



Testimony  
of

**Daliah Heller, PhD, MPH**  
**Assistant Commissioner**  
**Bureau of Alcohol and Drug Use Prevention,**  
**Care and Treatment**

**New York City Department of Health and Mental Hygiene**

before the

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

and

**New York City Council Subcommittee on Drug Abuse**

regarding

**The State of Drug Abuse & Treatment in NYC**

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City Hall  
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Good morning, Chairperson Koppell, Chairperson Cabrera, and members of the Committee. 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 the state of drug abuse & treatment in New York City.

Today, I will discuss the most recent data on drug use trends in New York City, and the Department's work in prevention, care, and treatment. Reducing drug-related morbidity and mortality is a top priority for DOHMH. The negative health and social consequences of drug use can be devastating for individuals, families, and communities, and as the City's public health leaders, it is our obligation to promote evidence-based solutions. The Department works to reduce these problems on multiple fronts. We contract with community-based prevention, harm reduction, and treatment programs to provide services in neighborhoods throughout the City. In addition, we identify and promote new and effective strategies to address problems of drug use, and solicit community input to ensure we are responsive to new and emergent issues in a timely manner. We also work closely with our City, State, and community partners to improve systems of care and to ensure our responsiveness to problems of drug use.

#### *Data on illicit drug use and health*

First, I would like to provide an overview the Department's most recent data on drug use, which we released in our *Vital Signs* publication this past February. According to the National Survey on Drug Use and Health, 16% of New Yorkers – corresponding to one million people – reported using illicit drugs in the past year, compared to a 14% national average. Excluding marijuana, New Yorkers are slightly more likely to use illicit drugs than Americans overall. Two trends are particularly concerning: nonmedical use of prescription pain relievers (opioids such as oxycodone) and cocaine use have both increased, with rates among men more than doubling between 2002 and 2007 to about 6%.

Use of illicit drugs is associated with substantial drug-related morbidity and mortality, including unintentional drug poisoning death (or “overdose”), injuries, sexually transmitted infections such as HIV, hepatitis B and C, liver disease, hypertension, and depression. One in ten hospitalizations in NYC is related to drug use. In 2007, there were nearly 55,000 drug-related emergency department visits, and cocaine was the most frequently cited drug

for all age groups, representing more than half of all drug-related visits. In 2006, opioids were specifically identified in 46% of all drug-related hospitalizations, and cocaine in 47%. Nearly two-thirds of all drug-related hospitalizations were among New Yorkers ages 35-54 years and half were of New Yorkers who live in low-income neighborhoods.

Accidental overdose is the fourth-leading cause of premature adult death in New York City, and is the third-leading cause of death among New Yorkers aged 25-34. Three-quarters of fatal overdoses involve opioids, half involve cocaine, 40% involve alcohol, and a third involve sedatives; importantly, 98% of overdoses involve multiple substances. Men account for 74% of overdose deaths and 60% of decedents are aged 35-53 years. Rates of fatal overdose differ across racial/ethnic groups by age: rates for the youngest decedents, 15-34 years old, are highest among white New Yorkers; for 35-44 year-olds, Hispanic New Yorkers have the highest rates, and among 45-54 year-olds, black New Yorkers have the highest rates. However, despite these numbers, we are encouraged by recent data that reveals that overdose deaths in New York City declined by 27% from 2006 through 2008, falling to their lowest level since 1999. We hope to see this trend continue.

It is important to note that despite all the data on the health impact of illicit drug use, the most commonly used psychoactive substance, responsible for more deaths in New York City than from all other drugs combined, is alcohol. Moreover, alcohol-related morbidity – chronic illnesses such as cirrhosis, cancer, and heart disease, as well as its effects on suicide, homicide, domestic violence, sexually transmitted diseases, and motor vehicle accidents – far exceeds that of illicit drugs.

### *Prevention*

Prevention is the first step in reducing the negative effects of drug use. 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 are exploring ways in which issues around drug use can be integrated into a variety of programs in youth-serving venues, such as schools and after-school programs.

Early intervention can also help to prevent the progression of problems with drug use. The screening, brief intervention, referral, and treatment (or SBIRT) model has been proven effective for significantly reducing harmful alcohol and drug use when a universalized screening approach is implemented, and a brief, motivational interview is provided for individuals

identified, to encourage and support behavior change. We promote this intervention in health care settings where providers can take advantage of “teachable moments,” such as emergency departments, primary care offices, and our Department’s STD clinics. We are working with our State partners to implement this approach more widely in primary care. We are also testing SBIRT in other venues, including eviction prevention and employment programs. Finally, we are working to integrate SBIRT into the electronic medical records at several community health centers in NYC, to ensure its reach in clinical practices.

### *Treatment*

Currently, the treatment field is undergoing a paradigm shift, strengthening an approach which emphasizes a recovery-oriented model of care, and we look forward to supporting this development. In addition, we promote medication-assisted treatment, which has proven particularly effective for resolving problems of opioid dependence, improving health outcomes and helping individuals lead productive lives. Buprenorphine is the first major innovation in opioid dependence treatment in over 40 years, and has presented a unique opportunity to integrate treatment into primary care. The Department is pursuing a multi-pronged strategy to increase awareness of and access to Buprenorphine treatment. We have built relationships with public, private and non-profit partners, as well as with consumer, provider and other stakeholders, including the Council, to expand Buprenorphine supply and demand in New York City. As the need for integrating education about the medication into community-based programs has become apparent, we are in the process of developing a train-the-trainer curriculum for programs, to ensure programs can deliver Buprenorphine education as a component of their routine services. DOHMH has also created a physician mentoring network to support doctors in prescribing Buprenorphine, and we continue to sponsor two certification trainings for doctors each year. In December 2009 (the most recent data available), 4,200 unique individuals were prescribed Buprenorphine, a 50% increase over the same month in 2008.

### *Harm Reduction*

Many people with substance use disorders eventually stop using drugs, and simple tools and approaches can help them reduce harm to themselves and others until they are able to stop. Harm reduction, which addresses the health needs of individuals who continue to use drugs, remains a central component of our approach, ensuring a continuum of care for addressing problems of drug use.

Since 2004, the Department has funded syringe exchange programs to prevent the incidence of HIV, hepatitis C, and other blood-borne viral and bacterial infections, and to engage injecting drug users into care. In New York City, authorized syringe-exchange programs have been operating since 1992, and HIV prevalence among injecting drug users has fallen by nearly 80% since the early 1990s. We continue to work with our community and State partners to provide and expand community-based harm reduction services for injecting and other drug users.

DOHMH is also working to prevent opioid overdose deaths by expanding community-based access to and use of the opioid antidote naloxone, an opioid antagonist traditionally used in emergency medicine. With the support of the Council, DOHMH continues to work with community-based organizations to educate, train, and distribute overdose prevention kits with naloxone to New Yorkers who may find themselves in a position to save a life. We target these efforts to at-risk populations and focus our education efforts to communities where rates of drug-related morbidity and mortality are highest. We also offer intranasal naloxone, a needle-less alternative to the injectable formulation, to registered opioid overdose prevention programs. Our education and training resources include a palmcard and a training video, which instruct how to prevent and respond to an overdose situation. Since the overdose prevention program began in 2006, more than 4,000 overdose rescue kits have been distributed, and trained responders have reported over 300 overdose reversals.

With the generous support of the City Council, we continue to work with the Injecting Drug Users Health Alliance (also known as IDUHA) to support programs for syringe access expansion and related harm reduction services, overdose prevention and response, and hepatitis C and Buprenorphine education.

Lastly, I would like to mention our work in the city jails. We continue to collaborate with the Department of Corrections to expand and coordinate discharge planning into community-based drug treatment for inmates from throughout the facilities on Rikers Island. Through the work of our own Department's Correctional Health Services, we continue to provide and expand upon treatment opportunities for incarcerated individuals in the city jails. The KEEP Program at Rikers Island has in the realm of 20,000 admissions for methadone treatment services each year, including about 5,000 admissions for methadone maintenance. In 2008, we initiated an evidence-based treatment readiness program for inmates entitled "A Road Not Taken," now operating in five housing units at Rikers Island.

In summary, reducing drug-related morbidity and mortality remain a top priority for DOHMH, and we appreciate the Council's tremendous ongoing support for programs that help us achieve this goal.

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

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