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MANITOBA OPIOID AGONIST THERAPY RECOMMENDED PRACTICE MANUAL

1.12 Managing Co-Occurring Psychiatric Disorders in the Context of Opioid Use Disorder

GENERAL CONSIDERATIONS

In prescribing opioid agonist therapy (OAT) for patients with opioid use disorder, providers are certain to see some individuals presenting with psychiatric symptoms of a mental health disorder. Patients can present with symptoms of anxiety, depression, and/or psychosis. It is often very difficult to tell if these symptoms are a natural part of the recovery process, induced by substances, a normal reaction to a stressful life, or rather indicative of a psychiatric disorder requiring specific medication or psychotherapy .

This chapter will cover basic principles of psychiatric assessment of patients being treated for opioid use disorder (OUD) and provide recommendations for management of mental health symptoms. Assessment and treatment of some specific psychiatric symptoms will also be discussed, along with a brief review of issues related to personality disorders, in the context of managing opioid use disorder.

General Principles of Mental Health in Addiction

The OAT prescriber must recognize that that it is impossible to make a definitive psychiatric diagnosis and formulate a successful treatment plan when substance use is out of control. Generally*, stabilizing substance use and harm reduction measures should take priority over prescribing psychiatric medications in the initial stages of treatment.

*Acute psychosis or mania may be an exception and will be discussed in more detail later in this chapter.

Negative emotions are extremely common in early recovery. In fact, people are unlikely to make changes until they have experienced negative consequences because of their addiction. These consequences are often associated with uncomfortable feelings and emotions.

Substance use disorders can mimic primary psychiatric disorders by different pathways:

- **Intoxication**: For example, intoxication with stimulants can cause psychotic symptoms.
- **Withdrawal**: Commonly, mild withdrawal from benzodiazepines or alcohol often presents with increased anxiety, even without physiological signs of sedative withdrawal. Anxiety, poor sleep, loss of appetite, low motivation, and loss of interest can all be associated with opioid use, particularly in withdrawal.
- **Chaotic & dangerous lifestyle**: This is often required to maintain the addiction and pattern of use. The daily need to get money to buy opioids/other drugs, to safely purchase supplies, to find a safe place to use, and to prevent troublesome circumstances (e.g., being robbed, "ripped off", injured, or arrested), along with the cycle of intoxication and withdrawal, will inevitably lead to disturbances in mood, behaviour, and cognition.
- **Regular long-term use of substances**: This can lead to symptoms identical to primary psychiatric disorders. The best evidence of this is with long-term use of alcohol causing major depressive features, but long-term use of cannabis, benzodiazepines, and opioids can also be associated with depression. The best treatment is usually abstinence along with lifestyle changes and supportive therapy with cognitive behavioural therapy (CBT) elements. The value of 12-step/peer-support groups cannot be understated for many individuals in recovery.

SPECIFIC CONSIDERATIONS

This manual section offers expertise and recommendations for the care of patients with OUD under the following headings:

- Separating a primary psychiatric disorder from substance-induced disorder
- Key principles when considering psychiatric medications
- Depression & anxiety
- Post-traumatic stress disorder
- Psychosis & schizophrenia
- Attention-deficit/hyperactivity disorder
- Personality disorders
- Sleep disorders

Helpful resources are linked throughout and listed in **Appendix L**.

SEPARATING A PRIMARY PSYCHIATRIC DISORDER FROM SUBSTANCE-INDUCED DISORDER

Step 1 – A proper psychiatric history

A psychiatric history and assessment, taken when patients are seen prior to initiating OAT, is recommended. However, it can be difficult to get a complete history while the patient is experiencing acute symptoms. Providers may need to complete a more thorough psychiatric review as patients stabilize on OAT, or as new symptoms present.

Essential parts of the psychiatric history include:

- **Review of past psychiatric hospitalizations/emergency visits**. If there is a history of these, get consent to obtain the medical records of the encounters. Gathering collateral information from family may also be helpful.
- **Review of prescribed psychiatric medications**. If there is past or current use of prescribed psychiatric medications, obtain consent for relevant records and review E-chart and/or DPIN as able.

  If the patient is presently prescribed **psychoactive/sedating medications, particularly benzodiazepines**, it is strongly recommended the OAT provider take over prescribing and limit the amount dispensed. Ideally, if ongoing prescribing is indicated and effective, the dispensing frequency should mirror the OAT dispensing schedule. Communication with the patient's primary care provider, pharmacy, and/or specialist(s) is also required to review the plan and rationale for the OAT prescriber to take over prescribing these medications. It is important to emphasize that the primary care provider and/or specialist(s)'s care is still essential to the patient's other medical needs, while highlighting that **some changes to the medication regimen may be required for safe OAT induction and ongoing care**. Likewise, good communication with the pharmacy promotes interprofessional collaboration, patient safety, and consistent messaging around medication management. The chapter, Managing Polypharmacy, Benzodiazepines, Alcohol, & Polysubstance Use in OAT, provides detailed recommendations for managing psychoactive/sedating medications and benzodiazepines.

  Briefly, the concurrent prescribing of OAT and benzodiazepines is associated with increased mortality and should generally be avoided. Please see the polypharmacy chapter section, "Managing Prescribed and Illicit Benzodiazepines & Z-Drug use" for detailed guidance on this important topic.
- **Review of past psychiatric treatment or consultation**. Again, ask for consent to obtain these medical records. Discuss openly with the patient the importance of communicating with their circle-of-care providers as needed (e.g., family physician, pharmacist, psychiatrist, counsellors, and other professionals involved). This requirement for transparency facilitates patient safety for OAT induction and ongoing care, and is typically outlined in treatment agreements with patients (see the Comprehensive Assessment chapter for more details).

Step 2 – Chicken or the egg

Which came first? Psychiatric symptoms or substance use? If substance use preceded the appearance of psychiatric symptoms, this increases the likelihood that the symptoms are substance induced.

Step 3 – Ask about past abstinence

What happened during their longest period of abstinence? How did they feel – what happened with their symptoms? The DSM-5 states that if the symptoms are still prominent after a month, a primary disorder is likely. Review past instances of abstinence, associated life events, and the patient's experiences. For example, events that can be associated with longer periods of abstinence can include incarceration, work where urine drug testing is common (such as an isolated work camp), or pregnancy/perinatally (if the patient chose to remain mostly abstinent during this time). Note: These examples are generalizations only and are mentioned as a possible suggestion to gathering information in the interview.

Step 4 – Get a family history

Is there a family history of mental health issues? The more specific the history, the better. For example, a family history of bipolar disorder with several hospitalizations and successful treatment with Lithium is more useful information than "…everyone in my family is crazy, they just don't know it". Encourage patients to elaborate and seek details.

Step 5 – What are they using?

Are the symptoms consistent with the substance(s) they are using? For example, psychotic symptoms are very commonly seen with use of psychostimulants such as cocaine or amphetamines. However, if a patient reports psychotic symptoms with alcohol use, this is more suggestive of a primary psychotic disorder.

Step 6 – Objective observation

How does the patient look objectively when they are not aware you are observing them? This is much easier to assess when a patient is in a supervised environment such as a psychiatric ward, medical withdrawal-management unit, or a residential treatment facility. If they are observed to be outgoing and boisterous on the unit, but when you meet, they report marked anxiety symptoms and a need for prescribed benzodiazepines, this may be suggestive of "drug-seeking" behavior. For out-patient clinics, you may see incongruency in the patient's behavior in the waiting room compared to their presentation during the visit, which may also suggest drug-seeking behaviour.

It is not uncommon for patients to struggle with difficult thoughts and feelings, particularly in early recovery, when the numbing and sedating effects of regular drug use have lifted. They

may still seek prescribed or over-the-counter medications (other than their drug of choice) to alleviate this discomfort. **Learning coping skills and distress tolerance in recovery takes time.** Remind and encourage patients that navigating difficult states of mind, and the associated physiological and psychological symptoms, is part of recovery. The OAT provider can help differentiate between behaviours and symptoms that stem from a need to sooth unwanted thoughts and feelings, compared to symptoms of a primary psychiatric disorder.

Step 7 – Give it time

Given much of the above, a short period of observation is helpful before prescribing psychiatric medication. Generally, it is advised to optimize OAT first before adding psychiatric medication.

Step 8 – Explore the symptoms

Get a very clear idea of the patient's symptoms. A statement of "I'm depressed" does not necessarily mean a diagnosis of major depression. For example, some patients will report "anxiety" (and a need for benzodiazepine prescribing), but on further assessment they more accurately struggle with serious anger management difficulties.

Step 9 – Don't rush diagnosis

Be aware that individuals may have various reasons or "hidden agendas" in their complaints (e.g., looking for drugs, hospitalization, reasons not to work, etc.). Taking the time to gather collateral and medical records, and not rushing to make a diagnosis of a psychiatric disorder or decide on a clinical treatment plan, is often in both yours and the patient's best interest.

KEY PRINCIPLES WHEN CONSIDERING PSYCHIATRIC MEDICATIONS

There are at least four possible prescribing scenarios for patients on OAT and psychiatric medications. Some providers may prescribe all the patient's medications, including the OAT, psychiatric, and primary care medications (e.g., for high blood pressure, thyroid issues, diabetes, etc.). Some may prescribe the OAT and primary care medications, while the psychiatric medications are left to the psychiatrist to manage. Conversely, some may prescribe the OAT and all psychoactive/sedating medications, while primary care providers manage the other medications. And some prescribe only OAT, although this is **not recommended** (unless in the context of a RAAM clinic or emergency/urgent care, where OAT may be initiated and even titrated short term, with appropriate and timely communication back to any primary care or specialist providers and pharmacies involved).

It is **strongly recommended** that the community-based OAT provider take over prescribing of any psychoactive and/or sedating medications to mitigate risk of overdose or misuse, by implementing the medication management strategies recommended in this manual. Please refer to above mentioned chapter regarding polypharmacy and benzodiazepines for detailed recommendations about the OAT provider's role in managing psychoactive/sedating medications.

If there is more than one prescriber involved, **all prescribers must communicate with each other to minimize the chance of dangerous drug interactions and accidental medication overdose**. If the psychiatrist wishes to continue managing the psychoactive/sedating medications, collaboration and communication is key, and the dispensing schedule for these medications should mirror the OAT dispensing schedule in most circumstances.

Communication must also occur with the pharmacy about the plan for managing these medications. Controlled dispensing instructions, such as "dispense as per OAT schedule", must be written on all relevant prescriptions. If there is more than one prescriber involved, ideally all medications should be dispensed through one pharmacy. This will minimize the chances of adverse drug interactions.

There may be occasional circumstances when the prescriber's risk assessment, considering all medications and psychosocial factors, would safely allow for less controlled dispensing of psychoactive/sedating medications. Clinical judgment can be applied; for example, if a patient is paying out of pocket for medications and there are no high-risk behaviours identified, the additional cost of daily dispensing may not be justifiable. **The prescriber must document their risk assessment and rationale for dispensing intervals that diverge from the OAT schedule**.

PRESCRIBING ESSENTIALS: PATIENTS ON OAT & PSYCHIATRIC MEDICATIONS

1) Communicate with other prescribers, pharmacists, and other professionals within the circle of care. Be transparent with patients that consenting to this communication is important for safety (often outlined in treatment agreements when initiating care and revisited as needed).
2) Patients with substance use disorders are accustomed to taking substances as they see necessary to alleviate mood or anxiety symptoms. As a result, emphasize the need to take psychiatric medication exactly as prescribed, and not to change the dose or timing unless they have spoken with the prescriber.
3) Avoid polypharmacy or doses higher than recommended. As a rule, it is advisable to ensure one medication is at an optimal dose before prescribing a second.
4) Minimize the use of "prn" mediations. This may lead to overuse, or the failure to use healthy coping strategies before reaching for medication or a "chemical fix."
5) Set realistic expectations with the patient. It is very unlikely that a medication will alleviate all symptoms completely – a modest reduction in symptoms is the most likely outcome.
6) Be cautious of the amounts dispensed to minimize the risk of overdose or diversion – dispensing should mirror the OAT witness and carry schedule in most circumstances.
7) Monitor compliance by checking DPIN, ordering occasional comprehensive urine drug screens (UDS) in addition to point-of care testing, and conducting pill counts as needed. See other chapters of this manual for detail guidance around UDS use.

The information presented here is consistent with the latest Substance Abuse and Mental Health Service Administration recommendations (see TIP 42)[1]. Free resources are available at samhsa.gov.

DEPRESSION & ANXIETY

Generally, symptoms of anxiety and depression will show substantial improvement within two to four weeks of abstinence. **Pharmacological treatment is usually not recommended until OAT is optimized**. However, telling the patient they are "not really depressed" may come across as invalidating to them and may negatively impact engagement in care. Most patients will accept that there are different subtypes of depression/anxiety (e.g., substance-induced vs bipolar vs major depression), each with its own recommended treatment. Offer support and encouragement, while noting that it is impossible to know the best treatment without a period of abstinence and assessment.

If depressive symptoms continue despite optimizing OAT, further assessment should include:

- Review the course of depressive symptoms, specific symptoms of depression, and psychosocial stressors.
- Review recent substance use with the patient. A comprehensive UDS can be informative; but note that generally urine screening does not detect alcohol. Point-of-care UDS does not detect alcohol and possibly some benzodiazepines – negative UDS results do not rule out ongoing substance use. See other manual sections for more guidance on urine drug testing.
- If not recently done, send the patient for lab work including CBC,TSH/T4, kidney function, liver function, glucose, Beta-HCG, and any other investigations suggested by a review of systems. Rule out if any physical health conditions may be contributing to symptoms.
- Review prior psychiatric system contact and treatment, as per *Step 1* above.

Management of Depression

If considering specific psychiatric treatment following assessment, several options are available:

1) For mild to moderate depression, some patients benefit from supportive therapy, behavioral activation including regular exercise (the best evidence is for aerobic exercise), and healthy lifestyle advice.
2) Specific psychotherapy for depression, especially CBT, can be effective. Some multidisciplinary clinics have counsellors that can provide this individually or in a group setting. Resources are also included in **Appendix L** and the patient handout, Emotions, Anxiety, and Addiction.
3) If prescribing antidepressant medication, an antidepressant with a low propensity for interactions or side-effects is generally the best initial choice. Additionally, a history of any prior antidepressant trials should be obtained.
4) Consultation with an addiction aware psychiatrist can be considered. There should be agreement between the OAT prescriber and the primary care provider about who will

request a consultation and who will prescribe any medication recommended. Preferentially the OAT provider should prescribe any psychoactive/sedation medications, as above.

Practical examples of the assessment and management of other mood and anxiety issues are outlined in the VIGNETTES for BARB and CHERYL, respectively.

VIGNETTE: BARB STRUGGLES WITH DEPRESSED MOOD

Barb is a 35-year-old woman in the clinic that has been stable on 75 mg of methadone for several years. The nurses all find her quite likeable; she has weekly dispensing and usually stops in to chat when she picks up her weekly doses and always treats the staff to her homemade baking. The staff book her into clinic on an urgent basis, as she has reported being increasingly sad, with no interest in previously enjoyed activities, poor sleep, loss of appetite and concentration, loss of energy, and thoughts of dying with no active suicidal plan.

When seen, she is close to tears for most of the interview and definitely not her usual energetic and bubbly self. A review of psychosocial stressors is unremarkable, there are no new physical symptoms, and she denies any substance use other then cannabis which she has been using regularly for years.

She reports being hospitalized for approximately 3 months on a psychiatric ward at age 23, but really cannot remember any details, other than she had follow-up for a couple of months and had to take some red and white capsules, which she discontinued long ago.

There are no acute safety issues; she is agreeable to meeting with the staff on Wednesday and Friday and seeing you again on Monday. She is sent for blood work to see if there is any physical contribution to her symptoms and she signs a consent for release of information to obtain her medical records.

The discharge summary from her past admission arrives later that week. It indicates she had a severe manic episode which required a lengthy psychiatric hospitalization – she was stabilized on Lithium and eventually discharged.

When seen the next week, she was started back on Lithium, agreed to more frequent meetings with her nurse, and her depression improved substantially over the next few weeks.

Teaching Points

- If an antidepressant had been started without knowing that Barb had a history of bipolar mood disorder, it may have precipitated a manic episode.
- Patients often do not have a perfect recollection of why they were in hospital or what the treatment was. This is probably because they are under a great deal of stress at the time.
- Additionally, patients are often prescribed relatively large doses of benzodiazepines and/or other sedatives to treat acute psychiatric symptoms when admitted to inpatient wards – this can interfere with the formation of new memories.
- Gathering collateral outside of patient report is essential.

VIGNETTE: CHERYL STRUGGLES WITH ANXIETY

Cheryl is a 22-year-old woman, recently started on OAT, presently at buprenorphine/naloxone 12 mg daily and titrating. At her initial assessment she reported regular use of IV hydromorphone, methamphetamine, benzodiazepines (non-prescribed), cannabis, and alcohol. She has witnessed dispensing 7 days a week. The nurses report she adheres to clinic expectations, but is quite emotional and labile. Her recent UDS was positive for fentanyl and cannabis. Cheryl states, "The guy must have laced the marijuana". She informs the nurses she wants to talk about anxiety at her next appointment.

Cheryl reports a very chaotic early life and upbringing. She was in a series of foster homes and has never had a period of stability. She has had several psychiatric assessments throughout her childhood and early adulthood, but no sustained follow up. She has been prescribed several different antidepressants, mostly of the SSRI class. She reports many side effects from these, and at no time have antidepressants been taken regularly for longer than two weeks.

A review of her psychiatric symptoms is positive for nearly *all criteria of all anxiety disorders*. She is increasingly irritable when you ask her to elaborate or give examples of symptoms. She mentions on more than one occasion that she has used her friend's Xanax – it was effective for all her symptoms and all she needs is for you to prescribe this for her. It is difficult to redirect her to discuss other treatment options. She leaves your office in a huff when she realizes you will not prescribe alprazolam.

Teaching Points

- The buprenorphine dose can likely be increased, based on clinical assessment and ongoing withdrawal. (See chapter on buprenorphine induction for details.)
- It is very unusual for illicit suppliers to lace cannabis with fentanyl. The most likely explanation is the continued use of fentanyl – hence the need for further OAT titration.
- CBT is the recommended first-line treatment for anxiety, regardless of the subtype. The handout Emotions, Anxiety, and Addiction lists community resources and recommended reading for the treatment of anxiety disorders.
- Benzodiazepines *are not* recommended as a first-line treatment for anxiety disorders. They are easy to start, but very difficult to stop, particularly for patients that have a pre-existing substance use disorder (SUD). At best, benzodiazepines are a third-line treatment for severe and acute issues in patients who do not have SUD and should only be considered when all other treatments have failed – they are *not recommended for individuals with OUD*. If benzodiazepines are used, dispensed amounts should be limited (mirroring the OAT schedule as described above), closely monitored and, ideally, short-term.
- Alprazolam seems to be the most requested benzodiazepine. This may be due to the rapid onset of action and short half-life; even patients without a substance use disorder can find themselves taking it more frequently than prescribed. CPSM standards of practice indicate alprazolam prescribing should be avoided, due to the risk of abuse and diversion.
- Non-benzodiazepine medications for anxiety are not necessarily benign. Quetiapine can be associated with serious metabolic effects including weight gain and diabetes. Some antidepressants have interactions with OAT (particularly methadone). If these options are chosen, they must be monitored carefully with limited dispensing.

POST-TRAUMATIC STRESS DISORDER (PTSD)

Many patients with substance use disorder have experienced traumatic events in their lifetime. This does not necessarily mean that they have post-traumatic stress disorder, even though they may report that they have PTSD.

PTSD is associated with a triad of symptoms including:

1) Re-experiencing the traumatic event through flashbacks or nightmares.
2) Avoidance of activities that remind them of the traumatic event.
3) Heightened arousal including symptoms such as being easily startled, disturbed sleep, and increased irritability or outbursts of anger.

Managing PTSD

Treatment generally begins with stabilizing the substance use disorder, along with initial cognitive behavioral recommendations, and learning *grounding techniques* that orient patients to the *here and now* and to utilize coping strategies. **This requires regular and consistent practice and rehearsal, when not acutely distressed, in order to successfully utilize these techniques in times of distress or when triggered**. Reliving the initial trauma is not recommended until stabilization and coping techniques have been achieved.

Occasionally, patients will indicate they have been diagnosed with complex PTSD. This refers to someone who has suffered numerous traumatic or abusive events during childhood and has developed symptoms that are consistent with a cluster B personality disorder, particularly borderline personality disorder.

Treatment recommendations for complex PTSD are similar to those with more classic PTSD. There are two programs in Winnipeg that have particular expertise in its treatment. The Short Term Assessment & Treatment (STAT) Program, a multidisciplinary day hospital at the Health Sciences Centre, can be a helpful resource. They offer courses in dialectical behavioral therapy (DBT), a specialized type of psychotherapy that has shown to be quite beneficial in patients with symptoms consistent with borderline personality and frequent suicidal ideation. The Co-Occurring Disorders Initiative (CODI) also offers DBT and specializes in consultation and management of concurrent mental health and substance use disorders, particularly for patients whose rehabilitation needs are not well met by less intensive programming. Both STAT and CODI require referral from a medical care provider who follows the patient longitudinally, to incorporate consultative recommendations into their care. Again, there should be agreement between the OAT prescriber and the primary care provider about who will initiate the referral and follow through on recommendations. Preferentially the OAT provider should prescribe any psychoactive/sedation medications.

Another program that may be helpful is the Heartwood Healing Centre which accepts self-referral and offers specialized treatment for individuals who have suffered abuse.

Medications & PTSD

The SSRI class of antidepressants has the most evidence for PTSD treatment. Benzodiazepines are *not recommended*. There is also some evidence to suggest the use of the antihypertensive medication prazosin can be helpful for treating nightmares related to PTSD. Before starting this medication, a baseline blood pressure and heart rate should be obtained, and blood pressure monitored during the initial stages of treatment.

Although there is a strong lobby for the use of "medical marijuana", the evidence for the successful use of cannabis in PTSD treatment is limited. Cannabis is not a benign substance and has effects on cognition and mood. Regular use, particularly of smoked cannabis, can lead to increased anxiety symptoms as the effects quickly wear off. This can exacerbate baseline anxiety already associated with PTSD.

If patients ask for specific recommendations on the use of cannabis, edible cannabis with a low THC content and high CBD content may be an option. Some case studies have suggested it may be particularly helpful for symptoms of nightmares. Please see the polypharmacy and polysubstance use chapter noted above regarding cannabis use. Additional information can be also found in the CPSM Standard of Practice for Authorizing Cannabis for Medical Purposes, which came into effect November 1, 2020.

PSYCHOSIS & SCHIZOPHRENIA

Symptoms of psychosis include hallucinations (usually auditory), delusions, and markedly disorganized thinking or behavior. Psychosis can be associated with several psychiatric disorders including schizophrenia, mania, psychotic depression, and substance use.

Patients with psychosis often require an urgent psychiatric assessment and possible psychiatric hospitalization. In Winnipeg, two resources that can provide rapid assessment are the Crisis Response Centre (817 Bannatyne Ave) and the Mobile Crisis Team which can be reached at 204-940-1781. If a patient does not wish to access these or other crisis resources, and you believe they are an imminent threat to themselves or others, or will suffer substantial physical or mental deterioration, any physician in Manitoba can complete a **Form 4 of the Mental Health Act**. This is an application for Involuntary Psychiatric Assessment which authorizes that a person can be taken to a facility for assessment by a psychiatrist. More information is available in the WRHA Mental Health Practice Guideline Appendix D Guide to Complete Form 4.

Substance-Induced Psychosis

Substance-induced psychosis will likely be the most common cause of psychosis seen in OAT practice. Schizophrenia is generally associated with disorganization of thinking and behavior, and frequently a lack of motivation, which can make it very difficult to execute the behaviours required to sustain daily opioid use.

Substance-induced psychosis is being seen more frequently in Winnipeg largely due to the increased community use of methamphetamine. Methamphetamine can cause a long-acting psychosis that is very difficult to differentiate from schizophrenia.

The psychosis that is caused by cocaine is generally short-lived (less than 24 hours) and often the psychotic symptoms are not bizarre in nature, but rather could have some basis in reality. For example, some common symptoms of cocaine-induced psychosis could be the patient believing that the police are hiding outside their residence, or are listening in on their telephone conversations. Conversely, methamphetamine-induced psychosis can be associated with more implausible delusions such as secret devices being implanted under the skin.

Patients with psychosis of any type generally require assessment in an emergency ward. If the psychosis resolves overnight, perhaps with the use of a sedative along with antipsychotic medication, it is generally assumed to be substance induced. The treatment recommendation is to stop using psychostimulants. Once a person has experienced psychotic symptoms because of psychostimulant use, the symptoms are far more likely to return in a more pronounced fashion and to last longer with continued use, due to a neurological phenomenon known as kindling.

If the symptoms do not resolve in the emergency ward, the patient is often admitted to psychiatry and treated with antipsychotic medications. If methamphetamine was being used, it becomes close to impossible to tell whether this was a primary psychotic disorder such as schizophrenia or induced solely by methamphetamine use. If the symptoms resolve in hospital, they are generally discharged with a prescription for antipsychotic medication.

Cannabis & Psychosis

The regular use of cannabis has also been associated with psychotic symptoms and a diagnosis of schizophrenia. One Swedish study indicated the prevalence of schizophrenia was six times higher than the normal population for patients that had used cannabis more than 50 times in their lifetime[2].

There is some debate in the literature as to whether cannabis causes schizophrenia, or causes the symptoms to appear earlier in one's life. In either case, it is **strongly recommended that patients with a psychotic disorder do not use cannabis, as it has a negative effect on prognosis**. If patients are insistent on using cannabis, they should be strongly encouraged to use a strain with a low percentage of THC. A benefit of legal suppliers and commercial storefronts for cannabis is that consumers can choose the strain that they use, including the THC/CBD content. Again, see the polypharmacy and polysubstance use chapter regarding cannabis use and OAT.

Investigations

If your patient presents with psychotic symptoms, some websites and advocacy agencies recommend a complete medical workup including a CT scan or MRI of the brain, and an EEG.

Generally, these investigations are not fruitful, however there are some red flags in the history that would suggest such tests be done on an urgent basis. Indicators of a potential medical cause of psychosis include:

- A history of seizures,
- Focal neurological signs, and
- Disorientation or delirium.

Treatment for Psychosis

Treatment recommendations for psychosis include stopping the use of those substances that may be contributing to the symptoms. If the physician believes that the psychosis is a primary disorder, first-line treatment is an antipsychotic medication.

There is some debate about the advantages of one antipsychotic over another. When choosing an antipsychotic, consider the potential for side effects. Many antipsychotics have marked metabolic side effects, including weight gain and diabetes, and caution should be used in prescribing these. Another consideration is whether the antipsychotic medication is available in a long-acting injectable form. There is substantial evidence that patients treated with a long-acting formulation of an antipsychotic are less likely to be hospitalized, will have more improvement in symptoms, and achieve greater functional improvement. **These decisions may be best made in consultation with a psychiatrist**. Collaboration and communication remain essential to build safety into the medication management plan – again the dispensing of any psychoactive medications should mirror the OAT dispensing schedule in most circumstances.

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD)

There has been an explosion in the diagnosis of ADHD and prescription of psychostimulant medication in both children and adults over the past 20 years. Some experts have suggested that the increase in diagnosis is due, in part, to sociological factors and technological innovations that cause constant interruptions in our day-to-day life.

ADHD has also been associated with an *increased* rate of substance use disorder, while proper treatment of ADHD, at least in children, has been associated with a *decreased* rate of substance use disorder.

There are many self-assessment forms available online that people can complete, and frankly, many people that complete these forms will test positive for ADHD and then assume that they have a diagnosis and need treatment, particularly with prescribed psychostimulants. **It is advisable that patients who report having ADHD symptoms, and who are requesting treatment, have an assessment by a psychiatrist or psychologist**. If the diagnosis is confirmed by a specialist who is well versed in ADHD assessment, there are some considerations before treatment is initiated.

Managing ADHD

There are many non-pharmacological measures that can be utilized before prescription medication is considered. There are several websites or self-help books available to learn self-regulation and coping skills. One resource that many patients have found helpful is "Driven to Distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood through Adulthood" by Hallowell and Ratey[3]. There is also evidence that regular aerobic exercise can be a useful treatment.

Prescribing Considerations for ADHD

If pharmacological treatment is considered, there are some non-stimulant medications that have a very low risk of addiction. These include atomoxetine and bupropion (Wellbutrin®).

If psychostimulant medication is considered, it is *not recommended* to prescribe an immediate release formulation such as methylphenidate (Ritalin®) or dextroamphetamine (Dexedrine®). These have a higher rate of addiction, and can be crushed and used by insufflation or intravenously. There are newer longer-acting and tamper-resistant formulations available that have a relatively low risk of developing a substance use disorder. Even though the risk for misuse/diversion of these newer formulations is lower than immediate release formulations, patients should be dispensed limited amounts at a time, ideally, mirroring the OAT dispensing schedule in most circumstances.

Compliance with psychostimulant medications must be monitored through comprehensive UDS, DPIN checks and, if indicated, pill counts. A comprehensive UDS is required to detect these specific medications. Of note, a comprehensive UDS can be used to not only check for the use of illicit substances such as cocaine or non-prescribed opioids, but also to check if prescribed medication is being taken.

Again, please see the polypharmacy and polysubstance use management chapter for further guidance around UDS use, particularly "KNOW YOUR TOOL: INTERPRETING COMPREHENSIVE UDS RESULTS" to understand the limitations of this test. If prescribers need a specific medication identified that is not included on the list of 80 substances tested for in Manitoba (often to monitor compliance with a prescribed medication), they may request Diagnostic Services test for that medication, by adding a written request on the comprehensive UDS requisition. The clinical rationale for needing this information should also be documented on the requisition.

PERSONALITY DISORDERS

Personality disorders are long-term patterns of behavior and inner experiences that differ significantly from what is expected. The pattern of experience and behavior begins by late adolescence or early adulthood and causes distress or problems in functioning.

Improvement is Gradual

Patients with personality disorders can be very disruptive to the clinic and lead to staff burn-out. However, psychiatric treatment is not fruitless for these individuals and gradual improvement is often seen, over the course of months and years. Some patients presenting with personality disorder symptoms markedly improve as OAT is optimized, but it is impossible to predict which patients will improve.

The STAT and the CODI programs outlined above may be helpful resources for some individuals with personality disorder, once substance use is stabilized. These programs will accept referrals for patients that are stable on OAT. Keeping local crisis numbers and resources handy for patients is also essential for times of increased distress or instability.

See **Appendix L** for more information on personality disorders. There is much information online and books published to better understand the experience of individuals with personality disorders. The Centre for Addiction and Mental Health patient booklet, Borderline Personality Disorder: An information guide for families[4] is a helpful resources for patients and clinicians.

Compassion combined with clear boundaries is often needed to support patients with OUD, particularly if the patient is struggling with personality disorder symptoms. It is important that all patients and prescribers understand their respective expectations and responsibilities when it comes to participating in OAT care. Mutual respect is essential and worth the investment of time and effort. **Reviewing and signing a Treatment Agreement that includes behavioral expectations is a useful tool to assist in clarifying roles and expectations**. A clear discussion of boundaries around behavior may be needed so that patients understand that threats or aggression to staff, pharmacists, or co-patients, will not be tolerated and may result in discontinuation of care. Treatment agreements can be revisited in early treatment when patients are stabilizing on OAT, ideally when they are clear-headed and able to retain more information, to ensure mutual understanding of expectations.

SLEEP DISTURBANCES

It is worth noting that sleep problems are a common experience for patients with substance use disorders and/or psychiatric disorders. Sleep problems also occur in healthy individuals as part of everyday day life. Likewise, this is a very frequent complaint of patients on OAT, particularly in early recovery.

The chemical roller-coaster of intoxication and withdrawal that accompanies regular substance use can greatly disturb the natural sleep-wake cycle and dismantle circadian rhythms. This warrants discussion, as a good night's sleep is essential to early recovery – to learn new skills, to emotionally regulate, and to manage triggers and cravings. Sleep is an important part of self-care to sustain sobriety.

Some patients will benefit from simple encouragement, teaching around sleep hygiene, and reassurance that sleep will improve as their recovery progresses. Often sleep improves naturally once patients stabilize on OAT and establish a healthier diurnal sleep-awake cycle, but this may also take several weeks.

Tips for a Good Night's Sleep

While quite common, discussing sleep problems in early recovery is essential. When sleep is jeopardized, particularly if patients are accustomed to chemical sedation for sleep, they may seek non-prescribed (illicit) or over-the-counter medications to induce sleep. This can increase their risk of accidental overdose.

Most patients will benefit from education on Sleep Hygiene practices. There is also good evidence for the effectiveness of CBT for insomnia as first-line treatment for sleep disturbances. Referral to the WRHA Psychology Services Sleep Disorders Online Treatment Program may be useful. Some patients can also navigate online and practice CBT for insomnia skills themselves, and there are several useful sites and apps available to promote sleep (see **Appendix L**).

Nighttime Sedation

If medications are considered for nighttime sedation, ideally these should be short-term and with limited dispensing for safety. Benzodiazepines and Z-drugs are *not recommended*. Discuss collaboratively with the patient that sleep aids may be used short-term to help reset the sleep cycle in early recovery. Highlight that they should be used alongside behavioral strategies that promote sleep as part of overall wellness.

Quetiapine and trazodone are commonly prescribed in lower doses to manage insomnia and/or acute anxiety in early treatment. This strategy is often used while waiting for a SSRI, SNRI and/or CBT interventions to take effect. It is important to note that given their sedating and psychoactive properties, quetiapine and trazodone can also increase the overall risk of overdose when combined with other sedatives. Again, dispensing of these should be limited to the OAT dispensing schedule in most cases.

IN SUMMARY

Many patients on OAT report psychiatric symptoms. A mental health history must be taken prior to the initiation of OAT for all patients, and a thorough psychiatric assessment completed if they report psychiatric symptoms – if not prior to starting OAT, then as they stabilize. In some patients, psychiatric symptoms may not present until later in treatment, necessitating a complete psychiatric review and collection of collateral information relevant to the concerns at that time.

If a psychiatrist, primary care provider, and/or mental health professional are treating the patient, consent to communicate with them should be obtained for safety and planning, as outlined in the treatment agreement signed with the patient during OAT induction.

Communication and collaboration, between all those involved in the patient's care, are key to ensure safe medication management. Clarify who is prescribing what medication and ensure the dispensing is limited to the OAT dispensing schedule for any sedating and/or psychoactive medications, in most cases.

Many patients with psychiatric symptoms improve with OAT. If symptoms persist, psychiatric mediation can be prescribed, but caution and close monitoring is advised.

OAT is most effective when combined with psychosocial interventions. Ideally these interventions are available and reasonably accessible for patients, but this is not always the case. The OAT team can advocate for access to appropriate interventions and coach patients to explore self-help and peer-based supports. A list of community resources can be found at the Canadian Mental Health Association site (mbwpg.cmha.ca) and in their local Resource Guide.

References

1. Substance Abuse and Mental Health Service Administration. *Treatment Improvement Protocol (TIP) 42: Substance Use Disorder Treatment for People With Co-Occurring Disorders*. SAMSAH. 2020. Available at: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-004_Final_508.pdf
2. Andréasson S, Engström A, Allebeck P, Rydberg U. Cannabis and Schizophrenia: A longitudinal study of Swedish conscripts. *The Lancet*. 1987 Dec 26; 330(8574):1483-1486. doi: 10.1016/s0140-6736(87)92620-1.
3. Hallowell EM, Ratey JJ. *Driven to Distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood through Adulthood*. Anchor Books, division of Random House; 1994.
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Appendix L

ADDITIONAL MENTAL HEALTH RESOURCES

Anxiety & Depression

ADAM Homepage	https://www.adam.mb.ca/
MDAM Homepage	http://www.mooddisordersmanitoba.ca/
CBT with Mindfulness	https://cbtm.ca/
CBT Institute Manitoba Resources	https://cbtmanitoba.com/resources/

Canadian Mental Health Association

CMHA Manitoba & Winnipeg	https://mbwpg.cmha.ca/
CMHA Resources Guide	https://mbwpg.cmha.ca/wp-content/uploads/2017/11/MHRG_ALL_2020.pdf

Substance Abuse and Mental Health Service Administration

SAMHSA Homepage https://www.samhsa.gov/

TIP 42: Substance Use Disorder Treatment for People with Co-Occurring Disorders

https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-004_Final_508.pdf

Canadian Centre for Addiction and Mental Health

Professional Resources	https://www.camh.ca/en/professionals
Patient Resources	https://www.camh.ca/en/your-care
Guides & Handouts	https://www.camh.ca/en/health-info/guides-and-publications

Psychosis & Schizophrenia

Peer Connections Manitoba	https://peerconnectionsmb.ca/

WRHA Primary Care/Shared Care Mental Health Practice Guidelines

Guide to Complete Form 4 Application by Physician for Involuntary Psychiatric Assessment

https://professionals.wrha.mb.ca/old/professionals/primary-care-providers/files/APPENDIXDGuide.pdf

Trauma & Personality Disorder

Heartwood Healing Centre	https://heartwoodcentre.ca/
PTSD Handout	https://www.camh.ca/-/media/files/guides-and-publications/posttraumatic-stress.pdf
Co-occurring Disorders Outreach	https://sharedhealthmb.ca/services/mental-health/codi/

Short Term Assessment & Treatment (STAT) Program

https://umanitoba.ca/medicine/department-psychiatry (Community and Partners dropdown menu)

Borderline Personality Disorder: An information guide for families

https://www.camh.ca/-/media/files/guides-and-publications/borderline-guide-en.pdf

Zero Shades of Grey: Living with BPD

https://www.pennmedicine.org/news/news-blog/2018/may/zero-shades-of-grey-living-with-bpd

Sleep Problems & Insomnia

Sink Into Sleep	https://sinkintosleep.com/
WRHA Sleep Disorders	https://wrha.mb.ca/psychology/services/sleep-disorders/

Sleep Hygiene Handouts

https://www.anxietycanada.com/sites/default/files/SleepHygiene.pdf

https://www.cci.health.wa.gov.au/~/media/CCI/Mental-Health-Professionals/Sleep/Sleep---Information-Sheets/Sleep-Information-Sheet---04---Sleep-Hygiene.pdf