

**HEALTH COMMITTEE  
OF THE  
SUFFOLK COUNTY LEGISLATURE**

**Minutes**

A regular meeting of the Health Committee of the Suffolk County Legislature was held in the Rose Y. Caracappa Legislative Auditorium of the William H. Rogers Legislature Building, 725 Veterans Memorial Highway, Smithtown, New York on Thursday, February 6th, 2014 at 2:00 p.m.

**Members Present:**

***Legislator William Spencer - Chair***  
*Legislator Kate Browning - Vice-Chair*  
Legislator Rob Calarco  
Legislator Monica Martinez  
Legislator Robert Trotta

**Also In Attendance:**

*P.O. DuWayne Gregory - Legislative District No. 15*  
George Nolan - Counsel to the Legislature  
Renee Ortiz - Chief Deputy Clerk/Suffolk County Legislature  
Craig Freas - Budget Analyst/Legislative Budget Review Office  
Lora Gellerstein - Aide to Legislator Spencer  
Bill Schilling - Aide to Legislator Calarco  
Debbie Harris - Aide to Legislator Stern  
Greg Moran - Aide to Legislator Trotta  
Lisa Pinkard - Aide to Legislator Martinez  
Tom Vaughn - County Executive Assistant  
Amy Keyes - County Executive's Office  
Phyllis Seidman - Bureau Chief/County Attorney's Office  
Art Flescher - Director of Community Mental Health/DHS  
Dr. Jeffrey Reynolds - Executive Director/LICADD  
    Long Island Council on Alcoholism and Drug Dependence  
Michael Seilback - American Lung Association  
Kevin McEvedy - AME/Legislative Liaison  
All Other Interested Parties

**Minutes Taken By:**

Alison Mahoney - Court Reporter

*(\*The meeting was called to order at 2:06 P.M. \*)*

**CHAIRMAN SPENCER:**

Would everyone please stand for the Salute to the Flag led by Legislator Calarco.

***Salutation***

Remain standing, please, for a moment of silence for all those who are serving this country around the world to protect our liberty.

***Moment of Silence Observed***

Good afternoon and welcome to the Health Committee. I'm Legislator William Spencer and I've been given the privilege to chair this committee for the 2014 Legislative year. So I thank Presiding Officer Gregory for that privilege and I'm happy to continue serving the chairmanship of this committee.

I'm happy to welcome our new members; Legislator Trotta and Legislator Martinez, thank you very much and I'm looking forward to working with you. This committee does tend to be very exciting, just because of its scope where we deal with everything with environmental issues to the Department of Health, and then also the Board of Health and public health issues. So I appreciate your insight and participation. And we also have Legislator Browning and Calarco, our senior members who are returning. So thank you, look forward to working with you.

I do have a presentation today from Dr. Jeffrey Reynolds of LICAD, the Long Island drug epidemic, and Art Flescher from the Department of Office of Mental Service. And what we're going to do, we have a very brief agenda and we also only have one card in our public portion. So what we're going to do is we're going to take the card, we're going to do our agenda and then we're going to have our presentations.

Before we do that, I wanted to make a couple of brief remarks about this year's Health Committee and the direction that I see us taking. We've got some major challenges ahead of us. We know that we're looking at our health care centers, and as we make adjustments to continue to provide the services that our constituents rely and depend on and that we carry out our Article 6 service in terms of protecting the public against sexually transmitted disease, Tuberculosis, looking at Vector Control issues, as we figure out a way in our changing economy to use our health care dollars efficiently, one big issue that we'll be addressing is the consolidation and the transfer of our health care facilities. And we will make sure that we provide the appropriate oversight and give the discussion and the background that is necessary so that we won't have anyone that will ever be hurt as we take economic actions. We want to make sure that our public is protected.

We also will hopefully obtain a new Medical Examiner this year. We know that that process is under way. Recently we've seen that the County Executive has also laid out a very large program with regards to water quality, and within the Health Department, the DEC where we have our sanitarians, our well inspectors, our wastewater department, we want to make sure that we have the appropriate staff that we can carry out our functions, but also at the same time be, again, aware of some of the challenges economically.

We also are dealing with a major drug epidemic on Long Island. And as we have had physicians who have -- now with I-STOP where we are now getting the word out, and we had a summit recently where we had over a hundred physicians who participated and Art Flescher organized it with the Suffolk County Medical Society, where we see that as we control prescription drugs -- Oxycodone, Hydrocodone -- and as we get those off of the street, we know that because of supply and demand the cost of these pills have gone from 10 to \$20 a pill to as much as 30 to \$50

per pill.

We're also seeing a rise in heroin use. Heroin is an alternative, but heroin tends to be something that we can't control its concentration or purity and we see that a lot of lives are being placed at risk. We want to make sure that we have the appropriate health services, that we expand our Narcan Program so that we can save lives, but after we save those lives we need to make sure that they get the appropriate care. So we're going to definitely start off talking about the drug epidemic today and get into some detail there.

So we have a very, I guess, rich agenda ahead of us this year, but with the support of my colleagues and the public, we, you know, hope to answer and provide some substantial solutions to some of these challenges that we face.

So with that, I'm going to move on to the public portion. I have no -- I have one piece of correspondence and that's Legislator Browning regarding the Jail Medical Unit. We are going to be working with Legislator Browning and the Administration to give her some feedback with regard to that. Legislator Browning, do you have a --

**LEG. BROWNING:**

Oh. Well, just real brief. I know that we have employees who are still on the preferred list and -- who have been laid off, and I know that they keep saying that it's a different title in the Jail Medical Unit, but it's a non-competitive position, and I've been told that there are agency employees still working in the Jail Medical Unit. So I'm trying to understand, if there's agency employees working at the Jail Medical Unit, why aren't those County employees who were laid off being put into those positions? And I know that there are I believe some full-time positions that might be coming up which they should be eligible for, so I'm looking forward to getting an appropriate response.

**CHAIRMAN SPENCER:**

Well, we have received Legislator Browning's correspondence and we have reached out to the Commissioner and also to the Administration to make sure that you get satisfactory interest to your inquiry. So, thank you.

With that, moving on to the public comments, I have one card this morning. And if there's anyone else in the public that wishes to be heard, you'll have that opportunity. But Michael Seilback from the American Lung Association, and he is speaking to IR 1039. So, good morning, Michael. Thank you for coming. And as per the rules of our committees, you have three minutes to address the committee, and after that there may be Legislators that may have questions for you.

**MR. SEILBACK:**

Thank you very much. My name is Michael Seilback and I'm the Vice-President for Public Policy and Communications for the American Lung Association of the Northeast. I'm happy to be here, this is the first time meeting many of you on the committee. But the Lung Association's here today to speak in support of IR 1039, sponsored by Chairman Spencer, and that's a bill that would regulate the sale of tobacco products and raise the selling age from 19 to 21.

As you might know, an overwhelming number of smokers start by the time they reach the age of 21; in fact, estimates show that it's approximately 90%. While we've taken great strides in reducing the use of tobacco in New York State and here in Suffolk County, over 23,000 New Yorkers are going to die this year from tobacco use. If we know that 90% of them are starting at such a young age, anything we can do to make it less likely that kids are going to start smoking is a beneficial step in the right direction. As you probably know, New York City recently took that step and some cities in Massachusetts have taken that step, and initial data from those towns in Massachusetts have shown that smoking rates have decreased by youth by almost 50%. Now, it's fair to say those samples are somewhat small and it's unclear whether that could be replicated here

with a 50% reduction, but if we were to see just 15%, 15% less can't start smoking, and we were to see less people dying from tobacco, I think that would be a great thing and something that you all, as a Health Committee, should seriously consider.

So with that, I just want to say that I want to be a resource for you. We have offices right down the road, and I'm from Commack so I'm happy to work with you on this. Thank you very much.

**CHAIRMAN SPENCER:**

Thank you, Michael. I appreciate that. And you know that also -- Well, we have a public hearing on this particular issue coming up on Tuesday. Again, I have a question, if I could, and you still work with the American Lung Association. Do you have an idea of just for per smoker, just per year, is there any sort of numbers as to just what the economic impact in terms of smoking is in health care?

**MR. SEILBACK:**

Sure, we do. In New York, recent data from the CDC shows that smoking rates -- smoking causes over \$10 billion a year in health care costs, just New York alone. And of that, at least 5.4 billion is directly tied to Medicaid, which obviously has a direct effect here on the County level. So again, decreasing smoking rates isn't just going to save lives, but it's going to save dollars.

**CHAIRMAN SPENCER:**

And as far as with the American Lung Association, we're looking at, again, just with the concern of raising the smoking age and limiting people's access. From your point of view, I guess with alcohol or even with marijuana, they argue that there may be some medicinal properties that are involved. From your point of view, is there ever any benefit at all to smoking?

**MR. SEILBACK:**

Cigarettes are the one product, Legislator, that when used as directed will kill one out of two users. There's no product on the market today that has that same level of death and disease, that when used as directed, legal product, is going to likely kill one out of two users. So, frankly, no, there's no medicinal benefit to smoking cigarettes.

**CHAIRMAN SPENCER:**

All right. Well, I appreciate your expertise and, you know, this is something we will be taking up, I'm sure there will be a very lively discussion. But just again, having you and your organization bring this matter to our attention, we appreciate your support and I look forward to working with you.

Any committee members have any questions for Mr. Seilback at this time? No. Thank you so much.

**MR. SEILBACK:**

Thank you.

**CHAIRMAN SPENCER:**

Is there anyone else that wishes to be heard for our public comment this morning? Is there anyone else that wishes to be heard? With that, I'll close the public comment section.

We're going to go to our **Introductory Resolutions** at this time on our agenda:

***IR 1037-14 - Declaring the week of February 23, 2014 through March 1, 2014 as "Eating Disorders Awareness Week" in Suffolk County (Spencer).*** I'd like to make a motion to approve.

**LEG. BROWNING:**

Second.

**CHAIRMAN SPENCER:**

Second by Legislator Martinez. All those in favor? Opposed? Abstentions? *Motion is carried (VOTE: 5-0-0-0).*

*IR 1039-14 - Adopting Local Law No. -2014, A Local Law to raise the legal age for the sale of tobacco products in Suffolk County (Spencer).* I'll make a motion to table for public hearing.

**LEG. CALARCO:**

Second.

**CHAIRMAN SPENCER:**

Second by Legislator Calarco. All those in favor? Opposed? Abstentions? Okay. *Tabled (VOTE: 5-0-0-0).*

Okay, so that completes our agenda.

I have one quick thing before we go on to our presentation. Is Tom here from the Deputy Executive's Office?

**MS. KEYES:**

He's outside, I'll go grab him.

**CHAIRMAN SPENCER:**

Okay. So there was -- we wanted to get an update with regards to the Medical Examiner, and I understand that there's a search that's taking place. Tom, could you update us with regards to the Medical Examiner search?

**MR. VAUGHN:**

Actually, Mr. Chairman, in your soliloquy to begin the meeting, I thought that you did an excellent job of that, of updating us on our Medical Examiner search. The search is ongoing. The last search that we did for our prior Medical Examiner took approximately seven months. We have been interviewing candidates, it is something that is definitely -- I mean, it's of the highest priorities and we need to find someone, we need to get them in there, but it's also a matter of finding the right qualified individual to put into that spot and it is an ongoing search and something that we take very, very seriously.

**CHAIRMAN SPENCER:**

Thank you, we appreciate that. Have there been any interviews at this point that have been conducted; any viable candidates come forward?

**MR. VAUGHN:**

I think that those are actually two different questions; I can answer the first one and I can't answer the second one. So the first one is, yes, there have been interviews done, I know that there have been a number of interviews done. As to the viability of any of the candidates, that would not be something for me to judge.

**CHAIRMAN SPENCER:**

Thanks a lot, Tom. We appreciate any information you can give us at future meetings. Thank you.

Health Committee - February 6, 2014

All right. So with that, again, I'm happy to have Dr. Jeffrey Reynolds here. Dr. Reynolds, if you could come forward and have a seat at the table. He's the -- and Art, would you mind coming up and joining him? Because I think that just really we're going to address just a very important issue. And Art, you had a very nice meeting, Dr. Reynolds was there last week where you involved physicians. But we know recently with the passing -- what's the actor's name?

**MR. NOLAN:**

Phillip Seymour Hoffman.

**LEG. BROWNING:**

Phillip Seymour Hoffman, yeah, and just to lose a talent like that. And I understand that there were maybe 103 bags of heroin in his apartment, arrests have been made. But part of the issue is that as soon as we arrest some they are quickly replaced by others, and we see that we've declared a war on drugs in this country, but drug use has not declined. So Dr. Reynolds, I won't steal any of your thunder by talking too much, but if you could just update us about this particular issue and your thoughts. And Art, if you have also some comments, I'd greatly appreciate it. So thank you, Dr. Reynolds.

**DR. REYNOLDS:**

Thank you for having me. How long do we have this afternoon?

**CHAIRMAN SPENCER:**

Typically an active discussion can carry on for a while, but as far as just a formal presentation, maybe 10, 15 minutes if that's okay?

**DR. REYNOLDS:**

That's fine, I can do that. I can talk longer if need be at a very rapid pace, as some folks have noted this morning.

**LEG. BROWNING:**

Legislator Calarco, after 10 minutes he just phases out.

**DR. REYNOLDS:**

He's already talking to Kate.

*(\*Laughter\*)*

It's my pleasure to be here. I certainly appreciate --

**LEG. BROWNING:**

I'm just kidding. I am on the record, I was kidding with my very conscientious colleague, Legislator Calarco.

**DR. REYNOLDS:**

We can all agree on that.

As you correctly noted, President Nixon declared war on drugs in 1971. And if we look at where we are now, certainly we're no better off than we were back then; in fact, some would argue that we're infinitely worse off than we were back then.

Similarly, here on Long Island, several publications wrote about a burgeoning heroin epidemic more than a decade ago, and the headlines were national in nature. They talked about heroin impacting the suburbs, it caught national news and should have been our call to action. We sit here now a decade later, hundreds of news stories later, thousands of fatalities later, saying "So what do we

do?"

We don't handle all problems like that on Long Island; some things we take very seriously. So if you look at the process after Sandy, we stepped back, we said, *"What went wrong here? What went right? What do we need to do to rebuild the system in a way that works?"* Heroin is tearing apart people's homes and tearing apart people's families left and right, and we're no better off than we were ten years ago and, in many regards, we're infinitely worse off.

The data that we got a week or so ago from the Medical Examiners in both Counties suggested that the overdose fatalities are beginning to level off, that there's been a shift away from prescription drugs over to heroin. That's something that's consistent with what we see at LICAD in our three offices across Nassau and Suffolk. And I've shared with some of you before that five years ago we were serving a hundred families per month, last month that number had jumped to 767. It wasn't all at one time, it's been a gradual build up over time, and as the cases have increased, so have the complexity. And so the days of, you know, someone coming through and saying *"I'm using two to three bags of heroin a day a couple of times a week,"* that's not the case profile. And the other case profile is increasingly younger folks, meaning between the ages of 17 to 21. Their average level of use is 10 to 15 bags of heroin per day. And whereas a year ago I'd say that 1 to 2% had actually moved on to injecting, the number now is almost 15% have moved on to injecting.

It gets worse because addiction does that if you do nothing about it; it does that in the individual and it does that as a community. And while I think Nassau and Suffolk were pretty slow to acknowledge the threat of heroin in a suburban environment, in some ways that gave the drug a running head start on our young people. Phillip Seymour Hoffman, of course, has refocused some of the attention, and once again I'll tell you that so far today a TV station from Spain, a TV station from Japan and a network have been in my office talking to former heroin users about what it's like to struggle with heroin on Long Island; so once again, we're in the national news.

My hope is that this time we accelerate the pace of change and deal with this once and for all. I think that one of the bright lights on the horizon really was the passage of the I-STOP legislation. It's something that was a long time in coming. By no means did it act to solve all the problems, in some regards it made some of them immediately worse. At the very least, I-STOP was akin to shutting down the gas line at a major raging fire. For once we're not seeing Opiates flowing out into the streets in record numbers. It means that doctors are beginning to call patients out and to challenge them a little bit more. It means that pharmacists have a better handle on who's walking through the door for the fifth time in a week to get Oxycontin, and it means that there's a whole bunch of folks who are at a crossroads. Lots of those folks wind up in our offices. In fact, since the beginning of the year, more than 300 folks have come to us and said, *"My doctor or my pharmacist called me out, this has just gotten too hard to manage. I don't think I have a problem but other people do, perhaps we should talk."*

If you close the door on those folks, they find other alternatives. Their addiction doesn't magically disappear. Some of those folks have entered the treatment system; more of those folks have tried to enter that treatment system and have been denied access. Those folks who are denied access quickly migrate over to heroin, which is the direction they were headed in anyway. When we talk about Vicodin at this point going for 40 to \$30 per pill and you need to take five or six a day in order to not get high but to feel normal. Real easy when someone taps you on the shoulder and says, *"Heroin is exactly the same chemical compound and it's only \$10,"* and you're off and running.

Obviously, the risks associated with pharmaceutical-grade prescription misuse is significant. The risks, of course, increase when we talk about heroin that might be contaminated with Fentanyl, obviously the risks multiply when we talk about injection drug use, which also carries with it the risk of Hepatitis C, HIV and other blood-borne pathogens.

It's been disheartening for us to watch such bold action taken on the part of the State Legislature where they voted unanimously to do I-STOP and to close down the supply and then watch us not deal with the demand side of this, and that's meant a whole lot of folks who have said, *"All right, you squeezed me out of the system. Now what?"*

The access to treatment, the problems relate to a number of things. First and foremost, and I think Art will agree with me on this, bed capacity is a huge issue. Getting somebody into detox at this point in time is an exercise in futility. The notion is if you're doing a pure Opiate detox, it's not life threatening and you needn't be in an inpatient situation. It sounds well and good, I understand it medically, but real hard to explain to the parents of an 18 year-old who's writhing in pain on a bathroom floor. Real hard to explain to those parents how you keep that kid under wraps as they go through a process that can take three to five days. Real tough to explain to those parents why there's no bridge to treatment once they've gone through detox. So obviously inpatient detox is not for everybody, but when we set folks up and we send them to ER's and they're ushered right back out, we've, in essence, confirmed what they already believed; *"See, I told you this wasn't a big deal. I don't have a problem."* I saw someone driven back out of the NUMC Emergency Room into a snow storm who used within four hours of being out again; this is after it took us six months to get him to the door.

The other huge barrier which I hope the State Legislature will address, and anything you can do to encourage that would be welcomed, is the rampant discrimination on the part of insurance companies who have told our clients, even those who are using 10 to 15 bags a day, one recently who had two non-fatal overdoses and they said to him, *"You're not sick enough to warrant inpatient treatment, try outpatient treatment once a week and then we'll talk."* *"You must fail"*, and that's the term they used, *"at outpatient treatment before we'll pay for inpatient treatment."* Of course, this is the same insurance who had no problem paying for probably \$20,000 worth of narcotics as this person got hooked, but refused to pay a couple of grand for the treatment to clean up the mess.

When they pay for inpatient treatment, they will approve three days at a time. We know the gold standard for inpatient treatment used to be 28 days, now we know that if a young person is out there doing their thing for three to four years, if it took them that long to walk into the woods, walking them out in 28 days is probably not going to be successful. Three days is a joke. And what will happen is they'll pay for three to seven days-worth of inpatient treatment, that person will be discharged, that person will use drugs again, Mom and Dad go back to the insurance company and say, *"We've got a problem again, we need another admission,"* and they'll say, *"Look, we tried that once, it didn't work out."* And so families are left with few options. And of course this is after you've gotten the person through the door, and most of you know that LICAD does a fair amount of family-based interventions in which we spend a lot of time working with the family on how to deal with a loved one who's addicted, but also working with the addicted person about getting access to treatment.

Those are the key barriers. The State Legislature has a bill in both houses to deal with this issue and our hope is that it happens. If we think about the entire problem as a continuum, a continuum that at one end is primary prevention, particularly with young people, and at the other end is recovery support. There's no point along the way in which we are doing enough, and at every point along the way there are significant gaps. When we talk about prevention and when we get into a crisis like this, it becomes easier to talk about Narcan and treatment and those kind of things, but keep in mind that the things we're talking about are preventable.

On the education side, while we were gaining some steam and more districts were doing parent education forums, we saw more evidence-based workshops happening in classrooms, most of that has gone away with the advent of Common Core. And the school districts will now say, *"We'd love to do that. We know we should be doing more, but we just don't have the time to do activities that are discretionary in nature."* And as much as I try to convince them that kids who are drunk, high

or dead of an overdose don't do well on standardized tests, it's a hard sell when their back is against the wall in terms of these tests. At the same time, you've got kids who have more stress than ever before. Kids who have untreated stress, kids who have untreated mental health issues, depression, anxiety that is already within them that is exacerbated potentially plays itself out in later substance abuse. So at the same time the risk has increased, the resources for these kids has dropped.

On the treatment side of things, I've gone through some of the challenges in treatment. There are fewer treatment beds now between Nassau and Suffolk than there ever have been before. More and more hospitals are getting out of the detox business. A, it's not profitable; B, there are some hospitals that don't want to be seen as, quote/unquote, "*that type of hospital*", and you have families that are being turned away left and right. We find ourselves in a situation, and it's evolving, where up until, you know, a few months ago we were saying to folks, "*Did you ever take a Xanax?*" Because Xanax gets you an immediate detox placement because it's known to be dangerous, it's known to cause seizures, same thing with alcohol.

Now that's changed because as folks haven't been able to get their hands on Opiates, they'll put whatever they can get. Although different drug, different impact, different place, you have people who are desperate at this point in putting whatever they can get their hands on into their bodies, so we are seeing more mixing of Benzos and Opiates.

Finally, on the recovery side of things. And, you know, kind of our expectation is that we'll send folks off to treatment in a best, best, best case scenario for 28 days. Pull them out of the polluted pond for 28 days, put them in a safe place, give them some new skills, give them 30 days-worth of clean time and then we throw them right back in the pond and say, "*Boy, why'd you get sick again?*" They got sick again because our community, by and large, doesn't have a lot of resources in it, is not supportive of recovery. Long Island is one of the few major metropolitan areas without a recovery center. We also don't have a recovery high school as most other areas do. And although I firmly believe that every high school should be a recovery high school, they're not. And so we're making a sizeable investment in treatment only to see it wasted when we don't give folks the proper support. That argument also relates directly to the State's continued unwillingness to regulate sober homes, an issue near and dear to Legislator Browning I know. Time and time again we see folks who actually go off to pretty good treatment, maybe a third or fourth treatment stint, get placed into a house that's anything but sober, relapse within a short amount of time and are out on the street again.

The price we pay for all of this, including the insurance denials, and the insurance denials is a great example of the ultimate cost shift away from private sector corporations to the Medicaid rolls, because the first piece of advice we give to folks that run into insurance barrier is to "*Let's see if we can get you off and get you on to Medicaid where the regulations are very different.*"

Long and short of it is that the private corporation, whether it be Empire or somebody else, is let off the hook, we the taxpayers are on the hook. And then you pray to God that that kid winds up into treatment before they wind up in the Suffolk County Jail or in a box in the Medical Examiner's Office. And all too often those kids are not making it into treatment. Those kids, as long as they're out there doing their thing, the only way to finance their habit is by distributing to their friends, and their friends. And so when we think about how come this has gotten worse -- and at least once a week somebody says, "Well, is it getting any better?" And I'm tired of saying no, but the answer is a resounding no, it's not getting better.

So here's -- I know that Art's going to speak about some things that the County has done that I think are very, very positive. I happen to think that the expanded distribution of Narcan is absolutely critical, because too many folks are losing their battle before they ever see the doors of LICAD or any licensed treatment facility across the Island. And so we can look -- and I've actually spoken to some of the folks who have been revived with Narcan who have gotten a second shot, so

that's absolutely important. But we've got to do better than simply keeping people alive, because eventually that's going to run out. Someone who overdoses has a multiplied risk for a subsequent overdose; they've been down the road once, their level of use is actually pretty high, their risk is multiplied. And so while we're able to bring them back and give them a second shot, it doesn't last forever.

The education of doctors is absolutely critical in all of this, because if we want to deal with the supply issues around prescription Opiates, then we need to educate the doctors and pharmacists, quite frankly, who are on the front lines of telling patients, *"No, it's not going to happen."*

The awareness around this problem tends to go in fits and starts. With the death of Phillip Seymour Hoffman we're at a height. I think Art and I would probably both agree that prior to that, we began to see a waning interest in this issue. The County can do more. We need to have a dialogue. If we can't get folks who are detoxing at the hospitals, what can we do on an outpatient basis to support those folks? While there are treatment facilities out there, there aren't nearly enough resources for families, so families wind up in a situation where if your son/daughter/sister/brother says, *"No, I don't have a problem and I'm not going to treatment,"* for a lot of families that becomes the end of the conversation; it doesn't have to be.

To the extent that you guys can continue to raise the profile of the issue, and most of the policy issues happen on a State level, but there are little things that I think the County can do. And maybe we can have a rich conversation about that after Art talks about some of the efforts the County has already made into this.

So I thank you for the opportunity. I wish I could come before you with better news, it seems like every time I've come before you in the past five years or so it's to say the problem's getting incrementally worse and I'm here again to tell you the same, and I long for the day when I can give you a different piece of news.

**CHAIRMAN SPENCER:**

You actually did give us a little glimmer of good news in indicating that -- just with regard to looking at the prescription drugs, that there has been some impact and even some decrease and some deaths, I noticed in some of the numbers that came out at our forum just last week. So, you know, we're -- you know, I think any time that you start to make an impact on the problem, you have some unintended consequences, but I still think that is part of the road to solving a problem. Seeing the resurgence in heroin because we're starting to really drive up the demand because we're starting to work on the supply side of things. So I do see a little glimmer that we need to follow up on that.

We'll take some questions shortly. I'm going to ask Art. Thank you. Art is right here in Suffolk County and really put together a fantastic program last week. I think the speakers were phenomenal, we had a great panel that came together and it was great to do that with the Medical Society, so I commend you on that. And I'm looking forward to hearing what you have to say. Jeff, you have such a great way of explaining the problem to us, to me as a lawmaker. You keep us informed and it's always -- when you come before us, I always leave a little smarter, a little more informed, so I thank you for that. Art, the floor is yours, and thank you again.

**MR. FLEISCHER:**

Thank you, Dr. Spencer, and good afternoon to members of the committee. I'd also like to commend Jeff on his eloquent overview of the situation. I'm certainly not going to belabor a lot of those points because I think they were said so well.

A couple of things I just wanted to mention. I mean, as you mentioned, Dr. Spencer, it's no surprise that the heroin problem has experienced such a resurgence. I mean, based upon the reality, when I first started working in addictions some 35 years ago, one of the things I learned from my heroin-addicted clients was truly we could all be in that position. Because one of the things that was really clear, when you ask an addict about their drug of choice and you say, "*How did you feel the first time you ever used,*" and one of the differences between somebody who moves on to addiction and somebody who may use a medication for pain killing properties after surgery or whatever it might be, is somebody that moves on to addiction almost from the instant will say, "*For the first time in my life I felt normal. For the first time in my life, I felt as if I was in tact, that I belonged in the world and I felt comfortable with people.*" And I remember sitting there very often thinking it's really a great thing, in a sense, that people have to go to high crime areas, to areas where they'll have to go into shooting galleries, where they'll have to take a lot of personal risk before they'll be exposed to heroin, because it clearly had such a pull on people. And what we've learned, of course, is that this is a significantly addictive substance that creates a chronic relapsing illness. And when we talk about that, as Jeff pointed out, part of the issue is there's an expectation that once people enter treatment they're cured, that somehow this problem has disappeared. And if they're not cured, they fail, and a lot of it has to do with our language and understanding of the nature of these problems.

So lo and behold, we move into our current situation where pharmaceutical Opioids are widely available and suddenly that supply is cut off -- or not so suddenly, but certainly over time -- and it's no surprise whatsoever that people have gravitated towards heroin. We've seen in our methadone clinics for more than a decade now a tremendous increase in the purity of heroin. The supply of heroin is coming from Columbia, far more than it's coming from Afghanistan at this point. And in general, the potency is so high that, as Jeff mentions, a significant percentage don't inject. When I first started in my career, everybody who used heroin injected, the potency was too low to be able to snort or smoke it or whatever it might be. So now you have people that don't have to use needles, tremendous exposure to the availability of the drug and it's so highly addictive. So that's how we're in the situation. And when we look at it and we say, "*Well, what response do we have?*" I agree, the good news is that with I-STOP and with some of the changes that have been made, I think the pharmaceutical aspect is at least being contained at this point and I think it's likely to continue to improve.

The heroin issue is not going to improve any time quickly. And with that, we need to approach it on all fronts. What we're trying to do is, as mentioned, the seminar we had last week I was also very pleased with. We had three panelists, three physicians who presented from different perspectives, and what impressed me so much was the audience of about 120 prescribers, their attention was wrapped. And afterwards -- now, normally you end something, and we ended a few minutes late, actually, and people are very busy, and normally people scurry off. In this case, you couldn't empty the room with the amount of questions that came up, people that came up to me about specific issues surrounding their practice, that, "*Now that one doctor is refusing to prescribe to them, they're coming back to me as the general practitioner and expecting me to prescribe. What treatment resources are available? What do we do?*" And I think that's where our challenge is and that's where working together we're trying resolve this.

I would like to touch on a couple of specific points; one is the whole issue of hospital detox and the issue of Opiates. It is true that from a medical necessity standpoint, detoxification can be handled on an out-patient basis, but that is assuming that somebody complies with the regimen that's presented to them. That's assuming they're in a safe home environment, they're not using in between visits to whatever outpatient provider they're going to; very difficult. What we're doing is -- and we would have had the meeting the other day except for the weather. Most of you may be aware, or some of you may be aware that Catholic Charities operates a crisis residence, a crisis service known as Talbot House in Bohemia, and they've had that service for many years, and it started out as really a program that dealt primarily with alcoholics and over time it has progressed

to dealing with other drug issues. We're going to be working with Talbot House to develop some kind of subacute care, detoxification program so that we can address some of those issues in terms of people that are not able to get into a hospital but -- and may not need a hospital but they need to be out of their environment for a few days. And we're going to use a variety of different strategies, one being the drug Suboxone in terms of going through the stabilization period of Suboxone while in Talbot House and starting treatment at Charities or other providers. That's a very concrete thing we're going to start doing because I think that's really important. It's going to be a little complicated in terms of cost and a variety of things, but it's really necessary because there aren't detox beds, and I don't think we're at a point where we're going to get insurance companies to allow that many people to go into a detox program just for heroin addiction. If there are Benzodiazepine abuse or alcohol, it's a different issue, but certainly heroin or other Opiates, it doesn't happen.

The other part of it is that we're looking at a variety of funds.

The County Executive has initiated a several point strategy, one is going to be to work with local school districts in terms of a video we're going to be developing in terms of addressing some of the issues surrounding this problem; from medicine cabinet awareness to understanding how to dispose of medicines, how to recognize warning signs with their children. And in general, we're going to try to utilize probably social media and other ways of communicating to families some of these issues.

Jeff alluded to the Narcan initiative. We're pleased that aside from the Health Department having the ability to train laypersons, LICAD also has that certification, as does the Long Island Minority AIDS Coalition, and there's a commitment to develop a centralized calendar so that all three entities work together. And basically what you're going to see is, hopefully, Narcan trainings be ubiquitous. Pretty much every week there should be a training somewhere because it represents a great way to get people into treatment, educate families and give them life-saving medication in case of an overdose.

We're also working with all of our substance abuse providers to make sure that they're as comfortable addressing Opiate addiction as they are some of the other drugs of abuse that people have through ongoing training and really encouraging greater access to care, at least on an out-patient basis more quickly.

The key issue that I would reinforce is that there is the issue of insurance companies refusing to allow for rehab. And particularly rehab I have a discomfort with because I don't understand that exactly, the idea that you have to have gone through a course of out patient treatment and then relapse multiple times before you can go into a rehab. A lot of this is based upon timing and readiness, and some people are ready at different points than others. And I think that advocates need to continue to push, because although we're talking about commercial insurers, the entire field is moving into Managed Care. All of the Medicaid programs within two years are going to be in a Managed Care environment operated by the very same insurance companies that we're frustrated with at this point. So, you know, as we speak, our Chemical Dependency Subcommittee is meeting and that's one of their key issues, is how to really work on that and to reach some level of true parity so that other chronic diseases that are treated where you're allowed to relapse, you're allowed to have the care that you need can occur with addiction as well.

So those are general comments. I'll be happy to address more specific questions, but thank you for your attention and your time.

**CHAIRMAN SPENCER:**

Art, thank you. And again, Art is the Director of the Health Office of Mental Services within Suffolk County. You're really doing a fantastic job and I appreciate your presentation. Legislator Browning has some questions for you.

**LEG. BROWNING:**

Actually, I have a couple. First of all, I'm happy to hear what you say about Talbot House, but what is the age? Because I know one of the biggest problems we have is adolescents. So what would the age group be and how many beds are you actually talking?

**MR. FLEISCHER:**

Well, Talbot House is a 30-bed facility, and it is 18 and above, that is true, so it wouldn't deal with kids younger. But I will say that there is a new addition to our capability in the field. St. Charles Hospital is opening a 5-bed adolescent detox unit to go with an adult unit. You're shaking your head no; not enough beds, right?

**LEG. BROWNING:**

No, that's a drop in the bucket.

**MR. FLEISCHER:**

It is, it is, but it's far more than we have right now. And who knows? I mean, that may be on the table in terms of how to address -- for example, a program I respect very much, Outreach Project, as I know you do as well, you know, they provide long-term treatment for adolescents. They certainly would not be opposed to doing some work regarding shorter term things maybe even addressing this. There's going to be a lot of discussions around; if we can't do it one way, how are we going to do it another? And the good news, I guess, is that New York State OASIS is at least talking about the ambulatory part of detox. And if we can get them -- because they really do believe that a lot of this can be done in out-patient settings. And again, as I said, I understand the difference, but I think an inpatient setting that maybe isn't quite as costly as a hospital or as highly medicalized would probably work far better than trying to assume that everybody can do this on an out-patient basis. So I think there's more openness to that, and unfortunately some of the high profile issues that have occurred have increased that openness.

**LEG. BROWNING:**

Jeff, I think maybe when you talk about the recovery high schools, because I know William Floyd School District has the program in their school district. Now, since we've talked about this a couple of years ago and you guys did the presentation, I think it has to be two years ago, and that was a recommendation that you made.

**DR. REYNOLDS:**

Yes.

**LEG. BROWNING:**

How many school districts have actually moved forward and are doing similar to what William Floyd is doing?

**DR. REYNOLDS:**

I don't know of any. I think it hasn't happened. And so you've got an increasing number of young people out there who have a history of substance abuse, who perhaps have turned the corner without any support. And, you know, one of the other lessons out of Sunday's death was that you can be clean for 22 years and relapse, and for many folks that's a part of the process. This is a chronic relapsing condition. And so, no, I don't think that we've made a lot of gains there.

There's really -- what I see is a disconnect between kind of the youth-serving world and then there's the addiction world. And kind of the vantage point I have for this is I'm also Chair of the Nassau County Youth Board and there the issues are the same; that I come from the addiction world, yet the youth organizations, in many cases, aren't in regular contact with the addiction world. There aren't cross programs happening, there aren't cross discussions happening. I think the schools operate in some ways in kind of -- I don't want to say an isolated kind of way, but in a way that's

not necessarily accessible to all of the organizations and feel increasingly pressured. And so if you go to a district now and say, *"Look, I think you ought to have 12-step meetings every Friday afternoon in the school,"* and they look at you as if you've lost your mind, that's so far from the realm of their reality. Yet you can rattle off the names, and some of our parents go to school board meetings and do this, the names of kids who have died of overdoses in the past five years. We haven't seen that.

And, you know, as I mentioned on the prevention side of things, the notion of prevention now is to take a thousand kids, throw them into an auditorium and they say, *"Scare them for an hour,"* which I guess we could do, but it doesn't have any value; it's not the same of talking with kids in small groups and role-playing some of the dilemmas that they're going to have to face.

**LEG. BROWNING:**

Because, I mean, you talked about, you know, times have changed and kids are under more pressure, and some kids handle pressure better than others, just like adults. You know, I guess it's a certain type of personality, the ones who are most likely or most -- you would most likely see could go in that direction of using some kind of substance to handle the pressure, so I would assume that they should at least try to target them.

But with the Narcan, since Narcan's been used here in Suffolk County since we started this, have you been able to track how many of the people who have been rescued through Narcan have been rescued more than once? Have passed away since? And, you know, just how many cases of Narcan have we done so far, since we started this?

**DR. REYNOLDS:**

You want me to do that based on the calls or do you want to do it?

**MR. FLEISCHER:**

No, I think based on the calls. You have the stats from last year.

**DR. REYNOLDS:**

Yeah, I know about what they are within a few. So our organization actually receives the information from the Department of Health, from Art, and then we have counselors who actually reach out to those folks to have a conversation about the rescue and such. In many cases the data is somewhat limited because there's an officer at the scene writing down a number, and if the save happened in a public place then you don't get a lot of good data. I think last year there were a total of 90 calls. There were, of those that I know of -- and I think this number is pretty good -- four that have been saved more than once in the past.

The willingness to go to treatment is actually pretty high, so our concern was are folks freaked out and when a counselor calls them and says, *"Hey, I heard you had an overdose. Can we help you?"* Folks were not, they were actually pretty responsive. You know, a fair amount of folks said, *"No, this was a one-time thing, I'll be fine,"* and, you know, we'll push and prod a little bit because an overdose isn't a one-time thing and then leave the information with them. But a fair amount said, *"Yeah, look. I had a quick conversation with a social worker in the hospital but that was really it and maybe I should do something about this."* So I think it's been very successful.

I think before that there was almost -- and I don't want to downplay the role of hospital social workers, but that's a crisis-oriented place in which the offer of treatment, if it happens, happens in a very hurried kind of way at the height of a crisis. So our ability to have some of those conversations -- so I'd say, you know, of the 90 names we got, we were able to have substantial conversations with probably a quarter of those folks. And I think even in cases where the person didn't say, *"Yes, you're right. I should come in for an evaluation and go to treatment";* the person now has a go-to person who they can call in the event that they want to make some changes.

In other cases they've said, "*Look, I don't think I have a problem but my Mom does, why don't you talk to her.*" And so in those cases we are talking to the family and kind of going through the ins and outs who, of course, paint a very different picture than perhaps the identified patient did and we're able to at least work with the family on a bridge. So I think that's been very successful. It's something that we took on because, quite frankly, we had a conversation here, I think in this room, where we said, "*So what's happening with the saves,*" and there wasn't a lot of dialogue happening with them, so we've taken that on and we're doing it and I think it's very successful.

**LEG. BROWNING:**

Okay. Did you mention --

**MR. FLEISCHER:**

Just to add --

**LEG. BROWNING:**

-- the number that have been passed away that have been Narcan saves?

**DR. REYNOLDS:**

I don't know of any. However, we wouldn't necessarily have that, so we don't get all the death reports and there's no way to go back and match that up. I'll tell you, word travels pretty quickly in some of these circles, so I knew about the frequent fliers pretty quickly and I don't know of any fatalities. It doesn't mean that there haven't been any, but none that I'm aware of.

**MR. FLEISCHER:**

I think telling is the fact that, as Jeff said, there have been about four that have had more than one resuscitation. This program only started in July, so --

**LEG. BROWNING:**

No, I actually think it's a good number. When you're looking at 90, four is not bad.

**MR. FLEISCHER:**

If I could, I just want to mention, you mentioned recovery schools.

We have had preliminary discussions with BOCES regarding this. It's always been a dollars and cents issue, as you could imagine, but I think it's one that we're going to continue because the problem you run into is that in many school districts there aren't enough kids that are truly in recovery. There are kids that may have gone into rehab, there may be an outpatient treatment, and they are ambivalent about stopping and continuing to use. And those kids that really want recovery need to be in an environment where they have the support of other kids in recovery. And it would be really useful, particularly after coming out of long-term treatment, to have that ability, because withdrawal we usually think of, as mentioned, three to five days, but there's something called protracting withdrawal. And particularly with Opiates, it changes your brain chemistry to a point where it takes several months before you reach that equilibrium again and that balance. So they really need that ongoing support, not to mention the life skills that other recovering peers can offer.

So I agree with you. I think the difference is what's going on in William Floyd is an agency that went in to operate a drug treatment program; a true recovery school would communicate those values throughout every moment of the day. It would be really exciting to have and I'd really love to see it.

**LEG. BROWNING:**

And, you know, talking about our school districts, because I've been to the Project Outreach, they have their luncheon event every year. It was funny, last year and the year before, and I'm not going to mention the school district, but they had children who have recovered -- I know you've

been there, Art -- both of those children come from the same school district, and that was the one thing that I picked up on. And I said, "*Somehow I don't think that school district wants to recognize they have a real problem.*" That's the shame of it. I know Sachem has done a phenomenal job. When they started to see that they were losing kids to drug addiction and overdoses, they didn't run away from it, they faced up to it and said, "*Yeah, we have a problem.*" So I have to give them credit for the things that they've done.

The other thing, last thing, on Sunday the newspaper article about the soldiers with the PTSD and passing away. And I can see already, you know, the families are saying, well, Northport didn't have -- they only have eight beds and, you know, they're saying it took three years for one of them -- had a three-year wait to get a bed, and yet it's one saying, "*Oh, no, we had the beds, there wasn't a wait,*" and the families are saying something different. And from the top down, you know. First of all, our Federal government should be taking care of our soldiers, bottom line, and should not -- they should not have to wait for a bed. And again, then we go to the State level and it seems on the mental health, you know, the drug addiction, the funding just keeps getting cut and cut and now it's down to us, where we don't have the money, and now we're trying to figure out ways to do things with little or no money. But is there something that we could do also? I mean, we're talking about a closed nursing home, that there's an effort to sell it, and we have programs like Father Frank with Hope House.

We have so many great programs and non-profit organizations that would probably jump at the opportunity to say, "*I'd love to take a floor. I'd love to be able to do something.*" And I know Father Frank, we've talked, that he'd like to have a pilot program, but where do you have it? There is no space.

So, you know, again I think my colleagues, we should seriously look at what we have in the County that could help, because it's not, you know, one neighborhood over another. Every single neighborhood in Suffolk County has this problem. And again, it's not just the adults, it's our kids, and I keep saying that. We're not addressing the sober home issue, we're having a really difficult time with this. However, you know, this is about our kids today and what are we going to do if we don't have regulated residences for the kids?

So I don't know if you can comment on that issue with the Newsday, but I just thought that was really disturbing, to find out that these guys did not get the help they should have gotten.

**DR. REYNOLDS:**

So I'd say three things. The issue of returning veterans is really significant, the connection to addiction is very, very direct, particularly when we're talking about PTSD. You know, that's where you begin to see the crossover between the management of physical pain and the management of psychic pain. And the downside is that Oxycontin and Vicodin work really well for both, and so we've seen a high number of addicted return soldiers.

In terms of the responsibility and the beds, you know, I think it speaks to the need to give families some direction and navigation. Imagine you're a parent, and I talk to these parents day-in and day-out who are at work poking away at their computer, on their cell phone trying to manage their kid's addiction, keep it hidden and at the same time find someplace, any place that will take them. I've got parents who literally are quitting their jobs to be home all day to make sure the kid doesn't clear everything out of the house and try to make treatment arrangements, and that shouldn't be.

The two other things that I'd say is there's a lot that we can do without funds. The Sheriff, I don't know, six months ago called all of the non-profit organizations around the table and said, "*What can you do? We have no money, what can you do for free?*" We were willing to send a clinician in every Friday morning to work with a select group of young people around relapse prevention. Every group around the table said we can do one thing or another, and the program has been successful.

No money, for better or worse. We all agreed to do it because it's the right thing to do and because in a crisis, that's what you do.

On the other hand, the County isn't spending more money -- any more money on this problem than it was ten years ago, and the problem has gotten worse. It's going to take money to fix. The same way the Sandy clean-up has required money to fix, we've got to spend some money here if we want it to get better. And you guys know this, I wound up -- those of you that were here know that I had to come back here last year to beg for a restoration of our \$35,000 grant, and we had done four times what we had projected in the contract. And so I recognize that times are tough. Times have never been good, I've been coming here for 25 years and nobody ever said, "*This is the year. We have a whole bunch of money, here's a box, what do you want to fund.*" We have a crisis going on, and it might mean that the County has to spend more. And here's the big news; you're spending it anyway. You're spending it on law enforcement, you're spending it on building new jails, you're spending it on medical costs, you're spending it on community disorganization. You are spending the money anyway. The question is do you want to spend probably a tenth of what you're spending now in order to clean up the problem.

**LEG. BROWNING:**

Okay. And, you know, when you're talking -- somewhere I read just not too long ago, and I don't know if it was the actor when he passed away. There was something that I read and it said something about maybe -- they didn't necessarily pass away from the overdose, it might have been suicide.

**DR. REYNOLDS:**

Well, substance abuse is most considered to be a pretty damaging kind of thing. You know, there's not an element of free will for most folks. You know, I had some troubles with the language around overdose. You know, he died of a heroin overdose, but he died of heroin. You know, the overdose would suggest that if you just use enough heroin you're not going to overdose and everything will be okay. And so, you know, I think we're doing a lot of education around these issues now and I think any time there's a celebrity death it gives us an opportunity. It also brings out the worst in people in some cases, too; any of you who have read the Newsday comment boards kind of know what those are like. It's always a reality check for us in terms of the level of stigma, but it has advanced the conversation about addiction as a disease and as a chronic relapsing condition as opposed to something you just clean up and put behind you and that's the end of it.

**CHAIRMAN SPENCER:**

Gentlemen, thank you very much. I think that you could not have given us a better overview and insight into this topic. Legislator Martinez said her question was answered. I wanted to find out more, because the recovery high schools preceded me, but I am having an upcoming meeting with all the Superintendents, I have like six school districts. And Jeff, I would love for you to come.

I'm just wondering, is there high schools interested in becoming a recovery high school? I would imagine that there's more than one way to do it and that it doesn't necessarily -- most of the time it would really be looking at the budgetary limitations, but I would imagine that there are some high schools that have existing space that could be utilized. Do you have the blueprint or, Art, do we have the blueprint if a Superintendent was interested in exploring this, that we would be able to guide them? And where there were costs involved, where they could look at perhaps alternatives in utilizing existing expertise and existing infrastructure to limit the cost to be able to make this happen?

**DR. REYNOLDS:**

There's a National Association of Recovery Schools that is kind of the network for all of the schools nationwide, as well as for those who want to start up their recovery high school. I've actually been to see one in Minnesota, it's very, very effective, there's several in Boston. So they're around and

there's a whole national organization set up to help plan out how you do this with -- for maximum impact with minimum dollars.

**CHAIRMAN SPENCER:**

I think that's a great idea. And if I were just speaking off the top of my head, too, I think that one of the things that I find to be an issue in certain communities is the denial, and so when you talk about a recovery high school, sometimes there is a stigma that's associated with it. And, you know, if there is a stigma that's associated with the word "*recovery high school*", we could call it "*Sinners of Excellence for Submittal Support of our Youth*", or whatever we need to do.

(\*Laughter\*)

We could call it whatever we want to if we can get the job done. So I would like to work with you on that, at least in my district, because there is definitely a big need that's there, and Art also. Legislator Martinez has another question, so go right ahead

**LEG. MARTINEZ:**

Thank you both for being here. Actually, when you go to the school districts -- and now I'm going back to the recovery high schools -- I'm assuming you're focusing on that district's needs; yes?

**DR. REYNOLDS:**

Yeah.

**LEG. MARTINEZ:**

And, for example, in some districts, let's say, for example, you're going now with recovery high schools, some students begin at a younger age level. So does that mean that those children are able to attend these schools as well even though they're at the high school, or do you keep it just to high schoolers?

**DR. REYNOLDS:**

It depends what the model is. You know, a recovery high school I think is an ideal kind of thing. I think it would be better if all of the schools have integrated some programs into the average day. I don't think we should necessarily have to take all the kids in recovery and throw them in their own school, any more than I think we should do that with GLBT kids or anybody else. However, I do think there's got to be a place for those kids that have struggles within the average schools.

So they're mostly set up for high schools. You could certainly have them at every grade level. And I would say the more immediate answer is for there to be a dialogue in districts about what are the specific issues facing that district and what's the best approach. All of the districts have room in their day and have physical space available to do the things we're talking about, and if they say they don't they're not trying hard enough.

**LEG. MARTINEZ:**

Thank you.

**MR. FLEISCHER:**

I would also just add that you would hope that school district personnel will become more aware of the needs of kids in recovery, in general. So I think there's not a great understanding. There's -- oftentimes I get feedback, "*Well, he completed that program.*" And it's like, no, that's just the beginning. And so there needs to be a lot more awareness across the entire faculty in terms of understanding what somebody who is in recovery is up against and how difficult it can be.

**CHAIRMAN SPENCER:**

Legislator Calarco now has a question.

**LEG. CALARCO:**

Well, you know, you start thinking about it and in the conversation we're having about the school districts and who wants to, I guess in a sense, own up to their problems and not own up to them? Do we have the numbers, at least of those that we know of that are either in treatment and from what school districts they've come from, or are kids who are -- have overdosed and what school districts they're from so that we can actually start quantifying these? And while the school districts may not want to recognize they have a problem, we can publicize that there's a problem and say, hey, you know what? Here's the 62 school districts in Suffolk County and here's the number of kids coming from each school district that we know have a problem because they're in treatment, and we don't obviously say who the kids are but we have this many coming from a school district in treatment.

You know, sometimes until you raise it to a level that people have to accept that there is an issue, they will continue to not accept it. So some school districts have been much more willing to say, *"You know what? We know we have a problem, we're going to try to deal with it,"* but there's an awful lot out there that would just rather say, *"Well, it's just a minor issue. You know, I have a large student population and it's only just a couple of kids. It's not really a problem."*

**DR. REYNOLDS:**

The data is increasingly hard to come by, most of that has historically been collected by New York State OASIS. We're not seeing the level of data that we once were, and even then there was a real reluctance I think to divide it up by zip code because the thinking really is this goes across the board. And yes, it's to varying degrees, but it goes across the board.

Absent data, what's been successful for us is to actually mobilize parents whose kids have struggled or kids who -- parents of kids who have died, to bring them back to the school district and stand up at a school board meeting and say, *"Look. You know, my kid was in your school and I don't blame anyone for his death, but maybe you didn't do enough and maybe we could be preventing some of this."*

I think that most of the Superintendents and principals actually understand to a certain extent that there are issues within the districts. Those issues and our approach isn't always focused on Opiates, and sometimes it's easier for districts to talk about underage drinking, marijuana use and things that seem less stigmatizing, if you will, than heroin and Opiates. So absent the data, it's mobilizing parents to say, *"Look, there's something going on here."*

I think the upshot of all of this heroin crisis is that, you know, back in the day when I started doing this, most of the folks who used heroin were chronic users, tended to be from minority, poorer communities and, as such, it didn't get the attention that it is now. Now you have a whole group of middle class folks who had no exposure to heroin addiction in the past, are slow to recognize that heroin can impact their families, but are sometimes viewed as being more politically potent than other populations and, quite frankly, are frightened, angry, disappointed and are willing to speak out a little bit more. We're trying to harness some of that to right some of the wrongs, not only that are happening today but that have been going on for 30 years.

**LEG. CALARCO:**

Well, I think that gets to the point of why we need to quantify it a little bit more specific than just, you know, across the board, Suffolk County has X number of people who are dying from overdose or X number of people who need treatment. Because it's very easy to say, *"Well, it's not my neighborhood. It's not my community, it's not my neighborhood, it's the next one over that's causing all the problems."* And as you just said, the reality is is the problems having more and more impact. I'm in middle class communities, the very ones that are most likely to say, *"It's not happening in my neighborhood, it's really not my problem,"* and that highlights the need to really, you know, put your finger on it a little bit more specifically.

**MR. FLEISCHER:**

If I could also address that. One of the things that has been a bit gratifying is New York State OASIS offers school surveys of drug use where every kid in the district will take a survey. In the last go-around, which was about I guess almost three years ago, there were more districts than in the past that were willing to do the survey.

In the past there was always concern, *"It would reflect badly upon us, maybe affect property values,"* or whatever it might be, so there was more willingness. So one thing I tell parents when they inquire is, I said find out if your school agreed to do a student survey. And rather than focus only on the kids that are in treatment, focus on prevalence within your district and what strategies you're doing.

I would also mention the Prevention Resource Center that we contract with is working with coalitions throughout the County, and there are more active coalitions of parents and interested stakeholders than ever before. And that's really where a lot of these things change, because they can exert the pressure on their local school districts and communities to really say, *"What are you doing? How are you addressing this? How do we know? Why are we treating this as if it's not our problem?"* I think there's some success with that, we have more work to do, but there is a little more awareness that this problem, there's no community immune to it and that's a positive.

**DR. REYNOLDS:**

Doc, you asked a question of Michael, you didn't ask it of us, but I'd be a fool to let the opportunity slip by. You asked him about marijuana use. And as we talk about Opiates, this is a big issue that's beginning to face our population. In the context of Opiates, things like alcohol and marijuana use among young people somehow seem much less serious, both to young people and to parents. The current debates around legalization have made it much harder for us to deal with young people who are smoking marijuana. There's a direct relationship between use and your perceived risk of using a drug. We've watched the perceived risk drop and the use increase precisely at a time when the use of tobacco is beginning to drop, when we're seeing driving while impaired fatalities beginning to drop, we're beginning to give back some of those gains. Some of the states that have moved towards legalization and/or very liberal medical marijuana distribution polices have seen dramatic increases in car fatalities and treatment admissions and some of the negative indicators.

So I was glad you asked the question. As we gear up kind of in the addictions world, there's a part of us that looks at this and says, *"Okay, our waiting room is already filled to capacity around Opiates. What happens as we continue to have this marijuana discussion?"* And you have more and more young people who develop issues around marijuana, or who go on to use other things. And it doesn't mean that every kid who smokes a joint today is going to put a needle in their arm tomorrow, but in a lot of regards, specifically in one in six, you will see that progression. And marijuana use in and of itself obviously has a significant impact on the developing brain and that kid's behavior pattern. So I was glad that you asked the question, it is germane to this conversation as well and it's kind of the next big thing that's looming on the horizon for us.

**MR. FLEISCHER:**

And I think that is a good point, the idea that every generation has what we call generational amnesia. So a lot of people are aware of the dangers of Opiates that were -- that are in our age group; new generations weren't aware of it. Likewise, cocaine is now a distant memory to a lot of people as being a major concern. Crack, who even remembers, right? But it comes -- it waxes and wanes, and we're always looking towards, *"Well, where does this go?"* Because it's all part of the same discussion which is the whole issue of how we educate people and how we get them to see the risk, because the perception of risk, as Jeff said, with marijuana right now is a huge issue, because it really is basically saying, *"Guess what! The truth is being told, there's no danger here,"* and that's certainly not accurate.

**CHAIRMAN SPENCER:**

Gentlemen, thank you. A Very, very, very important topic, very insightful discussion. I couldn't think of a better two people in this County, we're fortunate that you are here. Thank you very much, and this discussion will continue. And I think that's important, that we keep talking and, more importantly, that we keep looking for solutions. So, thank you.

With that, I have no other business before this committee. Again, Legislator Trotta and Martinez, the other committees were like 10, 15 minutes, welcome to Health. It doesn't get any shorter than that.

*(\*Laughter\*)*

**LEG. BROWNING:**

This is short.

**CHAIRMAN SPENCER:**

*(Laughter)* This is short. With that, we stand adjourned. Thank you.

*(\*The meeting was adjourned at 3:19 P.M. \*)*

alison