New York State Senate
Joint Senate Task Force on Opioids, Addiction, and Overdose Prevention Public Hearing
August 9th, 2019
Written Testimony of The Bronx Defenders
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The Bronx Defenders ("BxD") has provided innovative, holistic, and client-centered criminal defense, family defense, immigration representation, civil legal services, social work support, and other advocacy to indigent people in the Bronx for more than 20 years. Our staff of close to 400 represents nearly 28,000 people every year and reaches thousands more through community outreach. The primary goal of our model is to address the underlying issues that drive people into the various legal systems and to mitigate the devastating impact of that involvement, such as deportation, eviction, the loss of employment and public benefits, or family separation and dissolution. Our team-based structure is designed to provide people seamless access to multiple advocates and services to meet their legal and related needs.

I. Introduction

My name is Dinah Ortiz-Adames and I am the Parent Advocate Supervisor for the Family Defense Practice at the Bronx Defenders. Thank you to Senators Rivera, Harckham, and Carlucci as well as the rest of the Task Force for inviting me to testify on this important issue. In our work at The Bronx Defenders, we see the criminalization and stigmatization of opioid use every day. Whether it is a call to the state central registry for child abuse and maltreatment by hospital staff when a baby tests positive at birth for opioids related to a mother's Medication-Assisted Treatment (MAT), or an arrest by an undercover narcotics officer for a five dollar drug sale, the consequences for our clients as a result of their struggles with addiction are vast and severe. The systems that we work within everyday respond to addiction in a punitive manner that is in many ways in conflict with predictive factors for successful engagement in treatment and subsequent recovery.[1] Forcing people through threat of punishment — incarceration, removal of their

[1] DSD Program (2018). Drug courts in the Americas. New York: Social Science Research Council.

children — is not working. We see in our work everyday that people are more engaged in treatment when their participation is voluntary.

The opioid crisis has generated a recognition among some policymakers that the War on Drugs has failed and that drug dependency must be treated as a public health problem outside of the criminal and family legal systems. In order to make this new vision a reality, we must move away from a system that uses the threat of state force as its primary tool. We need to invest in pre-arrest diversion programs that allow people to seek the help they need without the threat of jail hanging over them. We need to look critically at mandated reporting in the child protection system and provide resources for treatment to parents without the looming threat of losing their children. The Bronx Defenders supports a complete transformation of the way the criminal legal and child protection systems respond to substance use. But because we also understand that this type of transformation will not happen overnight, we urge policymakers to take an important first step by expanding treatment options and reducing barriers to access.

II. Effective treatment for opioid use is not one size fits all

Whether our clients access treatment voluntarily or through a court mandate, the options currently available to them are inadequate. The primary obstacles we see are:

- A lack of insurance or financial resources to access treatment;
- Inflexible treatment schedules and a lack of childcare;
- Over-reliance on restrictive abstinence-based treatment models; and
- Lack of access to Medication-Assisted Treatment (MAT).

Making treatment more accessible is one concrete step towards shifting the narrative of addiction. With better, more inclusive services in place, fewer people will become system-involved and those that do will be much more likely to succeed and avoid harsh collateral consequences.

A. High quality treatment is inaccessible to those without insurance

The quality of treatment currently available to opioid users is largely determined by a person's financial resources. Those with private health insurance have a much larger array of options and the quality of the care is dramatically better. For those with more limited resources but who receive Medicaid, the quality of care tends to be poorer. For those who are ineligible to receive public health insurance, however, the options narrow to a handful of programs in New York City. For example, for our clients in need of long-term residential treatment who do not have health insurance, it is nearly impossible to find a program that will accept them. As a result, we see our undocumented clients linger in jail longer, waiting for a program that will take them without insurance. We have seen clients relapse after being released from jail to treatment because their insurance was not yet active when they tried to access services. Discharge planning services as they currently exist are intended to plan for re-entry before a client is released, but that is not what is happening. We still see clients being released without active insurance or even the identification needed to access treatment. The additional step of having to go the Medicaid office is often all it takes to deter someone who otherwise would have managed to make that difficult transition successfully. Our clients' children stay in foster care because they cannot afford to pay out of pocket to access the treatment that they need to convince a judge they can parent -successfully — effectively punishing parents and their children for lacking the financial resources to access treatment.

Fully funded, high quality treatment programs regardless of insurance eligibility are a necessity in targeting this issue. Our current system punishes the poor and their children by restricting access to treatment. Making free, high quality treatment programs available will dramatically increase access to treatment.

B. Treatment hours are inflexible and treatment providers rarely offer childcare

Our clients receive constant messaging from treatment providers that they must prioritize their attendance in treatment over their livelihoods. This often means that our clients lose their jobs in order to comply with their required programming. We have seen clients be forced to choose

treatment compliance over their employment out of fear of removal of their children. Inflexible treatment schedules make it impossible to maintain employment while engaging in treatment. While many outpatient treatment programs offer evening groups, working parents are faced with the choice between engaging in treatment and parenting their children. The programs that offer childcare are so rare that it is extremely unlikely that a working parent will be able to successfully juggle employment, treatment, and caring for their child. The rigid nature of the available programming does not address the needs of our clients and sets them up for failure. We see our clients being forced to make impossible decisions, any of which could lead to them failing in the eyes of the court system.

C. Abstinence-based Treatment Models do not work for everyone

Recovery looks different for everyone. Traditionally, recovery means sobriety. The treatment programs that are recognized and utilized by criminal courts, family courts, and immigration courts are exclusively abstinence-based, requiring complete sobriety. Beyond that, abstinence-based treatment options are largely what are available to our clients in the community. This means that measures of success are determined by abstinence from any and all substances. These measures are based on the 12-step model of recovery, which looks at drug use in a binary: either you are completely sober or you are using. Any drug use at all is considered failure. We see this in our advocacy every day in a variety of different settings. In criminal court, when clients are participating in outpatient treatment and drug tested on a weekly basis, we frequently see reports marked as "non-compliant" because someone tested positive for cannabis, despite negative tests for heroin, their identified drug of choice. In an all or nothing treatment model, this is failure. Even if this person had been using heroin daily for 10 plus years, and has found that smoking cannabis once a week keeps them from returning to heroin use, substance use is failure. This limited view does not acknowledge that this person has taken important steps to lessen the harms associated with opioid use, therefore avoiding the risk of overdose and death.

D. Medication-Assisted Treatment (MAT) is still heavily stigmatized by the treatment community

Medication-Assisted Treatment (MAT) has been identified as the gold standard of treatment for opioid use disorder. The passage of bills S5935/A7246A and S4808/A2904 during this year's legislative session was monumental in ensuring access to MAT treatment, but the problem of recognizing MAT as a necessary and often long-term part of the recovery process unfortunately still remains. MAT — like methadone and buprenorphine — reduce the urge to use opioids. However, our clients who receive methadone or buprenorphine often find themselves falling on the wrong side of the drug use binary. Traditional treatment models and court mandated treatment often discourage MAT and see the long term use of MAT as failure. Because it is viewed as a temporary aid on the path to complete sobriety, we see clients being tapered off of their methadone in treatment programs so quickly that they relapse. In the court context, clients who use MAT are viewed as still dependent on a substance and often cannot successfully complete court-mandated treatment until they are no longer using medication assisted treatment. Judges acknowledge that they have taken a step, but the overwhelming message is that they are not fit to parent their children or walk freely from a criminal conviction until they have weaned themselves off of it. Long term use of MAT which suppresses the urge to use opioids can protect our clients from overdosing, and dying. We see once again that treatment as it currently exists ultimately expects everyone to achieve 100 percent sobriety, lacking the understanding that success looks different for all people who use drugs.

III. Expanding access to and recognition of harm reduction practices in New York will reduce barriers and save lives

"Harm reduction" has become a buzz word in the last decade or so and can mean many things, but in this context it means acknowledging that recovery looks different for everyone and it does not always mean that someone stops using opioids, completely and forever. For many opioid users, the impossibility of complete and total sobriety, in a world where that is often perceived as the only option, prevents them from seeking help at all. Harm reduction, at its core, meets people where they are. It provides people with a variety of options and those options can change depending on where someone is with their use today, tomorrow, or next month. Harm reduction

practices redefine success in a way that greatly increases the likelihood that someone will take steps towards reducing the harm associated with their opioid (or any substance) use.

A. Harm reduction principles have proven to increase engagement with services

People who use drugs are a marginalized group. One less tangible, but no less valid, barrier to engagement with treatment is the stigma that surrounds substance use, the shame that users are made to feel as an inherent part of the abstinence-based treatment models. The 12-step model at its core is about taking accountability which also includes a great deal of self-blame. The harm reduction model, however, centers the needs of its participants. Instead of trying to force someone into the pre-molded shape of a pathway to sobriety, harm reduction shapes the pathway around the needs and goals of the individual. Harm Reduction practitioners redefine success for each person based on where they are when they take the first step towards change, and acknowledging each step along the way. From this perspective, "[e]ngagement is an outcome in and of itself".[2]

B. Increased funding for harm reduction programs including fentanyl testing, Naloxone training, and needle exchanges

In New York City, programs like The Washington Heights Corner Project and St. Ann's Corner for Harm Reduction offer lifesaving services like testing heroin for the presence of fentanyl, and supplying clean needles to opioid users. Their staff goes into communities and provides free overdose prevention trainings and naloxone kits— they teach people how to administer naloxone, a life-saving intervention reverses overdose. An invaluable resource, these programs could reach many more people if they had more funding. Additionally, stakeholders in criminal, family, and immigration courts do not currently recognize programs like these as an acceptable form of treatment. These stakeholders are familiar with the program models that they know, the big names that can afford to send representatives to court to speak directly with Judges. The groups that are out in the community providing access to these crucial resources are the ones truly meeting people where they are, and as a result they do not cater to the demands of the legal

[2] Lee, H. & Zerai, A. "Everyone Deserves Services No Matter What": Defining success in harm-reduction-based substance user treatment. *Substance Use & Misuse, 45,* 2411–2427

system. Expanding access to and funding for these programs is one significant step towards shifting the narrative of this issue from punishment to public health. With more access, we will see more recognition of how immensely these resources benefit communities like the South Bronx.

C. Development of Supervised Consumption Sites in the Bronx

Supervised Consumption Sites (SCS) are legally sanctioned facilities that allow people to consume pre-obtained drugs under the supervision of trained staff and are designed to save lives, reduce the risk of overdose and provide safe places to use and discard drug-related litter. They provide a space for people to use drugs safely and with access to medical advice and referrals to drug treatment. These sites are a first step for many people who cannot yet take the leap to stop using. SCS's have been proven to reduce overdose deaths, reduce transmission of disease, and increase the numbers of individuals with substance use disorders initiating treatment.[3] Currently, these sites are operational in twelve countries around the world, but the United States is not one of them.[4] The Bronx has the highest overdose rate in New York City. Last year the Mayor's office called for a one year pilot program of supervised consumption sites in the Bronx, Brooklyn, and Manhattan. The establishment of these sites could be crucial to saving lives, especially in the Bronx, but we have not seen any movement towards making this happen, in part because of opposition of key stakeholders.

D. Education of judges and other stakeholders is crucial in expanding access to services

Change is gradual, and with the large majority of available substance use treatment being abstinence-based, it is not surprising that judges and other key stakeholders in the systems in which we work are not familiar with the full array of options that our clients should be offered

[3] Task Force on Opioid Therapy and Physician Communication (2017). Establishment of a Pilot Supervised Injection Facility in Massachusetts. *Massachusetts Medical Society.*
[4] Supervised Consumption Services. (2019). *The Drug Policy Alliance*. Retrieved from http://www.drugpolicy.org/issues/supervised-consumption-services

when entering into treatment, either voluntarily or as part of a court mandate. Expanding the definition of successful engagement with treatment goes beyond the funding of alternative models of treatment. It requires widespread education, campaigns, and, most importantly, the amplification of the most impacted voices. People who use drugs know what is needed in order to truly combat this epidemic. Those are the voices that need to be heard. It is apparent in our work every day that stakeholders do not have the information they need to be making critical decisions about the future of our clients' lives. One example of this is with regard to supervised consumption sites. Despite the demonstrated need for alternative interventions with regard to opioid use in the Bronx, the Bronx District Attorney, Darcel Clark, has come out publicly against them. Yet, at the same time, we see the creation of new treatment court initiatives continuing to tell people who use drugs what they need and what services will help them. It is time that we hear from those who are impacted the most, and that our partners in combating this crisis take the time to listen.

IV. Conclusion

We need a complete transformation of the way we look at and respond to opioid use. Our systems as they currently exist are punitive in nature, and, as a result, they are set up to force opioid users into one mold, one model of treatment that is expected to work for everyone. Traditional treatment models are not effectively combating overdose and other collateral consequences of problematic drug use, and it is time that we take a step back and think critically about how to best serve opioid users in a way that allows for individualized needs and circumstances. People are not one size fits all, and the services offered to them should not be either. Thank you all for your time in convening this hearing, and for taking steps moving forward to address this extremely important issue.