The SCE Narrative is written by the Sentinel Community Epidemiologist (SCE) and provides their interpretation of important findings and trends based on available national data as well as sources specific to their area, such as data from local medical examiners or poison control centers. As a local expert, the SCE is able to provide context to the national and local data presented.

This SCE Narrative contains the following sections:

- Highlights
- Primary and Emerging Substance Use Problems
- Local Research Highlights (if available)
- Infectious Diseases Related to Substance Use (if available)
- Legislative and Policy Updates

The SCE Narratives for each of the 12 Sentinel Community Sites and detailed information about NDEWS can be found on the NDEWS website at www.ndews.org.
Highlights

INCREASE IN OVERDOSE DEATHS IN 2016
• Every seven hours a New Yorker dies of an unintentional drug poisoning (overdose); in NYC, more deaths are now attributable to overdose than to motor vehicle crashes, homicides, and suicides combined.
• Overdose rates increased for the sixth consecutive year in New York City. Provisional data show a dramatic increase from 937 overdose deaths (13.6 per 100,000) in 2015, with 1,374 (19.9 per 100,000) confirmed deaths in 2016. This represents a 46% increase.
• Of the 1,374 drug overdose deaths in 2016, 44% involved fentanyl, whereas prior to 2015, not more than 4% of overdose deaths involved fentanyl.

BENZODIAZEPINES
• From 2010 to 2016, there was an 86% increase in benzodiazepine-involved overdose deaths.
• In 2016, 33% of all overdose deaths involved benzodiazepines.

COCAINE
• Cocaine-involved overdose deaths increased by 61% from 2015 to 2016.
• 37% of overdose deaths involved cocaine and fentanyl without heroin, up from 11% in 2015, raising additional concern and risk for recreational cocaine users who are likely opioid naïve.
• In 2016, 1 in 10 noncrisis drug treatment admissions reported crack/cocaine as the primary substance (10.8%, n = 7,698).

MARIJUANA
• In 2016, marijuana was the second most common primary drug (excluding alcohol) reported upon admission to drug treatment (19.8%, n = 14,085).

OPIOIDS (HEROIN, OPIOID ANALGESICS AND FENTANYL)
• Heroin was involved in 55% of all overdose deaths in 2016, making it the most common substance involved in overdose deaths.
• In 2016, heroin was the most common primary drug (excluding alcohol) reported upon admission to drug treatment (29%, n = 20,768).
• The rate of opioid-analgesic-involved overdose deaths increased from 2015 to 2016 (3.1 to 3.5 per 100,000); nevertheless, opioid analgesics were involved in only 18% of all overdose deaths, down from 31% in 2010.

LOCAL PUBLIC HEALTH RESPONSES
• In 2016, the NYC Department of Health and Mental Hygiene (DOHMH) issued multiple Health Alerts on the increased presence of fentanyl in NYC. Fentanyl “Health Alert” flyers were distributed to harm reduction programs, to drug treatment programs, and to people who use drugs (PWUD) to increase awareness about the risk of fentanyl and to encourage risk reduction practices.
• The DOHMH established a Rapid Assessment Response (RAR) initiative, based on an infectious disease outbreak model. RAR enables timely and targeted interventions on the discrete geographic or the discrete demographic level.
• In response to the increasing rate of fentanyl-involved overdose, the RAR team conducted interviews to assess knowledge of fentanyl among PWUD and program staff and explored the presence of an active nonpharmaceutical fentanyl market in NYC.
• As part of the Mayor’s HealingNYC initiative, DOHMH aims to quadruple its naloxone distribution target of 15,000 kits per year to 65,000 by fiscal year 2019 (FY19).
Primary and Emerging Substance Use Problems

OVERVIEW

Morbidity

Opioid-Related Hospitalizations

In 2014 (the most recent year for which data are available), there were approximately 60,000 drug-related hospitalizations among New York City (NYC) residents 13–84 years of age, with a rate of 819.9 per 100,000 residents. Opioid-related hospitalizations accounted for approximately one third of drug-related hospitalizations in 2014 (n = 19,778), with a rate of 272.1 per 100,000 residents.

In 2014, nearly two thirds of opioid-related hospitalizations (n = 12,639) were among males. The rate of opioid-related hospitalizations among male New Yorkers was higher than the rate among female New Yorkers in 2014 (371.7 vs. 209.0 per 100,000 residents, respectively).

Black New Yorkers had the highest rate of opioid-related hospitalizations in 2014 (316.5 per 100,000 residents) followed closely by Hispanic New Yorkers (299.3 per 100,000 residents). The rate of opioid-related hospitalizations among Black New Yorkers in 2014 was nearly twice the rate among White New Yorkers (316.5 vs. 185.9 per 100,000 residents, respectively).

Rates of opioid-related hospitalization were highest among New Yorkers 55–64 years of age (644.3 per 100,000 residents), followed by New Yorkers 45–54 years of age (552.0 per 100,000 residents). Rates of opioid-related hospitalizations were also highest in highest poverty neighborhoods (591.4 per 100,000 residents), nearly four times higher than the rate in lowest poverty neighborhoods (152.8 per 100,000 residents).

Cocaine-Related Hospitalizations

Cocaine-related hospitalizations accounted for more than one third of the approximately 60,000 drug-related hospitalizations in NYC in 2014 (the most recent year for which data are available; n = 19,796), with a rate of 279.5 per 100,000 residents.

More than two thirds of cocaine-related hospitalizations were among male New Yorkers (n = 13,335). The rate of cocaine-related hospitalizations among male New Yorkers was nearly twice the rate among female New Yorkers (397.8 vs. 192.2 per 100,000 residents).

Black New Yorkers had the highest rate of cocaine-related hospitalizations in 2014 (585.8 per 100,000 residents), more than twice the rate among Hispanic New Yorkers (222.3 per 100,000 residents), and nearly six times the rate among White New Yorkers (98.4 per 100,000 residents). Furthermore, Black New Yorkers accounted for almost half of all cocaine-related hospitalizations in 2014 (n = 9,705).
Rates of cocaine-related hospitalizations were highest among New Yorkers 45–54 years of age (678.4 per 100,000 residents), followed by residents 55–64 years of age (468.9 per 100,000 residents). Rates of cocaine-related hospitalizations were highest in the highest poverty neighborhoods (657.8), more than ten times the rate in the lowest poverty neighborhoods (56.1 per 100,000 residents).

**Prescription Monitoring Program (PMP)**

The NYC Department of Health and Mental Hygiene (DOHMH) tracks opioid analgesic and benzodiazepine prescriptions by analyzing data for all NYC residents who fill opioid analgesic or benzodiazepine prescriptions. In 2016, 1,732,029 benzodiazepine prescriptions were filled by 430,803 residents, and nearly 2 million (1,767,699) schedule II opioid analgesic prescriptions were filled by 560,978 NYC residents. Almost 70% of schedule II opioid analgesic prescriptions filled by NYC residents were for oxycodone (n = 1,223,707). Additionally, of the 645,706 NYC residents who filled an opioid analgesic prescription, less than 1% (n = 2,203, or 0.4%) met the criteria of doctor shopping, which is defined by a history of filling an opioid analgesic prescription from four or more prescribers at four or more pharmacies.

**Mortality**

In 2016, there were 1,374 unintentional drug poisoning (overdose) deaths in NYC, with a rate of 19.9 per 100,000 New Yorkers. Drug overdose rates were highest among males, White New Yorkers, 45–54-year-olds, and residents of Staten Island. Residents of the highest poverty neighborhoods had the highest rate of drug poisoning deaths (25.9 per 100,000); the rate was nearly double that of residents from medium-income neighborhoods (13.9 per 100,000). The rates among the highest poverty neighborhoods and the lowest poverty neighborhoods were 20 per 100,000 and 14.9 per 100,000, respectively. In 2016, nearly all (97%) overdose deaths involved more than one substance and 82% of overdose deaths involved an opioid.

**Figure 1. Unintentional Drug Poisoning (Overdose) Deaths, New York City, 2000–2016**

*Data for 2016 are provisional and subject to change. Source: NYC Office of the Chief Medical Examiner and NYC DOHMH Bureau of Vital Statistics.*
Drug overdose data in NYC were obtained by linking death certificates from the Bureau of Vital Statistics with medical examiner files and toxicology reports. The NYC DOHMH reports only unintentional drug poisoning deaths (X40-X44, F11-F16, and F19 codes); therefore, DOHMH does not report on suicide or undetermined manners of death. Additionally, because of a large methadone maintenance treatment population in NYC, methadone is reported separately from other opioids.

**BENZODIAZEPINES**

- From 2010 to 2016, there was an 86% increase in benzodiazepine-involved overdose deaths.

In 2016, there were 448 benzodiazepine-involved overdose deaths (6.5 per 100,000 New Yorkers). Compared with 2015, both the rate and the number of benzodiazepine-involved overdose deaths increased from 5.4 to 6.5 and from 370 to 448, respectively. 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 2016. Benzodiazepines were present in 59% of deaths involving opioid analgesics, 32% of deaths involving heroin, and 50% of deaths involving methadone.

In 2016, benzodiazepines (n = 1,033) were the primary drug in 1% of noncrisis drug treatment admissions. Benzodiazepines were more frequently reported as the secondary drug at admission. Benzodiazepines were reported as the secondary drug in nearly 15% (n = 277) of admissions when prescription opioids were the primary and in 7% (n = 1,550) of admissions when heroin was the primary.

Of 44,769 total National Forensic Laboratory Information System (NFLIS) drug report samples in NYC in 2016, 4.3% (n = 1,921) tested positive for alprazolam, and alprazolam was the fourth most commonly seized substance. Compared with 2015, there was a 15.7% increase in law enforcement seizures of alprazolam. In contrast, there were 465 seizures of clonazepam in 2016, representing a 5.9% decrease compared with 2015.

**COCAINE/CRACK**

- Cocaine-involved overdose deaths increased by 61% from 2015 to 2016.

- In 2016, 1 in 10 noncrisis drug treatment admissions reported crack/cocaine as the primary substance (10.8%).

In 2016, there were 630 cocaine-involved overdose deaths (9.2 per 100,000 New Yorkers). This rate represents a 61% increase compared with 2015 (N = 394, 5.7 per 100,000) and a 14% increase compared with 2006, the previous peak in cocaine-related overdose deaths (N = 508 deaths; 8.1 per 100,000 New Yorkers).

Black New Yorkers had the highest rate of cocaine-related overdose deaths (11.7 per 100,000 New Yorkers), which marked a change from prior years (2012–2015), in which White New Yorkers had slightly higher rates. 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 2015.
Cocaine was present in 50% of overdoses involving heroin, 11% of overdoses involving methadone, 15% of overdoses involving opioid analgesics, and 27% of overdoses involving benzodiazepines.

In 2016, 1 in 10 noncrisis treatment admissions reported crack/cocaine as the primary substance (10.8%, \( n = 7,698 \)). For these admissions, alcohol was the most frequently reported secondary substance (34%, \( n = 2,645 \)), followed by no secondary substance (26%, \( n = 1,972 \)) and marijuana (21%, \( n = 1,643 \)). When alcohol was reported as the primary substance, more than one in five admissions list crack/cocaine as the secondary substance (23%, \( n = 5,313 \)).

Of 44,769 total NFLIS seizures in NYC in 2016, 30.6% (\( n = 13,707 \)) tested positive for cocaine, and cocaine was the most commonly seized substance. This represents a small (2.0%) decrease compared with 2015, when there were 13,989 cocaine seizures.

Figure 2. Cocaine-Involved Overdose Deaths, by Race, New York City, 2000–2016*

MARIJUANA

- In 2016, marijuana was the second most common primary drug (excluding alcohol) reported upon admission to drug treatment (19.8%, \( n = 14,085 \)).

The NYC DOHMH does not report on the presence of marijuana in drug overdose deaths.

In 2016, marijuana was the second most common primary drug (excluding alcohol) reported upon admission to drug treatment (19.8%, \( n = 14,085 \)).

Of 44,769 total NFLIS seizures in NYC in 2016, 29.3% (\( n = 13,123 \)) tested positive for cannabis, and cannabis was the second most commonly seized substance. Compared with 2015 (\( n = 12,333 \)), there was a 6.4% increase in cannabis seizures.

METHAMPHETAMINE
Unlike other regions of the country, methamphetamine use in NYC remains confined to select populations. Health-related harms of methamphetamine use are not widespread.

Of 44,769 total NFLIS seizures in NYC in 2016, 1.6% (n = 729) tested positive for methamphetamine, which represents a 37% increase compared with 2015, when there were 532 seizures of methamphetamine.

NEW PSYCHOACTIVE SUBSTANCES (OTHER THAN OPIOIDS)

- During June 2017, there were 178 K2-related emergency department visits in New York City detected by syndromic surveillance. These numbers are similar to recent months and remain much lower than July 2015, when K2-ED visits peaked, exceeding 1,200 in a single month.

The NYC DOHMH does not report on the presence of synthetics in drug overdose deaths.

OPIOIDS

- Heroin was involved in 55% of all overdose deaths in 2016, making it the most common substance involved in overdose deaths.

- In 2016, heroin was the most common primary drug (excluding alcohol) reported upon admission to drug treatment (29%, n = 20,768).

- From 2015 to 2016, the percentage of overdose deaths involving opioid analgesics (excluding fentanyl) fell from 23% to 18%. The rate of opioid-analgesic-involved overdose deaths increased from 3.1 to 3.5 (per 100,000) during the same period.

- In 2016, the rate of methadone-involved overdose deaths increased by 27% (2.8 per 100,000) compared with 2015 (2.2 per 100,000). During this time, the percentage of overdose deaths involving methadone remained relatively constant (16% compared with 14%).
In 2016, there were 751 heroin-involved overdose deaths (10.8 per 100,000 New Yorkers). This is more than triple the 2010 rate (3.1 per 100,000 New Yorkers). Heroin was involved in 55% of all overdose deaths in 2016, making it again the most common substance involved in overdose deaths.

Similar to data from 2010–2015, White New Yorkers, New Yorkers 45–54 years of age, and Bronx and Staten Island residents had the highest rates of heroin-involved overdose deaths in 2016. Residents of the highest poverty neighborhoods had the highest rate of overdose deaths involving heroin (15 per 100,000 New Yorkers), nearly double that of residents of wealthiest neighborhoods (7.7 per 100,000). The rate of heroin-involved overdose increased in all NYC boroughs. Rates also increased among all races/ethnic groups, particularly among Black New Yorkers (61% increase from 2015 to 2016).

In 2016, 42% of all heroin-involved deaths involved cocaine, compared with 44% in 2015. In addition, 39% of heroin-involved deaths involved alcohol, compared with 40% in 2015. A total of 32% of heroin-involved deaths also involved benzodiazepines, compared with 41% in 2015.

In 2016, heroin was the most common primary drug (excluding alcohol) reported upon admission to drug treatment (29%, $n = 20,768$).

Of 44,769 total NFLIS seizures in NYC in 2016, 16.3% ($n = 7,276$) tested positive for heroin, and heroin was the third most commonly seized substance. This is an 8.9% increase in heroin seizures increase compared with 2015, when there were 6,680 heroin seizures.
Fentanyl

Fentanyl, a semisynthetic opioid 50–100 times more potent than morphine, is sold illicitly for its heroin-like effects and may be mixed with heroin or cocaine as a combination product with or without the user’s knowledge. Recent law enforcement seizures in several jurisdictions across the United States, including NYC, have identified fentanyl sold in powder and pill formulations, which may be marked as other substances, including benzodiazepines and opioids analgesics.

Fentanyl was involved in 44% of all overdose deaths during 2016 \( (n = 598) \), which was a dramatic increase from 16% in 2015. Prior to 2013, fentanyl was uncommon in NYC, accounting for less than 3% of overdose deaths.

Fentanyl has been most often present in heroin-involved deaths; nevertheless, fentanyl has been increasingly identified in overdose deaths involving cocaine, without heroin. In 2016, 37% of overdose deaths involved cocaine and fentanyl without heroin, up from 11% in 2015. Provisional 2017 data suggest that fentanyl is present in more than one third of overdose deaths involving cocaine without heroin. NYPD laboratory testing data have confirmed the presence of fentanyl mixed in with cocaine products.

Most fentanyl-involved deaths in 2016 also involved heroin (61%). After heroin, cocaine was the second most common co-involved substance (47%), followed by alcohol (38%) and benzodiazepines (32%). The rate of fentanyl/heroin-involved deaths increased by 253% from 2015 to 2016 (1.5 to 5.3 per 100,000), whereas the rate of fentanyl/cocaine-involved deaths increased by 356% over the same period (0.9 to 4.1 per 100,000).

The NYC DOHMH developed a Fentanyl “Health Alert” flyer to distribute to harm reduction programs, drug treatment programs, and people who use drugs to advise of the presence of fentanyl in NYC and provide harm reduction information. On June 1, the NYC DOHMH also released a Health Advisory alerting New Yorkers to the risk of fentanyl-involved overdose among recreational cocaine users.

Of 44,769 total NFLIS seizures in NYC in 2016, 3.8% \( (n = 1,699) \) tested positive for fentanyl, and fentanyl was the sixth most commonly seized substance (up from 12th in 2015). This represents a 694% increase from 2015 when there were 214 fentanyl seizures.
In 2016, there were 241 opioid-analgesic-involved overdose deaths (excluding fentanyl), with rate increases from 3.1 per 100,000 New Yorkers in 2015 to 3.5 in 2016. The rate was highest among White New Yorkers (6.2 per 100,000), which was almost four times higher than that for Black New Yorkers (1.6 per 100,000). The rate among Hispanic/Latino New Yorkers was 3.9 per 100,000. Unlike previous years, when rates were highest among the 45–54 age group, in 2016, rates of opioid analgesic-involved deaths were highest among New Yorkers 55–64 years of age (5.8 per 100,000). Also, in contrast to previous years, rates were highest among residents living in the highest poverty (poorest) neighborhoods (3.9 per 100,000); nevertheless, the rates among those living in the lowest poverty (wealthiest) neighborhoods were not far behind (3.8 per 100,000).

Most opioid analgesic-involved deaths in 2016 also involved benzodiazepines (59%). Heroin was the second most common co-involved substance (46%), followed by cocaine (39%) and alcohol (31%). These percentages were consistent with those seen in the previous four years.

In 2016, prescription opioids were listed as the primary drug in 2.6% (n = 1,871) of all drug treatment admissions. Among these admissions, there was most frequently no reported secondary substance (27%, n = 505), followed by marijuana (17%, n = 322) and benzodiazepines (15%, n = 277).

**Methadone**

There were 195 methadone-involved overdose deaths in 2016 (2.8 per 100,000 New Yorkers). This rate reflects a 27% increase from 2015, when 2.2 out of every 100,000 New Yorkers died of a methadone-involved overdose.
Nonprescription methadone was reported as the primary substance in 0.1% \((n = 81)\) of drug treatment admissions. Nonprescription methadone was infrequently reported as the secondary substance of drug treatment admissions \((0.4\%, \ n = 275)\).

The methadone maintenance population in NYC is 30,000–33,000 individuals. The number \((n)\) of methadone-involved overdose deaths has been steadily increasing since 2014.

Of 44,769 total NFLIS seizures in NYC in 2016, less than 1% \((n = 298)\) tested positive for methadone. Methadone seizures decreased by 19.2% compared with 2015 \((n = 369)\).

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**Local Research Highlights**

**Timely Response to Emerging Drug Issues**

Emerging drug trends and associated risk behaviors often require a quicker response than more conventional scientific research methods allow for.\(^1\) Rapid assessment and response (RAR) is a research method that can be used to investigate public health risk behaviors and associated consequences,\(^2\) and it has been widely used to examine drug use.\(^3,4\) Unlike traditional epidemiological studies designed to produce exact estimates and quantify relationships, RAR uses both qualitative and quantitative methods to gather data quickly in response to a question or crisis requiring a timely intervention. Public health surveillance data sources used by NYC DOHMH in support of RAR investigations include unintentional drug poisoning (overdose) mortality data and syndromic emergency department data. Qualitative data gathered in the course of ongoing research studies\(^5\) and event reports from community-based organizations may also guide RAR investigations. RAR investigations focus on either a discrete geographic area or a discrete demographic group experiencing adverse health consequences associated with drug use.

In response to increasing rates of fentanyl-involved overdose, the RAR team conducted interviews with staff of programs interacting with substance users and persons who use drugs (PWUD) to assess their knowledge of fentanyl and to explore whether there was an active nonpharmaceutical fentanyl market in the city. Findings demonstrated that in many cases, PWUD and service providers lacked knowledge about nonpharmaceutical fentanyl and that PWUD were not deliberately seeking out fentanyl to use. The RAR team focused on two geographically defined areas where data indicated increased rates of opioid-involved mortality visiting all New York Office of Alcohol and Substance Abuse Services (OASAS)

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\(^{5}\) Data collected by the NYC Department of Health and Mental Hygiene, Bureau of Alcohol and Drug Use Prevention, Care and Treatment.
licensed substance use treatment providers to inform and educate staff about the emerging fentanyl issue.

Site visits ($N = 25$) were informal and involved presentation of the following materials: (a) overdose mortality data, including rates of fentanyl-involved drug overdose deaths, a borough-level fact sheet, and an Epi Data Brief on citywide heroin- and fentanyl-involved overdose mortality; (b) fentanyl education materials for providers and patients, including NYC DOHMH fentanyl alert posters and basic information on fentanyl and associated risks; (c) a list of pharmacies that dispense naloxone under the NYC DOHMH standing order in UHF 303; and (d) information on opioid overdose prevention program (OOPP) enrollment through NYS DOH. In addition to substance use treatment programs, pharmacies listed on the NYS DOH website as offering syringe access through the expanded syringe exchange program (ESAP) were visited and provided educational materials similar to those described earlier. These visits are ongoing. Buprenorphine providers listed on the SAMHSA website will also be targeted by RAR staff and provided with mortality data and fentanyl educational materials.

To date, a total of 52 programs and 56 ESAP pharmacies in two NYC UHF neighborhoods have been visited and provided with mortality data and educational materials. Information and materials were well received, and afterward, requests were made by some programs for further, more formal data presentations to both staff and clients. RAR activities to date have emphasized the importance of communicating directly with services that intersect with PWUD to ensure they have the appropriate knowledge and materials to inform and educate their clients about the risks of fentanyl and to encourage dispensation of naloxone.

Naloxone Initiatives

NYC DOHMH began distributing naloxone kits to community based organizations in 2009, and it has provided more than 56,000 naloxone kits to certified opioid overdose prevention programs (OOPPs) to date, with naloxone distribution increasing each year. As part of the Mayor’s HealingNYC initiative, NYC DOHMH aims to quadruple its distribution target of 15,000 kits per year to 65,000 by fiscal year 2019.

Figure 5. Intranasal (IN) Naloxone Kits Dispensed by OOPPs* ($N = 42,268$) by Setting, Excluding NYPD: 2009–2016
*Opioid overdose prevention programs.
Source: Data were collected by the DOHMH Bureau of Alcohol and Drug Use Prevention, Care and Treatment, in partnership with Opioid Overdose Prevention Programs.

NYC DOHMH is increasing staff capacity to maximize expansion efforts and make naloxone outreach and trainings more accessible to New Yorkers. As trends in overdose morbidity and mortality emerge, staff can quickly respond by providing naloxone kits in affected areas, while longer term systems are put in place to ensure more sustainable naloxone access once NYC DOHMH staff members have completed their outreach. DOHMH is simultaneously working to increase capacity at other community-based organizations interested in dispensing naloxone; a request for proposals (RFP) was released in late 2016 to fund staffing enhancements, and 12 organizations were selected.

Figure 6. Overdose Reversal/Naloxone Use Reports \((N = 1,370)\) Submitted to DOHMH: 2010–2016

Youth and Substance Use

The 2015 NYC Youth Risk Behavior Survey (YRBS) was administered to public high school students in NYC. Alcohol and marijuana were reported as the top two most common drugs used: 15.9% of students reported marijuana use and 20.9% of students reported alcohol consumption during the past 30 days. While Staten Island had the largest percentage of high school students reporting marijuana use (18.2%), Manhattan had the highest rate of high school students who use alcohol (25.6%). Male high school students reported a significantly higher use of prescription drugs (opioid analgesics, benzodiazepines, stimulants and others) and illicit drugs (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 has increased significantly among high school students over the past decade, from 1.8% of NYC high school students in 2005 to 2.5% in 2015. The proportion of 12th grade students having consumed alcohol during the past 30 days (31.9%) is nearly triple that of 9th grade...
students (12.8%). Between 2011 and 2015, the percentage of high students who reported binge drinking during the past 30 days significantly decreased for 9th, 10th and 12th graders.

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**Infectious Diseases Related to Substance Use**

New HIV diagnoses in NYC decreased by 54% from 2001 to 2015, from 5,862 to 2,493 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 43 diagnoses in 2015. As of December 31, 2015, there were 121,616 people living with HIV/AIDS (PLWHA) in NYC. Of these, 15,918 (13.1%) people reported a history of IDU and 2,651 (2.2%) were men who have sex with men/IDUs.

In 2015, 48 acute hepatitis B cases were reported (0.6 per 100,000 New Yorkers), and there were 7,719 newly reported chronic hepatitis B cases (90.9 per 100,000 New Yorkers), with Brooklyn reporting the highest rate of infection (99.9), followed closely by Queens (97.5). 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. Nevertheless, 7,328 people were newly reported with chronic hepatitis C in 2015 (86.3 per 100,000 New Yorkers). Among individuals 0–29 years of age, there were 796 newly reported hepatitis C cases in 2015. Data on the number of hepatitis B and C cases resulting from intravenous drug use are unavailable.

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**Legislative and Policy Updates**

**Naloxone in Pharmacies**

As the demographic range of New Yorkers impacted by opioid misuse expands, the City has been exploring mechanisms to expand access to naloxone in innovative settings to reach emerging populations at high risk of opioid overdose. On December 7, 2015, NYC DOHMH Health Commissioner Mary Bassett issued a standing order to authorize naloxone dispensing in pharmacies. As of April 1, 2017, New Yorkers at risk of opioid overdose, as well as concerned family members and friends, can access this life-saving medication upon request in 748 pharmacies citywide.

More information on naloxone in pharmacies, including a list of participating pharmacies, can be found at the NYC DOHMH website: [https://www1.nyc.gov/site/doh/providers/health-topics/naloxone-and-overdose-prevention-in-pharmacies.page](https://www1.nyc.gov/site/doh/providers/health-topics/naloxone-and-overdose-prevention-in-pharmacies.page)
Increasing Access to Buprenorphine in NYC

Recent changes in federal legislation now allow for buprenorphine prescribing by nurse practitioners and physician assistants. The NYC DOHMH is expanding its buprenorphine training initiative to support these additional prescribers, with a goal of training 1,500 new prescribers in primary care settings over three years. NYC DOHMH has launched a buprenorphine nurse care manager model in seven federally qualified health centers (FQHCs), FQHC look-alikes, and other safety net settings; is developing and disseminating patient and provider-facing materials on buprenorphine; and is offering technical assistance to providers interested in prescribing buprenorphine. These initiatives will help the City connect 20,000 more New Yorkers to medication-assisted treatment by 2022.
Data Sources

Data for this report were drawn from the following sources:

Prevalence
- **NYC YRBS**: The 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.

- **NYS PDMP**: The Prescription Drug Monitoring Program (PDMP) managed by the New York State Department of Health collects data from drug dispenses on schedule II–IV controlled substances.

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 2000–2016. Methadone is reported separately and not included in opioid analgesic analyses.

Treatment
- **The New York State Office of Alcoholism and Substance Abuse Services (OASAS)**: Treatment admissions data were collected through the Client Data System for 2010–2016.

HIV and Hepatitis data
- **HIV data**: 2015 HIV surveillance data were collected from the NYC DOHMH HIV Epidemiology and Field Services Programs’ annual report.

- **Hepatitis data**: 2015 hepatitis data were collected from the NYC DOHMH Bureau of Communicable Diseases’ annual report.

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