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 Committee on General Welfare jointly with the New York City Council Committee on Mental Health, Disabilities and Addiction

on

Opioid Overdoses Among NYC's Homeless Population

February 27, 2018
250 Broadway, 14th Floor Chambers
New York, NY

Good morning, Chair Levin, Chair Ayala, and members of the committees. I am Dr. Gary Belkin, Executive Deputy Commissioner of the Division of Mental Hygiene at the New York City Department of Health and Mental Hygiene. On behalf of Commissioner Bassett, thank you for the opportunity to testify on the opioid overdose epidemic in New York City.

Nationally, we are in the midst of a drug overdose epidemic driven by both prescription and illicit opioids, primarily heroin and fentanyl. In New York City, drug overdose is the leading cause of unintentional injury death for all New Yorkers, and the leading cause of death among New Yorkers aged 25 to 34. In 2016, there were 1,374 overdose deaths from all drugs in New York City—the highest on record. A New Yorker dies from a drug overdose every seven hours. This is more than the number of deaths from homicides, suicides, and motor vehicle crashes combined. Opioids were involved in more than 80% of all drug overdose deaths in 2016, with the vast majority involving heroin and/or fentanyl.

The opioid crisis affects every neighborhood in New York City, but drug overdose death rates are highest in Staten Island and the South Bronx. If the South Bronx were its own state, it would have the sixth highest drug overdose rate in the nation. Similarly, if Staten Island were its own state, it would be in the top ten. The largest numbers of overdose deaths were among Bronx residents followed by Brooklyn residents.

The overdose epidemic affects all racial groups in New York City. In 2016, the rate of opioids overdose deaths was highest among White New Yorkers, followed closely by Latino New Yorkers, and then Black New Yorkers. However, death rates among Black New Yorkers increased 85% between 2015 and 2016 — more than double the rate increase among White and Latino New Yorkers.

Specific to today's hearing, people who are homeless or unstably housed are at particular risk of drug overdose or harms related to drug use. The homeless account for 1% of New York City population, but in 2016 they accounted for 7% of drug overdose deaths. As you'll soon hear from Commissioner Banks, drug overdose is the leading cause of death among homeless persons.

We have found that the stigma associated with drug use and addiction remains one of the biggest barriers to people seeking help. Especially for low income communities – particularly those of color – that were targeted by the War on Drugs. It is not enough to increase the availability of treatment and social services. We must also break through the stigma, identify community voices and leadership, and provide harm reduction services. This Administration strongly believes in a public health approach to ending overdose deaths; one that works alongside our criminal justice partners, not in conflict.

To address the opioid epidemic, the Administration is undertaking a number of new and expanded initiatives that focus on both the geographic areas and populations most severely affected—including people who are homeless or unstably housed. In March 2017, the Mayor launched *HealingNYC*: a comprehensive response to the opioid overdose epidemic. *HealingNYC*, building off the key principles for public health action for mental health of *ThriveNYC*, aims to

reduce opioid-related overdose death by 35 percent over five years by focusing efforts on four goals. These are:

- **Prevent opioid overdose deaths** by distributing naloxone—a life-saving drug that can reverse opioid overdose—to communities and social networks where risk of drug overdose is highest;

- **Prevent opioid misuse and addiction** by investing in prevention and education, as well as by providing counseling and linkages to care for individuals who use opioids or who recently experienced an overdose;

- **Protect New Yorkers with effective drug treatment** by making investments into our health care system in order to increase capacity to provide medications for addiction treatment, which are the most effective form of opioid use disorder treatments; and

- **Protect New Yorkers by reducing the supply of dangerous opioids** through data-driven law enforcement strategies.

The Health Department is leading the implementation of seven of the twelve strategies outlined in *HealingNYC*. A few of our achievements to date include:

- Distributed over 45,000 naloxone kits to registered Opioid Overdose Prevention Programs as of January 31, 2018, putting us ahead of schedule to meet our goal of 100,000 naloxone kits distributed per year.

- Launched Relay, a nonfatal overdose response system, in five hospital emergency departments. Relay deploys trained peer advocates into hospitals where they meet with individuals immediately following an overdose to provide naloxone, overdose risk reduction support, and connections to other services and care.

- Trained and provided technical assistance to over 630 prescribers on buprenorphine. Along with methadone, buprenorphine is the most effective treatment for opioid use disorder and protects people from dying of overdose.

- Awarded funding to seven organizations to implement the Buprenorphine Nurse Care Manager initiative, which will expand access to buprenorphine in primary care settings across 14 individual geographic sites. These sites are all Federally Qualified Health Centers in safety net settings serving people who are public insurance beneficiaries, uninsured or underinsured in all five boroughs. When fully operational, these initiatives will have the capacity to serve over 2,500 patients.

- And, we launched a new outreach team called Rapid Assessment and Response, which allows us to use real-time data to identify neighborhoods experiencing adverse health consequences associated with drug use. To date, the team has been deployed to five New York City neighborhoods where they have educated people who use drugs, substance use treatment programs, and other community members on overdose prevention and harm

reduction strategies. These neighborhoods include Crotona/Tremont, High Bridge/Morrisania, Hunts Point/Mott Haven, Lower East Side/Union Square, and East Harlem.

The Health Department is working closely with many of our sister agencies on this important work – including the Department of Social Services. Because of the high risk of overdose among people who are homeless or unstably housed, we have partnered with the Department of Homeless Services and community-based organizations on several key *HealingNYC* initiatives that address this population. Commissioner Banks will be addressing these efforts in his testimony.

Turning now to the suite of bills that are being heard pre-considered today. The Health Department supports the intent of this legislation. We share the Council's goals to ensure the distribution of naloxone and provide adequate training and education to New Yorkers on this important public health issue. Much of this work is already underway through *HealingNYC* and we look forward to discussing with you further.

For example, the Health Department has been providing free naloxone to syringe exchange programs since 2009. Since then over 42,000 naloxone kits have been distributed through these lifesaving programs. Syringe exchange programs have a long history in New York City and are on the front line of this epidemic. I am hopeful that you will hear from some of them today. We trust in the expertise of syringe exchange program leadership to train their own staff to distribute naloxone. In fact this has been one of the core functions of syringe exchange programs in New York City for the past decade.

In addition, our "I Saved a Life" citywide media campaign is currently running on social media, in transit centers, local newspapers, subway cars, and bus shelters throughout the City. The campaign features stories of six heroic New Yorkers who have used naloxone to save the lives of family members, friends, neighbors and others. It also directs the public to call 311 or to our website for more information on where to get naloxone as well as other resources.

We look forward to discussing the legislation with the City Council further.

I want to thank the Mayor and First Lady for their unprecedented support to this topic. And thank you to Speaker Johnson, Chairs Levin and Ayala and the members here today for your partnership and voices. Together we will change the course of the opioid epidemic.

I am happy to take your questions.

Human Resources Administration
Department of Homeless Services

Department of Social Services

Testimony of Steven Banks, Commissioner
New York City Department of Social Services

Oversight Hearing - Opioid Overdoses Among NYC's Homeless Population
New York City Council's Committee on General Welfare
February 27, 2017

Good afternoon. Thank you Chairs Levin and Ayala and members of the City Council's General Welfare Committee and Committee on Mental Health, Disabilities, and Addiction for inviting us to testify and respond to committee questions today. My name is Steven Banks, I am the Commissioner of the New York City Department of Social Services (DSS) and in this capacity oversee the Human Resources Administration (HRA) and the Department of Social Service (DHS). I am also joined by DHS's Medical Director, Dr. Fabienne Laraque.

Before beginning my testimony, I would like to take a moment to welcome the new members of the Council as well as welcome those members new to these committees. I look forward to our partnership as we work together to improve the lives of low-income and vulnerable New Yorkers.

An essential way to address homelessness and its associated traumas is prevention. The Administration has made unprecedented investments to address homelessness and the economic insecurity felt by low-income New Yorkers, many of whom rely on HRA and DHS programs, benefits, and services. Since FY14 we have enhanced our services and assistance, including these initiatives:

- **Created and implemented rental assistance programs** and restored Section 8 and New York City Housing Authority priorities, which though September 2017 have helped over 71,000 children and adults move out of, or avert entry into, shelter;
- **Established the Homelessness Prevention Administration** within HRA and provided emergency rental arrears assistance to 217,000 households through FY17;
- Launched the **largest municipal commitment *ever* to build and expand supportive housing** by committing to developing 15,000 new units in 15 years;
- Aggressively **expanded free legal assistance** for New Yorkers facing eviction, harassment by unscrupulous landlords and other displacement pressures by increasing funding for legal services for tenants from $6 million in FY13 to $77 million by FY18 – a 12-fold increase, providing legal assistance to over 180,000 New Yorkers. And just last month the Mayor

announced that residential evictions by marshals dropped by 27 percent from 2013 to 2017, with more than 70,000 New Yorkers being able to stay in their homes during that time;

- And began implementation of **universal access to legal services** for all New York City tenants facing eviction in Housing Court and in NYCHA termination of tenancy proceedings, which at full implementation in FY22 will serve 400,000 New Yorkers annually with $155 million in funding;

The major investments made by this Administration over the last four years have resulted in the shelter census remaining roughly flat year over year for the first time in more than a decade.

While 70% of shelter residents are families, today I will largely focus my testimony on our shelter system for single adults where we have seen increased opioid use and we have targeted our prevention efforts.

Reforms

Following Mayor de Blasio's 90-day review of homeless services, DHS has been implementing a series of 46 reforms aimed at addressing challenges that developed over many decades in order to address gaps in service delivery, inadequate programming, and the safety and security of shelter clients. These efforts include significant improvements in how DHS delivers and ensures health care for those seeking or residing in shelter, recognizing that vulnerable and homeless New Yorkers navigate a myriad of challenges, which include a greater likelihood of medical illness, mental health and substance use issues, and poor health outcomes. The transient and stressful nature of homelessness can compound health issues for these individuals who are often disconnected from medical and behavioral healthcare.

In November 2016 DHS provided comprehensive testimony before the General Welfare Committee in a two-part oversight hearing on Medical and Behavioral Health Services in the DHS shelter system. The testimony presented a detailed accounting of the agency's broader efforts to reform Medical and Behavioral Health Services in the DHS shelter system.

Reforms as they relate to this hearing topic include adding appropriately licensed and experienced clinical staff to the DHS Office of the Medical Director (OMD). These individuals assist the Medical Director in designing evidence-based standards of care, planning and implementing newly expanded program monitoring and oversight, and will conduct evaluations of existing programs and services. Before the fall of 2016, in addition to the existing licensed Medical Director, there was one licensed social worker, one administrator/deputy to the Medical Director, three administrative/clerical staff and one staff analyst in the DHS Office of the Medical Director. As part of the findings of the 90-day review, we added experienced and

qualified licensed clinical staff. The Medical Director position was filled in September 2016 with the selection of Dr. Laraque, a physician experienced in public health, and additional, newly created positions include: a Director of Mental Health Services with a PhD in Clinical Psychology, an Administrative Nutritionist and Registered Dietician, a Senior Executive Director for Program Planning and Evaluation with a Masters in Public Health (MPH) and PhD in Health Systems Research, a Quality Management Coordinator with an MPH and PhD in Public Health Nutrition, and two additional staff with MPH degrees. This more robust staffing allows DHS to better respond to those in shelter with medical and behavioral health needs and to design, plan, and oversee such services. Additionally, through funding provided through Healing NYC, the Medical Director's office oversees two Opioid Overdose Prevention Coordinators, and within HRA's Office of Customized Assistance there is an additional Opioid Overdose Prevention Coordinator.

Further, we are improving the hospital and nursing home shelter or Safe Haven referral process. This includes clarifying conditions which make a person medically inappropriate for any DHS site and modernizing the referral process. The institutional referral procedure was revised and a new fillable referral form was created.

We are also working with DOHMH to provide Mental Health First Aid training to non-clinical staff at DHS facilities. This training will equip staff with tools to better support clients with mental health and substance use disorders, and includes our continued naloxone administration training.

And as a part of these reforms, in September 2016, DHS strengthened its long-standing naloxone training practice by promulgating an agency policy requiring staff from all shelters to participate in comprehensive naloxone trainings to ensure shelters across the city are equipped to administer the life-saving drug. To date, all providers have participated in the training and all shelters now have staff equipped to administer naloxone, including frontline staff, security staff, and social service staff at shelters for both adults and families. Staff on our street outreach teams and at dedicated facilities for street homeless individuals such as Safe Havens and drop-in centers have also been trained. In early 2017, DHS became an independent state-certified Opioid Overdose Prevention Program (OOPP), led by the Office of the Medical Director. The Medical Director is also the clinical director of the OOPP and the existing licensed social worker is the OOPP Program Director. The naloxone administration training program uses a train-the-trainer model, thereby multiplying the impact of the program by establishing the existence of at least one trainer per site able to train other staff and clients. And as a result of a partnership with the Council and Councilmember Ritchie Torres, this policy is now codified in law, LL225 of 2017. Later in this testimony, we will update you on the numbers of clients and staff who have been trained so far. In discussing substance use among our homeless population

it is critical to note that addiction more often than not precedes the experience of homelessness and as was discussed by our colleagues at DOHMH, like substance misuse in general, the misuse of opioids cuts across age, race, ethnicity, class and neighborhood.

Intake and Assessment

Both our DHS system and HRA's HIV/AIDS Services Administration (HASA) have screening services for clients with medical and/or behavioral health conditions.

For single adult clients seeking DHS services, intake occurs at three locations: for men at the 30th Street shelter in Manhattan and for women at the Franklin shelter in the Bronx or the HELP Women's Shelter in Brooklyn. Recently, we modified our intake questions so as to obtain additional, useful information from clients. We ask: "are you currently using any illegal drugs or prescription medication for non-medical reasons" and we added three questions on history of overdose. Following intake, clients enter assessment shelters, where we use two validated drug and alcohol screening tools: 1) AUDIT-C (for alcohol use disorder identification) and 2) DAST-10 (for illicit and prescription drug misuse).

Within DHS there are six assessment shelters which require that shelter medical providers offer each client the opportunity to engage in a medical history and physical, as well as a psychiatric assessment, within five to ten days, respectively, of the client's arrival – recognizing entry into the DHS system may be the first contact a client has had with health care systems in several years.

The medical history and physical includes routine laboratory testing and preventive care, including Pap smears, screening for colon and prostate cancer, and referral for mammograms. The client is also screened for communicable or infectious diseases, such as tuberculosis and HIV. The psychiatric assessment includes, but is not limited to, any chief complaint, history of any present illness, past psychiatric history, substance use history, medications, family and social history, and a full mental status examination. In addition to the medical, behavioral and social health assessments, each client's financial and housing history are obtained at intake.

HASA clients must meet eligibility criteria for the program, including applying and being found eligible for cash assistance. All clients applying or recertifying for cash assistance who self-identify or appear to have a substance use history are referred for a substance use assessment by an on-site Credentialed Alcoholism and Substance Abuse Counselor (CASAC) and are offered a referral for the appropriate treatment and/or harm reduction services as needed. We use an electronic instrument that is based upon the Addiction Severity Index that assesses client functioning with respect to substance use and treatment history as well as medical, mental health, employment, legal, and housing issues. It also includes a section to assess a client's

motivation towards treatment and has decision support logic that helps the CASAC make determinations and standardizes determinations among CASACs.

Connections to Care

Both DHS and HASA work to meet clients where they are at, an important tenant of a harm reduction and trauma-informed approach to care. Using peer-reviewed, evidence-based research we continue our work to engage clients and connect them to appropriate care both on and offsite.

Among the facilities that constitute the DHS portfolio, 47 single adult shelters have access to on-site health care. The other facilities within the DHS portfolio for single adults secure and maintain linkage agreements to neighborhood and community health care providers to which clients are referred. This continuum of care and presence of options is important as some clients will choose to utilize offsite services as a result of being previously connected to care or to maintain their privacy. As with so much of our work within the shelter system, we recognize that a one-size fits all approach is not always going to work and that the availability of choice ultimately benefits our clients.

At DHS shelters there are opportunities for clients to participate in a variety of behavioral health services, including psychiatric assessment, ongoing medication management, individual therapy, and group therapy related to mental illness and substance use as well as psychoeducation related to trauma. For clients with co-occurring mental health and substance use disorders, the medical provider will work to first stabilize the client and then provide supportive services including harm reduction and health promotion to reduce the frequency and duration of both drug/alcohol and/or psychiatric hospitalizations.

As mentioned earlier, DHS, through the OMD, is an Independent State Certified Opioid Overdose Prevention Program. DHS is in the process of finalizing its written Substance Use and Overdose Response Policy. This policy has been developed by the DHS Medical Director and her team and will formalize a series of robust action steps we are taking to address opioid overdose deaths and substance use in shelter. We are also developing a comprehensive overdose response and substance use Toolkit for shelter staff that includes tools for Overdose Response Trainers and Overdose Prevention Champions, as well as tools for staff trained to administer naloxone, educational materials, and resources for clients. Overdose Prevention Champions are being identified at shelters and other DHS sites to serve as the lead trainer and coordinator for all overdose prevention and response activities at their site.

This Substance Use and Overdose Response Policy will cover topics related to substance use and overdose prevention, overdose response and naloxone administration, how to obtain naloxone, training policy, training targets, client engagement following non-fatal overdoses

utilizing proven harm reduction approaches, resources for substance use prevention and harm reduction, and reporting information. For example, the policy will focus on inquiring about whether linkages to substance use treatment and Medication Assisted Treatment (MAT) were made by hospital staff, following up if such connections have not been made, and monitoring if connection to care is refused.

Currently, at DHS, the OMD follows up on every overdose to require shelter providers to link the client to drug treatment programs, counseling, and harm reduction programs. Additionally providers will conduct a refresher naloxone administration training and a client naloxone dispensing drive. The shelter director is required to offer naloxone administration training to the affected clients, his or her roommates and friends. DHS also educates providers on harm reduction and on the availability of medication assisted treatment. Shelter staff members are trained to follow up on non-fatal overdoses and offer and link clients to substance use services. Shelter providers and onsite clinical providers are expected to refer clients who have a substance use disorder, to drug treatment programs, regardless of whether they've had an overdose.

Thorough its Medical Director, HRA is also an Independent State Certified Opioid Overdose Prevention Program. All HASA clients applying or recertifying for cash assistance who self-identify or appear to have a substance use history are referred for a substance use assessment by an on-site CASAC. Clients who are identified as having a substance use disorder are offered a referral for the appropriate treatment and/or harm reduction as needed. Those identified as using opioids or in contact with other clients using opioids will be offered responder training and provided naloxone.

Following the implementation of our resident training plan pursuant to Local Law 225 of 2017, at intake, all HASA clients will be offered training as a responder. Clients can opt-out of this training. Following training, each trained responder will be given a naloxone kit. HRA's plan will ensure a sufficient supply of kits and proper storage. This approach is the result of meeting with advocates and hearing directly from impacted individuals concerning implementing a training plan that decreases stigma – we believe this opt-out approach at the front door is just that.

All HASA contracted transitional housing programs are required to offer referrals for appropriate substance use treatment to its residents. Commercial emergency housing operators are required to have linkages to community-based organizations providing services such as treatment referrals and harm reduction including naloxone responder training. Additionally, the HASA program is in discussion with VOCAL-NY, the Harm Reduction Coalition, New York Harm Reduction Educators, and other community-based organizations to formalize partnerships to train residents to administer Naloxone with a focus on our SRO sites.

DHS, via its medical office, is partnering with all the medical clinics, Federally Qualified Health Centers, and providers of healthcare for homeless New Yorkers who serve the shelter system, meeting monthly to plan programs, exchange ideas and brainstorm on best ideas to meet the numerous challenges of the clients and settings. The DHS OMD additionally has begun to meet with the independent state-certified OOPP that serve shelters. The DHS OMD also actively participates in RxStat, a citywide, multiagency task force on opioid overdoses and is represented on the Municipal Drug Advisory Council. In addition, the DHS OMD has started a mortality review committee, where deaths that meet certain criteria are examined. A City Medical Examiner participates on this Committee.

Overdose and Naloxone

Opioid misuse continues to be a national and citywide challenge. In FY17, there were 1,461 overdose deaths citywide compared to 85 overdose deaths among homeless persons, including both street homeless individuals and shelter residents. Drug overdose has been the leading cause of death among individuals experiencing homelessness since 2014.

In FY17, overdose deaths comprised the largest proportion of homeless deaths, with 85 deaths (27%). Overall, at least 311 homeless people died in FY17 and the leading cause of death among them was drug use, with 103 deaths. Of those, 85 were from drug overdoses and the remaining 18 were from chronic drug use. Of these 85 deaths, 26 occurred in shelter—up from the 20 that occurred in shelter in FY16; 36 occurred in a hospital—up from the 13 that occurred in a hospital in FY16; and 24 occurred outdoors/other—up from the 18 that occurred outdoors/other in FY16. More than three-quarters of the overdose deaths in shelter were opioid overdoses, according to toxicology reports received from the Office of the Chief Medical Examiner by the OMD.

In CY16, within DHS facilities, DHS staff administered naloxone 112 times. In CY17, DHS staff administered it 236 times, saving 214 lives by reversing those overdoses. This data shows that 91% of clients who experienced overdoses in shelter were saved with Naloxone administration in 2017, with an increase to 94% in the last quarter of CY17.

Our policies to respond to the prevalence of substance use and substance use disorders among our shelter population do not end at connecting clients to appropriate care, we are also working to prevent overdoses through the utilization of additional harm reduction approaches.

Building on nearly a decade of work we continue to train staff, security and residents. Beginning in 2009 DHS Peace officers have been trained in Naloxone administration during their basic training. Since 2014, we've partnered with NYU Medical School to train clients at the 30th Street intake shelter, with more than 120 clients trained in the last calendar year alone. And in the fall of 2016, DHS through the OMD implemented a DHS policy requiring at least one trained staff

member per shift to be present onsite at all shelters. And thanks to the partnership of this Council and advocates, in accordance with the new local law sponsored by Councilmember Torres, we are finalizing a plan to train shelter residents within DHS shelters in naloxone administration.

In August 2017, DHS OMD launched a new initiative to identify and train opioid overdose prevention Champions as a lead trainer and coordinator at each shelter. To date, 117 Champions have been identified and trained. OMD conducts trainings for Champions each month.

In 2017, 2,323 DHS staff, including shelter staff, Champions and DHS Peace Officers were trained, and 2,861 naloxone kits were dispensed. And an additional 310 outreach staff members have been trained to administer Naloxone. A total of 777 clients have also been trained so far by DHS, DOHMH and NYU medical students. In all, 265 training sessions have been held.

Within HASA and HRA, all CASACS are trained in Naloxone administration and HRA as well as DHS will be submitting a plan to fully implement resident training pursuant to Local Law 225 of 2017.

Naloxone is just one element of our multipronged approach to addressing the opioid epidemic. We recognize addiction as a medical condition and we are working to change and challenge stigma, especially among these most vulnerable New Yorkers. We are working to ensure that clients know that they can speak openly about their substance use to staff and encourage clients to disclose to case managers so that connections to care can be made. Providers often will utilize house meetings to disseminate information to clients about recognizing overdoses and the availability of naloxone as well as training schedules. We also recognize the value of our advocate community and peer leaders and are working in partnership with them to disseminate information about harm reduction and safer using practices.

Recognizing that clients may be using substances, we communicate with clients about how taking breaks or missing doses can lower their tolerance and make them more susceptible to overdose. We also provide information about the danger of mixing opioids with other medications, or drugs, especially benzodiazepines, alcohol, or cocaine. Information is also provided on the dangers of Fentanyl and that the drug is a much stronger opioid that may require additional doses of naloxone to reverse an overdose. We also inform clients that Fentanyl is not only found in heroin, but also cocaine and counterfeit street pills that can't always be detected by sight, taste or smell. We provide this information and warning because clients may not always be aware that using Fentanyl makes the risk of overdose increasingly likely. We also provide Fentanyl warning posters in shelters, safe havens and drop-in centers.

Security in Shelter

Working in partnership with the NYPD, DHS Peace Officers received and will continue to receive enhanced training to handle a mental health crisis. This enhanced training is intended to give DHS Peace Officers the skills to identify the use of controlled substances (both illegal and legal). DHSPD first responders are on the frontlines of fighting this epidemic. Since 2009, as described earlier, DHSPD officers have been trained in naloxone administration. DHS Peace Officers and DHS-funded private security inspect restrooms regularly to ensure the safety of our clients.

Continued Partnership

We are in the midst of a crisis, and by utilizing evidence-based, compassionate, client- centered responses we are seeing positive shifts in how we identify and respond to substance use and the presence of clients with substance use disorders in our shelter system. We are seeing an increase in naloxone administration as a result of increased training. We are reviewing and implementing new policies and procedures informed by data and best practices and we look forward to partnering with the Council as we continue our response to this terrible epidemic and its devastating impacts. Thank you for this opportunity to testify and I welcome your questions.

"My neighbor's boyfriend knocked on my door at 2am and told me she was overdosing. I got to the apartment and found her passed out. I gave her naloxone and in a few minutes she started coming through. It was lucky I was home and had naloxone to save her."

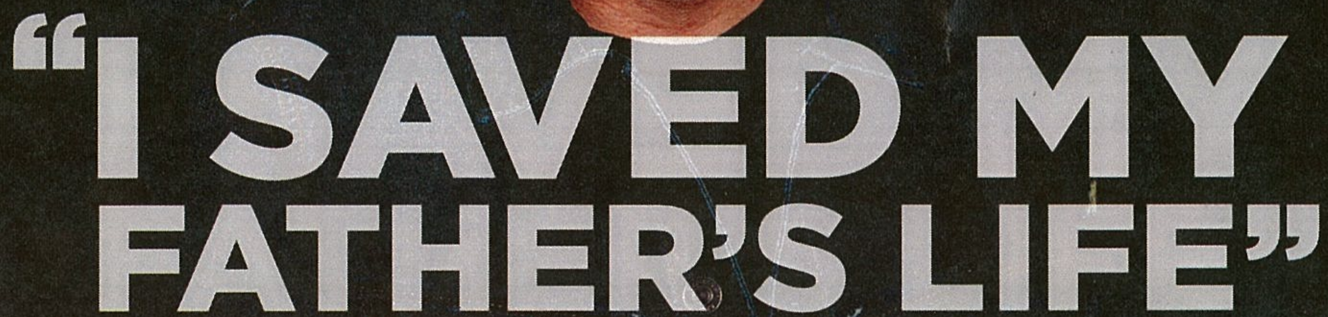
~Billy, Manhattan

NALOXONE is an emergency medicine that prevents overdose death from prescription painkillers and heroin.

To find out more about naloxone and where to get it, call 311 or visit nyc.gov/health/naloxone.

If you need help or referral to treatment, call 888-NYC-Well

Thrive NYC | NYC Health



"I got trained in overdose prevention after I spent 4 years in the army. One night at home, my dad fell out of bed. He wasn't breathing and he had turned blue. I knew he had used heroin before, I grabbed my naloxone gave it to him. After a few minutes, he started breathing again and he came out of it. That was a life-changing moment for both of us."

~Brian, Queens

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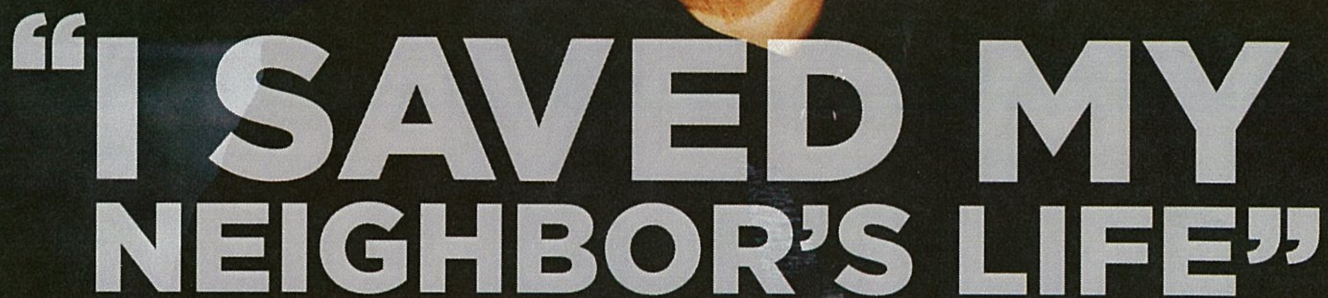

"I took a different way home from work one night and found my neighbor on the ground. He was blue and not breathing. I gave him naloxone, which I always carry, and in 2 minutes he was breathing again. As we waited for the ambulance, it hit me that if I hadn't come home this way, his family would be getting a very different phone call that night."

~Evelyn, Manhattan

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Thrive NYC | NYC Health

"I've had one best friend I could always rely on. A few years ago, we were hanging out. He looked like he was falling asleep. I shook him to wake him up but couldn't. He was overdosing. I gave him a dose of naloxone and he came back. Today, I still have my best friend."

~Shantae, Bronx

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"My fiancé was addicted to heroin and prescription pills. One night I came home from holiday shopping, and found him lying on the bathroom floor. His lips were blue, his skin was gray. I called 911, grabbed my naloxone, and gave him a dose. If I didn't have naloxone, he would have died that night."

~Theresa, Manhattan

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Thrive NYC

NYC Health

"I found my friend slumped on her bed turning blue. She couldn't breathe. I ran to get my naloxone and gave it to her. I thought she was dead. When she came to, she didn't know what had happened or why I was crying. I'm glad I had naloxone. It gave her a second chance."

~*Will, Brooklyn*

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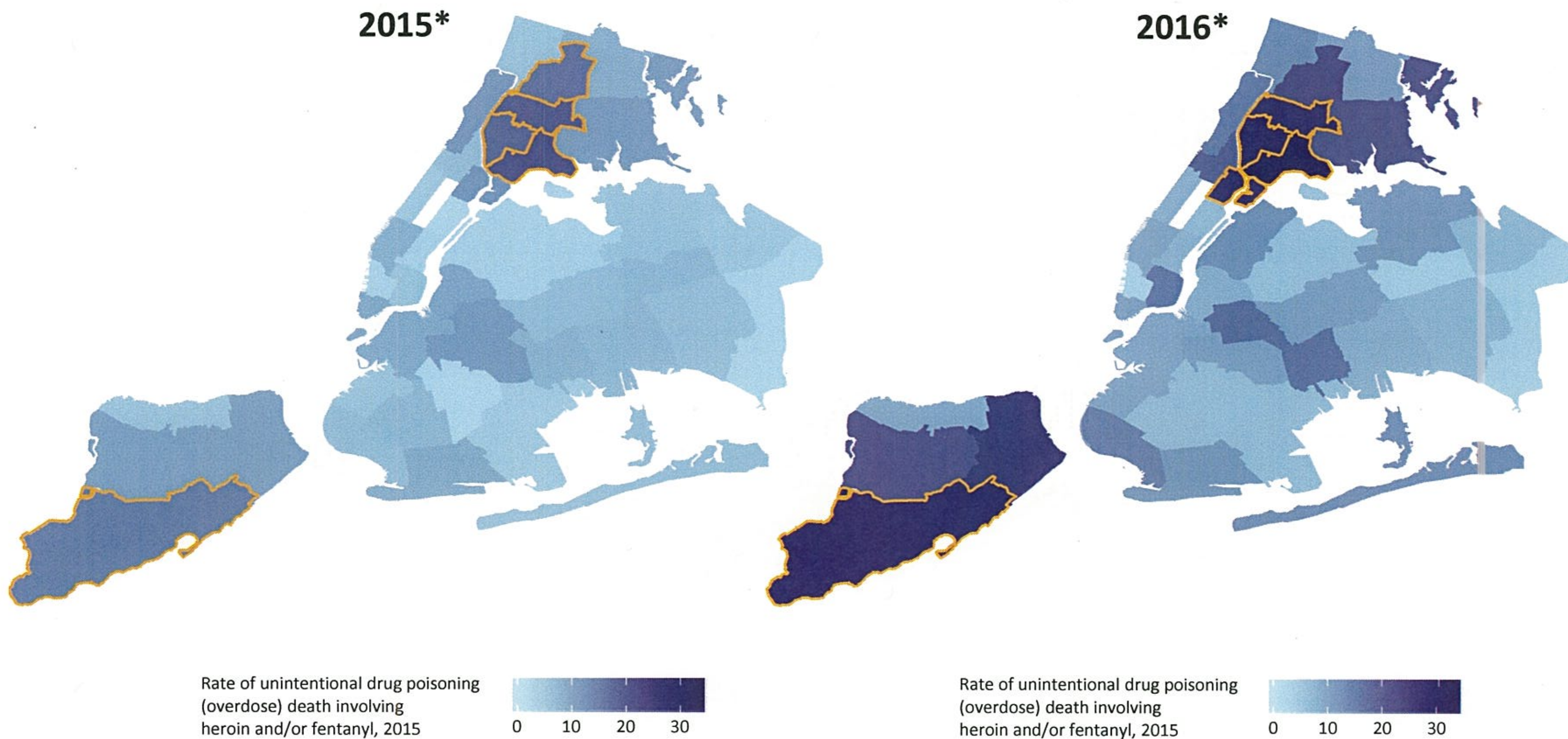
Thrive NYC | NYC Health

Map 2. Top five New York City neighborhoods: Rates of unintentional drug poisoning (overdose) involving heroin and/or fentanyl by neighborhood^ of residence, 2015 and 2016*

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 2000-2014 updated October 2015. Analysis by Health Department's Bureau of Alcohol and Drug Use Prevention, Care and Treatment.



*Data for 2015 and 2016 are provisional and subject to change.

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

Testimony of
Coalition for the Homeless
And
The Legal Aid Society

On

Oversight: Opioid Overdoses Among NYC's Homeless Population

Presented before

New York City Council
Committee on General Welfare
Committee on Mental Health, Disabilities and Addiction

Giselle Routhier
Policy Director
Coalition for the Homeless

Josh Goldfein
Staff Attorney
The Legal Aid Society

February 27, 2018

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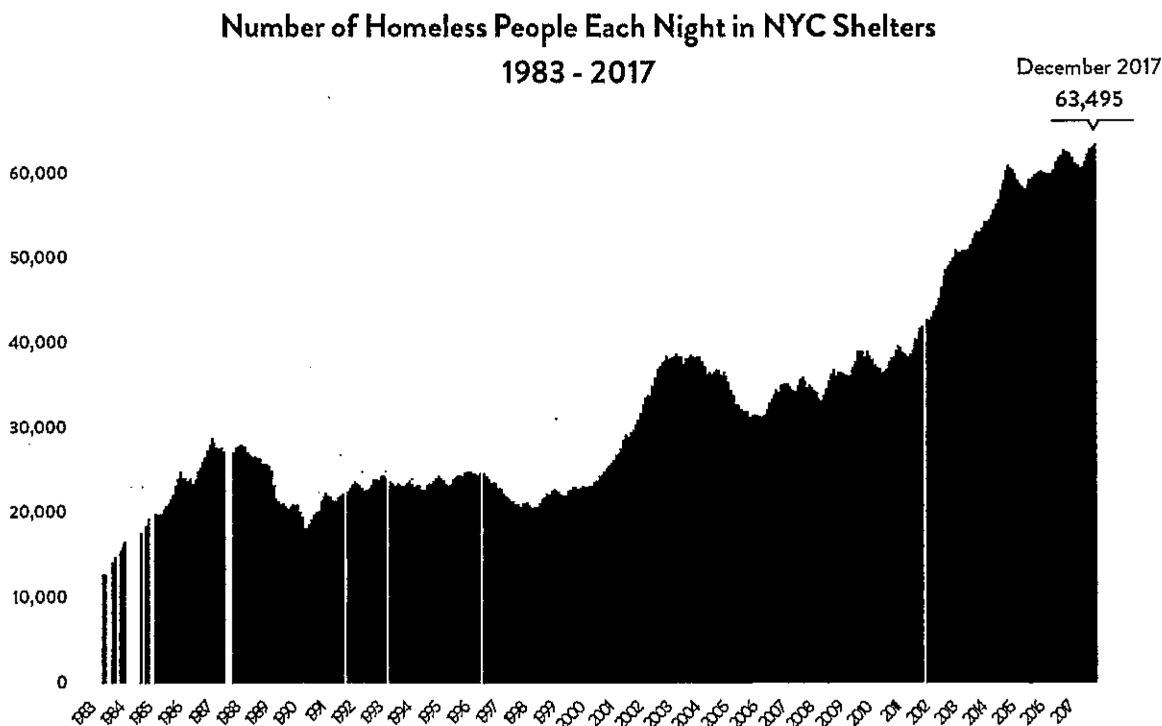
The Coalition for the Homeless and The Legal Aid Society welcome this opportunity to testify before the New York City Council Committees on General Welfare and Mental Health, Disabilities and Addiction regarding opioid overdoses among NYC's homeless population.

Record Homelessness in NYC

New York City is in the midst of the worst homelessness crisis since the Great Depression. Each night, more than 63,000 New Yorkers sleep in City shelters. Over the course of fiscal year 2017, a record 129,803 unique individuals spent some time in a shelter, including more than 45,000 children. Thousands of additional men and women bed down on the streets or in the subways.



Source: NYC Department of Homeless Services and Human Resource Administration; LL37 Reports
Data include individuals in veteran's shelters, Safe Havens, stabilization beds, and HPD emergency shelters.

The Opioid Epidemic

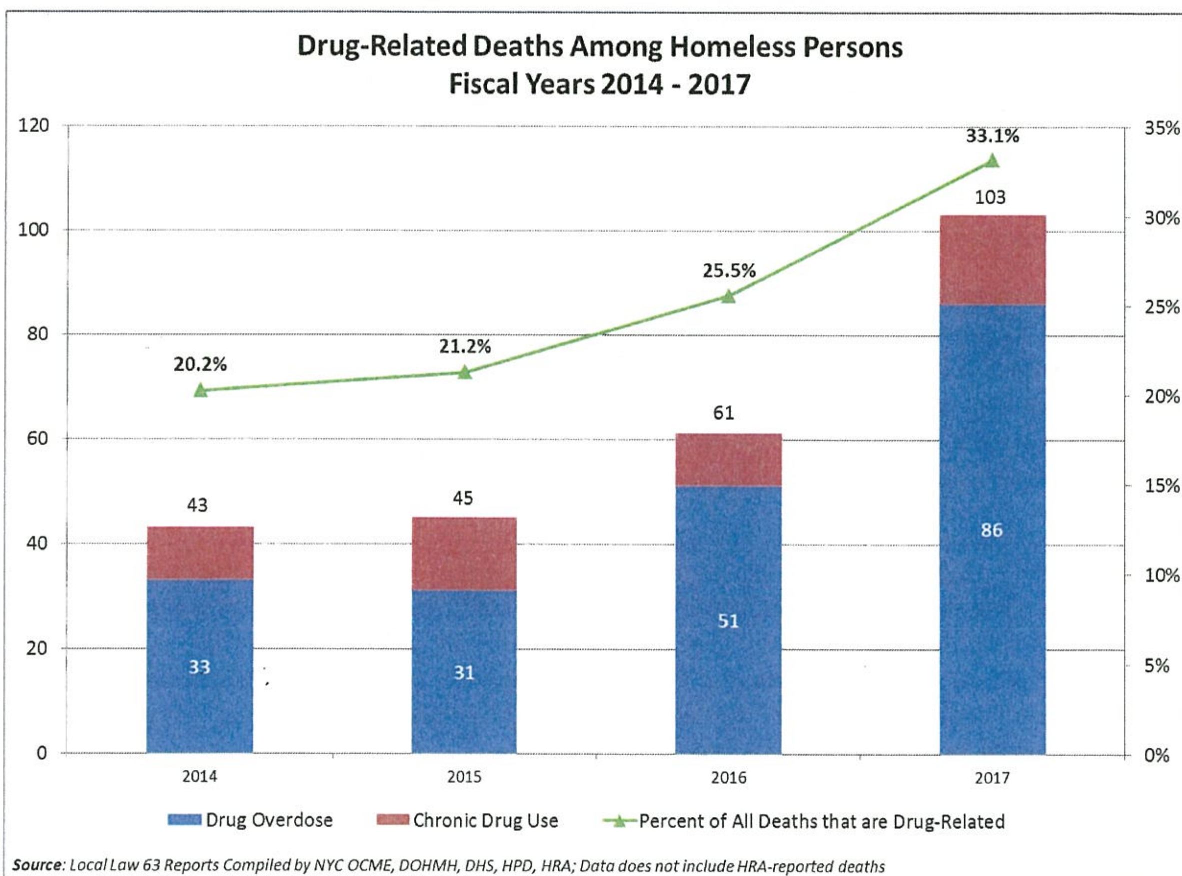
At the same time, New York City and localities across the country are also grappling with a rapidly worsening opioid epidemic. The NYC Department of Health and Mental Hygiene estimates that someone dies of a drug overdose every seven hours in New York City, and more New Yorkers die as a result of drug overdoses than the number dying as a result of homicides, suicides, and motor vehicle crashes combined.[1] According to provisional data, there were 1,068 overdose deaths in New York City between January and September 2017 – an 81 percent increase from the 590 overdoses during the same period in 2014.[2]

[1] https://www1.nyc.gov/assets/doh/downloads/pdf/basas/provisional-overdose-report-third-quarter.pdf
[2] Ibid.

The rising availability of the potent opioid fentanyl has made the crisis even deadlier. NYC DOHMH estimates that fentanyl is implicated in half of all overdose deaths.[3] People struggling with addiction often do not realize that they have injected fentanyl until it is too late, and opioid antagonists such as naloxone are at times not strong enough to reverse an overdose involving fentanyl.

The Opioid Crisis' Impact on Homeless New Yorkers

The opioid crisis has not left any population untouched, including homeless New Yorkers. Drug-related deaths ranked as the leading cause of death among homeless men for the past three fiscal years, and among homeless women for the past five fiscal years.[4] The number of drug overdose deaths increased from 51 in fiscal year 2016 to 86 in fiscal year 2017 – a nearly 70 percent increase. An additional 17 deaths in fiscal year 2017 were categorized as a result of chronic drug use. One in three reported deaths of homeless people were drug-related in fiscal year 2017, up from one in five in 2014.[5] In fiscal year 2017, 64 of the drug-related deaths were among sheltered homeless people, and 39 were among unsheltered homeless people.[6]



Source: Local Law 63 Reports Compiled by NYC OCME, DOHMH, DHS, HPD, HRA; Data does not include HRA-reported deaths

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[3] Ibid.

[4] Twelfth Annual Report on Homeless Deaths (July 1, 2016 – June 30, 2017), Local Law 63 (2005).

[5] Ibid.

[6] Ibid.

The Department of Homeless Services reported 81 overdose incidents (including non-fatal incidents) in the first four months of fiscal year 2018, compared with 12 within the same period in fiscal year 2017.[7] These heartbreaking statistics underscore the urgent need for much more effective access to treatment and harm reduction modalities.

How to Combat the Crisis

We commend the City Council for the successful passage of Intro. 1443 last session, which requires the Department of Social Services and the Department of Homeless Services to offer training to staff and shelter clients in administering lifesaving opioid antagonists. Among the preconsidered introductions before the Council today, we particularly support Intro. 1430, which requires the Department of Social Services and the Department of Homeless Services to refer individuals receiving opioid antagonists for additional services. This bill has the potential to help disrupt the cycle of addiction and overdoses that plagues too many of our clients.

However, the unavailability of treatment and harm reduction services remains a barrier to successful engagement among homeless individuals. It is vital that a sufficient number of providers in licensed settings be trained to prescribe buprenorphine. The City should also encourage more medical professionals serving in community-based settings to receive the necessary training. The City and State should partner to increase community-based care options, with appropriate licensing structures, so clients have ample access to medication-assisted treatment. Clients who need or are prescribed buprenorphine or other opioid treatment medication should receive shelter placements consistent with this need, and not be assigned to shelters with abstinence requirements that disallow medication-based treatment.

Meanwhile, we continue to see the NYPD using counter-productive tactics. Criminal possession of a controlled substance in the 7th degree (for very small amounts) is still one of the 5 most frequently charged crimes, meaning that police are still much more often arresting people for drug possession than diverting them to treatment centers. For example, Legal Aid staff have observed a trend in Brooklyn where officers arrest people coming and going from a methadone clinic to get easy collars.

This approach will not be successful. The sheer magnitude of the opioid crisis demands that the City take bold but productive steps. We recommend that the City reinforce effective harm reduction strategies, such as opioid antagonist training and distribution, syringe exchanges, and fentanyl testing. We also encourage the City and State to license and open supervised injection facilities to reduce the risk of death among people using opioids. Initiatives to reduce opioid use in the shelter system should use peer support networks to help establish and foster the personal connections needed to enhance client safety.

We applaud the City Council for its attention to this important issue and commitment to helping New Yorkers in need. We thank you for the opportunity to testify and look forward to partnering on effective solutions to address the crisis and save lives.

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[7] http://www1.nyc.gov/assets/operations/downloads/pdf/pmmr2018/2018_pmmr.pdf

About The Legal Aid Society and Coalition for the Homeless

The Legal Aid Society: The Legal Aid Society, the nation's oldest and largest not-for-profit legal services organization, is more than a law firm for clients who cannot afford to pay for counsel. It is an indispensable component of the legal, social, and economic fabric of New York City – passionately advocating for low-income individuals and families across a variety of civil, criminal and juvenile rights matters, while also fighting for legal reform.

The Legal Aid Society has performed this role in City, State and federal courts since 1876. It does so by capitalizing on the diverse expertise, experience, and capabilities of more than 1,100 lawyers, working with some 800 social workers, investigators, paralegals and support and administrative staff. Through a network of borough, neighborhood, and courthouse offices in 26 locations in New York City, the Society provides comprehensive legal services in all five boroughs of New York City for clients who cannot afford to pay for private counsel.

The Society's legal program operates three major practices — Civil, Criminal and Juvenile Rights — and receives volunteer help from law firms, corporate law departments and expert consultants that is coordinated by the Society's Pro Bono program. With its annual caseload of more than 300,000 legal matters, The Legal Aid Society takes on more cases for more clients than any other legal services organization in the United States. And it brings a depth and breadth of perspective that is unmatched in the legal profession.

The Legal Aid Society's unique value is an ability to go beyond any one case to create more equitable outcomes for individuals and broader, more powerful systemic change for society as a whole. In addition to the annual caseload of 300,000 individual cases and legal matters, the Society's law reform representation for clients benefits more than 1.7 million low-income families and individuals in New York City and the landmark rulings in many of these cases have a State-wide and national impact.

The Legal Aid Society is uniquely positioned to speak on issues of law and policy as they relate to New York City's runaway and homeless youth. Each of our three practice areas routinely interacts with the RHY population. The Legal Aid Society is counsel to the Coalition for the Homeless and for homeless women and men in the *Callahan* and *Eldredge* cases. The Legal Aid Society is also counsel in the *McCain/Boston* litigation in which a final judgment requires the provision of lawful shelter to homeless families. Recently Legal Aid, along with institutional plaintiffs Coalition for the Homeless and Center for Independence of the Disabled – NY, settled *Butler v. City of New York* on behalf of all disabled New Yorkers experiencing homelessness. Legal Aid's Juvenile Rights Practice provides comprehensive representation as attorneys for children who appear before the New York City Family Court in abuse, neglect, juvenile delinquency, and other proceedings affecting children's rights and welfare. Last year, our staff represented approximately 34,000 children. Last year, the Society's Civil Practice provided free direct legal assistance in more than 48,500 cases and legal matters through neighborhood offices in all five boroughs, and 23 specialized units, of which the Homeless Rights Project is one. Our Criminal Practice handles over 220,000 trial and post-conviction cases a year, some of which arise out of arrests predicated on our clients' homeless status. Our perspective comes from daily

contact with children and their families, and also from our frequent interactions with the courts, social service providers, and State and City agencies.

In addition to representing many thousands of children, youth, and adults each year in trial and appellate courts, we also pursue impact litigation and other law reform initiatives on behalf of our clients. On December 30, 2013, The Legal Aid Society, in collaboration with Patterson Belknap Webb & Tyler, LLC, filed *C.W. v. The City of New York*, a federal class action lawsuit on behalf of RHY in New York City. The lawsuit seeks to establish that young people in New York have a right to youth-specific shelter, and to remedy (1) the City's consistent failure to provide an adequate number of shelter beds for RHY, (2) its routine discharge of youth from crisis shelters before permanent housing has been secured, and (3) its longstanding failure to provide reasonable accommodations or mental health services to RHY with disabilities. Our goal in litigation is to ensure that the City creates and maintains enough youth-specific beds to meet the needs of *all* youth seeking shelter. No youth should languish on the street while relegated to a shelter waiting list or be discharged from shelter due to arbitrary time limits. In addition, we seek to ensure that youth discharged from shelter are provided with due process prior to any ejection from shelter. All five of the bills at issue today would bring us closer to these goals, by giving youth more time in crisis shelter to secure other housing, by fostering transparency and accountability in service provision, by streamlining the intake and assessment process between DYCD and DHS, and by providing young adults aged 21-24 with age-appropriate services.

Coalition for the Homeless: Coalition for the Homeless, founded in 1981, is a not-for-profit advocacy and direct services organization that assists more than 3,500 homeless New Yorkers each day. The Coalition advocates for proven, cost-effective solutions to the crisis of modern homelessness, which is now in its fourth decade. The Coalition also protects the rights of homeless people through litigation involving the right to emergency shelter, the right to vote, and life-saving housing and services for homeless people living with mental illness and HIV/AIDS.

The Coalition operates 11 direct-services programs that offer vital services to homeless, at-risk, and low-income New Yorkers. These programs also demonstrate effective, long-term solutions and include: Supportive housing for families and individuals living with AIDS; job-training for homeless and formerly-homeless women; and permanent housing for formerly-homeless families and individuals. Our summer sleep-away camp and after-school program help hundreds of homeless children each year. The Coalition's mobile soup kitchen distributes over 900 nutritious hot meals each night to homeless and hungry New Yorkers on the streets of Manhattan and the Bronx. Finally, our Crisis Intervention Department assists more than 1,000 homeless and at-risk households each month with eviction prevention, individual advocacy, referrals for shelter and emergency food programs, and assistance with public benefits as well as basic necessities such as diapers, formula, work uniforms, and money for medications and groceries.

The Coalition was founded in concert with landmark right to shelter litigation filed on behalf of homeless men and women (*Callahan v. Carey* and *Eldredge v. Koch*) and remains a plaintiff in these now consolidated cases. In 1981 the City and State entered into a consent decree in *Callahan* through which they agreed: "The City defendants shall provide shelter and board to each homeless man who applies for it provided that (a) the man meets the need standard to

qualify for the home relief program established in New York State; or (b) the man by reason of physical, mental or social dysfunction is in need of temporary shelter." The *Eldredge* case extended this legal requirement to homeless single women. The *Callahan* consent decree and the *Eldredge* case also guarantee basic standards for shelters for homeless men and women. Pursuant to the decree, the Coalition serves as court-appointed monitor of municipal shelters for homeless adults, and the City has also authorized the Coalition to monitor other facilities serving homeless families.

Project Renewal's Testimony to the Committee on Mental Health, Disabilities, and Addiction (jointly w/ General Welfare) Regarding Opioid Overdoses Among NYC's Homeless Population

February 27, 2018

Good afternoon, Chairs Ayala and Levin and members of the Committees on Mental Health, Disabilities and Addiction, and General Welfare. My Name is Jody Rudin and I am Chief Operating Officer at Project Renewal. It is an honor to provide testimony on this important topic.

Project Renewal is a comprehensive homeless services organization, serving homeless individuals in New York City for over fifty years. With funding and support from City, State and Federal agencies, we provide housing, healthcare and employment services to roughly 16,000 people annually.

Project Renewal's healthcare services include primary and oral health care, along with a range of behavioral health services, such as psychiatry and addiction treatment. These services are provided in multiple settings, including our shelters, Article 28 clinics and three OASAS-licensed programs. Our sixteen housing programs include a combination of shelters, transitional and permanent housing. We run seven Department of Homeless Services (DHS)-contracted shelters with a total of 942 beds. All seven shelters have a significant number of individuals struggling with addiction; two of the shelters are specifically designated for individuals with substance use disorders.

As part of Project Renewal's commitment to provide high quality care and manage risk, we maintain robust systems for incident response, reporting, investigation and review. In June 2017, we began tracking internal incidents involving the administration of Narcan by shelter staff. Over the first seven months of FY 2018, we had 34 instances, double the number compared to the last seven months of FY 2017, with 17 instances. In only one instance, the use of Narcan did not result in an overdose reversal. The use of Narcan in shelters has risen sharply over the last two months; eight instances in December and 10 in January, effectively tripling the number of times Narcan was administered.

Project Renewal has responded to the rising risk of opioid-related deaths with an enhanced initiative to provide staff and client training in Narcan. In the first seven months of FY18, we trained 158 staff and 319 clients. In the last seven months of FY17, we trained 236 staff and 79 clients. Over the last year, 10 clients reported administering Narcan to their friends. We are incorporating Narcan training in the orientation for all new Project Renewal employees. Additionally, we have secured commitments from the security firms we employ that they will train their guards posted within our shelters.

In order to ensure that these life-saving measures maintain the highest priority, particularly within our shelters, we have designated a staff person at each site to serve as a champion. We are identifying resources to build the infrastructure to support this program – including components such as data collection and report submission, inventory tracking and ordering, and trainings for staff and client.

The routine overdoses occurring in our shelters, and the role of our staff in saving lives, have raised many questions about what shelter should look like in the context of the opioid crisis. Many of our shelter staff, some of whom are entry level workers, have suddenly found themselves at ground zero of the opioid crisis and are routinely in the position of saving lives. We are grappling with questions relating to staff counseling, and reviewing the physical environments of our facilities to ensure that our shelters are designed to allow for rapid response on the part of our staff in cases of a possible overdose. Specifically, we know that most of the overdoses at our sites occur in the bathrooms. Consequently, we are assessing the configuration of our bathroom stalls and evaluating the ways to monitor the bathrooms.

We are also dealing with the philosophical question of drug use within shelters and the lack of safe places to do so. Historically, there has been a zero-tolerance policy relating to drug use. However, if the goal is to save lives, it makes sense to consider a more flexible approach to minimize the risk to clients who may otherwise overdose in locations where they are less likely to be found and saved. In order to have this conversation in a meaningful way, we need to have it alongside our funders and partners in government to help formulate the policy. Towards this end, we recommend that a joint taskforce be convened with homeless services providers, along relevant City agencies.

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Homeless Services United
Testimony before the Committees on General Welfare and Mental Health, Disabilities and Addiction
Opioid Overdoses Among NYC's Homeless Population
February 27, 2018

My name is Catherine Trapani, and I am the Executive Director of Homeless Services United (HSU). HSU is a coalition of approximately 50 non-profit agencies serving homeless and at-risk adults and families in New York City. HSU provides advocacy, information, and training to member agencies to expand their capacity to deliver high-quality services. HSU advocates for expansion of affordable housing and prevention services and for immediate access to safe, decent, emergency and transitional housing, outreach and drop-in services for homeless New Yorkers.

Thank you Chairs Levin and Ayala for calling this hearing today. The opioid crisis has hit our community hard – there has been a 69% increase in deaths of homeless people from overdoses between FY16 and FY17. We are certainly not alone; the United States lost 64,000 Americans to overdoses in 2016 alone. The crisis is deadlier than the Vietnam War.

In order to stem the loss of life, we need to start treating this like what it is, an epidemic. Tools are available to curtail the loss of life and we need to employ every single one of them to ensure that no more lives are needlessly lost to fatal overdoses.

Treating overdoses:

The Department of Homeless Services has done an excellent job making sure that shelter staff have access to life saving overdose treatments like Naloxone. All shelter staff have access to the treatment and shelter residents are also receiving training to administer the drug to persons believed to be suffering the impact of an overdose. We applaud this initiative and encourage sustaining it with ongoing training for staff and residents alike to ensure that everyone is equipped to respond in an emergency.

Treating addiction and preventing overdoses:

The time immediately following a nonfatal overdose is an optimal time to engage substance users about treatment options or at least about safe usage. We need to make sure that those options are well suited to the needs of our clients, widely available, and well understood by staff and residents alike to maximize engagement and reduce the likelihood of another overdose.

Availability of appropriate treatment:

Medications like buprenorphine and Suboxone have been proven to reduce the risk of relapse as well as the risk of fatal overdoses more effectively than psychological support and detoxification (total abstinence from use). In fact, persons relapsing following detoxification are at a higher risk for overdose

than those using medications like buprenorphine and Suboxone. Such treatments should be widely available yet, because medical professionals must get special training to prescribe the drugs, not all doctors and nurse practitioners are able to administer this kind of treatment or even understand how to do so. This is simply unacceptable – **all doctors and nurse practitioners working in NYC Health + Hospitals facilities as well as those working in shelter based or mobile clinics for homeless and formerly homeless New Yorkers should be required to receive the training and file for the necessary DEA waivers to administer buprenorphine treatment.** All shelters, safe havens and drop-in centers should be resourced to provide their clients with access to primary care (including doctors and nurse practitioners who can prescribe buprenorphine). Access to treatment must also extend to permanent supportive housing programs where homeless clients are often referred to continue their recovery; these programs, especially those using a "housing first" model, must be appropriately resourced to provide onsite medical care for those in need. Integrating effective treatment into existing care and service networks lowers barriers to engagement and makes treatment more accessible to those most in need.

In addition to integrating care into mainstream medical and homeless services, we need to ensure that care and treatment is available to persons who may not want to receive treatment in the place they are seeking shelter or primary medical care. Some shelter residents may fear being judged if they express a need for substance use treatment services to their shelter caseworker. Still, they may be receptive to treatment if they could access it in a more neutral setting. For this reason, programs such as the one operated by HSU member Neighborhood Coalition for Shelter must be supported so that they too can help homeless New Yorkers access care free from real or perceived judgment and stigma. Substance use programs like this one typically rely on Medicaid funding to support treatment services however, many other services that help people stay the course and continue on their recovery journey cannot be billed to Medicaid. **A funding source should be developed to support case management services in community programs that improve opportunities for recovery including housing and benefits access, food pantries and other nutrition supports, transportation.**

Awareness of treatment options:

If we want persons using opioids to take advantage of expanded treatment options, talking about substance use treatment needs to be a normal and non-stigmatized as talking about treating diabetes, heart disease or any other public health concerns. The more we can educate clients, social service staff and health care providers about effective medical interventions, the more people we will be able to enroll in treatment.

The City recently launched a campaign on featuring ads in subways to spread awareness of Naloxone. A critical next step is to **extend public education campaigns to include raising awareness of effective treatments like buprenorphine so that drug users know that medications can help in recovery without triggering the painful symptoms of withdrawal.**

Reducing harm for those still using:

Those least connected to care and services are the most likely to overdose. As discussed above, abstinence based, detoxification care models are not as effective as treatments that include medication and other tools geared towards reducing harm. If the goal is to save lives – and it should be – we need to have a plurality of options to accommodate the needs of people in different stages on the road to recovery. Harm reduction recovery programs should be widely available where clients can get information about all available treatment options as well as support in safer usage to reduce the likelihood of fatal overdose and the spread of disease.

Recovery is not incompatible with harm reduction. In fact, engaging persons who are using substances in a nonjudgmental, collaborative way may incentivize utilization of recovery services.

To increase access to effective harm reduction services the City should:

1) Ensure that harm reduction supplies are widely available to persons still using opioids.
   a. Needles, cases, tourniquets, alcohol pads, bleach and the like should be available to persons who continue to use to reduce the spread of disease
   b. Test strips/kits should be widely available so users can discover if their supply contains a high concentration of fentanyl so they can better avoid fatal overdoses
   c. Safe syringe disposal should be widely available to reduce litter and the spread of disease

2) Integrate safe injection sites into programs serving addicts including drop-in centers and harm reduction programs so that those most at risk of overdosing can be monitored and saved should an overdose occur. **Not a single fatal overdose has been recorded at any safe injection site around the world.**
   a. Allowing rapid response to overdoses also increases the likelihood of getting someone engaged into treatment programs (there is a window of opportunity post overdoes where someone is more likely to be receptive to entering treatment). If services are all co- located, the person can go to an already trusted, nonjudgmental source to receive the care they need.

Harm reduction, especially safe injection sites are controversial even though we know that it saves lives. Despite all evidence to the contrary, some still argue that they somehow promote drug use or will encourage more people to use. In thinking about how to respond to naysayers in preparation for today's testimony, I am reminded of the early days of the AIDS epidemic. People were dying in large numbers but, because those who were most impacted were gay and had little political capital, the people in power to support interventions did nothing to help. Inaction was justified by focusing on "life choices" of those impacted, people were stigmatized, shamed and blamed. Activists fought hard to change the narrative and encourage the development of treatment options as they watched their friends and loved ones perish. By the time their campaigns began to succeed thousands of lives had already been lost. The situation today with opioid deaths is much the same, with one critical difference – unlike back in the early 80s when treatment options for people living with AIDS hadn't yet been developed, **we know exactly what works to treat addiction yet we are still denying treatment to those who need it most because of the stigma attached to drug use.** The "war on drugs" has cost more lives than the Vietnam War yet we still insist on clinging to failed policies; something has to change. **A sustained coordinated effort to get the services and treatment to the people that need it most is necessary to reduce the loss of life.** A holistic approach that includes raising awareness and providing multiple entry points into service and treatment programs that are nonjudgmental, normalized and easy to access is essential. If we are serious about reducing the number of deaths due to opioid overdoses

Whether you seek treatment via regular medical care providers or community, shelter and housing resource programs, you should have access to high quality care, including medication regimes that reduce cravings, prevent withdrawal symptoms and prevent overdoses. I am encouraged by DHS's early steps to ensure access to overdose treatment such as Naloxone and am hopeful that we can learn the lessons from past epidemics and quickly move to implement comprehensive solutions discussed today.

Thank you for the opportunity to testify.

Oversight - Opioid Overdoses Among NYC's Homeless Population

Committee on Mental Health Disabilities and Addiction
The Honorable Diana Ayala, Chair

Committee on General Welfare
The Honorable Stephen T. Levin, Chair

Testimony of
Christy Parque, President and CEO
The Coalition for Behavioral Health
February 27, 2018

My name is Christy Parque, and I am the CEO of the Coalition for Behavioral Health (The Coalition) Thank you, Council Member Diana Ayala and Council Member Stephen T. Levin, for convening today's Hearing specifically to discuss opioid overdoses among NYC's homeless population and to also discuss heroin and opioid addiction and the City's response to these problems. Although addiction is a long-standing concern, recent reports on the increasing deaths from overdoses or health care consequences, especially, among our most vulnerable New Yorkers including the homeless warrant increased attention.

The Coalition is the umbrella advocacy and training organization of New York's behavioral health community, representing over 140 non-profit community-based agencies that serve more than 450,000 consumers and employ well over 35,000 workers. Our members serve the entire continuum of behavioral health care in every neighborhood of New York City, and communities across Long Island, Westchester, Rockland and Orange counties. Coalition members provide access to the range of outpatient mental health and substance use services, supportive housing, crisis intervention, peer support services, employment readiness, Personalized Recovery Oriented Services (PROS), Club Houses, education and nutritional services, as well as many other supports that promote

recovery. The Coalition also trains over 4000 human services providers annually on cutting edge and proven clinical and best business practices through generous support from the New York City Council, New York City Department of Health and Mental Hygiene (DOHMH), New York State Office of Mental Health OMH), and in conjunction with foundations and leaders from the behavioral health sector.

We are grateful for this opportunity to offer our thoughts on the heroin and opioid epidemic in New York City and how the New York City Council in tandem with the New York City Department of Health and Mental Hygiene can continue to support the efforts of providers on the front line of the epidemic.

COMBATTING THE EPIDEMIC IN NEW YORK CITY

We are fortunate to have the leadership of Mayor Bill de Blasio and First Lady Chirlane McCray championing the call to action. Recent, staggering reports on the numbers of New Yorkers dying from overdoses among the general population and among our vulnerable subpopulations including young people and people who are homeless, are of grave concern. Healing NYC: Preventing Overdoses, Saving Lives, a report from the de Blasio administration, presents a thorough plan to combat this scourge. It comes at an opportune time as the federal government has proposed cuts to Medicare and Medicaid that would reduce funding of at least $30 B over 10 years, 23% of the national loss if the cuts are enacted.

These cuts threaten the viability of our health care system and particularly that of Health + Hospitals, a leading institution serving those suffering from addiction disorders

Making Health + Hospitals a system of excellence for addressing the opioid epidemic is one of nine strategies promoted in the Healing NYC report.

The Coalition is aware of the several bills that are being considered by the NYC Council. While we will not go into detail on the individual bills, we do want to recognize and commend the NYC Council for all its efforts to focus on educating and steering primary resources to help individuals in crisis and for promoting de-stigmatizing those who use substances. We also congratulate the NYC Council for not including any punitive enforcement initiatives.

PRINCIPLES FOR EFFECTIVE PREVENTION, TREATMENT AND RECOVERY

The Coalition would like to take this opportunity to iterate our guiding principles for effectively combating the opioid epidemic, based on the experiences of on the ground member organizations. We know what works – it is contingent on NYC to provide sufficient facilities and programs to ensure every individual with the disease of addiction

can be treated at the appropriate level of care for the appropriate length of time to develop the foundational skills to sustain long-term recovery.

PREVENTION

It is now known that substance use disorders do not occur immediately but over time, making it "both possible and highly advisable to identify emerging substance use disorders, and use ...interventions to stop the addiction process before it becomes more chronic, complex and difficult to treat." It becomes clear that adopting a chronic care management approach to treatment of substance use disorders, but using behavioral health oriented interventions, medications, social supports, clinical monitoring and recovery support services, will lead to better outcomes and prevent more relapses. It should be noted that behavioral health providers have long relied on a robust menu of cross sectional services to address the multiple needs of individuals with behavioral health illness.

Prevention efforts need to be contemporary and creative in our schools and communities, as we see ages of onset drop while the drugs used are becoming increasingly more aggressive.

TREATMENT

Addiction is a disease and should be treated as such. It was not always the case that substance use disorder was considered an illness. Despite the failure of a criminal-justice based model to realize any meaningful objectives or slow the growth of substance use, it wasn't until neurobiology was able to document the effect of substances on the brain that it became apparent that substance use disorders caused neuro-adaptions that compromise brain function and drive transition from controlled, occasional substance use to chronic misuse, changes that may endure long after an individual stops using substances.

The "Just Say No" campaign of the Reagan era exemplified the attitude that addiction was both aberrant and the volitional choice of the individual. But perceptions are slow to dissolve, and notions of "aberrant behavior" and addiction as a social issue persist. One of our member agencies recognized this persistence in law enforcement calling it "a hold over, (we) need to educate and (have them) understand. They are more sensitive than in the past, but (they) need more education." The Coalition believes promoting public education and awareness raising to de-stigmatize substance use disorders is essential to ensure adequate and meaningful treatment and recovery support services remain viable and available.

It is also possible that another holdover from the abstinence era is the slow uptake on medication-assisted treatment. Medication-assisted treatment has been shown to be

effective to decrease reactivity to drug- conditioned cues and decrease craving. Yet, despite its potential for recovery medication-assisted treatment is underutilized whether due to resistance from uninformed providers or consumers, or issues related to insurance coverage and policies. The Coalition recommends public awareness campaigns as well as education of medical practitioners and insurers so that more individuals can benefit from medication-assisted treatment.

RECOVERY

Fortunately, we have seen the emergence of recovery support services in the forms of peer mentors, recovery coaches, clubhouses and recovery centers. These are critical elements to securing sustained abstinence and recovery for individuals post-treatment and those seeking access to treatment.

HOMELESSNESS AND SUBSTANCE USE

Substance use disorders cannot be separated from other mental health issues. 46% of individuals in New York State with behavioral health disorders live with both substance use disorders and mental illness[1]. It is estimated that 20-25% of homeless people in the US suffer from some form of mental illness[2]. Unfortunately, there are not enough behavioral health providers to serve them. In NYC generally, there are 82 full time equivalent behavioral health professional in designated shortage areas although only 30% of the total NYC population resides in designated shortage areas. Estimates are that 118 more full time equivalent behavioral health professionals are needed to meet the demand.[3] Recruiting those professionals to work in shelters is a sincere challenge. Yet, there are resources available for homeless people.

The demonstration of Certified Community Behavioral Health Clinics includes 5 clinics in New York City that are required to include in their service plan the full range of behavioral health services, and in particular, those associated with substance use disorders. It shows great promise and must include a federally qualified health centers to ensure a comprehensive and holistic array of services.

There is also a specific program of federally qualified health centers serving homeless people. The federal Health Care for the Homeless Program (homeless health centers) was premised on the confluence of poor health and behavioral health within the homeless community. The enacting legislation required, unlike community health centers in general, that providers specifically identified and funded as Health Care for the Homeless programs include behavioral health care in their array of services. Given what is known about the neurological genesis of addiction, and the high rate of co-morbidity of substance use disorders and mental illness, it follows that many individuals with dual disorders would be at risk for financial and housing instability.

Homeless health centers, as all the health center programs, were established to ensure access to comprehensive, high quality health care for people with challenges to accessing care. The solution for homeless people was to provide services on their terms. New York City homeless health centers developed a system of intensive outreach, shelter based clinics and mobile clinics to make it easier for people living rough and sheltered individuals and families to access care. To its credit, the de Blasio administration has recognized the positive effect of these clinics. Yet, there are still many homeless sites that lack on-site clinics and many do not have the funding to offer a full array of mental health screenings, prevention, treatment and other behavioral health services.

CONCLUSION

I would like to thank the NYC Council for allowing us this opportunity. We look forward to working with the NYC Council to help drive down the incidences of opioid overdose. The Coalition would also welcome a convening for all relevant parties to discuss solutions to the behavioral health service shortages in the homeless services system.

Christy Parque
President and CEO

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[1] Office of Mental Health. The Current State of Behavioral Health- Opportunities for Integration and Certified Community Behavioral Health Clinics. 2017.
[2] National Coucil for the Homeless, July 2009.
[3] Heun-Johnson, et. Al. The Cost of Mental Illness: New York Facts and Figures,. 2018.

GMHC Testimony:
NEW YORK CITY COUNCIL COMMITTEE ON HEALTH
NYC Health Committee Hearing on the Opioid Crisis
New York City Council Mark Levine Health Committee Chairperson

Contact: Cecilia Gentili, Director of Policy & Public Affairs
Gay Men's Health Crisis (GMHC)
CeciliaG@gmhc.org, 212-367-1587

Good morning. My name is Cecilia Gentili and I am the Director of Policy at Gay Men's Health Crisis, known as GMHC. Founded in 1982, GMHC is the world's first AIDS service organization. In 2016, we served over 12,000 clients across New York City, and our housing staff services over 900 clients. At any given time, our substance use clinic provides services to 150-200 clients.

Over the past several years, the problems of both opioid addiction and overdoses—including deaths from overdoses—have become a significant public health crisis in New York City, New York State, and the nation. In 2017, opioid deaths across the U.S. reached an all-time high with approximately 66,000 deaths.

GMHC believes that New York City and New York State need to learn from the lessons of the HIV response and develop a plan to end the opioid crisis in the city and state by 2025, employing a similar process of partnering with relevant stakeholders to draft a comprehensive strategic plan to address the problem.

We believe that, instead of placing Band-Aids on individual aspects of the opioid problem, a comprehensive plan would address all aspects of the epidemic. This kind of overall approach will be more effective in both assessing and confronting what we're facing.

Governor Andrew Cuomo has recognized this kind of logic and has developed a plan for the city and the state to address HIV/AIDS—and end the epidemic by 2020.

So, I'm here today on behalf of GMHC to ask the New York City Council to issue a call for a comprehensive collaborative opioid plan. While we believe that the HealingNYC Plan launched by First Lady Chirlane McCray is a good first step, we ask the Council to fund the development of a comprehensive strategic development process, engaging a wide-reaching community partnership, to develop a more comprehensive plan.

Like the HIV response, an opioid plan must address the comprehensive continuum of care, which would include:

- Programming on education and prevention issues
- Intervention strategies to address overdoses and prevent overdose deaths
- Harm reduction strategies that provide effective treatments for addiction, such as improving access to buprenorphine and/or methadone

- Management of ongoing drug use, including access to clean needles and the opening of safe consumption facilities
- Addiction treatment access including funds for expansion of access to buprenorphine and allowing people access to buprenorphine in shelters
- A response to the overall issue of pain management which drives opioid use. We need to develop better pain-management strategies
- Development of roadmaps for care for different client populations, including those living on the street, those in supportive housing, and those in normal shelter settings
- Interventions for prevention of blood-borne infections like HIV and Hepatitis C due to high-risk sexual behavior and intravenous drug use
- Addressing the chronic instability that often accompanies opiate addiction
- Providing access to and funding for health care and safe housing through linkage agreements, and the development of healthcare facilities and housing for poor people living with substance use and mental health issues

Like HIV/AIDS, the opioid epidemic is a public health crisis and will require a comprehensive strategy that incorporates all components of a continuum of care and support for opioid users, and one that involves all stakeholders at all levels of the response. Without this kind of comprehensive response with buy-in from all stakeholders, the opioid epidemic will continue to spin out of control and the city and the state will continue to needlessly lose thousands of citizens each year to it.

# # #

FOR THE RECORD

Comments of the Corporation for Supportive Housing for the New York City Council Committee on General Welfare and Committee on Mental Health, Disabilities and Addiction Joint Hearing on Opioid Overdoses Among NYC's Homeless Population February 27, 2018

My name is Kristin Miller, and I am the Director of the Metro Team at the Corporation for Supportive Housing (CSH). CSH's mission is to advance solutions that use housing as a platform to deliver services, improve the lives of the most vulnerable people, and build healthy communities across the country. CSH has a 27-year track record of innovation and investment in New York. Since 1991, CSH has made over $138M in loans to supportive housing developers for the creation of over 15,000 permanent supportive and affordable housing units in New York State.

As we've heard again and again this afternoon, heroin and opioids are destroying people's lives and damaging families and neighborhoods. I am here today to talk about supportive housing, a proven solution to help fight this epidemic. CSH's *Supportive Housing's Vital Role in Addressing the Opioid Epidemic in New York State*[1], released in 2016, provides a background of the opioid epidemic in New York communities, and cites research on supportive housing as a solution for individuals facing substance use disorders. Supportive housing combines affordable housing with services that help people who face the most complex challenges, including mental health, addiction and chronic health issues, to live with stability, autonomy and dignity. Quality supportive housing takes a housing first approach, which connects individuals with complex challenges to permanent housing as quickly as possible and then wraps supportive services around them, without requiring treatment compliance or sobriety (barriers that keep out the most vulnerable). Housing stability has been demonstrated to be critical in providing people using heroin the opportunity to address their substance use disorder.[2] A study published in 2014 by the National Center on Addiction and Substance Abuse found that supportive housing was successful in reducing the use of, and costs associated with crisis care services including shelters, detox centers, jails and medical care (hospitalizations and emergency department visits). The findings suggest that individuals actively using substances can be housed successfully and stably *without* imposing treatment requirements.[3]

I want to recognize the tremendous commitments to supportive housing in recent years by New York City. CSH congratulates the Mayor in making commitments of creating 15,000 units of supportive housing to house our most vulnerable New Yorkers, and the work that has been done by government agencies get capital, operating and services funding out the door for these units to start bringing them online. We need the support of both Committees here today to continue to ensure that funding is allocated each year to realize the full commitment of units. In addition, we need help need your help to educate your communities on the benefits of supportive housing. Not only is this intervention the best way to help the most vulnerable individuals experiencing homelessness stabilize and recover, but it has also been demonstrated to improve the safety of neighborhoods,

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[1] Available here: http://www.csh.org/wp-content/uploads/2015/12/CSHPolicyBrief_SupportiveHousing_NYSOpioidEpidemic_12.8.15.pdf
[2] Gray, Paul; Fraser, Penny. *Housing and heroin use: The role of floating support.* Drugs: Education, Prevention, and Policy. Vol. 12, Iss. 4, 2005.
[3] Neighbors, Charles; Hall, Gerod; et.al. *Evaluation of NY/NY III Housing for Active Substance Users.* The National Center on Addiction and Substance Abuse. 2014.

increase or stabilize property values, and reduce public expenditures on crisis services. You can find more information on the impact and outcomes of supportive housing at our website: http://www.csh.org/supportive-housing-facts/evidence/.

We urge the Committees to ensure that the full commitment of the new units is realized, that barriers are lowered so that people and communities struggling with the opioid epidemic have access to the supportive housing they need, and to help their communities understand the importance and impact of supportive housing. Now is the time to build support in our communities for low-barrier supportive housing, a critical intervention in the effort to help vulnerable individuals experiencing homelessness and substance use stabilize and recover.

Please don't hesitate to contact me at (Kristin.miller@csh.org) or call (212.986.2966 x231) with questions. Thank you for your consideration.

Testimony on Behalf of BOOM!Health
On
The New York City Council Oversight Hearing on Opioid Overdoses among New York City's Homeless Population

Meeting Date: February 27th, 2018

BOOM!Health is a community-based nonprofit organization in the Bronx, NY and is deeply committed to a vision of health, wellness and safety for all, particularly the needs of marginalized and stigmatized communities at highest risk of homelessness, overdose, HIV, Hepatitis C, and other chronic health conditions. Guided by an ethos of harm reduction, we aim to remove barriers to accessing primary care, as well as HIV and Hep C prevention services, while supporting participants on their journey towards wellness and self-sufficiency.

The everyday reality for individuals experiencing addiction and housing instability is not easy. For many their primary focus is survival and they are constantly stigmatized and ostracized from society. Drug-use disorders and homelessness have the ability to perpetuate each other. Studies have shown that individuals with drug-use disorders are at increased risk of homelessness and homelessness has been linked to subsequent increases in drug use including injection-related risk behaviors.[1,2] These problems can be exacerbated by untreated mental illness and the stress of living on the streets. Researchers in Boston and Philadelphia have conducted large scale studies that found housing instability is a risk factor for death and mortality among individuals experiencing homelessness is three to nine times that of the general population.[3,4]

One of the greatest predicators of death is unobserved overdose. Individuals who are street-homeless are at greatest risk for unobserved overdose because they often use in spaces out of public view due to the criminalization of illicit drugs. A survey conducted by the Injection Drug Users Health Alliance (IDUHA) found that individuals who were street-homeless were 9.2 times more likely to report injecting drugs in a street or park and 8.2 times more likely to inject in a public bathroom.[5] The survey found that individuals who inject in public and semipublic spaces are twice as likely to have overdosed in the past year compared those injecting in private residences and harm reduction participants who reported injecting in public spaces were 62% more likely to have witnessed an overdose in the past year.[6]

The Bronx has been battling the opioid epidemic for decades. In 2016, 26% (308) of all overdose deaths in New York City impacted a Bronx resident.[7] Between 2013 and 2016 the number of individuals who have died from an unintentional overdose in the Bronx has almost doubled, the largest increase in all of the five boroughs.[8] People are dying due to the mixing of substances, whether it is known to them or not at the time of consumption. The majority of heroin and cocaine in New York City is laced with fentanyl—a powerful synthetic opiate. It is no surprise that in 2016, the Bronx had the highest number of unintentional drug overdoses that involved fentanyl.[9]

The stigma and negative perception around substance abuse is so pervasive that individuals face discrimination even when seeking treatment from healthcare professionals. No physical or psychiatric condition is more associated with social disapproval and discrimination than substance dependence.[10] Our prejudices are so ingrained that it is not surprising to find individuals who use so-called 'soft drugs' like marijuana but further stigmatize those using 'harder drugs' like heroin.

As the epidemic continues we must seek out solutions that effectively and humanely address the problem. We can no longer let people die when we have a viable solution—safer consumption spaces (SCS). SCSs are an evidence based harm reduction intervention where individuals can use pre-obtained illegal drugs under the supervision of medical professionals connected to services and resources including drug treatment. Studies of Vancouver's safer consumption space, Insite, have shown that SCSs are successful in attracting at-risk populations, are associated with less risky injection behavior, fewer overdose deaths, increased client enrollment in drug treatment services, and reduced nuisances associated with public injection.[11] A survey of Insite participants found that 75% changed their injecting practices as a result of utilizing the facility and of those individuals 71% indicated that the SCSs had led to less outdoor injecting. [12] SCSs would be located in harm reduction centers like BOOM!Health where staff are trained in harm reduction principles including non-judgmental and non-coercive provision of services and resources. The mutual respect and acknowledgement between participants and staff reduces barriers to treatment. People are going to use drugs whether or not they are legal. We cannot sit idly on the sidelines as we watch so many unavoidable deaths right in front of our eyes.

It is essential for New York City government officials and city agencies to recognize that the opioid and overdose epidemic has been endemic in parts of our city for decades and does not look the same across all five boroughs. All individuals regardless of their substance use or housing status should be treated with dignity, respect and support. This dynamic challenge requires a dynamic solution, and it is unacceptable to fight this alarming epidemic while only acknowledging the issue as it relates to more sympathetic communities.

The City Council has already funded a study that was conducted by the Department of Health and Mental Hygiene on SCSs but the report has not been released. At the very least the City of New York should release this report as it is essential towards battling the opioid epidemic and helping others understand the benefits and purpose of SCSs.

On behalf of our participants, we thank you for your time and commitment to all residents of New York City regardless of their housing status.

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[1] Topp L, Iversen J, Baldry E, Maher L, *Collaboration of Australian NSP Housing instability among people who inject drugs: results from the Australian needle and syringe program survey*. J Urban Health. 2013;90(4):699–716.

[2] Linton SL, Celentano DD, Kirk GD, Mehta SH. *The longitudinal association between homelessness, injection drug use, and injection-related risk behavior among persons with a history of injection drug use in Baltimore*, MD. Drug Alcohol Depend. 2013;132(3):457–65.

[3] Hibbs J, Benner L, Klugman L, Spencer R, Macchia I, Mellinger A, et al. *Mortality in a cohort of homeless adults in Philadelphia*. N Engl J Med. 1994;331(5):304–9.

[4] Baggett T, Hwang S, O'Connell J, Porneala B, Stringfellow E, Orav J, et al. *Mortality among homeless adults in Boston: Shifts in causes of death over a 15-year period*. JAMA Intern Med. 2013;173(3):189–95.

[5] Injection Drug Users Health Alliance (IDUHA). *Public Injection Drug Use among NYC Harm Reduction Participants*. July 2015.

[6] Ibid.

[7] Paone D, Nolan ML, Tuazon E, Blachman-Forshay J. *Unintentional Drug Poisoning (Overdose) Deaths in New York City, 2000–2016*. New York City Department of Health and Mental Hygiene: Epi Data Brief (89); June 2017.

[8] Ibid.

[9] Ibid.

[10] Goffman, E. *Stigma: Notes on the management of a spoiled identity*. Englewood Cliffs: Prentice-Hall. 1963.

[11] Hedrich D., Kerr T., Dubois Arber F. *Drug consumption facilities in Europe and beyond. Harm Reduction: Evidence, Impacts, and Challenges.* European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2010, 305-332.

[12] Steven P. et al., *Injection Drug Users' Perceptions Regarding Use of a Medically Supervised Safer Injecting Facility*, Journal of Addictive Behaviors 32:5. (2007):1088-1093.

First, I want to thank the Council for allowing me the opportunity to testify. That thanks comes not just from me, but from the members, leaders and staff of VOCAL-NY. We are a grassroots organization dedicated to ending the failed war on drugs, ending mass incarceration, homeless and the AIDS epidemic here in New York.

I will not waste any time talking about the scale of the crisis we are in. Sadly, we are all very aware. Instead, I want to focus on specific actions that our city can take to immediately reduce our overdose crisis, while providing care and compassion to people struggling with opioid dependency. I also must point out where City Hall is failing, and at times leading our city in the wrong direction.

I want to start with positive steps taken by this Council, and how they can be strengthened.

- **Going from studying, to funding Safe Consumption Spaces:** Over a year ago, the Council allocated a $100,000 to do a feasibility study on creating safer consumption spaces in New York City. These facilities are well studied, proven public health interventions. Major news sources across the county are showing support for them in the editorial pages, most recently the New York Times just last weekend. And San Francisco, Seattle, Philadelphia and Ithaca, NY have all taken action to create them in response to their overdose crisis. The Council took the right step to fund this study. **We now need the Council's leadership again to either allocate funding, or take legislative action to move New York City forward in creating these facilities.**

- **Funding for Council Member Torres' Int 1443:** Late last year the Council passed critical legislation to address overdose deaths inside shelters and among the street homeless. It requires the training of shelter staff and, very critically, the training of shelter residents themselves. **For this legislation to be successful, the Department of Social Services needs adequate funding. We need the Council to urge City Hall to provide that funding.**

Next, I want to speak about the bills discussed today. We want to applaud the Council for taking action to tackle overdose, but **we urge this body to look past naloxone and beginning looking to other, effective public health interventions.**

To be clear, the focus on naloxone is not the fault of City Council Members. It is our job in the harm reduction and public health community to provide you with additional solutions, which is what I want to begin to do today. These interventions could be advanced through a mix of legislative action, and city funding.

- **Expanding access to buprenorphine:** Public health experts have long pointed to medicated assisted treatment as a vital tool in combating overdose, and opioid dependency. While New York City's access to methadone is good, many barriers remain to accessing buprenorphine. Even our federal government, under President Trump, is expanding access to this treatment option. The Department of Health and Mental Hygiene is taking steps to expand access, but more must be done. **City Council should identify legislative and budget action to expand access buprenorphine, including increased funding to the DOHMH and the Department of Social Services to expand access to people struggling with opioid dependency.**

- **Expanding pre-arrest diversion programs:** Pre-arrest diversion programs are expanding across the country. These programs provide people struggling with chemical dependency services instead of arrest. These programs should also been seen as tools for law enforcement. Currently, police are provided no alternative to arresting people, even when they know that the person needs help, not a jail cell. These programs are only effective when connected to adequate services and are truly PRE-arrest. **City Council should look into legislative and budget action to expand access to pre-arrest diversion programs.**

- **Increase funding for post-overdose support:** The vast majority of people who overdose do not die, but end up in emergency rooms across the city. Once the emergency medical issue is resolved, we have an opportunity to provide care and support for people. This begins with a simple question, "what do you need"? This can be the beginning of getting people housing, into treatment, trained on naloxone or any number of first steps to being in a better place. The DOHMH has launched a program like this called RELAY, but it is small. **City Council should expand access to these programs through the City budget.**

Last, I want to point to actions by City Hall that are detrimental to our city's ability to tackle this crisis.

- **Healing NYC and misallocation of city funds:** It cannot be stated enough that **our city must invest in proven, public health measures to tackle overdose and opioids.** Also, **criminalization and law enforcement tactics focusing on the supply side of drugs do not work.** We have given the law enforcement approach time to prove whether it works. It hasn't. Overdose deaths are going up, and never has there been proof of law enforcement reducing drug use. In fact, the country with the most success at reducing overdose deaths, incarceration and cost to the government has been Portugal where drugs have been decriminalized and money has been invest in care and treatment. This approach works. Sadly, City Hall allocated half of all Healing NYC funds to the NYPD. This was a program that was supposed to focus on a public health response to tackling this crisis. **City Council should urge City Hall to expand funding for the DOHMH, DSS and other public health interventions. This can begin with City Hall reallocating all Healing NYC funds from the NYPD to the DOHMH.**

City Council must also question the NYPD and City Hall on what metrics they use for proving success. All public health interventions are scrutinized, why isn't the NYPD's?

Thank you for the opportunity to speak today. We at VOCAL-NY are here to work alongside the Council in whatever capacity.

There is a path forward for ending this overdose crisis, and providing real care to people struggling with drug dependency. Thankfully our Department of Health and Mental Hygiene, and our Department of Social Services are filled with people who understand this. Also, we have a city filled with public health experts and services providers who understand. What we need now is the financial and political support from the city to implement these interventions.

For more information or to discuss information provided in this testimony, please contact Jasmine Budnella, Drug Policy Analyst, VOCAL-NY (jasmine@vocal-ny.org / 720-480-5262).

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

Date: ______

(PLEASE PRINT)

Name: Catherine Trapani

Address:

I represent: Homeless Services United

Address:

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Name: Jasmine Budnella

Address: 80-A 4th Ave

I represent: VOCAL-NY

Address: 80-A 4th Ave.

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Name: Kassandra Frederique

Address:

I represent: Drug Policy Alliance

Address: 330 7th Avenue, 21st floor NY NY 10001

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Name: Anya van Wagtendonk

Address: 932 St. Marks Ave.

I represent: ______

Address: ______

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Name: Doug Berman

Address: ______

I represent: Coalition for Behavioral Health

Address: 123 William St, NY, NY

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Name: jordyn rosenthal

Address: 226 144th St Bronx NY

I represent: BOOM! Health

Address: same

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Name: Scott Auwarter

Address: 1130 Grand Concourse

I represent: BronxWorks

Address: 1130 Grand Concourse, Bronx, NY 1

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Date: 2-27-18

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Name: Kristin Miller

Address: ________

I represent: Corporation for Supportive Housing

Address: 61 Broadway, NY, NY

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Name: Jody Rudin

Address: ________

I represent: Project Renewal

Address: ________

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(PLEASE PRINT)

Name: Cécilia Gentili

Address: Director of Policy & Public Affairs

I represent: GMHC

Address: 224 W 29th Street, NY, NY 10001-5204

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(PLEASE PRINT)

Name: Dr. Fabienne Laraque

Address:

I represent: NYC DHS (Medical Director)

Address:

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(PLEASE PRINT)

Name: Andrea L. Hleton

Address: 124 Apple Hill Rd

I represent: Bronxworks

Address: 1130 Grand Concourse, Bronx NY

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(PLEASE PRINT)

Name: Dr. Gary Belkin

Address: Executive Deputy Commissioner, DOH

I represent: ______

Address: ______

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(PLEASE PRINT)

Name: Dr. Hillary Kunins

Address: Asst. Commissioner

I represent: DOHMH

Address: ______

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Date: 2/27/18

(PLEASE PRINT)

Name: Josh Goldfein + Giselle Routhier
Address: 199 Water St NYNY 129 Fulton St NYNY
I represent: Legal Aid Society Coalition for the Homeless
Address: ________

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☐ in favor ☐ in opposition

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(PLEASE PRINT)

Name: Steven Banks, Commissioner
Address: ________
I represent: DSS
Address: ________

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