Lisa Dixon (00:07):

Welcome to our podcast, Psychiatric Services From Pages to Practice. In this podcast, we highlight new research or columns published this month in the Journal of Psychiatric Services. I'm Lisa Dixon, Editor of Psychiatric Services, and I'm here with our podcast editor and my co-host, Josh Berezin. Hi, Josh.

Josh Berezin (00:26):

Hi, Lisa.

Lisa Dixon (00:26):

Today we are going to be able to talk to Dr. Joe Parks, who's the medical director of the National Council on a hugely important topic, fentanyl.

Josh Berezin (00:37):

We're honored to have Dr. Joseph Parks, who is the medical director at the National Council for Mental Wellbeing, here to talk about his and co-authors paper, Guidance for Handling the Increasing Prevalence of Drugs Adulterated or Laced With Fentanyl. So Dr. Parks, thank you so much for joining us today.

Dr. Joseph Parks (00:53):

Thank you Josh. Really appreciate the opportunity to talk about this topic. We teed it up when the DEA put out an alert that people should know about this and be worried, but the DEA didn't say what they should do other than be alert and be worried. So we thought some guidance was needed on exactly what one could do in such a situation.

Lisa Dixon (01:11):

Spoken only as a psychiatrist, right?

Dr. Joseph Parks (01:14):

There you go, yeah.

Josh Berezin (01:16):

So just taking a step back. For anybody who doesn't know, what is the National Council?

Dr. Joseph Parks (01:21):

So the National Council for Mental Wellbeing represents organizations that provide treatment for mental illness and substance use disorder nationally, about 3,300 organizations. We're really the entity that is the national voice for organizations treating people with serious mental illness and serious substance use disorders.

Josh Berezin (01:40):

And you already mentioned some of the reasons why you decided to issue the guidelines, but just out of curiosity, is it common for the National Council to issue guidelines? Is that something that's in your general wheelhouse?

Dr. Joseph Parks (01:52):

We do. We have actually a series of guidance that we make available. Our major way of generating this is the Medical Directors Institute. This is a group of about three dozen physicians, mostly psychiatrists who are medical directors at member organization. So these are people that both have administrative responsibilities and are still directly clinically practicing. So we use them to bridge that gap between policy and practice and to explain clinical issues and administrative terms to administrators and administrative issues and clinical terms to clinicians. If you go on our website and look up Medical Directors Institute, National Council Mental Wellbeing, you'll find additional papers on medication adherence, on the Wit decision, which relates to some aspects of parity, on mass violence. That one gets a lot of traffic because unfortunately it's still a big problem and several other topics.

Lisa Dixon (02:45):

In my experience, the National Council and the medical directors group is just sitting right in this incredibly relevant, informed, realistic space and addressing the issues of our time.

Dr. Joseph Parks (02:59):

Thank you. That's really what we're trying to do. We're trying to come up with a way to explain complicated topics and to follow up with a few specific concrete doable recommendations, things that are not high in the sky philosophy, but things that people can do right now if they're in mental health treatment organizations or in states policy positions, dealing with those topics.

Josh Berezin (03:22):

And fentanyl, I think, is another one of those very sadly big ticket items that it's in the news and it's affecting providers, it's affecting families, kind of-

Lisa Dixon (03:33):

Killing people, right?

Josh Berezin (03:37):

Killing people on a daily basis. And so this is not just topical, but really, really necessary. So what are some of the guidelines that you all are proposing here?

Dr. Joseph Parks (03:50):

Well, the first really is to just be aware this is out there and occurring a lot. It's really become almost a marketing approach to other street drugs. It gets added to counterfeit pills, Oxycontin pills. It gets added to counterfeit methamphetamine pills. It gets put on various smokable items and it's very addictive and it makes it more likely the person will buy more. So it's like cheese on your burger. It gets put on all the burgers, whether you know it's there or not. So I think that's the first finding.

(04:23):

And interestingly now even if you think you're getting fentanyl, 23% of the time you're getting xylazine or tranq with it. So I think the take home message here is when you think you're buying something, you can't be sure. You should understand that you're buying a mystery pill or a mystery substance. So I think we've gone with four broad pillars of approach to this and they're generic in a way. One is to use an in incremental approach to behavior change, basically harm reduction. A lot of people are worried, but they're not ready to change yet. We need to think in terms of motivational interviewing. We're at the point where they're contemplative and we need to work with them from there.

Lisa Dixon (05:02):

So can I just ask a question about that, Joe? They're contemplative, what are they contemplating?

Dr. Joseph Parks (05:05):

They are worried about the safety of the drugs they're taking. Even if they don't want to change yet, they don't know when they get a new dose, what it is or what it isn't. Almost everybody using out there knows somebody that's overdosed and many of them have overdosed. And once you've overdosed once, you're certainly going to have it on your mind again, even if you're still using. I assume people are more contemplative than in complete denial just because of the reality on the streets out there.

Lisa Dixon (05:33):

Is it fair to say that people are contemplating the possibility that they could be risking taking fentanyl as opposed to contemplating the possibility of stopping using drugs altogether? Is there a difference there?

Dr. Joseph Parks (05:51):

I think there is a difference, but the ladder is a stepping stone on the way to the former. Remember in motivational interviewing, we find the discrepancy we can and then we build on that discrepancy as opposed to rush them in a way that we break the engagement, which is really the second pillar. It's really about keeping the person engaged. Certainly we would love to see them abstinent, but really for me, my main point of any interaction is to have a second interaction. And part of that is keeping them alive. And part of that is interacting with a way that in a way that they are willing to talk to me again and that I haven't leaned on them so hard that they're going to blow me off and I'm not going to get that second attempt to help them.

(06:35):

And I think our third pillar is really the importance of integrated care. There's not enough psychiatrists around. We are way out on waiting lists. People can't get to us. So the bulk of this is going to happen with emergency rooms, with primary care doctors, with paramedics, and the social response can't involve just substance use disorder specialists. It has to be much broader than that. And the final one is just ways we can be vigilant. Fentanyl test strips are a huge opportunity, but there's some recommendations we could also go to in terms with drug testing in general and approaches to that.

Josh Berezin (07:13):

Just before we get into some of those specifics for fentanyl, as you mentioned, the first three pillars of the guidelines that you're talking about are really universal best practices, harm reduction, engagement, integrated care. Is that something that you were purposefully doing, sort of like a go back to basics approach here? It's this huge problem and when I read it I was like, "Oh, it's the same basic idea for this that it is for everything else. We just have to remember to do it and be mindful that the consequences are even more dire than what we're used to dealing with."

Dr. Joseph Parks (07:48):

We went that way because of basics are always important. If you don't get the basic rights, you can't do the fancy stuff at all. Second, it's the uncertainty involved. The point of the paper is you don't know where you're going to run into fentanyl, but even if you think you're buying fentanyl, you don't know if all you're buying is fentanyl, you could adding xylene with it. And these are not drug specific approaches with the exception of the things we can do to be vigilant about fentanyl in particular, which is mostly

around naloxone, broad opiates, but not fentanyl alone. And then fentanyl test strips. So much of the problem is based in uncertainty that we thought it was important. And second, if you don't get the basics, you don't do the fancy stuff correctly either.

Josh Berezin (08:37):

And just talking about the fentanyl test strips, I was surprised and also a little bit disheartened that they're to learn that they're considered drug paraphernalia in some states, and it reminded me that not everywhere has this harm reduction approach baked in. So I'm just wondering if you've heard or seen or think that the ubiquity of the opioid crisis and the fentanyl crisis is changing things more towards a harm reduction approach in some of those places where it might not necessarily be already ingrained.

Dr. Joseph Parks (09:12):

I think it is. That's the real good news since we did the original work surveying to get the information for this paper is we've seen huge movements and I think fentanyl test strips are the canary in the coal mine showing the way the field's changing more towards acceptance of harm reduction. We are now up to only 14 states where fentanyl test strips are still illegal and in 10 of those 14 states have legislative proposals underway right now to change. Some of the latest ones that have changed are Mississippi, Kentucky, Utah, certainly states that were not at all into harm reduction before that have now moved in that direction. We have legislation passed in Texas and Florida in one of their houses unanimously that is awaiting passage in the second house. I think it's clearly becoming the standard of public policy rather than the exception. That's very gratifying.

Josh Berezin (10:06):

Do you think that there might be some spillover into more general approaches or do you think it's going to stay locked into fentanyl and opioids?

Dr. Joseph Parks (10:18):

I think that it is going to continue to become slowly more generalized. I think that's why we see the sweeping policy changes around buprenorphine prescribing. I think no matter what your political persuasion or location, enough people know a friend or a relative that's overdosed or died that we're past the point of thinking that's a problem for this other population and not for my people. So I think we're coming to bipartisan consensus, not all at once, but we're moving in the right direction. Another improvement we've seen is we're not seeing the hysterical pronouncements about how you can get fentanyl intoxication just by touching things and you can get it through the skin. We used to see that you touch a dollar bill that has fentanyl on it and somebody keeled over and that was never true. That was urban myth media hysteria and those have calmed down. And that was another point of our report to address myths, as well as to get people to understand things they didn't understand, yet that they should.

Josh Berezin (11:23):

Stepping back from the paper a bit, this isn't the first drug of abuse to have widespread use and really deleterious effects. What do you see as some of the broader systems or policy drivers of fentanyl being in the drug supply? And if those point us towards either solutions towards the fentanyl and opioid crisis or thinking about how we can get ahead of whatever the next thing is going to be.

Dr. Joseph Parks (11:58):

Before we go on to the broader policy issues, I'd like to share a few more specifics about fentanyl that not all our listeners may know really.

Josh Berezin (12:05):

Yeah, that's great.

Dr. Joseph Parks (12:06):

One is that there's a lot of fentanyl analogs out there and the fentanyl test strips pick up about 10 of those analogs, but they don't pick them all up. So you need to always advise people and understand yourself that just because your sample tests negative doesn't mean that there's not some other fentanyl analog in it or something that won't get picked up on a fentanyl test strip like xylazine, like tranq. So it gives you some information, but it's not an insurance policy that this sample is particularly okay. The other myth that's out there is that somehow fentanyl test strips encourage people to use more and there's actually been a research done on this, a couple of different studies, and they report that about 85% of people using illicit drugs, they really want to know this. There's only 15% say, "I don't care, I'm taking whatever, get out of way."

(12:58):

85% want to know something. And those when asked say, "Well, so what did you do different when you used it?" They report things like taking a smaller dose, snorting instead of injecting a much safer use message, pushing the plunger more slowly while the needle's in so they can assess the effect of the drug, being more careful to keep naloxone nearby and sometimes skipping, deciding not to use in that instance at all. So it does actually, every time you test, you're reminding yourself that you should be worried. It is kind of like a self done cognitive intervention in the direction of abstinence or at least safer use, which of course we have to keep them alive or we're never going to get them abstinent.

Lisa Dixon (13:44):

Speaks to the notion of incremental and engagement.

Dr. Joseph Parks (13:47):

Yes, which of course is the same issue for many people that have diabetes, all their behavior changes, incremental and behavioral, also about eating and exercise. So much of the little of what we do is one dose and their fixed.

Josh Berezin (14:00):

It also makes me think about how fentanyl is perceived among young people, first time users, and if that's affecting some of their behavior as well, if they're more wary to experiment with drugs, particularly with opioids or pills bought off the street.

Dr. Joseph Parks (14:25):

I think the younger the person is, the more they have to be offered the solution immediately. So they're not going to be figuring out how they can get mail order fentanyl test strips from a state that allows it if they're in a state that doesn't. They're only going to use them if a friend handed them a couple or they're laying around somewhere, then they might fiddle with them and give them a try. I think the younger person is the more immediately available we need to make the opportunity.

(14:51):

The one policy thing that we've not seen any movement on that would be helpful, it's not so much policy, it's business practice, fentanyl is available as a separate urine or serum drug test but it is not routinely included on those panel urine drug screens you get or on the blood panels you get. You have to order it separately. And that seems just like bad clinical practice. Think of all the people that I've run into that I'm testing for something else I'm suspicious of in their urine and they didn't even know their stuff was contaminated with fentanyl. That can be a big message. There's a lot of people that are taking fentanyl that don't even know it and if we could pick it up because it was part of our broad panels. And that's really something we need to be leaning more on the companies that do the panel testing, that make the Combi lab strips.

Lisa Dixon (15:43):

And you do mention that in the paper and I just don't understand why there would be any resistance to it. Is there some inside reason? Does it make it cost more and then they don't think they're going to be able to get the money? Why not?

Dr. Joseph Parks (15:58):

I don't know. I haven't had opportunity to talk to any of the leadership level people in the companies that do that business yet. So if you're listening, please think about it and get back to us. Let us know. We'd love to know why this makes sense to you because it doesn't make sense to us.

Josh Berezin (16:12):

So that's something that I didn't really know about before the paper and talking to you about that it's not really widely available on routine drug testing that we do. What else is really specific to fentanyl that people should know about?

Dr. Joseph Parks (16:29):

One is that in overdose situations, at times you get this unusual wooden chest syndrome where it causes a marked rigidity in the chest wall musculature, which can make it very difficult to administer naloxone without having airway management also. This is rather specific to fentanyl as opposed to other drugs, but it is, of course, an acute emergency consideration for treatment. The other thing is when people are on fentanyl, they're going to need multiple doses of naloxone. So if somebody isn't responding, it's probably worth a second and a third dose. They could just be on a high dose of fentanyl and then induction. And the third point is that as opposed to other opiates like heroin, Oxycontin it's more difficult to induce somebody on buprenorphine and it's more likely that you'll need to take an approach like microdosing where instead of a single dose induction, you nudge up to it slowly.

(17:29):

I think the other thing that we're seeing that's going to be an improvement to fentanyl help is the broader use of buprenorphine and the move towards inducing people right in the ER or immediately and not referring them to a specialty program to do the induction. The moment they say, "Yes this is your moment of opportunity," and so many people change their mind by the next morning, it's important to get that induction done right then when they say yes and that's getting better. I think ERs could improve further. I think they will improve further and that's another way we should encourage them to improve in that way.

Lisa Dixon (18:03):

Now Joe, while you were talking, I was reminded of the fact that I just had to renew my DEA number and I was required to do a training, an eight-hour training in order to renew. And I think it's a one-time deal and I did it and it took me eight hours and I learned an awful lot from the training. It was one of these online trainings and then I thought, "Wow, it shouldn't just be me as a psychiatrist, that the whole team should be required to learn some of the basics." So one question that leads me to a question about the role of non-prescribing non-psychiatric professionals in this fight, what do you think about this requirement for additional training by the drug enforcement administration?

Dr. Joseph Parks (18:56):

Yeah, given how prominent the problem is, I think it's reasonable given that we're prescribing these medications. If we prescribe something, we're required to know how to deal with it. And we do prescribe prescription opiates. I know we're talking about illegal opiates here, but we prescribe it. If we're allowed to do it, we better know how to deal with it, including treating the side effects. We felt that way about tardive dyskinesia. We're a little ambivalent about metabolic syndrome, but if I give something that causes a problem, I should be responsible for that. And it's the same with understanding treating opiate disorders. And Lisa, I really like your point about it's important for the whole team to know it. Again, it goes to there's not enough of us and we don't have the bulk of the personal interactions. And that's a real change agent. A personal interaction is what really changes things and it's a dose response curve. How much interaction, how frequently, and they're going to have longer interactions more frequently with people other than us.

Josh Berezin (19:55):

So we've talked about a couple things that are moving in the right direction here. In general, are you optimistic? Where's the wind blowing for you?

Dr. Joseph Parks (20:09):

I think if we're going to do this as our life's work, it's a marathon and you got to stay optimistic. I am optimistic because people are seeing it as a problem and are looking for things they can do about it. I'm concerned because chemists are brilliant people and they will always find new molecules and new ways to modify more molecules and it won't always be fentanyl. We're seeing that with xylazine. There's all kinds of fentanyl analogs, which is why I think it's great to know the specifics, but we got to get really good at the basics that apply to everything because in five years we'll be talking about a different drug, but it's still going to be harm reduction, vigilance, the four pillars we mentioned, integrated care, because we can't do it all.

Josh Berezin (20:54):

Well, I think it's a very concrete way of thinking about a problem that can otherwise seem overwhelming to clinicians, to society. So I'm very appreciative of you all taking this on and publishing the paper and then coming on the podcast this morning to share some of this with us and our listeners. It was really a pleasure. So thank you so much.

Dr. Joseph Parks (21:18):

Thank you for the opportunity, Josh. And if I could just give the listeners, ask them to take a look at the National Council for Mental Wellbeing website, look up the Medical Director Institute publications and see if there's anything else you find useful that we've put out there. Please use the browser search and take a look for us.

Josh Berezin (21:34):

Sounds good. And we'll post that to the show notes as well.

Lisa Dixon (21:37):

Yeah, and I just want to echo that this article is it's to the point, it's clear, it's definitive, and it's really an important read.

Dr. Joseph Parks (21:48):

Thank you. Thank you, Lisa. High praise.

Lisa Dixon (21:50):

That's it for today. We want to thank Aaron van Dorn, who mixes and edits the podcast, as well as Demarie Jackson who provides important production support. We invite you to visit our website, ps.psychiatryonline.org to read the article we discussed in this episode, as well as other great research. We also welcome your feedback. Please email us at psjournal@psych.org and you can also rate and review the podcast on iTunes, Stitcher, or wherever you listen to it. I'm Lisa Dixon.

Josh Berezin (22:19):

I'm Josh Berezin.

Lisa Dixon (22:20):

Thank you so much for listening. Talk to you next time.

Speaker 4 (22:23):

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