

1 BEFORE THE NEW YORK STATE SENATE MAJORITY COALITION  
2 JOINT TASK FORCE ON HEROIN AND OPIOID ADDICTION  
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3 PUBLIC FORUM: NEW YORK COUNTY

4 PANEL DISCUSSION ON MANHATTAN'S HEROIN EPIDEMIC  
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6 Senate Hearing Room, 19th Floor  
7 250 Broadway  
8 New York, New York 10025

9 May 1, 2014  
10 9:30 a.m. to 3:00 p.m.

11 PRESENT:

12  
13 Senator Philip M. Boyle, Task Force Chairman  
14 Chairman of the Senate Committee on Alcoholism and  
Drug Abuse

15 Senator David Carlucci  
16 Vice Chairman of the Joint Task Force

17 Senator Martin J. Golden, Task Force Forum Moderator  
18 Member of the Joint Task Force

19 Senator Michael F. Nozzolio  
20 Vice Chairman of the Joint Task Force

21 Senator Simcha Felder  
22 Member of the Joint Task Force  
23  
24  
25

1 MEDICAL PANELIST INTRODUCTIONS:

PAGE 8

2 Dr. Andrew Kolodny  
3 Chief Medical Officer  
4 Phoenix House Foundation  
5 Also the president of Physicians for  
6 Responsible Opioid Prescribing

7 Dr. Bradford Goff  
8 Psychiatrist  
9 Lutheran Medical Center

10 Henry Bartlett  
11 Executive Director  
12 Committee of Methadone Program Administrators  
13 of New York State (COMPA)

14 Dr. Hillary Kunins  
15 Acting Executive Deputy Commissioner  
16 NYC Department of Health and Mental Hygiene

17 AUDIENCE PARTICIPATION AND Q&A

PAGE 57

18 ----oOo----

19 LAW-ENFORCEMENT AND COMMUNITY INVOLVEMENT  
20 PANELIST INTRODUCTIONS:

PAGE 67

21 William McGoldrick, Esq.  
22 Attorney At Law  
23 Retired Detective Sergeant from the  
24 New York State Police

25 Linda Sarsour  
Executive Director  
Arab-American Association of New York

Rabbi Simcha Feuerman  
Director of Operations, OHEL Children's Home  
President of NEFESH (International Network of  
Orthodox Jewish Mental-Health Professionals)

"The Detective"  
Representative, NYC District Attorney's Office &  
undercover investigator [Not on video; only audio]

AUDIENCE PARTICIPATION AND Q&A

---oOo---

PREVENTION PANELIST INTRODUCTIONS:

Gary Butchen  
Executive Director  
Bridge Back to Life Center

William Fusco  
Executive Director  
Dynamic Youth Community

Karen Carlini  
Associate Director  
Dynamic Youth Community  
Also, Co-Chair, Association of  
Substance-Abuse Providers, Adolescent  
and Young Adult Committee for NYS

Ruchama Clapman  
Founder, and Executive Director  
Mothers and Fathers Aligned Saving Kids

James Hollywood  
Assistant Vice President, Residential Services  
Samaritan Village

AUDIENCE PARTICIPATION AND Q&A

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1           SENATOR GOLDEN: [No audio.] They'll be  
2 right up.

3           I'm going to start with my opening remarks.

4           Simcha's here.

5           Simcha, come on in.

6           I'm joined by Senator Mike Nozzolio,  
7 Senator Simcha Felder, who's part of our task Force.

8           And, here comes our chairman now, Phil Boyle,  
9 who is the Chairman, and with my co-host here,  
10 Simcha Felder.

11           So I'll be turning this over for you to open  
12 this up, sir.

13           SENATOR BOYLE: Sure.

14           Thank you, Senator Golden, and thank you  
15 Senator Simcha Felder, for co-hosting this forum.

16           And, Senator Nozzolio, thank you for joining  
17 us.

18           This is the ninth of 17 forums around the  
19 state we're holding as part of this Heroin and  
20 Opioid Task Force.

21           The mission of the Task Force is to have a  
22 report due about June 1st, and then subsequent  
23 legislation before session ends this year, to combat  
24 this statewide epidemic.

25           We've gotten some great testimony and

1 feedback interaction over the last several of our  
2 forums.

3 And we look forward to hearing from our  
4 witnesses today and getting some good ideas.

5 Obviously, as Senator Golden probably  
6 mentioned, we're focusing on prevention, treatment,  
7 and law enforcement.

8 So any of you, if you, through your  
9 expertise, whether it's in any of those areas,  
10 thinking outside the box, what has worked, what do  
11 you not think will work, and, if you ever thought  
12 there ought to be a law, this is the time to talk  
13 about it.

14 So thank you, and I appreciate being here.

15 Thank you.

16 SENATOR GOLDEN: Simcha?

17 SENATOR FELDER: I just want to thank  
18 Senator Golden for hosting this event, and being  
19 gracious enough to include my name.

20 SENATOR NOZZOLIO: Just my comments, briefly:

21 It's wonderful to be with my -- all my  
22 colleagues, especially two of them from  
23 New York City, Senator Golden and Senator Felder.  
24 Thank you for your attention to this issue.

25 What we're finding, is that the epidemic of

1 heroin is not exclusive to the inner cities anymore.

2 Certainly, we're in the biggest city and --  
3 in our state, but today we want to hear your  
4 experiences.

5 But, the Task Force is finding this is an  
6 issue now, small cities, suburbs, rural areas. It's  
7 pervasive across the state.

8 So thank you very much for your testimony.

9 Without further ado, Chairman, thank you.

10 SENATOR GOLDEN: I want to thank again our  
11 Chairman and our Co-Chairman, and, of course,  
12 Mike Nozzolio for coming today, and being part of  
13 this Task Force today.

14 I just want to point out two --  
15 three paragraphs here that are important, and then  
16 we're going to open up.

17 In February this year, "New York Times"  
18 reported that the federal Drug Enforcement  
19 Administration heroin seizures in New York State  
20 increased 67 percent over the last 4 years, seizing  
21 144 kilograms of heroin, 20 percent of the seizures  
22 nationwide, valued at \$43 million.

23 My colleague Simcha is from Brooklyn, and  
24 myself, southwest Brooklyn, an unfortunate a number  
25 of people who have lost their lives, or been

1 hospitalized and currently addicted, to prescription  
2 drugs, heroin, and more.

3 We're going to hear from some of the people  
4 from southwest Brooklyn. I guess they had another  
5 death there last week, and an overdose of heroin.

6 Today's "Daily News," you see an actress in  
7 England, they just came up. She had overdosed in  
8 early April, and they're saying that that now is a  
9 heroin overdose, as well.

10 According to the New York City Department of  
11 Health, 84 Brooklyn residents, "84," died,  
12 unintentional overdoses involving heroin in 2012,  
13 26 more than in 2011.

14 What we've been able to do in the state of  
15 New York is to address I-STOP on the opiates, on the  
16 prescription drugs, Oxycontin.

17 And in 2011, there were 22 million painkiller  
18 prescriptions written in New York State, in the  
19 homes of 20 million people.

20 Think about the numbers. Those are  
21 astounding.

22 But we did so good on I-STOP in bringing  
23 those prescription-drug overdoses down. Still,  
24 there's a significant number of opiate deaths out  
25 there by pill.

1           But I will tell you that they went -- the  
2 water raised itself and to the level [indicating],  
3 and heroin has come in and picked up that area, and  
4 you can pick up a deck of heroin today, 3, 5, 7,  
5 8 dollars.

6           And you can have hundreds of decks of heroin  
7 on you and it's not a felony here in the state of  
8 New York.

9           It should be.

10          And we're going to listen to testimony, as my  
11 good colleague has said, on all areas; not only on  
12 the arrests and conviction and jail time for the  
13 people that are selling this drug, as well as those  
14 for treatment and prevention, as well.

15          So I want to thank you all for being so  
16 patient here today, and I turn this back over to my  
17 colleague Senator Boyle.

18          SENATOR BOYLE: Thank you, Senator.

19          And we have our initial panel.

20          Just briefly introduce yourself, and then  
21 where you're from, for the record.

22          SENATOR GOLDEN: You have to use the mic,  
23 Doctor.

24          DR. BRADFORD GOFF: I'm Bradford Goff. I'm  
25 the chairman of psychiatry at Lutheran Medical

1 Center in Brooklyn.

2 DR. ANDREW KOLODNY: My name is  
3 Andrew Kolodny. I'm the chief medical officer of  
4 the Phoenix House Foundation, a national nonprofit  
5 addiction-treatment agency located in Brooklyn,  
6 throughout New York State, and different parts of  
7 the country.

8 I'm also the president of Physicians for  
9 Responsible Opioid Prescribing, which is a national  
10 organization representing doctors in the fields of  
11 pain, addiction, primary care, public health,  
12 emergency medicine, and other specialties.

13 HENRY BARTLETT: My name is Henry Bartlett.  
14 I'm the executive director of COMPA. And we're the  
15 provider coalition in New York State that represents  
16 those treatment programs that use addiction medicine  
17 as part of the comprehensive treatment of opioid  
18 dependence.

19 DR. HILLARY KUNINS: Good morning.

20 I'm Dr. Hillary Kunins. I'm the acting  
21 executive deputy commissioner for mental hygiene at  
22 the New York City Department of Health and  
23 Mental Hygiene.

24 SENATOR BOYLE: Now, the way --

25 And thank you very much, all of you, for

1 coming, and agreeing to take time out of your  
2 schedule to be here.

3 We like to be a little more informal about  
4 this. It's not, technically, a hearing. It's a  
5 forum.

6 And, so, if we can just ask questions.

7 If any of my colleagues, obviously, want to  
8 chime in, or any of you want to answer a question  
9 that might have been directed at somebody else,  
10 please feel free. We're trying to get as much  
11 information as possible.

12 Dr. Kolodny, I'd just like to start with you.

13 You're part of an organization that looks at  
14 prescription, and overprescribing, perhaps.

15 A lot of people feel that the current heroin  
16 crisis is a result of the I-STOP legislation,  
17 perhaps -- or an exacerbating factor of the heroin  
18 situation, I should say.

19 Several years ago -- or a couple years ago,  
20 we passed the I-STOP legislation, which cut down on  
21 prescription overprescribing, and pharmacy and  
22 doctors included, which may have led us to go  
23 toward -- some of the addicts to go towards heroin.

24 Can you give me an example how you feel about  
25 that? Or, do you think that's where we're head --

1 what we're looking at?

2 DR. ANDREW KOLODNY: Yeah, I think there's a  
3 half-truth mixed in there.

4 SENATOR BOYLE: Okay.

5 DR. ANDREW KOLODNY: The explanation for the  
6 rising use of heroin and -- across New York State,  
7 especially in suburban and rural counties, is  
8 actually very easy to find.

9 If you speak to a new heroin user, someone  
10 who's become addicted to heroin over the past  
11 decade, and this is an individual who is very likely  
12 to be White, and between the ages of 20 and 35, what  
13 they will tell you is that, their addiction, the  
14 reason that they were using heroin, is that they  
15 became addicted to opioids. And that addiction  
16 began through use of painkillers, and they switched  
17 to heroin because heroin was easier to access.

18 This trend of people switching, getting  
19 addicted to painkillers and then moving to heroin,  
20 has been going on for the past decade. This is not  
21 something that just happened overnight in the  
22 context of I-STOP.

23 SENATOR BOYLE: Okay.

24 And to what --

25 SENATOR NOZZOLIO: Can Hillary add --

1           SENATOR BOYLE: Oh, I'm sorry. Go ahead.

2           DR. HILLARY KUNINS: I'm sorry to jump in,  
3 but I just want to add to what Dr. Kolodny  
4 mentioned, about New York City data.

5           We know, in New York City, that heroin  
6 overdoses began to rise from 2010 to 2011, which  
7 predates I-STOP, and predates many of our  
8 New York City efforts around promoting more  
9 judicious opioid prescribing.

10          SENATOR NOZZOLIO: On that point, the  
11 demographic that the doctor presented, is a  
12 demographic that has gone through a  
13 prevention-education process for most of their  
14 school lives in this state.

15          The D.A.R.E. program across New York, the  
16 antidrug programs, the -- how did there become such  
17 a disconnect for that generation, or that age group,  
18 that you mentioned, Doctor?

19          DR. ANDREW KOLODNY: When we talk about  
20 opioids, we're talking about painkillers and heroin.  
21 And drugs like Vicodin and Percocet are,  
22 essentially, heroin pills. The active ingredient in  
23 those medications is almost identical to heroin.  
24 The effects are indistinguishable.

25          It doesn't mean we should prescribe them

1 because they're, essentially, heroin pills, but we  
2 should prescribe them cautiously. They're good for  
3 end-of-life care or for short-term use.

4 The young people who are becoming addicted to  
5 opioids through use of painkillers are not really  
6 aware, I believe, that they are using a drug very  
7 similar to heroin. It's not until they're really  
8 addicted that they begin to figure out that it's  
9 essentially the same thing as heroin.

10 Many of us may have experimented with drugs  
11 when we were young, and many of us may have made a  
12 distinction in our mind what a soft drug was, maybe  
13 marijuana, and what a hard drug was, and we would  
14 are known to stay away from heroin.

15 The young people who have become addicted,  
16 who are now using heroin, when painkillers came  
17 along, to them they were a soft drug. They came out  
18 of mom's medicine chest. They were prescribed by a  
19 doctor. They were not cut with anything. They  
20 didn't realize they were playing with fire.

21 SENATOR NOZZOLIO: It snuck up on them, in  
22 effect, an addiction that was never meant to happen,  
23 but happened.

24 DR. ANDREW KOLODNY: Correct.

25 SENATOR NOZZOLIO: Senator Boyle mentioned

1 three important components of this Task Force.

2 And, your thoughts on prevention and  
3 treatment, particularly from this panel, would be  
4 very helpful.

5 Mr. Bartlett, did you --

6 HENRY BARTLETT: Yeah, I -- thank you for the  
7 opportunity to be here.

8 I want to talk about two things, very  
9 briefly: One is prevention of overdose, and then  
10 second is treatment.

11 I know that Senator Phil Boyle has been very  
12 active in promoting overdose prevention, doing  
13 trainings, making sure that folks have access to an  
14 overdose-prevention kit, like this [holding up an  
15 item].

16 I was in a meeting on Tuesday, in Washington,  
17 where SAMHSA is going to make a lot more of these  
18 available, they're trying to make a lot more of  
19 these available, to the treatment programs in  
20 New York.

21 And we're going to play an active role in  
22 doing training and handing out these kits.

23 We've already done that in conjunction with  
24 the Harm Reduction Coalition and Vocal New York,  
25 but, clearly, a lot more needs to be done.

1           Secondly, I just want to talk a little bit  
2 about the evidence-base of treating opioid  
3 addiction.

4           There's a lot that's going on in the name of  
5 treating opioid addiction. Some of it's  
6 evidence-based, and some of it is not.

7           And I brought three reports for you folks on  
8 the panel, the first of which is the NIH Consensus  
9 Statement that was written 14 years ago, which talks  
10 about the use of -- I'm sorry, 17 years ago, which  
11 talks about the use of addiction medicine as part of  
12 a comprehensive approach to treatment, including  
13 counseling and wraparound services.

14           And the NIH consensus panel, all that time  
15 ago, concluded that, far and away, the most  
16 effective way of dealing with chronic long-term  
17 opioid addiction was to use an addiction medicine,  
18 along with counseling and wraparound services.

19           What's interesting is that, in the 17 years  
20 since this has been published, really hasn't been  
21 any major contradictions to this.

22           And I want to talk about what I mean when  
23 I say "evidence."

24           I mean peer-reviewed outcome studies, subject  
25 to the rigors of academia, published in scholarly

1 journals.

2 That ought to be the basis for where we  
3 decide to expand our treatment of this epidemic.

4 And the other two reports that are much more  
5 recent, these were published in November of 2013 by  
6 SAMHSA, one talks about the efficacy of methadone  
7 treatment; the other about the efficacy of  
8 buprenorphine treatment.

9 What's interesting about all of these is that  
10 they support one another, and each of these cite  
11 multiple previous studies that have been done.

12 So I want to encourage us to think about, as  
13 we move forward with treatment, that if additional  
14 resources are made available, and we certainly hope  
15 they will be, that the resources are spent in a way  
16 that it promotes evidence-based care where we have  
17 the highest likelihood of achieving a positive  
18 outcome for these newly addicted folks.

19 SENATOR GOLDEN: If you could expand on that:  
20 What type of dollars, and what type of -- where  
21 would that money be spent?

22 HENRY BARTLETT: Well, I think that there are  
23 a number of venues where addiction medicines could  
24 be provided where they're not being provided now.

25 One is, for example, is through the

1 drug-court system. We have a very mixed bag with  
2 the drug courts. Many of them are simply not  
3 embracing the science and best practices associated  
4 with addiction medicine.

5 I had a drug court judge say to me: Henry,  
6 I'm not opposed to the use of methadone or  
7 buprenorphine. We just don't want it because we  
8 have a philosophy that is drug-free.

9 And I pointed out to him that "philosophy"  
10 was a Greek word that meant the love of wisdom. And  
11 I didn't know how you could love wisdom and reject  
12 science.

13 So there are a lot of additional venues where  
14 addiction medicines could be used, and are not being  
15 used.

16 Opioid-treatment programs are certainly, you  
17 know, embracing it.

18 The medically-supervised outpatient programs  
19 licensed by OASAS, many of them are using it, others  
20 are not; residential settings, a number of other  
21 outpatient settings.

22 SENATOR BOYLE: If I can just -- can I ask  
23 the other doctors on the panel: Do you concur with  
24 that conclusion about, whether it's Suboxone,  
25 methadone, for -- along with treatment, is that the

1 best way of going about doing it?

2 Or --

3 DR. ANDREW KOLODNY: So we've got an epidemic  
4 of people with the disease of opioid addiction  
5 and --

6 SENATOR BOYLE: Yes.

7 DR. ANDREW KOLODNY: -- and that's why we're  
8 seeing heroin flooding into communities. People  
9 need to feed that addiction.

10 To bring this epidemic under control,  
11 obviously, for the people who already have this  
12 disease, we have to see that they have access to  
13 effective treatment.

14 For the people with this disease, I think the  
15 majority of them will require long-term treatment  
16 with a medication.

17 I believe methadone is less useful for the  
18 epidemic that we have today than it was for the  
19 epidemic we had in the 1970s, when you had an  
20 epidemic that disproportionately affected inner-city  
21 communities.

22 Having people go to a methadone clinic every  
23 day made more sense than when you have an epidemic  
24 that's disproportionately affecting suburban and  
25 rural communities.

1           I think methadone is very important for a  
2           subset of people with this disease who need that  
3           structure.

4           But I do believe that Suboxone is probably  
5           our best tool for bringing this epidemic, or  
6           buprenorphine, under control.

7           SENATOR BOYLE: Doctor?

8           DR. BRADFORD GOFF: Just a little bit to add  
9           to my background:

10          I've been in the addiction-treatment  
11          business, really, for 30 years, board certified  
12          for 20.

13          And I'm a chairman of the department of  
14          psychiatry, but I've run treatment programs for  
15          addiction and substance abuse and outpatient  
16          programs, community-based programs, because, at  
17          Lutheran, we have a very large clinic system.

18          And I've also had a private practice.

19          So, I've seen people at all levels.

20          And it's really clear that buprenorphine  
21          comes out way ahead.

22          Methadone is very good, used as it's been for  
23          many years, and it was groundbreaking in terms of  
24          replacement therapy.

25          Buprenorphine adds something new and

1 different because it's more available.

2 It's still expensive, so it's hard to get to  
3 the underserved population.

4 Unless people have Medicaid, they can't get  
5 it.

6 And they often lose their Medicaid, and then  
7 they go out of the hospital and they don't get it,  
8 and they come right back in the hospital.

9 And that's something we need to attend to, in  
10 addition to the cost of naloxone, which we'll  
11 probably speak to, as well.

12 But, for most people who have become addicted  
13 to these substances, and these addictions hold on  
14 hard. They grab hold of the brain, they hijack the  
15 brain.

16 These medications which are replacement  
17 therapies and reduce the cravings for drugs, and  
18 allow people time to make other choices, are  
19 critical.

20 Nothing else has been more effective.

21 Good treatment programs are good treatment  
22 programs, but these medications are a blessing to  
23 people. And we need to get them out there more.

24 SENATOR BOYLE: Thank you.

25 DR. HILLARY KUNINS: A few words that I'll

1 add.

2 Just to give you a sense my background, also:

3 I'm currently at the City, as you heard.

4 And I'm also an internist and board certified  
5 in addiction-medicine practice, both primary care  
6 and addiction medicine for 16 years in The Bronx.

7 A few thoughts:

8 I think the City's perspective may be -- we  
9 share many of the commonalities that you just heard.

10 We very much support access to availability  
11 of awareness of medicines that treat addiction.

12 For us, and for -- as I teach and talk about  
13 addiction, I think about diabetes.

14 One would never say to a diabetic: Gee, just  
15 really try to lose some weight and exercise. And,  
16 if you need insulin, well, that's if it's really bad  
17 or if you've failed your other approaches.

18 That's not the approach that we take I think,  
19 in medicine, generally.

20 We use the tools that are effective and  
21 what's available at the right time, with the  
22 patient's consent.

23 And, as Mr. Bartlett said, the evidence  
24 surely supports the superiority of medication for  
25 the treatment of opioid dependence.

1           And I think we are lucky that we have  
2 effective medicines, and less lucky in the  
3 addictions from -- to some other substances.

4           That said, there is tremendous stigma around  
5 these medicines.

6           And as a public-health practitioner now, one  
7 of our most important roles, both at the city and  
8 state level, I think is to reduce stigma around  
9 addiction, around accessing treatment to addiction,  
10 and, in particular, around accessing treatment to  
11 medications for addiction.

12           This is a terrible problem we have in the  
13 field, and I think it costs many lives.

14           The issue of whether buprenorphine or  
15 methadone, I think our view at the City may be  
16 slightly different.

17           I think both treatments are effective.

18           I think methadone comes with certain kinds of  
19 restrictions at both the federal and state level  
20 that makes it sometimes less appealing to some folks  
21 interested in accessing treatment.

22           But let us just be clear: We shouldn't  
23 confuse the medicine with how we prescribe or  
24 deliver it.

25           And I think making both available in as many

1 settings as we can will help us fight against the  
2 problem that we're facing right now, both here and  
3 nationally.

4 SENATOR BOYLE: Thank you very much.  
5 I really appreciate that.

6 Just a couple of follow-up questions.

7 First of all, if anybody in the audience has  
8 any questions, please, you have a card. You can  
9 give to it my staff there, and we'll be happy to ask  
10 it along the way.

11 Regarding methadone, for example, now, having  
12 toured some of the treatment facilities upstate,  
13 seen that, as you say, Doctor, in the urban centers  
14 that might be a different story.

15 But I can think of one I visited upstate,  
16 where people were traveling two hours each way, each  
17 day, every day. It just didn't seem like the most  
18 efficient use of treatment.

19 And, so, this follows up my question with,  
20 the drug VIVITROL, which is now a month -- every  
21 month you can get a shot, is that the answer, or are  
22 there downsides to that?

23 Or, uh -- please.

24 DR. ANDREW KOLODNY: I think for the people  
25 with the disease of opioid addiction, there's a

1 small subset who might be helped by VIVITROL. And  
2 that subset might be people who are young, who have  
3 not been addicted for very long, and who live in a  
4 controlled setting, perhaps with their parents. If  
5 they miss their monthly injection, the alarm is  
6 going off and the parents are bringing them in.

7 Because the big risk with VIVITROL is, if the  
8 person misses their injection, they're very high  
9 risk for an overdose death.

10 So I think for some people with this disease,  
11 it's helpful, but it's a second line below  
12 buprenorphine and methadone.

13 HENRY BARTLETT: We support the use of all  
14 three of the medications which are approved by the  
15 federal government for the treatment of opioid  
16 addiction. Each of them have their own strengths.

17 And you're absolutely right, Senator Boyle,  
18 the regulations requiring folks to come in so  
19 frequently to be medicated on site, at least  
20 initially, in methadone clinics are kind of  
21 Draconian. And I would say that they don't serve  
22 the public-health interest as much as maybe they did  
23 20 years ago.

24 But we really are available -- we're  
25 promoting the availability of all three medications.

1           We did a whole round of trainings for OTP  
2 staff (opioid-treatment program staff) in how to use  
3 VIVITROL when it's clinically appropriate.

4           I'd also point out, that unless you get a  
5 discount, the cost of the injections is about  
6 \$1200 a month.

7           SENATOR BOYLE: Right, right.

8           HENRY BARTLETT: So it's an expensive  
9 alternative, but, you know, we're in favor of as  
10 many tools as possible in the tool kit.

11          SENATOR BOYLE: Thank you.

12          DR. BRADFORD GOFF: I think one more thing  
13 that's worth mentioning is, buprenorphine has been  
14 out for a while. It's a good drug, an easy drug to  
15 administer; and, yet, of all the drugs that we have,  
16 it's got very strange requirements as far as  
17 physicians to be authorized to prescribe it, and it  
18 has the DEA showing up at your office every once in  
19 a while, to check and see if you're keeping a log of  
20 the prescriptions.

21          And we don't do this for any other  
22 prescribed -- any other controlled substances, so  
23 it's quite strange.

24          But what it does is, it is quite intimidating  
25 to physicians, especially non-addiction-trained or

1 non-psychiatric physicians, to take this on, which  
2 is really the initial intent.

3 And until that changes, I think we're going  
4 to continue to see an underutilization of this drug.

5 So anybody who can get the word out anywhere,  
6 just talking to Andrew about this, and that there is  
7 some promise of some change, is going to be very,  
8 very helpful.

9 There's just no reason for any restrictions.

10 And, certainly, physicians need to be trained  
11 better in the prescribing of all controlled  
12 substances, all narcotics. They need CME training.

13 And I would advocate for that thing, at least  
14 one hour mandatory, to get relicensed in the state  
15 of New York, about buprenorphine and prescription  
16 narcotics.

17 But, I think we'll see more people interested  
18 if we just make it a little bit easier to have it  
19 accessible, because it's so easy to use. The  
20 patients like it, they come back for it. They come  
21 back 30 days, and it keeps them off heroin.

22 SENATOR BOYLE: Right. Okay.

23 Yeah, well, one of the things we talked  
24 about, Suboxone, that we got testimony from a doctor  
25 upstate, the only one in his area that -- and it's a

1       federally regulated, obviously, drug, so it is a  
2       certain State issue here, but we can try and lobby  
3       our federal colleagues.

4               But he said he's the only doctor that does  
5       Suboxone. That the auditor came in, and the first  
6       he did was read him his Miranda rights, to say,  
7       "You have the right to remain silent."

8               And he wasn't being accused of anything. It  
9       was just a normal -- this was the interview, which  
10      gave him a bad feeling about even doing it.

11              And that's -- a lot of physicians are going  
12      to feel that way. They don't want to be put under a  
13      microscope like this. They want to help people,  
14      obviously, with addiction.

15              Not the best system, and something that we  
16      are going to advocate to change, I believe.

17              Senators?

18              SENATOR NOZZOLIO: Dr. Kunins, I believe it's  
19      your testimony, the written submission, that said  
20      that there were, to date, over 500 overdose  
21      reversals reported in New York City. And you  
22      believe that statistic may even be underreported in  
23      terms of its quantity.

24              I'm concerned, in the more rural areas of our  
25      state, and including our small cities, where

1 hospitals aren't accessible as they are in the major  
2 cities.

3 What availability do we have, or should we  
4 establish, for the reversal drug of most  
5 effectiveness, and how we deploy that?

6 You have a myriad of sheriffs, officers,  
7 State Police, local police departments. It's not  
8 one department like there is in New York City,  
9 primarily.

10 The State Police has just yesterday announced  
11 how the Division of Criminal Justice Services and  
12 the Office of Alcoholism and Prevention in our state  
13 is providing kits to State Police officers.

14 The question is: How much broader can we  
15 distribute this with a degree of certainty?

16 And what type of distribution would you think  
17 would make sense?

18 DR. HILLARY KUNINS: Thank you for the  
19 question.

20 So just to give you a sense of what we've  
21 been doing in New York City since late 2008:

22 As you know, the New York -- New York State  
23 has an overdose -- Opioid-Overdose Prevention Law  
24 passed in 2006, which allowed for the training of  
25 laypeople to recognize overdose and administer

1       naloxone, the medicine you're talking about.

2               In New York City, starting in late 2008, we  
3 began to fund and distribute intranasal form of the  
4 medicine, which is, I believe, what's being used  
5 with law enforcement, to train community members,  
6 either who themselves were drug users, and,  
7 therefore, at higher risk for either observing or  
8 experiencing an overdose; and, to their social  
9 networks, to their friends and family.

10              And we have -- in that 500, at a minimum, is  
11 really from that -- by and large, that work since  
12 2009, distributing through community-member work.

13              We believe that distributing through  
14 community networks provides, widely, an incredible  
15 opportunity to prevent overdose fatalities; that is,  
16 to intervene by someone who is close to the person  
17 or who is a first responder.

18              And we think that that gives, obviously, the  
19 person who may be experiencing an overdose another  
20 chance of reducing their risk; getting healthy in  
21 the future.

22              I don't -- we don't see much downside to the  
23 distribution.

24              It sounds like that's what your question was  
25 based on.

1           It's a safe medicine. It has some mild  
2 adverse effects that are temporary, not  
3 longstanding.

4           From the --

5           SENATOR NOZZOLIO: What does it -- pardon me.

6           What does --

7           DR. HILLARY KUNINS: People wake up in a --  
8 can wake up in a start, and can feel uncomfortable  
9 in the moment, but it passes really quickly.

10          SENATOR NOZZOLIO: Is there any special  
11 expertise necessary to administer?

12          DR. HILLARY KUNINS: So we liken it to other  
13 first-aid strategies, EpiPens, and so forth, that --  
14 think about defibrillators that are widely available  
15 in airports, and so forth.

16          So it is at that level of administration:  
17 easy to recognize, easy to administer.

18          If you don't have an opioid in your body, it  
19 doesn't have any ill effects. So if you get it  
20 wrong, in other words, it won't cause harm.

21          We also -- another concern that gets raised,  
22 is does it promote riskier drug use?

23          We have no evidence to suggest that that's  
24 true.

25          SENATOR NOZZOLIO: That was one of my

1 questions.

2 DR. HILLARY KUNINS: And then, finally, you  
3 referred to access to hospitals.

4 So, obviously, in New York City, with the  
5 density of hospital and health-care facilities,  
6 that's not been a huge issue for us; though, part of  
7 the training is to encourage laypeople, and,  
8 certainly, with first responders to call 911 to get  
9 the person in for further monitoring and assessment.

10 SENATOR NOZZOLIO: Thank you.

11 SENATOR BOYLE: Doctor, if could I just  
12 follow up with that:

13 One of the things -- I'm a former EMT. I've  
14 seen Narcan used like a miracle drug, but those with  
15 much more experience than I and others say that,  
16 sometimes, the patient who gets Narcan will wake up  
17 swinging and agitated.

18 I mean, is there a way to -- for a senior  
19 citizen, for example, to administer the Narcan  
20 nasally and just step away, or go into the next  
21 room? Is that a strategy?

22 DR. HILLARY KUNINS: So, certainly, that's  
23 part -- as part of the training is to make people  
24 aware of that possibility.

25 In our experience, now monitoring this

1 program for -- since 2009, we've not heard of sort  
2 of adverse effects from the people administering it  
3 ever, people getting -- I don't know, getting hit,  
4 falling down, or something like that.

5 So, that's not been part of our New York City  
6 experience at all.

7 SENATOR BOYLE: Great.

8 SENATOR NOZZOLIO: And, excuse me,  
9 Mr. Chairman.

10 Administering this drug does not, in your  
11 opinion, require any additional expertise than any  
12 normal EMT would have in terms of training, in any  
13 event? Is that fair to say?

14 DR. HILLARY KUNINS: No.

15 And, again, I encourage you to think of it as  
16 a first-aid procedure. Think about how widely we've  
17 been able to train laypeople in a variety of  
18 first-aid strategies: Splinting, CPR. Again,  
19 defibrillation that's available widely.

20 I think it's really at that -- in that kind  
21 of domain of procedures.

22 SENATOR NOZZOLIO: Certainly, it's a first  
23 step in our -- one of our segments which is  
24 treatment.

25 DR. HILLARY KUNINS: Yes.

1           SENATOR NOZZOLIO:  It's -- we want to make  
2           sure that the person survives this ordeal.

3           Doctor, from Phoenix House perspective,  
4           prevention, particularly for this age group seeming  
5           to fall into addiction with -- in very uncharted  
6           ways, what would you prescribe we could do as a  
7           state to focus on prevention measures?

8           DR. ANDREW KOLODNY:  So I appreciate that  
9           question.

10          All of you should have a graph.

11          And I think to understand really how to deal  
12          with this mess, it's important to understand how we  
13          got here.

14          And, this is the -- a CDC slide.

15          This graph is the CDC's chief speaking point  
16          about the epidemic that we're dealing with  
17          nationally, and I'll explain what we are looking at.

18          The green line represents opioid consumption  
19          in the United States.

20          And what you see is that, beginning in the  
21          late 1990s, prescribing of opioids began to take  
22          off.

23          The red line represents overdose deaths from  
24          painkillers, specifically.

25          And the blue line represents addiction to

1       opioids, represented by people coming in for  
2       treatment.

3               What the CDC is saying is, that this epidemic  
4       was really caused by the medical community; that as  
5       doctors began to overprescribe these medications,  
6       especially for conditions where they're probably not  
7       safe or effective, like long-term chronic pain, like  
8       low-back pain, that as the prescribing took off,  
9       it's led to paralleled increases in addiction and  
10      overdose deaths.

11              What the medical community and the dental  
12      community has inadvertently done, in many cases,  
13      we've gotten our own patients addicted, or, we've  
14      wound up stocking our patients' medicine chests with  
15      a hazard for their kids.

16              So, to bring this epidemic under control, we  
17      need, obviously, to treat people who have this  
18      disease, but we have to prevent people from getting  
19      the disease in the first place.

20              And I think the most important way to prevent  
21      people from getting this disease, and there are many  
22      different things that need to be done, but the most  
23      important thing is to get the medical community and  
24      the dental community to prescribe more cautiously.

25              SENATOR NOZZOLIO: That gets to the supply.

1           How about the demand?

2           How can we engage in enhancing prevention at  
3 the outset, by some type of encouraging certain  
4 types of behavior?

5           And I think that's -- certainly, you've got  
6 the medicine chest, anybody can open it.

7           DR. ANDREW KOLODNY: Yes.

8           SENATOR NOZZOLIO: You've got the pills in  
9 there, anybody can take them.

10          But, how do you prevent them from taking them  
11 in the first place?

12          DR. ANDREW KOLODNY: Well, I think the  
13 message that the medical community and the dental  
14 community needs to hear is very similar to the  
15 message that the public needs to hear, which is that  
16 these pills are, essentially, heroin pills.

17          If young people understood, when they're  
18 experimenting with drugs, that there -- that  
19 they're -- that this is not a soft drug; that this  
20 is a hard drug that could kill them, that can alter  
21 the rest of their life through addiction, if they  
22 understood that, they might be less likely to  
23 experiment with painkillers.

24          But, again, I think the real answer boils  
25 down to not exposing such a large percentage of our

1 population to a highly addictive drug. And that's  
2 where prescribers come into play.

3 SENATOR NOZZOLIO: That's an excellent point.

4 Thank you.

5 Doctor.

6 DR. BRADFORD GOFF: I want to add, too, that,  
7 I-STOP, which I think, tremendous legislation, and  
8 has had great effects on beginning to reverse  
9 diversion, has had other ramifications.

10 At my hospital, I was -- became responsible  
11 for really training physicians in I-STOP, and  
12 getting up before hundreds of people in medical  
13 staff meetings and beginning to talk to them. And  
14 they were not happy at having to take this on at  
15 all.

16 And most understood it, of course, to being,  
17 It's something I have to do before I send the  
18 patient out the door with the usual prescription of  
19 a narcotic, or whatever I'm prescribing; rather than  
20 thinking of it as something that I'm going to look  
21 at when the patient comes in the door, or when  
22 I accept the patient for the first time, or I may do  
23 on all of my patients, because it, number one, tells  
24 me about what medications they're using, what  
25 they're prescribing, and compliance habits are,

1 where they go to their pharmacies, what doctors they  
2 see.

3 Is that consistent with what they're telling  
4 me?

5 So I've trained, certainly, my doctors that  
6 I'm responsible for, to get this at the front end.

7 And the response is really very impressive.  
8 People really think this is a good system. They've  
9 learned a lot.

10 They actually talk to their patients.

11 And a lot of patients wander into this not  
12 knowing that accumulation of these drugs that they  
13 really don't understand, because doctors haven't  
14 really educated them well about it, really do have  
15 adverse effects and build up, and you get caught in  
16 something you don't want to get caught in, or you  
17 get sick, or you're at risk, or your children are at  
18 risk.

19 Once they find that out, they make changes.

20 So doctors I think become more respectful  
21 with a program like I-STOP.

22 The patients have become more respectful, in  
23 understanding what the -- why it's important to pay  
24 attention to narcotics, and why we need all of  
25 these, not only for what goes on on the street.

1           And everybody favors that among patients I've  
2       seen who are not addicts, is this is a good idea:  
3       We need to protect people, but, also, I need to be  
4       aware myself.

5           So it's -- I'm not sure people talk about  
6       I-STOP in terms of a good learning and clinical  
7       intervention, but that's what I've found.

8           SENATOR GOLDEN:   Doctor, are you still seeing  
9       at the -- in Lutheran Medical, is Oxycontin and --  
10      are the pill forms of the opiates still the largest  
11      number of visits --

12          DR. BRADFORD GOFF:   It's the -- partly, it's  
13      the demographic.   I think -- and, partly, where you  
14      are in Brooklyn.

15          Of course, there's Sunset Park, Bay Ridge,  
16      and so forth, and we know lots of deaths are  
17      occurring in that whole area, and have been  
18      occurring.   There's always been a lot of heroin in  
19      our parts of Brooklyn.

20          And the pills have been there, too.   They've  
21      been prescribed, not so much in our area of  
22      Brooklyn, but Staten Island is just across the  
23      bridge, and that's like an epicenter of prescribing  
24      of narcotics.

25          And then, in Suffolk County, not too far

1 away, as well, in terms of the map.

2 So it gets in and makes its way in.

3 I think there's tending to be less, but it's  
4 hard to tell. It's hard to yet tell whether it's  
5 affecting heroin use. It's still there.

6 I get very concerned, as everybody else  
7 would, with new medications like Zohydro, which is,  
8 you know, what are they thinking to approve yet  
9 another drug with no deterrents in it?

10 We're putting another Oxycontin out on the  
11 streets, potentially. We shouldn't be doing things  
12 like that.

13 So, as long as it's available, it's going to  
14 be there.

15 And just learning from the gentleman that  
16 will speaking about the effectiveness of diversion  
17 tactics, and are at work in the state of New York,  
18 and how there's still huge diversion of substances  
19 going on. It's still there, it's still dangerous,  
20 it's still the whole --

21 SENATOR GOLDEN: What's your capacity right  
22 now?

23 Your capacity, obviously, has increased over  
24 the last few years now, especially in the last  
25 two years.

1           What's your capacity today?

2           And what do you see happening --

3           DR. BRADFORD GOFF: I think our ER is just  
4 like the statistics. I mean, we've seen that, you  
5 know, threefold increase in people coming in with  
6 heroin overdoses over the last 10 years, and it  
7 still continues.

8           I mean, so the visits continue. That's not  
9 counting the people who die, of course.

10          And we know, from going to town-hall  
11 meetings, and so forth, in Brooklyn, more and more  
12 kids, more and more young adults.

13          In terms of availability of naloxone, I think  
14 it's great to put it in the hands of the first  
15 responders who are policemen and EMTs, but I think  
16 the real first responders are family members and  
17 friends, and even, sometimes, the victims  
18 themselves.

19          And I hope someday we're even talking about  
20 having, like an EpiPen for allergic reactions, that  
21 parents of adolescents and young adults actually  
22 have a naloxone pen in their home as a part of their  
23 emergency preparedness kit, because disasters do  
24 happen.

25          And in this day and age, maybe everybody

1       should have them, because you just don't know what  
2       your kid may get into.

3                SENATOR GOLDEN:  Thank the young people that  
4       are in the crowd.

5                There were a number of young people in and  
6       out of this room, and I want to thank them for  
7       coming to this today.

8                Last question for me on this issue:  
9       Marijuana.

10              Does anybody believe that marijuana is not a  
11       gateway drug, amongst our professionals here?

12              DR. ANDREW KOLODNY:  I don't think anybody  
13       knows whether or not it is a gateway drug.

14              We do -- you know, it's an interesting  
15       question related to today's topic, because when we  
16       look at the populations that are most affected by  
17       the epidemic today, we're talking about people from  
18       suburbs who are White and middle-class.

19              In areas, like Sunset Park, which were hit  
20       with a heroin epidemic in the 1970s, or in  
21       New York City's inner-city communities which are  
22       mostly African-American or Latino, in many of those  
23       communities, what we've seen since the late 1970s  
24       has been a decline in heroin use, and since the  
25       '90s, a decline in crack-cocaine use, but very heavy

1 marijuana use.

2 And when we look at the populations now that  
3 are dying of heroin overdoses, it's mostly White  
4 people.

5 So what we haven't seen, despite very heavy  
6 marijuana use in some of those populations, we  
7 really haven't seen heroin or crack coming back into  
8 those communities, which would be evidence to  
9 suggest that perhaps it's not a gateway drug.

10 It's a very complicated question.

11 There are very good reasons to be concerned  
12 about marijuana, especially legalization, but  
13 whether or not it's a gateway drug is -- I don't  
14 think we know.

15 SENATOR NOZZOLIO: 20 years ago, would you  
16 say that Oxycontin was a gateway drug?

17 DR. ANDREW KOLODNY: I wouldn't call  
18 Oxycontin a gateway drug because Oxycontin,  
19 oxycodone, is, basically, the same drug as heroin.  
20 It's basically -- it's essentially the same.

21 SENATOR NOZZOLIO: I have a question that  
22 I'd like to pursue with you, Doctor, regarding the  
23 pharmaceutical companies' potential willingness to  
24 engage in an education program.

25 Again, from your threshold statement, the

1 heroin addiction is a direct result of this use,  
2 I know they're in a dilemma.

3 But I wonder what your experience has been  
4 with the manufacturers of those products.

5 DR. ANDREW KOLODNY: So that's a terrific  
6 question, and I appreciate it.

7 I'm going to refer to this graph again.

8 Now, suppose you're the manufacturer of a  
9 product, where, as sales of your product are  
10 increasing, you're making enormous profits. It's  
11 associated with these horrible adverse outcomes,  
12 like addiction and overdose deaths. You're not  
13 going to be happy about that. Even if you don't  
14 have a conscience, it's not good PR for your  
15 company, but at the same time, you don't want to see  
16 your sales go down.

17 What the pharmaceutical companies are saying  
18 right now, in the context of an epidemic caused by  
19 too much prescribing of opioids, what they're saying  
20 is that: This green line can and should continue to  
21 go up because millions of people have chronic pain.  
22 But, if we teach doctors what they call "safe and  
23 effective opioid prescribing for chronic pain," we  
24 can make the red line and blue line go down.

25 And that's not really true.

1           I think, in many ways, the content of the  
2 education, the dominant education for physicians  
3 right now, they're being taught that if you monitor  
4 your patient very closely -- if you check their  
5 urine, if you check I-STOP -- all prudent things to  
6 do if you have patients on these treatments.

7           But what they're saying is, by doing these  
8 things, you can turn this into something that's safe  
9 and effective, that turns out rosy in the end.

10          And it doesn't work.

11          For example, if you start your patient with  
12 low-back pain on long-term opioids, and you're  
13 checking -- so they say, Well, check I-STOP.

14          So you check I-STOP and you see, four months  
15 into this, the young woman starts to visit multiple  
16 doctors, what that information is telling you is  
17 that the patient is now addicted.

18          The doctor can say, "Well, I guess I can't  
19 prescribe for you anymore," but the patient is left  
20 holding the bag. The patient now has that disease,  
21 and if they can't get a doctor to prescribe  
22 painkillers, they'll seek heroin.

23          So, the education for the medical community  
24 should be, and it's the message the CDC is trying to  
25 deliver, the message should be these are good

1 medicines for end-of-life care. They're good  
2 medicines when you use them on a short-term basis  
3 for severe acute pain; surgery, a severe accident.  
4 But we should not be putting patients on long-term  
5 opioids for common chronic problems.

6 And, unfortunately, the pharmaceutical  
7 industry does not like that message.

8 SENATOR CARLUCCI: Can I follow up with that,  
9 on a question?

10 When we talk about prescriptions, is there a  
11 move, or is there something that we can do, to  
12 really regulate that; that prescribers can only do  
13 it in limited dosage, or, that refills have to be  
14 done in person?

15 What would you say to that?

16 DR. ANDREW KOLODNY: That's a terrific  
17 question.

18 And I think one of the reasons we have this  
19 crisis today was really a failure of regulation; the  
20 federal government's part of failure to regulate the  
21 companies that were making these products.

22 Had they regulated those companies  
23 appropriately, had they applied the Food, Drug, and  
24 Cosmetic Act, and prevented them from promoting  
25 these medicines for conditions where they're

1 probably not safe or effective, we might have  
2 prevented this problem.

3 On the state level, and this is happening  
4 across the country, the state agencies that are  
5 supposed to protect the public from doctors who are  
6 prescribing recklessly are state medical boards.  
7 And across the country they have really failed to do  
8 that.

9 What should be happening, is that state  
10 medical boards should be proactively using the same  
11 data that's in I-STOP to notify doctors who are  
12 prescribing these medications in high doses, or in  
13 combination with drugs like Xanax, that  
14 "We're concerned about this. Don't do it."

15 And if they see that it continues, to,  
16 potentially, investigate them, to have medical  
17 boards possibly take licenses away from doctors  
18 before they kill patients, or before we have to put  
19 them in jail.

20 And we're not seeing that happen.

21 I think there is quite a bit that we could be  
22 doing here.

23 And, you know, at the beginning  
24 Chairman Boyle said that this would be an  
25 opportunity to suggest potential legislation.

1 I think one thing we could be doing right  
2 now, would be to say to doctors that have lots of  
3 patients on long-term opioids for chronic pain,  
4 perhaps doctors who have 10 or more patients on this  
5 treatment, where the data would tell you if you've  
6 got 10 patients on this treatment, that maybe 3 of  
7 them are addicted, we could be mandating doctors who  
8 have multiple patients on long-term opioids to be  
9 trained in prescribing buprenorphine.

10 We would be expanding access to this  
11 treatment exactly where we need it, where you've got  
12 the patients who are addicted.

13 And what's nice about that, is when a doctor  
14 finds out on I-STOP that the patient is doctor  
15 shopping, instead of firing the patient and saying  
16 "You're an addict, get out of my office," they would  
17 have the ability to treat that condition.

18 I believe a bill like that may have been  
19 introduced by Senator Maziarz last year.

20 I think MSSNY didn't like it because it  
21 mandated doctors who have with multiple patients on  
22 this treatment to do something. And MSSNY doesn't  
23 like when you mandate doctors to do anything.

24 SENATOR CARLUCCI: Well, Doctor, what's  
25 shocking to me, and I'm sure many of the members of

1       this panel, is we've traveled around the state and  
2       we've heard from people that are suffering with  
3       this. And we hear about, just recently, doctors  
4       prescribing an initial dosage of 75 pills.

5               Why is that continuing to happen when we have  
6       these highly educated professionals, you know,  
7       having the same data we have?

8               What's the disconnect there?

9               DR. ANDREW KOLODNY: Yeah, the problem is  
10       that the prescribers don't recognize that these are,  
11       essentially, heroin pills.

12              If the dentist understood that a Vicodin was  
13       a heroin pill, I don't think they'd give a teenager  
14       40 pills after a wisdom-teeth procedure. They might  
15       give them one or two. Or maybe they'd give them  
16       Advil.

17              The prescribers are underestimating the risks  
18       of these medications, in part, because they've been  
19       badly misinformed.

20              The reason the prescribing took off, the  
21       prescribing that caused this crisis, was because of  
22       a campaign to encourage aggressive prescribing, and  
23       that campaign had quite a bit of misinformation in  
24       it.

25              SENATOR NOZZOLIO: And there has to be some

1 responsibility here on the patient, too. The  
2 patient may not understand what they're getting.

3 I know that's a doctor's responsibility, but,  
4 think of yourself in a doctor's office here. He  
5 writes a scrip, she writes a scrip, and the patient  
6 goes on their merry way, not understanding the  
7 complexities of this medicine.

8 Not being educated by the doctor, I think  
9 that's the threshold, but doctors have limitations,  
10 too.

11 Educating patients may be another component  
12 of this.

13 Any of your -- the panel's thoughts?

14 DR. HILLARY KUNINS: I agree.

15 I just want to also reiterate a few things  
16 that Dr. Kolodny said.

17 I do think we need to raise awareness about  
18 risks of --

19 SENATOR NOZZOLIO: With patients --

20 DR. HILLARY KUNINS: -- of prescription  
21 opioids with patients.

22 As an example, in New York City, we ran a  
23 PSA, highlighting risks to a mom who lives in  
24 Staten Island, who perhaps we'll see tomorrow.

25 And that, again, following on the intense

1 marketing of these medicines as really being able to  
2 treat much more than they are claimed to treat, and  
3 underestimating the risks.

4 So, reeducating the public.

5 In addition, I want to just really reiterate  
6 what Dr. Kolodny said, is it is easier to write a  
7 prescription for Oxycontin right now than it is for  
8 buprenorphine.

9 And that imbalance of regulation is perhaps  
10 something that the state or federal government might  
11 be able to address.

12 In New York City, we've issued guidelines  
13 around what we call "judicious prescribing," to  
14 promote the kind of practice patterns that  
15 Dr. Kolodny is referring to.

16 For acute pain, 3-day supply of prescriptions  
17 is often enough, so the 75 pills is really,  
18 typically, not needed.

19 Reducing the -- or increasing awareness that  
20 long-term use of chronic opioids typically does not  
21 result in better function or in pain control, on  
22 average.

23 And, finally, these medicines are excellent  
24 for treatment of end-of-life pain. We do not want  
25 to see that reduced or access to that very important

1 treatment.

2 But I think raising awareness of doctors,  
3 other prescribers, who really, again, underestimate  
4 the risks; believe that they can pick out the  
5 patient for whom the opioid will be safe, is simply  
6 not true.

7 We overestimate our effectiveness in that  
8 area, and doctors need to be engaged.

9 And we in New York City have been engaging  
10 prescribers.

11 And the State, we would welcome State  
12 participation in that, as well.

13 SENATOR GOLDEN: When these kids are  
14 taking -- the doctor gives the Vicodin or the  
15 Oxycontin, the kids don't know they're taking  
16 heroin.

17 DR. ANDREW KOLODNY: Correct.

18 SENATOR GOLDEN: All right, so we're talking  
19 about doctor-patient education there.

20 We need to be able to educate the kids that  
21 are in our schools.

22 You guys all remember D.A.R.E.

23 Did this work when we seen that here, when  
24 those types of operations in our educational system,  
25 when we went into the schools?

1           Did you see a drop-off in the -- or not?

2           You know, be honest with us, did you see a  
3 drop-off in use of narcotics when you had these  
4 programs in our schools?

5           DR. ANDREW KOLODNY: Well, I don't recall  
6 D.A.R.E. focusing on painkillers. It may have  
7 focused on heroin.

8           And what we're all recognizing is that, the  
9 young people who are experimenting with painkillers  
10 and ultimately winding up addicted, and then maybe  
11 turning to heroin, when they're using those  
12 painkillers, they didn't recognize that they were  
13 using a drug similar to heroin.

14           It's -- there are, in terms of the evidence  
15 that's out there supporting social-marketing  
16 campaigns to prevent drug use, many of the campaigns  
17 that have been tried over the years haven't worked  
18 well.

19           For example, "Just Say No," which was  
20 Nancy Reagan's campaign, where the focus there was  
21 on modeling "Say No" behavior.

22           But there are effective social-marketing  
23 campaigns that can prevent people from picking up a  
24 drug in the first place.

25           It's very difficult, once they're already

1 using, to get them to stop through social marketing.

2 But, the effective campaigns are the ones  
3 that dramatize the negative consequences of use.

4 For example, the ad that New York City ran,  
5 I thought was a very good ad, which showed somebody  
6 using painkillers and dying of an overdose.

7 SENATOR GOLDEN: What about the educational  
8 system in our schools, you don't believe that we  
9 should go into our schools at the early grades of  
10 third -- three -- in the third grade, fifth grade --  
11 fourth grade, fifth grade, sixth grade, and be  
12 teaching and laying this out?

13 DR. ANDREW KOLODNY: I think that would be a  
14 very important thing to do.

15 SENATOR GOLDEN: So a D.A.R.E. program,  
16 something similar to a program -- not D.A.R.E., but  
17 something similar to a D.A.R.E. would work?

18 DR. HILLARY KUNINS: So my awareness of  
19 the -- I just want to summarize a few points about  
20 the science behind those programs.

21 The D.A.R.E. program has been studied, and  
22 actually not shown to be terrifically effective,  
23 unfortunately, in reducing drug-taking behavior.

24 Now, again, it did not focus on prescription  
25 opioids. It predates that.

1           The science behind those programs are  
2 typically best when the programs focus broadly on  
3 social connectedness, family support, all the things  
4 that we know work to protect young people from risk.

5           So those programs ought to be, in my view,  
6 broad-based focus on integration into communities  
7 and families, and around all kinds of risk-taking  
8 behaviors.

9           So to -- it is important to raise awareness  
10 about this specifically with school children, but,  
11 there are educators and -- who are well-informed  
12 about these strategies. And we should look to the  
13 science.

14           Again, not the medical evidence, but the  
15 educational evidence, to formulate those programs  
16 thoughtfully.

17           SENATOR GOLDEN: What are our public schools  
18 doing?

19           DR. HILLARY KUNINS: So I would defer to my  
20 colleagues from the City DOE.

21           There are -- there is health education  
22 happening in all the schools, and, there is a  
23 standard curriculum.

24           SENATOR GOLDEN: Thank you.

25           SENATOR BOYLE: I think we're going to have

1 to wrap up this panel.

2 I appreciate your time very much.

3 Any final words or thoughts that you wanted  
4 to say and didn't get a chance on our question?

5 DR. ANDREW KOLODNY: Just something to  
6 encourage you to work on, as you're going around the  
7 state.

8 And, I'd also like to just thank you very  
9 much for trying to really understand this problem  
10 and how to address it.

11 I think we have to recognize that the  
12 populations that are most affected right now are  
13 very different from the populations previously  
14 affected by addiction.

15 The crack-cocaine epidemic of the '80s and  
16 '90s disproportionately affected people who are low  
17 income and minority, and had Medicaid. Similarly,  
18 in the '70s.

19 The people affected most today are people who  
20 are working-class and middle-class who have  
21 commercial insurance.

22 And our whole system right now, our  
23 addiction-treatment system, is very much focused on  
24 serving Medicaid populations.

25 I think it's very important for you to sit

1 down with some of the commercial insurers, to make  
2 sure that we're funding the right treatment  
3 programs; that we've got the right models out there.

4 SENATOR BOYLE: We are doing that.

5 And I can tell you that insurance is going to  
6 be a big part of this legislative package, and the  
7 question of what medically necessity -- the  
8 "medical necessity" is.

9 We're dealing with, not only health-care  
10 professionals, but also insurers, as well, to see if  
11 we can get an agreement by most.

12 And I will point out, I'm sorry, we've been  
13 joined, obviously, by Senator Carlucci, who, along  
14 with Senator Nozzolio, is the Vice Chair of the  
15 Task Force.

16 Thank you, gentlemen.

17 That is a big issue.

18 Thank you very much.

19 HENRY BARTLETT: I just wanted to point out,  
20 briefly, talking about "medical necessity," that,  
21 frequently, where a patient winds up in treatment  
22 depends on what door they happen to enter.

23 And, you know, we've heard people say for  
24 years that there's no wrong door to treatment.

25 I think there's a lot wrong doors to

1 treatment, and some people end up in a level of care  
2 that's inappropriate for them.

3 OASAS is working now on a patient-placement  
4 instrument and protocol called "Locator 3."

5 And, you know, Locator 3 is going to be used  
6 as part of Medicaid managed care.

7 The managed-care companies are going to be  
8 required to use this to determine the appropriate  
9 level of care, and to use it for utilization review.

10 Well, I say, if it's good enough for the  
11 poorest people among us on Medicaid, it ought to be  
12 good enough for those of us who have health  
13 insurance.

14 And it would be good for the health-insurance  
15 companies to use some version of Locator 3, or a  
16 similar evidence-based instrument, that places  
17 patients at the appropriate level of care to begin  
18 with, so we don't wind up with opiate-addicted  
19 individuals being seen in a level of care where they  
20 have a less-than-optimal chance of achieving  
21 recovery.

22 SENATOR BOYLE: Wonderful.

23 Any questions from the audience for our  
24 panel?

25 I didn't see any written.

1 Oh, yes.

2 LIZ BARARDI [ph.]: Hi. My name is  
3 Liz Barardi [ph.], and I'm here both representing my  
4 son Carter, who you described completely. He passed  
5 away January 12th of an overdose of heroin.

6 He had back surgery and was prescribed  
7 fentanyl patch, after I told the doctor he had a  
8 predisposition to addiction.

9 And it was two months before I understood  
10 what was in that patch.

11 And, he was denied twice by MVP, Value  
12 Options, inpatient treatment that three Columbia  
13 doctors insisted he needed.

14 I got him that help, but, he ultimately died  
15 three days into a sober home.

16 And I'd like to ask, I know it's an extension  
17 of what you're talking about, but, it is an industry  
18 that is out of control.

19 There's no oversight.

20 It's a step down for many people.

21 And it's actually, for many people, the only  
22 place they can go to get away from their triggers,  
23 and to have their addiction addressed on an  
24 outpatient level.

25 And I'm just wondering, is anybody -- it's a

1       lifelong disease.

2               Is anybody considering regulations of sober  
3 and recovery homes? Standards that people can rely  
4 on in a database?

5               SENATOR BOYLE: Yes. We actually just passed  
6 legislation like that in the Senate -- on the Senate  
7 committee, recently, on regulation of sober homes.

8               It has been a longtime problem.

9               I know Senator Zeldin from Long Island has a  
10 bill on that, and it's something that we can -- we  
11 should try and address.

12              The problem as, as I'm sure you've heard, the  
13 state agencies are pointing at the town, who's going  
14 to regulate it.

15              No, it has no treatment per se in some of  
16 these sober homes.

17              What I experienced in the district  
18 I represent, is we had people buying houses, taking  
19 in 30, 35 people with addiction problems, taking  
20 their social-services money and paying off the  
21 mortgage in two or three years, and then selling the  
22 house and kicking everyone out.

23              They ran it just to make the money. They  
24 were not there to help the people.

25              LIZ BARARDI [ph.]: The stories I've heard,

1 now that we've started safe sober living, from  
2 across this country, but, I'll talk about New York  
3 today:

4 One mother, they wouldn't take her son out of  
5 detox because he was on Suboxone. They gave her a  
6 list of other homes. And, the manager was drunk  
7 when she arrived to visit it.

8 A young woman told me that the manager was  
9 sexually harassing her.

10 My son's case, the manager had no car. He  
11 used my son as his taxi driver, and to visit his  
12 friends, and so forth.

13 And the -- I'm not sure if he's a co-owner or  
14 he's the head of it, I found out was arrested in  
15 2009 for selling-- while on probation for another  
16 crime, for selling heroin, Suboxone, and other  
17 opiates from his own driveway.

18 And while still on probation, in 2011, this  
19 man was managing sober homes.

20 I mean, we have a problem.

21 SENATOR BOYLE: No question.

22 Well, we're very sorry for your loss.

23 Thank you for coming today.

24 LIZ BARARDI [ph.]: Well, yes, but, thank  
25 you.

1           And I hope that, really, all these agencies  
2 can come together.

3           And you are an amazing panel.

4           So, I'm grateful to be here today and hear  
5 you.

6           SENATOR BOYLE: Thank you.

7           In the back?

8           MATT CURTIS: I'm Matt Curtis. I'm the  
9 policy director at Vocal New York. We're a  
10 grassroots advocacy group that does work on behalf  
11 of people affected by drug use, HIV, and massive  
12 incarceration.

13           First, a quick "thank you" to all the  
14 Senators here today, who all of you voted in favor  
15 of a bill that, hopefully, will become law very  
16 soon, that Senator Hannon sponsored, to allow much  
17 greater community access to naloxone.

18           I think it's through standing-order  
19 prescribing. I think it's a pathway that we've seen  
20 work in other states, that will be hugely beneficial  
21 for the Phoenix Houses of the world, and other  
22 things like that, making this important medication  
23 more available.

24           Now a question, real quick:

25           One thing that hasn't been discussed here,

1 but I think really needs to be considered as part of  
2 the public-health response to this, is syringe  
3 access.

4 And, you know, we've had 20-plus years of  
5 legal syringe access in New York State. We allow  
6 sales through pharmacies.

7 And, you know, what we've seen is, not only  
8 has that been incredibly effective at reducing  
9 HIV transmission, reducing hep C transmission, it's  
10 been a pathway for people to get into drug  
11 treatment, into primary medical care, into other  
12 kinds of things they need. And, has reached people  
13 that wouldn't otherwise get access to those  
14 services.

15 So, you know, it's become part of the  
16 mainstream continuum of care when you're dealing  
17 with opioid or other drug dependency.

18 So the problem is, we're now, with this new  
19 rise in heroin use around the state, we're starting  
20 to see, for example, through hepatitis C incident  
21 surveillance, new pockets of infections among people  
22 around the state.

23 And, we've got major gaps in access in parts  
24 of Brooklyn, in Queens, in the city, and, certainly,  
25 in Long Island and most of upstate, where there are

1 very few providers.

2 So I just kind of want to see if the panel or  
3 anyone here has any thoughts about including that in  
4 the, kind of, package of things that this Task Force  
5 will come up with in the future?

6 DR. HILLARY KUNINS: Thanks, Matt.

7 So that -- I would like to just state our  
8 City support, also, for the need for syringe access  
9 as part of the continuum of care.

10 As you know, we at the City have oversight,  
11 and fund, participate in the funding, of the syringe  
12 access programs in New York City.

13 And, that is an area that is very important  
14 in engaging folks who may not come into other kinds  
15 of care.

16 The syringe-access programs do a lot of  
17 community outreach, and are real experts in helping  
18 people seek whatever services they are ready for at  
19 the time: distributing naloxone, encouraging people  
20 to get tested for hepatitis C, engage in other  
21 risk-reduction behaviors.

22 SENATOR BOYLE: Needle exchange: yes? no?

23 DR. ANDREW KOLODNY: Yes, but I will say the  
24 equation was easier when we had an HIV epidemic and  
25 when the heroin wasn't as good; and, so, just about

1 everybody was -- most people were injection-users,  
2 and we realized that giving out clean needles wasn't  
3 going to turn people into heroin addicts.

4 It's more -- it is a little more complicated  
5 today.

6 When the majority of people are beginning  
7 this addiction with pills, crushing pills, and when  
8 they're snorting heroin, there is a fair question  
9 about whether easier access to needles could  
10 encourage a transition from intranasal use to  
11 injection use.

12 I do however think, overall, they're a very  
13 good thing, and they're an opportunity to engage  
14 with users, and to test them for hepatitis C.

15 I don't know that we've got evidence -- I  
16 would ask Matt -- that syringe exchange is working  
17 all that well on reducing hepatitis C.

18 It's worked very well with reducing  
19 HIV infections, but the virus is different. It's  
20 much easier to get hep C. Even if you're not  
21 sharing needles, you're just sharing works.

22 SENATOR BOYLE: Just a quick question before  
23 we -- I think we have a debate here:

24 But, is there any evidence of -- are you more  
25 likely to overdose with a needle versus snorting it?

1 DR. ANDREW KOLODNY: Yes.

2 SENATOR BOYLE: You are?

3 DR. ANDREW KOLODNY: You are.

4 SENATOR BOYLE: Okay.

5 DR. HILLARY KUNINS: So just -- I think  
6 Andrew raises some excellent points.

7 One thing I just want to add, so as to not  
8 leave you with this place, is:

9 My clinical experience from the '90s, in  
10 The Bronx, is that many, many people came into  
11 methadone treatment having never injected.

12 And this was actually, I think, in many ways,  
13 a great success story of the syringe-exchange  
14 programs and harm reduction, generally; which is,  
15 they were the key awareness-raisers about risks of  
16 injection.

17 And that was a great success story, that not  
18 more of my patients had HIV, and had, in fact, never  
19 injected.

20 And we, obviously, should take from those  
21 lesson, aggressively, as we're encountering this new  
22 epidemic.

23 SENATOR BOYLE: Thank you.

24 DR. HILLARY KUNINS: And we need to work on  
25 hep C education, and thinking about risk reduction.

1 Matt may have more.

2 SENATOR BOYLE: Thank you very much.

3 One last question for the panel, please?

4 The gentleman in the back.

5 JEREMY THOATE [ph.]: Hi. My name is

6 Jeremy Thoate [ph.] -- sorry.

7 My name is Jeremy Thoate. I'm actually an

8 educator from Long Island, from suburbia.

9 And just a couple of points I think you  
10 should hear.

11 Number one: Kids in suburbia, and  
12 everywhere, they know that drugs work; they work for  
13 the purpose that they take them.

14 And more and more kids in suburbia, I can  
15 say, are taking them to dull the pain; whether it's  
16 the stress they have in their lives, whether it's  
17 the issues with family, whether it's, you know, all  
18 different things that are going on in society.

19 So -- so, uh, you know, those things are very  
20 important.

21 So to piggyback on the point before: More  
22 needs to be done in the educational system. Nothing  
23 even close to enough is being done.

24 And the D.A.R.E. programs are not being --  
25 have not, and are not, effective.

1           And would I just urge this panel to consider  
2 putting more money into community coalitions that  
3 are popping up all throughout the state.

4           They are -- they give us the ability,  
5 locally, to work together in our communities, with  
6 the specific community issues that are going on in  
7 each specific community.

8           And that may be a very good way to get the  
9 attention of that community.

10           [Microphone not working.] Parents aren't  
11 educated, and they don't have the skills anymore to  
12 deal with this.

13           SENATOR BOYLE: Thank you very much.

14           And I do believe that our Task Force  
15 recommendations will be more of a holistic approach  
16 in that way.

17           Panel, thank you very much. We truly  
18 appreciate you taking your time.

19           And the next panel will be regarding  
20 law-enforcement issues and community involvement:

21           Bill McGoldrick;

22           Linda Sarsour;

23           Rabbi Feuerman;

24           A representative of the District Attorney's  
25 Office here in New York City, and an undercover

1 investigator.

2 [Pause in the proceeding.]

3 [The proceeding resumed, as follows:]

4 SENATOR GOLDEN: We're going to start.

5 Again, I'm going to point -- I'm going -- a  
6 lot of young people in the room, again, I want to  
7 point out. Thank you very much for being here and  
8 being part of this.

9 I just want to ask, and don't be embarrassed  
10 by it, but -- because a lot of people --  
11 professionals don't -- aren't aware of it:

12 Anybody here recognize that Vicodin was  
13 heroin?

14 Anybody here did not recognize Vicodin was  
15 heroin when they were growing up?

16 Right?

17 How many? Be honest, be honest. Come on,  
18 let's go.

19 Right?

20 So when did you -- well, we're going to ask  
21 some questions later.

22 When did you figure out Vicodin was heroin?

23 Okay?

24 Linda, I'd like to, real quick, what's going  
25 on in your community?

1           And if you can, please, just briefly tell me  
2 what happened last week.

3           LINDA SARSOUR: So, thank you, my  
4 State Senator, Marty Golden, for having me here.

5           So last -- well, up -- starting, probably,  
6 for the past, about, 15 months, we've already had  
7 about 9 young men in our community, between  
8 ages 17 and 23, up to the last one last week, a  
9 young man who died of overdose. All these young men  
10 died from overdose.

11           About three months ago, we had two young men,  
12 one passed away.

13           One was at Lutheran for quite a while,  
14 originally from Morocco. He's out now, and  
15 potentially -- trying to help groom, potentially,  
16 having him be some sort of spokesperson as someone  
17 who, pretty much, went to death, and back.

18           And we support this initiative and this  
19 Task Force, and the impact that it has, really, on  
20 community, not just on the people who are kind of on  
21 the path to addiction or already there.

22           And what we support, also, is a three-pronged  
23 approach, which includes the enforcement piece,  
24 includes the educational piece, and it also includes  
25 an alternative -- alternative programs and

1 opportunities.

2           What we hope to see, also, is that, you know,  
3 in a place like Bay Ridge, and with this particular  
4 population, we want to see, you know, multicultural  
5 and bilingual assistance. And I'm sure that's  
6 something that would be helpful to other  
7 communities, as well, especially looking at the new  
8 populations of folks that are being affected --

9           SENATOR GOLDEN: Is this community the  
10 Arab-American community?

11           LINDA SARSOUR: Yes.

12           SENATOR GOLDEN: Are very new in the past  
13 year or so, you'd say that --

14           LINDA SARSOUR: I would say two years now --

15           SENATOR GOLDEN: Two years.

16           LINDA SARSOUR: -- that we've been at least  
17 hearing about it.

18           And I think the issue around it is that, you  
19 know, these are -- like you said before, and others  
20 on the panel have said, this is not about, you know,  
21 these, like, low-income, you know, kids from the  
22 streets. These are from good families. You know,  
23 hard-working families. And their parents have no  
24 idea. They don't have bad parents. Their parents  
25 don't know what the signs are, to understand --

1           SENATOR GOLDEN: I'm going to go to the Rabbi  
2 now.

3           Rabbi, are you similar?

4           Up in your communities and around the course  
5 of the city, what are you seeing, Rabbi?

6           RABBI SIMCHA FEUERMAN: I think that we're  
7 seeing plenty of prevalence.

8           We have, at OHEL Children's Home and Family  
9 Services, of which I'm director of operations, we  
10 receive foster-care placement from mothers that test  
11 positive, you know, at birth from drug abuse.

12           At our outpatient centers, we have  
13 individuals coming in for treatment.

14           I think that there are two points, I would  
15 say, that are important:

16           I think, one, is I actually am also president  
17 of an organization, Orthodox Mental-Health  
18 Professionals. And I sent out an e-mail to the  
19 listserv, asking for people's experience, and  
20 polling them.

21           And one of the common things that we found  
22 is, I think that abuse starts oftentimes in youth,  
23 through experimentation, through very innocent  
24 experimentation, because these are not found on  
25 seedy street corners. These are found in the family

1 medicine chest.

2 So, clearly, early intervention, and  
3 culturally-sensitive intervention, is extremely  
4 important.

5 You know, in a parallel fashion, our  
6 organization has done a lot of work in the last  
7 10 years in terms of sexual abuse in the Orthodox  
8 community.

9 And it's a very similar idea, that if you  
10 want to help educate a community, an insular  
11 community, you really need to understand their  
12 underlying beliefs, their assumptions, how they see  
13 themselves, and talk to them in a way that they'll  
14 get the message; because, otherwise, you know, you  
15 provide general education, but they don't think it  
16 applies to them, or in some way, it doesn't apply to  
17 them, the way it's being said.

18 So we do feel that early intervention and  
19 education is very key, and that it should be  
20 culturally sensitive.

21 SENATOR GOLDEN: Thank you very much.

22 I want to go over to Mr. McGoldrick.

23 The -- looking at what we're hearing between  
24 the communities across Brooklyn and across the city  
25 of New York, across the state of New York,

1       unfortunately, I get killed in my own community when  
2       I say this, but it's true, Brooklyn is the capital  
3       of Medicaid fraud, Medicare fraud, welfare fraud,  
4       insurance -- car-insurance fraud.

5               And, we're moving into, number one, into two  
6       other areas, and that's drug diversion, and it seems  
7       to be heroin death and overdosing death.

8               Since we have concentrated areas, we know  
9       that we are the capital of -- in the nation on a  
10       number of these different issues.

11              Isn't there a way of coming in here and going  
12       and looking at these points across the state,  
13       putting our efforts into overlays -- technology  
14       overlays, and understanding, not just where these  
15       frauds are going, but, specifically in the drug  
16       diversion, and specifically in the pain doctors, and  
17       specifically in the doctors that are selling or are  
18       moving these prescription, and the pharmacies that  
19       are selling these?

20              Can you help me out on that one?

21              WILLIAM MCGOLDRICK:  Yes.

22              Thank you, Senator Boyle, and  
23       Senators Nozzolio and Golden, for the opportunity to  
24       speak to you today.

25              I'm an attorney with 32 years' experience in

1 New York State, but I'm also a retired detective  
2 sergeant from the New York State Police.

3 For the last 20 years, I've been providing  
4 Medicaid-fraud investigative and audit services to  
5 the United States Health and Human Services, Center  
6 for Medicaid and Medicare Services, New York State  
7 Department of Social Services, New York State  
8 Department of Health, New York State Department --  
9 or, New York State Office of Medicaid Inspector  
10 General, and New York City HRA.

11 I'm accompanied here today by a confidential  
12 consultant who is a retired NYPD narcotics  
13 detective, who has worked with me throughout those  
14 20 years in a very specific area.

15 We will refer to him as "The Detective."

16 He is an expert in drug diversion. Our  
17 efforts have been focused in that area for the  
18 state of New York.

19 The doctors who spoke this morning very well  
20 established the proposition that pills and heroin  
21 are hand-in-hand.

22 The supply of pills that comes into the  
23 problem, that creates the problem, comes from the  
24 medicine cabinet, which education and awareness is a  
25 key.

1           The Detective, actually, this morning, over  
2 coffee, said: Why don't the Senators talk about  
3 having a piece of paper handed to people, with the  
4 prescription, and say, "Don't keep this in your  
5 medicine cabinet."

6           You know, think Eddie Haskell coming to visit  
7 your house and asking to use the bathroom. When he  
8 knows the pills are worth \$40 apiece, what's he  
9 going do? You know, he's going to visit everybody's  
10 bathroom.

11           So as The Detective was saying, that's a very  
12 quick fix, maybe. A little piece of paper, "Find a  
13 secure place to put this."

14           That's number one.

15           Number two, for years, I've been trying to  
16 get a straight answer on why we can't get a better  
17 disposal method.

18           You know, in the old days they used to flush  
19 it. It's dangerous stuff, but it's dangerous for  
20 the environment.

21           Now people don't know where recovery centers  
22 are. And people are not going to get on -- in their  
23 car or in the subway and go to some disposal center  
24 to get rid of the stuff.

25           So that's one supply: the medicine cabinet.

1           The AMA seems to think that 70 percent of the  
2 illicit trade, the stuff that's on the street that's  
3 being abused, is coming out of the medicine cabinet.

4           I don't believe that.

5           I believe that the majority of the illicit  
6 painkiller pills that are causing the problem now  
7 are coming out of drug diversion. Around I have a  
8 crystal clear example of that, and it's in the form  
9 of two federal cases.

10           Within 18 months, the United States  
11 Attorney --

12           SENATOR GOLDEN: If you can, when you're  
13 doing that drug diversion, [unintelligible] you also  
14 see how that leads into heroin?

15           WILLIAM MCGOLDRICK: Right, and it's --  
16 they're hand-in-hand, obviously, from what the  
17 doctor said.

18           The United States Attorney for the Southern  
19 District of New York, Preet Bharara, and it's in the  
20 package I gave you, announced two federal cases: one  
21 in July of 2012, and one only two months ago.

22           And in both cases, the New York State  
23 Medicaid program, inadvertently, and through fraud,  
24 supplied \$500 million worth of pills in each case.

25           So it's a billion dollars worth of

1 prescription painkiller pills that hit the street  
2 because the New York State Medicaid system was being  
3 defrauded.

4 Now, Social Services, Health Department, and  
5 Medicaid Inspector General, all those years, there  
6 have been successive contracts for Medicaid-fraud  
7 investigators.

8 And, basically, they're retired members of  
9 NYPD, multiethnic, and they get out and they  
10 investigate the bad doctors.

11 And The Detective can tell you in a moment  
12 that that's actually a very fruitful way to do it.  
13 You get the word off the street. You know,  
14 "Where do I go to get a prescription for Percocet?"  
15 or something like that.

16 And it's a very direct way of dealing with  
17 it. These are licensed professionals.

18 Unline heroin, which is coming across the  
19 borders from many different countries, diversion of  
20 prescription painkiller pills is -- involves -- it  
21 involves professionals; there are pharmacies and  
22 doctors.

23 It's a closed system, so you can take steps.

24 Every bad doctor that you kick out of the  
25 system who's prescribing a million dollars worth of

1       this stuff a year is going to save -- it's going to  
2       save lives, and save the state a million dollars.

3                SENATOR GOLDEN:   The doctor pointed out  
4       earlier this morning about the -- how they were --  
5       the diversion, especially in the -- let's say the  
6       pain health centers.

7                Isn't there a way that we can do technology  
8       overlays to find out which health centers are doing  
9       the prescriptions, and what you can find out who  
10      they addicted, and how they're going into heroin,  
11      and where the heroin's coming in -- and how is the  
12      heroin coming into Brooklyn?

13               WILLIAM MCGOLDRICK:   The New York State  
14      Department of Health and the New York State Medicaid  
15      Inspector General and the New York Attorney General  
16      have access to the "MMIS" system, which is the  
17      Medicaid Management Information System; and, the  
18      Fraud and Abuse Management System that sits on top  
19      of that.   That's an IBM product.

20               They can search for every prescription and  
21      patterns of prescriptions that were written.

22               You can look for the doctor in The Bronx  
23      who's overprescribing and the stuff is all being  
24      filled in Suffolk, which is an actual case.

25               They can look for a pediatrician who, maybe,

1 somebody stole his pad. All of a sudden, this  
2 pediatrician is ordering oxycodone.

3 They've got all these filters  
4 [unintelligible] that they can do, but, they need  
5 the staff.

6 Up until September 30, 2011, there were  
7 60 people working on this kind of stuff, on  
8 outsourced contracts.

9 Those contracts ended on -- at the end of  
10 September. Within 10 months, the federal  
11 U.S. Attorney had its first \$500-million case.

12 There was a limbo period where those  
13 contracts didn't exist at all. And at the end of  
14 that period, when they just started to come up  
15 again, there was the other \$500-million case.

16 Instead of 60 people, they've got 6.

17 So that's something that, you know, the  
18 Senators can address, is going back to OMIG and find  
19 out why that contract -- or those -- there's three  
20 of them, why aren't they being used?

21 They're contracts for auditors, nurses,  
22 computer people, and investigators.

23 I don't know if it's for lack of funding.

24 If it is for lack of funding, I can tell you  
25 this: For 20 years, it's been calculated that it

1 returns at least 10-to-1 on the money.

2 So if it's five million dollars a year,  
3 they're saving fifty.

4 The Detective, I wanted him to tell you about  
5 something that's happening now, where you have these  
6 illegal pharmacies popping up.

7 We just spoke about this, over coffee.

8 Drug diversion has so many ramifications,  
9 that it needs a lot of studying.

10 In addition to putting the dangerous pills on  
11 the street, part of the act of a criminal diversion  
12 ring is to sell the medication back to a pharmacy,  
13 who buys it at 10 cents on the dollar, and keeps  
14 selling it.

15 Now, it doesn't have to be painkillers. It  
16 could be HIV meds.

17 One of the most despicable things I've ever  
18 heard was the New York District Attorney -- Attorney  
19 General case. They arrested two pharmacists who  
20 were buying the lifesaving AIDS/HIV meds from the  
21 AIDS patients before they took it.

22 You know, there's a special place in hell for  
23 people like that.

24 But, I'll ask The Detective now to explain  
25 what's going on in certain areas of the city, and

1       it's kind of part and parcel with that, where  
2       legitimate medications are coming out of the  
3       pharmaceutical supply chain and then being  
4       dangerously reintroduced.

5               "THE DETECTIVE": [Not on video; just audio.]

6               Good morning, Senators, and thank you for  
7       having me here today.

8               SENATOR GOLDEN: The mic closer, please.

9               "THE DETECTIVE": [Not on video; just audio.]

10              This is an education thing that -- you know,  
11      like the first committee said, people need to be  
12      educated.

13              I can go out all day and get you whatever you  
14      want, but if you don't educate the public, it's  
15      going to keep happening.

16              And, there are pharmacies out there that are  
17      buying prescriptions; they're buying your  
18      medications back.

19              We have an area in The Bronx where bodegas  
20      are getting into the game now. They're buying  
21      medications from people and reselling it, or  
22      shipping it out of the country.

23              It's a big epidemic.

24              You know, it needs to be -- we also need to  
25      educate people on how to get rid of their

1 medications when they don't use it.

2 Not everybody's addicted. There are people  
3 that are -- legitimately have their medications, but  
4 they need to get rid of it, and there's no way of  
5 getting rid of it.

6 SENATOR GOLDEN: Well, stay on that -- the  
7 pharmacy; the bogus pharmacies.

8 I haven't -- I got to tell you, I'm getting  
9 an education here myself here this morning.

10 Where are they?

11 And how do we know they're out there?

12 And how do we --

13 "THE DETECTIVE": [Not on video; just audio.]

14 They're in all the boroughs. They're in all  
15 our boroughs.

16 SENATOR GOLDEN: [Unintelligible] you're  
17 talking about the people that are set up that are  
18 inside the operation that are workers within the  
19 operation? Or there's actually owners of the  
20 pharmacies that are doing this?

21 "THE DETECTIVE": [Not on video; just audio.]

22 It's -- there are people that stand outside  
23 the pharmacies that are steers.

24 SENATOR GOLDEN: Okay?

25 "THE DETECTIVE": [Not on video; just audio.]

1           Okay?

2           Sometimes they work with the pharmacies,  
3 sometimes they don't work with the pharmacies.  
4 Sometimes they're on their own. But sometimes they  
5 work with the pharmacy.

6           We have doctors that take money to write you  
7 a prescription for painkillers.

8           SENATOR GOLDEN: We've already said that.

9           "THE DETECTIVE": [Not on video; just audio.]  
10 Right.

11          So, you know, it's an epidemic, and people  
12 need to be educated on it; on how not to do that,  
13 and how, you know, to prevent from getting caught up  
14 in that.

15          SENATOR GOLDEN: Wouldn't the audits and the  
16 overlays -- technology overlays, wouldn't that show  
17 where the doctors are, again with the I-STOP, and  
18 with the shopping of -- the doctor shopping, and  
19 where there's more prescriptions coming out of a  
20 certain borough or certain town, village, or city?

21          WILLIAM MCGOLDRICK: Yes, the I-STOP will  
22 prevent the overprescribing part of the illicit  
23 supply.

24          What the I-STOP doesn't stop is this criminal  
25 diversion.

1           And very quickly, the way it works is:

2           They borrow a Medicaid card from somebody.  
3       You know, they may go to a men's shelter and give  
4       the guy a \$20 bill, and take his card. They get a  
5       prescription that was stolen.

6           In your package, there's a picture of a stand  
7       on the Grand Concourse, where all they did, all day  
8       long, was buy stolen blank prescriptions, and then  
9       they would sell them to the people on these teams.

10          And there's a picture in there, in that  
11       package, of a scrip writer. All she does is sit  
12       down with them and write the prescription for what  
13       they want. That's her job, and she gets paid for  
14       that.

15          And then there's a picture of the man who  
16       escorts the people into the pharmacy, sees that they  
17       get the prescriptions filled, puts them in his  
18       shopping bag, and then they move down  
19       Tremont Avenue, in that case, to the next pharmacy,  
20       and the next pharmacy.

21          That criminal-diversion team is not going to  
22       be stopped by I-STOP. It's not going to show up.

23          I-STOP is a very good program, a very  
24       worthwhile program, but that's only one segment of  
25       the illicit supply.

1           The three major areas, I believe, are:

2           Number 1: Criminal diversion of prescription  
3 drugs.

4           And we happen to have a penal-law statute for  
5 that, which is a very good statute. It has felony  
6 levels, so it's serious.

7           I think the next is the -- the theft out of  
8 the medicine cabinet. I think that's in the -- not  
9 a volume, that's next.

10          And the last is the doctor shopping.

11          But I want The Detective to tell you about  
12 the non-professional locations that are getting into  
13 the pharmacy business now.

14          "THE DETECTIVE": [Not on video; only audio.]

15          We have a certain amount of bodegas in our  
16 Bronx area that are also getting into it. They're  
17 buying the prescription drugs from people, and  
18 they're selling it or they're sending it away.

19          Sometimes a big part of that is Viagra,  
20 LEVITRA, they're selling it out of their bodegas.

21          You know, you have eight bodegas in a  
22 two-block area. You know, they're not all selling  
23 groceries, you know?

24          And, you know, we don't know if they're  
25 involved with pharmacies, but that's part of it.

1           WILLIAM MCGOLDRICK:  And the point to take  
2 away from that, is there's so much money in this  
3 stuff that it's a rapidly growing enterprise.

4           When it's \$40 a pill, 180-count pill supply,  
5 according to the federal case, by the time they get  
6 finished selling it up the chain, that one  
7 prescription I got filled could be worth anywhere  
8 from 6,000 to 18,000 dollars.

9           And the way I described a criminal-diversion  
10 team, you can see it's not hard to assemble, not  
11 hard to get a Medicaid card, and, apparently, it's  
12 not hard to get scrips, that are all part of the  
13 package.

14           So, again, this is one particular area of --  
15 and I believe the major source of these pills that  
16 the State can do something about.

17           There are contracts in place, and they just  
18 have to put that back to the robust program that it  
19 was.

20           SENATOR NOZZOLIO:  Let me follow up with you,  
21 Counselor and The Detective:

22           The -- you're assured that the statutes we  
23 have is -- in terms of criminal deduct, are  
24 sufficient?

25           WILLIAM MCGOLDRICK:  [Nods head.]

1           SENATOR NOZZOLIO: But they're certainly not  
2 sufficient to deter this action?

3           WILLIAM MCGOLDRICK: Criminal diversion of  
4 prescription drugs goes up to a C felony. And  
5 that's a pretty good -- that particular segment is  
6 covered.

7           SENATOR NOZZOLIO: I'm Chairman of the Codes  
8 Committee, and I'm very interested in your  
9 assessment here of this.

10           Go ahead.

11           Go ahead.

12           No, you go.

13           SENATOR GOLDEN: How much drugs do you need  
14 to get a C felony on a drug diversion?

15           How much -- what sale --

16           WILLIAM MCGOLDRICK: You know, the face value  
17 would have to be about 5,000. It kind of goes up  
18 like the old grand-larcenies statute. It's by the  
19 value of the -- by the drugs.

20           SENATOR GOLDEN: And it goes for the seller?

21           WILLIAM MCGOLDRICK: Yeah -- well, yes, yes.

22           SENATOR NOZZOLIO: Back to this inquiry  
23 that -- it's -- these graphs that we were shown at  
24 the last hearing, where you've got the enormous  
25 growth of opiate sales, these are, I assume, the

1 doctor gave us opiate legitimate sales.

2 WILLIAM MCGOLDRICK: No, that would be --

3 SENATOR NOZZOLIO: What kind of graph would  
4 we see if this was into the black market that you  
5 suggest?

6 WILLIAM MCGOLDRICK: Well, ironically,  
7 because these -- take the billion dollars in sales  
8 that were represented by the two federal cases, they  
9 would show up on that chart, because they billed the  
10 New York State Medicaid program \$1 billion.

11 \$1 billion represents 2 percent of the entire  
12 state budget for Medicaid. That was over an  
13 18-month period.

14 But, I mean -- and that's only two cases.

15 And one of the problems, and I've talked  
16 to -- I had lunch with representatives from three of  
17 the pharmaceutical manufacturers, two weeks ago,  
18 looking to get funding to do something with NYSAC  
19 (the New York State Association of Counties) which  
20 has a very strong interest in this.

21 And they tell me that the problem is, that --  
22 they keep hitting the system by resale of these  
23 drugs, and they're contaminating the drugs. And  
24 they have counterfeit drugs coming from foreign  
25 countries.

1           I mean, it's so bad, that they're getting  
2           calls from Iowa, their security divisions, wanting  
3           to know why the 40-milligram stuff is in a  
4           30-milligram package.

5           There was a case on Tremont Avenue, reported  
6           in "The Post," a 7-year-old boy, who's mother got a  
7           prescription filled for Ritalin, accidentally got an  
8           adult dose of methadone, and very nearly died.

9           That's a result of a pill-mill operation.  
10          The stuff goes out legitimately, but it looks like a  
11          legitimate sale.

12          And it is a legitimate sale, because it's  
13          billed to the State, but now it comes back in.

14          We've got two pharmacists who work with us,  
15          who are also retired NYPD. They've been in some of  
16          these pharmacies, where, they were accompanied by  
17          law enforcement because now they're -- the place is  
18          going to get taken down.

19          And there were dozens and dozens of these  
20          pill bottles that were brought back from the street,  
21          purchased back, opened, waiting to be resorted.

22          And it's not just limited to painkiller  
23          medications. It's limited to anything that's  
24          worth -- well, not limited -- it's anything that's  
25          worth money: asthma medications, heart medications.

1           Any of us could wind up going to get a  
2           prescription filled for anything, and get something  
3           that's been out on the street, in somebody's trunk,  
4           mixed around, and put back in.

5           So drug criminal -- criminal diversion of  
6           prescription drugs is an emerging problem. And  
7           I think it's the leading problem of the pills, which  
8           the doctors have told you now is the leading  
9           problem -- leading cause, or the causal connection,  
10          for the heroin.

11          And this is something the State can do  
12          something about. They've done it before, and  
13          they've done it very effectively.

14          I suspect, that with the Medicaid redesign  
15          team and a couple of other things, this kind of fell  
16          out. Somebody didn't realize that these  
17          three contracts that sit in OMIG right now are being  
18          underutilized, and it was an 18-month gap.

19          SENATOR NOZZOLIO: So, Counselor, thank you  
20          for this assessment.

21          We're grappling with, as Chairman of the  
22          Committee said, it's a three-prong approach. You've  
23          got prevention, treatment, and then prosecution.

24          And we need to focus on the supply aspects  
25          here, is what you're telling us; the illicit supply?

1 WILLIAM MCGOLDRICK: Yes.

2 SENATOR NOZZOLIO: Not the legitimate supply.

3 I mean, I know the doctors are saying it's  
4 just more -- that more pills in mommy and daddy's  
5 medicine chest.

6 Well, it's not that, according to what you  
7 just described.

8 WILLIAM MCGOLDRICK: That's the number two  
9 source, by volume. I wouldn't know what it is.

10 But the number one source right now is  
11 criminal diversion of prescription medications. And  
12 it's through -- they're -- New York State Medicaid  
13 is getting hit very badly, but other  
14 prescription-benefit programs are getting hurt, as  
15 well.

16 SENATOR NOZZOLIO: Do you feel, in terms of  
17 the elements of prosecution, that the statutes are  
18 significant enough to allow and enable the  
19 prosecution?

20 It's the investigation and apprehension is  
21 where the challenge appears to be?

22 WILLIAM MCGOLDRICK: Yes, it's a very  
23 specific area; a very specific expertise to  
24 investigate it.

25 The NYPD, we've worked with the various --

1 all the DAs. All the DAs are aware of the  
2 problem, but nobody has the resources.

3 And, imagine, I mean, we had a team that  
4 included two NYPD members who were pharmacists. We  
5 had nurses, doctors. And, again, somehow it fell  
6 out.

7 And after it fell out, a billion dollars in  
8 fraud occurred in just two case.

9 So, it's a pretty clear indicator of -- or an  
10 argument to restore the efforts at OMIG.

11 SENATOR NOZZOLIO: Thank you.

12 SENATOR GOLDEN: On a Medicaid card, and I'm  
13 just throwing this out there, it may not be possible  
14 because of the large volume, and because of HIPAA,  
15 the -- isn't there -- the State, that when they give  
16 out the Medicaid cards, isn't there an unusual -- is  
17 there any way of doing an unusual medical usage?

18 WILLIAM MCGOLDRICK: The State sometimes  
19 restricts recipients who are somehow -- who are  
20 suspected of abusing the cards.

21 You know, you always have the fine line of  
22 wanting people to get treatment. And then, of  
23 course, you've always got the criminals who will  
24 abuse, you know, any kind of a public-benefit  
25 program.

1           One of the problems in the system, I'd have  
2           to double-check, but for as long as I can remember,  
3           a lost Medicaid card was replaced with another card  
4           with the exact same number, which -- you know, so  
5           you have dozens and dozens of cards with the same  
6           numbers.

7           So you couldn't even track, you know, the  
8           guy -- the guy could say, Well, it wasn't the card  
9           that I have.

10           SENATOR GOLDEN: Could they track the same  
11           person that lost the card four times in a year, or a  
12           stolen card three times in a year?

13           WILLIAM MCGOLDRICK: You know, again, they  
14           can put some people, if their numbers, they can --  
15           you can tell, from the Fraud and Abuse Management  
16           System that sits on MMIS, you can tell if certain  
17           recipients' cards being abused. And that's for  
18           New York.

19           If it was New York City, that would be  
20           New York City HRA to call the person in and evaluate  
21           what's going on.

22           They can be put on restriction, where they  
23           have to go to a certain pharmacy and use certain  
24           doctors.

25           But that's not the part of the problem.

1           The fact that you can rent a Medicaid card,  
2           you know, from the indigent population, people who  
3           are homeless, people who are out at a men's shelter,  
4           that's hard to control.

5           But what you can control, because it's a  
6           closed system of professionals, is the prescribing  
7           doctors, the ordering providers, and the pharmacies,  
8           things that are going wrong on the pharmacies.

9           And, you don't need -- I mean, it's great to  
10          have it, and it's a great way to make the cases, but  
11          you don't even need the sophisticated computer  
12          models and all that.

13          The Detective will tell you, he can go out on  
14          the street right now and get the name of six doctors  
15          that are writing prescriptions.

16          It's not that much of an investigation to  
17          build up a case to have the person -- the doctor  
18          arrested and thrown out.

19          We had one pharmacy on Tremont Avenue, you  
20          know, with video and audio, we had pictures of them,  
21          buying Medicaid cards, and buying drugs back.

22          You know, they're not difficult cases to  
23          make, but there's a lot of them to be made, and  
24          there's not enough effort. There's, virtually, no  
25          effort.

1           SENATOR GOLDEN: Is there any legislation  
2 that you think we can pass at this -- this Senate  
3 that you think could help?

4           And are the DAs -- are there enough  
5 incentives for the DAs to take these cases, and to  
6 help in the city and the state?

7           WILLIAM MCGOLDRICK: Within the last year  
8 I've met with each of the five DAs in  
9 New York City, and I've met with DA Kathleen Rice in  
10 Nassau, and Tom Spota out in Suffolk. They're all  
11 dying to do something. They all said they would  
12 love to have resources like this.

13           There's a proposal that we have, through the  
14 Suffolk County DA, to put together teams for  
15 Long Island, where they're losing 10 people every  
16 month for 2 years.

17           The statistics that the doctor from the city  
18 had, it was 58 people a year in New York City.

19           Two western counties, six a month in --

20           Fifty-eight people a month in New York City,  
21 I mean. Six in the western counties of the state.

22           So you're talking about 60, 70 people a  
23 month.

24           It's time to get a couple of projects  
25 together and get it studied, you know. There are

1 enough knowledgeable people around who can look at  
2 the different aspects of the problem and come back  
3 to you with suggestions for changes in the law.

4 SENATOR NOZZOLIO: Your testimony is very  
5 helpful.

6 Elaborate a bit on the abrupt ending of those  
7 contracts that were used to -- for the Medicaid  
8 Inspector fraud -- Medicaid Inspector General in  
9 terms of this ferreting out fraud.

10 You say the contracts abruptly ended; then  
11 restored after two years of dormancy?

12 WILLIAM MCGOLDRICK: Yes.

13 SENATOR NOZZOLIO: And then -- but you said  
14 18 months, those investigations' contracts were  
15 restored, but on a very minimal and ineffective  
16 basis.

17 Could you elaborate on the "minimal" and  
18 "ineffective" part?

19 WILLIAM MCGOLDRICK: There are 6 -- instead  
20 of a staff of 60, there are 6: 2 investigators each  
21 from 3 companies, who have -- they're were  
22 experienced companies.

23 And because of that 2-year gap with no  
24 investigations, the Medicaid Inspector General's  
25 Office had a 9,000-case backlog.

1           So, they're trying to prioritize.

2           And, their mission is not only prescription  
3 drugs. It's all forms of Medicaid fraud: fraud in  
4 transportation, ambulettes, labs...all manner of  
5 fraud.

6           So that's one segment of it.

7           To my knowledge, of the six investigators  
8 there right now, there may be one or two, and that's  
9 it; so it's not a program anymore.

10          And it's -- of all the things they do, if you  
11 want to put saving lives first, and reducing the  
12 public-health crisis, that, to my mind, would be the  
13 primary mission of that unit right now.

14          SENATOR NOZZOLIO: Although, certainly, the  
15 costs -- or the benefits are also --

16          WILLIAM MCGOLDRICK: It always pays 10-to-1.

17          We had an HIV case, there's was a growth  
18 hormone by the name -- called "Serostim" that was  
19 being diverted and sold back to the pharmacies. And  
20 it was a very, very expensive medication.

21          The State was spending \$120 million a year  
22 for, like, 10 years on that stuff.

23          When the investigation was concluded, it was  
24 reduced to \$80 million a year, and stayed at that  
25 number for 10 years.

1           So to my mind, those contracts paid for  
2 themselves forever, right then and there.

3           And that case was found by a New York City  
4 detective, Patrick Kelly -- Lord have mercy on him,  
5 he's no longer with us -- just by doing what cops  
6 do.

7           He was out by a pharmacy, he saw something  
8 suspicious. They found out the person had a forged  
9 prescription. They brought it back. They got the  
10 pharmacist and they said, "What is this is stuff?"

11           And the guy said: Well, that's a growth  
12 hormone for AIDS patients.

13           "Why are they selling it?"

14           "Well, we didn't know."

15           Well, it just was because it was an expensive  
16 medication. And by getting it for nothing with a  
17 Medicaid card and then selling it back to the  
18 pharmacy, they were able to bill the State \$2,000 a  
19 dose for every one of those that they did.

20           And nobody was treated with the drugs. It  
21 was just a -- what -- you know, a classic pill-mill,  
22 where they sold it over and over again.

23           So, if the outsourcing of Medicaid  
24 investigations ever proved itself, it proved itself  
25 on that one case.

1           The investigator himself brought the  
2 information back to them from the street, and it  
3 resulted in a \$40-million-a-year savings for many  
4 years.

5           So that's -- the diversion part is something  
6 that the State can actually doing something about.

7           And I -- and this is -- the marijuana  
8 discussion about gateway, whether it is or it isn't,  
9 we now know that the pills are the superhighway.  
10 There's -- it is the direct route. You know, the  
11 direct cause.

12           SENATOR GOLDEN: Is there -- did -- anything  
13 that popped up here today that you think that we can  
14 do that -- to strengthen some of our laws here in  
15 the state of New York that would help in preventing  
16 more actual overdoses and sales and death?

17           LINDA SARSOUR: I definitely highly support  
18 the crackdown on the pharmacies and the doctors, and  
19 that partnership. That's absolutely happening.  
20 I won't deny that that's happening.

21           But what I'm concerned about, is that the --  
22 people that are being impacted from our community  
23 are not the kids that are going into a pharmacy with  
24 the prescription. That's not what they're doing.

25           So I'm trying to figure out, to balance the

1 enforcement piece and the legislation around, you  
2 know, monitoring the criminal diversion, which  
3 I think -- the drug diversion, which I think is a  
4 big issue.

5 And I know that, even stories that we've  
6 heard, where there's been a couple of doctors.

7 I remember, two years ago, there was one in  
8 Sunset Park that got caught on that.

9 But I just don't think that that's what's --  
10 this population of 17 to 23 are not the ones going  
11 into the pharmacies.

12 So I'm trying to figure out --

13 SENATOR GOLDEN: Going into their mother's  
14 and father's medicine cabinets, though? Aren't  
15 they -- don't these kittle [sic] parties --

16 LINDA SARSOUR: They're doing -- they're  
17 doing -- they're doing the skittle parties, but  
18 they're also being sold those pills, buy the pills.  
19 So there are some pills that they're buying for,  
20 like, \$5 a pill.

21 They're buying -- the kids are showing us,  
22 you know, little Ziploc bags that they find with  
23 their friends, or at their friends' houses.

24 So the kids are being really honest about the  
25 stories, and how they're getting the pills, or how

1 they see their friends taking the pills.

2 But, you know, back to the original, like,  
3 the legislation passes, and then there's always the  
4 enforcement piece, and how long does that take?

5 But in the meantime, how many more kids in  
6 our community have to die. Right?

7 So I'm trying to figure out, also, back to  
8 the gentleman in the back who's an educator from  
9 Long Island, the idea of, like -- like, for example,  
10 in Bay Ridge, you know this, Senator, like, we don't  
11 have youth programs. Like, we don't have a  
12 PAL program in Bay Ridge.

13 Kids don't want to go to McKinley Junior  
14 High School if they're 16, to play at a junior high  
15 school.

16 Just figuring out, what other alternative  
17 programs can we add to a larger holistic approach to  
18 combating this issue?

19 Because we -- I just don't want to see  
20 another mother in my office, crying, and telling me  
21 she didn't know why her son didn't wake up in the  
22 morning, because he came all home and -- that's how  
23 all our kids are die. They're -- literally, they  
24 just don't wake up.

25 That's most of the stories that we -- at

1 least seven of the eight kids, their mother went to  
2 wake them up in the morning, to go to school, or to  
3 go to work, and they just don't wake up.

4 And that's how their mother finds out that --  
5 later on, that it was an overdose.

6 They can't tell. They don't smell like  
7 marijuana. They can't smell it on them. They can't  
8 see it in their eyes.

9 They just don't know how to -- so how do we get  
10 all those points?

11 But we, as a community, wholeheartedly  
12 support the enforcement mechanisms.

13 And any legislation, we would be willing to  
14 stand to say that we would crackdown on doctors and  
15 pharmacies in this work.

16 SENATOR CARLUCCI: Now, Linda, how about, in  
17 cases, and I don't know if you've experienced this,  
18 where it is obvious that someone has a problem, and  
19 they maybe come to you or and look for help, have  
20 you had experiences like that, with -- and finding  
21 treatment for people that need it?

22 Because we've heard this problem, where it's  
23 obvious someone has a problem. They've actually --  
24 they're actually looking for help, and not able to  
25 get the treatment that they need.

1           And we've heard from private insurance, but  
2 other issues, as well.

3           Do you have any experience with that?

4           LINDA SARSOUR: And my colleagues from  
5 Lutheran, I used to work at Lutheran, actually, but,  
6 you know, people think it's an easy process. They  
7 think that they show up to a center, like a  
8 Lutheran, and then they, like, take you, and then  
9 it's all, like, great.

10          That's not how it is.

11          I mean, there's a waiting list. There's also  
12 an age limit.

13          Like, Lutheran, for example, they don't do  
14 adolescents. Like, that's not their focus area.

15          So, like, our population, talking about kids  
16 between, you know, that are -- I mean, the ones that  
17 have passed away are 17 to 23, but we know kids  
18 using this as young as 13.

19          That's not a population that they focused on.

20          And the other issue around it is, like, you  
21 want to be able to treat kids with the partnership  
22 of the parents, right, but if you don't speak their  
23 language, if you don't -- back to my brother over  
24 here, like, this -- this -- the assumptions, that  
25 when we're talking about drugs in the community,

1 this community doesn't think that it's them.

2 They don't -- for example, we don't even talk  
3 about things like HIV in our community because, you  
4 know us, we're, like, religious, and we're, you  
5 know, monogamous.

6 Like, there's a lot of issues in our  
7 community that require a level of sensitivity.

8 And I think the way you do that is, you go  
9 through faith-based, community-based, organizations  
10 who understand these.

11 So back to another proposal in the back,  
12 around building coalitions of government, you know,  
13 and this is something that's already happening in  
14 our area, government, faith-based, community-based,  
15 organizations, and others, you know, school system,  
16 and creating this partnership.

17 Because, our community also is about, you  
18 know, you don't want -- you don't want to think I'm  
19 a bad parent because my kid's on drugs.

20 So, sometimes they wait too long.

21 Maybe they do know. They wait too long,  
22 because they're worried that people are going to,  
23 you know, talk about them, like, as if that's more  
24 important than their child's life.

25 And I think we could be very helpful in being

1 the liaisons between the community and this issue,  
2 but also having community members stand up and say:

3 If the pharmacies are getting this on the  
4 streets of our community, then we're going to stand  
5 against it.

6 If the doctors in our community are bringing  
7 this to the streets, we're ready to stand against  
8 them.

9 And, how do we create that holistic approach?

10 SENATOR BOYLE: One of the things, Linda,  
11 that we've seen in other forums, and I'd like to get  
12 out of this Task Force, is to change the stigma  
13 involved.

14 You mentioned that, where, you know, if you  
15 walked up to someone on the street and they said,  
16 "Well, my son has cancer," you'd say, "Oh, my God,  
17 what can we do to help?"

18 No one wants to mention that their child is  
19 an addict, but it is a disease.

20 LINDA SARSOUR: Absolutely.

21 SENATOR BOYLE: And that's the bottom line.

22 And I think that that mindset is changing,  
23 but we're not there yet.

24 LINDA SARSOUR: Absolutely.

25 SENATOR GOLDEN: The -- Rabbi, did you want

1 to add anything?

2 RABBI SIMCHA FEUERMAN: Well, first of all,  
3 I absolutely concur with what Linda said.

4 And, also, just share with you that there's a  
5 saying in the Talmud, that the mice does not -- the  
6 mouse does not steal; rather, it is the hole that  
7 steals.

8 And, you know, clearly, enforcement and  
9 prevention are very, very important, no question  
10 about it.

11 But I do think that when you're dealing with  
12 families and young children, the education piece is  
13 extremely important.

14 And, also, somehow, you have to find a way to  
15 balance the fear that comes with enforcement,  
16 versus, you want people to feel comfortable coming  
17 forward.

18 And that's always a problem in any area of  
19 mental health, because there's a criminal aspect to  
20 many kinds of mental-health crimes and related  
21 crimes.

22 So we need to find a way, and part of that is  
23 with cultural sensitivity; however, just plain old  
24 sensitivity, too, to find a way, where people feel  
25 comfortable to get treatment, and to talk about

1 their problems; and, yet, that we have strong  
2 enforcement, because you have to have both.

3 LINDA SARSOUR: Could I just ask a quick  
4 question?

5 So, about two months ago, we actually brought  
6 information to the 68th Precinct about a potential,  
7 actually, apartment, where we think that someone --  
8 a mother and her sons, actually, were part of this,  
9 like, selling. Right?

10 And when these kids told us this, and I asked  
11 them, like, "How long do you think has been  
12 happening?" they're, like, "Oh, this has been  
13 happening a long time."

14 I'm, like, "Why didn't you ever tell anyone?"

15 And what they were worried about, and this  
16 something we should think about, is they were  
17 worried that if the, you know, NYPD undercovers are  
18 going to be monitoring this, like, location, that,  
19 would the kids who are coming out of that apartment  
20 be then subject to the enforcement around that?

21 So, our kids are the ones with the  
22 information. They know who's selling in our  
23 community, but what they're worried about, is if  
24 they come forth, or they find something on them,  
25 that they're going to be part of that.

1           And I personally can't guarantee to them,  
2           because I'm not in law enforcement, to say to them:  
3           No, we want this information. You can be helpful to  
4           us, and what that looks like.

5           Because I think that's the apprehension about  
6           bringing information, is that these young kids who  
7           are -- need just -- they just need -- they just need  
8           a lot of things, but they don't need to be arrested  
9           and put behind bars, because, it's not them; they're  
10          not the problem.

11          So I'm wondering if that's something we're  
12          thinking about when we're looking at the enforcement  
13          piece, that these young kids are not caught up in  
14          the system.

15          That's actually, kind of --

16          SENATOR GOLDEN: In most cases, NYPD uses  
17          undercovers, and they use those that are coming out  
18          into a drug sale. Generally, they've watched and  
19          observed this individual several times.

20          The unfortunate reality, we did do a -- an  
21          event in Bay Ridge, and it takes, you know, a good  
22          several months, by the time you do a number of buys,  
23          to be able to get that -- to -- crime to stand in a  
24          court.

25          So it takes a period of time to build a case.

1           So while that takes that time, that drugs are  
2 still being sold at that location, so people get  
3 upset because they think the police department's  
4 doing nothing, or, you know, Why is this allowed to  
5 go on and to exist?

6           What they're doing is, are building cases.

7           And you've seen a number of cases that have  
8 been brought in the past several weeks, and how many  
9 people have been arrested in that community because  
10 of drugs.

11           So it does take time, but it does come -- the  
12 community has to let us know.

13           The Muslim- and Arab-American community is  
14 very insulated. And the same in the Jewish  
15 communities.

16           So, they have to be the ones that have to  
17 come forward, to let us know where the locations  
18 are, and we have to be able to get in there and get  
19 our undercovers in there, and make sure we make  
20 those arrests.

21           And we will, and we have; and we will save  
22 lives, as long as there is a communications.

23           Which I think is a good communication today  
24 with NYPD. I think Lutheran is doing a good job,  
25 but Lutheran's limited, and HIPAA, and they're

1 limited in why they can intervene in a family.

2 We've had families come into our office that  
3 did not want the community to know that they had a  
4 problem, and that we've taken those children.

5 There's going to be some providers coming up  
6 here and they're going to speak very shortly.

7 And we've gotten them into treatment; and  
8 that's what it's about, is getting the people into  
9 treatment that are addicted.

10 What we want to do, though, we want to make  
11 sure we get the drugs out of the community.

12 And if they're in the community, the  
13 community knows; so they've got to let us know.

14 And I think we have a much better working  
15 relationship today than we had in the past, when it  
16 came to drugs. And we're going to continue to do  
17 that.

18 Anything else you can add?

19 Anybody from the audience want to a question  
20 here, that -- go ahead, sir.

21 LUKE PARDNER [ph.]: My name is  
22 Luke Pardner [ph.]. I'm a member of Dynamic Youth,  
23 and I've been a recovering drug addict for the past  
24 year.

25 And my question is about education, because,

1 when I was a kid, I was educated as to what drugs  
2 were. My cousin was a recovering heroin addict, and  
3 I knew what it could do, but that didn't stop me  
4 from doing any of the drugs.

5 I went to the D.A.R.E. program, I did all of  
6 these things, knowing what could possibly happen,  
7 and it didn't really stop me.

8 I feel that, when it comes to education, if  
9 you put a group of children or young adults in with  
10 an adult or an older figure or someone that holds,  
11 you know, authority, it's less interesting, it holds  
12 less value to you.

13 When I was younger, I would get more advice  
14 and I would take it in better from people that were  
15 my age.

16 I feel that when it comes to education, it  
17 would be better if someone that was going through it  
18 or has done it recently, and of the same age range,  
19 could teach the younger children about what we've  
20 gone through, how we've dealt with it, and what it  
21 will cause.

22 I feel, like, if -- I wanted to know if  
23 there's a way that that could happen?

24 SENATOR BOYLE: Yeah, we are certainly  
25 advocating for peer-to-peer education. And I think

1 that we've heard that a lot around the state, too.

2 I mean, it's one thing to have the police  
3 officer come in, the person you can't relate to, but  
4 some -- we have young people who are still going  
5 through it, that explain what they went through, and  
6 that scares people. I think it has much more of an  
7 effect, let's say.

8 And were certainly going to try and add that  
9 to our package.

10 LUKE PARDNER [ph.]: Thank you.

11 SENATOR GOLDEN: Any other questions?

12 NAZAR ANOWI [ph.]: Yeah, hi. My name is  
13 Nazar Anowi [ph.]. I'm a CASAC with OASAS. Also, a  
14 resident of the Bay Ridge area.

15 I've known -- my family and I have known  
16 Marty Golden. [Inaudible] to try to do our best.

17 I honestly think a big part of the  
18 law enforcement is going to have to get involved.

19 The community -- the kids are very private,  
20 very quiet. They are scared, but not scared in the  
21 manner where it could be beneficial to them,  
22 themselves, and their families.

23 So that is one factor.

24 Also, maybe like an anonymous toll-free  
25 number that can be used, that families can speak,

1 because it's a two-part disease. The family  
2 suffers, as well as the children, and the community  
3 as a whole.

4 So that is one area I think maybe the  
5 Arab-American Support Center can work on, you know,  
6 having some type of, also, like a liaison between  
7 Medicaid, because it's very expensive to get  
8 treatment. A lot of people want treatment, and a  
9 lot of people don't know how to go forth in getting  
10 it.

11 So maybe somebody from, like, Medicaid,  
12 informing them of long-term HRA-type benefits that  
13 are available.

14 But I think a big part has to do with what  
15 the NYPD has been working on, and just applying a  
16 little bit more pressure in not giving so many  
17 options, other than to work with them or to be  
18 mandated to a long-term treatment program, which  
19 I feel is probably the best treatment plan.

20 It would give the families time to heal. It  
21 would give them time to heal.

22 But it all falls into the place of  
23 enforcement of, like the Rabbi mentioned, fear.  
24 There is a lot of fear, but not a fear in the sense  
25 where they can recover from it. It can be a

1 motivator.

2           And that is a key area of which I think  
3 that -- you know, I know, Marty Golden, you have a  
4 lot of these pamphlets in your door, you know, with  
5 Internet, and safety, and parents. And that looks a  
6 lot towards the generation that has not been  
7 affected by it, you know, and parents really getting  
8 involved, you know.

9           I work a little bit with Apple, with  
10 development, and they would love to participate in  
11 different kind programs, to work with the kids who  
12 are not just from the Arab. Bay Ridge is very  
13 diverse. You have every nationality in there.

14           So getting them in there prior to them going  
15 to high school, and the peer-pressure factor is very  
16 big.

17           So, kind of breaking it up in that area, but,  
18 I think that would be a positive.

19           SENATOR GOLDEN: There are faith-based  
20 operations out there that do get a person from their  
21 home, to Medicaid, to a treatment center.

22           My office does it, others will do it.  
23 They're out there.

24           The unfortunate part is, a lot of people  
25 don't know they're out there.

1           And I think that's the education part that my  
2 colleague Senator Boyle has talked about as  
3 something that we have to do look to do better.

4           NAZAR ANOWI [ph.]: Absolutely.

5           Thank you.

6           SENATOR NOZZOLIO: I have a question for the  
7 young that man stood up.

8           Could you be so kind as to indulge me in a  
9 question?

10          First of all, thank you for your courage. It  
11 took an awful lot to stand up in the middle of the  
12 room and tell us about your personal journey.

13          And I appreciate that very much, and respect  
14 it very much.

15          Help us by understanding how -- you said you  
16 had the D.A.R.E. education, you said you were a  
17 participant there.

18          What elements encouraged you to begin this  
19 type of conduct, the -- taking the opiates?

20          Was it availability?

21          Was it opiates themselves?

22          Were there gateway drugs?

23          What got you engaged in this?

24          LUKE PARDNER [ph.]: For me, it started with  
25 smoking marijuana when I was very young. And then,

1 I was probably about 16, I started smoking  
2 marijuana.

3 And what happened, the opiates was, Clonopin,  
4 was something that I liked, because my mom had it in  
5 her -- in her -- in the bathroom in the little --

6 SENATOR NOZZOLIO: Medicine chest.

7 LUKE PARDNER [ph.]: -- medicine chest,  
8 exactly.

9 And once I got that, my other friends knew  
10 about other drugs, and I kind of just experimented a  
11 little bit. And it kept going until I ended up in  
12 rehab.

13 SENATOR NOZZOLIO: That was Senator Golden's  
14 question earlier today, in terms of, what is -- is  
15 marijuana, in fact, a gateway drug?

16 LUKE PARDNER [ph.]: To me I believe it is,  
17 yes.

18 SENATOR NOZZOLIO: Well, again, thank you for  
19 your courage, and your comments.

20 BRETT WILSTENSTOFF [ph.]: Thank you all for  
21 having this panel. I really appreciate it.

22 My name is Brett Wilstenstoff [ph.]. I'm a  
23 graduate student at the Albert Einstein College of  
24 Medicine up in The Bronx, and a volunteer with the  
25 syringe exchange up there, as well.

1           So I found my brother when he had overdosed  
2           on heroin. We didn't know he was using, so we had  
3           no naloxone on hand. We were at the mercy of the  
4           paramedics getting there on time to bring him back,  
5           which, thankfully, they did.

6           So, I was in the situation of not having any  
7           resources available. And it seems like a lot of  
8           other people are in the same situation.

9           And, so, we all, though, have in our  
10          households fire extinguishers for that rare  
11          occurrence of a fire.

12          Why don't we all have naloxone in our  
13          medicine cabinets on the rare chance of an overdose?

14          It seems kind of a very pragmatic approach.  
15          There's different ways of going about it.

16          I mean, of course, education was a huge role.

17          And being it more available for, like,  
18          over-the-counter availability would be one thing  
19          which I know is moving through right now.

20          Another would be a co-prescribing mandate,  
21          which I've suggested, in which the first opioid  
22          prescription, per year, per patient, regardless of  
23          dosage, would get naloxone with it.

24          And what that would do, is it would widen the  
25          naloxone-distribution network, so that any household

1 that has an opioid in it, also has naloxone.

2 And the naloxone lasts, the shelf life, for  
3 two to three years. So even if that dosage is gone,  
4 and then some problem arises later on down the line,  
5 naloxone is available and a person's life can be  
6 saved.

7 And, so, I just want to know your thoughts,  
8 and, also, I'd just like your ideas on wider  
9 naloxone distribution.

10 Thanks.

11 SENATOR BOYLE: Well, I think we all  
12 certainly support the wider distribution.

13 I know that many of us have had classes.

14 I mean, I held one on Long Island last week.  
15 We had 150 people taking the class.

16 One of the things is, we need to straighten  
17 out and have a uniform system in New York State on  
18 how to get that into people's hands.

19 These classes, you have to take the class to  
20 get certified, obviously. And it's about a  
21 45-minute class, it's not that hard.

22 And we are looking for a wider prescription.

23 The idea of giving -- a doctor giving it with  
24 the prescription, the problem is, they haven't taken  
25 that class.

1           But we do want to make it as widely available  
2           to first responders, certainly to laypeople, family  
3           members of addicts, addicts themselves.

4           We have done a pretty good job of getting it  
5           more widely distributed, but we're going to go  
6           further with it this legislation, too.

7           Thank you.

8           Oh, yes?

9           CLARENCE BOWDEN: Good afternoon, and thank  
10          you, gentlemen.

11          My name is Clarence Bowden. I'm one of the  
12          directors of New York Therapeutic Community  
13          Serendipity 1.

14          And this is more of a comment and statement,  
15          but it's also going towards that gateway question of  
16          marijuana.

17          I haven't heard anything about alcohol being  
18          mentioned.

19          I've done sessions with older gentlemen who  
20          talked about, 6 and 7 years old, being sent, to  
21          bring a drink to the parent, the alcohol spilling on  
22          their hand, them licking it off, and it progressing  
23          over time till they becoming addicted.

24          All right, so let's not forget alcohol and  
25          its role in this gateway process.

1           Yes, I agree, marijuana is one of those  
2 gateway drugs, but alcohol is right up there in that  
3 same realm.

4           So that's just my comment and my statement.

5           SENATOR GOLDEN: I don't think anybody here  
6 disagrees with you.

7           Go ahead.

8           Thank you.

9           CLARENCE BOWDEN: Okay, but that's what my  
10 statement was.

11          SENATOR NOZZOLIO: Thank you.

12          SENATOR BOYLE: Thank you very much.

13          And I'd like to thank the panel very much,  
14 for your input and insights.

15          SENATOR NOZZOLIO: Thank you very much.

16                   [Applause.]

17          SENATOR BOYLE: Our next panel is a  
18 representative of Dynamic Youth Community,  
19 Samaritan Village, Bridge Back to Life Center, and  
20 MASK.

21                   [Pause in the proceeding.]

22                   [The proceeding resumed, as follows:]

23          SENATOR BOYLE: Thank you very much.

24          This is our final panel; and if you could  
25 briefly introduce yourself and tell us where you're

1 from.

2 GARY BUTCHEN: Good afternoon.

3 I'm Gary Butchen, the president and CEO of  
4 Bridge Back To Life Center. We're a network of  
5 outpatient chemical-dependency programs located  
6 throughout the city and out on Long Island.

7 SENATOR BOYLE: Thank you.

8 WILLIAM FUSCO: Good afternoon, Senators.

9 My name is Bill Fusco. I'm the executive  
10 director of Dynamic Youth Community, which is a  
11 43-year-old residential program with outpatient  
12 services in Brooklyn, but also servicing  
13 Long Island, Staten Island, Upstate New York. We  
14 have 86 beds in Fallsburg, New York; 16 beds in  
15 Brooklyn, New York.

16 And, we're very glad to be here.

17 Thank you.

18 KAREN CARLINI: Good afternoon, and thank you  
19 for this opportunity today.

20 My name is Karen Carlini. I'm the associate  
21 director at Dynamic Youth Community.

22 But I think also important to note, that I'm  
23 the co-chair for the ASAP (Association of  
24 Substance-Abuse Providers), Adolescent and Young  
25 Adult Committee for the state.

1           So I'm here representing both.

2           Thank you.

3           SENATOR BOYLE: Thank you.

4           RUCHAMA CLAPMAN: Good afternoon.

5           I'm Ruchama Clapman. I'm the founder and  
6 executive director of MASK. "MASK" is Mothers and  
7 Fathers Aligned Savings Kids.

8           I started the organization, we just started  
9 our 16th year.

10          Senator Golden and Senator Felder have been a  
11 partner and supported MASK through many, many years.

12          Thank you again.

13          MASK, we have a help line. We are a referral  
14 agency. We have support groups for parents. We are  
15 a school liaison. We do inpatient and outpatient  
16 referrals and placements for families that, children  
17 do drugs, alcohol, eating disorders, gambling, and  
18 Internet addiction.

19          Thank you.

20          JAMES HOLLYWOOD: Good afternoon, Senators.

21          My name is Jim Hollywood from  
22 Samaritan Village.

23          Samaritan Village has a number of  
24 substance-abuse treatment programs throughout  
25 New York State: 839 beds in total, 2 outpatient

1 programs.

2 Our residential programs focus on specialized  
3 services for young mothers and children, veteran  
4 services for men and women, and a  
5 methadone-to-abstinence residential treatment  
6 program.

7 SENATOR BOYLE: Great.

8 Thank you very much.

9 And if I could, first question -- we'll get  
10 into a lot of the issues, and the insurance, and  
11 stuff like that.

12 My first question out of the box, and for the  
13 treatment providers, inpatient: What's the magic  
14 number of days that you think, minimum, is needed  
15 to -- you have an opioid addict, heroin addict, come  
16 in, they went through detox, they're there; how long  
17 do you need to keep them?

18 KAREN CARLINI: I'll take it.

19 I'm in the middle, so, you know, we have both  
20 sides.

21 I think it's -- it's a hard question to  
22 answer.

23 I think that -- you know, we provide  
24 long-term residential treatment.

25 We provide long-term residential treatment of

1 one year, with an aftercare program, with outpatient  
2 follow-up, because the people that come to our  
3 program, that's what they need. That's what, you  
4 know, the level-of-care determination told us.

5 I think that it's really important that the  
6 treatment provider is the person that's making that  
7 assessment.

8 I know that there's pending legislation right  
9 now that would make that happen.

10 But the idea of long-term residential,  
11 I would say, you know, at least, you know, 6 months,  
12 in terms of the emerging adults, that 18- to  
13 25-year-old, for what happens to them: What happens  
14 for the brain, and what happens, you know,  
15 scientifically, to people, and then what happens to  
16 them, emotionally.

17 For a family, someone talked about before,  
18 the time it takes for a family to heal. I think  
19 they need that time. That can't happen in a short  
20 period of time.

21 So, I can answer it, you know, from our  
22 perspective; although, I think that there are  
23 shorter terms that might work in different  
24 circumstances.

25 JAMES HOLLYWOOD: Can I --

1           SENATOR BOYLE: Go ahead.

2           JAMES HOLLYWOOD: So when the research --  
3 when you look at the research, any treatment over  
4 90 days seemed to be more effective when people stay  
5 engaged in treatment, whether it's outpatient  
6 treatment, residential treatment.

7           So, you see the most positive effect when  
8 people stay engaged over 90 days.

9           And, so, when we look at "What is the magic  
10 number?" it really also talks about the severity of  
11 the addiction, the co-occurring disorders that might  
12 accompany someone's addiction.

13           Addiction is a biopsychosocial disease, and  
14 how far it impacts someone's development.

15           Employment becomes an issue.

16           Housing becomes an issue.

17           So when you really try to boil down, What is  
18 the essential elements of treatment? it's a holistic  
19 approach that looks at the mind, the body, and, as  
20 well as the social connectedness of an individual.

21           So, there's no magic number.

22           90 days seems to be indicated in research, at  
23 minimum. And that goes for regardless of which  
24 level of care you're in.

25           The more contact people have in treatment,

1 the better outcomes that are available.

2 GARY BUTCHEN: You know, just building on  
3 Mr. Hollywood's point, it's difficult to give you an  
4 exact number, especially if we're talking about  
5 legislation that's going to force the insurance  
6 companies to pay for what's being called  
7 "medical necessity." It's very difficult to hammer  
8 down a certain amount of days.

9 If Dr. Kolodny was still in the room he could  
10 tell you, every patient is different, and the  
11 physician from Lutheran.

12 So, just from a detox point of view, you  
13 know, managed-care companies are now telling the  
14 inpatient folks, three to five days.

15 And, you're lucky to get five. They start  
16 doing discharge planning 24 hours in on a detox.

17 You can't move a person over to an inpatient  
18 rehab while they're still tremulous and going  
19 through withdrawal.

20 Then they want to route them out of the  
21 emergency room down to my level of care, in the  
22 outpatient system of care, but folks are coming in,  
23 they're still in mild withdrawal symptoms.

24 So, I'd love to be able to sit here and give  
25 you an exact number, but Jim's point is right on the

1 money. I mean, SAMHSA and NYDA and all the research  
2 has shown, the longer a person's engaged in  
3 treatment, the better the outcomes.

4 The juxtaposition of all of that, is the  
5 insurance companies aren't allowing us to hold  
6 people in treatment that long anymore. You know,  
7 they're sending us fewer and fewer patients, and  
8 they want them out of treatment faster and faster.

9 SENATOR NOZZOLIO: Yes.

10 RUCHAMA CLAPMAN: You know, from a parent  
11 point of view, and from dealing with over  
12 15,000 families, I have a whole different spin.

13 My spin is, is that, the first month when a  
14 kid gets put into a rehab, or young adult, or  
15 whatever, they're there against their will. They're  
16 not even listening.

17 The second month, the 60 days, they're  
18 finally coming to accept that they need to be there.

19 By 90 days, they're like, Wow, I'm really  
20 here?

21 The first 90 days are not treatment. It's  
22 just really a holding pen, to get them to understand  
23 that's where they need to be, and then they start to  
24 listen.

25 So, if anyone thinks that the first 90 days

1 they should be out of there, I mean, you're really  
2 wasting your money, because all of them that come  
3 out after 90 days, we have documented, do not do  
4 well.

5 They need, minimum, not a day less, than  
6 six to nine months. "Not a day less."

7 SENATOR BOYLE: Karen, you mentioned  
8 "level-of-care determination."

9 Can you walk me through that process?

10 KAREN CARLINI: Well, right now, I know  
11 somebody mentioned before that OASAS is in the  
12 process of developing what would be called the  
13 "Locator," and that would be able to determine that  
14 level of care.

15 But for an assessment, a counselor goes  
16 through a process of, you know, assessing the client  
17 to determine whether they need, you know, outpatient  
18 care, residential, you know, and various other  
19 things. There could be mental health is considered.  
20 Family support is considered.

21 So there's all sorts of things that would  
22 determine where that person needs to be.

23 Currently, obviously, we do that as treatment  
24 providers.

25 What I think we fear is that, with insurance

1 coming in, and what's happened already for people  
2 that are working with the insurance companies,  
3 they're making that determination.

4 That's really what -- people aren't getting  
5 what they need because the determination is being  
6 made by someone who's not a practitioner.

7 SENATOR NOZZOLIO: And that's our dilemma.

8 Our dilemma is, and that's why the Chairman  
9 asked the question, because, in the three-prong  
10 approach that the Task Force is taking -- the  
11 prevention, treatment, and additional prosecution --  
12 in a three-prong approach, the treatment end,  
13 we're -- began, at least I did, with -- at a loss.

14 And, it was 19 years ago that I worked to set  
15 up the first drug-treatment prison in this state's  
16 history, if not the nation's history, and that was a  
17 90-day model. Willard, was a 90-day model.

18 And I agree with you, it's a very subjective  
19 issue, and it's very difficult to say "90 days."

20 I mean, I can just -- as you mention, the  
21 person in treatment, I can mention the inmate at  
22 Willard, that their motivation was, if they get out  
23 of the program, they'll go to jail, a longer jail  
24 sentence.

25 So they had some, at least recognition.

1           But, 90 days is -- but, at the same token,  
2           the Chairman asked this question, because we're  
3           going to have to ask the same question, and maybe  
4           even tell the insurers what they're going to have to  
5           provide.

6           And they're not going to like it no matter  
7           what it is.

8           9 days, 9 minutes, 90 years, I mean, it's not  
9           going to matter, from their perspective, except the  
10          question of cost.

11          And, we'll have to be sensitive to that, too,  
12          because everybody pays enormous insurance costs when  
13          we have to pay them, in health insurance.

14          And the fact is, we need some guidance.

15          I think that's just the -- the beginnings  
16          are: We'd like it longer, we understand that, we  
17          get it.

18          But the question is: How can we measure the  
19          stick so that the insurance companies will  
20          appreciate the fact that this is a more effective  
21          way to approach the problem?

22          GARY BUTCHEN: Well, we're at an interesting  
23          point, because Senator Hannon's bill, 4623, the  
24          Access to Care Bill, talks about all levels of care  
25          within OASAS, including residential, which the

1 insurance companies have never paid for before.

2 That's always been either on the families or on the  
3 State or it was funded in particular ways.

4 So it is going to be an interesting debate as  
5 to whether or not the Access to Care Bill is going  
6 to include all the levels of care, as it should; or  
7 if the insurance companies are going to give an even  
8 greater pushback on covering only what's in the  
9 essential-benefit package.

10 So that's going to be a juggling act that the  
11 Senators are -- you know, you're going to have to  
12 deal with.

13 But we -- we, I think, all agree, regardless  
14 of our focus or our level care, that we agree with  
15 you. I mean, the Minnesota model that came out of  
16 treatment 30, 40 years ago was 30 days of rehab.

17 The average length of stay in rehab now is  
18 under 16 days. That's all predicated on what  
19 managed care is willing to pay for, unless, as --  
20 as -- the families are willing to go into bankruptcy  
21 and foreclose on their homes, and take out second  
22 mortgages, for their children.

23 So when the insurance companies come back to  
24 the Legislature and say, "We don't want to pay for  
25 it because we're going to have to raise premiums,"

1 that's a weak argument because they raise premiums  
2 in New York State every year.

3 You know, I'm also, you know, a  
4 small-business owner, and I pay the premiums for my  
5 company. I can tell you that my premiums go up  
6 anywhere from 8 to 10 percent every year regardless  
7 of the bills that you pass or don't pass.

8 So that's something that really should not be  
9 the prevailing argument, whether or not it's good  
10 policy or not, because, obviously, as some of the  
11 other folks have testified earlier, and  
12 The Detective and the investigator have said, if we  
13 invest a few dollars early on, the fiscal  
14 implications, the economic implications, down the  
15 road pay huge dividends.

16 SENATOR NOZZOLIO: Mr. Butchen, that's very  
17 well stated, and I certainly agree with your  
18 concept.

19 We're just trying to hammer out the  
20 appropriate guidance to give the carriers, in terms  
21 of this focus, and what will be effective; what is  
22 necessarily the evidence coming from providers like  
23 yourselves who have to deal with these issues.

24 It's certainly subjective. I understand it's  
25 different, one size doesn't fit all, but, one policy

1 will have to fit all in this state, in a sense, of  
2 at least guidance.

3 So, any kind of guidance you can give us to  
4 give the carriers, we appreciate.

5 And we're willing to make the statement that,  
6 yes, you need to provide this care.

7 We did it with a lot of other things over the  
8 last few years.

9 But the question becomes, how much?

10 WILLIAM FUSCO: Senator, could I just mention  
11 the fact that the amount of monies necessary really  
12 varies tremendously.

13 For Dynamic Youth, it's under \$30,000 a year.

14 For one year in treatment, it's under  
15 \$30,000.

16 I can quote you programs that are one month  
17 for \$30,000.

18 So, I mean, to just look at it from a sense  
19 of time or length is not necessarily the best  
20 measuring stick.

21 You know, honestly, I thought the measuring  
22 stick really should be, you know, what the cost is.

23 And the fact is, is that we've run studies a  
24 number of times, you know, throughout our years,  
25 about short-term and what we call "Band-Aid

1 approaches."

2 And, we have a lot of kids who have been in  
3 the 15 days, 20 days in Florida; 15 days here,  
4 15 days there; all over the place for millions of  
5 dollars. "Millions of dollars."

6 So, if you shorten the length of treatment so  
7 short, whatever you're spending really is just  
8 throwing money away.

9 So, you know, you really need to think, not  
10 necessarily -- you really need to think of, what's  
11 going to be effective?

12 We stand by the model of 9 months to a year  
13 for severe opiate addicts who are between the ages  
14 of 17 and 24. We think that that really is the  
15 model that, you know, works, and gives a young  
16 person a chance to really get their -- you know,  
17 their recovery in place for themselves.

18 SENATOR BOYLE: And so --

19 SENATOR NOZZOLIO: How many children -- I'm  
20 sorry, Mr. Chairman.

21 SENATOR BOYLE: Go ahead.

22 SENATOR NOZZOLIO: How many children,  
23 Mr. Fusco, have -- in that age -- not children --  
24 how many young adults in that age group is your  
25 agency done -- dealt with, and, in terms of

1 experience level?

2 What numbers are we talking about in terms of  
3 population you're familiar with?

4 WILLIAM FUSCO: Well, we deal exclusively  
5 with 17- to 24-year-olds, and we have for the last  
6 43 years. We've been -- we're the first residential  
7 program exclusively for adolescents in  
8 New York State.

9 Right now we have 86 beds in Fallsburg,  
10 New York, which, you know, is near Monticello,  
11 New York. And we have 16 beds in Brooklyn,  
12 New York. And we have an aftercare of about 100,  
13 125, who, after being in treatment, continue on with  
14 their families, on a -- sometimes, starting on a day  
15 basis, and then moving on to night basis, and moving  
16 on from there.

17 So, in total, we probably serve somewhere  
18 around 175 to 200 families a year.

19 SENATOR GOLDEN: What's the drug of choice?

20 WILLIAM FUSCO: Absolutely.

21 I just wrote it down.

22 We're running right now, 30 percent,  
23 prescription drugs; 63 percent, heroin.

24 SENATOR GOLDEN: And how's that changed over  
25 the last two years, three years?

1 WILLIAM FUSCO: I have that number, too.

2 In 2011, it was 47 percent, prescription  
3 drugs; 27 percent, heroin.

4 Going back to 2007, it was 13 percent,  
5 prescription drugs; 21 percent, heroin.

6 So we went from a little bit over 40 percent  
7 in '07. In 2011, 73 percent. 93 percent today.

8 SENATOR GOLDEN: And how has it changed  
9 the -- getting these drugs over the last  
10 three years: By purchasing illegally? Homes?  
11 Prescription? Doctor shopping?

12 WILLIAM FUSCO: I don't have that --

13 KAREN CARLINI: I think there are various  
14 reasons.

15 You know, some of the kids in the program are  
16 here today, so I think they're probably the best to  
17 ask. And we -- believe me, we ask them a lot.

18 But, there's different answers.

19 Some, like one of the kids that stood up  
20 earlier today, from the medicine cabinet.

21 Some from a party.

22 You know, some, even from an injury. Maybe  
23 they were an athlete and there was an injury, and it  
24 started that way.

25 But, their stories aren't very different than

1 most of the stories you've heard in the last few  
2 years, in terms of how people start, especially  
3 young people.

4 SENATOR GOLDEN: Can I ask that young man to  
5 stand up again?

6 We're going to pick on you today.

7 How many pounds you weigh?

8 LUKE PARDNER [ph.]: How much do I weigh?

9 165.

10 SENATOR GOLDEN: 165 pounds.

11 How many times did it take before he's  
12 addicted to heroin?

13 How many times before he takes a hit on  
14 heroin, before he goes to the actual crushing,  
15 snorting, taking that pill?

16 How long does it take him to get addicted?

17 KAREN CARLINI: Level of pain --

18 SENATOR GOLDEN: How long did it take you to  
19 get addicted?

20 WILLIAM FUSCO: That's a tough call.

21 I can't give that call.

22 I mean, I'm going to say, the average amount  
23 of opioid addiction in the program is going anywhere  
24 from one year to about six years.

25 So, you know -- and the level of addiction,

1       you know, I mean -- Senator, let's start with the  
2       fact that, you know, a lot of our kids like to get  
3       high, unfortunately.

4               And as these drugs -- as these drugs vary,  
5       and modify, and go back and forth, there is an  
6       underlying fact of, you know, working with families,  
7       of trying to help people stay clean and sober, is a  
8       really, really, really important task.

9               SENATOR GOLDEN:  What I was trying to point  
10       out, I think a man of this weight -- a young man of  
11       this weight, three to four to five hits of heroin is  
12       enough to addict him.

13              That's what I was trying to point out.

14              You had your hand up back there.  Real quick.

15              ANTHONY ALVERNO [ph.]:  [Not using a  
16       microphone.]

17              My name is Anthony Alverno [ph.].  I'm  
18       currently in treatment.

19              And, it takes three to five days of  
20       continuous use to get an opiate habit.

21              WILLIAM FUSCO:  Right.

22              SENATOR GOLDEN:  Thank you.

23              ANTHONY ALVERNO [ph.]:  From what  
24       I understand.

25              SENATOR GOLDEN:  Thank you very much.

1 I'm sorry. Go ahead be, Mr. Fusco.

2 WILLIAM FUSCO: So I guess, when -- you know,  
3 when talking about the level of care, and, honestly,  
4 it was really the first thing that came to mind for  
5 me, I think it is essential that we think in terms  
6 of length of stay.

7 It can be, not necessarily, an intensive  
8 medical model. I don't think that that's necessary.

9 So there are ways of making costs, I think,  
10 you know, for, you know, inside the peer situation,  
11 reasonable.

12 But I think that the length of stay in a  
13 supportive environment is very, very critical to a  
14 lot of young people getting a chance of getting  
15 their lives back.

16 JAMES HOLLYWOOD: And if I could, just back  
17 to the point of insurance, you know, it's sort of  
18 coming at the worst time, I think, that health-care  
19 reform, as the opiate addiction has risen.

20 Because, like the gentleman had pointed out,  
21 three to five uses and you're addicted.

22 The prescription-drug epidemic really sort of  
23 heightened the fuel of the addiction, because it was  
24 pharmaceutical grade. It was always, you know,  
25 Oxycontin is Oxycontin is an Oxycontin. Right?

1           And, so, a bag of heroin varies considerably.

2           And that's the concern about heroin overdose,  
3 you know, when people transition, is the dosing is  
4 not regulated or controlled.

5           So what happens with -- and I think, is that,  
6 the prescription-pill epidemic which might be waning  
7 because of I-STOP, or other trends that might be  
8 happening.

9           But the heroin epidemic is the thing that  
10 I most worry, is because there's going to be an  
11 inconsistency in the supply and the quality, which  
12 would only fuel other behaviors which get folks in  
13 trouble.

14           So back to the impact of the health care, is  
15 that this is a lifelong chronic, progressive disease  
16 which people can recover from.

17           The length of time in treatment is an  
18 impacting element in terms of people's overall  
19 recovery.

20           So, to really think about the fact that we  
21 have such increasing numbers of young adults who  
22 have a chronic, progressive relapsing disease,  
23 starting at 16, 17, 18, and 19, now that's going to  
24 project over their lifetime.

25           That's going not just affect us in this

1 budget year or this funding year, but you're going  
2 to talk about, this is going to be a protracted  
3 experience for us as a state and a community.

4 SENATOR BOYLE: Thank you very much.

5 And let's just ask, I'm asking about the  
6 insurance aspect of this:

7 So, now, can you tell me how your patients  
8 are paid for, and what's the process to come in?

9 You argue with the insurance company for a  
10 couple days and then you finally get coverage?

11 Or how does that work?

12 KAREN CARLINI: Well, I think one thing  
13 that's important to note, is some of us aren't  
14 necessarily collecting insurance.

15 Remember, we provide residential services.

16 SENATOR BOYLE: Right. Well, however it is,  
17 yeah.

18 KAREN CARLINI: So how that's happened, up  
19 until now, is through State aid, and, you know,  
20 other third-party funding that we've tried to secure  
21 to make that happen.

22 The process for the insurance companies  
23 varies from one insurance company to the other; and  
24 it depends. It is never close enough to what the  
25 cost, you know, should be, or what the prescribed

1 visit should be, you know.

2 And I think Gary probably should talk about  
3 this a little bit more, in terms of what happens for  
4 you in the process. If you don't mind?

5 GARY BUTCHEN: No, that's fine.

6 Well, we're in a unique position because  
7 we're a private program. We receive no funding.

8 So, we're dealing with managed-care companies  
9 every single day for everything that we do, and we  
10 have been for 20 years, so we've seen the genesis of  
11 managed care since its inception.

12 Theoretically, as an outpatient system of  
13 care, the managed-care companies would want to use  
14 my level of care as opposed to residential or  
15 inpatient or even detox.

16 But even at the outpatient system, it's an  
17 argument.

18 So we have clinicians, physicians,  
19 psychologists, who do full-blown evaluations on  
20 patients. And when we determine that someone needs  
21 a higher level of care, there's no better expert in  
22 the room at that moment than us.

23 We're on the phone with the insurance  
24 company, and it could be a managed company based in  
25 Salt Lake City, or Philadelphia, or anywhere around

1 the country, and we're arguing with a nurse who  
2 hasn't seen the patient; we're arguing with a  
3 physician who, by the way, is not a an addiction  
4 psychiatrist, it could be a podiatrist; who's  
5 telling us what level of care.

6 "Try to hold the patient in your outpatient  
7 system."

8 Or, "We'll give you one to two days of detox,  
9 and then we want them back into your ambulatory  
10 detox to manage the mild to moderate withdrawal  
11 symptoms."

12 So we're saying to them: So you know that  
13 you're going to send me back a patient who's going  
14 to be uncomfortable, you're not going to allow them  
15 to complete their course of care, and I am supposed  
16 to pick up the pieces?

17 That's, if, they even come back into my door,  
18 as opposed to going to cop on the streets again  
19 because they're horribly uncomfortable.

20 So we deal with this issue every single day.

21 We offer the intensive-outpatient level of  
22 care, also.

23 And I know that you've probably heard  
24 testimony from around the state about how difficult  
25 it is to get people into detox or rehab.

1           We can't even get them authorized for the  
2 intensive-outpatient level of care.

3           They just want them in standard outpatient,  
4 and then the old argument, let them go to a 12-step  
5 program.

6           SENATOR BOYLE: Give me an example of the  
7 difference between regular outpatient and intensive  
8 outpatient.

9           What kind of service --

10          GARY BUTCHEN: Intensive outpatient is --  
11 should be at least 9 hours a week, or more.

12          We offer it 5 days a week, 3 hours a day; so  
13 it could be up to 15 hours. And that's,  
14 theoretically, a step down between the rehab and  
15 standard outpatient.

16          Standard outpatient is psychotherapy,  
17 45-minute session once a week. A couple of groups,  
18 60 minutes, 90 minutes, once or twice a week.

19          SENATOR BOYLE: Right.

20          GARY BUTCHEN: So it's a step down in the  
21 continuum.

22          So we're offering that buffer level between  
23 residential and outpatient. And that was created  
24 back in the early '90s by managed care, because they  
25 didn't want to pay for the residential-treatment

1 component.

2 So it became a level of care that the  
3 managed-care companies created.

4 SENATOR BOYLE: Regarding the -- now, any you  
5 take Medicaid or -- any facilities?

6 GARY BUTCHEN: Yes.

7 SENATOR BOYLE: Okay.

8 GARY BUTCHEN: On a fee-for-service basis.

9 SENATOR BOYLE: Any trouble --

10 GARY BUTCHEN: Outpatients.

11 SENATOR BOYLE: Just outpatients?

12 GARY BUTCHEN: Any outpatients not in the  
13 residential-treatment program.

14 SENATOR BOYLE: Any trouble with coverage of  
15 that, or arguing about --

16 JAMES HOLLYWOOD: In the Medicaid, or --

17 SENATOR BOYLE: Yeah, Medicaid. I'm sorry.  
18 Medicaid, yeah.

19 JAMES HOLLYWOOD: I'll defer to you.

20 KAREN CARLINI: No, not necessarily. I mean,  
21 there aren't problems with accessing treatment.

22 If someone is on Medicaid and they come into  
23 our program, we're able to bill for that.

24 The issues with Medicaid have nothing to do  
25 with people being denied treatment as a result of

1 being on Medicaid.

2 I think that's what you're asking?

3 SENATOR BOYLE: Yes.

4 JAMES HOLLYWOOD: Except the concern is now,  
5 we're -- this -- so, substance-abusing population  
6 had a carve-out, which is no longer going to exist.  
7 And as we move to managed care, managed Medicaid,  
8 then we're going to be subject to --

9 KAREN CARLINI: We'll experience the same  
10 problems with managed care. It is important to say  
11 that.

12 With straight Medicaid, we don't have the  
13 kinds of problems that we anticipate with managed  
14 care that Gary's program already experiences.

15 SENATOR BOYLE: That was my question: So  
16 you're not experiencing it yet, but you may --

17 KAREN CARLINI: We're not yet, but, yeah, we  
18 will.

19 I think we anticipate the same thing that  
20 everybody else is experiencing now.

21 SENATOR BOYLE: I mean, obviously, one of the  
22 big questions is, ObamaCare comes in, and addiction  
23 services are supposed to be one of the 10 areas  
24 covered.

25 How much, and what limits are going to be put

1 in place with that, is going to be a question.

2 KAREN CARLINI: Right, we're very -- yeah,  
3 we're very concerned about that.

4 We're very concerned about co-pays.

5 We're very concerned, you know, yeah, about  
6 limits on length of stay. And visits.

7 WILLIAM FUSCO: We would also like to say  
8 that the block grant certainly has been a major part  
9 of the funding for the residential programs. And we  
10 would like to see that continue. And, of course,  
11 the State aid to localities.

12 They really are the umbrella. That's really  
13 the safety net.

14 KAREN CARLINI: Yeah, I think that that's  
15 important to say, because, while I say that,  
16 currently, we don't have issues with Medicaid in  
17 terms of the treatment, we would never be able to  
18 support our program solely on Medicaid.

19 So -- and especially our program, and maybe  
20 some others, with younger people, many aren't on  
21 Medicaid anyway.

22 So we have, about, 40 percent of our  
23 population are on Medicaid in the outpatient  
24 program. And that's certainly not a lot.

25 SENATOR GOLDEN: The other 60 percent?

1           KAREN CARLINI: Private insurance, that we're  
2 really not able to access enough, you know, to  
3 support the program.

4           Some are getting on now. There is a little  
5 bit of a difference with ObamaCare.

6           But, the private insurance, we haven't been  
7 able to access private insurance at this point.

8           SENATOR GOLDEN: Samaritan, James, your  
9 situation?

10          JAMES HOLLYWOOD: So, the  
11 residential-treatment programs are funded, as Billy  
12 pointed out, by net-deficit funding, which is  
13 State -- uhm, uhm --

14          KAREN CARLINI: State aid.

15          JAMES HOLLYWOOD: -- State aid, comes with a  
16 block grant. And that's a part of the match.

17          The other part is local DSS supports through  
18 congruent care level to funding, from both the  
19 County or the City, in that regard.

20          And back to, the number for us, it's a little  
21 bit over \$20,000 a year per bed. And it's built,  
22 basically, on an economy of scale.

23          I mean, the programs are bigger than even the  
24 research might support.

25          So when we look at, not just the length of

1 time, also want to look at the size of programs.  
2 Want to look at how effective our programs could be,  
3 especially in light of the residential redesign,  
4 which is occurring right now.

5 And, you know, there's a hope that the  
6 residential redesign would look at incorporating  
7 insurance money alongside of State aid and congruent  
8 care support.

9 SENATOR GOLDEN: Is there anybody on that?

10 Is there a task force on that?

11 How's that being created?

12 JAMES HOLLYWOOD: It's a task force led by  
13 OASAS and a number of providers.

14 SENATOR GOLDEN: Are you on that?

15 JAMES HOLLYWOOD: Samaritan Village is  
16 represented on it, yes.

17 KAREN CARLINI: Yes, TCA -- regional TCA and  
18 OASAS co-chair the group. And it's a pretty wide  
19 representation.

20 SENATOR GOLDEN: And you're comfortable the  
21 way it's moving?

22 JAMES HOLLYWOOD: We're encouraged by it.

23 Uhm -- and the big thing --

24 SENATOR GOLDEN: That's a good word.

25 JAMES HOLLYWOOD: Yes, we are encouraged, the

1 fact that residential treatment is being -- is  
2 looked to be -- being preserved as part of the  
3 treatment continuum.

4 For the severely addicted, the removing  
5 people from their social environment and bringing  
6 them to a much more therapeutic environment has  
7 benefits.

8 And as other panel members have pointed out,  
9 you know, the length of time, six to nine months  
10 seems to be much more impactful, especially for a  
11 younger population.

12 For folks that we serve, who are adults, you  
13 know, the length of stay, again, anything over  
14 90 days is helpful.

15 The worry that we have, is that we become --  
16 we become like an inpatient rehab, which is more of  
17 a 30-day model. You know, that we'll get pressed to  
18 drop below even the 90-day that we're hoping to at  
19 least get out of the residential redesign.

20 Because that, for us, is a bare minimum. You  
21 know, that's sort of the minimum dose, effective  
22 dose, of residential services for severely addicted  
23 individuals.

24 SENATOR GOLDEN: I'm not sure we can do this,  
25 but I'm going to ask my Chairman. I guess we'll

1 have to sit down and discuss this.

2 I don't know if there's any way we can  
3 support some of your recommendations, from this  
4 Task Force. And, I guess we'd have to look to the  
5 Committee Chair, and to the chair -- the chair  
6 members, as, you know, which ones we could support,  
7 if, in fact, we could support.

8 JAMES HOLLYWOOD: Certainly.

9 Thank you.

10 SENATOR BOYLE: Any other questions from the  
11 audience?

12 Yes.

13 KEN: [Not using a microphone.]

14 How you doing?

15 I'm Ken [unintelligible] from Serendipity 1.

16 I have two things to say, real quick.

17 SENATOR GOLDEN: Louder and slower.

18 KEN: Two things to say.

19 One, I want to reiterate how hard it is to  
20 get into detox.

21 I got turned away from five different  
22 hospitals on Long island, and I was told to go home  
23 and don't use.

24 And that's not happening for a person who has  
25 an addiction problem.

1           SENATOR GOLDEN: I'm not going to pick on my  
2 friends from Long Island, but Lutheran Medical would  
3 take you in, like that [snaps fingers].

4           Go ahead.

5           [Laughter.]

6           KEN: I've been to quite a few.

7           The other thing, as far as how long you need  
8 to be in rehab, or a long-term treatment facility,  
9 the longer, the better.

10          For me, I -- that's why I'm in a one-year  
11 program, because I know I need it.

12          But, for a lot of people I know out on  
13 Long Island, that have jobs, and, you know, actually  
14 work and just aren't homeless, you can't just take a  
15 year off from work.

16          So having the 28-day programs, or the short,  
17 the Band-Aid programs, as they said, still available  
18 is definitely necessary, too.

19          So you want to keep that in mind, not to try  
20 to cut them out.

21          But the long-term is definitely vital, too.

22          SENATOR BOYLE: Thank you?

23          JAMES HOLLYWOOD: If I could just add --

24          SENATOR GOLDEN: Go ahead, James.

25          JAMES HOLLYWOOD: If I could just add to

1 that, and I appreciate you bringing up that point:

2 I think we need to have -- look at all levels  
3 of care as being effective. Right? And we look at  
4 what's -- you know, what is needed for that  
5 individual.

6 And, clearly, people who are employed and  
7 need to go back to a supporting a household, and  
8 themselves, and they have those means, they might  
9 actually be indicated in terms of their social  
10 connectedness, and that they could return to the  
11 community.

12 But back to what Gary said, is then, maybe,  
13 it's an intensive outpatient program; one that could  
14 be intensified in services that support working  
15 folks, because it's the aftercare. It's not the --  
16 you know, detox works.

17 But it's really the aftercare that follows up  
18 around the detox that will ensure that it sticks.

19 So -- so it really is, you know, there's no  
20 one model that works. If it was, we would have  
21 maybe discovered it and not have a panel today.

22 But, it's really going to be, I think, a  
23 broad-based approach, looking at varying levels of  
24 care: medication-assisted treatment incorporated in  
25 that. Naloxone incorporated, even in

1 treatment-provider programs. Providing education to  
2 our patients and our family members.

3 So, I support what was said.

4 SENATOR GOLDEN: Narcotics, obviously, is a  
5 terrible disease. And, whether it's Oxycontin or  
6 hydrocodeine [sic] or heroin, I don't know, there  
7 might be one or two in there.

8 Any of you that progressed quickly enough to  
9 using a needle, in the crowd, that would want to?

10 [Some audience members raise hand.]

11 SENATOR GOLDEN: Why don't you just --  
12 anybody want to talk about it, how long it took  
13 them?

14 Go ahead. Right there.

15 AUDIENCE MEMBER: I did Oxycontin for, like,  
16 six years, I would say, you know.

17 Lower? Higher? [Motioning with microphone.]

18 SENATOR GOLDEN: No, higher.

19 AUDIENCE MEMBER: I did Oxycontin for about  
20 six years. And once I progressed to heroin,  
21 I was -- ended up shooting heroin within a month.

22 And when you learn on the streets how much  
23 easier it is to, how much better it is, from  
24 everybody, they just -- it's just -- the talk about  
25 it, you know, nobody can resist it.

1           And once you start doing it, there's really  
2 no other way of, like, you know, putting it down,  
3 because once you get that sensation, I guess you  
4 could say, it never changes. You know?

5           SENATOR GOLDEN: And you're constantly  
6 chasing the high that never comes back?

7           AUDIENCE MEMBER: Yeah, you could say that,  
8 I guess.

9           It's more of, like, the -- just the fact that  
10 you think you need something that you don't actually  
11 need. You know, what I mean?

12           And until you are able to get away from it,  
13 which is what the long-term treatment centers are  
14 able to do for you, you know what I mean, is to put  
15 you away from your environment and away from, like,  
16 being on the streets, and stuff --

17           SENATOR GOLDEN: How did you get the help  
18 that you've gotten?

19           AUDIENCE MEMBER: How did I get there?

20           SENATOR GOLDEN: How did you get here?  
21 How did you get to the facility?

22           AUDIENCE MEMBER: I actually got lucky,  
23 because I live on Long Island, and it was a lot  
24 harder for me to get to a program that was upstate.  
25 So my mom actually knew -- through a psychiatrist,

1 was able to get me into Dynamite.

2 SENATOR GOLDEN: Okay.

3 And how long have you been in the program  
4 now?

5 AUDIENCE MEMBER: Almost 13 months.

6 SENATOR GOLDEN: 13 months.

7 And how are you progressing?

8 AUDIENCE MEMBER: I'm doing fine. I haven't  
9 used or picked up anything in 13 months.

10 I actually just came down from the upstate  
11 facility, so now I'm in outpatient facility down  
12 here. And, you know, it's working. It works very  
13 well.

14 The people at Dynamite are just fantastic,  
15 with the way that the program works, you know. And  
16 that's really --

17 SENATOR GOLDEN: Give it to the -- the mic to  
18 the young man with the white suit on, right back  
19 there.

20 Right there.

21 You had your hand up?

22 Okay, I'm sorry.

23 Okay, whoever wanted to speak back there, go  
24 ahead.

25 CHALID HUSSEIN [ph.]: Would you mind if I --

1           SENATOR GOLDEN: Yeah, go ahead.

2           CHALID HUSSEIN [ph.]: Okay. Since I have  
3 it, I figured I might as well, anyway.

4           SENATOR GOLDEN: Closer to you.

5           CHALID HUSSEIN [ph.]: My name's  
6 Chalid Hussein [ph.]. I'm actually a member of  
7 Dynamite Youth right now.

8           I'm actually a member of the Bay Ridge  
9 community, as well. I have been for about 18 years.

10          And I relate a lot to a lot of things that  
11 were said here today, particularly, I mean, just the  
12 way prescription pills have kind of taken over my  
13 life, and the life of so many of my close friends.

14          Linda Sarsour that was speaking earlier, she  
15 mentioned a few deaths in the Bay Ridge community  
16 over the past --

17          SENATOR GOLDEN: How did you get to  
18 prescription drugs?

19          CHALID HUSSEIN [ph.]: My first time, I got  
20 it prescribed by a doctor. I was about 19 years  
21 old, I had gotten in a car accident. I was having  
22 acute knee pain, and he prescribed me  
23 ninety 10-milligram Oxycodone pills, without any  
24 instruction how to use them.

25          He said, "Follow the bottle."

1           And the bottle said, "Take every 4 hours, or  
2 take as needed."

3           But that's how I got my hand on them,  
4 initially.

5           I mean, after I become addicted, me and my  
6 friends, we started taking them out of our parents'  
7 medicine cabinets.

8           Just, any way we could get our hands on them.  
9 Doctor shopping.

10          Just, everything, it just followed. It just  
11 became about, any way we could get them.

12          And it eventually progressed to heroin, once  
13 I found out about heroin, after doing it the first  
14 time. Just, after experiencing that initial high,  
15 there was just no going back to that --

16          SENATOR GOLDEN: Using a needle?

17          CHALID HUSSEIN [ph.]: Yes. Eventually  
18 I did, yet.

19          SENATOR GOLDEN: And how many of your friends  
20 were using -- went to needles?

21          CHALID HUSSEIN [ph.]: It's hard to give you  
22 a number, but almost every single person that I used  
23 the prescription pill with, that I ever used an  
24 opiate with, eventually ended up doing heroin.

25          SENATOR GOLDEN: And how many would you say

1 that was?

2 CHALID HUSSEIN [ph.]: Maybe, about, 20,  
3 25 of my close friends.

4 SENATOR GOLDEN: And you all hung out in the  
5 same areas in Bay Ridge?

6 CHALID HUSSEIN [ph.]: Yes.

7 SENATOR GOLDEN: Okay.

8 CHALID HUSSEIN [ph.]: Two of them, actually,  
9 the most recent ones, the one that just left the  
10 hospital in a coma, and the one that just passed  
11 away.

12 I had about six friends, six personal  
13 friends, die this past year in Bay Ridge alone.  
14 Just overdoses of heroin.

15 SENATOR GOLDEN: What woke you up?

16 What brought you to the realization that you  
17 needed this program or you were going to die?

18 CHALID HUSSEIN [ph.]: It's hard to word  
19 this, but, uhm, I was lucky enough to go to the  
20 point of abuse, like abusing myself to the point  
21 where I realized I needed help.

22 I was sitting -- I was sitting in a jail cell  
23 on Rikers Island, at the bottom, at my rock bottom,  
24 when I realized I needed help.

25 And, I was lucky enough to get referred to

1 Dynamite, actually.

2 I was lucky enough to get referred to this  
3 program, where, I mean, just the model is so much  
4 more intense. It's not just, like, about taking the  
5 drugs away, because there's so much underlying the  
6 drugs.

7 You take that out of the picture, but there  
8 was just so much more damage that I had done to  
9 myself, like, emotionally, behavioral-wise, and,  
10 just, there's so much underlying the drug use that  
11 needed attention, that I was able to get the help.

12 SENATOR GOLDEN: Thank you very much.

13 CHALID HUSSEIN [ph.]: Thank you.

14 SENATOR GOLDEN: Do me a favor, anybody else  
15 wants to briefly, and you don't have to share.

16 I know honesty is a big part of this program.

17 We just want to see the importance of the  
18 program, and try to -- how the program has helped  
19 you.

20 JOE: My name is Joe, I'm 24 years old. I'm  
21 currently with Dynamite Youth Center.

22 I have been to countless detoxes, countless  
23 30-day rehabs, 60-day rehabs.

24 SENATOR GOLDEN: How old are you?

25 JOE: 24 years old.

1           SENATOR GOLDEN: Go ahead.

2           JOE: My addiction started, I was 21 years  
3 old, I was injured in an accident. I was prescribed  
4 Oxycontin.

5           Within a month, I was, you know, addicted,  
6 bad.

7           Six months later I was IV'ing heroin, which  
8 led me to -- you know, in between that time period,  
9 I was in countless detoxes. I couldn't even tell  
10 you.

11          I'm a resident -- I was a resident from  
12 Staten Island.

13          Countless detoxes.

14          Landed me in my first rehabilitation center  
15 in Florida. I was there for 30 days.

16          Halfway house, my parents had continued to  
17 send me from one place to another.

18          I became homeless a dozen times, you know, in  
19 three different states. Bounced around all over the  
20 place.

21          I came to my realization 18 months ago.  
22 Walked into Dynamite.

23          I was in a shelter in Staten Island. I was  
24 sitting on a cot. I had lost everything.

25          I come from an upper middle-class family,

1       grew up good, good high schools.

2                You know, sitting on a cot, homeless, in the  
3       street, back in Staten Island, and had realized that  
4       I didn't want to live this way anymore. I was going  
5       to die. I had overdosed four times. I almost lost  
6       my left arm.

7                And, I'm 18 months sober now, due to  
8       long-term treatment.

9                UNKNOWN SPEAKER: Congratulations.

10               SENATOR GOLDEN: Very good.

11                        [Applause.]

12                SENATOR BOYLE: Quick question, I'm sorry.

13                Describe the first time you tried heroin.

14                So you're injured, you tried Oxycodone,  
15       opioids.

16                The first -- could you say, Well, it's  
17       cheaper?

18                Did someone say, Hey, we can get it, this  
19       thing, for the same high?

20                Or how did it work?

21                JOE: Well, for oxycodone, Oxycontin, at this  
22       point, at \$25 a pill, I mean, my habit had increased  
23       to \$200 a day.

24                Now, I have been -- you know, I was let go.  
25       I had worked for a family business. I was let go,

1 because of stealing, and other, you know, things  
2 I was doing.

3 So, I mean, to support that was -- you know,  
4 it was astronomical, which had led me to, you know,  
5 a cheaper -- you know, a cheaper high.

6 SENATOR BOYLE: Financially.

7 JOE: Financially cheaper, you know, which  
8 had brought me into -- you know, dealing with pills,  
9 you're dealing with an upper -- you're dealing with  
10 a middle-class group of people, growing up on  
11 Staten Island.

12 Doing heroin, and other drugs that I had  
13 explored, it led me into bad places. You know, bad  
14 areas.

15 You know, so...

16 SENATOR BOYLE: Thank you.

17 JOE: You're welcome.

18 SENATOR BOYLE: Good luck.

19 SENATOR GOLDEN: If there's just two more, if  
20 we can, because it's near our end.

21 And do me a favor, again, just be brief, and  
22 help us out, where you think you can give us a  
23 description of how we can be more helpful, as a  
24 Task Force, to get more help for you, and for your  
25 family.

1           LEEANN [ph.]: My name is Leanne. I'm 25,  
2 and I'm part of Dynamic Youth.

3           And, you were speaking before about, like,  
4 how -- you were wondering if marijuana was a gateway  
5 drug, and that's exactly how I started.

6           I started drinking and using marijuana, and  
7 also with the Vicodin, that was the opening for the  
8 opioid addiction for me.

9           SENATOR GOLDEN: Did you know Vicodin was  
10 heroin?

11          LEEANN [ph.]: No, not at the time.

12          At the time, I didn't have an injury. I was  
13 just experimenting. And a lot of, I guess it was  
14 peer pressure, were taking it. And once I did that,  
15 it just led on and on.

16          It was more of like a tolerance thing for me,  
17 where that wasn't enough, so I moved to Oxycontin,  
18 and then eventually to heroin.

19          And for me --

20          SENATOR BOYLE: Was that a financial thing  
21 for you, too --

22          LEEANN [ph.]: Absolutely.

23          SENATOR BOYLE: -- because you realized  
24 Oxycontin was so much more expensive?

25          LEEANN [ph.]: Absolutely. I mean, it was a

1 tolerance thing, where I would have to -- at the  
2 time, I felt like I needed it, or else I would, you  
3 know, withdraw.

4 And, so, it was a financial thing, it was a  
5 tolerance thing.

6 And I've been to countless 28-day rehabs,  
7 30-day rehabs, where I would get out and I would use  
8 right away, because I felt very awkward in society.

9 I was just taken out for a little bit, just  
10 to, pretty much, for me, I feel like it's just  
11 getting the drugs out of your system at that point.

12 Where, someone said that -- you know, my  
13 mother wanted me to go in, and I was still battling,  
14 like: I don't need to be here. This is not me, I'm  
15 not like them.

16 You know?

17 So, with the long-term treatment, for me,  
18 I feel like there's no other way, than to go away  
19 for a while, to get out of -- see, I'm from  
20 Staten Island. I needed to get away from there.

21 And, also, it's long enough for me to feel,  
22 like, comfortable without using, because I've been  
23 using for so long, that I can interact with other  
24 people. I can learn how to, like, just be in life  
25 without, you know, using after so long.

1           And then, coming down, also, the big part for  
2 me was maintaining it. Going to, you know, the  
3 outpatient part, you know, five days a week, and  
4 adjusting back in, because that's where I mess up,  
5 where I feel uncomfortable, and stuff like that.

6           You know what I mean?

7           So, for me, to get into Dynamite, it took an  
8 arrest, which, honestly, was -- it was a bad time in  
9 my life, but it was the best thing that ever  
10 happened to me, because it got me in; it opened my  
11 eyes.

12           And I feel like that's a big thing for a lot  
13 of people, sometimes that is case.

14           And, unfortunately, that was my case, but, it  
15 was the best thing, you know, that ever happened to  
16 me.

17           SENATOR NOZZOLIO: When you were arrested,  
18 what was the next step?

19           LEEANN [ph.]: The next step was, they  
20 already knew my history of me trying to get clean  
21 before; going into rehabs was not working.

22           And they said: You know, you can't just do a  
23 28-day. It doesn't work for you.

24           So they said, you know, "You should go away  
25 for a while," and they told me to go away for

1 nine months.

2 In Dynamite, you know, my nine months went  
3 up, and I was, like, "I'm not leaving. This is  
4 great. You know what I mean? I'm not going to  
5 leave this place. It just saved my life, and I'm  
6 going to continue with it."

7 So that's what I did at that point.

8 But, I don't -- you know, I could have gotten  
9 to a worse place, if that -- if I didn't get stopped  
10 there. You know, I feel like it was like a sign, or  
11 something. That's how I look at it.

12 SENATOR NOZZOLIO: Thank you.

13 SENATOR GOLDEN: Well, coming back to you  
14 guys in a minute, anybody else wants to share?

15 SENATOR BOYLE: Got one more back there.

16 SENATOR GOLDEN: Okay.

17 We're going back to the panel, shortly.

18 If there's anything that you think we left  
19 out, that we should be focused on, please, give  
20 us -- right after this person, give us some  
21 direction.

22 Go ahead.

23 PATRICK: Hi, my name is Patrick. I'm 21  
24 years old, and I am a member of Dynamic Youth  
25 Community.

1           And the thing I wanted to stress the most was  
2           about how the insurance companies treated me,  
3           because Dynamic Youth Community is my  
4           17th program.

5           I started at the age of 16 with the opiates.  
6           I was in lacrosse accident, and I shattered my  
7           thumb, and the doctor, he prescribed me Roxicodone,  
8           and he said I had "the good stuff."

9           Didn't even -- which I thought was absolutely  
10          terrible. He didn't explain to me how addictive the  
11          substance was, or anything about that.

12          I mean, I don't even know if he was educated.

13          But the way it worked with the insurance  
14          companies was, I go to a 30-day program, and then  
15          they would say, "No, you need two weeks," even  
16          though it was against what the -- what they had  
17          said -- what the rehabilitation center had said.

18          So I kept going back and forth through that,  
19          and it ended up being a disaster.

20          I went from program to program to program,  
21          until finding a long-term treatment program, which  
22          showed how to -- along with the addiction, how to  
23          rebuild your life skills, which someone who became  
24          an addict as young as I did, did not achieve.

25          So now -- now, aside from the addiction and

1 learning how to stay sober, and learning how to  
2 stay -- learning how to have fun again in recovery,  
3 now I know how to hold a job, how to --

4 UNKNOWN SPEAKER: [Inaudible.]

5 PATRICK: And, I just wanted to know if  
6 there's any steps that you guys are taking in order  
7 to go against what the insurance companies are  
8 saying? Or, with the funding, how it's going the  
9 work towards long-term treatment?

10 Because, obviously, the success rates with  
11 that, with extreme cases like me and some of my  
12 peers that are here, what's going to happen?

13 What are the steps that are going to be taken  
14 to go forth with that?

15 SENATOR GOLDEN: Well, I believe I'm going to  
16 let the Chairman speak to that in the a moment.

17 But I'm going to tell you, the more I listen  
18 here, and the more I see you stand up and tell me  
19 how many times you've gone to detox, how many times  
20 you've been in programs, how long it took you to  
21 finally get it, and to get the help that you needed,  
22 it looks like it was extremely more costly, had we  
23 made the investment up front and put you into a  
24 program that would have fixed you and put you on the  
25 right track in the first place.

1 I think it was much more costly, the path  
2 that many of you have taken, unfortunately.

3 But I guess that comes to the professionals,  
4 and understanding and keeping the -- those different  
5 people that are affected in the program.

6 I guess, then, how long that program lasts  
7 is -- and you guys have to make the diagnosis, as to  
8 what the -- you know, what that deadline or what  
9 that timeline is.

10 So I do believe that, the more we look at  
11 this, the more we hear, the smarter thing to do here  
12 is to make the investment up front, and sooner.

13 Of course, having to deal with our insurance  
14 companies and Medicaid and the redesign team here in  
15 the state of New York, as well as the Obama health  
16 care, is going to be a lot more difficult to do than  
17 what I've just said.

18 Chairman.

19 SENATOR BOYLE: Yes, Senator Golden,  
20 I couldn't agree more. And, we've heard this over  
21 and over again, and whether it's 4 rehabs, or 17, it  
22 really is, the system is not the most efficient that  
23 it can be, in terms of tax dollars, and helping  
24 young individuals, such as yourselves, to go through  
25 recovery, and an important thing Patrick said,

1 learning the life skills that you weren't able to  
2 the first time.

3 And that's exactly what we're going to look  
4 to do as part of this Task Force.

5 And when we issue our report, which is going  
6 to come out June 1st, you can look at it, and I can  
7 promise you young people that what you said here  
8 today is going to be part of that report.

9 And we've learned a lot from you.

10 I appreciate it very much.

11 Our panelists, if you'd like to, any final  
12 comments or thoughts?

13 SENATOR GOLDEN: Mr. Fusco, I know you got a  
14 word or two.

15 [Laughter.]

16 GARY BUTCHEN: That's why I'm going to go  
17 first.

18 You have a Herculean task in front of you.

19 There are so many moving parts to this  
20 problem; from the physicians who spoke earlier about  
21 the medicines that are available to us; versus the  
22 stigma; to the woman who spoke earlier about the  
23 debacle in sober homes; to the -- really, the  
24 Mason-Dixon Line between the Medicaid and managed  
25 Medicaid versus pure commercial insurance plans; and

1       what the juggling act that all of us sitting here  
2       have to deal with every single day.

3               The system that exists, and the variety of  
4       programs that we all offer, does have remarkable  
5       outcomes, when the people who have tried 17 times;  
6       or 16 times, try the 17th time to get in.

7               That should never be the case.

8               What I'm imploring you to do, is really take  
9       a good hard look at "medical necessity," regardless  
10      of whether it's 4623, or any other version of it.

11              Because, if this panel, if we were replaced  
12      by the medical directors of the managed-care  
13      companies operating in New York State, they would  
14      convince you that they've got fantastic policies  
15      that dictate medical necessity for the treatment of  
16      addictions.

17              The problem is, they're all different,  
18      they're all proprietary, and they're not shared with  
19      their own provider network unless you FOIL them.

20              If New York State puts on the books a  
21      definition of "medical necessity" that they all have  
22      to be held accountable to, then what we were talking  
23      about earlier would bear better results.

24              SENATOR BOYLE: We are going to. That's one  
25      thing I'm pretty certain is going to come out of

1 this in terms of insurance.

2 When we deal -- when I've talked to  
3 10 different insurance companies with 10 different  
4 definitions of "medical necessity," and all of them  
5 are trying to sneak their way out of coverage,  
6 basically, we're going to put their feet to the  
7 fire, I can promise you.

8 And thank you for those comments.

9 SENATOR NOZZOLIO: Well, in our -- and you  
10 mentioned this earlier, Mr. Butchen: You pay them  
11 now or you pay them later.

12 I mean, that's the kind of issue that, you  
13 have a problem that can be dealt with financially,  
14 appropriately, and significantly now; or we pay more  
15 because the problem wasn't resolved.

16 KAREN CARLINI: Last week I attended the  
17 National Prescription Drug-Abuse Conference in  
18 Atlanta. And for three days, they threw all sorts  
19 of statistics to us, many of which we know, and we  
20 know in New York, it's happening all over the  
21 country.

22 But one of the things they talked about was,  
23 just in this last decade, 125,000 people died from  
24 overdose from just hydrocodone.

25 And that number was just compelling to me.

1           For all I know and for all I hear, that  
2 number was compelling, because they talked about, if  
3 we did a moment of silence for those 125,000 people,  
4 it would take three months to accomplish;

5           And that it's, also, twice as many people who  
6 died in Vietnam.

7           And when we think about the spillover from  
8 Vietnam, and everything that's happened as a result  
9 of what people suffered in Vietnam, where are we  
10 going to be as this problem continues?

11           The thing that made me feel good, or what  
12 I walked away with, was in every workshop, every  
13 plenary, every session that I attended, everyone had  
14 the same message about collaboration.

15           And I think we're finally there.

16           I can't thank this panel enough, and what's  
17 happened, you know, in the New York Senate, in terms  
18 of pulling us all together as a group, and every  
19 component of it, because, without collaboration,  
20 this is not going to get solved.

21           And as Gary said, there's so many different  
22 pieces. And we're trying to balance that, as well.

23           I mean, to us, it's like a moving machine  
24 every day; it changes, and what we have to do.

25           So I think what -- maybe what we're asking

1 is, that you be sensitive to the fact that we don't  
2 overregulate.

3 You know, we don't want to look at, you know,  
4 and talk about law enforcement, we want to make sure  
5 that those that need treatment get treatment.

6 Those that -- you know, so we look at that.

7 When we look at prevention, we look at  
8 education.

9 We look at what we have to -- we do have to  
10 mandate people to do, but that you lean on the  
11 treatment community to help provide that, because of  
12 our experience.

13 Like Bill said, we're 43 years.

14 You know, I'm with the program 42.

15 Bill's with, from day one.

16 So, we've certainly seen it all -- well, no,  
17 we haven't seen it all, unfortunately.

18 This was a lot for us. More than we had seen  
19 in the 30 years in the past.

20 So, we have work to do.

21 But, again, I thank you, and appreciate the  
22 effort.

23 SENATOR BOYLE: Thank you Karen.

24 Thank you very much.

25 Yes.

1           RUCHAMA CLAPMAN: I'd like to touch on the  
2 issue of family.

3           The families -- once the young adult is put  
4 into rehab, the families must get educated, whatever  
5 they're learning in the rehab, so when the kid gets  
6 out, the family recognizes the red flags, et cetera.

7           But, prevention is the number one message  
8 that I'd like to leave today with; is that, a  
9 regular parent, after interviewing 15,000 parents,  
10 I interview every family myself, and the one thing  
11 for sure, they don't know the connection between  
12 their medicine cabinet and heroin, opiates, or  
13 anything.

14           So, ads, user-friendly, to a regular mom and  
15 dad that are not in the drug community, is very  
16 important.

17           And, also, prevention in the elementary  
18 schools, to make it more user-friendly, so that it  
19 gets translated from their point of view; not from  
20 adults and us that are sitting at the tables.

21           Thank you very, very much for today.

22           SENATOR BOYLE: Thank you.

23           SENATOR GOLDEN: Thank you.

24           JAMES HOLLYWOOD: And all I can do is  
25 reiterate the -- what the panel said here, is,

1 really, it's a broad-based approach that will  
2 soften, or try to solve, this problem: from  
3 education, from prevention, from the use of Naloxone  
4 and first emergency responders for the families  
5 members, for those suffering with addiction, as  
6 well.

7 And, really, to look at the need for a  
8 spectrum of treatment intervention.

9 Community-based care, community-based detox,  
10 does work and is effective.

11 Medication-assisted treatments are important.

12 They mentioned it earlier, the first panel:  
13 methadone and Suboxone and VIVITROL, and the like,  
14 finding the right mix for people.

15 And an important thing to recognize the need  
16 for, the severely addicted, is a long-term  
17 residential treatment does work; has been an  
18 effective part of the New York State model in  
19 treating addictions.

20 You know, over the past 30 years, starting  
21 with the DTAP and TASK initiatives, have solved a  
22 great problem of court diversion, and the need for  
23 court diversion; and, so, it has served the state  
24 well when that was a crisis, when crack cocaine was  
25 a crisis. When jails were overcrowded.

1           And I think it will serve a great role,  
2 moving forward, during this epidemic, is to be able  
3 to provide long-term care for those who need it, as  
4 the members of this audience sort of testified to.

5           SENATOR BOYLE: Thank you.

6           WILLIAM FUSCO: Senators, could I just say,  
7 back in 2007, Jerry Kasar [ph.] --

8           SENATE A/V PERSON: [Not using a microphone.]

9           I don't mean to interrupt. We've got to get  
10 all this in, and then change the tape. And then you  
11 can --

12          SENATOR GOLDEN: Two minutes.

13          WILLIAM FUSCO: I've got two minutes, that's  
14 simple.

15          KAREN CARLINI: No, no, no. He has to change  
16 the tape in two minutes.

17          WILLIAM FUSCO: Oh, two minutes to wait?

18          We have a couple kids that can sing back  
19 here.

20          SENATOR GOLDEN: Well, I got to tell you,  
21 I got to give all these kids credit.

22          I tell you, you guys are the lucky ones.

23          Right?

24                        [Applause.]

25          SENATOR GOLDEN: How many kids don't make it?

1           How many people, and how many more wakes are  
2 we going to go to?

3           How many more families' hearts are going to  
4 be broken?

5           So, God has been good and gifted you.

6           And I thank you.

7           And I thank all the different providers here  
8 today for the great work that they've been able to  
9 do, to return these young men and women back to  
10 their families and to the society, and to allow them  
11 to go forward and to be productive.

12           So, we thank you, too, this panel, for all  
13 its good work that they've done, and they continue  
14 to do.

15           Give this panel a round of applause, and the  
16 previous panels.

17                   [Applause.]

18           WILLIAM FUSCO: I did want to mention,  
19 Senator, that back in 2007, Jerry Kasar and myself,  
20 under your leadership, went to Albany and talked  
21 about the tremendous amount -- the tremendous  
22 percentage of prescription drugs, young people that  
23 were coming into our program.

24           And at that time, we were told that nobody  
25 can tell the AMA what to do.

1           And, we've been on a mission ever since,  
2           trying to say, as we saw what was happening in our  
3           communities.

4           And I do have to say, I think one of the  
5           things that we try to tell the young people here,  
6           who don't necessarily come forward all the time,  
7           that they're contributing.

8           That it's time that people come out and say  
9           what's going on.

10          And that's part of the solution.

11          And I think they see themselves as part of  
12          the solution now.

13          Thank you.

14          SENATOR GOLDEN: For those that testified  
15          here today, I just want to say, all of my colleagues  
16          here today that came in from across the state, take  
17          this very, very seriously.

18          And they're all approachable.

19          So if there's something that you did not get  
20          out, that you're -- either you're one of the ones  
21          that testified, or if you're one of the audience,  
22          please, contact any one of us.

23          The Chairman will make sure that it's taken  
24          into consideration, any of your thoughts that you  
25          have that that may not have been brought up, that

1 you -- you know, you're walking out the door and  
2 said, "Gee, I should have said this."

3 Please, we are all approachable.

4 SENATOR BOYLE: Thank you.

5 Mr. Vice Chairman, any final comments?

6 SENATOR NOZZOLIO: There was one lady that  
7 asked to speak, in the blue? You rose your hand a  
8 couple of times?

9 I don't know if anybody saw you behind the  
10 post here, but I did.

11 AUDIENCE MEMBER: I practice in Bay Ridge.  
12 I'm a medical provider. I know what's being done to  
13 look into --

14 UNKNOWN SPEAKER: They can't see you.

15 AUDIENCE MEMBER: Oh.

16 Hello.

17 I'm not a very good public speaker.

18 But I know what's being done to -- in terms  
19 of monitoring pharmacies and physicians, and we're  
20 aware of this.

21 What is being done to get the drugs off the  
22 streets?

23 If we had no heroin, would we be even having  
24 this discussion today?

25 SENATOR NOZZOLIO: I don't know if you were

1 here when the prior panel was here --

2 AUDIENCE MEMBER: I was.

3 SENATOR NOZZOLIO: -- but,  
4 Attorney McGoldrick and a detective went through a  
5 laundry list of items that are ongoing deficiencies,  
6 not necessarily in the punishment statutes, but in  
7 the investigative areas.

8 And that we're going to be working, in terms  
9 of helping eliminate a lot of the supply that the  
10 taxpayers actually are paying for, in putting it out  
11 into the streets. Not the taxpayers, but other  
12 unscrupulous individuals are putting it out into the  
13 street.

14 And I think that's certainly something.

15 And our mission, stated by Chairman Boyle, is  
16 threefold:

17 It's prevention, first;

18 Treatment, second;

19 And, prosecution, third.

20 And that's an approach, a lot of moving  
21 parts, as Gary said, but that's what we're focused  
22 on.

23 AUDIENCE MEMBER: Do you feel that it's  
24 working?

25 SENATOR NOZZOLIO: Obviously, if it was, we

1 wouldn't be here.

2 I think much of it's working.

3 When I see our young people in the center  
4 here, standing up and saying they're drug-free, that  
5 gives us hope.

6 And that's -- it can be done, if it's done  
7 the correct way.

8 And that's what you all have given us  
9 evidence about today.

10 But as our law-enforcement officers have  
11 given us evidence today, that it's a problem where a  
12 lot more resources need to be deployed to defeat it  
13 at that end.

14 Again, it's many moving parts to this very  
15 important problem.

16 And thank you, from my personal standpoint,  
17 for adding to the discussion in a very, very great  
18 way.

19 Thank you.

20 SENATOR BOYLE: And I'd, too, like to thank  
21 you, Vice Chairman Nozzolio.

22 And, Senator Golden, thank you for hosting  
23 this forum.

24 Thank you to our panelists, and each of the  
25 panelists.

1           And to the young people, best of luck in your  
2 recovery. We'll be praying for you.

3           And, thank you for everything. We got a lot  
4 of good ideas out of this.

5           And as Senator Golden said, if you think of  
6 something you didn't remember to say now, contact  
7 our office, because we've got until June 1st.

8           Thank you very much.

9           [Applause.]

10  
11           (Whereupon, at approximately 12:42 p.m.,  
12 the forum held before the New York State Joint  
13 Task Force on Heroin and Opioid Addiction  
14 concluded, and adjourned.)

15  
16                               ---oOo---