

A photograph of a woman with long blonde hair hugging a child with long blonde hair. The woman is wearing a grey sweater and the child is wearing a blue and grey patterned sweater. They are both looking towards the camera with a slight smile.

The Heroin Epidemic

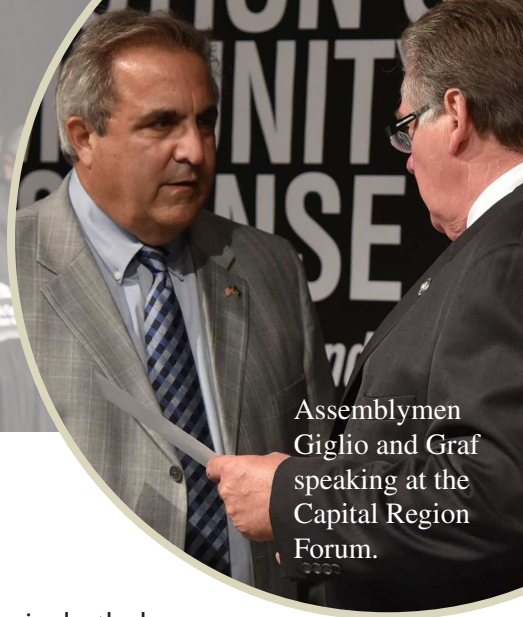
A Report on Heroin Use,
Treatment, Prevention &
Education Efforts in NYS

From the Assembly Minority
Task Force on Heroin Addiction
& Community Response

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Assemblymen Giglio and Graf speaking at the Capital Region Forum.

EXECUTIVE SUMMARY



According to the federal Centers for Disease Control and Prevention, heroin deaths have quadrupled in the decade between 2002 and 2013. This increase has occurred across all cross sections of society, including men, women, all races, income levels, and most age groups. In 2013, there were more heroin overdoses in New York City than homicides, according to the city's Department of Health. According to the federal Drug Enforcement Agency, New York accounts for about 20 percent of federal drug seizures every year. The Atlantic Magazine reported in its October 2014 issue that the newest front in the war on drugs is the battle with prescription opioid painkillers. The plentiful and inexpensive nature of these drugs in the 1990s resulted in a tripling of deaths due to overdoses in the United States. Some of this increased drug use was attributed to changes in medical thinking beginning in the 1980s, that all forms of pain (including chronic pain) should be treated more aggressively and that newly-developed controlled-release opioid medications could be used to treat pain without significant risk of addiction. In the late 1990s and 2000s, many states passed legislation that controlled the ability of patients to visit multiple prescribers in order to receive multiple prescriptions for opioids and other controlled substances (popularly known as "doctor shopping"). As prescription opioids became more difficult and more expensive to acquire, prescription opioid addicts started turning to heroin. In New York alone, in 2014, there were more than 118,000 admissions to in-state treatment programs for heroin and opioid addictions, a 17.8 percent increase over 2009.

As a result of this problem, the Assembly Minority Task Force on Heroin Addiction & Community Response held seven forums throughout the state to gather information from local officials, health care providers, parents of addicted children, and individuals who were addicted to heroin, on the crippling effects of addiction, the cost to communities, and the cost to families. Assemblyman Joseph M. Giglio, Ranking Minority Member of the Committee on Correction, and Assemblyman Al Graf, Ranking Minority Member of the Committee on Codes, traveled the state with members of the Assembly Minority Conference to listen to concerns and gather information in an attempt to bring about common-sense changes to deal with the heroin epidemic facing the state.

The testimony provided at the forums highlighted the fact that a multi-pronged approach to solving this problem will be needed. Hospitals should not be allowed to release an individual who was administered naloxone (often referred to by the brand-name Narcan), an opioid reversal drug, for a heroin overdose within mere hours of receiving the antidote drug. Likewise, addiction information needs to be readily available to parents when they find out their child has an addiction problem. Preventing addiction through education was a common theme, from health classes, as early as 3rd grade, to middle and high school, to professional development classes for doctors and nurses about the addictive nature of prescription drugs. Several of those who testified said the medical community should have a uniform standard for the amount of opioids prescribed for any one type of pain management to ensure individuals aren't receiving too much medication. However, the vast majority of the discussions centered on the actual process of getting off drug addiction - detoxification, rehabilitation, and recovery - and living a productive life.

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Detoxification is generally seen as the first step in the long recovery process, and the startling lack of facilities and programs was a great concern to forum participants. In some cases, parents said they had their children arrested just to get them into detoxification programs. Addicts characterized the process of detoxification as imagining the worst flu you have ever had and multiplying that by one hundred to get an understanding of the physical pain felt, right down to the marrow of your bones. Individuals struggling with addiction are all too aware that the moment they shoot up heroin, all of those withdrawal symptoms immediately go away. Throughout the forums, those who testified estimated that the detoxification process took from seven to fourteen days; however, some insurance companies presently allow fewer than three days for detoxification. To that end, addicts are being discharged at the height of experiencing withdrawal from addiction and predictably start using drugs again. Additionally, many hospitals are closing their detoxification centers because of substandard Medicaid reimbursement rates. The state must reevaluate the present rates of reimbursements and make additional funds available to encourage hospitals to (re)open and maintain detoxification facilities. Families also said that detoxification centers have discriminated against patients by not providing services based on age. At one forum, parents of a 14-year-old girl testified that the hospital informed them their daughter was too young for the hospital to admit for detoxification, and they were left with no choice but to take her home and detoxify her themselves. Before a detoxification center can release a patient to a rehabilitation program, the detoxification center must create an individualized long-term care plan under the supervision of the Office of Alcohol and Substance Abuse Services (OASAS).

Following detoxification, rehabilitation programs for addicts are fraught with problems, from an unwillingness of insurance companies to pay for inpatient treatment, to the lack of treatment programs resulting in long waiting lists, to the high cost of drugs used to help treat heroin addiction. Rehabilitation centers should accept patients through OASAS and let OASAS act as a clearinghouse for available rehabilitation beds. During the course of treatment, rehabilitation centers should create individualized recovery plans for each patient to help them maintain their sobriety. Rehabilitation centers should coordinate the transfer of patients to a licensed recovery program. To prevent the operation of substandard rehabilitation centers, the state needs to implement an accreditation process, much like those for hospitals or nursing homes, to ensure professionalism and a uniform course of treatment provided. Upon the patient's successful completion of a rehabilitation program, the center providing the services will coordinate the transfer of the patient to a licensed recovery program.



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While detoxification and rehabilitation are imperative, there has to be a long-term recovery (after care) plan for addicts to prevent them from relapsing into drug use. At the forums, many recovering addicts expressed concerns with the way they were released from treatment programs with no clear, long-term plan for recovery. Licensed recovery providers should assist the patient in maintaining his or her individual after-care program either in the form of an outpatient program, sober home placement, or halfway house setting. Each program must have on staff a certified drug counselor who will take the lead in maintaining the patient's recovery program. In order to be a licensed recovery provider, the applicant should be required to submit a detailed program plan encompassing the above responsibilities to OASAS, which will be responsible for monitoring compliance.

Finally, the criminal justice system utilizes varying penalties when handling heroin dealers compared to other drug dealers. Whether it's the amount of drugs in the possession of a dealer that determines whether he/she can go to a drug diversion program or whether a dealer should be held responsible for the death of a customer, there are a lot of inconsistencies in current Penal Law.

The cost of heroin addiction can't be measured solely by what the state and local governments allocate for drug rehabilitation and criminal justice programs. Heroin and opioid addiction takes an untold hardship on families who don't know what to do with a relative addicted to heroin or other opioids. Stealing from family and friends to maintain an addiction, the embarrassment of a family member with an addiction, and the loss of a life from addiction all take a toll on families and communities. As many law enforcement officers said at the forums, "We'll never arrest our way out of this problem."

This report highlights significant problems facing the state and offers a number of potential solutions. It looks at the problems addicts and their families face in their attempts to get off heroin or other opioids, as well as the need for education to begin earlier in schools so that children are more aware of the dangers of drugs. Presently detoxification, rehabilitation, and recovery are treated as three separate and decoupled programs. It became apparent during the course of the forums that these three phases must work hand-in-hand and in conjunction with one another to facilitate successful treatment for addiction.



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Prevention & Education

While this report mainly focuses on taking steps to treat heroin or other opioid addiction, this section focuses on preventing individuals from using or becoming addicted to heroin or other opioids. The road to recovery is both long and arduous, and while people suffering from heroin addiction should certainly seek treatment (which this report will outline); it would be much more desirable to avoid heroin or other opioid use and addiction entirely from the start. Unfortunately, as with any addiction, there is a high rate of relapse among those who do not seek or fail to complete treatment and stick with a lifelong recovery plan. Focusing on prevention would lessen the rate of relapse by exposing fewer people to heroin from the outset.

According to professionals working to combat the heroin and opioid epidemic, both in the health and corrections fields, the best way to control and attempt to end the epidemic isn't to simply treat people, but to steer people away from trying heroin or other opioids in the first place. Unfortunately, once an individual is addicted to either prescription opioids or a lethal drug like heroin, it is an intense process to fight and beat the addiction. The ability to prevent people from becoming addicted to prescription opioids would be the most efficient course of action, since medical professionals have found it common that some heroin addicts started by using, and then subsequently abusing, prescription opioid pills.

This could be due to myriad reasons, such as doctors overprescribing pain medication or the person simply becoming addicted through the prescribed usage. For example, in some cases doctors prescribed 30 or more pills when only a few were needed before switching to an over-the-counter medication such as aspirin or acetaminophen. This unused medication becomes a venue for addicts to obtain opioids. Once an addicted individual loses access to such medication, they may riffle through friends' and family members' medicine cabinets in order to steal leftover medication that they were lawfully prescribed, and either never disposed of or finished using. Once individuals who are addicted to prescription pills can no longer gain access to them or afford paying up to \$60-\$100 per pill on the street, they find that heroin is a cheaper alternative.

Additionally, many parents and addicts presented testimony at the hearings indicating that their road to addiction began by being prescribed opioids for sports-related injuries. Two former soldiers with service-related injuries reported being over-prescribed opioids. The common theme when receiving these medications was the lack of information about the addictive qualities of the medication, or the available option of a non-opioid substitute. Neither the patients nor the doctors had adequate information on the signs of addiction or what to do if addiction to these medications became a concern.

Currently, doctors, nurses, dentists, and other professionals are required to take courses on pain management and prescribing opioids. Unfortunately, the courses given to these professionals regarding pain management do not include information on addiction. It is important that any health care professional who prescribes medications is required to take courses related to addiction for licensing purposes.

Unfortunately, to the detriment of our children, as the state has moved toward a more structured curriculum, time constraints have forced many, if not the majority, of the school districts to eliminate programs related to addiction and wellness. The lack of education or information related to addiction can lead to increases in experimentation with drugs. Testimony from the forums indicated that some children are prone to experiment first with prescription opioid pills at a "pill party" and then later with heroin, because the risks associated with heroin use was not discussed at school.

During the forums, many professionals indicated that drug prevention education beginning in the 3rd grade is crucial to combating this problem.

Funding for resource officers in the classrooms has been slashed because of budget constraints at the school

"KIDS NEED TO BE ARMED WITH INDIVIDUAL TOOLS TO MAKE THE BEST POSSIBLE CHOICES THEY CAN. PARENTS NEED TO BE GIVEN THE BEST POSSIBLE TOOLS TO HELP THEIR KIDS BEGIN TO UNDERSTAND AND HELP THEM AS FAMILIES BECOME VERY STRONG AND GOOD CITIZENS AND HAVE STRONG FAMILY POLICY. SCHOOLS NEED TO ADAPT."

— KYMBERLY LAUBE
EXECUTIVE DIRECTOR, HUGS, INC.

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level, though a few sheriffs' departments indicated that they have scrimped and saved to maintain these programs through their budgets.

The forums also showed that although an instructional program with law enforcement involvement is desirable at the lower grades, peer-to-peer programs with trained students is more effective at the middle and high school levels. Testimony provided indicated that peer-to-peer programs are more successful at the higher levels, because during that period of adolescence, students relate better to their peers, while they usually laugh at or don't take seriously structured adult instruction.

Additionally, local officials around the state have been successful in getting unused medication out of people's medicine cabinets through prescription drug disposal programs (popularly known as "shed the med" programs). Some county officials reported that these programs have resulted in the collection of hundreds of pounds of unused medications which they then destroy at a cost to the local taxpayer. Currently, individuals can go to an advertised drug disposal event or deliver unused medication to local law enforcement for destruction. However, the current system is merely scratching the surface of getting these unused and freely-accessible pills out of the hands of children. Additional programs capable of disposing of unused medications must be developed.

Information is crucial. Parents need a place to which they can turn or a number they can call if they are unsure if their child is using heroin or other addictive medications or what to do if they are. Numerous times at the forums, parents indicated that they had no clue their children were experimenting with heroin or addicted to heroin, until they found themselves in the emergency room with their child recovering from a heroin overdose. Parents testified that they were told by the medical professionals that their children were addicted to heroin, were being discharged and they received no further guidance or information as to getting additional help.

The state must create a clearinghouse for information when it comes to addiction. The state, through OASAS, must create a database, broken down by region, to allow parents and other family members to acquire the help and information they need to assist their loved one.

Additionally, because of the lack of adequate services available to parents fighting a child's addiction, parents are going to extreme measures to help their children. One parent who works as a health care professional, faced with her child recovering from an overdose in the hospital and being brought back from death with the administration of naloxone and facing release, said that her daughter had attempted suicide. She told everyone in the emergency room that her daughter was threatening to kill herself, in her attempt to get her child



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Detoxification

The first step in the treatment of heroin addiction is detoxification. By itself, detoxification is not the sole solution because for many using heroin, the addiction will eventually lead them back to using unless they receive further treatment. Withdrawal, while not necessarily life-threatening, is extremely painful and a process that is often difficult. Many heroin and other opioid users in New York are frequently revived from overdoses and released back to their community within hours of being brought back from death, and continue to struggle. Numerous firsthand accounts by parents, families, and recovering addicts all stressed the importance of having detoxification available for addicts when they decide to seek treatment.

For many heroin and opioid users, detoxification is the first step toward recovery, but this first step is often difficult to take and due to the lack of beds available for detoxification, individuals wanting to take that first step are frequently told to wait. Many testified about the long wait and lack of beds available for detoxification and specifically said the lack of services is causing more people to overdose and continue their addiction. At the forums, the task force also learned about the lack of detoxification services available for individuals under the age of 18. At one forum, a mother described her role in helping her young daughter through detoxification in their family home after being told her child was too young to detox at the hospital. Heroin and other opioids are affecting a wide range of individuals, and in order to help fight the crisis, treatment needs to be available for individuals across age groups, genders, and regions.

More detoxification services in hospitals and other health-care facilities are crucial; however, county jails are also faced with providing detoxification services to individuals being held for criminal acts. Due to federal law, which only allows Medicaid and Medicare to cover the cost for services if an individual leaves a correctional facility, counties are required to cover the cost of detoxification services. Many sheriffs testified to problems treating an inmate population when the majority is addicted to opioids.

“THERE IS NO IN-PATIENT FACILITY ON LONG ISLAND THAT’S GOING TO DETOX A 14-YEAR OLD...I HAD TO BRING MY DAUGHTER HOME. THAT WAS THE FIRST OF MANY TIMES I HAD TO BRING MY DAUGHTER HOME TO DETOX BECAUSE SHE CAN’T GET ADMITTED BECAUSE SHE’S TOO YOUNG TO BE A HEROIN ADDICT.”


— MOTHER OF A HEROIN ADDICT
LONG ISLAND



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Along with the lack of available detoxification beds, insurance was the most frequently mentioned issue from forum participants. Families, recovering addicts, and professionals all expressed concerns regarding insurance reimbursements, the “fail first” process for rehabilitation, and the short time frame in which an individual is covered for treatment by insurance. Several individuals expressed that in order for an addict to be given an inpatient rehabilitation bed, they needed to fail at outpatient rehabilitation as many as three times, and after being admitted into a rehabilitation facility, the individual only received a maximum of thirty (30) days in treatment. For many addicts, this time frame is not long enough and upon discharge, individuals often find themselves falling back into old habits. In 2014, New York State passed legislation prohibiting a blanket “fail first” requirement. This provision took effect in April 2015, but due to insurance renewal periods, individuals would only see these changes in their 2016 plans. Even with these changes, it is important to continue to enforce and strengthen prohibitions on insurers from establishing blanket “fail first” requirements.

Many family members and recovering addicts expressed concern over the continued use of naloxone as a way to force immediate detoxification. Naloxone, while helpful in saving an individual’s life immediately after an overdose, doesn’t help them end their addiction. One of the most pressing issues heard throughout the forums was the lack of resources available to families to help their loved ones battle addiction. Without resources, families were left feeling hopeless and at a loss about what steps they could take to help their loved one. This became especially true when their loved one asked for help but could not receive treatment for weeks, and by the time a bed was available the addicted individual would no longer want help. Additionally, families often recognize the need for professional help long before the addict. Through testimony provided at each of the forums, it became clear that families need an empowering tool to get their loved one help with substance abuse, even when the loved one no longer wants such help.



Community member testifying at the Binghamton forum.

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Detoxification centers must assist in weaning an individual off all substances, diagnose any medical or psychological underlying causes of addiction, and develop an independent care plan for each patient. This will require more communication and a greater network between various agencies and organizations. During the course of treatment at the detoxification center, the center will initiate acquiring insurance coverage for the three paths of treatment. The detoxification center will additionally work with OASAS to secure rehabilitation services upon discharge. The detoxification center will provide assistance transporting the patient to the rehabilitation center, and transfer the patient medically to the rehabilitation center with discharge orders which will include the individualized long-term care plan instructions.

“A LOT OF OUR CHILDREN IN OUR COMMUNITY ARE DYING. WE HAVE A LOT OF BARRIERS - THE INSURANCE COMPANIES, ACCESS TO TREATMENT. WE HAVE TO DO A BETTER JOB OF OUR RESOURCES COMING TOGETHER...”

— ROBERT SANDS
ADMISSIONS COUNSELOR, RENAISSANCE HOUSE

SOLUTIONS

- > Provide more adequate reimbursement rates and funding to incentivize increasing the number of detoxification beds throughout all regions of the state.
- > Enforce and strengthen prohibitions on insurers establishing blanket “fail first” requirements.
- > Prohibit detoxification centers from turning away addicts based on age and/or gender.
- > Require insurance companies to reimburse for expanded time periods for detoxification.
- > Enact legislation to allow individuals with addiction problems to be detained on an emergency basis in a hospital for 72 hours, following the current model used for individuals with mental illness.
- > Require OASAS to conduct a survey and provide a report regarding the availability of detoxification services for persons under 18, as well as evidence-based recommendations regarding the establishment of detoxification programs for these individuals.
- > Require a mandatory 72-hour hold by hospitals for anyone who has been administered naloxone.
- > Develop a civil process to allow families to petition a court to order a severely addicted individual into outpatient or inpatient treatment.
- > Provide reimbursement funding to cover the detoxification costs provided by county jails.



Joseph S. Saladino
Member of Assembly

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Rehabilitation

At all the forums, availability of post-detoxification rehabilitation services for heroin and opioid addicted individuals was a paramount concern, regardless of the geographic location of the event in question. Individuals in recovery and their loved ones told countless horror stories about the difficulties of finding appropriate rehabilitation services for those suffering from opioid addiction, often resulting in tragic loss. At the same time, rehabilitation providers expressed their frustration with requirements imposed by insurers that limited their ability to provide services to individuals in need.

Consistently, the individuals expressing concerns about rehabilitation services raised criticism of insurers (both public and private) and their unwillingness to pay for inpatient rehabilitation in general, and long-term (longer than a month) inpatient rehabilitation in particular. Many parents talked about the extreme amounts of money (often tens of thousands of dollars) they had spent to secure the benefits of long-term inpatient treatment for their children after insurers had denied payment, often because the addicted person had not met the insurer's requirement that they "fail first" in a less-intensive level of rehabilitation before seeking inpatient treatment. In this context, both parents and professionals voiced their anger at what they perceived as continual disparate treatment of addicted persons when compared to populations with other chronic health problems, such as individuals with Type 2 Diabetes or smoking-induced lung diseases.

Even in cases where an insurance company, governmental agency, or parent was willing and able to pay for inpatient rehabilitation, providers and parents reported significant difficulties in locating available treatment beds, with professionals and parents often resorting to hounding rehabilitation providers multiple times a day in the hope of finding an open bed. For many New Yorkers, appropriate services were simply unavailable within a reasonable driving distance of the addicted person's hometown. For example, residents of the rural portions of the Southern Tier and the North Country said inpatient rehabilitation services were often not available in their home county or any nearby counties, thus requiring those seeking inpatient treatment to travel several hours to the more populous counties located along the Thruway Corridor. Residents in these areas also reported more difficulty in accessing medication-assisted treatment options, such as methadone and buprenorphine (commonly referred to by the brand name Suboxone), which tend to be more readily available in urban areas.

With regard to medication-assisted treatment, many providers and patients spoke of the rehabilitative potential of both opioid substitution therapies (such as methadone and buprenorphine) and a newer treatment involving an extended-release formulation of the opioid antagonist naltrexone (sold under the brand name Vivitrol). However, their praises were often tempered with concerns that these treatments are not being utilized to their full potential due to high costs (in the case of naltrexone and buprenorphine) or laws and regulations limiting the number of clients who can be served by an individual provider (in the case of buprenorphine and methadone).

Another frequent concern was the lack of attention paid, in both the inpatient and outpatient environments, to the treatment of co-occurring psychological disorders (such as schizophrenia, bipolar disorder, major depression, anxiety, and post-traumatic stress



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disorders) in individuals who are addicted to heroin and other opioids. Many family members and addicted individuals testified that underlying mental health issues often served as a contributing factor to the decision to begin using heroin or other opioids and as a complicating factor to effective rehabilitation and recovery. On a statewide level, the major difficulties reported in providing treatment to individuals with co-occurring disorders included lack of coordination and information sharing between health care providers, as well as Medicaid and other insurance rules that make it difficult or impossible to bill for providing mental health and substance abuse treatment services to the same individual in a single day. This matter is further complicated in rural areas of the state by a small and aging population of mental health care providers.

Lastly, concerns were raised that health care professionals often failed to treat substantial physical problems that often serve as a major underlying factor in an individual's addiction and as an impediment to the rehabilitation and recovery process. While efforts have been made in the last ten years to improve coordination between substance abuse, mental health, and physical health care providers, more work needs to be done to ensure that these forms of care are properly coordinated for all individuals with addiction.

SOLUTIONS

- > Increase state resources for all rehabilitation services.
- > Require the state Department of Financial Services to aggressively investigate alleged violations of state and federal laws that require parity in the provision of substance abuse services.
- > Enforce and strengthen prohibitions on insurers establishing blanket “fail first” requirements. Require OASAS to develop an electronic system to track the availability of detoxification and rehabilitation beds on a daily basis and require OASAS to assist with inpatient placement for immediate care.
- > Require OASAS to evaluate the effectiveness and availability of medication-assisted treatment, and to provide recommendations to the Legislature regarding the expansion of opportunities for medication-assisted treatment.
- > Require the Office of Mental Health (OMH) and OASAS to develop guidelines regarding the coordination of care for persons with co-occurring substance abuse/mental health problems.
- > Develop a pilot program to provide additional funding to expand innovative live-work-educate rehabilitation programs, such as the Credo Farm of Jefferson County and those run by the Delancey Street Foundation.
- > Require third-party accreditation of rehabilitation facilities to create a uniform course of treatment for patients and ensure professionalism in facilities throughout the state.
- > Continue to develop improved care coordination between substance abuse, mental health, and physical health care providers, to ensure that addicted individuals receive the full spectrum of services necessary to be successful in their rehabilitation and recovery.

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Recovery (Aftercare)

While not necessarily given the same attention as detoxification and rehabilitation, which tend to draw a lot of focus because of their crisis-driven nature, long-term recovery (also referred to as after-care) is an equally vital component in the successful treatment of addiction. Without successful strategies in place to engage the addicted person who is re-entering the community after detoxification and/or rehabilitation, it is highly likely that the addicted individual will continue bouncing from crisis to crisis, at a great cost to themselves, their loved ones, and society.

Family members and recovering addicts consistently voiced frustration at the lack of recovery planning for addicts leaving inpatient institutions. A commonly heard complaint was that addicts were discharged from inpatient rehabilitation services without a detailed plan for their first two weeks in the community, often leaving it to the recovering individual or their loved ones to make necessary medical appointments and track down community-based recovery resources, such as 12-step groups. This lack of a structured recovery plan, especially for the first two weeks post-treatment, was cited as a critical yet overlooked component in the process of enabling the addict to maintain their recovery.

While the initial few weeks of post-rehabilitation recovery were recognized by many speakers as a particularly difficult and vulnerable time for the recovering addict, many pointed out the need for additional services to help persons in recovery gain skills and training necessary to function in society. Often mentioned was a need for persons in recovery to receive training in day-to-day life skills, such as managing stress, handling financial transactions (e.g. finding and renting apartments, budgeting for necessary expenses), and seeking and maintaining employment, as well as formal academic and/or vocational training. Some raised the possibility of establishing and/or expanding “recovery coaching” programs to provide more individualized professional attention to individuals in recovery.

Lastly, significant concerns were raised with regard to the availability of appropriate housing for persons in recovery. For example, on Long Island in particular, concerns were raised about so-called sober homes. Sober homes are ostensibly substance-free residences, usually catering to low-income individuals with alcohol and substance abuse problems that fall outside of the current regulatory jurisdiction of OASAS. While the landlords of these residences often present themselves as benevolent caretakers of persons in need, significant cases exist where they have not only failed to keep their residences substance-free, but have warehoused tenants in dangerous conditions and received illegal payments from outpatient substance abuse treatment providers in exchange for requiring their tenants to receive services from such providers. Outside of Long Island, concerns about housing were more general in nature and focused on the lack of funding for supportive housing opportunities (combining housing and additional community-based services) for persons in recovery.

SOLUTIONS

- Require every person exiting a rehabilitation program to receive a detailed recovery plan that addresses their medical, social, and vocational/education needs.
- Require OASAS, in consultation with appropriate state and local agencies, to evaluate the availability of and need for appropriate supportive housing opportunities for persons in recovery, as well as strategies to eliminate inappropriate and exploitative housing providers (including unscrupulous sober home providers).
- Require OASAS to develop certification standards and stringent regulations for all recovery programs, both residential and non-residential, to ensure that they are effective, substance-free, and habitable.
- Require that all recovery programs have a certified drug counselor on staff to effectively monitor the program and the progress of its participants.

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Criminal Justice

According to State Police Troop B Major Charles Guess, “Given the reality of the world we live in, concerns of terrorism and all the other issues that plague our society, heroin is the number one problem facing law enforcement and society today.” Law enforcement, prosecutors, and judges testifying at the forums collectively agreed that “we cannot arrest or incarcerate our way out of this problem.”

Heroin and opioid addiction are responsible for the vast majority of property crimes, affect death rates by overdose, and contribute significantly to the violent crime rate. Criminal Justice professionals at the forums indicated that jail was the “end of the line” when nothing else worked and stressed the need for better education and more effective drug treatment. They vowed to continue to address demand by stemming drug availability. Many parents were grateful to law enforcement for finally getting their child the help they needed.

Speakers recognized the distinction between persons committing crimes to support their drug habit and drug dealers who are playing the system. Many criticized provisions of the state’s Judicial Diversion Program, enacted in 2009 as further Rockefeller Drug Reform, which allows judges to divert drug dealers to treatment instead of prison, without the consent of the prosecutor. They were also frustrated that the diversion program generally only fails its participants for repeated noncompliance or a particularly serious new arrest. Drug dealers should not benefit from programs designed to help addicts get the treatment they need.

Another common frustration among law enforcement is the inequity in state law pertaining to heroin weights. Under current law, a heroin dealer must possess roughly 13 times as many doses (about 500 doses) as a cocaine dealer to be ineligible for judicial diversion. This prevents prosecutors from seeking the tougher sentences that heroin dealers deserve.

Additionally, current law does not adequately punish heroin dealers for the deaths they cause. Since 1972, the appellate courts have held there are no provisions in Penal Law which make death resulting from the sale of heroin to a user a criminal offense. Since then, courts have been inconsistent in their application of a reckless or criminally-negligent standard where a seller provides a dangerous substance to a user who dies as a result. The Nassau County District Attorney and other prosecutors appealed to task force members to fill the void by passing a felony Death-by-Dealer statute to hold dealers criminally responsible for these deaths.

While jails and prisons are trying to battle the heroin and opioid epidemic, efforts are often thwarted by the smuggling of contraband into these facilities. This contraband often includes drugs and provides inmates with access to heroin and other opioids. Contraband only adds to the continued struggle in battling heroin and opioids and makes it more difficult to encourage rehabilitation and recovery. While current law does penalize smuggling contraband into jails and prisons, heightened penalties need to be created for both those smuggling in the contraband and for the inmates receiving such contraband.

“GIVEN THE REALITY OF THE WORLD WE LIVE IN, CONCERNS OF TERRORISM AND ALL THE OTHER ISSUES THAT PLAGUE OUR SOCIETY, HEROIN IS THE NUMBER ONE PROBLEM FACING LAW ENFORCEMENT AND SOCIETY TODAY.”

— MAJOR CHARLES GUESS
NY STATE POLICE TROOP B COMMANDER



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According to Broome County Sheriff Harder, the county jail previously had an alcohol and drug addiction recovery program. With the use of this program, recidivism rates were at 17 percent. Due to overcrowding in the facility, this program had to be cut, and recidivism rates have since increased to 44 percent. Sheriffs throughout the state reported similar findings; for example, Sheriff Whitcomb of Cattaraugus County testified that the county has become too fiscally challenged to effectively treat an inmate population when the majority is addicted to opioids.

Multiple law enforcement representatives testified that the female population that is addicted to opioids is increasing at an alarming rate. As of mid-October 2015, of the 26 female inmates in the Cattaraugus County jail, approximately 22, or 85 percent, were addicted to opioids. More specifically, the rate at which addicted pregnant women are being incarcerated is also increasing, but the counties do not have the resources to treat these women, thus jeopardizing the health of both the mother and the baby.

“APPROXIMATELY 46 PERCENT OF THE PEOPLE IN JAIL HAVE A DRUG PROBLEM...WE USED TO RUN A PROGRAM IN OUR FACILITY FOR ADDICTION, WHETHER IT WAS ALCOHOL OR DRUGS, BUT WE’RE SO CROWDED WE DON’T HAVE THE ROOM ANYMORE TO RUN THOSE PROGRAMS. THERE ARE PEOPLE OUT THERE TRYING TO GET HELP BUT THERE IS NO PLACE TO GO.”

— SHERIFF DAVID HARDER, BROOME COUNTY

Currently, one of the most beneficial tools for battling a heroin overdose is naloxone. Naloxone is a prescription medicine that reverses an overdose by blocking heroin or other opioids in the brain and therefore prevents an overdose from becoming fatal if properly administered. At each forum, testimony was presented on the benefits of naloxone and how many lives it has saved.

However, families worry that loved ones will experience a heroin overdose and naloxone will not be available or will not be properly administered. Additionally, families are concerned about what occurs after naloxone is administered, as most individuals are immediately released from the hospital because heroin withdrawal is not deemed to be life threatening.

SOLUTIONS

- > Prohibit drug dealers from participating in the state’s Judicial Diversion Program, mandating imprisonment instead.
- > Lower the amount of heroin required to constitute a class A-I or A-II drug felony, both non-divertible felony charges, making more drug dealers ineligible for drug diversion and subject to harsher penalties.
- > Enact a felony Death-By-Dealer statute to hold heroin dealers criminally responsible for the deaths they cause.
- > Direct the Office of Court Administration to contract with an external research organization to evaluate the implementation and effectiveness of the state’s Judicial Diversion Program.
- > Authorize each county and state correctional facility in New York to have a wing dedicated to the detoxification and rehabilitation of inmates and enable them to apply for financial reimbursements for expenses.
- > Heighten penalties for contraband smuggled into correctional facilities.
- > Require the court to sentence a prisoner to consecutive time when committing a criminal offense while in custody or incarcerated.
- > Require all police departments to have naloxone training and kits supplied.
- > Mandate training for police officers and emergency personnel on administration of naloxone.
- > Require a mandatory 72-hour hold by hospitals for anyone who has been administered naloxone.

SUMMARY OF FINDINGS & SOLUTIONS

Ideas Requiring Further Study

During the course of conducting these forums, many additional areas of concern were brought to the attention of the task force members. As a result, the task force has come up with a variety of solutions and proposals, some of which are outlined in the report and some that require further study. Many of the concerns expressed will require a large collaboration between the federal government and New York State.

The task force believes the following issues require further study as part of the continued effort to end the heroin epidemic in New York.

IDEAS

- Requiring pharmacies to serve as secure drug drop-off locations (known as “Shed the Meds” programs in certain regions).
- Adding an additional fee of five cents to each opioid prescription, with the funds generated being deposited into a dedicated fund used to reimburse counties for any expenses related to the collection and disposal of medication from secure drug collection sites. As part of this program, counties would require their health departments, with the cooperation of their local sheriff’s office or police departments, to purchase and maintain locked drop-off boxes placed in all pharmacies so people can conveniently dispose of unused medication while picking up new prescriptions.
- Addressing the problems faced by counties that border other states with regard to out-of-state “doctor shopping” by developing additional penalties for individuals who cross state lines to procure prescription drugs to sell in New York.
- Evaluating the use of methadone, Vivitrol, and other medication-assisted treatment to determine if and when these treatments should be used on a lifelong basis, as well as evaluating options to transition persons in recovery out of medication-assisted treatment.
- Re-tooling and utilizing closed state facilities for detoxification and treatment.
- Calling on the Governor to declare the heroin epidemic as a public health priority and to develop his budgetary priorities accordingly.
- Investigating means, including possible bulk purchasing arrangements by the state, to reduce the cost of Vivitrol and other forms of medication-assisted treatment.
- Working with the federal government to expand access to buprenorphine treatment, including the possible expansion or elimination of the cap on the number of buprenorphine patients who can be seen by a single physician.



TASK FORCE RECOMMENDATIONS

The challenges faced by current and former addicts and their family and friends are real and more needs to be done to help them, including increased funding to support detoxification and rehabilitation facilities. New Yorkers must have the necessary tools to help fight this epidemic and prevent the continued spread of heroin throughout the state. It is imperative that the heroin problem is examined in detail from every perspective, including prevention, detoxification, rehabilitation, recovery, and criminal justice. In doing so, those who suffer from addiction will get the help they need, and those who continue to sell heroin throughout New York will face significant consequences.

HELP (Heroin ELimination & Prevention) Plan

PROVIDE DRUG AND HEROIN EDUCATION

- Create public service announcements regarding heroin and other opioid abuse;
- Require schools to provide drug education beginning in 3rd grade, with a focus on interactions between pupils, peers, and individuals; and
- Require prescribers to receive appropriate continuing medical education regarding opioid prescription and the signs of addiction.

CREATE SUPPORT TOOLS AND ADVOCACY PROGRAMS

- Provide state support for school resource officer programs;
- Require OASAS to create a family navigator/advocacy program;
- Require OASAS to develop an electronic system to track the availability of detoxification and rehabilitation beds on a daily basis;
- Develop guidelines regarding the coordination of care for persons with co-occurring substance abuse/mental health problems by OASAS and OMH;
- Require every person exiting rehabilitation to receive a detailed recovery plan; and
- Evaluate the availability of and need for appropriate supportive housing opportunities.

INCREASE FUNDING AND IMPROVE METHODS FOR TREATMENT AND RECOVERY

- Provide more funding to increase the number of detoxification beds throughout all regions of New York;
- Evaluate the effectiveness and availability of medication-assisted treatment, and provide recommendations to the Legislature regarding the expansion of opportunities for medication-assisted treatment;

TASK FORCE RECOMMENDATIONS

- Enact legislation to allow individuals with addiction problems to be detained on an emergency medical basis in a hospital for 72 hours, following the current model used for individuals with mental illness;
- Require OASAS to conduct a survey and provide a report regarding the availability of detoxification services for persons under 18, as well as evidence-based recommendations regarding the establishment of detoxification programs for these individuals; and
- Require a mandatory 72-hour hold by hospitals for anyone who has been administered naloxone.

REEVALUATE INSURANCE AND PARITY LAWS AND REIMBURSEMENT RATES

- Prohibit insurance companies from establishing blanket “fail first” requirements;
- Require insurance companies to evaluate reimbursements for expanded time periods for detoxification; and
- Require DFS to aggressively investigate alleged violations of state and federal parity laws.

CRIMINAL JUSTICE AND JUDICIAL IMPROVEMENTS

- Develop a civil process to allow families to petition a court to order a severely addicted individual into outpatient and/or inpatient treatment;
- Prohibit drug dealers from participating in the state’s Judicial Diversion Program, mandating imprisonment instead;
- Lower the amount of heroin required to constitute a class A-I or class A-II drug felony, both non-divertible felony charges, making more drug dealers ineligible for drug diversion and subject to harsher penalties;
- Direct the Office of Court Administration to contract with an external research organization to evaluate the implementation and effectiveness of the state’s Judicial Diversion Program;
- Enact a felony Death-By-Dealer statute to hold heroin dealers criminally responsible for the deaths they cause;
- Require all police departments to have naloxone training and kits supplied; and
- Mandate training for police officers and emergency personnel on administration of naloxone.

IMPROVE CONNECTIONS BETWEEN CORRECTIONAL SYSTEM AND ADDICTION SERVICES

- Require the court to sentence a prisoner to consecutive time when committing a criminal offense while in custody or incarcerated;
- Require each county and state correctional facility in New York to have a wing dedicated to the detoxification and rehabilitation of inmates;
- Heighten penalties for contraband smuggled into correctional facilities; and
- Provide reimbursement to county jails to cover the detoxification costs provided to inmates.



Potential Funding and Budgetary Suggestions

Members of the Assembly Minority Task Force on Heroin Addiction & Community Response, after hearing testimony from addicts, parents, family, friends, and experts across various fields, have proposed a wide-ranging list of solutions. These solutions, if implemented, could save the state and insurance companies millions of dollars. The task force has compiled a list of possible funding sources to help offset the initial cost of these proposals to achieve future savings.

- Currently there is \$2.1 billion in unbudgeted reserves for monetary settlements. Dedicate a portion of this funding to increased services or beds.
- Reevaluate current asset forfeiture structure to give a higher percentage toward addiction services.
- Offer a credit to hospitals on their Gross Receipts Tax if they were to run a detox program in their facility.
- Divert a portion of the Covered Lives Assessment to raise the reimbursement rate to increase the length of stay allowed in a rehabilitation center.
- Increase the percentage given to OASAS under the current Medical Marijuana Program. It is currently at 5 percent.
- Utilize closed youth facilities as potential sites for detox/rehabilitation for adolescents under the age of 18.
- Dedicate a portion of the casino gambling fee to heroin/opioid treatment within OASAS.
- Offer a tax credit to small businesses that hire a recovering/former addict who is in an outpatient program or aftercare plan.
- Utilize federal grant funding in prevention education.
- Utilize DSRIP funding to connect primary care and behavioral health.
- Coordinate with SUNY/CUNY and private schools to offer scholarships to students who will work in peer-to-peer counseling.
- Require students in the summer youth program (which received \$30 million in the 2015-2016 Budget) to participate in a prevention program while employed (similar to Assembly intern program and ethics).
- Allow police officers to have a room in a school for paperwork purposes which will give them a presence on the campus.
- Coordinate with the Hire-a-Vet program to hire veterans as School Resource Officers.

TASK FORCE EVENT SUMMARY

Long Island

DATE/VENUE: September 22, 2015 at Walt Whitman High School in South Huntington

SCHEDULED TIME: 6 – 9 p.m.

ASSEMBLY MEMBERS PRESENT: Alfred Graf, David McDonough, Michael Fitzpatrick, Andrew Raia, Joseph S. Saladino, Thomas McKevitt, Michael Montesano, Brian Curran, Edward Ra, Andrew Garbarino, Chad Lupinacci, Dean Murray

CROWD: Approx. 75

SPEAKERS: 22

VIDEO:

Part 1: <https://youtu.be/IO3-THPIhL0>

Part 2: <https://youtu.be/2dGtO-HVtig>

MEDIA:

Long Island Exchange: <https://www.longislandexchange.com/press-releases/assemblyman-lupinacci-joins-task-force-to-fight-long-island-heroin-epidemic/>

Huntington Patch: <http://patch.com/new-york/huntington/lupinacci-joins-task-force-fight-long-island-heroin-epidemic-0>

Capital Region

DATE/VENUE: September 28, 2015 at Hudson Valley Community College in Troy

SCHEDULED TIME: 6 – 8 p.m.

ASSEMBLY MEMBERS PRESENT: Joseph M. Giglio, Alfred Graf, James Tedisco, Steven McLaughlin

CROWD: Approx. 50

SPEAKERS: 20

VIDEO: <https://youtu.be/-98nX4m-j5U>

MEDIA:

TWC: <http://www.twcnews.com/nys/capital-region/news/2015/09/28/assembly-minority-task-force-forum-on-heroin-addiction-at-hvcc.html>

TASK FORCE EVENT SUMMARY

Plattsburgh

DATE/VENUE: September 30, 2015 at the Former PARC Simulation Building in Plattsburgh

SCHEDULED TIME: 6 – 8 p.m.

ASSEMBLY MEMBERS PRESENT: Joseph M. Giglio, Alfred Graf, Janet L. Duprey, Daniel Stec

CROWD: Approx. 100

SPEAKERS: 20

VIDEO: <https://youtu.be/YjwJE9au3Vg>

MEDIA:

Press Republican: http://www.pressrepublican.com/news/forum-on-heroin-epidemic-set-for-wednesday-in-plattsburgh/article_cd6305c4-6617-11e5-a9b6-1723f343210d.html

Adirondack Daily Enterprise: <http://www.adirondackdailyenterprise.com/page/content.detail/id/556723/-We-are-not-going-to-arrest-our-way-out-of-the-problem-.html?nav=5239>

Fox 44 TV: <http://www.mychamplainvalley.com/news/the-north-country-takes-on-addiction-from-all-angles>

Press Republican: http://www.pressrepublican.com/news/local_news/assembly-minority-task-force-tackles-heroin-crisis/article_d32832f3-246a-521e-a006-3d7f96160a7b.html

Sun Community News: <http://www.suncommunitynews.com/articles/task-force-seeks-to-combat-heroin/>

Carthage Republican Tribune: <http://www.carthagerepublicantribune.com/mtg01/heroin-task-force-holds-plattsburgh-forum-20151001>

Watertown Daily Times: <http://www.watertowndailytimes.com/mtg01/heroin-task-force-holds-plattsburgh-forum-20151001>

Amherst

DATE/VENUE: October 7, 2015 at Sweet Home High School in Buffalo

SCHEDULED TIME: 5:30 – 7:30 p.m.

ASSEMBLY MEMBERS PRESENT: Joseph M. Giglio, Alfred Graf, Raymond Walter, Jane Corwin, David DiPietro

CROWD: Approx. 35

SPEAKERS: 15

VIDEO: <https://youtu.be/OmPrjez5Bvk>

MEDIA:

Amherst Bee: http://www.amherstbee.com/news/2015-10-14/Front_Page/Heroin_Task_Force_holds_public_meeting_at_Sweet_Ho.html

Lockport Union Sun & Journal: http://www.lockportjournal.com/news/local_news/regional-heroin-response-forum-set/article_3605c2f2-5cc9-5496-9bd1-29c2a4d44109.html

TWC Buffalo: <http://www.twcnews.com/nys/buffalo/news/2015/10/7/heroin--epidemic--assembly-minority-task-force--amherst.html>

TASK FORCE EVENT SUMMARY

Olean

DATE/VENUE: October 8, 2015 at Jamestown Community College in Olean

SCHEDULED TIME: 2 – 4 p.m.

ASSEMBLY MEMBERS PRESENT: Joseph M. Giglio, Alfred Graf, Andrew Goodell

CROWD: Approx. 50

SPEAKERS: 15

VIDEO: <https://youtu.be/X0nrhM6LyDY>

MEDIA:

AM 1480: <http://wlea.net/state-assembly-to-hold-heroin-hearings-in-olean/>

Post Journal: <http://www.post-journal.com/page/content.detail/id/677628/Heroin-Task-Force-To-Meet-In-Olean.html?nav=5004>

Salamanca Press: http://www.salamancapress.com/news/article_5abaed3a-6e86-11e5-8457-672f5e863e01.html

Olean Times Herald: http://www.oleantimesherald.com/news/article_10fe5dd0-6e40-11e5-84cb-4b83790c1211.html

Carthage

DATE/VENUE: October 19, 2015 at Carthage High School in Carthage

SCHEDULED TIME: 6 – 8 p.m.

ASSEMBLY MEMBERS PRESENT: Joseph M. Giglio, Alfred Graf, Will Barclay, Ken Blankenbush

CROWD: Approx. 60

SPEAKERS: 15

VIDEO: https://youtu.be/b4JpUo0NI_w

MEDIA:

Daily Courier Observer: <http://www.mpcourier.com/news03/assemblymen-to-discuss-heroin-epidemic-monday-in-carthage-20151019>

Watertown Daily Times: <http://www.watertowndailytimes.com/news03/assemblymen-to-discuss-heroin-epidemic-monday-in-carthage-20151019>

Malone Telegram: <http://www.mymalonetelegram.com/col25/we-must-address-our-heroin-and-opioid-epidemic-20151015>

TWC North Country: <http://www.twcnews.com/nys/watertown/news/2015/10/19/north-country-residents-discuss-heroin-epidemic.html>

The Moose: <http://www.themoose.net/edit-news-articles/14032-heroin-epidemic-blankenbush-press-release>

Journal & Republican: <http://www.journalandrepublican.com/news03/assemblymen-to-discuss-heroin-epidemic-monday-in-carthage-20151019>

TASK FORCE EVENT SUMMARY

Binghamton

DATE/VENUE: October 20, 2015 at SUNY Broome in Binghamton

SCHEDULED TIME: 6 – 8 p.m.

ASSEMBLY MEMBERS PRESENT: Joseph M. Giglio, Alfred Graf, Clifford W. Crouch

CROWD: Approx. 50

SPEAKERS: 15

VIDEO: <https://youtu.be/XpXc8FLQIIM>

MEDIA:

Fox 40: <http://www.wicz.com/news2005/viewarticle.asp?a=40596>

Press & Sun Bulletin: <http://www.pressconnects.com/story/news/2015/10/19/forum-held-heroin-addiction/74218866/>

Ch 12: <http://www.wbng.com/news/local/Assembly-minority-task-force-fighting-heroin-epidemic-with-final-forum--334899511.html>

WEBO: <http://www.newsradiowebo.com/?p=28497>

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