



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

before the

**New York City State Assembly Committee on Alcoholism and Drug  
Abuse**

on

**Programs and Services for the Treatment of Opioid Abuse**

**December 12, 2013**

**250 Broadway  
New York, New York**

Members of the Assembly Committee on Alcoholism and Drug Abuse, thank you for providing the New York City Department of Health and Mental Hygiene with the opportunity to submit testimony on programs and services for the treatment of opioid abuse, a public health issue of great concern to the Department.

The misuse of opioids has been an issue in New York City for decades. Drug overdose is currently the third leading cause of premature death among New Yorkers, and 72% of those deaths involve opioids.<sup>1</sup> Opioids are a class of substances that include both opioid analgesics (painkillers) and heroin. In recent years, opioid analgesic misuse has become a local and national epidemic. In New York City, between 2005 and 2011, the rate of overdose deaths from opioid analgesics increased by 65%; in 2011, 220 New Yorkers died of overdoses involving these drugs.<sup>2</sup> In Staten Island, where the epidemic is most prevalent, rates of opioid analgesic overdose deaths increased by 261% between 2005 and 2011.<sup>3</sup>

Similar to national trends, heroin-associated overdoses in New York City have also increased for two successive years. In 2011, 284 New York City residents died of heroin-associated overdoses; in 2012, that number rose to 352, a rate of 5.3 per 100,000 New Yorkers.<sup>4</sup> Although opioid overdose is the most extreme result of opioid misuse, many New Yorkers suffer from opioid dependence, which can severely impact overall health and quality of life. New York City data from the National Survey on Drug Use and Health (NSDUH) indicate there are approximately 77,000 New Yorkers suffering from opioid addiction.<sup>5</sup>

---

<sup>1</sup> Personal communications with Surveillance Unit, Bureau of Alcohol and Drug Use, NYC DOHMH

<sup>2</sup> Paone, et. al. *Epi Data Brief*, No. 27. 2011

<sup>3</sup> *ibid.*

<sup>4</sup> Paone, et. al. *Epi Data Brief* No 33. 2012

<sup>5</sup> Personal communication with Surveillance Unit, Bureau of Alcohol and Drug Use, NYC DOHMH

## Opioid Treatment

With the rapid growth in opioid misuse there is an increased need for services to treat New Yorkers with opioid dependence. Forms of treatment vary greatly in their effectiveness. Research shows that short-term detoxification alone is the least successful strategy for treating opioid addiction and that, while behavioral therapeutic interventions are somewhat more effective, medication-assisted treatment with methadone or buprenorphine, in conjunction with counseling, produces the best outcomes for treating opioid addiction.<sup>6</sup>

An extensive body of research supports the effectiveness of both methadone and buprenorphine in treating opioid addiction.<sup>7</sup> Positive outcomes among patients treated with methadone and buprenorphine include reductions in drug use and criminal justice involvement, increases in employment, and decreases in high-risk sexual behavior and HIV infection.

Although both methadone and buprenorphine are available in New York City, methadone is more readily available. The system of methadone maintenance providers in New York City is well-established and is one of the most extensive and sophisticated in the nation. Methadone treatment is available in state-licensed, highly regulated opioid treatment programs, where patients are directly supervised taking their methadone by clinical staff. By contrast, buprenorphine can only be prescribed by physicians in general practice settings and outpatient drug treatment programs. The availability of buprenorphine in general medical settings may increase its appeal for some patients seeking treatment.

---

<sup>6</sup> John W. Davison, et. al. Outpatient Treatment Engagement and Abstinence Rates Following Inpatient Opioid Detoxification, *Journal of Addictive Diseases* 2006;25(4):27-35

McLellen et. al. The Effects of Psychosocial Services in Substance Abuse Treatment. *JAMA*. 1993;269(15):1953-1959

<sup>7</sup> Marsch LA. The efficacy of methadone maintenance interventions in reducing illicit opiate use, HIV risk behavior and criminality: a meta-analysis. *Addiction* 1998;93(4):515-32.

Johnson R, et. al. A comparison of levomethadyl acetate, buprenorphine and methadone for opioid dependence. *NEJM* 2001: Volume 343 (18): 1290-97

## **Treatment Challenges**

In New York City, data show that rates of treatment for people with opioid addiction are better than for other drug problems, although there is still a large treatment gap. Of the estimated 77,000 New Yorkers with opioid dependence, approximately 36,000 receive methadone maintenance treatment, and 15,000 receive treatment with buprenorphine, indicating approximately one third of New Yorkers with opioid addictions are not receiving any treatment.<sup>8</sup>

While the system of methadone maintenance providers in New York City has the clinical infrastructure in place to expand capacity, methadone maintenance is not appealing to many people due to the longstanding stigma associated with opioid treatment programs (commonly called OTPs or methadone clinics). In addition, the highly regulated and structured OTP setting may dissuade some patients from seeking or successfully obtaining care. These regulations, for example, require nearly all people enrolling in methadone maintenance to visit the clinic six days a week for supervised medication administration through the first three months of treatment, presenting logistical challenges and precluding patient anonymity. Finally, the methadone maintenance system, similar to other parts of the drug treatment system, is poorly coordinated with the mainstream healthcare and social service systems, creating barriers to effective and patient-centered care.

As an alternative to the addiction treatment system, primary care is increasingly recognized as an important setting for the engagement and treatment of people with substance use disorders. Buprenorphine is a lynchpin in the expansion of opioid addiction treatment to primary care clinics. Unfortunately, primary care physicians are often reluctant to accept patients with substance use disorders and are even more reluctant to directly treat drug use issues. Currently, the number of

---

<sup>8</sup> Surveillance Unit, Bureau of Alcohol and Drug Use, NYC DOHMH

buprenorphine prescribers in New York City is inadequate to meet need, especially given the increasing rates of opioid misuse.

### **Addressing opioid use in New York City**

The Department is taking a multi-pronged approach to addressing the opioid epidemic. This includes working to save lives at immediate risk through the provision of Overdose Prevention Programs and through education and awareness-raising campaigns. In the last fiscal year, Overdose Prevention Programs funded through the Department trained 3,974 people and distributed to them overdose rescue kits with naloxone, a medication which can reverse opioid overdose.

In addition, the Department is monitoring and improving prescribing practices to reduce the abundance and accessibility of opioid analgesics. Using data from the New York State Prescription Monitoring Program, the Department tracks opioid prescribing patterns in New York City and uses this information to conduct prescriber and public education. The Department has developed guidelines for judicious opioid prescribing and disseminates these in primary care and emergency departments. To date, 45 New York City hospitals have adopted the Department's emergency department opioid prescribing guidelines. The Department also recently conducted a "public health detailing" campaign in Staten Island, visiting nearly 1,000 prescribers there to conduct one-on-one educational sessions on our guidelines.

Another key area of focus for the Department is collaborating with New York City's methadone maintenance system to improve services and reduce the stigma associated with this form of treatment. As a contractor of state and local funds for treatment programs, the Department is working with the New York State Office of Alcoholism and Substance Abuse Services (OASAS) to promote more patient-centered practices in methadone maintenance

programs, including technical assistance with the implementation of clinic-based overdose prevention programs and peer-based recovery support services, which may help patients become more engaged in care.

We are also working to increase access to buprenorphine. During our Staten Island detailing campaign, we disseminated buprenorphine information to all prescribers and we recently held a special training on buprenorphine for Staten Island physicians. We have also made funding available to contracted drug treatment programs across the New York City to start up buprenorphine treatment. In addition, we are in contract with all fourteen of New York City's syringe exchange programs and include buprenorphine education as a standard service. The Department is currently seeking funding for innovative programs that could promote buprenorphine access in primary care, such as a nurse-led primary care management program that has been effective in other states in expanding access to this form of treatment.

Finally, through our contracts with the City's syringe exchange programs, the Department is working to reduce harms associated with drug injection. These programs have had a direct impact on the decrease in HIV incidence in the City and they are critical for engaging current drug users in healthcare. Syringe exchange programs funded by the Department have been particularly focused on hepatitis C care management and referral, health education, and overdose prevention.

Even with these efforts, however, the opioid epidemic in New York City continues to be a significant public health concern, and ensuring that all patients suffering from opioid dependence have access to effective treatment needs to be a top priority. In addition to increasing access to medications for people with opioid addiction, we recommend increasing funding for recovery support services through the Medicaid redesign process. In particular, a key area of focus should be integrating substance use disorder treatment into the broader healthcare and social service

system. Clinical providers of substance use disorder treatment should be better aligned with mental health treatment and primary care providers to facilitate information and resource sharing to better deliver care for patients with opioid and other drug dependence issues. Health homes and other care coordination services should also be a critical component of improving continuity of care. Finally, as new systems of public and private insurance are implemented, we recommend that funding is maintained for people and recovery services not covered by Medicaid or other insurance.

Thank you again for the opportunity to submit testimony. We would be happy to provide additional information.