What's Drugs Got To Do With It?:

Breaking down the 5 W's of Crystal Meth and Psychosis

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Content Overview

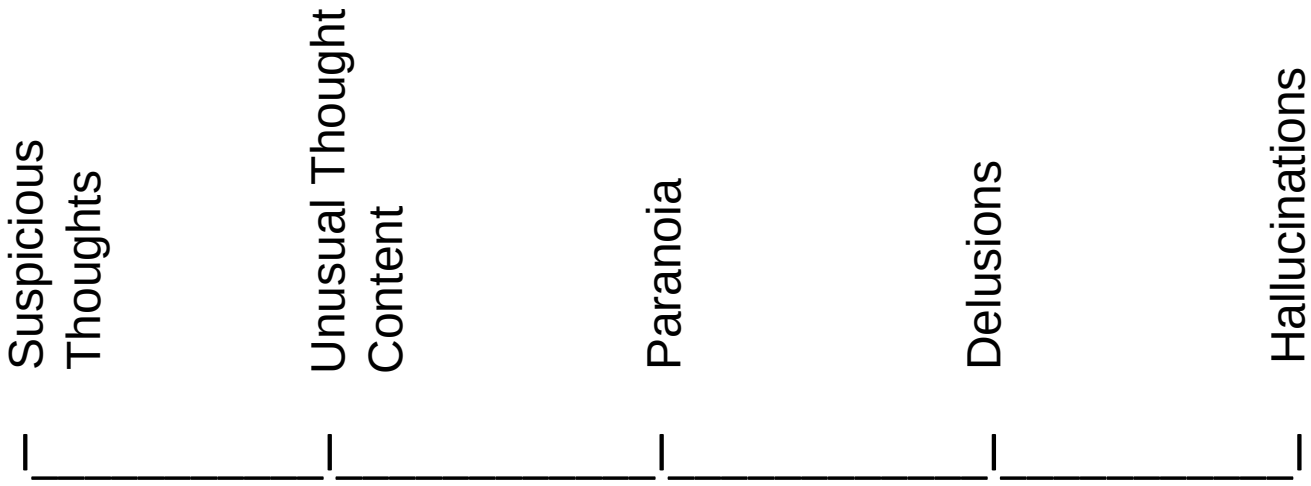
- **WHO**?
  - Case study snapshot
- **WHAT** does methamphetamine use and psychosis look like?
  - Continuum of suspicious behaviour/psychosis
  - Prevalence and complicating factors
  - Substance induced vs. Substance disorder vs. Psychotic disorder
- **WHY** does psychosis happen?
  - Chicken or the egg?
  - Does it really matter?
- **WHEN and HOW** do we engage and/or intervene?
  - Maximizing connection, reducing risk
  - Broad engagement to specific interventions (during & post-use)
- **WHERE** do we go?
  - Hospitalization, medication, safe spaces, community supports

WHO?

One Person's Story

WHAT?

Continuum of Meth-Related Effects



Methamphetamine Induced Psychosis

- Meth use may trigger a pre-existing psychotic illness, or contribute to the development of chronic psychosis

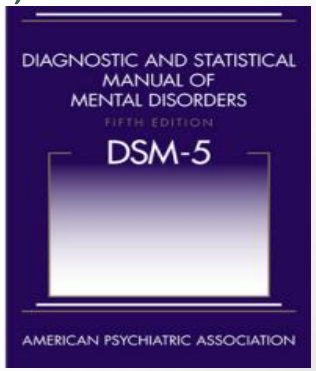
- Prolonged / intense meth use may generate psychotic symptoms including:
  - Delusions
    - Can be fixed, false belief that remains in place even in the face of evidence / proof to the contrary
  - Suspicion
    - excessively suspicious / distrustful response towards others – argumentative / challenging / avoidant as a result
  - Paranoia
    - delusions of persecution; exaggerated self-importance
  - Ideas of Reference
    - The false belief that statements / acts have particular reference to the self (messages via TV / radio, etc.)
  - Hallucinations (both auditory and visual)
    - A sensory experience of something that does not exist

Substance Use Disorder- Stimulant related

- Removed Diagnoses of Substance Abuse and Substance Dependence
- Now…
- 'Substance Use Disorder'
  - Mild (2-3 criteria)
  - Moderate (4-5 criteria)
  - Severe (6+ criteria)

<u>Criteria for Diagnosis</u>

- Failure to meet role obligations
- Craving or a strong desire or urge to use a substance
- Tolerance
- Withdrawal
- Continued use despite known harm
- Loss of control
- Attempts to cut down
- Salience
- Reduced involvement in social, occupational or recreational activities



Prevalence of Meth and Psychosis

- Studies can be varied regarding the prevalence of psychotic symptoms in methamphetamine users. Some studies show a prevalence of 23% even after adjusting for pre-existing psychotic disorders (McKetin et al., 2006), and as high as 60% (Salo et al., 2013).
- More often the individuals diagnosed with substance-induced endorsed positive symptoms and less negative psychosis symptoms. (Grant et al. 2013)
- Persecutory delusion and auditory hallucinations are the most common reported symptoms of meth induced psychosis (Grant et al., 2012)
- Other common reported symptoms included delusions of reference, visual hallucinations, and thought broadcasting (Grant et al., 2012)

Prevalence of Meth and psychosis

- Chen et al. (2003)
  - 17% experienced psychosis despite being abstinent for 1 month
- Iwanami et al. (1994) N=104 hospitalized Meth users
  - 52% symptoms abated within 1 week
  - 26% symptoms persisted more then a month
  - 16% symptoms persisted for more then 3 months

Complicating Factors

- Lack of sleep
- Lack of food and poor nutrition
- Homelessness
- Head injury, ADHD, learning disability (Fujii, 2002)
- Polysubstance misuse

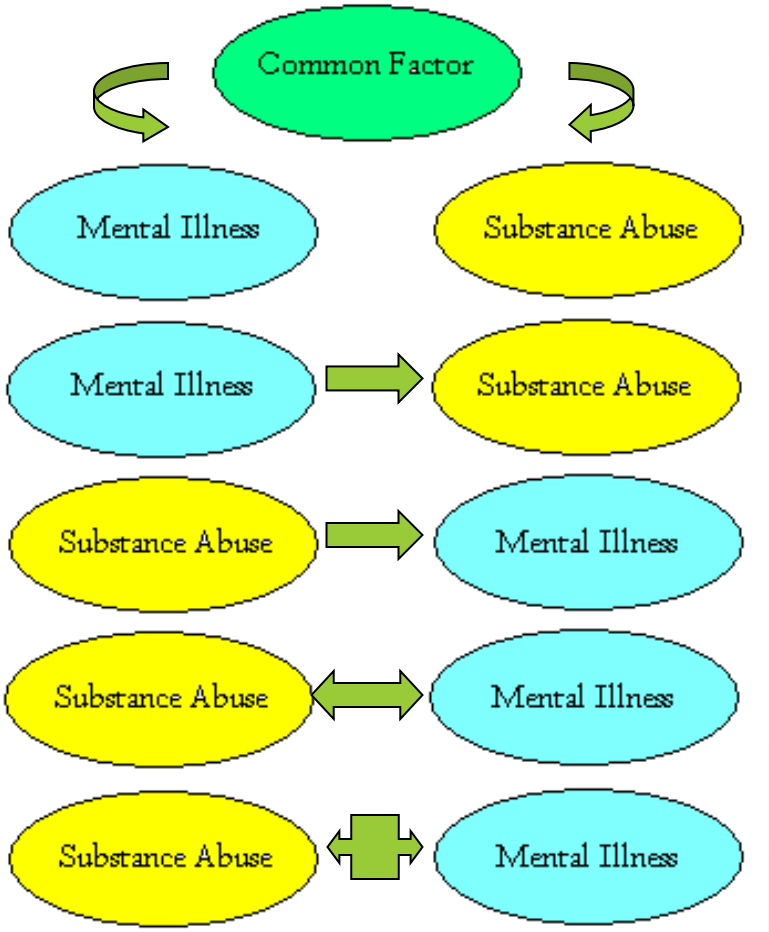
WHY?

So What Comes First?

Or Does It Really Even Matter?

Chicken or the Egg

- Common Factor Model
- Secondary Substance Use Model
  self-medication model
- Secondary Mental Health Model
  substance-induced disorders
- Bidirectional
- Minimal inter-relationship



Does it Really Even Matter?

Substance	Effect/Symptom	Mental Illness
Alcohol Intoxication	Euphoria, mood lability, decreased impulse control, increased confidence	Hypomanic state
Alcohol Withdrawal (protracted)	Insomnia, fatigue, mood lability, hostility, decreased sexual interest	Major Depression
Cocaine or Methamphetamine	Euphoria, perceived increase in powers of thought, strength and accomplishment, paranoid delusions	Psychosis
Methamphetamine binge and then alcohol binge	Period of euphoria followed by a period of depression	Bipolar Disorder
Chronic marijuana use	Low motivation, decreased interest in activities, role problems, isolation	Depression
Opioid Withdrawal	Anxiety, agitation, depression, anhedonia, sleep disturbances	Anxiety Disorder Major Depression

http://www.ncbi.nlm.nih.gov/books/NBK64178/

- In a study of 400 subjects recruited from five psychiatric emergency departments with at least one psychotic symptom and some substance use in the previous 30 days, 44% of subjects were diagnosed with a substance-induced psychosis while 56% were diagnosed with primary psychosis (Grant et. Al, 2012)

And the Research Says

- Early onset, Longer duration and more frequent use (Chen, 2003, Ujike and Sato 2004)
- Dependent Methamphetamine users were 3 times more likely to experience psychosis then non-dependent (McKetin et. Al., 2006)
- familial loading for schizophrenia and mental illness, the more likely a METH user is to develop psychosis and the longer that psychosis is likely to last. (Chen, 2003; Salo, 2008)
- Route of administration does not affect likelihood of psychosis (Matsumoto et. Al, 2002; McKetin et al. 2006 & 2008) but does effect severity (Zweben et.al., 2004)
- Reduction in dopamine transporter density can contribute to persistent mental health symptoms including psychotic symptoms, even if use stops (Sekine et. Al., 2001)

WHEN and HOW?

Maximizing Connection, Reducing Risk

- Keep the environment calm
- Speak calmly and quietly
- Move slowly and deliberately / narrate movement
- Avoid humour, sarcasm, jokes
- Don’t argue or try to correct seemingly false / inaccurate beliefs or perceptions
- Validate the emotion related to the beliefs / perceptions
- Show compassion. Offer support. Explore what could help to calm the fear / discomfort

Engaging

- Understand addiction as a **health issue**
- Know your own **biases** and be accountable for them
- Adopt a **non-judgmental** attitude
- Be **patient**. People will often present as emotionally hyper-sensitive or distressed. Cognitive function may be impaired for many reasons
- Express **empathy** – seek to understand. This may not change the limits we set, but it can help people accept them.
- Don't underestimate risk of **suicide**. Withdrawal is highly correlated with depression, suicidal thoughts and behaviours.
- Provide **information** about community resources
- Offer **HOPE**

Interventions

“Quicker” Wins

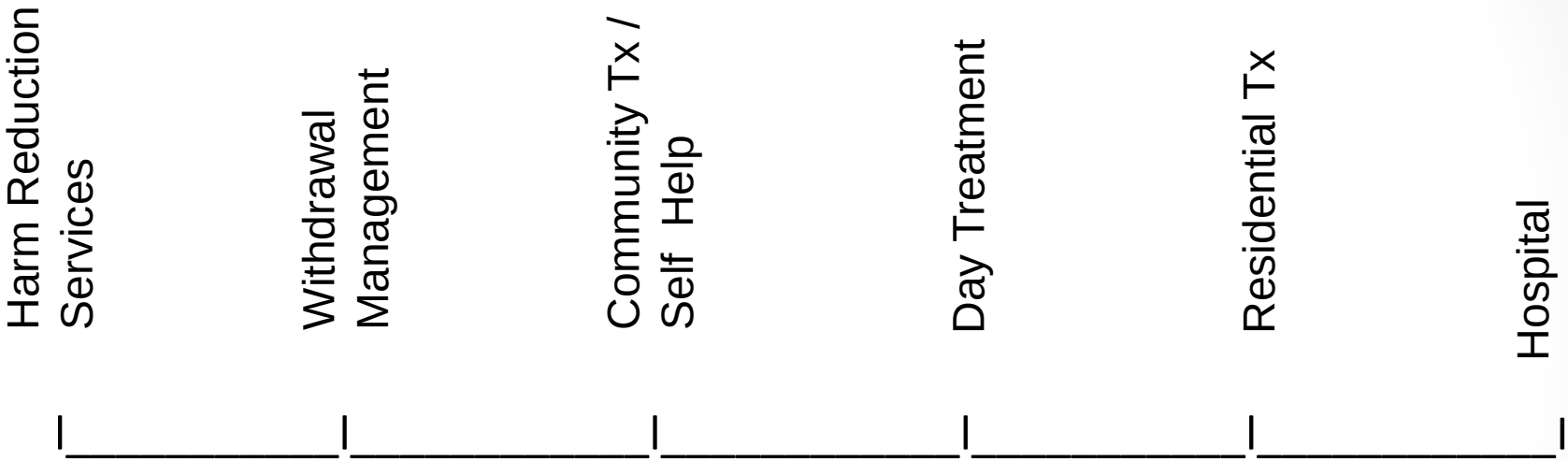
- Support continued use of medication unless advised not to
- Explore uncertainty about suspicion – make it a strategy
- Continue to check for insight and work with what you see – as time passes, this will hopefully increase. Check with questions
- Help the person plan for a safer “crash” if they are ready to take a break
- Help the person to “cope with voices” (see handout)

Longer-Term

- Use motivational approaches: match your support to stage of change
- Keep expectations of your relationship flexible – it will vary!
- Don’t personalize ANYTHING

WHERE?

Intervention Continuum



Adjunct Services

Medical Treatment Options

Crisis Support Services

Treatment Options

- When to contact withdrawal management
  - Seeking help, suspicious but not psychotic, need a safe place to "come down"
- When to contact primary care
  - Continuing to experience paranoia / suspicion while abstinent but no imminent risk
- When bring someone to ER
  - Risk of harm to self / other
  - So disorganized / delusional unable to make safe choices for self
  - Important to emphasize risk and any pre-existing mental health issues
  - The hospital may not be able to release information to you, but you can always release information to hospital staff
  - Describe what you see rather than using medical language

Hospitalization

- Forms
  - Form 1- application for psychiatric assessment - up to 72 hours
  - Form 2 – Order for examination - J of P
  - Form 3 – Certificate for involuntary admission – up to 2 weeks – CCB
  - Form 4 – Certificate for renewal – 1 month, 2 months, 3 months –CCB

- Medication
  - May be prescribed anti-psychotic medication for duration of hospital stay.
  - May receive a prescription upon discharge, either short or long-term.

- Duration of Stay
  - Stabilization stays are generally brief: 24 – 28 hours and will occur in EAU
  - Average length of stay on acute unit 12-14 days

Wrap up and Take Home

- Psychosis symptoms resulting from Crystal meth use can range on a continuum from suspicious thoughts to hallucinations.
- Prevalence of psychosis in users can occur in as high as 60% in users, and is more likely to occur in individuals with pre-existing mental illness, early onset and longer duration of use.
- **TREAT THE SYMPTOMS NOT THE DIAGNOSIS**. Symptoms can persist for longer than 3 months after last usage in up to 16% of users.
- When engaging with individuals remember safety is #1 both for you and your client.
- Know your options for treatment, match your intervention to their stage of change, and know when to bring in help.
- Show your empathy, know your biases, and remember people with concurrent crystal meth use and psychosis are **PEOPLE FIRST.**

QUESTIONS

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