ALCOHOLISM & DRUG ABUSE WEEKLY
News for policy and program decision-makers

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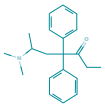

OPIOID TREATMENT PROGRAMS

Central registry concerns growing among OTP providers and patients

The "central registry" is a state-run system in every state with opioid treatment programs (OTPs) and is designed with one purpose: to keep patients from enrolling in more than one program. The model central registry is New York's, set up decades ago by John Phillips, long retired from the state but an active member and co-president of Stop Stigma Now. Legally, a central registry preserves the confidentiality of patient information, and collects no information other than what is needed to prevent multiple enrollments. It collects nothing about dose, pregnancy status, and so on.

But there are clear signs that this data is valuable, and one company in particular is trying to scoop it up, which violates patient confidentiality, not only under 42 CFR Part 2 but under basic HIPAA protected health information [PHI] regulations.

However, there are 15 states that have not taken it upon themselves to set up their own registries, but have instead availed themselves

See **Central registry** page 2

Bottom Line...
States must rely on their central registry to prevent methadone patients from enrolling in more than one clinic, but sometimes the requests for information are not lawful, according to OTPs and their lawyers.

Broad group of substance use patients susceptible to developing schizophrenia

New research suggests that a large number of individuals who present at hospital emergency departments for substance use are at significant risk of developing schizophrenia or schizoaffective disorder. The study found a higher-than-expected magnitude of risk for patients who did not exhibit symptoms of psychosis during their emergency visit.

"Prior research supported that individuals with substance-induced psychosis would be at a very elevated risk of transitioning to a schizophrenia spectrum disorder," Daniel T. Myran, M.D., M.P.H., lead author of the study and assistant professor in the Department of Family Medicine at the University of Ottawa, told *ADAW*. "We suspected that individuals with substance use without psychosis (e.g., intoxication) would also be at elevated risk but were surprised about the magnitude (e.g., almost 10-fold higher than the general population)."

The overall findings suggest that both substance use prevention activity in the community and clinical

See **Schizophrenia** page 7

Bottom Line...
A new study adds to the research base in its finding that individuals with substance use-related emergency department visits without signs of psychosis are still at significant risk of developing a schizophrenia spectrum disorder.

Central registry from page 1

of a company called Lighthouse Software Solutions. Raleigh, North Carolina. According to several OTPs, Lighthouse requests information above and beyond what is required, and what is legal under the regulations of the federal Substance Abuse and Mental Health Services Administration (SAMHSA), which regulates OTPs.

One OTP owner and operator, Zachary Talbott, president of Talbott Legacy Centers, which operates OTPs in Georgia and Tennessee, which uses Lighthouse, sent this email to his staff last month:

> "We will be entering no more assessment or other data into Lighthouse, as company counsel after TA [technical assistance] from the SAMHSA-funded Center of Excellence for Protected Health Information (CoE PHI) provided by attorneys from the Legal Action Center [advised] that such entries beyond those things necessary to prevent multiple enrollments in one OTP is unlawful."
>
> "Please still make sure your caseloads are correct in Lighthouse, but that's it beyond the things we do on the day of intake."

Stop Stigma Now has been agitating for months about central registry problems. President Sy Demsky, former director of the Mount Sinai OTPs in New York City, wrote to SAMHSA last spring calling for it to add confidentiality concerns to its proposal to spend $1 million a year on the CoE PHI (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.33714). In that letter, Demsky wrote:

> "Because these NOFO [notice of funding opportunity for the CoE] requirements are general, there is no mention of the confidentiality implications of central registries. SAMHSA is well aware that [42 CFR Part 2] permits practitioners who are not OTPs to access medical information from central registries without restrictions on what they can do with the information. The concern is that the needs of hundreds of thousands of OTP patients and their families for specific information about central registries and the implications of Part 2 rules on their protected health information may be ignored."

Consulting with that CoE is a good idea for any OTP required to submit information to Lighthouse or any other central registry. As Demsky's letter went on to note: "The NOFO specifically requires the successful grantee to 'Work collaboratively with SAMHSA and the [Department of Health and Human Services] HHS Office for Civil Rights and other federal and non-federal partners to determine the correct interpretations of privacy statutes and regulations and their application.' Thus, the opportunity to protect those who require the assistance of opioid treatment programs can be salvaged."

The Legal Action Center, based in New York, has for decades been the lead organization on confidentiality, 42 CFR Part 2, and substance use disorder (SUD) treatment. So its involvement in helping programs like Talbott's navigate the requests of private sector registries is key to making sure methadone patients don't lose confidentiality; the risk of disclosure of their treatment records is significant, and includes job and custody loss, as well as health care discrimination.

The State Opioid Treatment Authority (SOTA) plays an important role in regulating OTPs in the state and should be involved in making sure that OTPs operate legally. OTPs, for their part, understandably do not want to break any laws, despite the data requests from Lighthouse.

Depite participating in the central registry to prevent multiple enrollments, however, OTPs may put their own compliance with state regulators' interpretations of their state regulations at risk; in fact, failing to enter confidential assessment, legal, pregnancy, and other data into Lighthouse required by the State Opioid Treatment Authority resulted in noncompliance notices

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from Tennessee to Talbott, a copy of which was obtained by *ADAW*.

Lighthouse

On the Lighthouse website, the main page, in large letters, states: "The Central Registry, there is no other alternative" and goes on with the bullets: "Immediate dual enrollment verification; Upload projected emergency medication information to our system; Emergency notifications to clinics, patients and SOTA; Patient portal with real time information about clinic closure status."

The website also states: "Our system takes away the need to assemble data for mandated reporting by the clinics as required by the state SOTA." And it adds: "Ensuring protection for your patients and compliance with federal and state laws."

We asked Lighthouse to respond to questions about the New York registry and other issues. In fact, Lighthouse was brought in by New York's OASAS after hurricane Sandy and now dosage information is required as well. But nothing else.

Below are comments from Lighthouse president Mark Engler; we will talk to him more in the future. We are reprinting them here wholecloth.

"Nearly 8 years ago Lighthouse responded to an RFQ posted by the State of New York regarding a bid for operation of an electronic central Registry. We were awarded the contract per the bid terms. That bid and response is public. Prior to the Lighthouse Central Registry dual enrollment verifications were done via means that lacked confidentiality, such as fax, phone calls, and meetings between clinic staff sharing photos of recent patient admissions.

"Our company was founded on the premise of improving patient confidentiality and safety. Our vision is to ensure patients are provided a continuum of care during stressful events so that they are treated with dignity. The choices patients make in an emergency can have dire consequences including relapse, overdose and death. One of the core functions of The Central Registry is to ensure patients have the ability to receive information during emergencies with instructions about where to go or what to do when their home clinic is forced to close.

"Our vision is to ensure patients are provided a continuum of care during stressful events so that they are treated with dignity. The choices patients make in an emergency can have dire consequences including relapse, overdose and death."

Mark Engler

"Using the New York Lighthouse Central Registry as an example we provide a HIPAA compliant means of determining if a patient is enrolled at multiple sites, and we operate pursuant to State and Federal rules. Our system is based on the patient's consent, both to receive emergency notifications or to receive emergency medication and to perform a dual enrollment search. Those that do not consent are never contacted by the Central Registry during a disaster. Further if a patient seeks treatment at an open clinic during a disaster, the patient must consent before a search can be made in the Central Registry for their dosing records. Thus, patient consent drives access to information in the Central Registry. Further all PHI in the Central Registry is maintained in a secured encrypted database.

"Answering your questions below as to the information requested (which most interestingly don't involve PHI):

1. Site information: The name, address and phone numbers of a site are important and necessary for dual enrollment verification. Further we can direct displaced patients to open treatment centers, and we are responsible for making sure the site information is accurate.
2. Program Director: The program director controls access at their clinic site to the Central Registry. They approve staff access, and it is important that the position be accurately maintained in the Central Registry.
3. Staff: We ask the program director to review current staff with access to the Central Registry so that any employee who has left can be removed.
4. Counselors (if applicable): There is no requirement in NY to list counselors.
5. Active Patient Census: Each site is required by our contract with NY to accurately reflect their census. This is extremely important, as a valid dual enrollment search relies on all patients being in the NY Central Registry.
6. Patients missing projected emergency medication: Our emergency medication capability relies on entry of dosing information by a clinic. For example, in New York western regions last year thousands of patients faced emergency clinic closures. Without accurate dosing information, patients seeking alternative sites to obtain medication face delays until a doctor's order can be secured. Identifying patients missing medication information is part of our contract.
7. Patients who have consented to be contacted in an emergency: As stated above when a clinic is forced to close, we have the ability to contact all consenting

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patients in seconds. A patient must consent to receive a text or email from the clinic via the Central Registry. We do not contact any patient during an emergency that does not consent. The reason we ask a clinic this question is that they are required by Federal rule to have the ability to contact all patients that may be displaced. Thus, we force a clinic to be aware of which patients need to be accounted for outside of those that consent to receive messaging, should the clinic close.

"As I have stated above, we do not ask for PHI except for that needed to fulfill our obligations under our contract. All PHI is encrypted. Interestingly the points raised below do not contain PHI, thus i remain confused as to your reference that we are seeking information about patient's PHI when the data below concerns clinic information that is required by state rule."

Indeed, Lighthouse does operate New York's central registry. We will be following up on this story in future issues.

Disclosure and redisclosure

Demsky and Stop Stigma Now have criticized SAMHSA's Dec. 2, 2022 Notice of Proposed Rulemaking (NPRM) for not adequately assessing confidentiality (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.33628). Specifically, the 71 pages of the NPRM tried to harmonize 42 CFR Part 2 with HIPAA, as required by the CARES Act. In the preamble, the proposal was made to replace the phrase "redisclose or use" with "use or redisclose" as relating to preventing a registry from using or redisclosing Part 2 records. This aligns HIPAA and 42 CFR Part 2 language.

But the NPRM also permits disclosure by a central registry to a non-member treating provider, with "no discussion in the NPRM of the duties and obligation of either the member program, the central registry, or the treating provider to the privacy or confidentiality of an identified patient who is enrolled in a member program," Demsky told *ADAW*. "Nor does the NPRM address the need for data standards to prevent central registries and their agents from gathering information beyond that [which is] necessary to prevent multiple enrollments in a program."

"The effort is being supported by entities that seem more interested in the business opportunities created by a volume approach to drug treatment."

Rob Kent

The NPRM did not restrict the central registry issues to multiple enrollment, but rather, added that it is about "duplicative prescriptions or to inform prescriber decision-making regarding prescribing of opioid medications or other prescribed substances," noted Demsky. "In short, this is about clinical care," he said, adding "there is no provision regarding non-disclosure governing the behavior of the treating prescriber" ("the non-member appears to be free to do whatever they want with the information garnered from the 'member' program," said Demsky).

"Members" are federally regulated OTPs.

Implications for office-based methadone

Concerns that a non-member treating prescriber could get information about a methadone patient without that patient's consent from the central registry loom large at a time when the push for office-based methadone is growing. Even the National Institute on Drug Abuse (NIDA) is conducting a randomized controlled trial comparing office-based methadone with office-based buprenorphine. The goal of eradicating OTPs is sometimes within sight of the advocates of such a move.

"Given that there is a lack of direction about redisclosure by the treating physician who receives information from the central registry, and the reality that most central registries do not have the capacity to communicate with the plethora of practitioners in a given jurisdiction who could be classified as a treating prescriber, I believe that the NPRM fails in this regard," said Demsky, who urged that it be entirely withdrawn.

National registry for bupe

The idea of a national registry would not be welcome by states such as New York, where the standards of confidentiality and accuracy — and allegiance to the law — are long engraved.

There is, however, talk of a national registry for buprenorphine. The concern is not so much multiple enrollment (that is SAMHSA's concern) as it is diversion (that is the DEA's concern). Here's what Rob Kent, formerly general counsel of New York's Office of Addiction Services and the Office of National Drug Control Policy, told us last month:

"There is an ongoing effort in Washington, D.C. led by the Drug Enforcement Administration [DEA] to limit medical professionals' ability to treat opioid use disorder with the lifesaving medicine, buprenorphine. So that everyone is clear, the law (known as the X-waiver) which limited medical professionals' ability to prescribe buprenorphine to individuals to treat their opioid use disorder was repealed by an act of Congress in December 2022. The new effort is an attempt to recreate the X-waiver in the form of a

'special registry.' The effort is being supported by entities that seem more interested in the business opportunities created by a volume approach to drug treatment. It is also part of a broader effort to demonize fentanyl as a pretext to punishing those who use it," said Kent.

"Historically, the default approach in drug policy is to create new criminal penalties under the false premise that this will reduce the drug supply. Be clear, these laws do not reduce the supply of drugs and rarely capture the traffickers. They usually ensnare and punish individuals who are selling small amounts to support their own drug use," he added.

"The federal government should stop taking the usual approach and simply continue the emergency rules which were used during the National COVID-19 Public Health Emergency and allow telephonic initiation on buprenorphine. This can be done under the national opioid public health emergency which is still in effect."

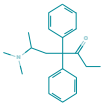
Kent noted that more than 110,000 people each year are dying from overdoses in the United States. "That is pretty convincing evidence that we are still in an emergency."

If a special registry is needed to guard against the risk of diversion, the DEA should answer these questions, said Kent:

- How much buprenorphine is being diverted?
- How much is diverted from prescriptions for pain and how much for the treatment of opioid use disorder?

The answers to these questions will tell us if we have a real problem or if the "special registry" is a solution in search of a problem, said Kent.

"Clearly, lack of government oversight cannot be a concern, as every prescriber of buprenorphine is already subject to DEA oversight by virtue of needing a DEA registration to prescribe any controlled substance. Further, every prescriber is subject to state oversight as they must hold a professional state license to prescribe medications and they have additional obligations with their state prescription drug monitoring programs," Kent said. •



OPIOID TREATMENT PROGRAMS

"Liberating methadone" confab at NYU: Part 1

Last month, a meeting entitled "Liberating Methadone: Building a Roadmap and Community for Change," was held at New York University (NYU) in New York City. The aim of the two-day meeting was to "make sure that methadone is available to everyone who needs it," and "to fight the power and the bureaucracy that is keeping people from having access," according to Noa Krawszyk, Ph.D., assistant professor at the NYU Department of Population Health and an organizer of the meeting.

This was a two-day meeting; *ADAW* was not able to attend, but the organizers who were at NYU shared information for what was essentially a 17-hour Zoom call.

The first session began with Ayana Jordan, Ph.D., associate professor of psychiatry in the NYU Department of Population Health, who stressed that the meeting would be focused on "solutions and access-oriented strategy about how we truly liberate methadone."

The NYU Department of Population Health hosted the conference, which did not involve any of the organizations representing opioid treatment programs (OTPs), the only providers allowed to treat opioid use disorder with methadone, or methadone patients. In general, the tenor of the conference was that OTPs do more harm than good. "We need to build a better system of care," said Jordan.

The American Association for the Treatment of Opioid Dependence, The National Alliance for Medication Assisted Recovery, and the Coalition of Medication-Assisted Treatment Providers and Advocates of New York were not invited to participate in the conference, *ADAW* was told by those organizations.

Indeed, the message of "liberate methadone" was a sentiment expressed to free it of opioid treatment programs, to allow office-based prescribing, and more.

The joint event was co-sponsored by NYU Langone Health, the Urban Survivors Union, and the National Coalition to Liberate Methadone. Other funders were:

- The National Institute on Drug Abuse;
- Pew Charitable Trust; and
- Vital Strategies.

"Unfortunately, it's a rare thing to see and hear people whose lives have been affected by the drug war and our treatment system," said Jordan. "Pew will be writing a report. And we will be publishing all the abstracts. Addiction Science Clinical Practice has agreed to publish the posers in open access," Jordan added.

An unusual meeting at an academic medical center, with openly avowed drug users, the well-organized conference included a lunch table where attendees were assigned to eat at certain tables so they could mingle with others of possibly varying viewpoints.

"We know that methadone is a very controversial and complicated topic, and truly should be a very intense conversation," said Jordan. "There are a lot of emotions and important perspectives we want to take into account, but the purpose of the conference is to get people together from different perspectives on how to increase access to methadone."

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Aaron Ferguson, on the "leadership team" of the Urban Survivors Union, which also helped organize the conference, said from the podium "I'm a person who owes my life to diverted methadone."

And he warned: "If you're not ready, you better start getting ready."

Sounding a keynote for the meeting, Ferguson said, "People who use and have used drugs think we have the same right to health care as everyone else." He added that the "stories of people who are non-compliant" are central to methadone reform.

Louise Vincent

At this point, Louse Vincent of the Urban Survivors Union discussed a podcast in which she recorded her telephone conversation with a clinic that refused to accept her back into treatment due to attendance lapses and drug test failures. Vincent explained that her daughter had died, she had an amputation, and was traveling for work during this time. But the clinic response said that she "would not be accepted back because of [your] history."

The audience of about 300 people was very supportive of Vincent. "So apparently, I had a lot of years where there was a positive drug screen somewhere." [laughter].

Vincent concluded by saying, "I do believe that community and love are the solutions to our problems."

Ferguson, who has been a patient on methadone and has worked in an opioid treatment program, does outreach "trying to get methadone into jails," he said. "I see people come in the door, afraid of overdosing, afraid of losing their family and their job, they walk into a treatment center, and it is so painful to see what is supposed to be the solution be the problem," he said. •

Next week: More coverage of the "Liberate Methadone" meeting at NYU.

More about the Liberate Methadone conference

From the NYU Langone website: "Funding for this conference was made possible by the Pew Charitable Trusts and Vital Strategies with support from Bloomberg Philanthropies, an R13 DA058520 from the National Institute on Drug Abuse (NIDA), and the NYU-H+H Clinical and Translational Science Institute (CTSI), which is supported by the National Center for Advancing Translational Sciences (NCATS), National Institutes of Health, through Grant Award Number UL1TR001445. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies or views of the funders or the Department of Health and Human Services; nor does mention by trade names, commercial practices, or organizations imply endorsement by the U.S. Government."

More substance use events at NYU Langone

This fall NYU Langone will be sponsoring four public, free Zoom seminars on substance use. Registration is required. For more information, see below.

HIV

Predict, Detect, Diagnose: Confronting Outbreaks of HIV and Other Infectious Diseases Among People Who Use Drugs

Tuesday, October 17, 2023, 4 – 5pm

Register here: https://nyulangone.zoom.us/webinar/register/WN__aSvwnaQSx-MMMoozJX0RA

Contact: Caroline Barnes | caroline.barnes@nyulangone.org

Speaker: Gregg Gonsalves, Ph.D., Associate Professor of Epidemiology, Yale School of Public Health Yale School of Public Health, Co-Director, Global Health Justice Partnership

From Canada

COEP Seminar: Jaime Arredondo Sanchez Lira, PhD

Thursday, November 30, 2023, 1 – 2pm

Register here: https://nyulangone.zoom.us/webinar/register/WN__FXH1eSgTb2_mWEcke980A

Contact: Caroline Barnes | caroline.barnes@nyulangone.org

Speaker: Jaime Arredondo Sanchez Lira, Ph.D., Canada Research Chair on Substance Use, Canadian Institute for Substance Use Research; Assistant Professor, School of Public Health and Social Policy, University of Victoria, B.C., Canada

Oswaldo Cruz Foundation

COEP Seminar: Francisco Inacio P. M. Bastos, MD, PhD

Monday, December 11, 2023, 12 – 1pm

Register here: nyulangone.zoom.us…

Speaker: Francisco Inacio P. M. Bastos, M.D., Ph.D., Senior Researcher, Oswaldo Cruz Foundation

Krawczyk

DPH Substance Use Research Group

Wednesday, December 13, 2023, 1 – 2pm

Zoom Meeting ID: 976 4911 5677

Zoom Passcode: 2022

nyulangone.zoom.us…

Seminar Host(s): Noa Krawczyk

National Coalition to Liberate Methadone: Part 8 Rulemaking

Below are some of the comments from the National Coalition to Liberate Methadone to the Substance Abuse and Mental Health Services Administration (SAMHSA) proposed rule on Part 8 (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.33643 for more).

"The National Coalition to Liberate Methadone (NCLM) appreciates the opportunity to submit comments in response to the Substance Abuse and Mental Health Services Administration's proposed rule changes to 42 CFR Part 8 Medications for the Treatment of Opioid Use Disorder. Founded in 2022, the NCLM is a national organization made up of over a hundred people, including patients with lived or living experience on methadone, patient advocates, addiction medicine clinicians, and substance use researchers across several U.S. states. NCLM members are active participants, providers, evaluators and clinical leaders of OTP clinics across the country, giving them deep expertise and commitment to improving the health of people on methadone. NCLM supports efforts to expand methadone treatment access for all individuals with opioid use disorder, as methadone has several decades of evidence supporting its efficacy in reducing morbidity and mortality, and improving quality of life and treatment retention.

Summary of Comments

"We are pleased to see SAMHSA take steps to improve quality and access to methadone treatment and are in support of the proposed rule changes as we have summarized below, with several detailed suggestions for your consideration.

"First, we believe these proposed changes are a significant step forward in making OUD treatment more effective and less burdensome. (1) Primarily, we believe increased take-home flexibilities (42CFR § 8.12) will benefit patients on methadone by improving quality of care, increasing treatment retention, and as a result save lives. In addition, we are pleased with the proposals to improve; (2) Split Dosing (42CFR § 8.2 and 8.12); (3) Telehealth and Counseling (42CFR § 8.12); and (4) Intake Screening and Full Examination Physical Requirements (42CFR § 8.12). We believe these changes will lead to improved outcomes among patients, and we make several suggestions to add clarifying and supporting language.

"We also feel strongly the need to suggest additional changes to be incorporated into the rule. This includes (1) Expand definitions of facilities allowed to dispense methadone for treatment initiation (42CFR § 8.2 and 8.11); (2) Remove the stipulation requiring exception requests for patients entering treatment more than twice in a 12-month period (42CFR § 8.12); (3) Add changes to OTP certification processes to ease the burden of opening and sustaining OTPs (42CFR § 8.11 and 8.12); (4) Eliminate the rule limiting initial methadone dosages to 30mg (42CFR § 8.12); (5) Create a mechanism by which to keep individual OTP clinics accountable for allowing access to more take-home doses; and (6) Allow methadone to be prescribed from office-based settings and dispensed from community pharmacies (42CFR § 8.12).

Take home doses

"We applaud SAMHSA's decision to eliminate the 8-point eligibility criteria for take homes in favor of deferring the take home decision to the clinical judgment of the admitting provider to individualize patient care, including explicitly: (1) Removing duration of treatment thresholds for number of take-home doses; (2) Eliminating the prerequisite for engagement in substance use counseling for continuing in care and/or receiving take-homes; (3) Eliminating the need for abstinence or negative urine toxicology results as criteria for take home doses.

…

"In summary, we commend SAMHSA for emphasizing patient-clinician shared decision making in take home dose decisions. We further recognize that next steps will be holding individual states and OTPs accountable for implementing these updated take-home recommendations, as research has found not all patients felt the full benefits of expanded take-homes during COVID-19." •

Schizophrenia from page 1

interventions for patients who have experienced a substance use-related emergency visit could be helpful in decreasing the incidence of schizophrenia and related disorders.

The study, "Transition to schizophrenia spectrum disorder following emergency department visits due to substance use with and without psychosis," was published online Sept. 27 in *JAMA Psychiatry*. It was supported by the University of Ottawa site of the entity formerly known as the Institute for Clinical Evaluative Sciences, funded by health ministries in Ontario.

Cohort study in Ontario

The retrospective cohort study spanned the period between January 2008 and March 2022, and included results for all residents aged 14 to 65 in Ontario. The investigators excluded from the analysis any individual who had a hospital, emergency department or outpatient treatment visit for psychosis in the past two years.

The investigators identified all individuals with a substance use-related emergency department visit, either with or without psychosis, and examined results separately

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for the various substances involved (cannabis, cocaine, amphetamines, alcohol, polysubstance use and "other"). They used a model of analysis that adjusted for age and sex, and another model that adjusted for other clinically relevant variables such as area income, rural residence, substance used at emergency visit, and past mental health treatment. The researchers did not have access to individual data on race and ethnicity.

More than 407,000 individuals in the cohort (4.1% of the total cohort) had an emergency department visit for substance use and 3.4% of those visits involved a substance-induced psychosis. The investigators found that within three years of the emergency visit, 18.5% of those who had substance-induced psychosis and 1.4% of those who did not exhibit psychotic symptoms transitioned to a schizophrenia spectrum disorder. Compared with the general population, those with an emergency visit with psychosis had a 163-fold greater risk of schizophrenia, while those with a visit without psychosis had a 10-fold greater risk. Adjustment for multiple variables attenuated the risk somewhat, but the risk was still found to be elevated after adjustment, the researchers reported.

They found that for individuals who had substance-induced psychosis, cannabis was the drug associated with the highest risk of transition to a schizophrenia spectrum disorder. The highest-risk substances for individuals who had an emergency visit without psychosis were amphetamines, polysubstance use and cannabis, in that order.

For all emergency department visits related to substance use, a higher risk of schizophrenia was seen with males and younger individuals. The risk for males relative to females was particularly high in the 14-to-18 age group.

"Adding to the literature, we found that substance use without psychosis presentations were also at elevated risk of transition, and given their higher prevalence, they were associated with three times the absolute number of transitions," Myran and colleagues wrote in their study paper. "Consequently, primary prevention efforts aimed at reducing substance use and substance use disorders could substantially reduce the population-level burden of chronic psychoses."

Myran termed the group that had experienced an emergency visit without psychosis as "lower-risk, but far more common."

He and colleagues did cite several limitations to their analysis. They did not have access to detailed data on patterns of substance use, and they pointed out that the study design did not allow them to draw the conclusion of a causal link to schizophrenia. "Further research examining the risk of transition following different types of encounters for substance use is indicated," they wrote in conclusion.

Addressing two populations

In his comments to *ADAW*, Myran offered a perspective on how clinical programming should address the two types of emergency department presentations that were examined in the cohort study.

"I believe the findings highlight that individuals with substance-induced psychosis could benefit from brief interventions in the emergency department, including education and referrals aimed at reducing future substance use," said Myran, who is also a lecturer at the University of Ottawa's School of Epidemiology and Public Health. "Referrals could include first-episode psychosis programs and addiction medicine services."

He added, "A challenge is what to do with the far more common presentations for substance use without psychosis. Again, the findings suggest that intervention and counseling in the [emergency department] could be appropriate and that some selected individuals with higher-risk features might benefit from referral.

"Importantly, the findings highlight the opportunity for preventive measures aimed at reducing substance use in the population level to decrease the development of schizophrenia spectrum disorders," Myran said. •

Coming up...

AMERSA's annual conference will be held **November 2-4** in Washington, DC. For more information, go to **https://amersa.org/2023-conference/**

The **American Academy of Addiction Psychiatry annual symposium** will be held **December 7-10** in San Diego. For more information, go to **https://www.aaap.org/training-events/annual-meeting/2023-annual-meeting/**

The **2024 AATOD conference** will be held **May 18-22** in Las Vegas. For more information, go to **https://aatod.eventscribe.net/**

In case you haven't heard...

Alcohol is an increasing worry among treatment professionals, and for good reason. The most recent data has shown that driving under the influence (DUI) incidents are on the rise as well. The prevention and treatment implications are well known. Many in the field know that like opioids, which may kill faster via overdoses, alcohol is also lethal. It just takes longer for people to die. And studies have shown that in the over-50 age range, people are dying faster from alcohol use than ever (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.32555).

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