ADDICTION AND PSYCHIATRY
A 45 MINUTE PRIMER

DR. JIM SIMM FRCPC CCSAM

PSYCHIATRY DAY

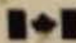
DECEMBER 14, 2018

FACULTY/PRESENTER DISCLOSURE

- **Faculty: Dr. Jim Simm FRCPC CCSAM**

- **Relationships with commercial interests: (list None if no disclosures)**
  - **Grants/Research Support:**
  - **Speakers Bureau/Honoraria: Janssen Pharmaceuticals**
  - **Consulting Fees:**
  - **Other:**

- **Mitigating potential bias: (delete this section if no disclosures above)**
  - I have been sponsored by Janssen to speak on the topic of early use of long-acting antipsychotics for patients with schizophrenia. The literature provides robust evidence for this treatment, and I do not limit my prescribing to Janssen products.



Canada Revenue Agency   Agence du revenu du Canada

Year / Année: **2016**

T4A

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Payer's name – Nom du payeur: **Janssen Inc.**

061 – Payer's Account Number (15 characters) / Numéro de compte du payeur (15 caractères):

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Original

ADDICTION

1. Chronic use despite adverse consequences.
2. Loss of control over intake.
3. Preoccupation with substance or activity.
4. Denial.
5. Note: Tolerance and dependence are not required for the diagnosis.
6. A chronic disorder (?disease;?behavioral pattern) with a progressive course, but treatment is available.

IS IT A DISEASE?

- Are we doing people a favour by telling them they have a "chronic, relapsing brain disease" or that most heavy drug users stop or substantially decrease their use eventually, and with help you may quit sooner rather than later.
- You may be more susceptible to addiction than others for genetic reasons but that does not mean that you are not responsible for your use and the consequences. (Much like Type II diabetes)

INTRODUCTION

- Negative emotions are extremely common in early recovery. In fact, people are unlikely to be prepared to change until they have experienced negative consequences as a result of their addiction.
- Careful balance needs to be struck between using these negative emotions as an impetus for change or having them as an barrier to engaging in treatment.

INDICATORS OF SUBSTANCE ABUSE

- Behaviors
  - Frequently missed or cxl'd appts
  - Frequent minor illnesses
  - Lost prescriptions for narcotics
  - Arriving at appts intoxicated
  - Unusual or specific Rx request
  - Emotionally erratic

INDICATORS OF SUBSTANCE ABUSE

- Observation
  - Tremerous
  - Sweating
  - Flushed
  - C/o indigestion, anxiety
  - Palmar erethyema, dupuytren's contractures,spider naevi, teleangiectasia, facial mooning, parotid enlargement
  - Repeated social difficulties

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INDICATORS OF SUBSTANCE USE

- Lab
    - CBC, GGT,AST,ALT
    - Urine Drug Screen (Street vs Comprehensive)

WHAT WAS THE FIRST SPORT TO HAVE ITS' ATHLETES REGULARLY DRUG-TESTED?

INTRODUCTION

- Substance use disorders can mimic primary psychiatric disorders by different pathways:
  - Intoxication
  - Withdrawal
  - Chaotic and dangerous lifestyle required to maintain the addiction.
  - Regular long-term use of substances can led to symptoms identical to primary psychiatric disorders, and the best treatment is usually abstinence along with lifestyle changes and supportive therapy with CBT elements

PSYCHIATRIC PRESENTATIONS OF SUBSTANCE ABUSE

- Depression/Anxiety
  - Can look identical to "primary" depression.
  - Depression and anxiety often clear relatively quickly once the substance abuse stops, so don't be too eager to start medications. If you do decide to prescribe, avoid any addicting medication (e.g benzodiazepines), unless it is to treat withdrawal on an in-patient basis.

PSYCHIATRIC PRESENTATIONS OF SUBSTANCE ABUSE

- Causes of Depression/Anxiety
  - Long-term alcohol use
  - Sedative-hypnotic use
  - Opioid use
  - Cocaine/amphetamine withdrawal
  - Marijuana use
  - General medical conditions secondary to substance abuse

PSYCHIATRIC PRESENTATIONS OF SUBSTANCE ABUSE

- Psychosis and Mania usually require immediate treatment even if substance-induced for patient safety. With few exceptions these patients will need to be hospitalized on a secure unit.

- Psychotic patients should have a drug screen done and can be treated with lower than usual doses of antipsychotics (usually). If substance-induced, usually will return to "normal" within a few days. Repeated presentations with substance-induced psychosis is a strong indicator of a primary psychotic illness.

WHO REQUIRES INPATIENT DRUG WITHDRAWAL

- Drug Factors-Physiologically problematic (alcohol,BZs, opioids)
- Patient factors
  - Multiple drugs
  - Psychologically/physically unstable
  - (lack of) support system, unstable social enviroment
  - History of withdrawal seizures or serious withdrawal symptoms (eg delirium tremens)
  - Quantity, pattern of drug use
  - Consider relapse potential
  - Inability to follow instructions, follow through with appointments on out-patient basis

PSYCHIATRIC PRESENTATIONS OF SUBSTANCE ABUSE

How do you separate a primary psychiatric disorder from a substance induced disorder?

1. Which came first?
2. What happened during the longest period of abstinence?(DSM-IV suggests that if the symptoms are still prominent after a month, a primary disorder is likely, dementia would be an exception.)
3. Is there a family history?

PSYCHIATRIC PRESENTATIONS OF SUBSTANCE ABUSE

4. Are there old medical records available? Is reliable collateral information available through family or caregivers?
5. Are the symptoms consistent with the drug abused?
6. How does the patient look objectively when they are not aware you are observing them?
7. A short period of observation is helpful before starting definitive treatment.(e.g. observing for neuro-veg. symptoms)

PSYCHIATRIC PRESENTATIONS OF SUBSTANCE ABUSE

8. Get a very clear idea of what the patient's symptoms are."I'm depressed" does not = a dx of depression.

9. Be aware that many drug users may have hidden agendas in their complaints (Looking for drugs, hospitalization, excuses not to work etc.) and gathering collateral, and not rushing to a decision is often in both yours and the patients best interest.

PHARMACOTHERAPY (GENERAL PRINCIPLES)

- If you have decided that a disorder is primary, then it would be treated as you would treat any other patient. Remember that many of these patients expect instant results and will adjust the dosage and timing as they see fit, so extra time must be spent explaining how the medications work and what can realistically be expected.

MEDICATIONS FOR ADDICTIONS

- Alcohol
  - disulfarim -Antabuse
  - naltrexone -Revia
  - acamprosate -Campral
- Opiates
  - Methadone
  - Buprenorphine/naloxone (Suboxone)
  - Naltrexone
- Others
  - nil

ADDICTION AND EXERCISE

- Addiction
  - Most work done with nicotine
  - Summary
    - +’ve effects on cravings, withdrawal sx’s and smoking behavior seen with high or low intensity aerobic exercise, with 5 min periods of isometric exercise
    - Best results (effect size of 4-6)seen with brisk 1 mile walk, but this may not always be practical
    - Trend toward more rapid and consistent effect than NRT

Addiction, 2007, 102(4),p534

INTERVIEWING SKILLS

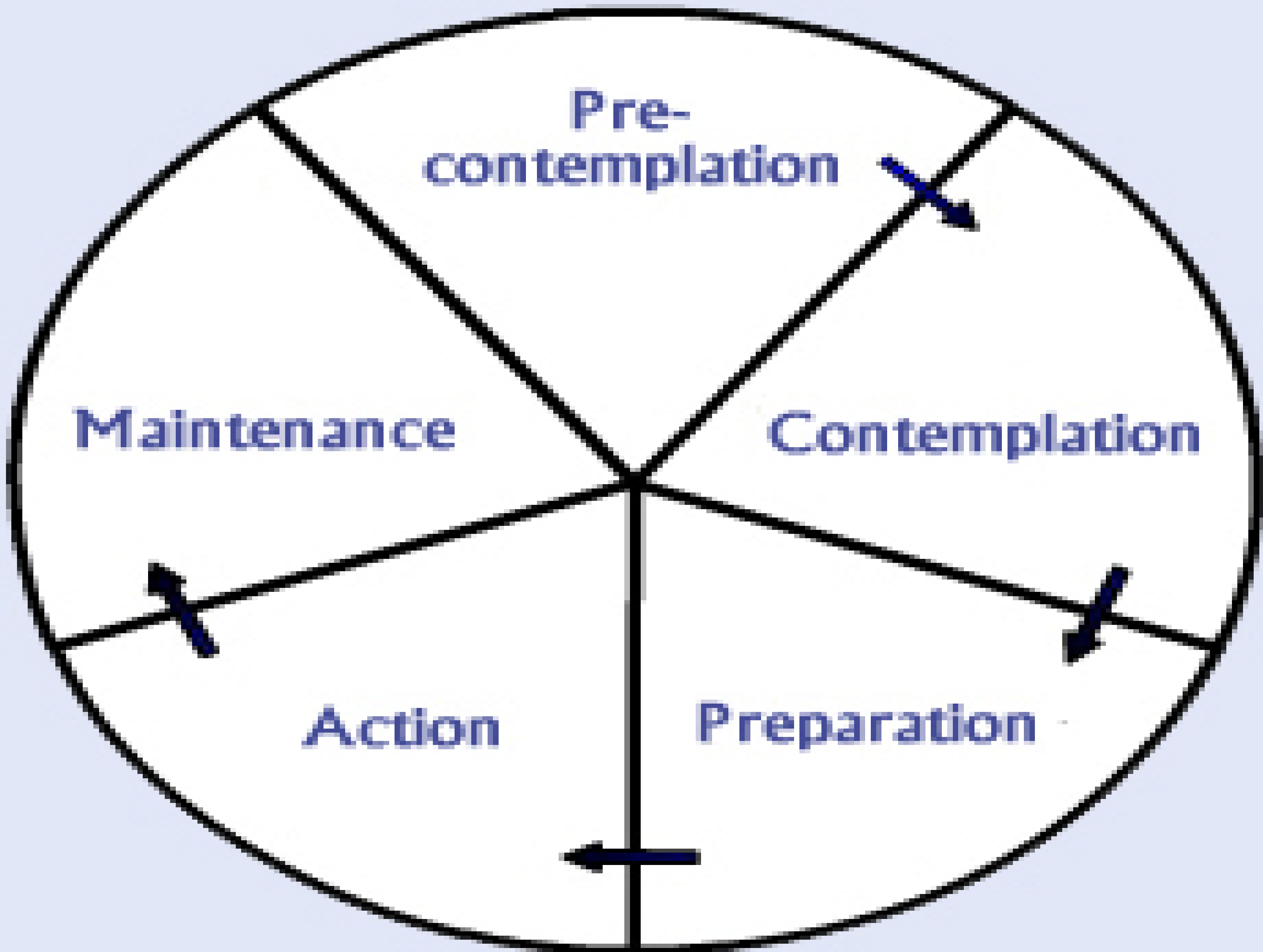
- **Factors which impede history taking.**
  - **Patient specific.**
    - **Denial, minimization,rationalization.**
  - **Physician specific.**
    - **Don’t wish to upset patient.**
    - **Don’t see it as a medical problem, but as a moral problem.**
    - **Lack of knowledge.**
    - **Belief the disease is untreatable.**

WHY YOU SHOULD SPEND A FEW MINUTES GIVING ADVICE

- **Physician advice is effective:**
  - **Randomized trials have shown that brief advice by a physician with problem drinkers reduces alcohol consumption, hospital admission rates and emergency room visits**
- **Many patients will accept referral to formal alcohol and drug treatment programs**

ENHANCING MOTIVATION

Addiction is a life-long, chronic disease which is marked by relapses and remissions. It is not cured by detoxification or even month long programs. The best results are seen when the patient makes the decision to stop for their own reasons and has input into the treatment plan.


Pre-
contemplation
Contemplation
Preparation
Action
Maintenance

ENHANCING MOTIVATION

- Best you can realistically hope for is to move patient up one stage.

PRINCIPLES OF MOTIVATIONAL INTERVIEWING

1. General expression of empathy
2. Note discrepancy between actual and desired behaviors (e.g. How substance use impedes achievement of long-term goals)
3. Avoidance of arguments (agree to disagree)
4. Avoid direct confrontation of resistance. Provide evidence from lab, history, collateral

PRINCIPLES OF MOTIVATIONAL INTERVIEWING

5. Provide education of the damage of substance use, the course of the illness and factors which may modify it.

6.Support patients self-efficacy and his/her ability to change.

DRUG AND ALCOHOL TREATMENT

- **Treatment works, although not as well or as often as we would like.**
- **"The rates of relapse and recovery in the treatment of drug addiction are equivalent to those of other chronic medical diseases."(asthma, hypertension, diabetes)**

Mclennan et al, JAMA,2000, 1689-95

PLAIN TALK

- People make changes when they can find their own reasons for making changes. MET aims to help people find these reasons, that is, what motivates them.
- Once people have found reasons to change, what will it take to make them "ready, willing and able"

WHAT IS CHANGE TALK?

Clients are more convinced by arguments they have presented to themselves more so than arguments presented by others.

In MET we strive to elicit their own arguments for change and the value in such change.

- Trying to change a patient’s behaviour
- Thinking it’s your job to change a patient’s behaviour
- Using dire threats: they may kick-start the process but then it’s up to the patient
- Taking on too much responsibility
- Evaluating yourself on the patient’s success

MONDAY, DECEMBER 12, 2005

FOUNDED IN 1872

Winnipeg Free Press

A12

DISTURBING TREND

Ex-addict SUES DRUG SUPPLIER

Crystal meth's new danger

Girls using it as weight-loss drug

By Katie Lewis

MAINLINE TO METH PART 4 / Crystal meth's impact on society forces governments to toughen enforcemen

Martin to fight meth

Canada's open door to meth

meth victim requests

DECEMBER 11, 2005

FOUNDED IN 1872

Winnipeg Free Press

MAINLINE TO METH PART 2 / How hard is it to get the prime ingredient for crystal meth? It's no problem

MAINLINE TO METH

Saskatchewan Premier Lorne Calvert is flanked by Premier Joe Handley of the NWT, left, and Manitoba Premier Gary Doer at Western Premiers' Conference last May. The premiers agreed to devise a joint strategy to battle crystal meth.

CHUCK STOODY / CANADIAN PRESS ARCHIVES

Daughter 'smelled like death'

Grieving mom tells students how crystal meth can destroy life

Crystal meth

, JANUARY 6, 2006

MANITOBA

A5

cold remedies heading behind counter

'Meth Kickers saved my life': ex-addict

Program pays off, but deadly drug's hard to escape

WINNIPEG FREE PRESS, SATURDAY, DECEMBER 10, 2005

MAINLINE TO METH Users can get hooked on a single dose

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Smith, Kline & French Laboratories, Philadelphia

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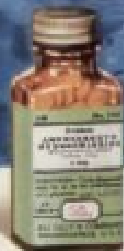

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Lilly

SINCE 1876

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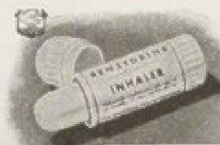

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10 METHAMPHETAMINE MYTHS

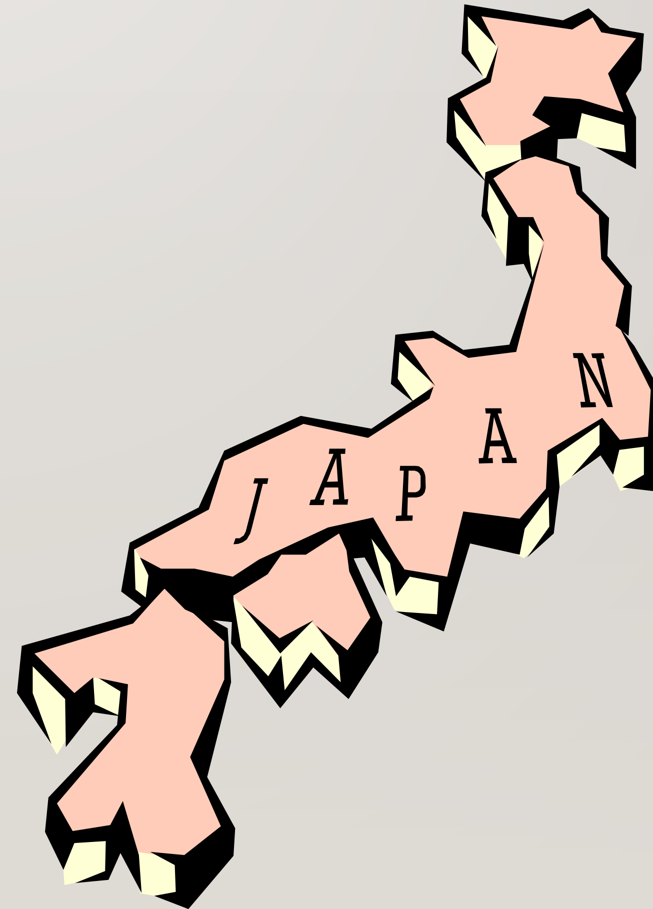
1. Epidemic sweeping USA and Canada.
2. Meth addiction is untreatable
3. Meth is instantly addictive for 90% of those that try it.
4. This is the worst drug of all time, nothing matches the devastation it causes.
5. Meth will destroy your brain, even one hit can cause permanent brain damage.

10 METHAMPHETAMINE MYTHS

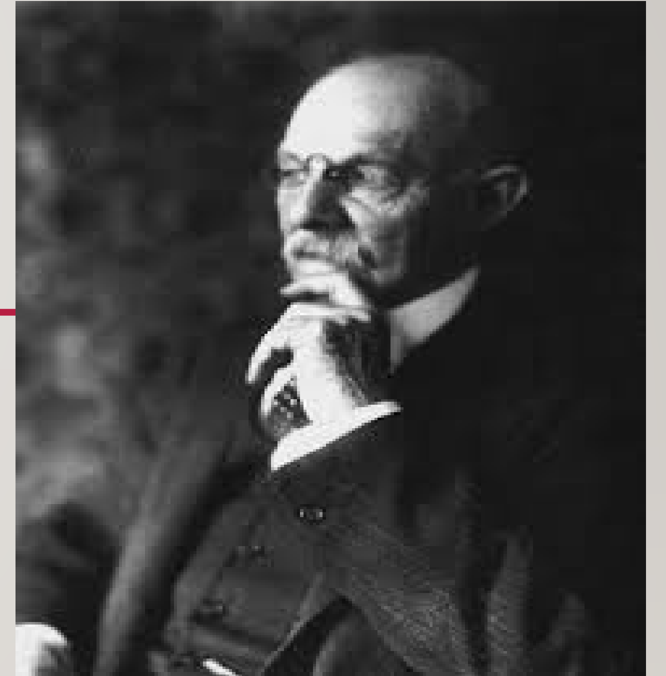
6. An enormous crime wave is sweeping North America due to Meth.
7. When you use Meth toxins build up in your body and cause your teeth to fall out and build up under your skin.
8. Methamphetamine causes horrible damage to the unborn.
9. Meth targets young kids and is sweeping through our schools.
10. Meth addicts are incredibly violent and unsafe to see alone.

METHAMPHETAMINE INDUCED PSYCHOSIS

- Post-war methamphetamine epidemic in Japan.
- A substantial portion did not resolve within a month and 15% took 5 or more years to recover in absence of ongoing use.



Connection?



The earliest reference to opium growth and use is in 3,400 B.C. when the opium poppy was cultivated in lower Mesopotamia (Southwest Asia). The Sumerians referred to it as Hul Gil, the "joy plant."

Swing Is Alive
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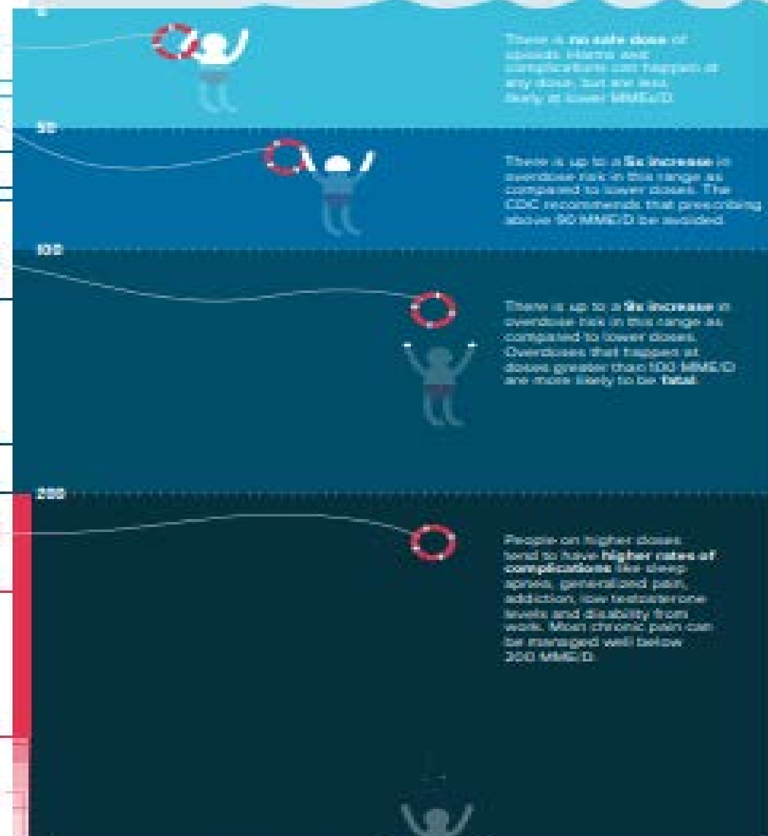
CPSM standard of practice for opioid prescribing for Chronic non-cancer pain is an ethical requirement for all physicians in Manitoba. Full information is available on the Cpsm.mb.ca website



OPIOID TREATMENT

- Maintenance vs Abstinence
- Abstinence has risks due to loss of tolerance and overdose. Increased risk of death by OD after short term treatment (detox). Patients are not admitted for just detox for this reason. Admission to the Addictions Unit must be followed by treatment, the longer the better. Nearly all studies show the outcome is worse for those attempting abstinence.

PSYCHIATRIC RESOURCES

- Psychiatry Central Intake an option. But usually only a one-time consult with recommendations, although may initiate referral to resource with longer-term follow-up.
- CODI (Dr. Josh Nepon FAX 204-787-7480). May provide ongoing services, the referrer must be willing to follow-up on their recommendations. All diagnoses reasonable including personality disorders
- Group CBT-Attn Dr J. Sareen/ Psychealth Center
- NIHB may fund psychologist
- Community Resources (see handout)
- www.CBTm.ca

APPEARANCES CAN BE DECEIVING

Chris Walter; Canadian Author “East Van”, “Punch The Boss” and many others

Thanks for your attention, I'd be pleased to answer any questions you have!