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

PUBLIC FORUM: OTSEGO COUNTY

PANEL DISCUSSION ON HEROIN EPIDEMIC IN ONEONTA

SUNY Oneonta
108 Ravine Parkway
Oneonta, New York 13820

April 28, 2014
9:30 a.m. to 12:00 p.m.

PRESENT:

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Chairman of the Senate Committee on Alcoholism and Drug Abuse

Senator James Seward, Task Force Forum Moderator
Member of the Joint Task Force
Chairman of the Senate's Standing Committee on Insurance

Senator Thomas O'Mara
Member of the Joint Task Force

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PANELIST INTRODUCTIONS (Continued):

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Sheriff
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PANELIST INTRODUCTIONS (Continued):

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Mike MacInerny
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New York State Police, Troop C

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Primary-Care Physician
Bassett Healthcare Network

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SENATOR SEWARD: Well, good morning, everyone, and I want to welcome everyone here for our Senate Special Task Force forum on Heroin and Opioid Addiction to -- here in Oneonta.

And, we have a very distinguished group that's gathered here today, and we look forward to your input on our discussion.

As we all know, heroin and opioid use has reached epidemic proportions across the state, across the nation, and, unfortunately, right here in our area as well.

The statistics are shocking.

You know, nationwide, heroin-overdose deaths increased 55 percent between 2000 and 2010.

Here in New York State, overdoses killed 2,051 people in 2011, more than twice the number just in 2004.

Further, drug-overdose deaths are the leading cause of accidental death for people ages 25 to 64, with more than 40 percent attributed to heroin and opioids.

These are numbers from the State Attorney General.

And these types of statistics mirror what I am told is going on right here in our area,

similar numbers, similar trends. Particularly, when you look at the increased hospitalizations, program admissions, for heroin and opioid uses, the numbers are staggering.

Lives are being lost, families are being destroyed. Our health-care dollars are being stretched, and law enforcement and prosecution dollars are also being stretched thin.

And so that's why, this year, our Senate Majority Coalition created a Special Task Force on Heroin and Opioid Addiction, to examine this rise in heroin and opioid use to develop recommendations for attacking this problem.

This is one of 12 forums that are being held across the state, so it is critical that we bring together stakeholders and experts to develop a comprehensive strategy for attacking this problem.

We need your information, your insights, and recommendations for action.

We have with us today those who have personal stories regarding this issue. We have law enforcement and prosecution; those involved with treatment, medical providers, educators.

And I look forward to a productive session here today.

I'm honored to be joined here for this hearing by two of my colleagues.

First of all, the Chair of our Task Force, Senator Phil Boyle, the former member of the Assembly, now in the Senate, who chairs our task force. He is from Suffolk County;

Along with another one of our members of the Task Force, my colleague Senator Tom O'Mara from the Elmira area.

And I would ask Senator Boyle, if you would like to make a few remarks?

SENATOR BOYLE: Sure, thank you very much Jim, and thank you for hosting this.

I want to thank Senator Seward and Senator O'Mara for being part of this Task Force, and for all the panelists today, and all the participants in the audience, for coming.

As Senator Seward said, this Task Force that I'm chairing -- we're actually up to 15 forums now -- and we're going around the state, and what we're looking for is:

Whether you're a prevention provider, a treatment provider, or a law-enforcement official, every day you deal with this heroin epidemic on a statewide basis. It goes from the west, down to

Suffolk County where I live.

If you could say, "If I could just change this law, or a couple laws," that's what we're looking for today; some input to say:

How can we change the system to better help with prevention, to stop young people from starting the use of heroin and other opioids?

The treatment that may not be there when you need it.

And, of course, the law enforcement to put these drug dealers away for a very long time.

Thank you, Senator.

I look forward to an exchange.

SENATOR SEWARD: Thank you, Senator Boyle.

Senator O'Mara?

SENATOR O'MARA: Thank you, Chairman.

It's a pleasure to be here this morning.

I'm a Senator from the Southern Tier, Finger Lakes region. I live in Big Flats. And, my district goes from Elmira to Hornell, including Ithaca and Penn Yan; so, that's the Finger Lakes and Southern Tier regional.

I'm a former prosecutor myself, having been an ADA in Manhattan, and an ADA in Chemung County, and District Attorney of Chemung County, through out

the 1990s.

And it's amazing the resurgence that heroin and opioids has made since that time, because it was not a significant or major problem back in that time.

But, to see this resurgence is very alarming.

And, look forward to the product that we come out with this Task Force.

I thank Senator Boyle for his leadership on this, and I hope that we can make it 16 forums, with one in Elmira/Corning coming up.

But I thank everyone for their participation this morning. I look forward to your input, and a successful product coming out of our Task Force conferences around the state.

SENATOR SEWARD: Thank you, Senator O'Mara.

At this point, I'd like to go around the table and have everyone, simply, if you would introduce yourselves, and indicate what -- if you're representing an organization or an entity just, let us know that, as well.

So, everyone can introduce themselves.

Why don't we start right here with you, Justin.

JUSTIN THALHEIMER: Hi, I'm Justin

Thalheimer. I'm with Otsego County Addiction Recovery Services.

NANCY ORTNER: I'm Nancy Ortner. I'm with the Schoharie County Chemical Dependency Unit.

CHRISTOPHER KEMP: My name is Chris Kemp, and I'm the director of the Delaware County Alcohol and Drug Abuse Services.

DA RICHARD NORTHRUP: My name is Richard Northrup. I'm the Delaware County District Attorney.

DA JAMES SACKET: James Sacket, Schoharie County District Attorney.

DA JOSEPH McBRIDE: I'm Joe McBride, Chenango County District Attorney.

DR. STEVE GRAHAM: Steve Graham. I'm an obstetrician/gynecologist with Bassett.

DR. JOSEPH SELLERS: Joe Sellers. I'm an internist and pediatrician with Bassett, and the secretary of the State Medical Society.

DR. KELLY ROBINSON: Dr. Kelly Robinson, medical director of A.O. Fox Emergency Department right here in Oneonta.

JOE BIVIANO: Joe Biviano, administrator of Take Back Chenango.

ROBERT CLIPSTON: Robert Clipston, co-founder

of Take Back Chenango.

NICK SAVIN: Nicholas Savin, district superintendent at the Otsego Northern Catskills BOCES.

JOE BOOAN: I'm Joseph Booan. I'm the director of student services at ONC BOCES.

Our two centers are in Grand Gorge and in Milford.

NORINE HODGES: Norine Hodges, the executive director of the Schoharie County Council on Alcoholism and Substance Abuse.

DAVID RAMSEY: Dave Ramsey, director of Delaware County Alcohol and Drug Abuse Council.

JEANETTE TOLSON: Jeanette Tolson, executive director of Friends of Recovery of Delaware and Otsego counties.

JULIE DOSTAL: Julie Dostal, executive director of the LEAF Council on Alcoholism and Addictions in Otsego County.

UNDERSHERIFF CRAIG DuMOND: Craig DuMond, Delaware County Undersheriff.

SHERIFF THOMAS MILLS: Tom Mills, Delaware County Sheriff.

SHERIFF ERNEST CUTTING, JR.: I'm Ernie Cutting, Sheriff in Chenango County.

SHERIFF TONY DESMOND: Tony Desmond, Schoharie County Sheriff.

SHERIFF RICHARD DEVLIN: Richard Devlin, Otsego County Sheriff.

SGT. GARY LEAHY: Gary Leahy, State Police, Oneonta.

MIKE MacINERNY: I'm Mike MacInerny. I'm a senior investigator with the State Police, assigned Oneonta.

MYLEA BUFFO: Mylea Buffo, I'm an addict.

DEB FRANCE: Deb France, I'm a parent.

SENATOR SEWARD: And I would also mention that, in the audience today:

We have Tina Molett, who is with our colleague Senator Bonacic. Also, a supervisor on the Delaware County Board of Supervisors.

And, also, we're delighted that the Chairman of the Delaware County County Board of Supervisors, Jim Eisel, is with us today as well.

Our format today is that, we have prepared a series of questions and discussion points to help lead us through a discussion on this issue.

Everyone should feel free to chime in at any point if they feel that they have something to contribute to the point that's being discussed at

that particular time.

I would also like to invite members of the audience to submit any questions, you know, for our panel, or any general statements.

They are -- there are index cards at the check-in table, and questions and comments can be made at any point during our forum here today.

And because of our session schedule, I know the three senators need to be in Albany by 2:00, so, we need to conclude by noon today.

Of course, we do have a number of police with us here.

[Laughter.]

SENATOR SEWARD: I would also like to mention at the outset, that if any one of our panelists or anyone in the audience has prepared any written statements that would you like to have become part of our record of this forum, please submit them to staff at the table, and those comments and statements will become part of our record here today.

To start our discussion this morning, I would like to call on both Deb France and Mylea Buffo, who have joined us, who both have personal experience and personal stories regarding this issue.

I thought that would be a good way to start our discussion.

To the extent you feel comfortable in discussing -- briefly discussing your personal stories, we would like to ask you at this time.

DEB FRANCE: Good morning.

My name is Deb France, and I'm here as a parent to put a face on this epidemic of heroin and opioid addiction by telling my personal story.

My husband, Bob, and I are your typical middle-class family. We have a house, two jobs, two cars, two children, and a dog. We're active in the community and our church, and our sons participated in sports, band, and chorus, as well as Cub Scouts.

When our youngest son Jeremy, a talented, personable young man, was 16 or 17, he had his wisdom teeth pulled and was given a prescription for pain reliever.

Suddenly, our typical family was turned upside down, and the story goes terribly wrong from here.

Whether it was because of his anxiety disorder or an ordinary experimenting teenager, it doesn't matter, but Jeremy found a high from these

meds and it became a downward spiral.

We don't necessarily know how the path continued or what led to what, but Jeremy went from buying prescription pills from his classmates, to heroin and any other opiate he could get his hands on.

When he was 18, he chose to leave home rather than to abide by our rules, and ended up stealing to support his habit.

Arrested and put in jail, he came back home and eventually revealed his addiction to us one sleepless night as we helped him go through withdrawals.

As parents, we did extensive research and looked for resources to help our son within our community while trying to keep our dirty little secret within our home.

At that time, access to outpatient treatment locally was long and cumbersome. This led us to an out-of-state agency which took our money to provide an in-home Suboxone treatment, minus any counseling or support.

When this did not work, and, in fact, made matters worse, we researched inpatient facilities and enrolled him in a 30-day program.

After 14 days, our insurance company would no longer pay for his inpatient stay, stating he would be okay with intensive outpatient therapy.

Of course, they did not take into consideration that the facility was two hours away from our home.

We ended up paying out-of-pocket to keep him there for the entire 30 days which the treatment plan indicated was necessary.

After his discharge, he was enrolled in the local chemical dependency clinic. He continued to struggle, and around his 19th birthday, could no longer deal with his addiction and attempted suicide.

Luckily, he survived, and because of a State mandate, once medically stable, he was transferred to a psychiatric facility.

We again struggled with the insurance company, who told the hospital he was a heroin addict, "cut him loose."

We were fortunate enough to have a sympathetic nurse-practitioner friend who bucked the system, despite possibly losing her job over it, and because of this, helped him stay in the hospital long enough for us to find an out-of-state rehab

facility that our insurance would pay for.

Interestingly enough, Marworth was a facility filled with rescue and medical professionals who were being treated for addictions related to their 9/11 experiences.

From Marworth, Jeremy was transferred to Cayuga Addiction Recovery Services (or, CARS) in Trumansburg, New York.

Again, insurance would not pay for his stay there, but we sacrificed his college fund to private-pay, and Jeremy stayed there for seven months, doing well with this highly-intensive program.

On discharge, he was again enrolled in the local chemical-dependency center, and we were optimistic that we had our loving son back.

As the addiction community will tell you, relapse is a part of the recovery process, and Jeremy would do well for a while, and then he would struggle.

He did fairly well for several years, but then relapsed, and because of this probation violation, he was sent to jail.

Jeremy was incarcerated alongside some of his dealers, and at the same time, the local king pin

was also arrested and put in the Otsego County facility.

One month after his release from jail, and one week after his 23rd birthday, Jeremy successfully committed suicide.

His final words to us were, that he loved us, but he could not handle this addiction and he did not want to be a burden anymore.

What I hope you can learn from the story, is that heroin and opioid addiction does not discriminate based on age, sex, income, or social status.

The power of this drug is incredible, and those who become addicted are often helpless to overcome it.

Every day, doctors are prescribing opiates for pain relief, and although not everyone becomes addicted, the numbers that do are staggering.

When pain relievers are no longer accessible, heroin provides a cheap option that is readily available in our schools and community.

Studies show that 1 in 4 of those who try heroin become addicted.

The collateral damage to our community that this epidemic brings is staggering.

There is -- I'm sorry -- opportunity to set up drug rings to profit, a court system is overrun with drug-related cases, jails are filled with addicts and dealers, and families are torn apart and lives are lost.

My husband and I struggled to find accessible resources to provide help for our son.

We both feel that we need to invest in prevention programs and community education, as well as treatment centers at the local and state level.

Insurance companies need to recognize this addiction is a disease and provide the length of treatment necessary to assist in recovery.

We need to recognize that jail is not the place for addicts unless there is a recovery program to assist them and work on the underlying causes.

We are pleased that this issue is starting to get some recognition for the crisis that it is, and hope that forums such as these will help to open dialogue and generate effective prevention and treatment options.

Thank you for the opportunity to share my story.

SENATOR SEWARD: Thank you very much, Deb. I know it's not easy.

And, Mylea, did you have anything you wold like to add at this point?

(Non-working microphone.)

MYLEA BUFFO: I'll share my story.

My name is Mylea Buffo, I'm 27 years old. I'm an opiate and heroin addict.

I will give you the short version of my story because it's traumatizing, and the things that I've done and seen are unspeakable.

My addiction started about seven years ago when I was having back pain and my family doctor prescribed me hydrocodone.

I felt superhuman. I had zero pain, slept better than I ever had, zero anxiety, zero depression, and more energy than I could have ever imagined.

Soon it was not enough.

Within a year, I was seeing a different doctor and I ended up on oxycodone, 30 milligrams, 6 times a day; OPANA, 20 milligrams, 3 times a day; and, OPANA, 40 milligrams, 2 times a day.

People on their death beds do not receive this type of medication.

It's hard not to blame the doctors, but I have to take the responsibility to recover.

It no longer felt good. It caused more pain, sleepless nights, the energy was gone. I was more anxious and depressed than ever, and it became I had to have it; it was no longer I wanted it.

I was self-medicating, and seems I was on a mission to destroy my life. I was so out of control, and the more out of control it got, the worse I got in my addiction.

I was hiding my pain in medications that made my complete healing system numb.

I was filling prescriptions for a month, every week, using up to six different pharmacies a month.

Every day I would wake up and snort or inject pills, and I would not be able to do anything in my life without doing pills first.

To take a shower, I would have to do pills before and after.

I was so high I was oblivious to anything going on around me. My only thought was about drugs.

Soon my sister got me to go to detox for three days, and my family doctor found out and was so mad, he cut me off.

I hid for so many years behind the fact that

my scripts were legal, so I was not an addict.

And that was now gone: I was an addict.

The last conversation I had with my doctor, he said: You'll experience withdrawals for seven days.

On the 23rd day of my withdrawals, I was cursing at him.

I can remember so many times when I would just watch people at the store and wonder, Why can't I be normal?

I was now buying street drugs, and what most people refer to as "risky behavior" was just a normal day in my life.

I didn't care where I was. I was injecting drugs, using with people who had hepatitis, and I was always in trouble with the law.

Every day, I had in my mind that there was no help, there was no chance for me.

While normal people were wishing for good health and happiness, I was wishing with every injection that God would take my pain away and let me die.

I wanted it so bad, I could imagine my own kids at my funeral saying goodbye to me. And I truly believed that that was best for them; that

they had a better chance in their lives if I was dead.

My addiction was so bad, my boyfriend would check me all the time, wherever I passed out, to make sure I was still breathing.

By this point in my addiction, I completely signed my life to the devil. Feeling stuck with no way out, I ended up with the heroin. It was cheaper, quicker, and easier to inject.

This was a whole nother addiction for me.

I would hide it as much as I could from everyone, because I was now addicted to the needle worse than I could have ever imagined.

My risky behavior was now off the charts. I was no longer the same person.

I have so many classmates, and had awful marks; and still, to this day, I tried to minimize my addiction.

I made things worse -- to make things worse, I ended up getting arrested. And I am currently in drug court for criminal possession of a controlled substance.

The night of my sentencing was the best night I slept in seven years, because the worry of my legal issues were finally being taken care of, and

it was a sense of relief I'd never experienced.

I made a choice that I didn't want to live like this anymore, and I take drug court very seriously, because I know, if there's a chance for me, drug court is the way to freedom from my chains of addiction.

Today I am five months clean and sober.

I do not take any medication except for a blood-pressure medication, because, after seven years of addiction, my heart rate is abnormal, and I take an antidepressant.

It took me seven years to completely self-destruct, and I work every day at rebuilding my life. Every day is a struggle. There's a war going on inside my body, with my brain saying, "Go get that magic pill," and my heart saying, "Haven't you had enough?"

Every time I hear of a young life being taken from an overdose, it makes me sick to my stomach, because that should have been me.

Narcan is a life-saving -- is life-saving, but it is an addict's worst nightmare, because it puts you in instant withdrawals.

Five months ago, I can say with complete honesty, that I would have been laughing at New York

for the negative feedback with the I-STOP system, because it was so easy to get around the pharmacies and doctors.

Today I realize I was naive and undereducated. I have learned more in the past few months about my addiction than I did the last seven years on the streets.

I hear a lot of negative feedback from people who are legitimately getting narcotic scripts and believes that the I-STOP system is causing them grief.

Maybe we should ask them if they know what they are taking. Or, if they know that pain medication actually causes more pain than the reason they take the pain medication to begin with.

And while I'd like to say, those legitimate scripts is how I got started, like most other addicts, and if you have a legitimate medical reason and you follow the rules, then it won't cause you grief, let's not forget it's very easy to become addicted, and you can take them properly and still be dependent on them.

I would like to ask them if their grief from the system is worth some child's life, because this is how kids are becoming addicted from your

medication cabinets.

So many people have been caught from doctor shopping and pharmacy shopping, and with the uprise in heroin, screams "the system is working."

It's not good for anyone in recovery to have such access to heroin on the street, but I do believe, in time, with the I-STOP, there will be less addiction.

There just needs to be more education for younger people and the already-addicted.

I realize that I will always have to deal with my addiction, and, now, only time and education will help me.

In my life, if I could save just one kid from the pain and suffering I've been through or seen, I will be completely satisfied with the way that my life has turned out.

Thank you.

SENATOR SEWARD: Thank you very much, Mylea.

You know, we started out the forum talking about statistics, but the both you, and Deb, have reminded us that there are real people behind these numbers and real-life situations.

So, I/we greatly appreciate your sharing your personal stories with us.

In terms of our discussion this morning, I'd like to first call on our law-enforcement community, and others that may want to join in, but, I'd like to first hear from our law-enforcement partners, to tell us a little bit of what is out there in our communities, in terms of, you know, heroin use, in terms of the arrests that are being made.

Is it -- what is it, dealers, or users, or possession?

If you would like to -- to just kick off our discussion this morning, from the law enforcement point of view.

Who would like to be first here?

SHERIFF ERNEST CUTTING, JR.: I'll jump in.

Ernie Cutting from Chenango County.

About three years ago, in Chenango County, we started seeing more and more heroin on the street. At that point in time, I had sounded the alarm in the media that it was here.

In past years, heroin was a minor thing. You know, very few people. There was a stigma to sticking a needle in your arm.

But a lot of the kids that we talk to that were addicted to heroin, were -- told us that they were brought on to heroin by saying you could snort

it, it's not as addictive. Which was wrong.

In that time, this last year, heroin had become such a problem.

And I've relayed this story several times:

I had gone to a local community.

I live in Afton, New York, just down 88. I had gone to Bainbridge for breakfast. And I walked with my son, and I walked in, and I was besieged by the people there, they were so outraged.

And I made a commitment, from that day, that we were going to attack this problem.

From last March to December, I pulled an officer specifically to handle narcotic arrests. And in that time, he's arrested 60 -- there were 60 felony arrests, and 58 misdemeanor and violation arrests, specifically related to heroin.

What troubles me even more, though, is the hepatitis issue that's created from the needles.

I've had a meeting with our County Public Health on the hepatitis issue.

I also am active in inmates working to return something back to the communities. We do roadside pick-up garbage.

This last spring, we had gone from the city-of-Norwich line to the village-of-Oxford line

on Route 12, approximately 7 miles, and back. And in that time they picked up 46 heroin needles that had been used, and a bunch of other drug paraphernalia just right on Route 12.

And I thought of some kid walking along the road, potentially, picking that up and potentially sticking themselves. It was very concerning to me.

That brings in that huge -- the public information, you know, on what the problems are out there, potentially.

And that's just a little bit of what we're seeing in Chenango County.

I'm in it up to my ears. We have several arrests, and it's just never ending.

And we have people from all over the county, taking back Chenango. We've joined together, and trying to work together, the citizens of Chenango County and law enforcement, opening lines of dialogue, and working together to try to handle some of what's going on in the community.

That's a little bit of what we're facing.

SENATOR SEWARD: Thank you, Sheriff.

Anyone else?

Craig?

UNDERSHERIFF CRAIG DUMOND: Thank you,

Senator.

We saw similar things in 2012 in Delaware County, just alarming statistics.

And I can relate to the Sheriff's community-service work program.

One of the first things that we did was notice that, as well.

We were actually -- initiated our program as garbage pickup along some county roads, and our officers and inmates were experiencing so many hypodermic instruments being discarded along our county roads, that we had to put a sharps container in the sheriff's vehicle, just to properly secure these instruments.

It was very alarming.

And then we just, basically, saw an explosion in heroin and related drugs in 2012. As a matter of fact, it was up 229 percent from the previous year, our arrests.

And then, in 2013, we're up another 26 percent from there.

So the problem is not -- it's definitely not going away. It's getting larger.

Our arrests are up 36 percent, you know, mainly attributable to drug abuse and drug sales.

So, we have a significant problem on our hands.

We, as well, took one of our road-patrol deputies off the road and assigned him to narcotics full time. That's hard to do when your arrests and your complaints are up, but we made a decision, you know: We can continue to chase around the symptoms, or we can try to attack the disease.

And since the common denominator was heroin, we decided we wanted to go there.

And our numbers, as Sheriff Cutting has seen over in Chenango County, are a reflection of that.

We implemented the canine unit. We did that with -- we had to do that because of the limited resources that the County of Delaware has. We had to do that with private and corporate donations. We were successful in that program.

And then we thought, what do we do to start educating our kids?

And so we instituted the School Substation Program, where we have deputies in and out of schools on a regular basis;

And, a tip line for community individuals to phone in tips, because the community involvement in this problem is key, as well as community meetings.

But what we started this year was a task force. It's very similar to what you're doing here, just on our county level. The District Attorney and all of the stakeholders are involved in that task force.

And what's -- already, what's very similar to what we're hearing here is, we're seeing that a huge emphasis, and we're all agreeing, that a huge emphasis needs to be placed on education, treatment, and then aggressive law enforcement, if we're going to attack this problem.

We're not going to arrest our way out of this problem. It's going to take a collaborative teamwork approach from all the various stakeholders.

We're hoping that, you know, you can help us.

SENATOR SEWARD: Thank you.

Anyone else from law enforcement?

Sheriff Devlin?

SHERIFF RICHARD DEVLIN: Yeah, I agree fully with the Sheriff Cutting and Sheriff DuMond's statements.

We're seeing the same thing here in Otsego County: Arrests are up dramatically. Our resources are taxed.

On the correctional side of things, we have

jails full of heroin addicts. 60 percent of our current population has some sort of addiction, and, we do not have the resources to treat those people.

We're dealing with withdrawal symptoms, underlying medical conditions, which is increasing our local fees for medical costs. Additional manpower for monitoring these people because they cannot be left alone.

So. We're seeing that increase on the correctional side, as well as the law-enforcement side.

SENATOR SEWARD: Sheriff Desmond.

SHERIFF DESMOND: Thank you, Jim.

In Schoharie County, we are having a problem that -- getting a lot of crimes committed to obtain money to purchase heroin and other drugs.

The sheriffs here, I read in the papers, and they talk to them, and they're doing a tremendous job fighting this problem with arrests. They've taken people off of the road and put them into investigations.

Sadly, that we are still experiencing the effects from the flood of 2011, and funds are very limited to do anything like this.

If there was some way where we could get some

money, we could probably go into the investigations of heroin, and work with our neighboring sheriffs here on this problem.

But like I said, the limited number of investigators and deputies we have, and, compounded by the fact that we have to transport all our prisoners into Albany, we just don't have the resources that we need, but, we certainly would like to find some somewhere.

Thank you.

SENATOR SEWARD: Any comments from the State Police point of view?

MICHAEL MacINERNY: I don't really have any statistics to lay out, but, I mean, it's very obvious that a large percentage of the crimes that we investigate are driven by drug addiction, committed by those that are addicted to drugs.

We've seen -- recently we've seen a big uptick in robberies of convenient stores. And, we've had a bank robbery, a number of convenient stores, that we later found out were driven by the drug addiction.

It just seems that those are things that we probably didn't have near as many, going back a few years. And, it just seems to be more and more

prevalent at this time.

The State Police, we don't have any part in the treatment of the drug addicts, but, anything that we can do to help any other agency, you know, we're willing, and would like to do.

SENATOR SEWARD: You know, the question that I have for, you know, law enforcement, and I'd ask, our District Attorneys perhaps would like to chime in, what recommendations, if any, do you have, you know, for us?

I mean do we need, you know, stronger penalties for, particularly, dealers?

Or -- or, what can we do to be helpful to you, from the law-enforcement and prosection side of it, in terms of -- is there any recommendations anyone might have for us as we formulate our recommendations?

DA JOSEPH McBRIDE: Senator, I'll briefly respond and give you the picture, what's going on in Chenango County.

We have a very small rural community of farmlands, manufacturing; great place to raise your kids.

Unfortunately, as the Sheriff said, you're going to hear from some other members of our

community, that we've had a terrible heroin problem for the last few years.

By example: I had to cover a small justice court in the town of Sherborne.

And when I was in there, there was a young gentleman with a John Deere hat on and a John Deere shirt, and he was before the judge for possession of heroin. This kid looked like he just got off the field from bailing hay.

I would never have imagined that, in my lifetime, that I would have seen that.

When something happened, when we were kids, and we were growing up, you knew you could do a lot of silly things, but you would never, ever, go take this drug because you knew it was a death sentence. It was going to change your life.

So we need the education out there to make sure that these kids know that.

The second thing is, unfortunately, as the Sheriff said, in places where you would never suspect it, including our neighborhoods and our parks, our city parks, our county parks, and on the road, kids are being exposed to drug paraphernalia, which are very dangerous.

And, unfortunately, at this point, we have to

start educating our kids at the elementary school about, What do we do when we see needles? What do we do when mommy and daddy are using drugs?

And we want, not to arrest them, but we want to keep people safe.

Somehow, we have to get back to that education, so that every kid in New York State knows that he cannot ever experiment with heroin because it's such an addictive drug.

Two things:

Heroin's different.

When we send these guys to jail for 60 days, 90 days, and do whatever, unless they're in treatment, the first place they're going is the last place they got a fix.

I don't know what the biology is or what goes on in their mind, but they don't stop. And we need to do something to make sure that they're -- there are people, places, and things, when they change.

The next problem that my county has, and I'm sure some of the smaller counties, is we are a very safe community.

So, when someone's dealing dope in a big, larger city outside of our jurisdiction, it's very safe to come to our community and to sell narcotics.

Now, when I get them, I try to be as tough on them as I can, but that's an ongoing problem, when someone who's dealing the product is, literally, being shot in the bigger metropolitan areas, and think it's safe to come to Chenango.

Now, that's a problem for Chenango, and we need help in fighting those issues.

That's my 30 seconds, and I'll just pass the mic.

JAMES SACKET: Thank you.

Senators, just a couple -- actually, a number of points I wanted to touch on. Most -- some of them have already been touched on.

Combating this in a small county, and I think most law enforcement would agree with me, it's hard to infiltrate the dealers.

The dealers in Schoharie County have a tendency to come from the tri-city areas or outside.

Schoharie County has 33,000 people, on a good day, and our communities are still recovering from "Irene" and "Lee."

It's very hard to infiltrate.

Many of the people that are arrested in our community are -- have misdemeanor weight: criminal possession of controlled substance in the

seventh degree, or, possession of a hypodermic.

And, many times, just residue, or a very small amount, but we know that they are heroin addicts.

The heroin-user community is very tight.

A police officer is not going to go up to the door and knock on the door, and say, "Can I buy some drugs?"

We have a very tough time infiltrating that tight-knit secret system, so that's one of the problems that we face.

I-STOP, unfortunately, has worked, in my opinion, so well, that it's driven the drug people underground, the drug users to an underground arena, where it's very hard, as I said, to infiltrate.

We know, we have an idea, who's using the heroin.

Finding the dealers as they come into Schoharie County are very difficult.

These are -- the people that we arrest are not driving around in Lexuses or BMWs, with two or three cell phones. These are people that are struggling. They're young people that don't have a lot of education or skills, and, sadly, they're caught in a downward spiral.

Many of the crimes that we see -- burglaries, larcenies, home invasions -- in Schoharie County, daytime residential burglaries, in my 17 years, I can't remember so many of them. It was very rare.

We used to have the camps, the summer camps, those types of burglaries, where people would steal -- break in and steal items.

But now we're seeing cash, jewelry, weapons, electronics...brazen daytime burglaries, where people just break in with no regard.

And even in villages it's happening.

So, it's very difficult to be everywhere all the time.

Areas you would think that it wouldn't happen are now being attacked.

So, another thing I really want to emphasize is the Good Samaritan laws that we have.

The Good Samaritan Law is, if a young person, or anyone, sees a person in the throes of an overdose, please call the medical providers, the ambulance, 911. Get the people the help before they overdose so we have a chance to at least try to treat them.

That also goes for alcohol, too.

Our most abused drug, our legal drug, I'm

sure law enforcement also would agree with me, causes an awful lot of problems in our community, and has for years.

But, if you see someone overdosing from heroin or from alcohol, young people need to know they need to call help and they won't be arrested, so long as there's no evidence of drug trafficking.

Thank you very much.

DA RICHARD NORTHRUP: I would certainly agree that education and prevention, in my opinion, are the key to attacking this problem.

Virtually every crime that we prosecute is somehow drug-related: assaults, sex offenses, burglaries, larcenies, forgeries.

Virtually everything is now drug-related, and a large percentage of that is heroin-related; whereas, just a few years ago it was more oxycodone and hydrocodone.

And, we've made some strides, the Sheriff's Office in Delaware County, a lot of the Village departments, the State Police, have made a lot of undercover, confidential-informant buys. We're prosecuting those cases.

We don't necessarily need tougher sentencing for drug sales.

To sell just a pinch, just a pinch, of heroin is a high-grade felony. It's a Class B felony. You can do up to nine years in prison for that.

We don't need tougher sentencing laws.

We need more education and prevention before people get to that point.

A lot of the people that we're seeing making sales are not the drug dealers from the Syracuse, Albany, Binghamton, New York City area, that channel the stuff here.

We're getting the street-level dealers who are selling to perpetuate their own addiction. Those people don't necessarily need to go to prison. They need to go to rehab, they need to get straightened out, so they're not doing that anymore when they get out.

And the key, really, is rehab for a lot of these people, but, they shouldn't be in the system to begin with, most of these people.

They should -- if they just increased the education, take on an initiative like we have in the past with other things, smoking and drinking, things like that, it would make a huge difference.

I think that's where the legislation needs to be implemented, because if we can do that, we'll see

a dramatic decrease in the crime, in many respects.

SENATOR SEWARD: Thank you.

Let's move on to some of those other alternatives.

I first would like to mention the -- you know, the drug courts.

I understand that this is -- and, Mylea, you're a product of the drug court?

MYLEA BUFFO: Yes, I am.

SENATOR SEWARD: Which county?

MYLEA BUFFO: Otsego.

SENATOR SEWARD: Right here in Otsego.

Is -- could somebody share with us your experiences in terms of the drug-court process?

Is that a good alternative?

DA RICHARD NORTHRUP: It has here in Delaware County. It has been a good alternative. We've seen quite a lot of success.

There's some failures, too.

But the way we operate in Delaware County is that, if someone is deemed an appropriate candidate for drug court, they have to plead guilty to the felony charge, or a felony charge, and they sign a contract. And they go in, and they are in the drug-treatment program as part of a 5-year probation

sentence, and they have to participate in the drug-treatment court for up to 18 months.

They're under heightened supervision, heightened treatment.

And if they successfully complete, they get a watch and a cake, and sobriety.

And they stay on probation for the rest of the five years, but, while they're in the drug treatment program, if they don't succeed, if they flunk out of drug court, they contractually agree that they'll go to prison for the maximum term.

So there's a big incentive, and it has resulted in some good success in Delaware County.

SENATOR SEWARD: Anyone else would like to share the experience regarding that option?

NORINE HODGES: One thing I was going to express is, we've instituted in Schoharie County a program for people new to drug court. We call it our "Drug Court Recovery-Coach Program."

I was sharing it with my colleagues here today.

And, it's to help people new to drug court become more successful. We run it for three weeks, two nights a week.

The first night is educational, about

addiction; about all the pieces you were talking about, Mr. Northrup.

And the second night, we actually bring folks in who have sobriety; who have gone through drug court and have sobriety under their belt for some time, and they talk about how it was, what they did, and where they are today.

And then each of the participants has to relate to what they heard, and the stories are very similar. Many of them start out with a sports injury in high school and/or dentists.

You know, that -- that dentist piece is very important. The wisdom teeth, the Vicodin, that kind of thing.

And then they talk about, in and out of institutions, and treatments, and so forth.

Many of them say they wish, that when they had originally gotten caught, that it was stricter at that end; that someone stopped them earlier on their path.

And then the last night, they actually chair a mock AA meeting.

They do these three weeks in lieu of going to AA or self-help. And we really focus on sobriety, sponsorship, AA; the value of the 12 steps, going

through all the 12 steps.

And, I think it really helps.

Everybody tells the story, "We're only as sick as our secrets," so it allows that piece as well.

SENATOR SEWARD: Thank you.

Anyone else?

JUSTIN THALHEIMER: I'd like to speak on behalf of the drug court.

It's well-represented today, drug court works.

It gives people a chance. It's, uhm -- excuse me, I'm a little nervous.

But, it really gives people a good chance.

They're monitored regularly.

They're -- there's -- if they get out of jail -- once they plead to whatever they have to plead to, or it's a diversion, or however it goes, they get out of jail, and they're monitored so closely, and asked to do so much, and they have to do it sober.

And if they don't, they -- if they don't, then it's easier for us to get them into treatment because, sometimes, you have to pull teeth to get somebody into rehab.

And what drug court does, you can get a Court order, and it gets people into treatment.

And, my only wish for drug court is that it was easier to get into.

Why wait until they have a felony that's going to be disruptive to your life for the rest of your life?

Long after treatment ends, that felony is still there.

The people, I consider them very lucky.

If you're on probation, and you get asked to go to drug court by a probation officer, I consider you very lucky, because you might actually get into drug court with misdemeanors.

SENATOR SEWARD: Are you saying that we should have people get into the drug court, perhaps on lesser charges?

Is that what you're suggesting?

JUSTIN THALHEIMER: Right. Or have that felony wait until the end of five years, possibly.

I don't know, at the end of probation, just have that sentence -- I don't know all this legal stuff, so, bear with me.

UNKNOWN SPEAKER: "Expunged." I think "expunged" is the word you're looking for.

JUSTIN THALHEIMER: Excellent.

Yeah, absolutely, at the end of five years, if they've demonstrated they haven't been back into the law enforcement after they graduate from drug court, it just doesn't stay with them forever. A felony does.

I think a lot of people are doing these online applications, where the felony just -- they never even get to see a human. They never even get to interview.

So, I really think that would make a great difference.

And, if we can get them into drug court, with misdemeanors, with a lesser charge, that would be great.

SENATOR SEWARD: Thank you.

JAMES SACKET: Senator?

SENATOR SEWARD: Yes?

JAMES SACKET: May I respond to that?

In Schoharie County, we have approximately 60 people in our drug court. Around 50 criminal cases, and 10 around -- from the family court. It's a combined court.

We have misdemeanors in there.

There's also a program called

"Judicial Diversion," where the person is placed on interim probation for two years, and then the final three years can then be placed on regular probation once they complete the treatment core program.

What that allows them to do is, seal their conviction. Or, also, there's also the possibility of vacating the conviction.

So what we do is, place the ball in the court -- in their court. If they walk the walk and talk -- if they talk the talk, and then walk the walk, they're able to come out of that with a clean record, just as Justin was mentioning.

That allows them, if they've done what they're supposed to do, on our end, then we either seal the record, or look to vacate the conviction with either no conviction at all or a misdemeanor.

In our drug-treatment core program, we take misdemeanors. We want to get these young people before they get a chance to get too far into the system, so they don't -- we don't have to wait for their felonies.

We also expect people to relapse.

Part of that is, if you have a treatment issue, what we try to do is up the level of treatment.

If you commit crimes, then you're going to go to prison.

However, the incentive, the 10-ton weight over your head, is always there for many people.

What we found is, that many -- keeping people out of prison, in the community, either have to work or go to school, or, they have to do community service. They're monitored. They have to do three to five self-help meetings a week. They're in treatment; they have group and individual. They meet with their probation officer once a week. And, they're required, they're also randomly tested for drugs and alcohol.

So what we found, in our experience in about 10 years in Schoharie County is, people, while they're in drug court, do well.

We often speculate, it would be nice to see people, in a way, in lifetime drug court, because that's where they do their best.

Once they get off of drug court -- and we also treat alcoholics, too, in our treatment courts -- they slip back into their old ways, they go back to the old neighborhoods, they fall into the bad habits again.

But while they're on drug court, we're saving

the money from having them in prisons.

But what we really need, in my opinion, is more resources for treatment.

Heroin, we've gone to long-term inpatient residential for months, even up to a year, year and a half. That seems to be the only way to really attack the heroin problem for some of these serious heroin addicts.

We need the resources.

If we're going to treat this public health issue, that's the way we have to treat it, in my opinion.

SENATOR BOYLE: Just a quick question, Jim, or one of the other prosecutors:

What we're seeing in other parts of the state, is a case where actual dealers are kind of using the drug court to say, Well, I just need to -- some treatment, and then -- to reduce what they're looking at.

Are you seeing anything like that?

DA JOSEPH McBRIDE: Actually, that goes on all over the state.

And in every drug court, every county has different rules.

There are state guidelines. And every DA and

judge and every treatment team makes the evaluation of who comes in, and who doesn't.

As was stated before, local dealers who are, you know, young kids, young adults, who get involved in the wrong system, are treated differently than gentlemen or women who come from out of town and try to sell heroin.

So that does happen, but it's not effective, because we usually, the rules, when they were started, say, We are the gatekeepers.

Now, Judicial Diversion changed that a little, so they can get people into drug court without our permission.

But most of the time, they have to have the DA's consent before they're allowed into the program.

Just to drug-treatment court, and our person here today who is a member can probably say, it changes your life.

It's not a "you show up and you talk once."

In our county, you are there at least once for three hours at a meeting, where you listen to your problem and everyone else's problem. You know that you're going to be monitored.

In our county, you have to phone in every

day. And if you don't phone in, you miss a phone call, they are very strict with the excuses.

Because I'm sure, as all the people in treatment know, that they are very good at not telling the truth. They've been doing it for a long time and being very successful.

So -- but it changes your people, places, and things. You have to start hanging out with people, you have to go to work, and have you to go to school, or you have to do some community service.

And when those people do get into the program, and they buy into the program, and they're not just trying to get over, it changes their life forever.

It seems that, not only their lives, but their family lives and the community lives.

And in the small towns, and all three of us here are from small communities, you know these people. They're your friends' kids. They're people you see from the community. Its not like it's just the people from the other side of the railroad tracks.

Heroin and drug addiction affects all of us.

And so, drug court, with all of its flaws, has been very effective.

If you wanted to open it up to the misdemeanor level, you can't do that with the tremendous amount of resources that we don't have right now.

There's probably 10 or 15 professionals on the County court treatment court, and it's -- they are straining their schedules to make all the meetings and do everything that needs to be done.

So, if you're going to do anything, please fund those positions, and that would help it make it effective, and we could start earlier, and identify those people who are in the city courts and the justice courts, who we can tell, from our experience, aren't going to have this one-time experience, but seem to have a problem with a particular drug.

Thank you.

SENATOR SEWARD: We have some representatives here from Taking [sic] Back Chenango.

ROBERT CLIPSTON: Yep.

SENATOR SEWARD: And if you could share with us, briefly, what that organization is all about, and would that serve as a model for other counties?

ROBERT CLIPSON: Well, what we do is, we travel to every town and city within

Chenango County, where we're asked to go.

People normally from the town will ask us to come in. We try to educate adults and local law enforcement, mayors, whoever shows up to the meeting.

It is an open forum. They have the opportunity to speak with the sheriff or the DA. They both come to any meeting.

We try to educate them on the addiction of heroin. What they need to do with their children.

Education is very important. It starts early. You got to start in kindergarten, or before, because a lot of people are going to parks and finding needles.

What does the little kid do with the needle? First thing you do is pick it up.

So educating children, all children, is very important.

And, to educate them on the addiction, and everything, would be a plus, because you're seeing a lot of heroin addicts coming out, ranging from 12-years-old, and up.

So by the time they're in sixth grade, they've already been hit; they've already been approached, and they've already seen it.

So, we kind of tell them, you know, education is the key.

We also -- we're working on setting up a neighborhood-watch network throughout the county, because, in our view, if you don't know your neighbors and who is around you, you're not going to know if there's something going that shouldn't be going on.

A lot of these drug dealers are coming into our county from the city -- from Utica, from Syracuse, from Binghamton -- and you can see by the arrests in the paper.

And what the Sheriff and the DA have done, that, we live in a box. And the way I describe it in most meetings is: Everybody lives like this [indicating]. You got shutters on both sides. Your neighborhood is actually your house. If it doesn't happen here, it's not happening.

And you see that all over the state.

People have closed-up.

Social media has pretty much said: You don't have to go out and talk to people. You don't need to know everybody. You can do it on the computer.

Well, if you're not out talking, you're leaving a very open field for these drug dealers to

come into your neighborhood, because that's what they want. They don't want you to know them. They don't want you to know anything.

If, as communities, we can come together and get people to know everybody, and have people watching out for their communities, you'll prevent these drugs from coming to your neighborhood.

And that's something that we really express.

The first thing we tell them is: We want you to go out and we want you to meet two neighbors. You don't have to be best friends, you don't have to have a barbecue. Go out and say "Hi." You know, introduce yourself. Get to know their kids.

Because kids get a bad rap.

I don't care where you go, if you see a group of kids walking down the street, you automatically assume they're in trouble, they're doing something wrong.

Well, when I was a kid, you walked down the street, you were in a group of kids, you were going to play football or do something. You're trying to find something to do.

But a lot of these kids now are looked at as hoodlums, so we try to take that view away, and say: You know, these are kids. If you get to know them,

maybe you're going to stop them from doing something that you don't want them to do, like, doing heroin or an opiate drug.

We also -- we do a lot of training classes.

We have one coming up on May 1st. We're working with Chenango County Drug and Alcohol. They're doing an addiction training for us at the local Elks Club, which is great.

We also work with Catholic charities. We work with the Elks Club.

Any organization that's already established, we try to work with them, what they are already doing, and build on it.

Chenango County is 911 square miles, and there's 23 towns and villages within Chenango County, which makes it a pretty widespread thing.

And as the Sheriff says, there's usually, with what he has in resources, two cars in Chenango County at one time.

If you get a call in Afton, and your cars are out in [unintelligible] and over in Sherburne, it's going to be a while before someone gets there.

So, you know, funding and education is very important for this if we're actually going to

stop --

SENATOR SEWARD: Now, is your group, I mean, is that all volunteer?

Or is there --

ROBERT CLIPSON: Right now, we're a grass-roots group.

My wife actually set this up after a death of one of her high school friends, that never should have happened.

And what happened was, she went out to her car at 6:30 in the morning, as normal, getting ready to go to work. Ex-boyfriend shows up, pretty much beat her to death right in her driveway.

All the neighbors heard something. They all rolled over and went to sleep, assuming there were kids outside.

Well, if we had a watch program, or we built awareness, and someone actually got up and went to their door to see what was going on, she'd still be alive today.

JOE BIVIANO: Strongest part of our group -- we're 1700 members. We're fastly approaching 2,000 members. We started in December. The first thing we did was seek out law enforcement.

We are in partnership with the Sheriff of

Chenango County. We are in partnership with the DA of Chenango County. We support law enforcement.

It's just like he says, we've educated ourselves.

The strongest part of our group is grandmothers. "Grandmothers."

They see their grandchildren being raised by an addict, what can they do? What are their rights?

The strongest part, when a grandmother says: My daughter went to an apartment and there were needles in there, and the boy got a needle in his foot, what do we do?" here's the question you have to ask yourself:

Law enforcement is operating on a 1950s budget throughout the United States. You ask them and ask them to do more.

I worked 25 years in a jail. I was also a mayor. I know what it is to keep budgets down, but I respect these people.

Our group works 100 percent with law enforcement. We work in every community.

When a grandmother says, What do I do about these needles? Who picks up the needles in the park? Who picks up the needles in a day-care center? Who picks them up?" what's the answer?

We have no answer.

When I first started in the jail over a quarter of a century ago, I was a hardhat.

Today I've turned myself around. I really believe in the needle-exchange program.

Who's going to pick up these needles? Who's going to do something with these needles?

You know, hepatitis C is the biggest disease we have in each one of these counties.

Now, having worked in a jail and knowing, like, in Chenango County, and I assume all of you are the same way, with limited budgets, and asking to be more and more, and more and more, piled on you, how do you expect a guy to patrol 911 square miles with two cars?

That's 1950s-style stuff.

They need help, and the State Police need help.

And the State Police have been very good with the CNET. The CNET's been very good to us in Norwich in Chenango County.

But some of the things that I want to tell you is, the jails.

I worked in a jail, and we used to give a guy who had heroin, we would give him stewed prunes

three times a day to get the cramps out of them.

Today they got meds.

Okay, so the guy goes to jail, then he goes to rehab. Goes to rehab for 28 days.

Do you really think 28 days is going to help end rehab? Never in a chance in life.

95 percent of the addicts today go back to being a drug addict if they're in heroin.

"95 percent."

The way to help is the jails; the jails have the resources. Give them the monies. Give them the education. Give them the nurses and the staffing to go out another level: the level of rehabs.

Now, you've closed jails throughout the state.

Chenango County, you closed Pharsalia, and then you closed Georgetown.

We need rehab centers.

But the one thing I found, with working with the DA and the Sheriff, we work in every town, and we work strongly with law enforcement, and we found their hands are tampered. They cannot do their job because they don't have the money.

That's where the help is needed.

And the rehabs; the rehabs are important.

28 days doesn't work.

You send a kid to shock camp.

I heard these guys, 28 days.

You go to shock camp 92 days, you're out. You come back, you failed the program, okay, you go away for a little bit. Then they go back and they go to shock camp again.

I know a guy in Chenango County who's been to shock camp four times, with the same judge.

Boy, that really makes you mad, because I hear what him when he says, "I learned how to sell drugs better in my community."

Take Back Chenango works for grandmothers. We're growing with grandmothers, believe it or not. That's the strongest key.

Thank you.

SENATOR SEWARD: Well, I commend you for your, you know, community members coming together and, you know, attacking this problem from a neighbor-by-neighbor basis. That's very, very important.

I wanted to talk, in mentioning the treatment programs, I know we have a number of representatives of groups that are involved in treatment here today, and I would just like to give you an opportunity at

this point, to -- let's shift our focus over to, you know, the treatment opportunities that exist in this region. And, what could we be doing to make it that -- better or more effective in attacking this problem?

Who would like to go first?

CHRISTOPHER KEMP: First of all, just some statistics:

From 2003 to 2008, we treated less than 10 people through those years for heroin addiction.

In 2013, 65 of our admissions were directly related to heroin.

So, it is a big deal.

I also -- drug court has been very successful. I think it's a great program, but something needs to happen earlier in the process.

Something needs to happen with the misdemeanor-level arrests, that we tell you, that one of the problems we have in Delaware County, is people will choose county jail over treatment.

So I would love to see some way for us to be able to get into the jails and work with these individuals while they're incarcerated at the county level, because at this point, you go sit in your county six months, and you get out, and you're

leaving with the same information you went in with, and, sometimes, information you shouldn't have.

So, I would love to see some way to get in the jails and work with these individuals, and at least set them up with some aftercare plans and give them some education.

I love that program you were talking about.

And, certainly, I just think it's a shame that we have to rely on Court orders to get people into inpatient treatment. It's ridiculous that someone has to get a felony-level arrest to get the level of treatment that they need.

I would like to see managed care -- I would like to see the decisions be left in the clinicians' hands; not in the managed care, someone sitting in front of a computer screen.

I can tell you a number of cases, where the person is sitting in our office, crying, saying, "I cannot do this on outpatient level." And the insurance company saying, "Well, you have to fail at outpatient treatment first."

And, unfortunately, what we're dealing with these days, one failed attempt at outpatient treatment can be death. It can be a felony-level arrest.

And, you know, the other reason for earlier interventions, I mean, by the time people get to felony-level arrest, they've lost their family, they've lost their kids, they've lost, you know, all their supports.

So I would like to find some way to intervene in this process at a much earlier level.

You know, I concur with everyone else, I think, without exception, in Delaware County, the heroin starts with prescription drugs.

You know, we were talking about this the other day. I can't think of a case in Delaware County where it didn't start without prescription drugs or their first drug use was heroin.

That may not be true in all the counties, that's just my experience.

I-STOP is excellent legislation. It certainly has caused a spike in heroin use, there's no denying that. But I think in the long run, I think that will level out if people aren't starting with the addiction prescriptions.

So I hope that that's the case.

The other problem that we've experienced is the lack of Suboxone providers that will accept

Medicaid. That's a problem in Delaware County.

I wanted to thank, my colleagues and I have discussed, the possible legislation to allow nurse practitioners to prescribe Suboxone.

One of the problems that we have is, the OASAS regulations are, that you need to have the Data 2000 Waiver for your medical director.

Medical directors, locally, don't want to prescribe Suboxone, so we end up referring out, and that gives you very little control over that drug.

Diversion of Suboxone is a big problem.

It's -- the evidence shows that Suboxone is a very effective drug in the treatment of opioid addiction. There just needs to be some way we can work to have more control over that medication.

And I think, you know, having that in the clinic where we can say, "Do the films." It's distributed in films. That we can do the counts and say: If you don't come to your treatment appointment, you don't get your Suboxone.

I think one of the problems is, people are seeing Suboxone as a be-all and end-all. You know, "I take this medication and I'm all better."

That's not true, because if you don't make those recovery lifestyle changes when that Suboxone

isn't there, you're going to be left as the same person you were when you started.

I don't want to monopolize what we have here, so I will, uh...

And I think it is a multilevel approach. I think prevention, treatment, and law enforcement, we all need to work together.

And I will say, in Delaware County, we're definitely all working together on this project. The board of supervisors have been very supportive in this project. And I think its -- it's a -- the whole community needs to be involved in this.

Because I really like what you said about the guy that -- the kid in the John Deere hat, because it's absolutely true. This is everywhere. This isn't who you think it is.

And, I just want to close on saying:

Recovery is possible.

The people in recovery often don't get the press. There are people in long-term recovery from heroin addiction. They're aren't the ones in the newspaper. And due to the confidentiality of treatment, we see them; you don't.

You know, I run into them every day in the grocery store. They're in long-term recovery from

opioid addiction.

So it is possible, and it does happen.

Thank you.

SENATOR SEWARD: Thank you.

Any other comments from the treatment community?

DR. STEVE GRAHAM: Senator, if I may?

SENATOR SEWARD: Yes.

DR. STEVE GRAHAM: I'd like to add to Mr. Kemp's comments.

Some people require ongoing ready access to opiates to meet the physiologic needs of their opiate addiction.

I'm an obstetrician/gynecologist. Addiction medicine was not part of my training. Until the last five years, it was not part of my practice; however, opiate-addicted women do become pregnant, and, they are at increased risk for adverse reproductive outcomes.

In May 2012, the American College of Obstetricians and Gynecologists, and the American Society of Addiction Medicine, issued a joint opinion titled "Opiate Abuse, Dependence, and Addiction In Pregnancy."

In that committee opinion, they cited a

2008 study that estimated that 1 out of 1,000 pregnant women had used heroin in the past 30 days.

Be that as it may be, in our practice at Bassett, I'm presently aware of seven pregnant heroin users who are presently enrolled in programs of opiate-agonist therapy.

That would be a rate 10 times the committee opinion's estimate.

Those are only patients that we know about.

During pregnancy, chronic untreated heroin use is associated with an increased risk for a variety of obstetrical complications, and although heroin withdrawal is not fatal to a healthy adult, fetal death is a risk in the obstetrical patient.

The injection of opioids carries with it the risk of infection at the injection site, in the heart, bones, blood, hepatitis B, C, HIV.

And, additionally, the lifestyle issues associated with illicit heroin use in the pregnant woman puts the woman at risk for engaging in activities such as prostitution, theft, drug dealing, violence, to support herself or to support her addiction.

Such activities expose these women to sexually-transmitted infections, becoming the

victims of violence themselves, legal consequences, including loss of child custody, criminal proceedings, and incarceration.

Since the 1970s, methadone maintenance has been the standard treatment of heroin addiction during pregnancy.

Recently, this treatment has also been used for prescription-opioid abuse.

The rationale for opioid-assisted therapy during pregnancy is to, first, prevent the complications of illicit opiate use and narcotic withdrawal, encourage prenatal care and drug treatment, reduce criminal activity, and avoid the risks to the patient of associating with the drug culture.

Treatment reduces the risk of obstetric complications. The babies aren't born addicted. And, neonatal abstinence syndrome is an expected but treatable condition that follows prenatal exposure to opiate agonist, and it requires collaboration with the aftercare team, but, there are road blocks to treatment.

Methadone maintenance is dispensed on a daily basis only by a registered substance-abuse treatment program.

For my patients, the local methadone-maintenance treatment programs can be found in Amsterdam, Albany, Binghamton, and Syracuse. These are trips ranging from one to nearly two hours, each way, every day, and these logistical issues make methadone maintenance functionally unavailable for many of my patients.

It has been illegal for physicians to write a prescription for any opioid for the treatment of opioid dependence outside of a licensed treatment program.

Now, the Drug Addiction Treatment Act of 2000 did change the law, permitting physicians who meet certain qualifications to treat a limited number of opioid-addicted patients with buprenorphine.

Unlike methadone, which may be administered only through a very tightly controlled program, buprenorphine may be prescribed by an approved physician in a medical-office setting.

Patients considered for using buprenorphine must be able to manage and also administer their medications safely and adhere to the drug program.

The Substance Abuse and Mental Health Services Administration website lists 1736 physicians with buprenorphine waivers in the

State of New York.

Though that number of buprenorphine-approved physicians might suggest that the urban-centered distribution of methadone-maintenance programs has been mitigated, rural New York, likewise, experiences a misdistribution of buprenorphine-waived physicians.

The Bassett Healthcare System is an integrated health system with 6 affiliated hospitals, 28 regional health centers, and it provides care and services to people living in an 8-county area covering 5600 square miles; yet, within that system, I am the single physician who is licensed to prescribe buprenorphine for opiate addiction. And my practice is strictly limited to pregnancy.

So why are physicians not rushing to embrace office-based opiate-agonist therapy with buprenorphine?

Well, there may be a variety of reasons, but would I like to address one that can be solved only by government.

Drug addiction is a disease that government first views as a crime, as most of the conversation today has been centered on the legal issues. And,

as a treating physician of addicts, I become associated with criminality.

This was distressingly demonstrated to me when I was subjected to a routine audit of buprenorphine-waived physicians by the Drug Enforcement Administration. They opened the conversation with me by reading me my Miranda rights, and advised me that anything that I said to them could be used against me in a court of law.

It was not an endearing moment.

Yet drug addiction involves presumptive criminality only for those drugs that we choose to define as "illegal."

Nicotine is a highly addictive psychoactive substance that is legally marketed in a variety of forms. Its use is associated with disease, disability, and death at rates that dwarf the problem of opiate addiction; and, yet, nicotine addicts can call 1-86-NY-QUITS [sic] and receive nicotine-replacement therapy from New York State.

The NYsmokefree.com website asserts that nicotine-replacement therapy, such as patches or gum, may double your chances of quitting because it works by reducing uncomfortable nicotine-withdrawal symptoms.

What an idea?

Nicotine addicts have a chemical dependency, and we as a society offer to address the physiologic needs of their chemical dependency without repercussion, and with a view toward improving their overall health.

Like the much larger problem of tobacco, opioid addiction is very serious, but the law-enforcement approach that we have taken over the years has unquestionably failed.

We need fundamental changes and reforms in drug policies, and I long for a day in which we can treat opiate addiction in the same relaxed, realistic way that we apply to tobacco.

[Applause.]

SENATOR SEWARD: Thank you, Dr. Graham.

Just one quick question: What's the protocol when a baby is born, you know, with -- from a -- the mother is an addict -- heroin addict?

DR. STEVEN GRAHAM: The babies typically demonstrate difficulties on, about, day three or four of life, and so they need to be in the hospital longer for initial observation.

We have a scale in which we assess various signs and symptoms that the baby is demonstrating --

heart rate, respiratory rate, feeding difficulties, jitteriness -- that indicate to us the degree of withdrawal that the baby is going through.

We then start to replace, uhm -- morphine as our substitute of choice, and administer that in a decreasing dose over a period of four to six weeks, until the baby is completely withdrawn, and has been observed for several days without any demonstrable symptoms of neonatal abstinence, and then the baby is discharged from the hospital.

SENATOR SEWARD: Thank you.

Any other comments from the treatment or medical community here?

JUSTIN THALHEIMER: I have seen Suboxone or buprenorphine work. And under the right circumstances, generally monitored very tightly, it does work.

I'm also seeing that we are treating people for buprenorphine addiction at the clinic. They get it from the streets.

If there is a way that we could have it prescribed at our OASAS facilities.

And in a rural county, like Chris was saying, that's really difficult to get someone to, not only get the Data 2000 Waiver, but be an addiction

specialist, the OASAS requirements for a medical director is really difficult to -- really difficult to find somebody in a rural county who's going to be an addiction specialist, plus get the Data 2000 Waiver.

So we've also seen -- I've seen -- like I said, I've seen Suboxone work. I've seen it not work more.

It's -- out in the streets, they can exchange one film for one bag of heroin.

Right now, I think the price is 20 bucks apiece for either a bag or a film of Suboxone.

It works if it's able to be monitored tightly, and that means, when people come in to see me, and if they are on Suboxone, I am doing Suboxone counts that I put in their progress notes.

It has to be monitored very tightly.

I also want to speak on -- really quickly, on VIVITROL.

VIVITROL is a medication, where a heroin addict is given an injection every 28 days, and, you know it's in their system. You know that their motivation for quitting is high when they sign on to give VIVITROL. They're very motivated to be done with it. They get sick and tired of being sick and

tired.

And this medication, VIVITROL, is every 28 days, and I can't speak regarding the risks and all that stuff you see on TV, but, you know it's in their system. And, they can shoot heroin if they want, but it's a waste. It blocks the receptors.

I don't know, and, actually, I was asked in the past week, "How does it work with opiates?" because -- because it does work; it blocks the receptors. It blocks the receptors until their next injection 28 days later.

And after three months, they go on a holiday, to see how they're going to take. And the second they want to get back on it, you get them back on it.

But it's a -- with our heroin addicts who have been on VIVITROL, and there's not very many, I wish I had a higher end number to tell you, but we're at 100 percent.

They're all in recovery and doing well.

Thank you.

SENATOR SEWARD: Thank you Justin.

Dr. Sellers.

DR. JOSEPH SELLERS: On behalf of the physicians of the State Medical Society, I want to

thank the Senate for convening this panel, and for hearing from the community.

You asked for some specific things you folks could do in state government, and I'm going to give you a few that I hope will be pursued.

But I think that this is such a complex issue, and it requires some work on the part of the federal government, you know, as my colleague mentioned, about Suboxone.

Suboxone prescribing is a federally regulated issue, but it does require us to talk to our Congressmen and to our -- you know, the federal government, and advocate there.

Many of the things, though, that can help our communities are things that the state government can do.

But the bottom line still is, I think the solution to our problem is going to be local, and it's going to be done by community groups. Community groups like the ones that have spoken to us here.

Just to maybe set the tone for why young people turn to drugs, why young people do the things they do:

I don't know if it's education. It's more

attitude. They know things are wrong.

I raised four teenagers. I know they did many things that were wrong, and they knew they shouldn't do them, but they had an attitude, "Bad things aren't going to happen to me."

And what we know from brain studies is that, your brain, when you're born, starts developing at the bottom of the head, moving up, and forward. And this part here [indicating] is the last part to develop, the prefrontal cortex: the part that has wisdom; the part that can predict consequences; the part that can plan to the future.

The prefrontal cortex in women is pretty well developed by about age 19.

In men, maybe 25, 26.

So those that do law enforcement near college campuses notice that most of the trouble is by young men.

[Laughter.]

DR. JOSEPH SELLERS: With that said, we do know that exposure to drugs earlier in life alters brain chemistry.

And so one of the things that's really concerning is the use of opioids by men before age 25, by women before age 19.

If they can get through this, we don't see -- I don't see too many patients who started using substances of any sort in their 30s and 40s, and there is a biological reason for that.

Mylea did mention the I-STOP, and how that may be helping prevent some of the availability of opioids in the community.

And, you know, the State Medical Society worked closely with the Health Department, and educating the physicians, and getting this program up and running, but I think we need the Health Department to do some data check, to let us know.

I hear, anecdotally, about the turning to heroin, but I haven't seen any actual statistics on that. And I think that would be important if we're going to refine I-STOP and make it work better.

I hear, anecdotally, from physicians, I know in my own practice, we share when we have been fooled by somebody.

There are patients that we didn't ever believe would be doctor shopping, but we find out they were using multiple pharmacies and multiple physicians to gain access to opiates.

And, again, it can be that young man in the

John Deere hat. People can -- when they're looking for drugs, they can do a great sales job.

And, so, I-STOP is, I think, has been helpful there.

I would like to see more data, if the Health Department can mine data about that.

And then, talking to physician colleagues, physicians I think have changed their prescribing habits to a great degree in New York State, which I think is very good.

Hopefully, the dentists are being more careful about what they give when you have your wisdom teeth extracted, or the quantity of medication they provide.

But, again, I think that should be looked at; and, so, some study by the State Health Department.

We worry about the death rate from opiate overdose, and there are some specific things that can help with that.

There is an "opiate antagonist, non-patient specific order" bill that Senator Hannon has in the Senate and Assemblyman Dinowitz has in the Assembly.

The State Medical Society strongly supports the ability of physicians to give a prescription for Narcan nasal spray to the family members of somebody

with an addiction problem.

And, again, this is not a total solution, but it's one part that could be done in this legislative session to get that going. And to follow that up with the training, the education to the community, and to make this a less-common event for somebody to overdose on an opiate.

The Medical Society also is very concerned about the availability of treatment.

And we heard Deb France talk about the hassle she had to go through with insurance companies, and having to leave the state. And this is a family that had some resources. They had money saved for a college education.

Many of our families have no resources and are encountering similar problems.

Treatment is essential for combating our opiate issues. Treatment, though, needs to be geared to the individual, not just his or her drug abuse. They need to remain on treatment for an adequate period of time. Professionals need to be given the ability to steer patients to inpatient versus outpatient, based on that individual's needs, and the professional assessment.

And, again, we need to have proper funding.

We need to make sure that insurance is not standing in the way, and not preventing people from getting the care they need.

On a personal note, I've been living in Schoharie County for 25 years, practicing internal medicine, caring for adults, and, pediatrics, caring for children, so I have a lot of the crossover, a lot of the adolescents in my practice.

I see all families being affected by this issue, but, some families more than others. Some things we know that are risky.

There was a great study done over the last 10 years by the Kaiser Foundation in California, that talks about adverse childhood experiences, and the things that happen to children that lead to them being more susceptible to substance abuse and other untoward consequences.

And it was interesting to hear the talk about grandmothers, because the one thing that was shown in a study, and I can get you the references for this, there be a protective influence, was for a child to have a strong grandmother relationship.

So, you know, I think that there are things that maybe we need to think differently about.

You know, how do we, as a community, support

grandmothers' involvement in their grandchildren's lives, where maybe parents are overwhelmed?

Lastly, I think there's a strong correlation with our current rural upstate drug issues and the court [unintelligible] upstate, for opportunity for young people, that when unemployment goes up, when economic opportunity goes down, we know that drug abuse also goes up.

And, so, I know that, Senator Seward, you're a strong supporter of moving our business community forward in Upstate New York.

We -- you know, we've been in, essentially, a recession in our area for the past 50 years.

And, you know -- and I don't think we can address this issue without addressing the economy.

If the economy is better, there's more opportunity for young people. There's more resource for law enforcement, and education, and all the other partners that need to participate in solving this problem.

So I'll close by saying:

The physicians of the state are very concerned.

And the State Medical Society, as the organization representing all the physicians in the

state, stands prepared to do whatever we can to help state government, to help local community agencies, to work within education, to work in helping to gather data and best practices, and so that we can all work together, every aspect of society.

Because this is a total society problem, and no one solution is going to bring about a change that we need.

Thank you.

SENATOR SEWARD: Thank you, Doctor.

Any other comments from the medical or treatment --

DR. KELLY ROBINSON: Yes, we have two emergency physicians over here.

We'd like to say something on this.

SENATOR SEWARD: Sure.

DR. KELLY ROBINSON: Augie, you want to start?

DR. AUGUST J. LEINHART: Sure.

Thank you for this opportunity.

I'm here on behalf of the New York Chapter of the American College of Emergency Physicians.

I'm a board-certified emergency physician.

I'm the chief of the emergency services at Bassett.

I'm the Chairman of the Regional Advisory Committee of the Adirondack Appalachian Regional EMS Council.

And, I'm a member of the New York State Emergency Medical Advisory Committee, the CMAC.

I will not underscore the epidemic causing all of us to be here.

Both prescription narcotics and heroin now account for more national fatalities than motor vehicle crashes among young Americans.

Both New York and Massachusetts have enabling legislation.

In New York it's Title 10, Section 80.138, with Good Samaritan protection;

For the creation of in-sequence programs;

Trainers, who can also dispense naloxone kits, naloxone being the antagonist for overdose, and responders.

In Massachusetts, police departments have a front-line 911 response role in responding to overdoses. And it's very analogous to automatic external defibrillator deployment. AEDD is, they're deployed in airports, they're deployed in police cars. So, very similar deployment scheme is in place in Massachusetts.

New York State needs to deepen and broaden its deployment program, architecture, and process across the state.

Once money programs are registered by the New York State Department of Health, the training of registered trainers can begin, and the intranasal naloxone widely available to users, addicts, bystanders, family members, and police, and other registered certified responders.

Multiple distribution sites for naloxone kits can be identified.

I particularly applaud the State of Massachusetts, and encourage New York to develop methods of:

One, defining the contents of a standardized kit to include, not just naloxone and the method and tools for intranasal administration, but other relevant materials, encouraging engagement with systems of care, starting with 911 for police and EMS, and contact information for those seeking assistance with rehab programs;

Establishing a statewide 1-800 information hotline for accessing naloxone counseling and rehab programs;

And, establishing a statewide protocol with

standing orders.

Standing orders are used in EMS, and they allow prescription to a person not personally examined by the prescriber.

In the state of Massachusetts, it's signed by a single medical director for the entire state, permitting the dispensing of naloxone kits under his authority. Emergency departments and other prescribers can then readily provide standardized state -- standardized and deployed kits.

In the meantime, wide dispersal of the opioid-overdose prevention program, as outlined in existing legislation, is needed now throughout the state of New York.

Thank you.

DR. KELLY ROBINSON: Hi, Dr. Kelly Robinson, medical director of the ED at A.O. Fox.

My colleagues have already touched on a number of things that I wanted to mention, so I'm just going to reemphasize the most salient points.

How do we keep our opioid-addicted patients out of jail?

How do we keep them out of the morgue?

I think there are, like, four points that I would just like to emphasize that have not been

mentioned.

One is, we need to have more widespread detox rehab on demand.

I don't know whether the current ACA legislation includes coverage for rehab and/or detox, but, if that -- if we're going to keep the ACA, it can be fixed and not thrown out, I think that is definitely something we need to work together to have implemented with ACA.

Next, Dr. Leinhart already touched on more widespread use of Narcan. That's going to keep a lot of patients alive until they get to the emergency department.

Police, firefighters, EMS, family members, all need to be versed at using these medications intranasally. You don't need IV access. It's very efficacious.

So, that should be looked at further.

We should actually implement what we've seen in New York City, where emergency physicians are regulated, in that, they cannot write prescriptions for more than 12 opioids in any ER visit.

I would like to see that statewide. I think that would really help us in our battle to keep patients from becoming opioid-addicted.

If we could have legislation protecting us, we would not have the dilemmas we go through, confronting these patients who present to the emergency department, requesting opioids.

If we had a law to back us up, it would make our job a lot easier.

I haven't heard anyone mention what I've seen work in other communities.

They have -- community organizations have pill-gathering sessions.

What they do is, they advertise in the community, that everybody bring in their prescription opioids to a pill dump.

And, literally, you have thousands and thousands of pills out in the community that are just waiting for your kids to take and/or distribute.

So I would love to see more community organizations have those type of programs.

And everything else has been touched upon.

NORINE HODGES: Just to that last one, I'm very excited.

We did do our Prescription Take-Back on Saturday, as well did my colleagues along here. We collected over 150 pounds' worth.

But I'm very excited, our head of our pharmacy at our local hospital has found some money, and I believe Dr. Sellers' group as well, to help us collect. And in the sheriff's department and our local police departments have a permanent site.

The prohibited piece was the expense of disposing of them. And they have put together, themselves, enough money so we can do that on a regular basis. Its about $1,000 a trip to dispose of these.

In between, right now, the DA picks them up the last Saturday of April and the last Saturday of October for the National Take-Back.

SENATOR SEWARD: And we recently, I was involved with a press conference here in Oneonta.

And the Oneonta Police Department, on Main Street, there's is a dispense -- there's a site there for disposal of these unused pharmaceuticals, which -- on an ongoing basis.

And I would just like -- before we move on, I would just like to highlight: I know, in Schoharie County, tomorrow evening, there's a free Narcan training opportunity, from 6:30 to 8:00, at the Cobleskill Fire Department, right on East Main in Cobleskill.

So looking -- perhaps you'd like to share more on that?

NANCY ORTNER: I just want to add to that, that Mr. Sacket is going to be speaking about the Good Samaritan Law, as well, then, at that forum.

SENATOR SEWARD: Great.

And I'm in the process of scheduling additional training opportunities here in Oneonta, and others throughout my district.

So, this is something that I think is certainly very much needed.

Any other?

JULIE DOSTAL: Prevention?

SENATOR SEWARD: Yes, Julie.

JULIE DOSTAL: Okay. I would like to speak from the prevention education. We've heard a lot of that.

At LEAF, we do education, information, and referral, and I can speak to some of the points that we've heard.

There's nothing more heartbreaking to have a parent, a mom or a dad, or a grandparent, call up and ask us where we might find help for a son or a daughter or a grandchild, and have to tell a mom or a dad, that because of current insurance laws and

rules, that their child or their grandchild has to fail at outpatient before they can go to an appropriate level of care.

I'm not sure what other disease we function in our culture, where we tell people they have to fail in order to get an appropriate level of care.

So that's really hard from our point, and it points out for us, in the prevention and education side of things, that we are dealing with an epidemic, with real people and real lives and real families.

And this is not the epidemic, the addiction epidemic, of "those people."

This is the addiction epidemic of "our people."

And we actually, I -- LEAF just recently had an art and poetry contest, and we had a 14-year-old write a poem about his experience with his older brother who is also a teenager.

And I have just a few lines to read from his poem, a 14-year-old, this is Eric:

"Friends thought it was a joke because all they did was seem to provoke.

"Nowadays, I'm just torn inside out because, to express it, I'm writing these raps that no one

wants to hear me in, and when I relapse, no one wants to hear me out.

"I'm always looking for the answer, and I swear, I need some heroine. No, not the monster. I need "a heroine"; something to believe in, a hero, just because me is too much feeble to let go of the needle."

That's Eric, a 14-year-old.

And we have the opportunity now to be Eric's hero. We have the opportunity to be every Erics' hero, and every Erics' older brother's hero.

And one of the main things, from a prevention standpoint, that I want to put out there, is that we need to be able to have the opportunity to address the broader social norms that make the use of intoxicants normal, and even embraced by a growing number of people.

From a purely prevention standpoint, the State of New York is limiting its own potential for addressing the larger societal questions by actively promoting and seeking revenue from the sale and manufacture of intoxicants.

An environment that champions intoxicants will inevitably reap the harm from intoxicants.

I work with a group of my peers from around

the state, and we developed some strategies that we would like to suggest as prevention-level strategies.

One, of course, is to confront the broader social and cultural messages that reduce the perception of harm related to intoxicants, including opiates, alcohol, and marijuana.

We would like to see programs and strategies that help to decrease the accessibility to prescription medications through a variety of means, including:

Educating those same grandparents and parents on prescription-medication management in their home;

Increasing the number of drop boxes in each community, as has already been talked about;

Promoting the frequency of Drug Take-Back days;

And exploring commonsense approaches to facilitate medication disposal at pharmacies.

We would also like to suggest an increase in the perception of harm in regard to prescription medication and heroin.

Many of the young people that we talk to, and that talk to us, will say: It's medication, what's the harm?

And, so, we really need to talk to young people about the fact that, just because it has an "Rx" on the bottle does not mean it's safe.

We would love to be able to work with you in educating key impactors, especially in physicians and the pharmacists, on this disease model of addiction.

And to -- and in support of my colleagues who also work in treatment and law enforcement, I say that we would like to further increase community-wide access to trainings on naloxone.

That is a lifesaving opportunity that we have, to be able to give treatment, and to be able to give folks the opportunity to have a naloxone kit that can save a life.

And that takes resources and that takes training.

And, so, we would like to promote that.

Thank you.

SENATOR SEWARD: Thank you, Julie.

Sheriff, did you want -- do you have a comment?

SHERIFF THOMAS MILLS: Yes, I would like to say a few words.

I think it's important, the education

component. It's extremely significant.

It's got to start young, and you got to continue it. It's that age group that is critical, because they're the source of everything.

I think they're always looking for something to do.

There's activities out there they can get involved in: the Girl Scouts, the Boy Scouts, 4-H.

And it's important for them to have something to do.

Idle time creates problems.

Treatment: Treatment is a huge issue, and trying to address it.

Sometimes I think just giving them something else to replace something is not real treatment. You got to get people off.

I'm not trained in that, but you also have to have the law enforcement involved.

You got to have some teeth in the program, you know.

I don't object with any of the ideas you have. You're the ones that end up pushing the cases before the courts.

But, you talk about addicts, they should be brought into treatment.

Dealers, they ought to ratchet down.

I've been involved nearly 50 years in law enforcement, and I can still remember my first marijuana arrest right here in Oneonta. And it's been nothing but downhill.

But, if you don't do anything about that, it's just going to keep getting worse.

Thank you.

SENATOR SEWARD: Thank you.

I'd like to ask our educators at the table to please comment.

We've been talking about education and prevention, and, I'd like to take a couple of minutes to call on our educators at the table, in terms of what we're seeing today in the schools, and this issue of greater, you know, education, and as part of our prevention efforts, some say starting right in kindergarten.

So, I'd like to call on Mr. Booan and Mr. Savin, if they would like to comment at this point.

JOE BOOAN: Thank you, Senator Seward, and I appreciate the invitation today.

Mr. Savin and I represent ONC BOCES.

ONC BOCES is a consortium of 19 different

school districts in Delaware, Otsego, Schoharie, and Greene counties.

We have two centers: one in Grand Gorge and one in Milford.

And primarily at those centers we're serving middle school- and high school-aged students.

Occasionally, we have sites inside our component districts that serve other students younger than middle school.

I can speak a little bit about our centers.

I was a principal at one of those centers for many years, and now I'm the director and oversee the two centers.

I think it's difficult to determine the true picture of substance use and abuse in our schools.

As you can imagine, middle-schoolers and high-schoolers don't readily go to the principal's office, or even to our counselors, to talk about things that they are doing illegally or abusing, but we do hear a lot of chatter around substance abuse.

I can tell you, to date, we have not processed an intervention or interaction specific to heroin in either one of our two centers, but that's not certainly to say that it's not occurring.

We have processed several interactions and

interventions related to prescription medication: the oxys and the hydros. That's, I would say, is a significant problem in our school, as is marijuana abuse.

In terms of the supports that we would have in our centers and our school centers, I can tell you that we make it our goal that every teacher know every student in our schools. And we believe very strongly, it starts with having our staff connected to everybody that comes through our door.

Our teachers, just by nature of running a -- technical-education programs in our schools, speak to students, but more from -- about substance use and abuse, but more from an employability perspective.

They're not substance-abuse counselors, and they're not family counselors. They are instructors and teachers, but we do talk about it in every one of our programs.

We have school-based counselors, but their mission is pretty specific: Their mission is to address successes experiences around academic and social issues that are occurring in schools.

They're not substance-abuse counselors, they're not family counselors.

When we recognize abuses, we refer out to many of the agencies that are seated around this table.

A lot of times our first stop is with the Otsego County Sheriff's Office or the Delaware County Sheriff's Office or the New York State Police, who are -- who play a critical role in supporting us and keeping our schools safe.

Education in New York State, you know, perhaps could be said across the country, has gone through a huge transformation over the last few years, in terms of standards-based education, assessing students, collecting data.

We've focused very -- we have focused very intently on how we're educating students at a time when I think resources have been significantly challenged.

There was a time when we had substance-abuse counselors located directly in our schools. We had resource officers or D.A.R.E. officers to provide prevention. And those things are sadly missed.

When funding goes away, the reality is, programs that support and prevent go away.

So, personally, what I would like to see from

where I sit, in addition to our emphasis on standards-based education, which is critically important to the mission of educators, we need to have an education initiative surrounding how we prevent. Get back to more of a prevention model with the issues that we're talking to today.

That cannot happen without the proper resource and funding.

Thank you.

ROBERT CLIPSTON: This is actually something we've seen in Chenango County.

We've heard it from several people, that they would love to see resource officers in our schools.

It does happen in -- Unadilla Valley, there is a resource officer there. That's actually very successful. He can talk to, and, you know, incorporate himself with students, from kindergarten, all the way up to seniors, which is great, because a lot of our young people are scared of officers.

They see a cop and they want to go the other way.

Well, this gives the law-enforcement side of things a chance to -- you know, co -- you know, they can mingle with everybody. And, after a while,

everybody comes around and they start -- they start, you know, liking each other, and they look up to him, and they'll go to him with their problems.

But right now, in a lot of schools, you see kids aren't going to go to an adult, they're not going to go to their counselors, they're not going to go to the principal, and tell them about problems they're seeing. It's not something they do.

We need peer programs.

You know, you take five or six teenagers and go in and talk to third- and fourth-graders, you're going to get a better result than you're going to get if you bring someone in with a textbook.

Kids are more likely to listen to other kids that they look up to. They're not going to listen to us first.

So, you know, in our county, we've actually expressed trying to get peer programs together, and trying to get local teenagers involved, to help younger kids so they don't end up in serious problems.

But -- and the resource manager would be a great asset to all schools in New York State, because you want to have that camaraderie. You want the kids to be able to go to law enforcement and

say: Hey, this is what I see. This is what's going on.

You know, kids see a lot more than we do. You know, they're around a lot more than we are.

We're at work all the time.

They could be walking with their buddies down the street and see a number of things going on that we will never see.

And something else I wanted to touch on: A lot of people have talked about treatment.

But what we've found, we've reached out to several people out-of-state, in Florida, and other places, trying to find proper treatment facilities and what really works.

And what really seems to work with a heroin addiction is a long-term treatment, and it has to be caught early. You're looking at a 14-month treatment.

And to get a 14-month treatment, insurance companies have to come around.

We can't have, which we see in Chenango County, is insurances refuse to pay for this treatment.

A lot of these kids, and a lot of these addicts, cannot afford treatment. They're not rich.

You know, they don't have money sitting in the bank that they can spend it on.

You know, you see addiction, they're not robbing people because they just want more. They're robbing people because they've already gotten rid of everything they have. They've gotten rid of their job, their family, their money...everything.

So we need to come up with some kind of solution that is localized treatment, where, you know, you could have a treatment center in Chenango County, or a treatment center in Delaware County, or Otsego County, that they're not traveling 800 miles to get what they need.

I mean, we found a treatment center through a church that's relatively cost. You know, the cost is down, it's 14 months, but it is out of state. And it's for 18 and younger.

Now, there's nothing available for 18 to 25.

So we need to come up with a solution for that problem.

Something else that I've seen in Chenango County is the amount of foster kids due to the drug problem that we have.

The amount of foster kids is going through the roof. I mean, we have 64 kids currently, this

year alone, in foster care. And close to 30 of them are because of drugs.

So this isn't just affecting the addicts; it's affecting the families.

When he talked about grandparents, those are grandparents that are taking care of their kids' kids, because their kids are addicts.

SENATOR SEWARD: Thank you very much.

JEANETTE TOLSON: May I say just a few words?

I just wanted to say that our organization offers recovery services in the community, which are support services for people who are not in treatment, support services for people in conjunction with their treatment, and support services when they're done with treatment.

And one of the things that we try to assist people with, is, you know, rebuilding that life that took years and years of an addiction to break -- you know, to fall apart.

And some of the things we've heard today about people feeling very overwhelmed with trying to put that life back together, causes people to give up, causes people to feel like there aren't enough resources available.

And one of the things that's very, very

beneficial to people when they're rebuilding their life, is the ability to gain employment.

And, you know, we help -- we have some employment services for people who are trying to get back into the workforce, but one of the challenges is getting employers to hire people and take a chance on someone who has a history of addiction.

And I think that if we had some additional incentives from the state government, to hire people who have an addiction, and to -- you know, tax incentives, or whatever, to have them take that step: hire people who have a history of addiction and are in recovery.

They will start to see that people can get back into the workforce, be productive members of society, which will help change the stigma, and allow people to start feeling like they can contribute to society again.

So, thank you.

SENATOR SEWARD: Thank you.

Before we get to some of the questions from the audience, I just wanted to -- just ask the question from -- to our -- to those involved with treatment:

In terms of the detox option here, where

would an addict go to complete a detox program in this area?

JUSTIN THALHEIMER: Want me to take this?

First of all, I want to thank law enforcement, because they've saved a lot of lives by just taking people right off the streets --

[Applause.]

JUSTIN THALHEIMER: -- and putting them in jail. It's not the prettiest detox, but it's better than no detox at all. It's not pretty, but they save lives. Even recently, they've saved lives.

Detox for opiates is really tough because it's never been treated as a life-threatening thing.

It's just -- it's -- you're going to feel really uncomfortable, like uncomfortable that most of us can't imagine, but it's never been treated as life-threatening, so it's very difficult to keep somebody in -- or, to get them into detox.

And, unfortunately, when they're going into the local emergency rooms, which are overwhelmed, if they're intoxicated, a lot of times, before they go into really active detox symptoms, they're discharged.

I mean, like everybody else, as soon as they're fixed, they're discharged, so they don't get

to the services they need.

Unfortunately for us, we've got, Delaware Valley Emergency Room does middle, mild, detox, and that's with some -- with other things attached.

And then there's Spark up in Schenectady.

We do not have the resources for detox locally.

Like I said, I mean, if somebody gets pulled off of probation or parole and they get pulled into the jails to detox there, it's not pretty, but it's better than no detox at all.

DA RICHARD NORTHRUP: One of the difficulties, opiate withdrawal is not considered a medical necessity, and often what they'll recommend, Suboxone was originally designed for withdrawal of opiates.

So, really, there are little or no resources for opiate detoxification.

I -- with the -- I'm a proponent of inpatient detoxification for opiates, because I think it works the best.

And as I said earlier, there are no [unintelligible] Suboxone providers locally, so these people are really left hanging out there.

Like Justin said, unfortunately, a lot of detox is done in jail.

NANCY ORTNER: And I would add to that, in Schoharie County, if someone comes in and is looking to be detoxed, we send them to St. Peter's in Albany. So it's not in Schenectady; it's in Albany.

JUSTIN THALHEIMER: Oh, thank you.

NANCY ORTNER: So it's a bit farther.

Or, St. Mary's in Troy, or Amsterdam.

And it's a gamble, because we can't call ahead.

If we call ahead, they say, "We can't guarantee a bed."

And, so, they get to whichever facility they decide to go to, and then they may or may not be admitted, depending on whether there's a bed available. Or, depending on whether they're really showing some withdrawal symptoms.

So, they have to be very sick, and have a bed, in order to get detoxed.

UNKNOWN SPEAKER: And have the right insurance.

DAVID RAMSEY: Senator --

SENATOR SEWARD: Yes.

DAVID RAMSEY: -- if I might?

UNKNOWN SPEAKER: And have the right insurance.

NANCY ORTNER: And -- yes. Thank you.

And have the right insurance.

DAVID RAMSEY: I can kind of echo a lot of the comments about the frustrations that I have.

As a council director, one of the services I provide is doing formal interventions for families. Someone calls, their -- a relative is in trouble.

And it's a laborious multistage process, but it can be very effective, but over the years, and I've been doing this for 16 years, the customer has changed. It's no longer the middle-aged alcoholic that used to be who I was called to assist.

And now, as, sadly, in the last four or five year, is reflecting the statistics that we're talking about here. They are young people in teens or in their 20s, and the parents that are calling are frantic. Their world has been turned upside down.

And, again, it is not a stereotypical profile. These are good families -- so-called good families. These are people unemployed. It's a very democratic medical illness that we're dealing with

here. It will take anybody.

But one of the things I have been extremely frustrated about, is I get someone at that intervention, agreeing to go to treatment for heroin addiction, and as has been said here, it's a very uphill battle to persuade, you know, first of all, to get them into a detox. Some of these places will not detox from opiates.

But if you are successful, then the battle becomes, and it is a battle, with the insurance company.

There is legislation, I think, being considered now in Albany, and I really, really hope that it's given serious consideration, because we are losing people, losing their lives, because, you know, the decisions are made for profit reasons.

That's what insurance companies are about: They are ultimately beholding to their shareholders.

And there is a conflict of interest there.

These are public-health issues. They cannot be allowed to be in the driver's seat when these decisions are being made.

Turn that back to the professionals. The medical professionals that are here today, the professional CASACs, the alcohol and drug

counselors; people who are on the ground with the patient, who understand that you can't tell a heroin addict who is shooting, you know, 15, 20 bags of heroin a day, to go to an outpatient clinic and "You'll be okay." That's not going to work.

And, so, they have to be held accountable for this. I think it's absolutely criminal what's going on with the insurance companies.

[Applause.]

DAVID RAMSEY: The other, more promising trend, is someone sitting right next to me here, Jeanette Tolson, who runs the local recovery center.

Which, and by the way, we are very grateful for your support, early support for that Senator Seward. Your funding of that at a critical time for us, I think, turned everything around.

But we know, the statistics are clear, that when people come out of treatment, and we're assuming that you're giving them the very best treatment possible, they still tend to relapse in the first three to six months of discharge from those treatment facilities.

If we provide them with recovery centers, that rate of relapse plummets.

So this is smart money to invest in recovery

centers.

It's also smart to invest in recovery coaches.

Norine, myself, and Jeanette are all trained recovery -- master trainers for recovery coaching.

We have approximately, in the state now, close to 1,000 people trained up as recovery coaches. And that's a rigorous 35-hour training of peer support.

OASAS has been the state agency that oversees substance abuse in New York State. OASAS has been very helpful in that effort, too. They have also trained peers in this area.

And that provides someone who is newly sober, who is frustrated, intimidated, about just about everything that's coming their way, because they're newly sober, this gives them, literally, a hand to hold, to go through these frustrations that precede a relapse.

And so we know that recovery coaches are having a huge effect on reducing relapse with addicts and alcoholics. We can certainly do that.

My final comment would be, just, you know, ditto the comments here this morning about getting to them early, getting to them in the jail. That's

where they end up, in the criminal justice system.

If we can provide them with treatment, and there's no reason, I think, that we can't do this, it's just the will to do it, to get them in the county jails, in the state prisons, with good, solid treatment and counseling.

Otherwise, you're just having them sit in a box for up to a year, with nothing. No insight, no change in their attitude or approach to life.

Those things are being tried, particularly now in Maryland. They're having great success with programs that are taking place in the county jails.

So there's encouraging signs there, but we're missing an opportunity there.

We have that captive audience. We can get to them with a message of hope.

So, thank you, Senator.

SENATOR SEWARD: Thank you.

Yes --

NORINE HODGES: I'm sorry, Dr. Sellers.

I just wanted to address, before we move on, and it's the last thing I will address, but, prevention education.

We are in every classroom, from kindergarten through high school. Every grade, every student,

we're loaves and fishes. One full-time and three part-time, we go into every class with an evidenced-based [unintelligible] life skills, as well as a few others.

We do twenty-thousand 101 contacts.

We have reduced the early initiation of alcohol for our tenth-graders -- that 15-year-old brain we've been talking about, it's pretty crazy -- by 87 percent.

And our twelfth-graders look at using prescription drugs the wrong way, to use them for not what they're attended, 65 percent.

This program works, every student gets it. It's a scaffolding program. It's relevantly designed so it's meaningful for every age group, working on decision-making, how to handle emotions, communication skills, social skills.

We've got our first tenth-grade class that's had the program since kindergarten. The numbers for that particular age group, because it is a strange time in life, there, with the brain development, amazing.

And now OASAS (the Office for Alcoholism and Substance Abuse) has agreed to survey in the fall.

We do it every two years. And that, my

tenth-grade group, will be seniors. And it really does work.

And I think, those monies, that every school used to get those monies. They were the drug-free and safe-school monies.

They -- with the federal government took that away, made them into big block grants that only a few schools -- I've been a peer reviewer for those grants -- only, you know, 10 to 20 schools in the country can access those monies; whereas, before, every school had those monies.

So we did have counselors in the schools, and then we did have other education programs.

But my colleagues and I struggle to get into all the classrooms. And we've just been very blessed in Schoharie County. Every teacher loves it, every teacher wants us back. Children do petitions to have us come back.

We do bullying now, violence in the classroom, as well.

So these programs work.

[Applause.]

DR. JOSEPH SELLERS: My colleague Dr. Leinhart pointed out to me that we don't always interact with the people sitting around this table.

That, you know, one of things, we don't have a system for communicating between medicine, the community resources, education, law enforcement.

And many of the folks who are having difficulty with substance abuse wind up in emergency-medicine facilities on a regular basis, multiple times, before they would ever be seen by law enforcement.

And, so, I think one of the -- hopefully, a good outcome from this, would be for all of us to commit to interacting more.

And, so, I'm going to volunteer these guys to --

[Laughter.]

DR. JOSEPH SELLERS: -- anybody who wants to meet with the ER directors from Bassett and Fox should get their cards today before you leave.

And they should know about the programs that are out there.

Law enforcement should know what's going on.

They should talk to you guys about how do you interact with the EMS system, and the rescue squads, and the people who are out in the community. Or the EMS guys are going into people's house all time, and see things, and report to us, things that would, you

know, turn your hair gray.

Lastly, if I can, because I know you wanted to switch to taking questions, and there is a physician from Bassett I asked to come here today, who is putting together, with the LEAF group, a community event that's going to be in Cooperstown on May 22nd.

And I think it would be helpful for the group here to hear about what Dr. Weinstock [ph.] has to say.

DR. WEINSTOCK [ph.]: Do you want me to talk about the event? Or [inaudible].

DR. JOSEPH SELLERS: I think it would be nice if you talked about the "why" of your event, and then the "what," because I think it's -- it's an example, I think, of finding a community-based solution.

SENATOR SEWARD: Okay, go ahead.

DR. WEINSTOCK [ph.]: Sure.

Hi, I'm Judy Weinstock, and I'm the newest physician, I think, in the entire Bassett system.

I'm a primary-care physician, and I moved -- I moved here with my husband nine months ago, to come to a place that had a slower pace of life. And, was never interested in drug addiction or

prescribing opioids.

And this has become a passion of mine by accident.

So, Dr. Sellers asked me to tell you a little bit about my experience.

So I came to Bassett to be -- work part-time as a primary-care physician. Just a regular family doctor.

And my first three days, most of my patients; so I saw 10 patients a day, so about 9 a day were seeking opioid prescriptions.

And I kind of went like this [indicating], and said, "You know, these are not appropriate prescriptions. This is not how I was trained." And immediately started looking for resources to help me.

And what Mylea said in the beginning really resonated with me.

She said, "It's hard not to blame the doctors."

Well, the doctors blame themselves.

It's hard for the patients not to blame the doctors, but, also, we get blamed when we don't prescribe, when someone's in back pain and they're seeking opioids.

So in four months, I have received more threats, more complaint letters, you know, I've had more patients fire me, and every single one of those has been a narcotic-related complaint or threat or firing.

So, the resources that I was looking for was pain management. I needed help. These patients are in pain, and some of them have been on these medications for 20 years. They're not even close to admitting they have a problem with opioids. They have a problem with pain first.

And I found -- I spent, I don't know, 80 hours a week my first three weeks of working there, looking for resources.

And I have a handout for patients of 12 pain-management clinics they can go to, which include neurologists and board-certified fellowship-trained pain-management specialists, et cetera.

Well, I've had to whittle down the -- the list down to nine, because I just can't get patients into four of them.

And the closest one is Syracuse, and the waiting list is nine months, and "I" must detox a patient off of opioids before they'll be seen.

So how do I do that? I give them Imodium and Zofran and clonidine, and say, I know you're going to get diarrhea, but Imodium works a little bit better, you know.

So that -- so the second resource is psychiatry mental health. I need help.

Addiction and mental-health problems are like this [indicating.] They're not separate issues.

And to get -- I need help with this.

And then, of course --

[Applause.]

DR. WEINSTOCK [ph.]: And then, of course, the addiction problem.

So those are the resources I want. And, really, that's what all the primary-care and emergency-med docs want, and that's really what the law enforcement wants, and what the patients want, and what the families need.

And, you know, Mylea, I feel like I've seen you 20 times last week. You know, I don't want you to go to jail. I don't want to you live on the street. I want to hug you and take care of you.

And that's what all the doctors want.

That's what we all want, you know?

So I can talk forever.

I will stop and talk about the events, though.

I think, probably on my second month of living here, I said: Not enough people know about this, and not enough people get together.

The docs know about it, the cops know about it, the detox centers know about it, but not enough of the community knows about it.

We've got to get the word out there.

So there's a similar town in Vermont, St. Albans, and there was a documentary made about that town and the drug problem there.

And the kids in this documentary, they wear the John Deere clothing, they work on farms. You know, they work at Wal-Mart.

It's our community.

And, so, together with LEAF and Justin Thalheimer's helping, and the docs are helping. I mean, everybody who hears about it wants to get involved.

So we're having the movie shown as a free community event in Cooperstown at the Fenimore Museum on May 22nd, which is a Thursday night. And the director of the movie is coming. And one of the kids who is a recovering addict is in

the movie.

And this is what the poster looks like, and the movie is called "The Hungry Heart."

And the idea is, to get everybody to come together and talk about the fact that this is a community problem.

And, so, I have a lot of these posters if you want to put them up. They were graciously donated by LEAF.

Thank you, Julie.

And -- oh, Judge Burns [ph.] will be there, as well, talking about how the problem affects us from a law standpoint.

I think I'll end there.

SENATOR BOYLE: Thank you very much.

SENATOR SEWARD: Thank you very much, Doctor.

[Applause.]

SENATOR SEWARD: In the few -- the very few minutes that we have remaining, I wanted to get to some of the audience questions that's been raised.

And the first one is -- regards -- it's from Pete Maloney [ph.], the assistant chief of the Oneonta Fire Department.

He's asking: "Is there a plan to provide continuous supplies and support to law enforcement

for the Narcan kits?

"And will EMS agencies, who also respond to overdoses, be supplied by this program?"

I'd like to ask Senator Boyle to address that, what we're doing at the state level. I know he's involved.

SENATOR BOYLE: Yeah, that's an excellent question, Chief.

And what I found going around the state is, that there's really no clear-cut program or agenda on the way to address this Narcan situation.

It -- the irony is unbelievable, given the fact that there are Narcan trainings.

And I'm glad to see you're having one here.

We had one on Long Island the other night. We had 150 people participating.

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

And I'm sure the emergency room doctors have seen it numerous times over their career.

The irony is, right now, under state law, we can get it prescribed and give a course, and have it given out to a citizen, a concerned citizen, but you cannot have it on your first responder vehicle for a fire department, for example, because the department

itself cannot be trained.

It's really a county-by-county thing.

And I can tell you that, as part of this legislative package that's going to come out of these hearings, we're going to have a unified system, so as many people -- first responders, parents, addicts themselves -- will get access to Narcan.

[Applause.]

SENATOR SEWARD: Both Bob Kerry and Pamela Tillman [ph.] have asked questions regarding, and it's come up several times in the discussion here today, regarding, you know:

"Why are insurance companies, rather than recovery professionals, dictating whether or not an inpatient receives treatment?

"And what is the status of Senate and Assembly bills?"

And, you know, as -- I chair the Insurance Committee in the Senate, and, of course, as a member of this Task Force, I can report to you that, between now and June 1st, when we look to come up with the recommendations from this Task Force, that this is certainly going to be a key issue for us, because, number one, we need a much more

uniformed standard in terms of coverage in the state.

Because I've heard stories of people showing up at the inpatient centers, and, you know, they -- their families are in tears, they're in a crisis situation, and they're on the phone with someone in a cubicle at an insurance company.

And, you know, it's a very uneven standard that's used, and, it does not help us with our efforts with recovery, with what the current situation is.

So, I can't give you a specific answer here today but other to say, that this is a key issue for us. And I suspect that we will have a much better answer as part of these Task Force recommendations, so people can get the treatment that they need.

There's a question here about -- this is from Pastor Romano?

Oh, yes, yes.

Shall I read your question?

Yeah.

It says: "I have a daughter incarcerated. Involved in prison ministry, I would like to know about easier ways to get funding and help for more faith-based rehab housing and traditional" -- "and

transitional, and programs."

There's that question.

Obviously, I think, I suspect, that that will also be part of our -- Senator Boyle, wouldn't you say that would be part of our deliberations?

SENATOR BOYLE: Absolutely. You know, faith-based, whatever community groups, will be a part of it.

But we heard a little bit of the testimony here today, where, again, the irony, where you're trying to get treatment from an insurance company.

And I've had parents across the state say: I purposely had my child incarcerated because that's where they could get help.

That is a messed-up system, and it's going to change.

[Applause.]

SENATOR SEWARD: Absolutely.

[Applause.]

SENATOR SEWARD: This would be brass for our medical folks that are here with us.

Pastor Romano had a further question.

"What are the side effects of VIVITROL?"

Anyone?

Do you have the answer to that question?

BETH: It has not been around --

SENATOR SEWARD: Could you identify yourself.

BETH: [Speaking without a microphone.]

Beth Viviani [ph.], [unintelligible].

SENATOR SEWARD: Right.

BETH: Some reviews that have been done on that shows that there have been no long-term studies yet. That [unintelligible] going on long enough for there to be studies.

SENATOR SEWARD: Excellent answer.

We have a question regarding the legal -- this is from Henry Azblofox [ph.] --

Yes.

-- from Oxford.

I'm going to try to read this question.

It says: "The legal pain killers are dangerous in too many instances.

"Even Purdue Pharmacy, the manufacturer, has admitted their so-called 'safe formularies' was a problem.

"Can the State ban or drastically restrict medical use?

"Maybe pain is preferrable to risk of addiction."

Is there a response for that?

DR. KELLY ROBINSON: I think we spoke to restricting the use of prescriptions from the emergency department.

If we could be limited in the number of opioids we could prescribe, such as what they have in New York City, that would benefit the rest of the state.

SENATOR SEWARD: I remember you making that point.

Yes, Doctor, do you have a response to that?

DR. WEINSTOCK [ph.]: Yes. I was asked to give a lecture to the medical students about appropriate opioid prescribing, and there are no guidelines at all, really.

These are FDA-approved for patients who have -- who are dying of cancer.

That's really who it's approved for: people who are dying.

And so, when somebody comes in with back pain, what do you do?

Do you treat a 20-year-old with back pain the same way as you treat a 99-year-old with back pain, as you treat somebody who just got back surgery?

And, so, I gave seven scenarios to the med students, and these are people who are being trained

to be doctors, and there was no straight answer for each one.

As Mylea said, these medications didn't just help her back pain. They helped her mental pain, they helped her despair, they helped her depression. She felt superhuman.

How do you take that away?

DR. JOSEPH SELLERS: You know, one of the things that's unfortunately happened, there's a pendulum.

And when I started in medicine, giving opioids was considered to be something that you didn't do. People would become addicted.

And then there was the movement, What about people with cancer pain? What about people with terminal pain?

And then the overall organization that certifies and inspects hospitals, the Joint Commission on Health-Care Organizations put through that everybody should have a fifth vital sign every time they encounter the medical system, and that should be their pain level.

So if you're ever in a hospital or an ER and you see those pictures, [unintelligible], the thing is, everybody has a right to be treated for pain.

Medicare still requires hospitals to survey the patients that leave the hospital, the emergency room, a series of questions, and one is: How is your pain? Was your pain adequately addressed?

A pendulum swung, because of, I think well-intended, you know, actions on the part of the regulators, but it was -- it swung too far.

And it still is a very tough dynamic, and it's very tough, because, unfortunately, addicts can, and drug-seekers, people trying to get drugs so they can sell them on the streets, can be very convincing about their pain.

And it's a tough, tough situation.

But I think that the more we educate ourselves, educate our patients, and be just careful use of potentially addicting drugs.

But we can't stop using them, because there still are people who cannot work, whose lives would be turned upside down, without adequate pain relief.

It's just very difficult to sort out who, and when, and how much.

And, again, we need more government help, more government, research. I think this is at the federal level, about best practices for, you know: What is the ideal practice for somebody having their

wisdom teeth extracted, that minimizes the risk of long-term addiction, but still gives the person some relief?

Because, you know, there is significant pain associated with having your wisdom teeth extracted?

SENATOR SEWARD: Thank you.

DR. STEVEN GRAHAM: [Speaking without a microphone.] If I may?

SENATOR SEWARD: Yes.

DR. STEVEN GRAHAM: One of the problems with opiates is that they work.

[Laughter.]

DR. STEVEN GRAHAM: And, one of the principal mechanisms of action that they have, is they function as an antidepressant.

One of the things that we're going to be seeing, perhaps in the near future, is a novel antidepressant that is in Phase 3 trials right now.

The principal active ingredient is buprenorphine.

[Microphone handed to speaker.]

DR. STEVEN GRAHAM: That's actually all I had to say.

[Laughter.]

DR. STEVEN GRAHAM: Other than the fact that,

again, narcotics are antidepressants.

One of the reasons people use narcotics, is because they act as an effective antidepressant.

SENATOR SEWARD: Thank you, Doctor.

JUSTIN THALHEIMER: I'm sorry.

I just wanted to say that, based on what you were saying, I know a lot of people will go into the emergency room, looking for these meds, or to their primary-care physicians.

These medications are also mimicking and magnifying the pain.

So it's not like the addict is going in without pain. They just don't know where it's actually come -- a lot of times, they don't know where it's coming from. It mimics and magnifies it.

If the scale of 1 to 10 is a 4, after you're opioid-dependent, that same scale is going to be at about a 7 or an 8.

It's -- it doesn't -- when you're looking for the -- when you are addicted to the opiate, you're --

DR. WEINSTOCK [ph.]: There's a medical term for that. It's called "hyperalgesia." And it's -- that is, that your body isn't able to produce it's own pain killers.

So I always tell my patients: When you stub your toe, it hurts a lot more than when I stub my toe. And I believe you.

And anybody who's delivered babies, I used to deliver babies, and I used to deliver the methadone-addicted babies, and it was so hard to control their labor pain. The regular epidurals didn't work. And it wasn't -- it was real.

Doctors want their patients to be pain-free.

SENATOR SEWARD: Thank you.

There's one other question on the pain-meds issue.

Is it, Bridgette Brown [ph.]?

Bridgette, yeah, why don't you give her the microphone.

Did you have any -- did you have a follow-up question on this issue?

BRIDGETTE BROWN: I've been in recovery since 1990, from alcoholism.

And in '97, I was put on -- where I had fourth-stage breast cancer, I was put on opioids. And I was told there was Oxycontin, and I would never become addicted to it.

Well, I don't take opioids anymore.

I never, as far as I'm concerned, engaged in

drug-seeking. But, I have had a lot of pain, and the doctors are afraid to prescribe -- and I know many people like myself, to prescribe pain medication. They're afraid, because of the I-STOP laws, and everything else.

And there are, definitely, many people pain.

That I had sciatica for seven weeks. I went to the emergency room three times. I saw Dr. Kelly, and I was given nothing for my pain.

I didn't want opioids, but there really isn't else.

The pharmaceutical companies are not producing pain medication that will help us, because they make so much money from the opioids, I guess.

So we need help.

I mean, there are legitimate people, and, of course, you said that, that need pain medication.

Thank you.

SENATOR SEWARD: Thank you very much.

Just a couple of more here.

We had, from Karen Van Vauckenberg [ph.], who said: "What is the political stance on making access for levels of care available, such as insurance paying for treatment, acupuncture, pain management, recovery coaching, and peer-support

groups?

"All the different pathways, together, are more successful than are intervention one at a time."

I think that sums it up very well in terms of why we're here today.

It's, obviously, going to take a multipronged strategy to address this problem.

And, obviously, that's -- you know, we have this wide-ranging panel here.

There are others at various other forums that have been held around the state, and with all of this input, we will be looking to develop that multipronged strategy.

BRIDGETTE BROWN: Thank you, Senators.

SENATOR SEWARD: And, finally, Matthew Ward?

We're way over time, but if you would like to make your point briefly, we would very much like to hear your comment.

MATTHEW WARD: I'm Matthew Ward. I am a drug-court participant, as well.

And, you know, my story, you know, originated, you know, through drinking, moving on, blah, blah, blah.

The "Emerald City" you hear, that we're

talking about, is opioid addiction. But, without putting, you know, a specific substance, you know, into the discussion, I think that we all in this room, it's fair to say, 100 percent of us are affected by addiction.

And, you know, I just want to see, you know, that same willingness that's asked of me in my recovery. You know, if I want what, you know, people living clean and healthy have, and I'm willing to go to any length to get it, you know, I want to see the same things occur.

You know, I'm accompanied by a set of parents that had, you know, their child, just back and forth, and back and forth, trying to get the insurance company to pay for this.

Myself, four times I went to rehab before I wound up with a felony, you know.

And, I am educated, I have a deep career, all these things that went circling the drain, you know, as I attempted, over and over and over again.

You know, the window of time, when an addict says, "I need help," might be 15 seconds. And we're supposed to wait 30 days for some response from an insurance company?

You know, so, I just -- I do thank everybody

who's up there today, for assembling on this.

I think that it's a huge step in the right direction.

And, you know, collaboratively, I think input from everybody -- law enforcement; government; the counselors, you know, that advocate; you know, people in recovery; people who are still active, seeking recovery -- you know, we can all make this happen if we work hard at it.

So, thank you.

[Applause.]

SENATOR SEWARD: Thank you, Matthew.

I just want to close, ask Senator Boyle to give the concluding comments.

But I just want to close by saying how much I appreciate all of you being here this morning.

This is a huge problem for our area. It's no longer a big-city problem. We have it right in our small towns and our rural communities in this part of the state, as well.

It's a growing problem, and we need to deal with it.

And, I appreciate the comments that everyone has made here today. They've been very insightful and helpful to us, our Task Force, as we do our

work.

And, no question that, you know, we need to look to expand treatment opportunities earlier, and also look to additional education and prevention measures to be taken.

The insurance-coverage issue is huge, and very key in many, many cases.

We're going to look for a better answer there, so people can get the treatment that they need, and get it earlier.

And, there are many other aspects of this issue that we need to deal with.

So, I want to just say thank you all for participating.

And those of you in the audience, I hope you found it to be interesting, and I appreciate your input, as well.

I particularly want to thank Deb and Mylea for being here, to remind us that we may talk statistics, but they are real people behind these numbers. And, we owe it to you, and all those you represent, to deal with this problem successfully.

So with that, I would like to ask our Chair of our Task Force, Senator Boyle, to close.

I appreciate my colleague Senator O'Mara for

joining us, as well.

SENATOR BOYLE: Thank you, Jim, and thank you so much for hosting this, and SUNY Oneonta; Senator O'Mara, for participating, and all the panelists.

We got some good ideas today. I know we can think of three or four bills -- potential bills to come out of here.

As Dr. Sellers says, this communication should continue.

And if you think about something, in talking in the next few months, or the next few years, please contact us, because there's always room for legislation to help us combat this drug tragedy.

And, thank you for all the people participating in the audience, for coming today.

I was looking forward to this forum probably more than any of them, because I knew I had the Chair of the Insurance Committee here, and this was going to be -- he's the man, on this.

And, also, to Deb and Mylea, thank you so much.

And I know, I'll end with saying:

Mylea, I know you said in your beginning, that your goal was to, someday, help save a life.

Well, you did today.

Thank you for participating.

Thank you all.

[Applause.]

(Whereupon, at approximately 12:11 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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