**CSB Meeting 11.14.24**

- **Attendees:** Adrienne Abbate, Felecia Pullen, Tina Saha, Winnie Ho, Ellenie Tuazon, Soteri Polydorou, Julia DeWalt, Deb Pantin, Brooke Gasdaska, Anika Kalra, Sonia Lopez, Janet Smith-Dobson

- NYC Health Department Updates
    - New Bureau of Alcohol and Drug Use Prevention, Care, and Treatment (BADUPCT) and Mental Hygiene leadership
        - Dr. Rebecca Linn-Walton – new BADUPCT AC
        - Dr. H. Jean Wright II – new EDC for Division of Mental Hygiene
    - Opioid Settlement Funds treatment funding concept paper now on Public Health Solutions website, RFP will be out this winter
    - Sent alerts to providers about carfentanil, medetomidine, and BTMPS in the drug supply
    - Working with RxStat to explore opportunities for sharing EMS data
    - Working to provide more current overdose data to partners and the public
    - Publication of new paper on the Relay program
    - Newest Peer Corps cohort graduated recently
- 2023 Provisional Overdose Mortality Data
    - Overview of social determinants of health – non-medical factors that affect health. These include:
        - Structural racism – results in unequal distribution of resources
        - Limited community investment and disinvestment leading to notable differences in income, wealth, employment opportunities, etc.
        - Other social and environmental circumstances that impact drug use behaviors and outcomes
    - 3,046 overdose deaths in 2023 – stabilization/slight decline since 2022
    - Someone died of an overdose in NYC every three hours
    - Substances involved in overdoses
        - Fentanyl drives overdose crisis in NYC – involved in 80% of overdose deaths
        - Other takeaways: Opioids involved in 83% of overdose deaths, cocaine involved in more than half, alcohol is commonly involved, proportion involving heroin continues to decline
    - Impact of overdose epidemic has not been equal
    - Overdose deaths by demographic characteristics

        - Majority of overdose deaths occurred among males, but noticed an increase among women in 2023
        - Majority of overdose deaths occurring among Black and Latino NYers
        - Most of those dying of overdose are 35 and above – largest proportion is among 35-54 year olds, but 55-84 year olds have similar rates
        - Age group most impacted varies by race/ethnicity: In Black NYers, highest rates are among those ages 55-84, while in Latino and White NYers, rates are highest among those ages 35-54
            - Older Black NYers are experiencing increasingly high rates
        - Q: Can you disaggregate the 15-35 age group further?
            - A: Majority of deaths in this age group are among those 18-35
            - Need to align work around prevention/need for work in schools, addressing co-occurring mental health and SUD
        - Q: Do we have analyses between race and age and drug of choice?
            - A: Re: drug of choice, we can only analyze by substances present in the body at time of death. Epi Data Brief has data by race and substances involved, and by age and substances involved, but not all three together – analysts are currently looking into this
    - Overdose deaths by geography
        - Bronx has highest number and highest rate of overdose death
        - Neighborhoods with highest rates: Hunts Point-Mott Haven, Crotona-Tremont, Highbridge-Morrisania, East Harlem, Fordham-Bronx Park (same neighborhoods as in 2022)
            - Q: What is the rate in Central Harlem?
                - A: 60.6 overdose deaths per 100,000
            - Q: What UHF neighborhoods are the OPCs in?
                - A: Washington Heights/Inwood and East Harlem
    - Overdose deaths by setting – where people are overdosing
        - Most overdose deaths occurred in a private home (their home or another person's home)
        - Second most common setting is public outdoor (primarily on the street)
        - 10.4% occurred in SRO/supportive housing settings
        - 8.3% occurred in public indoor settings
        - A smaller proportion occurred in shelters (4.1%), on public transit (2.9%), or in a medical/treatment facility (1.5%)

        - Q: Does “medical/treatment facility” category include OPCs?
            - A: There have been no overdose deaths in OPCs.
    - Structural and contextual factors contributing to overdose crisis
        - Disparities are a result of poverty, unstable housing, unemployment, institutionalized racism, criminalization and stigma, mass incarceration, barriers to accessing treatment, internalized shame, risk of using alone, and a lack of community supportive services, worsened by gentrification
- **Discussion**
    - Insights around engagement/connection for non-white NYers, especially older Black men
        - Members shared anecdotal observations – there are many Black and Latino men over 60 who are isolated, live alone, minimal contact with family and friends. Need for additional support for isolated adults
    - What substances are older Black men using?
        - Members shared anecdotal observations – increases in crack/cocaine use
        - Need to explore factors contributing to crack/cocaine use in older Black men – is it considered socially acceptable, cheaper, easy to obtain, etc.?
    - Do we know why numbers decreased among white NYers – was it naloxone, messaging, etc.? Important to know what’s worked to inform how we address disparities.
        - Important to note that cultural responsiveness should be at the center of any messaging and intervention. Generalized messages/interventions will not be effective for every race and group.
        - Anecdotal observations shared – hearing that bupe access has increased in white communities and that had an impact. When you look at medical providers who provide bupe, they are providing more through medical practices.
        - Important to look at the quality of life-related assets communities have, and have these drive interventions to make impacts on upstream factors
    - There is variability in access to medications for opioid use disorder (MOUD). Do we have the data to see if different communities have different access to MOUD and medications for alcohol use disorder?
        - People with greater wealth and opportunity have better medical outcomes – needs to change

- How is the Health Department working with senior adults/in places where older adults live?
    - Rapid Assessment and Response has been doing presentations, trainings, and discussions with older adults in senior centers, senior residences, adult day service settings, veteran centers/housing, etc.
    - Wellness Initiative for Senior Education – aims to help improve lifestyle among senior adults
    - State report being developed to address medical and behavioral health among older adults. Looking closely at *how* and *where* older adults access care – will be helpful to see findings/recommendations
    - Anecdotal observations: Hearing that alcohol use is increasing among older adults
    - Ideas: Work in nursing homes, collaborating with/cross-trainings with Meals on Wheels, training home health aides on naloxone
- What can we do about cocaine-involved overdoses? There are no medications like MOUD for cocaine use
    - Some evidence (not as strong as MOUD's evidence) that topiramate may be effective – starting to use more in acute care/detox settings
- Disparities by race, age, and drugs involved: layer this with health inequities and treatment disparities, how do we address all of this? Every year we see disproportionate burdens of death among Black and Brown people. What is the strategy to address it? Especially with regards to older Black men?
    - We see similar patterns in alcohol and drug use morbidity (e.g., ED visits, hospitalizations) – need upstream interventions
    - When opioid analgesics were the main issue and white people were most impacted, people became interested in compassionate care, bupe access, etc.
    - Now organizations encounter pushback when they want to focus on alcohol and other substances – still a strong prioritization of opioids
    - Health Department would love to explore opportunities to partner on/leverage work CBOs are doing
    - Have to acknowledge our limitations as a government institution for doing this work in our communities – trust is important.
    - Health Department is doing focus groups to understand how to best reach these communities
    - Idea: Health Department has hypertension initiatives where community health workers do interventions in barber shops to reach Black men – opportunity for alignment across divisions

            - Important to have community members driving messaging. When messaging isn't driven by/created by people in the community, it's not going to work
        - Importance of faith community – what can faith leaders do to help with trauma and substance use? This is a space where people find connections and networks
- Should be referring to political determinants of health rather than social determinants of health. Need to understand how we can reshift investments to reduce what we're seeing with health, housing, education disparities
- Collective assumption is that older adults have been using longer and their relationship with drugs has a different context and history. Needs to be discussed separately from prevention strategies, because the interventions needed to address them are not the same. Would love to get a better sense of that personal context for older Black NYers. Unclear how to address the alarming trends we see among this specific demographic group without that. We also can't expect this wave to end now – there's still a slightly younger cohort of older adults coming up, and we're still experiencing the worst effects of the war on drugs from decades ago. Need to think about how to engage around this and have these conversations.
- Framing status of overdose crisis as "deaths are decreasing" is a mistake. Want to challenge NYC to change the narrative we're putting out there.
    - Rates are barely going down, and we've seen a decrease before that went back up the following year
    - Even national decreases are not across-the-board – certain groups are seeing increases
    - Don't start with "there's been a slight decrease," start with "there's been an increase in Black and Brown communities"
    - When people hear there's been a slight decrease, they think the work is done and we don't have to invest as many resources into it – need to make sure the work continues
    - Frustrating to hear people say that this is great news, rate is going down. Understand desire to say it's getting better, but it hides the real trends – people who are invisible are made invisible again
    - We also saw increases in women, and a large proportion of pregnancy/postpartum deaths are overdoses. BADUPCT is working with maternal health on this
- Family reunification – families often don't know how to work with someone who has used for a long time. Causes despair among clients and families.

    - Do we have any data to indicate whether these trends have any relationship to THC?
        - Law enforcement agencies planning to do more testing of cannabis for other substances
        - Persistent rumors that there's fentanyl in cannabis, but no evidence of cannabis being contaminated with fentanyl
            - But people report experiencing this – what explains that?
            - Opioids are more stigmatized than cannabis – all self-report, and people feel safer reporting cannabis use than opioid use
            - We see news reports (similar to ones about people overdosing from touching fentanyl) but with further investigation, none of these reports have been substantiated
            - Distracts from core issues – people point to cannabis legalization as an easy scapegoat to explain increases in overdoses
    - Q: Upcoming administration has less compassion for people who use drugs – what is role of local government, CBOs, and grassroots groups to prepare for these shifts?
    - Q: Health Department operates Peer Corps. Ideas of how else we can move the peer workforce forward?
        - Pay equity – peers relive trauma and aren't paid enough to live off of
        - Health Department is working to start a pilot around vocational support. Vocational support is often tied to treatment, so it ends when a person leaves treatment, but that's when it's most needed. Need stronger relationships between treatment and recovery supports. OASAS is also cutting funding to vocational services.
        - Recent study found that outpatient program staff are unlikely to make referrals to recovery centers even if they are aware of them.
        - Opportunity to find a bridge between OTPs and RCCs – how make OTPs aware that RCCs don't "steal patients" – maybe a campaign?
    - NYPD training should be a focus, specifically in communities of color
        - CSB member witnessed officers treating someone who was overdosing with apathy – wouldn't let her give them naloxone or intervene
- Community updates
    - Public health vending machines coming to Staten Island – executing contract now and planning a harm reduction town hall (would love Health Department representation)