Faculty Panel 2

Adam Lake: Is ASAM advocating for legalization of sterile syringe access and other harm reduction efforts?

Caitlin E Martin: for the exam, what level of information about pharmacologic management of co-occuring psychiatric conditions in pts with SUD will be expected?

Carriedelle Fusco: Can you speak to changes that we may see in 42 cfr, it remains a huge barrier to expanding treatment.

Bella: Does nicotine help schizophrenia?

Sean Leonard: nicotine can decrease blood levels of some antipsychotics, and also provide stimulant effect (similar to caffeine) many schizophrenics self-medicate the sedating adverse reactions of their medication regimen.

- Dr. DeVido: Yes--I agree with the Sean Leonard's comment. Nicotine may provide some perceived relief from some of the negative cognitive symptoms in schizophrenia, but the risks of nicotine use far outweigh those benefits, and the impacts on metabolism of other medications may be deleterious.

Laurence E. Torpey, MD: Timing can be used to see cause and effect as well. Like primary prevention. if I never used THC is my incident rate of Schizophrenia?

- Dr. DeVido: Yes, timing can help strengthen the impression of the association between the exposure and outcome. In the study that I presented, they were looking at psychotic illness as the outcome, which was different than transient, acute psychotic episodes in response to cannabis use.

Teresa Ainsworth: How to safely address and treat co-morbid benzodiazepine abuse/addiction in the setting of outpatient MAT buprenorphine clinic that is not dedicated to benzodiazepine misuse treatment? (client refuses detox, if has Rx doesn't want to taper, doesn't want to change over to Klonopin, etc)

- Dr. DeVido: This is a very common tricky situation. Often, what I'll do is start by trying to form as solid of a relationship as possible, starting with focusing on one substance at a time--in this case, start by really focusing on the opioid use disorder first, and indicate that we'll revisit the BZs later. When coming back to the BZs, I often will try to explore what their concerns are about discontinuing the BZs--for example, often folks are concerned about rapid detox, and I talk with them about a doing a long, careful taper as a response to that concern.

Caitlin E Martin: After administering naloxone for an opioid OD, what are recommendations on 'when' to start buprenorphine for continued OD protection and of course OUD tx? Immediately? If yes, at a certain dose?

Doug Coslett: What about the ethical commitment to the patient for his/her confidentiality?

Kirit: dr.landess,what if the proffesional is not incompetent or has any patient care related problems?do we still report to the state board?

Jamie Redwing: I would suggest that referring a possilby impaired MD would best be to the state's physician health program

- Adam Lake: PHPs have a long record of recommending intensive treatments for everyone
- Leslie Milton Dally: Still better to self report than be referred directly to the board. Either way unfortunately overly intense treatment will be mandated, but at least there is disciplinary action.
- Leslie Milton Dally: ***at least there is NO disciplinary action usually in the case of self reporting to PHP's.
- Jamie Redwing: TRUE. However the abstinence rates are ddramatically improved. Abstinience rates for "general AA" e.g. is up to 6 to 7 % at 1 yr. But PHPs RX-ing LT treatement have up to a roughtly upper 80's to low 90% at 5 years. This data comes from a published article in the late 90's - wish I could remember the name.....
- Abbie: J Wesley Boyd with Harvard has some excellent articles about pros and cons of PHPs. There are some major issues
- Jamie Redwing: thanx, Abbie
- Abbie: IMO Abstinence rates with PHPs are great not so much because of the programs themselves but because it becomes an issue of losing your medical license if you don't comply
- Abbie: Caution is Warranted when Engaging with a State Physician Health Program: Comment on "A Retrospective Cross-Sectional Review of Resident Care-Seeking at a Physician Health Program". One of many articles by Dr. Wesley Boyd
- Dr. DeVido: PHPs vary significantly from state to state, as do boards' approaches to impaired physicians. It can be helpful to familiarize oneself with the PHP (if one exists) in one's state and what their approaches and obligations might be. As an aside, data from PHPs do also show significant positive outcomes in terms of abstinence
- Jamie Redwing: great discussion re: impaired PHP prgms - thnx, all

Abbie: Following up on the question about Suboxone being prescribed to physicians----does anyone know about specific medical board policies by state? I know that for quite a while TX was NOT allowing doctors to take Suboxone, but that became a big issue and they have backtracked.

Teresa Ainsworth: just a comment - prior ER career before Addiction - Naloxone'd clients are Not happy and do not want to stay no matter how severe their obtundation therefore the leave AMA in a huff

Adam Lake: Anyone starting buprenorphine at this time, might be good timing, but a hard time to have a thorough talk about it.

Leslie Milton Dally: At the same time CDC guidelines are being used for opioid prescribing