Testimony delivered to
JOINT SENATE TASK FORCE ON OPIOIDS, ADDICTION & OVERDOSE PREVENTION

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Good Morning Senators Rivera, Harckham and Carlucci, and thank you for the opportunity to speak today on the impact of NY State's response to the current opioid epidemic as reflected by trends in Suffolk County, Long Island and to reflect on further actions that may increase success in curtailing this tragic process that has been increasing for too many years. By way of background, I am the Inaugural Director of Addiction Psychiatry at Stony Brook University. After decades of related work in New York City, I moved to Long Island to assist Stony Brook in constructing a clinical, research, and academic platform to help better face the epidemic, which has an epicenter in Suffolk County. I am also head of Public Policy for the American Academy of Addiction Psychiatry.

First, I would like to underscore the important contributions to our community response to the epidemic by the Suffolk County Heroin and Opiate Advisory Panel, a commissioned group established in May, 2010 and chaired by county Legislator Sarah Anker, and whose members including leadership from Suffolk County and State government and community treatment and advocacy stakeholder organizations, have put forth significant collaborative effort that has borne substantial results. The Panel released 48 recommendations in 2010 in the areas of prevention, treatment, and recovery, and there have been actions taken in support of these recommendations, many with profound impact, such as: leading the State in roll-out of DSRIP-supported SBIRT in Article 28 hospital emergency departments and county health centers; production and distribution of resource guides to inform the public; implementation of evidence-based programs and curricula in the schools; Asset Forfeiture funds used to purchase a mass spectrometer for the Suffolk County Crime Lab; increased inpatient,

outpatient and residential treatment capacity in Suffolk County for adults and adolescents, including the novel open-access DASH Center, a joint collaboration of the Suffolk LGU, OMH and OASAS that offers 24/7 assessment and stabilization for those with co-occurring substance and other mental disorders; and most directly, the Suffolk County Health Department providing naloxone administration training broadly to first responders and all hospitals distributing naloxone kits to appropriate patients and families in the emergency department and inpatient units. There are now learning collaboratives focused on increasing patient access to MAT and implementing MAT in hospital emergency departments; the latter efforts supported by both the Greater NY Hospital Association Opioid ED Collaborative and the Emergency Department Opiate Response Working Group, chaired by Legislator Kara Hahn.

I hereby present additional actionable recommendations that I believe will further our efforts to inform the public, reduce stigma, and lower barriers to access to treatment:

- **Deploy public service announcements** in broadcast, cable and web-based media informing the public about the mortal risk attributable to the increasing presence of lethally potent synthetic opioids such as fentanyl and fentanyl-analogues not only in the illicit opioid supply, but also in the supply of illicit stimulants.

- Train first responders not only in the administration of naloxone rescue, where Suffolk County has already made impressive impact, but also in the **disease model of addiction** to help in de-stigmatization of addiction as a cultural change. While we can frequently get frustrated with the self-destructive behavior of those in the throes of an opioid use disorder, it's important to remember that no one sits in their 5th grade class and aspires to being addicted to heroin as an adult. Active compassion will lower the barriers for those struggling with opioid use disorder (OUD) to engage in treatment.

- Support the provision of medication for addiction treatment (MAT) as the **primary, effective, medically stabilizing and life-saving intervention**, because it is the most effective intervention for OUD. Psychosocial interventions, while important to recovery do

not show the same magnitude of effect over time for most people with opioid use disorder as compared to the evidence base for psychosocial treatment of alcohol or stimulant use disorders.

- NY State and DOH should support the premise that providing default detoxification from opioids to medically ill patients with OUD on med/surg inpatient units is **no longer the appropriate standard of care**. Rather, the default approach should be inpatient induction onto buprenorphine or other MAT so that patients are not discharged into the community with no opioid tolerance to protect them against opioid overdose.

- A foundational support for the onset and maintenance of the opioid epidemic has been the **traditionally poor training of physicians** in the appropriate conditions for prescribing of opioids for acute and chronic pain, and the undertraining of physicians about OUD and its medical treatments. While Health Commissioner Howard Zucker's July 2017 web-based training on proper prescribing of opioids was an important start, physician behavior both in individual practice as well as in institutional settings is slow to change without administrative support and oversight. However, each year there is a new class of medical school graduates traditionally undereducated about pain and addiction diagnosis and treatment. Better we begin to supply physicians and other prescribers that are well trained about substance use disorders into the pipeline. In lieu of legislative mandate, the legislature could support Governor Cuomo in pressing that all accredited medical, nursing, and physicians' assistant, schools' and/or programs' Deans in NY State provide expanded SUD curricula and at least two weeks' full time didactic and clinical exposure to diagnosis and treatment of SUD, regardless of trainees' intention for residency or specialization, since patients with SUD show up in all areas of medicine. Specialty-trained addiction psychiatrists and addiction medicine physicians could then treat cases with higher medical and psychiatric complexity and appropriately serve as hub-and-spoke model consultants to systems of care.

- Further, there are not enough addiction specialists to identify and treat all of our citizens afflicted with opioid use disorder. As such, the medical treatment of opioid use disorder must be **mainstreamed to non-specialist primary care clinicians**. All physicians, physician's assistants and nurse practitioners should be given buprenorphine waiver training (while this training continues to be mandated), as well as naloxone rescue training during medical, dental, or nursing school or post-graduate training.

- DOH Commissioner Zucker can request that a basic hold-harmless message from the NY State Good Samaritan law is clearly printed **on DOH-distributed naloxone rescue kit bags** to help reduce the reluctance to call 911 by those who find someone having an opioid overdose and are concerned about legal consequences.

- NY State and DOH should require hospitals to **report the number** of individuals presenting to the emergency department for acute medical care **who report risky substance use** of any kind, in order to effectively plan for the size and scope of response needed from addiction professionals within each hospital setting. A recent example for reference is the medical impact associated with vaping. It is easy to overlook the level of need related to SUD when focused on the presenting medical problem alone. These data can be used to compile statewide reports that reflect prevalence and fed back to providers for planning purposes.

Thank you for your time and attention. I am available to answer any questions you might have.