Opioid Agonist Therapy 101:
An Introduction to Clinical Practice Workshop

Presentation Title:

OAT and Co-Occurring Psychiatric Disorders: a 45 minute primer

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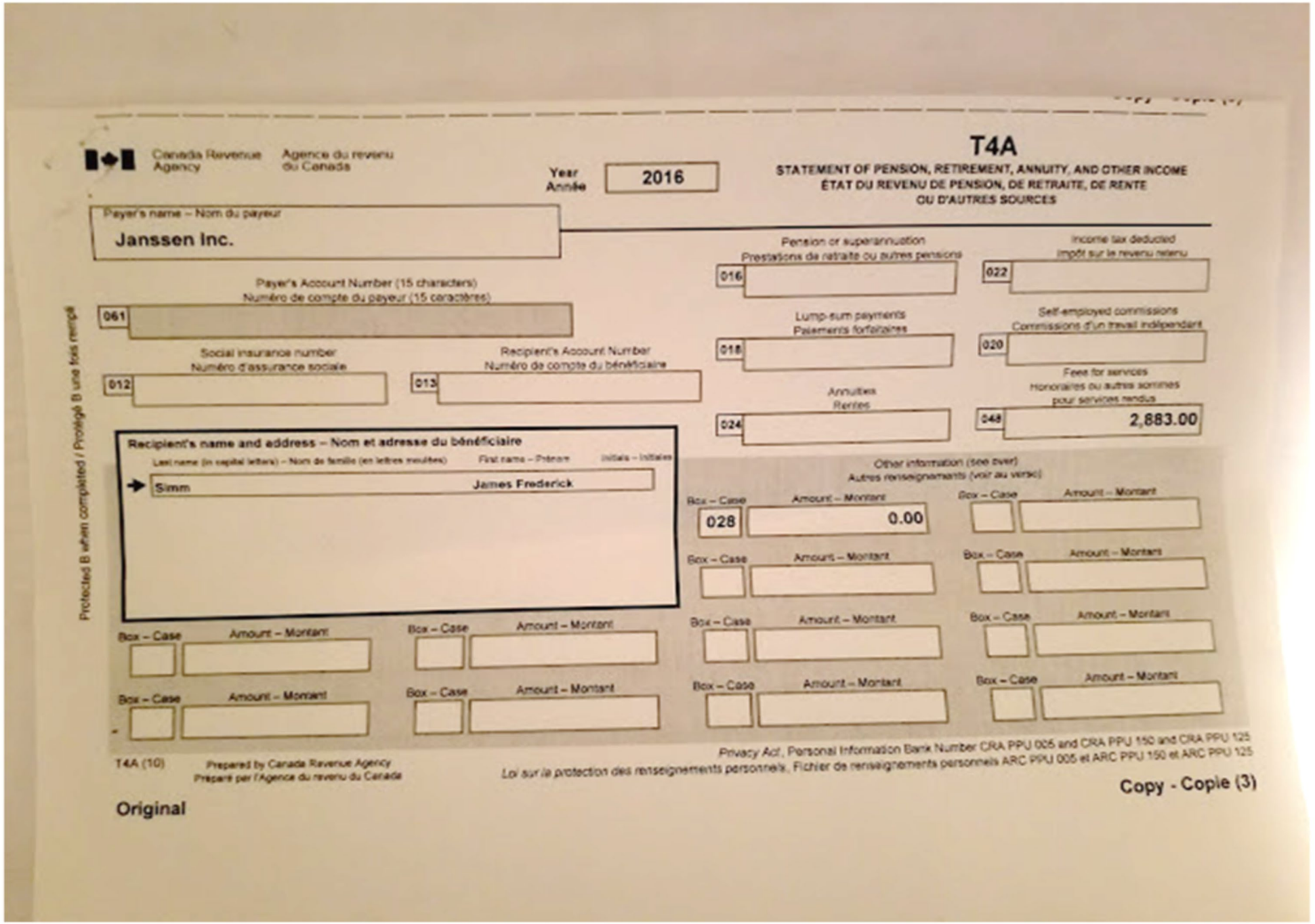
Sept 13, 2019

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.



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Objectives

- Overview of the common psychiatric presentations associated with opioid use disorder
- Assessment of Co-occurring psychiatric disorders
- Initial approach to treatment
- When to refer
- Local Resources

Introduction

- Information presented today is consistent with latest SAMHSA (Substance Abuse and Mental Health Service Administration) recommendations. Free pdfs are downloadable from their samhsa.gov. (TIP 42)
- Epidemiologic studies show high rate of co-morbidity of addictions and mental health disorders. Common co-morbidities are other addictions and personality disorders.
- Hard to make a definitive psychiatric diagnosis and treatment plan when substance use is out of control

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 lead to symptoms identical to primary psychiatric disorders, and the best treatment is usually abstinence along with lifestyle changes and supportive therapy with CBT elements. The value of 12 step groups for many cannot be understated.

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 not treating them and having them as a barrier to engaging in treatment.

Introduction

- Anxiety and depression will generally show substantial improvement with 2-4 weeks of abstinence. Generally would not recommend pharmacological treatment .
- However, telling patient they are “not really depressed” sounds invalidating to them
- Most patients will accept that there are different sub-types of depression/anxiety and it is impossible to know the best initial treatment without a period of abstinence.

Introduction

- However, mania and psychosis are major barriers to treatment (even if substance-induced) and need to be stabilized first. This often requires hospital admission.

Introduction

- On initial assessment, if patient has been taking their psychiatric medications as prescribed and is not having adverse side-effects, generally don't change anything before initiating OAT. (even if you suspect the symptoms are substance induced). Even though antidepressants such as SSRIs are not typically considered addictive, they have very uncomfOATable discontinuation syndromes.
- High doses of BZs (over 20 mgm diazepam equivalents daily) may be an exception. Don't suddenly stop though, gradual taper is recommended.

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-5 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 patient's best interest.

OAT and Depressive symptoms

- 35 yr old woman, stable on 16 mgm B/N . UDS '-ve. Synthroid and OCP.
- 4 wk history of inc. sadness, poor sleep, 15 lb weight loss, not suicidal but "sometimes I wish I didn't wake up"

OAT and depression

- History
  - Course of illness, specific symptoms of depression, psychosocial stressors
  - Substance use- UDS generally doesn't pick up ETOH and possibly some BZs
  - Lab- CBC,TSH/T4, Kidney, liver, glucose,BHcG
  - Review of systems
  - Prior psychiatric contact and treatment

OAT and Anxiety

- 22 yr old woman, recently started on program,polysubstance use (IV hydromorph , methamphetamine, ETOH, BZs)
- B/N at 12 mgm and considering Increasing
- UDS cannabis, fentanyl ("The guy must have laced the MJ")
- Wants to talk about anxiety and treatment

OAT and Anxiety

- Course of symptoms, subtypes of anxiety
- Lab- usual
- Prior treatment (nil)
- Psychosocial history- Chaos since birth

OAT and Anxiety

- Options
  - CBT first line no matter the type of anxiety
  - www.CBTm.ca
  - Optimize B/N dosage
  - BZs not indicated, at least 3rd line
  - Other meds not benign (quetiapine, gabapentin, SSRIs can increase side effect burden, citalopram Inc QTc)

OAT/PTSD

- Quite common that patients with addictions have experienced traumatic events
- Triad of symptoms, re- experiencing, avoidance, heightened arousal
- "Complex PTSD"- refers to pattern of symptoms associated with multiple traumatic events in early life leading to condition indistinguishable from Cluster B PD.

OAT/PTSD

- Addiction Stabilization and supportive therapy with basic premises of grounding techniques and CBT initial recommendations. Re-living trauma NOT recommended early on.
- Benzodiazepines not recommended
- SSRIs first line pharmacotherapy
- Although there is a strong lobby group for 'Medical Marijuana" for PTSD, the evidence is far from overwhelming.
- Laurel Center provides services for women with complex PTSD, best results if addictions are relatively stable.

OAT and psychosis

- Where to start?
  - Symptoms of schizophrenia
    - Auditory hallucinations most common
    - Delusions-What is the evidence for beliefs?
    - Negative symptoms, flat affect, anhedonia, social withdrawal, poor hygiene
    - Disorganization of thought and behaviour
  - Are symptoms directly associated with intoxication (stimulants or cannabis)?
  - Time course of symptoms, usually a prodrome prior to frank psychotic symptoms

OAT and psychosis

- Not common, it is hard to maintain an OUD if you have disorganized thoughts and behavior.

OAT and psychosis

- 23 yr old male, on program for 6 months, stable on 75 mgm methadone, UDS shows only cannabis and methadone, girlfriend on program states over last month he just stays in the basement and is continually accusing her of having affairs.

OAT and psychosis

- Differential
  - General medical conditions (quite unlikely in otherwise healthy young adult)
    - Red Flags- Seizure, focal neurological findings, disorientation/delirium
  - Substance-induced
    - Methamphetamine-more and more common in Winnipeg, use can trigger a psychosis that is indistinguishable from SCZ
    - Cocaine-Generally non-bizarre delusions that resolve after 24 hrs
    - Cannabis- Strong evidence that regular use is associated with SCZ in a small percentage of regular users, esp with positive family history

OAT and Psychosis

- Primary Psychotic disorders
  - SCZ vs Bipolar vs psychotic depression
  - Generally need psychiatric assessment ASAP if acutely ill
  - Consider CRC @ 817 Bannatyne Av., where they can be seen quickly and a number of treatment options are available (hospitalization, quick referral to specialist services)
  - If refusing services and felt to be a danger to self or others, contact Mobile Crisis unit (204-940-1781)

OAT and Psychosis

- Treatment
  - Pharmacological-1st line antipsychotic choice should be low side-effect profile with long-acting option (aripiprazole/risperidone/paliperidone)
  - Quetiapine/olanzapine not available in long-acting and have marked metabolic side-effects
  - Manitoba Schizophrenia Society and CMHA have resources for both patients and families

OAT and Personality Disorders

- Pervasive pattern of instability of interpersonal relationships,self-image, and affects, and marked impulsivity,beginning by early adulthood and present in a variety of contexts.
- They are stably unstable.

How Do they present?

- 1.Angry, manipulative or self-destructive behaviors.
- 2. Sense of entitlement, Feels the rules should not apply to them.
- 3.Compares you to other staff or caregivers. Acts as though they have a personal relationship with you or previous caregivers

How Do they present?

- 4.Different symptoms and stressors on each admission. Symptoms rapidly change and are inconsistent. (e.g. laughing with co-patients and 10 minutes later feel awful and have never been happy)
- 5. Adhere poorly to treatment recommendations.
- 6.Evoke frustration and anger in their caregivers and between members of the team.
- 7. Frequent substance abuse.

How Do they present?

- 8. Every situation is a crisis and requires immediate attention.
- 9. Frequent requests for staff time and favors. Undying praise if these requests are granted, eternal damnation if you are unable or unwilling to meet their demands.

Problematic Behaviors for Staff

- 1. Impossible to please.
- 2.High demand on your time, detracts from care of other patients.
- 3.Exploit other patients.
- 4. Disrupt the treatment team.
- 5.Induce fear, anger, frustration, burn-out.
- 6.Begin to question your own competence.
- 7. Question the competence and decision-making of your co-workers

Strategies for Managing the Borderline Patient

- Do not assume a trusting relationship or consistency. The patient will find it almost impossible to provide this. Consistency, appropriateness, and boundaries must be provided by the professional.
- Do not be unduly moved by pleas, threats, demands, manipulations or the patients' mistrust.

Strategies for Managing the Borderline Patient

- Recognize that the borderline personality has a chronic illness, which may resolve very slowly over time. There are no quick fixes, and the possibility of suicide or self-harm is ever present.
- Important for staff to have an opportunity to meet to develop care plans, and also to “vent”.

Strategies for Managing the Borderline Patient

- Clarify treatment expectations early so as not to lead to disappointment/conflict. These patients often react dramatically to disappointment.
- As much as is possible give a sense of control to the patient. This would include the right to make decisions that you believe are not in the best interest of the patient.

Strategies for Managing the Borderline Patient

- Recognize your own limitations and communicate this to the patient. You are responsible for providing sound clinical judgment and advice, but not for the patient's actions.
- Sound, consistent limit setting which is consistent among staff.
- Pick your battles wisely

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

Take Home points

1. The most common co-morbidities are personality disorders (Cluster B) and other addictions
2. For anxiety and depression (Non-psychotic/ suicidal) stabilize OAT before adding psychotropic medication.
3. Have patients sign a release of info so you can communicate with their PCPs or psychiatrists
4. Don't assume that all psychiatrists know the risk of combining BZs with OAT (esp Methadone)

Take Home points

5. Get collateral. (discharge summaries, consultant reports etc.)
6. Know your consultant. Not all psychiatrists are comfortable with OAT
7. Be aware of drug interactions between OAT and psychotropic medications
8. Many medications have abuse potential that we would not normally suspect. (gabapentin, buproprion,quetiapine,)
9. Time is your ally.

Thanks for your attention!
??Questions??
!!Comments!!

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

How Do they present?

- 4.Different symptoms and stressors on each admission. Symptoms rapidly change and are inconsistent. (e.g. laughing with co-patients and 10 minutes later feel awful and have never been happy)
- 5. Adhere poorly to treatment recommendations.
- 6.Evoke frustration and anger in their caregivers and between members of the team.
- 7. Frequent substance abuse.