Managing Psychosis in Addictions Clinics: Substance-Induced and Beyond

Welcome!

Please sit at a table by adding yourself to one of the tables below the slides.

You can then speak to you tablemates without the rest of the audience hearing.

Please introduce yourself, your profession and role, and the setting in which you work. We are going to review a case together. Please discuss how you would approach this case in your clinic.

Managing Psychosis in Addictions Clinics: Substance-Induced and Beyond

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September 22, 2023

camh

Faculty/Presenter Disclosure

- **Presenter: Tanya S. Hauck, Tim Guimond**
- **Relationships with financial sponsors:**
  - Fellowship funding from Bellwood Health Services

I will be discussing off-label pharmacotherapy treatments for stimulant use disorder and off label treatment for stimulant-induced psychosis.

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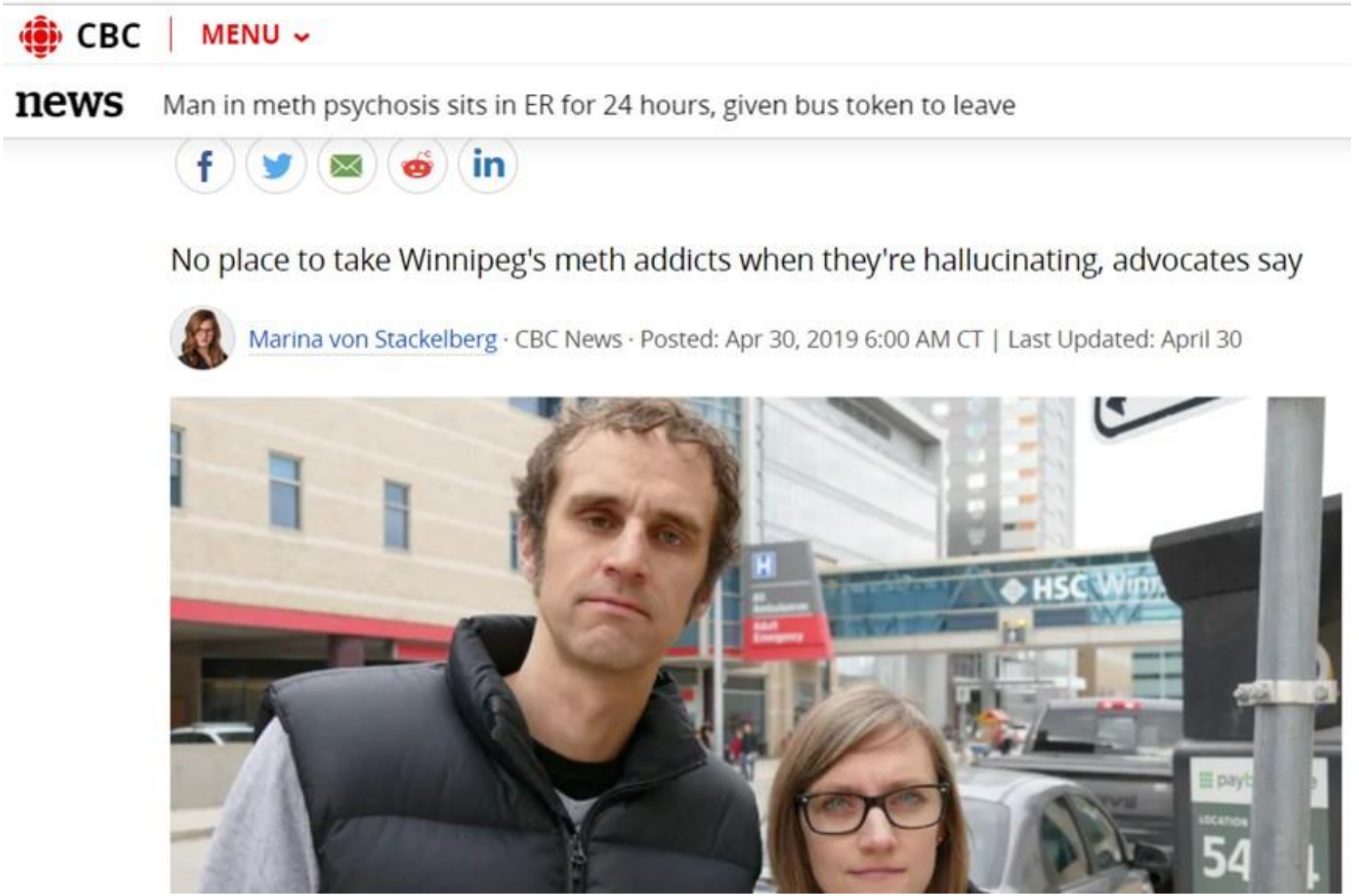


https://www.cbc.ca/news/canada/manitoba/hsc-meth-psychosis-1.5115291

Objectives

At the end of this session, participants will be able to do the following

1. Describe the criteria for psychotic disorders such as schizophrenia
2. Demonstrate an approach to the initial management of psychotic symptoms
3. Recognize the role of capacity and consent in treatment

Managing Psychosis in Addictions Clinics: Substance-Induced and Beyond

If this talk were helpful, we would discuss…

My background and main work setting is…

1

Epidemiology of psychosis

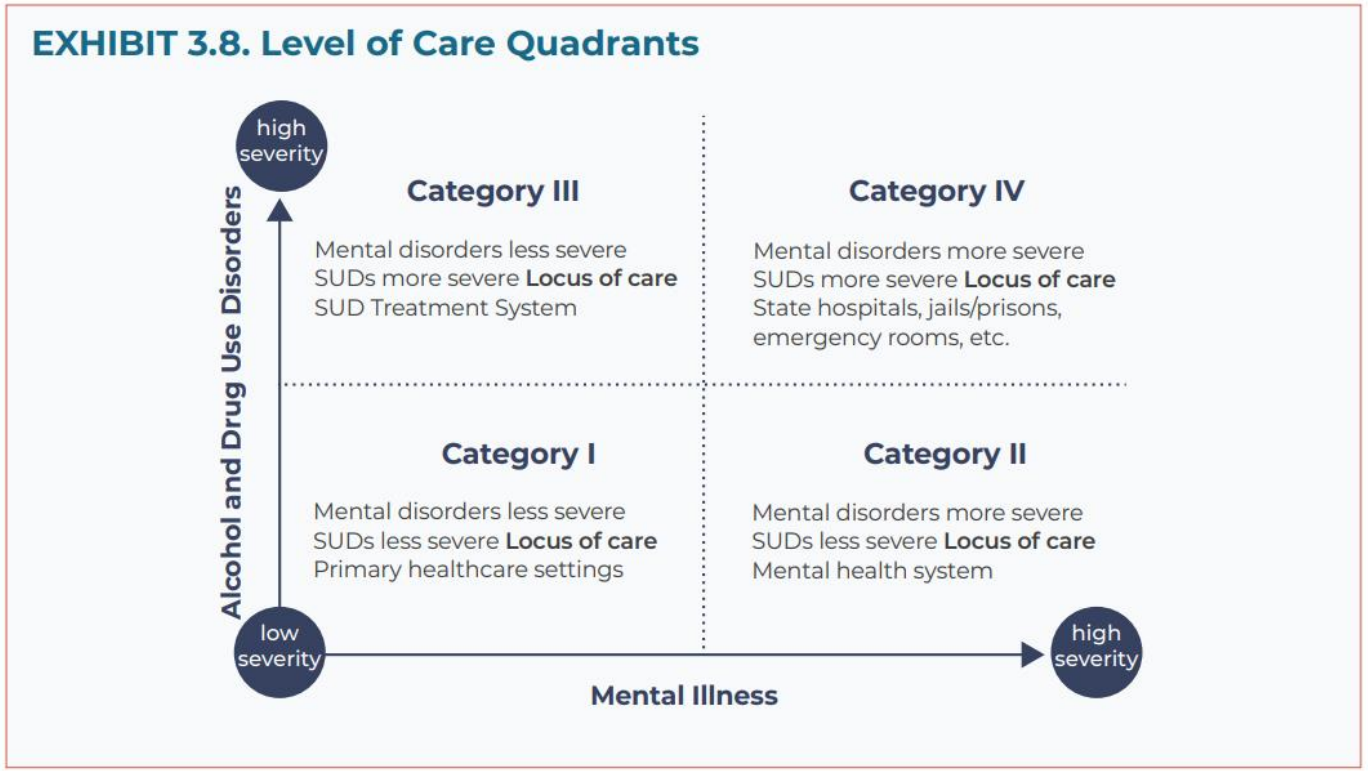
“Fred”

You are working as a prescriber in a rural RAAM clinic. A new patient Fred comes in with his friend seeking care. He has been using fentanyl, and would like to restart methadone. You assess him and discuss his options, and start 30 mg of methadone today. His friend says, “you should tell them about last year, you were in the psych ward” and he dismisses it. “Yeah, they said I had psychosis, I don’t remember that anyway, I was high. I’m ok now”. He is living with his friend, and appears organized during the assessment. You do not think he has any symptoms of psychosis. He does report he uses methamphetamine, “just sometimes, it’s not a big thing, when someone has it, I don’t pay for it”. He is happy to restart methadone and you refer him for counselling in the RAAM. He wants to apply to residential treatment.

In your small groups, please consider:

- ❑ How common are psychotic disorders?
- ❑ What are some possible psychotic disorders he may have had?
- ❑ What are your next steps?

Models are available to help counselors make treatment and referral decisions based on the severity and impact of each disorder. For instance, the quadrants of care (also called the Four Quadrants Model) is a conceptual framework that classifes clients in four basic groups based on relative symptom severity, not diagnosis (Exhibit 2.3). The quadrants of care were derived from a conference, the National Dialogue on CoOccurring Mental Health and Substance Abuse Disorders, which was supported by SAMHSA and two of its centers—CSAT and the Center for Mental Health Services—and co-sponsored by the National Association of State Mental Health Program Directors and the National Association of State Alcohol and Drug Abuse Directors. The quadrants of care is a model originally developed by Ries (1993).



https://www.ncbi.nlm.nih.gov/books/NBK64184/figure/A74172/

Differential Diagnosis of Psychosis

- ❑ Schizophrenia or schizoaffective disorder
- ❑ Major depressive disorder with psychotic features
- ❑ Bipolar disorder, manic episode
- ❑ Dementia/Neurocognitive impairment
- ❑ Delirium or alcoholic delirium tremens/hallucinosis

Schizophrenia (DSM5, 2013)

- 0.3%–0.7% lifetime prevalence
- onset of psychotic symptoms usually between late teens and early thirties
- males are more likely to have poor premorbid functioning
- late onset is more common in females
- most individuals who are diagnosed do not have a family history

Stimulant-induced psychosis

"The overall median prevalence of persistent symptoms across these studies was **25%**" after >1 month of abstinence.

Longitudinal studies reported persistence in 40% of participants.

Studies have shown transition to a diagnosis of schizophrenia to be 33-38% at 6-7 years, or 16% at 16 years.

→psychotomimetic properties of the drug precipitating psychosis in anyone

→methamphetamine precipitating primary psychosis in predisposed individuals

→...a combination of both forming a heterogenous population among methamphetamine users

Voce et al, Substance Use & Misuse 2019; 54(4): 549–559

Accessing care with stimulant-induced psychosis

Urbanoski, 2018:

OR 0.250 (0.206 to 0.304) of seeing a psychiatrist, 30 days after an ED visit, for individuals who visited an emergency department 5+ times in a year for substance use disorder.

"Controlling for sociodemographic characteristics, comorbidities and past-year service use, those with 1–4 ED visits for SUD and those with 5+ ED visits for SUD had **reduced odds of being hospitalised or visiting a psychiatrist** in the 30 days following their index ED visit, relative to those with no ED visits for SUD".

2

Symptoms and diagnosis

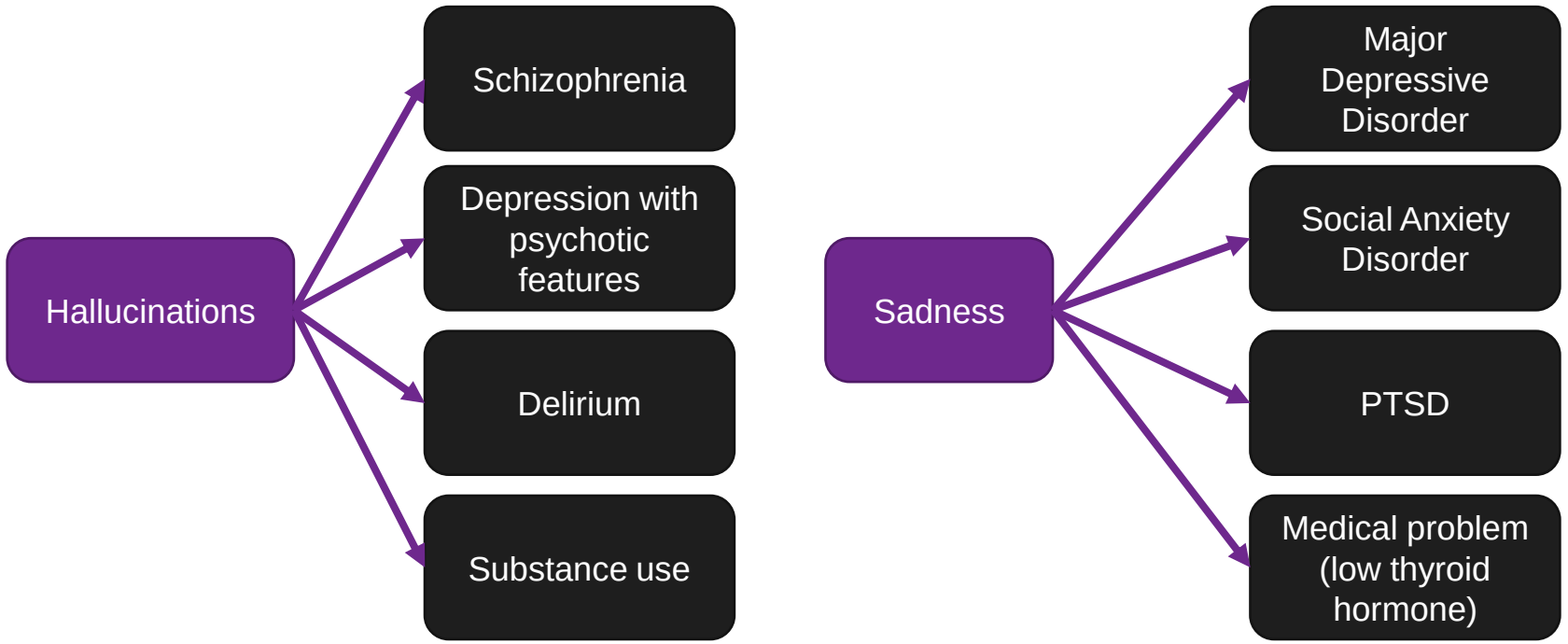
“Fred”

Fred returns a week later and you increase his methadone dose. He is noticeably different. His friend says, “I’m worried about him, I want him to stay at my place, but he’s talking about his cell phone being hacked, it sounds weird, and he’s freaking me out”.

In your small groups, please consider:

- ❑ What are common symptoms of psychotic disorders?
- ❑ What are your next steps?

Symptom versus Diagnosis



Formal Definition (DSM5)

Delusions

Hallucinations

Disorganized Speech

Abnormal Psychomotor Behaviour

Negative Symptoms

Salience

Delusions

A fixed, false belief which may “feel 100% real”

Spectrum of experiences with variations in **insight**

Content may be persecutory, grandiose, somatic (related to the body) or religious

Things may seem meaningful and important which are actually entirely random

Hallucinations: can occur in any of the five senses

Auditory Hallucinations

Very common in psychotic states

May be noises or music

May be words, or sentences, or multiple voices talking to each other

Mumbled or clear

Often hostile, threatening, obscene, insulting

May also be very normal and nonthreatening

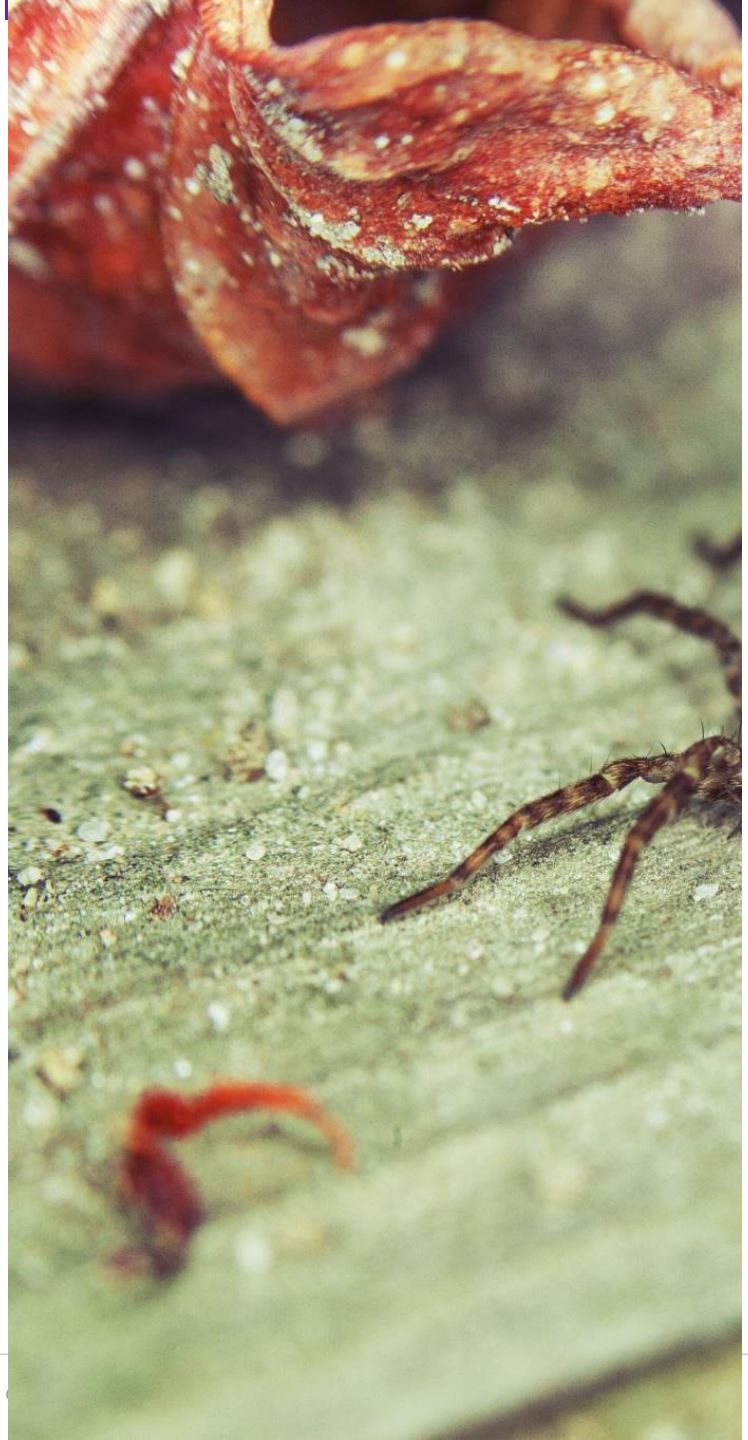
May be commanding

Visual Hallucinations

Somewhat common in psychotic disorders

Illusion: misperception of a stimulus

****very common human experience**



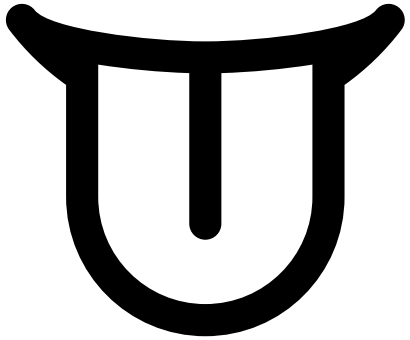
Tactile Hallucinations

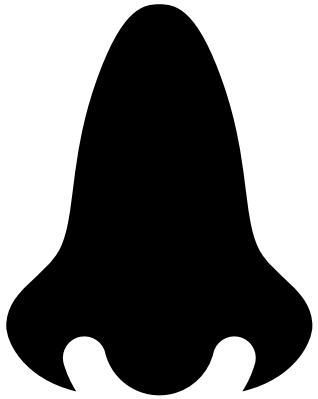
Can be a feature of alcohol withdrawal – **formication**

-or a symptom related to stimulant use

Otherwise relatively rare and concerning for a neurological or medical cause

Cenesthetic hallucinations are altered sensations of bodily organs





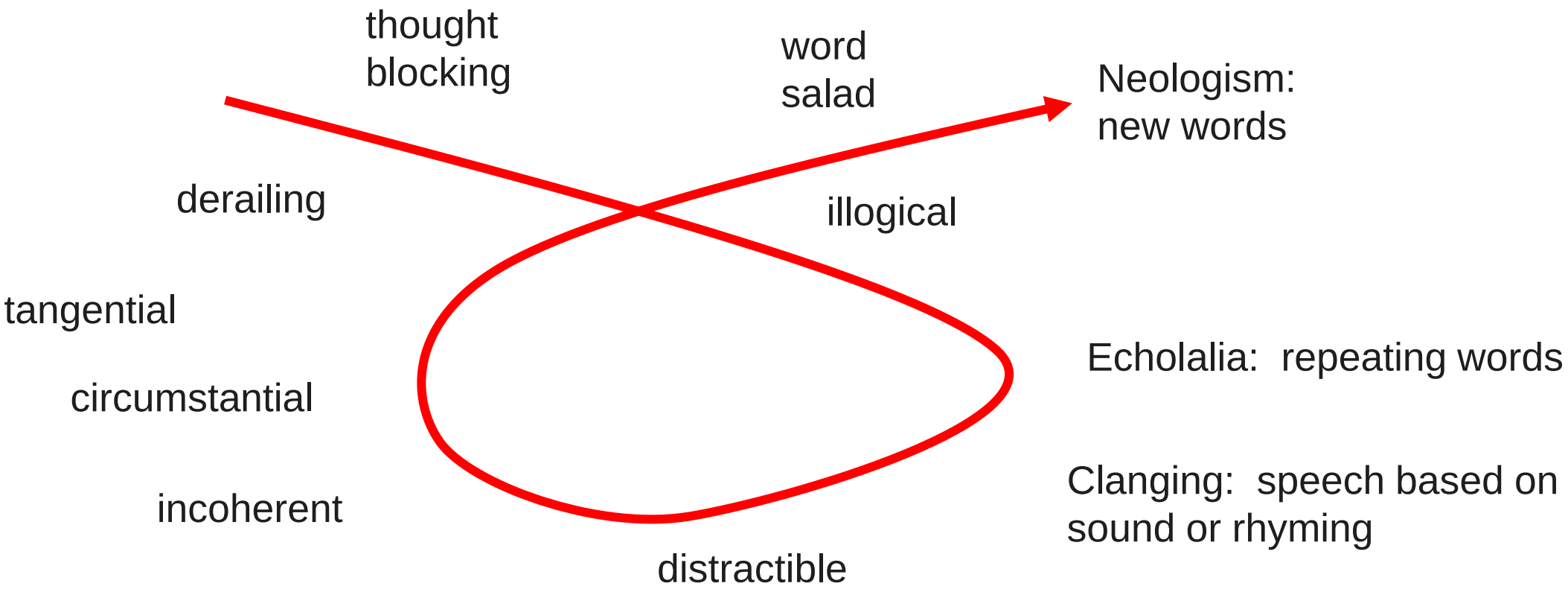
Olfactory or Gustatory Hallucinations

May occur but more rare

Rare in schizophrenia

May be a neurological or medical problem!

Disorganized Speech (and thought)



Psychomotor Behaviour

Grossly disorganized behaviour

Catatonic behaviour: posturing, being very slowed down

Mutism

May alternate between agitation and being almost frozen

These symptoms are more common in schizophrenia compared to substance related psychosis.

Negative Symptoms

Affective flattening: flat facial expression

Alogia: reduced spontaneous speech

Avolition-apathy: loss of goal-directed behaviour

Anhedonia-asociality: less interest in pleasure/enjoyment

Negative symptoms are more common in schizophrenia, and less common in psychosis related to substance intoxication or withdrawal.

Alcoholic Hallucinosis versus Delirium

In alcohol withdrawal, hallucinations are common

- They are usually non-threatening
- The patient has good insight into this being withdrawal
- They are not confused or disoriented

In Delirium (or Delirium Tremens)

- They are physically sick (high blood pressure)
- Agitation
- There are severe, frightening hallucinations **without** insight
- The patient is confused and disoriented

Psychotic Disorders (DSM5)

Criteria for schizophrenia:

A. Two or more of: (for > 1 month)

1. Delusions
2. Hallucinations
3. Disorganized speech
4. Disorganized/catatonic behaviour
5. Negative symptoms

B. Impaired functioning

C. Continuous signs of a disturbance for >6 months

D. Is not schizophoaffective/bipolar disorder

E. Is not better attributable to a substance

F. Delusions/hallucinations if pre-existing ASD

Criteria for substance/medication-induced psychotic disorder:

A. Presence of 1 or both of:

1. Hallucinations 2. Delusions

B. Evidence (labs, history, examination):

1. Symptoms occurred after intoxication/withdrawal/medication

2. The substance is capable of producing these symptoms

C. Not better explained by another disorder, e.g. the symptoms predate the substance, persist "about one month" after cessation, other evidence of a recurrent mental disorder

D. Is not delirium

E. Causes distress

With/without perceptual disturbances is a specifier for stimulant intoxication**. (DSM5)**

Stimulant-induced psychosis

The general definition of a substance-induced mental disorder means that the symptoms are not better explained by a non-substance induced disorder, such that (DSM-5):

- symptoms do not precede the onset of substance use
- symptoms do not persist for a substantial period of time **("about one month")** after withdrawal/intoxication
- there is not other evidence that there is an independent non-substance induced disorder, such as recurrent episodes

(DSM-5)

***this relates to the importance of urinalysis (broad spectrum) or at least having immunoassay for methamphetamine in your clinic**

(there is a similar definition for substance-induced anxiety, depression, and so on)

The complexity, in clinical practice, is how to proceed if a clear history of the period prior to substance use is unavailable, and if abstinence is not likely in the near future for assessment purposes.

Stimulant-induced psychosis

The most common symptoms of methamphetamine-associated psychosis are:

- **persecutory** and referential delusions
- **auditory** and visual hallucinations
- conceptual disorganization, hyperactivity, inappropriate affect, depression also common

Negative symptoms such as flat affect, social withdrawal, poverty of speech, avolition, reduced movement are less common (compared to schizophrenia).

Voce et al., 2019 (20–30% of participants were female in these studies)

Voce et al, Substance Use & Misuse 2019; 54(4): 549–559

Tips to help with psychosis

Focus on the emotions not the delusions or the content of the voices

Focus on trying to get through this, reminding them that it is ‘worse’ because of the drugs

Keep your voice soothing, be gentle

Pause and allow time for the person to gather their thoughts, but if they seem distracted gently help them refocus

Methamphetamine withdrawal makes people very hungry, always have snacks

3

Treatment of Psychosis

“Fred”

Fred is worried about losing his housing. He says he keeps hearing his sister, who is several provinces away. He also thinks there are drug dealers in the walls and has been trying to make holes and find them, upsetting his friend. He is moderately open to the idea that this is related to methamphetamine and a symptom of mental health disorder and wants you to help get rid of this problem.

In your small groups, please consider:

- ❑ What is your approach to treatment?
- ❑ What are you going to tell Fred about risks and benefits?
- ❑ What kind of monitoring are you going to do and plan for the future?
- ❑ Would Fred be a good candidate for a long-acting injectable medication?

Health Quality Ontario Standards for Schizophrenia

https://www.hqontario.ca/

Quality Statements to Improve Care: Summary

These quality statements describe what high-quality care in the community looks like for people with schizophrenia.

Quality Statement 1: Care Plan and Comprehensive Assessment

Adults with schizophrenia have a care plan that is regularly reviewed and updated, and that is informed by a comprehensive assessment.

Quality Statement 2: Physical Health Assessment

Adults with schizophrenia receive a physical health assessment on a regular basis.

Quality Statement 3: Self-Management

Adults with schizophrenia have access to information and education that supports the development of self-management skills.

Quality Statement 4: Family Education, Support, and Intervention

Families of adults with schizophrenia are given ongoing education, support, and family intervention that is tailored to their needs and preferences.

Quality Statement 5: Access to Community-Based Intensive Treatment Services

Adults with schizophrenia have timely access to community-based intensive treatment services based on their needs and preferences.

Quality Statement 6: Housing

Adults with schizophrenia have a safe, affordable, stable living environment that reflects their needs and preferences.

Quality Statement 7: Antipsychotic Monotherapy

Adults with schizophrenia are prescribed a single antipsychotic medication, whenever possible.

Quality Statement 8: Treatment With Long-Acting Injectable Antipsychotic Medication

Adults with schizophrenia are offered the option of a long-acting injectable antipsychotic medication.

Quality Statement 9: Treatment With Clozapine

Adults with schizophrenia whose symptoms have not responded to previous adequate trials of treatment with two different antipsychotic medications are offered clozapine.

Quality Statement 10: Continuation of Antipsychotic Medication

Adults with schizophrenia whose symptoms have improved with antipsychotic medication are advised to continue their antipsychotic medication for the long term.

Quality Statement 11: Cognitive Behavioural Therapy for Psychosis and Other Psychosocial Interventions

Adults with schizophrenia are offered cognitive behavioural therapy for psychosis and other evidence-based psychosocial interventions, based on their needs.

Quality Statement 12: Promoting Physical Activity and Healthy Eating

Adults with schizophrenia are offered readily accessible interventions that promote physical activity and healthy eating.

Quality Statement 13: Promoting Smoking Cessation

Adults with schizophrenia who smoke tobacco are offered pharmacological and nonpharmacological interventions to help them reduce or stop smoking tobacco.

Quality Statement 14: Assessing and Treating Substance Use Disorder

Adults with schizophrenia are asked about their substance use and, if appropriate, they are assessed for substance use disorder and offered treatment.

Quality Statement 15: Employment and Occupational Support

Adults with schizophrenia who wish to find work or return to work are offered supported employment programs. Adults with schizophrenia who are not seeking paid work are supported in other occupational or educational activities, in accordance with their needs and preferences.

The Canadian Journal of Psychiatry /
La Revue Canadienne de Psychiatrie
2017, Vol. 62(9) 586-593

DOI: 10.1177/0706743717719897
TheCJP.ca | LaRCP.ca

Canadian Schizophrenia Guidelines: Introduction and Guideline Development Process

Tamara Pringsheim, MD[1] and Donald Addington, MD[2]

Abstract

Introduction: The aim of the Canadian Schizophrenia Guidelines is to provide evidence-based recommendations for the treatment of schizophrenia and schizophrenia spectrum disorders. The target users are health care professionals. Recommendations are provided as guidance to physicians and patients, with the goal of improving the overall standard of care of individuals with schizophrenia.

Methods: The guidelines were developed using the ADAPTE process, a systematic approach and alternative to de novo guideline development, in which an existing guideline is customised to suit the local context. We assembled a multidisciplinary team of experts, patients, and family carers from across Canada with the goal of involving individuals with diverse areas of expertise and offering different perspectives

Canadian Psychiatric Association Guidelines 2017

Cognitive-behavioural therapy *(CBT) for psychosis should be offered to all individuals diagnosed with schizophrenia whose symptoms have not adequately responded to antipsychotic medication and are experiencing persisting symptoms, including anxiety or depression. CBT can be started during the initial phase, the acute phase, or recovery phase, including in-patient settings.*

Family intervention *should be offered to all individuals diagnosed with schizophrenia who are in close contact with or live with family members and should be considered a priority when there are persistent symptoms or a high risk of relapse. Ten sessions over a 3-month period should be considered the minimum effective dose. Family intervention should encompass:*

- ❑ *Communication skills*
- ❑ *Problem solving*
- ❑ *Psychoeducation*

NICE Guidelines: Psychosis and Schizophrenia in Adults (2014)

Offer CBT to all people with psychosis and schizophrenia (acute phase or later)

Family interventions to families of people with psychosis or schizophrenia

Art therapy starting in acute phase and later on (can help alleviate negative symptoms)

Do not routinely offer counselling or supportive therapy to people with psychotic disorders (individualize care)

Do not routinely offer adherence therapy or social skills training (individualize care)

Use of peer support services if available

Psychosocial interventions

Beyond psychological and pharmacological treatments, additional supports and social interventions:

- Employment
- Housing
- Education
- Peer support
- Family-centered care and support for family members and caregivers

Medication Treatment

NICE Guidelines: Psychosis and Schizophrenia in Adults (2014) – Pharmacologic Treatment

Antipsychotics are the primary treatment

Established evidence for their efficacy in

- Acute psychotic episodes
- Relapse prevention over time

Several agents available – must balance efficacy and side effects

***These guidelines are generally for *schizophrenia* and not for stimulant-induced psychosis**

Canadian Psychiatric Association Guidelines 2017

Following resolution of positive symptoms of the first episode of schizophrenia, the duration of maintenance treatment with antipsychotics should be ***at least 18 months.***

Following resolution of positive symptoms of an acute episode of schizophrenia, patients should be offered maintenance treatment and antipsychotic medication ***for 2 and possibly up to 5 years or longer.***

Antipsychotics improve mortality

Taipale et al, Schizophrenia Research, 197, pp. 274–280

Schizophrenia Research 197 (2018) 274–280

Contents lists available at ScienceDirect

Schizophrenia Research

journal homepage: www.elsevier.com/locate/schres

Antipsychotics and mortality in a nationwide cohort of 29,823 patients with schizophrenia

Heidi Taipale [a,b], Ellenor Mittendorfer-Rutz [a], Kristina Alexanderson [a], Maila Majak [c], Juha Mehtälä [c], Fabian Hoti [c], Erik Jedenius [d], Dana Enkusson [d], Amy Leval [d], Jan Sermon [e], Antti Tanskanen [a,f,g], Jari Tiihonen [a,g,*]

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"adjusted risk of death was 56% lower during use of any antipsychotic compared to no use of antipsychotic"

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ABSTRACT

Introduction: It has remained controversial if antipsychotic treatment is associated with increased or decreased mortality among patients with schizophrenia, and if there are any clinically meaningful differences between specific agents and routes of administration.
Methods: We linked prospectively gathered nationwide register-based data during 2006–2013 to study all-cause mortality among all patients aged 16–64 years with schizophrenia in Sweden ($N = 29,823$ in total; $N = 4603$ in the incident cohort). Multivariate Cox regression models were adjusted for clinical and sociodemographic covariates. Sensitivity analyses with the incident cohort were conducted to control for survival bias.
Results: During the mean follow-up of 5.7 years, 2515 patients (8.4%) died. During the maximum follow-up (7.5 years), the lowest cumulative mortality was observed for second generation (SG) long-acting injection

Long-term treatment is beneficial in schizophrenia

20-Year Nationwide Follow-Up Study on Discontinuation of Antipsychotic Treatment in First-Episode Schizophrenia

Jari Tiihonen, M.D., Ph.D., Antti Tanskanen, Phil.Lic., Heidi Taipale, Ph.D.

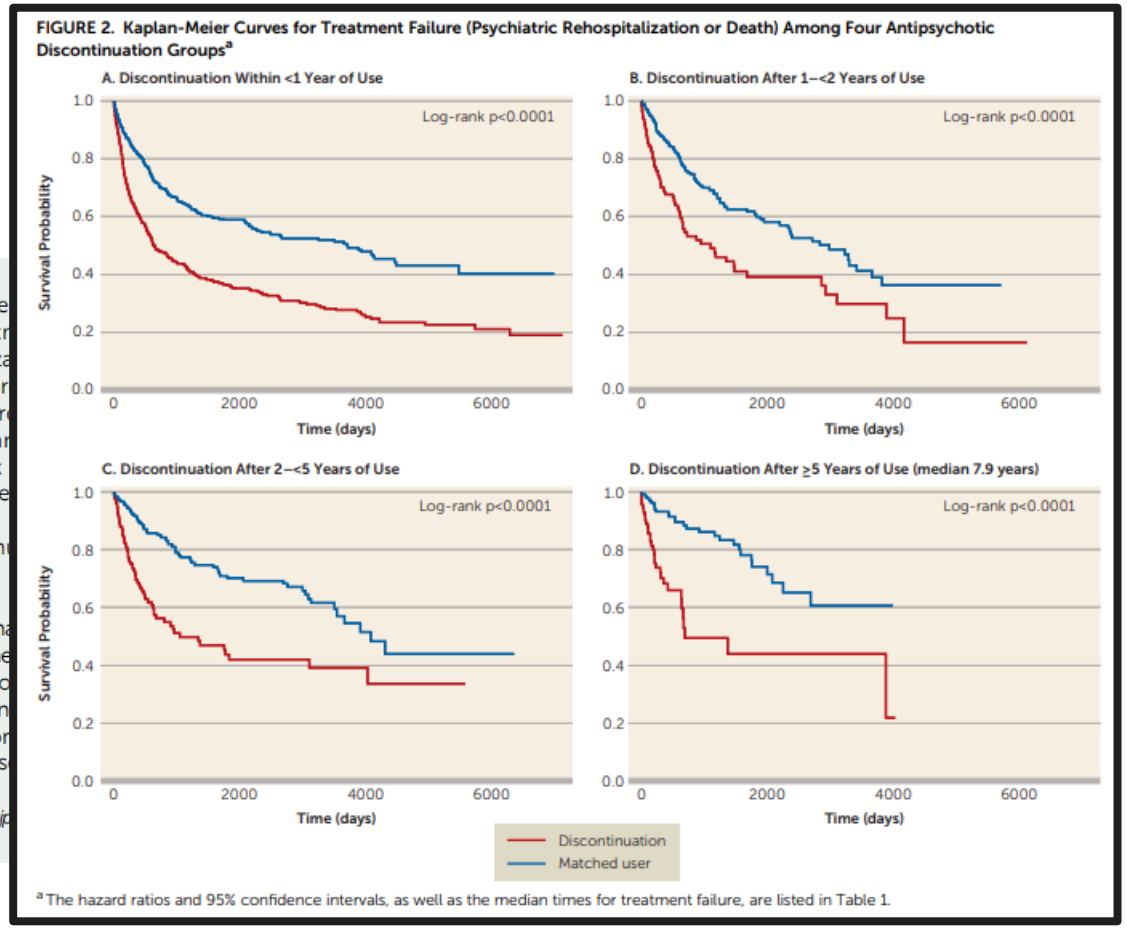
Objective: It is generally believed that after the first episode of schizophrenia, the risk of relapse decreases with time in patients who are stabilized. Many treatment guidelines recommend that after stabilization, antipsychotic treatment should be continued for 1–5 years, and longer exposure should be avoided if possible. However, there is no published evidence to substantiate this view. The authors used nationwide databases to investigate this issue.

Method: Prospectively gathered nationwide register data were used to study the risk of treatment failure (psychiatric rehospitalization or death) after discontinuation of antipsychotic treatment. Multivariate Cox regression was used to assess outcomes among all patients hospitalized for the first time with a schizophrenia diagnosis in Finland during the period of 1996–2014 (N=8,719).

Results: The lowest risk of rehospitalization or death was observed for patients who received antipsychotic treatment continuously (adjusted hazard ratio=1.00), followed by patients who discontinued antipsychotic use after discharge from the first hospital treatr ratio=1.63, 95% CI=1.52–1.75), within 1 year (haza 95% CI=1.57–2.24), within 1–2 years (hazar 95% CI=1.43–3.14), within 2–5 years (hazar 95% CI=2.07–5.13), and after 5 years (a median (hazard ratio=7.28, 95% CI=2.78–19.05). Risk 174%–214% higher among nonusers and patie discontinuation of antipsychotics compared who received antipsychotic treatment contin to 16.4 years.

Conclusions: Whatever the underlying mecha results provide evidence that, contrary to gene risk of treatment failure or relapse after disco antipsychotic use does not decrease as a fun during the first 8 years of illness, and that lor psychotic treatment is associated with increas

Am J Psychiatry 2018; 175:765–773; doi: 10.1176/appi.ajp



Tiihonen et al, Am J Psychiatry. 2018 Aug 1;175(8):765-773

Polypharmacy is not always or necessarily bad

JAMA Psychiatry | Original Investigation

Association of Antipsychotic Polypharmacy vs Monotherapy With Psychiatric Rehospitalization Among Adults With Schizophrenia

Jari Tiihonen, MD, PhD; Heidi Taipale, PhD; Juha Mehtälä, PhD; Pia Vattulainen, MSc; Christoph U. Correll, MD; Antti Tanskanen, PhLic

IMPORTANCE The effectiveness of antipsychotic polypharmacy in schizophrenia relapse prevention is controversial, and use of multiple agents is generally believed to impair physical well-being.

OBJECTIVE To study the association of specific antipsychotic combinations with psychiatric rehospitalization.

DESIGN, SETTING, AND PARTICIPANTS In this nationwide cohort study, the risk of psychiatric rehospitalization was used as a marker for relapse among 62 250 patients with schizophrenia during the use of 29 different antipsychotic monotherapy and polypharmacy types between January 1, 1996, and December 31, 2015, in a comprehensive, nationwide cohort in Finland.

Editorial page 468
Related article page 508
Supplemental content

"At the aggregate level, any antipsychotic polypharmacy was associated with a 7% to 13% lower risk of psychiatric rehospitalization compared with any monotherapy"

Tiihonen et al, *JAMA Psychiatry.* 2019;76(5):499-507.

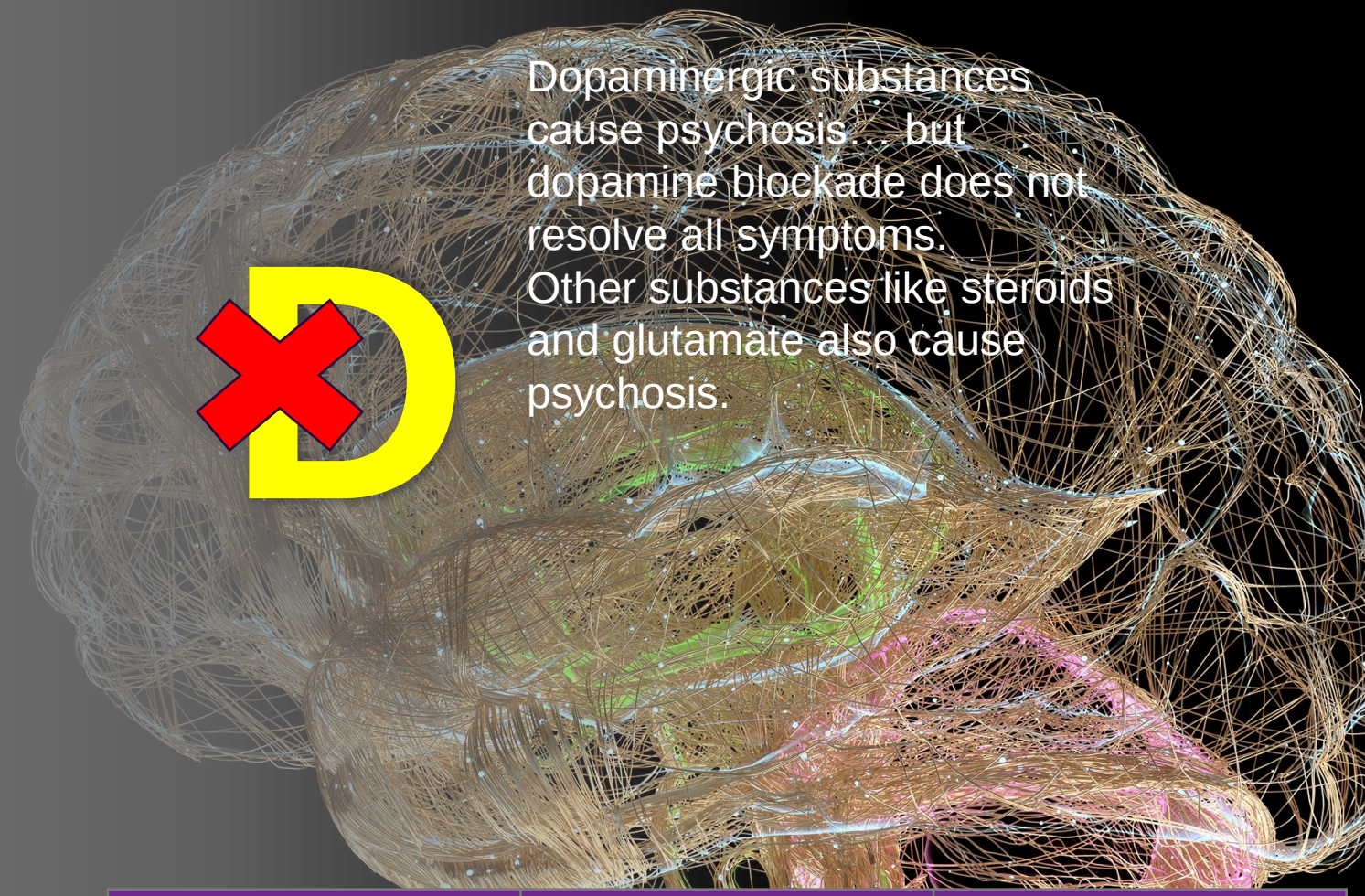
"Although the results do not indicate that all types of polypharmacy are beneficial, the current treatment guidelines should modify their categorical recommendations discouraging all antipsychotic polypharmacy in the maintenance treatment of schizophrenia"

Antipsychotics

First Generation	Second Generation	Third Generation
Haloperidol (Haldol)	Olanzapine (Zyprexa)	Aripiprazole (Abilify)
Loxapine (Loxapac)	Quetiapine (Seroquel)	Brexpiprazole (Rexulti)
Zuclopenthixol (Clopixol)	Quetiapine XR	Cariprazine (Vraylar)
Fluphenazine (Modecate)	Risperidone (Risperdal)	
Flupenthixol (Fluanxol)	Paliperidone (Invega)	
Methotrimeprazine (Nozinan)	Ziprasidone (Zeldox)	
Trifluoperazine (Stelazine)	Clozapine (Clozaril)	
Perphenazine	Asenapine (Saphris)	
Chlorpromazine	Lurasidone (Latuda)	

Mechanism of Action and Dopamine Pathways

1. Nigrostriatal → movement disorders
2. Mesolimbic → positive symptoms
3. Mesocortical → negative symptoms
4. Tuberoinfundibular → hyperprolactinemia



Dopaminergic substances cause psychosis… but dopamine blockade does not resolve all symptoms.
Other substances like steroids and glutamate also cause psychosis.

Anticholinergic	Alpha blockade	Histamine
Constipation Blurred vision Dry mouth Urinary retention Delirium	Hypotension Sedation Salivation	Sedation Weight gain

Selecting a Medication

Canadian Schizophrenia Guidelines 2017:

"**The inconsistency of findings argues against established clinical superiority for a specific antipsychotic in first-episode schizophrenia or, in fact, antipsychotic class** (i.e., second generation antipsychotic [SGA] vs. first-generation antipsychotic [FGA]). In meta-analyses specific to early or first-episode schizophrenia, one reported no differences between antipsychotic class in terms of efficacy or discontinuation rates but clear side effect differences.18 A more recent meta-analysis reported that SGAs were superior to FGAs in terms of all-cause discontinuation rates (number needed to treat ¼ 12), although, again, they appeared similar in terms of changes in total psychopathology."

→ second generation antipsychotics are preferred as mood stabilizers

→third generation antipsychotics (aripiprazole) have impulse control disorder warnings for gambling, binge eating, shopping and sexual behaviour

https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-warns-about-new-impulse-control-problems-associated-mental-health#:~:text=Talk%20to%20your%20health%20care,seem%20out%20of%20the%20ordinary.

7

Treatment With Long-Acting Injectable Antipsychotic Medication

Adults who are admitted to an inpatient setting with a primary diagnosis of schizophrenia are offered the option of a long-acting injectable antipsychotic medication.

What This Quality Statement Means

For Patients

You should be offered long-acting antipsychotic medications. These are injected once or twice a month.

For Clinicians

Offer the option of long-acting injectable antipsychotic medications to people with schizophrenia. Offer this option early in the course of antipsychotic treatment.

For Health Services

Through adequately resourced systems and services, ensure that clinicians are able to offer long-acting injectable antipsychotic medications to people with schizophrenia.

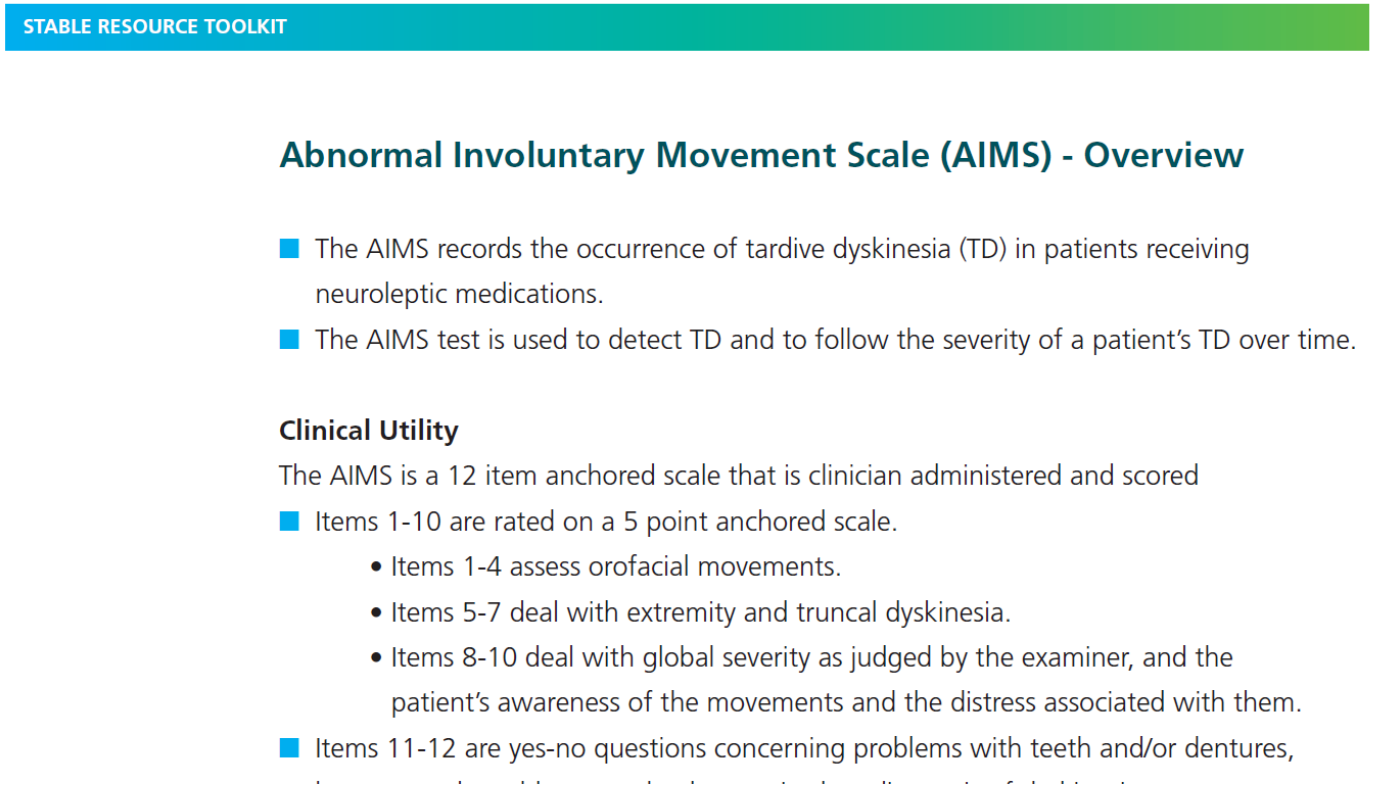
DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Long-acting injectable antipsychotic medications

These medications are injected every 2 to 4 weeks. The option of treatment with long-acting injectable antipsychotic medications should be offered early in the course of antipsychotic treatment.

Abnormal Involuntary Movement Scale

http://www.cqaimh.org/pdf/tool_aims.pdf



STABLE RESOURCE TOOLKIT

Abnormal Involuntary Movement Scale (AIMS) - Overview

- The AIMS records the occurrence of tardive dyskinesia (TD) in patients receiving neuroleptic medications.
- The AIMS test is used to detect TD and to follow the severity of a patient's TD over time.

Clinical Utility

The AIMS is a 12 item anchored scale that is clinician administered and scored

- Items 1-10 are rated on a 5 point anchored scale.
  - Items 1-4 assess orofacial movements.
  - Items 5-7 deal with extremity and truncal dyskinesia.
  - Items 8-10 deal with global severity as judged by the examiner, and the patient's awareness of the movements and the distress associated with them.
- Items 11-12 are yes-no questions concerning problems with teeth and/or dentures,

Metabolic Monitoring

Life expectancy is 15-25 years lower in schizophrenia! This is primarily related to cardiovascular disease.

Monitoring: How Often and What to Do

Applies to patients prescribed antipsychotics and metabolically active mood stabilizers and antidepressants

Frequency: As a minimum review those prescribed a new agent at baseline and at least once after 3 months. Weight should be assessed monthly in the first 3 months of taking a new antipsychotic as rapid early weight gain may predict severe weight gain in the longer term. Subsequent review should take place annually unless an abnormality of physical health emerges, which should then prompt appropriate action and/or continuing review at least every 3 months.

	Baseline	4 weeks	8 weeks	12 weeks	Quarterly	Annually
Personal/FHx	X					X
Lifestyle Review[1]	X	X	X	X	X	X
Weight/WC	X	X	X	X	X	X
BP	X			X		X
FPG/HbA1C	X			X		X
Lipid Profile[2]	X			X		X

History: Ask about family history (diabetes, obesity, CVD in first degree relatives <60 yrs), gestational diabetes. Note ethnicity.

[1]Smoking, diet, and physical activity [2]If fasting lipid profile cannot be obtained, a non-fasting sample is satisfactory

Derived from consensus guidelines 2004, j clin. psych 65:2

J Psychopharmacol. 2010 Nov; 24(4_supplement): 9–15.

http://help4psychosis.ca/wp-content/uploads/2015/08/Canadian-Cardiometabolic-Risk-Management-Postcard.pdf

6

Treatment With Clozapine

Adults who are admitted to an inpatient setting with a primary diagnosis of schizophrenia who have failed to respond to previous adequate trials of treatment with two antipsychotic medications are offered clozapine.

Clozapine has many risks, this is a good reason to refer to subspecialty services

What This Quality Statement Means

For Patients

If you have tried at least two different antipsychotic medications and your symptoms have not improved, you should be offered clozapine. Clozapine is taken orally.

For Clinicians

Offer people with schizophrenia clozapine if they have tried two antipsychotic medications without success.

For Health Services

Through adequately resourced systems and services, ensure that clinicians are able to offer clozapine as a treatment for people with schizophrenia who are admitted to hospital.

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Failure to respond

This refers to schizophrenia that has not improved despite adequate dosages and durations of two antipsychotic medication trials, with reasonable assurance of medication adherence during the trials. The trials may or may not have been initiated within an inpatient setting.

Treatment of stimulant-induced psychosis

Generally, second-generation antipsychotics are recommended and a tapering attempt at 6 months to determine if they are necessary. (Wodarz, 2017)

There are concerns that neuroleptics can promote cravings due to dopamine blockade (Härtel-Petri, 2017)

In general, if there are significant symptoms, and particularly if there is possibly an underlying primary psychotic disorder (schizophrenia) consider treating with an atypical antipsychotic, based on patient preferences, risks and benefits.

Things to consider from our RAAM experience:

- is it possible to obtain further history about the onset of symptoms?
- is abstinence reasonably likely or desired from the patient's perspective?
- is there good insight into the symptoms?
- even if the symptoms are episodic, are the consequences severe?
- even with reasonably good insight, are the symptoms leading to significant functional impairment, such as inability to remain in a safe housing environment or participate in medical tests?

Treatment of stimulant-induced psychosis

- ❑ review symptoms, goals of treatment
- ❑ review risks, benefits and alternatives with the patient, including abstinence from stimulants as an alternative treatment
- ❑ discuss the need for metabolic monitoring, and risks of movement disorders with all antipsychotics
- ❑ prescribe lower doses and go slower if the patient has never used an antipsychotic before
- ❑ second generation antipsychotics are preferred
- ❑ there is limited evidence, but aripiprazole has had negative trials and has a warning for impulse control disorders and cocaine cravings (Behavioural Pharmacology 2017, 28:63–73)

Example of treatment plan:

3 mg paliperidone for one week, then 6 mg paliperidone for one week

Then 150 mg IM loading dose of paliperidone (day 1) and 100 mg first dose IM on day 8.

Following this, 100 mg IM every four weeks. *also comes as q12 week and q6 months

There are very few options for SGA LAIs: paliperidone and risperidone and aripiprazole.

There are older LAIs (haloperidol, zuclopenthixol decanoate, flupenthixol) that are harder to get.

Acute Treatment of Methamphetamine Induced Psychosis

▶ **Table 5** Psychopharmacological treatment of methamphetamine intoxication.

First choice: benzodiazepines	
Substance	**Typical doses and dosage intervals**
Diazepam	10 mg orally, if necessary repeat after 30 min; alternatively, 2.5–5.0 mg i. v. bolus, if necessary repeat after 5–10 min
Midazolam	5–10 mg orally (tablets or drops), if necessary repeat after 30 min; alternatively, 2.0–2.5 mg i. v. bolus or i.m., if necessary repeat after 5–10 min
Lorazepam	1.0–2.5 mg orally, if necessary repeat after 60 min; alternatively, 2–4 mg i. v. bolus, repeat after 5–10 min
Add-on treatment, if neccessary: antipsychotics	
Substance	**Typical doses and dosage intervals**
Olanzapine	10 mg orally (orally dissolving tablets), if necessary repeat after 60 min; alternatively, 5–10 mg i.m., if necessary repeat after 120 min
Risperidone	2 mg orally (orally dissolving tablets), if necessary repeat after 60 min
Second choice: Haloperidol	5 mg orally (tablets or drops), if necessary repeat after 60 min; alternatively, 5–10 mg i.m., if necessary repeat after 5–10 min
In most cases, high cumulative doses are to be expected	
ECG monitoring with i. v. application required	

Wodarz N et al. Evidence-Based Guidelines for the … Pharmacopsychiatry 2017; 50: 87–95

Stimulant-induced psychosis

Fluyau et al, Front. Psychiatry 10:740. 2019

TABLE 2 | Provides a summary on demographic, setting, duration of a trial, study design, and standardized scales.

Study name	Participants	Setting/ country	Age	Study design/ duration	Jadad	GRADE	Drug doses (mg/d)	Standardized rating scales/amphetamine-induced psychosis criteria	Comments
Verachai et al. (51)	Quetiapine = 36 Haloperidol = 44	**Inpatient** hospital **Thailand**	**≥18**	**Randomized** 4 weeks	4	R+	Quetiapine: 100, 200, up to 300 mg/d Haloperidol: 2, 4, up to 6 mg/d	PANSS/ clinical interview and urine positive for methamphetamine	Double-blinded, methamphetamine-induced psychosis GRADE downgrades due to small sample size, no placebo controlled
Wang et al. (49)	Aripiprazole = 21 Risperidone = 21	**Inpatient** hospital China	18–60	**Randomized** **25 days**	3	R+	Aripiprazole: 5–10 mg/d initially, 5–15 mg/d Risperidone: 2–4 mg/d initially, 4–6 mg/d	PANSS/ *DSM-IV* diagnosis criteria	Methamphetamine-induced psychosis GRADE downgrades due to small sample size, trial was not double-blinded
Farnia et al. (50)	Aripiprazole = 27 Risperidone = 26	**Inpatient** hospital Iran	18–60	**Randomized** 6 weeks	4	R+	Risperidone: 4 mg/d, bedtime Aripiprazole:15mg/d, bedtime	Assessment of negative symptoms (SANS) and assessment of positive symptoms (SAPS)/*DSM-IV* diagnosis criteria	Double-blinded, amphetamine-induced psychosis GRADE downgrades due to small sample size, no placebo controlled
Sulaiman et al. (53)	Aripiprazole = 19 Placebo = 18	Medical center **Malaysia**	18–60	**Randomized** 8 weeks	4	R+	Aripiprazole: 5–10 mg po daily	PANSS *DSM-IV* diagnosis criteria	Double-blinded and placebo-controlled, methamphetamine-associated psychosis GRADE downgrades due to small sample size
Samiei et al. (52)	Haloperidol = 22 Risperidone = 22	**Inpatient** hospital Iran	35.3–34.6	**Randomized** 1 month	3	R+	Haloperidol: 5 up to 20 mg/d Risperidone: 2, 4, up to 8 mg/d	Scale of assessment of positive symptoms (SAPS)/ *DSM-IV-TR* diagnosis criteria	Not double-blinded, methamphetamine-associated psychosis GRADE downgrades due to small sample size, no placebo controlled
Leelahanaj et al. (48)	Olanzapine = 29 Haloperidol = 29	**Outpatient** **Thailand**	**≥15**	**Randomized** 4 weeks	4	R+	Olanzapine: 5, 10, up to 20 mg/d Haloperidol: 5, 10, up to 20 mg/d	Brief Psychiatric Rating Scale Clinical Global Impression Severity Scale/ *DSM-IV* diagnosis criteria	Double-blinded, amphetamine psychosis GRADE downgrades due to small sample size, imprecision (broad 95% CI)

General Considerations

- ❑ Individuals who use stimulants are at higher risk of movement disorders, which may be a reason to avoid older, high-potency antipsychotics such as haloperidol and monitor for EPS
- ❑ Risperidone and olanzapine may help positive symptoms
- ❑ Aripiprazole may result in lower treatment retention and side effects
  - ❑Aripiprazole is a **partial dopamine agonist** and has an association with gambling disorders, it is possible that may increase methamphetamine use
- ❑ Given that it is difficult to differentiate schizophrenia and MAP, reassess the need for pharmacotherapy frequently and involve family if the patient is in agreement
- ❑ Antipsychotics lower the seizure threshold in acute intoxication, and there is concern about rhabdomyolysis
- ❑ All patients taking antipsychotics for any reason need monitoring of metabolic and movement disorder side effects

Pharmacopsychiatry 2017; 50: 96–104
Am J Psychiatry 2007; 164:160–162
***Pharmacopsychiatry* 2017; 50: 87–95**

4

Acute emergencies and the Mental Health Act

“Fred”

Fred’s friend has brought him to clinic a week later and he is visibly agitated. You put him in an empty room and give him a snack, and his friend says, “he’s really scaring me, he’s convinced people are in the walls, he put holes in my walls with a knife, he says I’m ‘in on it’ “. He has stopped taking his medication. “He was holding a knife this morning and told me he will hurt me if I ‘work with them”. You see Fred and he is calm. He tells you he can hear the drug dealers from the room, they are plotting to kill him, and he wants you to get him “protective custody”.

In your small groups, please consider:

- ❑ What do you do next?
- ❑ Does Fred meet criteria for a Form 1?
- ❑ If there is no one who can issue a Form 1, what are other options?

Red Flags

Delirium
(CONFUSION)

Sedation

Agitation

Delirium

"A disturbance in **attention** (i.e., reduced ability to direct, focus, sustain, and shift attention) and **awareness** (reduced orientation to the environment)" that **fluctuates** (DSM5)

What day is it today?

Where are you right now?

Can you tell me the days of the week backwards?

Agitation

Monitor frequently

Delusions or hallucinations with a lack of insight is a big concern

The person may become fearful, attempt to protect themselves or others

Any physical agitation should be noted

Prioritize the safety of staff and other patients

How can a patient be assessed by psychiatry?

1. He saw his family physician 4 days ago for another issue (his foot was painful) and his doctor noticed he was talking to himself in the waiting room. His mother calls his doctor, and his doctor issues a form 1, calls the police and the police apprehend him.
2. His friend calls police **urgently when they are threatened**, and the police bring him to the hospital as a disturbed person.
3. The next day, his mother visits a Justice of the Peace, describes the circumstances and obtains a **form 2**, and the police apprehend the person and bring him to hospital for consideration of a form 1.

Answer:

All of the above are correct

Police can apprehend a person for an assessment

Anyone can request a form 2 for an assessment (during business hours)

Any physician can issue a form 1 after performing an assessment (and within 7 days)

The only difference is that only a form 1 has powers of detention and the other two pathways only provide an assessment

*this talk does not represent legal advice

The Mental Health Act (MHA)

Applies to “patients” in psychiatric facilities

Not every hospital is a psychiatric facility (“Schedule 1”)

- Many rural hospitals are not Schedule 1 facilities

The MHA:

- allows for involuntary hospitalization
- incorporates obligations in terms of rights

What is a form 1?

"Application for psychiatric **assessment**"

This assessment may take up to 72 hours, but the detention only commences at a "Schedule 1" facility

The patient receives a notification ("Form 42") *only* upon arrival at the Schedule 1 facility

Any physician may fill out a form 1 after performing an assessment

The physician has 7 days after an assessment to fill it out

The form gives authority for 7 days afterwards for police to apprehend the person

Upon arrival at the facility the detention lasts a maximum of 72 hours

Housekeeping

Fill out the physician information accurately

The **dates** are very important

ONLY Box A OR Box B, not both.

Box B is rarely used except by ACT/psychiatrists because many other criteria must be fulfilled.

Box A:

Past/Present Test:

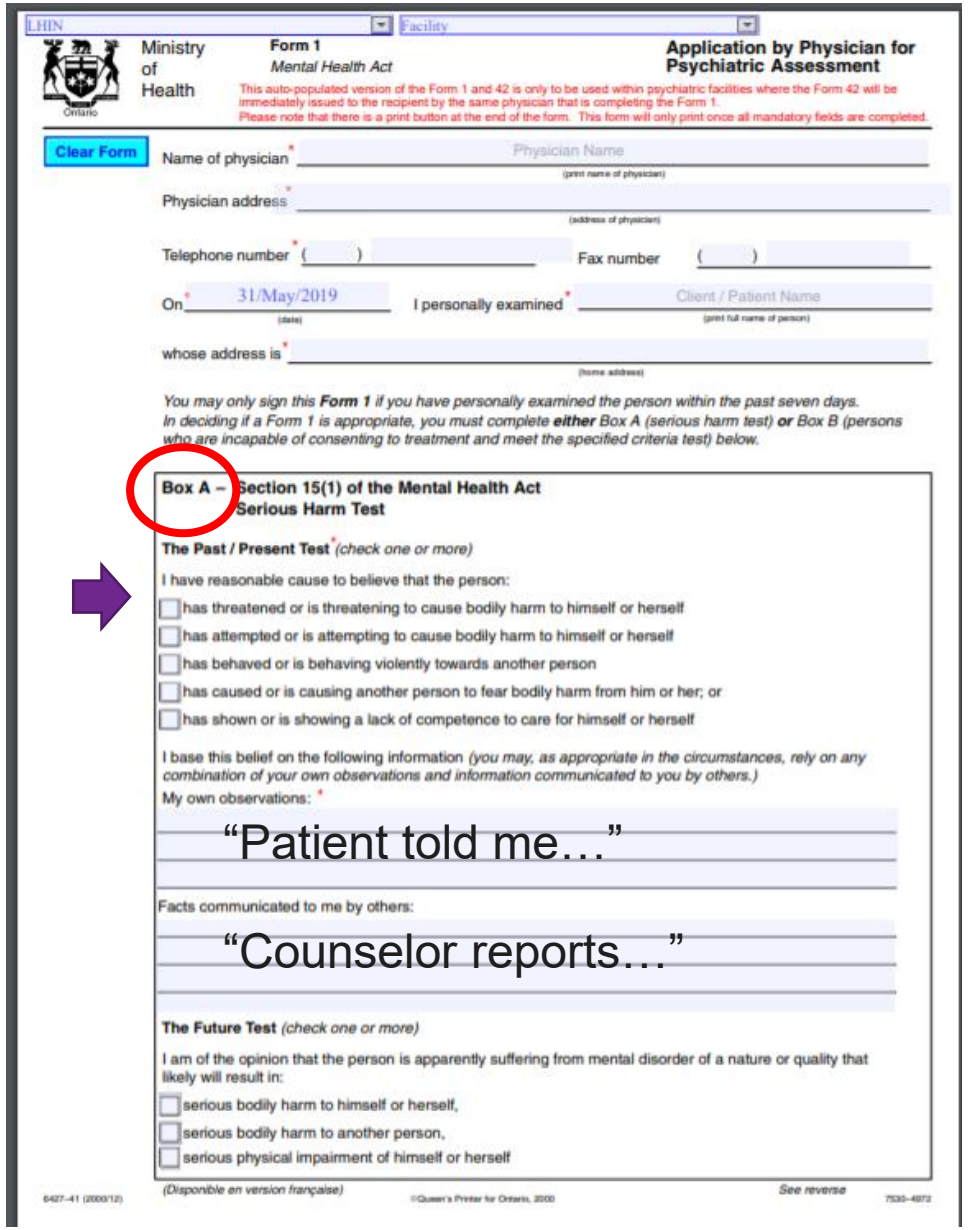
What is the RISK?

Logically connected to the box that is checked:

“patient threatened to kill person X”

“patient told nurse they would kill themselves and had pills with them to overdose on”

“patient is not wearing shoes, temperature today is -15C”



LHIN | Facility

Ministry of Health

Form 1
Mental Health Act

Application by Physician for Psychiatric Assessment

This auto-populated version of the Form 1 and 42 is only to be used within psychiatric facilities where the Form 42 will be immediately issued to the recipient by the same physician that is completing the Form 1.
Please note that there is a print button at the end of the form. This form will only print once all mandatory fields are completed.

Clear Form

Name of physician * Physician Name
(print name of physician)

Physician address *
(address of physician)

Telephone number * ( ) Fax number ( )

On * 31/May/2019 I personally examined * Client / Patient Name
(date) (print full name of person)

whose address is *
(home address)

*You may only sign this **Form 1** if you have personally examined the person within the past seven days.*
*In deciding if a Form 1 is appropriate, you must complete **either** Box A (serious harm test) **or** Box B (persons who are incapable of consenting to treatment and meet the specified criteria test) below.*

Box A – Section 15(1) of the Mental Health Act
Serious Harm Test

The Past / Present Test *(check one or more)*

I have reasonable cause to believe that the person:

- ☐ has threatened or is threatening to cause bodily harm to himself or herself
- ☐ has attempted or is attempting to cause bodily harm to himself or herself
- ☐ has behaved or is behaving violently towards another person
- ☐ has caused or is causing another person to fear bodily harm from him or her; or
- ☐ has shown or is showing a lack of competence to care for himself or herself

I base this belief on the following information *(you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)*

My own observations: *

“Patient told me…”

Facts communicated to me by others:

“Counselor reports…”

The Future Test *(check one or more)*

I am of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in:

- ☐ serious bodily harm to himself or herself,
- ☐ serious bodily harm to another person,
- ☐ serious physical impairment of himself or herself

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Box A:

Future Test:

What is the MENTAL DISORDER?

Same box must be checked!

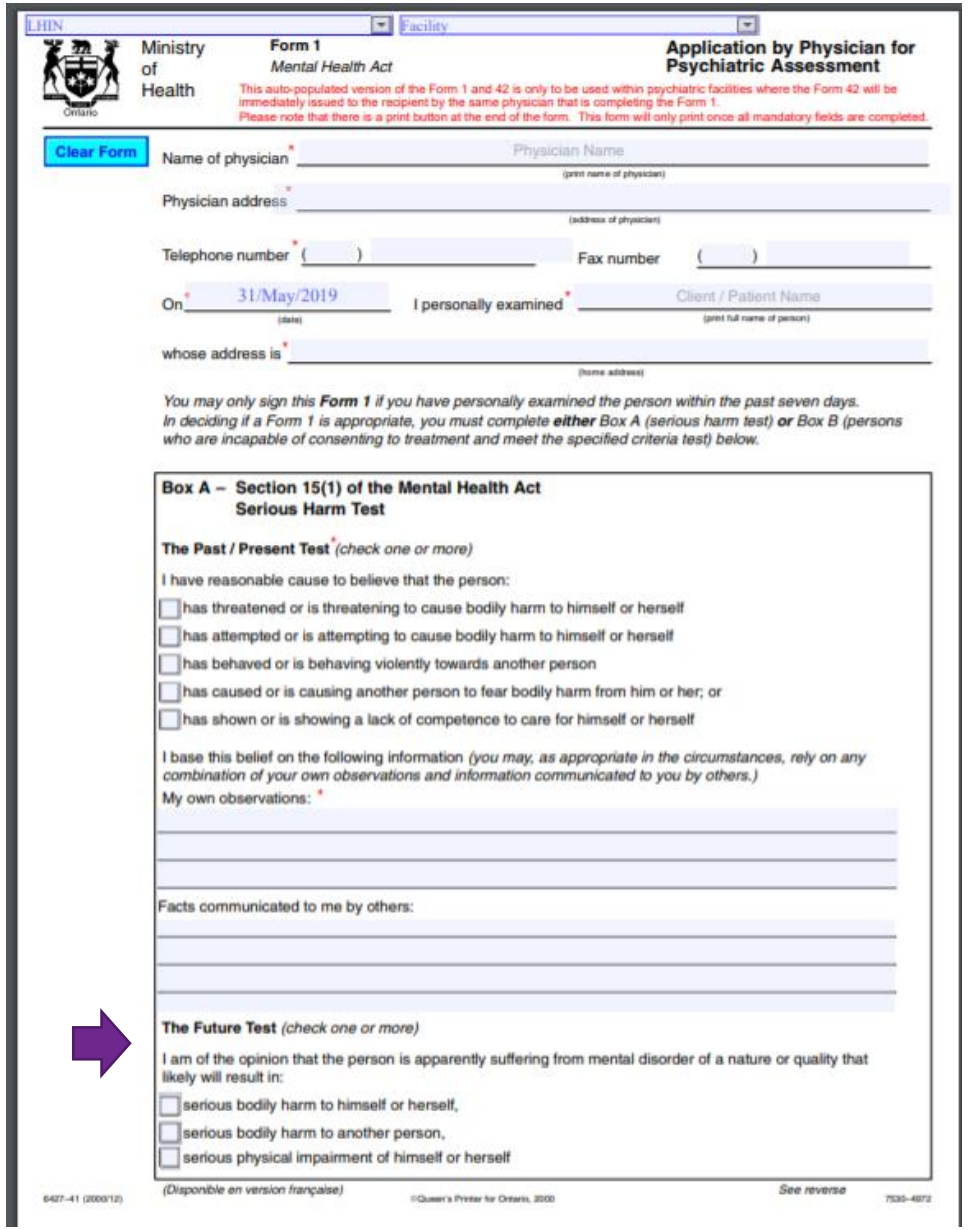
“patient is talking to himself”

“speech is disorganized”

“patient is tearful, appears depressed”

****symptoms** of a mental disorder, do not need a diagnosis

*****substance use/intoxication is considered a mental disorder



LHIN | Facility

Ministry of Health — Form 1 *Mental Health Act* — **Application by Physician for Psychiatric Assessment**

This auto-populated version of the Form 1 and 42 is only to be used within psychiatric facilities where the Form 42 will be immediately issued to the recipient by the same physician that is completing the Form 1.
Please note that there is a print button at the end of the form. This form will only print once all mandatory fields are completed.

Clear Form

Name of physician * Physician Name (print name of physician)

Physician address * (address of physician)

Telephone number * ( ) Fax number ( )

On * 31/May/2019 (date) I personally examined * Client / Patient Name (print full name of person)

whose address is * (home address)

*You may only sign this **Form 1** if you have personally examined the person within the past seven days.*
*In deciding if a Form 1 is appropriate, you must complete **either** Box A (serious harm test) **or** Box B (persons who are incapable of consenting to treatment and meet the specified criteria test) below.*

Box A – Section 15(1) of the Mental Health Act
Serious Harm Test

The Past / Present Test *(check one or more)*

I have reasonable cause to believe that the person:

- ☐ has threatened or is threatening to cause bodily harm to himself or herself
- ☐ has attempted or is attempting to cause bodily harm to himself or herself
- ☐ has behaved or is behaving violently towards another person
- ☐ has caused or is causing another person to fear bodily harm from him or her; or
- ☐ has shown or is showing a lack of competence to care for himself or herself

I base this belief on the following information *(you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)*

My own observations: *

Facts communicated to me by others:

The Future Test *(check one or more)*

I am of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in:

- ☐ serious bodily harm to himself or herself,
- ☐ serious bodily harm to another person,
- ☐ serious physical impairment of himself or herself

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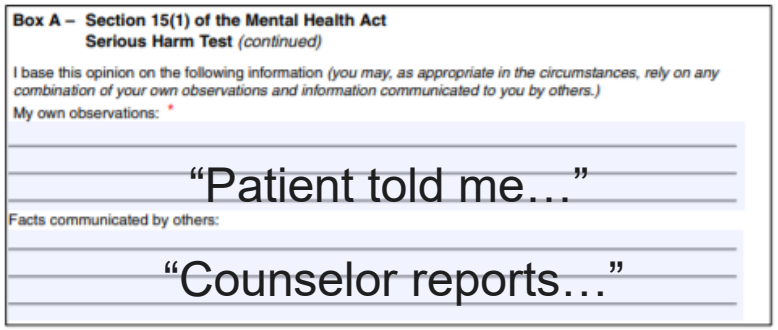
Still Box A



Box A – Section 15(1) of the Mental Health Act
Serious Harm Test *(continued)*

I base this opinion on the following information *(you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)*

My own observations: *

"Patient told me…"

Facts communicated by others:

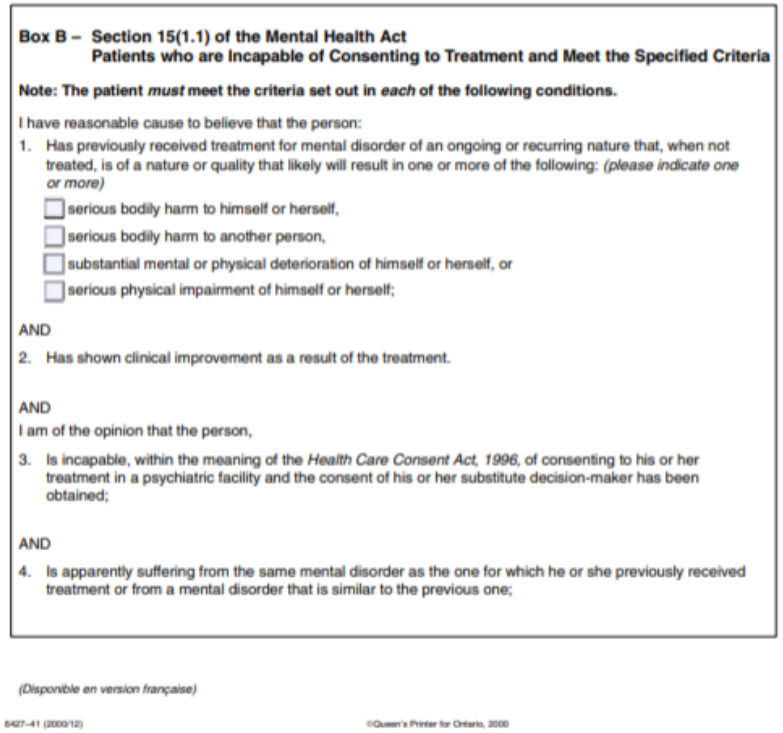
"Counselor reports…"

This is Box B:

Avoid this unless you are sure you have all criteria and are very confident in using this:

1. Past treatment for a disorder which caused a risk to self/others
2. Improved with treatment
3. Is incapable as per HCCA AND SDM agrees to treatment
4. Is having the same disorder again
5. Given the history AND current symptoms this is likely to results in harm again

DO NOT USE BOX A and BOX B together



Box B – Section 15(1.1) of the Mental Health Act
Patients who are Incapable of Consenting to Treatment and Meet the Specified Criteria

Note: The patient *must* meet the criteria set out in *each* of the following conditions.

I have reasonable cause to believe that the person:

1. Has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in one or more of the following: *(please indicate one or more)*
   - ☐ serious bodily harm to himself or herself,
   - ☐ serious bodily harm to another person,
   - ☐ substantial mental or physical deterioration of himself or herself, or
   - ☐ serious physical impairment of himself or herself;

AND

2. Has shown clinical improvement as a result of the treatment.

AND

I am of the opinion that the person,

3. Is incapable, within the meaning of the *Health Care Consent Act, 1996*, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained;

AND

4. Is apparently suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;

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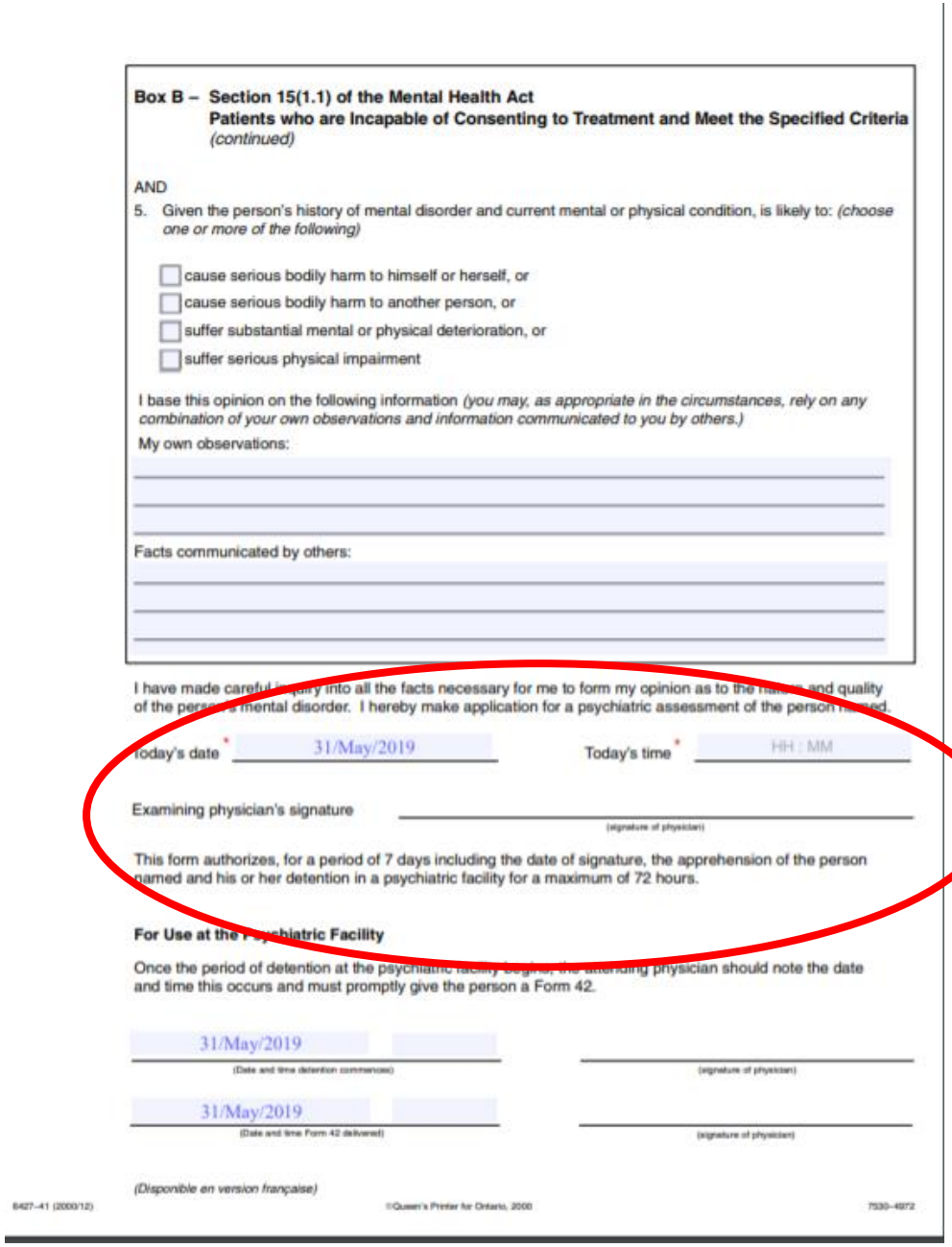
Last page

Sign only the part that is circled with the date, time and signature unless you are in a schedule one hospital.

DO NOT fill out the bottom, that is only for when they arrive at the hospital to start the 72 hour clock. You do NOT give them a form 42 until they arrive at the appropriate (schedule 1) hospital.



Box B – Section 15(1.1) of the Mental Health Act
Patients who are Incapable of Consenting to Treatment and Meet the Specified Criteria
(continued)

AND

5. Given the person's history of mental disorder and current mental or physical condition, is likely to: *(choose one or more of the following)*

- ☐ cause serious bodily harm to himself or herself, or
- ☐ cause serious bodily harm to another person, or
- ☐ suffer substantial mental or physical deterioration, or
- ☐ suffer serious physical impairment

I base this opinion on the following information *(you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)*

My own observations:

Facts communicated by others:

I have made careful inquiry into all the facts necessary for me to form my opinion as to the nature and quality of the person's mental disorder. I hereby make application for a psychiatric assessment of the person named.

Today's date * 31/May/2019 Today's time * HH : MM

Examining physician's signature

(signature of physician)

This form authorizes, for a period of 7 days including the date of signature, the apprehension of the person named and his or her detention in a psychiatric facility for a maximum of 72 hours.

For Use at the Psychiatric Facility

Once the period of detention at the psychiatric facility begins, the attending physician should note the date and time this occurs and must promptly give the person a Form 42.

31/May/2019 (Date and time detention commences)

(signature of physician)

31/May/2019 (Date and time Form 42 delivered)

(signature of physician)

(Disponible en version française)

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General approach

Make a logical connection:

“Patient told nurse they want to die, patient showed me a knife”

□ has threatened or is threatening to cause bodily harm to himself or herself

“Patient appears depressed, tearful, not making eye contact”

□ serious bodily harm to himself or herself

keep in mind there is a box for **causing another person to fear bodily harm, which may include your clinic

The Mental Health Act

“The Mental Health Act sets out the powers and obligations of psychiatric facilities in Ontario. It governs the admission process, the different categories of patient admission, as well as directives around assessment, care and treatment.

The Act also outlines the powers of police officers and Justices of the Peace to make orders for an individual, who meets certain criteria, to undergo psychiatric examination by a physician. Patient rights are also referred to, including procedural details such as rights of appeal to the Consent and Capacity Board.”

CMHA, https://ontario.cmha.ca/provincial-policy/criminal-justice/mental-health-and-addictions-legislation/

Police Apprehension/Wellness Check/“Emotionally Disturbed Person”

Mental health act, section 17

“17 Where a police officer has reasonable and probable grounds to believe that a person is acting or has acted in a disorderly manner and has reasonable cause to believe that the person,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or

(c) has shown or is showing a lack of competence to care for himself or herself”

https://www.ontario.ca/laws/statute/90m07#BK14

Are there other forms?

For example, the patient is reassessed in hospital and continues to make threats and express paranoid content. He is placed on a form 3, and a Rights Advisor advises him of his right to have a hearing.

There are a number of other forms under the Mental Health Act

These are generally used by psychiatrists in psychiatric facilities

These have different meanings, for example, a form 3 lasts for a maximum of 14 days

5

Capacity and referrals

“Fred”

Fred was admitted to the mental health unit for a three weeks. During that time he was found incapable to consent to treatment and the unit phoned his sister to make medication decisions for him. You are not sure what the implications of this are, and wonder if you could refer him to a program that has more appropriate services than you RAAM clinic.

In your small groups, please consider:

- ❑ What does incapacity to consent to treatment mean in this case?
- ❑ If Fred asks you to switch his antipsychotic back to the one you used before, instead of the one in the hospital, should you? How would you? What does it mean if you do?
- ❑ What kind of service might be most helpful for Fred right now?

Capacity and Consent to Treatment

Treatment capacity is SEPARATE from hospitalization or detention

Consent is based on capacity, and there is no age of consent in Ontario

Ontario's *Health Care Consent Act* defines capacity with respect to treatment as follows:

"A person is capable with respect to a treatment…if the person is able to understand the information that is relevant to making a decision about the treatment…, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision."

- ❑ capacity is specific to the treatment
- ❑ consent must be obtained prior to starting a treatment (except in emergencies) by the capable person or incapable person's substitute decision maker
- ❑ any inpatient or outpatient can contest a finding of incapacity, with respect to any treatment by requesting a hearing of the Consent and Capacity Board

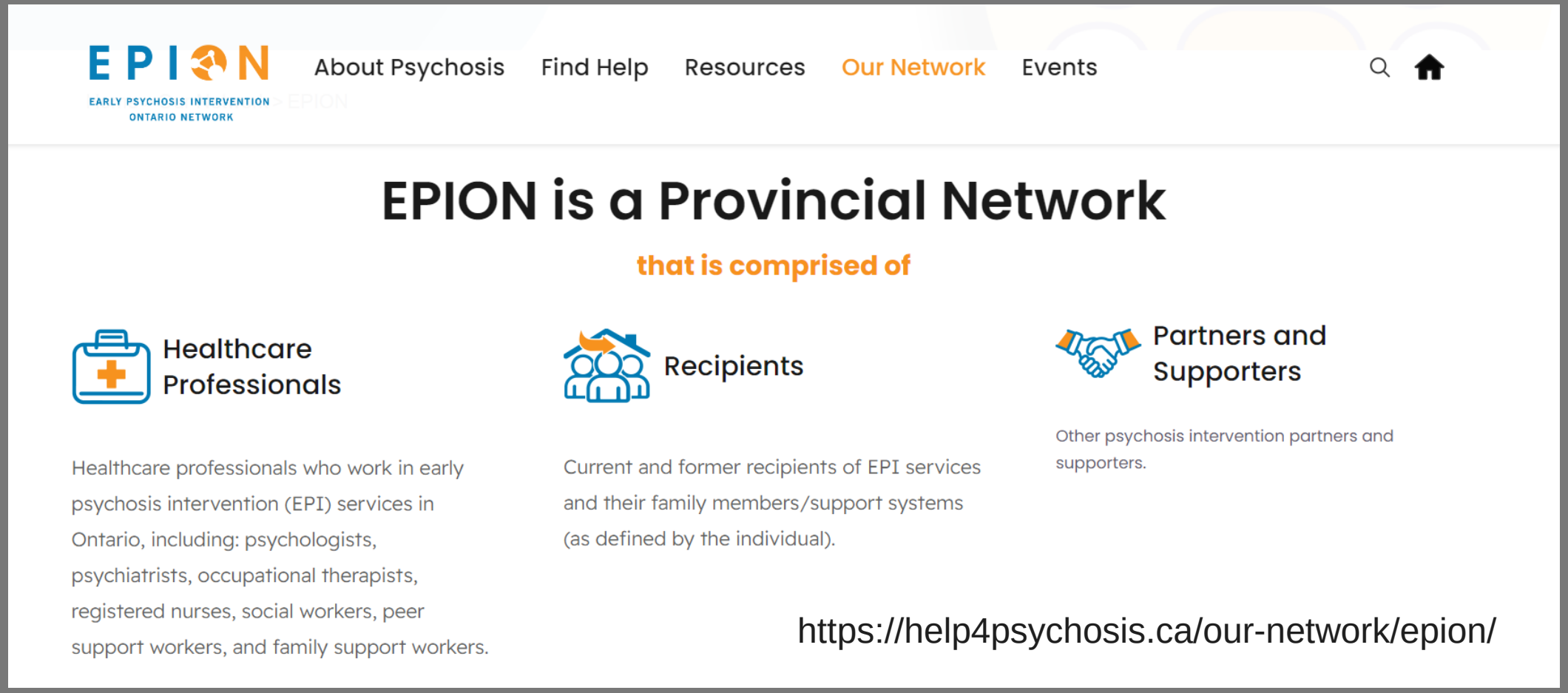
Incapacity findings can be reversed by making a finding of capacity. ***We make capacity findings (by default) most of the time, because patients are presumed capable.***

Assertive Community Treatment

https://ontarioactassociation.com/resources/

- ❑ team-based care for patients who have had significant hospital admissions
- ❑ team members include doctors, nurses, case workers, counsellors, peer support workers
- ❑ often provide care for patients on Community Treatment Orders
- ❑ according to this resource, 100% of Ontario ACT are over capacity

Early Psychosis Intervention



Thank you

To the whole team at the Brant Haldimand Norfolk RAAM who do this work every day and for their contribution to these slides and incredible teamwork.

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