Canadian Consortium for Early Intervention in Psychosis

Substance Use Disorder and First Episode Psychosis

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Disclosures

None

Objectives

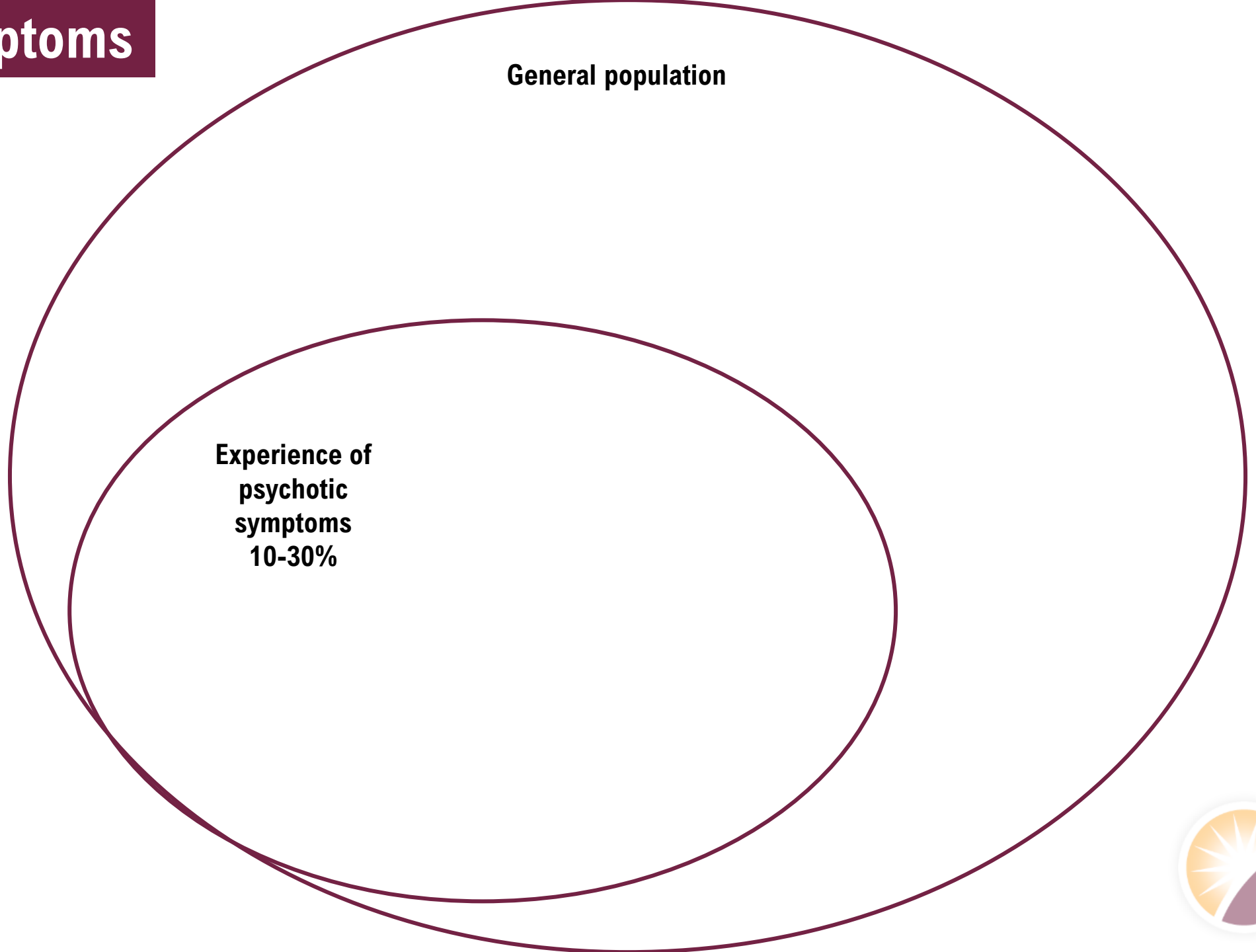
- Know the link and the impact of substance use on the development and maintenance of psychotic symptoms

Based on a clinical vignette;

- Discuss induced versus primary psychotic disorder and its management
- Discuss therapeutic interventions for co-occurring disorder (substance use disorder (SUD) and first episode psychosis (FEP))

Know the Link and Impact of Substance Use on the Development and Maintenance of Psychotic Symptoms

Psychotic Symptoms



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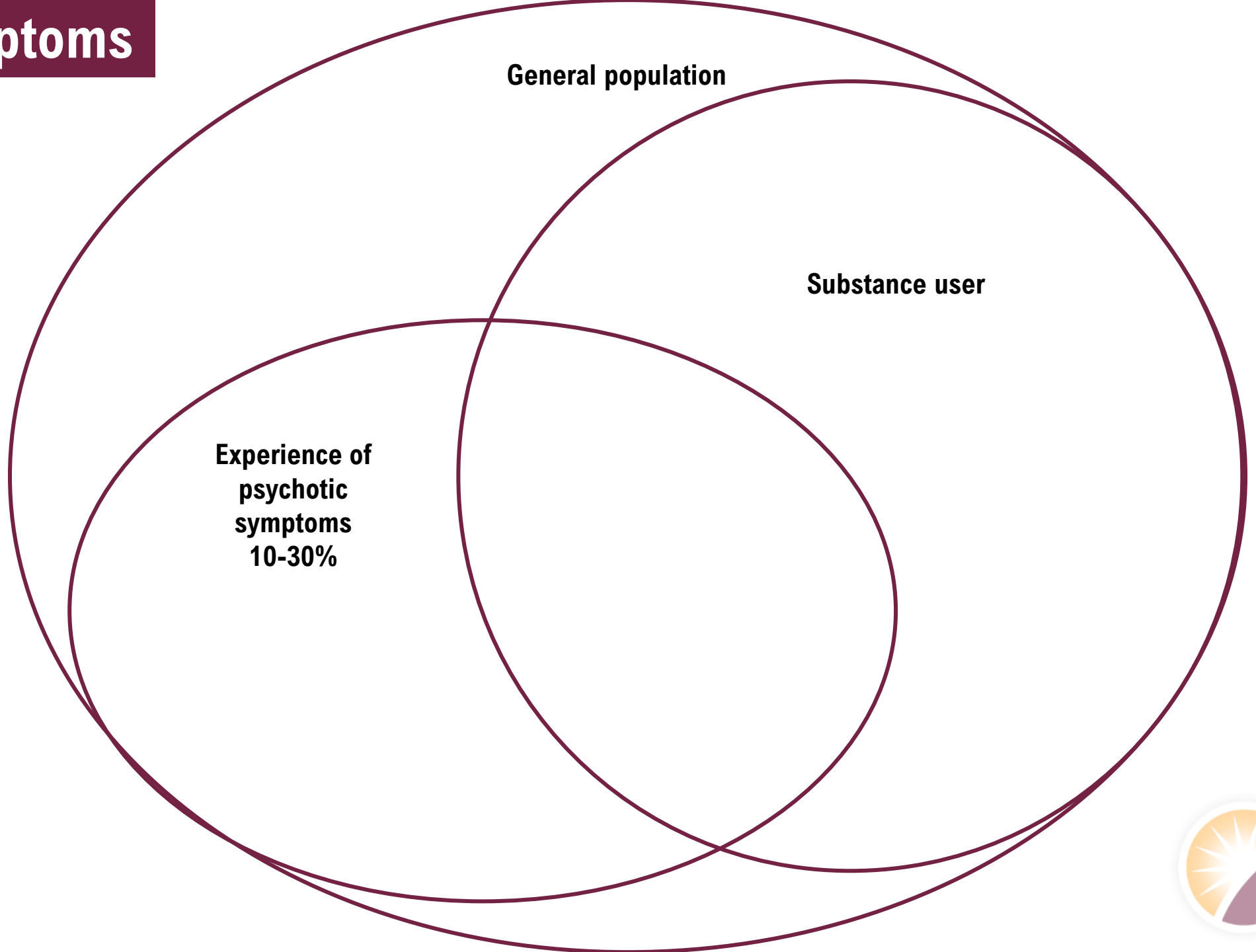

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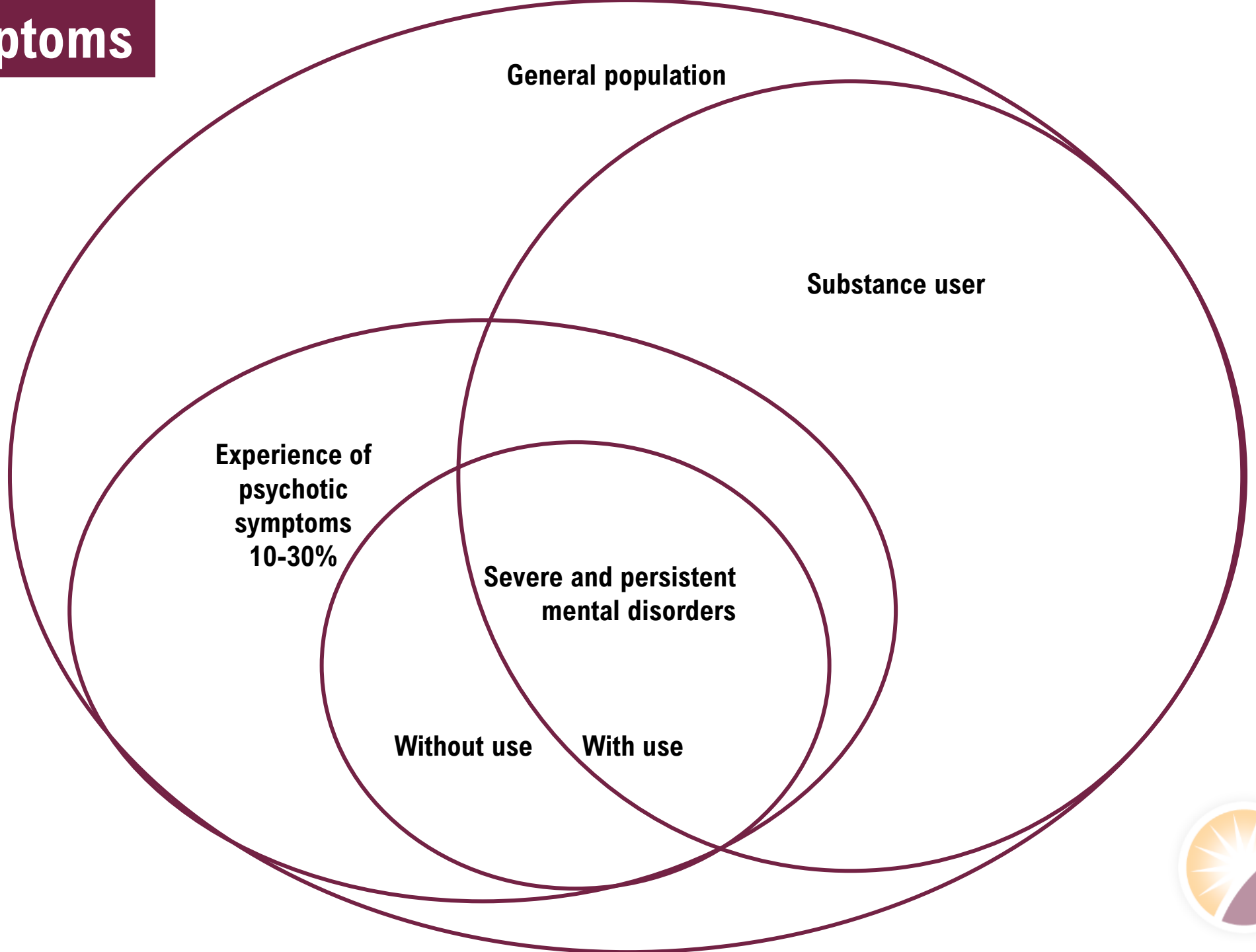

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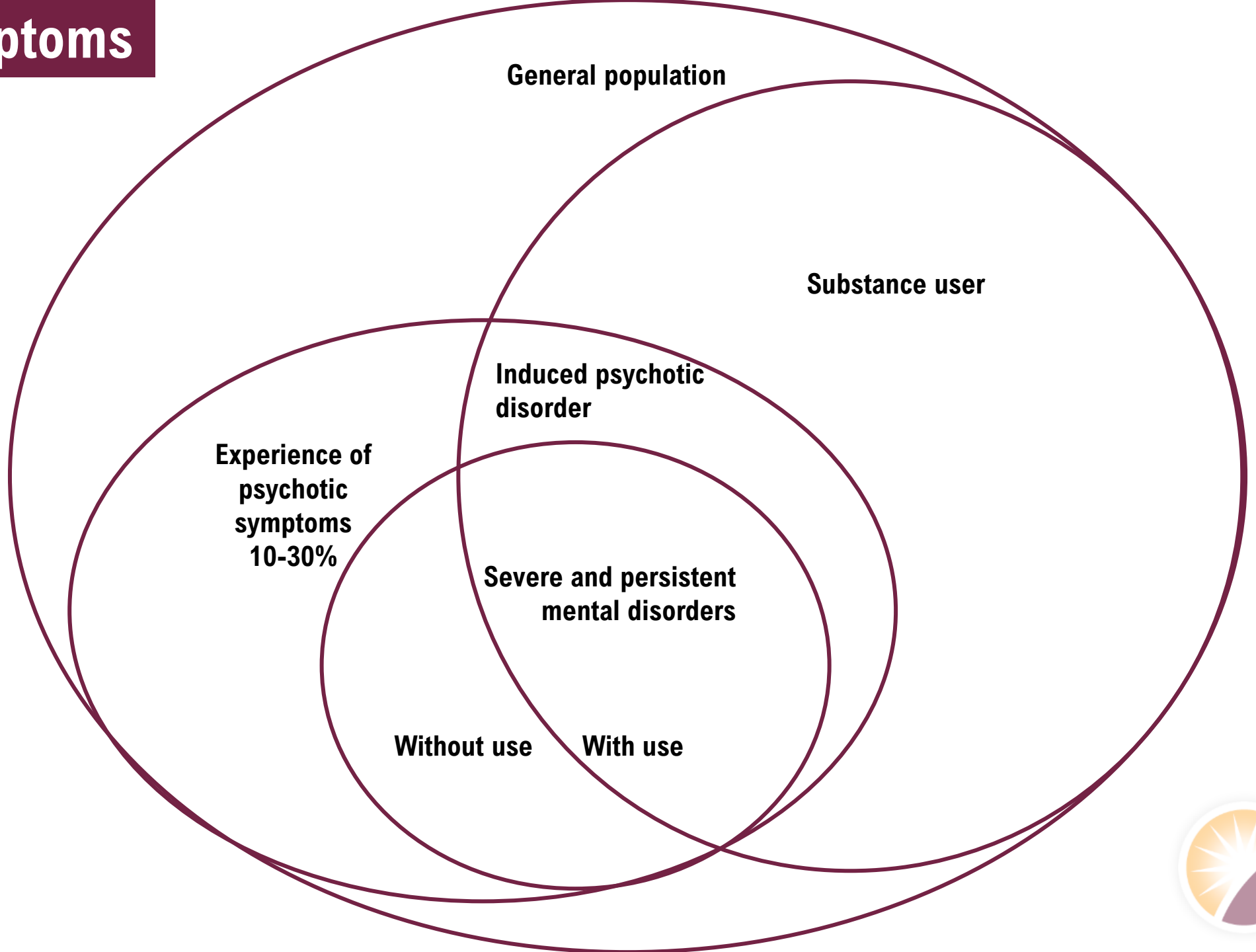

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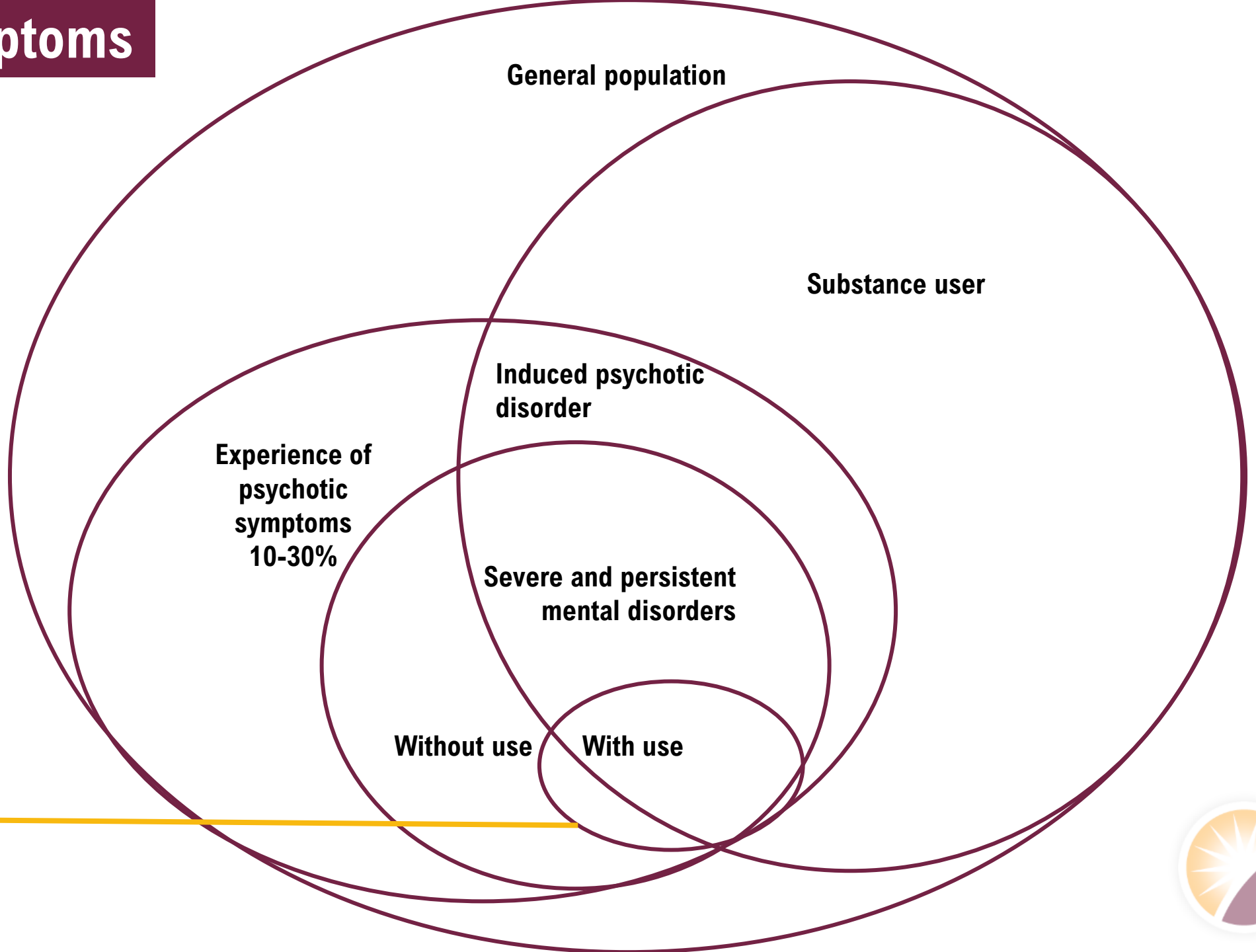

FEP + SUD at admission 59% of patients
(Abdel-Baki et al, 2017)

What is the most common substance used to induce psychotic disorders?

a) Tobacco
b) Alcohol
c) Cannabis
d) Cocaine
e) Amphetamines
f) Opiates

From Induced Psychotic Disorder to Primary Psychotic Disorder

- Schizophrenia spectrum or bipolar conversion rate: **32.2%**
  - 26.0% schizophrenia, 8.4% bipolar
- Chronic disorder initially induced by:
  - **Cannabis: 47.4%**
  - Mixed: 35.0%
  - Amphetamines: 32.3%
  - Hallucinogens: 27.8%
  - Alcohol: 22.1%
  - Opiates: 20.9%
  - Cocaine: 20.2%
  - Sedative: 19.9%

Review **amphetamine-induced** disorder to primary psychotic disorder : **22 - 33%**
(Bramness and Rognli, 2016)

Starzer, 2018

Substance Use vs. Substance Use Disorder

Cannabis

- In the past 12 months (Canadian Cannabis Survey, 2020)
  - M 31% F 23%
  - 16-19 years old: 44%.
  - 20-24 years old: 52%.
  - 25+ : 24%
  - Less than one day a month 35% ----- every day 18%

- Cannabis Use Disorder (CUD)
  - General population: approximately 9-10% (National Academies of Sciences, Engineering, and Medicine. 2017)
  - First Episode Psychosis (FEP): 43% (Abdel-Baki et al, 2017)

Risk of Psychotic Disorder and Cannabis

- Compared to those who have never used cannabis: **ever use OR 1.41**, frequent use OR 2.09 (Moore et al, 2007)

- There appears to be a **dose-response** effect with risk up to 3.9 (**OR 3.90**) for daily use (Marconi et al, 2016)

- **Daily use OR 3.2** compared to never having used cannabis
- **High THC** (10%+) **OR 4.8** (DiForti et al, 2019)

- Cannabis associated with early onset: **2.7 years earlier**, and may trigger psychosis (Large et al, 2014)

Risk of Psychosis and Stimulants

- 13-25 years old on methylphenidate or **amphetamines** (1:660) (Moran et al., 2019)

- Risk factors for psychosis in methamphetamine users :
  - Qt, frequency of use and severity of dependence: 3-11 times + risk
  - Poly-drug addiction, especially alcohol addiction and frequent cannabis use
  - No related socio-demographic factors
  - Inconsistent: duration, starting age

Systematic review, 20 articles, low to moderate quality; Arunigiri et al, 2018

Psychotic Disorder + SUD: Consequences

Associated with a poor prognosis

- More severe psychopathology (Faridi et al., 2012)
- More positive symptoms (Harrison et al., 2008)
- Higher relapse rate (Malla et al., 2008; Wade et al., 2007)
- Worse for multiple SUD and stimulant (amphetamines, cocaine) (Ouellet-Plamondon et al., 2017)

The damage is done?

If Use is Stopped…

- Improved prognosis
  - More employment/education, better social functioning, less positive symptoms (Abdel-Baki et al, 2017)

- Cannabis arrest vs. continuation:
  - Fewer relapses, shorter hospital stays, fewer positive symptoms (Schoeler et al, 2016)

Which Substance Costs Canadian Society The Most?

a) Tobacco
b) Alcohol
c) Cannabis
d) Cocaine
e) Amphetamines
f) Opiates

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Tobacco + Alcohol = 63% of costs
66,000 preventable deaths in 2017

Opioid crisis: more than 5,000 opioid-related deaths in 2017

46 billion per year
More than 1200$/Canadian

Costs and harms of substance use in Canada (2015-2017)

Discuss Induced Versus Primary Psychotic Disorder and its Management

Case Study: Philip

- 25 years old, Caribbean origin, in Québec for more than 6 years, married, no occupation, wife supporting him.
- Long time cannabis user, about 2g per day
- FEP
  - 1st contact via hospitalization 1 week
  - Auditory hallucinations with mandatory content and paranoia for a few days
  - Increase in cannabis use over the past 1-2 weeks (relationship stressor)
  - Treatment: risperidone 2mg hs, rapidly improved
  - He no longer has symptoms at discharge but has several side effects: numbness, sexual dysfunction, weight gain, and increased snoring

Induced vs. Primary Psychosis?

- Age of the person
- Detailed substance use and symptoms timeline
- Duration of symptoms when consumption is stopped
- Evolution
- Intensity
- Type of symptoms (typical of the substance?)
- Collateral information and family history
- Deterioration of functioning?

Case Study: Philip (continued)

Induced vs. primary psychosis?

- What do we do?
  a) The medication is maintained for 18 months as recommended by the Canadian guidelines before considering a change?
  b) We change the medication for a molecule that would have fewer side effects?
  c) Gradual withdrawal from risperidone is attempted, based on the likelihood that the disorder is induced and not primary?

Case Study: Philip (continued)

- Importance of collaborative decision making, the affected person is at the heart of his or her treatment
  - Psychological education for the young man and his family
    - Individual and couple
    - Family group and youth educational groups offered (non-participation)
  - Discussion of the balance of benefits vs. risks vs. side effects
  - Discussion of the overall treatment following a FEP: medication, psychological treatment, occupational and vocational project, overall health including healthy lifestyle habits

Case Study: Philip (continued)

- 1st year of follow-up without recurrence or consumption:
  - Gradual reduction of medication as Philip wants complete cessation
  - Risperidone 0.25mg + PRN at 1 year
- Follow-up
  - Teaching the warning signs of relapse to the young adult and his spouse
  - Work on healthy lifestyle habits
    - Follow-up encouragement with a peer worker, kinesiology group by vidioconference 3 times a week, sports group (but difficult to attend...)
  - Relapse prevention for cannabis use
  - Working on the current problem: disabling social anxiety

Case Study: Philip (continued)

- 2nd year follow-up
  - Relapse (relational stressor and death of a loved one)
    - Hospitalization 1 month
    - Auditory hallucinations in the foreground
    - Treatment: change to aripiprazole 30mg die + olanzapine 20mg hs + trazodone 100mg hs
  - Gradual disappearance of residual symptoms over 2 months
  - Global health
    - Symptoms of sleep apnea: sleep clinic consultation
    - Addition of metformin for antipsychotic-related weight gain
    - Encouragement and support for physical activities and healthy lifestyles
  - Family meeting with the youth's mother

Case Study: Philip (continued)

- 3rd year follow-up
  - Aripiprazole per os monotherapy
    - Fear to decrease the medication but pressure from wife to do so
  - Symptoms
    - No psychosis. Anxiety improving with gradual exposition
  - Global health
    - Symptoms of sleep apnea: CPAP (continuous positive airway pressure)
    - Metformin
    - Encouragement and support for physical activities and healthy lifestyles: outreach with a peer worker
  - Continued gradual exposure objectives
  - Team transfer preparation in general psychiatry

Induced vs. Primary Psychosis?

- Significant transition from induced to primary psychosis
  - Importance of following these persons
  - 50% risk vs. 50% chance of not developing a disorder...
  - Importance of informing people with concurrent FEP and SUD, and accompanying them in their decision and their journey

Induced vs Primary Psychosis? Integrated Treatment Plan

- Bio
  - Treat as primary disorder, stop under medical supervision
- Psycho
  - Psychological education
  - Motivational interviewing and cognitive-behavioral techniques adapted to the stage of change
  - Issues related to the crisis/situation
  - Teamwork: psychiatrist / case manager / peer worker / Addiction readaptation centre
- Social
  - Involve the network if possible + psycho-education
  - Housing okay?
- Harm reduction
  - Reduce use, other substances, safe environment
  - Screening STBBIs, etc.

Discuss Therapeutic Interventions For Co-Occurring Disorders (FEP and SUD)

SUD and Psychosis… Different Trajectories

- *Travis* ------ Induced psychosis
- *Michelle* ------ Induced psychosis that becomes chronic by perpetual substance use
- *Sonia* ------ Primary disorder with favorable prognosis + SUD, relapses not always related to use
- *Melissa / Igor* ------ Primary disorder with mixed prognosis + variable SUD during follow-up, SUD having an impact occasionally
- *Paule / Zac* ------ Primary disorder with significant impact of SUD: main barrier to recovery
- *Aline / Stéphane* ------ Primary disorder with significant impact of SUD: impasse

Psychosocial Interventions

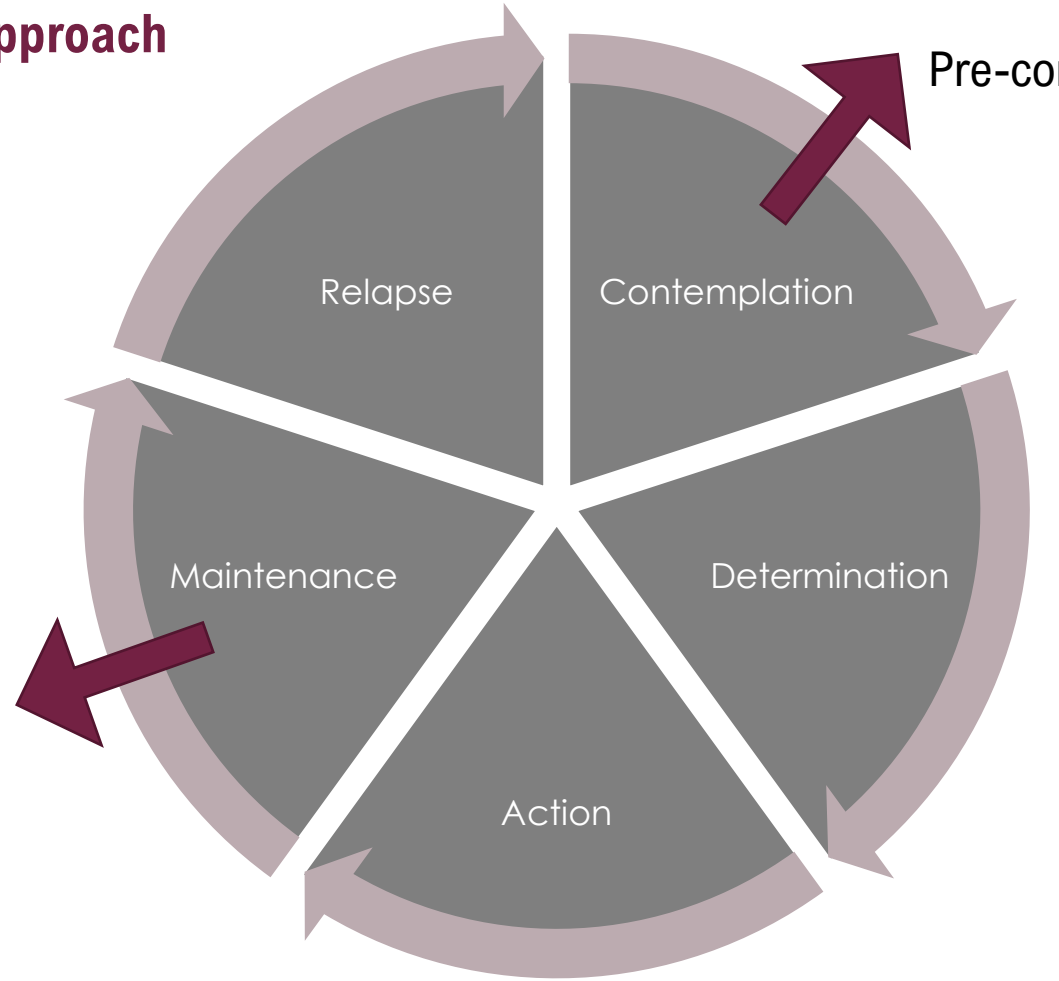
None demonstrated superiority in studies vs. follow-up in FEP clinic: 50% decrease in SUD in 1st year of follow-up

Few studies

Methodological limitations

Stages of Change

Cognitive-Behavioral Approach



Pre-contemplation

Motivational Techniques

Final exit from the issue

Psychological Education

- Address the most relevant information for the person
- E.g. cannabis: Risk on cognition, amotivation, foetus, driving, etc...
  - Cannabis health file INSPQ https://www.inspq.qc.ca/cannabis

Reliable info sources:

CCEIP : cannabis order set https://ippcanada.org/ressource/formulaire-dordonnances-standardisees-sur-le-cannabis-et-la-psychose-precoce/

: cannabis education file https://ippcanada.org/wp-content/uploads/2018/11/Cannabis-Educational-Folder-French-1.pdf

INSPQ : Cannabis and health file, alcohol and health file

Health Canada

Canadian recommendations for the safer use of cannabis https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/drugs-health-products/cannabis-10-ways-reduce-risks/lrcug-postcard-fra.pdf

INESSS: Alcohol withdrawal and relapse prevention

CAMH

AQPPEP

Premierepisode.ca

Cannabisandpsychosis.ca

Application Drugs and new trends in the RCMP

Motivational Spirit

- Goal: to encourage behavior change by helping to explore and resolve ambivalence about change (Miller & Rollnick, 1991)
  - Expressing empathy
  - Developing the discordance between life experience and personal values and goals
  - Supporting personal effectiveness
  - Dancing with the *resistance*
    - Avoiding direct confrontation
    - Suggesting without imposing
    - Use the emergence of resistance to modify your intervention strategy
  - Listen to the language of change
    - Must come from the person (freedom of choice, autonomy), but can be helped to develop.

Motivational Interviewing

- Importance
  - If this change was easy, how important would it be to make this change now, from 0 to 10?
- Trust
  - If you decided to make this change now, what would be your confidence level in making it, from 0 to 10?
  - What is needed to earn a point?
  - What can help?

Harm Reduction

- Attempts to mitigate the negative consequences associated with use. Does not give the green light to use drugs, but helps to better manage drug use when the person is not considering stopping.
- **Prioritized goals to address the most pressing issues first.**
- Reaching the most vulnerable
- A bond of trust that can make all the difference
- Help the patient to set a goal(s)

Harm Reduction Strategies

- Psychosocial impacts of substance use
  - Ensuring stability in housing
  - Encourage non-use social activities
  - Discuss/prevent the legal impacts of substance use
  - Accompanying in legal proceedings
- Financial implications
  - Make a budget with the youth, ensuring that basic needs are met
  - Helping the young person to settle his or her debts
  - Trust, if needed
- Focus on overall health (STBBIs screening, naloxone kit, hepatitis vaccines, contraception) and safe substance use

Pharmacology

Injectable antipsychotic = fewer relapses and hospitalizations and increased time to relapse

Clozapine may have an advantage

Treating substance use disorders:

- Tobacco
- Alcohol
- Opiates

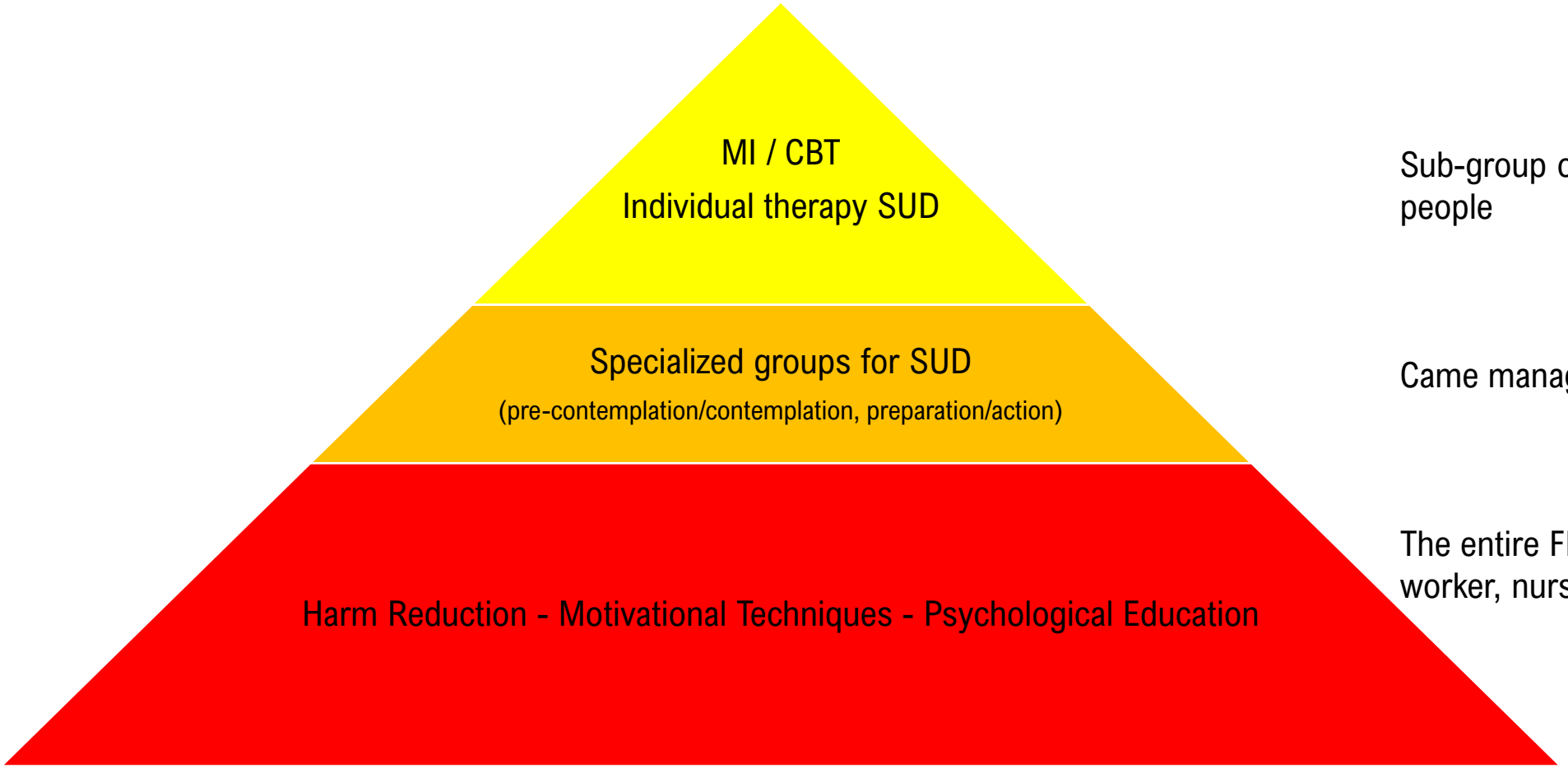
Naloxone kit for everyone!

Practice Guides

Integrated treatment adapted to concurrent disorder

- Case management
- Detailed assessment and feedback for SUD and psychosis
- Harm reduction
- Motivational interviewing / Cognitive behavioral therapy: adapted to the stage of change
- Pharmacotherapy
- If dangerous, consider hospitalization and/or referral to a rehabilitation service for long-term SUD treatment
- Provide culturally sensitive interventions

Staged Interventions for Substance Abuse



Sub-group of the team of a few specialized people

Came manager, peer worker

The entire FEP team: case manager, peer worker, nurse, psychiatrist

<u>Therapeutic Alliance</u>

Understanding the person (choices, needs, aspirations, limitations)

FEP - SUD Particularities: Challenges and Opportunities

- Age and developmental stage: discovery, pleasure, impulsiveness, immaturity
- Circumstances leading to treatment: voluntary or involuntary
- Widespread use among peers: often normalized in the environment, socialization
- Secondary cognitive difficulties: less present at the beginning of the course
- Network more present but family distress often high

In Conclusion

- Concurrent disorder is very prevalent and associated with a poorer prognosis, but there is a noticeable improvement upon cessation of use
- Induced psychotic disorders should be taken seriously as they may be a precursor to a severe disorder
  - Adapt the approach and follow-up accordingly
- An integrated treatment, according to the stage of change of the person and the severity of the disorders is to be recommended

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Questions?

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