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To: NYS Joint Senate Task Force Public Hearing on Opioids, Addiction & Overdose Prevention

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Testimony for November 15 Joint Senate Task Force Public Hearing On Opioids, Addiction & Overdose Prevention

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My name is Dionna King and I am the New York State Policy Manager for the Drug Policy Alliance, the nation's leading organization working to advance policies and attitudes to best reduce the harms of both drug use and drug prohibition.

I have had the pleasure of attending multiple public hearings convened by this task force and have learned from those working to end the current overdose crisis and prevent needless drug-related death. Policy proposals that were once considered political anathema are now the center of discourse as policymakers and legislative leaders continue to see the value of harm reduction. Overdose prevention sites, syringe exchanges, low- or no-threshold medication maintenance and supportive housing are all effective interventions and if New York State commits to sustained investment in developing a harm reduction infrastructure, lives can and will be saved.

I have also witnessed multiple service providers and physicians discuss the impact of stigma and stress an urgent need to change the narrative regarding drug use and addiction. This is vital and I want to plainly say that we cannot erode stigma, we cannot fully commit to harm reduction, if we continue to criminalize and incarcerate people who use drugs. I implore the members of this taskforce to put forth a policy agenda that makes the case for removing drug use from the purview of the criminal legal system and instead centers other avenues for engaging with people who use drugs in a way that reinforces their humanity and individual needs.

Felony and Misdemeanor Drug Arrest Post-Rockefeller Drug Law Reform

Drug arrests across the state fell precipitously following Rockefeller Drug Law reform, however, New Yorkers can still be arrested for felony and misdemeanor drug offenses. In 2018, there were over 20,000 felony drug arrests in New York, with the majority of those arrests for possession of meager quantities of controlled substances or for low-level sales. While 20,000 is a dramatic decline considering New York's role in mass incarceration, the current overdose crisis should force lawmakers to reckon with the impact of criminalization on access to healthcare, housing, employment and other social determinants to health that have an effect on substance use disorder.

The social environment in which people engage in substance use impacts their overall health and influences drug users' risk behaviors. Incarceration in and of itself negatively impacts an individual's h

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eath, and for those experiencing opioid dependency the cycle of release and reentry contributes to increases in morbidity and mortality.[1]

All drug decriminalization and public health

Portugal's model of all drug decriminalization is touted as a global model of success. Portugal's shift toward decriminalization effectively curbed the transmission of HIV, and removing criminal penalties for drug possession was a component of a plan that emphasized low- or no-threshold treatment access and a robust harm reduction infrastructure. New York State has taken steps toward providing alternatives to incarceration and drug treatment services allocated through judicial diversion programs, but the state has failed to fully divest from criminalization -- and to what end?

Judicial diversion, jail-based treatment, or other coercive forms of treatment do not have to be the sole driver connecting people to healthcare systems. In 2001, Portugal ceased criminalizing drug use, the results have been dramatic. The number of people voluntarily entering treatment has increased significantly, while overdose deaths, HIV infections, problematic drug use, and incarceration for drug-related offenses have plummeted. [2] Drug decriminalization has had a remarkable impact on overdose death rate. In 1999 Portugal recorded 369 drug overdose deaths, by 2015 that number had fallen to 54.[3]

Subjecting individuals who experience substance use disorder or use drugs non-problematically to incarceration or contact with the criminal legal system does nothing to mitigate the harms of problematic substance use. Law enforcement interventions exacerbate the overdose epidemic; people who are subjected to law enforcement interaction can be rendered vulnerable to conditions that weaken their civil liberties and the social and economic connections that create stability and recovery capital. Materially, incarceration and judicial diversion programs isolate individuals from harm reduction and treatment resources that reduce the risk associated with drug use such as disease transmission. The threat of law enforcement diminish the effectiveness of strong public health laws, such as the Good Samaritan Law and syringe decriminalization.

It is for these reasons, the Drug Policy Alliance, the United Nations and the World Health Organization support the repeal of laws that criminalize drug use and possession of drugs for personal use. Additionally, the UNAIDS strategy firmly declared that drug decriminalization is a necessary if we are to fully protect people who use drugs from the social and legal environments that fail to protect people against stigma and discrimination.[4]

In 2009, New York lawmakers took a tremendous step towards scaling back their contribution to the war on drugs by reforming the Rockefeller Drug Laws. Although the number of arrests for drugs across the state declined in the wake of these reforms, the criminal legal system continues to have negative contacts with people who use drugs. Now 10 years removed, it's time to assess the impact of those efforts and the validity of shifting from jails to drug courts and other forms of surveillance.

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New York State provides a detailed example of what it looks like to move from an incarceration to a treatment mandate. In 2009, after the passage of legislation to reform the Rockefeller Drug Laws through the Drug Law Reform Act (DLRA), community-based treatment providers were expected to work in close proximity to the criminal justice system as a number of people were now diverted into their care. In a 2014 study on providers' perspective on the implementation of DRLA, surveyed providers noted that their relationships with their criminal justice partners were less than ideal, with 82 percent calling the relationships either "not adequate" or "somewhat adequate;" almost all believed that the reforms inherently required a realignment of the criminal justice-treatment provider relationships.[5] A resounding source of the tension between providers in the community and people in the justice system is the unwillingness to seek and consider the opinions of providers when making both macro and micro decisions related to providing care. On the subject of the implementation of DRLA, surveyed providers asserted that important aspects related to assessment and treatment of mandated clients continue to be dominated by criminal justice rather than clinical concerns.[6]

Feedback from interviewed treatment provider: At my clinic, we're abstinence-based, but I'm very harm reduction focused, I train my staff and we have shifted, but we can only provide services...we're working with people who are mandated by parole or Human Resources Administration. You can have the same goals as your client, but if the outside mandater doesn't have those goals, there can't be a true therapeutic alliance. We assume that our clients are traumatized, everyone who goes through the carceral system and ends up in the shelter system - everyone who comes to us has history of trauma, but as soon as they test positive one time parole violates them and they go back to jail. So whatever progress is made in treatment, they're back in the system, they're getting re-traumatized and coming back out. Even if they're not mandated to treatment in the future, they're not going to voluntarily seek those services because they've had such a bad experience in the past. It has to be a comprehensive systems level change.

Topline issues with drug courts and other problem-solving courts that address SUD

Through our relationships with treatment service providers, defense attorneys and harm reduction services providers we have identified several key-issues with drug courts.

- Despite legislation requiring judges to allow the use of MAT in drug courts, we are aware that some drug court defendants are asked to discontinue the use of MAT or are not recommended to programs that provide MAT. [7]
- Drug courts order defendants to meet requirements that fall out of the purview of use cessation or harm reduction. Namely, they require participants to hit certain development goals such as securing employment or completing a GED program, which isn't harmful in and of itself, but it

becomes burdensome when defendants fail to meet these metrics and are required to stay in the program for periods of time that are beyond the possible sentence. [8]

- While it is recommended that drug courts use assessment tools to determine the level of care/treatment needed for a particular defendant, they are not required to do use a certified alcoholism and substance abuse counselor (CASAC) nor are they required to use the New York State Level of Care for Alcohol and Drug Treatment Referral (LOCADTR). The purpose of these tools is to place defendants in the most appropriate and least restrictive programs. However, judges may prefer more restrictive in-patient programs even when it's not necessary, meaning defendants have to upend their lives to participate programs; this can contribute to loss of employment, interruption of education and place burdens on defendants with children.
- To enter drug court, defendants must often plead guilty without a preliminary hearing and/or grand jury indictment.[9]
- Through RDL reform, individuals who succeed in drug court are supposed to be given the offer to have their sentenced sealed post drug court completion, but a low percentage of drug court graduates have had their records sealed, leaving individuals burdened by criminal records.[10]
- Drug courts enjoy some success at reducing the recidivism rates of participants (definitively in the short term, with more variation in long-term recidivism), but they fail to significantly reduce prison populations for various reasons. Just from sanctions alone, a drug court participant may spend more days in jail than they would had they pleaded not guilty and received a sentence reduction.[11]
- The costs for drug court treatment are usually paid for by the participant's insurance, which can be a barrier to people without private insurance or with plans that do not cover the drugs. Failure to meet treatment recommendations or abstain from drugs can also result in sanctions administered by the judge.
- Accessibility is a crucial factor in determining who will be able to participate and receive the diversion services of the drug court. Participants are regularly drug tested and must attend frequent hearings. But getting to court can be difficult for people who do not have cars, especially when public transportation is not available.
- At a time when drug courts are being proffered as a solution to the opioid crisis by state and federal lawmakers, it is crucial to understand and measure their effectiveness. However, many courts do not make any statistics, even basic facts, about the courts available either online or upon request. In fact, any attempts to get basic facts were repeatedly rejected by court administration. In order to better measure the effectiveness of drug courts, data must be made available to researchers for the purpose of evaluating these programs.

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Coercive treatment is not the answer

As overdose deaths continue to increase or remain at record highs, many lawmakers have proposed the interventions that lean heavily on involuntary or coercive treatment and civil commitment. There are ethical and legal implications to consider as the standards for commitment rest on assertions made by outsiders who consider substance use to be evidence that the person in question will harm himself/herself. Accidental overdose does not indicate that the person is a threat to themselves or indicate that the person is suicidal; additionally, and perhaps most importantly, there is no concrete evidence that suggests that compulsory treatment and detainment contribute to positive treatment outcomes.

As policymakers begin to explore 72-hour holds as a response to substance use, it is important to look at the existing research to understand if this intervention is effective and if there are unintended consequences that will exacerbate the overdose crisis.

A brief review of existing research shows the following trends:

- A third of opioid users who were committed to treatment who participated in a Massachusetts study relapsed on the day of their release.
- Health law scholars are deeply skeptical of most states' SUD civil commitment regimes, suggesting that "the prospects for positive outcomes ... are especially bleak, given the standard of care currently available [in these facilities]." One core criticism of civil commitment for opioid dependence, in particular, is lack of access to MAT and to appropriate psychosocial interventions. Rather than offering evidence-based treatment, "the treatment provided is often not rooted in science at all."[12]

Alternative responses

Overdose response does require a swift reaction, especially if the person was revived using naloxone, which will result in them experiencing a state of active withdrawal. These options are supported by evidence and research, and do not reinforce stigma:

Relay: A peer-delivered emergency department-based response to nonfatal opioid overdose. Relay, a peer-delivered response to nonfatal opioid overdoses, provides overdose prevention education, naloxone, support, and linkage to care to opioid overdose survivors for 90 days after an overdose event. From June 2017 to December 2018, Relay operated in seven New York City emergency departments and enrolled 649 of the 876 eligible individuals seen (74%). Preliminary data show high engagement, primarily among individuals not touched by harm reduction or naloxone distribution.[13]

If New York moves toward decriminalizing possession of drugs for personal use, the treatment and harm reduction network must be overhauled and expanded to communities with low-threshold drug user health services in settings that are non-carceral and non-coercive. The Drug Policy Alliance partnered

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with community groups to develop the Drug Addiction Treatment and Recovery Act which will repeal criminal possession laws and allocates tax-revenue, generated through recreation marijuana sales, for treatment and harm reduction resources.

New York has yet to pass marijuana taxation and regulation policy, but the pending legislation does require a percentage of the revenue to go toward health programs that will support people who use drugs and harm reduction. With this new source of income, and the potential settlement funding provided through current pharmaceutical lawsuits, we encourage New York to invest in the following as an alternatives to criminalization:

Overdose Prevention Centers: These legally sanctioned facilities allow people to consume pre-obtained drugs under the supervision of trained staff and are designed to reduce the health and public order issues often associated with public drug consumption.

Peer Recovery Coaches: Peers with lived experience are able to assist people access harm reduction and treatment resources and can serve as a non-judgmental mediator. Peer support has demonstrated success when applied in hospitals and outpatient clinical settings.[14]

Reproductive Health Clinics for Women Who use Drugs: Pregnant people who use drugs or who are in recovery from substance use with the aid of medications experience stigma and surveillance when seeking access to reproductive health care. The fear of judgement, criminalization or child welfare intervention can lead people to not seek healthcare services. In order to promote parent and newborn health, cities have developed specialty health reproductive health service for people who use drugs. Vancouver's Sheway Clinic is an excellent service model. The program consists of prenatal, postnatal and infant health care, education and counseling for nutrition, child development, addictions, HIV and Hepatitis C, housing, and parenting. Sheway also assists in fulfilling basic needs, such as providing daily nutritious lunches, food coupons, food bags, nutritional supplements, formula, and clothing. [15]

Syringe Access and Harm Reduction Programs: There are some communities in New York State that lack a centralized harm reduction service provider or do not have adequate public transportation infrastructure to support access to brick and mortar harm reduction services. Providers, such as Community Action for Social Justice in Long Island, have adapted to meet the needs of their clients by commuting directly to their clients but this is taxing on organizations. New York State must support the expansion of harm reduction service providers in high need communities that will benefit from a brick and mortar institution while also investing in mobile services that can provide naloxone, clean syringes, and other safe use supplies and administer buprenorphine.

Statewide Prison and Jail-based MAT Programs: Many of New York's jails and prisons lack the resources to provide adequate, evidence-based treatment for substance use disorder. Facilities that offer

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treatment tend to prioritize cognitive and behavioral care over comprehensive interventions that include medication used for maintenance therapy such as methadone and buprenorphine.

Supportive Housing and Housing First Models: Supportive housing programs are a way of increasing housing access and stability for chronically homeless individuals, while improving access to services and decreasing vulnerability to HIV and other diseases.[16] Supportive housing is affordable housing that links tenants with wrap-around supportive social services, and has been shown to improve lives, benefit communities, and decrease Medicaid costs.

While abstinence-only housing remains the dominant approach to affording supportive and transitional housing to people, programs are beginning to adopt low-demand or harm reduction philosophies in order to accept clients in any state of change. The goal is to first provide basic supports, including housing, case management, and access to substance abuse treatment, to motivate reduced substance use.[17] The shift from abstinence-based housing to a housing first model evolved as providers learned that sobriety restrictions create unnecessary barriers to services, and clients often fail to complete the program due to the stringent sobriety requirements. In a study on 41 New York Service provider's views of harm reduction versus abstinence and treatment first policies, treatment first providers communicated that many clients were mandated to attend intensive treatment such as rehab or detox, or clients left the programs entirely.[18] The study found that housing first providers viewed harm reduction as a more effective way to work with clients in both the short run and the long run. Housing first policies allowed for more effective and honest communication between clients and providers – as clients are not fearful that they would lose housing due to their drug use. Further, housing first providers recognize that abstinence is a component of harm reduction and make accommodations for clients that choose abstinence.

I wanted to use this testimony to convey the importance of all drug decriminalization and lay out the limitations of Rockefeller Drug Law reform and various other criminal justice diversion tactics. DPA ask that this overdose taskforce legitimately consider removing all criminal penalties for personal possession of controlled substances and paraphernalia, and fully endorse harm reduction and treatment services.

We look forward to further conversations with the Assembly regarding the implementation of these recommendations.

Thank you for your time.

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