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

TO EXAMINE THE ISSUES FACING COMMUNITIES

IN THE WAKE OF INCREASED HEROIN AND OPIOID ABUSE

SUNY Albany
D'Ambra Auditorium
Life Sciences Research Building
1400 Washington Avenue
Albany, New York 12222

June 2, 2015
6:00 p.m. to 8:00 p.m.

PRESIDING:

Senator Terrence Murphy, Chair

Senator George Amedore, Jr., Co-Chair

Senator Robert Ortt, Co-Chair

Senator Richard Funke

Senator Kathy Marchione

SENATOR AMEDORE: Okay. We are -- we're going to get started. Sorry for a couple-minute delay, but I waited for some of my colleagues, and I'm glad to see that they were able to make it.

Welcome, everyone, who is present.

And I want to thank and welcome all of you to the fourth in a series of statewide forums hosted by the Senate Task Force on Heroin and Opiate Addiction.

I'd like to thank my Co-Chairs, Senator Terrence Murphy, and Senator Robert Ortt, and all of my colleagues on the Task Force, the members who are here this evening, which we have, Senator Funke, and I know I saw out in the lobby, Senator Kathy Marchione, for being here tonight.

Thank all of you for being here: those who will give testimony and share their stories, to -- as well as all of those who are just here to listen.

You know, being a part of this helps us make good public policy and help eradicate this problem in the state.

The purpose of the Task Force is to develop solutions to help eradicate the problem, once and for all, and to do so we need to approach this from very different -- many different sides, by

increasing prevention and awareness, by providing treatment options for those who need it, by supporting continued recovery to prevent relapses, and, from a law-enforcement perspective, by cracking down on mid- and high-level dealers who are putting these deadly drugs on the street.

Heroin addiction and abuse is an issue that touches every single person in this room and in our community. It's in our neighborhoods, it's in our schools. It's just not an urban issue. It is in rural communities, it's in suburban communities.

And this is an issue that we need to work together on, and it's going to take the whole community effort to help bring the -- help bring a significant difference to families who are suffering and who are going through this nightmare, and those who are addicted, how we can help them overcome their addictions.

We must remove the stigma that too often comes with heroin abuse. People should not be ashamed to seek help, and know where they can go and seek that help.

So family members and loved ones who are here this evening, and the ones that you know, if they're going through this nightmare like I said, they need

to help tell their story, and be supportive in the communities, because there's many others who really don't know where they can turn for help.

No one person will end this epidemic, and we need to all work together.

And I want to thank all of you for your time, for your efforts, and your passion.

At this time, I would like to introduce one of the task Force co-Chairs, and that is Senator Murphy, for any opening remarks.

SENATOR MURPHY: Yes, sure.

First of all, thank you, Senator Ortt, for allowing me to be here.

SENATOR AMEDORE: Ortt's down there.

SENATOR MURPHY: Ortt's down there, and you're right here. Okay.

[Laughter.]

SENATOR MURPHY: Thank you, Senator Amedore.

But, no, in all seriousness, this is -- thank you, the people, for showing up tonight.

This is an unbelievably important topic for New York State, nonetheless the Hudson Valley region.

I've got -- had the opportunity to go up and -- oh, excuse me -- and be in Rochester

with Senator Funke at a Task Force that he held.

And this is an epidemic, like Senator Amedore said, and we are here to address it head on.

We understand it is a major problem.

We understand that it has no boundaries.

It has no religion, Father.

It has no race.

It has no ethnicity.

You would be surprised what your neighbor's doing.

And we want to, like Senator Amedore said, take the stigma off. It's not a needle in the arm anymore. It's in pill form that these kids are overdosing on.

And it has multiple, multiple avenues that we need to address.

And why we're all sitting up here tonight as the Task Force, and as -- with my colleagues, is to hear what we need to do to improve.

And we've listened already, with this year's bill. This year's bill, after the Task Force got together, we understood that nurses in schools were not allowed to administer Narcan. And we all thought, how ridiculous was that?

And we made sure, not only did we allow that

the school nurses have the ability to administer the Narcan, but we also funded it, to make sure that they had the opportunity of (a) getting certified, and (b) having the naloxone kits within the school district.

So we are listening.

We do want to hear your testimony.

And, again, it's an honor and a privilege to be here, and I will turn it back over to Senator Amedore.

SENATOR AMEDORE: Thank you, Senator Murphy.

We also have Co-Chairman of the Task Force, Senator Robert Ortt.

SENATOR ORTT: Thank you, Senator Amedore.

I can't think of a worse insult than to call you Senator Ortt, so I apologize for my colleague, but...

[Laughter.]

SENATOR AMEDORE: What are friends for?

SENATOR ORTT: Yeah, exactly.

But, I really want to echo the comments of my Co-Chairs.

This is the fourth -- as Senator Amedore said, this is the fourth hearing we've done around the state. I've been at three of them. This is my

third.

And, certainly, in the first two, and I'm sure tonight, you hear certain themes that sort of recur.

Whether it's the family members who are here tonight, and, certainly, for those family members who are here, who have lost a child or lost a loved one, my heart, our hearts, go out to you. You're living this, you live this every day;

To the service providers, you're on the front lines fighting this every day. You've been fighting it, you've known it's an issue for probably many years;

And, obviously, I don't know if there's any law-enforcement officials, but I know there were law-enforcement officials in Rochester, and at the hearing up in Niagara County, which is the area that I represent.

And one thing you learn, is this is a multi-component issue. There is not one area, or one silver bullet, that is going to fix this.

There is a law-enforcement component. There is a service-provider component. There is an issue, when you talk about insurance companies, and access to care and access to services. There is certainly

a funding component. But there's also an education component, and a community component.

And all of you who are here, we need your help.

There are certainly things that we can do at our level, and I know we will.

But, ultimately, for the parents out there, hopefully, there's some parents here, that have children, that haven't dealt with this, and you will be able to take some things away tonight, or, when you go talk to your friends, you will be able to take some things away, as this discussion continues, because I believe we're doing this the right way. We're doing it as a bottom-up approach.

It's not someone from Albany saying, Here's what we need to do.

We need to hear it from all of you who are here.

And from the folks who are testifying tonight, who are on the front lines, who have dealt with this, who have either looked at a young person addicted to opioids or heroin in the face, or have seen a young person, addicted, pass away, or whatever it might be, we need to hear from you.

And that is what's going to collectively,

myself, Senator Murphy, Senator Amedore, and the rest of our colleagues, to be able to formulate some sort of solutions, some legislation, that will, hopefully, save lives, and help alleviate this epidemic from getting worse, because I think we can all agree it's certainly not going in the right direction. It's getting -- I think it's getting worse at this point.

And every time I pick up a newspaper and I see, you know, statistics, they're not going in the right direction.

So that's what this is about tonight.

I certainly want to thank my colleagues for being here, and for their commitment.

Many of them have traveled around the state to multiple hearings as well, so, it shows that they care.

And, I want to thank all of you for being here.

And, certainly, we are here to try and help you, and be part of a long-term conversation, to save our communities and save our families.

So, I thank you for having me.

SENATOR AMEDORE: Thank you, Senator Ortt.

At this time, I'd like to introduce two

Task Force members; and one person, particular, in the Capital Region you're very familiar with, and that's Senator Kathy Marchione.

SENATOR MARCHIONE: Thank you.

First, I would certainly like to echo my thanks to both, you, Senator Amedore, and to Senator Ortt, for putting these forums together, and for traveling throughout the state.

You know, this is the second year that I've sat on the Task Force.

And, I had a hearing myself last year at the Hudson Valley Community College, and it was at 9 a.m. in the morning, and there are about 250 seats in the auditorium, and there was hardly a seat available, and we needed to overflow that into another room and people watched it on a screen.

And I sat there and I gulped hard because, at that point, if it wasn't real to me before that time, it certainly is real to me what a problem this is in our community.

You know, we've all seen, it was last year, or two years ago, that the governor in Vermont, through his State of the State, did nothing but talk about heroin.

It is a critical problem.

And, you know, the State has done a lot in the last year. There were a number of pieces of legislation that they looked at, that we passed, and there is a lot further to go.

And that's why I thanked Senator Amedore and Ortt for continuing.

There are a number of pieces of legislation that have already been introduced, that they are introducing, that will continue to fight the heroin epidemic.

And I think what is also good, and I think why people looked at this as a real effort, is we are looking at it holistically. We're not just looking at a heroin problem.

That we're looking at law enforcement and saying, well, let's toughen penalties, because that will do it.

We looked at legislation, and passed legislation, and still have more to do, that prevents opioid abuse and overdoses. So you have that component.

And, also, increasing the availability of addiction treatment.

So, I am very happy to be with you this evening. This is a very serious issue that I've

taken very seriously.

And, I look forward to listening to all of our presenters this evening.

SENATOR AMEDORE: Thank you, Senator Marchione.

And, a Senator that is all the way from Rochester, and someone who is doing a marvelous, a great job in the State Senate, that is Senator Funke.

SENATOR FUNKE: Thanks, George, very much.

Heroin killed 65 people in my district in 2013, which was double what it was the year prior to that, which was double the year prior to that.

So, here we are.

Nobody wakes up in the morning and says, Let me try heroin.

You know, it could be a high school football player who has a knee injury and winds up on oxycodone for the pain, and becomes addicted to oxycodone. And when that treatment is over, what's next?

It could be a peer-pressure circumstance at a party.

The problem is that, that one time, can be the first step on the road to-full blown addiction.

So tonight we want to hear from you, we want to hear from those affected by this.

And the most important thing I think is, what comes next after tonight?

What comes next?

What are we willing to do as a group, all of us in this room, to solve this horrible problem?

And make no mistake, it's going to take all of us to get our arms around this and figure it out, and work toward some solid solutions; not just talk about this anymore, but come up with real ways to combat this problem.

So I thank Senator Amedore and Senator Murphy and Senator Ortt for co-chairing this really important Task Force, and for Senator Marchione for all her work last year before us three freshmen arrived on the scene here.

I have to be the oldest freshman in the history of freshmen --

[Laughter.]

SENATOR FUNKE: -- but, here I am, and it's wonderful to be here with you tonight.

Thanks.

SENATOR AMEDORE: Thank you, Senator Funke.

At this time I would like to invite to the

table here, Dr. Peter Provet from the Odyssey House, and, Father Peter Young, who is the CEO of Peter Young Housing, Industries & Treatment Center.

And what we have done this evening, is we have kind of a long list of participants, so we kind of doubled and sometimes tripled up, you know, the groups, so that we can get everyone in and speak without being here until 2 a.m.

So, I appreciate you coming, and thank you for your time.

Doctor.

DR. PETER PROVET, Ph.D.: Good evening.

It's my pleasure to be here.

And thank you, Senators, so very much, for holding these important testimony hearings on heroin and opioid abuse in New York State. Your interest and support are vital, and very much appreciated.

I also want to thank the many concerned citizens who are here this evening to learn and talk about what is happening in our communities, and how, together, we can stop heroin and other drugs of abuse from taking more lives.

My name is Dr. Peter Provet. I'm the president of Odyssey House.

Founded in 1967 in New York City,

Odyssey House is a human-service organization serving New Yorkers with substance-abuse and mental-health disorders, including young families, older adolescents, adults, and senior citizens.

The people we serve enter treatment in a variety of ways: as an alternative to incarceration, from homeless shelters, hospital detox centers, psychiatric hospitals, and with the support of concerned family and friends, some just walk into our mission office and ask for help.

However people reach us, whatever their history of substance abuse, we offer the same: a place of safety, understanding, and opportunity to grow and engage in a lifesaving recovery.

Odyssey House has a long history with heroin.

As I mentioned, our organization was founded in 1967 as a self-help model for heroin addicts in New York City.

For close to 50 years, we've saved lives, reunited families, stabilized communities. Hundreds of thousands of New Yorkers have started the journey to recovery in our programs.

Each day, around 2500 men, women, and children participate in our residential outpatient and peer-recovery services.

Last year we provided over 200,000 days of residential treatment; 18,000 outpatient visits, and individual and group counseling sessions; 11,000 primary-medical and dental visits; and 7,500 classroom hours to youth.

Much has changed in addiction in 50 years.

Today we know more about brain chemistry and the effect drugs of abuse have on the neural pathways that govern our behavior.

We can offer people medically-assisted treatments to help control cravings, blunt the effects of powerful narcotics and stimulants, and, potentially, save the lives of people who have overdosed, as you just spoke to.

These are vital advances and welcomed by all of us in the treatment field, but detox, which includes, often, buprenorphine and naloxone treatment, are not really treatment. They're the start of a treatment process that requires a long-term commitment to behavioral change.

We have all heard the data on the increased abuse of heroin.

In New York City, deaths from heroin were higher last year than they have been since 2003.

In 2013, 420 New Yorkers died from a heroin

overdose.

In 2013, the same year, Odyssey House, coincidentally, treated the same number of opioid abusers, 420 people who did not lose their lives.

In the last three years, from 2012 to 2014, the number of people coming into our treatment programs reporting opioids as their primary drugs increased by 18 percent.

100 percent of our outpatient-services staff are trained in opioid-overdose prevention techniques, including the emergency use of lifesaving naloxone injections, which you mentioned, Senator. And we're training our residential staff in these very same techniques.

We all know the ones we reach in time are the lucky ones.

We also know that drug addiction is a complex illness, characterized by intense, and at times, uncontrollable, drug craving, along with compulsive drug-seeking and use that persists even in the face of devastating consequences.

While the path to drug addiction begins with the voluntary act of taking drugs, over time, a person's ability to choose not to do so becomes compromised, and seeking and consuming the drug

becomes compulsive. This behavior largely results from the effects of prolonged drug exposure on brain functioning.

Simply put, addiction is a brain disease and affects multiple brain circuits, including those involved in reward and motivation, learning and memory, and inhibitory control over behavior.

Because drug abuse and addiction have so many dimensions and disrupts so many aspects of an individual's life, treatment is far from simple.

Effective treatment programs typically incorporate many components, each directed to a particular aspect of the illness and its consequences.

Addiction treatment must help the individual stop using drugs, maintain a drug-free lifestyle, and achieve productive functioning in the family, at work, and in society.

Because addiction is typically a chronic disease, people cannot simply stop using drugs for a few days and be cured. Most patients require long-term or repeated episodes of care to achieve the ultimate goal of sustained abstinence and recovery of their lives.

And allow me to mention and emphasize this

point: We speak of a "chronic relapsing disease."

NIDA (the National Institute of Drug Abuse) coined that term, under its director Alan Leshner, so, maybe 10 or 15 years ago. "Chronic relapsing disease."

One of our biggest struggles in breaking the stigma -- and I heard several of you Senators talk to this outside -- breaking stigma is directly related to this, because when people see an addict, they get treatment, but they still go back to using drugs, often people blame the addict.

Not that the addict doesn't have a great deal of responsibility for their behavior. Of course they do, and we have to address that.

However, if we think of this as a chronic relapsing disease of the brain, it helps address that problem of blaming the addict.

Just like with cigarette smoking, as I'm sure many people in the audience have struggled with, or perhaps continue to do, the number-one way people stop smoking cigarettes is a process. They stop, and they start. They stop, and they start. They stop, and they start. They stop, and it clicks.

This has been researched and found, consistently, that is the most successful way to

stopping cigarettes: it's a back-and-forth.

Same with drugs, unfortunately.

Scientific research published by NIDA, which I have mentioned, and others, since the mid-'70s, shows that treatment can help patients addicted to drugs stop using, avoid relapse, and successfully recover their lives.

Based on this research, key principles have emerged that form the basis of any effective treatment program.

Addiction is a complex but treatable disease that affects brain function and behavior. We emphasize this over and again.

No single treatment is appropriate for everyone. Treatment needs to be readily available. Effective treatment tends to multiple needs of the individual, not just his or her drug abuse.

Remaining in treatment for an adequate period of time is critical.

Counseling, individual or group, and other behavioral therapies, are the most commonly used and necessary forms of drug-abuse treatment, and, more and more, we're discovering medications are an important element of treatment for many patients, especially when they're combined with counseling

techniques.

Individual's treatment and service plans must be assessed continually and modified, as necessary, to ensure that they meet the individual's changing needs throughout the treatment process.

Many drug-addicted individuals also have other mental disorders, and we've come to refer to this issue as a "co-occurring" problem.

Medically-assisted detoxification is only the first stage of addiction treatment, and by itself, does little to change long-term drug-abuse patterns.

Treatment does not need to be voluntary to be effective.

Drug use during treatment must be monitored continuously, as lapse during treatment do occur, and the individual shouldn't be blamed. They need to be addressed and confronted, not blamed.

Treatment programs should assess patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, as well as provide targeted risk-reduction counseling to help patients modify or change behaviors that place them at risk of contracting or spreading infectious diseases.

Medication and behavioral therapy, especially

when combined, are important elements of an overall therapeutic process that begins often with detoxification, followed by treatment and relapse prevention.

Easing withdrawal symptoms can be important in the initiation of treatment, preventing relapses necessary for maintaining its effects.

And sometimes, as with other chronic conditions, episodes of relapse may require return to prior treatment components, which I've mentioned.

A continuum of care that includes a customized treatment regimen, addressing all aspects of an individual's life, including medical and mental-health services, and follow-up options, community- and family-based support systems, for example, can be crucial to a person's success in achieving and maintaining a drug-free lifestyle.

A young resident in our long-term youth program in lower Manhattan recently talked about the swift and steep decline he experienced from abusing prescription drugs that went to heroin addiction.

Tomas (ph.) is a 26-year-old young man originally from Ukraine. He immigrated to this country with his family when he was 10. His family settled in Philadelphia, opened a construction

business.

Tomas went to school, he graduated, and went to work in the family business. But family problems, a breakup with a girlfriend, and other issues led to or were exacerbated by an onset of depression.

At 21 he started using cocaine, benzodiazepines, alcohol, and marijuana.

At 23 he progressed to heroin. By this time he had stopped going to work. His family told him to leave, and he was supporting his growing heroin addiction by shoplifting, stealing, and forging checks.

He left his hometown and made his way to New York City to escape. Several times he tried to quit heroin on his own, each time he failed, and each time he started using more. He also started stealing again to support his $100-a-day habit.

Eventually he was arrested and sent to Rikers Island, where, as part of his sentencing, he was referred to Odyssey House as an alternative to incarceration.

Tomas counts himself one of the lucky ones.

While he saw other addicts overdose, he never did. He's grateful for the chance to be in

treatment. It's a slow process, but he is getting his life together. His family is supportive. He plans to go back to school.

But he also knows he runs a real risk of relapse, and he's volunteered for monthly Vivitrol injections, and to attend outpatient recovery support groups when he leaves residential treatment.

Tomas is only 26 years of age. He has his life in front of him. He's lucky to be in treatment.

But how many others will not survive the biggest opioid-abuse epidemic our country has faced?

Thank you, Senators, for hearing my testimony, and thank you so much for your support.

SENATOR AMEDORE: Thank you, Doctor.

Appreciate the testimony.

And I want to go right to Father Peter Young for your witness.

FATHER PETER YOUNG: Thank you, Senator.

I am very happy -- I am coming from a very different kind of background.

SENATOR AMEDORE: That's why we put you two together.

FATHER PETER YOUNG: Good combination.

[Laughter.]

FATHER PETER YOUNG: You know, it's an important kind of thing, because I'm coming in from the experience of dealing with the guys and gals on the street. And in -- the Green Street was, at that time, that I was sent to in '58, '59, that was known as the largest brothel in the east, which is something about Albany. More than Rochester, it's Lyell Avenue.

When we know the routine of what goes on in the different cities, the big thing was, and I had a great benefit of growing up in Albany with Harry Albright, a guy that became secretary to Governor Rockefeller. So I'd go up and have coffee with him in the morning, and I would sit there, and we would often sit down with -- Rocky would be there, and he would say, Well, Father, what are you doing today? And, I would say, Come down.

And he came down to visit.

So the governor came down to visit.

Trouble? Okay.

And when the governor would come down, he would come down and visit, and he would often be amazed at the 100 or so guys I would have sleeping on the floor, and he would say, What are you doing with them? How are you helping them? They've got

the Harlem problem.

I said, Harlem? What do you mean by the "Harlem problem"?

He said, Well, they're using some kind of a drug there. You seem to have the same kind of guy and gal in there. And you're taking in and taking care of them, but what do you with them?

And I said, It's not Harlem. It's a heroin problem, Governor. It's the heroin, it's heroin.

And I tried to explain to it him at that time. And we became very great buddies.

And he then said, You know, I'm very interested, and I want to try to -- he gave me a parking place on the ramp, which was a big help. He got me in and off the Capitol.

And with that kind of fun, we had a good time, because we would have lunch with him and enjoy the opportunity.

And he said, You know, Father, what we need to do, we need to try to get you to try to give us a little bit of the idea, you're working with these people, and Harry thinks you're a nice guy. So let's -- if we can -- what do we do? Let's plan, and I'll sign the bill in 10 years.

I said, That's great.

That was for 240.40 in the penal code. That was the decriminalization of alcoholism as a crime. And that was a big one, because 35,000 meetings and 14 years of my life later, we had the bill signed, and it did what the-- Senator Amedore was talking about: it destigmatized.

And that's a -- very important. I'm glad you brought that up, Senator, because that's so important.

If you were to go to an AA meeting before that, you would never really see any kind of women represented.

After that bill passed, you couldn't believe what happened. The people came out of the woodwork, out of the closet, so to speak, and they came, and they participated. And it was a very important thing because, then, it opened the door and it created an environment of friendship, and an environment that would welcome people.

And women were the beneficiary.

You would go to a meeting or a participation with a fellowship, and you'd see the women participating as much as the men; and, therefore, that door is open.

I think the Senator hit a very important key

word, that this really needs to be addressed, and that's what I think we're about: Trying what we could to find a way to do it.

I was lucky, I was a friend of the governor, and the governor knew a lot of rich people. He knew Brinkley Smithers. And Brinkley Smithers and Senator Harold Hughes then were -- then working with me. They sent me all over the country on all of these different "missionary trips," as they would call it.

Harold Hughes, and the senator from Iowa, and he and I did all the speaking at the different conferences about the disease of addiction, talking about it as a disease, an illness, as the doctor had said, very carefully, and I was listening to that and I said, Amen, Doctor.

It's a disease, an illness; an illness that we need to address, and do it as best we can with the most competent care.

We did it, with the idea of traveling around with those two, and traveling around, and Brinkley Smithers would take care of everything, because he was one of the founders of IBM.

And in talking with him, we started many of the journeys. At that time, we were fighting a

temperance movement. That tells you how old I am.

And we were trying still to talk about the "i over the e," the "intellect over the emotions."

The brain.

The brain, the cortex of that brain, has got the thinking power.

The doctor would know more than I.

But the craving is the mesolimbic area of the brain, and that needs to be addressed; and, therefore, we're looking at the kind of competence that they have to put that together, and try to get that competent kind of feeling to take care of that craving, so we have time.

And that's what I try to stress: You need time for this miracle to happen. You just can't do it quickly and say, He's better now, he's had a week in a rehab.

That's not going to work.

We often think about the many things that are going on.

One of the problems I would like, if I could, just to put out on the table, we have a terrible time, we're talking about merging right into mental health now in New York State.

We have been there, and we know what

happened. We were one-half of 1 percent in the budget in addictions for alcohol and drugs.

One-half of 1 percent.

If we merge, I think we need to be well-represented financially, and being capable to do what we need to do to take care of the people that are sick and suffering with this progressive, insidious disease.

I just keep thinking about how all of that happened, because you need to have the kind of foundation, and you need to have the idea of what they have to have in order to take care of that disease, that Rocky was so competent in thinking of, and what he needed to do.

He was really the person that had a dedication.

His father tried to give money to AA, and they refused it. And he said, I don't understand it, but I'll work with Marty Mann and you, and we'll try to find out if we can get that kind of program going here in New York State.

But it was, again, a council on alcoholism, a council that took care of the need. And at that time it was an easy thing, because working with heroin at that time, it was only 7 percent potency.

Now it's about 47 percent potency.

So we're dealing with many different kinds of drugs. They're getting now with a little fentanyl in here and there. It's dangerous kind of routine.

The kind of routine that I'm proud of is, to know, and to know what happened with that administration, the kind of way that they dealt with the problem: competently, compassionately, and in a very dedicated way.

But then came the Medicaid kind of funding.

When the Medicaid funding came, then you were caught with a lot of the paperwork.

The fun in the field is gone. There's no longer an enjoyable counselor that I've met lately. They are finding it very difficult to work in the field because there's always, the Medicaid kind of fraud unit will come in and check, and find out, knocking on your door, and finding out where you are, what you're doing, for anything you ever do, because, anything, if you give a free day of care, then you're under Medicaid fraud.

So there's a fear, an anxiety, in the field right now.

It does not mean that we are bad. It means that we need to be carefully able to endorse and

support and help people that are still sick and suffering, and be as wide open in the field as we can.

I plead on that kind of score, because I know the unhappiness that I find in the field with counselors, it's just overwhelming.

They're no longer eager to get in the field. They're trying to get out of the field, rather than in it.

So I just beg you to try to address the idea:

How do we merge Article 28 and Article 31?

How do we do that?

How do we work with the Article 30 -- those two sections of law need to be addressed, so we can get a team approach.

And I know Senator Murphy would well know better than I how that all happens.

When you're running a wellness center, you're dealing with that kind of game all the time, trying to figure out how you put the two of those together, the public health to the mental health, and try to blend them, putting them together into --

SENATOR MURPHY: It's a difficult challenge.

FATHER PETER YOUNG: Difficult. Thank you. I thank you for that vote.

And I just appreciate it.

So I just feel grateful again, as the doctor said, to be here, to be able to share the idea.

And in the 58 years that I've had of doing it, I'm a little -- kind of sorry now that I don't have any answers. I just have experience.

SENATOR MURPHY: We need your experience.

FATHER PETER YOUNG: Thank you, Senator.

SENATOR AMEDORE: Well, thank you, Father Young.

I want to just put out, any of my colleagues, if they have questions, I would just ask that you probably keep them kind of pointed and short.

We're here, really, to do more listening, and we'll ask questions as we see fit.

But, we can sit here all night long and go over a lot of different back-and-forths, but, there's a lot speakers, and, there are -- everyone's important, and everyone should be heard.

SENATOR FUNKE: I just have one question.

SENATOR AMEDORE: Yeah, go ahead.

Senator Funke.

SENATOR FUNKE: I'd just like to ask the doctor, about Vivitrol.

Can you tell me about that, and the

effectiveness of that, and where in the treatment Vivitrol comes in?

DR. PETER PROVET, Ph.D.: I mean, you go back to methadone, and how these drugs work are, now, we understand a little more, in blocking opiate receptors in the brain.

And for people who are willing to accept administration, it's definitely something that is a promising part of a treatment regimen.

The downside, of course, is to think that a pill, however it works effectively in blocking the opiate receptor in the brain, is a cure for addiction, because we know addiction is far more than the drug. Addiction is a lifestyle. Addiction is lack of motivation. Addiction is walking away from life and its challenges.

And so what we want to make sure doesn't happen is, as we embrace medical-assisted treatment, we don't leave behind behavioral (inaudible) critical in helping the person change their attitudes, their behaviors, their family, relationships, and so forth. That must be emphasized.

People who are looking to cut budgets too quickly want to say, Well, you have all these

medications now. Aren't they the answer?

Because the real treatment takes time and far more of a financial investment.

FATHER PETER YOUNG: If I could just share one comment about Vivitrol, and naltrexone has been around, and it does what he's talking about.

I think it's better than the pill form because, now, if you take pills, you can sell the pills. And a lot of them are being sold on the street all the time.

At least if you take a shot of Vivitrol, at $1300-plus a day -- a shot, with that $1300 or so in the butt, that takes a commitment.

I know -- either -- I'm the same school that Odyssey is talking about, Amen, that takes a treatment plan. That only will take care of the chill-down, so you can begin to talk with a guy before he shakes-out.

SENATOR MURPHY: So you need the wraparound approach?

FATHER PETER YOUNG: Yes. Absolutely.

SENATOR MARCHIONE: I have just one question.

Doctor, you stated that it does not need to be voluntary, the program, to be effective.

I always thought, at least what I have been

led to believe, that someone has to hit bottom, and they have to want to change, in order for change to be effective.

But I didn't hear that from you.

DR. PETER PROVET, Ph.D.: Yes, very important and interesting issue.

Someone does have to get to a bottom to really want to change, but that doesn't always happen before they get into treatment.

Treatment helps them find the bottom very often.

Having alternative-to-incarceration programs has probably been one of, if not the most important, policy move in New York State to advance treatment.

At Odyssey House, and other fine programs in New York -- Phoenix House, Samaritan Village, Daytop, so forth -- all of our programs work with the criminal justice system. People get a choice: Come into treatment or be prosecuted for a low-level drug crime.

They choose coming into treatment.

Once they get into treatment, we help them find motivation to change. That takes time. People aren't immediately ready to quit their addiction.

So, getting forced into treatment sometimes,

often, is necessary to get them to that bottom, to help them realize they have nothing in their lives, that they want to change and live a far more successful and happy life.

SENATOR MARCHIONE: Thank you.

And just a statement for Father Young, and I told this story once, and I think it's so indicative of Father.

I heard a story one time, because he's been running these programs for a very, very long time, that someone needed a pair of shoes, and it was very cold outside. And Father got out of his car, went in, took his shoes off, and came back out in his stocking feet, to help someone.

And that should never go unnoticed, Father.

Thank you.

FATHER PETER YOUNG: Thank you.

Thank you, Senator.

SENATOR AMEDORE: That's why you're wearing no socks tonight?

FATHER PETER YOUNG: That's it.

[Laughter.]

SENATOR AMEDORE: Thank you so much for being here, and your testimony.

FATHER PETER YOUNG: I thank you for the word

"destigmatize" and "de-stigmatize."

SENATOR AMEDORE: Very important.

Next I would like, we have on the agenda, Deb Rhodes from Albany County Substance Abuse, and, Joe LaCoppola from Conifer Park.

FATHER PETER YOUNG: Hi, Deb. How you doing?

DEBRA RHOADES: Good. You're a hard act follow.

SENATOR AMEDORE: Hello, Deb. How are you?

DEBRA RHOADES: I'm well, thank you.

SENATOR AMEDORE: Ladies always go first.

DEBRA RHOADES: Okay. Thank you.

Thank you, Senators.

My name is Debra Rhoades, and I am the alcohol and substance abuse coordinator for Albany County. I'm here on behalf of Dr. Steven Giordano, the Albany County Director of Community Services, and Daniel P. McCoy, our Albany County Executive.

First, I would like to thank the Joint Senate Task Force on Heroin and Opiate Addiction for your interest in learning about the issues our communities are facing in the wake of an unprecedented opiate and heroin epidemic.

In my role as alcohol and substance abuse

coordinator, I work for the Albany County local government unit, or, "LGU," as stipulated in Mental-Hygiene Law, to oversee, coordinate, and plan for local substance-use-disorder services.

We are fortunate in Albany County to have multiple substance-use-disorder prevention and treatment providers; however, I'm here to tell you that we are just touching the tip of the iceberg in terms of the needs of our residents.

The opiate epidemic has created a huge challenge for our local community providers.

In Albany County, we have seen the number of individuals seeking treatment for opiates as their primary drug of abuse increase 300 percent over the last decade.

Local governments, schools, community-based providers, are experiencing an increased demand for services that is challenging to keep up with. These demands include ever-more frequent calls from desperate parents and other family members seeking help and direction in getting their loved ones the care that they so often urgently need.

The number of requests for expert presentations about the opiate, heroin, epidemic coming from professionals, schools, parents, and

community groups to provide education and guidance is unprecedented.

Similarly, on the national and state levels, the data indicates that the prevalence of substance-use disorders, in general, far outpaces the availability of and access to science-based, quality prevention and treatment options.

The local government unit in each county is uniquely situated, and we are your eyes and ears on the ground in each local community.

In Albany County we routinely assess the needs of individuals and their families impacted by addiction in our community and link them to available services. We identify service gaps and plan for needed services, and, we monitor effectiveness of existing services.

The LGU is constantly taking the pulse of what is going on, and we know that addiction, not simply limited to heroin and opiate addiction, is a public-health problem requiring multiple solutions and a partnership of multiple stakeholders.

We strongly support the many voices you've heard calling for increased funding.

Without additional resources, we will never be able to adequately confront this multifaceted

problem. And although we also know that money alone is not the answer, we have identified several specific areas that we believe, with adequate funding, can positively transform how we treat addiction in Albany County and across New York State.

First, we must do a better job educating the medical and behavioral-health workforce to treat addiction like other chronic medical illnesses.

A crucial step towards meeting this goal is to require that addiction education be an integral part of the academic training and preparation for all New York State-licensed medical and behavioral-health professionals.

With this training, physicians, psychiatrists, psychologists, dentists, social workers, nurses, and nurse practitioners, physician assistants, and licensed mental-health counselors will be better prepared to meet the challenges they will face on the front lines in our communities serving those with substance-use disorders.

Although hard to fathom, given the seriousness of this current situation, addiction education is often an afterthought in many professional and academic training settings at

present.

We must double our efforts to make naloxone widely available to those who could benefit from its use.

A logical next step would be to make naloxone, or, Narcan, available at all pharmacies.

This epidemic is not limited only to those addicted to heroin. The potential for opiate overdose extends to those who are prescribed opiate pain medication across the age spectrum, and who, for one reason or another, are unable to use the medications as prescribed. Having naloxone available to these individuals and their families has the potential to save additional lives.

Also, increasing opportunities for medication disposal at local pharmacies will remove unsafe, frequently-abused medications off the streets and out of the hands of our youth.

Third: In order to effectively combat this epidemic, we need to be able to reliably ascertain what it is we are actually up against. Too often the available data, particularly as it relates to overdose deaths, is difficult to obtain, inadequate in one way or another, typically vague and dated, and varies from one source to another.

We need a comprehensive statewide database to help us understand the full extent of the heroin epidemic in real time, as close -- or as close to it as possible.

We need to put in place a standardized, mandated reporting system, requiring specific details about all alcohol- and drug-related deaths, including the enumeration and identification of all drugs discovered upon autopsy.

Such a reporting system would allow for a better understanding of what specifically is happening in each of our communities, and serve as a public-health alert system, much like we have in place for contagious diseases.

Knowledge of surges in drug-related deaths, as well as deaths involving new drugs, could allow health, behavioral-health, and law-enforcement professionals to pinpoint outbreaks and respond to emerging local trends in real time.

Four: Access to science-based, quality treatment is often hampered as a consequence of inadequate health insurance, or, as a consequence of having no health insurance at all.

Please continue to in your efforts to ensure that addiction treatment is a covered benefit like

all other medical conditions, and that treatment is affordable for all that seek it.

Additionally, please continue in your efforts to ensure access to treatment as an alternative to costly incarceration, when deemed appropriate.

Drug courts and other diversion programs are a proven mechanism to disrupt the cycle of addiction, and are integral to local efforts to get ahead of this community problem, and should include all of the options currently available to the general public.

Five: We have mentioned science-based treatment more than once tonight, or at least I have.

The science is growing and the results are increasingly irrefutable.

We urge you to support efforts that propose to increase access to medication-assisted treatment for opiate addiction.

We must follow the science, and utilize and increase access to all addiction medications, including, but not limited to, Suboxone, methadone, and Vivitrol.

Equally important, is ensuring that there are mechanisms in place for insurance reimbursement of

these vital adjunct treatments.

Presently, we continue to hear of situations in which medications are available, but the insurance coverage and reimbursement simply is not.

Finally, please do not let yourself be seduced by believing this is just a heroin problem.

Many experts in the field believe that we missed an opportunity to fully address problems associated with alcohol abuse when we focused our attention solely on drunk-driving.

We have an opportunity not to repeat history.

Please consider -- oh.

The heroin epidemic is the battle. Addiction is the war.

Please consider, favorably, all prevention and treatment efforts designed at thwarting the largest -- the larger problem of addiction in our homes, schools, and communities.

On behalf of Dr. Giordano and County Executive McCoy, please accept our gratitude for this opportunity to present testimony before the Task Force.

Under their leadership, Albany County has taken many important steps to address these problems. We've identified opiate abuse as a

priority problem.

And our community-health improvement plan, as part of the New York State prevention agenda, we are involved in sponsoring opiate-awareness events in the community. We are hosting Narcan trainings across the county. And we recognize the importance of treating co-existing mental-health problems which plague many living with addiction.

We are grateful for the many community partners with whom we stand unified, in hopes of turning the tide, one individual at a time.

And we hope that the recommendations we have presented to you tonight will be helpful as you join us in these efforts.

Thank you very much.

SENATOR AMEDORE: Thanks, Deb.

Can you go back in your remarks there?

DEBRA RHOADES: Uh-huh.

SENATOR AMEDORE: "The battle and the war," say that again, so everybody here understands.

DEBRA RHOADES: My favorite line, I must say.

The heroin epidemic is the battle. Addiction is the war.

[Applause.]

DEBRA RHOADES: Thank you.

SENATOR AMEDORE: Good evening, Joe. How are you?

JOE LaCOPPOLA: Good evening, Senator. I'm doing well. Thank you.

And good evening, Senators, and thank you again for inviting us, and myself, and most importantly, thank you for convening these hearings throughout New York State.

We, as every other state, and as you've heard this evening, are in the midst of a public-health crisis.

The use of illicit opiates has no boundaries and does not discriminate. It has destroyed families, and its death tolls continue to rise on a daily basis.

We, as a state, and as providers, need to take responsibility and come forward, as we've heard tonight, to support medication-supported recovery and become leaders in its acceptance, and be able to leave our biases at the doors, to be able to work with individuals with the disease of opiate addiction.

And I think the important piece is looking at this as a disease, and that we are blessed to have medications to be able to address this disease of

opiate addiction.

The importance of using medication-supported recovery is not to just address the disease alone, but to assist individuals to be able to engage into treatment, and to be comfortable to gather the tools that are necessary to assist them in their recovery.

It is also important for individuals to understand the medication, and medication alone, is not the answer, and to understand, as with any other medications, to treat the disease of opiate addiction, as treating other medical diseases, that individuals do not have to see this as a lifelong commitment to that medication.

But programs, and the individuals that are working with individuals with the disease of opiate addiction, understand, at some point, to explore options without medication-supported recovery.

We heard about the stigma associated to the disease of addiction.

We also have to understand that the stigma that's associated with individuals who participate in medication-supported recovery, individuals have great difficulties to walk out the side of the door and be looked at, and not being -- and being told that they are not truly in recovery because they are

using a medication.

That's inappropriate, and that they are truly in recovery, and we need to be able to strongly give that message to them.

A successful program integrates medication-supported recovery with talk and group therapy. Scientific evidence has shown medication-supported recovery assists the community, due to patients no longer engaging in criminal activities to support his or her illicit use, and also assists in decreasing the spread of infectious diseases.

Some of the recommendations that I present tonight is the one -- is looking at: How can we get more money into the treatment-services program?

One of them is looking at deeming all medication-supportive recovery-services treatment programs -- opiate-treatment programs, in the country, and in New York State, have to be accredited.

And as soon as the program is accredited by, for example, the Joint Commission or CARF, the sooner OASAS can come in and do a complete review of the same standards that are reviewed by the Joint Commission, which programs to pay for.

What we're saying is that, we cease, and we go to deeming, and allow just the Joint Commission of the accreditation that's been given to programs, and take the money that's saved from those reviews and reinvest it back into treatment.

Secondly, and we're working on this, is the removal of a census capacity.

Again, you talk about stigma, and you talk about programs.

And, presently, any OTP (opiate treatment program) has to give a census capacity.

And here we have -- are now in the midst of an epidemic, and programs have waiting lists, and, presently, can only have certain capacity of 200, 300, depending on their location.

It's a rigorous process to get that census capacity lifted when we submit those applications.

We are working closely with the State, but we have to go through an application process and have to meet certain criteria.

We understand, in regards to public perception and programs, we have to understand, too, we're in the middle of a crisis right now, and the sooner we eliminate the capacity, the more individuals we can get into treatment.

We ask that we be looked at just like any other outpatient program that does not have census capacity, and be able to show that we have the staffing and the resources to be able to meet the needs of the patients. We'll be able to soon -- be able to get patients into programs much sooner than we are now presently.

Lastly, we ask that you look at the implementation of the managed care in a manner that protects our patients, the field, and the delivery of treatment services.

As we move our state to a full managed care, we want to ensure that the services that are being provided presently, continue to be provided without any interruption from the managed-care providers.

Also, we have to look at, as a state, that when we look to open an OTP, that we stand together.

The bias and the stigma that's associated with it, to open a program anywhere, is very high.

We have many of the (unintelligible) saying, that we're going to draw an element to the community; when, in fact, we are trying to help a community.

We need to eliminate that and stand together as we open these programs.

I conclude by again thanking you for convening these hearings, and willingness to hear -- to begin the development of legislation that would address the public-health crisis, and, most importantly, show the residents of New York State that we have a problem, and we want to work together to address this problem, so that individuals that need treatment can get the treatment they so deservedly deserve.

Thank you.

SENATOR AMEDORE: Thank you, Joe.

I got a quick question for you.

I know you gave us three or four good points.

One of the questions that I have is: What laws or regulations would you like to see changed?

JOE LaCOPPOLA: Well, I want to thank you, for one, is we have the bill presently, that's coming to the Senate floor for a vote.

That bill will allow individuals who are receiving medication-supported recovery not be required to be tapered off their medication, as some drug courts do require right now.

So that's a huge bill that I ask that we continue to move forward and get passage, that that bill pass.

I think another piece of legislation, as I said, is that we get some movement in regards to having programs deemed. I think that that would allow much more funding back into treatment, what is spent right now on the resources for reviewers, and we can actually treat more individuals.

Secondly, is, again, looking at the census capacity, and eliminating that for all opiate-treatment programs, and allowing programs to be able to show that they're physically -- have a physical plan to treat patients, and fiscally able to do it and provide the staffing.

SENATOR AMEDORE: Thank you.

Anyone have any questions?

SENATOR MURPHY: Very quickly, Deb?

DEBRA RHOADES: Yes.

SENATOR MURPHY: Over-the-counter Narcan, that you were talking?

DEBRA RHOADES: Yes.

SENATOR MURPHY: The kids are having pill parties now. You, Deb, would be in charge of the Narcan, to come to the party.

So it's a false sense of security.

I understand it, we are treating a symptom.

Totally understand where you're

(unintelligible), but this is exactly the next level these kids have taken it to, where they come in and put the pills in a bowl, and everyone picks one up, and, Deb, you're in charge.

They make sure someone is in charge of the Narcan for the party.

DEBRA RHOADES: Except for, it's my understanding that when you revive somebody with Narcan, it's very unpleasant.

SENATOR MURPHY: Oh, yes.

DEBRA RHOADES: Very, very unpleasant.

SENATOR MURPHY: They're very violent. Very violent.

Secondly, drop-box.

Drop-boxes, you said, the Shed Your Med program.

Senator Martins did one, I'm going to say, a few months ago in Long Island. 500 pounds of medication he took in, in one day.

DEBRA RHOADES: Believable.

SENATOR MURPHY: But those drop-boxes have to be under supervision 24 hours a day, whether it's at a police station, or get with your pharmacist.

And, I can't agree with you more, and I think a lot of us can agree with you: 15 days in a rehab

is a joke. It's a waste of money.

Keep your money.

Let's just do it the right way, and that's why we're trying to get -- you know, have these forums.

DEBRA RHOADES: Thank you.

SENATOR AMEDORE: Thank you.

Appreciate it, Deb.

SENATOR FUNKE: It occurs to me that it's about attitudes, too, and about changing attitudes.

Because, you know, I don't know, I watched television this morning for an hour, getting ready to go to the office, and so on, and I don't know how many drug commercials I saw on TV.

But, we are producing drugs in this country at such a rapid rate. And you listen to the side-effect part of the commercial, you know, you'll grow the head of a German Shepherd.

[Laughter.]

SENATOR FUNKE: It is longer than the commercial itself, and, you know, kids see this, and on and on and on it goes, and I wonder about the attitudes.

And, I don't know, when I was a kid, I got hurt, you know, I was told to "suck it up."

Today, we have every kind of drug known to mankind as a pain reliever to deal with this kind of a problem. And we've got doctors prescribing this stuff over and over and over again.

So, you know, I just wonder sometimes about the attitudes that we're all living with in this society today, and how we begin to change that, that a pill can fix everything in your life.

DEBRA RHOADES: Agreed.

SENATOR FUNKE: I don't know if we have any answers for that, but we better start to figure it out, though.

SENATOR AMEDORE: Thank you.

Next we have, Dr. Charles Argoff from Albany, med pain management specialist, and, Dr. Christopher Gharibo from NYU Langone Medical Center.

And if I pronounced your name wrong, please still testify, come and speak.

[Laughter.]

SENATOR AMEDORE: You know how many times everyone gets my name wrong? And it's the most simplest name. Easy. "I'm-a-door."

[Laughter.]

DR. CHARLES ARGOFF: Good morning, Senators.

SENATOR AMEDORE: Thank you. Good afternoon -- or, good evening, and thank you for being here.

And, why don't you start.

DR. CHRISTOPHER GHARIBO: Thank you for the invitation. It's a privilege to be here.

I'd like to give a background on myself.

I'm a pain-medicine physician. I'm an anesthesiologist by training.

I've been practicing in New York State for the last 17 years, and I do both acute- and chronic-pain medicine, and I believe I can give some context with respect to the beginning of the beginning on how opioid overprescribing can, potentially, become an issue, and then give you four specific suggestions on what we can do to mitigate this problem as much as possible.

I applaud the growing concern, I applaud the industry-wide effort on the part of the legislators, on the part of the clinicians, and the patients, as well as the pharmaceutical industry, to get ahead of this problem.

But I think we need to have a certain degree of balance within the conversation.

There's, clearly, abundant opioid misuse,

abuse, and diversion, but I think we also need to recognize that there is a chronic-pain problem in the country as well.

And to a large extent, it could be tolerated and dealt with, but, we also need to recognize that we are dealing with an aging population, with a spectrum of pain problems, that, at some point, are not good orthopaedic candidates for surgery, for joint replacements, or for spine surgery, that have advancing disease, that need to be functional, psychosocially, physically, and in many respects.

And that's where a credible pain-medicine program comes into play with respect to maintaining our population's function.

So, we need to recognize both sides of the issue.

What I have seen is that there's been a lot of anti-opioid talk, and I believe a lot of it is for a good reason. But I think we need to acknowledge that controlled substances, especially opioids, are evidence-based, to the extent of evidence supporting opioid use in chronic pain, when appropriately prescribed, is mechanism-based, physiologically, and is literature-based, based on the literature that's available out there, that's as

good as any, and better than most.

Now, I'm not here as a pro-opioid candidate, but the extent of literature supporting opiates expands from 3 months to 6 months, to up to 12 months, with good pain reduction and improvement in functionality and quality-of-life parameters.

Now, having said that, clearly, there has been an overprescribing that has developed in the last 15 years, through my career, that has reached ridiculous levels, usually as part of opiate monotherapy, not pain medicine.

There is a group of drug-peddling physicians that overprescribe opioid monotherapy. It's the, sort of, 5 to 10 percent that calls themselves "pain-medicine physicians," but are simply drug-pushers that are prescribing to addicts and diverters and misusers and abusers, where the doctor is, essentially, acting as a dealer.

But, nevertheless, it's that 5 percent that gives the 95 percent a bad name.

Appropriately trained, pain-medicine physicians practice a multidisciplinary, opioid-sparing, multi-mechanistic, analgesic plan of care that focuses on function, not just giving out opioids.

And I think there are a lot of legitimately trained and well-meaning pain-medicine physicians that are doing the right thing.

Now, there are many physicians that are misprescribing, in good faith, and are not aware of the evolving standard within pain medicine, because there has been inadequate training in pain medicine during their internship as residency, and throughout their attendingship.

There has been no ongoing follow-up with respect to opiate-prescribing standard of care across the country, and this starts at the beginning of the beginning.

For somebody -- for example, for somebody who has had a knee replacement, that is given 120 oxycodones 10s, is probably not the good beginning of the beginning for that individual patient.

A subset of those patients may be at a high risk for addiction, and then it starts innocently as misuse, because, I want to dance a little bit more at my daughter's wedding.

And then they get a withdrawal from that.

The next morning they double-up on it because of that withdrawal.

And that's the pattern that we don't want.

So what I'm here to propose to you, for New York State, is that many physicians out there are lacking knowledge.

And many pain-medicine physicians that are legitimately trained are not the problem, but the clinical community is undertrained with respect to pain medicine.

There needs to be a mandatory educational program that covers non-opioids interventional therapies, not pharmacological therapies, physiotherapies, and appropriate opioid prescribing that mitigates risk, where opioids are prescribed in a responsible fashion, in a limited fashion, when the pain is acute and subacute. And if the pain is chronic, the opioids are prescribed as part a multimodal or a multidisciplinary plan of care.

We're not in the area -- era of opioid monotherapy.

We're in the era of balanced analgesia, where the dosing needs to be reasonable and the pill units needs to be reasonable. The prescriber should not give three separate lines of, and four separate lines of, an opioid, plus a benzodiazepine, and so on and so forth.

And that is currently taking place in the community, with a very simplistic evaluation, an excessive overprescribing, poorly focusing on controlled substances.

And when you speak with those physicians that are being reviewed by OPMC, or whoever else, they're saying -- all they say is, Well, aren't these pain medications?

Well, it's more complicated than that, and I really think they lack a foundation and education for appropriate prescribing.

So I propose a mandatory educational program for all prescribers.

I think the federal REMS can be a start, but it can be expanded to include other areas of pain medicine, as to how to appropriately go about prescribing.

The second area that I think we need help with is integration of the prescription-database monitoring program, where it integrates with the surrounding states.

Preferably, it should be a federal program, but we need to integrate with the surrounding -- as many surrounding states and second-level states as much as possible, so that we know what else is going

on in Connecticut, New Jersey, Vermont, and so on, and that we're also aware of benzodiazepine prescriptions by primary care or by psychiatry or any other clinician, because most of these deaths -- or, about 30 percent of the deaths that are occurring are due to combination controlled substances that have a synergistic effect on respiratory depression, and they also increase the addiction risk, the psycho-active response, and the withdrawal magnitude upon taking these substances.

Another effort that we propose, that has already been mentioned, last year, Attorney Holder announced an expanded drug take-back program.

We support a similar measure in New York State.

This needs to be done discreetly. Maybe a police station is not the best place to deposit these medications. But, it really needs to be quite discreet, where it is easy for the patient, and practical for the patient, to be able to return their unused prescriptions. And this can be done by the patient or by parents or by loved ones.

And the fourth measure is that we're -- I think technology can help us as well.

Appropriate prescribing needs to limit the

pill units, needs to be part of a combination non-pharmacological and a non-opiate plan.

But abuse-deterrent opioids have also shown to be of some benefit in mitigating risk, misuse, and abuse. They have lower street value, and they, potentially, prevent the most common form of misuse and abuse, and that is oral. You either crush it, dissolve it, pulverize it, or you solubilize it in Coke, Sprite, alcohol...take your solvent.

And these are the step in the right direction, but I believe these need to be quite comprehensive. They need to cover long-acting and short-acting opioids.

If you leave a way out, it's like squeezing parts of a balloon, where, the clinician may just opt to prescribe the non-abused deterrent formulation, because it is cheaper to prescribe and is covered by the patient's insurance company.

So the abuse-deterrent opioids need to be covered, different molecules need to be available, but they still need to be prescribed in a responsible fashion. They shouldn't lower the threshold for prescribing opioids, but need to be made available in the marketplace.

So, I will sum up by saying that: We need to

balance the benefit and the risks of these controlled substances.

They clearly offer benefit to millions of patients across the country. They just need to be given responsibly.

But, the doctors often lack the know-how, because they lack the education, and they need the tools to be able to do it the right way.

Thank you.

SENATOR AMEDORE: Thank you.

Doctor, you brought up an interesting point.

As a matter of fact, Senator Murphy and I, today, had a meeting with the Chairman of the Health Committee, and that's Senator Kemp Hannon, and we talked about the I-STOP, and the technology and the database, and how we can make it more integrative with surrounding states.

But the statistics is astonishing, and how the tracking and finding that even the shoppers of doctors are, considerably, being eliminated, almost 80 percent, by tracking and seeing and watching what's happening with the I-STOP prescriptions.

DR. CHARLES ARGOFF: Senator, I have -- I know you may have other questions, but I just want all of us in this room to feel extremely proud in

New York State, that that program is the best -- in my -- I mean, we are national educators. And, in fact, we spoke at a MSSNY-sponsored CME Pain Conference recently, and work with MSSNY and the foundation, to enhance physician education in New York State, and beyond.

But, there is no better PMP in the country. And the fact that it -- that none of us can write a prescription for a controlled substance without having to query it, we have a lot to be proud of.

There are many states that have APMP, but it is by no means as comprehensive, and it is not even man -- and it's not always mandated.

So I think we have -- it's a big step in the right direction.

And I echo the Dr. Gharibo's thoughts about being able to see what's going on around us as well.

But I think we have a lot to be proud of.

SENATOR AMEDORE: We do, and that was also brought up, because the individuals who really helped put that database, the programmers, and, really, the brains behind it, were in the room, and we discussed this. And we are leading the way in New York State with the I-STOP, in the United States, New York State is.

So we -- we're proud of that, and how we can continue to improve it, and make sure that it's really benefiting in this situation.

So, thank, you for that.

Yes, sir.

DR. CHARLES ARGOFF: You know, when -- I heard earlier -- so I'm a neurologist by training, and so I'm very nerdy, and I'm very mechanistic-oriented.

We get along, even though he's an anesthesiologist, and that's good.

But, you know, others pointed out earlier that there's a disease of addiction.

And what many of us may not realize, that there are 100 million adults in this country, based upon an Institute of Medicine report, that experience disease of chronic pain, and that disease affects every part of our body, and by no means is the use of opioid pharmacology and opiate medications the answer.

But approximately five medical schools in this country teach an undergraduate medical-school course on pain management.

Comprehensive pain management is not taught.

The average prescriber is not -- so I echo

Dr. Gharibo's concerns about education.

The average prescriber has never had a formal course on pain management.

We could lead the way, and we have so many wonderful medical schools, nursing schools.

Look at this community, those of you from around here, right, law school, Albany College of Pharmacy Health Sciences.

We have so many programs that we could integrate, and pave the way, to showing how we can all work together to help curb disease of both addiction and chronic pain.

Many people, a person comes in, I hate to say it, a certain percentage of people in this room, have both diseases. It's just the nature of being a human being.

And so we need to all be adequately trained to do that.

I got a referral recently from a primary-care physician in Hudson Valley.

And, literally, I presented this to the FDA at a hearing not too long ago as well.

And the basic referral is: This is a 65-year-old woman who's been under our care for 20-- I'm sorry, a 60-year-old woman who's been under our

care for 20 years. During that time, she's had neck surgery, she's had various pain complaints. She's been on opioid therapy for 10 years and has done well. We've tried other things: Nerve blocks. Other medications. Physical therapy. Acupuncture. Just living with it, as you mentioned earlier. But she functions on a stable dose.

Then the tone of the letter in the referral changes.

It then says: Our group practice has been very concerned about the changes in the way opioids are being viewed, and we've decided not to prescribe opiates to anyone who doesn't have cancer. We'd like you to consider taking over this person's care.

I'm -- I see a lot of -- I see about 30 patients today. That's a lot. I start at seven in the morning. I work at an academic institution, but I take care of real people.

I can't take care of everyone.

Chris can't take care of everyone.

We can't -- we need -- 100 million people in this country have chronic pain. Some of them need opioid therapy.

People are shying away from prescribing what may be the best treatment for individual people,

because they're afraid of being chastised, gone after, reported to OPMC, et cetera.

So, we need to find the right balance.

We need to be able to properly treat, both, the disease of addiction, the disease of chronic pain. We need to find what's best for each person, but there's a huge obstacle in this.

And I don't know if your efforts can do anything about this, but I hope they can.

There are views to turn opioid -- there are medicines which are safer than others.

And, by the way, have any of you ever gone and gotten Tylenol?

You know there's a tamper-proof top. Right?

It doesn't mean you can't -- isn't that better than having a kid being able to open it?

Doesn't deter everything.

So, why is it that a payer of health care, not a purveyor or provider of health care, can decide that they won't -- they will choose to pay for a less-safe medicine in a category, because they don't want to pay for it.

How is that allowed in our state?

How is it allowed that a patient has to default to whatever they can afford, and that may be

the most dangerous medication?

Many people who become addict -- who become addicted, they -- patients -- people -- people -- we're all people. Patients are people.

They don't go into a room and -- into an office and say, By the way, Doctor, or, Nurse, I just want you to know I'm a drug addict.

Many of us don't know what would happen if we were exposed to certain substances, and how our nervous systems would behave.

So why aren't we putting forth in New York State, to help curb heroin and opiate addiction, comprehensive pain management?

Meaning that, physical therapy is also important, cognitive and behavioral therapy, learning mindful meditation, all the non-medical approaches, interventions.

This morning I spent -- I know I'm a neurologist. You know, you don't think of neurologists doing nerve blocks, but she knows I do.

I did nerve blocks. I assess people for non-medical therapies through nerve blocks and injections. Those are important.

Why are we not being person- and patient-focused and finding out what's best?

But what's really happening, is because the path -- the way that the medical care is going, is the path of what is paid for. And we have to stop that. And that's leading, that's leading, to heroin and opioid addiction.

If hydrocodone and acetaminophen or oxys are cheap, that's what people are getting in the urgent-care centers right now. Everywhere around here, that's what they're getting, they're getting 20 pills.

I have three children, two of whom have undergone wisdom-tooth extractions. One on Long Island, where we lived before moving up here, the north shore of Long Island, and one up here.

Each of them got 60 hydrocodone and acetaminophen pills.

For -- 60, with -- in those days there were refills -- with refills, because that was the path of least resistance.

But, getting back to the payers: If they are not curbed, let's put -- I hate to be blunt, but I'm from Brooklyn originally, so please accept that.

[Laughter.]

DR. CHARLES ARGOFF: United Healthcare, for example, for example, or a publicly-traded

health-care insurance company --

OFF-CAMERA SPEAKER: Like Blue Cross and Blue Shield.

DR. CHARLES ARGOFF: -- or, you know -- a not-for-profit, that's thing that joke.

But, anyway, any public -- they have a fiduciary responsibility -- I'm not a lawyer, but I think I'm right here -- to their shareholders first.

That's perverse.

They're not providing health care. They're not looking at curbing that, because they don't usually cover addiction services. They're off their doles once that happens.

You see how sick that is?

So they don't -- they actually allow -- they're not going to -- they don't want to invest.

We have a -- the FDA has published guidance for how industry can develop abuse-deterrent opiates.

We have designated both short-acting that -- "short-acting" means they're used -- they only last a couple hours.

Longer-lasting, they can last 12 hours, 24 hours.

We have abuse-deterrent opioids, those which have been proven to prevent abuse, not full-proof, not like the tamper-proof.

But what would you rather: Just anything out there, like, any cap that can be opened by any child, or are we accepting of a tamper-proof approach?

We're accepting of seat belts. Seat belts save lives.

Abuse-deterrent opioids, already, with extended-release oxycodone, which is Oxycontin, there's epidemiologic evidence that since the new formulation, which is considered abuse-deterrent is out there, we now know that we can reduce morbidity and mortality. We can reduce abuse and misuse.

Why -- why are we allowing -- it's -- pain management is not about opioids only. But if opioids still are an effect -- there are many people who need these medications, with cancer or not without -- by the way, there are more people without cancer with chronic pain, than with cancer.

Are we going to discriminate against people with non-cancer because they're not dying?

That's crazy.

But if we do -- if we're talking and focusing

on opioid therapy, just for a second, and there are those therapies which are available, which have proven to be more effective at curbing abuse, can anyone on this panel please tell me why we would allow a non-abuse deterrent-opioid to be sold in this state?

I'm just asking.

If we all want to work together as a community, I need to take care of people and control, God forbid, anyone in this room should have pain that needs pain control, and an opioid might be what would help you.

Do you want me to prescribe medicine that's based upon what's -- you know, not what's best?

Of course not.

So why aren't we focusing on the best and most safest ways to approach this?

We also represent the New York State Pain Society, which was developed several years ago to advance the mission of comprehensive pain care.

And I hope that our comments have been helpful.

SENATOR AMEDORE: Very helpful. Thank you.

And, I kind of understand, me personally going through a recent surgery, and being treated as

such with different medications, and then going through in the healing process.

It is about managing, with the whole process of physical therapy, and pain management, and how we can -- how I can do that without relying on one specific prescription of drugs or pain pills, that then could completely overtake your system very easily.

But there's a lot of people that are needing that extra help.

And, it's interesting, this past Memorial Day, I spoke with a veteran who had back surgery back in 1991, and he's still on all of these various pain medications, the same that were even prescribed to me just six weeks ago.

And I got to thinking, boy, what's the difference between him and me?

Now, the doctors are continuing to give it to him.

And, you know, is there a system or a check in place that needs to be?

And it's one of the reasons why we had this discussion today with the whole I-STOP, in finding out, you know, how we can really target and stop the overprescribing of these drugs.

Yes, sir.

DR. CHRISTOPHER GHARIBO: Just one comment, Senator.

I think one of the problems has been in the last 15 years or so, is that we sort of went through an era where we thought we could treat all pain.

The bottom line is, we can't. We can only limit it to a certain degree, and some pain is to be expected and is a part of our existence, that there needs to be coping mechanisms in place to accept certain degree of pain.

But the patient comes in with the expectation that we could do omnipotent, we can abolish pain, which is just not the case.

SENATOR AMEDORE: So if I stood up right now, you would totally understand that sitting down is very painful for me, and I do need to kind of relieve myself from the pain.

[Laughter.]

SENATOR AMEDORE: But thank you so much for your coming in. It's very helpful, and it's a totally different perspective that we're really not hearing sometimes. And it's all about that little pill that really starts this problem, but it's being abused, and it's not the physician's fault.

But in those instances, there are physicians that are kind of overprescribing, or they are working the system, and they're being caught because of the system, the new database, which is good.

So...

SENATOR FUNKE: I just have one question, George.

And, you know, we can pass a bunch of laws. I guess that's -- I'm new at this.

DR. CHRISTOPHER GHARIBO: Isn't that what you do?

SENATOR FUNKE: I guess that's what they do down here, is they pass a bunch of laws.

But my question is: What's going on within the medical community itself in terms of discussing this?

What's going on in medical programs where docs are being trained right now?

Are there programs in place now where you're talking about this all the time and trying to come up with solutions and better programs and better awareness and -- and that on your own?

DR. CHARLES ARGOFF: So the federal government has mandated education -- has mandated that education be developed -- continuing medical

education be developed -- it's called the "REMS" programs (risk evaluation mitigation strategy programs) -- for various types of pain medications, so that physicians and nurse practitioners, physician assistants, other prescribers, can be adequately better trained.

There -- we -- this weekend we have a three-day meeting in Manhattan, that is open to anyone who wants to go, at the Marriott Marquis, the New York State Pain Society, an annual scientific meeting. There are multiple societies.

I am president of the American Academy of Pain Medicine Foundation, which has launched numerous education programs across the country, and beyond, to do this.

But, it really starts at the level of undergraduate medical education, undergraduate nursing education, where, to the Senator's point earlier, it's not about the little pill. It's about looking at the whole person, getting to know how is he going to recover from his surgery, maybe a little medication, maybe physical therapy, maybe getting up every 30 minutes so he can stretch and feel better.

And, how does somebody -- you learn so much during your undergraduate years in medical and

nursing school and pharmacy school, and I think would you agree that -- too, that that's how you practice, going forward. We need to start earlier, during the development of health-care professionals.

But there are many things that are going on right now.

It's -- it's -- we are seeing nationally, as well, a decrease in deaths.

But what wasn't made, one other point, though, see, even when people are prescribing medications appropriately to non-addicts, people are dieing unexpectedly.

So we have a lot of work to do, because who here doesn't want to have access for themselves or their loved ones for the right medication for you?

And we have to be safer about it, but we have a long way to go.

I don't know if you want to add --

SENATOR FUNKE: Thanks.

DR. CHRISTOPHER GHARIBO: (Unintelligible) Voluntary education has not worked. There are also tens of thousands of physicians that are just not up to date with respect to appropriate prescribing. We need to have mandatory education that can be tied to, for example, DEA registration.

SENATOR ORTT: It would be, if I'm not mistaken, when you go through your CMEs, you have a menu of things you can to take that year to fulfill that requirement.

It could be added to your CME, couldn't it, pain medication or pain management?

DR. CHARLES ARGOFF: It could be like, I can't -- we can't work in New York State without infection control, without child-abuse --

SENATOR ORTT: You make it mandatory, so many hours --

DR. CHARLES ARGOFF: -- make it mandatory.

I know it was just fought, and I don't understand how that -- that's not going to benefit our state.

SENATOR MURPHY: I have to do it with ethics. I need 13 -- I need 12 credits of ethics every 3 years.

You can make it mandatory for --

SENATOR FUNKE: As a Senator, or as a chiropractor?

[Laughter.]

SENATOR MURPHY: I don't know, why don't you tell me, Funk. You should tell me.

But, you know that, in every three years,

there's a certain amount, that you just make it mandatory. That's all.

Well, listen, thank you so much for coming in, and I really appreciate every -- your-all testimony.

Next we'll have Mickey Jimenez --

SENATOR ORTT: Jimenez, right?

MICKY JIMENEZ, RN, BSN: Right.

SENATOR MURPHY: Jimenez? Okay. I'm sorry. -- and Julie Dostal -- Dostal.

See?

Sorry. I'm bad at pronouncing names.

Well, thank you very much for coming tonight.

MICKY JIMENEZ, RN, BSN: You're welcome.

SENATOR MURPHY: Would you like to start?

MICKY JIMENEZ, RN, BSN: Sure.

Good evening members of the Senate Task Force.

Let me begin by thanking you all, and all the members of the Senate and your staff, for the incredible effort involved in holding this, and all the other forums across the state.

It is an incredibly timely opportunity for me and other providers in the Capital District treatment and recovery community to discuss a

problem of staggering proportions: the explosion of heroin and opiate addiction in the region.

My name is Migdalia Jiminez, also known as "Mickey," for short, and I am the regional director of Camino Nuevo, an Acacia affiliate of the Capital District, of the only bilingual chemical-dependency program, offering both counseling and methadone treatment.

Acacia Network is an integrated-care organization with offices in New York City, Buffalo, and in Albany. It is the second-largest Hispanic not-for-profit organization in the country.

The organization's mission is to partner up with its community, lead change, and promote healthy and prosperous individuals and families.

The mission is realized through three main delivery systems: primary-care health care, behavioral health care, and housing.

With 63 years of combined experience, the Acacia Network has demonstrated ability to scale high-quality, comprehensive services for thousands of residents. The network operates 3 methadone ambulatory treatment programs and 1 methadone residential treatment program for over 1100 people every day.

While we distinguish our services from other providers with the regards to our language and cultural competency, our services are available to English and Spanish-dominant speakers alike.

And while we have been open slightly more than a year as an outpatient counseling, it's only in the last five weeks that we opened our methadone clinic here in Albany, and we have, as of this week, 100 people already in our clinic.

I have been leading the effort at Camino Nuevo, "new path" in English, for the last six months; yet, in the short span of time, I have witnessed firsthand how great the need for treatment in general, and how acute the need is for Spanish-language services in particular.

My career in health care spans some 30 years. I am a registered nurse. I have a bachelor's in nursing, and some graduate work in business.

Needless to say, I am no stranger to the world of heroin addiction, with all of its attendant problems, whether medical such as HIV and AIDS, hep B and hep C, or social, such as poverty, low educational achievement, or domestic abuse.

When you come from an inner-city minority neighborhood, as I did, Williamsburg, Brooklyn, you

see it all around you, from the time you get your first warning from your parents or siblings saying, Stay away from a particular corner, or, Look out for the so-and-so who is known in the neighborhood as a dealer.

And that was the public's perception of the problem; that is, this is mainly a problem for certain people or certain communities.

But the truth was almost never so.

Heroin has been an American problem for at least a century. The difference now, is that it has bled out from these communities into the suburbs and rural areas with all deadly force and unpredictability of a hurricane.

There are those more imminently qualified than me to discuss the numbers and the data. There is also no lack of study, either written or being written, that can paint the dire picture with greater effectiveness than what I can offer.

But having considered these questions that have -- that are the subject of this hearing and all of its elements, it is my opinion that all of our efforts will fall short unless we change the paradigm and transform the conversation.

In fact, we need a radically different

approach to this problem, and for that we need new vocabulary.

Instead of waging a war on drugs, we need to begin a campaign of compassion.

Instead of winners and losers, we need to be pursuers of dreams and goals, trying to, each day, to make it to the next without risking our lives on the main streets of our cities, towns, and villages.

We need to go from bleakness of incarceration to hope of transformation through treatment.

The stigma inherent in the vocabulary of warfare makes people soldiers locked in mortal combat.

In many neighborhoods of color, it makes people view our police force, officers of the peace, an occupying force instead of what they should be, members of the community with a vested interest in helping its residents.

If we are to lock in a war on drugs, then why are so many casualties just ordinary citizens, and not narco traffickers or money launderers?

So many years after the war on drugs was declared, it's all like we're all become prisoners of war, unable to escape its effect or escape from becoming collateral damage.

I would like to conclude by saying that I have a fairly unique perspective on the problem of heroin and opiate addiction.

Beyond the confines of Camino Nuevo's clinic I have become so fond of, I am a mother of two law-enforcement children. My son is a New York State police investigator, and my daughter who works for the Attorney General as an investigator. Both have firsthand experience with this issue.

I would rather they be part of a campaign of compassion than soldiers in a war of Pyrrhic victories.

Addiction is a disease, and those afflicted and those who love them married out compassion.

I have additional exhibits for your consideration.

Thank you.

SENATOR MURPHY: Thank you so much.

Julie.

JULIE DOSTAL, Ph.D.: Thank you, Senators.

Thank you very much for inviting me here tonight. I'm so glad to be here.

Thank you for convening this very, very important hearing.

And I really want to say, thank you, for the advances that were made, based on the last rounds of hearings.

I would also be very remiss if I didn't offer a big thanks to my Senator, Senator Seward, who has been very, very supportive in my area, in helping us work on this epidemic.

So I wanted to pass that along.

I am Julie Dostal. I'm the executive director of the LEAF Council on Alcoholism and Addictions in Otsego County.

Tonight, though, I am here representing CANYS (the Council on Addiction of New York State). I'm the president of that organization.

The councils are an interesting part of New York State history. Actually, New York State has the most extensive council system of any state in the United States, and it is something worth being very proud of.

Right now, currently, there are 37 councils in New York State.

And back in the beginning, in 1988, OASAS had the foresight with New York State to support community members and the New York Council in establishing councils all around the state, and the

councils have been working hard ever since.

We do currently have 37 members in CANYS that cover the state, and we are the folks that are out there doing the work; a lot of work, not all of the work, but we are doing work out there.

And we are happy to stand in the proud tradition of NCADD (the National Council on Alcoholism and Drug Dependence), as was mentioned earlier, founded by Mrs. Marty Mann, who was the first woman to become sober in AA.

So it's a wonderful tradition that we are happy to be out there working on.

We are doing the work; we are happy to be doing the work.

Councils like to think of ourselves as the friendly front porch to the community, or for the community, into the prevention, treatment, and recovery system.

When people need help, they call us, they say, What do we do? Where do we go? How do we find help?

And, in doing so, we are able to do a lot of great work with families, and with youth, and with schools, and people in our community. We are out there, doing, and working with opiate task forces in

nearly every community that we're in.

We are helpful in helping to provide Narcan trainings.

We are in the forefront of providing universal prevention.

I'm going to get back to universal prevention.

We've been working with the Combat Heroin media campaign.

And, we do community town halls. We bring the community together for discussions around opiate and heroin.

We consult with local elected officials.

And, we are able to provide education, information, and referral to family and individuals who need and want help, and are ready to take that step.

We have the privilege of being the neutral door. We don't have a horse in the race. It doesn't matter to us if people go to this treatment center or that treatment center; if people get this medication or that medication.

What matters to us is that people have a pathway to recovery.

This is the system that, tonight, I'm very

honored to represent. And I want you to know and, I want all of our elected officials to know, that the Councils of New York State stand ready to partner with this Task Force to do the work necessary to save lives.

And that's why we're here.

I want to step back for just a second to that idea of universal prevention.

I'm a preventionist, that's what I do.

I worked in intervention for a long time on the mental-health side. I worked in a crisis-intervention unit in an emergency department.

And the idea of being able to prevent something before it ever started, called my name.

And that is what we do in the field of prevention.

It's really hard to prove prevention, it's really hard to prove what hasn't happened, but that's the work that we do. And we want to move way back and try to stop this heroin and opiate crisis back at the kindergarten level before those kids ever have to face it at 13, 14, and 15 years of age. Unfortunately, some younger.

Here's what I know: For every dollar spent on prevention, $7 is saved on the associated costs

of addiction.

Here's something else that I know:

Based on the Shoveling Up II report from CASAColumbia, big, big report, it reports that New York State spending on addiction and risky use constitutes 21.6 percent of the state budget. That constitutes $13.4 billion spent on addiction in New York State.

This is from the CASA II report.

I am very sad to say, that 2 cents of every one of those dollars is spent on prevention and treatment. 98 cents of those dollars goes to the consequences of addiction.

The science informs our practice in prevention, and what we know, is that universal prevention moves the dial. An effective long-term view of the opiate crisis can only mean that every child gets prevention, early, and often.

Currently, with state resources, we are only -- now, we're 37 councils, and then all the other prevention providers, I think there's a total of 300 prevention providers that are OASAS-funded providers.

Currently, with those providers, we are able to reach only 8 to 12 percent of New York State

children in any given year.

8 to 12 percent.

To move the dial, we, as New York State, have to do better. We have to do better at that.

Also, to go to where this particular crisis has taken us, I am a preventionist, I really want to look at preventing a problem before it ever starts.

In my community, I've had to redefine a little bit what I do, because, right now, I find myself, my agency finds ourselves, our community finds ourself, in the position of having to prevent death. Not just prevent addiction to begin with, but to prevent death.

And I was able to submit written testimony from my agency, and I believe that's submitted.

And -- so that was before I was asked to speak as the president of CANYS.

So I'm going to share the last few paragraphs of that testimony, because I believe that they apply to circumstances that most councils find themselves in.

The people of our community are dying because of lack of access to pathways out of their addiction.

The startling facts in my county are:

That we have zero Suboxone prescribers for the general population.

We have zero methadone prescribers for the general population.

We have zero inpatient beds within the county -- within my county.

And we have zero sober-housing options for people in crisis or people coming out of treatment.

When a person with addiction reaches out to councils for a referral, the only quick option many of us have is to offer them outpatient treatment.

We are very fortunate to an excellent OASAS-funded outpatient clinic in our area; however, for the opiate-addicted individual, outpatient treatment with no withdrawal medication leaves them with two gut-wrenching choices, and this is what the recovering community tells me:

Their choice is:

To "sick it out" and deal with the horrendous withdrawal, which an option that is universally feared by the addiction population;

Two: Find a way to get enough drugs to stave off the withdrawal.

People in recovery have shared with me that this last option often includes committing a felony.

I took a quick poll of my peers and found that many counties are in the same situation as Otsego.

I do not have the full picture, but I can say, without reservation, that in a state with resources like New York State, even one county without access is too many.

We would -- would we tell a person with diabetes, who has no transportation, that they had to figure out a way to drive more than an hour to get their insulin?

Would we limit a doctor, who sees diabetics, to 100 patients?

Would we -- would a doctor refuse to give a patient their insulin because they weren't being compliant with their dietary restrictions?

The answer is "no."

Addicted people should have the same access to health care as people with diabetes and other chronic diseases.

Our system pushes people to illegal activity just so they won't get sick.

It is time we stopped treating addicts like inmates, and began to treat them like people with an illness who deserve equal access to treatment.

So what do we need?

One: We need universal, evidence-based prevention.

Number two: We need equal access to all paths of recovery.

Number three: We need safe and sober housing for people who want recovery; affordable housing.

And, number four: We need no limits on doctors who want to treat people with addiction.

Thank you for your time and consideration in hearing my testimony.

We are heartbroken in our area. Too many are dying, and too many families are impacted in extremely negative ways.

Councils stand ready to stand with you as we work to solve this problem together.

Thank you.

[Applause.]

SENATOR AMEDORE: Thank you.

Julie, could you go back and hit Point Number 2?

JULIE DOSTAL, Ph.D.: Point Number 2, yes, sir.

Equal access to all paths of recovery.

Whether that includes inpatient treatment,

outpatient treatment, medication-assisted treatment, straight from use to recovery without treatment, sober housing...all of those things. All pathways.

In my field of work, and with councils, we respect all paths of recovery.

And we think that, since it is an illness, that the pathway to recovery should be between a patient and their doctor.

SENATOR AMEDORE: You know, one of the things that we looked at during the budget process -- I chair the Alcohol and Substance Abuse Committee -- in speaking with OASAS and the Commissioner, you always hear these stories that there's long waiting lists, and there's long waiting lists for treatment centers and for a bed.

And then you talk to others, and there's no waiting lists. As a matter of fact, we got all kinds of beds that are open and vacant.

And so, you know, in this process, we have to kind of divert our resources, because, as you've said, there are counties that don't have anything.

And I just don't think that it's right to have families or a patient having to travel 4 hours to get to a bed, and then stay there just for 7 days, or maybe 14 days, and think that the problem

is solved and it goes away.

So, we are working on that.

JULIE DOSTAL, Ph.D.: Thank you.

SENATOR AMEDORE: It's something that our Committee, I'm committed, as a Chair, to try to make sure that we have the funds, but the bed's available across the State of New York.

JULIE DOSTAL, Ph.D.: Thank you very much.

SENATOR AMEDORE: And I know, Senator Ortt, he chairs Mental Health.

Correct?

SENATOR ORTT: Yes.

SENATOR AMEDORE: He and I have had some field trips as well, and -- in looking at this problem.

So, we're working on it.

JULIE DOSTAL, Ph.D.: Thank you.

SENATOR AMEDORE: You're welcome.

I'm sorry, Mickey, if I missed -- did you already --

MICKY JIMENEZ, RN, BSN: Yeah, I did it.

SENATOR AMEDORE: Okay.

Thank you so much for attending and being here.

Your submitted report and testimony is much

needed. Appreciate it.

SENATOR AMEDORE: At this time, I'd like to call up, Robert Lindsey, CEO of Friends of Recovery, and, John Copolla, executive director of Alcoholism and Substance Abuse Providers in the state of New York.

ROBERT LINDSEY: My name is Bob Lindsay. I am the CEO of Friends of Recovery - New York.

We represent the voice of individuals and families living in recovery from addiction, families living with active addiction, families who have lost a family member to addiction, or people who have been otherwise impacted by addiction.

I want to thank all of you for your leadership in hosting these hearings, and I can do that at length, but I really want to focus on the comments.

Number one, I am absolutely living proof of the value of New York's prevention efforts.

I started in this field as a volunteer when I was in college, connected to a local Council on Alcoholism and Drug Abuse. I chaired a local narcotics guidance council when I was still in college, and there I learned that addiction is a primary, chronic, progressive, fatal, if untreated,

and genetically-predisposed, disease, like other chronic diseases which run in my family, heart, diabetes, and cancer.

And, for me, since 1976, made the choice not to use alcohol and other drugs, and the reason's simple:

I have 11 family members living life today in recovery from addiction, ranging from a cousin who is 36 years in recovery, to my brother-in-law who is now 30 days in recovery. They are nurses, corporate executives, teachers, businessmen, musicians, and moms and dads. None of them ever chose to become addicted.

Plain and simple, their body responded differently to the effects of alcohol and drugs than other people.

It has to be overwhelming for you to sit here today, and as you have in all the other hearings, and to listen to the pain and the suffering, and the scope of the problem. It is so far-reaching.

It must feel at times that it is hopeless, and you must ask yourselves: Can we make a difference? Is there hope? Where do we begin? How can we help?

The reality, it is all about the miracle of

recovery.

I have been privileged to help, both directly and indirectly, thousands of individuals and families, and much of that was doing direct clinical work.

And I loved it, and I was good at it, but I stopped doing it, because I saw too many people die, not because we couldn't help them, but because what they needed was not available to them, and decided the policy is what this is really all about.

Fundamentally, we've got to change the way we do this.

It is time to stop investing in the problem: active addiction.

Time to start investing in the solution, which is all about recovery.

The hearing today is focused around heroin, but as Deb so well said: Heroin is the battle. Addiction is the war.

This is not just about heroin.

And, again, we cannot repeat what we did with drinking and driving. We've been effective. We reduced 28,000, down to 10,000.

But the reality is, now, 88,000 people a year die from alcohol-related deaths. 44,000, all other

drugs. 15 people per hour.

22 million people live with active addiction.

$57 million per hour is the cost that you and I pay as taxpayers for the consequences that Julie talked about.

The solution, real simple, is all about recovery.

23 million people today live life in recovery.

The world at large is clueless to that fact, because they do it quietly, they do it silently, they do it in secret, in too many cases.

They have shifted from being a tax burden, to a taxpayer.

78 percent went on to further their education, in their recovery.

28 percent have started their own business, in recovery.

87 percent vote.

84 percent volunteer in their community.

They are breaking the cycle of addiction in their family.

They've reduced arrests, from 53 percent, to 5 percent.

On, and on and on.

That is the value of what recovery is all about.

With one individual, lifetime savings of $3.2 million to $5.2 million. One person, that's what we're talking about.

Next point: Family, family, family.

This is a lot about facts and data, but this is really about heart.

Plain and simple, hearts are breaking all over New York State. Families are absolutely desperate for a neutral resource that they can go to to get the information they need as primary client; somebody to sit down with me, help me understand what addiction is, how it's affected my family member, how it's affecting me, and what we need to do together.

So frequently, they are viewed only as an attachment to the patient.

They need to be seen as primary client.

Next one: We need to change the conversation from the drama and the chaos of active addiction, to the hope and health of recovery.

And to do that, Friends of Recovery - New York, with support from OASAS, is launching a groundbreaking initiative to educate and engage

millions of New Yorkers and families who are living in recovery, families who have lost family members, and people who have been impacted by addiction, to really give a voice to recovery.

For decades, shame and stigma have kept too many of us quiet.

We will be silent no more.

Stigma and discrimination:

Stigma and shame prevent millions of individuals and families from seeking help.

We are dedicated to breaking down the barriers that are created by stigma, that result in discrimination, and that discrimination plays itself out in policy, whether that be access to treatment, whether it be in housing, whether it be education, or employment.

So, our call to action, we want to be very specific here in terms what have we want to recommend, and I've included here a very interesting quote from the police chief in Gloucester, Massachusetts.

He says, "I've never arrested a tobacco addict, nor have I ever seen one turned down for help when they develop lung cancer, whether or not they have insurance. The reasons for the difference

in care between a tobacco addict and an opiate addict is stigma and money; petty reasons to lose a life."

So recommendation number one, is that it is all about making this a priority in terms of funding.

OASAS is grossly underfunded in terms of dollars and resources.

The increase in the mental-health budget this year alone was equal to the entire budget of OASAS.

Plain and simple, we are not making this a priority, when we're spending $4.4 billion on developmental-disability services, $3.9 billion on mental-health services, and less than $600 million, total, on alcoholism and addiction services.

So, what we need to do:

Number one: We need to expand support for public awareness of addiction and recovery.

The Combat Heroin campaign has been terrific. It has raised awareness of the problem, increased hope for recovery, providing information about how to get help. But, we need to invest in this campaign, going forward, and we need to make it available all the time.

The only time that somebody knows what

resources are out there is when they start looking.

So if we don't make it available all the time when they need it, they may not have any idea where to go or who to call.

Family education and recovery support:

Again, as I said earlier, families are desperate for that resource that is neutral, as Julie referenced, in terms of the role the councils play.

Years ago, I met with a CEO of a Fortune 500 company, who came to me because of his wife's alcoholism and addiction, and he said, I don't have a clue as to what to do.

And I sat with him and I said, Here's what alcoholism and addiction are. Here is how your wife has been affected. Here is how it's affecting your family. Here's what we need to do, together, going forward.

He said, My father died of alcoholism. My brother died of alcoholism. My wife is dying of her addiction. I have been to psychiatrists, social workers, clergy, and everybody, but nobody has ever helped me understand, until now, what we need to do.

And his wife is now 14 years in recovery. They have a son who is now six years in recovery,

married with three children.

We need to expand access to addiction treatment through insurance coverage.

Insurance pays all of the consequences for someone's active alcoholism and addiction, and, regrettably, far too infrequently, pays to actually provide treatment for the disease, which is the only way out.

Next one, physician education, we heard about it before.

We need to pass Senate 4348, requiring that physicians receive education on addiction and prescription medications.

We need to provide more access to medication-assisted recovery: Suboxone, methadone, Vivitrol, etc.

Regulation of sober-recovery homes.

We have a major crisis going on in New York, if you read "New York Times," with an outrageous organization that is providing services to people in recovery, and not providing them the help and support that they so desperately need.

For those who go through a reversal with Narcan, we need to get them engaged in treatment.

And then my last point, is that we need to

invest $30 million in recovery support-services infrastructure.

One of the biggest gaps in the system, is that when people leave treatment, when people leave correctional facilities, they do not have the supports needed and necessary to support their ongoing recovery in the community.

I lost a very good friend this last year, and his son, both, because of their addiction, and this was exactly the reason: not the support in the community they needed.

We need local recovery community organizations, which we are committed to developing. These are individuals and families that want to give back and help others.

We want to build recovery community centers in communities across the state.

And we need to engage peer recovery support across the board, because these are individuals with lived experience with alcoholism, addiction, and recovery, either as an individual or family, who can provide an invaluable role of support throughout.

So my last comment, and this comes from one of the women sitting behind me who testified at a Recovery Talks Community-Listening Forum, that four,

hosted in Saratoga on April 30th.

And she says, "Finally, recovery is made up of many miracles, but finding a place for help should not have to be one of them."

Thank you very much.

[Applause.]

SENATOR AMEDORE: Great testimony.

Rob, where did the $30 million come from.

ROBERT LINDSEY: The $30 million, in terms of the reinvestment --

SENATOR AMEDORE: Is it a number that -- is there data backing it, or is it just an idea, or a wish-list?

ROBERT LINDSEY: No, I mean, we do have some data that we can back it up with.

Essentially, what we're saying is, we need a recovery community organization built in every county.

And what we're doing on this one in particular, in many cases what we're doing, is partnering with the local council, which has been a voice in that community for many decades.

And what we're doing is, becoming a program of the council. That way, all the volunteer life and energy behind it gets devoted to going out into

the community and doing the work.

So the $30 million is about building the recovery community organizations, and, opening the recovery community centers.

SENATOR AMEDORE: Okay. I get the use for it. I just -- $30 million, when you're dealing with, sometimes, a state budget, and you're looking at billions of dollars. Or some people say, when you look at OASAS's budget, like you said, it's grossly underfunded. Grossly, without question.

And if the federal government even gives -- passes down 9, 11 million dollars, $30 million seems -- you know, seems like a lot of money, on paper here, for the whole entire state.

And that's why I asked where the 30 --

ROBERT LINDSEY: Well, I think, ultimately, the question is: Do we care about people that suffer from alcoholism and addiction: yes or no?

And if we do, we have got to put up the money, plain and simple.

I mean, it's really that simple.

[Applause.]

ROBERT LINDSEY: And these are individuals, many of them who are here, we're paying our taxes like everybody else. And we're saying, this is a

priority, and we've got to back it up.

I mean, that's really where we are.

That's the choice we have to make.

SENATOR AMEDORE: Great. Thank you.

ROBERT LINDSEY: You're welcome.

SENATOR AMEDORE: John, how are you?

JOHN COPPOLA: Good, good, good, Senator.

You know, I want to start my remarks, first, by just pointing out, Senator Amedore, Senator Marchione, Senator Murphy, and Senator Ortt, as I was listening to the testimony, I was thinking to myself, none of you are responsible for the system that we have in place right now. You're all relatively new to the Senate, and, it puts you in an unenviable position, that if you wanted to champion something, you know, maybe you would be up against whatever the rules of the -- you know, the Chamber are, whatever the rules are in the Assembly, or whatever, you know, the dynamic is between the Governor and the Senate and the Assembly.

And, so, to think about, you know, something landing on your laps like this crisis, and having to sit through the testimony that you sit through, if you said, Okay, so, this is a crisis, it's an epidemic, and we want to do something about that,

right, and I would go immediately to your question, Senator Amedore, about the $30 million, which, again, as I listened to Bob, think about $30 million and those other budgets, is a rounding error.

It's a rounding error.

And so -- but you're so correct, when we reduce the conversation -- and it should never, ever, be reduced to this -- when we reduce the conversation to, What is the current OASAS budget? And what is the current system? And the Governor's 2 percent cap, and we got to be mindful of that, and we can't do something in OASAS, we can't do it in other places, we're now subscribing to an absolutely horrific way of thinking about, you know, this issue.

When Julie gave her testimony, and she went through this litany of services that are not available in her community, and we think, okay, so how do we stretch that just a little bit, and think about some family that needs those services? And then, physically, what do they have to do?

Mom gets on the phone, dad gets on the phone, we start calling the people that we know. We start, you know, looking.

And so what does that feel like, and, what

does it feel, like that person who is ready for treatment, and there is none anywhere close to home?

And, so, this is dropped in your laps, day one, when you walk into the Senate.

And so, you know, on some level, what can we do to help you?

All right?

But it is, totally, 100 percent, unacceptable what we're putting on your plate and asking you to sort of do a report to fix this. Right?

So I think that, you know, it's a little ridiculous to talk about $30 million.

But when we go to Julie's example of what it's like in our county, and we start thinking and start asking Bob, So, Bob, tell us. Right?

Bob, you tell us what we have in recovery services; not, OASAS, please tell us what you have in services.

Because OASAS is going to tell you about the good work that they've done. They're not going to tell you about the ridiculous amount of work that still remains to be done.

SENATOR AMEDORE: They're the ones that say, there's is no waiting list.

JOHN COPPOLA: Right. So --

SENATOR AMEDORE: There's no empty beds.

JOHN COPPOLA: -- Senator -- Senator, let's talk about that for a minute. All right?

Let's talk about that.

So in your backyard, right, I get a phone call.

I know the system, I know the names, I got the phone numbers.

Somebody calls me and says, I got a 23-year-old, who's addicted to heroin, who wants help, and wants it now.

My first question is: Where are they?

Part of me is hoping that they're in jail, because that will buy me a little bit of time, you know, to see if I can find a bed.

So I call Hope House. Hope House had a waiting list at the time.

I called Hospitality House. Hospitality House was full.

This was somebody who has been in and out of treatment multiple times, and my instincts said to me, long-term residential treatment is what this person needs, or, or, medication-assisted treatment.

What is the waiting list at Whitney Young right now?

Acacia Network comes to Albany, God bless them, they open up a clinic, and we have 100 people, did I hear that, in the first month?

MICKY JIMENEZ, RN, BSN: Five weeks.

JOHN COPPOLA: Five weeks, 100 people.

Okay. So, if we simply say, what is the minimally acceptable level of services for us to have? Right? And, then, how do we construct that system?

So what we don't do, is we don't wave a magic wand at OASAS and say, Okay.

So what we do --

And I hope that you're all around for a long time to be working on this over the course of time.

-- but, how do we build a system that is okay?

So, Senator Amedore, it is not okay for anybody to tell you there's no waiting list, because if you scratch below the surface, we're playing games with words.

Crouse Hospital in Syracuse has a waiting list of over 300 people.

As far as I'm concerned, there is no conversation about why, right, because you're going hear 15 reasons why we have a waiting list, and why

we need to jump through 8,000 hoops to create at least some additional treatment for the folks.

Right?

So if the conversation was not about, why do we have waiting lists in Syracuse? but, how do we create treatment on demand in New York State?

How do we make sure, as Julie pointed out a little bit earlier, prevention, right, what resources are currently being committed to prevention in New York State?

How does that compare to resources that were committed 10 years ago or 20 years ago?

The federal government bailed on New York State and the other 49 states when it eliminated safe-and-drug-free schools. Right?

So was there an alarm that went off in the Capitol, and we said, What can New York State do to fill the hole created in our prevention system?

No, no, there wasn't.

No, there wasn't.

So we have about a third to half the number of school-based people in our prevention system right now that we had back in the '60s during that heroin crisis, and during the '70s.

So we have a depleted workforce doing

prevention in our schools and communities, and we -- and at a time when there's this demand.

Right?

So, again, it's unacceptable.

It's a bigger problem than we're going to solve by waving a magic wand, but, I think if we have a conversation about what each one of you in your district, right, just in your district, be selfish about this, what is reasonable for the people in your district?

What do you want in the way of prevention?

What do you want in the way of treatment?

And what do you want in the way of recovery supports?

I don't think $30 million is going to give us a recovery center in every one of the counties, and in some reasonable distribution on Long Island and New York City, Rochester, Syracuse, and any other place where we have a high concentration of folks.

Right?

But, again, I think there's an academic question here about, what is reasonable?

Right?

So what is a -- I think this is a fair question, I think: What's reasonable?

What's the reasonable distance to drive every single day to a methadone clinic to get your medication?

What's reasonable: an hour? two hours? three hours? four hours?

I mean, some people do it every day, three hours, and four hours, one way. Right?

Okay. So that's not reasonable.

It's indefensible, and it's not acceptable.

Right?

So I would just suggest that, as it relates to waiting lists, there should be none.

So the question is: How do we eliminate all of them?

And I'm not -- you know, I don't think we should be interested in whether we're talking about licensed capacity or treatment capacity or the census. These are words that are code words for regulations and a bunch of other things that, frankly, I don't think the moms and dads in this room who have lost children, who haven't been able to get their kids in, I don't think they could give a darn about anybody's census or license capacity or anything else.

But when somebody needs treatment, how do we

get them in, and what's reasonable?

Right?

Again, so I would just like to, sort of, frame the question there.

I would like to talk about one specific issue that hasn't been touched on tonight, which is -- and, again, the things I'm talking about, in my view, are not acceptable and they're indefensible.

So when Governor Pataki was governor, he had a brilliant idea, that we should create more community-based detox.

Why?

Well, because not everybody who was being detoxed in a hospital setting needed to be in a hospital setting.

So the idea was, to create this less expensive and more appropriate community detox system, so that not everybody who needed detox would have to go into a hospital if there wasn't a medical need for it.

So what do we have 20 or 30 years later?

We have less community detox. Less, not more. Less community detox.

And in the wonderful programs that we've just sort of constructed to drive down Medicaid costs in

New York State, only 4 of the 26 DSRIP projects have detox as one of the main projects that they're working on.

So -- so what we could easily do, is take a look -- and, again, it's hard for me to imagine that we wouldn't want to have some kind of detox resources also available in every county in the state, within driving distance, so the police, et cetera, could drop people off and let them get detoxed in a community setting.

So, again, I would sort of leave that on your laps as a reasonable topic that's been talked about for years, and it's not acceptable for us to have a conversation about why we haven't solved this problem.

Right?

We've come up with rates that are horrible. There is no incentive for people to start that business in the first place.

And, again, if it's less expensive than being in a hospital, why in God's name wouldn't we give people the rates they needed to pay their expenses to provide the service?

Right?

So if people go bankrupt -- and we had a

meeting in Senator DeFrancisco's office.

Representative from Crouse Hospital, representative from Syracuse Behavioral Health Care, both of whom do detox in the communities, both of whom said to Senator DeFrancisco, We will be closing our community detox programs.

Why?

Because they're sucking the money out of our whole agency. It's a service that's losing money, and it's just draining the resources for our organization, and we're not going to be fiscally viable.

So that's not acceptable.

And I think he recognized that, and I think that's something we really have to look at, because what parents are being told, is it's not medically necessary to admit your child to the hospital, or, what adults are being told, your husband or wife, it's not medically necessary to admit them to a hospital. So what -- and, we don't have a community-based alternative.

So where do you go, and what do you do?

You get arrested.

You know, please, God, you get arrested, and you detox on the floor of your cell, maybe. Right?

So, again, I would just like to suggest that there are a host of unacceptable things about this system that you inherited. It does not -- you did not create it.

And I'd like to think that you each will make a decision that somehow you'll find a way, when you do whatever report you do, that you're going to be the champions of whatever the recommendations are that you make, and to the -- you know, to the extent that some of them might not be politically correct, right, in terms of budget recommendations.

You know, I mean, I remember one of the things I learned, and I'm -- I'm just as guilty as anybody who works in any of the chambers, you know, this Albany lingo that we use. Right?

Will our budget request -- and this is something we talk about: Will our budget request pass the "laugh" test?

Right?

So we make a reasonable request for support for people who have addiction, and we have to figure out what the "laugh" test is.

You know, what's the number, you know, the magic -- so there is no science to this number, so what's the number that's not going to be -- that

will sort of fly under the radar, that maybe we can work with you-all to try to squeeze out of the budget?

Right?

That's not acceptable when we're talking about a crisis.

So I will end my testimony here by saying, you know, I have testimony from the New York Society of Addiction Medicine.

They're very concerned about physician education. You heard about that a little bit earlier.

There are folks who are really looking at the possibility of mandatory physician education so that we're not prescribing inappropriately, and that's something I think really deserves attention.

The whole access to addiction medicine is something that the society is concerned about, particularly addiction medicines, et cetera.

Bob mentioned the insurance issue, and I'll leave that alone.

I, again, would suggest that your final report be balanced; that you talk about prevention, you talk about treatment, and you talk about recovery support, and that we really look at, you

know, what is there that we need to do in each of our counties to make sure we have a comprehensive continuum of services?

Thank you.

SENATOR AMEDORE: Thank you, John.

[Applause.]

SENATOR AMEDORE: You're right, we did not -- we inherited this.

But I can tell you that this team up here has already been willing to stand against status quo in Albany, in many different ways.

[Applause.]

ROBERT LINDSEY: Just one point I want to make, in terms of the myth of the waiting list.

We send thousands and thousands of individuals out of New York State for treatment because it's not available here.

When families hear "wait list," they say "unacceptable," and they send their kids to Pennsylvania, to Florida, to California.

When I was at the Betty Ford Center, our number-two source of referral was New York State.

It's unacceptable.

It is absolutely unacceptable, because the capacity to put together a continuum of care, when

we're sending people two or three thousand miles away from hope, is very, very problematic, to say the least.

JOHN COPPOLA: And just one other final point.

You know, when you start thinking about adolescents, or you think about women with children, senior citizens, you know, to what extent are there specialized services available, not necessarily in every community, because that might be a little excessive, right, if we don't have enough of a population in that particular area?

But at least, regionally, to have services available for senior citizens who have addiction issues, for women, for young adults, young working adults, right, who have addiction issues.

These are all important issues for to us think about.

SENATOR AMEDORE: Certainly are.

Thank you.

ROBERT LINDSEY: Really appreciate your support.

SENATOR AMEDORE: Next up we have, Lisa Wickens-Alteri, and, Patty Farrell.

Now, the titles I could say are "moms."

How's what?

And Lisa is the president of Whiteman, Osterman & Hannah, Health and Human Services.

And, thank you for being here.

LISA WICKENS-ALTERI: Hi. Good evening.

So I'll try to make this brief. I know that we're losing people quickly.

I want to thank you for being here, and having this, the Task Force.

I've been involved with this, and was happy -- Senator Marchione actually invited me last year to speak, and was thrilled some of the legislation got passed last year.

So I did bring notes so that I wouldn't get too emotional.

So I'm a mother of an individual with substance-use diagnosis, currently in recovery.

I'm a registered nurse, and, formerly, I'm the deputy director of the Office of Health Systems Management for the Department of Health.

My role was oversight of many divisions, including, but not limited to, surveillance of hospitals, nursing homes, bioterrorism, health-care reimbursement...the list kind of goes on and on. It was a big job, and it was one of the reasons I left.

The other reason was, because I couldn't afford to get my son treatment.

I have told my story too many times to recount, but my purpose here has been to raise awareness of substance use, specifically of opiates.

Without explaining the horrific stories we went through, I believe the following illustrates our experience with addiction.

I looked into your eyes, I watched your gait, and I wait for the nod. I count your respirations, take your pulse, and keep watch through the night.

I attempt to listen to your phone conversations, not wanting to know, but afraid not to listen, so I can stop you, maybe protect you.

The hospital calls. You were found not breathing. I rush to your side. I rub your sternum to keep you breathing.

You made it for now, but what will tomorrow bring?

10 years.

My family and I spent 10 years living this scenario over and over and over again.

And I mentioned to you, I was the deputy director of the Office of Health Systems Management. I knew all the people in the hospitals, I knew the

people across the country, and I worked with CMS on a daily basis, but we couldn't get answers.

I lost a stepson to suicide because of his addiction.

When I was told, "You need to come," by the police, "but you need to bring a ski hat before they'll let you see him."

This is the disease that is just as deadly as heart disease or cancer.

The purpose of this forum is to hear recommendations regarding raising awareness, treatment options, preventing addiction, and informing people of the dangers of drugs, and, what action can our state and communities take to prevent potential drug-related crimes and keep heroin off the streets?

First, this forum needs to continue.

So, again, I thank you, and I commend you for your efforts.

Last year we began to share our stories, because people in the suburbs of New York State didn't believe it was happening in their backyard.

It is; it continues to do so.

Recent headlines point to the fatality of using heroin laced with fentanyl.

Some recent studies indicate that the peak of this heroin epidemic isn't going to reach until 2017.

So raising awareness needs to continue.

Last year we passed a comprehensive set of laws that addressed barriers to treatment, improving public education, inclusion of educational programs in our schools that are specific to popular drugs in our communities and updated every three years, increased naloxone, for instance, just to name a few.

That education that we had said we need, comprehensive education, based on developmental levels of the children, and based on the drugs that are in vogue in this time, still hasn't happened yet.

I believe we need to continue to empower change, and charge our communities and leaders and parent advocates, to give them the tools that they need to coordinate positive forums like this one.

We need to organize and hold forums that are specific to what our communities are asking for, including topics such as:

Where do I go to talk to someone about substance abuse for myself, my spouse, my child?

Are there pediatricians with experience in this area?

I have a 15-, 16-, 17-year-old at home that as abusing substances. What do I do to protect myself, my family, and my home. What are my options?

We need to develop a warm hotline.

We have a hotline. You can call and you can find out, when you call, and, you know, where are the treatment centers? and things like that.

But not a day, a week, goes by that I don't get an e-mail.

I've gotten emails, I've gotten calls, from Senators, Assemblymen, from across the state. I've gotten calls from government-relations people down in Long Island, saying, Can you help me?

I'm in Albany, but, we're making the call. I sit there, we talk. We try to get -- I listen.

And we need a hotline to talk to these parents, and to these uncles, nephews.

I'm actually getting calls from people at the hospital association. I've worked with these people for 20 years. They're experts. They know as many people as I do, but they're calling. They're not calling the head of OASAS. They're not calling, you

know, the big addiction centers where we know everybody.

They're calling because they need someone to talk to, someone that's real.

What do I say? How do I talk to my nephew about this? What's going to actually reach him?

And so my answer is, Tell him you love him, tell him you're right there with him, and I'm going to stick by you, and I'm not going to give up. I'm here.

That's my answer.

I'm a registered nurse, but I'm not a counselor.

But we do need a hotline, and something that's supported.

I know that there's probably hundreds of parents that would step up and do this.

I already said, I'll do it. I'll take three, five hours a week, and just answer the phone.

At one point I was calling every rehab I could find on the Internet, just to talk to someone, and listen.

Now, their motivation was, they wanted admission. But I wanted someone just to talk to that was empathetic, that understood. I knew that

they didn't care, but I wanted to listen -- I wanted someone to listen to me.

Treatment options, our culture, you know, what is medication-assisted treatment?

You know, it's one of the reasons my son's in recovery right now, is because there is medication-assisted treatment.

The problem is, going back to the original conversation that Bob and other people have raised, is that there's a certain stigma in this area of medication-assisted treatment.

And some of the best experts in addiction have said: Heroin and opiates is a really different addiction. It's tough.

And every addiction is hard.

And I don't want us to ignore any of them, but the one I am definitely personalized -- you know, I personalized is opiates.

The addiction goes up, like this. It's not a slow, progressive disease. It is a -- it's 90 miles per hour, straight.

And I'm telling you, we really need to actually break that.

I have asked people, some of the people that have already spoken are friends of mine, that

I called and I said, What's your take on Suboxone, methadone, on these -- on Vivitrol?

People are telling me that that's actually just as bad as their addiction. And I listened.

So we kept trying the hard fight of abstinence, and three overdoses later, and almost on a respirator, I said, You know what? Something doesn't feel right to me.

There is not one treatment modality for someone with high cholesterol.

There is not one treatment modality for cancer.

It's based on individual, their circumstances, and other parts of their body, where they are in a community. Everything.

Why is it any different for this?

So we need to start to work on that.

No one -- no one treatment works for everyone, and so I can't say that enough, because it's still something that I think even OASAS and clinicians in this disease space still struggle with.

We've mentioned dollars for treatment and education and prevention.

One of the things I think we've missed is,

what about the money for actually trying to get best practices, and to research evidence-based practices?

There are some great models in Europe. There are some great models in other states.

And Senator Hannon, who has been very supportive of myself and my family, show me -- you know, I can get -- we fought to get the insurance, right, because people would tell you us, you can't get in unless you fail three times in the outpatient over 12 months, blah blah blah.

But then once we get them in, what's the outcome we're looking at?

Someone said earlier, it's really hard to measure, what's a good outcome for addiction? mental health?

Well, if they're still breathing, and they start to actually decrease the times that they use, the longer they go, decrease in recidivism rate, those are actually good outcomes.

We don't have those to look at.

Supportive housing:

There has been lots of articles, we follow them. I follow everything across the country.

And, supportive housing is something that I think you've heard, but, there's, like, it's all

or nothing, in regards to addiction.

You use once, you get kicked out. You talk back. You do anything.

I took out a home-equity loan to put my son into something. And, they didn't give him the medication they had told him they were going to give him, and he said, But that's my medication. You have to give to it me.

And he got upset.

And they said, "You have to leave." And they kept the money.

And I was, like, well, you know, when I have a post-op patient, after they've had surgery, and they're telling me their pain's an 11 on a scale of 1 to 10, and you don't give it to them, they're going to get a little grumpy.

Are you going to kick them out of the bed and say, See ya?

Not going to do that.

But in this world, we do it.

And so we do it in supportive housing, we do it in inpatient treatment, we do it -- and it's acceptable?

Totally unacceptable.

So we have to do something like that.

We also have to regulate some of the sober homes.

There's people, you see the articles in the paper. It's something that we've brought up to OASAS, that they want do something about, too.

So, I think it's something we should actually identify, and possibly look at in the report, because there's a great -- there's a big need.

And, you know, the drug courts.

There's many people -- you heard John say, you know, I hope that when they call me, or they want help, that they're in jail.

And Craig Apple, who's a friend of mine, we were kids across the street, growing up together, since we were, like, four, says you can't arrest your way out of this. Right?

But, it's a first stop.

But then when they -- if they have the opportunity to go through a drug court, we have drug courts that are telling them they can't be in the drug court and get the benefits of that if they're on medication-assisted treatment.

So it's a law -- it's the drug courts stating that, what your treatment is supposed to be; not the clinician.

So maybe we should look at kind of stable -- maybe making that kind of a little bit more standardized, because depending on what county you are, and depending on what city you are, what drug court it is, you'll have a different set of rules.

I have a whole list of other ideas, but I think those are the primary ones.

I thank you again.

I'm happy to take any questions.

Thank you.

SENATOR AMEDORE: Thank you, Lisa. And, hang in there.

Hang in there.

LISA WICKENS-ALTERI: Thanks. I will.

SENATOR AMEDORE: Patty, she -- Patty Farrell is a mom who -- well, I'm sure she'll tell you the story, but, we have -- hopefully, very soon, we will have Laree's Law passed in Sente and, hopefully, passed in the Assembly, and -- and that would be great.

PATTY FARRELL: Yes, it would.

Thank you very much for inviting me today. I really appreciate being here.

My daughter, Laree Farrell-Lincoln, 5 days shy of her 18th birthday, I found her deceased in

her bed from a heroin overdose.

She was using for about four months. I had gotten her to detox. There were insurance issues. Two-day stint, that's it.

She was 18, so she could check herself out.

She did.

She got her Suboxone when she was there, so she felt better, no withdrawals.

Left.

I begged her, kept begging her, go inpatient, go inpatient, go inpatient.

I was to a point where I was going to have her arrested, just to get her off the streets. I figured she was safer in jail, which is a pretty horrid thing for a parent to think, but I really believed that.

Finally, she came to me and she said, "I'm ready, I'm ready, I'm ready."

At this point, she had lost 30 pounds, wasn't taking care of herself, wasn't doing her hair, makeup, shower...wasn't doing anything. She was falling away to absolutely nothing. I watched her deteriorate in front of my face. I watched her high in front of my eyes a couple of times.

I had people say, Throw her out.

Well, guess what? I'm not going to throw out my 18-year-old daughter onto the streets, when this is just the beginning of a long, long road. And I knew I had a long road ahead of me.

So, she finally decided she needed help. Got her into detox. And, thank God, I found a woman that was working at detox, that took to Laree, took to me.

And like a gentleman said earlier, I found a rehab -- she found me a rehab in Connecticut. There was nowhere to put her in New York State.

There were two doctors at detox that were saying, she needed to go inpatient. And there was one doctor at the insurance company that was saying, We're not paying for it.

So, basically, the girl at detox said, I remember them coming in, doing a presentation, this place from Connecticut, and they will take payments.

I said, Fine. Let's get her there.

So we got her there.

28 days, you're done.

You are done.

There is nothing better than long-term care.

28 days, she flat-out said, I am not ready to

go back out.

There was no -- she could have went to a sober house, which she would have had to work, have a car, et cetera, et cetera.

She chose to do the sober house, which was also down in the same area. So I brought her home, to get her car, get her bedding, because it was like an apartment, with four other girls that were detoxing or in recovery.

And, ultimately, she never made it to the sober house. She relapsed when she left my house, and went there the next morning, and, absolutely not, they wouldn't take her.

As you were just talking about Lisa, they would not take her because she had relapsed just that one night. And she was already prepared to be in that sober house for three months.

There's no sober houses locally.

There's -- long-term care is just, like, you don't even -- it's not even heard of, long-term care.

And that is the only thing that is going to help these guys come out of this.

It is -- this drug is just not prejudice.

It's starting with the young kids.

It's going to the 60-year olds. Because they started the I-STOP program, so now you've got grownups that are buying heroin.

I mean, it just -- the list goes on and on and on.

I had spoken a couple times in high schools.

Amazing, the reception I got from the kids.

Amazing.

They basically told the teacher, I'll never do that, because I'll never do that to my parents.

It was amazing, the reception that I got from these kids.

Which isn't -- it's a thought. It's actually something that I had -- I had written down a few of my ideas, because I was told we were kind of running short of time.

So, I'll give you guys what I had -- saw a couple of my ideas.

Laree's Law, I haven't heard enforcement since I walked in, but I also did walk in late.

I think enforcement, small-time drug dealers, the kids that are out there dealing just for their own use, maybe a couple days in jail, and then your drug court.

But we really got to start going after these

bigger guys that are selling to our families.

I mean, they're coming in. They're bringing it in from New York City, they're bringing it in from Mexico. They're selling it, they're transporting it on Heroin Highway.

I spoke at Senator Schumer's press conference.

I mean, it's just out of control, and we need to start getting these bigger sellers, and, the sellers, the bigger sellers, need to be start being held accountable, and being charged with a murder, homicide, charge.

They're walking out the door, and it's garbage.

They need to start being held accountable.

They know they can come into New York State. They know they can go over to Vermont. They know they can go over into Pennsylvania.

You got it, slap on the hand, Senator, and they're out the door. And we can't have it.

I mean, it's just going to keep coming in, more and more and more, it's just gonna keep on coming in, and you're going have more and more of this: my deceased daughter.

And it's every day in the obituaries.

Every single day.

And I'm a little over two years of losing her. She was my whole world.

She still is my whole world, which is why I'm sitting here. I don't want to see families go through this kind of hell.

So...

SENATOR AMEDORE: Well, thank you.

And for the listeners, there is -- on Route 155, New Karner Road, there's a big billboard. If any of you drive by it, it's kind of near between the corner of Central Avenue, when -- the Kohl's, kind of, shopping center there, that entry, and it's a -- it says "Heroin Kills, and there's a little picture on the bottom of that billboard, and it's Laree.

And that was -- the design was chosen, it was made by the students of Colonie school -- High School, and we unveiled that just a few weeks ago.

PATTY FARRELL: Yep. The design's incredible. It's a handgun, with a needle sticking out of the end of the handgun.

SENATOR AMEDORE: Yes.

PATTY FARRELL: That pretty much said it all.

SENATOR AMEDORE: It says "Heroin Kills."

PATTY FARRELL: Yeah, and the art teachers dedicated it to my daughter because she went to school there.

So, it's pretty incredible, if you want to take a look at it. It really is.

SENATOR AMEDORE: So we're working on it.

I sponsored the bill, and we will see it on the floor very shortly. It's already gone through the committees, and we're working with the -- with Assemblymember Mike DenDekker. And, hopefully, we can get --

PATTY FARRELL: I hope we get them.

SENATOR AMEDORE: -- keep our fingers crossed, and get it passed in the Assembly, so -- and that would go after, and hold these drug dealers much more accountable; not slapping them on the hand, but now charging them with homicide.

Thank you very much, Patty.

PATTY FARRELL: Absolutely.

Thank you, Senators.

Thank you very much.

[Applause.]

SENATOR AMEDORE: Next we have Elizabeth Berardi, Daniel Savona, and Peter Nekos.

I hope I got that one right.

Thank you.

Thank you for waiting, and thank you for being here.

Elizabeth, if you would be so kind as to start.

ELIZABETH BERARDI: Thank you, Senators, for inviting me to participate in this hearing.

My name is Elizabeth Berardi. I'm the founder of the non-profit organization Safe Sober Living, and a member of the Ulster County Task Force on Heroin.

Most importantly, I'm here as the mother of Carter Berardi, my son who suffered from the disease of substance-use disorder, and, ultimately, died January 12, 2014, at the age of 23, from acute heroin intoxication.

As my son bravely attempted to save himself from the disease of substance-use disorder, my efforts to navigate and save him from the addiction industry itself would prove be the hardest thing I've ever done.

Since Carter's death, I've been driven to understand exactly what occurred, and what I've learned has both stunned and sickened me.

My son's death was absolutely preventible.

I've been told Carter was put on a wait list when he inquired about methadone. It's happening in New York State and lives are being lost because of it.

I'm told many clinics choose not to expand the number of people they serve. They're all too aware that quotas must be met, and fear coming in under that quota which would cost them important state funding.

This clinic was the first point of contact that failed my son. As far as I'm aware, no help was given, no Narcan distributed, no clean needles offered, no harm-reduction counseling, and no contact with treatment.

My son also tried to find local doctors to help him, and in one case was told, "I don't deal with this in my practice."

The doctors in the emergency rooms that Carter went to time and again also let him walk out the door, either with more narcotics, or hopeless and ashamed, definitely not connected with treatment.

We need doctors and nurses that are educated about addiction. The time has come for the State to

mandate they receive further substance-abuse training.

Carter's doctor put him on fentanyl patches when he was recuperating from back surgery. The doctor did not consider an alternative, even after I told him my son had a genetic predisposition to addiction, which, according to CASAColumbia, accounts for 50 to 75 percent of the risk of addiction.

This should be a red flag for any physician.

The drug fentanyl that he prescribed, as stated by Wikipedia, is approximately 80 to 100 times more potent than morphine, and, roughly, 15 to 20 times more potent than heroin.

My son's insurance company, Value Options, denied him coverage.

New York State Attorney General Eric Schneiderman has since held them accountable for parity.

It will not bring back my son.

I do, however, believe it takes us one step closer to holding people responsible within the industry itself. There's no doubt other lives will be saved.

My son eventually relapsed, and while he was

in a Hudson Valley detox, I was told by a nurse that his insurance, once again, denied him inpatient treatment.

I took notes on the reasons stated by the detox for his insurance denial in order to appeal at a later date.

Since Carter's death, I've learned from the insurance company that the detox never requested the inpatient treatment for my son.

It's been a painful road trying to get the hospital to address the issue.

After misleading me for many months, they've now stated there was, indeed, a disconnect. Of course, this is the same detox that had my son sign a discharge plan that stated he was going to the wrong rehab in the wrong state.

Even worse, when I tried to report this error to several New York State departments, none seemed to feel it was within their purview.

This disconnect which occurred, altering my son's ability to obtain the best treatment possible, matters.

I do not want it to happen to anyone else's child.

There must be a point-person for this

epidemic with the authority to actually fix a problem in the system.

I'm asking that this epidemic and issues surrounding it be given emergency and expedited status.

The addiction industry has, basically, no guidelines and almost no oversight. Treatment centers are not rated or quality-controlled.

Joe Califano at CASAColumbia, and, separately, Thomas McClellan at the Treatment Research Institute, have been trying to rate rehabs for years.

As I read the clinical notes from my son's treatment center, I saw he was, literally, having cravings the day before he was discharged. The treatment center that claimed to be evidence-based had him use the Serenity Prayer to cope with his heroin cravings, and released him to a less-restrictive and -supportive environment.

This rehab even checked, the very next day, they even checked the "Finished Program" box on his discharge papers, as opposed to checking the "Against Medical Advice" box.

One week before he left the center, my son's therapist told me that his life depended on staying

in inpatient treatment longer.

The next week she said, "We need to strike while the iron's hot," and supported Carter's transfer to an unregulated sober home which they recommended.

My son died just after being discharged. He was three days out of that rehab.

There must be standards of care implemented that can be relied on by all.

To this point, according to a published report by CASAColumbia, while residential treatment programs must be licensed at the state level, standards vary widely.

For no other health condition are such exemptions from routine governmental oversight considered acceptable practice.

The sober-home industry, unless state-funded, is totally unregulated. It's an insidious one where patient brokering is not uncommon. We don't even know how many exist because they hide behind the FHA as if it were to protect the owners, not those suffering from substance-use disorder or other mental-health issues.

While there are some wonderful homes, many others purely serve as cash-cows.

The owner of Carter's sober home had previously been arrested for selling heroin and Suboxone in his own driveway while on probation for another crime.

I'm a great believer in second, third, or more chances for everyone. This, however, defies common sense, because he started managing sober homes while still on probation for that crime.

Further, as founder of Safe Sober Living, the stories I've been told about sober homes are heartbreaking. Sexual assaults, drugs, financial scams, ten people in a room instead of two, are common scenarios.

Most sober homes will expel someone if they prove positive on a drug screen. Most sober -- it's part of the house policy, rather than a continued care plan.

Michael Botticelli, referring to substance-use disorder, said, "We don't predicate saving someone's life from other diseases based on their compliance with treatment. We save their lives because their lives are worth saving."

NARR (the National Association of Recovery Residences) is a voluntary organization from the recovery community, and it's noted on the

White House web page. It's trying to implement such standards and oversight.

The majority of sober homes, however, that are causing the harm will not be voluntarily joining this. They will remain in the shadows until given absolutely no choice.

Those that have easily made it through the House and Senate in Florida, with the support of FARR, the Florida affiliate of NARR, will, I believe, quickly make its way around the country. To ensure -- it ensures safe sober housing with oversight and standards.

New York State should follow suit.

Florida House Bill 21 and Florida Senate Bill 326 are bipartisan-supported efforts to fix a seriously dangerous situation on the continuum of care.

In Gloucester, Massachusetts, the police chief has determined it best to offer detox to anyone that walks in and requests help. He's treating addiction as a medical condition, rather than a criminal one, when possible.

New York State should do the same.

Since my son's death -- and this is addressing stigma, really, on a larger scale --

since my son's death, I have found out the needle he used was simply thrown out. I asked the detective if they would throw a gun away at a crime scene.

I'm told that policy has now been changed.

That is because the police, the law enforcement, were open to change.

The investigation into my son's death is still ongoing. I've waited over a year for Apple to respond to a subpoena for Carter's phone texts so that the person who sold him the heroin can be found and stopped.

Until Apple feels this is a priority, I must wait.

I can only wonder why law enforcement is not being supported in their investigation of a death.

On a state and local level, much can be done.

Evidence-based treatment beds are needed, and must be rated on a regular basis to ensure the quality of care.

At the very least, up to three months of inpatient treatment should be covered by insurance.

I support Senator Murphy on this.

The LGBT community of which my son belonged has found certain specifically targeted supports help those in recovery.

These should be recognized and made available.

Harm reduction must be implemented across the state.

Like the recent AIDS crisis in Indiana, we will see the spread of hepatitis C and HIV if we don't offer clean needles to those already injecting. This point of contact also serves as an opportunity to offer testing, treatment, and support.

While legal in New York State, we need to make sure all county health departments are on the same page regarding implementing syringe-exchange programs.

I can tell you firsthand, this is not yet happening.

Emergency rooms could follow the recent Yale study, by offering buprophine (ph.) to anyone found to have an opioid addiction, and they could directly refer them to treatment.

The Massachusetts Senate has put aside money to develop two recovery high schools.

New York should do the same.

Sober dorms and collegiate recovery programs should be implemented across the state as well.

There should be protocol that medically-assisted treatments are available for those in the criminal justice system. Drug courts should have assigned addiction specialists to oversee the programs that could change the rate of recidivism dramatically.

An ombudsman in each New York State county could help with insurance parity, locate and point out community supports that may be available, answer basic questions to those in need, and help navigate on a local level.

As the laws of the disastrous war on drugs are pulled back, those who are incarcerated can now receive the mental-health and addiction treatment they deserve.

Communities will need to be a part of the solution, because city development and its environmental factors have a direct impact on addiction and the mental health of its residents.

Community recovery centers are also an important gathering spot, and should be considered part of any plan to solidify an area's commitment to healthy community.

My son was swept up in a crisis that continues to face our nation, stealing another life

approximately every 14 minutes.

On the fateful day of January 12, 2014, it was my precious son Carter's life who was stolen.

Carter tried very hard. He was forgiving of the stigma, silence, and lack of emotional and medical support.

Inside his gentle soul was a courageous man who suffered from a horrific illness.

My son, Carter Berardi, is, and will forever be, my hero.

I thank you for allowing me to be here today and share a story.

Thank you for what each one of you are doing to stem the tide of this epidemic.

I'm grateful for your efforts to understand and save lives.

Thank you.

[Applause.]

DANIEL SAVONA: Senator, how are you?

SENATOR AMEDORE: Very well, Daniel. How are you?

DANIEL SAVONA: I'm good.

Thank you for having us here.

SENATOR AMEDORE: Thanks for being here.

DANIEL SAVONA: Thank you for having us.

My name is Daniel Savona, and I'm a recovering addict, currently celebrating 2 years -- 2 1/2 years in recovery, after a good 10-year, 15-year battle with opiate addiction. I struggled for many years, trying to find help in recovery. It wasn't until I found the 12-step program -- I started in a detox facility, and then went into a rehab, and followed by a 12-step program.

I struggled for many years, in silence, as I've shared with you in the past, with the stigma of addiction.

I think addressing our concerns with the stigma of addiction, because we hide, and we're ashamed, and we're afraid to ask for the help, and that had prolonged my addiction for many years.

I think addiction touches all of us, as we can see.

I use the term "three degrees of separation" quite often, but, you know, as I become more familiar with people in recovery, and I speak a little bit more, I meet more and more people, that addiction touches everyone.

So, to have that stigma over me today, no. I'm proud of where I'm at.

I'm not proud of the things I've done, but

I'm definitely proud of where I am, and who I am today, and that's because of recovery.

I think we need to change the face of recovery, and that's why I'm sitting here today with you.

You and I met, you know, going back a few months ago, and, you didn't realize I was in recovery. And when I shared my story with you, I could tell you were surprised.

I think a lot of people out there are suffering from the same things.

I tried Suboxone for many years.

This is where Liz and I tend to agree to disagree on that.

I didn't find sobriety, what I call "sobriety," until I was free of all opiates.

I struggled.

I struggled with the Suboxone, the depression, the isolation, you know, all the side effects that came with it.

I think what it does, it beats you down. The depression, anxiety, that came with it were too much.

They talk about the expense of Vivitrol compared, you know, to the expense of Suboxone.

They want to put people on Suboxone when they come out of a 28-day program. At that point, the opiate is out of their system. To put them back on, they say, well, they're high risk.

Well, anyone that comes out of rehab is high risk at that point. But to put them back on an opiate, a Suboxone or a drug, that's going to start the addiction all over again, there's Vivitrol.

Vivitrol may be a little bit more expensive, but Vivitrol is non-narcotic, there's no opiates involved, and, it's a one shot a month. They can do a shot, where it beats the cravings, and it's a blocker, where, you know, you can't get high, you can't overstack it with heroin or alcohol.

So there are other options out there.

You know, we talked about the insurance companies in the past.

I was denied insurance on several occasions.

Right now I'm going through something.

I failed three detox, and with the three detoxes, and when I tried to get into rehab, I was denied coverage for rehab because they said my addiction wasn't bad enough. I needed to fail three outpatient programs.

Fortunately, at the time, we were able to pay

for rehab.

Now, 2 1/2 years sober, I'm having my life-insurance policy denied coverage. They're taking my life-insurance policy away because they said my addiction is -- I have a history of a drug addiction.

I'm in the best shape of my life, I'm the cleanest I've ever been, I'm the most healthiest I've ever been, and, now, it's life insurance. So if anything happens to me, it's about my family, it's not about me. And I'm being denied my -- they're taking it away from me, which I don't know how.

That's something we'll have to talk a little bit more about.

The disease of addiction, we're all predisposed.

You know, you and I talked about taking the opiates and stuff. And you were fortunate, you could put them down.

Guys like me, you know, I've used the expression before, when we use, there's, like, bells go off, bells and whistles go off, in our heads. And for some of us, it takes a long time to get them to stop.

I use -- it's a -- it's not the best expression, but, when I got into the opiates from chronic back problems, I was put on Oxycontin. And, you know, at one point, you know, my addiction, I had probably a $2,000-a-week drug habit.

And the first time I used Oxycontin, you know, and with cocaine, of course, I used, it's a bad expression, but, it was like kissing God.

For some of us addicts, you know, like I said, bells and whistles go off in our heads, and we're predisposed.

You know, other people can -- you know, they -- it doesn't affect them the same way.

So, as far as addiction being a disease, I think we need to change something with legislation, because it makes it so much easier for insurance companies to deny us help and coverage when we go into the hospital, when we go to detox, and ask for help. We're denied, you know.

And when an addict is asking for help, in that moment of clarity is the best time to pull them in, is when they're asking for help.

You know, I believe, you know, when people do want help -- it's hard to bring someone kicking and screaming to get recovery. Sometimes it takes what

it takes, incarceration, your bottom, whatever it is.

But when someone's asking for help, it's the best time to get them.

And when they go to the hospital, and they're asking for help, and they're denied because of insurance companies, I mean, there are people going back out and they're running, and maybe never to come back again.

And that's when these people, that's when we have to help them.

So -- I mean, you have your work cut out for you, you know, but, I can't sleep at night without trying to give back to the community that saved my life, and it was through recovery that I'm here today.

And as you well know, I'll share a little tidbit, 3 -- 2 1/2 years ago I was a full-blown raging drug addict. I had a significant drug problem.

2 1/2 years ago I found recovery.

And just 6 months ago my, wife won a family court judge in Ulster County.

And through -- you know, through the blessing of recovery, and through the miracle of recovery,

that's possible today.

So, I want to give back to the community that has helped me and has given me what I have today.

So, I'm here for whatever you need me for.

So, thank you.

SENATOR AMEDORE: Thank you.

Dan, you are a champion, truly.

[Applause.]

SENATOR AMEDORE: And it's astonishing, because if anyone could see what Dan -- and he's a big fella, I mean, he's very fit, trim, but if you could see the pictures that he showed me, months and months ago what he looked like --

DANIEL SAVONA: I was 163 pounds.

SENATOR AMEDORE: -- it was just -- it was a different person.

Different person.

He's a -- he's a loving father. You're a successful business person, businessman. You got a great family. And, you're a champion.

Thank you.

DANIEL SAVONA: Thank you. Thank you very much.

[Applause.]

SENATOR AMEDORE: Peter.

PETER NEKOS: Hi. My name is Pete Nekos.

I've been a pharmacist for 40 years, and I have 27 years in recovery, and, I work every day with this drug -- this problem. I see it all day long.

I'm an active member of AA.

People often ask me, after 27 years, Why do you still do it?

And I tell them I never expected to be an opiate addict, and I'm not taking any chances on relapsing, so I still go all the time.

SENATOR AMEDORE: Good for you.

PETER NEKOS: And I guess why I'm here is, I'm, pretty much, a summary of everybody that spoke today.

Being in the medical field, what all the doctors are talking about, I see that every day.

I currently have a son in state prison, because of drug addiction. He has seen -- he's only seen me sober, so, the knowledge was there. And he was so predisposed to it, with Attention Deficit, and everything, he just self-medicated.

And, you know, I can identify with all these people, because I've had to call 911, and perform CPR on him before they get there because he was all

blue, and -- you know.

I got more stories than you can talk to.

I also have not shied away from who I am and what I am.

I can remember when I developed this problem, you know, I had a back operation -- well, I had a ruptured herniated disk, and I ended up taking Percocet, and it became a way of life for me.

And, you know, tragedy had struck at a certain point in my life, where my wife's father was killed in a boat accident, my father was hit by a car, and my oldest son died, and I went into some four years of serious addiction.

And it came to the point where I wanted to get clean and sober.

And nobody knew what I was doing. I did it by myself. I had one friend that I did it with. He was a detective. And, we just partied together.

But I had a friend that was a lawyer that got into cocaine recovery. He saw me one day, and why that day, I decided to tell him.

He said I looked terrible, and I did look terrible. I was about 118 pounds.

And, that day, the miracle happened for me.

I took him in the back room and told him

I had a problem.

I had had cancer before that, so, you know, I really didn't think I was going to live forever anyway. That was in '75. You know, that goes back a ways and when I had that.

So, I got into recovery, and they told me I had to come back and do 90-90 (ph.).

And, I was a local pharmacist.

And the first day I got back, I stood up and said, I'm -- at that point in time I was only alcohol, I share, and I said, "I'm an alcoholic," stood up in a local meeting.

And I think that was a very big turning point in my life, instead of sitting in the back room and hanging my head. And I've been doing it for 27 years.

And I developed a program with Alcoholics Anonymous that's a spiritual program.

I can identify with Father over there, and everybody that spoke. I totally get it.

And, this program, I've been called by numerous people. I've helped undercover narcotic agents get clean and sober. I've been called into judges' chambers to help local policemen get clean and sober. My sister-in-law. It just goes on and

on and on.

And my family's been devastated by it.

The punitive aspects of getting in trouble as a young kid, drinking and driving, lost his license, drove again -- these aren't the only incidences by the way -- but when he had an accident without a license, they sentenced him to a year in state prison. Got out of that, went down to Key West, got busted with a tenth of a gram of Coke, and he's spending 18 months in the Florida state prison right now, where the guards and everybody are worse than the prisoners.

So, I've been around the whole spectrum: the sadness, the family fights.

And I ended up calling to have him arrested this past time, and that's when he violated parole and they took him down.

So I've done the hard things, calling the police on my kid.

And -- but recovery for me is a way of life.

And, just yesterday, I was talking to a retired football player from the NFL, and he was on Suboxone. And I took him aside and shared my story.

I have housewives.

Every line of work you can think of.

And I don't go out standing on a soapbox about this, but when they come to me, the kids, I take them aside and let them know I'm in recovery. And it makes a huge difference for them to know that someone else is there and I'm not judging them.

And I also have people on Suboxone that tell me it's a great drug.

My son used it to get off heroin. And then he got off of that, and he had a full year clean and sober, and he started smoking pot. It took him five weeks to go skyrocket again.

The people that are on it now, their life is dictated by the doctor's prescriptions, their vacations, everything. They all tell me that if they knew what they were getting into, they wouldn't have done it as a maintenance drug.

And I feel, from my experience, that the only maintenance in this program is a spiritual experience sufficient enough to help you recover from addiction.

And once you can find that little, that piece, you're on your way to a better life.

And my life has been, by far, better than my wildest dreams I could ever have imagined.

And, it's not all roses. Like I say, I still

have a son in prison right now.

So -- but life is good.

And, without recovery, for me, and the spiritual part of the camaraderie with (unintelligible), I've known guys in that program for 25, 27 years now, and we -- there's nothing we don't know about each other. And that camaraderie, and these guys helping you share your problem and lifting you up, it's not like any other group I know.

Every other group, it's who's got the biggest, whatever.

In Ulster County, you want to think about the incarceration of these young kids into the Ulster County Jail, when you have a rehab right there, Veritas Villa, that if a contract could be made somehow with them to get these kids in there to the rehab.

Because I had a reason. I had a business, I had family.

Danny had a business, he had a reason.

Kids that are coming in now, they don't have anything.

And if some type of a program could be developed, instead of putting them in jail to

support that system, and it's a money-making system, the whole thing with alcohol and fines, and every other thing, in conjunction, maybe with a Community College, to get these guys into the rehab, to teach them lawn-caring skills, carpentry skills, anything, that's the best thing to do is, because, when Danny came to me, he called me up one day, years ago, came up to the pharmacy and sat with me while I worked. He saw something that he liked.

It's a program of attraction. They want what you have; they just don't know how to get it.

The best kind of thing you can do is get these addicts to get a degree in counseling, or something else, so they can go out and promote it to their friends, and their friends see what they have, and then they want what they have, too.

And, you know, with the Community College down there, if something could be worked out with that, Veritas Villa, instead of throwing them in jail, I think would be a real big plus.

But I want this Committee to know there are a lot of guys like me out there, after 27 years, holding your head high.

And I don't care what anybody says. I haven't had a drink or drug in 27 years. What are

you going say to me? You know?

And I'm proud of it.

And I do know you guys have a daunting task.

And the fact that you are even here doing it, it's about time somebody's doing something.

SENATOR AMEDORE: Well, Peter, you know, you lead by example. 27 years is a life testimony that it can be done, it can -- you can overcome. And you give a lot of hope to a lot of parents in this room tonight.

And, you know, it's Friday evening, my wife and I shared our time with Teen Challenge of Albany, and what a great organization. It was a banquet, and they had their graduation ceremony of 14 men who hit rock bottom, but went through a 14-month program.

And I talked to each and every one of them, and they're changed, and they are set free of their addiction.

They're going to go through some hard times when they leave that facility. They know that. But it was a whole -- it was faith, it was treatment, it was a whole inside-out experience for them that has really set them on a path that they're going to be reacclimated into the community.

And God bless them, because they were great, and it was a success.

PETER NEKOS: You know, one of the things I wanted to say, with the pain-addiction guy, he left here, I was at a pain-addiction thing, and he couldn't explain certain things about addiction.

Everybody's going to get a physical addiction to narcotics.

I've had four operations the last four years. I had a toe cut off. I had my knee replaced. I had an Achilles tendon torn. And I had a hip replaced.

And for my knee -- my hip, I didn't use any pain pills.

But my knee, I had prescribed Percocet. I had 60 of them, and I took -- the most I took were 3 a day, the 5-milligram. I still was in a lot of pain.

The difference with an addict is, most people, when pain subsides, they reduce the medicine.

And after being in recovery for these years, I remembered the day that my wife was away, and the Yankees were coming on preseason, and I was going to take a shower, and I said, Oh, I'm going to take a pain pill, and sit and watch the Yankees.

And I realized at that point, that was the point of no return, because I didn't need the pain pill. That was a point of my experience of being in the program long enough, I was not taking the medication for the right reason. And at that point I dumped it away.

But it's the intent of why you're taking it.

And, if I had taken it -- and I remember another time, I was -- tore my Achilles tendon. And I was -- I had the operation on a Tuesday. On a Saturday I was in work, with a cast, and they had given me some pain pills, and I took them for one day, and I gave them back. And there they were in the -- in our cabinet.

When I had gone Saturday, a girl came in, 3:00 in the afternoon, beautiful day, and I go to get them, and there are my pills, my label. And I'm counting them out, and I'm talking to myself. I'm saying, Jesus Christ, I'm the one that's in pain, you know.

My very next thought was, I wonder how many I'll need tomorrow, because the next day was Easter.

That's what recovery does: It teaches you what your sickness, your illness, what your disease, is going to talk you into doing, and you're gonna

cross that line, and it starts all over again.

SENATOR AMEDORE: Well, again, thank you for coming, coming up from Ulster County, for your testimony, your story, because it brings -- gives a lot of hope to a lot of people.

[Applause.]

SENATOR AMEDORE: Bless you.

Our last speaker is Melody Lee. She's the policy coordinator of New York State Drug Policy Alliance.

MELODY LEE: Good evening, everyone.

So my name is Melody Lee. I'm a policy coordinator with the Drug Policy Alliance.

The Drug Policy Alliance is the nation's leading organization working to end the war on drugs, promote drug policies based in science, compassion, health and human rights, and works to reduce the harms associated with drug use, as well as drug prohibition.

So I'd really like to thank the Senate Drug Task Force tonight for inviting me to provide testimony. I really appreciate having the opportunity to share my recommendations.

I'd also want to take a moment just to thank all the folks who shared really personal stories

tonight, because I want to acknowledge that, no doubt, that's challenging, and it's very -- it's incredibly hard to kind of reexperience that in sharing, not only how it's touched your life through your family, but personally.

So, thank you again, for all who have come tonight.

So, I just want to begin with saying that, the reason that many of the folks are here in the room tonight is because we know that our current approach is not working, that it's failed. That people are dying.

We know that this is happening, and the result is, folks are feeling stigmatized, folks are not being able to access treatment. Folks are dying.

So the result is from a number of problems, including fragmentation of services, contradictory policies, and increased racial disparities.

Some of these things stem from, historically, bifurcated approaches.

One approach in which looks at drug use, really, as a crime that can't be tolerated, that should be punished.

And another that sees addiction as a chronic,

relapsing health issue or behavioral condition that requires ongoing treatment and support.

Neither of these views is all-encompassing, and should be recognized that there are patterns of drug use that do not result in significant harm or health problems, and don't actually require any intervention.

A public-health approach takes the view that our focus should specifically be on the harm caused by drug use, and our policy responses to it.

Above all, we need policies grounded in science that are effective.

As we've heard tonight, law-enforcement officials across the country are saying, we can't arrest our way out of the problem.

We have to be innovative. We have to think of really comprehensive solutions.

One of the complications in New York State around drug policies is that there are multiple actors at play, and, oftentimes, are responding in very different ways.

What we need to do is have a unified framework and better coordination to prevent us from working at cross-purposes.

Drug use and its associated harms continue.

What we see is mass incarceration of New Yorkers.

As I mentioned, racial disparity is at extreme rates.

Continued stigmatization of individuals and expenses that we can't afford.

As Father Young said earlier, stigmatization is a major issue that we must address. When we stigmatize folks, what ends up happening is, they fear accessing treatment, they fear asking for help.

And we really need to work to prevent that.

We need to work to prevent those barriers from being built so that folks can continue to know and ask for help, and be able to access the services that they need.

In New York State, the number-one treatment provider is DOCCS (the Department of Correction and Community Services (sic)).

So I'll say that again, just so people can really let that sit: The Department of Corrections and Community Supervision is the number one treatment provider.

That's incredibly problematic. We really need to address that issue. Folks need to be able to access treatment through a number of means, and

not through the criminal justice system.

More and more people are recognizing that the criminal justice system is costly, and, oftentimes, it results in worse health outcomes, and, oftentimes, as I said earlier, really extreme racial disparities.

A public-health approach works to really improve individual, family, and community outcomes by focusing on health and social needs through improved access and quality of services.

The Drug Policy Alliance and the New York Academy of Medicine worked for years on publishing a report that came out in 2013, called "A Blueprint for a Public Health and Safety Approach to Drug Policy in New York."

We did a series of community consultations with academics, physicians, experts, and hundreds of New Yorkers across the state, and the blueprint details a number of specific findings.

Two clear, overarching themes emerged from that work.

First, that structural issues, like disparities in income, education, and opportunity, profoundly shape individual experiences of drug policies, as does the neighborhood in which a person

lives.

In New York, these structural issues are overlaid with issues of race and racism, so that communities of color, just as affected by problematic drug use as white communities, are far more profoundly and detrimentally affected by our current policies' responses.

And I know that, earlier, Miss Jimenez spoke to this in her work.

So simply put, even though drug use is spread, roughly, evenly throughout the population, our responses are not, so we see police and services and resources available to people in need, varying.

Poorer communities, communities of color, generally have fewer resources which prevent and address drug use. They face more intensive policing, surveillance, and penalties.

Most of our current approaches tend to intervene at the level of the individual, but what we need to look at is a larger structural solution.

We need to recognize that there are a lot of intersections with problematic drug use, to access to housing, to employment, to mental-health services, and more.

I'm hoping, that as a result of the many

conversations you've had across the state, that we'll have a drug-policy framework that expands beyond just the punitive approach, and one that looks at how we can have a comprehensive, service-oriented discussion.

So the second overarching theme that emerged from this report is that, what we need to do is look at harm-reduction services more broadly.

And I know Elizabeth spoke to this as well.

So -- and I really want to just also thank Lisa who said this: We need to focus on the fact that we need a variety of treatment modalities. Not one single modality fits for everyone.

This is not the way that physicians approach any disease or condition. They recognize that individuals have very different needs and experiences, and so we have to have a variety of options at the table.

So to explain a little bit more about what "harm reduction" is, it means reducing the harms as best we can.

And someone earlier spoke to a really great metaphor around the use of seat belts.

So what we know is, for example, when people drive in a car, it's a risky -- it's a risky

behavior. That there are incredible rates of accidental death, because of people driving cars.

So what have we done in order to address the potential, you know, risks of driving?

We've established a lot of harm-reduction approaches. We have seat belts. We have stop signs. We have speed limits.

And so we need to think about our drug policies in the same way: That not all people are able to be abstinent. Not all people are willing to be abstinent.

That's just a reality.

And so what we need to do is, we need to come up with harm-reduction services that are very prevalent throughout the state that address a treatment continuum.

So in addition to providing, exclusively, treatment, we must also provide mental-health services, all sorts of wraparound services, including connections to housing and employment.

I'd also like to add that I really appreciate the leadership of both Senator Murphy and, you, Senator Amedore, on your legislation around medication-assisted treatment and drug courts.

I think a lot of folks have said throughout

this evening, how important it is that we have medication-assisted treatment available, and that folks have access to it, and that they are not prevented from having access if they're in a drug court.

Lastly, I think a really important point to make is that New York has had a track record of evidence-based approaches.

This has been demonstrated through the 2011 passage of the 911 Good Samaritan Law.

We know that that legislation passed unanimously in the Senate, and almost unanimously in the Assembly, with only two "no" votes.

I think that demonstrates that the Legislature knows that overdose fatalities are unbelievably preventible; that if we provide people with education, if we let people know that they should not fear arrest, that the number-one priority is to save a life, that they should call 911, they will.

And so, in that vein, we must continue to educate New Yorkers across the state around overdose-prevention services, and we need to increase naloxone access.

I think we've done some fantastic things

across the state by equipping a lot of law enforcement and first responders with naloxone, but we also need to dedicate funding for community-based organizations to continue to distribute naloxone.

A lot of these groups are in first contact with people who are using drugs or who are at risk of overdose, and so they need to have access to naloxone as well.

Families, and individuals who are prescribed opiates, they should know that naloxone exists.

And with the 911 Good Samaritan Law, I think we need to continue to push education around the existence of that law, because not -- there are a lot of New Yorkers who still do not know that law exists; that they do not know that there are protections that allow them to call 911.

They shouldn't feel like, when they pick up the phone, that what will be coming is a police car. They should know that an ambulance should be coming.

So with that, I would like to just say, again, thank you, to the Joint Senate Task Force, for continuing to push forward with an evidence-based approach.

And that I hope you will continue to hear many of the recommendations that were shared

tonight, particularly by a lot of the families who have experienced tremendous loss.

And that, know, we need to have solutions. We need to have comprehensive solutions.

Thank you.

[Applause.]

SENATOR AMEDORE: Thank you, Melody.

You know, one of the goals and objectives of this Task Force was not to just go and do what our -- my colleagues did last year when they started the Task Force, and they went around 18 different cities or -- and towns throughout the state of New York, and they came up with some excellent legislation, and they got a lot -- some of it passed and chaptered into law; but, literally, this time, having four different task forces that were in different parts of the state, that would really kind of start filling in the gaps and voids, and listening to, and not just come up with a whole barrage of different legislations that could probably just be a bunch of one-House bills and never get chaptered and make a difference.

This is about every member of this Task Force, of getting together, listening to the communities, and getting down deeper, and deeper,

because it's sometimes just not government that's going to solve this problem. It's we, the people, that are going to solve this problem.

And by engaging in conversation, and coming and sitting, you know, for the times that you have here tonight, and many of you testified in other Task Force meetings that we've had, we appreciate that.

Like I said in my opening remarks, there's not one person that is going to solve and eradicate this problem.

But, there's definitely services, there's definitely support, and there's definitely, I think, wise investments that the State of New York can make, and needs to make, in helping we, the people, eradicate this problem.

So thank you all for being here.

You have given us a tremendous amount of information. You have given us excellent testimony.

And, we will take it, and collaborate, and put forth a good package of bills that we know, and we've already been working on some, like I mentioned, Laree's law, that -- you know, that is a great thing. We talked about some law enforcement.

But the four-prong approach is constantly working at:

Prevention; educating, and preventing things from happening.

Treatment, and making sure we have the proper amount of treatment. And it's got -- I like the whole idea of treatment on demand.

And -- and, recovery, and making sure that those peer-to-peer services, those support wraparound services, are available.

There was a group of young adults who came into my office, oh, about a month -- no, probably about two months ago, before budget, and they were all recovering addicts. And they wanted to know how they can continue to stay relevant in this fight, and they wanted to get more involved, and they wanted to make sure that they're counseling or they're giving that support, and having their arm around the shoulder of someone going through a horrible time in their life.

And, you know, I told them -- Father, you'd like this.

I told them that, your effort, and grassroots effort, is a lot like what we read about, even in the Bible, where one person came and tried to create

this crusade, which, today, thousands of years later, people still have faith and worship in that God. And their efforts is not unnoticed, and it can catch fire in the communities where that -- it will create the wraparound services that we need.

And they can -- and we don't have to use taxpayer dollars to do that.

So, it is an effort that we all need to make, and we are.

And I look forward to working alongside all of you to help this problem, and end this problem.

Thank you so much.

Kathy, did you --

SENATOR MARCHIONE: Yeah, if I could just say a few closing remarks.

First, I want to say, thank you, to all of you who testified.

You know, I -- this is my second year at this, and I can tell you that, last year, we heard things that were very different than what I'm hearing tonight.

We are going deeper. We are hearing -- I'm hearing so many different things that evidence-based is what we need. I'm listening to best practices, is what we're looking at.

We talk money, but I'm not sure that we have the program that we believe, or the programs that we believe, will be the best for people who are in need. I'm not sure we've established those yet.

And sometimes I think that we can throw as much money at everything as we want, but if we haven't done the due diligence of looking at the best practices, and having information that would work.

We hear things like the treatment facilities aren't very good in locations, and they're better in others, and there aren't standards.

These are things I didn't hear last time.

This was a terrific forum for me tonight, to give me, and probably all of you, much more information.

And, you know, sometimes you start, you go to a hearing, and you get into it like we did last year, and you think you got to know a lot about a situation.

And then, the more you learn, the more you realize what you don't know, and the more we need to have the conversation continue, and come to some resolve, so that we can truly help people who are in need of help, with best practices, with best

programs, with best medications.

So, I just want to say, thank you, to all of you for opening up my horizons on completely different topics this time that we need to look at.

And, absolutely, I want to thank Senator Amedore and Senator Ortt for being the Co-Chairs of this very important committee.

SENATOR AMEDORE: Thank you, Senator Marchione.

And I would be remiss, I have to say one shout-out, thank you, to SUNY Albany for hosting us tonight.

So, thank you so much.

[Applause.]

SENATOR AMEDORE: Have a good night, everyone.

(Whereupon, at approximately 9:41 p.m., the public hearing held before the New York State Joint Senate Task Force on Heroin and Opioid Addiction concluded.)

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