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To: Committee on General Welfare, Committee on Mental Health, Disabilities and Addiction

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Testimony for Feb 27, 2018 Hearing on Oversight – Opioid Overdoses Among NYC's Homeless Population

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New York City faces dual crises of record overdose and homelessness. One in 5 people who experience homelessness are either in New York City or Los Angeles.[1] As of March 2017, there were there were 61,936 homeless people--including 15,525 homeless families with 23,445 homeless children--sleeping each night in the New York City municipal shelter system. This population is disproportionately Black and Latino.

At the same time, rates of opioid overdose are reaching crisis-level proportions. Every seven hours, someone dies of a drug overdose in New York City,[2] and overdose death now kills more people than traffic accidents, homicides and suicides combined.

Despite increased spending on treatment, in New York State deaths from drug overdoses increased 71 percent between 2010 and 2015. From 2013 to 2015, 7,213 New Yorkers across the state died of overdose. New York City saw more than 1,300 overdose deaths in 2016 alone–a 46 percent increase from 2015 and the sixth straight year of increased overdose rate.

Homeless Deaths in NYC

As disturbing as the aggregate overdose mortality numbers are, some groups are especially vulnerable.[3] In particular, people experiencing homelessness are among the most vulnerable populations, yet they tend not to be included in broader conversations about overdose in New York.

Amid the sixth straight year of increase in overdose deaths citywide, people who are homeless experience dramatically higher overdose rates than the general population.

In 2014-2015, New York City was reported to have had 212 homeless deaths—a new high since surveillance of homeless deaths began. The leading causes of death were overdose (45 deaths), which accounted for 1 in 5 deaths among homeless people in 2015—a rate that has been roughly consistent since 2006.

Homeless individuals have a 1.5- to 11.5-times greater risk of dying relative to the general population, for instance, depending on age, gender, shelter status, and morbidity.[4] In fact, people with substance use disorder who also experience homelessness may have a higher likelihood of death than people with a mental health disorder but no substance use disorder.[5]

Annual Report on Homeless Deaths, 2017 [6]			
	Homeless Deaths	**Drug Deaths**	**% of total deaths**
2006	162	38	24
2007	125	33	26
2008	190	43	23
2009	177	34	19
2010	190	35	18
2011	157	27	17
2012	170	29	17
2013	208	41	20
2014	213	43	20
2015	212	45	21

Need for Safer Consumption Spaces to Prevent Overdose Death

Overdose risk is particularly high for people experiencing homelessness because public drug use increases overdose risk. People experiencing homelessness are more prone to using alone in places like public restrooms, rushing injections for fear of being interrupted which can result in inconsistent dosage, and using more than they otherwise would because they don't know when they will have another opportunity for the modicum of privacy a public restroom affords.

In response to this reality, a broad range of New Yorkers are calling for safer consumption spaces (SCS), also called supervised injection facilities (SIF), as an emergency public health tool to combat overdose deaths. SCS are facilities where people can legally consume previously purchased illicit drugs with supervision from trained staff who help make their use safer, respond immediately to overdoses, and connect them with medical care, drug treatment, and social services.

Nearly 100 safer consumption spaces exist around the world, with millions of injections having taken place at some of them. Yet, not one overdose death has been documented in these facilities.

Supervised consumption spaces are designed to reduce the health and societal problems associated with drug use—and would be especially helpful for the city's population of people who experience homelessness and also use injection drugs.

Safer consumption spaces provide sterile injection equipment, information about reducing the harms of drugs, health care, treatment referrals, and access to medical staff. Some offer counseling, drug treatment, and other services. Extensive research on these facilities consistently demonstrates a variety of cost-saving public health benefits including reducing overdose deaths; increasing access to drug treatment; reducing public nuisance associated with illicit drug use, such as public drug use and improper syringe disposal; and reducing risk behaviors for Hepatitis C and HIV. Other studies have shown a decrease in crime in the area surrounding an SCS.

The New York Times Editorial Board on Sunday called for the city to implement safer consumption spaces (SCS) as a first-line intervention to combat skyrocketing overdose

deaths, amid movement in other cities around the country such as Philadelphia and San Francisco.

Over 100 healthcare providers released a letter in support of SCS, and the American Medical Association (AMA) voted to support the development of pilot safer consumption spaces last year. The New York Academy of Medicine and Massachusetts Medical Society also both publicly support safer consumption spaces, and the Journal of the American Medical Association published a review of research supporting safer consumption spaces.

Last year, the New York City Council allocated $100,000 to fund a feasibility study that still has not been released—although Mayor de Blasio recently pledged to publish the report "soon." As NYPD Commissioner James O'Neill stated recently, "This is about the sanctity of human life, keeping people safe, making sure that people stay alive." Today we call on the Mayor to release the study and immediately take action to implement safer consumption spaces to prevent additional overdose deaths in New York City.

In a moment when New York State's overdose crisis continues to grow--with overdose deaths killing more New Yorkers than traffic accidents, homicides, and suicide combined--we need bold thinking and action. If we want to save lives, reduce criminalization, and end racial disparities, we need comprehensive, innovative, and forward-thinking approaches like safer consumption spaces. New York is in a unique position to step up and implement innovative drug policies rooted in science, compassion, and public health as we did with syringe exchanges before. It is the time for New York City's elected officials to lead the way in implementing drug policies that can save lives immediately.

Homeless Shelters

A recent initiative in New York mandates that every homeless shelter maintain a naloxone kit and have a shelter employee trained in its use and directs the city to develop a plan to provide naloxone training for shelter residents. NYC has also begun providing harm reduction training, including overdose prevention and naloxone kits to people being released from NYC jails – a population greatly affected by both lack of housing and increased overdose risk. New York City began implementing similar harm reduction protocols in 2009. This included training single adult shelter, including safe haven,[7] medical staff and DHS police to treat opioid overdoses with intranasal naloxone.[8] More recently, New York City has required naloxone training for shelter staff and residents.

Challenges in the naloxone program's implementation have included staff discomfort with resuscitation and administering medication, including naloxone, to reverse drug overdose.[9] Furthermore, there have been reports of homeless shelter staff actively barring peer responses to people experiencing an overdose on shelter premises and prohibiting the use of naloxone, therefore resulting in overdose death.[10]

There is a clear need for additional overdose training and interventions for staff and clients in homeless settings. We support comprehensive implementation of naloxone distribution and training programs for staff and clients in all housing alternatives including temporary shelters and temporary housing in hotels and motels.

Health, Addiction and the Role of Stable Housing

Access to permanent, affordable housing is a critical component of maintaining the health and stability of people actively engaged in drug use and those in recovery. Homelessness and

unstable housing often co-occur with substance use disorder. Indeed, drug use can contribute to homelessness as a result of policies and practices that force people who use drugs out of their home.

Alternative forms of transitional or supportive housing have emerged to meet the needs of people who use drugs and who experience chronic homelessness. However, some of the programs mandate abstinence as a condition of housing; those who cannot comply find themselves homeless again. In particular, while Governor Cuomo has committed $10 billion to affordable housing units throughout the state, and Mayor Bill de Blasio has pledged to create 15,000 units of supportive housing over the next 15 years, homeless single adults with a substance use disorder, cannot access this housing unless they complete a course of treatment and demonstrate that they need housing to sustain abstinence.[11]

Further, those who are in recovery and lack housing are vulnerable to exploitation in the form of unregulated, three-quarter housing which has proliferated in the absence of permanent housing to meet the growing need of NY's homeless population. Three-quarter housing are privately operated, for-profit family homes or apartment buildings that rent beds to single adults, and were developed in New York City to contend with the housing shortages – particularly for vulnerable residents. Exploitative and dangerous housing practices within three-quarter housing units is widespread and well-documented.[12] In order to maximize profits, property owners pack tenants into small rooms, far exceeding the appropriate occupancy. Routine maintenance is neglected and the units are often plagued by infestations of bed bugs and vermin.

Without access to stable housing, people who use drugs can find themselves caught in the cycle of repeat incarceration and dependency on emergency medical service. Without significant reform of housing policy, both within the public and private sector, we will continue to be stuck in a vicious cycle: people who use drugs cannot secure housing because of their substance use and yet, without housing, they will not be able to adequately address the risks or harms of their substance use.

Recommendations

There are a range of evidence-based solutions that can save lives. They begin with our state and city adopting a public health approach to drug use rooted in science and best practices; interventions must be grounded in compassion, encouraging people to seek support, not hide their struggles because of stigma. Given the human toll of the opioid crisis, the collateral consequences to families across the state, and the cost of inaction, we must ensure that smart public policy trumps politics. Too often, political calculations have led decision makers to support policies that wage a "war on drugs" – which has been demonstrably ineffective and has further harmed individuals and communities.

To adequately tackle New York City's overdose crisis among people who are homeless, we must consider the following:

- **Naloxone:** New York has greatly expanded access to this life-saving medication that reverses opioid overdoses, but to ensure universal access we must expand distribution through community-based organizations serving people with a history of drug use. We must increase naloxone distribution in other settings**,** including by building on successful police EMT pilot programs, improving access through drug treatment and homeless services agencies, and giving kits to eligible individuals upon release from jail or prison.

- **Safer Consumption Spaces:** This intervention engages the most marginalized users, such as people who are homeless and those who are justice-involved. Safer consumption spaces take risky drug use off the street and provide supervision so people are not alone, a lifesaving intervention.

- **Provide Treatment and Harm Reduction Services in Emergency Rooms:** People who are homeless use emergency services more frequently than others. We recommend the initiation of low-threshold buprenorphine in the emergency room for people who have overdosed; distributing naloxone to anyone discharged from the emergency room who presented with overdose, drug use-related injury (abscess), or whose history indicates substance use disorder; and ensuring emergency rooms have an in-house overdose prevention educator.

- **Support the housing needs of people just released from jail or prison.** People undergoing reentry are more likely to experience homelessness and are at 130% increased risk for overdose during the first two weeks of reentry. We recommend that state funded supportive housing must have a portion targeted to people with criminal justice involvement; “transition centers” for people just released from prison for short-term housing and housing counseling; HUD change its definition of “homeless” to include people coming out of prison; and integration of overdose prevention, including naloxone training and distribution, as part of reentry protocols.

- **Increase access to low-barrier supportive housing and end reliance on three-quarter housing and shelters:** We support the statewide campaign for the creation of 20,000 units of supportive housing. People in crisis must be able to access such housing immediately. Housing is a critical support for people in recovery. Housing First models provide effective ways to link people struggling with opioid use to supportive housing, reducing their risk of fatal overdose.

- **Support the housing needs of people discharged from OASAS in-patient treatment facilities.** People leaving treatment are at particular risk for homelessness and overdose. We recommend; ending unwarranted evictions from OASAS-licensed in-patient programs—a hearing in housing court should be required for eviction for residents at property for at least 30 days; requiring OASAS disclose information regarding evictions, including inspection reports for each licensed program, number of complaints and type for each program, number of discharges from each program and the basis for the discharge; and the right to housing placement assistance prior to discharge. Any patient discharged from OASAS program should receive individualized housing placement services to assist the patient in securing safe, permanent alternative housing. Discharged patients should also receive a referral to a harm reduction program near them.

- **Expand pre-arrest diversion programs:** There is a growing recognition nationally that arrests and incarceration do nothing to end the overdose crisis, nor do they help people struggling with substance use disorders. For people experiencing homelessness, incarceration can interrupt whatever housing the individual may have been able to secure and means, when they are released, they will inevitably be on the street for a period of time before they are able to re-secure housing. Given dramatically higher rates of overdose following even brief periods of incarceration, it is

critical to reduce overreliance on arrest and provide meaningful pre-arrest diversion opportunities.

- **Improve data collection on criminal justice and homeless population overdose episodes and fatalities.** We recommend better tracking of the homeless population and conducting overdose case reviews for overdoses that occur near or within homeless or temporary housing settings.

As we seek to implement the above solutions, we must not fall back toward a punitive 'drug war' approach that is ineffective and can actually exacerbate problems. We must resist criminalization approaches:

- **Avoid arrests, mandatory minimums, and drug-induced homicide laws:** Research consistently shows that increased arrests nor increased severity of criminal punishment for drug law violations do not result in less use (demand) or sales (supply). Increasingly punitive prosecutions and sentences for drug offenses have no deterrent effect and do not keep our communities safer from harm.

- **Limit drug courts:** It is inappropriate for courts to impose or interfere with medical decisions. Some New York drug court judges routinely require individuals to cease opioid agonist treatment with methadone or buprenorphine, contravening medical judgment and putting people at greater risk of overdose and other health repercussions.

Avoid coercive or narrow approaches:

- **Involuntary treatment:** Holding someone to treat them against their will is very unlikely to result in sustained abstinence. Instead, forced abstinence will rapidly reduce opioid-dependent people's tolerance, which consequently increases the risk of subsequent fatal overdoses. Involuntary holds carry the risk of killing people. Further, compulsory treatment paradigms are highly susceptible to error and abuse, both as to diagnosis and treatment, as well as to constitutional protections of privacy and due process.

- **Abstinence-only treatment:** Abstinence may lead to good outcomes for some, but it should not be considered the only acceptable goal or criterion of success. Instead, smaller incremental changes in the direction of reduced harmfulness of drug use should be valued. This harm reduction framework helps people who use drugs who cannot or won't stop completely reduce the harmful consequences of use. Approximately 10% of people who need treatment for substance use disorders actually seek and receive treatment; data shows nearly a quarter of those do not engage with treatment because they aren't ready to totally stop using.

We look forward to further conversations with this committee regarding the implementation of these recommendations.

Thank you for your time,
Kassandra Frederique

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[3] *Policy Impact: Prescription Painkiller Overdoses*, Ctrs. for Disease Control and Prevention, *http*://www.cdc.gov/HomeandRecreationalSafety/pdf/PolicyImpact-PrescriptionPainkillerOD.pdf (last visited July 14, 2014).
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[6] “Annual Report on Homeless Deaths.” 2017. Local Law 63: Reporting Deaths of Homeless Persons. New York City Department of Health and Mental Hygiene. Bureau of Vital Statistics.
[7] Transitional housing alternatives to shelters - smaller than traditional shelters, laid out in private or semiprivate rooms, have few rules, and have no curfew.
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[11] "De Blasio Administration Announces Plan to Create 15,000 Units of Supportive Housing." The Official Website of the City of New York, 18 Nov. 2015.
[12] In 2013, John Jay Prisoner Reentry Institute published and extensive report highlighting the many exploitative and dangerous housing practices within Three-Quarter Housing units. At the time, Three-Quarter Housing was unregulated by any government agency despite receiving referrals from governmental agencies and community-based organizations under government contract and public funding. The Three-Quarter Housing Units were derelict, Almost 90% of the 317 addresses analyzed had a building code complaint made between 2005 and 2012 that resulted in at least one violation or stop-work order by the New York City Department of Buildings.