

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

Work Absence

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

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

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

Benefits & Costs of Absence from Work

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

IV. Maximize Recovery of Occupational Function

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

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

⁴ Shrey DE, Lacerte M. Principles and practices of disability management in industry. Winter Park, Florida:GR Press, Inc; 1995.

⁵ Simon GE, Revicki DA, Heiligenstein J, et al.. Recovery from depression, work productivity, and health care costs among primary care patients. General Hospital Psychiatry 2000;22(2): 153-162

- Pharmacologic treatment for depression and anxiety disorders can lead to significant improvement in function, but still leaves a significant gap in functional recovery for many individuals. Psychopharmacology can be augmented with referral for cognitive behavioural therapy, which has been shown to have specific benefit in promoting functional recovery^{6,7}.
- Assess capacity for activity. Encourage early, graduated functional activation. Consider prescription of activity.
- Take an active role in encouraging self-management efforts, focused on helping patients understand their diagnosis and ways to manage their symptoms. One way to augment standard treatment to support individual coping and promote functional recovery is dissemination of Self-Care material, for example the **Antidepressant Skills Workbook**, available at no cost from www.carmha.ca/publications or the depression and anxiety toolkits and wellness modules, available at no cost from www.heretohelp.bc.ca.
- If appropriate, the patient should be encouraged to investigate opportunities for assistance through the employer, for example Employee and Family Assistance Programs or extended health coverage for care by a psychologist.
- For severe mental disorders such as schizophrenia, referral to rehabilitation/supported employment program should be considered.

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

Further Reading

Bilsker D, Wiseman S, Gilbert M. Managing depression-related occupational disability: A pragmatic approach. *Can J Psychiatry* 2006; 51: 76-83.

Canadian Medical Association. CMA policy. The physician's role in helping patients return to work after an illness or injury. *Can Med Assoc J* 1997;156(5):680A-680F. 2000 Update located at www.cma.ca/staticContent/HTML/N0/I2/where_we_stand/return_to_work.pdf.

Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition, Text Revision (DSM-IV-TR). American Psychiatric Association, Washington DC, 2000.

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

⁶ Sherbourne CD, Wells KB, Duan N, et al.. Long-term effectiveness of disseminating quality improvement for depression in primary care. *Archives of General Psychiatry* 2001;58(7):696-703.

⁷ Hirschfeld RM, Dunner DL, Keitner G. Does psychosocial functioning improve independent of depressive symptoms? A comparison of nefazodone, psychotherapy, and their combination. *Biological Psychiatry* 2002;51(2):123-133.

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

⁹ Crook J, Moldofsky H. The probability of recovery and return to work from work disability as a function of time. *Qual Life Res* 1994; 3(suppl 1): S97-109.

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

ECT Indications

Primary Indications for Use

As stated in the APA guidelines, there is “compelling data . . . or strong consensus” supporting the use of ECT in the following conditions:

- Major Depressive Episode (arising from unipolar depression, as part of bipolar depression, or concomitant manic symptoms during “mixed states”) — ECT should be strongly considered, especially when associated with one of the following features:
 - acute suicidality with high risk of acting out suicidal thoughts
 - psychotic features
 - rapidly deteriorating physical status due to complications from the depression, such as poor oral intake
 - history of poor response to medications
 - history of good response to ECT
 - patient preference
 - risks of standard antidepressant treatment outweigh the risks of ECT, particularly in medically frail or elderly patients
 - catatonia.
 - Mania — ECT should be particularly considered if there is:
 - extreme and sustained agitation
 - “manic delirium”.
 - Schizophrenia* (According to the APA guidelines, the following associated features predict a favourable response to ECT):
 - positive symptoms with abrupt or recent onset
 - catatonia
 - history of good response to ECT.
- * Studies demonstrating a favourable response to ECT in regard to psychotic symptoms have generally used a combination of ECT and standard antipsychotics.

Secondary Indications for Use

- Catatonia (unrelated to the primary conditions described above)
- Parkinson's Disease
- Neuroleptic Malignant Syndrome
- Delirium (rarely considered for patients who require urgent treatment)
- Intractable Seizure Disorder
- Mood Disorder secondary to physical conditions

Cultural Considerations

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

Selection and Risk

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

Contraindications for ECT

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

ELECTROCONVULSIVE THERAPY (ECT)

- retinal detachment
- acute narrow angle glaucoma.

Those with cardiac pacemakers and implanted automatic defibrillators warrant some caution. (It is unlikely ECT would disrupt the functioning of a modern cardiac pacemaker)

ECT Providers

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

ECT Resources

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

Pharmacological Intervention

GENERAL PRINCIPLES OF PHARMACOLOGICAL INTERVENTION

Consider these clinical factors when choosing a medication:

- previous response
- side effects
- remission rates
- cost
- comorbid conditions
- drug-drug interactions
- dosing regimen

Educate the patients about treatment

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

Common problems faced by many patients:

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

Precautions when using Psychotropic medications:

- start low, go slow, keep going!
- psychotropic medications should be tapered prior to discontinuation.

Benzodiazepine Use in Primary Care

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

In the United Kingdom, the [Committee on Safety of Medicines](#) and the Royal College of Psychiatrists have made some recommendations for BDZ use.

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

MAJOR DEPRESSIVE DISORDER

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

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

MAJOR DEPRESSIVE DISORDER

Principles of Pharmacological Treatment of Depression

- If treating with antidepressants, initial response should occur within 3 – 4 weeks of treatment with a therapeutic dose.
- If there is no response (or no further improvement after partial response) after 3 – 4 weeks, increase medication every 2 – 4 weeks until remission of symptoms, maximum suggested dose is reached, or limiting side effects are experienced.
- If remission is achieved, maintain patient on medication for at least 6 months if first episode, and at least 2 years if:
 - second episode
 - suicidal/psychotic/severe
 - episode > two years
 - resistant or difficult to treat.
- Partial response Strategies (*See below, “Levels of Evidence”*)
 - Level 1 evidence: Augmentation
 - Proven Effective with TCAs (not SSRIs) – Lithium (target blood level 0.6 – 0.9; 600 – 900mg)
 - Probably Effective – Liothyronine Sodium (T₃-Cytomel®) more centrally acting than Levothyroxine Sodium (T₄-Synthroid®) 25 – 75mcg; low-dose atypical antipsychotic
 - Possibly Effective – Amphetamines (e.g., Dextroamphetamine: 5 – 10mg); Modafinil; Buspar, Tryptophan may be effective if target symptoms remain (e.g., poor sleep, low energy, poor concentration)
 - Level 2 evidence: Switching (*see Table: Washout Recommendations for Switching Antidepressants*)
 - Benefit of simplicity with better compliance
 - Switch within class once, then switch out
 - Level 3 evidence: Combination
 - e.g., SSRI + SNRI + Mirtazapine or Bupropion
- Non responder strategies
 - If there is no response, within 4 weeks of a therapeutic dose, switch within the same or out of class
 - If after two medications within a class there is no response, switch class
- Refractory patient strategies
 - Re-evaluate diagnosis (for example, mania/hypomania, subtype of depression)
 - Reassess treatment issues (for example, adherence, side-effects)
 - Reassess comorbidity
 - Axis I: Panic, OCD, PTSD, Substances, Psychosis etc
 - Axis II: Personality Disorder especially Cluster B, Dependent
 - Axis III: General medical conditions
 - Consider adding psychotherapy
 - Refer to a specialist, community health centre or rural outreach team

Levels of Evidence

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

MAJOR DEPRESSIVE DISORDER

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

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

RIMA :Reversible monoamine oxidase inhibitor; TCA = Tricyclic antidepressant; SNRI =Serotonin and norepinephrine reuptake inhibitor MAOI =Monoamine oxidase inhibitor ;SSRI = Selective serotonin reuptake inhibitor

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

Side Effect information from "The Canadian Psychotropic Handbook First Edition" 2000 Sudler and Hennessey

Side Effects= 0=none; 1=very low; 2=low; 3=moderate; 4=high; 5=very high

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

B= Antihistaminic (drowsiness, weight gain)

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

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

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

Not all medications listed are eligible for coverage under the No-Charge Psychiatric Medication Program (Plan G).

Coverage information is provided on the BC PharmaCare website at www.health.gov.bc.ca/pharme/outgoing/planqtable.html.

MAJOR DEPRESSIVE DISORDER

WASHOUT RECOMMENDATIONS FOR SWITCHING ANTIDEPRESSANTS

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

Switch to →	SSRI	Novel	TCA	RIMA	MAOI
Switch from ↓					
SSRI citalopram fluoxetine fluvoxamine paroxetine sertraline	No washout May have additive serotonergic side effects for 1 week (5 weeks for fluoxetine)	No washout May have additive serotonergic side effects for 1 week (5 weeks for fluoxetine)	No washout Start TCA at a lower dose Some SSRIs can increase serum TCA levels for 1 week (5 weeks for fluoxetine)	1 week (5 weeks for fluoxetine)	1 week (5 weeks for fluoxetine)
NOVEL bupropion-SR mirtazapine venlafaxine-XR	No washout May have additive serotonergic side effects for 1 week	No washout May have additive serotonergic side effects for 1 week	No washout	1 week	1 week
TCA desipramine nortriptyline amitriptyline imipramine others	No washout Serum TCA levels may be increased by some SSRIs for 1 week	No washout	No washout	1 week	1 week
RIMA moclobemide	3 days	3 days	3 days	N/A	3 days
MAOI* phenelzine tranylcypromine	2 weeks	2 weeks	2 weeks	2 weeks	2 weeks

MAJOR DEPRESSIVE DISORDER

Bipolar Disorder

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

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

- Discontinue antipsychotic typically six months after there has been a good response.
- Maintain on a mood stabilizer.
- A combination of a mood stabilizer and a very low dose of an antipsychotic is an option for treating refractory bipolar disorder.

ANXIETY DISORDERS

There are a variety of evidence-based medications for most but not all of the anxiety disorders.

Note on Benzodiazepines (see General Principles of Pharmacologic Treatments – Benzodiazepines in Primary Care)

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

TABLE OF MEDICATIONS INDICATED FOR SELECTED ANXIETY DISORDERS

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

Guidelines for Anxiety Disorders

Andrews, G., Creamer, M., Crino, R., Hunt, C., Lampe, L., & Page, A. (2003). *The treatment of anxiety disorders: Clinician Guides and Patient Manuals (2nd edition)*. United Kingdom: Cambridge University Press.

Andrews, G., Goldner, E.M., Parikh, S.V., & Bilsker, D. (2000). *Management of Mental Disorders: Volume I* (Canadian Edition). Vancouver: Bond Reproductions Inc.

Anxiety Review Panel. (2000). *Ontario Guidelines for the Management of Anxiety Disorders in Primary Care*, 1st Edition. Ontario Program for Optimal Therapeutics. Queen's Printer of Ontario.

EARLY PSYCHOSIS

General Principles of Starting Antipsychotic Medication

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

Advantages of the class of atypical antipsychotics include:

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

Disadvantages include:

- Significant risk of weight gain/diabetes/hyperprolactinemia.

Initial Dosing

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

Medication	Starting Daily Dose In mg. Per Day	Expected Lowest Effective Dose	Typical Higher Effective Dose
Risperidone	0.5 – 1 mg	1 – 2 mg	4 – 5 mg
Olanzapine	2.5 – 5 mg	5 mg	15 mg
Quetiapine	50 – 100 mg	300 – 400 mg	600 – 800 mg

Use of Other Medications

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

Side Effects

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

EARLY PSYCHOSIS

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

Evaluating Medication Response

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

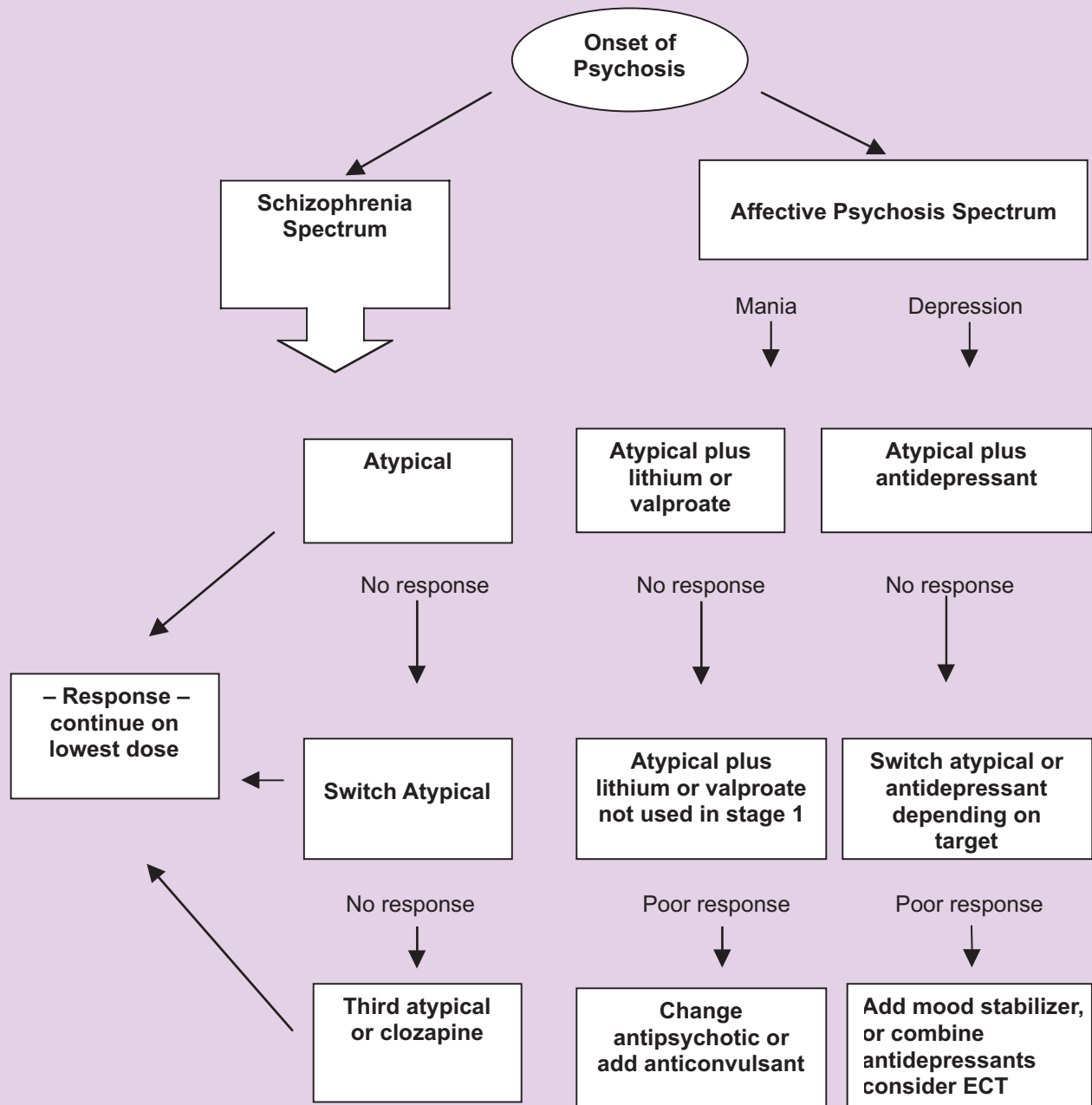
Switching Medications

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

Duration of Treatment

- Maintain the antipsychotic at least one year if the diagnosis is first break psychosis.
- In schizophrenia, approximately 20% never have a second episode.
- Continue medication indefinitely if this is a relapse.
- Monitor with frequent follow-ups if the medication is discontinued at the patient's request.

Pharmacotherapy Flow Chart for Psychosis



* Note — If history suggests schizoaffective bipolar type and patient presents in depressive phase, use antipsychotic and mood stabilizer and follow bipolar manic stream

EARLY PSYCHOSIS

Early-Psychosis-Specific Guidelines

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

Lambert M, Conus P, Lambert T, McGorry PD. Pharmacotherapy of first-episode psychosis. *Expert Opin Pharmacother* 2003;4(5):717 – 50.

The Australian Clinical Guidelines for Early Psychosis (1999/2000) available at:
www.eppic.org.au/

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

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

Disorder-Specific Guidelines

Canadian clinical practice guidelines for the treatment of schizophrenia.
The Canadian Psychiatric Association [see comments]. *Can J Psychiatry* 1998;43 Suppl 2:25S-40S.

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

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

Treatment of depression in primary care — Part 1: Principles of acute treatment.
BC Medical Journal Volume 44, Number 9, November 2002, page 473 – 478.
Agnes To, MD, Heidi Oetter, MD, and Raymond W. Lam, MD, FRCPC

Treatment of depression in primary care — Part 2: Principles of maintenance treatment
BC Medical Journal Volume 44, Number 8, November 2002, pages 479 – 484
Agnes To, MD, Heidi Oetter, MD, and Raymond W. Lam, MD, FRCPC

Practice Guidelines for the Treatment of Patients with Bipolar Disorder (Revision).
Arlington: American Psychiatric Association; 2002.