# Diagnostic Issues

## Diagnosis

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2 DIAGNOSTIC ISSUES
Diagnosis

THE PSYCHIATRIC INTERVIEW

Diagnoses should be made with direct reference to the DSM-IV or DSM-IV-TR. Typically, a psychiatric interview would have the following structure:

■ identifying information: age, marital status, occupation/financial support, living conditions, family
■ chief complaint
■ history of presenting illness
  ▪ based on the early information, is this a psychotic, anxiety, mood or substance disorder
  ▪ thoroughly review the symptoms of the disorder
  ▪ screen for the three other categories of disorder
■ substances of abuse — route, frequency, quantity, last use:
  ▪ alcohol, rubbing alcohol, Listerine
  ▪ stimulants: cocaine, crystal methamphetamine
  ▪ marijuana
  ▪ opiates — heroin, methadone, morphine, codeine, oxycodone (Oxycontin)
  ▪ benzodiazepines
  ▪ tobacco (chew, cigarettes)
  ▪ caffeine
  ▪ OTC and prescription (especially anticholinergics)
■ past psychiatric history
  ▪ hospitalizations
  ▪ suicide attempts (severity; parasuicidal nature — overdoses, wrist slashing; how they survived, were substances involved?)
  ▪ medication trials (whether trial was completed; whether remission was achieved — partial, full, duration; reasons for discontinuation)
  ▪ psychotherapy, counselling (age when first saw professional and for what reason)
■ past medical history
  ▪ hospitalizations
  ▪ history of injection drug use
  ▪ surgeries
  ▪ chronic illness
  ▪ head trauma, MVAs, loss of consciousness
  ▪ endocrine disorders — thyroid +/- medical or surgical intervention
  ▪ seizures
  ▪ risk/presence of HIV/ HCV/ HBV/TB
■ current and recent medications
■ family history
  ▪ psychiatric (suicides, substance use, hospitalizations, odd or estranged family members)
  ▪ medical/ surgical
Suicide Risk Assessment
— adapted from Rubenstein, Unutzer, Miranda et al, 1996

- Ask all patients at risk (including depression, anxiety disorders, psychosis, substance use disorders, personality disorders, etc.) if they have thoughts of death or suicide, or if they feel hopeless and feel that life is not worth living. Also ask if they have previously attempted suicide.
- If the answer is yes, ask about plans for suicide. How much have they thought about suicide? Have they thought about a method? Do they have access to material required for suicide? Have they said goodbyes, written a note or given away things? What specific conditions would precipitate suicide? What is stopping them from suicide?
- Assess risk factors for suicide.
- Warn the patient that agitation and suicide risk may increase early in treatment.
- Obtain collateral information from family or friends.
- Consider emergency psychiatric consultation and treatment if:
  - suicidal thoughts are persistent
  - the patient has a prior history of a suicide attempt or a current plan
  - the patient has several risk factors for suicide.
The symptoms of depression can be divided into 2 categories:
- cognitive, behavioural or emotional (low mood, loss of interest or enjoyment, trouble concentrating, feelings of guilt or self-blame, low self-esteem, thoughts of death and suicide)
- physical or neurovegetative (fatigue, psychomotor changes, disturbances of sleep and appetite/weight).

The symptom criteria for MDD can be recalled using the **SIG E CAPS** mnemonic:

- **S** — Sleep disturbance (too much or too little)
- **I** — Interest reduced (reduced pleasure or enjoyment)
- **G** — Guilt (excess) and self-blame or feelings of worthlessness
- **E** — Energy loss and tiredness
- **C** — Concentration problems
- **A** — Appetite changes (low appetite/weight loss or increased appetite/weight gain)
- **P** — Psychomotor changes (slowed down or speeded up)
- **S** — Suicidal thoughts.

The individual must have depressed mood (or loss of interest) and at least 4 other symptoms, most of the time, most days, for at least two weeks.

**DSM-IV or DSM-IV-TR Criteria: Major Depressive Episode**

Five or more of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure:

1. depressed mood, as described by the patient (e.g., feels sad or empty) or by observation (e.g., appears tearful)
2. markedly reduced interest or pleasure in all, or almost all, activities nearly every day
3. significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite
4. insomnia or hypersomnia (or increased need for sleep).
5. psychomotor agitation or retardation (observable by others, not merely subjective feelings of restlessness or being slowed down)
6. fatigue or loss of energy.
7. feelings of worthlessness or excessive or inappropriate guilt
8. reduced ability to think or concentrate, or indecisiveness
9. recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
Bipolar Disorder

- Bipolar disorder is often misdiagnosed as unipolar depression largely because mania and hypomania often go unrecognized.
  - In adolescents/youth, psychotic mania can be mistaken for schizophrenia.
- When a patient appears depressed, probe extensively for hypomania. Ask
  - Do they ever have periods when they need less sleep or go to bed later for even only a few days (sleep pattern changes can be as subtle as a couple hours)?
  - Do they ever feel the “opposite of depressed”? 
  - Do they have periods of taking on more responsibility or plans that they ultimately are unable to fulfill?
  - Do they ever feel overconfident or “grandiose”? 
  - Do their thoughts ever feel “sped up” or feel like they can’t speak quickly enough to get their words out or have friends tell them that they are speaking quickly?
  - Do they act impulsively — for instance with spending sprees, casual sex, or gambling?
- On history, bankruptcies, changes in sexual behavior, legal involvement, or sudden dismissals from employment may reflect a history of hypomania.
- On past psychiatric history, they may have been diagnosed early as having personality disorders, or have had multiple trials of antidepressants with similar outcomes: early mood improvement (in the first 1 – 2 weeks) with eventual treatment failure.
- Rule out or identify comorbid substance use, especially cocaine, crystal methamphetamine and alcohol.
- Depressive episodes in bipolar disorder may be indistinguishable from major depressive disorder. Alternatively, there is a tendency towards atypical symptoms:
  - hypersomnia
  - hyperphagia
  - leaden paralysis (a subjective feeling of heaviness in the limbs).
(See the DSM-IV or DSM-IV-TR Criteria.)
DIAGNOSING MAJOR DEPRESSIVE DISORDER

Mood Disorders — Diagnostic Decision Tree
(adapted from DSM-IV or DSM-IV-TR)

Depressed, elevated, expansive, or irritable mood

Due to the direct psychological effects of a general medical condition

Yes

MOOD DISORDER DUE TO A GENERAL MEDICAL CONDITION

No

Due to the direct psychological effects of a substance (i.e., a drug of abuse, a medication or a toxin)

Yes

SUBSTANCE INDUCED MOOD DISORDER

No

Determine type of present and past mood disorders

Elevated, expansive or iritated mood, at least 1-week duration; marked impairment or hospitalization

Yes

MANIC EPISODE

No

Elevated, expansive or irritate mood, at least 4-day duration; changes observable by others but less severe than a Manic Episode

HYPOMANIC EPISODE

No

At least 2 weeks of depressed mood or loss of interest plus associated symptoms, and not better accounted for by Bereavement

MAJOR DEPRESSIVE EPISODE

No

Criteria met for Manic Episode and Major Depressive Episode nearly every day for at least 1 week

MIXED EPISODE

Has ever had a MANIC EPISODE or a MIXED EPISODE

Yes

Psychotic symptoms occur at times other than during Manic or Mixed Episodes

BIPOLAR I DISORDER

No

Occurred exclusively during Schizoaffective Disorder (review Psychotic Disorders tree)

SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE

No

BIPOLAR DISORDER NOS (superimposed on a psychotic disorder)
DIAGNOSING MAJOR DEPRESSIVE DISORDER

1. Has ever had a HYPOMANIC EPISODE and at least one MAJOR DEPRESSIVE EPISODE
   - Yes: BIPOLAR II DISORDER
   - No: 2+ years of hypomaniac symptoms and periods of depressed mood

2. 2+ years of hypomaniac symptoms and periods of depressed mood
   - Yes: CYCLOTHYMIC DISORDER
   - No: Clinically significant manic/hypomaniac symptoms that do not meet criteria for a specific Bipolar Disorder

3. Clinically significant manic/hypomaniac symptoms that do not meet criteria for a specific Bipolar Disorder
   - Yes: BIPOLAR DISORDER NOS
   - No: Has ever had a MAJOR DEPRESSIVE EPISODE

4. Has ever had a MAJOR DEPRESSIVE EPISODE
   - Yes: Psychotic symptoms occur at times other than during Major Depressive Episodes
     - Yes: SCHIZOAFFECTIVE DISORDER, DEPRESSIVE TYPE
     - No: MAJOR DEPRESSIVE DISORDER
   - No: Depressed mood, more days than not, for at least 2 years with associated symptoms

5. Depressed mood, more days than not, for at least 2 years with associated symptoms
   - Yes: DYSTHYMIC DISORDER
   - No: Depressed mood not meeting criteria for one of above Mood Disorders that develops in response to a stressor

6. Depressed mood not meeting criteria for one of above Mood Disorders that develops in response to a stressor
   - Yes: ADJUSTMENT DISORDER WITH DEPRESSED MOOD
   - No: Clinically significant depressive symptoms that do not meet criteria for specific mood disorder

7. Clinically significant depressive symptoms that do not meet criteria for specific mood disorder
   - Yes: DEPRESSIVE DISORDERS NOS
   - No: No Mood Disorder (mood Symptoms that are not Clinically significant)
All anxiety disorders share basic symptoms of anxiety, fear, and avoidance. Panic attacks can occur across all anxiety disorders. Panic attack is defined as a sudden episodic rush of intense fear or terror along with physiological symptoms (e.g., rapid heart rate, shortness of breath) and concern about losing control, going crazy, having a heart attack, etc.

### Features of the Main Anxiety Disorders
adapted from DSM-IV or DSM-IV-TR

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<th>Type of Anxiety Disorder</th>
<th>Main Features</th>
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<td>Obsessive Compulsive Disorder</td>
<td>repeated, unwanted, intrusive thoughts/images/urges (obsessions) accompanied by repetitive behaviours or mental acts (compulsions) in attempts to neutralize anxiety</td>
</tr>
<tr>
<td>Social Anxiety Disorder</td>
<td>excessive fear of social or performance situations (e.g., being judged negatively by other people)</td>
</tr>
<tr>
<td>Generalized Anxiety Disorder</td>
<td>at least 6 months of chronic, uncontrollable and excessive worry about a broad number of issues in daily life</td>
</tr>
<tr>
<td>Post Traumatic Stress Disorder &amp; Acute Stress Disorder</td>
<td>re-experiencing the traumatic event along with physiological arousal and avoidance of reminders that does not resolve within 1 month (less than one month is diagnosed as Acute Stress Disorder)</td>
</tr>
<tr>
<td>Panic Disorder (with or without agoraphobia)</td>
<td>recurrent panic attacks that are initially unexpected and excessive fear of future panic attacks</td>
</tr>
<tr>
<td>Agoraphobia without history of panic disorder</td>
<td>excessive fear and avoidance of situations in which help may be unavailable or escape impossible when experiencing anxiety or panic symptoms</td>
</tr>
<tr>
<td>Specific Phobias</td>
<td>Excessive fear and avoidance of specific situations, objects or things</td>
</tr>
<tr>
<td>Anxiety Disorder due to a General Medical Condition</td>
<td>prominent symptoms of anxiety that are the direct physiological consequence of a medical condition (e.g., thyroid problems, hypoglycemia, congestive heart failure, arrhythmia)</td>
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FAMILY PHYSICIAN GUIDE | DIAGNOSIS

DIAGNOSING ANXIETY DISORDERS

Anxiety Disorders — Diagnostic Decision Tree
(adapted from The Ontario Anxiety Disorder Primary Care Guidelines 2000)

Step 1: Does the patient have the symptoms and signs of Anxiety?

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<th>Physical Symptoms</th>
<th>Psychological Symptoms</th>
<th>Functional Changes</th>
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<tbody>
<tr>
<td>• Palpitations</td>
<td>• Fear, anxiety,</td>
<td>• Sudden loss to</td>
</tr>
<tr>
<td>• Sweating</td>
<td>tension, worry,</td>
<td>chronic limitation</td>
</tr>
<tr>
<td>• “Butterflies”</td>
<td>indecision</td>
<td>• Self medicating</td>
</tr>
<tr>
<td>• in the stomach</td>
<td>• Apprehension,</td>
<td>(e.g., alcohol)</td>
</tr>
<tr>
<td>• Shortness of</td>
<td>startled easily</td>
<td>• Avoidance,</td>
</tr>
<tr>
<td>• breath</td>
<td>• Irritability</td>
<td>housebound</td>
</tr>
<tr>
<td>• Nausea/Diarrhea</td>
<td>• Restlessness, poor</td>
<td>• Poor relationships</td>
</tr>
<tr>
<td>• “Light headed”</td>
<td>• concentration</td>
<td>• High utilization</td>
</tr>
<tr>
<td>• Tremulous</td>
<td>• Insomnia</td>
<td>of medical resources</td>
</tr>
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Step 2: Consider and Treat other Causes of Anxiety or Co-morbidities

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<th>Substance Abuse</th>
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<td>• Hyperthyroidism</td>
<td>• Considerable overlap in symptoms</td>
<td>• Identify if abusing alcohol and/or drugs</td>
</tr>
<tr>
<td>• Temporal lobe</td>
<td>• Consider isolated depression symptoms such as anhedonia and weight changes</td>
<td>• Identify dependence and/or harmful/hazardous use</td>
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<tr>
<td>epilepsy</td>
<td>• Assess severity and suicidal ideation</td>
<td>• Educate regarding relationships between substance abuse and anxiety</td>
</tr>
<tr>
<td>• Endocrine dysfunction</td>
<td></td>
<td>• Initiate treatment plan (ARF phone number for anxiety substance abuse program)</td>
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<tr>
<td>• Pheochromocytoma</td>
<td></td>
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<tr>
<td>• Caffeine abuse</td>
<td></td>
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<tr>
<td>• Other stimulants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cardiac illness</td>
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DIAGNOSING ANXIETY DISORDERS

Anxiety Disorders - Diagnostic Decision Tree

- Symptoms of Anxiety (from page 31)
  - Are the symptoms predominantly:
    - Recurrent anxious thoughts?
      - Secondary to a specific experienced trauma?
        - <1 month?
          - Excessive worry and apprehension about common concern?
            - Yes
              - Excessive worry and apprehension accompanied by ritualised behaviour meant to neutralise the anxiety?
                - Yes
                  - OCD
                - No
                  - GAD
            - No
              - Excessive worry and apprehension about social situations?
                - Yes
                  - Social phobia
                - No
                  - Panic disorder with agoraphobia
        - >1 month?
          - Acute Stress Reaction
            - Yes
              - Panic disorder
            - No
              - Adjustment Disorder
    - In the form of panic, with physical (autonomic) symptoms?
      - Do the panic attacks come...
        - Out of the blue
          - Specific phobia
            - Specific trigger (e.g., heights, spiders, blood, etc.)?
              - Yes
                - Specific phobic avoidance of the situation?
                  - Yes
                    - Social phobia
                  - No
                    - Panic disorder
                - No
                  - Panic disorder with agoraphobia
**DIAGNOSING EARLY PSYCHOSIS**

The most common psychotic and manic symptoms are listed in the tables below. In early psychosis, the diagnosis may change over time (e.g., from schizophrenia to bipolar disorder, or from bipolar disorder to schizoaffective disorder) so re-assessments are needed regularly.

### Positive Symptoms

"Positive symptoms" are usually dramatic and are the first 4 of the 5 criteria listed above:

- delusions — fixed, false beliefs even in the face of contradictory evidence
- hallucinations — which may occur in any modality
- disorganized speech (e.g., tangentiality and loose associations)
- disorganized behaviour.

### Negative Symptoms

"Negative" symptoms are less dramatic and are so called because they are a decrease in normal experiences. They often precede the appearance of positive symptoms.

"Negative" symptoms are not synonymous with symptoms of depression. They include:

- avolition — lack of motivation, apathy
- affective flattening in either range or intensity
- alogia — decreased output of speech that reflects poverty of inner thought e.g., blocking
- anhedonia — absence of pleasure, asociality.

### DSM-IV or DSM-IV-TR Diagnosis

<table>
<thead>
<tr>
<th>DSM-IV or DSM-IV-TR Diagnosis</th>
<th>Main Symptoms</th>
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<tr>
<td>Schizophrenia A criteria</td>
<td>At least two of</td>
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<tr>
<td>Psychotic symptoms</td>
<td>• delusions</td>
</tr>
<tr>
<td></td>
<td>• hallucinations</td>
</tr>
<tr>
<td></td>
<td>• disorganized speech</td>
</tr>
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<td></td>
<td>• grossly disorganized or catatonic behaviour</td>
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<td></td>
<td>• negative symptoms, including flat affect, lack of speech or lack of motivation.</td>
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<td></td>
<td>OR one of</td>
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<td></td>
<td>• bizarre delusions (i.e. totally impossible and implausible)</td>
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<td></td>
<td>• voices keeping a running commentary (i.e. voices commenting on the person’s behaviour) or two or more voices conversing with each other.</td>
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<thead>
<tr>
<th>Bipolar I Disorder with Psychosis</th>
<th>Main Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manic symptoms</td>
<td>Distinct period of abnormally elevated, expansive or irritable mood plus at least three of:</td>
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<td></td>
<td>• decreased need for sleep</td>
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<td></td>
<td>• inflated self-esteem or grandiosity</td>
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<td></td>
<td>• racing thoughts</td>
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<td></td>
<td>• rapid speech</td>
</tr>
<tr>
<td></td>
<td>• easily distracted</td>
</tr>
<tr>
<td></td>
<td>• dangerous pursuit of pleasure with large risks</td>
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<td></td>
<td>• increase in social, work or sexual pursuits or agitation</td>
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<td></td>
<td>plus psychotic features (mentioned above).</td>
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</tbody>
</table>
Psychosis – Diagnostic Decision Tree (adapted from DSM-IV or DSM-IV-TR)

Delusions, hallucinations, disorganized speech, grossly disorganized behaviour, Negative Symptoms

Due to direct physiological effects of a general medical condition → YES

Psychosis due to a General Medical Condition

Due to direct effects of substance – medication, street drug, toxin → YES

Substance-induced psychosis

Schizophrenia A Criteria met for 1 month functioning → YES

Schizophrenia

Mania or major depression with psychosis

All periods of mood episodes brief compared to psychosis related → YES

Six months long A

Schizoaffective

Non-bizarre delusions for one month → NO

Mood episodes brief versus delusions → YES

Functioning not markedly impaired → YES

Delusional Disorder

NO

Psychosis NOS

NO

Mood disorder with psychosis

Delusions only during mood disturbance → NO

Psychosis NOS

More than 1 day and less than 1 month → YES

Brief Psychotic Disorder

Psychosis NOS

NO
Problems with Substance Use
- Substance use disorders (SUD) (substance abuse and substance dependence as defined in the DSM-IV or DSM-IV-TR) are a subset of substance related disorders.
- SUDs are further classified into substance abuse and substance dependence disorders depending on the number and type of associated problems.
- A patient exhibiting some but not all the criteria for a substance use disorder may still be experiencing problems related to their substance use, and require treatment.

Assessment
- Obtain full alcohol and drug histories including frequency, amount and route of use.
- Establish a diagnosis, either problematic use (not meeting criteria for abuse or dependence), abuse or dependence.
- Questions which cover the symptoms of dependence are useful in establishing either abuse or dependence but may also uncover negative consequences of use.
- Explore areas such as impulsive or high risk behaviours (e.g., rash driving, promiscuous behaviours) while intoxicated.
- A full physical examination, mindful of biological red flags, is the standard of care.
- Order blood work — including CBC, electrolytes, liver function tests as well as tests for renal function.
- Consider screening for HIV, Hepatitis B and C and STDs including syphilis, especially if there is suspicion of high-risk behaviours.
- Consider TB skin testing.
- Consider ordering urine drug screens to confirm the history.
  - Patients may believe that they have used one substance only to find that they have used another (e.g., methamphetamine is commonly substituted for, or is a major ingredient in, ecstasy and crack cocaine).
  - Non-disclosure of certain drugs may complicate treatment.

Pitfalls of Urine Drug Screens
- Depending on the methodology and cut offs used by the lab, there are both false positives and false negative tests.
- May be used for non-medical reasons — occupational safety, child protection/custody; therefore carefully consider the benefit/risk of drug screens, and discuss with patient when able.
- Opiates with codeine or morphine metabolites are detected more readily than meperidine in EMIT tests.
- Fentanyl and Methadone may not be detected and must be requested specifically.
- Heroin only detected if within 8 hours of last use — otherwise detected as morphine.
- Clonazepam and Lorazepam are poorly detected.
- Approximate windows of detection:
  - amphetamine/methamphetamine: 1 – 2 days
  - benzodiazepines: 3 – 5 days; up to 3 weeks or longer for prolonged use
  - cocaine: 2 – 4 days; up to 7 days or longer for prolonged use
  - ethanol: 2 – 14 hours
  - methadone: 3 days ( single use only) 5 – 7 days if chronic use
  - opiates (codeine, morphine, heroin): 1 – 3 days
  - THC: 5 days (moderate use); 10 days (heavy); up to 2 months (heavy, chronic)
  - LSD: 1 day
  - barbiturates: 1 day (short acting); 2 – 3 weeks (long).
DSM-IV or DSM-IV-TR Criteria: Substance Abuse and Dependence
The DSM-IV or DSM-IV-TR recognizes substance abuse and dependence as two presentations of substance use disorders. Withdrawal and Intoxication reflect more acute states and are not exclusive of the disorders.

Substance Abuse

Substance Abuse DSM-IV or DSM-IV-TR Criteria:
A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12 month period:
1. recurrent substance use resulting in a failure to fulfil major role obligations at work, school, or home
2. recurrent substance use in situations in which it is physically hazardous
3. recurrent substance-related legal problems
4. continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance
B. The symptoms have never met the criteria for substance dependence for the substance in question.

Substance Dependence
Substance dependence reflects a progression from abuse and reflects physiological, behavioural or psychological consequences.

Substance Dependence DSM-IV or DSM-IV-TR Criteria:
A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12 month period:
1. tolerance, as defined by either
   a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect or
   b) markedly diminished effect with continued use of the same amount of the substance
2. withdrawal, as manifested by either
   a) the characteristic withdrawal syndrome for the substance or
   b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
3. the substance is often taken in larger amounts or over a longer period than was intended
4. there is a persistent desire or unsuccessful efforts to cut down or control use
5. a great deal of time is spent in activities necessary to obtain the substance, use the substance or recover from its effects
6. important social, occupational, or recreational activities are given up or reduced because of use
7. the use is continued despite knowledge of having persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
**Glossary of Substance Use Terms**
— (adapted from the Substance Abuse Mental Health Services Administration website www.samhsa.gov)

**Blackouts:** A type of memory impairment that occurs when a person is conscious but cannot remember the blackout period. In general, blackouts consist of periods of amnesia or memory loss, typically caused by chronic, high-dose problematic alcohol or substance use. Blackouts are most often caused by sedative-hypnotics, such as alcohol and the benzodiazepines.

**Coke bugs:** Tactile hallucinations (also called formications) that feel like bugs crawling on or under the skin. Chronic and high-dose stimulant abuse can cause various types of hallucinations.

**Crack:** Cocaine (cocaine hydrochloride) that has been chemically modified so that it will become a gas vapour when heated at relatively low temperatures; also called “rock” cocaine.

**Downers:** Slang term for drugs that exert a depressant effect on the central nervous system. In general, downers are sedative-hypnotic drugs, such as benzodiazepines and barbiturates.

**DTs:** Delirium tremens; a state of confusion accompanied by trembling and vivid hallucinations. Symptoms may include restlessness, agitation, trembling, sleeplessness, rapid heartbeat, and possibly convulsions. Delirium tremens often occurs in chronic alcoholics after withdrawal or abstinence from alcohol.

**Ecstasy:** Slang term for methylenedioxymethamphetamine (MDMA), a member of the amphetamine family. At lower doses, MDMA causes distortions of emotional perceptions. At higher doses, it causes potent stimulation typical of the amphetamines.

**Eight (8) Ball:** 3.6g or 1/8th ounce.

**Hallucinogens:** A broad group of drugs that cause distortions of sensory perception. The prototype hallucinogen is lysergic acid diethylamide (LSD). LSD can cause potent sensory perceptions, such as visual, auditory, and tactile hallucinations. Related hallucinogens include peyote and mescaline.

**Ice:** Slang term for smokeable methamphetamine. Much as cocaine can be modified into a smokeable state (crack cocaine), methamphetamine can be prepared so that it will produce a gas vapour when heated at relatively low temperatures. When smoked, ice methamphetamine produces an extremely potent and long-lasting euphoria, an extended period of high energy and possible agitation, followed by an extended period of deep depression.

**Marijuana:** The dried leaves and flowering tops of the Indian hemp plan cannabis sativa; also called “pot” and “weed.” It can be smoked or prepared in a tea or food. Marijuana has two significant effects. In the non-tolerant user, marijuana can produce distortions of sensory perception, sometimes including hallucinations. Marijuana also has depressant effects and is partially cross-tolerant with...
sedative-hypnotic drugs such as alcohol. Hashish (or hash) is a combination of the dried resins and compressed flowers from the female plant.

**Nodding out:** Slang term for the early stages of depressant-induced sleep. Opioids and sedative-hypnotics induce depression of the central nervous system, causing mental and behavioural activity to become sluggish. As the nervous system becomes profoundly depressed, symptoms may range from sleepiness to coma and death. Typically, “nodding out” refers to fading in and out of a sleepy state.

**Opiates:** A type of depressant drug that diminishes pain and central nervous system activity. Prescription opiates include morphine, meperidine (Demerol), methadone, codeine, and various opioid drugs for coughing and pain. Illicit opioids include heroin, also called “smack,” “horse,” and “boy.”

**Paraphernalia:** A broad term that describes objects used during the chemical preparation or use of drugs. These include syringes, syringe needles, roach clips, and marijuana or crack pipes.

**Point:** 1/10th gram. A measurement of drug quantity.

**Uppers:** Slang term used to describe drugs that have a stimulating effect on the central nervous system. Examples include cocaine, caffeine, and amphetamines.
Early Detection

As with all disorders, the Early Detection of mental illness helps prevent short-term complications, initiate recovery and minimize negative long-term consequences of the disorder. Programs such as Early Psychosis Intervention (E.P.I.) have been internationally embraced as a standard of care because of their intended impact on outcomes.

Early Detection requires an awareness of Risk Factors, the observation of Warning Signs and the application of Screening Tools.

The Family Physician's Role in Early Detection
- Screen and assess any patient with symptoms of a psychiatric disorder.
- Encourage patients and family to openly discuss psychological problems.
- Note that many patients frame their distress somatically or report only physical symptoms because of a reluctance to express psychiatric symptoms.
- Keep in mind that patients’ personal beliefs and symptoms (e.g., avoidance, fear of negative evaluation, delusions, hallucinations) can interfere with disclosure and help-seeking behaviours.
- Provide educational materials in the waiting area to help patients recognize their own problems and encourage disclosure of symptoms during office visits (see section on self-management and information for families for free and easily accessible sources of educational materials).
Risk factors can be inherent or acquired and may interact with each other to result in illness expression.

**General Risk Factors**
- past history of any psychiatric disorder
- family history of any psychiatric disorders
- co-morbid medical illnesses
- history of physical or sexual abuse
- recent major negative life events
- pregnancy and post-partum periods
- presence of any psychiatric disorder increases risk of a secondary psychiatric disorders
- substance use including early onset tobacco use

**Disorder-Specific Risk Factors**

**Major Depressive Disorder**
- long term pain or chronic illness (e.g., diabetes, arthritis)
- cardiovascular disease
- family history of mood disorder
- pregnancy or postpartum
- long-term sleep problems
- substance use disorders
- female gender
- tobacco dependence

**Anxiety Disorders**
- higher incidence in adolescents/youth and the elderly
- stressful periods
- postpartum period
- chronic physical illness including chronic pain conditions
- substance use disorders

**Early Psychosis**
- family history of psychosis/psychiatric disorder
- history of head injury
- history of poor growth and development
- history of academic and social difficulties
- history of pregnancy and birth complications
- psychological trauma/ongoing stress
- substance use disorders (especially stimulants, cocaine)
- higher incidence in adolescence/youth
Substance Use Disorders
- family history of SUD
- past history of substance use disorder
- trauma and/or violence
- mental illness

Some additional factors that influence substance use are
- availability of substance (e.g. easy availability for tobacco, alcohol, and marijuana)
- occupation (e.g. health care workers, bartenders, truck drivers, etc.)
- social instability
- low cost
- speed of drug effect onset
- peer group
- culture (acceptability of certain substances in some cultures)
- chronic physical pain
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Screening Tools

General Screening Suggestions
- Screen adolescent populations at all visits, as they are infrequent and inconsistent users of health care.
- Screen adult populations if considered to be in at-risk population.
- Screen women at antepartum and post-partum visit (screen at 2 months with first infant immunization).
- Set reminders to screen on office charting systems.
- Build screens into social histories when discussing other high-risk behaviours such as unprotected sex or extreme sports.
- In order to ease apprehension with screening tools, especially teenagers, try “This questionnaire is like taking your emotional temperature — it is part of a normal visit”.
- If a screen is positive, complete a full history and physical, in an attempt to clarify the diagnosis, over the next 1 or 2 appointments.
SCREENING FOR MAJOR DEPRESSIVE DISORDER

There are a number of brief, valid, easy-to-administer assessment scales that can be used to detect depression in primary care. Two approaches are described here:

- the "two-quick-question" screening method
- use of the Patient Health Questionnaire 9 (PHQ 9).

The ‘Two-quick-question’ screening method

- Use during routine visits with high-risk individuals.
- Ask whether, in the last month, they have
  1. “lost interest or pleasure in things you usually like to do?”
  2. “felt sad, low, down, depressed or hopeless?”

An answer of ‘yes’ to either question triggers a more detailed assessment of other symptoms of depression such as sleep disturbance, appetite change or lack of energy.

Use of the Patient Health Questionnaire 9 (PHQ 9)

Having patients complete a PHQ 9 Questionnaire (see sample provided here) yields a wealth of information that can be used for both assessment and follow-up action. When reviewing the completed questionnaire, major depressive disorder is suggested if

- of the 9 items, 5 or more are checked as at least ‘more than half the days’
- either item a. or b. is positive, that is, at least ‘more than half the days.’

Other depressive syndrome is suggested if

- of the 9 items, a., b., or c., are checked as at least ‘more than half the days’
- either item a., or b. is positive, that is, at least ‘more than half the days.’

Also, PHQ 9 scores can be used to plan and monitor treatment. To score the instrument, tally each response by the number value under the answer headings, (not at all = 0, several days = 1, more than half the days = 2, and nearly every day = 3). Add the numbers together to total the score on the bottom of the questionnaire. Interpret the score by using the following guide.

<table>
<thead>
<tr>
<th>Score</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>The score suggests the patient may not need depression treatment</td>
</tr>
<tr>
<td>5-14</td>
<td>Mild to major depressive disorder. Physician uses clinical judgment about treatment, based on patient’s duration of symptoms and functional impairment.</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderate to major depressive disorder. Warrants treatment for depression, using antidepressant, psychotherapy or a combination of treatment.</td>
</tr>
<tr>
<td>20 OR HIGHER</td>
<td>Severe major depressive disorder. Warrants treatment with antidepressant, with or without psychotherapy, follow frequently.</td>
</tr>
</tbody>
</table>

The PHQ 9 instrument also includes a functional health assessment. This asks the patient how emotional difficulties or problems impact work, things at home, or relationships with other people. Patient responses can be one of four: Not difficult at all, Somewhat difficult, Very difficult, Extremely difficult. The last two responses suggest that the patient’s functionality is impaired. After treatment begins, functional status and number score can be used to assess patient improvement.
### Screening for Major Depressive Disorder

**Patient Health Questionnaire — PHQ 9**

(www.primary-care.org)

**Patient name:** ____________________________  **Date:** ____________________________

1. **Over the last 2 weeks, how often have you been bothered by any of the following problems?**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all (0)</th>
<th>Several days (1)</th>
<th>More than half the days (2)</th>
<th>Nearly every day (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Little interest or pleasure in doing things.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>b. Feeling down, depressed, or hopeless.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>c. Trouble falling/staying asleep, sleeping too much.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>d. Feeling tired or having little energy.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>e. Poor appetite or overeating.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>f. Feeling bad about yourself, or that you are a failure, or have</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>let yourself or your family down.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Trouble concentrating on things, such as reading the newspaper or</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>watching TV.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Moving or speaking so slowly that other people could have</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>noticed. Or the opposite; being so fidgety or restless that you</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>have been moving around more than usual.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Thoughts that you would be better off dead or of hurting yourself</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>in some way.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. **If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

<table>
<thead>
<tr>
<th>Difficulty Level</th>
<th>☐</th>
<th>☐</th>
<th>☐</th>
<th>☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not difficult at all</td>
<td>☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somewhat difficult</td>
<td></td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very difficult</td>
<td></td>
<td></td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Extremely difficult</td>
<td></td>
<td></td>
<td></td>
<td>☐</td>
</tr>
</tbody>
</table>

**TOTAL SCORE** ____________
Valid standardized scales for assessment of anxiety disorders in the primary care setting are not widely available or easily accessible. Two scales that may be used are

- **the Hospital Anxiety and Depression Scale (HADS)**
  - a self-report scale that helps to quickly identify cases with anxiety or depression
  - 14 easy to answer questions with 7 each related to anxiety and depression
  - Can be self-administered in the waiting area of the family physician

- **the Anxiety Disorders Screening Tool: Mini International Neuropsychiatric Interview (MINI)**
  The screening questionnaire used in the National Anxiety Disorders Screening Day is the Mini-International Neuropsychiatric Interview (M.I.N.I.). It is a short, structured, diagnostic interview that was developed by a group of psychiatrists and clinicians in the United States and Europe. The MINI was designed for DSM-IV or DSM-IV-TR and ICD-10 psychiatric disorders. The version in the screening program is designed to explore five Axis I psychiatric disorders (panic disorder, social phobia, post-traumatic stress disorder, generalized anxiety disorder, and obsessive-compulsive disorder) according to DSM-IV or DSM-IV-TR diagnostic criteria. Validated against both the SCID and ICD-10 diagnostic criteria, the MINI is a sensitive, valid and reliable instrument. See [www.heretohelp.bc.ca](http://www.heretohelp.bc.ca) for free on-line version with printable results. A copy of the MINI screening tool has also been provided here for immediate reference.
SCREENING FOR ANXIETY DISORDERS

Anxiety Disorders Screening Tool
Mini International Neuropsychiatry Interview (MINI)

Patient name: __________________________ Date: _______________________

PLEASE CIRCLE COMPLETELY Y (YES)
OR N (NO)

Section 1
1. Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way? Did the spells peak within 10 minutes? (If yes to either, please mark YES.) ........................................ Y N

If your answer to question 1 above is no, please proceed to Section 2
2. At any time in the past, did any of these spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner? .................................................. Y N

3. Have you ever had one such attack followed by a month or more of persistent fear of having another attack, or worries about the consequences of the attack? ............................................................... Y N

4. During the worst attacks that you can remember: Did you have skipping, racing or pounding of your heart? ................................................. Y N

Did you have sweating or clammy hands? ................................................... Y N

Were you trembling or shaking? ............ Y N

Did you have shortness of breath or difficulty breathing? ............................ Y N

Did you have a choking sensation or a lump in your throat? ........................... Y N

Did you have chest pain, pressure or discomfort? ........................................... Y N

Did you have nausea, stomach problems or sudden diarrhoea? ....................... Y N

Did you feel dizzy, unsteady, light-headed or faint? ....................................... Y N

Did things around you feel strange, unreal, detached or unfamiliar, or did you feel outside of or detached from, part or all of your body? ................................................. Y N

Did you feel that you were losing control or going crazy? ............................ Y N

Did you fear that you were dying? ........... Y N

Did you have tingling or numbness in parts of your body? ............................. Y N

Did you have hot flushes or chills? ............ Y N

5. In the past month, did you have such attacks repeatedly (2 or more) followed by persistent fear of having another attack? ......................................................... Y N

Section 2
1. In the past month, were you fearful or embarrassed being watched, being the focus of attention, or fearful of being humiliated? This includes things like speaking in public, eating in public or with others, writing while someone watches, or being in social situations? ........................................... Y N

If your answer to question 1 above is no, please proceed to Section 3
2. Is this fear excessive or unreasonable? ....................................................... Y N

3. Do you fear these situations so much that you avoid them or suffer through them? ................................................................. Y N

4. Does this fear disrupt your normal work or social functioning or cause you significant distress? ......................................................... Y N

Section 3
1. Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? ............................................. Y N

If your answer to question 1 above is no, please proceed to Section 4
2. During the past month, have you re-experienced the event in a distressing way (such as dreams, intense recollections, flashbacks or physical reactions)? ........... Y N

3. In the past month: Have you avoided thinking about the event, or have you avoided things that remind you of the event? ......................................................... Y N

Have you had trouble recalling some important part of what happened? ............ Y N

Have you become less interested in hobbies or social activities? ....................... Y N

Have you felt detached or estranged from others? ....................................... Y N

Have you noticed that your feelings are numbed? ....................................... Y N

Have you felt that your life would be shortened because of this trauma? ........ Y N
4. In the past month: Have you had difficulty sleeping? ................. Y N
   Were you especially irritable or did you have outbursts of anger? ................. Y N
   Have you had difficulty concentrating? .... Y N
   Were you nervous or constantly on your guard? Were you easily startled? .......... Y N
   5. During the past month, have these problems significantly interfered with your work or social activities, or caused significant distress? .......... Y N

Section 4
1. Have you worried excessively or been anxious about 2 or more things (e.g., finances, children’s well-being, misfortune) over the past 6 months? More than most others would? Are these worries present most days? .......................... Y N
   If your answer to question 1 above is no, please proceed to Section 5
   2. Do you find it difficult to control the worries or do they interfere with your ability to focus on what you are doing? ........ Y N
   3. When you were anxious over the past 6 months, did you, most of the time: Feel restless, keyed up or on edge? ............ Y N
      Feel tense? ................................................. Y N
      Feel tired, weak or exhausted easily? .... Y N
      Have difficulty concentrating or find your mind going blank? ......................... Y N
      Feel irritable? ............................................. Y N
      Have difficulty sleeping (difficulty falling asleep, waking up in the middle of the night, early morning waking or sleeping excessively)? ..................................... Y N

Section 5
1. In the past month, have you been bothered by recurrent thoughts, impulses, or images that were unwanted, distasteful, inappropriate, intrusive or distressing? (For example, the idea that you were dirty, contaminated or had germs, fear of contaminating others, fear of harming someone even though you didn’t want to, or fearing that you would act on some impulse, or fear or superstitions that you would be responsible for things going wrong, or obsessions with sexual thoughts, images or impulses, or hoarding, collecting or religious obsessions). ...................................... Y N

   If your answer to question 1 above is no, please proceed to Question #4
   2. Did they keep coming back into your mind even when you tried to ignore or get rid of them? ............................................. Y N
   3. Do you think these obsessions are the product of your own mind and that they are not imposed from the outside? .............. Y N
   4. In the past month, did you do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting or checking things over and over, or repeating, collecting, arranging things, or other superstitious rituals? ...................... Y N
   5. Did you recognize that either these obsessive thoughts or these compulsive behaviours were excessive or unreasonable? ......................................... Y N
   6. Did these obsessive thoughts and/or compulsive behaviours significantly interfere with your normal routine, occupational functioning, usual social activities, or relationships, or did they take more than one hour? .............................................. Y N

Section 6
1. Have you EVER...
   Discussed an emotional problem with your medical doctor? ............................................. Y N
   Received care from a psychiatrist? .............. Y N
   Received care from a psychologist, psychotherapist, social worker, family therapist, or other mental health professional? ............................................. Y N
   Been to Alcoholics Anonymous? .............. Y N
   Talked to a drug counsellor? .............. Y N

Section 7
Please fill ONE circle for each of the following 3 scales.
To what extent have emotional symptoms disrupted...
1. ... your work in the last month:
   not at all  mildly  moderately  mostly  extremely
   0 1 2 3 4 5 6 7 8 9 10
   2. ... your social life in the last month:
   not at all  mildly  moderately  mostly  extremely
   0 1 2 3 4 5 6 7 8 9 10
   3. ... your family life/home responsibilities in the last month:
   not at all  mildly  moderately  mostly  extremely
   0 1 2 3 4 5 6 7 8 9 1
**SCREENING FOR ANXIETY DISORDERS**

*Interpreting the Results of the Anxiety Disorders Screening Tool: Mini International Neuropsychiatric Interview (MINI)*

Question 1 must be answered positively to meet criteria

**Section 1 – Panic Disorder**

Rule out Panic Disorder if NO to Question 1
Panic Disorder lifetime if Y to Questions 1, 2 & 3 + (4 or more Y responses in Q4)
Panic Disorder current if Y to Questions 1, 2 & 3 + (4 or more Y responses in Q4) + Q5

**Section 2 – Social Anxiety Disorder**

Rule out Social Phobia if NO to Question 1
Social Anxiety Disorder if Y to Questions 1, 2, 3 & 4

**Section 3 – Post Traumatic Stress Disorder**

Rule out PTSD if NO to Question 1
Rule out PTSD if YES to Question 1 + NO to Question 2
PTSD if Y to Questions 1 & 2 + (3 or more Y responses in Q3) +
(2 or more Y responses in Q4) + Q5

**Section 4 – Generalized Anxiety Disorder**

Rule out GAD if NO to Question 1
GAD if Y to Questions 1 & 2 + (3 or more Y responses in Q3)

**Section 5 – Obsessive Compulsive Disorder**

Rule out OCD (obsessions) if NO to Question 1
OCD obsessions if Y to Questions 1, 2, 3, & 6
Rule out OCD (compulsions) if NO to Question 1
OCD compulsions if Y to Questions 4, 5, & 6

**CAUTION** – If there are several YES answers in any section even though the screening participant does not meet criteria, check the impairment scale (section 7). If substantial impairment is evident, it is recommended that the screening participant be referred for a complete clinical evaluation.
There are no self-report screening instruments for early psychosis that can be easily implemented.

Most young people are either reluctant to admit having psychotic experiences or they lack the vocabulary to easily describe their extraordinary experiences.

Observation of changes in appearance and activity should raise the index of suspicion.

Inquire about the presence of hallucinations (e.g., “when a person gets really stressed out their mind can play tricks on them — like hearing a whisper or even a voice saying things — has that ever happened to you?”)
Various screening tools are available that enable the family physician to quickly identify individuals who may have a substance use problem (see ensuing samples provided). When taking a substance use history, inquire

1. about the following classes
   - marijuana
   - cocaine/crack
   - “party drugs” — ecstasy, GHB, ketamine
   - prescription drugs — benzodiazepines especially Lorazepam, Diazepam and Clonazepam (readily available on the street)
   - solvents — gasoline, aerosols, glue
   - opioids — heroin, morphine, methadone, codeine, oxycodone
   - crystal methamphetamine, amphetamine, prescription stimulants (dexamphetamine, methylphenidate)
   - hallucinogens — LSD, “magic” mushrooms
   - alcohol — classify using standard drinks; also inquire re: the use of rubbing alcohol, mouthwash

2. (if affirmative) about route of administration of the specific substance
   - sniffing/snorting, injection, oral, smoking or inhalational
   - sharing of needles or paraphernalia (high-risk behaviours)

3. about quantity and frequency of use
   - # of Standard Drinks (Canadian)
   - Point = 1/10th g
   - Rock = variable amount usually 3 – 4 points

4. about concerns related to drug use
   - consider modifying the CAGE by substituting the substance of concern for “alcohol” or “drinking” (e.g., “Have you ever felt bad or Guilty about your cocaine use?”); although it is not evidence based, it may serve as an initial point of discussion.

The staff/clinician administered CAGE and self-administered AUDIT (Alcohol Use Disorders Inventory Test) are questionnaires that require less than 15 minutes in a primary care setting.

- The CAGE Questionnaire
  - There are 4 questions scored 0 or 1.
  - A score of 2 or greater is significant.
  - The combination of CAGE questionnaire, MCV and GGT activity will detect about 75% of people with an alcohol problem.
  - During pregnancy or adolescence, a score of 1 may signal problematic drinking. However, CAGE is not specific to pregnancy and consider using the TWEAK. (see Women’s Mental Health Appendix)

- The AUDIT Questionnaire
  - This 10-question survey of alcohol use is sensitive across cultures.
  - Scores for each question range from 0 to 4, with the first response for each question (e.g., never) scoring 0, the second (e.g., less than monthly) scoring 1, the third (e.g., monthly) scoring 2, the fourth (e.g., weekly) scoring 3, and the last response (e.g., daily or almost daily) scoring 4.
  - For questions 9 and 10, which only have three responses, the scoring is 0, 2 and 4 (from left to right).
  - A score of 8 or more is associated with harmful or hazardous drinking,
  - score of 13 or more in women, and 15 or more in men, is likely to indicate alcohol dependence.

- Also available is the DAST.
**SCREENING FOR SUBSTANCE USE DISORDERS**

**CAGE Questionnaire — Screen for Problematic Alcohol Use**

Alcohol dependence is likely if the patient gives two or more positive answers to the following questions:

- Have you ever felt you should **cut down** on your drinking?
- Have people **annoyed** you by criticizing your drinking?
- Have you ever felt bad or **guilty** about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (**eye-opener**)?

The combination of CAGE questionnaire, MCV and GGT activity will detect about 75% of people with an alcohol problem.
AUDIT (Alcohol Use Disorders Inventory Test) Questionnaire: Screen for Problematic Alcohol Use

Please circle the answer that is correct for you

1. How often do you have a drink containing alcohol?
   • Never
   • Monthly or less
   • 2 – 4 times a month
   • 2 – 3 times a week
   • 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day when drinking?
   • 1 or 2
   • 3 or 4
   • 5 or 6
   • 7 to 9
   • 10 or more

3. How often do you have six or more drinks on one occasion?
   • Never
   • Less than monthly
   • Monthly
   • Weekly
   • Daily or almost daily

4. During the past year, how often have you found that you were not able to stop drinking once you had started?
   • Never
   • Less than monthly
   • Monthly
   • Weekly
   • Daily or almost daily

5. During the past year, how often have you failed to do what was normally expected of you because of drinking?
   • Never
   • Less than monthly
   • Monthly
   • Weekly
   • Daily or almost daily

6. During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?
   • Never
   • Less than monthly
   • Monthly
   • Weekly
   • Daily or almost daily

7. During the past year, how often have you had a feeling of guilt or remorse after drinking?
   • Never
   • Less than monthly
   • Monthly
   • Weekly
   • Daily or almost daily

8. During the past year, have you been unable to remember what happened the night before because you had been drinking?
   • Never
   • Less than monthly
   • Monthly
   • Weekly
   • Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
   • No
   • Yes, but not in the past year
   • Yes, during the past year

10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?
    • No
    • Yes, but not in the past year
    • Yes, during the past year
Drug Abuse Screening Test (DAST)

The following questions concern information about your possible involvement with drugs (not including alcoholic beverages) during the past 12 months. Carefully read each statement and choose the response that is true (or mostly true) for you.

1. Have you used drugs other than those required for medical reasons? _____ Yes _____ No
2. Do you abuse more than one drug at a time? _____ Yes _____ No
3. Are you unable to stop using drugs when you want to? _____ Yes _____ No
4. Have you ever had blackouts or flashbacks as a result of drug use? _____ Yes _____ No
5. Do you ever feel bad or guilty about your drug use? _____ Yes _____ No
6. Does your spouse (or parents) ever complain about your involvement with drugs? _____ Yes _____ No
7. Have you neglected your family because of your use of drugs? _____ Yes _____ No
8. Have you engaged in illegal activities in order to obtain drugs? _____ Yes _____ No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? _____ Yes _____ No
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)? _____ Yes _____ No

Results for DAST

SCORE EACH YES RESPONSE WITH 1 POINT.

<table>
<thead>
<tr>
<th>Score</th>
<th>Degree of addiction</th>
<th>Suggested Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No Problem</td>
<td>None at this time</td>
</tr>
<tr>
<td>1 – 2</td>
<td>Low Level</td>
<td>Contact an outpatient programme in your area</td>
</tr>
<tr>
<td>3 – 5</td>
<td>Moderate Level</td>
<td>Contact a detox (if necessary) or an outpatient programme.</td>
</tr>
<tr>
<td>6 – 10</td>
<td>Substantial Level</td>
<td>Contact a detox or Emergency Room</td>
</tr>
</tbody>
</table>

### Screening for Substance Use Disorders

**Addiction Research Foundation Clinical Institute Withdrawal Assessment for Alcohol — Revised CIWA-Ar**

<table>
<thead>
<tr>
<th>Patient: ____________________________ Date: ____________ Time: ____________ (24 hour clock, midnight = 0:00)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulse or heart rate, taken for one minute: ____________ Blood pressure: ____________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nausea and Vomiting</strong></td>
<td>Ask: “Do you feel sick to your stomach? Have you vomited?” Observation.</td>
</tr>
<tr>
<td>0</td>
<td>No nausea and no vomiting</td>
</tr>
<tr>
<td>1</td>
<td>Mild nausea with no vomiting</td>
</tr>
<tr>
<td>2</td>
<td>Intermittent nausea with dry heaves</td>
</tr>
<tr>
<td>3</td>
<td>Constant nausea, frequent dry heaves and vomiting</td>
</tr>
<tr>
<td><strong>Tremor</strong></td>
<td>Observation.</td>
</tr>
<tr>
<td>0</td>
<td>No tremor</td>
</tr>
<tr>
<td>1</td>
<td>Tremor is present although not visible, but can be felt fingertip to fingertip</td>
</tr>
<tr>
<td>2</td>
<td>Tremor present, with patient’s arms extended</td>
</tr>
<tr>
<td>3</td>
<td>Severe, even with arms not extended</td>
</tr>
<tr>
<td><strong>Paroxysmal Sweats</strong></td>
<td>Observation.</td>
</tr>
<tr>
<td>0</td>
<td>No sweat visible</td>
</tr>
<tr>
<td>1</td>
<td>Barely perceptible sweating, palms moist</td>
</tr>
<tr>
<td>2</td>
<td>Beads of sweat obvious on forehead</td>
</tr>
<tr>
<td>3</td>
<td>Drenching sweat</td>
</tr>
<tr>
<td><strong>Anxiety</strong></td>
<td>Ask: “Do you feel nervous?” Observation.</td>
</tr>
<tr>
<td>0</td>
<td>No anxiety, at ease</td>
</tr>
<tr>
<td>1</td>
<td>Mild anxiety</td>
</tr>
<tr>
<td>2</td>
<td>4 moderately anxious, or guarded, so anxiety is inferred</td>
</tr>
<tr>
<td>3</td>
<td>Equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions</td>
</tr>
<tr>
<td><strong>Agitation</strong></td>
<td>Observation.</td>
</tr>
<tr>
<td>0</td>
<td>Normal activity</td>
</tr>
<tr>
<td>1</td>
<td>Somewhat more than normal activity</td>
</tr>
<tr>
<td>2</td>
<td>Moderately fidgety and restless</td>
</tr>
<tr>
<td>3</td>
<td>Restless, pace back and forth during most of the interview, or constantly thrashes about</td>
</tr>
<tr>
<td><strong>Auditory Disturbances</strong></td>
<td>Ask: “Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?” Observation.</td>
</tr>
<tr>
<td>0</td>
<td>Not present</td>
</tr>
<tr>
<td>1</td>
<td>Very mild severity</td>
</tr>
<tr>
<td>2</td>
<td>Mild severity</td>
</tr>
<tr>
<td>3</td>
<td>Moderate severity</td>
</tr>
<tr>
<td>4</td>
<td>Severe severity</td>
</tr>
<tr>
<td><strong>Visual Disturbances</strong></td>
<td>Ask: “Does the light appear to be too bright? Is it colour different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?” Observation.</td>
</tr>
<tr>
<td>0</td>
<td>Not present</td>
</tr>
<tr>
<td>1</td>
<td>Very mild severity</td>
</tr>
<tr>
<td>2</td>
<td>Mild severity</td>
</tr>
<tr>
<td>3</td>
<td>Moderate severity</td>
</tr>
<tr>
<td>4</td>
<td>Severe severity</td>
</tr>
<tr>
<td><strong>Orientation and Clouding of Sensorium</strong></td>
<td>Ask: “What day is this? Where are you? Who am I?”</td>
</tr>
<tr>
<td>0</td>
<td>Oriented and can do serial additions</td>
</tr>
<tr>
<td>1</td>
<td>Cannot do serial additions or is uncertain about date</td>
</tr>
<tr>
<td>2</td>
<td>Disoriented for date by no more than 2 calendar days</td>
</tr>
<tr>
<td>3</td>
<td>Disoriented for date by more than 2 calendar days</td>
</tr>
<tr>
<td>4</td>
<td>Disoriented for place or person</td>
</tr>
</tbody>
</table>

**Total CIWA-Ar Score:** ____________
**Rating's Initials:** ____________
**Maximum Possible Score:** 67

---

The CIWA-Ar is not copyrighted and may be reproduced freely. This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer. The maximum score is 67 (see instrument). Patients scoring less than 10 do not usually need additional medication for withdrawal.

General Warning Signs and Symptoms
- sleep disturbances
- appetite changes
- social withdrawal
- irritability
- indecisiveness
- absences from school or work
- loss of energy or agitation
- feelings of anxiety and depression
- multiple or unexplained physical complaints
- reports from others of out-of-character behaviour
Disorder-Specific Warning Signs and Symptoms

Major Depressive Disorder
In addition to the general warnings the person may experience
- loss of interest or pleasure in activities or relationships
- guilt
- complaints of decreased memory and concentration
- decline in functioning in primary roles (e.g., poor work performance, delayed bonding with baby)
- dangerous behaviour/impulsivity.

Anxiety Disorders
In addition to the general warnings the person may exhibit
- chronic symptoms of anxiety, worry, panic and stress
- sleep disturbance
- somatic symptoms (e.g., headache, gastrointestinal upset or stomach ache)
- frequent distressing thoughts, images, memories or urges
- difficulty concentrating or making decisions
- high rates of health care utilization (family physician visits, medical specialists, emergency room visits, ambulance service use, etc)
- excessive avoidance or use of safety behaviours (e.g., compulsions, reassurance seeking).

Early Psychosis
Collateral reports may be especially pertinent to detecting psychotic disorders. Vague changes in mood and behaviour are often noticed quite early by family and friends.

In addition to the general warnings the person may exhibit
- shifts in social circle or markedly reduced social activity
- decreased concentration
- decreased hygiene
- over-concern with physical functions and appearance or significant change in dress or appearance
- increased interest in metaphysics and spirituality
- inappropriate emotional expression
- reduced speech output or speech that is difficult to follow
- suspiciousness, paranoia or even delusional beliefs
- attending to internal stimuli or “talking/laughing to themselves”
- impulsivity
- irritability.
Substance Use Disorders
Alcohol and substance abuse disorders may present with any of the general warning signs and symptoms. In addition, potential warnings include those identified in the following table:

<table>
<thead>
<tr>
<th>Physical</th>
<th>Alcohol</th>
<th>Other Substances</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENERAL</td>
<td>Smell of alcohol, trauma</td>
<td>Trauma, weight loss (cocaine, methamphetamine and heroin)</td>
</tr>
<tr>
<td>CNS</td>
<td>Tremors, headaches, ataxia</td>
<td>Headaches, choreic movements, fluctuating level of consciousness</td>
</tr>
<tr>
<td>CVS</td>
<td>Hypertension, tachycardia</td>
<td>Hypertension, tachycardia, stroke, MI in young people</td>
</tr>
<tr>
<td>RESP</td>
<td>Gastritis, dyspepsia, pancreatitis, recurrent diarrhoea, signs of liver disease (jaundice, gynecomastia, testicular atrophy, telangectasia, spider nevi, palmar erythema), blood tainted stool</td>
<td>Asthma, Nasal septum perforation</td>
</tr>
<tr>
<td>GI</td>
<td>Gastrointestinal symptoms</td>
<td>Hepatitis, signs of liver disease</td>
</tr>
<tr>
<td>REPRODUCTIVE</td>
<td>Impotence, menstrual irregularities or infertility</td>
<td>Menstrual irregularities</td>
</tr>
<tr>
<td>HEENT</td>
<td>Scleral icterus, Parotid Gland enlargement</td>
<td>Injected conjunctiva (cannabis), pinpoint pupils (opioids), nasal complaints</td>
</tr>
<tr>
<td>DERM</td>
<td>Liver Signs</td>
<td>Track marks (IDUs), cellulitis, abscesses, excoriations</td>
</tr>
<tr>
<td>Lab Markers</td>
<td>Anemia with _MCV</td>
<td>Unexplained ALT elevations (IDUs)</td>
</tr>
<tr>
<td></td>
<td>GGT</td>
<td>HIV, HCV, HBV</td>
</tr>
<tr>
<td>Psychological Complaints</td>
<td>Depression, anxiety, fatigue, low energy, insomnia</td>
<td>Depression, anxiety insomnia, fatigue,</td>
</tr>
<tr>
<td></td>
<td>Paranoia and psychosis (methamphetamine, Gamma Hydroxy Butyrate and benzo withdrawal, cocaine and hallucinogens), Flat affect (Benzo, marijuana and stimulant withdrawal)</td>
<td></td>
</tr>
<tr>
<td>Social Complaints</td>
<td>Changes in school or work performance, marital discord, impaired driving, criminal charges including domestic violence, financial concerns</td>
<td>Changes in school or work performance, marital discord, impaired driving, criminal charges including domestic violence, financial concerns</td>
</tr>
</tbody>
</table>