
CHAPTER 15 – MENTAL HEALTH

*First Nations and Inuit Health Branch (FNIHB) Clinical Practice Guidelines for Nurses in Primary Care.
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Mental health is a broad topic addressed in several First Nations and Inuit Health publications. This chapter contains the clinical assessment and management of mental health concerns. The values and the philosophy integral to mental health care, including community programs and cultural consideration for First Nations and Inuit communities, are not addressed in this chapter. However, the approach to mental health care can be found in regional community health manuals, the National Orientation Manual and other First Nations lead organizations and associations.

INTRODUCTION

MENTAL HEALTH

“A state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.”¹ It is a balance between the mental, emotional, physical and spiritual health² of an individual and positive community functioning.

There is some agreement in the literature that mental health is evident in the following personal characteristics:³

- Self-awareness and accurate self-perception
- Self-actualization (realizing one’s full potential)
- Autonomy (independence in thought and action)
- Accurate perception of reality
- Commitment
- Possession of “mastery” skills (social and occupational ability to deal with the environment and adversity/stress)
- Openness and flexibility
- Long and satisfying interpersonal relationships
- Able to express and cope with emotions
- Self-esteem

The disparity between Aboriginal mental health and that of the rest of Canadians is of concern.^{4,5,6}

MENTAL ILLNESS

“A serious disturbance in thoughts, feelings and perceptions that is severe enough to affect day-to-day functioning.”⁷ A person with a mental illness may display some or all of the following behavioural characteristics:

- Social maladjustment
- Impaired reasoning or intellectual functioning
- Disorders of thinking, memory or orientation
- Delusions or disorders of perception
- Exaggerated, inappropriate or otherwise impaired emotional responses
- Impaired judgment or impulse control
- Unrealistic self-appraisal
- In addition to the effects on the individual client, mental illness often affects the family

Unlike the diagnosis of most physical disorders, diagnosis of a mental illness does not usually mean a specific cause can be identified.

MENTAL WELLNESS

“A lifelong journey to achieve wellness and balance of body, mind and spirit. Mental wellness includes self-esteem, personal dignity, cultural identity and connectedness in the presence of a harmonious physical, emotional, mental and spiritual wellness. Mental wellness must be defined in terms of the values and beliefs of Inuit and First Nations people.”⁸

MENTAL ILLNESS RISK AND PROTECTIVE FACTORS^{9,10}

Many social, environmental and economic factors can impact an individual’s mental health. An increased likelihood of, more severe, and/or longer length of mental illness are associated with the following *risk factors*:

- Social isolation (for example, lonely, caring for one with a chronic illness)
- Lack of education, transportation, housing
- Peer rejection (for example, social difficulties, communication problems, emotionally immature)
- Poor social support (for example, family discord or disorganization)
- Substance abuse or excessive use (personal, parental or perinatal)
- Displacement
- Racial injustice and discrimination
- Social disadvantage
- Exposure to violence, trauma and/or aggression
- Socially or legally unacceptable behaviour (for example, abuse of any form, neglect, domestic violence towards mother, criminal behaviour)
- Stress related to employment or life events (for example, personal loss, early pregnancy)
- Unemployment and/or poor work skills and habits
- Family history of mental illness
- Medical illness (for example, chronic pain or insomnia) and/or chronic disease

The following are *protective factors* for mental illness (for example, factors that decrease the risk of adverse outcomes if mental illness occurs, factors that counteract mental illness risk factors, factors that decrease the risk of developing mental illness) if they predate it:

- Ability to deal with stress and face adversity
- Adaptable
- Autonomous
- Positive parent-child relationships
- Good parenting, attachment and bonding
- Social involvement
- Social and emotional growth
- Social and conflict resolution skills

- Life skills, including problem-solving skills
- Self-esteem
- Social support of family and friends
- Good school performance
- Literate
- Physical exercise
- Cognitive stimulation early in life
- Feeling secure
- Feeling that have mastery and control

For the Aboriginal population in particular: knowing how to live on the land, being connected to culture and traditional activities, being involved in the community and aware of the history of Aboriginal peoples in Canada are protective factors.¹¹

MENTAL HEALTH ASSESSMENT: CLINICAL ASSESSMENT AND MANAGEMENT^{12,13}

The purpose of mental health assessment is to provide specific information about a client's behaviour, thoughts and feelings and the relation of these factors to the client's background, experiences and present circumstances. It provides the database for describing, diagnosing and eventually treating concerns. The information may be gathered from direct interviews with the client or from material provided by relatives, friends, or referring agencies. The assessment should provide enough data to rule out a psychiatric emergency such as suicidality, homicidality, psychosis, drug intoxication or withdrawal.

Good communication skills are essential to provide mental health care. This includes ensuring that the privacy and confidentiality of a client is respected during client care while maintaining personal safety during all client encounters. For more information on communication, *see "Communication" in the chapter "Introduction to the Clinical Practice Guidelines."*

One communication technique, the BATHE Model, helps develop a positive relationship with clients while also quickly screening for some mental health concerns. It can be used to elicit the chief concern and/or start an interview. It involves:¹⁴

- **Background** (for example, ask about what is happening in the client's life currently and/or any recent changes that have occurred to determine the context for the visit)

- **Affect** (for example, ask about their emotional response [feelings, mood] to the situation)
- **Trouble** (for example, ask about what concerns or worries the client the most about the situation)
- **Handling** (for example, ask about the resources and coping mechanisms the client is using to handle the situation)
- **Empathy** (for example, let the client know that their response is reasonable given the situation)

HISTORY

CLIENT PROFILE

General description of the client:

- Age, date of birth
- Sex
- Ethnic origin
- Relationship status
- Number and age of siblings or children
- Spouse or parents
- Living arrangements
- Employment status and occupation
- Education

If a client has difficulty stating this information, perform a more detailed cognitive screening (for example, Mini Mental Status Exam).

HISTORY OF PRESENTING PROBLEM

The following characteristics of each sign or symptom below, if present, should be elicited and explored:

- Onset
- Frequency
- Progression
- Potential precipitating factors (for example, stress, substance use)

Chief concern:

Use an open-ended question to find out what the client considers the chief concern and allow them time to disclose their perception of the problem.

Difficulties or changes in:

- Relationships (for example, not feeling safe, abuse)
- Usual level of functioning (for example, energy, speed of thoughts, activities participating in)
- Behaviour (for example, energy level, speech)
- Sleep
- Perceptions (for example, heard or saw people or things when alone or nothing is there; feels persecuted by others)
- Cognitive abilities (concentration, memory); if a client describes difficulty with memory, perform a more detailed cognitive screening (for example, Mini Mental Status Exam)
- Interest and pleasure in doing things

Increase in feelings of:

- Depression, hopelessness
- Mania (euphoria or irritability)
- Anxiety (on edge or has fears that knows are not rational but is unable to suppress them)
- Nervous or being overwhelmed (worried about many things)
- Suspiciousness
- Confusion

Somatic changes:

- Gastrointestinal (for example, abdominal pain)
- Insomnia, hypersomnia
- Lethargy, fatigue
- Weight loss or gain, loss of appetite (anorexia)
- Palpitations
- Nausea, vomiting
- Neurologic (for example, headaches, seizures, dizziness)
- Agitation, restlessness

- Decreased sexual energy or libido
- Concerns with no known physical cause

Integrative patterns and client's perception of their relationship to:

- Others
- Self
- Things and ideas
- Present situation
- Reality

RELEVANT HISTORY

Personal

- Recent major illness or diagnosis of chronic disease
- Anxiety or panic attacks (for example, sudden fear causing palpitations making client feel they may die)
- Hurt physically or emotionally in past year
- Review of systems related to presenting concern
- Stays in hospital and illnesses
- Past and current medical, mental illness, and neurologic history
- Prescription, over-the-counter and herbal medications (including compliance, duration, side effects)
- Education
- Religion
- Occupational background
- Ability to complete activities of daily living (for example, personal hygiene, getting dressed) and instrumental activities of daily living (for example, managing money, using telephone)
- Role function at work, school, and home
- Social adjustment and support
- Sexual history
- Social activity, including interests, hobbies, recreation
- Substance use (for example, alcohol; smoking; caffeine; recreational, prescription, or over-the-counter drugs) and abuse
- Significant life events (for example, divorce, abuse, death)
- Suicidal, homicidal or violent behaviour (lethality, treatment needed, dates)
- Legal involvement (for example, charges, violence)
- Maternal substance use, pregnancy or delivery problems
- Development as a child through to adolescence

Familial

- Birth order
- Perceived place within family
- Relationship with parents
- Relationships with siblings
- Integrity of family unit
- Mental health of biological family members:
 - Psychiatric diagnosis, symptoms, duration, treatment(s), response
 - Attempted or completed suicide
 - Substance abuse
 - Legal concerns

CLINICAL EXAMINATION

Much of the clinical examination is based on observation throughout the history taking, but sometimes questions will need to be asked in order to complete the mental status examination.

MENTAL STATUS EXAMINATION

Appearance

- Physical condition and general health (for example, age, skin, hair and nail condition)
- Dress (for example, clean, appropriate for season and presenting concern)
- Grooming (for example, unkempt)
- Eye contact and facial expression; ensure cultural differences are respected
- Posture (for example, rigid, slouched)
- Relatedness to interviewer (for example, cooperative, guarded, hostile, accessible)

Behaviour

- Motor activity (for example, psychomotor agitation/retardation, involuntary movements)
- General level
- Gait
- Gestures and mannerisms (for example, repetitive tapping, hand wringing)
- Awareness of environment
- Impulse control (for example, aggressive, hostile)

Speech

- Pitch, tone, volume, clarity (for example, monotonous)
- Rate, rhythm, articulation, spontaneity (for example, stutter, pressured, mute)

Mood and Affect

- Appropriateness
- Intensity
- Overall impression of affect (for example, depressed, anxious, angry, apprehensive, apathetic) and its appropriateness for the presenting concern
- Emotionality (dominant emotion, range of emotions, lability)
- Client's stated mood

Thought Processes¹⁵ (how client comes to a conclusion)

- Quality of logic and coherence
- Appropriate (for example, logical)
- Tangential (for example, digress from initial topic)
- Concrete or abstract
- Flight of ideas (stereotypic)
- “Word salad” (incoherent medley of words)
- Clang associations (words that rhyme or sound alike inserted in conversation without making sense)
- Echolalia (sentences said to the client are repeated back by the client)
- Neologisms (words created by client)
- Confabulation (fabrication of events or facts due to memory impairment; not lying; observed in alcohol-induced dementia)
- Idiosyncratic or unusual word usage
- Cognitive ability: concept formation, level of intelligence, articulation (precision, vocabulary level)
- General characteristics: speed of thought, spontaneity, flexibility or rigidity, distractibility, continuity, alertness, blocking (interruptions in train of thought)

Thought Content

- Central themes
- Self-concept
- Insight and awareness
- Judgment
- Delusions
- Obsessions
- Fears and phobias
- Somatic concerns (for example, hypochondriac, morbid thoughts)
- Overvalued ideas
- Rituals or compulsions
- Religiosity

- Suicidal or homicidal ideation; perform a risk assessment:
 - intent/suicidal ideation (for example, when the thoughts occur, feeling so upset wishes he/she was dead, talking or writing about suicide/homicide)
 - plan (if a plan exists, how, when and where of plan, how realistic it is, likelihood of someone rescuing them, any action taken [for example, stealing gun cabinet keys])
 - means to carry out plan (method availability at home and lethality [reality and client's perception] of the intended method)
 - what would cause or prevent him/her from carrying out plan
 - behaviour(s) that have been exhibited (for example, warning signs [see “Warning Signs of Potential Suicide” in the “Suicidal Behaviour” section], impulsive or high-risk behaviours)
 - see also “Suicidal Behaviour” section

Perception

- Hallucinations (any modality)
- Illusions
- Depersonalization (feel detached from body or vice versa)
- Derealization (things do not seem real)
- Sense of grandiosity or worthlessness
- Nihilism (the order of things has disappeared)

Cognition

- Level of consciousness
- Attention and concentration
- Knowledge of time, person, place, month, and year
- Remote and recent memory
- Memory retention (for immediate, recent and remote events)
- Ability to distinguish between internal and external stimuli
- Knowledge (for example, who is the prime minister)
- Abstraction (for example, what does a saying such as “Be kind to your shadow” mean, or how are two different objects similar)

Insight and Judgment

- Awareness and understanding into condition and need for assistance
- Ability to understand what is likely when acting a certain way

PHYSICAL EXAMINATION

In order to rule out physiological conditions that may present as a mental health concern, a thorough head to toe physical examination, including weight and height, should be completed after the client's psychological symptoms started.

ASSESSMENT AND INTERPRETATION

Identify strengths and problems.

Make provisional diagnosis.

Determine need for emergency actions:

- Overt homicidal or violent impulses
- Potential suicide
- Inability to function independently and no caregiver available
- Acute psychotic symptoms
- Delirium

POTENTIAL GOALS OF TREATMENT

Whenever possible, treatment goals should be identified and driven by clients as they are the ones who need to determine and prioritize what is most important for them to work toward, how they will do it, and in what time frame. These goals may be directly or indirectly related to their medical diagnosis. Agreement between the care provider and the client helps to facilitate progress toward them.

- Relieve or decrease symptoms (for example, reduce anxiety)
- Change attitude
- Change behaviour (for example, cessation of compulsive hand-washing, habit change, self-control)
- Develop insight (for example, an understanding of one's motivation, the reasons for emotional response, or the causes of disordered behaviour)
- Improve interpersonal relationships (for example, getting along with one's family, overcoming social anxiety or shyness, controlling anger)
- Improve personal functioning (for example, increase ability to accept responsibility, be productive)
- Improve social functioning (for example, improve ability to function socially within the community)

- Personal growth and well-being (for example, increase ability to adapt and cope in the future, increase physical activity)
- Prevent secondary effects on the family (for example, no baby born with fetal alcohol spectrum disorder, family caregiver not burdened, child not neglected)

NONPHARMACOLOGIC INTERVENTIONS

General interventions to support mental health care are described in the following documents:

- 100 Ways to Support Recovery: A Guide for Mental Health Professionals (available at: <http://www.schizophrenia.ca/100waystosupportrecovery2009.pdf>)
- Self Directed Recovery Workbook: Building Personal Responsibility and Self-Determination (available at: http://ccamhr.ca/resources/Self-directed_Recovery.pdf)

CONSULTATION AND REFERRAL

Consultation with another mental health provider (for example, physician, nurse practitioner, clinical nurse specialist, psychiatrist, psychologist, counsellor, social worker, mental health/wellness worker) is most often required in mental health care. This helps to ensure the client is linked to the best nonpharmacologic, pharmacologic, and specialist resources. Clients with, suspected to have, or at risk for serious mental or emotional impairments, psychoses, bipolar disorder, suicide and substance abuse require referral to an appropriate specialist as they will likely require long-term treatment. This consultation should take place early and regularly thereafter so that the client has a team of care providers to help them and so that further referral can take place if warranted.

Links with mental health and chronic disease (if the concern may be related to difficulties coping with a chronic disease) resources in the community should be made with the client's permission. Community resources may include community mental health/wellness worker, Native Aboriginal Youth Suicide Prevention Strategy worker, Native Aboriginal Drug and Alcohol Program worker, Brighter Futures/Building Healthy Communities worker, Indian Residential Schools Resolution Health Support or Cultural Support worker, community health representative, family visitor from the Maternal

Child Health program, community wellness worker, diabetes worker, Home and Community Care worker, other clients and/or families who have experienced the particular mental health concern and are willing to serve as resources to those affected.

HOSPITALIZATION AND CLIENT EVACUATION

The decision whether to treat the client on an outpatient basis or admit and/or evacuate the client to a hospital (voluntarily or involuntarily) depends on several factors. This decision must be made in consultation with a physician and/or psychiatrist. The following should be considered:

- Is this the first known episode? How certain is the diagnosis? Is there a need for close observation and monitoring (for example, symptoms of psychosis and their acuity, degree of functional impairment, acute moderate to severe mania)?
- How competent are the local medical and nonmedical (for example, community supports, friends, family) resources to deal with this mental health concern and with this client in particular? How available is psychiatric consultation, if it is required?
- How dangerous (for example, suicidal, homicidal), frightened or unpredictable is the client now or has he or she been in the past? How compliant is the client with directions and medication?
- What other medical needs does the client have (for example, comorbid conditions)?
- Is the client in need of shelter? To what extent is the family disrupted by the client? Would it be dangerous or disruptive to return the client to the family or friends (for example, can they provide adequate supervision, and a safe environment for the client)?
- What is the nature of the hospital program?
- What are the wishes of the client? Is the client capable of consent? Does the client meet the criteria for an involuntary admission?

Whether the client enters hospital voluntarily or involuntarily, it is very important that the family be kept informed (if the client is capable and consents) of his or her progress and that they maintain close contact with the client as much as possible.

INVOLUNTARY ADMISSION

Legal requirements, including consulting and referring to a psychiatrist, must be met before a person can undergo psychiatric assessment and/or be hospitalized against his or her will. These requirements vary from one jurisdiction to another, so you must refer to and follow the appropriate mental health legislation for your province or territory (for example, Form 1 admission). In most cases there must be evidence of risk of physical harm to the client or others before an unwilling person can be admitted. The assessment and recommendation for admission of one or more physicians is required in all jurisdictions.

EVALUATION OF TREATMENT

During follow-up care, caregivers need to determine whether the treatment has met the goals and expectations of both the client and caregiver. This helps determine whether the goals and treatment plan need to be revised.

COMMON MENTAL HEALTH, PSYCHIATRIC AND RELATED PROBLEMS

ANXIETY DISORDERS^{16,17,18}

A group of mental health conditions that have specific combinations of physical, emotional, and behavioural symptoms, including excessive anxiety, fear, panic, worry, avoidance, and compulsive rituals, in response to a perceived threat. An anxiety disorder can be distinguished from normal anxiety or worries by having symptoms that persist, are of a greater intensity than expected, and impair daily functioning (for example, occupational, social).

Early signs of an anxiety disorder include persistent behavioural inhibition (for example, shyness and avoidance of novelty). This along with risk factors listed below are linked to anxiety disorder development.

Specific types of anxiety disorders include:

- *Generalized anxiety disorder* – difficult to control excess worry most days about many different normal things (for example, health, finances) or activities (for example, work) that usually causes physical symptoms (for example, headache, nausea, sleeplessness); not tolerant of uncertainty; told worries too much
- *Obsessive compulsive disorder* – repetitive, unwanted, intrusive thoughts or images that cause anxiety (obsessions); repetitive, unwanted behaviours (for example, cleaning) or mental acts (for example, counting) done to decrease anxiety from the obsessions (compulsions)

- *Panic disorder (with and without agoraphobia)* – sudden, unexpected, recurrent attacks (for example, palpitations, chest pain, dizziness, sweating, trembling, shortness of breath, fear of losing control, nausea) without an obvious trigger; may actively avoid places where the attacks may take place; cannot tolerate physical symptoms
- *Post-traumatic stress disorder*¹⁹
 - a) personal exposure (witnessed, experienced, or confronted) to a traumatic event (for example, actual or threatened death or serious injury or threat to physical integrity of others) and response was intense fear, helplessness or horror and
 - b) the person persistently relives the traumatic situation and
 - c) the person persistently avoids stimuli related to the trauma and
 - d) the person has blunted responses and increased arousal that lasts for more than 1 month
- *Social anxiety disorder* – excessive fear or anxiety about social situations (for example, public speaking, interacting with others) and intolerant of others discussing them as a person
- *Specific phobias* – excessive, irrational fear or anxiety about an object (for example, snakes) or situation (for example, flying) so that it is usually avoided

The *Diagnostic and Statistical Manual of Mental Disorders IV Text Revision* (DSM-IV-TR) provides more specific criteria for the diagnosis of each anxiety disorder. The criteria for each disorder can be found on-line (available at: <http://www.clevelandclinicmeded.com/medicalpubs/diseasemanagement/psychiatry-psychology/>).

Risk Factors

- Family history of mental illness (in particular, anxiety)
- Personal history of childhood anxiety, including marked shyness
- Stressful or traumatic event (for example, abuse)
- Female
- Comorbid psychiatric disorder (in particular depression)

HISTORY

Excessive stress, anxiety or worry lately? If so:

- Symptoms experienced (see list below), onset, triggers (environment, situation, stimulus), duration, severity
- Associated avoidance behaviour
- Dysfunction (interference with ability to function at work/school, home, family life, socially)
- Life events (for example, major life changes, stressors) or trauma that may correlate temporally with onset
- Techniques and strategies to alleviate anxiety (including chemical substances used or abused)
- Rule in or out the specific type of anxiety disorder by asking clients whether their symptoms fit the definitions above

Symptoms can be in one or more of three clusters: emotional, physiologic, and cognitive.

Emotional

- Sense of doom
- Apprehension
- Fearfulness
- Worry (about others, future)
- Panic
- Helplessness
- Emotional blunting
- Irritable

Physiologic

- General: insomnia (often difficulty falling asleep) fatigue, weight loss
- Central nervous system (CNS): tremor, muscle aches/tension, headaches, dizziness, light-headedness, parasthesias, memory loss, restlessness
- Autonomic: sweating, dry mouth, increased heart rate, flushing, chills, trembling/shaking
- Gastrointestinal: nausea, diarrhea, anorexia, choking
- Cardiorespiratory: shortness of breath, hyperventilation, chest pain, palpitations
- Recurrent unwanted behaviours (for example, repetitive hand-washing, compulsive double-checking)

Cognitive

- Poor concentration
- Poor memory
- Recurrent intrusive thoughts or images
- Recurrent mental acts

Other History

- Review of systems
- Review use of caffeine, any other stimulants, alcohol, any recreational drug
- Review current medications, any over-the-counter (OTC) or herbal drugs
- Review for symptoms consistent with underlying medical illnesses (for example, thyroid disease, asthma, congestive heart failure)
- Review for symptoms consistent with another psychiatric illness (for example, depression, bipolar, substance abuse)
- Obtain a history from as many sources as possible (for example, partner, teacher, co-workers), as symptoms often differ between those interviewed, and symptoms may be more prevalent in some situations than others

PHYSICAL EXAMINATION

A full physical exam should be completed as well, including:

- Cardiorespiratory exam
- Thyroid exam
- Other exams as indicated by history and/or symptoms

DIFFERENTIAL DIAGNOSIS

- *Anxiety disorders*: generalized anxiety disorder, panic disorder with or without agoraphobia, social anxiety disorder, specific phobia, obsessive-compulsive disorder, post-traumatic stress disorder
- *Other psychiatric disorders*: depression, somatization, hypochondrias, personality disorders, victim of abuse (physical, sexual, or emotional), psychosis, dementia, adjustment disorder
- *Medical disorder*: endocrine (for example, hyperthyroidism, hypoglycemia, Cushing's disease), cardiorespiratory (for example, congestive heart failure [CHF], cardiac arrhythmia, mitral valve prolapse, angina, chronic obstructive pulmonary disease [COPD], asthma, pulmonary embolism), neurologic (for example, vestibular dysfunction, migraine, neoplasm, early dementia)
- *Substance use or withdrawal*: especially caffeine, nicotine, alcohol, cannabis, cocaine, amphetamines
- *Secondary to medication use*: for example, first 2 weeks of selective serotonin reuptake inhibitors

COMPLICATIONS

- Inability to perform activities of daily living
- Social phobias
- Substance abuse
- Depression
- Suicide (particularly in panic disorder)

DIAGNOSTIC TESTS

- Complete blood count
- Electrocardiography (ECG)
- Thyroid-stimulating hormone (TSH)
- Other tests may be required to rule out other conditions that may mimic an anxiety disorder

MANAGEMENT

Depending on the type of anxiety disorder, definitive treatment may involve psychotherapy, desensitization therapy and/or medications.

Goals of Treatment

- Decrease or stop anxiety symptoms
- Decrease or stop related disability
- Prevent recurrence
- Treat comorbidities

Appropriate Consultation

Consult physician:

- If there are any safety concerns
- If comorbid medical or psychological problem is suspected, since management will need to be tailored for the diagnosis
- If symptoms are so intense as to interfere with normal function, in which case a short course of a benzodiazepine (minor tranquilizer) may be indicated

Nonpharmacologic Interventions

Whatever treatments available, clients must be willing and motivated to try the treatment(s) they choose.

- Educate about disorder, potential treatments, general prognosis, individual aggravating and alleviating factors, and signs of and methods to cope with relapse
- Encourage the client to face their fear(s) gradually, improve relationships (if social anxiety), and/or expose themselves to situations or physical symptoms that make them anxious
- Have the client reduce the use of stimulants, especially caffeine and alcohol
- Review techniques to promote decreased anxiety:
 - breathing exercises (for example, deep breathing)
 - meditation and/or mindfulness
 - progressive muscle relaxation
 - aerobic exercise
 - time management skills
 - problem-solving skills (for example, describe the problem, generate solutions, select and plan for most reasonable approach, monitor and assess results, revise approach if needed)
 - sleep hygiene
- Counsel client about appropriate use of medications, if prescribed (dose, frequency, side effects, length of treatment is often 12–24 months)
- Encourage to participate in support group for emotional support and practical advice, if available

- Provide educational and self-help resources:
 - Books
 - *Clinical practice guidelines: Management of Anxiety Disorders* (available at: <http://publications.cpa-apc.org/browse/documents/213>) lists a number of self-help books for most anxiety disorders
 - Client handouts
 - *Here to Help British Columbia* (available at: <http://www.heretohelp.bc.ca/understand/depression-anxiety>)
 - Web sites
 - Canadian Mental Health Association (available at: http://www.cmha.ca/bins/content_page.asp?cid=3-94)
 - Canadian Network for Mood and Anxiety Treatment (available at: <http://www.canmat.org/di-anxiety.php>)
 - Here to Help British Columbia (available at: <http://www.heretohelp.bc.ca/skills/managing-anxiety>)
 - Anxiety Treatment and Research Centre (available at: <http://www.heretohelp.bc.ca/skills/managing-anxiety>)
 - Anxiety Disorders Association of Canada (available at: <http://www.anxietycanada.ca>)

Cognitive behavioural therapy, done by a trained therapist or specialist, can be very effective in treating anxiety disorders. It can include education, skills training (for example, problem-solving, social skills, monitoring emotions), exposure therapy, cognitive restructuring, and relapse prevention. Psychotherapy is often not available, but video conferencing may be available in your community to provide this intervention. The therapy helps clients recognize when they are anxious and encourages them to practice problem-solving strategies. Referral to a therapist or specialist should be done in consultation with a physician.

Pharmacologic Interventions

Consult a physician regarding medication use in acute/severe situations. Short-term use of lorazepam (Ativan) is a common approach, but it does not resolve the cause of the anxiety.

lorazepam (Ativan), 0.5–1 mg PO bid to tid prn

Benzodiazepines, SSRIs, SNRIs, anticonvulsants, and occasionally atypical antipsychotics may each have a role, depending on the type of anxiety.

Monitoring and Follow-Up

- Follow up weekly until the client sees a physician; otherwise follow up every 3 months
- Support and education about the illness process for the client as well as for the family are critical
- If medication is started, follow up at 1 week, then every 2 weeks for 6 weeks, then monthly to assess degree of anxiety (use visual analogue 1–10 scale), suicidal ideation, weight, tolerance of medication, adherence, and adverse effects of medication; if no improvement within 12 weeks, consult with a physician

Referral

Medevac urgently if there is profound disturbance, if there are safety issues or if the client needs more definitive treatment urgently. The decision whether to treat the client on an outpatient basis or admit and/or evacuate the client to a hospital (voluntarily or involuntarily) depends on several factors. This decision must be made in consultation with a physician and/or psychiatrist. For further considerations, see “Hospitalization and Client Evacuation” and “Involuntary Admission” sections above.

Arrange follow-up with a physician at next available visit for all but very severe cases.

DEMENTIA AND MILD COGNITIVE IMPAIRMENT^{20,21,22,23,24,25,26,27,28}

A range of disorders with a measurable deficit in cognition in at least one area (for example, memory, aphasia, apraxia, agnosia, executive function) from previous levels of function. It includes mild cognitive impairment and dementia.

Mild cognitive impairment (MCI): at least area of cognitive deficit, but no impairment in activities of daily living. Clients do not have dementia, but are likely at an increased risk for dementia.

There are many different kinds of MCI. Amnesic MCI has memory impairment for age and education (objective and subjective complaint). These individuals are more likely to progress to Alzheimer disease and/or vascular dementia. Non-amnesic MCI has impairment in one area of cognitive functioning other than memory.

Dementia: syndrome of progressive impairment of memory and at least one other area of cognitive function (for example, aphasia, apraxia, agnosia, executive function) compared to previous levels of function. It is sufficient to interfere with normal activities (for example, work, relationships) and independence. It may be due to an underlying reversible or irreversible process, but other diagnoses (for example, delirium, psychiatric concern, brain or systemic disease) are not better explanations.

TYPES OF DEMENTIA²⁹

Alzheimer disease (60–80% of cases) progresses gradually with memory loss about recent events. Other cognitive deficits may be present, but language and visuospatial abilities are usually affected early. Executive function problems, apraxia, and behaviour changes occur later in the disease.

Vascular dementia (10–20% of cases) has early executive dysfunction, but little memory impairment early on. Symptoms start abruptly and usually have a stepwise decline. Physical examination may demonstrate prior stroke(s).

Mixed dementia is a combination of Alzheimer disease and vascular dementia.

Frontotemporal dementia usually presents at a younger age (less than 75) with early behaviour and personality changes, and nonfluent aphasia.

Dementia with Lewy bodies progresses gradually with fluctuating cognitive function, persistent visual hallucinations, and parkinsonian motor activity.

Parkinson's disease dementia is a common feature of Parkinson's disease (PD); presents after the development of other neurologic manifestations of PD while Lewy Body dementia develops before motor manifestations of parkinsonism.

Alcohol-related dementia, including Korsakoff's syndrome.

Normal pressure hydrocephalus with the triad of dementia, urinary incontinence and gait disturbance.

CAUSES²⁹

- Senile plaques and neurofibrillary tangles (Alzheimer disease)
- Cerebrovascular accident
- Parkinson's disease
- Central nervous system causes such as tertiary syphilis or subdural hematoma)
- Nutritional deficiency (for example, Vitamin B₁₂ and thiamine deficiency)
- Chronic alcoholism as a cause of Korsakoff's dementia or nonspecific cognitive dysfunction

Risk Factors³⁰

- Older age
- Family history of dementia
- MCI (for dementia)
- History of head trauma with a loss of consciousness
- Lower educational level
- Lifestyle factors (for example, poor social networks, nonphysical activity, low mental activity)
- History of depression
- *Alzheimer disease* risk factors include female sex and family history
- *Vascular dementia* risk factors include cerebrovascular disease, dyslipidemia, diabetes, and chronic kidney disease

HISTORY

Elicit the history from the client, but it is just as important to elicit corroborating information from a caregiver, friend, or the family (informant).

- Client may present complaining of memory problems (recent and remote)
- Client is often troubled about their symptoms (in the case of MCI)
- More often, a caregiver or family member accompanies the client, having noticed the client's difficulties with tasks that previously were not a problem (cognitive or behavioural changes, for example, self-care, home care, shopping, finances)
- Discuss a variety of current events, premorbid and current financial abilities to develop a sense of the impairment
- Client reports difficulty with any one or more of:
 - Learning and remembering new things
 - Doing complex tasks (for example, driving, balancing a cheque book)
 - Reasoning (for example, not able to deal with unexpected events)

- Spatial ability and orientation (for example, gets lost)
- Language (for example, unable to find words)
- Behaviour
 - May present with concerns of inappropriate or bizarre behaviour, because of delusions and hallucinations
 - May present with mood and behavioural symptoms, including depression, anxiety, irritability, aggression, apathy, agitation, wandering, falls, sleep deficits, sexually inappropriate behaviour, delusions (MCI clients with these symptoms are more at risk of progressing to dementia). Take a careful history of events prior to the mood or behaviour occurring; also ensure the caregiver is asked about all these behaviours as they may not mention them
- Determine onset of symptoms and temporal course
- Record symptoms noted, objective behaviours observed
- Elicit degree of disturbance and dysfunction in activities of daily living and instrumental activities of daily living (ask about specifics, such as shopping, driving, self-care, handling of money, work performance or hobbies, as applicable; also inquire about ability to learn a new task). Document the findings to determine if there has been any progression at follow-up visits

DISTINGUISHING DELIRIUM FROM DEPRESSION

The chronic cognitive dysfunction associated with dementia and MCI should be differentiated from the acute and fluctuating level of consciousness associated with delirium. Although dementia puts patients at higher risk for delirium, that is, the two are often associated; delirium may also result from a number of other underlying medical conditions. Delirium is, by definition, a reversible deficit of attention. It is recognized on history by fluctuating agitation or psychomotor slowing over a period of hours to days. Tools such as the “digit span” (recalling a series of digits, starting with 2, and increasing the length of the series, until unable to recall a series on two attempts) can be helpful in testing attention in patients in whom delirium is suspected. Delirious patients should not undergo further cognitive testing until their acute condition has resolved.

SYMPTOMS ASSOCIATED WITH UNDERLYING MEDICAL DISORDERS

In order to help rule out an underlying medical condition, ask about the following:

- Constitutional: fevers, sweats, weight loss, fatigue
- Sensory: vision, hearing changes
- Neurologic: new headache (*see “Headaches: General Principles” in chapter 8, “Central Nervous System”*), tremor at rest, ataxia, dizziness, seizure (*see “Seizure Disorder (Chronic)” in chapter 8, “Central Nervous System”*), focal deficits, transient ischemic attack (TIA) (*see “Transient Ischemic Attack” in chapter 8, “Central Nervous System”*)
- Endocrine: symptoms of thyroid problems (hypothyroidism, hyperthyroidism), diabetes mellitus (*see “Hypothyroidism”, “Hyperthyroidism” and “Diabetes Mellitus” in chapter 10, “Hematology, Metabolism and Endocrinology”*), hypercalcemia
- Cardiopulmonary (*see chapter 4, “Cardiovascular System”*): shortness of breath (*see chapter 3, “Respiratory System”*), cough, chest pain, sleep apnea, palpitations
- Gastrointestinal (*see chapter 5, “Gastrointestinal System”*) and genitourinary (*see chapter 6, “Genitourinary System”*) symptoms: as deemed necessary (it is important to inquire about incontinence)
- Pain
- Delirium may be the presenting symptom of an underlying medical disorder

MEDICAL HISTORY

- Past medical history, including thorough psychiatric history
- Prescription, OTC or otherwise acquired drug or remedy, looking for drugs that impair cognition (for example, analgesics, anticholinergics, psychotropic drugs, sedative-hypnotics, steroids)
- Substance use and/or abuse

CLINICAL ASSESSMENT

- Orientation
- Assess for mood, hopelessness, apathy, vegetative symptoms of depression
- Inquire about suicidal ideation
- Assess for psychotic symptoms (for example, thought disorder, delusions, hallucinations)

- Assess for psychosocial stressors (for example, losses, abuse or neglect)
- Observe speech (word-finding difficulty), affect, mannerisms, grooming, psychomotor skills

MENTAL STATUS EXAMINATION

- A widely used tool is Folstein’s Mini Mental Status Examination (available at: http://www.bcguidelines.ca/pdf/cognitive_appendix_c.pdf). A score of less than 24 out of 30 would require further assessment of the cognitive status
- If the Mini Mental Status Examination is normal and dementia is suspected, further screening can be done by administering the Montreal Cognitive Assessment (available at: <http://www.mocatest.org>)
- Look for correlation between history and mental status examination; education level, intelligence, depression, delirium, age, culture, motor and visual impairments, and language can all affect the results of the above tests; additionally, mild dementias will not likely be identified with these tests
- Assessing judgment, by asking the person to interpret hypothetical situations (for example, waking to find the house on fire) is also helpful

PHYSICAL EXAMINATION

The physical exam is directed by the differential diagnosis, as generated by the history. A full physical exam should be completed and must include the following:

- Vital signs
- Hearing and vision assessments (including extraocular movements, fundi) (*see chapter 2, “Ears, Nose, Throat, and Mouth”*)
- Cardiovascular (*see chapter 4 “Cardiovascular System”*) and pulmonary (*see chapter 3 “Respiratory System”*) exam (for example, carotid bruits, evidence of atherosclerotic disease)
- Full neurologic exam (*see chapter 8 “Central Nervous System”*), looking for signs of parkinsonism (cogwheel rigidity, shuffling gait, fixed facial expression, resting “pill-rolling” tremor, soft voice) and stroke (motor or gait deficits, sensory deficits, cranial nerve deficits, aphasia/difficulty speaking)

DIFFERENTIAL DIAGNOSIS

- Delirium (acute and fluctuating, caused by infections, electrolyte disturbances, surgery, endocrine disturbances, cardiac ischemia, medications and constipation)

- Psychiatric disease (for example, bipolar disorder and depression)
- Substance use and abuse
- Metabolic disturbance (for example, B₁₂ deficiency [extremely rare], hypothyroidism)
- Neurologic disease (for example, brain tumour, Parkinson’s disease, cerebrovascular disease)
- Other psychiatric disorders: psychotic, amnestic or dissociative

Delirium, dementia and depression can be difficult to distinguish from each other. Depression in the elderly is often confused with dementia because of the accompanying apathy and associated cognitive difficulties.

DIAGNOSTIC TESTS

Unless an underlying cause is obvious, blood should be drawn for the following tests to rule out potentially reversible conditions:

- Complete blood count
- Electrolytes
- Albumin
- Calcium
- TSH
- Fasting blood glucose
- Vitamin B₁₂
- Creatinine
- Serum folic acid or red blood cell folate
- Consider urinalysis, urine for culture and sensitivity
- Consider serum alcohol level, urine toxicology screen

Other investigations will be driven by the history and presentation.

MANAGEMENT^{31,32,33}

Management is ultimately driven by the diagnosis. Ensure medical conditions (for example, delirium) are diagnosed and treated. All clients should be screened and treated (by a physician) for vascular risk factors (for example, hypertension, diabetes).³⁴

Goals of Treatment

- Identify and correct reversible causes
- Ensure safety of the client
- Treat cognitive, behavioural and psychological symptoms
- Optimize functioning and quality of life
- Decrease caregiver burden

Appropriate Consultation

Consult a physician if client is in acute distress, if there are unexplained new neurologic symptoms or focal deficits, upon the initial suspicion that client has dementia, if there is acute onset of cognitive impairment, if there are rapidly progressing symptoms (neurologic or cognitive), or if there are risk factors for serious intracranial pathology (for example, anticoagulant medication, history of trauma, previous cancer).

Nonpharmacologic Interventions

- Educate client and caregivers about safety measures and what to do should there be acute behaviour changes. Determine whether the client can safely remain at home. Encourage measures to ensure safety, and aid the client in optimal functioning and independence
- Educate caregivers about environmental interventions for behavioural disturbances (for example, redirection, distraction, providing structure, avoiding confrontation, reminiscing, avoiding stimulants and preceding events for the behaviour) after ruling out physical or environmental causes
- The Registered Nurses Association of Ontario's best practice guideline titled *Caregiving Strategies for Older Adults with Delirium, Dementia and Depression* (available at: http://www.rnao.org/Storage/69/6404_FINAL_-_Caregiving_-_BPG+_Supplement.pdf), revised 2010, provides a valuable resource for education
- Educate and mobilize community resources such as home care, friendly visitors, and/or long-term care placement, as required
- If client is incapable, discuss treatment decisions with substitute decision-makers and/or Power of Attorney; if client is capable, encourage them to appoint a Power of Attorney and develop a will
- Educate and support caregivers and family about managing their own stress (for example, refer to a support group or respite care, if available)
- Educate clients and caregivers about dementia, its stages and how to focus on the client's abilities

If agitation or behavioural issues are the concern, manage according to guidelines under “*Violence or Aggressive Behaviour in Mental Health Clients*” below.

Other resources for clients and caregivers include:

- *Dementia Guide* (available at: <http://www.dementiaguide.com/>)
- Alzheimer Society of Canada (1-800-616-8816) (available at: <http://www.alzheimer.ca/>)
- Veteran's Affairs Canada (available at: <http://www.veterans.gc.ca/eng/health/dementia>)
- Canadian Virtual Hospice (for later in the course of dementia) (available at: http://www.virtualhospice.ca/en_US/Main+Site+Navigation/Home.aspx)

Pharmacologic Interventions

If at all possible, do not medicate. In particular, avoid sedation and antipsychotics (for example, haloperidol), as it may cause falls, worsen symptoms of impairment, and/or cause severe deterioration/death in those with dementia.

Refer to a physician for pharmacologic treatment options:

- Dementia (for example, cholinesterase inhibitor and/or memantine)
- Symptomatic treatment for disturbing behaviours (such as hallucinations and depression) that cannot be controlled by nonpharmacologic measures
- Treatment of vascular and dementia risk factors

Monitoring and Follow-Up

Follow up regularly (for example, monthly or more often as necessary), preferably on a home visit, to enable you to assess client functioning, behaviour, and cognition in his or her own environment. Regularly monitor response to treatment and manage any new symptoms.

Arrange for all clients with non-urgent symptoms of MCI or dementia to see a physician at the next available visit. Further diagnostic testing and/or referral may be warranted.

After a diagnosis of MCI or for those with persistent cognitive concerns, ensure reassessment (cognitive and functional) by a physician in 1 year.

Referral

Medevac may be necessary for clients with potential underlying organic pathology or if the risk-safety assessment requires that the client be admitted to hospital. The decision whether to treat the client on an outpatient basis or admit and/or evacuate the client

to a hospital (voluntarily or involuntarily) depends on several factors. This decision must be made in consultation with a physician and/or psychiatrist. For further considerations, *see* “Hospitalization and Client Evacuation” and “Involuntary Admission.”

Refer clients and caregivers to occupational therapy, if available, for assistance with using aids to daily living and to help develop coping behaviours.

FAMILY VIOLENCE^{35,36,37,38,39,40,41,42,43,44,45,46,47,48,49}

“Abuse of power to harm or control a person who was or is a family member.”⁵⁰ It includes actual or threatened physical (for example, hitting, stalking), verbal (for example, threatening, coercing, harassing), emotional, financial, and spiritual abuse, social isolation, sexual assault, and neglect. It affects the physical and mental health of the victims. Often violence is toward a female from a male family member, but anyone can be victimized (including children who witness abuse). Partners, whether married (or not), and/or living together (or not), are still considered family members.

TYPES OF VIOLENCE⁵¹

Physical Abuse

An act that results in, or can result in, physical injury. Such acts include inflicting blows that cause bruising, striking with a hand or instrument, kicking, biting, burning, beating, throwing, rough handling, assaulting, using physical restraints, confining, shaking, and threatening to cause harm. Bruising is the most common form of physical injury reported due to spousal violence.⁵²

Emotional or Psychosocial Abuse

Repeated verbal or nonverbal attacks or omissions that affect, or could affect dignity, self-esteem, confidence, and self-worth. Such acts or omissions may include rejecting, criticizing, isolating, confining, intimidating, blaming, terrorizing, ignoring, corrupting, excessive pressuring, or verbally abusing or assaulting (for example, threats, humiliation, ridicule, insults) are categories of emotional/psychosocial abuse when the behaviours are repeated. This form of abuse can include spiritual abuse. Examples of emotional/psychosocial abuse include locking someone in a closet, preventing an older adult from attending church, threatening to leave the relationship,

controlling what another person does and who they see, damaging the other person’s belongings, or yelling at another person. Put-downs and name-calling are the most common form of emotional abuse reported due to spousal violence.⁵³

Neglect

A non-deliberate failure to provide for basic physical, emotional, developmental, psychological, medical, and educational needs that results in, or may result in, harm to a person who cannot fully look after themselves. This can include noncompliance with health care recommendations, withholding medical care, inadequate personal care, inadequate supervision, inadequate protection from environmental hazards, abandonment, withholding love or affection, lack of nurturing, and inadequate hygiene.

Financial Abuse

Acts involving an individual’s money or property when that person does not know about it and/or does not consent to it. It includes withholding all finances, fraud, theft of money or belongings, misuse of funds, withholding means for daily living (including food, medications, and shelter and preventing one from working), and a misuse of power of attorney.

Other

Information about sexual abuse is presented in the “Sexual Assault” section below.

Information about child maltreatment and child sexual abuse is presented in chapter 5, “Child Maltreatment” of the pediatric guidelines.

Risk Factors

- Pregnancy or postpartum (often begins or increases
- > 80 years old
- Frail older adult
- Female (increased in those < 35 years old, single, divorced, separated, smokers, low socioeconomic status, substance abuse by themselves or partner)
- History of childhood physical and sexual abuse
- Males < 35 years old and in common-law relationship⁵⁴

SITUATIONS IN WHICH TO SUSPECT FAMILY VIOLENCE

Maintain a high index of suspicion. Individuals are often reluctant to report abuse.

The following presentations raise suspicion of abuse:⁵⁵

- There is a delay in seeking medical attention for an injury
 - physical findings are not consistent with the history (for example, client makes excuses for abuser's behaviour, client may become aggressive and angry if confronted)
 - presents with chronic somatic concerns (for example, abdominal pain, chest pain, headache, insomnia, fatigue, and backache)
 - client reports anxiety attacks or depression
 - client reports stiff neck or shoulder muscles (due to violent shaking), which mimic the symptoms of whiplash
 - client reports marital problems, especially if reference is made to fighting, arguing, jealousy, impulsiveness or drinking
 - repeated suicidal gestures or attempts
- Noncompliance with appointments or therapeutic interventions or unresponsiveness to treatment
- Frequent visits to the health care facility, often for specific concerns
- Unusual client actions during history or physical examination (for example, secretive, sad, withdrawn, fearful, evasive, hostile, flat affect, uncontrollable crying)
- Increasing use of drugs or alcohol to cope
- Injuries on central part of body (chest, abdomen and genitalia), head and neck (possibly related to attempted strangulation), forearms (related to self defense), bruises of different stages
- Client's partner answers questions for client, is overly concerned about client's health, refuses to leave examination room, suggests that he/she is the victim, exaggerates or lies to make self look good or as the victim

CLIENT-PERCEIVED BARRIERS TO REPORTING OR DISCLOSING ABUSE⁵⁶

- Fear perpetrator will be arrested
- Hope/belief that things will change
- Fear of what the perpetrator might do if they find out about disclosure (for example, more abuse, abandon or institutionalize an older adult)
- Blame self for circumstances

- Feel like a failure, embarrassed or ashamed if admits abuse (stigmatization)
- Victim has no proof of abuse
- Fear of rejection by care provider (for example, nurse)
- Belief that there is no alternative and/or no one can help
- Ill or frail health (dependence on perpetrator)
- Communication difficulties
- Children are involved
- Isolation

HISTORY⁵⁷

The evidence is unclear whether routinely screening all clients for domestic violence is effective to prevent abuse.⁵⁸ However, the Registered Nurses Association of Ontario Best Practice Guideline on woman abuse⁵⁹ and most victims of abuse support routine verbal screening. It significantly improves detection rates of exposure to violence and can allow the nurse to assist individuals that are potentially or actually being abused.

Consider verbally screening for family violence as part of a medical or psychological assessment when:

- Findings in the history and/or physical examination may indicate family violence (for example, bruising, traumatic injury, appointments cancelled on short notice, improbable injury)
- A female is pregnant
- Presentation is after regular clinic hours
- Females have chronic abdominal or chest pain, headaches, and/or sexually transmitted infections
- Older adults dependent on a caregiver or presenting with injuries
- Initial clinic visit for new clients
- Well-child visit (ask for safety of all family members)
- Annual preventative care visits for females > 12 years of age

Interview and examine the client by herself or himself (unless accompanied by children under 3 only). The client will not feel free to talk or feel safe if the abuser is nearby. Allow the client to talk at their own pace and to openly state his/her feelings. Ask why they feel that way. Ask non-leading, non-judgmental and open-ended questions. Do not pressure. This may be the only chance the client has to disclose. Members of the family, boarding home staff or other caregivers should be interviewed separately.

Assure confidentiality, but educate about the limits of confidentiality in the presence of suspected abuse and that the encounter will be documented in his/her medical file.

Some screening tools have been developed for domestic violence, but none of the tools have well-established sensitivities and specificities.⁶⁰

While taking the history, look for and document:

- Inconsistencies or discrepancies in the history (for example, no history on mechanism of injury, partial history, history changes, difference between older adult and caregiver)
- History incompatible with the presenting problem/injury
- New or old injury with inadequate, evolving, or no explanation
- Delays in seeking medical attention after an injury
- Past record of repeated or unusual injuries
- Element of neglect or inappropriate supervision (for older adults)
- Unrealistic caregiver expectations of older adult
- Client avoiding questions
- Client reporting self-inflicted injury
- Indicators of family violence as detailed below

A complete family violence history includes the following information:

- Name(s), telephone number(s) and address(es) of the person(s) responsible, including the name(s), address(es), relationship to the victim, known facts (for example, intravenous drug use, physical description, substance use or abuse) of the alleged offender(s)
- Dates, times and location of incidents
- Exact mechanism and circumstance of injury and/or the experience
- Physical injury to victim, including pain and bruising
- Names of witnesses, including children, who saw injury occur and/or was with the client at the time
- Location of other people (including children) when it happened
- Health status until the injury happened
- What was done immediately after the injury; was medical care sought
- History of abuse by the same or another perpetrator
- How often abuse has happened
- Prior trauma or medical procedures in affected area

- History of abuse or child protection agency involvement with children
- Past medical history, including medications and immunizations
- Family history of conditions that account for easy bruising or bone fragility (for example, von Willebrand disease) or that are relevant to abuse
- Current living situation, who lives there, family composition and function, significant personal relationships, primary caregiver (if applicable)
- Observations of emotional abuse, neglect, or financial abuse
- Changes in eating, sleeping, or behavioural patterns
- Anger, fear, concern, rage, suicidal ideation or attempts, depression, anxiety
- Substance abuse
- Feelings of safety in the relationship with family member(s)
- How client feels about experience/situation
- If friends or family are aware that the client has been hurt; if she/he would tell them; if they would provide support to the client
- If the client has a safe place to go and what they might need in an emergency
- Assess for immediate health needs (for example, laceration, sexual assault)
- For older adults, whether the abuse or neglect reflects inadequate preparation or unrealistic expectations on the part of the caregivers
- For older adults, the attitude of the caregivers toward caregiving, control of the client's activities, extent of outside contacts, and the physical and emotional well-being of their charge

PHYSICAL EXAMINATION

- Objectively report what is observed to the client (for example, start statement with “I”), so client can offer additional information if they choose to; document it objectively as well
- Complete a full physical examination, including vital signs, height and weight; in particular, focus on integumentary, head, ears, eyes, nose, throat and abdominal examination; look for indicators of family violence as detailed below
- Note all injuries (including those on genitalia) on body map diagrams and with colour photographs if possible (for example, welts, burn marks)
- Note signs of neglect (for example, BMI, cleanliness of clothing, hydration of mucous membranes)
- Note signs of old, untreated injuries

- Note the client's behaviour, emotional responses and attitudes toward the caregivers
- Note ability to care for self (for example, activities of daily living and instrumental activities of daily living) and to protect self from danger by making and implementing decisions that consider the circumstances
- Assess mental competence and refer to territorial or provincial mental health legislation to determine possible courses of action (for example, power of attorney or by legal appointment of a legal guardian) if not competent
- Mental status examination for older adults; if cognitive impairment exists, the person may not provide a reliable history, so other information sources should be sought (for example, family, clergy, neighbours)
- Spit or urinated on
- Threatened to be killed or injured
- Pressured into alcohol or drug use
- Frequently misses work, school, or social events with no explanation
- Dresses in clothing that will hide bruises or scars (for example, sunglasses, long sleeves in summer)

INDICATORS OF FAMILY VIOLENCE⁶¹

Physical Abuse

- Bruises, welts, skin tears, and other lesions for which adequate explanation is lacking and/or in unusual or recognizable patterns and/or areas not usually injured; note that the colour of bruises does not accurately reflect age or onset of injury
- Sores, ulcerations, and other similar lesions that do not heal
- Serious bleeding injuries, especially to the head and face; in the case of sexual assault, there may be vaginal or anal tearing that requires stitching
- Internal injuries, concussion, perforated eardrums, damaged spleen or kidney, abdominal injuries, punctured lungs, severe bruising, eye injuries and strangulation marks on the neck
- Burns from cigarettes, hot appliances, scalding liquids, or acid
- Broken or cracked jaw, arm, pelvis, rib, collar bone or leg (or dislocations); in older adult, spiral fracture of long bones, or fractures at sites other than wrist, hip, or vertebrae
- Injuries in various stages of healing
- Dental injuries (for example, fractured teeth)
- Significant delay in getting treatment
- Scalp wounds or hair loss
- Afraid of caregivers
- Sudden change in behaviour
- Reports of unwanted physical contact (including things being thrown and/or being restrained against wishes)
- Force fed or denied food and drink
- Denial of any problems in relation to caregivers and/or overprotectiveness of caregivers
- Emotional and/or social withdrawal and passivity or lethargy; resignation to current life situation; major personality changes
- Fear and anxiety (for example, related to abandonment, authorities, or trying to please partner)
- Unusual ease in settling into a medical setting (relief from abusive situation)
- Absence of expectations of being comforted or receiving affection
- Low self-esteem
- Acts nervous around or fearful of caregiver and/or avoids eye contact
- Emotional disturbances (for example, suicidal ideation, depression, upset or agitated)
- Confusion
- Forced to do illegal activities
- States partner has a bad temper, is jealous or possessive
- Forced to drop charges
- Reports of frequent needs to account for time, activities and who talked to (for example, calls partner often)
- Social isolation
- Partner not allowing or forcing to use contraception
- Forced to have abortion
- No support from partner during pregnancy or birth
- Partner insistence to accompany client into clinic room
- Uses religion to justify abuse or situation
- Not able to attend church
- Destruction of client's property
- Unusual behaviours (for example, sucking, biting, rocking)

Neglect

- Malnutrition and dehydration when mental alertness enables expression of needs but immobility prevents independently meeting those needs
- Oversedation or withholding of prescribed drugs
- Failure to keep or make medical appointments for needed care (because no one will take the person to the appointment) resulting in untreated medical problems
- Missing dentures, glasses or hearing aids
- Poor hygiene
- Injuries due to lack of supervision (for example, pressure sores)
- Unsafe living conditions (for example, no heat, soiled bedding)
- Alcohol or medication abuse
- Unsupervised wandering
- Self-neglect (for an older adult)
- Abandoning a person that is in your care

Financial Abuse

- Abuser takes/withholds money and/or forges name
- Limited access to money or credit cards
- Unpaid bills when previously able to pay them
- Unexplained missing money or property (for example, unusual bank withdrawals)
- Transfer of property when person does not have the capacity to consent
- Living without affordable necessities for living
- Sudden changes to a will or bank account
- Inaccurate knowledge about financial situation

DIFFERENTIAL DIAGNOSIS

There are many potential differential diagnoses, including:

- Accidental injury (for example, fall, motor vehicle collision, bicycle accident, animal bite)
- Dermatologic condition (for example, contact dermatitis)
- Infection or sepsis
- Hematologic disorders
- Depression
- Anxiety disorder
- Self-neglect

COMPLICATIONS

- Economic dependence on abuser (due to abuser's control)
- Social isolation
- Psychological consequences (for example, anxiety, depression, low self-esteem, somatization, substance abuse, post-traumatic stress disorder, personality disorder, suicidal ideation)
- Repeated injuries (for example, trauma, lacerations, fractures, falls)
- Sexual health concerns (for example, sexually transmitted infections, unwanted pregnancy, infertility)
- Poor health (for example, difficulty walking, completing daily activities, memory loss, untreated medical conditions, poor nutrition, pressure ulcers)
- Death (suicide, murder, HIV, childbirth related)
- Pregnancy complications and poor outcomes, including cesarean section, hospitalization due to premature labor, low birth weight baby
- Increased risk of child abuse
- Self-neglect (in older adults)
- Short and long term effects (emotional, social, cognitive) on children who witness violence
- Loss of independence and required support

MANAGEMENT**Appropriate Consultation**

Consult a physician or nurse practitioner if the injuries require it (for example, need a medevac) and/or if referral to services is required.

Nonpharmacologic Interventions⁶²**If the client does not disclose abuse:**

- Respect their decision
- State your observations and why you are concerned for their health and safety, if you suspect abuse
- Educate about prevalence and negative effects of abuse
- Discuss services available for those experiencing family violence, if you suspect abuse
- Document the client's responses and your interventions (*see "Documenting Family Violence" section below*)

If the client discloses abuse:

- Do not minimize problems (for example, tell client he/she is experiencing abuse, you are concerned for his/her safety (and children if applicable), that violence is not his/her fault); ask how you, the care provider, can help them
 - Avoid “putting down” the abuser
- Do not discuss possible mechanisms of injury with the client. State simply that the injuries are a result of trauma. A suggestion can negatively influence the outcome or process of investigation
- If verbal abuse occurs in clinic, state that the behaviour is not acceptable
- Discuss and encourage use of client’s personal supports and resources that can be used to help deal with the situation (for example, sympathetic friends and family)
- Do not reassure the client that “everything will be fine;” educate the client about the nature and usual course of family violence and that it is a crime
- Help client to be objective (for example, how likely do you think that is) and to focus on present (for example, what could you do differently)
- Verbalize client priorities (for example, family more important than self) and that it is hard to make a change (for example, due to fear, economic dependence, no other place to go, belief that the abuse will stop and/or that the abuse is their fault)
- Encourage use of “I” messages with abuser (for example, “I feel angry when...”)
 - Assess client safety and potential for escalating behaviours (for example, afraid to go home, current and future safety requirements, increased frequency or severity of violence, threatened that will kill client or children, previous choking, availability of weapons, perpetrator knows victim plans to leave); a home visit may be required, particularly for older adults. Educate that situation may be life-threatening if weapons are available or threats have been made. Assist the person in leaving the home or the relationship if that is desired, but do not pressure the person to do so. Try to reduce anxiety and provide necessary information so that rational, informed decisions regarding life and safety can be made
- Assess danger to children in the household and whether they have witnessed violence. If concerned about child safety and/or if reporting is mandatory by law, *see “Reporting Family Violence.”* Educate about the negative effects of children witnessing abuse (for example, bedwetting, low self-esteem, dropping out of school, conflict with the law). Also encourage the client to contact their local child welfare agency
- Treat unmet medical needs (for example, depression, diabetes, reversible dementia, hypertension)
- If a child is involved, listen to the child’s feelings and discuss what they mean
- Help client develop a safety plan. It should include what to do in an emergency, where to go (for example, shelters, transition homes or the home of a sympathetic relative or friend), how to get there, and resources and documents needed for the client and children involved
- Educate about available resources (for example, police, family, shelter, job training, community support groups, financial support, justice/advocacy services) and counselling options; be cautious in giving written materials about these as it may cause more violence for the client. Support the client’s decision by referring them to and/or calling the resources agreed upon, after discussing the advantages and disadvantages of all options for their current situation
- Consult community social services to determine what form of assistance would be available and pertain to the client and/or the care providers
- Provide the client with a crisis line and/or family violence services number and/or web sites
 - The Centre for Suicide Prevention (available at: <http://www.suicideinfo.ca/csp/go.aspx?tabid=77>) maintains a list of crisis lines for all the provinces and territories
 - One service in British Columbia specifically for domestic violence is VictimLink BC (1-800-563-0808) (available at: <http://www.domesticviolencebc.ca/>)
 - Seniors Canada (available at: <http://www.seniors.gc.ca/c.4nt.2nt3col@.jsp?lang=eng&cid=161>) provides a list of resources on elder abuse by province (including telephone numbers)

Resources on family violence:

- Sheltersnet (available at: <http://www.sheltersnet.ca/en/women>) provides information and location of shelters, directed toward women
- Safety Planning for Aboriginal Women (available at: <http://www.thehealingjourney.ca/siteadmin/assets/documents/safety-plan-women.pdf>)
- A handout prepared by the British Columbia government (available at: <http://www.pssg.gov.bc.ca/victimservices/publications/docs/helphopehealing-are-you-experiencing-abuse.pdf>)
- Preventing Abuse and Neglect of Seniors (available at: http://www.legal-info-legale.nb.ca/en/index.php?page=preventing_abuse_and_neglect_of_seniors) provides information specific to New Brunswick
- Keeping Safe (available at: <http://www.keepingsafe.ca/keepingsafe/keepingsafe.html>) encourages safety in different aspects of life
- Printed resources:
 - Criminal and Family Law (available at: <http://www.onefamilylaw.ca/en/aboriginalwomen/>) is a resource for First Nations women
 - Ending Abuse in your Relationship (available at: http://www.legal-info-legale.nb.ca/en/uploads/file/pdfs/Ending_Abuse_09_EN.pdf) provides information specifically for Aboriginal women and some for those living in New Brunswick
 - Canadian Resource Centre for Victims of Crime (available at: http://www.crcvc.ca/docs/elder_abuse.pdf) is a general resource on elder abuse in Canada and provides specific suggestions to help the situation
 - Elder Abuse: The Hidden Crime; (available at: http://www.crcvc.ca/docs/elder_abuse.pdf) some of the brochure pertains only to older adults in Ontario, but most of it is general

Documenting Family Violence^{63,64,65}

Include the following information in a clear, legible, objective documentation:

- If negative abuse screening, document “no disclosure to abuse screening”
- Name and relationship of abuser
- Detailed description of the history and physical findings (both those that require medical attention and those that do not), including your observations
- Details of any explanations provided for abuse (be specific about what happened and where, time, date, and who witnessed it); document exact statements in quotations
- History of previous injuries or accidents (first incident of abuse, worst and most recent)
- Procedures performed (for example, funduscopic exam) and medical treatment provided
- Measurements, drawings and/or colour photos where appropriate
- Colour, size, shape, induration, texture, location, and level of discomfort or pain (pain scales to be used) related to lesions and bruises
- Behaviour of partner or other people accompanying client
- Safety check completed or not for both client and children
- Diagnosis (for example, domestic violence)
- Information given and referrals made with consent
- Final disposition

Do not use the words “denies” or “claims” as they are judgmental. Instead use “reports,” “chooses,” “declines,” or “client states.” Do not document conclusions or general statements.

Monitoring and Follow-Up

Provide continual, ongoing medical and emotional support. For older adults, use frequent home visits to assess their safety.

Referral

Offer to refer to an agency or individual who can discuss options with the victim. A counsellor or social worker can assist the client to increase self-esteem and provide continued support. Refer to other resources if the client is interested. Refer to a physician if the medical condition of the client warrants it.

Reporting Family Violence⁶⁶

Family violence may be classified as child abuse if a pregnant woman is affected and/or a child witnesses a parent being abused. For information on reporting family violence when a child or fetus is involved, refer to chapter 5 of the pediatric guidelines titled “*Child Maltreatment*”, under the “*Management of Child Maltreatment*” section.

Prevention

- Monthly home visits from the prenatal period through infancy (until child’s second birthday) for disadvantaged families, targeting first time mothers having one or more of the following: age less than 19 years, single parent status, and low socioeconomic status
- Have brochures available for those who suspect someone they know is being abused and advise what they can do to help. One such brochure is available from the British Columbia government (available at: <http://www.pssg.gov.bc.ca/victimservices/publications/docs/helphopehealing-someone-being-abused.pdf>)
- An Aboriginal resource for community strategies to prevent family violence is called the “*Healing Journey*” (available at: <http://www.thehealingjourney.ca/inside.asp?51>)

DOMESTIC VIOLENCE

An individual in or formerly in an intimate relationship or marriage aims to dominate and control the other individual. The repeated behaviours create fear and intimidate so that there is increasing isolation from others. The behaviours may be physical violence, psychological attacks, and/or financial abuse.

Aboriginal individuals are almost twice as likely as other Canadians to report being a victim of spousal violence, and females are more at risk of serious violence (for example, gun involvement, choking) than males. The majority of those who experience spousal violence also are victims of emotional and/or financial abuse.⁶⁷ Aboriginal women are 8 times more likely to be killed by their partner than other Canadians. Lastly, many reports show that over half and up to 90% of Aboriginal women in some communities experience domestic violence.⁶⁸ The numbers for men are slightly lower.⁶⁹

Risk Factors⁷⁰

In addition to those listed as risk factors under “*Family Violence*” above, risk factors include:

- Age under 35 for both male and female
- Blended families
- Gay, lesbian or bisexual
- Aboriginal

ELDER ABUSE^{71,72}

Behaviour of someone with an ongoing relationship of power or trust to and a duty toward (for example, caregiver in retirement home or client’s home, friend, spouse, child) an older adult (in Canada > 65 years, but some consider First Nations > 55 years old) that causes actual or potential harm (for example, physical abuse, emotional/psychosocial abuse, neglect, and/or financial abuse) to the older adult.

Older adult females are more likely to be abused by family members than males. Older adult females are most often abused by a spouse or an adult child, whereas older adult males are most often abused by an adult child. However, abuse by an acquaintance or stranger is also common in this group, yet is not accounted for in the definition of elder abuse.⁷³ The most frequent type of abuse is financial and emotional/psychosocial, followed by physical.⁷⁴

Aboriginal elders experience higher levels of abuse than other Canadian older adults.⁷⁵

Risk Factors

In addition to those listed as risk factors under “*Family Violence*” above, risk factors include:

- Inability to care for self (dependent on another person)
- Dementia
- Depression
- History of hip fracture or stroke
- History of abuse between family members
- Socially isolated
- External family stressors (for example, illness, death in family)
- Caregiver has problems (for example, mental illness, substance abuse, financial dependence on older adult, history of violence)

MANAGEMENT

In addition to the items discussed under “*Management*” for family violence, the following considerations for elder abuse should be made:

- The older adult, if judged competent, is entitled to make decisions that affect his or her life (for example, medical treatment, housing)
- Older adults may require referral to more community resources than are listed above under “*Nonpharmacologic Interventions*”. These include a home nursing program, Meals on Wheels, and home help aids to enable the elderly person to remain in his or her residence and community
- Engage social services and other members of the extended family to reduce the stress on the caregiver’s family
- Provide counselling to the abused elderly person and the caregiver individually
- If the caregiver is willing, consider referring them for treatment (for example, for depression, substance abuse)
- Consider if the situation requires an institutional placement

GANG INVOLVEMENT

Information about gang involvement is presented in chapter 19 “*Adolescent Health*” of the pediatric clinical guidelines.

MOOD DISORDERS

A disturbance of mood, usually recurrent, in which a “high” (mania) or a “low” (depression) is experienced with a greater intensity and for a longer period than usual.⁷⁶ The symptoms must cause significant distress and/or impair social, occupational or other functioning and must not be due to other physical or mental health disorders.

TYPES

- Bipolar disorder
- Depression: major depressive disorder, dysthymic disorder, seasonal affective disorder, and postpartum depression

RESOURCES FOR CLIENT EDUCATION

- Mood Disorders Society of Canada (available at: <http://www.moooddisorderscanada.ca>)
- Canadian Network of Mood and Anxiety Treatments (available at: <http://www.canmat.org>)
- Canadian Mental Health Association (available at: http://www.cmha.ca/bins/content_page.asp?cid=3-86)

CONDITIONS WITH DEPRESSED MOOD

Unhappiness, fearfulness and hopelessness can also appear in the following conditions:

- Substance-related mood disorder
- Mood disorder related to medical condition (including chronic diseases)
- Adjustment disorder with depressed mood (including pathological grieving)

NORMAL BEREAVEMENT⁷⁷

Bereavement is a reaction to losing a close relationship. Often the following are present:

- Feeling numb, in shock, intensely sad, anxious for the future and empty; having visual and auditory hallucinations of the deceased; chest tightness
- Signs and symptoms of a full depressive syndrome may be present (for example, sadness, sleep and appetite changes, agitation)
- Guilt, if present, is chiefly about things done or not done by the survivor
- The survivor may wish that he or she had died with the deceased
- Anger is a common reaction, because life goes on for others
- The survivor regards the depressed mood as normal
- The reaction may be delayed but rarely occurs later than the first 2 or 3 months after the death; periods of sadness may occur occasionally related to important events
- The bereaved person often becomes suddenly aware of his or her own mortality, which heightens any sense of insecurity
- The duration of “normal” bereavement varies considerably among different cultural and subcultural groups; abnormally long, intense, or debilitating bereavement is viewed as such by others of the same group

- Morbid preoccupation with worthlessness, prolonged and marked functional impairment, and marked psychomotor retardation suggest major depression rather than bereavement
- Members of the family can be expected to go through the grieving process at different rates, and will have certain reactions to that fact. They may be upset by each other or may attempt to protect each other from the unhappy feeling. Some members may feel guilt with regard to loving or enjoying other people or having fun while other members of the family are still grieving

Management of normal bereavement:

- Call the bereaved to offer condolences and offer an appointment to “check in”
- Describe for the bereaved the frequently observed or expected stages of bereavement: anger, despair, guilt, depression, and acceptance. Encourage maintenance of usual activity, sleep, exercise and nutrition routines
- Allow time to grieve and do not force acceptance of the death, which may take 1 or 2 years to be fully achieved. Encourage and permit the person to talk about the death and express feelings related to it
- Forewarn of the “anniversary phenomenon,” in which the loss is re-experienced 1 year later. This is a normal experience and can be used to deal with unresolved grief in a constructive way
- The belief systems of the person with respect to life after death should not be challenged, nor should the person be persuaded toward any particular belief. The person should simply be supported in his or her beliefs if they provide comfort and support
- Monitor for prolonged grief (grief lasting more than 6 months with feelings of emptiness, bitterness and mistrust) and symptoms of major depression

ADJUSTMENT DISORDER^{78,79}

- Identifiable psychosocial stressor (for example, marital, financial, diagnosis of a chronic disease or medical condition) occurred within 3 months of onset of disorder and is not normal grieving
- Maladaptive reaction consists of impairment of social or occupational functioning or symptoms in excess of the normal and expected reaction to the stressor and does not meet the criteria of another disorder
- Disturbance eventually remits after the stressor ceases (usually within 6 months)
- Does not meet criteria for major depressive disorder

MANAGEMENT

Supportive counselling, including:

- Explanation of the abnormal response to the individual, stressing its transient nature (it will resolve once the stressor is removed or the client adapts)
- Mobilization of natural supports (family, friends)
- Encouragement of a realistic sense of competency
- Mobilization of the individual’s personal resources and strengths

MOOD DISORDERS: BIPOLAR DISORDER^{80,81,82,83}

Bipolar I disorder is defined as one or more manic or mixed episodes. Almost all clients also experience depression, but it is not required for the diagnosis. Bipolar I is equally prevalent in men and women.

Bipolar II disorder is defined as one or more major depressive episodes and at least one hypomanic episode. It is more likely to begin at a younger age, is more common in women and those with a strong family history, and has a higher risk of suicide.

Bipolar spectrum disorder includes other related mood disorders, but most are not recognized by the *Diagnostic and Statistical Manual IV*.

As with all mood disorders, the symptoms must cause significant distress and/or impair social, occupational or other functioning.

The Diagnostic and Statistical Manual IV describes manic episodes as lasting at least 1 week (less if the person requires hospitalization) and include a distinct period of a persistently elevated, expansive or irritable mood and at least 3 (4 if it is irritable mood) of the following during that time. They can be remembered with the mnemonic DIGFAST:⁸⁴

- **D**istractibility (in speech or activity)
- **I**ndiscretion – excessive involvement in pleasurable activities with high likelihood of painful consequences (for example, shopping sprees, sexual indiscretions)
- **G**randiosity or inflated self-esteem (may be delusional)
- **F**light of ideas or subjective experience of racing thoughts
- **A**ctivity (goal-directed) increase or psychomotor agitation
- **S**leep – decreased need for it
- **T**alkativeness increased or pressure of speech

Mania may include psychotic features, but only if they occur during mood episodes, that are either mood congruent (for example, consistent with typical mania themes) or mood incongruent (for example, persecutory delusions).

Hypomania is defined the same as a manic episode, but the symptoms are only present for at least 4 days and it does not significantly impair functioning.

Mixed episodes are defined as the co-occurrence of a manic episode and a major depressive episode nearly every day for at least 1 week.

Rapid cycling is defined as 4 or more mood episodes in a year with full or partial remission for at least 2 months between episodes with similar symptoms or a switch from depression to mania or vice versa. This occurs in approximately 20% of those with bipolar disorder and is slightly more common in women.

Cyclothymia is defined as the alternation of hypomanic symptoms with mild depressive symptoms, often over at least 2 years; however, the symptoms do not meet the definition of manic, mixed, or major depressive episodes. Rarely are there periods without symptoms and the symptoms do not last more than 2 months at a time.

Between 1% and 2.4% of the general population has bipolar disorder, which generally starts between the ages of 14 and 24. If the disorder starts before age 19 then the individual is more likely to have significant disruptions in quality of life. Over 50% or 60% of those diagnosed with bipolar disorder have a first episode during childhood or adolescence.

The course of bipolar disorder is variable with relapses and remissions. Depressive symptoms occur more often than manic symptoms throughout the disorder.⁸⁵

Individuals with bipolar disorder often have comorbid conditions. Up to half of those with bipolar disorder also experience substance abuse, suicidal behavior, and/or anxiety disorders.

Information specific to bipolar disorder in adolescents is presented in chapter 19, “*Adolescent Health*” of the pediatric clinical guidelines.

Risk Factors

- Depression with a rapid onset, psychomotor retardation and psychotic features
- Family history of affective disorders (particularly bipolar disorder)
- History of psychomotor agitation or antidepressant-induced mania or hypomania
- Cyclothymia

HISTORY

The manic client is usually coerced into attending a health care facility by family or police officers and is often hostile, agitated, and perhaps belligerent. The client will attempt to tone down their feelings and grandiosity in order to appear normal and will rationalize or deny symptomatic behaviour. The history presented by family or others should be given considerable weight in making a diagnosis and deciding about treatment and management.

If a client suspected of having or known to have bipolar disorder is agitated, rapidly assess for the following prior to management:⁸⁶

- Risk of impulsive or dangerous behaviours toward others
- Suicide risk
- Insight into current situation
- Ability to comply with treatment

Assess a client for bipolar disorder if they present with:

- A history of or symptoms of depression, hypomania or mania
- Vague or nonspecific somatic concerns that are otherwise unexplained
- Reverse vegetative symptoms (for example, hypersomnia, hyperphagia)

Obtain the history from both the client and family or friends, if possible, as some clients believe that their hypomanic states are normal and not a concern (particularly if they are in a depression). Ask open-ended, non-leading, and general questions about mood and symptoms of depression and mania. Then ask about specific symptoms of depression and mania (for example, whether they have experienced the symptoms, and their duration in current and previous episodes).

Assess for:

- Mood lability
- Symptoms of mania and depression, including history of symptoms, duration and severity, and whether they meet diagnostic criteria for mania and/or major depressive disorder
- Degree of impairment in social and work relationships
- Sleep disturbances
- Psychotic symptoms (for example, delusions, hallucinations) and when they occur
- Impulsive or dangerous behaviours
- Prior episodes of mania, hypomania and/or depression
- Family history of mood disorders
- Suicide risk
- Substance use or abuse
- Medications (particularly antidepressants if rapid cycling)
- Medical and psychiatric history

PHYSICAL FINDINGS

Assess for the following physical and psychosocial findings. If the client is acutely agitated defer assessment until they are able to cooperate:

- General appearance (dress and grooming)
- Vital signs and weight
- Attitude and interaction (cooperative, guarded, or avoidant)
- Activity level (for example, calm, active, restless, psychomotor activity, abnormal movements)
- Speech
- Thought process (for example, coherent, disorganized, flight of ideas) and content (for example, delusions, obsessions, perceptual disorders, phobias)
- Perception, cognition, insight, and judgment
- Impulse control (for example, aggressive, hostile) and risk of harm to others
- Suicidal ideation
- Insight into condition
- Mood or affect
- Client interaction with family members or friends, if possible (for example, warm, nurturing, conflicting, rejecting, affectionate)

Rule out potential medical causes by doing a full assessment of the following:

- Neurologic system
- Cardiovascular system
- Thyroid

DIFFERENTIAL DIAGNOSIS

- Medical conditions (for example, multiple sclerosis, stroke, hyperthyroidism)
- Substance abuse
- Medications (for example, steroids, stimulants, levodopa, antidepressants)
- Psychiatric disorders (for example, schizophrenia)
- Major depression
- Personality disorders (for example, borderline, narcissistic, histrionic, antisocial)
- Anxiety disorders

COMPLICATIONS

- Cognitive impairment
- Disability (for example, unable to work); particularly for those with bipolar II
- Suicide
- Increased health care utilization
- Death

DIAGNOSTIC TESTS

A diagnosis of bipolar disorder requires initial and ongoing diagnostic tests. Consult a physician or nurse practitioner to establish the need for the following, unless the client will be starting lithium:⁸⁷

CBC, fasting serum glucose, fasting lipid profile, electrolytes, liver function tests, creatinine, BUN, calcium, serum bilirubin, PT, PTT, urinalysis, urine toxicology screen for substance use, TSH, pregnancy test (if female), prolactin, EKG (if > 40 years or if indicated).

MANAGEMENT

Goals of Treatment

- Control acute symptoms
- Prevent recurrence of mood episode
- Treat comorbid conditions
- Assist clients to accept their diagnosis, develop confidence, and become effective at self-management

Appropriate Consultation

If possible, consult a physician before giving any medication. Consult a physician if the client is experiencing or has previously experienced manic or hypomanic symptoms, even in the absence of current or previous depression.

Nonpharmacologic Interventions

If in acute manic phase, treatment is usually difficult, trying, and stressful for everyone involved. Manic clients seldom have insight into the mood disturbance and feel great. They resent the need for treatment as it may bring them down from the “high” and hospitalization will place external controls on their movements.

The basis of management is sensitivity and firmness. Be sensitive to the fact that the client is frightened and will do almost anything to defend against attacks, whether real or imagined, on his or her self-esteem. Avoid reacting to the client’s defensive assaults, recognize the source of the client’s anger, be concerned, and respond calmly. Such a response will reassure the client that there is no need to fear counterattack by the professional. Firmness indicates to the client that external controls will be used if the client is unable to exercise restraint or is overwhelmed by impulses. The client may respond by testing the professional’s determination.

In the initial stages of management, it is often necessary to employ the services of other staff or police officers, who would be capable of subduing and restraining the client. Do not hesitate to call for reinforcements if required (*see “Violence or Aggressive Behaviour in Mental Health Clients” below*).

Comorbid conditions must be treated as well as the bipolar disorder. During acute mania, the client should discontinue caffeine, alcohol, and any other substances used.

If diagnosis is not clear, ask the client to keep a mood diary or calendar where they rate their mood from 1 (most depressed) to 10 (most high) every day over a period of time. This can help identify manic or hypomanic episodes.⁸⁸

If stabilized, discuss and educate clients and family members about:

- Bipolar disorder, its nature, scope, treatment options, and need for long-term management (for example, the importance of medication adherence since if they are not medicated they have a 70% chance in 1 year and 95% chance in 5 years of having another incident⁸⁹)
- Potential early signs and symptoms of a relapse and an action plan to follow when this happens (for example, contact clinic immediately)
- Disease management techniques related to lifestyle (for example, exercise routine, avoiding substance use, good nutrition, sleep and stress regulation)
- The potential for drug-related side effects (for example, weight gain; nausea; diarrhea; renal, cardiovascular, endocrine, neurologic, dermatologic, and/or hematologic), cognitive impairment, and/or sedation and how to manage them
- Lithium treatment requires clients to be consistent in their salt, caffeine, and fluid intake and losses
- Discuss beliefs and attitudes about the illness, how it has affected their life and their beliefs about long-term effects of medication use
- An educational booklet titled “*What is Bipolar Disorder?*” from the Mood Disorders Society of Canada (available at: <http://www.mooddisorderscanada.ca/documents/Consumer%20and%20Family%20Support/Bipolar%20Brochure%20English%20FINAL%20150109.pdf>)

Pharmacologic Interventions

Medication is essential to control the disordered behaviour, to alleviate stress, and to treat the underlying disorder. Initial adjunctive treatment is to manage acute agitation:

lorazepam (Ativan), 1–2 mg SL/PO/IM

Consultation with a physician is required for all of the following medications:

In severe cases, neuroleptic tranquilizers may be necessary for short-term use until in hospital:

haloperidol (Haldol), 0.5–5 mg PO bid to tid prn OR 2–5 mg IM q4–8h prn

An antiparkinsonian agent may have to be added to counteract extrapyramidal side effects caused by the haloperidol.

Occasionally, high doses of medication fail to settle a highly agitated manic client. The client is in danger of physical collapse and/or may pose a danger to staff or other clients.

Discontinue any antidepressant therapy.

Treatment in acute mania should start or optimize therapy with lithium, anticonvulsants and/or atypical antipsychotic medications.

Long-term maintenance therapy depends on the type of bipolar disorder. This can help to prevent or dampen future manic attacks.

Before lithium therapy is started, the following baseline diagnostic tests should be done: CBC, electrolytes, renal, liver and thyroid function, electrocardiography (ECG).

Often bipolar disorder, particularly early in the disease (for example, in adolescents), is chronic and refractory to treatment. But it will often respond to the medications listed above.⁹⁰

Monitoring and Follow-Up

- Follow up weekly until the client is stable for at least 2 months, then monthly to assess medication adherence and efficacy
- Follow-up with regular, widely spaced appointments allows for continued education
- Repeat CBC and liver function tests 4 weeks after starting treatment and then every 3–6 months
- If taking lithium or divalproex, monitor trough serum levels 12 hours after the last dose (especially if the client is not adherent to their medications):
 - 5 days after any dosage change (or starting) for lithium
 - 3 to 5 days after any dosage change for divalproex

Two consecutive trough serum levels should be in the therapeutic range when a person is in the acute phase of treatment. Medication regimens need to be continued for at least 2 weeks at appropriate levels before assessing whether medication changes are needed, in consultation with a physician

- Repeat BUN, creatinine, TSH at 3 and 6 months after starting lithium, then repeat every 6 months⁹¹

- After the acute phase (stable for at least 2 months), monitor serum trough levels every 3–6 months, unless needed otherwise (maintenance phase), along with a complete blood count, electrolyte levels, liver function and ECG
- Since those with bipolar disorder are at increased risk for certain comorbid conditions (and this risk can be increased further with some drugs), routinely monitor in collaboration with a physician, for overweight/obesity, diabetes, metabolic syndrome, and dyslipidemia.⁹² Additionally, monitor for hematologic, hepatic, cardiovascular, and neurologic (for example, extrapyramidal symptoms) dysfunction. Assess females for polycystic ovarian syndrome

Referral

- Medevac most manic clients, after consultation with a physician, to a hospital for observation and treatment. Clients who are not sent to hospital should be referred to a physician regardless of severity of symptoms
- The decision whether to treat the client on an outpatient basis or admit and/or evacuate the client to a hospital (voluntarily or involuntarily) depends on several factors. This decision must be made in consultation with a physician and/or psychiatrist. For further considerations, see “Hospitalization and Client Evacuation” and “Involuntary Admission”
- Outpatient treatment runs risks arising from the client’s impaired judgment and erratic, unpredictable moods and behaviour
- Psychotherapy, pharmacotherapy, and psychoeducation have important roles in the management of bipolar disorder. If resources are available, referral should be made by a physician

MOOD DISORDERS: DEPRESSION^{93,94,95,96,97,98}

The *Diagnostic and Statistical Manual of Mental Disorders IV Text Revision* (DSM-IV-TR) provides the following criteria for diagnosis of a major depressive episode:⁹⁹

Five (or more) symptoms present for the same 2-week period, representing a change from previous functioning and at least one of the symptoms is depressed mood (for example, sad or irritable) or loss of interest or pleasure in usual activities for most of the day nearly every day.

All of the symptoms are listed in the mnemonic SADIFACES:

- S for **S**leep (for example, insomnia, hypersomnia, early morning wakening)
- A for **A**ppetite (for example, increased or decreased) or weight loss (more than 5% or not meeting expected gains in children) or weight gain
- D for **D**epressed mood (can be irritable in children and adolescents, such as aggression or antisocial behaviour); often worse in morning
- I for loss of **I**nterest (for example, apathy, boredom, change in grades, social withdrawal)
- F for **F**atigue
- A for psychomotor **A**gitation or retardation (change in energy level)
- C for decreased **C**oncentration or indecisiveness
- E for low self-**E**steem or excessive guilt (feeling worthless, hopeless)
- S for **S**uicidal/infanticidal/homicidal ideation or recurrent thoughts of death (including recent dangerous behaviours)

Symptoms must cause significant distress or impairment in social, occupational (for example, school) or home functioning. Symptoms are not due to another medical condition (for example, hypothyroidism), delusions, hallucinations, bipolar disorder, substances (for example, drug abuse), or bereavement.

A major depressive episode can be categorized as mild, moderate, or severe. Mild depression is characterized by 5–6 symptoms, mild symptom severity, and mild functional impairment or normal functioning but with substantial and unusual effort. Moderate depression is between mild and severe depression. Severe depression is characterized by most symptoms, severe symptom severity, and an observable disability. Symptoms of depression may vary by cultural background.

Major depressive disorder occurs when the client experiences one or more major depressive episodes. Major depressive disorder can have melancholic features (for example, mood that does not improve even temporarily, early morning awakening, severe weight loss) and/or psychotic features (for example, mood congruent delusions or hallucinations). Major depressive disorder affects 11% of Canadians at some point in their life,¹⁰⁰ yet over 30% of First Nations adults (27.2% of youth) have experienced major depression.^{101,102}

Seasonal affective disorder is a major depressive episode with regular onset and remission of symptoms within a particular season. It usually occurs in the fall and/or winter.

Postpartum depression is a major depressive episode occurring within 4 weeks postpartum where symptoms can last up to 1 year after delivery. It occurs in at least 10% of mothers and is not the postpartum blues that may occur within 4 days postpartum.¹⁰³

Subsyndromal/minor depression occurs when the client has fewer symptoms (for example 2–4) or a shorter duration of symptoms than required for a major depressive episode. The client may have functional impairment similar to a major depressive episode.

Dysthymic disorder occurs when depressed mood is present for most of the day on the majority of days for at least 2 years. Symptom-free periods may occur, but do not last longer than 2 months.¹⁰⁴ In addition, 2 or more of the following are present during this time: change in appetite, insomnia or hypersomnia, fatigue or low energy, low self-esteem, difficulty concentrating, and/or hopelessness. Symptoms are not as severe as those during a major depressive episode and there are no psychotic features. A major depressive episode may not occur during the first 2 years of dysthymia, yet half of those experience one at some time during their life.⁹⁷ Significant functional impairment occurs due to the length of symptoms. It may be superimposed upon or secondary to chronic mental disorder, personality disorder or organic mental disorder. It occurs in approximately 4% of Canadians during their life.¹⁰⁵ Aboriginal individuals living off reserve are 1.5 times more likely to have depression than those in the general population.¹⁰⁶

Females are twice as likely to be diagnosed with depression as males, starting in adolescence.¹⁰⁷ However, depression can occur at any age.

For specific information about depression in children and adolescents, see “Depression” in chapter 19, “Adolescent Health” of the pediatric guidelines.

CAUSES¹⁰⁸

- Genetics

Risk Factors^{109,110}

- History of depression (any kind)
- Family history of depression
- Mental illness (for example, anxiety or conduct disorders)
- Substance abuse
- Trauma
- Psychosocial adversity (for example, family dysfunction)
- Frequent use of the medical system
- Chronic conditions (for example, diabetes, pain, cardiovascular disease)
- Hormonal changes (for example, postpartum)
- Presenting with pain, unexplained physical symptoms, fatigue, insomnia

HISTORY^{110,111}

Assess for risk factors as listed above. If any risk factors are present, systematically screen (for example, at 6-week postpartum visit or 2-month well baby visit) and then assess for a depressive disorder.

Screening

The easiest way to screen for depression is to ask:

- In the past month, have you had little interest or pleasure in doing things you usually do?
- In the past month, have you been feeling down, depressed or hopeless?

If there is a “yes” answer to either one, a more detailed assessment is warranted.

Assessment

Standardized diagnostic aids can be used to assess for depressive symptoms, but an interview with the client and other key informants, if possible, is essential to investigate the DSM-IV-TR criteria. A diagnostic aid can help diagnose depression and track the client’s response to treatment. Examples include:

- Quick Inventory of Depressive Symptomatology (QIDS-16) (available at: <http://www.pfizerpro.com/resources/minisites/effexor/docs/QIDS-SR.pdf>); for scoring, see Interpretation (available at: <http://www.ids-qids.org/>) section
- Edinburgh Postnatal Depression Scale (available at: <http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf>) for during pregnancy and up to 1 year postpartum, completed while alone

Establish the onset of, duration of, and seasonal pattern of symptoms (for example, SADIFACES mnemonic above).

In addition to risk factors for depression and depressive symptoms, also assess:^{112,113}

- Other symptoms, including psychosis
- Medical history (including mental illness)
- Family history of mood disorders (including bipolar)
- Medications and previous response to treatment for depression, if applicable
- Substance use
- Potential underlying causes of symptoms (for example, bereavement (should not last > 2 months), family breakdown, loss of job, exposure to violence or abuse, foster care)
- Previous episodes of mania or hypomania; for symptoms see “*Bipolar Disorder*”; The Mood Disorder Questionnaire can be used to screen for the disorder (available at: <http://www.dbsalliance.org/pdfs/MDQ.pdf>). Two or more symptoms on the questionnaire warrants further investigation and assessment by a physician¹¹⁴
- Suicidal ideation, including questions about thoughts of death: what method they would use, and if they have the means available to them, previous attempts
- Whether a friend or family member has ever committed or attempted suicide
- Functioning at home
- Social history, including social and interpersonal relationships, work/school performance and behaviour

Older adults with depression may present by themselves concerned about memory loss, distractibility, and problems concentrating (also signs of dementia). They often demonstrate psychomotor retardation and show poor effort on psychological testing (for example, Mini Mental State Examination).¹⁰⁷

PHYSICAL FINDINGS¹¹⁵

Assess for:

- General appearance (dress and grooming)
- Mood or affect
- Attitude and interaction (cooperative, guarded, or avoidant)
- Activity level (for example, calm, active, restless, psychomotor activity, abnormal movements)
- Speech
- Thought process (for example, coherent, disorganized, flight of ideas) and content (for example, delusions, obsessions, perceptual disorders, phobias)
- Perception, cognition, insight, and judgment
- Impulse control (for example, aggressive, hostile)
- Client and family member or friend interaction, if possible (for example, warm, nurturing, conflict, rejecting, affectionate)

Rule out potential medication causes by doing a full assessment of the following:

- Neurologic system
- Cardiovascular system
- Thyroid function

DIFFERENTIAL DIAGNOSIS

- Dementia
- Bipolar disorder
- Major depressive disorder
- Dysthymia
- Schizophrenia
- Bereavement
- Substance use
- Anxiety disorder
- Medical conditions (for example, thyroid dysfunction, endocrine disorders, neurologic problems, anemia)

COMPLICATIONS

- Suicide (attempted or completed)
- Decreased quality of life
- Impaired work and social functions
- Malnutrition
- Bipolar disorder
- Major depressive disorder

DIAGNOSTIC TESTS

Consider ordering CBC, TSH, creatinine, electrolytes, an EKG, and liver function tests¹¹³ to rule out other potential causes of depressive symptoms.

MANAGEMENT

A mother with postpartum depression and symptoms of psychosis and/or suicidal/infanticidal ideation should not be left alone.

Goals of Treatment^{116,117}

The goals of acute (first 8–12 weeks) treatment are to reduce symptoms, prevent suicide, and improve functioning. During the maintenance phase (6–24 months) of treatment, the goal is to prevent recurrence of the symptoms, treat comorbid conditions, and to return to full functioning and quality of life.

Appropriate Consultation

Consult a physician for all depressed clients and/or if the client has attempted or has thoughts about suicide/homicide and/or has had psychotic symptoms.

Nonpharmacologic Interventions

Treatment plans need to be individualized, developed with the client, and consider the severity of depression and available resources. Treatment goals should be set for function at home, with peers, and at work/school. Family support is essential to help support the client's recovery process.

Discuss with the client the obligations of confidentiality and its limits. Talk to them about what might be helpful to share with their family and/or friends and, if they agree, how they think it would be best shared.¹¹⁸ Arrange for the support and involvement of family members/friends in their care. Postpartum women and/or older adults may require additional help at home.

Educate the client and the family about the depressive disorder they have, its symptoms, its expected course (regular functioning within weeks or months of treatment), its prognosis, and management options. Some resources are:

- *What is Depression?*, a booklet available from the Mood Disorders Society of Canada (available at: <http://www.mooddorderscanada.ca/documents/Consumer%20and%20Family%20Support/Depression.pdf>)
- Handouts on postpartum depression are available from Best Start (available at: <http://www.beststart.org/resources/ppmd/index.html>)

Establish a safety plan with the client. It should include restricting lethal means of suicide (for example, guns locked up in the home, removal of ropes and cords), involving a concerned third party, having spouse/parents/guardian/friend ask regularly about thoughts of suicide, watching for signs of drinking, and educating about who to contact in an emergency if the client has increased symptoms, becomes suicidal (for example, drawing morbid pictures, saying self-destructive things, giving away personal possessions), is homicidal, and/or has an acute crisis. This is particularly important during initial treatment.

Teach coping strategies to clients whose depression is related to loss and/or trauma. Encourage them to express some of their feelings associated with the event(s) (for example, journaling, poetry, music, talking to someone).¹¹⁹

For depression concurrent with chronic disease, talk to the client about how they are coping with the disease. Provide education and support to help them to better manage the condition and improve their quality of life.

For mild depression, actively support the client. Recommend client self-management through regular exercise, sleep, nutrition, and leisure activities. Supportive counselling should be offered, as it helps to find solutions to problems they identify.

Light therapy is effective in treating seasonal depression. Light therapy, exercise, yoga, and omega-3 fatty acids can also be used along with psychotherapy or pharmacotherapy for mild to moderate non-seasonal depression.¹²⁰

Subsyndromal depression may be better treated with psychotherapy interventions than pharmacologic ones.¹²¹

For moderate or severe depression, or if the client has other conditions (for example, anxiety disorder, substance use), the client will need pharmacotherapeutic treatment and/or psychotherapy. Psychoeducation, supportive counselling, client self-management, peer support, and regular monitoring are all supported treatments.

Psychotherapy (for example, cognitive behavioural therapy, psychodynamic therapy or interpersonal therapy) is effective for depression and dysthymic disorder. Psychodynamic and interpersonal therapy are effective and can help clients understand their relationships and decrease dysfunctional interpersonal behaviours. Cognitive behavioural therapy educates one on how to reformulate negative thoughts, how to identify and correct factors that make depression worse (for example, inactivity) and to learn problem-solving skills.

Evidence shows that a combination of medication and psychotherapy is more effective than either one alone.¹²² Psychotherapy is often not available in small communities, but video conferencing may be available to provide this intervention. Other psychotherapy options that are evidence based and do not rely on the care provider to have experience with psychotherapy are to assign sections of the following books or programs and then have an appointment to discuss client progress.^{123,124}

- Bibliotherapy with self-help books (for example, *Feeling Good* by Dr. David Burns, *Mind Over Mood*)
- Internet-based psychotherapy web sites (for example, MoodGYM [available at: <http://moodgym.anu.edu.au>])
- Self-care workbook titled *Antidepressant Skills Workbook* from the BC Mental Health & Addiction Services (available at: <http://www.comh.ca/publications/resources/asw/SCDPAntidepressantSkills.pdf>)
- Self-care workbook titled *Dealing with Depression: Antidepressant Skills for Teens* from the Centre for Applied Research in Mental Health & Addiction (available at: http://www.comh.ca/publications/resources/dwd/DWD_PrintVersion.pdf)
- Self-help groups may be useful for clients learning how to cope and for the support provided by other members

Educate about pharmacotherapy:

- Potential side effects (for example, the possibility of nausea, diarrhea, constipation, changes in appetite, sleep disturbance, sexual dysfunction, disinhibition) and if they will resolve spontaneously or not
- What to do if serious adverse events occur (for example, call the clinic immediately if client develops a rash, becomes agitated, speaks too fast, seems to have too much energy, can do with less sleep, has suicidal thoughts)
- Expected onset of effect (2–4 weeks for an effect to be noted)
- Need to continue treatment for at least 6–9 months after symptoms disappear (some may require it for life)
- Importance of taking medications daily and of continuing the medications even if feeling better
- Importance of only stopping the medication after checking with a physician or nurse practitioner and doing it slowly (to avoid withdrawal syndrome)¹²⁵

Pharmacologic Interventions¹²⁶

In many cases of depression (including during pregnancy and postpartum), medication is indicated, after the risks and benefits have been considered. Treatment usually begins with selective serotonin reuptake inhibitors (SSRI) antidepressants (for example, sertraline, citalopram) or serotonin norepinephrine reuptake inhibitors (SNRI) (for example, venlafaxine). However, medication should be individualized to the client's symptoms, comorbid conditions, previous response to antidepressants, and potential drug interactions. *Consult a physician to order all of these medications.*

The medication recommendations for treatment of dysthymic disorder do not differ from those for major depressive disorder.¹²⁷ However, the response is less predictable (for example, usually takes longer) and less complete than in major depressive disorder. If symptoms intensify, a trial of medication may be indicated, after a physician is consulted. A considerable proportion of dysthymic clients become psychologically dependent on their medications. Thus, medications should be used judiciously, and efforts should be made periodically to discontinue them.

SSRIs are the safest of the antidepressants if taken as an overdose.

Sleep medications are rarely indicated, except for short-term use, as insomnia secondary to depression usually responds to nighttime antidepressant medication.

Monitoring and Follow-Up

Monitoring needs may vary but generally a client should be monitored weekly for the first month and then biweekly for the next month, or until improvement has been noted. Regular follow-up is important, to monitor progress and to offer encouragement and support.

Treatment efficacy should be examined 4 weeks after starting:

- If < 20% improvement on a diagnostic aid scale is noted, a physician must be consulted about a possible change in treatment (for example, dosage increase, add on another medication, change in medication, psychotherapy)
- If > 20% improvement on a diagnostic aid scale is noted, client should continue medication for a total of 8–10 weeks until the efficacy is determined¹²⁸
 - If some improvement is noted after 8–10 weeks of psychotherapy and/or pharmacotherapy interventions, consult a physician to assess the need for another medication to be introduced, medication dosage increased, psychotherapy added, and/or a mental health professional consultation
 - If no more improvement is noted on a diagnostic aid scale after 8–10 weeks of psychotherapy and/or pharmacotherapy interventions: reconsider the diagnosis; assess the medication dosage and if they have been on the maximum dosage for 4–6 weeks, assess for a change in medication; consider adding psychotherapy, and/or consult a mental health professional
- Effective medications (> 50% reduction in diagnostic aid score [see “Assessment” under “History” in the “Depression” section above]) should be continued for at least 6–9 months after full remission of symptoms (diagnostic aid score within normal range). Medication doses are then tapered gradually, and the medication can be discontinued, provided there are no signs of relapse. Some individuals may require longer treatment (for example, those with dysthymic disorder due to its chronic nature). A physician or nurse practitioner will direct this

Monitor at least monthly for 6 months after full remission of symptoms. Assess medication efficacy, target symptoms (treatment goals), adverse reactions, and medication compliance. Once every 3 months during this period repeat the assessment of symptoms with a diagnostic aid as listed above. After this, regularly monitor for 6–24 months.¹²⁶ In particular, clients who have had depression as an adolescent should be routinely monitored.

Monitor all clients at each visit for goal achievement, change in depressive symptoms, functioning at home, work/school and socially, and for adverse events (for example, related to medication use, including suicidal ideation, agitation, mania, sexual dysfunction), even if the client is followed by a mental health professional. If on an SSRI/SNRI, monitor for increased agitation, irritability, or decreased sleep. If any concerns are present, consult with a physician as the dose may need to be decreased or the medication discontinued. A flow sheet to monitor depression is available on page 91 of the GLAD-PC Toolkit (available at: <http://www.glad-pc.org>).

Provide education to clients at each visit.

If only some improvement has been noted after all treatment options have been exhausted, explore medication adherence, comorbid disorders and ongoing concerns, and consider a referral to a mental health professional.

Referral

Most depressed and dysthymic clients can be managed on an outpatient basis. All clients should be referred to a physician or psychiatrist, regardless of severity.

The decision whether to treat the client on an outpatient basis or admit and/or evacuate the client to a hospital (voluntarily or involuntarily) depends on several factors. This decision must be made in consultation with a physician and/or psychiatrist. For further considerations, see “Hospitalization and Client Evacuation” and “Involuntary Admission” above.

Psychotherapy and psychoeducation have important roles in the management of depression. If resources are available, referral should be made by a physician.

Refer to a physician for follow-up as needed, especially if the client is on an antidepressant or there is no response to treatment after a reasonable trial. Links with mental health and/or chronic disease resources in the community are to be made.

PROBLEM GAMBLING^{129,130}

A behaviour where “you bet or risk money or something of value to have a chance to win or gain money or something else of value.”¹³¹

As with substance use, gambling can become an addiction. The addiction can be a psychological dependence (for example, needed to cope with problems) and/or physiological dependence (for example, increased need to gamble more to get the same effects, physical withdrawal symptoms). Most individuals start by experimenting socially. Addiction is a habit where the person cannot stop gambling, even though they try to. They are preoccupied with gambling, and they continue to gamble even though they experience negative consequences.

Gambling is a problem when it:

- Impairs role obligations at home, work and/or school
- Causes financial issues
- Produces emotional or physical health problems
- Causes social or interpersonal issues related to gambling (persistent or recurrent)

Gambling can become a behavioural addiction and a problem for 5% of the Canadians who gamble. Those who have problem gambling have a preoccupation and impaired control (for example, they are unable to cut back even with serious negative consequences) related to gambling. Approximately 5% of males report a pathological gambling problem.¹³² One study found 43% of Aboriginals to have significant problems with gambling,¹³³ often related to stressors, including the determinants of health.

Risk Factors¹³⁴

- Neurologic disorder (for example, attention deficit hyperactivity disorder)
- Mental illness (for example, depression, anxiety)
- Parents who are problem gamblers
- Social isolation
- Low self-esteem
- History of risk taking or impulsive behaviours
- Recent loss or change (for example, job loss)
- Financial problems
- History of abuse or trauma
- History of (or current) substance use, gambling or overspending
- Adolescents
- Aboriginals

Males are most likely to play sports lotteries and pools. Females are more likely to play lotteries and bingo.

HISTORY^{135,136,137,138}

The assessment for gambling problems includes the type of gambling involved in, frequency, time involved, amount gambled, reasons for gambling and perceptions of gambling activities (for example, luck, control), as well as the psychological and social harms, financial consequences and loss of control related to gambling behaviour.

In addition to gambling behaviours noted above, also assess:

- Feeling pressured to gamble in social situations
- When client first gambled, their history of quit attempts and/or treatment, and progression of gambling
- Issues resulting from gambling that are showing up at school (for example, absenteeism, dropping grades) or work, socially (family, peers, relationship), legally (for example, stealing when would not previously), and financially (for example, spending money even when can't afford it, sudden requests for money with little explanation)
- Family history of gambling, mental illness
- Assess for risk factors
- Medical history (including mental illnesses)
- Psychosocial history

Assess readiness to change and motivation to change on scales from 1 to 10.

COMPLICATIONS

- Increased suicides – 10% of suicides in Alberta are related to problem gambling;¹³⁹ 50–80% of problem gamblers have experienced suicidal thoughts and, of those, 12–16% have made lethal attempts on their lives^{140,141}
- Large financial losses
- Higher rates of family breakdown
- Engaging in illegal activities to support their addiction

MANAGEMENT

Goals of Treatment

Abstinence from gambling.

Nonpharmacologic Interventions

- Counsel to decrease gambling behaviours, with an aim for eventual abstinence; base this on the client's motivation to change and their own solutions
- Be positive and point out times when they have been successful
- Help the client see the consequences of gambling
- Involve the family in solutions and help them protect their assets from further losses
- Help build client's control and accountability
- Educate clients with a handout on gambling from the Aboriginal Healing Foundation; see page 94 of *Addictive Behaviours among Aboriginal People in Canada* (available at: <http://www.ahf.ca/downloads/addictive-behaviours.pdf>)
- Refer to a specialized counselling and/or treatment program, if they are motivated to quit (for example, residential treatment programs or telephone helplines [Ontario Problem Gambling Helpline 1-888-230-3505; Nova Scotia Problem Gambling Helpline 1-888-347-8888; Manitoba 1-800-463-1554; Quebec 1-866-767-5389 (bilingual service)])
- Help clients to develop a workable budget and manage their debts to relieve financial pressure. If the client consents, refer them to a financial institution or community resource (for example, a family member or an elder) for help
- ProblemGambling.ca is a web-based resource for both clients and professionals
- *Problem Gambling: Guide for Helping Professionals*, from the Centre for Addiction and Mental Health is a helpful resource for working with clients who gamble (available at: http://www.problemgambling.ca/EN/Documents/2990PG_Pro_ENG.pdf)

Prevention

- Educate family, community members, and adolescents about signs of gambling problems and what to do if they suspect someone of having one
- Consider routinely screening for gambling in all clients using the Centre for Addiction and Mental Health Short Gambling Screen¹⁴² where ≥ 2 “yes” responses indicate that there should be a more thorough assessment, as the client may have a gambling problem:
In the past 12 months, have you:
 - a. Gambled more than you planned?
 - b. Said you won or were winning money when you did not?
 - c. Felt guilty about how you gamble and/or what happens while you are gambling?
 - d. Had arguments about money that focused on gambling?
 - e. Had people criticize you for your gambling?

PSYCHOTIC DISORDERS

Psychosis can present as delusions, hallucinations, disorganized speech, bizarre behaviour, catatonia, withdrawal and social withdrawal.

The psychotic episode may be an accompanying symptom of an underlying psychiatric illness of which mania, depression, and schizophrenia are the most common. Other psychotic disorders include substance-induced psychotic disorder, delusional disorder, brief psychotic disorder, and schizoaffective disorder. About 3% of Canadians experience some kind of psychosis in their life.¹⁴³

CAUSES

The cause of psychoses is not known, although a number of causes are postulated. Family upbringing, social problems, and/or a “weak” character are not the cause. Use of psychoactive substances (for example, ecstasy, cocaine, LSD) can trigger a psychotic episode in persons predisposed to psychosis.

HISTORY, PHYSICAL FINDINGS, DIFFERENTIAL DIAGNOSIS, DIAGNOSTIC TESTS, COMPLICATIONS

The information regarding the clinical assessment of a client with psychosis is the same as for a client with schizophrenia (see “History,” “Physical Findings,” “Differential Diagnosis,” “Diagnostic Tests,” and “Complications” under “Schizophrenia”).

MANAGEMENT

Outcomes are improved if psychosis is diagnosed early and treatment started promptly. With effective treatment most people recover and go into remission.

All areas of management for psychotic disorders are the same as for schizophrenia (the acute phase); refer to these topics under the appropriate “Management” subheader under “Schizophrenia.”

SCHIZOPHRENIA^{144,145,146,147,148,149,150}

Disturbance for at least 6 months (including prodromal and residual symptoms) of a person’s life with an active phase of 2 or more characteristic symptoms present for a large amount of time in a 1-month period. Symptoms must cause significant distress or impairment in social, occupational (for example, school) or home functioning. Symptoms are not due to another medical condition (for example, hypothyroidism), substances (for example, drug abuse), medications, mood disorders, or schizoaffective disorder.

Schizophrenia is the most common chronic psychotic disorder, with 1% of Canadians affected. It occurs slightly more often in men than women. Onset is usually in adolescence or young adulthood, but some cases can occur after age 45. Women tend to demonstrate symptoms later than men, but have a better prognosis even though they have more comorbid conditions.

Psychosis (for example, a positive symptom present for any period of time) is a hallmark symptom for schizophrenia, but it is not required for diagnosis.

COURSE

The condition may present with insidious onset, or onset may seem sudden, with acute psychosis starting rapidly; however, prodromal symptoms are often identified retrospectively.

The course can vary with schizophrenia, as 10% completely recover after the initial diagnosis; 33% have intermittent symptoms and impairment; and over half experience chronic symptoms and functional impairment, even if they receive appropriate treatment.¹⁴⁷

- *Prodromal phase*: nonspecific changes in emotions, thoughts, perceptions, and behaviours (for example, anxiety, phobias, mild depression, apathy, personality change noted by friends and family, social withdrawal, marked functional impairment, lack of personal hygiene and grooming, perceptions not based on reality, decreased interest in usual activities, memory and concentration problems, bizarre behaviours, speech and ideas) occurring before the active phase; variable length (may be years); prognosis worse for the slowly developing disorder
- *Active/Acute phase*: 2 or more characteristic symptoms present for a large amount of time in a 1-month period; onset is sudden or slow; often precipitated by a psychosocial disorder (for example, marijuana use) and causes medical attention to be sought; begin treatment as soon as possible to decrease suffering
- *Stabilization phase*: prodromal and psychotic symptoms decrease after an acute episode and the initiation of treatment; phase lasts different lengths of time, depending on the person
- *Stable phase*: symptoms may be decreased or gone, but there is ongoing functional impairment

TYPES OF SCHIZOPHRENIC DISORDERS

There are several types based on the predominant symptoms:

- Disorganized type: disorganization of speech and behaviour, flat or inappropriate affect; has highest functional impact
- Catatonic type: > 2 of motor immobility (for example, posturing), excessive movements, extremely negative, mute, unusual voluntary movements, echolalia, or echopraxia (repetitive movement or gestures); is usually episodic
- Paranoid type: preoccupation with > 1 delusions or hallucinations; often have fewest functional impairments and are able to live independently; have highest suicide rate
- Residual type: no noted delusions, hallucinations, disorganized speech or behaviours; persistent symptoms (for example, negative ones); functional impairments persist
- Undifferentiated type: does not meet criteria of any of the above

CAUSES

Genetic predisposition: A higher prevalence is noted among family members of people with schizophrenia, and there is a higher concordance rate in identical than fraternal twins.

Environmental influences (for example, developmental insult, biological and psychosocial stressors): A higher prevalence is noted with advanced paternal age; first and second trimester and birthing insults (for example virus exposure, anoxia); and psychoactive drug exposure as an adolescent.

HISTORY

The typical client will present in an excited, agitated state, often with fearfulness or hostility, hallucinations and delusions, confusion and disorganization or poverty in speech and thought, vigilance and over-activity, poor grooming and hygiene. Mood is often blunted.

Most individuals with psychosis/schizophrenia are aware of and are distressed by their symptoms, but may be reluctant to disclose them. Establish a therapeutic relationship and directly ask about signs and symptoms. Interview the client and as many other sources (for example, family, friends, care providers) who knew the client before the psychosis as possible, with the consent of the individual. Complete a full mental health history, ensuring the following topics are covered:

- What the client is usually like
- Current symptoms (for example, mental and physical)
- Onset and course of prodromal symptoms
- Nature, severity, onset, frequency, quality and duration of characteristic symptoms
- Change in behaviour and functioning (for example, ADLs, social, sexual, cognitive, work, school)
- Side effects
- Medical conditions that might account for the symptoms and any accompanying delirium or dementia
- Suicidal ideation
- History of suicidal behaviours and/or aggressive/violent behaviours
- History of substance or medication use or withdrawal and its relation to the onset and course of psychotic symptoms
- Sexual health and history (for example, libido, menses, erectile dysfunction)

- Past medical and psychiatric history (for example, repeated relapses)
- Current living situation, including housing, finances, social support, activities of daily living, social activity, school and work, educational level, responsibility for children
- Developmental history (pregnancy and development)
- Social and academic functioning as a child and adolescent
- Family psychiatric history, including psychosis
- Quality of life

Symptoms that individuals may have include:

- Positive symptoms (symptoms that should not be present; for example, hallucinations, delusions, thought disorder, disorganized behaviour, inappropriate affect); also known as psychosis; often present at first diagnosis and require hospitalization; respond to pharmacotherapy, but do not usually completely resolve
- Negative symptoms (experiences that have been lost because of the illness; for example, slow thoughts, poverty of speech, lack of motivation, low energy, inability to gain pleasure from enjoyable experiences, flat affect); often present early (before acute phase or psychosis); functional incapacity is more likely with cognitive impairment present in childhood and negative symptoms
- Mood symptoms in relation to psychotic symptoms (for example, anxiety, irritability, depression, mood swings, feeling cut off from the world; affect is blunted, inappropriate or odd); can occur after a psychotic episode, so suicide is a risk
- Cognitive symptoms (for example, inability to focus, difficulties filtering out environmental stimuli, slowed processing and reaction times, decreased memory, organizational concerns); often present since birth, but slight decline after diagnosis; linked to functional impairment (for example, socially inept, poor school performance)

CHARACTERISTIC SYMPTOMS

Symptoms are sustained or recurrent in schizophrenia.

Delusion – fixed, false belief, even after evidence to the contrary is presented; not due to cultural or religious background. Types are:

- Persecutory: beliefs that others are spying on, plotting against, trying to hurt, or spreading rumours about the person

- Reference: events or objects are given peculiar and unusual significance, such as believing that the radio announcer is directing comments to the individual personally
- Thought broadcasting: belief that one's thoughts are broadcast to the external world
- Thought insertion: belief that thoughts that are not one's own are being inserted into one's head
- Being controlled: belief that one's feelings, impulses or actions are being imposed from external sources against their will
- Others are: somatic (for example, fear something is wrong with body), guilt (for example, blame self for bad things in world), grandiosity (for example, important, special powers), mind reading, religious or nihilistic

Disorganized speech:

- Loosening of associations: ideas shift from one unrelated thought to another
- Speech may be incoherent and incomprehensible (word salad)
- Speech may be vague, overly abstract, overly concrete, repetitive or stereotypical
- New words (neologisms) may be created, ideas may be repeated as if the person is stuck on one track (perseveration), train of speech may be interrupted (blocking) or sounds rather than meaningful concepts may govern word choice, which results in meaningless rhyming or punning (“clanging”)

Hallucination – perception in absence of external stimuli:

- Auditory hallucinations: the most common form; usually of voices speaking directly to the individual and occasionally giving commands (for example, to harm self), which may create danger for the individual or others
- Tactile hallucinations: typically involve electrical, tingling or burning sensations
- Others are: visual, gustatory and olfactory hallucination

Disorganized or catatonic behaviour:

- Observed especially in chronically severe and actively florid forms
- Catatonic posturing: rigid, bizarre posturing
- Catatonic excitement: purposeless, stereotyped, excited movement unrelated to external stimuli
- Catatonic stupor: client appears unaware of the environment

- Catatonic negativism: client actively counteracts or resists instructions or attempts to be moved
- Mannerisms, grimacing or waxy flexibility (remains passively in any position in which he or she is placed)

Negative symptoms:

- Blunting of affect: severe reduction of intensity of emotional expression
- Flattening of affect: virtually no signs of affective expression
- Avolition: inadequate interest or drive to start and inability to follow a course of action to its conclusion
- Alogia: inability to speak

PHYSICAL FINDINGS¹⁵¹

If an acute psychotic episode allows a safe assessment, complete a full clinical examination which includes a “*Mental Status Examination*”, as detailed in the mental health assessment section of this chapter. In addition, assess for the following physical and psychosocial findings:

- Family interactions, if possible (for example, warm, nurturing, conflicting, rejecting, affectionate)
- Physical examination should focus on the endocrine and neurologic systems, as well as other systems related to any of the symptoms being experienced
- Extrapyrimal symptoms (for example, parkinsonism, dystonia, akathisia, dyskinesia)
- Mental status, including competence to accept or refuse treatment (for example, a Mini-Mental Status Exam [see “*Mental Status Examination*” under “*Dementia and Mild Cognitive Impairment*” above])

DIFFERENTIAL DIAGNOSIS

- Affective disorders (bipolar disorder and depression)
- Organic or toxic psychosis (induced by drugs or medical illness)
- Schizophreniform disorder (symptoms < 6 months), brief psychosis, schizoaffective disorder (psychosis and mood disturbance), delusional disorder, substance-induced psychosis
- Tumor, head trauma, dementia, delirium
- Schizotypal or schizoid personality disorder

DIAGNOSTIC TESTS

For a first episode of psychosis and upon consultation with a physician or a nurse practitioner: urine drug screen, TSH, electrolytes, fasting serum glucose, fasting lipids, CBC, BUN, creatinine, LFTs, serum blood alcohol level. Consider if hepatitis C, HIV and STI tests (syphilis included) are required. These tests should be repeated as indicated during the stable phase of schizophrenia.

COMPLICATIONS

- Suicide
- Violence
- Substance use or abuse
- Homelessness
- Functional deterioration (for example, work, home, social, education, self-care)
- Medical illness (for example, cardiovascular disease, sexual dysfunction)
- Decreased life expectancy, quality of life and socioeconomic status
- Victimization
- Other mental illnesses (anxiety, depression)
- Complications of antipsychotic medication may include: obesity, diabetes mellitus, hyperlipidemia

MANAGEMENT

Management differs depending on the phase of the illness. The management plan for each phase is described under the appropriate heading and labelled according to phase, if applicable.

Goals of Treatment¹⁴⁶

Establish goals of treatment with the client and family members.

Acute Phase

- Decrease agitation
- Remission of psychotic symptoms such as delusions, hallucinations, disordered thinking and behaviour
- Facilitate a functional recovery process and development for the future (for example, improve social functioning, promote healthy development)
- Treat and/or prevent comorbid conditions (for example, suicidality, depression, substance abuse)
- Prevent future episodes of psychosis

Stabilization and Stable Phases

- Functional recovery
- Relapse prevention
- Education to understand and have insight into disease and to be able to detect early signs of relapse
- Prevent and monitor for side effects and comorbid conditions

Appropriate Consultation

Consult a physician or psychiatrist upon initial assessment and before administering any medication, if the client is experiencing psychotic symptoms, and/or if the individual has early warning signs or prodromal phase symptoms and psychosis is a possibility, even if they have not had any psychotic symptoms or episodes. Consult if a client has not responded to treatment (for example, only partial recovery of symptoms or function after 6–8 weeks), have not adhered to medication, have had intolerable medication side effects, have substance abuse problems, and/or if they have suicidal or homicidal behaviours.

Nonpharmacologic Interventions

Develop a positive relationship with the client and family (given confidentiality is respected and/or the appropriate referrals and forms have been completed [for example, release of information]) and provide realistic hope and optimism. It is important that clients, families and caregivers be engaged in the treatment process. Crisis intervention services aim to build a therapeutic relationship including listening, acknowledging the client and family's experiences, curtailing self-blame and shame, taking the concern seriously, being supportive, decreasing anxiety, instilling hope, encouraging them to use this experience as an opportunity for growth, involving them in the development of a therapeutic plan, and using calm, clear, and simple communication. Crisis intervention aims to increase the client's level of social, occupational/educational, cognitive, and behavioural functioning.¹⁵² Determine if the client is competent to accept treatment and give informed consent at each stage of treatment.

Acute Phase

Start by ensuring your own safety, the safety of other clients and staff, and the safety of the affected client. Establish firm control of the situation as soon as possible; it may entail the use of physical restraint as a last resort (*see Violence or Aggressive Behaviour in Mental Health Clients below*). In many instances, a show of force by numbers (for example, by having clinic staff, police, or security officers present) will settle the client sufficiently so that physical means of control need not be used.

Care must be taken to avoid exacerbating the situation by failing to give the excited client enough physical and psychological room (especially if he or she is suspicious or paranoid). The acutely psychotic or delirious client should be placed in a room that can be readily observed but that has minimal stimulation (for example, noise and light). Eye contact may be disturbing, as it may be interpreted as threatening or aggressive. Maintain a considerable physical distance to avoid being struck and also to appear less threatening to the frightened client. Questions asked should not be probing, and sensitive areas, if identifiable from previous background history, should be avoided. Delusion should not be challenged or supported.

If the excited, psychotic client appears on the verge of violence (to self or others) or escape, you should not obstruct the escape route or end up in an enclosed space alone with the client. It is preferable to allow the client to bolt than to risk being assaulted (*see "Violence or Aggressive Behaviour in Mental Health Clients"*).

Educate clients, family and caregivers:

- About psychosis/schizophrenia's causes, symptoms, course/recovery process, what the client is experiencing, and treatments
- To adhere to efficacious antipsychotic medications to decrease chance of relapse, even if they are feeling better. Relapse (psychosis and symptom worsening) can occur in 30% of those who are medication compliant and 80% for those who are not, within 1 year; there is a high risk if they discontinue medications in the first 2 years. Recovery from each subsequent relapse takes longer and the client does not recover as much (for example, symptoms remain). Relapse is associated with stopping medications, substance abuse, psychosocial stressors, and physical illness¹⁴⁷

- About medication benefits and potential side effects (extrapyramidal, metabolic-like weight gain, photosensitivity, others)
- About how to prevent relapse (for example, decrease stressors, consistent medication adherence as prescribed)¹⁴⁷
- About the importance of physical activity and good nutrition to decrease the likelihood of weight gain associated with antipsychotic use
- Provide written information on psychosis and/or schizophrenia. Online resources aim to educate clients and family members. These include:
 - *The Sooner the Better: Get Help with Early Psychosis: Information Guide (2004)* from the Nova Scotia Early Psychosis Program (available at: http://earlypsychosis.medicine.dal.ca/resources/FinalBooklet_July14_2008.pdf)
 - *Schizophrenia: A Handbook for Families (2002)* from Health Canada and the Schizophrenia Society of Canada (available at: <http://www.phac-aspc.gc.ca/mh-sm/pubs/schizophrenia-schizophrenie/index-eng.php>)
 - *Schizophrenia: The Journey to Recovery: A Consumer and Family Guide to Assessment and Treatment (2008)* from the Canadian Psychiatric Society and the Schizophrenia Society of Canada (available at: <http://www.schizophrenia.ca/RoadtoRecovery/schzioph-web.pdf>)
 - Canadian Mental Health Association (general information on schizophrenia) (available at: http://www.cmha.ca/bins/content_page.asp?cid=3-100&lang=1)
 - Schizophrenia Society of Canada (information and excellent educational resources) (available at: <http://www.schizophrenia.ca>)

Family/caregiver interventions:

- Educate the family on their role in supporting and managing the client at home or in the community during the different phases of treatment (for example, speaking slowly and simply in a low tone, clearly explaining what and why they are doing something, establishing a daily routine, offering praise, building their problem solving skills, and offering support to the client)
- Ensure that the client is safe and reduce environmental stressors and stimuli during acute psychosis
- Advise family members about how to behave toward the client, how to deal with the client's thought disorders and paranoid thinking, how to remotivate and encourage the client, and how to respond to bizarre behaviour and withdrawal
- Caution family members against talking about the client in his or her presence and to avoid being critical
- Encourage patience with respect to the client's anger or depression
- Prepare the family for what will happen if the client has to be hospitalized locally or evacuated for treatment
- Have the family assist and encourage the client to attend treatment sessions or other social appointments

Determine level of care and housing support required for the client (in consultation with family members, caregivers, a physician or psychiatrist and information from a home visit). In the early stages of recovery, the client may need close supervision, such as that provided in sheltered workshops (vocational), transition homes and day hospitals or daycare programs.

Stabilization Phase

Educate clients, family and caregivers:

- Schizophrenia is a chronic illness that requires ongoing treatment, monitoring, and support
- About the importance of medication adherence as prescribed, its benefits and potential side effects, particularly if the client has poor adherence (*see "Nonpharmacologic Interventions (Acute Phase)"*)
- About setting up reminders, prompts (for example, dossette) and self-monitoring (for example, always checking dossette when they brush their teeth) cues to help with medication compliance
- To recognize and immediately report the early warning signs of relapse/acute psychosis (especially increased social isolation, moodiness, difficulty thinking or sleeping, increased irritability, anxiety, depression, less insight, or the return of symptoms previously in remission)
- To recognize and immediately report potential antipsychotic side effects, including extrapyramidal side effects
- To avoid alcohol, tobacco, drugs (prescription, nonprescription and illicit) due to their potential interactions with antipsychotic medications
- To report signs and symptoms of depression and suicidal behaviour as soon as possible

- About stress management, how to problem solve, and how to decrease stress to prevent relapse
- About importance of discussing pregnancy with a physician prior to considering trying to become pregnant because of the potential adverse effects of the medications, genetic risks, and considerations for becoming a parent
- About client rights (for example, informed consent) and legal processes (for example, involuntary psychiatric assessment)
- To participate in local peer support, structured activity and/or self-help groups in the community and/or link clients affected by schizophrenia (if they agree); make referrals when possible to allow the client to have social supports and to combat the tendency to withdraw. Established groups may be able to provide resource material and ideas that could be applied in the care and self-care of a small number of clients
- To engage in activities important to them
- To structure daily activities, including education or work

Family/caregiver interventions:

- Advise the family to encourage the client to be self-sufficient by doing as much as possible for him- or herself. It is never easy to determine just what the client is capable of doing, and judicious trial and error, with constant alertness to signs of stress, is perhaps the only way
- The family can help the client with accepting the limitations imposed by the disorder (for example, on education, marriage, self-sufficiency)
- Emphasize the importance of keeping the client socially active
- The family itself may require some counselling because of the stresses of the illness, the caretaker role and the embarrassment experienced by family members
- Educate about local caregiver support groups

Stable Phase

Advocate for a supported employment program or volunteer work which allows the client to work to their capacity, to gain vocational skills, and to work toward goals they have (paid employment).

Education (as in the previous stages) and cognitive behavioural therapy should continue and be reinforced during this phase.

Client Counselling

The client with schizophrenia will likely experience a number of stresses and problems directly or indirectly related to the disorder, for which personal counselling is desirable:

- Sexual dysfunction may be a side effect of the medications and may present as decreased libido or cessation of menstruation
- Dating: the client may experience severe interpersonal anxiety and need social skills training and counselling in this regard
- Genetic risk: genetic counselling and planning for parenthood may be appropriate
- Family adjustment: the client may need help in dealing with problems with other family members, since these problems are often a direct result of the client's symptoms and may be long-standing
- Self-care: the client may need help and supervision with regard to personal hygiene, grooming, nutrition, financial management, and purchases
- Interpersonal difficulties: the client may require marital or family counselling, divorce counselling, or counselling and social skills training with regard to getting along with friends and acquaintances

Pharmacologic Interventions

Initiate treatment as soon as possible, as there are effective treatments. Delays in treatment increase the risk for slower and less complete recovery, in addition to serious distress for the client (for example, depression, social isolation, poor family relationships, fear, confusion, suicide, declining school performance, poor self-esteem). Early treatment improves negative, cognitive and mood symptoms for at least 2 years.¹⁴⁷

Acute Phase

If the client is experiencing psychotic agitation and/or is violent, medication can be administered (*see "Violence or Aggressive Behaviour in Mental Health Clients"*).

Antipsychotic medications are essential for treatment (acute and long term) and to alleviate symptoms in most people. They should be started as soon as possible. If clients have previously been on antipsychotics this should be noted along with their response, side effects and the client's preferred route of medication.

Consult a physician or psychiatrist before initiating any medication. Treatment is initiated with second-generation antipsychotics such as olanzapine and risperidone (preferred because of decreased side effects.) Often physicians start with a low dose and increase it slowly. Use of more than one antipsychotic at a time is not supported by evidence. Medications trials should last 4–6 weeks at the optimal dosage (some longer), as acute psychotic symptoms take this long to decrease. Generally it takes more than 2 months before the medication is fully effective.

If possible, before starting medications, do baseline ECG, complete blood count and liver function testing (LFT), as well as an assessment for any signs and symptoms of the antipsychotic side effects listed below.

Stabilization and Stable Phases

Most individuals with a first episode of psychosis will achieve remission of the positive psychotic symptoms. These symptoms should improve within 6–8 weeks. Some individuals have rapid resolution of positive psychotic symptoms, whereas in others resolution of symptoms can take months. Negative symptoms may take longer to improve.

Consult a physician or psychiatrist if the client is still having positive psychotic symptoms after 6–8 weeks on a medication with good adherence, as the goal is to reduce their intensity and duration. Medications used in an acute phase may not be therapeutic once stabilized. Increase compliance by encouraging the client to be involved in decision-making about medications (for example, preferred route, duration of action).

For a considerable number of clients, long-term use of an antipsychotic is necessary to afford the chance of a stable partial or full remission. Yet, some schizophrenic clients may remain well for years, or even indefinitely, without medication. It is impossible to predict which clients may safely and permanently discontinue antipsychotic medication.

Depression in the stable phase indicates a trial of an antidepressant. Consult a physician.

Antipsychotic Side Effects

Inquire from the client and report all side effects to a physician. These include cognitive side effects (for example, sedation, cognitive dulling) and extrapyramidal side effects.

Common side effects include orthostatic hypotension, dry mouth, blurred vision, constipation, weight gain, drowsiness, increased risk for diabetes and high lipid counts, and sexual dysfunction. Some of the more important side effects to assess for include:

Neuroleptic malignant syndrome

Tachycardia, fever, labile blood pressure, muscle rigidity, increased creatinine and WBC, altered level of consciousness, and autonomic dysfunction is a medical emergency that can occur at any time with all antipsychotics. It occurs more often in males, younger clients, when there is rapid administration of antipsychotics, and in the presence of dehydration, exhaustion, and agitation. Antipsychotic medications should be stopped immediately and a physician consulted. Other supportive measures can be implemented, such as rehydration and cooling.

Clozapine has potentially fatal side effects (for example, agranulocytosis, myocarditis, seizures). Educate about their symptoms (for example, fever, chills, sore throat, chest pain, tachycardia).

Extrapyramidal Side Effects

Prevention is the key. If they appear, a physician may consider reducing dosages or even discontinuing the medication and starting another second-generation antipsychotic. They occur more often with first-generation antipsychotics, intermittent medication adherence/treatment, females, older adults, substance abusers, diabetes, and affective disorders. The side effects can occur with second-generation medications and be more subtle.

Upon initiating an antipsychotic treatment, monitor closely over the first days and weeks. Assess for:

Dystonia

Moderate to severe muscle spasms, usually of the neck (causing tilting of the head), back muscles (causing arching), and tongue or eye. These often dramatic and frightening effects are easily reversed.

Assess and stabilize ABC (airway, breathing, and circulation). Consult a physician about use of:

benztropine (Cogentin), 2 mg IM

Parkinsonian Side Effects

Muscle rigidity, tremor, facial masking, decreased concentration, cognitive slowing, drooling and loss of associated movements (akinesia/bradykinesia). Treatment involves reducing the medication dosage and/or administering oral antiparkinsonian agents such as benztropine, which may be prescribed by a physician.

Akathisia

Inner restlessness, which can be excruciatingly distressing and which only sometimes is manifested in outward restless movements. This side effect, which can only be alleviated in the same manner as the parkinsonian side effects, is sometimes mistaken for psychotic agitation. It can increase risk of suicide. If a dosage reduction does not work, a benzodiazepine or beta-blocker may be prescribed by a physician.

Months or years after antipsychotic treatment starts watch for:

Tardive Dyskinesia

A serious and often irreversible side effect. It is a neurologic condition characterized by the gradual appearance of repetitive involuntary movement. These movements usually involve facial musculature and appear as lip-smacking, chewing, sucking, and tongue-thrusting. At times, the extremities, limbs and trunk may be involved. A physician must be consulted if patients demonstrate symptoms of tardive dyskinesia.

Monitoring and Follow-Up

Often treatment is a life-long proposition. Return to normal is unusual, and usually the person with schizophrenia remains disabled in one way or another and requires long-term rehabilitation and supportive care. Visits should be regular and frequent to prevent acute psychosis, to monitor drug compliance, effectiveness and side effects, to assess social support and efficacy of coping strategies, and to assess the phase of illness.¹⁵³ Visits also allow for more education, referrals to be made, and the client to ask questions. Regular follow-up is particularly important in first-episode psychosis as there tends to be poor medication adherence and increased rates of depression in the first 3 months.

Follow-up visits should occur weekly for the first 4–8 weeks of treatment (acute phase); then monthly for 6 months; then every 3 months (stabilization and stable phases) if they have had good functional

recovery and stable living conditions (more often if client does not meet these characteristics, uses substance(s), has limited social support, is changing medication(s), and/or has stressful life events).

If on clozapine, the physician will order regular CBCs to monitor for agranulocytosis.

Throughout the illness, the following should be monitored at each visit. Intervene as needed:

- Adherence to treatment and factors contributing to poor treatment adherence (for example, distressing drug side effects, denial of illness, complicated drug dosing, difficulty accessing treatment, and stigma)
- Changes in medications and the reasons
- Client satisfaction or quality of life; symptoms that persist may not be a stressor for clients, but may limit functional recovery

Specific monitoring recommendations should be done at the initial visit and when required, in addition to the following times. Intervene as needed:

- Current mental and physical symptoms of psychosis/schizophrenia and comorbid conditions (for example, mood disorders, suicidal ideation, aggression, impulsivity), including any changes from previous (for example, frequency, intensity/severity). Depression in schizophrenia can be assessed for using the Calgary Depression Scale for Schizophrenia: weekly in active phase, every 3 months if adherent to medication or more often if not (available at: <http://www.ucalgary.ca/cdss/>)
- Functional ability (for example, effect of current symptoms on ability to perform ADLs, to function socially, to work, to learn): every 3 months
- Substance use (including marijuana, nicotine): as indicated
- Cognitive function (Mini Mental State exam), including competence to accept or refuse treatment: as indicated
- Sexually transmitted infection risk assessment: as required
- Complete physical examination: annually

Medication side effect monitoring recommendations should be done before starting a new medication or dosage and when required.

If antipsychotics are withdrawn gradually, monitor regularly for signs and symptoms of a relapse for at least 2 years.

Referral

Acute Phase

For the first episode of psychosis, referral should be made urgently with a medevac to a hospital-based psychiatrist, or specialized early psychosis program.

Almost all acutely psychotic clients will need hospitalization and evacuation, and sometimes this must be accomplished on an involuntary basis.

The decision whether to treat the client on an outpatient basis or admit and/or evacuate the client to a hospital (voluntarily or involuntarily) depends on several factors. This decision must be made in consultation with a physician and/or psychiatrist. For further considerations, *see “Hospitalization and Client Evacuation” and “Involuntary Admission.”*

Stable and Stabilization Phases

Refer the client to see a psychiatrist or physician if the client has not responded to treatment (for example, only partial recovery of symptoms or function), has not adhered to medication, has had intolerable medication side effects, has substance abuse problems, and/or has suicidal or homicidal ideation or actions.

Cognitive behavioural therapy is effective when paired with pharmacotherapy. It should be offered, if available. Cognitive behavioural therapy should be reserved for clients who have not improved with 2 different courses of an antipsychotic and/or those who are having symptoms of depression, anxiety and/or stress.

The client should be assisted to make use of educational, employment, training and recreational opportunities. Advice and assistance may also be required with respect to housing, financial assistance, legal matters and other social services. Refer clients to social and life skills training programs if offered in the community.

Facilitate referral or directly refer to mental health or social service team providers (for example, a psychiatrist, clinical nurse specialist, community mental health workers), as indicated. Long-term treatment should be done by or done under their supervision. The following are absolute indications for referral: acute psychosis, high suicide risk, attempted suicide, no evidence of social support, comorbid conditions, history of depression. If the client is treated on an outpatient basis, the therapist or others must be available to respond to a crisis at all times. Links with mental health resources in the community are to be made.

SELF-INJURY

Information about self-injury is presented in the “*Adolescent Health*” chapter of the pediatric clinical guidelines.

SEXUAL ASSAULT^{154,155,156,157}

Any unwanted touching or sexual act¹⁵⁸ that is forced on a victim by another person without consent. It includes kissing; touching; fondling; grabbing of the breast, buttocks or genitals; holding the victim and rubbing against or squeezing him/her; tearing or pulling at the victim’s clothing; and attempted or completed vaginal, anal, or oral intercourse. It can occur due to the use of force or threat of force by the assailant (for example, physical violence or threats of physical violence to the victim or a loved one) or from a victim’s inability to consent (for example, intoxication with alcohol or drugs¹⁵⁹). Victims are overpowered and controlled by their assailants against their will.

The assault may include the assailant using or threatening to use a weapon, or there may be more than one assailant during the same incident. Aggravated sexual assault occurs if the assailant wounds, beats, injures, or endangers the life of the victim.¹⁶⁰ All kinds of sexual assault are a crime, whether the offender is known or unknown to the victim. Spouses can be charged with sexual assault.

Sexual assault does not include exhibitionism, genital exposure, voyeurism, verbal or gestural obscenities, or sexual harassment, although these too may be unwanted and psychologically disturbing.

If a client is under 18 years of age the law is very specific as to what constitutes sexual abuse and/or sexual exploitation. For more information on these definitions and sexual assault indicators *see “Sexual Abuse of Children” in the chapter “Child Maltreatment.”*

STATISTICS ON SEXUAL ASSAULT

- 90% of victims are female, but individuals of either gender and age can be a victim
- 39% of Canadian adult women report having been sexually assaulted at least once in their lives since age 16¹⁶¹
- 5–6% of sexual assaults are reported by men¹⁶²
- Over 50% of sexual assault victims reported to police in 2007 were < 18 years of age at the time of the assault¹⁶³
- 31% of all sexual assaults occur in residences, but more than 50% of the more serious assaults (for example, rape) occur in residences;¹⁶⁴ 67% of Americans over age 55 are assaulted in their own home or a home for the aged¹⁵⁵
- Sexual assaults by those known to the victim occur at least as often as those by strangers; in male toward female violence, 82% of all victims knew the aggressor and in 31% of reports the offender was a family member of the victim¹⁶⁵
- Most sexual assaults were related to unwanted touching (81%) compared to more severe forms¹⁶³
- 24% of females aged 18–24 years were sexually or physically assaulted by a boyfriend or their date^{162,163}
- In a significant number of sexual assaults (22%), weapons are used or displayed.¹⁶⁶ Approximately 23% of sexual assaults are accompanied by physical injuries¹⁶⁴
- Many sexual assault victims use more than one active strategy (for example, self-defense methods, pleading, reasoning, running, screaming, kicking) in attempting to prevent the assault; if this occurs the assailant does not become more violent and the victim is not injured more¹⁶⁷
- More sexual assaults occur during the summer
- Approximately 10% of sexual assaults in Canada are reported to police;¹⁶³ if the victim knows the assailant, they are less likely to report;¹⁵⁵ approximately 72% of victims report the assault to their friends and 41% report to their family

Risk Factors¹⁶⁸

- Women who are physically or emotionally abused
- Younger female
- Attending evening activities
- Alcohol or drug use (for example, marijuana)
- Student
- First Nations individuals
- Individuals with disabilities
- Individuals who were previously assaulted
- Children who have run away from home

COURSE OF RECOVERY

Recovery after sexual assault has been identified as the sexual assault-trauma syndrome.

- *Acute phase:* Days and weeks after the assault; characterized by anger, fear, anxiety, sleep problems, anorexia, shame, physical pain, and intrusive thoughts
- *Reorganization phase:* Months after the assault; some of the initial symptoms persist, along with the development of nightmares, phobias, and difficulty resuming their usual life, including sexual relationships

HISTORY

Clients are often afraid to disclose sexual assault for a variety of reasons, but present to the clinic for medical attention directly or indirectly related to the incident (for example, pregnancy, injury, depression, self-harm). Be sensitive and supportive.

If any injury requires immediate attention, focus on that prior to completing the history and physical examination.

Document the history as described under “*Family Violence*” above. In addition, ask about:

- Body parts touched or penetrated, whether a male ejaculated, and if condom(s) were used
- Use of weapons (or threatening to use one), force or threats (including to harm someone other than the victim) during the assault
- Memory loss or loss of consciousness
- Sexual history prior to and after the assault (for example, recent consensual sexual activity before or after the assault, condom use, sites of sexual contact)

- Whether the client showered, bathed, douched, voided, brushed hair, ate, used toothpaste or mouthwash, changed or removed a tampon, sanitary napkin or barrier contraceptive and/or changed their clothing after the sexual assault
- Areas that were hurt (for example, mouth, breasts, vagina, rectum)
- If the client or assailant bled
- Last menstrual period

PHYSICAL FINDINGS

Physical examinations for any form of sexual assault may require hours to complete. Ideally it is completed within 24 hours of the assault. Nurses may have to testify in court, if a case is heard.

As per regional policies, complete a forensic evidence (adult sexual assault examination) kit as soon as possible after the assault according to regional policies and with the permission of the client. Explain to the client that they do not have to report the sexual assault to the police, but that the evidence can be collected in case they decide to report it. Ensure all instructions for specimen collection are followed and completed with the materials provided in the kit (for example, fingernail scrapings, buccal mucosa swabs). Provide informed consent in writing prior to evidence being collected. Additionally, kits must be sealed, labeled and stored according to regional guidelines, ensuring that the chain of evidence is not broken at any time, even if the client is not planning on reporting the assault. Most kits do not test for sexually transmitted infections.

Have the client put on a gown to ensure that all body areas can be examined. Document the physical findings as required under “*Family Violence*” above. In addition, be sure to assess:

- Stained, torn or bloody clothing
- Breasts, genitalia and anorectal areas, including a speculum examination for females (if possible); females commonly have injuries on the posterior vagina and labia minora; males commonly are injured on the glans, frenulum or scrotum (erythema, excoriation, laceration)
- Prostate for tenderness
- Urethra for discharge
- Petechial hemorrhages of the palate (if a history of oral intercourse)
- Mental status examination, including unusual fear of a person

DIFFERENTIAL DIAGNOSIS

- Accidental or self-inflicted injury
- Urethral prolapse
- Constipation or diarrhea causing anal fissures or infection
- Vaginitis from harsh soaps or laundry detergents
- Prolonged contact with sand or chlorine
- Lichen sclerosus
- Labial adhesions

DIAGNOSTIC TESTS

To receive informed consent, educate that test results will be part of their medical record. If their case of sexual assault goes to court, the results could be used as evidence for or against them (for example, laboratory-confirmed drug use).

Screen the alleged assailant whenever possible.

- Urine pregnancy test
- Sexually transmitted infection testing; in particular if the client declines prophylactic treatment
 - Swabs (vaginal, rectal, pharynx/mouth and/or urethral depending on the areas of contact during the assault) for *Chlamydia* and *N. gonorrhoeae* culture and nucleic acid amplification testing (not pharynx or rectal); urine sample if not able to collect a swab
 - Swab for culture and sensitivity (for example, trichomoniasis)
 - Syphilis (treponemal and non-treponemal) and HIV antibody serology
 - Hepatitis B surface antigen (HBsAg) unless known to be immune to hepatitis B (for example HBsAg positive)
 - Hepatitis C antibody if assailant(s) are high risk for hepatitis C
- Consider urine drug screening if the client was unconscious or has difficulty remembering the event (for example, for flunitrazepam, gamma-hydroxy-butyrate)

CONSEQUENCES

The more severe the offence (for example, rape compared to unwanted touching), the more likely the person’s life will be negatively impacted.

- Somatic disturbances, including nausea, vomiting, poor appetite, insomnia, nightmares, headaches, fatigue, and specific or general soreness

- Cognitive changes, including difficulty in concentrating, fear of being alone, fear of death, fear of the offender's return and fear of a recurrence
- Interpersonal difficulties at work or school and with friends and family members
- Self-imposed restrictions in daily life
- Mental health concerns (for example, anxiety, depression, post-traumatic stress disorder, suicidal ideation/attempts, mood swings, loss of temper)
- Feeling lonely, worthless, afraid or suspicious of others
- Decreased self-esteem
- Sexual dysfunction or difficulties throughout life
- Misuse of prescription medications (for example, sedatives, stimulants, steroids)
- Gynecological problems: irregular menses, vaginal discharge, pelvic pain, dyspareunia, urinary infections
- Increased risk for cervical cancer
- Substance use/abuse
- Explain the medical procedures that the victim may undergo, the rationale for them (that is, to determine any injuries, test for sexually transmitted infections, and document assault for possible legal proceedings) and the documentation required
- Acknowledge that the medical examination and evidence collection process can be traumatizing, can cause more shame, and can cause feelings of loss of control
- Give the client control by letting them decide what they disclose, what is physically examined (including the forensic evaluation kit) and what is treated or not. *Be familiar with the forensic evaluation (adult sexual assault examination) kit.* Accord the victim the dignity of making his/her own decisions about who can be told that he/she has been assaulted and indicate that, whatever his/her decision, he/she has your support
- Treat injuries (for example, fractures, lacerations) according to the clinical practice guidelines for the specific concern
- Document the evaluation and treatment clearly and completely on the forms included in the forensic evidence kit, even if the client declines evidence collection. Documentation of the history, physical findings and specimens collected must also occur in the medical record
- Provide acute crisis counselling (for example, safety planning) according to those documented under “Nonpharmacologic Interventions” for “Family Violence”, if possible
- Provide psychosocial support, if possible
 - Clients need a lot of emotional support, usually as a result of the sexual assault-trauma syndrome
 - Ongoing counselling should be offered (and referrals made, as the client wishes)
- Offer to talk to the victim's family and friends about their reactions to the sexual assault and the ways in which they can support the victim during the recovery process. If the victim so wishes, explain to the family the importance of allowing the victim to talk about his/her experience at her own pace
- Help the victim to clarify the problems that need immediate attention (for example, where and with whom he/she can stay in order to feel safe) and assist him/her in taking actions to solve these problems
- Complete contact tracing according to the procedures described in chapter 11, “Communicable Diseases”

MANAGEMENT

Appropriate Consultation

Consult a physician when a client has an injury requiring consultation and/or if the client may require further medical or mental health care.

Nonpharmacologic Interventions

Immediately after the assault, allow the victim to wait in a quiet room away from any noise and confusion. Whenever possible, a same-gendered family member, resource person or advocate should remain with the client (if the client approves) throughout the stay at the medical facility (but they need to leave or be silent during the history and physical examination). When possible, ask the victim if he/she would prefer a female or male nurse. In all cases, another person should be present in the room during the medical examination.

- Maintain an empathetic, non-judgmental and non-intrusive attitude that communicates understanding of the emotional upheaval the victim is experiencing. State that you believe the client and that the assault was not their fault.¹⁵⁶ If the victim is reluctant to talk about his/her experience, do not probe or otherwise pressure him/her to do so. On the other hand, if the victim elects to vent, validate his/her emotions and “normalize” his/her reactions (that is, let him/her know that his/her experiences are not dissimilar to those of other victims)

Client education

- Discuss the risk for sexually transmitted infections and pregnancy
 - If anal sexual assault or if either person has trauma, bleeding, or genital lesions there may be a higher likelihood of transmitting HIV
- Advise to abstain from sexual intercourse until the course of prophylaxis has been completed and use condoms after that until infection is ruled out (for at least 3 months) to protect others
- Discuss confidentiality and that all information given by the victim will be kept confidential unless she specifically requests otherwise
- Discuss police and court procedures and what may be expected as a consequence of specific legal intervention. The decision to contact the police must be made by the victim. If the client is going to contact police, allow the client to call the police from the clinic
- Give contact information for services specifically available for sexual assault victims. In many areas, sexual assault crisis centres located in major urban centres will accept collect long-distance telephone calls
- Provide the client with a phone number that they can call at any time for support or help, such as the nursing station, or the Centre for Suicide Prevention maintains a list of crisis lines for all the provinces and territories (available at: <http://www.suicideinfo.ca/csp/go.aspx?tabid=77>)
- Give the victim information about the course of recovery and how counselling can help with this, even though thinking or discussing the assault may be painful initially. Encourage them to seek further help early to decrease risk of long-term concerns

Pharmacologic Interventions

Discuss the client's need and wish for prophylaxis for sexually transmitted infection (STI) (see “Sexually Transmitted Infections” in chapter 11, “Communicable Diseases”).

Prophylaxis should be offered at the initial visit to clients if: the client may not return for follow-up, the assailant is known to have a specific sexually transmitted infection, it is requested by the client or parent, there are signs or symptoms of a sexually transmitted infection, the client declined sexually transmitted infection testing, and/or penetration (vaginal, oral, or anal) occurred. The following infections warrant consideration:

- Gonorrhea
- Chlamydia
- Trichomoniasis (treat only if positive test result)
- Syphilis
- Hepatitis B vaccination and immune globulin (if not immune and there was penetration without a condom)
- HIV (if assailant known to be HIV positive and penetration without a condom; consult if assailant is thought to be high risk); it should be started as soon as possible and within 72 hours

For a complete discussion of the clinical presentation and treatment of sexually transmitted infections, refer to and follow the *Canadian Guidelines on Sexually Transmitted Infections* (available at: <http://www.phac-aspc.gc.ca/std-mts/sti-its/index-eng.php>).

Determine whether the sexual assault could have resulted in a pregnancy; if so, discuss the possibility of administering oral emergency contraception immediately (see “Emergency Contraception” in chapter 13, “Women's Health and Gynecology”).

Offer antiemetics (for example, dimenhydrinate) if the client is prescribed both an emergency contraceptive and antibiotic(s).

If wounds were sustained and are dirty or occurred outside offer tetanus toxoid if the client's immunization status is unknown or if it has been > 5 years since their last immunization.

Monitoring and Follow-Up

Follow-up in 1–2 weeks to:

- Review laboratory results
- Assess mental status and the victim's adjustment and provide support
- Refer to mental health services as required
- Repeat pregnancy test (even if received emergency contraception) 4 weeks after initial examination
- Document bruising not evident during the initial examination

- Give the victim information about the course of recovery. In particular, the victim should know that the symptoms he/she is currently experiencing will subside (the time frame is variable), but he/she is likely to re-experience these symptoms as part of the recovery process
- Repeat hepatitis B vaccinations at 1 month and 6 months, if applicable
- Repeat or complete sexually transmitted infection screening, if requested, if declined prophylaxis initially, if have symptoms or if required as follows:
 - If cultures for *Chlamydia* and *N. gonorrhoeae* are negative (taken within 48 hours of exposure), repeat after 1–2 weeks if prophylaxis was not given
 - Test for trichomonas and bacterial vaginosis after 1–2 weeks if prophylaxis was not given
 - Repeat HIV antibody testing at 6, 12, and 24 weeks after potential exposure
 - Repeat syphilis testing (treponemal and non-treponemal) and hepatitis C antibody testing (if done at baseline) at 12 and 24 weeks after potential exposure

Notifiable diseases may differ from one province or territory to another. Report any notifiable diseases in your province or territory according to local protocols.

Referral

Most clients will be able to be treated on an outpatient basis. If a medical evacuation may be warranted, consult a physician.

Refer the client to other appropriate and available services, depending on the client's wishes: sexual assault team/crisis centre, local police, mental health services, and/or victim support groups.

A counselling or psychotherapy referral should be considered early, if the client agrees. If it appears that the victim is unable to function, a psychiatric and psychological referral should be considered.

If anxiety or depression symptoms do not improve with psychotherapy or counselling, refer to a physician to consider prescribing antidepressants (selective serotonin reuptake inhibitors).

If the client is under 18 years of age, appropriate reporting of child abuse should take place (see “Sexual Abuse of Children” in chapter 5, “Child Maltreatment” of the *Pediatric guidelines*).

SUBSTANCE ABUSE^{169,170,171}

The *Diagnostic and Statistical Manual IV* criteria for substance abuse is the recurrent use of 1 or more substances with 1 or more of the following (related to substance use) for at least 1 year:¹⁷²

- Impaired role obligations at home, work and/or school
- Putting self and/or others in hazardous situations (for example, driving, swimming)
- Legal concerns (for example, arrested)
- Social or interpersonal issues related to the substance (persistent or recurrent)

The *Diagnostic and Statistical Manual IV* criteria for substance *dependence* (addiction) is when a person using 1 or more substances recurrently has 3 or more of the following:¹⁷²

- Tolerance (decreased effect with same dose)
- Withdrawal signs and symptoms after cessation (for example, delirium tremens)
- Consumed more than intended
- Client continually wants to decrease or control intake
- Time is used to get, consume, or recover from substance use
- Decreased social, occupational or recreational activities due to substance use
- Use despite physical and psychological concerns

Substance dependence is one form of substance abuse, but most forms of substance abuse are not substance dependence.¹⁷³ Substances that have the potential for abuse or dependence are tobacco; inhalants; alcohol; steroids; and/or prescription, over-the-counter, and/or illegal drugs (for example, cannabis, cocaine, opiates, amphetamines, hallucinogens). Many individuals start by experimenting socially and/or using the substance casually.¹⁷⁴

Drug abuse is widespread in North American society. It affects all ages, races, and socioeconomic classes, although women are slightly less likely than men to use or abuse substances. Of Aboriginal people, 26.3% report a substance abuse concern.¹⁷⁵ The use of substances usually begins in adolescence. Youth aged 15–24 use drugs and experience harm due to their drug use at much higher rates than those over age 25.¹⁷⁶ Nicotine is the most commonly abused drug, followed by alcohol, marijuana and then stimulants such as amphetamines and cocaine. In First Nations and Inuit communities, gas and solvent sniffing

also constitute a significant concern. Prescription (particularly oxycodone) and over-the-counter medications are increasingly being abused. Often clients abuse more than one substance. This increases the risk of negative consequences.

A resource that discusses substance abuse specific to the Aboriginal population is *Addictive Behaviours among Aboriginal People in Canada* (available at: <http://www.ahf.ca/publications/research-series>). It includes historical influences, cultural considerations for healing, successful treatment programs, and fact sheets on different addictions.

For specific information about substance abuse in children and adolescents, see “Substance Abuse” in the pediatric chapter 19, “Adolescent Health”.

For specific information on cocaine poisoning, see “Overdoses, Poisonings and Toxidromes” in chapter 20, “General Emergencies and Major Trauma”.

CAUSES

Many different factors may contribute to substance abuse, including genes, an individual’s brain, childhood problems, mental health concerns, stress, and cultural factors. Environmental factors are suggested to influence drug initiation, whereas the development of substance abuse is related to genetics.

Risk Factors^{177,178,179}

- Family history (parents or siblings) of alcohol or substance abuse/dependence and/or serious psychiatric illness
- Family conflict or disorganization (for example, relationship concerns, single parent)
- Substance abuse or use (to cope with stressors)
- Early age of first use (regardless of substance)
- Substance use within peer group (for example, friends who use regularly)
- Attention deficit hyperactivity disorder; bipolar disorder; schizophrenia; obsessive-compulsive disorder; borderline, antisocial, and psychopathic personality disorders; or depression
- History of impulsive, high-risk behaviour, particularly those with consequences (for example, jail, legal charges, accidents, unsafe sexual activity, school/work absenteeism, poor school/work performance)
- History of behavioural addictions (for example, gambling, eating dysfunction)
- History of abuse (emotional, physical or sexual)

- Stress, including facing discrimination or oppression, with poor stress management skills
- History of somatization
- Social isolation
- Poverty
- Low self-esteem
- Partner who is a substance abuser (in particular, for female clients)
- Frequent encounters with the law (for example, police)
- Age 16–45 years

HISTORY^{180,181,182}

All clients can hide the fact that they use a substance unless they are directly asked about the issue.

Pregnant women are more reluctant to reveal the use of a substance because of possible consequences. Discuss drug testing with new clients, pregnant women and clients presenting with new symptoms (For example, mental disorders, weight loss) or unexplained symptoms. Respect confidentiality at all times. Ask the client if he/she is open to discussing substance use and explain why detection tests may be needed. Get informed consent (at least verbally) and document the findings of the discussion in the client record.

Screening for substance use and abuse:

- The World Health Organization’s ASSIST Tool (available at: http://www.who.int/substance_abuse/activities/assist_test/en/index.html) can be used to screen clients age 18 and older for all forms of substance use, to determine their level of risk, and to determine what type of intervention may be warranted. *The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): Manual for use in Primary Care* describes the tool in detail (available at: http://whqlibdoc.who.int/publications/2010/9789241599382_eng.pdf)
- Ask family and/or friends about drastic changes in behaviour (for example, not telling others where they are going) or known/suspected substance use, if the client agrees
- Anyone at home using tobacco
- Assess for risk factors as described above

Substance Users

- For each substance used assess most recent use, frequency, intensity, patterns of use/abuse (when, where, with whom), how they obtain and/or pay for them, when first used, quantity used, amount of money spent, method of use (for example, oral, snort, inhale, inject subcutaneously or intravenously), form of substance used (for example, pill, syrup, powder), environmental triggers, history of injection or sharing needles, history of quit attempts and/or treatment and length of periods of abstinence, treatment methods that worked and did not in past, participation in Alcoholics Anonymous/Narcotics Anonymous, history of cravings or withdrawal symptoms, and progression of use
- Issues (positive and negative) resulting from substance use showing up at school or work (for example, absenteeism, dropping grades), socially (family, peers, relationship), legally (for example, stealing when would not previously), financially (for example, spending money even when cannot afford it, sudden requests for money with little explanation)
- Feeling that have to use the substance regularly, have to keep a supply, need the drug to help get through problems
- Ask about specific symptoms of dependence, depending on the type of substance used. *See Table 1, “Signs and Symptoms of Substance Dependence by Substance Class.”* Many of these signs and symptoms of dependence are seen positively by youth (for example, weight loss, stress reliever, hiding social insecurity)¹⁸³
- Assess readiness to change (quit for nicotine dependence) at this time and motivation to change on scale from 1 to 10

For alcohol and drug users:

- Ever drove a vehicle while under the influence of alcohol or drugs?
- Screen for problem alcohol and drug usage using the CAGE-AID mnemonic screening tool. It can give additional information to the World Health Organization’s ASSIST Tool’s risk levels (available at: http://www.who.int/substance_abuse/activities/assist_test/en/index.html):
 - C – Ever felt the need to **C**ut down or **C**hange your pattern of drinking or drug use?
 - A – Ever been **A**nnoyed by others criticizing your drinking or drug use?
 - G – Ever felt **G**uilty about what has happened while you are drinking or using drugs?
 - E – Ever had a drink or used drugs in the morning (**E**ye-opener) to help with a hangover or withdrawal symptoms

One ‘yes’ suggests a possible alcohol or drug problem and warrants further investigation, whereas 2 or more ‘yes’ answers indicates serious alcohol or drug problems. However, CAGE-AID is not as predictive for women, youth, or the elderly. Therefore, for alcohol users, females drinking > 1 drink a day (or > 3 at one time or > 7 per week) or males drinking more than 2 drinks a day (or > 4 at one time or > 14 per week) are at a higher risk of alcohol-related problems.¹⁸⁴

Table 1 – Signs and Symptoms of Substance Dependence by Substance Class^{185,186}

Class of Substance	Examples of Substances	Signs and Symptoms of Dependence
Cannabis Compounds ^{187,188} affect cognition, emotions and actions; contain THC	<ul style="list-style-type: none"> • Marijuana • Hashish • Hash oil 	<ul style="list-style-type: none"> • Heightened senses (for example, vision, taste, touch, hearing) • Decreased memory • Higher blood pressure and heart rate • Red eyes, dry mouth • Decreased ability to concentrate • Increased appetite • Less coordination, not able to judge distances, and slower reflexes • Feeling more relaxed, or anxious and paranoid

Table 1 – Signs and Symptoms of Substance Dependence by Substance Class^{185,186}

Class of Substance	Examples of Substances	Signs and Symptoms of Dependence
Depressants slow down central nervous system	<ul style="list-style-type: none"> • Barbiturates (for example, phenobarbital) • Benzodiazepines (for example, diazepam, lorazepam, clonazepam) 	<ul style="list-style-type: none"> • Feeling tired • Unclear speech, decreased memory and ability to learn • Confusion • Less coordination • Relaxation • Lower respiratory rate and blood pressure • Dizziness • Depression
	<ul style="list-style-type: none"> • Alcohol 	<ul style="list-style-type: none"> • Slower reflexes, movement and thinking • Aggression or depression • Unclear speech, decreased memory • Feeling tired • Less coordination • More relaxed and social • Flushed skin
	<ul style="list-style-type: none"> • Opioid analgesics (for example, heroin, morphine, codeine, methadone, oxycodone) 	<ul style="list-style-type: none"> • Constipation • Sedation • Confusion • Depression • Lower respiratory rate and blood pressure • Decreased pain • Needle marks (if injecting)
	<ul style="list-style-type: none"> • Inhalants¹⁸⁹ (for example, volatile solvents – glue, paint thinner, gasoline; aerosol cans – household aerosol sprays; gases – nitrous oxide, propane; nitrites – room deodorizers, video head cleaners) 	<ul style="list-style-type: none"> • Brief intoxication (alcohol-like, but increased perceptual distortion) • Dizziness, nausea, blurred vision, slurred speech • Sneezing or coughing • Slower reflexes • Disinhibition, stimulation, euphoria • Drowsiness or sleep • Death
Stimulants ^{190,191,192,193,194} speed up the central nervous system	<ul style="list-style-type: none"> • Amphetamines • Methamphetamines • Methylphenidate (Ritalin) • Cocaine* • Crack • Caffeine • Tobacco 	<ul style="list-style-type: none"> • High mood (euphoric), confident, irritable, depressed as drug wears off • Increased temperature, blood pressure and pulse • Decreased appetite and/or weight loss • Fast speech • Restless • Nasal congestion and mucous membrane damage if snorting (atrophy, perforation) • Insomnia • Paranoia
Hallucinogens ^{195,196,197} distort senses, emotions, feelings, and thoughts; may cause hallucinations at high doses	<ul style="list-style-type: none"> • LSD • Mescaline • Peyote • Psilocybin mushrooms • Phencyclidine (PCP) • Ecstasy† • Salvia • Ketamine 	<ul style="list-style-type: none"> • Mind-altering effects differ depending on the drug, episode, and person (for example, ecstasy or terror, mild sense of distortion to full hallucination) • Affect perception and behaviour (for example, judgment, risk taking)

* See “Cocaine” in chapter 14, “General Emergencies and Major Trauma”.

† Ecstasy has both stimulant and hallucinogenic properties.

Also assess the following in all clients who use substances:

- Physical health concerns (for example, fatigue, lack of motivation, impotence, sleep concerns, fevers)
- Potential underlying causes of symptoms/substance use (for example, family breakdown, exposure to violence or abuse, foster care)
- Prescription and over-the-counter medications used (including dosage, route and frequency) and for what purpose
- Medical history and comorbid conditions (including mental illnesses)
- Depression, suicidal behaviours, problem gambling, sexual addiction
- Psychosocial history, including family and peer relationships (are affected early), current school/work performance (are affected later) and behaviour, extracurricular activities, self-esteem, and acceptance of authority¹⁹⁸ to help determine if substance use is interfering with social growth

PHYSICAL FINDINGS

Assess for:

- Vital signs, including weight
- Mental status examination as described under “*Mental Health Assessment*”
- Client-family/friend interaction, if possible (for example, warm, nurturing, conflicting, rejecting, affectionate)
- Specific physical findings that might be noted for diseases associated with the substance of abuse (for example, oral thrush and posterior cervical lymphadenopathy in HIV), acute substance intoxication (for example, abnormal pupil size, strange behaviour, sweating), and/or certain classes of substances of abuse (see Table 1, “*Signs and Symptoms of Substance Dependence by Substance Class*”)
- Additional specific physical findings include track marks, tremor, slurred speech, evidence of malnutrition and poor self-care, poor oral hygiene

DIAGNOSTIC TESTS

Urine drug screen and serum alcohol levels can be completed to detect recent use, if medically necessary and if the client consents. Be aware that the client may substitute another substance for or dilute a urine sample.

If client has used injection drugs (even once) or is an intranasal cocaine user, test for HIV, hepatitis B and hepatitis C.

COMPLICATIONS^{199,200,201}

Substance use has many potential and real consequences. These include:

- Harm to brain development and cognitive concerns related to memory or attention
- Difficulties with the law (for example, stealing, motor vehicle accident, underage drinking, imprisonment)
- Cravings, increased desire to use, tolerance, withdrawal symptoms
- Suicidal behaviours
- Unsafe sexual activity, impotence
- Problems with friends, relationships, school, work (for example, sudden job loss, frequent changes), family, money, and emotional and mental health
- Diseases (for example, HIV, hepatitis, cancer, sexually transmitted infections, tuberculosis)
- Substance dependence
- Physical (for example, infection, sleep) and mental health (for example, anxiety, depression) concerns
- Victim of violent crime (for example, rape, assault, robbery, murder)
- Death (for example, overdose)
- Negative effects on a fetus (for example, alcohol, cocaine)
- Homelessness
- Accidents, injury (particularly physical trauma)
- Unpredictable behaviour

Of those who abuse drugs 53% also have a mental illness.²⁰² Complications related to a specific substance are described in the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): Manual for use in Primary Care on pages 11–18 (available at: http://whqlibdoc.who.int/publications/2010/9789241599382_eng.pdf).

MANAGEMENT

Treatment success for addictions depends on level of functioning at beginning of treatment, usual functioning, comorbid conditions, and client support systems. Comorbid conditions (for example, homeless, mental health concerns, relationship issues) must be addressed (for example, treated) during treatment, as they may be an underlying factor for substance abuse.

Goals of Treatment

- Behaviour change (for example, facilitate treatment and prevent relapse)
- Assess for and treat comorbid conditions, including medical and mental health

Base treatment on the client's individual goals. Goals early on should be easily attainable.

Nonpharmacologic Interventions^{203,204}

Stigma around addiction prevents families and individuals from seeking help and/or acknowledging the problem. One way to decrease stigma is by using language that puts the person first (for example, people with substance use problems).

All Clients (even if they do not use substances)

- Ask their opinions about substance use
- Educate with concrete facts about what the specific drug(s) is really doing to the client (*see Table 1, “Signs and Symptoms of Substance Dependence by Substance Class”*)
- Encourage healthy friendships with those who do not use substances
- Encourage participation in social/extra-curricular activities
- Point out strengths and resources (for example, positive achievements, positive peer/family relationships, good decisions made)
- Encourage to avoid combining substance use with risky behaviours (for example, sexual activity, driving, dangerous equipment)

Stages of Change: A well known model of behaviour change that provides a framework for how people change and their readiness to change is often used to provide appropriate interventions for a client's current stage of change. For more information see pages 7–10 and 28–30 of the “ASSIST-linked Brief Intervention for Hazardous and Harmful Substance Use: Manual for Use in Primary Care” (available at: http://whqlibdoc.who.int/publications/2010/9789241599399_eng.pdf). Further information is available from the *Centre for Addictions and Mental Health* (available at: http://www.camh.net/about_addiction_mental_health/drug_and_addiction_information/addiction_information_guide/addiction_change.html).

Substance Users

See headings below for specific information and interventions for some substances of abuse. Brief interventions are useful. The following interventions apply to all users of substances of abuse:

- Use the five A's: **A**sk about use, **A**dvice them to quit, **A**ssess their willingness to make a quit attempt, **A**ssist them by arranging/providing counselling and pharmacologic treatment, and **A**rrange follow-up
- Tell the client you are concerned about their substance use (using the term “disease” can reduce client guilt) and are available to listen
- Give them facts about the problem (for example, about the risks of use, signs and symptoms of problem use, specific information from their history and assessment to show the impact on their health and potential triggers for use, how drinking may be positive in their life, impact on long-term health, what withdrawal symptoms mean)
- Be patient, but persistent and empathetic, but firm
- Encourage change (not necessarily treatment); help the client resolve their ambivalence or denial about their personal substance use so they can move toward change; discuss treatment options if the client is interested
- Be positive and celebrate small successes
- Express confidence in the person to change
- Involve family members as much as possible in treatment, if the client agrees
- If substances are used more than occasionally, assist them to make changes by setting goals (for example, a contract to stop the problem behaviour, revealing the behavior to their parent[s])²⁰⁵
- Help them plan for handling scenarios where peer pressure or relapse may take place
- Discuss community resources that are available to them (for example, National Native Alcohol and Drug Abuse Program (NNADAP); social/extra-curricular activities)
- Help clients with practical issues (for example, housing, employment, transportation)
- Encourage clients to return to discuss substance use at any time
- Teach the client that substance abuse is a chronic disease that can relapse; educate about the warning signs of a relapse and that relapses should be expected, are normal, and should be used as a learning experience. Recovery is long term

- Tailor the intervention to the client’s stage of readiness to change:
 - Not ready (precontemplation) – raise awareness, educate them and encourage change
 - Unsure if ready (contemplation) – discuss their ambivalence to change, look to the future (for example, consequences), encourage change
 - Ready (preparation and action) – discuss treatment options, help them develop an action plan
- Tailor interventions according to level of risk, as assessed by the World Health Organization’s ASSIST Tool (available at: http://www.who.int/substance_abuse/activities/assist_test/en/index.html):^{206,207}
 - Lower risk clients should be given feedback on their scores and encouraged to remain at lower risk and/or abstain
 - Moderate-risk clients often respond well to brief 3–15 minute interventions at multiple visits. Provide feedback using the ASSIST feedback report card, giving a copy to the client (available at: http://www.who.int/substance_abuse/activities/assist_test/en/index.html)
 - For more information on appropriate interventions and motivational interviewing (helping the substance user recognize the need for change), see pages 11–21 and 31–34 of the *ASSIST-linked Brief Intervention for Hazardous and Harmful Substance Use: Manual for Use in Primary Care* (available at: http://whqlibdoc.who.int/publications/2010/9789241599399_eng.pdf). Provide general information on the specific substance(s) that they are using (see list below) and the booklet *Self-help Strategies for Cutting Down or Stopping Substance Use: A Guide* (available at: http://whqlibdoc.who.int/publications/2010/9789241599405_eng.pdf). If a client is in the moderate risk group, but has not used the substance within the past 3 months encourage them to continue abstaining and educate that they are at increased risk due to their previous problems with the substance
 - High-risk clients require all the interventions as described under moderate-risk clients above to encourage and motivate them to seek further assessment and treatment. They will often require longer interventions. In addition, discuss what is involved in treatment, and how to access it. Discuss past attempts to quit and assess their substance use history and physical health

- Provide clients who have injected drugs in the past 3 months with the ASSIST risk of injecting card (available at: http://www.who.int/substance_abuse/activities/assist_test/en/index.html) and go over it to help educate the client

Treatment for an addiction depends on the goal(s) of the client. Many are reluctant to agree to abstinence programs.²⁰⁸ Options for treatment can include:

- Harm reduction – to reduce substance use–related harm without client stopping substance use (for example, do not drink and drive, needle and syringe exchanges)
- Treatment programs – clients with significant substance abuse problems, and those requesting treatment should be referred to the most appropriate social services group (for example, *National Native Alcohol and Drug Abuse Program [NNADAP]*). Provincial alcoholism foundations also sponsor treatment programs aimed at specific client groups. In remote areas, consultation with a person with knowledge of appropriate referral agencies may be indicated to establish the most effective and practical treatment program. *NNADAP* (available at: <http://www.hc-sc.gc.ca/fniah-spnia/substan/ads/nnadap-pnlaada-eng.php>) and *National Youth Solvent Abuse Program (NYSAP)* (available at: <http://www.hc-sc.gc.ca/fniah-spnia/substan/ads/nysap-pnlasj-eng.php>) treatment centres are listed in the *online Treatment Centre Directory* (available at: http://www.hc-sc.gc.ca/fniah-spnia/substan/ads/nnadap-pnlaada_dir-rep-eng.php)
- Clients with antisocial behaviour in combination with significant drug or alcohol dependency usually require a long-term treatment program designed for their age group. Referral to a social worker or a *National Native Alcohol and Drug Abuse Program (NNADAP)* worker with knowledge of referral agencies is generally required

Clients and/or their families can get information, support, and/or find out about resources through the following services:

- Centre for Addiction and Mental Health Information, 1-800-463-6273 (available at: www.camh.net)
- Kids Help Phone, 1-800-668-6868 (available at: www.kidshelpphone.ca)
- Ontario Drug and Alcohol Registry of Treatment (for Ontario services), 1-800-565-8603 (available at: www.dart.on.ca)

- Health Canada’s First Nations, Inuit and Aboriginal Health treatment programs:
 - National Youth Solvent Abuse Program (NYSAP) (available at: <http://www.hc-sc.gc.ca/fniah-spnia/substan/ads/nysap-pnlasj-eng.php>)
 - National Native Alcohol and Drug Abuse Program (NNADAP) (available at: <http://www.hc-sc.gc.ca/fniah-spnia/substan/ads/nnadap-pnlaada-eng.php>)
- Government of Canada. *Youth drug prevention for parents; 2010* (available at: <http://www.nationalantidrugstrategy.gc.ca/parents/parents.html>)
- Your region’s poison control office

Pharmacologic Interventions

Occasionally, medications (for example naltrexone, disulfiram, methadone) are used to decrease the likelihood of relapse once abstinence has occurred. However, it is only helpful when combined with counselling and must be prescribed by a physician.

Monitoring and Follow-Up

After completion of an addiction treatment program, regularly assess the client’s recovery progress (for example, ask about cravings, using small amounts, anxiety, depression, relationships, and ability to function at school/work) in order to help prevent relapse. Discuss with a physician whether this should include urine drug testing.

Even if the client does not agree to an intervention or treatment, each time they visit monitor their use and encourage them to consider reducing or abstaining from use.

Referral

“Treatment is cost-effective, and even multiple episodes of treatment are worthwhile.”²⁰⁹ Clients who undergo treatment have less disability than those who do not. If the client has an addiction and agrees (the client has decided to change), in collaboration with a physician, refer to an appropriate (for the individual client, the substance, and the level of addiction) addictions treatment program or an addictions counselor. High-risk clients (as per World Health Organization’s ASSIST Tool [available at: http://www.who.int/substance_abuse/activities/assist_test/en/index.html] risk levels) in particular should be referred to a physician, a treatment program, and/or a counselor for further assessment and treatment.²¹⁰

Counselling is a common component of all treatment programs and some have self-help groups. Some programs may involve families and/or employers. Consult a physician to assist in referrals to treatment programs.

ALCOHOL ABUSE^{211,212,213}

The *Diagnostic and Statistical Manual IV* criteria for *alcohol abuse* is recurrent alcohol use with 1 or more of the following for at least 1 year:²¹⁴

- Impaired role obligations at home, work, and/or school
- Putting self and/or others in hazardous situations (for example, driving, swimming)
- Legal concerns (for example, arrested)
- Social or interpersonal issues related to alcohol (persistent or recurrent)

See “*Substance Abuse*” above for the criteria for *alcohol (substance) dependence*.

Binge drinking is when a male consumes 5 or more drinks at one time or a female consumes 4 or more.

Risky drinking is when a woman has more than 7 drinks a week or 3 drinks at a time or when a male has more than 14 drinks a week or 4 drinks at a time.

More Aboriginals (34%) consume no alcohol when compared with the Canadian population as a whole (21%); however, the number of heavy drinkers (≥ 5 drinks/week) who are Aboriginal is double that of the Canadian population. Of those who abuse alcohol, 37% also have a mental illness.²¹⁵ Of First Nations young adults, 83% drank alcohol in the past year. Also, First Nations males are twice as likely to drink weekly when compared to females.²¹⁶ Lastly, 10.2% of Aboriginal females admit to binge drinking at least weekly (higher than the rate for other Canadian females).²¹⁷

Drinking alcohol during pregnancy causes more preventable birth defects than anything else in North America. There are 365 babies born in Canada every year with fetal alcohol syndrome²¹⁸ (approximately 1% of births)²¹⁹ and the incidence is very high in the Canadian Aboriginal community (one study found 16% of children in one British Columbia community).²²⁰ This is likely related to determinants of health (for example, poverty).

Ethanol is found in standard alcoholic drinks as well as household products like mouthwash, perfume, cologne, baking extracts, and some over-the-counter medications.²²¹

The definition, clinical manifestations and treatment for “acute alcohol withdrawal” and “alcohol withdrawal delirium” are outlined in other sections of the adult mental health chapter.

For specific information about alcohol abuse in children and adolescents, see “Alcohol Abuse” in chapter 19, “Adolescent Health”.

CAUSES

A combination of biological (including genetics), psychosocial and environmental factors.

Risk Factors²²²

- One-third of surveyed alcoholics reported that at least one parent was alcoholic. Biological studies support this familial trend
- First Nations
- Male
- Single
- Lower income
- See other risk factors for substance abuse above

Risk factors for alcohol use in pregnancy: ²²³

- Smoker
- Substance use
- Non-caucasian
- Age 15–24 years
- Victim of physical or sexual abuse
- Less educated
- Single and/or little social support
- Low income
- Depression
- Living with substance users

HISTORY

Screen all clients for alcohol use and abuse annually, as detailed above (under “Substance Abuse”). Ensure the following groups are screened: females of child-bearing age and those who are pregnant,²²⁴ clients with a family history of alcohol abuse, those who smoke, and clients who are frequently injured.

A single screening question for alcohol use or dependence may be as effective as longer questionnaires (for example, CAGE-AID, Alcohol Use Disorder Identification Test [available at: http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf], CRAFFT for adolescents (available at: <http://www.ceasar-boston.org/clinicians/crafft.php>). An example is, “How many times in the past year have you had 5 (men) or 4 (women) or more drinks in a day?”²²⁵

For clients whose screen is positive for alcohol use, in addition to those questions listed under “Substance Abuse” above, ask about:

- The factors that define alcohol abuse and dependence
- Symptoms of potential complications
- Indicators of alcohol dependence (for example, memory loss or blackouts after drinking, sleep interruptions, and tremors)

PHYSICAL FINDINGS

Physical findings may be normal or there may be any of the following:

- Physical findings in acute intoxication: ataxia, slurred speech, uninhibited behaviour, stupor, coma, smell of alcohol on the breath, hypoglycemia
- Physical findings in chronic alcohol use: enlarged liver in some cases, evidence of malnutrition, tremor, poor oral hygiene, easy bruising, ascites, pedal edema, telangiectasia, rhinophyma, cognitive changes (see also section on dementia), jaundice, ataxia, nystagmus
- Physical findings in alcohol withdrawal: hypertension, tachycardia, tremor, anxiety, seizures, vomiting

DIFFERENTIAL DIAGNOSIS

In an acutely intoxicated client rule out the following, which may co-exist with alcohol intoxication:

- Head trauma
- Hypoxia
- Hypoglycemia
- Hypothermia
- Hepatic encephalopathy in patients with known liver cirrhosis

COMPLICATIONS OF CHRONIC ALCOHOL ABUSE^{226,227,228}

- Hypertension
- Malnutrition
- Gastrointestinal complications (for example, ulcers, pancreatitis, digestive concerns, acute alcoholic hepatitis, liver cirrhosis)

- Fetal alcohol spectrum disorder due to prenatal alcohol exposure
- Premature aging
- Decreased sexual performance
- Depression, anxiety,
- Harm to self or others (for example, violence, accidents [such as motor vehicle], injury, suicide, unable to control temper)
- Relationship, work and financial concerns
- Brain damage with cognitive problems, including memory loss
- Cancer (for example, mouth, throat, breast)
- Death

DIAGNOSTIC TESTS

No tests should be used to screen clients for alcohol use. Blood alcohol and ethanol concentrations do not correspond with the physical symptoms of intoxication.

Liver function tests (AST, ALT, GGT), blood alcohol and ethanol concentration, upon physician consultation, as liver function tests correlate very poorly to alcohol use and abuse. A complete liver panel including albumin, PT/PTT and bilirubin should be evaluated for patients who have suspected cirrhosis or alcoholic hepatitis.

Acutely intoxicated patients should have a rapid capillary glucose measurement to rule out hypoglycemia.

MANAGEMENT^{229,230}

Goals of Treatment

- Prevent alcohol withdrawal
- Encourage treatment program involvement (for example, counselling)
- Involve family, employment, and community resources
- Restore self-esteem
- Resolve social issues
- Improve physical health
- Abstinence from alcohol use or controlled drinking

Appropriate Consultation

Consult a physician before instituting medications, if the client is acutely intoxicated, and when assistance is needed to refer a client to a treatment program.

Nonpharmacologic Interventions

- All Alcohol Abusing and/or Dependent Clients
- Refer to “*Nonpharmacologic Interventions*” under “*Substance Abuse*” above, as they can be used for all substance users. Motivational interviewing can help all clients who are ambivalent about change
- Encourage participation in Alcoholics Anonymous, for any client who wants to stop drinking
- Treat comorbid conditions (for example, mood disorder, anxiety, sleep difficulties, smoking), in particular depression
- Encourage clients to exercise regularly and have a healthy diet
- Educate clients with a handout on alcohol from the Aboriginal Healing Foundation; see pages 80–81 of *Addictive Behaviours among Aboriginal People in Canada* (available at: <http://www.ahf.ca/publications/research-series>)
- Educate clients who are or who might get pregnant:²²⁴
 - to abstain from alcohol, as there is no known safe or unsafe level of alcohol to drink during pregnancy
 - low levels of alcohol consumption early in pregnancy is not a reason for pregnancy termination

Brief interventions and motivational interviewing as described under “*Substance Abuse*” have been very successful in treatment of alcohol abuse, but not alcohol dependence.

If a client is acutely agitated and/or is violent, medication can be administered (see “*Violence or Aggressive Behaviour in Mental Health Clients*” below).

Alcohol Dependent Clients

- If they wish to quit drinking, offer a psychosocial intervention or a pharmacologic one, but they may need treatment for alcohol withdrawal as well

Clients with Acute Alcohol Intoxication²³¹

- Support the client with care measures and allow them to rest
- Correct hypovolemia with intravenous normal saline and hypoglycemia if present, after consultation with a physician
- If altered level of consciousness, rule out other potential causes
- Closely monitor respiratory function until the client is sober
- Once client is sober, intervene appropriate to the client’s level of alcohol use

Pharmacologic Interventions

Encourage clients who are *alcohol abusers or dependent* to take a daily multivitamin containing folic acid.

For clients who are *alcohol dependent*, who want to decrease their alcohol consumption, and prefer medication instead of nonpharmacologic interventions (and are not pregnant), the following are examples of medications that may be prescribed by a physician: naltrexone, acamprosate. These medications can be initiated while the client is undergoing treatment for intoxication or withdrawal, although naltrexone can be started while a client is still drinking. Six months of medication is common. If medication is prescribed, educate about medication side effects and their tendency to decrease with continued treatment.

Acute Alcohol Intoxication

thiamine 100 mg IV (only if client is in a coma)

Continue thiamine 100 mg PO or IV daily for up to 3 days or until seen by a physician.

Monitor for hypoglycemia to assess need for glucose administration.

Monitoring and Follow-Up

Screen clients for alcohol use annually.

For clients who now abstain or who have recovered from alcohol abuse or dependence, follow up at least monthly for the first year (or 6 months after the end of pharmacologic treatment) to assess for relapse, treatment response and goals, medication side effects and adherence, and early signs of relapse. Continue to encourage Alcoholics Anonymous participation (if available), be supportive, and ensure comorbid anxiety and depression are treated throughout the follow-up period. Perform any laboratory testing required if the client is taking a medication (for example, naltrexone requires liver function tests).

Referral

A referral to a planned withdrawal program can be made if the *alcohol dependent* client is not already in withdrawal and the client agrees. Refer the client to a physician, social worker or National Native Alcohol and Drug Abuse Program (NNADAP) worker to help them through alcohol withdrawal.

Refer clients at medium or high risk of alcohol abuse or dependence before becoming pregnant or during pregnancy, if they agree, for treatment.²²⁴

For clients with acute alcohol intoxication and a decreased level of consciousness, consult a physician about a medevac.

ACUTE ALCOHOL WITHDRAWAL^{232,233,234}

According to the *Diagnostic and Statistical Manual IV*²³⁵ it is a syndrome experienced after cessation of or reduction in alcohol ingestion by a person who has been drinking for several days or longer with at least 2 of the following symptoms occurring within hours to days, causing distress or social, occupational or other problems with functioning.

Symptoms are:

- Early alcohol withdrawal: tremor, anxiety, autonomic hyperactivity
- Visual hallucinations
- Alcohol withdrawal seizures
- Delirium tremens: a late withdrawal syndrome (> 48 hr) in chronic alcoholics, carrying a mortality rate up to 20% if untreated; manifested by autonomic hyperactivity, confusion/delirium; may be complicated by cardiac arrhythmia, dehydration, electrolyte disturbances and aspiration

HISTORY

The amount of information gathered initially will depend on the client's medical condition. If a full history is not taken at the beginning, try to gather more information after the client is more comfortable.

Establish that the client has been using alcohol; the CAGE-AID and the Clinical Institute Withdrawal Assessment for Alcohol-revised (CIWA-Ar) (available at: http://www.tg.org.au/etg_demo/etg-ciwa-ar.pdf) scale can help determine the severity of withdrawal. The CIWA-Ar scale describes the severity of withdrawal, helps determine appropriate care, and can help monitor a client during detoxification. It should be completed with those clients thought to be in alcohol withdrawal who can talk and who have drank in the past 5 days. Mild withdrawal is a CIWA-Ar score of 10–15 and moderate and severe withdrawal is a CIWA-Ar score of > 15.

If client admits to alcohol use and is able, discuss the history questions listed under “*Substance Abuse*” above (for example, CAGE-AID) and ask about:

- The factors that define alcohol abuse and dependence
- Symptoms of alcohol withdrawal (*see “Course, Signs and Symptoms” below and “Signs and Symptoms” under “Alcohol Withdrawal Delirium”*)

- Symptoms of potential alcohol abuse complications
- Indicators of alcohol dependence (for example, memory loss or blackouts after drinking, sleep interruptions, and tremors)
- Past history for comorbid medical or psychiatric conditions that need to be treated (for example, gastrointestinal bleeding, electrolyte disturbance, infection, cardiovascular disease, pregnancy, psychiatric concerns)
- Previous alcohol withdrawal symptoms (if applicable), previous quit attempts, and risk factors for delirium tremens

COURSE, SIGNS AND SYMPTOMS

Symptoms usually begin within 4–12 hours after cessation or reduction in drinking (but can appear after a couple of days). If withdrawal continues, symptoms are often worse on the second day and get better by day 4 or 5. Anxiety, insomnia and autonomic hyperactivity may last (at lower levels) for up to 6 months. Symptom intensity increases with successive episodes of withdrawal.

Alcohol withdrawal can be categorized by stages: minor (stage 1) and major (stage 2). The symptoms of alcohol withdrawal may progress to stage 3 delirium tremens.

PHYSICAL FINDINGS

Complete a full physical examination (including psychiatric examination) to assess for signs of alcohol withdrawal and to rule out comorbid conditions.

DIFFERENTIAL DIAGNOSIS

- Infection (for example, meningitis)
- Trauma (for example, intracranial hemorrhage)
- Metabolic disorders (for example, disturbances of potassium, magnesium, phosphate, glucose)
- Drug overdose
- Liver failure
- Gastrointestinal bleeding

DIAGNOSTIC TESTS

- CBC
- Liver function tests (AST, ALT, GGT)
- Electrolytes, magnesium, phosphate
- Serum glucose
- Blood urea nitrogen and creatinine
- Urinalysis
- Urine drug screen
- Urine pregnancy test (for premenopausal women)

- EKG (for clients > 50 years or if a cardiac history)
- Chest x-ray (if chronic respiratory issues or current symptoms)
- Rapid capillary glucose

Rule out any differential diagnoses, in particular if the client has a decreased level of consciousness.

MANAGEMENT

Goals of Treatment

- Manage symptoms of acute alcohol withdrawal
- Prevent complications of withdrawal (for example, seizure, delirium tremens)
- Prevent Wernicke-Korsakoff syndrome
- Ensure the client gets appropriate treatment to help with their recovery
- Assess for and treat comorbidities

Appropriate Consultation

Consult a physician to arrange a medevac and if possible, before giving medications.

Nonpharmacologic Interventions

- Increased rest
- Hydration and nutrition: high-protein, high-carbohydrate diet and adequate fluid intake; for clients with moderate to severe symptoms, do not give anything by mouth (NPO) unless a physician states otherwise
- Monitor intake and output
- Correct blood glucose abnormality, after consultation with a physician
- All clients who receive more than one dose of medication should have an intravenous line with normal saline to keep vein open
- For client with moderate to severe symptoms (CIWA-Ar > 15), intravenous (IV) therapy with normal saline may be necessary, depending on the severity of symptoms and dehydration; adjust rate appropriately to correct or prevent dehydration

Psychological Support for Clients

- Be non-judgmental, reassure the client and be supportive
- Educate the client about the alcohol detoxification process and that it will take approximately 1 week. Treatment is successful if the client does not drink for at least 3 days, withdrawal symptoms are minimal and detoxification medications (for example, diazepam) are able to be stopped

- Give calm, firm direction in response to a demanding or volatile client
- Presence of a supportive person helps to decrease anxiety and agitation and increase safety
- Diversionary activities and conversation help to direct attention away from symptoms
- Quiet, calm environment decreases irritability and stimulation and promotes rest
- Encourage the client to continue treatment after acute withdrawal (for example, cognitive behavioural therapy, Alcoholics Anonymous, pharmacologic therapy)

For Clients with Hallucinations, Delusions, Illusions

- Avoid arguing about misperceptions, but also avoid validating or supporting them
- Gently reassure client of your reality, but don't expect acceptance of this
- Forewarn client before touching him or her; the client may be startled and frightened by your touch and may lash out to protect himself or herself
- Be aware that the client will respond to delusions and hallucinations as if they were real
- Identify misperceptions as symptoms of withdrawal
- Avoid low-voiced conversations within earshot of the client, as he or she may misinterpret them in a paranoid way. If you are frightened by the client, seek assistance, as clients are often sensitive to your fears and anxieties

Refer also to nonpharmacologic interventions that can be used for all substance users and alcohol abusers above.

Pharmacologic Interventions

Mild Symptoms (CIWA-Ar ≤ 15)

In consultation with a physician administer sedation as needed:

diazepam 10 mg PO q1h as needed, until client shows clinical improvement in symptoms (according to CIWA scale) or becomes mildly sedated (calm, but alert)

or

lorazepam 2 mg SL q1h prn, up to 3 doses

and

thiamine, 100 mg IM/IV daily for 3 days (to prevent Wernicke's encephalopathy); give before glucose

and

on an ongoing basis, a multivitamin with thiamine and folate PO daily

Moderate to Severe Symptoms (CIWA-Ar > 15)

In consultation with a physician administer sedation as needed:

diazepam 10 mg IV q20 minutes until client shows clinical improvement in symptoms (according to CIWA-Ar scale) or becomes mildly sedated (calm, but alert); do not use in clients with severe liver disease or in respiratory distress

and

thiamine 100 mg IM/IV daily for 3 days (to prevent Wernicke's encephalopathy); give before glucose

and

on an ongoing basis, a multivitamin with thiamine and folate PO daily

If the patient is experiencing seizures, hallucinations or delusions, consult a physician.

After acute detoxification, rehabilitation may include medications to help the client recover from alcohol dependence and decrease the likelihood of relapse. These must be prescribed by a physician.

Monitoring and Follow-Up

Clients with mild symptoms (CIWA-Ar ≤ 15) should be monitored every hour. Clients with moderate to severe symptoms (CIWA-Ar > 15) should be monitored every 15 minutes. Assess for:

- CIWA-Ar score – If the score is ≥ 10 , give diazepam 10 mg IV
- Vital signs and physical examination
- Seizure activity, hallucinations, delirium and respiratory status
- Continued abstinence
- Hydration status
- Electrolyte imbalance (and correct after consultation with a physician)

Treat comorbid conditions, as required.

Follow up with clients at least monthly for the first year after discharge from a detoxification program and at least biannually thereafter. Assess for relapse, treatment response and goals, medication side effects and adherence, and early signs of relapse. Continue to encourage Alcoholics Anonymous participation (if available), be supportive, and ensure comorbid anxiety and depression are treated throughout the follow-up period.

Referral

Medevac. Detoxification for all stages of withdrawal should take place in a supervised setting to monitor medication use (if medication is used), maximize safety and observe for signs of withdrawal seizures or delirium tremens. Consult a physician to discuss the medevac and ongoing care.

INHALANT ABUSE

For information about the definition, clinical presentation, and management of inhalant abuse, see “Inhalant Abuse” in chapter 19, “Adolescent Health” in the *Pediatric Clinical Practice Guidelines*.

MARIJUANA (CANNABIS) USE^{236,237,238,239}

A herbal substance that can cause intoxication, abuse, and dependence. See “Substance Abuse” above for the criteria for marijuana (substance) abuse and dependence.

Marijuana is the illicit drug most commonly used. Abuse of or dependence on marijuana is associated with abuse of alcohol or other drugs, mood disorders, anxiety disorders, and schizophrenia. A client dependent on marijuana, compared to one who abuses, is at a higher risk level for these problems.

Up to 36% of clients with pain have tried herbal cannabis for symptom relief (for example, pain, anorexia). Canadians can apply for a license to possess cannabis under the Medical Marijuana Access Regulations. There are also cannabis-based drugs (for example, nabilone, dronabinol) that are available for nausea and anorexia, but they are not approved for use in pain control. They are not known to lead to abuse or misuse, as their onset of action is not rapid and they do not have the same reinforcing properties as smoked marijuana does.²⁴⁰

Some teens and adults do not see marijuana as a significant drug of abuse, even though it has negative effects on memory and motivation and a withdrawal period of more than 6 weeks. In a study looking at “the past 30 days,” 22.4% of high school students report having used it.²⁴¹ Of Ontario students in grades 7 to 12, 26% had used it in the past year.

One third of First Nations youth self-report using marijuana in the past year. Twenty-nine percent of First Nations males aged 18–39 report using it daily. The use of marijuana by First Nations individuals is almost double the usage rate of Canadians in general at 26.7%.²¹⁶ Of cannabis users, 9% develop dependence.²⁴²

Risk Factors

- Youth and young adult (risk of dependence is highest at ages 17 and 18 and is minimal after age 30)
- Male
- Separated or divorced
- Psychiatric disorder

HISTORY

Screen all clients for marijuana use and abuse, as detailed above under “Substance Abuse” if they report use and/or use is suspected. In particular, youth should be screened. If the screen is positive, continue with the history for substance users (see “History” in “Substance Abuse” section above). In addition, ask about signs and symptoms of marijuana intoxication and/or withdrawal, depending on the client’s history.

COURSE, SIGNS AND SYMPTOMS

Intoxication: Physiological symptoms include tachycardia, injected conjunctiva, increased respiratory rate, hypertension, increased appetite, dry mouth; usually pleasant, but may have dysphoria, panic, paranoia, hallucinations, anxiety; changes in mood, attention, sociability, concentration, short-term memory, perception (including risk assessment), thought content; also impaired cognition, judgment, and coordination that lasts much longer than the client feels “high;” occurs within minutes if inhaled and within hours if ingested.

Withdrawal: May be uncomfortable and distressing, but does not threaten life. Symptoms include fatigue, yawning, psychomotor retardation, anxiety, depression, anorexia, anger, strange dreams, sleep changes, irritability, physical tension. Symptoms start 1 to 2 days after last intake, peaks at day 2 to 6 and resolves within 1 to 2 weeks.

DIFFERENTIAL DIAGNOSIS

- Other/poly-substance abuse or intoxication (for example, alcohol, hallucinogens, sedatives)
- Psychiatric illness (for example, mood disorders, anxiety disorder, schizophrenia)

COMPLICATIONS²⁴³

- Anxiety/paranoia/psychosis/panic attacks
- Cognitive dysfunction such as impaired memory, problem solving, attention and motivation
- Asthma, bronchitis, chronic obstructive pulmonary disease
- Periodontal disease
- Cancer (for example, lung, upper airway, throat); it has more carcinogens than tobacco smoke
- Heart disease
- Decreased libido, impotence and gynecomastia in men

DIAGNOSTIC TESTS

Urine drug test (if a physician agrees); usually used to monitor treatment progress and relapse.

MANAGEMENT***Nonpharmacologic Interventions***

Refer to “*Nonpharmacologic Interventions*” that can be used for all substance users. In addition to those:

- If client is acutely intoxicated, place client in a quiet room and provide supportive care until the acute effects subside
- Realize that few clients seek treatment (for example, psychotherapy including motivational interviewing) and few achieve or sustain abstinence, although reduced use is common.
- Educate about the potential for psychological dependence (crave the high) and/or mild physical dependence (after long term, frequent use)
- Those with physical dependence can have mild withdrawal symptoms for about a week (for example, irritability, anxiety, nausea, anorexia, sweating), but sleep disturbances may last longer
- Educate clients with information on cannabis:
 - A handout from the Aboriginal Healing Foundation; see page 90 to 91 of *Addictive Behaviours Among Aboriginal People in Canada* (available at: <http://www.ahf.ca/publications/research-series>)
 - *Marijuana: Facts for Teens* from the National Institute on Drug Abuse (available at: <http://www.nida.nih.gov/marijbrosch/marijteens.html>)
- Refer the client to a 12-step recovery program (for example, Marijuana Anonymous)

NICOTINE DEPENDENCE^{244,245,246,247,248,249}

Using one or more forms of nicotine/tobacco product (cigarettes, pipes, cigars, hookah, cigarillos, chewing tobacco and snuff): all can cause psychological and physical dependence.²⁵⁰ See “*Substance Abuse*” above for the criteria for nicotine (substance) dependence. It is a chronic disorder that often requires multiple interventions.

Nicotine is one of the most addictive (and lethal) drugs known. Cigarette smoke (including second hand) has about 4,000 chemicals and poisons and 50 of these cause cancer. Each cigarette shortens a life by about 10 minutes. Smoking is the number one preventable cause of death and disability in Canada²⁴⁵ and the leading preventable risk factor for cardiovascular disease.²⁵¹

Almost every smoker started before age 18. Many who learn to smoke cigarettes become addicted. The majority of clients who smoke report that they would like to quit and almost 60% of students who smoked tried to quit in the past year. However, only 5–7% of those who try to quit without help are still abstinent 1 year later. The same numbers are over 4 times higher if the client receives help from a health care provider.²⁵² This and the fact that few smokers seek help to quit underscores the need for nurses to be actively involved in screening for tobacco use, assessing readiness to change, and motivating clients to stop smoking.

Population smoking rates are 62% for First Nations and 72% for Inuit individuals. This is about 3 times the Canadian rate. Of these individuals, 60% began before they were 16 years old.²⁵³ Almost half of First Nations individuals (46%) smoke daily, although more in the age 18–29 group (54%) smoke daily and fewer in the older adult (≥ 60 years) group smoke daily (24%). More females than males smoke. Many First Nations children (36.6%) were exposed to some maternal smoking.²⁵⁴

For specific information about nicotine dependence in children and adolescents, see “*Nicotine Dependence*” in chapter 19, “*Adolescent Health*” in the *Pediatric Clinical Practice Guidelines*.

Risk Factors²⁵⁵

In addition to those risk factors for all substances:

- Perception that parents approve of smoking
- Cigarettes are available
- Genetics
- Females – preoccupied with weight and body image
- Males – increased levels of aggression and rebelliousness

HISTORY

All clients should be screened for nicotine use every time they present to the clinic (for example, have you used any tobacco product in the past 7 days? 6 months?). Ensure that you distinguish between use of traditional (for example, ceremonial) tobacco and commercial tobacco and respect the difference. Refer to the history of substance abuse that can be used to screen all clients. If the screen is positive, continue with the *history for substance users* above (see “History” in the “Substance Abuse” section). In addition to those questions, ask about:

- Signs and symptoms of nicotine withdrawal
- Symptoms of depression, schizophrenia or other substance abuse/dependence

COMPLICATIONS^{251,256}

The following complications are for those who smoke. Some of them are also for those exposed to second-hand smoke.

- Lung cancer
- Asthma, chronic obstructive pulmonary disease and respiratory infections
- Cancer (for example, lung, mouth, throat, bladder, breast)
- Pregnancy complications (for example, miscarriage, premature labor, low birth weight)
- Postpartum complications (for example, decreased breast milk, infant more at risk for Sudden Infant Death Syndrome)
- Osteoporosis
- Kidney damage
- Impotence
- Tooth and gum disease
- Premature skin aging, contact allergies
- Premature death (approximately 10–17 years earlier)

MANAGEMENT^{252,257,258,259,260,261}

If clients are using a tobacco product, a brief intervention (for example, 1–3 minutes) that recommends smoking cessation should be given, along with an offer of support and a helpline number, at a minimum. More intense interventions (for example, longer and at least 4 counselling sessions) for smoking cessation should also be used as they are more effective. The nurse should also consult and/or refer to another care provider for pharmacologic interventions and for more intense interventions if they do not have the knowledge to provide them. All interventions should be tailored to the First Nations and Inuit client and be culturally appropriate. Adolescents and pregnant, breastfeeding, and postpartum females in particular should have intense interventions to decrease the harm to others’ and/or the client’s health.

Goals of Treatment

- Complete and sustained abstinence from all tobacco products
- To engage tobacco users in behaviour change, as smoking cessation is a process
- To educate clients that counselling and pharmacologic interventions work best together

Appropriate Consultation

For clients interested in making a quit attempt, consult with and/or refer them to a physician, nurse practitioner or smoking cessation expert for counselling and/or pharmacologic treatment.

Nonpharmacologic Interventions^{262,263}

Refer to “nonpharmacologic interventions” that can be used for all substance users *above*. In addition:

- Advise all tobacco users to quit (with the care provider’s support) using a strong, clear, personalized and non-judgmental message at each appropriate visit (at least annually)
- Offer to support and encourage them in their attempt to quit when they are ready
- Provide those addicted to tobacco with practical smoking cessation counselling (for example, problem solving, skills building). This is first-line treatment for pregnant and breastfeeding women. Do not recommend reduction in smoking unless it is just before the client quits, as it does not affect mortality. Clients should be encouraged to completely abstain from tobacco products²⁵⁵

- Encourage the involvement of partners, family, friends and co-workers; encourage them to stop smoking as well
- Provide access for clients, family and friends to self-help materials and community resources (First Nations specific, if possible)
- Document nicotine use status on client chart regularly (for example, non-smoker, smoker, ex-smoker)
- Discuss what motivates the client to smoke and to quit (for clients in the contemplation stage)
- Develop a plan to quit, including what methods they will use (for clients in the contemplation or preparation stage)
- Do the WHY test (available at: http://www.rnao.org/Storage/71/6589_BPG_smokingcessation-rev-2007C.pdf) to determine the client's reasons for smoking (see pages 72–73)
- Determine the client's nicotine dependence using the Fagerstrom Test (http://www.niagarahealth.on.ca/pdf/services/fagerstrom_test.pdf) for clients ready to quit
- Discuss client's stage of change; for Stages of Change specific to smoking, see pages 63–65 of the following site: http://www.rnao.org/Storage/71/6589_BPG_smokingcessation-rev-2007C.pdf
- Have the client set a quit date within the next month (if the client is in the contemplation or preparation stage of change); encourage them to pick a day that will be mostly stress free
- Discuss possible challenges to quitting and triggers to restart (if the client is in the preparation stage of change)
- Refer clients to a toll-free telephone smoking cessation line (available at: <http://www.hc-sc.gc.ca/hc-ps/tobac-tabac/quit-cesser/nw-maintenant/1-800/prov-eng.php>) for your region or to the Canadian Cancer Society's Smokers' Helpline at 1-877-513-5333 (available at: www.smokershelpline.ca)
- Help make a plan for stressful situations (for example, quit with a friend, distract self by keeping busy, increase physical activity, change routine (do not go places where they would usually smoke), plan a reward for every day, think positively about benefits of not smoking, count money saved by not buying tobacco products, relaxation techniques, balance in lifestyle) (if the client is in the preparation stage of change)
- Educate:
 - that quitting smoking is the single most effective thing that they can do to increase their quality and length of life (see “*Benefits of Smoking Cessation*” below)
 - about the complications of smoking; be specific to the client if possible; emphasize the immediate negative effects on health for adolescent clients
 - that use of a smoking cessation aid (medication) as part of a cessation program helps more people succeed when it is used along with counselling than either method alone; there is 2–3 times the success rate for long-term quitting²⁶⁴
 - about different pharmacologic interventions and how to use them (for example, chew and park nicotine gum) (if the client is in the preparation stage of change)
 - to not “try just one” tobacco product after quitting
 - to list situations that may cause relapse and to write down three strategies that they will use to deal with the situation(s) (if the client is in the preparation stage of change)
 - to decrease caffeine intake when quitting, as there will be increased caffeine levels in their body for the same amount of caffeine
 - to avoid alcohol and other smokers when quitting
 - about the consequences of smoking cessation and how they may be overcome (for example, physical exercise, de-stressing, eating good foods)
 - parents about the harmful effects of second-hand smoke on their children
 - with a handout on commercial tobacco from the Aboriginal Healing Foundation (see pages 92–93 of *Addictive Behaviours Among Aboriginal People in Canada* [available at: <http://www.ahf.ca/publications/research-series>])
 - with a booklet based on the stages of change from the Canadian Cancer Society called *One step at a time: For smokers who want to quit* and *One step at a time: For smokers who do not want to quit* (available at: http://www.cancer.ca/Canada-wide/Publications.aspx?sc_lang=en)

- about resources for clients (for example, self-help, supportive) and care providers (for example, guide to help others) that are available from:
 - Inuit Tobacco Free Network (available at: <http://www.naho.ca/inuit/itn/whatsNew.php>)
 - First Nations, Inuit and Aboriginal Health – *Help on Quitting Smoking* (available at: <http://www.hc-sc.gc.ca/fniah-spnia/substan/tobac-tabac/help-aide-eng.php>)
 - CAN-ADAPTT Canadian Smoking Cessation Guideline: (each section has tools/resources at its conclusion; some are for specific populations such as Aboriginals and pregnant females [available at: <http://www.can-adaptt.net/English/Guideline/Files%20for%20download.aspx>])
- Smoking cessation resources for health care providers (in addition to those listed above for First Nations and Inuit clients) can be found on the following websites:
 - www.tobaccofreernao.ca has excellent smoking cessation resources for nurses (for example, guidelines, videos, downloadable documents, online community, educational opportunities)
 - The Ottawa Model for Smoking Cessation (available at: http://www.ottawamodel.ca/en_about.php)
 - Training Enhancement in Applied Cessation Counselling and Health from the Canadian Mental Health Association has their course materials available on-line, including one on interventions with Aboriginal clients (available at: <http://www.teachproject.ca/resources.htm>)

Benefits of Smoking Cessation^{251,255}

- Decreased cardiac events, including recurrent events (from 7–47 percent)
- Decreased risk of mouth, throat and lung cancer
- Decreased risk of stroke
- Decreased pregnancy complications
- Decreased chronic obstructive pulmonary disease symptoms for first 12 months and fewer exacerbations
- Improved asthma
- Decreased blood pressure, heart rate
- Improved sexual function
- Improved lung function and performance in sports
- Improved sense of smell and taste
- Saving money
- In children exposed to second-hand smoke, decreased risk of respiratory bronchiolitis

Cessation by age 40 avoids most tobacco-related diseases, but after this time there are still many health benefits.

Consequences of Smoking Cessation (Withdrawal)²⁵⁵

- Immediate: cravings, irritability, frustration, insomnia, anxiety, depression, decreased ability to concentrate, restlessness, increase in coughing, decreased heart rate, increased appetite (usually they improve within 1–3 weeks)
- Longer term: weight gain (average of 5 kg), increased risk of depression, worsening of ulcerative colitis

Pharmacologic Interventions

Consult with a physician or a nurse practitioner to prescribe a smoking cessation aid. Smoking cessation aids include nicotine substitution (for example, patch, gum) or non-nicotine drugs (for example, varenicline, bupropion). Note that these are covered by Non-Insured Health Benefits with an annual limit.²⁶⁵

For pregnant and breastfeeding women intermittent nicotine substitution (for example, gum) is preferred over the nicotine patch.

Monitoring and Follow-Up

A follow-up visit at least once before the quit date and within 3–7 days after quitting should be scheduled and/or done by telephone. Provide weekly follow-up for at least 3–6 months as needed for all those who have quit. Monitor for abstinence (if so, congratulate and compliment), relapse (if so, ask about willingness to quit again), and depression. Provide support, address concerns with concrete solutions, and continue/modify interventions as required.

Provide regular, scheduled follow-up for those who use tobacco products and are not interested in quitting. Educate clients at their stage of change for those not ready to quit.

For those who were successful quitting, follow up at least annually after the first year of cessation.

Referral

Refer clients wishing treatment to a community stop-smoking treatment program (if available) and/or a physician or nurse practitioner for both counselling and pharmacologic intervention.

Prevention^{266,267}

- Educate children early (when they are of school age) to abstain from tobacco use and about the complications of tobacco use (for example, leading cause of death in Canada – half who start smoking as a teen will die from tobacco-related causes) and second-hand smoke both at clinic visits and in school-based prevention programs
- Counsel about the short-term effects of nicotine use: bad breath, staining of the teeth and fingers, foul-smelling clothes, decreased athletic fitness and high financial cost
- Advocate for a minimum age for tobacco product sales on reserves and coordination across the country
- Use educational opportunities, like smoking-related illness in a family member or friend to educate individuals about the dangers of tobacco and cessation strategies
- Advocate for bans on smoking and non-traditional use of tobacco in public places and in vehicles
- Ensure tobacco products are behind counters and out of sight in stores
- Encourage all community members, in particular pregnant and postpartum females, to have smoke-free homes and to decrease all children's second-hand smoke exposure
- Screen for tobacco use and introduce smoking cessation strategies at all visits when appropriate
- Encourage discussion in the community to help change attitudes that accept recreational tobacco use

PRESCRIPTION AND OVER-THE-COUNTER DRUG ABUSE^{268,269,270,271,272}

Taking a prescription or nonprescription drug in a way that deviates from medical, legal, and/or social standards (for example, is not prescribed for the client, taking it in a route or at a dosage other than that prescribed, taking it for recreational purposes, not to improve an illness). The drug can cause intoxication, abuse and/or dependence. See “*Substance Abuse*” for the criteria for drug (substance) abuse and dependence.

Many types of medications can cause dependence and they are regulated by the federal *Controlled Drugs and Substances Act*. The most common classes are:²⁷³

- Opioids (for example, hydromorphone, oxycodone, meperidine)
- Central nervous system depressants (for example, phenobarbital, benzodiazepines [diazepam, lorazepam])
- Stimulants (for example, dextroamphetamine, methylphenidate [Ritalin, Concerta], and amphetamines [Adderall])

A number of First Nations communities have declared a state of emergency over the abuse of prescription narcotics, particularly oxycodone-containing drugs.²⁷⁴

Nonprescription drugs (for example, caffeine, pseudophedrine, dextromethorphan, herbal remedies, diphenoxylate) may be abused, but there is little risk for dependence.

Almost half of Aboriginals using addiction treatment centres have a problem with prescription drugs: 74% abuse benzodiazepines and over 60% abuse more than one prescription drug.²⁵³⁹ Opioid abuse is the third most common substance of abuse after alcohol and marijuana. Older adults are at risk for physical dependence on sedative-hypnotics, antidepressants, and pain medications. Females are likely to misuse prescription medication more than males.²⁷⁵

Information and tools for care providers, mainly related to opioid addiction and drug diversion, is available at Paincare.ca. The site requires registration, but it is free.

CAUSES

Prescription drugs are popular because individuals think they are safer than street drugs and that it is legal to take them without a prescription. These reasons are in addition to the other reasons clients use substances (for example, to relax or feel good, to decrease appetite, to experiment, peer pressure, due to addiction).²⁷⁶

Risk Factors

- Living in a rural, suburban or small urban area
- Client from out of town
- Health care worker
- Psychiatric illness, including personality disorder
- Past history of medication or substance abuse started while a young adult
- Younger age
- Drug factors (for example, fast onset of action, high dopamine surge, intravenous route)
- Prescriber practices (for example, overprescribing, lack of monitoring, not reviewing medical records or fully assessing a client)

HISTORY AND PHYSICAL FINDINGS^{277,278}

Refer to the “History” and “Physical Findings” that can be used for all substance users above. In addition to those questions, ask (including friends and family, if possible), observe, and review the client’s chart for:

- use of other substances of abuse (for example, alcohol, nicotine) at the same time as the drug
- stealing, forging or selling prescriptions
- taking medications at a higher dose than prescribed or in a different route (for example, snort, inject)
- benefits of use (for example, those abusing expect to have altered perception)
- large increase in the amount of medication needed (for example, if abusing they state that the medication is ineffective)
- frequently “losing” prescriptions or asking for refills before the quantity prescribed should have been used (for example, stating “I took too many”)
- going to more than one doctor to obtain prescriptions (for example, “doctor shopping,” emergency department visits reporting trauma) and/or purchasing from illicit dealers
- pressuring or begging the health care provider for a prescription
- giving excessive compliments to health care provider
- threatening to harm self or others
- behaving as though intoxicated (in person or when calling the clinic)
- withdrawal signs and symptoms as described in Table 2, “*Prescription Drug Withdrawal Course and Signs and Symptoms*” below

The Clinical Institute Withdrawal Assessment from Benzodiazepines (CIWA-B) scale describes the severity of withdrawal, helps determine appropriate care, and can help monitor a client during detoxification. It may be used to assess clients thought to be in benzodiazepine withdrawal. Mild withdrawal is a CIWA-B score of ≤ 20 , and moderate and severe withdrawal is a CIWA-B score of > 20 . The CIWA-B is available at: <http://www.health.qld.gov.au/atod/documents/24904.pdf> on pages 5–21 to 5–23.

The Clinical Opiate Withdrawal Scale (COWS) (available at: www.csam-asam.org/pdf/misc/COWS_induction_flow_sheet.doc) can be used to screen for withdrawal symptoms of clients thought to be on opioids.

Prior to prescribing a controlled substance (or consulting a physician about a prescription) understand the clinical, regulatory and legal responsibilities. The assessment includes:

- pain using a pain scale, if that is the client’s concern. Different scales, for all ages, can be found at the National Institute of Health Pain Consortium (available at: http://painconsortium.nih.gov/pain_scales/index.htm)
- the client fully (including mental status exam, eyes, nasal septum and for needle tracks in places easy to hide) and thoroughly
- response from previous treatment
- risk for alcohol or drug dependence concerns using the Opioid Risk Tool. It can be completed by self-report or in an interview. The tool is available at Paincare.ca under *Pain Management Tools and Addiction Assessment*. The site requires registration, but it is free
- dependence or abuse by screening the client for substance abuse or dependence as described under “History” in the “Substance Abuse” section

Table 2 – Prescription Drug Withdrawal Course and Signs and Symptoms^{234,279,280}

Medication	Signs and Symptoms	Most Severe Symptoms	Length of Recovery
Benzodiazepine ²⁸¹ Potentially serious medical complications	<ul style="list-style-type: none"> • Anxiety • Sleep and perceptual disorders • Depressed mood • Tremor • Headache • Seizures • Hypersensitivity to touch and pain • Muscular aches, pains • Autonomic hyperactivity (for example, sweating, tachycardia, hypertension) • Nausea/vomiting • Transient visual, tactile or auditory hallucinations • Psychomotor agitation 	Days 3–7 (if shorter half life) Up to 3 weeks (if longer half life)	2–4 weeks; can have persistent symptoms up to 1 year
Opioids Uncomfortable, but no serious symptoms or medical complications	<ul style="list-style-type: none"> • Dysphoria • Nausea/vomiting • Myalgia • Lacrimation, rhinorrhea • Pupillary dilation, piloerection, sweating • Diarrhea • Yawning/fatigue • Fever • Insomnia • Restlessness/agitation • Anxiety • Hypertension, tachycardia, hyperthermia 	Days 2–3	5–10 days, except methadone is much longer (cravings for many months)

DIFFERENTIAL DIAGNOSIS

- Physical dependence due to long-term use of the medication
- Pseudoaddiction (when a client is not given sufficient dosages of a pain medication for their legitimate needs, so they seek additional pain relief until it is controlled)

COMPLICATIONS²⁸¹

- Death (for example, overdose)
- Localized and systemic infections (if injected)

DIAGNOSTIC TESTS

Urine and/or serum drug testing is an option for some prescription drugs being abused, but it is not usually used for diagnosis (except if there is an inadequate history). It may be helpful to monitor treatment. Consult a physician before completing the tests.

Do lab tests to rule out and/or assess comorbid conditions. If the client has shared needles in the past, screen for hepatitis A, B and C, and HIV.

MANAGEMENT

Appropriate Consultation

The physician who prescribes the prescription drug should be consulted if abuse is suspected (for example, client history is positive for one or more potential indicators). They may wish to use a number of resources, including a client treatment agreement which is available for opioids, but can be adapted for other prescription drugs, under *Pain Management Tools, Addiction Assessment* at Paincare.ca The site requires registration, but it is free.

Consult a physician about individuals known to be abusing or who are dependent on prescription drugs. They must also be consulted if an individual is requesting treatment, as some prescription drugs require other medications to help with withdrawal symptoms and/or require tapering of dosages. The physician can help determine an appropriate treatment program.

Nonpharmacologic Interventions

Refer to nonpharmacologic interventions that can be used for all substance users above. In addition:

- Be professional and empathetic
- Give clear instructions on how to use the medication and that it is only to be used in that manner and for the concern it was prescribed
- Assist the client to recognize that they are misusing/abusing prescription medication and the risks (and how they are using it appropriately) and set positive goals for change; involve family and/or friends if the client consents
- Increase use of nonpharmacologic interventions for the client's concern to decrease the potential for misuse and abuse
- Counsel individuals and/or families to help them determine what may have contributed to prescription drug abuse²⁸³
- Help individuals learn skills needed to prevent recurrence (for example, social)²⁸³
- For clients wanting treatment, refer for cognitive behavioural therapy, if possible
- Encourage clients to talk about their addiction with individuals they can trust and to join a 12-step program such as Narcotics Anonymous, if one is available²⁸⁴
- Treat co-existing and/or undiagnosed medical or psychiatric concerns
- Watch for increased alcohol or tobacco use if undergoing withdrawal
- If the client has had an overdose, altered prescriptions, threatened office staff, or sold or bought medications from others do not prescribe any more medication (as it is unsafe); educate the client on signs and symptoms of withdrawal for the specific drug
- For clients using benzodiazepines, encourage relaxation and refer for cognitive behavioural therapy if the client wants treatment. Also educate about importance of not combining alcohol with benzodiazepine
- For clients wanting treatment for opioids refer for cognitive behavioural therapy, if possible
- Educate clients with:
 - Handout on opioids and benzodiazepines from the Aboriginal Healing Foundation (see pages 85– 89 of *Addictive Behaviours Among Aboriginal People in Canada* (available at: <http://www.ahf.ca/publications/research-series>)

- Website manual on benzodiazepines titled *Benzodiazepines: How they Work and how to Withdraw* (available at: <http://www.benzo.org.uk/manual/index.htm>) by Heather Ashton (it is very helpful for care providers as well)

Pharmacologic Interventions

Consult a physician about appropriate withdrawal protocols for prescription drug abusers requesting treatment and/or those experiencing withdrawal symptoms (for example, client should receive medication for nausea).

Benzodiazepine withdrawal treatment involves replacing usual dosage with long half-life benzodiazepine and then gradual tapering.

Opioid withdrawal treatment may include the use of methadone, naloxone or buprenorphine. If a client is prescribed methadone, more information and practice recommendations are available in *Supporting Clients on Methadone Maintenance Treatment* (available at: <http://www.rnao.org/Page.asp?PageID=122&ContentID=2946>), a Registered Nurses Association of Ontario Best Practice Guideline.

Monitoring and Follow-Up

Frequent follow-up should be completed during withdrawal and treatment to support the client and to monitor for relapse.

Referral

Refer client to an addiction specialist and/or treatment program for the specific medication that the client is abusing. Refer all clients interested in treatment for cognitive behavioural therapy, if available.

Medevac clients who are undergoing withdrawal, after consultation with a physician.

Prevention

- Create clinic policies that might include strategies to make diversion of prescription drugs to the street more difficult and to monitor prescription drug use
- Educate youth, parents and community members about the dangers of prescription drug use and strategies to prevent it (for example, returning all unused prescriptions to a pharmacy)

- Encourage use of controlled substance (for example, narcotic) client treatment agreement between the client and physician, if there may be long-term prescription drug use, that includes risks, benefits, rights, and responsibilities for both the client and physician (for example, only get prescription from one physician and one pharmacy, take as prescribed, plan ahead for refills, violation results in discontinuation of the drug)
- When controlled substances are prescribed, ensure that there is a full assessment documented, the medication and all care is clearly documented, the client's response to treatment is monitored, and the client is educated that the goal of treatment is restoring function, not complete relief of symptoms. The client must restrict access to their medication supply and be aware that it is illegal to sell or share their medication with others
- Do not prescribe potentially addictive medications to a client with a history of any kind of substance abuse (including nicotine) without consulting a primary care provider

EMERGENCIES RELATED TO MENTAL HEALTH

EMERGENCY EVALUATION²⁸⁵

Emergency psychiatric evaluations generally occur in response to thoughts, feelings, or urges to act that are intolerable to the patient, or to behavior that prompts urgent action by others, such as violent or self-injurious behavior, threats of harm to self or others, failure to care for oneself, bizarre or confused behavior, or intense expressions of distress. Patients presenting for emergency psychiatric evaluation have a high prevalence of combined general medical and psychiatric illness, recent trauma, substance use and substance-related conditions, and cognitive impairment. General medical and psychiatric evaluations should be coordinated.

Patients who will be discharged to the community after an emergency evaluation or individuals with significant symptoms but without apparent acute risk to self or others, may require more extensive evaluation than those who will be transferred to provincial facilities or services.

ALCOHOL WITHDRAWAL DELIRIUM^{286,287,288}

Acute alcohol withdrawal with sudden and severe mental status and neurologic changes. Also known as “delirium tremens” or “the DTs.” It is the third and most serious stage of alcohol withdrawal.

This condition should be regarded as a medical emergency. If a client has any of the signs or symptoms, they should be considered to have impending delirium tremens.

About 5% of clients experiencing alcohol withdrawal will have delirium tremens. Up to 5% of those with delirium tremens that is treated early and appropriately die, but if the condition is not treated the rate increases.

CAUSES

The cause involves the cumulative toxic effects of excessive alcohol intake and chronic nutritional deficiencies over an extended period of time. The most common precipitating factor is cessation or reduction in drinking, although the condition may also result from acute infection or head injury in a person who continues to drink.

Risk Factors

- History of continuous alcohol ingestion
- History of delirium tremens or withdrawal seizures
- Age > 30 years
- Comorbid condition
- Significant withdrawal symptoms with an elevated ethanol level
- Withdrawal symptoms start or are much worse after 48 hours since the last drink

HISTORY

Complete as much of the history as possible, as described under “*Acute Alcohol Withdrawal*” above.

COURSE

Onset usually occurs the second to fourth day (48–96 hours) after cessation or reduction in drinking, although it occasionally occurs earlier (but not within hours of cessation). Client will have had one or more minor and major symptom(s) of withdrawal prior to the symptoms of delirium tremens.

Clinical features develop over a short period and fluctuate over the course of a day. Exacerbations often occur at night.

The condition usually runs its course in 1–5 days but may persist for several weeks depending on premorbid personality, physical condition, severity of complications, and promptness and thoroughness of treatment.

SIGNS AND SYMPTOMS

The following signs and symptoms are more specific to delirium tremens, but the client may also have one or more of the minor and major symptom(s) of withdrawal at the same time.

- Autonomic hyperactivity: tachycardia, diaphoresis (severe), hypertension
- Fever may be present
- Restlessness, psychomotor agitation, irritability, increased startle reflex, anxiety; may reach state of panic (or may exhibit opposite extreme, with psychomotor retardation)
- Disorientation
- Mydriasis
- Delirium
- Clouded consciousness (reduced awareness of environment), disorientation, confusion, distractibility
- Memory disturbances, amnesia for period of DTs
- Perceptual disturbances: illusions, delusions and hallucinations, usually of a disturbing nature
- Speech disjointed and incoherent at times; speech may be pressured or retarded
- Emotional disturbances: fear, anxiety, depression, anger, euphoria and emotional lability
- May become self-destructive

PHYSICAL FINDINGS

Most findings are not specific, but examine for signs and symptoms as described above and assess:

- Full physical examination to rule out comorbid conditions, signs of trauma
- Vital signs, including pulse oximetry (for example, hyperventilation, tachycardia)
- Hydration status (*see “Dehydration [hypovolemia]” in chapter 5, “Gastrointestinal System”*)
- Mental status examination, including level of consciousness (will be altered)

DIFFERENTIAL DIAGNOSIS

- Alcoholic ketoacidosis
- Brain abscess or neoplasm
- Encephalopathy
- Head trauma
- Meningitis
- Psychosis
- Status epilepticus
- Substance toxicity or withdrawal (for example, cocaine, amphetamine, sympathomimetic)
- Wernicke encephalopathy

COMPLICATIONS

- Cardiac arrhythmia
- Pneumonia (for example, aspiration)
- Head trauma
- Aspiration
- Hypovolemia
- Hypokalemia, hypomagnesemia, hypophosphatemia
- Severe fluid and electrolyte disorders
- Comorbid medical condition that led to cessation of alcohol use
- Injury to client or others (for example, fall during seizure, altered mental state)
- Seizures
- Respiratory depression or arrest
- Death

DIAGNOSTIC TESTS

Complete the tests listed under “Acute Alcohol Withdrawal.” In addition, do creatinine kinase, lipase, ketones, serum ethanol concentration, blood cultures, and EKG.

Place client on a cardiac monitor and pulse oximeter, so that they can be monitored.

MANAGEMENT

Assess and stabilize ABCs (airway, breathing, and circulation). Treat presenting seizures as necessary (see “*Status Epilepticus (Acute Grand Mal Seizure)*” in chapter 8, “*Central Nervous System*”).

Goals of Treatment

- Manage symptoms of acute alcohol withdrawal
- Prevent complications
- Assess for and treat comorbidities

Appropriate Consultation

Consult a physician as soon as possible. If the client is not responding to benzodiazepines and the physician agrees, consult your regional poison control centre.

Adjuvant Therapy

- Give oxygen supplementation to keep oxygen saturation > 97% to 98%
- Start IV therapy with normal saline to keep vein open. Adjust rate according to level of hydration (see “*Dehydration [hypovolemia]*” in chapter 5, “*Gastrointestinal System*”)

Nonpharmacologic Interventions

Hydration and Nutrition

- Monitor intake and output
- Correct blood glucose abnormality with dextrose, after consultation with a physician
- Keep client NPO, unless physician states otherwise. If the client can have oral intake:
 - Encourage high fluid intake if client is alert and airway and gag reflex are patent
 - Give high-protein, high-carbohydrate, low-fat diet (in frequent small meals)

Encourage Orientation

- Keep room well lighted to avoid misinterpretation of shadows (use a night light after dark)
- Explain to client where he or she is and what is happening
- The presence of a familiar environment or person is often helpful

Decrease Anxiety

- Be non-judgmental and supportive
- Speak in a calm, firm manner
- Allow the client some control over their environment by permitting movement and actions within safe limits

- Offer gentle reassurances and direction; give advance warning of any nursing intervention
- Minimize stimulation in environment (the area should be quiet and uncluttered, away from outside activities)

Rest

- Provide a calm, quiet environment
- Sedate early; avoid allowing agitation to reach crisis level
- Prohibit visitors other than calming, supportive friends or family members
- Sponge baths and back rubs can be used to induce relaxation (although it might provoke agitation in some clients)

Safety

- Continuous supervision
- Restrain physically only when absolutely necessary to protect the client and/or caregivers, as described under “*Physical Restraints*”
- Remove dangerous objects
- Seek assistance if problems arise (for example, client is volatile); even when delirious, the client will often respond to a show of strength. *For further information, see “Violence or Aggressive Behaviour in Mental Health Clients”*

Interventions for clients with hallucinations, delusions and illusions are described under “*Nonpharmacologic Interventions*” in the “*Acute Alcohol Withdrawal*” section.

Pharmacologic Interventions

Sedatives (aim to achieve calm, alert, peaceful state):

diazepam (Valium), 10 mg IV, one dose

and

thiamine 100 mg IM/IV daily for 3 days (to prevent Wernicke’s encephalopathy); give before glucose

and

consider a multivitamin with thiamine and folate PO daily on an ongoing basis

Clients may require large doses of diazepam to become sedated. Therefore, these are the initial dosages upon physician consultation. Treat those who do not respond to high-dose benzodiazepines (for example, > 50 mg diazepam within first hour or > 200 mg diazepam within first 4 hours) with other medications as directed by a physician.

For hallucinations and/or delusions, consult a physician.

Monitoring and Follow-Up

Every 15 min until stable and then every hour assess:

- Vital signs including pulse oximetry and mental status
- Clinical Institute Withdrawal Assessment from Alcohol-revised (CIWA-Ar) scale (available at: http://www.tg.org.au/etg_demo/etg-ciwa-ar.pdf)
 - if the CIWA-Ar score is ≥ 10 , give diazepam 10 mg IV
- Seizure activity, hallucinations, delirium and respiratory status
- Continued abstinence
- Monitor hourly intake and output; care must be taken not to overload the system
- Client is often in poor physical condition and may require treatment of concomitant health problems
- Remove physical restraints as soon as client is chemically restrained
- Keep client under careful observation (*see “Violence or Aggressive Behaviour in Mental Health Clients” below*)
- The client is at risk of impulsive destructive behaviour because of anxiety, impaired judgment and disorientation

Referral

Medevac as soon as possible. Hospitalization is necessary to ensure safety (for example, airway), supervision, full medical management and avoidance of further alcohol consumption.

The client should be referred to rehabilitation after acute detoxification is completed.

DELIRIUM^{289,290,291,292}

Acute (hours to days) deterioration of ability to maintain or shift attention or focus, consequently accompanied by disorientation, decreased awareness and fluctuating level of consciousness and often associated with perceptual disturbances or changes in cognition (for example impaired recent memory and disorganized thoughts, language disturbance) not related to dementia; may be psychomotor changes (hyper- or hypo-active) and/or emotional disturbances (for example, hallucinations) usually due to an underlying organic problem (for example, medical illness, substance intoxication, medication side effect).

Be suspicious of this diagnosis, as it is often missed. Commonly seen in but not limited to the elderly. It has a large list of differential diagnoses for underlying causes. More than one factor may be involved.

CAUSES

Precipitating Factors

- Medications or their side effects (for example, opioids, diuretics, antiemetics, antiarrhythmics, corticosteroids, anticholinergics, sedative-hypnotics, antipsychotics, lithium, skeletal muscle relaxants, antihistamines, anticonvulsants, antidepressants, quinolones); may occur even at therapeutic levels
- Drugs of abuse (for example, ethanol, hallucinogens)
- Withdrawal from ethanol, benzodiazepines, barbiturates, selective serotonin reuptake inhibitors
- Poisons (for example, ethylene glycol, methanol, carbon monoxide, mercury, cyanide, Jimson weed)
- Polypharmacy
- Dehydration
- Immobility
- Malnutrition
- Metabolic abnormalities (for example, blood glucose, sodium, calcium, magnesium, or phosphate, hyperthyroidism or hypothyroidism, hypoxia)
- CNS pathology (for example, dementia, infection such as meningitis, seizure or tumour)
- Infections (for example, urinary tract infection, pneumonia, sepsis, systemic infections)
- Physical disorders (for example, burns, electrocution, hyperthermia, hypothermia)

Risk Factors

- Underlying brain diseases (for example, dementia, stroke, Parkinson’s disease)
- Older age
- Sensory impairment
- Malignancy
- Postoperative period
- Acute and chronic pain
- Decreased sensory function (for example, smell, vision)
- Sleep deprivation

HISTORY

Elicit the history from the client, but it is just as important to elicit corroborating information from a caregiver, friend or the family (informant).

- Delirium is almost always brought to attention by a caregiver or family member, as the client may have no concern. Presenting complaints may include memory problems, problems with awareness, level of consciousness, language, speech, attention or focus, or concentration difficulties (for example, client is “not acting right”)
- May present with concerns of inappropriate or bizarre behaviour, because of delusions and hallucinations
- Determine symptoms associated with attention concerns or level of consciousness (for example, drowsiness, lethargy, agitation, confusion, hallucination, tremors, myoclonus, psychomotor agitation, insomnia, restlessness, irritability, hypersensitivity to light/sound, anxiety); often older adults are withdrawn
- Determine onset of symptoms and temporal course (hours to days to develop; fluctuate; symptoms often worse in evening/night)
- Determine recent illnesses (for example, febrile, depression) and events (for example, trauma)

MEDICAL HISTORY

- Prescriptions, OTC or otherwise acquired drug or remedy (including herbal)
- Past medical history (for example, alcohol or drug abuse), including psychiatric history
- Recent illnesses
- Substance use and/or abuse

MENTAL STATUS EXAMINATION

- Most validated tool for delirium is the Confusion Assessment Method (available at: <http://www.rgpc.ca/best/Geriatric%20Fast%20Facts/CONFUSION%20ASSESSMENT%20METHOD.pdf>). It helps one determine when delirium is most likely, based on care provider observations. A short article is available to download (available at: [http://consultgerirn.org/uploads/File/Confusion%20Assessment%20Method%20\(CAM\).pdf](http://consultgerirn.org/uploads/File/Confusion%20Assessment%20Method%20(CAM).pdf))
- In the presence of delirium, the use of the Folstein’s Mini Mental State Examination may be of little use
- A quick test of attention can be done by using the digit span test, testing the patient’s ability to repeat a string of numbers. Patients with delirium have difficulty focusing or shifting their attention

PHYSICAL EXAMINATION

The physical exam is directed by the different potential causes, as generated by the history. A full physical exam should be completed and must include the following:

- General appearance (for example, dusky, jaundiced, needle tracks, smell of breath)
- Vital signs including temperature (consider that temperature may be under 38.3°C even with a serious infection) and pulse oximetry
- Hydration of skin and mucous membranes
- Condition of skin
- Areas of potential infection
- Hearing and vision assessments (including fundi) (*see chapter 1, “Eyes” and chapter 2, Ears, Nose and Throat*)
- Cardiovascular and pulmonary exam (note carotid bruits, evidence of atherosclerotic disease) (*see chapter 3, “Cardiovascular System” and chapter 4, “Respiratory System”*)
- Abdominal exam including genitourinary system (*see chapter 5, “Gastrointestinal System” and chapter 6, “Genitourinary System”*)
- Full neurologic exam, noting especially level of consciousness, level of attention, cranial nerve function, tremor, cogwheel rigidity, shuffling gait, deep tendon reflexes, focal deficits in sensory and motor function, aphasia, myoclonus (*see chapter 8, “Central Nervous System”*)

DIFFERENTIAL DIAGNOSIS

- Dementia
- Depression
- Substance use or abuse, medications
- Psychiatric disorders: psychotic, schizophrenia, mania
- Nonconvulsive status epilepticus

COMPLICATIONS

- Aspiration
- Prolonged hospitalization
- Death
- Institutionalization
- Functional and cognitive decline

DIAGNOSTIC TESTS

Unless the underlying cause is obvious, blood should be drawn for the following tests:

- Complete blood count
- Electrolytes
- Creatinine
- Calcium
- Blood glucose
- Blood urea nitrogen
- Urinalysis, urine for culture and sensitivity
- EKG
- Consider serum drug levels, urine toxicology screen, and liver function tests
- Consider TSH
- Consider a chest x-ray

Other investigations will be driven by the history and presentation.

MANAGEMENT

If unsure if the client is experiencing delirium, assume that they are and rule out common medical causes. Management is ultimately driven by the causative factor(s).

Goals of Treatment

- Identify and correct reversible causes (most common are fluid and electrolyte abnormalities, infection, drug toxicity, and metabolic conditions)
- Ensure safety of the client (for example, avoid aggravating factors, control dangerous behaviours)
- Optimize functioning and quality of life

Appropriate Consultation

Delirium in older adults is a medical emergency. Consult a physician if client is assessed as delirious or in acute distress, if there are unexplained new neurologic symptoms or focal deficits, if there is acute onset cognitive impairment, if the client has rapidly progressing symptoms (neurologic or cognitive), or if there are risk factors for serious intracranial pathology (for example, anticoagulant medication, history of trauma, previous cancer).

Nonpharmacologic Interventions

- Educate about delirium and support caregivers and family. Provide an educational handout such as the Registered Nurses Association of Ontario's *Caring for Persons with Delirium, Depression and Dementia* (available at: http://www.rnao.org/Storage/20/1446_DDD2_Fact_Sheet.pdf)
- Educate about factors that may cause or increase delirium (for example, malnutrition, dehydration, pain, immobilization, hearing and visual deficits) and what can be done to overcome these (for example, range of motion, preventing skin breakdown, decreasing noise, range of motion exercises if unable to mobilize)
- Educate about good sleep hygiene
- Encourage family and/or caregivers to frequently reassure, touch and verbally reorient client to help with disruptive behaviours
- Encourage measures to ensure safety (for example, constant observation, environmental changes), and aid the client in optimal functioning and independence; physical restraints should only be used as a last resort for disruptive and hyperactive behaviour as it can have many negative outcomes

If alcohol withdrawal is suspected, manage according to guidelines under “*Alcohol Withdrawal*” and “*Alcohol Withdrawal Delirium*” above.

If agitation or behavioural issues are of concern, manage according to guidelines in “*Violence or Aggressive Behaviour in Mental Health Clients*” below.

Pharmacologic Interventions

If at all possible, do not medicate. In particular, avoid sedation, as it may cause falls and worsen symptoms of impairment. Pharmacologic treatment is prescribed, in consultation with a physician, and aimed at the suspected underlying illness that caused the delirium.

Monitoring and Follow-Up

While awaiting Medevac, regularly monitor symptom severity and response to any medications given.

If client goes home, follow up regularly (for example, weekly or more often as necessary), preferably on a home visit, to enable you to assess the client functioning in his or her own environment. Delirium may take weeks to months to resolve.

Referral

Medevac is necessary for clients with delirium, potential underlying organic pathology or if the risk-safety assessment requires that client be admitted to hospital. The decision as to whether to treat the client on an outpatient basis or admit and/or evacuate the client to a hospital (voluntarily or involuntarily) depends on several factors. This decision must be made in consultation with a physician. For further considerations, see “Hospitalization and Client Evacuation” and “Involuntary Admission.”

SUICIDAL BEHAVIOUR^{293,294,295,296}

Suicidal behaviour is an individual's actions that range from fleeting suicidal thoughts to completed suicide.²⁹⁷ Suicide is death that occurs as the result of an action by an individual who knows that the action will cause death.²⁹⁸

- Most people who commit suicide give warning signs either verbally (common for youth) or through changes in their behaviour
- Many have seen a health care provider within the previous month
- Although suicides are most prevalent amongst those deemed to be at high risk, most suicides come from those who have never been identified as high risk²⁹⁹
- Suicide is often an impulsive act, so easy access to a means increases the likelihood of completing the act

Suicide is the leading cause of death for Aboriginals under age 44.³⁰⁰ In 2000, suicide accounted for 22% of all deaths among First Nations youth (10–19 years) and 16% among all young adults (20–44 years).³⁰¹ The suicide rates for First Nations youth (10–19 years) are 4.3 times greater than for the rest of Canada and for Inuit youth were approximately 11.6 times higher in the year 2000.³⁰² However, these rates may not be true in all Aboriginal communities: some have much higher rates (for example, eight hundred percent higher than the national average on some reserves) and others much lower rates, or have no suicides at all.³⁰³ More females (18.5%) than males (13.1%) attempt suicide,³⁰⁴ but males are four times more likely to be successful (die) during a suicide attempt than females as they usually choose more immediately lethal methods. There are many more attempts than those who are actually successful, particularly in the adolescent age group.³⁰⁵ Thirty-one percent of First Nations adults (21% of youth) state that they have

seriously considered suicide in their lifetime and 15% (9.6% of youth) have attempted suicide. Ten percent of First Nations youth have thought about suicide at least once by age 12 and this rate increases to 30% by age 17.³⁰⁶

Approximately 1 in 5 First Nations youth have had a close friend or family member commit suicide in the past year. Suicides in Aboriginal communities often occur in clusters. A suicide cluster refers to a group of suicides or suicide attempts, or both, that occur closer together in time and space than would normally be expected in a given community.³⁰⁷

Risk Factors^{308,309,310}

Predicting suicide is difficult, because it is relatively rare. Some risk factors can change from moment to moment, (for instance, substance use)³¹¹ and no risk factor alone can accurately predict suicidality.³¹² Key considerations include:

- Social isolation (for example, no community involvement, lack of healthy relationship with family, peers, or work/school)
- Major disruption in life (for example, unemployment, abandonment or loss; questioning sexual orientation, death of spouse or parent)
- Mental illness (including nonspecific behaviours like anorexia, personal neglect, impulsive or aggressive behaviour, psychosomatic concerns) in the past or currently
- Temperament or personality factors (for example, hypersensitive, impulsive)
- Abuse (physical, emotional or sexual) (for example, parental rejection or hostility)
- Family history or peer history of suicide or depression
- Trauma in early childhood (for example, unstable family, multiple home placements, conflict in significant relationships)
- Access to methods of self-injury (for example, firearms or lethal means such as prescription medications)
- Previous suicide attempt or expressed suicidal ideation; formulated plan
- Alcohol and substance use (it decreases inhibitions and increases impulsivity)
- Pathological gambling
- Loss of identity and low self-esteem (for example, feel worthless, helpless, powerless, lack of control, negative expectations for the future, no cultural values or beliefs)

- Poor school attendance or performance
- Peer modeling of maladaptive behaviours (for example, unable to respond to loss, wish to retaliate)
- Peer teasing, bullying or rejection (for example, interpersonal conflict)
- Poverty, lack of proper housing, and/or poor water quality
- Geographical isolation
- Lack of religious and/or spiritual connection
- Limited employment opportunities
- Feelings of discrimination or marginalization (including severe forms of bullying)
- Loss of control over land and living conditions
- Male
- Older adult or youth
- Breakdown of cultural values and belief systems
- Newly incarcerated or criminal justice encounters
- Familial history of Indian residential schools (trauma and grief)

Protective Factors^{313,314,315}

- Good physical and mental health (for example, sense of humour, optimistic)
- Strong problem solving, communication, conflict resolution and stress management abilities
- Strong spirituality and/or cultural ties
- Positive family and peer relationships (for example, harmony, acceptance, support, belonging, supervision, responsibilities)
- Emotional well being (for example, belief in survival, ability to cope)
- Family and peer modeling of a healthy lifestyle
- Positive attitude toward school and/or school success and/or positive self-esteem
- Early identification and appropriate treatment of mental illness (for example, significant others know about suicidal thoughts)
- Future orientation (for example, strong sense of value of life, fear of suicide)
- Access to mental health resources
- Community involvement and connectedness
- At a community level: community self-government, control over land, band-controlled schools, community control of health, fire and police services, cultural facilities³⁰⁰

Risk factors can be categorized as being either dynamic and modifiable or static and unmodifiable. Modifiable risk factors are those that are amendable to change. This is an important consideration, as the identification of modifiable risk factors should be used to direct decision-making regarding intervention and support planning.³¹⁶

WARNING SIGNS OF POTENTIAL SUICIDE

- Sudden change in behaviour (for example, more risky, self-neglecting, social withdrawal) or personality
- Increased use of alcohol or drugs
- Recent loss of friend or family member (particularly if they died by suicide)
- Many mood swings, outbursts, irritability or aggression
- Feeling hopeless, helpless, worthless, in despair
- Giving away valued possessions, putting affairs in order
- Preoccupation with death (for example, listening to music or watching shows that focus on death)
- Talking about suicide directly (for example, “I’m going to end it all”) or indirectly (for example, “Nothing matters anymore”) and/or hero worship of someone who died by suicide
- Threatening to commit suicide and/or increased intensity of suicidal ideation
- Having a plan for suicide
- Purchasing or stockpiling items that could be used for suicide
- Investigating balconies, bridges, rooftops

HISTORY³¹⁷

Establish a therapeutic relationship with the client, interview them alone and assure confidentiality. Open questions should be used when possible and the client allowed to talk freely, express emotion, and say what is wrong. However, closed questions will also need to be used to help ensure clear responses. Note verbal and non-verbal communication clues. Information should be obtained from both the client and significant others (for example, family, friends and/or professionals).

Asking clients about suicide will not give them the idea or encourage them to commit suicide. All clients disclosing thoughts related or potentially related to suicide should be taken seriously and then have a suicide risk assessment conducted.

Assess for those at high risk of attempting suicide (warranting a suicide risk assessment), using the mnemonic SADPERSONS + Family History³¹⁸:

- S – Sex (females > males, but more males complete suicide)
- A – Age over 16
- D – Depression (including insomnia, restlessness)
- P – Previous attempts (including the methods)
- E – Ethanol abuse (or other substances)
- R – lost Rational thinking (for example, voices telling client to harm self, poor impulse control)
- S – lack of Social support
- O – Organized plan (lethality of method, preparation for attempt)
- N – No significant other
- S – Sickness (for example, acute or chronic condition, terminal illness) and/or Stressors
- F – First-degree relative

Screening for suicidal ideation is warranted in those at high risk of attempting suicide due to the suffering these individuals may experience.

A suicide risk assessment includes an assessment of:

- Feelings about their life, as some think that it is not worth living
- Hopelessness ('do you think your life could ever get better'; 'how do you see the future')³¹⁹
- Helplessness (the feeling that nobody can help to improve the current situation)³¹⁹
- Anything to look forward to (but caution regarding patients who plan to wait until they have seen through a particular event, such as a birthday, before attempting suicide)³¹⁹
- Suicidal ideation (for example, thinking about death, talking about it, fantasizing about it, feeling so upset wishes he/she was dead, talking or writing about suicide); thought content; when the thoughts started; frequency; strength; ability to stop them; ever acted or almost acted on the thoughts; might act on thoughts in the future; what would stop client from acting; what would happen to those close to you if did act)
- Plan (if a plan exists, how, when and where of plan, how realistic it is, likelihood of someone rescuing them, any action taken [for example stealing gun cabinet keys, wrote will, wrote suicide note])
- Method availability at home, lethality (reality and client's perception) of the intended method

- Behaviour(s) that have been exhibited (for example, warning signs listed above, impulsive or high-risk behaviours)
- Intent to carry out the plan
- Previous suicide attempt(s) and method(s), thoughts before, anticipated outcomes, feelings and help received afterwards
- Previous self-harming behaviours
- Trigger event(s) for current and past thoughts/attempts (for example, ending of a relationship, parent separation, anniversary of loss, bullying, trouble with the law, chronic pain, history of abuse)
- Suicide attempts by adolescents, family members or significant others
- Motivation to commit suicide (for example, no other options, plea for attention or help, trying to hurt another person)
- Risk factors (as listed above in the SADPERSONS + Family history mnemonic, and under "risk factors" listed above)
- Protective factors that lower risk; these include the client's strengths, resources and positive coping mechanisms,³²⁰ including hope, reasons for living
- Substance use (for example, alcohol, drugs, any recent increase in use)
- Level of social support,³²¹ strengths and weaknesses of the family
- Self-perception and view of the future
- Mood (self-reported)
- Ability to care for self, including nutrition, daily activities, sleep, finances, coping ability
- Medications
- Past medical and mental health history
- Family history
- Forensic history (for example, trouble with the law)
- Education, occupation
- Contact information for family

PHYSICAL FINDINGS³²²

Physical findings include the mental status exam.

Assess for:

- General appearance (for example, dress, grooming, posture, position, eye contact, manner, attentiveness to examiner, emotional facial expression, alertness, age, body build, distinguishing features)
- Attitude and interaction (for example, cooperative, guarded or avoidant)
- Activity level (for example, calm, active, restless, psychomotor activity, abnormal movements, gait)

- Speech (for example, rate, rhythm, volume, amount, articulation, spontaneity)
- Thought process (for example, coherence, logic, organization, stream of thought, blocking, neologism, attention) and content (for example, suicidal/homicidal ideation, depressed, delusions, obsessions, phobias, paranoid or magical ideation, overvalued ideas, thought broadcasting, perceptual disorders, phobias)
- Perceptions (for example, hallucinations, illusions, depersonalization)
- Cognition (for example, orientation, memory, intellect, abstract thought, ability to read and write, level of consciousness) and judgment
- Insight (for example, awareness of illness)
- Impulse control (for example, aggressive, hostile)
- Affect (include stability, range, appropriateness, intensity)
- Family interactions, if possible (for example, warm, nurturing, conflict, rejecting, affectionate)
- Assess trauma findings (for example, cutting, substance use)

Perform a physical exam to rule out an underlying medical condition.

DIAGNOSTIC TESTS

Consider ordering the following tests, after consultation with a physician: serum toxicology screen, urine pregnancy test, serum drug or alcohol screening, TSH.

MANAGEMENT

If a client is intoxicated it is very difficult to conduct an accurate risk assessment and provide interventions. Therefore, they should be kept in a safe environment (for example, jail) with sympathetic support and continuous monitoring until sober and then reassessed.

Goals of Treatment

Reduce immediate risk, manage underlying concerns, improve self-esteem, increase sense of importance in the family and/or socially, and encourage healing.

Appropriate Consultation

Consult a physician if the client has: moderate or severe depression; depression and a comorbid mental illness; attempted suicide previously or just prior to the assessment; been self-mutilating; access to lethal means; hallucinations or delusions; and/or serious

and imminent (active plan and access to means) intent to commit suicide. Also consult if there is lack of family or friends to care for the client and/or there is increased family or nurse anxiety due to the client's behaviour.

If the client will not agree to the involvement of a concerned third party adult in the safety plan and the client has a plan (even if they state that they will not carry it out), a physician should be consulted.³²³

Nonpharmacologic Interventions³²⁴

Threatened or Suspected Suicidal Ideation

Determine the client's level of risk of completing their plan, based on the information gathered. Ensure the physical safety of the nurse and client prior to intervening (for example, remove objects that could be used to commit suicide). Recognize the limits of your own personal responsibility and the impossibility of guaranteeing that an individual will not commit suicide even after intervention and treatment.

Work with clients to decrease the stigma surrounding attempted suicide and mental illness. Instill hope for the client and family that there is help available. Do not try to talk the person out of suicide or convince him or her that things are really not so bad. These efforts may only firm the person's resolve. Attending exclusively or primarily to the suicidal behaviour itself (threats, gestures or attempts) may reinforce or encourage suicidal behaviour. The role of front-line medical staff depends upon their training and the local presence or absence of specialists in health and social services.

- Educate about suicide to let the client know their current feelings may be normal. For example, often people think about suicide when they think their life is intolerable, their problems seem to go on forever and they feel the problems are inescapable³²⁵
- Establish a written safety plan with the client. An outline of a safety plan can be found on page 2 of *Coping with Suicidal Thoughts* (available at: <http://ccamhr.ca/resources/Coping%20with%20Suicidal%20Thoughts.pdf>). This is particularly important during initial treatment. The safety plan should include:
 - What the client can do to replace suicidal thoughts or gestures (for example, go for a walk, call a friend) and how they can make their environment safe

- Phone numbers and who to contact if they feel unsafe (for example, the nursing station, a distress line, the police) at any time. All phone numbers given must be available to call at all times. The Centre for Suicide Prevention provides a list of Crisis Centres in Canada (available at: <http://www.suicideinfo.ca/csp/go.aspx?tabid=77>)
- How client needs will be met (for example, food, shelter, love, self-esteem) and how they perceive problems
- Reasons they have to live and solutions they have used to cope in the past (reinforce positive ones)
- Involving a concerned third party adult that the client agrees can provide support, motivation, and supervision. This person must be trusted, be someone who the client will talk to, and be informed about and agree to the safety plan
- Having the third party restrict access to lethal means of suicide, particularly those involved in the client's plan (for example, guns removed from or locked up in the home, removal of ropes and cords)
- Having the third party ask regularly about thoughts of suicide, watching for signs of drinking
- Educating the client and third party about who to contact in an emergency if there are increased symptoms, the client becomes suicidal (for example, drawing morbid pictures, saying self-destructive things, giving away personal possessions), is homicidal, and/or has an acute crisis
- Crisis intervention services at the time of a suicide attempt or ideation are essential, including phone counselling, listening, taking the concern seriously, being supportive, decreasing anxiety, and instilling hope. Crisis intervention aims to increase the client's level of social, occupational/educational, cognitive and behavioural functioning³²⁶ by counselling on the presumed cause of the problem. Some strategies include helping the client identify and work through problems, in addition to learning alternative coping mechanisms. Ask the client, "How much time can you give so that you and I can work together on this matter?" as often suicidal ideation waxes and wanes
- Family interventions are also needed immediately. These include encouraging family and friends to be supportive, motivating and caring throughout treatment,³²⁷ helping them understand what the client is going through, helping them deal with their guilt, self-blame and/or remorse, and helping them understand treatment options and community resources
- Establish a treatment plan for any mental health concerns identified (for example, depression, substance abuse). Make use of the community's resources to provide care and protect patients from self-harm³²⁸
- A verbal or written safety agreement (also known as "no harm" contract) may help a client not attempt suicide over a limited and specific period of time (for example, 24 hours). However, it does not guarantee safety. The agreement may be more helpful if the client did not have a suicide plan to start with and/or strongly states that they will not carry the plan out. The agreement details whom to contact if the client's situation changes. This agreement may be part of a safety plan, so the concerned third party should be aware of the agreement, at a minimum. The agreement does not negate the need for frequent follow-up visits or telephone contact.³²⁹ Additionally, it does not guarantee that the client will follow through on this agreement. A sample safety agreement is available on pages 134–135 of *Treating Child and Adolescent Depression: A Handbook for Children's Mental Health Practitioners* (available at: http://www.lfcc.on.ca/depression_handbook.html)

Attempted Suicide

Provide medical treatment as required and consider the potential for a drug overdose in addition to the other method(s) used. Observe the client at the level appropriate for their current risk of further attempts.

Enact a safety plan and crisis intervention counselling as described above under "*Threatened or Suspected Suicidal Ideation*." In particular, ensure that potential means of suicide have been removed. Provide counselling for the individual, family, and possibly community. State that this experience may be positive and/or constructive, if the individual and family agree to make it so.

Survivors of a Completed Suicide³³⁰

“For every suicide there may be many more people suffering from depression, anxiety, and other feelings of entrapment, powerlessness, and despair....The circle of loss, grief, and mourning after suicide spreads outward in the community. In small Aboriginal communities where many people are related, and where many people face similar histories of personal and collective adversity, the impact of suicide may be especially widespread and severe.”³³¹

Assess and provide interventions for those who were bereaved (for example, family, loved ones, peers, co-workers), within 2–3 days of the suicide, as they can experience grief with anger, despair, depression, feelings of blame, shame, an inability to comprehend what happened, and thoughts of suicide themselves. This can also be related to the stigma of suicide. Convey the understanding that their feelings are normal and that suicide was how the person chose to die. Be empathetic, console, and understand that they need to hear about the person who died. Encourage them and provide opportunity to talk about their grief and allow time to deal with their loss. Educate them that anniversaries of that person will be difficult, but that there may be an opportunity to start new traditions on these dates. Avoid sensationalizing, glorifying or vilifying their death. Specific interventions are described on page 105 of the Registered Nurses Association of Ontario’s *Best practice guideline: Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour* (available at: http://www.rnao.org/Storage/58/5263_Suicide_-Final-web.pdf).

Resources that can be given to survivors include:

- Honouring Life Network (available at: <http://www.honouringlife.ca/>), an online resource for youth from the National Aboriginal Health Organization
- Hope and Healing: A Practical Guide for Survivors of Suicide (available at: <http://ccamhr.ca/resources/Hope%20&%20Healing.pdf>) gives practical advice for survivors of a completed suicide who are residents of British Columbia, but some of the booklet can apply to anyone
- An on-line resource on suicide grief from the Canadian Association for Suicide Prevention (available at: <http://www.suicideprevention.ca/survivor-support/suicide-grief/>)

Pharmacologic Interventions

Various medications may be prescribed by a physician to help the client with their mood, sleep and/or anxiety. Educate about the medication and potential side effects.

Monitoring and Follow-Up³³²

Follow-up after suicidal ideation and/or suicidal attempts is very important. It should first occur within 48 hours and at least weekly until the client is stable. Some clients are relieved that someone is willing to talk about suicide, whereas others use these thoughts and/or behaviours to ask for help, as they are trying to communicate despair, frustration and/or unhappiness. The client who wants to end their life needs to be differentiated from the one who is asking for help, as there will be some difference in the interventions.

Regular follow-up visits or phone calls assess whether the client is using effective coping strategies (has implemented the plan), has social support from a third party (or needs additional support), and is finding resolution of the acute crisis phase (for example, no suicide attempts).^{333,334} They also allow for more education, referrals to be made, and the client to ask questions.

The safety agreement can be renewed as needed. Follow-up visits should include monitoring for depression and substance use.

Referral

Some clients can be managed on an outpatient basis with pharmacotherapy, psychotherapy and/or counselling support. All clients should be referred to a physician or psychiatrist, regardless of severity.

The decision whether to treat the client on an outpatient basis or admit and/or evacuate the client to a hospital (voluntarily or involuntarily) depends on several factors. This decision must be made in consultation with a physician and/or psychiatrist. For further considerations, see “Hospitalization and Client Evacuation” and “Involuntary Admission.”

Facilitate referral or directly refer to mental health or social service team providers (for example, a psychiatrist, clinical nurse specialist, community mental health workers), as indicated, as long-term treatment should be done by or done under their supervision. The following are absolute indications for referral: high suicide risk, attempted suicide, no evidence of social support, comorbid conditions, history of depression. If the client is treated on an

outpatient basis, the therapist or others must be available to respond at all times. Links with mental health resources in the community are to be made if the client agrees (for example, Native Aboriginal Youth Suicide Prevention Strategy worker).

Prevention of Suicide^{335,336}

A variety of strategies are needed to promote mental health. These may include:

- Teaching youth coping strategies, problem-solving skills and life skills. These include helping adolescents to talk about their issues/concerns
- Reducing access to lethal means (for example, guns,³³⁷ lethal doses of medications). Recommend that guns be removed from the home (for example, community safe lock-up), if risk factors for suicide are present. The Canadian Paediatric Society also recommends that firearms never be present in homes where children and adolescents live, but if they are present they should be stored according to Canadian regulations (for example, unloaded, locked and separate from their ammunition)³³⁷
- Ensuring adequate treatment for mental illness, and that individuals are made aware of available resources
- Addressing determinants of health
- Family support
- Support groups for youth (including peer support)
- Increasing awareness of suicide and teaching key community members (and anyone else who is willing to learn) how to recognize, assess risk, and help a suicidal person (community education)

VIOLENCE OR AGGRESSIVE BEHAVIOUR IN MENTAL HEALTH CLIENTS^{338,339,340,341,342}

Situations where the client or others have a high probability of being disabled and/or having their life at risk. They need first aid or require an immediate intervention. Acute agitation is anxiety with motor restlessness.

The majority of mental health clients are not particularly dangerous or violent. But, when clients behave violently or aggressively, the behaviour is often unpredictable and irrational, since it is a product of the client's psychopathology. The true source of the behaviour may not be apparent and actions may be illogical, as in the case of persecutory delusions, or actions may be abrupt and unexpected, as in hallucinatory states.

CAUSES

Violence in mentally ill clients occurs due to the same factors as in those without mental illness:

- Fear
- Frustration
- Disappointment
- Feelings of inferiority
- Invasion of personal space
- Loss of self-esteem
- Feelings of humiliation

Risk Factors^{343,344}

- Personality disorders such as borderline and antisocial personality disorders
- Acute psychosis
- Organic brain disorders or states with impaired impulse control, developmental disabilities
- Acute-phase bipolar affective disorder, manic phase
- Schizophrenia (paranoid and nonparanoid)
- Psychotic depression
- Organic functional disorders in which delusions or hallucinations are present, such as after head injuries, cerebral infections, metabolic diseases
- Male gender for physical abusive behaviour, female gender for verbally abuse behaviour
- Previous or current history of violence, assaultive, homicidal or suicidal behaviour, or threats to kill or injure self or others
- State of intoxication or impairment by drugs or history of substance abuse
- Previous expressions of anger or violent feelings
- Previous dangerous and impulsive behaviours
- Known individual trigger factors
- Recent high stress incidents (for example, death)
- Panic and other anxiety disorders, post-traumatic stress disorder (PTSD)
- Poor compliance with psychiatric treatments

EARLY WARNING SIGNS OF VIOLENCE

Try to predict and prepare for disturbed behaviour by noting the following:

- Loud and aggressive speech
- Provocative behaviours (for example, resisting authority, belligerence, refusal to communicate, verbal threats or gestures)
- Expressions of anger or aggression (for example, throwing things, hitting objects or self)

- Tense posture (for example, holding tight fists or gripping an object tightly)
- Tense and angry facial expressions
- Pacing, frequent changes in position
- Changes in the client's personality
- Over-arousal (for example, increase heart and respiratory rates, dilated pupil)
- Prolonged eye contact
- Erratic movements
- Fear
- Difficulty concentrating and unclear thought processes
- Violent delusions or hallucinations
- Repeat of behaviour that occurred in a previous violent/agitated incident
- Blocking escape routes

Trigger factors and early warning signs are different for each client.

HISTORY

Violent or agitated clients should not wait for care as it can escalate aggression, but “preferential treatment” may defuse it. Additionally, these clients should not be in contact with others who might escalate their behaviours or provoke them.

DIFFERENTIAL DIAGNOSIS³⁴⁵

There are many potential underlying disorders that can cause a client to act violently. Not all people presenting with a violent behavior or even just a violent ideation, have a mental disorder. Violence can be grossly divided into cognitive and emotional: the former is usually more related to a criminal attitude than to mental disorders, the opposite is for the latter.³⁴⁵ A first objective is to distinguish between the two situations, although the distinction is not always clear. Furthermore, identifying whether the clinical situation is due to a substance related disorder or to a general medical condition related disorder will be valuable.

Substance Related Disorders (for example, withdrawal delirium)

Further requires an assessment to distinguish between drug intoxication and withdrawal. In the first case alcohol and psychostimulants are the substances more frequently involved, in the second alcohol and benzodiazepines are significant.

General Medical Conditions Related Disorders (for example, delirium, dementia and neurological syndromes [such as complex partial seizures and brain temporal, frontal or limbic lesions]).

Almost any kind of mental disorder can undergo a life-time episode of violent or agitated behavior, but some diagnosis are more frequently associated with violence related problems. They are: first episode psychosis, chronic schizophrenia with exacerbation, mood disorders, cluster B personality disorders (for example, borderline, histrionic, antisocial personalities), panic disorders and other acute anxiety disorders including Posttraumatic stress disorder (PTSD).

DIAGNOSTIC TESTS

Serum alcohol and drug levels and others as directed by a physician or nurse practitioner.

MANAGEMENT

These guidelines for the management of violence assume that the violent person is a bona fide psychiatric or medical client. In some cases, the individual may have a personality disorder for which emergency treatment is not possible or appropriate. In this situation, the violence is best viewed as a matter for the police.

Ultimately, you must use your own judgment to determine if and when to intervene with a potentially violent client. Trust your feelings and judgment. If you feel threatened, act accordingly.

Goals of Treatment

In order of priority:

- Protect yourself, others and the client, in part by creating a safe environment
- Avoid or minimize an outburst of physical violence
- Recognize and reduce anxiety and fear in the client
- Resolve the agitated/violent state
- Prevent future episodes of agitation/violence

Appropriate Consultation

Whenever possible, medical consultation and assistance should be sought in dealing with violent clients. When circumstances make this impossible at the critical moment, the physician should be consulted as soon as possible afterward to discuss the action taken, the choice and dosage of any medication

given, and the future plan of care. The correct diagnosis, if possible to determine the underlying cause, is very important in the case of the violent client, and a consultation is an essential part of the management procedure.

Nonpharmacologic Interventions

If you are concerned, try not to see the client alone. Interview the client in a private room, but ensure it is not isolated from other staff. Potential weapons (for example, electrical cords, scalpels) should not be present in the room being used and any potential weapons (for example, pens, belts) noted by the care provider. Additionally, have a way of alerting others of danger and the need for security personnel. Keep the door open and ensure that both you and the client have an unobstructed path to the door, so that either of you can escape from the room if the situation is perceived as dangerous. The care provider should be situated between the client and the door.

Do not see the client if he or she has a weapon of any sort. Call for assistance.

Use non-verbal and verbal methods to control and allow the client to calm down as much as possible before physical and/or chemical restraint is used. However, if the client is uncooperative, agitated, and/or violent and has early warning signs of violence they should be immediately restrained.

Verbal and Non-Verbal Techniques

Use the following techniques to build trust. However, observe and judge the effects of these actions, since what may be psychologically subduing or calming to one client may be provocative to another. Attempts to “talk a client down” may even increase some clients’ agitation.

- Be honest (never lie) and straightforward
- Take the client seriously (their complaint, fear or suspicion). Acknowledge the concern, but do not agree or disagree. Indicate that your purpose is to try to help the client deal with the problem
- Treat the client with respect
- Use a firm, calm and soothing voice
- Approach the client in a professional and confident manner. Be as relaxed and reassuring as possible. Tell the client that the environment is safe and that they do not have a reason to be afraid. Remember as well that the unstable person is quite likely to remember what was said during an outburst of this sort. Unprofessional language or conduct is inappropriate at any time

- Be friendly (for example, offer food or a soft chair)
- Do not use direct eye contact, approach a client from behind or move suddenly
- Keep at least 1 meter away from the client; standing too close to the client may be perceived as a violation of personal space
- Set limits to their behaviour (for example, “I will talk with you if you stay seated and do not yell at me”) and redirect them
- Address violence directly (for example, ask “Have you been thinking about hurting yourself or others?” “Do you carry a gun?”)
- State the obvious (for example, “You look mad”)
- Be non-confrontational and do not threaten the client’s self-esteem (for example, do not argue with, criticize, interrupt, condescend or command the client)
- Attempt to determine the reason for the anger or violence and respond accordingly
- Do not respond to anger with anger or respond to insults or abusive language. Do not take personally what the unstable person may do or say to you
- Be supportive (for example, state “You have a lot of will power and are very good at controlling yourself,” “I realize you feel that way. Others in a similar situation have felt that way too. Many have found that...helps.”)
- Clarify what the client wants before responding to him/her
- Take every threat seriously
- Offer medication or physical restraint
- Do not threaten to use force unless it is immediately available
- Watch for signs of organic brain disorder, substance abuse, suicide attempts (for example, scars on wrists) or fighting, and for evidence of a weapon

Physical assault may occur, even if precautions are taken. Summon help, take a sideward position with arms and legs ready to protect or deflect an assault. Keep the chin tucked to protect the neck. Push toward the client’s face if bitten and hold the nares shut. If threatened with a weapon or taken hostage do not reach for the weapon, make sudden movement, argue, bargain or make promises. Try to make a human connection with the hostage taker.

Knowledge of the three core components of crisis intervention theory (a precipitating event, perception of the event, and the client’s usual coping methods) is fundamental to identifying and intervening with clients in crisis.³⁴⁶ Crisis intervention services aim to build a therapeutic relationship including

listening, acknowledging the client and family's experiences, taking the concern seriously, being supportive, decreasing anxiety, instilling hope, and using calm, clear, and simple communication. Crisis intervention also aims to increase the client's level of functioning.³⁴⁷

If non-verbal and verbal prompts have been used and the client has not de-escalated, excuse yourself and leave the room to get help. Do not hesitate to call the police if the client becomes too threatening.

Physical Restraints

Involuntary restraint and involuntary hospitalization are addressed in laws and regulations of provinces and territories (such as provincial Mental Health Acts and the *Criminal Code*) and can be complemented by regional protocols. The respective legislations should be referred to and their implications clearly understood. To restrain someone or to force them to involuntarily undergo treatment in ways other than provided for by legislation can lead to civil litigation and criminal assault charges. If additional support from family, community members or law enforcement officers is not sufficient to assess a client, a colleague assessment and concurrent treatment plan is required before using restraints, as it is not a standard intervention. A client who has the capacity to make reasonable decisions and is not suicidal or homicidal should not be restrained without their consent.

If medication is contraindicated, inappropriate or insufficient, and physical restraints are deemed necessary to allow for a diagnostic examination, to administer medication, and/or to prevent injury:

- Use restraints as a last resort when a client cannot be controlled by appropriate verbal or non-verbal communication and is an imminent threat to himself, herself or others or is destructive of property. After trying verbal and non-verbal techniques, leave the room to get assistance
- To ensure your safety and the safety of the client, five people are needed. The mere show of force may prove sufficient to allow the client to calm down without the use of force
- Have a clear plan of action with a leader. Decide who will do what and, if possible, assign at least one person to each limb
- Remove glasses, watches, jewellery or anything else that might be used as a weapon or could cause accidental injury from those who will be applying the restraints
- Inform the client of your intentions, explaining that the restraints will be applied because the client is unable to control himself or herself. Explain the procedure to the client and what will happen after they have been applied (for example, a medical and psychiatric examination, treatment) in a calm manner and continue talking reassuringly to the client throughout. Continue to use the verbal and non-verbal techniques noted above
- Apply restraints once you have decided to, even if the client does not appear dangerous anymore. Do not negotiate with the client
- If the client is armed with a potential weapon, defend yourself with objects (for example, hold a mattress in front of you or use 2 mattresses to immobilize or sandwich a client)
- Ask the client to cooperate and lie down. Each person restrains a limb by putting the major joint (knee or elbow) in extension and the team leader controls the head and neck while monitoring airway, breathing, and psychological status
- Do not count on your own strength equalling that of the client. A disturbed, violent person can be surprisingly strong
- Place one fully extended limb at a time into leather ankle and wrist restraints that are secured to the bed frame not the side rails prior to securing them to the client. A soft neck collar (for example, Philadelphia) can be applied to decrease head banging and biting). The client should be supine with the head elevated or side lying as these positions decrease risk of aspiration. At no time should pressure be applied to the neck, torso (thorax, abdomen or back), or pelvic areas
- Ensure that the restraints are snug enough to hold the client, but not so tight as to cause injury or cut off circulation; if chest restraints are used, ensure the chest can expand adequately for respiration
- Beware of being bitten or kicked
- If the client continually struggles against the restraints, aggressive use of chemical sedation is to be considered, in consultation with a physician. Intoxicated clients are at a higher risk of adverse events
- Frequently and carefully monitor a restrained client. Remove restraints as soon as possible

Pharmacologic Interventions

If it is deemed in the client's best interest because he or she is at risk of injuring self, others or property, or is likely to leave the premises before adequate treatment and he/she did not respond to non-verbal and verbal de-escalation techniques, chemical sedation should be considered, either with or without physical restraints. If possible, consult a physician first. Otherwise, give:

lorazepam (Ativan), 1–2 mg PO or SL

OR

lorazepam (Ativan), 1–2 mg IM (NOTE: Always reserve injectable route as the last resort if a patient is non-compliant to oral route)

For agitated clients with a known schizophrenia, antipsychotic agents (for example, haloperidol) can be used instead or with lorazepam.

All clients should be offered and encouraged to take an oral medication, as the client may view an injection as a punishment. Use lower doses of medication in older adults.

Do not use benzodiazepines such as lorazepam in a person acutely intoxicated with alcohol without consulting a physician, as these drugs are additive for respiratory depression.

If the medication given does not work, consult a physician before administering anything else.

Monitoring and Follow-Up

After Physical or Chemical Restraints are Applied/Given

- Frequently monitor the client, in particular respiratory status, vital signs, and level of consciousness
- Establish an intravenous port if a client was chemically restrained
- Perform an ECG if an antipsychotic medication was given
- Check distal circulation and reposition frequently for comfort and to prevent skin breakdown
- Remove any remaining potentially dangerous items from the client, including jewellery, glasses, belt, shoes, matches and contents of pockets
- Examine client for weapons concealed in the hands (for example, small, sharp objects such as broken glass, which may have been grabbed during application of the restraints)

- Evaluate regularly the need for hydration, nutrition, and elimination
- Provide assistance with personal hygiene and grooming
- Document why restraints were applied, who was involved, and have a colleague document that they agreed with the decision to restrain the client
- Remove physical restraints as soon as possible (for example, client is calm, assessment is complete, chemical sedation has been given). Remove the restraints one limb at a time, using the same precautions as when they were applied
- Watch for side effects of psychotropic medications and explain them to the client
- Complete an incident report, according to your regional policy

Evaluation after Client is De-escalated or Restrained

- Determine the cause (for example, precipitating event) of violence or agitation
- Medical and mental health history
- Medications
- Mental status examination
- Assess the client for capacity to consent to their care
- Diagnostic tests to rule out substance abuse
- Rule out medical causes of violence or agitation by assessing:
 - Capillary blood glucose testing
 - Oxygen saturation
 - Complete set of vital signs, including temperature
 - Level of consciousness, orientation
 - Complete physical examination, ensuring a complete neurologic examination (*see “Assessment of the Central Nervous System” in chapter 8, “Central Nervous System”*)

Clients > 40 years old with new psychiatric symptoms or with an acute onset of symptoms are more likely to have an organic cause (for example, delirium, stroke). If client is sedated and deteriorates, consider an infection or drug overdose.

Other Aspects of Monitoring

Evaluate the client's self-control and capacity for appropriate behaviour on a continuing basis. Watch for flare-ups of violent behaviour. Encourage the client to use their usual coping methods. Negotiate a realistic and concrete action plan, if the client is competent and capable.

If the client is under the influence of a substance, assess them frequently and keep them under observation until the client is no longer under the influence and a therapeutic intervention can be made.

If a secure room is used for confining a violent person after removal of restraints:

- Use the same precautions as noted under “Nonpharmacologic Interventions”
- Visit frequently to provide human contact and reality testing
- Always announce your intentions when you enter the room
- Be cautious with utensils and hot liquids when serving meals
- Do not leave potentially dangerous items in the room (for example, pens, electrical cords)

After the incident, debrief with all staff who were involved by discussing what happened, trigger factors, individual roles in the incident, current feelings and what can be done to address any concerns.

Referral

The decision whether to treat the client on an outpatient basis or admit and/or evacuate the client to a hospital (voluntarily or involuntarily) depends on several factors. This decision must be made in consultation with a physician and/or psychiatrist. For further considerations, see “Hospitalization and Client Evacuation” and “Involuntary Admission.”

Prevention

Consider creating a crisis protocol in advance of a situation:

- If circumstances permit, call for assistance before becoming involved with the client
- Attempt verbal and non-verbal de-escalation techniques first and early with any potentially violent/agitated client
- Know how to use approved physical interventions to restrain the client or defend yourself
- Be familiar with escape routes that you might need
- Keep potential weapons (for example, scissors, scalpels, letter openers, electrical cords) out of reach of clients
- Have a locked door entry into the clinical area from the waiting room, if possible
- Establish a method to alert other staff of a violent or agitated client and the need for help
- Regularly educate staff on crisis intervention (for example, review the use of restraints)
- Record (in the client's chart) the nature of a particular client's violence/agitation and interventions or actions that have been effective for managing a client in the past and try them first
- Anticipating and preventing violent behaviour is always the best strategy (see “Early Warning Signs of Violence”)
- If possible, a client with a psychiatric concern, care providers, and family members should disclose the trigger factors and early warning signs prior to the client becoming agitated or violent the next time. The client should be given a list of these

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1-800-463-6273 or www.camh.net

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