



Testimony  
of

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before the

**New York City Council Committee on Mental Health, Mental Retardation,**  
**Alcoholism, Drug Abuse and Disability Services and Sub-Committee on Drug Abuse**

regarding

**An examination of the state of drug policy and addiction in New York City,**  
**with a focus on reforming the Rockefeller Drug laws**

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Good morning, Chairperson Koppell, Chairperson Palma, and Committee members. My name is Daliah Heller, and I am the Assistant Commissioner for the Bureau of Alcohol and Drug Use Prevention, Care and Treatment of the New York City Department of Health and Mental Hygiene (DOHMH). On behalf of the Department, thank you for the opportunity to discuss drug policy in New York City.

Reducing drug-related morbidity and mortality is a top priority for DOHMH. To address problems of drug use and dependence in New York City, we develop and implement initiatives in diverse venues, where we can reach individuals experiencing these problems. We also work closely with our City, State, and community partners to improve systems of care, to ensure our responsiveness to problems of drug use.

Although this hearing is focused on policies regarding illicit drug use, I would like to note that alcohol is the most commonly used psychoactive substance: four times as many people experience problems with alcohol abuse and dependence in the United States as with illicit drugs. Alcohol has a far greater impact on morbidity and mortality, both nationally and here in New York City, including its involvement in accidents and violence.

Illicit drug use is associated with substantial morbidity and mortality in New York City, and a variety of drugs are involved. Cocaine use causes approximately 17,000 emergency room visits each year, more than twice the number of visits than any other illicit drug. Approximately 900 people die from accidental drug-related overdoses each year in New York City; it is the fourth leading cause of early adult death. Up to one-fourth of these deaths involve prescription opioids, such as oxycontin or vicodin. Drug-related hospitalizations and deaths are highest in neighborhoods with the lowest income levels, and vulnerable populations, such as the homeless, are at greater risk of drug-related death.

Drug use is devastating to individuals, families, and communities and we must take advantage of what works, whether those strategies are politically popular or not. The Department works to reduce these problems on multiple fronts. As the local governmental unit of the statewide service system, we contract with community-based prevention and treatment programs providing services in neighborhoods throughout the City. In addition, we work to develop, provide, and improve services for individuals who use drugs, and we make concerted efforts to solicit community input in doing so. Also, we partner with many city and State agencies to administer the New York New York III housing initiative, which for the first time includes supportive housing targeted specifically to individuals with a primary diagnosis of substance abuse.

To further describe this work, I will adopt the ‘four pillars’ framework for drug policy, to explain our approach to prevention, treatment, harm reduction, and law enforcement.

#### *Prevention*

We focus on two main areas in our prevention work. First, primarily with adults, we promote a model known as SBIRT, or screening, brief intervention, referral, and treatment. This model has been proven effective for significantly reducing risky or hazardous drug use with the implementation of universalized screening and a brief, motivational intervention with identified

individuals to address substance use problems. We have implemented this intervention in health care settings where providers can take advantage of “teachable moments,” such as in emergency rooms, primary care offices, and our STD clinics. We are also testing SBIRT in other venues, including eviction prevention and employment programs. We created a City Health Information publication about SBIRT, and sent it to more than 30,000 health care providers. We are also working with our Primary Care Information Project to expand this evidence-based practice via electronic health records.

Prevention efforts are particularly important for adolescents, to reduce their likelihood of developing later lifetime problems with drug use. We administer community-based prevention programs in coordination with the State, and through our school-based health clinics we work to ensure that potential problems among youth are appropriately addressed. Prevention through youth engagement and empowerment is an area into which we are particularly interested in expanding our efforts, in partnership with other youth-serving governmental and non-governmental agencies.

#### *Treatment*

Expanding opportunities for treatment remains a priority for the Department, and one which we have pursued extensively in a variety of venues and through a number of modalities. We continue to promote the availability and uptake of buprenorphine treatment for opioid dependence, as an alternative to methadone maintenance in New York City, and today, more than 3,000 New Yorkers are receiving buprenorphine treatment. To this end, we disseminate educational literature on buprenorphine for patients and providers, sponsor a physician mentoring program, and provide peer-based buprenorphine education to potential patients. Recently, we awarded competitive grants to three federally-qualified health centers in order to expand buprenorphine access in communities where drug-related morbidity and mortality are highest.

In addition, we have worked with our contracted providers over the past two years to increase the identification of co-occurring mental illness among their patients, and to support engagement in appropriate psychiatric care and treatment. As the State expands opportunities for providers to address this co-occurrence, DOHMH continues to offer training and technical assistance to help community-based providers build their capacity and respond effectively to these issues among their patients.

DOHMH is also working with other City agencies to improve treatment services. In partnership with the Human Resources Administration, we have implemented the Managed Addiction Treatment Services program (MATS) with great success, and we expect to realize significant Medicaid cost savings from this approach. MATS engages frequent users of inpatient detoxification services by offering them voluntary intensive case management services. These services assist individuals with stabilization in longer-term outpatient drug treatment, while addressing their other needs for housing and social service supports.

We are working with the Department of Correction to expand and coordinate discharge planning into community-based drug treatment for inmates throughout the facilities on Rikers Island. Through the work of our own DOHMH Correctional Health Services Bureau, we continue to

provide and expand upon treatment opportunities for incarcerated individuals in City jails. The KEEP Program at Rikers Island has 20,000 admissions for methadone treatment services each year, including about 5,000 admissions for methadone maintenance. In addition, last year we initiated an evidence-based treatment readiness program for inmates entitled “A Road Not Taken,” now operating in three housing units at Rikers Island.

The Department also appreciates continued City Council funding to support the provision of community-based services at a number of designated providers in New York City neighborhoods.

### *Harm Reduction*

Harm reduction, which addresses the health needs of individuals who continue to use drugs, remains a central component of the DOHMH drug policy approach. Since 2004, we have provided funding to syringe exchange programs to prevent the incidence of HIV, hepatitis C, and other blood-borne viral and bacterial infections. We continue to work with our State partners, to provide and expand community-based harm reduction services for injecting and other drug users.

DOHMH is working to promote naloxone distribution, an opioid antagonist traditionally used in emergency medicine. This month, we began offering intranasal naloxone to State-registered opioid overdose prevention programs, as a needle-less alternative to the injectable formulation. We are also completing work on tools and resources to expand this initiative in the community, including an overdose prevention training video and an informational palm card, which highlights the prevalence of overdose, and details prevention and response advice. We expect to begin widespread dissemination of these resources by April of this year.

We continue to work with the Injecting Drug Users Health Alliance (IDUHA) to support programs including syringe access expansion and related harm reduction services, overdose prevention and response, and hepatitis C and buprenorphine education, with the generous support of the City Council.

### *Law enforcement*

The recent rejuvenation of local and state-wide advocacy for the reform of New York State drug laws raises the issue of how the response to drug use in our City may be re-oriented. The Department supports a public health approach to drug policy, which would only be possible with significant legal reforms that are responsive to the problem of drug use itself. Such an approach may include expanding capacity in all treatment service types, a greater range of harm reduction strategies, and/or increasing alternatives to incarceration, including vocational and educational services.

The current fiscal environment also represents an enormous challenge for all of us. As part of Governor Paterson’s 2009-10 executive budget, the State Office of Alcoholism and Substance Abuse Services plans to eliminate its funding for the KEEP Program, despite the continued necessity for opioid dependence services among almost one-fifth of inmates ordered to jail. We are working with the Department of Correction, the Mayor’s Office and community advocates to restore this funding, and encourage the City Council to join us in our efforts.

In our own portfolio, we have worked diligently to ensure that fiscal reductions are recouped from voluntary program closures and, where necessary, remain limited to program enhancements, to preserve full programs.

The problem of stigma associated with drug use also represents a substantial impediment to the development and improvement of appropriate service systems in New York City. Through the work I have described here today, we are working to reduce and overcome this stigma. Through the Alcohol and Drug Use Councils of the Federation, meeting monthly in each borough, we seek the input, participation, and leadership of individuals who have experienced problems with drug use themselves.

Thank you again for the opportunity to testify. I welcome your questions at this time.

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