NYC Health

Testimony

of

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Executive Deputy Commissioner, Division of Mental Hygiene
New York City Department of Health and Mental Hygiene

before the

New York City Council Committee on Mental Health, Developmental Disability, Alcoholism, Substance Use, and Disability Services

Jointly with the

Council Committee on Public Safety

on

Oversight – Examining New York City's Response to Heroin Use and Overdoses

and

Int 0748 - 2015: An Office of Drug Strategy

June 23, 2015
Council Chambers – City Hall
New York City

Good morning Chairpersons Cohen, Gibson and members of the Committees. My name is Dr. Gary Belkin, and I am the Executive Deputy Commissioner for the Division of Mental Hygiene at the New York City Department of Health and Mental Hygiene. I am joined by my colleague, Dr. Hillary Kunins, Assistant Commissioner for the Bureau of Alcohol and Drug Use Prevention, Care and Treatment. On behalf of Commissioner Bassett, thank you for the opportunity to testify today on this important topic.

Overdose deaths involving opioids, which include both heroin and opioid analgesics, also known as prescription painkillers, are a serious public health problem in New York City. Opioid overdoses have claimed the lives of more than 7,000 New Yorkers over the last decade. Because heroin and opioid analgesics are chemically similar, some of the prevention and treatment strategies are also similar. I will speak about the health consequences and public health response for both.

Prescription painkiller misuse and overdose is both a national and a local health crisis. In New York City, emergency department visits related to prescription painkillers nearly tripled from 2004-2011, and rates of overdose death increased over 250 percent between 2000 and 2013. That translates to one New Yorker dying every other day from a prescription painkiller overdose. New York City has also seen heroin-involved overdose deaths double between 2010 and 2013. Both heroin and prescription painkillers can be risky drugs, and can lead to serious health and social consequences, including addiction and death from overdose transmission of infectious disease, particularly HIV and Hepatitis B & C. Stigma surrounding drug use and addiction can worsen these consequences.

Overdose deaths and other consequences of opioid misuse are preventable. The Department conducts public health surveillance on the health consequences of opioids and other drugs, such as opioid-related mortality and hospitalizations and opioid prescribing patterns, to identify geographic and population trends in order to target our responses. For example, in Staten Island, the borough with the highest rate of overdoses related to opioid-analgesics, the Department developed a multi-pronged approach, working with community stakeholders, conducting media campaigns, and disseminating clinical guidelines on judicious opioid analgesic prescribing for general practice and emergency departments. To disseminate guidelines further, the Department conducted one-on-one educational visits to approximately 1,000 prescribers in Staten Island, reinforcing safer prescribing practices. This campaign helped contribute to a 29 percent decrease in overdoses, a decrease infrequently seen in public health work – and received national attention. We are now completing a campaign in the Bronx, the borough with the second highest rates of opioid deaths.

The Department has also expanded addiction treatment services. Like many other health conditions, substance use disorders (or addiction) are treatable illnesses. In particular, medication-assisted treatment with methadone and buprenorphine (also known as Suboxone) is most effective. Ensuring widespread availability of medication-assisted treatment is a Department priority. We

sponsor the methadone treatment program at Rikers Island, the oldest jail-based program of its kind in the country.

A central Department strategy is to reduce the risk of HIV and Hepatitis B & C among people who use drugs includes providing a range of harm reduction services, including syringe access, which the Council has been instrumental in supporting. Harm reduction services, including those provided by New York City's syringe exchange programs, importantly engage and link people who use drugs in a range of health-promoting care and services.

Since 2009, the Department has increased access to naloxone, a medication that can reverse an overdose from opioid analgesics and heroin. Naloxone is safe and easy to use, has no significant adverse side effects, and no potential for abuse. Under the New York State Opioid Overdose Prevention Act, the Department supports state-registered programs to train laypeople as overdose responders and dispense naloxone kits to them. We have more than doubled our distribution of these kits in just the last three years, and dispensed over 32,000 kits since this program's inception.

Because of the Department's efforts, New York City is at the forefront of innovative overdose-reversal strategies. With our partners from harm reduction agencies, we are conducting a pilot program at the Rikers Island Visitors Center to train family members and friends of detained individuals in overdose prevention. Approximately 100 to 200 individuals are trained monthly, and 11 reversals have been reported to date. The Department is also continuing to work with the Department of Homeless Services to support their training of Peace Officers to recognize overdose and administer naloxone.

We also collaborate with the NYPD to provide technical support and equip police officers with naloxone kits. With funding from the State Attorney General, over 12,000 kits have been issued to patrol officers. We look forward to our continued partnership with the NYPD on this issue.

Based on results from a one-year evaluation of a naloxone training program administered at syringe exchange and methadone treatment programs, we estimate that over 1,300 overdose reversals annually result from the distribution of naloxone by our Department. With thanks to Council support, the Department's syringe exchange and harm reduction initiatives have been successful.

Office of Drug Strategy – Int 0748-2015

Also under consideration today is Intro 748, a bill that would create a city-wide Office of Drug Strategy to coordinate a comprehensive public health and public safety approach related to the impact of opioid use and its consequences. I would like to highlight our work in this area.

The Department's Bureau of Alcohol and Drug Use Prevention, Care and Treatment is responsible for planning and providing substance use services across New York City. This responsibility is carried out through the development, implementation, evaluation and promotion of

evidence-based programs and policies that address drug use and prevent drug-related deaths and illness. The Bureau also funds and oversees a portfolio of drug treatment and harm reduction service contracts, including methadone programs and harm reduction programs specifically serving New Yorkers with opioid use disorders. We are required by New York State Mental Hygiene law to develop a local services plan each year in which we prioritize strategies to reduce the impact of drug misuse on New Yorkers.

The Bureau collaborates regularly with advocates, peer groups, contracted providers, City and state agency partners, advisory groups, elected officials and community groups to ensure we are continuously working to meet the needs of the people we serve. We actively participate on a number of City and State workgroups, such as the Criminal Justice Taskforce and the redesign of Medicaid's behavioral health system that will provide intensive care coordination and enhanced services for individuals with significant behavioral health needs. We strongly advocate for legislation that addresses opioid use and overdose, and results in improved health and overdose prevention for people who use drugs.

The New York City Task Force on Prescription Painkiller Abuse, convened in 2011, was charged with developing and implementing coordinated strategies for responding to the growth of opioid analgesic misuse and diversion in New York City. As part of this Task Force, a data workgroup developed to compile and share the public health and safety data reflecting the consequences of opioid analgesic misuse in the City. The workgroup, led by the Health Department, included participants from City, State and federal government agencies, and became known as RxStat.

RxStat established a platform of data-sharing for public health and public safety collaboration and has evolved to influence policy and interventions in New York City. Under Mayor de Blasio's leadership, RxStat has expanded its initial focus on prescription opioid misuse to include all drug use. Supported in part by federal funds, including the Office of National Drug Control and Policy, its program, the NY-NJ High Intensity Drug Trafficking Area, and grants from the US Department of Justice-Bureau of Justice Assistance, monitoring and surveillance of drug-related data has expanded to include new data sources and more timely availability of existing data. Rx Stat has also resulted in an increased ability to monitor sudden increases in drug-related events that require urgent investigation, and a platform to share information and to strategize in response.

The Department looks forward to continuing to coordinate a public-health-driven strategy to promote evidence-based treatment, and reduce opioid-associated deaths in New York City. Thank you for the opportunity to testify. I would be happy to answer any questions.

Updated March 2015

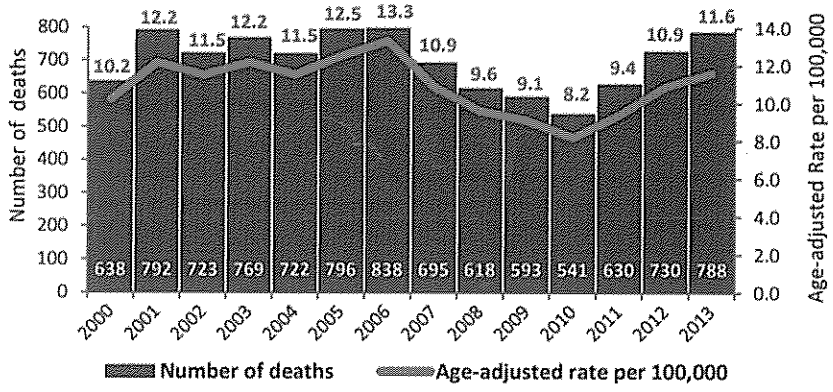
Epi Data Brief

New York City Department of Health and Mental Hygiene August, 2014 No. 50

Unintentional Drug Poisoning (Overdose) Deaths Involving Opioids in New York City, 2000–2013

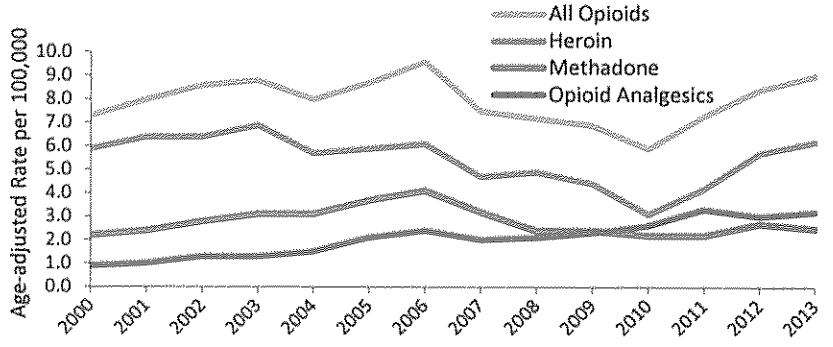
- In New York City (NYC) there were nearly 10,000 unintentional drug poisoning (overdose) deaths during the years 2000-2013, an average of 700 unintentional overdose deaths per year.
- From 2006-2010 the rate of overdose deaths decreased each consecutive year from 13.3 per 100,000 New Yorkers in 2006 to 8.2 per 100,000 New Yorkers in 2010, a 38% decrease.
- From 2010-2013, the rate of overdose deaths increased three years consecutively, from 8.2 per 100,000 in 2010 to 11.6 per 100,000 New Yorkers in 2013, a 41% increase.
- In 2013, more than three-quarters (77%) of overdose deaths involved an opioid.
- The rate of overdose deaths involving opioid analgesics increased by 256% from 2000 to 2013.
- The rate of overdose deaths involving heroin increased for three consecutive years from 3.1 per 100,000 New Yorkers (209 deaths) in 2010 to 6.2 per 100,000 New Yorkers (424 deaths) in 2013.
- Since 2008, the rate (2.4 per 100,000) of overdose deaths involving methadone has been stable.
- In 2013, methadone was involved in 21% (169 deaths) of overdose deaths, 2.5 per 100,000 New Yorkers.
- In 2013, nearly all (94%) of overdose deaths involved more than one substance.
- Benzodiazepines were found in 60% of overdose deaths involving opioid analgesics, 36% of deaths involving heroin, and 58% of deaths involving methadone in 2013.

Unintentional overdose deaths, New York City, 2000–2013



Source: NYC Office of the Chief Medical Examiner and NYC DOHMH Bureau of Vital Statistics

Unintentional overdose deaths by opioid type involved (not mutually exclusive), New York City, 2000–2013



Source: NYC Office of the Chief Medical Examiner and NYC DOHMH Bureau of Vital Statistics

Definitions: Unintentional drug poisoning deaths referred to as overdose deaths: Derived from death certificates and includes deaths from both illicit drugs and licit drugs taken for non-medical reasons. Excludes drug poisonings where the manner of death was intentional (suicide), undetermined, or homicide. Toxicology findings were abstracted from medical examiner files. Drugs are not mutually exclusive.

Opioids: Includes the entire family of opiates and opioids. Opiates are narcotic analgesics derived from "natural" opium. Opioids are synthetic and semi-synthetic drugs, such as methadone or heroin.

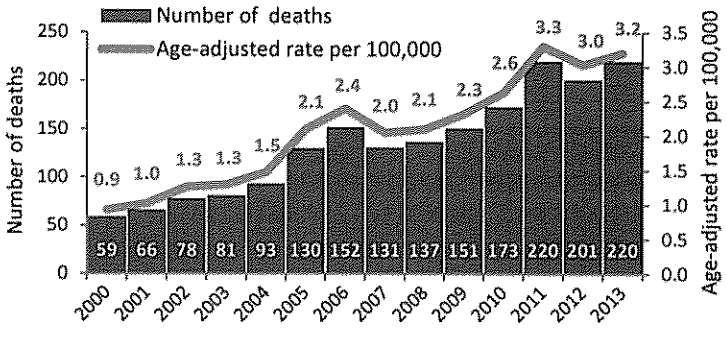
Opioid analgesics: Commonly known as prescription pain relievers, such as oxycodone (Percocet®) and hydrocodone (Vicodin®).

Methadone: A synthetic opioid used medically as an analgesic and to treat opioid dependence. Methadone is reported separately from opioid analgesics in New York City due to a large methadone maintenance population.

Unintentional overdose deaths involving opioid analgesics

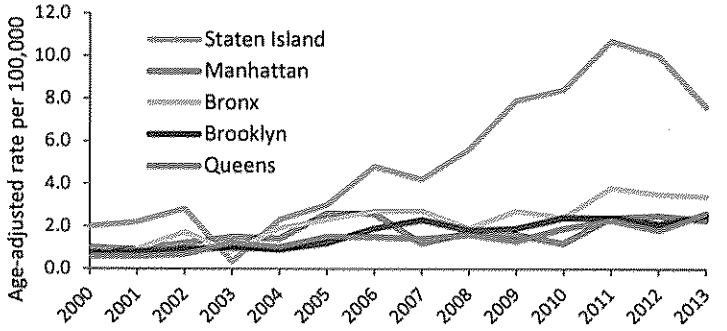
- Opioid analgesics were involved in 28% of overdose deaths in 2013.
- In 2013, the rate of overdose deaths involving opioid analgesics remained highest among Staten Island residents (7.6 per 100,000); however, the rate decreased for two consecutive years (by 29% from 10.7 per 100,000 in 2011).
- The rate increased from 2012 to 2013 in Queens from 1.8 to 2.6 per 100,000 residents and in Brooklyn from 2.1 to 2.5 per 100,000 residents.
- In 2013, residents of the lowest poverty (wealthiest) neighborhoods had the highest rate (4.1 per 100,000) of opioid analgesic-involved deaths compared with residents of all other neighborhoods.

Unintentional overdose deaths involving opioid analgesics, New York City, 2000–2013



Source: NYC Office of the Chief Medical Examiner and NYC DOHMH Bureau of Vital Statistics.

Unintentional overdose deaths involving opioid analgesics, by borough of residence New York City, 2000–2013

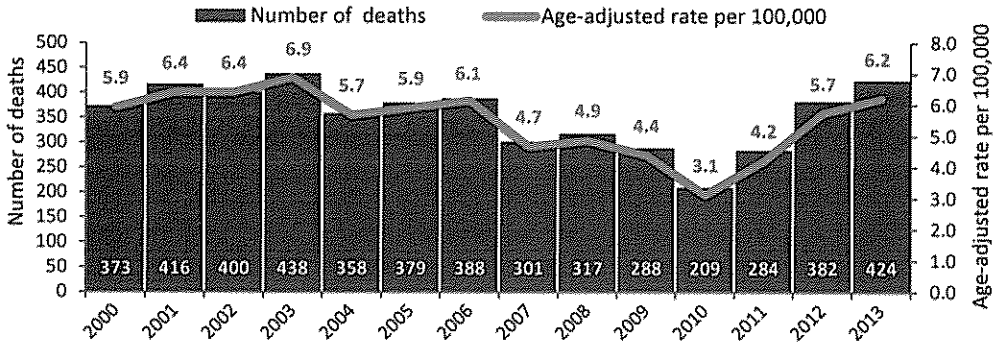


Source: NYC Office of the Chief Medical Examiner and NYC DOHMH Bureau of Vital Statistics.

Unintentional overdose deaths involving heroin

- In 2013, heroin was involved in 54% of all overdose deaths, making it the most common substance involved in overdose deaths.

Unintentional overdose deaths involving heroin, New York City, 2000–2013



Source: NYC Office of the Chief Medical Examiner and NYC DOHMH Bureau of Vital Statistics

Data Source:

NYC Office of the Chief Medical Examiner and NYC DOHMH Bureau of Vital Statistics:

Mortality data were collected through an in-depth review of data and charts from the Health Department's Bureau of Vital Statistics and the Office of the Chief Medical Examiner for 2000-2013. Methadone is reported separately and not included in opioid analgesic analyses.

Definitions:

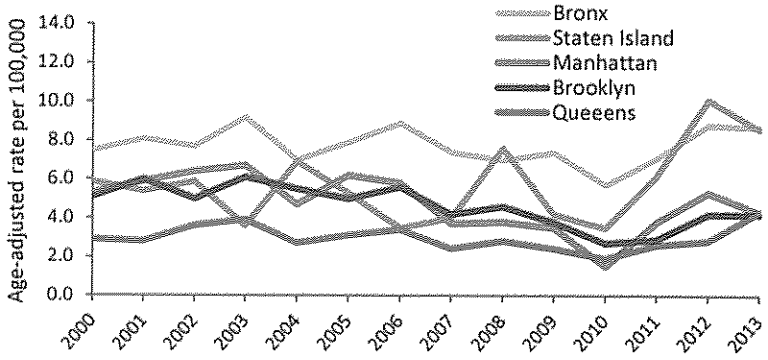
Rate Calculation: NYC DOHMH population estimates, modified from US Census Bureau intercensal population estimates 2000-2013, updated December 2014. These rates will differ from previously reported rates based on Census counts or previous versions of population estimates. Rates are age-adjusted to Census 2000 US standard population, except those for specific age groups.

Neighborhood poverty is based on ZIP code and is defined as the percentage of residents with incomes below 100% of the federal poverty level (per American Community Survey 2007-2011) in four groups: low (<10%), medium (10 %-< 20%), high (20 %-< 30%), and very high (>=30%).

Demographics of unintentional overdose deaths involving heroin

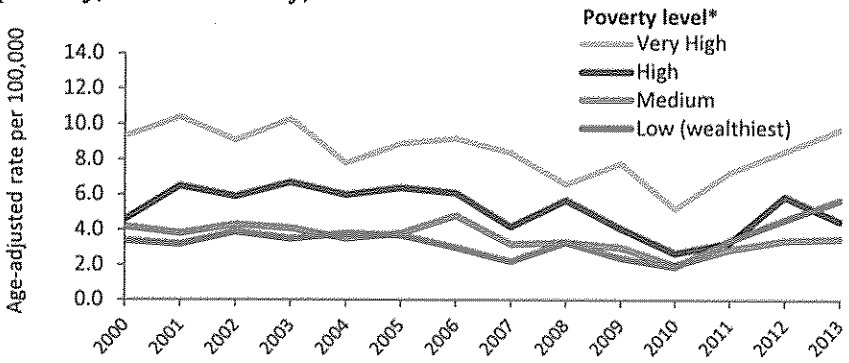
- In 2013, Bronx residents had the highest rate (8.7 per 100,000) of overdose deaths involving heroin, followed by Staten Island residents (8.6 per 100,000).
- The rate among Queens residents more than doubled from 1.9 in 2010 to 4.3 in 2013 per 100,000 residents.
- From 2010 through 2013, New Yorkers aged 35 to 54 had the highest rate of overdose deaths involving heroin.
- The largest increase (by age group) was among New Yorkers aged 15 to 34; the rate more than doubled from 2.1 per 100,000 in 2010 to 4.8 per 100,000 in 2013, a 129% increase.

Unintentional overdose deaths involving heroin by borough of residence, New York City, 2000–2013



Source: NYC Office of the Chief Medical Examiner and NYC DOHMH Bureau of Vital Statistics

Unintentional overdose deaths involving heroin by neighborhood poverty,* New York City, 2000–2013



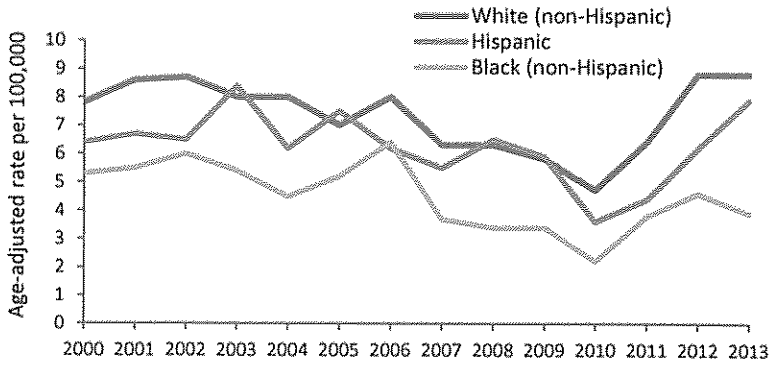
*Neighborhood poverty (based on ZIP code) defined as percent of residents with incomes below 100% of the Federal Poverty Level, per American Community Survey 2007-2011, in four groups: low (<10%), medium (10 %-< 20%), high (20 %-< 30%), and very high (>=30%).

Source: NYC Office of the Chief Medical Examiner and NYC DOHMH Bureau of Vital Statistics

- Residents of the highest poverty neighborhoods had a higher rate of overdose deaths involving heroin (9.7 per 100,000) than residents of all other neighborhoods in 2013.
- From 2010 to 2013, residents of the lowest-poverty (wealthiest) neighborhoods had the largest increase in rates (200%) from 1.9 per 100,000 in 2010 to 5.7 per 100,000 in 2013.

- The rate of overdose deaths involving heroin remained highest among white New Yorkers (8.8 per 100,000) in 2013.
- The largest increase was among Hispanic New Yorkers, from 3.6 per 100,000 residents in 2010 to 7.9 per 100,000 residents in 2013, a 119% increase.

Unintentional overdose deaths involving heroin by race/ethnicity, New York City, 2000–2013



Source: NYC Office of the Chief Medical Examiner and NYC DOHMH Bureau of Vital Statistics

Comment: For three consecutive years, the rate of heroin-involved overdose deaths increased in New York City, while the opioid analgesic mortality rate appears to have leveled off during the same time period. We cannot determine drug use patterns prior to the individual's death, thus, we cannot draw conclusions about the relationship between opioid analgesic use and heroin initiation. It is likely that some decedents did transition from opioid analgesics to heroin, while others may have increased their use of heroin and still others may have initiated heroin, without prior opioid analgesic use. In New York City, heroin mortality rates rose while prescribing rates of opioid analgesics remained stable.

New York City residents of low-income neighborhoods and white New Yorkers have the highest heroin-involved mortality rates; however, 2013 data show the highest increases are among residents of the wealthiest neighborhoods and younger New Yorkers.

DOHMH prevention and treatment activities

To prevent overdose and reduce adverse health consequences of heroin and prescription opioid use:

1. **Public awareness.** The Department of Health and Mental Hygiene (DOHMH) has conducted public awareness campaigns through television about overdose risk from prescription opioids.
2. **Overdose prevention**. DOHMH funds training of responders in overdose treatment and distributes naloxone, a medicine that reverses the effects of prescription opioids and heroin.
3. **Effective treatment for opioid dependence**. DOHMH funds and promotes quality improvement among substance use disorder treatment programs. DOHMH also conducts training, disseminates practice guidelines, and provides technical assistance to promote effective practice, particularly with buprenorphine, an effective medication for opioid dependence.
4. **Policy development and program initiatives.** DOHMH uses data to inform policy-makers and initiate new programs such as: advocating for relabeling of opioids to discourage their use for treatment of chronic non-cancer pain, making naloxone an over-the-counter medication, and urging hospital adoption of guidelines for judicious opioid prescribing in emergency departments.

Authored by: Denise Paone, Ellenie Tuazon, Daniella Bradley O'Brien, Michelle Nolan

MORE New York City Health Data and Publications

- For complete tables of data presented in this Brief, visit nyc.gov/html/doh/downloads/pdf/epi/datatable50.pdf
- For more information on drug use, check out the following Health Department resources:
  - Unintentional Drug Poisoning (Overdose) Deaths in New York City, 2000-2012
  - Unintentional Opioid Analgesic Poisoning (Overdose) Deaths in New York City, 2011
  - Opioid Analgesics in New York City: Prescriber Practices
  - Drugs in New York City: Misuse, Morbidity and Mortality Update
  - Patterns of Opioid Analgesic Prescriptions for New York City Residents
  - Prescription Drug Misuse and Illicit Drug Use among New York City Youth
  - City Health Information: Preventing Misuse of Prescription Opioid Drugs (includes prescribing guidelines)
  - New York City Emergency Department Disharge Opioid Prescribing Guidelines
  - Vital Signs: Illicit Drug Use in New York City
- Visit EpiQuery – the Health Department's online, interactive health data system: nyc.gov/health/EpiQuery

Data & Statistics at nyc.gov/health/data

Updated March 2015

Epi Data Tables

New York City Department of Health and Mental Hygiene

August 2014, No. 50

Unintentional Drug Poisoning (Overdose) Deaths Involving Opioids in New York City, 2010-2013

Data Tables

Data Sources

Bureau of Vital Stastics/Office of the Chief Medical Examiner: Mortality data were collected through an in-depth review of data and charts from the Health Department's Bureau of Vital Statistics and the Office of the Chief Medical Examiner for 2000-2013. Methadone is reported separately and not included in opioid analgesic analyses.
Rate Calculation: NYC DOHMH population estimates, modified from US Census Bureau intercensal population estimates 2000-2013, updated December 2014. These rates will differ from previously reported rates based on Census counts or previous versions of population estimates. Rates are age-adjusted to Census 2000, except those for specific age groups.
Neighborhood poverty is based on ZIP code and is defined as the percentage of residents with incomes below 100% of the Federal Poverty Level, per American Community Survey 2007-2011, in four groups: low (<10%), medium (10 %-< 20%), high (20 %-< 30%), and very high (>=30%).

To access the related Epi Data Brief, go to www.nyc.gov/html/doh/downloads/pdf/epi/databrief50.pdf

NYC Health

Table 1. Number and rate of unintentional drug poisoning (overdose) deaths, New York City, 2010-2013

Source: Bureau of Vital Statistics/Office of the Chief Medical Examiner, New York City; Rates calculated using NYC DOHMH population estimates, modified from US Census Bureau intercensal population estimates, 2010-2013. Updated December 2014. Analysis by Health Department's Bureau of Alcohol and Drug Use Prevention, Care and Treatment.

Rates per 100,000 New Yorkers are age adjusted, except those for specific age groups.

	2010			2011			2012			2013		
	Number	Percent	Rate	Number	Percent	Rate	Number	Percent	Rate	Number	Percent	Rate
Total Unintentional Drug Poisoning Deaths	**541**	**100%**	**8.2**	**630**	**100%**	**9.4**	**730**	**100%**	**10.9**	**788**	**100%**	**11.6**
Gender												
Male	386	71%	12.4	455	72%	14.2	534	73%	16.6	570	72%	17.7
Female	155	29%	4.4	175	28%	5.0	196	27%	5.7	218	28%	6.2
Race/Ethnicity												
Black (non-Hispanic)	128	24%	8.1	158	26%	10.0	180	25%	11.7	172	23%	10.7
Hispanic	150	28%	8.7	157	26%	8.8	192	27%	10.5	222	30%	12.1
White (non-Hispanic)	250	47%	11.6	300	49%	13.5	336	47%	15.6	358	48%	16.3
Age (years)												
15-24	30	6%	2.5	37	6%	3.2	48	7%	4.2	45	6%	4.0
25-34	85	16%	6.0	125	20%	8.7	140	19%	9.6	137	17%	9.3
35-44	121	22%	10.4	133	21%	11.5	158	22%	13.5	159	20%	13.6
45-54	194	36%	17.4	206	33%	18.5	245	34%	22.0	251	32%	22.6
55-64	93	17%	10.3	122	19%	13.2	122	17%	13.0	163	21%	17.1
65-84	17	3%	2.0	7	1%	0.8	17	2%	1.9	33	4%	3.6
Borough of Residence												
Bronx	128	27%	12.3	140	25%	13.3	171	26%	16.1	162	21%	15.0
Brooklyn	145	30%	7.3	158	28%	7.8	179	27%	8.9	165	21%	8.2
Manhattan	69	14%	5.3	103	18%	7.7	131	20%	9.8	136	17%	9.8
Queens	91	19%	5.0	97	17%	5.2	105	16%	5.5	145	18%	7.6
Staten Island	46	10%	12.2	69	12%	18.4	74	11%	19.9	64	8%	17.6
Borough of Death												
Bronx	132	24%	12.8	147	23%	13.8	175	24%	16.5	184	23%	17.2
Brooklyn	166	31%	8.4	172	27%	8.5	188	26%	9.4	197	25%	9.9
Manhattan	102	19%	7.6	134	21%	9.9	172	24%	12.9	191	24%	13.8
Queens	96	18%	5.3	100	16%	5.4	120	16%	6.4	152	19%	8.0
Staten Island	45	8%	12.0	77	12%	20.6	75	10%	20.1	64	8%	17.5
Neighborhood Poverty*												
Low (wealthiest)	80	17%	6.0	124	22%	8.8	119	18%	8.6	147	22%	10.6
Medium	150	32%	6.0	158	28%	6.2	194	29%	7.5	183	27%	7.1
High	112	24%	7.2	130	23%	8.4	164	25%	10.6	160	24%	10.0
Very High	130	28%	11.8	155	27%	13.9	182	28%	16.2	181	27%	15.9
Drug Type**												
Alcohol	243	45%	3.7	273	43%	4.1	316	43%	4.7	340	43%	5.0
Benzodiazepines	227	42%	3.5	210	33%	3.1	278	38%	4.2	298	38%	4.4
Cocaine	289	53%	4.4	319	51%	4.8	348	48%	5.2	364	46%	5.5
Heroin	209	39%	3.1	284	45%	4.3	382	52%	5.7	424	54%	6.2
Methadone	142	26%	2.2	146	23%	2.2	184	25%	2.8	169	21%	2.5
Opioid Analgesics	173	32%	2.6	220	35%	3.3	201	28%	3.0	220	27%	3.2

Top 5 NYC Neighborhoods^	**2010-2011 Rate**		**2012-2013 Rate**	
	Stapleton-St George	20.1	Hunts Point-Mott Haven	28.2
	Hunts Point-Mott Haven	18.2	South Beach-Tottenville	23.2
	Highbridge-Morrisania	15.9	Willowbrook	21.0
	Crotona-Tremont	15.8	Highbridge-Morrisania	19.1
	Willowbrook	14.8	Central Harlem	18.8

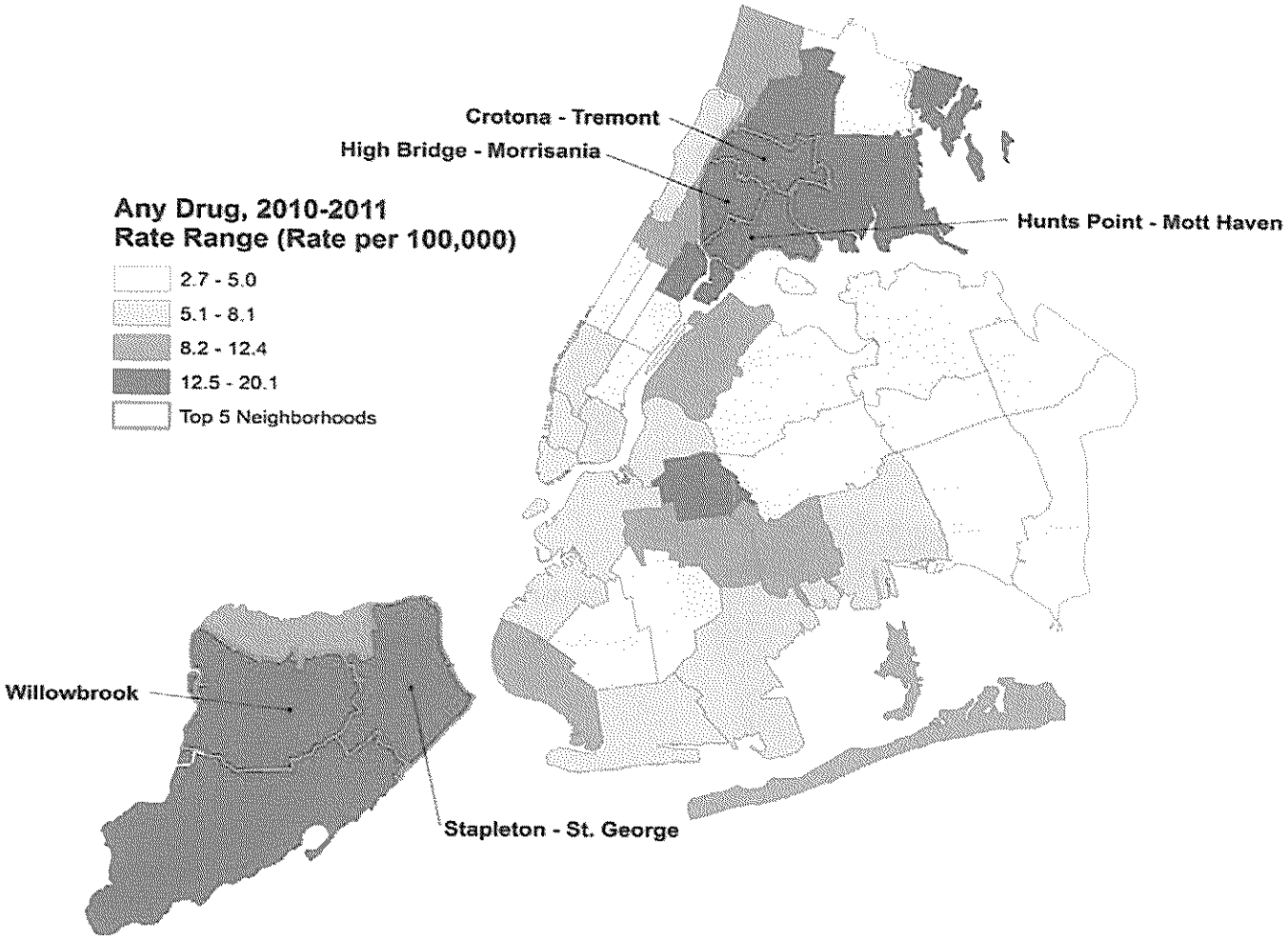
*Neighborhood poverty (based on ZIP code) was defined as percent of residents with incomes below 100% of the federal poverty level (Census 2000), separated into four groups: low (<10%), medium (10%-<20%), high (20%-<30%) and very high (>=30%).

**Drug Type, not mutually exclusive.; percent will not equal 100%.

^Top five of 42 NYC Neighborhoods

Map 1. Top five New York City neighborhoods: Rates of unintentional drug poisoning (overdose) by neighborhood* of residence, 2010-2011

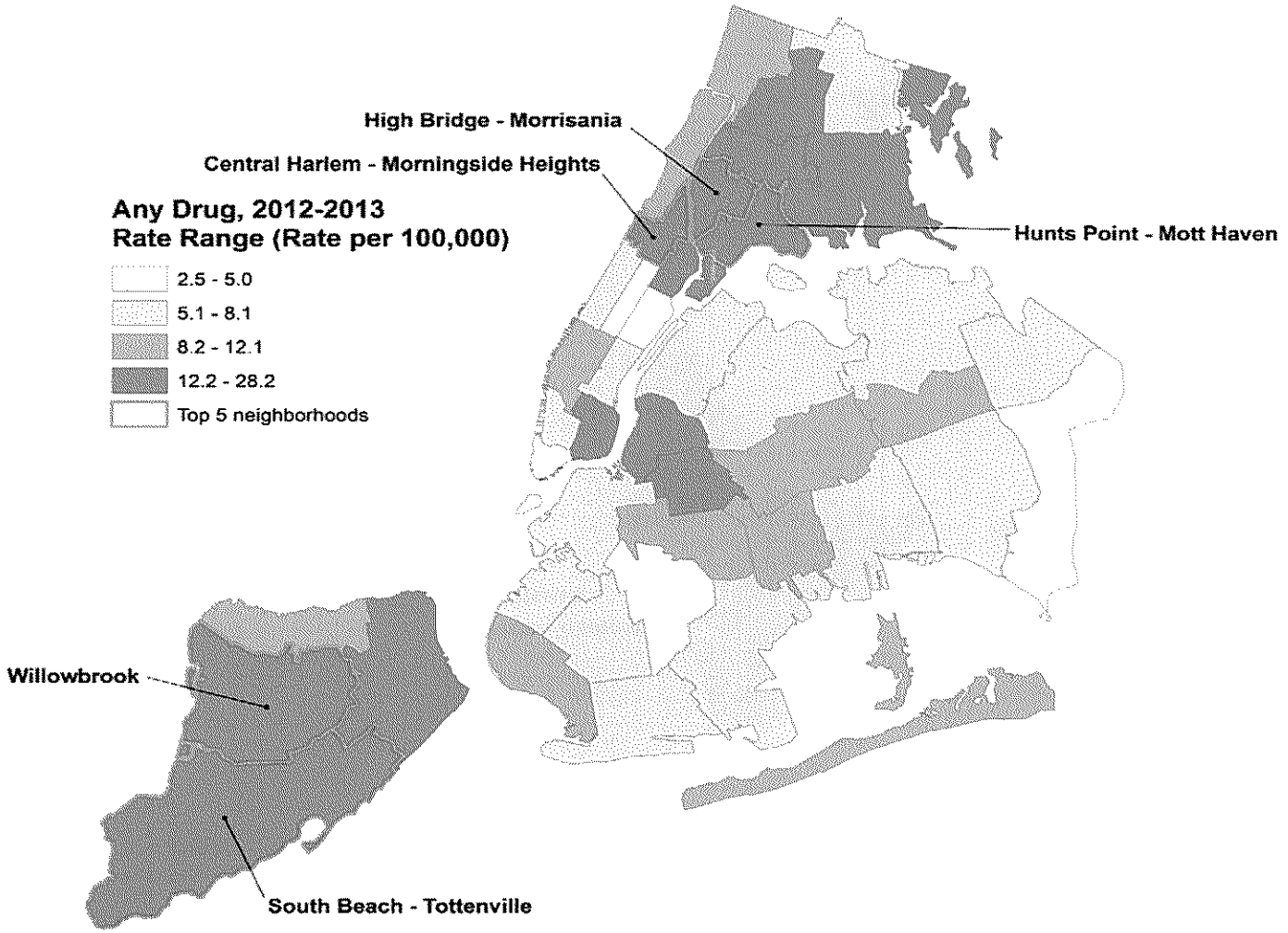
Source: Bureau of Vital Statistics/Office of the Chief Medical Examiner, New York City; Rates calculated using NYC DOHMH population estimates, modified from US Census Bureau intercensal population estimates, 2010-2011. Updated December 2014. Analysis by Health Department's Bureau of Alcohol and Drug Use Prevention, Care and Treatment.



*The United Hospital Fund (UHF) classifies New York City into 42 neighborhoods, comprised of contiguous zip codes.

Map 2. Top five New York City neighborhoods: Rates of unintentional drug poisoning (overdose) by neighborhood* of residence, 2012-2013

Source: Bureau of Vital Statistics/Office of the Chief Medical Examiner, New York City; Rates calculated using NYC DOHMH population estimates, modified from US Census Bureau intercensal population estimates, 2012-2013. Updated December 2014. Analysis by Health Department's Bureau of Alcohol and Drug Use Prevention, Care and Treatment.



*The United Hospital Fund (UHF) classifies New York City into 42 neighborhoods, comprised of contiguous zip codes.

Table 2. Number and rate of unintentional drug poisoning (overdose) deaths involving opioid analgesics, New York City, 2010-2013

Source: Bureau of Vital Statistics/Office of the Chief Medical Examiner, New York City; Rates calculated using NYC DOHMH population estimates, modified from US Census Bureau intercensal population estimates, 2010-2013. Updated December 2014. Analysis by Health Department's Bureau of Alcohol and Drug Use Prevention, Care and Treatment.

Rates per 100,000 New Yorkers are age adjusted, except those for specific age groups.

	2010			2011			2012			2013		
	Number	Percent	Rate	Number	Percent	Rate	Number	Percent	Rate	Number	Percent	Rate
Total Unintentional Drug Poisoning Deaths	**541**	**100%**	**8.2**	**630**	**100%**	**9.4**	**730**	**100%**	**10.9**	**788**	**100%**	**11.6**
Total Unintentional Drug Poisoning Deaths Involving Opioid Analgesics	173	32%	2.6	220	35%	3.3	201	28%	3.0	220	28%	3.2
Gender												
Male	109	63%	3.5	160	73%	5.0	141	70%	4.4	147	67%	4.5
Female	64	37%	1.8	60	27%	1.7	60	30%	1.8	73	33%	2.0
Race/Ethnicity												
Black (non-Hispanic)	21	13%	1.3	24	11%	1.6	40	20%	2.7	30	14%	1.9
Hispanic	32	19%	1.8	40	19%	2.2	42	21%	2.3	52	24%	2.8
White (non-Hispanic)	115	68%	5.5	152	70%	7.0	115	58%	5.4	131	62%	5.8
Age (years)												
15-24	13	8%	1.1	24	11%	2.1	23	11%	2.0	11	5%	1.0
25-34	33	19%	2.3	50	23%	3.5	39	19%	2.7	43	20%	2.9
35-44	47	27%	4.0	49	22%	4.2	49	24%	4.2	44	20%	3.8
45-54	52	30%	4.7	59	27%	5.3	56	28%	5.0	73	33%	6.6
55-64	27	16%	3.0	35	16%	3.8	32	16%	3.4	43	20%	4.5
65-84	1	1%	0.1	3	1%	0.3	2	1%	0.2	6	3%	0.7
Age (years-collapsed)												
15-34	46	27%	1.8	74	34%	2.9	62	31%	2.4	54	25%	2.1
35-54	99	57%	4.3	108	49%	4.8	105	52%	4.6	117	53%	5.1
55-84	28	16%	1.6	38	17%	2.1	34	17%	1.9	49	22%	2.6
Borough of Residence												
Bronx	25	17%	2.4	40	20%	3.8	38	21%	3.5	36	18%	3.4
Brooklyn	46	30%	2.4	48	24%	2.4	40	22%	2.1	51	26%	2.5
Manhattan	15	10%	1.2	31	15%	2.4	33	18%	2.5	31	16%	2.3
Queens	34	23%	1.9	42	21%	2.3	33	18%	1.8	51	26%	2.6
Staten Island	31	21%	8.4	40	20%	10.7	37	20%	10.0	28	14%	7.6
Borough of Death												
Bronx	27	16%	2.6	41	19%	3.8	39	19%	3.6	42	19%	3.9
Brooklyn	50	29%	2.6	52	24%	2.6	41	20%	2.2	60	27%	3.0
Manhattan	25	14%	1.9	38	17%	2.9	45	22%	3.4	38	17%	2.7
Queens	40	23%	2.2	45	20%	2.4	38	19%	2.0	54	25%	2.8
Staten Island	31	18%	8.5	44	20%	12.0	38	19%	10.1	26	12%	6.9
Neighborhood Poverty*												
Low (wealthiest)	42	28%	3.2	59	29%	4.2	54	30%	4.0	59	30%	4.1
Medium	54	36%	2.2	67	33%	2.6	57	31%	2.2	55	28%	2.1
High	25	17%	1.6	33	16%	2.1	36	20%	2.3	44	22%	2.8
Very High	30	20%	2.6	42	21%	3.7	34	19%	3.0	38	19%	3.3

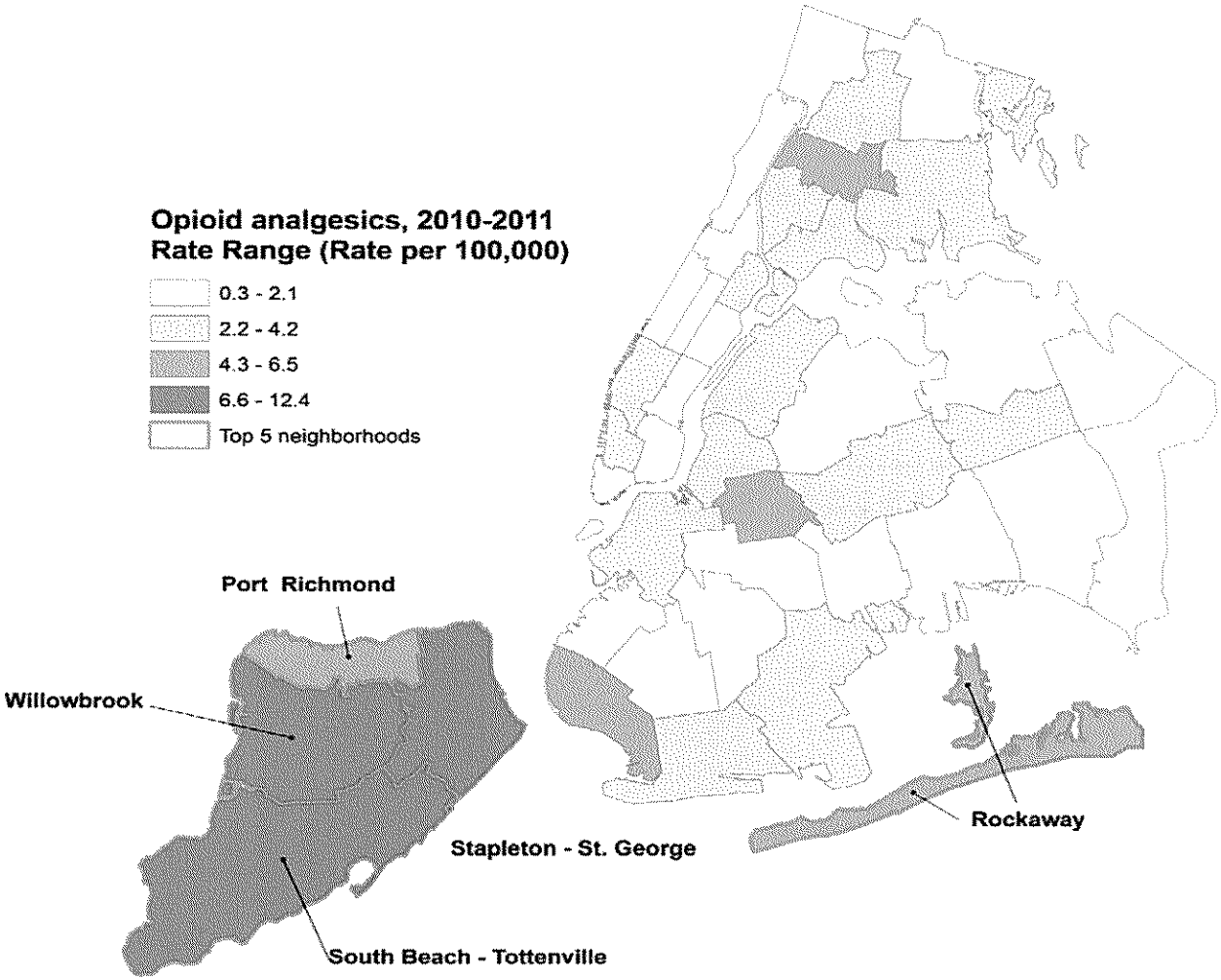
Top 5 NYC Neighborhoods^	**2010-2011 Rate**		**2012-2013 Rate**	
	Stapleton-St George	12.5	Willowbrook	11.7
	South Beach-Tottenville	10.1	South Beach-Tottenville	10.9
	Willowbrook	8.5	Stapleton-St George	6.3
	Rockaway	6.6	Hunts Point-Mott Haven	5.7
	Port Richmond	6.1	Kingsbridge-Riverdale	5.5

*Neighborhood poverty (based on ZIP code) was defined as percent of residents with incomes below 100% of the federal poverty level (Census 2000), separated into four groups: low (<10%), medium (10%-<20%), high (20%-<30%) and very high (>=30%).

^Top five of 42 NYC Neighborhoods

Map 3. Top five New York City neighborhoods: Rates of unintentional drug poisoning (overdose) deaths involving opioid analgesics by neighborhood* of residence, 2010-2011

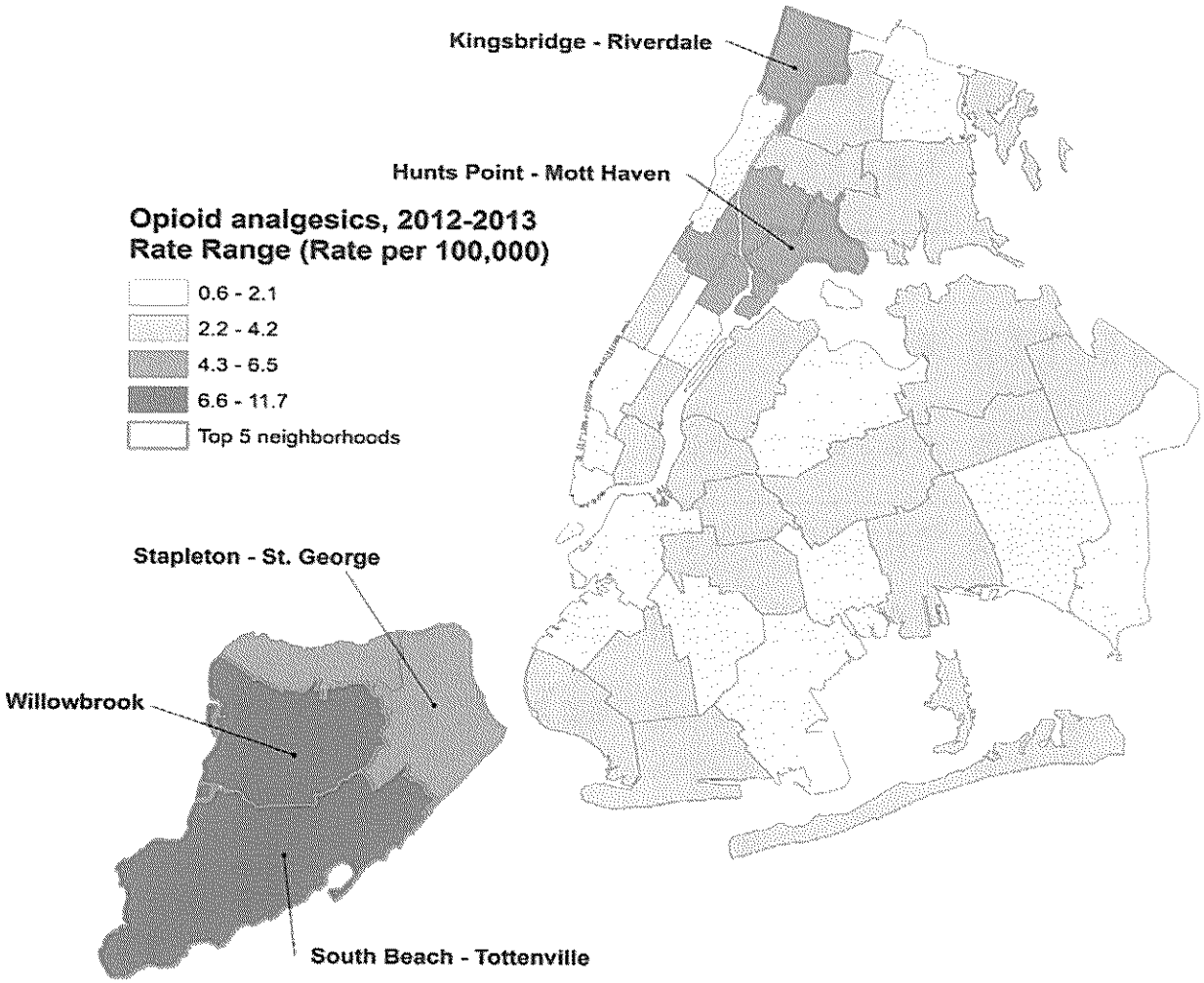
Source: Bureau of Vital Statistics/Office of the Chief Medical Examiner, New York City; Rates calculated using NYC DOHMH population estimates, modified from US Census Bureau intercensal population estimates, 2010-2011. Updated December 2014. Analysis by Health Department's Bureau of Alcohol and Drug Use Prevention, Care and Treatment.



*The United Hospital Fund (UHF) classifies New York City into 42 neighborhoods, comprised of contiguous zip codes.

Map 4. Top five NYC Neighborhoods: Rates of unintentional drug poisoning (overdose) deaths involving opioid analgesics by NYC neighborhood* of residence, 2012-2013

Source: Bureau of Vital Statistics/Office of the Chief Medical Examiner, New York City; Rates calculated using NYC DOHMH population estimates, modified from US Census Bureau intercensal population estimates, 2012-2013. Updated December 2014. Analysis by Health Department's Bureau of Alcohol and Drug Use Prevention, Care and Treatment.



*The United Hospital Fund (UHF) classifies New York City into 42 neighborhoods, comprised of contiguous zip codes.

Table 3. Number and rate of unintentional drug poisoning (overdose) deaths involving heroin, New York City, 2010-2013

Source: Bureau of Vital Statistics/Office of the Chief Medical Examiner, New York City; Rates calculated using NYC DOHMH population estimates, modified from US Census Bureau intercensal population estimates, 2010-2013. Updated December 2014. Analysis by Health Department's Bureau of Alcohol and Drug Use Prevention, Care and Treatment.

Rates per 100,000 New Yorkers are age adjusted, except those for specific age groups.

	2010			2011			2012			2013		
	Number	Percent	Rate	Number	Percent	Rate	Number	Percent	Rate	Number	Percent	Rate
Total Unintentional Drug Poisoning Deaths	541	100%	8.2	630	100%	9.4	730	100%	10.9	788	100%	11.6
Total Unintentional Drug Poisoning Deaths Involving Heroin	209	39%	3.1	284	45%	4.2	382	52%	5.7	424	54%	6.2
Gender												
Male	168	80%	5.3	222	78%	6.9	297	78%	9.2	326	77%	10.1
Female	41	20%	1.1	62	22%	1.8	85	22%	2.5	98	23%	2.7
Race/Ethnicity												
Black (non-Hispanic)	36	18%	2.2	61	22%	3.8	70	19%	4.6	64	16%	3.9
Hispanic	64	31%	3.6	79	28%	4.4	114	30%	6.2	146	36%	7.9
White (non-Hispanic)	105	51%	4.7	140	50%	6.4	191	51%	8.8	195	48%	8.8
Age (years)												
15-24	12	6%	1.0	17	6%	1.5	27	7%	2.4	32	8%	2.9
25-34	43	21%	3.1	63	22%	4.4	88	23%	6.0	92	22%	6.2
35-44	36	17%	3.1	64	23%	5.5	80	21%	6.9	84	20%	7.2
45-54	76	36%	6.8	88	31%	7.9	130	34%	11.7	125	30%	11.2
55-64	39	19%	4.3	49	17%	5.3	50	13%	5.3	78	18%	8.2
65-84	3	1%	0.3	3	1%	0.3	7	2%	0.8	13	3%	1.4
Age (years-collapsed)												
15-34	55	26%	2.1	80	28%	3.1	115	30%	4.4	124	29%	4.8
35-54	112	54%	4.9	152	54%	6.7	210	55%	9.3	209	49%	9.2
55-84	42	20%	2.4	52	18%	2.9	57	15%	3.1	91	22%	4.9
Borough of Residence												
Bronx	60	33%	5.7	75	30%	7.1	93	27%	8.8	94	27%	8.7
Brooklyn	55	30%	2.7	58	23%	2.9	84	25%	4.2	84	24%	4.2
Manhattan	20	11%	1.5	51	20%	3.8	73	22%	5.3	61	17%	4.3
Queens	35	19%	1.9	47	19%	2.6	53	16%	2.8	81	23%	4.3
Staten Island	14	8%	3.5	22	9%	6.2	36	11%	10.1	32	9%	8.6
Borough of Death												
Bronx	58	28%	5.6	80	28%	7.6	98	26%	9.3	109	26%	10.2
Brooklyn	69	33%	3.4	66	23%	3.3	96	25%	4.8	102	24%	5.1
Manhattan	37	18%	2.7	68	24%	5.0	96	25%	7.2	89	21%	6.3
Queens	33	16%	1.7	47	17%	2.6	59	15%	3.2	91	22%	4.8
Staten Island	12	6%	3.0	23	8%	6.5	33	9%	9.2	33	8%	9.1
Neighborhood Poverty*												
Low (wealthiest)	26	15%	1.9	46	18%	3.4	64	19%	4.6	78	22%	5.7
Medium	51	28%	2.0	73	29%	2.9	86	25%	3.4	90	26%	3.5
High	43	24%	2.7	52	21%	3.3	92	27%	5.9	73	21%	4.5
Very High	59	33%	5.2	82	32%	7.3	96	28%	8.5	110	31%	9.7

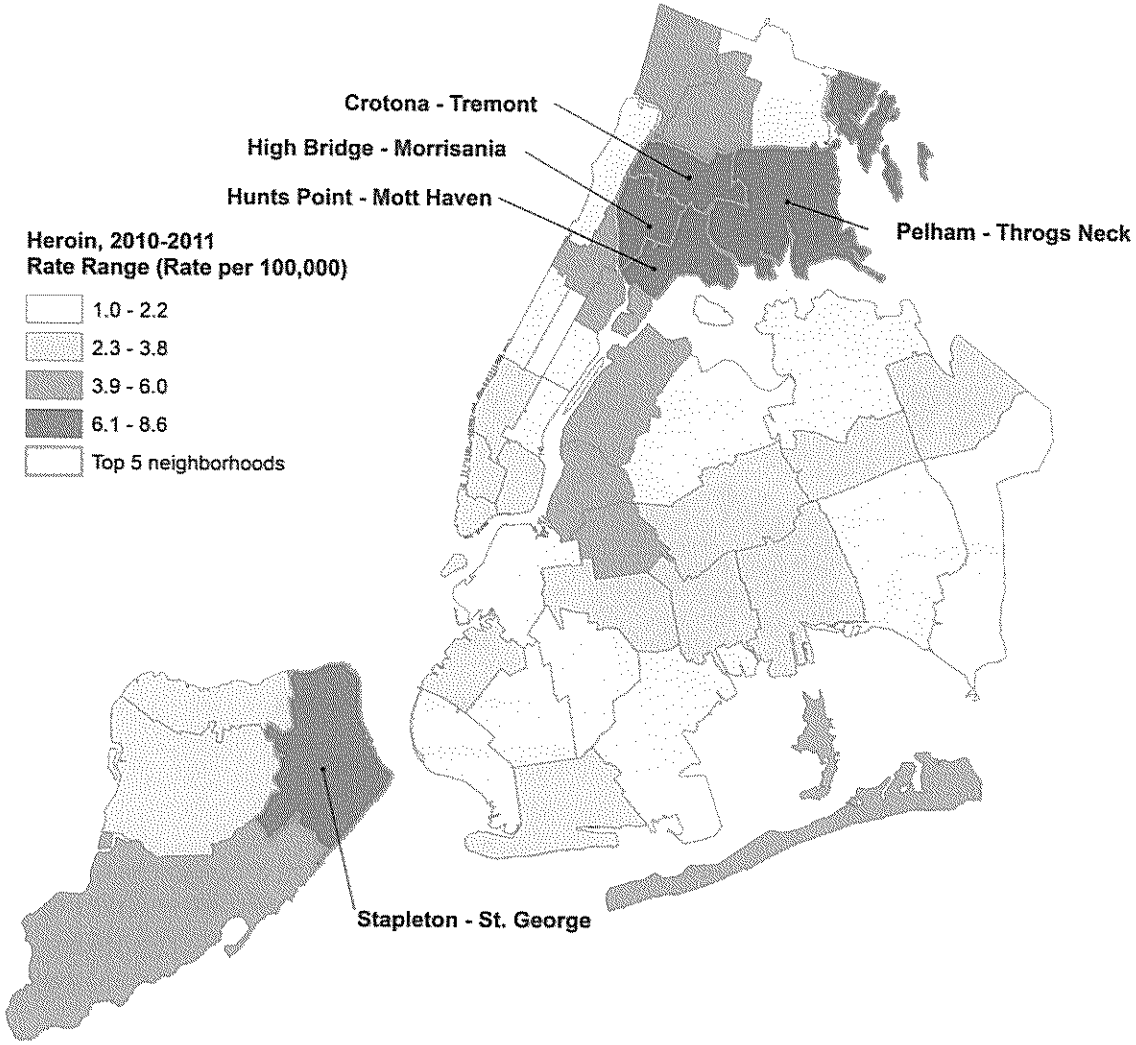
Top 5 NYC Neighborhoods^	**2010-2011 Rate**		**2012-2013 Rate**	
	Hunts Point-Mott Haven	8.6	Hunts Point-Mott Haven	16.5
	Crotona-Tremont	8.1	South Beach-Tottenville	12.8
	Pelham-Throgs Neck	8.0	Willowbrook	10.7
	Highbridge-Morrisania	7.0	Fordham - Bronx Park	10.6
	Stapleton-St George	6.9	Crotona-Tremont	10.3

*Neighborhood poverty (based on ZIP code) was defined as percent of residents with incomes below 100% of the federal poverty level per American Community Survey 2007-2011, separated into four groups: low (<10%), medium (10%-<20%), high (20%-<30%) and very high (>=30%).

^Top five of 42 NYC Neighborhoods

Map 5. Top five New York City neighborhoods: Rates of unintentional drug poisoning (overdose) deaths involving heroin by neighborhood* of residence, 2010-2011

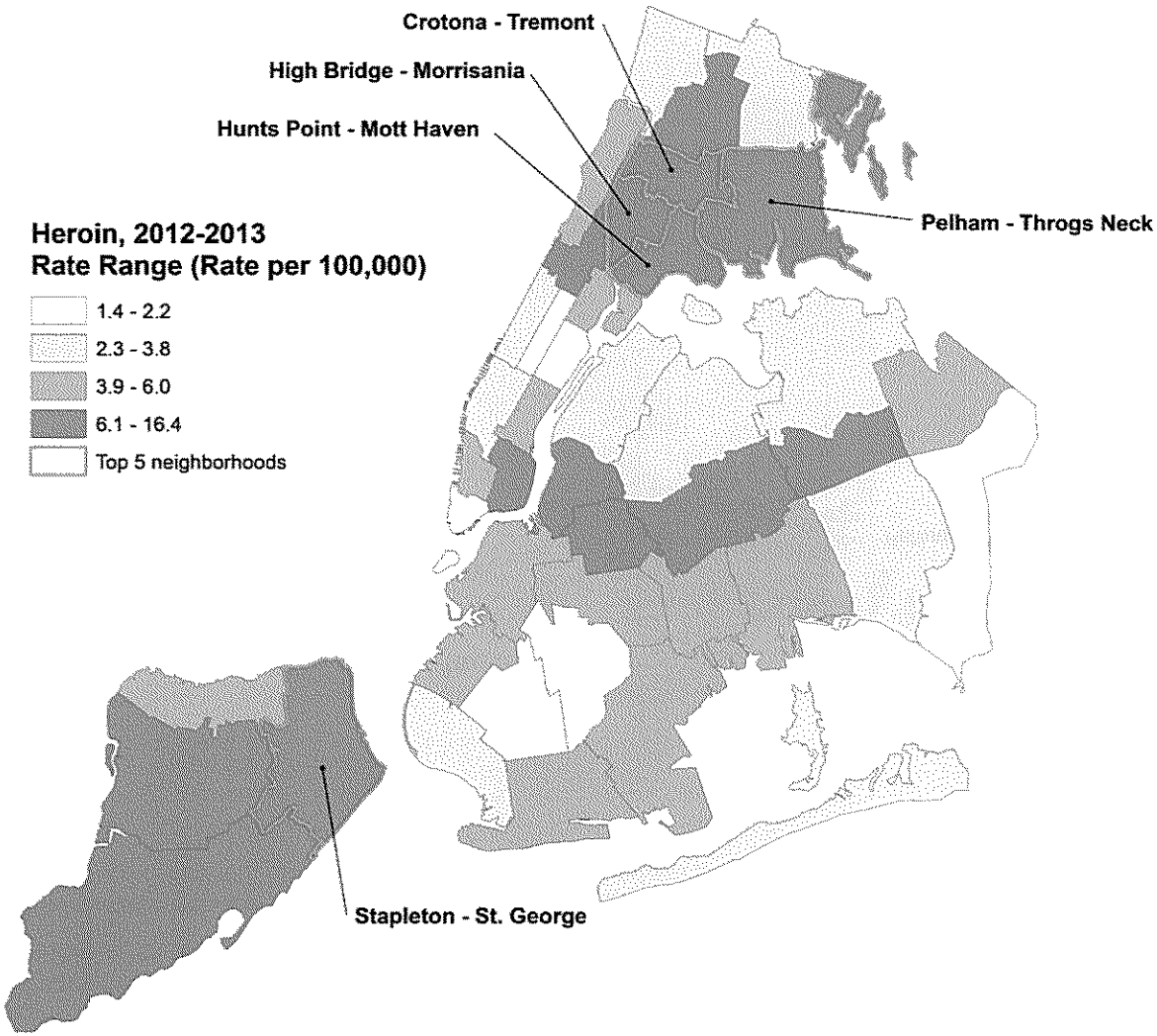
Source: Bureau of Vital Statistics/Office of the Chief Medical Examiner, New York City; Rates calculated using NYC DOHMH population estimates, modified from US Census Bureau intercensal population estimates, 2010-2011. Updated December 2014. Analysis by Health Department's Bureau of Alcohol and Drug Use Prevention, Care and Treatment.



*The United Hospital Fund (UHF) classifies New York City into 42 neighborhoods, comprised of contiguous zip codes.

Map 6. Top five New York City neighborhoods: Rates of unintentional drug poisoning (overdose) deaths involving heroin by neighborhood* of residence, 2012-2013

Source: Bureau of Vital Statistics/Office of the Chief Medical Examiner, New York City; Rates calculated using NYC DOHMH population estimates, modified from US Census Bureau intercensal population estimates, 2012-2013. Updated December 2014. Analysis by Health Department's Bureau of Alcohol and Drug Use Prevention, Care and Treatment.



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Epi Data Brief

New York City Department of Health and Mental Hygiene

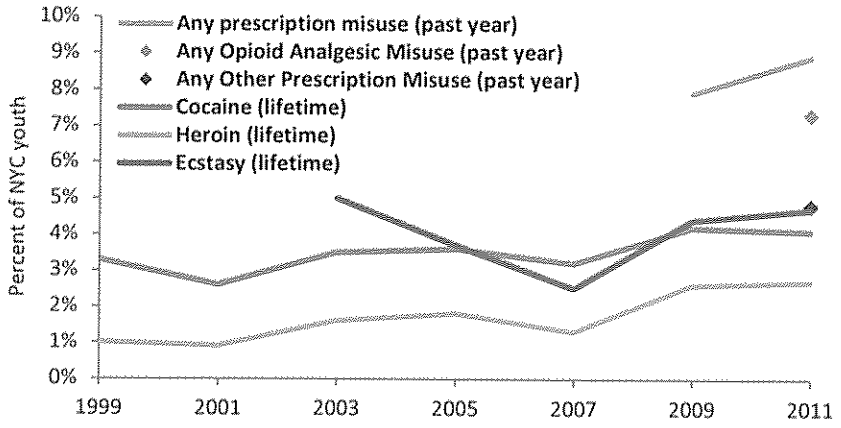
October 2013, No. 35

Prescription Drug Misuse and Illicit Drug Use among New York City Youth

- In 2011, 9% of New York City youth reported misusing (use without a prescription) any prescription drug in the past year.[1]
- Seven percent reported misuse of opioid analgesics (prescription pain medication, such as oxycodone), and 5% reported misusing other prescription drugs (such as Xanax® or Adderall®).[1]
- Prescription drugs were the most commonly misused drug in the past year among youth in NYC (9%) and during lifetime among youth nationally (21%).[1,2]
- Nearly 18% of NYC youth reported using marijuana in the past month, compared with 23% of youth nationally.[1,2]
- NYC youth who misused prescription drugs had higher rates of drug and alcohol use and other health risk behaviors than youth who did not misuse prescription drugs.[1]

Patterns of drug use among youth[1,2]

Prescription drug, cocaine, heroin and ecstasy use among youth, New York City, 1999-2011



Source: NYC Youth Risk Behavior Survey, 1999-2011

- From 1999 to 2011, NYC youth were less likely to use marijuana and cocaine than their peers nationwide, while heroin rates were similar in NYC and the nation in recent years.[1,2]
- Males were more likely to report misuse of all types of illicit and prescription drugs than females with the exception of opioid analgesics.[1]
- Nationally, lifetime cocaine use was reported by 7% of youth compared with 4% of NYC youth.[1,2]
- The prevalence of NYC and US youth reporting lifetime heroin use increased from 2007 to 2011 (1% to 3% and 2% to 3%) respectively.[1,2]
- Nationally, lifetime ecstasy use was reported by 8% of youth compared with 5% of NYC youth.[1,2]

Definitions

Youth: NYC public high school students in grades nine through 12.

Any prescription drugs:
Opioid analgesics (prescription pain medication such as Oxycontin® or Vicodin®) and/or **other prescription drugs** (benzodiazepines such as Xanax® or stimulants such as Adderall®).

Current drinking: Consuming at least one alcoholic drink during the past 30 days.

Binge drinking: Consuming five or more alcoholic drinks in a row (within a couple of hours) at least once during the past 30 days.

Misuse: Use without a prescription in the past 12 months.

Lifetime use: Use of drug ever during lifetime.

Data Sources

[1] **NYC YRBS:** The NYC Youth Risk Behavior Survey (YRBS), conducted in collaboration by the Health Department and the Department of Education, is an anonymous, self-administered biennial study of NYC public high school students in grades 9 to 12; 2011 was the first year that opioid analgesic misuse and other prescription drug misuse were asked as separate questions.

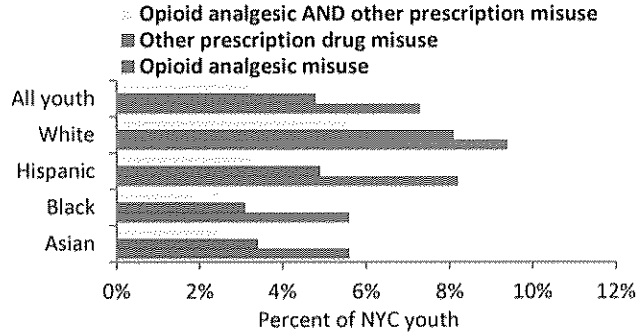
[2] **National YRBSS:** Conducted by the Centers for Disease Control and Prevention, the Youth Risk Behavior Surveillance System (YRBSS) monitors health-risk behaviors which contribute to leading causes of death and disability. The YRBSS includes a national school-based survey of public and private school students in grades 9 to 12 in the 50 states and the District of Columbia.

Authored by: Brian Yim, Daniella Bradley O'Brien, Brigid Staley, Denise Paone

Prescription drug misuse among youth[1]

- White youth were more likely to misuse opioid analgesics than black youth (9% vs. 5%).
- Black youth (2%) were least likely, compared with white (6%) and Hispanic youth (3%), to misuse both opioid analgesics and other prescription drugs.
- Other prescription drug misuse in the past year was higher in Manhattan (7%) and Staten Island (7%) than in the other NYC boroughs (4%).
- More than four in ten (43%) opioid analgesic misusers also misused other prescription drugs, and 66% of other prescription drug misusers also misused opioid analgesics.

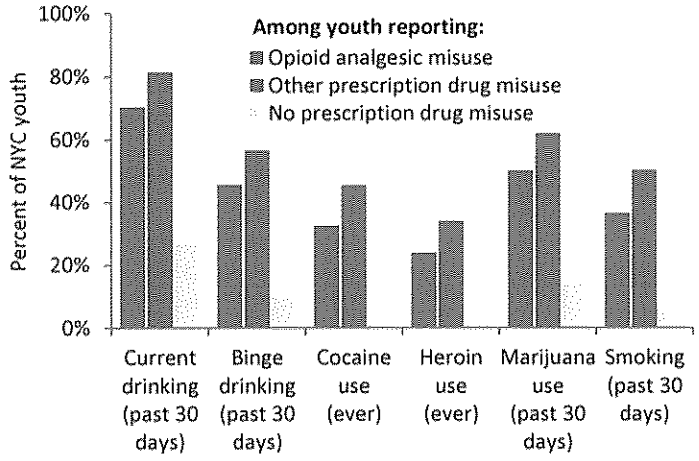
Prescription drug misuse among New York City youth by race/ethnicity, 2011



Source: NYC Youth Risk Behavior Survey, 2011

Misuse of prescription drugs in combination with other substances[1]

Use of alcohol and other substances among New York City youth by prescription drug misuse



Source: NYC Youth Risk Behavior Survey, 2011

- NYC youth who misused opioid analgesics or other prescription drugs were more likely to report use of alcohol, cocaine, heroin, marijuana and cigarettes than those with no prescription drug misuse.
- Current alcohol use was more than twice as common among those who misused opioid analgesics (70%) or other prescription drugs (81%), than among those who did not misuse prescription drugs (27%).
- Lifetime cocaine and heroin use were more than ten times higher among youth who misused opioid analgesics (32% and 24%, respectively) and those who used other prescription drugs (45% and 34%, respectively), than among those who did not misuse opioid analgesics or other prescription drugs (less than 2% for both).
- Current marijuana use was three times higher among youth misusing opioid analgesics (50%) and more than four times higher among youth misusing other prescription drugs (62%) than among those who did not misuse prescriptions (15%).
- More than one third of youth misusing opioid analgesics (36%) and half of those misusing other prescription drugs reported current cigarette smoking, compared with 6% of youth who did not misuse prescriptions.

MORE New York City Health Data and Publications

- For complete tables of data presented in this Brief, visit nyc.gov/html/doh/downloads/pdf/epi/datatable35.pdf
- For more information on prescription drug use, check out the following Health Bulletins: Is Your Child Abusing Prescription Drugs; Help to Stop Using; Vital Signs: Illicit Drug Use in New York City; and Opioid Analgesic Epi Data Brief
- Visit EpiQuery – the Health Department's online, interactive health data system at nyc.gov/health/EpiQuery

Data & Statistics at nyc.gov/health/data

Epi Data Tables
New York City Department of Health and Mental Hygiene October 2013, No. 35

Prescription Drug Misuse and Illicit Drug Use among New York City Youth

Data Tables

Data Sources

NYC YRBS: The NYC Youth Risk Behavior Survey (YRBS), conducted in collaboration by the Health Department and the NYC Department of Education, is an anonymous, biennial, self-administered survey of NYC public high school students in grades 9 to 12.

National YRBSS: Conducted by the Centers for Disease Control and Prevention, the Youth Risk Behavior Surveillance System (YRBSS) is an anonymous, biennial, self-administered survey of public and private school students in grades 9 to 12 in the 50 states and the District of Columbia.

To access the related Epi Data Brief, go to www.nyc.gov/html/doh/downloads/pdf/epi/databrief35.pdf

NYC Health

Table 1. Any self-reported prescription drug misuse among youth, US and NYC, 2009-2011

Source: NYC Youth Risk Behavior Survey 2011; National Youth Risk Behavior Surveillance System 1999-2011***

Prescription Drug Misuse[1]

	US* (lifetime use)	
Year	%	95% Confidence Interval
2009	20.2	(18.6-21.9)
2011	20.7	(19.2-22.2)

Any Prescription Drug Misuse[1]

	NYC** (past 12 month use)	
Year	%	95% Confidence Interval
2009	7.9	(7.1-8.8)

Prescription Drug Misuse[1]

	NYC** (past 12 month use)	
2011	%	95% Confidence Interval
Opioid Analgesics	7.3	(6.5-8.2)
Other Prescription Drugs	4.8	(4.3-5.3)

*US YRBSS is administered to both public and private schools.

**NYC YRBS is administered to public schools only.

[1] Misuse: Use without a prescription.

95% confidence intervals are a measure of estimate precision. The wider the interval, the more imprecise the estimate.

A p-value is a measure of statistical significance. A bold p-value less than .05 means there is a significant difference between that group and the referent (comparison) group.

Table 2. Any self-reported illicit drug use among youth, US, NYC and NYS (excluding NYC), 1999-2011

Source: NYC Youth Risk Behavior Survey 2011; National Youth Risk Behavior Surveillance System 1999-2011***

Marijuana (past 30 days)

	US*		NYC**		NYS (excluding NYC)		US vs. NYC	
Year	%	95% Confidence Interval	%	95% Confidence Interval	%	95% Confidence Interval	% Difference	P-value
1999	26.7	(24.2-29.4)	17.3	(14.0-21.2)	26.6	(23.2-30.3)	9.4	**<0.001**
2001	23.9	(22.3-25.5)	17.8	(14.4-22.0)	--	--	6.0	**0.003**
2003	22.4	(20.2-24.6)	15.3	(13.9-16.9)	23.4	(20.4-26.7)	7.1	**<0.001**
2005	20.2	(18.6-22.0)	12.3	(10.9-13.8)	21.4	(18.4-24.8)	8.0	**<0.001**
2007	19.7	(17.8-21.8)	12.4	(11.0-13.9)	20.5	(18.6-22.6)	7.3	**<0.001**
2009	20.8	(19.4-22.3)	15.0	(13.4-16.8)	22.9	(19.6-26.6)	5.8	**<0.001**
2011	23.1	(21.5-24.7)	17.7	(16.6-19.0)	22.1	(19.1-24.4)	5.3	**<0.001**

Cocaine (lifetime)

	US*		NYC**		NYS (excluding NYC)		US vs. NYC	
Year	%	95% Confidence Interval	%	95% Confidence Interval	%	95% Confidence Interval	% Difference	P-value
1999	9.5U	(8.2-11.1)	3.3	(2.0-5.4)	8.6	(7.1-10.3)	6.2	**<0.001**
2001	9.4	(8.2-10.7)	2.6	(1.7-3.9)	--	--	6.8	**<0.001**
2003	8.7	(7.6-9.9)	3.5D	(2.9-4.2)	7.4	(6.4-8.6)	5.2	**<0.001**
2005	7.6	(6.7-8.7)	3.6	(3.0-4.3)	5.9	(4.6-7.7)	4.1	**<0.001**
2007	7.2	(6.2-8.2)	3.2	(2.5-4.1)	8.3	(6.6-10.3)	4.0	**<0.001**
2009	6.4	(5.7-7.1)	4.2	(3.7-4.9)	--	--	2.2	**<0.001**
2011	6.8	(6.2-7.5)	4.1	(3.5-4.8)	6.8	(5.7-8.2)	2.8	**<0.001**

Heroin (lifetime)

	US*		NYC**		NYS (excluding NYC)		US vs. NYC	
Year	%	95% Confidence Interval	%	95% Confidence Interval	%	95% Confidence Interval	% Difference	P-value
1999	2.4	(1.9-3.0)	1.0	(0.6-1.8)	3.5	(2.6-4.7)	1.4	**<0.001**
2001	3.1	(2.7-3.6)	0.9	(0.5-1.7)	--	--	2.2	**<0.001**
2003	3.3	(2.6-4.1)	1.6	(1.3-2.0)	1.9	(1.4-2.6)	1.7	**<0.001**
2005	2.4	(2.0-2.8)	1.8	(1.3-2.4)	1.8	(1.2-2.7)	0.6	0.068
2007	2.3	(1.8-2.8)	1.3	(0.9-1.9)	3.8	(2.7-5.4)	0.9	**0.008**
2009	2.5D	(2.2-2.9)	2.6	(2.1-3.2)	4.3	(2.9-6.4)	-0.1	0.799
2011	2.9	(2.5-3.3)	2.7	(2.3-3.2)	4.1	(2.9-5.7)	0.2	0.453

Ecstasy (lifetime)

	US*		NYC**		NYS (excluding NYC)		US vs. NYC	
Year	%	95% Confidence Interval	%	95% Confidence Interval	%	95% Confidence Interval	% Difference	P-value
2003	11.1	(7.8-15.5)	5.0	(4.3-5.8)	6.7	(5.5-8.1)	6.1	**0.002**
2005	6.3	(5.4-7.3)	3.7	(3.0-4.5)	4.3	(3.2-5.9)	2.6	**<0.001**
2007	5.8	(5.0-6.6)	2.5U	(2.0-3.3)	7.0	(5.6-8.6)	3.2	**<0.001**
2009	6.7	(5.8-7.6)	4.4	(3.7-5.1)	6.3	(4.4-9.0)	2.3	**<0.001**
2011	8.2	(7.2-9.4)	4.7	(4.1-5.4)	8.0	(6.7-9.5)	3.5	**<0.001**

*US YRBSS is administered to both public and private schools.

**NYC YRBS is administered to public schools only.

-- Data not available

D Data rounded down to the nearest whole number for the purposes of reporting in the text.

U Data rounded up to the nearest whole number for the purposes of reporting in the text.

95% confidence intervals are a measure of estimate precision. The wider the interval, the more imprecise the estimate.

A p-value is a measure of statistical significance. A bold p-value less than .05 means there is a significant difference between that group and the referent (comparison) group.

Table 2a. Change in self-reported illicit drug use among youth, US and NYC, 1999-2011

Source: NYC Youth Risk Behavior Survey 1999-2011; National Youth Risk Behavior Surveillance System 1999-2011***

Marijuana (past 30 days)

	1999 vs 2011				2007 vs 2011				2009 vs 2011			
	% (1999)	% (2011)	% Change	P-value	% (2007)	% (2011)	% Change	P-value	% (2009)	% (2011)	% Change	P-value
US*	26.7	23.1	**-0.1**	**0.019**	19.7	23.1	**0.2**	**0.010**	20.8	23.1	**0.1**	**0.038**
NYC**	17.3	17.7	0.0	0.810	12.4	17.7	**0.4**	**<0.001**	15.0	17.7	**0.18**	**0.010**

Cocaine (lifetime)

	1999 vs 2011				2007 vs 2011				2009 vs 2011			
	% (1999)	% (2011)	% Change	P-value	% (2007)	% (2011)	% Change	P-value	% (2009)	% (2011)	% Change	P-value
US*	9.5U	6.8	**-0.3**	**0.001**	7.2	6.8	-0.1	0.604	6.4	6.8	0.0625	0.346
NYC**	3.3	4.1	0.2	0.353	3.2	4.1	0.3	0.091	4.2	4.1	0.0	0.730

Heroin (lifetime)

	1999 vs 2011				2007 vs 2011				2009 vs 2011			
	% (1999)	% (2011)	% Change	P-value	% (2007)	% (2011)	% Change	P-value	% (2009)	% (2011)	% Change	P-value
US*	2.4	2.9	0.2	0.150	2.3	2.9	**0.3**	**0.047**	2.5D	2.9	0.16	0.125
NYC**	1.0	2.7	**1.7**	**<0.001**	1.3	2.7	**1.1**	**<0.001**	2.6	2.7	0.0	0.776

Ecstasy (lifetime)

	2003 vs 2011				2007 vs 2011				2009 vs 2011			
	% (2003)	% (2011)	% Change	P-value	% (2007)	% (2011)	% Change	P-value	% (2009)	% (2011)	% Change	P-value
US*	11.1	8.2	-0.3	0.143	5.8	8.2	**0.4**	**<0.001**	6.7	8.2	**0.2**	**0.021**
NYC**	5.0	4.7	-0.1	0.601	2.5U	4.7	**0.9**	**<0.001**	4.4	4.7	0.1	0.451

*US YRBSS is administered to both public and private schools.

**NYC YRBS is administered to public schools only.

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95% confidence intervals are a measure of estimate precision. The wider the interval, the more imprecise the estimate.

A p-value is a measure of statistical significance. A bold p-value less than .05 means there is a significant difference between that group and the referent (comparison) group.

Table 3. Prevalence of any self-reported prescription drug misuse by gender, grade, race/ethnicity and borough of residence, NYC, 2011

Source: NYC Youth Risk Behavior Survey 2011

	Opioid Analgesics (past 12 month use)			Other Prescription Drugs (past 12 month use)			Opioid Analgesics and Other Prescription Drugs (past 12 month use)			Any Opioid Analgesics or Other Prescription Drugs (past 12 month use)		
	%	95% Confidence Interval	P-value	%	95% Confidence Interval	P-value	%	95% Confidence Interval	P-value	%	95% Confidence Interval	P-value
Total	7.3	(6.5-8.2)		4.8	(4.3-5.3)		3.3	(2.8-3.8)		9.0	(8.3-9.8)	
Gender												
Female	7.1	(5.9-8.5)	Referent	3.7	(3.1-4.4)	Referent	2.5D	(1.9-3.1)	Referent	8.5U	(7.5-9.7)	Referent
Male	7.1	(6.2-8.1)	0.952	5.6	(4.9-6.5)	**0.001**	3.9	(3.3-4.6)	**0.001**	9.2	(8.1-10.3)	0.418
Grade												
9	6.8	(5.2-8.7)	0.432	4.1	(3.1-5.4)	**0.021**	2.8	(2.0-3.9)	0.058	8.3	(6.6-10.4)	0.184
10	7.0	(5.7-8.7)	0.481	4.1	(3.2-5.2)	**0.016**	3.0	(2.2-4.0)	0.110	8.4	(7.0-9.9)	0.148
11	7.1	(5.7-8.6)	0.582	4.1	(3.2-5.3)	**0.010**	2.7	(2.0-3.7)	**0.019**	8.6	(7.3-10.1)	0.279
12	7.8	(6.3-9.5)	Referent	6.5D	(5.1-8.1)	Referent	4.3	(3.3-5.6)	Referent	10.3	(8.4-12.5)	Referent
Race/Ethnicity												
White Non-Hispanic	9.4	(6.9-12.7)	Referent	8.1	(6.2-10.3)	Referent	5.6	(3.9-8.0)	Referent	12.3	(8.1-9.6)	Referent
Black Non-Hispanic	5.6	(4.4-7.0)	**0.025**	3.1	(2.4-4.1)	**<0.001**	1.9	(1.2-2.8)	**0.004**	7.0	(10.1-15.0)	**0.001**
Hispanic	8.2	(7.1-9.4)	0.445	4.9	(3.9-6.2)	**0.009**	3.3	(2.5-4.4)	**0.043**	10.0	(5.7-8.4)	0.145
Asian	5.6	(3.8-8.0)	**0.038**	3.4	(2.5-4.5)	**<0.001**	2.5U	(1.6-4.0)	**0.014**	6.6	(8.8-11.4)	**0.001**
Other*	9.6	(6.1-15.0)	0.920	9.3	(5.9-14.3)	0.618	7.1*	(3.6-13.5)	0.584	12.3	(4.8-8.9)	0.982
Borough of Residence												
Bronx	7.5U	(6.6-8.6)	0.257	4.3	(3.3-5.5)	**0.022**	2.8	(2.2-3.6)	**0.008**	9.2	(8.0-10.7)	Referent
Brooklyn	7.1	(5.5-9.0)	0.212	4.1	(3.4-5.1)	**0.021**	2.8	(1.9-4.2)	**0.018**	8.6	(7.1-10.3)	0.551
Manhattan	7.6	(5.1-11.0)	0.382	6.8	(4.8-9.5)	0.963	3.9	(2.3-6.4)	0.266	10.7	(8.2-13.9)	0.270
Queens	6.8	(5.5-8.4)	0.093	4.6	(3.8-5.6)	0.055	3.4	(2.7-4.1)	**0.039**	8.2	(7.1-9.5)	0.279
Staten Island	8.8	(6.9-11.2)	Referent	6.7	(5.1-8.8)	Referent	5.4	(3.9-7.5)	Referent	10.5D	(8.4-13.0)	0.337
Borough of School												
Bronx	6.3	(5.5-7.2)	0.052	3.7	(3.0-4.6)	**0.006**	2.5U	(2.0-3.1)	**0.004**	7.7	(6.7-8.7)	Referent
Brooklyn	7.1	(5.5-9.2)	0.415	4.6	(3.7-5.7)	0.103	3.3	(2.2-4.8)	0.128	8.7	(7.2-10.5)	0.300
Manhattan	8.4	(6.0-11.8)	0.842	5.8	(4.5-7.4)	0.714	3.6	(2.5-5.0)	0.209	11.0	(8.8-13.6)	**0.012**
Queens	7.1	(5.7-8.8)	0.379	4.6	(3.7-5.6)	0.088	3.3	(2.7-4.1)	0.072	8.6	(7.5-9.8)	0.239
Staten Island	8.1	(6.7-9.8)	Referent	6.2	(4.8-8.0)	Referent	4.8	(3.5-6.4)	Referent	9.8	(8.1-11.9)	**0.046**

Bolded values indicate statistically different from the referent group (i.e., p-value < 0.05).

* Other category includes non-Hispanic students who selected American Indian/Alaska Native, Native Hawaiian/other Pacific Islander, or multiple race categories.

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Table 4. Prevalence of any self-reported illicit drug use by gender, grade, race/ethnicity and borough of residence, NYC, 2011

Source: NYC Youth Risk Behavior Survey 2011

	Marijuana (past 30 day use)			Cocaine (lifetime use)			Heroin (lifetime use)			Meth (lifetime use)			Ecstasy (lifetime use)		
	%	95% Confidence Interval	P-value	%	95% Confidence Interval	P-value	%	95% Confidence Interval	P-value	%	95% Confidence Interval	P-value	%	95% Confidence Interval	P-value
Total	17.7	(16.6-19.0)		4.1	(3.5-4.8)		2.7	(2.3-3.2)		2.8	(2.3-3.4)		4.7	(4.1-5.4)	
Gender															
Female	15.7	(14.1-17.5)	Referent	3.0	(2.5-3.8)	Referent	1.6	(1.2-2.1)	Referent	1.6	(1.3-2.0)	Referent	3.0	(2.4-3.8)	Referent
Male	19.7	(18.2-21.1)	**<0.001**	4.9	(4.1-5.9)	**<0.001**	3.5D	(2.8-4.2)	**<0.001**	3.7	(2.9-4.7)	**<0.001**	6.2	(5.2-7.3)	**<0.001**
Grade															
9	13.1	(11.2-15.3)	**<0.001**	4.0	(3.0-5.3)	0.131	3.1	(2.5-4.0)	0.452	3.0	(2.3-4.1)	0.921	3.5D	(2.7-4.5)	**<0.001**
10	16.7	(14.2-19.4)	**0.005**	3.3	(2.5-4.5)	**0.012**	2.4	(1.7-3.2)	0.547	2.4	(1.8-3.4)	0.310	4.3	(3.2-5.8)	**0.008**
11	20.9	(18.0-24.2)	0.771	3.2	(2.4-4.2)	**0.005**	1.7	(1.2-2.5)	0.053	1.8	(1.3-2.5)	**0.031**	4.5D	(3.5-5.7)	**0.008**
12	21.3	(19.6-23.2)	Referent	5.2	(4.2-6.4)	Referent	2.7	(1.9-3.9)	Referent	3.0	(2.2-4.0)	Referent	6.5D	(5.6-7.5)	Referent
Race/Ethnicity															
White Non-Hispanic	19.8	(17.3-22.6)	Referent	4.3	(3.0-6.1)	Referent	1.5D	(0.9-2.5)	Referent	1.8	(1.1-2.9)	Referent	5.7	(4.5-7.2)	Referent
Black Non-Hispanic	18.0	(16.0-20.1)	0.280	2.4	(1.8-3.2)	0.058	2.4	(1.8-3.2)	0.136	2.3	(1.6-3.2)	0.469	3.4	(2.6-4.4)	**0.012**
Hispanic	21.2	(19.5-23.0)	0.380	5.7	(4.8-6.8)	0.127	3.0	(2.4-3.7)	**0.004**	3.0	(2.3-3.8)	0.052	5.8	(4.7-7.0)	0.959
Asian	6.6	(4.8-9.0)	**<0.001**	2.7	(1.7-4.3)	0.119	2.0	(1.3-3.2)	0.351	2.1	(1.4-3.0)	0.620	2.6	(1.6-4.1)	**0.001**
Other*	24.7	(20.5-29.6)	0.081	6.2*	(2.9-12.5)	0.430	4.9*	(2.0-11.5)	0.108	4.6	(1.8-11.3)	0.197	7.3	(3.8-13.3)	0.474
Borough of Residence															
Bronx	18.5U	(16.3-21.0)	0.675	3.7	(2.7-4.9)	0.090	2.3	(1.7-3.3)	0.093	3.0	(2.3-3.9)	0.141	5.1	(4.2-6.3)	**0.032**
Brooklyn	17.9	(16.0-20.0)	0.467	3.8	(2.6-5.4)	0.124	2.6	(2.0-3.3)	0.149	2.5U	(1.9-3.4)	0.060	3.8	(2.9-4.8)	**0.002**
Manhattan	22.5D	(18.8-26.6)	0.224	4.7	(3.3-6.7)	0.568	2.9	(1.5-5.4)	0.476	3.6	(2.0-6.2)	0.453	5.4	(3.6-8.0)	0.091
Queens	14.6	(12.7-16.7)	**0.016**	4.1	(3.1-5.4)	0.185	2.6	(1.9-3.6)	0.206	2.1	(1.6-2.9)	**0.027**	4.5D	(3.6-5.6)	**0.007**
Staten Island	19.4	(16.2-23.0)	Referent	5.3	(3.9-7.2)	Referent	3.8	(2.5-5.6)	Referent	4.4	(2.9-6.6)	Referent	7.7	(5.7-10.2)	Referent
Borough of School															
Bronx	17.9	(15.5-20.6)	0.549	3.2	(2.3-4.6)	**0.035**	2.3	(1.6-3.4)	0.149	2.6	(1.9-3.4)	0.080	4.7	(3.7-5.9)	**0.030**
Brooklyn	17.5U	(15.3-20.0)	0.423	3.8	(2.6-5.6)	0.234	3.1	(2.5-3.9)	0.688	3.0	(2.2-4.2)	0.345	3.8	(2.8-5.1)	**0.003**
Manhattan	20.9	(17.7-24.6)	0.473	4.8	(3.4-6.8)	0.897	2.2*	(1.1-4.2)	0.189	2.8*	(1.5-5.4)	0.387	5.6	(3.7-8.3)	0.323
Queens	15.0	(13.1-17.1)	**0.034**	4.2	(3.3-5.3)	0.302	2.6	(1.9-3.6)	0.279	2.4	(1.8-3.2)	**0.047**	4.6	(3.8-5.5)	**0.015**
Staten Island	19.2	(16.1-22.7)	Referent	5.0	(3.9-6.3)	Referent	3.4	(2.4-4.9)	Referent	3.8	(2.8-5.1)	Referent	7.0	(5.4-9.0)	Referent

Bolded values indicate statistically different from the referent group (i.e., p-value < 0.05).

* Other category includes non-Hispanic students who selected American Indian/Alaska Native, Native Hawaiian/other Pacific Islander, or multiple race categories.

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Table 5. Prevalence of alcohol and other substance use by prescription drug (opioid analgesic and/or other prescription drugs) misuse in combination with alcohol and other substances among youth in public high schools, NYC, 2011

Source: NYC Youth Risk Behavior Survey 2011

	Among youth who in the past 12 months:								Misuse vs. No Misuse Comparison (p-value)			
	Misused opioid analgesics AND other prescription drugs (past 12 months)		Misused opioid analgesics (past 12 months)		Misused other prescription drugs (past 12 months)		Never misused any prescription drugs (past 12 months)					
Selected substances	%	95% Confidence Interval	%	95% Confidence Interval	%	95% Confidence Interval	%	95% Confidence Interval	Any Prescription Drugs vs. Never	Opioid Analgesics vs. Never	Other Prescription Drugs vs. Never	Opioid Analgesics vs. Other Prescription Drugs
Current drinking (past 30 days)	84.0	(79.0-88.0)	70.3	(65.3-74.8)	81.3	(76.9-85.1)	26.9	(25.1-28.9)	**<0.001**	**<0.001**	**<0.001**	**0.001**
Binge drinking (past 30 days)	67.6	(61.7-73.0)	45.6	(41.1-50.2)	56.4	(51.5-61.1)	9.9	(8.9-10.9)	**<0.001**	**<0.001**	**<0.001**	**0.001**
Cocaine (lifetime)	58.6	(51.2-65.7)	32.5D	(27.5-37.9)	45.4	(39.4-51.5)	1.5U	(1.2-2.0)	**<0.001**	**<0.001**	**<0.001**	**0.002**
Heroin (lifetime)	43.9	(33.8-54.4)	23.8	(18.9-29.5)	34.0	(26.7-42.1)	0.7	(0.5-1.1)	**<0.001**	**<0.001**	**<0.001**	**0.032**
Marijuana (past 30 days)	70.3	(64.2-75.7)	50.1	(45.2-54.9)	62.0	(56.2-67.5)	14.6	(13.4-15.8)	**<0.001**	**<0.001**	**<0.001**	**0.002**
Cigarettes (past 30 days)	59.4	(51.4-67.0)	36.5D	(31.2-42.1)	50.2	(43.5-56.9)	6.2	(5.3-7.2)	**<0.001**	**<0.001**	**<0.001**	**0.002**
Opioid analgesics (past 12 months)					66.4	(58.7-73.3)						
Other prescription drugs (past 12 months)			42.8	(37.0-48.8)								

Bolded values indicate statistically significant differences between groups (i.e., p-value < 0.05).

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PRESCRIBING OPIOID PAINKILLERS IN THE EMERGENCY DEPARTMENT

People sometimes misuse opioid painkillers, either by taking them in ways they weren't prescribed or by taking someone else's prescription. In New York City, one in four overdose deaths involve opioid painkillers. Our emergency department will only provide pain relief options that are safe and appropriate.

FOR YOUR SAFETY, WE DO NOT:

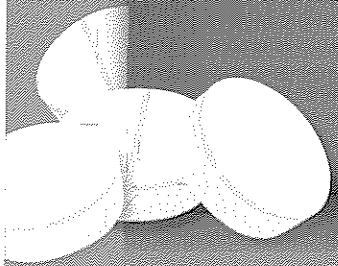
* **Prescribe long-acting opioid painkillers.**
  Such as oxycodone (OxyContin®), morphine (MSContin®), fentanyl patches (Duragesic®) or methadone.
* **Prescribe more than a short course of opioid painkillers.**
  3 days in most cases.
* **Refill lost, stolen or destroyed prescriptions.**

Prescription opioid painkillers can be just as dangerous as illegal drugs.

- Opioid painkillers can cause confusion, drowsiness and increased sensitivity to pain.
- People can become dependent on or addicted to opioid painkillers.
- An overdose of opioid painkillers can cause a person to stop breathing and die.

Keep your prescription opioid painkillers safe!

- Keep opioid painkillers in their original labeled containers.
- Keep opioid painkillers out of sight and out of reach of children, preferably in a locked cabinet or on a high shelf.
- Get rid of opioid painkillers you are no longer using by flushing them down the toilet.



Problem with painkillers?
Help is available – call 1-800-LIFENET

NYC Health

Decrease in Rate of Opioid Analgesic Overdose Deaths — Staten Island, New York City, 2011–2013

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From 2000 to 2011, the rate of unintentional drug poisoning (overdose) deaths involving opioid analgesics increased 435% in Staten Island, from 2.0 to 10.7 per 100,000 residents. During 2005–2011, disparities widened between Staten Island and the other four New York City (NYC) boroughs (Bronx, Brooklyn, Manhattan, and Queens) (*1*); in 2011, the rate in Staten Island was 3.0–4.5 times higher than in the other boroughs. In response, the NYC Department of Health and Mental Hygiene (DOHMH) implemented a comprehensive five-part public health strategy, with both citywide and Staten Island–targeted efforts: 1) citywide opioid prescribing guidelines, 2) a data brief for local media highlighting Staten Island mortality and prescribing data, 3) Staten Island town hall meetings convened by the NYC commissioner of health and meetings with Staten Island stakeholders, 4) a Staten Island campaign to promote prescribing guidelines, and 5) citywide airing of public service announcements with additional airing in Staten Island. Concurrently, the New York state legislature enacted the Internet System for Tracking Over-Prescribing (I-STOP), a law requiring prescribers to review the state prescription monitoring system before prescribing controlled substances. This report describes a 29% decline in the opioid analgesic–involved overdose death rate in Staten Island from 2011 to 2013, while the rate did not change in the other four NYC boroughs, and compares opioid analgesic prescribing data for Staten Island with data for the other boroughs. Targeted public health interventions might be effective in lowering opioid analgesic–involved overdose mortality rates.

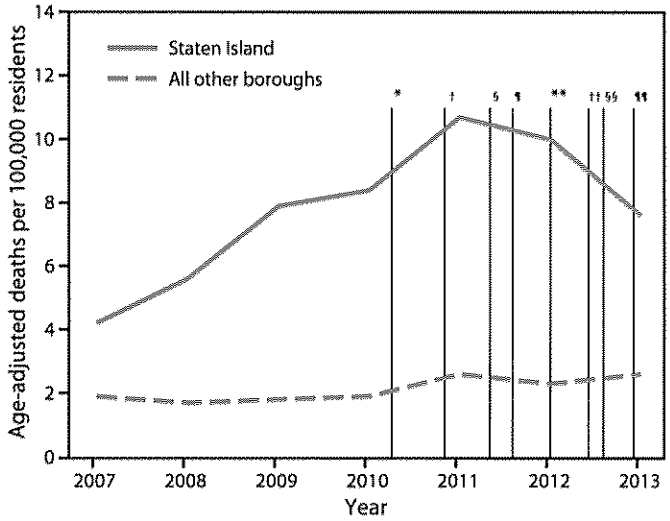
In NYC, the rate of opioid analgesic–involved overdose deaths increased 57% from 2005 to 2011, from 2.1 to 3.3 per 100,000 residents. While rates increased citywide, the rate in Staten Island increased 257% during the same period, from 3.0 to 10.7 per 100,000 residents (Figure). In April 2011, DOHMH reported citywide opioid analgesic–involved overdose mortality, highlighting the disproportionately high rates in Staten Island (*2*). This report received substantial media coverage, particularly among Staten Island local news outlets. In November 2011, DOHMH published opioid prescribing guidelines for general medical providers with the following key messages: 1) a 3-day supply of short-acting opioid analgesic is usually sufficient for acute pain, 2) avoid prescribing opioid analgesics for chronic noncancer pain, 3) avoid high-dose opioid analgesic prescriptions, and 4) avoid prescribing opioid analgesics to patients taking benzodiazepines (*3*). In January 2013, DOHMH released opioid prescribing guidelines for emergency departments (*4*) that were adopted citywide by 39 emergency departments, including both of Staten Island's hospitals.

Throughout 2013, DOHMH met in Staten Island with local hospital, addiction treatment, and syringe exchange programs, as well as local politicians to share overdose mortality trends and guidelines. In June 2013, the commissioner of health held two conferences for Staten Island physicians on judicious opioid prescribing. These guidelines were promoted to Staten Island prescribers via one-to-one office educational visits in which DOHMH recommendations, resources, and tools were disseminated. During 2012–2014, DOHMH aired two television advertisements highlighting the risks of opioid analgesics citywide, with additional airtime in Staten Island. These interventions occurred in close temporal proximity to the enactment and media coverage of I-STOP, state legislation implemented in August 2013 that requires providers to consult the state Prescription Monitoring Program, a registry of controlled-substance prescriptions filled by New Yorkers, before prescribing or dispensing Schedule II, III, or IV controlled substances.

To evaluate the impact of the public health interventions, DOHMH assessed changes in unintentional opioid analgesic–involved overdose mortality rates and changes in opioid analgesic prescribing patterns. Mortality data were derived from two linked sources, NYC death certificates and toxicology findings from the Office of the Chief Medical Examiner. Deaths were defined as unintentional drug poisoning (overdose) if the medical examiner determined manner of death as accidental and the underlying or multiple cause code was assigned an ICD-10 code of X40–X44, F11–F16, or F18–F19 (excluding F-codes with 0.2 or 0.6 third digit). Toxicology metabolites were abstracted from medical examiner files and linked to death certificate data.

Toxicology findings were used to describe the drugs involved in overdose deaths. Methadone-involved overdose deaths were reported separately, because there are approximately 30,000 New Yorkers maintained on methadone for opioid use disorders. Staten Island opioid analgesic–involved overdose rates were compared with the other four NYC boroughs combined. Overall, overdose rates also were assessed to determine whether changes in opioid analgesic–involved overdose rates were offset by changes in other drug poisonings, principally heroin.

FIGURE. Age-adjusted rate of unintentional drug poisoning (overdose) deaths involving opioid analgesics, by borough of residence, and New York City public health interventions — 2007–2013



Source: New York City Office of the Chief Medical Examiner and New York City Department of Health and Mental Hygiene 2007–2013.

* April 2011: Distributed a data brief citywide that highlighted overdose mortality and prescription use in Staten Island.

† November 2011: Distributed opioid prescribing guidelines to all providers citywide.

§ May 2012: Ran first public service announcement campaign citywide.

¶ August 2012: State legislation passed mandating use of the prescription monitoring program.

** January 2013: Distributed opioid prescribing guidelines to emergency departments citywide.

†† June 2013: Town halls convened in Staten Island by New York City commissioner of health and meeting held with Staten Island stakeholders. Implemented detailing campaign to promote opioid prescribing guidelines to prescribers in Staten Island.

§§ August 2013: Statewide mandatory prescriber use of prescription monitoring program begun.

¶¶ December 2013: Ran second public service announcement campaign citywide with additional targeted airing in Staten Island.

Data for opioid analgesic prescriptions filled by NYC residents were derived from the New York State Prescription Monitoring Program. DOHMH assessed median day supply and the fill rates of prescriptions and high morphine equivalent–dose prescriptions (>100 morphine milligram equivalents) (*5*) by borough of patient residence.

Age-adjusted rates were calculated using NYC population estimates for the period 2000–2013 and the U.S. Census 2000 standard population. To evaluate the impact of the public health interventions, prescription rates were compared annually and for the fourth quarters (October–December) during 2011–2013. Given that both office educational visits with Staten Island prescribers and implementation of I-STOP occurred in the third quarter of 2013, the fourth quarter of 2013 was compared with the fourth quarters of 2011 and 2012. Rate changes were tested using z-tests and 95% confidence intervals; comparisons were based on gamma confidence intervals distribution (*6*).

From 2000 to 2011, Staten Island residents had the highest rate of opioid analgesic–involved overdose mortality in NYC. From 2005 to 2011, the rate increased 257% in Staten Island, compared with a 44% increase in the other four boroughs combined. After implementation of the public health initiatives, opioid analgesic mortality rates decreased 29% from 2011 to 2013, from 10.7 to 7.6 per 100,000 Staten Island residents (Table 1). In comparison, the rate for the other four boroughs combined did not change from 2011 to 2013 (2.6 per 100,000 residents, for both years). Among Staten Island residents, the rate of heroin-involved overdose deaths fluctuated but had a net increase of 39% from 2011 to 2013, from 6.2 in 2011 to 8.6 per 100,000 residents in 2013. Among the other four boroughs combined, heroin-involved overdose deaths increased 35% during the same period (from 3.7 in 2011 to 5.0 per 100,000 residents in 2013). In Staten Island, overall drug-involved overdose deaths decreased 4% from 2011 to 2013, from a rate of 18.4 to 17.6 per 100,000 residents. During that period, the rate for the other four boroughs increased 20%, from 7.9 to 9.5 per 100,000.

The median day supply for filled opioid analgesic prescriptions for Staten Island residents was unchanged during 2011–2013 (30 days). In contrast, the median day supply for the other four boroughs was lower, but increased from 2011 to 2013, from 15 to 20 days (Table 2).

In 2011, Staten Island residents filled opioid analgesic prescriptions at a higher rate (502.0 per 1,000 residents) than did residents of the other four boroughs (236.7) and filled high-dose prescriptions at rates three times higher (132.4) than residents of the other boroughs (40.7) (Table 2). In 2012, the rate of opioid analgesic prescriptions filled decreased in all boroughs, whereas rates of high-dose prescriptions increased slightly. Compared with 2011, in 2013 the opioid analgesic prescriptions fill rate continued to decrease for residents of all boroughs, by 9.8% in Staten Island (to 452.9 per 1,000 residents) and by 8.2% (to 217.2) elsewhere. The rate of high dose prescriptions decreased 8.2% (to 121.6 per 1,000 residents) in Staten Island while increasing 4.7% (to 42.6) in the other four boroughs. The decrease in Staten Island rates of high dose prescriptions continued in the final quarter of 2013.

Discussion

After implementation of targeted and general public health initiatives, Staten Island saw 2 years of decreases in opioid analgesic high-dose prescribing and opioid analgesic–involved overdose mortality; the decreases followed 11 years of increases. In contrast, high-dose prescribing in the other four NYC boroughs increased without changes in opioid analgesic–involved overdose mortality rates. In addition, the decreases in opioid analgesic overdoses on Staten Island were not offset by increases in heroin-involved overdose mortality.

TABLE 1. Number and rate per 100,000 residents* of unintentional drug poisoning (overdose) deaths involving any drug, heroin, or opioid analgesics,† by borough of residence§ — New York City, 2011–2013

Borough of residence	2011		2012		2013		% rate change from 2011 to 2013
	Total	(Rate)	Total	(Rate)	Total	(Rate)	
New York City							
Any drug	567	(8.5)	660	(9.8)	672	(9.9)	+16.4¶
Heroin	253	(3.8)	339	(5.0)	352	(5.2)	+36.8¶
Opioid analgesics	201	(3.0)	181	(2.7)	197	(2.9)	-3.3
Staten Island							
Any drug	69	(18.4)	74	(19.9)	64	(17.6)	-4.3¶
Heroin	22	(6.2)	36	(10.1)	32	(8.6)	+38.7¶
Opioid analgesics	40	(10.7)	37	(10.0)	28	(7.6)	-29.0¶
Other four boroughs							
Any drugs	498	(7.9)	586	(9.3)	608	(9.5)	+20.3¶
Heroin	231	(3.7)	303	(4.8)	320	(5.0)	+35.1¶
Opioid analgesics	161	(2.6)	144	(2.3)	169	(2.6)	0.0

Source: Office of Chief Medical Examiner, New York City.
* Age-adjusted rates are calculated using intercensal estimates updated in December 2014, and are weighted to U.S. Census Standard 2000.
† The drug types are not mutually exclusive; most overdoses involved more than one substance.
§ Analysis limited to residents of Staten Island and the other four New York City boroughs (Bronx, Brooklyn, Manhattan, and Queens), based on data reported on death certificates.
¶ Statistically significant rate change ($p<0.05$), determined by z-tests and 95% confidence interval comparisons based on gamma confidence intervals distribution.

Decreases in opioid analgesic–involved overdose mortality have been reported from Wilkes County, North Carolina (*7*), Utah (*8*), Washington (*9*), and Florida (*10*). Each county or state employed a tailored strategy or combination of strategies to address opioid analgesic–involved overdose deaths, most of which included policy and clinical interventions. NYC employed both a general and geographically targeted approach, similar to Wilkes County, aiming to reach the entire NYC population and all prescribers, but found decreased mortality only in the targeted Staten Island area that received the most intensive interventions.

The findings in this report are subject to at least three limitations. First, although decreases were observed in both high-dose prescribing and opioid analgesic–involved mortality rates, it is not known whether decedents had taken prescribed or nonprescribed opioids, nor at what doses. Both decreases might be attributed to decreased risk for persons prescribed opioids or a decrease in the amount of opioids available for diversion to nonprescribed use. Second, law enforcement efforts to decrease the supply of diverted opioids or to reduce malpractice were not considered, although these efforts occurred during the period of the public health interventions. Finally, although the public health interventions were followed by a reduction in opioid analgesic–involved overdose mortality rates in Staten Island, it is not possible to determine the extent of each intervention's contribution to the decline.

Despite limitations, the fact that some of the initiatives were statewide or citywide (I-STOP, prescribing guidelines, and public service announcements), whereas others were Staten Island–specific (local media, local community engagement and conferences, tailored advertising messages, and office educational visits with prescribers) suggests that the community-specific initiatives might have been key to the decreases in Staten Island without corresponding decreases citywide. Staten Island's size (500,000 pop.) and relative geographic separation from the other four NYC boroughs also might have enhanced its saturation with prevention messages and strategies. This tailored and intensive approach might be effective in other jurisdictions with high rates of opioid analgesic–involved mortality.

What is known already?

Opioid analgesic–involved overdose mortality is a serious public health issue. In New York City, the rate of opioid analgesic–involved overdose deaths increased 57% citywide, from 2005 to 2011. However, in one borough, Staten Island, the rate increased 257% during that period.

What is added by this report?

This report shows that data-driven, multi-pronged public health strategies, including judicious prescribing guidelines, office educational visits with providers, dissemination of timely data reports, and media campaigns, might contribute to a reduction in the rate of opioid analgesic–involved overdose deaths in Staten Island.

What are the implications for public health practice?

Targeted public health interventions appear effective in lowering opioid analgesic–involved overdose mortality rates; the interventions in Staten Island might be replicated by other health departments.

[1]Bureau of Alcohol, Drug Use, Prevention, Care and Treatment, New York City Department of Health and Mental Hygiene; [2]Office of Noncommunicable Diseases, Injury and Environmental Health, National Center for Injury Prevention and Control, CDC; [3]The Public Good Projects, New York City.

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TABLE 2. Number and rate per 1,000 residents* of annual and quarterly (October–December) opioid analgesic prescriptions and high morphine equivalent dose prescriptions received,† by borough of residence§ — New York City, 2011–2013

Borough of residence	2011		2012		2013		% rate change from 2011 to 2013¶
	Total	(Rate)	Total	(Rate)	Total	(Rate)	
New York City							
Opioid analgesic prescriptions	2,172,238	(251.9)	2,167,719	(248.4)	2,029,541	(230.6)	-8.5%
High morphine equivalent dose prescriptions	395,605	(45.8)	419,476	(48.1)	413,801	(47.0)	+2.6%
Staten Island							
Opioid analgesic prescriptions	251,705	(502.0)	245,449	(487.3)	231,139	(452.9)	-9.8%
High morphine equivalent dose prescriptions	65,310	(132.4)	66,007	(133.7)	60,866	(121.6)	-8.2%
Other four boroughs							
Opioid analgesic prescriptions	1,920,544	(236.7)	1,922,270	(234.1)	1,798,402	(217.2)	-8.2%
High morphine equivalent dose prescriptions	330,276	(40.7)	353,469	(43.1)	352,935	(42.6)	+4.7%
Median days supply of drug							
New York City	16	—	20	—	20	—	—
Staten Island	30	—	30	—	30	—	—
Other four boroughs	15	—	17	—	20	—	—

Borough of residence	October–December 2011		October–December 2012		October–December 2013		% rate change from October–December 2011 to October–December 2013¶
	Total	(Rate)	Total	(Rate)	Total	(Rate)	
New York City							
Opioid analgesic prescriptions	553,650	(64.2)	531,109	(60.9)	496,100	(56.3)	-12.3%
High morphine equivalent dose prescriptions	107,013	(12.4)	105,477	(12.1)	104,886	(11.9)	-4.0%
Staten Island							
Opioid analgesic prescriptions	63,676	(127.0)	58,234	(115.3)	56,769	(110.7)	-12.8%
High morphine equivalent dose prescriptions	17,098	(34.7)	15,611	(31.5)	15,011	(29.9)	-13.8%
Other four boroughs							
Opioid analgesic prescriptions	489,974	(60.4)	472,875	(57.6)	439,331	(53.0)	-12.3%
High morphine equivalent dose prescriptions	89,915	(11.1)	89,866	(11.0)	89,875	(10.9)	-1.8%

Source: Bureau of Narcotic Enforcement, Prescription Drug Monitoring Program, New York State Department of Health, 2011–2013.

* Age-adjusted rates are calculated using intercensal estimates updated in December 2014, and are weighted to U.S. Census Standard 2000.

† Analysis includes prescriptions written for Schedule II (excluding codeine-2) and hydrocodone. Prescriptions written by veterinarians, or written under institutional licenses, or prescriptions with missing prescriber ID, or missing patient ID are excluded. Morphine equivalent dose (MED) is the equivalent of 1 mg of morphine; high MED prescriptions are greater than 100 MED.

§ Analysis limited to residents of Staten Island and the other four New York City boroughs (Bronx, Brooklyn, Manhattan, and Queens).

¶ All rate changes were statistically significant ($p<0.05$).

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City Health Information

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Preventing Misuse of Prescription Opioid Drugs

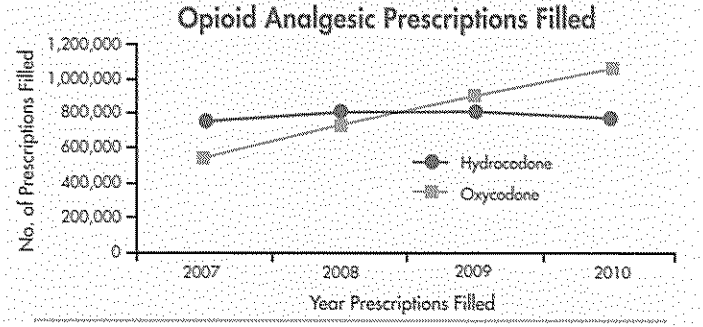
- **Physicians and dentists can play a major role in reducing risks associated with opioid analgesics, particularly fatal drug overdose.**
- **For acute pain:**
  - **If opioids are warranted, prescribe only short-acting agents.**
  - **A 3-day supply is usually sufficient.**
- **For chronic noncancer pain:**
  - **Avoid prescribing opioids unless other approaches to analgesia have been demonstrated to be ineffective.**
- **Avoid whenever possible prescribing opioids in patients taking benzodiazepines because of the risk of fatal respiratory depression.**

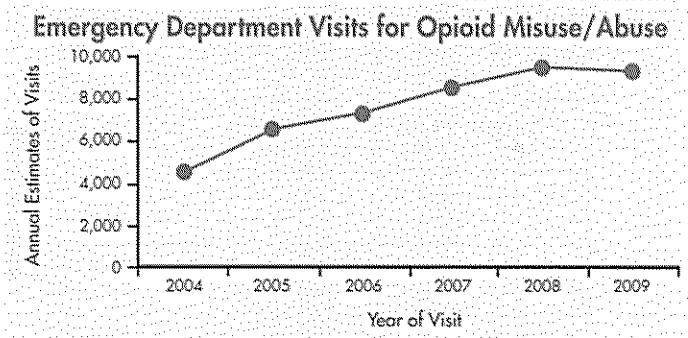
The use of prescription opioids to manage pain has increased 10-fold over the past 20 years in the United States.[1] Although opioids are indicated and effective in the management of certain types of acute pain and cancer pain, their role in treating chronic noncancer pain is not well established.[2]

Concomitant with the growth in opioid prescribing, opioid-related health problems have increased. Between 2004 and 2009, the number of emergency department visits for opioid analgesic misuse and abuse in New York City (NYC) more than doubled, rising from approximately 4500 to more than 9000 visits.[3] In 2009, 1 in every 4 unintentional drug poisoning (overdose) deaths in NYC involved prescription opioid analgesics, excluding methadone.[3] In NYC, one-third of unintentional drug poisoning overdose deaths involve a benzodiazepine[4,5]; the most common is alprazolam (Xanax®).[5] Risks of unintentional poisoning may be increased when opioids are taken with benzodiazepines because both cause respiratory depression.[6]

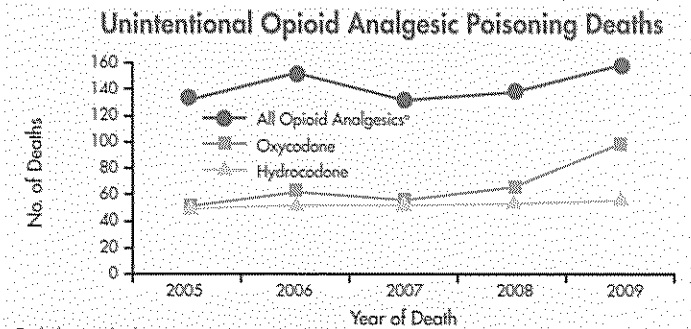
The use of prescription opioids in manners other than prescribed and the use of these medications without prescriptions are serious public health problems.[7]

TRENDS IN OPIOID ANALGESIC USE AND CONSEQUENCES, NEW YORK CITY, 2004–2010





Note: Methadone is included in opioid analgesic emergency department visits.



*Excluding methadone.
Note: Deaths may involve more than 1 opioid and be counted in more than 1 group.
Source: NYC Office of the Chief Medical Examiner and Office of Vital Statistics, New York State Prescription Drug Monitoring Program, Drug Abuse Warning Network (DAWN).

Nearly three-quarters (71%) of people aged 12 years and older who have used opioid analgesics for nonmedical purposes reported obtaining them for free or buying them from family or friends. In 80% of cases where opioid analgesics were obtained for free, the friend or relative had received the drugs from just one doctor.[8]

BOX 1. HEALTH RISKS ASSOCIATED WITH PRESCRIPTION OPIOIDS

- Fractures from falls in patients aged 60 years and older[9]
- Fatal overdose from respiratory depression.[6] Opioids suppress respiratory drive and decrease respiratory rate.[10] Respiratory depression is more common with use of alcohol, benzodiazepines, antihistamines, and barbiturates.[6,7]
- Tolerance, physical dependence, withdrawal, and opioid dependence (addiction)[11]
- Drowsiness[11]
- Increased pain sensitivity (hyperalgesia)[12]
- Sexual dysfunction and other endocrine effects[13]
- Constipation[14]
- Nausea/vomiting[6]
- Chronic dry mouth[15]
- Dry skin/itching/pruritus[6]

BOX 2. TOLERANCE, DEPENDENCE, AND ADDICTION

- **Tolerance** is a reduction in sensitivity to effects of opioids following repeated administration, requiring increased doses to produce the same magnitude of effect.[2]
- **Physical dependence**, which may occur even with ≤7 days of treatment,[16] is defined as occurrence of withdrawal symptoms when the opioid is abruptly discontinued or rapidly reduced.[17]
  - Symptoms of withdrawal include agitation, insomnia, diarrhea, sweating, rapid heartbeat, and runny nose.[2,11]

  Physical dependence is sometimes referred to as simply *dependence*,[2] but it is distinct from opioid dependence as defined by DSM-IV criteria.
- **Opioid dependence** is a maladaptive pattern of use leading to significant impairment or distress. The condition is diagnosed when 3 or more of the following DSM-IV criteria have occurred in the preceding 12 months: tolerance; withdrawal; inability to control use; unsuccessful attempts to decrease or discontinue use; time lost in obtaining substance, using substance, or recovering from using; giving up important activities; and continued use despite physical or psychological problems.[18] Maladaptive use of prescription opioids marked by impaired control is sometimes referred to as *addiction*.[17]

Providers should prescribe opioids only very cautiously, and clearly communicate the risks of opioid treatment to their patients (see **Boxes 1** and **2**). The guidance given here applies only to management of acute pain and chronic noncancer pain. See separate guidelines for management of pain due to cancer.[19]

CHOOSING PAIN MANAGEMENT THERAPY

There are many methods of managing pain. Generally, opioids should only be used if other measures to relieve pain are not likely to be effective (see **Box 3**). Evaluate all patients reporting pain with a physical examination and a detailed history that includes medication history and onset, location, quality, duration, and intensity of the pain. A thorough evaluation will help determine the cause and mechanism of the pain (neuropathic, inflammatory, muscle, or mechanical/compressive), and choose the appropriate therapy.[20,21] For neuropathic pain, effective agents include certain antidepressants and anticonvulsants and transdermal lidocaine.[22] A meta-analysis of randomized trials of opioids for chronic noncancer pain did not find that opioids produce better functional outcomes than nonopioid drugs; one study found that nonopioid drugs produced better functional outcomes than opioids.[23]

A medication history will identify potentially harmful drug interactions, for example, an increased risk of respiratory depression if a patient is taking benzodiazepines with an opioid. Validated pain scales (eg, 3-item PEG[24] or visual analog pain scale) may be helpful in initial pain assessment and with monitoring response to therapy[11] (**Resources—Assessment and Monitoring Tools**).

BOX 3. NONOPIOID APPROACHES TO MANAGING PAIN[2,6]

Pharmacologic approaches include:

- Acetaminophen
- Selected anticonvulsants
- Selected antidepressants
- Capsaicin (for neuropathic pain)
- Corticosteroids
- Nonsteroidal anti-inflammatory drugs (NSAIDs)
- Transdermal lidocaine

Nonpharmacologic approaches include:

- Behavioral management (eg, assessment for depression/stress, chemical dependency)
- Physical therapy
- Self-management therapies (eg, relaxation, cognitive behavioral therapy)

WHEN TO CONSIDER OPIOIDS

Acute Pain: Short-acting opioids such as codeine, hydrocodone (Vicodin®, Lortab®), immediate-release oxycodone (Percocet® or Percodan®), and hydromorphone (Dilaudid®) may be used to relieve acute pain when the severity of the pain warrants their use and when nonopioid therapies will not provide adequate relief.[25] For opioid-naive patients, always start with the lowest possible effective dose.[6] Do not prescribe long-acting opioids such as methadone, fentanyl patches, or extended-release opioids such as oxycodone (OxyContin®), oxymorphone, or morphine.[11] It is important to note that opioids can be used to treat acute pain in patients maintained on medication-assisted treatment (eg, methadone or buprenorphine) for opioid dependence.[26]

For most patients with acute pain (eg, post-trauma or surgery), a 3-day supply is sufficient; do not prescribe more than a 7-day supply. Episodic care providers in settings such as emergency departments, walk-in clinics, and dental clinics should not prescribe long-acting opioids.

Chronic Pain: Opioids should not be considered first-line medication for chronic noncancer pain. Opioids should be used for chronic pain only when other physical, behavioral, and nonopioid measures have not resolved the patient's pain, and only if used with extreme caution.[11] There is insufficient evidence that modest pain relief is sustained or that function improves when opioids are prescribed long-term for chronic noncancer pain.[2]

If opioids are considered for chronic pain, first confirm that other pain management strategies have not resolved the pain, and then carefully evaluate the patient's risk of opioid misuse (see **Figure**) and adverse events[11] (see **Box 1**). A personal or family history of substance abuse is the most strongly predictive factor for misuse; however, patients are often reluctant to disclose such information. Effective screening tools are available to help elicit a substance use history[6] (**Resources—Assessment and Monitoring Tools; *City Health Information***). A history of preadolescent sexual abuse and certain psychiatric conditions (eg, depression) are also risk factors[27] (see **Box 4**). Chronic opioid therapy is not absolutely contraindicated for patients at risk for opioid misuse, but extreme caution should be exercised. In such cases, consider consulting a pain management specialist (a physician specifically concerned with the prevention, evaluation, management, and treatment of pain[28]) or a physician who treats chronic pain, such as a rheumatologist.

Recognize the risk of adverse events, including physical dependence and withdrawal, opioid dependence (addiction), and overdose, and discuss these risks with patients. Explain the potential risk of alcohol and medication interactions. In particular, benzodiazepines and other central nervous system depressants may increase the risk of serious adverse events, especially in older patients.[29] This combination should be avoided as much as possible.[11] Screen patients for harmful or hazardous alcohol use, and provide brief intervention and referral where indicated (**Resources—*City Health Information***).

Note: The use of brand names does not imply endorsement of any product by the New York City Department of Health and Mental Hygiene. Please consult prescribing information for complete safety information, including boxed warnings.

FIGURE. OPIOID RISK TOOL

		Mark each box that applies	Item score if female	Item score if male
1. Family history of substance abuse	• Alcohol	☐	1	3
	• Illegal drugs	☐	2	3
	• Prescription drugs	☐	4	4
2. Personal history of substance abuse	• Alcohol	☐	3	3
	• Illegal drugs	☐	4	4
	• Prescription drugs	☐	5	5
3. Age (mark box if 16-45)		☐	1	1
4. History of preadolescent sexual abuse		☐	3	0
5. Psychological disease	• Attention-deficit disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia	☐	2	2
	• Depression	☐	1	1

Total Score _____ Risk Category _____

Low Risk: 0 to 3 Moderate Risk: 4 to 7 High Risk: 8 and above

Source: Webster LR, Webster R. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Med.* 2005;6(6):432.

BOX 4. PAIN AND MENTAL HEALTH

Identification and management of psychological comorbidities are integral to treatment of chronic pain.[30]

Depression and anxiety often coexist with chronic pain[30] and may increase the risk of opioid use and misuse.[6,31,32] The relationship is dynamic, as psychological factors may both influence pain and in turn be influenced by the level of pain.[31] Many patients with undiagnosed depression initially present to their providers with a primary complaint of pain (eg, headache, back pain).[33]

Use the Patient Health Questionnaire (PHQ-2) to assess for depression (**Resources—Depression CHI**).

A trial of opioid therapy should only be considered when the potential benefits are likely to outweigh potential harm[6] and the clinician is willing to commit to continued monitoring of the effects of treatment, including a plan to discontinue opioid therapy if necessary.[11] If you prescribe opioid therapy, register with the New York State (NYS) Health Commerce System to access the NYS Controlled Substance Information (CSI) on Dispensed Prescriptions Program so you can verify whether your patient has received controlled substance prescriptions from 2 or more prescribers and filled them at 2 or more pharmacies/dispensers during the previous calendar month (**Resources**).[34]

In addition to opioid therapy, the treatment plan for a patient with chronic pain should include appropriate nonopioid adjuvant therapies to relieve pain and help the patient cope with the condition. Coordinate care with the patient's other providers whenever possible.[6]

A written pain treatment agreement explaining the doctor's and patient's responsibilities in opioid therapy (eg, filling prescriptions at only one pharmacy) can be a valuable element of the pain treatment program[6] (**Resources**).

DOSING AND MONITORING

Avoid oversupplying patients with opioids to prevent misuse and diversion. Dosing and titration of opioids for chronic pain should be tailored according to the patient's previous response to opioid therapy, response to treatment, and potential or observed adverse events.[6]

Start opioid-naive patients and patients at increased risk of adverse events at the lowest possible effective dose and titrate slowly (see **Boxes 1, 5,** and **6**), as higher doses increase the risk of adverse events such as overdose.[6,35,36]

All conversions between opioids are estimates generally based on equianalgesic dosing (ED). For patients taking more than one opioid, the morphine-equivalent doses (MED) of the different opioids must be added together to determine the cumulative dose (see **Box 5**). Because of the large patient variability in response to these EDs, it is recommended that the calculated conversion dose be reduced by 25% to 50% to assure patient safety.[11] An opioid dose calculator is available at www.agencymeddirectors.wa.gov/Files/DosingCalc.xls. However, this calculator should not be used for converting a patient from one opioid to another. This is especially important in conversion to methadone, where additional caution is needed given the high potency and long and variable half-life of methadone.[6]

Furthermore, a recent study published in *JAMA* found that among patients receiving opioid prescriptions for pain, overdose rates increased with increasing doses of prescribed opioids.[36] Use the lowest possible effective dose of opioids. If dosing reaches 100 MED per day, thoroughly reassess the patient's pain status and treatment plan and reconsider other approaches to pain management.

BOX 5. CALCULATING CUMULATIVE MORPHINE-EQUIVALENT DOSES (MED)

Approximate equivalent doses for 30 mg morphine[11]:
Hydrocodone: 30 mg
Oxycodone: 20 mg

If a patient takes 6 hydrocodone 5 mg/acetaminophen 500 mg and 2 oxycodone 20-mg extended-release tablets per day, the cumulative dose is calculated as:

Hydrocodone 5 mg x 6 tablets/day = 30 mg/day
= 30 mg MED/day

Oxycodone 20 mg x 2 tablets/day = 40 mg/day
= 60 mg MED/day

Cumulative dose = 30 mg MED/day + 60 mg MED/day
= 90 mg MED/day

BOX 6. CONSIDERATIONS FOR OPIOID DOSING

- Acetaminophen warning with combination products. Liver damage can result from prolonged use or doses in excess of the recommended maximum total daily dose of acetaminophen, including over-the-counter products[11]:
  - Short-term use (<10 days): 4000 mg/day
  - Long-term use: 2500 mg/day
- For long-acting opioids. Monitor for adequate pain relief and for breakthrough pain at least until the long-acting opioid dose is stabilized. When calculating the starting dosage, be sure to include any short-acting opioids; consult with a pain management specialist for guidance.[11]
- Dosing caution. Doses ≥100 mg MED per day are associated with higher risks of overdose; the lowest possible effective dose should be prescribed at all times. If dosing reaches 100 MED per day, thoroughly reassess the patient's pain status and treatment plan and reconsider other approaches to pain management.

Always monitor for adverse effects (respiratory depression, nausea, constipation, oversedation, itching, etc).[11]

To ensure that the goals of pain management are met, carefully monitor patients receiving chronic opioid therapy:

- Follow up on a regular basis and document each assessment.[6]
- Assessment should include clinical observations of the patient's level of pain and physical functioning, as well as any adverse events.[11]
- Consider urine drug testing on all patients to monitor prescription drug adherence and nonprescribed drug use (see **Box 7**).[11]
- Closer and more frequent monitoring is required for patients at increased risk for adverse events or misuse.[11]
- If a patient does not experience significant improvement in physical function or pain status or if dosing reaches 100 MED per day, thoroughly reassess the patient's pain status and treatment plan and reconsider other approaches to pain management.

Discontinuing opioid treatment should be managed carefully; there are several protocols for safely tapering opioids. The simplest and safest taper is a dose reduction of 10% each day, 20% every 3 to 5 days, or 25% each week.[39]

BOX 7. URINE DRUG TESTING (UDT) FOR CHRONIC OPIOID THERAPY

- Urine drug testing and behavioral assessment can identify inappropriate drug use.[37]
- Inform the patient of the reason for UDT, its frequency, and its consequences.[11]
- Repeat randomly, depending on risk level (yearly for low risk to every 3 months for high risk).[11]
- If the patient demonstrates aberrant behavior, test at visit.[11]
- UDT can detect presence or absence of drug(s) but not how much of a drug was used.[11]
- Urine drug testing results should be interpreted in the context of information from patient interviews, physical examination, patient behavior such as requests for early refills, and confirmatory testing.[38]
- The following results should be viewed as red flags[11]:
  - Negative for opioids prescribed (might indicate diversion);
  - Positive for drugs you did NOT prescribe (benzodiazepines, other opioids) or for cocaine, amphetamine, or methamphetamine.
- If confirmatory testing and other information substantiate a red flag and the result is[11]:
  - Negative for prescribed opioids—consider stopping opioid therapy, particularly if diversion is suspected.
  - Positive for drugs you did not prescribe—consider referral to an addiction specialist or drug treatment program.

[a] Important: Immunoassays can cross-react with other drugs and vary in sensitivity and specificity. Unexpected immunoassay results should be interpreted with caution and verified by confirmatory testing using gas chromatography/mass spectrometry or liquid chromatography/tandem mass spectrometry to identify a drug or confirm an immunoassay result. Interpretation of results of confirmatory testing is complicated; consult with the laboratory before making a clinical decision.[11]

An algorithm giving detailed guidance on UDT in chronic opioid therapy is available in Appendix D of the Washington State Agency Medical Directors' Group, Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain (2010) at: www.agencymeddirectors.wa.gov/guidelines.asp.

TALKING TO PATIENTS ABOUT OPIOIDS

Clearly communicate with patients about opioid therapy (see **Box 8**) and state the goals of pain management. For acute pain, opioids are short-term therapy for the specific condition.[6,11] Explain that the pain should resolve before the medication supply runs out, but if pain is still present at scheduled follow-up, you will reevaluate.

For chronic pain, be explicit and realistic about the kind of relief opioids can provide. Opioids may be just one part of a multimodal treatment plan to reduce chronic pain intensity and improve quality of life, particularly functional capacity.[6] The treatment plan should also address the risks, benefits, and goals of opioid therapy, such as increased activity levels, improved quality of life, and reduced pain.[2]

Be sure that patients know they should keep their prescription in a safe, locked cabinet and that—unlike other medications—unused opioids should be flushed down the toilet.[40]

BOX 8. WHAT YOU SHOULD TELL YOUR PATIENTS ABOUT OPIOIDS

- Fill your prescriptions at only one pharmacy.[6]
- Keep the medication in a secure location, preferably locked.[41]
- Your body may become used to the drug (physical dependence) and stopping the drug may make you miss it or feel sick.[11]
- You may develop tolerance and need more medication to get the same effect.[11]
- There is a risk of opioid dependence (addiction) when taking this medicine.[16]
- Take the medication exactly as shown on the label—and not more frequently or less frequently.[41]
- An overdose of this medicine can slow or stop your breathing and even lead to death. You may experience side effects such as confusion, drowsiness, slowed breathing, nausea, vomiting, constipation, and dry mouth.[6,15]
- Avoid alcohol and other drugs that are not part of the treatment plan that we've discussed (eg, benzodiazepines) because they may worsen side effects and increase risk of overdose.[7] Be careful when driving or operating heavy machinery. Opioids may slow your reaction time.[6]
- Do not share medication with anyone.[29]
- Flush unused medication down the toilet.[40]

SIGNS OF PRESCRIPTION DRUG MISUSE

Protect your patients' safety by being alert to signs of misuse, but also be aware that all patients will develop a physical dependence if they are taking opioids daily for an extended period of time (days or weeks).[16] Some patients may display an overwhelming focus on opioid issues, demonstrate a pattern of early refills, or make multiple telephone calls or office visits to request more opioids.[2] Patients who misuse opioids may have a pattern of prescription problems that includes lost, spilled, or stolen medications, or escalating drug use in the absence of a physician's direction to do so.[2] If a urine screen reveals illicit or licit drugs that were not disclosed, is repeatedly negative for drugs prescribed, or if you learn that the patient has obtained opioids from multiple providers when checking the NYS CSI on Dispensed Prescriptions Program (**Resources**),[2] you should consider the possibility of opioid misuse.[6] Patients should understand that screening for misuse is a normal part of the pain management process.[2] If the patient demonstrates signs of misuse, discuss the need to improve compliance by reviewing the treatment agreement, emphasizing your concern for the patient. If signs of misuse continue, strongly consider discontinuing opioids. If you suspect your patient meets DSM-IV criteria (**Box 2**) for the diagnosis of opioid dependence and you are not already a buprenorphine prescriber, explain the option of buprenorphine detoxification and maintenance (**Resources—*City Health Information***) and refer the patient to an addiction specialist, buprenorphine provider, or methadone maintenance treatment program. If opioids are discontinued, patients should be tapered as described above.

SUMMARY

Pain relief poses treatment challenges that physicians must consider. While opioids are effective for certain types of pain, their increased use has contributed to increases in overdose deaths and opioid misuse.[42] Physicians and patients should be aware of the risks of opioid therapy, including overdose, misuse, diversion, and opioid dependence (addiction). ◆

RESOURCES

Assessment and Monitoring Tools

- Roland Morris Disability Questionnaire: www.chirogeek.com/001_Roland-Morris-Questionnaire.htm
- Pain, Enjoyment and General Activity (PEG): www.ncbi.nlm.nih.gov/pmc/articles/PMC2686775
- Graded Chronic Pain Scale (Washington State Guidelines): www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf
- Brief Pain Inventory: medicine.iupui.edu/RHEU/Physicians/bpisf.pdf
- Physical Functional Ability Questionnaire: www.cdc.gov/nchs/data/nhanes/nhanes_09_10/pfq_f.pdf
- Bieri Pain Scale: www.healthcare.uiowa.edu/igec/tools/pain/faces.pdf
- Visual Analog Scale: www.partnersagainstpain.com/printouts/A7012AS1.pdf
- Pain Management Resource Directory (includes assessment tools): www.compassionandsupport.org/index.php/for_professionals/pain_management
- AUDIT Alcohol Consumption Questions: www.ewashtenaw.org/government/departments/wcho/ch_auditc.pdf
- CRAFFT Adolescent Substance Abuse Screening Tool: www.childrenshospital.org/views/february09/images/CRAFFT.pdf
- Patient Health Questionnaire-2 for Depression Assessment: www.cqaimh.org/pdf/tool_phq2.pdf
- Sample Pain Treatment Agreements:
  http://hrsa.dshs.wa.gov/pharmacy/ChronicPainAgreement.pdf
  www.painmed.org/library/sample_agreements/controlled-substances-agrmt110803.pdf
  www.dopl.utah.gov/licensing/forms/OpioidGuidlines_summary.pdf

US and NYS Resources

- New York State (NYS) Controlled Substance Information (CSI) on Dispensed Prescriptions Program: www.nyhealth.gov/professionals/narcotic/practitioners/online_notification_program/
- NYS Department of Health Commerce System: https://commerce.health.state.ny.us/hcsportal/appmanager/hcs/home
  Password required. Please call the Commerce Accounts Management Unit at 1-800-529-1890 for assistance.
- Emergency Department Care Coordination. Provides guidelines for patients with chronic pain who recurrently use the emergency department: www.consistentcare.com
- Office of National Drug Control Policy: www.whitehousedrugpolicy.gov/drugfact/prescr_drg_abuse.html
- US Department of Justice Drug Enforcement Agency. Questions and Answers: State Prescription Drug Monitoring Programs: www.deadiversion.usdoj.gov/faq/rx_monitor.htm
- US Food and Drug Administration. Disposal by Flushing of Certain Unused Medications: What You Should Know: www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/ucm186187.htm
- NYS Department of Health Opioid Overdose Prevention: www.health.state.ny.us/diseases/aids/harm_reduction/opioidprevention/index.htm
- Physicians for Responsible Opioid Prescribing: www.responsibleopioidprescribing.org

New York City Department of Health and Mental Hygiene. *City Health Information*:

- Buprenorphine: An Office-based Treatment for Opioid Dependence: www.nyc.gov/html/doh/downloads/pdf/chi/chi27-4.pdf
- Improving the Health of People Who Use Drugs: www.nyc.gov/html/doh/downloads/pdf/chi/chi28-3.pdf
- Detecting and Treating Depression in Adults: www.nyc.gov/html/doh/downloads/pdf/chi/chi26-9.pdf
- Brief Intervention for Excessive Drinking: www.nyc.gov/html/doh/downloads/pdf/chi/chi30-1.pdf

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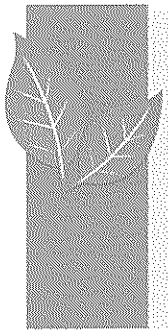

CHI Goes Paperless:

The New York City Department of Health and Mental Hygiene is pleased to announce that, beginning in April 2012, *City Health Information* will become a paperless publication, reformatted for electronic distribution and available only by subscription or at www.nyc.gov/health. To avoid missing a single issue and to learn more about the transition, subscribe today at www.nyc.gov/health/chi.

(Continued from page 29)

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Testimony: NYC Council Oversight Hearing: Examining NYC's Response to Heroin Use and Overdose: June 23, 2015:

Presented by Rose Kerr: Director of Education for the S.I. Borough President's Office

I wish to thank the members of the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Service and the Committee of Public Safety for allowing me to testify regarding: Oversight: Examining NYC's response to Heroin Use and Overdose.

I am the Director of Education for the Staten Island Borough President, James Oddo, and serve on his Task Force for the Prevention of Substance Abuse. As such, and having worked in service to school children in Staten Island for nearly 3 decades, it became clear early on that prevention efforts in our schools, and among our youth, plays a vital role in the defeat of the scourge that prescription drugs and heroin abuse presents to our community.

We may all be familiar with the statistics that highlight the seriousness of problem we face citywide, and especially on Staten Island. Data (see attachment 1) show that Staten Island leads NYC high school youth in:

- Alcohol use and binge drinking;
- Marijuana use;
- Cocaine use;
- Heroin use;
- Methamphetamine use;
- Ecstasy use;
- And other Rx drugs;

In addition, three of the top five NYC neighborhoods where unintentional deaths involving opioids have occurred, are in Staten Island (see attachment 2).

And, of the five top neighborhoods in NYC where unintentional deaths involving heroin have occurred, one is in Staten Island (see attachment 3).

In order to address this crisis the Office of the Borough President, the NYPD, NYC Public Schools, the New York Archdiocese schools, and community-based partners have begun a pilot program in Staten Island schools located in our four NYPD precincts. Utilizing the evidence-based curriculum "Too Good for Drugs" NYPD Borough Patrol officers and school teachers have presented collaborative lessons targeting 5th grade students during the regular school day. Our findings, as well as results from a study commissioned by the Florida Department of Education, analyzed over a sustained period of time, show that students who participated in the program gained positive effects in:

- Emotional competency skills;
- Social resistance skills;

- Gains in goal-setting and decision-making skills;
- Higher level of perception of harmful effects of substances;

Although we are heartened by the positive results of our small pilot, we are looking at one tiny step in the vast distance that lies ahead. Every child in NYC schools deserves the right to be educated, and be armed with the social, emotional and intellectual skills needed to fight the horror of substance abuse!

In addition to the schools' pilot, we have advocated to the Office of Alcoholism and Substance Abuse (OASAS) for the increase in the number of Substance Abuse Prevention and Intervention Specialists (SAPIS) staff in our schools. We currently have twelve SAPIS in our 70 Staten Island public schools. Even with the addition of 10 more SAPIS which have been recently proposed, our children remain profoundly underserved with only 30% of our schools covered overall, and only 5 of our 50 elementary schools served. Every school should be allocated a SAPIS staff member, and where the school enrollment dictates (as in Tottenville HS—with approximately 4,000 students) sufficient SAPIS to service the number of students enrolled.

Lastly, as a key component of the battle we face in the fight against substance abuse, we have petitioned our NYS Education Department to consider adding a mandatory "Substance Abuse Awareness" workshop to the requirements for teacher certification. With the support of this initiative, we empower those who are face-to-face with our children five days a week: the teachers of our public schools. The impact they have on our youngsters can never be underestimated.

Sadly, the age at which children are experimenting with drugs and alcohol is shockingly young, and early prevention and intervention are absolutely necessary if we are to stem the tide of addiction and death. Recognizing that young lives hang in the balance, NYC must step up to challenges our children face! Therefore, on behalf of the Office of the Staten Island Borough President, I urge this Oversight Committee to consider and support:

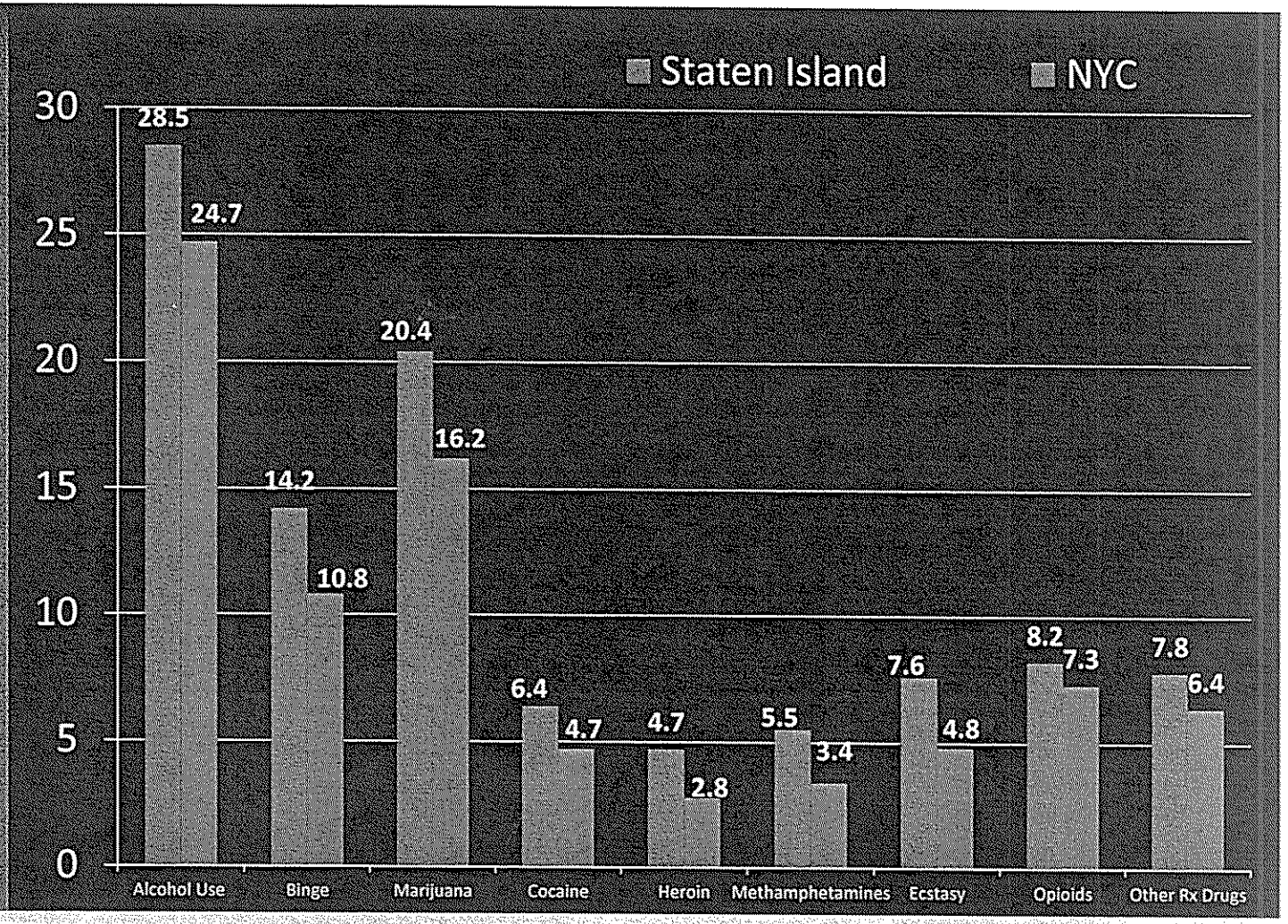
1. Implementation of the evidenced-based "Too Good for Drugs" curriculum throughout all grade levels K-12. As the epi-center for opioid abuse in NYC, Staten Island can serve as a borough-wide pilot for the city schools;
2. Increase of SAPIS staff throughout our Staten Island schools; sufficient to service all grade levels commensurate with need and school population;
3. Support of the addition of a "Substance Abuse Awareness" workshop to the teacher certification requirements;

Thank you for your time and attention to these urgent requests for youngsters the of Staten Island, and in all of NYC.

###

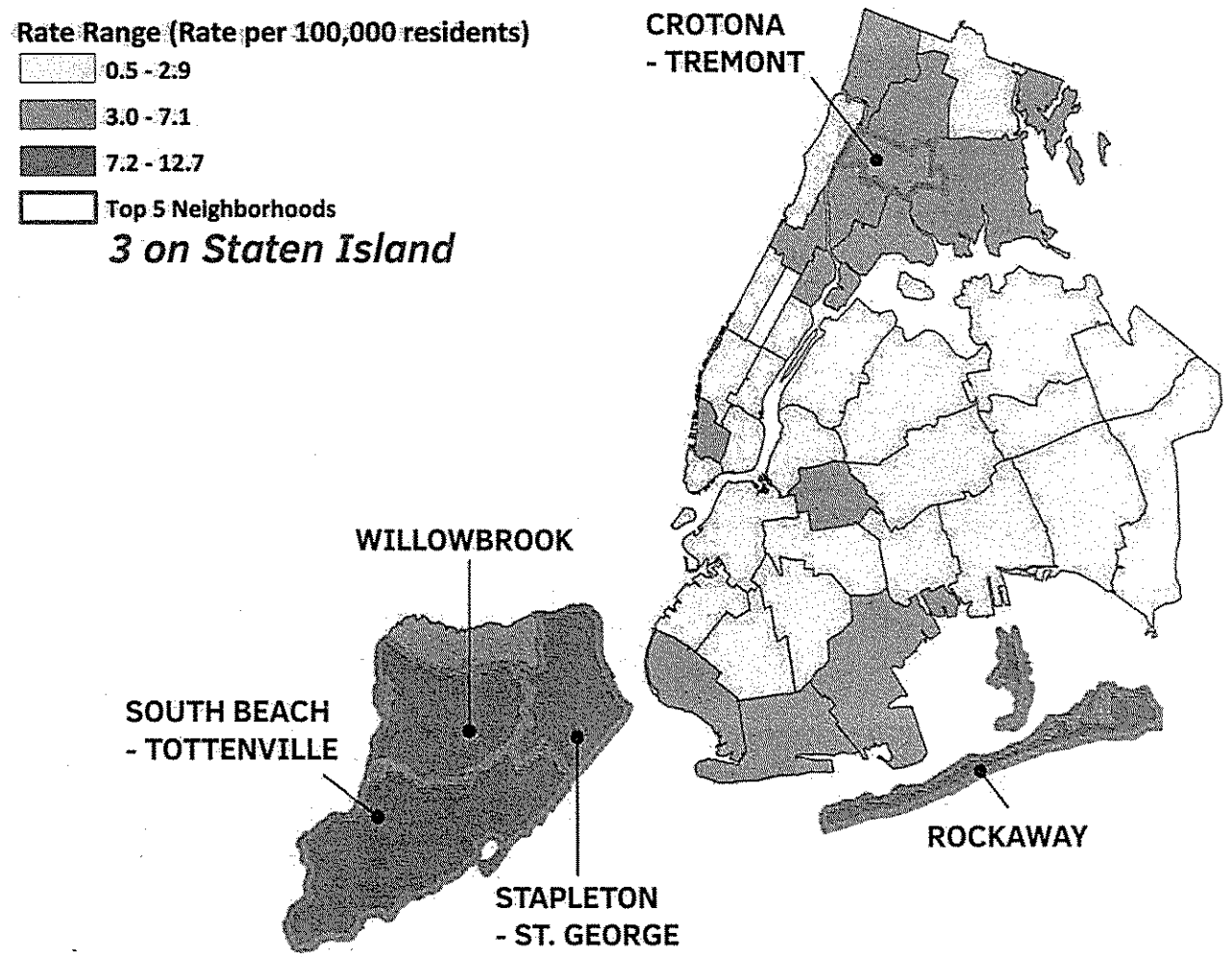
Alcohol and Substance Abuse among HS youth.

YRBS Data 2013



Unintentional deaths involving opioids by NYC neighborhood of residence.

NYCDOH
Epi Data Tables No. 33
2011 - 2012



Unintentional deaths involving heroin by NYC neighborhood of residence.

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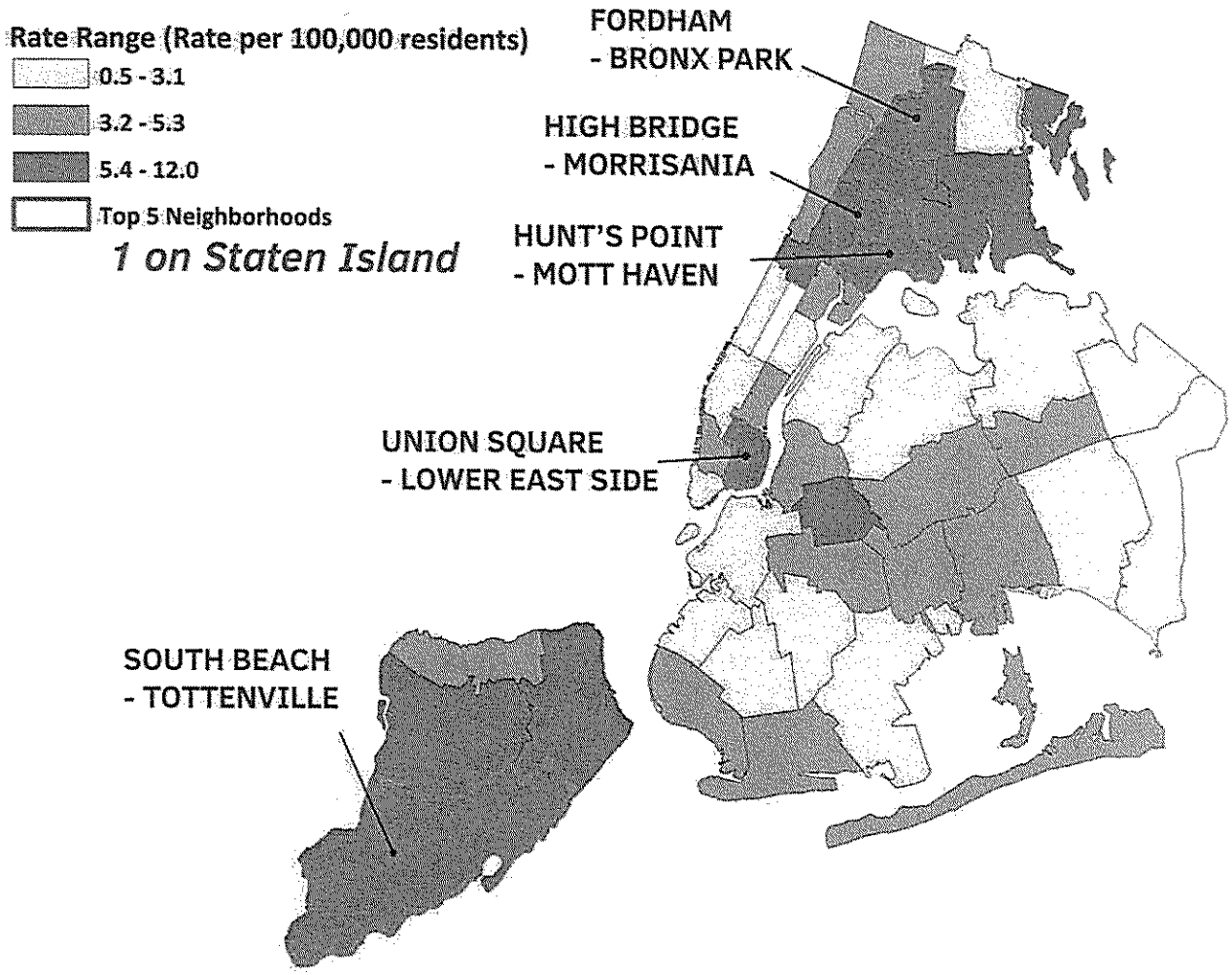

Testimony of

Bridget G. Brennan

New York City Special Narcotics Prosecutor

on

Int. No. 748 – In relation to an Office of Drug Strategy

Oversight: Examining NYC's response to Heroin Use and Overdose

Before the

New York City Council

Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

and

Committee on Public Safety

Tuesday, June 23rd, 2015

Members of the City Council, thank you for this opportunity to testify about the critically important topic of heroin use and overdose in New York City, and to respond to a proposal to create an Office of Drug Strategy. The fact that you are holding this hearing today demonstrates that you recognize the seriousness of the crisis we face. As some of you know, I have worked in the drug enforcement arena for more than two decades.

During that time, I have witnessed the devastation wrought on our communities by drug epidemics – death, addiction, related violence and property crime, and the incarceration of large numbers

of young people for drug crimes. I have also participated in successful strategies to reverse the downward spiral. Compare the New York City of 2015 to New York City of 1985, and you get the picture: today we see safer streets and much reduced rates of incarceration. At the height of the crack epidemic, in the 1990s, few believed that New York City would ever recover from the high level of violent crime caused by turf battles between crack organizations. But we did. And we changed our criminal justice practices. Between 2008 and 2012, the number of those sent to state prison from New York City declined from 2,500 to 1, 500 – a 40% drop – and 2008's numbers were far, far lower than those seen during the crack epidemic of the 1990's. We have come a long way, but it would be naïve to think backsliding is impossible.

The current challenges cannot be overstated. Heroin overdose death rates more than doubled between 2010 and 2013, according to the most recent data available from the New York City Department of Health and Mental Hygiene. To make matters even worse, New York City is a hub of heroin distribution for surrounding communities and the entire Northeast, where overdose rates are also skyrocketing. As political leaders, health professionals and law enforcement officials in the city, we have an enormous responsibility to our city and our region to rein in the heroin supply at its source.

I support a balanced, multi-disciplinary approach to curbing drug use that unites public health, law enforcement, education and socio-economic development towards shared goals. We cannot

medically treat our way out of this problem. Nor can we police our way out of it. We can make headway if we emphasize demand reduction, prevention and access to services for those afflicted with drug addiction, while at the same time maintaining a strong commitment to public safety and reducing the supply of addictive drugs in our communities. Law enforcement must have necessary tools and the support of the political establishment to successfully stem the flow of heroin that threatens to overwhelm many neighborhoods.

The proposed Office of Drug Strategy falls short of this ideal and, in my view, would be duplicative of work already performed by existing Mayoral agencies. I believe the proposed Office would actually impede an effective response by creating another layer of bureaucracy and draining badly needed resources from the agencies responsible for directly addressing urgent problems. So I oppose the proposal to amend the City Charter to create an Office of Drug Strategy.

Instead, for a successful and time-tested and much less expensive model of interagency cooperation on drug issues, we need look no further than the Mayor's Task Force on Prescription Painkiller Abuse and the associated workgroup, RxStat, which have been highly productive and adaptable in the face of the prescription pill and related heroin crises. Instead of creating a new agency, I suggest that we reinvigorate and revamp the Mayor's Task Force, which was set up under the prior administration to address the

widespread availability of legal and highly addictive drugs - and by widespread overprescribing in the medical community. In addition, a few unscrupulous doctors saw a chance to profit by selling prescriptions like common street dealers, and have caused untold harm as a result. A Health Department led campaign to enlighten doctors about the dangers of overprescribing and recommendations for changes in protocol has been very successful. The few doctors who use their medical credentials as a license to deal drugs have been vigorously pursued by law enforcement. We have made headway - with prescriptions for narcotic pills finally leveling off after years of increase.

Now we face another challenge. Heroin is a cheaper and readily available alternative than ever, thanks to Mexican drug cartels that are always on the lookout for ways to expand their trade. These cartels are flooding our area with heroin. Cartels make a fortune off of other people's misery. Heroin is light and easily transported. The value increases exponentially at each level in the distribution chain. The amount of heroin that constitutes a dosage is miniscule and tens of thousands of dosages can be created from a single kilogram. It is in the drug traffickers' interest to hook citizens of our city and the surrounding area on this dangerous drug. This is a case of the supply creating the demand and a strictly health based approach cannot reduce the supply of heroin.

Health concerns are irrelevant to drug profiteers. De-stigmatization of users and increasing access to drug treatment

become significant only after users become hooked on heroin. Public service announcements and Naloxone, while also important, will not stop shipments of heroin from making their way into our communities. Law enforcement response to the flood of heroin from criminal cartels must be powerful, or we leave our communities at their mercy.

As the abuse and sale of heroin becomes more pervasive, it is also becoming more overt and visible in the New York City of 2015. This spring my office pursued a case involving an individual who was selling heroin in and around Mott Haven Library, a New York Public Library facility located in the Bronx. We were asked to investigate by a citizen who had observed what was going on. The library contracts with a private firm to provide security, but the individual security guard apparently turned a blind eye to drug sales going on within the library.

In our case, a 51-year-old man made two drug sales to an undercover investigator from my office within the reading room of the library. His conduct was overt. A surveillance team also observed him sell to another customer right inside the main entrance of the library. Other customers gathered outside. During all of this, children from a nearby school passed in and out of the library.

In the moments before one sale to our undercover investigator, the security guard approached the heroin dealer inside the library and gestured towards a security camera, warning him to be careful because he might be recorded. The security guard then went into a

restroom and allowed the narcotics transaction to take place. All of this was captured on video. We informed the library of the evidence we recovered on its surveillance video and had a meeting to discuss general security and the prevention of future similar conduct. After our investigation and arrest of the seller, it is our understanding that the security guard who turned a blind eye to drug dealing was terminated.

As this incident makes clear, the responsibility for carrying out effective drug deterrence cannot reside simply within one agency – or even a handful of agencies. But, by creating an Office of Drug Strategy, I fear that some may think that those in charge of our libraries, our parks, and our schools, and our all too rare public spaces, are relieved of their responsibility to address this important issue.

It is time to reevaluate priorities – what is the city doing to curb the supply of addictive drugs on our streets and assure that our precious public spaces are safe and drug free? What are your constituents saying? How, for example, will de-stigmatization of drug use, as proposed in this initiative, help families struggling to keep their children away from drugs and drug dealing? Do we really want to normalize the use of heroin, crack and other destructive drugs? Is that a wise goal at this time, when New York City is being flooded with heroin?

This proposal appears to provide little opportunity for improvement for the vast majority of our city residents who seek

only quiet enjoyment in their libraries, recreation in their parks and safe travel on their subways.

On balance, I oppose the creation of an Office of Drug Strategy because I view it as unnecessary, and because we have already created a far superior model for productive collaboration. Finally, in my view, it fails to appropriately incorporate all elements needed for an effective drug strategy.

STATEMENT OF ASSISTANT CHIEF BRIAN McCARTHY
COMMANDING OFFICER, NARCOTICS DIVISION
NEW YORK CITY POLICE DEPARTMENT

BEFORE THE NEW YORK CITY COUNCIL
COMMITTEES ON PUBLIC SAFETY AND
MENTAL HEALTH, DEVELOPMENTAL DISABILITY, ALCOHOLISM,
SUBSTANCE ABUSE AND DISABILITY SERVICES
JUNE 23, 2015

Good morning, Chairs Gibson and Cohen, and Members of the Council. I am Assistant Chief Brian McCarthy, Commanding Officer of the Narcotics Division of the New York City Police Department. I am jointed by Sgt. Steven Sarao of the Office of the Deputy Commissioner, Management Analysis and Planning, who coordinates the Police Department's Naloxone program. On behalf of Police Commissioner William J. Bratton, we would like to thank you for the opportunity to discuss some of the ways in which the Department responds to heroin use and overdoses in New York City.

We have seen an unfortunate rise in the use of heroin in New York City. In some cases it is simply cheaper and easier to obtain than prescription opioids. In 2014 we seized 1,034 pounds of heroin, and as of June 6th this year, we have seized 716 pounds of heroin, which represents a 103% increase over the 353 pounds we seized by this time last year.

The NYPD's Narcotics Division employs a variety of strategies to combat the sale of controlled substances and choke off the supply of drugs coming into New York City. At a local level, we rely on information from the community regarding locations where drugs are sold, or about the individuals involved in these crimes, and we receive thousands of complaints each year. Calls to 911 will generate a complaint to the Narcotics Division and, possibly, a uniformed response if the incident is active in nature, for example, if the caller is reporting that they are observing drug sales directly. Calls to 311 or to the Mayor's Drug Hotline ((888) 374-DRUG) are routed to our Organized Crime Control Bureau's Field Operations Desk, which operates 24 hours, so that the caller may provide their information directly to us, anonymously if they so choose. We also make detectives from the Narcotics Division available to attend Precinct Community Council meetings, and receive information from many other sources, both within and outside the Department.

Our investigations are conducted using effective law enforcement techniques, such as drawing up and implementing tactical plans, employing undercover operations, executing search warrants, developing intelligence information through debriefing of prisoners, and obtaining court-ordered wiretaps. Our Narcotics Teams provide Citywide coverage in addition to other teams that perform specialized enforcement, such as our Tactical Response Teams, which focus particularly on the violence associated with drug sales. We conduct both short-term investigations and much lengthier investigations, with the goal of shutting down the supply chain, as far up as we can. And we constantly monitor the criminal activity surrounding drug sales, so that we can target our enforcement resources appropriately.

To that end, our partnerships with other law enforcement entities are invaluable. We work closely with the City's Special Narcotics Prosecutor, Bridget Brennan, and in fact a team of my investigators is co-located in her office, providing a constant liaison and mechanism for information-sharing. Both her office and the local District Attorneys' Offices play integral roles in supporting our investigations and in working together with us to achieve successful prosecutions. We participate in two federal task forces, the Drug Enforcement Task Force and the Organized Crime Drug Enforcement Strike Force. Our strong participation in these teams, which include many other law enforcement partners, ensures that our investigations do not have to be limited in scope to State criminal charges and local investigations. In fact, we can leverage the considerable reach of the federal government, to enable us to take our investigations as far as we can, including overseas.

The mission of the Narcotics Division is to put drug dealers out of business, and consequently our attention is mostly devoted to investigations. But there is another aspect to the heroin problem that the Department as a whole has committed to addressing, which is seen mostly from a Patrol perspective. Patrol officers are more likely to encounter individuals suffering from overdoses, either as a result of a 911 call or as a "pickup" job on the street. In light of a staggering increase in overdose deaths related to opioid painkillers and heroin, accompanied by the availability of a safe opioid antagonist, Naloxone, the Department began a pilot program in Staten Island in December, 2013 to enable police officers to administer Naloxone to someone suspected of having overdosed on an opioid. With the help and cooperation of the Department of Health and Mental Hygiene, and with the financial support of the New York State Attorney General, the pilot program was successfully implemented and ultimately expanded Citywide, so that at present there are 16,364 police officers trained in the use of Naloxone, and 12,546 Naloxone kits issued. Every precinct in the City now has trained officers and the necessary equipment.

Officers are instructed on how to recognize the signs of an opioid overdose and how to administer Naloxone, in a 75-minute training session based on a training guide issued by the New York State Division of Criminal Justice Services, "Opioid Overdose and Intranasal Naloxone Training for Law Enforcement." The Police Academy also delivers the Naloxone training to all police recruits. Since the inception of the pilot program, there have been 54 instances where Naloxone was deployed, with 27 having occurred in 2014 and 27 having occurred this year so far.

In conclusion, as Commissioner Bratton has said, addiction to controlled substances is a problem that requires a multi-agency approach, including effective drug treatment. The crucial part that law enforcement can play includes addressing the supply side of the equation, by dismantling drug operations and taking the product off the streets. Law enforcement, as first responders, may also have the opportunity to actually save the life of someone who has overdosed, through the prompt use of Naloxone.

We thank you for focusing public attention on the City's response to the scourge of heroin addiction, and we welcome your questions.

FOR THE RECORD

Examining NYC's response to Heroin Use and Overdose. June 23, 2015

Babak Tofighi, M.D., MSc. Babak.tofighi@nyumc.org

Good morning. I would like to thank the city council for inviting me to participate in this important hearing in response to the ongoing prescription opioid and heroin crisis, and offer testimony as a physician treating primarily vulnerable patients with substance use disorders at Bellevue Hospital.

My name is Babak Tofighi, M.D., M.Sc., and completed specialty training in Internal Medicine, and sub-specialty training in Addiction Medicine. I hold joint appointments at NYU School of Medicine and at Bellevue Hospital Center, where I work primarily in the inpatient detoxification unit, the office-based buprenorphine program, and work closely with colleagues in our Methadone Maintenance Treatment Program. As a faculty member at NYU School of Medicine, I'm involved in clinical trials assessing the efficacy of novel pharmacotherapies for the treatment of opioid and alcohol use disorders.

I would like to provide a brief background on the current public health crisis attributed to opioids, and link those findings with feasible, evidence-based strategies that may reduce the burden attributed to opioid use disorders – and specifically highlighting strategies that may leverage publicly funded, healthcare facilities in NYC to expand treatment capacity.

Background

An estimated 1.9 million Americans suffer from substance use disorders attributed to prescription opioid misuse, and another 500,000 Americans suffer from heroin use disorder. *The burden of the opioid misuse epidemic is significant, yet* fewer than 10% of persons with opioid use disorders are linked to specialty treatment. Further, despite the recent plateau of analgesic prescriptions in the US, Americans continue to initiate heroin use at increasing numbers due to reduced access to prescription opioids. Opioid overdose deaths, HIV and Hepatitis C virus transmission, healthcare utilization, and encounters with the criminal justice system pose major challenges to government and public health officials.

Scaling up treatment

Nonetheless healthcare facilities (e.g., hospitals, clinics, retail pharmacies, and community settings such as homeless shelters or family support groups, are integrating effective approaches to reduce diversion, misuse, and related deaths due to prescription opioids. Several implementation strategies that have demonstrated efficacy include:

- Implementation of overdose education and naloxone kit distribution to opioid users, first responders, and family members

- Utilizing prescription drug monitoring programs (PDMP) during routine patient encounters and referrals to specialty addiction treatment as needed. *Washington State's implementation of PDMP helped reduce opioid deaths by 27 percent between 2008 and 2012.*

- Medication assisted treatments (MAT) (i.e., buprenorphine, naltrexone, methadone, clonidine). *Baltimore witnessed a significant reduction in overdose deaths due to heroin, from 312 in 1999 to 106 in 2008 following city wide MAT expansion in 2000.*

Barriers to implementation

Any successful implementation effort must link patients with long term outpatient treatment. Although HHC facilities are well positioned to meet the anticipated rise of treatment seeking individuals that require substance abuse treatment, findings from Bellevue Montefiore, and Boston Medical Center have highlighted systems-, provider-, and patient-level barriers to successful integration of medication assisted treatment in primary care settings.

Health systems barriers include lack of ancillary staff support, Electronic Medical Records, low reimbursement for providers, and concern regarding regulatory audits by the DEA or state health officials. Patients have reported long-waiting times, frequent disruptions with insurance coverage for buprenorphine refills, and difficulty reaching healthcare staff.

Next steps

Advances in addiction treatment strategies, Affordable Care Act expansion, and increased inter-agency support towards addiction treatment highlights the pivotal and timely role of publicly funded healthcare facilities here in New York (e.g., HHC, FHRQ) to increase **linkage** to primary care based addiction treatment from emergency room, inpatient wards, prisons, homeless shelters, syringe exchange programs, and other spaces that may identify 'hard-to-reach' populations that are not in care.

Mainstream medical settings are also considering **integrated**, patient-centered systems of care that may address addiction treatment, co-morbidity management, and psychosocial needs in one clinical location with a coordinated network of healthcare staff. HHC and FHRQ facilities are uniquely positioned to respond to the increased demand for substance abuse treatment following Medicaid eligibility expansion.

Coordination between the Office of Drug Strategy and addiction treatment personnel may be facilitated with existing entities such as the Clinical Trials Network, New York City node and/or the American Society of Addiction Medicine. The aforementioned groups are well positioned to design, deploy, and rigorously evaluate early-phase pilot programs.

FOR THE RECORD

June 23, 2015

THREE-QUARTER HOUSE
TENANT ORGANIZING PROJECT

Testimony of Amy Blumsack, Community Organizer
Three-Quarter House Tenant Organizing Project

In Support of Intro 748,
Creating an Office of Drug Strategy in New York City

My name is Amy Blumsack, and I am the Community Organizer at Neighbors Together, a community based organization and large soup kitchen located in central Brooklyn. Our mission is to end hunger and poverty in the surrounding neighborhoods of Ocean Hill, Brownsville, and Bedford-Stuyvesant. Part of my role at Neighbors Together is to work with our members to effect policy changes that will bring greater stability to their lives and the surrounding community at large. In this capacity, I have the pleasure of organizing tenants of three-quarter houses with the Three-Quarter House Tenant Organizing Project, known as TOP. TOP is a union of current and former tenants fighting for dignified and safe living conditions for people living in three-quarter houses in New York City.

Three-quarter houses, sometimes known as illegal boarding houses or transitional houses, are private homes that rent beds to single adults. Three-quarter houses hold themselves out as programs, although they are unlicensed and unregulated by any government agency. The housing conditions are almost always bad, and often dangerous, yet despite the poor conditions, three-quarter houses provide essential housing of last resort for some of the city's poorest and most vulnerable populations. A vast majority of tenants who reside in three-quarter houses are black or Latino, many of whom were formerly incarcerated, chronically homeless, and are struggling with substance abuse, unemployment, mental illness and other medical issues. Tenants are often legally discriminated against, socially excluded, and locked out of the mainstream economy due to past involvement in the criminal justice system.

Tenants are often referred to three-quarter houses from inpatient substance abuse programs, after being released from prison or jail, or from service providers. Tenants tend to move into three-quarter houses because they are seeking a living situation that will provide them with some stability and assistance in getting back on their feet. Many tenants move in to three-quarter houses thinking they will be sober living environments with professional, licensed staff, that they will be attending a quality drug treatment program, and that they will receive assistance finding permanent affordable housing. Unfortunately, the reality of these houses is often far from what tenants are told they can expect.

Instead of getting the services and help they need to achieve their goals, three-quarter house tenants are illegally mandated to drug treatment programs not of their own choosing as a condition of keeping their bed, thereby making them pawns in Medicaid kickback schemes between three-quarter house operators and outpatient substance abuse programs. Tenants, who have real and serious needs such as treatment, housing, and employment, are left to choose between being homeless or keeping a roof over their heads, but at the cost of their other needs, while three-quarter

house operators, capitalizing on holes in government policies and oversight, are making money hand over fist.

What all three-quarter house tenants need, including the large number referred through substance abuse programs, is greater stability and support to assist them in achieving the highest levels of health and independence possible. It is for this reason that I and the Three-Quarter House Tenant Organizing Project are here today to advocate for the creation of an Office of Drug Strategy, to help ensure that city resources are consistently focused on reducing the number of people who develop substance use disorders, ending the criminalization of persons with histories of substance use, reducing drug-related crime, and opening every door available to promote health and wellbeing.

Intro 748's crucial proposal to empower the Office of Drug Strategy to convene city agencies, outside experts, and communities affected by drug use is both promising and exciting. Three-quarter house tenants with substance use disorders are constantly navigating the complex maze of various city agencies, each of whom is responsible for a piece of the context that has allowed the underground market for three-quarter houses to thrive. Three-quarter house tenants suffer from interplay of uncoordinated and shortsighted drug, policing, housing, and public assistance policies, the vast majority of which do not approach substance use from public health and harm reduction perspectives.

Such is a reality known all too well by many three-quarter house residents. Zero tolerance policies in housing, public assistance, criminal justice and elsewhere have the counterintuitive effect of treating relapse with punitive, instead of therapeutic, responses. Instead of being provided with additional support when a person's recovery is temporarily derailed by relapse—a time when the person is most in need of that support—TOP sees that individuals who stumble in their recovery are often faced with a parade of further destabilizing crises including illegal eviction, arrest and incarceration, loss of employment, and/or termination of essential public benefits. Substance use recovery is a process that requires patience, persistence and perseverance to overcome the often inevitable setbacks along the way. Substance use disorders affect diverse individuals in myriad ways. Thus, community and governmental responses must be just as diverse in fostering policies that promote public health and safety. The adoption of harm reduction models in the areas of treatment, criminal justice, and housing is a necessary means to acknowledge those differences while providing supports and environments that are tailored to the individual's needs.

Our hope is that an Office of Drug Strategy would help to coordinate the creation and enforcement of the various policies that affect people who struggle with substance abuse, including three-quarter house tenants. Please pass Intro 748 and empower the City to create an Office of Drug Strategy, which we believe will put people first through better coordination, oversight, and the creation of community supported policies that will help instead of hinder, people with substance use disorders.

Thank you for your time and consideration.

If you have any questions or would like more information related to the above testimony, please contact Amy Blumsack at Neighbors Together: 718-498-7256, or amy@neighborstogether.org.

The New York Academy of Medicine

At the heart of urban health since 1847

Testimony for the NYC Council Hearing on an Office of Drug Strategy
Angel Mendoza, MD, Health Policy Director

June 23, 2015

On behalf of The New York Academy of Medicine, thank you for the opportunity to discuss the proposed bill in the New York City Council, Intro 0748, calling for the establishment of an Office of Drug Strategy. The Academy was founded in 1847 to take on the critical health problems facing New York City at that time, and we have continued this basic mission up to the present. The Academy advances solutions that promote the health and well-being of people living in cities worldwide through active research, evaluation, education and policy work. We recognize the growing problem of overdose and opioids in New York City, and appreciate the Council's interest in this issue.

The New York Academy of Medicine supports Intro 0748 because drug policy cuts across all city agencies, and the need for a coordinating body with the ability to convene all the relevant decision-makers is widely recognized. Drug policy affects New Yorkers differently depending largely on a person's race, place, and income and the city's policies often work at cross-purposes across agencies. An Office of Drug Strategy would align and integrate fragmented policies and programs in New York City by directing them towards a public health approach thereby reducing morbidity, mortality, crime, cost, and inequities associated with drug use and the city's current response.

Dating back to the La Guardia Committee report prepared by the Academy in 1944, we have long taken a special interest in drug use and improving the health of drug users. In 1955, The Academy issued a ground-breaking report to the U.S. Senate, calling for many of the reforms we will suggest to you today.[1] We continue to contribute to a growing body of science pointing to the same conclusion – that drug use is not just a criminal justice problem: it is and has always been, a public health problem.

Increasingly, political leaders, care providers, and people directly affected by drug use recognize that we must reorient our drug policies towards a single aim – improving the health and safety of individuals, families and communities. In 2013, in partnership with the Drug Policy Alliance, we released the *Blueprint for a Public Health and Safety Approach to Drug Policy*, grounded in years of community and stakeholder consultations around New York.[2] Most recently, with funding from the MAC AIDS Fund, the Academy released a comprehensive report and case study, "The Integration of Harm Reduction and Healthcare: Implications and Lessons for Healthcare Reform", supporting key recommendations from the 2013 blueprint.[3]

One of the city-level policy recommendations to come out of the *Blueprint* was the creation of a multiagency, cross-sectoral body to assess existing New York City drug policies and programs with an aim towards alignment with a four pillars model of prevention, treatment, harm reduction and public safety. The body was to be comprised of representatives from relevant city agencies and various stakeholders, with input from those directly affected by drug use. Similar efforts for coordinating a comprehensive, public health drug strategy can be found in other localities such as Toronto and Vancouver (Canada), Frankfurt (Germany), and Victoria (Australia).[4,5,6] Specific tasks for such a body would extend beyond analysis and alignment of existing policy to include: strengthening trust and collaborative relationships between NYC agencies and the communities they serve; responding to localized drug related problems through a coordinated and unified structure; data analysis and research activities such as cost analyses of existing drug related policies and programs; and monitoring, investigating and addressing racial, gender, age and geographic disparities in health and socioeconomic outcomes, across administrative systems. The *Blueprint* also called for alignment of state and city policy development and planning as well as appropriate integration and coordination of parallel efforts and activities through this coordinated city body.

Our current drug policies are largely bifurcated into criminal justice and treatment approaches, often derived from the varying and at times irrational frameworks previously established to manage alcohol, prescription medications, tobacco, and illicit drugs. In some instances, potentially harmful policies need to be modified; in others, policies may need to be strengthened or clarified. Without a unifying body, policies will continue to be fragmented, impractical, and unclear, or even worse, unsafe. An Office of Drug Strategy would help to identify areas of conflict and concern, investigate local practices,

support city agencies and coordinate efforts toward solutions that are supported by evidence and that promote public health in all areas.

Rationale for the creation of this office arises from virtually every sector that touches New Yorkers' lives– from public safety and courts to housing and social services. Many of my colleagues here today are going to testify from these perspectives. I would like to talk about the benefit of an Office of Drug Strategy from my perspective as a developmental pediatrician and the former medical director for the city's Administration for Children's Services. In the area of child services, drug policy is particularly layered and complex. While parental drug use is linked to involvement with child welfare systems, questionable parenting skills and poor child outcomes (physical, developmental, MEB: mental–emotional-behavioral), it is challenging to tease out co-occurring issues and confounding factors.[7,8] Parent substance use is frequently associated with co-morbid mental and physical health conditions, and linked to traumatic life experiences such as sexual or physical violence, generational factors, and environmental stressors like poverty, domestic violence, and housing insecurity.[9] However, some researchers have suggested that these environmental stress or psychiatric issues may actually have more of an impact on parent behaviors than the drug use itself and several studies have found no difference in parenting practices between mothers who use drugs and those who do not.[10]

In fact, studies have found that the majority of mothers with substance use issues express a desire to be better parents[11] and comprehensive treatment models have shown positive outcomes for reunification and parenting skills improvement; but these programs are hard to come by.[12] In addition, internal and external barriers to substance use treatment for parents are compounded by many factors; most notably, by a lack of child care services and by philosophical differences between substance use treatment and the child welfare system.[13] Participation in substance use treatment is further complicated by federal law that mandates strict timelines for child placement. These timelines often do not coincide with parental treatment completion, or the nature of addiction which is commonly characterized by relapse.[14] Another challenging area of child welfare practice is in risk assessment. Risk assessment tools used in child welfare cases involving substance use generally measure "use" as a "uni-dimensional" occurrence.[15,16,17] But, these tools have proven ineffective at measuring risk of child abuse[18] as they do not take into consideration the co-occurring issues I mentioned earlier.

Promising models for treatment and child welfare risk assessment have emerged over the past several decades. There is substantial literature demonstrating that substance use treatment in combination with comprehensive services such as parenting interventions and other social services like counseling and child care can be effective at reuniting parents with their children.[19,20,21,22,23] Recovery services and prevention programs following treatment as well as family involvement in treatment have also demonstrated positive outcomes for both parents and children.[24] In terms of risk assessment, holistic, validated tools for measuring substance use are used outside of the child protection setting and may be molded to fit this setting,[25] and novel tools for a child welfare setting to measure risk in the context of substance abuse, taking into consideration other factors, are emerging.[26]

However, the status quo of agency silos presents a challenge for the use of these promising tools and models. First, there is a great need for communication and collaboration between substance use treatment providers and child services. An independent and separate Office of Drug Policy would be essential in integrating all the existing research, policy and understanding of current programming in this area to assist ACS in developing and identifying the best programs that would combine assurance for child safety balanced by the best evidence for parental treatment. Second, risk assessment must take other factors into consideration than just the use of substances and willingness to enter treatment. Given the existing evidence, treatment alone is not likely to be effective at achieving positive outcomes for both children and parents, without the provision of other comprehensive, integrated, and ongoing, prevention, recovery and supportive social services. An Office of Drug Strategy, armed with a mandate to pool existing resources could bring traditionally uncoordinated sectors together with the common goals of public health and safety and well-being of both children and adults.

Thank you again to the Council for the opportunity to testify and for your attention to this important issue. On behalf of the Academy, I urge you to take action by passing this bill.

For more information, please contact Angel Mendoza, MD at
212-822-7205 or amendoza@nyam.org.

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BOOM!
HEALTH

FOR THE RECORD

Thank you for allowing BOOM!Health to participate in this public hearing regarding legislation to create the New York City Office of Drug Strategy.

BOOM!Health is a non-profit organization in the heart of the South Bronx, NY that supports program participants on their journey towards wellness and self sufficiency through our service and advocacy model that works to actively remove barriers to accessing primary medical care, as well as HIV and viral hepatitis prevention. Services are provided out of our Harm Reduction Center, Prevention Center, and Central Office. Our new Wellness Center, scheduled to open in Summer 2015, will consolidate our Prevention Center and Central Office into a newly renovated center located in Melrose and feature a similar model to the Harm Reduction Center but with a focus on reaching LGBT Bronx residents through co-located primary care.

Operational since 1995 as CitiWide Harm Reduction, services at the three-story BOOM!Health Harm Reduction Center located in the Mott Haven section of the Bronx focuses on low-threshold engagement that addresses the safety and wellness of active drug users which includes a syringe exchange program and NYS certified Opioid prevention and reversal program. Last year, we provided more than 350 opioid reversal trainings and reversed 12 opioid overdoses. In 2011, BOOM!Health's Harm Reduction Center co-located a Federally Qualified Health Center (FQHC) and NYS OMH Article 31 behavioral health program run by community partner, HELP/PSI, and a community-based pharmacy operated by Evers Pharmacy (now BOOM!Pharmacy), and integrated these services into its nationally recognized comprehensive treatment model to improve health outcomes primarily for African-American and Latino Injection Drug Users.

We believe that creating the New York City Office of Drug Strategy is a crucial step in the right direction and would help BOOM!Health and other organizations that serve active and former drug users provide accessible, life-saving services. In our experience, we have seen first hand that the War on Drugs has not only failed our communities, it has caused and continues to cause problems for our public health efforts in the Bronx.

BOOM!Health's service delivery model, which overwhelmingly serves people of color, emphasizes eliminating every possible barrier so that the most vulnerable, low-income New Yorkers in the Bronx can access critical health and prevention services. We serve over 12,000 participants annually. 40% are Black/African-American, 55% Latino/Hispanic, and 5% Caucasian, and all of our participants live below the poverty line. In an annual survey conducted among our participants, almost 50% of all of our participants report using substances in the last 12 months. Alcohol and heroin are the most used substances among our participants, and participants report also using marijuana, K2, crack/cocaine, among others. And unfortunately, the communities we serve are some of the most policed in the state. The Mott Haven neighborhood in the Bronx has one of the highest arrest rates in the city, where our Harm Reduction Center is located. According to a survey we conducted during our work to help end the Stop and Frisk practice by the NYPD, half of those surveyed were stopped by the NYPD at least once in the past 12 months. Of those stopped, almost half were arrested. The environment this creates not only prevents us from doing our job in serving our communities, it also prevents those who need these vital services from accessing

BOOM! HEALTH

them, and, we know having a criminal record can cause many problems for those seeking employment, housing, and public benefits.

Additionally, like I've already mentioned, heroin is one of the most commonly used substances among our participants, and we provide a variety of harm reduction based services and opioid overdose reversal trainings to the community. Safe injection facilities, which would provide a new level of care and service to active and former injection drug users, would not be possible in this contradictory environment. Even so, in our survey, Thirty-six percent of the participants had not heard of SIF but over 50% would use one if it became available, especially if was a short walking distance. Even though Safe Injection Facilities are recommended in the official New York State Blueprint to End the AIDS epidemic by the year 2020, the contradictory environment that puts law enforcement and public health at odds when serving our communities has made this public health intervention an impossibility in the entire United States. In short, the contradictory, failed, and uncoordinated War on Drugs strategy is an enormous barrier for us to provide the care that our communities need.

We believe that the New York City Office of Drug Strategy can address this by developing a clear, coordinated, and alternative plan among all New York City agencies so that we can best serve our communities and send a clear message that does not stigmatize active and former drug users. We need to make sure that we continue this trend. Additionally, we believe that this Office should be housed in the Mayor's office because many city agencies, directly and indirectly, impact city policy on these issues. We need a strong office that has the power to address these cross-cutting policies and agencies. Further, the advisory council that is part of this legislation must have representatives from people who use drugs, service providers serving those using drugs, policy and researchers with real background knowledge and background on the issue. This is crucial to ensuring the success of any strategy that comes out of this office.

In conclusion, the state of New York has unfortunately been the leader in criminalizing and impoverishing people of color due to the war on drugs and prohibition, and New York City has already takes crucial steps against the War on Drugs, including the roll back of Stop and Frisk and reforms to low-level marijuana possession arrests. The development of the New York City Office of Drug Strategy will help us and the communities we serve eliminate barriers to health, wellness, and safety. Thank you.

John Hellman
Director of Advocacy and Communications
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We are the Drug Policy Alliance.

Testimony of gabriel sayegh
Managing Director, Policy & Campaigns
Drug Policy Alliance

Submitted to:

City Council of New York Committees on Public Safety & Mental Health, Developmental Disability, Alcoholism, Drug Abuse and Disability Services

Hearing on Intro. 748
Establishing an Office of Drug Strategy

June 23, 2015
New York, NY

Drug Policy Alliance | 131 West 33rd Street, 15th Floor, New York, NY 10001
212.613.8020 voice | 212.613.8021 fax | www.drugpolicy.org

Thank you members of the Committee on Public Safety and the Committee on Mental Health, Developmental Disability, Alcoholism, Drug Abuse and Disability Services for inviting our testimony. On behalf of the Drug Policy Alliance, I am pleased to testify in support of Intro. 748 calling on for the establishment of an Office of Drug Policy.

It's rare for New Yorkers to call for another government entity. But in this case, a broad array of institutions -- ranging from advocacy organizations, treatment groups, public defenders, public health organizations, to harm reduction providers -- are coming together to call for a single, mayoral-level office to coordinate our drug strategy and align our drug policies. For too long in New York, our drug policies have been fragmented, contradictory, and less effective than we know they can be. This bill is an important step in adopting a more rational approach to drug policy in NYC and continuing to realign drug policies from criminal justice towards a public health approach. With a comprehensive and coordinated municipal drug strategy, NYC can lead the nation in improving public health and safety by reducing the morbidity, mortality, crime, and racial disparities stemming from failed practices.

After 40 years of the "war on drugs," drugs are cheaper, more pure, and easier to obtain than ever, contributing to growing problems like the criminalization of our youth, mass incarceration, and an alarming increase in NYC heroin overdose deaths in recent years. Under current policies, city agencies often work at cross-purposes to address drug related issues, with conflicts arising between public health and more punitive approaches. For example, the Mayor has set policy to help young people avoid being swept into the criminal justice system for low level marijuana possession and yet many of the City's schools have zero tolerance policies for drug use, suspending the very youth that need help and support and putting them at greater risk for entering the criminal justice system. The Department of Health and Mental Hygiene (DOHMH) invests time and resources into promoting harm reduction strategies, such as syringe exchanges, to encourage people who use drugs to seek services and support, while the NYPD arrests these same individuals for low level possession. Agencies also often miss opportunities to provide support to people with substance use problems through housing programs, the welfare system, family and homeless services, and the courts. And current enforcement strategies have led to unacceptable racial disparities and eroded the trust between communities and law enforcement.

Part of the problem in New York and elsewhere is that for too long our drug policies have been bifurcated between a criminal justice and a public health approach, resulting in a confused and ineffective system that works well for no one. We are now seeing national, bi-partisan agreement that the criminal justice approach to drug policy, rooted in the "war on drugs" mentality, has been a failure. It has resulted in trillions of wasted dollars, millions of people in prison, and unscientific, anti-public health policy that has led to the loss of life from preventable drug overdose, HIV/AIDS & hepatitis C infections and more. Most importantly, there has been no meaningful impact on people's drug use.

New York can do better, and, in fact, we know what to do to improve drug policy in New York. Following the reform of the Rockefeller Drug Laws in 2009, The New York Academy of Medicine and the Drug Policy Alliance collaborated on the comprehensive *Blueprint for a Public Health Safety Approach to Drug Policy*. Called a timely and detailed blueprint for remaking New York's drug policies in a New York Times editorial, the Blueprint was the result of an exhaustive literature review and consultations with more than 500 experts and everyday New Yorkers about their vision for a better and more equitable system of dealing with drugs. The first recommendation of the Blueprint for the City of New York was to create a multi-agency, cross sectoral structure to help align the City's drug policies. Intro 748 does just that.

Such an office is needed because drug issues are too complicated for any one part of government to deal with, and people impacted by drugs and our drug policies cross multiple city agencies and service systems. Through better coordination, we can improve outcomes and save money. We need leadership to help set common objectives that ensure that city resources are consistently focused on the right things: reducing the number of people who develop substance use disorders, reducing crime and public disorder, and opening

every door available to promote health and wellbeing. Accordingly, the Office of Drug Strategy would be empowered to convene city agencies, outside experts, and communities affected by drug use in order to share concerns and innovations and take practical, coordinated steps to address problems related to drug use, crime, and drug policy. The De Blasio Administration has already endorsed this approach for other complicated, multi-faceted issues through its Behavioral Health Task Force and the Children's Cabinet.

The Office of Drug Strategy (ODS) would be the first of its kind in the nation and could be a model for how American cities can begin to unwind devastating drug war policies. But New York does not need to start from scratch; we can learn from dozens of other cities, notably in Europe and Canada that began developing coordinated municipal drug strategies in the late 1980s. That approach has led to significantly lower rates of drug use, crime, and public disorder, and improved public health outcomes, such as reducing rates of HIV/AIDS and overdose deaths, compared to New York.

The city has already taken some important steps in the right direction, including major reforms to low-level marijuana policing and the summons system and initiatives to pilot criminal justice diversion for people with mental illness and other conditions. The creation of the Office of Drug Strategy is the next logical step in ensuring further coordination among city agencies and continuing to reorient our policies towards improving public health and safety outcomes.

We believe the ODS will be most successful if it does the following:

- Roots New York's drug policies in science-based public health and harm reduction principles and strategies, not in ideology or politics.
- Recognizes that the majority of people who use drugs do not have a "problem" and that drugs are used, nonetheless, to criminalize them for their race, ethnicity and/or class.
- Addresses the historical and collateral consequences of the war on drugs and past practices, such as saddling young people with criminal records, devastating particularly communities through mass incarceration, and eroding trust between police and communities
- Challenges the stigma surrounding drug use, offering people who do have a problem with drugs a helping hand instead of punishment.
- Places the ODS within the Mayor's Office so that the ODS has the power and ability to address cross-cutting policies and agencies.
- Uses the proposed Advisory Council to center and involve those directly impacted by drug use and drug policies as well as experts and service providers. Policies are most effective when they are grounded in science, expertise, and the lived experiences of those most likely to be impacted by them.
- Serves as the leading voice for the City on drug-related matters, conveying to the media and the public the City's clear, comprehensive, and coordinated principles for public health and safety approach.

Please support Intro 748 and establish and Office of Drug Strategy.

Testimony of

Daliah Heller, PhD MPH

Clinical Professor of Public Health and Director of Public Health Practice

CUNY School of Public Health

before the

New York City Council Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

and

New York City Council Committee on Public Safety

regarding

Examining NYC's Response to Heroin Use and Overdose

and

Int. No. 748 - In relation to an office of drug strategy.

June 23, 2015, 10am

City Hall

Council Chambers

New York, NY

Good morning Chairperson Cohen, Chairperson Gibson, and members of the Committees. I am Daliah Heller, Clinical Professor of Public Health and Director of Public Health Practice at the City University of New York School of Public Health. Thank you for the opportunity to testify before you today.

You have already learned an enormous amount this morning from my colleagues at the city's Health Department on the state of heroin and other drug use in New York City. They have described the continuing preventable tragedy of increasing overdose deaths, and the many effective programs, policies, and initiatives they are funding and implementing to reverse this trend. I am going to keep my remarks brief and focus on the bill you have sponsored to create an office of drug strategy in New York City.

I have had significant experience working on drug policy, research, and programs in New York City government. From 2007 to 2011, I was Assistant Commissioner for the Bureau of Alcohol and Drug Use Prevention, Care, and Treatment at the New York City Health Department. Over the past two years, I have worked with both the Health Department and the Mayor's Office of Criminal Justice on several projects designing and documenting policies and initiatives on drug-related issues. My experience in New York City government has given me considerable insight into the potential value and significant impact that an office of drug strategy could have in our city.

I want to emphasize the need for such an office in this city, and for its positioning within City Hall, in the Mayor's office to gather, connect, and coordinate the drug-related work of public health and public safety in this city. In the current arrangement, many of our policies and

practices are fragmented or conflicting, because they are determined within agencies, rather than in collaboration across agencies. For people in this city, this lack of coordination complicates information, prevents access to services, and impedes their impact, and even increases the harms related to drug use. The primary goal of public systems and services is to help and protect the people of this city, and this is best achieved through ongoing and focused coordination.

It is important to recognize the history of drug laws and policies in this country when we consider a unified approach. The public health and public safety approaches to drug use have developed unevenly in this country, and without coordination. As I'm sure you are aware, we have witnessed massive growth in drug-related incarceration over the past forty years with the expansion of the war on drugs, alongside low and diminishing investment in health and social services. This approach has had a devastating effect on families and communities, while showing little impact on levels of drug use, which have remained steady throughout. Fortunately, there is widespread recognition today that we must adopt a different approach if we are going to reduce drug-related health and social harms. Given the reach and intensity of the forty-year drug war, we will need to be systematic and focused to accomplish real transformation.

I know that my colleagues at the Health Department are leading the dialogue and action of this administration on drug-related issues. They are experts in drug-related research and data, and innovators and drivers for drug-related programs and policies in New York City. They demonstrate and distinguish public health leadership on drug policy, an important role bringing national recognition to local work, and demonstrating the paradigm shift promoted by the federal Office of National Drug Control Policy, from criminal justice to public health.

All of the work of the Health Department has provided a strong foundation for growing a unified drug strategy in New York City. It is time now to establish a centralized coordinating body in the Mayor's office. A mayoral office of drug strategy will be empowered to align the drug-related work of the many city agencies, and to develop and carry forward policies and initiatives from an inter-sectoral perspective. It is an investment in a true public health and safety approach to illicit and non-medical drug use, and one which will no doubt reduce drug-related health and social problems in New York City.

Councilmembers, I applaud your work to introduce this legislation, and urge the City Council to ensure its passage into law, and to establish an office of drug strategy at City Hall.

Thank you for this opportunity to testify before you today.

TESTIMONY OF THE LEGAL ACTION CENTER

City Council Committees on Public Safety and
Mental Health, Developmental Disability, Alcoholism,
Substance Abuse and Disability Services

Hearing on Examining NYC's Response to Heroin Use and Overdoses
A proposal to establish a New York City
Office of Drug Strategy

June 23, 2015

Presented by

Sebastian Solomon
Director of State Policy
Legal Action Center

Good morning. My name is Sebastian Solomon. I am the Director of New York State Policy at the Legal Action Center. I appreciate the opportunity to address you today.

The Legal Action Center is the only public interest law and policy organization in New York City and the United States whose sole mission is to fight discrimination against and protect the privacy of people in recovery from drug dependence or alcoholism, individuals living with HIV/AIDS, and people with criminal records. LAC works to combat the stigma and prejudice that keep these individuals out of the mainstream of society. The Legal Action Center helps people reclaim their lives, maintain their dignity, and participate fully in society as productive, responsible citizens.

The Legal Action Center is the national expert on the federal privacy law protecting the confidentiality of those with histories of addiction. LAC was also one of the founders of and continues to co-chair and coordinate staff the Coalition for Whole Health, a national coalition bringing together advocates from the mental health and substance use disorder fields. The Coalition played a key role in advocating for passage of the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and ensuring that parity for behavioral health services was a key component of the Affordable Care Act.

In New York State, LAC works closely with the State Office of Alcoholism and Substance Abuse Services (OASAS), the New York State Association of Substance Abuse Providers, as well as a number of individual addiction providers across the State. In addition, LAC's Director and President, Paul Samuels, was appointed by the Governor in 2013 to chair the New York State Behavioral Health Services Advisory Council, which advises the State Office of Mental Health

and OASAS on issues relating to the provision of behavioral health services. We also provide direct legal services to those impacted by addiction and work to ensure meaningful access to medication assisted treatment and other substance use disorder services, as required under the MHPAEA.

Since the 1970s the United States has relied almost entirely on a series of "tough on crime"/ "war on drugs" approaches to reducing crime and addiction. However, over the last several years, a bi-partisan consensus has been building that these approaches have, by and large, failed. Additionally, polls from around the country show that Americans widely reject the war on drugs and the system of mass incarceration it has produced. Support for reforming this system of incarceration and treating addiction as a disease now exists across the political spectrum.

At the same time, substance use disorders (SUD) have become a leading cause of death in the United States, resulting in over 100,000 deaths annually. Drug overdose has also become the leading cause of injury-related deaths and the leading cause of death for individuals reentering society after incarceration. Three quarters of the over 7 million people in the criminal justice system have a substance use disorder and/or had alcohol or drugs in their systems at the time of their arrest. There are more deaths, illness, and disabilities from SUD than from any other preventable health condition and an estimated 25% of hospitalizations are directly related to substance use and mental health disorders. Additionally, one in eight of the troops returning from Iraq and Afghanistan from 2006 to 2008 were referred for counseling for alcohol disorders after their post-deployment health assessments. As has also been well established, the treatment

of substance use disorders and the outcomes for individuals affected by SUDs differs greatly depending on the individual's race and class.

In spite of this, barely 10% of the nearly 23 million Americans who suffer from SUD receive any specialty care, even though SUD is a chronic disease that can be effectively prevented and treated, and tens of millions of people are living in recovery from addiction. Treatment for SUD is as effective as the treatment of other chronic diseases, saving hundreds of thousands of lives and yielding enormous cost savings for the health care, criminal justice, child welfare and social services systems. Furthermore, the enactment of the federal parity law and the inclusion of parity in the ACA can play an important role in increasing access to addiction treatment. Additionally, the federal funding being made available through the ACA promises to pay for much of the healthcare, particularly the behavioral health and addiction treatment services, which is needed to help improve health in low income communities, thereby treating people in their communities and keeping them out of incarceration. Reducing incarceration will also result in financial savings. These savings can then be reinvested into further health and community needs. Lastly, increasing access to treatment and moving people out of incarceration can play an important part in changing attitudes towards substance use disorders around the country from a criminal justice focus to one that emphasizes public health.

New York City and State have already taken a number of important steps to begin moving from a criminal justice response to drug use and addiction to a public health approach. At the state level, in 2009, New York reformed its drug and property crime laws to increase access to

diversion and treatment, instead of incarceration, for those arrested for certain felonies who have an SUD. Last year, the State also moved to prevent individuals from being denied access to the treatment they need by insurance companies. Additionally, as part of its Medicaid redesign efforts, the State is looking to improve residential care, in part to be able to access Medicaid funding for this form treatment, thereby generating additional savings. It is also looking to provide additional support services for those with a serious SUD to help them achieve and maintain recovery and better reintegrate into society.

At the City level, the decision by the Mayor and the NYPD to end most arrests for possession of marijuana has helped massively reduce the racially disparate impact in the enforcement of this law. The City has also taken important steps towards a more public health centered approach to drug policy through some of the initiatives included in the Action Plan developed by the Mayor's Task Force on Behavioral Health and the Criminal Justice System last year as well as in some of the recommendations coming out of First Lady Chirlane McCray's forthcoming "Roadmap for Mental Health," both of which LAC contributed to.

However, while these are important first steps, there is still the need for the City to have an Office that coordinates drug policies across all city agencies, an Office that focuses on best practices, based on research and evidence, rather than on stereotype or bias. The impact of such lack of coordination can be seen in the continued harassment of individuals leaving State-funded, legal syringe exchange programs. Syringe exchanges have significantly reduced the spread of HIV through intravenous drug use in New York State. According to the NYS Department of

Health, HIV prevalence among injection drug users was 54% in 1990. By 2012, the prevalence rate had fallen to only 3%, due in large part to the increased access to clean syringes created by the legalization of syringe exchanges and other mechanisms for accessing clean syringes. In addition to the immense health impact, these interventions have resulted in massive financial savings to the City and State, as providing access to clean syringes is significantly cheaper than paying for HIV care. There is also evidence that syringe exchange programs help participants access drug treatment services, when they are ready, and help improve participants' health in a number of other ways. Yet, even as elements of the City (and State) show strong support for these programs, other elements, such as the police, target participants for arrest, thereby discouraging these individuals from participating.

I experienced this conflicting message in my first project at Legal Action Center. As part of this project, I legally acquired syringes from a pharmacy and joined a syringe exchange program. I then visited hospitals and nursing homes around New York City to dispose of my syringes. These facilities are mandated by State law to accept syringes from the public and disposing of syringes through these facilities decreases the risk of needle sticks and the anxiety and potential infection that could result. Yet, staff in these facilities, including Health and Hospital Corporation facilities, responded to my attempts to dispose of my syringes with confusion and often hostility. Furthermore, on more than one occasion, my fellow researchers and I were threatened with arrest by police officers working in these facilities. Such treatment obviously discourages most individuals from taking steps to safely dispose of used syringes.

The proposed legislation would allow for the City to develop the coordinated plan that is necessary for all elements of the City's government to be working together towards the same goals of improved health, access to treatment and a reduction in addiction. Achieving these goals would result in significant financial savings to the City and State through reduced involvement in the criminal justice and child welfare systems, as well as the collateral consequences that frequently result from involvement in these systems, including reduced access to employment and housing, and a resulting increased dependence on public benefits.

While New York City has only a limited role in setting drug policy compared with the State and Federal governments, it still plays an essential role in deciding how most of these polices are carried out in practice. Setting goals and developing coordination across agencies can ensure that all agencies are working together towards shared aims. Furthermore, convening agencies to work together can help to expose staff at the different agencies to the work being done by others and to different outlooks on issues of drug use and addiction. Lastly, having a centralized office can allow for longer term planning and better coordination of resources, so that money is not being wasted on conflicting or overlapping goals.

In order to achieve the goals of a coordinated, evidence-based approach across all City agencies, the proposed Office must be located within the Mayor's Office. New York City previously had an Office of Drug Strategy, during the Dinkins mayoralty. However, this agency did not achieve its desired goals and was eventually shut down. This failure shows, in part, the need for this Office to have the power of the Mayor behind it, supporting its goals. Without the support of the

Mayor's Office, the Office of Drug Strategy will not have the authority to convene different City agencies and to get them work together towards desired goals. To that point, the City already has a strong staff at the Bureau of Alcohol and Drug Use within the Department of Health and Mental Hygiene promoting important public health goals in regards to drug and alcohol policy. However, because of its location, within DOHMH, the Bureau does not have the authority to convene other City agencies or to push them to adopt an evidence-based, public health approach to issues of addiction and drug use.

Similarly, to achieve improved coordination and shared goals, it is important that all relevant and affected parties have a voice and play a role in developing the shared policy. Such an objective is achieved by the inclusion of an Advisory Council in the proposed legislation. This Council will include the government agencies involved in carrying out policies impacting those with substance use disorders, community members affected by drug and addiction policies (i.e., those who have experienced a substance use disorder themselves or in their families), as well as the providers who serve people impacted by substance use disorders. These different groups can provide varying perspectives and experiences to the City's efforts, based on firsthand knowledge and experience or based on access to research regarding best practices. As a result, the Office will be able to achieve greater "buy-in" by members of the community and by the City agencies that work with them.

I thank you for this opportunity to speak and hope that you will enact this important legislation, which will allow New York to respond effectively to the addiction crisis that has already taken the lives of too many New Yorkers.

WRITTEN TESTIMONY OF THE BRONX DEFENDERS

Hearing on Int. No. 748 - In relation to an Office of Drug Strategy

Committee on Public Safety jointly with the Committee on Mental health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

City Hall-Council Chambers, June 23, 2015, 10 a.m.

My name is Runa Rajagopal. I am a supervising attorney in the Civil Action Practice at The Bronx Defenders. The Bronx Defenders thanks the Committees for the opportunity to submit comments and testify in support of an Office of Drug Strategy.

Founded in 1997, our organization is nationally renowned for providing holistic and comprehensive legal services, which include civil, criminal and family defense, social services and community programs to approximately 35,000 low-income families in the Bronx each year. Our innovative, team-based model operates on multiple levels to address how an arrest and criminal charge alone can have a devastating impact on a person's life. In New York State, indicative of the rest of the nation, more than 1 in 3 people arrested are never convicted of any crime or offense, yet they suffer drastic collateral legal consequences and enmeshed penalties as a result of their arrest. This collateral damage, and the instability that results, can be far more devastating than any of the direct penalties that accompany the criminal conviction. This is especially true for drug arrests.

Civil Action Practice

The Civil Action Practice is designed to defend against the many enmeshed civil penalties that arise out of a person's arrest or family court involvement regarding the removal of children. Criminal accusations related to drugs can lead to a whole host of devastating civil consequences, not only for the person who stands accused but for his entire family. These consequences are often hidden and invisible to those accused of the crime, to practitioners, to probation officers, legislators and even to Judges and the courts. These consequences are scattered across dozens of sections of state statutes, local laws, and state and local agency regulations and policies. They can occur any time after an arrest and lead to job loss, denial of benefits or deportation, to forfeiture of property, suspension from school, eviction from one's home and a range of other consequences.[1]

This testimony will highlight a few of the many enmeshed civil penalties that arise out of current drug policies and will focus on the need for an Office of Drug Strategy to create an interdisciplinary, comprehensive approach to reduce the myriad discriminatory civil laws and practices that target and punish indigent people of color on the basis of drug arrests and to advance a more equitable, health-centered approach to drugs.

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[1] *See* "Consequences of Criminal Proceedings in New York State," Guide by The Bronx Defenders for Criminal Defense Attorneys, Civil Legal Services Attorneys and Other Reentry Advocates for an overview of such consequences in New York.

I. The Failure of the War on Drugs

We are all familiar with the alarming statistics surrounding the criminalization of drugs. In 2013, at least 1.5 million people were arrested on nonviolent drug charges in the United States.[2] The majority (80%) were arrested for possession of drugs only.[3] 50% of those in federal prison are there due to a drug conviction.[4] 16% of those in state prison are there because of a drug violation.[5] Despite being 13% and 17% of the population respectively and using drugs at the same rate as Whites, Blacks and Latinos represent almost 77% of those incarcerated for a drug offense in federal prison and 60% of those incarcerated in a state prison for drugs.[6]

In New York City, approximately 20% of those arrested were arrested for a drug crime in 2013 (only captures dangerous drug misdemeanors or felony drug offenses.[7]) Blacks and Latinos represent a whopping 84% of all people arrested for both felony and misdemeanor drug arrests in 2013.[8]

As public defenders in the Bronx, we bear witness to these statistics every day. We observe how the community we serve--mostly limited and low income black and brown families--are over policed, disproportionately arrested and incarcerated for drug related offenses. Drug arrests account for nearly 30% of all those we represented in criminal court in 2013 and 2014. Any public defender can describe the vicious cycle where hundreds, if not thousands of men, women and children are stopped and frisked, swept up for drugs, booked, brought to Rikers Island and then returned back to the streets only to begin the cycle again. As they wait years for a trial in the backlogged Bronx Courts, we know that there were countless other civil sanctions as a result of those arrests.

II. Devastating Consequences on Individuals and their Families

So called "collateral" consequences, are devastating and far-reaching and often are anything but collateral. Often, the civil penalties are more severe than the criminal "punishment" itself. These consequences are a result of alleged drug activity, whether or not there is a serious felony conviction, or any conviction at all, and sometimes whether or not there is even an arrest. Moreover, technology has made it easy to have unparalleled access to criminal history data which excludes low income people of color from basic aspects of work and life and further traps them in recurring encounters with the criminal justice system. Many of these civil law strategies used related to drugs have been embraced intentionally because they offer speedier "tough on

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[2] Federal Bureau of Investigation, "Crime in the United States, 2013," (Washington, DC: U.S. Department of Justice, 2015)
[3] "The Drug War, Mass incarceration and Race" Fact Sheet, Drug Policy Alliance, June 2015
[4] *Id.*
[5] *Id.*
[6] *Id.*
[7] New York city crime Data for 2013, as maintained by the NYPD
[8] *Id.*

crime" solutions that are "unencumbered by the rigorous constitutional protections associated with criminal trial, such as proof beyond a reasonable doubt, trial by jury, and appointment of counsel."[9] We see how unjust, unfair and discriminatory drug practices reach so far beyond an arrest so as to destroy lives, destabilize families and decimate entire communities of color.

A. Child Welfare System

One such example relates to drugs and child welfare policies. In representing parents every day in child welfare proceedings, we know that many people who use drugs and alcohol – and even those who suffer from drug or alcohol dependence – often remain fit to care for a child. This is true regardless of race or class. Repeatedly we see that it is often far more detrimental to disrupt crucial early attachment or to traumatize children by taking them from their homes than to support parents while their children are home.

Foster care is a last resort that should be used only when alcohol or drug dependency results in mistreatment of the child, or in a failure to provide the ordinary care required for all children. However, in New York, a simple allegation of drug use-even without a criminal conviction-can be grounds for children to be removed from their homes and placed in foster care and lead to further destabilization.

Nadine

Nadine's children were removed because she was living in hazardous conditions at the shelter where she was assigned and she was accused of using marijuana. She applied for public housing from the New York City Housing Authority and was assigned a priority code because six of her seven children are in foster care and the lack of housing is the sole remaining barrier to reuniting her family. Even though she has no criminal record, and there is no indication that she ever engaged in abuse of illicit drugs, at the urging of Family Court, Nadine entered a drug treatment program. She has repeatedly tested negative in five unannounced toxicology screenings, including one in court.

Her application was denied to housing because she disclosed that she is in a court-recommended drug treatment program (with which she is fully compliant). The ineligibility notification states: "Our investigation revealed that you have illegally used a controlled substance within the last three years. According to a letter, you are scheduled to attend therapy sessions weekly and will have toxicology testing weekly." Notably, there is no actual proof that she used a controlled substance within the last three years.

Though denying her public housing based on her self-reported drug treatment would punish Nadine for seeking treatment for her own health and wellbeing, the public housing authority continues to do so. Further, treatment by itself is not evidence of drug use; and it is not a sound predictor of future behavior. It is only faintly connected with any likelihood of consequence to the health or safety of public housing residents or staff.

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[9] *See* Mary M. Cheh, *Constitutional Limits on Using Civil Remedies to Achieve Criminal Law Objectives: Understanding and Transcending the Criminal-Civil Law Distinction*, 42 Hastings L.J. 1325, 1325-28 (1991)

B. **Employment, Education and Forfeiture Consequences**:

There are numerous other civil penalties related to the use of drugs that continue to destabilize and prevent those accuse and convicted of drug related offenses.

1. In employment: A study by the National Employment Law Project estimates that more than 600,000 job-seekers per year are adversely affected by common inaccuracies in federal background checks, such as the failure to report the outcome of a case, or the misreporting of cases that have been resolved favorably to the accused. Such is true for cases related to drugs. Moreover, employment laws do not prevent employers from denying jobs to individuals who are engaging in illegal drug use.
2. In education: loans suspend eligibility for any grant or loan for students convicted of any offense under federal or state law involving possession or sale of a controlled substance.[10] Moreover, simple possession of a marijuana cigarette cuts off federal student loans for a year.[11]
3. Forfeiture: The District Attorney (CPLR Art. 13-A), NYPD (NYC Admin. Code § 14-140 and Chapter 12 of Title 38 of the RCNY) or federal agencies can seize and keep any property alleged to be the proceeds of a crime or allegedly used as an instrumentality of a crime. Often times property on someone's person at the time of arrest will be alleged to be connected with the crime they are charged. When a person is charged with a drug related crime, like possession, if that person has cash on them, the NYPD seize the money and seek to keep it, arguing it is subject to forfeiture. Consider this example:

Benny

Benny lives on 161 Street in the Bronx. While he awaits his friend, a police officer approaches him. The Officer states he observed Benny making a drug sale. The officer proceeds, illegally, to search Benny and his entire car. In his pocket a small amount of marijuana is found. Benny is arrested, charged with drug sale by the Officer, taken to the precinct and his car impounded. Benny also has $800 in cash on him and that money is seized with the intent of being forfeited. When the District Attorney's Office reviews the charges and the facts, Benny's charges are reduced and he is given a Desk Appearance Ticket for a marijuana violation and he is told his case will most likely be dismissed. When he asks for his money back, which is cash he took out to pay his rent that day, he is told that the NYPD have designated his rent money as funds appropriate for forfeiture, even though he has not even been charged with a crime.

[10] 20 U.S.C. § 1091(r)(1)
[11] *Id.*

C. Drugs and Housing Displacement

A drug related arrest can lead to a multitude of housing consequences for an entire family and the potential for eviction is very high. The NYPD can bring a nuisance abatement action, a Landlord can bring an illegal use proceeding at the demand of the District Attorney's Narcotics Eviction Unit, the New York City Housing Authority may seek to terminate tenancy and/or the Section 8 administering agency may move to terminate the Section 8 subsidy. All of these actions can occur based on the conduct of any individual (the tenant of record, other occupants or guests) engaging in drug related activity and a tenant may face several of these cases based on the same nexus of facts from the criminal drug case, concurrently or subsequently.

1. Public Nuisance

Ana

Six months ago, the police raided Ana's public housing apartment. They emptied her HIV+ son's prescription pills into a plastic bag and arrested her younger son and nephew, charging them with selling ecstasy. Her nephew was searched and small quantity of marijuana was found in his pocket. In criminal court, the family produced the prescription records, but the ADA would not drop the case. To put the matter to rest, her nephew pleaded guilty to a possession violation (not a crime), the charges against Ana's son were dismissed, and the family considered their ordeal over. Five months later, the police evicted Ana's family completely without warning- through an ex parte closing order issued for a nuisance abatement action, stating Ana or someone in her apartment was possessing or selling drugs and thus causing a nuisance.

Nuisance abatement actions, resulting in immediate evictions, are one of the most invasive, disruptive, and counterproductive forms of civil forfeiture. Tenants face eviction, without notice or hearing, in actions brought by the New York Police Department Legal Bureau's Civil Enforcement Unit ("NYPD") under the local Nuisance Abatement Law.

Nuisance abatement cases are brought *ex parte*, without notice to the tenants. Often, the underlying criminal case has concluded. Most criminal charges involve only simple possession misdemeanors or mere violations (which are not crimes), or are dismissed altogether. Records are frequently sealed. Nevertheless, several months later in civil court, the NYPD frequently allege that drug sales took place. Courts then issue temporary closing orders, effectively evicting entire families from their homes. The NYPD enforces the orders by bringing a cadre of armed officers to the premises, guns drawn, and ordering everyone to leave. Families asleep in their beds or just sitting down to dinner are forced out onto the street, bewildered and shaken. They are told to come to court in a few days' time.

Background on Public Nuisance

In 1977, the City Council passed the Nuisance Abatement Law, Administrative Code §§ 7-701 et seq. (the "NAL"). The NAL was conceived and designed as a tool to combat the effects of illegal businesses on neighboring communities, in particular the shops and theaters in Times Square that profited from prostitution and made the neighborhood unwelcome to residents and tourists.[12] In its first thirty years, the NAL was used mostly as it was designed: to "close"[13] commercial spaces whose owners or tenants were carrying on an illegal business, including high-volume trafficking in illegal drugs.

In 2007, the law was substantially modified by decreasing the number of drug law violations within one year needed to trigger the NAL, from five to three. Since 2007, use of the NAL has shifted dramatically from almost exclusively commercial spaces being "closed" to a substantial and growing number of residential "closings."

In 2007, at a hearing before the Committee on Public Safety, an NYPD assistant commissioner testified that "We, as a policy, do not use the Nuisance Abatement Law as a substitute for eviction processes in people's residences.... We commence actions against apartments or private homes if our investigation has led us to believe that there are no residents in the premises, except the actual criminals. If there are family members, we look to other remedies because we are concerned about--We do not believe it's appropriate to use the Nuisance Abatement Law as a substitute for eviction statutes." However, NYPD is now doing just that: using the NAL as a substitute for eviction proceedings in Housing Court.[14]

Alarmingly, the apartments being "closed" almost always belong to low-income tenants of color. Very few, if any, are targeted at high-volume drug trafficking. Instead, families are being summarily evicted for possessing small amounts of drugs consistent with personal use.

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[12] See Peter J. O'Connor, *The Nuisance Abatement Law as a Solution to New York City's Problem of Illegal Sex Related Businesses in the Mid-Town Area*, 46 Fordham L. Rev. 57 (1977).

[13] Under Admin. Code § 7-707, the city can seek a "temporary closing order" from Supreme Court, providing that the subject premises be enjoined from further use by anyone.

[14] Real Property Actions & Proceedings Law § 711(5) permits the landlord, or the District Attorney, to commence a holdover eviction proceeding in Housing Court where the premises are being used for an illegal business.

drug sales took place. Courts then issue temporary closing orders, effectively evicting entire families from their homes. The NYPD enforces the orders by bringing a cadre of armed officers to the premises, guns drawn, and ordering everyone to leave. Families asleep in their beds or just sitting down to dinner are forced out onto the street, bewildered and shaken. They are told to come to court in a few days' time.

Facing homelessness, tenants are then pressured into signing oppressive stipulations, excluding family members from their homes, just to get back into the apartment. Others give up their possession rights altogether.

Diego

Diego had lived in his family's Bronx apartment since childhood, becoming the tenant of record after his grandmother's death. Last summer, the police executed a search warrant at the apartment and arrested Diego's brother and sister on charges of drug possession. His sister's case was dismissed and the record sealed.

Though Diego himself was not arrested, and though his brother did not reside in the home, months after the criminal case concluded, the NYPD evicted Diego's family without notice through an ex parte nuisance abatement action. Diego sought help from The Bronx Defenders and was eventually able to return to his apartment. But the ordeal continued, as is often the case, when his landlord brought an illegal-use holdover proceeding against him in Housing Court.

2. Illegal Use Proceedings

A landlord, at the insistence of the District Attorney (in New York City, each borough District Attorney has a special Narcotics Eviction Unit), may also bring a case to evict a tenant because that tenant used or allowed others to use the premises for any illegal trade or manufacture, or other illegal business. Under these laws, the elements include that the tenant or someone occupying the apartment engaged in: (a) illegal conduct, (b) that is a business, (c) on more than one occasion, (d) involving the premises to be recovered, (e) with the participation, knowledge, or passive acquiescence of one or more of the tenants of record.

These cases are brought by operation of 3 statutes: Real Property Law § 231(1), Real Property and Proceedings Law (RPAPL) § 711(5), RPAPL § 715. RPL § 231 voids the lease; RPAPL § 711(5) gives Landlord cause of action to evict; RPAPL§ 715(1) authorizes other parties to evict and establishes presumptions. These statutes permit eviction from private rental housing if it is alleged that the housing is being used in connection with illegal activity, and shift liability to the landlord for failing to do so.

In 1988, it was DA Robert Morgenthau who "dusted off" these ancient laws from the mid-1800s and used them against suspected drug dealers at the height of the crack epidemic.[15] Though

[15] Scott Levy, *Collateral Consequences of Seeking Order Through Disorder: New York's Narcotics Eviction Program,* 43 Harv. C.R.C. L. L. Rev. 541 (2008).

these cases are brought today under the same guise, in our experience most cases brought are against, at best, drug users or against the grandmothers, grandfathers, mothers and other family members of drug users or low level dealers who are then forced to leave their homes because of the actions of a single family member.[16]

Diego

Though Diego was able to stabilize his apartment after he was displaced by the NYPD nuisance abatement action, he received court papers indicating that his landlord was seeking his eviction, the basis being he used or let someone else use his apartment to sell drugs. After having resolved things in Civil Supreme Court, he now had to face his landlord's attorney in Housing Court.

3. Public Housing & Section 8 terminations or denial of housing

Additionally, Drug activity and arrests could lead to either denial of public housing or section 8 benefits or the termination of public housing or Section 8 benefits, if these are already being received. Under 42 U.S.C. § 1437d(l); 24 C.F.R. § 966.4, a public housing authority must mandatorily terminate any persons convicted of methamphetamine production on the premises of federally assisted housing. Additionally, public housing authorities may, in their discretion, terminate the following categories of tenants: i) persons engaging in illegal use of a drug, ii) persons abusing alcohol: iii) any person who furnished false or misleading information concerning illegal drug use, alcohol abuse, or rehabilitation of illegal drug users or alcohol abusers; or iv) terminate any tenant, member of the tenant's household, or guest who engages in any drug-related criminal activity on or off the premises, or any other person under the tenant's control engages in any drug-related criminal activity on the premises, public housing authorities have the authority to evict for drug-related activity even if the tenant did not know, could not foresee, or could not control behavior by other occupants or guests. Dep't of Housing & Urban Dev. v. Rucker, 535 U.S. 125 (2002).[17] If Public Housing Authorities do not terminate the tenant of record, they might instead make the tenant permanently exclude the family member who is accused of the drug activity, breaking up their family and further destabilizing them.

Under 24 C.F.R. §§ 960.203 & 960.204, these categories also exist in denying applicants admission to public housing. Though public housing authorities maintain their discretion regarding all offenses except the production of methamphetamine and can inquire into the context of the drug related offense and whether there has been rehabilitation, we find that they typically do not use this discretion and more often than not deny individuals and families who otherwise qualify for public housing or Section 8.

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[16] *Id.*

[17] Under Rucker, the U.S. Supreme Court allowed for the eviction of Pearlie Rucker, a 63 year old great grandmother because her daughter, who suffered from a development disability, was found with a crack pipe three miles from her project building and Willie Lees, a 71 year old grandmother whose grandson had been caught smoking marijuana in a parking lot.

Lucy

Lucy has struggled with drug use for many years. In 2010, she took a conviction related to possession of heroin. Since then, she has been in substance abuse counseling and in fact received a certificate confirming that she is in an advanced stage of recovery. She has taken parenting classes and is in school. She is working in retail to support herself and her two kids. Lucy was living with her father in New York City Housing Authority public housing. In 2013, he passed away. She applied to get her father's lease in her name, but was denied because of her conviction from 2009. At a hearing she demonstrated all the changes she made in her life, how she maintains her sobriety and how she grew up in this apartment, how she knows the people in her building, pays her rent on time and is otherwise, without any incident or problems in this apartment. NYCHA denies her application stating her heroin related conviction is a danger and threat to other public housing residents.

IV. Recommendations:

The Bronx Defenders supports the creation of an Office of Drug Strategy with the hope this agency will be in the Mayor's Office. Because drugs and the impact of drug war policies permeate so many aspects of our city, implicate many agencies and concerns hundreds of different laws and regulations, it will be imperative to have an office that has the power and ability to reconcile the many contradictory and discriminatory policies and practices regarding drug offenses.

The advisory council for this Office is critical and requires a broad range of stakeholders, including our clients and the communities who are the most directly affected by the criminalization of drugs. Criminal and Civil public defenders should also be represented on the interdisciplinary municipal drug strategy advisory council, as individuals with real experience and expertise essential in making the Office of Drug Strategy effective and routed in data. Moreover, subcommittees should be created to specifically address reducing the enmeshed civil penalties of drug arrests and also the intersection of drug policy and child welfare policy.

Submitted by,

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An Office of Drug Strategy
Testimony of Five Borough Defenders

Committee on Public Safety and Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

June 23, 2015
Presented by: Renate J. Lunn

Five Borough Defenders is an informal association of public defenders, civil rights attorneys, law students, academics, and all those who advocate on behalf of the civil rights of indigent New Yorkers. Since 2006, Five Borough Defenders has provided a forum for the public defense community to discuss, strategize, and encourage the vigorous defense of indigent New Yorkers. We also discuss and strategize around the failings of the criminal justice system. One such failure that we, as public defenders, see every day is that of the War on Drugs.

Thousands of men, women and children are cycled through paddy wagons, central booking, Rikers Island and then dumped back to the streets only to begin the cycle again. Our reliance on the criminal justice system to address drug addiction, a health issue, has resulted in the unnecessary waste of lives and resources.

The War on Drugs has failed. Our collective experience shows that at any given time, there is a public defender preparing to defend someone accused of selling drugs to an undercover police officer. The prosecutor is likely claiming that an undercover officer approached a crack user, maybe flirted with him a bit and got the addict to take her to his dealer. Since a couple of rocks were in it for him, the prosecutor explains, the addict helped coordinate the deal for the officer. What the prosecutor won't tell the jury is that the real dealers who distribute drugs all day are rarely, if ever, arrested. Thus, a typical defendant in a case like this, a middle-aged addict with no violent history, faces up to nine years in state prison if a jury convicts him. And even if sentenced to those nine years, his addiction has not been addressed. If police continue to target only these alleged "middlemen" who make no profit off the alleged crime and who are non-violent addicts, the real criminal justice problems stemming from sale and distribution of drugs, will never be addressed. There is no war on drugs, only a war on addicts.

Even when the city promotes policies that treat addiction as a health issue, those policies are not applied consistently.

Alex is a man in his late 30s who works for a high end catering company. He has served hors d'oerves to rap stars and UN officials. He also had a heroin addiction. He kicked the habit and now receives a daily dose of methadone from a clinic. When his defender met him he had no criminal record and was a patient at methadone clinic. Alex gets stopped and frisked regularly in front of the clinic. One day he was arrested *inside* the clinic after the police had chased another patient into the clinic, who they thought had acted suspiciously outside. In fact, the police activity outside the clinic is so common there is even a street sign reserving a parking spot for a police car. Alex is not alone, public defenders are familiar with the addresses of the methadone clinics in their boroughs, because that's where a large number of arrests occur. The police prey

upon people seeking help for their addictions by targeting them for unconstitutional searches. How can one city agency promote and fund these drug treatment centers and then another branch of government seek to punish people who use them?

Because we have members in every borough and who work in private practice as well as for public defender offices, we can see the inconsistencies between the boroughs. In Brooklyn, if a defendant is arraigned on a non-violent felony or a drug related charge, the case is screened and sent the next day to a drug court. One defender writes about her client:

> One of my favorite clients of all time is about to finish his two year treatment program in Brooklyn that covered two residential burglaries. He is a completely different person. He is so happy. He's going to college, spending time with his son, learning how to be a father. It's an amazing success. He would never have been offered treatment in Manhattan. He would be upstate.

On the other hand, in Manhattan, clients are only sent to treatment court months after their initial arraignment and often the judge's will only send the accused to be evaluated for treatment court after the client pleads guilty. Meaning our client has to plead to the most serious charge she's facing with a prison alternative of five years (for example), before she even *knows* if diversion will accept her, and before she even knows if she will be required to do inpatient or out-patient treatment. If she is not accepted, she has entered a plea and will have to do the upstate prison time. A recent Vera Institute Study supports this discrepancy we have observed: In the Bronx for every defendant sent to upstate prison, 2.1 defendants received diversion. In Brooklyn, the ratio is 1 to 1.5. In Manhattan, though, for every person in treatment there are a whopping 5.2 people in upstate prison.[1]

We don't all agree that drug courts are a panacea. We often agonize over these cases, worried that we're setting our clients up for failure. If someone "fails" treatment, they usually face a longer prison sentence than if they had negotiated a plea without treatment. We still want them as an option for non-violent addicts who are ready for treatment regardless of which borough they live in.

The sentencing disparities must be addressed while at the same time the city works to address the addiction that walks these clients right into the willing arms of undercover police. **Five Borough Defenders supports the creation of a city-wide Office of Drug Strategy.** Such an Office located in the Mayor's Office would be able to create consistent policies across a variety of agencies. An advisory council made up of treatment providers, medical professionals, drug users, public defenders and prosecutors would be able to craft consistent, evidence-based policies that ensure that drug users can safely access treatment without fear of police harassment and access treatment through the courts, if necessary, regardless of which borough they live in.

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[1] http://www.vera.org/sites/default/files/resources/downloads/drug-law-reform-new-york-city-summary-01.pdf.

Proposed Int. No. 748-A: ***Johnson, Cohen, Gibson, Constantinides, Eugene, Koo, Palma, Torres, Rodrigues and Levin***

COMPA

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COALITION OF MEDICATION-ASSISTED TREATMENT PROVIDERS AND ADVOCATES

Memorandum in Support

Int. No. 748-A- To create an Office of Drug Strategy to Build a Public Health and Safety Approach to Drugs in NYC

COMPA (Coalition of Medication-Assisted Treatment Providers and Advocates) supports Int. 748-A, Creation of an Office of Drug Strategy. OTPs (Opioid Treatment Programs) patients often utilize most/if not all of the agencies or departments, which will be involved in the Office of Drug Strategy, therefore they would benefit greatly from the coordination of service across multiple agencies.

COMPA supports the objective of this office which is to provide strategic leadership related to **coordinating** a public health and safety approach to illicit and non-medical drug use to reduce morbidity, mortality, crime, and inequities stemming from drug use and past or present drug policies. We also support the development of an annual plan for drug policy in the City of New York.

COMPA also supports the role of this office as **liaison** between city, state, and federal agencies working on issues related to illicit and non-medical drug use, including, but not limited to, programs and policies.

COMPA supports the location of the Office of Drug Strategy to be in a separate office of the Mayor's Office. This will ensure it has the ability to address the current policy contradictions and ensure better collaboration.

Sincerely,

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Testimony of Phillip Saperia, CEO
The Coalition of Behavioral Health Agencies, Inc.

"Intro 748: A Local Law to Amend the New York City Charter in Relation to an Office of Drug Strategy"

Good Morning, Chairman Cohen and members of the NYC Council Commitee on Mental Health, Developmental Disabilties, Alcoholism, Substance Abuse and Disability Services, and Chairwoman Gibson and members of the Committee on Public Safety. I would like to thank Council Member Corey Johnson for introducing this bill and the Council for the opportunity to testify.

We are grateful to Council Members Corey Johnson, Andrew Cohen, Vanessa Gibson, Costa Constantinides, Mathieu Eugene, Peter Koo, Annabel Palma, Ritchie Torres, Ydanis Rodriguez and Rory Lancman for sponsoring this bill.

I am Phillip Saperia, Chief Executive Officer for The Coalition of Behavioral Health Agencies. The Coalition is the umbrella advocacy organization of New York's behavioral health community, representing over 130 non-profit community-based behavioral health and substance abuse agencies that serve more than 350,000 clients/consumers throughout New York City and beyond. Our member agencies are on the ground, front-line safety net providers. We treat some of the most needy individuals, including those with dual diagnoses of mental health and substance abuse problems. Our providers serve the homeless and the formerly incarcerated as well as victims of trauma and abuse. The agencies we are represent are in every Council District and neighborhood.

Substance abuse, and the problems that often co-exist with it, are not new problems for our City. Yet they are growing—both in geographical boundaries and in users. Illicit drugs are cheaper, more potent and more widely available than ever before. In one of the most concerning examples of the devastation from substance abuse in New York City, we have suffered a 129% increase in heroin related overdose deaths of young people from 2010-2013. Another very recent concern, monitored by the NYC Dept. of Health and Mental Hygiene, is the rise of synthetic marijuana use, which resulted in 120 emergency room visits this past April. Drug and alcohol use have increased among adults and youth. Related hospital admissions are up.

The effects of substance abuse are far-reaching, harming individuals, families, and negatively impacting the quality of life in our neighborhoods. Increases in addiction also increase involvement with the criminal justice system, unemployment and homelessness. Addiction increases human suffering, while it increases the cost of hospitalization and health and behavioral health treatment. It increases costs in the public safety and criminal justice systems.

Many people with addictions have co-occurring mental health and physical health disorders that also must be addressed. What we need is a City-wide and holistic approach to these problems. What we need is a public health approach that addresses prevention, care, and support. Such an approach will break down the silos in government and in correlated support systems. It will require cooperation and coordination between the multiple government departments and systems that have responsibility for addressing the resulting problems in the most appropriate ways.

Intro 748, which seeks to establish a NYC Office of Drug Strategy as a means to a comprehensive public health approach to drug use, delineates an approach for coordinating such an effort. The Office of Drug Strategy would "provide strategic leadership related to coordinating a public health and safety approach to illicit and non-medical drug use in order to reduce morbidity, mortality, crime, and inequities stemming from drug use and past or present drug policies."

The Office would be tasked with bringing together relevant agencies and partners to provide their input on substance abuse issues, to evaluate what is working well, what sorely needs attention and to develop new approaches that are informed by up-to-date research and best practices. The Office would require a collaborative approach among government departments, stakeholder and advocacy groups that will address the multiple issues surrounding drug abuse. It will seek to enable efficient use of our city's resources, preventing duplication of efforts.

We are most supportive of the bill's creation of an advisory council to inform the work of the Office of Drug Strategy. The council would include people with experience and expertise in substance use such as: people with personal experience of drug use, service providers, public officials from many Departments, academic experts, and those with policy and research knowledge of substance abuse prevention, treatment and the continuum of recovery. The goal is to cast a wide net and be inclusive of the systems that are both impacted by and can impact upon substance use problems.

Given the need for cross agency collaboration, we support the bill's call for an independent office, yet we also call for strong and dispositive involvement of the Department of Health and Mental Hygiene, with its expertise in issues and practices of prevention and care which permeate this discussion.

The Office of Drug Strategy would be the first of its kind in this Country and could serve as a model for how a large City with complex infrastructure can create policies that are progressive and truly work to help individuals, families, and communities that need help for problems related to substance use. It's time for our City to take the necessary steps to create a healthier and safer New York and we strongly encourage you to pass Intro 748.

THE CENTER

FOR THE RECORD

Testimony

of

Glennda Testone
Executive Director
The Lesbian, Gay, Bisexual & Transgender Community Center

In response to the

New York City Council
Proposal for Int. 748

TITLE: A Local Law to amend the New York City charter in relation to an office of drug strategy.

Submitted on June 23, 2015
to the
Committee on Public Safety
jointly with the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

Council Chambers, City Hall
New York, NY 10007

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THE CENTER

Testimony of Glennda Testone, Executive Director
The Lesbian, Gay, Bisexual & Transgender Community Center

Good morning and thank you, Chairs Gibson and Cohen, for this opportunity to speak to the issues raised by Int. 748. The LGBT Community Center was founded in 1983 to support the LGBT community on issues such as those addressed by Int. 748, and we strongly support the creation of an office of drug strategy as it relates to our mission.

My name is Glennda Testone and I am the Executive Director at New York City's LGBT Community Center, where I have worked since 2009. Let me start by saying, the Federal government believes the LGBT community has the highest rates of substance abuse, and I can tell you first hand, this is true. I meet so many people who have managed – through the help of The Center – to beat addiction, and they are the lucky ones. So many more are sick and dying because of the ravages of substance abuse.

The Center has been very fortunate over the years to be able to collaborate with the City as it has worked to address the needs of LGBT New Yorkers including working with the Council and many City agencies to develop legislation, practices and policies to enable LGBT New Yorkers to be healthy and successful.

The Center encourages the creation of an office of drug strategy to provide strategic leadership to coordinate a public health and safety approach to address problems associated to drug use, particularly as it relates to heroin use and overdose, as proposed by Int. 748. Let me repeat, LGBT populations have the highest rates of tobacco, alcohol and other drug use.[1, 2, 3] Substance abuse also significantly increases risk for HIV among LGBT people.[4] Substance use increases impacts both to the user and society for long periods of time, accruing high public and personal costs during that period.[5, 6, 7, 8, 9]

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[1] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). *Healthy People 2020: Lesbian, Gay, Bisexual, and Transgender Health.* Washington, DC.

[2] Cochran, S. D., Sullivan, J. G., & Mays, V. M. (2003). Prevalence of Mental Disorders, Psychological Distress, and Mental Health Services Use Among Lesbian, Gay, and Bisexual Adults in the United States. *Journal of Consulting and Clinical Psychology, 71*(1), 53–61.

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THE LESBIAN, GAY, BISEXUAL & TRANSGENDER COMMUNITY CENTER
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Substance use treatment is a particularly cost effective solution,[10, 11, 12] and LGBT people are more likely to engage in effective treatment in LGBT-specific programs than traditional, non-LGBT programs.[13] To that end, The Center has operated an OASAS licensed, Article 32, Part 822 Chemical Dependence (Medically Supervised) Outpatient Service since 2007 called Center Recovery.

Center Recovery currently provides treatment for over 400 unique LGBT people annually and is built upon The Center's 32-year history offering a continuum of LGBT-affirming substance use treatment and support services. The Center functions as a Recovery-Oriented System of Care (ROSC) and offers a whole host of substance use care and support services including not only treatment and prevention, but also continued care and case assistance with related needs such as housing, education and employment, as well as access to over 80 12-step recovery groups available onsite weekly.

The growth of opioid abuse is well documented in New York State, and 66% of Center Recovery participants admitted into treatment services report opioids as their primary, secondary or tertiary substance. Opioid abuse is also beginning to be understood as a significant substance abuse health disparity for LGBT youth.[14] Research indicates the likelihood of substance abuse among LGB youth is a staggering 190% higher than the likelihood of substance abuse among heterosexual youth.[15]

In a 2014 Center study with disconnected LGBT adolescents and young adults, 19% reported using heroin and 26% abusing prescription opioid analgesics – a precursor to other opiate use, especially heroin.[16] To tackle this problem, The Center will open the city's – and perhaps the country's – first treatment program for LGBT youth this summer. A core component of The Center's treatment services is expertise in addressing the spectrum of opioid addiction including ancillary medication management for the treatment of opioid withdrawal symptoms and opioid maintenance treatment involving buprenorphine.

It would be of tremendous value and future cost savings if the office of drug strategy proposed as part of Int. 748 provided the leadership we need to address the serious problems with addiction that are acutely felt in the LGBT

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[10] Cost review: Drug abuse, treatment, incarceration, (n.d.). *The New York Academy of Medicine.* Retrieved November 16, 2014 from www.drugpolicy.org/docUploads/ndny_costeff.pdf

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community.

LGBT people who engage in substance use are more likely to be involved in the criminal justice system (for both substance and non-substance related offenses), have difficulty staying in school and retaining employment sufficient for livelihood and to have poor physical and mental health outcomes. Addressing and treating substance use for LGBT people who require treatment would mean that a significant quantity of public and private resources would no longer be needed for the care of substance-induced health and related disparities, and could be used for some other purposes.

Addressing substance abuse also has substantial benefits including $8.87 benefit for taxpayers and crime victims for every $1 invested,[17] while the Drug Treatment Alternative-to-Prison (TDAP) and similar programs can save the state $39,130 per person treated.[18] The United Nations and the World Health Organization indicate there is at least a 3:1 cost savings "in terms of reduction in the number of crime victims, as well as reduced expenditures for the criminal justice system." When the costs associated with crime, health and social productivity are included, that saving can rise to 13:1.[19]

I urge the City to take a stand and show NYC's LGBT population that their health and lives matter by passing Int. 748 in acknowledgment of the health disparities that LGBT New Yorkers face. This action reflects the City's commitment to providing the resources LGBT New Yorkers need to live the happy, healthy lives they deserve.

Thank you for the opportunity to offer this testimony,

Glennda Testone
Executive Director
The Lesbian, Gay, Bisexual & Transgender Community Center

[17] Cost review: Drug abuse, treatment, incarceration, (n.d.). *The New York Academy of Medicine.* Retrieved November 16, 2014 from www.drugpolicy.org/docUploads/ndny_costeff.pdf

[18] Zarkin, Gary A., Laura J. Dunlap, Steven Belenko & Paul A. Dynia, "A Benefit-Cost Analysis of the Kings County District Attorney's Office Drug Treatment Alternative to Prison (DTAP) Program," Justice Research and Policy, Vol. 7, No. 1 (Washington, DC: Justice Research and Statistics Association, 2005), p. 20.

[19] UNODC/WHO (2009). Principles of Drug Dependence Treatment, Discussion Paper. United Nations Office on Drugs and Crime, World Health Organization, Vienna, Austria

Thank you Chairman Cohen, Chairwoman Gibson and Honorable members of both the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services and the Committee on Public Safety. It is an honor to sit here today, representing the board, staff and participants of St. Ann's Corner of Harm Reduction.

I founded St. Ann's Corner of Harm Reduction in 1990 when syringe access to injection drug users was politically controversial and over 50% of the city's drug injectors were infected with HIV. I can attest to the challenging politics that polarized this city, paralyzed policy makers and allowed HIV to spread unchecked because of cumulative misunderstanding and fear of drugs and drug users.

The success of the last 25 years in reducing injection related HIV/AIDS to less than 4% of new incidence has been the result of a paradigm shift in policy from punitive prohibition to harm reduction.

The economic and social benefits of providing syringe access is also measured in decreases in hospitalizations, emergency room visits, linkage to drug treatment and in a surer path to drug abstinence. Yet, for all the success of the last 25 years, we continue to address the complexity of drug use, piece meal. Like the parable of the blind men and the elephant our policies lead to duplication of effort, or worse of all--infighting among so many bureaucracies engaged in turf battles as our society loses both its grasp of the issue and its authority to bring leadership and healing to our wounded families and communities.

In one year a short while ago, the policies associated with Stop & Frisk and Broken Windows marched over 650,000 New Yorkers for cannabis possession through the arrest-prison turnstile; can anyone say those policies reduced cannabis use? In fact, New Yorkers continue to use drugs, lots of drugs: and they use drugs because they medically need them or because they want drugs recreationally. Now is the time for innovation, integration, and collaboration.

- Cannabis has been decriminalized in New York since the 1970s. Thirty years earlier, the LaGuardia report supported legalization. Given the ubiquity of marihuana use in New York and the legalization of marihuana in Colorado, Washington, and Oregon, are we at a juncture in NYC where legalization offers social and economic benefits? What agency within City government can lead that discussion?
- Thousands of New York's seriously ill are counting on their state to enact and implement compassionate law to allow them to relieve their symptoms with Cannabis with their doctor's advice. The State Assembly has thrice passed a medical marijuana bill, in June

Joyce A. Rivera, MPhil., MA, Founder & Executive Director of St. Ann's Corner of Harm Reduction, Bronx, NY;
Adjunct Lecturer, Anthropology Department, John Jay College of Criminal Justice, City University of New York.

2007, June 2008, and in June 2014. Do New Yorkers need a unique agency within the City to foster science and trust in the doctor – patient relationship? Yes, they do.

Then there are the formerly legal opioid users, the ones who became medically dependent following an accident, an operation, or through continuous social learning that are now displaced into the illicit heroin market. Who among us is not surprised with Staten Island alternating with the Bronx on which borough has the highest number of unintentional opioid over dose? The heroin market now is two-prong: everywhere in the United States, middle class users are joining the older ranks of ghetto-based drug users.

New York City needs a central drug policy coordinator whose focus is on integration, communication and collaboration, bringing together the oversight, the public health, the research, and the justice approaches. Bring our addiction services back home to NYC, they don't belong in Albany. While the politics are integrating harm reduction, there are institutions that have become fossils and resist change.

- Integrate substitution therapy and patients into the medical fold without exclusionary pre-conditions.
- Make unintentional opioids-analgesic overdose education a funding priority. Explore the utility of making Naloxone available over-the-counter
- Fund non-traditional, non-abstinence-based therapeutic milieu such as those cultivated in IDUHA agencies.
- Pilot and evaluate one or two Safe Injection Facilities.
  ✓They bring the severely addicted into a therapeutic interaction with the health care system;
  ✓Foster the possibility of dis-use, gradual detoxification and withdrawal under relative safe circumstances;
  ✓Create a healing relationship with users who are relegated to the streets or hidden and engaged in risky drug practices. .

The success of syringe access must be institutionalized further through maintenance, expansion and education.

- Syringe possession is legal in New York State yet drug users who fit a profile are routinely stopped, arrested, their program identity cards are thrown away and they are unnecessarily put through the criminal justice system. Unnecessary and unjust arrests interrupt treatment, undermine health promotion and disease prevention.

Joyce A. Rivera, MPhil., MA, Founder & Executive Director of St. Ann's Corner of Harm Reduction, Bronx, NY;
Adjunct Lecturer, Anthropology Department, John Jay College of Criminal Justice, City University of New York.

- Demand accurate reality-based drug education in the schools. Lying to children undermines institutional authority; our families and communities are the best place for instilling cultural values; inaccurate drug information pollutes our education; bring back science to our schools.

I support the establishment of a fully funded ~~Drug Care Bureau~~ Office of Drug Strategy dedicated to restoring balance in our institutional relationships to drug use. The current imbalance conflates a complex phenomenon into so many aimless, expensive and defeatist battles. The Bureau would report directly to the City Council and the Mayor. Proposed responsibilities include:

✓ Building and strengthening partnerships with key and local, regional and national stakeholders – policymakers, community-based organizations, media outlets, faith-based organizations, research institutions, corporate and philanthropic representatives – as a defined effort to increase mobilization, awareness, community-based capacity and institutionally integrated public health drug policy.

✓ Increasing Awareness. Educate local and national stakeholders – such as: policymakers, media outlets, federal agencies and the general public – about evidence-based strategies for addressing the complexity of drug use. Inform elected officials of recent advances emerging from social, medical, behavioral and community research.

✓ Developing multiple-source evaluation opportunities with multiple-stream dissemination outlets.

In summary, the ~~Drug Care Commissioner's office~~ Office of Drug Strategy would integrate addiction and drug policy within its own field so that harm reduction, substitution therapies, ambulatory treatment programs and residential treatment programs, as modalities would be linked vertically; horizontally, this Bureau would coordinate and collaborate with mental health, law enforcement, housing, labor, academia, and business, to name a few sectors.

Thank you Chairman Cohen, Chairwoman Gibson and members of the Committees and City Council. I am happy to answer any questions related to this testimony and my professional work related to drug use.

Joyce A. Rivera, MPhil., MA, Founder & Executive Director of St. Ann's Corner of Harm Reduction, Bronx, NY; Adjunct Lecturer, Anthropology Department, John Jay College of Criminal Justice, City University of New York.

New York City Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

Public Hearing

A Local Law to amend the New York city charter in relation to an Office of Drug Strategy

June 23rd, 2015

City Hall

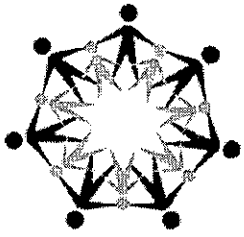
250 Broadway - Committee Room 14th Floor

TESTIMONY GIVEN BY:

Douglas Apple

Board Member – 3rd Vice President

Alcoholism & Substance Abuse Providers of New York (ASAP)



New York Association of Alcoholism and Substance Abuse Providers, Inc.

11 North Pearl Street. Suite 801

Albany, New York 12207

Good morning, I am Douglas Apple, 3rd Vice President of the Board of The Alcoholism and Substance Abuse Providers of NYS, (ASAP), a state-wide organization representing more than 200 substance abuse treatment providers and prevention programs. I am also the Executive Vice President of Samaritan Village, a treatment provider located in Queens. I want to thank the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services for organizing this hearing to discuss the proposed legislation on an Office of Drug Strategy.

ASAP strongly supports legislation to create an Office of Drug Strategy to coordinate New York City's broad array of services dedicated to preventing and addressing the problems associated with drug use. We also want to thank Councilman Corey Johnson for his leadership on this issue. As the chair of the Health Committee, his holistic approach to addressing this important issue is critical as the City faces ever increasing levels of substance abuse. We further want to recognize the coalition of more than 15 agencies who have signed on to support this legislation, led by VOCAL-NY and the Drug Policy Alliance, and who rallied earlier this morning on the steps of City Hall to bring much needed attention to this issue. ASAP stands with these organizations and with the many families who have been affected by the scourge of drug addiction.

The Office of Drug Strategy can play a central role in coordinating dozens of agencies that deal with the many issues associated with substance abuse. As this issue touches so many New Yorkers, young and old, a comprehensive strategy must include all agencies from the Department of Education to the Department of Health and Mental Hygiene to the Police Department to the Department of Youth and Community Development, and many others. Moreover, this new office could spur innovation based on research and best practices - increasing the health and safety of individuals and communities, while saving the city money.

Across the country and across the political aisle there is growing consensus that the drug war has been a failure. The consequences of which have been the incarceration of millions, trillions of wasted dollars and tens of thousands of lives lost from policies that promoted criminalization over public health and science.

New York City has been, and should continue to be a national leader in offering alternatives that promote healthy and safe communities. This office would bring to the fore innovative, new strategies associated with a harm reduction approach protecting health and public safety with the goal of reducing the morbidity, mortality, and crime, as well as inequities, stemming from past or current policies. This means that part of the office's work will be to overcome the negative effects of criminalization in poor communities of color, which too often drive people away from education and opportunity and toward violence, criminality, and prison.

We need alternatives that promote public health and science in the treatment of those people who need help, as opposed to politics, propaganda or stigma. We need to acknowledge that the majority of people who use drugs do not have a "problem", but are often criminalized for their race, ethnicity and/or class, We also need to acknowledge that there are major collateral

consequences that need to be addressed for those individuals and communities hit hardest by the drug war.

This office will have a mandate to create a public health approach to drug use that promotes science and data to truly help people in need. Because drugs and the impact of drug war policies permeate so many aspects of our city and city policy, we need an office that has the power and ability to address these cross-cutting policies and agencies.

The best way to make the Office of Drug Strategy effective is to make it an office inside the Mayor's Office to ensure it has the power and ability to address broad policies and provide the Mayor with guidance as he and his senior advisors, led by Deputy Mayor Lilliam Barrios-Paoli, formulate strategy.

If passed, it is critical that the Office of Drug Strategy have an broadly representative advisory council with representatives who are people who use drugs, service providers serving those using drugs, family members affected by the challenges of substance abuse and community members who understand the impact of drug use in neighborhoods. We applaud Council Members Johnson, joined by Councilmembers Andy Cohen and Vanessa Gibson who are sponsors of this bill, and stand committed to working closely with them and the many organizations and individuals who are fighting everyday to prevent and address the issues of substance use disorder that plague our City.

Thank you for your time.

SUBMITTED TESTIMONY OF:

Lisa Schreibersdorf – Executive Director

BROOKLYN DEFENDER SERVICES

The New York City Council

Committee on Mental Health

Committee on Public Safety

JUNE 23, 2015

Lisa Schreibersdorf
Executive Director

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My name is Lisa Schreibersdorf and I am the Executive Director of Brooklyn Defender Services (BDS). BDS provides innovative, multi-disciplinary, and client-centered criminal, family and immigration defense, civil legal services, social work support, reentry assistance, and advocacy to more than 45,000 indigent Brooklyn residents every year. We thank the Committee on Mental Health and the Committee on Public Safety for holding this hearing to discuss a coordinated city plan for drug policy and for providing the opportunity to testify today.

Introduction

We are in the midst of a massive transformation in the public discourse around a variety of criminal justice issues to which our organization has been a party for nearly two decades. More and more, illicit drug use is being seen as a public health, rather than law enforcement issue. The consequences of unmanaged drug use continue to impact every community in New York City; the vast criminalization of drug use over the past forty years has done little to curb use or to make drugs less available or less lethal, and has introduced stunning, unacceptable inequities to the criminal justice system.

A shift from a paradigm of punishment and enforcement, to one of harm reduction and public health will complicate reform efforts already underway, as well as those not-yet-imagined. There will be transfers of responsibilities between city agencies that are not always aligned on priorities and, likely, a reapportionment of resources, as well.

The vast majority of drug users, of course, do not have a drug problem and while other users might benefit from supportive services, current enforcement strategies have led to racial disparities and eroded the trust between communities and law enforcement. Brooklyn Defender Services was involved in the rollback of the draconian Rockefeller Drug Laws and has experienced first-hand the benefits of reviewing and changing failed law enforcement policies.

Brooklyn Defender Services supports the creation of a central city-wide office to chart a course for a comprehensive, coordinated approach to drug policy in New York City. Currently many city agencies: the Department of Homeless Services, the Administration for Children's Services, the New York City Police Department and the Department of Health and Mental Hygiene among them, have a role in shaping drug policies. The police department plays the primary role. Many of these individual efforts, while well-intentioned, are nevertheless in conflict, leaving agencies to work at cross-purposes to one-

another. This is a detriment to the residents of New York City impacted by these services, some of whom are our clients. These disparate strategies mean agencies miss opportunities to provide support to people with substance use problems through, for example, housing programs, public assistance, family and homeless services and the courts.

An Office of Drug Strategy, tasked with coordinating a municipal plan for managing the use of illicit drugs, would both improve legal outcomes for our clients and provide greater clarity of purpose to the various treatment opportunities that some of our clients are able to access through the legal system. Too often we see well-meaning programming actually create unexpected problems for our clients and their families due to a lack of a comprehensive, inclusive and coordinated process.

Below are some examples of how this proposal would impact our clients and our work.

Criminal Practice

The impact of an Office of Drug Strategy is perhaps obvious for our criminal practice as drug crimes represented two of the top-five charges at arraignment city-wide in 2014. Two of the top three felony charges seen in New York City in 2014 were drug-related. In addition to determining whether or not a law enforcement response to drug use is the most effective way to ensure safety in our Borough, an Office of Drug Strategy could coordinate care for drug users through the arrest-to-arraignment process, which typically takes around 24 hours. For someone withdrawing from alcohol, these hours can be deadly; rarely a day goes by without an ambulance parked outside Brooklyn Criminal Court.

This office could recommend that the City put an end to NYPD practices such as soliciting methadone from our clients outside of treatment facilities, or arresting our clients there for loitering. These practices make our clients uncomfortable seeking treatment they have received through programming at the Courts. We recently represented a man who while begging for money on the sidewalk, was approached by a plainclothes officer who said he would give him money for drugs. Our client is not a drug dealer, but did have his own prescription medications on him, which he takes for a variety of physical and mental health needs. He had not intended to sell any of these drugs on this day – in fact he needs them himself – but found the offer too good to pass up. He was arrested for giving the officer a single pill and after bail was set, he was put on Rikers Island. He was eventually released following advocacy from our office and his case ended with a plea to disorderly conduct. This is not an atypical case and highlights several areas for potential reform at the

city level, from the initial enforcement action, to the decision to detain pretrial, to the fact that throughout the entirety of the criminal justice process, no options were provided to our client that might fundamentally alter his circumstances.

Housing

Drug arrests and even drug and alcohol use are some of a variety of violations that can prohibit a person from living in New York City Housing Authority developments. Other issues such as fighting, which may be associated with drug or alcohol usage, can also be used as grounds for eviction. Homelessness, however, makes people more vulnerable to arrest, at least, and in many occasions more prone to self-harming behaviors such as alcohol and drug usage. Meanwhile there is not enough supportive housing to meet the needs of people who are seeking assistance. The Office of Drug Strategy could recommend wider access to 2010e subsidies, and the creation of specialized shelters with services for people who use drugs.

Family Defense

Our family defense practice has a long history of working at the intersection of drug policy and the child welfare system. In the 1990s a vast majority of our cases came out of the crack cocaine epidemic; in the two most recent quarters we had 122 cases where drug use was the primary allegation for child welfare proceedings – 46 where accusations of marijuana and prescription drug use alone initiated the case. Other types of neglect allegations stem from drug use even when that is not the primary allegation. We find that marijuana usage, even in cases where drug use is not indicated as an area of concern, often remains a barrier to reunification after a child is taken from its parents' custody. At a time when the Mayor is working to lessen the criminal penalty for marijuana, no such step-down is occurring within the realm of child services.

Another area we see as problematic is the termination of parental rights due to positive pre-natal drug tests. Many of these tests occur without a patient's consent, and, from an equity standpoint, Black mothers are more likely than their similarly situated White peers to have their children taken away due to a positive pre-natal drug test. This is not supposed to be a basis for child removal. Importantly, some mothers might choose to forego medical care while pregnant because of this fear, leading to negative overall health outcomes.

Immigration

Drug arrests, from the lowest level possession to the highest level sales, can have immigration consequences such as mandatory detention and deportation. Significant opportunities for education remain throughout the diverse spectrum of criminal justice actors and service providers. Recent reforms around the use of summonses for marijuana possession showed how a central policy unit sensitive to how the criminal justice system impacts immigrants uniquely can be helpful: right to counsel in even the least serious cases remain very important for people without citizenship. By considering how outcomes will be addressed in Immigration Court, the Office of Drug Strategy could work to minimize the collateral consequences of enforcement execution so there are not inequitable outcomes due to immigration status. The decriminalization of drug use would have a profound positive impact for our immigration clients. It is not to the public's benefit for people to avoid treatment because they are concerned about the possible immigration consequences.

Conclusion

These are just some of the many ways we see a potential Office of Drug Strategy playing a positive role in coordinating the City's response to the public health issue of drug use. If given enough resources to thoroughly complete investigations and to convene the many agencies responsible for creating and implementing drug policy, this office could serve as a national model for one of our nation's primary issues. It is critical that such a body utilizes the vast wealth of knowledge on this topic possessed by current and former drug users and consumers of the social services provided as treatment. Thank you very much for the opportunity to testify today. As always we remain available for any further questions that you might have.

Sincerely,

Lisa Schreibersdorf
Executive Director

Brooklyn Defender Services 177 Livingston Street, 7th Floor Brooklyn New York 11201 T (718) 254-0700 F (718) 254-0897 www.bds.org @bklyndefenders

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Dr. Ross McDonald

Address: Correctional Health Services, NYC DOHMH

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Rina Rajagopal, The Bronx Defenders

Address: 360 E 161st St Bx, NY 10451

I represent: The Bronx Defenders (public defenders in the Bx w/ those accused of crimes)

Address: _____

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THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: 6/23/15

(PLEASE PRINT)

Name: Babak Tofighi

Address: 462 1st Ave

I represent: Bellevue Hospital Center

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 748 Res. No. _____

X in favor ☐ in opposition

Date: 6/23/15

(PLEASE PRINT)

Name: Dalia Heller

Address: ~~125~~ dalia.heller@sph.cuny.edu

I represent: ~~Self~~ self

Address: (work at CUNY SPH)

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6/23/15

(PLEASE PRINT)

Name: Adrienne Abbate

Address: 125 St Pauls Ave

I represent: Tackling Youth Substance Abuse

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 748 Res. No. _____

☑ in favor ☐ in opposition

Date: 6/23/15

(PLEASE PRINT)

Name: NOAH DATTNER ESQ.

Address: 630 THIRD AVENUE NYC 10017

I represent: ~~LEGAL COMMENTATOR~~, PRIVATE

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6/23/15

(PLEASE PRINT)

Name: Hillary Kunins

Address: Assistant Commissioner, NYC DOHMH

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6/23/15

(PLEASE PRINT) 6/23/15

Name: Dr. Gary Belkin

Address: Executive Deputy Commissioner, NYC DOHMH

I represent: Assistant Commissioner, NYC DOHMH

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 748 Res. No. _____

☑ in favor ☐ in opposition

Date: 6/23/'15

(PLEASE PRINT)

Name: Irwin Daum Bail

Address: 1025 6th Ave (top floor)

I represent: ACT UP, NMDWC

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Doug Apple

Address: 11 North Pearl Street Albany NY 12207

I represent: ASAP - Alcoholism + Substance Abuse

Address: Providers of NY State

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 748 Res. No. _____

☒ in favor ☐ in opposition

Date: 6/23/2015

(PLEASE PRINT)

Name: Glenda Testone

Address: 397 Greene Ave Brooklyn, NY 11216

I represent: LGBT Community Center NYC

Address: 208 W. 13th St NYC 10011

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 748 Res. No. _____

☑ in favor ☐ in opposition

Date: 6/23/15

(PLEASE PRINT)

Name: Amy Blumsack

Address: 2094 Fulton St Brooklyn NY 11233

I represent: Three-Quarter House Tenant Organizing Project

Address: same as above

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 748 Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: gabriel sayegh (Drug Policy Alliance

Address: 330 7th Avenue 21st floor

I represent: Drug Policy Alliance

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 0748 Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: ANGEL MENDOZA, MD

Address: 1216 Fifth Ave New York NY 10029

I represent: New York Academy of Medicine

Address: 1216 Fifth Ave, NY, NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: John Hellman

Address: 359 W 52nd St New York, NY 10019

I represent: BOOM! Health

Address: 540 East Fordham Rd Bronx, NY 10458

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____
☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Annette GAUDINO

Address: 3635 JOHNSON AVE #4K BRONX 10463

I represent: ACT UP/NY

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____
☑ in favor ☐ in opposition

Date: 7/1/31

(PLEASE PRINT)

Name: Joyce Hirota

Address: 247 Bowery Grove St NY

I represent: St. Ann's Corner of Harm Reduction

Address: 886 Westchester Avenue, Bx NY 10459

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 748 Res. No. _____
☑ in favor ☐ in opposition

Date: June 23rd

(PLEASE PRINT)

Name: Sebastian Solomon

Address: ~~222~~

I represent: Legal Action Center

Address: 225 Varick St, 10014

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: 6/23/2015

(PLEASE PRINT)

Name: Renata Lunn

Address: 104 Adelphi ST Brooklyn NY 11205

I represent: 5 Borough Defenders

Address: 104 Adelphi ST #241 Brooklyn NY 11205

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 06/23/2015

(PLEASE PRINT)

Name: SGT STEVEN SARAO

Address: NYPD

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 06/23/2015

(PLEASE PRINT)

Name: CHIEF BRIAN McCATHY

Address: COMMANDING OFFICER, NARCOTICS DIVISION

I represent: NYPD

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6/23/15

(PLEASE PRINT)

Name: Rose Kerr

Address: 1 Borough Hall 10 Richmond Terrace SI

I represent: Borough President James ODDO

Address: RT B. Hall · 10 Richmond terrace

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6-23-15

(PLEASE PRINT)

Name: Rhonda Ferdinand

Address: 80 Centre St

I represent: Special Narc. Pros.

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6-23-15

(PLEASE PRINT)

Name: Bridget Brennan

Address: 80 Centre St

I represent: Special Narcotics Pros.

Address:

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 748 Res. No. _____

☐ in favor ☐ in opposition

Date: 6-23-15

(PLEASE PRINT)

Name: PHILLIP SAPERIA

Address: 90 BROAD ST. 8TH FLOOR

I represent: THE COALITION OF BEHAVIORAL HEALTH AGENCIES

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 962-A Res. No. _____

☒ in favor ☐ in opposition

Date: 6/23/15

(PLEASE PRINT)

Name: Chris Widelo

Address:

I represent: AARP NYC

Address: 780 3rd Ave NY, NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 748 Res. No. _____

☒ in favor ☐ in opposition

Date: 6/23/15

(PLEASE PRINT)

Name: CAROLINE WATERMAN

Address: 765 PINES LAKE DR. WEST WAYNE NJ

I represent: CompA

Address: NY, NY

Please complete this card and return to the Sergeant-at-Arms