College of Pharmacists of Manitoba

November 23, 2021

Overdose in the Era of COVID-19 & Approaching Mental Health in Pharmacy Practice

Dr. Marina Reinecke

MBChB, CCFP(AM), ISAM, Medical Consultant,
Prescribing Practices Program, College of
Physicians and Surgeons of Manitoba

Manitoba's Overdose Crisis in the Era of COVID-19

Manitoba's Overdose Crisis in the Era of Covid-19

A CPhM Professional Development Event

MARINA REINECKE MBCHB, CCFP(AM), ISAM

Faculty/Presenter Disclosure

- **Faculty:** Marina Reinecke
- CPSM employee – Consultant to the Prescribing Practices Program, CPSM
- Medical Director – OHA OAT program, OCN, MB
- Member of the MMDRC and AIRC
- Former HSC Medical Director of Addiction Services

- **Relationships with commercial interests:** None

Faculty/Presenter Disclosure

- **With thanks to:** Erin Knight (Co-author – health system recommendation slides)

- **Relationships with commercial interests:** None

- Medical Director, Addiction Services - Health Sciences Centre
- Medical Co-Lead, Rapid Access to Addiction Medicine (RAAM) Hub - Shared Health
- Program Director, Addiction Medicine Enhanced Skills Residency Program - University of Manitoba
- Medical Director, Island Lake Addiction Program - Four Arrows Regional Health Authority
- Addiction Physician, OAT clinic – Opaskwayak Health Authority
- Family Physician, Aboriginal Health and Wellness Centre

Acknowledgements

We wish to recognize and thank:

- The Office of the Chief Medical Examiner of Manitoba.
- Dr John Younes, Chief Medical Examiner

Learning Objectives

- **At the conclusion of this activity, participants will be able to:**
- **Discuss historic and recent trends/changes in MB overdose death data reported by substance.**
- **Recognize shifting overdose death data trends in the context of the pandemic.**
- **Demonstrate how existing frontline addiction services that can impact survival are strained, despite recent investments.**
- **Propose an appropriate health system response to address the overdose crisis by applying accepted evidence-based & cost-effective interventions.**

Polling Questions:

1. Between 2013-2018 in Manitoba, which opioid is responsible for the largest number of overdose deaths, either as primary cause or as a major contributing factor?

a) Fentanyl
b) Carfentanil
c) Codeine
d) Tramadol
e) Oxycodone

Polling Questions:

2. In 2018 in Manitoba, which benzodiazepine contributed to the largest number of overdose deaths?

a) Alprazolam
b) Diazepam
c) Temazapam
d) Bromazepam
e) Lorazepam

Polling Questions:

3. In Manitoba, most opioid overdose deaths can be attributed to:

a) A single prescribed opioid
b) Multiple prescribed opioids
c) A single illicit opioid
d) One or more opioids combined with multiple other drugs
e) Opioids in combination with alcohol

Polling Questions:

4. In Manitoba between 2014-2017, which two drug classes were the top contributors to opioid overdoses?

a) Alcohol and benzodiazepines
b) Antipsychotics and antidepressants
c) Benzodiazepines and antidepressants
d) Statins and antihypertensives
e) Benzodiazepines and Z-drugs

Polling Questions:

5. In Manitoba in 2018, which two over-the-counter ingredients contributed to the largest number of deaths?

a) Acetaminophen and ASA
b) Acetaminophen and pseudoephedrine
c) Diphenhydramine and dextromethorphan
d) Dextromethorphan and acetaminophen
e) Ibuprophen and desloratadine

Polling Questions:

6. In Manitoba, in 2020, which two individual drugs were the most common contributors to drug and alcohol overdose deaths according to the OCME?

a) Diphenhydramine and dextromethorphan
b) Fentanyl and alcohol
c) Fentanyl and Methamphetamine
d) Dextromethorphan and methamphetamines
e) Methamphetamines and alprazolam

Polling Questions:

7. In Manitoba, between 2017 and 2020, which individual drug was the most consistent primary cause of drug and alcohol overdose deaths according to the OCME?

a) Diphenhydramine
b) Fentanyl
c) Alcohol
d) Dextromethorphan
e) Methamphetamines

Polling Questions:

8. In Manitoba, between 2017 and 2020, which individual prescription drug was the most consistent primary cause of drug and alcohol overdose deaths according to the OCME?

a) Zopiclone
b) Fentanyl
c) Codeine
d) Methadone
e) Alprazolam

CPSM Prescribing Practices Program

Department of Quality

- **Chief Medical Examiners' Death Review**
- OAT Prescriber Training, Mentoring and Auditing
- Benzodiazepine and Z-drug Prescribing Standard Implementation and Resource Development
- Individual Informal Case Support/Mentoring

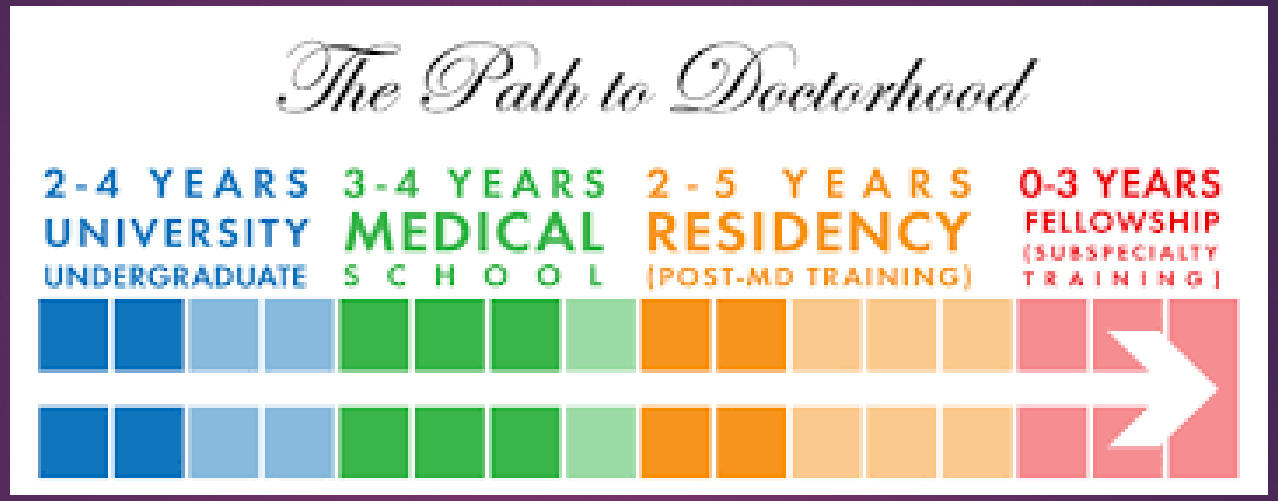
Chief Medical Examiners' Death Review

Chief Medical Examiners' Death Review - Joint process with CPhM!!

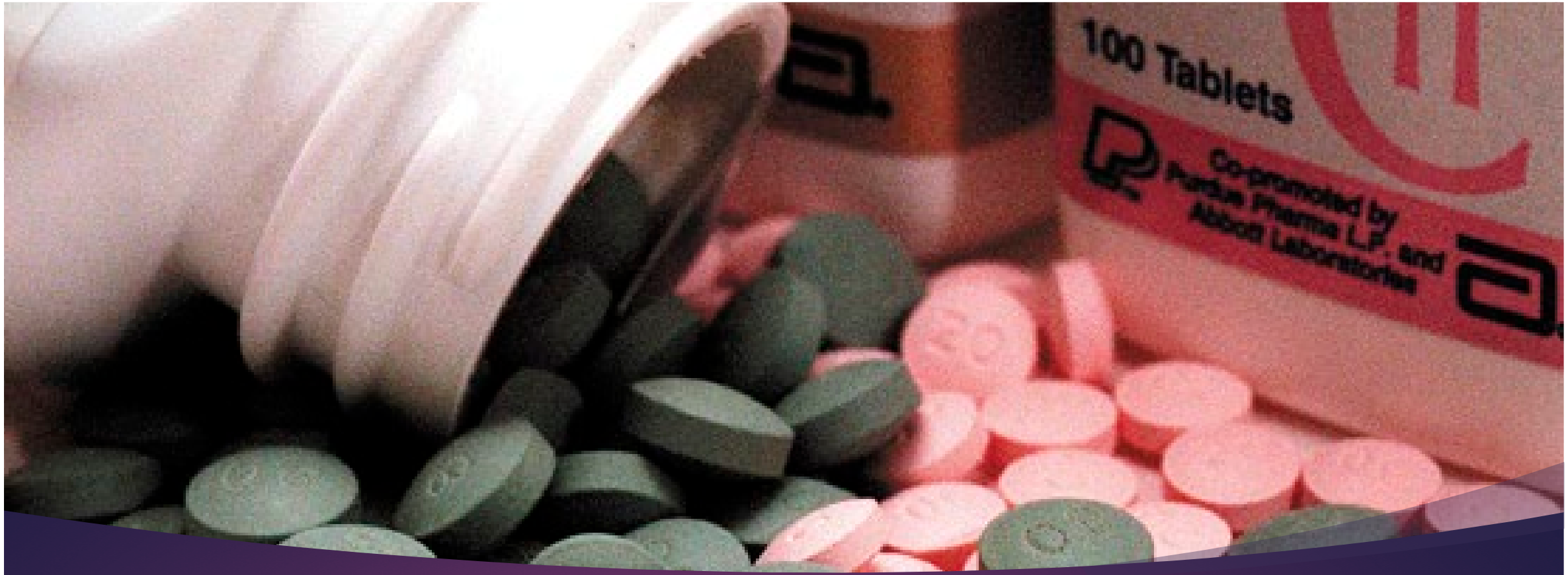
- Relationship initiated by the previous ME who was concerned regarding the number of prescription drug related deaths
- Reviewers: Historically 4 medical consultants with extensive primary care experience in the management of pain, addiction and mental health concerns. *Currently and new: Pharmacist*
- **Adult Inquest Review Committee**
- All deaths involving prescription medications undergo detailed review
- No chart information unless we ask for it (high volume and educational process and meant to prompt self-reflection)
- Methadone; buprenorphine/naloxone deaths

Chief Medical Examiners' Death Review

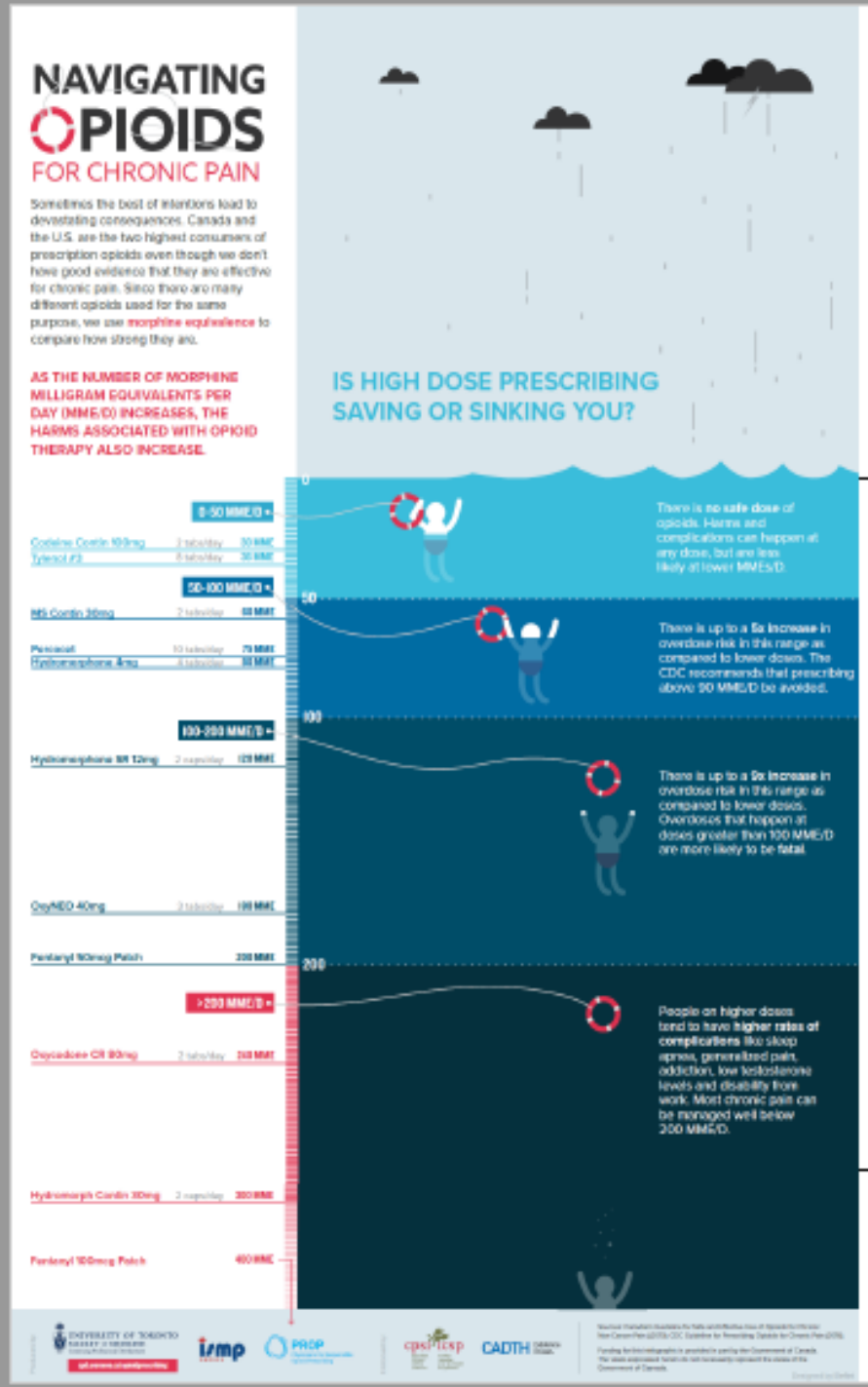
- Prescribers receive standard cover letter plus relevant resources if needed
- Plus summary of the ME report highlighting the manner of death, cause of death, notable circumstances of death, toxicology findings and summary of relevant DPIN data
- Feedback to prescribers in 3 categories:
  - FYI
  - Prescribing falls outside of guidelines, best practices (standardized evidence-based quality indicators, e.g. concomitant opioids and benzo's); includes resources
  - Significant concerns (rare)



Historically there has been a lack of meaningful safe prescribing education on undergrad, postgrad, and CPD level.



Big Pharma & OXYCONTIN: Historically physicians have been exposed to aggressive pharmaceutical marketing techniques.



Updated March 1, 2018

Number* of Unique Patients in Manitoba with "Average Morphine Equivalence Per Day"**

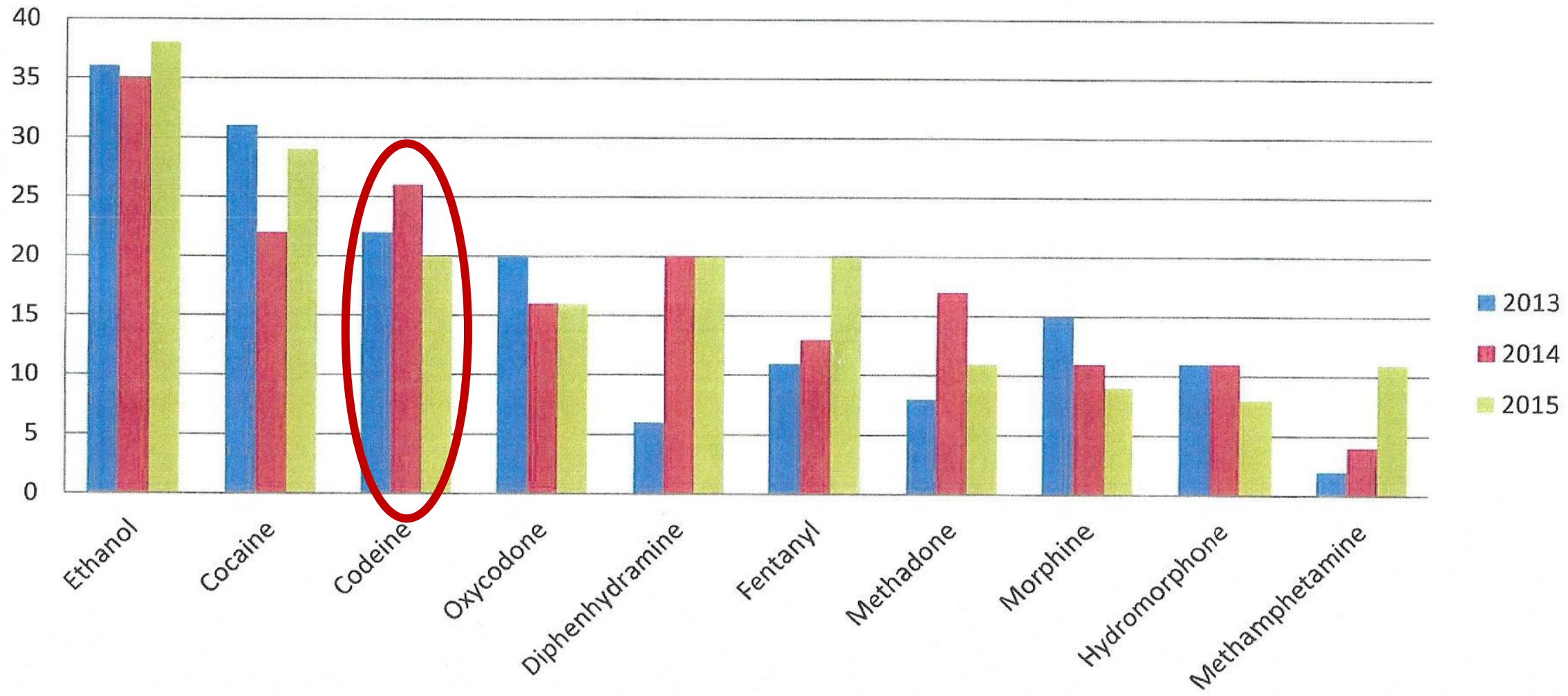
Ave. MME Per Day	Q4 2017: Oct. 1 2017 to Dec. 31, 2017		% Var. # Unique Patients from Prev. Year	Q4 2016: Oct. 1 2016 to Dec. 31 2016	
	# Unique Patients	Proportion of Unique Patients		# Unique Patients	Proportion of Unique Patients
0 to 50	4,203	45.2%	↑ 1.8%	4,128	44.5%
50 to 90	2,365	25.5%	↑ 4.0%	2,273	24.5%
90 to 200	1,937	20.8%	↓ (0.7%)	1,951	21.0%
>200	787	8.5%	↓ (14.6%)	922	9.9%
	9,292	**100.0%**	**↓ (2.5%)**	**9,274**	**100.0%**

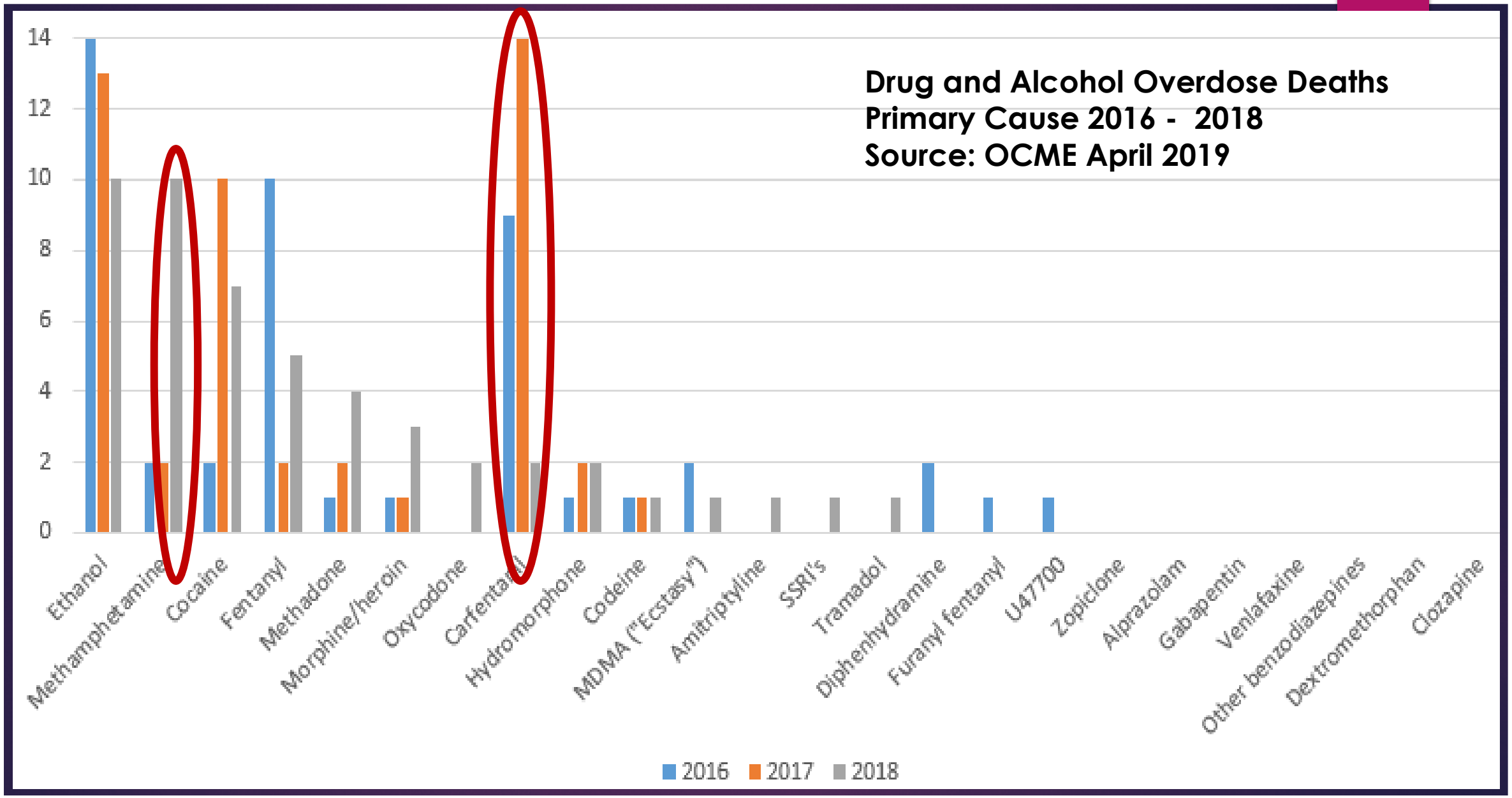
*Data source is DPIN, excludes Long Term Care & Palliative Care clients; does not include drugs dispensed in hospital. Includes fentanyl.
** MME Per Day Calculated by taking Total MME divided by Days Supply

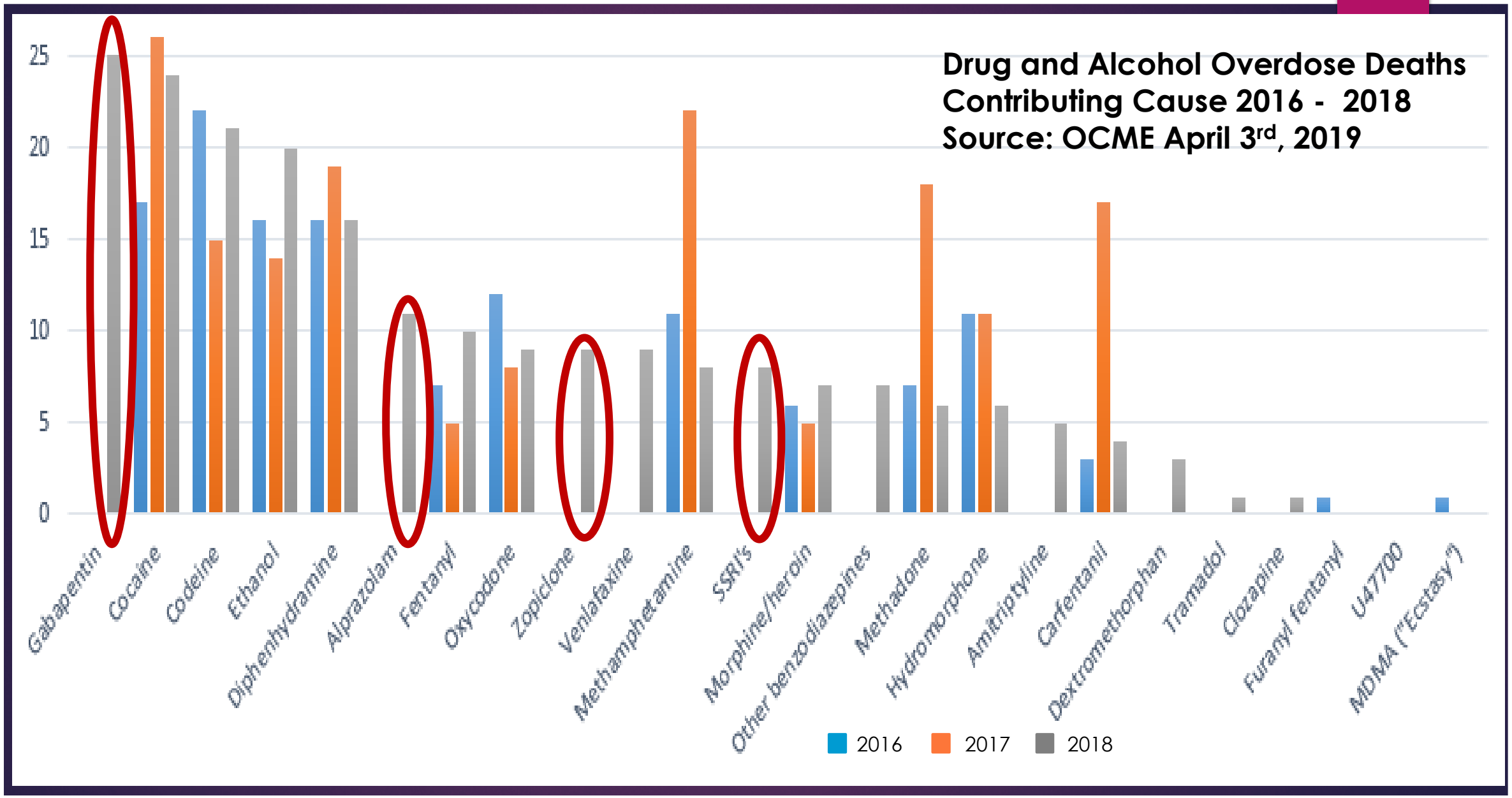
The pandemic and non-prescription fentanyl

- Fentanyl smuggled in from China via west coast.
- Different fentanyl analogues with varying strengths (carfentanil)
- Attainable from internet pharmacies – 1 kg goes a long way (100K street value)
- Adulterated into other drugs:
  - West coast heroin 70% +
  - Local – adulterated into powdered cocaine, crystal meth, fake oxys.
  - Blotter tabs

Drug and Alcohol Overdose Deaths (primary or contributing cause) 2013-2015 source: OCME Nov 3, 2016




Drug and Alcohol Overdose Deaths
Primary Cause 2016 - 2018
Source: OCME April 2019
14
12
10
8
6
4
2
0
Ethanol
Methamphetamine
Cocaine
Fentanyl
Methadone
Morphine/heroin
Oxycodone
Carfentanil
Hydromorphone
Codeine
MDMA ("Ecstasy")
Amitriptyline
SSRI's
Tramadol
Diphenhydramine
Furanyl fentanyl
U47700
Zopiclone
Alprazolam
Gabapentin
Venlafaxine
Other benzodiazepines
Dextromethorphan
Clozapine
2016
2017
2018

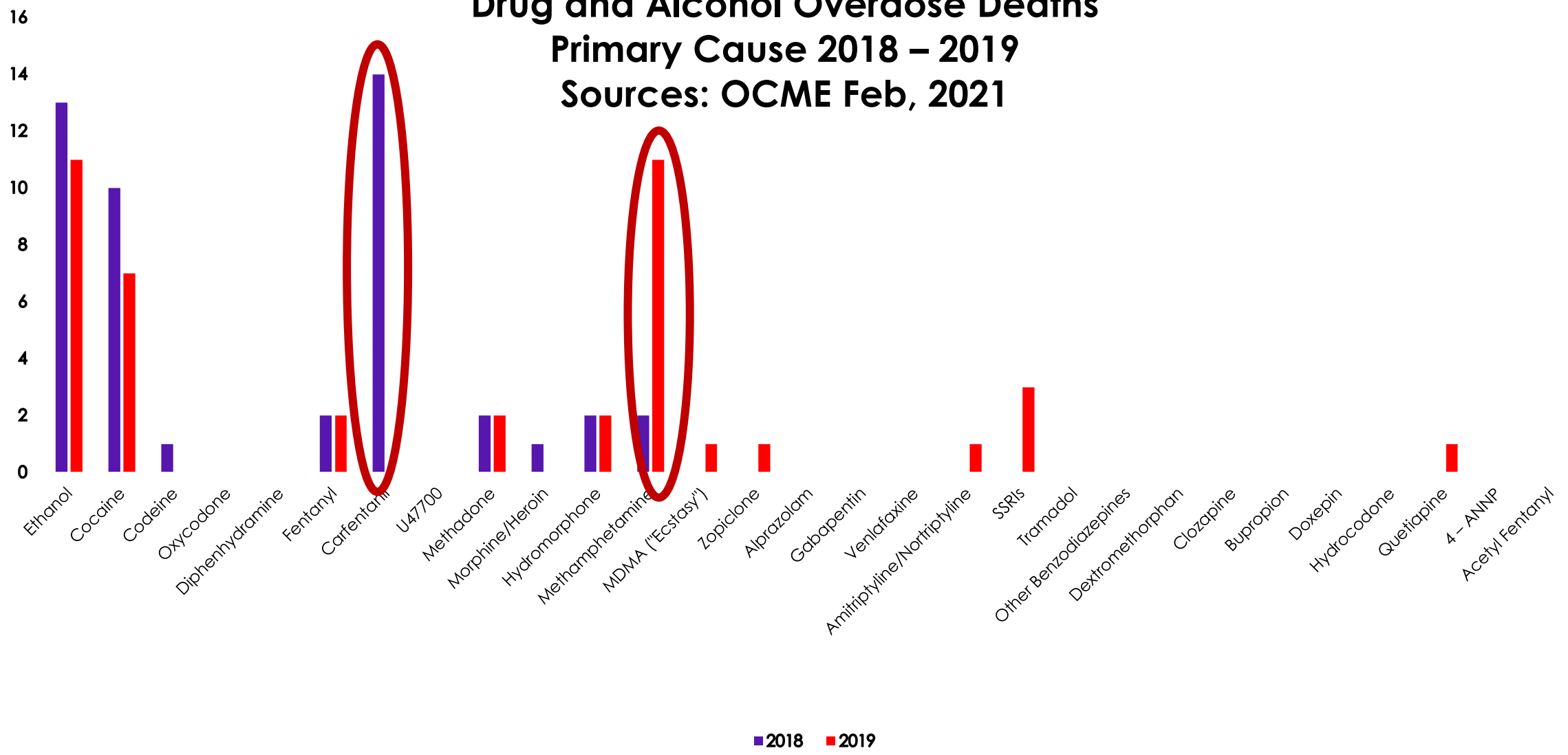

Drug and Alcohol Overdose Deaths
Contributing Cause 2016 - 2018
Source: OCME April 3rd, 2019
25
20
15
10
5
0
Gabapentin
Cocaine
Codeine
Ethanol
Diphenhydramine
Alprazolam
Fentanyl
Oxycodone
Zopiclone
Venlafaxine
Methamphetamine
SSRI's
Morphine/heroin
Other benzodiazepines
Methadone
Hydromorphone
Amitriptyline
Carfentanil
Dextromethorphan
Tramadol
Clozapine
Furanyl fentanyl
U47700
MDMA ("Ecstasy")
2016
2017
2018

Important changes in 2018

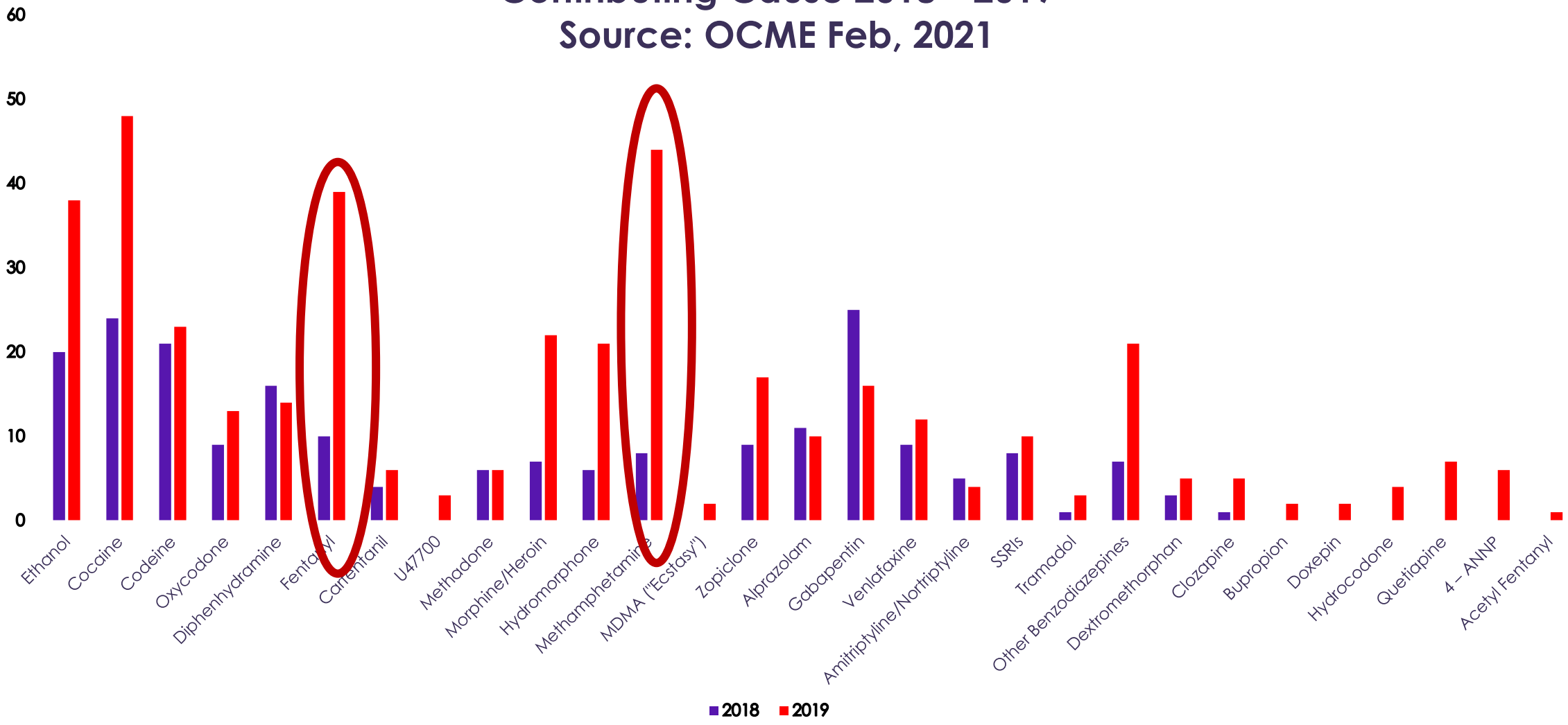
- Opioid deaths have leveled off.
- **Stimulant-related deaths are climbing rapidly. Alprazolam** and **gabapentin**, as well as **diphenhydramine**, have become significant drugs of abuse.

- Note that more than one drug is often involved in a given death where a drug is given as a "contributing" cause.
- Overall, **138 drug-related deaths in 2018**. This does not include deaths where drug intoxication led to death by other means (MVAs, suicides, homicides, etc.), or where death occurred due to the effects of chronic drug use (cirrhosis, etc.).

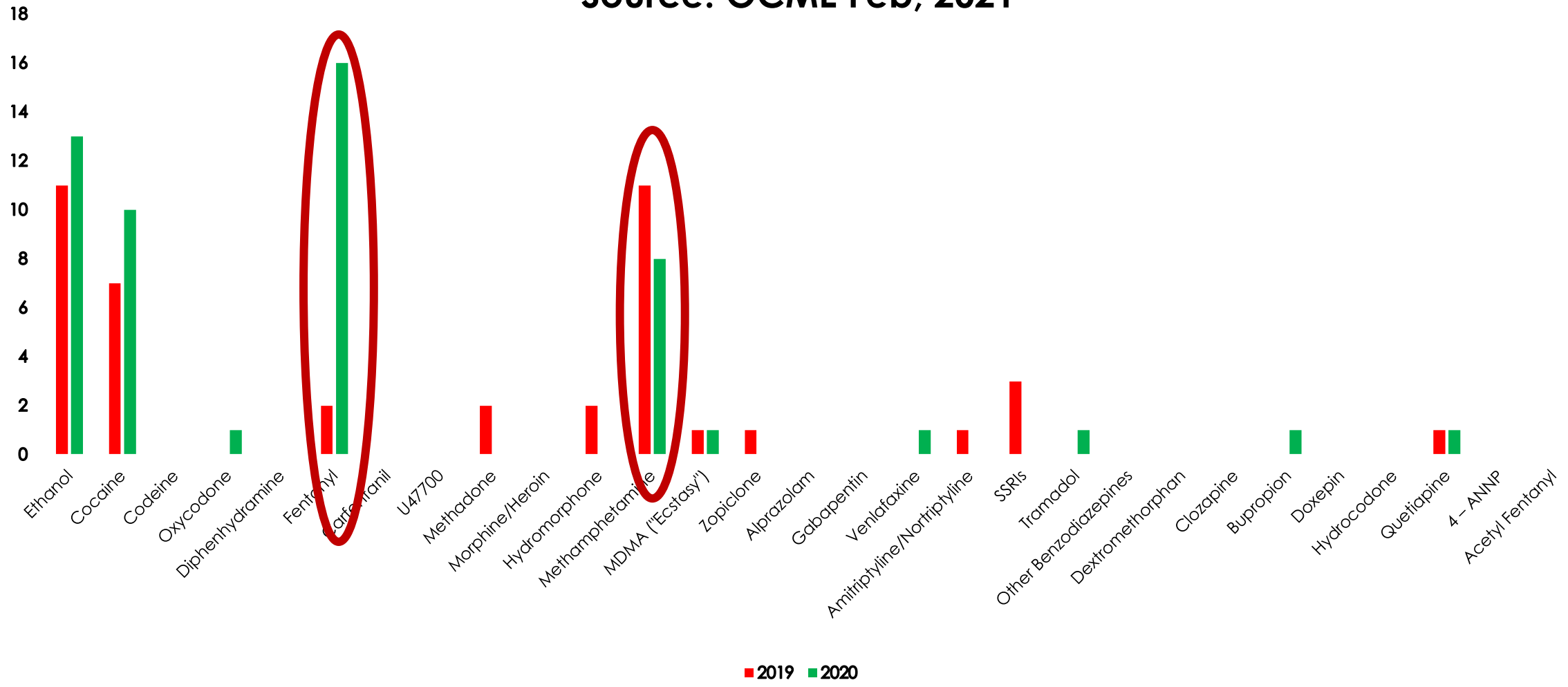
Drug and Alcohol Overdose Deaths
Primary Cause 2018 – 2019
Sources: OCME Feb, 2021



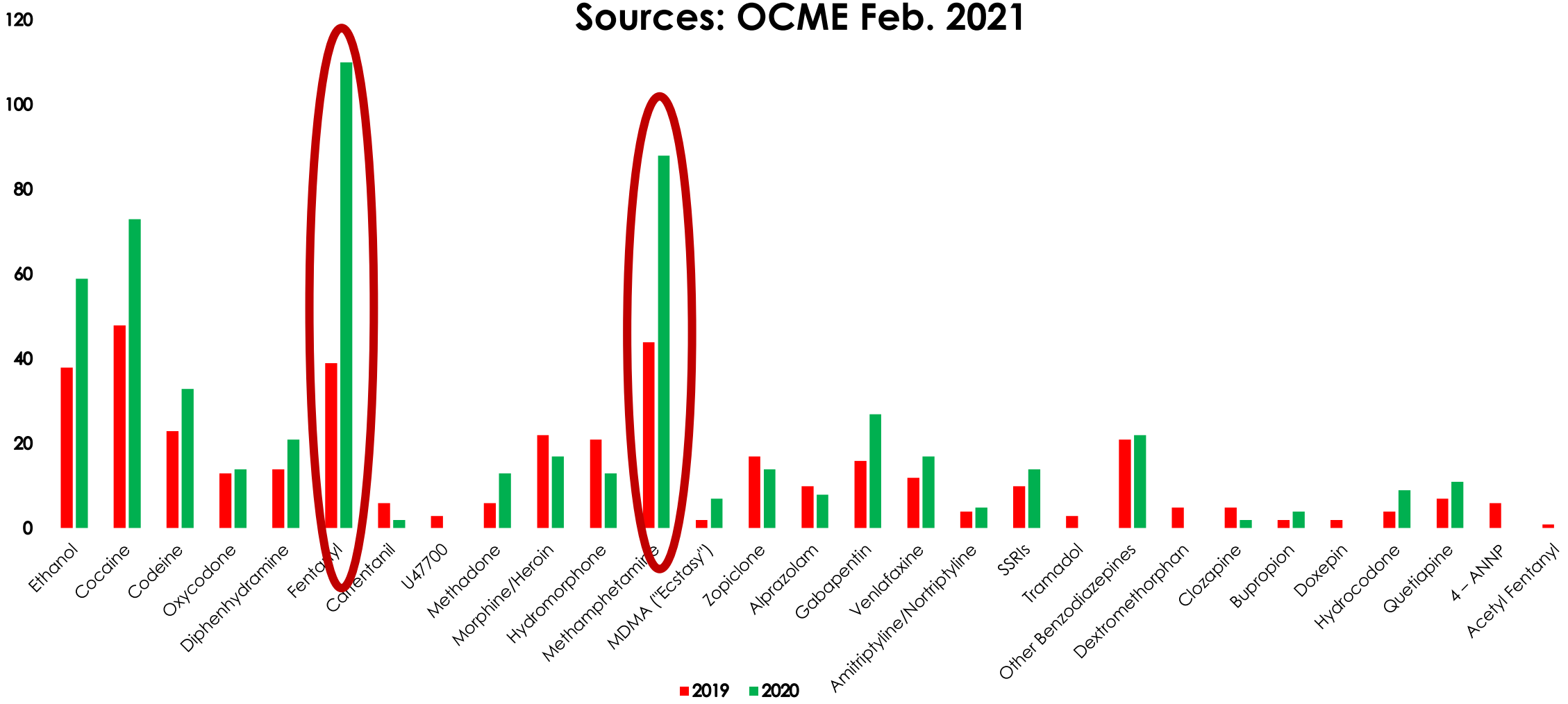
Drug and Alcohol Overdose Deaths Contributing Cause 2018 - 2019 Source: OCME Feb, 2021



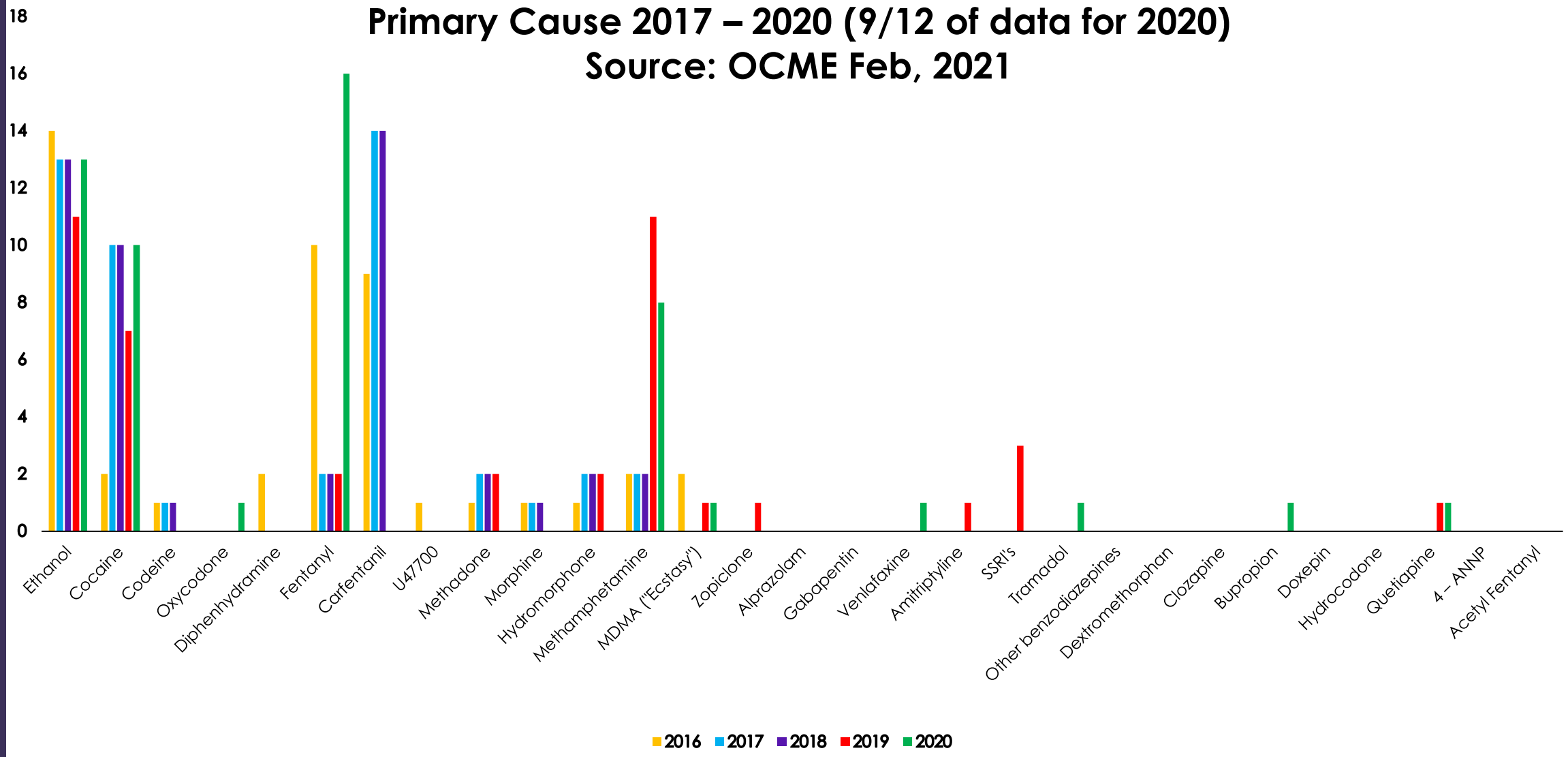
Drug and Alcohol Overdose Deaths
Primary Cause 2019 – 2020 (9/12 of data for 2020)
Source: OCME Feb, 2021



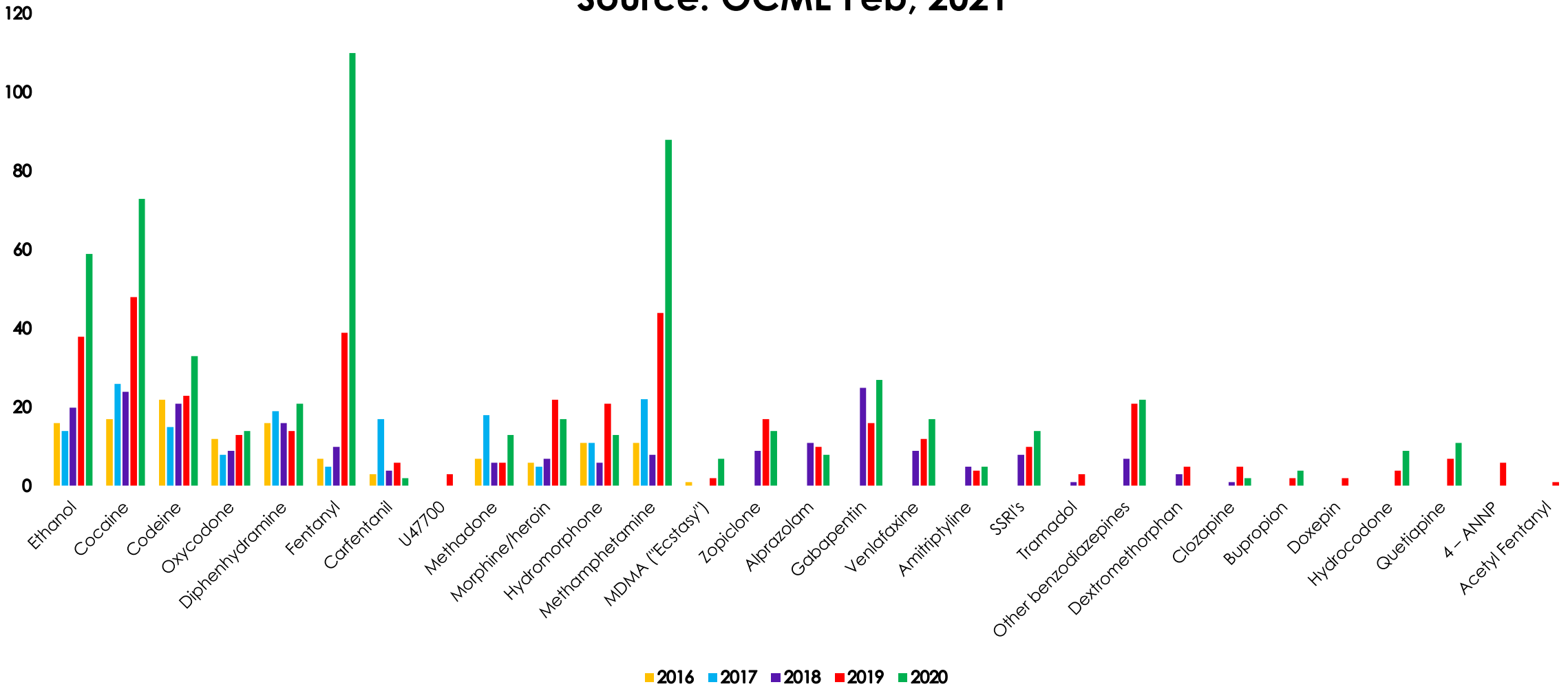
Drug and Alcohol Overdose Deaths
Contributing Cause 2019 – 2020 (9/12 of data for 2020)
Sources: OCME Feb. 2021



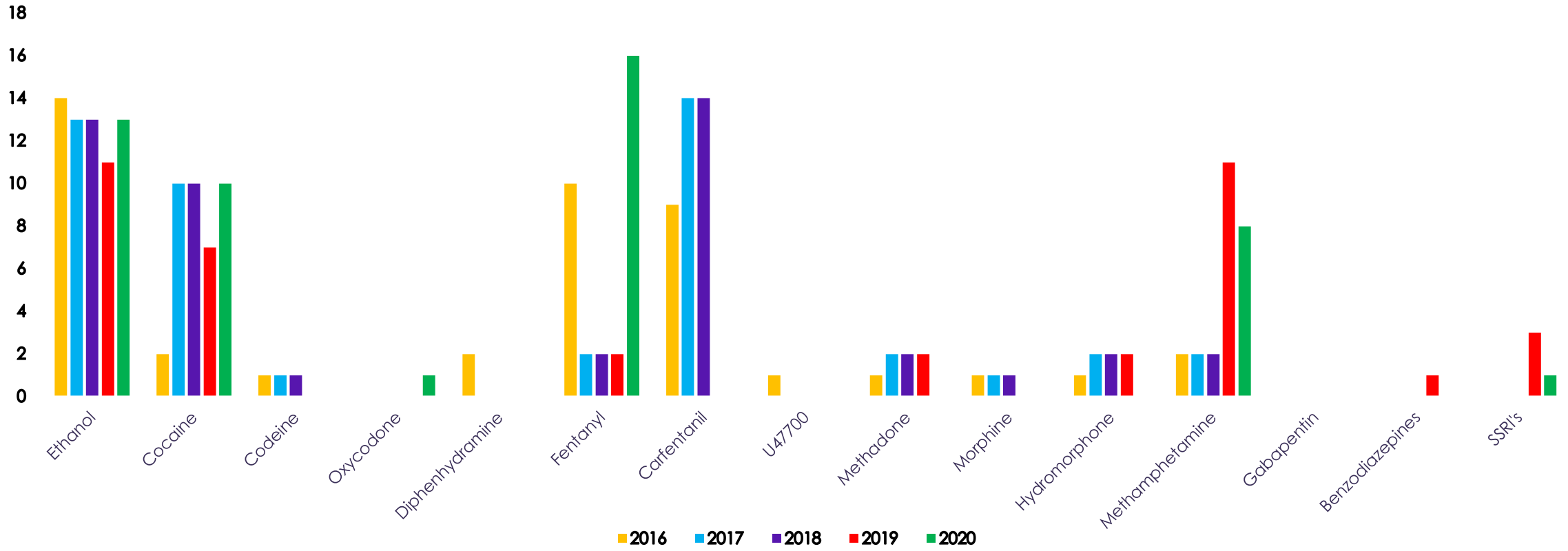
Drug and Alcohol Overdose Deaths
Primary Cause 2017 – 2020 (9/12 of data for 2020)
Source: OCME Feb, 2021



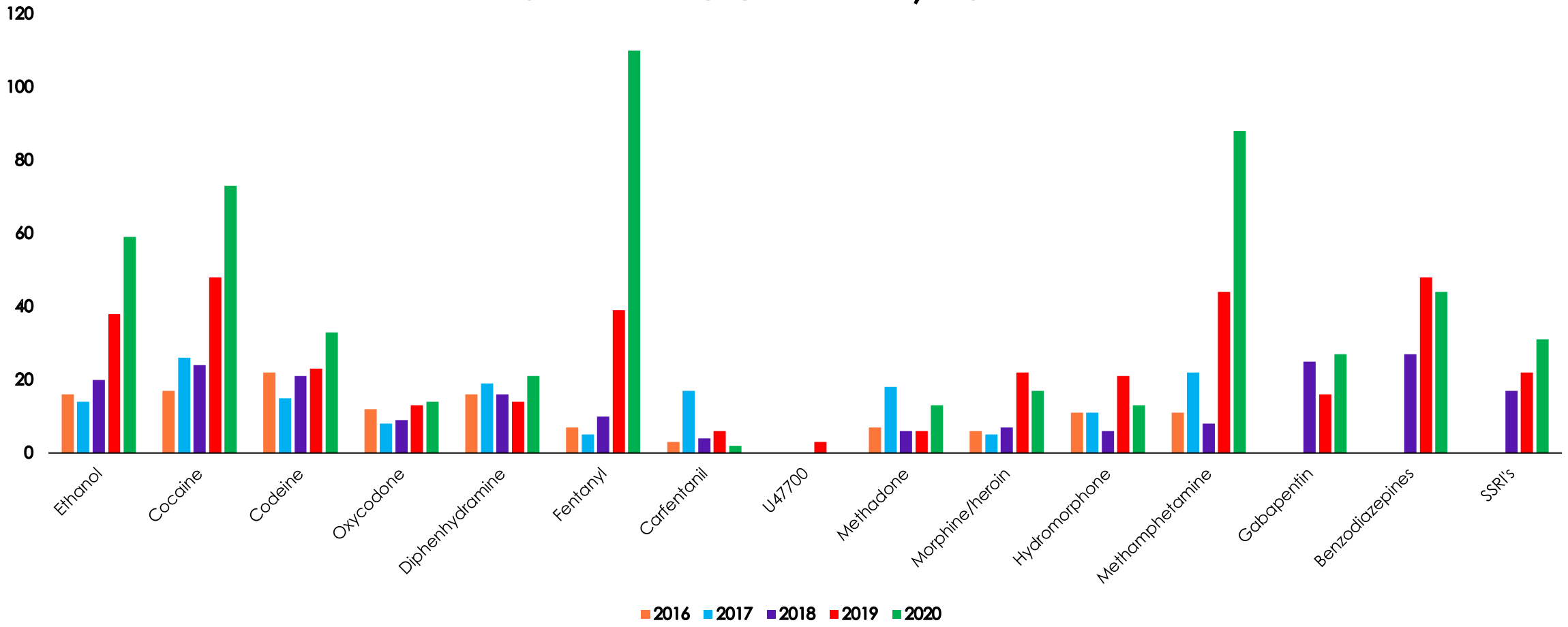
Drug and Alcohol Overdose Deaths
Contributing Cause 2017 – 2020 (9/12 of data for 2020)
Source: OCME Feb, 2021



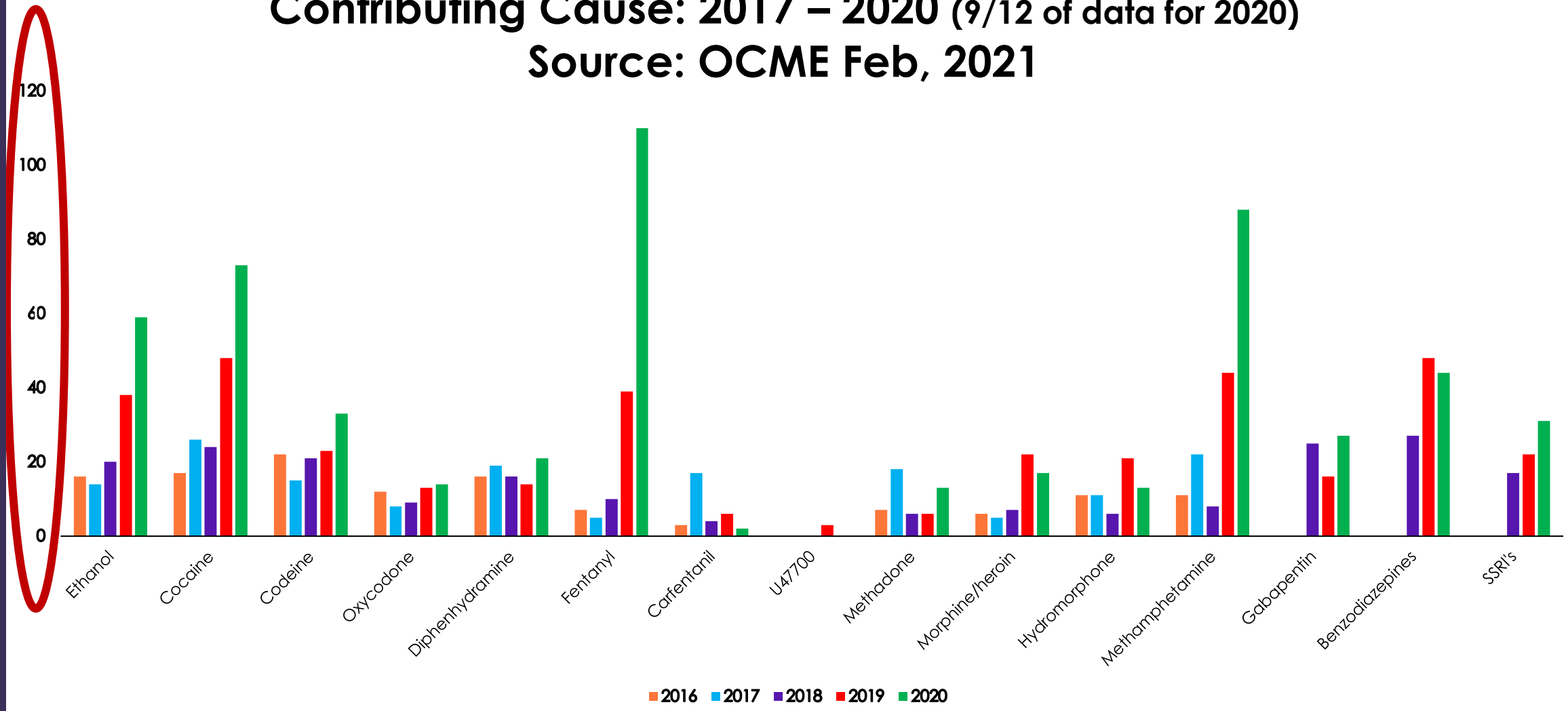
Drug and Alcohol Overdose Deaths
Primary Cause: 2017 – 2020 (9/12 of data for 2020)
OCME Feb, 2021



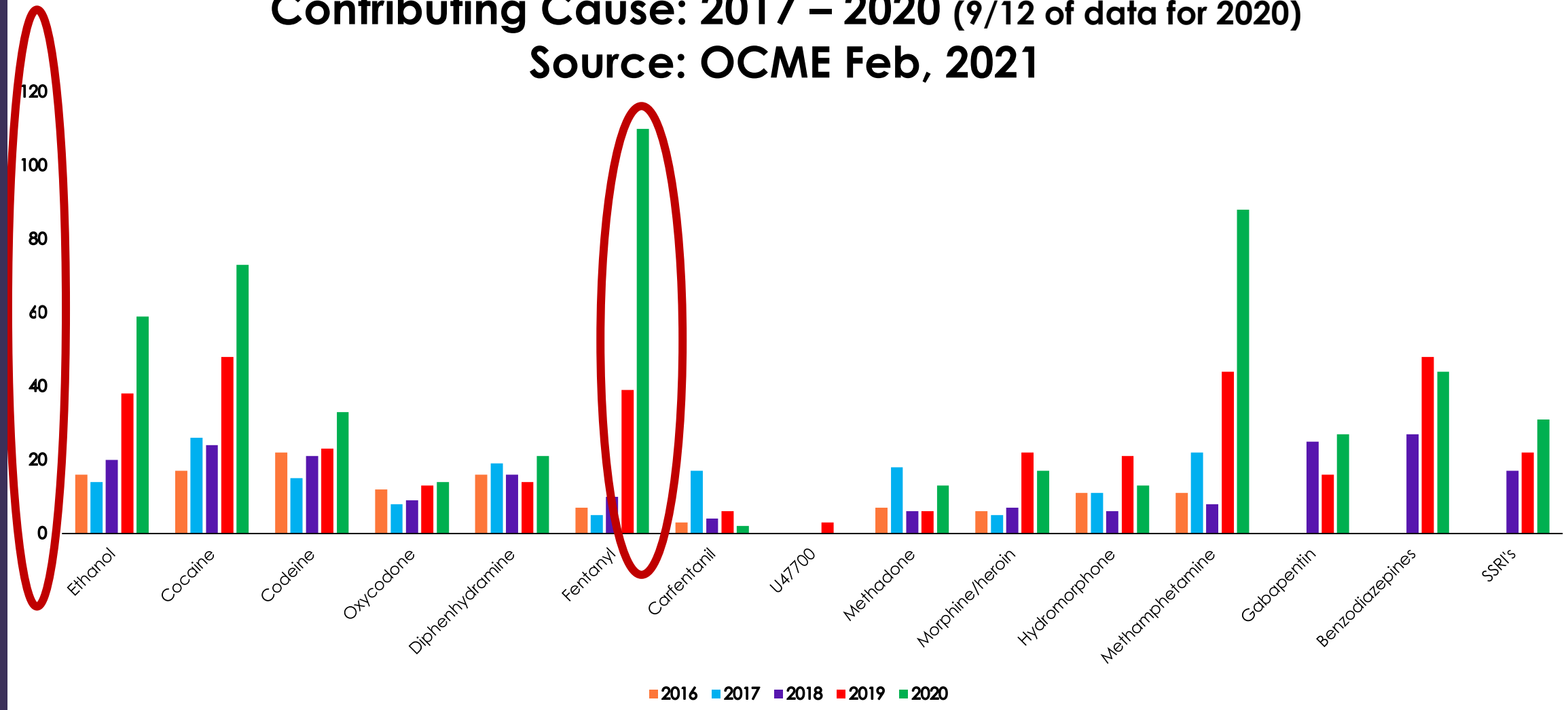
Drug and Alcohol Overdose Deaths
Contributing Cause: 2017 – 2020 (9/12 of data for 2020)
Source: OCME Feb, 2021



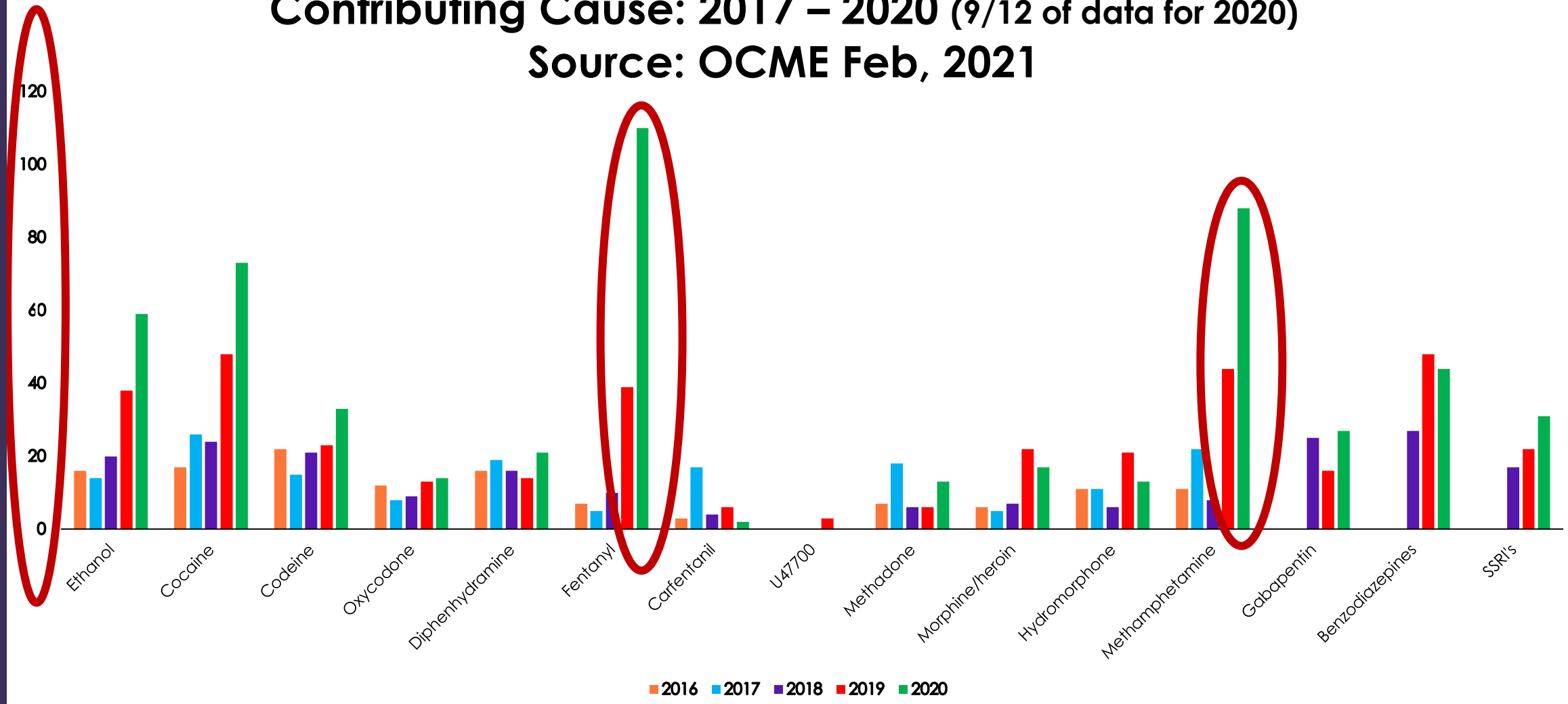
Drug and Alcohol Overdose Deaths
Contributing Cause: 2017 – 2020 (9/12 of data for 2020)
Source: OCME Feb, 2021



Drug and Alcohol Overdose Deaths
Contributing Cause: 2017 – 2020 (9/12 of data for 2020)
Source: OCME Feb, 2021



Drug and Alcohol Overdose Deaths
Contributing Cause: 2017 – 2020 (9/12 of data for 2020)
Source: OCME Feb, 2021



2019..

- **TOTAL NUMBER OF DRUG-RELATED DEATHS: 191**

- Deaths due to single opioid toxicity: 6
- Deaths with one or more opioids contributing: 87
- Total opioid-related deaths: 93 (49% of all drug-related deaths)
- Fentanyl-related deaths: 41 (44% of all opioid-related deaths, 21% of all drug-related deaths)

2020 and 2021

- **TOTAL NUMBER OF DRUG-RELATED DEATHS:**
- **259 total drug-related deaths in 9 months!**
- Primarily due to toxic street supply of fentanyl, cocaine, and methamphetamine
- **Final total was 372 deaths in 2020 - most of them young with many years of work and life left to live!**
- **2021 is of grave concern:199 drug-related deaths in Manitoba from January to June 2021**

Important changes in 2019-2021

- Drug supply coming from the U.S. land border, has been disrupted by the pandemic border closures to non-essential traffic. Mail carried drug supply has become more expensive (supply and demand), more toxic and containing higher concentrations of fentanyl and additional substances are being added in.
- Concurrent changes in prescribing and regulation may contribute?
- **Toxic supply and contaminated drugs** are now commonplace in Winnipeg and surrounding areas e.g., "down" which can be a combination of fentanyl, heroin as well as other CNS depressants.

How should we respond?

- **Overview of our services & limitations**
  - **Within the health sector**
    - RAAM
    - Opioid Agonist Therapy
    - Withdrawal management
    - Hospital based services
  - **Outside the health sector**
    - Residential & non-residential treatment programs
    - Peer & community-based supports

Common limitations among services:

- capacity
- wait lists
- accessibility, especially rural/remote
- stigma

Clinical trends in 2020-2021

- **Significant increase in opioid related presentations at RAAM**
  - Most significantly "down", a potent fentanyl analogue (+- benzo +- meth)
- **Highest volume RAAM clinic in Winnipeg, located at CRC:**
  - "re-directing" on average 30% of people who present due to high volumes
    - January - March 2021 at CRC RAAM:
      - 249 people NOT SEEN due to capacity, on average 6.6 people per drop-in clinic
      - opioids account for 73% of presentations
- **Similar trends noted through in-hospital services**
  - Increase in opioid related consults requiring OAT
  - More patients with difficulty stabilizing on traditional OAT

What evidence-based interventions we don't (but should!) have

1. **Specialized OAT service providing Sustained Release Oral Morphine (SROM) and Injectable Opioid Agonist Therapy (iOAT)**
   - Increases retention in treatment, improves social outcomes, reduces illicit drug use and related harms
   - Allows engagement in care for people who have been unsuccessful or are not prepared for treatment with 1st line OAT
2. **Managed Alcohol Programs (MAPs)**
   - improves social outcomes, reduces use of acute care services (e.g. EMS, emergency, contact with police)
3. **Supervised consumption/overdose prevention sites**
   - Strong evidence-base, *repeatedly shown to be cost effective*
     - Reduces harms including overdose and medical consequences (HIV, HCV, SSTI)
     - Increases engagement in care

What you may be hearing about, but where the evidence is unclear…

- **Safe supply ???**
  - **Medications (generally opioids) prescribed by a physician to allow people to use drugs without needing to resort to the toxic illicit drug supply**
  - **Need to study and understand unintended consequences**
    - Iatrogenic Opioid Use Disorder (OUD)
    - Overall impacts on fatal and non-fatal overdose
  - **Larger discussion re: decriminalization vs. legalization**
    - Removing opioid prescribing from medical oversight, similar to cannabis trajectory
  - **? Applicability of safe supply discussion to non-opioids**
    - **Benzodiazepines**
    - **Stimulants**
    - **Other sedatives (e.g. gabapentin, ketamine, GHB)**

Where decision makers could start to effect change

1. **Addressing stigma within our existing systems & services**
   - Mandate ALL publicly funded treatment programs to support opioid agonist therapy (OAT)
   - Require EIA to recognized Substance Use Disorders (SUDs) as a disability
   - Develop standardized, transparent & evidence-informed Child & Family Services (CFS) practices for parents with SUDs
   - Declare governmental support for harm reduction practices including Managed Alcohol and Supervised Consumption

2. **Facilitating easier access to buprenorphine (+- methadone)**
   - Provincial plan for supporting patients in northern/remote communities, leveraging long-acting formulations (Sublocade, Probuphine)
   - Formalizing support for existing (and needed expansion!) of in-hospital addiction consult services
   - Enhancing capacity within primary care – billing codes, access to supports
     - resources: Point of care UDS, harm reduction services including intranasal naloxone
     - staffing: Nursing/case management, counseling (CBT, DBT, MI)

3. **Developing specialist-led programs employing SROM & iOAT**
   - to increase the menu of options, and engage more people in care, especially those with severe disease and substance related harms

4. **Establishing Supervised Consumption/Overdose Prevention Sites and Managed Alcohol Programs**
   - integrated with health care and social supports

Example: PHS (Portland Hotel Society) Community Services Society

- Focused on housing, healthcare, harm reduction & health promotion
- Multiple funding streams including the health sector – a whole system approach!
- Programs include:
  - Multiple supply distribution programs and overdose prevention sites
  - Insite: supervised consumption, drug testing, overdose treatment, wound care
  - Onsite: 12-bed medically supported detox, 18-bed transitional housing
  - Community Managed Alcohol Program
  - Community Transitional Care Team: residential setting with 24/7 me antibiotics to facilitate earlier discharge from hospital
  - Health, dental and Opioid Agonist Therapy services, including iOA
  - Supportive housing

What it could ultimately look like

- **Manitoba Centre of Excellence for Addiction Medicine**
  - **low barrier drop-in space, with access to**
    - supervised consumption (all routes) +- drug checking
    - harm reduction supplies and education
    - primary care services
      - e.g. wound care, vaccinations, STBBI testing & treatment
    - social work & housing supports
    - peer support navigators
  - **co-located with**
    - Expanded urban RAAM clinic, addressing high Wpg volumes
      - Centre of the hub & spoke model
      - Supports rapid assessment as a bridge between harm reduction & treatment
    - Centralized Manitoba OAT service
    - iOAT and SROM clinic
    - Managed alcohol program
  - **transitional housing with nursing supports**

Criteria for success:

-identify partner agencies
-meaningfully engage with people who use (PWU) drugs and peer networks
-integrate educational, research & policy initiatives
-foster communication & partnership between sectors
-develop care & referral pathways
-focus on building capacity within the whole system

Dr. Marina Reinecke

MBChB, CCFP(AM), ISAM, Medical Consultant,
Prescribing Practices Program,
College of Physicians and Surgeons of Manitoba

Questions

Session Break

College of Pharmacists of Manitoba

Overdose in the Era of COVID-19 & Approaching Mental Health in Pharmacy Practice

Dr. Christine Leong

B.Sc. (Gen), B.Sc. (Pharm), Pharm.D.,
Assistant Professor, College of Pharmacy,
Rady Faculty of Health Sciences

Approaching Mental Health in Pharmacy Practice

APPROACHING MENTAL HEALTH IN PHARMACY PRACTICE

Presenter: Dr. Christine Leong, BSc, BScPharm, PharmD

College of Pharmacy, University of Manitoba

Presented to: College of Pharmacists of Manitoba

November 23, 2021

CONFLICT OF INTEREST / DISCLOSURES

- Presenter Name: Christine Leong
- I have no conflicts of interest to disclose
- Member of the Adults Inquest Review Committee (AIRC), Chief Medical Examiner Office of Manitoba
- Speaking fees for current program
  - I have received a speaker's fee from the College of Pharmacists of Manitoba for this learning activity

LEARNING OBJECTIVES

- By the end of this presentation, participants should be able to:

1. Recognize the signs and symptoms of someone experiencing a mental health crisis
2. Describe the pharmacist's role in helping patients experiencing a mental health crisis
3. Explore strategies for communicating with patients experiencing a mental health crisis
4. Identify resources for patients in need of mental health support

CASE 1: DREW, 49M

- History of PTSD, alcohol use disorder, depression, hypertension, GERD, withdrawal seizures, insomnia, and polysubstance use
- He has a hematoma on his forehead from a fall earlier today (blackout)
- He appears uninterested in engaging in conversation (one-word responses, flat affect), lost quite a bit of weight, eyes are bloodshot, tired

CASE 1: DREW, 49M (DOB: OCT 10, 1970)

Date Dispensed	Drug Name	Strength	Days Supply	Quantity	Prescriber
Oct 8, 2020 Sept 10, 2020 Aug 12, 2020 Jul 15, 2020 Jun 18, 2020 May 22, 2020	Diazepam	5 mg	28	56	Dr. X
	Metoprolol	25 mg	28	56	Dr. X
	Olanzapine	10 mg	28	28	Dr. X
	Pantoprazole	40 mg	28	28	Dr. X
	Perindopril/indapamide	8/2.5 mg	28	28	Dr. X
	Quetiapine	300 mg	28	28	Dr. X
	Sertraline	25 mg 100 mg	28 28	84 28	Dr. X
	Zopiclone	5 mg	28	56	Dr. X
Jul 15, 2020	Naltrexone	50 mg	28	28	Dr. Y

CASE 1: DREW, 49M (DOB: OCT 10, 1970)

Date Dispensed	Drug Name	Strength	Days Supply	Quantity	Prescriber
Oct 8, 2020 Sept 10, 2020 Aug 12, 2020 Jul 15, 2020 Jun 18, 2020 May 22, 2020	Diazepam	5 mg	28	56	Dr. X
	Metoprolol	25 mg	28	56	Dr. X
	Olanzapine	10 mg	28	28	Dr. X
	Pantoprazole	40 mg	28	28	Dr. X
	Perindopril/indapamide	8/2.5 mg	28	28	Dr. X
	Quetiapine	300 mg	28	28	Dr. X
	Sertraline	25 mg 100 mg	28 28	84 28	Dr. X
	Zopiclone				
Jul 15, 2020	Naltrexone				

What are your thoughts or concerns about this patient?

What is your approach?

CASE 1: DREW, 49M (DOB: OCT 10, 1970)

Date Dispensed	Drug Name	Strength	Days Supply	Quantity	Prescriber
Oct 8, 2020 Sept 10, 2020 Aug 12, 2020 Jul 15, 2020 Jun 18, 2020 May 22, 2020	Diazepam	5 mg	28	56	Dr. X
	Metoprolol	25 mg	28	56	Dr. X
	Olanzapine	10 mg	28	28	Dr. X
	Pantoprazole	40 m			
	Perindopril/indapamide	8/2.			
	Quetiapine	300			
	Sertraline	25 m 100			
	Zopiclone	5 m			
Jul 15, 2020	Naltrexone	50 m			

How confident do you feel about addressing the potential concerns you have for this patient?

A. Very confident
B. Somewhat confident
C. Somewhat not confident
D. Not confident

CASE 1: DREW, 49M (DOB: OCT 10, 1970)

Date Dispensed	Drug Name	Strength	Days Supply	Quantity	Prescriber
Oct 8, 2020 Sept 10, 2020 Aug 12, 2020 Jul 15, 2020 Jun 18, 2020 May 22, 2020	***Diazepam***	5 mg	28	56	Dr. X
	Metoprolol	25 mg	28	56	Dr. X
	Olanzapine	10 mg	28	28	Dr. X
	Pantoprazole	40 mg			
	Perindopril/indapamide	8/2.5 mg			
	Quetiapine	300 mg			
	Sertraline	25 mg 100 mg			
	Zopiclone				
Jul 15, 2020	***Naltrexone***				

- Multiple sedating medications
- PTSD with diazepam as outpatient
- Naltrexone not refilled/alcohol use
- Hematoma on forehead
- Withdrawn/weight loss

What are your thoughts or concerns about this patient?

What is your approach?

CASE 1: DREW, 49M (DOB: OCT 10, 1970)

Date D	Drug Name	Strength	Days pply	Quantity	Prescriber
C				56	Dr. X
S				56	Dr. X
A				28	Dr. X
Ju					
Ju					
M					
	Quetiapine	300 mg			
	Sertraline	25 mg 100 mg			
	Zopiclone				
Jul 15, 2020	***Naltrexone***				

- Substance use and overdose risk
- Trauma-informed care
- Suicide ideation

ltiple sedating medications
SD with diazepam as outpatient
trexone not refilled/alcohol use

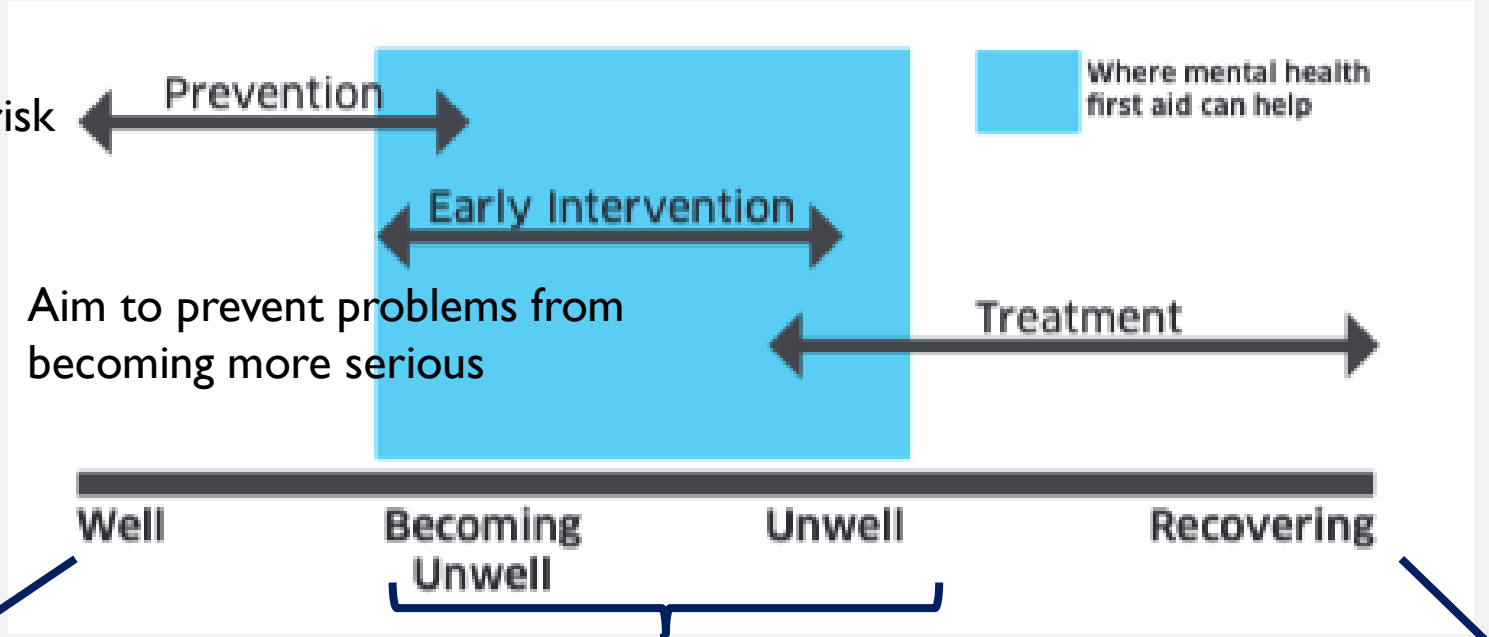
- Hematoma on forehead
- Withdrawn/weight loss

What are your thoughts or concerns about this patient?

What is your approach?

MENTAL HEALTH SPECTRUM

For everyone/those at risk



Medication
Psychological
Support groups
Rehabilitation
Family/friends
Professional (family physician, psychiatrist)
Counsellor

- Cope with stress
- Work productively
- Contribute to community
- Feel capable despite life's challenges

- Affects a person's thinking, emotional state, behaviour
- Negative effects on health and social function

- Find new meaning of living a satisfying, hopeful, contributing life as one grows beyond the effects of mental illness

Mental Health Commission of Canada. Mental Health First Aid – Reference Guide.

SUBSTANCE USE AND MENTAL HEALTH

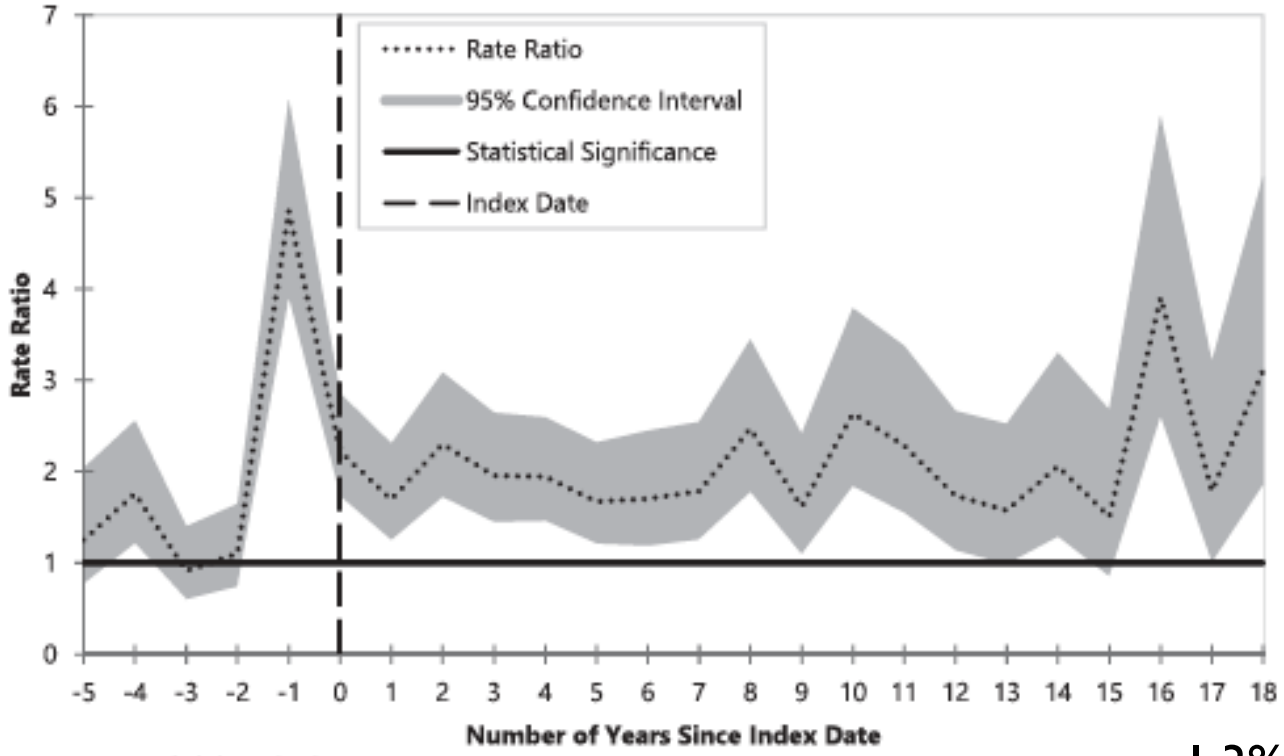
- **2 in 5** people who experienced anxiety or depression reported not seeking medical treatment for it[1]
- **95%** of people with SUD did not seek treatment because they perceived they did not need it[2]
- **17.5%** of people with SUD who perceived they needed SUD treatment did not receive treatment because they were concerned about their neighbors/community having a negative opinion about them[2]

What role is stigma playing in treatment for people with mental illness and SUD?

CAMH Mental Illness and Addiction: Facts and Statistics; Han et al. Center for Behavioral Health Statistics and Quality, 2020

ALCOHOL USE DISORDER IN MANITOBA

a Adjusted Rate Ratios of Alcohol Related Cancers for Males with AUD* (cases) and without AUD (matches), Before and After Index Date



*AUD: Alcohol Use Disorder
Index Date: Date of first diagnosis of AUD
Adjusted for mental disorders, age at diagnosis, region of residence, and postal code (neighbourhood-level income).

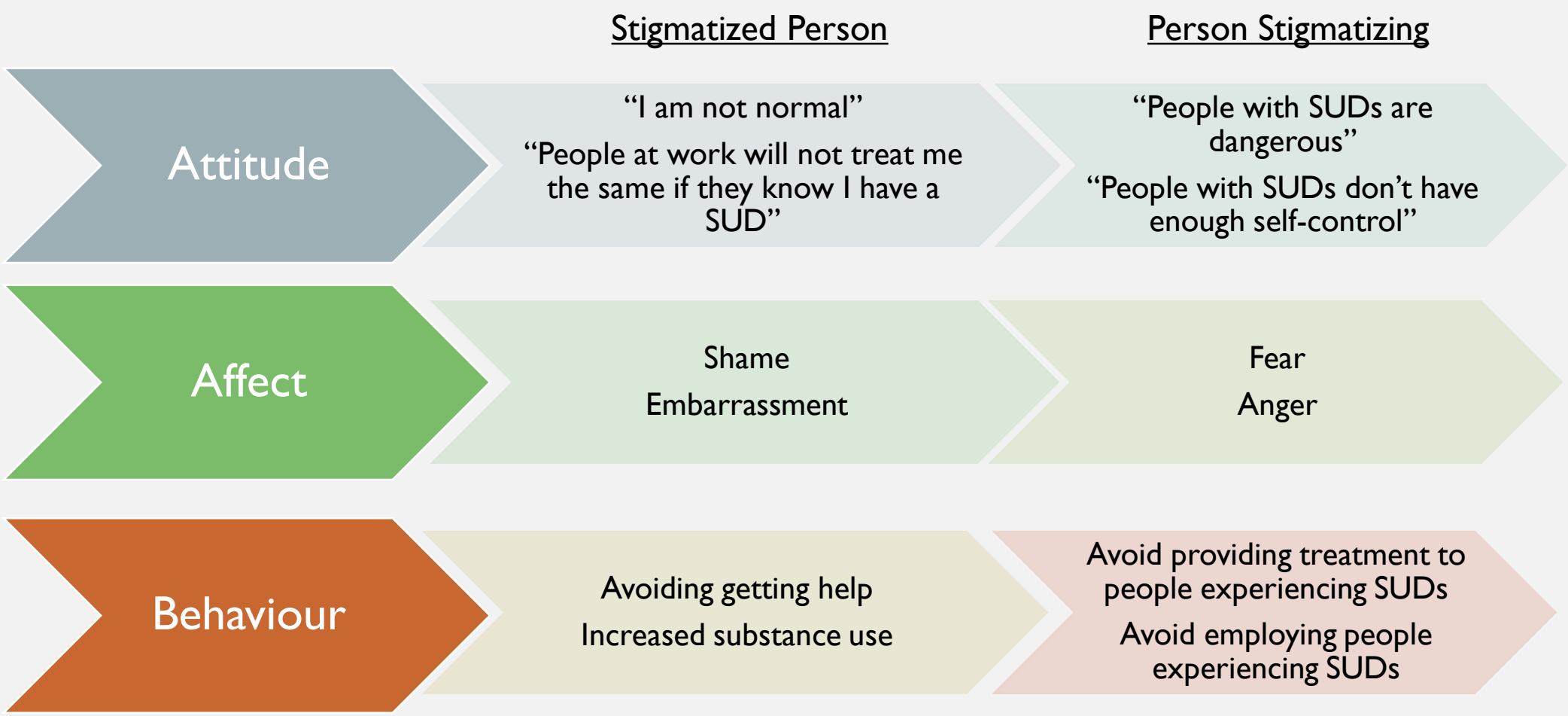
- Alcohol related cancers, diabetes, ischemic heart disease diagnoses **peaked one year prior** to **AUD recognition**
- Problematic drinking more likely to be detected when individuals seek care for a serious medical condition
- Need for better recognition and early treatment of problematic alcohol use in primary care

1.3% with AUD take AUD pharmacotherapy in Manitoba between 1996 and 2015

58% naltrexone, 36.3% acamprosate, 5.7% disulfiram

Leong C, Bolton J, Okechukwu E, et al. Addiction 2021

MEASURING STIGMA



Corrigan et al. Psychiatr Serv 2012;63(10):963-73

STIGMATIZING LANGUAGE

- **Questioning credibility** (implies disbelief) *"He claims that the NRT isn't working for him"*
- **Disapproval** (convey patient is unreasonable) *"Informed patient there is no evidence for this, but patient has strong beliefs"*
- **Stereotyping** (quoting incorrect grammar) *"Reports that the bandage got "a li'l wet""*
- **Difficult patient** (info with little clinical importance to convey annoyed)

  "She perseverated on the fact that "a lot of stuff is going on at home" but that "you wouldn't understand"
- **Unilateral decisions** (emphasize physician authority)

  "She was told to discontinue…"

Park et al. JAMA Network Open 2021;4(7):e2117052; Nyblade et al. BMC Medicine 2019;17:25

SMALL ACTIONS HAVE A LARGE IMPACT

- **Non-Stigmatizing Person-Centered Language** "person experiencing a substance use disorder"
- **Training/Resources** National Alliance on Mental Illness – Stigma Free; SAMHSA The Power of Perceptions and Understanding 4-part webcast series; CAMH Understanding Stigma Course

Stigmatizing	Respectful
It drives me ***crazy***.	It ***bothers/annoys/ frustrates*** me.
This is ***nuts***.	This is ***interesting/strange/ peculiar/funny***.
This individual ***suffers*** from depression.	They ***live with/are experiencing*** depression.
Mentally ill or ***insane*** person	Person ***living with a mental health problem or illness***
Committed suicide, ***successful*** suicide	***Died*** by suicide
Failed or ***unsuccessful*** suicide attempt	***Attempted*** suicide
Substance ***abuse***	Substance ***use*** or ***substance use disorder***
Everyone who is a ***junkie...***	Everyone who ***uses substances...***
They used to be an ***addict***.	They are ***in recovery.***

Safer Language Reference Guide. Available: https://www.mhfa.ca/en/safer-language-reference-guide (Accessed August 12, 2021)

CASE 1: DREW, 49M

- Admits to using substances because his medications that his doctor prescribed for anxiety "don't work"
- Drug of choice is alcohol, started drinking at 14 years old
- Daily drinker 15 beers
- Snorts cocaine <1x/month at most
- Sought treatment at HSC Psychiatry and AFM three months ago for low mood and alcohol use

CASE 1: DREW, 49M

- Two years ago, experienced a frightening home invasion with minor injuries
  Since then has been ++hypervigilant

  boarded up window, does not leave apartment, ++checking behaviors, restless sleep waking up to smallest sounds

- Found brother post hanging at 17 years of age

  Feels guilt, self-blame

- Recurring nightmares about brother and about home invasion

CASE 1: DREW, 49M

- Two years ago, experienced a frightening home invasion with minor injuries Since then has been ++hypervigilant

  boarded up window, does not leave apartment, ++checking behaviors, restless sleep waking up to smallest sounds

- Found brother post hanging at 17 years of age

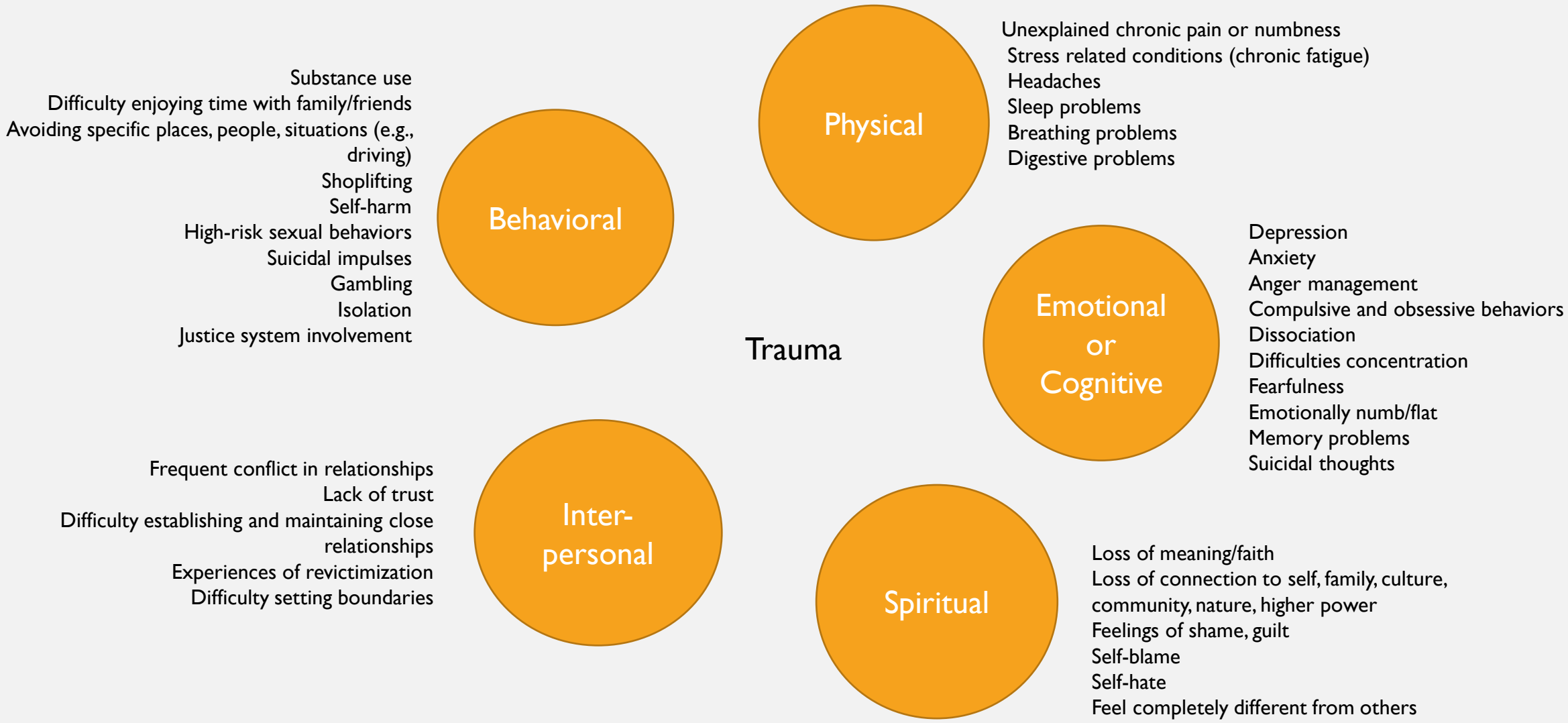
  Feels guilt, self-blame

- Recurring nightmares about brother an

Elements of trauma

- Repeated living of memories of the traumatic experience
- Avoidance of reminders of trauma
- Pattern of increased arousal
- Negative cognitions and mood

WHY IS IT IMPORTANT TO BE TRAUMA-INFORMED?



From The Trauma Informed Practice Guide, 2013

FROM (Deficit Perspective)	TO (Trauma Informed & Strengths Based)
What is wrong?	What has happened?
Symptoms	Adaptations
Disorder	Response
Attention Seeking	The individual is trying to connect in the best way they know how
Borderline	The individual is doing the best they can given their early experiences
Controlling	The individual seems to be trying to assert their power
Manipulative	The individual has difficulty asking directly for what they want
Malingering	Seeking help in a way that feels safer

Adapted from Royal College of Nursing, 2008 in Trauma Informed Practice Guide, May 2013

HOW CAN PHARMACISTS CAN MAKE A DIFFERENCE

- Learn about trauma and trauma-informed care
- Approach things with curiosity
- Willingness to be empathetic, to listen and learn from those affected by trauma
- Treat those affected by trauma as equal
- Explain why we are asking sensitive questions
- Be flexible
- Be comfortable with unknown

This is the information. This is the common experiences that people experience. You may experience X, Y, and Z. These reactions are normal and not everyone will experience it. Treatment is just one form of therapy.

CASE 1: DREW, 49M

- Over last few months having worsening mood, frequent unprompted crying episodes.
- Fleeting suicide ideation but no history of suicidal attempts (psychiatry note)
- No energy, no concentration, anhedonia, poor appetite, and lost 100 lbs due to not leaving apartment to grocery shop.
- Feeling sad about his birthday coming up. Says, "I sometimes don't see what the point of anything is anymore"

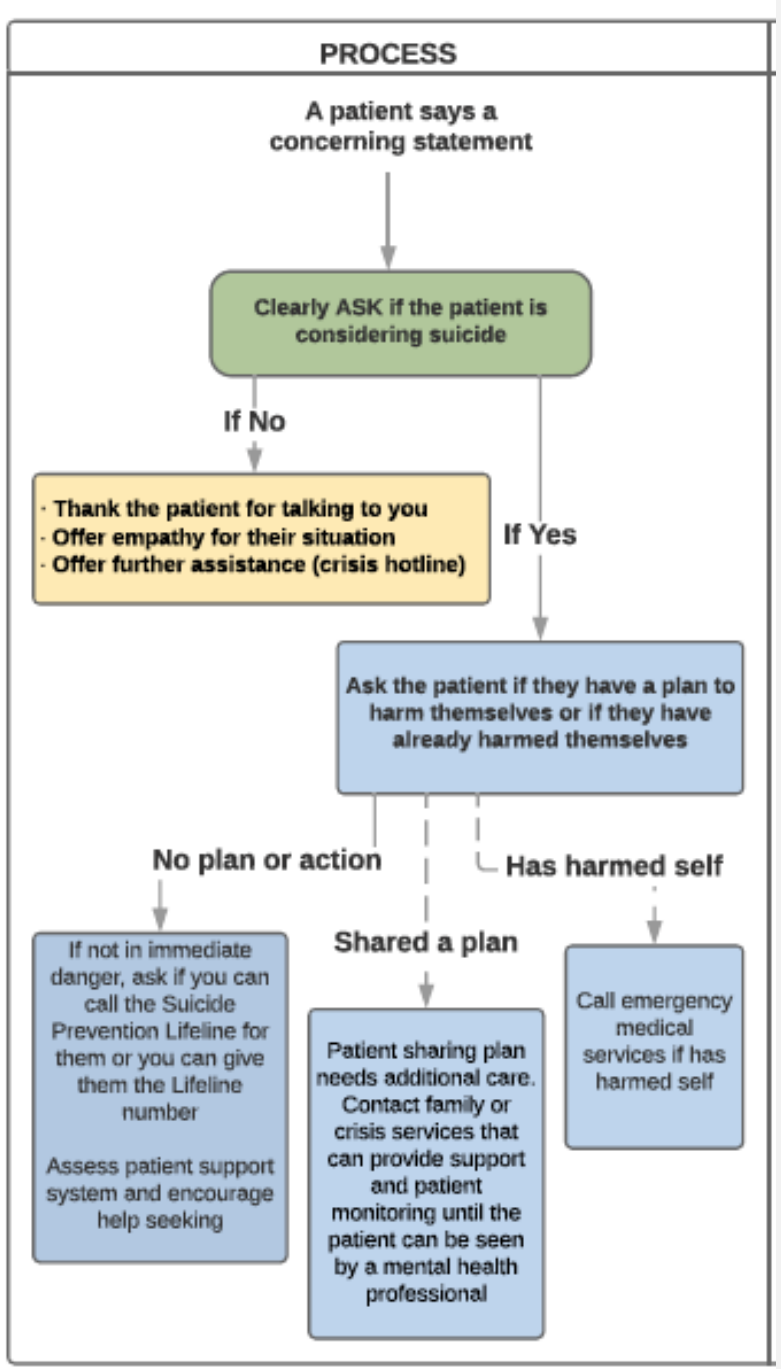
CASE 1: DREW, 49M

- Lives alone in apartment
- Worked as a mechanic 4 years ago but stopped working following a physical injury from being hit by a car while riding a bike; currently on EIA
- Separated from ex-wife 20 years ago; no contact with daughter (28 years old) but some with son (25 years old), poor social supports
- Current stressors: getting evicted, financial issues

SUICIDAL IDEATION WARNING SIGNS POTENTIALLY ENCOUNTERED BY PHARMACISTS

Patient concern type	Warning sign
Statements/questions	• How much of this medicine would it take to kill someone? • What combination of medicines could I use to kill myself? • If I overdose on this medicine and don't die, what damage will it cause? • I can't take living like this anymore • The side effects of this medication are worse than death • I just wish I could go to sleep and neve wake up • I am going to kill myself
Behaviors, non-verbal	• Someone who is typically cheerful, is now looking down and depressed • Decline in hygiene (change in frequency of showers, make-up, dress) • Anxiety, agitation, lack of sleep, or sleeping too much • Dramatic mood changes

Witry et al. Currents in Pharmacy Teaching and Learning 2019;11:585-91.



Witry et al. Currents in Pharmacy Teaching and Learning 2019;11:585-91.

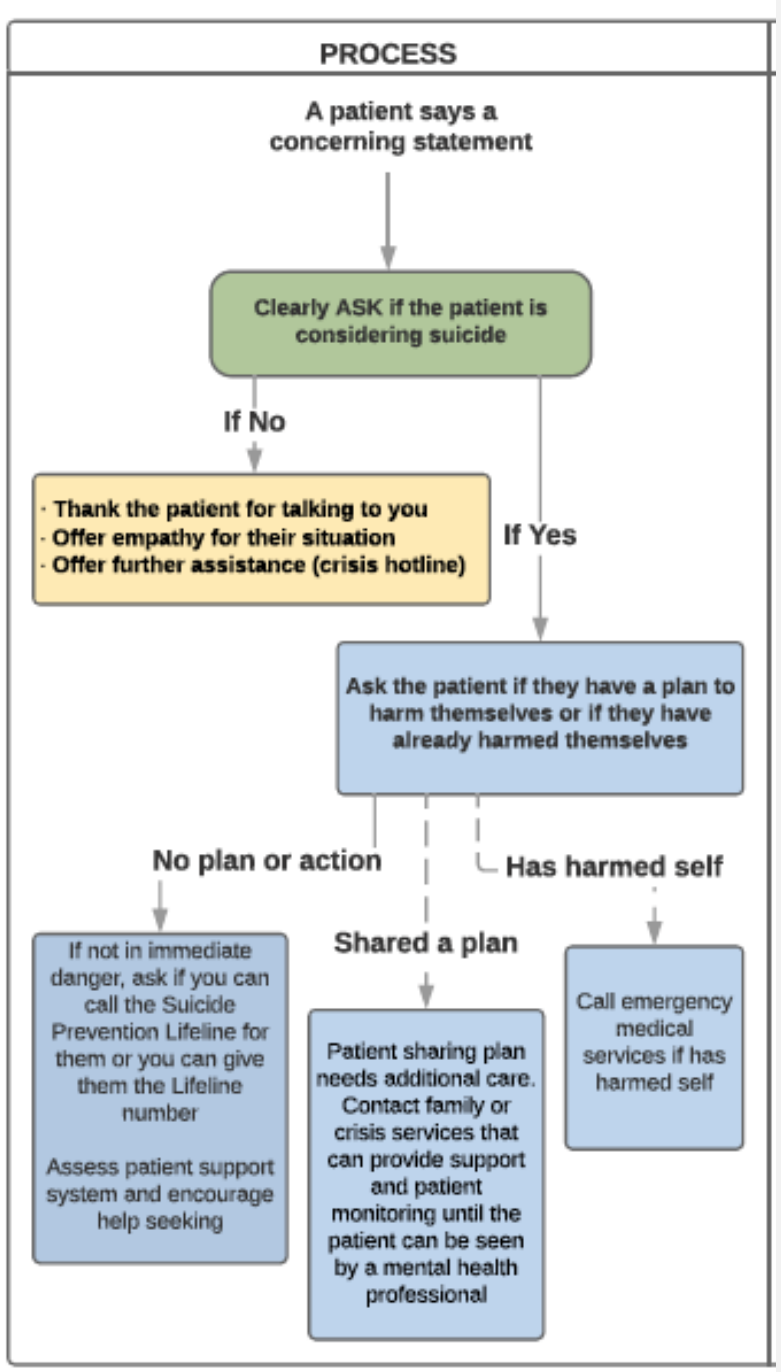
Asking if the patient is considering suicide:

- "I am concerned about some of the information that you told me. I need to ask if you have thought about suicide or harming yourself or others? I care about you and I want to know that you are ok."
- "With the information that you told me, I am wondering if you are thinking about suicide?"
- "When you say that you don't see the point in anything anymore, have you had thoughts about suicide?

- Practice responding ahead of time
- Try to remain calm and listen
- Be direct
- Name their emotion and allow them to talk
- Show you care

If the answer is no:

- "Thank you for sharing with me. It sounds like you are overwhelmed with everything going on. Can I call someone for you or connect you with a counselor who can provide support?"
- "Thank you for talking to me. It sounds like you have been having a rough year. Can I offer you some resources and a crisis hotline number in case you need to call someone?"



Asking if the patient is considering suicide:

- "I am concerned about some of the information that you told me. I need to ask if you have thought about suicide or harming yourself or others? I care about you and I want to know that you are ok."
- "With the information that you told me, I am wondering if you are thinking about suicide?"
- "When you say that you don't see the point in anything anymore, have you had thoughts about suicide?

- Practice responding ahead of time
- Try to remain calm and listen
- Be direct
- Name their emotion and allow them to talk
- Show you care

If the answer is yes:

- "I don't want anything bad to happen to you, would it be all right if I called the suicide lifeline for you?"
- "Is there someone I can call to make sure you stay safe?"

Witry et al. Currents in Pharmacy Teaching and Learning 2019;11:585-91.

NATIONAL RESOURCES

211	Through partnerships with United Way, each province and territory has access to 211, a database of social support resources
CRISIS SERVICES CANADA 1.833.456.4566/text 45645	Connect with trained crisis responders Hours and availability: crisisservicescanada.ca/
KIDS HELP PHONE 1.800.668.6868 Text 686868 Kidshelpphone.ca	24/7 access to a counsellor for persons aged 5 to 20. Available in French and English
HOPE FOR WELLNESS 1.855.242.3310 Hopeforwellness.ca	Counseling and crisis intervention for Indigenous peoples. Available 24/7 in English, French, Cree, Ojibway, and Inuktitut.
WELLCAN Wellcan.ca/download the app	Wellbeing resources for Canadians during the COVID-19 pandemic, including mental health, financial and social support info.

LOCAL RESOURCES

Crisis Response Centre (CRC) Located at 817 Bannatyne Avenue	Drop in 24/7 for adults experiencing a mental health crisis.. If you refer a patient to visit the CRC, please call the Mobile Crisis Line (204-940-1781) to let staff know your concerns. Patients under the Mental Health Act (Form 4) must go to an emergency department.
Mobile Crisis Service Call 204-940-1781	A 24/7 phone service assisting individuals experiencing a mental health or psychosocial crisis. If appropriate, Mobile Crisis can meet with individuals in crisis at a location within Winnipeg that is comfortable for them.
Klinic Crisis Line Call 204-786-8686	A 24/7 phone service assisting individuals experiencing amental health crisis, difficulty coping or need help sorting out a problem.
Rapid Access to Addictions Medicine Clinic (RAAM) CRC 817 Bannatyne Ave or River Point Centre 146 Magnus Ave	A drop in clinic for individuals seeking help with high risk substance use and addictions. Not for individuals needing urgent medical attention.
Rapid Access to Consultative Expertise (RACE) Call 204-940-2573 M-F 9a-4p	For quick access to psychiatric consultant for questions that may not require an in-person assessment of the patient (e.g., med adjustment, choice/timing of investigations, suitability of referrals)

The Patient Self-Help Guide for Mental Health in Winnipeg

I am interested in self-help resources.

Online Modules & Courses

E-Couch *(FREE)*
Interactive modules.
Website: ecouch.anu.edu.au

CBT-i Coach *(FREE)*
For treatment of insomnia.
Website: mobile.va.gov/app/cbt-i-coach

Here to Help *(FREE)*
Self-guided modules on wellness topics.
Website: www.heretohelp.bc.ca/wellness-modules

MindShift *(FREE)*
Skills building for coping with anxiety.
Website: www.anxietycanada.com/resources/mindshift-app

Mood Gym *($$)*
Structured modules.
Website: moodgym.com.au

PTSD Coach Canada *(FREE)*
Information on PTSD & tools for screening and tracking symptoms.
Website: www.veterans.gc.ca/eng/stay-connected/mobile-app/ptsd-coach-canada

Stress Strategies *(FREE)*
Learn stress management strategies.
Website: www.stressstrategies.ca

Self-Guided Workbooks

Some books include:
- The Mindfulness and Acceptance Workbook for Anxiety – J. Forsyth & G. Eifert
- Mind Over Mood – D. Greenberger & C. Padesky
- Feeling Good: The New Mood Therapy – D. Burns
- Overcoming Depression and Low Mood: A Five Areas Approach – C. Williams
- Calming the Emotional Storm – S. van Dijk
- DBT Made Simple – S. van Dijk
- Self-Compassion: The Proven Power of Being Kind to Yourself-K. Neff
- Full Catastrophe Living: Using the Wisdom of your Body and Mind to face Stress, Pain and Illness-J. Kabat-Zinn

Mindfulness Meditation Apps
- Breathe: www.breathe.com
- Calm in the Storm: www.calminthestormapp.com
- Headspace: www.headspace.com
- Simple Habit: www.simplehabit.com
- Stop Breathe & Think: www.stopbreathethink.com

Psyber: psyberguide.org – reviews mental health apps based on credibility, user experience, & transparency

I am in crisis and need help now.

Mobile Crisis Service: 204-940-1781
Crisis Response Centre: 817 Bannatyne Avenue
Manitoba Suicide Phone Line: 1-877-435-7170
Klinic Crisis Line: 204-786-8686

The Canadian Mental Health Association service navigator:
Website: www.mbwpg.cmha.ca/programs-services/snh/
Phone: 204-775-6442

The WRHA Mental Health Resource Guide:
www.mbwpg.cmha.ca/resources/mental-health-resource-guide-for-winnipeg/

Guide to Health & Social Services for Indigenous Peoples in Manitoba:
www.wrha.mb.ca/aboriginalhealth/services/files/AHSGuide.pdf

Online database for services in Manitoba:
http://mb.211.ca/

I want to access counselling or therapy.

For a comprehensive list of counselling services in Winnipeg, please see page 8 of the WRHA Mental Health Resource Guide (linked above).

For fee counselling services (fees vary; may be covered by insurance plans):
Manitoba Psychological Society: mps.ca/find-psychologist/
Other therapists: www.psychologytoday.com/ca

I am open to trying online or text-based therapy:
- *7 Cups:* www.7cups.com
- *Beacon:* www.mindbeacon.com
- *InkBlot:* Ink.inkblottherapy.com
- *Joyable:* joyable.com
- *Talkspace:* www.talkspace.com

Things to consider –
I am a student:
There is likely counselling available through your college/university free of charge or at a reduced rate. Contact your Student Services for more information.

I work/have a partner who works/have parents who work:
You may have access to therapy through an *Employee Assistance Program (EAP)*. Contact Human Resources or your employee insurance company.

Questions to ask when choosing a therapist:
www.therapyreferral.org/resources/interviewing-a-therapist

I want to become more educated about mental illness.

Canadian Mental Health Association:
https://cmha.ca/mental-health/understanding-mental-illness

Centre for Addiction & Mental Health:
www.camh.ca/en/health-info

Here to Help: www.heretohelp.bc.ca

Aboriginal Healing Foundation www.ahf.ca
Alberta Family Wellness Initiative – Brain story certification course https://www.albertafamilywellness.org/
Canadian Mental Health Association www.mbwpg.cmha.ca
Klinic Community Health www.klinic.mb.ca
Trauma Informed www.trauma-informed.ca
Trauma Recovery www.trauma-recovery.ca

CASE 1: DREW, 49M (DOB: OCT 10, 1970)

Date Dispensed	Drug Name	Strength	Days Supply	Quantity	Prescriber
Oct 8, 2020 Sept 10, 2020 Aug 12, 2020 Jul 15, 2020 Jun 18, 2020 May 22, 2020	***Diazepam***	5 mg	28	56	Dr. X
	Metoprolol	25 mg	28	56	Dr. X
	Olanzapine	10 mg	28	28	Dr. X
	Pantoprazole	40 mg			
	Perindopril/indapamide	8/2.5 mg			
	Quetiapine	300 mg			
	Sertraline	25 mg 100 mg			
	Zopiclone				
Jul 15, 2020	***Naltrexone***				

- Multiple sedating medications
- PTSD with diazepam as outpatient
- Naltrexone not refilled/alcohol use
- Hematoma on forehead
- Withdrawn/weight loss

What are your thoughts or concerns about this patient?

What is your approach?

CASE 1: DREW, 49M

- MHFA — Assess safety/severity, Listen, Give Reassurance, Encourage help/support
- Re-assess the efficacy and safety of medications to determine need for continued use (renal/liver function monitoring, obesity/sleep)
- Help create a gradual taper schedule with frequent follow-up to reduce the risk of combination sedating medications
- Limit dispensing quantities (weekly or daily)

FINAL THOUGHTS

- Create a safe space in your practice, use person-first language
- Approach encounters with curiosity
- Explain the purpose of questions
- Allow space to identify needs
- Convey acceptance in body language and tone
- Accumulation of small things for patients to feel seen and heard
- Support patients to open up and seek support to begin healing when ready

SELF-CARE ASSESSMENT WORKSHEET

Physical Self-Care
___ Eat regularly (e.g. breakfast, lunch and dinner)
___ Eat healthy
___ Exercise
___ Get regular medical care for prevention
___ Get medical care when needed
___ Take time off when needed
___ Get massages
___ Dance, swim, walk, run, play sports, sing, or do some other physical activity that is fun
___ Take time to be sexual—with yourself, with a partner
___ Get enough sleep
___ Wear clothes you like
___ Take vacations
___ Take day trips or mini-vacations
___ Make time away from telephones
___ Other:

Psychological Self-Care
___ Make time for self-reflection
___ Have your own personal psychotherapy
___ Write in a journal
___ Read literature that is unrelated to work
___ Do something at which you are not expert or in charge
___ Decrease stress in your life
___ Let others know different aspects of you
___ Notice your inner experience—listen to your thoughts, judgments, beliefs, attitudes, and feelings
___ Engage your intelligence in a new area, e.g. go to an art museum, history exhibit,
sports event, auction, theater performance
___ Practice receiving from others
___ Be curious
___ Say "no" to extra responsibilities sometimes
___ Other:

Emotional Self-Care
___ Spend time with others whose company you enjoy
___ Stay in contact with important people in your life
___ Give yourself affirmations, praise yourself
___ Love yourself
___ Re-read favorite books, re-view favorite movies
___ Identify comforting activities, objects, people, relationships, places and seek them out
___ Allow yourself to cry
___ Find things that make you laugh
___ Express your outrage in social action, letters and donations, marches, protests
___ Play with children
___ Other:

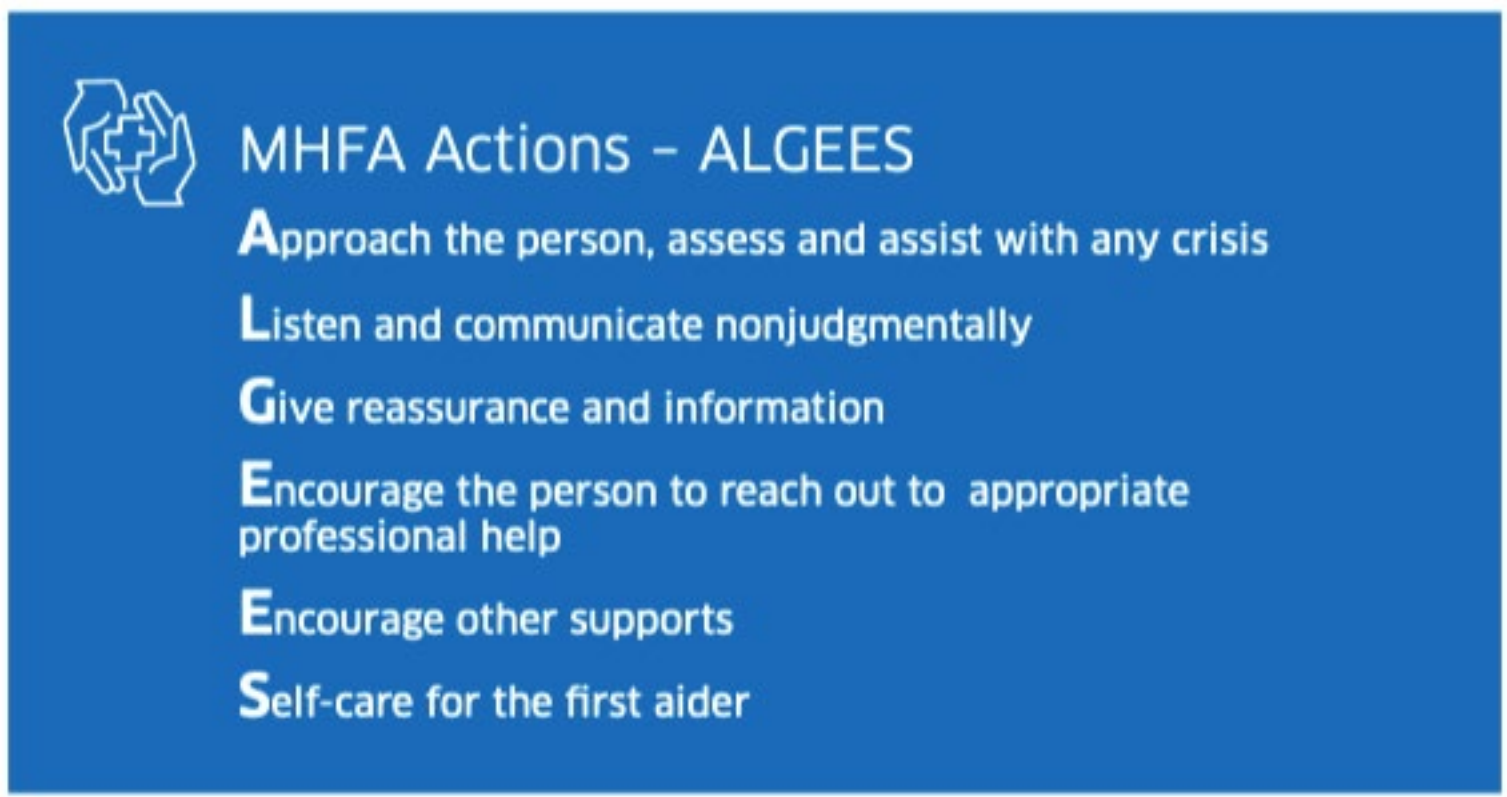
Spiritual Self-Care
___ Make time for reflection
___ Spend time with nature
___ Find a spiritual connection or community
___ Be open to inspiration
___ Cherish your optimism and hope
___ Be aware of nonmaterial aspects of life
___ Try at times not to be in charge or the expert
___ Be open to not knowing
___ Identify what in meaningful to you and notice its place in your life
___ Meditate
___ Pray
___ Sing
___ Spend time with children
___ Have experiences of awe
___ Contribute to causes in which you believe
___ Read inspirational literature (talks, music, etc.)
___ Other:

Workplace or Professional Self-Care
___ Take a break during the workday (e.g. lunch)
___ Take time to chat with co-workers
___ Make quiet time to complete tasks
___ Identify projects or tasks that are exciting and rewarding
___ Set limits with your clients and colleagues
___ Balance your caseload so that no one day or part of a day is "too much"
___ Arrange your work space so it is comfortable and comforting
___ Get regular supervision or consultation
___ Negotiate for your needs (benefits, pay raise)
___ Have a peer support group
___ Develop a non-trauma area of professional interest
___ Other:

Balance
___ Strive for balance within your work-life and workday
___ Strive for balance among work, family, relationships, play and rest

Source: Transforming the Pain: A Workbook on Vicarious Traumatization. Saakvitne, Pearlman & Staff of TSI/CAAP (Norton, 1996)

MENTAL HEALTH FIRST AID (MHFA)



MHFA FOR MANITOBA PHARMACISTS RESEARCH

- Recruiting practicing community pharmacists to participate in a pilot project to train pharmacists in Mental Health First Aid
- Time commitment entails:
  - MHFA Training (~8 hours online or in-person)
  - Debrief Session (~1 hour)
  - Pre- and post-training surveys
  - Patient encounter forms for 3 months

Eligible for Self-Study Continuing Education credit

- Honorarium $100 for your participation
- Funded by the Canadian Foundation for Pharmacy
- Contact: Christine.leong@umanitoba.ca

THANK YOU!

Dr. Marina Reinecke

MBChB, CCFP(AM), ISAM, Medical Consultant,
Prescribing Practices Program,
College of Physicians and Surgeons of Manitoba

Questions

COMPLETE

College of Pharmacists of Manitoba

Overdose in the Era of COVID-19 & Approaching Mental Health in Pharmacy Practice