Public Hearing for the Joint Senate Task Force on Opioids, Addiction & Overdose Prevention

The task of gaining control on the epidemic of drug use and overdoses requires multi-faceted approaches that addresses current issues and red-tape, long-term plans for the developing drug culture, and past flops and misinformation, such as the War on Drugs and Nancy Reagan's "Just Say No" campaign, respectively. This testimony's sole purpose however is to give you a look into my perspective as a gay male recovering from Crystal Methamphetamine addiction, in an environment mostly tailored for heterosexuals who use Opioids and Alcohol. I am educated, holding a Bachelor's of Science in Biomedical Engineering, and am currently undergoing treatment in a Community Residence for Substance Use Disorder (SUD). The following are my opinions and experiences in recovery, and should not be taken as from an expert or professional. Suggestions for addressing these issues follow my personal recovery below. Those highlighted in yellow pertain, or are related, to Opioids and overdoses. As this essay is to provide a perspective not typically seen on Long Island, I have mostly omitted those pertaining to opiates, which preceded my Crystal Meth addiction.

Like many individuals with SUD, I found my way into daily use through prescribed pain killers. I used them daily for five years until I was introduced to Crystal Meth through a friend. I didn't know it was Meth when I first used it, only knowing its effects and its street name, Tina. It also goes by Crystal, T, and Tea in the gay community, ice and glass in the straight community, and Speed and Crank being outdated terms. In certain parts of the country it is called Dope, rather than Heroin, which usually takes that title. About a month in I learned what I was actually using.

I quickly proceeded from smoking, to intravenous use. In a few months time, I had proceeded to daily use and in half a year since first use, started seeking treatment. I had a mental breakdown, was taken to a nearby hospital, and given Valium and Haldol, which forced me to sleep. Upon awakening I found out I was diagnosed Bipolar (while unconscious), and brought to a psych ward. I was prescribed Zyprexa, for mood stabilization. While consulting the Psychiatrist at my outpatient, I expressed the severe side effects of the Zyprexa, and my cravings to use. He suggested upping the dose, and prescribing Suboxone for cravings, despite my plea that I had been clean off Opiates for almost a year.

When consulting a rehabilitation program after a relapse, I was told they could not take me until I went to a detoxification center. Upon going to a detox, I was told I could not be taken because there is no detox for Methamphetamine. These roadblocks hindered me and

encouraged use because I did not know what to do. I was looking for help but could not receive it even when I looked.

At several rehabs and crisis centers, I was continually the only openly gay man, and usually the only Crystal Meth addict. My treatment plan was always exactly the same as all the other addicts. I typically was given the same sleep schedule as opioid and alcohol users. My complaints that acute and post-acute withdrawal for me required extra sleep fell on deaf ears. I would not get enough sleep, be dazed and drowsy all day, and would rapidly fall back into REM (dream) sleep at night. The quick descent from being awake to a dream state would scare my mind, causing what might have been pleasant dreams to be nightmares. I would have dreams about normal things, like going on walks, but my brain would perceive it as frightening. I would be woken up, unrested, and continue the cycle. At one facility I was convinced to be put on a medication that helped with night terrors. I begrudgingly agreed to it, thinking they might know better for me. I had nightmares every night for almost 45 days straight, until I stopped the med.

On many occasions, the admissions specialist thought I was addicted to Methadone when I said my drug of choice was Meth. The jail-house and macho-male mentalities are typically dominant in these facilities, leading to prolific use of gay slurs and homophobia.

Through several attempts I eventually got a 12-step Sponsor and started working with him. After some relapses, I found I was not able to communicate, nor work with my sponsor. Facilities tend to limit outside communication and won't allow visitors in. So I was staying in long-term facilities, but wasn't allowed to work a program of recovery. I would have every intention of staying sober, but found I had no control upon transition from institutionalization to freedom. With these relapses, I found myself more desperate, and less mentally cognitive. Befogged by cognitive function, it became near impossible for me to research facilities and programs on my own. Something as simple as getting an oil change for my car gave me great anxiety. Getting sober seemed impossible upon my own faculties.

I continued to attend 12-step programs, build a support system of sober friends, and work with my sponsor. Things have gotten better and I've gotten into a Community residence which offers strict structure, vocational training, and my sponsor to come in for step work.

I was lucky enough over the span of all my facilities to have met openly gay counselors, counselors in recovery, and Crystal Meth addicts in long term recovery. Several free programs, such as CASJ, Project Safety Net, Legal Aid and welfare programs helped me receive Narcan training, sort health issues, get testing, and prepare me for the future. Having a case worker at my last facility helped me get my DSS case in order so that I could move on to the next phase of treatment. I felt trapped within my own head and within the system. Only by having these people and welfare programs did I build confidence that the system was there to help me.

1. Part of a plan to deter use of Crystal Methamphetamine could be public education on popular gay dating/hook-up apps, such as Grindr, Scruff, and Bumble. I wasn't fearful of something called Tina. Knowing it is Crystal Meth could have deterred me from its initial use. Some organizations, such as Project Safety Net, already use profiles to provide STD/STI testing and PrEP education and counseling.
    - This may help deter some users who don't previously have substance abuse issues or behaviors. People who suffer with SUD typically will not be deterred in the long run by this.
2. Education of Physicians and Clinicians on typical stages of Acute Withdrawal and Post-Acute Withdrawal may provide easier transition into recovery for all addicts. Many addicts may exhibit symptoms similar to other mental health disorders in early recovery as their brains heal and hormones level out. These diagnoses can make it harder in later recovery to obtain proper housing and treatment, as they may be forced into the MICA (Mentally Ill Chemical Abuser) category, greatly reducing these options. Overturning these diagnoses can take extended periods of time.
3. Suboxone education for Physicians by a non-pharmaceutical representative would greatly help. It is essentially the new-age Methadone, a program that has failed to yield recovery results. Doctors seem to prescribe in random fashion, and on maintenance, rather than a taper to zero milligrams. Suboxone (specifically Buprenorphine) and Methadone are opioid medications. The person is only switching chemicals to a Doctor regulated opiate. The underlying problem that provokes use is not dealt with, leading to permanent maintenance on these drugs. People on permanent maintenance are always a risk to relapse and overdose. Dealing with the underlying issue helps remove users from all chemicals.
4. Being denied by a facility can be extremely degrading, lowering enthusiasm to try to become sober. It can also prolong or increase use. Receiving treatment needs to be facilitated. If a specific treatment center cannot provide for an addict, they should be educated in directing them where to go. If this is also unavailable, they should be able to provide the addict with harm-reduction services until treatment can be found.
5. The ratio of Men-to-Women in treatment tends to be greatly skewed towards males. These men tend to have greater issues expressing emotional damage. From my experience, there are many men in recovery who are not openly gay, performed homosexual acts for drugs or money, or have traumatic homosexual

experiences, such as molestation, sexual abuse, and sexual assault. Treatment geared toward expressing emotions, losing jail-house mentality/emotional flat-lining, and trauma therapy may prove of great value.

6. Training for counselors on all drugs is imperative for future harm reduction. Understanding that every drug has different side-effects and withdrawals is paramount to personal recovery. Treating every person in a facility as "addict," provides equality. However, treatment plans for "opioid addict," "alcoholic," "meth addict," "benzo addict," etc. will bring greater recovery to the individual.
7. Welfare and free programs, such as those listed above, should be pushed at all treatment facilities. All programs I encountered were at one well-established facility. On the outside, an addict may be overcome by strong feelings like Hunger, Anger, Loneliness, and Tiredness. Programs like Project Safety Net, which provide services and help for individuals after leaving treatment, greatly benefit the addict.