NEW YORK STATE BAR ASSOCIATION

Report and Recommendations of the New York State Bar Association **Task Force on Opioid Addiction**

October 2025

Approved by the House of Delegates October 25, 2025.

Report and Recommendations of the New York State Bar Association Task Force on Opioid Addiction:
"Being Forgotten" – A Persistent Public Health Crisis

August 2025

Table of Contents

I. Introduction and Executive Summary

In Fall 2024, President Domenick Napoletano established the New York State Bar Association (NYSBA) Task Force on Opioid Addiction and charged the Task Force with investigating all aspects of the substance use and opioid addiction problem in New York. The Task Force presented an initial Report on its proceedings and work in progress to the NYSBA Executive Committee and House of Delegates at the Annual Meeting in January 2025.

The Task Force's charge and focus encompass the larger public health policy contexts of the problem at the intersection of opioid addiction and substance use and mental health disorders, including its social and economic determinants. The Task Force has undertaken a comprehensive examination of the issues in their full complexity and consulted widely with those with knowledge and expertise that bear on the depth and breadth of the problem in order to describe and frame the problem clearly and comprehensively.

There is a strong consensus among Task Force members that the opioid addiction problem is a full-blown public health crisis, affecting diverse communities and populations. As we in the New York State Bar Association learned through our study and examination of the COVID-19 pandemic,[1] health crises such as the opioid addiction problem affect not only individuals and families, but the broader public as well. Social determinants of health such as income, education, housing, racism, and inequities in access to healthcare, including mental health and social services, are an important part of the picture. We pay particular attention to at-risk populations and communities who have *been forgotten* in the crafting and implementation of policy, including older people; people residing in institutional settings, including those who are incarcerated; mothers; pregnant women, and birthing people; and persons who lack tolerance to opioids/adulterated opioids. We identify their vast unmet needs and lived experience of *being forgotten*[2] as its own persistent public health crisis, creating a moral imperative to provide access to care as discussed more fully below.

Throughout the process of inquiry and in the drafting of this final report, the Task Force has reached a clear consensus that herculean work is still desperately needed to reduce the high number of overdose deaths in New York. To respond meaningfully to the magnitude and urgency of the substance use and opioid addiction problem, the Task Force calls for the

[1] NYSBA Health Law Section, *COVID-19 Report*, Nov. 2020, https://nysba.org/app/uploads/2021/01/health-Law-Resolutions-and-report-with-cover-approved-November-2020.pdf.

[2] To advance the goals of the Task Force and specifically to inform the shaping of policy for the purposes of this Report, Dr. Morrissey conducted an oral history interview with Task Force Member Ann Marie Foster, President and CEO of Phoenix House and a well-known and respected leader in the field.[2] Ms. Foster provided the Task Force with key insights as to the multiple approaches Phoenix House is employing in working with all those affected by the crisis, including families and communities. In her interview, Ms. Foster drew upon her years of experience working across communities and populations affected by the opioid addiction public health crisis to describe the depth and breadth of the problem from a lived experience lens of "*being forgotten.*"

development of a comprehensive and integrated plan that is strategically located at the intersection of substance use, mental health disorders, and opioid addiction.

The Task Force recommends that such a plan must address the following overarching policy issues:

- **Treatment Capacity, Programs and Services**:
    - Expanding treatment capacity and increasing funding for residential and inpatient treatment programs as an important part of both short- and long-term strategies to reduce the thousands of deaths from substances still occurring in New York annually;
    - Expanding and increasing funding for prevention services; and
    - Expanding and increasing funding for integrated recovery supports and services as an essential part of a system that aims both to reduce morbidity and mortality and ensure equitable access to needed health, mental health, and social services across all settings;
- **Pricing**: Securing a lower price for the purchase of naloxone;
- **Workforce**: Expanding the addiction workforce and increasing workforce funding, including education and training across both professional and non-professional workforces;
- **Fund Distribution**: Improving the coordination and the distribution of funds in a way to reduce deaths from substances, including the efficiency and effectiveness of opioid settlement fund distribution; and
- **Research**: Expanding research training capabilities and increasing funding to enable research, including qualitative methods such as oral history, and mixed methods studies, in order to understand better the problem of opioid addiction; the leading causes of deaths from substance use, including alcohol; the social determinants of substance use and addiction; and importantly, to deepen understanding of the lived experience of all those persons and communities suffering with substance use and addiction and in need of integrated health, mental health, and social services. The experience of service providers is also viewed as an important part of a well-developed and funded research agenda.

II. Problem Framing: *Being Forgotten* – A Persistent Public Health Crisis

In the late 1990s, the federal government approved the use of highly addictive opioids such as OxyContin to manage chronic pain. That action, combined with aggressive marketing by opioid manufacturers, led to the beginnings of the opioid epidemic. Many individuals who suffered acute injuries were prescribed opioids to manage the pain associated with their injuries and often

became addicted to these drugs. Many also died from overdose. Further, individuals with chronic pain were also offered opioids to manage their pain.

Government actions intended to address the increase in drug overdoses, such as limiting the length of opioid prescriptions for acute injuries, contributed to a shift away from prescribed opioids to heroin which must be grown and cultivated. Around 2014, we saw another shift away from heroin to synthetic opioids, such as fentanyl, that are cheaper to manufacture and can be produced in a garage.

The result of this multi-decade epidemic is that more than 760,000 individuals have died from drug overdose. At its peak, the CDC estimates that in 2022 more than 100,000 individuals died from drug overdose.[3] These numbers have started to decline and in 2024 it is estimated that approximately 80,000 individuals succumbed to drug overdose. However, the loss of 80,000 individuals is hardly a successful outcome and more focused work is necessary.[4] Further, overdose deaths are increasing in communities of color.[5]

Opioids include prescription opioids (natural and semi-synthetic opioids and methadone), heroin, and synthetic opioids other than methadone (primarily illicitly manufactured fentanyl). Opioid-involved overdose deaths rose from 49,860 in 2019 to 81,806 in 2022.[6]

In New York, the government is spending billions annually to address substance use, yet it seems there is no overarching, integrated plan to address treatment capacity and to coordinate the distribution of funds to reduce deaths from substances.

More specifically, Task Force Members have voiced serious concerns regarding overall treatment capacity for individuals with substance use issues, in particular whether New York State has sufficient treatment capacity in programs designed to address the complex issues of substance users. To assess treatment capacity, a Freedom of Information Law Request was submitted to the New York State Office of Addiction Services and Supports (OASAS) regarding the number of treatment opportunities available in 1990, 1999, and 2024, and the number of individuals who accessed treatment in statewide programs during that time frame. The years chosen for comparison loosely correspond to the initiation and expansion of court-sanctioned treatment in New York State, and compared the numbers of programs and individuals in treatment to 2024, when overdose deaths are much higher than in 1990 or 1999. Here are the results of our inquiry and comparison:

---

[3] See Nat'l Inst. on Drug Abuse, *Drug Overdose Deaths: Facts and Figures*, https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates#Fig2.
[4] Nat'l Ctr. for Health Statistics, *Provisional Drug Overdose Death Counts*, https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.
[5] Merianne R. Spencer, Matthew F. Garnett, Arialdi M. Miniño, *Drug overdose deaths in the United States, 2002–2022*, Nat'l Ctr. for Health Stastistics Data Brief no. 491 (2024), https://dx.doi.org/10.15620/cdc:135849.
[6] Ctrs. for Disease Control and Prevention, CDC WONDER, https://wonder.cdc.gov/.

The number of treatment programs that were operational for at least one day during the following calendar years for programs located statewide compared to those located in New York City:

	Statewide	NYC
1990	1,040	398
1999	1,522	554
2024	1,027	352

The number of unique individuals who accessed treatment in programs located statewide compared to those located in NYC for the following calendar years:

	Statewide	NYC
1990	42,443	24,700
1999	240,255	116,660
2024	190,139	71,374

We note that there has been an approximately 30% decrease in statewide treatment centers between 1999 and 2024, and an approximately 20% decrease in people seeking treatment statewide between 1999 and 2024. During this time period, overdose deaths increased by approximately 400%. It is clear that, at present, New York State lacks adequate appropriate treatment facilities for at risk substance users."

These results support the narrative we build in this Report concerning the many individuals struggling with substance use disorders, mental health disorders, and opioid addiction, who count among the forgotten. While more research needs to be done to understand the complexities underlying the data, such as the relationship between the closure of centers and the increase in deaths and why there was a decrease in people seeking treatment, we sharpen our focus in this Report on the experience of specific at-risk populations affected by the unrelenting nature of the present public health crisis.

III. At-Risk Populations: A Moral Imperative to Provide Equitable Access to Care

Persons Incarcerated in Correctional Facilities

Task Force members have shared serious concerns about the opioid addiction problem as it continues to affect the health and well-being of individuals who are incarcerated. While we do not undertake in this Report a full examination of risks of incarceration at the community and population levels or the more global problem of mass incarceration in the United States, we do bring a sharpened focus to the issue of access to treatment for those serving time in jails and prisons who are living and struggling with substance use and opioid addiction. In this context,

we call attention to the urgent and vast unmet needs of those individuals who may be living in correctional facilities while dealing with the challenges of substance use and addiction, including pregnant women and birthing people, those growing old, in some cases developing dementia,[7] and dying in correctional care. We frame this matter not only in terms of government policy and applicable statutes and regulations, but also as social, public health, and ethical obligations and responsibilities of a just society that constitute a moral imperative to provide access to care.

Older Persons in Community and Institutional Settings

The opioid crisis was declared a public health emergency on October 26, 2017.[8] A largely overlooked population in this public health emergency are adults aged fifty-five (55) and older. According to a study of Medicare beneficiaries conducted between 2006 and 2019, one in six older people living in the community are opioid users.[9] Opioid prescription use increased from 2006 to 2013 and then declined slightly before plateauing.[10] Although new prescription guidelines were introduced in 2016 (and updated in 2022), opioid use has greatly increased since the COVID-19 pandemic.[11]

Opioid use and overuse affect this population in a unique manner. As people age, their chances of finding themselves with a chronic pain condition increase.[12] There is a higher risk of drug interactions and complications from prescription drug use.[13] Natural decreases in blood flow and volume can result in poor opioid metabolism, thereby leading to a lack of desired effects and the concurrent prescribing of additional opioids.[14] In patients with multiple opioid prescriptions, overdose is very likely to occur with long-term use.[15] Additionally, adults over sixty (60) years of age have the highest instance of accidental and intentional opioid overdoses, including overdoses with suicidal intent.[16] When treating patients with dementia, or patients with otherwise impaired cognitive function, it is difficult to ascertain pain levels and determine proper dosing

---

[7] Tina Maschi, Jung Kwak, Eunjeong Ko, & Mary B. Morrissey, *Forget me not: Dementia in prisons*, 52(4) Gerontologist 441, 441–51 (2012), https://dx.doi.org/10.1093/geront/gnr131

[8] See https://www.hhs.gov/sites/default/files/opioid%20PHE%20Declaration-no-sig.pdf (last accessed December 25, 2024).

[9] Morgan I. Bromley et al., *Burden of Chronic and Heavy Opioid Use Among Elderly Community Dwellers in the U.S.*, 3(2) Journal of Preventative Medicine 100175 (April 2024), https://www.sciencedirect.com/science/article/pii/S2773065423001128 (last accessed December 25, 2024).

[10] *Id.*

[11] *Id.*; see also Deborah Dowell, Kathleen R. Ragan, Christopher M. Jones, Grant T. Baldwin, Roger Chou, *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022*, 71(3) Morbidity and Mortality Weekly Report 1, 1–95 (2022), http://dx.doi.org/10.15585/mmwr.rr7103a1 (last accessed December 25, 2024).

[12] *Id.*

[13] *Id.*

[14] *Id.*

[15] *Id.*

[16] Alexander Dufort & Zainab Samaan, *Problematic Opioid Use Among Older Adults: Epidemiology, Adverse Outcomes and Treatment Considerations*, 38(12) Drugs & Aging 1043, 1043–53 (2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC8421190/ (last accessed December 25, 2024).

for opioids.[17] Patients in the older population in general are subject to additional adverse effects and risk factors, such as constipation, sedation, cognitive impairment, alcohol use, depression, and falls.[18] In the case of weakened renal systems, there may be a slower breakdown of opioids, and the risk of constipation may increase because of decreased intestinal motility and gastric function.[19] Opioids can impact the respiratory system and burden older people with pre-existing respiratory conditions.[20] In this age range, psychiatric illness is a common comorbidity, and methadone patients often have additional comorbidities such as cardiac disease, HIV, hepatitis, and diabetes.[21]

Overall, this population is not well educated on the use of opioids.[22] There have been some steps taken to advance education. The CDC has a website dedicated to prescription awareness.[23] The U.S. Department of Health and Human Services issued advisories in 2017 regarding Medicare Part D and opioid prescribing, and the prescriptions of opioids to Medicaid beneficiaries.[24] In 2017, the Administration for Community Living had also called attention to this problem in the aging population.[25] However, it appears that minimal research and attention have been devoted to the older adult population in the post-COVID-19 era, and hence, greater investments in research, education, and oversight are called for.

Task Force Member Ann Marie Foster shares in her oral history interview that we need to do a much better job reaching and serving older people struggling with substance use and opioid addiction.[26]

Persons Who Lack Tolerance to Opioids/Adulterated Opioids

The nature of the illicit drug supply is constantly changing. Heroin has largely been replaced with illicitly manufactured fentanyl. Two emerging concerns are fentanyl being pressed into pills that look like approved medications such as Ritalin, Xanax, and OxyContin. These pills are

---

[17] Morgan I. Bromley et al., *Burden of Chronic and Heavy Opioid Use Among Elderly Community Dwellers in the U.S.*, 3(2) J. of Preventative Medicine 100175 (April 2024), https://www.sciencedirect.com/science/article/pii/S2773065423001128 (last accessed December 25, 2024).
[18] *Problematic Opioid Use Among Older Adults, supra* note 16.
[19] *Id.*
[20] *Id.*
[21] *Id.*
[22] *Id.*
[23] See CDC, *Rx Awareness*, https://www.cdc.gov/rx-awareness/ (last accessed December 25, 2024).
[24] Dep't of Health & Human Servs. Off. of Inspector General, *Opioids in Medicare Part D: Concerns about Extreme Use and Questionable Prescribing*, https://oig.hhs.gov/oei/reports/oei-02-17-00250.pdf; Dep't of Health & Human Servs., *State Medicaid Director Letter Re: Strategies to Address the Opioid Epidemic*, https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf (both last accessed on December 25, 2024).
[25] Admin. for Community Living, *Summary of ACL Stakeholder Discussion: Opioid Public Health Emergency*, Mar. 7, 2018, https://acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/OpioidStakeholderMeetingSummary-2018_0.pdf (last accessed on December 25, 2024).
[26] Ann-Marie Foster Oral History, 2025, Appendix E of this Report.

being sold on the black market to individuals who believe they are buying the above-referenced medications. Many of these individuals do not regularly use opioids, and have no tolerance to opioids or are opioid naive. These individuals are at an even higher risk of overdose. Ensuring that they have access to an overdose reversal agent is imperative.

Another emerging concern is that some of the illicit fentanyl is now being adulterated, or mixed, with animal tranquilizers, such as xylazine. It has been reported that this mixture lengthens the euphoria of the drug. However, this mixture also causes open wounds on the individual's body. These concerns led the White House Office of National Drug Control Policy (ONDCP) and the Drug Enforcement Administration to identify fentanyl adulterated by xylazine as a serious emerging national drug threat.[27]

IV. Addictions Professionals

The addiction care system is unable to recruit and retain workforce professionals and support staff and such impediments are impacting access to treatment. Many providers report upwards of 20% vacancy rates for staff in their program and many programs are serving at less than their licensed capacity.

The current Task Force has convened stakeholder experts to make recommendations to address the pressing workforce issues. Possible recommendations include using opioid litigation settlement funds and opioid stewardship funds to pay for new workforce initiatives. Such initiatives could include loan forgiveness, scholarships, tuition reimbursement, and exploring whether to allow addiction care providers to buy into the state retirement system and the NYS Employee Health Insurance Program. Review of OASAS staffing regulations is also called for in order to address the workforce crisis without compromising patient safety.

Research Evidence and Workforce Recruitment and Retention

Across the United States, there is a projected employment rate of "23% indicating 75,100 jobs will become available to work within this field from 2022 to 2032."[28] The behavioral health system has had its difficulties in recruiting and retaining their workforce.[29] Stigma historically is

---

[27] See U.S. House of Representatives Committee on Oversight & Accountability, *Hearing on the Role of Pharmacy Benefit Managers in Prescription Drug Markets*, July 27, 2023. https://www.congress.gov/118/meeting/house/116288/documents/HHRG-118-GO00-Transcript-20230727.pdf; Drug Enforcement Admin., *The Growing Threat of Xylazine and its Mixture with Illicit Drugs*, Oct. 2022, https://www.dea.gov/sites/default/files/2022-12/The%20Growing%20Threat%20of%20Xylazine%20and%20its%20Mixture%20with%20Illicit%20Drugs.pdf.

[28] Bureau of Labor Statistics, *Employment Projections,* 2020,, https://data.bls.gov/projections/nationalMatrix?queryParams=21-1018&ioType=o (retrieved January 30, 2022).

[29] Ellen Bouchery, & Judith Dey, *Substance use disorder workforce issue brief*, Assistant Secretary for Planning and Evaluation (ASPE), U.S. Dep't of Health & Human Servs., May 31, 2018, https://aspe.hhs.gov/reports/substance-use-disorder-workforce-issuebrief.

a concern for recruitment.[30] [31] [32] Burnout has historically been identified as a key issue in retention.[33] However, more recent research has identified additional key issues in recruitment and retention. These include worker dissatisfaction, supervision and training, and low wage compensation.[34]

Employee dissatisfaction is often related to lack of organizational resources, high caseloads, strained coworker relationships, poor documentation, inadequate supervision, burnout, and low wages.[35] [36] [37] A recent study showed addictions professionals who were satisfied with their work environment are less likely to leave their current positions.[38] And addictions professionals who have a higher sense of comradery with their coworkers are also less likely to leave their current positions.[39] Worker dissatisfaction should be further explored in independent studies to examine its impact on both variables such as retention and recruitment. A specific definition of worker dissatisfaction in the behavioral health field can help researchers identify unique issues relevant to their workforce.

Concerns related to supervision and training are a twofold issue. Frontline staff often have an overload of documentation requirements, high caseloads and an overall lack of supervision.[40] [41] [42] Midline and senior staff are often subject to administrative supervision but lack clinical supervision.[43] Newly learned training by behavioral health professionals may not be

---

[30] Lori J. Ducharme, Hannah K. Knudsen, & Paul M. Roman, *Emotional exhaustion and turnover intention in human service occupations: The protective role of coworker support*, 28(1) J. of Sociological Spectrum 81, 81–104 (2007), https://doi.org/10.1080/02732170701675268.
[31] Hannah K. Knudsen, J. Aaron Johnson, & Paul M. Roman, *Retaining counseling staff at substance abuse treatment centers: effects of management practices*, 24(2) J. of Substance Abuse Treatment 129, 129–35 (2003), https://doi.org/10.1016/s0740-5472(02)00357-4.
[32] Hannah K. Knudsen, Lori J. Ducharme, & Paul M. Roman, *Research participation and turnover intention: An exploratory analysis of substance abuse counselors*. 33(2) J. of Substance Abuse Treatment 211, 211–17 (2007), https://doi.org/10.1016/j.jsat.2006.12.013.
[33] *Supra* notes 30, 31, 32.
[34] Kristy Aristy, *Workforce Development Issues in the Field of Addictions: A study of factors that impact retention with addiction professionals in New York State*, Publication No. 30993128 (Feb. 29, 2024), (Doctoral dissertation, Yeshiva University), https://repository.yu.edu/items/d4cd7df7-52bb-41b5-9222-1c68a5147c49.
[35] *Id.*
[36] Carrie B. Oser, Elizabeth P. Biebel, Erin Pullen, & Kathi L. H. Harp, *Causes, consequences, and prevention of burnout among substance abuse treatment counselors: a rural versus urban comparison*, 45(1) J. of Psychoactive Drugs 17, 17–27 (2013), https://doi.org/10.1080/02791072.2013.763558.
[37] Jennifer Murphy, *Improving the Recruitment and Retention of Counselors in Rural Substance Use Disorder Treatment Programs*, 52(3) J. of Drug Issues 434, 434–56 (2022), https://doi.org/10.1177/00220426221080204.
[38] *Supra* note 34.
[39] *Id.*
[40] *Supra* note 31.
[41] Linda Wermeling, *Social work retention research: Three major concerns*, 3(1) J. of Sociology, Social Work, and Social Welfare 1, 1–8 (2009), https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=e2446b289f2ed291760cfb8009ffa75173ab2148.
[42] Thomas L. McNulty, Carrie B. Oser, Aaron J. Johnson, Hannah K. Knudsen, & Paul M. Roman, *Counselor turnover in substance abuse treatment centers: An organizational-level analysis*, 77(2) Sociological Inquiry 166, 166–93 (2007), https://doi.org/10.1111/j.1475-682X.2007.00186.x.
[43] *Supra* note 31.

implemented because of the lack of guidance through regular supervision. Behavioral health professionals who are provided with adequate supervision may have positive workplace relations, an increased sense of professional comradery & teamwork, and increased productivity and overall work satisfaction population.[44]

In behavioral health, addictions professionals earn low wages and may have little to no benefits.[45] In New York State, there is a wide range of salaries. These salaries depend on credentials/licensure and current education level (i.e., high school diploma, $20,000 to master's level, $50,000).[46] [47] Research shows that "44% of addictions treatment agencies do not provide an increase salary based on cost-of-living expenses annually"[48] [49]

Furthermore, "59% of organizations do not provide bonuses or additional incentives for addictions professionals."[50] There is limited data related to wages and compensation. Additionally, there is limited research on the differences in wages between various racial groups.

Research shows that there is an opportunity to develop work strategies that specifically target and reflect an understanding of the diverse nature of the behavioral health workforce.[51] Having a better understanding of the impacts of retention and recruitment is critical to the overall health of patients affected by substance use disorders. Based on current research, there are several suggested actions that may improve retention and recruitment rates for this segment of the workforce.[52] These include, but are not limited to, the following:

- **Promote studies examining issues related to worker dissatisfaction**.
  State studies should include definitions that are specific to their workforce characteristics and crisis. Additionally, conversations related to the overall wellness of behavioral health professionals within the workplace should be supported.[53] This can also include discussions surrounding a positive work environment, as a positive work environment increases optimism about work.[54] These discussions may increase productivity, promote positive work behaviors, and foster a consensual attitude in the workplace.

---

[44] *Supra* notes 31, 34, 41, 42.
[45] *Supra* note 34.
[46] *Id.*
[47] Luke Nasta, Patricia Strach, *What drives staffing levels for substance use disorder (SUD) services in New York State?*, SUNY Rockefeller Institute of Government, Nov. 2021, https://rockinst.org/wp-content/uploads/2021/11/NYS-SUD-Workforce-2021.pdf.
[48] Aristy, *supra* note 34, at 35.
[49] Office of Alcoholism and Substance Abuse Services, *2019 Local Plan Analysis – Summary Results: 2019 Treatment Provider and program staffing surveys*, 2019, https://omh.ny.gov/omhweb/planning/docs/2019lspguidelines.pdf.
[50] *Supra* notes 48, 49.
[51] *Supra* notes 34, 37.
[52] *Supra* notes 34, 37, 49.
[53] *Supra* note 34.
[54] *Id.*

- **Support constant and consistent supervision in the workplace**.
  Supervision should be consistent with both front line staff and managerial staff and should include a combination of clinical and administrative supervision.[55] When consistency increases, the process of professional learning increases. Supervision enables the workforce to improve their capabilities through emerging evidence-based practices[56]; and allows supervisors to practice their clinical skills in real time. Supervision should be used as a tool for follow-up skills when a behavioral health professional engages in training.

- **Address burnout in the workplace**.
  Burnout is linked to employee dissatisfaction and poor supervision and training.[57]Addressing burnout through various methods of supervision maximizes the overall well-being of behavioral health professionals. Exploring worker dissatisfaction and problem solving in this area may increase job satisfaction and reduce stress at work.[58]

- **Support competitive salaries and benefits for addictions professionals**.
  "Offering competitive salaries in the current industry standard is key in the workplace."[59] Behavioral health professionals value salaries that include medical benefits, paid time off, and retirement options as desirable benefits for the workforce.[60] Providing competitive compensation, consistent supervision, and addressing employee dissatisfaction can improve retention rates in the workplace,[61] and may also help to address the competitive recruitment needs of this specific workforce.

- **Retention and recruitment: Respective challenges**.
  There are unique dimensions to the respective challenges posed by retention and recruitment. Retention should focus on the immediate needs of the workplace population. Recruitment efforts should focus on the type of population needed for the use of evidence-based practices and continuing to encourage populations who have experienced recovery firsthand to work in the behavioral health field.

Diversion Programs, Treatment Courts, and Direct Service Provision Recommendations

- **Adequate funding and staff for specialty courts are needed**.
  Funding levels for specialty courts are currently insufficient. Many specialty court parts are already overwhelmed by the magnitude of need and are struggling to meet demand.

---

[55] *Id.*
[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] Aristy, *supra* note 34, at 81.
[60] *Id.*
[61] *Id.*

This means that for many projects the choice is either high caseloads or long waitlists, neither of which is conducive to supporting recovery.

Complicating this need, specialty courts are also struggling to attract and retain talent in diversion settings. As of July 1st, 2023, there were only 13,362 LMSWs (Licensed Masters Social Workers), 11,600 LCSWs (Licensed Clinical Social Workers), and 3,347 LMHCs (Licensed Mental Health Counselors) in New York City. Post-pandemic, many licensed professionals are choosing more flexible, often remote roles. Court diversion work is very demanding and for the most part requires staff to work in-person, so creative ways of supporting the demand and caring for our workforce must be considered.

- **Ensure that direct services staff have access to clinical support**.
  Work in the substance use field is emotionally challenging. Staff supporting diversion efforts are regularly exposed to human suffering and trauma, inadequate resources, high caseloads, and unrelenting demands. Without adequate support, these demands place workers at high risk for burnout, compassion fatigue and vicarious trauma. Clinically informed supervision/consultation is essential to ensuring that staff have enough support to do the work effectively, and sustainably. Funding recommendations should take into consideration the need for healthy work environments by establishing caseload targets, and creating a budget for the clinical supervision and training of diversion staff. Additionally, direct service professionals who experience harm have access to resources, and support systems, to process trauma encountered on the job.

- **Support training for judges on recovery, harm reduction, serious mental illness, and risk management**.
  The expansion of diversion opportunities should consider judicial training on the concepts of recovery, harm reduction, serious mental illness, and the management of risk. This is new territory for many judges and the more support and education that can be provided, the better.

- **The courts should take an official position on cannabis use to ensure uniformity**.
  Since the legalization of cannabis, some specialty courts have modified their response to cannabis use but there is no uniformity from site to site.

- **Ensure that behavioral health resources exist in communities**.
  For diversion efforts to be successful, there need to be adequate programming options in our communities. The expansion of diversion opportunities must also consider the treatment landscape of the communities in question, particularly in rural areas where transportation can be an obstacle.

  Expanding diversion opportunities will also require staff in diversion settings to support, and secure placements for, clients with increasingly complex needs. Although the

population on Rikers Island has decreased in recent years, the percentage of our Rikers population struggling with mental health conditions has increased. According to the National Center for Access to Justice:

> "Today, more than half of people in Rikers have been diagnosed with a mental illness, and one in five has been diagnosed with a serious mental illness. Rikers is the largest provider of psychiatric services in New York City and one of the largest providers in the world."[62]

Diversion efforts in NY are already hindered by the lack of appropriate treatment options. Although New York City is resource-rich compared to other jurisdictions, there is currently only one residential substance use provider for persons with serious mental illness, namely Harbor House. Many other providers do not currently have the staffing to support this population. The outpatient treatment landscape for this population in New York City is more robust, but there are often long waitlists to secure appointments or access resources. Outside of the five boroughs, resources are often considerably limited and complicated by inadequate public transportation.

- **Support collaboration across all systems and government agencies to ensure implementation of equitable diversion programs**.
  While policy goals aim to identify and implement equitable diversion pathways for all populations with functional impairments, achieving those goals requires effective collaboration across all systems, government offices, and agencies. Coordinated efforts are needed to craft coherent policy and ensure its successful implementation. The Department of Mental Hygiene, which is composed of the Office of Addiction Services and Supports (OASAS), the Office of Mental Health (OMH), and the Office for People with Developmental Disabilities, (OPWDD) needs to be meaningfully engaged to ensure that adequate services exist in all jurisdictions. These three entities currently operate in silos, which means that diversion staff need to learn how to navigate entirely separate systems and services. Where possible, consideration should be given to hiring behavioral health experts with knowledge and understanding of specific populations and the organizations responsible for coordinating services.

  The addiction care system is unable to recruit and retain workforce which is impacting access to treatment. Many providers report upwards of 20% vacancy rates for staff in their program and many programs are serving at less than their licensed capacity. The current Task Force is convening stakeholder experts to make recommendations to the state on programs to address the workforce issues. Possible recommendations include

[62] National Center for Access to Justice, *To Close Rikers Island by 2027, Charting a New Path on Mental Health May be the Key*, Sept. 26, 2023, https://ncaj.org/news/close-rikers-island-2027-charting-new-path-mental-health-may-be-key.

using opioid litigation settlement funds and opioid stewardship funds to pay for the new initiatives which could include loan forgiveness, scholarships, and tuition reimbursement, as well as exploring whether to allow addiction care providers to buy into the state retirement system and the NYS Employee Health Insurance Program. The group should also review OASAS staffing regulations for recommendations for possible changes to address the crisis without compromising patient safety.

- **EMT initiation of addiction medicine**.
  There is already pending legislation (A.9882-A/S.9926) that would allow Advanced Emergency Medical Technicians to administer the opioid use disorder medicine, buprenorphine, in the field under the supervision of a physician. The State of New Jersey also allows this.

- **Expand and fund interdisciplinary/interprofessional workforce education and training**.
  Task Force members have shared their own lived experience of distress and vicarious trauma in serving the communities affected by opioid addiction across diverse settings. This is a hidden issue that has not received adequate attention and calls for more thoughtful planning to ensure we are making mental health– and trauma-informed services available to the professional workforce in addiction. Funding to expand interprofessional workforce education and training is desperately needed across public and private settings.

- **Convene a group of stakeholders to review the Medicaid reimbursement model**.
  New York State should convene a group of stakeholder experts to review the current Medicaid reimbursement model for substance use services and develop a report with any recommendations for changes to the model.

- **Integrated mental health and addiction treatment**.
  Many individuals with a substance use disorder also need treatment for mental health issues.[63] New York State requires separate program licenses from OMH and OASAS to treat each condition in separate settings. While New York has made some progress in permitting co-occurring treatment, however, it is limited to outpatient programs. More work is needed to allow OMH and OASAS programs to treat co-occurring mental health issues and addiction in one program setting.

- **Telehealth**.
  The federal Drug Enforcement Administration (DEA) recently extended the rule until December 31, 2025, allowing for prescribers to initiate patients on buprenorphine

[63] National Institute on Drug Abuse, *Co-Occurring Disorders and Health Conditions*, https://nida.nih.gov/research-topics/co-occurring-disorders-health-conditions#mental.

through a telephonic appointment. This rule was put into place during COVID and it has helped expand access to this life-saving medication. The federal government should consider making this rule permanent or continuing it until the federal opioid public health emergency ends. (this study shows superior retention in treatment for patients initially evaluated via telemedicine – Joshua J. Lynch et al., *Comparison of 30-day Retention in Treatment Among Patients Referred to Opioid Use Disorder Treatment From Emergency Department and Telemedicine Settings* 165 J. of Substance Use & Addiction Treatment 209446 (2024), https://doi.org/10.1016/j.josat.2024.209446).

- **The use of telemedicine to prescribe controlled substances**.
  In March 2020, as a result of the COVID-19 pandemic, the federal Drug Enforcement Administration (DEA) and Health and Human Services (HHS) put in place a temporary rule that allowed DEA-registered prescribers to initiate and continue controlled substance prescriptions by audio-visual or audio-only forms of telemedicine. That rule has been extended several times and is currently in effect until December 31, 2025. Recently, the DEA proposed a new rulemaking that would allow prescribers to obtain a newly created Special Registration to continue to use telemedicine when prescribing controlled substances. These new proposals will significantly impact prescribers' management of chronic pain, end of life care, and the treatment of opioid use disorder. We believe that before the DEA adopts a new Special Registration requirement, a study should be conducted which examines the impacts of the current emergency telemedicine rule so that we can understand whether a Special Registration is required. Until the study is complete, we recommend that the emergency rule remain in effect.

- **Expand access to methadone**.
  Turning to federal law, the Modernizing Opioid Treatment Access Act (S.644/H.R.1359) would allow board-certified practitioners to prescribe methadone for opioid use disorder to their patients. Currently, they are only allowed to offer methadone through a licensed opioid treatment program. This proposed legislation would allow qualified practitioners to prescribe methadone either at an opioid treatment program or by a physician or psychiatrist with a specialty certification in addiction medicine.

V. Opioid Litigation Settlement Funds

New York State has reached settlements of over $2.6 billion in total with companies participating in the manufacturing, selling, distributing, dispensing and promoting of opioids.[64] The opioid settlements include payment schedules lasting for up to 18 years.[65]

In June 2021, New York enacted legislation establishing an opioid settlement fund to ensure that the settlements funds would be utilized for abatement.[66] The legislation also established an advisory board — the Opioid Settlement Fund Advisory Board (OSFAB) — to provide recommendations to the legislature regarding settlement fund allocations.[67]

This legislation (Chapter 190 of the Laws of 2021) stipulates that opioid settlement funds "shall be used to supplement and not supplant or replace any other funds, including federal or state funding, which would otherwise have been expended for substance use disorder prevention, treatment, recovery or harm reduction services or programs."[68] [69]

Language in updated Chapter 171 of the Laws of 2022 specifies:

> Eligible expenditures shall include services and programs that are consistent with the approved uses and terms of the statewide opioid settlement agreement . . . , which may only include:
>
> (i) to prevent substance use disorders through an evidence-based youth-focused public health education and prevention campaign, including school-based prevention and health care services and programs to reduce the risk of substance use by school-aged children;
>
> (ii) to develop and implement statewide public education campaigns to reduce stigma against individuals with a substance use disorder, provide information about the risks of substance use, best practices for addressing substance use disorders, and information on how to locate services that reduce the adverse health consequences associated with substance use disorders or provide treatment for substance use disorders;
>
> (iii) to provide substance use disorder treatment and early recovery programs for youth and adults, with an emphasis on programs that provide a continuum of care that includes screening and assessment for substance use disorders and co-occurring disorders, active treatment, family involvement, case management, relapse management for substance use and other co-occurring behavioral health disorders, vocational services, literacy services,

[64] Office of the N.Y. State Attorney General, *Opioid settlements*, https://ag.ny.gov/nys-opioid-settlement#:~:text=Allocation%20of%20funds&text=The%20funds%20are%20allocated%20to,settlements%20are%20used%20for%20abatement (last visited Dec. 31, 2024).
[65] Opioid Settlement Fund Advisory Board, *Annual Report*, Nov. 1, 2024, https://oasas.ny.gov/system/files/documents/2024/11/2024-osfab-report_0.pdf.
[66] Office of the New York State Attorney General, *supra* note 64.
[67] *Id*.
[68] N.Y. Senate Bill S7194, June 5, 2021, https://legislation.nysenate.gov/pdf/bills/2021/S7194.
[69] N.Y. State. Fin. Law § 99-nn(3).

parenting classes, family therapy and counseling services, crisis services, recovery services, evidence-based treatments, medication-assisted treatments, including medication assisted treatment provided in correctional facilities, psychiatric medication, psychotherapy and transitional services programs;

(iv) to provide harm reduction counseling and services to reduce the adverse health consequences associated with substance use disorders, including overdose prevention and prevention of communicable diseases related to substance use, provided by a substance use disorder service provider or qualified community-based organization;

(v) to provide housing services for people who are recovering from a substance use disorder. Such housing services shall be appropriate, based on the individual's current need and stage of recovery. Such housing services may include but are not limited to supportive housing services;

(vi) to support community-based programs that reduce the likelihood of criminal justice involvement for individuals who have or are at risk of having a substance use disorder;

(vii) to provide programs for pregnant women and new parents who currently or formerly have had a substance use disorder and newborns with neonatal abstinence syndrome; and/or

(viii) to provide vocational and educational training for individuals with or at risk for a substance use disorder.[70] [71]

The Office of Addiction Services and Supports (OASAS) is the lead agency responsible for monitoring and overseeing the Opioid Settlement Fund, including the distribution of Regional Abatements to localities for initiatives aiming to address addiction and opioid use disorder in communities. [72]Funds are made available every year to 55 local governmental units, five large cities, and 21 other litigating entities, calculated using population, overdose death rates, and mental health and equity indicators. Areas of priority include "investments across the service continuum, harm reduction, recovery, housing, treatment, priority populations, prevention, transportation, research, and public awareness."[73]Additional information on Opioid Settlement

[70] N.Y. Senate Bill S7870, Jan. 14, 2022, https://legislation.nysenate.gov/pdf/bills/2021/S7870.
[71] N.Y. Mental Hyg. Law § 25.18(a)(1)(i)-(viii).
[72] OASAS, *Opioid Settlement Funding Initiatives*, https://oasas.ny.gov/opioid-settlement-funding-initiatives (last visited Dec. 31, 2024).
[73] *Id*.

Fund Regional Abatements can also be found on the OASAS website,[74] including a link to a document of approved uses of funds.[75]

The OASAS website also includes information on projects offered through the Opioid Settlement Funding initiative, including open projects currently being offered and awarded projects, for which the deadlines to apply have passed.[76]Links to each project provide additional information on the scope of work as well as expense reports. In addition, the OASAS website also includes links to funding opportunities for not-for-profit organizations, local government units, and other businesses.[77]

New York's Opioid Settlement Fund Tracker provides information about the state's opioid settlement fund spending, including initiatives, the number of awards distributed to the initiatives, and award amounts.[78] [79] The Tracker allows sorting by date and initiative as well as by priority area for fiscal years 2023, 2024 and 2025. Over $366 million from the state's settlement fund share has already been made available.[80]

The OSFAB prepares annual reports with recommendations for settlement fund spending, which are then reviewed by the governor, president of the Senate, speaker of the Assembly, and chairs of several legislative committees.[81] The most recent OSFAB 2024 Annual Report includes the chart in Appendix B showing "receipts for all settlements, including the money that goes directly to the local government units, as well as funds deposited into the State's Opioid Settlement Fund (OSF). Additionally, the chart illustrates the regional shares, which are determined by the settlement agreements, and the remainder that is available for State investment."[82]

The November 1, 2024 OSFAB 2024 Annual Report also includes the chart in Appendix B showing "the amount of money made available by NYS OASAS reflective of the board's spending recommendations by priority area." [83]

Notably, the 2024 OSFAB Annual Report also includes a "letter of concern," in which OSFAB expresses "significant concerns with the State agencies' inability to provide comprehensive timely information for the board to make full data driven recommendations" for allocation of the

---

[74] OASAS, *Opioid Settlement Fund Regional Abatements*, https://oasas.ny.gov/opioid-settlement-fund-regional-abatements (last visited Dec. 31, 2024).
[75] OASAS, *Schedule C - Approved Uses*, https://oasas.ny.gov/system/files/documents/2023/02/approved-uses.pdf.
[76] OASAS, *supra* note 72.
[77] OASAS, *Procurement and Funding Opportunities*, https://oasas.ny.gov/procurement (last visited Dec. 31, 2024).
[78] Nat'l Academy for Health Science Policy, *State Opioid Settlement Spending Decisions: New York*, May 17, 2024, https://nashp.org/state-tracker/state-opioid-settlement-spending-decisions/new-york/.
[79] OASAS, *Opioid Settlement Fund Tracker*, https://oasas.ny.gov/fy-2023-opioid-settlement-fund-initiatives (updated Dec. 5, 2024).
[80] *Id*.
[81] Nati'l Academy for Health Science Policy, *supra* note 78.
[82] Opioid Settlement Fund Advisory Board, *supra* note 65.
[83] *Id.*

opioid settlement funds.[84] The letter enumerates several limitations, which are summarized below.

- **Lack of Access to Current Data and Outcome Analysis**
  Need for "tailored data from the state's health, mental health, and addiction services divisions," including "up-to-date, comprehensive data on the state of opioid addiction and treatment outcomes," which are "essential for assessing immediate needs, identifying effective strategies, and understanding persistent challenges. Qualitative research designs can provide real-time data."[85]

- **Absence of Impact Assessments on Early Fund Distributions**
  Need for "[c]ritical feedback on the effects of funds allocated in the initial two years" in order to understand "how these funds impacted treatment access, recovery rates, and community needs . . . . Impact data is essential to identify initiatives that merit continued support or modification."[86]

- **Disconnect from New York State Strategic Plans to Address Addiction**
  Need for OSFAB's recommendations to be in "in alignment with broader State agency Strategic Plans, including those of the Office of Addiction Services and Supports (OASAS), Department of Health (DOH), and Office of Mental Health (OMH). However, limited integration with these plans restricts the Board's ability to recommend funding for programs and services that will be sustained by the State after settlement dollars have been exhausted. A closer alignment would ensure recommendations leverage statewide resources and initiatives more comprehensively."[87]

- **Need for Continuous Monitoring and Reporting Mechanisms**
  Need for "[s]tandardized, centralized, real-time data collection sharing and reporting" to "enhance the Board's capacity to adapt its recommendations to evolving trends within the opioid crisis. Continuous monitoring and key performance indicators would allow the board to respond dynamically to shifts in circumstances. Populations at high risk for overdose mortality such as the justice involved and disproportionately high rates in Black, Latine/x and Indigenous individuals would help tailor responses to specific community needs."[88]

- **Need for Consistent Updates on State Agency Funding Allocations:**

[84] *Id.*
[85] *Id.*
[86] *Id.*
[87] *Id.*
[88] *Id.*

> "Consistent transparency on the distribution of state funding, State Opioid Response (SOR) funding, block grants, and settlement funds across the three agencies would support the board's ability to make informed recommendations. Understanding program-specific allocations is necessary to assess program effectiveness and prioritize funding for future recommendations."[89]

The concerns raised by OSFAB potentially warrant further consideration and mitigation implementation in order to support and enhance OSFAB's ability to make timely and data-supported recommendations.

Concerns have also been raised about the slow pace of opioid settlement fund distribution. For instance, a recent *Newsday* investigation reported that in Long Island, Nassau and Suffolk Counties have received a combined $213.5 million in opioid settlement funds and have issued $97.2 million in contracts and grants. However, only a small portion ($8.1 million, or 3.8%) of the $213.5 million available to date has actually been spent in the three years since the settlement.[90] The authors of the article noted that although restrictions exists on how municipalities can spend opioid settlement funds, "there is no deadline for localities to distribute the money — and, in fact, no regulation mandating county officials ever utilize the money."[91]

Some of the roadblocks identified in slowing down the pace of funding distribution include a "lack of urgency to get opioid settlement funds to vendors, bureaucratic red tape and a cumbersome grant reimbursement process[.]"[92] The cumbersome grant reimbursement process potentially puts smaller organizations without experienced grant writers on staff at a disadvantage when trying to access settlement fund dollars.

A closer look is potentially warranted at how to best improve the efficiency and effectiveness of opioid settlement fund distribution.

Coordination of Effort

Given the breadth of state agencies that impact drug policy and the vast and competing issues and priorities that they face; the Governor should consider appointing a Drug Czar, ideally an individual with lived experience related to this position. Timely coordination is necessary across all of the state agencies that impact the barriers that affect addiction, mental health and health care, and New York State should have one point person to lead this work.

---

[89] *Id.*
[90] Robert Brodsky & Anastasia Valeeva, *Less than 4% of Long Island's opioid lawsuit settlement millions spent as overdose deaths continue*, Newsday, Dec. 6, 2024, https://www.newsday.com/long-island/opioid-lawsuit-settlement-fund-nassau-pajdcpif.
[91] *Id*.
[92] *Id*.

Recommendations

The Task Force submits the following summary recommendations to the NYSBA Executive Committee and House of Delegates:

Legislation and Regulation

1. **Support Enhancing patient access to medication assisted treatment of opioid disease Bill A.3496 (McDonald)/S.2625 (Fernandez)** [93]

   "Enhancing patient access to medication assisted treatment of opioid disease" amends § 6801 of the Education Law and § 3331 of Public Health Law and would permit pharmacists to prescribe controlled substances in NY Schedules III, IV, and V that have received an indication for treatment of opioid use disorders (Medication-Assisted Therapy, or MAT). The word "prescribe" is required in state law to enable the DEA to issue federal registration to pharmacists necessary for prescribing. The pharmacist would be working collaboratively with a physician or nurse practitioner under a non-patient-specific order for continuity of care. The Task Force recommends that NYSBA support this legislation.

2. **Support Expanding Access to Overdose Reversal Agents (A.265-A/S.4150)**

   Reversing overdoses is the first step to stopping overdose deaths. Expanded access to overdose reversal agents is the first step. There is already pending legislation (A.265-A (Steck)/ S.4150 (Harckham))[94] which would require NYS to make all FDA approved forms of overdose reversal agents available. Current law requires schools and SUNY campuses to make overdose reversal agents available. The state should examine further what other settings should have overdose reversal agents available. Given that there are multiple overdose reversal products and yet the state only purchases one such product; the state should consider issuing a procurement to take advantage of the competition. Such an action is likely to produce pricing that is less than currently offered. This action would allow the state to purchase more of this life-saving medicine. The Task Force recommends that NYSBA support this legislation.

3. **Support Amending the New York Public Health Law**

   Many provisions of the Public Health Law are inconsistent with terminology used in the medical literature concerning care of patients with opioid use disorder and may need to be amended, as follows:

[93] See https://www.nysenate.gov/legislation/bills/2025/S2625.
[94] See https://www.nysenate.gov/legislation/bills/2025/A265/amendment/A.

- PHL § 3331(1): "no [controlled] substance . . . may be prescribed for or dispensed to an *addict or habitual user.*

- PHL Ch. 45, Art 33, Title V "Dispensing to *Addicts and Habitual Users*" should be amended to adjust the outdated terminology.

- PHL § 3350: "Controlled substances may not be prescribed for or administered or dispensed to *addicts or habitual users*, except" . . .

- PHL § 3351: "Dispensing for medical use" has been identified by practitioners as intimidating and difficult to understand. Consider rewriting in its entirety.

- PHL § 3372: "Practitioner patient reporting" of diagnosis of "*addict or habitual user*".

The Task Force recommends that NYSBA support amendments to this legislation.

4. Support Amending Senate Bill 7177, enacted Laws of N.Y. 2024 Ch. 466[95]

Permits dispensing 72-hour supply of controlled substance from hospital ERs *only* if there is no 24-hour pharmacy service. This excludes a significant portion of hospitals from the coverage of this law and is not consistent with DEA regulation (21 CFR §1306.07(b)). The Task Force recommends that NYSBA support the clarifying language contained in the Governor's 2025-26 Executive Budget proposal.

5. Support Amending Public Health Regulations, Title 10, Public Health, Part 80

The Task Force recommends that these current regulations be amended to harmonize with federal law and to, more importantly, remove incorrect, outdated and highly stigmatizing language as follows:

- Section 80.65 [prescription] "issued to an *addict or habitual user* . . . is not a prescription" thus not valid. In addition to the language issue, patients with substance use disorders require controlled substances on occasion for reasons completely separate from their dependence.

- Section 80.73(j) should be harmonized with DEA regulation permitting partial filling of Schedule II controlled substances by the dispensing pharmacist (21 C.F.R. § 1306.13).

[95] See https://www.nysenate.gov/legislation/bills/2023/S7177/amendment/B.

- Amendments to Sections 80.62, 80.63, and 80.84 have been published in the NYS Register for notice and comment (May 15, 2024) but not yet been adopted. The Task Force recommends adoption.

6. **Support Expanding Access to Substance Use Disorder (SUD) services in jails and prisons**

   The Task Force recommends that New York State apply for a federal Centers for Medicare and Medicaid Services 1115 Medicaid Waiver to provide SUD services to individuals being held in state and local correctional facilities for up to 90 days prior to release. This federal waiver would better enable state and local correctional facilities to meet their legal requirements pursuant to § 19.18-c of the Mental Hygiene Law. It would also acknowledge that among individuals who are released from prison, opioid overdose is a leading cause of death with a risk more than ten-fold the general population.[96]

7. **EMT Initiation of Addiction Medicine**

   There is already pending legislation (A.9882-A/S.9926) that would allow Advanced Emergency Medical Technicians to administer the opioid use disorder medicine, buprenorphine, in the field under the supervision of a physician. Only certain EMS agencies will be permitted to do this now under pilot program protocols even though legislation has not yet been enacted. The State of New Jersey also allows this.

Addictions Workforce: Retention & Research Recommendations

Across the United States, there is a projected employment rate of "23% indicating 75,100 jobs will become available to work within this field from 2022 to 2032."[97] The behavioral health system has had its difficulties in recruiting and retaining their

[96] Daniel M. Hartung & Caitlin M. McCracken et al., *Fatal and nonfatal opioid overdose risk following release from prison: A retrospective cohort study using linked administrative data*, 147 J. of Substance Use & Addiction Treatment 208971 (April 2023), https://doi.org/10.1016/j.josat.2023.208971.
[97] Bureau of Labor Statistics, *Employment Projections*, 2020, https://data.bls.gov/projections/nationalMatrix?queryParams=21-1018&ioType=o (retrieved January 30, 2022).

workforce.[98] Stigma historically is a concern for recruitment.[99] [100] [101] Burnout has historically been identified as a key issue in retention.[102] However, more recent research has identified additional key issues in recruitment and retention. These include worker dissatisfaction, supervision and training, and low wage compensation.[103]

Employee dissatisfaction is often related to lack of organizational resources, high caseloads, strained coworker relationships, poor documentation, inadequate supervision, burnout, and low wages.[104] [105] [106] A recent study showed addictions professionals who were satisfied with their work environment are less likely to leave their current positions.[107] And addictions professionals who have a higher sense of comradery with their coworkers are also less likely to leave their current positions.[108] Worker dissatisfaction should be further explored in independent studies to examine its impact on both variables such as retention and recruitment. A specific definition of worker dissatisfaction in the behavioral health field can help researchers identify unique issues relevant to their workforce.

Concerns related to supervision and training are a twofold issue. Frontline staff often have an overload of documentation requirements, high caseloads and an overall lack of

---

[98] Ellen Bouchery & Judith Dey, *Substance use disorder workforce issue brief* Assistant Secretary for Planning and Evaluation (ASPE), US Dep't of Health & Human Servs., May 31, 2018, https://aspe.hhs.gov/reports/substance-use-disorder-workforce-issuebrief.

[99] Lori J. Ducharme, Hannah K. Knudsen, & Paul M. Roman, *Emotional exhaustion and turnover intention in human service occupations: The protective role of coworker support*, 28(1) J. of Sociological Spectrum 81, 81–104 (2007), https://doi.org/10.1080/02732170701675268.

[100] Hannah K. Knudsen, J. Aaron Johnson, & Paul M. Roman, *Retaining counseling staff at substance abuse treatment centers: effects of management practices*, 24(2) J. of Substance Abuse Treatment 129, 129–35 (2003), https://doi.org/10.1016/s0740-5472(02)00357-4.

[101] Hannah K. Knudsen, Lori J. Ducharme, & Paul M. Roman, *Research participation and turnover intention: An exploratory analysis of substance abuse counselors*, 33(2) J. of Substance Abuse Treatment 211, 211–17 (2007), https://doi.org/10.1016/j.jsat.2006.12.013.

[102] *Supra* notes103, 104, 105.

[103] Kristy Aristy *Workforce Development Issues in the Field of Addictions: A study of factors that impact retention with addiction professionals in New York State*, Publication No. 30993128 (Feb. 29, 2024), Doctoral dissertation, Yeshiva University, https://repository.yu.edu/items/d4cd7df7-52bb-41b5-9222-1c68a5147c49.

[104] *Id.*

[105] Carrie B. Oser, Elizabeth P. Biebel, Erin Pullen, & Kathi L. H. Harp, *Causes, consequences, and prevention of burnout among substance abuse treatment counselors: a rural versus urban comparison*, 45(1) J. of Psychoactive Drugs 17, 17–27 (2013), https://doi.org/10.1080/02791072.2013.763558.

[106] Jennifer Murphy, *Improving the Recruitment and Retention of Counselors in Rural Substance Use Disorder Treatment Programs*, 52(3) J. of Drug Issues 434, 434–56, https://doi.org/10.1177/00220426221080204.

[107] *Supra* note 107.

[108] *Id.*

supervision.[109] [110] [111] Midline and senior staff are often subject to administrative supervision but lack clinical supervision.[112] Newly learned training by behavioral health professionals may not be implemented because of the lack of guidance through regular supervision. Behavioral health professionals who are provided with adequate supervision may have positive workplace relations; an increased sense of professional comradery & teamwork, and increased productivity and overall work satisfaction population.[113]

In behavioral health, addictions professionals earn low wages and may have little to no benefits.[114] In New York State, there is a wide range of salaries. These salaries depend on credentials/licensure and current education level. (i.e., high school diploma $20,000 to master's level, $50,000).[115] [116] Research shows that "44% of addictions treatment agencies do not provide an increase salary based on cost-of-living expenses annually"[117] [118]

Furthermore, "59% of organizations do not provide bonuses or additional incentives for addictions professionals."[119] There is limited data related to wages and compensation. Additionally, there is limited research on the differences in wages between various racial groups.

Research shows that there is an opportunity to develop work strategies that specifically target and reflect an understanding of the diverse nature of the behavioral health workforce.[120] Having a better understanding of the impacts of retention and recruitment is critical to the overall health of patients affected by substance use disorders. Based on current research, there are several suggested actions that may improve retention and

---

[109] *Supra* note 104.
[110] Linda Wermeling, *Social work retention research: Three major concerns*, 3(1) J. of Sociology, Social Work, and Social Welfare 1, 1–8 (2009), https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=e2446b289f2ed291760cfb8009ffa75173ab2148.
[111] Thomas L. McNulty, Carrie B. Oser, Aaron J. Johnson, Hannah K. Knudsen, & Paul M. Roman, *Counselor turnover in substance abuse treatment centers: An organizational-level analysis*, 77(2) Sociological Inquiry 166, 166–93 (2007), https://doi.org/10.1111/j.1475-682X.2007.00186.x.
[112] *Supra* note 104.
[113] *Supra* notes 104, 107, 114, 115.
[114] *Supra* note 107.
[115] *Id.*
[116] Luke Nasta, Patricia Strach, *What drives staffing levels for substance use disorder (SUD) services in New York State?*, SUNY Rockefeller Institute of Government, Nov. 2021, https://rockinst.org/wp-content/uploads/2021/11/NYS-SUD-Workforce-2021.pdf.
[117] Aristy, *supra* note 107, at 35.
[118] Office of Alcoholism and Substance Abuse Services, *2019 Local Plan Analysis – Summary Results: 2019 Treatment Provider and program staffing surveys*, 2019, https://omh.ny.gov/omhweb/planning/docs/2019lspguidelines.pdf.
[119] *Supra* notes 121, 122.
[120] *Supra* notes 107, 110.

recruitment rates for this segment of the workforce.[121] These include, but are not limited to, the following:

- **Promote specific state studies surrounding the issues related to worker dissatisfaction**.
  State studies should include definitions that are specific to their workforce characteristics and crisis. Additionally, conversations related to the overall wellness of behavioral health professionals within the workplace should be supported.[122] This can also include discussions surrounding a positive work environment, as a positive work environment increases optimism about work.[123] These discussions may increase productivity, promote positive work behaviors, and foster a consensual attitude in the workplace.

- **Supervision should be constant and consistent in the workplace.**
  Supervision should be consistent with both frontline staff and managerial staff and should include a combination of clinical and administrative supervision.[124] When consistency increases, the process of professional learning increases. Supervision enables the workforce to improve their capabilities through emerging evidence-based practices;[125] and allows supervisors to practice their clinical skills in real time. Supervision should be used as a tool for follow-up skills when a behavioral health professional engages in training.

- **Address burnout in the workplace.**
  Burnout is linked to employee dissatisfaction and poor supervision and training.[126] Addressing burnout through various methods of supervision maximizes the overall well-being of behavioral health professionals. Exploring worker dissatisfaction and problem solving in this area may increase job satisfaction and reduce stress at work.[127]

- **Competitive salaries and benefits must be offered to addictions professionals**.
  "Offering competitive salaries in the current industry standard is key in the workplace."[128] Behavioral health professionals value salaries that include medical benefits, paid time off, and retirement options as desirable benefits for the workforce.[129] Providing competitive compensation, consistent supervision, and

[121] *Supra* notes 107, 110, 122.
[122] *Supra* note 107.
[123] *Id.*
[124] *Id.*
[125] *Id.*
[126] *Id.*
[127] *Id.*
[128] Aristy, *supra* note 107, at 81.
[129] *Id.*

addressing employee dissatisfaction can improve retention rates in the workplace,[130] and may also help to address the competitive recruitment needs of this specific workforce.

- **Retention and recruitment: Respective challenges**
  There are unique dimensions to the respective challenges posed by retention and recruitment. Retention should focus on the immediate needs of the workplace population. Recruitment efforts should focus on the type of population needed for the use of evidence- based practices; and continuing to encourage populations who have experienced recovery firsthand to work in the behavioral health field.

Diversion Programs, Treatment Courts, and Direct Service Provision Recommendations

- **Adequate funding and staff for specialty courts are needed**.
  Funding levels for specialty courts are currently insufficient. Many specialty court parts are already overwhelmed by the magnitude of need and are struggling to meet demand. This means that for many projects the choice is either high caseloads, or long waitlists, neither of which is conducive to supporting recovery.

  Complicating this need, specialty courts are also struggling to attract and retain talent in diversion settings. As of July 1st, 2023, there were only 13,362 LMSW's (Licensed Masters Social Workers), 11,600 LCSWs (Licensed Clinical Social Workers), and 3,347 LMHCs (Licensed Mental Health Counselors) in New York City. Post-pandemic, many licensed professionals are choosing more flexible, often remote roles. Court diversion work is very demanding and for the most part requires staff to work in-person, so creative ways of supporting the demand and caring for our workforce must be considered.

- **Ensure that direct services staff have access to clinical support**.
  Work in the substance use field is emotionally challenging. Staff supporting diversion efforts are regularly exposed to human suffering and trauma, inadequate resources, high caseloads, and unrelenting demands. Without adequate support, these demands place workers at high risk for burnout, compassion fatigue and vicarious trauma. Clinically informed supervision/consultation is essential to ensuring that staff have enough support to do the work effectively, and sustainably. Funding recommendations should take into consideration the need for healthy work environments by establishing caseload targets, and creating a budget for the clinical supervision and training of diversion staff. Additionally, direct service professionals who experience harm have access to resources, and support systems, to process trauma encountered on the job.

[130] *Id.*

- **Consider training for judges on recovery, harm reduction, serious mental illness, and risk management**
  The expansion of diversion opportunities should consider judicial training on the concepts of recovery, harm reduction, serious mental illness, and the management of risk. This is new territory for many judges and the more support and education that can be provided, the better.

- **The courts should take an official position on cannabis use to ensure uniformity**.
  Since the legalization of cannabis, some specialty courts have modified their response to cannabis use but there is no uniformity from site to site.

- **Ensure that behavioral health resources exist in communities**.
  For diversion efforts to be successful, there need to be adequate programming options in our communities. The expansion of diversion opportunities must also consider the treatment landscape of the communities in question, particularly in rural areas where transportation can be an obstacle.

  Expanding diversion opportunities will also require staff in diversion settings to support, and secure placements for, clients with increasingly complex needs. Although the population on Riker's Island has decreased in recent years, the percentage of our Rikers population struggling with mental health conditions has increased. According to the National Center for Access to Justice.

  > "Today, more than half of people in Rikers have been diagnosed with a mental illness, and one in five has been diagnosed with a serious mental illness. Rikers is the largest provider of psychiatric services in New York City and one of the largest providers in the world."[131]

  Diversion efforts in NY are already hindered by the lack of appropriate treatment options. Although New York City is resource-rich compared to other jurisdictions, there is currently only one residential substance use provider for persons with serious mental illness, namely Harbor House. Many other providers do not currently have the staffing to support this population. The outpatient treatment landscape for this population in New York City is more robust, but there are often long waitlists to secure appointments or access resources. Outside of the five boroughs, resources are often considerably limited and complicated by inadequate public transportation.

- **Support collaboration across all systems and government agencies to ensure implementation of equitable diversion programs**.
  While policy goals aim to identify and implement equitable diversion pathways for all populations with functional impairments, achieving those goals requires collaboration

[131] National Center for Access to Justice, *To Close Rikers Island by 2027, Charting a New Path on Mental Health May be the Key*, Sept. 26, 2023, https://ncaj.org/news/close-rikers-island-2027-charting-new-path-mental-health-may-be-key.

across all systems, government offices, and agencies. Coordinated efforts are needed to craft coherent policy and ensure its successful implementation. The Department of Mental Hygiene, which is composed of the Office of Addiction Services and Supports (OASAS), the Office of Mental Health (OMH), and the Office for People with Developmental Disabilities, (OPWDD) needs to be meaningfully engaged to ensure that adequate services exist in all jurisdictions. These three entities currently operate in silos, which means that diversion staff need to learn how to navigate entirely separate systems and services. Where possible, consideration should be given to hiring behavioral health experts with knowledge and understanding of specific populations and the organizations responsible for coordinating services.

The addiction care system is unable to recruit and retain workforce which is impacting access to treatment. Many providers report upwards of 20% vacancy rates for staff in their program and many programs are serving at less than their licensed capacity. The current Task Force is convening stakeholder experts to make recommendations to the state on programs to address the workforce issues. Possible recommendations include using opioid litigation settlement funds and opioid stewardship funds to pay for the new initiatives which could include loan forgiveness, scholarships, and tuition reimbursement, as well as exploring whether to allow addiction care providers to buy into the state retirement system and the NYS Employee Health Insurance Program. The group should also review OASAS staffing regulations for recommendations for possible changes to address the crisis without compromising patient safety.

- **EMT initiation of addiction medicine**.
  There is already pending legislation (A.9882-A/S.9926) that would allow Advanced Emergency Medical Technicians to administer the opioid use disorder medicine, buprenorphine, in the field under the supervision of a physician. Only certain EMS agencies will be permitted to do this now under pilot program protocols even though legislation has not yet been enacted. The State of New Jersey also allows this.

- **Interdisciplinary/interprofessional workforce education and training**.
  Task Force members have shared their own lived experience of distress and vicarious trauma in serving the communities affected by opioid addiction across diverse settings. This is a hidden issue that has not received adequate attention and calls for more thoughtful planning to ensure we are making mental health and trauma-informed services available to the professional workforce in addiction. Funding to expand interprofessional workforce education and training is desperately needed across public and private settings.

- **Convene a group of stakeholders to review the Medicaid reimbursement model**.
  New York State should convene a group of stakeholder experts to review the current Medicaid reimbursement model for substance use services and develop a report with any recommendations for changes to the model.

- **Integrated mental health and addiction treatment**.

Many individuals with a substance use disorder also need treatment for mental health issues.[132] New York State requires separate program licenses from OMH and OASAS to treat each condition in separate settings. While New York has made some progress in permitting co-occurring treatment, however, it is limited to outpatient programs. More work is needed to allow OMH and OASAS programs to treat co-occurring mental health issues and addiction in one program setting.

- **Telehealth**.
  The federal Drug Enforcement Administration (DEA) recently extended the rule until December 31, 2025, allowing for prescribers to initiate patients on buprenorphine through a telephonic appointment. This rule was put into place during COVID and it has helped expand access to this life-saving medication. The federal government should consider making this rule permanent or continuing it until the federal opioid public health emergency ends. (this study shows superior retention in treatment for patients initially evaluated via telemedicine – Joshua J. Lynchet al., *Comparison of 30-day Retention in Treatment Among Patients Referred to Opioid Use Disorder Treatment From Emergency Department and Telemedicine Settings* 165 J. of Substance Use & Addiction Treatment 209446 (2024), https://doi.org/10.1016/j.josat.2024.209446).

- **The use of telemedicine to prescribe controlled substances**.
  In March 2020, as a result of the COVID-19 pandemic, the federal Drug Enforcement Administration (DEA) and Health and Human Services (HHS) put in place a temporary rule that allowed DEA-registered prescribers to initiate and continue controlled substance prescriptions by audio-visual or audio-only forms of telemedicine. That rule has been extended several times and is currently in effect until December 31, 2025. Recently, the DEA proposed a new rule-making that would allow prescribers to obtain a newly created Special Registration to continue to use telemedicine when prescribing controlled substances. These new proposals will significantly impact prescriber's management of chronic pain, end of life care, and the treatment of opioid use disorder. We believe that before the DEA adopts a new Special Registration requirement, a study should be conducted which examines the impacts of the current emergency telemedicine rule so that we can understand whether a Special Registration is required. Until the study is complete, we recommend that the emergency rule remain in effect.

- **Expand access to methadone**.
  Turning to federal law, the Modernizing Opioid Treatment Access Act (S.644/H.R.1359) would allow board-certified practitioners to prescribe methadone for opioid use disorder to their patients. Currently, they are only allowed to offer methadone through a licensed opioid treatment program. This proposed legislation would allow qualified practitioners

[132] National Institute on Drug Abuse, *Co-Occurring Disorders and Health Conditions*, https://nida.nih.gov/research-topics/co-occurring-disorders-health-conditions#mental.

to prescribe methadone either at an opioid treatment program or by a physician or psychiatrist with a specialty certification in addiction medicine.

Opioid Litigation Settlement Funds

New York State has reached settlements of over $2.6 billion in total with companies participating in the manufacturing, selling, distributing, dispensing and promoting of opioids.[133] The opioid settlements include payment schedules lasting for up to 18 years.[134]

In June 2021, New York enacted legislation establishing an opioid settlement fund to ensure that the settlements funds would be utilized for abatement.[135] The legislation also established an advisory board — the Opioid Settlement Fund Advisory Board (OSFAB) — to provide recommendations to the legislature regarding settlement fund allocations.[136]

This legislation (Chapter 190 of the Laws of 2021) stipulates that opioid settlement funds "shall be used to supplement and not supplant or replace any other funds, including federal or state funding, which would otherwise have been expended for substance use disorder prevention, treatment, recovery or harm reduction services or programs."[137] [138]

Language in updated Chapter 171 of the Laws of 2022 specifies:

> Eligible expenditures shall include services and programs that are consistent with the approved uses and terms of the statewide opioid settlement agreement . . . , which may only include:
>
> (i) to prevent substance use disorders through an evidence-based youth-focused public health education and prevention campaign, including school-based prevention and health care services and programs to reduce the risk of substance use by school-aged children;
>
> (ii) to develop and implement statewide public education campaigns to reduce stigma against individuals with a substance use disorder, provide information about the risks of substance use, best practices for addressing substance use disorders, and information on how to locate services that reduce the adverse health consequences associated with substance use disorders or provide treatment for substance use disorders;

---

[133] Office of the N.Y. State Attorney General, *Opioid settlements*, https://ag.ny.gov/nys-opioid-settlement#:~:text=Allocation%20of%20funds&text=The%20funds%20are%20allocated%20to,settlements%20are%20used%20for%20abatement (last visited Dec. 31, 2024).
[134] Opioid Settlement Fund Advisory Board, *Annual Report* (Nov. 1, 2024), https://oasas.ny.gov/system/files/documents/2024/11/2024-osfab-report_0.pdf.
[135] Office of the N.Y. State Attorney General, *supra* note 111.
[136] *Id*.
[137] N.Y. Senate Bill S.7194, June 5, 2021, https://legislation.nysenate.gov/pdf/bills/2021/S7194.
[138] N.Y. State. Fin. Law § 99-nn(3).

(iii) to provide substance use disorder treatment and early recovery programs for youth and adults, with an emphasis on programs that provide a continuum of care that includes screening and assessment for substance use disorders and co-occurring disorders, active treatment, family involvement, case management, relapse management for substance use and other co-occurring behavioral health disorders, vocational services, literacy services, parenting classes, family therapy and counseling services, crisis services, recovery services, evidence-based treatments, medication-assisted treatments, including medication assisted treatment provided in correctional facilities, psychiatric medication, psychotherapy and transitional services programs;

(iv) to provide harm reduction counseling and services to reduce the adverse health consequences associated with substance use disorders, including overdose prevention and prevention of communicable diseases related to substance use, provided by a substance use disorder service provider or qualified community-based organization;

(v) to provide housing services for people who are recovering from a substance use disorder. Such housing services shall be appropriate, based on the individual's current need and stage of recovery. Such housing services may include but are not limited to supportive housing services;

(vi) to support community-based programs that reduce the likelihood of criminal justice involvement for individuals who have or are at risk of having a substance use disorder;

(vii) to provide programs for pregnant women and new parents who currently or formerly have had a substance use disorder and newborns with neonatal abstinence syndrome; and/or

(viii) to provide vocational and educational training for individuals with or at risk for a substance use disorder.[139] [140]

The Office of Addiction Services and Supports (OASAS) is the lead agency responsible for monitoring and overseeing the Opioid Settlement Fund, including the distribution of Regional Abatements to localities for initiatives aiming to address addiction and opioid use disorder in communities.[141] Funds are made available every year to 55 local government units, five large cities, and 21 other litigating entities, calculated using population, overdose death rates, and mental health and equity indicators. Areas of priority include "investments across the service continuum, harm reduction, recovery, housing, treatment, priority populations, prevention,

[139] N.Y. Senate Bill S.7870, Jan. 14, 2022, https://legislation.nysenate.gov/pdf/bills/2021/S7870.
[140] N.Y. Mental Hyg. Law § 25.18(a)(1)(i)-(viii).
[141] OASAS, *Opioid Settlement Funding Initiatives*, https://oasas.ny.gov/opioid-settlement-funding-initiatives (last visited Dec. 31, 2024).

transportation, research, and public awareness."[142]Additional information on Opioid Settlement Fund Regional Abatements can also be found on the OASAS website,[143] including a link to a document of approved uses of funds.[144]

The OASAS website also includes information on projects offered through the Opioid Settlement Funding initiative, including open projects currently being offered and awarded projects for which the deadlines to apply have passed.[145] Links to each project provide additional information on the scope of work as well as expense reports. In addition, the OASAS website also includes links to funding opportunities for not-for-profit organizations, local government units, and other businesses.[146]

New York's Opioid Settlement Fund Tracker provides information about the state's opioid settlement fund spending, including initiatives, the number of awards distributed to the initiatives, and award amounts.[147] [148] The Tracker allows sorting by date and initiative as well as by priority area for fiscal years 2023, 2024 and 2025. Over $366 million from the state's settlement fund share has already been made available.[149]

The OSFAB prepares annual reports with recommendations for settlement fund spending, which are then reviewed by the governor, president of the Senate, speaker of the Assembly, and chairs of several legislative committees.[150] The most recent OSFAB 2024 Annual Report includes the chart in Appendix B showing "receipts for all settlements, including the money that goes directly to the local government units, as well as funds deposited into the State's Opioid Settlement Fund (OSF). Additionally, the chart illustrates the regional shares, which are determined by the settlement agreements, and the remainder that is available for State investment."[151]

The November 1, 2024 OSFAB 2024 Annual Report also includes the chart in Appendix B showing "the amount of money made available by NYS OASAS reflective of the board's spending recommendations by priority area."[152]

Notably, the 2024 OSFAB Annual Report also includes a "letter of concern," in which OSFAB expresses "significant concerns with the State agencies' inability to provide comprehensive

---

[142] *Id*.
[143] OASAS, *Opioid Settlement Fund Regional Abatements*, https://oasas.ny.gov/opioid-settlement-fund-regional-abatements (last visited Dec. 31, 2024).
[144] OASAS, *Schedule C - Approved Uses*, https://oasas.ny.gov/system/files/documents/2023/02/approved-uses.pdf.
[145] OASAS, *supra* note 119.
[146] OASAS, *Procurement and Funding Opportunities*, https://oasas.ny.gov/procurement (last visited Dec. 31, 2024).
[147] Nat'l Academy for Health Science Policy, *State Opioid Settlement Spending Decisions: New York*, May 17, 2024, https://nashp.org/state-tracker/state-opioid-settlement-spending-decisions/new-york/.
[148] OASAS, *Opioid Settlement Fund Tracker*, https://oasas.ny.gov/fy-2023-opioid-settlement-fund-initiatives (updated Dec. 5, 2024).
[149] *Id*.
[150] Nat'l Academy for Health Science Policy, supra note 124.
[151] Opioid Settlement Fund Advisory Board, *supra* note 112.
[152] *Id.*

timely information for the board to make full data driven recommendations" for allocation of the opioid settlement funds.[153] The letter enumerates several limitations, which are summarized below.

- **Lack of Access to Current Data and Outcome Analysis**
  Need for "tailored data from the state's health, mental health, and addiction services divisions," including "up-to-date, comprehensive data on the state of opioid addiction and treatment outcomes," which are "essential for assessing immediate needs, identifying effective strategies, and understanding persistent challenges. Qualitative research designs can provide real-time data."[154]

- **Absence of Impact Assessments on Early Fund Distributions**
  Need for "[c]ritical feedback on the effects of funds allocated in the initial two years" in order to understand "how these funds impacted treatment access, recovery rates, and community needs . . . . Impact data is essential to identify initiatives that merit continued support or modification."[155]

- **Disconnect from New York State Strategic Plans to Address Addiction**
  Need for OSFAB's recommendations to be in "in alignment with broader State agency Strategic Plans, including those of the Office of Addiction Services and Supports (OASAS), Department of Health (DOH), and Office of Mental Health (OMH). However, limited integration with these plans restricts the Board's ability to recommend funding for programs and services that will be sustained by the State after settlement dollars have been exhausted. A closer alignment would ensure recommendations leverage statewide resources and initiatives more comprehensively."[156]

- **Need for Continuous Monitoring and Reporting Mechanisms**
  Need for "[s]tandardized, centralized, real-time data collection sharing and reporting" to "enhance the Board's capacity to adapt its recommendations to evolving trends within the opioid crisis. Continuous monitoring and key performance indicators would allow the board to respond dynamically to shifts in circumstances. Populations at high risk for overdose mortality such as the justice involved and disproportionately high rates in Black, Latine/x and Indigenous individuals would help tailor responses to specific community needs."[157]

- **Need for Consistent Updates on State Agency Funding Allocations:**

[153] *Id.*
[154] *Id.*
[155] *Id.*
[156] *Id.*
[157] *Id.*

> "Consistent transparency on the distribution of state funding, State Opioid Response (SOR) funding, block grants, and settlement funds across the three agencies would support the board's ability to make informed recommendations. Understanding program-specific allocations is necessary to assess program effectiveness and prioritize funding for future recommendations."[158]

The concerns raised by OSFAB potentially warrant further consideration and mitigation implementation in order to support and enhance OSFAB's ability to make timely and data-supported recommendations.

Concerns have also been raised about the slow pace of opioid settlement fund distribution. For instance, a recent *Newsday* investigation reported that in Long Island, Nassau and Suffolk Counties have received a combined $213.5 million in opioid settlement funds and have issued $97.2 million in contracts and grants. However, only a small portion ($8.1 million, or 3.8%) of the $213.5 million available to date has actually been spent in the three years since the settlement.[159] The authors of the article noted that although restrictions exists on how municipalities can spend opioid settlement funds, "there is no deadline for localities to distribute the money — and, in fact, no regulation mandating county officials ever utilize the money."[160]

Some of the roadblocks identified in slowing down the pace of funding distribution include a "lack of urgency to get opioid settlement funds to vendors, bureaucratic red tape and a cumbersome grant reimbursement process[.]"[161] The cumbersome grant reimbursement process potentially puts smaller organizations without experienced grant writers on staff at a disadvantage when trying to access settlement fund dollars.

A closer look is potentially warranted at how to best improve the efficiency and effectiveness of opioid settlement fund distribution.

Coordination of Effort

Given the breadth of state agencies that impact drug policy and the vast and competing issues and priorities that they face; the Governor should consider appointing a Drug Czar, ideally an individual with lived experience related to this position. Timely coordination is necessary across all of the state agencies that impact the barriers that affect addiction, mental health and health care. New York State should have one point person to lead this work.

---

[158] *Id.*
[159] Robert Brodsky & Anastasia Valeeva, *Less than 4% of Long Island's opioid lawsuit settlement millions spent as overdose deaths continue*, Newsday,Dec. 6, 2024, https://www.newsday.com/long-island/opioid-lawsuit-settlement-fund-nassau-pajdcpif.
[160] *Id*.
[161] *Id*.

Conclusion

The immensity and seriousness of the issues that the Task Force on Opioid Addiction has confronted and studied during its term of service continue to stagger our minds and communities. These challenges cut across diverse constituencies and groups, including the individuals who have generously served on or appeared before the Task Force; the leadership and members of Sections who have supported our work; and external communities with whom we have meaningfully engaged. The sentiments at the core of our work speak to the urgency for action to mitigate a persistent crisis that is serpentine in its entanglements and long resistant to change and interventions. We submit the below recommendations to the New York State Bar Association in a spirit of hope that they may help to advance New York State's change agenda both by saving lives and reducing suffering through harm reduction.

Summary of Recommendations

- Increase funding for qualitative and mixed methods research in order to understand better the problem of opioid addiction and the leading causes of deaths from substance use, and to deepen understanding of the lived experience of all those persons and communities suffering with addiction and in need of integrated health, mental health and social services.
- Expand and increase funding for residential or inpatient treatment programs as an important part of the solution to the thousands of deaths from substances still occurring in New York State annually.
- Expand and increase funding for prevention services.
- Expand and increase funding for integrated recovery supports and services.
- Secure a lower price for the purchase of naloxone.
- Expand the workforce and increase workforce funding, including education and training across both the professional and non-professional workforces.
- Improve the coordination and the distribution of funds to reduce deaths from substances, including the efficiency and effectiveness of opioid settlement fund distribution.
- Expand education, research, and oversight of the 55 and older population regarding the use of opioids, not just by putting an informational blurb on a website but via community outreach. .
- Ensure broader access to overdose reversal agents and fentanyl test strips.
- New York State should apply for a federal Centers for Medicare and Medicaid Services 1115 Medicaid waiver to provide SUD services to individuals being held in state and local correctional facilities for up to 90 days prior to release.
- Regarding workplace retention, the Task Force suggests promoting specific state studies surrounding the issues related to worker dissatisfaction, constant and consistent supervision in the workplace, addressing burnout in the workplace, offering competitive

salaries and benefits to addiction professionals, and research retention and recruitment separately.

- Regarding diversion programs, treatment courts, and direct service provision: adequate funding and staff are needed for specialty courts; ensure that direct services staff has access to clinical support to process trauma encountered on the judge; more training for judges on recovery, harm reduction, serious mental illness, and risk management; courts should take an official position on cannabis; ensuring behavioral health resources exist in communities; support collaboration across all systems and government agencies to ensure implementation of equitable diversion programs; integrated mental health and addiction treatment; convene a group of stakeholders to review Medicaid reimbursement.
- Telehealth allowing prescribers to initiate patients on buprenorphine through a telephonic appointment should remain in place.
- Expand access to methadone.
- A closer look at how opioid settlement funds are distributed is warranted to improve the efficient and effectiveness of opioid settlement fund distribution.
- The governor should consider appointing a Drug Czar and appoint an individual with lived experience to this position.

Appendix A
Treatment Not Jail Act (TNJA) Minority Position

The Bill Comment Memorandum for the Treatment Not Jail Act (A.4869 (Forrest)/ S.4547 (Ramos)) [162] suggests that Conditional Pleas should not be eliminated. However, while the NYSBA Task Force on Mental Health and Trauma Informed Representation recommended passage of the Treatment Not Jail Act in 2023 and this is policy of the New York State Bar Association,[163] there is not a universal consensus among Task Force members on this issue at this point in time.

Many support the elimination of conditional pleas, particularly because of the collateral consequences that adversely affect non-citizens who are required to plead up front. The case made here is that elimination of conditional pleas would allow for more treatment for those in need of such services. When an indictment remains hanging over a person's head as an incentive to be successful in the program, it is argued that it is very unlikely that a failed treatment result would result in anything other than a plea at a later time.

The NYSBA Task Force recognizes that lawmakers in Albany can play a vital role in expanding treatment options for justice-involved individuals through thoughtful and appropriate legislation. The great strength of the Task Force is statewide representation of viewpoints from all areas of criminal justice and the treatment community and our respectful and collaborative approach. We have seen the problems that arise when legislation is promulgated without meaningful input from all affected constituencies.

Our Task Force welcomes the opportunity to review A4869 (Forrest) S4547 (Ramos) sometimes referred to by the title given by its sponsor, "Treatment Not Jail" (TNJA). The efforts of bill drafters to enhance and make widely available alternative-to-incarceration programs are recognized and endorsed. However, few of the affected parties represented on our taskforce have been involved in the original drafting of the bill. We share our expertise and experience in evaluating this proposal.

There is not a consensus among Task Force members on this bill. Task Force members who are representative of District Attorneys in the state as well as the courts, as represented by the Unified Court System's Comment Memorandum on the bill, believe that conditional pleas should not be eliminated. However, some members do support the elimination of conditional pleas, particularly because of the collateral consequences that adversely affect non-citizens who are required to plead up front. The case is made by those members that eliminating conditional pleas allows for more treatment for those

[162] Provided by the Unified Court System, link not available
[163] Report and Recommendations of the New York State Bar Association Task Force on Mental Health and Trauma Informed Representation, at 19, June 2023, https://nysba.org/wp-content/uploads/2023/06/final-report-Task-Force-on-Mental-Health-and-Trauma-Informed-Representation-June-2023.pdf.

needing such services. They further argue that when no plea is taken the indictment remains as a sufficient incentive to succeed in the program. The NYSBA Task Force on Mental Health and Trauma Informed Representation recommended passage of the Treatment Not Jail Act in 2023.[164]

The UCS acknowledges that certain collateral consequences may result from a guilty plea that could impact housing, employment and immigration. We propose that the way to navigate around those concerns is to augment judicial discretion to adjust pleas as needed. A number of Task Force members believe that to simply remove the plea requirement altogether would undermine the effectiveness of the remedy we are trying to achieve in the first place.

Many of our concerns were thoughtfully evaluated by the UCS in its comprehensive comment on TNJA. The critique is over nine pages in length and detailed in its analysis. Listed below are points raised in the OCA review that reflect Task Force concerns:

- The Treatment Not Jail Act **requires** that eligible defendants **must be** offered court administered diversion options, **but** does not establish funding for this mandate. Most diversion programs are administered by third-party service providers working collaboratively with the court system in each county. A law that requires every court to offer diversion in every county without providing funding or options when treatment resources are unavailable is unworkable.

- UCS analysis of the bill raised concerns about expanding the types of offenses and conditions eligible for alternative to incarceration. The bill removes all eligibility restrictions regarding the type of offense and/or background of the defendant. Previous restrictions to eligibility include limiting the type of eligible offense to mostly narcotics-related offenses[165], and exclusion of violent felony predicate offenders, defendants with a prior class A narcotics-related felony conviction, and persistent violent felony offenders. All of these offenders are eligible for treatment consideration under the proposed legislation. In addressing the large-scale expansion of eligibility the bill proposes, the UCS discussed providing the court with the authority to determine whether a defendant meets a base threshold for eligibility based upon a preliminary assessment made by the court. The UCS comments do not directly address the concerns inherent to greatly expanding category of defendants who are diversion eligible. We would welcome the opportunity to discuss the issues raised by the proposed expansion to eligibility.

[164] *Id.*
[165] Additional offenses are defined in CPL § 216.00(1).

- While the UCS is supportive of ATI programs for defined conditions with recognized treatment regimens, not every defendant commits a crime because of serious mental health or substance use issues, and not every mental health condition can be remedied with existing treatment regimens. Protecting the public is a primary responsibility of the legislature and the court system, and the expansion contemplated by the bill in its present form does not require judicial evaluation of the nature of the crime or availability of proven treatment regimens and potential public safety risks. One of the many consequences of the eligibility expansion will be a vast increase in the number of hearings if either party disagrees with the determination to offer diversion. The current system does not have the capacity to withstand this anticipated increase in volume. Offering alternatives to incarceration to every defendant risks overburdening an already strained system, and potentially jeopardizes availability of services to those most likely to benefit from a diversion option.

- Finally, the bill eliminates a consistent feature of successful alternative-to-incarceration programs, the requirement of a plea of guilty in order to participate. By pleading guilty, the defendants acknowledge their crime and recognize that the court retains the authority to oversee their treatment. Diversion courts have existed for decades, and the plea and court oversight has long been a hallmark feature of the most successful. Experience has demonstrated that a key to success is participants' acceptance of responsibility for their actions. Continued judicial oversight builds public confidence in the programs, and reinforces the participants' willingness to address issues which have led to criminal behavior. As discussed in the UCS analysis, the statute currently gives prosecutors and courts the discretion to not to require a plea prior to participation in treatment.

- UCS acknowledged that collateral consequences involving housing, employment and immigration may result from a guilty plea but advised that judges are currently authorized to exercise discretion to adjust pleas as appropriate. To simply remove the plea requirement altogether would undermine the effectiveness of the remedy and eliminate accountability. This could potentially undermine public confidence in the fairness and safety of the expanded program. Additionally, as discussed in the UCS analysis, under TNJA defendants may request diversion at any time prior to trial. In addition to the potential of diminished effectiveness of delayed treatment, this would expose witnesses to identification pursuant to the discovery process before the defendant decides to accept the offer of treatment.

- The only apparent concern of TNJA is the health of a defendant; however, the concerns of victims and other parties to a prosecution that are inherent in these

proceedings must be considered. There are cases in which the victim and community will believe justice is served when a defendant receives treatment, and there are many cases in which that would not be a just resolution. If the prosecutor, the sworn representative of the "People," is removed from the discussion about a treatment plea, and the presiding judge will have no continuing oversight over the defendant in treatment, the victim and public may fairly feel their interests are not protected. There are many cases in which the prosecutor is the only party that has spoken to the victims and the only person properly positioned to represent their interest.

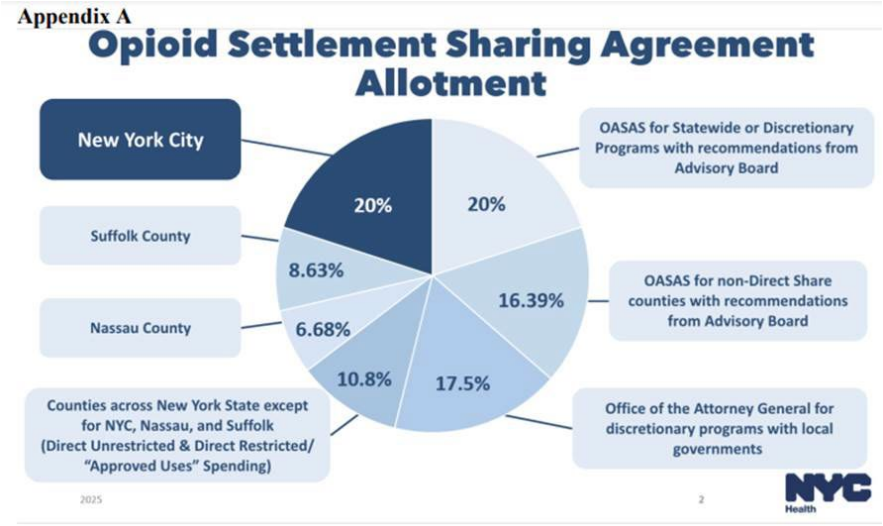
- Another consideration is evidence spoliation. By halting a prosecution without a plea, there is a significant risk that, should treatment be unsuccessful and the case is resumed months or more later, the prosecution will be significantly damaged by delay. Witness memories, DNA evidence, surveillance videos, and more can all fade or expire. Even in cases where evidence is gathered, there are collateral concerns such as proper storage and even storage costs for halted prosecutions.

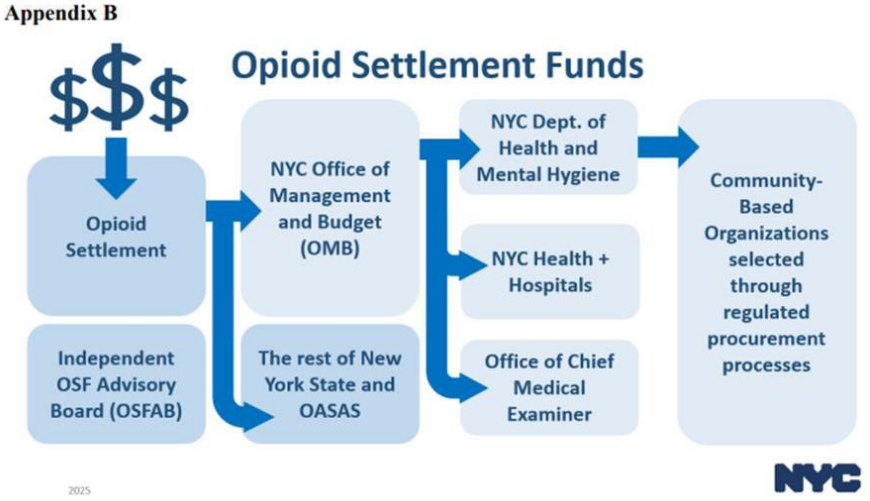
- Another factor not considered is witness and victim cooperation. Should a victim feel a prolonged course of treatment is already an injustice, there is a risk that they will be uncooperative during such a delay, further stymying a court case.

The Treatment Not Jail Act would expand alternatives to incarceration for people with mental health needs, intellectual disabilities, and a host of other clinically defined "functional impairments." While we support the expansion of diversion opportunities, we propose that serious consideration be given to ensure: adequate funding and appropriate staffing for diversion efforts, that behavioral health resources exist in communities, and that direct practice staff receive clinical support. These concerns are not hypothetical in nature. One need only turn to our Youth Parts and Family Court to see what the practical effect of such an unfunded mandate. In March of 2024, a group of nearly one hundred organizations, including legal and social services providers throughout New York, Majority Leader Andrea Stewart Cousins, and Assembly Speaker Carl Heastie sent a letter to Governor Hochul in which they said, "Despite . . . significant progress, New York State has failed to fully deliver on its promise to fund community-based services and programs that provide alternatives to incarceration and reentry programs for young people under 'Raise the Age.' " New York residents cannot be asked to further endure the consequences of unfunded programming, especially in light of TNJA's broadened scope to include any crime, regardless of classification, be it violent felonies up to and including homicide.

Appendix B
January 28, 2025 New York City Council Committee on Mental Health, Disabilities and Addiction Oversight Hearing on Allocation of Opioid Settlement Funds in New York City

On January 28, 2025, New York City Council's Committee on Mental Health, Disabilities and Addiction conducted an oversight hearing entitled "Oversight: Examining New York City Opioid Settlement Fund Investments."[166] Testimony by Dr. Rebecca Linn-Walton from the NYC Department of Health and Mental Hygiene (the Health Department) discussed how the Health Department is utilizing the opioid settlement funds and included graphics showing the distribution of funds and the flow of opioid settlement funds to New York City (see below).[167]





[166] NYC Dep't of Health & Mental Hygiene, Testimony of Rebecca Linn-Walton, Ass't Comm'r, *Oversight: Examining New York City Opioid Settlement Fund Investments*, Jan. 28, 2025, nyc.gov/assets/doh/downloads/pdf/public/testi/testi-20250129-opioid-settlement.pdf.
[167] *Id.*.

In her testimony, Dr. Linn-Walton also summarized Health Department programs supported by the opioid settlement funds:

> Beginning in Fiscal Year 2023, the Health Department utilized $8.6 million in opioid settlement funding to expand wrap-around services and hours at existing syringe services programs to strengthen care connections and increase hours and support community naloxone distribution. As part of the City's phased released of opioid settlement funding, the Health Department's total allocation will scale up to $23.7 million annually beginning in Fiscal Year 2026. . . .
>
> Starting in Fiscal Year 2026, the Health Department will use $4.1 million to expand wrap around services at all 14 Syringe Service Providers. One million will be used to expand the Relay program to two additional emergency departments, which will bring the total number to 17 emergency rooms city-wide. Three million will improve and expand substance use service provision on Staten Island through partnerships with 8 community-based organizations across prevention, harm reduction, treatment, and recovery services.
>
> Additionally, four million will be allocated to expand Methadone and Buprenorphine treatment programs, and three million to expand recovery supports. The vast majority of funds will be directed to community-based organizations selected through a regulated procurement process.[168]

Testimony from Ann Marie Foster, CEO and President of Phoenix House New York and Long Island, highlighted that community-based organizations, such as Phoenix House, have encountered barriers to accessing opioid settlement fund money with many of these organizations receiving zero dollars to date.[169] She discussed the possibility of using opioid settlement funds for capital investments, to address the fragmentation in services, and to expand comprehensive public awareness campaigns. She also emphasized the need for innovative and creative strategies for utilization of settlement funds in order to reach and help vulnerable communities.

---

[168] *Id.* at 2.

[169] *Testimony by Ann-Marie Foster, President and CEO of Phoenix House*, citymeetings.nyc, Jan. 28, 2025, https://citymeetings.nyc/city-council/2025-01-28-0100-pm-committee-on-mental-health-disabilities-and-addiction/chapter/testimony-by-ann-marie-foster-president-and-ceo-of-phoenix-house.

Appendix C
Task Force on Opioid Addiction

Task Force Members

Mary Beth Quaranta Morrissey, Esq., PhD, MPH, Task Force Chair[170]

Bridget G. Brennan, Esq., Special Narcotics Prosecutor

Heather Butts, Esq., Assistant Professor of Health Policy and Management, Columbia University Mailman School of Public Health

Jonathan D. Cohn, Esq., Partner, Gerstenzang, Sills, Cohn & Gerstenzang

David Condliffe, Esq., Executive Director, Center for Community Alternatives, Inc.

Margaret Davino, Esq., Partner, Fox Rothschild, LLP

Hon. Susan Eagan, Erie County Court Judge

Nigel I. Farinha, Esq., Chief Diversity, Equity & Inclusion Officer, Office of the Special Narcotics Prosecutor

Eric Gonzalez, Esq., Brooklyn District Attorney

Hon. Shannon M. Heneghan, Presiding Judge of the Opioid Intervention Court, the Adolescent Diversion Program and the U-CAN Court, Buffalo City Court

David Heslin, Esq., Bureau Chief - Drug Treatment, Brooklyn District Attorney

Robert Kent, Esq., President, Kent Strategic Advisors, LLC

Dana Levin, Esq., Principal Law Clerk to Hon. Ellen N. Biben, New York County Supreme Court – Criminal Term

Giulia Marino, Esq., Partner, Marino & Marino, P.C.

[170] Mary Beth Quaranta Morrissey, Esq., PhD, MPH, is a healthcare attorney and health and gerontological researcher; Immediate Past Social Welfare Policy PhD Program Director, Yeshiva University Wurzweiler School of Social Work; Founder and President, Collaborative for Palliative Care, White Plains, New York, and Director, Collaborative for Palliative Care Interdisciplinary Aging, Public Health and Palliative Care Certificate Program; Immediate Past Chair, New York State Bar Association (NYSBA) Health Law Section; Member, NYSBA Elder Law Section, and NYSBA Disabilities Rights Committee; CLE Chair, NYSBA Sections Caucus; Former Delegate, NYSBA House of Delegates; Past Chair, NYSBA Medical Aid in Dying Task Force; and Past Chair, NYSBA Mandatory Vaccination Task Force.

Julia Markov, Science Specialist, Philips Lytle LLP

Leah Rene Nowotarski, Esq., Wyoming County Public Defender

Lisa Smith, Esq., Partner, Philips Lytle

Andrew Warshawer, Esq., New York County District Attorney's Office

Karl G. Williams, J.D., Professor of Pharmacy Ethics & Law, Wegmans School of Pharmacy/St. John Fisher University

Task Force Advisors

Kamilah Archibald-Goins, Resource Coordinator III, Superior Criminal Courts, C.O.U.R.T.S. Program

Kristy Aristy, PhD, Yeshiva University Wurzweiler School of Social Work

Hon. Ellen N. Biben, New York County Supreme County - Criminal Terms

Alvin Bragg, Esq., New York County District Attorney's Office

Ann-Marie Foster, President and CEO, Phoenix House NY | LI

Nicole Keary, Esq., Deputy Attorney General, Statewide Organized Crime Task Force

Mike Klein, Urban Strategies

Joshua Lynch, M.D., University of Buffalo Jacobs School of Medicine and Biomedical Sciences

Susan McCafferty, Statewide Opioid Court Project Director, UCS Office for Justice Initiatives, Division of Policy & Planning

Michael E. McMahon, Esq., Richmond County District Attorney

Kenneth J. Murphy, Esq., Office of the Rockland County Public Defender

Ruth O'Sullivan, Senior Director of Clinical Practice, Center for Justice Innovation

Timothy Pezzoli, Esq., Legislative Counsel & Deputy Bureau Chief of Appeals, Richmond County District Attorney's Office

NYSBA Staff

Alexander Dickson

NYSBA Staff Liaison

Moe Whitcomb, NYSBA Assistant to the Executive Offices

Appendix D
Acknowledgments

The Task Force acknowledges and thanks the following individuals who appeared before the Task Force:

Amy Jane "A.J." Agnew, Law Office of Amy J. Agnew, P.C.

Kristy Aristy, PhD., Master Counselor CASAC-G., Adjunct Professor, Yeshiva University Wurzweiler School of Social Work

Thomas V. Caprio, M.D., MPH, Professor of Medicine/Geriatrics; Chief Medical Officer, Home Care & Hospice; University of Rochester Medical Center.

Brian Feldman, Esq., Partner, Aurelian Law PLLC

Michael Gamberg, Assistant District Attorney, Staten Island District Attorney's Office.

Robert Horne, Esq., Managing Attorney, Regional Immigration Assistance Center

Mike Klein, President and CEO of Urban Strategies

Regina LaBelle, JD, Director, Center on Addiction and Public Policy at the O'Neill Institute for National and Global Health Law at Georgetown University Law Center

Joshua Lynch, DO, Professor of Addiction and Emergency Medicine, University of Buffalo Jacobs School of Medicine

Julia M. Markov, PharmD, Science Specialist, Phillips Lytle, LLP

Ruth O'Sullivan, LCSW, Senior Director of Clinical Practice, Center for Justice Innovation.

Kamilah M. Archibald-Goins, Resource Coordinator III, Superior Criminal Court - C.O.U.R.T.S Program

Karl G. Williams, JD, MBA, BS, Director of Legislative Advocacy at the University of Buffalo School of Pharmacy and Inaugural Sciences and Clinical Professor of Pharmacy Practice.

Appendix E
Oral History Interview with Ann-Marie Foster,
President and CEO of Phoenix House and Task Force Advisor

00:10:53.410 --> 00:11:00.129
mmorris4: I just want to confirm that you're you've agreed to the consent that I had sent over.

00:11:00.270 --> 00:11:03.009
Ann Foster: Yes, except for the last paragraph, I believe.

00:11:03.010 --> 00:11:06.060
mmorris4: If you would just cross that out, sign it and send it back to us.

00:11:06.360 --> 00:11:07.150
Ann Foster: Okay. Will do.

00:11:07.150 --> 00:11:14.019
mmorris4: Would be great. But we're in agreement, and if I may just start out by clarifying

00:11:14.720 --> 00:11:17.800
mmorris4: Ann Marie beyond the actual document

00:11:18.070 --> 00:11:25.260
mmorris4: that once we finish up today, we'll make the recording available to you. Yes, Moe.

00:11:26.030 --> 00:11:27.170
Ann Foster: Yes, and you.

00:11:27.170 --> 00:11:38.830
mmorris4: Can review it, and you can decide. If you want us, we'll all review it to see if we're all comfortable about releasing it, but we don't have to. We can rely upon my write up.

00:11:39.210 --> 00:11:39.880
Ann Foster: Okay.

00:11:39.880 --> 00:11:47.320
mmorris4: It depends upon how it goes, what may come out, but I don't want you to feel as if we're obligating you right now.

00:11:47.820 --> 00:11:49.779
mmorris4: To the release of the recording.

00:11:50.180 --> 00:11:50.960
Ann Foster: Okay.

00:11:51.200 --> 00:11:54.720
mmorris4: Well, so we can decide after you have a chance to look at it.

00:11:54.990 --> 00:11:58.600
Ann Foster: Alright, and when you say the release of the recording, where, where would it be released?

00:11:58.600 --> 00:12:00.540
mmorris4: Well to the task force.

00:12:00.660 --> 00:12:02.729
Ann Foster: Oh, okay, okay. To the.

00:12:02.730 --> 00:12:03.730
mmorris4: Task, force.

00:12:03.730 --> 00:12:04.720
Ann Foster: Sure, sure.

00:12:04.720 --> 00:12:11.939
mmorris4: And then again, we don't have to publish it beyond that. But let me start by saying,

00:12:12.400 --> 00:12:21.529
mmorris4: 1st of all, let me identify myself with the recording and you and Moe. Should probably do the same. I'm Mary Beth Morrissey.

00:12:22.120 --> 00:12:25.969
mmorris4: I'm chair of the New York State Bar Association, opioid task force.

00:12:26.320 --> 00:12:36.059
mmorris4: and I want to welcome you, Ann Marie, to join us for joining us this morning. And please introduce yourself.

00:12:36.430 --> 00:12:43.010
Ann Foster: Thank you, Mary Beth, so I'm Ann Marie Foster. I'm the President and CEO of Phoenix House of New York and Long Island.

00:12:44.170 --> 00:12:50.180
mmorris4: And would you speak just for a moment to your role on the task force.

00:12:50.720 --> 00:13:07.089
Ann Foster: Yes, I am one of a few treatment providers on the task force, and it's been an opportunity to be able to represent the field as best as I possibly can. As it relates to substance use, and mental health disorders in our community.

00:13:08.080 --> 00:13:13.049
mmorris4: Excellent. Thank you so much, Ann Marie and Moe, would you introduce yourself.

00:13:13.400 --> 00:13:24.389

Moe Whitcomb (NYSBA): Sure I'm Moe Whitcomb. I am an executive assistant at the New York State Bar Association, and I'm also the staff liaison for the task force on opioid addiction.

00:13:25.370 --> 00:13:29.300
mmorris4: Thank you so much, Moe. We're grateful for your time and support this morning.

00:13:29.770 --> 00:13:41.859
mmorris4: So, Ann Marie, just to go back. I should also add, for the record that I am a researcher and a qualitative researcher. And what we're planning to do today is in the nature of an oral history

00:13:42.060 --> 00:13:59.329
mmorris4: and oral histories are exempt from the Federal regulations, so we don't have to seek an IRB approval, because our goal is to use it just as your story and testimony. We're not looking to generalize knowledge in any way.

00:13:59.500 --> 00:14:02.389
Ann Foster: So that's consistent with the Federal regulations.

00:14:02.770 --> 00:14:03.600
Ann Foster: Awesome.

00:14:03.600 --> 00:14:17.499
mmorris4: Do you have any questions about what we're doing in terms of the process? I'll be asking you some open-ended questions, looking forward to your responses, and of course you can jump in at any time and add anything that you'd like.

00:14:17.860 --> 00:14:19.330
Ann Foster: Sure, understood.

00:14:19.330 --> 00:14:30.782
mmorris4: And one of the goals from my perspective, is, as I may have mentioned to you, I think your colleagues, our colleagues view you as the glue.

00:14:31.130 --> 00:14:31.730
Ann Foster: So.

00:14:31.730 --> 00:14:41.280
mmorris4: On the task force because of your immense knowledge, background, history, and work, as well as your reputation in the field

00:14:41.390 --> 00:14:52.419
mmorris4: and as a change agent, and so I think that will be powerful in terms of helping to bring all the different pieces of our report together. That's my hope.

00:14:52.650 --> 00:14:54.570
Ann Foster: Thank you. I believe that. Yes.

00:14:54.890 --> 00:15:06.550
mmorris4: All right. Excellent. So if you wouldn't mind starting out by telling us a little bit about how you first became involved in this important work that you're doing. Even before Phoenix House.

00:15:07.480 --> 00:15:34.020
Ann Foster: Awesome. Well I often tell my story that it starts from my own personal experience. I remember when I first came to Phoenix House, my board chairman says no one really knows you in the field, and so people got to get to know you, and we need you to be a little bit more forward facing my head was kind of down doing the day-to-day operations, and when I thought about it when he said that to me it just took me back to that 8 year old girl

00:15:34.050 --> 00:15:39.890
Ann Foster: who at the time I lost my mother to gun violence randomly.

00:15:39.970 --> 00:15:50.939
Ann Foster: and I was the oldest of my siblings. A sister who was 5, and my brother was like 16 months at the time when she passed away, and she was only 27 years old.

00:15:50.940 --> 00:15:52.050
mmorris4: Oh, my gosh!

00:15:52.050 --> 00:15:54.457
Ann Foster: But I can remember

00:15:55.160 --> 00:16:05.610
Ann Foster: her being in Kings County Hospital. I can remember the nurses breaking the rules to let my Mom's kids come up to the ICU to see her

00:16:06.035 --> 00:16:18.089
Ann Foster: and that the nurses in the healthcare team ended up becoming like family, because I had an aunt who was right behind my mom, who was getting married. Shortly thereafter she subsequently passed away.

00:16:18.340 --> 00:16:22.899
Ann Foster: She had been in the hospital for 6 months from a gunshot wound. Today. People.

00:16:28.100 --> 00:16:35.290
Ann Foster: And so I bring that story up because I just have vivid memories of being in the hospital, of being around people

00:16:35.440 --> 00:16:54.209
Ann Foster: who were caring for her and felt like, that's what I wanted to do. I wanted to be in healthcare. I wanted to help people to make a difference, and I remember my first big word that I learned was that my mom didn't actually die from the gunshot wound. She died from a nosocomial infection.

00:16:55.520 --> 00:17:20.829
Ann Foster: And so she. Again she was shot in April and died in October, and I was about to say that today, if someone gets shot sometime depending on where they get shot. They get stitched up, and probably out the next day. Kind of thing. But this was in the seventies and late seventies. And so, as I continued on with my studies, and, working. And my first job was back at the city hospital system, the very system

00:17:20.849 --> 00:17:34.670
Ann Foster: I was born in, and that my mom died in. And I've always believed that individuals who come from the community who understand the community are some of the

00:17:35.870 --> 00:17:48.559
Ann Foster: Some of the folks that are able to make some of these changes that are necessary in the community and are able to speak to the community with a culturally sensitive way about them. And so

00:17:48.720 --> 00:18:00.270
Ann Foster: that was my journey to healthcare and another just really quick story to before I landed at H and H, I worked for a managed care company. At the time was HIP.

00:18:00.440 --> 00:18:24.280
Ann Foster: That was my first job out of school, and the woman who was the administrator was beautiful. She was just. She used to walk around very nice suits and very professional, and tell all the doctors and nurses and folks what to do. And I remember, just talking to her, saying,
Hey, this is kind of what I want to do. And she said, Listen, if we get it right with women's health, and that's another passion of mine.

00:18:24.612 --> 00:18:32.429
Ann Foster: Then you get the whole family, because the women are the decision makers. And so I worked in women's health at the time, and I was just 21 years old

00:18:33.620 --> 00:18:45.750
Ann Foster: and I started there in women's health, and I always remember her saying that if we get it right for the women, then we get the whole family, and we're able to improve outcomes. And so from that

00:18:45.780 --> 00:19:10.319
Ann Foster: I moved into health and hospitals and worked at the Mecca. I like to call Bellevue Hospital in terms of psychiatry and child, and adolescent, and just saw it all. Just saw it all during my 7 years that I was there. And that's what ultimately led me to Phoenix House to go specifically to deal with individuals who struggle with substance use, and mental health, disorder.

00:19:11.140 --> 00:19:17.499
mmorris4: Well, first of all, I want to express my, still, my deepest condolences to you all these years later on losing [your mom]

00:19:18.550 --> 00:19:24.399
mmorris4: an early age. Yeah, but she certainly must be looking down, and so proud of you.

00:19:24.720 --> 00:19:25.310
Ann Foster: I believe so.

00:19:25.310 --> 00:19:32.420
mmorris4: The leader you have become in our communities here in New York City and beyond. So

00:19:32.590 --> 00:19:51.279
mmorris4: that's why we are taking time to learn more about your experience, because, of course, it's very meaningful and relevant for everybody who's working on these very intransigent issues and not easy to change, in other words, not easily subject to a change process.

00:19:51.280 --> 00:19:51.810
Ann Foster: Right.

00:19:51.810 --> 00:20:07.559
mmorris4: So, Ann Marie, would you tell me a little bit about what you where you ended up in terms of your schooling? And I'm sorry that I don't know the answer. But are you a social worker? How would you frame the field that you're in?

00:20:07.840 --> 00:20:17.639
Ann Foster: So it's interesting. So I am not a social worker. I'm not a nurse, I'm not a physician. I will say I am a healthcare executive.

00:20:17.640 --> 00:20:40.460
Ann Foster: I am a policy maker and changer. And so my schooling from High school here in Brooklyn upstate New York to Utica college of Syracuse University with undergrad degree in biology. There was a time again when I shared that early story, that oh, I'm going to be a doctor and save the world. And that's a whole other story

00:20:40.460 --> 00:20:52.980
Ann Foster: about how people who look like me are not necessarily supported. To go into that field. I definitely had those conversations when I was an undergrad like you should think about doing something else.

00:20:52.980 --> 00:21:11.900
Ann Foster: And so there is a story behind that I almost made my way to Meharry Medical School, and then I came home, and I had a wonderful grandmother who passed away 3 years ago, and I thought my world was over when I wasn't able to get to medical school.

00:21:11.900 --> 00:21:13.799
mmorris4: And what was your grandmother's name? Ann Marie.

00:21:13.800 --> 00:21:30.252
Ann Foster: Josephine, Josephine Ellis, Josephine Ellis! Oh, my God! Again taking up the

mantle when her daughter passed away, my mother, she ended up raising my me and my 2 siblings. So grandmother then became caregiver, and

00:21:30.710 --> 00:21:43.969
Ann Foster: she passed away 3 years, 2021, 4 years ago, almost 4 years ago. But I remember her telling me your life is not over. God has a plan right? And you need to figure that out.

00:21:44.090 --> 00:22:08.218
Ann Foster: And so that's when I started working at the HIP center. And then I went into New York City health and hospitals. As a mid-level manager and in the Infection control department, and then I moved into the Medicine Department. Working for medicine administration, for the New York City health and hospitals and

00:22:08.740 --> 00:22:22.099
Ann Foster: wanting to move up, wanting to grow in the field, but needing realized that I needed to go back to school. And so I ended up going to Baruch College, and I did my master's there in public administration, and had some.

00:22:22.657 --> 00:22:24.329
mmorris4: Great college, great.

00:22:24.330 --> 00:22:24.800
Ann Foster: Absolutely.

00:22:25.500 --> 00:22:42.129
Ann Foster: who knew that was a former deputy mayor, was one of the individuals who was leading the program. I remember her finally, a woman named Barbara Fife. She used to be, I think, the deputy mayor under Dinkins at the time. Gail Brewer, who's still around? Who is the city council member.

00:22:42.130 --> 00:22:42.680
mmorris4: Sure.

00:22:42.680 --> 00:22:52.279
Ann Foster: He was one of our professors at the time. So just, a wealth of knowledge and information as it relates to public policy right here in New York.

00:22:52.280 --> 00:23:03.400
mmorris4: Sure. Sure. Well, that's such an inspiring narrative, Ann Marie. And we've seen that, of course, in all our conversations and dialogues with you and our colleagues on the task force.

00:23:03.400 --> 00:23:03.900
mmorris4: Okay?

00:23:03.900 --> 00:23:20.700
mmorris4: And you really helped us understand more deeply what the issues are at stake in this work we're doing on the task force, and if you don't mind, I'd like to spend a little time on

that, because I think it would be helpful to our audiences as we write up the Task Force report.

00:23:20.840 --> 00:23:39.469
mmorris4: Would you share a little bit with us on how you frame the problem of substance use, and addiction. I know you're also very mindful of language. So and social determinants of health. So not just what occurs at the individual level.

00:23:39.800 --> 00:23:40.300
Ann Foster: Sure.

00:23:40.300 --> 00:23:44.529
mmorris4: The environment. So please share with us a little bit on that.

00:23:45.050 --> 00:23:54.450
Ann Foster: So, for me. And it's similar to this, how I even started this conversation with you, Mary Beth, is that everyone has story right? And this problem

00:23:54.450 --> 00:24:19.159
Ann Foster: of addiction and mental health disorders. It all starts with a story I like to say. And again, I take this from my healthcare experience, and I'm blanking right now, and there was a whole movement like people don't wake up in the morning and say, what I'm going to go out

there and commit harm to someone, or I'm going to do that. I mean, it might be a small segment of the population that does that. But there are

00:24:19.680 --> 00:24:40.459
Ann Foster: circumstances and things that come across the individual's life. And, again, using my own self as an example. I know when I share my story to people they were like, Wow! I remember a mentor way back when I shared my story, and how I was raised and lost my mom. And they were like.

00:24:41.040 --> 00:24:50.640
Ann Foster: but you're okay, like, Oh, my God, you should have been this, that. Or this should have happened to you, or maybe you should have went to jail. And so what you realize is that

00:24:50.850 --> 00:25:02.330
Ann Foster: if we don't intervene in people's lives to address some of the challenges that folks are experiencing as they navigate this thing called life.

00:25:02.570 --> 00:25:17.759
Ann Foster: Then what do we expect, as it relates to mental health issues. What do we expect, as it relates to folks seeking out substances to numb the pain that individuals have gone through, and so I like to see that I believe that

00:25:18.290 --> 00:25:19.760
Ann Foster: everyone has a
00:25:20.000 --> 00:25:35.000

Ann Foster: should have the opportunity to recover from whatever the substances or the mental health issue that they might be dealing with, and so, and that there's no one solution

00:25:35.820 --> 00:25:38.549
Ann Foster: to that recovery journey.

00:25:38.740 --> 00:25:39.150
mmorris4: And.

00:25:39.150 --> 00:26:04.720
Ann Foster: I've heard stories of people who were incarcerated, someone who is near and dear. She worked for me for many years. She tells the story that she was one of the folks that we see in the movie American gangster, with Bra and Panty and dealing cocaine and doing all of that in Harlem, and she goes to

00:26:05.260 --> 00:26:06.730
Ann Foster: Rikers Island.

00:26:07.100 --> 00:26:32.890
Ann Foster: and she's facing time, and she says she remembers just walking in the yard, and the light was just so bright from the sunlight, and she says that it's as if God spoke to her and said, I'm gonna give you one more chance. This is it. One more chance? And she tells the
story. She goes before the judge, and they offer her treatment, and she goes to a place called Odyssey House. Well, that's not Phoenix House, but she goes to Odyssey House.

00:26:32.890 --> 00:26:33.360
mmorris4: Sure.

00:26:33.360 --> 00:27:03.060
Ann Foster: She does her treatment there, and from there she's offered an opportunity to start working well. Part of that working ended her up working for me at a New York City health and hospital, and when I tell you she was one of the best assistants I ever had while working there, and I had no idea that this was her story. But what came together? You had a court system who was willing to give this individual treatment. You had your own. The person had her own

00:27:03.940 --> 00:27:08.889
Ann Foster: Self-reflection, Conversation with her. God.

00:27:09.140 --> 00:27:10.030
mmorris4: And then.

00:27:10.300 --> 00:27:26.470
Ann Foster: And met the opportunity, and the rest is history. This woman is married, she has children, she has grandchildren, she works in her church, and there's a redemption story that can be told with many individuals who struggle
00:27:26.640 --> 00:27:31.930
Ann Foster: if we see them, and if we choose to give them the opportunity to recover.

00:27:32.300 --> 00:27:53.679
mmorris4: Sure that's such a. Again a meaningful narrative. And I'm thinking about what you said, and reflecting on it as we're talking. I also hear what you're saying about the meaning and value of work and the opportunity to work. Would you? Would you say a little bit more about that, and how you've seen that play out in people's lives.

00:27:53.840 --> 00:28:06.309
Ann Foster: It is so important. I remember someone said to me, why don't you use? Why don't you use if I even said that to you, Mary Beth, why don't you use? Why don't you use.

00:28:06.750 --> 00:28:07.370
Ann Foster: But.

00:28:07.370 --> 00:28:08.069
mmorris4: We haven't.

00:28:08.070 --> 00:28:18.939
Ann Foster: For work. We have connections. We have a family right? All of these things are things that individuals who do struggle with addiction and mental health. They want it for themselves as well, and so.

00:28:18.940 --> 00:28:19.700
mmorris4: Oh!

00:28:19.700 --> 00:28:26.009
Ann Foster: Definitely a Phoenix house is something that we stress is part of the process that

00:28:26.430 --> 00:28:50.060
Ann Foster: When an individual is ready to work, we either are sending them out on job interviews. We're working with them to get them back into school. We're working to help them get reconnected with family. We seek out internships for our clients. We seek out opportunities for careers that they never thought of like. Right now one of the hottest films that are out there is Sing Sing.

00:28:50.140 --> 00:28:54.380
Ann Foster: and it talks about. This is the whole acting

00:28:54.890 --> 00:29:16.800
Ann Foster: programs that are inside the State Prison. I believe it's called. I want to say, RTA, but don't quote me on that. But what's powerful about that is that we have something very similar. We have acting in our treatment programs with an organization called Stella Adler.
They have a specific criminal justice acting program. And so you come into treatment

00:29:16.920 --> 00:29:34.599
Ann Foster: and you're able to tap into things that you didn't get when you were in high school, or you didn't get when you were in middle school, and there might have been something inside of

you that felt like you wanted to be an actor, and here you are presented with this opportunity. Now you're writing a script, and you're acting it out.

00:29:34.730 --> 00:29:59.459
Ann Foster: and you're finding a passion that you never knew that you had. We've had folks go on to do extra work in movies in New York City and law and order, and I gotta tell you I can invite you, Mary Beth. They do their shows. I remember the 1st time I saw a show at Phoenix House. I couldn't tell who was the professional actor versus who was the person that was in our room.

00:29:59.460 --> 00:30:00.340
mmorris4: Sure.

00:30:00.540 --> 00:30:14.020
Ann Foster: Because they opened up something inside of them. So work and interning and going back to school are all part of the supports that individuals need as they're on this recovery journey.

00:30:14.370 --> 00:30:28.829
mmorris4: Right? Right? This is your language, and what you're sharing with us just is helping to make sense of all of this for us, which is what I knew would come out of our conversations.

00:30:28.840 --> 00:30:48.699
mmorris4: Would you? Would you mind, Ann Marie, taking a few minutes at this point, since you've described so beautifully some of the interventions and strategies that Phoenix House is employing with all of the different people you serve from so many diverse communities. Could you tell us a little bit about the diversity of the programs you have? I know that it's a big

00:30:48.720 --> 00:30:50.290
mmorris4: operation.

00:30:50.640 --> 00:30:54.840
Ann Foster: And yeah, tell us a little bit about what those programs look like.

00:30:55.190 --> 00:31:02.450
mmorris4: And how are you evaluating the impact of the programs? You as the leader.

00:31:02.600 --> 00:31:16.130
Ann Foster: Yes, so it's a struggle. And when I joined Phoenix House it was very different from where it was many, many years ago. Phoenix House was one of the largest at the time, well, over a thousand beds

00:31:16.130 --> 00:31:39.650
Ann Foster: they had in their operation, and when I arrive we're down to about 400 plus beds. So that's a different conversation, as it relates to the state and funding and the closure of residential treatment beds. And probably more. So a push towards outpatient. But we have
what's called residential treatment programs. We have 4,

00:31:39.670 --> 00:31:49.690
Ann Foster: one in New York City in Queens in particular, and the other 3 are out in Suffolk County, we're the largest provider of beds in Suffolk County there.

00:31:50.293 --> 00:32:17.850
Ann Foster: We also have outpatient treatment programs again, one in New York City and one out in Long Island as well, and we have what's called community residences. These are where our individuals who have SMI – serious mental illness. They live with us for long periods of time. We have one in queens, and we also have one in Long Island, and we also to kind of round out, for we have a recovery center in Brooklyn.

00:32:18.406 --> 00:32:25.480
Ann Foster: and the recovery center is a very special place we have. We should have recovery centers all across. The State

00:32:25.620 --> 00:32:33.780
Ann Foster: and the country for that, for that matter. It's a free peer driven recovery program

00:32:33.780 --> 00:33:02.309
Ann Foster: that anyone can access it. I love it because, and my team likes to say it's like the lowest threshold of accessing our system. You don't need to have an insurance card. You don't even need to have an Id card. And so what we found is that, as we have New Yorkers coming in, they'll just stop at our door and want to ask questions, or pick up a Narcan or pick up some Fentanyl test strips, or try to get connected to how to get the New York City Id.

00:33:02.310 --> 00:33:16.449
Ann Foster: Again. It's a place that people could just walk in and and get access to services, and that they're connected. And most of the individuals who work there are individuals who are in recovery themselves. And so again, they have

00:33:16.450 --> 00:33:34.339
Ann Foster: again a unique story to be able to reach individuals who are seeking services there. So that's our programming, residential, outpatient recovery center. And we are moving into. And I'm very excited about this later this month we should be opening our 1st clubhouse.

00:33:34.520 --> 00:33:39.580

mmorris4: Oh, great! And that would be another step in this continuum of care.

00:33:39.760 --> 00:33:40.320
Ann Foster: It just.

00:33:40.320 --> 00:33:40.790
mmorris4: Sound, good.

00:33:40.790 --> 00:33:41.739
Ann Foster: And what you think

00:33:41.740 --> 00:33:49.389
Ann Foster: little bit, outside of it, it's mostly you have to have a mental health diagnosis. I see?

00:33:49.971 --> 00:33:55.756
Ann Foster: And again, it is a program where it's a social

00:33:56.610 --> 00:34:19.800
Ann Foster: place for individuals who struggle with mental health that they have a place to go to work and work on their goals and things that they want. Everyone is familiar with Fountain House, and so they have been working with us as we bring up our 1st clubhouse in the Harlem community, and we are super excited about being able to stand that program up in Harlem.

00:34:20.210 --> 00:34:21.800
mmorris4: Well, congratulations!

00:34:21.800 --> 00:34:22.580
Ann Foster: Thank you.

00:34:22.580 --> 00:34:30.299
mmorris4: That's wonderful. And would you? Would you tell us a little bit, Ann Marie, about

00:34:30.896 --> 00:34:45.579
mmorris4: Given all the challenges that of course, we've discussed for so many months in the task force. And, of course, what from your own experience and life history of, doing this work.

00:34:45.739 --> 00:34:57.919
mmorris4: the enormous challenges. How do you folks? You and your team at Phoenix House evaluate? How the programs are doing. If you understand what I'm saying. I mean, what? What are we looking at?

00:34:58.330 --> 00:35:01.559
mmorris4: Because I would think that it's a challenge to to.

00:35:01.560 --> 00:35:01.930
Ann Foster: It is.

00:35:01.930 --> 00:35:03.450
mmorris4: Engage in that process.

\00:35:03.660 --> 00:35:19.512
Ann Foster: It is. We tons of metrics, tons of data, sometimes not very coherent, hard to pull it. But we all have, and most of our programs have a quality division in our programs. And so they're constantly reviewing.

00:35:19.930 --> 00:35:34.270
Ann Foster: The treatment fidelity like, are we doing what we say? We're going to do and what

are the outcomes? And so, if we talk broad numbers, one of the biggest is in terms of completion of treatment goals. An individual will come in

00:35:34.270 --> 00:35:55.250
Ann Foster: and say, These are the goals that they'd like to set for themselves, and they work it out with their counselors. And so after a period of time, we're evaluating. How successful are they with completing treatment goals again. And we've really adopted over the years at Phoenix House a Harm. Reduction. Approach to treatment.

00:35:55.250 --> 00:35:55.760
mmorris4: And.

00:35:56.128 --> 00:36:05.699
Ann Foster: At one time Phoenix House was very much an abstinence based program. And so one had to completely stop using all substances and realize that

00:36:05.720 --> 00:36:35.189
Ann Foster: again, as I started out by saying, there are some people that will work for, and they'll never touch a drink again, or they'll never use heroin again, and there are other people.
Well, I was using 4 bags, and I'm down to one bag, and we need to celebrate that individual going down to one bag. And so that's part of the chart review process that our quality teams are looking at. And I can share that about 45% of the individuals who come into our treatment program successfully complete.

00:36:35.547 --> 00:36:43.320
Ann Foster: The program. We would love to see that number much higher, but we know that relapse is part of the journey, and so.

00:36:43.320 --> 00:36:53.139
mmorris4: Absolutely. I was just going to say that this is not. What you typically see in in terms of health, healthcare and healthcare outcomes. It's very, very different.

00:36:53.460 --> 00:37:06.210
Ann Foster: Absolutely. The other is that individuals who struggle with substance use, and that number, and I believe, is the same die about 25 years younger than the average population.

00:37:06.710 --> 00:37:17.479
Ann Foster: and it may not all necessarily be related to their substance use, but it could also be because of the lack of care and attention to their medical.

00:37:17.490 --> 00:37:44.459
Ann Foster: And so one of the things we are pleased that we do, and we're in partnership with FQHC [Federally Qualified Health Center]. Is that we work with our medical providers to make sure individuals are paying attention to BMI, paying attention to their a 1 Cs, going to see the

gynecologist and taking care of that side that they were not taking care of going to the dentist. We have dental care and dental vans that show up at our programs, because again.

00:37:44.540 --> 00:38:01.899
Ann Foster: when you are struggling with substance use, you are lockstep and focused on that and not taking care of the other medical side of you. And so when you come into treatment, we would like to say we embrace a holistic and wellness approach to your treatment. And so we're taking care of the medical.

00:38:02.040 --> 00:38:09.389
Ann Foster: And we get data from our FQHC partners to see how we're doing. And again, it's a struggle because we

00:38:09.490 --> 00:38:35.530
Ann Foster: not many programs. And we struggle with it as much as the support that we have from the internships that we have and relationship programs like NYU and Northwell, to have that medical care. So we can be monitoring individuals, BMI, that we can be monitoring their glucose levels and teaching people how to do their own finger sticks. Should they be diabetic things of that nature? But we're not necessarily funded to do all of those things.

00:38:35.530 --> 00:38:49.879
mmorris4: Of course. And also, we mentioned earlier the impact of the social determinants of health over which individuals have no control. And of course, probably better than any of us, that during the pandemic

00:38:50.552 --> 00:38:59.629
mmorris4: there was a big learning curve for folks in terms of understanding how social determinants of health play into people's lives.

00:38:59.630 --> 00:39:00.660
Ann Foster: Absolutely.

00:39:00.660 --> 00:39:09.849
mmorris4: And that brings us to the bigger umbrella of public health. And what I hear you talking about really are public health crises.

00:39:09.980 --> 00:39:22.130
Ann Foster: Absolutely. We don't want to say it out loud. I write and I talk about it. I heard someone say that Covid was the biggest public health crisis to us.

00:39:22.320 --> 00:39:45.729
Ann Foster: I would agree, but we always felt that we were in an epidemic during a pandemic like we were already suffering. The field was already suffering. We were woefully underfunded for decades, and so when this pandemic hit, it just blew the lid off of something that folks that have been in the substance use field for so many years knew.

00:39:45.920 --> 00:39:46.290
mmorris4: Type.

00:39:46.290 --> 00:40:00.900

Ann Foster: About being forgotten, the folks that were in treatment, that struggle with substance, use, and mental health completely forgotten, and I think where you were probably heading is. One of the things that we learned was that people didn't even have access to the Internet.

00:40:01.070 --> 00:40:08.450
mmorris4: Yes, yes, the digital inequities, digital inequities. We have some doctoral students working on those issues.

00:40:08.450 --> 00:40:33.120
Ann Foster: Absolutely, absolutely so. Just a plug for our recovery center. During that time we received funding, and we created something called a tele booth, and I like to tell people, I said. If you remember when Superman used to go into the telephone booth and spin around and come out. Well, it's a booth about that size, or some people call like a pod, and you can go to the recovery center and just get free access to a tablet or a laptop

00:40:33.120 --> 00:40:55.110
Ann Foster: and be able to join in on your Aa. Meeting, because during the pandemic we're all home. We have 5, 6 people living with us, maybe more. I don't need my Aa. Meeting, and so everybody in the house can hear that. That's what I'm doing. Or now you're telling me that your elderly grandmother has to go on zoom to talk to her, doctor. Well, what the hell is, Zoom? And how do I do that?

00:40:55.110 --> 00:41:07.969
Ann Foster: So you can go into the recovery center and just access book an appointment and go in and use one of the 2 telebooths that we have and be able to get on a laptop and and have your zoom doctors meeting.

00:41:08.150 --> 00:41:14.740
mmorris4: That's terrific. That's really terrific. You mentioned older people.

00:41:14.930 --> 00:41:31.320
mmorris4: and I know that there is a prevalence of substance use among older people, and I'm wondering if you could share a little bit about the populations and communities of older people. You may be serving. What does that look like? How do their needs differ?

00:41:31.880 --> 00:41:41.499
Ann Foster: Yes, we, I can tell you. That's an area that we need to do a much better job on. And the data definitely supports especially older black men

00:41:41.510 --> 00:42:08.250
Ann Foster: are dying at a faster rate in Harlem, in those communities, and I don't think we're doing enough of a job. Things like going out to nursing homes, really trying to connect with our veterans to make sure that they are aware of the deadly threats I was sharing with someone recently. And I sit on this biweekly task force with representatives from the Dea, and you keep hearing about people just don't

00:42:08.360 --> 00:42:13.849
Ann Foster: understand. If you are not getting medicines directly from the pharmacy.

00:42:14.030 --> 00:42:35.720
Ann Foster: You should be very afraid you shouldn't do it, because it's very likely that it might have Fentanyl in it. And when you talk about our elderly population, when resources are limited, and you're seeing these commercials on TV telling you, oh, you can buy, or maybe these ads that come up on your computer. You can buy your medicine here for 7 bucks.

00:42:35.720 --> 00:42:49.650
Ann Foster: You don't know where that's coming from, probably from China, and it probably has Fentanyl. And so our older population are very vulnerable to this crisis, and we definitely need to do a better job.

00:42:50.080 --> 00:42:56.529
Ann Foster: In Phoenix House. Our Median age is somewhere about 52 and mostly male.

00:42:56.540 --> 00:42:58.790
Ann Foster: We've talked about that in a different.

00:42:58.790 --> 00:43:00.010
mmorris4: Mostly male.

00:43:00.010 --> 00:43:00.880
Ann Foster: Mostly, male.

00:43:00.880 --> 00:43:04.189
mmorris4: What? What percentage? If you just could give us a rough idea.

00:43:04.190 --> 00:43:05.350
Ann Foster: About 70.

00:43:05.610 --> 00:43:06.560
mmorris4: Really.

00:43:06.560 --> 00:43:07.609
Ann Foster: Yeah. Mostly men.

00:43:07.610 --> 00:43:14.350
mmorris4: Amazing, amazing. And what? How do you account for that? Because it doesn't reflect what's really going on? I mean

00:43:14.620 --> 00:43:17.909
mmorris4: barriers for women accessing the services or.

00:43:17.910 --> 00:43:44.460

Ann Foster: Absolutely, absolutely. Women, how many hats do we wear? Right? Do we have to deal with? And are we raising our hand to tell anyone we need help. No, we're just pushing forward. We have kids to care for our parents to care for our that plays into it. I also think that there are not enough resources specifically for women. Beds that will accommodate women and children.

00:43:45.339 --> 00:43:58.929

Ann Foster: That's, I think, a concern. And again, when we deal with the courts, or fear that our children might be taken away from us if we buy as someone who's struggling with addiction or mental health, and so.

00:43:58.930 --> 00:44:02.370
mmorris4: Issue big issue that we deal with in social welfare.

00:44:02.550 --> 00:44:13.099
Ann Foster: Absolutely, absolutely. So. I think that's another population that we could do a much better job in trying to outreach and support women who struggle with addiction.

00:44:13.250 --> 00:44:16.999
mmorris4: And I know we've also talked about women who are pregnant.

00:44:17.280 --> 00:44:17.750
Ann Foster: Yes.

00:44:17.750 --> 00:44:21.929
mmorris4: You're also seeing that community.

00:44:22.120 --> 00:44:40.280
Ann Foster: Yes, and luckily, the State does say oasis does have pregnant women as a priority population. So that again, if there's a bed that's available in the system, and the woman ident person identifies as being pregnant. They get the bed. They are priority.

00:44:40.280 --> 00:44:40.640
mmorris4: See.

00:44:40.640 --> 00:44:40.980
Ann Foster: Us.

00:44:40.980 --> 00:45:00.959
mmorris4: I see, I see. Well, this is just so very helpful. And, Marie, could we move for a few minutes? I don't want to keep you too long this morning. I know you're very busy. But could we move for a few minutes to the work of the New York State Bar Association, and I want to take the opportunity to recognize our President, Domenick Napoletano

00:45:00.960 --> 00:45:20.440
mmorris4: for appointing this task force, and I'll share with you that I've enjoyed the work so

much with you, our prosecutors, such as Nigel, Bridget, and folks coming from all different backgrounds policy, on the ground work.

00:45:20.660 --> 00:45:30.799
mmorris4: And it's been challenging for us to get our arms around. You know, as we're discussing this morning the problems they're just so big.

00:45:31.030 --> 00:46:00.450
mmorris4: It seems as if we're not experiencing the kind of, and I'm going to put it in quotes success that we would like that. There are some breakdowns that our colleagues have been talking about one of the things that I've heard and correct me if I'm wrong that there seems to be, I'm going to call it a distribution problem that perhaps we have resources, but they're not

getting to the people who need them. Is that a correct way to describe at least part of the problem.

00:46:01.200 --> 00:46:04.290
Ann Foster: Say part of the problem, because one thing I think

00:46:04.500 --> 00:46:09.639
Ann Foster: again, just sharing a Phoenix House. Phoenix House had over a thousand beds.

00:46:10.370 --> 00:46:33.200
Ann Foster: Across the city. And I really Long Island. And today we're a fraction of that, and that is across the field, like we have not been able to get a number to say, how many beds do we have in the system? In, let's say, 1990, 1995. To how many beds do we have today? And so.

00:46:33.460 --> 00:46:37.700
mmorris4: So you're not getting that data from the from the agencies.

00:46:37.700 --> 00:46:39.370
Ann Foster: Correct, correct the government.

00:46:39.370 --> 00:46:40.240
mmorris4: Agencies.

00:46:40.440 --> 00:47:09.409
Ann Foster: And then what happens? I mean again, we should not be surprised if I take a step back, and I don't have the exact numbers. But there was a movement, a time when our mental health beds were closed across the system. And so now what do we see now? Everyone say, oh, well, why are they on the street? Why are they on the street? Well, what do we do? We closed beds. We closed resources. We did not fund these kinds of programs. And so it ends up being cyclical in terms of the problem.

00:47:09.410 --> 00:47:20.800
mmorris4: And also I wanted to highlight during your wonderful testimonies that you're sharing with us this intersectionality of substance, use, and mental health. Of course.

00:47:20.800 --> 00:47:30.250
Ann Foster: Absolutely, absolutely there really is. And I think that is also that's another whole conversation. A problem is how we silo that out

00:47:31.070 --> 00:47:38.110
Ann Foster: said, and, if mental health is like the stepchild to the system.

00:47:38.670 --> 00:47:52.020
Ann Foster: Substance use disorder is the bastard. No one wants to talk about that, and I've said that, and I know I'm on the record. I believe that no one wants to talk about folks who struggle with substance use.

00:47:52.300 --> 00:47:59.400
mmorris4: So you're saying that? We continue to have a resources problem.

00:47:59.400 --> 00:48:00.200
Ann Foster: Absolutely.

00:48:01.430 --> 00:48:02.580
Ann Foster: Absolutely and.

00:48:02.580 --> 00:48:03.610
mmorris4: And funding.

00:48:03.610 --> 00:48:06.999
Ann Foster: Yes, yes, we are forgotten.

00:48:07.000 --> 00:48:15.269
mmorris4: I like that I'd like to use that as perhaps the title of our report. I like it being forgotten.

00:48:15.390 --> 00:48:18.869
mmorris4: I think it captures it so well. What do you think, Moe?

00:48:20.740 --> 00:48:22.270
Moe Whitcomb (NYSBA): I love that idea. I think it.

00:48:22.270 --> 00:48:28.239
mmorris4: Yes, this is why I love oral history. And yeah, this, yeah, I really like that.

00:48:28.630 --> 00:48:55.750
Ann Foster: No, it's so true. I mean people who die from overdoses and die from substance use. 1st of all, if we start talking about the family, and I can think of another story of a woman that I worked very closely for many, many years, and she's been following me on LinkedIn, and maybe 5 years later, after we've had this relationship and I've been with Phoenix House. She disclosed to me that her brother died of an overdose. This is someone I know.

00:48:55.750 --> 00:48:56.100

mmorris4: Oh!

00:48:56.100 --> 00:49:02.350
Ann Foster: But she just could not even utter the words to share because of the shame because of this stigma.

00:49:02.350 --> 00:49:02.670
mmorris4: Of course.

00:49:03.260 --> 00:49:21.739
Ann Foster: How about your brother was poisoned? It was unintentional. He didn't. He didn't want to die of a Fentanyl overdose. He thought he was doing cocaine, and because of what's happening. So again, giving people the language, giving people the space to be able to talk about these things.

00:49:21.740 --> 00:49:22.200
mmorris4: Sure.

00:49:22.200 --> 00:49:27.189

Ann Foster: Is part of the problem, and then being able to get the resources that's needed

00:49:27.350 --> 00:49:56.660
Ann Foster: because we should be screaming from the raps. There's as I've been telling. I had another colleague I was sharing. We do it for gun violence. If there's a shooting on a particular block or a shooting in a neighborhood. You have the police out there with the the megaphones, and they're telling people or putting up signs. We should be doing that every time there's an overdose. If you see a white, a white bicycle, or something like this, what does that mean? Somebody got hit by a car with a bicycle or something in a neighborhood.

00:49:56.770 --> 00:50:07.100
Ann Foster: When you see a yellow ribbon tied around the tree during war, what do we do when somebody dies in the McDonald's bathroom from an overdose. Nothing. You don't know about it.

00:50:07.460 --> 00:50:08.709
mmorris4: We don't know.

00:50:08.710 --> 00:50:09.770
Ann Foster: Anything about it.

00:50:10.550 --> 00:50:12.570
mmorris4: Oh, very very sad.

00:50:12.890 --> 00:50:13.220
Ann Foster: We're.

00:50:13.220 --> 00:50:36.700

mmorris4: Very, very sad. And this resonates with my work, because, of course, I'm sure that most of the people that you're serving whom you're serving do not have access to, bereavement services, palliative care, which again, is much broader than just strictly medical care. But the approach to really mitigating suffering because this is about suffering.

00:50:36.860 --> 00:50:38.249
mmorris4: That's right. Recognizing.

00:50:38.250 --> 00:50:41.999
Ann Foster: The suffering that so many are going through with these problems.

00:50:42.170 --> 00:50:56.809
Ann Foster: I mean, when you hear the stories we do, and and Mary, Beth and Moe. I will definitely invite you this August every year. August 31st is called International Overdose Awareness Day, where all across the world people observe folks who have died from overdoses.

00:50:56.810 --> 00:50:57.730
mmorris4: Oh yes!

00:50:57.730 --> 00:51:11.289

Ann Foster: Here are some of the stories, and it was a gentleman that was in our program, and he said, I'm doing it for my wife who died of an overdose, and he they have 5 kids, and his daughter was at 2 years old without her mom

00:51:11.900 --> 00:51:37.799
Ann Foster: when you and he and he's doing the work. He's so strong I'm forgetting his name, but I'm seeing his face right now. And so you hear those stories of why people are saying, what I'm going to make a change. This is going to be different this time, because they've lost so many people have lost their people who will not have their loved ones around the dinner table because of Fentanyl, because of an overdose.

00:51:37.800 --> 00:51:51.469
Ann Foster: and they didn't expect it. You have high school kids that they get ready to celebrate their prom, and they go out, and they have a good time, and a friend gives them something, and they think it is having a good time. Well, that something had Fentanyl in it, and they died.

00:51:51.510 --> 00:52:16.600
Ann Foster: They didn't expect to die. They were getting ready to start their life go off to college. And so, if we're not educating and talking to our young people, to our elderly, our veterans, telling them about the perils of substance use and how our drug supply is tainted with Fentanyl. And we have, we're trying to launch a campaign. We believe it's 1 and done

00:52:16.810 --> 00:52:24.520
Ann Foster: one and done. This is not the drugs of your parents back in the day that you could survive it through, one and done.

00:52:24.520 --> 00:52:26.819
mmorris4: That's the name of a new campaign you're launching.

00:52:26.820 --> 00:52:28.230
Ann Foster: Yes, yes.

00:52:28.230 --> 00:52:33.110
mmorris4: About the Fentanyl, and absolutely invasion.

00:52:33.250 --> 00:52:34.340
Ann Foster: Absolutely.

00:52:34.340 --> 00:52:37.170
mmorris4: Drug supply. Yes, yes.

00:52:37.600 --> 00:52:56.880
mmorris4: Well, Ann Marie, let me let me just spend a few minutes with you, if I may be so bold to get a sense from you in terms of our report, what you would recommend. And again, I know we've spent so much time on this, but I really want to learn from your vast experience and knowledge and acumen.

00:52:57.030 --> 00:53:10.309
mmorris4: What would you suggest that we prioritize in our report in terms of the recommendations again 1, 2. It sounds as if funding would be at the top of the list.

00:53:10.830 --> 00:53:14.979
Ann Foster: Yes, so I will start, because I remember when we 1st started.

00:53:14.980 --> 00:53:15.420
mmorris4: Yes.

00:53:15.660 --> 00:53:25.139
Ann Foster: That it. It's massive in terms of that this whole thing has. But it was behind the whole Treatment Not Jail [bill].

00:53:25.140 --> 00:53:28.359
mmorris4: Yes, yes, we had some difficult conversations on that.

00:53:28.360 --> 00:53:30.960
Ann Foster: Yes, and the intent

00:53:31.180 --> 00:53:41.939
Ann Foster: is great, and I don't think anyone would dispute that people need treatment as I started. Recovery is possible for all. But there has been no investment for that treatment.

00:53:42.320 --> 00:53:49.380
Ann Foster: Where are folks going? Where are we putting them? If you say you want treatment,

and what kind of treatment?

00:53:49.700 --> 00:53:50.610
Ann Foster: Right.

00:53:50.610 --> 00:53:57.230
mmorris4: So you're you're framing this as a top priority should be the call for investment in treatment.

00:53:57.230 --> 00:53:59.240
Ann Foster: Absolutely, absolutely.

00:53:59.240 --> 00:54:00.110
mmorris4: That.

00:54:00.110 --> 00:54:08.219
Ann Foster: That covers. The capital needs for facilities. You have a judge that's on the task force that said

00:54:08.450 --> 00:54:17.039
Ann Foster: I would send more people to treatment if I had a place to send them. But I don't. So then go to jail, and that shouldn't be. That should not be.

00:54:17.340 --> 00:54:18.740
mmorris4: Right, right.

00:54:18.940 --> 00:54:38.600
Ann Foster: So we need to invest, and you have to make space for all the different little pockets that exist. So there are people that might be violent offenders, and you need to figure

out where to put them. You have people who are sex offenders. They don't have a place to go for treatment all these different

00:54:39.120 --> 00:54:50.339
Ann Foster: pockets that we heard throughout the task force. We need to be sensitive to our LGBTQ trans. Community that they also have access to treatment. The visually impaired.

00:54:50.340 --> 00:54:50.740
mmorris4: Right.

00:54:50.740 --> 00:54:52.979
Ann Foster: This is so fun. I mean, the list can go on.

00:54:52.980 --> 00:54:58.560
mmorris4: And we talked about women, of course, and we're pregnant and older people.

00:54:58.930 --> 00:55:04.070

Ann Foster: Women and women who? Okay, I'll come to treatment. But I'm bringing my toddler with me. What does that look like?

00:55:04.070 --> 00:55:04.730
mmorris4: Others.

00:55:05.380 --> 00:55:06.030
Ann Foster: Right.

00:55:07.370 --> 00:55:16.200
Ann Foster: And so there has to be a bold investment in access making treatment accessible to folks who need it.

00:55:16.470 --> 00:55:18.800
Ann Foster: And it needs to be culturally sensitive

00:55:19.220 --> 00:55:22.139
Ann Foster: needs to be local needs, to be in their communities.

00:55:23.480 --> 00:55:31.470
Ann Foster: Not some faraway place that their loved ones can, because again, the goal is to get them reintegrated back into success. Back.

00:55:31.470 --> 00:55:38.710
mmorris4: Reintegrated into the community so that the community-based programs are obviously.

00:55:38.710 --> 00:55:39.100
Ann Foster: Absolutely.

00:55:39.100 --> 00:55:42.570
mmorris4: Critically important, such as what Phoenix House is doing.

00:55:43.350 --> 00:55:48.870
mmorris4: And would you be comfortable with our saying in the report that Phoenix House, of course, is a paradigm

00:55:49.720 --> 00:55:55.620
mmorris4: in terms of the programs and care, and that this is something that we should try to replicate.

00:55:55.880 --> 00:56:19.689
Ann Foster: Yes, yeah, and many are doing it. We're not unique. I would say. Many of my colleagues are doing this kind of work very involved in the community involved in creating community-based organizations. There are quite a few. I say, Samaritan village. There's organizations like Outreach and Elmcore. They're out there, tapped into their community meeting. The community needs

00:56:19.690 --> 00:56:26.350
Ann Foster: again. It's 1 thing for treatment. But remember, it's when you mentioned the whole social determinants of health like.

00:56:26.350 --> 00:56:26.970
mmorris4: Right.

00:56:26.970 --> 00:56:32.699
Ann Foster: We've had to pivot into offering food, because we know during food insecurities.

00:56:32.700 --> 00:56:34.770
mmorris4: Food, insecurity, absolutely.

00:56:35.451 --> 00:56:53.369
Ann Foster: Pantries. That was something that I copied from another agency Elmcore, that they were doing this for years, providing food for their constituents. And I said, Well, we need to do it, too, because how are we trying to coach you on? Stop using substances and you're hungry. Can't feed your children.

00:56:53.370 --> 00:56:54.040
mmorris4: Yes.

00:56:54.040 --> 00:57:11.380
Ann Foster: I'm seen as a resource that okay, I could go there and get food, and I could get recovery coaching, and I could get medication for assisted treatment, and I can help my son, who's smoking marijuana and not going to school. I mean, now you've bought in to what we're trying to provide.

00:57:12.260 --> 00:57:14.759
mmorris4: Support, to, to the whole family.

00:57:15.560 --> 00:57:23.500
Ann Foster: Correct, absolutely, absolutely so. There has to be like, I said, a bold investment in resources for treatment.

00:57:23.940 --> 00:57:38.069
mmorris4: And do you think the? And again, I'm sorry that I'm not more knowledgeable about the funding and how it works? But I'm assuming that you're talking about investment at all levels of government.

00:57:38.560 --> 00:57:39.620
Ann Foster: Absolutely. Yes.

00:57:39.620 --> 00:57:41.060
mmorris4: State as well as local.

00:57:41.340 --> 00:57:56.470
Ann Foster: Absolutely absolutely no question. And we are very afraid right now, because with the potential cuts from the Federal Government, we get a lot of our dollars through the State from the State, through the Feds.

00:57:58.080 --> 00:58:17.100
Ann Foster: Terms of block grants. We are very concerned about that. So there's a lot of advocacy from our treatment providers and what that would look like individuals who are coming out of being incarcerated. When they come out. They need to have insurance so that they can access care. We know they're a vulnerable population, as well, too.

00:58:17.430 --> 00:58:27.129
mmorris4: What? What? Just again, a rough idea, what percentage of the communities and populations you serve are non-citizens.

00:58:29.860 --> 00:58:34.900
Ann Foster: For us, locally. For us I can only speak for Phoenix House. The number is very small.

00:58:35.150 --> 00:58:35.850
mmorris4: Is it.

00:58:36.070 --> 00:58:37.280
Ann Foster: Very small.

00:58:37.770 --> 00:58:42.700
Ann Foster: And that's probably because the bulk of our beds are out in the island

00:58:42.910 --> 00:58:44.640
Ann Foster: right? So the demographics are.

00:58:44.640 --> 00:58:45.749
mmorris4: Say Long Island.

00:58:45.750 --> 00:58:55.100
Ann Foster: Long Island. Yes, the bulk of our beds are out there in the island. I would say less than 20%, maybe even less than 15%.

00:58:55.100 --> 00:58:55.470
mmorris4: Really.

00:58:55.470 --> 00:58:56.980
Ann Foster: Are non-citizens.

00:58:57.450 --> 00:59:04.509
mmorris4: And do you think one of the reasons, perhaps, is that non-citizens are reluctant to access.

00:59:04.510 --> 00:59:05.620
Ann Foster: Correct. Yes.

00:59:05.620 --> 00:59:05.960
mmorris4: This.

00:59:06.570 --> 00:59:16.630
Ann Foster: And in recent weeks, many in the field are saying that we're seeing a decrease in individuals not accessing care because of their immigration statuses.

00:59:18.500 --> 00:59:20.139
mmorris4: that's not a surprise.

00:59:20.140 --> 00:59:22.340
Ann Foster: Not at all, not at all.

00:59:22.490 --> 00:59:28.769
Ann Foster: And so we're going to see more silent deaths, forgotten individuals.

00:59:28.770 --> 00:59:45.210
mmorris4: Sure. Sure. So this is. This is very helpful to us in terms of the job of writing up these recommendations. Would you be so kind as to share possibly a second recommendation. I'm thinking myself about workforce education and training.

00:59:45.210 --> 00:59:46.870
Ann Foster: That's exactly the second one there.

00:59:46.870 --> 00:59:48.750
Ann Foster: Okay, I was about

00:59:48.750 --> 00:59:54.099
Ann Foster: to say. And again, it's like chicken and egg. So you give me this wonderful building.

00:59:54.100 --> 00:59:54.470
mmorris4: Yep.

00:59:54.470 --> 00:59:58.890
Ann Foster: Great facilities. I don't have any staff to put in there.

00:59:58.890 --> 01:00:00.410
Ann Foster: Yes, yes.

01:00:00.410 --> 01:00:13.909
Ann Foster: I remember a doctor who used to be at New York City. Department of Health, and he wrote, he said, that we are woefully unprepared for the tsunami that's coming.

01:00:13.910 --> 01:00:14.530

mmorris4: Because.

350
01:00:14.530 --> 01:00:25.380
Ann Foster: Don't have the workforce. Yeah. Don't have the State talks about us having Ksachs and Surpas. The number is so small.

01:00:25.960 --> 01:00:42.929
Ann Foster: And then, when you have the competing environments where folks can remote a social worker, I can stay home and be a social worker and do telehealth the whole day. I don't have to go inside to a brick and mortar building, and so we're not prepared. We do not have the workforce.

01:00:43.130 --> 01:00:54.929
mmorris4: Would you? Would you just comment further on the telehealth services? Do you think that's an approach that is not terribly effective for the populations you're serving

01:00:55.050 --> 01:01:06.440
mmorris4: because it doesn't involve, a community it doesn't involve the all of the other ancillary services. Would I be bold to make that statement.

01:01:06.730 --> 01:01:11.239
Ann Foster: I will say it's 1 of the tools in the toolkit. We're happy that we have it.

01:01:11.240 --> 01:01:11.729
mmorris4: We're happy.

01:01:12.080 --> 01:01:29.239
Ann Foster: A regulation afforded us the ability to be able to start someone on mat services via telehealth. So it's a tool. But it's not for everyone, and there are. And so it should be. It's just that it should be an option

01:01:29.685 --> 01:01:38.320
Ann Foster: for individuals. I think some folks that are in rural communities in some parts of our State and our country, where, for that matter, that.

01:01:38.320 --> 01:01:38.690
mmorris4: Right.

01:01:38.690 --> 01:01:49.610
Ann Foster: You have probably one psychiatrist in. God knows what radius you would need telehealth, so to speak, that someone would be seen. But again.

01:01:49.770 --> 01:01:59.870
Ann Foster: I don't think it's the be all end all. And then for some people they need community, they need to be around other individuals and come in for their services.

01:01:59.870 --> 01:02:11.450
mmorris4: Right that that's how I would see it. I bring a public health, social background. But that's very much how I would see it. I like the way you've described it as a tool, one of the tools

01:02:11.770 --> 01:02:37.819
mmorris4: in the toolkit. And let me ask you one other question. One of the things that I've been working on in the work that I do in palliative and end of life care. And also, training people across the professions is a retooling our workforce education and training to equip people at a generalist level.

01:02:37.920 --> 01:02:51.440
mmorris4: Yeah, be able to provide services. So again, not focused on specialist level training. But what we can do to expand the generalist level workforce. What are your thoughts on that for the for the work that you're doing.

01:02:52.550 --> 01:03:17.670
Ann Foster: I think that makes sense that makes perfect. And we're gonna have to do something. We're gonna have to be creative to do something they're not able to fill the positions. Many organizations, myself included. We have a 30 to 40% vacancy rate. And so we need to look at the skills. Look at the tasks that are needed in our organization. And I agree, think about more of a generalist

01:03:18.080 --> 01:03:20.129
Ann Foster: title, so to speak.

01:03:20.453 --> 01:03:48.940
Ann Foster: I think the State could do a much better job. I remember years ago, early in my career, when we struggled with nurses, and we were going overseas, going to the Philippines to get nurses. There was a push that if you decided to go to college and pursue a nursing degree that they would pay for it, and I know there's some steps that are being taken for that. But we need to do more of that, as it relates to like CASAC and CRPA's.

01:03:48.940 --> 01:04:03.809
Ann Foster: and licensed mental health clinicians to get them involved, to get them the support they need. Early, like we should be talking to kids in high school, encouraging them to go into this space, and that the State would cover.

01:04:04.140 --> 01:04:06.770
mmorris4: I see so subsidizing the education.

01:04:06.770 --> 01:04:08.540
Ann Foster: Absolutely, absolutely.

01:04:10.100 --> 01:04:10.679
Ann Foster: And I think

01:04:10.680 --> 01:04:27.800

Ann Foster: I think internships are a key. I know for us, because again folks graduate out of social work, school or PA. School or Np. They're immediately thinking the big hospitals right and not thinking community-based organizations like a Phoenix house to do this kind of work.

01:04:28.710 --> 01:04:32.440
mmorris4: And, Ann Marie, I'm going to make this our last question, and sure

01:04:32.440 --> 01:04:39.269
mmorris4: you a chance to say anything you'd like to add. But we've covered a lot of ground, and we're so grateful to you.

01:04:39.792 --> 01:04:51.639
mmorris4: What about research? What are we missing in terms of research? And again, just bringing my perspective to the table. I would say that probably not having enough conversations with people.

01:04:51.730 --> 01:05:09.949
mmorris4: We're probably collecting data, and it sounds from our colleagues who have been talking with us for so many weeks and months that some of the data we don't even get, and we don't have access to that. Perhaps we're not doing well enough in terms of getting these stories

01:05:10.460 --> 01:05:14.840
mmorris4: and documenting people's stories and sharing them.

01:05:15.540 --> 01:05:28.739
Ann Foster: Absolutely absolutely so what? Our colleague? and again Bridget Brennan, introduced us. Dr. Jason Graham is part of a program. I think it's Rx. Stat.

01:05:28.950 --> 01:05:41.860
Ann Foster: That they got some funding out of HITDA, and I might be messing the story up a little bit, but I believe they hired epidemiologists, and they also have social workers on their team that they.

01:05:42.130 --> 01:05:55.399
Ann Foster: when they come across a family that experienced an overdose death. They are doing kind of what you just said. The conversations right? But think of that's the OCME people are dead already, right? And now.

01:05:55.400 --> 01:05:56.060
mmorris4: Yes.

01:05:56.060 --> 01:06:06.659
Ann Foster: And so one of the points that I think that we struggle with, and I know where there's steps being taken to try to get. That is, the near fatal overdoses the people who didn't die

01:06:06.840 --> 01:06:07.550
Ann Foster: right.

01:06:07.550 --> 01:06:08.650
mmorris4: Interesting. Yes.

01:06:09.278 --> 01:06:11.010
Ann Foster: We should be talking to them.

01:06:11.250 --> 01:06:11.820
mmorris4: Yes.

01:06:11.820 --> 01:06:18.420
Ann Foster: Now what happened like, how many times did you touch a system? Where did you go for treatment?

01:06:18.610 --> 01:06:25.910
Ann Foster: That here you are almost overdosed and died right so that we can really try to somehow

01:06:26.140 --> 01:06:36.029
Ann Foster: target the interventions to help these folks that are the near misses, because we know the death we talk about how many people die? How many people almost died from.

01:06:36.030 --> 01:06:36.690
mmorris4: Right.

01:06:36.870 --> 01:06:39.090
Ann Foster: We don't have a handle on that number.

01:06:39.090 --> 01:06:39.980
mmorris4: Right.

01:06:39.980 --> 01:06:50.250
Ann Foster: So I think if there was an opportunity for some sort of research, I know we're trying to get data through either EMS or NYPD. When they show up.

01:06:50.720 --> 01:06:59.569
Ann Foster: To a non-fatal overdose. Where are they entering that information? And then what's the follow up, so to speak, of that individual.

01:06:59.700 --> 01:07:03.250
mmorris4: That happened, I think we would learn a whole lot.

01:07:03.900 --> 01:07:05.590
Ann Foster: From that from that group.

01:07:05.810 --> 01:07:14.230
mmorris4: I think so absolutely, and I hope that I'll be able to play a part here in terms of moving this type of research along.

01:07:14.550 --> 01:07:15.850
Ann Foster: Absolutely.

01:07:15.850 --> 01:07:36.189
mmorris4: So tell me, Ann Marie, is there anything else you'd like to share with us this morning that you would like to see included in our write-up. And again I'm going to share the transcript with you. I want to thank Mo again and Mo. I'll give you a chance in a moment to ask Ann Marie anything you've been thinking about.

01:07:36.610 --> 01:07:39.000
mmorris4: any last thoughts for us.

01:07:40.550 --> 01:07:41.400
Ann Foster: You know I.

01:07:41.400 --> 01:07:45.190
mmorris4: We'll, of course, be going back to the task force. I think we're meeting on Wednesday, aren't we, Moe?

01:07:45.190 --> 01:07:45.690
Ann Foster: Yeah.

01:07:45.690 --> 01:07:47.520
mmorris4: So glad we got this in, and I'll

01:07:48.450 --> 01:07:51.769
mmorris4: we'll tell them about our conversations.

01:07:51.770 --> 01:08:15.170
Ann Foster: Yes, I think for me this has been an interesting time this last year or so being involved, not only the task force, I think also partnership with the work I've been doing with the Dea and the Special Narcotics office, and I know folks question sometimes, what do you do with all these law enforcement people, I think what I'm doing with them is that

01:08:15.440 --> 01:08:24.770
Ann Foster: they realize that they're not going to law enforcement their way out of this crisis, and I think the more that government can understand that and hear that.

01:08:25.710 --> 01:08:34.490
Ann Foster: It's as if you know I've heard one of the DEA guys say, listen! As soon as we remove the bad actors another group pops back up.

01:08:34.580 --> 01:09:04.320

Ann Foster: We're not doing anything. We're not doing anything. And so we're pouring more and more resources and dollars into law enforcement. There's a place for law enforcement absolutely. But, as I told, I think I shared on the group, and I've got to get her name. She is powerful, Marybeth. She's a judge out of Michigan, and she talked about her own daughter, and before her daughter struggled with heroin she had an issue before.

01:09:04.380 --> 01:09:07.319
Ann Foster: and so she

01:09:08.260 --> 01:09:15.790
Ann Foster: She shared that. What are we doing? We're saving people's lives, but we're doing very little to restore their lives.

01:09:16.329 --> 01:09:18.539
Ann Foster: I think that's 1 of the keys.

01:09:21.180 --> 01:09:25.600
mmorris4: I understand that that's I think that's very also very meaningful.

01:09:25.609 --> 01:09:25.889
Ann Foster: Yeah.

01:09:26.449 --> 01:09:27.379
Ann Foster: Yes.

01:09:29.770 --> 01:09:31.879
mmorris4: Just taking some notes here.

01:09:32.593 --> 01:09:39.470
mmorris4: Mo! Do you have any burning questions you'd like to ask Ann Marie before we let her go this morning?

01:09:39.779 --> 01:10:04.399
Moe Whitcomb (NYSBA): I don't think I have any questions, but I just wanted to thank you, Ann Marie, for sharing your story especially, and for highlighting the importance of people sharing their stories because Mary Beth knows this but I, in a past life, did mental health counseling for people in prison, and so I just know how important it is to humanize these situations and the people, and so sharing the stories is like

01:10:04.409 --> 01:10:10.969
Moe Whitcomb (NYSBA): such an important part of that. So I just sort of wanted to highlight that because you had talked about that. And I think that's a really important part of the work.

01:10:11.160 --> 01:10:13.510
Ann Foster: Absolutely, absolutely. I think it.

01:10:13.950 --> 01:10:33.390

Ann Foster: The stories does it all. It helps shape us in terms of policy decision makers when they hear the stories because you get to see the humanity in the individual, and you see your own self or your own loved one in the stories, and it doesn't make it so foreign to you.

01:10:33.630 --> 01:10:35.520
Ann Foster: So yeah, powerful.

01:10:35.940 --> 01:10:49.429
mmorris4: Well, I want to offer my time and services to be available to you, Emory. If you identify anyone who would like to share their story, I would be very, very happy and honored.

01:10:49.995 --> 01:11:09.380
mmorris4: To make that opportunity available, so don't hesitate to reach out. Please keep me in mind again. We can't thank you enough for all you've done for us in the task force, and we look forward to sharing this experience with everyone. Do you think we'll have the Transcript by Wednesday or.

01:11:09.380 --> 01:11:10.109
Moe Whitcomb (NYSBA): Yeah, it should.

01:11:10.110 --> 01:11:11.210
mmorris4: Tomorrow. So maybe.

01:11:11.210 --> 01:11:14.129
Moe Whitcomb (NYSBA): It should upload in a couple of hours. I should have it in a couple of hours.

01:11:14.130 --> 01:11:20.400
mmorris4: Okay, and we'll send it to you first, of course, Ann Marie. Well, listen. Feel better.

01:11:20.610 --> 01:11:21.630
Moe Whitcomb (NYSBA): Thank you.

01:11:21.630 --> 01:11:22.510
mmorris4: Better, and.

01:11:22.510 --> 01:11:23.109
Ann Foster: All right.

01:11:23.110 --> 01:11:26.040
mmorris4: Indebted to you for you. Thank you.

01:11:26.040 --> 01:11:30.040
Ann Foster: It was an honor. Thank you so much, Mary, but you were great. Take care, guys.

01:11:30.040 --> 01:11:31.050
mmorris4: Thank you.

01:11:31.050 --> 01:11:34.590
mmorris4: So see you tomorrow, bye.

Appendix F1
New York's Substance Use Treatment Landscape:
A Call for Sustained, Equitable Investment Amid Structural Barriers to Care
By Ann-Marie Foster

This article originally appeared in the NYSBA Health Law Journal (Vol. 30, No. 3). It is reprinted here with permission.

Introduction

Since the onset of the COVID-19 pandemic, the increase in substance use and opioid-related harms has intensified across the United States, with New York State reflecting many of the national trends.[1]

Despite mounting evidence that substance use disorders require specialized, sustained care, our state continues to face a treatment landscape marked by diminishing capacity and uneven access. While mental health services have benefited from renewed policy attention and funding, substance use treatment often remains subsumed under broader behavioral health efforts – overlooked in policy prioritization and underserved in clinical infrastructure.

Behavioral Health Treatment Disparities in New York

The conflation of mental health and substance use treatment, though clinically appropriate in the context of co-occurring disorders, presents structural challenges in care delivery. Like mental illnesses, substance use disorder (SUD) is a behavioral health condition – one that significantly impairs a person's ability to function in daily life.[2] Yet, despite overlapping features, SUDs are distinct medical conditions requiring tailored pharmacological and psychological interventions.

Recognizing these complexities, a growing body of research highlights the value of integrated care models designed to address both mental health and substance use disorders concurrently. Studies demonstrate that integrated care effectively treats individuals with co-occurring disorders, with sustained delivery of such services leading to improved outcomes including reduced substance use, enhanced psychiatric functioning, and increased treatment engagement.[3]

---

[1] U.S. Centers for Disease Control & Prevention, *Understanding the Opioid Overdose Epidemic* (last visited May 23, 2025), https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose-epidemic.html.
[2] Hamwey M & Norman C & Suss R & Tuazon E & Carey E & McAteer J & Fei C & King L & Abdelnabi J & Arango T & Caton, J,Gareca M, Harocopos A, Jackson J, Jimenez C, Khalife D, Klein K, Manta S, Stratton N, *The state of mental health of New Yorkers*, (May 2024), https://www.nyc.gov/assets/doh/downloads/pdf/mh/state-of-mental-health-new-yorkers.pdf.
[3] Helene Chokron Garneau, Mehret T. Assefa, Booil Jo, James H. Ford II, Lisa Saldana, & Mark P. McGovern, *Sustainment of Integrated Care in Addiction Treatment Settings: Primary Outcomes From a Cluster-Randomized Controlled Trial*, 73(3) Psychiatric Services, 280–286 (2022), https://doi.org/10.1176/appi.ps.202000293.

New York State exemplifies the critical need for such integrated care models, as demand continues to outpace access to effective treatment. Across the state, approximately 2.8 million individuals aged 12 and older struggled with substance use disorders (SUDs) in the past year. Despite this overwhelming need, only about 730,000 individuals receive care through the state's certified treatment programs, overseen by the New York State Office of Addiction Services and Supports (OASAS), which manages 1,700 programs statewide.[4] [5] More than 1.4 million New Yorkers are also affected by co-occurring substance use and mental health disorders – further underscoring the demand for integrated care models that simultaneously address patients' needs.[6]

In New York City, nearly one in four adults – about 1.5 million people – experience a mental health disorder annually, and more than two-thirds receive some form of treatment annually.[7] In contrast, the treatment gap for substance use is far more severe. In 2023, only about 207,000 residents reported receiving any substance use treatment while nearly 90,000 people – 1.3% of residents – reported needing but not receiving care, according to the NYC Department of Health and Mental Hygiene.[8]

This disparity reflects not only a resource imbalance but a deeper structural neglect. Where mental health crisis services have seen expansion, substance use stabilization programs are often limited to short-term contracts. Nowhere is this neglect more apparent than in the fundamental building blocks of addiction care.

For instance, in general emergency care settings, defibrillators are routinely available for cardiac arrest, yet life-saving addiction interventions, such as opioid blocker naloxone, are still not universally available in treatment settings. Medication-assisted treatment (MAT) remains underutilized in many communities due to regulatory barriers, inadequate provider training, and stigmatization within health care systems.[9]

The misalignment in care delivery mirrors a broader social discomfort in addressing substance use – one still shaped by stigma, fear, and misunderstanding. As a result, individuals with SUDs

---

[4] New York State Office of Addiction Services and Supports, *Addiction Data Bulletin,* (Sept 2023), https://oasas.ny.gov/system/files/documents/2023/09/addiction_data_bulletin.pdf#:~:text=Recent%20data%20indicate%20that%202.8,SUD%20in%20the%20past%20year.&text=Provisional%20data%20indicate%20that%206%2C358,died%20from%20alcohol%2Drelated%20causes.

[5] New York State Office of Addiction Services and Supports, *Treatment, Harm Reduction and Recovery,* https://oasas.ny.gov/about.

[6] Stephen Isaacs, Paul Jellinek, Jacqueline Martinez Garcel, Kelly A. Hunt, & Will Bunch, *New York State Health Foundation: Integrating Mental Health and Substance Abuse Care*, 32 (10) Health Affairs, 1846–1850 (2013), https://doi.org/10.1377/hlthaff.2013.0479.

[7] *Id*.

[8] *Id*.

[9] Michelle Mancher & Alan I. Leshner, *Barriers to Broader Use of Medications to Treat Opioid Use Disorder*, 5 Medications for Opiod Use Disorder Save Lives (Mar. 30, 2019), https://www.ncbi.nlm.nih.gov/books/NBK541389/.

are less likely to seek care, less likely to receive effective treatment, and more likely to encounter insufficient support.[10]

Substance Use Treatment Shortage and Capacity Decline

Despite a growing need for addiction care, New York has experienced a sharp decline in its substance use treatment infrastructure over the past two decades. According to OASAS, between 1999 and 2024, New York State saw nearly a 30% decrease in statewide treatment centers, and an approximately 20% decrease in the number of individuals seeking treatment statewide. Yet, during this same time period, overdose deaths surged by nearly 400%.[11]

While substance use treatment has diminished, mental health programs have benefited from programmatic expansion and public support. Per Governor Hochul's office, the FY 2026 enacted budget builds in over $196 million in new mental health investments, including $160 million to add 100 forensic inpatient psychiatric beds in New York City, $16.5 million to enhance Assisted Outpatient Treatment programs, and $2 million to bolster staffing at the Office of Mental Health.[12] These initiatives build upon a multi-year, $1 billion plan to strengthen the continuum of mental health care statewide.[13]

In contrast, there are currently no open requests for proposals (RFPs) for recovery community and outreach centers (RCOCs), which play a crucial role in helping individuals sustain addiction recovery through peer support, community connection, and access to wraparound services. The absence of capital dollars reflects a broader disinvestment in substance use treatment infrastructure that supports long-term recovery rather than short-term crisis stabilization. As the state issued RFPs for crisis and intensive stabilization centers two years ago, these centers have not been established due to lack of adequate funding.

This paradox – fewer treatment options amid escalating need – signals a structural failure to resource addiction services in proportion to their public health impact, despite overwhelming evidence that addiction requires targeted, evidence-based approaches fundamentally different from general mental health care.

---

[10] Carlos Blanco, Miren Iza, Jorge Mario Rodriguez-Fernandez, Enrique Baca-Garcia, Shuai Wang, & Mark Olfson, *Probability and predictors of treatment-seeking for substance use disorders in the U.S.*, 149 Drug and Alcohol Dependence, 136–144 (Apr. 1, 2015), https://doi.org/10.1016/j.drugalcdep.2015.01.031.

[11] Freedom of Information Law Request 2025-07, New York State Office of Addiction Support and Services.

[12] Press Release, *Governor Hochul Signs Legislation to Improve Mental Health Care and Strengthen Treatment for Serious Mental Illness as part of FY 2026 Budget* (last visited May 9, 2025), https://www.governor.ny.gov/news/governor-hochul-signs-legislation-improve-mental-health-care-and-strengthen-treatment-serious?utm_source.

[13] Press Release, *Transforming New York State's Continuum of Mental Health Care,* https://www.governor.ny.gov/programs/transforming-new-york-states-continuum-mental-health-care.

Bridging Substance Use Treatment Gaps

When New York received the Substance Use Prevention Treatment (SAPT) block grant – federal COVID-era funding authorized by the 2021 Coronavirus Response and Relief Supplemental Appropriation Act – OASAS awarded 20 grants to behavioral health providers statewide. These funds supported comprehensive integrated treatment programs, medication delivery systems, mobile medication units, and improvements to the statewide SUD system, and a new opioid treatment location, significantly improving capacity for substance use prevention and treatment.[14]

However, many of these programs now face financial cliffs as emergency funds expire, leaving them vulnerable to closure or service reductions in the absence of a sustained funding model. Furthermore, follow-up funding opportunities have not been made available to substance use providers in the time since, even as increased community need persists.

Low-threshold substance use services – such as syringe exchange programs, HIV and hepatitis C testing, access to buprenorphine and methadone, and care referrals – form the foundation of effective harm reduction.[15] Interventions like providing fentanyl test strips and distributing naloxone are proven strategies that, when backed by sustained investment, can collectively prevent and reverse thousands of overdoses across the state.[16] Evidence shows that medications like methadone and buprenorphine reduce drug overdose deaths by more than 50%.[17]

Yet for many New Yorkers, even these basic services remain out of reach. There are fewer than 20 recovery community organizations operating statewide – a gap that leaves thousands without access to the peer support, resources, and stability essential to long-term recovery.[18]

---

[14] Substance Abuse and Mental Health Services Administration, *SAMHSA Grants* (2022), https://www.samhsa.gov/grants/grants-dashboard?f%5B0%5D=by_award_fy%3A2022&f%5B1%5D=by_nofo_number%3ASP-22-001#awards-tab.

[15] Substance Abuse and Mental Health Services Administration, *Advisory: Low Barrier Models of Care for Substance Use Disorders* (Dec. 2023), https://library.samhsa.gov/sites/default/files/advisory-low-barrier-models-of-care-pep23-02-00-005.pdf.

[16] Substance Abuse and Mental Health Services Administration, *Harm Reduction* (Jul. 2024), https://www.samhsa.gov/substance-use/harm-reduction.

[17] Ashly E. Jordan, Sarah Gorry, Mary Brewster, Pamela Mund, Andrew Heck, China O. Cunningham, *Addiction Data Bulletin* (No. 2024-03), Office of Addiction Services and Supports (Jun. 2024), https://oasas.ny.gov/addiction-data-bulletin-june-2024.

[18] Friends of Recovery New York, *Recovery Community Organizations (RCO)*, https://for-ny.org/recovery-community-organizations/.

Conclusion

New York stands at a critical juncture in its response to the substance use crisis. While strides have been made in expanding mental health services, substance use treatment programs face significant challenges due to funding uncertainties and structural disparities.

The expiration of emergency federal funds, such as the SAPT block grant, has left many programs vulnerable. The U.S. Department of Health and Human Services' decision to retract approximately $12 billion in federal grants – initially allocated during the COVID-19 pandemic for various health initiatives, including addiction treatment – has had a profound impact on states like New York.[19]

The reliance on one-time settlement funds and temporary federal grants has created a precarious financial landscape for substance use treatment providers. Without a stable and sustained funding model, these programs risk closure or significant service reductions, leaving countless New Yorkers without access to critical care.

To effectively address this crisis, New York must invest in a truly integrated behavioral health system – one that treats substance use and mental health as interconnected yet distinct components of care. This requires developing sustained, dedicated funding streams that support comprehensive treatment models, expanding harm reduction initiatives, and providing specialized clinical training across disciplines. By prioritizing integrated care that meets individuals where they are, the state can build a more equitable, resilient, and responsive public health infrastructure capable of addressing the full spectrum of behavioral health needs.

Ann-Marie Foster, FACHE, is the president and chief executive officer of Phoenix House of New York and Long Island, and is a member of the NYSBA Task Force on Opioid Addiction. Under her leadership, Phoenix House serves over 4,000 individuals annually, offers clinical services, and provides residential, recovery and outpatient treatment for people with substance use and co-occurring mental health disorders, as well as vocational and educational support. Prior to her time at Phoenix House, Ann-Marie led the country's largest psychiatric program, Bellevue Hospital Department of Psychiatry, as the senior associate executive director and has served in various leadership roles in NYC H+H.

[19] Kanishka Singh & Ahmed Aboulenein, *U.S. pulls back $12 billion in funding to state health departments*, Reuters (Mar. 27, 2025), https://www.reuters.com/business/healthcare-pharmaceuticals/us-government-pulls-back-over-11-billion-funding-state-health-departments-2025-03-26/.

Appendix F2
Advising Clients in a Time of Uncertainty: An Overview of the Issues Facing Addiction Care System Providers
By Robert Kent

This article originally appeared in the NYSBA Health Law Journal (Vol. 30, No. 3). It is reprinted here with permission.

At a time of great uncertainty for the addiction care system under the new federal administration, it is important for attorneys who provide legal advice to addiction care programs to remain calm and focused on their work and to, first and foremost, attempt to calm their clients.

Legal principles that many of us thought were settled are now being questioned. Actions are being taken by the executive branch that will necessarily require clarity through the courts, and Congress will need to decide whether it will assert its place in our federal governmental system.

Regardless of one's political leanings, it is clear that the current federal administration is looking to run the government differently from past administrations. These decisions will certainly be subject to scrutiny from a legal and policy perspective. I have faith that the three branches of our federal government will resolve legal questions and policy directions, and we will move forward.

As stated, the current federal administration is moving at a rapid pace, and it is critical that we as advisors on the law remain engaged and involved in working with our clients, especially those of us who work with addiction care providers. The leaders of that system are especially unsettled with the current pace of federal action as it comes on the heels of the COVID-19 pandemic which wreaked havoc on a system that was already in survival mode. For context, the New York addiction care system has been dealing with a multi-decade opioid overdose death epidemic that still results in more that 5,000 lives lost annually,[1] and alcohol related deaths in the state are more than 6,700 annually.[2] The addiction care system leaders further struggle with inadequate reimbursement rates, private insurance overreach, and the inability to recruit and retain an experienced workforce.

With this context, it is easy to understand why the addiction care system is reacting with great concern. As discussed below, I have experienced their stress firsthand. Below, I attempt to lay out some thoughts on some of the issues that are particularly impactful for the addiction care system.

Federal Actions Affecting The Addiction Care System

[1] *See* information at the following link: https://health.ny.gov/statistics/brfss/reports/docs/2224_bingeheavydrinking.pdf.
[2] *Id.*

My work has placed me front and center with the provider stress. Some specific examples come to mind. In late January 2025, the federal Office of Management and Budget (OMB) issued a directive to freeze all federal spending. This caused an immediate and almost hysterical reaction. By 7 a.m. on the day of the announcement, I started receiving calls/text messages and emails from clients and other concerned addiction program leaders asking for advice on how to handle this situation. My first response was that everyone needed to calm down to be able to assess the action and develop a plan of action. My second response was to offer my opinion and belief that the directive would be challenged in court by the end of that day. Thirdly, I believed that a court would pend the directive to assess its impact and its legality. That is what happened. In fact, the OMB directive was rescinded.[3]

In March 2025, the Department of Health and Human Services (HHS) sent letters to state agencies across the country announcing that they were terminating contracts related to COVID-19 stimulus funding. The reaction of those affected by this decision was similar to the reaction to the OMB spending freeze directive. My reaction was also similar to that of the OMB directive. These contract terminations have been enjoined by a federal court while the court reviews their legality.[4]

The legal arguments being put forward by those challenging the federal actions include: the power of the purse resides with the Congress and not with the president; the President must follow the Impoundment Control Act to defer or rescind spending already approved by Congress; and actions such as contract terminations must follow the Administrative Procedure Act, where notice and an opportunity to be heard are required.[5]

The most important thing we can do as attorneys is to gather the facts and plainly and calmly discuss them with our clients. In the remainder of this article, I will explore areas and issues that I believe are important to understand in order to effectively provide legal advice to addiction care system providers.

The state versus federal budget making process

Of interest to New York attorneys, especially those who are involved in the legislative process, the federal budget making process is significantly different from that of New York.

In New York, following the state constitution and subsequent court decisions, the governor proposes the budget, the state Legislature has limited power to modify the proposal, and the executive is actively involved in negotiations to come to an approved state budget.

[3] *See State of New York et al v. Trump et. al.,* 25-cv-00039-JJM-PAS.
[4] *See State of Colorado et al v. U.S. Department of Health and Human Services, et. al.* 25-cv-00121-MSM-LDA.
[5] *See*, e.g., 42 U.S.C. § 300x-55(a)

In contrast, at the federal level, while the executive proposes the budget, Congress negotiates a final budget. I learned this difference firsthand when I worked at White House Office of National Drug Control Policy (ONDCP). We developed the drug policy components of the president's budget proposal and after it was submitted to Congress, I asked my colleagues when we would start negotiating sessions with the House and Senate. I was advised that we were not involved at this point as it was now a congressional function. I was also advised that I should not wait by my phone for calls from congressional negotiators about our budget proposal.

Article 1, Section 9, Clause 7 of the U.S. Constitution states that "No Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law." It flows from this language that the power of the purse must be exercised through the lawmaking process, allowing Congress to craft the terms of appropriations or deny appropriations outright through legislation.

Impoundment Control Act

In 1974, Congress enacted the Impoundment Control Act[6] in response to attempts by the executive branch to refuse to spend congressionally appropriated funds. The act operates on the constitutional premise that the President must obligate funds appropriated by Congress, unless otherwise specifically empowered to withhold them. The act allows the President to temporarily impound – i.e., withhold the obligation or expenditure of – appropriated funds in certain circumstances if the President notifies the Congress by transmitting a special message.

The Impoundment Control Act provides for two types of impoundments: deferrals and rescissions, which are codified.[7]

Deferral

- A deferral occurs when an agency temporarily withholds funds from obligation or expenditure.

- Deferrals are authorized only to provide for contingencies, to achieve savings made possible by changes in requirements or greater efficiency of operations, or as otherwise specifically provided by law.

- A deferral may not extend beyond the end of the fiscal year in which it is proposed.

Rescission

A rescission is the proposed cancellation of budget authority that has been provided by Congress before that authority would otherwise expire.

[6] *See* 2 U.S.C. §§ 681–688.
[7] 2 U.S.C. §§ 683–684.

The President may propose a rescission for policy or other reasons.

Once a rescission is proposed to Congress, the President can withhold the budget authority for 45 days while Congress is in continuous session. Unless Congress completes action on a rescission bill to approve the proposed rescission within that time, the budget authority and obligation to spend the appropriated funds remain in effect and must be made available for obligation.

The current federal administration is questioning the legality of this act, and it is at the heart of some of the funding actions being taken. The federal courts system will have to offer us clarity on this issue as we move forward.

What Is an Executive Order?

Many of the actions being taken by the current administration are being implemented through executive orders.[8] While such orders were extensively used at the federal and state levels during the COVID-19 public health emergency, we still lack a firm grasp on the legal effect of such orders. Even so, we can and should educate our clients on basic principles about the legal impact and reach of such orders.

In the interest of clarity, an executive order is a written directive from the President, or the Governor of a state that has such authority, ordering the executive branch of government to implement and follow existing laws. At the federal level, the President is granted this power under Article II of the U.S. Constitution, which obliges the president to ensure that laws are faithfully executed. Executive orders are usually issued to reinforce that programs and policies are carried out while staying within the rule of law and they are subject to judicial review and interpretation. The courts can strike down executive orders on the grounds that the president lacked authority to issue them. An executive order cannot override existing federal laws and statutes. They cannot be used to bypass the authority of other branches of government, which have equal power. The President cannot overrule the Supreme Court's interpretation of the law and cannot single-handedly change laws that have been passed by Congress. Thus, while it is always important to understand the contents of the executive order, it is also important to discern whether the order is ensuring that existing law is being faithfully executed or whether instead the order is an attempt to override existing law, or a Supreme Court order, and whether the President has the authority to issue the order.

Department of Health and Human Services Reorganization

In March 2025 HHS Secretary Robert F. Kennedy, Jr. announced, as part of his Make America Healthy Again plan, to reorganize the various offices and components of the department.[9] As

[8] Executive Orders can be found at the following link: https://www.federalregister.gov/presidential-documents/executive-orders.
[9] *See* https://www.hhs.gov/press-room/hhs-restructuring-doge.html.

said previously, whether this proposal makes sense is a policy call. However, many of the component agencies and offices of the HHS were created by Congress in statute, with specific duties and responsibilities that were established by Congress. Thus, it is my opinion that any effort to reorganize HHS will require the approval of Congress.

The Office of National Drug Control Policy (ONDCP)

Given my history as the general counsel at ONDCP, I have been asked whether the current administration will close the office. During his first term, President Trump did propose to eliminate the funding to support the work of ONDCP and to move the two grant programs that the office oversees, the High Intensity Drug Trafficking Areas, or HIDTA, and Drug Free Communities, to other federal agencies. I am not going to offer an opinion on whether ONDCP should be eliminated as that is a policy call for others and my goal in this article is to educate others on the issues.

From a legal perspective, ONDCP was created, and exists, in federal statute[10] and any effort to eliminate the office must be effectuated by an act of Congress. The statutes have placed within ONDCP several statutory obligations, including the development of the National Drug Control Strategy and the obligation to declare emerging drug threats, which must be reviewed, and accounted for, during the congressional budget making process.

Some Parting Thoughts

As already stated, many in the addiction care system are fretting over possible federal and state funding reductions. I suggest that both levels of government focus on "found money" – money that does not require them to raise taxes or cut funding elsewhere. Just like the dollar bill you find in your suit pocket, like the quarters in between the seat cushions, there is "found money" in the addiction care system. We just need government to make it easier to find!

Managed care and insurance companies are the suit pocket, the seat cushion! They are making it difficult to access the "found money" and it is my opinion that government is allowing it to happen! Let me give you a few examples. First, the situation when insurers claw back, or take back money, already paid to a provider for medically necessary care that they approved for a person who was verified to be insured at the time the care was provided. I know of examples of clawbacks that occurred seven years later! The worst offenders are insurance programs for government employees, who in many instances are not subject to state laws because federal law protects them! This is completely unfair! When insurers negotiate a price for their product, they include a financial cushion for the situations like the one I describe. It is part of the back-and-forth negotiations between the insurers and their customers. However, they are shifting their risks to treatment providers who were not part of their contract negotiation and do not benefit

[10] *See* 21 U.S.C. §§ 1701–1715.

from the negotiated financial cushion. If government ended this practice, needed funds would stay in the system.

Government should also end all prior authorization for accessing addiction services and medications. Providers and insurers waste so much time and money fighting about initial access to treatment when that time and money would be better spent on the treatment and associated recovery. The federal government should consider amending the Employee Retirement Income Security Act of 1974 (ERISA),[11] a law that shields state employee health insurance programs and many other insurance programs from state laws. The ERISA amendment would set a minimum standard that prior authorization is prohibited and then every state should eliminate prior authorization in their laws.

State governments should consider using opioid settlement funds to increase reimbursement rates for providers. Making this type of investment will give providers funds to hire more staff, and to compete in the marketplace for that staff. It will also make more opioid related treatment available, which should be the overriding priority for the use of these funds.

Federal and state governments should also start enforcing their parity laws and other laws that govern treatment. Until this occurs, these laws are almost meaningless.

While I understand the current concerns, our job as advocates and attorneys is to fight for and protect our clients and assist them in their advocacy efforts.

Robert A. Kent is the president of Kent Strategic Advisors, a consulting firm focused on drug policy and assisting stakeholders with making treating and recovery more accessible. He most recently served as general counsel with the White House Office of National Drug Control Policy (ONDCP). Prior to that he served as the general counsel for the New York State Office of Addiction Services and Supports (OASAS).

[11] *See* 29 U.S.C. §§ 1001 *et seq*.

Appendix F3

From Punitive to Prosocial: A Typology of State Laws Addressing Prenatal and Postpartum Drug Use

By Kristen Underhill, Megan E. Marziali, Sam D. Gardner, Emilie Bruzelius, Morgan Philbin, Silvia S. Martins

This article originally appeared in the NYSBA Health Law Journal (Vol. 30, No. 3). It is reprinted here with permission.

Research described in this article was funded by R01 DA053745 (MPIs: Martins, Philbin).

Introduction

The U.S. rate of maternal mortality – around 22 deaths for every 100,000 live births – far exceeds the rate in peer countries. These deaths disproportionately occur among women of color, and more than 80% of them may be preventable.[1] For every maternal death, there are many cases of severe maternal morbidity: approximately 700 to 800 cases for every 100,000 delivery hospitalizations.[2] Although there are many immediate causes of death for pregnant and postpartum people, mental health and substance use are important contributing factors.[3] A review of 14 state Maternal Mortality Review Committees from 2008-2017 found that approximately 11% of maternal deaths with a known cause were related to mental health, among which more than two-thirds were among people with past or present substance use; this does not account for cases where substance use may have been a contributing factor to other causes of death.[4] Substance use during pregnancy can have consequences for mothers, their infants, and their families; it is related to pregnancy complications, severe maternal morbidity, comorbid conditions, lack of prenatal care engagement, gender-based and domestic violence, and difficulty parenting.[5]

---

[1] Laura G. Fleszar et al., *Trends in State-Level Maternal Mortality by Racial and Ethnic Group in the United States*, 330 JAMA 52 (2023); Munira Z. Gunja et al., Insights into the U.S. Maternal Mortality Crisis: AN International Comparison, The Commonwealth Fund, Jun. 4, 2024, https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/insights-us-maternal-mortality-crisis-international-comparison.

[2] Ashley H. Hirai, Pamela L. Owens, and Lawrence D. Red, *Trends in Severe Maternal Morbidity in the US across the Transition to ICD-10-CM/PCS from 2012-2019*, 5 JAMA Network Open e2222966 (2022).

[3] Zane Frazer, Krystle McConnell, and Lauren M. Jansson, *Treatment for Substance Use Disorders in Pregnant Women: Motivators and Barriers*, 205 Drug & Alcohol Dependence 107652 (2019); Marcela C. Smid et al., *Early Lessons from Maternal Mortality Review Committees on Drug-Related Deaths – Time for Obstetrical Providers to Take the Lead in Addressing Addictio*n, 2 Am. J. Obstetrics & Gynecology 100177 (2020).

[4] Susanna L. Trost et al., *Preventing Pregnancy-Related Mental Health Deaths: Insights From 14 US Maternal Mortality Review Committees, 2008–17*, 40 Health Aff. 1551 (2021).

[5] World Health Organization, Guidelines for Identification and Management of Substance Use and Substance Use Disorders in Pregnancy (2014), available at https://www.who.int/publications/i/item/9789241548731; Jennifer R. Havens et al., *Factors Associated with Substance Use During Pregnancy: Results from a National Sample*, 99 Drug & Alcohol Dependence 89 (2009); Kerry-Ann Louw, *Substance Use in Pregnancy: The Medical Challenge*, 11

Many U.S. states have undertaken legislation or agency regulation with a stated goal of minimizing harms related to prenatal substance use. Research has examined the effectiveness of various state approaches, including mandatory reporting requirements, criminalization, and routine testing. A comprehensive typology of these laws does not yet exist. A framework for categorizing and understanding these laws is important for mapping the field and considering how different legal strategies may interact to affect the lives of pregnant people and their families.

In this article, we catalog ways in which U.S. states have used legislation, criminal prosecution, and court decisions to address drug use by pregnant and postpartum people. Although people of all genders can have children, many laws are written with gender-specific language (e.g., pregnant women), and this paper reflects these choices; we should understand these laws, however, as impacting all pregnant people.

Punitive and Prosocial Laws

While state laws are varied exist on a continuum, in this paper we follow the many researchers in this field and categorize laws as punitive or prosocial. When legislation is specifically drafted to address prenatal or postpartum drug use, it is generally extended to the use of controlled substances, with exceptions or defenses for drugs lawfully prescribed by a medical provider. Where courts have interpreted general statutes (e.g., child abuse and neglect laws) as applying to prenatal or postpartum drug use, the interpretation may be lacking in these nuances.

Punitive laws expose people to adverse consequences attaching to drug use by the pregnant person, on the assumption that negative consequences will motivate the pregnant person to refrain from drug use, or will motivate their partners or families to stop them from using drugs. Penalties can include imprisonment, fines, termination of parental rights, or investigation by child welfare departments; abstinence from drugs is necessary to avoid these sanctions. Punitive laws assume that people can and do respond rationally to legal incentives – that we constantly recalibrate based on risks and benefits, so that punishments deter us and rewards attract us. These laws focus on individual decision-making and motivation, rather than targeting social or structural factors that affect substance use or treatment. For such laws to be effective, at minimum people need to know about the law, and to have the material opportunity and autonomy to comply. The design of punitive laws rarely, if ever, accounts for how these assumptions play out in the lives of individuals with substance use disorders.

Prosocial laws, on the other hand, do not attach adverse consequences to drug use; instead, they employ a variety of strategies to increase the likelihood that the pregnant person will have an opportunity to access treatment. These approaches generally increase the rights and resources

Obstetric Med. 54 (2018); Marian Jarlenski et al., *Substance Use Disorders and Risk of Severe Maternal Morbidity in the United States*, 216 Drug & Alcohol Dependence 108236.

that pregnant people can use to engage with care, which in turn can minimize harms associated with drug use. For example, prosocial laws might subsidize treatment, require drug treatment centers to prioritize the admission of pregnant people, or ban drug treatment centers from discriminating against pregnant people. The behavioral assumptions of these laws are more flexible; they work through a range of pathways, they do not require total abstinence, and they can address social and structural features that impede access to treatment. Compared to punitive approaches, these laws are more likely to accommodate the complex behaviors involved in substance use, which are shaped not only by individual factors, but by many social and structural factors driving substance use or access to treatment.[6]

Types of Punitive Laws
Criminalization of Prenatal Drug Use

Rarely, U.S. states have specifically imposed criminal penalties on people who use drugs while pregnant. For example, Tennessee's "fetal assault law," which was effective from 2014-2016, categorized and penalized prenatal drug use as criminal assault.[7] More frequently, state prosecutors and judges have interpreted general criminal law as encompassing prenatal drug use, subjecting people to jail time for their behavior while pregnant. For example, a Missouri appellate court upheld a criminal conviction for endangering the welfare of a child and felony murder in the second degree when prenatal drug use contributed to the death of a newborn (*State v. Scroggs*, 521 S.W.3d 649 (Mo. Ct. App. 2017)).

Other U.S. state courts, however, have rejected these charges, sometimes finding that a fetus is not included in the meaning of "child" or "person" for the application of general criminal law (see *State v. Aiwohi*, 123 P.3d 1210 (Haw. 2005) (manslaughter); *Johnson v. State*, 602 So.2d 1288 (Fla. 1992) (delivery of controlled substance to a minor)). New York is one such state, where courts have held that child endangerment and second-degree manslaughter charges do not apply to a pregnant person's conduct toward an unborn fetus. *See, e.g.*, *People v. Jorgensen*, 907 N.Y.S.2d 439 (N.Y. Sup. Ct. 2010) (child endangerment); *People v. Jorgensen*, 19 N.Y.S.3d 814 (N.Y. 2015) (second-degree manslaughter); *People v. Morabito*, 580 N.Y.S.2d 843 (N.Y. City Ct. 1992) (child endangerment).

Sentencing and Probation Related to Prenatal Drug Use

[6] *See* Ali Farhoudian et al. *Barriers and Facilitators to Substance Use Disorder Treatment: An Overview of Systematic Reviews*, 16 Substance Abuse: Research and Treatment doi:10.1177/11782218221118462 (2022) (describing empirical support for structural and social factors influencing access to SUD treatment); Nora D. Volkow & Carlos Blanco, *Substance Use Disorders: A Comprehensive Update of Classification, Epidemiology, Neurobiology, Clinical Aspects, Treatment and Prevention*, 22 World Psychiatry 203 (2023) (describing a variety of influences on likelihood of SUD).
[7] Caroline K. Darlington et al., *Revisiting the Fetal Assault Law in Tennessee: Implications and the Way Forward*, 22 Pol'y, Pol., & Nursing Pract. 93 (2021).

Another strategy is to increase penalties for drug-related offenses when the defendant is a pregnant person, compared to a person who is not pregnant. For instance, an Idaho court upheld the revocation of a pregnant woman's probation due to drug possession, in part relying on state laws authorizing emergency medical treatment for minors and state action to protect children (*State v. Hanchey*, 500 P.3d 1159 (Ct. App. Idaho 2021)).

Civil Commitment

Although it is rare, U.S. states might also legislate to permit civil commitment of a pregnant person who uses substances. For example, the Oklahoma Prenatal Addiction Act specifies that "in some instances it may be necessary to use the authority of the state to intervene for the purpose of preserving and protecting the health and well-being of the child," and allows a district attorney to convene a multidisciplinary team to determine whether to subject a pregnant person to involuntary commitment for treatment (63 Okl. St. Ann. § 1-546.5).

Child Abuse and Neglect

Many U.S. states have enacted specific legislation or have interpreted general laws to categorize prenatal drug use as child abuse or neglect, for child protection purposes. Where prenatal drug use qualifies as child abuse or neglect, it triggers all of the laws that follow from this classification, including mandatory reporting and adverse impacts for parental rights. For example, South Dakota law includes a section specifying that prenatal substance is civil child abuse or neglect (S.D. Codified Laws § 26-8A-2). Because prenatal drug use is included in the child welfare statute, it automatically becomes subject to mandatory reporting by health care providers and other reporters. Other states have explicitly refused to include prenatal drug use as child abuse or neglect, such as Pennsylvania (23 Pa. C.S.A. § 6386), where the state code specifies that prenatal drug exposure "*shall not constitute a child abuse report*." Laws vary in conditions for classifying prenatal drug use as child abuse or neglect; some states require actual harm to the infant, while other states simply require exposure.

New York State cases have found that prenatal drug use alone cannot support a finding of child neglect under the Family Court Act § 1012(f)(1)(B) (including when it is established via a positive toxicology test in a newborn); however, a finding of neglect is proper when the child is "in imminent danger of becoming impaired" due to the drug use. *See In re Nassau Cnty. Dep't Soc. Servs. on behalf of Dante M. v. Denise J.*, 87 N.Y.2d 73 (N.Y. 1995); *In re Leo RR*, 183 N.Y.S.3d 636 (N.Y. App. Div. 2023) (finding neglect based on newborn toxicology and a finding linking toxicology to impairment). Under the Family Court Act § 1046(a)(iii), proof of a parent's repeated drug use that results in "a substantial state of stupor, unconsciousness, intoxication, hallucination, disorientation, or incompetence, or a substantial impairment of judgment or a substantial manifestation of irrationality" is also prima facie evidence of neglect if the parent is not participating in treatment, although it does not shift the burden of proof. *See In re Fam. Ct. Act*, 950 N.Y.S.2d 491 (Fam. Ct. 2012) (finding that a positive newborn toxicology

test for marijuana, along with the mother's admission of having used marijuana, did not establish the frequency of use or the level of impairment required for a showing of neglect); *In re Saaphire A.W.*, 166 N.Y.S.3d 627 (N.Y. App. Div. 2022) (similar).

Termination or Limitation of Parental Rights

By explicit law or the interpretation of general laws on parental rights, many U.S. states have included prenatal substance as a contributing factor or dispositive reason for terminating parental rights. For instance, Kentucky allows the termination of parental rights for children diagnosed with neonatal abstinence syndrome (Ky. Rev. Stat. Ann. § 625.090), while Georgia courts have considered prenatal drug use relevant under the general law for parental rights termination (*In re Levi*, 206 S.E.2d 82 (Ct. App. Ga. 1974)). These laws might also instruct courts to consider whether the parent has had an opportunity to complete substance abuse treatment. New York State courts have interpreted general law (Family Court Act § 631) to find permanent neglect and terminate rights where children were born with positive toxicology, and where the birthing parent was judged to have made insufficient efforts to provide an adequate and stable home in the time since the birth. *See, e.g.*, *In re Sarah C.*, 7 N.Y.S.3d 569 (N.Y. Sup. Ct. 2015) (terminating custody despite completion of drug treatment and a parenting class); *In re Elijah D.*, 902 N.Y.S.2d 736 (N.Y. Sup. Ct. 2010) (terminating custody after finding that the mother had made inadequate progress in completing the state's plan for services).

Testing and screening. In *Ferguson v. Charleston*, the Supreme Court held that it is a violation of the Fourth Amendment for a state hospital to test a pregnant person for drugs against their will (532 U.S. 67 (2001)). Many states, however, have drug testing and screening laws that require or allow health care providers to offer toxicological tests to pregnant or immediately postpartum people, and Fourth Amendment protections do not apply against private hospitals. In some states, a verbal screening test consisting of inquiring about drug use is administered, rather than a toxicological test. Testing can also apply to the neonate, with biological testing conducted shortly after birth to determine the presence of controlled substances. Consent procedures for mandatory testing vary by state. For example, in North Dakota testing is mandatory if there are signs or complications that indicate possible use of a controlled substance; the birthing parent's consent is only necessary when a biological specimen from the pregnant person or infant is not already available (N.D.C.C. § 50-25.1-17) (recently amended to change testing from mandatory to discretionary, and to exempt physicians from mandatory reporting obligations when they are providing postpartum or substance use services).

Administrative regulations in New York require midwifery birth centers to provide "a system for screening" pregnant people for substance use and other complications before admitting them to give birth, "and for referral of patients as appropriate to a higher-level facility." N.Y. Comp. Codes R. & Regs. tit. 10, § 795.7. Toxicology or other drug testing, however, is not mandatory.

The New York State Assembly is presently considering several bills that would bar drug testing of pregnant and postpartum people and newborns without informed consent (S320B, S4821).

Penalties for Non-Birthing Partners

Some U.S. state courts have terminated the parental rights of a non-birthing parent, on the grounds that the non-birthing parent had a duty to prevent the pregnant person from using substances. In several West Virginia cases, for example, courts have upheld the termination of a father's parental rights when the mother used drugs while pregnant, agreeing that the father "knowingly permitted" the drug use to take place (*In re A.C.L.M.*, 801 S.E.2d 260 (W. Va. 2017); *In re W.M.*, 2024 WL 2197171 (W. Va. 2024)). Under New York case law, a father neglects a child if there is impairment or imminent risk of impairment, and the father either engages in drug use that contributes to the pregnant mother's use, or fails to exercise care to prevent the pregnant mother from using drugs. *In re Baby B.W.*, 49 N.Y.S.3d 599 (N.Y. App. Div. 2017) (father's use contributed to mother's use while pregnant); *In re Thamel J.*, 76 N.Y.S.3d 56 (N.Y. Sup. Ct. 2018) (father used drugs with mother while she was pregnant, father "knew or should have known" that the mother was using drugs "but failed to take any steps to stop her drug use").

State of the Evidence

Thus far, several empirical studies have found that punitive laws are largely ineffective or harmful for the health outcomes of birthing people and their infants. Rather than deterring substance use or reducing neonatal drug withdrawal syndrome, punitive policies can increase barriers to accessing medical care, leading to population-level decreases in drug treatment and prenatal care engagement.[8] These outcomes are linked to adverse impacts for infants.[9] Evidence on implementation also suggests that the enforcement of these laws disproportionately affects lower-income pregnant women and women of color – groups that already face significant structural barriers to care. As a result, punitive laws like the foregoing approaches may exacerbate existing health disparities.[10]

---

[8] Cara Angelotta et al., *A Moral or Medical Problem? The Relationship between Legal Penalties and Treatment Practices for Opioid Use Disorders in Pregnant Women*. 26 Women's Health Issues 595 (2016); Anna E. Austin, Rebecca B. Naumann and Elizabeth Simmons, *Association of State Child Abuse Policies and Mandated Reporting Policies with Prenatal and Postpartum Care Among Women Who Engaged in Substance Use During Pregnancy*, 176 JAMA Pediatrics 1123 (2022); Meghan Boone and Benjamin J. McMichal, *State-Created Fetal Harm*, 109 Georgetown L.J. 476 (2021); Angelica Meinhofer et al., *Prenatal Substance Use Policies and Newborn Health*., 31 Health Econ. 1452 (2022); John J. Prindle, Ivy Hammond and Emily Putnam-Hornstein, *Prenatal Substance Exposure Diagnosed at Birth and Infant Involvement with Child Protective Service*s, 76 Child Abuse & Neglect 75 (2018); Sarah Cm Roberts, Claudia Zaugg, and Noelle Martinez, *Health Care Provider Decision-Making Around Prenatal Substance Use Reporting*, 237 Drug & Alcohol Dependence 109514 (2022).

[9] Laura J. Faherty, *Association of Punitive and Reporting State Policies Related to Substance Use in Pregnancy with Rates of Neonatal Abstinence Syndrome*. 2 JAMA Network Open e1914078 (2019); Meinhofer et al., *supra* note 8.

[10] Katy B. Kozhimannil et al., *Substance Use Disorder Treatment Admissions and State-Level Prenatal Substance Use Policies: Evidence from a National Treatment Database*. 90 Addictive Behaviors 272 (2019); S.C.M. Roberts et

Prosocial Laws

Preferential Drug Treatment Access

To increase access to drug treatment for pregnant people, some states have enacted laws requiring some or all treatment facilities to prioritize pregnant people who present for services. In certain cases, states will specify the drug use services to which priority access applies, such as opioid treatment programs. One such example is Delaware, where an administrative regulation requires licensed opioid treatment programs to "provide priority in initiating treatment" to pregnant clients (16 Del. Admin. Code 6001-14.0).

Creation and Funding of Targeted Programs

Priority treatment access is only effective where drug treatment is available. To increase treatment access, many state legislatures have established and funded programs addressing prenatal drug use and its health impacts. One example is Colorado's state-funded treatment program for "high-risk pregnant women," including those who use drugs (CO ST § 27-80-112). Targeted programs can also include the establishment of support services for families and infants impacted by prenatal drug use. For example, a Florida pilot program provides training and support to parents of infants born exposed to drugs (F.S.A. § 409.16742).

Public Funds Allocated for Establishing Drug Treatment Programs

Other statutes may focus on allocating or generating resources for existing treatment programs. For example, an Arizona law directed intergovernmental collaboration to create substance use treatment programs for pregnant women, requiring all "all agencies" to "actively seek grants and other funds for the purposes of this act" (A.R.S. § 36-2903). The state also uses some Temporary Assistance for Needy Families funds to supplement prenatal substance use treatment (A.R.S. § 46-300.04). New York law authorizes the use of statewide opioid settlement funds "to provide programs for pregnant women and new parents who currently or formerly have had a substance use disorder and newborns with neonatal abstinence syndrome," which includes drugs other than opioids. N.Y. Mental Hygiene Law § 25.18.

Prohibition of Discrimination by SUD Treatment Centers and Prenatal Care Providers

Where there is concern that substance use disorder treatment services are reluctant to serve pregnant people, state legislatures have banned discrimination on the basis of pregnancy. For example, a recently repealed Iowa statute specified that state-funded substance abuse treatment programs "shall not discriminate against a person seeking treatment solely because the person is

---

al., *Does Adopting a Prenatal Substance Use Protocol Reduce Racial Disparities in CPS Reporting Related to Maternal Drug Use? A California Case Study*. 35 J. Perinatology 146 (2015); Maria X. Sanmartin et al., *Association Between State-Level Criminal Justice-Focused Prenatal Substance Use Policies in the US and Substance Use-Related Foster Care Admissions and Family Reunification*. 174 JAMA Pediatrics 782 (2020).

pregnant, unless the program . . . refers the person to an alternative and acceptable treatment program" (Iowa Code § 125.32A). The Oklahoma Prenatal Addiction Act both bars state-funded drug treatment centers from refusing to treat pregnant women, and requires those centers to prioritize the treatment of pregnant women if space and staff expertise are available (63 Okl. St. Ann. § 1-546.4).

Support for Current Standard of Treatment

In some states, laws or regulations have provided guidance on what types of treatment or services should be made available to pregnant people. Indiana, for example, created a pilot for treating pregnant or postpartum women for opioid dependency, specifying that the program include "if appropriate, medication assisted treatment with a long acting, nonaddictive medication approved by the federal Food and Drug Administration for the treatment of opioid or alcohol dependence." (Ind. Code § 16-35-10-4). A Florida administrative regulation asks clinicians to inform pregnant people who use drugs of the risks of taking and not taking methadone during pregnancy, stating that "if the medication is not taken, risk includes withdrawal syndrome which has been associated with fetal demise." (Fla Admin. Code §4.65D-30.0142).

State of the Evidence

Although limited research has been conducted in this area, priority treatment policies have been linked to increased prenatal care utilization and a decrease in births with adverse health outcomes (e.g., early gestational age and low birth weight).[11] Prosocial policies are also associated with increases in the proportion of pregnant women accessing treatment for substance use disorder.[12]

Mandatory Reporting

Mandatory reporting laws require people to report known or suspected prenatal drug use, or the birth of a child with suspected drug exposure, to a state agency like child protection services, law enforcement, or the department of health. Mandatory reporting statutes specify the categories of reporters, including health professionals, the method for reports (e.g., phone call, written notification, receiving agency), and ways in which reported information will be used. Sometimes these laws explicitly require reporting of prenatal drug use, often for purposes of creating a plan of safe care (POSC) for the newborn. In other states, where courts or legislatures have determined that prenatal drug use is a form of child abuse or neglect, mandatory reporting requirements trigger investigation and follow-up by child protection services. New York health care providers must report to child protective services when there is "reasonable cause to

[11] Meinhofer et al., *supra* note 8.
[12] Kozhimannil et al., *supra* note 10; Nadia Tabatabaeepour et al., *Impact of Prenatal Substance Use Policies on Commercially Insured Pregnant Females with Opioid Use Disorder*. 140 J. Substance Abuse Treatment 108800 (2022).

suspect" that a child is abused or maltreated, including neglected. N.Y. Soc Serv. L. §§ 412, 413. Courts have found that "neglect" under the Family Court Act can include prenatal drug use under the conditions described above, if the child is impaired or in imminent danger of being impaired. Consequently, providers must exercise judgment to identify when a case presents a "reasonable cause to suspect" conditions that meet the courts' definition of "neglect." Providers of substance use treatment are mandatory reporters. N.Y. Mental Hygiene Law § 32.11.

U.S. state laws differ in how they handle mandatory reports of prenatal drug use. Under the federal Child Abuse Prevention and Treatment Act (CAPTA), states must track the number of infants affected by prenatal substance exposure, ensure development of a plan of safe care, and facilitate referrals to appropriate services. Some state laws limit mandatory reporting for these purposes exclusively. For example, a New Mexico law requires reporters to complete a POSC for drug-exposed newborn, but also states that "a finding that a pregnant woman is using or abusing drugs . . . shall not alone form a sufficient basis to report child abuse or neglect to the department" and that "notification by a health care provider . . . shall not be construed as a report of child abuse or neglect" (NM ST § 32A-4-3). In many other states, however, mandatory reporting requirements trigger investigation by child protective services or law enforcement. For example, Georgia law states that controlled substance use during pregnancy is "prenatal abuse," which mandatory reporters must relay to the Division of Family and Children Services (Ga. Code Ann., § 19-7-5), which can forward reports to law enforcement.

State of the Evidence

Qualitative and quantitative findings suggest that mandatory reporting obligations can amplify patients' mistrust of clinicians, which is a known barrier to medical care. Interviews with pregnant women suggest the belief that clinicians are aligned with child protective services, and that providers would impose legal consequences or share information if a drug test came back positive.[13] Clinicians, too, note that mandatory reporting laws can complicate their efforts to build and support provider-patient trust.[14] Mandatory reporting obligations can impede patient-clinician communication, including information sharing by the patient, which is a known barrier to high quality medical care.[15]

[13] Sarah C.M. Roberts and Amani Nuru-Jeter, *Universal Screening for Alcohol and Drug Use and Racial Disparities in Child Protective Services Reporting*, 39 J. Behavior & Health Servs. Res. 3 (2012); Sarah C.M. Roberts and Amani Nuru-Jeter, *Women's Perspectives on Screening for Alcohol and Drug Use in Prenatal Care*, 20 Womens Health Iss. 193 (2010).

[14] Sarah Cm Roberts, Clauda Zaugg, and Noelle Martinez, *Health Care Provider Decision-Making around Prenatal Substance Use Reporting*, 237 Drug & Alcohol Dependence 109514 (2022).

[15] American College of Obstetrics & Gynecology, *ACOG Committee Opinion No. 473: Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist*, 117 Obstetrics & Gynecology 200 (2011); Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). *AWHONN Position Statement: Optimizing Outcomes for Women with Substance Use Disorders in Pregnancy and the Postpartum Period*, 48 J. Obstetric,

Conclusions

U.S. states are actively adopting legislation with the stated purpose of addressing substance use by pregnant and postpartum people, and they have used a wide range of legal tools for this goal. However, many of these policies rely on outdated models of addiction behavior that are isolated to individual level factors and heavily on deterrence, rather than on linkages to harm reduction, substance use treatment, and comprehensive medical services. Empirical evidence for punitive approaches has suggested that these interventions can be ineffective or harmful, and that they put pressure on clinical providers and their treatment relationships with pregnant people. Modernizing this area of law will be an important step toward improving future outcomes for pregnant people, their infants, and their families, and there is an acute and pressing need for evidence-based regulation in this area.

Table 1

Category of Law	Example
Punitive Laws	
Criminalization	*State v. Scroggs*, 521 S.W.3d 649 (Mo. Ct. App. 2017)
Sentencing and Probation	*State v. Hanchey*, 500 P.3d 1159 (Ct. App. Idaho 2021)
Civil Commitment	63 Okl. St. Ann. § 1-546.5
Child Abuse and Neglect	Family Court Act § 1012(f)(1)(B) with case law, such as *Nassau County Dept. of Social Services on Behalf of Dante M. v. Denise J.*, 661 N.E.2d 138 (N.Y. 1995); Family Court Act § 1046(a)(iii) with case law, such as *In re Fam. Ct. Act*, 950 N.Y.S.2d 491 (N.Y. Fam. Ct. 2012)
Termination of Parental Rights	*In re Sarah C.*, 7 N.Y.S.3d 569 (N.Y. Sup. Ct. 2015)
Testing and Screening	N.D.C.C. § 50-25.1-17
Penalties for Non-Birthing Partners	*In re Thamel J.*, 76 N.Y.S.3d 56 (N.Y. Sup. Ct. 2018)
Prosocial Laws	
Treatment preferences	16 Del. Admin. Code §6001-14.0

Gynecologic & Neonatal Nursing 583 (2019); Marian Jarlenski et al., *Obstetric and Pediatric Provider Perspectives on Mandatory Reporting of Prenatal Substance Use*, 13 J. Addiction Med. 258 (2019).

Targeted programs	F.S.A. § 409.16742
Public funds	N.Y. Mental Hygiene L. § 25.18
Anti-discrimination laws	Iowa Code § 125.32A,
Mandatory reporting	
Mandatory reporting	N.Y. Soc Serv. L. §§ 412, 413