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

PUBLIC FORUM: NEW YORK COUNTY

PANEL DISCUSSION ON MANHATTAN'S HEROIN EPIDEMIC

Senate Hearing Room, 19th Floor
250 Broadway
New York, New York 10025

May 1, 2014
9:30 a.m. to 3:00 p.m.

PRESENT:

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

Senator David Carlucci
Vice Chairman of the Joint Task Force

Senator Martin J. Golden, Task Force Forum Moderator
Member of the Joint Task Force

Senator Michael F. Nozzolio
Vice Chairman of the Joint Task Force

Senator Simcha Felder
Member of the Joint Task Force

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Chief Medical Officer
Phoenix House Foundation
Also the president of Physicians for Responsible Opioid Prescribing

Dr. Bradford Goff
Psychiatrist
Lutheran Medical Center

Henry Bartlett
Executive Director
Committee of Methadone Program Administrators of New York State (COMPA)

Dr. Hillary Kunins
Acting Executive Deputy Commissioner
NYC Department of Health and Mental Hygiene

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William McGoldrick, Esq.
Attorney At Law
Retired Detective Sergeant from the New York State Police

Linda Sarsour
Executive Director
Arab-American Association of New York

Rabbi Simcha Feuerman
Director of Operations, OHEL Children's Home
President of NEFESH (International Network of Orthodox Jewish Mental-Health Professionals)

"The Detective"
Representative, NYC District Attorney's Office &
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Executive Director
Bridge Back to Life Center

William Fusco
Executive Director
Dynamic Youth Community

Karen Carlini
Associate Director
Dynamic Youth Community
Also, Co-Chair, Association of
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Mothers and Fathers Aligned Saving Kids

James Hollywood
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SENATOR GOLDEN: [No audio.] They'll be right up.

I'm going to start with my opening remarks.

Simcha's here.

Simcha, come on in.

I'm joined by Senator Mike Nozzolio, Senator Simcha Felder, who's part of our task Force.

And, here comes our chairman now, Phil Boyle, who is the Chairman, and with my co-host here, Simcha Felder.

So I'll be turning this over for you to open this up, sir.

SENATOR BOYLE: Sure.

Thank you, Senator Golden, and thank you Senator Simcha Felder, for co-hosting this forum.

And, Senator Nozzolio, thank you for joining us.

This is the ninth of 17 forums around the state we're holding as part of this Heroin and Opioid Task Force.

The mission of the Task Force is to have a report due about June 1st, and then subsequent legislation before session ends this year, to combat this statewide epidemic.

We've gotten some great testimony and

feedback interaction over the last several of our forums.

And we look forward to hearing from our witnesses today and getting some good ideas.

Obviously, as Senator Golden probably mentioned, we're focusing on prevention, treatment, and law enforcement.

So any of you, if you, through your expertise, whether it's in any of those areas, thinking outside the box, what has worked, what do you not think will work, and, if you ever thought there ought to be a law, this is the time to talk about it.

So thank you, and I appreciate being here.

Thank you.

SENATOR GOLDEN: Simcha?

SENATOR FELDER: I just want to thank Senator Golden for hosting this event, and being gracious enough to include my name.

SENATOR NOZZOLIO: Just my comments, briefly:

It's wonderful to be with my -- all my colleagues, especially two of them from New York City, Senator Golden and Senator Felder. Thank you for your attention to this issue.

What we're finding, is that the epidemic of

heroin is not exclusive to the inner cities anymore.

Certainly, we're in the biggest city and -- in our state, but today we want to hear your experiences.

But, the Task Force is finding this is an issue now, small cities, suburbs, rural areas. It's pervasive across the state.

So thank you very much for your testimony.

Without further ado, Chairman, thank you.

SENATOR GOLDEN: I want to thank again our Chairman and our Co-Chairman, and, of course, Mike Nozzolio for coming today, and being part of this Task Force today.

I just want to point out two -- three paragraphs here that are important, and then we're going to open up.

In February this year, "New York Times" reported that the federal Drug Enforcement Administration heroin seizures in New York State increased 67 percent over the last 4 years, seizing 144 kilograms of heroin, 20 percent of the seizures nationwide, valued at $43 million.

My colleague Simcha is from Brooklyn, and myself, southwest Brooklyn, an unfortunate a number of people who have lost their lives, or been

hospitalized and currently addicted, to prescription drugs, heroin, and more.

We're going to hear from some of the people from southwest Brooklyn. I guess they had another death there last week, and an overdose of heroin.

Today's "Daily News," you see an actress in England, they just came up. She had overdosed in early April, and they're saying that that now is a heroin overdose, as well.

According to the New York City Department of Health, 84 Brooklyn residents, "84," died, unintentional overdoses involving heroin in 2012, 26 more than in 2011.

What we've been able to do in the state of New York is to address I-STOP on the opiates, on the prescription drugs, Oxycontin.

And in 2011, there were 22 million painkiller prescriptions written in New York State, in the homes of 20 million people.

Think about the numbers. Those are astounding.

But we did so good on I-STOP in bringing those prescription-drug overdoses down. Still, there's a significant number of opiate deaths out there by pill.

But I will tell you that they went -- the water raised itself and to the level [indicating], and heroin has come in and picked up that area, and you can pick up a deck of heroin today, 3, 5, 7, 8 dollars.

And you can have hundreds of decks of heroin on you and it's not a felony here in the state of New York.

It should be.

And we're going to listen to testimony, as my good colleague has said, on all areas; not only on the arrests and conviction and jail time for the people that are selling this drug, as well as those for treatment and prevention, as well.

So I want to thank you all for being so patient here today, and I turn this back over to my colleague Senator Boyle.

SENATOR BOYLE: Thank you, Senator.

And we have our initial panel.

Just briefly introduce yourself, and then where you're from, for the record.

SENATOR GOLDEN: You have to use the mic, Doctor.

DR. BRADFORD GOFF: I'm Bradford Goff. I'm the chairman of psychiatry at Lutheran Medical

Center in Brooklyn.

DR. ANDREW KOLODNY: My name is Andrew Kolodny. I'm the chief medical officer of the Phoenix House Foundation, a national nonprofit addiction-treatment agency located in Brooklyn, throughout New York State, and different parts of the country.

I'm also the president of Physicians for Responsible Opioid Prescribing, which is a national organization representing doctors in the fields of pain, addiction, primary care, public health, emergency medicine, and other specialties.

HENRY BARTLETT: My name is Henry Bartlett. I'm the executive director of COMPA. And we're the provider coalition in New York State that represents those treatment programs that use addiction medicine as part of the comprehensive treatment of opioid dependence.

DR. HILLARY KUNINS: Good morning.

I'm Dr. Hillary Kunins. I'm the acting executive deputy commissioner for mental hygiene at the New York City Department of Health and Mental Hygiene.

SENATOR BOYLE: Now, the way --

And thank you very much, all of you, for

coming, and agreeing to take time out of your schedule to be here.

We like to be a little more informal about this. It's not, technically, a hearing. It's a forum.

And, so, if we can just ask questions.

If any of my colleagues, obviously, want to chime in, or any of you want to answer a question that might have been directed at somebody else, please feel free. We're trying to get as much information as possible.

Dr. Kolodny, I'd just like to start with you.

You're part of an organization that looks at prescription, and overprescribing, perhaps.

A lot of people feel that the current heroin crisis is a result of the I-STOP legislation, perhaps -- or an exacerbating factor of the heroin situation, I should say.

Several years ago -- or a couple years ago, we passed the I-STOP legislation, which cut down on prescription overprescribing, and pharmacy and doctors included, which may have led us to go toward -- some of the addicts to go towards heroin.

Can you give me an example how you feel about that? Or, do you think that's where we're head --

what we're looking at?

DR. ANDREW KOLODNY: Yeah, I think there's a half-truth mixed in there.

SENATOR BOYLE: Okay.

DR. ANDREW KOLODNY: The explanation for the rising use of heroin and -- across New York State, especially in suburban and rural counties, is actually very easy to find.

If you speak to a new heroin user, someone who's become addicted to heroin over the past decade, and this is an individual who is very likely to be White, and between the ages of 20 and 35, what they will tell you is that, their addiction, the reason that they were using heroin, is that they became addicted to opioids. And that addiction began through use of painkillers, and they switched to heroin because heroin was easier to access.

This trend of people switching, getting addicted to painkillers and then moving to heroin, has been going on for the past decade. This is not something that just happened overnight in the context of I-STOP.

SENATOR BOYLE: Okay.

And to what --

SENATOR NOZZOLIO: Can Hillary add --

SENATOR BOYLE: Oh, I'm sorry. Go ahead.

DR. HILLARY KUNINS: I'm sorry to jump in, but I just want to add to what Dr. Kolodny mentioned, about New York City data.

We know, in New York City, that heroin overdoses began to rise from 2010 to 2011, which predates I-STOP, and predates many of our New York City efforts around promoting more judicious opioid prescribing.

SENATOR NOZZOLIO: On that point, the demographic that the doctor presented, is a demographic that has gone through a prevention-education process for most of their school lives in this state.

The D.A.R.E. program across New York, the antidrug programs, the -- how did there become such a disconnect for that generation, or that age group, that you mentioned, Doctor?

DR. ANDREW KOLODNY: When we talk about opioids, we're talking about painkillers and heroin. And drugs like Vicodin and Percocet are, essentially, heroin pills. The active ingredient in those medications is almost identical to heroin. The effects are indistinguishable.

It doesn't mean we should prescribe them

because they're, essentially, heroin pills, but we should prescribe them cautiously. They're good for end-of-life care or for short-term use.

The young people who are becoming addicted to opioids through use of painkillers are not really aware, I believe, that they are using a drug very similar to heroin. It's not until they're really addicted that they begin to figure out that it's essentially the same thing as heroin.

Many of us may have experimented with drugs when we were young, and many of us may have made a distinction in our mind what a soft drug was, maybe marijuana, and what a hard drug was, and we would are known to stay away from heroin.

The young people who have become addicted, who are now using heroin, when painkillers came along, to them they were a soft drug. They came out of mom's medicine chest. They were prescribed by a doctor. They were not cut with anything. They didn't realize they were playing with fire.

SENATOR NOZZOLIO: It snuck up on them, in effect, an addiction that was never meant to happen, but happened.

DR. ANDREW KOLODNY: Correct.

SENATOR NOZZOLIO: Senator Boyle mentioned

three important components of this Task Force.

And, your thoughts on prevention and treatment, particularly from this panel, would be very helpful.

Mr. Bartlett, did you --

HENRY BARTLETT: Yeah, I -- thank you for the opportunity to be here.

I want to talk about two things, very briefly: One is prevention of overdose, and then second is treatment.

I know that Senator Phil Boyle has been very active in promoting overdose prevention, doing trainings, making sure that folks have access to an overdose-prevention kit, like this [holding up an item].

I was in a meeting on Tuesday, in Washington, where SAMHSA is going to make a lot more of these available, they're trying to make a lot more of these available, to the treatment programs in New York.

And we're going to play an active role in doing training and handing out these kits.

We've already done that in conjunction with the Harm Reduction Coalition and Vocal New York, but, clearly, a lot more needs to be done.

Secondly, I just want to talk a little bit about the evidence-base of treating opioid addiction.

There's a lot that's going on in the name of treating opioid addiction. Some of it's evidence-based, and some of it is not.

And I brought three reports for you folks on the panel, the first of which is the NIH Consensus Statement that was written 14 years ago, which talks about the use of -- I'm sorry, 17 years ago, which talks about the use of addiction medicine as part of a comprehensive approach to treatment, including counseling and wraparound services.

And the NIH consensus panel, all that time ago, concluded that, far and away, the most effective way of dealing with chronic long-term opioid addiction was to use an addiction medicine, along with counseling and wraparound services.

What's interesting is that, in the 17 years since this has been published, really hasn't been any major contradictions to this.

And I want to talk about what I mean when I say "evidence."

I mean peer-reviewed outcome studies, subject to the rigors of academia, published in scholarly

journals.

That ought to be the basis for where we decide to expand our treatment of this epidemic.

And the other two reports that are much more recent, these were published in November of 2013 by SAMHSA, one talks about the efficacy of methadone treatment; the other about the efficacy of buprenorphine treatment.

What's interesting about all of these is that they support one another, and each of these cite multiple previous studies that have been done.

So I want to encourage us to think about, as we move forward with treatment, that if additional resources are made available, and we certainly hope they will be, that the resources are spent in a way that it promotes evidence-based care where we have the highest likelihood of achieving a positive outcome for these newly addicted folks.

SENATOR GOLDEN: If you could expand on that: What type of dollars, and what type of -- where would that money be spent?

HENRY BARTLETT: Well, I think that there are a number of venues where addiction medicines could be provided where they're not being provided now.

One is, for example, is through the

drug-court system. We have a very mixed bag with the drug courts. Many of them are simply not embracing the science and best practices associated with addiction medicine.

I had a drug court judge say to me: Henry, I'm not opposed to the use of methadone or buprenorphine. We just don't want it because we have a philosophy that is drug-free.

And I pointed out to him that "philosophy" was a Greek word that meant the love of wisdom. And I didn't know how you could love wisdom and reject science.

So there are a lot of additional venues where addiction medicines could be used, and are not being used.

Opioid-treatment programs are certainly, you know, embracing it.

The medically-supervised outpatient programs licensed by OASAS, many of them are using it, others are not; residential settings, a number of other outpatient settings.

SENATOR BOYLE: If I can just -- can I ask the other doctors on the panel: Do you concur with that conclusion about, whether it's Suboxone, methadone, for -- along with treatment, is that the

best way of going about doing it?

Or --

DR. ANDREW KOLODNY: So we've got an epidemic of people with the disease of opioid addiction and --

SENATOR BOYLE: Yes.

DR. ANDREW KOLODNY: -- and that's why we're seeing heroin flooding into communities. People need to feed that addiction.

To bring this epidemic under control, obviously, for the people who already have this disease, we have to see that they have access to effective treatment.

For the people with this disease, I think the majority of them will require long-term treatment with a medication.

I believe methadone is less useful for the epidemic that we have today than it was for the epidemic we had in the 1970s, when you had an epidemic that disproportionately affected inner-city communities.

Having people go to a methadone clinic every day made more sense than when you have an epidemic that's disproportionately affecting suburban and rural communities.

I think methadone is very important for a subset of people with this disease who need that structure.

But I do believe that Suboxone is probably our best tool for bringing this epidemic, or buprenorphine, under control.

SENATOR BOYLE: Doctor?

DR. BRADFORD GOFF: Just a little bit to add to my background:

I've been in the addiction-treatment business, really, for 30 years, board certified for 20.

And I'm a chairman of the department of psychiatry, but I've run treatment programs for addiction and substance abuse and outpatient programs, community-based programs, because, at Lutheran, we have a very large clinic system.

And I've also had a private practice.

So, I've seen people at all levels.

And it's really clear that buprenorphine comes out way ahead.

Methadone is very good, used as it's been for many years, and it was groundbreaking in terms of replacement therapy.

Buprenorphine adds something new and

different because it's more available.

It's still expensive, so it's hard to get to the underserved population.

Unless people have Medicaid, they can't get it.

And they often lose their Medicaid, and then they go out of the hospital and they don't get it, and they come right back in the hospital.

And that's something we need to attend to, in addition to the cost of naloxone, which we'll probably speak to, as well.

But, for most people who have become addicted to these substances, and these addictions hold on hard. They grab hold of the brain, they hijack the brain.

These medications which are replacement therapies and reduce the cravings for drugs, and allow people time to make other choices, are critical.

Nothing else has been more effective.

Good treatment programs are good treatment programs, but these medications are a blessing to people. And we need to get them out there more.

SENATOR BOYLE: Thank you.

DR. HILLARY KUNINS: A few words that I'll

add.

Just to give you a sense my background, also:

I'm currently at the City, as you heard.

And I'm also an internist and board certified in addiction-medicine practice, both primary care and addiction medicine for 16 years in The Bronx.

A few thoughts:

I think the City's perspective may be -- we share many of the commonalities that you just heard.

We very much support access to availability of awareness of medicines that treat addiction.

For us, and for -- as I teach and talk about addiction, I think about diabetes.

One would never say to a diabetic: Gee, just really try to lose some weight and exercise. And, if you need insulin, well, that's if it's really bad or if you've failed your other approaches.

That's not the approach that we take I think, in medicine, generally.

We use the tools that are effective and what's available at the right time, with the patient's consent.

And, as Mr. Bartlett said, the evidence surely supports the superiority of medication for the treatment of opioid dependence.

And I think we are lucky that we have effective medicines, and less lucky in the addictions from -- to some other substances.

That said, there is tremendous stigma around these medicines.

And as a public-health practitioner now, one of our most important roles, both at the city and state level, I think is to reduce stigma around addiction, around accessing treatment to addiction, and, in particular, around accessing treatment to medications for addiction.

This is a terrible problem we have in the field, and I think it costs many lives.

The issue of whether buprenorphine or methadone, I think our view at the City may be slightly different.

I think both treatments are effective.

I think methadone comes with certain kinds of restrictions at both the federal and state level that makes it sometimes less appealing to some folks interested in accessing treatment.

But let us just be clear: We shouldn't confuse the medicine with how we prescribe or deliver it.

And I think making both available in as many

settings as we can will help us fight against the problem that we're facing right now, both here and nationally.

SENATOR BOYLE: Thank you very much. I really appreciate that.

Just a couple of follow-up questions.

First of all, if anybody in the audience has any questions, please, you have a card. You can give to it my staff there, and we'll be happy to ask it along the way.

Regarding methadone, for example, now, having toured some of the treatment facilities upstate, seen that, as you say, Doctor, in the urban centers that might be a different story.

But I can think of one I visited upstate, where people were traveling two hours each way, each day, every day. It just didn't seem like the most efficient use of treatment.

And, so, this follows up my question with, the drug VIVITROL, which is now a month -- every month you can get a shot, is that the answer, or are there downsides to that?

Or, uh -- please.

DR. ANDREW KOLODNY: I think for the people with the disease of opioid addiction, there's a

small subset who might be helped by VIVITROL. And that subset might be people who are young, who have not been addicted for very long, and who live in a controlled setting, perhaps with their parents. If they miss their monthly injection, the alarm is going off and the parents are bringing them in.

Because the big risk with VIVITROL is, if the person misses their injection, they're very high risk for an overdose death.

So I think for some people with this disease, it's helpful, but it's a second line below buprenorphine and methadone.

HENRY BARTLETT: We support the use of all three of the medications which are approved by the federal government for the treatment of opioid addiction. Each of them have their own strengths.

And you're absolutely right, Senator Boyle, the regulations requiring folks to come in so frequently to be medicated on site, at least initially, in methadone clinics are kind of Draconian. And I would say that they don't serve the public-health interest as much as maybe they did 20 years ago.

But we really are available -- we're promoting the availability of all three medications.

We did a whole round of trainings for OTP staff (opioid-treatment program staff) in how to use VIVITROL when it's clinically appropriate.

I'd also point out, that unless you get a discount, the cost of the injections is about $1200 a month.

SENATOR BOYLE: Right, right.

HENRY BARTLETT: So it's an expensive alternative, but, you know, we're in favor of as many tools as possible in the tool kit.

SENATOR BOYLE: Thank you.

DR. BRADFORD GOFF: I think one more thing that's worth mentioning is, buprenorphine has been out for a while. It's a good drug, an easy drug to administer; and, yet, of all the drugs that we have, it's got very strange requirements as far as physicians to be authorized to prescribe it, and it has the DEA showing up at your office every once in a while, to check and see if you're keeping a log of the prescriptions.

And we don't do this for any other prescribed -- any other controlled substances, so it's quite strange.

But what it does is, it is quite intimidating to physicians, especially non-addiction-trained or

non-psychiatric physicians, to take this on, which is really the initial intent.

And until that changes, I think we're going to continue to see an underutilization of this drug.

So anybody who can get the word out anywhere, just talking to Andrew about this, and that there is some promise of some change, is going to be very, very helpful.

There's just no reason for any restrictions.

And, certainly, physicians need to be trained better in the prescribing of all controlled substances, all narcotics. They need CME training.

And I would advocate for that thing, at least one hour mandatory, to get relicensed in the state of New York, about buprenorphine and prescription narcotics.

But, I think we'll see more people interested if we just make it a little bit easier to have it accessible, because it's so easy to use. The patients like it, they come back for it. They come back 30 days, and it keeps them off heroin.

SENATOR BOYLE: Right. Okay.

Yeah, well, one of the things we talked about, Suboxone, that we got testimony from a doctor upstate, the only one in his area that -- and it's a

federally regulated, obviously, drug, so it is a certain State issue here, but we can try and lobby our federal colleagues.

But he said he's the only doctor that does Suboxone. That the auditor came in, and the first he did was read him his Miranda rights, to say, "You have the right to remain silent."

And he wasn't being accused of anything. It was just a normal -- this was the interview, which gave him a bad feeling about even doing it.

And that's -- a lot of physicians are going to feel that way. They don't want to be put under a microscope like this. They want to help people, obviously, with addiction.

Not the best system, and something that we are going to advocate to change, I believe.

Senators?

SENATOR NOZZOLIO: Dr. Kunins, I believe it's your testimony, the written submission, that said that there were, to date, over 500 overdose reversals reported in New York City. And you believe that statistic may even be underreported in terms of its quantity.

I'm concerned, in the more rural areas of our state, and including our small cities, where

hospitals aren't accessible as they are in the major cities.

What availability do we have, or should we establish, for the reversal drug of most effectiveness, and how we deploy that?

You have a myriad of sheriffs, officers, State Police, local police departments. It's not one department like there is in New York City, primarily.

The State Police has just yesterday announced how the Division of Criminal Justice Services and the Office of Alcoholism and Prevention in our state is providing kits to State Police officers.

The question is: How much broader can we distribute this with a degree of certainty?

And what type of distribution would you think would make sense?

DR. HILLARY KUNINS: Thank you for the question.

So just to give you a sense of what we've been doing in New York City since late 2008:

As you know, the New York -- New York State has an overdose -- Opioid-Overdose Prevention Law passed in 2006, which allowed for the training of laypeople to recognize overdose and administer

naloxone, the medicine you're talking about.

In New York City, starting in late 2008, we began to fund and distribute intranasal form of the medicine, which is, I believe, what's being used with law enforcement, to train community members, either who themselves were drug users, and, therefore, at higher risk for either observing or experiencing an overdose; and, to their social networks, to their friends and family.

And we have -- in that 500, at a minimum, is really from that -- by and large, that work since 2009, distributing through community-member work.

We believe that distributing through community networks provides, widely, an incredible opportunity to prevent overdose fatalities; that is, to intervene by someone who is close to the person or who is a first responder.

And we think that that gives, obviously, the person who may be experiencing an overdose another chance of reducing their risk; getting healthy in the future.

I don't -- we don't see much downside to the distribution.

It sounds like that's what your question was based on.

It's a safe medicine. It has some mild adverse effects that are temporary, not longstanding.

From the --

SENATOR NOZZOLIO: What does it -- pardon me.

What does --

DR. HILLARY KUNINS: People wake up in a -- can wake up in a start, and can feel uncomfortable in the moment, but it passes really quickly.

SENATOR NOZZOLIO: Is there any special expertise necessary to administer?

DR. HILLARY KUNINS: So we liken it to other first-aid strategies, EpiPens, and so forth, that -- think about defibrillators that are widely available in airports, and so forth.

So it is at that level of administration: easy to recognize, easy to administer.

If you don't have an opioid in your body, it doesn't have any ill effects. So if you get it wrong, in other words, it won't cause harm.

We also -- another concern that gets raised, is does it promote riskier drug use?

We have no evidence to suggest that that's true.

SENATOR NOZZOLIO: That was one of my

questions.

DR. HILLARY KUNINS: And then, finally, you referred to access to hospitals.

So, obviously, in New York City, with the density of hospital and health-care facilities, that's not been a huge issue for us; though, part of the training is to encourage laypeople, and, certainly, with first responders to call 911 to get the person in for further monitoring and assessment.

SENATOR NOZZOLIO: Thank you.

SENATOR BOYLE: Doctor, if could I just follow up with that:

One of the things -- I'm a former EMT. I've seen Narcan used like a miracle drug, but those with much more experience than I and others say that, sometimes, the patient who gets Narcan will wake up swinging and agitated.

I mean, is there a way to -- for a senior citizen, for example, to administer the Narcan nasally and just step away, or go into the next room? Is that a strategy?

DR. HILLARY KUNINS: So, certainly, that's part -- as part of the training is to make people aware of that possibility.

In our experience, now monitoring this

program for -- since 2009, we've not heard of sort of adverse effects from the people administering it ever, people getting -- I don't know, getting hit, falling down, or something like that.

So, that's not been part of our New York City experience at all.

SENATOR BOYLE: Great.

SENATOR NOZZOLIO: And, excuse me, Mr. Chairman.

Administering this drug does not, in your opinion, require any additional expertise than any normal EMT would have in terms of training, in any event? Is that fair to say?

DR. HILLARY KUNINS: No.

And, again, I encourage you to think of it as a first-aid procedure. Think about how widely we've been able to train laypeople in a variety of first-aid strategies: Splinting, CPR. Again, defibrillation that's available widely.

I think it's really at that -- in that kind of domain of procedures.

SENATOR NOZZOLIO: Certainly, it's a first step in our -- one of our segments which is treatment.

DR. HILLARY KUNINS: Yes.

SENATOR NOZZOLIO: It's -- we want to make sure that the person survives this ordeal.

Doctor, from Phoenix House perspective, prevention, particularly for this age group seeming to fall into addiction with -- in very unchartered ways, what would you prescribe we could do as a state to focus on prevention measures?

DR. ANDREW KOLODNY: So I appreciate that question.

All of you should have a graph.

And I think to understand really how to deal with this mess, it's important to understand how we got here.

And, this is the -- a CDC slide.

This graph is the CDC's chief speaking point about the epidemic that we're dealing with nationally, and I'll explain what we are looking at.

The green line represents opioid consumption in the United States.

And what you see is that, beginning in the late 1990s, prescribing of opioids began to take off.

The red line represents overdose deaths from painkillers, specifically.

And the blue line represents addiction to

opioids, represented by people coming in for treatment.

What the CDC is saying is, that this epidemic was really caused by the medical community; that as doctors began to overprescribe these medications, especially for conditions where they're probably not safe or effective, like long-term chronic pain, like low-back pain, that as the prescribing took off, it's led to paralleled increases in addiction and overdose deaths.

What the medical community and the dental community has inadvertently done, in many cases, we've gotten our own patients addicted, or, we've wound up stocking our patients' medicine chests with a hazard for their kids.

So, to bring this epidemic under control, we need, obviously, to treat people who have this disease, but we have to prevent people from getting the disease in the first place.

And I think the most important way to prevent people from getting this disease, and there are many different things that need to be done, but the most important thing is to get the medical community and the dental community to prescribe more cautiously.

SENATOR NOZZOLIO: That gets to the supply.

How about the demand?

How can we engage in enhancing prevention at the outset, by some type of encouraging certain types of behavior?

And I think that's -- certainly, you've got the medicine chest, anybody can open it.

DR. ANDREW KOLODNY: Yes.

SENATOR NOZZOLIO: You've got the pills in there, anybody can take them.

But, how do you prevent them from taking them in the first place?

DR. ANDREW KOLODNY: Well, I think the message that the medical community and the dental community needs to hear is very similar to the message that the public needs to hear, which is that these pills are, essentially, heroin pills.

If young people understood, when they're experimenting with drugs, that there -- that they're -- that this is not a soft drug; that this is a hard drug that could kill them, that can alter the rest of their life through addiction, if they understood that, they might be less likely to experiment with painkillers.

But, again, I think the real answer boils down to not exposing such a large percentage of our

population to a highly addictive drug. And that's where prescribers come into play.

SENATOR NOZZOLIO: That's an excellent point. Thank you.

Doctor.

DR. BRADFORD GOFF: I want to add, too, that, I-STOP, which I think, tremendous legislation, and has had great effects on beginning to reverse diversion, has had other ramifications.

At my hospital, I was -- became responsible for really training physicians in I-STOP, and getting up before hundreds of people in medical staff meetings and beginning to talk to them. And they were not happy at having to take this on at all.

And most understood it, of course, to being, It's something I have to do before I send the patient out the door with the usual prescription of a narcotic, or whatever I'm prescribing; rather than thinking of it as something that I'm going to look at when the patient comes in the door, or when I accept the patient for the first time, or I may do on all of my patients, because it, number one, tells me about what medications they're using, what they're prescribing, and compliance habits are,

where they go to their pharmacies, what doctors they see.

Is that consistent with what they're telling me?

So I've trained, certainly, my doctors that I'm responsible for, to get this at the front end.

And the response is really very impressive. People really think this is a good system. They've learned a lot.

They actually talk to their patients.

And a lot of patients wander into this not knowing that accumulation of these drugs that they really don't understand, because doctors haven't really educated them well about it, really do have adverse effects and build up, and you get caught in something you don't want to get caught in, or you get sick, or you're at risk, or your children are at risk.

Once they find that out, they make changes.

So doctors I think become more respectful with a program like I-STOP.

The patients have become more respectful, in understanding what the -- why it's important to pay attention to narcotics, and why we need all of these, not only for what goes on on the street.

And everybody favors that among patients I've seen who are not addicts, is this is a good idea: We need to protect people, but, also, I need to be aware myself.

So it's -- I'm not sure people talk about I-STOP in terms of a good learning and clinical intervention, but that's what I've found.

SENATOR GOLDEN: Doctor, are you still seeing at the -- in Lutheran Medical, is Oxycontin and -- are the pill forms of the opiates still the largest number of visits --

DR. BRADFORD GOFF: It's the -- partly, it's the demographic. I think -- and, partly, where you are in Brooklyn.

Of course, there's Sunset Park, Bay Ridge, and so forth, and we know lots of deaths are occurring in that whole area, and have been occurring. There's always been a lot of heroin in our parts of Brooklyn.

And the pills have been there, too. They've been prescribed, not so much in our area of Brooklyn, but Staten Island is just across the bridge, and that's like an epicenter of prescribing of narcotics.

And then, in Suffolk County, not too far

away, as well, in terms of the map.

So it gets in and makes its way in.

I think there's tending to be less, but it's hard to tell. It's hard to yet tell whether it's affecting heroin use. It's still there.

I get very concerned, as everybody else would, with new medications like Zohydro, which is, you know, what are they thinking to approve yet another drug with no deterrents in it?

We're putting another Oxycontin out on the streets, potentially. We shouldn't be doing things like that.

So, as long as it's available, it's going to be there.

And just learning from the gentleman that will speaking about the effectiveness of diversion tactics, and are at work in the state of New York, and how there's still huge diversion of substances going on. It's still there, it's still dangerous, it's still the whole --

SENATOR GOLDEN: What's your capacity right now?

Your capacity, obviously, has increased over the last few years now, especially in the last two years.

What's your capacity today?

And what do you see happening --

DR. BRADFORD GOFF: I think our ER is just like the statistics. I mean, we've seen that, you know, threefold increase in people coming in with heroin overdoses over the last 10 years, and it still continues.

I mean, so the visits continue. That's not counting the people who die, of course.

And we know, from going to town-hall meetings, and so forth, in Brooklyn, more and more kids, more and more young adults.

In terms of availability of naloxone, I think it's great to put it in the hands of the first responders who are policemen and EMTs, but I think the real first responders are family members and friends, and even, sometimes, the victims themselves.

And I hope someday we're even talking about having, like an EpiPen for allergic reactions, that parents of adolescents and young adults actually have a naloxone pen in their home as a part of their emergency preparedness kit, because disasters do happen.

And in this day and age, maybe everybody

should have them, because you just don't know what your kid may get into.

SENATOR GOLDEN: Thank the young people that are in the crowd.

There were a number of young people in and out of this room, and I want to thank them for coming to this today.

Last question for me on this issue: Marijuana.

Does anybody believe that marijuana is not a gateway drug, amongst our professionals here?

DR. ANDREW KOLODNY: I don't think anybody knows whether or not it is a gateway drug.

We do -- you know, it's an interesting question related to today's topic, because when we look at the populations that are most affected by the epidemic today, we're talking about people from suburbs who are White and middle-class.

In areas, like Sunset Park, which were hit with a heroin epidemic in the 1970s, or in New York City's inner-city communities which are mostly African-American or Latino, in many of those communities, what we've seen since the late 1970s has been a decline in heroin use, and since the '90s, a decline in crack-cocaine use, but very heavy

marijuana use.

And when we look at the populations now that are dying of heroin overdoses, it's mostly White people.

So what we haven't seen, despite very heavy marijuana use in some of those populations, we really haven't seen heroin or crack coming back into those communities, which would be evidence to suggest that perhaps it's not a gateway drug.

It's a very complicated question.

There are very good reasons to be concerned about marijuana, especially legalization, but whether or not it's a gateway drug is -- I don't think we know.

SENATOR NOZZOLIO: 20 years ago, would you say that Oxycontin was a gateway drug?

DR. ANDREW KOLODNY: I wouldn't call Oxycontin a gateway drug because Oxycontin, oxycodone, is, basically, the same drug as heroin. It's basically -- it's essentially the same.

SENATOR NOZZOLIO: I have a question that I'd like to pursue with you, Doctor, regarding the pharmaceutical companies' potential willingness to engage in an education program.

Again, from your threshold statement, the

heroin addiction is a direct result of this use, I know they're in a dilemma.

But I wonder what your experience has been with the manufacturers of those products.

DR. ANDREW KOLODNY: So that's a terrific question, and I appreciate it.

I'm going to refer to this graph again.

Now, suppose you're the manufacturer of a product, where, as sales of your product are increasing, you're making enormous profits. It's associated with these horrible adverse outcomes, like addiction and overdose deaths. You're not going to be happy about that. Even if you don't have a conscience, it's not good PR for your company, but at the same time, you don't want to see your sales go down.

What the pharmaceutical companies are saying right now, in the context of an epidemic caused by too much prescribing of opioids, what they're saying is that: This green line can and should continue to go up because millions of people have chronic pain. But, if we teach doctors what they call "safe and effective opioid prescribing for chronic pain," we can make the red line and blue line go down.

And that's not really true.

I think, in many ways, the content of the education, the dominant education for physicians right now, they're being taught that if you monitor your patient very closely -- if you check their urine, if you check I-STOP -- all prudent things to do if you have patients on these treatments.

But what they're saying is, by doing these things, you can turn this into something that's safe and effective, that turns out rosy in the end.

And it doesn't work.

For example, if you start your patient with low-back pain on long-term opioids, and you're checking -- so they say, Well, check I-STOP.

So you check I-STOP and you see, four months into this, the young woman starts to visit multiple doctors, what that information is telling you is that the patient is now addicted.

The doctor can say, "Well, I guess I can't prescribe for you anymore," but the patient is left holding the bag. The patient now has that disease, and if they can't get a doctor to prescribe painkillers, they'll seek heroin.

So, the education for the medical community should be, and it's the message the CDC is trying to deliver, the message should be these are good

medicines for end-of-life care. They're good medicines when you use them on a short-term basis for severe acute pain; surgery, a severe accident. But we should not be putting patients on long-term opioids for common chronic problems.

And, unfortunately, the pharmaceutical industry does not like that message.

SENATOR CARLUCCI: Can I follow up with that, on a question?

When we talk about prescriptions, is there a move, or is there something that we can do, to really regulate that; that prescribers can only do it in limited dosage, or, that refills have to be done in person?

What would you say to that?

DR. ANDREW KOLODNY: That's a terrific question.

And I think one of the reasons we have this crisis today was really a failure of regulation; the federal government's part of failure to regulate the companies that were making these products.

Had they regulated those companies appropriately, had they applied the Food, Drug, and Cosmetic Act, and prevented them from promoting these medicines for conditions where they're

probably not safe or effective, we might have prevented this problem.

On the state level, and this is happening across the country, the state agencies that are supposed to protect the public from doctors who are prescribing recklessly are state medical boards. And across the country they have really failed to do that.

What should be happening, is that state medical boards should be proactively using the same data that's in I-STOP to notify doctors who are prescribing these medications in high doses, or in combination with drugs like Xanax, that "We're concerned about this. Don't do it."

And if they see that it continues, to, potentially, investigate them, to have medical boards possibly take licenses away from doctors before they kill patients, or before we have to put them in jail.

And we're not seeing that happen.

I think there is quite a bit that we could be doing here.

And, you know, at the beginning Chairman Boyle said that this would be an opportunity to suggest potential legislation.

I think one thing we could be doing right now, would be to say to doctors that have lots of patients on long-term opioids for chronic pain, perhaps doctors who have 10 or more patients on this treatment, where the data would tell you if you've got 10 patients on this treatment, that maybe 3 of them are addicted, we could be mandating doctors who have multiple patients on long-term opioids to be trained in prescribing buprenorphine.

We would be expanding access to this treatment exactly where we need it, where you've got the patients who are addicted.

And what's nice about that, is when a doctor finds out on I-STOP that the patient is doctor shopping, instead of firing the patient and saying "You're an addict, get out of my office," they would have the ability to treat that condition.

I believe a bill like that may have been introduced by Senator Maziarz last year.

I think MSSNY didn't like it because it mandated doctors who have with multiple patients on this treatment to do something. And MSSNY doesn't like when you mandate doctors to do anything.

SENATOR CARLUCCI: Well, Doctor, what's shocking to me, and I'm sure many of the members of

this panel, is we've traveled around the state and we've heard from people that are suffering with this. And we hear about, just recently, doctors prescribing an initial dosage of 75 bills.

Why is that continuing to happen when we have these highly educated professionals, you know, having the same data we have?

What's the disconnect there?

DR. ANDREW KOLODNY: Yeah, the problem is that the prescribers don't recognize that these are, essentially, heroin pills.

If the dentist understood that a Vicodin was a heroin pill, I don't think they'd give a teenager 40 pills after a wisdom-teeth procedure. They might give them one or two. Or maybe they'd give them Advil.

The prescribers are underestimating the risks of these medications, in part, because they've been badly misinformed.

The reason the prescribing took off, the prescribing that caused this crisis, was because of a campaign to encourage aggressive prescribing, and that campaign had quite a bit of misinformation in it.

SENATOR NOZZOLIO: And there has to be some

responsibility here on the patient, too. The patient may not understand what they're getting.

I know that's a doctor's responsibility, but, think of yourself in a doctor's office here. He writes a scrip, she writes a scrip, and the patient goes on their merry way, not understanding the complexities of this medicine.

Not being educated by the doctor, I think that's the threshold, but doctors have limitations, too.

Educating patients may be another component of this.

Any of your -- the panel's thoughts?

DR. HILLARY KUNINS: I agree.

I just want to also reiterate a few things that Dr. Kolodny said.

I do think we need to raise awareness about risks of --

SENATOR NOZZOLIO: With patients --

DR. HILLARY KUNINS: -- of prescription opioids with patients.

As an example, in New York City, we ran a PSA, highlighting risks to a mom who lives in Staten Island, who perhaps we'll see tomorrow.

And that, again, following on the intense

marketing of these medicines as really being able to treat much more than they are claimed to treat, and underestimating the risks.

So, reeducating the public.

In addition, I want to just really reiterate what Dr. Kolodny said, is it is easier to write a prescription for Oxycontin right now than it is for buprenorphine.

And that imbalance of regulation is perhaps something that the state or federal government might be able to address.

In New York City, we've issued guidelines around what we call "judicious prescribing," to promote the kind of practice patterns that Dr. Kolodny is referring to.

For acute pain, 3-day supply of prescriptions is often enough, so the 75 pills is really, typically, not needed.

Reducing the -- or increasing awareness that long-term use of chronic opioids typically does not result in better function or in pain control, on average.

And, finally, these medicines are excellent for treatment of end-of-life pain. We do not want to see that reduced or access to that very important

treatment.

But I think raising awareness of doctors, other prescribers, who really, again, underestimate the risks; believe that they can pick out the patient for whom the opioid will be safe, is simply not true.

We overestimate our effectiveness in that area, and doctors need to be engaged.

And we in New York City have been engaging prescribers.

And the State, we would welcome State participation in that, as well.

SENATOR GOLDEN: When these kids are taking -- the doctor gives the Vicodin or the Oxycontin, the kids don't know they're taking heroin.

DR. ANDREW KOLODNY: Correct.

SENATOR GOLDEN: All right, so we're talking about doctor-patient education there.

We need to be able to educate the kids that are in our schools.

You guys all remember D.A.R.E.

Did this work when we seen that here, when those types of operations in our educational system, when we went into the schools?

Did you see a drop-off in the -- or not?

You know, be honest with us, did you see a drop-off in use of narcotics when you had these programs in our schools?

DR. ANDREW KOLODNY: Well, I don't recall D.A.R.E. focusing on painkillers. It may have focused on heroin.

And what we're all recognizing is that, the young people who are experimenting with painkillers and ultimately winding up addicted, and then maybe turning to heroin, when they're using those painkillers, they didn't recognize that they were using a drug similar to heroin.

It's -- there are, in terms of the evidence that's out there supporting social-marketing campaigns to prevent drug use, many of the campaigns that have been tried over the years haven't worked well.

For example, "Just Say No," which was Nancy Reagan's campaign, where the focus there was on modeling "Say No" behavior.

But there are effective social-marketing campaigns that can prevent people from picking up a drug in the first place.

It's very difficult, once they're already

using, to get them to stop through social marketing.

But, the effective campaigns are the ones that dramatize the negative consequences of use.

For example, the ad that New York City ran, I thought was a very good ad, which showed somebody using painkillers and dying of an overdose.

SENATOR GOLDEN: What about the educational system in our schools, you don't believe that we should go into our schools at the early grades of third -- three -- in the third grade, fifth grade -- fourth grade, fifth grade, sixth grade, and be teaching and laying this out?

DR. ANDREW KOLODNY: I think that would be a very important thing to do.

SENATOR GOLDEN: So a D.A.R.E. program, something similar to a program -- not D.A.R.E., but something similar to a D.A.R.E. would work?

DR. HILLARY KUNINS: So my awareness of the -- I just want to summarize a few points about the science behind those programs.

The D.A.R.E. program has been studied, and actually not shown to be terrifically effective, unfortunately, in reducing drug-taking behavior.

Now, again, it did not focus on prescription opioids. It predates that.

The science behind those programs are typically best when the programs focus broadly on social connectedness, family support, all the things that we know work to protect young people from risk.

So those programs ought to be, in my view, broad-based focus on integration into communities and families, and around all kinds of risk-taking behaviors.

So to -- it is important to raise awareness about this specifically with school children, but, there are educators and -- who are well-informed about these strategies. And we should look to the science.

Again, not the medical evidence, but the educational evidence, to formulate those programs thoughtfully.

SENATOR GOLDEN: What are our public schools doing?

DR. HILLARY KUNINS: So I would defer to my colleagues from the City DOE.

There are -- there is health education happening in all the schools, and, there is a standard curriculum.

SENATOR GOLDEN: Thank you.

SENATOR BOYLE: I think we're going to have

to wrap up this panel.

I appreciate your time very much.

Any final words or thoughts that you wanted to say and didn't get a chance on our question?

DR. ANDREW KOLODNY: Just something to encourage you to work on, as you're going around the state.

And, I'd also like to just thank you very much for trying to really understand this problem and how to address it.

I think we have to recognize that the populations that are most affected right now are very different from the populations previously affected by addiction.

The crack-cocaine epidemic of the '80s and '90s disproportionally affected people who are low income and minority, and had Medicaid. Similarly, in the '70s.

The people affected most today are people who are working-class and middle-class who have commercial insurance.

And our whole system right now, our addiction-treatment system, is very much focused on serving Medicaid populations.

I think it's very important for you to sit

down with some of the commercial insurers, to make sure that we're funding the right treatment programs; that we've got the right models out there.

SENATOR BOYLE: We are doing that.

And I can tell you that insurance is going to be a big part of this legislative package, and the question of what medically necessity -- the "medical necessity" is.

We're dealing with, not only health-care professionals, but also insurers, as well, to see if we can get an agreement by most.

And I will point out, I'm sorry, we've been joined, obviously, by Senator Carlucci, who, along with Senator Nozzolio, is the Vice Chair of the Task Force.

Thank you, gentlemen.

That is a big issue.

Thank you very much.

HENRY BARTLETT: I just wanted to point out, briefly, talking about "medical necessity," that, frequently, where a patient winds up in treatment depends on what door they happen to enter.

And, you know, we've heard people say for years that there's no wrong door to treatment.

I think there's a lot wrong doors to

treatment, and some people end up in a level of care that's inappropriate for them.

OASAS is working now on a patient-placement instrument and protocol called "Locator 3."

And, you know, Locator 3 is going to be used as part of Medicaid managed care.

The managed-care companies are going to be required to use this to determine the appropriate level of care, and to use it for utilization review.

Well, I say, if it's good enough for the poorest people among us on Medicaid, it ought to be good enough for those of us who have health insurance.

And it would be good for the health-insurance companies to use some version of Locator 3, or a similar evidence-based instrument, that places patients at the appropriate level of care to begin with, so we don't wind up with opiate-addicted individuals being seen in a level of care where they have a less-than-optimal chance of achieving recovery.

SENATOR BOYLE: Wonderful.

Any questions from the audience for our panel?

I didn't see any written.

Oh, yes.

LIZ BARARDI [ph.]: Hi. My name is Liz Barardi [ph.], and I'm here both representing my son Carter, who you described completely. He passed away January 12th of an overdose of heroin.

He had back surgery and was prescribed fentanyl patch, after I told the doctor he had a predisposition to addiction.

And it was two months before I understood what was in that patch.

And, he was denied twice by MVP, Value Options, inpatient treatment that three Columbia doctors insisted he needed.

I got him that help, but, he ultimately died three days into a sober home.

And I'd like to ask, I know it's an extension of what you're talking about, but, it is an industry that is out of control.

There's no oversight.

It's a step down for many people.

And it's actually, for many people, the only place they can go to get away from their triggers, and to have their addiction addressed on an outpatient level.

And I'm just wondering, is anybody -- it's a

lifelong disease.

Is anybody considering regulations of sober and recovery homes? Standards that people can rely on in a database?

SENATOR BOYLE: Yes. We actually just passed legislation like that in the Senate -- on the Senate committee, recently, on regulation of sober homes.

It has been a longtime problem.

I know Senator Zeldin from Long Island has a bill on that, and it's something that we can -- we should try and address.

The problem as, as I'm sure you've heard, the state agencies are pointing at the town, who's going to regulate it.

No, it has no treatment per se in some of these sober homes.

What I experienced in the district I represent, is we had people buying houses, taking in 30, 35 people with addiction problems, taking their social-services money and paying off the mortgage in two or three years, and then selling the house and kicking everyone out.

They ran it just to make the money. They were not there to help the people.

LIZ BARARDI [ph.]: The stories I've heard,

now that we've started safe sober living, from across this country, but, I'll talk about New York today:

One mother, they wouldn't take her son out of detox because he was on Suboxone. They gave her a list of other homes. And, the manager was drunk when she arrived to visit it.

A young woman told me that the manager was sexually harassing her.

My son's case, the manager had no car. He used my son as his taxi driver, and to visit his friends, and so forth.

And the -- I'm not sure if he's a co-owner or he's the head of it, I found out was arrested in 2009 for selling-- while on probation for another crime, for selling heroin, Suboxone, and other opiates from his own driveway.

And while still on probation, in 2011, this man was managing sober homes.

I mean, we have a problem.

SENATOR BOYLE: No question.

Well, we're very sorry for your loss.

Thank you for coming today.

LIZ BARARDI [ph.]: Well, yes, but, thank you.

And I hope that, really, all these agencies can come together.

And you are an amazing panel.

So, I'm grateful to be here today and hear you.

SENATOR BOYLE: Thank you.

In the back?

MATT CURTIS: I'm Matt Curtis. I'm the policy director at Vocal New York. We're a grassroots advocacy group that does work on behalf of people affected by drug use, HIV, and massive incarceration.

First, a quick "thank you" to all the Senators here today, who all of you voted in favor of a bill that, hopefully, will become law very soon, that Senator Hannon sponsored, to allow much greater community access to naloxone.

I think it's through standing-order prescribing. I think it's a pathway that we've seen work in other states, that will be hugely beneficial for the Phoenix Houses of the world, and other things like that, making this important medication more available.

Now a question, real quick:

One thing that hasn't been discussed here,

but I think really needs to be considered as part of the public-health response to this, is syringe access.

And, you know, we've had 20-plus years of legal syringe access in New York State. We allow sales through pharmacies.

And, you know, what we've seen is, not only has that been incredibly effective at reducing HIV transmission, reducing hep C transmission, it's been a pathway for people to get into drug treatment, into primary medical care, into other kinds of things they need. And, has reached people that wouldn't otherwise get access to those services.

So, you know, it's become part of the mainstream continuum of care when you're dealing with opioid or other drug dependency.

So the problem is, we're now, with this new rise in heroin use around the state, we're starting to see, for example, through hepatitis C incident surveillance, new pockets of infections among people around the state.

And, we've got major gaps in access in parts of Brooklyn, in Queens, in the city, and, certainly, in Long Island and most of upstate, where there are

very few providers.

So I just kind of want to see if the panel or anyone here has any thoughts about including that in the, kind of, package of things that this Task Force will come up with in the future?

DR. HILLARY KUNINS: Thanks, Matt.

So that -- I would like to just state our City support, also, for the need for syringe access as part of the continuum of care.

As you know, we at the City have oversight, and fund, participate in the funding, of the syringe access programs in New York City.

And, that is an area that is very important in engaging folks who may not come into other kinds of care.

The syringe-access programs do a lot of community outreach, and are real experts in helping people seek whatever services they are ready for at the time: distributing naloxone, encouraging people to get tested for hepatitis C, engage in other risk-reduction behaviors.

SENATOR BOYLE: Needle exchange: yes? no?

DR. ANDREW KOLODNY: Yes, but I will say the equation was easier when we had an HIV epidemic and when the heroin wasn't as good; and, so, just about

everybody was -- most people were injection-users, and we realized that giving out clean needles wasn't going to turn people into heroin addicts.

It's more -- it is a little more complicated today.

When the majority of people are beginning this addiction with pills, crushing pills, and when they're snorting heroin, there is a fair question about whether easier access to needles could encourage a transition from intranasal use to injection use.

I do however think, overall, they're a very good thing, and they're an opportunity to engage with users, and to test them for hepatitis C.

I don't know that we've got evidence -- I would ask Matt -- that syringe exchange is working all that well on reducing hepatitis C.

It's worked very well with reducing HIV infections, but the virus is different. It's much easier to get hep C. Even if you're not sharing needles, you're just sharing works.

SENATOR BOYLE: Just a quick question before we -- I think we have a debate here:

But, is there any evidence of -- are you more likely to overdose with a needle versus snorting it?

DR. ANDREW KOLODNY: Yes.

SENATOR BOYLE: You are?

DR. ANDREW KOLODNY: You are.

SENATOR BOYLE: Okay.

DR. HILLARY KUNINS: So just -- I think Andrew raises some excellent points.

One thing I just want to add, so as to not leave you with this place, is:

My clinical experience from the '90s, in The Bronx, is that many, many people came into methadone treatment having never injected.

And this was actually, I think, in many ways, a great success story of the syringe-exchange programs and harm reduction, generally; which is, they were the key awareness-raisers about risks of injection.

And that was a great success story, that not more of my patients had HIV, and had, in fact, never injected.

And we, obviously, should take from those lesson, aggressively, as we're encountering this new epidemic.

SENATOR BOYLE: Thank you.

DR. HILLARY KUNINS: And we need to work on hep C education, and thinking about risk reduction.

Matt may have more.

SENATOR BOYLE: Thank you very much.

One last question for the panel, please?

The gentleman in the back.

JEREMY THOATE [ph.]: Hi. My name is Jeremy Thoate [ph.] -- sorry.

My name is Jeremy Thoate. I'm actually an educator from Long Island, from suburbia.

And just a couple of points I think you should hear.

Number one: Kids in suburbia, and everywhere, they know that drugs work; they work for the purpose that they take them.

And more and more kids in suburbia, I can say, are taking them to dull the pain; whether it's the stress they have in their lives, whether it's the issues with family, whether it's, you know, all different things that are going on in society.

So -- so, uh, you know, those things are very important.

So to piggyback on the point before: More needs to be done in the educational system. Nothing even close to enough is being done.

And the D.A.R.E. programs are not being -- have not, and are not, effective.

And would I just urge this panel to consider putting more money into community coalitions that are popping up all throughout the state.

They are -- they give us the ability, locally, to work together in our communities, with the specific community issues that are going on in each specific community.

And that may be a very good way to get the attention of that community.

[Microphone not working.] Parents aren't educated, and they don't have the skills anymore to deal with this.

SENATOR BOYLE: Thank you very much.

And I do believe that our Task Force recommendations will be more of a holistic approach in that way.

Panel, thank you very much. We truly appreciate you taking your time.

And the next panel will be regarding law-enforcement issues and community involvement:

Bill McGoldrick;

Linda Sarsour;

Rabbi Feuerman;

A representative of the District Attorney's Office here in New York City, and an undercover

investigator.

[Pause in the proceeding.]

[The proceeding resumed, as follows:]

SENATOR GOLDEN: We're going to start.

Again, I'm going to point -- I'm going -- a lot of young people in the room, again, I want to point out. Thank you very much for being here and being part of this.

I just want to ask, and don't be embarrassed by it, but -- because a lot of people -- professionals don't -- aren't aware of it:

Anybody here recognize that Vicodin was heroin?

Anybody here did not recognize Vicodin was heroin when they were growing up?

Right?

How many? Be honest, be honest. Come on, let's go.

Right?

So when did you -- well, we're going to ask some questions later.

When did you figure out Vicodin was heroin?

Okay?

Linda, I'd like to, real quick, what's going on in your community?

And if you can, please, just briefly tell me what happened last week.

LINDA SARSOUR: So, thank you, my State Senator, Marty Golden, for having me here.

So last -- well, up -- starting, probably, for the past, about, 15 months, we've already had about 9 young men in our community, between ages 17 and 23, up to the last one last week, a young man who died of overdose. All these young men died from overdose.

About three months ago, we had two young men, one passed away.

One was at Lutheran for quite a while, originally from Morocco. He's out now, and potentially -- trying to help groom, potentially, having him be some sort of spokesperson as someone who, pretty much, went to death, and back.

And we support this initiative and this Task Force, and the impact that it has, really, on community, not just on the people who are kind of on the path to addiction or already there.

And what we support, also, is a three-pronged approach, which includes the enforcement piece, includes the educational piece, and it also includes an alternative -- alternative programs and

opportunities.

What we hope to see, also, is that, you know, in a place like Bay Ridge, and with this particular population, we want to see, you know, multicultural and bilingual assistance. And I'm sure that's something that would be helpful to other communities, as well, especially looking at the new populations of folks that are being affected --

SENATOR GOLDEN: Is this community the Arab-American community?

LINDA SARSOUR: Yes.

SENATOR GOLDEN: Are very new in the past year or so, you'd say that --

LINDA SARSOUR: I would say two years now --

SENATOR GOLDEN: Two years.

LINDA SARSOUR: -- that we've been at least hearing about it.

And I think the issue around it is that, you know, these are -- like you said before, and others on the panel have said, this is not about, you know, these, like, low-income, you know, kids from the streets. These are from good families. You know, hard-working families. And their parents have no idea. They don't have bad parents. Their parents don't know what the signs are, to understand --

SENATOR GOLDEN: I'm going to go to the Rabbi now.

Rabbi, are you similar?

Up in your communities and around the course of the city, what are you seeing, Rabbi?

RABBI SIMCHA FEUERMAN: I think that we're seeing plenty of prevalence.

We have, at OHEL Children's Home and Family Services, of which I'm director of operations, we receive foster-care placement from mothers that test positive, you know, at birth from drug abuse.

At our outpatient centers, we have individuals coming in for treatment.

I think that there are two points, I would say, that are important:

I think, one, is I actually am also president of an organization, Orthodox Mental-Health Professionals. And I sent out an e-mail to the listserv, asking for people's experience, and polling them.

And one of the common things that we found is, I think that abuse starts oftentimes in youth, through experimentation, through very innocent experimentation, because these are not found on seedy street corners. These are found in the family

medicine chest.

So, clearly, early intervention, and culturally-sensitive intervention, is extremely important.

You know, in a parallel fashion, our organization has done a lot of work in the last 10 years in terms of sexual abuse in the Orthodox community.

And it's a very similar idea, that if you want to help educate a community, an insular community, you really need to understand their underlying beliefs, their assumptions, how they see themselves, and talk to them in a way that they'll get the message; because, otherwise, you know, you provide general education, but they don't think it applies to them, or in some way, it doesn't apply to them, the way it's being said.

So we do feel that early intervention and education is very key, and that it should be culturally sensitive.

SENATOR GOLDEN: Thank you very much.

I want to go over to Mr. McGoldrick.

The -- looking at what we're hearing between the communities across Brooklyn and across the city of New York, across the state of New York,

unfortunately, I get killed in my own community when I say this, but it's true, Brooklyn is the capital of Medicaid fraud, Medicare fraud, welfare fraud, insurance -- car-insurance fraud.

And, we're moving into, number one, into two other areas, and that's drug diversion, and it seems to be heroin death and overdosing death.

Since we have concentrated areas, we know that we are the capital of -- in the nation on a number of these different issues.

Isn't there a way of coming in here and going and looking at these points across the state, putting our efforts into overlays -- technology overlays, and understanding, not just where these frauds are going, but, specifically in the drug diversion, and specifically in the pain doctors, and specifically in the doctors that are selling or are moving these prescription, and the pharmacies that are selling these?

Can you help me out on that one?

WILLIAM McGOLDRICK: Yes.

Thank you, Senator Boyle, and Senators Nozzolio and Golden, for the opportunity to speak to you today.

I'm an attorney with 32 years' experience in

New York State, but I'm also a retired detective sergeant from the New York State Police.

For the last 20 years, I've been providing Medicaid-fraud investigative and audit services to the United States Health and Human Services, Center for Medicaid and Medicare Services, New York State Department of Social Services, New York State Department of Health, New York State Department -- or, New York State Office of Medicaid Inspector General, and New York City HRA.

I'm accompanied here today by a confidential consultant who is a retired NYPD narcotics detective, who has worked with me throughout those 20 years in a very specific area.

We will refer to him as "The Detective."

He is an expert in drug diversion. Our efforts have been focused in that area for the state of New York.

The doctors who spoke this morning very well established the proposition that pills and heroin are hand-in-hand.

The supply of pills that comes into the problem, that creates the problem, comes from the medicine cabinet, which education and awareness is a key.

The Detective, actually, this morning, over coffee, said: Why don't the Senators talk about having a piece of paper handed to people, with the prescription, and say, "Don't keep this in your medicine cabinet."

You know, think Eddie Haskell coming to visit your house and asking to use the bathroom. When he knows the pills are worth $40 apiece, what's he going do? You know, he's going to visit everybody's bathroom.

So as The Detective was saying, that's a very quick fix, maybe. A little piece of paper, "Find a secure place to put this."

That's number one.

Number two, for years, I've been trying to get a straight answer on why we can't get a better disposal method.

You know, in the old days they used to flush it. It's dangerous stuff, but it's dangerous for the environment.

Now people don't know where recovery centers are. And people are not going to get on -- in their car or in the subway and go to some disposal center to get rid of the stuff.

So that's one supply: the medicine cabinet.

The AMA seems to think that 70 percent of the illicit trade, the stuff that's on the street that's being abused, is coming out of the medicine cabinet.

I don't believe that.

I believe that the majority of the illicit painkiller pills that are causing the problem now are coming out of drug diversion. Around I have a crystal clear example of that, and it's in the form of two federal cases.

Within 18 months, the United States Attorney --

SENATOR GOLDEN: If you can, when you're doing that drug diversion, [unintelligible] you also see how that leads into heroin?

WILLIAM McGOLDRICK: Right, and it's -- they're hand-in-hand, obviously, from what the doctor said.

The United States Attorney for the Southern District of New York, Preet Bharara, and it's in the package I gave you, announced two federal cases: one in July of 2012, and one only two months ago.

And in both cases, the New York State Medicaid program, inadvertently, and through fraud, supplied $500 million worth of pills in each case.

So it's a billion dollars worth of

prescription painkiller pills that hit the street because the New York State Medicaid system was being defrauded.

Now, Social Services, Health Department, and Medicaid Inspector General, all those years, there have been successive contracts for Medicaid-fraud investigators.

And, basically, they're retired members of NYPD, multiethnic, and they get out and they investigate the bad doctors.

And The Detective can tell you in a moment that that's actually a very fruitful way to do it. You get the word off the street. You know, "Where do I go to get a prescription for Percocet?" or something like that.

And it's a very direct way of dealing with it. These are licensed professionals.

Unline heroin, which is coming across the borders from many different countries, diversion of prescription painkiller pills is -- involves -- it involves professionals; there are pharmacies and doctors.

It's a closed system, so you can take steps.

Every bad doctor that you kick out of the system who's prescribing a million dollars worth of

this stuff a year is going to save -- it's going to save lives, and save the state a million dollars.

SENATOR GOLDEN: The doctor pointed out earlier this morning about the -- how they were -- the diversion, especially in the -- let's say the pain health centers.

Isn't there a way that we can do technology overlays to find out which health centers are doing the prescriptions, and what you can find out who they addicted, and how they're going into heroin, and where the heroin's coming in -- and how is the heroin coming into Brooklyn?

WILLIAM McGOLDRICK: The New York State Department of Health and the New York State Medicaid Inspector General and the New York Attorney General have access to the "MMIS" system, which is the Medicaid Management Information System; and, the Fraud and Abuse Management System that sits on top of that. That's an IBM product.

They can search for every prescription and patterns of prescriptions that were written.

You can look for the doctor in The Bronx who's overprescribing and the stuff is all being filled in Suffolk, which is an actual case.

They can look for a pediatrician who, maybe,

somebody stole his pad. All of a sudden, this pediatrician is ordering oxycodone.

They've got all these filters [unintelligible] that they can do, but, they need the staff.

Up until September 30, 2011, there were 60 people working on this kind of stuff, on outsourced contracts.

Those contracts ended on -- at the end of September. Within 10 months, the federal U.S. Attorney had its first $500-million case.

There was a limbo period where those contracts didn't exist at all. And at the end of that period, when they just started to come up again, there was the other $500-million case.

Instead of 60 people, they've got 6.

So that's something that, you know, the Senators can address, is going back to OMIG and find out why that contract -- or those -- there's three of them, why aren't they being used?

They're contracts for auditors, nurses, computer people, and investigators.

I don't know if it's for lack of funding.

If it is for lack of funding, I can tell you this: For 20 years, it's been calculated that it

returns at least 10-to-1 on the money.

So if it's five million dollars a year, they're saving fifty.

The Detective, I wanted him to tell you about something that's happening now, where you have these illegal pharmacies popping up.

We just spoke about this, over coffee.

Drug diversion has so many ramifications, that it needs a lot of studying.

In addition to putting the dangerous pills on the street, part of the act of a criminal diversion ring is to sell the medication back to a pharmacy, who buys it at 10 cents on the dollar, and keeps selling it.

Now, it doesn't have to be painkillers. It could be HIV meds.

One of the most despicable things I've ever heard was the New York District Attorney -- Attorney General case. They arrested two pharmacists who were buying the lifesaving AIDS/HIV meds from the AIDS patients before they took it.

You know, there's a special place in hell for people like that.

But, I'll ask The Detective now to explain what's going on in certain areas of the city, and

it's kind of part and parcel with that, where legitimate medications are coming out of the pharmaceutical supply chain and then being dangerously reintroduced.

"THE DETECTIVE": [Not on video; just audio.]

Good morning, Senators, and thank you for having me here today.

SENATOR GOLDEN: The mic closer, please.

"THE DETECTIVE": [Not on video; just audio.]

This is an education thing that -- you know, like the first committee said, people need to be educated.

I can go out all day and get you whatever you want, but if you don't educate the public, it's going to keep happening.

And, there are pharmacies out there that are buying prescriptions; they're buying your medications back.

We have an area in The Bronx where bodegas are getting into the game now. They're buying medications from people and reselling it, or shipping it out of the country.

It's a big epidemic.

You know, it needs to be -- we also need to educate people on how to get rid of their

medications when they don't use it.

Not everybody's addicted. There are people that are -- legitimately have their medications, but they need to get rid of it, and there's no way of getting rid of it.

SENATOR GOLDEN: Well, stay on that -- the pharmacy; the bogus pharmacies.

I haven't -- I got to tell you, I'm getting an education here myself here this morning.

Where are they?

And how do we know they're out there?

And how do we --

"THE DETECTIVE": [Not on video; just audio.]

They're in all the boroughs. They're in all our boroughs.

SENATOR GOLDEN: [Unintelligible] you're talking about the people that are set up that are inside the operation that are workers within the operation? Or there's actually owners of the pharmacies that are doing this?

"THE DETECTIVE": [Not on video; just audio.]

It's -- there are people that stand outside the pharmacies that are steers.

SENATOR GOLDEN: Okay?

"THE DETECTIVE": [Not on video; just audio.]

Okay?

Sometimes they work with the pharmacies, sometimes they don't work with the pharmacies. Sometimes they're on their own. But sometimes they work with the pharmacy.

We have doctors that take money to write you a prescription for painkillers.

SENATOR GOLDEN: We've already said that.

"THE DETECTIVE": [Not on video; just audio.]

Right.

So, you know, it's an epidemic, and people need to be educated on it; on how not to do that, and how, you know, to prevent from getting caught up in that.

SENATOR GOLDEN: Wouldn't the audits and the overlays -- technology overlays, wouldn't that show where the doctors are, again with the I-STOP, and with the shopping of -- the doctor shopping, and where there's more prescriptions coming out of a certain borough or certain town, village, or city?

WILLIAM McGOLDRICK: Yes, the I-STOP will prevent the overprescribing part of the illicit supply.

What the I-STOP doesn't stop is this criminal diversion.

And very quickly, the way it works is:

They borrow a Medicaid card from somebody. You know, they may go to a men's shelter and give the guy a $20 bill, and take his card. They get a prescription that was stolen.

In your package, there's a picture of a stand on the Grand Concourse, where all they did, all day long, was buy stolen blank prescriptions, and then they would sell them to the people on these teams.

And there's a picture in there, in that package, of a scrip writer. All she does is sit down with them and write the prescription for what they want. That's her job, and she gets paid for that.

And then there's a picture of the man who escorts the people into the pharmacy, sees that they get the prescriptions filled, puts them in his shopping bag, and then they move down Tremont Avenue, in that case, to the next pharmacy, and the next pharmacy.

That criminal-diversion team is not going to be stopped by I-STOP. It's not going to show up.

I-STOP is a very good program, a very worthwhile program, but that's only one segment of the illicit supply.

The three major areas, I believe, are:

Number 1: Criminal diversion of prescription drugs.

And we happen to have a penal-law statute for that, which is a very good statute. It has felony levels, so it's serious.

I think the next is the -- the theft out of the medicine cabinet. I think that's in the -- not a volume, that's next.

And the last is the doctor shopping.

But I want The Detective to tell you about the non-professional locations that are getting into the pharmacy business now.

"THE DETECTIVE": [Not on video; only audio.]

We have a certain amount of bodegas in our Bronx area that are also getting into it. They're buying the prescription drugs from people, and they're selling it or they're sending it away.

Sometimes a big part of that is Viagra, LEVITRA, they're selling it out of their bodegas.

You know, you have eight bodegas in a two-block area. You know, they're not all selling groceries, you know?

And, you know, we don't know if they're involved with pharmacies, but that's part of it.

WILLIAM McGOLDRICK: And the point to take away from that, is there's so much money in this stuff that it's a rapidly growing enterprise.

When it's $40 a pill, 180-count pill supply, according to the federal case, by the time they get finished selling it up the chain, that one prescription I got filled could be worth anywhere from 6,000 to 18,000 dollars.

And the way I described a criminal-diversion team, you can see it's not hard to assemble, not hard to get a Medicaid card, and, apparently, it's not hard to get scrips, that are all part of the package.

So, again, this is one particular area of -- and I believe the major source of these pills that the State can do something about.

There are contracts in place, and they just have to put that back to the robust program that it was.

SENATOR NOZZOLIO: Let me follow up with you, Counselor and The Detective:

The -- you're assured that the statutes we have is -- in terms of criminal deduct, are sufficient?

WILLIAM McGOLDRICK: [Nods head.]

SENATOR NOZZOLIO: But they're certainly not sufficient to deter this action?

WILLIAM McGOLDRICK: Criminal diversion of prescription drugs goes up to a C felony. And that's a pretty good -- that particular segment is covered.

SENATOR NOZZOLIO: I'm Chairman of the Codes Committee, and I'm very interested in your assessment here of this.

Go ahead.

Go ahead.

No, you go.

SENATOR GOLDEN: How much drugs do you need to get a C felony on a drug diversion?

How much -- what sale --

WILLIAM McGOLDRICK: You know, the face value would have to be about 5,000. It kind of goes up like the old grand-larcenies statute. It's by the value of the -- by the drugs.

SENATOR GOLDEN: And it goes for the seller?

WILLIAM McGOLDRICK: Yeah -- well, yes, yes.

SENATOR NOZZOLIO: Back to this inquiry that -- it's -- these graphs that we were shown at the last hearing, where you've got the enormous growth of opiate sales, these are, I assume, the

doctor gave us opiate legitimate sales.

WILLIAM McGOLDRICK: No, that would be --

SENATOR NOZZOLIO: What kind of graph would we see if this was into the black market that you suggest?

WILLIAM McGOLDRICK: Well, ironically, because these -- take the billion dollars in sales that were represented by the two federal cases, they would show up on that chart, because they billed the New York State Medicaid program $1 billion.

$1 billion represents 2 percent of the entire state budget for Medicaid. That was over an 18-month period.

But, I mean -- and that's only two cases.

And one of the problems, and I've talked to -- I had lunch with representatives from three of the pharmaceutical manufacturers, two weeks ago, looking to get funding to do something with NYSAC (the New York State Association of Counties) which has a very strong interest in this.

And they tell me that the problem is, that -- they keep hitting the system by resale of these drugs, and they're contaminating the drugs. And they have counterfeit drugs coming from foreign countries.

I mean, it's so bad, that they're getting calls from Iowa, their security divisions, wanting to know why the 40-milligram stuff is in a 30-milligram package.

There was a case on Tremont Avenue, reported in "The Post," a 7-year-old boy, who's mother got a prescription filled for Ritalin, accidentally got an adult dose of methadone, and very nearly died.

That's a result of a pill-mill operation. The stuff goes out legitimately, but it looks like a legitimate sale.

And it is a legitimate sale, because it's billed to the State, but now it comes back in.

We've got two pharmacists who work with us, who are also retired NYPD. They've been in some of these pharmacies, where, they were accompanied by law enforcement because now they're -- the place is going to get taken down.

And there were dozens and dozens of these pill bottles that were brought back from the street, purchased back, opened, waiting to be resorted.

And it's not just limited to painkiller medications. It's limited to anything that's worth -- well, not limited -- it's anything that's worth money: asthma medications, heart medications.

Any of us could wind up going to get a prescription filled for anything, and get something that's been out on the street, in somebody's trunk, mixed around, and put back in.

So drug criminal -- criminal diversion of prescription drugs is an emerging problem. And I think it's the leading problem of the pills, which the doctors have told you now is the leading problem -- leading cause, or the causal connection, for the heroin.

And this is something the State can do something about. They've done it before, and they've done it very effectively.

I suspect, that with the Medicaid redesign team and a couple of other things, this kind of fell out. Somebody didn't realize that these three contracts that sit in OMIG right now are being underutilized, and it was an 18-month gap.

SENATOR NOZZOLIO: So, Counselor, thank you for this assessment.

We're grappling with, as Chairman of the Committee said, it's a three-prong approach. You've got prevention, treatment, and then prosecution.

And we need to focus on the supply aspects here, is what you're telling us; the illicit supply?

WILLIAM McGOLDRICK: Yes.

SENATOR NOZZOLIO: Not the legitimate supply.

I mean, I know the doctors are saying it's just more -- that more pills in mommy and daddy's medicine chest.

Well, it's not that, according to what you just described.

WILLIAM McGOLDRICK: That's the number two source, by volume. I wouldn't know what it is.

But the number one source right now is criminal diversion of prescription medications. And it's through -- they're -- New York State Medicaid is getting hit very badly, but other prescription-benefit programs are getting hurt, as well.

SENATOR NOZZOLIO: Do you feel, in terms of the elements of prosecution, that the statutes are significant enough to allow and enable the prosecution?

It's the investigation and apprehension is where the challenge appears to be?

WILLIAM McGOLDRICK: Yes, it's a very specific area; a very specific expertise to investigate it.

The NYPD, we've worked with the various --

all the DAs. All the DAs are aware of the problem, but nobody has the resources.

And, imagine, I mean, we had a team that included two NYPD members who were pharmacists. We had nurses, doctors. And, again, somehow it fell out.

And after it fell out, a billion dollars in fraud occurred in just two case.

So, it's a pretty clear indicator of -- or an argument to restore the efforts at OMIG.

SENATOR NOZZOLIO: Thank you.

SENATOR GOLDEN: On a Medicaid card, and I'm just throwing this out there, it may not be possible because of the large volume, and because of HIPAA, the -- isn't there -- the State, that when they give out the Medicaid cards, isn't there an unusual -- is there any way of doing an unusual medical usage?

WILLIAM McGOLDRICK: The State sometimes restricts recipients who are somehow -- who are suspected of abusing the cards.

You know, you always have the fine line of wanting people to get treatment. And then, of course, you've always got the criminals who will abuse, you know, any kind of a public-benefit program.

One of the problems in the system, I'd have to double-check, but for as long as I can remember, a lost Medicaid card was replaced with another card with the exact same number, which -- you know, so you have dozens and dozens of cards with the same numbers.

So you couldn't even track, you know, the guy -- the guy could say, Well, it wasn't the card that I have.

SENATOR GOLDEN: Could they track the same person that lost the card four times in a year, or a stolen card three times in a year?

WILLIAM McGOLDRICK: You know, again, they can put some people, if their numbers, they can -- you can tell, from the Fraud and Abuse Management System that sits on MMIS, you can tell if certain recipients' cards being abused. And that's for New York.

If it was New York City, that would be New York City HRA to call the person in and evaluate what's going on.

They can be put on restriction, where they have to go to a certain pharmacy and use certain doctors.

But that's not the part of the problem.

The fact that you can rent a Medicaid card, you know, from the indigent population, people who are homeless, people who are out at a men's shelter, that's hard to control.

But what you can control, because it's a closed system of professionals, is the prescribing doctors, the ordering providers, and the pharmacies, things that are going wrong on the pharmacies.

And, you don't need -- I mean, it's great to have it, and it's a great way to make the cases, but you don't even need the sophisticated computer models and all that.

The Detective will tell you, he can go out on the street right now and get the name of six doctors that are writing prescriptions.

It's not that much of an investigation to build up a case to have the person -- the doctor arrested and thrown out.

We had one pharmacy on Tremont Avenue, you know, with video and audio, we had pictures of them, buying Medicaid cards, and buying drugs back.

You know, they're not difficult cases to make, but there's a lot of them to be made, and there's not enough effort. There's, virtually, no effort.

SENATOR GOLDEN: Is there any legislation that you think we can pass at this -- this Senate that you think could help?

And are the DAs -- are there enough incentives for the DAs to take these cases, and to help in the city and the state?

WILLIAM McGOLDRICK: Within the last year I've met with each of the five DAs in New York City, and I've met with DA Kathleen Rice in Nassau, and Tom Spota out in Suffolk. They're all dying to do something. They all said they would love to have resources like this.

There's a proposal that we have, through the Suffolk County DA, to put together teams for Long Island, where they're losing 10 people every month for 2 years.

The statistics that the doctor from the city had, it was 58 people a year in New York City.

Two western counties, six a month in --

Fifty-eight people a month in New York City, I mean. Six in the western counties of the state.

So you're talking about 60, 70 people a month.

It's time to get a couple of projects together and get it studied, you know. There are

enough knowledgeable people around who can look at the different aspects of the problem and come back to you with suggestions for changes in the law.

SENATOR NOZZOLIO: Your testimony is very helpful.

Elaborate a bit on the abrupt ending of those contracts that were used to -- for the Medicaid Inspector fraud -- Medicaid Inspector General in terms of this ferreting out fraud.

You say the contracts abruptly ended; then restored after two years of dormancy?

WILLIAM McGOLDRICK: Yes.

SENATOR NOZZOLIO: And then -- but you said 18 months, those investigations' contracts were restored, but on a very minimal and ineffective basis.

Could you elaborate on the "minimal" and "ineffective" part?

WILLIAM McGOLDRICK: There are 6 -- instead of a staff of 60, there are 6: 2 investigators each from 3 companies, who have -- they're were experienced companies.

And because of that 2-year gap with no investigations, the Medicaid Inspector General's Office had a 9,000-case backlog.

So, they're trying to prioritize.

And, their mission is not only prescription drugs. It's all forms of Medicaid fraud: fraud in transportation, ambulettes, labs...all manner of fraud.

So that's one segment of it.

To my knowledge, of the six investigators there right now, there may be one or two, and that's it; so it's not a program anymore.

And it's -- of all the things they do, if you want to put saving lives first, and reducing the public-health crisis, that, to my mind, would be the primary mission of that unit right now.

SENATOR NOZZOLIO: Although, certainly, the costs -- or the benefits are also --

WILLIAM McGOLDRICK: It always pays 10-to-1.

We had an HIV case, there's was a growth hormone by the name -- called "Serostim" that was being diverted and sold back to the pharmacies. And it was a very, very expensive medication.

The State was spending $120 million a year for, like, 10 years on that stuff.

When the investigation was concluded, it was reduced to $80 million a year, and stayed at that number for 10 years.

So to my mind, those contracts paid for themselves forever, right then and there.

And that case was found by a New York City detective, Patrick Kelly -- Lord have mercy on him, he's no longer with us -- just by doing what cops do.

He was out by a pharmacy, he saw something suspicious. They found out the person had a forged prescription. They brought it back. They got the pharmacist and they said, "What is this is stuff?"

And the guy said: Well, that's a growth hormone for AIDS patients.

"Why are they selling it?"

"Well, we didn't know."

Well, it just was because it was an expensive medication. And by getting it for nothing with a Medicaid card and then selling it back to the pharmacy, they were able to bill the State $2,000 a dose for every one of those that they did.

And nobody was treated with the drugs. It was just a -- what -- you know, a classic pill-mill, where they sold it over and over again.

So, if the outsourcing of Medicaid investigations ever proved itself, it proved itself on that one case.

The investigator himself brought the information back to them from the street, and it resulted in a $40-million-a-year savings for many years.

So that's -- the diversion part is something that the State can actually doing something about.

And I -- and this is -- the marijuana discussion about gateway, whether it is or it isn't, we now know that the pills are the superhighway. There's -- it is the direct route. You know, the direct cause.

SENATOR GOLDEN: Is there -- did -- anything that popped up here today that you think that we can do that -- to strengthen some of our laws here in the state of New York that would help in preventing more actual overdoses and sales and death?

LINDA SARSOUR: I definitely highly support the crackdown on the pharmacies and the doctors, and that partnership. That's absolutely happening. I won't deny that that's happening.

But what I'm concerned about, is that the -- people that are being impacted from our community are not the kids that are going into a pharmacy with the prescription. That's not what they're doing.

So I'm trying to figure out, to balance the

enforcement piece and the legislation around, you know, monitoring the criminal diversion, which I think -- the drug diversion, which I think is a big issue.

And I know that, even stories that we've heard, where there's been a couple of doctors.

I remember, two years ago, there was one in Sunset Park that got caught on that.

But I just don't think that that's what's -- this population of 17 to 23 are not the ones going into the pharmacies.

So I'm trying to figure out --

SENATOR GOLDEN: Going into their mother's and father's medicine cabinets, though? Aren't they -- don't these kittle [sic] parties --

LINDA SARSOUR: They're doing -- they're doing -- they're doing the skittle parties, but they're also being sold those pills, buy the pills. So there are some pills that they're buying for, like, $5 a pill.

They're buying -- the kids are showing us, you know, little Ziploc bags that they find with their friends, or at their friends' houses.

So the kids are being really honest about the stories, and how they're getting the pills, or how

they see their friends taking the pills.

But, you know, back to the original, like, the legislation passes, and then there's always the enforcement piece, and how long does that take?

But in the meantime, how many more kids in our community have to die. Right?

So I'm trying to figure out, also, back to the gentleman in the back who's an educator from Long Island, the idea of, like -- like, for example, in Bay Ridge, you know this, Senator, like, we don't have youth programs. Like, we don't have a PAL program in Bay Ridge.

Kids don't want to go to McKinley Junior High School if they're 16, to play at a junior high school.

Just figuring out, what other alternative programs can we add to a larger holistic approach to combating this issue?

Because we -- I just don't want to see another mother in my office, crying, and telling me she didn't know why her son didn't wake up in the morning, because he came all home and -- that's how all our kids are die. They're -- literally, they just don't wake up.

That's most of the stories that we -- at

least seven of the eight kids, their mother went to wake them up in the morning, to go to school, or to go to work, and they just don't wake up.

And that's how their mother finds out that -- later on, that it was an overdose.

They can't tell. They don't smell like marijuana. They can't smell it on them. They can't see it in their eyes.

They just don't how to -- so how do we get all those points?

But we, as a community, wholeheartedly support the enforcement mechanisms.

And any legislation, we would be willing to stand to say that we would crackdown on doctors and pharmacies in this work.

SENATOR CARLUCCI: Now, Linda, how about, in cases, and I don't know if you've experienced this, where it is obvious that someone has a problem, and they maybe come to you or and look for help, have you had experiences like that, with -- and finding treatment for people that need it?

Because we've heard this problem, where it's obvious someone has a problem. They've actually -- they're actually looking for help, and not able to get the treatment that they need.

And we've heard from private insurance, but other issues, as well.

Do you have any experience with that?

LINDA SARSOUR: And my colleagues from Lutheran, I used to work at Lutheran, actually, but, you know, people think it's an easy process. They think that they show up to a center, like a Lutheran, and then they, like, take you, and then it's all, like, great.

That's not how it is.

I mean, there's a waiting list. There's also an age limit.

Like, Lutheran, for example, they don't do adolescents. Like, that's not their focus area.

So, like, our population, talking about kids between, you know, that are -- I mean, the ones that have passed away are 17 to 23, but we know kids using this as young as 13.

That's not a population that they focused on.

And the other issue around it is, like, you want to be able to treat kids with the partnership of the parents, right, but if you don't speak their language, if you don't -- back to my brother over here, like, this -- this -- the assumptions, that when we're talking about drugs in the community,

this community doesn't think that it's them.

They don't -- for example, we don't even talk about things like HIV in our community because, you know us, we're, like, religious, and we're, you know, monogamous.

Like, there's a lot of issues in our community that require a level of sensitivity.

And I think the way you do that is, you go through faith-based, community-based, organizations who understand these.

So back to another proposal in the back, around building coalitions of government, you know, and this is something that's already happening in our area, government, faith-based, community-based, organizations, and others, you know, school system, and creating this partnership.

Because, our community also is about, you know, you don't want -- you don't want to think I'm a bad parent because my kid's on drugs.

So, sometimes they wait too long.

Maybe they do know. They wait too long, because they're worried that people are going to, you know, talk about them, like, as if that's more important than their child's life.

And I think we could be very helpful in being

the liaisons between the community and this issue, but also having community members stand up and say:

If the pharmacies are getting this on the streets of our community, then we're going to stand against it.

If the doctors in our community are bringing this to the streets, we're ready to stand against them.

And, how do we create that holistic approach?

SENATOR BOYLE: One of the things, Linda, that we've seen in other forums, and I'd like to get out of this Task Force, is to change the stigma involved.

You mentioned that, where, you know, if you walked up to someone on the street and they said, "Well, my son has cancer," you'd say, "Oh, my God, what can we do to help?"

No one wants to mention that their child is an addict, but it is a disease.

LINDA SARSOUR: Absolutely.

SENATOR BOYLE: And that's the bottom line.

And I think that that mindset is changing, but we're not there yet.

LINDA SARSOUR: Absolutely.

SENATOR GOLDEN: The -- Rabbi, did you want

to add anything?

RABBI SIMCHA FEUERMAN: Well, first of all, I absolutely concur with what Linda said.

And, also, just share with you that there's a saying in the Talmud, that the mice does not -- the mouse does not steal; rather, it is the hole that steals.

And, you know, clearly, enforcement and prevention are very, very important, no question about it.

But I do think that when you're dealing with families and young children, the education piece is extremely important.

And, also, somehow, you have to find a way to balance the fear that comes with enforcement, versus, you want people to feel comfortable coming forward.

And that's always a problem in any area of mental health, because there's a criminal aspect to many kinds of mental-health crimes and related crimes.

So we need to find a way, and part of that is with cultural sensitivity; however, just plain old sensitivity, too, to find a way, where people feel comfortable to get treatment, and to talk about

their problems; and, yet, that we have strong enforcement, because you have to have both.

LINDA SARSOUR: Could I just ask a quick question?

So, about two months ago, we actually brought information to the 68th Precinct about a potential, actually, apartment, where we think that someone -- a mother and her sons, actually, were part of this, like, selling. Right?

And when these kids told us this, and I asked them, like, "How long do you think has been happening?" they're, like, "Oh, this has been happening a long time."

I'm, like, "Why didn't you ever tell anyone?"

And what they were worried about, and this something we should think about, is they were worried that if the, you know, NYPD undercovers are going to be monitoring this, like, location, that, would the kids who are coming out of that apartment be then subject to the enforcement around that?

So, our kids are the ones with the information. They know who's selling in our community, but what they're worried about, is if they come forth, or they find something on them, that they're going to be part of that.

And I personally can't guarantee to them, because I'm not in law enforcement, to say to them: No, we want this information. You can be helpful to us, and what that looks like.

Because I think that's the apprehension about bringing information, is that these young kids who are -- need just -- they just need -- they just need a lot of things, but they don't need to be arrested and put behind bars, because, it's not them; they're not the problem.

So I'm wondering if that's something we're thinking about when we're looking at the enforcement piece, that these young kids are not caught up in the system.

That's actually, kind of --

SENATOR GOLDEN: In most cases, NYPD uses undercovers, and they use those that are coming out into a drug sale. Generally, they've watched and observed this individual several times.

The unfortunate reality, we did do a -- an event in Bay Ridge, and it takes, you know, a good several months, by the time you do a number of buys, to be able to get that -- to -- crime to stand in a court.

So it takes a period of time to build a case.

So while that takes that time, that drugs are still being sold at that location, so people get upset because they think the police department's doing nothing, or, you know, Why is this allowed to go on and to exist?

What they're doing is, are building cases.

And you've seen a number of cases that have been brought in the past several weeks, and how many people have been arrested in that community because of drugs.

So it does take time, but it does come -- the community has to let us know.

The Muslim- and Arab-American community is very insulated. And the same in the Jewish communities.

So, they have to be the ones that have to come forward, to let us know where the locations are, and we have to be able to get in there and get our undercovers in there, and make sure we make those arrests.

And we will, and we have; and we will save lives, as long as there is a communications.

Which I think is a good communication today with NYPD. I think Lutheran is doing a good job, but Lutheran's limited, and HIPAA, and they're

limited in why they can intervene in a family.

We've had families come into our office that did not want the community to know that they had a problem, and that we've taken those children.

There's going to be some providers coming up here and they're going to speak very shortly.

And we've gotten them into treatment; and that's what it's about, is getting the people into treatment that are addicted.

What we want to do, though, we want to make sure we get the drugs out of the community.

And if they're in the community, the community knows; so they've got to let us know.

And I think we have a much better working relationship today than we had in the past, when it came to drugs. And we're going to continue to do that.

Anything else you can add?

Anybody from the audience want to a question here, that -- go ahead, sir.

LUKE PARDNER [ph.]: My name is Luke Pardner [ph.]. I'm a member of Dynamic Youth, and I've been a recovering drug addict for the past year.

And my question is about education, because,

when I was a kid, I was educated as to what drugs were. My cousin was a recovering heroin addict, and I knew what it could do, but that didn't stop me from doing any of the drugs.

I went to the D.A.R.E. program, I did all of these things, knowing what could possibly happen, and it didn't really stop me.

I feel that, when it comes to education, if you put a group of children or young adults in with an adult or an older figure or someone that holds, you know, authority, it's less interesting, it holds less value to you.

When I was younger, I would get more advice and I would take it in better from people that were my age.

I feel that when it comes to education, it would be better if someone that was going through it or has done it recently, and of the same age range, could teach the younger children about what we've gone through, how we've dealt with it, and what it will cause.

I feel, like, if -- I wanted to know if there's a way that that could happen?

SENATOR BOYLE: Yeah, we are certainly advocating for peer-to-peer education. And I think

that we've heard that a lot around the state, too.

I mean, it's one thing to have the police officer come in, the person you can't relate to, but some -- we have young people who are still going through it, that explain what they went through, and that scares people. I think it has much more of an effect, let's say.

And were certainly going to try and add that to our package.

LUKE PARDNER [ph.]: Thank you.

SENATOR GOLDEN: Any other questions?

NAZAR ANOWI [ph.]: Yeah, hi. My name is Nazar Anowi [ph.]. I'm a CASAC with OASAS. Also, a resident of the Bay Ridge area.

I've known -- my family and I have known Marty Golden. [Inaudible] to try to do our best.

I honestly think a big part of the law enforcement is going to have to get involved.

The community -- the kids are very private, very quiet. They are scared, but not scared in the manner where it could be beneficial to them, themselves, and their families.

So that is one factor.

Also, maybe like an anonymous toll-free number that can be used, that families can speak,

because it's a two-part disease. The family suffers, as well as the children, and the community as a whole.

So that is one area I think maybe the Arab-American Support Center can work on, you know, having some type of, also, like a liaison between Medicaid, because it's very expensive to get treatment. A lot of people want treatment, and a lot of people don't know how to go forth in getting it.

So maybe somebody from, like, Medicaid, informing them of long-term HRA-type benefits that are available.

But I think a big part has to do with what the NYPD has been working on, and just applying a little bit more pressure in not giving so many options, other than to work with them or to be mandated to a long-term treatment program, which I feel is probably the best treatment plan.

It would give the families time to heal. It would give them time to heal.

But it all falls into the place of enforcement of, like the Rabbi mentioned, fear. There is a lot of fear, but not a fear in the sense where they can recover from it. It can be a

motivator.

And that is a key area of which I think that -- you know, I know, Marty Golden, you have a lot of these pamphlets in your door, you know, with Internet, and safety, and parents. And that looks a lot towards the generation that has not been affected by it, you know, and parents really getting involved, you know.

I work a little bit with Apple, with development, and they would love to participate in different kind programs, to work with the kids who are not just from the Arab. Bay Ridge is very diverse. You have every nationality in there.

So getting them in there prior to them going to high school, and the peer-pressure factor is very big.

So, kind of breaking it up in that area, but, I think that would be a positive.

SENATOR GOLDEN: There are faith-based operations out there that do get a person from their home, to Medicaid, to a treatment center.

My office does it, others will do it. They're out there.

The unfortunate part is, a lot of people don't know they're out there.

And I think that's the education part that my colleague Senator Boyle has talked about as something that we have to do look to do better.

NAZAR ANOWI [ph.]: Absolutely.

Thank you.

SENATOR NOZZOLIO: I have a question for the young that man stood up.

Could you be so kind as to indulge me in a question?

First of all, thank you for your courage. It took an awful lot to stand up in the middle of the room and tell us about your personal journey.

And I appreciate that very much, and respect it very much.

Help us by understanding how -- you said you had the D.A.R.E. education, you said you were a participant there.

What elements encouraged you to begin this type of conduct, the -- taking the opiates?

Was it availability?

Was it opiates themselves?

Were there gateway drugs?

What got you engaged in this?

LUKE PARDNER [ph.]: For me, it started with smoking marijuana when I was very young. And then,

I was probably about 16, I started smoking marijuana.

And what happened, the opiates was, Clonopin, was something that I liked, because my mom had it in her -- in her -- in the bathroom in the little --

SENATOR NOZZOLIO: Medicine chest.

LUKE PARDNER [ph.]: -- medicine chest, exactly.

And once I got that, my other friends knew about other drugs, and I kind of just experimented a little bit. And it kept going until I ended up in rehab.

SENATOR NOZZOLIO: That was Senator Golden's question earlier today, in terms of, what is -- is marijuana, in fact, a gateway drug?

LUKE PARDNER [ph.]: To me I believe it is, yes.

SENATOR NOZZOLIO: Well, again, thank you for your courage, and your comments.

BRETT WILSTENSTOFF [ph.]: Thank you all for having this panel. I really appreciate it.

My name is Brett Wilstenstoff [ph.]. I'm a graduate student at the Albert Einstein College of Medicine up in The Bronx, and a volunteer with the syringe exchange up there, as well.

So I found my brother when he had overdosed on heroin. We didn't know he was using, so we had no naloxone on hand. We were at the mercy of the paramedics getting there on time to bring him back, which, thankfully, they did.

So, I was in the situation of not having any resources available. And it seems like a lot of other people are in the same situation.

And, so, we all, though, have in our households fire extinguishers for that rare occurrence of a fire.

Why don't we all have naloxone in our medicine cabinets on the rare chance of an overdose?

It seems kind of a very pragmatic approach. There's different ways of going about it.

I mean, of course, education was a huge role.

And being it more available for, like, over-the-counter availability would be one thing which I know is moving through right now.

Another would be a co-prescribing mandate, which I've suggested, in which the first opioid prescription, per year, per patient, regardless of dosage, would get naloxone with it.

And what that would do, is it would widen the naloxone-distribution network, so that any household

that has an opioid in it, also has naloxone.

And the naloxone lasts, the shelf life, for two to three years. So even if that dosage is gone, and then some problem arises later on down the line, naloxone is available and a person's life can be saved.

And, so, I just want to know your thoughts, and, also, I'd just like your ideas on wider naloxone distribution.

Thanks.

SENATOR BOYLE: Well, I think we all certainly support the wider distribution.

I know that many of us have had classes.

I mean, I held one on Long Island last week. We had 150 people taking the class.

One of the things is, we need to straighten out and have a uniform system in New York State on how to get that into people's hands.

These classes, you have to take the class to get certified, obviously. And it's about a 45-minute class, it's not that hard.

And we are looking for a wider prescription.

The idea of giving -- a doctor giving it with the prescription, the problem is, they haven't taken that class.

But we do want to make it as widely available to first responders, certainly to laypeople, family members of addicts, addicts themselves.

We have done a pretty good job of getting it more widely distributed, but we're going to go further with it this legislation, too.

Thank you.

Oh, yes?

CLARENCE BOWDEN: Good afternoon, and thank you, gentlemen.

My name is Clarence Bowden. I'm one of the directors of New York Therapeutic Community Serendipity 1.

And this is more of a comment and statement, but it's also going towards that gateway question of marijuana.

I haven't heard anything about alcohol being mentioned.

I've done sessions with older gentlemen who talked about, 6 and 7 years old, being sent, to bring a drink to the parent, the alcohol spilling on their hand, them licking it off, and it progressing over time till they becoming addicted.

All right, so let's not forget alcohol and its role in this gateway process.

Yes, I agree, marijuana is one of those gateway drugs, but alcohol is right up there in that same realm.

So that's just my comment and my statement.

SENATOR GOLDEN: I don't think anybody here disagrees with you.

Go ahead.

Thank you.

CLARENCE BOWDEN: Okay, but that's what my statement was.

SENATOR NOZZOLIO: Thank you.

SENATOR BOYLE: Thank you very much.

And I'd like to thank the panel very much, for your input and insights.

SENATOR NOZZOLIO: Thank you very much.

[Applause.]

SENATOR BOYLE: Our next panel is a representative of Dynamic Youth Community, Samaritan Village, Bridge Back to Life Center, and MASK.

[Pause in the proceeding.]

[The proceeding resumed, as follows:]

SENATOR BOYLE: Thank you very much.

This is our final panel; and if you could briefly introduce yourself and tell us where you're

from.

GARY BUTCHEN: Good afternoon.

I'm Gary Butchen, the president and CEO of Bridge Back To Life Center. We're a network of outpatient chemical-dependency programs located throughout the city and out on Long Island.

SENATOR BOYLE: Thank you.

WILLIAM FUSCO: Good afternoon, Senators.

My name is Bill Fusco. I'm the executive director of Dynamic Youth Community, which is a 43-year-old residential program with outpatient services in Brooklyn, but also servicing Long Island, Staten Island, Upstate New York. We have 86 beds in Fallsburg, New York; 16 beds in Brooklyn, New York.

And, we're very glad to be here.

Thank you.

KAREN CARLINI: Good afternoon, and thank you for this opportunity today.

My name is Karen Carlini. I'm the associate director at Dynamic Youth Community.

But I think also important to note, that I'm the co-chair for the ASAP (Association of Substance-Abuse Providers), Adolescent and Young Adult Committee for the state.

So I'm here representing both.

Thank you.

SENATOR BOYLE: Thank you.

RUCHAMA CLAPMAN: Good afternoon.

I'm Ruchama Clapman. I'm the founder and executive director of MASK. "MASK" is Mothers and Fathers Aligned Savings Kids.

I started the organization, we just started our 16th year.

Senator Golden and Senator Felder have been a partner and supported MASK through many, many years.

Thank you again.

MASK, we have a help line. We are a referral agency. We have support groups for parents. We are a school liaison. We do inpatient and outpatient referrals and placements for families that, children do drugs, alcohol, eating disorders, gambling, and Internet addiction.

Thank you.

JAMES HOLLYWOOD: Good afternoon, Senators.

My name is Jim Hollywood from Samaritan Village.

Samaritan Village has a number of substance-abuse treatment programs throughout New York State: 839 beds in total, 2 outpatient

programs.

Our residential programs focus on specialized services for young mothers and children, veteran services for men and women, and a methadone-to-abstinence residential treatment program.

SENATOR BOYLE: Great.

Thank you very much.

And if I could, first question -- we'll get into a lot of the issues, and the insurance, and stuff like that.

My first question out of the box, and for the treatment providers, inpatient: What's the magic number of days that you think, minimum, is needed to -- you have an opioid addict, heroin addict, come in, they went through detox, they're there; how long do you need to keep them?

KAREN CARLINI: I'll take it.

I'm in the middle, so, you know, we have both sides.

I think it's -- it's a hard question to answer.

I think that -- you know, we provide long-term residential treatment.

We provide long-term residential treatment of

one year, with an aftercare program, with outpatient follow-up, because the people that come to our program, that's what they need. That's what, you know, the level-of-care determination told us.

I think that it's really important that the treatment provider is the person that's making that assessment.

I know that there's pending legislation right now that would make that happen.

But the idea of long-term residential, I would say, you know, at least, you know, 6 months, in terms of the emerging adults, that 18- to 25-year-old, for what happens to them: What happens for the brain, and what happens, you know, scientifically, to people, and then what happens to them, emotionally.

For a family, someone talked about before, the time it takes for a family to heal. I think they need that time. That can't happen in a short period of time.

So, I can answer it, you know, from our perspective; although, I think that there are shorter terms that might work in different circumstances.

JAMES HOLLYWOOD: Can I --

SENATOR BOYLE: Go ahead.

JAMES HOLLYWOOD: So when the research -- when you look at the research, any treatment over 90 days seemed to be more effective when people stay engaged in treatment, whether it's outpatient treatment, residential treatment.

So, you see the most positive effect when people stay engaged over 90 days.

And, so, when we look at "What is the magic number?" it really also talks about the severity of the addiction, the co-occurring disorders that might accompany someone's addiction.

Addiction is a biopsychosocial disease, and how far it impacts someone's development.

Employment becomes an issue.

Housing becomes an issue.

So when you really try to boil down, What is the essential elements of treatment? it's a holistic approach that looks at the mind, the body, and, as well as the social connectedness of an individual.

So, there's no magic number.

90 days seems to be indicated in research, at minimum. And that goes for regardless of which level of care you're in.

The more contact people have in treatment,

the better outcomes that are available.

GARY BUTCHEN: You know, just building on Mr. Hollywood's point, it's difficult to give you an exact number, especially if we're talking about legislation that's going to force the insurance companies to pay for what's being called "medical necessity." It's very difficult to hammer down a certain amount of days.

If Dr. Kolodny was still in the room he could tell you, every patient is different, and the physician from Lutheran.

So, just from a detox point of view, you know, managed-care companies are now telling the inpatient folks, three to five days.

And, you're lucky to get five. They start doing discharge planning 24 hours in on a detox.

You can't move a person over to an inpatient rehab while they're still tremulous and going through withdrawal.

Then they want to route them out of the emergency room down to my level of care, in the outpatient system of care, but folks are coming in, they're still in mild withdrawal symptoms.

So, I'd love to be able to sit here and give you an exact number, but Jim's point is right on the

money. I mean, SAMHSA and NYDA and all the research has shown, the longer a person's engaged in treatment, the better the outcomes.

The juxtaposition of all of that, is the insurance companies aren't allowing us to hold people in treatment that long anymore. You know, they're sending us fewer and fewer patients, and they want them out of treatment faster and faster.

SENATOR NOZZOLIO: Yes.

RUCHAMA CLAPMAN: You know, from a parent point of view, and from dealing with over 15,000 families, I have a whole different spin.

My spin is, is that, the first month when a kid gets put into a rehab, or young adult, or whatever, they're there against their will. They're not even listening.

The second month, the 60 days, they're finally coming to accept that they need to be there.

By 90 days, they're like, Wow, I'm really here?

The first 90 days are not treatment. It's just really a holding pen, to get them to understand that's where they need to be, and then they start to listen.

So, if anyone thinks that the first 90 days

they should be out of there, I mean, you're really wasting your money, because all of them that come out after 90 days, we have documented, do not do well.

They need, minimum, not a day less, than six to nine months. "Not a day less."

SENATOR BOYLE: Karen, you mentioned "level-of-care determination."

Can you walk me through that process?

KAREN CARLINI: Well, right now, I know somebody mentioned before that OASAS is in the process of developing what would be called the "Locator," and that would be able to determine that level of care.

But for an assessment, a counselor goes through a process of, you know, assessing the client to determine whether they need, you know, outpatient care, residential, you know, and various other things. There could be mental health is considered. Family support is considered.

So there's all sorts of things that would determine where that person needs to be.

Currently, obviously, we do that as treatment providers.

What I think we fear is that, with insurance

coming in, and what's happened already for people that are working with the insurance companies, they're making that determination.

That's really what -- people aren't getting what they need because the determination is being made by someone who's not a practitioner.

SENATOR NOZZOLIO: And that's our dilemma.

Our dilemma is, and that's why the Chairman asked the question, because, in the three-prong approach that the Task Force is taking -- the prevention, treatment, and additional prosecution -- in a three-prong approach, the treatment end, we're -- began, at least I did, with -- at a loss.

And, it was 19 years ago that I worked to set up the first drug-treatment prison in this state's history, if not the nation's history, and that was a 90-day model. Willard, was a 90-day model.

And I agree with you, it's a very subjective issue, and it's very difficult to say "90 days."

I mean, I can just -- as you mention, the person in treatment, I can mention the inmate at Willard, that their motivation was, if they get out of the program, they'll go to jail, a longer jail sentence.

So they had some, at least recognition.

But, 90 days is -- but, at the same token, the Chairman asked this question, because we're going to have to ask the same question, and maybe even tell the insurers what they're going to have to provide.

And they're not going to like it no matter what it is.

9 days, 9 minutes, 90 years, I mean, it's not going to matter, from their perspective, except the question of cost.

And, we'll have to be sensitive to that, too, because everybody pays enormous insurance costs when we have to pay them, in health insurance.

And the fact is, we need some guidance.

I think that's just the -- the beginnings are: We'd like it longer, we understand that, we get it.

But the question is: How can we measure the stick so that the insurance companies will appreciate the fact that this is a more effective way to approach the problem?

GARY BUTCHEN: Well, we're at an interesting point, because Senator Hannon's bill, 4623, the Access to Care Bill, talks about all levels of care within OASAS, including residential, which the

insurance companies have never paid for before. That's always been either on the families or on the State or it was funded in particular ways.

So it is going to be an interesting debate as to whether or not the Access to Care Bill is going to include all the levels of care, as it should; or if the insurance companies are going to give an even greater pushback on covering only what's in the essential-benefit package.

So that's going to be a juggling act that the Senators are -- you know, you're going to have to deal with.

But we -- we, I think, all agree, regardless of our focus or our level care, that we agree with you. I mean, the Minnesota model that came out of treatment 30, 40 years ago was 30 days of rehab.

The average length of stay in rehab now is under 16 days. That's all predicated on what managed care is willing to pay for, unless, as -- as -- the families are willing to go into bankruptcy and foreclose on their homes, and take out second mortgages, for their children.

So when the insurance companies come back to the Legislature and say, "We don't want to pay for it because we're going to have to raise premiums,"

that's a weak argument because they raise premiums in New York State every year.

You know, I'm also, you know, a small-business owner, and I pay the premiums for my company. I can tell you that my premiums go up anywhere from 8 to 10 percent every year regardless of the bills that you pass or don't pass.

So that's something that really should not be the prevailing argument, whether or not it's good policy or not, because, obviously, as some of the other folks have testified earlier, and The Detective and the investigator have said, if we invest a few dollars early on, the fiscal implications, the economic implications, down the road pay huge dividends.

SENATOR NOZZOLIO: Mr. Butchen, that's very well stated, and I certainly agree with your concept.

We're just trying to hammer out the appropriate guidance to give the carriers, in terms of this focus, and what will be effective; what is necessarily the evidence coming from providers like yourselves who have to deal with these issues.

It's certainly subjective. I understand it's different, one size doesn't fit all, but, one policy

will have to fit all in this state, in a sense, of at least guidance.

So, any kind of guidance you can give us to give the carriers, we appreciate.

And we're willing to make the statement that, yes, you need to provide this care.

We did it with a lot of other things over the last few years.

But the question becomes, how much?

WILLIAM FUSCO: Senator, could I just mention the fact that the amount of monies necessary really varies tremendously.

For Dynamic Youth, it's under $30,000 a year.

For one year in treatment, it's under $30,000.

I can quote you programs that are one month for $30,000.

So, I mean, to just look at it from a sense of time or length is not necessarily the best measuring stick.

You know, honestly, I thought the measuring stick really should be, you know, what the cost is.

And the fact is, is that we've run studies a number of times, you know, throughout our years, about short-term and what we call "Band-Aid

approaches."

And, we have a lot of kids who have been in the 15 days, 20 days in Florida; 15 days here, 15 days there; all over the place for millions of dollars. "Millions of dollars."

So, if you shorten the length of treatment so short, whatever you're spending really is just throwing money away.

So, you know, you really need to think, not necessarily -- you really need to think of, what's going to be effective?

We stand by the model of 9 months to a year for severe opiate addicts who are between the ages of 17 and 24. We think that that really is the model that, you know, works, and gives a young person a chance to really get their -- you know, their recovery in place for themselves.

SENATOR BOYLE: And so --

SENATOR NOZZOLIO: How many children -- I'm sorry, Mr. Chairman.

SENATOR BOYLE: Go ahead.

SENATOR NOZZOLIO: How many children, Mr. Fusco, have -- in that age -- not children -- how many young adults in that age group is your agency done -- dealt with, and, in terms of

experience level?

What numbers are we talking about in terms of population you're familiar with?

WILLIAM FUSCO: Well, we deal exclusively with 17- to 24-year-olds, and we have for the last 43 years. We've been -- we're the first residential program exclusively for adolescents in New York State.

Right now we have 86 beds in Fallsburg, New York, which, you know, is near Monticello, New York. And we have 16 beds in Brooklyn, New York. And we have an aftercare of about 100, 125, who, after being in treatment, continue on with their families, on a -- sometimes, starting on a day basis, and then moving on to night basis, and moving on from there.

So, in total, we probably serve somewhere around 175 to 200 families a year.

SENATOR GOLDEN: What's the drug of choice?

WILLIAM FUSCO: Absolutely.

I just wrote it down.

We're running right now, 30 percent, prescription drugs; 63 percent, heroin.

SENATOR GOLDEN: And how's that changed over the last two years, three years?

WILLIAM FUSCO: I have that number, too.

In 2011, it was 47 percent, prescription drugs; 27 percent, heroin.

Going back to 2007, it was 13 percent, prescription drugs; 21 percent, heroin.

So we went from a little bit over 40 percent in '07. In 2011, 73 percent. 93 percent today.

SENATOR GOLDEN: And how has it changed the -- getting these drugs over the last three years: By purchasing illegally? Homes? Prescription? Doctor shopping?

WILLIAM FUSCO: I don't have that --

KAREN CARLINI: I think there are various reasons.

You know, some of the kids in the program are here today, so I think they're probably the best to ask. And we -- believe me, we ask them a lot.

But, there's different answers.

Some, like one of the kids that stood up earlier today, from the medicine cabinet.

Some from a party.

You know, some, even from an injury. Maybe they were an athlete and there was an injury, and it started that way.

But, their stories aren't very different than

most of the stories you've heard in the last few years, in terms of how people start, especially young people.

SENATOR GOLDEN: Can I ask that young man to stand up again?

We're going to pick on you today.

How many pounds you weigh?

LUKE PARDNER [ph.]: How much do I weigh?

165.

SENATOR GOLDEN: 165 pounds.

How many times did it take before he's addicted to heroin?

How many times before he takes a hit on heroin, before he goes to the actual crushing, snorting, taking that pill?

How long does it take him to get addicted?

KAREN CARLINI: Level of pain --

SENATOR GOLDEN: How long did it take you to get addicted?

WILLIAM FUSCO: That's a tough call.

I can't give that call.

I mean, I'm going to say, the average amount of opioid addiction in the program is going anywhere from one year to about six years.

So, you know -- and the level of addiction,

you know, I mean -- Senator, let's start with the fact that, you know, a lot of our kids like to get high, unfortunately.

And as these drugs -- as these drugs vary, and modify, and go back and forth, there is an underlying fact of, you know, working with families, of trying to help people stay clean and sober, is a really, really, really important task.

SENATOR GOLDEN: What I was trying to point out, I think a man of this weight -- a young man of this weight, three to four to five hits of heroin is enough to addict him.

That's what I was trying to point out.

You had your hand up back there. Real quick.

ANTHONY ALVERNO [ph.]: [Not using a microphone.]

My name is Anthony Alverno [ph.]. I'm currently in treatment.

And, it takes three to five days of continuous use to get an opiate habit.

WILLIAM FUSCO: Right.

SENATOR GOLDEN: Thank you.

ANTHONY ALVERNO [ph.]: From what I understand.

SENATOR GOLDEN: Thank you very much.

I'm sorry. Go ahead be, Mr. Fusco.

WILLIAM FUSCO: So I guess, when -- you know, when talking about the level of care, and, honestly, it was really the first thing that came to mind for me, I think it is essential that we think in terms of length of stay.

It can be, not necessarily, an intensive medical model. I don't think that that's necessary.

So there are ways of making costs, I think, you know, for, you know, inside the peer situation, reasonable.

But I think that the length of stay in a supportive environment is very, very critical to a lot of young people getting a chance of getting their lives back.

JAMES HOLLYWOOD: And if I could, just back to the point of insurance, you know, it's sort of coming at the worst time, I think, that health-care reform, as the opiate addiction has risen.

Because, like the gentleman had pointed out, three to five uses and you're addicted.

The prescription-drug epidemic really sort of heightened the fuel of the addiction, because it was pharmaceutical grade. It was always, you know, Oxycontin is Oxycontin is an Oxycontin. Right?

And, so, a bag of heroin varies considerably.

And that's the concern about heroin overdose, you know, when people transition, is the dosing is not regulated or controlled.

So what happens with -- and I think, is that, the prescription-pill epidemic which might be waning because of I-STOP, or other trends that might be happening.

But the heroin epidemic is the thing that I most worry, is because there's going to be an inconsistency in the supply and the quality, which would only fuel other behaviors which get folks in trouble.

So back to the impact of the health care, is that this is a lifelong chronic, progressive disease which people can recover from.

The length of time in treatment is an impacting element in terms of people's overall recovery.

So, to really think about the fact that we have such increasing numbers of young adults who have a chronic, progressive relapsing disease, starting at 16, 17, 18, and 19, now that's going to project over their lifetime.

That's going not just affect us in this

budget year or this funding year, but you're going to talk about, this is going to be a protracted experience for us as a state and a community.

SENATOR BOYLE: Thank you very much.

And let's just ask, I'm asking about the insurance aspect of this:

So, now, can you tell me how your patients are paid for, and what's the process to come in?

You argue with the insurance company for a couple days and then you finally get coverage?

Or how does that work?

KAREN CARLINI: Well, I think one thing that's important to note, is some of us aren't necessarily collecting insurance.

Remember, we provide residential services.

SENATOR BOYLE: Right. Well, however it is, yeah.

KAREN CARLINI: So how that's happened, up until now, is through State aid, and, you know, other third-party funding that we've tried to secure to make that happen.

The process for the insurance companies varies from one insurance company to the other; and it depends. It is never close enough to what the cost, you know, should be, or what the prescribed

visit should be, you know.

And I think Gary probably should talk about this a little bit more, in terms of what happens for you in the process. If you don't mind?

GARY BUTCHEN: No, that's fine.

Well, we're in a unique position because we're a private program. We receive no funding.

So, we're dealing with managed-care companies every single day for everything that we do, and we have been for 20 years, so we've seen the genesis of managed care since its inception.

Theoretically, as an outpatient system of care, the managed-care companies would want to use my level of care as opposed to residential or inpatient or even detox.

But even at the outpatient system, it's an argument.

So we have clinicians, physicians, psychologists, who do full-blown evaluations on patients. And when we determine that someone needs a higher level of care, there's no better expert in the room at that moment than us.

We're on the phone with the insurance company, and it could be a-managed company based in Salt Lake City, or Philadelphia, or anywhere around

the country, and we're arguing with a nurse who hasn't seen the patient; we're arguing with a physician who, by the way, is not a an addiction psychiatrist, it could be a podiatrist; who's telling us what level of care.

"Try to hold the patient in your outpatient system."

Or, "We'll give you one to two days of detox, and then we want them back into your ambulatory detox to manage the mild to moderate withdrawal symptoms."

So we're saying to them: So you know that you're going to send me back a patient who's going to be uncomfortable, you're not going to allow them to complete their course of care, and I am supposed to pick up the pieces?

That's, if, they even come back into my door, as opposed to going to cop on the streets again because they're horribly uncomfortable.

So we deal with this issue every single day.

We offer the intensive-outpatient level of care, also.

And I know that you've probably heard testimony from around the state about how difficult it is to get people into detox or rehab.

We can't even get them authorized for the intensive-outpatient level of care.

They just want them in standard outpatient, and then the old argument, let them go to a 12-step program.

SENATOR BOYLE: Give me an example of the difference between regular outpatient and intensive outpatient.

What kind of service --

GARY BUTCHEN: Intensive outpatient is -- should be at least 9 hours a week, or more.

We offer it 5 days a week, 3 hours a day; so it could be up to 15 hours. And that's, theoretically, a step down between the rehab and standard outpatient.

Standard outpatient is psychotherapy, 45-minute session once a week. A couple of groups, 60 minutes, 90 minutes, once or twice a week.

SENATOR BOYLE: Right.

GARY BUTCHEN: So it's a step down in the continuum.

So we're offering that buffer level between residential and outpatient. And that was created back in the early '90s by managed care, because they didn't want to pay for the residential-treatment

component.

So it became a level of care that the managed-care companies created.

SENATOR BOYLE: Regarding the -- now, any you take Medicaid or -- any facilities?

GARY BUTCHEN: Yes.

SENATOR BOYLE: Okay.

GARY BUTCHEN: On a fee-for-service basis.

SENATOR BOYLE: Any trouble --

GARY BUTCHEN: Outpatients.

SENATOR BOYLE: Just outpatients?

GARY BUTCHEN: Any outpatients not in the residential-treatment program.

SENATOR BOYLE: Any trouble with coverage of that, or arguing about --

JAMES HOLLYWOOD: In the Medicaid, or --

SENATOR BOYLE: Yeah, Medicaid. I'm sorry. Medicaid, yeah.

JAMES HOLLYWOOD: I'll defer to you.

KAREN CARLINI: No, not necessarily. I mean, there aren't problems with accessing treatment.

If someone is on Medicaid and they come into our program, we're able to bill for that.

The issues with Medicaid have nothing to do with people being denied treatment as a result of

being on Medicaid.

I think that's what you're asking?

SENATOR BOYLE: Yes.

JAMES HOLLYWOOD: Except the concern is now, we're -- this -- so, substance-abusing population had a carve-out, which is no longer going to exist. And as we move to managed care, managed Medicaid, then we're going to be subject to --

KAREN CARLINI: We'll experience the same problems with managed care. It is important to say that.

With straight Medicaid, we don't have the kinds of problems that we anticipate with managed care that Gary's program already experiences.

SENATOR BOYLE: That was my question: So you're not experiencing it yet, but you may --

KAREN CARLINI: We're not yet, but, yeah, we will.

I think we anticipate the same thing that everybody else is experiencing now.

SENATOR BOYLE: I mean, obviously, one of the big questions is, ObamaCare comes in, and addiction services are supposed to be one of the 10 areas covered.

How much, and what limits are going to be put

in place with that, is going to be a question.

KAREN CARLINI: Right, we're very -- yeah, we're very concerned about that.

We're very concerned about co-pays.

We're very concerned, you know, yeah, about limits on length of stay. And visits.

WILLIAM FUSCO: We would also like to say that the block grant certainly has been a major part of the funding for the residential programs. And we would like to see that continue. And, of course, the State aid to localities.

They really are the umbrella. That's really the safety net.

KAREN CARLINI: Yeah, I think that that's important to say, because, while I say that, currently, we don't have issues with Medicaid in terms of the treatment, we would never be able to support our program solely on Medicaid.

So -- and especially our program, and maybe some others, with younger people, many aren't on Medicaid anyway.

So we have, about, 40 percent of our population are on Medicaid in the outpatient program. And that's certainly not a lot.

SENATOR GOLDEN: The other 60 percent?

KAREN CARLINI: Private insurance, that we're really not able to access enough, you know, to support the program.

Some are getting on now. There is a little bit of a difference with ObamaCare.

But, the private insurance, we haven't been able to access private insurance at this point.

SENATOR GOLDEN: Samaritan, James, your situation?

JAMES HOLLYWOOD: So, the residential-treatment programs are funded, as Billy pointed out, by net-deficit funding, which is State -- uhm, uhm --

KAREN CARLINI: State aid.

JAMES HOLLYWOOD: -- State aid, comes with a block grant. And that's a part of the match.

The other part is local DSS supports through congruent care level to funding, from both the County or the City, in that regard.

And back to, the number for us, it's a little bit over $20,000 a year per bed. And it's built, basically, on an economy of scale.

I mean, the programs are bigger than even the research might support.

So when we look at, not just the length of

time, also want to look at the size of programs. Want to look at how effective our programs could be, especially in light of the residential redesign, which is occurring right now.

And, you know, there's a hope that the residential redesign would look at incorporating insurance money alongside of State aid and congruent care support.

SENATOR GOLDEN: Is there anybody on that?

Is there a task force on that?

How's that being created?

JAMES HOLLYWOOD: It's a task force led by OASAS and a number of providers.

SENATOR GOLDEN: Are you on that?

JAMES HOLLYWOOD: Samaritan Village is represented on it, yes.

KAREN CARLINI: Yes, TCA -- regional TCA and OASAS co-chair the group. And it's a pretty wide representation.

SENATOR GOLDEN: And you're comfortable the way it's moving?

JAMES HOLLYWOOD: We're encouraged by it.

Uhm -- and the big thing --

SENATOR GOLDEN: That's a good word.

JAMES HOLLYWOOD: Yes, we are encouraged, the

fact that residential treatment is being -- is looked to be -- being preserved as part of the treatment continuum.

For the severely addicted, the removing people from their social environment and bringing them to a much more therapeutic environment has benefits.

And as other panel members have pointed out, you know, the length of time, six to nine months seems to be much more impactful, especially for a younger population.

For folks that we serve, who are adults, you know, the length of stay, again, anything over 90 days is helpful.

The worry that we have, is that we become -- we become like an inpatient rehab, which is more of a 30-day model. You know, that we'll get pressed to drop below even the 90-day that we're hoping to at least get out of the residential redesign.

Because that, for us, is a bare minimum. You know, that's sort of the minimum dose, effective dose, of residential services for severely addicted individuals.

SENATOR GOLDEN: I'm not sure we can do this, but I'm going to ask my Chairman. I guess we'll

have to sit down and discuss this.

I don't know if there's any way we can support some of your recommendations, from this Task Force. And, I guess we'd have to look to the Committee Chair, and to the chair -- the chair members, as, you know, which ones we could support, if, in fact, we could support.

JAMES HOLLYWOOD: Certainly.

Thank you.

SENATOR BOYLE: Any other questions from the audience?

Yes.

KEN: [Not using a microphone.]

How you doing?

I'm Ken [unintelligible] from Serendipity 1.

I have two things to say, real quick.

SENATOR GOLDEN: Louder and slower.

KEN: Two things to say.

One, I want to reiterate how hard it is to get into detox.

I got turned away from five different hospitals on Long island, and I was told to go home and don't use.

And that's not happening for a person who has an addiction problem.

SENATOR GOLDEN: I'm not going to pick on my friends from Long Island, but Lutheran Medical would take you in, like that [snaps fingers].

Go ahead.

[Laughter.]

KEN: I've been to quite a few.

The other thing, as far as how long you need to be in rehab, or a long-term treatment facility, the longer, the better.

For me, I -- that's why I'm in a one-year program, because I know I need it.

But, for a lot of people I know out on Long Island, that have jobs, and, you know, actually work and just aren't homeless, you can't just take a year off from work.

So having the 28-day programs, or the short, the Band-Aid programs, as they said, still available is definitely necessary, too.

So you want to keep that in mind, not to try to cut them out.

But the long-term is definitely vital, too.

SENATOR BOYLE: Thank you?

JAMES HOLLYWOOD: If I could just add --

SENATOR GOLDEN: Go ahead, James.

JAMES HOLLYWOOD: If I could just add to

that, and I appreciate you bringing up that point:

I think we need to have -- look at all levels of care as being effective. Right? And we look at what's -- you know, what is needed for that individual.

And, clearly, people who are employed and need to go back to a supporting a household, and themselves, and they have those means, they might actually be indicated in terms of their social connectedness, and that they could return to the community.

But back to what Gary said, is then, maybe, it's an intensive outpatient program; one that could be intensified in services that support working folks, because it's the aftercare. It's not the -- you know, detox works.

But it's really the aftercare that follows up around the detox that will ensure that it sticks.

So -- so it really is, you know, there's no one model that works. If it was, we would have maybe discovered it and not have a panel today.

But, it's really going to be, I think, a broad-based approach, looking at varying levels of care: medication-assisted treatment incorporated in that. Naloxone incorporated, even in

treatment-provider programs. Providing education to our patients and our family members.

So, I support what was said.

SENATOR GOLDEN: Narcotics, obviously, is a terrible disease. And, whether it's Oxycontin or hydrocodeine [sic] or heroin, I don't know, there might be one or two in there.

Any of you that progressed quickly enough to using a needle, in the crowd, that would want to?

[Some audience members raise hand.]

SENATOR GOLDEN: Why don't you just -- anybody want to talk about it, how long it took them?

Go ahead. Right there.

AUDIENCE MEMBER: I did Oxycontin for, like, six years, I would say, you know.

Lower? Higher? [Motioning with microphone.]

SENATOR GOLDEN: No, higher.

AUDIENCE MEMBER: I did Oxycontin for about six years. And once I progressed to heroin, I was -- ended up shooting heroin within a month.

And when you learn on the streets how much easier it is to, how much better it is, from everybody, they just -- it's just -- the talk about it, you know, nobody can resist it.

And once you start doing it, there's really no other way of, like, you know, putting it down, because once you get that sensation, I guess you could say, it never changes. You know?

SENATOR GOLDEN: And you're constantly chasing the high that never comes back?

AUDIENCE MEMBER: Yeah, you could say that, I guess.

It's more of, like, the -- just the fact that you think you need something that you don't actually need. You know, what I mean?

And until you are able to get away from it, which is what the long-term treatment centers are able to do for you, you know what I mean, is to put you away from your environment and away from, like, being on the streets, and stuff --

SENATOR GOLDEN: How did you get the help that you've gotten?

AUDIENCE MEMBER: How did I get there?

SENATOR GOLDEN: How did you get here?

How did you get to the facility?

AUDIENCE MEMBER: I actually got lucky, because I live on Long Island, and it was a lot harder for me to get to a program that was upstate. So my mom actually knew -- through a psychiatrist,

was able to get me into Dynamite.

SENATOR GOLDEN: Okay.

And how long have you been in the program now?

AUDIENCE MEMBER: Almost 13 months.

SENATOR GOLDEN: 13 months.

And how are you progressing?

AUDIENCE MEMBER: I'm doing fine. I haven't used or picked up anything in 13 months.

I actually just came down from the upstate facility, so now I'm in outpatient facility down here. And, you know, it's working. It works very well.

The people at Dynamite are just fantastic, with the way that the program works, you know. And that's really --

SENATOR GOLDEN: Give it to the -- the mic to the young man with the white suit on, right back there.

Right there.

You had your hand up?

Okay, I'm sorry.

Okay, whoever wanted to speak back there, go ahead.

CHALID HUSSEIN [ph.]: Would you mind if I --

SENATOR GOLDEN: Yeah, go ahead.

CHALID HUSSEIN [ph.]: Okay. Since I have it, I figured I might as well, anyway.

SENATOR GOLDEN: Closer to you.

CHALID HUSSEIN [ph.]: My name's Chalid Hussein [ph.]. I'm actually a member of Dynamite Youth right now.

I'm actually a member of the Bay Ridge community, as well. I have been for about 18 years.

And I relate a lot to a lot of things that were said here today, particularly, I mean, just the way prescription pills have kind of taken over my life, and the life of so many of my close friends.

Linda Sarsour that was speaking earlier, she mentioned a few deaths in the Bay Ridge community over the past --

SENATOR GOLDEN: How did you get to prescription drugs?

CHALID HUSSEIN [ph.]: My first time, I got it prescribed by a doctor. I was about 19 years old, I had gotten in a car accident. I was having acute knee pain, and he prescribed me ninety 10-milligram Oxycodone pills, without any instruction how to use them.

He said, "Follow the bottle."

And the bottle said, "Take every 4 hours, or take as needed."

But that's how I got my hand on them, initially.

I mean, after I become addicted, me and my friends, we started taking them out of our parents' medicine cabinets.

Just, any way we could get our hands on them.

Doctor shopping.

Just, everything, it just followed. It just became about, any way we could get them.

And it eventually progressed to heroin, once I found out about heroin, after doing it the first time. Just, after experiencing that initial high, there was just no going back to that --

SENATOR GOLDEN: Using a needle?

CHALID HUSSEIN [ph.]: Yes. Eventually I did, yet.

SENATOR GOLDEN: And how many of your friends were using -- went to needles?

CHALID HUSSEIN [ph.]: It's hard to give you a number, but almost every single person that I used the prescription pill with, that I ever used an opiate with, eventually ended up doing heroin.

SENATOR GOLDEN: And how many would you say

that was?

CHALID HUSSEIN [ph.]: Maybe, about, 20, 25 of my close friends.

SENATOR GOLDEN: And you all hung out in the same areas in Bay Ridge?

CHALID HUSSEIN [ph.]: Yes.

SENATOR GOLDEN: Okay.

CHALID HUSSEIN [ph.]: Two of them, actually, the most recent ones, the one that just left the hospital in a coma, and the one that just passed away.

I had about six friends, six personal friends, die this past year in Bay Ridge alone. Just overdoses of heroin.

SENATOR GOLDEN: What woke you up?

What brought you to the realization that you needed this program or you were going to die?

CHALID HUSSEIN [ph.]: It's hard to word this, but, uhm, I was lucky enough to go to the point of abuse, like abusing myself to the point where I realized I needed help.

I was sitting -- I was sitting in a jail cell on Rikers Island, at the bottom, at my rock bottom, when I realized I needed help.

And, I was lucky enough to get referred to

Dynamite, actually.

I was lucky enough to get referred to this program, where, I mean, just the model is so much more intense. It's not just, like, about taking the drugs away, because there's so much underlying the drugs.

You take that out of the picture, but there was just so much more damage that I had done to myself, like, emotionally, behavioral-wise, and, just, there's so much underlying the drug use that needed attention, that I was able to get the help.

SENATOR GOLDEN: Thank you very much.

CHALID HUSSEIN [ph.]: Thank you.

SENATOR GOLDEN: Do me a favor, anybody else wants to briefly, and you don't have to share.

I know honesty is a big part of this program.

We just want to see the importance of the program, and try to -- how the program has helped you.

JOE: My name is Joe, I'm 24 years old. I'm currently with Dynamite Youth Center.

I have been to countless detoxes, countless 30-day rehabs, 60-day rehabs.

SENATOR GOLDEN: How old are you?

JOE: 24 years old.

SENATOR GOLDEN: Go ahead.

JOE: My addiction started, I was 21 years old, I was injured in an accident. I was prescribed Oxycontin.

Within a month, I was, you know, addicted, bad.

Six months later I was IV'ing heroin, which led me to -- you know, in between that time period, I was in countless detoxes. I couldn't even tell you.

I'm a resident -- I was a resident from Staten Island.

Countless detoxes.

Landed me in my first rehabilitation center in Florida. I was there for 30 days.

Halfway house, my parents had continued to send me from one place to another.

I became homeless a dozen times, you know, in three different states. Bounced around all over the place.

I came to my realization 18 months ago. Walked into Dynamite.

I was in a shelter in Staten Island. I was sitting on a cot. I had lost everything.

I come from an upper middle-class family,

grew up good, good high schools.

You know, sitting on a cot, homeless, in the street, back in Staten Island, and had realized that I didn't want to live this way anymore. I was going to die. I had overdosed four times. I almost lost my left arm.

And, I'm 18 months sober now, due to long-term treatment.

UNKNOWN SPEAKER: Congratulations.

SENATOR GOLDEN: Very good.

[Applause.]

SENATOR BOYLE: Quick question, I'm sorry.

Describe the first time you tried heroin.

So you're injured, you tried Oxycodone, opioids.

The first -- could you say, Well, it's cheaper?

Did someone say, Hey, we can get it, this thing, for the same high?

Or how did it work?

JOE: Well, for oxycodone, Oxycontin, at this point, at $25 a pill, I mean, my habit had increased to $200 a day.

Now, I have been -- you know, I was let go. I had worked for a family business. I was let go,

because of stealing, and other, you know, things I was doing.

So, I mean, to support that was -- you know, it was astronomical, which had led me to, you know, a cheaper -- you know, a cheaper high.

SENATOR BOYLE: Financially.

JOE: Financially cheaper, you know, which had brought me into -- you know, dealing with pills, you're dealing with an upper -- you're dealing with a middle-class group of people, growing up on Staten Island.

Doing heroin, and other drugs that I had explored, it led me into bad places. You know, bad areas.

You know, so...

SENATOR BOYLE: Thank you.

JOE: You're welcome.

SENATOR BOYLE: Good luck.

SENATOR GOLDEN: If there's just two more, if we can, because it's near our end.

And do me a favor, again, just be brief, and help us out, where you think you can give us a description of how we can be more helpful, as a Task Force, to get more help for you, and for your family.

LEEANN [ph.]: My name is Leanne. I'm 25, and I'm part of Dynamic Youth.

And, you were speaking before about, like, how -- you were wondering if marijuana was a gateway drug, and that's exactly how I started.

I started drinking and using marijuana, and also with the Vicodin, that was the opening for the opioid addiction for me.

SENATOR GOLDEN: Did you know Vicodin was heroin?

LEEANN [ph.]: No, not at the time.

At the time, I didn't have an injury. I was just experimenting. And a lot of, I guess it was peer pressure, were taking it. And once I did that, it just led on and on.

It was more of like a tolerance thing for me, where that wasn't enough, so I moved to Oxycontin, and then eventually to heroin.

And for me --

SENATOR BOYLE: Was that a financial thing for you, too --

LEEANN [ph.]: Absolutely.

SENATOR BOYLE: -- because you realized Oxycontin was so much more expensive?

LEEANN [ph.]: Absolutely. I mean, it was a

tolerance thing, where I would have to -- at the time, I felt like I needed it, or else I would, you know, withdraw.

And, so, it was a financial thing, it was a tolerance thing.

And I've been to countless 28-day rehabs, 30-day rehabs, where I would get out and I would use right away, because I felt very awkward in society.

I was just taken out for a little bit, just to, pretty much, for me, I feel like it's just getting the drugs out of your system at that point.

Where, someone said that -- you know, my mother wanted me to go in, and I was still battling, like: I don't need to be here. This is not me, I'm not like them.

You know?

So, with the long-term treatment, for me, I feel like there's no other way, than to go away for a while, to get out of -- see, I'm from Staten Island. I needed to get away from there.

And, also, it's long enough for me to feel, like, comfortable without using, because I've been using for so long, that I can interact with other people. I can learn how to, like, just be in life without, you know, using after so long.

And then, coming down, also, the big part for me was maintaining it. Going to, you know, the outpatient part, you know, five days a week, and adjusting back in, because that's where I mess up, where I feel uncomfortable, and stuff like that.

You know what I mean?

So, for me, to get into Dynamite, it took an arrest, which, honestly, was -- it was a bad time in my life, but it was the best thing that ever happened to me, because it got me in; it opened my eyes.

And I feel like that's a big thing for a lot of people, sometimes that is case.

And, unfortunately, that was my case, but, it was the best thing, you know, that ever happened to me.

SENATOR NOZZOLIO: When you were arrested, what was the next step?

LEEANN [ph.]: The next step was, they already knew my history of me trying to get clean before; going into rehabs was not working.

And they said: You know, you can't just do a 28-day. It doesn't work for you.

So they said, you know, "You should go away for a while," and they told me to go away for

nine months.

In Dynamite, you know, my nine months went up, and I was, like, "I'm not leaving. This is great. You know what I mean? I'm not going to leave this place. It just saved my life, and I'm going to continue with it."

So that's what I did at that point.

But, I don't -- you know, I could have gotten to a worse place, if that -- if I didn't get stopped there. You know, I feel like it was like a sign, or something. That's how I look at it.

SENATOR NOZZOLIO: Thank you.

SENATOR GOLDEN: Well, coming back to you guys in a minute, anybody else wants to share?

SENATOR BOYLE: Got one more back there.

SENATOR GOLDEN: Okay.

We're going back to the panel, shortly.

If there's anything that you think we left out, that we should be focused on, please, give us -- right after this person, give us some direction.

Go ahead.

PATRICK: Hi, my name is Patrick. I'm 21 years old, and I am a member of Dynamic Youth Community.

And the thing I wanted to stress the most was about how the insurance companies treated me, because Dynamic Youth Community is my 17th program.

I started at the age of 16 with the opiates. I was in lacrosse accident, and I shattered my thumb, and the doctor, he prescribed me Roxicodone, and he said I had "the good stuff."

Didn't even -- which I thought was absolutely terrible. He didn't explain to me how addictive the substance was, or anything about that.

I mean, I don't even know if he was educated.

But the way it worked with the insurance companies was, I go to a 30-day program, and then they would say, "No, you need two weeks," even though it was against what the -- what they had said -- what the rehabilitation center had said.

So I kept going back and forth through that, and it ended up being a disaster.

I went from program to program to program, until finding a long-term treatment program, which showed how to -- along with the addiction, how to rebuild your life skills, which someone who became an addict as young as I did, did not achieve.

So now -- now, aside from the addiction and

learning how to stay sober, and learning how to stay -- learning how to have fun again in recovery, now I know how to hold a job, how to --

UNKNOWN SPEAKER: [Inaudible.]

PATRICK: And, I just wanted to know if there's any steps that you guys are taking in order to go against what the insurance companies are saying? Or, with the funding, how it's going the work towards long-term treatment?

Because, obviously, the success rates with that, with extreme cases like me and some of my peers that are here, what's going to happen?

What are the steps that are going to be taken to go forth with that?

SENATOR GOLDEN: Well, I believe I'm going to let the Chairman speak to that in the a moment.

But I'm going to tell you, the more I listen here, and the more I see you stand up and tell me how many times you've gone to detox, how many times you've been in programs, how long it took you to finally get it, and to get the help that you needed, it looks like it was extremely more costly, had we made the investment up front and put you into a program that would have fixed you and put you on the right track in the first place.

I think it was much more costly, the path that many of you have taken, unfortunately.

But I guess that comes to the professionals, and understanding and keeping the -- those different people that are affected in the program.

I guess, then, how long that program lasts is -- and you guys have to make the diagnosis, as to what the -- you know, what that deadline or what that timeline is.

So I do believe that, the more we look at this, the more we hear, the smarter thing to do here is to make the investment up front, and sooner.

Of course, having to deal with our insurance companies and Medicaid and the redesign team here in the state of New York, as well as the Obama health care, is going to be a lot more difficult to do than what I've just said.

Chairman.

SENATOR BOYLE: Yes, Senator Golden, I couldn't agree more. And, we've heard this over and over again, and whether it's 4 rehabs, or 17, it really is, the system is not the most efficient that it can be, in terms of tax dollars, and helping young individuals, such as yourselves, to go through recovery, and an important thing Patrick said,

learning the life skills that you weren't able to the first time.

And that's exactly what we're going to look to do as part of this Task Force.

And when we issue our report, which is going to come out June 1st, you can look at it, and I can promise you young people that what you said here today is going to be part of that report.

And we've learned a lot from you.

I appreciate it very much.

Our panelists, if you'd like to, any final comments or thoughts?

SENATOR GOLDEN: Mr. Fusco, I know you got a word or two.

[Laughter.]

GARY BUTCHEN: That's why I'm going to go first.

You have a Herculean task in front of you.

There are so many moving parts to this problem; from the physicians who spoke earlier about the medicines that are available to us; versus the stigma; to the woman who spoke earlier about the debacle in sober homes; to the -- really, the Mason-Dixon Line between the Medicaid and managed Medicaid versus pure commercial insurance plans; and

what the juggling act that all of us sitting here have to deal with every single day.

The system that exists, and the variety of programs that we all offer, does have remarkable outcomes, when the people who have tried 17 times; or 16 times, try the 17th time to get in.

That should never be the case.

What I'm imploring you to do, is really take a good hard look at "medical necessity," regardless of whether it's 4623, or any other version of it.

Because, if this panel, if we were replaced by the medical directors of the managed-care companies operating in New York State, they would convince you that they've got fantastic policies that dictate medical necessity for the treatment of addictions.

The problem is, they're all different, they're all proprietary, and they're not shared with their own provider network unless you FOIL them.

If New York State puts on the books a definition of "medical necessity" that they all have to be held accountable to, then what we were talking about earlier would bear better results.

SENATOR BOYLE: We are going to. That's one thing I'm pretty certain is going to come out of

this in terms of insurance.

When we deal -- when I've talked to 10 different insurance companies with 10 different definitions of "medical necessity," and all of them are trying to sneak their way out of coverage, basically, we're going to put their feet to the fire, I can promise you.

And thank you for those comments.

SENATOR NOZZOLIO: Well, in our -- and you mentioned this earlier, Mr. Butchen: You pay them now or you pay them later.

I mean, that's the kind of issue that, you have a problem that can be dealt with financially, appropriately, and significantly now; or we pay more because the problem wasn't resolved.

KAREN CARLINI: Last week I attended the National Prescription Drug-Abuse Conference in Atlanta. And for three days, they threw all sorts of statistics to us, many of which we know, and we know in New York, it's happening all over the country.

But one of the things they talked about was, just in this last decade, 125,000 people died from overdose from just hydrocodone.

And that number was just compelling to me.

For all I know and for all I hear, that number was compelling, because they talked about, if we did a moment of silence for those 125,000 people, it would take three months to accomplish;

And that it's, also, twice as many people who died in Vietnam.

And when we think about the spillover from Vietnam, and everything that's happened as a result of what people suffered in Vietnam, where are we going to be as this problem continues?

The thing that made me feel good, or what I walked away with, was in every workshop, every plenary, every session that I attended, everyone had the same message about collaboration.

And I think we're finally there.

I can't thank this panel enough, and what's happened, you know, in the New York Senate, in terms of pulling us all together as a group, and every component of it, because, without collaboration, this is not going to get solved.

And as Gary said, there's so many different pieces. And we're trying to balance that, as well.

I mean, to us, it's like a moving machine every day; it changes, and what we have to do.

So I think what -- maybe what we're asking

is, that you be sensitive to the fact that we don't overregulate.

You know, we don't want to look at, you know, and talk about law enforcement, we want to make sure that those that need treatment get treatment.

Those that -- you know, so we look at that.

When we look at prevention, we look at education.

We look at what we have to -- we do have to mandate people to do, but that you lean on the treatment community to help provide that, because of our experience.

Like Bill said, we're 43 years.

You know, I'm with the program 42.

Bill's with, from day one.

So, we've certainly seen it all -- well, no, we haven't seen it all, unfortunately.

This was a lot for us. More than we had seen in the 30 years in the past.

So, we have work to do.

But, again, I thank you, and appreciate the effort.

SENATOR BOYLE: Thank you Karen.

Thank you very much.

Yes.

RUCHAMA CLAPMAN: I'd like to touch on the issue of family.

The families -- once the young adult is put into rehab, the families must get educated, whatever they're learning in the rehab, so when the kid gets out, the family recognizes the red flags, et cetera.

But, prevention is the number one message that I'd like to leave today with; is that, a regular parent, after interviewing 15,000 parents, I interview every family myself, and the one thing for sure, they don't know the connection between their medicine cabinet and heroin, opiates, or anything.

So, ads, user-friendly, to a regular mom and dad that are not in the drug community, is very important.

And, also, prevention in the elementary schools, to make it more user-friendly, so that it gets translated from their point of view; not from adults and us that are sitting at the tables.

Thank you very, very much for today.

SENATOR BOYLE: Thank you.

SENATOR GOLDEN: Thank you.

JAMES HOLLYWOOD: And all I can do is reiterate the -- what the panel said here, is,

really, it's a broad-based approach that will soften, or try to solve, this problem: from education, from prevention, from the use of Naloxone and first emergency responders for the families members, for those suffering with addiction, as well.

And, really, to look at the need for a spectrum of treatment intervention.

Community-based care, community-based detox, does work and is effective.

Medication-assisted treatments are important.

They mentioned it earlier, the first panel: methadone and Suboxone and VIVITROL, and the like, finding the right mix for people.

And an important thing to recognize the need for, the severely addicted, is a long-term residential treatment does work; has been an effective part of the New York State model in treating addictions.

You know, over the past 30 years, starting with the DTAP and TASK initiatives, have solved a great problem of court diversion, and the need for court diversion; and, so, it has served the state well when that was a crisis, when crack cocaine was a crisis. When jails were overcrowded.

And I think it will serve a great role, moving forward, during this epidemic, is to be able to provide long-term care for those who need it, as the members of this audience sort of testified to.

SENATOR BOYLE: Thank you.

WILLIAM FUSCO: Senators, could I just say, back in 2007, Jerry Kasar [ph.] --

SENATE A/V PERSON: [Not using a microphone.]

I don't mean to interrupt. We've got to get all this in, and then change the tape. And then you can --

SENATOR GOLDEN: Two minutes.

WILLIAM FUSCO: I've got two minutes, that's simple.

KAREN CARLINI: No, no, no. He has to change the tape in two minutes.

WILLIAM FUSCO: Oh, two minutes to wait?

We have a couple kids that can sing back here.

SENATOR GOLDEN: Well, I got to tell you, I got to give all these kids credit.

I tell you, you guys are the lucky ones.

Right?

[Applause.]

SENATOR GOLDEN: How many kids don't make it?

How many people, and how many more wakes are we going to go to?

How many more families' hearts are going to be broken?

So, God has been good and gifted you.

And I thank you.

And I thank all the different providers here today for the great work that they've been able to do, to return these young men and women back to their families and to the society, and to allow them to go forward and to be productive.

So, we thank you, too, this panel, for all its good work that they've done, and they continue to do.

Give this panel a round of applause, and the previous panels.

[Applause.]

WILLIAM FUSCO: I did want to mention, Senator, that back in 2007, Jerry Kasar and myself, under your leadership, went to Albany and talked about the tremendous amount -- the tremendous percentage of prescription drugs, young people that were coming into our program.

And at that time, we were told that nobody can tell the AMA what to do.

And, we've been on a mission ever since, trying to say, as we saw what was happening in our communities.

And I do have to say, I think one of the things that we try to tell the young people here, who don't necessarily come forward all the time, that they're contributing.

That it's time that people come out and say what's going on.

And that's part of the solution.

And I think they see themselves as part of the solution now.

Thank you.

SENATOR GOLDEN: For those that testified here today, I just want to say, all of my colleagues here today that came in from across the state, take this very, very seriously.

And they're all approachable.

So if there's something that you did not get out, that you're -- either you're one of the ones that testified, or if you're one of the audience, please, contact any one of us.

The Chairman will make sure that it's taken into consideration, any of your thoughts that you have that that may not have been brought up, that

you -- you know, you're walking out the door and said, "Gee, I should have said this."

Please, we are all approachable.

SENATOR BOYLE: Thank you.

Mr. Vice Chairman, any final comments?

SENATOR NOZZOLIO: There was one lady that asked to speak, in the blue? You rose your hand a couple of times?

I don't know if anybody saw you behind the post here, but I did.

AUDIENCE MEMBER: I practice in Bay Ridge. I'm a medical provider. I know what's being done to look into --

UNKNOWN SPEAKER: They can't see you.

AUDIENCE MEMBER: Oh.

Hello.

I'm not a very good public speaker.

But I know what's being done to -- in terms of monitoring pharmacies and physicians, and we're aware of this.

What is being done to get the drugs off the streets?

If we had no heroin, would we be even having this discussion today?

SENATOR NOZZOLIO: I don't know if you were

here when the prior panel was here --

AUDIENCE MEMBER: I was.

SENATOR NOZZOLIO: -- but, Attorney McGoldrick and a detective went through a laundry list of items that are ongoing deficiencies, not necessarily in the punishment statutes, but in the investigative areas.

And that we're going to be working, in terms of helping eliminate a lot of the supply that the taxpayers actually are paying for, in putting it out into the streets. Not the taxpayers, but other unscrupulous individuals are putting it out into the street.

And I think that's certainly something.

And our mission, stated by Chairman Boyle, is threefold:

It's prevention, first;

Treatment, second;

And, prosecution, third.

And that's an approach, a lot of moving parts, as Gary said, but that's what we're focused on.

AUDIENCE MEMBER: Do you feel that it's working?

SENATOR NOZZOLIO: Obviously, if it was, we

wouldn't be here.

I think much of it's working.

When I see our young people in the center here, standing up and saying they're drug-free, that gives us hope.

And that's -- it can be done, if it's done the correct way.

And that's what you all have given us evidence about today.

But as our law-enforcement officers have given us evidence today, that it's a problem where a lot more resources need to be deployed to defeat it at that end.

Again, it's many moving parts to this very important problem.

And thank you, from my personal standpoint, for adding to the discussion in a very, very great way.

Thank you.

SENATOR BOYLE: And I'd, too, like to thank you, Vice Chairman Nozzolio.

And, Senator Golden, thank you for hosting this forum.

Thank you to our panelists, and each of the panelists.

And to the young people, best of luck in your recovery. We'll be praying for you.

And, thank you for everything. We got a lot of good ideas out if this.

And as Senator Golden said, if you think of something you didn't remember to say now, contact our office, because we've got until June 1st.

Thank you very much.

[Applause.]

(Whereupon, at approximately 12:42 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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