REPORT OF THE JOINT SENATE TASK FORCE

ON OPIOIDS, ADDICTION AND OVERDOSE PREVENTION

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EXECUTIVE SUMMARY

Throughout the information-gathering process, the Task Force received recommendations from directly impacted individuals and families, medical and treatment professionals, advocates, and others who called on the State to address one of the most serious public health crises impacting New York today, one which has cost the lives of tens of thousands of New Yorkers over the last decade.

Some of these recommendations emphasized more general themes that the speakers felt New York needed to focus on in addressing this issue. These included: prioritizing saving lives; ensuring that New Yorkers who use drugs have access to needed, evidence-based services; and acting to reduce the negative societal consequences that accompany drug use, such as barriers to employment and housing, and criminal justice and child welfare involvement. Speakers also called for New York to address the root causes of drug use, such as adverse childhood experiences and social determinants of health.

In addition to these more general recommendations, participants called for a number of specific actions. Based on this input, there was near unanimous agreement among Task Force members to recommend that New York take the following actions:

Prevention

New York has taken several important steps in recent years to address the over-prescribing of opioids. However, more needs to be done to prevent the development of substance use disorder (SUD) and intervene as soon as signs of possible problematic use appear. These include:

Preventing Drug Use Among Youth

- **Ensuring that school-based substance use education is evidence-based**.

Educating the Medical Profession about Preventing and Addressing SUD

- **Requiring education on pain management and SUD for medical, dental, mental health, and nursing students and professionals**; and
- **Identifying opportunities and incentivizing use of early identification and intervention strategies**.

Adopting Best Practices for Addressing the Risks Caused by Opioid Prescribing

- **Expanding patient access to safer prescriptions**;
- **Discussing risks and alternatives to opioid prescriptions with patients**; and
- **Co-prescribing an opioid antagonist with opioid prescriptions**.

Removing Insurance Barriers to Alternatives

- **Expanding coverage of non-opioid alternatives**.

Increasing Funding

- **Investing in the prevention workforce and programming**;
- **Expanding access to sober activities**; and
- **Incentivizing screening and early intervention.**

Harm Reduction

New York has been a national leader in adopting life-saving harm reduction policies. The State must continue to seek out and adopt all strategies that will save lives and reduce the health consequences of drug use. To achieve this goal, the Task Force was nearly unanimous in recommending:

Increasing Access to Overdose Reversal Medications

- **Increasing access to overdose reversal medications to individuals at highest risk of overdose**;
- **Ensuring that first responders carry and know how to use overdose reversal medications**; and
- **Removing disincentives to carrying or using overdose reversal medications**.

Increasing Funding

- **Supporting and expanding Drug User Health Hubs**;
- **Supporting and expanding crisis stabilization centers**; and
- **Funding housing and shelter services for individuals who use drugs.**

Treatment and Recovery

New York has one of the best developed treatment systems in the country. Yet too many New Yorkers remain unable to find care that is evidence-based and appropriate to their needs. The Task Force offers the following near unanimous recommendations:

Improving Access to Evidence-Based, Person-Centered Treatment

- **Establishing an easily-accessible phone, text, and online directory to help people locate needed services**;
- **Ensuring treatment providers are providing high quality, evidence-based care**; and
- **Addressing on-going patient brokering**.

Ensuring that all New Yorkers Have Access to Medication Assisted Treatment

- **Requiring that emergency rooms offer MAT following overdose**; and
- **Exploring alternative options for providing MAT**.

Addressing Remaining Insurance Barriers

- **Eliminating insurance barriers that limit access to the full range of MAT**;
- **Prohibiting or limiting daily co-payments for treatment**;
- **Addressing ongoing rate disparities between SUD and mental health care and other health care**;
- **Mandating insurance standards for network adequacy**; and
- **Increasing the role of non-medical considerations in determining patient care needs**.

Increasing Access to Services that Support Long-Term Recovery

- **Developing guidelines on best practices for recovery housing**; and
- **Ensuring access to employment and other needed services**.

Increasing Funding

- **Building on New York's existing public education campaign**;
- **Incentivizing medical providers to offer SUD care**;
- **Addressing the crisis in the prevention and treatment fields**;
- **Supporting the treatment workforce to create greater stability in the field**;
- **Improving funding effectiveness by increasing the role of counties**; and
- **Funding services within rural communities.**

Non-Health Factors

The Task Force heard about a number of non-health issues that impact New Yorkers who use drugs, such as criminal justice and child welfare involvement, and the loss of housing and employment. The Task Force's near unanimous recommendations include:

Identifying New Funding Sources

- **Establishing an Opioid Settlement Fund**.

Using Research to Maximize the Effectiveness of All Interventions

- **Increasing access to data.**

Reducing Arrests and Incarceration

- **Increasing opportunities for diversion from incarceration**;
- **Reforming problem-solving courts**;
- **Allowing individuals to safely dispose of syringes and drugs without fear of arrest**;
- **Limiting the use of incarceration as punishment for a positive drug test for individuals on parole or probation**; and
- **Increasing funding for providers offering services to divert individuals from arrest or incarceration and link them to community programming**.

Improving SUD Care During Incarceration

- **Improving SUD care for incarcerated individuals**; and
- **Ensuring access to MAT for incarcerated individuals and those under community supervision**.

Improving Prenatal and Neonatal Care

- **Barring drug testing without maternal consent except in cases of medical emergency**; and
- **Establishing model programs for treating neonatal abstinence syndrome**.

Using Best Practices to Address Parental Drug Use and Keep Families Together

- **Requiring the Office of Children and Family Services (OCFS) to develop guidance for addressing prenatal and parental drug use and ensuring these policies are adopted**;
- **Requiring the use of best practices by the child welfare and family court systems**;
- **Limiting the use of drug testing by the child welfare system**; and
- **Establishing more supportive conditions for working parents.**

Federal Recommendations

In addition to the recommendations above, the Task Force call on the Federal Government to take the following actions:

- **Baseline and increase recent federal funding to address the overdose epidemic**;
- **Remove unnecessary barriers to MAT, including approving new models of care**;
- **Continue and expand the Certified Community Behavioral Health Clinics (CCBHC) program**;
- **Support successful transition from incarceration by allowing states to bill Medicaid prior to release**; and
- **Amend the Americans with Disabilities Act (ADA) to establish protections for individuals who have a current addiction to drugs**.

Additional Issues under Consideration

The Task Force also heard from a number of hearing and roundtable participants, including directly impacted individuals and families, medical and public health professionals, and advocates about additional interventions intended to save lives and reduce the risk of bloodborne diseases.

While there was support from the Task Force Chairs and others for some of these items, the Task Force as a whole was unable to reach agreement on including the following as recommendations:

- **Removing unnecessary barriers to syringe access**;
- **Establishing an overdose prevention center pilot initiative**; and
- **Decriminalization of low-level drug possession**.

INTRODUCTION

In 2018, 3,268 New Yorkers died from an opioid-related overdose. This was 384 fewer individuals than in 2017, the first reduction since 2010. However, the number of deaths is still nearly two-and-a-half times higher than the 2010 total when 956 New Yorkers died of an opioid overdose. The decrease is due in large part to legislative, policy and budgetary actions taken at the Federal, State and local levels over the last few years, which have significantly increased access to lifesaving tools and care.

However, these decreases have been uneven, as certain regions and communities have seen major reductions in deaths, even while others continue to see increases. New York is also beginning to see increases in the number of people struggling with and dying from substances other than opiates, including cocaine and methamphetamine. According to the Federal Centers for Disease Control and Prevention, one in six overdose deaths in New York in 2017 were caused by drugs other than opioids.[1]

New York has approached issues of addiction with foresight, which has helped limit other harms caused by drugs. New York was among the first states to increase safe access to unused syringes, resulting in an over 90% reduction in the number of new HIV cases attributable to injection drug use since 2002. These reductions have helped put the State on track to end the HIV epidemic. New York was also among the first states to move away from a punitive approach to drugs. In 2009, under Senate Democratic control, the State enacted landmark reforms to the Rockefeller Drug Laws, resulting in major decreases in the number of incarcerations for drug crimes. These decreases contributed significantly to the 39% reduction in state incarcerations in the past twenty years.

To build on these successes and to address ongoing problems, Senate Majority Leader Andrea Stewart-Cousins announced the creation of the Joint Senate Task Force on Opioids, Addiction & Overdose Prevention on July 22, 2019. Leader Stewart-Cousins charged the Task Force with carrying out a holistic review of New York's overdose crisis and its approach to drug use, with a focus on saving lives and improving individual and community health.

This Joint Task Force continues the Senate's years-long efforts to deal with the negative effects of substance misuse in our communities. The recommendations of at least two prior senate task forces (2014, 2018) and independent hearings (2013) have resulted in increased funding for education, prevention, treatment and recovery.

The Task Force's work also builds on a series of historic pieces of legislation passed by the Senate Democratic Majority in 2019 to address the overdose epidemic, including legislation to:

- **Prevent new addiction**, including increasing access to abuse deterrent opioid medication formulations (S6397 – Carlucci) and creating training materials for screening for substance use disorders (S2507 – Kaplan).

[1] https://www.cdc.gov/drugoverdose/data/statedeaths.html

- **Increase reporting requirements**, including requiring quarterly reporting on the outcome of initiatives to address the overdose epidemic (S4650 – Sanders) and requiring that opioid overdose death certificates include the type of opioid involved (S1668 – Brooks).
- **Increase access to naloxone**, including establishing an online directory of distributors (S4499 – Harckham) and requiring that high schools carry naloxone (S3772 – Addabbo).
- **Increase insurance coverage for drug treatment**, including doubling the length of treatment that insurers are required to cover to 28 days of drug treatment and limiting co-pays, thereby helping to ensure that people receive the care they need. The Senate also passed legislation eliminating formulary restrictions for medication assisted treatment in both Medicaid (S5935A – Harckham) and private insurance (S4808 – Harckham).
- **Improve addiction care for incarcerated individuals**, including $1 million in new funding for substance use disorder care in local jails, ensuring incarcerated individuals have access to medication assisted treatment (S2161B – Bailey) and expanding oversight of substance use disorder treatment and other healthcare for incarcerated individuals (S1073A – Rivera).

Task Force Process

In order to better understand the scope of the problem in different communities across the state and develop solutions, the Task Force held public hearings, roundtables and conducted site visits to learn more about continuing challenges and innovative approaches for addressing these issues.

> *"People who use drugs must be included in any meaningful decision-making processes about addiction and overdose. Unfortunately, intense stigmatization and criminalization frequently preclude the involvement of people who use drugs, even when their perspectives are sought."*
>
> *- Tina Wolf, Executive Director and Co-Founder, Community Action for Social Justice*

In addition to offering an opportunity to hear from experts, these events enabled Task Force members to hear from the people most directly impacted, those currently using drugs, those in recovery, families who have lost relatives, and families who have relatives who continue to use or are incarcerated. These experiences reinforced the need to center the voices of those with lived experience in the conversation about how to address substance use as those closest to the problem are often best able to offer perspectives that can help with developing solutions.

Hearing and Roundtables

- **August 9** – Public Hearing, St. Barnabas Hospital, The Bronx
- **August 26** – Roundtable, Madison County Office Building, Wampsville
- **September 16** – Roundtable, St. John's University, Staten Island
- **October 3** – Roundtable, Putnam County Training and Operations Center, Carmel
- **October 3** – Public Hearing, Putnam County Training and Operations Center, Carmel
- **October 15** – Public Hearing, Patchogue Theatre of the Performing Arts, Patchogue
- **October 30** – Roundtable, Catholic Health Medical Center, Buffalo
- **November 15** – Public Hearing, Legislative Office Building, Albany

Site Visits

- **August 27** – Site Visit, Roswell Park Comprehensive Cancer Center, Buffalo
- **August 27** – Site Visit, Neonatal Abstinence Unit, Sisters Hospital, Buffalo
- **August 29** – Site Visit, Overdose Prevention Center, Parkdale Queen West Community Health Center, Toronto
- **October 4** – Site Visit, Russell E Blaisdell Addiction Treatment Center, Orangeburg
- **October 30** – Site Visit, Niagara County Jail, Lockport
- **November 21** – Site Visit, Interborough Development and Consultation Center, Brooklyn

Task Force site visits also offered an opportunity to learn about innovative approaches for preventing or responding to problematic substance use.

On August 27, the Task Force met with Dr. Emese Zsiros, a researcher at Roswell Park Comprehensive Cancer Center in Buffalo. Dr. Zsiros presented research demonstrating exciting opportunities for prescribing fewer opioids to patients following cancer surgery. In the study, patients who had ambulatory or minimally invasive cancer surgery were prescribed no or minimal quantities of opioids. The research showed that prescribing fewer opioids did not impact postoperative pain scores, complications, or increases in prescription refill requests.[2]

Also, on August 27, the Task Force visited Sisters Hospital in Buffalo to learn about their state-of-the-art unit for addressing the needs of infants born with neonatal abstinence syndrome. Sisters' approach focuses on keeping mother and child together throughout the child's hospitalization, based on research showing that allowing mothers to stay with their children has a positive impact on both mother and baby. Contact between mother and child is calming for the baby and has been shown to help mothers continue on their road to recovery.

On August 29, the Task Force visited an overdose prevention center in Toronto, in which medical professionals supervise safer use for individuals suffering from addiction. The site is located within a community health center, which allows participants to receive health and other services and enables immediate entry into treatment when a person is ready. Staff informed the task force of efforts to engage and inform community stakeholders, and the financial and social benefits of fewer overdoses on the local health care system.

On October 30, the Task Force toured the Niagara County Jail to learn more about the jail's strategies for providing substance use disorder treatment. Here, incarcerated individuals suffering from substance use disorder are kept in a separate pod from the rest of the population. During their time in the pod, they have access to medication-assisted treatment and group therapy sessions offered by outside counselors who specialize in substance use disorder treatment. Individuals incarcerated in the facility told Task Force members that, for the first time in their lives, they felt like they were getting help from people who actually care about them. Employees of the jail are also in open communication with recovery services so that incarcerated individuals are connected with support services upon discharge.

[2] http://bit.ly/39PCgb4

BACKGROUND INFORMATION

HISTORY OF THE OVERDOSE EPIDEMIC

The traditional narrative attributes the overdose epidemic to the overprescribing of opioids. But many researchers now believe the causes to be more complex.[3] In 2017, the National Academy of Sciences concluded that "overprescribing was not the sole cause of the problem. While increased opioid prescribing for chronic pain has been a vector of the opioid epidemic, researchers agree that such structural factors as lack of economic opportunity, poor working conditions, and eroded social capital in depressed communities, accompanied by hopelessness and despair, are root causes of the misuse of opioids and other substances and [substance use disorder] SUD."[4]

"Back when I started my career in 1994, we arrested everybody for every drug thing there was. The War on Drugs was full-steam ahead. I did that myself. I caused a ton of trauma within my community. And I continued to cause that for a long time until I finally started to talk to people… [who told me] 'you are causing trauma to a lot of folks and folks that don't look like you'... Not only were we causing trauma by the arrest and incarceration cycle but we weren't driving crime down because we weren't getting to the root cause of the issue."

- Brendan J. Cox, former Albany Chief of Police

Some sources have suggested that the epidemic is the next chapter in a long history of drug misuse in the U.S. that includes the heroin and crack epidemics.[5] Researchers also tie the epidemic to other "diseases of despair," including alcohol-related diseases and suicide, which have resulted in a decrease in life expectancy among men and an increase in the number of deaths and the death rate among many demographic groups.[6] Some public health researchers argue that as a result of this, interventions to address the current epidemic will be unsuccessful if underlying structural factors are also not addressed.[7]

At the same time, the response to the current epidemic has been significantly different to the response to the heroin and crack epidemics. While the response to prior epidemics was mostly based on punitive approaches like the "war on drugs," the current epidemic has elicited calls to replace criminal justice responses to drug use with a public health approach.[8] Many point to race as a key factor in this change. Yet, despite popular perception, the current epidemic is not solely white, with people of color representing an increasing share of those dying of overdoses.[9]

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5846593/pdf/AJPH.2017.304187.pdf
[4] https://www.ncbi.nlm.nih.gov/books/NBK458662/
[5] https://www.statnews.com/2017/10/29/opioid-epidemic-shares-chilling-similarities-with-past-drug-crises/
[6] Some articles emphasize the fact that people generally use drugs, at least initially, because they provide pleasure, though the development of problematic use may be linked to socioeconomic, environmental or genetic factors.
[7] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5846593/pdf/AJPH.2017.304187.pdf
[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5105018/
[9] https://www.nytimes.com/2019/02/26/opinion/opioid-crisis-drug-users.html

SCIENCE OF SUBSTANCE USE DISORDER

Substance use disorder (SUD) is a chronic health condition that develops when psychoactive substance use leads to negative consequences. Substances include alcohol, tobacco, and prescription and illicit drugs. Use of these substances in high doses or inappropriate circumstances can cause health and social problems, including SUD. The term addiction is no longer used in contemporary medical diagnoses, but in general it refers to more severe SUDs, characterized by negative consequences, compulsive use, cravings, and loss of control.

Substance use and SUD are increasingly viewed as being on a spectrum as opposed to a strict binary. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM–5), the principal authority for psychiatric diagnoses in the U.S., combines substance abuse and substance dependence into a single disorder, SUD, measured on a continuum from mild to severe.[10] Understanding this spectrum is important because people with mild SUD may stop or cut down on their use with education and advice, while people with more severe SUD may need more formal treatment.

There have also been advances in the physiological understanding of SUD. Brain imaging shows changes in the brains of patients with a SUD, leading many researchers to describe SUD as an "acquired chronic illness, similar … to type 2 diabetes," *i.e.*, manageable but not yet curable.[11, 12] Areas of the brain that regulate mood, motivation, and self-control are affected in patients with SUDs, though patients may regain normal function with medication and/or behavioral treatment.

> *"It is a disease, and we have to treat it as such. It doesn't just go away because you have been sober for a year or two, or you're leaving rehab. It's a disease."*
>
> *- Debbian Fletcher-Blake, CEO, VIP Community Services, Inc.*

Not all users will develop a SUD. In fact, just "a minority of people who use drugs ultimately become addicted." Researchers estimate that only approximately 10% of those exposed to addictive drugs will develop a severe addiction, though statistics vary depending on the drug.[13] One Institute of Medicine study gives the rate of "dependence" among those who try heroin as 23%.[14] Some individuals are more susceptible to drug use and addiction than others, due to genetic factors and a host of environmental and social factors,[15] including family history, childhood trauma, early exposure to drug use, high risk environments, and mental illness.

[10] https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Substance-Use-Disorder.pdf
[11] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5525418/
[12] Others have questioned the brain disease model. Alternative theories emphasize socioeconomic and environmental factors (e.g. https://bit.ly/2xW4Oyp) or view SUD as a learning disorder (https://nyti.ms/2KoauGB)
[13] https://www.nejm.org/doi/full/10.1056/NEJMra1511480
[14] https://nyti.ms/2MEmJ4O
[15] https://bit.ly/2ylKIQc

CONSEQUENCES OF DRUG USE

Drug use can have severe negative consequences, impacting a person's employment, access to housing and health care, and even the loss of children and liberty.

Criminal Justice. Involvement in the criminal justice system creates instability in an individual's life. Cycling in and out of jails is a common experience for those with a SUD because they are often arrested for misdemeanor possession of drugs or for crimes that support their use (*e.g.*, petit larceny or sex work). These arrests remove the individual from their support systems by negatively impacting family connections, housing, and employment. The experience can be especially destabilizing for those on medication assisted treatment (MAT) or in early drug treatment. The period following release from incarceration can be an especially dangerous time for those with an opioid use disorder (OUD). The trauma of incarceration can also increase the likelihood of an individual developing a SUD, of overdose, and of death from drug use.

Child Welfare. Historically, child welfare systems have responded to drug use through removal of children from the household and through other intrusive interventions, even when drug use does not place the child at risk. This is especially true among low-income communities of color. Once a child is removed, it can be very difficult for parents to have the child returned. Research suggests that removal from parents and placement into foster care may result in trauma that can negatively impact the child. One study found that the trauma caused by placement in foster care may even result in an increased likelihood of developing a SUD.[16] This research indicates that removal should only be used as a last resort when needed to protect the welfare of the child. The child's removal may also impact the parent's success in treatment. Separately, advocates report that child welfare systems in New York continue to remove both newborns and children from parents on MAT.

Employment. Under both Federal and State law, past drug addiction and past or current alcohol addiction are considered disabilities. As a result, employers may not fire or refuse to hire individuals for past drug addiction. It is also illegal for employers to discriminate against individuals who are in treatment for a SUD, including those on MAT. (These laws do not prevent employers from firing individuals who do not perform their job functions or break workplace rules.)[17] However, these laws do not protect employees where there is evidence of current drug use. Individuals may be fired for both a current addiction to drugs and for drug use not caused by a SUD, regardless of whether the drug use interferes with the performance of job functions.

Separately, a number of recent articles have questioned the value of employee drug testing in many fields, though not enough research has been done on this topic.[18] One study found a correlation between race and increased drug testing, including among more white collar jobs.[19] At the same time, another study found that use of drug testing increased employment rates among low skilled black men, likely because the test counters employer stereotypes.[20]

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[16] https://www.ncbi.nlm.nih.gov/pubmed/21049532
[17] https://lac.org/resources/learn-your-rights-discrimination-hiv-aids-addiction-criminal-record/
[18] https://www.sciencedirect.com/science/article/abs/pii/S0001457514001547
[19] https://www.ncbi.nlm.nih.gov/pubmed/24112118
[20] https://www.econstor.eu/bitstream/10419/62463/1/717900614.pdf

Housing. As in the employment context, it is illegal for real estate brokers, landlords and sellers to discriminate against individuals for past drug addiction, or past or current alcohol addiction. However, landlords, sellers, and brokers can and do ask about illegal drug use and can refuse to rent or sell to someone who is currently using drugs illegally.

Within public housing, U.S. Department of Housing and Urban Development (HUD) regulations require that public housing authorities (PHAs) deny admission to applicants currently engaging in illegal drug use.[21] PHAs are given significant latitude in defining current use and are not required to inquire about current drug use.[22] The New York City Housing Authority (NYCHA) goes beyond the federal requirements as its admission forms ask about drug use and its tenant selection plan mandates denial of anyone who has illegally used drugs in the prior three years. Families remain ineligible for three years after an ineligibility finding, unless they can show that the individual in question has been drug-free for a year. Separately, NYCHA bars admission for four years to households that include those convicted of misdemeanor drug possession.[23] However, denials can be overcome by demonstrating rehabilitation. NYCHA also sometimes evicts residents convicted of drug possession.[24] Both policies go beyond what the federal government requires.

Health care. It is illegal for health care providers or insurers to deny care or coverage to individuals (or to charge individuals more for coverage) because of a disability, including SUD, even if the individual is currently using drugs illegally. Yet, despite these protections, individuals with a SUD, especially those who currently use drugs, are routinely denied needed care. [25]

BEST PRACTICES

Prevention. Research shows that childhood, especially adolescence, is the period of highest risk for developing a SUD, as greater than 50% of first diagnoses occur by age 25. This period is particularly significant because the brain is especially sensitive when it is still developing. While nearly two-thirds of young people who try a substance do not develop a chronic problem, the other third may be at risk of misuse and dependence.[26]

Risk factors, such as those described earlier, impact the likelihood of drug misuse.[27] Many of these same factors also predict delinquency, violence, risky sexual behaviors, school misbehavior, and dropping out of school.[28] Awareness of these risk factors can enable the tailoring of prevention strategies to the patient. Research supports approaches that reduce stigma, provide accurate and credible information, use peers and schools, are culturally appropriate, and

[21] https://www.ncbi.nlm.nih.gov/pubmed/23490450
[22] https://www.hud.gov/sites/documents/PIH2015-19.PDF
[23] https://www1.nyc.gov/assets/nycha/downloads/pdf/TSAPlan.pdf
[24] https://www1.nyc.gov/assets/nycha/downloads/pdf/law-ansf-case-handling-guidelines.pdf
[25] https://www.ncbi.nlm.nih.gov/pubmed/23490450
[26] https://psycnet.apa.org/record/2010-21811-002
[27] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4398056/
[28] https://www.sciencedirect.com/science/article/abs/pii/S0306460302002988

employ strengths-based, trauma-informed models. Research also suggests that traditional fear-based strategies are largely ineffective and even counterproductive.[29]

Treatment. Many individuals with problematic substance use are able to address their use on their own or with minimal support. Intervention and access to care for those exhibiting early signs of problematic drug use have also been shown to be effective in preventing the worsening of a SUD. For others, more significant interventions are required. In such cases, timely access to care can be essential for successfully engaging the person in treatment. If individuals are unable to access the care they need when they are ready to receive it, many will choose not to pursue treatment and will instead continue with their problematic usage.

Yet, according to the Federal Substance Abuse and Mental Health Services Administration's "2016-2017 National Survey on Drug Use and Health," only 8.5% of New Yorkers twelve and over who needed SUD treatment received treatment in a specialized facility. This number does not take into account a number of factors, including individuals addressing their SUD outside a specialized facility and the individual's own readiness to address their substance use. Furthermore, since 2017, New York has added one thousand two hundred opioid treatment slots and two hundred residential treatment beds. However, in spite of these factors, the fact that only 8.5% of individuals received such care in 2016 and 2017 indicates that thousands of New Yorkers are not receiving needed care to address their SUD.

There is also broad scientific consensus that, for most people with an OUD, FDA-approved medications are the most effective means of treating the OUD and of preventing overdoses. These medications have other positive impacts, including reducing bloodborne diseases and involvement in criminal behavior. Medications do not exist for other forms of SUD (except alcohol). Behavioral interventions, including psychotherapy and psychosocial supports, community-based supports, and referrals to services can help many people with these other use disorders.

There is also significant overlap between those diagnosed with SUDs and other mental disorders – 48% of individuals with a SUD also suffer from mental illness.[30] Treating these conditions in silos reduces the likelihood of success in addressing either. Additionally, individuals with a SUD use significantly more medical resources than the general

"All three O agencies have created their own separate, siloed funding for crisis… They can't respond in every crisis even though they're supposed to. So we see an increase in psych hospitalization of people with developmental disabilities and autism. OASAS had the open access grant, again a great resource... It can't be 24/7. It's only funded for two more months. And then OMH has their crisis. So our goal was to... create one comprehensive behavioral crisis hotline number that, you don't have to ask the person… I know you're mentally ill but are you using substances. We can only get you into this door."

- Michael Orth, Commissioner, Westchester County Department of Community Mental Health

[29] https://bit.ly/2YEFg3f

[30] http://bit.ly/36BERU3 (Calculation of the number of individuals with any mental illness and substance use disorder (9.2 million) divided by the number of individuals with a substance use disorder (19.3).)

population and are more likely to develop costly medical conditions.[31] As a result, integration of SUD care with care for other mental disorders and primary care is a best practice.

For those wishing to stop using drugs, housing stability is essential. To succeed, housing must take into account the nature of drug use and treatment. People have different needs depending on where they are in their recovery. Housing models must also factor in the reality that relapse is part of recovery, so patients will likely transition between different types of housing.

Recovery. In line with the changing perspectives on SUD as a treatable chronic brain condition, researchers recognize that relapse is often part of recovery and that relapses can occur even after many years without drug use. As a result, individuals may need continued supports for many years, or even the rest of their lives. The nature of these supports vary over the course of an individual's life. In recognition of this, New York and other states have moved away from the traditional acute care model of drug treatment towards "recovery-oriented systems of care"[32] that continue to provide individualized supports after the individual has completed treatment.

INSURANCE

Insurers have traditionally imposed significant barriers to access to SUD care. To address these barriers, in 2008, Congress enacted the Mental Health Parity and Addiction Equity Act. Under this law, which only applied to large group plans, mental health and SUD must be covered equally with medical and surgical care. In 2010, the ACA required covered plans to include SUD care as an essential health benefit.

New York has also enacted a number of insurance reforms to enable New Yorkers to obtain care, including requiring that insurers cover four weeks of treatment, cover medication-assisted treatment, and use a State approved tool for determining an individual's level of care need. The State also created an ombudsman program, the Community Health Access to Addiction & Mental Healthcare Project (CHAMP), to help ensure New Yorkers are not prevented from accessing needed services as a result of insurance barriers. Separately, the New York Attorney General's Office has brought a number of enforcement actions against insurers for failure to comply with these federal and state laws.[33] Despite these efforts, advocates, providers and patients argue that insurers continue to deny needed care.

HEALTH AND SERVICE NEEDS

While treatment is successful for many, not everyone is able to avoid problematic use. Numerous strategies have been used with the goal of keeping individuals alive and reducing the likelihood of bloodborne diseases and other conditions. Strategies to achieve this are generally referred to as "harm reduction." These strategies aim to reduce the negative consequences associated with drug use.[34]

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[31] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5525418/
[32] https://www.oasas.ny.gov/recovery/ROSC.cfm
[33] https://bit.ly/2YHx06u
[34] https://harmreduction.org/about-us/principles-of-harm-reduction/

Health. Some of the more familiar examples of harm reduction include access to sterile syringes, naloxone kits, and strips to test for the presence of fentanyl. Across Europe, Australia, and Canada, the operation of overdose prevention centers also exist -- spaces where individuals can use pre-obtained drugs under the supervision of medical professionals. Within these facilities, staff members are able to provide sterile injection supplies and collect used hypodermic needles and syringes while also referring patients to treatment options, job training, and other social services.

Housing. A number of studies have shown that housing plays a key role in enabling individuals to properly care for their health. This is equally true in the case of drug use. Some advocates argue for a "Housing First" model to provide housing for those currently using drugs without requiring abstinence. The Housing First model has been shown to promote housing stability,[35] particularly among people who have been without a home for long periods and who have serious psychiatric disabilities, a SUD, or other disabilities. The model can also assist someone to transition into treatment when ready. The Center on Addiction evaluated a New York City supportive housing program for individuals not yet willing to commit to abstinence, and found that the program was successful in reducing the use of shelters, jails, and medical services. This reduction in crisis services resulted in savings, which offset the cost of the housing program.[36]

[35] https://endhomelessness.org/resource/housing-first/
[36] www.centeronaddiction.org/the-buzz-blog/supportive-housing-improves-addiction-recovery.

GENERAL THEMES FROM HEARINGS AND ROUNDTABLES

Based on the input the Task Force received from participants throughout our hearings and roundtables, there was near unanimous agreement to recommend that New York's policies be based on the following priorities:

- **Saving lives**: Echoed throughout these events was the importance of prioritizing saving lives. Those who use drugs are as deserving as all other individuals. Saving lives is the only way of ensuring that individuals have a chance to address their substance use.
- **Prevention:** Public health experts and others emphasized the importance of prevention. Investments in prevention can save lives and money while improving health. Some of the elements needed to prevent SUD are beyond the scope of this report.[37] However, evidence-based prevention programs and services have been shown to be effective. These programs are significantly underfunded.
- **Reducing harm:** Families and individuals, as well as doctors and public health professionals, expressed strong support for the use of harm reduction measures to achieve the goal of saving lives and reducing the spread of bloodborne diseases. These strategies, which involve meeting people where they are, help improve the quality of life of individuals with a SUD. This in turn increases the likelihood of individuals seeking help.
- **Treating SUD as a disease:** There was broad acceptance among participants, including criminal justice and public health professionals, as well as individuals and families, that SUD is a chronic, relapsing disorder, not a moral failing or crime. New York must therefore adopt a public health-based approach to drug use, centered on support for the individual, rather than the belief that drug use is a choice for which people need to be punished.
- **Addressing SUD rather than opioids**: A number of participants emphasized that the "opioid crisis" is not new but rather the next in a series of addiction crises that includes the heroin epidemic of the 1970s and the crack epidemic of the 1980s and '90s. To limit future crises, the State must address root causes of substance misuse.[38] Participants pointed out that certain regions have recently seen increases in admissions to care, hospitalizations, and deaths due to drugs such as cocaine and methamphetamine.
- **Addressing stigma**: Nearly everyone the Task Force heard from identified stigma as a central element contributing to the perpetuation of a SUD. Stigma discourages individuals from seeking services that keep them alive, entering treatment when they are ready to address their use, and remaining sober upon treatment completion. It also

> *"The only moral argument that matters in this discussion is the one that says I have a moral issue with allowing people to die a preventable death, while we have evidence-based solutions to prevent them."*
>
> *- Cortney Lovell, Co-Founder, Our Wellness Collective*

[37] E.g. addressing Adverse Childhood Experience, social determinants of health and trauma (see below)
[38] Ibid.

discourages use of MAT and contributes to "not in my backyard" (NIMBY) attitudes that limit new, needed programming.

- **Offering evidence based, person-centered treatment on demand**: Lack of access to treatment remains a significant concern. We heard from parents and others about the challenges involved in getting loved ones into treatment and ensuring that they get the right type and quantity of treatment. This treatment must also be based on the latest research. Treatment plans should identify the individual's specific needs and their treatment goals. Addressing the needs of those with a co-occurring mental health disorder is essential. Treatment must also be based on the individual's substance choice, be culturally competent and take into account what community supports are available to the individual during and after treatment. Lastly, treatment must be based on a harm reduction, rather than pure abstinence model. Harm reduction – reduced or healthier drug use – must be acknowledged as progress along with total abstinence from substances.

> *"There's still the shame and stigma in the Emergency Room with 'Oh the frequent flyer is back.' 'Oh, that guy.' 'These people.' Those words have to stop. They are sick people trying to get well. They're not dirty people trying to get clean. They're sick people trying to get well."*
>
> *- Linda Ventura, mother who lost her son*

- **Increasing access to recovery support services that help individuals maintain their sobriety or reduced substance use:** As treatment providers, family members, and others explained, individuals without access to safe housing, employment and educational opportunities, and other supports are less likely to maintain the benefits of the treatment that they receive. Lack of access to supports increases the likelihood of relapse, overdose and death. It also means that the resources invested in helping the individual were wasted.
- **Investing in the workforce:** Providers and provider coalitions described a workforce crisis in the community behavioral health sector. They pointed out that helping people with a SUD is emotionally challenging work. Salaries for those who provide such services have barely increased in recent years. As a result, staff are able to find jobs of equal or better pay without many of the challenges and stresses involved in this work. This has led to programs facing significant turnover. High turnover decreases the likelihood of participant success because, without staffing consistency, individuals are unlikely to develop the trust needed to address their use.

> *"The community behavioral health sector is at a tipping point. Our turnover rate in 2017 was between 35 and 40% annually of staff who are working front lines and, frankly, suffering all kinds of trauma as a result of what they're seeing... [That] we don't pay them for the care that they provide and for being on the front lines… is completely unacceptable."*
>
> *- Lauri Cole, MSW, Executive Director, New York State Council for Community Behavioral Healthcare*

Through this process, the Task Force concluded that addressing substance use requires addressing larger societal issues that contribute to some people's decision to use substances and to the likelihood that this use will become problematic. These societal issues are beyond the scope of this report but success in preventing future crises will depend on a strategy for addressing them. These issues include:

- **Adverse Childhood Experiences (ACEs)**: Studies show that negative experiences during childhood—such as experiencing or witnessing violence or abuse, instability due to parental separation or household members being in jail or prison, or having a family member attempt or die by suicide—can contribute to the development of a SUD, as well as to a range of other negative behaviors, including delinquency and violence. New York must take steps to protect individuals from such experiences and provide appropriate care to children who experience them. On January 1, 2020, California launched a first-of-its kind ACEs initiative, "ACEs Aware."[39] The initiative calls on all Medi-Cal providers to get trained on and perform routine screening for ACEs and toxic stress. Providers will now be able to receive payment for conducting ACEs screenings for children and adults. The Task Force recommends that New York State establish a similar initiative. The State should also consider encouraging, or even mandating, additional screening for children in the K through 8th grade setting.

> *"I had a mental problem in essence, because I was abused as a child. I didn't know how to deal with it, and the drugs are what kept me going."*
>
> *- Albert Wright, person with lived experience*

- **Social Determinants of Health:** Social Determinants of Health, including housing, education, healthcare, and employment, increase the likelihood of developing SUD. Addressing these societal factors will save lives and improve health.
- **Trauma, including sexual trauma**: Individuals who experience a traumatic experience are at increased risk of developing a SUD. Decreasing the likelihood of trauma and providing appropriate care to individuals who have suffered trauma are essential to preventing SUD.

[39] https://www.acesaware.org/

PREVENTION

New York has taken several important steps in recent years to address the over-prescribing of opioids. However, more needs to be done to prevent SUD.

As indicated above, some steps are beyond the scope of this report, such as addressing adverse childhood experiences, trauma, and other social determinants of health. Others include ensuring that young people receive evidence-based substance use education, investing in a prevention infrastructure that has been crippled by underfunding, and ensuring that all New Yorkers have access to evidence-based pain management care, including access to alternatives to opioids.

Among these items, a majority of the Task Force has identified the following priorities, which we believe will help limit future harms from drug use:

POLICY RECOMMENDATIONS

Youth Prevention

Young brains are still developing. As a result, using alcohol and drugs at an early age can contribute to the development of SUD. Research has shown that prevention education can be an effective tool in preventing both substance use and other problematic behaviors.

To prevent youth substance use, the Task Force recommends:

- **Ensuring that school-based substance use education is evidence-based:** New York requires that all children receive education about substance use[40] and allows the Commissioner of Education to make recommendations regarding curriculum modernization.[41] New York must build on this foundation by requiring that substance use education be based on the most recent research and include information about the link between mental health and SUD.

Medical Education

SUD contributes significantly to health care costs, both because SUD-related treatment and hospitalizations are expensive and because SUD significantly increases the likelihood of developing other expensive medical illnesses such as arthritis, heart disease, diabetes, and asthma.[42]

The medical system can play a key role in preventing SUD if doctors, nurses, and other staff are properly trained on best practices for addressing their patients' use. Strategies such as "Screening, Brief Intervention, and Referral to Treatment" (SBIRT) have been shown to be effective in interrupting substance use before it worsens.

[40] NY Education Law § 804 (2) and (3)
[41] NY Education Law § 804 (6)
[42] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5525418/

To achieve these goals, the Task Force recommends:

- **Requiring education on pain management and SUD for medical, dental, mental health, and nursing students and professionals:** Most medical students receive almost no education in either pain management or SUD. To address the current crisis and prevent future ones, all medical and dental students and professionals must be aware of evolving best practices for addressing pain, including non-opioid alternatives. They must also be able to identify and properly intervene when a patient is at risk of or suffering from SUD. Nursing and mental health students and professionals also need further training in these areas. This training could also help reduce the widespread stigma within the medical profession.
- **Identifying opportunities and incentivizing use of SBIRT:** New York City Health + Hospitals (H+H) has established initiatives to identify patients with or at risk of a SUD, both in the emergency room and among those receiving other hospital care, even if the SUD is not the reason for their stay. DOH should identify and work with other hospitals, medical providers, and dentists to develop similar programming.

Opioid Prescribing

New York already limits initial opioid prescriptions for acute pain to a seven-day supply. However, New York can do more to address overprescribing, such as working with doctors who continue to prescribe at higher-than-average rates, better educating patients about the risks associated with opioids, and ensuring that New York's I-STOP program contains information about patient prescriptions from other states and sources, including the Veterans Administration. The Task Force has identified the following priority for continuing to address overprescribing:

- **Expanding patient access to safer prescriptions:** Patients looking to avoid risks associated with opioid prescriptions face counterproductive barriers. Insurers sometimes place barriers that limit patient's access to safer forms of opioids. Separately, patients concerned about the quantity of drugs in their household cannot obtain a portion of the prescribed quantity of medication without forfeiting the remaining pills.
- **Discussing risks and alternatives with patients:** Medical professionals should be discussing the risks and alternatives available for pain management.
- **Co-prescribing an opioid antagonist with opioid prescriptions:** Providing a prescription for an opioid antagonist every time an opioid is prescribed ensures that patients will have access to the life-saving medicine they may need if an overdose occurs.

Insurance

Lack of coverage for alternatives to opioids (e.g. physical therapy, meditation, acupuncture, occupational therapy, chiropractic) and higher out-of-pocket costs incentivize patients to select opioids to treat pain. To address these barriers, the Task Force recommends:

- **Expanding coverage of non-opioid alternatives:** Expanding coverage and addressing costs of non-opioid alternatives will lower reliance on opioids, thereby reducing the likelihood of patients developing a SUD as a result of a prescription.

FUNDING RECOMMENDATIONS

As part of its approach to prevention, New York must also increase funding for its prevention infrastructure. The Task Force recommends the following funding priorities:

- **Prevention workforce and programming**: The New York Association of Addiction Services and Professionals reports that prevention programs across the State have lost more than a third of their staff over the past 15 years, due in large part to inadequate pay.[43] As a result, services cannot keep up with existing need, let alone address new challenges.
- **Sober activities:** Research shows that early use of substances correlates with the development of SUD. Having too much free time and a lack of alternative activities can result in young people experimenting with, or continuing to engage in, substance use. To reduce the likelihood that this will happen, the State funds a number of youth clubhouses. These must continue to be funded and other opportunities to engage in healthy activities should be identified and supported.
- **Incentives for screening and early intervention:** Early intervention creates health savings, as well as savings in other areas. It also increases productivity and reduces victimization. Early screening is effective in identifying problematic use early and providers can bill Medicaid for this service. DOH should incentivize providers to expand the use of evidence-based screening for substance use.

[43] http://www.asapnys.org/wp-content/uploads/2019/05/Budget-Priorities-February-2019.pdf

HARM REDUCTION

New York has been a national leader in adopting life-saving harm reduction policies, including policies that increase access to sterile syringes and naloxone. In 2011, New York enacted the Good Samaritan Law. This law protects individuals who are overdosing and those who witness an overdose from being charged or prosecuted for certain crimes when seeking emergency care for the overdosing individual. Most recently, the State took steps to expand access to these services in underserved regions, especially rural communities.

New York must continue to seek out new strategies that will save lives and address other ways in which the use of drugs and society's response to it have caused harm to individuals and communities.

> *"I started in a harm reduction program at my university… Had I been criminalized, had I been forced into an abstinence only program, which I tried at first and did not work, and actually led to my last overdose, I would say that I probably would not be here today."*
>
> *- Jaron Benjamin, Vice President, Community Mobilization, Housing Works*

To build on New York's successes, the Task Force reached near unanimity in proposing the following items:

POLICY RECOMMENDATIONS

Access to Overdose Reversal Medications

Expanded access to overdose reversal medications has reduced the number of overdose deaths in New York. According to DOH, naloxone was administered nearly 17,700 times in 2018 in the State. To further expand access to these live-saving medications, New York should pass legislation:

- **Increasing access to overdose reversal medications to individuals at highest risk of overdose:** Individuals with a history of SUD are among those at highest risk of experiencing or observing an overdose. This includes individuals who previously overdosed, those discharged from a SUD treatment facility, those leaving incarceration, and individuals under criminal justice supervision. Because individuals with SUD are disproportionate users of health resources, many individuals being discharged from hospitals are also at high risk. To reduce the likelihood that overdoses result in death, these groups must have access to these lifesaving medications.
- **Ensuring that first responders carry and know how to use overdose reversal medications:** At Task Force events, participants testified that some emergency medical technicians (EMTs) refuse to carry naloxone. Emergency medical service providers also sometimes have trouble obtaining reimbursement following administration of naloxone.

In the midst of a crisis, it is essential that EMTs, first responders, and others likely to witness overdoses be prepared to save the life of someone who has overdosed.

- **Removing disincentives to carrying or using overdose reversal medications:** Many medical professionals carry naloxone in case they encounter an overdose. This has led some insurers to assume that these medical professionals are using drugs and may therefore be at higher risk of overdose. As a result, some insurers have denied life insurance to these individuals. Separately, certain public accommodations where patrons are more likely to use drugs, including restaurants and bars, refuse to carry naloxone because they are afraid of possible liability for administering it. New York should address these concerns in order to maximize the probability that individuals who are most likely to witness an overdose carry these medications.

> *"Even though there's been tremendous strides in how we think and talk about [drug use] on Staten Island, there is still stigma creeping into some of the conversations... We hear people saying 'why are you giving him Narcan three times. You know, he should have like gotten it by now.' Or 'why does somebody have to go to detox more than once.' So there's still a lot of stigma and really basic lack of understanding about addiction and the disease itself."*
>
> *- Diane Arneth, Executive Director, Staten Island Operations Community Health Action of Staten Island (CHASI)/Brightpoint Health*

FUNDING RECOMMENDATIONS

The Task Force calls on New York to expand lifesaving harm reduction programming by providing additional funding for:

- **Drug User Health Hubs**: The AIDS Institute funds 12 Hubs. These facilities build on traditional syringe exchange services (SEP) by offering health, mental health, MAT, and other support services to clients. New York must expand this program to all SEP sites interested in providing expanded services. It must also ensure that all SEPs have the resources needed to maximize their ability to save lives and prevent bloodborne diseases and other costly outcomes.
- **Crisis stabilization centers:** The FY 2018 budget included funding to establish facilities offering 24/7 services to people in crisis, including linkage to treatment. Nine of the twelve facilities announced by the Executive have opened. New York must move to open the remaining facilities, and expand to other sites. New York should also identify alternative funding sources, including billing insurance. Based on early results from Suffolk County, these programs reduce hospitalizations, resulting in Medicaid savings.
- **Housing and shelter**: Shelters and supportive housing programs should not require sobriety as a condition for admission or continued habitation. Studies have shown that "Housing First" supportive housing programs contribute to reduced substance use, increased housing stability and reductions in crime.

TREATMENT AND RECOVERY

Despite New York's significant new investments in increasing treatment capacity, too many New Yorkers remain unable to access the treatment they need. To ensure that they receive the care they need, the Task Force, with near unanimity recommended:

POLICY RECOMMENDATIONS

Ensuring Access to Evidence-Based, Person-Centered Treatment

New York has one of the best developed treatment systems in the country, yet too many New Yorkers remain unable to find care that is evidence-based and appropriate to their needs.

The Task Force heard a wide array of recommendations for improving care, including addressing continuing geographic and demographic disparities in access. One significant barrier was language access. While New York has developed new strategies for reaching underserved populations, such as expanding the use of telehealth, the State must continue to seek alternative models that can fill gaps.

Maximizing the use of individuals with lived experience and ensuring they are well supported, expanding services for families, and addressing bureaucratic reporting and hiring barriers are also essential.

The Task Force has prioritized the following recommendations:

- **Establishing an easily-accessible phone, text, and online directory to help people locate needed services**: This directory must help people identify all services that can help reduce the risk of death and improve health, including harm reduction, treatment and post-treatment services that meet the individual's needs based on factors such as program capacity, location, demographics served, ability to treat health and mental health needs, and insurance accepted. Services must be accessible to non-English speakers. This directory must include information about buprenorphine prescribers beyond OASAS-licensed facilities. The State's Buprenorphine Working Group should be used as a resource in identifying appropriate prescribers. To the extent practicable, the hotline should also be able to link individuals to mental health services. For those in crisis, New York should explore using the three-digit emergency number recently approved by the Federal Communications Commission for those at risk of suicide. This number could potentially be used for other at-risk individuals.
- **Ensuring treatment providers are providing high quality, evidence-based care:** New York is developing a rating system based on an analysis of the quality of care provided by treatment programs. Information obtained through this process should be used to develop new measures for outcomes and to help providers improve care. To ensure that care is evidence-based, New York must better integrate mental health, SUD and physical care. While the State has taken steps to integrate licensing, factors such as reporting requirements and funding streams act as barriers to programs wishing to better integrate services. New York must also ensure that staff are educated on best practices for

providing patient-centered care, including trauma-informed care, and addressing the needs of particular demographic groups, including those with mental health disorders. To reduce the likelihood of relapse and the resulting risk of overdose and death, providers must make every effort to locate patients lost to care, so long as these efforts do not violate patient confidentiality or trust.

- **Addressing on-going patient brokering:** Patient brokering, the practice of steering patients to addiction treatment providers outside of New York State in exchange for referral payments, puts patients' lives at risk and causes severe financial hardship to individuals and families. In 2018, New York made it a misdemeanor for individuals to receive payment in exchange for such a referral.[44] OASAS also created an informational campaign to warn patients and families about these practices.[45] However, witnesses reported that brokers continue to prey on vulnerable families. New York must enforce existing laws and make every effort to educate those at risk. New York's new rating system will also be helpful in steering patients to reputable providers.

Medication Assisted Treatment

New York has taken significant steps to increase access to MAT. However, too many New Yorkers are still unable to access these medications. MAT saves lives, improves treatment retention, and enables patients to participate in work, social activities, and relationships with partners and family. New York must therefore adopt all available options to address remaining gaps, including:

> *"My staff, my social workers work very hard. It's true. We have clients who sit 40 to 60 days on Rikers Island waiting for a methadone bed to open up."*
>
> *- Chris Pisciotta, Attorney in Charge, The Legal Aid Society, Criminal Defense Practice, Richmond County Office*

- **Requiring that emergency rooms offer MAT following overdose:** FY 2019-2020 Budget included language requiring hospitals to include access to MAT in their emergency room policies and procedures. However, if hospitals do not offer immediate access, patients will be lost to care. Furthermore, because most patients are in withdrawal after an overdose reversal, many use opioids again at a time when they are at increased risk. Hospitals must therefore be required to offer these lifesaving medicines. Furthermore, because Federal regulations only allow doctors who have not received a Federal waiver to prescribe buprenorphine to administer one day's medication at a time for up to three days,[46] New York should consider mandating that hospitals have doctors who have received the Federal waiver available. This would enable patients to leave with a prescription for buprenorphine. New York must also ensure that peers are available in emergency rooms to support and assist patients following an overdose, and that patients are offered meaningful opportunities for linkage to services in the community.

[44] NY Mental Hygiene Law § 32.06
[45] https://oasas.ny.gov/treatment/stop-treatment-fraud
[46] https://www.deadiversion.usdoj.gov/pubs/advisories/emerg_treat.htm

- **Exploring alternative options for providing MAT**: Even though New York has been a leader in expanding access to MAT, certain options continue to be underutilized. The Federal SUPPORT Act allowed certain categories of nurses to prescribe buprenorphine. Nurses can be an essential tool in expanding access to MAT and are less expensive than doctors. New York has not taken sufficient advantage of this opportunity. In New Jersey, the Commissioner of Health recently issued an Executive Directive allowing EMTs to offer buprenorphine following an overdose reversal.[47] This policy will save lives by alleviating withdrawal symptoms that can lead a person to reuse soon after a reversal. New York should also explore expanding the use of home induction for buprenorphine where appropriate. Lastly, the State must expand access to methadone, including removing barriers to "take-home" medication and using more office-based providers.[48]

Insurance

New York has taken groundbreaking steps to address insurance barriers to care. However, the Task Force heard about a number of remaining barriers, including continuing challenges in obtaining insurance coverage for the full length of care a person needs, problems caused by disagreements between insurers and providers in interpreting the instrument developed by OASAS to determine what level of care a patient needs, and problems with insurers refusing to pay for care even when the care was recommended by the OASAS instrument. Medicaid rules such as restrictions on payments for physical and behavioral care were also identified as barriers.

Medicaid and insurance restrictions that limit access to needed care and create barriers to effective treatment increase treatment failure and put individuals' health and lives at risk. Existing laws must also be enforced. To address remaining barriers, the Task Force recommends:

- **Ensuring patients have access to the full range of MAT:** Last year, New York enacted legislation requiring that certain private insurers cover all forms of MAT. However, some insurers, including Medicaid, are still not required to cover all medications.
- **Prohibiting or limiting daily co-payments for treatment:** Many patients must visit facilities numerous times a week or even daily. The FY 2019-2020 Budget barred certain insurers from charging more than one copayment per day for outpatient treatment. However, daily copays can still be a significant barrier to care.
- **Addressing ongoing rate disparities between SUD and mental health care and other health care:** A November 2019 study found that mental health and SUD providers continue to be paid significantly less for providing the same service as other providers.[49] Despite steps taken to address inequality in coverage, this disparity has more than doubled between 2013 and 2017.
- **Mandating insurance standards for network adequacy:** Patients must go out-of-network significantly more often for SUD and mental health care than for other care, with disparities also increasing significantly between 2013 and 2017. To address this disparity, New York should require insurers to have adequate provider networks.

[47] https://www.state.nj.us/health/news/2019/NJDOH%20Executive%20Directive%2019-004.pdf
[48] https://www.ncbi.nlm.nih.gov/books/NBK64164/pdf/Bookshelf_NBK64164.pdf
[49] http://bit.ly/2PD3sBO

- **Increasing the role of non-medical considerations in determining patient care needs:** Factors such as lack of access to community supports, especially housing, can impact a patient's treatment success. As a result, they should play a greater role in determining both the type and duration of services that the patient receives. Changing "medical necessity" to "clinical necessity" would require insurers to cover the additional time needed to ensure providers do not discharge individuals who do not have a place to stay.

Recovery

There is now widespread acceptance that SUD is a chronic, relapsing condition. To assist a person's continued recovery, they often need post-treatment supports. These may include case management, employment and education assistance, and access to safe, sober environments. Therefore, to address continued barriers to successful recovery, the Task Force recommends:

- **Developing guidelines on best practices for recovery housing:** Safe and stable housing is especially important for people in early recovery. However, many providers of "recovery housing" offer accommodations that are sub-standard, increasing the likelihood of relapse. At the same time, the federal Fair Housing Act limits the ability of the State to regulate these houses. New York must identify and support models that will best serve those in early recovery without violating federal law.

> *"If they're going to be homeless when they leave there… what is the point of treatment? And we have emergency housing saying… you have to be homeless for a few days and then maybe we'll help you. Well, do you know what you just said to someone who's struggling to stay sober? You are not worth it. You're not worth having a roof over your head, you're not worth having food in your stomach."*
>
> *- Linda Ventura, Mother who lost her son*

- **Ensuring access to employment and other needed services:** To better ensure successful recovery, individuals must be able to become full members of society. New York has taken several steps to support individuals in recovery, including establishing the Heroin and Opioid Addiction Wraparound Services Demonstration Program,[50] and creating a tax credit for employers who hire those in recovery. However, a continued lack of supports, along with barriers, from discrimination in employment and housing to challenges obtaining a driver's license, continue to limit successful participation in the community.

FUNDING RECOMMENDATIONS

New York has increased funding for SUD services in recent years. The State has also developed innovative ways of reaching patients, outside of the traditional treatment structure, including through ambulatory centers and mobile vans, and through the expanded use of telehealth.

[50] Mental Hygiene Law § 19.18-a, enacted in 2014 to establish this program, expired on March 31, 2019.

However, more must be done to increase access to treatment and recovery supports. At the same time, the State's creation of a rating system for addiction treatment programs is an opportunity to ensure that the State's limited resources fund best practices.

The Task Force heard about a number of funding needs. We also heard recommendations for ensuring that underserved communities receive funding and that that funding is used in the most effective ways. Transportation options in transit deserts, increased wraparound services, and stable housing for those in early recovery were just some of the major gaps discussed.

The Task Force has identified the following treatment and recovery funding priorities:

- **Public education campaign:** Stigma is one of the most significant barriers to success. Strategies to reduce stigma are one of the Task Force's top priorities. Stigma discourages people from seeking help or remaining in treatment, causes NIMBYism which makes harder to establish new treatment and recovery programs, and discourages health providers and others from serving individuals who use drugs. Continued stigma against the use of MAT limits the use of this best practice. At the same time, increased awareness about fentanyl and other contaminants in the drug supply is essential to saving lives. New York created the "Combat Addiction" campaign to address some of these issues. The State must build on this base to develop a multi-faceted campaign to maximize understanding of substance use and addiction.

> *These are people who are very sick in our society and we need to be able to step up and help them. We have to meet them where they are at, unjudgmentally, and don't look at them as a drug addict. Look at them as a human being, your brother, your sister, your mother, your father, your whoever. And we're never going to get out of this mess that we're in if we keep giving them the wrong messages… People do not just wake up and then want to say, 'well I think I want to get hooked on drugs.'"*
>
> *- Asia Betancourt, person in long-term recovery, Community Leader, Voices Of Community Activists & Leaders (VOCAL-NY)*

- **Incentivizing medical providers to offer SUD care:** Many medical providers remain unwilling to treat SUD because of stigma. In the 1980s, doctors were similarly reluctant to treat those with HIV. In the 1990s, New York began offering higher rates to incentivize providers to treat HIV, which resulted in significantly more doctors treating individuals with HIV/AIDS. New York must offer similar incentives to encourage doctors to treat SUD.
- **Addressing the crisis in the prevention and treatment fields:** Medicaid reimbursement rates for most SUD services have not increased in over ten years. These rates are often significantly below the cost of providing services, causing severe financial stress to providers. New York must review rates by looking at needs in different communities and either bring rates in line with the cost of services or explore alternative payment models.
- **Supporting the treatment workforce to create greater stability in the field**: A 2018 survey of the community-based SUD and mental health workforce found turnover rates

of between 35 and 40 percent annually, which is extremely high. Constant turnover decreases treatment success by preventing patients from developing lasting and trusting relationships with their providers. This relationship of trust is essential to addressing trauma and other factors that often contribute to substance use. New York recently took steps to support this workforce with a long overdue COLA and scholarship program to encourage those working in the field to invest in their careers as treatment providers. Nevertheless, providers are still unable to offer competitive wages for a job that is significantly more challenging than many fields offering comparable pay. More support and funding are therefore needed to address the high turnover rate among those providing these essential services. In addressing this crisis, New York must include funding for peers and ensure that all staff have opportunities for career advancement.

- **Improving funding effectiveness by increasing the role of counties:** County departments of health and mental hygiene have significant knowledge of the SUD and mental health landscape in their counties. These entities should be involved in local funding decisions. These decisions could be combined with the Local Services Plans that local governments are already required to create each year. Funding decisions should also take into account the significant overlap between the SUD and mental health populations. Increased collaboration and coordination between counties could maximize the effectiveness of State funds.
- **Funding for services within rural communities**: Rural counties have smaller populations and do not have the same grant-writing and other resources needed to obtain SUD-related grants as larger jurisdictions. However, these communities have been hugely affected by the overdose epidemic. The State should establish grants that are specifically targeted to the needs of rural communities.

NON-HEALTH FACTORS

The Task Force heard about a number of non-health issues that New York must address, such as criminal justice, child welfare consequences of drug use, and the loss of housing and employment. With near unanimity, the Task Force identified the following items as top priorities in this area.

FUNDING

The Task Force heard a number of ideas for possible funding sources including new alcohol taxes, reinvesting savings from reduced incarceration, and ensuring that community-based programs, which received minimal funding from Medicaid redesign, receive a larger share of Federal funds in the future.

> *"[Last year, the Executive Budget] ha[d] an increase of $646,000... We hear about 2% caps all the time. That would have been $13 million.... Last year, we looked at a multiyear approach. The request that we had made...was $100 million. and I know that would help to address workforce and address some of the infrastructure needs that programs have."*
>
> *- John Coppola, MSW, Executive Director, New York Association of Addiction and Services and Professionals, Inc. (ASAP)*

The Task Force recommends with near unanimity prioritizing:

- **Establishing an Opioid Settlement Fund:** Much of the money that states received through tobacco settlements was used to pay for programs and services unrelated to the harms of tobacco use, contrary to the lawsuits' goals. New York is currently involved in a number of lawsuits against manufacturers and distributors of opioids, which could result in the State receiving millions of dollars. Money obtained from these lawsuits must be used to address the harms of drug use and the ways in which drug laws have been enforced. Individuals, families, and communities impacted by the overdose epidemic and by New York's former, more punitive approaches to drug use must be included in decisions regarding the use of this funding.

RESEARCH

Better research about the use of drugs and its impact on communities throughout New York can provide key insights. To enable such research, the Task Force recommends the following with near unanimity:

- **Increasing access to data:** The DOH website contains limited, out-of-date statistics, which are hard to find.[51] The State must increase the amount of data that is publicly available and make it more accessible. In light of the evolving nature of the epidemic, this data should not be limited to opioid-related statistics. New York should also allow researchers to study de-identified data from different State agencies. This would allow

[51] https://on.ny.gov/36z0wfq

the State to identify areas of highest need and possible future problems, as well as develop strategies for responding to needs that are identified.

CRIMINAL JUSTICE

New York has enacted landmark criminal justice reform legislation in recent years. In 2009, New York took significant steps to reform the 1973 Rockefeller Drug Laws, which are now widely recognized as one of the foundations of mass incarceration. These reforms significantly reduced the incarceration of individuals whose crimes were related to their drug use.

More recently, in 2019, New York enacted groundbreaking pre-trial reforms that will prevent hundreds of thousands of New Yorkers, including many who use drugs, from having their lives derailed by unnecessary incarceration.

Since the beginning of the overdose epidemic, New York's law enforcement agencies have made significant changes in how they address drug use. Law enforcement agencies increasingly view SUD as a medical, rather than criminal justice issue. Many agencies have begun connecting those who use drugs to services, rather than incarcerating them. To ensure law enforcement agencies continue moving towards a health-centered approach, the State should create educational materials and mandate training of all appropriate officers. At the same time, despite these changes in law enforcement attitudes to SUD, over 32,000 New Yorkers continued to be arrested for misdemeanor possession of drugs[52] in 2018.[53] The Task Force heard from certain individuals about challenging interactions with law enforcement officers who were responding to an overdose seeking to obtain information about the source of the drugs.

Too many people also continue to be incarcerated for crimes linked to their drug use, even when the crime did not involve violence. This period of incarceration does little to increase public safety or improve public health outcomes for those being incarcerated or the communities they come from. Instead, incarceration increases mortality, causes instability in the individual's life that can negatively impact participation in drug treatment and can have serious negative mental health consequences. It also creates instability within families, which are a key source of support for those struggling with SUD.

"I have a dear friend who has become like a daughter to me... She went to prison at 19 for 2 years for cocaine possession. She always says that… the behaviors you need in order to survive in prison are the exact opposite of what you learn in recovery... in prison kindness is weakness. In recovery, kindness is strength. She came out of prison bitter, lost and confused and totally shut down. She had learned how to isolate."

- Barbara Wilhelm, Mother of Incarcerated Son

Upon release from incarceration, individuals face an array of challenges reintegrating into the community because of their criminal record, such as lack of access to employment and housing.

[52] NY Penal Law § 220.03
[53] Data received from the NYS Division of Criminal Justice Services

New York State and a number of localities have taken significant steps to reduce the criminal justice involvement of those who use drugs; these actions have improved public safety and helped save lives. To build on these successes, the Task Force agreed with near unanimity to recommend:

Policy Recommendations

Reducing Arrests and Incarceration

- **Increasing opportunities for diversion from incarceration:** Thanks in part to the 2009 reforms of the Rockefeller Drug Laws, New York has increased the use of alternatives to incarceration for individuals convicted of most drug and many property offenses. However, many individuals are still incarcerated for crimes related to their drug use, even when the crime did not involve violence. Alternatives to incarceration have lower recidivism rates than incarceration and cost significantly less. Eligibility for diversion should be expanded to additional offenses.
- **Reforming problem-solving courts**: Problem-solving courts, including drug courts, have been implemented as a tool to keep many New Yorkers out of jails and prisons. These courts have enabled participants to access treatment as opposed to being incarcerated. However, some courts have not adopted best practices. There is also a lack of research on efficacy. To address these issues, New York should evaluate the practices and outcomes of these courts, require that treatment decisions be made by trained professionals, and limit the ability to deny graduation for failure to meet non-treatment goals such as education and employment. The State should also address insurance and transportation challenges that limit access to and success in problem-solving courts. Ensuring that these programs are successful will improve public safety, help families and communities, and save money.
- **Allowing individuals to safely dispose of syringes and drugs without fear of arrest**: For more than two decades, New York has recognized that providing access to sterile syringes is an effective public health intervention for preventing the spread of disease. As a result, the State created and expanded syringe exchange programs and established the Expanded Syringe Access Program. However, if individuals cannot dispose of used syringes without being arrested, this sensible public health intervention that the State has invested in so heavily will fall short of its aims. Separately, some law enforcement agencies have established policies to allow individuals to dispose of drugs without fear of arrest when seeking help. We recommend adopting policies that enable the disposal of drugs and syringes in a responsible manner, without fear of arrest.

Incarceration

- **Improving SUD care for incarcerated individuals:** In 2009, New York enacted legislation giving DOH oversight over HIV and hepatitis C care in prisons and jails. As a result, the vast majority of HIV+ individuals in DOCCS receive medical treatment and

are linked to care post-release.[54] DOCCS also treats significantly more people for hepatitis C than other states. However, DOCCS care for other conditions, including SUD, does not meet the same standard. Most incarcerated individuals do not receive treatment services until they are approaching their release from incarceration. Individuals who relapse are regularly penalized. Much of the care that is provided is not based on best practices. There are a number of steps New York must take to improve care. OASAS should provide ongoing guidance and monitoring of SUD treatment within correctional facilities to ensure that incarcerated individuals are receiving evidence-based care; individuals should not be placed in solitary confinement following an overdose or a positive drug test; and OASAS and DOCCS must provide additional reporting on the extent of SUD within correctional facilities, the substances involved, and the treatment being provided to those who are incarcerated.

- **Ensuring access to MAT for incarcerated individuals and those under community supervision**: Lack of access to MAT is one of the most significant deficiencies in correctional SUD treatment. Studies have shown that the likelihood of death by overdose during the first two weeks following release from incarceration is up to 129 times greater than for the general population. The establishment of a MAT program within the Rhode Island correctional system contributed to a 61% reduction in overdose deaths post-release.[55] According to the National Sheriffs' Association, access to MAT "[c]ontribut[es] to the maintenance of a safe and secure facility for inmates and staff"[56] and "[stems] the cycle of arrest, incarceration, and release, thereby increasing public safety."

> *"For any other disease in corrections, for inmates who have a legitimate prescription… those medications are continued. It's only for this one disease, opioid use disorder, one chronic disease, the patients are denied their legitimate prescription to help them feel well. I think it's a human rights issue."*
>
> *- Gale Burstein, MD, MPH, FAAP, Commissioner, Erie County Department of Health*

- **Limiting the use of incarceration as punishment for a positive drug test for individuals on parole or probation:** Incarceration for a positive drug test causes harm to someone already struggling to control their drug use. It should only be used as a very last resort.

Funding Recommendations

At Task Force hearings, members heard from providers offering innovative models in which law enforcement officers link individuals to social services and treatment, rather than arresting them. Other programs offer alternatives to incarceration following conviction. These programs have contributed to the significant reductions in crime and incarceration in New York, thereby saving the State millions of dollars. New York should build on these successes by increasing funding for:

[54] https://www.health.ny.gov/diseases/aids/general/statistics/docs/partner_services.pdf
[55] https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2671411
[56] https://www.sheriffs.org/publications/Jail-Based-MAT-PPG.pdf

- **Providers offering services to divert individuals from arrest or incarceration and link them to community programming**: Funding for these programs generate savings through reduced incarceration and reduced health care costs. They also contribute to reduced shelter usage.

CHILD WELFARE

The impact of the overdose epidemic on children and families has been immense. The United Hospital Fund estimates that over 125,000 children in New York under the age of 18 have been affected by the epidemic as of 2017.[57] New York must take all steps necessary to ensure that children whose parents are struggling with a SUD receive the evidence-based supports that they need. New York must also ensure that children struggling with SUD receive treatment that is tailored to their specific needs.

The Task Force identified with near unanimity the following priorities for addressing the needs of children:

Prenatal and Neonatal Care

Between 2008 and 2014, the number of babies born in New York with neonatal abstinence syndrome (NAS) more than doubled.[58] There have been recent advances of treatment of NAS. However, few hospitals in New York provide evidence-based care.

Allowing mothers to stay with infants born with NAS has a positive impact on both mother and child. Contact between mother and child is calming for the baby and has been shown to help mothers continue on their road to recovery.

However, Medicaid and private insurance do not cover the duration of stay needed to properly monitor the baby for symptoms of NAS or the cost of allowing mothers to stay with their children.

To ensure the use of best practices for prenatal and neonatal care, the Task Force recommends:

- **Barring drug testing without maternal consent except in cases of medical emergency**: Fear of drug testing disincentivizes women from seeking medical care, including pre-natal care. This harms the welfare of both the mother and the fetus.[59] As a result, such testing should only be used with the consent of the mother or when medically necessary based on best practices.
- **Establishing model programs for treating neonatal abstinence syndrome:** New York included $350,000 in the FY 2019-2020 budget to support up to four infant recovery centers to increase access to evidence-based care.

[57] https://uhfnyc.org/news/article/uhfs-suzanne-brundage-testifies-about-impact-opioid-epidemic/
[58] https://rb.gy/hruzpf
[59] https://rb.gy/dkmubv

Childhood

Youth who are placed in out-of-home care experience trauma that negatively impacts their development. These interventions can compromise social and family networks. Children in foster care report significantly worse mental health, employment, and education outcomes, as well as higher rates of homelessness and incarceration.

New York must therefore adopt policies that prioritize keeping families together by limiting the removal of children to situations in which leaving a child with its parents will result in harm. To achieve this, the Task Force recommends:

- **Requiring the Office of Children and Family Services (OCFS) to develop guidance for addressing prenatal and parental drug use and ensuring these policies are adopted**: The National Center on Substance Abuse and Child Welfare (NCSACW) has a number of resources on best practices for addressing parental substance use.[60] New York is currently working with NCSACW to improve practices in certain areas. The State should develop guidance laying out best practices for serving children and families impacted by drug use and take steps to ensure that all local agencies adopt these policies. OCFS must include input from directly impacted individuals and families in developing any new guidance.
- **Requiring the use of best practices by the child welfare and family court systems**: There is significant anecdotal evidence that child welfare and family court treatment mandates for parents are often not evidence-based, including limiting the use of MAT. It is essential that parents receive care that is evidence-based to ensure that children remain with their parents in safe environments.
- **Limiting the use of drug testing by the child welfare system:** NCSACW recommends that "a positive drug test or a series of positive drug tests…not be used as the sole determining factor in the removal of a child from the home or to determine parental visitation" because "tests do not provide sufficient information for substantiating allegations of child abuse or neglect or for making decisions about the disposition of a case."[61] However, such tests result in prejudicial decision-making. In light of this, other states have restricted the use of drug testing by child welfare agencies. New York should enact similar restrictions.
- **Establishing more supportive conditions for working parents:** The availability of evening appointments, and no- to low-cost childcare during any court-mandated activities will provide the necessary support to individuals trying to maintain their recovery.

[60] https://ncsacw.samhsa.gov/
[61] https://ncsacw.samhsa.gov/resources/resources-drug-testing-in-child-welfare.aspx

FEDERAL RECOMMENDATIONS

While there is much that New York can do on its own, there are certain reforms that require federal action. The Task Force therefore, with near unanimity, calls on the federal government to take the following steps:

- **Baselining and increasing recent federal funding to address the overdose epidemic:** The Task Force was pleased to see that the recently approved federal budget maintains $1.5 billion in dedicated funding to respond to the overdose epidemic, the same level of funding allocated in FY18 and FY19. Furthermore, in light of recent statistics showing that one in six overdose deaths in New York in 2017 were caused by drugs other than opioids,[62] we support Congress's decision to eliminate restrictions limiting the use of this money to opioid response. Since 2017, New York has received $142.5 million from these targeted grants. While this funding has been important, it is nowhere near enough to address the scope of the epidemic. The funding must also be reallocated each year. We therefore call on the federal government to baseline the money included in these grants and to increase funding in line with the scope of the epidemic.
- **Removing unnecessary barriers to MAT, including approving new models of care:** MAT is the gold standard for treatment of opioid use disorder. With over 47,000 Americans and over 3,000 New Yorkers dying each year from opioid overdoses, access to these medications is essential to saving lives. Barriers imposed by the federal government, limit New Yorkers' access to MAT. The federal government must act immediately to reduce or eliminate barriers that limit access. One urgent concern is lack of access to medications, especially methadone, in rural parts of the State. We therefore call on the federal government to urgently approve the use of mobile methadone vans.
- **Continuing and expanding the Certified Community Behavioral Health Clinics (CCBHC) program:** In 2014, the federal government enacted the Protecting Access to Medicare Act, which allowed the establishment of a two-year demonstration program to pilot CCBHCs in up to eight states with the goal of increasing access to behavioral health care and improving the coordination of a person's physical and behavioral health care needs. New York was one of the eight states selected by the Department of Health & Human Services. The pilot began in 2017. Early results suggest that these programs increase access to needed mental health and SUD care. Congress has repeatedly approved short-term extensions to the pilots. Congress should make this program permanent and allow states to establish any programs that they need.
- **Supporting successful transition from incarceration by allowing states to bill Medicaid prior to release**: DOCCS estimates that 83% of incarcerated individuals are in need of SUD treatment upon release. However, Medicaid cannot pay for services received in a correctional institution. Allowing limited use of Medicaid during the 30 days prior to release would allow states to set up transition plans that enable a smooth continuation of care from incarceration to the community. Doing this would reduce the use of expensive emergency room and detoxification care, thereby saving state and federal governments significant amounts of money. These reforms would also improve

[62] https://www.cdc.gov/drugoverdose/data/statedeaths.html

public safety by reducing recidivism and generate other savings from reduced use of shelters. The federal Centers for Medicare and Medicaid Services should approve New York's request to amend its waiver to allow the use of Medicaid dollars to pay for limited services for high-need individuals during the last 30 days of incarceration. Alternatively, Congress should enact HR 1329 which would allow the use of Medicaid during the 30 days prior to release.[63]

> *"Sadly, the last overdose that occurred in the shelter was a parolee five days after he was released and before his Medicaid could kick in and treatment could commence."*
>
> *- Kevin O'Connor, Executive Director, Joseph's House & Shelter*

- **Amending the Americans with Disabilities Act (ADA) to establish protections for individuals who have a current addiction to drugs:** The Federal Rehabilitation Act's protections against discrimination on the basis of a disability included protections for all individuals with a SUD, whether their addiction was to alcohol or drugs. When the federal government enacted the ADA, it included protections for individuals currently or formerly addicted to alcohol and those previously addicted to drugs. However, it specifically excluded those who are currently addicted to drugs. As a result, such individuals are not protected from discrimination, even if their SUD does not impact their ability to perform their jobs. This means that individuals are unable to request a reasonable accommodation to enter treatment. The federal government should remedy this disparity by extending ADA protections to those who are addicted to drugs.

[63] https://www.congress.gov/bill/116th-congress/house-bill/1329/text

APPENDIX A
Legislative Recommendations

The Task Force, with near unanimity, recommends that the following legislation be enacted:

Prevention

Medical Education

- S.2507, sponsored by Senator Anna Kaplan, would require OASAS to develop new training materials for use by qualified health professionals.
- S.7102-A, sponsored by Senator Brian Benjamin, would require that DOH update the mandatory three-hour training for prescribers based on the most up-to-date guidance and evidence-based practices.
- S.7132, sponsored by Senator Toby Stavisky, would require medical and mental health providers to receive training in pain management and SUD.

Opioid Prescribing

- S.5653-A, sponsored by Senator Jen Metzger, would ensures that DOH's periodic analysis of data from the prescription drug monitoring program include an examination of potential inappropriate prescribing.
- S.6397, sponsored by Senator David Carlucci, would ensure that abuse-deterrent drugs approved by the FDA are accessible to patients and that insurance coverage does not disadvantage access for patients to drugs approved by the FDA as abuse-deterrent.
- S.7115, sponsored by Senator Gustavo Rivera, would allow patients to request that a prescription be only partially filled without limiting future access to the rest of the prescription.
- S.5150-B, sponsored by Senator Peter Harckham, would require prescribers to co-prescribe an opioid antagonist with the first opioid prescription of the year to certain patients at high risk of overdose.

Harm Reduction

Access to Overdose Reversal Medications

- S.6650, sponsored by Senator Peter Harckham, would require that populations that are most at risk for overdose – individuals being discharged from treatment facilities, state prisons, or hospitals – be provided with naloxone prior to discharge.
- S.3159-A, sponsored by Senator Peter Harckham, would prohibit insurers from denying life insurance to, or otherwise discriminating against, individuals prescribed naloxone.
- S.5457, sponsored by Senator Peter Harckham, would expand the list of entities specifically authorized to possess, distribute, and administer naloxone to include public accommodations.

Treatment and Recovery

Ensuring Access to Evidence-Based, Person-Centered Treatment

- S.1063-A, sponsored by Senator Roxanne Persaud, would require SUD counsellors to receive sensitivity training and up-to-date training on evidence-based practices.
- S.4599, sponsored by Senator Kevin Parker, would create an explicit list of rights for patients receiving treatment in a SUD program that must be placed in conspicuous places throughout treatment facilities and given to every patient upon intake.
- S.4741-B, sponsored by Senator Peter Harckham, would require treatment programs to notify patients of their right to identify emergency contacts and require OASAS to develop guidelines for protocols to be used by treatment programs in communicating with these contacts.

Insurance

- S.6694, sponsored by Senator David Carlucci, would establish a workgroup to conduct an analysis on rates for behavioral health services. This would help identify continuing disparities between rates for behavioral and physical health care, identify appropriate rates for care, and offer solutions to address low rates.

Recovery

- S.4496-A, sponsored by Senator Monica Martinez, would establish the recovery living task force to develop best practice guidelines for recovery housing and offer recommendations for legislation to put these recommendations into practice.

Non-Health Factors

Criminal Justice

- S.6288-A, sponsored by Senator Luis Sepúlveda, would require OASAS to provide the Legislature with annual reports on the extent and nature of SUD and treatment access within DOCCS facilities.

Child Welfare

- S.5480, sponsored by Senator Gustavo Rivera, would require that DOH and OASAS establish a pilot program with at least four infant recovery centers in areas of need in the state.

APPENDIX B
Additional Issues under Consideration

During the hearing process, Task Force members heard from families, advocates and others about additional interventions intended to save lives and reduce the risk of bloodborne diseases.

The Task Force Chairs and certain Task Force members expressed support for some of these items. However, the Task Force as a whole was unable to reach consensus.

We have chosen to include these items in order to provide the full breadth of issues brought before the Task Force at hearings and roundtables.

Increasing Syringe Access

Programs such as syringe exchanges and the Expanded Syringe Access Program (ESAP) have led to a massive reduction in the number of new HIV and hepatitis C cases caused by the sharing of syringes.

As mentioned earlier in the report, access to clean syringes has contributed to an over 90% reduction in the number of new HIV cases in New York State attributable to injection drug use since 2002. A 2014 report from NYS AIDS Institute meanwhile, found that the prevalence of HIV among injection drug users in New York City decreased from 54% in 1990 to 3% in 2012.

According to a 2005 study, hepatitis C prevalence among injection drug users in New York City also declined, from 90% in 1990 to 63% in 2001. The study found that the decline in new hepatitis C cases correlated with the large-scale expansion of syringe exchanges during this period. Other studies from outside New York have also found that access to clean syringes, especially when combined with increased access to MAT, can help reduce the likelihood of contracting hepatitis C.

However, barriers to accessing clean syringes remain. To address these, certain Task Force members called for:

- Removing unnecessary barriers to syringe access: There were over seven hundred arrests in 2018 in which criminal possession of a hypodermic instrument was the most serious charge. Many other individuals are arrested each year for this charge in order to increase leverage during plea negotiations. Such arrests discourage individuals from obtaining clean syringes, putting them at risk of bloodborne diseases and other avoidable harms. ESAP also includes unnecessary restrictions that limit access.

Overdose Prevention Centers

As described earlier in the report, on August 29, Task Force members visited an overdose prevention center in Toronto. The facility provides an environment for supervised drug use with quicker access to care if needed. It also helps reduce other negative consequences of use, such as

syringe litter and the spread of bloodborne diseases. Like other such facilities, the site has not had an overdose death since opening.

Also, like other such facilities, the Toronto site is staffed by medical professionals and people with lived experience. Staff explained that those with lived experience help make participants more comfortable. This can help them open up, which can contribute to a decision to reduce or stop use. Staff also noted that the health center's other services, by meeting participants' needs, have also helped some people decide to curtail or stop their use. Furthermore, locating the facility within a health center enables immediate entry into treatment when a person is ready to stop using.

"After losing my son, the work of grief is contemplating what I could have done differently to save him and keep him alive. And there's certainly a lot of things like, I wish he was offered Suboxone but he never was, I wish he wasn't incarcerated – he was incarcerated multiple times, I wish he was offered more treatment, he wasn't. I have a list that goes on and on. But of all of those things, even when I think about them, I can always say afterwards I'm not sure if it would have saved Jeff. What I know would have saved Jeff was him not being alone when he died. That would have saved him. If he was not alone, if someone would have administered Narcan, if he was in a safer consumption site, I know that would have saved his life. And I would do anything to have him back anything, anything. And if I had to watch him use, I would have him back. And that's not something that I ever imagined myself saying."

- Alexis Pleus, Family Member and Founder, Executive Director and Board Ex Officio Chair, Truth Pharm

Before visiting the site, the Task Force met with local elected officials who explained their support for the facility. Facility staff meanwhile described their efforts to engage the local community prior to opening the facility and that community support, including from local businesses and a nearby school, has increased since the site opened. Lastly, the Task Force learned that the local hospital credits the facility with reductions in emergency usage, resulting in financial savings to the local healthcare system.

Several bodies of public health experts, including the American Medical Association, AIDS United, and the Infectious Diseases Society of America, the HIV Medical Association and the Society of Infectious Diseases Pharmacists have expressed their support for these facilities as a recommended strategy to save lives and reduce harms to the individual and public health.

Certain Task Force members therefore call for:

- Establishing an overdose prevention center pilot initiative: By preventing overdoses from resulting in death, overdose prevention centers achieve one of the most important goals identified by Task Force event participants – saving lives. Furthermore, services provided by such facilities not only prevent death, they also reduce the likelihood of bloodborne diseases and other negative health consequences that result from drug use. Some studies also suggest these sites can contribute to reductions in crime. Throughout the hearings and round tables, Task Force members heard widespread support from directly impacted individuals and families, as well as from medical and public health professionals and

advocates for establishing overdose prevention centers in New York. A two-year pilot program in interested jurisdictions, combined with an evaluation, would enable the State to determine the impact of these facilities and make future decisions about whether to include them in its efforts to address the overdose crisis.

"I think particular attention should be paid to safe injection facilities or overdose prevention sites. Senator Mayer… said 'sighting is difficult.' Third Avenue BID said we want one here. And we demanded that the city government actually relocate it from Longwood into the hub at the South Bronx… Very selfishly, and I am very open about this, it is not an attractive commercial corridor when… you have to step over someone who is overdosing. Nor is it right for us to communicate a message that it is okay to step over someone who is overdosing. Nor is it okay for us to create prohibitive laws where now I can't call NYPD because now that person is going to have a criminal record because they overdosed… Because we care so much about our consumer base, just very blatant about that. And I think, the overdose prevention centers are one immediate, immediate action that we can take to address overdose and provide a safe environment for folks."

- Michael C. Brady, Executive Director, The Third Avenue BID

Decriminalization of Low-Level Drug Possession

In addition to calling for the decriminalization of syringe possession and the establishment of overdose prevention centers, some advocates called for decriminalizing low-level possession of all drugs, based on the model adopted by Portugal in 2001. While no members of the Task Force were prepared to endorse this policy, some members felt additional attention to this approach was needed.

Under the Portuguese model, individuals possessing drugs for personal use are connected to the public health system, rather than the criminal justice system. Since adopting this policy, Portugal has seen a significant decrease in the number of overdose deaths. (Prior to adoption, overdose deaths in Portugal were rising rapidly. It now has the lowest rate of overdose deaths in Western Europe.) There were also huge decreases in the number of new HIV and hepatitis infections. The rate of problematic drug use also decreased. Entry into treatment, meanwhile, increased significantly following the adoption of this policy.

APPENDIX C
Task Force Hearing and Roundtable Participants

Bronx Hearing

St. Barnabas Hospital, SBH Auditorium, Main Building, 1st Floor,
4422 Third Avenue, Bronx, New York
August 9, 2019

Members Present:

Task Force

Senator David Carlucci, Co-Chair
Senator Peter Harckham, Co-Chair
Senator Gustavo Rivera, Co-Chair
Senator George A. Amedore, Jr.
Senator Jamaal T. Bailey
Senator Patrick M. Gallivan
Senator Diane J. Savino

Non-Task Force

Senator Alessandra Biaggi
Senator John C. Liu
Senator Shelley B. Mayer

Speakers:

Len Walsh, Executive Vice President & Chief Operating Officer
SBH Health System

Charles T. Barron, M.D., Deputy Chief Medical Officer, Behavioral Health
New York City Health + Hospitals

Rebecca Linn-Walton, Assistant Vice President, Office of Behavioral Health
New York City Health + Hospitals

Dr. Denise Paone, Director of Research and Development, Bureau of Alcohol and Drug Use Prevention, Treatment, and Care
NYC Department of Health and Mental Hygiene

Lisa Landau, Bureau Chief, Health Care Bureau
New York State Office of the Attorney General

Howard A. Greller, M.D., Director of Research and Medical Toxicology, Department of Emergency Medicine
SBH Health System

Chinazo Cunningham, M.D.
Montefiore Medical Center

Russell Kamer, M.D., Member, Addiction and Psychiatric Medicine Committee
Medical Society of the State of New York (MSSNY)

John Coppola, Executive Director
Alcoholism and Substance Abuse Providers of New York State (ASAP)

Demetria Nelson, Administrative Director, Addiction Treatment Services
BronxCare Health System on behalf of Coalition of Medication-Assisted Treatment Providers and Advocates of New York State (COMPA)

Joseph Baudille, President
New York Chiropractic Council

John Lamonica, Past President
New York Chiropractic Council

Ken Robinson, Executive Director
Research for a Safer New York, Inc.

Mike Selick, Hepatitis C Training and Policy Manager
Harm Reduction Coalition

Jasmine Budnella, Drug Policy Coordinator
VOCAL-NY

William Cruz, Addiction Program Specialist at OASAS
Public Employees Federation Council Leader & Statewide Labor Management Chair for OASAS

Beverly Williams
Public Employees Federation, Steward

Debbian Fletcher-Blake, CEO
VIP Community Services, Inc.

Carmen Rivera, VP, Communications & External Affairs
VIP Community Services, Inc.

Julia DeWalt, Director of Communications, Advocacy, and Community Engagement
BOOM!Health

Van Asher, Harm Reduction Services/Syringe Access Program Manager
St. Ann's Corner of Harm Reduction

Angie Woody, Director of Overdose Prevention
New York Harm Reduction Educators

Adrian Feliciano, Jr., Director of Harm Reduction Services
Washington Heights Corner Project

Robert (Shade) Rivera, Peer Navigator
Housing Works

Michael C. Brady, Executive Director
The Third Avenue Business Improvement District (BID)

Christina Mansfield, Vice President
The Osborne Association

Tracy Pugh, Senior Manager, Overdose Prevention Program
Vital Strategies

Written Testimony

Joseph Turner, President and CEO
Exponents

Sana Bloch, M.D.
Medalliance Medical Health Services

Bronx Borough President

The Bronx Defenders

Brooklyn Defender Services

Hudson River Healthcare

Madison County Roundtable
Board of Supervisors Chambers,
Madison County Office Building, Wampsville, NY
August 26, 2019

Members Present:
Task Force
Senator David Carlucci, Co-Chair
Senator Peter Harckham, Co-Chair
Senator Gustavo Rivera, Co-Chair
Senator Rachel May, Sponsor
Senator Betty Little

Speakers:

Eric Faisst, Public Health Director
Madison County Health Department

Kathleen Newcomb, Deputy Sheriff
Broome County Sheriff's Office

Ellen Earley
Parent and advocate

Alexis Pleus, Family Member and Founder, Executive Director and Board Ex Officio Chair
Truth Pharm

Dennis Gregg, Family Member, Co-Founder
HEAL of Madison County and Onondaga County

Justine Waldman, Medical Director
The REACH Project, Inc.

Alessandra Miller, Director of Drug User Health
ACR Health

Kristen Cerio, Prevention Health Advocate
ACR Health

Robert Ross, Chief Executive Officer
St. Joseph's Addiction Treatment and Recovery Center

Susan Jenkins, **Executive Director**
BRiDGES, Madison County Council on Alcoholism & Substance Abuse, Inc

Lisa Hoeschele, Executive Director
Family Counseling Services of Cortland

Kim Langbart, LCSW MPA, Vice President of Integrated Healthcare
Liberty Resources, Inc.

Lance Salisbury, Supervising Attorney
Tompkins and Schuyler County Assigned Counsel Program

Staten Island Roundtable
Kiernan Suite, Kelleher Center
St. John's University - Staten Island Campus
Staten Island, NY
September 16, 2019

Members Present:
Task Force
Senator David Carlucci, Co-Chair
Senator Peter Harckham, Co-Chair
Senator Gustavo Rivera, Co-Chair
Senator Diane Savino, Sponsor
Senator Patrick M. Gallivan

Non-Task Force
Senator John C. Liu

Speakers:

Michael E. McMahon, District Attorney
Richmond County District Attorney's Office

Chris Pisciotta, Attorney in Charge
The Legal Aid Society, Criminal Defense Practice, Richmond County Office

Daniel Greenbaum, Attorney in Charge
The Legal Aid Society, Juvenile Rights Practice, Richmond County Office

Diane Arneth, Executive Director, Staten Island Operations
Community Health Action of Staten Island (CHASI)/Brightpoint Health

Asia Betancourt, Community Leader
Voices Of Community Activists & Leaders (VOCAL-NY)

Joseph Conte, Executive Director
Staten Island Performing Provider System, LLC

Joanne Pietro, Associate Executive Director, Department of Psychiatry and Behavioral Science
Staten Island University Hospital

Annette White, Program Supervisor
Richmond University Medical Center

Luke Nasta, Chief Executive Officer
Camelot Counseling

Avi Schick, Executive Director
Silver Lake Behavioral Health

Angela Malone, Division Director, Behavioral Health & Criminal Justice Services
EAC Network

John Reilly, MD, Orthopedic Surgeon

Hudson Valley Roundtable

Putnam County Training and Operations Center
Carmel, NY
October 3, 2019

Members Present:
Task Force
Senator David Carlucci, Co-Chair
Senator Peter Harckham, Co-Chair
Senator Gustavo Rivera, Co-Chair
Senator Betty Little

Non-Task Force
Senator Jen Metzger
Senator Sue Serino

Speakers:

Michael Orth, Commissioner
Westchester County Department of Community Mental Health

Wendy Brown, Deputy Public Health Director
Sullivan County Public Health Services Department

Darcie Miller, Commissioner of Social Services and Mental Health
Orange County Mental Health Administration

Michael J. Piazza, Jr., Commissioner
Putnam County Departments of Mental Health, Social Services and the Youth Bureau

Jacqueline Johnson, Deputy Commissioner and Director of Community Services
Dutchess County Department of Behavioral & Community Health

Michael Leitzes, Commissioner
Rockland County Department of Mental Health

Hudson Valley Public Hearing
Putnam County Training and Operations Center
Carmel, NY
October 3, 2019

Members Present:
Task Force
Senator David Carlucci, Co-Chair
Senator Peter Harckham, Co-Chair
Senator Gustavo Rivera, Co-Chair
Senator Patrick M. Gallivan

Non-Task Force
Senator Jen Metzger
Senator Sue Serino

Speakers:

Jill F. Faber, Deputy Attorney General for Regional Affairs
New York State Office of Attorney General

Justin Gurland, Founder
Release Recovery

Ashley Brody, Chief Executive Officer
Search for Change

Susan Salomone, Co-Founder and Executive Director
Drug Crisis In Our Backyard

Michele McKeon, Chief Operating Officer
Regional Economic Community Action Program (RECAP)

Jaron Benjamin, Vice President, Community Mobilization
Housing Works

Tomoko Udo, Assistant Professor
University of Albany School of Public Health

Annette Kahrs, Program Director
Hope Not Handcuffs-Hudson Valley

Dean Scher, Chief Executive Officer
Catholic Charities Community Services of Orange and Sullivan

Patrice Wallace-Moore, Chief Executive Officer/Executive Director
Arms Acres

Adrienne Marcus, Executive Director
Lexington Center for Recovery

Allison Dubois, Executive Vice President/Chief Operating Officer
Hudson River Healthcare

Karla Lopez, Supervising Attorney
Community Health Access to Addiction and Mental Healthcare Project (CHAMP)

Jeffrey Veatch, President
Justin Veatch Fund

Lauren Mandel, Program Director
Keep it Moving

Stephanie Marquesano, Founder and President
the harris project

John Tunas, Development Associate and Club Alumni
Boys & Girls Club of Northern Westchester

Patricia Strach, Interim Executive Director
Rockefeller Institute of Government

Long Island Public Hearing

Patchogue Theatre for the Performing Arts
Patchogue, NY
October 15, 2019

Members Present:

Task Force

Senator Peter Harckham, Co-Chair
Senator Gustavo Rivera, Co-Chair
Senator Monica R. Martinez, Sponsor
Senator Patrick M. Gallivan

Non-Task Force

Senator James Gaughran
Senator Todd Kaminsky
Senator Anna M. Kaplan
Senator Kevin Thomas

Speakers:

Ann Marie Csorny, Director
Division of Community Mental Hygiene Services, Suffolk County

Maureen McCormick, Executive Assistant District Attorney
Nassau County District Attorney

Colleen McKenna, Correction Coordinator, Sheriff's Addiction Treatment Program and Coordinator, Suffolk County Criminal Justice Coordinating Council
Office of the Sheriff, Suffolk County

Gerard Gigante, Chief of Detectives
Suffolk County Police Department

Sarah Smith, Person in Recovery

Claudia Friszell, Member
Families in Support of Treatment (FIST)

Linda Ventura, Founder
Thomas' Hope Foundation

Adam Birkenstock, Director of Programming
Long Island Council on Alcoholism & Drug Dependence (LICADD)

Jo Ann Ferdinand, Judge (Ret.), Brooklyn Treatment Court, Kings County Supreme Court
New York Association of Treatment Court Professionals (NYATCP)

Tina Wolf, Executive Director and Co-Founder
Community Action for Social Justice (CASJ)

Archimedes Jao, MD, Medical Director, Keith D. Cylar Community Health Center
Housing Works

Steven Rabinowitz, Vice President
Families for Sensible Drug Policy

John Venza, Vice President of Adolescent and Residential Services
Outreach

Mary Silberstein, Division Director of Integrated Care and Behavioral Health Treatment Services
CN Guidance & Counseling Services

Richard Rosenthal, MD, Director, Division of Addiction Psychiatry
SUNY Stony Brook University School of Medicine

Maria Mezzatesta, Regional Manager, MAT/Genesis Programs
HRHCare

Cathy A. Samuels, Project Director
Massapequa Takes Action Coalition

Buffalo Roundtable

Catholic Health Medical Center
Buffalo, NY
October 30, 2019

Members Present:
Task Force
Senator Peter Harckham, Co-Chair
Senator Gustavo Rivera, Co-Chair
Senator Timothy M. Kennedy, Sponsor
Senator Patrick M. Gallivan

Non-Task Force
Senator Chris Jacobs

Speakers:

Gale Burstein, MD, MPH, FAAP, Commissioner
Erie County Department of Health

Honorable Shannon M. Heneghan, Buffalo City Court Judge
Presiding Judge, Opioid Intervention Court

Nancy Nielsen, MD, PhD, Senior Associate Dean for Health Policy
Jacobs School of Medicine and Biomedical Sciences at the University of Buffalo

Emese Zsiros, MD, PhD, FACOG, Assistant Professor of Oncology
Department of Gynecologic Oncology, Roswell Park Comprehensive Cancer Center

John Sperrazza, Chief Operating Officer
Sisters of Charity Hospital

Avi Israel, President/Founder
Save the Michaels of the World

Emma Fabian, MSW, Senior Director of Harm Reduction
Ivette Chavez Gonzalez, Peer Outreach Navigator
Evergreen Health Services

Pastor James E. Giles, President/Chief Executive Officer
Back To Basics Outreach Ministries, Inc.

Andrea Ó Súilleabháin, Executive Director
Partnership for the Public Good

Christine Adamczyk, Coucilmember
Cheektowaga Town Board

Jennifer Barry, MS, CRC, Program Manager, Chemical Dependency
Erie County Medical Center Corporation

Jodie Altman, Deputy Executive Director
Kids Escaping Drugs, Inc. & Renaissance Addiction Services, Inc.

Anne Constantino, President and Chief Executive Officer
Horizon Corporations

Elizabeth Woike-Ganga, LCSW-R, Chief Operating Officer
BestSelf Behavioral Health

Mark A. Sullivan, President & CEO
Catholic Health

Hans P. Cassagnol, MD, MMM, Executive Vice President & Chief Clinical Officer/Physician Executive
Catholic Health

Albany Public Hearing
Van Buren Hearing Room A
Legislative Office Building
Albany, NY
November 15, 2019

Members Present:
Task Force
Senator David Carlucci, Co-Chair
Senator Peter Harckham, Co-Chair
Senator Gustavo Rivera, Co-Chair
Senator Patrick M. Gallivan
Senator Betty Little

Non-Task Force
Senator Thomas F. O'Mara
Senator James Tedisco

Speakers:

Albert Wright, Person with Lived Experience

Ronald Anderson, Person with Lived Experience, Leader
Katal Center for Health, Equity, and Justice

Cortney Lovell, Co-Founder
Our Wellness Collective

John Coppola, MSW, Executive Director
New York Association of Addiction Services and Professionals, Inc. (ASAP)

Allegra Schorr, President
Coalition of Medication Assisted Treatment Providers and Advocates (COMPA)

Nadia Chait, Associate Director of Policy & Advocacy
The Coalition for Behavioral Health

Lauri Cole, MSW, Executive Director
New York State Council for Community Behavioral Healthcare

Richard Juman, Psy.D
New York State Psychological Association (NYSPA)

Dionna King, Policy Manager
Drug Policy Alliance (DPA)

Lauren Manning, Assistant Director
Center for Law and Justice

Keith Brown, Director of Health and Harm Reduction
Katal Center for Health, Equity, and Justice

Sarah Ravenhall, MHA Executive Director
New York State Association of County Health Officials (NYSACHO)

Kelly Hansen, Executive Director
New York State Conference of Local Mental Hygiene Directors, Inc. (CLMHD)

Barbara Wilhelm, Mother

Angelia Smith-Wilson, MSW, Executive Director
Friends of Recovery – New York (FOR-NY)

Christine Khaikin, Health Policy Attorney
Legal Action Center (LAC)

Veronica P. Glueck, Probation Officer, Westchester County Probation Department
New York State Probation Officers Association (NYSPOA)

Eric Linzer, President and Chief Executive Officer
New York Health Plan Association (NYHPA)

Kathy Preston, Executive Vice President
New York Health Plan Association (NYHPA)

Dr. Sander Koyfman, Behavioral Health Medical Director
Wellcare NY, New York Health Plan Association (NYHPA)

Dr. Melissa Perry, Medical Director of Behavioral Health
BlueShield of Northeastern New York, New York Health Plan Association (NYHPA)

Brendan J Cox, Chief (Ret.), Director of Policing Strategies
LEAD National Support Bureau

Magdalena Cerdá, DrPh, Director, Center for Opioid Epidemiology and Policy and Associate Professor, Department of Population Health
NYU School of Medicine

Diana Aguglia, Regional Director
Alliance for Positive Health

Stephanie Lao, MSW, Executive Director
Catholic Charities Care Coordination Services -Project Safe Point (PSP)

Samantha Arsenault, Vice President of National Treatment Quality Initiatives
Shatterproof

Kevin O'Connor, Executive Director
Joseph's House & Shelter

Van Smith, Founder and Executive Director
Recovery Houses of Rochester (RHOR)

Suzanne Brundage, Director, Children's Health Initiative
United Hospital Fund (UHF)

Shane Bargy, Executive Director
Boys & Girls Clubs of Schenectady (BGCS)

Jenn O'Connor, Director of Policy and Advocacy
Prevent Child Abuse New York (PCANY)

Douglas Cline, MD, Director
New York State Pain Society (NYPS)

Muhammad Jalaluddin, MD
UR Medicine St. James Hospital

Carole Deyoe, RPh, Director of Pharmacy Practice
Pharmacists Society of the State of New York (PSSNY)

Timur Lokshin, DACM, L.Ac., Diplomate of Acupuncture (NCCAOM), Chair, Advocacy Committee
Acupuncture Society of New York (ASNY)

Bryan Ludwig, DC, Executive Officer
New York Chiropractic Council

Jason Brown, DC, President
New York State Chiropractic Association (NYSCA)

Brendan Sullivan, DPT and Chair of the Opioid Alternative Special Committee
New York Physical Therapy Association (NYPTA)

Written Testimony

Timothy Hunt, MSW, Associate Research Scientist and Associate Director, Social Intervention Group (SIG)
Columbia University School of Social Work

Stephanie Grolemund, President
New York State Association of Nurse Anesthetists (NYSANA)

Payam Goudarzi, DDS, President
New York State Dental Association

Kate Powers, Director of Legislative Affairs
New York State Office of the Attorney General

Elizabeth Deutsch, RN

David M. Reiner, Senior Director, State Government Affairs
Quest Diagnostics

Alan J. Wilmarth, CASAC, Administrative Director, Behavioral Health
United Health Services Hospitals, Inc.

Mary Shaheen, Vice President
United Way of New York State (UWNYS)

2019 REPORT

NEW YORK STATE JOINT SENATE TASK FORCE

OPIOIDS, ADDICTION AND OVERDOSE PREVENTION