

Thank you, Senator Carlucci, Senator Rivera and the Committee. I appreciate being given a moment of your time to talk about suicide and suicide prevention.

I am Kathleen Carney, Licensed Mental Health Counselor and the Clinic Director of Lexington Center for Recovery in Airmont, NY, where we provide treatment for those who have a primary substance use disorder. As a clinic director, I have noticed an increase in the number of clients presenting with a substance use disorder and having a combined serious mental health disorder that includes previous suicide attempts. This is what sparked my need to connect with our local Suicide Prevention Coalition, which has been a valuable resource within Rockland County.

Statistically we know that approximately 30-40% of those who are diagnosed with a Substance Use Disorder also have a diagnosable Mental Health Disorder. The reality is that ratio is much higher. Many clients do not wish to have a diagnosable substance use or a mental health disorder. In addition, many clients have never been properly diagnosed until they come into treatment. Instead many clients have been self-medicating their mental health symptoms with substances prior to treatment.

There is a correlation and connection between mood, alcohol and drug use and suicidal thoughts and behaviors. If someone has an alcohol or drug use disorder, they are more likely to have suicidal thoughts, to make a non-fatal suicide attempt and to die by suicide.

As noted in the New York State Suicide Prevention Task Force Report reducing risk factors linked to suicidal behaviors such as substance use or misuse is likely to reduce suicidal behaviors. I would echo my colleague's sentiments in recommending that the Suicide Prevention Training noted in the 2019 New York State Suicide Prevention Task Force report be offered to all clinicians, including behavioral health and substance abuse providers throughout NY state, and not just those employed by NY state. It is the hope that through screening and prevention, more at risk individuals will be identified and treatment made available.

From a treatment perspective, we have implemented protocols to screen for at risk clients that would be identified at the time of intake. We utilize a modified mini screen to help identify any clients that may be experiencing emotional stressors, behavioral crisis or have a mental health diagnosis. We screen for the severity of the alcohol or drug use.

We then do a safety check for at risk individuals to determine if a client is currently suicidal that is conducted by a program director or other licensed clinician. If available, the staff psychiatrist and the staff nurse would also be brought in. We have also utilized the Behavioral Health Response Team (BHRT) which is our local Mobile Crisis Team or 911, to come to the clinic to also evaluate clients when needed.

Overall we tend to see two different types of concerns that might be deemed "at risk" for suicide. One is for clients who may have had a previous or recent unsuccessful attempt of suicide while under the influence of alcohol or another substance (separate from

opioid overdoses). In many cases, alcohol abuse makes suicidal ideations more frequent which increases the probability of a suicide attempt. In addition, Alcohol abuse negatively impacts a person's life which can be a contributing factor in suicide. For example, alcohol and other substance use makes many mental health disorders, such as bipolar, borderline personality & depressive disorders, worse. Alcohol and other substance use can cause negative consequences in a person's life to include their employment, family, relationships, and/or create legal problems which add to a person's life stressors and may influence the risk of suicide.

The other concern, which is a growing epidemic, are Opioid Overdoses. We have seen the rise of suicide attempts rise with Opioid Overdoses, so it is important to explore the connection and work to help substance use disorder clients find stability and social connectedness and treatment. There is a blurred line between opioid overdose deaths that are intentional and unintentional because of active addiction. We know that addiction is a brain disease and with progression of active addiction comes an increase of risky behaviors and erosion of consequential thinking.

It is believed with active addiction, the synapse connection in the part of the brain that handles memories, consequential thinking and judgment is not fully working together. The way I explain it is if I come to a traffic light at 5am in the morning with absolutely no one on the road, I might think it is OK for me to make a right on red even though there is a sign that states, "No right on red". If I was in active addiction, my brain might say, "Its ok to make a right turn here, no one will ever know!" If I have a sober brain, the connections would be working and my brain would say, "No, you tried that once before and got a ticket as there was a red light camera". So this can explain how consequential thinking is different with a sober brain and one that is in active addiction. With the use of opioids, the potential consequence of overdose is not fully comprehended by the substance user.

Now with fentanyl in our area and on the streets we will continue to see a rise in unintentional suicide as fentanyl is now not just being mixed with other opioids or heroin, which increases a potential to overdose as the drug is much more potent. Fentanyl is now being mixed with cocaine, laced in marijuana and found in street-made versions of benzodiazepines such as Xanax and Klonopin.

As such there is a greater need to offer Medication-Assisted Treatment for anyone with an Opioid Use Disorder. This would entail continuing to work to reduce barriers and simplify the process to obtain insurance coverage and prior authorizations for medications and treatment alike. Medication Assisted Treatment has been repeatedly proven to reduce overdose deaths.

When we look at recovery rates for a substance use disorder, the rates are about 30% which is low. When we add medication assisted treatment, the rate increases to about 65%. I often hear the argument that the addict is just replacing one drug for another. But this is not true, it is about two concerns:

1. The most important aspect is saving someone's life

2. Helping to correct a chemical imbalance.

It is also important to consider how opioids impact a person's mood. When a person is using an opiate, their mood is brought up to a level 10 (many clients describe it as chasing euphoria). When a person stops using an opioid besides experiencing withdrawal, their mood sinks down to a level -3 (below baseline). This is how they start each day with less motivation and desire to do the things that would help them like attend treatment and take care of themselves. With the use of MATs, for example, Suboxone which brings a person's mood up to a level 2 or 3. This is not high enough for person to be high but just enough to allow a person to be motivated to do the things that they need, such as treatment. This is where the internal work begins.

We need to be able to offer the use of Methadone, buprenorphine (Suboxone) or Naltrexone (Vivitrol) in conjunction with counseling around overdose and suicide prevention, treatment for any mental health conditions and Naloxone (Narcan) distribution for clients and their families.

Treatment must address both substance use and mental health disorders simultaneously in order for long term recovery to be achieved. Treatment will also take time as it is not a quick fix. These disorders are lifelong disorders and while remission is very possible, the tools and support need to be made available to give the brain time to heal to allow a person to achieve long term recovery. Overall, the brain will take approximately 18 months to heal from active addiction. As a person is growing up, our brains learn natural ways to help us feel good. With the use of an opiate, our brains learn a short-cut to the pleasure center. When a person continues to use opiates, the brain begins to prefer to take the shortcut to the pleasure center and the old brain pathway sort of becomes overgrown with weeds. With early recovery, the brain is healing and weeding those old overgrown pathways to get them to work again. In time, when a client does the internal work and starts to rebuild and accomplish things in their life again, they create the life they want to live and this is where long term recovery happens.

Continued aftercare with a therapist and psychiatrist, love and social support are crucial to mental wellbeing. Access to education, employment and other future-oriented opportunities are also important.

One other aspect that is often overlooked when talking about suicide is the connection to gambling addiction. The National Council on Problem Gamblers reports that one in five problem gamblers have attempted Suicide which is at a higher rate than any other addictive disorder.