentioned a couple of times, others
23 have mentioned, about a -- after treatment, you
24 know, having a safe and sober place to go.

25 And I wanted to hear from Noel -- both,

1 Noel Feik, and I know Kelly Liner from Friends of
2 Recovery of Delaware and Otsego county, that has a
3 site here in Oneonta, that's a safe and sober
4 location, at least on a daytime basis.

5 Yours is a residential.

6 Well, if you would just bring everyone up to
7 date in terms of your perspectives on what we're
8 talking about here today.

9 NOEL CLINTON-FEIK: Sure.

10 So, thanks for the shout-out from Julie, on
11 Crossroads.

12 We are not enough. We are always at full
13 capacity.

14 For those of you that do not know, we offer
15 sober living for folks coming out of prison, jail,
16 or rehab, down on Route 7.

17 What we're seeing is that, not only folks
18 coming out on an emergency basis needing housing,
19 but once folks come with us, and they get off the
20 system, and they're successful, and having an
21 entry-level position, they don't have anywhere in
22 this community to live.

23 The lack of affordable housing is then the
24 next barrier.

25 So this county spends a million dollars a

1 year in sheltering homeless.

2 And, there is great opportunity to reallocate
3 those funds to house those folks in appropriate
4 housing.

5 So there are several other places in the
6 county where you can be housed on an emergency
7 basis, and those locations are not supervised or
8 monitored or have expectations of folks living there
9 on their behavior.

10 You know, you can go over to, someplace, and,
11 you know, the drug dealer that you had a
12 relationship with before you went into jail, will be
13 waiting for you.

14 And so when folks get out of jail or prison,
15 back to the point of having no money, you know, they
16 want to stay sober and be in the recovery and --
17 continue their recovery. But without the
18 employment, it's just easy to go sell a few bags to
19 get some funding.

20 One thing that I'll point out is, when you
21 get out of state prison, the emergency money that
22 you're given, which is \$250 upon your release, takes
23 42 days to get.

24 So we often have folks show up at the
25 Crossroads, or we'll pick them up at the bus stop,

1 they have the clothes on their back, and they have
2 no money.

3 And if it's a Friday night at 5:00, when
4 we're waiting for DSS to open up Monday at 8 a.m.,
5 they have that entire weekend that we're trying to
6 subsidize or find ways to get them funding.

7 So there's an opportunity, also, to look at
8 the lack of funding that they have.

9 So, for me, it's about money up-front, when
10 they get released from prison or jail, continuing
11 their insurance when they're released; as well as
12 another issue that we're having: the lack of
13 supportive sober housing in the community, and
14 employment.

15 SENATOR SEWARD: Kelly, did you have anything
16 that you would like to add?

17 KELLY LINER, RN: Yes.

18 I would like to talk about having more
19 funding for more recovery centers.

20 I know there was some money that came out
21 last year, and I think there were six proposals, you
22 know, that were granted.

23 But that's not enough for all of
24 New York State.

25 Right now, we're one of three recovery

1 centers in the state. There's one in Rochester,
2 I think one in The Bronx, and then the one we have
3 in Oneonta.

4 And some of the services we offer, recovery
5 coaching, which I know Mary is very interested in
6 having a say in that.

7 If -- when somebody -- when people get out of
8 jail, they're left to figure out where to go to
9 overcome barriers and obstacles in early recovery.

10 This is a critical time, and, unfortunately,
11 people end up relapsing. And because they have not
12 been taking the drugs for a period of time, they're
13 at higher risk of overdosing, and death.

14 So, if we could have more funding, to support
15 staffing of recovery coaches, to provide services to
16 those needing assistance upon release from jail,
17 prison, or rehab, that would increase their chance
18 of success in beating the group of addiction.

19 And there's been overwhelming evidence that
20 shows that community-based recovery services and
21 peer supports are needed to help individuals with
22 addiction build and sustain recovery.

23 We must see immediate increase in funding
24 from OASAS's budget, and the money would be used to
25 fund recovery organizations and centers, it would

1 fund the implementation of recovery coaches and
2 family-support navigators in every county across the
3 state.

4 And, only then, will we see a change in the
5 system to treat addiction like the chronic disease
6 that it is, instead of a moral deficiency that it's
7 not.

8 SENATOR SEWARD: Kelly, could you give us
9 some idea of the number of people that go through
10 your -- what's the name of your facility?

11 KELLY LINER, RN: Friends of Recovery of
12 Delaware and Otsego county, and we run the recovery
13 community center called the "Turning Point."

14 SENATOR SEWARD: Turning Point.

15 KELLY LINER, RN: Yes.

16 SENATOR SEWARD: That's what I had -- it
17 escaped my mind, Turning Point.

18 KELLY LINER, RN: Right.

19 On average, monthly, there are over a
20 thousand visits to our center, not unique
21 individuals. A lot of repeat people.

22 SENATOR SEWARD: But, basically -- and I was
23 there, of course, I was involved with, you know, the
24 starting of that center, with your founder.

25 The -- Betty Courier (ph.).

1 KELLY LINER, RN: Yes.

2 SENATOR SEWARD: And, basically, that's that
3 safe and sober place where people can go during the
4 day.

5 It's kind of --

6 KELLY LINER, RN: Yes, we're open from
7 9:00 to 4:30. We would like to be able to expand
8 our hours.

9 SENATOR SEWARD: Uh-huh.

10 I'm surprised there are not more options
11 around the state.

12 I mean, you say there -- we sort of take
13 Turning Point for granted. I mean, we have it here
14 and it's a wonderful place.

15 That should be replicated.

16 KELLY LINER, RN: Right. Definitely.

17 OFF-CAMERA SPEAKER: Can I just add to that,
18 briefly?

19 SENATOR SEWARD: Sure.

20 NOREEN HODGES: OASAS gave out, as Kelly
21 said, six opportunities to build a recovery center.

22 75 people apply for it across the state.

23 350,000 a year -- up to 350,000 a year, for
24 5 years.

25 When I asked the person who wrote that grant

1 why they did it that way, as opposed to, which
2 the -- many of the recovery -- national recovery
3 groups would like to see done differently, but
4 I asked, Why only six?

5 And he said, Because we want to have six
6 really, really great centers to model.

7 And I said, Because I'm a council, and
8 there's a council in every county in this state,
9 just about, why not give every council, that's
10 certainly funded by OASAS, \$40,000, and to hire
11 somebody that could start coordinating the services?

12 I believe totally in grassroots, as well as
13 legislation, from the top down, bottom up, will meet
14 in the middle.

15 They could get the community going, so that
16 every community could have a Turning Point.

17 I have wanted a Turning Point for years for
18 Schoharie County.

19 And I do know of one person, Second Chance
20 Opportunities in Albany, that wrote one of the
21 grants. It's a recovery center, putting people back
22 into employment out in Albany.

23 I begged, I had coffee, I had lunch, "If you
24 have any extra dollars, please send them to
25 Schoharie County."

1 It's just the stories just pile up and pile
2 up and pile up, in our communities.

3 And that's what I would love to see.

4 I'm just going to put this out there: Give
5 40,000 to at least --

6 How many councils are there?

7 OFF-CAMERA SPEAKER: 33.

8 NOREEN HODGES: Okay.

9 -- \$40,000, that would be a lot less than
10 that 350,000 for 6 places for 5 years.

11 And then what happens at the end of
12 five years?

13 Versus, hiring somebody that could coordinate
14 all services in -- in -- a great, great area,
15 because, absolutely, coming out is going to save
16 lives.

17 SENATOR SEWARD: Thank you.

18 I can assure you that the Chair of the
19 Oversight Committee for OASAS has made a note of
20 that.

21 SENATOR AMEDORE: Yeah, I did.

22 NOREEN HODGES: Thank you so much.

23 KELLY LINER, RN: Can I say something else
24 about the recovery coaches?

25 SENATOR SEWARD: Yes.

1 KELLY LINER, RN: In order for the home- and
2 community-based waiver, to get reimbursed for
3 services through Medicaid, a recovery coach, in
4 order to get certified through New York State, if
5 they have any sort of criminal history, they cannot
6 get certified. I think it's until five years after
7 they have finished probation, or, you know,
8 completely done with all that.

9 So -- and then there's CASACs, they can be
10 credentialed with a history of arrests, and they
11 counsel people who have issues with addiction.

12 It just doesn't make sense.

13 So I don't know if something could be changed
14 with that, because the recovery coaches are people
15 who have a lived experience with addiction, and they
16 are very helpful with people. Especially in early
17 recovery, they can share their experience, strength,
18 hope, what worked for them.

19 You know, they can navigate the system, the
20 barriers that are out there for people in early
21 recovery.

22 You know, find out what resources that are
23 available to them. Build on their strengths.

24 SENATOR SEWARD: That's excellent points.

25 NOEL CLINTON-FEIK: Can I just bring up

1 another point that I missed on a gap?

2 SENATOR SEWARD: Sure.

3 NOEL CLINTON-FEIK: While we have folks at
4 the county level in jail, there really is an
5 opportunity to take that audience, that's, you know,
6 a captured audience, and give them education
7 regarding their recovery and their addiction.

8 We can start the process while they're here,
9 while they're in jail.

10 It's -- I'm on the jail ministry team, and
11 it's so sad to go in to do service, and hear the
12 ladies say, you can't wait to go upstate, because
13 there's more to do, and there's resources when you
14 go to state prison, on starting to work, you know,
15 their the recovery, or, you know, whatever they need
16 to do.

17 And it's sad that we're here at the county
18 level and they're, literally, sitting in their cell
19 doing nothing.

20 And, so, if we're going to try and help the
21 ones that are -- you know, need to go to jail, let's
22 start now at the county level, on giving them
23 resources to start, you know, their recovery.

24 CHRIS COMPTON: (Inaudible.)

25 SENATOR SEWARD: Sure.

1 CHRIS COMPTON: One of the difficulties in
2 providing services by licensed providers, is you
3 can't get reimbursement because they don't have
4 coverage on their jail.

5 I would love to see OASAS come up with some
6 funding for current providers, to be able to provide
7 services, or make change in the health-care law, so
8 we can be reimbursed.

9 Because I agree, 100 percent, why aren't we
10 offering people services in jail?

11 I think it's a perfect opportunity.

12 And then to develop, I agree with everyone
13 on, the transitional housing.

14 You know, we could also assist with them,
15 when they get out of jail, in setting up the
16 housing.

17 Right now we have a recovery coach in jail
18 that arranges for services upon release.

19 But I think -- definitely think that more
20 needs to be done there.

21 OFF-CAMERA SPEAKER: And there's also an
22 opportunity to test folks for hep C while they're in
23 jail, and start providing some medical care for that
24 group.

25 SENATOR AMEDORE: Albany County Sheriff

1 Craig Apple is already doing it. It's called
2 "SHARP."

3 OFF-CAMERA SPEAKER: Isn't that amazing.

4 SENATOR AMEDORE: And it's a great pilot
5 program. OASAS is behind it as well.

6 It's amazing program.

7 And not only are they getting treatment,
8 helping with recovery, but, also, the acclimation
9 back into society, with helping with a job, a
10 good-paying job.

11 And, it has made a difference, and it's
12 completely voluntary.

13 So, he's got the facility in Albany County,
14 within his jail, to kind of segregate from general
15 population, get the treatment.

16 And, also, they are -- he's got a provider
17 with Vivitrol. So before they leave, they're
18 getting a shot of Vivitrol.

19 But now we need the support housing.

20 We need the -- after that 28 days, go back,
21 and keep that thing going.

22 RUTH ROBERTS: Chenango and Delaware recently
23 received some OMH (Office of Mental Health) funding
24 that allowed us to expand what our current forensic
25 services and our local county jails looked like.

1 And, actually, the Sheriff from
2 Delaware County and the Sheriff from Chenango County
3 and my counterpart and I talked about six months
4 ago, but we developed what we're calling
5 "transitional support services," specifically, to
6 engage individuals while they're spending time in
7 the jail, engage them in that relationship, and
8 begin to do some real life planning as to what life
9 is going to look like once you leave the county
10 jail.

11 And that can include, certainly, access to
12 treatment, but it can also include education,
13 vocational.

14 Certainly, where you gonna live?

15 And that's often the biggest question.

16 And then, coming up with a plan, and then,
17 following that individual, as they leave the jail.

18 So, as they walk out of the county jail,
19 they're still receiving that support in those --
20 that service from our transitional workers.

21 And we've staffed it with a case manager kind
22 of person, along with a peer advocate, and they work
23 side by side, to work with that individual.

24 It's very new.

25 We'll see, you know, what it looks like. I'm

1 hoping that the outcomes are good.

2 And -- but, in general, our state agencies,
3 both OMH, but particularly OASAS, does not recognize
4 the importance of funding services in real-life
5 situations, such as the county jail.

6 I mean, we provide outpatient treatment
7 services in our clinic. We're not permitted to
8 carry those services anywhere else outside of our
9 brick-and-mortar walls.

10 There are other places where people can be
11 reached, where we can -- we can be instrumental in
12 beginning that treatment process.

13 And to have these rules where it can only
14 happen within, you know, this certain floor space
15 that's designated in an OASAS-licensed clinic is
16 absurd.

17 So, I mean, don't even get me started on the
18 regulations that exist.

19 [Laughter.]

20 RUTH ROBERTS: You know, and I play by the
21 rules, in general.

22 Okay?

23 I have my law-enforcement people over there.

24 [Laughter.]

25 RUTH ROBERTS: In general, I play by the

1 rules.

2 But, the layers and layers of regulations
3 that are in place by our state agencies is, quite
4 frankly, just mind-boggling.

5 SENATOR SEWARD: Absolutely.

6 Ruth, I thought the points, in terms of the
7 services in the county-jail facilities, I think is a
8 key one.

9 The two dreaded words that we at the head of
10 the table here are very cognizant of, and that is
11 "unfunded mandates" --

12 RUTH ROBERTS: Yes.

13 SENATOR SEWARD: -- on the counties.

14 However, I think, you know, OASAS, through
15 regulatory reform and some additional funding,
16 I think that would be --

17 RUTH ROBERTS: There has been recent
18 progress, particularly in residential.

19 And, hopefully, they'll be willing to look at
20 other areas as well.

21 You know, we would certainly welcome that.

22 And you mentioned the county.

23 You know, because we're a County-operated
24 clinic, there's also this local share that our
25 county government is very concerned with, that is

1 often a part of these types of programs that we're
2 operating.

3 And -- you know, and I have to answer to
4 those folks too.

5 So, from month to month, and budget year to
6 budget year, you know, they're looking at the local
7 share, and then also dealing with the 2 percent tax
8 cap, and that is really putting a crunch.

9 I mean, there's a lot of folks that are
10 sitting on that board of supervisors that nod their
11 head and they agree that we need these services, but
12 more and more I'm hearing:

13 Do we really need mental-health services?

14 Do we really need substance-abuse services.

15 Are people really, even, getting better?

16 But, you know, that's where they go when the
17 money gets tight.

18 So, you know, we've got to be able, again, to
19 look at the whole big picture, and relieving some of
20 the tax burden at the local level really needs to be
21 looked at; otherwise, these types of programs are in
22 jeopardy.

23 SENATOR SEWARD: Thank you, Ruth.

24 We have 10 minutes left in our program and --
25 today, and I did want to turn to two other

1 individuals, two other issues.

2 First of all, Joe Yelich from the --
3 Superintendent of the Oneonta School District.

4 I also wanted to hear, within our 10-minute
5 period, from Jason Gray, from the Sidney EMS, to
6 give us the EMS perspective in terms of the
7 availability of Narcan, and, you know, what you see
8 out there as you respond to an emergency situation.

9 So, Mr. Yelich, do you want to go first?

10 SUPT. JOSEPH YELICH: Yes, thank you.

11 All of what we've talked about manifests
12 itself in a school environment, pretty much,
13 everything that we've said here.

14 Our partners at LEAF and ASA and the
15 behavioral-health folks who come in and work in our
16 schools do a great job of talking to kids in advance
17 of addiction or use becoming a problem.

18 But when it becomes a problem, we then have
19 to deal with it just the way that everybody else
20 does.

21 We've got great-quality nurses, we've got
22 counselors, and we've got school psychologists.

23 The fact that Dr. Johns is here in the
24 capacity of psychiatric support is a logistical
25 anomaly for some places.

1 That you've been here for 20 years is
2 outrageous.

3 Thank you.

4 Because I've come from other counties where
5 trying to find psychiatric support is impossible.

6 So, trying to provide a collaborative
7 environment in schools, where we can create
8 partnerships that work together to manage the
9 situation, both on the front end and preventive, but
10 also on the back end, we work with our
11 law-enforcement partners to determine, you know,
12 once we've dealt with disciplinary issues, find
13 drugs on our campus, and find those individuals who
14 are dealing, we find out whether they have entered
15 into the unfortunate, dubious, and dangerous
16 entrepreneurship, or whether they're users.

17 You know, the businessman versus the user,
18 Mr. Big doesn't care which of those guys that guy
19 is, but, he's on our campus.

20 And, we're a ready supply of individuals who
21 are gullible and very influenced, so we worry about
22 it.

23 So having a quality relationship with law
24 enforcement is big.

25 Having a quality relationship with juvenile

1 justice is a big deal for schools as well.

2 Co-location of mental-health services on our
3 campuses, something that I have been able to do in
4 another county, and trying to do that here, working
5 with Susan, to try to place mental-health
6 professionals in our organization.

7 Treatment regimes that take months, years,
8 really do require that loving and caring
9 environment.

10 And, Jim, you know we've got one, you send
11 your grandchildren there.

12 So, we take care of that on a daily basis,
13 but we're tending to be pretty good at managing the
14 issues of whether you're good at math or biology or,
15 you know, English-language arts, but, you know,
16 we're not really equipped to be comprehensive case
17 managers.

18 You know, so having a partnership that
19 provides the opportunity for us to help families
20 with navigation, system of care, grants that provide
21 the opportunity to co-locate multiple services on
22 the schools' campuses, create community schools, so
23 to speak, is a model that's in existence, and it has
24 been successful, and has great potential for
25 success.

1 So, you know, I appreciate the invitation,
2 and the welcome, but, also want to say that, going
3 forward, it's going to require collaborative effort,
4 and the ability to take multiple funding streams,
5 and bring a confluence together that gets that
6 flowing in a positive direction.

7 It's creating an environment where the kids
8 who are 5 and 6 and 7 years old, and who are in
9 crisis because of the problems that are at their
10 homes, or, you know, the foster-care relationships
11 that are established when they're taken from one
12 community because of massive dysfunction in another
13 community, and then come to ours, we can help them
14 with programming, we can help them with their
15 schooling.

16 But, we don't know how to get after the
17 question of ongoing care for their family and system
18 navigation that would be in place.

19 So -- and anything that can be done to
20 provide a system of care support, wraparound care
21 support, those kinds of programs that could be made
22 available to schools, I think schools are open to
23 that, and welcoming.

24 SENATOR SEWARD: Absolutely.

25 And that collaborative effort that you talked

1 about, particularly in the bringing a variety of
2 services into the schools -- I forget who mentioned
3 it -- was it you, Dr. Johns, talked about silos,
4 in terms of regulatory silos, that come down from
5 Albany and the various agencies?

6 We need to break those down, for sure.

7 In the time remaining, I just wanted to --
8 Jason, did you have anything that you would like to
9 add from the EMS perspective?

10 JASON GRAY: Yes, I do. Thank you.

11 I know that I would like to reiterate a lot
12 of the points that some of the colleagues here also
13 brought up, is the fact that, you know, we have an
14 increased number of responses to opiate and heroin
15 overdoses in patients.

16 Narcan was difficult for us to obtain for
17 some time. Once law enforcement started to have all
18 the Narcan that they were carrying, there was a
19 shortage for EMS providers, and that since has
20 subsided.

21 So, the Narcan availability is there for us
22 now, and it's -- that's a great thing.

23 Narcan is also readily available in many
24 other homes, thanks to some of the Narcan outreach
25 programs that have been in the communities.

1 There have been several, just in the general
2 Sidney area.

3 So there's a lot of Narcan that's available
4 in homes of families and patients, or, in some
5 cases, even the users themselves have Narcan.

6 And we've seen an increase in responses.

7 And some of the problems that we find during
8 our responses to these patients is that, we don't
9 have a definitive transport decision for those
10 patients.

11 The emergency rooms tell us that they may
12 treat them for a couple hours, monitor the
13 situation, and, then, simply discharge them, with
14 some additional information and phone numbers to
15 call.

16 And I know that a lot of the other folks here
17 today say that that's -- that's also the problem
18 that they're encountering.

19 So, patients that were not breathing when we
20 arrived, couple of hours later, are discharged from
21 the medical facility, with a little to no
22 information, and expected to navigate the system on
23 their own once they're discharged.

24 There's no place for us to take a patient who
25 is -- who can't get any closer to crisis than an

1 overdose? There's no place for us to take them
2 that's going to provide continued, long-term,
3 ongoing support.

4 Those patients that were not breathing are
5 now two hours back out on the streets.

6 And that's -- that's a big problem that we
7 have, that there's just no -- there's no good place
8 to take these patients. There's no definitive care.

9 And, you know, if the patient was involved in
10 a motor vehicle accident, or the patient had a
11 stroke, or any of these other things, there's
12 definitive-care facilities that we take patients to
13 that are specialty resource centers.

14 With this type of patient, there's simply
15 no -- there's no place to take them, besides the
16 local hospital, which is likely going to discharge
17 them within a couple of hours' time.

18 So, that's one of the major issues that we
19 have found.

20 Certainly, anything that can be done
21 legislatively, or collaboratively between all these
22 groups, to increase the number of beds available
23 locally.

24 And I really like Bassett's plan to use some
25 of their outreach centers to provide those -- that

1 outpatient service, because, really, every
2 community -- most communities have some type of
3 community outreach, whether it's a Bassett or UHS
4 clinic.

5 Having those clinics available to provide
6 that ongoing outpatient care right in the community
7 where the patient lives, would be phenomenal.

8 But, in the short term, patients that are in
9 severe crisis, that had just overdosed, are likely
10 to be discharged from the hospital within a couple
11 of hours' time.

12 And that's just not an acceptable -- just not
13 an acceptable health-care decision.

14 SENATOR SEWARD: Thank you for the -- your
15 comments.

16 And, we are at the finishing point of our
17 session today, and I really appreciate everyone's
18 views and candor here today; they've all been very
19 helpful.

20 And before we conclude, I would like to see
21 if any of my -- our Task Force members would like to
22 make any concluding remarks.

23 Senator Akshar.

24 SENATOR AKSHAR: Sure.

25 You know, unfortunately, I think, from time

1 to time, we hear people in the community say that
2 people don't care.

3 And I think that, to the contrary, we do, and
4 today's a clear indication of that.

5 There are services available. We just need
6 to ensure that they're more readily available.

7 And to each of you, I say, thank you, for
8 everything that you do, and for providing us some
9 insight as to the things that we can do, my
10 colleagues and I, to make this easier.

11 To the men in uniform, I say, thank you, to
12 the people that work for you. Of course, you have a
13 close spot in my heart, due to my background.

14 So thank you for everything that you do.

15 And really, truly, from the bottom of my
16 heart, I thank each of you for the things that you
17 bring to the table.

18 Thank you.

19 SENATOR SEWARD: Senator Amedore.

20 SENATOR AMEDORE: It's very encouraging to
21 hear the -- the amount of support and the
22 collaboration that this region has already been
23 working towards, and with, very much.

24 Many things that were discussed, you are not
25 alone.

1 No matter where we go with this Task Force,
2 we hear the same type of problems, same type of
3 possible solutions.

4 And I will say that, we are very fortunate in
5 the Senate to have our Conference. In the Majority
6 Conference, that this is one of our top priorities.

7 Yes, it's education, and funding, and
8 being -- making sure that our economy is strong, and
9 job creation, but this is truly a quality-of-life
10 issue for all of our community.

11 It doesn't matter how old in the age range,
12 this is a quality-of-life issue.

13 If we want to curb crime in our streets and
14 the local communities, we have to deal with this
15 issue.

16 We want to deal with someone who is
17 struggling with a substance abuse, in a wide range
18 of the spectrum of substances.

19 We have to curb and talk about this issue.

20 And, believe it or not, there are many issues
21 that -- and solutions that have been talked about
22 today, that your suggestions, that we are kind of
23 already developing in legislation or policy, that we
24 just haven't exposed yet to the public because we're
25 still vetting and working these things out.

1 To Jason's point with the Narcan, absolutely,
2 it's a big issue, particularly when, now, you can go
3 over-the-counter and anyone can have a Narcan kit --
4 (naloxone), and OASAS has no idea, DOH has no idea
5 or clue, how many will be issued over-the-counter or
6 when it's administered, and how many reversals were
7 given.

8 So we have to do something about it, and
9 we're working on that.

10 And whether it's in this year's budget or
11 it's standalone pieces of legislation, we're working
12 towards solutions.

13 Most encouraging thing, though, is this
14 problem of quality-of-life issue that's affecting
15 all of us, it's involving with some -- I think, some
16 real compassion and passionate solutions that we can
17 help fix and curb this problem.

18 So, the eradication of the heroin epidemic,
19 yes, we can.

20 Whether it's stricter law enforcement and
21 more treatment and recovery, it's -- I look at it as
22 the whole overall substance-abuse problem, in
23 general, in all of our communities, and how we can
24 get New York to be much better in the quality of
25 care in treatment, and as -- to be as most -- the

1 most efficient as possible with the taxpayer
2 dollars.

3 So, yes, OASAS should rethink some things
4 differently.

5 And, yes, we should have stricter laws on the
6 books, in some instances.

7 But, for someone who is struggling with an
8 addiction, we -- the solution is not just rest,
9 throw them in a jail cell, and think that the
10 problem goes away.

11 No.

12 It's much bigger and broader than that.

13 So, I thank you all for your words of
14 encouragement, support, and educating me, to help go
15 back to Albany to help you solve this problem.

16 SENATOR SEWARD: Thank you.

17 Senator Murphy.

18 SENATOR MURPHY: First of all, thank you all
19 very much for being here today on this incredibly,
20 incredibly important topic.

21 Just a few notes.

22 Jason, as a health-care provider, and a
23 former EMT, knowing that this Task Force and our
24 Conference has been the lead on this, as a group, to
25 try and do the right thing.

1 If I've heard it once, I've heard it,
2 actually, three times, that, yourself, as a former
3 EMT, they've gone in, they've saved the person,
4 brought them to the hospital. They have walked out
5 because they're over 18 years old. They sat down at
6 the dinner table that night and had dinner with the
7 mother and father, had no idea that they were even
8 in the hospital, went upstairs, overdosed, and died.

9 Three times, that this conference has heard
10 that.

11 It's unacceptable.

12 And we're working on some things like that.

13 To Superintendent Joe, last year, when we
14 found out that it was actually illegal for school
15 nurses to administer the lifesaving antidote Narcan,
16 this Conference was so dedicated to it, we put it in
17 our one-House bill.

18 And to what Senator Seward said here, we
19 don't like unfunded mandates.

20 We gave it the opportunity for the school
21 nurses to be certified in it, to have a kit that's
22 available to them, and we funded it.

23 Over a quarter-million dollars, to allow all
24 schools in New York State to opt into it, because we
25 don't like shoving things down people's throats.

1 Why they wouldn't do it? I don't know.

2 But we gave them the opportunity, and we
3 funded it.

4 So we are trying to do a lot of things.

5 We hear you loud and clear.

6 To the law enforcement, to our business
7 owners that are making this a business, we do need
8 stiffer penalties.

9 And we are, we do have, our Senate, our
10 colleagues right here, we have passed laws, but we
11 need it on the other side of the aisle too.

12 It's a group effort, as we've said.

13 We're not tackling this alone.

14 It is a group effort.

15 And, you know, for the -- the real-time
16 assistance, again, Joe, you know, you had Doc, like
17 you said, you have a golden opportunity. That could
18 be two minutes where that person says "I want help."

19 It's a quick phone call, and -- and knowing
20 that we can get that person, because that's gone in
21 15 minutes. They changed their mind.

22 I've seen it firsthand.

23 And it's -- you've got to have the
24 availability of being able to get that person when
25 they're -- I don't want to say vulnerable -- when

1 they're accepting of, "I want help," or they're
2 screaming out for help, or they finally reached the
3 lowest point in their life, and having us to have
4 the availability to get them somewhere.

5 So, yes, we are listening to you, loud and
6 clear, and, I'll let you know.

7 Senator Seward, thank you so much for the
8 opportunity of allowing me to be here.

9 Not only is our Task Force, you know, leaving
10 here and going to Yates County, and then down to
11 Brooklyn on Friday, but, our entire Conference is
12 very passionate about this.

13 We realize it is a major, major epidemic.

14 And it is just a privilege to be here, and
15 thank you for your time.

16 For your time of be here, thanks.

17 SENATOR SEWARD: Well, thank you,
18 Senator Murphy.

19 And I want to say to you and Senator Amedore
20 and Senator Akshar, thank you for traveling here to
21 Oneonta and this region of the state to hear the
22 comments from our local folks.

23 And, I know that the expertise, the comments
24 we've heard here today, they're going to be part of
25 the Task Force deliberations as we formulate

1 additional state legislation, and impacting state
2 policy.

3 And, just to conclude, I just want to -- on
4 behalf of all of those that I am very privileged to
5 represent in this region of the state, I also want
6 to say, thank you, to all of you who are on those
7 front lines every day, in addressing this serious
8 problem for the people of our area.

9 Your insights have been invaluable, and we --
10 we are -- I really appreciate your views and your
11 candor here today.

12 And the sad fact is, despite our collective
13 best efforts, this continues to be a very serious
14 life-taking problem.

15 And, we've got to redouble our efforts, and
16 make the necessary changes to beat this, this
17 epidemic.

18 And -- but I'm optimistic we can do that, if
19 we continue to collaborate and come together at
20 meetings such as this, and then take the appropriate
21 action.

22 I again want to say to everyone in the room,
23 we've had a very excellent discussion here today.

24 But, if anyone would like to submit any kind
25 of written comments to the Task Force, we welcome

1 those. And as I said earlier, if you would get them
2 to my local office right here in Oneonta, I will see
3 that the Task Force receives those written comments
4 that will help in their deliberations.

5 So, again, thank you all for participating,
6 and, stay tuned, because, we hope to take action in
7 the upcoming budget, and the subsequent balance of
8 the session.

9 Thank you so much.

10 [Applause.]

11
12 (Whereupon, at approximately 2:13 p.m.,
13 the public hearing held before the New York State
14 Joint Senate Task Force on Heroin and Opioid
15 Addiction concluded.)

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