### General Treatment Recommendations

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3 MANAGEMENT ISSUES
Provide treatment as soon as possible in order to:
- reduce symptoms and suffering
- prevent secondary problems from occurring such as
  - loss of job
  - physical health problems
  - mental health problems
  - social isolation
- lower risk of relapse.

With inappropriate treatments or no treatment at all, many of these disorders have a high rate of relapse and worsen over time.

Treatment options of psychiatric disorders consist of non-pharmacological as well as pharmacological interventions.
Psychotherapies and Other Non-pharmacological Interventions
Psychotherapies, lifestyle modifications, stress management strategies, relapse prevention, and brief interventions are all important aspects in the management of the disorders listed in this Guide. For some conditions (mild depression or anxiety), they can be as effective as medication for remission. For more severe conditions (severe depression, acute psychosis), non-pharmacological interventions provide as essential component in obtaining and maintaining health.

**Psychotherapies, including Cognitive Behavioural Therapies (CBT)**

- **Cognitive Behavioral Therapy (CBT)**
  - A time limited psychotherapy which teaches the patient to identify automatic, dysfunctional thoughts and distorted beliefs and to develop positive new behaviours and coping strategies
  - Focuses on current problems and uses a process of teaching, coaching, and reinforcing positive behaviours to address the interactions between how we think, feel and behave
  - Follows a structured style of intervention, including the use of ‘homework’, or between-session practice
  - Key elements include:
    - psychoeducation
    - relaxation training (e.g. controlled breathing, progressive muscle relaxation)
    - cognitive skills training (e.g. challenging cognitions that are maladaptive)
    - overcoming avoidance via gradual exposure to feared situations
    - planning for relapse prevention and maintaining gains.
  - Administered individually or in groups, and also incorporated in self-directed resources
  - Evidence supports the effectiveness of CBT for many common mental disorders
  - Visit [www.healthservices.gov.bc.ca/mhd/publications.html](http://www.healthservices.gov.bc.ca/mhd/publications.html) to access the Core Information Document on Cognitive Behavioural Therapy developed by the Centre for Applied Research in Mental Health and Addictions, Simon Fraser University.

Other schools of Psychotherapy include the following:

- **Interpersonal Psychotherapy (IPT):** is a time limited individual or group therapy which examines 2 of 4 interpersonal areas: grief, role transition, role dispute and interpersonal conflicts. Core principles include that the illness is not the patient’s fault, and that by understanding the connection between the illness and life events, the patient can use this to solve their current difficulties.
Psychodynamic Psychotherapy: Both brief and long term, focus on the transference, countertransference and resistance between patient and therapist.

Supportive Therapy: Is focused on problem solving and advice giving.

Lifestyle Issues
There are several basic but important healthy lifestyle choices which should be stressed regardless of the illness:
- personal hygiene (encourage laundry, showering and personal grooming)
- regular exercise (provide guidelines for regular exercise and target heart rates)
- healthy, regular meals (provide guidelines; refer to a dietician)
- sleep hygiene (discuss regulation of sleep hours, encourage a reduction in evening stimulation)
- substance use (discuss caffeine and alcohol intake, and recreational drug use)
- housing (safe, supported, drug free).

Stress Management Strategies
- relaxation training using specific techniques such as imagery or progressive muscle relaxation
- problem solving techniques that involve learning to analyze problems, brainstorm and evaluate solutions and then carry out the solutions in small steps
- resources for stress management are listed in the sections on ‘Information for Families’ and ‘Information for Self-Management’.

Relapse Prevention
Preventing relapse of the mental illness is a key goal of treatment.
- Prior to a relapse there are usually early warning signs — it is important that patients learn to recognize their own early warning signs.
- Develop a ‘Relapse Prevention Plan’ with all patients.
- Outline steps to be taken if early warning signs are detected.
- Actions in the plan might include:
  - making an appointment to come in
  - stress management techniques
  - “Rescue medications”
- Share the plan with the patient’s family or close friends so they may help identify warning signs.
Resources for Psychological Treatment in BC

1. Private psychiatrists by referral.

2. For a province-wide list of private psychologists contact the British Columbia Psychological Association at www.psychologists.bc.ca or toll free: 1-800-730-0522

3. Ambulatory Psychiatric Clinics or Day Programs at hospitals, or community Mental Health Centres (call the BC Partners Mental Health Information Line at 1-800-661-2121 or (604) 669-7600 for listings in your community)

4. Changeways: A best-practice, group-based psychoeducational program for depression, offered in a number of hospitals and community health centres throughout the province (www.changeways.com)

5. Many people may be able to access a psychologist through an Employee Assistance Programs (EAP) if they or their spouse are working.

Major Depressive Disorder

- In patients with mild to moderate depression, evidence-based psychological treatments are as effective as antidepressant medications.
- First-line psychotherapies include Cognitive Behavioural Therapy (CBT), Interpersonal Psychotherapy (IPT) and Problem-Solving Therapy (PST).
- Although less stringent evidence exists, Brief Psychodynamic Psychotherapy has been shown to be effective in certain suitable populations.
  - Poor response has been predicted by low motivation, severe ego weaknesses such as impulse-control problems and poor reality testing, a tendency toward concrete thinking, poor object-relatedness and unstable family/home environment. ("Synopsis of Treatments of Psychiatric Disorders" Gabbard 1996.)
- For most patients, combined treatment with pharmacotherapy and psychological treatment is no more effective than either therapy alone. Combined treatment should be considered for patients with:
  - chronic or severe depressive episodes
  - comorbidity
  - poor clinical response to either antidepressant or psychological treatment alone
- Effective psychological treatments for depression include:
  - cognitive behavioural therapy
  - interpersonal psychotherapy
  - brief psychodynamic psychotherapy
  - supportive therapy
  - group therapy
- Consider patient preferences and availability of resources when considering options.
- Patients can benefit from supportive management by family physicians, especially when combined with medication treatment.
- Good evidence exists to support the use of light therapy for Seasonal Affective Disorder (SAD)
  - SAD treatment guidelines and Lightbox retailers can be found at: www.ubcsad.ca
Bipolar Disorder
- CBT has shown early, promising results as an adjunct to pharmacological interventions.

Brief Intervention for Depression
This section describes a brief problem-solving intervention for depressed patients that is evidence-based and practical to implement in a typical primary care practice.

The research literature shows Cognitive Behavioural Therapy (CBT) is an effective intervention for depression of mild to moderate severity, whether combined with antidepressant medication or not. But the amount of advanced training and treatment time required for effective CBT is not feasible for most general practitioners. The Brief Intervention is based on CBT principles, but uses recent research on self-care methodology to provide a form of intervention that is feasible in a real-world primary care practice.

Evidence shows:
- Distribution of self-care material based on CBT principles leads to substantial improvement in mild to moderate severity depression. A high proportion of patients find self-care material acceptable and use it to achieve significant and lasting improvement in mood symptoms. Many feel empowered by knowing that they are actively participating in their recovery.

- For relatively mild depression, effective intervention focuses on encouragement of self-care and problem-solving. For relatively severe depression, intervention focuses on standard evidence-based treatments such as antidepressant medication or CBT, while self-care can serve as an adjunct.

The general practitioner is in an excellent position to support and coach self-care, given the frequency of visits, high level of established trust and professional credibility. Self-care manuals have been developed by Mheccu, UBC for this purpose. An Antidepressant Skills Workbook for adults is available for free download and unlimited copying at www.carmha.ca, under Self Care. Translations of this workbook are available in French, Chinese (Traditional and Simplified) and Punjabi. A version for adolescents, Dealing with Depression: Antidepressant Skills for Teens, is also available.

Five steps of brief intervention for depression
1. Explain the biopsychosocial model of depression:
The acronym **STEP-A** (Situation, Thoughts, Emotions, Physical State and Actions) can serve as a mnemonic for this model.

a. Each of these areas can affect the others, so a person can spiral down into a depression that feels overwhelming and out-of-control.

b. Medication works on Physical State, but important changes also can be made in Thoughts and Actions.

2. Distribute CBT-based self-care book (e.g. the SCDP), whether giving a copy or information about how to access it.
   a. Inform the patient that research evidence shows depressed individuals can use the skills taught in this book to recover from depression, and it works along with medication (where this has been prescribed)
   b. Briefly describe the skills taught in the material: e.g. for SCDP, skills are Activation, Change of Depressive Thinking and Problem Solving.
   c. Encourage the patient to **Give It a Try.** Ask the patient to look it over before the next visit and offer to answer questions then.

3. Help the patient to get started.
   a. Discuss with the patient which of the skills to focus on initially.
   b. Assist the patient to set a first goal. For example, if there is a clear precipitating situational problem, begin with problem-solving and help the patient to identify a few possible actions; then assign the patient to write out the pros and cons of each action and identify the best or least bad one. Another example would be a physically inactive patient for whom a program of exercise would be beneficial for mood: help the patient to set a modest (but gradually increasing) exercise goal.

4. Check on how it went, ask about new goals or another skill to try.
   a. Praise the patient generously for any attempts made.
   b. Don’t tie achievement of a goal or new learning to any short-term mood changes — point out that mood changes happen gradually as a person practices new skills and achieves small goals.

5. Encourage continued practice of skills and goal setting.
   a. Praise generously. Remember that behavioural or cognitive change is very difficult, especially for depressed individuals, so be impressed when changes are made.
   b. Check how the person is doing with practicing skills and setting goals, even in the context of a quick office visit.

Note: This Brief Intervention, though based on CBT principles, is not equivalent to CBT provided by a mental health professional with specialized training in this method. The next step to a more intensive level of CBT intervention might involve referral to a cognitive behavioural group program. In British Columbia the Changeways group depression treatment program operates at outpatient mental health facilities in many regions of the province. Alternatively, consider referral to individual CBT (generally, 8 – 15 sessions).
Early Psychosis

- Psychological and social interventions for patients with psychosis are adjuncts to medication — they are not substitutes for pharmacotherapy.
- The addition of these psychosocial intervention leads to better short and long-term outcomes.
- All patients with psychosis should receive:
  - patient and family education
  - stress management
  - relapse prevention
  - problem solving
  - supportive counselling
  - assistance with housing, finances, and school and work opportunities.
- Certain early psychosis patients may also benefit from CBT in particular for treating secondary problems that can co-occur with psychosis, such as depression and anxiety, and persistent psychotic symptoms that do not respond to medication.

Substance Use Disorders

Stages of Change Model

- Originally developed to understand the experiences a person has when reducing substance use by DiClemente & Prochaska (1982).
- The model has since been applied to understanding a person’s experience and readiness for change for a variety of other behaviours, including mental health problems.
The model has not been validated for all disorders — it may be most useful in the treatment of substance misuse or other harmful behaviors, eating disorders, or in addressing adherence issues.

Progression through these stages is not always linear; people tend to move back and forth between stages, and relapse to a prior stage is always possible.

Understanding the stages of change can guide the tailoring of therapy to meet a person’s needs and further encourage change at his or her particular point in the change process.

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<th>What the Patient is Experiencing</th>
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<td>Precontemplation</td>
<td>unaware or denies there is a problem • may be feeling angry, anxious or embarrassed about having the “problem” discussed</td>
<td>• develop a therapeutic relationship • offer compassion, empathy and hope • reassure the individual about choices and next steps</td>
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<td>Contemplation</td>
<td>aware that there is a problem and is seriously thinking about overcoming the problem • not yet made any commitment to take action to overcome the problem • may be feeling ambivalent, apprehensive or relieved at discussing the problem</td>
<td>• provide support • encourage self-evaluation of the pros and cons of overcoming the problem or not • share examples of people who have successfully overcome a similar problem • offer information about the problem, the range of treatment options and the success of treatment • assist in making a plan and setting timelines</td>
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<td>Action</td>
<td>working on the problem to overcome it • engagement in treatment and making significant efforts to succeed • may be on an emotional “roller coaster” grieving old behaviours but enthusiastic about change</td>
<td>• work on treatment plan • affirm positive changes and provide support for difficult changes to behaviour or lifestyle • refer to community and professional programs to ensure a full range of care and support is provided • work with the person to develop a relapse prevention plan</td>
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<td>Maintenance</td>
<td>maintain success in having overcome the problem • focus on lifestyle changes and self-management skills • may be feeling greater comfort but have concerns about continuing success</td>
<td>• continue with relapse prevention work • watch out for new emerging issues and treat or refer as appropriate • discuss and normalize lifestyle changes. • reinforce self-management efforts</td>
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<td>Relapse</td>
<td>relapse may or may not occur • when relapse does occur, may be feeling like a “failure” and may have reduced motivation to continue to work on overcoming the problem</td>
<td>• give hope • re-affirm accomplishments and review and revise treatment plan • normalize relapse and move forward with new plans • explore triggers for relapse and revise relapse prevention plans</td>
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Brief Interventions for Substance Use Disorders

- Evidence suggests that simply asking a patient about alcohol use can reduce consumption.
- After completing an initial screen followed by a detailed assessment with lab work and a urine screen, carry out a “Brief Intervention.”
- The “Brief Intervention” is an evidence-based, five step, time limited intervention focused on changing behaviour and increasing compliance for alcohol use disorders.
- While there are numerous models of “Brief Intervention” with no consensus on number of visits, try 2 – 3 10 – 15 minute visits over a 6 – 8 week period.
- The “Brief Intervention” is well established as a counselling tool for such medical issues as hypertension, diabetes and obesity.
- An increasingly large body of evidence supports the expansion to effective interventions, including “Brief Interventions” by physicians.

The Five Steps include:
1. providing feedback about screening results, impairment and risks while clarifying the findings
2. assessing the patient’s readiness to change based on the “Stages of Change” (see previous page)
3. informing the patient about safe consumption limits and offering harm reduction strategies
4. negotiating goals and strategies for change
5. arranging for follow-up treatment.

Typically, candidates for brief intervention will be in one of the first three stages of change and are ambivalent. The brief intervention is meant to reduce the level of ambivalence and guide the patient further along the stages.

1. Provide feedback about screening results, impairment and risks while clarifying the findings
   - What often moves someone from the precontemplative to contemplative stage is convincing, personal, and timely information.
     - “As your family physician, I am concerned about how much you are drinking and how this is impacting your health/you socially.”
     - “Your unborn child could develop a birth defect called Fetal Alcohol Syndrome — there are no safe levels of alcohol consumption while you’re pregnant.”
   - It is essential that the information be intimately tied to the individual’s addictive behaviour, and runs contrary to their expectancies.

2. Assess the patient’s readiness to change based on the stages of change
   - Be clear about the stage of change. Matching stage specific interventions is critical to the successful outcome.
     - “What do you think about your alcohol/consumption?”
     - “Do you believe that your alcohol/consumption has had negative consequences? What are they?”
3. Inform the patient about safe consumption limits and offer harm reduction strategies
   - Harm reduction (HR) strategies are evidence-based measures aimed at reducing the harm to the patient while continuing to use. It is not the goal of therapy but a highly effective way to engage a user in the discussion of treatment.
   - While abstinence remains the traditional way to reduce harm associated with use, patients may not be prepared for this.
   - HR strategies can be offered at all stages of change.
     - For the pre-contemplative user these may be broader strategies to address overall health, as there is simultaneously an acceptance of the person’s ambivalence and communication of concern for their overall health.
     - Safe consumption limits are useful and may be more specific to the contemplative user. (Men: 14 drinks/week; no more than 2/day; Women: 9 drinks/week; no more than 2/day)
     - Aim to reduce the incidence of common co-morbid illness, such as HIV, Hep C and STD’s while using. Encourage the use of clean needles and safe injection techniques. Suggest switching to lower potency substances or reducing use as other ways to reduce harm (e.g., "Rubbing alcohol is very dangerous. While you think about cutting back, would you consider switching to beer or wine?"; “Sharing needles can put you at high risk for getting HIV or Hepatitis C. Do you have a source of clean needles? Do you use bleach and clean water?"; “Have you thought of smoking instead of injecting?”)

4. Negotiate goals and strategies for change
   - When negotiating goals, successful outcomes are most likely if goals specific to the stage of change are generated.
   - Use the BC Partners Problem Substance Use Workbook when developing short-term goals. Email bcpartners@heretohelp.bc.ca or call 1-800-661-2121 or (604) 669-7600 for further information on workbooks
   - Goals might include (with Stage of Change noted):
     - Harm reduction strategies (precontemplative)
     - Attending a meeting (contemplative) or schedule an appointment with an AD counsellor (e.g., “Have you thought of going to a meeting — you might find others who understand your situation.”)
     - Reducing quantity or frequency of use (contemplative: e.g., “You need to reduce your drinking — can you cut down to 2 or 3 drinks three times per week?”)
• Entering detox or applying for treatment (action: “With the amount you’re consuming, it would be wise to stop in a supportive medical environment like detox.”; “You’ve tried to quit on your own. I think it is worth trying a treatment centre.”)
  - Strategies for Change
    • Behavioural Modification Techniques (e.g., “What are some triggers for use? When you have relapsed in the past, what kind of things triggered you.”; “Let’s talk about ways to avoid these situations.”; “What are other ways you have coped with triggers in the past?” e.g., exercise, calling a friend)
    • Self-help Directed Bibliography (e.g., “Here is some information on substance use. I would like you to review it so that we may discuss it at the next visit”; “Try this website for some information”)

5. Arrange for follow-up treatment

Patient preference is an important determinant of treatment outcomes. A 3 month engagement in treatment has been shown to be a key threshold, as positive, long-term outcomes increase significantly after this stage.

“Let’s schedule a follow-up appointment to discuss your use” or “to discuss detox/treatment options”.

- Positive evidence exists for numerous treatment modalities, but no one treatment has been identified above the rest.
- Early treatment is often pharmacologically based and requires a withdrawal management period either at home, in a “daytox” programme, a residential detox or a medical detox.
- A broad range of treatment services are available and are highly patient specific.
- Post detox, inpatient treatment settings include Residential Treatment and Support Recovery Homes.
- Outpatient programmes range from intensive day programmes to AD counselling or group work.
- Modalities may include any one or more of pharmacotherapy, psychological or behavioural interventions or self-help groups.
INTRODUCTION

Mental disorders are major contributors to occupational impairment, absence, and disability. This is particularly true for depression, the primary source of disability in many occupational sectors. The World Health Organization projects that, by 2020, depression will be the second leading cause of disability in the developed world. Depression raises the risk for secondary physical and psychiatric illness, as well as for injuries and accidents. Lessons learned from appropriate management of depression-related impairment are often relevant for other psychiatric disorders, including adjustment and anxiety disorders.

The family physician plays a major role in the clinical management of mental disorders. As in other areas of medicine, the role of the family physician is to restore health; optimize social, psychological, physical, and functional capabilities; and, minimize the negative impact of injury/illness.

The tasks of the family physician are to: provide a clinical diagnosis; establish appropriate clinical goals; recommend/implement evidence-based treatment, in line with existing standards; and monitor clinical response.

The family physician can make a significant contribution toward the prevention and mitigation of occupational disability, with support from the psychiatrist, psychologist and/or other mental health professional for more severe or treatment resistant patients.

Management of workplace mental health issues can be challenging, as the family physician:

a) is trained to focus on symptomatology and diagnosis, rather than functioning (including occupational functioning);

b) may not be informed about the particular job or job requirements held by the patient and the degree to which the individual is able to meet those requirements;

c) is interacting with unfamiliar systems (e.g., employers; insurers); and

d) may feel torn between the concerns of patient/worker, the employer, and the insurer.

Nevertheless, this is a critical issue for the patient and all concerned parties. Failure to provide appropriate, timely and specific information can lead to exacerbation and increased complexity of mental health conditions; increased risk of injury, accident or incident; and/or delayed financial compensation for disabled patients.

| STEPS: |
| I. Assess Impairment and Functioning |
| II. Communicate Effectively with the Employer and/or Insurer |
| III. Collaborate with Patient on Decision-making around Accommodation and Work Absence |
| IV. Maximize Recovery of Occupational Function |
MANAGING WORKPLACE MENTAL HEALTH ISSUES

I. Assess Impairment and Functioning

The role of the physician is to evaluate Impairment (diagnosis, symptomatology, functional deficits) rather than Disability (patient’s incapacity to carry out a particular job, which is determined by the employer or insurance adjudicator).

Impairment is defined by the World Health Organization as “any loss or abnormality of psychological, physiological or anatomical structure or function”. Delineation of impairment requires a statement of diagnosis and detailed description of symptomatology.

- Family physicians have expertise in assessing and documenting degree of impairment, including:

  diagnosis:
  - Be specific as possible, preferably using DSM-IV-TR diagnosis (e.g., “stress” is not a psychiatric diagnosis).
  - Include information on expected course and prognosis.
  - Include information on evidence-based treatment.

  symptomatology:
  - Provide sufficient details, particularly with respect to symptoms that may impact occupational functioning.
  - Because symptom constellations within a diagnosis vary from patient to patient, specify a patient’s particular symptoms, their severity, and how they impact work performance.
  - When describing impairments, provide details such as their frequency, intensity, and duration, as well as any ameliorating factors or supports that may assist the patient in maintaining a greater functional level.

  functional impairment:
  There are four areas in which deficits may occur:
  (b) activities of daily living (e.g., patterns of eating and sleep, activities outside the home)
  (b) social functioning;
  (c) concentration, persistence, and pace;
  (d) deterioration or decompensation in complex or work like settings (e.g., how a patient’s symptoms might cause problems in work function)

  The GAF (Global Assessment of Functioning) index has questionable reliability and validity, but nevertheless remains the standard index of functional status.

  Careful determination of the GAF with respect to consistency with stated symptomatology and evident functional limitations will greatly assist with determination of a patient’s insurance eligibility (e.g., a claimant separately describing a reasonable family life, some volunteer work, and a relaxing trip to Hawaii, does not have a GAF of 40-45).

- Provide information on functional impairments specific to a patient’s particular occupation. In complex patients, a job analysis may be of value.

- Be cognizant of appropriate language for describing functional deficits (e.g., it is not meaningful to state that a patient “can’t concentrate” and “can’t sleep”; it is most unlikely that a patient is, for example, so depressed that he is entirely unable to concentrate or sleep to any extent for any period of time). It is more appropriate to describe some degree of impairment, whether in terms of reduced capacity, time limits of sustained concentration, or specific difficulty with concentrating on several tasks at the same time.

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1 The American Medical Association’s Guides to the Evaluation of Permanent Impairment (5th Ed.)
MANAGING WORKPLACE MENTAL HEALTH ISSUES

- Although disability requires the presence of significant impairment in ability to perform daily activities, including occupational activities, impairment alone does not determine disability. Factors such as age, general health, social supports, motivation, satisfaction with job and supervisor/manager are important determinants.¹

Impairment does not necessitate disability. A patient may be able to remain at work with significant impairments, if appropriate accommodations can be provided by the employer. Consider the contributing role of factors such as age, general health, social supports, motivation, and job satisfaction.

II. Communicate Effectively with the Employer and/or Insurer

- A unique aspect of management of workplace mental health issues is the need to communicate with unfamiliar systems, such as employers and/or insurers

- Employers may require clinical information from the family physician to make necessary accommodations in the workplace; similarly, the family physician may need information from the employer to address the impact of symptoms on occupational function

- Insurers require information from the family physician on clinical diagnosis, functional impairments, prognosis, recommended treatment, and duration of treatment to (a) adjudicate claims for eligibility for benefits and (b) ensure the patient has access to appropriate treatment
  - Complete forms in a timely and thorough manner. Although extra paperwork can be frustrating, disability evaluation forms are the primary way for insurance case managers to obtain the information needed to perform their job effectively
  - Discuss billing for additional paperwork with the patient in situations where this is not reimbursed by the insurer.

- Obtain specific consent to communicate with the insurer and/or employer, including informing patients of what information will be released

In complex patients (e.g., those that are treatment-refractory or require workplace accommodation) it may be helpful to directly communicate with the employer or insurer (as well as other treatment providers).

III. Collaborate with Patient on Decision-making around Accommodation and Work Absence

- Encourage patients to be actively involved in decision-making with respect to their care, rehabilitation and work plan (e.g., decisions around modifying duties at work, taking leave from work, and returning to work). Failure to do so may encourage hopelessness and helplessness, which can impede compliance and recovery. It is helpful to elicit information on the patient’s expectations for recovery.

Prolonged absence from one’s usual roles – including prolonged absence from work – has negative impact on an individual’s mental, social, and physical well-being and health.

Accommodation

- Consider appropriateness of accommodation in the workplace, as an alternative to complete work absence.

MANAGING WORKPLACE MENTAL HEALTH ISSUES

- In cases where accommodation in the workplace is being considered, encourage the patient to communicate with the employer.

Work Absence

- Collaboratively consider the advantages and disadvantages of work absence. If an absence from work is suggested, it should be a part of an overall treatment plan with specific recommendations and goals in mind for the time away from work.

Develop a definable treatment plan, including a plan for treatment if a work absence is recommended. Do not put an open-ended return to work date.

- Set a definite duration for the work absence.
  - In recommending leave duration, consider norms of treatment response (e.g., it is realistic to expect substantial recovery from uncomplicated treated depression and anxiety disorders in 6-8 weeks).

Benefits & Costs of Absence from Work

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient removed from occupational stresses, allowing stabilization in a protected environment.</td>
<td>Patient may become inactive and socially isolated, a behavioural pattern likely to worsen depression and reinforce anxiety.</td>
</tr>
<tr>
<td>Less risk of work incidents, especially in safety-sensitive positions.</td>
<td>Patient may develop a secondary anxiety pattern after extended work absence in which they become more apprehensive about work return.</td>
</tr>
<tr>
<td>Patient has more time for activities conducive to recovery such as psychotherapy or exercise programs.</td>
<td>Prolonged absence from work is a negative prognostic factor with regard to whether an individual ever returns to work.⁴</td>
</tr>
</tbody>
</table>

IV. Maximize Recovery of Occupational Function

- Although it was previously believed that restoration of occupational function lags behind symptomatic recovery in depression, current research indicates that symptom remission and recovery of function are typically synchronous⁵.

Symptomatic and functional recovery should be evident within the first few months of treatment. Failure to achieve functional recovery within 6-8 weeks for common mental disorders, such as depression and anxiety disorders, indicates the need for a change in treatment strategy or involvement of other mental health treatment providers.

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Pharmacologic treatment for depression and anxiety disorders can lead to significant improvement in function, but still leaves a significant gap in functional recovery for many individuals. Psychopharmacology can be augmented with referral for cognitive behavioural therapy, which has been shown to have specific benefit in promoting functional recovery\textsuperscript{6,7}.


Take an active role in encouraging self-management efforts, focused on helping patients understand their diagnosis and ways to manage their symptoms. One way to augment standard treatment to support individual coping and promote functional recovery is dissemination of Self-Care material, for example the Antidepressant Skills Workbook, available at no cost from www.carmha.ca/publications or the depression and anxiety toolkits and wellness modules, available at no cost from www.heretohelp.bc.ca.

If appropriate, the patient should be encouraged to investigate opportunities for assistance through the employer, for example Employee and Family Assistance Programs or extended health coverage for care by a psychologist.

For severe mental disorders such as schizophrenia, referral to rehabilitation/supported employment program should be considered.

Early intervention efforts targeted at assisting patients to regain function are effective in decreasing subsequent disability, and in reducing secondary illness reinforcers (e.g., reduction of responsibility; avoidance of stressors work and personal life; family sympathy)\textsuperscript{8,9}.

Further Reading


Includes: Global Assessment of Functioning (GAF) Scale; Social and Occupational Functioning Assessment Scale (SOFAS)


\textsuperscript{8} Bjorndal A. Follow-up of persons on long-term sick leave. A cohort study in the city of Moss. Tidsskr Nor Laegeforen 1994; 114: 2857-62.

Electroconvulsive therapy (ECT) is a safe and effective treatment for a variety of psychiatric and some medical conditions. It has proven superiority in prospective studies comparing ECT with “sham” ECT and with standard antidepressant treatment in “medication-resistant” patients. Especially when patients are identified early in the course of hospitalization and offered ECT as a treatment option, there can be a reduction in the length of stay and hospitalization cost, owing to both efficacy and rapidity of response. Despite generally higher seizure thresholds in the elderly, evidence suggests that response rates are higher in both the “young” elderly (65 – 74), and “old” elderly (75 or greater), with fewer complications compared to certain antidepressants. Nevertheless, ECT can induce side effects and may be physically risky for certain individuals. Relapse rates after an acute course of ECT can be high without continuation or maintenance pharmacotherapy and/or ECT.

ECT Indications

Primary Indications for Use
As stated in the APA guidelines, there is “compelling data . . . or strong consensus” supporting the use of ECT in the following conditions:
- Major Depressive Episode (arising from unipolar depression, as part of bipolar depression, or concomitant manic symptoms during “mixed states”) — ECT should be strongly considered, especially when associated with one of the following features:
  - acute suicidality with high risk of acting out suicidal thoughts
  - psychotic features
  - rapidly deteriorating physical status due to complications from the depression, such as poor oral intake
  - history of poor response to medications
  - history of good response to ECT
  - patient preference
  - risks of standard antidepressant treatment outweigh the risks of ECT, particularly in medically frail or elderly patients
  - catatonia.
- Mania — ECT should be particularly considered if there is:
  - extreme and sustained agitation
  - “manic delirium”.
- Schizophrenia* (According to the APA guidelines, the following associated features predict a favourable response to ECT):
  - positive symptoms with abrupt or recent onset
  - catatonia
  - history of good response to ECT.
* Studies demonstrating a favourable response to ECT in regard to psychotic symptoms have generally used a combination of ECT and standard antipsychotics.
Secondary Indications for Use
- Catatonia (unrelated to the primary conditions described above)
- Parkinson’s Disease
- Neuroleptic Malignant Syndrome
- Delirium (rarely considered for patients who require urgent treatment)
- Intractable Seizure Disorder
- Mood Disorder secondary to physical conditions

Cultural Considerations
- There may be specific beliefs in certain cultures surrounding electricity and touching of the head that can prevent patients from accepting ECT as a form of treatment.
- Another barrier occurs in refugees and immigrants who may have experienced incarceration for political reasons in psychiatric institutions and who have been subjected to ECT involuntarily without psychiatric indication.
- Survivors of torture who have been subjected to electrical shocks may also resist the notion of ECT.
- The reluctance to proceed with ECT is unfortunate in these circumstances, since these individuals may benefit significantly from ECT in treating mood and psychotic disorders that have developed as a complication of trauma or migration.

Selection and Risk
- Patient selection is critical in ensuring a high degree of confidence that ECT will be more effective than other treatments considered, while minimizing risk.
- ECT evaluation also addresses the presence of concurrent medical conditions that can increase risk, as well as the concurrent use of medical or psychiatric medications that can alter risk.
- The risk is defined as serious morbidity and mortality, which is most likely cardiopulmonary in nature if occurring, and is considered in line with the risk associated with other low-risk procedures under a general anesthetic.
- A widely-quoted risk figure is 1.6 deaths per 10,000 in a (typical) course of 8 ECTs.

Contraindications for ECT
- **There are no absolute contraindications for ECT.** ECT may be deemed necessary even when such “relative contraindications” identified by the APA guidelines are present:
  - unstable or severe cardiovascular conditions, such as recent myocardial infarction
  - unstable angina, poorly-compensated heart failure, and severe valvular cardiac disease including critical aortic stenosis
  - aneurysm or vascular malformation that might be susceptible to rupture with increased blood pressure
  - increased intracranial pressure, as may occur with some brain tumours or other space-occupying cerebral lesions
  - recent cerebral infarction
  - pulmonary conditions such as severe chronic obstructive pulmonary disease, asthma, or pneumonia
  - patient status rated as ASA (American Society of Anesthesiologists) level 4 or 5
- Conditions having substantially higher risk with ECT include:
  - Pheochromocytoma
ELECTROCONVULSIVE THERAPY (ECT)

- retinal detachment
- acute narrow angle glaucoma.
Those with cardiac pacemakers and implanted automatic defibrillators warrant some caution. (It is unlikely ECT would disrupt the functioning of a modern cardiac pacemaker)

ECT Providers
- Community psychiatrists provide ECT.
- The ECT is carried out using general anaesthetic — an induction agent and a muscle relaxant, and the patient is managed by an anaesthesiologist.
- ECT is done in hospital/surgical day care ORs or PARs.
- ECT is safe on an outpatient basis, appropriate for maintenance ECT.

ECT Resources
Visit www.hlth.gov.bc.ca/mhd/publications.html for ECT Guidelines for Health Authorities in BC, available on the BC Ministry of Health web page. An ECT information video for families is available at mental health and addictions centres across BC, and ECT information for families is available also in Chinese and Punjabi on the above website.
Pharmacological Intervention
GENERAL PRINCIPLES OF PHARMACOLOGICAL INTERVENTION

Consider these clinical factors when choosing a medication:
- previous response
- comorbid conditions
- side effects
- drug-drug interactions
- remission rates
- dosing regimen
- cost

Educate the patients about treatment
- Review with patients and families
  - Goals and benefits of treatment 1) Full Remission 2) Return to premorbid function
  - Side effects of various medication choices
  - Warn patients about suddenly discontinuing a medication and rebound symptoms which may occur
- Discuss medication onset timelines with patients
  - Antidepressants for depression: 4 – 6 weeks (if sooner, consider hypomania induction). Routine follow up within the first 2 weeks of prescribing an SSRI is prudent and always warn patients/families to monitor for increased suicidal ideation.
  - Antidepressants for anxiety: 2 – 3 weeks
  - Benzodiazepines: acute relief NOT advised to use for longer than 2 weeks
  - Antipsychotics: some reduction in psychotic symptoms within 1 week of starting therapeutic dose but longer time needed for fixed, delusional beliefs and negative symptoms

Common problems faced by many patients:
- stigma of being on medications
- cost
- dosing schedule adherence — time at which patient is most likely to take medication is in evening
- belief that the medication may not be helpful or appropriate
- side effects even at very low doses
- excessive use of benzodiazepines
- problems with adjusting to taper when decreasing or eliminating medications
- return of symptoms when medications are no longer taken.

Precautions when using Psychotropic medications:
- start low, go slow, keep going!
- psychotropic medications should be tapered prior to discontinuation.

Pharmacological information in this Guide was last updated in March 2006, based on input from PharmaCare.
Benzodiazepine Use in Primary Care

- British Columbia and Canada has no official guidelines for prescription use of Benzodiazepines.
- The College of Physicians and Surgeons of British Columbia has posted Benzodiazepines and Other Targeted Substances Regulations: Guidance Document for Practitioners and Questions and Answers on their website www.cpsbc.ca/cps. This is published by Health Canada and discusses issues of theft, storage, destruction, etc. of targeted substances.
- The College of Physicians and Surgeons of British Columbia has endorsed the UK protocol for BDZ withdrawal management entitled Benzodiazepines: How they work and how to withdraw (The Ashton Manual) benzo.org.uk.

In the United Kingdom, the Committee on Safety of Medicines and the Royal College of Psychiatrists have made some recommendations for BDZ use.
- BDZs can clearly provide critical and wide-ranging symptom relief for a variety of medical conditions and procedures.
  - BDZs should typically be used intermittently or in the short term (two weeks duration).
  - Chronic BDZ therapy should be used in exceptional cases with a clear medical indication, individualized treatment planning, close monitoring, and frequent evaluation.
  - In general, BDZ use is best avoided in pregnancy, breast-feeding, the elderly, and those with a history of addiction.
    - There is a risk of significant cognitive impairment, falls and trauma in the elderly
  - If needed in these populations for acute substance withdrawal or for symptoms refractory to other treatments, BDZ therapy should be carefully administered.
MAJOR DEPRESSIVE DISORDER

- Antidepressant medication is indicated for moderate to severe depression. Most studies show a considerable placebo effect in cases of mild depression.
- Encourage open, honest discussions with the patient about their beliefs and concerns surrounding antidepressant medications.
- After 1 medication
  - 65 – 75% of treated patients have clinically significant improvement
  - 50 – 60% have complete recovery
  - 15% have improvement with residual symptoms
  - 25% have minimal improvement
- Responder definition *
  - Partial Responder: 25 – 50% decrease in HAM-D scale
  - Non-Responder: <25% decrease in HAM-D scale
  - Responder: ≥50% decrease in HAM-D scale

* The definition of Responder is based on the HAM-D or “Hamilton Rating Scale for Depression” — a 24 item, clinician administered scale introduced in 1960 and used to standardize research
- Refractory: non-responder to >2 medications from different classes
- Current evidence does not indicate that any one class of antidepressant is significantly superior in treating depression. First line agents are selected for their overall tolerability and effectiveness.
- Use antidepressants with caution where there is a concurrent substance use problem
  - There is no evidence for the prescription of antidepressants in the context of ongoing substance abuse or dependence
Principles of Pharmacological Treatment of Depression

- If treating with antidepressants, initial response should occur within 3 – 4 weeks of treatment with a therapeutic dose.
- If there is no response (or no further improvement after partial response) after 3 – 4 weeks, increase medication every 2 – 4 weeks until remission of symptoms, maximum suggested dose is reached, or limiting side effects are experienced.
- If remission is achieved, maintain patient on medication for at least 6 months if first episode, and at least 2 years if:
  - second episode
  - suicidal/psychotic/severe
  - episode >two years
  - resistant or difficult to treat.

Partial response Strategies (See below, “Levels of Evidence”)

- Level 1 evidence: Augmentation
  - Proven Effective with TCAs (not SSRIs) — Lithium (target blood level 0.6 – 0.9; 600 – 900mg)
  - Probably Effective — Liothyronine Sodium (T3-Cytomel®) more centrally acting than Levothyroxine Sodium (T4-Synthroid®) 25 – 75mcg; low-dose atypical antipsychotic
  - Possibly Effective — Amphetamines (e.g., Dextroamphetamine: 5 – 10mg); Modafinil; Buspar, Tryptophan may be effective if target symptoms remain (e.g., poor sleep, low energy, poor concentration)
- Level 2 evidence: Switching (see Table: Washout Recommendations for Switching Antidepressants)
  - Benefit of simplicity with better compliance
  - Switch within class once, then switch out
- Level 3 evidence: Combination
  - e.g., SSRI + SNRI + Mirtazapine or Bupropion

Non responder strategies

- If there is no response, within 4 weeks of a therapeutic dose, switch within the same or out of class
- If after two medications within a class there is no response, switch class

Refractory patient strategies

- Re-evaluate diagnosis (for example, mania/hypomania, subtype of depression)
- Reassess treatment issues (for example, adherence, side-effects)
- Reassess comorbidity
  - Axis I: Panic, OCD, PTSD, Substances, Psychosis etc
  - Axis II: Personality Disorder especially Cluster B, Dependent
  - Axis III: General medical conditions
- Consider adding psychotherapy
- Refer to a specialist, community health centre or rural outreach team

Levels of Evidence

| Level 1 | at least one randomized controlled study |
| Level 2.1 | well-defined controlled trial without randomization |
| Level 2.2 | well-designed cohort or case-controlled studies, preferably multicentre or more than one research group |
| Level 2.3 | very significant results from uncontrolled trials from more than one centre comparing results with and without intervention |
| Level 3 | opinions of respected clinical authorities based on clinical experience, descriptive studies, or reports of expert committees |
### MAJOR DEPRESSIVE DISORDER

#### THERAPEUTIC DOSES AND COSTS OF COMMONLY PRESCRIBED ANTIDEPRESSANTS

<table>
<thead>
<tr>
<th>ANTIDEPRESSANT</th>
<th>USUAL STARTING AND (DAILY DOSE) (MG)</th>
<th>SIDE EFFECTS (KEY BELOW)</th>
<th>COST PER DAY ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FIRST LINE ANTIDEPRESSANTS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SSRI</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citalopram (Celexa)</td>
<td>10 qd (20-40)</td>
<td>0 0 0 4 2</td>
<td>0.94-1.88</td>
</tr>
<tr>
<td>Fluoxetine (Prozac)</td>
<td>10 qd (20-40)</td>
<td>0 0 0 4 3</td>
<td>1.08-2.16</td>
</tr>
<tr>
<td>Fluvoxamine (Luvox)</td>
<td>25 qd (100-200)</td>
<td>0 0 0 4 3</td>
<td>0.95-1.90</td>
</tr>
<tr>
<td>Paroxetine (Paxil)</td>
<td>10 qd (20-40)</td>
<td>0 0 0 4 3</td>
<td>1.18-2.36</td>
</tr>
<tr>
<td>Sertraline (Zoloft)</td>
<td>25 qd (50-150)</td>
<td>0 0 0 4 3</td>
<td>1.07-3.21</td>
</tr>
<tr>
<td><strong>SNRI</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venlafaxine (EffexorXR)</td>
<td>37.5 qd (75-300)</td>
<td>0 0 0 4 2</td>
<td>1.73-5.19</td>
</tr>
<tr>
<td><strong>SECOND LINE ANTIDEPRESSANTS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Novel action</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bupropion-SR (Wellbutrin)</td>
<td>100 qam (150-300)</td>
<td>0 0 0 0 2</td>
<td>0.88-1.54</td>
</tr>
<tr>
<td>Mirtazapine (Remeron)</td>
<td>15 qd (30-60)</td>
<td></td>
<td>1.33-2.66</td>
</tr>
<tr>
<td>Trazodone (Desyrel)</td>
<td>50 bid (200-400)</td>
<td>0 1 3 3 2</td>
<td>0.84-1.68</td>
</tr>
<tr>
<td><strong>TCA</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amitriptyline (Elavil)</td>
<td>25 bid (100-250)</td>
<td>5 5 4 2 2</td>
<td>0.32-0.80</td>
</tr>
<tr>
<td>Clomipramine (Anafranil)</td>
<td>25 bid (100-250)</td>
<td>2 3 3 3 3</td>
<td>0.86-2.15</td>
</tr>
<tr>
<td>Desipramine (Norpramin)</td>
<td>25 bid (100-250)</td>
<td>1 2 1 1 3</td>
<td>0.92-2.28</td>
</tr>
<tr>
<td>Imipramine (Tofranil)</td>
<td>25 bid (100-250)</td>
<td>2 4 1 3 3</td>
<td>0.66-1.65</td>
</tr>
<tr>
<td>Nortriptyline (Aventyl)</td>
<td>25 qd (75-150)</td>
<td>1 4 2 1 2</td>
<td>0.77-1.63</td>
</tr>
<tr>
<td><strong>RIMA</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Molindone (Manerix)</td>
<td>150 bid (450-600)</td>
<td>2 1 3 2 2</td>
<td></td>
</tr>
<tr>
<td><strong>THIRD LINE ANTIDEPRESSANTS</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>MAOI</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phenelzine (Nardil)</td>
<td>15 qam (30-75)</td>
<td>3 3 3 3 3</td>
<td>0.74-1.86</td>
</tr>
<tr>
<td>Tranylcypromine (Parnate)</td>
<td>10 bid (20-60)</td>
<td>2 2 3 2 3</td>
<td>0.73-2.20</td>
</tr>
</tbody>
</table>

Data adapted from the BC Drug Formulary and the Manufacturers’ list (2001)

RIMA = reversible monoamine oxidase inhibitor; TCA = tricyclic antidepressant; SNRI = Serotonin and norepinephrine reuptake inhibitor

**MAOI** = Monoamine oxidase inhibitor; SSRI = Selective serotonin reuptake inhibitor

* Use with caution because of dietary restrictions and drug-drug interactions


**A** = Anticholinergic (dry mouth, blurred vision, constipation, urinary retention, sweating, tachycardia, confusion)

B = Antihistamine (drowsiness, weight gain)

C = Anti-alpha adrenergic (orthostatic hypotension, dizziness, reflex tachycardia, sedation)

D = Serotonergic (GI distress, headache, nervousness, akathisia, EPS, sweating, sexual dysfunction, anorexia)

E = Adrenergic (tremors, tachycardia, sweating, insomnia, sexual dysfunction)

Not all medications listed are eligible for coverage under the No-Charge Psychiatric Medication Program (Plan G). Coverage information is provided on the BC PharmaCare website at www.health.gov.bc.ca/pharme/outgoing/plangtable.html.
## MAJOR DEPRESSIVE DISORDER

**Washout Recommendations for Switching Antidepressants**

Adapted from Guidelines for the Diagnosis and Pharmacological Treatment of Depression. Toronto, ON, Canadian Network for Mood and Anxiety Treatments, 1998.

<table>
<thead>
<tr>
<th>Switch to</th>
<th>SSRI</th>
<th>Novel</th>
<th>TCA</th>
<th>RIMA</th>
<th>MAOI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Switch from</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SSRI</strong></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>citralopram</td>
<td>No washout</td>
<td>No washout</td>
<td>No washout</td>
<td>1 week</td>
<td>1 week</td>
</tr>
<tr>
<td>fluoxetine</td>
<td>May have additive serotoninergic side effects for 1 week (5 weeks for fluoxetine)</td>
<td>May have additive serotoninergic side effects for 1 week (5 weeks for fluoxetine)</td>
<td>Start TCA at a lower dose</td>
<td>(5 weeks for fluoxetine)</td>
<td></td>
</tr>
<tr>
<td>fluoxamine</td>
<td></td>
<td></td>
<td>Some SSRIs can increase serum TCA levels for 1 week (5 weeks for fluoxetine)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>paroxetine</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>sertraline</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NOVEL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>bupropion-SR</td>
<td>No washout</td>
<td>No washout</td>
<td>No washout</td>
<td>1 week</td>
<td>1 week</td>
</tr>
<tr>
<td>mirtazapine</td>
<td>May have additive serotoninergic side effects for 1 week</td>
<td>May have additive serotoninergic side effects for 1 week</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>venlafaxine-XR</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>TCA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>desipramine</td>
<td>No washout</td>
<td>No washout</td>
<td>No washout</td>
<td>1 week</td>
<td>1 week</td>
</tr>
<tr>
<td>nortriptyline</td>
<td>Serum TCA levels may be increased by some SSRIs for 1 week</td>
<td>Serum TCA levels may be increased by some SSRIs for 1 week</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>amitriptyline</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>imipramine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>others</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RIMA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>moclobemide</td>
<td>3 days</td>
<td>3 days</td>
<td>3 days</td>
<td>N/A</td>
<td>3 days</td>
</tr>
<tr>
<td><strong>MAOI</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>phenelzine</td>
<td>2 weeks</td>
<td>2 weeks</td>
<td>2 weeks</td>
<td>2 weeks</td>
<td>2 weeks</td>
</tr>
<tr>
<td>tranylcypromine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**MAJOR DEPRESSIVE DISORDER**

**Bipolar Disorder**
Generally, initiate a mood stabilizer on admission with mania, hypomania, or bipolar depression.

<table>
<thead>
<tr>
<th>MOOD STABILIZER</th>
<th>USUAL STARTING AND DAILY DOSE (MG)</th>
<th>PLASMA LEVELS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FIRST LINE MOOD STABILIZER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lithium Carbonate</td>
<td>300 bid (900-1800)</td>
<td>0.8-1.0 mmol/L</td>
</tr>
<tr>
<td>Nausea, vomiting, diarrhoea, dry mouth, weight gain, fatigue, dizziness, fine hand tremor, polyuria, hypothyroidism, cognitive blunting, psoriasis, acne, alopecia, edema, teratogen; Toxicity: ataxia, vertigo, dysarthria, confusion, nystagmus.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valproate (Epival)</td>
<td>250 bid (750-1750)</td>
<td>350-700 umol/L</td>
</tr>
<tr>
<td>Nausea, vomiting, diarrhoea, rash, indigestion, sedation, tremor, alopecia, weight gain, menstrual disturbances, thrombocytopenia, leucopenia, teratogen Toxicity: ataxia, nystagmus, diplopia, dysarthria.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carbamazepine (Tegretol)</td>
<td>100 bid (600-1200)</td>
<td>17-50 umol/L</td>
</tr>
<tr>
<td>Allergic skin reactions, drowsiness, headache, diplopia, blurred vision, ataxia, dizziness, nausea, vomiting, tremor, dry mouth, confusion, sedation, low WBC, weight gain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lamotrigine</td>
<td>25qd (75-250)</td>
<td>Nil</td>
</tr>
<tr>
<td>Skin rash, dizziness, diplopia, headache, somnolence, ataxia, nausea, vomiting, blurred vision, sedation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SECOND LINE MOOD STABILIZER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gabapentin</td>
<td>300 qd (900-1800+)</td>
<td>Nil</td>
</tr>
<tr>
<td>Somnolence, dizziness, ataxia, fatigue, nystagmus, tremor, diplopia</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ANTI-MANIC ADJUNCTS</strong></td>
<td></td>
<td>Nil</td>
</tr>
<tr>
<td>Clonazepam (Rivotril) Atypical Antipsychotics</td>
<td>2 bid (6-12 acute)</td>
<td>Nil</td>
</tr>
<tr>
<td>See below</td>
<td></td>
<td>Nil</td>
</tr>
</tbody>
</table>

- Discontinue antipsychotic typically six months after there has been a good response.
- Maintain on a mood stabilizer.
- A combination of a mood stabilizer and a very low dose of an antipsychotic is an option for treating refractory bipolar disorder.
There are a variety of evidence-based medications for most but not all of the anxiety disorders.

Note on Benzodiazepines (see General Principles of Pharmacologic Treatments — Benzodiazepines in Primary Care)
- Consider Benzodiazepines under some circumstances for short term management of anxiety symptoms until benefits from other longer-acting treatments are apparent.
- Prescribe Benzodiazepines for periods of no longer than 2 weeks.
- Do not use Benzodiazepines as the first line of treatment as they
  - are subject to abuse, dependence, and/or diversion
  - have risk of sedation
  - can cause dangerous interactions with other drugs or alcohol, and
  - often create rebound anxiety that promotes increased use.

### TABLE OF MEDICATIONS INDICATED FOR SELECTED ANXIETY DISORDERS

<table>
<thead>
<tr>
<th>TYPE OF ANXIETY DISORDER</th>
<th>SRIS (INCLUDING SSRIS)</th>
<th>TCAS AND RELATED ANTI-DEPRESSANTS</th>
<th>BENZOS*</th>
<th>OTHERS</th>
</tr>
</thead>
</table>
| Obsessive Compulsive Disorder | √ | √ clomipramine only | | Some evidence for augmentation of SRIs with clonazepam or buspirone
| | | | | Or atypical antipsychotics |
| Social Anxiety Disorder | √ | | √ | |
| Generalized Anxiety Disorder | SSRIs and Venlafaxine | √ | √ | Buspirone |
| Post Traumatic Stress Disorder | √ | | | |
| Panic Disorder with or without Agoraphobia | √ | | √ | |
| Agoraphobia only | No evidence based medications for Agoraphobia without Panic Disorder | | | |
| Specific Phobias | No evidence based medications for specific phobias | | | |

Guidelines for Anxiety Disorders


**EARLY PSYCHOSIS**

**General Principles of Starting Antipsychotic Medication**
- The treatment of choice is a single atypical antipsychotic medication.
- The use of several antipsychotics at once is not recommended.
- The newer atypical antipsychotics (e.g., risperidone, olanzapine, clozapine and quetiapine) are preferred over the older typical antipsychotics (e.g., haloperidol).

Advantages of the class of atypical antipsychotics include:
- As effective as “typicals” in treating psychosis
- Favourable side effect profile
  - Low risk of serious side effect like tardive dyskinesia
  - Lower incidence of EPS
- Target negative symptoms as well as positive symptoms
- Are effective at resolving acute mania.

Disadvantages include:
- Significant risk of weight gain/diabetes/hyperprolactinemia.

**Initial Dosing**
- First-episode patients are more sensitive than other patients to the effects of antipsychotic medications, and therefore much lower doses are needed.
- For example, after a low starting dose, first-episode patients often respond to 2 mg of risperidone or 5 – 10 mg of olanzapine.
- Side effects should be closely monitored, especially at the beginning of treatment.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Starting Daily Dose</th>
<th>Expected Lowest Effective Dose</th>
<th>Typical Higher Effective Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risperidone</td>
<td>0.5 – 1 mg</td>
<td>1 – 2 mg</td>
<td>4 – 5 mg</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>2.5 – 5 mg</td>
<td>5 mg</td>
<td>15 mg</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>50 – 100 mg</td>
<td>300 – 400 mg</td>
<td>600 – 800 mg</td>
</tr>
</tbody>
</table>

**Use of Other Medications**
- If mood symptoms are also present, a mood stabilizer or antidepressant should be started as well.
- Benzodiazepines are helpful for managing sleep disturbance, agitation and anxiety in the acutely psychotic/manic patients.

**Side Effects**
- Significant weight gain is a common side effect, especially with clozapine, olanzapine and quetiapine.
  - Weight gain may lead to discontinuation.
  - Weight gain increase risk for obesity-related disorders such as diabetes.
  - Diet and exercise are the main treatments for overcoming the weight gain.
- Sedation is common with the newer atypicals, although not with risperidone.
- Overdose from antipsychotics is rare and unlikely to cause death.
EARLY PSYCHOSIS

- Extrapyramidal side effects such as akathisia, and Parkinsonism can occur even with olanzapine and risperidone.
  - Benztropine is effective against Parkinsonism (start with 0.5mg qd-BID — caution: may cause increased cognitive slowing).
  - Lorazepam is an effective first line agent against akathesia (a subjective sense of internal restlessness which may be exhibited behaviourally and misdiagnosed as agitation).
- Sexual side effects are common and need to be openly discussed.

Evaluating Medication Response

- Most patients will show a good response within the first six weeks of treatment, and an almost complete response in the first six months. Delusions may persist in an attenuated form, however.
- Responders are more likely to be
  - female
  - have less severe symptoms
  - older at age of onset
  - well-adjusted beforehand
  - free of movement disorders.

Switching Medications

- Consider switching if there is a poor response after two months on a reasonable dose.
- Tapering one while titrating another is an effective approach.
- Clozapine is reserved for use when at least two other antipsychotics have been unsuccessful. It is a restricted medication due to the 1% risk of agranulocytosis.

Duration of Treatment

- Maintain the antipsychotic at least one year if the diagnosis is first break psychosis.
- In schizophrenia, approximately 20% never have a second episode.
- Continue medication indefinitely if this is a relapse.
- Monitor with frequent follow-ups if the medication is discontinued at the patient’s request.
*Note—If history suggests schizoaffective bipolar type and patient presents in depressive phase, use antipsychotic and mood stabilizer and follow bipolar manic stream.
EARLY PSYCHOSIS

Early-Psychosis-Specific Guidelines

Early Psychosis: A Care Guide (2002). This is a made in BC document that summarizes all treatments. Available on-line at: www.carmha.ca


The following documents are available on-line at: www.healthservices.gov.bc.ca/mhd/publications.html.

- Early Psychosis — A Care Guide (PDF 3.2MB)
- Early Psychosis — A Care Guide Summary (PDF 2.8MB)
- Early Psychosis: A Guide for Physicians (PDF 0.8MB)
- Early Psychosis: A Guide for Mental Health Clinicians (PDF 0.9MB)
- Early Identification of Psychosis: A Primer (PDF 83KB)
- Minimizing Damage — Maximizing Outcomes: The Importance of Early and Effective Treatment for Psychosis (PDF 69KB)

Disorder-Specific Guidelines


The Treatment of Bipolar Disorder: Review of the Literature, Guidelines. The Canadian Network for Mood and Anxiety Treatments (CANMAT)

Goodwin GM. Evidence-based guidelines for treating bipolar disorder: recommendations from the British Association for Psychopharmacology. J Psychopharmacol 2003;17(2):149 – 73; discussion 147


A full review of possible pharmacological interventions is beyond the scope of this Guide. Generally, interventions are categorized based on the phase of treatment.

- **Withdrawal management**: medications may be used to facilitate the process of withdrawal and to treat the symptoms of withdrawal.
- **Relapse prevention**: relapse is discouraged through use of medications that block the desired effects of problematic substances or cause negative effects when problematic substances are used.
- **Maintenance**: a medication (only methadone in BC) is prescribed for regular use to block withdrawal symptoms and reduce cravings.
- **Treatment of concurrent psychiatric disorders**: medications are used to treat a concurrent psychiatric disorder.

**Available Pharmacotherapy Medications**

- **Withdrawal Agents** — long-acting, cross-tolerant agents:
  - Benzodiazepines: clonazepam, phenobarbital
  - Opioids: methadone
  - Alcohol: diazepam, phenobarbital
- **Replacement Therapies**
  - Nicotine replacement therapy
  - Methadone
- **Anti-craving**
  - Alcohol: naltrexone
  - Nicotine: buproprion
- **Agents for Concomitant Psychiatric Symptoms**

Important considerations in choosing medication include:

- effectiveness
- indications
- safety profile — overdose, drug interactions
- impact on concurrent disorders (physical and psychiatric)
- cost
- abuse, dependence, and diversion potential
- Substance use can interfere with medication pharmacodynamics & exacerbate symptoms.

**Principles of Substance Withdrawal Management (by Substance Type)**

- The experience of detoxification, or the reversal of physical dependence, is a treatable syndrome which may cause significant distress or impairment.
- Withdrawal is specific to:
  - the individual — variable in onset, duration, and intensity
  - the problematic substance (usually the opposite of the direct pharmacological effects of a drug)
  - the amount, route, duration and frequency of use (generally worse in heavy or prolonged substance use).
- Not due to general medical condition or another mental disorder
- The plan of care should be individualized & frequently reassessed.
- Generally, prescribe medications used in withdrawal management for no longer than two weeks.
Substance Use Disorders

- Use medications to minimize the risk of harm (e.g., to prevent or manage seizures or hypertensive crisis while assuaging signs and symptoms of withdrawal).
- Review medical and psychiatric comorbidity in order to determine the level of care required for withdrawal management (outpatient vs inpatient)
  - High-risk withdrawals should be done as inpatients where close medical monitoring is available
- Potential high-risk withdrawal:
  - physical illness — CAD, HTN, HIV
  - prior seizure history with withdrawal
  - elderly
  - brain injured
  - psychiatric illness
  - pregnancy
  - withdrawal from prolonged CNS depressants (Alcohol, Benzos, Barbituates).

Alcohol

- Withdrawal begins within 6 to 24 hours of consumption and tends to persist for up to 4 – 7 days. Disruption in sleep may last up to 1.5 years.
- Indications for receiving withdrawal meds include: dependence, past seizures, delirium tremens, underlying conditions which make tolerance to withdrawal difficult e.g., anxiety, psychosis and those with concurrent medical condition such as coronary artery disease, hypertension, and pregnancy.
- Strong evidence exists for the use of benzodiazepines, and Phenobarbital in withdrawal management. Carbamazepine, Phenytoin and Valproic Acid are also used in hospital settings but while preventing seizures, do not prevent Delirium Tremens.
- Withdrawal management may be in the form of a symptom-based protocol, a loading protocol or a gradual taper. The CIWA-AR (the Clinical Institute Withdrawal Assessment — Alcohol) is a 10 item withdrawal symptom list used in both symptom-triggered and fixed-dose protocols. It can be used with benzodiazepines (commonly diazepam) or Phenobarbital.
- Pharmacological intervention is indicated for scores of 10 or greater.

Benzodiazepines

- Regardless of how benzodiazepines are used, either as prescribed or problematically, withdrawal syndrome is highly likely with regular use.
- The College of Physicians and Surgeons of British Columbia has endorsed the UK protocol for BDZ withdrawal management entitled Benzodiazepines: How they work and how to withdraw (The Ashton Manual) benzo.org.uk/manual/index.htm. This is also linked on the CPSBC website www.cpsbc.bc.ca/physician/documents/index.htm.
- Withdrawal symptoms present within 1 – 2 days of discontinuation with short acting benzodiazepines and may take up to 4 days with longer acting benzodiazepines.
- Symptoms of withdrawal include: anxiety, restlessness, irritability, insomnia and depression. Seizures and delirium can occur with benzodiazepine withdrawal.
- The discomfort associated with withdrawal tends to peak by day 7 – 10 but may take several weeks or longer to clear depending on the benzodiazepine.
- Withdrawal is often managed by substituting the problem drug with a longer acting benzodiazepine such as diazepam, clonazepam, or chlordiazepoxide and taper over weeks to months.
- Use caution when tapering from alprazolam due to the risk of withdrawal seizures.
Opioids
- For heroin, morphine, codeine and oxycodone withdrawal begins within hours of discontinuation and peaks within 2 – 4 days.
- For methadone, withdrawal begins 24 – 36 hours after the last dose.
- Patients will often detoxify themselves safely at home.
- For others, management of withdrawal can be attained either with a Clonidine protocol or with a rapid methadone taper. Methadone, usually used as a maintenance therapy, can also be used as a substitution medication and be tapered over several weeks to months.

Stimulants
- Physical symptoms of withdrawal are unpleasant but not life threatening. Patients usually complain of hyperphagia and hypersomnia.
- Dysphoria and suicidal ideation may occur.
- Use low dose atypical antipsychotics to manage psychosis, paranoia, anxiety and insomnia.

Marijuana
- Physical signs may include mild increases in heart rate, blood pressure, and body temperature and anorexia.
- Psychological symptoms may include anxiety, depression, irritability, insomnia, tremors, and chills.
- Withdrawal usually last several days (6 – 10), although subtle symptoms may persist for weeks.
- Treatment is mainly education and support.

Polysubstance Use
- There is a hierarchy of withdrawal management priority based on risk of harm to the patient
  - Prioritize as follows: Alcohol/benzos > opiates > cocaine and stimulants > marijuana
- Consider referral for inpatient detox.

Relapse Prevention (by Substance Type)
Once detoxification is completed, medications which block pleasurable effects of drugs, modulate cravings, or trigger significant physical adverse effects with relapse have had limited albeit documented success in preventing relapse.


**SUBSTANCE USE DISORDERS**

**for Nicotine**

Agonist substitution therapy or nicotine replacement therapy is effective:

- proven efficacy in helping cigarette smokers quit smoking when used as part of a comprehensive behavioural smoking cessation program
  - increase quit rates by 1.5 – 2x
  - success independent of additional support or treatment setting
- nicotine polacrilex (nicotine gum)
- transdermally delivered nicotine (nicotine patch)
- nicotine inhaler (Nicorette inhaler) puffed and delivered orally (not really inhaled)
- contraindicated if vascular compromise or arrhythmia
  - immediate post-myocardial infarction period
  - life-threatening arrhythmias
  - worsening angina pectoris
- Buproprion (Zyban) — indicated for smoking cessation at a dose of 150mg/day po q daily for 3 days and then 150mg po bid
  - used to reduce cravings but not for nicotine withdrawal per se
  - can be used safely with nicotine replacement therapy
  - should be started at least one week prior to the target quit date.

**for Alcohol**

**Naltrexone** can be used:

- a competitive opioid antagonist.
- cost is approximately $200/month
- indicated for alcohol intake reduction and relapse prevention
- most thoroughly scientific established adjunct in alcoholism treatment (Sinclair, 2000)
  - in several randomized trials, patients engaged in counselling and treated with adjunctive Naltrexone were shown to decrease the intensity and severity of their binge drinking; success of treatment evaluated in terms of health and patient satisfaction
  - less effective with abstinence based supportive therapy
  - can be used safely without prior detox
  - effective even when taken only on days when drinking is expected
  - intermittent use can continue indefinitely
- optimal treatment
  - initial dose of 12.5 - 25mg/day and titrate to effect, as high as 150mg;
    a standard dose is 50mg
  - combined with psychosocial therapy >3 months
- use with caution in patients with liver disease and pancreatitis and contraindicated if in liver failure
  - obtain baseline function prior to initiation.

**Disulfiram** (Antabuse) remains an option:

- Antabuse removed from the Canadian market in 2004, but still available via the federal Special Access Program (must be ordered under special physician request)
- Disulfiram is commonly available in compounded capsules made by a number of pharmacies in BC. These are a PharmaCare benefit in lieu of the now discontinued Antabuse.
- interferes with the metabolism of the intermediary product of alcohol oxidation, acetaldehyde which triggers an unpleasant reaction: throbbing headache, sweating, flushing, nausea, and vomiting; the reaction can last up to 3 hours and,
while a deterrent to alcohol consumption, it may be avoided by simply not taking the medication on the day in question; however, alcohol consumption should not occur for about 36 hours after the last pill

- use should be limited to highly motivated patients with a spouse or partner able to supervise daily ingestion
- obtain EKG and liver enzymes/function prior to initiation

**Maintenance Therapy for Opioids**

**Methadone**

- The College of Physicians and Surgeons of British Columbia have released a Methadone Maintenance Manual 2004 that is available through their member website or can be ordered. [www.cpsbc.ca/cps](http://www.cpsbc.ca/cps) (First Login -> College Programs -> Methadone).
- For complete information on Methadone Treatment or to obtain Methadone licensing, refer to the College of Physicians and Surgeons website: [www.cpsbc.ca](http://www.cpsbc.ca).
- Synthetic opioid agonist
- Currently the only evidence-based maintenance treatment available for opioid dependence approved for use in British Columbia.
- It is a controlled substance and requires duplicate prescriptions in BC. Its use is administered by the College of Physicians and Surgeons of BC and requires a Health Canada exemption.
- Best researched treatment for opioids
  - Better treatment retention rates
  - Reduces morbidity and mortality
  - Curbs spread of infectious disease
  - Work best if program is numerous, accessible, and flexible (Mattick et al, 2003)
- Methadone is well absorbed through the gastrointestinal tract. It reduces or eliminates withdrawal symptoms and reduces craving.
- If dosed appropriately, the person is able to work or perform tasks unimpaired and without the rush or risks associated with heroin.
- Before beginning methadone maintenance treatment (MMT), there must be “evidence of extensive past opioid use and/or failed treatment”.
- It is generally a once daily dosed medication and initially, MMT requires daily dispension and witnessed ingestion. Frequent urine drug screens are required.
- Although persons on MMT may not discontinue illicit drug use completely, they can still experience benefit from maintenance therapy, e.g., reduced frequency of injection, reduced needle sharing, reduced crime.

**Precautions in management of Concurrent Mental Health and Substance Use Disorders**

- As there are high levels of comorbidity, screening for concurrent disorders is important
- Some patients may be predisposed to a protracted withdrawal syndrome difficult to distinguish from a comorbid psychiatric illness.
  - Protracted withdrawal syndrome is subject of considerable controversy (Geller, 1994).
  - Not as predictable as those of acute withdrawal.
SUBSTANCE USE DISORDERS

■ Use caution when prescribing medications for managing a mental illness in patients with a concurrent substance use problem
■ For all,
  - avoid benzodiazepines if possible.
■ For anxiety,
  - consider low dose antipsychotics for short term relief of anxiety.
■ For mood disorders,
  - use anti-depressants with caution as aggressive treatment may lead to the induction of hypomania
  - the early remission phase of most substance dependence can present with a self-limited period of depression marked by dysphoria and/or atypical depression
  - approximately 60% of bipolar patients have an SUD — keep a high index of suspicion for this illness.
■ For insomnia,
  - low potency medications such as Trazodone 25 – 100mg (best for middle and late insomnia)
  - consider short term atypical antipsychotics in low dose (quetiapine 12.5 – 50 mg)
■ For psychosis,
  - treat aggressively and hospitalize if indicated
  - crystal methamphetamine induced psychoses can take weeks to months to clear.

Serotonin Specific Reuptake Inhibitor (SSRI) Discontinuation Syndrome
■ Effects are generally mild, short-lived, and self-limiting but can be distressing and may lead to missed work days and decreased productivity.
■ “SSRI discontinuation syndrome” is now widely accepted.
■ Symptoms are most likely to occur 24 – 48 hours after discontinuation or after a large dose decrease.
■ Symptoms may last up to weeks after interruption of treatment, and may be relieved by restarting antidepressant therapy.
■ SSRIs with shorter half lives, such as paroxetine, sertraline, citalopram, produce discontinuation symptoms that persist for up to 1 – 2 weeks after treatment cessation.
■ Due to its longer half life, Fluoxetine may cause symptoms beginning as late as 25 days and up to 56 days after discontinuation.

Clinical features
■ Physical or Somatic complaints
  - dizziness and light-headedness
  - nausea and vomiting
  - fatigue, lethargy
  - myalgia, chills and other flu-like symptoms
  - sensory and sleep disturbances
■ Psychological manifestations
  - changes in mood, affect, crying spells, irritability
  - neurovegetative changes in appetite or sleep
  - anxiety and/or agitation
SSRI specific observations
- skin disorders with abrupt cessation of sertraline
- flu-like withdrawal syndrome with paroxetine
- extra-pyramidal symptoms have been reported with fluoxetine.

Clinical Notes
- Symptoms of discontinuation may be mistaken for relapse into depression or physical illness.
- Misdiagnosing these symptoms may lead to unnecessary investigations and/or treatment.
- Rebound depression can occur in patients treated with an SSRI for other disorders e.g., Obsessive Compulsive Disorder.
- Paradoxical mood changes have been reported on abrupt withdrawal, including mania or hypomania.
- The syndrome is distinct from the classic withdrawal syndrome associated with alcohol and barbiturates — there is no craving or med seeking distinguishing it from abusive or addictive behaviour.

Diagnostic Criteria
- 2 or more of the following symptoms, developing within 1 to 7 days of discontinuation or reduction in dosage of an SSRI, after at least 1 month’s use, when these symptoms cause clinically significant distress or impairment and are not due to a general medical condition or recurrence of a mental disorder.
  - dizziness
  - vertigo or feeling faint
  - paresthesia
  - diarrhoea
  - gait instability
  - insomnia
  - nausea or emesis
  - visual disturbances
  - light-headedness
  - shock-like sensations
  - anxiety
  - fatigue
  - headache
  - irritability
  - tremor

Precautions when discontinuing SSRIs
- Taper SSRIs before discontinuation.
- The syndrome is more likely to occur when
  - medication has been taken for longer than 2 months
  - the SSRI has a short half life (e.g., paroxetine)
  - higher doses are used.
- Neonatal SSRI Discontinuation Syndrome can follow maternal use of antidepressants during pregnancy and possibly breast-feeding. Consider this when making treatment decisions.
- Educate patients not to stop therapy without a consultation.
- For most SSRIs, taper over a period of 2 weeks or more to reduce/minimize symptoms.
- Fluoxetine has a longer half-life and may be discontinued more abruptly.
- Consider tapering high doses of paroxetine more gradually, over 4 weeks or longer.
- Treat mild symptoms by simply reassuring the patient that they are usually transient.
- For more severe symptoms, reinstitute the original dosage and slow the rate of taper or switch to a longer acting medication like fluoxetine.
- In cases in which the SSRI is restarted, symptoms generally resolve within 72 hours.
Tobacco Cessation in Mental and Substance Use Disorders

This section is under development. When the content for this section is complete, it will be posted on the Ministry of Health Services, Mental Health and Addictions website at: http://www.health.gov.bc.ca/mhd/physicians_guide.html.
The No-Charge Psychiatric Medication Program (Plan G) is available to individuals of any age who are registered with a mental health and addictions centre and who are in clinical and financial need. The program provides 100% coverage of the eligible costs of certain psychiatric medications.

Patients who are eligible for subsidy for the MSP program are also eligible for Plan G. Individual patient eligibility is determined by the patient’s physician and the local mental health centre. Registration is required.

The drugs eligible for coverage under the No-Charge Psychiatric Medication Program are listed in the Plan G formulary on the BC PharmaCare website at www.health.gov.bc.ca/pharme/outgoing/planetable.html by both brand and chemical name. Drugs in the formulary identified as “Limited Coverage” require prior Special Authority approval from PharmaCare. For these medications, the patient’s physician must submit a Special Authority Request to PharmaCare. For more information on Special Authorities, visit www.health.gov.bc.ca/pharme/sa/saindex.html.

For more information on the program, or to request Plan G application forms, physician’s offices can contact their local mental health centre. Plan G application forms can also be downloaded from the BC Pharmacare website at www.health.gov.bc.ca/exforms/mhdforms/3497.pdf.
APPLICATION FOR
PSYCHIATRIC MEDICATION COVERAGE

A. TO BE SIGNED AS TRUE BY THE APPLICANT

Name: ___________________________________________ Gender: □ M □ F

Address: ___________________________________________ Postal Code: __________________________

Telephone: ___________________________ Date of Birth: ____________ YYYYY MM DD

Personal Health Number (PHN) ___________________________ Mandatory

1. The cost of the prescribed psychiatric medication is a significant barrier to me taking my medication. I have no other financial coverage, and I believe I qualify for Premium Assistance ($28,000 family adjusted net income plus $3,000 per dependent).

2. I consent to the release of financial and clinical information about me to the mental health centre and the Ministry of Health for the sole purpose of verifying my eligibility for this program.

3. I understand that the personal information collected on this form relates directly to and is necessary for program operations. The information will be handled in accordance with the Freedom of Information and Protection of Privacy Act. If I have any questions about the collection and use of this information, I will contact my Health Authority.

Signature of Applicant ___________________________ Date ____________

B. TO BE SIGNED BY THE PRESCRIBING PHYSICIAN - Send to local Mental Health Centre/Authority. (Do NOT send to MSP/PharmaCare or Mental Health & Addictions Headquarters.)

Check a, b or c

I certify that the patient:

a. □ has been hospitalized for a psychiatric condition,

OR without the medication

b. □ is likely to require hospitalization,

OR

c. □ other serious consequences are very likely (e.g. unemployment, child neglect, etc.)

Name of prescribing physician (print) ___________________________ Signature ___________________________ Date ____________

C. APPROVAL BY MENTAL HEALTH CENTRE / AUTHORITY

Signature of Director or Designate ___________________________ Date ____________

Note: This authorization will expire in □ 1 year Date: ____________

□ or earlier Date: ____________

HLTH 3497 Rev. 2005/11/07
Crisis Management
Crisis Management

- Crises are common when treating patients with a psychiatric disorder. Crises may include a relapse of symptoms, disruptive behaviour, or risk of harm to self or others.

- Crises offer a time-limited window of opportunity to encourage the patient to make positive steps towards treatment and ongoing recovery.
  - Several provincial mental health crises intervention units are built on this principle.
  - The window for positive change is often limited to 24 – 48 hours.

- Potential crisis situations include:
  - risk of suicide
  - overdose or self-harm behaviours such as cutting or burning (most typically used in an attempt to relieve distress and tension)
  - inability to perform regular tasks of daily living or self-care
  - refusal of management or support options despite acute symptoms, significant interference, ongoing distress, or risk of self-harm.
CRISIS MANAGEMENT

Strategies Prior to Onset of a Crisis:
- Ensure families have access to information about how to ensure safety and provide support before crises occur.
- Work with patient and family to develop management plan before crises occur (e.g., coping options, lists of useful contact numbers, when to seek professional help).

Crisis Management in the Office
- Ensure the physical safety of you and your staff, other patients and the patient in crisis.
  - Consult with another staff member if crisis or conflict is anticipated
  - Provide panic alarms or emergency signals
  - Use a critical incident book/database to record all threats or episodes of violence
  - Provide de-escalation training to all staff
  - Ensure that the entire waiting area can be seen from the reception desk
  - Provide a means of exit for you and your staff that doesn’t involve crossing the patient’s path
  - Call the police if situation seems likely to become violent

- Problem-solve with patient and supportive family or friends.
  - Identify the trigger or triggers, if there is one
  - Generate concerns from the patient
  - Identify options or alternative coping strategies
  - Reassure that the crisis will pass
  - Review supports and options should the crisis return

- Assess whether this crisis can be managed in the community.
  - Outreach resources (e.g., housing, social services) for community treatment may be available to help avoid hospitalization.

- If hospitalization is necessary, assess whether the patient is certifiable
  - Stock “Form 4’s” in your office
  - Consider contacting Police, EHS or Mental Health Team
  - Stock prn medications such as Lorazepam (1 – 2mg po, sl, im), Diazepam (10 – 20mg po, im), Olanzapine (5 – 10mg po/rapid dissolve — Zydis), Seroquel (25 – 50mg po)

- Consider referral to specialist for on-going management and treatment options.

- De-escalation of the patient in crisis:
  - The ability to ‘de-escalate’ an upset or unreasonable patient and avoid confrontation and conflict is an important crisis management skill.
  - The approach, although useful with a wide variety of upset patients, may be ineffective with an acutely psychotic or intoxicated patient.
  - Escalation can best be avoided by having consistent rules which might be posted in the lobby of the Waiting Area (e.g., “We do not prescribe Benzodiazepines on intake interviews”)

- Stages involved in de-escalation:
  1. Allow the patient an opportunity for self-expression.
  2. Acknowledge the patient’s voiced concern without being apologetic.
  3. Empathize with the situation to help defuse tension.
  4. Explain why a particular demand cannot be met.
  5. Negotiate a compromise if necessary.
Two new documents are provided below on pages 3.65 and 3.71

- Working with the Suicidal Patient: A Guide for Health Care Professionals. This document outlines steps in assessing the client, providing advice, support, and information, including development of safety plans.
- Coping with Suicidal Thoughts. This document is a brief guide to help individuals decrease thoughts of suicide, connect with helpful resources, make their homes safe, and develop safety plans. It is a supplement to professional care and it is not intended to replace professional care.

Two other very helpful documents are available and can be downloaded without cost from the MoH Mental Health & Addictions website: www.healthservices.gov.bc.ca/mhd/publications.html and from the CARMHA website: www.camh.ca.

- Working with the Client who is Suicidal: A Tool for Adult Mental Health & Addiction Services. This is a best practice guide for clinicians to improve assessment and intervention with adults presenting in crisis with suicidal ideation and plans.
- Hope & Healing: A Practical Guide for Survivors of Suicide. This document was designed to help survivors through difficult times. It focuses on practical matters that survivors need to deal with after a suicide, including help, resources, and information for them to access.
Working with the Suicidal Patient
A Guide for Health Care Professionals

Task One: ASSESS

1. Assess current suicidal ideation

**Is suicidal ideation present now?**
Have you gotten to the point where you did not want to go on? Have you had thoughts of not wanting to be alive? What about right now?

**Passive Ideation:** The patient would rather not be alive, but does not indicate a plan that involves an act of initiation = LOWER RISK (e.g., I’d rather not wake up in the morning; I wouldn’t mind if a car hit me when I was crossing the road)

**Active Ideation:** The patient has acute thoughts of completing suicide = HIGHER RISK (e.g., I do think about killing myself; I feel like throwing myself into traffic)

**Intense, continuous ideation = HIGHER RISK**

**Is there a plan?**
Do you have a plan as to how you would end your life?

**Detailed, thought-out plan = HIGHER RISK**

**Is there intent?**
You talk about wanting to die, and have even considered [taking pills] but are you intending to do this?

**Low Intent:** Suicidal thoughts and fantasies about plans, with absolutely no intent to put these plans into action. Fantasizing about suicide can provide some comfort to those in distress to know there is always a way out = LOWER RISK (e.g. Oh no, I could never do that, I have children)

**High Intent:** Expression of specific intent to end life = HIGHER RISK (e.g., I intend to do this as soon as my daughter’s graduation is over)

**Ambivalent or Unclear Intent:** Ask about what has helped in past. What has stopped you from ending your life to this point? What has helped in the past when/if you’ve had these thoughts?

2. Obtain details if there is a suicide plan

**How lethal is the plan?**
How lethal does the patient believe the method(s) to be?

**Is there access to means?**
Obtain specific details. (What pills do you have or would you take to overdose?)

**Has patient chosen a time and/or place?**
How isolated is the patient? What preparations have been made (e.g., buying rope)?

**Has patient made final arrangements?**
Has patient prepared a suicide note, settled their affairs or communicated to others?

Higher lethality, access to means, preparations and arrangements = HIGHER RISK

3. Gather details on current and previous attempts

**Previous attempts, especially in past year = HIGHER RISK**

**Triggers of Present Attempt**
Walk me through the last 24 hours. At what point did you consider suicide?

**Triggers of Past Attempts**
Tell me about other times you have seriously considered suicide or made an attempt. What chain of events led up to attempts you’ve made in the past?

**Lethality**
Assess the lethality of the method(s). What was the likelihood that the patient would be found after they made the attempt?

**Impulsivity**
Was attempt carried out in the heat of anger (impulsive) or was it carefully thought-out (planned), with day and time picked in advance? What was the direction of hostility (goal to hurt self or others)?

**Intoxication**
Was patient intoxicated at time of attempt (substance use can lead to disinhibition and can contribute to individuals acting in atypical ways)?

**Expectations of Dying**
What did you think would happen to you when you [cut your wrists/take an overdose]? How did you think others would respond? Did you truly think you would die?

**Outcome**
Was medical intervention required? How was this accessed (e.g., patient called for help vs. being found unresponsive by others)?
Feelings About Survival
Guilt, remorse, embarrassment = LOWER RISK
Disappointment, self-blame = HIGHER RISK (e.g. I couldn’t even get this right and kill myself properly)

4. Obtain information on psychiatric and other history

Obtain information on psychiatric history (e.g., depression, psychosis), including symptoms that may suggest undiagnosed mental illness; substance use/abuse (alcohol, drugs); and past/current mental health treatment, including all current and past psychiatric medications.

Obtain information on other chronic and acute stressors (e.g., loss of relationship, loved one, job; gambling/financial stressors; trauma/abuse; struggle with sexual identity issues; changes/discontinuation of medications).

Assess for protective factors, such as family, friends, pets, religion, and therapist.

Ask about any other relevant and contributory factors. (Is there anything else I should know about?)

5. Conduct mental status examination

Emotional State
What is the patient’s self-reported mood vs. their observed affect?

Extremes in emotional state/mood (no vitality, emotionally numb or unbearable emotional pain/ turmoil) = HIGHER RISK

Behaviour & Appearance
How is the patient behaving (agitated, alert, cooperative)?
How do they appear (hygiene, speech)?

Thought Process
Is the patient oriented? Are attention, concentration and memory intact? Assess thought process (logical, organized), thought content (paranoid, delusional), and judgment and reasoning.

Problem-Solving Capacity
Can the patient generate strategies and options for problem-solving through their difficulties?

Reasons for Living & Level of Hope
What reasons do you have for living? How hopeful do you feel that your current situation could change? What is needed to change to help you feel not so hopeless?

Feelings of hopelessness, helplessness, and view of future as empty or meaningless = HIGHER RISK

6. Communicate with families/significant other(s)

Obtain contact information for, and consent to speak with, family/significant other(s). Connecting with family and friends demystifies what’s happening, and allows the patient’s support system to develop confidence in the assessment and treatment process.

Inform next of kin/emergency contact if patient has made suicide attempt.

Note: In an emergency, consent is not required to release information to family/significant other(s), although it is a courtesy to inform the patient of disclosure of information.

Solicit input from family or significant others, as this is helpful for risk assessment and safety planning. Inquire about changes in behaviour, signs of depression, hopelessness, past attempts, any communication of intent, difficulties adhering to treatment, and examples of risky behaviour (important when decisions are made about certification).

Include family/significant other(s) in discussions regarding safety and treatment planning (discuss ways family/friends can implement support in the patient’s home environment).

Acknowledge feelings of family/friends (e.g. fear, anger). Guide them to seek psycho-educational and emotional supports for themselves. Provide referrals for support agencies.

7. When to make a specialist referral

Refer patients with a psychiatric history to mental health/psychiatry.

The high-risk patient should be admitted to hospital or provided a high-priority referral for a mental health or psychiatric assessment to provide recommendations about management.

SAD PERSONS provides a useful screening acronym to identify the high risk patient:

- Sex (male)
- Age (adolescent or elderly)
- Depression
- Previous attempt
- Ethanol abuse
- Rational thinking loss (psychosis)
- Social supports lacking
- Organized plan
- No spouse/partner
- Sickness – especially chronic/uncontrolled pain
Other factors suggesting high risk are: multiple risk factors; profound hopelessness; lack of protective factors; high lethality; premeditation of present attempt; and/or family history of suicide, depression or substance abuse.

8. Communicate with primary care provider(s)

Obtain information from patient and/or their family about the patient’s current health and mental health care provider(s). Communicate with patient’s primary care provider(s) to ensure continuity of care.

Task Two: ADVISE

1. Provide meaning and support

**Explain a Model of Suicide**
Provide a model to help the patient understand their suicidality, and to normalize their feelings. People think seriously about suicide when they experience the 3 Is in their life situation: **Intolerable** (meaning their life situation is so painful that it seems unbearable), **Interminable** (it seems like it’s going to go on like this forever), and **Inescapable** (it seems like nothing they’ve tried has changed or will change their experience).

**Provide Coping Strategies**
Provide *Coping with Suicidal Thought*, a document to help individuals decrease thoughts of suicide, develop a safety plan and connect with helpful resources.

**Reinforce the Value of Treatment**
Treatment (both therapy and medication) can help to reduce your suffering. Therapy can help you to identify and address underlying issues that are contributing to you feeling this way, and provide you new ways of dealing with your life problems. Medication can help you with difficulties you are having with (depressed mood, anxiety, sleep, appetite).

**Address Ambivalence in Order to Instill Hope**
Many people have mixed feelings about suicide, and are just looking for some way to get out of the pain they are feeling. There are ways you can find support to help with that pain that don’t include ending your life.

**Reinforce Positive Coping Used in the Past**
*What has helped in the past when you’ve had these thoughts?*

2. Develop a safety plan

Develop an interim, written safety plan with the patient to help them stay safe until they secure longer-term professional supports.

Discuss with the patient how to make their environment safe (remove risky means of self-harm; have friend or family on-site for the short-term).

Generate with the patient adaptive means of self-soothing and coping with distress (calling a friend, going for a walk).

Generate with the patient reasons they have for living, and methods they have used to cope in the past. Work with the patient on completing the *Safety Plan* provided in the patient handout, *Coping with Suicidal Thoughts*.

Indicate to patient that if they try these steps and still do not feel safe, they should go to a hospital emergency room or call 911.

3. Provide information

Provide a written copy of a treatment plan, including details of medications (if applicable) and dates of follow-up appointments.

If the patient is prescribed antidepressants, explain that there may be temporary increased risk as symptoms of depression resolve at different rates, and improvement of mood may be delayed in comparison to improvement in physical symptoms such as energy or sleep.

Provide contact numbers of primary care providers (family physician, psychiatrist, psychologist), local crisis lines (1-800-SUICIDE) and mental health centres.

Instill hope. Most importantly, let the patient and their family/friends know that there is help available. Indicate that although you cannot guarantee that there will be no further attempts or difficult feelings, prognosis will be much better if the patient adheres to the treatment plan. Indicate that it may take time to find the right diagnosis and treatment, and time for patient to make accompanying changes.

4. Follow-up

Follow-up with the patient and/or family or significant other(s) within 48 hours to answer any questions they have, and to offer further information, including providing referrals.

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*Note:* This document is intended to be a guide to working with the suicidal adult, and should not replace a psychiatric consultation. When suicide risk exists, an expert opinion should be sought to determine the need for hospitalization and clarification of diagnosis.
Coping with Suicidal Thoughts

I’m seriously thinking about suicide. What should I do?

If you are thinking about suicide, you are not alone. Many people have thoughts of suicide, for a number of reasons. Thoughts of suicide can be very scary. You probably feel hurt, confused, overwhelmed and hopeless about your future. You may feel sadness, grief, anger, guilt, shame, or emptiness. You may think that nothing can be done to change your situation. Your feelings may seem like they are just too much to handle right now. It is important to know that thinking about suicide does not mean that you will lose control or act on these thoughts. Having thoughts of suicide does not mean you are weak, or ‘crazy’. Many people think about suicide because they are looking for a way to escape the pain they are feeling.

Even though your situation seems hopeless and you wonder if you can stand another minute of feeling this bad, there are ways to get through this and feel better. You don’t have to face this situation alone. Help is available. Here are a few ideas that you can use right now.

- **Connect with others:** If you are worried that you may lose control or do something to hurt yourself, tell someone. Make sure you are around someone you trust. If you live alone, ask a friend or family member to stay with you. If you don’t know anyone or can’t reach friends or family members, call 1-800-SUICIDE (1-800-784-2433).

- **Keep your home safe by getting rid of ways to hurt yourself:** It is important to get rid of things that could be used to hurt or kill yourself, such as pills, razor blades, or guns. If you are unable to do so, go to a place you can feel safe.

- **Develop a safety plan:** It is very helpful to have a written safety plan when you have thoughts of hurting yourself. Have a trusted family member, friend, or professional help you to complete this safety plan. Keep this plan somewhere you can see or find easily. Write down the steps you will take to keep yourself safe (see the following example). Follow the steps. If you follow these steps and still do not feel safe, call a crisis line, get yourself to a hospital emergency room or call 911.

*This document is not intended to replace professional care with a therapist or physician.*

1-800-SUICIDE (1-800-784-2433)
Safety Plan

If you have thoughts of hurting yourself, start at Step 1. Go through each step until you are safe. Remember: Suicidal thoughts can be very strong. It may seem they will last forever. With support and time, these thoughts will usually pass. When they pass, you can put energy into sorting out problems that have contributed to you feeling so badly. The hopelessness you may feel now will not last forever. It is important to reach out for help and support. You can get through this difficult time. Since it can be hard to focus and think clearly when you feel suicidal, please copy this and put in places where you can easily use it, such as your purse, wallet or by the phone.

1. Do the following activities to calm/comfort myself:

2. Remind myself of my reasons for living:

3. Call a friend or family member:
   Name: 
   Phone: 

4. Call a backup person if person above is not available:
   Name: 
   Phone: 

5. Call a care provider (psychologist, psychiatrist, therapist):
   Name: 
   Phone: 

6. Call my local crisis line:
   Phone: 

7. Go somewhere I am safe:

8. Go to the Emergency Room at the nearest hospital.

9. If I feel that I can’t get to the hospital safely, call 911 and request transportation to the hospital. They will send someone to transport me safely.

1-800-SUICIDE (1-800-784-2433)
How can I better understand my suicidal thoughts and feelings?

Some problems and experiences, especially those that have been around for a long time, can leave you feeling hopeless and overwhelmed. At these times, you may think that you have no options left. You may think about suicide as a way to escape intense emotional pain.

People who kill themselves often think that their problems are unbearable and can't be fixed. They feel like nothing they have tried has or will change their situation. Their emotional pain can distort thinking so it becomes harder to trust, or to see possible solutions to problems, or to connect with available love and support. Even if it seems that you can't stand another minute, it is important to remember that feelings (e.g., grief, anger, sadness, loneliness, shame), especially at this intense level, don't last forever. Sometimes thoughts of suicide can become very strong, especially if you have taken drugs or alcohol. It is important to not use non-prescription drugs or alcohol, particularly when you feel hopeless or are thinking about suicide.

Some of the thoughts you may be having are:
- believing there are no other options;
- sensing your family or friends would be better off without you;
- thinking you've done something so horrible that suicide is the only option;
- experiencing unbearable pain that feels like it will go on forever;
- wanting to escape your suffering;
- wanting to let your loved ones know how much you hurt; and
- wanting to hurt or get revenge on others.

Your feelings of pain are very real. However, it is important to know that there is hope. With the help of professionals and the support of family and friends, you can learn about what is causing your suffering and how you can change or manage it. Hurting or killing yourself are not your only options. Professionals can help you learn new skills for dealing with your pain. These might include: developing new skills to cope; seeing your problems in a new light; improving your ability to handle intense and painful emotions; improving your relationships; increasing your social supports; or medications.

Some other things that may lead you to think of suicide are:

**Mental health problems:** Some mental health problems, such as depression or anxiety, can increase feelings of suicide. Mental health problems are treatable. It is important to talk to your doctor if you feel low, depressed, or anxious. Counseling or medication may help. There are also free resources that can help (e.g., the Antidepressant Skills Workbook, at www.carmha.ca).

**Conflict with loved ones:** You may feel that your family or friends would be better off without you. It is important to remember that conflict with others doesn't last forever. Ending your life is not a way to solve that conflict. We know that people who lose a loved one to suicide say that their lives are not better off.

**Loss:** Many different types of loss can increase the chances you may feel suicidal. Some examples that may set off feelings of suicide include: a break-up; losing a job; losing social status; or losing a loved one or friend. Knowing someone who has died by suicide can increase the chance that you think of suicide as an option. As difficult as your loss may seem, there are people and services that can help you get through difficult times, such as Griefworks BC (1-877-234-3322).

**Financial/legal problems:** Financial or legal problems, such as overwhelming debt, gambling problems, or problems with the law, can be very stressful. It is important to know that there may be free services that can help you deal with financial or legal problems. These include the Credit Counselling Society (1-888-527-8999), the Problem Gambling Help Line (1-888-795-6111), or the Legal Services Society (1-866-577-2525).

**Lack of connection to friends and others:** Thoughts of suicide can increase if you spend a lot of time alone, or don't feel you can tell anyone your problems. Talk to someone, like a professional, about ways that you can increase social supports in your life. You may feel that the people that are in your life don't understand the pain you are feeling. Talk to a professional about ways that you can let others know of the pain and unhappiness you are

1-800-SUICIDE (1-800-784-2433)
feeling. The Social Supports wellness module at www.heretohelp.bc.ca gives ideas for how to improve your social supports.

Drug and alcohol problems: Using alcohol or drugs can make feelings of depression, anxiety, and thoughts about suicide worse. Drugs and alcohol can change the way you think about problems in your life. If drugs or alcohol are causing your problems, you can get information on treatment from the BC Alcohol and Drug Information and Referral Service (1-800-663-1441).

Medical problems: Medical problems such as diabetes, thyroid problems, chronic pain, or multiple sclerosis can increase chances that you may think about suicide. Make sure you have proper medical care for health problems. Some medications can increase feelings of suicide. It is important to speak to your doctor about this. You can also get information by calling the BC NurseLine (1-866-215-4700) or the Living a Healthy Life with Chronic Conditions programs (1-866-902-3767).

Sexual identity issues: People who are lesbian, gay, bisexual, or transgender may have a higher risk of suicide. Confusion about sexual identity and fears of possible or real rejection from family or friends can make things worse. There is support available. Prideline (1-800-566-1170) is a peer support and information phone line. Prideline is open 7 days a week, from 7:00 p.m. to 10:00 p.m.

What else can I do to decrease thoughts of suicide?

Problem-solve: It is always helpful to think of ways other than suicide that you can solve your problems. First, make a list of all the problems you are dealing with in your life. Second, make a list of all the solutions you can think of to those problems. You can ask someone you trust to help you with this. Dealing with 1 or 2 small problems can help to put an end to immediate feelings of suicide. Once you are thinking more clearly, you can tackle other bigger problems. You can find worksheets on Problem-Solving and Healthy Thinking in the Antidepressant Skills Workbook (www.carmha.ca) or at www.heretohelp.bc.ca.

Some examples of common problems and ideas for solutions are:

Problem: Depressed mood
Possible Solution:
- Call 1-800-SUICIDE for emotional support, short-term problem-solving and referrals for longer term help.
- See your family doctor to discuss options for treatment (e.g., medications, changes in medications, undiagnosed illnesses).
- Take care of yourself by resting, exercising regularly, eating regularly and spending time with friends.

Problem: End of a relationship
Possible Solution:
- Talk to friends about the pain you feel.
- Get help from a crisis line or counselor.
- Join a social group.

Think of reasons for living: Most people who think about suicide want to escape their pain, but they do not always want to die. When you feel low, it’s easy to stay focused on things that are negative and upsetting in your life. This makes it easy to think of suicide as the only option. Start thinking about some reasons you have for living. For example, many people have relationships with loved ones, pets they love, religion, goals and dreams, or responsibilities to others in their life that give them reasons to live and prevent them from acting on their suicidal thoughts. Think of all of the reasons you have for living. Write them down. Remind yourself of them when you are feeling low.

Remember things that have helped in the past: Many people have had thoughts of suicide before. Think of some of the things that helped you feel better when you faced the same types of problems in the past. Some examples are: having faith and trust that time always helps; reaching out to friends and family; seeing a professional; going to a support group; following a safety plan; doing something you enjoy; not being alone; keeping a journal; or not drinking or using drugs.

1-800-SUICIDE (1-800-784-2433)
Talk to a trusted friend, family member, or professional: It's important to speak to someone you trust about how you feel. Sometimes just talking about how you feel can help. It is important to be open about all of your thoughts. If you have a suicide plan, it is important to tell someone what your plan is. People often say they are relieved that they shared how they felt with someone. Talking can help you feel less alone.

Get treatment for mental health problems: It is important to get treatment for depression, anxiety, and alcohol and drug problems. Just seeing your family doctor may not be enough. It can help to see a mental health specialist, such as a psychologist or a psychiatrist. You can get referrals from your doctor or learn how to find a specialist from one of the referral lines listed on the following page. If you are already receiving treatment, speak up if your treatment plan is not working.

Do the opposite of how you feel: When you have thoughts of suicide, it can be helpful to do the opposite of how you feel. For example, when people feel depressed they usually want to be alone. Doing the opposite, for example getting in touch with others, can help with feelings of depression.

How can I decrease chances that I will feel suicidal in the future?

Get professional support: You can get help and referrals from your doctor or from referral lines listed on the following page. If the first referral doesn't work for you, ask for another.

Identify high-risk triggers or situations: Think about the situations or factors that increase your feelings of despair and thoughts of suicide. Work to avoid those situations. For example, going to a bar and drinking with friends may increase feelings of depression. If this is a trigger for you, avoid going to a bar or seeing friends who drink.

Self-care: Taking good care of yourself is important to feel better. It is important to do the following:
- eat a healthy diet;
- get some exercise every day;
- get a good night’s sleep; and
- decrease or stop using alcohol or drugs, as these can make feelings of depression and suicide worse.

Follow through with prescribed medications: If you take prescription medications, it is important to make sure you take them as your doctor directed. Speak to your doctor if medications aren't working, or if side effects are causing you problems. If you have just begun taking antidepressants, it is important to know that symptoms of depression resolve at different rates. Physical symptoms such as energy or sleep may improve first. Improvement in mood may be delayed. Speak to your doctor if you are feeling worse.

Structure and routine: Keep a regular routine as much as possible, even when your feelings seem out of control. Here are some tips for creating structure in your life:
- wake up at a regular time;
- have a regular bed time;
- have planned activities in your day, such as going for a walk or going to the gym; and
- continue to go to work or school.

Do things you enjoy: When you are feeling very low, do an activity you enjoy. You may find that very few things bring you pleasure. Think of things you used to enjoy doing at times you didn’t feel so depressed or suicidal. Do these things, even if they don’t bring you enjoyment right now. Giving yourself a break from suicide thoughts can help, even if it is for a short time.

Think of personal goals: Think of personal goals you have for yourself, or that you’ve had in the past. Some examples are: to read a particular book; travel; get a pet; move to another place; learn a new hobby; volunteer; go back to school; or start a family.

1-800-SUICIDE (1-800-784-2433)
What can I do to learn more?

Useful Phone Numbers (24 hrs/day, 7 days/week)
1-800-SUICIDE (1-800-784-2433)
BC Mental Health Information Line: 1-800-661-2121
BC Alcohol and Drug Information and Referral Service: 1-800-663-1441
Problem Gambling Help Line: 1-888-795-6111

Other Useful Phone Numbers
Credit Counselling Society: 1-888-527-8999
Mood Disorders Association of BC: 604-873-0103
Early Psychosis Intervention Program: 1-866-870-7847
Griefworks BC: 1-877-234-3322
Legal Services Society: 1-866-577-2525
SAFER (Suicide Attempt Follow-up, Education and Research): 604-879-9251
Vancouver Crisis Centre: 1-866-661-3311

Useful Websites
Anxiety Disorders Association of BC: www.anxietybc.com
BC Schizophrenia Society: www.bcss.org
Canadian Mental Health Association – BC Division: www.cmha.bc.ca
Early Psychosis Intervention Program: www.psychosisucks.ca
BC Partners for Mental Health and Addictions Information: www.heretohelp.bc.ca
Mood Disorders Association of BC: www.mdabc.ca
Youth Support: www.youthinbc.com

Books

1-800-SUICIDE (1-800-784-2433)
ADMISSIONS TO ACUTE CARE

Admission to hospital may be indicated when the patient poses potential harm to themselves or other people, for example, when the patient is demonstrating
■ active suicidal thoughts or plans
■ homicidal thoughts or plans
■ psychotic symptoms
■ risky behaviour or inability to care for self or others.

Admission to the hospital can be either voluntary or involuntary.

Voluntary Admission to Hospital:
■ Whenever possible, admission should occur with the patient’s consent.
■ Generally the patient is not an AWOL risk and may have insight to their illness and need for treatment.
■ If the patient were to AWOL, they are considered low risk for self harm, very low risk to harm others.
■ Adults are defined as persons 16 years of age and older for purposes of the Mental Health Act.
■ An adult may voluntarily seek admission to a designated facility for treatment of a mental disorder under either the Hospital Act or the Mental Health Act.
■ Voluntary admissions under the Mental Health Act require the person to request admission. Voluntary patients may discharge themselves at any time — just like non-psychiatric patients admitted to a hospital under the Hospital Act.
■ Most hospitals admit and treat voluntary psychiatric patients in the same way that they deal with any other patients.

Involuntary Admission to Hospital:
■ Involuntary admission and treatment (also known as certification) is considered when a person is in need of psychiatric treatment and either lacks insight to this need or refuses. Certification must clearly list one of three conditions:
- risk of harm to self
- risk of harm to others
- risk of further deterioration without treatment is imminent.

The patient must meet the Mental Health Act definition of “person with a mental disorder”, a disorder of the mind that requires treatment and seriously impairs the person’s ability to react appropriately to the person’s environment, or to associate with others.

In British Columbia the rules and procedures regarding involuntary admission and treatment are contained in the Mental Health Act and the Guide to the Mental Health Act at www.healthservices.gov.bc.ca/mhd/publications.html. A list of designated provincial and regional facilities is available at www.healthservices.gov.bc.ca/mhd/publications.html

Medical Certification (Involuntary Admission) Through a Physician’s Medical Certificate
■ One Medical Certificate completed by a physician who examines a person and finds that the person meets the involuntary admission criteria of the Mental Health Act (section 22) provides
- legal authority for an involuntary admission for a 48-hour period.
ADMISSIONS TO ACUTE CARE

- authority for anyone, including ambulance personnel, police or, if the physician believes it is safe, relatives or others, to take the person to a designated facility (See the Guide to the Mental Health Act for a list of designated facilities).

- A second Medical Certificate must be
  - completed by a different physician
  - completed within 48 hours of initial admission, otherwise the patient must be discharged or admitted as a voluntary patient.

- Once the second medical certificate is completed, the person may be admitted as an involuntary patient for up to one month from the day of initial admission.

- To extend involuntary hospitalization beyond the first month, a physician must examine the person and complete a Renewal Certificate (Form 6), before each certificate period expires.

Criteria for Involuntary Admission

- In order for a physician to fill out a Medical Certificate, the physician must have examined the patient and be of the opinion the patient meets ALL four of the criteria, which are described below. The opinion must be based upon information from the examination and preferably includes information received from family members, health care providers, or others involved with the person.

- The FOUR criteria for involuntary admission must include that the person
  - is suffering from a mental disorder that seriously impairs the person’s ability to react appropriately to his or her environment or to associate with others
  - requires psychiatric treatment in or through a designated facility
  - requires care, supervision, and control in or through a designated facility to prevent the person’s substantial mental or physical deterioration or for the person’s own protection or the protection of others and
  - is not suitable as a voluntary patient.

- The words “in or through” a designated facility mean that a patient initially requires inpatient treatment as an involuntary patient, but may subsequently be placed on leave and continue to receive psychiatric treatment on an outpatient basis, while [legally] remaining under the care, supervision, or control of the designated facility.

Validity of the Medical Certificates

- Unless the person is admitted, a Medical Certificate is valid for only 14 days following the date of the examination. If the person is not admitted during this 14-day period, the certificate becomes invalid.

- Only a physician licensed to practice medicine in British Columbia may complete a Medical Certificate. An educational license is not sufficient. The physician does not have to be a psychiatrist.

Additional questions and issues related to involuntary admissions are discussed in the Guide to the Mental Health Act.
Mental Health Certification

FORM 4

MENTAL HEALTH CERTIFICATE

[Sections 22, 28, 29 and 42, R.S.B.C. 1996, c. 288]

I, ________________________________, MD., certify that I examined

physician’s name (please print)

first and last name of person examined (please print) on ____________________ dd / mm / yyyy

In summary form, the reasons for my opinion are:

information may be obtained through interviews, observations and collateral sources

1. In my opinion, this person

has a disorder of the mind that requires treatment and which seriously impairs the person’s ability to react appropriately to his/her environment or to associate with others (section 1 of the Mental Health Act);

and

2. In my opinion, this person

(a) requires treatment in or through a designated facility; and

(b) requires care, supervision and control in or through a designated facility to prevent his/her substantial mental or physical deterioration or for the protection of the person or for the protection of others; and

(c) cannot suitably be admitted as a voluntary patient

This person ☐ was ☐ was not brought to me by a police officer or constable under section 28 of the Act.

Note: if above space is insufficient, continue on back of form

Signed ________________________________

physician’s signature date of signature (dd / mm / yyyy)

physician’s address (please print) telephone

Note: This medical certificate, when duly signed, is authority for anyone to apprehend the person who is the subject of this certificate and to transport the person to a designated facility for admission and detention for a 48 hour period. If a second medical certificate is completed within that period, it provides authority to detain the person for one month from the date of admission under the first certificate.

If this is a first medical certificate, it becomes invalid on the 15th day after the date upon which the physician examined the person who is the subject of the certificate unless the person has been admitted on the basis of it. HL TH 3504 Rev. 2003/01/23 (PINK)
Discharge Planning
- Discharge planning is critical for maintaining gains and preventing future lapses/relapses following inpatient or outpatient psychiatric care.
- Proper discharge planning is generally a result of consensus decision-making between the inpatient/outpatient physician, the family physician, the outpatient psychiatrist (if relevant), and allied professionals (psychotherapist, counsellor, outreach nurse, etc).
- A discharge planning meeting, whenever possible, is recommended to ensure comprehensive care.

Elements of Successful Discharge Planning
- Complete referrals and schedule follow-up appointments before discharge.
- Apply for Pharmacare Special Authority coverage for medications that require it (e.g. olanzapine) before discharge (see website at www.health.gov.bc.ca/pharme/sa/saindex.html for details).
- All individuals discharged from acute care should schedule a family physician follow-up appointment within 15 days and no later than 30 days of discharge.
  - Review symptoms, monitor medications and track effectiveness of management plan at follow-up.
  - Consider keeping a registry of patients with mental illness in order to ensure and monitor regular follow-up.
- Consider other resources:
  - specialists (i.e., community psychiatrist for medication management or ongoing care)
  - psychotherapist or counsellor for talk therapy, further support, or booster CBT
  - outreach (e.g., home care)
  - support groups (e.g., AA).
- Distribute self-management information (books, websites, etc — see information on self-management and information for families section for options).
- Plan for how to respond to crises, lapses and relapses.
- Include supportive family and friends, as they play a critical role in assuring successful planning.
  - Review concerns about the future.
  - Mediate and encourage the collaborative resolution of problems between patients and families.
Evaluation of Progress

Psychiatric disorders tend to follow a Chronic Disease Model, with partial and complete remissions, recurrences and relapses as part of the natural course of illness. Some symptoms may wax and wane, while others may resolve completely. Monitoring progress is critical to maximize treatment successes and minimize failures.

Office Management

- The frequency of office visits to evaluate progress can be increased or decreased depending on status.
- Early follow-up should occur at least weekly or biweekly, depending on severity, until the patient begins to show clear improvement.
- Visits can then be reduced to monthly or less often, depending on individual circumstances.
- Consider “Shared-Care” approaches, where referred specialists complete more detailed evaluations of progress.
- Assess symptoms specific to the diagnosed psychiatric disorder(s) rather than general symptoms.

Goals of the Evaluation

The goals of the evaluation should be to

1. identify progress
2. review treatment — both pharmacological and non-pharmacological interventions, and modify as needed
3. respond to lapses or relapses early
4. ensure patient safety when there is a risk of suicide, self-harm, or harm to others
5. identify patient’s plan for ongoing recovery
6. identify barriers to progress.

Identifying Progress

Reviewing progress reinforces the patient’s efforts and communicates a clear interest by the family physician in the care of the patient.

- Review overall quality of life using the “Global Assessment of Functioning Scale (GAF)”.  
  - the GAF is from the DSM-IV or DSM-IV-TR and is an overall rating of the patient’s psychological, social and occupational functioning on a scale ranging from 1 to 100.
  - this is the rating listed on “Axis V” of most psychiatric consultations.
  - use the GAF at specific time intervals (e.g., every 3 months) to track overall progress.
  (See 3.65 for a GAF)

- Discuss symptom severity (mental health and any other co-morbid health problems) using scales wherever possible.
  - simple symptom rating scales such as “On a scale of 1 to 10, 1 being the worst, 10 being the best” work very well if answers are documented and scales are used consistently.
  - questions such as “what would it take to go from a 4 to a 6?” often yield helpful and insightful answers.
EVALUATION OF PROGRESS

- Assess ability to function independently and effectively in a variety of settings (home, work/school, social)
  - symptom scales should be used in different settings and can help identify stressful situations.
- Collect collateral information from key family or friends as they should be involved in the evaluation process and are often the best of observers of progress.

Reviewing Treatment Effects
Pharmacological
- Review medications:
  - side effects
  - adherence
  - dosing schedule — simple schedules have higher adherence rates.
- Review indications for prescribed medications:
  - frequently upon initiation
  - at minimum every 3 months if on maintenance therapy.
- Taper or titrate to effect.
- Early side effects may be as a result of starting at too high a dose. Lower the dose and re-titrate if necessary.

Non-pharmacological
- Review adherence with psychotherapist or group or sponsor.
- Encourage discussion of concerns and identify misconceptions regarding therapy.
- Explore the effect of therapy on the patient—triggers, flashbacks, withdrawal, mood, etc.
  - The family physician may be viewed as objective or neutral by the patient.
  - Patients sometimes withhold from their therapist uncomfortable feelings or experiences.
- Encourage completion of therapy including formal termination with therapists or groups.

Responding to Lapses or Relapses Early
- Normalize relapses and lapses as part of the chronic disease model.
- Discuss events leading to the episode. Review
  - recent discontinuation or change in meds
  - recent physical health
  - recent social stressors or losses.
- Review self-management strategies.
- Encourage patient to re-connect with support groups.
- Use medications as needed for a brief period to restore health and resolve target symptoms.

Ensuring Patient Safety
Generally, there is an increased risk of suicide and self-harm behaviour in the mentally ill.

- Assess suicidal ideation, self-harm behaviour or homicidal ideation frequently, especially with relapses.
- Identify acute stressors and problem solve.
EVALUATION OF PROGRESS

- Increase frequency of visits if necessary.
- Encourage involvement of family and friends in the self-management discussion.
- Send the patient to a local ER or certify if necessary.
- Contact police if there is specifically stated homicidal ideation.

Identifying the patient’s plan for ongoing recovery
Engage the patient in a discussion of their plan to maintain or establish responsibilities and roles. This includes:
- return to employment or vocational training
- school strategies
- safe and affordable housing
- stable relationships
- healthy lifestyles
- stress management strategies.

Identifying barriers to progress
As with any medical illness, progress may be slowed by unaddressed concerns of the patient. Reinforce that the family physician cares about the outcome and is committed to being an integral part of the treatment team. If the evaluation of progress shows limited advancement, consider the following:
- intolerance of medication side effects
- difficulty tolerating psychotherapy (e.g., distress associated with exposure component of CBT)
- fears and concerns about the aftermath of making progress that may lead to ambivalence or problems with treatment adherence (e.g., fears of returning to work or living independently)
- patients, family, and friends may require time to adjust to positive changes in patient (e.g., reduced need for assistance, desire to move out into own home, forming new relationships with others, trying new things, being more assertive)
- pushing too fast and too soon (e.g., premature return to work or school, taking on too many new responsibilities).
Addressing these issues may help bring the treatment back on track.

### CUES FOR EVALUATING PROGRESS

areas to explore when monitoring progress — assessing both negative and positive elements

<table>
<thead>
<tr>
<th>Depression</th>
<th>Anxiety</th>
<th>Psychosis</th>
<th>Substance Use</th>
</tr>
</thead>
</table>
| Biological | • constipation  
• weight gain or loss | • sympathetic symptoms (e.g., rapid heart rate, GI upset, diarrhea, SOB, chest pain) | • Weight gain  
• Extrapyramidal symptoms- cogwheeling, decreased arm swing, rigidity, shuffling gait | • comorbid medical conditions, e.g., cellulitis, liver stigmata, abscesses or active tract marks. |
| Medication side effects | • weight gain  
• sexual dysfunction  
• insomnia | • weight gain  
• sexual dysfunction  
• insomnia | • weight gain  
• sexual dysfunction  
• increased cholesterol  
• akathisia — subjective feeling of restlessness  
• QTc prolongation | • nodding off, constipation (methadone) |
| Laboratory | • mood stabilizer levels  
• TSH | • TSH | • cholesterol changes, increased blood glucose  
• ECG | • changes in GGT, MCV, liver enzymes or reversal of biological red flags |
| Psychological | • sleep, appetite, libido  
• concentration, feelings of guilt or worthlessness  
• interests, hobbies  
• anxiety and substance use | • overall anxiety  
• avoidance of activities  
• cognitive symptoms such as: fear of dying, fear of negative evaluation, phobias  
• lack of energy  
• need to escape fearful situations  
• panic attack frequency, intensity  
• coping responses | • psychotic symptoms: positive and negative  
• self harm risk to self or others  
• mood, anxiety and substance use  
• stress management  
• level of insight | • cravings, mood or anxiety symptoms, psychotic features  
• boredom,  
• pessimism  
• stage of change |
| Social | • relationships  
• attendance to therapy or groups  
• return to work or school  
• hospitalizations | • relationships  
• attendance to therapy or groups  
• return to work or school  
• hospitalizations | • extent and quality of relationships,  
• community involvement  
• caregiver burden  
• grooming and hygiene  
• status of main role functions (e.g., work, school) | • relationships, presence of sponsors, meeting participation, hospitalizations  
• loss of “using” peers, academic performance, employment |
| Scale | • PHQ-9  
• GAF | • GAF | • -AIMS (abnormal involuntary movement scale)  
• -GAF | • AUDIT or CAGE  
• GAF |
| Self Management | • ability to gain access to, understand, and use information to promote and maintain good health | • ability to gain access to, understand, and use information to promote and maintain good health | • ability to gain access to, understand, and use information to promote and maintain good health | • ability to gain access to, understand, and use information to promote and maintain good health |
# Global Assessment of Functioning (GAF) Scale

<table>
<thead>
<tr>
<th>Psychopathology</th>
<th>Social and Occupational Functioning (SOFAS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider psychopathology on a hypothetical continuum of mental health to illness. Do not include impairment due to physical or environmental limitations.</td>
<td>Consider social and occupational functioning on a continuum from excellent to grossly impaired. Include impairments in functioning due to physical limitations, as well as those due to mental impairments. Impairment must be a direct consequence of mental and physical health problems. The effects of lack of opportunity and environmental limitations are not to be considered.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.</td>
<td>Superior functioning in a wide range of activities.</td>
<td>100</td>
</tr>
<tr>
<td>91</td>
<td>Absent or minimal symptoms (e.g., mild anxiety before an exam), generally satisfied with life, no more than everyday problems or concerns (e.g., occasional argument with family members)</td>
<td>Good functioning in all areas. Occupationally and socially effective.</td>
<td>91</td>
</tr>
<tr>
<td>90</td>
<td>If symptoms are present, they are transient and expected reactions to psychosocial stressors (e.g., difficulty concentrating after a family argument).</td>
<td>No more than slight impairment in social, occupational, or school functioning (e.g., infrequent interpersonal conflicts, temporarily falling behind in schoolwork).</td>
<td>90</td>
</tr>
<tr>
<td>81</td>
<td>Some mild symptoms (e.g., depressed mood, mild insomnia).</td>
<td>Some difficulty in social, occupational, or school functioning but generally functioning well. Has some meaningful interpersonal relationships.</td>
<td>81</td>
</tr>
<tr>
<td>71</td>
<td>Moderate symptoms (e.g., flat affect, circumstantial speech, occasional panic attacks).</td>
<td>Moderate difficulty in social, occupational or school functioning (few friends, conflict with peers or coworkers).</td>
<td>71</td>
</tr>
<tr>
<td>61</td>
<td>Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting).</td>
<td>Serious impairment in social, occupational or school functioning (e.g., no friends, unable to keep a job).</td>
<td>61</td>
</tr>
<tr>
<td>51</td>
<td>Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in judgement, thinking, or mood.</td>
<td>Major impairment in several areas, such as work, school, or family relations (e.g., depressed man avoids friends, neglects family and is unable to work; child frequently beats up younger children, is defiant at home and is failing at school).</td>
<td>51</td>
</tr>
<tr>
<td>41</td>
<td>Behaviour is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgement (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation).</td>
<td>Inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).</td>
<td>41</td>
</tr>
<tr>
<td>31</td>
<td>Some danger of hurting self or others (e.g., suicidal attempts without clear expectation of death; frequently violent; manic excitement) OR gross impairment in communication (e.g., largely incoherent or mute).</td>
<td>Occasionally fails to meet minimal personal hygiene (e.g., smears feces); unable to function independently.</td>
<td>31</td>
</tr>
<tr>
<td>21</td>
<td>Persistent danger of severely hurting self or others (e.g., recurrent violence) OR serious suicidal act with clear expectation of death.</td>
<td>Persistent inability to maintain personal hygiene. Unable to function without harming self or others or without considerable external support (nursing care and supervision).</td>
<td>21</td>
</tr>
</tbody>
</table>

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1) **Psychopathology Score**  
2) **SOFAS score**

- Starting at the top of the scale, ask yourself "is EITHER the patient’s symptom severity OR the patient’s level of functioning WORSE than what is indicated in the range?"

- Move down the scale until you find a range which matches the patient’s symptom severity OR level of functioning, **WHICHEVER IS THE WORST**.

- Double check your selection of a range by referring to the range immediately below the one chosen: it should have examples which are too severe on BOTH symptom severity and level of functioning. IF NOT BOTH — keep moving down the scale.

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*Table from DSM-IV, American Psychiatric Association, Washington, 1994.*
Management Plan Worksheet (for Patients)
Management Plan Worksheet

This plan will help you manage any lapses, relapses or crises. Keep this in an easy to access place and make sure your family and other important support providers have a copy. This way everyone can work together towards the shared goals of wellness and recovery.

Your Family Doctor’s Name and Contact Information is:

When I am well and my symptoms are stable, I am able to do the following:
Check off those that apply to you. Use blank spaces to add your own personal signs of wellness.

| take care of my appearance and shower regularly |
| attend work or school regularly |
| keep up with work or schoolwork |
| keep up with household chores |
| keep up with paying bills |
| get together with family or friends to do social activities ______ times per week |
| exercise regularly |
| eat healthy meals regularly |
| take medications as prescribed |
| keep regular sleeping hours (go to bed and get up at roughly same time each day) |
| socialize with other people without getting extremely irritable or starting arguments |

In the past my symptoms have included:
Check off those that apply to you. Use blank spaces to add other symptoms that have bothered you in the past.

| problems sleeping (too much/ too little) |
| feeling anxious or tense or panicky |
| not feeling as hungry as normal or unusual increases in appetite |
| problems with thinking, concentrating or making decisions |
| unwanted or upsetting thoughts you can’t easily get rid of |
| feeling down or sad |
| increases in bodily aches or pains |
| missing work or school |
| using drugs or alcohol even though it leads to harm |
| not enjoying hobbies or other usual fun activities |
| not wanting to go out or spend time with family or friends |
| becoming easily annoyed at others |
| avoiding things you need to do |

It can be overwhelming to complete this worksheet on your own.

Ask your spouse, family, close friends or physician to help you fill it out and brainstorm ideas.
Past triggers for my symptoms have included:
Check off those that apply to you. Use blank spaces to add additional triggers you have experienced.

| break-up of relationship or family conflict |
| losing a job or hours cut back |
| bad life event (describe): |
| good life event (describe): |
| drug or alcohol use |
| substantial changes in health behaviours (e.g., smoking, exercise) |
| physical illness |
| changes in medications |

**Early warning signs**
When any of these occur I will increase my use of self-management skills. I will follow the plans outlined below as needed with the support of my family, friends and family physician.

| My early warning signs include: |
| My early warning signs include: |
| My early warning signs include: |
| My early warning signs include: |
| My early warning signs include: |

*Remember: sometimes warning signs will be the same as they were before the first episode; however, sometimes these warning signs can be completely different. Therefore, be alert to all early warning signs.*
With your family physician and family develop a plan outlining what to do if warning signs are present.

Example: What to do if you experience an increase in panic attacks and urge to avoid things
Example: What to do if you begin to hear voices or see things that are not actually there.

If these early warning signs appear — follow this relapse prevention plan:

1. 
2. 
3. 
4. 
5. 

Consider including in this relapse prevention plan:
- making an appointment to see your doctor
- ways to reduce your level of stress or helpful coping behaviours
- changes to medication approved by your doctor

With your family physician and family develop an emergency plan in case things suddenly become much worse.

Example: What to do if you overdose during a relapse in your problematic drug or alcohol use
Example: What to do if you become extremely depressed and suicidal

If things become suddenly become much worse — follow this emergency plan:

1. 
2. 
3. 
4. 
5. 

Consider including in this emergency plan:
- address for nearest hospital
- contact information for other emergency resources
- contact information for family or other people who can help provide

Successful self-management skills take time to develop. You, your family and your family physician will most likely need to revise this management plan from time to time based on your own experiences. With a good management plan in place, patients and families live full and rewarding lives despite the presence of mental health or substance use problems.

As you progress in your recovery it can help to begin thinking about or working towards some of your life goals. Be realistic, break goals down into manageable tasks and don’t take on too much too soon. Use the back page to begin brainstorming ideas about your future goals and dreams.