It could be someone you know.

Welcome to SBH Bronx Health Talk produced by SBH Health System and broadcast from the beautiful studios at St. Barnabas Hospital in the Bronx. I'm Steven Clark.

The Bronx has the highest rate of deaths from opiate overdoses in New York City. In fact, if the South Bronx was a state it would have the second highest fatal overdose rate in the country after West Virginia. With us today to discuss the problems of opiate addiction is Dr. Jenna Butner, an addiction medicine specialist at SBH Health System. Welcome Dr. Butner.

Thanks for having me.

Sure. To get started, I guess it's fair to say that people become addicted to opiates in many different ways and they come in all different colors, ethnicities and backgrounds, right?

Yes, that's correct. Addiction in general, whether opioid, alcohol, cocaine doesn't discriminate based on ethnicity or socio-economic background. We see addiction is basically pervasive throughout all different types of people and different backgrounds.

Are prescription opiate overdose common here in the Bronx?

So prescription opioids are not as commonly used here in the Bronx in general so the rate of addiction with prescription opioids according to the Center for Disease Control is actually only one percent. Prescription opioids in general have a much higher street value and we are not seeing them as commonly used here in the Bronx due to socio-economic reasons. That being said, they still are being used throughout the country and can be a conduit to either heroin use or what not. With prescription opioids we mostly worry about diversion. That's a very very big problem not only in the Bronx but throughout the country.

What do you mean by diversion?

So diversion is essentially having the prescription and either selling it or giving it to a family member or friend. Most people who do start using prescription opioids are basically the medications are diverted from somebody else. We see that in the literature.

I had spoken to your colleague Dr. Samuels about the problem with painkillers and the fact that he sees many patients who come in whether it's for cancer related or surgical related incidents and they very easily get painkillers that they can easily become addicted to.

You know there's a big misconception with getting a prescription for a prescription opioid and developing an addiction so just to be very

clear
there's a difference between addiction and there's a difference between a physiologic dependence so just to expound on that so if somebody has prescribed an opioid, their body may develop like a tolerance to that and that does not equate to developing an addiction to it so a lot of times we hear from patients there's a fear of if they are prescribed an opioid of them getting quote addicted. Addiction is actually a diagnosis that there's certain criteria that do need to be met and the diagnosis is that it is a chronic disease of the brain and in order to make a diagnosis it has to actually be present for over one year so there's a lot of elements behind that actual diagnosis as opposed to just your body developing a dependence if you will.

I've read that the latest drug on the scene is fentanyl mixed with cocaine. Is that something you're seeing here?

Yeah so thank you for bringing this up. It's a very important concept here in regard to discussing opioids so there are two kinds of fentanyl. There's fentanyl that is prescribed for cancer pain and chronic non-cancer pain. This is prescribed by medical providers in a monitored setting. The other source of fentanyl that we're now seeing flooding essentially the market, if you will, is coming in from Mexico and from China. These are synthetic opioids and it's important to know fentanyl is almost a hundred times stronger, more potent, than morphine so even just one use of it can lead to fatal

overdose and like you said the problem is that people are not just buying fentanyl illicitly. What's happening is that fentanyl is being we say laced with really any drug so whether it's heroin, or cocaine we're even seeing it pop up if you will in urine drug screens for people who smoke marijuana so it's being laced in so many different illicit drugs and this is the kind of culprit behind a lot of the overdoses that we're seeing.

To help combat the problem of addiction in the Bronx I know city officials distributed 15,000 naloxone kits throughout the Bronx by the end of last year and while I know naloxone saves lives is that getting to the heart of the addiction problem here in the Bronx?

That's a great question. So naloxone is a really very important medication which essentially blocks opioid overdoses. There's a couple of different issues here. Number one to address your question naloxone is not a treatment for opioid addiction. It's a form of treatment that we say is called "harm reduction" and harm reduction is basically meeting the patient where they're at so if somebody is continuing to use any substance, in this case particularly heroin, naloxone is basically a tool that we can give to them whether in the form of a free kit or a prescription that'll help prevent death essentially.
So we're meeting the patient you know where they're at. Naloxone is really at the severe end of the spectrum as far as just preventing this

mortality but it is a very very important tool if you will that anybody can use. In general, I actually like to offer a prescription of Narcan to many of my patients regardless if they have a substance use disorder because really in fact most people if you ask them either know somebody or they see it you know whether they're on the subway or maybe walking down the street and to have that as a tool in case you know in case of emergency is so important and I just want to add too that it's a comment again on the fentanyl the problem here now with naloxone is that the heroin being used is so so so strong that one dose of Narcan or naloxone is not touching the patient so the problem is that a patient is requiring many many many doses just to prevent overdose so this is kind of the gray area where we're really seeing so many overdoses.

That's interesting. I didn't know that. How does an individual end up as your patient? Is that after they overdose or are arrested or someone intervenes and realizes they have a problem or is it all the above?

Yeah, you know it's all of the above. One of the problems with; well, it's not a problem with addiction treatment, is that only one in ten people actually seek out treatment so we're missing 90 percent of people and the people who actually do come in for treatment are usually on the severe end of the spectrum where they've had that incident whether that overdose, whether that arrest, whether that anything that you just mentioned so the people that were either the

people who are at high risk of developing addiction or who already have an addiction may be on a milder spectrum, they're really not presenting to us. We're really missing a large percentage of the population, but that being said you know addiction treatment as with any treatment I always say you know my rule of thumb is that a patient for substance use treatment needs to meet you halfway. I can you know we can go ninety-nine percent, but if that patient is not motivated or you know doesn't recognize that you know they have a chronic disease it's really difficult to make any strides with that.

Okay so let's talk now about the treatment. Now I know from a medical perspective you offer both methadone and suboxone so why don't we talk about the differences between the two of them.

Okay, that is a very complex question, but I'm happy to try to tackle that so so we're also we're just to be clear we're talking specifically about opioid use disorder. So there are three approved medications for opioid use and those are one methadone; two suboxone, which is the brand name I just want to be clear, the actual medication is called buprenorphine, but for our purposes we'll just stick with suboxone; and the third treatment is maltrexhome which is an opioid blocker and that can be actually given in the form of an injection so just to kind of parse out the difference between the three so methadone is a very patient who go on to a methadone program can be very successful what it is it's a full opioid medication if you agonist if you will and the

way it works is that a patient gets titrated or optimized to a dose where they're able to not have craving and to basically you know get up and go about their day. The difference with methadone is that it's federally regulated and it cannot be prescribed from a medical providers office for the indication of opioid use disorder so it must be given at a dispensary which are, you know, heavily monitored. They're located throughout the country and then at that methadone program it provides a little bit more guidance and oversight so patients

in most programs they have to attend meetings a certain amount of group meetings per week or per month. They have to meet with a caseworker, maybe a social worker, so it's a more multidisciplinary approach and there's much more accountability. The second medication, suboxone or buprenorphine works as an opioid agonist like methadone and it also is an antagonists like naltrexone which we'll talk about. so buprenorphine is also a very great medication and that can be prescribed by a medical provider in an office-based setting and it can also be prescribed in a kind of like a methadone dispensary type setting. The difference with this will actually you know it does function in in a similar way to methadone in that the goal is to decrease cravings to enable somebody to function and what it does though is that it really blocks those opioid receptors and so if a person uses heroin, any opioid while taking this medication, the effect is blocked so essentially the person doesn't feel the effect of any of these opioids while taking suboxone so it's a really it's a really great

medication for preventing opioid use and then that being said you know if it is prescribed in an office-based setting there is a little bit more independence for the patient in the sense they don't have to come daily for dosing there may be you know depending on the provider they would come weekly or every two weeks

So you give them like a week or a two week or a monthly supply?

Yeah so treatment contracts are you know agreements are in place and then according to the provider whatever you know program they have set up and you know a lot of patients who are maybe full-time employed or have difficulty getting to a clinic or maybe hadn't been using so much or for so long a time this might be more appropriate for them. But that being said, methadone would be also a great option.

But there's a trust involved with supply.

Yeah there is a mutual type of trust as with methadone as well people who are in programs they can get take-home bottles and what not so it's a similar concept and then the third medication just to touch on naltrexone that is a medication it can be given in the form of a pill or most commonly it's given in an injectable form that's given once a month. The goal of that is to basically block those opioid receptors so if you use while getting medication and nothing will be felt and you know it's used for opioid use, it's also given for alcohol use disorders

and other illicit drugs you know off-label. So it is another treatment option, not one that I particularly you know use for patients with opioid use but it is an option. We see it a lot used in the incarcerated population, also in the adolescent population so there are certain groups that it's you know used a little bit more so is that

Is the medication forever or do you wean them over time?

That's a great question and that's really the golden question with substance use treatment. We all kind of struggle with this question and really my answer that I give my patients is for however long you need to be taking this medication you know for somebody for example with diabetes I can't tell them how long they'll need insulin. It depends on so many factors. How they're responding to treatment, their diet, etc. so it's the same concept with substance use. It also depends on the you know the patient's circumstances change over time. you know different goals and what not I always my approach is if it's not broken, don't fix it. You know treatment for substance use disorder is medication and also you know the psychosocial part of counseling or group therapy.

Okay, so that's part of the treatment also?

Yeah exactly. I mean studies show that specifically with suboxone you know addition of counseling what not doesn't actually provide

better outcome but that being said that you know a lot of patients with substance use disorders they have a, there's a large percentage with past trauma and you know abuse and co-occurring mental health disorders, and it's so important to incorporate that as part of the treatment and that can be in the form of individual therapy, group therapy, going to a 12-step program AAA, Narcotics Anonymous so there are so many tools and really you know some patients don't really respond to that they're like it just doesn't work for them and that's okay I always tell them to try it and you know again revisit it if their circumstances change and you know as many tools that we can use are you know with as with anything it is better

It's a tough business. What constitutes a victory?

Yeah so a victory you know we can define victory of course is really abstinence and not only abstinence actually let me take that back. So successful treatment in substance use would be either a reduction in the amount of use or abstinence, which is essentially not using the drug, and really measuring it in terms of life outcomes so whether that is in the form of obtaining a job, having healthy relationships with family members and co-workers and friends, addressing other medical psychiatric conditions. You know some patients are not able to achieve that abstinence and again it's really meeting them where they're asked so in the form of either harm reduction or what not that for me that's a successful outcome

as well so it's really ended. It really is patient and provider specific. There's no defined victory if you will. It's really what the goals of treatment are between the patient and the provider, but it is you know it's an ongoing discussion every time they come.

Okay, well thank you Dr. Jenna Butner for joining us on SBH Bronx Health Talk today. Again for more information on addiction medicine or other services available at SBH Health System visit www.sbhny.org and thank you for joining us. Until next time.