BEFORE THE NEW YORK STATE SENATE MAJORITY COALITION
JOINT TASK FORCE ON HEROIN AND OPIOID ADDICTION

PUBLIC FORUM: MONROE COUNTY

PANEL DISCUSSION ON ROCHESTER'S HEROIN EPIDEMIC

Monroe County Office Building
39 West Main Street
Rochester, New York 14614

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10:00 a.m. to 12:00 p.m.

PRESENT:

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

Senator Joseph E. Robach, Forum Moderator

Assemblyman Mark Johns
State Assembly, Ranking Member of Drug and Alcohol Committee

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SENATOR ROBACH: Sorry for the little slight delay.

I try to be Marine Corps-disciplined and right on time.

We're gonna start, if everybody could just stand, and we'll start with the Pledge of Allegiance before we start our forum.

(All present at the forum recite, as follows:)

"I pledge allegiance to the flag of the United States of America and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all."

SENATOR ROBACH: And, maybe if we could just take one quick moment of silence for people we've lost to this, and other drug addictions, and maybe couple that with all our military people who are serving, just take a moment of reflection.

(A moment of silence was observed.)

SENATOR ROBACH: Thank you.

I am very happy to be joined by my colleague Phil Boyle, who's one of the Co-Chairs of the Task Force.

And unlike many very important things we look at, we usually try to, you know, hit key geographic

points, but because this has been so growing, impacted so many families, so many things, we're actually having 12 hearings across the state, to make sure that we give everybody an opportunity.

And we are learning, unfortunately, via a lot of bad incidents, sometimes those that are tragic, that this is certainly not just a New York City problem, a "big city" problem.

It is urban, suburban, and hitting every demographic of our community and of our state.

So, I want to, first and foremost, thank Phil for heading this up.

Senator Boyle, I should be respectful.

Can I call you Phil?

SENATOR BOYLE: Sure, yes.

SENATOR ROBACH: But, you know, we're trying to take a very, very aggressive approach to this, and we really want to hear what people have to say.

We've had the first hearing in Long Island; very eye-opening.

And I'm sure we're going to hear that across the state from a wide range of people impacted by this heroin epidemic.

Very quickly, before we get started, I want to thank my colleague Mark Johns from the Assembly

for participating today, and showing his interest.

And, also, just quickly introduce, Ann Cheweko [ph.], from my colleague Senator Pat Gallivan's Office, who's also a member on the Task Force, and has been participating in these, too.

Without further ado, I'll open it up to my colleague Senator Boyle.

SENATOR BOYLE: Thank you, Senator Robach.

And I'd like to thank my friend and colleague Senator Robach for hosting this forum here in Rochester, and, my former colleague Assemblyman Mark Johns for attending, and Senator Gallivan, as well, and the other Senators and Assembly people in the area, for their participation.

This is a serious issue on a statewide level.

I can tell you that I -- growing up in an Irish household, I kind of am familiar with addiction, mostly with alcohol, and -- but really got a lesson, when I was recently elected to the State Senate last year, and made Chairman of the Committee on Alcoholism and Drug Abuse.

The heroin epidemic that we're seeing on a statewide level is truly staggering, and the numbers

in the Rochester area are scarry, quite frankly.

I've been reading the "Democrat and Chronicle" reports, and watching the news reports, from Long Island, to see a four- and fivefold increase in use and overdoses in the Rochester area in just the last couple years.

With this, we've created this Task Force.

We're going around the state with 12 forums, as Senator Robach said, including one on the Seneca Nation, because it's a problem cross-country, really.

And what we're looking for, and I thank you all for coming here, participating, and watching, however you're going to be involved, because we're looking for a multipronged approach of facing this epidemic.

One of them, I believe, is prevention: to stop our kids from ever using heroin in their lives.

To teach them about the potential threats and life-threatening situations they can put themselves in.

Of course, the second prong is treatment.

For those who are addicted now, we have so many tragic stories of people who sought treatment and they could not get it because of the current

lack of beds and lack of insurance coverage.

And, of course, a third, and very important part, is law enforcement.

We're gonna hear from prosecutors, from law-enforcement officials, to tell how we can change the current laws, to make sure drug dealers and heroin dealers are put in jail for a very, very long time, to get this scourge off of our streets.

We had a very productive hearing.

This is actually the second hearing of the twelve.

And our first one on Long Island, we good ideas for possible legislation.

The mission of the Task Force is to issue a report by June 1st, and then pass subsequent legislation, based on that report, in the remaining weeks of the session.

We're under a tight time frame, unfortunately, but I think we can do it.

And we also need to convince the New York State Assembly to pass this these needed pieces of legislation, as well.

So, today, we look forward to the testimony of the people speaking, and we look to hear about your personal stories, whether you're a treatment

provider, a prevention expert, or law-enforcement official, give us ideas about, if there -- If I had one way to change the law, a couple of ways to change the law, to make this fight against heroin more effective, please let us know, and we look forward to hearing from you.

Thank you so much for coming.

And our first witness --

Oh, Mark. Sorry.

ASSEMBLYMAN JOHNS: Good morning, everyone.

Assemblyman Mark Johns, representing the 135th District.

I appreciate Senator Robach, Senator Boyle, for inviting me down to this.

I'm the Ranking Member on the Drug and Alcohol Committee in the State Assembly; here to learn, for the time that I'm here, about some of the problems.

We're already too familiar with what goes on in the last couple weeks here in Rochester area: the tragedy with heroin use among young people.

And I'm here to learn, and, hopefully, together, we'll cobble together legislation that we can get, and help the people, especially younger people, in New York State avoid this epidemic.

Thank you very much for having me here today.

SENATOR BOYLE: Thank you so much, Mark.

Our first speaker will be Bill Hochul, a U.S. District Attorney for the Western District of New York.

WILLIAM J. HOCHUL, JR.: Thank you, Senator Boyle, Senator Robach, and Assemblyman Johns, for hosting and convening this very important session here in the western part of New York State.

As the United States Attorney, I'm responsible for the enforcement of federal law in 17 counties.

Those include right here where we're sitting, in Monroe, all the way to Buffalo, down to the Cattaraugus Reservation, and, frankly, to Elmira, New York.

From my perspective, we are in the middle of a heroin and prescription-pill epidemic.

Frankly, we began seeing alarming statistics several years ago, including when I first became United States Attorney in 2010.

Now, as you've already no doubt discovered, the heroin problem frequently begins as a prescription-pill abuse problem.

One of the problems confronting us in law enforcement is that prescription pills are legal commodities.

Nevertheless, what we've seen on rare, yet noteworthy cases, is that medical professionals themselves frequently abuse their Hippocratic Oath and their licenses.

We've had cases where medical professionals have exchanged prescriptions in exchange for things like money; sex; a gas grill, in one instance.

We've also had instances where other medical professionals take unused prescription pills, such as when a patient in a hospital die, and then put those on the black market.

But by far the most common way that prescription pills enter the stream of illegal commerce is the family's own medicine cabinet.

Part of this, from our vantage point, is because there's such a large quantity of prescription pills that are frequently prescribed.

When not all of them are used, they're stored just down the hall where they can be used perhaps in a future occasion.

But, yet, when they're discovered either by other young people or other family members with a

need, what we see is the thefts now, not just of the family jewels, but, frankly, of these very valuable prescription opiates.

To give you a perspective additionally on the size of our problem, you may be familiar with the DEA Drug Take-Back Program.

There's now been seven programs, and that's one of the initiatives that we in federal law enforcement believe is as important as strict law enforcement; that is, removing the excess drugs.

Well, in Western New York, our prescription take-back has led the nation since it started.

And over the seven take-backs we've had, people have turned in over 103,000 pounds of unused, unneeded prescription pills. Literally, millions and million of doses.

But when we're not prosecuting prescription-pill traffickers, we in law enforcement are seeing a spike and an increase in heroin trafficking, both in numbers of traffickers and in the amount of seizures that we've been recovering.

Frankly, we also see polysubstances, such as heroin mixed with fentanyl.

And on that score, what we're able to do, at least under federal law, is ensure that those who

directly cause the death of their customer, even if it's a small amount of drugs, face substantial periods of time in jail; up to life imprisonment, in some instances.

As for suggestions, I continue to applaud your efforts to seek a multifaceted approach.

One thing we did in 2011, is we convened many experts from the medical, the treatment, the law enforcement, the educational communities, and we heard from families who have suffered losses.

Some of them are here in this room today.

What we have found, is that the medical community has a role to play, whether it be increased curriculum and training in medical school, or increased continuing legal or medical education for postgraduates.

We also strongly support treatment centers, so that people who certainly have the need, whether they're suffering from addiction, or perhaps they have this urge to get back into their former ways, have a place to go and met with qualified, trained professionals.

Well, one of the most valuable things that law enforcement has begun doing, and this happened in Buffalo about two weeks ago, is equipping police

cars with antidotes or antagonists to these opiates that really act as a way of suppressing the breathing and other respiratory and vital functions.

Narcan has been placed in all Buffalo police cars, and also given to other first responders.

That's certainly a way, that when somebody who's suffering or is in the throes of an addiction is discovered by law enforcement or first responders, this gives those people a fighting chance to get other medical professionals involved.

And then, finally, the treatment piece, which, hopefully, will remove the addicts -- or, the addictions from the person's life.

In conclusion, we in law enforcement agree that it is an epidemic.

We're doing everything we can, by targeting, investigating, and prosecuting those who illegally sell heroin, and the sometimes legal drug of prescription-pill opiates.

But, it is a multifaceted approach.

The United States State Attorney General has said it will require a mixture of law enforcement, education, and treatment, and I wholeheartedly concur.

I look forward to looking with you in any way

possible.

SENATOR ROBACH: Thank you, Bill, for your very cogent comments.

If I could just start:

So, you know, you talked about, and I think there's a real difference, obviously, we have -- I don't know who or why, but, the market is clearly flooded with very, very potent, yet inexpensive heroin.

And I don't mean the street dealers.

Somebody's behind this, and making a lot of money.

Do you think you have the tools now as a prosecutor, when you get the people that are really in there?

Are the sentencing guidelines and punishment adequate for this crime, do you feel?

WILLIAM J. HOCHUL, JR.: When it comes to heroin, absolutely. We have very strong guidelines, Senator.

And, frankly there is not a lot of weight of drugs which will get the defendant maximum exposure when it comes to opiates, including heroin.

We need, though, continued resources when it comes to being able to track the source of the

heroin.

We -- lately, on the DEA side, they've detected, and developed the ability, to try to test where that heroin originated. Literally, send it back to the poppy fields of a particular country or other.

But, certainly, we in law enforcement are doing everything we can to identify, with the available resources we have.

SENATOR ROBACH: Yeah, thanks.

And I was just gonna say, I think that was a good comment on, the Narcan, can help first responders, law enforcement, stop the overdose from being fatal.

But -- and we want to do that. I think that's gonna happen all over New York.

But, you know, ideally, we'd like to, you're right, a multi-approach; meaning, we'd like to get them much, much earlier, so we don't need the Narcan, and they're not in that situation.

But, yeah, I think we're gonna go that route, and I think that's gonna happen even separately from this Task Force.

I think it's already in process of happening all over.

SENATOR BOYLE: Thank you, Bill.

Just to follow up on Senator Robach's question:

Now, from what I've seen on the state-level penal code, there may be -- need to be an increase in some of the penalties.

But you're saying, on the federal level, that there's sufficient criminal penalties against the dealer; it's really just a matter of resources to find out?

WILLIAM J. HOCHUL, JR.: That's right, Senator.

One way that the law on the federal side is very beneficial, has to do with the supply of any quantity of drug that causes -- directly causes a death.

Ordinarily, the sentencing guidelines are driven by the weight of the seizure. Say, a kilogram of heroin would call for a certain amount of jail time.

But with the federal law relating to causing a death, even the smallest amount of drugs, if it causes death, can subject the dealer to up to life imprisonment.

So that is a very good tool that we are able

to use.

And, frankly, we have charged it last year in a case, where it was just a one small bag that caused the death of somebody.

SENATOR BOYLE: Wow.

Thank you very much.

That's great.

SENATOR ROBACH: Thank you, bill.

WILLIAM J. HOCHUL, JR.: Thank you.

SENATOR ROBACH: Before we get to our next testimony, I just want to introduce Jay Grasso [ph.], over in the corner, who's here representing my colleague Senator Mike Ranzenhofer's Office.

Thank you for being here, Jay.

And our next testimony will be from Theresa DeLone, who will be sharing a personal story.

Hi, Theresa.

THERESA DELONE: Hi.

Thank you for having this Task Force.

I'm not a public speaker, so I apologize if my testimony is not as --

AUDIENCE MEMBER: Could she speak up?

THERESA DELONE: Yes, I will try.

SENATOR ROBACH: Yes, just speak right in the mic.

Thanks.

THERESA DELONE: Okay.

So, I'm here today to spend a few minutes talking with you, not as a licensed professional, but a mom who has a son who is a heroin addict.

I can't quote any statistics or any studies; however, I can speak to you about my experience, and offer some thoughts on what I believe is needed to help in the fight against addiction.

Everyone says, "Not my child, not my family," but addiction does not discriminate.

It affects people from all walks of life: single-family homes -- or, single-parent homes, two-parent homes, and people from every social and economic group.

It is an equal opportunity destroyer.

My son is more than a heroin addict.

He is a loving, caring, and sensitive young man.

He was an athlete, a very responsible student, and an employee, prior to his addiction.

He had several full-time jobs, was recognized by his employer as hard-working. And even asked to

travel on behalf of one of his companies.

Once his addiction took over his life, he lost friends, jobs, and finally was isolated by his addiction.

He has become someone -- he became someone that we did not even recognize.

Addiction is called "a family disease," and I can tell from you my personal experience that this is true.

As their addiction progresses, your family life becomes chaotic.

The family members suffer from various side effects from the addict's behavior, from financial problems, sleeplessness, emotional distress, and some even suffer from physical illnesses.

Trusts and respects are lost, and is replaced with suspicion and fear.

There are many emotions felt by the family members: anger, helplessness, embarrassment, worry, and fear are just a few.

You're angry that your family has been affected by this terrible disease.

Angry at your loved ones that they are using drugs.

Angry that your sense of a normal family life

has been destroyed by the drugs.

You feel helpless that you cannot either help your family or your addict.

There are many sleepless nights and worry, and a lot of tears.

You live in fear that you will get the phone call that no family wants to get: that your son or daughter is either in the hospital from an overdose, or has, worse yet, died.

The family believes that they are helping their addict, but, many times, what we are doing is enabling the addict.

Imagine turning your own son into the police for stealing yet another item from your home?

Imagine the shock and embarrassment you feel when police officers are at your door to arrest your son and remove him from your home in handcuffs.

The heartache that you feel when your son is calling from jail, asking to be bailed out; and saying "no," not because you don't have the money to bail him out, but because you feel he's safer in jail, off the streets, away from the drugs; or, that you just need a break and some peace and quiet from the addict.

My son has missed many holidays, birthdays,

Mother's Days, important family events, like college graduations.

You have an emptiness in your heart that your son or daughter is suffering from this terrible disease.

I could tell you many stories that would probably horrify you, but I'm gonna move on to things that I think would help in fighting this addiction.

Once our families have reached the limit of what they can deal with on their own from the addiction, they may turn your addict out onto the street, which now you have a homeless addict on the street who is desperate for money to get drugs.

They will steal, they will lie, they will manipulate; they will do anything in their power to get a drug.

I would believe that many of the homeless on our streets today are either current addicts or are former addicts, and are still looking for a way to find their way to recovery.

Our schools are also affected by this crisis.

The addiction to pain killers is starting much younger than it ever was in the past.

These students are not paying attention in

class. They're not getting the education that they need. Likely, they're disruptive to other students, if they're even attending class at all.

Many of these younger addicts are not gonna continue on to go to college, because they just cannot make it to college, which, then again, is gonna lead to a life of low-paying jobs, or worse yet, they will continue with crime in order to support their addiction.

What can we do as a community?

This is a question for which I do not have an answer, but I'll offer some suggestions and thoughts that I think will help.

We must, must, must continue these discussions.

There are so many young people that are in need of help.

Parents must be educated about the crisis in our schools, our communities, and our families.

They need to learn all they can about addiction, and, also, what treatment options are available if they find themself in need.

We must stay connected to our children, know their friends, support their interests, and stay involved their life.

Casual conversations about drugs and addiction are not going deep enough for our families to know what addiction looks like, how it affects your life, your family, and how it escalates until your life is totally out of control.

Our children need to understand that drugs and addiction will ruin their life and take away their dreams.

More treatment options are needed.

Everyone is an individual, and every road to recovery is different.

No two people will travel the same path to recovery, and each need to find what works for them, and need an opportunity to obtain the best treatment that they can.

Many addicts have private insurance, and still, yet, cannot get the treatment that they need.

My son, when he was reaching out for help, I had a private insurance policy for which I pay every single month, year after year after year, and he was denied many, many times for getting the help he needs.

When you have an addict who is reaching out for help and they are denied the help that they are asking for, this is overwhelming to them.

They no longer have an option, or they feel they have no options, and they do not know what to do next.

Families don't have options either, because, what do you do?

You have a child who is doing the right thing, who is trying to get help, yet nobody will help them.

Addiction is a disease.

I don't think there's a medical professional who will say it is not a disease.

Why do the insurance companies not recognize it as a disease?

It is a disease that, untreated, will kill the addict. There's is no question about it.

I personally know of a young girl who has recently lost her life.

She was sent out from detox after seven days, to wait on when a treatment bed would become available to her.

Unfortunately, she died before that bed was available.

We cannot continue to send our children out on the streets after a 7- or a 10-day detox. It is not enough.

They are given the option of: To wait until a bed is available, or, they are told to seek outpatient treatment.

And if you ever tried to get an outpatient-treatment appointment, you will wait weeks in some cases.

My son was recommended many times for a mental-health evaluation.

Do you know how long he had to wait for an appointment? Weeks, and months, before anybody would even schedule an appointment for him.

By then it was too late.

He was either back on the streets or he was in jail.

My son has made a lot of mistakes for which he has paid dearly.

He has spent many days in jail, which is not where you want an addict because that's not where they're getting any treatment.

Intensive inpatient treatment is a level of treatment that our children must have available to them in order to sustain their sobriety.

During their stay there, they can concentrate on only themselves. They can get the help they need for both their physical and mental wellbeing.

Many of these addicts lack coping skills.

They need to get coping skills.

And by being inpatient, off the streets, where they can access to a counselor at any hour of the day and night, is extremely important.

I agree with Phil, in the fact that -- and I apologize for using your first time name, I don't remember your last name -- we need to get Narcan into the hands of all our first responders.

And any family who has an addict living in your home, you must have Narcan available to you.

If you don't, your child or your loved one may die waiting for a first responder to get there who has Narcan. Some of them do not.

These children do not have to die.

We have this drug available.

It will help get them to at least to the hospital, where their life can be saved, and they have an option of getting recovery.

In closing:

I am thankful that my son's parole officer saw his potential and recommended inpatient treatment for him over a return to jail.

Today my son is almost 9 months clean and sober.

His journey has been a long and a bumpy road with multiple relapses.

Without seven months of intensive inpatient treatment, I believe that my son would not be alive today. His addiction would have taken his life.

As a community, we need to ban together to find ways to reduce, and eventually end, this heroin crisis before it's too late.

Too many of our young people are dying, and we are not talking about the things that are important.

We must find a way to help those who are already addicted, and to prevent others from becoming addicted, and prevent other families from having to go through what many of these families who are sitting here today I'm sure have gone through.

Thank you for your time, and thank you for creating this Task Force to address this crisis our families and community is facing.

SENATOR ROBACH: Thank you, Theresa.

And I'm glad that your son is moving in the right direction.

THERESA DELONE: Thank you.

And that's a day-to-day thing, I will tell you.

Today, knock on wood, he is doing well.

That could change on a dime, unfortunately.

SENATOR BOYLE: Thank you so much, Theresa.

And I, too, hope for the best for you and your family.

A couple of things you touched on was:

The insurance coverage.

And that is one of the issues we've been hearing in -- at other forums and discussions; that, these insurance companies -- yours didn't cover at all -- but others of them say: Well, we're gonna give you three days of treatment, and then come out, and I'm sure you'll be free of heroin after three days.

THERESA DELONE: That's right.

SENATOR BOYLE: It just doesn't happen that way.

THERESA DELONE: Exactly.

SENATOR BOYLE: It needs to be the medical professionals that make these decisions, and not the insurance companies.

And we're certainly looking at that for potential legislation.

You also did touch on the Narcan use.

I can tell you that, as a former EMT, I've

seen Narcan work personally, and it is truly a miracle drug.

It's Naloxone, and Narcan is a brand name.

To watch a young man who is at death's door -- lips were blue, not breathing, not responsive, just about to be pronounced dead, really -- and they gave him Narcan, and within one minute, he was awake, alert, and talking to me in a normal conversation.

It's unbelievable.

And we need to do it, not just for first responders, but get it available in the general public.

We are hosting an opioid-Narcan treatment campaign on Long Island.

I know Senator Robach is gonna look into it, one here in Rochester, as well.

Where, you don't have to be a first responder. Anybody can get it.

It's less-than-an-hour class.

And, they will give you a nasal spray.

It's not gonna be a syringe you need to stick in someone's arm.

You can do it nasally, so you can, literally, save a life.

Hopefully not your family's life or a neighbor's life, but you will save a life.

Thank you so much.

THERESA DELONE: And I do have Narcan, I will say. I do have it available to me.

But what I find unusual, is that I was told when I was given it, that it may be, if somebody stopped me, if a police officer stopped me, that it may be confiscated.

And that to me is unbelievable in today's heroin-addiction crisis, that somebody would confiscate something from me that I could save my child with.

SENATOR BOYLE: Well, thank you for making me aware of that. I was not sure.

And that's one of the laws we need to change if that's the case.

Thank you so much, Theresa.

THERESA DELONE: Thank you.

[Applause.]

ASSEMBLYMAN JOHNS: Okay, we'd now like to introduce Jennifer Faringer. She's director of National Council on Alcoholism & Drug Addiction in the Rochester area.

JENNIFER FARINGER: And, good morning.

And I certainly would like to thank Senator Robach, Senator Boyle, and Assemblyman Johns.

This is an important, important issue for our community, and our state.

I'd like to talk about a couple of issues.

Some of them have been raised, but certainly to address the issue of the rise in heroin use, the fatal-overdose increases, but, without speaking about the related prescription over-the-counter misuse and abuse, the two are inextricable.

So, specifically -- let's take section by section.

Specifically, the problem is related to prescription or over-the-counter pain meds or opiates.

They've reached epidemic proportions in the past decade.

According to the Center for Disease Control's Vital Signs Report on prescription pain meds, 15,000 people die each year from prescription-med overdoses.

One in 20 people, age 12 or older, reported using prescription pain meds for non-medical reasons.

What does that mean, "non-medical reasons"?

It means getting ahold of a script that was never intended for you in the first place.

Whether given -- kindly given, or, whether getting through methods of diversion, illegally obtaining, prescription pain meds have been overprescribed, with enough prescribed in 2010 to medicate every adult in the United States around the clock for a month.

To me that's a staggering, staggering figure.

For women alone, deaths from scripts, pain-meds, overdoses increased more than 400 percent since 1999.

That's compared to an increase of 265 percent among men, which already is an alarming statistic in itself.

For every woman that dies from pain-med overdose, 30 women seek help at emergency rooms for pain-med misuse consequences.

So what are those common scripts and over-the-counter opiates that are diverted, abused, misused?

Most commonly, we're looking at Vicodin, Percocet, Oxycontin, and, Opana, one of the more recent.

Even more recently, sadly, approved by the FDA is the even more potent Zohydro ER.

It's now in the market.

There's a number of AGs across the country that are looking to revoke that approval.

This is more potent than anything we've ever seen, and, certainly, if released widely, will -- will -- I can't even imagine the escalate in terms of numbers.

So, Zohydro ER, bad thing, needs to be off the -- off the market.

Additionally, with kids, we think about the opiate over-the-counter dextromethorphan, which is a primary ingredient in the over-the-counter cough products.

If taken as intended, one teaspoon every four to six hours, you're fine.

But that's not how it's being taken.

It's being taken in the amount of 25 to 30 times the amount of recommended doses.

That's taking it by the bottle; not by the teaspoon.

When you do that, the consequences are enormous. So, any abuse of these products.

If taken as prescribed, or taken as

recommended on the bottle, not a problem.

It's when we're prescribed or we take the excess that we get into the issue.

So now the problems specific to the rise in our community around heroin abuse:

Across multiple sectors in our community, all data points to the fact that we're in the midst of a sharp increase in heroin use, as well as increase in overdose fatalities from heroin.

There are so many factors, it's very complex, that are responsible for this shift in demographics across the board, that we see in Rochester, in Monroe County, in the Finger Lakes region, as well as the state of New York.

And there's many similarities.

We know from research studies that the following factors identified as predictors of drug abuse are responsible for the shifts in demographics that we're experiencing, and those factors include things like: How accessible, how available, is heroin?

Unfortunately, it's extremely accessible, extremely available.

And that is not limited to what was, prior, its accessibility in the urban area, but it's

extended out equally into the suburban and rural areas in New York.

Increasing, but still variable, is that potency.

And a prior speaker addressed that: the potency of heroin itself.

So you've got availability, you've got potency.

The potency is a variable.

That means that the addict that perhaps has been incarcerated, and now goes back on the street, gets ahold, (1) there's the tolerance issue coming into play, but (2) there's the issue of, now, you have perhaps a heroin that's much more potent.

And, it's buyer beware. How would you know that?

Overprescribing of opioid scripts:

Although, with I-STOP, which is a -- is a positive step, we're gradually seeing an impact in this area.

But we still hear, unfortunately, there are those physicians that, instead of prescribing after a post-op, a few pills to get you to your primary-care physician, which would be the ideal route, they're being prescribed 60, 70, 80 pills a

pop.

You know, a couple -- it's a bad, bad news all around.

So regarding purity:

We know that the purity of heroin is available, with 60 to 70 percent range typical, but, there's a real -- a much wider variation, from -- anywhere from 3 to 70 percent in actuality.

And the issue of potency variance plays a striking role, and it is responsible for the increasing number overdoses and subsequent fatalities, as well as the tolerance issue.

If a client has been detoxed and returns to the community and relapses, the likelihood of overdose and death is high due to, again, both tolerance and potency.

Additionally, then you've got the issue of heroin possibly being cut with things like fentanyl, an opiate in itself; a synthetic opiate.

That's been evidenced in several recent local cases of overdoses.

Cutting heroin, already with variable potency, with now a synthetic opioid, fentanyl, serves to further increase the potency of the final heroin combination, making the final product even

more potent and more deadly.

Regarding costs:

We know there's a variation in cost, but street-level heroin is currently at an all-time low in our region, as well as in the state.

Locally, we're hearing prices such as $10 a bag, and as low as six to eight in New York City.

Compare this with the street cost of diverted Oxycontin, for example, you're looking at 80, maybe 100 dollars a tab.

So it's no surprise then, that the patient who becomes addicted -- if you follow this out:

They become addicted to their legal pain med, because they're overprescribed.

If you take your full 80 to 90, 100, chances are, you're gonna become addicted.

You go to the street -- because you can't obtain another 80 to 90, hopefully, but you go to the street to try to get ahold of Oxycontin, you're paying a huge cost.

So it stands to reason then, that the user would then shift to the much more available, much more accessible, and much less costly heroin on the street; the illegal heroin.

With overprescribing practices, patients,

again, following their outpatient dental, following their outpatient surgeries -- or, I think I spoke to this -- have been known to be prescribed opiates in excess of the actual need, the 60 to 80 tabs, versus, the few tabs to get them to their primary care.

And at this point, one of two things happen:

Either they take it for the few days following the procedure, just to get them over the post-op pain, but, then, put the often large remaining quantity in their medicine cabinets; hence our campaign, through the National Council on Alcoholism & Drug Dependence, has been an awareness campaign around, "Do you know what's in your medicine cabinet?"

So being very aware of excess -- the potential excess of opiates in your cabinet.

If you place the unused portion of the prescription in their medicine cabinet, they increase the likelihood of diversion of that product, and they become targets in themselves.

We try to warn, for example, realtors:

When you're having a house showing, are you aware, or do you have a party that's going along with the realtor, and then you have another party

that's maybe checking out the medicine cabinet in the bathroom?

You know, those are all ways to divert.

Or is the house targeted, because you know that the occupant is either a senior citizen, one that's had a dental surgery, outpatient surgery, for which there's likely excess opioids in the medicine cabinet.

Another scenario might include a patient taking their pain med longer than the time needed to address their post-op pain.

In this case, they're likely seeking the euphoric high produced from this family of drugs: the opiates.

With the opiate family, there's a fairly rapid progression to addiction; and once addicted, and unable to get more of the script again, it's very likely that they switch to the cheaper and more available heroin.

Then regarding the demographic shift, and as a prevention professional, this is something that certainly has caught my attention, our attention, as well as in the treatment community.

Recently what we're seeing is a dramatic shift in user demographics across the board, from

the heroin user -- former heroin-user profile -- age, gender, ethnicity -- being one vision, one profile, to the more current and very different user profile.

The shift has been seen and verified through surveys at local schools, verified through intake data at treatment-provider sites, through needle-exchange programs.

The more current profile includes, unfortunately, a younger population, with an average age now showing up in treatment, at needle-exchange programs, 16 to 29.

A very different age range than what we were seeing before, even five years, and, certainly, a decade ago.

The shift is also now primarily Caucasian, with increasing number of female users; when, before, the profile was primarily male.

Additionally, there's a geographical profile shift, from previous users coming primarily from an urban setting, to current users coming from, equally, all demographics.

Urban, suburban, rural, it knows no boundaries now.

The broad demographic shift is being driven

by all of the above factors, and includes, unfortunately, that decreasing perception of risk among young people and young adults.

Note the recent case at University of Rochester, the young woman who -- a young college student, who took heroin and it was a fatal death associated with that.

Perception of risk in our field is a strong predictor or driving factor in subsequent drug use.

So what are some of the solutions?

I think they're varied.

And I applaud you again for convening a Task Force that addresses all the issues.

One of the primary pieces, and Bill Hochul talked about this, certainly, the DA is conducting again a safe Take-Back Day, Saturday, April 26th, from 10 to 2.

It's the seventh of those Take-Back days in Monroe County. They've been particularly successful, of course, as well as New York State.

And from our region, the take-back has been over 36,000 pounds collected from over 16,000 individuals.

That's enormous.

Additionally, in Monroe, I think we could

serve as possibly a model for the state of New York in terms of frequency: frequency of location, frequency of dates.

So we go above and beyond bragging about Monroe County.

But that's okay, Joe. Right?

SENATOR ROBACH: Brag on.

JENNIFER FARINGER: In Monroe County, if you go to the Monroe County site, HHW, you see multiple opportunities.

So we have the wonderful two DA, fall and spring; excellent.

But, also, if you go to the Monroe County site, you see several sites, anywhere from three to four a month, multiple locations across the county.

So, there truly is no excuse for someone with unused meds to get those scripts off the street.

And there's confusion, too, about that.

It's a totally confidential way to get things off the street, to get them safely incinerated. No environmental impact.

Just the elimination of potential diverted opiates.

And then support the full implementation of the needed I-STOP.

We're in the place right now of, potentially, being fully implemented by the end of this year, perhaps early next year, but this helps to further curb those overprescribing practices; the doctor, pharmacy, shopping; the potential diversion of prescription pain meds.

And increased prevention resources, in the form of community education and awareness, similar to those RFPs that were offered a number of years ago -- and I know, certainly, we applied, and participated in this -- around the methamphetamine epidemic.

We were so sure it was going to come into Rochester, Monroe County, we did a huge full-blown media community-awareness campaign.

And I think this would be a likely strong strategy again.

Prevention efforts would also target physicians, pharmacists, linking them to community-based prevention experts.

Efforts would need to include broad and intense community-awareness campaigns, targeting youth, targeting parents, regarding the risks of the opiates, both those that are legal and those that are illegal.

And, certainly, I would like to encourage this support around Narcan (Naloxone).

Right now we have an issue where they are being prescribed.

They're available, certainly, to first responders. Hugely important.

Not the police force.

But there are a couple local efforts:

One through Strong, where we're educating -- they are educating providers, family members, and giving them, actually, scripts.

So someone, if they have -- if the education, [unintelligible] education, they're carrying their Narcan. They have a script that allows them permission to carry that Narcan.

Needle-exchange programs, or Trillium's, offer -- also are offering the same thing.

This is through the Harm Reduction Coalition.

So, again, prevention, treatment, harm reduction, I think it's a multifaceted approach.

And, I thank you very much for offering us this opportunity.

SENATOR ROBACH: Thank you, Jennifer.

Just, really quickly --

JENNIFER FARINGER: Yes.

SENATOR ROBACH: -- and I would agree that, you know, I learned a long time ago, believe it or not, even helping seniors with their income tax, how much one doctor was -- I was more, from the medical side, worried, a doctor in Florida was giving them something I knew enough about to know this was upping them, and a doctor in Rochester was giving them something that was gonna take them down.

I said, "How could this be?"

JENNIFER FARINGER: Yes.

SENATOR ROBACH: And we have the turn-in programs, Stem the Meds, all those, those will work well.

Would you have any ideas, though?

Like, I almost think we have to go more elemental root, and, like, maybe have something with the Medical Society, because what you said is so true.

Obviously, if the prescription is for a smaller amount, (a) it's not gonna erroneously addict the individual, which is the most important thing.

JENNIFER FARINGER: Right, right.

SENATOR ROBACH: But then, secondarily, if you don't have those 30 or 40, or 20, extra doses --

JENNIFER FARINGER: Floating around?

SENATOR ROBACH: Yes.

-- it eliminates the risk.

And, clearly, what we're hearing everywhere:

Nobody goes out and starts, as the entry-level drug, is not heroin.

It's something else, working up the chain.

JENNIFER FARINGER: It is, it is.

SENATOR ROBACH: So, do you have any thoughts or -- I don't know, in the field?

I mean, maybe there should be some merging of, like, the Medical Society, with the drug-prevention side, to get doctors a little bit more in tune to that, in doing what they could do to help?

I mean, we don't want them to not prescribe what they need, but, clearly, that's where it comes from.

JENNIFER FARINGER: Right, and those conversations are already happening.

We have two physicians right here that are part of Monroe County Medical Society, Addiction Medicine Committee.

And as a prevention provider, I sit on that committee as well.

But that's been a constant conversation, to get it out, and how do you best get it out to the broader community?

Those that are in attendance at the meeting are full aware of the implications.

But, then, how do you we get it out?

And we're trying through a variety of sources.

But, can we do more? Absolutely.

And you bring up a target population that I typically include, and didn't today -- thank you, Joe -- around senior citizens.

Because I think it's -- it's interesting:

Working closely with our DEA agent around, how do we better get out the information about the DEA Safe Take-Back days?

There was an attempt to, how can we connect with senior facilities?

Because that's an issue as well.

You've got senior facilities, who, through a variety of regulatory issues, aren't able to participate.

So maybe lessening some of those blocks that prevent those.

Or treatment providers that have a med cab

that's full of opiates; and, yet, there's a block from connecting them.

So private citizens can go to the Safe Take-Back days.

We need to eliminate -- that would be another recommendation: We need to eliminate any barriers that would prevent any organization, agency, with, actually, bags of unused scripts, because these are all potential diversions.

SENATOR ROBACH: Well, thank you.

JENNIFER FARINGER: You're welcome.

SENATOR BOYLE: Thank you, Jennifer.

We really appreciate your testimony.

ASSEMBLYMAN JOHNS: Thank you.

JENNIFER FARINGER: Thank you.

SENATOR BOYLE: Our next speaker will be Jessica Sherman, the program director for Face 2 Face.

SENATOR ROBACH: Good morning.

JESSICA SHERMAN: Good morning to all of you, and thank you for organizing this forum, and for the opportunity to speak.

I'm a licensed master social worker from Kids Escaping Drugs.

Kids Escaping Drugs is a foundation that

focuses on community outreach, education, and early intervention for youth and their families.

The foundation also supports, and is affiliated, with Renaissance Addiction Services, Incorporated, known for their Renaissance Campus, long-term residential rehab in West Seneca for youth, ages 12 to 20.

I wanted to speak to all of you today because drug addiction among adolescents has become an epidemic in Western New York, across our state, and all over our country.

Addiction is attacking the average American teenager.

Prescription medications are being passed around school hallways like candy, as the profit from selling these pills far exceeds any allowance our kids receive.

Heroin, which is initially seen by teens as something only used by desperate drug fiends, is making its way in our communities and into our homes.

Too many of our young people are sliding down the slippery slope of addiction due to the physical dependence that comes with these opiates.

Unfortunately, there is still a very powerful

stigma attached to the disease of addiction.

This stigma prevents our youth from reaching out from help, and it prevents their parents from being educated about the warning signs of this terrible life-altering disease.

While treatment may be available, too many of our kids do not receive the amount or the type of treatment that is necessary; and, therefore, do not experience the positive outcomes treatment can provide.

Circumstantially, countless teens often wind up right back on the street, sticking the needle back in their arm.

I'd like to take the next few moments to paint you a picture of how this happens.

The disease of addiction does not discriminate.

Athletes, honor-role students, musicians, artists, all cliques of kids, and all types of families are being affected.

What starts out as harmless curiosity and experimentation turns into a living nightmare.

Kids are lying and manipulating; stealing medications from their sick family members; crashing cars; pawning family valuables, like wedding rings;

and, oftentimes, becoming violent and aggressive while under the influence.

Parents are at a loss as to how their good-hearted innocent child has turned into someone who only cares about getting the next fix and who will go to any extreme to obtain it.

In my experience working with students from all schools across Western New York, I can report to you, with confidence, that there is a very strong stereotype about who a drug addict is.

They are usually described as a man with frizzy hair, and yellow teeth, in a flannel shirt, with a paper bag in his hand, and he usually lives under a bridge.

Society is still teaching teenagers that addiction could not possibly happen to them because they don't fit this stereotype.

Our kids also have no fear about taking prescription medications.

The media and society is constantly bombarding them with messages to take this pill or that pill for whatever may trouble them.

Too many teenagers are under the false impression that these pills are safer than street drugs because they come from our doctors.

The message society isn't delivering is that these medicines will destroy their lives and may kill them.

90 percent of adolescents who receive treatment on the Renaissance Campus enter addicted to prescription medications.

Our young people are starting out with pain killers, like hydrocodone and Loratab [sic]; pills they can buy from their peers with their lunch money.

Very quickly, they become tolerant to these medications, and may need as many as 15 at a time to achieve the high they are seeking.

Before too long, many kids progress into stronger pain pills, like Opana and fentanyl. However, these pain killers are much more expensive, and due to the passing of I-STOP, the supply has been limited on the street.

Many teens will need to spend hundreds of dollars a day to maintain their physical tolerance to these pills and to prevent opiate withdrawal.

This is when heroin comes into the picture for most of them.

This is evidenced by the fact that 70 percent of the patients who receive treatment on the

Renaissance Campus are addicted to heroin at the time of their admission.

I don't know about you, but this percentage disturbs me greatly.

Due to the availability of heroin in a powder form, many desperate kids will begin purchasing $10 bags they can snort, the same way they're used to snorting the pills.

All of them swear they will never stick a needle in their arm; however, most times, in a matter of months, or even weeks, this is exactly what they are doing.

Our teens are full-blown heroin addicts, but they don't see it as a problem because they still don't fit that stereotype that they've been taught.

Most young people get so desperate in their addiction that they will go to any length to get high.

Almost all of them begin selling drugs, stealing and robbing, to support their habit.

Inevitably, a high percentage of these kids end up interfacing with the legal system, and many are placed in drug-treatment courts.

90 percent of teens who receive treatment on the Renaissance Campus are Court-mandated to be

there.

Unfortunately, in too many instances, legal trouble is the first time the parents have the opportunity to realize just how involved in drugs their children are.

It is extremely important to educate parents and family members about addiction.

When parents have the opportunity to learn about the struggle their child is going through, they are much more likely to support them in their recovery and to not enable them to relapse.

Many of the parents we work with on Renaissance Campus have no idea about the dangerous situations their children have been in, nor do they understand the desperation their children experience to remain under the influence and avoid withdrawal.

By educating parents and families about these struggles, we empower them to understand why their child's behavior has changed so drastically, and we teach them how they can support their children in healthy ways.

When adolescents are mandated into rehab, it provides addiction professionals the opportunity to implement the intense counseling that we know is necessary, but, oftentimes, that children and their

parents are not ready to accept.

When young people are addicted to drugs as strong as opiates, it is extremely imperative that they receive long-term residential treatment.

Many teens who succeed at the Renaissance Campus state that it took them several months just to feel normal and for the drugs to get out of their system.

The strong denial that comes with addiction is especially evident with teenagers, as they have not faced as many severe consequences as adult addicts.

Once their mind is clear, we are able to address the denial, and empower the teens to accept their addiction and begin to work towards recovery.

There is also a strong social influence present with teens who use.

Many of them are very attached to the people they purchase from and the people they use with.

For these reasons, a 28-day program is not, and will never be, an effective form of treatment for an adolescent who is addicted to such powerful substances. It is not enough time away from the influences or the drug.

We are doing our kids a disservice by

treating them the same way adult addicts are treated.

Teenage addicts do not experience the same symptoms as an adult, but we treat them like they do.

As long as we continue to treat our addicted kids this way, we will continue to see a high rate of relapse, and, inevitably, countless teenagers will continue to die as a result of accidental overdose.

If we want to give our youth any chance of remaining clean, sober, and healthy, we need to give them the opportunity to pursue long-term, intensive residential treatment, and we need to work closely with their families.

What I ask of you today, is to support prevention and education for our youth about how dangerous prescription drugs can be.

We need to make sure that our kids understand the strong correlation that exists between opiate pain killers and heroin.

I also ask your help for our teens who are already in the depths of addiction.

Please support long-term residential treatment for adolescents, and encourage your

colleagues to do the same.

Please help us advocate for these services so we can give these kids a second chance at life, as they are our future.

Thank you.

[Applause.]

SENATOR ROBACH: Thank you.

ASSEMBLYMAN JOHNS: Jessica, let me just ask you one question:

As some of the previous speakers have said, are you finding that there's a problem with insurance companies paying for --

JENNIFER FARINGER: Absolutely.

With the treatment that we provide on the Renaissance Campus, some insurance companies are only providing three days of coverage. And then it's up to the family to try and come up with the means to do what they have to do to keep their kid in treatment. And, oftentimes, they may not be able to.

We see a tremendous problem with that.

SENATOR BOYLE: What is the cost for what you consider adequate stay, would you say?

JESSICA SHERMAN: Treatment on our campus can cost a family as little as $11 a day.

It's on a sliding scale. It varies, based on a family's income, but we can treat kids for as little as $11 a day.

Medicaid also covers treatment for our youth if they qualify for that.

SENATOR ROBACH: Thank you.

SENATOR BOYLE: Thank you, Jessica.

Actually, as Chairman of, not only the Task Force, but the Senate Committee on Alcoholism and Drug Use, I'd like to come and visit the campus, if I could --

JESSICA SHERMAN: Please do. We would be thrilled to have you.

SENATOR BOYLE: Thank you very much.

JESSICA SHERMAN: Thank you.

SENATOR ROBACH: Thank you.

ASSEMBLYMAN JOHNS: Okay, now we'd like to welcome up our Monroe County Undersheriff, William Sanborn.

Come on up.

UNDERSHERIFF WILLIAM SANBORN: Good morning, and thank you for the opportunity to represent Sheriff O'Flynn at this very important discussion.

Monroe County, New York, has been seeing an increase in both heroin sales and use.

In the area of illegal drug sale and use, historically, Rochester has recognized cocaine as the leading problem drug; however, the availability of heroin at a cheap price is steadily increasing its use.

It is believed that a large portion of the heroin users today began with their use of prescription opiate drugs, the most common being Percocet and Oxycontin.

Percocet contains about 5 milligrams of the drug oxycodone, and is designed to be a quick-release pain reliever that lasts about 5 hours.

Oxycontin contains between 2 to 16 times more oxycodone than Percocet. It is designed to be a slow-release pain-relieving pill, but if you crush the pill, the effects are almost instantaneous.

Opiates have addictive properties.

Although opiates are designed to be pain relievers, they also have a psychological and physiological effect of making you feel good, bringing a sense of euphoria no matter how bad things really are.

For some, this is the reason why they initially start abusing the medication, but they

continue its use because their bodies begin to feel that they need the drug to keep them from feeling horrible.

The body begins to adapt to the drugs and completely upsets the body's natural hormones, such as serotonin.

The abuser needs to take more of the opiate to feel normal, and when they aren't high, they do not feel well.

That being known, the reason that some may switch from prescription opiates to heroin might really come down to availability and price.

The Drug Enforcement Administration has stepped up their enforcement efforts by cracking down on prescription-drug crimes.

Additionally, efforts have been made to reduce Oxycontin abuse by adding an ingredient to the pill which makes it very difficult to crush into a powder, which is the preferred method of ingestion because it produces the quicker high.

I'm told that the patent on that substance will soon expire and the FDA has to make a determination whether they are going to require all manufacturers of opiate pills to use that ingredient.

An issue with imposing this requirement is that it adds significant cost to the drugs.

In our area today, the average 20-milligram Oxycontin pill sold on the street is usually going between 30 and 50 dollars. Compare this cost to that of a deck of heroin which costs about $10.

For a bundle of heroin, which is 10 decks, the cost found locally range from 50 to 80 dollars.

We are seeing more and more young adults turning to heroin as a cheap and more readily accessible alternative to the more costly and difficult-to-obtain prescription opiate.

Fentanyl is one of the most powerful prescription opioids. It is designed to be a slow-release pain killer, and is usually prescribed to cancer patients.

It typically comes in a patch form, but if you cut the patches, there's a powder inside.

The drug dealers can add fentanyl to the heroin as a booster and to make it more powerful.

The goal of any drug dealer is to make you a long-term customer.

Once they have you, they can quickly increase prices for it, knowing that will you need the drug.

Known as "speedballing," heroin can also be

combined with cocaine.

Of course, none of these drug dealers are licensed pharmacists so you never really know what exactly you're getting.

That presents a great danger to the user.

The Drug Task Force, in which the Sheriff's Office participates, reported that 2013 yielded almost 2 1/2 times more seized or confiscated heroin than the year before.

According to our Director of Alcohol and Chemical Dependency for the Monroe County Sheriff's Office, Craig Johnson, we have seen a quadrupling of heroin addiction in the inmate population over the last two or three years.

The Monroe County Jail has observed a large number of opiate and heroin addicts enter our custody.

In 2013, there were 634 self-reported opiate addicts.

The below statistics were obtained when the inmates, at the time of their booking, came into the jail and made a self-report of opiate use on the streets.

These individuals who reported their addiction are placed on withdrawal protocols while

in our custody.

In 2013, there were 634 individuals that came into our jail custody who reported their addiction.

For the first quarter of this year, we have 168 persons who entered the jail and reported their addiction.

In March alone, there were 71.

These are only the people that are self-reporting. This isn't the total number.

An overwhelming percentage of property crimes are directly related to drug addiction. This includes heroin.

A recent police shooting involving one of our deputies is just one tragic example of the effects of heroin.

The suspect, being a heroin user, is now facing charges for having stolen a car, robbing a bank, stealing from Wegman's Supermarket, attempting a carjacking, and pulling out a gun and threatening the deputy, before he was shot.

Fortunately, he lived, and is presently in the custody of the jail, while the police officer and no one else in the community were physically injured.

According to the Centers for Disease Control

and Prevention, drug overdoses are now the leading cause of accidental death.

Statistics recently released by the Monroe County Medical Examiner reports 65 regional heroin deaths in 2013, 29 deaths in 2012, and 11 deaths in 2011; a significant increase year to year.

We are currently seeking grant funding for Narcan -- or Naloxone -- a drug that reverses an opiate overdose instantly.

The Quincy Police Department, a Boston suburb, have been using Narcan since 2010. Officers have administered the drug 221 times, and reversed 211 overdoses.

Ocean County, New Jersey, has begun training police officers in all 31 local police departments to use those drugs, since overdose deaths doubled, from 53 in 2012, to 112 in 2013.

Ambulance and EMS providers actively utilize this drug in our community.

We have it also with our nurse and medical care in the Monroe County Jail.

Going forward, we must identify current and emerging trends relative to opiates and heroin.

Law enforcement must have shared

communication, and work together with the Public Health Department, the Medical Examiner's Office, non-profit organizations that deal with matters of drug addiction and rehabilitation, schools, our law-enforcement partners, the District Attorney's Office, and the courts.

We must promote public awareness and education to combat this threat to which, at a great expense, compromises our health, our safety, our wellbeing, and our quality of life for everyone in our community.

Thank you.

[Applause.]

SENATOR ROBACH: Thanks, Bill.

SENATOR BOYLE: Thank you.

Thank you, Bill.

And your statistics are truly mind-boggling.

And I can tell you that, it gets to -- the former hearing we had on Long Island, there's a lot of taxpayer money being used to jail, and give services in the jails to drug addicts, purely are there for the reasons of being an addict, and them needing the money for that.

We actually had a treatment provider, probably the preeminent one on Long Island, give

testimony last week, that when parents come to him, desperate, because their children are addicts and they're going to crime to do it, they actually give advice on how to get the child arrested, because the treatment they're gonna get is going to be in prison.

The insurance companies are not covering them. They're not giving the treatment services they need.

So they're saying: Listen, make sure -- this is the way you get your child arrested, but make sure he or she doesn't have a lot of drug on them so they don't go to prison for a long time; just long enough to get treatment.

And that's a sad state of affairs here in New York, and we need to change that.

Thank you, Bill.

ASSEMBLYMAN JOHNS: Thank you, Bill.

UNDERSHERIFF WILLIAM SANBORN: Thank you.

SENATOR ROBACH: Thanks, Bill.

Our next testimony will be Lori, who will be sharing a personal story.

LORI DRESHER: Thank you.

Thank you Senators and Assemblyman, and all of you in the back for being here today.

I apologize for my back being to you.

Kind of rude.

SENATOR ROBACH: It's either them or us.

[Laughter.]

LORI DRESHER: So -- can you hear me back there okay?

I believe I'm here today to actually be the voice of many parents who aren't able to find their own voices, either because they're too bereft, too overwhelmed, or too depleted to stand here today.

My son is 23 years old. His story, while gut-wrenching to our family, is not unusual, sadly.

And just to dispel the myth that heroin and opioid addiction is a ghetto problem, I am a White, college-educated, middle-income taxpayer.

I raised my kids in Penfield, New York.

I'm a self-employed organization development and business consultant.

And my former husband of 22 years, and father my children, has been employed by Xerox for the past 35 years.

Our son started using opiates in high school, like so many other kids.

I quote him, "It was so easy. So many parents had these drugs in their medicine cabinets.

You could use them in school, and they didn't make your breath smell or your eyes red."

And then towards his senior year in 2008, access started to dry up. Pills became harder to get, and more and more expensive.

It was then that my son was introduced to heroin. It was cheap, and readily available, as you've heard here already on a number of occasions.

Once he tried smack, he never really went back to pills.

Over the course of the past six years:

My son was arrested three times, maybe by someone in this room, who knows.

Has been on probation, and gone through intense outpatient rehab twice.

He's completed a 30-day inpatient rehab in July of 2012, because, according to the insurance companies, you must fail numerous times before they will allow you into an inpatient-care facility. And even then, they will dole out your time at a few days at a time.

He relapsed two months later. Stayed clean then for 14 months. Relapsed again this past November. Detoxed twice. And issued a suicide note to his family on April 3rd, less than two weeks ago.

We have spent countless thousands of dollars on lawyers, doctors, health insurance, outpatient and inpatient programs. And possibly the most humbling of all, and humiliating of all, pawn shops.

After my son's suicide threat, we detoxed him at home because no detox facility in the surrounding area would take him.

Apparently, it is rare to die from a heroin detox, and they reserve these beds for alcohol and crack addicts instead.

His physician called us with a lengthy set of instructions for drugs and doses, and explained the hell that my son would experience over the next three to five days.

I recall thinking, I wonder if immediately after my recent heart surgery, my doctor would have sent me home with a pocket full of pills and said:

Good luck. Sorry, we don't have a facility to help provide aftercare in a hospital environment where you'll be safe. You may die, but chances are you'll survive. And try the Internet for aftercare.

A week ago tomorrow, my ex-husband drove my son to Pennsylvania for extended rehab.

They explained the cost for the first 30 days would be $38,000, payable in advance.

The aftercare would cost twenty to fifty-four thousand dollars, and they would make their recommendation in three weeks.

They explained that they would submit a claim to our insurance company, but there were no guarantees.

The best we could hope, was that one-half of the first 30 days would be reimbursed.

We once again drained bank accounts and retirement accounts, because there is no limit beyond which you would not go to help your kid get better.

We sent our son away as though he were going to summer camp, with a bag and toiletries, and a letter from me, stating: That things would have to be different this time. This time there would be no bailout. This time his option, should he choose the wrong path, is Medicaid and The Salvation Army.

And even as I wrote the words, I knew my resolve would dwindle if there were a next time.

I came here today, not to tell yet another tragic story of an addict and his family's pain to find peace, but to share with you my belief, and that of my son's, the key priorities for preventing and treating this national, state, and

community-wide epidemic that is destroying and claiming the lives of our young and their families.

On my son's drive to Pennsylvania last week, I called him on his dad's cell phone, and in a sense, interviewed him for this talk.

I asked him to share his unique and highly informed perspective, as an addict.

The following four points are our combined ideas:

Number one: Create broad and free access to addiction prevention and treatment services.

This illness of addiction is not afforded the same access and ongoing care of almost all other chronic illnesses.

There is also so little funding, comparatively, for research into recognizing, treating, and preventing these conditions.

Limits are placed on doctors, and filters, like "medical necessity," are applied so much more stringently.

If we treated more and had fewer incarcerations, we would save our community a lot of time, and, importantly, a lot of lives.

Number two: Apply a dual-focused approach to addiction and mental-health issues.

According to my son, every addict he knows suffers from other mental-health afflictions, primarily depression and anxiety.

My son's primary physician medically treated him for these conditions.

As of last week, he was prescribed Zoloft, clonidine, hydroxyzine, Neurontin, and Zofran, and in addition to Suboxone and Subutex, but no mental-health counseling or cognitive therapy were offered.

Number three: Stop incarcerating, and start treating the illness of addiction with funding, research, treatment, and compassion.

There is so much judgment and stigma around opioid and heroin use in our community, it is no wonder our criminal justice system follows suit.

We incarcerate addicts to remove the scourge from our streets to prevent them from infecting our young.

They are our young, and they're sick.

The prevailing perception that addicts get high because they enjoy the euphoria of drug is a myth.

Addicts primarily use heroin in order not to get sick from withdrawal; and, yet, we put them in

jail where they're unlikely to receive proper medical treatment.

We need to treat addiction as a disease and go after its cure as aggressively as we do cancer, heart disease, and AIDS.

We successfully overcame our funding preventive stigma of AIDS.

We should be able to do the same thing to save our children.

According to my son, one of the most successful interventions available is drug court, where non-violent offenders are successfully treated and reformed through drug court right here in our own Monroe County.

Rather than judgment-based incarceration, offenders sustain a year-long program of treatment, and are held accountable to their own reform.

Many go on to be productive members of society.

Unfortunately, there are currently less than 2500 drug courts operating in the United States today.

Imagine the price to society and communities where the only treatment option is incarceration.

And, number four: Block the sophisticated

street system that supports drug addiction.

There is an incredibly strong street system and infrastructure to support opioid and heroin addiction.

If there were only such a strong system to support their treatment.

And as much as we want to point the finger at drug dealers, many of them are our children simply being resourceful in their need to survive.

This system --

(A This system includes social media.

A simple Facebook request can garner private messages, locating sources for any street prescription drug available.

And I learned this firsthand by going into my own son's Facebook account.

My son's Facebook account and text messages read like the who's who of an underground drug cartel.

(B) This system includes well-meaning, as well as conscience-avoidant physicians, dispensing Suboxone and Subutex to recovering addicts, often well beyond the optimum period of detoxification and stability.

My son was on and off Suboxone for the

two years since his inpatient rehabilitation, with no plan to get him off.

Instead of insisting on drug testing before dispensing the drug on a monthly basis, which creates a revolving door of dependent patients, my son's doctor would simply write the prescription.

And I mean no disrespect to the doctors who are here with us today, because a number of them are doing a tremendous amount of good, trying to help our addictive children.

Addiction specialists are well aware of the street value of Suboxone to addicts. It is the only way they can possibly detox from the drug, and most have no way of obtaining it legally.

My son and other friends took advantage of this, and used their Suboxone scripts as street currency to afford their heroin.

And, again, I'd like to note that Suboxone is highly effective in treating heroin addiction.

Unfortunately, the manufacturer of Suboxone has made it cost-prohibitive recently for addicts to afford it. 300 to 500 dollars a month; thus, the high street value.

And, (C) Pawn shops, and even reputable jewelry stores, know an addict when they see one.

They happily turn a blind eye, knowing these items were likely stolen from family members and friends, as they predict the profits they will rake in from their sales.

Addicts are welcomed into their shops, and either given cash for the value of the gold or silver when melted, or given a fraction of the cash value of the items being pawned.

Again, I learned this firsthand when I went to try to recover some of my stolen goods.

In theory: If the seller comes back to claim the pawn, they are charged an excessive fee, and the item is returned.

But as we all know, more often than not, the addict never returns for the item, and it is sold in an extraordinarily profitable return.

In the past two years, my son has sold all of my valuable jewelry, a large-screen TV, a laptop computer, two electric guitars, and untold other valuables.

In conclusion: I am cautiously optimistic that this epidemic of heroin and opioid addiction is finally gaining the attention of our legislators and community leaders.

We must start with this important dialogue.

And I commend our leaders for initiating this in the state of New York, where New York City alone saw an 84 percent rise in fatal overdoses between 2010 and 2012.

The dialogue must quickly be followed by radical action, and I will help in any way that I can: my son's life is on the line.

Thank you.

[Applause.]

SENATOR ROBACH: Thank you.

SENATOR BOYLE: Thank you.

SENATOR BOYLE: Our next speaker will be James Wesley, Drug Chemistry Supervisor for the Monroe County Crime Lab.

JAMES WESLEY: Good morning, Senator Boyle, Senator Robach, and Assemblyman Johns, and thanks for the opportunity to speak today.

I've been working, identifying drugs, since 1976, first in the clinical lab intox; and then, beginning in 1993, in the crime laboratory.

So let's start with narcotic prescriptions, because that's kind of where this all started.

Beginning in the late 1990s, there was a large increase in the use and abuse of narcotic pain relievers throughout the United States.

There's a chart that I've included. It's The National Forensic Lab's statistics, where we've tracked this, and it documents the increase.

The potency of these pain relievers also increased.

In the '90s -- in the early '90s, all there was was a 5-milligram Percocet. But with the introduce of Oxycontin in 1996, that ramped up to 10, 20, 40, and 80 milligrams; essentially, almost a sixteenfold increase in the potency.

On this 12-year ramp up, of note is the substantial increase in oxycodone, hydrocodone, and, alprazolam, something that we don't talk about much, but it's followed these two opiates up in a very, very high increase.

And, also, the recent mention of the buprenorphine, which is, Suboxone is up 700 percent in terms of misuse, which, that's really phenomenal.

During that time, narcotic-pill submissions to crime labs, as a proportion of all drug submissions, and what I refer to as the "big four" across the United States -- cannabis, cocaine, heroin, and meth -- were 95 to 99 percent of everything they got in.

But during that time frame of 2000 to 2012,

these drugs increased, from 1.3, to 8.3 percent, of all drugs coming into the crime labs.

There was also a substantial increase in, which we don't talk about much, but, hydromorphone, which is Dilaudid, methadone, and, again, the buprenorphine.

However, the absolute numbers are not as extreme as the absolute numbers of hydrocodone, oxycodone, and alprazolam.

So now to heroin:

After a slight decrease in 2011, heroin began a dramatic increase in 2012, and continued through 2013.

If you review the Monroe County Crime Lab heroin statistics, which I've provided, there's an 800 percent increase in the number of decks submitted to the lab in that two-year period.

The average number of heroin items submitted per case also dramatically increased.

So, for instance, a typical bust in 2011 would have 16 decks. Now it has 49.

The biggest case submitted in 2011 was 126 decks.

In 2013, we had a case with 1500 decks of heroin.

And the composition also changed.

Before 2011, it was very unusual to see anything in the heroin other than the heroin.

They would cut it with mannitol and some other things, but it didn't have any properties.

A review of the cases from the second half of 2013 indicates that 64 percent of the items contain heroin plus another drug.

And what are these other drugs?

The biggest ones are caffeine and procaine.

And people might think: What's that, that's nothing. Caffeine's coffee, and procaine has no effects.

Procaine actually is a stimulant in the body and acts a lot like cocaine. So when you have procaine in with the heroin, you have a manufactured speedball, and now you have additional effects on the heart in addition to the effects on the breathing.

Other more dangerous drugs, such as xylazine, which is a horse tranquilizer, fentanyl, have been identified in the submissions, but a deck of heroin doesn't have to have these to be toxic or fatal.

We talk a lot about potency, and we talk a lot about it, is it more concentrated?

I don't -- we don't have a concentration data.

The typical heroin in Rochester used to be about 50 percent. And, I don't have potency data because we don't quantitate heroin anymore.

But let's assume it's 50 percent, and that isn't changing.

What's changing is the amount in the bags.

In a typical submission; in other words, 30 bags in the dealer's pocket, that heroin could range from 50 to 70 milligrams.

So just depending on what he pulls out, you could have four times the amount, or half the amount, just what he pulls out of his pocket.

And if you're cooking up five bags at a time, look at the range in which you might be sticking in your arm.

So, that's really phenomenal.

In my opinion -- and I've got one more thing to talk about -- but in my opinion, for millions of Americans, narcotic prescriptions, and now heroin, have become a daily solution to dealing with stress and anxiety.

I know it's hard to believe that, but I think that's how it has been used; and that's both

dangerous and sad.

The other thing, the other chart, was people have said: What's this accessibility? I don't understand, what's changed?

Ten years ago we would see heroin, from being distributed only in a small part of the community, and you would go just there to get heroin.

And I just pulled some cases, just to look as an example.

In 2000, of 20 cases that I pulled: Fifteen were just heroin; in other words, the busts only had heroin in them. And five had heroin plus either a little bit of marijuana or a little bit of cocaine.

In 2013 -- I call this the "case mix" - I also pulled 20 cases. Only 10 cases had just heroin. But believe it or not, the biggest one was 1291 decks, versus 40 decks in 2000.

But more cases have additional drugs in them; meaning, they have coke, they have marijuana, they have heroin, they have pills.

So it's almost a one-stop shop now. If you go to someone that used to only have weed, now they also have pills, heroin, and coke.

So the availability, as I see it, is more dealers dealing with a polydrug availability, and

then making it easier for that to spread.

And, pretty much, that's it.

Thank you.

SENATOR BOYLE: Yeah, just quick:

Thank you so much for your testimony. It's very enlightening.

What was said earlier about trying to find out the source of where this heroin is coming from, and, not being a chemist by any stretch of the imagination, is it possible to find out, do you think, like, what region or what country, based on, I don't know if it's got, not DNA, but, I mean, it's some other specifics of that heroin, where it's coming from?

JAMES WESLEY: The DEA used to have a source program, that they did that on special testing.

And there's kind of a move to, maybe, revitalize it.

SENATOR BOYLE: Yeah, yeah.

JAMES WESLEY: So what it would mean is, the labs, and we've got an intern from Roberts Wesleyan now, who's actually pulling out a really good bunch of statistical data.

So by the summer, we're gonna have a lot more data on the nuances of this whole heroin.

But, yeah, you would need to actually look at the data, and not just what's in the reports, which is the heroin.

You have to drill down to the mass-spec data and see: What are the relative peeks? Which one has the dipyrone? Which one has this? and almost come up with a little profile of what's down low.

With those profiles, you might be able to source it back, but that's gonna need a little -- probably a little bit funding, because the labs are -- I mean, they're overworked, and they're getting cases out.

We're gonna have to revisit the cases, and look down low and see if we can make comparisons, but I think it's possible.

SENATOR BOYLE: Thank you.

SENATOR ROBACH: Thanks, Jim.

[Applause.]

SENATOR ROBACH: Our next testimony will be provided by Dr. Jeremy Cushman, who is the EMS Medical Director at the University of Rochester.

DR. JEREMY T. CUSHMAN: Gentlemen, thank you.

I appreciate the opportunity to share with you my experience with our current epidemic of opiate use, and my role as EMS Medical Director for

Monroe County and the City of Rochester, as well as an emergency physician at the University of Rochester.

Although I certainly support the efforts of my colleagues in treating and preventing opiate overdose, my testimony this morning is gonna center specifically on the role of first responders in providing the reversal agent, Naloxone, as you mentioned earlier, Senator, to individuals that have sustained an overdose; an important action that the Senate may wish to consider to help us battle this public health crisis.

As you are likely aware, opioids are an important tool in managing pain, whether it's part of care for a broken ankle or contributing to a patient's postsurgical recovery.

However, when opiates are taken in super-therapeutic doses, whether pharmaceutical or heroin, prescribed or illicit, these medications can cause respiratory depression.

Slowing of the respiratory rate can progress to apnea -- or the absence of breathing -- and this is the primary cause of death in opiate overdoses.

Importantly, there is a very narrow window between respiratory depression and irreversible

death as a result of an opiate overdose.

This is where the medication called "Naloxone," otherwise known as "Narcan," comes into play.

By pharmacologically blocking the opiate, it rapidly reverses the respiratory depression that's caused by an opiate overdose.

Now, the advantage of Naloxone is that it will not harm the patient, even if the cause of the respiratory depression or absence of breathing is not due to an opiate, as is often the case for someone using other drugs of abuse, or after a trauma or a medical emergency.

Further, Naloxone can be administrated by attaching a small device to the medication syringe, allowing the medication to be sprayed up the nose.

Just as effective as delivered through a needle, this dramatically decreases the risk to any type of user or responder.

Although it is important that we be cautious to not interpret that every overdose -- every opiate death is reversible, there is no doubt that Naloxone can reverse many opiate overdoses.

The culture of heroin and prescription-drug use is different in different communities, and so

the recognition of an opiate overdose is critical in order to provide that lifesaving care.

In many communities, the use of prescription opiates or heroin is done in seclusion, and so the patient may not be recognized to have overdosed until 15 minutes, or 15 hours, after the overdose, in which case no amount of Naloxone is, quite frankly, going to make a difference and reverse their death.

In other circumstance, groups of individuals who use or abuse opiates, and an overdose will be rapidly identified and emergency assistance is summoned.

This is where we have the greatest potential for Naloxone being a successful intervention.

Along with my colleagues at the Albany Medical Center, and in Suffolk County, the Rochester Fire Department, under my supervision, began participation in the pilot project nearly two years ago, which demonstrated to the Department of Health that emergency medical technicians can safely identify patients with an opiate overdose and successfully administer Naloxone as a nasal spray.

To date, we have had 112 uses, of which 101

were successfully reversed.

Eleven, unfortunately, died, often, but not exclusively, as a result of complications from opiate use.

This data was integral to providing the evidence to then-State Department of Health Commissioner Shaw, to add this medication to the scope of practice of all certified EMS responders in the state.

Fast-forward a few months: We now have seen the State's Attorney General and the Executive Deputy for the Division of Criminal Justice Services announce important programs designed to get Naloxone into the hands of the law-enforcement officers, who, in many jurisdictions, are the first responders on scene, to render this potentially lifesaving medication.

These represent further extensions of our pilot program, given the successful demonstration by law-enforcement officers, particularly in Rensselaer and Suffolk counties.

To date, we have had a number of different and disparate programs aimed at the same goal, which is, essentially, to get Naloxone into the hands of first responders.

I would offer, that the Senate Task Force on Heroin and Opioid Addiction has a unique opportunity to codify its support for Naloxone programs, and do so in a medically responsible way, through legislation modeled after the Public Access Defibrillation and Epinephrine Auto-Injector statutes.

So to take a step back:

About 20 years ago, automated external defibrillators became widespread in our communities; and to this date, along with CPR, are the two single most important predictors of someone surviving a cardiac-arrest event.

And just like Naloxone, these devices save lives every single day.

Now, the wisdom of the Legislature at that time, was to codify a process by which AEDs could become pervasive in our community, while not restricting their use to a particular responder.

Furthermore, the program retains the importance of physician oversight for the AED program, to assure that the medical standards are being met, despite those standards changing significantly over the last 20 years, and to assure the quality assurance of individual utilizations.

After all, we want to be sure that every medical intervention, whether it's defibrillating or administrating Naloxone, is being done properly, and with appropriate training, oversight, and tracking to fully measure the impact on the community's public health.

Anecdotally, as the Medical Director for Monroe County, I am the physician responsible for over 1400 AEDs in this county alone. And, by requirement, and statute, review every one of those uses, to make sure that it was appropriate. And in some cases, we find errors that allow us to improve the system in which we provide care.

Now, Article 30 of Public Health Law; specifically, Section 3000-B, outlines the use of AEDs, much like Section 3000-C outlines the use of epinephrine auto-injectors.

I would encourage the Senate to consider legislation modeled after these two existing statutes for the use of Naloxone, and have taken the liberty of providing sample legislation in my written testimony that is modeled after that exact existing statute.

Now, this would accomplish a number of goals:

Number one: It would increase the

availability of Naloxone to first responders of all backgrounds -- fire, EMS, law enforcement -- as it does for AED and epinephrine auto-injector programs.

Number two: It would increase the availability of Naloxone to other responders with unique opportunities to intervene.

This could include things like, college-campus security, probation officers, jails, courts, schools, other public interests, and individuals.

Number three: It would assure the proper training and recognition of opiate overdoses is received prior to carrying or administering the medication.

Four: It would assure that all state and federal regulations regarding the procurement, handling, distribution, storage, administration, and disposal of a pharmaceutical are met.

Fifth: It would assure that any use of Naloxone is reported immediately to the appropriate emergency medical-services system, to allow additional medical evaluation and stabilization.

And although Naloxone is a wonderful medication to reverse an opiate overdose.

Despite, many times, these people walking --

waking up and, literally, walking away, there is a small number of individuals that have rebound symptoms, and can be very sick, even though, initially, they look very well.

Next, to assure that the use of Naloxone is reported to the emergency health-care provider who can facilitate community surveillance and quality assurance for proper use. It could assist in the development of a system of Naloxone distribution that would be both operationally and fiscally sound, so as, we can assure that Naloxone is placed where it is most likely to be used.

And, lastly, and, unfortunately, most importantly: It would extend Good Samaritan protection to those who render assistance or oversee such a Naloxone program, consistent with statute.

I applaud the Senate Majority Coalition leaders for announcing this Task Force, and for the invitation from you, Senator Robach, for attending this Senate -- this hearing today.

And I certainly believe that by responsibly enabling public-access Naloxone programs, through the statute modeled after existing, highly successful programs, we will undoubtedly save more lives.

SENATOR ROBACH: Thank you, Dr. Cushman.

This is good to have in here.

And I think it's our intent, we're even -- go -- we want to go above and beyond first responders.

DR. JEREMY T. CUSHMAN: Absolutely. And that's --

SENATOR ROBACH: And I think it was Theresa who made the comment that, you know, if you unfortunately know you may be more likely to have that need in your family or with your loved one, that you'd be able to have that, and be under no liability or any criminal activity.

Senator Boyle's actually had a training in Long Island, to even help people who are at the most desperate part of their lives with their family members, do that.

But, you know, while it doesn't save everybody, the Boston one, I think, was 210 out of 222. Rochester, 101 out of 112. Those are pretty good numbers.

So, that's definitely gonna be a portion of it, I think.

Some of it's already underway, on the emergency side.

We'd like to take it somewhere else; and you're right.

Interestingly enough, Senator Alesi, and myself, who was a former legislator from here, did the defib regulation, which was controversial at the time, because we were mandating public buildings had to have these.

Roll it back, eight years later, every year we have a ceremony with the people whose lives have been saved.

And, again, it's the same demographic.

Everybody thinks it's only gonna be these 80-year-old grandparents.

It's 45-year-old fathers, 50-year-old mothers, and it's saving their lives.

So, hopefully, we won't have to do this with [unintelligible].

DR. JEREMY T. CUSHMAN: Absolutely. I think that legislation would allow that safety net for everyone, not just first responders, to be able to do that, but provide some consistency, so that we can measure it. And as things change over time, provide additional guidance to those individuals.

SENATOR ROBACH: Thank you for your expert testimony, and we have every intention to

implementing that.

SENATOR BOYLE: Yes, Doctor, that was tremendous.

And, we're gonna act on your recommendations, certainly, especially regarding the Good Samaritan Law.

I know -- for those of you unfamiliar with the Good Samaritan Law we passed a few years ago in the State Legislature, it provides an opportunity for, if someone is in a situation where someone is experiencing an overdose, you can call the police, and even if there's drug paraphernalia there, heroin around, you will not be prosecuted for it.

If there's, you know, 1,000 bags of heroin and a gun, that doesn't count for those; but, for small users.

I remember, as I say, when I went for EMT training, I'd be in the hospital, getting the training, and, a car would pull up, and, "thump," and everyone would run out there. And the kids had got their friend who was having an overdose, they'd throw him out of the car, and just keep going.

But, now, the situations, we've had it on Long island, tragedy, where were a dozen kids getting high on heroin, and they all left, and the

girl died right on the couch.

No one called the police, and when she -- they easily could have saved her life.

A quick question about the use of this modification:

Now, as Senator Robach said, we're having the training on Long Island for average individuals. Not first responders; everyone should have it.

I totally agree, get it out as much as possible.

Are you familiar with the law in terms of how that occurs, that we can -- have you -- can you do that now in Suffolk County, where a family of citizens, a group of citizens, can take a class, and walk away with a spray Narcan?

Or what kind of training; what does the law say about that?

DR. JEREMY T. CUSHMAN: So the law says nothing.

SENATOR BOYLE: Okay.

DR. JEREMY T. CUSHMAN: So if I wanted to, I can take all these people right now and I can spend a half hour training all of them.

I can provide them that medication, under my license.

SENATOR BOYLE: Okay.

DR. JEREMY T. CUSHMAN: And so, then, it is my responsibility, as a physician, that I have, essentially, bestowed that upon them to administer, as my agent.

And my concern for other physicians is that they might not feel comfortable with that.

SENATOR BOYLE: Right.

DR. JEREMY T. CUSHMAN: And that's where some of those liability protections come into place.

SENATOR BOYLE: Well, that's something we need to look at in terms of this legislation.

DR. JEREMY T. CUSHMAN: I think it also addresses some of the comments mentioned earlier, in terms of, "I'm afraid that if I get pulled over and I have this medication in here," and so forth.

We have some individuals that are very well-meaning physicians, that are going out and they are teaching folks how to draw up with a needle, the Naloxone, before they give it.

That's -- there's too many risks, there's too many hazards, to that.

When, essentially, we have the best practices that Michael Daley [ph.] in the Albany area, myself, others, have come up, that work for first

responders, that we know work for laypeople, if you will, and, how do we standardize that?

Just as AED programs, whereby that individual obtains authorization to use that, and identifies what training curriculum they are using, and, provided that training curriculum meets the expectations of the Department of Health, then, it is a done deal.

SENATOR ROBACH: I think I know the answer, but I just want to be sure, for my own general knowledge:

There is no, really, other usage for Narcan, except for that. There's no nefarious or "high" purpose for that. Right?

If somebody who wasn't -- let's say if a kid got ahold of it, it really wouldn't do anything to them. Right?

DR. JEREMY T. CUSHMAN: Yeah, so that's very, very important, Senator, and that there's a couple of things.

Not only will it not harm anybody, it won't harm them -- so if I gave myself some Naloxone right now, I wouldn't notice anything.

I'd probably have a little bit of nasal drip because I squirted it up my nose. But beyond that,

I wouldn't notice anything.

I also am not aware of any published case reports of anyone having an allergy to it.

Right, there's certainly medications that some people are allergic to.

To my knowledge, there are no public case reports of an allergy to it.

So, literally, there is no harm, that I know of, in administering this, even to someone that has not had an opiate overdose.

SENATOR BOYLE: Great.

SENATOR ROBACH: Thanks.

SENATOR BOYLE: Thanks.

Real quick, Doctor, one other area that I need to look at, in terms of getting this out to first responders is:

Now, I'm a volunteer firefighter. I've been there for 18 years. And, ironically, we can see, we've studied it a little bit, that I know that there's, what, paid firefighters in Rochester in the city? But you have --

SENATOR ROBACH: Uh-huh. Both.

SENATOR BOYLE: -- you have -- okay, you have some volunteers in the outskirts, maybe.

That, we can be trained with Narcan

individually, but not as a volunteer fire department.

And, now, we do not have an ambulance with our fire department. We don't have a bus [unintelligible], you know.

But, we often arrive before the ambulance does, and, there may be five of us that have got the training.

We can individually use Narcan, but, we can't carry it on the fire equipment, the rescue equipment, where it would do the most good, and we have -- where we can have training for the entire fire department.

So I really would like to, you know, follow your lead.

And I thank you for your leadership in this last couple of years to get it out to every first responder.

DR. JEREMY T. CUSHMAN: Well, I have it on a bunch of fire trucks around this area --

SENATOR BOYLE: You do?

DR. JEREMY T. CUSHMAN: -- the volunteers --

SENATOR BOYLE: On volunteer. Okay, good.

And it's on the rig?

DR. JEREMY T. CUSHMAN: Uh-huh.

SENATOR BOYLE: That's great.

DR. JEREMY T. CUSHMAN: Where it needs to be.

SENATOR BOYLE: Perfect.

Thank you very much.

SENATOR ROBACH: Thank you, Doctor.

DR. JEREMY T. CUSHMAN: Thank you both, Senators.

[Applause.]

SENATOR ROBACH: Our next testimony will be provided by Lisa Thompson, who will also share a personal story.

Thank you, Lisa.

LISA THOMPSON: Thank you for having me here this morning, or, almost this afternoon.

My name is Lisa Thompson, and I'm here today to share with you my personal experience, in hopes of shedding light on a horrible opiate and heroin addiction in the state of New York.

I am one of those parents that has dealt with a son that was addicted to opiates, and then heroin, along with other drugs.

He began at the age of 16.

I was going through divorce, and found out he was smoking marijuana.

As time went on, his personality began to

change more, so I searched his room and found a bottle with a few pills of Oxycontin.

I confronted him, and he came clean. He said a family member gave him one, and he thought it gave him a better high.

After a long talk with him, I sent him to Park Ridge Chemical Dependency outpatient.

To him it was a joke.

Had I been more educated, I would have known at the time he didn't want help, because he didn't think he had a problem; therefore, he stopped going, and continued to use.

I began to educate myself on drug abuse so I can learn how an addict thinks, so I would somehow be able to help my son.

Five years into it, he finally sat me down and told me he's still using and wants to stop, but can't.

He tried on his own, but failed. Even found a Suboxone doctor for help.

He would then lie to the doctor and told him he was going to counseling, but he wasn't.

With Suboxone, if you feel the urge to get high, you don't take it.

After failing numerous drug tests, the doctor

would no longer treat him. So because of withdrawal, he continued to use.

This turned into a 10-year battle, to the point that it almost took his life.

He desperately wanted help and didn't know how to stop on his own.

After an attempt of suicide because he didn't want to live a life of addiction, he was brought to Strong Memorial Hospital Mental Health.

I'll never forget the look on his face when he saw me. It was heart-wrenching.

I sat in on his evaluation and was crushed to find out he had been using heroin for a few years. He was told it was the same thing as opiates, but cheaper.

He then turned to me and said, "I didn't want to see the look of disappointment on your face again. I just can't do this anymore."

Sixteen hours later, in the midst of withdrawal, they released him to me, citing he was no longer a threat to himself.

I was told they didn't have the resources to help him any further because they had no rehab program.

Then the hunt for help began.

Making numerous phone calls to what I knew of the drug rehabs here in Rochester, New York, thinking there would be no problem getting him in one, unfortunately, I was wrong.

I was told there were no beds available for two weeks, or no beds at all.

Another rehab center could take him, but didn't take health insurance. The cost was $3,000; money I didn't have.

I also knew they had detox centers in the city because he had been to one, but the State shut them down.

I ran out of resources, and began to break down and cry, because my son was going through withdrawal and I had no help, no more places to call, because there are not enough places to get help.

Being a mother and feeling helpless to the point of knowing my son could die was the most difficult and frightening time of my life.

I would not wish the pain I went through with him on anyone.

I am asking you if there is, somehow, we can open more rehab centers, not just for detox, but counsel for addicts.

Long-term counsel is the key to recovery.

It is also important for medical professionals, not insurance companies, to decide who needs treatment, and to what extent.

We help people that are in need of welfare, the disabled, and the unemployed.

Why not help this life-threatening disease, because people are dying.

Fortunately, we found help, the help we needed, through Teen Challenge, a Christian-based rehab in Syracuse, New York.

They are extremely limited and rely on donations.

My son spent 16 months in inpatient recovery this time, because he wanted to be there.

You don't fix a 10-year addiction with 3 months of inpatient.

He is doing well, and two years' clean.

With continued support, he is making a new life for himself.

I have my son back.

Unfortunately, some families aren't as blessed, which is the reason why I am here today.

SENATOR ROBACH: Thank you.

[Applause.]

SENATOR BOYLE: Thank you very much, Lisa.

And that is what we're hearing from a number of people, so you're not alone in this struggle.

And, I believe that we -- we did increase the funding for treatment by $2.8 million in this state budget, not nearly enough, but it's a first step in the right direction.

LISA THOMPSON: Thank you.

SENATOR BOYLE: And with your testimony, and the testimony of others, we're gonna look to do more.

LISA THOMPSON: Okay. Thank you very much.

SENATOR BOYLE: Thank you.

SENATOR ROBACH: Thank you.

SENATOR BOYLE: Next speaker is Jeanne Beno.

Dr. Beno?

And Dr. Beno is the chief toxicologist in the Monroe County Medical Examiner's Office.

DR. JEANNE BENO: Thank you.

Thank you for the opportunity to speak today.

I'm here as a representative of the Medical Examiner's Office.

I direct the forensic toxicology laboratory for the ME's Office in Monroe County.

Now, while we are a County-funded laboratory,

we are a regional lab, because we contract with the region to perform testing, so, I'll have data to present that includes a much larger region than Monroe County itself.

For the Medical Examiner's Office, we receive cases from up to 12 counties. And in driving-impairment cases, we receive cases from 7 counties beyond Monroe County.

We began to see this problem in heroin-related deaths beginning, approximately, July of 2012.

Prior to that time, you can see in the data I provided, we were averaging perhaps one heroin overdose fatality a month in the Medical Examiner's Office in Rochester.

In July of 2012 we had a sudden spike to four. Although, then, in August we had none.

But then, beginning in September, the number of deaths rose, and continued to rise, and stay at a much higher rate until the present time.

In 2011, we had 11 deaths due to heroin that were investigated by the Medical Examiner's Office.

In 2012, there were 29.

In 2013, there were 65 fatalities.

Of those deaths, 77 of them occurred in

Monroe County, 10 in Chemung, 6 in Wyoming, 4 in Ontario, 4 in Steuben, 3 in Livingston, and 1 in Orleans.

Now, while the death investigation in Monroe County is all coordinated by the Medical Examiner's Office. In surrounding counties, there isn't uniform death investigation. They are coroner systems.

Some of those counties send, virtually, any suspicious death to our office for investigation and autopsy, but others send only selective cases.

So, I believe that our total number of heroin deaths is an underrepresentation of what the true problem is.

If you look at our data on age of heroin-addicts' deaths, our oldest in this time period, I believe, was 67 or 68.

So you can imagine that if a coroner is investigating the death of a 67- or 68-year-old, unless there's clear evidence of heroin paraphernalia at the scene, they're probably gonna simply release that body as coronary-artery disease.

So lack of uniform death investigation leads to an underrepresentation of the number of deaths.

The other thing is, the reliance,

particularly in those other counties, perhaps, on clear signs of heroin use.

You can, of course, and most often you do, inject heroin intravenously.

But the purity is high enough that it can be very effective as a drug if snorted intranasally, like, commonly, lines of cocaine are snorted, or by smoking it, so that the evidence of track marks or recent puncture marks in the arm as your criteria for looking for a possibility of drugs, particularly heroin, may not be present. It may not be the appropriate choice to make your decision on.

In addition, it's very common that the scene of a heroin death is cleaned up prior to investigators getting there.

Family, friends, clean up the paraphernalia so that there's nothing there.

Even when there's clear signs from our investigators' standpoint of -- that they were using intravenous drugs, based on the signs on the body, the families often deny it.

So, there's still a lot of this attempt to kind of cover up.

Looking a little more at the demographics of the heroin deaths, part of what's happened in this

rise in heroin deaths that's particularly disturbing, is the change in the ages.

In the early 2000s, we had a spike in heroin deaths. That occurred when the street purity of heroin really started to rise.

So, again, because you could smoke or snort heroin, you could introduce a lot of people to heroin who weren't willing to use needles.

There was always this barrier we commonly heard from families, no, they wouldn't abuse heroin.

They would abuse -- they might abuse cocaine, or they might abuse marijuana, but they would never use an intravenous drug. There was somehow this stigma of intravenous-drug use.

I don't think that's there any longer, but it was at that time.

But once the purity increased, you could administer this drug by other routes effectively. Once you're addicted, you'll go to the intravenous route.

So in that period of time, we had a spike in heroin deaths, but the average age, or the most -- the age with the highest frequency of death, was individuals in their 40s, and these were people that were chronic heroin users.

In our demographics from this period of time, our highest number of heroin deaths has occurred in the 20- to 24-year-old age range.

Obviously, these are young heroin users; people that have not been abusing heroin for a very long time, and it's, obviously, a very disturbing trend.

More than half of the heroin deaths are in people under 35.

In terms of gender: 80 percent of the heroin deaths are in males, 20 percent are in females.

Now, if I back up just a moment to the heroin -- number of heroin deaths:

A problem we saw in December, and then January of this year, is that, on the street, we started seeing heroin that was cut with fentanyl, or fentanyl that was substituted for heroin, in the packets.

And there's was a lot -- it's an -- it a very important, disturbing issue, but it doesn't undercut the importance of understanding that heroin is toxic in and of itself.

But at that point in time, we had six heroin deaths in December of 2013.

But at the same time, I believe we had

five individuals who died from -- who were known to be heroin users, they were injecting intravenously, but they had fentanyl in their heroin packets instead of heroin.

So -- and in one case, we had several die in one night, and many other people hospitalized, from a batch of fentanyl-tainted heroin that was released on the street.

Okay, going back to our demographics:

82 percent of the heroin fatalities are Caucasian.

Again, this kind of -- the perception oftentimes in the public has been that this is an inner-city problem.

It is clearly not an inner-city problem.

13 percent are African-American; 1 percent, Asian; 1 percent, Hispanic; and 1 percent other nationalities.

That may mean that they're mixed-race or American-Indian, or that the racial profile wasn't clear at our -- at the time we received that case.

A problem we see in heroin deaths is that heroin isn't the only drug, as some of the parents spoke to the number of drugs their kids are prescribed.

These individuals are, oftentimes, on many other drugs. We may see as many as a dozen other drugs in their system at the same time.

So it's a very complicated phenomenon. It's not only the toxicity of the heroin, but it's the added effects of all these other drugs that are underlying the toxicity and the number of deaths.

One of the types of cases where we see heroin deaths are in individuals who have just been released from rehab or just been released from jail.

It's a real problem with not having a long enough rehabilitation period.

If you simply keep somebody in rehab for a month, and long enough for them to lose their tolerance to the heroin, and you put them back out on the street, their urge is to go and use immediately. And, commonly, they go back and use the amount of heroin that they'd been using prior to incarceration or prior to treatment, and that is, oftentimes, too much for them at that point in time, and it's lethal.

So one final point I wanted to make is, that the heroin and the opiate problem does not just affect those individuals who become addicted.

It affects the rest of the population at

large, as can be demonstrated on our data on driving-impairment due to opiates.

So, in 2013, the number of cases seen by our office in -- for driving under the influence of drugs in which opiates were detected, increased 48 percent.

The number of cases that were positive for morphine, which is the primary analyte that you test for when looking for heroin, increased 80 percent.

So, clearly, the prevalence of heroin on the street is seen also in the prevalence of heroin in drivers.

And one other small point: While the numbers are small, the number of driving-impairment cases positive for buprenorphine, which is the active drug in Suboxone, increased, from four, to twelve.

So that may also be reflective of the fact that it's being used a lot more to treat heroin, or, that the Suboxone that's being prescribed to heroin addicts, to try and prevent them from going back to heroin, is being diverted to the street so they can pay for their heroin.

So I appreciate your time.

Thank you.

SENATOR ROBACH: Thank you.

SENATOR BOYLE: Thank you, Doctor.

A quick question: Regarding the use of fentanyl mixed with the heroin, is it more likely that someone is gonna overdose?

I know that it's a very strong drug, obviously.

And I think of the case of Philip Seymour Hoffman, Rochester-area native, obviously, that, they said he had 77 decks in his apartment, and they think that he might have been using it, and because of the delayed reaction of the fentanyl, he might not have realized how much he was putting in his system.

Or other addicts, obviously.

Is it -- are they more likely to overdose with these mixed, or with pure heroin?

DR. JEANNE BENO: Well, I think they're more likely to overdose with fentanyl, for the simple reason that it's an extremely potent drug.

And, so, the knowledge of the person preparing this powder in a packet, and diluting or cutting that powder down to an amount that's a reasonable amount for a high, but not so much that would kill you, the ability, or the knowledge,

really isn't there.

When we're talking about heroin, we're talking about milligram doses.

When we're talking about fentanyl, we're talking about microgram doses.

And, so, the idea that somebody can cut a powder down so that you're only administering a certain number of, you know, micrograms is pretty difficult to understand that they could do that.

SENATOR BOYLE: Thank you.

SENATOR ROBACH: Kind of continuing on Senator Boyle's question: You know, with this alarming rate of increase all across the state, now we're -- I think we're finding out, believe it or not, from having this, unfortunately, seems to be going on all over the country.

Do you think that's due to the increase in the volume of people using the heroin? If it's the potency in what they're cutting with? Or if it's, you know, even the age of the users seems to be aging to younger and younger?

Maybe I'm answering the question.

Or is it all of the above?

DR. JEANNE BENO: Well, I mean, certainly, all of the above are a factor.

I think the potency --

Jim Wesley could probably speak to that a little better, although, I don't think they're running potency all the time.

-- but I think the potency's been relatively high since the early 2000s.

I think there has to have been a real shift in the number of users, and the age of the users, because we would never see the number of young people like this that we -- in the past.

SENATOR ROBACH: Well, and you raise such a good point, but I think when you're at that point where you're addicted, you just want to get it.

But, you know, because it's not measured, you don't know exactly what you're getting.

And even the comment he made, about the difference in one dose to the next being sometimes three times stronger, I mean, man, whew!

DR. JEANNE BENO: 20 years ago, heroin on the street, you probably thought it was a good deal if you got a 10 percent pure heroin.

Now it's just pretty common to have 50 percent.

And, again, if your dealer is commonly giving you 20 percent or 30 percent, and the next day you

get much higher, whether intentionally, whether it's because some drug comes into town and the dealer is worried that, you know, somebody's gonna bust them, so they just, you know, break it out into packets and throw it out on the street without cutting it, all of those are variables, that the user can't control and has no knowledge of.

SENATOR BOYLE: Thank you, Doctor.

SENATOR ROBACH: Thank you, Doctor.

DR. JEANNE BENO: You're welcome.

SENATOR ROBACH: Our next testimony will come from our dynamic Monroe County District Attorney, Sandra Doorley.

DA SANDRA DOORLEY: As always, Senator, it is a pleasure.

SENATOR ROBACH: Thank you.

DA SANDRA DOORLEY: Senator Boyle, nice to meet you.

I'm Sandra Doorley, the District Attorney of Monroe County.

I deal with Senator Robach very often.

So, thank you.

It's actually really a pleasure to be here and speak to both of you today.

Two years ago, a young woman, she was a

gifted athlete, she graduated from a suburban Monroe County high school, with plans of attending a respected out-of-state university on a full scholarship.

Months later, she was implicated in a rash of violent armed robberies that had occurred throughout the county.

That once-promising young woman is now serving 11 years in the New York State Department of Corrections.

Three months ago, a 22-year-old man, once a decorated high school athlete, entered the Wegman's Supermarket in Pittsford Plaza and was observed shoplifting several items.

He was pursued from the store, and the young man then attempted to force a woman from her car before fleeting to another business across the street.

Moments later, that same young man drew a weapon on a police officer who responded with deadly force.

Just weeks ago, a 19-year-old woman, a recovering addict with a promising future, was found dead in her dorm room at the University of Rochester.

Her death prompted the president of that institution to issue a plea to the student body, young scholars attending one of the most distinguished universities of our nation, to seek help if they find themselves battling the same demons that led to their classmate's ultimate and untimely death.

Three tragic events affecting three different people whose paths had never crossed.

Three heartbreaking stories with the single common denominator, that being heroin.

Ten years ago, these stories and the fates of these three individuals would have shocked the community.

Today, they are considered pedestrian.

They're regrettable, tragic, and all-too-common stories which fill up our daily newspapers and newscasts with images of sobbing parents, memorial services, and emaciated, vacant-eyed mugshots.

This is the face of heroin; the face of the opiate epidemic that is sweeping our nation; an epidemic whose effects are felt no less in Monroe County than in any other urban center in America. And we are woefully unprepared.

For decades, heroin use and the addiction was associated with poverty and blight, a drug of the urban poor, conjuring up images of needle-filled parking lots, homelessness, and long lines at methadone clinics.

In the last several years, heroin has crawled out of the alleyways and the drug houses into our high school, into our dorm rooms, and into kitchens across New York State, and our nation.

No longer is heroin a drug of some imagined junky underclass.

It is a drug that has impacted every strata of society without regard for income, education, race, or gender.

Heroin and its opiate cousins have become the crack cocaine of the twenty-first century; an epidemic that's having a profound impact on a generation of young people growing up in our community.

Heroin is fueling a frightening wave of violent crime in our community, the likes of which we have rarely seen and in places that we've never seen it before.

After this body has deliberated over the testimony that you will hear today, I'm confident

that appropriate and thoroughly considered action will be taken in the Legislature of our state.

Today, many qualified and experienced people will make many important observations and give voice to many worthy ideas.

As District Attorney, I appreciate the opportunity to speak to you, and I ask that you consider the following recommendations:

First, please curtail the ability or the availability of opiate pain killers in the community by passing laws that limit the frequency with which these drugs are prescribed, and by further encouraging the use and development of less addictive alternatives.

It's no secret that the recent rise in the use of heroin is fueled by the accessibility of opiate-based medications.

Young people who would never have considered experimenting with an illicit stigmatized drug like heroin feel safe experimenting with drugs produced by reputable pharmaceutical companies and prescribed by physicians.

Many realize too late, however, that these drugs have the same addictive properties as their inexpensive street-level cousins.

Before long, that young people who might never have considered trying heroin are driven by addiction to this lower-priced, readily available, and powerful alternative.

Secondly, please consider amending the Penal Code of the State of New York to make drug dealers responsible for the results of their sales.

In short, amend the law to make the sale or dispensing of a drug which results in a death a homicide offense.

Currently, a person who provides an illicit drug that results in the death of a user can typically only be charged with criminal sale of a controlled substance, unless unusual facts exist that may allow us to charge a homicide offense.

While amending our current laws would certainly not eradicate the illicit-drug trade on our street, holding drug dealers accountable for the true cost of their activities would significantly diminish the open availability of these dangerous drugs, and would perhaps give drug dealers reason to pause before selling to young, inexperienced users seeking cheap alternatives to prescription medication.

Here in Monroe County we have seen a drastic

rise in the number of felony offenses involving the possession or sale of heroin or other opiates.

A comparison of the first quarter of 2013 to the first quarter of 2014 shows nearly a 45 percent increase in the total number of felony indictments for heroin and other opiates.

And perhaps more telling, the number of defendants indicted for felony possession or sale of heroin or opiates more than doubled in the first quarter of 2014 as compared to the first quarter in 2013; going from 11 defendants charged in 2013, to 24 in 2014.

It's documented here in Monroe County, we've seen the rise.

The destruction caused by heroin and opiate addiction is a problem confronting all New Yorkers.

And I would like to thank the members of this body for bringing this issue before the public, and for working with those of us in law enforcement and the treatment community to begin working towards a solution.

This problem has been years in the making and it will not be solved overnight.

Today's forum, however, is an important first step towards a lasting solution, and I appreciate

the opportunity to share my thoughts and recommendations.

Thank you.

SENATOR ROBACH: Thank you, Sandra.

SENATOR BOYLE: Thank you so much, Sandra.

[Applause.]

SENATOR BOYLE: Quick question.

DA SANDRA DOORLEY: Sure.

SENATOR BOYLE: And thank you for your leadership in prosecuting these drug dealers and other -- in heroin, particularly.

One question is: That we're looking at possession charges, and how we can change the law, the criminal code, to make it stronger.

I have legislation, for example, which would make possession of 50 bags of heroin a felony.

Now, as you understand, there's a little bit of the politics involved here --

DA SANDRA DOORLEY: Exactly.

SENATOR BOYLE: -- because, several years ago we rolled back the Rockefeller drug laws, and we have to get legislation, not just past the State Senate, where Senator Robach and I serve, but also the New York State Assembly, maybe in our New York City-focused and not quite "throw the book

at them" types; we'll say.

Now, without going full-boards back to the Rockefeller drug laws, how would you recommend, if you could write a law tomorrow, to increase the penalties on possession, because you know it's going to -- this person is a dealer?

For example, though, when I mentioned the Philip Seymour Hoffman case, obviously, Philip Seymour Hoffman was not dealing drugs, but he had 77 bags in his apartment when he died.

What is an appropriate amount to say, You are dealing this drug, this is not for personal use?

Or how do you do it?

You can't do it by weight because it's lighter than cocaine. Right?

I mean --

DA SANDRA DOORLEY: You've gotta to redraft or recreate the definition of "the seller."

You know, one of the problems that I see:

You know, I'm a big supporter of drug courts and drug-treatment facilities in our community, you know, but the problem is the seller.

You know, our judicial-diversion program, Section 216 of the Penal Law, that's all well and good for the user; for the person who really and

truly wants help in battling this hideous addiction.

But we have to stop -- we have to stop the sellers from using this as a tool to get out of their criminal ramifications and their penalties.

We need to make the statutes tougher for sellers.

Sellers are the ones that are addicting our children in the cities and the suburbs.

We've got to stop them.

And perhaps if -- and the most frustrating thing, when I tried to gather all the information, I was only able to track our felony offenses, because criminal possession of a controlled substance in the seventh degree, which captures so much of the heroin that we're seeing on the street, we don't keep records.

That's a low level of your decks and your bundles, and those are just getting disposed of, because of the weight.

SENATOR BOYLE: Yeah, right, and that gets to -- just to follow up, that gets to another situation.

We had a case in Suffolk County, where they arrested a guy with 864 bags. Only a misdemeanor.

DA SANDRA DOORLEY: Right, right.

SENATOR BOYLE: Crazy.

DA SANDRA DOORLEY: So you've gotta lower those thresholds. Or, just create a -- you know, we have our own statute for marijuana offenses.

Perhaps take the heroin and opiates out of the "controlled substance" and create a separate statute.

SENATOR ROBACH: I think a good first step, and I was wondering what you thought of that:

Bill Hochul was here earlier.

And, in the federal statute, I can't remember what the amount was, but it's relatively low, coupled with a death caused by it, then that seller can actually be given a life sentence -- up to a life sentence.

I mean, I think we -- I think, as a local prosecutor, you ought to have that tool, as well.

DA SANDRA DOORLEY: Absolutely. They use the murder or the homicide as the aggravating factor for the possession or sale of the controlled substance.

That's a suggestion as well.

SENATOR ROBACH: You would favor that; right?

DA SANDRA DOORLEY: Yes.

I mean, one of the most frustrating things, and I don't mean to keep talking: We charged a

woman with the death of another woman.

What had happened was, she had sold or given her enough heroin to cause her to overdose and die.

We had facts and allegations that this seller knew that this woman had, or was having, bad reactions to heroin, but despite that, helped her inject herself the final and last time.

Because of the facts as we knew it, we were able to charge a homicide, but that's not always the case.

And people who do that, people -- the sellers who provide that, should be penalized as well.

SENATOR ROBACH: Yeah, we need to do something, 'cause right now, they're flooding the market, and they're flooding it cheap.

And I don't think they're too afraid of getting caught, or what's gonna happen, from the seller's side.

DA SANDRA DOORLEY: Exactly.

It's very cheap.

SENATOR ROBACH: Thank you very much.

SENATOR BOYLE: Thank you very much.

DA SANDRA DOORLEY: Thank you very much.

[Applause.]

SENATOR BOYLE: Our next speaker is Paige Prentice, the vice president of operations at Horizon Health Services.

PAIGE PRENTICE: Good afternoon.

Kind of going towards last, you end up being a summary, so...

Thank you for convening this forum and inviting testimony from the community to help guide your actions.

The opiate epidemic and its devastating and fatal impact on our communities, on our neighbors, our families, and our children, is, unfortunately, well documented.

According to the (CDC Center for Disease Control), in 2001, 4,000 people died directly related to overdose from prescription opiates.

This figure does not include heroin overdose; only those from prescription pain relievers.

In 2010, that number increased to 16,500.

Last year, as people have stated, the overdose deaths are still climbing, with the fastest-growing population being our adolescents and our young adults.

In 2011, heroin was the second most commonly used drug by patients presenting to our emergency

departments.

Having said this, I'm relieved to think that I'm not here to convince you that there's a problem.

Obviously, you're well aware.

Today I will offer suggestions on important steps to effectively intervene for long-term resolution.

We are making progress, and I thank you for your leadership in making these things happen.

The passaging of I-STOP legislation in 2013, which helped stop the unknowing and/or reckless prescription of pain relievers to those who are likely not going to use them responsibly, was helpful.

Treatment bed capacity was increased by 50 beds in New York State, with 25 of those beds specifically designated to Western New York.

And, very recently, the positive support for Naloxone legislation, the life-threatening opiate-overdose reversal medication.

Last week, two parents that were trained by Horizon in opiate-overdose prevention were able to, literally, save the lives of their children who overdosed in their home.

Naloxone is a powerful tool that must be more

widely available, but there's more to do.

We must dramatically expand treatment access, and this is a multifaceted task.

We must further increase treatment bed capacity in New York State, especially in Western New York.

Currently in Western New York, we have a 70-person waitlist to get into intensive residential treatment.

It is agonizing and devastating to look a parent in the face and tell them: I'm sorry, there's no bed for your son today.

We must hold insurance companies accountable to create access to care; not impose barriers to care.

This means establishing humane and standardized criteria for coverage authorization, and keeping deductibles and co-pays at manageable levels.

And I say "humane," because it is a moving target. Every day, you'll have an insurance carrier, and he says you only have to suffer this much to get in.

But the other insurance carrier feels differently, and they think have you to suffer a

little bit more, and "we can't give you treatment until you're suffering just enough."

That's inhumane.

We must advocate to federal officials to allow physician extenders -- nurse practitioners and physician assistants -- to be able to prescribe Suboxone.

Currently, only a medical doctor can prescribe Suboxone.

If not nurse practitioners and physician assistants together, then start with just nurse practitioners.

If community-based detoxification programs are going to be successful, we have to increase the number of medical providers that can prescribe Suboxone.

We must further enhance community-wide access for Naloxone.

We must educate the medical community on the signs and symptoms of problem drug use, and options for referral.

We must promote and increase the frequency of national Drug Take-Back days, and we must promote and increase the prevalence of accessibility of community medication drop-boxes.

Thank you for your time and attention.

SENATOR ROBACH: Thank you, Paige.

[Applause.]

SENATOR BOYLE: Our next speaker is Avi Israel. He's the president of Save the Michaels of the World.

AVI ISRAEL: My name is Avi Israel.

And I want to take a moment, Senators, and thank you for giving me the opportunity to speak here.

On June 4th of 2011, I lost my only boy to suicide. My son put a shotgun to his head and pulled the trigger, in my back bedroom.

My boy, Michael, was prescribed into addiction by his doctors. He was prescribed opiates for Chron's disease.

Since that day, my family and I have been fighting to inform the public of the danger of opiates and pain killers, and a subsequent rise in heroin use.

We have formed a group of parents who, like us, have lost kids, and have kids addicted to these drugs.

We have named our group "Save the Michaels of the World," and our group was very instrumental in

the passing of I-STOP.

I'd like to take a minute and get from my script, and touch on something that was not touched here at all.

The creation of this epidemic, and we cannot deny it, was started by the medical community.

There's no way -- and there's no way to get around it.

The overprescribing, they're prescribing of opiates for ridiculous minor pain, has gone out of control.

So New York State has passed a great law that's called "I-STOP."

It has curbed the doctor shopping, and reduced the overprescribing of this dangerous drug; however, I-STOP was never completed, and very important components of this legislation were never implemented, such as prescriber education, pharmacist education, and a public-awareness campaign.

For that, gentlemen, we can go right down to the second floor to Capitol Hill and speak to our Governor and the Department of Health.

There was a workgroup in charge of education and certification standards for prescriber and

pharmacists, has come up with 15 recommendations, but failed to reach a conclusion on any one of the recommendations; so, subsequently, everything was dropped by the Department of Health.

The Department of Health has not done anything to implement any of those recommendations.

The provision in I-STOP to educate and inform the public never got off the ground.

I know this one for a fact; I was part of that committee.

In a recent meeting in Albany, with the top personnel at the Department of Health, I asked a question: What happened to the public-awareness campaign?

The answer was a shoulder shrug and "I don't know."

The Department of Mental Health and OASAS were supposed to be combined together, to one department, to give the public an easier access for treatment.

Nothing ever happened.

So subsequent to that, we have mental treatment; mental facilities that can treat mental treatment, that can also treat addiction, with empty beds sitting there empty. Nobody's getting the

treatment.

In my opinion, to get the answers for this epidemic, and it is an epidemic, all we need to do is get down to the second floor and get somebody moving over there.

Number one: We need to make a mandatory prescriber education in recognizing addiction early.

"Early," is a must.

If we could get doctors to understand and recognize the dangers of overprescribing that leads to addiction, and how to treat the addiction, this will be half the battle.

As for DEA statistics, 4 out of 5 overdoses start with pain killers.

Now, just to add to those numbers:

In Erie County, last year alone, we had 124 deaths. 84 of them were from prescription pain killers, 20 of them were heroin, and the rest were other prescription drugs.

Number two: Educate the public as a whole of the danger of abusing opiates, starting with kids, parents, and educators.

This is a must.

We have accomplished this with Buffalo with great success.

And, you have this [unintelligible] right in front of you.

With the help of BlueCross and BlueShield of Western New York, a public-awareness campaign was launched last October, and included every media outlet in Western New York: television, radio, and print.

Our community welcomed and embraced the information.

School systems around the Buffalo area have extended invitation to our coalition of parents, treatment providers, law enforcement, and media, for the purpose of informing students of these dangers.

Senators, if we are going to win this war, it's gonna be with the same spirit that helped pass I-STOP, with the legislative body and the Executive Branch working together for the good of the people.

The Governor and his staff must get involved and make some bold decisions.

We need mandatory education for all prescribers. That's got to be a must.

Public-awareness campaign is a must. We have to do it, we have to educate the public.

Easy access to treatment, I don't even have to say it, that's got to be a must.

Making sure that doctors recognize, and able to treat addiction, will save on the waiting time for people who are suffering from this disease.

That is -- that must be a must.

Mandating these simple requirements can save the future of our kids.

So, we have an epidemic in this country. I mean we, cannot deny it.

We have an epidemic in this state.

The antidote for this is education.

Thank you.

SENATOR ROBACH: Thank you, Mr. Israel.

And let me say how sorry I am for your loss, and -- but thank you at the same time.

I can't remember if it was Senator Maziarz or Senator Grisanti --

AVI ISRAEL: Yes.

SENATOR ROBACH: -- who told me how helpful you were in getting I-STOP legislation, which while not perfect, I think is saving some people, or helping us avoid it.

But I think we all agree up here that we definitely do have to do more.

And, you know, I have a great deal of respect for doctors, but they're like everybody else,

there's such a wide spectrum.

And you're right, every doctor needs to know that there has to be a cost-benefit ratio.

So, what you're talking about is prescribing the right thing, which is different than prescribing huge amounts, which also gets out in the community.

When the person using it may only need five instead of twenty-five, there's twenty there that are kicking around.

But, yes, we have to do a better job with all of it.

AVI ISRAEL: I think it's important to understand that the medical community has a responsibility here.

SENATOR ROBACH: Absolutely.

AVI ISRAEL: There's no reason to prescribe 30 pills for a root canal. We can do it with two or three.

You know, but more important, I think, than anything else, is the fact that none of the doctors, not any doctor, really understands addiction.

And the way to treat it, in my opinion, is to recognize it early. Not wait 8 or 10 months down the road when it's late.

If a doctor can recognize it, and a doctor is

able to treat it, and have the knowledge in treating addiction, we can save a lot of lives.

We don't have to wait 10 months down the road.

SENATOR BOYLE: I, too, would like to thank you, Mr. Israel, and I'm sorry for your loss. And thank you for your advocacy.

I will say that one of the pieces of legislation that we've already drafted for this package does require mandatory education for physicians on their continuing medical education about the dangers of overprescribing and prescriptions.

And you also touched upon the prevention.

At our Long Island forum, we had a forward-thinking superintendent of schools who has a program in the schools for the kids, and prevention.

And someone asked him: Well, how young is appropriate to start?

They start in kindergarten, right away.

AVI ISRAEL: I just want to mention that Senator Maziarz does have legislation, it's S-6671, which deals with doctor education, which I think we need to give it a very serious look.

SENATOR BOYLE: Absolutely.

AVI ISRAEL: And hopefully we can --

SENATOR ROBACH: And, obviously, the purpose for this forum is to push those things.

And we're gonna have a new Health Commissioner, too.

And maybe, as you talked about, you know, maybe the Commissioner's on the second floor, doing something different. Maybe this will help be the catalyst, as well.

AVI ISRAEL: The second floor definitely need to get -- they need to get involved.

SENATOR BOYLE: Thank you.

SENATOR ROBACH: Thank you, Mr. Israel.

AVI ISRAEL: Thank you.

[Applause.]

SENATOR ROBACH: Our next testimony will be from Dr. Michael Foster, who is the clinical director of chemical dependency at Unity Health Systems.

DR. MICHAEL FOSTER: My name is Mike Foster.

I'm a family physician by training, and practice primary-care medicine here in Rochester for 23 years.

I also am board certified in addiction medicine, and I currently am the director over at

the Unity Park Ridge Chemical Dependency Treatment Center.

Thank you very much, Senator Robach and Senator Boyle.

Some of this that I'm gonna say has been said so many times over that I hesitate to say it, but I'm gonna spin on ahead here.

Opiate addiction, and heroin addiction in particular, continues to strain our health-care and criminal justice systems.

SENATOR ROBACH: Amen.

DR. MICHAEL FOSTER: The enormous burden of suffering and ongoing media coverage of the problem has left little room for doubt that we are indeed dealing with an epidemic.

The Data 2000 Act provided a very significant tool for treatment of opiate addiction, by making medication-assisted treatment with buprenorphine, also known as "Suboxone," and other manufacturers, by making this medication-assisted treatment available to addicted persons in physician offices and clinics.

The recent I-STOP law has already contributed to a drastic reduction in the supply of diverted prescription pain pills.

These legislative actions have provided essential infrastructure support for addiction-treatment efforts.

The American Society of Addiction Medicine defines "addiction" as a chronic, progressive, incurable brain disease characterized by relapses and remissions.

The definition is disheartening, but accurate.

With treatment, however, there is hope.

Remission can be longstanding and sustained with proper treatment.

We call this "recovery."

Abstinence and recovery allows for normalization of the neurochemical dysfunction that drives the apparent and often criminal behavior associated with active addiction.

Recovery is associated with a community-wide reduction in crime and joblessness and incarceration.

Recovery results in lives saved and families salvaged.

Historically, accepted experience with opiate addiction is that less than 10 percent of patients remain in treatment long enough to achieve a

remission; whereas, upwards of 80 percent can achieve this with medication assistance.

This observation is described in this 2003 study from "The Lancet," which I've referenced in my notes, in which the retention rate for opiate addicts with medication-assisted treatment was 75 percent, compared to zero percent for patients treated with detox and counseling only.

Retention and treatment is of critical importance when dealing with opiate addiction, because retention and treatment is the one variable most strongly associated with a sustained recovery.

Medication assistance is essential because the medication allows for the gradual restoration of the neurochemical milieu, which allows the addict to remain in treatment and engage functionally during the treatment process.

Today I'd like to make a remark about a lingering encumbrance which I believe hampers our efforts to adequately treat the disease of opiate addiction.

First and foremost would be the cap which limits the number of patients that a DEA-waivered physician may treat with buprenorphine or buprenorphine/Naloxone.

The current law places a 30-patient limit on newly waivered physicians, and allows them to apply for a 100-patient waiver after a year.

The cap was surely a prudent and well-intentioned measure at the onset, but our collective experience has subsequently shown that, despite this dramatic success that we have experienced with buprenorphine, the duration of treatment is lengthy, almost always involving a year, or several years, of continuous treatment.

This has resulted in a very serious bottleneck effect, such that, in this community, our waivered physicians are nearly always at a point of complete saturation.

It's difficult to imagine any other epidemic disease for which a patient might seek care, only to be told the treatment's not available because the doctor can only treat 100 patients in aggregate.

This limitation to access expands geometrically in addiction-treatment centers, such as my workplace, where we have thousands of addicted patients who are self-referred and referred by other clinicians; and, yet, that 100-patient cap still applies to the doc.

And even with several doctors on staff, we

really cannot adequately meet the needs of our population.

Certainly, it would be more helpful if more physicians obtained the DEA waiver and availed themselves as buprenorphine prescribers.

The promised DEA audit is a disincentive for many physicians who might otherwise be willing to apply for the waiver. Indeed, one might even question the need for a waiver in the first place.

Why do we require a waiver for the treatment of a disease, when no waiver is required to prescribe the pain-killer medications that perpetuate the addiction problem?

SENATOR ROBACH: Amen.

DR. MICHAEL FOSTER: Arguably, buprenorphine is safer than most other mainstream opiates.

It's my hope that this Task Force might make recommendations to lawmakers to remove or amend the patient-cap limitation for DEA-waivered buprenorphine prescribers.

Specifically, I might suggest that we make an effort to double or triple the limit; or, perhaps to make such allowances available for physicians who work in treatment centers that specialize in the treatment of addictive disease.

This would certainly improve access for vital medication-assisted treatment for heroin- and opiate-addicted people.

Opiate addiction is a deadly disease.

It's unfathomable to me that our society would limit access for lifesaving treatment to a person with cancer or any other lethal disease; yet, we end up doing just that for those stigmatized with the disease of addiction.

Thank you.

SENATOR BOYLE: Thank you very much.

SENATOR ROBACH: Could I just ask a question, because [unintelligible] won't say.

I used to always make my joke, and say: The federal government's a pay cut above us, but, in this one, we really have to work together.

And, you know, I think we were all thinking the same thing before, you said: Why have a waiver at all?

And I was just wondering why, the federal government, why did they put that waiver in place to begin with?

Was there some abuse of the other drug?

Or --

DR. MICHAEL FOSTER: I thought you guys would

know that.

[Laughter.]

DR. MICHAEL FOSTER: I believe that the waiver is in place, because there was significant discussion and back-and forth about whether buprenorphine should be scheduled for use, you know, as an outpatient drug in a more broad setting, like physicians offices; as opposed to a drug like methadone, which can only be administered in a licensed methadone-treatment facility.

So I think on one side we had an argument, trying to make access more achievable, less stigmatized. You could go into the doctor's office and get treatment.

On the other hand, there was a pushback, I'm sure, that was saying: Look, the doctors are not responsible in how they're prescribing other drugs. Why would we assume they'll be responsible in how they prescribe this one?

And there were comments even earlier today in some of the fantastic testimonials that we heard, about Suboxone being misused on the street. About, maybe doctors perhaps not being as scrupulous as they ought to be in -- regarding the behavior of their addicted patients.

And, certainly, diversion happens.

You know, heroin-addicted individuals, when they stray from their -- you know, from their right course of action with their recovery, they will use Suboxone as currency on the street.

And that's not okay, and it is vexing.

One of the challenges of treating the disease of addiction, is that -- is the behavioral aspect of the treatment.

You know, it is a disease, without question.

We see the neurochemistry, we see the brain-image studies, we see the neural pathways that open up, that are not there in normal people, that actually emanate from the primitive reptile brain, the mid brain, the source of our instinctive drives, that connect directly to the frontal lobe which is where action and the plans are executed.

We see those pathways light up in addicted brains, and normal folks don't have that.

So when a normal person gets an impulse to do something to pleasure one's self, it normally circuits through the part of the brain that thinks about consequences and values, and all those -- logic, and prior experience.

But in the addict's brain, the notion about

using, it comes on with the strength of a visceral drive, and it goes right to the part of the brain that initiates that action.

That's why these folks that normally are loveable and, you know, honorable, and enjoyable, and great people, they become impulsive, and they become criminal.

And, you know, in treatment, we can pull them back from the edge.

But the other thing that nobody wants to hear is, that this is not a curable disease.

You know, in AA they toss about the analogue of saying: Once the cucumber becomes a pickle, it can never again be the cucumber.

So those "pickled" folks in AA, they get to decide, you know, number one, if they're gonna live or die. And then they get to decide if they're gonna be a sweet pickle or a sour pickle, but they accept the fact that they are pickles.

And so it is with addicts.

And there isn't a patient anywhere in the world that wants to hear that kind of story.

SENATOR ROBACH: But I just want to make two comments.

One is, going back to, I guess I'm in the

camp, where it's federal or state, or what we can do, that the motivating guide posts should be on the other drug.

Your numbers said it exactly.

So, without treatment of the appropriate length and some other medication, and you can call it, you know, you're never cured, but you can control it, so we have a different definition of what "cured" is.

DR. MICHAEL FOSTER: You can have an almost normal life, and it can be a damned good life.

SENATOR ROBACH: Right, but 80 percent, to 10, I think were the numbers you used --

DR. MICHAEL FOSTER: Yes.

SENATOR ROBACH: -- that, to me, would seem that they outta let you use that on the patient's benefit, without waiver, I guess.

I'm gonna suggest that's something that we include in ours, because --

DR. MICHAEL FOSTER: This is the -- this is the -- there are numerous -- this -- there's all kinds of data to support that perspective.

But that is the article that I cited.

SENATOR ROBACH: Right. Got you.

SENATOR BOYLE: You just also mentioned, from

your -- in your --

SENATOR ROBACH: Now you're hearing from the reptile brain center.

[Laughter.]

SENATOR BOYLE: -- from your -- in your system, now you said you had numerous physicians, and they're maxed out, if you will, and they're still --

Can you just give me actual numbers, or approximate numbers?

DR. MICHAEL FOSTER: We have, between myself and other docs, some of whom are part-time, we probably have the equivalent of three full physicians.

Nobody wants to hear about the economics of physician reimbursement, but -- but I would point out that somebody has to pay the doctor, and the doctor's gotta earn his keep.

And, so, if a doc is so inclined as to be willing to treat addicts, and take the training that's necessary to do that, and avail themselves to that, and then you tell them they can only have 100 patients, he can't make a living to do that. And the institution that hires him cannot generate the revenue to hire another doctor.

It just isn't possible to do that.

And the role for physicians in addiction treatment is a limited role.

SENATOR ROBACH: Right.

DR. MICHAEL FOSTER: You know, traditionally, addiction is treated probably poorly by almost everybody, but, mostly treated by non-physician clinicians. And doctors have a role.

You know, I can go on about how important that may be, but it's a peripheral role, it's a niche role. And in the case of opioid addiction, we provide the medicine, we provide the drug, that allows that addict to be well enough to be in treatment, and to stay; hopefully for a long enough time to get better.

So of the thousands of patients, my institution, we have over 130,000 outpatient visits a year, but -- and I'm sure there's a lot of money that gets generated doing that, but most of those visits don't involve seeing a doctor.

And so, you know, for them to pay me, you know, I see these Suboxone patients, but I can only see 100, and I do a few other things here and there.

But there isn't enough role to hire like 10 more doctors for the treatment center.

So the treatment center needs a break.

They need -- they need their doc to be able to see more Suboxone patients.

And that's just the -- that's the economics of it.

AUDIENCE MEMBER: Can I say something, please?

SENATOR BOYLE: Yeah.

AUDIENCE MEMBER: (No microphone used.)

My name's [unintelligible]. I'm here [unintelligible] for Horizon Health Services, and [unintelligible].

In Western New York, we have a 45-day wait for somebody to see a Suboxone doctor.

We have a 4-month wait to get into a methadone clinic.

So you have kids -- again, I'm going back to the insurance nightmare.

You have kids that are going through detox, that have no place to go, that are being put back out on the street. And then they have to wait another 45 days to see a Suboxone doctor.

SENATOR ROBACH: Right.

AUDIENCE MEMBER: That's unacceptable.

SENATOR ROBACH: Well, if the federal

government lifted the waiver, I think it would shorten the time period.

So, that's what I meant when I said that should be the guidepost, because, besides medical reimbursement, you have all these people waiting, I don't know what you want to call them, clients, people needing service that you can't service, even though it may save their life.

That's pretty crazy.

AVI ISRAEL: We only have six doctors in the Buffalo area. The second largest city in New York State, only six doctors that can prescribe Suboxone.

SENATOR ROBACH: Is that pretty, uh -- pretty standard for here, too, in Monroe?

DR. MICHAEL FOSTER: We have more than that number here, but, you know, there's a lot of docs that will get the waiver. But a lot of these docs are primary-care docs who are very busy, and they'll get the waiver, and they might be willing to see a handful of addicts in their own practice, but they don't necessarily want to throw open the flood gates to the whole city; and, so, you know, that limits a funny thing.

You know, for a lot of docs out there, that

limit doesn't even come close to the number that they're actually seeing. It doesn't affect them.

But for docs who have dedicated their practice to the treatment of addiction, or where that's a big part of their practice, it puts a governor on things that really kind of chokes them off.

SENATOR ROBACH: And just so I make sure I understand this correctly: So -- you know, I don't mean to diminish this, but let's say you've got somebody who's seeing 30, somebody that's seeing 100, if you knew that there was a patient that needed that, would that doctor then refer to this other guy that may not be using his full 30?

DR. MICHAEL FOSTER: Oh, sure.

SENATOR ROBACH: Okay.

DR. MICHAEL FOSTER: Yeah, absolutely. Yeah, in fact, there's enough --

SENATOR ROBACH: It sounds like, in Buffalo --

DR. MICHAEL FOSTER: -- water finds its level here.

Almost all the docs that are willing to see patients in the Rochester area are always near capacity; and that's just how we are.

And, you know, once we get them in treatment, and they do well and they've shaped up, and it's really the most fantastic thing to observe how desperately ill some of the folks are when they come in, and how really fantastic they look after a while. But then, sometimes, it's hard for us to know what to do with them.

Because the best data out there really supports this notion that this is a chronic disease, and, it doesn't mean you're gonna be chronically sick with it, but you gotta take care of it long-term.

For a lot of -- nobody knows yet what the optimal duration of Suboxone treatment is.

One woman made a comment about, you know, some frustration that her son had been on for years.

And, clearly, not everybody needs to be on that long, but there really are a lot of cases where, probably, they need to be on that long.

And the end point is hard to define, because there's never a point where there's no risk of relapse.

And when relapse happens, you know, then we kind of wish we had thunk the other way, you know.

But -- so -- so the incentive to force people

off Suboxone is not there.

That's been tried. There's been studies that have done that. They have disappointingly high relapse rates.

So we'd like to be able to let people come off Suboxone at a rate that they're comfortable with, and not always be saturated --

SENATOR ROBACH: And I do think, though, that what -- you know, usual medical, science, or quantification sort of dictate that the more you use that, and the more people do it and control it, you'll have some idea.

And I know everybody's different, and we're very complex --

DR. MICHAEL FOSTER: Oh, absolutely.

SENATOR ROBACH: -- but, you know, the physiology of that will come out that, you know, maybe the average of length of time is about a certain amount of years.

And then maybe if you got somebody that's not responding, you put them back --

DR. MICHAEL FOSTER: We're probably close to that.

You know, we talk about best practices in so many areas of medicine. And I think that kind of

information is, you know, coming forth, people are sharing their experience.

And I think we'll have some consensus with time, but it isn't gonna be that this is a short-term quick fix. You know, that isn't going to be the result.

SENATOR ROBACH: Thank you very much.

SENATOR BOYLE: Thank you very much, Doctor.

DR. MICHAEL FOSTER: Thank you very much for having me.

SENATOR ROBACH: We have one last --

Thank you, Doctor.

[Applause.]

SENATOR ROBACH: I just want to say, before we get to our last speaker, too, in addition, and thank everyone who came, testified, this has been great, I think. And I think you're gonna see some good results from this.

I don't always say this at every hearing I participate in on different things, but, a number of people, also, and I want to thank them, did give written testimony, too. And some people who had very personal stories were not comfortable with standing up and saying them, but they included their testimony in this, too. And that's going around the

state as well.

So, thank you.

And with that, we will get to our last speaker, who is Lisette Castro, from Trillium Health.

LISETTE CASTRO: Hi.

Thank you for letting me speak, Senator Robach and Senator Boyle.

My name is Lisette Castro, and I'm the Harm Reduction Coordinator for Trillium Health's Syringe-Exchange Program.

"4,011 clients."

4,011 clients since the program started in 1994.

1,907 clients since April 2012, to April of 2013.

18,234 syringes handed out last month.

We do have Narcan available for clients and their families, and anyone who is willing to carry Narcan, who is around somebody who is using, can properly inject them and reverse an overdose.

Last week I had 14 clients who came to us and told us that they had reversed an overdose.

So on top of the people that did pass away within the last couple of months, that number would

have increased substantially.

We can hand out Narcan; however, because Narcan has to be given in a prescription form, that is what's stopping us in getting more Narcan out there.

This is not a problem that is new to us. We have been seeing this problem for quite a while.

We knew; because of history, and the quantity and the quality of heroin out on the street was weak for a couple of years, we knew that this would come back around.

Back in 2000 we had quite a few overdoses because of the tainted batches of heroin. Then that kind of slowed down.

So the price of heroin went from $20 a bag, to $10 a bag, because of the lack of quality.

Now it's back up to $15, and in some places $20 a bag, because it's more potent and people overdose.

People are still scared to come and ask for help because, here I get 10, 15 clients a week that want to go into treatment. We have one detox with 37 to 40-some beds.

Like I said, I'm serving 1,097 clients a year.

What is that amount of beds?

It does nothing for our clients, at all.

The one thing that all the clients always say, "It sucks to be an addict in Monroe County."

I've been in this field 16 years, and when I first started, we were able to send people outside of Monroe County for detox and inpatient because they were lengthier programs.

With the changes in the HMO, no outside Monroe County help.

And, now, the insurance companies have to decide whether this patient can detox at home, or needs to be detoxed medically.

And who's the one with the pain? The client. They know their situation best.

We need more education in high schools.

When I do have conversations with clients, which is every day, because, the way I know my information, is I get it from them.

There is no education in high schools, in elementary, about heroin.

SENATOR ROBACH: Right.

LISETTE CASTRO: When I do educational presentations about the effects of heroin to juvenile delinquents, and in some high schools, the

first thing I ask is: Do you know you can die from heroin?

And the answer is: No.

They do not know the addictiveness of heroin. They believe it's a drug just like marijuana, where you can smoke marijuana one day, and then never touch it again.

They're not knowing the addictiveness of heroin.

And, as parents, as educators, we urge people to educate their kids, and, put in more education.

We have come a long way as far as HIV prevention with IV-drug users.

When we first started our program right in Rochester, in Monroe County it was pretty high, people getting infected with HIV because of IV-drug use.

It has dramatically decreased because of our program; however, heroin is on the rise again.

We do meet people where they're at, but when they want to get into a program, we refer them, and we put them where they're supposed to be.

But as a -- as human-service workers, it sucks when our hands are tied behind our back when we have a client saying: Look, I can't do this

anymore. I need to go in a program.

Insurance barriers. Bed availability.

Do the treatment actually works for the person?

The Suboxone, buprenorphine, the reason why the 30 patient, was because they wanted the doctor to be able to not just prescribe the pill, but to take care of the client all the way around: inpatient, counseling.

If a regular primary doctor, who does not work with people and drug addiction, they're not gonna -- they're just gonna prescribe the pill, and then you're gonna get those that constantly relapsing from the pill.

More of the Suboxone providers are in mental-health facilities and substance-use facilities.

Do we need to get more out there? I believe so.

But, of course, it has to -- you have to work around the whole thing. It just can't be prescribing the pill, "I'll see you back in 30 days for your refill."

It's not gonna work.

Methadone program here in Rochester,

six months to a year waiting list, two programs in Rochester.

I have 4,000 clients.

Two methadone programs.

Thank you for your time.

SENATOR ROBACH: Yeah, let me -- just to --

Thank you.

And, you know, I would say this: I sense your frustration.

But I do want to thank you, because I think Trillium does a lot of good things.

LISETTE CASTRO: Thank you.

SENATOR ROBACH: And we'd be worse off without it.

I was just curious again, because I don't want to get all bogged down in it:

So, do you have doctors that work with you?

How do you get Narcan now?

LISETTE CASTRO: Our Narcan is through the Harm Reduction Coalition.

SENATOR ROBACH: Okay.

LISETTE CASTRO: So anyone can come to us and be trained on Narcan. Preferably our clients, but anybody who's around.

SENATOR ROBACH: And that's like a waiver;

right?

LISETTE CASTRO: Right. They'll have this little blue card that I sign off on, that says they've been trained in opiate overdose. And they can legally administer the Narcan, with that card.

Our physician also gives them a prescription that legalizes them to carry the Narcan.

So part of that: They're supposed to call 911 in between that, but they are legal to carry and administer the Narcan.

SENATOR ROBACH: I just want to ask you one other question, too, because, you know, this has really been helpful, and I think we really are gonna come up with some good things. And maybe this is my old-guy brain.

See, I don't get that what you said about that.

I'm always thinking that these people are getting addicted, the young people, because there are similar receptors in the brain, and they're doing this other stuff, that they think that's not as dangerous, which leads them to what really is dangerous.

You kind of said something different.

I mean, I don't even like getting a shot from

a doctor when I know it's gonna help me, go to that step.

You know, it's hard for me, really, like a 16-year-old girl is going: I'm not afraid to inject myself, and I don't think there's anything bad.

But if that's the case, we have to then really gotta, maybe, even have some multipronged approaches, even inside our public awareness, because that's kind of a different thing.

I mean, I don't want to get too autobiographical, but, you know, I grew up in the city of Rochester, too, and there were certain things that you just -- even your older brothers, or even the kids you who were doing other stuff with, or drinking, they would say: Get away from that guy, you don't mess around with that. That'll kill you.

If the kids don't know that now, that's very scary to me.

LISETTE CASTRO: And --

THERESA DELONE: (No microphone used.)

Can I just add something?

My son -- I'm sorry [unintelligible].

If you would talk to my son, he would tell you, he was one of the ones who said: I will never,

ever stick a needle in my arm.

SENATOR ROBACH: Right, but that's what I'm saying. So there's two different --

THERESA DELONE: It makes no difference. They're way far into their addiction.

SENATOR ROBACH: Right. There seems to be two different tracks.

And what's coming out in the testimony very, very much, it seems like the explosion of this has definitely been linked to, I'm really starting to believe, almost scientifically, that using those other opioid drugs that are over this -- pharmaceutical, and I won't call them controlled, but you know what the dosage is.

It's a little bit more controlled; therefore, Not good, but not as explosively dangerous to death, is leading to people that normally wouldn't do what your son did, Well, if I can't go get that, I'll take whatever I can get, because I need something.

But, what this young lady, Lisette, said, is in addition to that, there's people that think trying heroin maybe at a party, or something, is no different than smoking marijuana, that's a different population group, and that's very scare to me.

LISETTE CASTRO: And it's different.

I mean, I've been working in this field 16 years. And when I first started, the age difference from the ones I'm seeing now, were more than 30s, 40s late 50s.

Now, the youngest client have I right now, I believe she's 16 years old.

SENATOR ROBACH: Oh, geez!

LISETTE CASTRO: The regular clients right now on a regular basis are between 16 and 25.

And another thing with this crowd, your older crowd would sniff the heroin or sniff the opiates until, you know, they were spending too much money, so then they would mainline and go ahead and inject.

See, the younger generation is sniffing, maybe, for less than 30 days, or maybe not even sniffing the heroin, and then going straight to injecting.

So it's a lot different than what we used to see back 15, 20 years ago.

So I hope, and I'm --

SENATOR ROBACH: Well, hopefully they're seeing now, because it's all over, from our backyards, to our colleges, to Hollywood, and everywhere else, people are dying.

So, I hope people are paying attention to it

for their own sake.

LISETTE CASTRO: So do I.

Thank you so much for this opportunity.

SENATOR ROBACH: You're welcome.

Thank you.

SENATOR BOYLE: Thank you very much. We really appreciate it.

SENATOR ROBACH: You want to close us out?

[Applause.]

SENATOR BOYLE: I'd like to thank Senator Robach and his staff for hosting this today, and for all the presenters, and everyone who came in support, and advocates.

I do know that if you were not able to speak today, you can contact my office.

Just Google it, in Albany. Deanna and Susan here, we're gonna be taking testimony and ideas from everyone.

Anything you can think of between now and June 1st, please let us know.

And I can say that we got a lot of good ideas out of today's testimony, and, it's gonna be part of the report, and part of the legislation, presumably, that we see in the coming weeks and months.

And thank you again.

We're gonna beat this heroin epidemic together.

Yes?

THERESA DELONE: (No microphone used.)

[Unintelligible.]

SENATOR ROBACH: Theresa, could we stop you? I don't think we could.

THERESA DELONE: I'm wondering, as people who are sitting here listening to all this testimony, what can we continue to do to help you get these things through?

Because as I said, many times, our kids are dying.

SENATOR ROBACH: We will come back to you.

So, there will probably be some recommendations. Probably some -- not probably. Definitely be some kind of legislation to deal with some of these things, on everything from, you know, the very end, the other way, to, you know, what Mr. Israel talked about, of how we can advertise better, to how we can enforce.

And then I think the big one and the hardest one will be, you know, what we can do, you know, Senator Boyle has been working on legislation about insurance coverage.

And then, also, creating a little bit more of an infrastructure, uhm, so if people do need that longer stay, they can get that. And then deal with the things Dr. Foster talked about. Maybe even after that, they may need something else.

I'm not an expert.

I don't know if the other drug is better than methadone.

I just think it's so hard, because everybody, you know, on length of their addiction, their own physiology, it's not an exact science kind of thing.

But we're gonna do all those things.

And so when those come out, I think that will also be in the newspaper.

And we'll hope that, you know, you will advocate for those things, and talk to people who are in the legislative field, from the Governor, on down, to say: Let's at least try some of these things, if not all of them, and then maybe we'll see a different environment in the future.

And then, again, we could all do that, you know, whether it's Facebook, whatever it is.

I mean, I do have to say, it's just -- you know, I'm a father, too, and it kills me when I hear those things.

It's almost hard for me to believe that, in today, with all the medicine we have, that, you know, people are dying from this. But they are.

But, my God, we also got all do a part early on.

You know, we're gonna try to do what we can.

But, quite frankly, I'm gonna know my kids. And I know, probably, more kids in the community.

But I don't know yours.

And, earlier, people also can't be afraid to make that jump and say it's bad.

You know, you've gone through it: The longer you wait to take the fight, the harder it's gonna be.

So, we can all do that, too.

I don't know what else to do.

It's a challenge, but, we're gonna be on it.

AUDIENCE MEMBER: (No microphone used.)

Could I mention something?

SENATOR BOYLE: Yeah.

AUDIENCE MEMBER: [Unintelligible.] I'm a senior vice president of marketing communications at BlueCross/BlueShield of Western New York.

I know health-insurance companies get banged a lot, but I have to tell you that, Horizon Health

Services came to us about three years ago, saying, outpatient treatment is not working, and it's not effective.

You'd spend less money by paying and covering residential treatment that goes for at least three months, than to pay all this, and cover by insurance all this outpatient treatment.

And we said: We're in.

In five minutes, we said: We will run the pilot.

And then we expanded the pilot a year ago.

So I just ask for -- to -- you know, we -- when Avi Israel came to us, I mean, we put 300,000 bucks behind this thing, and 100 meetings, to get this thing off the ground.

95 percent awareness in Western New York in the 8 counties in 4 months.

So, not everything that health-insurance companies do is bad, and I just ask you for that, for that perspective.

And also for those -- for the health-insurance companies who are actually stepping into this thing, recognizing that there's better ways and better solutions, and that we have an obligation to leverage our example, to put pressure

on other health-insurance companies who aren't doing it, because we are a community-based not-for-profit health-insurance company.

And there's a lot of not-for-profit health-insurance companies in this state, but leverage some of the stuff that we're doing and other people are doing that are really completely surprising by the community that we would ever do it.

And, yet, we're making decisions in five minutes, not by committee.

So I just want to bring that perspective, because, you know, we put a lot behind it, because, you know what? We have 1800 associates that work for our company, and we're parents, too.

SENATOR ROBACH: Right, and that's a good point.

You know, the other thing, certainly not hostile to insurance, but, you know, maybe those pilots, and that's why they're called "pilots," if they're working, maybe we can see some expansion of those across the state.

AUDIENCE MEMBER: And we are expanding, and we love to share that information, so that we can leverage what we're doing to put pressure on other

health-insurance companies to follow suit.

SENATOR ROBACH: Thank you.

AUDIENCE MEMBER: I just don't want to be -- we're not all -- you know, I mean, we are doing some good things, and, often, we're above oil and tobacco on a good day.

[Laughter.]

SENATOR BOYLE: Well, I do want to thank you for those comments. And, you have a great company.

That's why I use you.

AUDIENCE MEMBER: We're not Excellus.

We're BlueCross/BlueShield of Western New York.

SENATOR BOYLE: But, do you -- if you could, please, we're gonna have 10 more forums around the state. If you could have someone give some testimony, or let us know about your program and your pilot, we would love to hear about it.

AUDIENCE MEMBER: Great.

SENATOR ROBACH: Thank you very much.

(Whereupon, at approximately 1:03 p.m., the forum held before the New York State Joint Task Force on Heroin and Opioid Addiction concluded, and adjourned.)

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