

NDEWS *National Drug Early Warning System*

Funded at the Center for Substance Abuse Research by the National Institute on Drug Abuse

New York City Sentinel Community Site (SCS) Drug Use Patterns and Trends, 2018

November 2018

NDEWS Coordinating Center

National Drug Early Warning System (NDEWS) ♦ www.ndews.org ♦ ndews@umd.edu ♦ [@ndewsnews](https://twitter.com/ndewsnews) ♦ network.ndews.org

NDEWS is funded under NIDA Cooperative Agreement DA038360 awarded to the Center for Substance Abuse Research (CESAR) at the University of Maryland, College Park. Opinions expressed in this report may not represent those of NIH or NIDA.

NDEWS *National Drug Early Warning System*

Funded at the Center for Substance Abuse Research by the National Institute on Drug Abuse



Sentinel Community Epidemiologists (SCEs)

Atlanta Metro

Brian J. Dew, PhD
Dept of Counseling and Psychological Svcs
Georgia State University
Phone: 404-413-8168
bdew@gsu.edu

Chicago Metro

Lawrence J. Ouellet, PhD
School of Public Health
University of Illinois at Chicago
Phone: 312-355-0145
ljo@uic.edu

Denver Metro

Marion Rorke, MPH
Dept of Public Health and Environment
City and County of Denver
Phone: 720-865-5453
marion.rorke@denvergov.org

Wayne County (Detroit Area)

Cynthia L. Arfken, PhD
Dept of Psychiatry and Behavioral
Neurosciences
Wayne State University
Phone: 313-993-3490
cynthia.arfken@wayne.edu

Los Angeles County

Mary-Lynn Brecht, PhD
Integrated Substance Abuse Programs
University of California at Los Angeles
Phone: 310-983-1196
lbrecht@ucla.edu

Maine

Marcella H. Sorg, PhD, RN
Rural Drug and Alcohol Research Program
University of Maine
Phone: 207-581-2596
mhsorg@maine.edu

Southeastern Florida (Miami Area)

James N. Hall, BA
Center for Applied Research on Substance Use
and Health Disparities
Nova Southeastern University
Phone: 786-547-7249
upfrontin@aol.com

New York City

Denise Paone, EdD
Bureau of Alcohol and Drug Use
Prevention, Care and Treatment
New York City Dept of Health & Mental
Hygiene
Phone: 347-396-7015
dpaone@health.nyc.gov

Philadelphia

Suet T. Lim, PhD
City of Philadelphia
Dept of Behavioral Health and Intellectual
disAbility Services
Community Behavioral Health
Phone: 215-413-7165
suet.lim@phila.gov

San Francisco

Phillip O. Coffin, MD, MIA
San Francisco Dept of Public Health
Phone: 415-437-6282
phillip.coffin@sfdph.org

King County (Seattle Area)

Caleb Banta-Green, PhD, MSW, MPH
Alcohol and Drug Abuse Institute
University of Washington
Phone: 206-685-3919
calebbg@u.washington.edu

Texas

Jane C. Maxwell, PhD
School of Social Work
The University of Texas at Austin
Phone: 512-656-3361
jcmaxwell@austin.utexas.edu

National Drug Early Warning System (NDEWS) New York City Sentinel Community Site (SCS) Drug Use Patterns and Trends, 2018

Cody Colon-Berezin, M.S.P.H., Ellenie Tuazon, M.P.H., Bennett Allen,
Lara Maldjian, M.P.H., Charles Ko, M.P.H., Elizabeth Mello, M.S., Angela Jeffers, M.P.H.,
Holly Catania, J.D., Alexandra Harocopos, Ph.D., and Denise Paone, Ed.D.
New York City Department of Health and Mental Hygiene

Highlights

OVERDOSE DEATHS IN 2017

- There were 1,487 unintentional drug overdose deaths in New York City (NYC), up from 1,425 in 2016.
- There was an average of nearly four drug overdose deaths each day in NYC or one death every six hours.
- The rate of unintentional drug overdose death increased for the seventh consecutive year, from 8.2 per 100,000 residents in 2010 to 21.2 per 100,000 in 2017.
- More than eight in ten (82%) overdose deaths involved an opioid.
- For the first time since tracking of overdose deaths began in 2000, fentanyl was the most commonly involved substance, involved in 842 (57%) overdose deaths.
- Heroin was the second most common substance, involved in 771 (52%) of all deaths.
- Cocaine was involved in 49% of overdose deaths in 2017, up from 46% in 2016.

COCAINE/CRACK

- Cocaine was involved in 49% of overdose deaths in 2017, up from 46% in 2016.
- In 2017, 146 overdose deaths involved cocaine and fentanyl without heroin, which was an increase from 122 overdose deaths in 2016.
- In 2017, 39% of overdose deaths involving cocaine without heroin also involved fentanyl.
- In 2017, 1 in 10 noncrisis treatment admissions reported cocaine as the primary substance (10.2%, $n = 7,937$).

HEROIN

- In 2017, heroin was involved in 771 (52%) of all deaths, making it the second most commonly involved substance in overdose deaths.

- The rate of heroin-involved overdose deaths remained stable from 2016 to 2017 (11.1 to 11.0 per 100,000 residents).
- In 2017, heroin was the most commonly reported primary drug upon admission to drug treatment (34%, $n = 26,315$). This is an increase of 5,547 admissions from 2016, when alcohol was the most commonly reported primary substance.

PRESCRIPTION OPIOIDS/OPIOID ANALGESICS, NO FENTANYL

- Opioid analgesics were involved in 14% of all overdose deaths in 2017.
- The rate of opioid analgesic-involved overdose deaths decreased from 2016 to 2017 (4.0 to 3.1 per 100,000)

FENTANYL & OTHER NONPRESCRIPTION SYNTHETIC OPIOIDS

- Fentanyl was involved in 57% of all overdose deaths in 2017, making it the most commonly involved substance in overdose deaths.
- The rate of fentanyl-involved overdose deaths increased from 2016 to 2017 (9.1 to 12.1 per 100,000 residents).

NDEWS Priority Substances

COCAINE/CRACK

Key Findings

- Cocaine was involved in 49% of overdose deaths in 2017, up from 46% in 2016.
- In 2017, 146 overdose deaths involved cocaine and fentanyl, without heroin, which was an increase from 122 overdose deaths in 2016.
- In 2017, 39% of overdose deaths involving cocaine without heroin also involved fentanyl.
- In 2017, 1 in 10 noncrisis treatment admissions reported cocaine as the primary substance (10.2%, $n = 7,937$).

Polydrug Use

Among cocaine-involved overdose deaths, 53% involved fentanyl, 48% involved heroin, and 48% involved alcohol. Less than a quarter of cocaine-involved overdose deaths involved benzodiazepines (24%), while fewer involved opioid analgesics (13%) or methadone (10%).

Additional Findings

As in 2016, Black New Yorkers continued to have the highest rate of cocaine-related overdose deaths (15.5 per 100,000 New Yorkers) in 2017. New Yorkers 45–54 years of age, Bronx residents, and individuals living in the highest poverty neighborhoods had the highest rates of cocaine-involved overdose deaths. These subgroups are the same high-risk groups that were reported in 2016.

In 2017, 1 in 10 noncrisis treatment admissions reported crack/cocaine as the primary substance (10.2%, $n = 7,937$). For these admissions, alcohol was the most frequently reported secondary substance (33%, $n = 2,653$), followed by no secondary substance (25%, $n = 1,989$) and marijuana (22%, $n = 1,775$). When alcohol was reported as the primary substance, nearly one in four admissions list crack/cocaine as the secondary substance (24%, $n = 5,815$).

Of 47,247 total National Forensic Laboratory Information System (NFLIS) seizures in NYC in 2017, 30% ($n = 14,178$) tested positive for cocaine, and cocaine was the most commonly seized substance. This represents an increase compared with 2016, when there were 13,707 cocaine seizures.

METHAMPHETAMINE

Key Findings

- Unlike other regions of the country, health-related harms of methamphetamine use are not widespread in NYC.
- In 2016 and 2017, methamphetamines were involved 4% of overdose deaths.
- Of 47,247 total NFLIS seizures in NYC in 2017, 2% ($n = 953$) tested positive for methamphetamine. This represents an increase compared with 2016, when there were 729 seizures of methamphetamine.

HEROIN

Key Findings

- In 2017, heroin was involved in 771 (52%) of all deaths, making it the second most commonly involved substance in overdose deaths.
- The rate of heroin-involved overdose deaths remained stable from 2016 to 2017 (11.1 to 11 per 100,000).
- In 2017, heroin was the most commonly reported primary drug upon admission to drug treatment (34%, $n = 26,315$). This is an increase of 5,547 admissions from 2016, when alcohol was the most commonly reported primary substance.

Polydrug Use

In 2017, 69% of all heroin-involved deaths also involved fentanyl, and 46% of all heroin-involved deaths involved cocaine, compared with 43% in 2016. In addition, 42% of heroin-involved deaths involved alcohol, and 33% of heroin-involved deaths also involved benzodiazepines, which is consistent with 2016 data.

Additional Findings

Similar to trends from 2010 to 2016, White New Yorkers and Bronx and Staten Island residents had the highest rates of heroin-involved overdose deaths in 2017. In 2017, however, New Yorkers ages 55–64 had the highest rates of heroin-involved overdose deaths (17.7 per 100,000). Residents of the highest poverty neighborhoods had the highest rate of overdose deaths involving heroin (17.7 per 100,000), more than double that of residents of wealthiest neighborhoods (7.5 per 100,000). Rates decreased among Latino and White New Yorkers from 2016 to 2017.

In 2017, heroin was the most common primary drug reported upon admission to drug treatment (34%, $n = 26,315$). This is an increase of 5,547 admissions from 2016, when alcohol was the most common primary substance reported upon admission.

Of 47,247 total NFLIS seizures in NYC in 2017, 16.1% ($n = 7,614$) tested positive for heroin, and heroin was the third most commonly seized substance. This is an increase in heroin seizures compared with 2016, when there were 7,276 heroin seizures.

PRESCRIPTION OPIOIDS

Key Findings

- Prescription opioids, or opioid analgesics excluding fentanyl, were involved in 14% of all overdose deaths in 2017.
- The rate of opioid-involved overdose deaths decreased from 2016 to 2017 (4 to 3.1 per 100,000).

Polydrug Use

Approximately half of opioid analgesic-involved deaths in 2017 also involved benzodiazepines (51%, down from 58% in 2016). Approximately half of opioid analgesic-involved deaths also involved heroin (49%).

Cocaine was the third most common co-involved substance (44%, up from 37% in 2016), followed closely by fentanyl (43%) and alcohol (34%).

Additional Findings

The rate of opioid analgesic-involved overdose deaths was highest among White New Yorkers (5.2 per 100,000), and increased among Black New Yorkers from 2016 to 2017 (2.1 to 2.7 per 100,000). The rate among Latino New Yorkers was 2.7 per 100,000, which was a decrease from 2016. In 2017, rates of opioid analgesic-involved deaths were highest among New Yorkers 45–54 years of age (5 per 100,000). Consistent with 2016 data, rates were highest among residents living in the highest poverty (poorest) neighborhoods (3.6 per 100,000); however, rates among those living in the lowest poverty (wealthiest) neighborhoods were not far behind (3.0 per 100,000).

In 2017 prescription opioids were listed as the primary drug in 3% ($n = 2,115$) of all drug treatment admissions. Among these admissions, there was most frequently no reported secondary substance (32%, $n = 682$), followed by marijuana (16%, $n = 335$) and benzodiazepines (12%, $n = 263$).

FENTANYL AND OTHER NONPRESCRIPTION SYNTHETIC OPIOIDS

Key Findings

- Fentanyl was involved in 57% of all overdose deaths in 2017, making it the most commonly involved substance in overdose deaths.
- The rate of fentanyl-involved overdose deaths increased from 2016 to 2017 (9.1 to 12.1 per 100,000).

Polydrug Use

Fentanyl was involved in 57% of all overdose deaths during 2017 ($n = 842$), which was an increase from 44% in 2016. Prior to 2015, fentanyl was relatively uncommon in NYC, accounting for less than 5% of overdose deaths.

Fentanyl has been most commonly present in heroin-involved deaths; however, fentanyl has been increasingly identified in overdose deaths involving cocaine, without heroin. In 2017, 146 overdose deaths involved cocaine and fentanyl without heroin, which was up from 122 in 2016. Provisional 2017 data suggest that 39% of overdose deaths involving cocaine without heroin also involve fentanyl. NYPD laboratory testing data have confirmed the presence of fentanyl mixed in with cocaine products.

The majority of fentanyl-involved deaths in 2017 also involved heroin (63%). Cocaine was the second most common co-involved substance (46%), followed by alcohol (40%) and benzodiazepines (31%). The rate of fentanyl/heroin-involved deaths increased by 34% from 2016 to 2017 (5.6 to 7.5 per 100,000), while the rate of fentanyl/cocaine-involved deaths increased by 27% over the same period (4.4 to 5.6 per 100,000).

Additional Findings

Of 47,247 total NFLIS seizures in NYC in 2017, 6.7% ($n = 3,146$) tested positive for fentanyl, and fentanyl was the fourth most commonly seized substance (up from sixth in 2016). This represents an 85% increase from 2016, when there were 1,699 fentanyl seizures.

Other Priority Substances in New York City

BENZODIAZEPINES

Key Findings

- Benzodiazepines were involved in 29% of overdose deaths in 2017, down from 33% in 2016.
- In 2017, 433 overdose deaths involved benzodiazepines.

Polydrug Use

A total of 60% of deaths involving benzodiazepines also involved fentanyl ($n = 258$), 58% involved heroin, and 40% involved cocaine. In 25% of deaths involving benzodiazepines, opioid analgesics were also involved, which was a decrease from 2016 (34%).

Additional Findings

Similar to prior years, White New Yorkers, New Yorkers 45–54 years of age, Staten Island residents, and residents of the lowest poverty (wealthiest) neighborhoods had the highest rates of unintentional benzodiazepine-involved deaths in 2017.

Of 47,247 total NFLIS seizures in NYC in 2017, 3.1% ($n = 1,469$) tested positive for alprazolam, and alprazolam was the fifth most commonly seized substance. This represents a 24% decrease compared with 2016 ($n = 1,921$). Similarly, there were 395 seizures of clonazepam in 2017, representing a 15% decrease compared with 2016 ($n = 465$).

Local Research Highlights

RELAY: NON-FATAL OVERDOSE RESPONSE SYSTEM¹

Most (75-80%) individuals with nonfatal opioid overdose (OD) are taken to an emergency department (ED)^{2,3}. EDs thus offer a unique opportunity to reach individuals who are at high risk for future OD death, as survivors of an opioid overdose are 2-3 times more likely to have a subsequent fatal overdose than people who use drugs but have never overdosed⁴. To address this need, the NYC Department of Health and Mental Hygiene (DOHMH) has implemented Relay as part of the city's comprehensive opioid strategy, *HealingNYC*.

Relay is a 24/7 hospital-based, nonfatal opioid overdose response system to provide survivors of a nonfatal overdose with tailored information and linkage to care. In the hours after someone with a nonfatal OD presents to a collaborating ED, a Relay "Wellness Advocate" – DOHMH staff member who has firsthand experience with substance use and is trained as a peer advocate – is dispatched to the site and arrives within the hour. Upon arrival, the Wellness Advocate offers patient-centered overdose risk reduction counseling, overdose response training and naloxone, employs motivational interviewing to aid patients in identifying immediate support services, and offers referrals and navigation services. Referrals include opioid use disorder treatment, harm reduction services, or other non-substance use related support and medical services.

After the individual's discharge from the ED, Wellness Advocates continue to offer counseling, connection and escort to support services to program participants for an additional 90 days. Wellness Advocates have targeted contact points with all consented participants at 24-48 hours after ED discharge, 30, 60 and 90 days, as well as intermittent engagement as requested/needed by participants. Based on other peer-led behavioral interventions, Wellness Advocates serve as positive role models to the individual, building a relationship that can foster engagement, motivation, and initiation of treatment and, thereby, reducing risk for future OD.

¹ Kunins HV, Jeffers A, Chambless DH, Paone D, McNeely J, Welch AE. Implementation and feasibility of Relay: a public health led non-fatal overdose response system in New York City. Poster presentation for *The College on Problems of Drug Dependence (CPDD)* Annual National Conference, 2018, San Diego, CA.

² Watson, D.P., et al., Lay responder naloxone access and Good Samaritan law compliance: postcard survey results from 20 Indiana counties. *Harm Reduction Journal*. 2018. 15(1), p. 18.

³ Tracy, M., et al., Circumstances of witnessed drug overdose in New York City: implications for intervention. *Drug and Alcohol Dependence*. 2005. 79(2), p.p. 181-90.

⁴ Caudarella, A., et al., Non-fatal overdose as a risk factor for subsequent fatal overdose among people who inject drugs. *Drug and Alcohol Dependence*, 2016. 162, p.p. 51–5.

Targeting hospitals in the New York City neighborhoods with the highest opioid overdose mortality rates, Relay is currently operational at 6 hospital systems (7 ED sites) across the city and will expand to a total of 15 hospitals by June 2020. Current collaborating EDs include:

- New York Presbyterian-Columbia Medical Center located in Washington Heights (launched June, 2017)
- Montefiore Medical Center located in the Bronx (launched June 2017)
- Richmond University Medical Center located in Staten Island (subcontracted through Community Health Action of Staten Island, launched June 2017)
- Maimonides Medical Center located in Brooklyn (launched September 2017)
- St. Barnabas Hospital located in the Bronx (launched January 2018)
- New York Presbyterian-Allen Hospital located in Northern Manhattan (launched March 2018)
- Jamaica Hospital Medical Center (launched August 2018)

In its first year of operation, Relay has received and responded to a total of 607 calls from hospitals requesting a Wellness Advocate dispatched to their site. Of these, 55 cases were not eligible for Relay because they were not opioid-related events; another 72 were not screened because they left the ED before the Wellness Advocate arrived or they never medically stabilized. Of the remaining 480 eligible participants, 354 (74%) consented to participate in Relay. In addition, 296 participants accepted referrals to additional support services and 539 naloxone kits were distributed; 64% of naloxone recipients said it was the first time receiving a kit.

NALOXONE EXPANSION PROGRAM

The NYC DOHMH Bureau of Alcohol and Drug Use Prevention, Care and Treatment (BADUPCT) continued to expand its promotion and distribution of naloxone throughout NYC. Naloxone is a safe and effective medication that can reverse the effects of opioid overdose, and naloxone distribution is one proven strategy for reducing rates of overdose mortality.⁵ In NYC, free naloxone is distributed to lay persons at risk of experiencing or witnessing an overdose by Opioid Overdose Prevention Programs (OOPPs). Organizations across the city can become OOPPs by registering with the New York State Department of Health. Once registered, OOPPs provide free overdose response trainings and naloxone to clients and staff to teach them how to recognize and respond to an overdose.

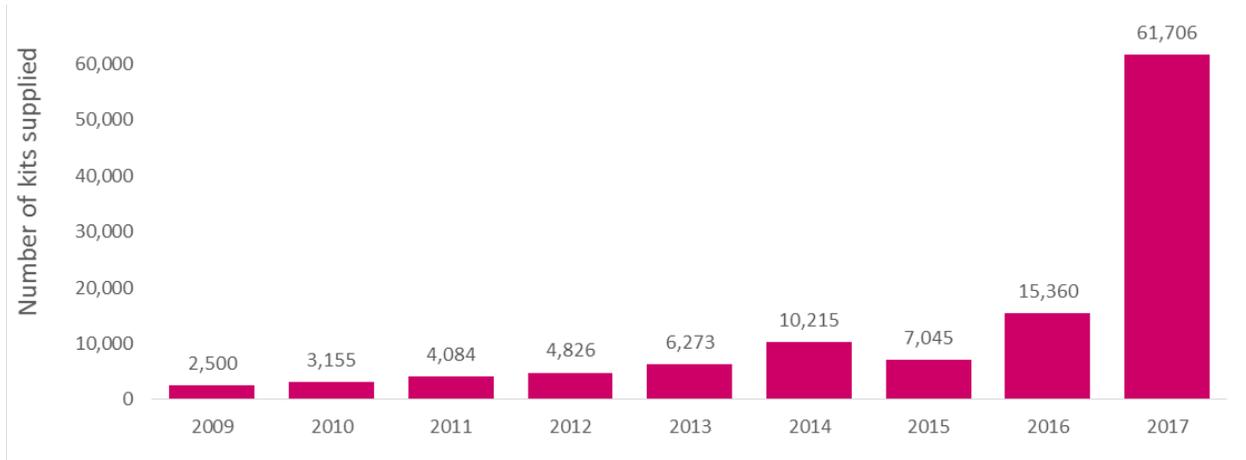
DOHMH provides naloxone, oversight, and technical assistance to OOPPs located in NYC. OOPPs include government agencies, homeless shelters, educational institutions, community based and multi-service organizations, healthcare institutions, public safety organizations, drug treatment programs, and syringe exchange programs (SEPs). In addition to supplying naloxone, DOHMH is also a registered OOPP and provides regular overdose response trainings and dispenses naloxone kits throughout the city.

The number of naloxone kits supplied to OOPPs by DOHMH rose gradually from 2009 to 2016 and then increased dramatically from 2016 to 2017 (Figure 1). DOHMH supplied 15,360 kits in 2016 and 61,706 in

⁵ Walley AY, Xuan Z, Hackman HH, et al. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. *BMJ*. 2013, 346. DOI: <http://doi.org/10.1136/bmj.f174>.

2017, which was greater than a fourfold increase—resulting in part from an increasing number of registered OOPPs and increased investment in naloxone as a response to significant increases in overdose mortality from 2015 to 2016 in NYC.

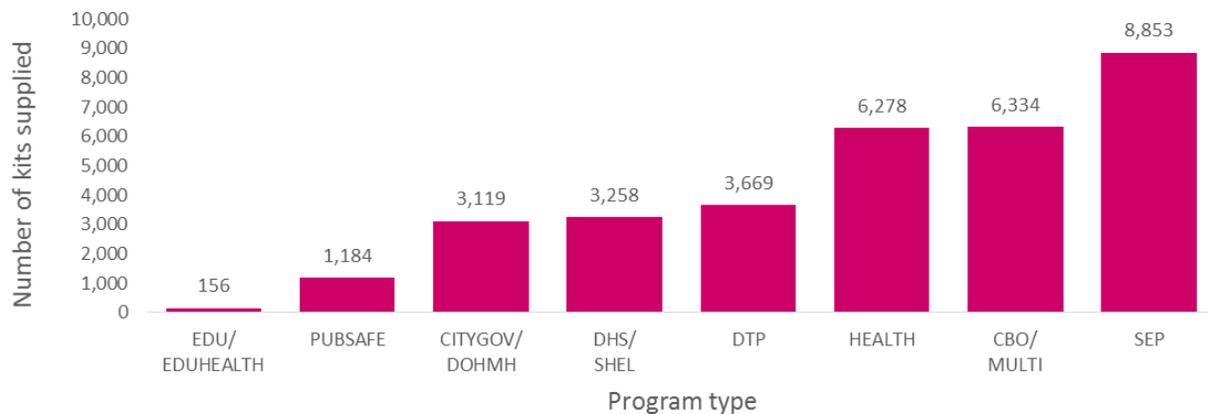
Figure 1. Number of Naloxone Kits Supplied by DOHMH to OOPPs,* 2009–2017 (n = 115,164)



*Does not include NYPD or Correctional Health Services.

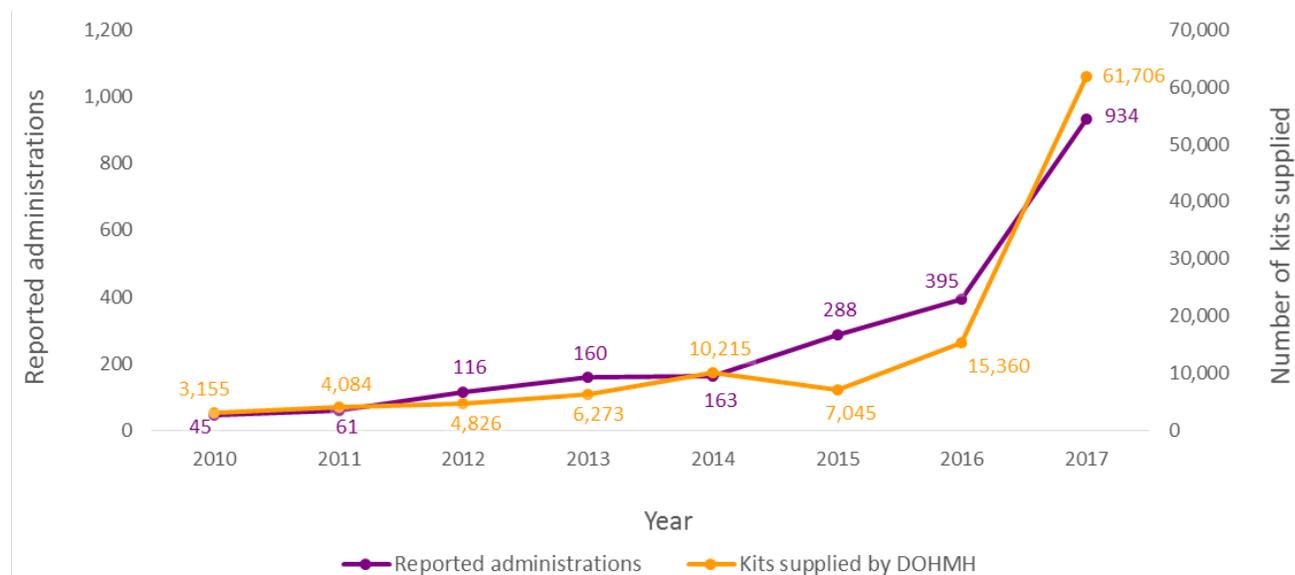
In 2017, there were 165 registered OOPPs in NYC. SEPs received more kits from DOHMH (Figure 2) and reported dispensing more kits to trained responders than any other type of OOPP. SEPs received 27% of all kits ordered in 2017, although accounting for only 8% of OOPPs.

Figure 2. Number of Naloxone Kits Supplied by DOHMH to OOPPs,* by Program Type, 2017 (n = 61,706)



The number of naloxone administrations reported to NYC DOHMH increased from 2010 to 2017 (Figure 3), closely mirroring the increase in naloxone provision to OOPPs by DOHMH over time. In 2017, SEPs reported more naloxone administrations than any other program type (n = 470).

Figure 3. Number of Reported Naloxone Administrations and Number of Naloxone Kits Supplied by DOHMH to OOPPs, 2010–2017*



*Does not include NYPD or Correctional Health Services.

In 2018, BADUPCT will continue to expand its workforce capacity to increase direct naloxone dispensing to individuals and technical assistance for OOPPs. This expansion will also enable the bureau to collect naloxone distribution data in a new way: OOPPs will move from an aggregate reporting system to individual-level reporting. For the first time, we will collect information about the recipient of each naloxone kit, including their zip code of residence, as well as the location of the dispensing OOPP site and the zip code where the kit was dispensed. By collecting this new demographic and geographic data about naloxone kit recipients, DOHMH will have a better understanding of whether the OOPP initiative is reaching New Yorkers in neighborhoods with the highest rates and numbers of overdose fatalities.

RAPID ASSESSMENT AND RESPONSE (RAR)

RAR is a research method that uses a mixed-method approach to quickly gather data in response to a question or crisis requiring timely intervention. Public health surveillance data used by NYC DOHMH in support of RAR investigations includes unintentional drug poisoning (overdose) mortality data and syndromic ED data. Data gathered in the course of ongoing research studies⁶ and event reports from community-based organizations may also guide RAR work. Investigations focus on discrete geographic areas and/or discrete demographic groups experiencing adverse health consequences associated with drug use.

⁶ Data collected by the NYC Department of Health and Mental Hygiene, Bureau of Alcohol and Drug Use Prevention, Care and Treatment.

The RAR team continues to respond to increased fentanyl-involved overdose rates by conducting in-person visits to service providers who intersect with people who use drugs (PWUD) in targeted neighborhoods. Between November 2016 and December 2017, the team visited 98 New York State Office of Alcoholism and Substance Abuse Services (OASAS)-licensed drug treatment facilities and 129 pharmacies participating in the Expanded Syringe Access Program located within five UHF neighborhoods to provide a range of educational materials including borough-specific data and information pertaining to fentanyl and naloxone. Visits were well-received and 19 programs requested and were provided with additional in-depth presentations for staff and/or clients. Programs that were not providing overdose prevention training and naloxone to their clients were provided with information and support to register as an OOPP. RAR visits have emphasized the importance of communicating directly with services that intersect with PWUD to ensure they have the appropriate tools to educate their clients about the risks of fentanyl and to encourage dispensation of naloxone.

After numerous overdose events at several supported housing/safe haven programs, the RAR team is also working with program staff to deliver overdose prevention training and naloxone to residents in these facilities. This has included individual risk reduction assessments as well as a review of overdose risk in supported housing/safe haven environments more broadly. During “days of action” residents of the programs are provided with overdose mortality data, information about fentanyl, and training for overdose prevention and naloxone administration. RAR staff are exploring the potential to implement “naloxone champions”—residents within each of the facilities trained to respond to onsite overdoses and to dispense naloxone to their peers. The RAR team will continue to collaborate with programs to assess and mitigate overdose risk in these settings.

Additionally, the RAR team has been working closely with NYC Parks and community stakeholders in the Bronx to respond to reports of increased public drug use that has adversely impacted the recreational use of these spaces. Injection drug use is occurring in plain sight in many borough parks, and data suggest that more than 5,000 syringes are being improperly discarded each month. The RAR team is conducting an assessment including interviews with PWUD and key stakeholders as well as field observations in the parks and surrounding areas to explore the service needs of a population that has grown as a result of displacement and gentrification.

MEDIA CAMPAIGNS

The DOHMH uses media campaigns to promote understanding and awareness of opioids (alcohol and other drugs), their associated risks, as well as information on risk reduction and overdose prevention, where to get help, training, support, and other services. Our 2017 campaigns focused on overdose prevention—specifically those involving opioids. The ads incorporate harm reduction principles and anti-stigma messaging, and a guiding aim is for New Yorkers to see that people with drug issues are like them. Another important aim is let people know that opioid addiction can happen to anyone and that treatment is readily available in NYC. We promote what the evidence shows to be the most effective for the most people: opioid agonist medications (methadone and buprenorphine) through the testimonials of New Yorkers who are taking these medications for their opioid addiction. Another aim is to generate public conversation and to encourage New Yorkers to engage in conversations about drug use and support.

First Naloxone Campaign: Save a Life, Carry Naloxone December 2016–January 2017

The goal of this campaign was to raise public awareness about opioid overdose and naloxone and its role in overdose prevention. The campaign included posters on buses, ads in print and on social media, in local barber shops, nail salons and laundromats, the Staten Island Ferry terminals, and billboards in the Bronx (in both Spanish and English).

Figure 4. Ad from First Campaign on Naloxone (2016)



Visits to the DOHMH overdose prevention website increased dramatically from 72 in November 2016 (one month prior to the print and social media ad launch) to 18,600 in January 2017, one month after the launch. The number went down to 1,114 in February 2017, and then spiked up again to 10,274 in March, the first month that the TV ads appeared. Notably, there was a small number of visits to the DOHMH Spanish language website prior to March when we launched our ad on local Spanish TV. That month saw 10,470 visits to the Spanish language website and 965 more in April.

Second Naloxone Campaign: I Saved a Life with Naloxone May–June, 2017

The goal of the second naloxone campaign was to raise public awareness about naloxone while humanizing and valorizing real New Yorkers who used naloxone to reverse an overdose. The campaign included posters in subway cars and in bus shelters in highly impacted neighborhoods, as well as ads on social media (Facebook and Twitter).

Campaign recall survey results showed that 33% of New Yorkers surveyed saw the Save A Life, Carry Naloxone and I Saved a Life ads, and 78% of them reported that they took action after seeing the ad. Most frequently, they talked to friends and family about overdose, searched for more information online, and interacted about it on social media. One third of those who took action were between the ages of 25 and 34.

Figure 5. Ad from Second Campaign on Naloxone (2017)



I'm Living Proof: November–December 2017

This campaign featured 30-second testimonials of four New Yorkers who take methadone or buprenorphine tell their experiences with the medication and how it help them manage their opioid addiction. The testimonials were shown on television and linked ads on social media, and appeared in local papers and in posters on subways, and in neighborhood businesses in English and in Spanish, for four weeks.

Figure 6. Ad from the Living Proof Campaign (2017)



I'm Living Proof: Digital/Social Media Metrics

The ads were successful in reaching the target populations: people between the ages of 18–34 living in areas of the city that have been experiencing the highest rates of overdose deaths. A total of 922,160 viewers watched the ads to completion. Completion rates were higher in the zip code targeted ads as compared to general ad placement.

There were 1.13 million impressions generated on Facebook and Instagram and 2.22 million on Twitter. Viewers ages 18–34 engaged more with the ads than viewers in other age groups. Facebook and

Instagram ads reached over 414,000 people, and averaged 1.8 views per person in English, and over 178,000 users for an average of 2.2 times per person in Spanish. Viewers clicked through to the English landing page on the DOHMH website 826 times, and over 330 times to the Spanish webpage. On Twitter, the videos were viewed to completion over 265,000 times, with younger people (ages 18–34) completing the videos more than older watchers. More men than women watched the videos, and engagement rates were higher in the targeted zip codes than in the citywide placed ads.

I'm Living Proof: Television

The commercial aired a total of 1,169 times between March and April 2017 at all times throughout the day, including during popular daytime shows and the evening news. The Spanish language ads ran during popular news and entertainment shows and were also targeted to the same zip codes as the other media ads.

Overdose Education and Naloxone: STOP OD NYC

In May 2017, the DOHMH launched its mobile overdose prevention education app. The app allows users to find naloxone via pharmacies or community-based programs and report an overdose reversal online. It is available for free download on Android and iOS devices and had been downloaded more than 1,300 times by July 2017. The app has been enhanced and re-released in May 2018. To date, 3,229 individuals have downloaded the app and it has been used 2,354 times.

Figure 7. Sample 2017 Stop OD App Social Media Ad



YOUTH AND DRUGS

The 2017 NYC Youth Risk Behavior Survey was administered to public high school students in NYC. Alcohol and marijuana were reported as the top two most common substances used during the past 30 days: 16.2% of students reported marijuana use and 17.9% of students reported alcohol consumption. Although Manhattan had the greatest percentage of high school students reporting marijuana use (19.7%), Staten Island had the highest percentage of high school students who consume alcohol (21.5%). Male high school students reported significantly higher use of prescription drugs during the past 12 months (opioid analgesics, benzodiazepines, and stimulants) and any lifetime illicit drug use (cocaine, heroin, ecstasy, and synthetic marijuana). Marijuana was the only drug whose use did not significantly differ between male and female students.

Reported lifetime heroin use among students increased 54.7% from 2015 to 2017. This was a significant increase from 2.5% of students reporting lifetime heroin use in 2015 to 3.9% of students in 2017. The proportion of 12th grade students having consumed alcohol during the past 30 days (24.9%) is over two times that of 9th grade students (10.9%). Between 2015 and 2017, the percentage of high school

students who reported binge drinking during the past 30 days significantly decreased from 8.5% in 2015 to 5.0% in 2017; the significant decrease was seen among all grades.

Infectious Diseases Related to Substance Use

New HIV diagnoses in NYC decreased by 61% from 2001 to 2016, from 5,862 to 2,279 cases reported. Significant decreases were also reported among subpopulations by sex, race/ethnicity, age at diagnosis, borough of residence at diagnosis, and transmission risk. Among injecting drug users (IDUs), there were 845 HIV diagnoses in 2001 and only 32 diagnoses in 2016. As of December 31, 2016, there were 123,887 people living with HIV/AIDS in NYC. Of these, 15,594 (12.6%) reported a history of IDU and 2,777 (2.2%) were men who have sex with men/IDUs.

In 2016, 61 acute hepatitis B cases were reported (0.7 per 100,000 New Yorkers), and there were 8,439 newly reported chronic hepatitis B cases (89.8 per 100,000 New Yorkers), with Brooklyn reporting the highest rate of infection (111.0), followed closely by Queens (108.8). Because it is difficult to identify at which time point an individual became acutely infected with hepatitis C, the NYC DOHMH does not report surveillance data of acute hepatitis C. 11,626 people were newly reported with chronic hepatitis C in 2016, or 136.0 per 100,000 New Yorkers, which was a 57.6% increase from 2015. Among individuals 0–29 years of age, there were 1,722 newly reported hepatitis C cases in 2016. Data on the number of hepatitis B and C cases resulting from intravenous drug use are unavailable.

New Substance-Related Legislative and Policy Updates

INCREASING ACCESS TO BUPRENORPHINE IN NYC

Federal legislation now allows for buprenorphine prescribing by nurse practitioners and physician assistants. The NYC DOHMH has expanded its buprenorphine training initiative to support these additional prescribers, with a goal of training 1,500 physicians, nurse practitioners, and physician assistants as new buprenorphine prescribers by 2022. To date, more than 1,000 prescribers have been trained. NYC DOHMH has launched a buprenorphine nurse care manager model in 14 primary care clinics, has developed and disseminated patient and provider-facing materials on buprenorphine, and is offering technical assistance to primary care practices, SEPs, and EDs to facilitate buprenorphine treatment. These initiatives will help the city connect 20,000 more New Yorkers to medication-assisted treatment by 2022.

SUPPORT FOR OVERDOSE PREVENTION CENTERS IN NYC

In May 2018, DOHMH released a report presenting results from a feasibility study of supervised injection in NYC and recommendations for implementation of up to four sites, termed Overdose Prevention Centers (OPCs). Study estimates suggest that OPCs could avert up to 130 overdose deaths and up to \$7 million in annual health care costs. Mayor de Blasio endorsed DOHMH's recommendations, and the administration outlined a planning process with communities and key stakeholders.

MUNICIPAL DRUG STRATEGIES COUNCIL

In March 2017, the NYC Council passed legislation to task the de Blasio administration with developing a collaborative government and community body to develop and coordinate a citywide strategy to substance use. DOHMH chairs and convenes the body that was formed, the Municipal Drug Strategy Council. The Municipal Drug Strategy Council released its first report in May 2018; the report includes a thorough review of NYC's ongoing programs and policies that work to meet the needs of people with substance use disorders and presents short- and long-term recommendations to fill gaps and expand future work.

HEALING NYC (2.0)

In March 2018, the de Blasio administration expanded its comprehensive strategy to address the opioid epidemic by \$22 million annually, bringing the city's total annual investment to reduce opioid overdose deaths to \$60 million. The additional funds will expand DOHMH's nonfatal overdose response program at additional hospitals across NYC, increase naloxone distribution, and develop new avenues for effective treatment delivery.

OASAS NALOXONE DISTRIBUTION POLICY

In March 2018, OASAS issued a directive requiring all OASAS licensed programs to have identified staff trained in the use of naloxone and naloxone kits readily available in the event of an overdose. In June this policy was extended to also require that a naloxone kit or prescription be offered to clients receiving services, as well as to their significant other(s) if available.

Treatment Tables

Table 1a: Trends in Non-Crisis Admissions* to Programs Treating Substance Use Disorders, New York City Residents, 2013-2017
 Number of Admissions and Percentage of Admissions with Selected Substances Cited as Primary Substance at Admission, by Year and Substance

	Calendar Year									
	2013		2014		2015		2016		2017	
	(#)	(%)	(#)	(%)	(#)	(%)	(#)	(%)	(#)	(%)
Total Admissions (#)	83,577	100%	80,447	100%	80,334	100%	71,242	100%	78,125	100%
Primary Substance of Abuse (%)										
Alcohol	25,814	30.9%	25,762	32.0%	24,503	30.5%	23,213	32.6%	24,397	31.2%
Cocaine/Crack	11,225	13.4%	9,553	11.9%	8,596	10.7%	7,698	10.8%	7,937	10.2%
Heroin	21,833	26.1%	22,409	27.9%	26,217	32.6%	20,768	29.2%	26,315	33.7%
Prescription Opioids**	2,671	3.2%	2,310	2.9%	2,115	2.6%	1,871	2.6%	2,115	2.7%
Methamphetamine	422	0.5%	474	0.6%	471	0.6%	630	0.9%	733	0.9%
Marijuana	19,049	22.8%	17,082	21.2%	15,347	19.1%	14,085	19.8%	13,628	17.4%
Benzodiazepines**	702	0.8%	778	1.0%	793	1.0%	1,033	1.4%	965	1.2%
MDMA	74	0.1%	76	0.1%	52	0.1%	70	0.1%	53	0.1%
Synthetic Stimulants**	19	0.0%	36	0.0%	35	0.0%	43	0.1%	92	0.1%
Synthetic Cannabinoids	0	0.0%	50	0.1%	312	0.4%	142	0.2%	108	0.1%
Other Drugs/Unknown	1,768	2.1%	1,917	2.4%	1,893	2.4%	1,689	2.4%	1,782	2.3%

NOTES:

***Non-Crisis Admissions:** Includes non-crisis admissions to outpatient, inpatient, residential, and methadone maintenance treatment programs licensed in the State. Each admission does not necessarily represent a unique individual because some individuals are admitted to treatment more than once in a given period.

****Substance Categories:** **Prescription opioids** includes non-prescription methadone, buprenorphine, other synthetic opiates, and OxyContin; **Benzodiazepines** includes benzodiazepines, alprazolam, and rohypnol. **Synthetic Stimulants** includes other stimulants and a newly created category, synthetic stimulants (created in 2014).

unavail: Data not available.

2017 data are as of 5/29/2018. 2016 data are as of 5/24/2017. 2015 data are as of May 2016. 2013 and 2014 data are as of May 2015.

SOURCE: Data provided to the New York City NDEWS SCE by the New York State Office of Alcoholism and Substance Abuse Services (OASAS), Client Data System accessed from Local Governmental Unit (LGU) Inquiry Reports.

Table 2a: Demographic and Drug Use Characteristics of Non-Crisis Treatment Admissions* for Select Primary Substances, New York City Residents, 2017
 Number of Admissions, by Primary Substance and Percentage of Admissions with Selected Demographic and Drug Use Characteristics

	Primary Substance																	
	Alcohol		Cocaine/Crack		Heroin		Prescription Opioids**		Methamphetamine		Marijuana		Benzo-diazepines**		Synthetic Stimulants**		Synthetic Cannabinoids	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Number of Admissions (#)	24,397	100%	7,937	100%	26,315	100%	2,115	100%	733	100%	13,628	100%	965	100%	92	100%	108	100%
Sex (%)																		
Male	18,543	76.0%	5,566	70.1%	19,893	75.6%	1,488	70.4%	690	94.1%	10,488	77.0%	688	71.3%	78	84.8%	86	79.6%
Female	5,854	24.0%	2,371	29.9%	6,422	24.4%	627	29.6%	43	5.9%	3,140	23.0%	277	28.7%	14	15.2%	22	20.4%
Race/Ethnicity*** (%)																		
Black	10,662	43.7%	4,496	56.6%	6,434	24.4%	261	12.3%	194	26.5%	7,801	57.2%	102	10.6%	30	32.6%	47	43.5%
White	6,450	26.4%	1,411	17.8%	8,855	33.7%	1,271	60.1%	324	44.2%	1,284	9.4%	552	57.2%	34	37.0%	25	23.1%
Other	7,285	29.9%	2,030	25.6%	11,026	41.9%	583	27.6%	215	29.3%	4,543	33.3%	311	32.2%	28	30.4%	36	33.3%
Age Group*** (%)																		
< 26	1,547	6.3%	355	4.5%	1,642	6.2%	314	14.8%	68	9.3%	4,800	35.2%	281	29.1%	16	17.4%	22	20.4%
26-45	10,790	44.2%	3,043	38.3%	10,827	41.1%	1,273	60.2%	489	66.7%	7,241	53.1%	452	46.8%	56	60.9%	65	60.2%
46+	12,060	49.4%	4,539	57.2%	13,846	52.6%	528	25.0%	176	24.0%	1,587	11.6%	232	24.0%	20	21.7%	21	19.4%
Route of Administration (%)																		
Smoked	0	0.0%	4,635	58.4%	213	0.8%	53	2.5%	412	56.2%	13,123	96.3%	0	0.0%	28	30.4%	92	85.2%
Inhaled	44	0.2%	2,921	36.8%	14,895	56.6%	301	14.2%	73	10.0%	156	1.1%	5	0.5%	15	16.3%	6	5.6%
Injected	20	0.1%	220	2.8%	10,939	41.6%	74	3.5%	211	28.8%	0	0.0%	4	0.4%	12	13.0%	4	3.7%
Oral/Other/Unknown	24,333	99.7%	161	2.0%	268	1.0%	1,687	79.8%	37	5.0%	349	2.6%	955	99.0%	37	40.2%	6	5.6%
Secondary Substance (%)																		
None	11,088	45.4%	1,989	25.1%	8,377	31.8%	682	32.2%	288	39.3%	7,250	53.2%	141	14.6%	42	45.7%	26	24.1%
Alcohol	0	0.0%	2,653	33.4%	2,653	10.1%	214	10.1%	103	14.1%	3,886	28.5%	156	16.2%	16	17.4%	24	22.2%
Cocaine/Crack	5,815	23.8%	224	2.8%	9,204	35.0%	231	10.9%	55	7.5%	1,204	8.8%	113	11.7%	5	5.4%	20	18.5%
Heroin	1,502	6.2%	839	10.6%	2	0.0%	230	10.9%	9	1.2%	242	1.8%	213	22.1%	1	1.1%	6	5.6%
Prescription Opioids**	264	1.1%	111	1.4%	1,469	5.6%	80	3.8%	6	0.8%	218	1.6%	125	13.0%	3	3.3%	4	3.7%
Methamphetamine	53	0.2%	44	0.6%	70	0.3%	3	0.1%	0	0.0%	55	0.4%	4	0.4%	1	1.1%	0	0.0%
Marijuana	4,800	19.7%	1,775	22.4%	2,635	10.0%	335	15.8%	121	16.5%	3	0.0%	151	15.6%	14	15.2%	25	23.1%
Benzodiazepines**	467	1.9%	119	1.5%	252	1.0%	263	12.4%	10	1.4%	252	1.8%	18	1.9%	3	3.3%	0	0.0%
Synthetic Stimulants**	22	0.1%	9	0.1%	9	0.0%	4	0.2%	1	0.1%	22	0.2%	10	1.0%	0	0.0%	0	0.0%
Synthetic Cannabinoids	42	0.2%	32	0.4%	9	0.0%	2	0.1%	0	0.0%	73	0.5%	0	0.0%	0	0.0%	0	0.0%

NOTES:
***Non-Crisis Admissions:** Includes non-crisis admissions to outpatient, inpatient, residential, and methadone maintenance treatment programs licensed in the State. Each admission does not necessarily represent a unique individual because some individuals are admitted to treatment more than once in a given period.
****Substance Categories:** Prescription opioids includes non-prescription methadone, buprenorphine, other synthetic opiates, and OxyContin; Benzodiazepines includes benzodiazepines, alprazolam, and rohypnol. Synthetic Stimulants includes other stimulants and a newly created category, synthetic stimulants (created in 2014).
*****Race/Ethnicity and Age:** Categories for New York City are not the same categories presented for other NDEWS sites.
unavail: Data not available; Percentages may not sum to 100 due to missing data, rounding, and/or because not all possible categories are presented in the table. Category frequencies may not sum to drug total due to missing data and/or not all possible categories are presented in the table.

2017 data are as of 5/29/2018.

SOURCE: Data provided to the New York City NDEWS SCE by the New York State Office of Alcoholism and Substance Abuse Services (OASAS), Client Data System accessed 05/29/2018 from Local Governmental Unit (LGU) Inquiry Reports.

Table 1b: Trends in Crisis (Detox) Admissions* to Programs Treating Substance Use Disorders, New York City Residents, 2013-2017
 Number of Admissions and Percentage of Admissions with Selected Substances Cited as Primary Substance at Admission, by Year and Substance

	Calendar Year									
	2013		2014		2015		2016		2017	
	(#)	(%)	(#)	(%)	(#)	(%)	(#)	(%)	(#)	(%)
Total Admissions (#)	47,107	100%	46,483	100%	45,018	100%	42,109	100%	40,907	100%
Primary Substance of Abuse (%)										
Alcohol	27,637	58.7%	26,733	57.5%	25,205	56.0%	22,689	53.9%	22,767	55.7%
Cocaine/Crack	2,955	6.3%	2,230	4.8%	2,038	4.5%	2,024	4.8%	1,478	3.6%
Heroin	12,925	27.4%	13,825	29.7%	14,439	32.1%	14,425	34.3%	13,921	34.0%
Prescription Opioids**	1,231	2.6%	1,086	2.3%	939	2.1%	846	2.0%	764	1.9%
Methamphetamine	18	0.0%	21	0.0%	23	0.1%	28	0.1%	20	0.0%
Marijuana	693	1.5%	615	1.3%	538	1.2%	452	1.1%	348	0.9%
Benzodiazepines**	1,272	2.7%	1,448	3.1%	1,234	2.7%	1,137	2.7%	1,134	2.8%
MDMA	0	0.0%	2	0.0%	4	0.0%	4	0.0%	0	0.0%
Synthetic Stimulants**	5	0.0%	2	0.0%	7	0.0%	2	0.0%	3	0.0%
Synthetic Cannabinoids	0	0.0%	30	0.1%	114	0.3%	50	0.1%	42	0.1%
Other Drugs/Unknown	371	0.8%	491	1.1%	477	1.1%	452	1.1%	430	1.1%

NOTES:

***Crisis Admissions:** Includes detox admissions to all licensed treatment programs in the State. Each admission does not necessarily represent a unique individual because some individuals are admitted to treatment more than once in a given period.

****Substance Categories:** **Prescription opioids** includes non-prescription methadone, buprenorphine, other synthetic opiates, and OxyContin; **Benzodiazepines** includes benzodiazepines, alprazolam, and rohypnol. **Synthetic Stimulants** includes other stimulants and a newly created category, synthetic stimulants (created in 2014).

unavail: Data not available.

2017 data are as of 5/29/2018. 2016 data are as of 5/24/2017. 2015 data are as of May 2016. 2013 and 2014 data are as of May 2015.

SOURCE: Data provided to the New York City NDEWS SCE by the New York State Office of Alcoholism and Substance Abuse Services (OASAS), Client Data System accessed from Local Governmental Unit (LGU) Inquiry Reports.

Table 2b: Demographic and Drug Use Characteristics of Crisis (Detox) Treatment Admissions* for Select Primary Substances, New York City Residents, 2017
 Number of Admissions, by Primary Substance and Percentage of Admissions with Selected Demographic and Drug Use Characteristics

	Primary Substance																	
	Alcohol		Cocaine/Crack		Heroin		Prescription Opioids**		Methamphetamine		Marijuana		Benzo-diazepines**		Synthetic Stimulants**		Synthetic Cannabinoids	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Number of Admissions (#)	22,767	100%	1,478	100%	13,921	100%	764	100%	20	100%	348	100%	1,134	100%	3	100%	42	100%
Sex (%)																		
Male	19,122	84.0%	1,196	80.9%	11,703	84.1%	569	74.5%	17	85.0%	308	88.5%	867	76.5%	2	66.7%	38	90.5%
Female	3,645	16.0%	282	19.1%	2,218	15.9%	195	25.5%	3	15.0%	40	11.5%	267	23.5%	1	33.3%	4	9.5%
Race/Ethnicity*** (%)																		
Black	11,251	49.4%	1,031	69.8%	3,908	28.1%	111	14.5%	8	40.0%	200	57.5%	116	10.2%	2	66.7%	17	40.5%
White	5,065	22.2%	166	11.2%	4,503	32.3%	399	52.2%	7	35.0%	54	15.5%	652	57.5%	1	33.3%	11	26.2%
Other	6,451	28.3%	281	19.0%	5,510	39.6%	254	33.2%	5	25.0%	94	27.0%	366	32.3%	0	0.0%	14	33.3%
Age Group*** (%)																		
<26	421	1.8%	28	1.9%	1,067	7.7%	99	13.0%	1	5.0%	48	13.8%	127	11.2%	0	0.0%	3	7.1%
26-45	7,739	34.0%	451	30.5%	6,816	49.0%	427	55.9%	17	85.0%	180	51.7%	636	56.1%	2	66.7%	25	59.5%
46+	14,607	64.2%	999	67.6%	6,038	43.4%	238	31.2%	2	10.0%	120	34.5%	371	32.7%	1	33.3%	14	33.3%
Route of Administration (%)																		
Smoked	0	0.0%	1,067	72.2%	96	0.7%	14	1.8%	14	70.0%	341	98.0%	0	0.0%	0	0.0%	19	45.2%
Inhaled	36	0.2%	312	21.1%	7,465	53.6%	60	7.9%	2	10.0%	2	0.6%	2	0.2%	1	33.3%	12	28.6%
Injected	79	0.3%	70	4.7%	6,247	44.9%	22	2.9%	2	10.0%	0	0.0%	3	0.3%	2	66.7%	9	21.4%
Oral/Other/Unknown	22,652	99.5%	29	2.0%	113	0.8%	668	87.4%	2	10.0%	5	1.4%	1,129	99.6%	0	0.0%	2	4.8%
Secondary Substance (%)																		
None	9,383	41.2%	168	11.4%	3,175	22.8%	253	33.1%	4	20.0%	56	16.1%	264	23.3%	0	0.0%	12	28.6%
Alcohol	2	0.0%	741	50.1%	3,396	24.4%	84	11.0%	5	25.0%	134	38.5%	209	18.4%	0	0.0%	6	14.3%
Cocaine/Crack	6,892	30.3%	52	3.5%	3,829	27.5%	73	9.6%	2	10.0%	72	20.7%	143	12.6%	1	33.3%	9	21.4%
Heroin	3,213	14.1%	197	13.3%	3	0.0%	71	9.3%	1	5.0%	42	12.1%	299	26.4%	0	0.0%	2	4.8%
Prescription Opioids**	225	1.0%	15	1.0%	515	3.7%	43	5.6%	0	0.0%	4	1.1%	95	8.4%	1	33.3%	2	4.8%
Methamphetamine	17	0.1%	3	0.2%	13	0.1%	0	0.0%	0	0.0%	2	0.6%	2	0.2%	0	0.0%	1	2.4%
Marijuana	1,934	8.5%	240	16.2%	873	6.3%	73	9.6%	1	5.0%	0	0.0%	70	6.2%	1	33.3%	7	16.7%
Benzodiazepines**	876	3.8%	39	2.6%	2,011	14.4%	141	18.5%	1	5.0%	23	6.6%	25	2.2%	0	0.0%	1	2.4%
Synthetic Stimulants**	7	0.0%	0	0.0%	4	0.0%	1	0.1%	1	5.0%	0	0.0%	2	0.2%	0	0.0%	0	0.0%
Synthetic Cannabinoids	60	0.3%	7	0.5%	12	0.1%	1	0.1%	0	0.0%	6	1.7%	0	0.0%	0	0.0%	0	0.0%

NOTES:
 ***Crisis Admissions:** Includes detox admissions to all licensed treatment programs in the State. Each admission does not necessarily represent a unique individual because some individuals are admitted to treatment more than once in a given period.
 ****Substance Categories:** Prescription opioids includes non-prescription methadone, buprenorphine, other synthetic opiates, and OxyContin; Benzodiazepines includes benzodiazepines, alprazolam, and rohypnol. Synthetic Stimulants includes other stimulants and a newly created category, synthetic stimulants (created in 2014).
 *****Race/Ethnicity and Age:** Categories for New York City are not the same categories presented for other NDEWS sites.
unavail: Data not available; **Percentages** may not sum to 100 due to missing data, rounding, and/or because not all possible categories are presented in the table. Category frequencies may not sum to drug total due to missing data and/or not all possible categories are presented in the table.

SOURCE: Data provided to the New York City NDEWS SCE by the New York State Office of Alcoholism and Substance Abuse Services (OASAS), Client Data System accessed 5/29/2018 from Local Governmental Unit (LGU) Inquiry Reports.

Sources

DATA FOR THIS REPORT WERE DRAWN FROM THE FOLLOWING SOURCES:

Prevalence

- NYC YRBS: The 2017 NYC Youth Risk Behavior Survey (YRBS), conducted by the NYC Departments of Health and Education, is an anonymous, self-administered biennial study of NYC public high school students in grades 9 to 12.

Morbidity

- SPARCS: The Statewide Planning and Research Cooperative System currently collects patient-level detail for each hospital inpatient stay and outpatient emergency department visits. Data on inpatient hospital stays are presented.

Mortality

- Bureau of Vital Statistics/Office of the Chief Medical Examiner: Mortality data were collected through an in-depth review of data and charts from the Health Department's Bureau of Vital Statistics and the Office of the Chief Medical Examiner for 2000–2017. Methadone is reported separately and not included in opioid analgesic analyses. Data for 2017 are provisional and subject to change.

Treatment

- The New York State Office of Alcoholism and Substance Abuse Services (OASAS): Treatment admissions data were collected through the Client Data System for 2010–2017.

HIV and Hepatitis data

- HIV data: 2016 HIV surveillance data were collected from the NYC DOHMH HIV Epidemiology and Field Services Programs' annual report.
- Hepatitis data: 2016 hepatitis data were collected from the NYC DOHMH Bureau of Communicable Diseases' annual report.

For additional information about the substances and substance use patterns discussed in this report, please contact Denise Paone, Ed.D., Senior Director of Research & Surveillance, Bureau of Alcohol and Drug Use Prevention, Care and Treatment, NYC Department of Health and Mental Hygiene, 42-09 28th St, Long Island City, NY, Phone: (347) 396-7015, E-mail: dpaone@health.nyc.gov.