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

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PUBLIC FORUM: JEFFERSON COUNTY

PANEL DISCUSSION ON HEROIN EPIDEMIC IN WATERTOWN AND SURROUNDING COUNTIES

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Dulles State Office Building, 11th Floor
317 Washington St.
Watertown, New York 13601

April 25, 2014
1:00 p.m. to 3:00 p.m.

PRESENT:

Senator Patricia Ritchie, Task Force Forum Moderator
Member of the Joint Task Force

Assemblyman Will Barclay

Assemblyman Kenneth Blankenbush

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SENATOR RITCHIE: I want to welcome you to this forum. It's a bipartisan Senate Task Force on Heroin and Opioid Addiction.

You need only to look at the daily newspaper to understand the deep interest in this issue and the real cause for concern.

In the State Senate, we are very interested in understanding the full scope of the problem and the full range of ideas to help solve it.

Today's forum is one of thirteen across New York State, and two being held in the North Country.

There was so much interest, not only is one being held in Plattsburgh, the one that covers Jefferson, St. Lawrence, and Oswego county is being held today in Watertown.

If there's one thing we know already, the problem has no geographic, regional, or economic boundaries. It's a problem upstate and downstate, urban and rural, affecting children and families.

Wealthy, middle-class, and poor families are dealing with this right now. Heroin is touching every single corner of our state. We must find solutions that apply equally across the spectrum.

Before we hear from experts, which will

include a cross-section of law enforcement, treatment, and, also, from firsthand accounts whose lives have been affected by this, I want to introduce and thank my fellow panelists, Assemblyman Will Barclay and Assemblyman Ken Blankenbush, for being here today.

We are here to facilitate the conversation, and to get as much information as we can, on how the problem is impacting our families and our communities.

We will hear a lot of numbers and statistics today, but for today's discussion, I want you to remember four:

"10"; that's the going rate for a single hit of heroin in some of our communities;

"23"; that's the percentage of first-time users who will become addicted to this drug, according to the State Health Department;

"87"; that's the number of heroin overdoses reported last year to the Poison Control Center in Syracuse which covers our region. That's nearly 8 times the amount from just 5 years ago;

And, "414"; that's the number of hits that police right here in Watertown seized from one alleged drug dealer earlier this month.

And there's one other number that's very important, and that's the number on the Poison Control Center poster up here. That's the number that every household should have next to their telephone.

And, before we start the program, I want to turn it over to the Assemblymen for their comments.

Certainly appreciate them both being here today.

Assemblyman Barclay.

ASSEMBLYMAN BARCLAY: Thank you, Senator, and good afternoon, everyone.

I want to thank the Senator for holding this hearing, and inviting me to attend.

I think what Senator Ritchie mentioned about this being kind of across, whether it's social status, whether it's geographic area, or whatever else, it really is a problem, and we're seeing it in a lot of rural areas, unfortunately.

And, you know, it's unfortunate, because I think sometimes we think we get some drug problem under control, another one seems to pop up, whether it's with, you know, back in the '90s, or '80s, we had the crack cocaine epidemic. And then we moved into -- lately, we've had a lot of synthetic drugs.

And now, certainly, this heroin is getting on the radar screen, which is tragic, obviously.

So, I think this hearing couldn't be anymore timely, and I'm thrilled to be here, and I look forward to hearing everybody's testimony.

SENATOR RITCHIE: Thank you.

ASSEMBLYMAN BLANKENBUSH: And, again, thank you for showing up, everyone, today.

And, again, thank you to the Senator for having this hearing here today, and inviting me.

As the Senator and the Assemblyman have said, this is an important issue. And, it's -- I'm here today to listen to you, to get as many of your facts and stories that we can get together today.

And, so, instead of me talking any further, I'm going to just toss it to the Senator and we can get going, so we can hear from you.

Thank you.

SENATOR RITCHIE: We'll just start with a few ground rules.

We certainly appreciate the speakers who are here today.

If you could keep your testimony to within five minutes. We have a number of speakers who have asked to testify.

We also had numerous calls from people who also wanted to testify.

If they want to submit written testimony, or, if we have time at the end, we can see if that's a possibility.

Sarah Compo [ph.] will be the timekeeper, who will try to keep us on track.

We have a limited amount of time, from one to three, for the hearing.

And with that, we'll get started.

Our first speaker is from Jefferson County Public Health, and a Watertown City Councilman, Steve Jennings.

STEVE JENNINGS: Good afternoon, Senator, and Assemblymen. Thank you.

I want to thank Senator Ritchie and the members of the bipartisan Senate Task Force for working to address heroin and opioid addiction in our state, and for investing the time to hear from your constituents about a plague that is slowly decimating our families and communities.

I, of course, have lots of statistics, so, get your pen out, Ken.

[Laughter.]

STEVE JENNINGS: The opioid abuse and

overdose epidemic has reached crisis proportions in recent years.

A 2012 federal survey on drug use and health reported that the number of people who said they used heroin in the past 12 months rose 79 percent, from 373,000 people in 2007, to 669,000 people in 2012.

The agency also reported that the number of people dependent on heroin rose 106 percent, from 179,000 people in 2007, to 369,000 people in 2011.

It is evident that heroin is highly addictive.

The National Institutes of Health estimate that approximately 23 percent of individuals who use heroin become dependent.

The U.S. Centers for Disease Control report that, in 2010, opioids, including both prescription pain killers and heroin, were responsible for nearly 20,000 overdose deaths in this country.

And while prescription pain killers continue to account for the majority of opioid overdoses, deaths from heroin overdose increased by 45 percent between 2006 and 2010, fueling concern nationwide that progress in reducing prescription pain-killer misuse is being offset by a dramatic rise in heroin

use, and it's attendant social and health consequences, including addiction, hepatitis C, and overdose.

Active abuse of prescription opioids and heroin is alive and well in Jefferson County, and as a result, we are clearly seeing increased hepatitis C diagnosis, overdose, and overdose deaths.

I want to share with you the impact of what we're experiencing.

Hepatitis C, our cases have significantly risen in Jefferson County since 2001.

Hepatitis C is a contagious liver disease that ranges in severity, from a mild illness lasting a few weeks, to a serious, chronic lifelong illness that attacks the liver.

Most people contract chronic hepatitis C.

Unlike hepatitis A and B, there's no vaccine to prevent hepatitis C.

Jefferson has seen its chronic hepatitis C cases jump from 1 in 2001, to 59 in 2007, to 67 in 2013.

Jefferson's rise is not out of line with what's occurring statewide and nationally.

The increase can be attributed to more

testing, which we in public health are pushing, and it's a good thing, but it's also a result of increased high-risk injection-drug use: the sharing of needles and other drug paraphernalia, and the resulting blood-borne transmission of virus.

Treating and managing individuals with chronic hepatitis C is complex and expensive.

Many people currently with hepatitis C choose to forego the care that they need due to lack of access to an infectious-disease specialist and the cost for treatment, but this only serves to exacerbate disease, and dramatically increase the cost, and right at the point where they face required medical intervention to live.

On the overdose front, there is significant activity in our county.

Consider the 2-year time period, 2011 through 2012:

Fire and emergency management calls indicate 698 overdose calls;

301 people visited the Samaritan Medical Center Emergency Department, with 30 percent of these people presenting with self-inflicted injury related to overdose or suicide attempt, and 25 percent of these individuals presenting with

opioid overdose;

There were 199 total inpatient hospital stays at Samaritan due to drug overdoses, with 74 percent of these individuals admitted with self-inflicted injury related to overdose or suicide attempt, and 38 percent of these stays specifically due to opioid overdose.

[Microphone not working at speaker podium.]

STEVE JENNINGS: Overdose deaths in Jefferson County, particularly those related to opioids, are on the rise. Overdose deaths spiked 80 percent between 2010 and 2011, and have remained at the highest levels we've ever experienced since.

Of the 48 overdose deaths from 2011 to 2013, 79 percent had lethal toxicology attributed to opiates, and 50 percent of these were specifically due to heroin or morphine overdose.

Morphine is a breakdown product of heroin.

Since 2011, drug overdoses have become the leading cause of injury death in Jefferson County.

As a City Councilman, the drug and heroin loose in my city, and its impact on neighborhoods, children, and families, is alarming and deeply concerning.

Of all Samaritan emergency department and

engagement admissions mentioned, 48 percent were residents of the city. Of all the overdose deaths, 44 percent were residents who lived in the city.

Though the total county population of 118,000, only 22 percent are city residents.

These program data, compared against population concentration of the city versus the rest of county, underscored that drug use and all its associated activities [inaudible] is most prevalent in the city of Watertown.

And, so, a combination of short-term and long-term approaches are needed to combat the drug problem in our communities.

And as I alluded to previously, there is great concern of the tightening up of prescription-drug ordering and dispensing, which we support, is having the unintended consequence of increasing heroin use and overdose for those opioid-addicted.

Emerging overdose-education and naloxone-distribution programs are working, but currently rely on limited funding and loose policy amid a growing need.

Tighter policy and greater availability of target funds now, through public health and

prevention, emergency medical service, addiction treatment and recovery services, would hasten the expansion of these programs to meet growing need and demand.

Long-term or legislative commitment to invest and maintain support to the opioid-overdose fatality prevention efforts within the State Department of Health, county health, and mental-health departments and community-based organizations, strengthen the ability to deliver ongoing overdose recognition and intervention training and education, and expand access to rescue medication and other evidenced-based strategies, and needed to control the current crisis and mitigate it for our future.

To conclude:

There's much to be done and no time to lose in the battle against opioid overdose.

We need long-range efforts to address the underlying causes and factors which led to this initial rise in prescription-opioid misuse and the resultant growth in heroin use, together with immediate action to avoid additional deaths and tragedies in the short term.

Please feel free to contact me if you need more information, and I thank you for your time and

attention.

SENATOR RITCHIE: Before you go --

[Applause.]

SENATOR RITCHIE: -- Steve, do you mind taking a couple of questions before you go?

You mentioned rescue medication, and Narcan has been something that we keep hearing over and over again.

Can you give us your opinion on Narcan?

STEVE JENNINGS: We certainly are supportive of expanding its access and availability in the community. We worked, most previously, on getting it on our basic levels -- basic life-support squad levels. The advanced life support squads are carrying [inaudible].

But -- so that policy was enacted recently.

There's a great push to have law enforcement carry it, and I think the Attorney General recently sponsored something in that regard.

I think the policy is loose, and I think we need something tighter and broader statewide on naloxone.

And, there's great controversy on who should administer it. Some agencies are very much for it; others are not.

So, working on that front I think would be a benefit.

SENATOR RITCHIE: Do you have any questions?

ASSEMBLYMAN BARCLAY: I do.

What were the -- you gave us the last statistics, and, I'm sorry, I missed.

I think I heard that all -- over all the overdoses you had, 25 percent are related to opioids, or -- I guess --

STEVE JENNINGS: And heroin.

ASSEMBLYMAN BARCLAY: -- and heroin.

So what does that equal in actual numbers?

STEVE JENNINGS: In the numbers?

ASSEMBLYMAN BARCLAY: Yeah.

STEVE JENNINGS: So, between 2011 and 2013, so we have a total of 48 overdose deaths.

38 had a lethal toxicology attributed to opiates;

And, 50 percent were specific to heroin and morphine. Of that 50 percent, 6 were heroin, 13 were morphine.

ASSEMBLYMAN BLANKENBUSH: And then -- I'm sorry, I should know what you do, but, I know you're on the City Council.

But are you also involved in the hospital?

Or --

STEVE JENNINGS: I'm a public-health planner with the County Health.

ASSEMBLYMAN BARCLAY: I apologize. I should know that. I'm sorry.

So -- I mean, the general addiction of these things is because people were on prescription drugs, and then moving off of prescription drugs because they can no longer get them, presumably? Is that the case, where they're looking for an alternative?

STEVE JENNINGS: Or it's a combination.

ASSEMBLYMAN BARCLAY: Or a combination.

STEVE JENNINGS: People have, we call it [inaudible]. They have many drugs in their systems when they expire. It's often a combination.

ASSEMBLYMAN BARCLAY: And what's responsible for the cheaper price for heroin now? Do you know?

STEVE JENNINGS: I don't know.

ASSEMBLYMAN BARCLAY: Usually, I would think a lot of demand out there would cause the price to go up.

STEVE JENNINGS: I'm sure law enforcement will talk about [inaudible].

They're [inaudible] selling huge quantities, I'll bet.

I'm glad we're catching them, but we're probably not catching all of them, though.

ASSEMBLYMAN BARCLAY: Thanks.

ASSEMBLYMAN BLANKENBUSH: Steve, is there an age bracket that is more -- you know, is it a middle --

STEVE JENNINGS: It tends to be more middle.

People have a perception that it's young people, really young people.

It tends to be high 20s through young 50s, I would say, that's predominantly.

If you're asking about deaths, that's what we're seeing in deaths.

I think addiction is probably all over the place.

SENATOR RITCHIE: Thank you, Steve.

STEVE JENNINGS: Thank you, Senator.

SENATOR RITCHIE: Next we'll have Nichole Smith from Jefferson County.

[Microphone not working at speaker podium.]

NICHOLE SMITH: Hi, good afternoon.

My name is Nichole. I'm really glad to be here. I'm a little nervous.

I came just to share a little bit.

I've been in recovery since March 4th of

2012.

Since that time, I am now enrolled in a [inaudible] program at JCC. I'm working. I'm a single mom.

I have been able to restore relationships with family. I practice yoga. I have a sponsor.

And, there's just so many things great about recovery that I wish more people could experience.

I would like to share everything that I have experienced, with others, to try to help them, and just to speak to someone on the same level and understanding.

I did have about 10 years where I was addicted to cocaine and prescription drugs.

My son lost his father, at 31 years old, because of addiction.

I've lost several friends as well.

I lost my son for approximately a year. I have full custody back, raising him on my own.

As I said, going to school, working, and just enjoying life, positively, in recovery.

And, I'm very grateful.

My faith has been a big part of it as well.

Everything's different for everybody, but that's been huge for me.

So, as I said, I'm just very grateful to be here, so, thank you very much.

SENATOR RITCHIE: I want to say how much we appreciate you coming here and sharing that with us.

And, if you're comfortable answering a couple of questions?

NICHOLE SMITH: Sure, that's fine.

SENATOR RITCHIE: Can you tell me how you first got, I guess, the opportunity, or what made you, the first time, try whatever you started with?

Well, just so other people can kind of know what happens, that -- I think, pushes somebody the very first time to try it.

NICHOLE SMITH: I think a lot of it was due to peer pressure. That's always a big issue.

I had unresolved issues dating back to childhood that, you know, I never handled properly.

Addiction is a mask. You know, drug use and addiction is a mask. Unresolved issues, feelings, things that never were addressed properly.

I have been in counseling, you know, things like that.

I was on antidepressants for years upon years. I no longer need to take them today.

So that's something that, you know, says

a lot about where I'm at in life, and how positively things are going.

SENATOR RITCHIE: And what was the turning point to get you to the point that you were seeking help?

NICHOLE SMITH: Well, it took me a few times. Most people it does. It doesn't usually happen the first time, unfortunately.

I would say that the major turning point was CPS becoming involved, with my son, and, you know, saying, "You can't see your son anymore."

That was my bottom.

Everybody's is different.

Sometimes that's not even enough for certain people, you know.

But that was for me, that was it.

SENATOR RITCHIE: And was it easy for you to find services when you got to that point?

NICHOLE SMITH: Yes, I think so.

If you look, it's there, you know, if you really want it.

That's what it boils down to: it's there, it's available.

SENATOR RITCHIE: Thank you.

ASSEMBLYMAN BARCLAY: Thanks for testifying.

NICHOLE SMITH: You're welcome.

ASSEMBLYMAN BARCLAY: I think it's going to be very helpful for us.

But -- and just to follow up a little bit on Senator Ritchie's comments about, yeah, I guess we're trying to hear testimony, what we can do in state government to help people like you, and others, who have been addicted.

And maybe you don't know, but, can you explain what kind of roadblocks you might have had that we could change, or take out, that would make recovery easier for people?

Obviously, funding is always a big issue.

NICHOLE SMITH: Yeah, that's what I was going to say, plus, insurance issues.

I know that, financially, I've heard people say they can't afford, you know, to get help that they need.

I think maybe any kind of way that -- to put out there, you know, that there is help, any kind of -- just so it's more available for people to see, I think, you know.

ASSEMBLYMAN BLANKENBUSH: Do you think -- I'm sorry to interrupt you.

Do you think education would have been

beneficial to you, like, at an earlier age?

I mean, do you feel like that -- I know these are hard questions -- and maybe it would or maybe it wouldn't, it's hard to say, but, would you think that's --

NICHOLE SMITH: A little bit, maybe, yeah.

Yeah, a little bit more in the school system, a little bit more education, because, really, people don't understand what it is to be addicted.

They don't understand there's a lot of discrimination against addicts. People have to -- decided that they don't change.

That's not true.

You know, just, yeah, I think a little bit more education.

ASSEMBLYMAN BARCLAY: Thank you.

ASSEMBLYMAN BLANKENBUSH: Nichole, just one question.

NICHOLE SMITH: Sure.

ASSEMBLYMAN BLANKENBUSH: You said you were addicted to cocaine for 10 years?

NICHOLE SMITH: Uh-huh.

ASSEMBLYMAN BLANKENBUSH:

Was that the drug you -- was that your drug of choice at first?

NICHOLE SMITH: Yes, sir.

ASSEMBLYMAN BLANKENBUSH: And was that because of the cost of it, or the availability of it, or -- why -- why, one day, did you say --

NICHOLE SMITH: I kind of just started out as experimenting, which normally is the way it goes.

I think it's availability.

ASSEMBLYMAN BLANKENBUSH: Okay.

SENATOR RITCHIE: I certainly appreciate you coming here today, because your testimony, along with some of the other testimony that we're going to hear from people whose lives have been affected, I think is really what's going to help us find ways to help.

And I know when I initially saw the statistics, the one that really jumped out at me, is that almost a quarter of the people who try heroin are addicted from that point.

And, if you're a young kid and you're out with your friends, and you try it once, it could affect your life, you know, forever. And that truly was really alarming.

So, we appreciate you coming and sharing your story.

Thank you.

NICHOLE SMITH: You're very welcome.

Thank you.

[Applause.]

SENATOR RITCHIE: Next we have Jefferson County District Attorney Cindy Intschert.

DA CINDY INTSCHERT: Good afternoon.

First, I would like to express my appreciation to you, Senator Ritchie, also to you Assemblyman Blankenbush and Assemblyman Barclay, and the members of the Joint Task Force, for recognizing and addressing the havoc that is absolutely being wreaked in our communities by the onslaught of heroin, prescription drugs, and other opioids that are flooding our streets.

Based on the cross-section of representation that's here today, it's clear that this is a community-wide problem that affects the health and safety of our citizens in a myriad of ways; and as this is not a singular problem, there's no single answer.

Again, thank you for seeking out our perspectives on this issue.

Let me briefly share with you some of my observations as a prosecutor with the Jefferson County District Attorney's Office for more

than 28 years.

Although I don't have any statistics in this regard, I have to tell you that I don't recall hearing about heroin cases in my early days as a prosecutor.

Those that existed, if any, were definitely the exception, and not the rule. This general trend continued until just a few years ago.

In 2007, 3 percent of the drugs seized by the Metro Jeff Narcotics Task Force, by searches or by undercover buy, involved heroin.

In 2009, that percentage rose to 10 percent.

In 2012, 27 percent; in 2013, 38 percent; and to date, in 2014, approximately 40 percent, of the drug arrests by the task force involved heroin.

Particularly noteworthy is the fact that the cost of a bag of heroin, as you've already mentioned, Senator, is less than half of what it was just one year ago, and if that's not an indicator of supply and demand, I don't know what is.

Arrests involving prescription drugs, while nowhere near as prevalent, have also seen higher percentage numbers in recent years.

The growing prevalence of heroin addiction in Jefferson County is reflected in the defendants who

have been referred to Jefferson County's drug court since we began operating in 2002.

Drug court is designed to target and to assist those non-violent felony defendants who offend primarily due to drug and/or alcohol misuse and addiction, and for whom standard rehabilitation programs, quite frankly, haven't worked.

It's hoped that, through intensive drug treatment, mental-health treatment, and through regular and consistent court contact, these defendants can recover from their addictions, lead drug- and alcohol-free lives, and become law-abiding contributing members of our society.

The number of defendants who have participated in drug court over the last six years, for whom heroin is their drug of choice, has, on average, been double the number of heroin defendants that we saw in our early years of operation.

You've heard some, you'll hear more today, but the effects that we see from heroin and opiate addiction are absolutely devastating.

The intelligence gathered by law enforcement indicates that many addicted defendants are telling us that some of them will do anything for that next fix.

They'll steal from their parents, their grandparents, their loved ones, their friends, to get the money for that next high.

They shoplift, forge credit card receipts, and burglarize to obtain goods to sell.

Young women are prostituting themselves for the drug or for the money to buy it, and they leave their children unattended while they focus on that very next high.

Heroin waste, including used needles on the streets and in our recreation areas, is yet another public-safety concern.

As you know in our hearing here today, this is a multi-faceted problem without a single answer.

The focus on attempting to control the illegal sale of prescription drugs needs to continue. We know that many turn from pharmaceuticals to heroin because heroin is half the cost on the street, and often provides a quicker, more intense high.

From the criminal justice side, we're attempting to reduce both the supply and the demand of heroin, opiates, and all other illegal drugs.

I don't believe that there's a single elected district attorney who believes that the appropriate

answer is to simply lock up everyone who's offended because of a drug problem. Each case needs to be reviewed individually.

And while I can't speak for my colleagues, I believe that each of us looks to rehabilitate through the criminal justice system, where appropriate, while still holding people accountable for their criminal actions.

That rehabilitation can take different forms and require many different resources, including substance-abuse service providers, mental-health counseling, and when necessary and appropriate, incarceration.

Those efforts target the demand for drugs.

Our law-enforcement and prosecution community, including the drug task force, also works to reduce the drug supply.

There's been a significant relaxation of our drug laws in the last decade, and we continue to work within that framework to take drugs and dealers off the streets.

I believe, personally, however, that the available programming for repeat drug dealers, we used to call them "pushers," could be tightened up.

Perhaps more resources could be devoted to

screening out those dealers who, after conviction, work the system by claiming a non-existent drug problem; and in so doing, tie up the rehabilitation beds, the substance-abuse counselors, and the mental-health workers that are needed by the true addicts.

Again, I thank you for your interest in addressing the issues today, and I appreciate the invitation and opportunity.

SENATOR RITCHIE: Thank you.

Just a couple questions, Cindy.

Can you tell us where the local heroin seems to be coming from? Do you know?

DA CINDY INTSCHERT: I'd prefer not to get too specific, but would I say south of here, from some of the larger cities coming up north.

SENATOR RITCHIE: I know you mentioned earlier how heroin didn't seem to be a problem up until just recently.

And I know, until people started calling the office and asking for some help, whether it be law enforcement or, either, someone looking for services, in the past, when I heard of heroin use, I would immediately think it wasn't in the area and it was something that was coming from New York City.

So, it is really hard to believe that this problem is so prevalent in the three counties that I represent.

And, appreciate all that you are always doing to stay on top of everything.

And just one more question, just for my own personal knowledge: Can you just tell me what happens if you suspect someone is using heroin?

Just kind of walk me through what happens if one of your -- if an officer pulls over someone, how it ends up on your desk?

Is everyone pulled over's case referred immediately to the DA's Office? Or --

DA CINDY INTSCHERT: If someone is pulled over and they have -- the officers have probable cause to search the car, and they make an arrest, that case is referred to the District Attorney's Office.

SENATOR RITCHIE: That case is automatically referred?

DA CINDY INTSCHERT: Yes.

SENATOR RITCHIE: Okay, great.

ASSEMBLYMAN BARCLAY: Thanks for your testimony.

Just two, I guess, relatively short

questions.

How is heroin usually ingested? Is it needles, mostly, or is it -- I mean, you can smoke it too; right?

Do you know?

DA CINDY INTSCHERT: It can be smoked. It's also an injectable drug.

I think the general intelligence is that it is -- that it's injected, but it's also being made available in pill form.

ASSEMBLYMAN BARCLAY: Right.

DA CINDY INTSCHERT: Capsule form, excuse me.

ASSEMBLYMAN BARCLAY: Interesting.

And then how -- you've mentioned, maybe, stronger laws for those who deal in this drug.

Are heroin dealers unique, opposed to other type of drug dealers?

Is there a drug dealer that sells whatever you need?

Or -- what's your experience with that?

And then, I guess, specifically, you know, what kind of -- any idea of what kind of laws to strengthen, that you're looking for against heroin dealers?

DA CINDY INTSCHERT: Again, I was referencing

those cases where individuals have been convicted and they're headed to prison.

ASSEMBLYMAN BARCLAY: Right.

DA CINDY INTSCHERT: And when they have an addiction problem and there are programs available in prison, that's rehabilitation.

But those individuals that are playing the system and, quite frankly, they consider it the cost doing business: Well, I haven't used up my [unintelligible]. I haven't used my case eligibility. I haven't been to Willard yet.

ASSEMBLYMAN BARCLAY: Right.

DA CINDY INTSCHERT: That's a concern.

That's a concern for those individuals that can truly benefit from those programs.

ASSEMBLYMAN BARCLAY: Do you think that's local, or do you think those people are -- I mean -- so what I'm saying, is there a big drug dealer somewhere along that's pushing this off to maybe smaller dealers, and then how it gets up to our area is mostly abusers that also tend to be drug dealers, too?

Is that --

DA CINDY INTSCHERT: I'm sorry, with regard to the playing the system?

ASSEMBLYMAN BARCLAY: Well, yeah.

So, I mean, I would see the ones that are playing the system are either mid-level or high-level dealers.

I assume there's -- again, I'm probably saying more than I know.

I'm assuming there's dealers out there that are also addicts, and they just happen to be dealing, because they are addicts --

DA CINDY INTSCHERT: Correct.

ASSEMBLYMAN BARCLAY: -- and they have to pay for their own habit, I suppose.

DA CINDY INTSCHERT: Yes, yes.

ASSEMBLYMAN BARCLAY: I mean, is that -- I would also guess, and I don't know this, I guess [unintelligible], that's primarily the type of dealer you have, probably, in our areas, or, no? Maybe not? Or you don't know?

DA CINDY INTSCHERT: I think we see both.

ASSEMBLYMAN BARCLAY: Okay. All right.

DA CINDY INTSCHERT: I think we see both.

Thank you.

ASSEMBLYMAN BARCLAY: Thanks.

SENATOR RITCHIE: Ken?

ASSEMBLYMAN BLANKENBUSH: Yes, Cindy, you

know, in the news, nationwide, now, we're talking -- you're hearing in the news, where there are going to be some releases from prisons because of judges having mandatory sentencing on addicts that have been put in prison, and that they've been -- there's going to be some leniency.

Does -- in New York, is there mandatory sentences if you're convicted of certain drug-related crimes in the state of New York?

Or does the judge have the -- does the judge have the availability to look more at, instead of jail, putting them someplace to get help?

[Microphone not working at speaker podium.]

DA CINDY INTSCHERT: There is considerably more discretion being provided by the judges.

And, quite frankly, there are [inaudible] in the system [inaudible] who are trying to craft, you know, the appropriate disposition.

There is some mandatory sentences, and much of that was taken away, in what we refer to as the Rockefeller [inaudible.]

[Microphone now working at speaker podium.]

DA CINDY INTSCHERT: You know, again, I think it's a -- we've spoken of those individuals who deal, who prey on others. Those individuals who are

dealing in small amounts which, in turn, preys on others, but it's also done to feed an addiction.

So you've got the businessman, if you will, or businesswoman, versus, he or she that may be motivated by their drug problem.

And I think that there may -- again, it's a matter of resources, in order to -- you know, to be able to ferret out who's playing the system. It takes time, it takes trained individuals.

And I don't know if that's somewhere that the State would like to expend resources or not.

SENATOR RITCHIE: Cindy, I just have one last question to follow-up: If there was one thing that the Legislature could do, in your views, to help the situation, what would it be?

DA CINDY INTSCHERT: One thing?

[Laughter.]

SENATOR RITCHIE: Well, if you have more than one thing, that's okay, too.

DA CINDY INTSCHERT: Oh, boy.

You know, I think -- again, I think laws that permit us to target the actual dealers, and to see that they're not headed toward some of the programs that others can benefit from, and be rehabilitated, and come back out and be contributing members of

society, is great.

But in order to have those programs work, whether it's with an individual who is on probation, who has voluntarily said, "I have a problem and I need help," our service providers need money and need people.

SENATOR RITCHIE: Thank you.

DA CINDY INTSCHERT: Thank you.

[Applause.]

SENATOR RITCHIE: Next will be Mark Koester of Madison County.

MARK KOESTER: Senator, good to see you again. Assemblymen.

We met a month ago, maybe two, and we chatted briefly about this.

So I have the honor of, thus far, spending about $400,000, in 5 rehabs, for my -- one of my sons. It's been an 8-year process. It's pretty devastating to the family.

What happens is, in the beginning, you send your son off to rehab with the hope that they're going to get fixed.

That typically doesn't happen the first time around. And then -- but they do get sober, they come home, and you have all the hope in the world,

and then, some short period of time later, back they go.

And, now, you still have that same hope; it's your child. And the worst thing for a parent is to lose a child.

So you dig into your pockets, you come together as a family, and you send them back off.

Well, for me, that happened four times.

On the fourth time, what I was told by all the counselors, is that: You cannot do it again. If your child is going to die, they're going to die. So if they know that you will help them, they will continue. They will continue doing what they're doing.

So, I wasn't going to help him.

And, about 90 days ago, he overdosed, or should I say, died, four days in a row in an apartment in Utica, at which time the counselors said, "I think he's ready."

So, I did it again.

He's now in Florida. He is 90 days sober, which is great news.

He is finding it hard right now to get back into society, 'cause for 10 years, or 8 years, he's been out of society.

So, he also knows that he is $150 away from death.

All addicts know that.

If he decides, one time, to do anything, he'll be dead in a week. It's that devastating.

So one of the questions is: How did he get started?

I suspect that will be a question.

So 8 years ago, my wife of 30 years had a brain aneurysm and dropped dead in front of me, which was pretty devastating. We didn't have any warning. I didn't, and neither did my kids.

And, we live in a small town, and at that time, doctors were prescribing pain killers almost like candy, seriously.

My son had a bad back.

And in the -- and this is definitely cleaned up -- but in the receiving line in the funeral, the doctors in my town told me and all of my children, whatever we wanted to help us deal with the grief, they would help us with.

And, within two months, from my 12 1/2-year-old daughter who was taking Ambien, to my 16-year-old son who was taking Xanax, to my next son who generally stayed out of it, to my oldest son

who had a bad back and was taking pain killers, I stopped all that.

I thought I did.

But, at that time, he could get the pain killers easily. He would get two vials a month of 180, sell the 180 for 5 bucks apiece, that's how he made a living, and then do the other -- he would take the other.

So, from that time, you progress to more and more pain killers, and then you realize that heroin is way cheaper, way easier to get, and feels a whole lot better.

And that's the problem we have now.

In my little town, just last week, seven teenagers were arrested for heroin.

I'll say, less than a month prior to that, three men in their early -- late 20s were arrested for heroin.

So, I know this, that if I was going to invest in a sure thing, I would invest in a chain of rehabs.

I'm not trying to be funny, but it's very, very serious, as I see it.

And so, for me, I believe that we need to look at the laws.

If a drug dealer deals heroin, how many people is he going to kill?

I mean, this is death. Does it go to manslaughter?

I don't know, but it -- literally, you are dealing something, like guns, that will kill. There's no if, ands, or buts about it.

And, my son, like I say, was dead more than four times.

So, how do you change the laws? I don't know.

But, I remember a friend of mine went to China. And if you got caught shoplifting, they would cut your arm off.

So guess what? There wasn't a lot of shoplifting in China, in my opinion.

So, I don't know what needs to be done law-wise.

I do know that we were lucky enough to be able to send my son to good rehabilitation centers; but it was also $400,000.

Most people are not going to be able to do that.

So, government-subsidized rehabilitation centers, I think are -- I don't even know -- we

didn't really look into any, I don't know what that situation is.

I got to think our jails are going to be filling up quick, if they're not already full, because it is an epidemic.

So that's my story, and, I'm glad to be able to speak about it.

And, right now, my son is 90 days sober, so, we're on the path.

Thank you.

SENATOR RITCHIE: Well, first, I want to say thank you for testifying.

I know it must have been difficult, considering what you've gone through.

I'm glad to hear that your son is 90 days on his way to a productive life.

I know that you mentioned that it's difficult for him now.

Is that because, after someone has been, for 10 years, kind of out of the ability of getting a job or going to college, is that why it's difficult for him to get back into day-to-day activities?

Or --

MARK KOESTER: I think it's probably similar to getting out of jail. And, you get out of jail,

and all of a sudden, you're in a whole different environment.

So for 10 years you've been lying, or 7 years or 8 years you have been lying, cheating, stealing.

There was a lot of times he would just go to the stores, shoplift for enough to go to the pawn shop and get enough for that night.

The next day was the same; day in, day out.

And he had a wife and three children.

So, uhm...

Yes.

Sorry. I just felt some emotion, and I actually lost my train of thought.

SENATOR RITCHIE: So now that he is in a much better place, what can be done for someone like your son, who has gotten over this huge hurdle, to help them continue on this path?

What -- does there need to be more services in place to help those that are recovering find jobs, that are something that would, you know, help them remain clean?

Is there --

MARK KOESTER: The outpatient aftercare is as critical, or more critical, than getting them sober.

You can take an addict, put him into detox,

and get him sober in a couple of weeks.

You know, in a month, two months, he's a different person.

It's the "afterwards" that is critical; which is where he's at right now.

I could get a call tomorrow that he's gone.

So, we are paying for aftercare, which is counseling three times a week and meetings every day.

SENATOR RITCHIE: Just one last question, because it's been four times that he had gone through that previously.

Is there something in particular that would trigger him to start over?

Or -- I'm just trying to figure out what the best plan of action is; if there's a need for certain services in the community?

If -- what makes this time so much different from your son, because he was at the very end, and that's why he's in this place this time?

What can we do to help people get to this point before they get to the very end and have to go through what he did?

MARK KOESTER: That is a great question, and the answer is: You can't do anything.

Once they're hooked, until they get to a bottom, as we discussed.

And everybody's bottom is different.

His bottom was death.

So the key is education in the schools, and to do our best to prevent people starting on it.

And, I would say that that's a start, for sure.

I really believe that laws for dealers should be hugely tightened. I think we need to look at it differently. They're not drug dealers; they are -- they're murderers.

[Applause.]

ASSEMBLYMAN BARCLAY: Thanks for testifying here. Your testimony is very powerful.

The -- I guess a question I have, I think you hit on it a little bit with Patty's question:

But -- so he was in rehab four times.

Did he go to the same treatment center all four times?

MARK KOESTER: Five rehabs.

There was -- the last two have been the same -- no, back up.

The last two have been in the same location. Two different rehabs, but several hundred yards

apart.

ASSEMBLYMAN BARCLAY: Is there any kind of -- I know you said after -- after treatment -- outpatient treatment is more important than the actual treatment, but was there any difference between the treatment centers that you think was more effective?

I mean, he went back, obviously, so it couldn't have been all that effective.

MARK KOESTER: The treatment centers that he was in, initially, were very strict: Ties to dinner. No smoking.

He's very intelligent, and actually brilliant, and, he loves to break the rules.

So the treatment centers that worked were the treatment centers that said, "We will help you if you want to be helped." There were no fences, and no particular rules, so you could -- they gave you enough rope to either kill yourself or succeed.

ASSEMBLYMAN BARCLAY: And so after he had those four episodes where he overdosed, that's what, as you said, was his bottom, and that's what got him into the --

MARK KOESTER: That was it.

ASSEMBLYMAN BARCLAY: And were these all

in-state treatment centers, or all over the place? Or, where were they?

MARK KOESTER: There was one in-state. Two out of -- and four out-of-state.

ASSEMBLYMAN BARCLAY: Okay. Thank you.

SENATOR RITCHIE: Thank you very much.

MARK KOESTER: Thank you.

[Applause.]

SENATOR RITCHIE: Next we will hear from the Oswego County Sheriff, Reuel Todd.

SHERIFF REUEL TODD: Again, I want to thank Patty -- or, Senator Ritchie for putting this together, and our Assembly people for being here.

We have, without even saying it, a huge problem: Heroin is extremely addicting, as everybody knows.

It's use in the past two years has more than doubled.

And, in 2002, there were about 166,000 people, according to the NIJ, addicted.

By 2012, it was 335,000, and they say it has more than doubled, and maybe tripled, in the last two years.

And I've already been asked by a couple of people what I think, and I believe a retraction of

the Rockefeller drug laws, which reduced the penalties for the possession, and especially the, sale of heroin, has greatly enhanced the penalties; or, the ratio of probability of the crime to the punishment.

There is no punishment.

If someone comes in now and says, "Well, I'm not just a seller, I'm a user," we send them off to a drug rehab, where they pick up more clients.

Lack of jobs and lack of punishment all combine to make this a huge problem.

A few years ago we had a problem, a really huge problem, with bath salts. Nobody paid a lot attention at first. It wasn't affected by law. It was legalized marijuana.

Then young people were getting killed, same as they are now with heroin. They're doing crazy things: Walking in front of cars, trains. Jumping from buildings.

There isn't any day, just about, you go by and read the "New York Post," that there isn't somebody that's jumped in front of a subway car down there.

It's continued to get worse; more kids have died.

We need to do something.

We investigated on the bath salts. We changed the laws and we started locking people up. The guy that was importing it from China got, what, 16 years down in Utica.

16 years, it's not enough, but it was something. I mean, if he got 16 years for every death, for every child that died, I would say it might have been good, because you're right, these drug dealers are murderers.

When the most viral YouTubes, the video, come out here in Watertown, where a child brought some of this legal marijuana, or, bath salts, the parent took the law into his own hands, which I don't condone, but, it's hard for me to disagree, went in with a baseball bat and destroyed the shop.

That's when everything went viral, and it started to draw a lot of attention.

The guy gets arrested for losing his child.

Another family from our county, whose son drowned after he used bath salts, went public, demanding legislation.

And, I know most of you people supported that legislation.

What do you hear about bath salts now? Very,

very little, because the law was strengthened. We punished the people, we made it not profitable.

As long as it's profitable, they will continue.

Every day, according to the NIJ, there are 105 people that die from overdoses in this country.

"105."

But we take the laws and we strengthen things, and take away guns from legal people, but we're not doing anything, really.

We're closing prisons. We weakened the law; the Rockefeller drug laws.

When you look at what has transpired, the last five years, when they took away the Rockefeller, decreased them, the Rockefeller drug laws and the penalties, and everything else, what has happened with the trade? It has increased dramatically.

Look at what we're doing.

With all the tax money that I see wasted, it doesn't make sense to me to be weakening the laws and closing prisons.

If we have this much drugs, we should have a lot more prisoners, that's all I can tell you.

When we save the money -- tax money, we,

supposedly, don't take from the people, and we give it back to people to spend on the funerals of their children.

I think it's time that we all got viral again and started saving the lives of our loved ones.

[Applause.]

SHERIFF REUEL TODD: My views.

SENATOR RITCHIE: Thank you, Sheriff.

What ages do you -- have you been seeing in Oswego County that have been affected?

Is it across the board?

SHERIFF REUEL TODD: It's pretty much across the board.

And, again, these two people, this gentleman over here, and this young lady, that talked, I'm so proud of them, because, I had a very close relative, a brother, that was addicted, and I went through the rehab thing.

You have to have a sponsor, and I did it with him, and it's amazing.

But I can tell you, neither one of those kids, the first drug they took was heroin or cocaine.

Am I right?

Alcohol, weed, right on up the line, that's

where it starts.

It starts, alcohol, at a young age, because alcohol, well, it's better than cocaine; right? It's better for you.

We see it in every -- we had a -- Narcan saved a 17-year-old in our county the other day.

But, I had a 48-year-old neighbor, two months ago, that died from a heroin overdose.

And the thing about it is, what you're putting in your body, you don't know, because when these -- if you get a hot load, which is anything more than 7 percent, at least that's what it was when I worked undercover in '78 and '79, your average dosage of heroin is about 4 percent. Everything else in there is just cut right down, whether it's Drano.

You know, same stuff for bath salts.

Battery -- all this stuff, they mix in there.

Rat poisoning.

They don't care what they put in there, but they make more money.

But if you get a hot load from somebody that maybe hasn't cut it again, and it goes up -- if you go, from 4, to 7 percent heroin, your heart explodes. It just plain blows apart. The valves

and the vessels and everything, they'll just blow apart.

So I'm telling you, right from the 16-year-old, up to 48-year-old, we're seeing it.

SENATOR RITCHIE: I know Assemblyman Barclay touched on this earlier, and I've heard from a number of law-enforcement individuals who believes the I-STOP program has been so successful that it is forcing more people to use heroin.

Do you think that's true?

SHERIFF REUEL TODD: I believe it is.

And, again, that's -- again, the I-STOP program is great. Any program that helps anybody.

You know, my brother who, again, went through this, and never give up hope.

Because I honestly didn't think then that he would make it through the program.

Don't ever give up hope, because you never know.

When they finally hit rock bottom, and they realize it, they're either going to die sometimes, and sometimes they do, I'll be honest with you, but, never give up hope.

The I -- it helps, but, again, when you can go to mental-health facilities, like he was saying,

and get a prescription of 180 pills of quasi drug, of a drug that is -- they give you to help you get through the effects when you don't have that, and they take it out and sell it for 5 or 10 dollars, take the money and buy cocaine or heroin.

And heroin is so cheap now, compared to what it was when I worked undercover. And we saw very little.

In '78 and '79, we saw very little heroin. It was all weed back then.

And now it's -- now they're importing it.

It's so much -- if you got a package of heroin that's that big, you're talking thousands and thousands of dollars.

You take -- the cost of weed is up, compared to what -- it's kind of reversed itself.

A bag of weed is worth, it's about 40 bucks now, and that's what heroin was. And a little pill like that now is five.

UNKNOWN SPEAKER: Well, '78 and '79 was a long, long time ago.

[Laughter.]

SHERIFF REUEL TODD: Well, I don't want to date myself.

Yet, I've been in here a long time.

ASSEMBLYMAN BARCLAY: I just had a quick question, and I don't know if you can answer it.

The DA mentioned that 40 percent of the drug task force, I don't know if they're arrests, or whatever, covered heroin.

Do you have any idea where heroin stands in Oswego County, compared to meth or synthetics or any other drug?

SHERIFF REUEL TODD: Heroin is picking up very fast in our county.

Meth, we've concentrated so much on so many of these meth labs, when, all of a sudden, the price of heroin has dropped so much, people were turning in their neighbors, and stuff, FOR making this.

We aren't seeing as much meth now as we are heroin, because it's there, you can get it.

ASSEMBLYMAN BLANKENBUSH: Thanks.

SENATOR RITCHIE: Thank you, Sheriff.

[Applause.]

SENATOR RITCHIE: Next we'll have, Adam Bullock, RN, and director of Behavioral Health Services at Canton-Potsdam Hospital.

ADAM BULLOCK, RN: I want to thank Senator Ritchie for having me here, and thanks to the Assemblymen as well, and for listening to us

about what's going on with heroin.

I'm the treatment side of things.

Canton-Potsdam Hospital, we have an outpatient clinic for chemical dependency. We have an inpatient detox program. We have an inpatient rehab, and also a behavioral-health clinic; a psychiatric clinic.

So, I see folks on all spectrums of the problem, let's say it that way.

And what I've given you is kind of showing some of the increase that we're seeing on the treatment side.

The blue, and what you'll see first, is 2011.

You'll see a doubling, from 2011 to 2012, and then, again, it doubled, from 2012 to 2013, across all of our service lines.

That's all -- that's with the heroin use.

The next sheet is your opiate percentages.

You would think, and with I-STOP and with the increase in heroin, you would see a decrease with the synthetic opioids; however, you're not.

You'll see that in that second page, "Opiate Use Percentages."

Not until 2013 are you seeing some of the decline in that. Some of it's I-STOP. Some of it's

the increase of the availability and the cheapness of heroin.

And your last page, you will see, is comparing the quarters, 2014, to give you a snapshot of what's currently going on, to the last two years.

You see detox, from '12 to '14, increasing from 16, to 45 percent, of the folks we're seeing. Rehab has gone from 18 percent, to 53 percent.

Our outpatient continues to rise as well.

But, there's a drastic jump on that last page, kind of showing the fourth quarter.

I am open to questions.

I just wanted to give you a little bit of what we're seeing.

SENATOR RITCHIE: Can you tell me if you believe there's enough facilities or treatment centers here, as far as the increase in the number of heroin users?

ADAM BULLOCK, RN: That's an interesting question.

There's plenty of beds.

Canton-Potsdam Hospital, our rehab, where you would think, and that's kind of you're talking about is that inpatient rehab, or outpatient, our occupancy rate's around 87 percent in our rehab.

The reason that you see an epidemic, and you don't see patients in the beds, it doesn't make sense, does it?

Through this increase, we've also seen the decrease in payers. We've seen the inability to get patients into treatment facilities.

They continue to raise the standard: An individual hasn't failed at outpatient. They haven't failed enough at outpatient.

It doesn't matter what the data is.

I have a young woman in treatment right now, who is a registered professional nurse, using at work. Showed up at a -- had some other issues, Child Protection involved.

Insurer allowed us to have her in treatment for 12 days.

We tried to re-review that this morning.

The insurance company denied us, and said: Had you -- the doctor from the insurance company said: Had you called up me previously, I wouldn't have given her any days.

This is a woman that also has failed at outpatient therapy.

This is non-stop, it's every day. It's a battle that we fight.

[Applause.]

ADAM BULLOCK, RN: Thank you.

SENATOR RITCHIE: Can you elaborate on the process of how someone is trying to get help, and seeks out your services, what the insurance company can or cannot do?

ADAM BULLOCK, RN: They can deny you access to treatment.

SENATOR RITCHIE: And is there any appeal on that?

ADAM BULLOCK, RN: No.

SENATOR RITCHIE: If somebody comes in and is looking to turn their life around, and to get into -- to have some rehab services, you're telling me that the insurance company can just come back and deny them payment?

ADAM BULLOCK, RN: Absolutely.

AUDIENCE MEMBER: Absolutely.

ADAM BULLOCK, RN: Absolutely.

"Amen!"?

[Audience members say, "Yes."]

ADAM BULLOCK, RN: The biggest problem you have, the insurance company issue is bigger than heroin problem, because you can't get anyone any help.

AUDIENCE MEMBER: Emergency room.

ADAM BULLOCK, RN: I fought with an insurance company the other day, and I said: You're shooting your own self in the foot.

Instead of getting their subscribers the help that they need, they'll continue to pay for emergency room visits, they'll continue to pay for detoxes, they'll continue to pay on these other, and they don't even look at the data.

I said: Look at the evidence.

But they continue to deny.

ASSEMBLYMAN BLANKENBUSH: What do they tell you, the reasons why, the denial? Just that it's not covered?

[Microphone not working at speaker podium.]

ADAM BULLOCK, RN: Sometimes there's -- theres a coverage, but they're not qualified?

ASSEMBLYMAN BLANKENBUSH: I don't get that.

Can you explain it?

ADAM BULLOCK, RN: Well, say you call us, and you're looking for -- say you're looking for a rehab bed.

Sometimes I can't get you in at all. You don't have the benefit, is some of that.

But, you do have the benefit, but you don't

qualify because: You haven't tried outpatient. You've only failed once at outpatient. You should try to go to an intensive outpatient before you can come to rehab.

So, you know, they raise the gradient.

And, it does not matter what's going on in your personal life.

Then they'll say, Okay -- after you fight with them for an hour, they'll say: Okay, you can come in. We'll give you three days.

The counselor doesn't even have time to write a treatment plan in three days, and we have to call the insurance company. We're not even to the bottom of it yet.

And they'll give us four more days.

What do you do in four more days? You try to collect more data. You try to work. The patient doesn't even have his bags unpacked, because they know that they're going to have to leave.

They'll turn around and they'll ask them to leave.

I have a pregnant -- a pregnant individual have to leave us after seven days.

SENATOR RITCHIE: What's the normal amount of days that is needed for somebody to recover in

rehab?

ADAM BULLOCK, RN: I'm not able to answer that question.

Ideally, you would want at least a 28-stay in the rehab.

It depends on the individual's circumstance, socioeconomic status.

SENATOR RITCHIE: Well, I understand there's a variable --

ADAM BULLOCK, RN: Yes.

SENATOR RITCHIE: -- but when you're talking, 3 days, 4 days, and maybe 7 days, that's a far cry from 28 days.

So, in the end, they're actually wasting their own money, because they're not giving you enough money to even accomplish anything.

ADAM BULLOCK, RN: Exactly, and they don't get that. And that's the argument we continue to use, but, you don't see them buying the logic.

14 days is your typical now.

The biggest issue that we've seen, is when we started seeing a lot of the managed Medicaid products.

You know, there were some individuals that were able to get help. Managed Medicaid stepped in.

BHO stepped in.

That was one of the worst things that had hit us, was every patient who had had the BHO (the Behavioral Health Organization), we had to call in all that information, we would spend hours.

And we continue to spend hours on those individuals now.

I see our friends from Samaritan shaking their heads, also.

Hours of time.

Now, I'm supposed to be with -- have my hands tied, trying to help somebody, and I'm spending all my time on the telephone, fighting with the insurance company. And I can't even begin with their prescriber.

It's not mine. This isn't a person that I'm paying for that stay.

That's what's happened with the BHO. It's just gotten worse and worse. The fight has gotten harder and harder. The length of time it takes for the insurance companies has gotten longer and more difficult.

MARK KOESTER: We didn't get dime one, out five rehabs, from the insurance company.

ADAM BULLOCK, RN: It's insane.

MARK KOESTER: I wasn't going to fight with them.

ADAM BULLOCK, RN: That's right.

ASSEMBLYMAN BLANKENBUSH: So it sounds to me like, if you have $400,000, you can get rehab.

AUDIENCE MEMBER: I had a friend who had to refinance his house. His son's in rehab right now.

He'll be in there for three days, come home, and go right back into it, I'm sure, because that's just enough time to dry him out.

SENATOR RITCHIE: Well, there's very few parents who would have those kinds of resources.

And we certainly commend you for staying the course with your son.

But, what does that mean for, you know, the majority of families who don't have those kind of resources? What happens to their family members?

They come in and they stay for three days, and they send them home, and, then, what, they end up at the emergency room?

ADAM BULLOCK, RN: Yes.

SENATOR RITCHIE: And what happens at the emergency room? They're signed up for outpatient services?

ADAM BULLOCK, RN: Nothing.

SENATOR RITCHIE: Nothing?

They just get them through that small crisis, and then their sent back --

ADAM BULLOCK, RN: We also, at Canton-Potsdam, we have a detox unit. We have seven beds on the detox unit.

There's 54 people waiting for beds, with opiate issues, for those 7 beds.

While they're waiting, what do they do?

The withdrawal symptoms of opiate dependence and opiate withdrawal is: They have nausea, they have vomiting. There's anger. There's chills, there's sweats. They can't eat. They're curled up in a ball waiting, for a bed.

They show up at an emergency room, no one is going to give them opiate to take them out of withdrawal. No one wants to give them a benzo, a Valium, or something to keep them at ease.

Generally, they'll give them a little bit of clonidine, maybe a couple Valium, and they send them back home.

That's exactly what happens, until they finally detox on their own at home.

I frequently hear: I detoxed at home, I'm ready to come in.

You know, because one of the questions we ask in our rehab, when we do evaluations on the outpatient side: Are you going to detox? When was your last use?

SENATOR RITCHIE: So, is that what you're referring to, that they haven't gone through that process first before they're allowed to go to Canton-Potsdam for a rehab, to an actual facility?

ADAM BULLOCK, RN: Yeah, if you want to come into rehab, or the facility, we want to make sure that you're able to engage, and you're not going to go into withdrawal.

If we put you in a rehab facility, we want to detox you before you come.

So, they'll just spend a couple days there. It's a 5-day methadone taper.

Or if it's alcohol withdrawal, which is life-threatening, has to be treated before you can engage in treatment.

SENATOR RITCHIE: And this is my last question, I promise:

Can you tell me, for those that detox, and then they don't actually get to go into like a rehab program, what's the statistics on their success rate after?

ADAM BULLOCK, RN: Uhm, I don't have statistics; nor does anybody, you know, success rate.

People have lost contact. People are dying. People are moving on to other treatment facilities.

There's no data on that.

But we continue to see them.

You will see, also, I have percentages on re-admission rates that we've had.

For the three years, I gave you representation: 623 admissions to our detox. 45 percent of them are re-admissions.

So, half the people came back, yeah, that were able to.

With rehab, over those three years, there were 296 admissions.

28 percent were re-admitted; 83 in outpatient.

64 percent are coming back into the cycle.

SENATOR RITCHIE: I guess I'm going to have to ask you one more question, after that.

Those that aren't coming back are -- those that aren't coming back in for rehab the second time, are you assuming that they're able to hold a productive life, and not use the drug again?

Or, are they just not coming back because they've given up hope?

ADAM BULLOCK, RN: My mind says is that, one, they're incarcerated. Two, they're at another treatment facility. A small percentage are healthy. And the rest of them are no longer with us.

SENATOR RITCHIE: That's pretty scary.

ADAM BULLOCK, RN: That's the truth.

SENATOR RITCHIE: Thank you.

[Applause.]

ASSEMBLYMAN BARCLAY: Just two questions, I want to follow up:

For a detox on heroin, you use, what's it called, "methadone"?

ADAM BULLOCK, RN: Use the methadone.

ASSEMBLYMAN BARCLAY: And is -- I know with alcohol detox, it is very dangerous during that time, people -- is it the same?

Because some drugs there's not a problem with, as far as life-threatening detox.

Where does heroin fall in that? Is that more like alcohol --

ADAM BULLOCK, RN: Alcohol withdrawal is life-threatening because of the cardiac instability, seizures that happen.

Heroin generally is not life-threatening. The individual feels like they're going to die; generally doesn't.

ASSEMBLYMAN BARCLAY: Just the information you gave us, you have percentages here.

I assume that's percentages of all drug use? Is that what the "100 percent" is?

And then --

ADAM BULLOCK, RN: Yeah, the "100 percent" would be all patients.

ASSEMBLYMAN BARCLAY: Admitted patients for drug use?

ADAM BULLOCK, RN: Yeah.

ASSEMBLYMAN BARCLAY: And, then, is the -- on the last page --

ADAM BULLOCK, RN: No, that's drugs and alcohol, of all our admissions.

The percentage was for heroin.

ASSEMBLYMAN BARCLAY: Okay, drugs and alcohol.

And then, is this the number -- in the last page, you have: "First-quarter heroin-use percentages," and then you have "60" on the left-hand side.

Is that the number of admitted, all for drug

and alcohol?

ADAM BULLOCK, RN: Yeah, we just used "60" as our gauge because it got over the 50.

If you look at the second one, "Rehab," the green, was 53.

53 percent of our current patients in the last three months, in rehab, were there for heroin.

ASSEMBLYMAN BARCLAY: That's the percentage, okay, that makes sense.

Then what are we talking -- I guess what I'm ultimately trying to get at: What are we talking about, actual numbers here, versus percentages?

ADAM BULLOCK, RN: Well, 600 over the year. You're going to take 300 --

ASSEMBLYMAN BARCLAY: Well, just go with the heroin-usage percentage, first.

ADAM BULLOCK, RN: Probably 150 in the last three months, out of 300.

ASSEMBLYMAN BARCLAY: Oh, that's the first quarter.

ADAM BULLOCK, RN: Yeah.

ASSEMBLYMAN BARCLAY: So you're looking at, what --

ADAM BULLOCK, RN: January, February, March.

ASSEMBLYMAN BARCLAY: All tole for the year?

ADAM BULLOCK, RN: Yes.

ASSEMBLYMAN BARCLAY: Wow, holy smokes.

ADAM BULLOCK, RN: So about half. 150 out of 300, I'd throw it around there.

SENATOR RITCHIE: Thank you.

[Applause.]

SENATOR RITCHIE: Our next testimony will be from Dr. Moehs.

Doctor, thank you.

DR. CHARLIE MOEHS: Well, thank you for the opportunity to allow me to talk to you today about some thoughts I have about drug addictions.

I have practiced in the Watertown area for 30 years. I have a private practice in occupational medicine. Worked at the New York State prison in Cape Vincent for 16 years, retiring in 2006.

As a specialist in HIV at the prison, I was offered to take a course to allow me to prescribe buprenorphine. Since then, I have become hooked on working with addicted patients, and follow the largest number of patients with opioid addictions on Suboxone in Jefferson County.

In addition, I'm involved in inducing patients on buprenorphine, Suboxone, for other hospital services, and my practice performs many

drug tests for uses by social services, probation, the courts, and Child Protective Services.

We have a large experience with the problem of drug and alcohol problems in this county.

I'm a member of the American Society of Addiction Medicine, and I'm on the New York State Chapter's Committee On Public Policy.

This area is blessed by two strong outpatient addiction programs: Credo Foundation, and Samaritan Hospital Addictions Services.

These programs are open to all potential patients who choose, and the treatment programs are individualized according to the needs of the individual, and attention is given in terms of advice and encouragement, and other issues, such as education, vocational information, living and housing, and other services.

Patients need to graduate from the program, and if they fail because of non-attendance or relapse or other issues, they are given the opportunity to re-enroll.

Many of these patients benefit from using Suboxone as a means of avoiding cravings for drugs and help them stabilize their outlook on life.

In general, the treatment of drug addicts

with Suboxone can be short, such as 8 to 12 months, or longer, as the patient struggle with improving their lives and feeling comfortable being off of the Suboxone.

Longer treatment is often advisable, as patients require time to develop living skills past their initial addiction program.

Continuing with Suboxone allows them to live without cravings and become productive before they come off the medication.

Studies are available to review, concerning these approaches.

Suboxone itself can be difficult to stop, as patients become physiologically dependent and suffer withdrawals if the medicine is stopped too rapidly.

Tapering patients too rapidly or taking the patient off the medication arbitrarily and before they're ready will lead to relapse.

In my practice, I have several patients who have been on Suboxone for eight years. Three and four years is an average, and some patients are less, of course.

One problem is that, drug addiction tends to be a catch-all phrase and does not describe the severity of the addiction. Many patients begin

their addiction in teenage periods, and in some cases, even in preteens. These adolescents are, thus, subject to brain insults as a result of the addiction, that makes overcoming the addiction very difficult.

Patients who begin their addiction in their 20s might be perhaps easier to treat, but variables, such as family support, education, job opportunities, and the understanding of realistic goals, are needed to go through a program and complete it.

Before they can be done with their addictive ways, the patient sometimes needs longer treatment and specialized treatment.

The longer the patient is addicted is a factor, as well.

I have patients in their 40s and 50s who have been addicted all their lives and are struggling to remain sober. Some have developed characteristics that make them dishonest to themselves and others. They use drugs when they become frustrated, and they lack the ability to deal with life on life's terms. They are anxious, they are fearful, they are depressed, and they are unable to keep a job, unable to avoid a marginal way of

living, and they are unable to recognize a life without the support of social services, health care provided by Medicaid, and in all situations, persons addicted are felt to have an illness related to changes in the brain.

I have patients who have been raped or abused by family members, who have seen their patients [sic] abuse each other, or whose parents have been in jail, for much of their developing lives.

I have a patient who received an apparatus to use cocaine as a birthday gift when they became 16 years old.

I have a high rate of pregnancy among Suboxone users.

I have had a few amazing successes; people who have taken control of their lives, gotten good jobs, and are now successfully living the American dream.

I have had several patients who have attended and graduated from Jefferson Community College and are going on to obtain higher degrees.

I have a patient who recently obtained a master's degree, and was sought after for a job that is paying over $60,000 a year; and he is just now

coming off his Suboxone.

I have had many failures: people who have relapsed, people who have been arrested and gone to jail; failed probation, failed the addiction programs.

I have patients who lie and use, and continue to struggle.

People are fearful about getting off the Suboxone, and since they lack the confidence to make the changes they need, they don't become successful.

To improve our treatment here in Watertown, we should have a detox program.

Currently, patients need to go to Syracuse or Potsdam.

And we heard from that individual in Potsdam.

Thank you very much. It was quite illuminating.

There is often a wait time of several weeks or a month to get into detox.

The truth is, is that when you're ready to make a change, you need to do it when you are ready, or other influences will intervene and the patient gives up.

Detox can be outpatient and can be more versatile than the existing inpatient programs.

Funding will be needed for this to be in place, and flexibility of the development of the service should exist.

Detox optimally will run concurrently with outpatient addiction treatment.

We need more Suboxone providers.

Not all doctors want to deal with the messy issues of addiction treatment, so there needs to be support and working agreements with existing treatment programs so that longitudinal treatment issues can be dealt with.

These issues are programmatic, social-services networking, mental- and behavioral-health coordination, case management, job training, partner and marriage counseling, and a host of services that physicians might not have easy access to.

Until we have this, doctors will not become prescribers.

If they have a particularly difficult patient, they need to be able to seamlessly transfer that patient to a higher level without simply discharging them from their program.

What I'm describing is an integrated help system where prescribers and addiction-treatment

providers work together in managing the patient according to their individual needs, until they can be successfully discharged.

We need improved mental-health services.

70 percent of addicted patients have an additional mental-health diagnosis.

Although we have a new mental-health organization in Watertown, it still takes several months for many patients to be seen, and psychiatric services should be part of the hub that I described.

Within the hub, long-term root-treatment programs should be available to provide ongoing support while the patient remains on Suboxone.

A statewide issue is that, if a patient is on Suboxone and is arrested and put in jail, his or her medication, just as medicine for diabetes, hypertension, and heart disease, needs to be continued. This patient should not be put in jail and forced to undergo the painful rigors of rapid detoxification in a jail cell. That's just inhumane.

Lastly, the issue of legalization of marijuana is troublesome to me, and it's troublesome to our task force.

It's a known toxic substance for the

developing brains of children and adolescents. Brain damage can occur if the current movement for use of marijuana, even for the ill patient, is implemented.

At a minimum, stringent regulatory rules will be needed to control its use, and there should be no consideration given to allowing expanded use to become a steppingstone to legalized marijuana in this state.

Thank you again for letting me speak to you today.

I have one other comment that I wrote down, and that's about the insurance companies, and they certainly have a huge effect on the prescribing of Suboxone.

Suboxone, I haven't said much about it.

Most people know something about it, but, it's similar to methadone, except it can be given on an outpatient basis, and patients can carry it with them. They don't need to go every day into a methadone program, and, it certainly is helpful.

It has some negative effects, it often can be abused, and so on and so forth; and, so, that's an issue.

But the insurance companies currently control

Suboxone, as it were.

So we can prescribe it, but we have to get it approved. And they may not approve the dose that we want. If we are -- they may not approve the dosing mechanism that we have. For example:

If somebody is on 16 milligrams, and you want to reduce them down to 12;

You might want to change them to a different dosage form, instead of 8-milligram tablets, or strips.

But, you're often not allowed to do that.

If I have a patient coming down from Suboxone and they're on 8 milligrams, and I want to reduce it by 1 milligram at a time, it's difficult to do that unless I change the dosage for it.

Well, they might not approve the particular dosage for them; and, so, I'm telling the patient, Well, you gotta to cut your pill, or you gotta cut your strip.

And, you know, how do you judge 1 milligram from an 8-milligram strip?

So, the insurance companies have a big say in what's going on.

And, we have no idea how long they're going to approve them. In other words, if we have

somebody who's on that medication for two years, they very well may say: Well, two years is long enough, we're not going to pay for it anymore.

We don't know that.

So, thank you again.

[Applause.]

SENATOR RITCHIE: Doctor, just a couple questions.

Do we have enough doctors and nurses and social workers to cover this area?

Because I'm always hearing that there's a shortage for doctors in other areas in the counties that I represent.

DR. CHARLIE MOEHS: Well, we are pretty well supplied, I would say.

Family-practice and primary-care doctors, you always can use more of them.

But, I'm the only doctor in practice that prescribes Suboxone.

I'm a family physician, I've specialized in that, and I'm particularly interested in addiction problems.

We don't have any other primary-care doctors who are prescribing.

We have two psychiatrists right now.

There are some who are certified, but they're not really involved.

And, I can tell you that, from my experience, it's not easy. It's not just a matter of writing a prescription for Suboxone, because they need extra services, they need more help.

And, you know, unless you're willing to give it, you're not going to prescribe.

SENATOR RITCHIE: You touched upon one of the points that I was kind of trying to understand, because, when somebody gets to the point, like you talked about earlier, when his son got to the point where he realized he wanted help, and then you go to get the services and you're put on a waiting list.

DR. CHARLIE MOEHS: Right.

SENATOR RITCHIE: By the time you get to that, your circumstances may have changed.

So, for how many people are slipping through the cracks, that they're not able to get the services they need at the time they're ready to receive them?

DR. CHARLIE MOEHS: Well, I think that that's a hard number to really get at there, but it's a significant number.

I mean, I think if there are 50 patients

waiting, how many of those eventually drop out, you know?

40 percent? 100 percent?

AUDIENCE MEMBER: We get dozens of calls every week for Suboxone, and we're at capacity. Dr. Moehs is at capacity.

So, you have a number of people who are ready to come forward, but there's no access to the medication support.

DR. CHARLIE MOEHS: I have people calling me every day, to try to get into the program. And I'm limited to 100 patients. That's a lot.

There are a lot of doctors who will stay with the initial allowed amount, which is 25.

SENATOR RITCHIE: You'd think we would be doing all we could to make sure that those individuals who are at the point where they're going to try and get help are able to immediately get treatment while they're in that frame of mind, versus sending them back home waiting for, you know --

DR. CHARLIE MOEHS: Well, some of them might be in a rehab program, and then the rehab program will want to get them on Suboxone.

But, if you don't have room, you know, then

they go searching around for doctors. And some might drive to Syracuse or elsewhere to try to get on the Suboxone? Or. They buy it on the street, because it has a street value.

AUDIENCE MEMBER: Same with heroin, they oversold it.

DR. CHARLIE MOEHS: But I think the issue that I'm trying to describe, is that if we have a really well-honed system, where doctors in treatment facilities work closely together, really closely, and that you can pass a patient back and forth, the problem then for the physician of dealing with addiction issues that they might not be capable of doing or they don't totally understand, they can give that patient back to the rehab, so the rehab can work with that patient, and then maybe send them back to that doctor.

And there are models in this country where that works very well.

Burlington, for example, is one where they have that kind of a hub system, where the mental-health addiction-treatment program is the main entity, and they have a variety of primary-care doctors who simply prescribe the medication.

SENATOR RITCHIE: Thank you.

ASSEMBLYMAN BARCLAY: Doctor, how do you spell that, subox --

DR. CHARLIE MOEHS: Suboxone, S-U-B-O-X-O-N-E. And the generic name is buprenorphine. Bu-pre-nor-phine.

ASSEMBLYMAN BARCLAY: I'm not going to try that.

[Laughter.]

DR. CHARLIE MOEHS: I'm going to give you a copy of my --

ASSEMBLYMAN BARCLAY: So that is in lieu -- that there's other methadone? Is that a --

DR. CHARLIE MOEHS: Methadone is another similar-type drug, yes.

ASSEMBLYMAN BARCLAY: And these drugs -- and I don't know anything about these, so just bear with me.

These drugs, one helps you detox, and also keeps you off the addiction?

DR. CHARLIE MOEHS: Well, yes, it helps resolve the cravings that you might have for the use of opiates, yes.

ASSEMBLYMAN BARCLAY: And what kind of drugs are these? Are they --

DR. CHARLIE MOEHS: They are opioid-like

drugs, but they have a limit. Methadone, less so. But Suboxone has a limit that it will work. So, up to 32 milligrams, perhaps, you won't have any further effect.

In fact, 16 milligrams is probably the maximum amount. You can't give more, and you can't get higher, or you can't get high at all.

Most people who are on Suboxone, and, in fact, not pointing them out, there are a few of my patients here who are on Suboxone, and they'll tell you that it just makes them feel normal, and they function just as normally as anybody else. There is no specific ill-effect of the medication. It doesn't make you high.

ASSEMBLYMAN BARCLAY: Great. Thank you.

SENATOR RITCHIE: Thank you, Doctor.

[Applause.]

SENATOR RITCHIE: We are going to take a short break, say, 10 minutes.

We're halfway through the testimony; and, so, we'll take a quick break.

Thank you.

(A recess was taken.)

(The forum resumed, as follows:)

SENATOR RITCHIE: We're ready to get started

now.

The next person testifying will be Chelsea Mulchany.

Chelsea.

CHELSEA MULCHANY: Hi. I just want to say thank you, and, I apologize if I get emotional.

I already am. Excuse me.

I don't have anything written down. I just have my own life experience with this drug.

I don't have good memories.

(Audience member offers tissue.)

CHELSEA MULCHANY: Thank you.

I don't have good experience.

In September of 2013, my boyfriend passed away because of a heroin overdose.

We lived together for two years, and I tried my hardest to try to get him to stop.

Unfortunately, like others have spoke today, a big issue is insurance; not allowing him to stay in a facility prevented him from getting clean, and staying clean.

In September, he finally went to a rehab for the second time. He got out because insurance wouldn't let him stay any longer than six days.

The day that he got out, he begged me and

begged me to try to get him help.

He told me how he felt like the devil was inside of him. He could not get the devil out of him.

Unfortunately, six days later he passed away at his mother's house, in the bathroom, and his 10-year-old niece found him.

I don't really know what else to do to try to get it out there that there needs to be more help. The system is broken. It is not effective, whatsoever.

In January, we found out my brother was addicted to heroin.

Luckily -- well, not luckily, but, it was not at the point where he was injecting. He was only ingesting by sniffing.

So what had happened is, we sent him to a rehab facility called "Syracuse Teen Challenge." He was there for 90 days, and he just got out on Monday.

He has a wife who is an RN.

He himself was in the union, had a good job.

Just, got mixed up in the wrong thing, because he was addicted to opiates for 10 years, and it led to, eventually, being addicted to heroin.

My father, who owns his own company, is sick. He has autoimmune polyneuropathy, and he also has Lupus. They give him pain pills. He became addicted to the pain pills, and now he is on Suboxone, and he will be for the rest of his life.

I really don't know what else to say, other than, there needs to be more options for those who are addicted to drugs, opiates, alcohol, any other drug besides heroin, as well.

But, there just needs to be more options to get help, and to stay clean, because it's just not working the way it is now.

Really, that's all have I to say.

[Applause.]

SENATOR RITCHIE: First, I just want to say how much we all appreciate you coming here and telling the story, because if we don't hear, unfortunately, heartbreaking stories like that, it never gets ramped up to the next level to really do something about it.

So, appreciate how tough that was for you.

CHELSEA MULCHANY: Thank you.

SENATOR RITCHIE: And if you, you know, would be willing to answer a few questions?

CHELSEA MULCHANY: Sure, yeah.

SENATOR RITCHIE: Can you tell me how long your boyfriend struggled with this before that happened?

CHELSEA MULCHANY: Well, probably a total of, addiction, in general, about five years.

He was captain of his high school football team. He was an All-State champion wrestler. He grew up and lived right outside of Las Vegas, in Henderson, Nevada.

It began just partying. You know, the drinking. Recreational drug use turned into addiction to pain pills, which then turned into addiction to heroin.

He then decided he wanted to get clean, and he came to live with his mother here on this side of the country.

And, the kids that he went to the middle school with are all addicted to opiates and heroin, and, you name it, they have it, they do it.

And it just spiraled out of control.

The last two months of his life, he was using $700 or more a week of heroin, which is about a bundle to a bundle and a half a day, which I believe is a lot, a day.

SENATOR RITCHIE: You talked about the need

for more services?

CHELSEA MULCHANY: Right.

SENATOR RITCHIE: And I understand that he didn't get to stay as long as he needed to the last time.

What other problems did you run into when he was trying to look for services?

CHELSEA MULCHANY: The prices of rehab facilities.

I called the New York State Hotline, to try to get him into a rehab, and they said: Unfortunately, the cheapest rehab that we have available is $14,000 a month.

"A month." And that was the cheapest.

The most expensive that they could tell me was $50,000 a month.

SENATOR RITCHIE: Do you have any questions?

ASSEMBLYMAN BARCLAY: I do, thanks.

I just want to echo the Senator's words: It's really very good of you to come. And I know it's not an easy thing to do, to relive somebody's bad memories.

CHELSEA MULCHANY: Thank you.

ASSEMBLYMAN BARCLAY: Can you explain a little bit, and maybe you don't know, or whatever

you're willing to testify, where he got the heroin from?

CHELSEA MULCHANY: Yeah, sure.

I live in Oswego County, in Fulton, New York, where I say, we, as a county, around that area, get drugs; specifically heroin, from Syracuse. Generally, the west side of Syracuse.

It's everywhere.

You can walk into a supermarket, ask pretty much anybody, they can tell you:

Oh, yeah, sure, right over here on this corner;

Right behind that school;

Right over there behind the teen -- the Boys and Girls Club, right there, right in that alleyway? Yeah, just walk back there.

ASSEMBLYMAN BARCLAY: So it's purchased similar ways, you know, my experience, I guess, as seeing it on TV:

Where, you're in your car, there's someone on the street. You pull up and say, "I want to buy this"?

CHELSEA MULCHANY: Yeah.

ASSEMBLYMAN BARCLAY: They either get a runner to come get it, or --

CHELSEA MULCHANY: Uh-huh.

ASSEMBLYMAN BARCLAY: Yeah.

CHELSEA MULCHANY: Yep.

ASSEMBLYMAN BARCLAY: It's not someone's house --

CHELSEA MULCHANY: It's easy.

ASSEMBLYMAN BARCLAY: It's easy.

CHELSEA MULCHANY: Right. It's incredibly easy to get your hands on. It's shockingly scary how easy it is to get your hands on heroin.

ASSEMBLYMAN BARCLAY: That is scary.

Thank you.

CHELSEA MULCHANY: You're welcome.

SENATOR RITCHIE: Assemblyman?

ASSEMBLYMAN BARCLAY: Your brother, how old is your brother?

CHELSEA MULCHANY: My brother just turned 27.

ASSEMBLYMAN BARCLAY: Okay.

Now, he was in a teen center, you said?

CHELSEA MULCHANY: Well, the name of it is "Syracuse Teen Challenge." It's not just focused to teens. It's focused to, really, any man -- it's a men's community.

ASSEMBLYMAN BARCLAY: Now, he was allowed to stay there for 90 days?

CHELSEA MULCHANY: Right.

They want you to stay there for 14 months.

They keep you in Syracuse for about three to four months, and then ship you to Pennsylvania to their other portion of the rehab facility.

He has a family. My nephew is almost 5 years old. You know, he's got a mortgage. He's married; he's got to support his family.

So, after about 90 days, he got out, and -- which was on Monday, and, is back to work.

Unfortunately, I, as an individual, don't have a lot of hope that he's going to stay clean.

And it's sad, just because there's been so many times where I've saved my boyfriend's life myself. I gave him CPR and brought him back to life about five times myself, because I was too scared to call somebody else for help.

ASSEMBLYMAN BARCLAY: Thank you.

CHELSEA MULCHANY: You're welcome.

SENATOR RITCHIE: Thank you. We do really appreciate you coming, and talking to us today.

[Applause.]

SENATOR RITCHIE: Just to let everyone know, the Assemblyman will have to leave before we finish.

We want everyone to understand that he

believes it's important, and has a prior commitment.

So, Jeanne Weaver of Jefferson County is the next testimony.

JEANNE WEAVER: Thanks for allowing me to be here.

I just want to say, begin to say, that this wasn't probably any of my life plan to be standing up here and airing my family's addiction issues, you know, but, obviously, plans change, and I'm here.

I hope that some of this experience that I share will help.

I personally envision that this growing heroin epidemic is like a black plague that's infecting and destroying our communities, sickening and killing our children and young adults, and has far-reaching consequences.

We have a strong family history of addiction. We also have a family history of recovered addicts.

My father was a morphine addict. He was a World War II veteran who was very badly wounded, and, addicted to morphine for pain.

And, my husband became an alcoholic as a way of medicating a loss of -- in a divorce of his children.

And, my son, I am the mother of a heroin

addict and alcoholic, who is now currently 61 days sober, finally, at least at this point.

I'm also a grateful member of Al-Anon and Nar-Anon, which is family support groups for loved ones of alcoholics and/or drug addicts. Very, very important program for me, because, I was crazy, which, living in an addicted house can make you that way. And these support groups are very helpful.

I had a whole laundry list of my family history.

Basically, I want to -- I guess I'll touch more on my son's.

You know, he was a brilliant, engaging young man; big heart. He was a college graduate, and stonemason.

And, like most of us, made some pretty stupid choices, even though he went through all the D.A.R.E. programs, and everything, that was there, you know, as a teenager.

Like, we never did any of that stupid stuff as teenagers.

And, in time, he found himself a full-blown heroin addict and alcoholic, and, most recently, living in an unfinished cellar in a drug house in a Pittsburgh suburb, which has recently been

condemned.

And, he also had a little bit of touch with this fentanyl-laced heroin that killed somewhere in the number of about, 23, I think, people OD'd in about a week down there.

He had lost everything --

Then, this is about the third time that this has happened.

-- his home, his job, his truck, a girlfriend, their baby, and his dog.

He was facing two warrants in two different states.

He has currently satisfied the legal matters in that -- in the first state, and is working on this now.

He's reconnecting with his girlfriend and child, and working on this reconciliation, and is addressing his drug and alcohol problems.

He started a new job, as an outpatient rehab.

And, through Credo, he attends two or more AA meetings a week, and does not have easy access to NA, which would be really important.

There are NA meetings in Watertown, but, outlying areas, there's nothing.

And a lot of these people don't have their

license anymore, so it's really hard to get there to these meetings.

So because of that, we're doing a lot of driving. And some of these meetings and appointments are at least a 70-mile round trip.

And he's lucky, because he's got parents that are standing behind him, you know, to help him do this.

He wanted to go into inpatient rehab, but was denied by the insurance company. He did not qualify because he had been sober for too many days.

That's a big problem.

He'd only been -- he'd probably been sober, maybe three weeks.

So, the insurance company has renamed his illness a behavioral problem, which pretty much relieves them of paying for inpatient addiction treatment.

The fact is, that they do just about what they can to avoid paying for inpatient treatment because it is expensive. And they do, in their contract, say they provide for these things.

And they also work pretty diligently in decreasing the time that they spend in inpatient.

And I think -- or, you guys have heard this.

That is just one of my issues.

And the reason for some of this history that I think is important for you guys to know, is that we, just all of us people here now, we're, like, regular working-class Americans, middle-class Americans.

We're not the low-life trash that people would think of as a heroin addict or a junky or a dope fiend, and their family members.

We -- you can see a stream of BMWs driving into the inner city any day, with all these little yuppies going in to get their fixes.

You can see on a Friday night, a line of young teens and young adults at a pharmacy counter, there to pick up their syringes so they can party safely.

You'll see a lot of older adults becoming opiate addicts because they are seeking arthritic pain relief.

You'll see a local high school lacrosse team with a roster of pill-poppers. And I know that for a fact.

These kids nowadays have no respect or fear for heroin like we did. You know, somebody said "heroin," you ran.

This is not the way it is now. This is just one of the pieces of equipment to party with at this point in time.

So what I want to say is: Heroin has no respect to persons. There's no one that's exempt from this anymore. It's just us; all of us.

I wanted to spend a little bit of time with our personal experience, and I know I don't want to run over too much, but: Life is filled with chaos and guilt, fear and panic, insanity, for both the family members and the addict.

The addict's loved ones become so enmeshed in covering for, and trying to save their addict, that they lose themselves.

We become addicted to the addicts, and we become sick; and then we become sick in -- spiritually, physically. I can say "ill."

In a point of desperation, which was relatively close in time, I wrote to Dr. Phil. That tells you how desperate and crazy you can get.

[Laughter.]

JEANNE WEAVER: And he hasn't called me yet, but, I'm waiting.

[Applause.]

JEANNE WEAVER: We'll do just about anything,

you know.

There's -- you know, I want to go through some history of this, but, probably the -- some of it would be that, that he -- even though the strong family history, he very well could have become an addict, you know. But, he was injured in football at 15, was prescribed an opiate for the pain. Ultimately became, you know -- ultimately, continued using some opiate, on some level, right up through the use of heroin.

And he said to me, he loved the way that made him feel, and he never stopped using it during these next few years.

I think his -- I know his use escalated in college, where you will find a lot of drugs to help along with that.

By the time he came home, there was a lot of personality changes. He was testy and unhappy, verbally abusive, among other things. Would not cop to anything but smoking a little weed. Had an anger problem; went to anger management.

Over the next couple of years, there was escalating chaos in our house; strange happenings: Crazy friends. Missing money. Missing -- anything that wasn't tied down, that had of any value, would

come up missing.

And, you know, we were clueless, really, to why this. This didn't look like anything I had ever seen or had any experience with.

Finally, after some pretty significant stuff going on, he came and told us about this.

And that was just the beginning of our experience of knowing where we were, you know, at with him.

He had been -- he did end up going into rehab in about that time, and they -- day two, they were talking discharge plans.

Now, this is not -- we're going: What, are you're kidding me? You know, we're expecting at least 30 days here.

"Day two."

He was out -- sent out on the 15th day, with a pat on the butt, and a "you're cured," and a coin, and a to-do list.

You know, it just wasn't -- it wasn't what we -- we tried really hard, working with the insurance company. They just said "no."

He had OD'd at least twice.

He has common physical issues, mental, you know, stuff that goes along with this, emotional,

spiritual, damage from the drugs. He's made suicide threats.

And -- and this thing, as I said, I am in much fear for his life.

We did everything.

We did everything; we do did nothing. We spent money. We enabled. We detached. We removed him from the home.

That's really hard, kicking your kid out. Especially one that we feel was sick, you know, it was really difficult.

Anyways, I think that's about all I'll say about that.

But -- so as I can say, I haven't heard anything from Dr. Phil, yet.

[Laughter.]

JEANNE WEAVER: Because I'm waiting.

This brings me to another -- my next concern is that, you know, after reading and researching much of the physiological effects on drugs on brain chemistry, I'm fully convinced that this is a disease. It's a chronic disease, that with a known caused progression, and outcome, left untreated.

Good news is, you can successfully manage drug addiction or alcohol addiction.

Problem, herein, and you've heard this: This area, Jefferson tri-county area, is sorely in need of more treatment facilities; particularly, I feel, inpatient.

You know, the ones that we have are stretched right to their limits, with a long waiting list.

And, the only way you get into these now, of course, if the insurance company blesses you with this, and that doesn't always happen.

As, you know, we -- my son was recommended by his physician, by somebody that was -- that's in jail. He spent some time in jail, and they had a process they went through there.

That was recommended by her, and the person at Credo; all sent recommendations for rehab, and they said: No. He's been sober too long.

So then your choices are with this:

Out-of-pocket for fifteen to thirty-five to fifty thousand dollars a month, which we all have in our back pocket;

Or, Medicaid, you know.

And, he's not on Medicaid.

Addicts don't do real well with long waiting periods, because they're in the throes of withdrawal, and, they want -- they're ready.

When they're ready, they're ready, and they're not -- their patience is about, like, this long [indicating].

Right?

So, anyways, we need more facilities, and outpatient and inpatient treatment;

Well-trained professionals who understands that addiction is an illness, and treated accordingly;

And insurance companies that are going to be required to cooperate a little bit;

And more "Dr. Moehs," because these -- you know, you need these kind of people around to deal with this.

Another issue I have is, you know, I haven't had the opportunity to stand beside my son in court; because, many, if not all, eventually find themselves in legal issues.

And I certainly don't advocate for the absence of accountability for bad or criminal behavior.

What I do feel, is that all the players in the legal system become more cognizant that this disease -- that this is a disease process, and that this disease process leads addicts to take part in

criminal activities that they would not have been involved in otherwise had they been sober.

Their judgment, to conceptualize actions versus consequences, is dysfunctional due to the brain damage and paramount to the chemicals.

And what I would like to see is, is more judges placing more emphasis on treating the illness that causes the bad behavior, combined with some level of accountability, based on the treatment programs.

And that is what our judge here recently has done, after quite a bit of talking with him, because he was ready to hang him.

And, maybe he should be. At least he was in there, which scared him.

You wouldn't send a diabetic to jail without the insulin to manage his illness, where, you know, do you send an addict to jail without something to manage his illness?

You know -- so, again, we need to work on a better system to meet the needs of the addicts who break the law, especially the large number of drug-related cases seen in the legal system. It's huge.

I would hope we could wait -- would not wait

till they're, like, diseased at Stage 4, but, maybe -- where they're committing felonies and really bad stuff. Try to recognize their illnesses at Stage 1, when the legal issues just begin.

I guess my final one is directed at -- I shouldn't say "at" physicians, but, it's about the medical field.

I've worked in physical therapy for years. We treat pain with, you know, hands-on means.

Doctors are required to assess and assist in pain management for their patients, which has led to this overprescribing of opiates, along with the assistance of the pharmaceutical companies.

For pain control, many, if not all these patients that are on these opiates, like Oxycontin, or whatever, oxycodone, whatever, become addicted to the medication, you know. And they're taking it because they're supposed to take it.

Now, who's responsible for their addictions?

Most doctors are not trained, or are not really interested, in treating addiction; not the addiction, you know, they've had a hand in creating.

You know, and when there is a doctor who will try to wean them, the patients, off of opiates, they're dropping the amount that they have.

So these people need, you know, they're addicted. They're going to go out and find the street drugs to satisfy their cravings, or to keep them from withdrawals, because the withdrawals are pretty nasty, kind of scary.

Rapid-Response group is doing, you know, pretty good job dealing with this.

But, for you, I would say, the governor of Vermont, and New Jersey, have started doing some pretty good programs for how to deal with the legal issues, and stuff. And I think that would be a model to look at.

And I just said, you know, my question would be: Considering all the studies about the brain dysfunction, you know, with drugs and the damage it does, especially with the developing brain, you know, why would a doctor send a 15-year-old home with a prescription for Vicodins? 60 Vicodin tablets, and three refills?

He can't have alcohol until he's 21, but he can have Vicodins, you know.

And, maybe we should rethink that.

I said, maybe a few days of discomfort managed by Tylenol would be better than a lifelong battle with addiction.

[Applause.]

JEANNE WEAVER: I just want to close by saying:

I probably have annoyed a lot of people, but that's too bad, I guess.

I'm just real thankful to see that we're starting, you know, you guys are here, and to help fight this battle, and fight for our loved ones, because these are our babies that this is happening to, and they don't know what they're getting into.

And I would just say, educate yourself about the disease of addiction. That really will change your mind about this whole thing.

[Applause.]

JEANNE WEAVER: So, anyways, I'm done.

SENATOR RITCHIE: Thank you, and, appreciate your testimony, and appreciate your recommendations, because we're going to forward those on to the full panel.

Thank you.

[Applause.]

SENATOR RITCHIE: Next we have Detective Sean O'Brien from the St. Lawrence County Sheriff's Department.

DET. SEAN O'BRIEN: Good afternoon, Senator,

Assemblymen.

I come before you today as a man that's boots on the ground.

I'm assigned to the St. Lawrence County Drug Task Force.

My goal, at the end of the day, is to target drug dealers. Not the users, the dealers.

And while national statistics are frightening, I have before you local statistics in St. Lawrence County.

Heroin, essentially, was non-existent in the law-enforcement side, dealers, before 2012.

I take a step back for a second.

The oxycodone that we were faced with, preferably, the oxy 80s are CDN; oxy 80s that we were attempting to purchase, was at a -- probably a high in 2010-2011.

There was a change in the formula somewhere in that 2011-2012 area.

We had a 57.10 decrease in oxycodone-sales cases.

Now we have heroin.

So as I stated before, the direct result of the oxycodone was the change in the formula, and it was difficult to abuse because could you no longer

smoke it or inject it.

2013, our heroin cases increased 280 percent.

2014, we're on track, at this particular moment, 120 percent above 2013.

We have a problem.

And, to be quite candid, and not to take anything away from the heroin and opioid addiction, but next year our fear is, it's going to say: Heroin and opiate and meth, because, we need to stay out in front of the curve.

This is a result of what's going on.

I'm telling you, at least in St. Lawrence County, we have a 500 percent increase in meth.

So we're a little slower up north.

[Laughter.]

DET. SEAN O'BRIEN: We -- the meth -- or, the heroin and -- the heroin is not coming from the north; it's coming from the south.

As stated before, the metropolitan -- major metropolitan areas -- Syracuse, Rochester, Buffalo, New York City -- they come to our area.

Not only is this scary and frightening numbers regarding drug sales or crimes that were -- or people that are arrested, we have a rise in

property crimes.

As a few have stated, their children were out stealing, doing what they had to do, to get their fix.

So, it's not just about the drugs -- it's -- it is about the drugs, because it causes the children to go out and offend.

Much like the oxy problem, if the source is targeted, you will limit the amount available. Period.

Therefore, we need to find some different approaches on what we're going to do.

Suggestions?

Patrolmen interdicting individuals and identifying individuals that are bringing the product into our communities. People aren't growing this in our backyards; people are bringing it to us.

Undercover operations need to increased to include controlled buys, to identify the sources that are out of the area.

To further accomplish these tasks, multiagency cooperation needs to be established.

Now, we do have quite an entourage, if you will, of -- and -- a cross-section of law enforcement on our task force in

St. Lawrence County, but, it basically boils down to funding. And, you know, it's all about the money, unfortunately.

Sitting here today, our hearts go out to those that have lost their loved ones. It's a tragedy.

And I'll be honest, the gentleman that I'm here with today, we were out in the hall at the break, and we said: You know what? This lights a fire under us.

So you can rest assured tonight that we will be working our hardest to try to curb this problem.

Having said that, a suggestion of mandatory prison sentences that takes the discretion away from the judges may not be a bad idea, similar to the Rockefeller laws, as the Sheriff and the DA spoke of earlier.

That pretty much...

Drug prices in St. Lawrence County, you folks here speak of $10 a packet of heroin?

We pay 35 to 50 dollars per packet. And it wasn't just once. Constant.

So, the prices, supply and demand, basic economics, but, to pay for a $50 packet of heroin, you've go to steal that much more out of people's

cars, you have to steal that much more out of businesses.

And, like I said, next year, our fear is that it's going to be a heroin and opiate and meth addiction.

Thank you.

[Applause.]

SENATOR RITCHIE: Detective, can you tell me where you believe the heroin is coming from, especially if it's at a higher rate than maybe has been said occurs in Jefferson or Oswego county?

DET. SEAN O'BRIEN: Like I said, I think it's the -- I would say it's south. It's definitely the -- seems to be the metropolitan areas in those communities.

SENATOR RITCHIE: And do you believe that the laws on the books are not tough enough now to keep the drug dealers off the street?

DET. SEAN O'BRIEN: That's, the dealers.

SENATOR RITCHIE: The dealers, right.

DET. SEAN O'BRIEN: Not the abusers.

Not the abusers; the dealers.

SENATOR RITCHIE: But I --

DET. SEAN O'BRIEN: I mean, if you're caught with a certain quantity of heroin, if you're caught

with X amount of packets of heroin; if you're with 100 packets of heroin, or 150 packets of heroin, you're not a user; you're a dealer.

And this person doesn't need to go to -- you know, and a lot of good businessmen aren't using. They are making money, they're making profit.

I mean, if it's 7 or 10 dollars on the streets of Watertown today, it's 35 just 35 miles north.

SENATOR RITCHIE: Well, I'm sure everyone who's here today, is sole purpose is to help those people who, unfortunately, got caught up in it, and we want to do our best to make sure that they get put back on the right track, with resources, because of what it's doing to them and their family.

But there are some who are dealing, who are making a profit, who, unfortunately, are giving the 15-year-old kid the opportunity to get hooked on his first try.

And those are the people that we should all be working towards making sure that they're no longer on the street.

DET. SEAN O'BRIEN: Absolutely.

[Applause.]

SENATOR RITCHIE: Just two things:

You mentioned not enough resources for the drug task force.

If we're looking for some kind of solutions, is that something you think should be part of the talk, that, certain grant funding allowed to be looked at?

DET. SEAN O'BRIEN: Absolutely. Absolutely.

We -- the drug task force in St. Lawrence County has been organized by the sheriff, Keith Knowlton.

And my understanding is, that was his center, and, he knew the drug problem was coming.

And here we are many, many years later, and that's where the money needed to be spent.

Unfortunately, we're strapped for manpower. We don't have enough manpower.

And, people in the community need to understand that the border patrol has a function, that the State Police have a function, the Sheriff's Office has a function.

They don't see the St. Lawrence County Drug Task Force members, because we try to blend in.

So, we need to reallocate or spend a little more in the undercover operations.

And, I understand the constant complaints of:

Oh, I've passed X amount of police cars in a 5-mile area.

So we need to reallocate money if you want to attack this problem.

[Applause.]

SENATOR RITCHIE: Do you have any specifics, or could you pass on specifics at a later time, with the number of arrests in the last year?

DET. SEAN O'BRIEN: Absolutely.

SENATOR RITCHIE: Updated?

DET. SEAN O'BRIEN: Absolutely.

SENATOR RITCHIE: Thank you, Detective.

Assemblyman?

ASSEMBLYMAN BARCLAY: (Shakes head.)

SENATOR RITCHIE: Thank you.

DET. SEAN O'BRIEN: Thank you.

Thank you very much.

[Applause.]

SENATOR RITCHIE: Next speaker is Anita Seefried-Brown, program director at the Jefferson County Alcohol and Substance Abuse Council.

ANITA SEEFRIED-BROWN: Good afternoon.

And, thank you, Senator Ritchie, and all the members of the New York State Senate Task Force, on

giving us the opportunity to speak with you and bring our concerns to you.

The Rapid-Response Workgroup is comprised of representatives from various nonprofit, county, state, agencies, as well as concerned citizens, including parents of overdose victims and parents of addicted children.

And, we're addressing -- beginning to address the issues of prescription-drug abuse and prevention of overdose deaths in Jefferson County.

And as already stated by somebody before, I don't remember who, we do applaud the passing of the I-STOP legislation, or, also called "Internet system," for tracking overprescribing, which is designed to curb the overprescribing of opiate-based medications by physicians and doctor shopping for narcotic medications by patients.

The legislation had some unintended consequences.

Anecdotally, we know that a number of patients whose narcotic pain prescriptions don't last till the end of the month seek pain relief via heroin use.

Others who have used narcotic pain prescriptions non-medically, and used to pay 50 or

60 dollars a pill, are now buying heroin for less money and get the same, if not better, euphoric high.

While we have made some great strides, the scourge of cheap and very potent heroin has created an incredible crisis in the nation, the state, and right here in Jefferson County.

According to one member of the clergy who ministers, in his own words, "To the least among us," he says, "that even heroin dealers warn heroin users about the drug's potency."

Can you imagine that? Somebody telling you: Hey, look, this is some really strong stuff. You know, take it easy on it.

This reverend has earned the respect and the trust of the drug users, their families, and family members. He is compassionate, and believes in the goodness of users, even when they themselves have abandoned themselves.

Drug users may implore him -- even drug users will implore him, even during the deep of night, to come to the aid of a drug user in the throes of an overdose.

Some are saved. Others die, becoming yet another sad statistic.

According to the Jefferson County Medical Examiner's Office, between 2011 and 2013, 48 overdose deaths have occurred.

Cynics might say: 48 deaths in 3 years, out of a population of 120,000 residents, while sad, that's not so bad.

However, let's examine how many people are projected to be impacted by those 48 overdose deaths while using the Center for Disease Control and Prevention's methodology:

One death, according to the CDC, impacts ten persons entering treatment for abuse;

32 persons showing up in the emergency room department for a misuse or abuse;

130 people who abuse or who are dependent;

825 non-medical users.

So for one death, there is a total of 998 people impacted -- projected to be impacted.

So let's look at the 48 deaths in Jefferson County:

480 treatment admissions for abuse;

1,536 ED visits for misuse or abuse;

6,240 people who abuse or who are dependent;

39,600 non-medical users;

For a total of 47,904 people impacted by only

48 deaths.

The deceased individuals may have had their struggles with addiction, a chronic, potentially life-threatening disease that affects the individual physically, mentally, spiritually, and emotionally; nevertheless, they were somebody's sons, daughters, and husbands, and fathers.

They were loved, and they will be missed, even though they may have put their families through living hell while in the throes of their disease.

Addiction creates an obsession for the drug of choice and the compulsion to use it regardless of the known consequences.

Heroin and narcotic pain medications have incredible addiction potential. People will lie, cheat, steal, and break the law to feed their addiction.

This destructive behavior is a symptom of the disease itself which affects the user's ability to resist wrongdoing and enables them to justify their behavior, and allows them to ignore any feeling of guilt for their actions.

Essentially, nothing is off limits when trying to satisfy the need for the next fix.

It is easy to see, but not justifiable, why

society views addicts as losers, criminals, persons not worthy of our care and concern.

But we all know that addiction does not discriminate based on economic status, on your standing in the community, or your level of education.

The good news is, that as with many other diseases, addiction can be controlled and treated successfully.

While with proper treatment, even coerced treatment such as drug court, many addicts can live full lives in recovery.

Many others continue to suffer in silence, afraid to seek treatment and obtain available services they so desperately need and deserve.

Reducing stigma will result in individuals seeking and receiving treatment for their disease, enabling them to enjoy full and productive lives.

Reducing stigma, treating individuals, and supporting recovery are also associated with dramatic improvements in all areas of life: Family, health, and finance. Higher civil engagements; voting increases significantly. And, dramatic decreases in public-health and safety risks and associated reducing costs.

While reducing stigma will lead many addicts to seek treatment, educating clients about available medication-assisted treatment is equally important.

Over the years, advances in medication-assisted treatment and recovery, opiate addicts were supported by methadone and Suboxone, drugs designed to ease opiate cravings; however, these medications can easily be diverted on the illegal market.

A new, non-addicting, non-divertible medication named "VIVITROL" is on the market.

The injectable medication eases cravings for 30 days, allowing the person to fully focus on treatment and recovery; however, the drug is still quite expensive, at between 750 and 1,000 bucks per injection.

Also, many physicians are reluctant to become VIVITROL-approved providers, citing a lack of interest by clients to use this medication, and also cost factors.

Dr. Moehs is one of the very few who is a VIVITROL-approved provider.

The Rapid-Response Workgroup has also been working hard to make Narcan, an opiate-reversal drug, widely available.

Sometimes we have the notion that only drug addicts, particularly heroin addicts, die from opiate overdoses.

Anyone who is using opiate-based substances, illegal, as well as legal ones, are at great risk of experiencing or dying from an overdose.

Timely application of Narcan will restore breathing and prevent death.

The overdose-prevention rescue kits are relatively inexpensive; anywhere between $12 and $25.

The already mentioned minister is eager to attempt Narcan training; and most importantly, he will invite drug users, their friends and family members, to become trained, and to receive Narcan rescue kits, as most overdoses are, in fact, witnessed.

Dear Senator Ritchie: Again, we appreciate your interest and your time.

Supporting education and awareness-building of addiction as a brain disease, helping us reduce stigma about addiction, helping us distribute Narcan deep and wide into the community, will help to alleviate the drug problem in the community.

There is no one single method to begin

addressing this issue, as DA Ms. Intschert has already mentioned.

It really takes concerted efforts of all sectors of the community to be involved.

One we have already talked about: law enforcement.

Chief Currier in Messina, for reasons of his own, he really emphasizes compassionate policing; keeping people who are being arrested accountable, but in a compassionate way.

People who are users, they already know that they're not living up to their potential.

Getting it from the police, as they're being arrested, you know, the sense that they're considered, perhaps, low-lifes, or whatever, the arresting person may communicate verbally or non-verbally, is not productive, and will continue to further disincentivize the individual to help seek treatment that is so desperately needed.

[Applause.]

SENATOR RITCHIE: Anita, first I want to commend you for being so involved in every issue.

You were so helpful on the bath-salts issue.

ANITA SEEFRIED-BROWN: Thank you.

SENATOR RITCHIE: And you can tell that you

don't do it because it's your job, because you do it for the right reasons: because you truly want to help people.

And, appreciate you coming here today and talking about it.

We've heard from so many people testifying that the insurance is a real issue.

When people are at the point where they really need help, and either they're not able to get in, or, once they are there, they're only allowed to stay for a short period of time.

Can you tell me what you've seen on your end when it comes to that?

ANITA SEEFRIED-BROWN: Well, I work for the Alcohol and Substance Abuse Council, which is a prevention agency, and, we are not treatment.

When we deal with clients who are in need of treatment, we will refer them to a higher level of care.

So, we send them to Samaritan or to Credo or to another facility in the neighboring counties.

So I cannot really speak to the insurance issue directly, I apologize.

SENATOR RITCHIE: And do you think there are enough services available right now, considering the

huge spike in use?

I know there's been talk from the doctor, that he is the only one who provides that one specific drug.

And now you're saying that other doctors don't prescribe, what, the injection of this other drug.

ANITA SEEFRIED-BROWN: Correct.

SENATOR RITCHIE: So, is there something that needs to be done at that level, too, to get either more doctors here who are willing to participate in that, or, to get other doctors more involved, to ask them to be able to prescribe this?

ANITA SEEFRIED-BROWN: Last year, Miss Fitzgerald and I worked very hard to -- in organizing a physician-education program, and part of the physician-education program was to entice physicians to become VIVITROL-approved.

They don't even -- it doesn't even take a physician to become VIVITROL-approved. A nurse practitioner can also become VIVITROL-approved.

I am not exactly clear why physicians are so reluctant to use it.

Perhaps there are reimbursement issues involved.

Perhaps it is not -- perhaps it is the sense that addicted persons should tough it out, and should attempt to, you know, work the steps, work with their counselors, and don't necessarily want to have the addict, the benefit of a medication that would ease their cravings.

I really cannot speak to it cogently.

Maybe Miss Fitzgerald would be able, or Mr. Scordo would be able, to give us some insight.

I mean, cost of it is certainly an issue.

I tend to think, if a business person, a pillar of the community, would come to a private provider and specifically ask for this medication, it is my sense that that person would receive the medication.

Number one, the client already knew enough to ask for it; and, secondly, the client has enough money to pay for it, and the doctor doesn't have to wait for reimbursement for this rather expensive medication.

Now, that medication actually is also available in pill form and is very inexpensive.

The issue with the pill form is, that it has to be taken every single day. And the addict has to make a decision every single day to stay clean and

sober that day.

The decision to stay clean and sober is taken away from the addict by their 30-day injection.

There is no guessing: Well, my friend from Syracuse University is coming up on Friday, so I'm not going to take my medication, which will interfere with a high and be ready to party, and pick up my medication treatment again on Monday.

SENATOR RITCHIE: Thank you.

ANITA SEEFRIED-BROWN: Thank you.

[Applause.]

SENATOR RITCHIE: Next we have Jim Scordo, executive director of Credo Community Center.

JIM SCORDO: Senator Ritchie, Assemblyman Barclay, thank you very much for the opportunity to come to Watertown, and hear, as we obviously had a very full house with a great deal of interest in this topic.

As everyone has stated, and we've heard over and over today, addiction does not discriminate; does not discriminate against race, gender, ethnicity, socioeconomic status, neighborhoods you live in, particularly when you look at the opiate addict.

Not unusual that will you see an opiate

addict that is -- we've heard individuals that completed high school, that completed college, that were athletes, that had jobs, and, something happened; an injury, a surgery, a medical condition, that required that they were on pain killers for a period of time, and became addicted.

Very common.

Very common, that that's where that addiction starts for many of those individuals.

And there's a fairly high percentage of individuals that become dependent on the opiate prescriptions that will then go on to heroin use.

You know, we've heard from, the I-STOP program has done a great job of shutting some of that down. But what that also has done, is the unintended consequences has resulted in people -- the heroin is now more affordable, so they'll switch to the heroin.

The addictions to opiates and addictions to heroin is one of the most difficult addictions to treat.

I get family members, friends, people who know me, who call and say: I've got a friend, I've got a family member, who's addicted.

And I hold my breath and hope that they're

not going to tell me it's to opiates or it's to heroin, because that's a very difficult addiction, more difficult than any others that we've seen, to overcome.

The triggers: I can see somebody on the right path. And after being in treatment for a period of time, improve their health, put on 30 pounds, get their -- everything going back in their life, get a job, have an apartment, and everything going well, and then a trigger, and then something happens where they're drawn back to that addiction.

We've heard that over and over here today of different individuals who experienced that.

We've seen an increase in individuals who come to seek treatment at Credo, with both the opiates and in the heroin.

If we were to look at our residential program, our women's program, OASAS has a criteria, that if they're pregnant or if they're an IV-drug user, they get top priority to come into residential treatment sooner.

95 percent of our women who are in our residential program have an opioid addiction, because of that. They take priority over any other

addiction, and we have a houseful of them: 15 individuals, and 5 of them have their children with them.

In our adolescent program, we've got about 90 percent who are addicted to either opiates or heroin.

When we look at the treatment approach, you know, across the state, and across the nation, we have not had great results. This is a very challenging addiction to try to help someone over overcome.

We've taken a look at many different approaches.

We found that an individualized treatment approach, a holistic treatment approach, perhaps is the best way to go to try to treat that individual.

Medication-assisted therapy, as we heard from Dr. Moehs.

And we may need to make sure that we're treating, what was the underlying reason that perhaps led to this addiction?

Was it a mental-health issue?

Was it a trauma issue, that -- blocking the emotional pain?

Was it a physical?

Was it a primary care?

Was it an old injury?

So, we need to make sure, as part of our treatment approaches, that we're dealing, not with just addiction, but we need to deal with their mental illness, we need to make sure we're addressing their primary care, so if there's that injury that needs medication, we can do so, and not put them at risk of falling back into that full addiction with the opiates.

You asked a number of the speakers, "what you're recommendations were."

I've been in this field long enough, and I don't remember what the epidemic was, whether it was the cocaine that we were facing, or what it was, but not even sure whether it was the '80s or '90s, but we identified a three-prong approach: That, it needs to be a combination of law enforcement, it needs to be prevention, and it needs to be treatment; and we need to focus on all three.

We heard the detective from St. Lawrence County talk about they need resources.

They absolutely need resources.

They need to be able to buckle down on the dealers that are coming into our communities.

They're not our local people who are dealing.

These are people who are coming in.

Read the papers, look at the names there.

They're not names that I recognize at all that are from our community or from the North Country.

These are people from outside of the area that are coming in here, and, it's a business.

It's a business, and they're making money off it.

So law enforcement needs some dollars.

Prevention needs dollars.

Years ago, I remember when the Alcohol Substance Abuse Council was in a good share of the schools, having a student-assistance counselor that was there for all of the students.

And if they were in every one of the schools right now, I'm sure that one of the things they would be talking about and doing presentations with students on, and getting families in the audience, they'd be talking about opiates.

And Anita could tell you how many schools they were in at one point, and what they're in now.

And what's -- it's not that the schools didn't want them. It's that the schools could not

afford that.

So we need to make sure that we're putting money into prevention and education to prevent this from happening.

Despite all those efforts, we're still going to have some who are going to need treatment, and we need to have the full continuum of care. We can't just say, Well, we're going to do this in an outpatient basis.

We need to have detox available.

We need to have inpatient treatment.

We need to have outpatient treatment.

We need to have various levels of residential care.

We need to have permanent support of housing, apartments, available.

We need to have employment vocational services as part of that.

Case-management services as part of that treatment.

I'm concerned, as we were hearing earlier, about what we're seeing with insurance companies, and they're denying individuals inpatient care.

I'm concerned, as we approach a managed-care environment in 2015, what is that going to do?

What is that going to to do for people trying to access care?

Are we going to be looking at shorter lengths of stays?

Are we going to have to continue to send individuals out of state?

Why is that happening? Why do people in New York have to go out of state for treatment?

That's ridiculous. We should be able to treat those individuals here.

I'm concerned that, as we deal with this addiction with opiates, that research will show that longer lengths of staying in treatment produce better outcomes, particularly for the opiate addict.

And, are we going to see shorter lengths of stays driven by managed care?

Are we going to see that they need to fail two or three or four times in an outpatient before they go inpatient?

How many of them are -- before they end up failing that third time, how many of them are going to end up dead?

We need to work around that.

People who have mental health, to think that, all of these individuals, we're going to be able to

treat them on an outpatient basis is not realistic. We need to make sure we have other levels of care.

Otherwise, all we're going to do, is we're going to shift the cost. We're going to shift the cost to our local state -- or, our local jails and our state correctional facilities.

We need the beds for -- as the detective was talking about, we need those beds for the individuals who are dealers. Those are the individuals that we need to be incarcerating.

We don't need to be incarcerating somebody who has an opiate addiction or who has an untreated mental illness. Those individuals deserve the right to have treatment. This is 2014.

[Applause.]

JIM SCORDO: I'm pleased that, you know, we have representation on this Task Force. I see this as an opportunity.

I think New York State Office of Alcohol and Substance Abuse Services is willing to take a look at how we can go about enhancing treatment services.

There's a residential redesign committee that meets every Friday. I'm on the conference call every Friday, as they take a look at, as we go towards a managed-care environment, how can we make

sure that residential treatment is still an option and still available, and that managed care cannot deny that and say, "We're not going to do that," as it currently happens.

As they start working towards the parity laws, making sure that the private insurance companies recognize that addiction and mental illness should be treated very much like somebody who's, if they've got cancer, if they've got heart, if they've got diabetes, if they have primary care, and they need to be treated in a hospital setting, then that's what they need to do.

We need to advocate for the same.

[Applause.]

JIM SCORDO: We'll be happy to be a part in anything we can do to assist you in your efforts, and we look forward to working with you.

SENATOR RITCHIE: I know Anita touched on the stigma that goes along with this.

Can you tell me, in your opinion, how we need to change that? How do we start to change that?

JIM SCORDO: It's an ongoing process.

And you would think, in 2014, that we would be past this. This is not 1970, when, you know, addiction and mental illness was, really -- there

was a stigma attached to that.

We've gone and made great leaps and strides with that, but, it still exists.

It still exists, particularly if you're an opiate addict.

When we had the whole media thing, they wanted to do a story, Channel 7, I was cautious about putting any one of our individuals who's in recovery from an opiate addicts, in front of the TV and showing their face, when they're trying to get a job in this community, or they're going to JCC, and how they're portrayed as an opiate addict, and what people envision, more so than any other drugs, is that person with a needle stuck in their arm, and a junky, and the stereotype.

Now, geez, I got that person employed.

Or, the person that comes in, did you know that the person you got sitting behind the counter who waited on me is a junkie and an opiate addict?

That's the mentality that still exists, particularly with opiate addiction.

It's ongoing education.

I come back to my prevention-education piece: We need education. That's important to help overcome that stigma.

It's a difficult battle, and it just needs to be ongoing, constantly.

SENATOR RITCHIE: Thank you.

JIM SCORDO: Thank you very much.

[Applause.]

SENATOR RITCHIE: We have a couple more speakers.

Penny Morley, prevention director at Farnham Family Services.

PENNY MORLEY: I don't know, he's kind of a hard act to follow.

But, ironically, prevention, I believe is really the key.

You talked about earlier, or someone talked about, going into schools and doing education.

It's not just education.

The student-assistance counseling that he spoke about, we have in Oswego County, and we're in five school districts throughout the county.

We used to be in eight.

And, it makes a difference to those children, to have a connection with an adult that they can count on, and that can help them with those decision-making skills.

One of the people that spoke earlier said,

I "didn't know how to deal with my feelings."

That's something that our kids aren't being taught necessarily at home, so we need to help them with that.

And that's what we do: Help them learn how to cope with their feelings, help them make healthy choices.

All those things that, you know, we kind of take for granted sometimes, they're not getting taught.

So, that's what we do in our program.

Another thing we do is talk about drugs and alcohol. You know, what's not helpful for them to use, those kind of things, starting at very young ages.

We're in K through 12 in our schools; and, so, really, you start out with very simplistic things. You know, not putting things in your body that wouldn't be healthy.

And then when you get to middle school, talking about drug use, over-the-counter medication, and the actual prescription meds, because that's where we're seeing kids are starting. They're starting in seventh grade.

It's not, Oh, they're in high school, they're

going to start using someone else's medication.

They're bringing it to school, and they're sharing.

So that's something we talk about in the schools.

And, one of the things that I think is really important, is we need to talk to our, kids because they do listen.

And that's something, if I could say one thing to a parent: Talk to your kids.

No matter how much they roll their eyes, throw their hands up, say some nasty things, they hear what you have to say, and they will listen, and it will come back to them.

It's not the only answer. There is not one answer, but it does help.

We also -- the information I gave you at our agency, my director couldn't be here with us today, so, I brought some agency information as well.

From 2010, our heroin use of our clients was 2 percent, to 2014.

Just starting 2014, from January til today -- or, sorry, Monday, 16 percent of our clients are using heroin.

That is a huge increase.

And, we started seeing a rise in late 2012, early 2013, and we've talked about all the reasons that started.

Those unintended consequences, you know, had happened, but we're addressing them now.

So, we started an opioid group for the agency, for people that were in treatment.

We also have a doc that works with us, that does Suboxone, so he works closely with our staff.

I believe there's only two doctors in Oswego County that provides Suboxone treatment.

So -- and Oswego County's pretty big, so we have waiting lists, as well.

I can get those numbers to you, too, if you want those, because I don't have those off the top of my head, but can I get them.

So, the increase in heroin in our city is frightening.

The city of Oswego has seen an increase, and Fulton.

Ironically, I wish the Sheriff was still here, because our people that are coming into treatment are not reporting heroin use in the outlying areas. They're reporting, still meth.

So I'm with the gentleman behind me, we're a

little slower over in Oswego County with some of our development, but we are seeing heroin increase in the city areas, so -- from self-report from our clients.

So that's the information I have in that regard.

I spoke with one of my contacts at Oswego Hospital. I wanted to know how many overdosed people they get in the ER.

And she said, you know, she said: Last night we had two. And in the last month we've had 10.

I mean, that's Oswego. It's not -- you know, it's not a huge population of people, so we're seeing an increase in heroin, and we're trying to address it in our treatment. And our prevention counselors are addressing it with our youth.

And, it really is going to be very important that we have that two-pronged approach that we can do.

And it's -- the funding piece is so important, because if we don't have funding, our counselors aren't in the schools.

I'm a grant-writing fiend, and, I do my best to get money in, but there's not a lot of money out there.

So, one of the other things I wanted to mention, I sat with Mr. Barclay about a week, or two weeks ago, maybe, and I had mentioned this to him: Something we're trying to do is form a coalition for Oswego County, to address drug and alcohol use in adolescents.

And, we used to have a coalition for Oswego, but that was many years ago.

So, we're trying to get this coalition off the ground so that we can try and apply for some Drug-Free Community funding, so that maybe we can actually address some of the other issues, the more environmental issues, that we see.

So...

SENATOR RITCHIE: Can you elaborate on the programs that you have at the schools?

Is it one counselor per school? Is it full-time?

PENNY MORLEY: That's a great question.

I actually have three counselors.

I have a counselor three days a week at APW High School. Then she goes to Phoenix Elementary -- I'm sorry, Phoenix Middle School, and Phoenix High School. Those are her schools.

I have a counselor that covers just the elementary schools in Oswego. She covers all five of them.

And, then, another counselor that covers Mexico Middle School, Mexico High School, Oswego High School, and Oswego Middle School.

SENATOR RITCHIE: And the counselors, do they go into each class?

Are they in an office so the kids can come in and talk to them?

How does that work?

PENNY MORLEY: The majority of their time is spent with students, either one-on-one or in groups.

And, students can self-refer. Students can be referred by a principal, by a teacher, parents call us.

They also do classroom presentations, but their main goal is that focused one-on-one or small-group interaction with youth.

We use the 4-day developmental assets.

I'm not sure if you're familiar with that, but one of those is -- has been hugely studied.

I can send you some information on that.

But one of the things in there is, if you have one connection with an adult, as a youth, just

one, you can be more successful.

So, if that one person isn't your parent or a relative or someone close to you, it can be that student-assistance counselor.

SENATOR RITCHIE: Do you have any idea how many kids would come to the counselor on their own to speak with them?

PENNY MORLEY: Oh, yeah. I have all those stats. I can send you the numbers.

Roughly, the students that seek out the counselors usually are at the older ages, and I'd say probably half would actually come on their own.

SENATOR RITCHIE: Okay.

If you could get me those numbers, that would be helpful --

PENNY MORLEY: Yeah, absolutely.

SENATOR RITCHIE: -- you know, as we look to find ways, or look to fund certain programs.

This sounds like something that, for those schools that have someone there, they have a great advantage.

But for the other schools, that's too bad that they don't have the same counselor there for the kids to reach out to.

PENNY MORLEY: We used to be in Fulton City

schools, K-12, and the funding dried up probably 10 years ago.

And people are still are, like, Aren't you coming back to Fulton? Aren't you coming back to Fulton?

And it's, just -- it's a money issue.

You know, the money, the Drug-Free Schools money that they had no longer exists in the way it did.

So, we have to try and find other funding.

SENATOR RITCHIE: Thank you.

PENNY MORLEY: Thank you.

ASSEMBLYMAN BARCLAY: I really have more of a comment more than a question.

Although, the numbers that -- I think you told me the numbers that the counselors actually see in the school is probably substantial, if I recall.

PENNY MORLEY: Yeah, but I don't want to quote a number and have that on record, and be wrong.

ASSEMBLYMAN BARCLAY: Right.

PENNY MORLEY: But I can send that to you.

ASSEMBLYMAN BARCLAY: Yeah, I don't remember the specifics of who voluntarily goes, versus who's referred -- or who goes on their own, versus...

I just want to compliment you. I think you guys are doing, really, a wonderful job, you and your director in Oswego County, and I look forward to working with you on that.

I know you've been in touch with my office about the child-care counseling, and we'll definitely help out any way we can.

PENNY MORLEY: Excellent.

Thank you so much.

SENATOR RITCHIE: Thank you.

[Applause.]

SENATOR RITCHIE: Cherie Moore of Jefferson County.

CHERIE MOORE: Hi, I'm Cherie, and I'm actually from Lewis County.

I'm a member of the local Al-Anon Family Support Group; a wife, mother of two children, and I have a successful career.

Just to let you see a difference in backgrounds:

I grew up in a middle-class family with no addicts in my life.

My father was a successful insurance agent, and my mother raised us six children.

I have been married to my current husband for

18 years. My two children grew up in a home with no alcohol, no drugs, or even prescriptions in our home, other than the common antibiotic.

We have both worked, and have successful careers, but I am currently dealing with a heroin addict.

My daughter has worked in jobs since she was in ninth grade, with the summer youth programs and fast-food restaurants.

She took a civil-service exam at 19 years old and obtained a job with the County. She has always been very dependable, reliable, and a hard-worker.

She worked overtime, holidays, and whenever she was called in for all her jobs.

My daughter has always been very responsible with her bills and has excellent credit even to this day.

She has never been in any trouble at all any time, until recently.

In 2011, when my daughter was 24, she moved out on her own, with a roommate. This roommate introduced her to heroin and other acquaintances, people, and she started dabbling socially.

It was not every day, and she could take it or leave it at first.

She was still working, making good money, saving for a new truck, and looking to buy a house.

She had a great life ahead of her.

Then, in 2012, she met a person that she liked, a male friend. There was a drastic change in her behavior, attitude, and lifestyle.

She quit her County job.

She was impossible to talk to, get ahold of, or even get any sort of comment from her or commitment for anything.

She worked a couple of minimum-wage jobs, but her life was a mess, and she had made mine a mess.

I was in constant fear for her life, since I knew this person was abusive, and I was going crazy, trying to figure out what was going on and how to help her.

She lived in a camper trailer with no heat, electrical, running water, et cetera.

She wasn't raised this way.

She would still take a shower daily at a relative's house, but she was not keeping up with the hygiene she normally did.

She lost a lot of weight and was not eating properly.

During all of this, she maintained jobs and

was high-functioning, and kept her bills paid, even though she went through every bit of her savings and took a loan out for more money.

I can honestly say, that with all the changes in her life and the downward motion she was in, she never stole from our household or any member of it.

This went on until February of 2013.

She came to me and her brother, asking for help. She admitted to the drug use, that she was an addict, and knew she needed help.

This was the first time I really knew what was going on with the changes in her life.

She had only been using steady for less than a year.

We were trying to research and figure out help for her, but because she had no insurance -- actually, she was in between, because she was turning 26 and was losing our insurance -- there was nothing available.

She was on unemployment which made it too much money. Just not enough for Medicaid.

She didn't make a lot of money at her jobs, but, again, that was still too much for Medicaid.

She had to move back home.

She was laid off from her job and on

unemployment.

She was really trying to get her life back in order.

In May of 2013, she met up with the person that she had been with previously; was in the wrong place at the wrong time.

To me, it was good, to some degree, because of some of the outcome, but it is affecting her life for the rest of it, because of the system.

She had this person in her car, and they were stopped. My daughter was arrested because it was her car. She had no idea what this person had with them.

There was no charges for possession, sales, or driving under the influence.

The charges were for manufacturing meth.

There was no meth in the car, and nothing mixed together as in manufacturing.

There were items in a bag that could be used for meth. My daughter had no idea they were there, and to this day, has no idea how to even make meth. It was not what she had ever been involved in.

She spent 45 days in jail, and was appointed a lawyer from the courts; not a public defender.

This lawyer visited my daughter one time for

less than 10 minutes the whole 45 days she was in.

I was the one that informed him she was housed out to Oneida County. He had no clue.

I had called him several times, upon my daughter's request -- because, in jail, you have no access to call your lawyer -- asking him to please go meet with her. There were things she wanted to discuss with him, and she had questions.

He insisted that she knew what she needed to know, and told me not to call his office again.

This is a lawyer being paid by the County to do nothing.

How is this a good thing?

Well, while in jail, my daughter met with a counselor for pretrial release. She was honest, and admitted her heroin addiction, hoping that she would get help from someone.

She was released on pretrial, and in the course of the past year, my daughter has been in two inpatient rehabs.

The first one was 28 days;

And the second one, it was 6 weeks, only because it was a 3-week program. The jail -- she was sent to jail in between the two rehabs, because the judge decided she needed help, and she was going

to sit in jail until she got into the rehab.

When she got in the second rehab, it was for three weeks. She had to stay six weeks, because she had to wait for a bed for a halfway house, which they didn't tell her she was going to till after she was in the rehab.

In the rehabs that are three weeks, you're sitting there, you're doing the program. When you have to stay longer, you're just repeating the same program.

Will it help to repeat? Yes, to some degree, but it also does not help, because you're not getting any extra help. You're not getting anything different.

She put herself -- before she went to jail the second time, she was doing outpatient rehab weekly. It was minimum, two days a week.

She put herself into extensive outpatient, and she is currently in the halfway house.

She still only saw her lawyer one time, except for five minutes before court.

And I know this for a fact, because I was with her every time during the whole 2 stints of 45 days each.

So that was a total of 90 days in jail, she

saw her lawyer once.

She is currently six months clean. She will be coming home in a couple of weeks.

You are probably wondering why I'm giving you all this background?

Well, my main concern is stigma with the system itself.

These are people that are degree-educated, but not street-educated. They are supposed to be there to help people, are supposed to be -- they're supposed to be there to help and -- to help the people that are innocent -- well, they are supposed to be there to help, and to -- and people are supposed to be innocent until proven guilty.

Well, I learned an eye-opening lesson this past year about our so-called "system," and the people that work in it.

And this is Jefferson County that all of her legal stuff was in.

The lawyer had nothing good to say about my daughter, and he does not even know her.

During this whole situation this past year, he did nothing to help her, would not meet with her. Tried to cut deals, and said to her face: I don't care if you go to trial. It is more money for me.

He called her "a severe drug addict" in court in front of everyone present that day.

He doesn't know what she even does for drugs: how often, how much, or for how long.

Another situation with stigma in the system?

During one of the outpatient meetings, my daughter met a very nice young man that was there for alcohol abuse. He was mandated by drug court.

They struck up a friendship and were really supporting and helping each other.

They encouraged each other to go to outside NA and AA meetings.

This person was honest with his drug-court counselor and the judge, and let them know about the friendship.

The counselor gave him a hard time from then on, telling him that he had to stay away from her; that she was a low-life loser, that she was no good for him. She doesn't have a job, and she is a drug addict that he does not need to be around.

This is coming from a person that has no clue about my daughter's history.

The judge and the counselor would make comments when he had to report, and were repeatedly asking him if he was still hanging around her.

He was told that if he did not drop the friendship, he would not graduate from drug court.

The counselor insisted he spend no time with her and that he tell her to get lost.

Who are they to judge when a person is good for another person, or not?

Who are they to judge my daughter, degrade her character, and call her "a low-life loser," when they have never met her?

Do they know her life history or her situation? No.

The insurance companies -- again, back to insurance, because it does fall back on them -- they're fighting the treatment of drug addiction. They are trying to say it is behavioral problem.

Drug addiction is a disease that affects the brains.

Drug can alter important brain areas that are necessary for life-sustaining functions, and can drive the compulsive drug abuse that marks addiction.

I talked to my daughter before I came here, and I asked her her opinion; and I asked her, as a drug addict in the system, in the jails, in the rehabs, in the halfway house, what she felt. What

she felt that these people need, and she needed.

Part of it was, this area has a huge health problem with diseases and hep C due to the uncleanliness of the drug users that have no choice.

In all honesty, drug abuse and addiction is so large across the USA, it will never go away.

We need to work on making people healthy the right way, and then you will see a difference.

The area needs to implement a needle-exchange program. People cannot afford to get clean supplies or dispose of their dirty-needles supplies the safe way.

Not to promote the drug use, but to promote safety, to promote health.

A needle-exchange program will help protect the public: The little 3-year-old playing in Thompson Park, the grade-school kids out on the playground, et cetera, that don't even realize, when they're picking up something and they're jabbed with a needle, that now, maybe at 8 years old, they're getting hep C from a dirty needle.

The needles get thrown out improperly, and anyone that comes in contact with them can be exposed to something.

The drug addicts have no access to sharps

containers. They have no access to dispose of these.

It's going to be there. It's always going to be there, to some degree.

To help with that, to me, I looked at both sides, and I said: Well, you're promoting the drug addiction.

She said: No, you're helping with the safety of the youth, because these drug addicts will throw their stuff anywhere. They don't care where it is or who gets it.

I don't know if you want to hear about my opinion on the legal system, so I'll go on to treatment.

Treatment needs to be longer than two to three weeks. Just because they are over the withdrawal, detox does not mean they are better, and now have behavioral issues instead of disease issues.

Not everyone should be classified the same. The system needs to treat each addict situation separately.

Everybody that talked today mentioned they need to have individual plans. And they really do.

Most people are dual-diagnosed with mental

health and drug addiction. Some are just addiction.

They should not be put together in the same programs, such as outpatient rehabs, halfway houses.

They need to be treated differently than each other.

Halfway-house people have to follow the same program no matter what the addiction or mental-health problem.

Local outpatient programs are the same program, structured the same for everyone, no matter what the issue: drugs, alcohol, mental health.

It doesn't work.

There needs to be a separate program that deals with the specific problem.

Then there's the issue of getting other help if needed.

In-patient treatment rehabs or treatment for cravings and withdrawal, there are addicts asking, begging, for help to change their life and get clean.

This is exactly what happened to my daughter before she went to jail the second time.

She was in extensive outpatient. She was at mental health. She had counselors. She had group counseling. She had individual counseling.

She begged everybody to help her with the cravings.

Nobody would help her. Nobody would talk to her. Nobody would give her the time of day.

In October she got frustrated. She relapsed.

She didn't relapse because she wanted to.

She relapsed to prove a point, and to try to get some help.

That's when the judge put her in jail for another 45 days.

They get frustrated and mad, and then they say "To hell with it."

No one wants to help or cares that they want to get help.

My daughter put herself in the extensive outpatient because the local program wouldn't.

The regular program is group two times a week for an hour; one-on-one, one time a week for an hour.

Intensive is group four times a week for an hour; one-on-one is every two weeks.

She begged everyone for help, and ended up back in jail for another 45 days.

Group treatment needs to be structured like NA and AA meetings. And this is coming from an

addict that has been through them all.

They need to be able to discuss current issues going on in their life and get help with real suggestions; examples of actual experiences, stories of how other addicts handled similar situations or got through it.

Right now, they only do State-required work pages. They are all general, and really don't do much to help the addict.

She goes -- currently, in the halfway house, she herself is going to an NA or an AA meeting once a day, seven days a week, sometimes twice a day, because she wants to, because that helps her.

She goes to the group three times a week because it's mandated. She doesn't get that much help out of it.

In jail there is no treatment or help at all.

If you are detoxing from heroin, it can last up to a week. They make you suffer. They do nothing for it.

There are meds to help with withdrawal, but in jail, no one gets anything.

There is practically no counseling in jail.

You can sign up, but good luck if you see anyone.

My daughter was in for a total of 90 days between the two. She signed up first thing both times, and never once saw anyone.

SENATOR RITCHIE: Thank you.

CHERIE MOORE: You're welcome.

[Applause.]

SENATOR RITCHIE: We have one last speaker, Aaron Vortel from ACR.

Is Aaron still here?

AUDIENCE MEMBER: No, they've left.

SENATOR RITCHIE: All right.

I guess we're all set.

I thank everyone for coming.

All the testimony will be forwarded on to the full Senate Task Force.

And, I appreciate everybody staying longer than we were supposed to, but the testimony has really been helpful, and, appreciate all your time.

Thank you.

(Whereupon, at approximately 4:04 p.m., the forum held before the New York State Joint Task Force on Heroin and Opioid Addiction concluded, and adjourned.)

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