Diagnostic Procedures

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Diagnosis

THE PSYCHIATRIC INTERVIEW

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

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

- social
  - place of birth, labour and delivery, growth and development
  - early, middle and high school performance
  - family relations — parents, foster care, siblings
  - abuse — sexual or physical
  - relationships — "coming out" experiences
  - post-secondary education, employment, vocational training
- mental status exam
  - appearance, behaviour, speech, rapport, reliability, mood and affect, thought form and content, insight, judgment, cognitive ability, suicidal ideation
- physical exam — evidence of intoxication/withdrawal, track marks, conjunctival injection (THC users), stigmata of chronic liver disease, etc
- impression
- Multi-Axial Diagnosis
  - Axis I: psychiatric disorders
  - Axis II: personality disorders, coping styles/defences
  - Axis III: comorbid medical conditions which may contribute to psychiatric presentation
  - Axis IV: social stressors/circumstances which may contribute
  - Axis V: GAF score

Suicide Risk Assessment

— adapted from Rubenstein, Unutzer, Miranda et al, 1996

- Ask all patients at risk (including depression, anxiety disorders, psychosis, substance use disorders, personality disorders, etc.) if they have thoughts of death or suicide, or if they feel hopeless and feel that life is not worth living. Also ask if they have previously attempted suicide.
- If the answer is yes, ask about plans for suicide. How much have they thought about suicide? Have they thought about a method? Do they have access to material required for suicide? Have they said goodbyes, written a note or given away things? What specific conditions would precipitate suicide? What is stopping them from suicide?
- Assess risk factors for suicide.
- Warn the patient that agitation and suicide risk may increase early in treatment.
- Obtain collateral information from family or friends.
- Consider emergency psychiatric consultation and treatment if:
  - suicidal thoughts are persistent
  - the patient has a prior history of a suicide attempt or a current plan
  - the patient has several risk factors for suicide.

DIAGNOSING MAJOR DEPRESSIVE DISORDER

The symptoms of depression can be divided into 2 categories:
- cognitive, behavioural or emotional (low mood, loss of interest or enjoyment, trouble concentrating, feelings of guilt or self-blame, low self-esteem, thoughts of death and suicide)
- physical or neurovegetative (fatigue, psychomotor changes, disturbances of sleep and appetite/weight).

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

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

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

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

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

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

Bipolar Disorder

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

  (*See the DSM-IV or DSM-IV-TR Criteria.*)

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

Depressed, elevated, expansive, or irritable mood

Due to the direct psychological effects of a general medical condition
- Yes → MOOD DISORDER DUE TO A GENERAL MEDICAL CONDITION
- No ↓

Due to the direct psychological effects of a substance (i.e., a drug of abuse, a medication or a toxin)
- Yes → SUBSTANCE INDUCED MOOD DISORDER
- No ↓

Determine type of present and past mood disorders ↓

Elevated, expansive or irritated mood, at least 1-week duration; marked impairment or hospitalization
- Yes → MANIC EPISODE
- No ↓

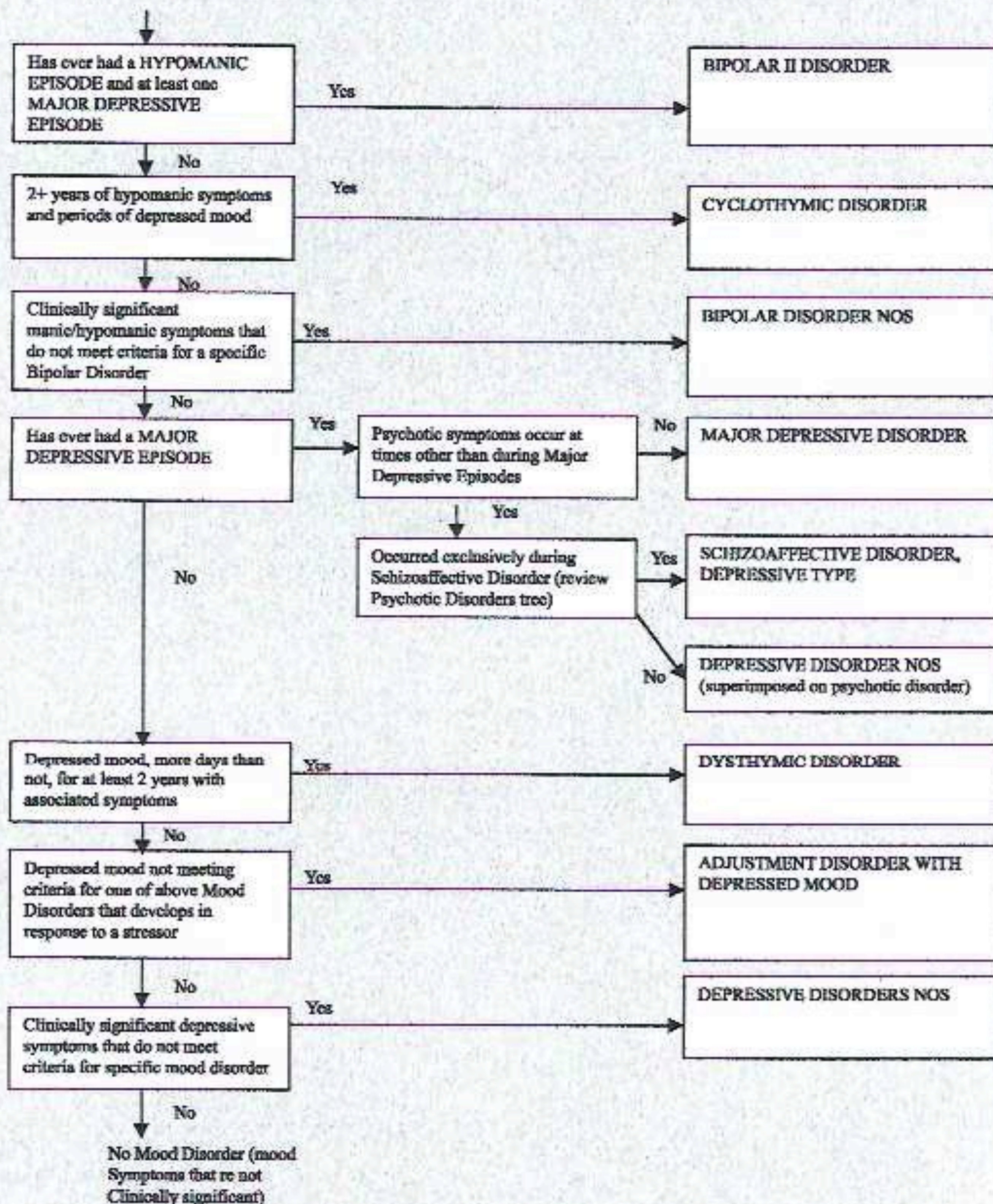
Elevated, expansive or irritated mood, at least 4-day duration; changes observable by others but less severe than a Manic Episode
- Yes → HYPOMANIC EPISODE
- No ↓

At least 2 weeks of depressed mood or loss of interest plus associated symptoms, and not better accounted for by Bereavement
- Yes → MAJOR DEPRESSIVE EPISODE
- No ↓

Criteria met for Manic Episode and Major Depressive Episode nearly every day for at least 1 week
- Yes → MIXED EPISODE
- No ↓

Has ever had a MANIC EPISODE or a MIXED EPISODE
- Yes → Psychotic symptoms occur at times other than during Manic or Mixed Episodes
  - No → BIPOLAR I DISORDER
  - Yes → Occurred exclusively during Schizoaffective Disorder (review Psychotic Disorders tree)
    - Yes → SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE
    - No → BIPOLAR DISORDER NOS (superimposed on a psychotic disorder)
- No ↓

DIAGNOSING MAJOR DEPRESSIVE DISORDER



DIAGNOSING ANXIETY DISORDERS

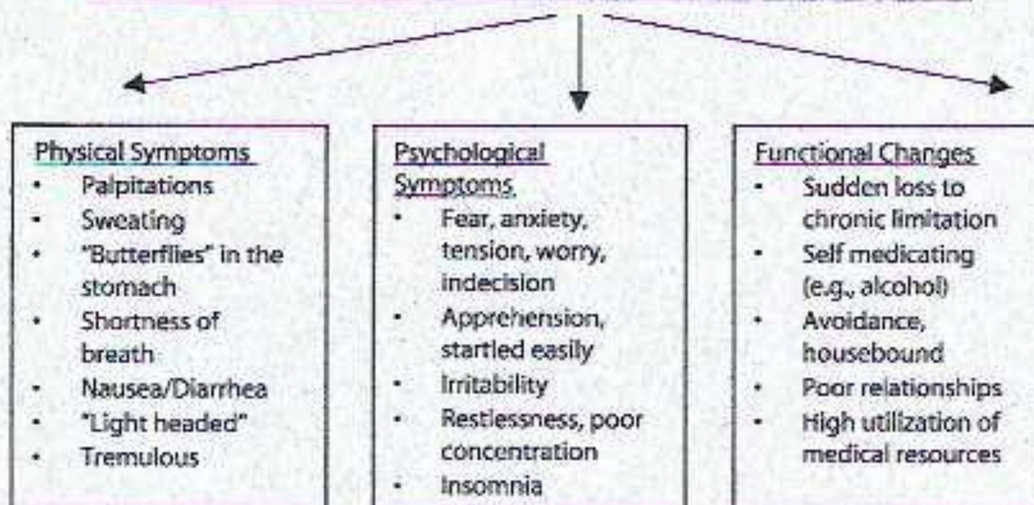
- All anxiety disorders share basic symptoms of anxiety, fear, and avoidance.
- Panic attacks can occur across all anxiety disorders. Panic attack is defined as a sudden episodic rush of intense fear or terror along with physiological symptoms (e.g., rapid heart rate, shortness of breath) and concern about losing control, going crazy, having a heart attack, etc.

FEATURES OF THE MAIN ANXIETY DISORDERS
adapted from DSM-IV or DSM-IV-TR

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

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

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

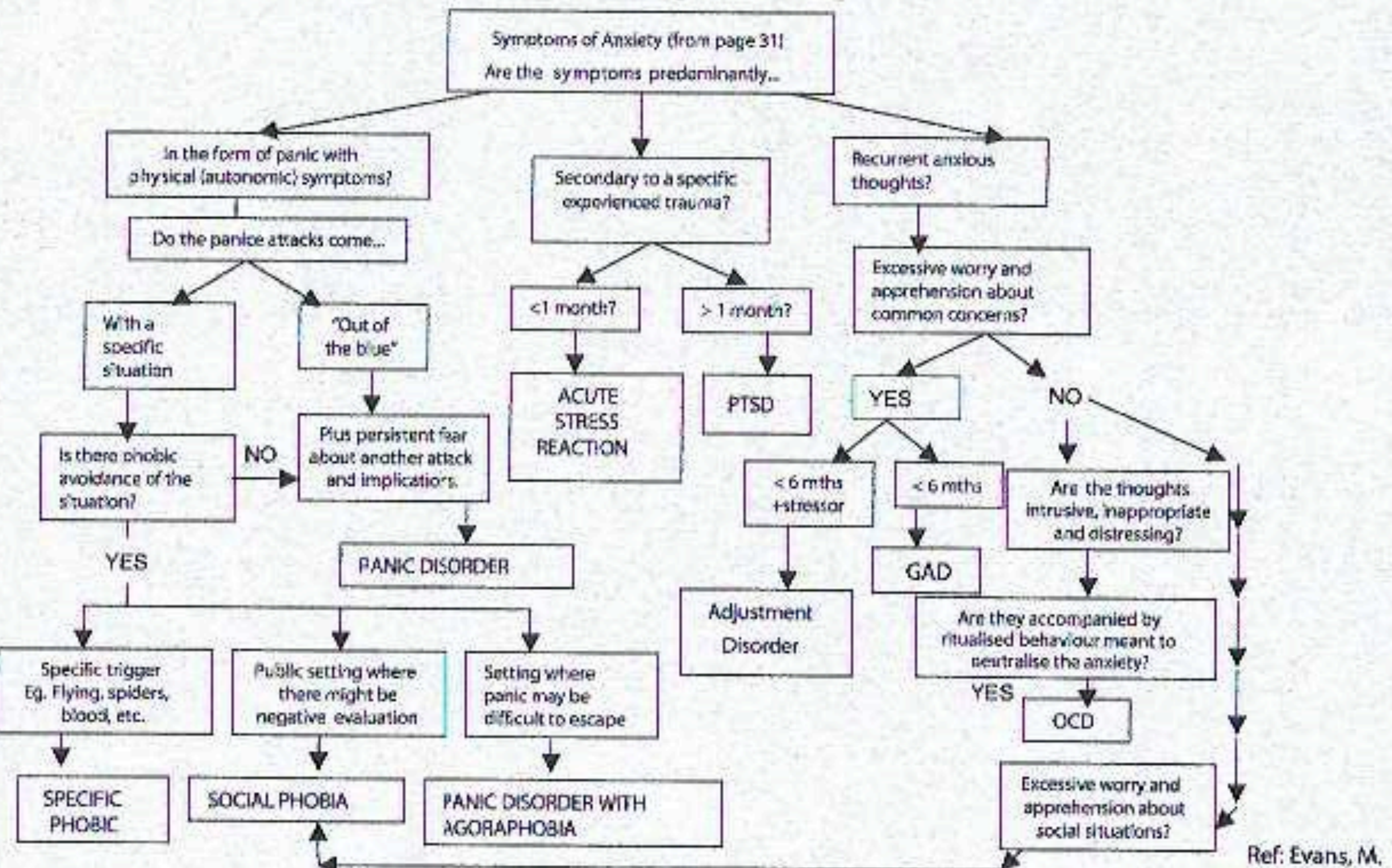


Step 2: Consider and Treat other Causes of Anxiety or Co-morbidities

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

Reference: Evans, M. (2000)

Anxiety Disorders — Diagnostic Decision Tree



Ref: Evans, M.

DIAGNOSING EARLY PSYCHOSIS

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

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

Positive Symptoms

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

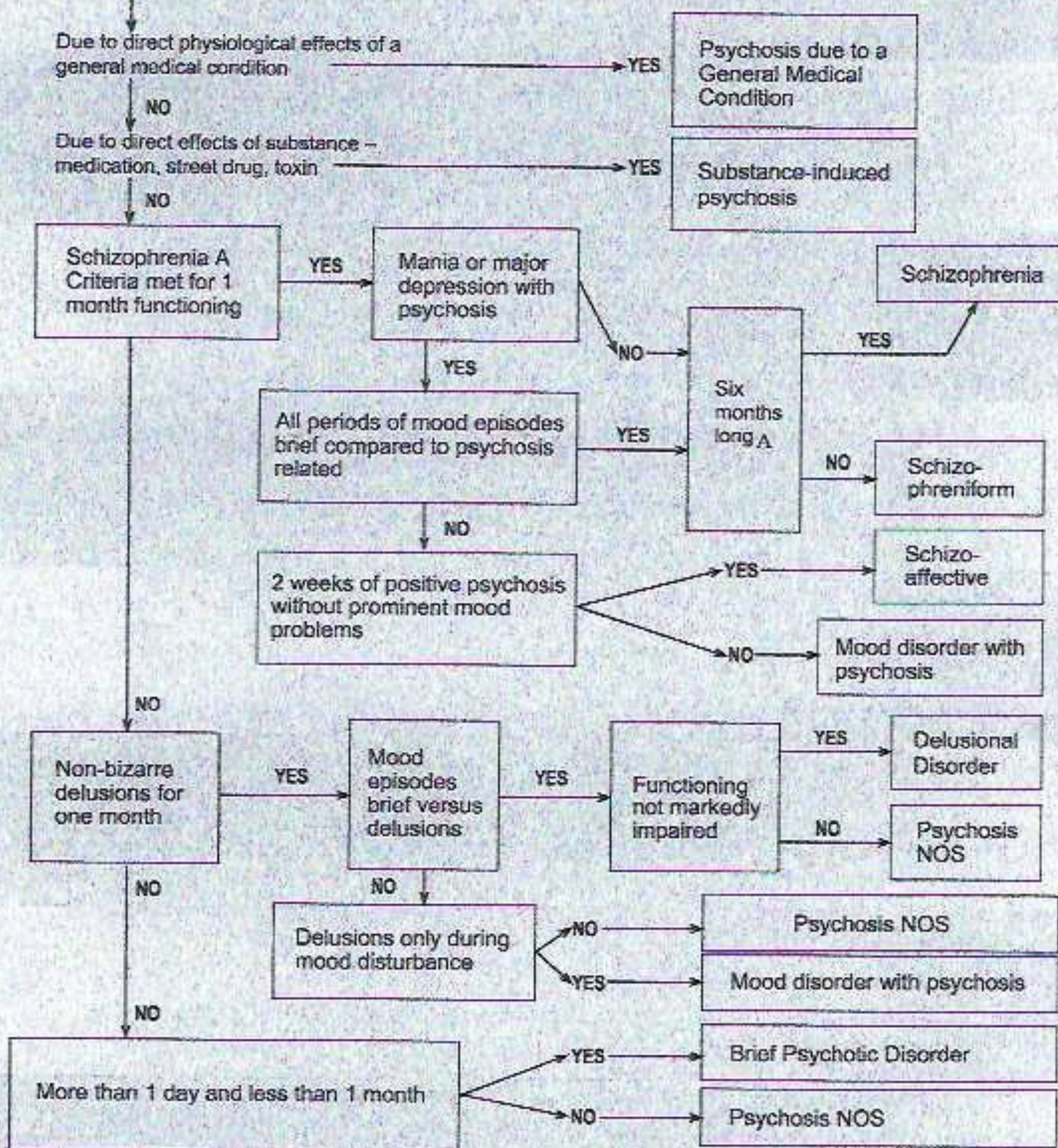
- delusions — fixed, false beliefs even in the face of contradictory evidence
- hallucinations — which may occur in any modality
- disorganized speech (e.g., tangentiality and loose associations)
- disorganized behaviour.

Negative Symptoms

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

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

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


Psychosis – Diagnostic Decision Tree (adapted from DSM-IV or DSM-IV-TR)
Delusions, hallucinations, disorganized speech, grossly disorganized behaviour, Negative Symptoms
Due to direct physiological effects of a general medical condition
YES
Psychosis due to a General Medical Condition
NO
Due to direct effects of substance – medication, street drug, toxin
YES
Substance-induced psychosis
NO
Schizophrenia A Criteria met for 1 month functioning
YES
Mania or major depression with psychosis
NO
Six months long A
YES
Schizophrenia
YES
All periods of mood episodes brief compared to psychosis related
YES
NO
Schizo-phreniform
NO
2 weeks of positive psychosis without prominent mood problems
YES
Schizo-affective
NO
Mood disorder with psychosis
NO
Non-bizarre delusions for one month
YES
Mood episodes brief versus delusions
YES
Functioning not markedly impaired
YES
Delusional Disorder
NO
Psychosis NOS
NO
NO
Delusions only during mood disturbance
NO
Psychosis NOS
YES
Mood disorder with psychosis
NO
More than 1 day and less than 1 month
YES
Brief Psychotic Disorder
NO
Psychosis NOS

Problems with Substance Use

- Substance use disorders (SUD) (substance abuse and substance dependence as defined in the DSM-IV or DSM-IV-TR) are a subset of substance related disorders.
- SUDs are further classified into substance abuse and substance dependence disorders depending on the number and type of associated problems.
- A patient exhibiting some but not all the criteria for a substance use disorder may still be experiencing problems related to their substance use, and require treatment.

Assessment

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

Pitfalls of Urine Drug Screens

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

DSM-IV or DSM-IV-TR Criteria: Substance Abuse and Dependence

The DSM-IV or DSM-IV-TR recognizes substance abuse and dependence as two presentations of substance use disorders. Withdrawal and intoxication reflect more acute states and are not exclusive of the disorders.

Substance Abuse

Substance Abuse DSM-IV or DSM-IV-TR Criteria:

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12 month period:
   1. recurrent substance use resulting in a failure to fulfil major role obligations at work, school, or home
   2. recurrent substance use in situations in which it is physically hazardous
   3. recurrent substance-related legal problems
   4. continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

B. The symptoms have never met the criteria for substance dependence for the substance in question.

Substance Dependence

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

Substance Dependence DSM-IV or DSM-IV-TR Criteria:

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

Glossary of Substance Use Terms

—(adapted from the Substance Abuse Mental Health Services Administration website www.samhsa.gov)

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

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

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

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

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

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

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

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

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

Marijuana: The dried leaves and flowering tops of the Indian hemp plan cannabis sativa; also called "pot" and "weed." It can be smoked or prepared in a tea or food. Marijuana has two significant effects. In the non-tolerant user, marijuana can produce distortions of sensory perception, sometimes including hallucinations. Marijuana also has depressant effects and is partially cross-tolerant with

sedative-hypnotic drugs such as alcohol. Hashish (or hash) is a combination of the dried resins and compressed flowers from the female plant.

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

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

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

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

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

Early Detection

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

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

The Family Physician's Role in Early Detection

- Screen and assess any patient with symptoms of a psychiatric disorder.
- Encourage patients and family to openly discuss psychological problems.
- Note that many patients frame their distress somatically or report only physical symptoms because of a reluctance to express psychiatric symptoms.
- Keep in mind that patients' personal beliefs and symptoms (e.g., avoidance, fear of negative evaluation, delusions, hallucinations) can interfere with disclosure and help-seeking behaviours.
- Provide educational materials in the waiting area to help patients recognize their own problems and encourage disclosure of symptoms during office visits *(see section on self-management and information for families for free and easily accessible sources of educational materials).*

RISK FACTORS

Risk factors can be inherent or acquired and may interact with each other to result in illness expression.

General Risk Factors

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

Disorder-Specific Risk Factors

Major Depressive Disorder

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

Anxiety Disorders

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

Early Psychosis

- family history of psychosis/psychiatric disorder
- history of head injury
- history of poor growth and development
- history of academic and social difficulties
- history of pregnancy and birth complications
- psychological trauma/ongoing stress
- substance use disorders (especially stimulants, cocaine)
- higher incidence in adolescence/youth

RISK FACTORS

Substance Use Disorders

- family history of SUD
- past history of substance use disorder
- trauma and/or violence
- mental illness

Some additional factors that influence substance use are

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

SCREENING FOR MAJOR DEPRESSIVE DISORDER

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

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

The 'Two-quick-question' screening method

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

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

Use of the Patient Health Questionnaire 9 (PHQ 9)

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

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

Other depressive syndrome is suggested if

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

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

	GUIDE FOR INTERPRETING PHQ-9 SCORES
SCORE	ACTION
0–4	The score suggests the patient may not need depression treatment
5-14	Mild to major depressive disorder. Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.
15-19	Moderate to major depressive disorder. Warrants treatment for depression, using antidepressant, psychotherapy or a combination of treatment.
20 OR HIGHER	Severe major depressive disorder. Warrants treatment with antidepressant, with or without psychotherapy, follow frequently.

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

Patient Health Questionnaire — PHQ 9

(www.primary-care.org)

Patient name:______________________________ Date: ________________

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

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

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

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

TOTAL SCORE ______________

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

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

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

Anxiety Disorders Screening Tool
Mini International Neuropsychiatry Interview (MINI)

Patient name: ____________________ Date: __________

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

Section 1

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

If your answer to question 1 above is no, please proceed to Section 2

2. At any time in the past, did any of these spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner? .... Y N

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 2

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

If your answer to question 1 above is no, please proceed to Section 3

2. Is this fear excessive or unreasonable? .... Y N

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

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

Section 3

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

If your answer to question 1 above is no, please proceed to Section 4

2. During the past month, have you re-experienced the event in a distressing way (such as dreams, intense recollections, flashbacks or physical reactions)? .... Y N

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

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

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

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

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

Have you felt that your life would be shortened because of this trauma? .... Y N

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

Section 4

1. Have you worried excessively or been anxious about 2 or more things (e.g., finances, children's well-being, misfortune) over the past 6 months? More than most others would? Are these worries present most days? .... Y N

If your answer to question 1 above is no, please proceed to Section 5

2. Do you find it difficult to control the worries or do they interfere with your ability to focus on what you are doing? .... Y N
3. When you were anxious over the past 6 months, did you, most of the time: Feel restless, keyed up or on edge? .... Y N
Feel tense? .... Y N
Feel tired, weak or exhausted easily? ..... Y N
Have difficulty concentrating or find your mind going blank? .... Y N
Feel irritable? .... Y N
Have difficulty sleeping (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively)? .... Y N

Section 5

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

If your answer to question 1 above is no, please proceed to Question #4

2. Did they keep coming back into your mind even when you tried to ignore or get rid of them? .... Y N
3. Do you think these obsessions are the product of your own mind and that they are not imposed from the outside? .... Y N
4. In the past month, did you do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting or checking things over and over, or repeating, collecting, arranging things, or other superstitious rituals? .... Y N
5. Did you recognize that either these obsessive thoughts or these compulsive behaviours were excessive or unreasonable? .... Y N
6. Did these obsessive thoughts and/or compulsive behaviours significantly interfere with your normal routine, occupational functioning, usual social activities, or relationships, or did they take more than one hour? .... Y N

Section 6

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

Section 7

Please fill ONE circle for each of the following 3 scales.
To what extent have emotional symptoms disrupted...

1. ... your work in the last month:
not at all mildly moderately mostly extremely
0 1 2 3 4 5 6 7 8 9 10
2. ... your social life in the last month:
not at all mildly moderately mostly extremely
0 1 2 3 4 5 6 7 8 9 10
3. ... your family life/home responsibilities in the last month:
not at all mildly moderately mostly extremely
0 1 2 3 4 5 6 7 8 9 1

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

Question 1 must be answered positively to meet criteria

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

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

Section 3 – Post Traumatic Stress Disorder ____________
Rule out PTSD if NO to Question 1
Rule out PTSD if YES to Question 1 + NO to Question 2
PTSD if Y to Questions 1 & 2 + (3 or more Y responses in Q3) + (2 or more Y responses in Q4) + Q5

Section 4 – Generalized Anxiety Disorder ______
Rule out GAD if NO to Question 1
GAD if Y to Questions 1 & 2 + (3 or more Y responses in Q3)

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

CAUTION – If there are several YES answers in any section even though the screening participant does not meet criteria, check the impairment scale (section 7). If substantial impairment is evident, it is recommended that the screening participant be referred for a complete clinical evaluation.

SCREENING FOR EARLY PSYCHOSIS

- There are no self-report screening instruments for early psychosis that can be easily implemented.
- Most young people are either reluctant to admit having psychotic experiences or they lack the vocabulary to easily describe their extraordinary experiences.
- Observation of changes in appearance and activity should raise the index of suspicion.
- Inquire about the presence of hallucinations (e.g., " when a person gets really stressed out their mind can play tricks on them — like hearing a whisper or even a voice saying things — has that ever happened to you?")

Various screening tools are available that enable the family physician to quickly identify individuals who may have a substance use problem *(see ensuing samples provided)*.

When taking a substance use history, inquire

1. about the following classes
   - marijuana
   - cocaine/crack
   - "party drugs" — ecstasy, GHB, ketamine
   - prescription drugs — benzodiazepines especially Lorazepam, Diazepam and Clonazepam (readily available on the street)
   - solvents — gasoline, aerosols, glue
   - opioids — heroin, morphine, methadone, codeine, oxycodone
   - crystal methamphetamine, amphetamine, prescription stimulants (dexamphetamine, methylphenidate)
   - hallucinogens — LSD, "magic" mushrooms
   - alcohol — classify using standard drinks; also inquire re: the use of rubbing alcohol, mouthwash
2. (if affirmative) about route of administration of the specific substance
   - sniffing/snorting, injection, oral, smoking or inhalational
   - sharing of needles or paraphernalia (high-risk behaviours)
3. about quantity and frequency of use
   - # of Standard Drinks (Canadian)
   - Point = 1/10th g
   - Rock = variable amount usually 3 – 4 points
   - "Mickey" = 13 fl. ounces
   - "8 Ball" or an 1/8th of an ounce = 3.6g
4. about concerns related to drug use
   - consider modifying the CAGE by substituting the substance of concern for "alcohol" or "drinking" (e.g., "Have you ever felt bad or Guilty about your cocaine use?"); although it is not evidence based, it may serve as an initial point of discussion.

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

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

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

  (Source: Saunders JB, Aasland OG, Babor TF *et al.* Development of the alcohol use disorders identification test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption II. *Addiction* 1993, 88: 791 – 803).

Also available is the DAST.

CAGE Questionnaire — Screen for Problematic Alcohol Use

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

- Have you ever felt you should **C**ut down on your drinking?
- Have people **A**nnoyed you by criticizing your drinking?
- Have you ever felt bad or **G**uilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (**E**ye-opener)?

The combination of CAGE questionnaire, MCV and GGT activity will detect about 75% of people with an alcohol problem,

AUDIT (Alcohol Use Disorders Inventory Test) Questionnaire: Screen for Problematic Alcohol Use

Please circle the answer that is correct for you

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

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

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

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

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

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

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

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

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

10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?
- No
- Yes, but not in the past year
- Yes, during the past year

Drug Abuse Screening Test (DAST)

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

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

Results for DAST

SCORE EACH YES RESPONSE WITH 1 POINT.

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

Source: Gavin DR; Ross HE; Skinner HA. Diagnostic validity of the Drug Abuse Screening Test in the assessment of DSM-III drug disorders. British Journal of Addiction 84(3): 301 – 307, 1989. (23 refs.)

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

Patient: ____________ Date: ________ Time: ________ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute: ____________ Blood pressure: ______

NAUSEA AND VOMITING -- Ask "Do you feel sick to your stomach? Have you vomited?" Observation. 0 no nausea and no vomiting 1 mild nausea with no vomiting 2 3 4 intermittent nausea with dry heaves 5 6 7 constant nausea, frequent dry heaves and vomiting	**TACTILE DISTURBANCES** -- Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation. 0 none 1 very mild itching, pins and needles, burning or numbness 2 mild itching, pins and needles, burning or numbness 3 moderate itching, pins and needles, burning or numbness 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations
TREMOR -- Arms extended and fingers spread apart. Observation. 0 no tremor 1 not visible, but can be felt fingertip to fingertip 2 3 4 moderate, with patient's arms extended 5 6 7 severe, even with arms not extended	**AUDITORY DISTURBANCES** -- Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation. 0 not present 1 very mild harshness or ability to frighten 2 mild harshness or ability to frighten 3 moderate harshness or ability to frighten 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations
PAROXYSMAL SWEATS -- Observation. 0 no sweat visible 1 barely perceptible sweating, palms moist 2 3 4 beads of sweat obvious on forehead 5 6 7 drenching sweats	**VISUAL DISTURBANCES** -- Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation. 0 not present 1 very mild sensitivity 2 mild sensitivity 3 moderate sensitivity 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations
ANXIETY -- Ask "Do you feel nervous?" Observation. 0 no anxiety, at ease 1 mild anxious 2 3 4 moderately anxious, or guarded, so anxiety is inferred 5 6 7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions	**HEADACHE, FULLNESS IN HEAD** -- Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity. 0 not present 1 very mild 2 mild 3 moderate 4 moderately severe 5 severe 6 very severe 7 extremely severe
AGITATION -- Observation. 0 normal activity 1 somewhat more than normal activity 2 3 4 moderately fidgety and restless 5 6 7 paces back and forth during most of the interview, or constantly thrashes about	**ORIENTATION AND CLOUDING OF SENSORIUM** -- Ask "What day is this? Where are you? Who am I?" 0 oriented and can do serial additions 1 cannot do serial additions or is uncertain about date 2 disoriented for date by no more than 2 calendar days 3 disoriented for date by more than 2 calendar days 4 disoriented for place/or person
	Total CIWA-Ar Score ______ Rater's Initials ______ Maximum Possible Score 67

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

Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar). *British Journal of Addiction* 84:1353-1357.

Warning Signs for Onset or Relapse

General Warning Signs and Symptoms

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

Disorder-Specific Warning Signs and Symptoms

Major Depressive Disorder

In addition to the general warnings the person may experience

- loss of interest or pleasure in activities or relationships
- guilt
- complaints of decreased memory and concentration
- decline in functioning in primary roles (e.g., poor work performance, delayed bonding with baby)
- dangerous behaviour/impulsivity.

Anxiety Disorders

In addition to the general warnings the person may exhibit

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

Early Psychosis

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

In addition to the general warnings the person may exhibit

- shifts in social circle or markedly reduced social activity
- decreased concentration
- decreased hygiene
- over-concern with physical functions and appearance or significant change in dress or appearance
- increased interest in metaphysics and spirituality
- inappropriate emotional expression
- reduced speech output or speech that is difficult to follow
- suspiciousness, paranoia or even delusional beliefs
- attending to internal stimuli or "talking/laughing to themselves"
- impulsivity
- irritability

Substance Use Disorders

Alcohol and substance abuse disorders may present with any of the general warning signs and symptoms. In addition, potential warnings include those identified in the following table:

Summary of Biopsychosocial Complaints and Presentation of Problematic Alcohol and Substance Use

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

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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A2662B 10-04-2005

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PLEO

Schizophrenia

This survey is designed to provide a quick assessment of whether you show signs and symptoms of schizophrenia or psychosis. However, no test is 100% accurate. No matter what your score is, you should seek help if you have any concerns about yourself or your loved ones.

This questionnaire was developed by the PRIME group at Yale University Medical School.

1. I feel that others control what I think and feel.
   Not at all (0.0) Just a little (1.0) Somewhat (2.0) Moderately (3.0) Quite a lot (4.0) All the time (5.0)
2. I hear or see things that others do not hear or see.
   Not at all (0.0) Just a little (1.0) Somewhat (2.0) Moderately (3.0) Quite a lot (4.0) All the time (5.0)
3. feel it is very difficult for me to express myself in words that others can understand.
   Not at all (0.0) Just a little (1.0) Somewhat (2.0) Moderately (3.0) Quite a lot (4.0) All the time (5.0)
4. I feel I share absolutely nothing in common with others, including my friends and family.
   Not at all (0.0) Just a little (1.0) Somewhat (2.0) Moderately (3.0) Quite a lot (4.0) All the time (5.0)
5. I believe in more than one thing about reality and the world around me that nobody else seems to believe in.
   Not at all (0.0) Just a little (1.0) Somewhat (2.0) Moderately (3.0) Quite a lot (4.0) All the time (5.0)
6. Others don't believe me when I tell them the things I see or hear.
   Not at all (0.0) Just a little (1.0) Somewhat (2.0) Moderately (3.0) Quite a lot (4.0) All the time (5.0)
7. I can't trust what I'm thinking because I don't know if it's real or not.
   Not at all (0.0) Just a little (1.0) Somewhat (2.0) Moderately (3.0) Quite a lot (4.0) All the time (5.0)
8. I have magical powers that nobody else has or can explain.
   Not at all (0.0) Just a little (1.0) Somewhat (2.0) Moderately (3.0) Quite a lot (4.0) All the time (5.0)
9. Others are plotting to get me.
   Not at all (0.0) Just a little (1.0) Somewhat (2.0) Moderately (3.0) Quite a lot (4.0) All the time (5.0)
10. I find it difficult to get a hold of my thoughts.
   Not at all (0.0) Just a little (1.0) Somewhat (2.0) Moderately (3.0) Quite a lot (4.0) All the time (5.0)
11. I am treated unfairly because others are jealous of my special abilities.
   Not at all (0.0) Just a little (1.0) Somewhat (2.0) Moderately (3.0) Quite a lot (4.0) All the time (5.0)
12. I talk to another person or other people inside my head that nobody else can hear.
   Not at all (0.0) Just a little (1.0) Somewhat (2.0) Moderately (3.0) Quite a lot (4.0) All the time (5.0)

Schizophrenia

Scoring Key

14 and Up: Likely schizophrenia 10 – 13: Possible early schizophrenia -- see your doctor! 0 – 9: Unlikely

For more information about this survey

- The PRIME Group at Yale University.