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

R0UNDTABLE DISCUSSION

TO EXAMINE THE ISSUES FACING COMMUNITIES

IN THE WAKE OF INCREASED HEROIN AND OPIOID ABUSE

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

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

PRESIDING:

Senator James L. Seward, Sponsor

Senator Terrence Murphy, Chair

Senator George Amedore, Jr., Co-Chair

Senator Fred Akshar

SPEAKERS:

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

John Muehl
District Attorney
Otsego County

Joe McBride
District Attorney
Chenango County

Richard Devlin
Sheriff
Otsego County Sheriff's Office

Craig DuMond
Undersheriff
Delaware County Sheriff's Office

Mike Covert
Police Chief
Cooperstown Police Department

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

Noel Clinton-Feik
Co-owner
Crossroads Inn

Joseph Yelich
Superintendent
Oneonta City Schools

Jason Gray
Paramedic
Chief of Sidney EMS

SPEAKERS (Continued):

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

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

Celeste Johns
Chief of Psychiatry
Bassett Medical Center

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

Ruth Roberts
Director of Community Services
Chenango County

Noreen Hodges
Council on Alcoholism and Substance Abuse
Schoharie County

Mary Rose Rosenthal
Alcohol and Drug Abuse Council
Delaware County

Chris Compton
Director
County Alcohol and Drug Abuse Services

Susan Matt
Director of Community Services
Otsego County

Julie Dostal
Executive Director
LEAF Council on Alcoholism and Addictions

SENATOR SEWARD: We're going to get started.

Apologize for a short delay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What's happening today?

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

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

First, Senator Murphy.

SENATOR MURPHY: Sure.

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

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

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

You're the ground game.

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

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

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

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

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

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

Went to the wake last night.

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

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

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

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

So, I am all ears.

Thank you.

SENATOR SEWARD: Thank you, Senator Murphy.

Senator Amedore.

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

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

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

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

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

And we, literally, have gone around this

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

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

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

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

important topic being discussed today.

Thank you.

SENATOR SEWARD: Thank you, Senator Amedore.

And next, Senator Akshar.

SENATOR AKSHAR: Well, good afternoon, everyone.

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

Thank you to everybody who is sitting around the table.

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

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

So, Senator Seward, thank you for hosting this.

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

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

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

Thank you.

SENATOR SEWARD: Thank you very much.

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

We'll start with you, Judge Burns.

JUDGE BRIAN BURNS: Thank you.

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

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

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

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

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

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

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

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

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

Thank you.

SHERIFF RICHARD DEVLIN: Richard Devlin, Otsego County Sheriff.

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

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

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

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

And we have seen it, of course, in the

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

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

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

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

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

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

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

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

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

NOEL CLINTON-FEIK: Good morning. I'm

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

problem that we're dealing with.

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

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

So, thank you.

I'm glad I'm here.

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

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

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

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

We started an orientation program for drug

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

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

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

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

I was just talking to Police Chief from Cooperstown.

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

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

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

And I'm also a DSRIP project chair --

co-chair.

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

We are a prevention education agency, same as Noreen.

We also do referral information, workshops.

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

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

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

CHRIS COMPTON: Hi, everyone.

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

We are a medically-supervised outpatient treatment program.

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

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

Otsego County also runs clinical services.

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

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

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

JULIE DOSTAL: Good afternoon.

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

I'm also the chair of the Otsego County

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

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

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

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

And I also want to thank everyone in the audience.

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

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

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

But if anyone at the table or anyone in the

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

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

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

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

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

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

What type of services and treatment are

currently available?

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

What treatment programs: inpatient, outpatient, other options?

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

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

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

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

Glad to be here.

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

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

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

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

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

You can look us up at recoveryseek.org.

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

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

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

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

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

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

Where we see some needs, is that next?

Is that what you'd like to hear next?

SENATOR SEWARD: Yes.

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

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

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

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

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

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

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

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

It warrants a full-court press, but the

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

It sends a mixed message, and addiction is addiction.

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

So I just wanted to put that on the table.

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

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

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

With a state as rich in resources as

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

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

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

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

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

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

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

No, we would not.

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

And, finally, prevention.

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

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

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

Use us.

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

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

Please consider this as you look to solutions.

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

We are heartbroken in our area.

Too many are suffering.

Too many are dying.

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

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

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

Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

that we have for people who struggle with mental illness.

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

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

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

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

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

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

I mean, who says that?

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

I think the other things in addiction, you know, what we struggle with in treatment is certainly access.

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

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

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

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

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

Something is broken with the system.

And I think families have been saying that,

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

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

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

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

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

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

So, it was a huge uphill battle.

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

So we need -- we need treatment that is

funded at a sustainable, reasonable way.

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

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

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

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

So, I think the regulations have been a barrier.

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

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

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

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

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

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

SENATOR SEWARD: Thank you, Susan.

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

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

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

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

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

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

It is medication-assisted treatment.

It is not just treatment with medication.

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

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

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

That has not happened, yet.

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

In terms of what might be helpful to move

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

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

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

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

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

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

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

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

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

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

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

That is a potential barrier.

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

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

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

We know the stigma that is around addiction.

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

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

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

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

That's federal?

DR. JAMES ANDERSON: Yes, federal.

It's CFR 42, Part 2.

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

SENATOR MURPHY: Okay.

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

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

DR. JAMES ANDERSON: Yes, Senator.

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

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

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

And the issue is, sustainability, as well as

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

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

But, they have to be sustainable.

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

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

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

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

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

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

our area, on any level.

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

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

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

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

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

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

We're siloed.

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

Health or by OASAS.

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

That's regulatory reform that we desperately need.

I think I'll stop here.

SENATOR SEWARD: Those are good points for us.

I wanted to call on Chief Covert.

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

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

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

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

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

That doesn't do anything for us.

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

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

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

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

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

A lot of it takes four to seven days just to

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

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

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

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

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

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

appointment, and then you're an outpatient.

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

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

But it's still not enough.

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

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

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

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

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

worried about the police.

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

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

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

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

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

It's a one-way ticket.

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

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

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

They tell me, reluctantly, heroin, or opiates.

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

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

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

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

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

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

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

They can't get fake prescriptions anymore.

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

All right?

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

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

Some of my people are using 25 packs a day.

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

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

And the family -- I have ANGELS that come

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

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

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

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

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

It's a skeleton in their closet.

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

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

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

Everybody in the room knows that

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

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

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

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

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

So I try and send them out of state.

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

[Laughter.]

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

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

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

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

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

Her neighbor was a movie star.

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

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

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

The hangups that we have, is not having money.

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

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

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

It doesn't help.

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

Our hospitals are -- hands are tied.

I dealt with the subject yesterday at Bassett.

Morphine pills.

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

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

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

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

SENATOR SEWARD: Chief, just briefly, the --

you mentioned there are 350 treatment centers?

CHIEF MIKE COVERT: 253.

SENATOR SEWARD: 253.

Are any of those in New York State?

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

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

Two.

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

SENATOR SEWARD: Uh-huh.

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

CHIEF MIKE COVERT: They are privately-owned.

SENATOR SEWARD: -owned.

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

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

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

SENATOR SEWARD: I see.

SENATOR MURPHY: So we have nobody in-network?

CHIEF MIKE COVERT: Nobody.

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

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

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

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

OFF-CAMERA SPEAKER: Right, right, right.

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

OFF-CAMERA SPEAKER: Yes. Exactly.

SENATOR MURPHY: Gotcha.

CHIEF MIKE COVERT: And that's our problem.

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

And that was just -- and I just looked in

Schenectady to Albany.

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

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

OFF-CAMERA SPEAKER: Right.

SENATOR AKSHAR: Has anybody found that problematic?

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

Has anybody had any dealings with that?

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

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

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

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

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

RUTH ROBERTS: I hear mixed information about

the bed availability across the state.

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

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

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

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

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

Something is really wrong, and something

needs to be fixed.

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

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

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

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

Prevention, prevention.

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

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

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

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

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

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

That's how small that window of opportunity is.

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

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

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

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

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

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

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

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

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

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

It's very difficult.

We then create all sorts of barriers for them.

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

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

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

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

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

You know, everybody has skin in the game.

Everybody has a part in the solution here.

SENATOR SEWARD: Thank you, Ruth.

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

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

RUTH ROBERTS: Thank you. I appreciate that.

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

This has all been very good comments, and we

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

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

And I appreciate that, Judge.

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

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

Are they helping?

Are they hurting?

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

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

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

[Laughter.]

SENATOR SEWARD: Use the mic there.

JUDGE BRIAN BURNS: Thank you, Joseph.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

That helps the reentry process.

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

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

It's not just hospitals were providing painkillers.

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

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

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

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

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

But these are the people who are really

responsible for bringing this into our community.

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

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

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

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

SENATOR SEWARD: Thank you.

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

JUDGE BRIAN BURNS: Absolutely.

SENATOR SEWARD: Any other comments from our law enforcement?

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

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

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

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

[Laughter.]

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

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

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

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

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

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

And then he would send his mule with the drugs.

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

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

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

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

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

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

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

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

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

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

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

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

DA JOE McBRIDE: Thank you, Senator.

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

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

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

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

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

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

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

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

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

We have a very conservative community.

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

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

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

How does that help me?

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

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

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

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

That being said, there are very serious issues.

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

There are now 230.

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

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

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

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

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

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

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

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

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

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

Well, he just got of jail.

Those people aren't getting in.

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

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

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

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

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

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

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

And that's because of money.

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

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

We need to find a way to provide that service.

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

Thank you, and that's all I have.

SENATOR SEWARD: Thank you, Joe.

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

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

UNDERSHERIFF CRAIG DuMOND: Thank you, Sheriff.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

punishment they deserve, because they do.

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

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

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

And it's heartbreaking.

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

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

Okay?

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

could be beneficial in helping us to address these problems.

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

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

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

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

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

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

Because, these victims are losing everything.

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

We have significant increased foster care.

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

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

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

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

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

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

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

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

SENATOR SEWARD: Thank you.

Any other comments, law enforcement?

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

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

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

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

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

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

[Laughter.]

LT. DOUG BRENNER: Because it seems as though

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

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

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

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

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

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

SENATOR SEWARD: Yes.

SENATOR MURPHY: Chief, is it?

LT. DOUG BRENNER: No, Lieutenant.

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

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

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

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

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

Since I-STOP legislation, now we find bags.

SENATOR MURPHY: Gotcha.

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

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

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

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

They're stealing it from our veterans.

They're stealing it from our seniors.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

It needs to be a pull system.

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

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

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

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

You know, I got off track a bit.

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

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

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

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

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

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

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

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

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

And, again, you can never go to any one

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

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

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

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

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

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

bad guy.

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

Are we getting the patients back to where they need?

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

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

SENATOR SEWARD: Thank you, Dr. Jones.

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

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

How do question get rid of the excess pills?

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

Doesn't everybody?

[Laughter.]

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

know how much I could get for those?

Oh, my god.

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

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

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

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

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

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

I am not sure (inaudible) Delaware.

OFF-CAMERA SPEAKER: We do.

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

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

RUTH ROBERTS: But if there could be some

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

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

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

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

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

SENATOR SEWARD: Good point.

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

And I wanted to hear from Noel -- both,

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

Yours is a residential.

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

NOEL CLINTON-FEIK: Sure.

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

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

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

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

The lack of affordable housing is then the next barrier.

So this county spends a million dollars a

year in sheltering homeless.

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

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

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

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

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

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

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

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

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

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

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

KELLY LINER, RN: Yes.

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

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

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

Right now, we're one of three recovery

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

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

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

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

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

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

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

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

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

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

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

SENATOR SEWARD: Turning Point.

KELLY LINER, RN: Yes.

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

KELLY LINER, RN: Right.

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

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

The -- Betty Courier (ph.).

KELLY LINER, RN: Yes.

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

It's kind of --

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

SENATOR SEWARD: Uh-huh.

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

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

That should be replicated.

KELLY LINER, RN: Right. Definitely.

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

SENATOR SEWARD: Sure.

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

75 people apply for it across the state.

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

When I asked the person who wrote that grant

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

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

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

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

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

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

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

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

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

And that's what I would love to see.

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

How many councils are there?

OFF-CAMERA SPEAKER: 33.

NOREEN HODGES: Okay.

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

And then what happens at the end of five years?

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

SENATOR SEWARD: Thank you.

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

SENATOR AMEDORE: Yeah, I did.

NOREEN HODGES: Thank you so much.

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

SENATOR SEWARD: Yes.

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

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

It just doesn't make sense.

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

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

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

SENATOR SEWARD: That's excellent points.

NOEL CLINTON-FEIK: Can I just bring up

another point that I missed on a gap?

SENATOR SEWARD: Sure.

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

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

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

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

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

CHRIS COMPTON: (Inaudible.)

SENATOR SEWARD: Sure.

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

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

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

I think it's a perfect opportunity.

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

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

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

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

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

SENATOR AMEDORE: Albany County Sheriff

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

OFF-CAMERA SPEAKER: Isn't that amazing.

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

It's amazing program.

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

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

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

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

But now we need the support housing.

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

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

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

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

Certainly, where you gonna live?

And that's often the biggest question.

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

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

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

It's very new.

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

hoping that the outcomes are good.

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

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

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

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

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

[Laughter.]

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

Okay?

I have my law-enforcement people over there.

[Laughter.]

RUTH ROBERTS: In general, I play by the

rules.

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

SENATOR SEWARD: Absolutely.

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

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

RUTH ROBERTS: Yes.

SENATOR SEWARD: -- on the counties.

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

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

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

You know, we would certainly welcome that.

And you mentioned the county.

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

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

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

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

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

Do we really need mental-health services?

Do we really need substance-abuse services.

Are people really, even, getting better?

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

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

SENATOR SEWARD: Thank you, Ruth.

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

individuals, two other issues.

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

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

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

SUPT. JOSEPH YELICH: Yes, thank you.

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

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

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

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

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

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

Thank you.

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

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

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

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

So having a quality relationship with law enforcement is big.

Having a quality relationship with juvenile

justice is a big deal for schools as well.

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

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

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

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

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

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

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

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

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

SENATOR SEWARD: Absolutely.

And that collaborative effort that you talked

about, particularly in the bringing a variety of services into the schools -- I forget who mentioned it -- was it you, Dr. Johns, talked about silos, in terms of regulatory silos, that come down from Albany and the various agencies?

We need to break those down, for sure.

In the time remaining, I just wanted to -- Jason, did you have anything that you would like to add from the EMS perspective?

JASON GRAY: Yes, I do. Thank you.

I know that I would like to reiterate a lot of the points that some of the colleagues here also brought up, is the fact that, you know, we have an increased number of responses to opiate and heroin overdoses in patients.

Narcan was difficult for us to obtain for some time. Once law enforcement started to have all the Narcan that they were carrying, there was a shortage for EMS providers, and that since has subsided.

So, the Narcan availability is there for us now, and it's -- that's a great thing.

Narcan is also readily available in many other homes, thanks to some of the Narcan outreach programs that have been in the communities.

There have been several, just in the general Sidney area.

So there's a lot of Narcan that's available in homes of families and patients, or, in some cases, even the users themselves have Narcan.

And we've seen an increase in responses.

And some of the problems that we find during our responses to these patients is that, we don't have a definitive transport decision for those patients.

The emergency rooms tell us that they may treat them for a couple hours, monitor the situation, and, then, simply discharge them, with some additional information and phone numbers to call.

And I know that a lot of the other folks here today say that that's -- that's also the problem that they're encountering.

So, patients that were not breathing when we arrived, couple of hours later, are discharged from the medical facility, with a little to no information, and expected to navigate the system on their own once they're discharged.

There's no place for us to take a patient who is -- who can't get any closer to crisis than an

overdose? There's no place for us to take them that's going to provide continued, long-term, ongoing support.

Those patients that were not breathing are now two hours back out on the streets.

And that's -- that's a big problem that we have, that there's just no -- there's no good place to take these patients. There's no definitive care.

And, you know, if the patient was involved in a motor vehicle accident, or the patient had a stroke, or any of these other things, there's definitive-care facilities that we take patients to that are specialty resource centers.

With this type of patient, there's simply no -- there's no place to take them, besides the local hospital, which is likely going to discharge them within a couple of hours' time.

So, that's one of the major issues that we have found.

Certainly, anything that can be done legislatively, or collaboratively between all these groups, to increase the number of beds available locally.

And I really like Bassett's plan to use some of their outreach centers to provide those -- that

outpatient service, because, really, every community -- most communities have some type of community outreach, whether it's a Bassett or UHS clinic.

Having those clinics available to provide that ongoing outpatient care right in the community where the patient lives, would be phenomenal.

But, in the short term, patients that are in severe crisis, that had just overdosed, are likely to be discharged from the hospital within a couple of hours' time.

And that's just not an acceptable -- just not an acceptable health-care decision.

SENATOR SEWARD: Thank you for the -- your comments.

And, we are at the finishing point of our session today, and I really appreciate everyone's views and candor here today; they've all been very helpful.

And before we conclude, I would like to see if any of my -- our Task Force members would like to make any concluding remarks.

Senator Akshar.

SENATOR AKSHAR: Sure.

You know, unfortunately, I think, from time

to time, we hear people in the community say that people don't care.

And I think that, to the contrary, we do, and today's a clear indication of that.

There are services available. We just need to ensure that they're more readily available.

And to each of you, I say, thank you, for everything that you do, and for providing us some insight as to the things that we can do, my colleagues and I, to make this easier.

To the men in uniform, I say, thank you, to the people that work for you. Of course, you have a close spot in my heart, due to my background.

So thank you for everything that you do.

And really, truly, from the bottom of my heart, I thank each of you for the things that you bring to the table.

Thank you.

SENATOR SEWARD: Senator Amedore.

SENATOR AMEDORE: It's very encouraging to hear the -- the amount of support and the collaboration that this region has already been working towards, and with, very much.

Many things that were discussed, you are not alone.

No matter where we go with this Task Force, we hear the same type of problems, same type of possible solutions.

And I will say that, we are very fortunate in the Senate to have our Conference. In the Majority Conference, that this is one of our top priorities.

Yes, it's education, and funding, and being -- making sure that our economy is strong, and job creation, but this is truly a quality-of-life issue for all of our community.

It doesn't matter how old in the age range, this is a quality-of-life issue.

If we want to curb crime in our streets and the local communities, we have to deal with this issue.

We want to deal with someone who is struggling with a substance abuse, in a wide range of the spectrum of substances.

We have to curb and talk about this issue.

And, believe it or not, there are many issues that -- and solutions that have been talked about today, that your suggestions, that we are kind of already developing in legislation or policy, that we just haven't exposed yet to the public because we're still vetting and working these things out.

To Jason's point with the Narcan, absolutely, it's a big issue, particularly when, now, you can go over-the-counter and anyone can have a Narcan kit -- (naloxone), and OASAS has no idea, DOH has no idea or clue, how many will be issued over-the-counter or when it's administered, and how many reversals were given.

So we have to do something about it, and we're working on that.

And whether it's in this year's budget or it's standalone pieces of legislation, we're working towards solutions.

Most encouraging thing, though, is this problem of quality-of-life issue that's affecting all of us, it's involving with some -- I think, some real compassion and passionate solutions that we can help fix and curb this problem.

So, the eradication of the heroin epidemic, yes, we can.

Whether it's stricter law enforcement and more treatment and recovery, it's -- I look at it as the whole overall substance-abuse problem, in general, in all of our communities, and how we can get New York to be much better in the quality of care in treatment, and as -- to be as most -- the

most efficient as possible with the taxpayer dollars.

So, yes, OASAS should rethink some things differently.

And, yes, we should have stricter laws on the books, in some instances.

But, for someone who is struggling with an addiction, we -- the solution is not just rest, throw them in a jail cell, and think that the problem goes away.

No.

It's much bigger and broader than that.

So, I thank you all for your words of encouragement, support, and educating me, to help go back to Albany to help you solve this problem.

SENATOR SEWARD: Thank you.

Senator Murphy.

SENATOR MURPHY: First of all, thank you all very much for being here today on this incredibly, incredibly important topic.

Just a few notes.

Jason, as a health-care provider, and a former EMT, knowing that this Task Force and our Conference has been the lead on this, as a group, to try and do the right thing.

If I've heard it once, I've heard it, actually, three times, that, yourself, as a former EMT, they've gone in, they've saved the person, brought them to the hospital. They have walked out because they're over 18 years old. They sat down at the dinner table that night and had dinner with the mother and father, had no idea that they were even in the hospital, went upstairs, overdosed, and died.

Three times, that this conference has heard that.

It's unacceptable.

And we're working on some things like that.

To Superintendent Joe, last year, when we found out that it was actually illegal for school nurses to administer the lifesaving antidote Narcan, this Conference was so dedicated to it, we put it in our one-House bill.

And to what Senator Seward said here, we don't like unfunded mandates.

We gave it the opportunity for the school nurses to be certified in it, to have a kit that's available to them, and we funded it.

Over a quarter-million dollars, to allow all schools in New York State to opt into it, because we don't like shoving things down people's throats.

Why they wouldn't do it? I don't know.

But we gave them the opportunity, and we funded it.

So we are trying to do a lot of things.

We hear you loud and clear.

To the law enforcement, to our business owners that are making this a business, we do need stiffer penalties.

And we are, we do have, our Senate, our colleagues right here, we have passed laws, but we need it on the other side of the aisle too.

It's a group effort, as we've said.

We're not tackling this alone.

It is a group effort.

And, you know, for the -- the real-time assistance, again, Joe, you know, you had Doc, like you said, you have a golden opportunity. That could be two minutes where that person says "I want help."

It's a quick phone call, and -- and knowing that we can get that person, because that's gone in 15 minutes. They changed their mind.

I've seen it firsthand.

And it's -- you've got to have the availability of being able to get that person when they're -- I don't want to say vulnerable -- when

they're accepting of, "I want help," or they're screaming out for help, or they finally reached the lowest point in their life, and having us to have the availability to get them somewhere.

So, yes, we are listening to you, loud and clear, and, I'll let you know.

Senator Seward, thank you so much for the opportunity of allowing me to be here.

Not only is our Task Force, you know, leaving here and going to Yates County, and then down to Brooklyn on Friday, but, our entire Conference is very passionate about this.

We realize it is a major, major epidemic.

And it is just a privilege to be here, and thank you for your time.

For your time of be here, thanks.

SENATOR SEWARD: Well, thank you, Senator Murphy.

And I want to say to you and Senator Amedore and Senator Akshar, thank you for traveling here to Oneonta and this region of the state to hear the comments from our local folks.

And, I know that the expertise, the comments we've heard here today, they're going to be part of the Task Force deliberations as we formulate

additional state legislation, and impacting state policy.

And, just to conclude, I just want to -- on behalf of all of those that I am very privileged to represent in this region of the state, I also want to say, thank you, to all of you who are on those front lines every day, in addressing this serious problem for the people of our area.

Your insights have been invaluable, and we -- we are -- I really appreciate your views and your candor here today.

And the sad fact is, despite our collective best efforts, this continues to be a very serious life-taking problem.

And, we've got to redouble our efforts, and make the necessary changes to beat this, this epidemic.

And -- but I'm optimistic we can do that, if we continue to collaborate and come together at meetings such as this, and then take the appropriate action.

I again want to say to everyone in the room, we've had a very excellent discussion here today.

But, if anyone would like to submit any kind of written comments to the Task Force, we welcome

those. And as I said earlier, if you would get them to my local office right here in Oneonta, I will see that the Task Force receives those written comments that will help in their deliberations.

So, again, thank you all for participating, and, stay tuned, because, we hope to take action in the upcoming budget, and the subsequent balance of the session.

Thank you so much.

[Applause.]

(Whereupon, at approximately 2:13 p.m., the public hearing held before the New York State Joint Senate Task Force on Heroin and Opioid Addiction concluded.)

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