New Yorkers are more likely to die of drug overdoses than from homicides, suicides, and car crashes combined. 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 Faith Daniel. Addiction has plagued the US for years but in recent years, the problem has grown significantly worse especially within the Bronx. In 2017, the Bronx had the largest number of deaths due to drug overdose in New York City. While opioid addiction can't be discussed without talking about the social determinants of health such as income, employment, housing, education, and access to health services, at the same time, addiction does not discriminate and no age, race, or socioeconomic class is immune. With me today to discuss the issue of addiction is Jennifer Rogers, administrative director of the addiction medicine department at Saint Barnabas Hospital. Welcome Jennifer.

Thank you.

So let's begin by discussing the department's inpatient treatment program. Who is likely to be admitted to this unit and what services do we offer?

Sure. So our inpatient unit is a twenty-four bed, coed, locked, detox unit. It is available for patients going through both opiate or alcohol withdrawal. There's one pathway right now to detox and that is

through our emergency department. They will be seen by a medical doctor as well as a case act counselor who is trained in addiction medicine and can do the proper assessments to determine who is best to be admitted. Our average length of stay is about three to five days and this level of care is primarily for patients that are looking to get off of any type of substance that they are currently addicted to. So we do opiate and alcohol withdrawal and it's usually the first phase of treatments, so somebody that's newly coming off of something whether it be drinking, or prescription drugs, drugs that they're buying off of the street, and their body is physically dependent on the chemical. They will require the hospital stay to physically detox them off of the drug.

And what does withdrawal look like?

Sure. So there are several industry standard tools that we use to identify the symptoms and rate those symptoms to know if somebody is in severe versus moderate versus minimal withdrawal. And we reserved the detox level of care for the more I would say moderate to severe withdrawal. There are some detoxes that can be done outpatient and that would be the more minimal to moderate withdrawal but for- in terms of symptoms I would say, we're looking at things like: increased heart rates, sweats, stomach upset nausea, diarrhea, vomiting, something we call tachycardia which is increased heart rate. There's also body aches. With alcohol withdrawal, there's a risk of

seizures in some patients so that's where we really want to have the contain 24 hour level of care that we have just to watch for things like that.

And given those some symptoms which seem like extremely severe and very uncomfortable for anybody to deal with, what are some examples of treatment options to help with- cope with those withdrawal symptoms and also like help the person to never want to go back?

Sure. So when they come into the detox level of care they're going to be assessed to start on a taper- a medication taper- for either the opiates or the alcohol where the doctor will bring the dose up and down depending on their use history- a number of factors: their symptoms, their use history, how they're presenting in front of the doctor at that time, and the doctor can then adjust the- the taper as the days go on. The goal is to make the patient comfortable enough where they're not experiencing those severe symptoms every single day. On top of the taper, the doctor will also prescribe what we call comfort medications and those medications will be to attack things such as the symptoms I just spoke about. So they'll- they'll prescribe medications to stop the stomach upset or to stop the body aches to bring down the heart rate on top of the taper that the patient is on to stop the- or to help the body wean off the dependency on the substance.

Do individuals usually respond well to those treatments?

They do. Patients-uh, some patients that have been through several rounds of detox because not everybody is going to get clean the very first time.

Right. Right.

And in fact, most statistics say that it does take several attempts at detox before people are getting clean. There are people that come in and they can get it the first time but it's not the norm.

Is there an average number?

Off the top of my head, I want to say maybe six or seven attempts but I don't- I don't have those numbers. The patients generally are in need of something else. You can't just send somebody into detox and expect that they're going to be treated during the three to five days that they're here and send you out the door, good luck, and send them on their way. It's not gonna work that way. They're going to need connection to care afterwards and that's the- the problem that we're seeing is that so many patients, either the craving is too strong to go back to that substance, the withdrawal symptoms are too much, or the patients just too sick and they want to go back to the substance, or the psychosocial stressors: their environment, their neighborhood, their stressors in life.

It could be a number of things where the patient doesn't have enough coping skills to that off they are going to return to use so we need the patient to be connected to some type of a support system some type of ongoing treatment to help with that

I know you mentioned a little bit about the psychosocial stressors but are there any other common underlying issues that are involved in why people turn to drugs or why addiction is so heavy?

Sure so I would say here in the Bronx, the community that we are treating, we see a predominantly high number of people who are on the streets; homeless individuals who are coping with the stressors of living on the streets on a daily basis and that is their coping mechanism. They're faced with a way to escape their reality- their day-to-day life- and they turn to substances to help them cope with that some people are- are using just again that escape reality theme we see throughout things. People turn to drinking and drugs when they're going through family issues, relationship problems, losing a job, a number of things.

Right and I think that's definitely a reality of living in the Bronx like I'm from the Bronx and even last weekend, I like, saw somebody like- using like right next to me because on my on my block there's a lot of abandoned houses so it's like an easy place, um, and I think that that's like a place not for a judgment because we don't know the story behind

why someone is like getting involved in drugs.

Absolutely.

Yeah there's no like specific like narrative, especially in the media. There's a lot of um- representation of what it looks like and like the person that works right next you could be struggling so there's no room for judgment I believe.

And I think that's- that the point that you just made has been made even more clear recently with the opiate epidemic because this- I think historically addiction and issues with substances has been thought to be: it's somebody else's problem, or it's happening over there. And once the opiate crisis hit it kind of took- it didn't care your- your race, your class, your economic status, what neighborhood you are from. We see it across the boards from CEOs of companies down to the homeless guy on the street. It does not discriminate and quite honestly that's with every substance. It just became more socially acceptable I think with the opiates because it turned into the, people -it was more socially acceptable to say: "I got hooked on a medication that my doctor gave me" or, "I got this because of an injury. It wasn't my fault. I got started on this and I didn't intend to go to drugs I just- I ended up that way."

That's interesting. It kind of reminds me of the cocaine epidemic that

happened in the 90s and how it was like so- like race was such a big part of that-

Exactly.

and I think that with the opioid epidemic it's pretty similar-

Exactly.

and like the- it's interesting how like history replays itself in that way.

Yes.

And how its being- um, portrayed but I think we can't talk about like addiction without including mental health.

Exactly.

That is such a big factor and if someone is struggling with mental health issues what can the OPD clinic offer them and what is the OPD clinic?

Okay so we have outside of, we- just talked about the inpatient detox and we also have two outpatient programs. The OPD clinic is our outpatient counseling program. We are located at 4451 3rd Avenue.

It's directly across the street from the main entrance to the hospital- on the second floor of the Hemodialysis Building. Here we offer groups and individual counseling. We primarily targets the non medication assisted treatment track there. It's for patients that might be a little bit further along in their recovery. They are just in need of support groups, may be learning more coping skills to deal with the psychosocial stressors, and they're replacing using drugs with coping skills. And they're learning those coping skills in these groups and sessions with their counselor. We also offer in the OPD classes and groups that satisfy various court mandates. So drug courts, ACS mandates, domestic violence mandates, DWI mandates, and then the topic that you brought, up the mental health side of things. There is really a lot of comorbidity, and comorbidity is just having both the mental health as well as the substance abuse or having one or more diagnoses. A patient is either typically doing one of two things: either self-medicating, maybe they're- they're going through a depression or maybe they are, have addic- bipolar diagnosis or a mental-health diagnosis of some sort. They're not happy with the medication the doctor gave them and they're using substances, street drugs, alcohol, to self-medicate versus take the intended medication. The flip side of that is there's people out there that have been using drugs and alcohol for so long that they've now done damage to their- to their mental health and so now they've caused almost a mental health diagnosis.

And in what are the different treatments and so if somebody that's

saying like if they became so dependent that it caused something versus like if they were coping- is there a different approach to how we do that?

Well here at St. Barnabas, we offer basically just the individual counseling where the counselor will work on that work with the patient one-on-one versus a larger group setting. So I think there's more- we do see a lot more of, here in this program, of patients that come in that are self-medicating, that don't want to take the medication, either maybe they don't have the copay to afford their medication that was prescribed to them for their bipolar disorder or they're from a family that says we don't believe in taking this medication; "you can- maybe there's an herbal remedy" or maybe "we don't- we don't want you to take- we don't want our family to be associated with mental health or taking antipsychotics or any type of- of medication associated with that- that word." So the patient is left with going out and using to then self-medicate and so the group setting would be appropriate for that we have a lot more there's-there's-there's something I guess across the board that we can we can focus in on. There's more than one person going through it we can have groups regarding how to build up coping skills to handle situations like this or provide psycho-education which is basically the counselor giving patients information that they might not have had you know prior whereas an individual session you're just focusing right on that patient's individual needs at the time.

And with these two approaches do we as St. Barnabas go with the total sobriety so approach where it's like you can't be using while you're in treatment or it's like a harm reduction approach?

So we actually have two pathways, we have- I just spoke about the OPD clinic which is 4451. We also have 4535 third Avenue which is our MMTP clinic or our methadone clinic and that clinic is geared towards more of that harm reduction model or maintenance model, where patients are maybe freshly out of detox and they need- they're not quite there yet; their body is still going through the physical dependency on the substance, they're still experiencing things like cravings, they're experiencing things such as what we call "PAWS" our Post Acute Withdrawal Symptoms where they're having that continued stomach upset, that continued racing pulse, sweats, and they need the medication to kind of ward that off. So the MMTP clinic offers methadone, suboxone, and we also offer vivitrol, and those are the three maintenance drugs that we currently use. And you know, it's-it's kind of an assessment issue. Somebody comes in they're not sure "Do I want to go the non-medication route or- or do I need the medication in it?" We have patients also that have been on the medication-assisted side for ten plus years, 20 plus years, where they're just not able to come off the medication. We also have patients that end up getting addicted to their maintenance drugs so methadone is a big problem. Patients have been, you know, thought that

methadone is a wonder drug I got off- it's the "only way I got off heroin," "It's the only way I got off of any of the opiates and it's the only thing that works for me" but then you're on methadone for 20 plus years and can't get off the methadone. So if there's-there's problems with that as well and we're faced with that every day.

So I wanted to switch gears a little bit and talk a little bit about the DOH Project Relay and I just wanted to know like how successful it's been what-what it's- a what does it entail? And if I was a patient that was admitted for a drug overdose what would that process look like if they were to be enrolled?

Sure, so Department of Health started a campaign a few years ago by the name of Project Relay and they partnered with several facilities across the five boroughs in which they would be alerted when somebody came in with a non fatal opiate overdose. So somebody comes in, they are unconscious, they're brought in by EMS, they end up in the ED, it sends an alert to a team of caseworkers who are trained in the field and they present immediately to the facility what it-wherever the facility is. We happen to be one of the facilities they partner with. The case manager will meet with the patient in the ED and attempt to provide psycho education on overdose and harm reduction and provide the patient with the narcan kit which is the inter nasal spray that we have in all of our departments and all throughout the facility that can reverse the effects of an opiate overdose. They

also- the case manager will also stay with the patient post discharge from the emergency room to try to help them get connected to care. So they'll stay with them I believe it's 30 to 60 days after they're discharged and make sure they're connected to a treatment facility, they have what they need, they're going to NARAA and they stay in their lives as a source of support to help them get back on track. If they can't meet with them in the ED the case manager from project relay will come up to the detox unit. Sometimes that does happen. Sometimes somebody is just out of it, they- they're unconscious, they've been revived and brought back to life and they're feeling miserable, they're not willing to meet with somebody in the ED so they wait and maybe a couple of days later up on the unit the project relay case manager can meet with the patient there as well.

Has it been successful? Um- have you had success stories with it?

Yeah we've had a couple of success stories, I don't have much in the way of data yet but I just know personally from working up on the detox unit and then seeing the patients that actually present to one of the aftercare facilities that we have, the OPD or the MMTP, we've seen a number of patients come through and the referral source is that Project Relay. The case manager from Project Relay also have been instrumental in making referrals for us even if it's just a patient that they're not meeting in our ED, they just know them from the community or their work in other places, they'll make referrals to our

program so.

Right that's awesome. Um, so to wrap things up my question would be for any listeners who have family members or friends that are struggling with addiction, what advice would you give to them on how to support their loved one?

Sure, so I think it's the very first thing I would say is something you mentioned earlier which is that no judgement. I think too many people think of drug use and addiction as a choice and it is actually now defined as a disease. So think of it as- when somebody a family member that's come to you and told you they have cancer, would you refuse them the help or disown them because of that cancer diagnosis? Addiction is now defined as a disease of the brain and we have to start treating it as that and take away that stigma.

And if someone would like to learn more about the services that's offered here at St. Barnabas, where can they find it?

Rogers: Sure so we have the SBH website: sbhny.org and you can click on the addiction medicine link. We also have the main phone number for information would be 718-960-6214. Any of the people that answer the phone there can give you information about our three programs. We have walk-in appointments, five days a week that you can present to either of the ambulatory clinics to be seen. And we're

trying to get involved in the community going to more health fairs and seeing people in the community.

Well thank you so much Jennifer for joining us at SBH Bronx Health Talk. Again for more information on services available at St. Barnabas visit www.sbhny.org. Thank you for joining us.

Thank you.