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

PUBLIC FORUM: CLINTON COUNTY

PANEL DISCUSSION ON PLATTSBURGH'S HEROIN EPIDEMIC

Clinton County Government Center
137 Margaret Street
Plattsburgh, New York 12901

April 25, 2014
10:00 a.m. to 12:30 p.m.

PRESENT:

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

Senator Betty Little, Task Force Forum Moderator
Member of the Joint Task Force

SPEAKERS:	PAGE	QUESTIONS
Derek Champagne District Attorney Franklin County	9	22
Andrew Wylie District Attorney Clinton County	26	52
Matthew Bell Detective Plattsburgh City Police Department DEA Adirondack Drug Task Force	26	52
Shawn McKeen Personal Story Resident of Plattsburgh	26	52
Kathleen Camelo, M.D. Director Center for Student Health and Psychological Services at SUNY Plattsburgh	56	64
Michael Kettle, RN, BSN CASAC Director of Regional Services Joseph LaCoppola CASAC Conifer Park	65	83
Beth Lawyer Director North Star Behavioral Health Services For Citizen Advocates, Inc.	85	93
Charles Everly, M.D. Medical Director, Emergency Room CVPH Hospital	95	112
Kenneth Thayer Nursing Director, Emergency Care Center CVPH Medical Center	95	112
Connie Wille Executive Director Champlain Valley Family Center	115	127

SPEAKERS (Continued):	PAGE	QUESTIONS
John Schenkel, M.D. Clinton County Addiction Treatment Services	128	
Peter Bacel Counselor Friends of Recovery New York	133	138
AUDIENCE PARTICIPATION BEGINS:	139	

---oOo---

SENATOR LITTLE: Let me begin by thanking everyone for being here, and especially thank our panelists.

What we're going to do is, hear a number of presentations, and then it will be open, if anyone has any questions or comments, that would like to say something or question at the end, all right, as we get through with the program.

I'd also like to thank Clinton County for the use of their legislative room.

And we have two of our County legislators here today. Patty Wadell and Pete Pat Keenan are here, and I appreciate their efforts in having us use the room.

Across New York State, not just in Clinton County, but communities large and small, rural and urban, are seeing an increase in the use of heroin and prescription opioids, and the impact of this abuse and addiction is multifaceted: crime increases, emergency-care-needs rise, and more and more is asked of our mental-health providers.

The impact on families is profound, as loved ones struggle to help a son, a daughter, husband, or wife break the dependency from heroin, or a narcotic, like Oxycontin or Vicodin.

And the greatest, and certainly the most tragic impact, is the one that is endured by the addict, particularly, as we see the number of overdoses increasing in the past couple of years.

We've had way too many lives lost as a result of this.

All of us here today recognize that heroin and prescription-drug addiction is a public-health crisis in desperate need of a comprehensive cure and solution.

My colleagues in the Senate want to ensure that our response as a state is more effective than what we have had in the past, and that means, being here today, talking to local stakeholders, and hearing, really, from the people who are involved in the issue, what the needs are and what the concerns are out there; what we need, and what type of really good legislation would be helpful.

I was pleased to be asked to join the bipartisan New York State Senate Task Force on Heroin and Opioid Addiction which we had formed this past March.

Many forums and hearings have already been held across the state, with several more to follow in the next couple of weeks.

But leading our effort is my colleague and friend Senator Phil Boyle.

I remind everyone, turn off our cell phones, and I will do mine as soon as I'm finished, because I hope it doesn't ring.

[Laughter.]

SENATOR LITTLE: But, we need to do that.

I served with Senator Boyle in the Assembly, as well as welcomed him into the Senate recently.

And he is Chairman of the Senate Committee on Alcoholism and Drug Abuse, and he is also the Chair of this Task Force.

This is an issue that he is very passionate about, and I'm grateful to have him come to the North Country to be with us here in Clinton County today.

And I would ask all of you to join me in welcoming him today, and having him here with this Task Force.

So, Senator Phil Boyle.

Thank you.

[Applause.]

SENATOR LITTLE: I should have also said he's from Long Island. One of our Long Island guys.

SENATOR BOYLE: Thank you so much, Betty, and

thank you for your leadership in the Senate, as joining the Task Force, to combat this heroin epidemic.

And thank you for our panelists today, and for everyone.

What we're looking for is for input from everyone, whatever the reason.

And as Betty has said, she and I served together in the Assembly, and it's my first time in her district, but I didn't realize how popular she was, until I was getting in the elevator this morning, and I said to a woman: Well, how you doing?

She goes: Great. I just got a hug from my Senator.

I was, like, Wow!

[Laughter.]

SENATOR LITTLE: My friend Donna. That's great.

SENATOR BOYLE: But this is a statewide epidemic.

And, we've been to Buffalo, Long Island where I'm from, the North Country now, to get input.

We're really focusing on three areas: Prevention, treatment, and law enforcement.

And, so, as we hear from the panelists today, what we've been asking for, and we've had a very good exchange of ideas, and gotten a number of good, potential pieces of legislation which we'll be passing in these areas, so whatever area you're in -- prevention, treatment, or law enforcement, or others; a family member, if you've lost someone -- if you said, "If I could change the law, one law or two laws, what would I do?" that's what we're looking for here today.

The mission of the Heroin Task Force is to come up with a report; we're going to report by June 1st. And then, in the final weeks of the session, we're going to pass legislation to combat this heroin/opioid problem that's caused so many tragedies throughout the state.

And, I'm looking forward to the testimony today.

Thank you, Senator.

SENATOR LITTLE: Thank you, Phil.

We're going to change the program just a bit.

Our District Attorney from Franklin County, Derek Champagne, does have a court appearance coming up shortly, so, we're going to move him up to the front, and our Clinton County District Attorney has

agreed to go along with that, too.

So, appreciate that.

Derek, thank you very much for being here.

DA DEREK CHAMPAGNE: Thank you, Senator.

Good morning, and thank you for the opportunity to speak today.

Franklin County, my county, just to the west of here, has a population of 51,000 people. We have, over 17 percent of our population lives below the poverty level. We have no interstates, we have no throughways. And 12 months ago, we had little, if any, heroin in our county.

Today, we can buy heroin in any community, at any time, in Franklin County.

I can't buy a 2-by-4 piece of lumber in my county anytime after noon on Sunday, but I can buy heroin seven days a week, anytime of the day or night, in one of the most rural counties in the great state of New York.

Current prices in our county are between 20 and 30 dollars per dose, compared to 4 to 5 dollars in some of our cities. Even so, it's cheap, even at $20 in our communities.

As you're well aware of, it's highly addictive, and has, unfortunately, become glamorized

by popular culture and the users themselves.

On a recent investigation, we discovered a -- Facebook photos of one of our target's friends with needles in their arms, actually on Facebook, like it was something cool or something to be impressed about.

My investigator recently bought heroin from a girl who showed him, with pride, the fact that she had hundreds of needle marks in her arms like it was some impressive feat.

I've police officers with 15 years on the job who have never seen heroin until the past 12 months.

I've probation officers who have asked me to buy them gloves so they don't get punctured or stabbed from needles, because their searches -- in their searches, as part of their daily jobs, they're now finding needles on a regular basis as part of their daily duties.

It's as if we turned off the faucet in my particular county for prescription drugs, due to some of the very good legislation that we passed, as well as working with the drug companies, and, essentially, turned on five faucets worth of heroin.

Drug dealers in our county were organized 24 months ago. We would target houses, we would

target individuals, we would target known dealers.

Today, it's as if every user in my county has become a heroin dealer to support their habit.

I mentioned our poverty level up front because the obvious question is: Where do people in a poor county, in a rural county, get money to buy their heroin?

What we've seen is there's, essentially, two ways for them to do it:

The first is, to become a dealer themselves;

Or the second is, to engage in criminal conduct to obtain money or funds to support their habit.

In the packet that I've provided to you, I've provided three statements of defendants.

The first exhibit is Exhibit A, the defendant's statement, in summary -- and I provided it for you -- is the same from a defendant talking about, how he was sitting around with four individuals who were all going through withdrawal one night, and, they had no money to purchase drugs that night.

So the defendant thought that night about, What can I do, and what should I do?

And, he thought about breaking into cars for

money, and he realized that he couldn't get enough money from breaking into cars.

So he walks up the road and he breaks into his neighbor's garage. And then, after breaking into the garage, he walks up to the next house and breaks into his neighbor's house.

He used all of the money from the items sold and the cash he found for drugs, as did his co-defendant, as you can read in the statement.

And in the last line of his statement, he says: I only took the items to pay for drugs, and I'm sorry for my action.

The second exhibit I provided to you is another defendant's statement -- and these are all very recent cases -- where the defendant was with two of his friends, having a discussion about needing money.

One of the friends goes to the neighbor's house and steals 100 silver dollars, prescription pills, and a .45-caliber pistol.

You can then read through the statement, how:

They go and sell the gun that same night for cocaine and heroin.

A week later, they drive to Albany, after selling the silver dollars, to buy heroin and

cocaine.

A few days later, they go and sell the coins from another home they burglarized, and they again buy heroin.

A few days after that...this is, through the statement, you can, essentially, read it being repeated again and again.

And a few weeks later, another burglary, with another handgun stolen in county to sell, so they can buy drugs.

In the last paragraph of the defendant's statement in Exhibit B, I'm paraphrasing, he states:

All three of us have been involved in selling heroin for a while. I usually would sell heroin to get money to buy enough heroin to support my habit. We would make at least two trips to Syracuse a week to buy heroin. Because of my addiction to drugs, I participated in the above crimes. I hope I can attend a court-ordered inpatient program so I can get off drugs for good.

The third statement I provided, Exhibit C, the defendant talks about buying $200 worth of heroin.

He tells you how he shoots up five bags of heroin, then he shoots up five more bags; and then,

in this condition, he decides to walk to one of our gas stations in the village of Malone and buy cigarettes.

When he gets inside, he realizes he doesn't have enough money, but he realizes there's a lot of money in the drawer that the clerk just opened.

So he pulls out a knife and he robs a clerk.

He then takes that money, he runs to friend's house, immediately orders up $200 of heroin, which is immediately delivered to his friend's house.

He shoots up five bags of heroin, goes looking for one of his other friends, to enjoy the evening, and ends up passing out in a snowbank. And the Malone Village police arrest him in the snow bank.

The problem, and the reason why I illustrate these three examples, is that they all involve serious crime; crimes against real people in the community.

It's not someone abusing a script or faking symptoms for a script. It is violent crime to purchase a substance which has no legitimate source or ability to be purchased.

And we're seeing these same facts played out in our county again and again.

Heroin is also easy to hide.

And I brought with me, which you've seen, which I need back 'cause there's heroin in here.

[Laughter.]

DA DEREK CHAMPAGNE: But one of the problems we're having with law enforcement, obviously, is when we had cases regarding 50 pounds of marijuana, or 100 pounds of marijuana, it wasn't so easy to transport, and it wasn't so easy to hide.

The reason I illustrate this is, the size of heroin, it's -- essentially, it's a hinderance to law enforcement.

And, unfortunately, it illustrates that more enforcement likely isn't the answer -- and that's coming from a prosecutor -- as heroin can be quickly hidden and secreted from law enforcement.

Another issue that is obviously concerning, is the tolerance which is built up to heroin by users means that either more crimes must be committed or more products must be sold by the user.

One defendant we recently arrested in our county was using $500 of heroin a day. He had to be closely watched when he was finally caught and incarcerated because of concerns he would die coming off that much heroin, as far as his addiction.

His habit obviously led to his arrest, because he was willing to sell to anyone and everyone in our county.

Obviously, most of what I just spoke about you probably know, so, what, if any, recommendations do I've?

My first recommendation that I outlined is better coordination, which would likely involve funding for advocacy groups.

One of the issues that we've seen from law enforcement is, we need some referral system for law enforcement when they respond to a scene and meet someone who's high on drugs.

Presently, if that person is not committing a crime, we could, essentially, have law enforcement respond to a scene with four or five or six people who are all high on drugs, and we're in a situation of telling law enforcement: You have to leave, and tell them "Have a nice day," if there's no crime being committed in your presence.

I'd ask the Task Force to consider: Is there some way we can get those names or those people -- people's names to advocates? Or, to work with some sort of new system regarding advocacy for law enforcement with those types of situations?

Some sort of intervention, or at least, at a minimum, give them some card, or some sort of information, regarding what we're obviously observing on a day-to-day basis in our communities.

What can or should law enforcement do of calls from people asking for help?

My investigator, on Wednesday night, received a call regarding a 17-year-old girl who is now selling heroin to support her addiction.

What system can we put in place for law enforcement when they receive these types of calls?

My second area for you to consider would be source funds for law enforcement.

And that would be, obviously, as I'm sure you've heard, many of the narcotics funds have dried-up for the law enforcement, for the police agencies, and there's really not the funds that we have anymore to use for investigations.

But what I'm talking about, as far as thinking outside the box in a new area, is source funds to pay citizens who want to help law enforcement, who aren't addicts, and who aren't working off criminal charges.

Typically, confidential informants are users

who have an addiction.

One of the problems that we have, is these people, quite often, are not willing to give up their main supplier. They may give us everybody else, and they may give us all of their friends' suppliers, but if you think they're going to truly give you their supplier, it's typically not the case.

Lately, however, though, we have had a number of concerned citizens willing to work for money.

I believe a question for your Task Force to answer is: Can funds be provided to police for this purpose?

These people are often good citizens and not criminals. They may simply be unemployed or on hard times, but funds for this purpose to law enforcement across the state could be a valuable tool for you to consider, if we can have those people assist law enforcement through either controlled buys or through reliable information.

The third area I'd ask you to look at is tracking of overdosed deaths, and distribution of that data to the public, as well as law enforcement.

As an example: It's my understanding that 22 people died in the New York-New Jersey area from

heroin laced with fentanyl during the three-week period that the media was covering the death of Actor Philip Seymour.

These deaths were, essentially, a footnote in a couple articles, and from law enforcement which I spoke to.

That number of 22 deaths in a 3-week period is truly a staggering number, and it's important for the public and for law enforcement to know this type of information.

Every county in New York State should be tracking heroin and drug overdoses.

I don't know how many currently are, but I can tell you, until last week, my county was not. We had nothing in place to track drug overdoses.

The death certificate might simply say, "Cardiac failure of a 22-year-old adult male."

The State needs to track why people are dying in each county, and each county department of health would likely be a good place to start.

This information needs to be available to multiple agencies, as well as the public, and could be part of a media campaign by the State to deglamorize heroin.

The fourth area I'd ask to you consider is

expansion of intelligence centers.

Expansion of funding to DCJS or the New York State Police for intelligence centers in each geographical area I believe is critical.

Analysts need to be aware the problem is not 200 or 250 miles away.

How are these addicts -- how do these addicts know how go to Syracuse? How do they know to go to Albany? How do they know how to go to Massachusetts?

How can we, as law enforcement, connect the dots and understand the trade and flow of product?

Funding to establish additional crime-analysis centers is critical to understanding trends, understanding patterns, quicker responses, and a coordinated approach to this epidemic problem.

The fifth area would be treatment funding.

Obviously, you're going to hear from treatment experts, and you have, so this is just our view from law enforcement and defense attorneys dealing with the situation.

But from our perspective, we believe the 28-day programs are simply not working. We believe they're too short.

And we believe, our observation, is that,

quite often, it's insurance issues or cost issues which are not allowing us to put these people in longer treatment.

If our view from law enforcement is correct, I would ask you to analyze and address if there's some way for us to deal with that issue statewide.

In the final area I'd ask for, is money for testing, for probation departments.

In my county, some of the officers are reluctant to test because, quite frankly, the defendants are required, typically, pursuant to their terms and condition of probation, to pay for the test.

Many of these individuals are unemployed, they're going through rough times. They're trying to get Probations working with them to get them reestablished. And many of them have children.

So, we're in an awkward situation, where I see there's a hesitation to go ahead and tell somebody, Yes, you have to pay 30 or 40 dollars for a test; but, yet, we want to catch these people before they relapse.

So, I do believe some sort of funding to probation departments for testing would be important.

Hopefully, my testimony, Senators, somewhat surprises you, because I'm a career prosecutor who's not asking for more police, I'm not asking for more prosecutors, and I'm not asking more people to be arrested.

Rather, I'm asking for coordination, I'm asking for assistance, and I'm asking for new approaches.

The Rockefeller drug laws were imposed during the last heroin epidemic that devastated urban areas nearly 40 years ago.

Our current situation may very well devastate rural and urban areas if we do not quickly find solutions.

Please find a coordinated, aggressive approach before we are forced to lock up these addicts for the violent crimes which they are starting to commit.

If they are not free from addiction, I believe they will be locked up in another way.

Thank you very much for your time and attention today.

SENATOR BOYLE: Thank you, Derek. That was tremendous testimony. Really, just very concise.

And, I feel like a judge with all the --

[Laughter.]

SENATOR BOYLE: I would say -- I ask you one question, though:

In the cases that you prosecuted -- and I understand what you're saying about the weight of heroin, which adds to the problem of finding out the correct laws on how we're going to increase the criminal penalties.

I've legislation that would make possession of 50 bags or more a felony. It's now a misdemeanor.

And, I'm not foolish enough to think that's going to be the final law, because we need to get it passed through the Assembly.

But, how would you do it, in terms of changing the actual language to the law, to say: We want to increase the penalties, but not go by weight?

Is there anything you can think of, as a prosecutor?

It's tough, I know.

DA DEREK CHAMPAGNE: I'd have to really sit down and think about it.

SENATOR BOYLE: Oh, yeah, you can think about it. You don't have to answer it now.

But, I mean, if you could talk to your fellow prosecutors, of a way.

And I understand, you're absolutely right, we're not going to arrest our way out of this epidemic.

But, there are some situations, and we had one in our county: There was a guy caught with over 600 bags of heroin, and they could only charge him with a misdemeanor, based on whatever circumstances it was, you know.

We can't have things like that.

And I understand Philip Seymour Hoffman had 77 bags in his apartment. I know Philip Seymour Hoffman was not dealing drugs.

So how we make that line, is the question.

And any input you can think of, we'll be happy to get the information.

DA DEREK CHAMPAGNE: Okay.

SENATOR BOYLE: Thank you, Derek.

SENATOR LITTLE: I've one question, Derek.

When you talked about the 22-year-old that just gets listed as, you know, heart failure, or something, there is no drug testing when someone dies like that, and, suddenly?

DA DEREK CHAMPAGNE: We -- law enforcement

and -- actually, we just -- I just -- we just put in place in Franklin County, last week, that we have asked the department of health to go and, essentially, look behind each death certificate.

So our department of health is making the added effort to, basically, call and see what goes on.

But, no, we've had -- well, there's typically a toxicology, but, unless there's an active criminal investigation, or there's circumstances surrounding the death that would warrant a full-scale criminal investigation, we honestly, Senator, never hear about it.

I mean, quite often, because we're a small county, we hear: Oh, there was a drug overdose in St. Lawrence County.

I've a situation right now that, 10:00 last night I received a call, where we have a young man who was deceased.

There's is -- that's the belief.

But, no, if we don't look into it, or the department of health doesn't look into it, we had nothing in place in our county.

And my concern is, what are the other 61 counties doing as well?

SENATOR LITTLE: Right.

SENATOR BOYLE: One other quick question.

I was reading some of the media reports on the heroin situation up here in the North Country, and I saw several arrests on Suboxone.

Are you finding that, too, that it's being used -- I mean, I know some people deal it as part of their heroin addiction.

Are you finding an increase in that, as well?

DA DEREK CHAMPAGNE: Suboxone, we've seen a lot more selling of Suboxone. And we have had a couple of cases where it's being sold, to go ahead and, you know, support their other addictions.

Yes, definitely.

SENATOR BOYLE: Thank you very much.

SENATOR LITTLE: Thanks very much. We really appreciate it.

So our next speaker is going to be our own Clinton County District Attorney, Andrew Wylie. And he has with him, Shawn McKeen, and Detective Bell.

And I would ask that we have no photographs of the detective or no video of the detective while he is here.

I would ask you to please respect that.

DA ANDREW WYLIE: (Speaking off video.)

Senators, I want to thank you for the opportunity to be here today.

It's nice to, uh -- I guess we haven't formally met Senator Boyle, but we can do that afterwards.

With me today, I do have Detective Matthew Bell, who's with the Adirondack Drug Task Force, the Plattsburgh City Police Department; as well as, Shawn McKeen.

And I think what we'd like to do is, to present more of a storyline of a heroin addict; how it's impacted -- or, how it impacts his life, and give you kind of a brief history of what we've had here in Clinton County.

Before I move on to Shawn's story, I'd like to just touch base with what we've been seeing here in Clinton County over the last four or five years.

Heroin, in Clinton County, as in most of the North Country communities, has increased over the past four to five years, very drastically so here in Clinton County, as far as our prosecutions.

There was a point in time, and Shawn may be able to discuss this as well, that heroin -- heroin is sold in -- referenced in "bindles" and "bundles."

A "bindle," we can use that as, let's say,

one bag. And a "bundle" is 10 bags.

So they're purchasing -- back in, let's say, 2009, 2010, they're purchasing a bag of heroin for approximately $50;

Whereas, today, here in Clinton County, at least, you can pretty much buy a bag of heroin for about 25, to 30 dollars;

Where, it's sold down in New York City or in the Syracuse area, or further south in the larger communities, probably at 10 or 15 dollars a bag.

So they're, almost, a true heroin trafficker is, basically, doubling their money.

And as DA Champagne mentioned, we find a lot of these situations, where we have the addicts that are making runs to Albany, they're making runs to Syracuse, they're making runs to the city, New York, or New Jersey, or even Boston, to buy the heroin, and then coming back, selling what they can, to continue their habit, and also feeding their habit with the heroin that they buy.

So those are the situations that we're looking at.

And I'll just show you, in 2010 -- we have this chart, referencing:

Going back, from 2010, these are prosecutions

that have occurred in Clinton County over the last four years.

And, we can see that in -- the blue graph represents heroin buys, and the reddish graph represents morphine. Both opiates.

And we're just focusing on these for today's purposes, obviously.

But, we've had a drastic increase in that, where you can see we've had -- in 2010, we had about two prosecutions. And in 2013, we have over 40 prosecutions.

And those were a result of a drug roundup that we had in December; the largest drug bust that has ever occurred in the North Country.

And of the 60 individuals that were arrested in December, 40 of them were relative to heroin, and then the additional, morphine, as well.

We also have the synthetic opiates.

There's been a -- there hasn't been as large of an increase in the prosecutions, with the exception of 2013, with the number of arrests that we did do in that December drug roundup.

But you can see, from the different synthetic opiates that are here, what we find that -- is that these individuals, such as Shawn, start off with,

and I think DA Champagne mentioned it, you'll have an individual who is injured. They go to the hospital, or they go to their doctor, and they are prescribed some type of a controlled substance to regulate their pain. They will then proceed from that medication to becoming addicted to it.

And at some point in time, that addiction leads to, they need something more to -- it's not really, maybe, for the pain anymore; it's the addiction.

And to satisfy that addiction, it's bumped up to heroin and morphine.

And, that's where we're seeing a lot of these overdoses that we've had.

Just within the last few weeks, we had a young male who overdosed on heroin.

He was a star athlete at our local high school. There were some injuries that he received. Started with the pain medication, and then it just grew to a heroin addiction, and overdosed and died.

So, we're really looking at, you know, trying to see what we can do, on the law enforcement end, to, obviously, prosecute the people that are bringing it.

My main concern:

Not that an addict who is making trips down south and bringing the heroin back here and selling it in our community. That is, obviously, a large concern of ours, and we will continue to prosecute those individuals, as we can, with the appropriate sentencing, involving mostly treatment.

But it's the drug traffickers that are coming up here, just for the sole purpose of profit, selling the heroin; and what it does to us.

And, so, in addition to each and every one of the points that DA Champagne mentioned, we certainly are looking for, as Senator Boyle mentioned: What can we do to -- probably, these are the individuals that you're referencing, of how can we impose greater sanctions or penalties on these individuals?

And I think that's the one thing that we have to look at, legislatively: To raise the penalties, to show that, you know, this is not going to be tolerated in New York State; whether it's here in Clinton County, or whether it's in, you know, Suffolk County, or Long Island, or out in Rochester, or Buffalo area.

The last chart that I've is the opiate blockers, and these are the drugs that we are seeing being sold, as well: Methadone. And, Suboxone,

which you were talking about.

So, I know we've had, you know, issues here with Clinton County, whether we were going to have a methadone clinic placed here in the county. And those are all issues that are still, you know, coming up.

One of the things that, uhm -- treatment is the biggest thing, I think, that we need, obviously, for our addicts that are suffering from heroin addiction, or some of the other synthetic drugs that we have.

And, one of the things that we were discussing, we've been discussing, is that we need, probably, more localized treatment programs, and lengthier treatment programs in our communities.

You know, we have a situation, where, we have very limited facilities here locally. Basically, we have, what, Canton-Potsdam facility is one inpatient program, where you have an individual -- I'll just use Shawn as an example:

He'll go to Canton-Potsdam. And he will, at Canton-Potsdam, because there's no other facilities there, he's going to meet up with somebody from Rochester, or he may meet up with somebody from Long Island, or he may meet up with somebody from

Syracuse. And through those connections that they're making, they're making connections throughout the state.

And while there, they're talking about their heroin addictions. They're talking about where they get their heroin from.

And, so, they're now they're receiving, you know, new roads to travel, to seek out and find heroin.

So, if we can have more facilities available, which not only would prevent, you know, some of those situations from occurring, it will also provide open beds for individuals.

If I've an arrest today, and we make a determination that this is an individual that needs treatment, well, there may not be a bed available for that individual for -- you know, for days or weeks.

And, if there comes a point in time where a bed becomes available, and they don't have transportation to that facility, that becomes a problem, too.

And we have -- I guess we don't have the sheriff on our list, but, you know, Dave Favreau is a prime example of being able to talk about the cost

that it is, you know, to house individuals at the county jail, regarding, uhm -- if we use, just in this situation, the heroin addicts.

I mean, we've talked about it before, with meth.

But, dealing with what we have here today, if we can have more facilities available for treatment of these individuals, we're going to lessen the cost of the counties at the jail, we're going to lessen the costs of medical treatment that's going to be required for the county to pay, through individuals that are being detained at jail, when they should really be in treatment.

You know, I don't have any issue with him housing those drug traffickers that are coming up from -- you know, from the city, or from other parts of the state, that are just selling for their sole purpose of profit, but that's where we're focused on.

So those are the issues that I think are important to bring out.

If you have any questions regarding those, I'll be happy to answer those.

Otherwise, I would just turn this over right now to Detective Bell. He can tell about some of

the law-enforcement issues that we have.

And then I'd like to you have a few minutes with Shawn, which I think you will be very impressed with his story.

SENATOR LITTLE: Thank you.

DET. MATTHEW BELL: (Speaking off video.)

Good morning.

My name is Matthew Bell. I'm a detective with the Plattsburgh Police Department. I've about 17 years, a little more, working with the police department, 10 of which now have been, primarily, just narcotics investigations.

I started narcotics in about 2004.

And from about, 2004, to 2011, heroin, pretty much, was $50, as Mr. Wylie said, a bag.

The terms are: A bag; or, a "bindle" is one bag of heroin, a "bundle" is ten.

It was unheard of to buy a bundle, or, 10 bags, of heroin, from 2004 to 2011. It had never been done before. It was always $50 a bag.

And, typically, from 2004 to 2011, as far as Plattsburgh goes, you'd have a group of heroin addicts, they'd get together, they would pool their money, and they would either go to Utica, Albany, Schenectady, or, a huge source was called the

"Red Hook Projects" in New York City.

And the lengths they would go to get the heroin down in Red Hook Projects:

We went down there for an investigation as part of the DEA, and the officers down there told us not to get out of our cars, because they would throw TVs off the roof at us if they knew we were law enforcement.

So, typically, from 2004 to 2011, it was just a group of people, they pooled their money, they'd go down and get it. And we'd have, like, outbreaks of heroin for, maybe, four, five, or six months, but then we'd clamp down on it.

And -- as with, we had a rash of meth before, now it's backed down a little bit. But, at this juncture, the heroin is, it's unprecedented.

We could go out every day, buy, buy, buy.

As Mr. Champagne alluded to, our resources are limited.

Right now, typically, we can buy a bag of heroin, from between 20 to 30, maybe 35 if we're buying it individually.

Our stats say, basically, to get a bundle, or, 10 bags, of heroin in New York City, right now it's $70.

So, if these individuals that are coming up here to traffic per se, that's their main reason for being up here.

If they spend $70, and they come up here and they sell it as a bundle for 220, they're making $150 profit. That's just on 10 bags; so, they're doubling their money.

If they -- their $70 investment, if they come up here and sell it as single bags, they're making about $270.

So, it's just crazy, the amount of profit these guys have; and that's what they're doing it for at this point.

We're not seeing the local people travel down as much, because they don't need to. They come up -- it's everywhere.

Again, I had never purchased, until last year, 10 bags of heroin at once.

In 2011, just to bring things home to us, I had a mother and father contact me, and said: We found something in the storage room of our house where our 18-year-old child stores his stuff.

They brought me 599 bags of heroin.

This kid had just graduated from a local high school here in Plattsburgh.

In 2012, for the very first time, we purchased heroin from a Plattsburgh State University student.

My previous eight years, nine years, we would buy marijuana, sometimes a little cocaine, some hallucinogenic mushrooms. Never heroin.

And, that 2012 buy of heroin is just the beginning. They're doing it now, it's so lucrative.

And, as Mr. Champagne alluded to, I think the pharmaceutical companies have done a really good job in making the oxycodones and OPANAs and other drugs, the morphines, that the addicts would crush and shoot, difficult to do.

And I think Shawn will allude to that.

Right now, our intel is telling us, Albany, Schenectady, and New York City are our main sources.

Our investigations are very difficult. We're here in Plattsburgh; I can't go out and buy heroin.

Pretty much, the only people that can go out and buy heroin are people that use heroin.

Again, Mr. Champagne alluded to the fact:

I've got -- or, the task force, as a whole, we might have five or six different people that, mainly, they're just buying the heroin for us, as confidential informants, because they've been

arrested. And between their attorneys and the District Attorney's Office, they're trying to work charges off.

But the big thing is, a heroin addict is not going to go out and buy heroin for you during a controlled buy, unless he's got somewhere else, or she's got somewhere else, to get more heroin from.

Prior to working at the City Police Department, I worked at the Sheriff's Office for five years, and I've seen people that are -- the term is "dopesick." And, I've seen it.

I think Shawn will get into it.

It's horrible. These people will do anything they can to not be dopesick.

Probably, I don't know, it was about five years ago, we had some individuals that were so sick, in broad daylight, they went to Kinney Drugs here in Plattsburgh, with knives, jumped over the counter, into the pharmacy, and demanded narcotics.

If that's the only good thing that heroin's done here, the pharmacies aren't really a target anymore, because the people don't need to break into the pharmacies because heroin is so available to them.

So our investigations are very difficult. We

have to use informants that are addicts.

And, I'd be fooling myself, or anyone else in this the room, if I said, I didn't have any indication that, after we got done this control buy, and we got the heroin from the person, that they probably weren't going to go back to that same individual later on in the day and buy heroin for themselves; because, it's a sickness that I, obviously, can't describe.

As far as getting into -- obviously, I'm law enforcement. Obviously, people do need help.

We had an 18-year-old, the other day. We were doing a surveillance on a house that we knew they were dealing heroin from.

We followed her. We lost her for a few minutes. And we pulled up to the car, 18 years old, and as I got to the car, she had a needle loaded with heroin and was right about to inject herself with it. It was right in front of her apartment complex. Her mother and her 12-year-old sister were witness to this whole thing.

As far as penalties go, you alluded to 50 bags is a felony.

I guess the North Country's a little bit different than Albany, New York City.

50 bags of heroin here, we're charging a B felony: criminal possession with intent to sell.

Again, as I've said, the majority of this heroin is not coming from Keysville, New York, or Westport, New York.

I think it would be very good to try to enact some type of legislation that, uhm -- put a mileage on it.

We have all kinds of resources, that I'm not going to get into, that we know exactly, sometimes, when these people are leaving Albany, when they're leaving Schenectady, when they're leaving New York City.

Why not put a mileage on it?

If you travel more than 60 miles, either with a narcotic drug with the intent to sell it, and we can articulate and prove that in court, why not -- right now, the biggest penalty is a Class B felony for a sale, if it's -- weight-wise, if you don't get over a half ounce or more.

Why not enact some type of legislation: If you are coming up here for the sole purpose of selling this, either bump that up, regardless of the weight, to an A-II felony; or, possibly doubling the sentencing guidelines?

And, if anything, if we can charge this, and these people get into court, minimum they're going to have to do is take the stand and say: Okay, I transported this up here, but I didn't transport it 60 miles away.

I mean, they're going to have to -- you have a defendant, and if we can articulate that, I think it would be a -- very good for us in the North Country.

I said, we have ways to tell when they're coming. We're not going to, obviously, get into those ways.

But, either doubling sentencing guidelines, or upping it, if they're bringing it up here, regardless of the weight.

SENATOR LITTLE: Thank you.

Wow. That is...

DET. MATTHEW BELL: I'll introduce Shawn, quickly.

Shawn and I met in 2004. And, you guys can all probably figure out how Shawn and I met. It wasn't -- we weren't going out to have lunch together.

I think, probably, in 2006, I actually took Shawn -- myself, and another detective, that's since

retired, actually drove him to Canton-Potsdam for rehab.

You know, we realize it's not just throwing the cuffs on people, but people do need help.

But, Shawn and I met in 2004. You know, we stayed in contact then. And, you know, I've tried to help, you know, friends of his out.

And I think, when you guys listen to Shawn's story, you guys are -- your eyes are going to, you know, be widened greatly.

So, this is Shawn McKeen.

SHAWN McKEEN: Hi.

First, I want to thank Mr. Wylie and Mr. Bell for asking me to come speak here.

It's an honor and a privilege to be able to share my experience and my story.

You know, this really hits home for me, not only because of my experience with opiates or heroin, but because I've seen many of my friends get lengthy prison sentences, and I've seen loved ones of mine die.

I grew up in Plattsburgh, middle-class. My mom was an accountant, and my dad worked for the City. I had a really good childhood. There was no abuse, no neglect. Not a broken home.

I had a really good life.

When I was in my early 20s, I was prescribed a pain killer, hydrocodone, for a pinched nerve in my neck.

And I can't explain what happened when I began taking it. I don't know why some people can take it and be okay, and why some can't. I don't know, chemical reaction? I really don't know.

I just know that, from the moment I first took hydrocodone, that euphoric feeling that it gave me, I clung to it. What it gave me was so amazing, the euphoria, the confidence, I felt, or at least I thought at the time, I was a better worker, a better son, a better father, a better employee, a better student, while on this medication.

And it went like that for a long time. I didn't really -- when I would see friends stealing from their families or from each other, I would kind of, you know: Who does that? You know, who steals from your family? You have serious problems, you know?

And I came to realize why they were stealing from their families, because it's only a matter of time before the drugs turn on you. The first time you have to go without them; when you run out of

your prescription, or, you're cut off by your doctor because he knows you're abusing them, or, when the dose that you started off on is no longer working.

It happened to me really quickly, and I progressed to, at the time, there was a big craze with Oxycontins. And I became addicted to Oxycontins, and I stuck with Oxycontins for quite a while.

But I can't stress that, see, withdrawal is, there's two pieces to withdrawal:

There's the physical aspect of it, which is horrible: diarrhea, vomiting, muscle cramps, lethargy, no motivation, hot flashes, cold flashes.

Then there's the mental component: the mental obsession, the mental cravings, that don't go away.

Even when the physical is gone, the mental stays. The brain never forgets that euphoric feeling.

After a while, using isn't fun anymore. It's more necessary to survive.

I got clean in 2008.

And, when I first -- I'm going to jump back.

When I first was into Oxycontins and hydrocodones, in Plattsburgh, there was never really heroin around.

If you could find it, it was $50 a bag, and you usually didn't want to do it because you didn't know what you were getting. Sometimes it could be really good; other times it could be not good.

So, I got clean in 2008; and, I graduated from college, and I got a job as a counselor. And there were some circumstances that happened in my life at that time, in 2010, where I relapsed.

And when I relapsed, I noticed that these pharmaceutical companies had revamped their formulas. You could no longer abuse Oxycontin or OPANAs. You couldn't crush them up; you couldn't shoot them, you couldn't snort them.

And that's when I noticed that it was no longer pharmaceuticals that were in this town. It was heroin, and no longer was it $50 a bag. It was 20 to 30. And, you could buy as much of it as you wanted. There were -- there are so many dealers, that they're in competition with each other now, so they have to offer cheaper prices and have better quality.

You know, the sickest part of this is, when I would -- you know, in active addiction, when I would hear stories of heroin killing people, or hurting them, you know, overdosing, that's the

heroin that I would want, because I know it's good.

That's sickness, that's insanity. And I would do anything to get it.

You know, the best way I can compare it is like a Dr. Jekyll and Mr. Hyde.

When I'm clean and sober, I'm a good member of my community. I help my family out. I'm a good employee, a good student.

When I'm actively using opiates or heroin, I'm a monster. I will steal, I will lie, I will snitch, I will cheat, I will break into my grand -- anything I can do, just because the physical and mental component to withdrawal is so horrible.

Sorry, I'm really nervous.

SENATOR LITTLE: That all right. Take your time.

SHAWN McKEEN: So, with talking about the withdrawal: The first day getting through it isn't usually as bad as the next day. But when day two or day three or day four come, that's when I'm ready to rob a pharmacy, rob a house, rob my friends. Really, rob anybody.

Thank God I've never had to resort to violence to ever acquire a drug, but I'm sure that that's not that far away.

You know, being a heterosexual male, and thinking, could I do a homosexual act to get this drug?

It's sick. A sickness.

Nobody enjoys it after a while. Addicts don't enjoy it.

We do at first; it's fun at first, you know.

But after a while, it's not fun. The things you have to do, the desperation that comes with it; the despair in your mother's and father's eyes, I wouldn't wish it on anybody.

And how bad heroin is up here, it's on every street corner. It's not just people from, you know, poverty that are doing it. It's not low-economic or socioeconomic backgrounds that struggling with it.

It's middle-class America.

It's kids that I went to school with, that graduated from Rutgers, from Clemson, that are into this stuff. It's not just people that are poor. It's affecting this whole county and everybody in it, one way or the other.

I've been clean again for almost a year. May 27th, I'll have a year clean again.

And, I'm getting ready to graduate from Plattsburgh State University.

And, so, my story is kind of a happy one right now, but everybody's story isn't happy.

There was a picture...

DET. MATTHEW BELL: Do you want the picture?

SHAWN McKEEN: Yeah.

This is Anna.

Anna was a girlfriend of mine for three years. She was from Venezuela. She was so beautiful, so smart; the type of girl to walk in a room and everybody would looked because of how bubbly she was. A true gem, in every sense of the word.

Anna was also -- struggled with opioid addiction.

And we met in a Narcotics Anonymous meeting. And, we dated, and fell in love.

And Anna found out, in 2010, that she had a rare kidney disease, hereditary. Her father had had it, and it killed her father.

And when she found out she had this kidney disease, we both were devastated, because of how young she was, and because it was a death sentence. There was nothing they could do besides slow it down.

We both relapsed.

And, how we had met these connects to get our heroin, was when we were both in rehab, going from rehab -- in Plattsburgh, there isn't one around here.

So, if you don't have private health insurance, you're not going to go to a very prestigious place. You're going to end up at a pretty big facility. There are some downstate.

And me being from the North Country, going down there, I was put in with a bunch of folks that were from Syracuse, Albany, New York City.

Like Mr. Bell and Mr. Wylie touched on, this is where we meet our connections. There is no rehab facility in this area.

So when we do get help, and we're fortunate enough to get help, we get to these rehabs, and we talk about how much we're paying for heroin in the North Country. And other people hear this, and they're amazed, they're astonished, that somebody would pay $30, 40, upwards of 50 dollars, a bag.

And that's how that deadly cycle begins.

In 2012, I was arrested for a DWAI, and I was given the opportunity to go out to Rochester and live in a halfway house, and get clean again.

And I made the decision to do that.

When I was gone to Rochester, Anna's health deteriorated, and she ended up passing away.

And, I didn't want to share a lot about Anna because it's really emotional for me, but I just want to end with:

She would choose, instead of -- she had to go to dialysis to survive, to clean her blood. And the withdrawal was so bad, even knowing that if she skipped dialysis, her potassium levels could rise and it could kill her, she would make the decision to skip dialysis to go get high, knowing she could die.

But the withdrawal, on top of that physical and mental obsession, was so strong, that it eventually led her to skipping dialysis, and having a heart attack and passing away.

And while my life is good right now, there's no guarantee that Mr. Wylie won't be prosecuting me next year for a crime.

Because it never goes away. I still crave it, I still think about it, I still miss it.

Even knowing the devastation it will cause in my life, even knowing that to use is to die, and not just physically; mentally, spiritually, emotionally; I still think about it, I still fantasize about it,

I still miss it.

And the worst part is, that it's everywhere up here, and it's so easy to get.

No matter how much, or how good of a job these guys do with locking people up, you see the same people that get out of prison and go right back to it.

You see people that are coming up, it almost seems by the bus load, from places like Albany, and the city, you know, that are preying on the weak.

I think it would really help this area if we had an inpatient rehab facility.

I know that they've done, you know, work with methadone and Suboxone, and I think that has its place, as well, but that's not the solution. That's putting Band-Aid on a wound that needs stitches.

We need an inpatient program up here; or at least a detox unit.

Thanks for letting me share.

SENATOR LITTLE: Shawn, I just want to say, it took a lot of courage, and I really admire you for coming here and telling your story, and it definitely is an eye-opener.

But, you will be in my prayers, that you can continue, because you certainly -- I just admire you

for coming here.

Thank you so much for being here and sharing your story.

SENATOR BOYLE: Thank you, gentlemen.

Thank you Shawn, very much.

I appreciate the fact that you say there needs to be treatment centers, and that's one of the things we're working on now.

We did include some funding in the last budget for an expansion of treatment facilities, but, for an area in North Country to have something like that, to help Shawn, and others, is vitally important.

I was interested, you talk about the price here.

I'm from Suffolk County, and what we saw was, after the I-STOP legislation on prescription drugs, the price of an oxycodone pill, for example, went up to $30, but a bag of heroin is $6.

So I can imagine, and I appreciate your telling me this, that when you go to rehab, down, and talk to downstaters, these drug dealers are the people who maybe get addicted, and realize they can sell a bag of heroin for that much more money upstate, they're coming upstate.

And, I love the idea of a mileage limit, and I think that that would be a good piece of legislation, to say: You're not traveling -- if you're an addict, you are not traveling 60 miles-plus to just take it yourself. You're selling it.

And I think that's a good idea for legislation.

DA ANDREW WYLIE: Just in closing on that, with what Detective Bell said:

For the 8-plus years that I have been a prosecutor here in Clinton County, it's very common to see these dealers come up here to Clinton County.

An investigation, you know, commences; we do an indictment, we do an arrest.

And, I pull their rap sheets, and we look at their rap sheets, and they have -- you know, they have several previous convictions. It could be for, you know, an arrest for Criminal Possession and Criminal Sale of a Controlled Substance, 3rd; whether it's cocaine, whether it's heroin, and, down in the city areas. And, their sentences, they're reduced down to misdemeanors, and they're given, you know, a slap on the wrist, basically, and they find they can, you know, profit so much here in

Clinton County.

And I guess it's always, you know, I've said it more than once to many criminal defendants, I said: You're not in Kansas anymore. You know, this is Clinton County. You're here for the sole purpose of trafficking, whether it's cocaine, whether it's heroin, whether it's, you know, some other opiate, and, we're going to prosecute you for that, and we're going to send you away for that.

When it comes to the individuals that are the addicts, like Shawn, we try to find avenues to help them.

And that's what we do in Clinton County.

SENATOR LITTLE: You know, working together, I think we do need something, and I will make that a priority. And, immediately can think of, in Skylar Falls, the buildings, the state buildings, that are sitting there empty.

So, we have a place, and I'll do my best.

So, thank you.

DA ANDREW WYLIE: Thank you, Senators.

SENATOR BOYLE: And, District Attorney, real quickly: You did mention the fact that, the multiple convictions.

We had a forum in Putnam County last night,

and we had a defense attorney saying: It's ridiculous what they're giving my clients, in term of lenient consequences.

He had one -- one defendant, one client of his, 30 misdemeanors.

He says: You know, you have a third DWI and you're getting a felony charge, perhaps.

We gotta do it for drugs as well.

Thank you very much, gentlemen.

Good luck, Shawn.

SENATOR LITTLE: Thank you.

[Applause.]

SENATOR LITTLE: And our next speaker is Dr. Kathleen Camelo, who is the director of the Center for Student Health and Psychological Services.

I'm assuming at SUNY Plattsburgh?

DR. KATHLEEN CAMELO: Yes.

SENATOR LITTLE: Thank you.

DR. KATHLEEN CAMELO: Thank you, Senators.

I really do want to thank you for the opportunity to address your Task Force, on behalf of our campus at SUNY Plattsburgh, and on behalf of our Center for Student Health and Psychological Services.

As we already know, OASAS estimates that 1.9 million residents, age 12 or older, experience substance dependence or abuse, and this number actually includes 153,000 adolescents.

Our community is not immune to this growing problem.

So what is the scope of opioid, heroin, and illicit-drug use on our campus?

Our recently hired AOD Coordinator, Patrick Minnet [ph.], who is a certified alcohol- and substance-abuse counselor, has experienced the same level of addiction on our campus as in the community.

In the previous two years, we have had at least 150 to 200 student visits to our previous alcohol-and-other-drug coordinator for assessments and counseling.

Currently, we are awaiting the results of the Campus Course Survey, which is a tool that's developed specifically to assess alcohol and substance use on the college population.

Once we receive these results, our alcohol-and-other-drug coordinator will convene our Alcohol and Drug Campus Task Force, to analyze these results, discuss and update targeted prevention

programming and social-marketing campaigns, to address those areas of greatest use and abuse.

We really need to focus on prevention, as well as treatment.

In addition to programming, we really need to train our residence-hall staff, and we are expanding that training, so they can recognize substance abuse and use in their peers, and refer those patients for treatment and counseling. And we are doing this.

We continue to educate our center staff, our physicians, our counselors.

And, recently, we had Champlain Valley Family Services provide an in-service on training on heroin and opiate use to our center staff, which includes counselors and medical professionals.

Our center is actually one the first centers in the SUNY system to combine health, mental-health, and alcohol- and substance-abuse services in one center. And we really want to provide a comprehensive, holistic approach to the health and wellbeing of our student population.

Our center is actually housed with university police; we're in the same building. And that's actually helped us to create a very good working relationship with the university police.

Daily, we are informed, our center, of any 911 transports of our students to CVPH if they've experienced any alcohol intoxication or any suspected drug overdose.

We are then able to proactively contact these students and offer our services in a timely manner.

Our dean of students is also made aware of these students if they are charged with violating the code of conduct.

So at Plattsburgh State, if you have an alcohol intoxication or a drug overdose suspected, you will actually be violating an "endangerment" clause in the code of conduct; and, therefore, you will get a judicial charge, and you will have to meet with the dean of students, who then, at this point, really will mandate UCR alcohol-and-other-drug coordinator for an assessment. And, hopefully, that will open the door for continued treatment.

Our University Police Chief, Arlene Sabo [ph.], is committed to the training of our university police officers in the use of the emergency Narcan kits, which our officers will be available in the event that they are first responders to see those students, if they've

encountered an overdose.

We know that this first response, if a student or a patient has had an overdose, using Narcan right away can save a life.

So, our university police are committed.

Our alcohol-and-other-drug coordinator is also currently creating a listserv, where we are actually looking at SUNY AOD coordinators across the SUNY system, so that we can meet together and discuss ideas on best practices in addressing alcohol and substance abuse on our campus.

And this group will actually be having their first meeting at Plattsburgh State, since we are actually hosting the College Counseling Centers of New York Annual Conference, and they will be meeting together to share ideas.

And, again, Patrick has spearheaded that.

Our athletic department actually realizes this isn't -- obviously, we have within our athletes. And, actually, that decreases their performance, if they have been using alcohol or substances.

They actually just received a grant from the NCAA, for the purpose of the grant, is to provide a framework to address alcohol and related behaviors,

using research-based initiatives, and focusing on student athletes and residence-hall students.

Our students don't drink and use drugs in isolation. They do this behavior with their peers, so we can't just target one group.

As you are very much aware, our campus is located in the City Center.

And, in 2003, our Center of Student Health and Psychological Services applied, and received, a small grant from OASAS to create a campus and community partnership.

Over the past 11 years, the partnership has had members from key stakeholders, including the college campus, Clinton Community College, campus and city police, local government officials, school districts, Champlain Valley Family Services, Behavioral Health Services North, and interested parents of school-aged children.

The purpose of the partnership is to address our communities' needs.

Alcohol and substance use has been a priority for the partnership, and with this key framework in place, we were eligible and received grant funding from OASAS in the past, to establish a social norming campaign, to address alcohol use in the

18- to 25-year-old college population and workforce.

And in addition, because we have this partnership in place, it makes us eligible for other grant funding. And we did receive a 5-year, 500,000, drug-free community grant, to focus on alcohol and substance use specifically in the 18-and-younger age group.

We are currently in the final year of that grant, which will end on September 23rd.

Funding from OASAS for grants to prevent substance use and abuse and treatment in the college population has been severely cut.

And if we have opportunities, our task force and our partnership will apply for those grants, and continue these programs so that we can continue to work on this growing problem.

Finally, our center, in talking about treatment, and the need for continued treatment and more extensive treatment, our center, with the assistance of our AOD coordinator, and with the support of the director of community services, Sherry Gillette [ph.], campus administration, and, of course, OASAS, is in the process of partnering with Champlain Valley Family Services, under the directorship of Connie Wille, to provide

comprehensive outpatient treatment services for our students experiencing alcohol and substance abuse and dependence.

Our students like don't like to leave campus. They actually like our services, but, they oftentime need more treatment.

So this service will be provided on campus by Champlain Valley Family Services' staff. And we are waiting funding approval -- the final approval from OASAS, and their support. And we will actually be the first SUNY comprehensive college partnership with a community service.

So, hopefully, this is something that will happen across other SUNY campuses, with us taking the lead.

As we heard from Shawn, we have students that are in withdrawal. And, unfortunately, it's very, very difficult for family members, or for anyone, to actually try and care for someone when they're experiencing such severe withdrawal symptoms.

So, again, I guess I reiterate, that we really do need a treatment facility for detoxification.

It's that time when the student comes to you and says, "I want to quit"; yet, they're in the

midst of withdrawal.

And if you can't help them, again, as we know, they'll fall by the wayside and start searching for drugs.

And it's very hard for a caregiver.

And, also, I think we need to look at insurance coverage.

Although we have insurances that will pay for alcohol detoxification, because it's considered a life-threatening illness, or withdrawal, we're -- insurances will not cover detoxification -- inpatient detoxification.

So I think that's one other area that we really need look at.

So, we're looking to you for increased -- helping to find us funding, and helping us with our treatment and prevention efforts.

So, thank you very much.

SENATOR LITTLE: Thank you.

SENATOR BOYLE: Thank you.

Doctor, a quick question: Could you just -- how much are the grants you're talking about, from OASAS, that you receive?

DR. KATHLEEN CAMELO: Actually, we received a $250,000 grant in the past. And that was working,

again, with the 18- to 25-year-old college population, and the workforce, again, knowing that these two groups, you know, intermingle, and we can't just work with one group and not the other.

So, $250,000.

The original seed money to start the partnership was around 8,000 to 10,000.

SENATOR BOYLE: All right, very good. Very good.

DR. KATHLEEN CAMELO: But we have the man force, we have the power; we continue to need the funding.

And, of course, no budget cuts, et cetera, may have made that difficult.

So thank you for your time.

SENATOR BOYLE: Thank you.

SENATOR LITTLE: Well, thank you for all that you're doing at SUNY Plattsburgh, in recognition of the needs that are there.

Thank you.

[Applause.]

SENATOR LITTLE: Next we're going to hear from Michael Kettle, who is an RN, BSN, and CASAC counselor. He is director of regional services of Conifer Park.

He came up today from Broome County; so, thank you.

And, Joseph LaCoppola, who is also from Conifer Park. Thank you. And he is from the local area.

So, thank you.

MICHAEL KETTLE: Good morning, Senator Little. Good morning, Senator Boyle.

Thank you so much for hosting this Task Force, and others around the state.

It's clear that this is not just limited to this area, but it's a statewide epidemic right now, and I believe it's a nationwide epidemic right now.

I'm here today representing Conifer Park, but I'm here on behalf of three people, as well: Phil Graham, and Andrea, and now, Shawn.

I want to thank Shawn for sharing his experience, strength, and hope with this group.

As all folks who find the strength and the courage to not remain anonymous, that's the stories that you need to hear more of, and there's lots of those stories out there. Those are success stories. These people that have found treatment, or found a way to discover recovery; and whatever that means to them.

I've been in health care since 1980.

I'm actually an alumnus of Plattsburgh State.

And, I've been in the addictions field for 30 years. I've been with Conifer Park for 26 of those years.

One year into the field of addiction, and I didn't know a whole lot, but I had a family member that found recovery.

Actually, I have three generations of recovery in my family: father, brother, and a nephew.

I know treatment works.

But I know the end result, if it doesn't work, or if people don't have access to treatment. And it's death for many people.

One year into the field -- I had worked in the ER for 4 1/2 years, and then stepped into an addictions-field position at this hospital I was at.

But I got a call from a colleague of mine I had worked with, and went to college with, had meals with his family.

What I didn't know about him, is that he was a recovering heroin addict. And once he got his nursing license and started to work in the OR, he had access to narcotics unlike ever before.

But I got a call from him, as a reference, could he come over and work at our ER, that I had just left.

I said, "Absolutely." Didn't hesitate.

Within two months, I was getting a call from the head nurse, saying: Mike, I'm wondering about this Phil you recommended. We're -- we're -- our narcotic counts are off. He always got a story.

Clearly, what had occurred, he had relapsed.

We got him into treatment, and, six months later, he was dead from an overdose.

He found a way into a hospital in Upstate New York, got access to a prescription, and that illness that never left him, and it never does -- and I think Shawn made that very aware to everybody in this room -- came back with a vengeance.

So he left two sons and a wife behind.

Two years ago, I got a call from a very good friend of mine, whose son played lacrosse with my son. Great kid. Great sport.

He had had a sports injury, was prescribed Vicodin, and off to the races. For whatever reason, he became addicted.

Not everybody does.

He was in his second year at the university locally, and he was on the street now, finding what he could no longer get from his physician.

He's in recovery. He's one year two months one day and probably 13 minutes clean right now.

The last young lady, and I'm going to reference my phone here, only because, social media, I believe, will have something -- a part to play when we look at things that we can do.

Our young people today are text-savvy.

So, when we talk about prevention, we talk about access to better knowledge, and what things are out there as a resource, social media is there.

But this was an e-mail I received from Andrea, just yesterday morning.

On our Web site, there are -- it's a screening tool you can take, and there's ways to ask for help, and we're happy, obviously, to try to do that.

Her name: "I'm Andrea. I'm 19, and I'm a student at OCC."

That's a community college.

"I've been addicted to pain killers, oxys, hydros, et cetera, and marijuana and alcohol, since I was 17."

I won't read her whole thing.

Her last statement to me: "This is really a cry for help."

Phil was 42, Graham.

Two years ago, he is 23 right now, I believe.

But she was 17, and she's addicted.

And I say that, very importantly, that this is an addiction. This is a different epidemic than in the '60s.

And, heroin, I think today, a lot of people still think of heroin as hippies and long hair.

That doesn't -- it's not there anymore. These are younger people dying today, for sure.

So I'm here on behalf of Conifer Park. We are a chemical dependency provider; have done so for 30 years.

We do offer medically-supervised detox, adult rehabilitation, and adolescents, over two hours away from here. And we do provide those services to people in this community, as best we can.

We provide medication-assisted treatment through treatment, as well as many other evidence-based practices.

We also have six outpatient clinics, one of which is here in Plattsburgh. All of our

six locations offer medication-assisted treatment.

Recently, in the fall of November 2013, we were granted a license from OASAS to provide methadone in this area. We currently have 23 individuals on methadone.

We recently also got approved by the Department of Health to provide Narcan training, and to become certified to provide that training to families and members of the community.

All of these initiatives, in the last year, have been because, in the last three to five years, the significant increase in opiate use we're seeing come through the outpatient and the inpatient sector, for sure.

Some problems that I'd like to identify, and these are not -- these are not blameful problems, these are not finger-pointing problems, but they are reality today of what we face.

Treatment is one thing, but having access to that treatment. And somebody mentioned the insurance piece.

Access to all levels of care, with regards to managed care and medical-necessity criteria, resulting in denials and limited stays at detoxification and inpatient levels of care, are

part of the problem.

The limited number of Suboxone X-licensed physicians to continue dosing as many patients complete our outpatient program who may be in need of further medication-assisted treatment, is part of the problem.

Narcotic-prescription practices vary from one discipline to another, and many times results in access of unused medication, and continued prescribing, with no intervention for substance-abuse treatment in the course of treating the whole patient.

I have a colleague of mine whose mother was just placed in a nursing home about a month ago. She is a chronic-pain patient, and in the last 10 years, she has stockpiled her meds under her bed because she would use one or two, three or four, and then boxed up the rest.

I don't want to put a street value of what was underneath her bed, but it certainly contributes to some of the problems and issues that we're seeing today; and that's supply and demand.

Some of the solutions, I just offer these, is an insurance task force.

And some of these may actually be occurring

as we speak.

An insurance task force that brings insurance providers, OASAS, and treatment providers together, to establish and better define a standardized medical and clinical necessity tool for all inpatient levels of care, that promote access, rather than restrictions, to care.

A collaborative initiative to bring hospitals and primary-care practices together with alcohol- and drug-treatment providers, to explore the possibility of having a limited number of physicians on staff who are X-licensed to be able to prescribe Suboxone.

I can go to a hospital today and find 50 to 100 physicians that can write a prescription for an opiate, but not for a prescription for Suboxone that is evidence-based and shows that it can work for some, but not for all.

To continue to build the upon I-STOP laws in reducing the amount of narcotic prescription medication that is being abused and prescribed.

And, lastly, to educate identified services and implement SBIRT, which is a screening tool. The acronym stands for "Screening, Brief Intervention, Referral To Treatment."

And I'd like to see this in all hospital emergency rooms, primary-care practices, and other identified health-care settings, including college medical-counseling centers.

So I'm grateful to hear some of the things that are taking place here locally at Plattsburgh.

And, an attempt for earlier intervention and education for those starting on the path to abuse.

Thank you.

SENATOR LITTLE: Thank you, Mike.

Joe.

JOSEPH LaCOPPOLA: Yes, good morning, Senator Little; good morning, Senator Boyle.

And thank you very much for inviting us to participate on this panel, and most importantly, thank you for convening these hearings throughout New York State.

I'm a CASAC. I've been in the field for over 23 years, and the majority of my career has been working in medication-supportive recovery, assisting patients and individuals with the disease of opiate addiction, with either methadone or Suboxone.

New York State is in the midst of a public-health crisis. As we know, the disease of opioid addiction has no boundaries and does not

discriminate. It has destroyed families, and its death toll continues to rise on a daily basis.

As you've heard at past hearings, the increased use of illicit opiates has increased at an alarming rate, and the implementation of I-STOP, being that the intent was positive, has resulted into this.

This is due to individuals that were getting prescribed opiates and are abusing them, who have been discharged from their provider's practice.

These individuals continue to need the illicit opiates, not for the euphoric effect, but to be able to function on a daily basis, as what we heard this morning from Shawn.

When meeting with individuals in the act of withdrawal, they compare it to having the flu times 10 to 100 times over; not only the physical, but the mental-health piece to it.

Again, no one, and I repeat, no one wakes up every day wanting to use the illicit opiate, as what they tell us every day, is they just want to feel normal.

Our patients seeking admissions are younger, with the average age being 19 to 25.

They report their first use around the age of

15.

Many report that their illicit use was due to the availability of the opiates in the home, and the medicine cabinet became the new dealer.

They also report, that after being prescribed opiates after a surgery, a dental procedure, or injury, with many of the conversations, are teenagers that have had wisdom teeth pulled, receive a script for oxycodone, with three refills at 30 a pop.

We don't have to tell you what happens after that.

Patients reported, when the prescribed opiates are not available, they quickly turned to using heroin, and the dealers soon had a new market.

This, in turn, has caused the havoc in communities due to the increase in crime, and also the public-health concern due to increases in infectious diseases like hepatitis C.

Throughout the state, our substance-abuse programs have seen an increase in opiate admissions.

We at Conifer Park in Plattsburgh have been no different.

In 2011, the total number of patients admitted for opiates was 62, compared for 88 for

alcohol diagnosis.

In 2012, that number increased to 146, which outnumbered alcohol admissions were at 88.

And in 2013, we now have over 120 admissions for opiates.

This past November, as Mike reported, that is addressing this, and being able to afford medication treatment to everyone, assisted treatment to everyone, we at Conifer Park opened the first new methadone program -- I think this is significant to hear -- in New York State in 18 years.

Again, in 18 years, this is the first new program, the first located.

Any other time anybody wanted medication-supported recovery methadone services, would have to travel to Albany to receive that treatment. There was no other program outside of Albany.

This is the first, upstate, in this area, ever.

The program is integrated in medication-supportive recovery.

And let's make sure that that's clear today:

It's not just the medication. It's medication-supportive recovery.

Patients are required to engage in treatment, which includes individual and group counselings, and at their first visit, it's strongly and thoroughly talked to them in regards to, their participation is mandatory.

Again, it medicationally supports them so they can engage in treatment without experiencing the cravings and withdrawals from opiates.

We as a treatment field need to embrace medication-supported recovery. No other modality of substance-abuse treatment has been studied and researched.

The results clearly show better outcomes for patients who participate in medication-supported recovery than those who are not afforded the opportunity to do so.

Too many times we hear, and also see, the providers require patients to be free from all illicit substances so they can remain in the program.

To expect someone to engage in treatment when they are experiencing cravings and withdrawals is setting them up for failure, and possible death.

Also, our treatment field needs to embrace the harm-reduction model. To expect any patient

that has used a substance, and to comply 100 percent with an attendance agreement, is, again, setting the patient up for failure.

We as a field need to take baby steps, meet the patients where they're at, and the field has to remind ourselves, this is not our treatment, but it's the patient's treatment.

Another area that we have to look at is, not all -- and, again, I want to be very clear -- it's not all, but some court judges -- drug-court judges and coordinators do not support medication-supported recovery. They require patients to taper from the medication before they can participate, and/or not allow one to graduate from drug court, because they have a belief that they're not completely free from the illicit substance.

They do not, and I repeat, they do not require an individual to taper off of their medications for psychotropics for mental health, and/or they do not allow -- they allow them to participate with psychotropics for mental health, and they allow them to participate with medications for any physical-health conditions.

I believe that a legislation is needed that would require all drug-court coordinators and judges

to participate in medication-supported recovery in-service, and to be required to accept the clinic's recommendations, which would include medication-supported recovery if it is recommended from a licensed OASAS medical facility.

[Applause.]

JOSEPH LaCOPPOLA: I conclude with some recommendations that I believe, if acted on, can immediately improve access to treatment and assisting the public crisis -- the public-health crisis.

One: Methadone programs are the only outpatient substance-abuse treatment services that have a patient capacity.

That means, when applying for a license, the state agency, OASAS, says that you can only have 100, or some programs only can have a capacity of 300.

This, in turn, has led to patients being placed on waiting lists, and as we know, many of those patients may not live till their number is called.

I believe it's unethical to have to tell someone who is wanting treatment today, that: Sorry, we have no available spots, but we'll be

happy to put you on a waiting list.

No other medical profession that treats anyone for any diseases has a licensed capacity.

Programs who seek to have their capacity increased, to meet the needs of the community and patients, have to complete a lengthy application, and a review process can take over a year by our regulatory agency to approve.

I'm asking for a legislative action to eliminate census capacity for all methadone-treatment programs immediately.

Two: Methadone programs embrace all medications, including methadone, Suboxone, and VIVITROL, that address the disease of opioid addiction.

We, the methadone programs, have the ability to dispense Suboxone to patients, but are not able to do so at this time because of the inadequate reimbursement that is presently offered.

For a year and a half, the Committee of Methadone Program Administrators, who I'm a member of the board, has been working with DOH and OASAS to agree on a reimbursement rate that adequately covers the expense of the medication.

As of today, we still do not have an

agreement on that.

You have heard at these hearings that one of the concerns, is some providers prescribing Suboxone do not require patients to participate in treatment, or do not even meet with the patients.

And another concern is the availability of Suboxone on the streets.

By intervening, and asking that you intervene, with DOH and OASAS to agree on a reimbursement rate, will adequately reimburse providers, increase access to treatment, and also address the issues just mentioned.

Third, and, lastly: All methadone programs in the United States are required to be accredited.

The programs, we pay for this, and are reviewed every three years, and have to submit yearly reviews, to ensure we're meeting the compliance and standards.

Soon after they leave our programs, OASAS comes in with their agency and does a complete review of the programs that were just completely just seen by the accreditation agency.

I am recommending legislative assistance, that OASAS reviews be discontinued, or as we say, the programs be deemed, and the savings that is

going to be -- the savings from this be reinvested back into the budget for funding additional substance-abuse treatment and prevention services.

I again thank you very much for having us today, and affording us the opportunity to present.

SENATOR LITTLE: Thank you for some really good recommendations, too.

Thank you.

SENATOR BOYLE: Thank you, gentlemen.

One question: You mentioned the Suboxone and the VIVITROL.

Not being a doctor or a chemist, what do you think is better? Or is it just on an individual basis?

JOSEPH LaCOPPOLA: Totally an individual basis, Senator. And that's one of the pieces that we offered our program.

We don't make that decision at the beginning when the person comes in for the intake.

That's between the doctor and the patient, in deciding what medication would be best to assist them.

SENATOR BOYLE: Okay.

MICHAEL KETTLE: There's some patients that would not be a good fit for methadone and/or

Suboxone and/or VIVITROL.

But having those three as an option is a tool that I think today we need.

And just -- I do have to hold this up.

When I worked in the ER for four years, I had the opportunity to use Narcan/naloxone, to bring somebody back from death's doorstep.

It worked 30 years ago. It works today.

I got this kit. I carry this in my car.

I got this kit from the Northern Tier Providers Association that did a training back in the fall of 2013, and I've kept this in my car since.

Only because you referenced Broome County: Our sheriff's department just got trained in the last two weeks. They've had three lives saved, and the last one was 23 years of age.

In a matter of two weeks.

"Two weeks."

SENATOR BOYLE: That's an excellent point.

And would I recommend, perhaps, a Narcan training program up here.

As a former EMT, I've seen Narcan work, and it truly is a miracle drug.

SENATOR LITTLE: [Unintelligible] was

trainer. Is that right? And he can do the training.

SENATOR BOYLE: Thank you, gentlemen.

MICHAEL KETTLE: Thank you very much.

JOSEPH LaCOPPOLA: Thank you.

SENATOR LITTLE: Thank you.

[Applause.]

SENATOR LITTLE: Now I have, Beth Lawyer, who is the director at North Star Behavioral Health Services Citizen Advocates, Inc., which operate in Clinton, Essex, somewhat; and Franklin counties.

BETH LAWYER: Thank you, Senators, for the opportunity to speak today.

And, you know, I have -- I will submit to you in my written testimony a number of statistics around the current problem. I don't think I need to repeat them right now.

I think we've had, you know, a clear visual of the nature of the problem.

But I really appreciate the opportunity to share today.

I know you're looking for recommendations.

I'm the director of North Star Behavioral Health Services for Citizen Advocates.

And I'm also a vice president -- second

vice president for the Association of Substance Abuse Providers in New York State.

At North Star, we provide the full continuum of behavioral-health services.

We serve Franklin County, and some of the communities in the neighboring counties, and our services include school and community prevention programs, outpatient clinic services, recovery supports for substance abuse and mental illness, as well as a comprehensive array of community-support services.

We have residential programs, supportive housing, case management, et cetera.

I would say that I concur greatly with some of our other representatives this morning, particularly the comments that Joe just made around medication-assisted treatment.

We also provide medication-supported recovery. And, certainly, that linkage with Suboxone and treatment is critical.

And I'll talk more about that in a minute.

We've also had a great opportunity to work with DA Champagne. He's been a real advocate for prevention and intervention. And, he works with us on our Franklin County Task Force to address some of

these issues.

The one piece that I will share with you about statistics, that I think matches what we've seen already this morning, is that our North Country communities have not been isolated from the problem.

We've seen this increase directly in our outpatient clinics over the past year and a half.

In 2001 and 2012, less than 1 percent of all our outpatient admissions were coming to treatment, reporting heroin as their primary substance use.

"Less than 1 percent."

That rose to 5.3 in 2013; very quick rise.

And in 2014, to date, it's 7 percent of our total admissions related to heroin.

Over 20 percent of all our outpatient admissions, right now, are related to a primary use of opiates.

I note that I'm not here to convince you that there's a problem, but to offer some suggestions.

I do, however, want to point out, and thank you for your leadership in some things that have worked:

The passage of I-STOP has been a great success in helping curb the unknowing, reckless, or irresponsible prescription of opiate pain relievers

to folks who were not likely to use them responsibly.

The positive recent legislation to support naloxone, and Narcan, that we've already discussed this morning.

Safe Take-Back days and unused prescription-drugs boxes, they collect harmful prescriptions, they get them off the street, and they prevent misuse and abuse.

I want to highlight the expansion of the treatment beds, by 50 beds, that was made.

Also, your support of innovated treatment opportunities.

At our outpatient clinics, we've long documented that over 60 percent of those who come to us for substance-use-disorder treatment have a co-occurring mental illness.

And we are -- we are really pleased to be part of an integrated supported pilot for a collaborative care model that integrates substance-use-disorder treatment and mental-health treatment under one roof, through one door, one treatment plan; shared staff.

Our early indications are showing that it's a cost-savings to Medicaid, as well as showing some

improved outcomes.

So, we thank you for your support of that.

There's still much to do.

And as Senator Little said, the critical solutions lie in a three-pronged approach, and that includes: Law enforcement. Treatment, being access to care that is readily available, and effective. And, cost-savings and lifesavings investments in prevention.

So, I have a couple of recommendations I'd like to propose; and the first is around prevention, which very dear to my heart.

As an unintended consequence of school funding and school-budget issues, many of our local school districts have been forced to drop or decrease contractual arrangements they had with OASAS-certified prevention programs that used to support fully embedded full-time prevention professionals in our school.

These prevention experts worked in close partnership with school staff and administrators. They provided comprehensive, evidence-based prevention education, intervention, screening, and brief counseling. They identified and referred indicated use to treatment.

The prevention workforce decline in New York State as a result of these lost partnerships with our schools is significant.

In Franklin County alone, we've seen a loss of 2 out of the 7 school-district contracts, and a decrease to part-time and others, leaving many of our children without the comprehensive prevention programming that we know can work.

Without a reversal of this trend, I fear we'll see the negative impacts well into the future.

Rather than a decline, the prevention infrastructure in New York State should be expanded and utilized to address, not only the opiate crisis, but early intervention and education around all areas of substance abuse, mental health, suicide prevention, and physical and emotional wellness.

We must also expand statewide and local prevention efforts in the form of community and medical education and awareness, targeting parents and community leaders, as well as physicians and pharmacists.

We're organizing a community forum on heroin and other opiates in Malone on May 12th, with a panel and some guest speakers, but, that's only a beginning, and it's certainly not enough.

Budgeted resources identified for prevention, to address the opiate and heroin problem, need to be funneled to the community-based prevention experts who can utilize evidence-based prevention strategies that will work.

Efforts also need to include a broad and intense community-awareness media campaign that targets our youth and parents regarding the risks of opiates, both legal and illegal.

We need to expand access to and the availability of the Narcan and the opioid-overdose training beyond emergency services, law enforcement, and fire departments, to include the broad scope of human-services professionals.

I'm glad to hear that we have an opportunity to get some training.

But there's been a lot of red tape, and it's not easy to get training up here, or for human-service professionals to have access to the kits.

Expanding treatment access, that's come up a number of times. And I cannot emphasize that enough, about removing insurance-coverage barriers that are currently preventing our clients from getting the care that they need.

We need a mechanism to hold insurance companies accountable, to create access to care and not impose barriers.

We need to look at establishing humane and standardized criteria for coverage authorization and the level of care determinations that were just discussed.

Another thing that we're seeing is that, in some of the insurance plans, the deductibles that clients have are so high, that there's no way they're going to reach them or enter treatment, or can even begin to look at that.

Another suggestion, after Kathleen spoke, that struck me, was as she was describing all the work they've put into creating an outpatient clinic on the campus site.

Those barriers don't have to be -- that shouldn't be so difficult.

And we find the application process; the ability to establish outpatient clinic services or satellites in schools, on campuses, it's just too difficult right now when we're facing this epidemic.

So I would really suggest looking at those, at what regulations at this juncture can be waived or simplified, so that we can have an easier time

creating sites of service where the clients are at: meet them where they're at, and meet where the need is.

And, again, as my colleagues have said, I would advocate for -- I would encourage you to advocate to our federal officials to allow those physician-extenders to provide Suboxone.

And, also, assure that linkage to treatment and collaborative care. We need that to be a cornerstone of opiate-dependence care.

If we want community-based detoxification programs to be successful, if we want to reduce hospitalizations and ER presentations, we must increase the number of medical providers that not only can prescribe, but understand addictive diseases and the treatment.

I thank you.

I believe that there's an opportunity here; I believe there's hope, moving forward; that we can work together, we can address the needs of the communities, the issues of heroin and opioid addiction in New York State.

So I thank you for your time and your attention, and the work ahead.

SENATOR LITTLE: Thank you, Beth.

And thank you very much.

SENATOR BOYLE: Thank you, Beth. Very insightful.

Just a real quick question: You mentioned the prevention.

In terms of age-appropriateness, do you have programs, what's the youngest you start, or you would recommend?

BETH LAWYER: Well, we've actually had the opportunity in the -- and as my prevention colleagues could concur, to work from kindergarten, right on through.

And using evidence-based curriculum, if we're talking about pushing classroom work, those are designed and developed in an age-appropriate sequential way.

We now that the times of transition are critical, from elementary to middle school, middle school to high school.

And I think in light of the health crisis that we're talking about today, that that middle and high school age is so critical.

And, you know, it saddens me deeply when I think of the districts we're not serving, because

they can't afford to contract. And our base funding doesn't give us enough to go everywhere all the time. We need that supplement.

So, you know, I really think that middle-, high school level, is critical right now.

SENATOR BOYLE: Thank you.

SENATOR LITTLE: Thank you.

Our next speakers are from CVPH: Dr. Charles Everly, who is the medical director of the emergency room at CVPH Hospital here in Clinton County; and, Kenneth Thayer, who is the nursing director of Emergency Care Center at CVPH Medical Center.

Thank you both for coming today.

DR. CHARLES EVERLY: Okay, well -- so, the number one fear is public speaking, and the number two fear is death.

So --

[Laughter.]

DR. CHARLES EVERLY: Jerry Seinfeld said that --

SENATOR LITTLE: I only have number one to fear today.

DR. CHARLES EVERLY: Jerry Seinfeld said, that, "If you're at a funeral, that means you'd

prefer to be in the casket than giving the eulogy."

So that's how I feel.

[Laughter.]

DR. CHARLES EVERLY: So, Kenny and I are here to offer a perspective from the emergency department. Certainly, we don't try and represent the entire medical community.

But, in terms of our responsibility in the emergency department, you know, I gathered some numbers, and I just wanted to share some with you.

So, the second leading cause of accidental death in the United States is from prescription narcotics. Not from heroin overdose; from prescription narcotics.

Death from opioid analgesics, prescription narcotics outnumbered deaths from cocaine and heroin combined.

Sales of opioid analgesics to hospitals, practitioners, and pharmacies have quadrupled between 1999 and 2010.

In 2010, we distributed enough narcotics to supply every American adult with 5 milligrams of hydrocodone every four hours for one month.

SENATOR LITTLE: Wow!

DR. CHARLES EVERLY: So, it's a huge number.

So -- so that's the entire medical community.

From the emergency department, how big of a role do we play?

Well, between the ages of 10 and 29, we prescribe -- we're third on the list of numbers of prescription written for narcotics? And then, from 30 to 39, we're fourth.

So, we write a lot of prescriptions for narcotic medications.

You know, the emergency department, it's a difficult place to work. We're the safety net for the community.

We don't know our patients. We receive them and we get a snapshot of their life. A lot of times we don't have any medical information about them.

So, 42 percent of all emergency department visits are pain-related; and, so, part of what we do is pain relief. And there's nothing more satisfying than to be able to relieve somebody's pain.

We have a joint-commission focus pain management.

When -- if you've ever gone to the emergency department recently, within the first 60 seconds, if you have pain, they're going to ask to you grade your pain. And you'll probably hear that question

five, six, seven more times as you go through the department.

And if you don't speak English, then we'll have smiley faces to frowny faces that you can point to.

So, we want to know about your pain.

In addition, patient-satisfaction scores actually have questions regarding: Did your doctor manage your pain well?

And, initially, these were simply scores that would inform the doctors whether, you know, our patients liked us, and whether we did a good job.

But now they're going to be linked to reimbursement; and, so, there's even more importance on being able to adequately control somebody's pain.

So, I'm giving you a perspective on the impetus for us to be able to control pain and to prescribe medications.

Having said that, we're afraid of narcotics, and we were very happy to have the I-STOP law passed. It allowed us to take some of the responsibility off of us when we're speaking to patients and we say: Look, this is a state law. This is what we can do for you. We can't give you a 30-day supply of your narcotic medication.

So, when you're practicing in the department, you've got two patients: you've got an acute-pain patient and you've got a chronic-pain patient.

And the acute-pain patient is quite easy. We treat their pain, we prescribe narcotic medications for them, if necessary, and a lot of times it is. But, we won't give them more than a 5-day course, sort of in conjunction with the I-STOP law.

But it's the chronic-pain patients that come in with an acute exacerbation. And, it's a much smaller number, but, the people who we believe are drug-seeking.

Those are the difficult patients, because you have somebody with chronic pain who is on medication. They may have lost their medication, they may have an acute exacerbation, and we're put in a difficult spot, because we want to make people feel better.

It's very difficult to send somebody out the door, hunched over and grabbing their back in pain. It's just -- it's not satisfying, as a physician.

So we want to help them, but we're putting people in danger.

So what we have done within the past six months, is to author, and this is what I put in

front of you, a -- "Prescribing Guideline for Narcotics and Sedatives for the Emergency Department."

And this is nothing unique. I think, back in 2010, people were starting to do this.

And this was put together, after reviewing "American College of Emergency Physicians: Clinical Guidelines for Narcotic Prescribing from the Emergency Department."

And essentially what it's doing, is it's allowing us to responsibly provide analgesia, narcotic analgesia, for those patients in acute pain, but, it recognizes that chronic-pain management is a complex issue, and it is not managed well from the emergency department.

And, so, this is what our physicians in the emergency department are now leaning against and using.

What we need to do with this, is we need to provide this as general information in our waiting room and to our patients so that there's a mutual expectation.

SENATOR LITTLE: Understanding, yeah.

DR. CHARLES EVERLY: Yeah.

So -- and we're working on that.

We've got a clinical pharmacist in our emergency department that helps us review patients' medications, because it's very time-consuming to call pharmacies and to find out what medications people are on. And, so, that helps us.

A lot of times they'll let us know that this patient is on a pain-management contract that we didn't know about, or the patient had visited several other facilities in the area or several other pharmacies in the area and had gotten medications.

So, that's a layer of protection for us that we're trying to engage in.

We need to communicate better with our local providers.

Kathy came over to us from SUNY Plattsburgh, with her staff, and we were able to talk about how we could coordinate our services better, because we do, unfortunately, get students from her -- from the university, that are either under the influence of drugs and alcohol. And once they're treated, we don't just want to release them out the door.

So, they have follow-up there.

You know, I'm going to stop yammering and stammering and let Kenny talk about, sort of, what

we need in terms of community services.

And you've already heard it from everybody here, because, frequently, we can help -- a patient will come in with a narcotic-withdrawal syndrome, and, you know, we've deemed them "medically stable." There's not really anything we can do.

And, we can give them information for outpatient services, but, frequently, there's not much more that we can do. And we want to be able to give them an alternative than just sending them out the door and handing them a piece of paper with some phone numbers on it.

KENNETH THAYER: Thanks, Charles.

So, I'm just going to share with you some brief numbers I've put together, just for 2013, at least for our ED.

Related to overdoses and drug abuse, and comparatively to 2012, you know, know, we're, primarily, about a 50,000-visit ER. Of that, a lot of it ends up becoming a lot of primary care because of primary-care resources in the community.

Of that approximately 50,000, we're doing about 3,000 crisis interventions per year. A lot of that's a dual-diagnosis. Whether it's psychiatric or if it's substance abuse, a lot of them are hand

in hand.

But the breakdown out of that is, you know, that we can directly attribute back to narcotic overdose. We've got about 300 cases in 2012, and up to about 400 in 2013. So, it's an increase of 100 narcotic-directly-attributed overdoses.

Some of those overdoses would range from, the person coming in completely apneic; not breathing. We give them a shot of Narcan. They wake up, and they sign themselves out of the emergency department 45 minutes later, against medical advice.

We've fixed them, we've gotten rid of their high, basically, and now they're going to sign themselves out and they're going to go try to find themselves their next dose, or fix, basically.

So, we clearly are seeing our numbers, you know, elevate over the last few years.

And I think it was pointed out earlier that the data out there that directly tracks narcotic overdoses and abuse are not that great.

We basically -- we base -- my data is based off of diagnosis codes, and it's all lumped together in a series of numbers, and then we just pull our reports based on that.

You know, the effects that it's having on the

ED relates to patients: the other patients that are in the emergency department, the staff that are in the emergency department.

From a patient -- basically, from a safety perspective, we have seen a tremendous increase in the utilization of Plattsburgh City police, sheriff's department, State Police, and, basically, making a desperation call. And, you know, city police has about a one-minute, two-minute response time to the emergency department, and we've seen that on several occasions this year compared to previous years.

January, last year, we had a patient that was using some unknown substances. I can't directly attribute it back to an opiate or a heroin, but it pretty much presented that way.

He ended up assaulting ten of my staff, one of which ended up having to be treated, and lost days from work, which, obviously, impacts, you know, our staffing.

What we have done, in replacement of that, is that we have now established an agreement with law enforcement, related to those patients coming in of serious threat to our staff, and law enforcement is now staying in our ED, with those individuals,

because of the risk for safety of our other patients and our staff members.

The violence in the ED has increased also, tremendously, directly related to not understanding I-STOP laws.

And if the physicians, two years ago, were prescribing, sometimes, you know, a 30-day supply of Lorcet or Vicodin or oxycodone, and now we've cut that down to a max of five days, that has obviously generated some serious questions. And, we've had holes kicked in our walls. We have had staff, again, assaulted. And we've had people arrested from the emergency department for assaulted behavior on our staff.

As far as support from the Legislature, I thank you for the legislation that was passed related to a felony as being charged for individuals that assault a health-care worker.

I think consistency amongst the -- you know, the prosecution, as far as not getting just charged with menacing, which is a misdemeanor, and continuing with the felony, would be supportive.

A lot of times my staff have went to the police department, they have filed the reports, and the person ends up getting charged with menacing

because it's related to, they did not have capacity to make that decision.

They personally put that medication into their arm, they took it by mouth, they're making that decision.

The challenging part becomes, with these patients, we are trying to support them, we're trying to treat them, and is a two-way street.

We can offer them the services, but they've got to be willing to take the services that we are giving them.

We give them the information. It's up to them to make that phone call to arrange the services.

One practice that previously took place was, I believe it was Tom Latinville from Conifer Park, several years ago, we had actually made a phone call to him, on patients that were in the emergency department seeking rehab and detox.

He would physically come to the emergency department and do the intake of [unintelligible], right then and there.

However, I do not feel that any of our outpatient services right now have the resources or the funding to support that.

And I think, as far as, from the legislation, and from that perspective, where could you help us? That would be a great resource to our outpatient services, as far as getting them the resources and the funding to be able to provide that.

Insurances is another barrier for us.

A lot of times we can offer these individuals inpatient services. Most of the time we're transferring to Conifer Park; St. Joe's, Saranac Lake; St. Peters; Canton-Potsdam.

Canton-Potsdam is the only one that will really take anybody as long as they have an available bed.

However, sometimes the insurance companies get in the way, in that, they want a failed outpatient before they'll take an inpatient.

And a lot of the different services are like that.

These individuals that are addicted, they can't afford a failed outpatient. That failed outpatient may be their one and only.

So we need to make that access available, and, working with the insurance companies to -- to, you know, take down some of those barriers from that would be highly appreciated.

The other thing that -- I also recently started working with North Country Health-Care Providers, which is a group of seven hospitals around the region. We meet in Potsdam. And, I was asked to sit on this. It's part of the New York State Prescription Drug Task Force.

And as the seven hospitals, a group, we were focusing on some key goals, and we're still working through that.

One of them is, consistency across the North Country related to policies in our emergency departments, primarily, for prescribing guidelines around narcotics, which we have, you know, put in place.

But the other one focuses around law enforcement having the ability to have Narcan on board. You know, the police cars, giving them appropriate training.

Again, that comes back to funding, and making sure they have the appropriate education with that.

And then the other one is prescription-drug drop-offs.

I know our City police department here in Plattsburgh does honor that, but I do not know if they have -- they still have to provide the funding

to pay for that to be disposed of. That is a medical waste. It is highly expense to get rid of.

But that is only one location in Clinton County. And I feel, by broadening that, and giving that ability for the grandmas that have been stockpiling medications, to get rid of them more consistently, it eliminates some of those prescription drugs that are on the street.

With the -- you know, going on to the -- you know, with the I-STOP legislation, it's almost that it's -- it's kind of turned focus away from prescription drugs and it's made it easier for heroin, and it's kind of created a market, as it was said earlier.

Heroin is now the lucrative market instead of the prescription drugs, because of the pharmaceutical companies.

You know, we've done a little bit of work with Conifer Park, as far as introducing the SBIRT program. That is an Emergency Nurses Association-supported, you know, assessment.

It's a matter of being able to -- us, on our side, having the resources to implement that.

That's an -- approximately, a 15-minute assessment. There's specific training that I know

Mike has offered to the hospital. It's a matter of getting the appropriate people there, and trained, and then giving us the time to do it.

As with anything, whether it's education or health care, we are all experiencing, you know, financial situations, where it's not easy to, you know, mobilize a boatload of resources to pull out and make that happen.

So, you know, it comes down to, you know, we need to have the appropriate funding, we need to have the appropriate resources.

I think the greatest impact that we see in the emergency department, is access on the outpatient side.

We can see the patient, we can refer them to treatment. Our resources are limited in the North Country.

I believe the three services that we have here in Plattsburgh do a phenomenal job at trying to get our patients in as quickly as possible. But, again, that's only an intake eval, and a lot of times, it doesn't get them started on the treatment plan, and then they have -- they get put on that so-called "waiting list."

We need more resource in the community.

Inpatient detox, rehab, we do not have that at CVPH; so, therefore, it's creating a transport to another facility, which is sometimes two hours away.

I'll leave with you just one recent -- actually, two recent experiences.

We had, a female in our department wanted help. We spent 36 hours; kept her in the emergency department.

Could have discharged her, probably, after 6 hours, and said, you know: We just -- we're giving you the resources.

We didn't feel that was in the best interest. We kept her for 36 hours. We finally got a bed secured at St. Peters in Albany.

We put her in an ambulance to send her down there, because we didn't feel it was comfortable putting her in a personal auto that we couldn't guarantee that she would actually make it there.

We put her in an ambulance. She got there; she signed herself out as soon as she got to the facility. And she probably arranged for somebody to pick her up in Albany.

And -- you know, so she did not extend her treatment.

The other one, I'll go back to about a year

ago, which is just an experience that kind of just opens your eyes, is a -- you know, I've cared for a lot of overdoses in the department myself.

This one was a pregnant female. She, literally, delivered in my arms.

And the first question she asked is, "I need my fix."

It wasn't about the baby.

It was about, "I need my fix."

This is truly a disease that needs some serious focus and some serious attention to.

So, anything from a perspective from -- that you can do to support the North Country in combating this serious disease that's affecting us, and -- as well as the rest of the state, would be appreciated.

Thank you.

SENATOR LITTLE: Thank you.

I think just being here and hearing the different stories and testimony and figures will help us get more attention and get more services.

The I-STOP program, Doctors, do you get a complete rundown on just about everyone you put in, or is it a work-in-progress?

DR. CHARLES EVERLY: Well, as you know, the emergency department -- the emergency physicians are

exempt, because the work involved in looking up patients and their narcotic history, it would take too long, it would slow things down.

And that's part of the role of the clinical pharmacist.

But, when we have time, when the department is not overwhelmed, yes, we do use it, and it's actually very helpful.

SENATOR LITTLE: But that's the point of only giving five days of a prescription; right?

DR. CHARLES EVERLY: That is correct.

SENATOR BOYLE: One of the other issues, you mentioned about the insurance coverage, and it's been a statewide problem, as well.

There are some pieces of legislation: One from Senator Kemp Hannon from Long Island, to mandate insurance coverage of treatment.

We're going to work on that. It's going to be, obviously, a tough thing to get passed.

However, one of the things that I've been looking at, is dealing with the insurance companies, and I think a blue-ribbon panel was mentioned earlier, about the definition of "medical necessity."

Because you have a dozen different insurance

companies, and they have a dozen different definitions of "medical necessity," I think we need a unified answer to see: Does this person meet these criteria? Yes, they need to get coverage.

KENNETH THAYER: Absolutely.

I mean, the inconsistencies between the insurance companies create several barriers.

You know, a lot of the high-deductible health-care plans, it was already mentioned earlier.

These -- you know, even middle-class families, it is very difficult to, either, meet that deductible, or you get hit with -- you know, right now, an ER visit, if you get -- if you come in for an ER visit, whether it's in the fast-track for an ear infection, or for chest pain, if you get discharged, you're going to get hit with a $500 deductible, in most places.

It used to be 50. Right?

You know, so, it is twofold.

Now, I understand that's to bring down health-care costs, and, maybe, some of the overutilization of the emergency department, but, again, these patients can't afford that. Most of them are either unemployed or they have, you know, the entry-level positions.

SENATOR BOYLE: Thank you very much.

SENATOR LITTLE: Thank you.

[Applause.]

SENATOR LITTLE: We'll next hear from the Champlain Valley Family Center, executive director, Connie Wille.

CONNIE WILLE: Good morning.

SENATOR LITTLE: Thank you, Connie.

CONNIE WILLE: Good afternoon.

On behalf of the staff and the board of directors from Champlain Valley Family Center, and Jack and myself, I want to thank you, Senator Little and Senator Boyle, for making the time to come to our community, to learn about the heroin/opioid crisis in our community.

Before I address the group, I want to introduce you to Jack. Jack is in recovery from opiate dependence, and courageously volunteered to speak with you today.

SENATOR LITTLE: Thank you.

Thank you, Jack.

JACK: Thank you.

Well, when I was asked to speak here today, initially, I was very afraid of being judged for who I was and not for who I am today.

Who knows or cares about a junkie who has overdosed four times by the age of 23?

At the age of 12, I began smoking cigarettes.

At the age of 13, I had drank and got drunk for the very first time.

From 14 to 18 I was smoking pot daily.

At age 14, I began seeing commercials on TV, warning parents to lock up your medicine cabinets. This is what peaked my curiosity, and I started looking in those medicine cabinets.

I would read the names on the bottles, go to my computer in my room, type the medicine name into Google, find out what it was for, and how it would make me feel.

I found several that were for moderate to severe pain. I would then go back and type the word "high" next to the medicine name, and it would tell me what to feel, what to expect, how much to take, the side effects, and so on.

From age 14, I continued using Percocets, oxycodones, Xanax, fentanyl, hydrocodones...pretty much any opiate you could imagine.

I did this all the way up until to age 18, when I was arrested and sentenced for burglary.

Shortly after my release at age 21,

I discovered heroin, and began using it, initially, by snorting several times a week.

It only took about a month before I was doing what I said I would never do: I started shooting heroin on a daily basis.

My first overdose happened 2 1/2 months after I started. By chance, my parents had found me.

My heart had stopped three times on the way to the hospital before emergency surgery saved my life.

However, this did not stop my addiction.

I overdosed three more times and needed hospitalization for each of them.

After the third overdose, I thought I was ready for help. I went to an inpatient treatment and to a halfway house.

While at the halfway house, I started using heroin again and overdosed for the fourth and final time.

In the throes of my addiction, my parents kept my disease a secret to only my immediate family.

My parents and sisters felt afraid, ashamed, embarrassed, and most of all, helpless. Often they lied or covered for me with others, with my job,

with other things that I could never meet.

Meanwhile, I was so overwhelmed with my disease, I could see no possible way out. There were days when I just didn't really care about living anymore. I was so terrified of running out of money and not being able to buy the next bag, and scared to death of going into withdrawal.

My life was constant turmoil. I felt as if I was just surviving, like I wasn't even alive. I couldn't see any possible way out.

But thank God for that fourth overdose, because without it, I wouldn't be here today.

I have suffered some severe consequences due to my addiction. I have had heart surgery, suffered from a pulmonary embolism. I now have hearing loss, with some pretty severe tinnitus, which is caused from also brain damage, and, some, you know, short-term memory loss, a little bit of long-term memory loss.

But, in spite of all the consequences of my disease, to my family and myself, my motivation to remain clean has finally overpowered my desire to get high.

Today I am nine months and three weeks clean. It is the longest period of time I have been clean

since the age of 12.

Before I ever touched a drug, I did very well in school. My grades were As and Bs.

I obtained my GED in 2009, and now I have a goal of, one day, going back to college.

And today, most of all, I have hope.

Connie told me that talking here today may help with the addiction policies in New York.

If there is anything that can be done to reduce the stigma for families and addicts, then I will be glad I did this today.

Too many people, my friends included, are dying from addiction.

Please do not judge them, and find a way to help them.

If it wasn't for what has been available to me, then I wouldn't be alive today.

[Applause.]

SENATOR LITTLE: I can't thank you enough for having the courage to come here.

And I do think that your words today will help, for people to avoid the stigmatization, and to help people, and to feel as though, you know, these problems exist, and we need to do something about it, and help them.

Thank you.

CONNIE WILLE: I've had the privilege of serving as the executive director of Champlain Valley Family Center for the past 14 years. It has been my good fortune to work with a staff and board that is passionate about the mission of the agency, absolutely committed to preventing, intervening, and treating chemical dependency, and always eager to improve their skills to serve our clients.

It is a profession that is filled with both heartbreak and miracles, and always with an abundance of hope and hard work.

With regard to the opiate/heroin crisis in Clinton County, there are three New York State OASAS-certified outpatient providers, and they are: Clinton County Addiction Services, Conifer Park, and Champlain Valley Family Center.

There is also one OASAS-certified halfway house called "Twin Oaks."

I decided to give you a picture of the increase in opiate diagnoses in this county for the past three years.

In 2011, there were 429 individuals diagnosed with an opiate disorder, and of that number,

169 were using opiates by IV-injection.

In 2012, there were 507 individuals diagnosed with an opiate disorder, and of that number, 254 were using opiates by IV-injection.

In 2013, there were 646 individuals diagnosed with an opiate disorder, and of that number, 417 were using opiates by IV-injection.

Over the past three years in Clinton County, there has been over a 40 percent increase in individuals that have a diagnoseable opiate disorder, and over a 65 percent increase that are of -- in those, that are using by IV-injection.

I want you to understand that there is a far greater pool of individuals in Clinton County that are abusing opiates, that have not sought treatment services for a variety of reasons.

At Champlain Valley Family Center, we have observed the population of opiate abusers decrease in age, whereas, it used to be an average age of late 30s, we now see the population shift to very-early to mid-20s.

In looking at the first quarter of 2014 at Champlain Valley Family Center, the trend looks worse.

In terms of a diagnoseable opiate disorder

and IV-injection, over 50 percent of the clients admitted to the CVFC outpatient clinic had a diagnosis for opiate disorder.

I am sure that the physicians can affirm, that in looking at the IV-drug use in our community, medical costs that will continue to increase are related to hep C, HIV, a variety of infections at IV sites, cardiovascular and pulmonary issues, high-risk pregnancies, and most traumatic of all is the overdoses.

This is the tip of the iceberg, as the county is experiencing an increase in the need for homeless housing, foster-care placement, arrests.

And, personally, I have met with many parents in our community who have an adolescent or young adult that is abusing opiates, and their fear and anxiety is palpable.

You heard in Jack's story about the absolute chaos that comes with the addiction.

The families of the addicts suffer terribly.

The stigma and withdrawal from opiates attached to this disease is preventing many people from seeking services.

The dilemma that faces outpatient clinics is that, with opiate addiction, we have been challenged

to move from the role of a traditional chemical-dependency counselor to crisis managers and family interventionists.

The cost for heroin has decreased and the availability has increased significantly.

I have had staff tell me that clients reported -- that clients are telling them that it is cheaper to purchase heroin than it is marijuana in our community.

In thinking about and preparing for today's meeting, I focus my attention on significant issues that Champlain Valley Family Center, like other providers, have experienced since 2009, and there are seven items I would like to bring to your attention.

I have done countless assessments on clients over the past 27 years. Not one of those clients started out with IV-drug use.

The progression is, typically, alcohol, tobacco, and marijuana.

Please consider resources for prevention services when you convene in Albany; and, please, don't make it a one-shot deal.

Ongoing, thoughtful policy would really help what we're doing in our communities.

Federal and State grants for prevention services have evaporated. CVFC has lost a total of $519,000 since 2009 for prevention services.

I'm not a researcher. I cannot tell you there is a direct cause and effect between the loss of prevention dollars and subsequent prevention services, and the increase in opiate addiction.

I personally believe that there is.

CVFC had obtained grant dollars to provide services to the Clinton County Jail. Those services included assessments, group sessions, and referral services. Individuals that participated in the programming all left the jail with an appointment at an outpatient clinic or a bed in a rehab.

The grant that funded this programming was a line-item cut in CVFC dollars that we received from OASAS. This cut occurred in 2009, and that was a real loss, I believe, to our community.

Like other outpatient clinics, Champlain Valley Family Center is represented at all three drug courts in Clinton County.

On an average, eight hours each week of clinical-staff time is devoted to the drug courts, and there is absolutely no fiscal support for this service.

Drug courts are having a positive impact in this community, and CVFC remains committed to the process.

Growth and fiscal support of drug courts is needed.

It is common now for clients coming into Champlain Valley Family Center for treatment services to have an insurance deductible of at least $3,000.

Imagine working for minimum wage in Clinton County, needing treatment, and learning that your insurance company will not pay for treatment until you have paid $3,000 out-of-pocket for medical and/or treatment services.

Quite frankly, the amount might just as well be $100,000.

Since 2009, there has been no COLA for our field in the New York State budget.

What that means to a not-for-profit is absolutely no salary increases. This, of course, results in staff turnover, with the vast majority of the staff taking jobs with the State of New York; primarily, prisons and colleges.

And that's a loss to our field.

Understanding what tolerance and withdrawal

from opiates feels like is critical to understanding the addiction.

I had a client one time explain his withdrawal to me, like this:

"Connie, imagine the worst flu that you ever had in your entire life, multiply that times 100, and also know that even the marrow in your bones hurt."

People regularly come into Champlain Valley Family Center in acute withdrawal.

Insurance companies will not pay for inpatient detox services, as there is no medical necessity. This perpetuates the ongoing use of opiates, as the addict cannot be safely and humanely detoxified.

An inpatient or an ambulatory detox is greatly needed in this county, but who can take the financial risk knowing that the service will not be reimbursed?

And, regularly, we send people to inpatient, and watch them back into our community within 7 to 10 days.

It's just not long enough.

Many of those same folks that we're sending to inpatient are still coming back and testing dirty

after an inpatient stay.

They need more time.

Early in this discussion I mentioned the increase in homelessness.

Additional resources for housing and housing staff, including recovery coaches, is essential to helping people feel safe, move forward in their recovery, and, quite simply, have an address that their name is attached to.

I'm a pragmatic realist, and know that there is a finite amount of money in the state coffers; however, I implore you to consider what is happening in this county, and in New York State, in your policy and budgeting sessions.

Please remember that young people are dying out here and families are being torn apart.

I want to sincerely thank you for coming to Clinton County and listening to our experiences, our concerns and suggestions, related to this growing epidemic.

Thank you.

SENATOR LITTLE: Thank you.

SENATOR BOYLE: Thank you very much, Connie.

[Applause.]

SENATOR BOYLE: I would say, Jack and Shawn,

if we get one thing out of this, besides legislation, to change the stigma in New York State is something I would like to see, so, six months from now, if a parent talks to a friend and says, "My son or daughter is addicted to" heroin or an opiate, they're going to have the same reaction, or, if someone has say, "I'm an addict," they have the same reaction to say, I have cancer, or, a cardiac problem.

It is a disease, and New Yorkers need to understand that. And I think they will very shortly.

[Applause.]

SENATOR LITTLE: Dr. John Schenkel, who is with the Clinton County Addiction Treatment Services.

Thank you, Doctor.

DR. JOHN SCHENKEL: Hello, and I'd like to thank both of you for being here, and, in anticipation of the work you're going to need to do, because it's not a small amount of work to change things, is it?

I'm going -- we're out of time, really, so I'm going to really cut my dissertation very short.

I would just like to mention that, there's

been a lot of discussion over gateway drugs. And I don't think people understand how important sugar happens to be in that. Most children are solidly addicted to a drug before they ever try alcohol or cigarettes.

I don't know what can be done about that, but, I just think people's thinking needs to be cleared up.

I also think that the age, as was mentioned before, of addicts has gone down considerably, and that's because pain pills have been so available.

I've had clients whose very first drug of abuse was OPANA, in the seventh grade. Not cigarettes, not alcohol; OPANA.

And, so, we have a lot of younger addicts who have started in middle school and high school.

And, it used to be that addicts were older, and you could sort people out.

People who have had problems, early problems with mothering, would be very attracted to opiates.

Now it's not like that, because, at the age of middle school and high school, these kids don't believe that anything could possibly overpower their will.

They will try it, they will get into it, even

if they think they know the consequences.

It's very sad.

But, there is also an older population of addicts.

I would guess, about 40 percent of the people presenting for treatment for addiction became addicted being treated for pain. And, we can treat their addiction, and buprenorphine is actually a very good drug for treating pain.

The elephant in the doctor's office happens to be the fact that opiates are very, very good at treating acute pain. They actually make chronic pain worse. That is a process called "hyperalgesia."

Buprenorphine is the only drug I know that can treat pain without inducing hyperalgesia, but, when we discharge people from a treatment program who are in pain and in need of pain relief, they may be on, by that time, a fairly low dose of buprenorphine. Like, 8 milligrams is usually enough to cover pain once the hyperalgesia is gone, but there are no physicians in the community who are willing to prescribe buprenorphine to treat pain.

And this is a direct result of the DEA.

And, I'm going to skip a lot of the other

stuff I have here, and get to what I think you could do. Okay?

SENATOR LITTLE: And you could give us a copy of your remarks when you leave, too.

DR. JOHN SCHENKEL: Okay, I can do that.

I just typed these up last night.

SENATOR LITTLE: Oh, that's all right, but we'd be glad to hear your ideas.

DR. JOHN SCHENKEL: I don't know what can be done about insurance companies, but insurance companies are, basically, calling all the shots; not treatment agencies.

Insurance companies decide what I can prescribe and what I cannot prescribe.

Insurance companies decide whether somebody can go into rehab or detox, and it's usually "no."

But, agency burnout is a big problem. All agencies in the community are simply overwhelmed.

Just, for example: Just the facilities for supervised visitation for children who have been taken from their parents because their parents are using, there's a three-month waiting list.

Now, what do you think that does to the kids?

It's everywhere.

And, of course, you know, you can always say,

"Well, you know, throw more money at it," but, there's no money to throw at anything, these days.

The counselor at Clinton County Addiction Services, who runs the buprenorphine group, has -- follows 85 clients.

Now, 50 percent of a clinician's time is now taken up with paperwork. This is due to two things:

Bureaucrats who are constantly requiring more and more paperwork, because they equate paperwork with treatment.

And, actually, everything -- every requirement that is placed on the system for more or better paperwork actually decreases the amount of time spent with patients.

When I started as a physician back in the '70s, I think we spent 20 percent of our time recording what we did.

It's now 50 percent.

Computers have actually increased the amount of time it takes to do the paperwork, by at least 50 percent.

Computers, electronic medical records, are very time-consuming.

The electronic prescriptions have been sold with the promise that they're going to reduce

medication errors.

They have actually increased medication errors by at least a factor of 20. And this is because these programs are written by people who know nothing about the processes that these programs are supposed to be organizing.

Please, get the bureaucrats off our back.

SENATOR LITTLE: Okay.

[Laughter.]

SENATOR LITTLE: Something we've been trying to do in a lot of areas, actually.

[Laughter.]

DR. JOHN SCHENKEL: And I think I'll leave it at that.

SENATOR LITTLE: Thank you very much for being here today.

[Applause.]

SENATOR LITTLE: Our last speaker today is Peter Bacel, counselor, Friends of Recovery New York.

PETER BACEL: I'm a counselor at [unintelligible] House [unintelligible] in Syracuse. I work in their detox program, but I was in the methadone program for seven years. I've been in their detox for the last year.

But I came here as a Friends of Recovery.

If you haven't heard of them, we promote recovery coaching.

And I know Phil probably knows Richard Buckman from Long Island. He's one of our board members. I'm a board member from the Syracuse area.

There's Bill Bowman from Watertown, and he has the whole North Country.

We could use somebody, probably -- I could have thought, you know, him as North Country, but when I got to Watertown, I was still three hours from Plattsburgh.

So, you know.

[Laughter.]

SENATOR LITTLE: Big area. And I'll attest to that.

PETER BACEL: And I did -- I'll leave these here. These are some brochures on For New York.

And, I'm also on the advisory board for Hope Connections. That's a recovery-coach facility in Syracuse that was funded by the Office of Mental Health, through a grant.

And, I'm also a person in long-term recovery.

I know we've run out of time.

I wanted to talk about, to me, I consider "north," when I worked in the methadone clinic in Syracuse, we have patients that come from Watertown, and that's quite a few.

And, I'll just try to shorten this.

I had a couple that came in from there.

Well, I saw her for -- she was with our clinic maybe three times, and she had -- oh, nine months was her longest sobriety with me. And, she wasn't with our clinic, but, she overdosed.

But at the time, I had her significant other, and I helped him get through that.

But, there's a good part to this story, I was thinking of this couple from up north, because, she overdosed.

But, he has tapered off methadone, and now is being sustained on Suboxone. And, you know, he's employed, four years later, you know, living a productive life. But, he travels to Syracuse for Suboxone.

And I know there aren't enough facilities up north. There just aren't enough facilities up here.

And I think that, I was hired to treat her, living, you know, an hour away, that if there, you know, had been more in her area, might have been a

different outcome.

And there's also this Senate Bill 4623.

I guess it's -- we'd like it moved to the Insurance Committee agenda for a vote.

SENATOR BOYLE: Is that the Hannon bill?

PETER BACEL: Richard Buckman told me to tell you about it.

SENATOR BOYLE: I'm not very good at numbers, but I'll look it up.

PETER BACEL: Yeah, it's the one that's going to put treatment in the hands of the doctors instead of the insurance companies.

SENATOR BOYLE: Yeah, that's Senator Hannon's bill I was referring, yeah.

PETER BACEL: Yeah.

And, so, I know he's been working on it for a couple of years.

And that's another thing: This For New York, we've been working on legislation, and this is an important bill. Everybody's been talking about it, really, here.

And, I had another testimony. I'll just skip through it. I'll leave a copy with you.

SENATOR LITTLE: Thank you.

PETER BACEL: But, basically, this was

somebody who the insurance company denied treatment I had recently in our detox.

And the punchline really is: He never had treatment, but I had to release him to outpatient, and he's an officer that carries a firearm.

And, Sandra Manell [ph.], she had another similar story, of somebody who never had treatment, and she had to release them to, you know, outpatient. And, he's a school bus driver.

You know, and these are people we clearly feel needed, you know, at least a 28-day program.

And I was thinking, too, when I came out:

I went by St. Joe's. And in the last year, I got one female in there, I think, to their 90-day program.

But, we need more 90-day programs; not 30-day programs.

Like, St. Joe's is a very good facility in Saranac. I know it's mostly alcoholics that are referred there.

But, a lot of times, 30 days isn't long enough.

And, lastly, my management at work wanted me to talk about Zohydro, if you could keep it out of New York.

It's a new hydrocodone that's been approved by the FDA, that is probably coming, but it's five times stronger than what's on the market now. It's time-released, but it's abusable.

It's not like -- they were talking about, it's abusable, it's more addictive. And, it's just going to create problems, we feel. I think it's going to outweigh it's benefits.

But, yeah, I'll leave these here.

And if there's anybody from this area that would like to join For New York, we would be glad to have you.

SENATOR LITTLE: Thank you.

And we're glad you got to appreciate the size of the North Country, and the need for more facilities; so, it's one more voice joining us and saying this. But it's very true.

And we appreciate you coming from Syracuse, so...

SENATOR BOYLE: And I agree with you on Zohydro, it's very dangerous.

The FDA has approved this, despite the fact their own advisory board voted 9-to-2 against allowing it.

And I think this is an issue that's going to

be ongoing in the coming months.

Thank you for your testimony.

[Applause.]

SENATOR LITTLE: You know, it's a testament to the people that we've had, and the information that has been given here, that so many of you have been able to stay. And it's only since I started noticing, about twenty after twelve, that people had to leave.

So, that really said a lot about it: that were you willing to stay and listen to everyone, even after your own presentations.

We are running late.

If there's anybody that wanted to make a very quick and brief comment, something that we could talk to you about later, or do if you wanted to make any kind of a statement, we would let do you that.

Quickly.

AUDIENCE MEMBER: My name is --

SENATOR LITTLE: You can use the microphone if you want.

AUDIENCE MEMBER: And if I may impose five more minutes of your time, I would like read a prepared statement.

I am a mother who seeks assistance for my

20-year-old son, my only child, who has fallen into the tragedy of heroin addiction existing in our community, state, and nation.

November 28th, our family's nightmare began with our fears and concern over our son's life. I suspected he may be using drugs.

December 16th, my worst fears were confirmed, as I observed the signs and symptoms of my son's substance abuse.

December 17th, fear, frustration, pure chaos, now existed in our home.

Immediately, we educated ourselves regarding substance abuse, and sought the advice of local law enforcement.

After many desperate visits with our son, to communicate our concerns and offer our support, he refused to listen, as well as accept the support of his family.

December 26th, upon arriving at my son's apartment, to bring him food items, I entered the apartment and witnessed my son sleeping on the couch.

Unaware that I was there, I observed his arms for the first time. I awoke him. When I left that day, he told me he would never speak to me again.

Five long days passed before I heard from my son.

January 2nd through January 20th, communication did begin with our son.

He asked us to pick him up several times from his apartment, and also asked for money, as he was unemployed at this time.

We provided transportation and money to him, realizing that he may be using the money for drugs.

January 21st, our son came to us and asked for help. He confirmed even more of our worst nightmare and fears, and requested that we bring him to Canton-Potsdam detox.

I drove him immediately towards this facility.

He informed me that, over the past month, he had tried on his own to seek help and assistance from this addiction that he knew was spiraling out of control.

Unable to find the help he knew he needed, he came to us.

At Canton-Potsdam detox, as I sat with my son during the intake process, my heart broke again, listening to him reveal to a nurse this drug-addiction path that he had taken.

While I thought my prayers had been answered, the nurse then informed us that they could not help him, as, they did not meet medical necessity; therefore, the beds were full.

We left the facility.

My son, now convinced that he did not have a problem because he's not a good enough drug addict.

My husband and I, much determination to seek the assistance and treatment that our son desperately needs has been quite challenging, and confusing to say the least.

Our quest for assistance has included:

Many phone calls to many of these agencies that are here today.

Many local professionals. Canton-Potsdam detox, and Conifer Park in Plattsburgh, provided conflicting available treatment information.

We have excellent medical insurance that covers, are you ready, 100 percent.

I have a paper: Substance-abuse treatment, only if our son is deemed medically necessary.

This criteria was not explained to us until we continuously, continuously, asked for the definition of "medically necessary."

During a February snowstorm, we drove to

Conifer Park detox, as an admission counselor told us to come down to this facility.

After waiting an hour in the waiting room, our son was called for an evaluation.

The first question from staff was: How will you be paying for this treatment?

Costs were explained to our son, and he was back out in less than five minutes.

I intervened, and explained he was covered under my insurance.

The evaluation then was conducted by an admissions nurse who provided different information than the admissions counselor.

Again, our son was not deemed a medical necessity.

During our drive back home in the snowstorm, anger, resentment, fear, and frustration were the feelings we experienced, as it seemed that the professionals in which we sought treatment from for our son were willing to let his life slip through the cracks.

We will not and cannot let this happen.

Continuing to not know how to get the treatment necessary to save our son's life, and after more advice from law enforcement, we made a

heartbreaking and toughest decision we had ever had to make: We had our son charged with criminal possession of a forged instrument third degree, a felony that even drug dealers don't even get felonies, and petty larceny.

We knew he had stolen a personal check and cashed it for $120 earlier in the year. Minimal, considering the large amount of money that we had already given him.

This would get him into what I determined to be protective custody, and our hope that a judge would order treatment for his drug addiction.

On February 7, 2014, Canton-Potsdam detox informed us that they would have a bed available that day, and our son needed to confirm that he wanted it.

But it was too late.

State Police were in the process of picking him up for these charges, and as they did, I was speaking with him on the phone, telling him the bed was available, three weeks later.

Our son was taken to Clinton County Jail, and then released on pretrial release.

Our son violated his pretrial release on purpose.

When his lawyer informed him there was a bench warrant for his arrest, he turned himself into authorities the same day.

In his mind, jail was a safety net for the time being, and he began to believe that the treatment he wanted could be attained through this pathway.

He is set to appear in front of a judge next month, for felony charges, for $120 check, keep that in mind.

Unfortunately, sadly, without our support, he is doomed to fall through the cracks, and who knows what would happen to him and others around him.

Unable to accept this confusing and daunting system and path that we seek for treatment, and determined to save our son's life, we are here to speak on his behalf.

There are major holes in our system for those who seek treatment to save their lives, and we do believe that it starts with our getting the word out to you, our elected officials, and as many people as we can speak to.

Finally, because, how do you expect an addict to receive the help and treatment they painfully seek when those doors are opened slightly, then

closed more often than not, time and time again?

How can two educated parents, and all the parents who are experiencing this nightmare of their children's addictions, get accurate advice and treatment doors opened, and keep them opened, to save a life?

Please help me.

Thank you.

[Applause.]

SENATOR LITTLE: Thank you.

And it is -- that, too, is an eye-opener.

And I think that we've learned a lot here of things that we need to be doing in the Legislature.

And, certainly, I give a lot of credit to Senator Boyle, who chairs the Alcohol and Drug Committee, and this Task Force, for taking it on, and realizing.

It somewhat reminds me of a few -- several years ago, when we spent years getting mental-health parity in our insurance.

And I think that we are seeing the same thing happening here, as we have a crises in this drug addiction, and the accessibility is mind-boggling, just how accessible it is, and learning that today, that we have to continue working with the insurance

companies, working so that there isn't a stigma.

And, very definitely, doing something about this "medical necessity."

Waiting until you're almost so far into it that it's going to be too late before anything gets done, is not acceptable.

And there's something that we have to do, as we go forward.

So, thank you to so many of you for being here today, for testifying.

Shawn and Jack who did, and you as well, really appreciate it. You put a face on the issue, and you make it very, very clear to us that we need to do something.

And, we need more services here in the North Country.

Thank you very much.

SENATOR BOYLE: Thank you, Senator Little, for hosting this, and the Clinton County government.

And thank you, everyone, for testifying, and the audience members.

I think the most recent testimony and -- reminded me of one we had on Long Island, where one of our drug counselors, a preeminent one on Long Island, told us, in front of all the

district attorneys and the prosecutors down there, that they actually advise parents in your situation on how to get their child arrested.

AUDIENCE MEMBER: It is exactly what happened.

We have many friends in law enforcement. My husband and I are very prominent people in this community. And, I work for a local school.

So, yes, unfortunately, knowing exactly what we were willing to do to save a life, who wasn't destroyed yet, who hasn't walked that horrible path.

And I sat in those waitings rooms, my husband and I.

And, St. Joseph's I think would have been the perfect fit for my child, but one of the stipulations there, was that you needed to be clean for 30 years -- or, not 30 years -- 30 days prior.

That's very difficult for someone who is an educated teenager, who had the world at his hands, in his hands. An accelerated student.

We're not talking -- these are very bright individuals.

And I commend both of these young men for standing here today.

I pray one day my son is standing here doing

this, advocating for people.

SENATOR BOYLE: There's no question that the system is broken.

And that's why, with the leadership of Senator Little and others in Albany, I promise you that we're going to change this system for the better to protect our children's lives.

Thank you so much for coming today.

[Applause.]

(Whereupon, at approximately 12:52 p.m., the forum held before the New York State Joint Task Force on Heroin and Opioid Addiction concluded, and adjourned.)

---oOo---