

# Evaluation of Progress

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

## *Office Management*

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

## **Goals of the Evaluation**

The goals of the evaluation should be to

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

## *Identifying Progress*

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

- Review overall quality of life using the “Global Assessment of Functioning Scale (GAF)”.
  - the GAF is from the DSM-IV or DSM-IV-TR and is an overall rating of the patient’s psychological, social and occupational functioning on a scale ranging from 1 to 100.
  - this is the rating listed on “Axis V” of most psychiatric consultations.
  - use the GAF at specific time intervals (e.g., every 3 months) to track overall progress.  
(See 3.65 for a GAF)
- Discuss symptom severity (mental health and any other co-morbid health problems) using scales wherever possible.
  - simple symptom rating scales such as “On a scale of 1 to 10, 1 being the worst, 10 being the best” work very well if answers are documented and scales are used consistently.
  - questions such as “what would it take to go from a 4 to a 6?” often yield helpful and insightful answers.

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

### *Reviewing Treatment Effects*

#### Pharmacological

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

#### **Non-pharmacological**

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

### *Responding to Lapses or Relapses Early*

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

### *Ensuring Patient Safety*

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

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

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

### *Identifying the patient's plan for ongoing recovery*

Engage the patient in a discussion of their plan to maintain or establish responsibilities and roles. This includes:

- return to employment or vocational training
- school strategies
- safe and affordable housing
- stable relationships
- healthy lifestyles
- stress management strategies.

### *Identifying barriers to progress*

As with any medical illness, progress may be slowed by unaddressed concerns of the patient. Reinforce that the family physician cares about the outcome and is committed to being an integral part of the treatment team. If the evaluation of progress shows limited advancement, consider the following:

- intolerance of medication side effects
- difficulty tolerating psychotherapy (e.g., distress associated with exposure component of CBT)
- fears and concerns about the aftermath of making progress that may lead to ambivalence or problems with treatment adherence (e.g., fears of returning to work or living independently)
- patients, family, and friends may require time to adjust to positive changes in patient (e.g., reduced need for assistance, desire to move out into own home, forming new relationships with others, trying new things, being more assertive)
- pushing too fast and too soon (e.g., premature return to work or school, taking on too many new responsibilities).

## EVALUATION OF PROGRESS

Addressing these issues may help bring the treatment back on track.

<b>CUES FOR EVALUATING PROGRESS</b> areas to explore when monitoring progress — assessing both negative and positive elements				
	<b>Depression</b>	<b>Anxiety</b>	<b>Psychosis</b>	<b>Substance Use</b>
Biological	<ul style="list-style-type: none"> <li>constipation</li> <li>weight gain or loss</li> </ul>	<ul style="list-style-type: none"> <li>sympathetic symptoms (e.g., rapid heart rate, GI upset, diarrhoea, SOB, chest pain)</li> </ul>	<ul style="list-style-type: none"> <li>Weight gain</li> <li>Extrapyramidal symptoms- cogwheeling, decreased arm swing, rigidity, shuffling gait</li> </ul>	<ul style="list-style-type: none"> <li>comorbid medical conditions, e.g., cellulitis, liver stigmata, abscesses or active tract marks.</li> </ul>
Medication side effects	<ul style="list-style-type: none"> <li>weight gain</li> <li>sexual dysfunction</li> <li>insomnia</li> </ul>	<ul style="list-style-type: none"> <li>weight gain</li> <li>sexual dysfunction</li> <li>insomnia</li> </ul>	<ul style="list-style-type: none"> <li>weight gain</li> <li>sexual dysfunction</li> <li>increased cholesterol</li> <li>akathisia — subjective feeling of restlessness</li> <li>QTc prolongation</li> </ul>	<ul style="list-style-type: none"> <li>nodding off, constipation (methadone)</li> </ul>
Laboratory	<ul style="list-style-type: none"> <li>mood stabilizer levels</li> <li>TSH</li> </ul>	<ul style="list-style-type: none"> <li>TSH</li> </ul>	<ul style="list-style-type: none"> <li>cholesterol changes, increased blood glucose</li> <li>ECG</li> </ul>	<ul style="list-style-type: none"> <li>changes in GGT, MCV, liver enzymes or reversal of biological red flags</li> </ul>
Psychological	<ul style="list-style-type: none"> <li>sleep, appetite, libido</li> <li>concentration, feelings of guilt or worthlessness</li> <li>interests, hobbies</li> <li>anxiety and substance use</li> </ul>	<ul style="list-style-type: none"> <li>overall anxiety</li> <li>avoidance of activities</li> <li>cognitive symptoms such as: fear of dying, fear of negative evaluation, phobias</li> <li>lack of energy</li> <li>need to escape fearful situations</li> <li>panic attack frequency, intensity</li> <li>coping responses</li> </ul>	<ul style="list-style-type: none"> <li>psychotic symptoms: positive and negative</li> <li>self harm risk to self or others</li> <li>mood, anxiety and substance use</li> <li>stress management</li> <li>level of insight</li> </ul>	<ul style="list-style-type: none"> <li>cravings, mood or anxiety symptoms, psychotic features</li> <li>boredom,</li> <li>pessimism</li> <li>stage of change</li> </ul>
Social	<ul style="list-style-type: none"> <li>relationships</li> <li>attendance to therapy or groups</li> <li>return to work or school</li> <li>hospitalizations</li> </ul>	<ul style="list-style-type: none"> <li>relationships</li> <li>attendance to therapy or groups</li> <li>return to work or school</li> <li>hospitalizations</li> </ul>	<ul style="list-style-type: none"> <li>extent and quality of relationships.</li> <li>community involvement</li> <li>caregiver burden</li> <li>grooming and hygiene</li> <li>status of main role functions (e.g., work, school)</li> </ul>	<ul style="list-style-type: none"> <li>relationships, presence of sponsors, meeting participation, hospitalizations</li> <li>loss of “using” peers, academic performance, employment</li> </ul>
Scale	<ul style="list-style-type: none"> <li>PHQ-9</li> <li>GAF</li> </ul>	<ul style="list-style-type: none"> <li>GAF</li> </ul>	<ul style="list-style-type: none"> <li>-AIMS (abnormal involuntary movement scale)</li> <li>-GAF</li> </ul>	<ul style="list-style-type: none"> <li>AUDIT or CAGE</li> <li>GAF</li> </ul>
Self Management	<ul style="list-style-type: none"> <li>ability to gain access to, understand, and use information to promote and maintain good health</li> </ul>	<ul style="list-style-type: none"> <li>ability to gain access to, understand, and use information to promote and maintain good health</li> </ul>	<ul style="list-style-type: none"> <li>ability to gain access to, understand, and use information to promote and maintain good health</li> </ul>	<ul style="list-style-type: none"> <li>ability to gain access to, understand, and use information to promote and maintain good health</li> </ul>

## Global Assessment of Functioning (GAF) Scale \*

<b>Psychopathology</b> Consider psychopathology on a hypothetical continuum of mental health to illness. Do not include impairment due to physical or environmental limitations.		<b>Social and Occupational Functioning (SOFAS)</b> Consider social and occupational functioning on a continuum from excellent to grossly impaired. Include impairments in functioning due to physical limitations, as well as those due to mental impairments. Impairment must be a direct consequence of mental and physical health problems. The effects of lack of opportunity and environmental limitations are not to be considered.	
100 91	Life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.	Superior functioning in a wide range of activities.	100 91
90 81	Absent or minimal symptoms (e.g., mild anxiety before an exam), generally satisfied with life, no more than everyday problems or concerns (e.g., occasional argument with family members)	Good functioning in all areas. Occupationally and socially effective.	90 81
80 71	If symptoms are present, they are transient and expected reactions to psychosocial stressors (e.g., difficulty concentrating after a family argument)	No more than slight impairment in social, occupational, or school functioning (e.g., infrequent interpersonal conflict, temporarily falling behind in schoolwork).	80 71
70 61	Some mild symptoms (e.g., depressed mood, mild insomnia).	Some difficulty in social, occupational, or school functioning but generally functioning well. Has some meaningful interpersonal relationships.	70 61
60 51	Moderate symptoms (e.g., flat affect, circumstantial speech, occasional panic attacks).	Moderate difficulty in social, occupational or school functioning (few friends, conflict with peers or co-workers).	60 51
50 41	Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting).	Serious impairment in social, occupational or school functioning (e.g., no friends, unable to keep a job).	50 41
40 31	Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in judgement, thinking, or mood.	Major impairment in several areas, such as work, school, or family relations (e.g., depressed man avoids friends, neglects family and is unable to work; child frequently beats up younger children, is defiant at home and is failing at school).	40 31
30 21	Behaviour is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgement (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation)	Inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).	30 21
20 11	Some danger of hurting self or others (e.g., suicidal attempts without clear expectation of death; frequently violent; manic excitement) OR gross impairment in communication (e.g., largely incoherent or mute)	Occasionally fails to meet minimal personal hygiene (e.g., smears feces); unable to function independently.	20 11
10 1	Persistent danger of severely hurting self or others (e.g., recurrent violence) OR serious suicidal act with clear expectation of death	Persistent inability to maintain personal hygiene. Unable to function without harming self or others or without considerable external support (nursing care and supervision).	10 1

1) \_\_\_\_\_ Psychopathology Score

2) SOFAS score \_\_\_\_\_

- Starting at the top of the scale, ask yourself "is EITHER the patient's symptom severity OR the patient's level of functioning WORSE than what is indicated in the range?"
- Move down the scale until you find a range which matches the patient's symptom severity OR level of functioning, WHICHEVER IS THE WORST.
- Double check your selection of a range by referring to the range immediately below the one chosen: it should have examples which are too severe on BOTH symptom severity and level of functioning. IF NOT BOTH — keep moving down the scale.

\* Table from DSM-IV, American Psychiatric Association, Washington, 1994.

## Management Plan Worksheet

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

Your Family Doctor's Name and Contact Information is:

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**When I am well and my symptoms are stable, I am able to do the following:**

Check off those that apply to you. Use blank spaces to add your own personal signs of wellness.

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

**In the past my symptoms have included:**

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

<input type="checkbox"/>	problems sleeping (too much/ too little)	<p>It can be overwhelming to complete this worksheet on your own.</p> <p>Ask your spouse, family, close friends or physician to help you fill it out and brainstorm ideas.</p>
<input type="checkbox"/>	feeling anxious or tense or panicky	
<input type="checkbox"/>	not feeling as hungry as normal or unusual increases in appetite	
<input type="checkbox"/>	problems with thinking, concentrating or making decisions	
<input type="checkbox"/>	unwanted or upsetting thoughts you can't easily get rid of	
<input type="checkbox"/>	feeling down or sad	
<input type="checkbox"/>	increases in bodily aches or pains	
<input type="checkbox"/>	missing work or school	
<input type="checkbox"/>	using drugs or alcohol even though it leads to harm	
<input type="checkbox"/>	not enjoying hobbies or other usual fun activities	
<input type="checkbox"/>	not wanting to go out or spend time with family or friends	
<input type="checkbox"/>	becoming easily annoyed at others	
<input type="checkbox"/>	avoiding things you need to do	

**Past triggers for my symptoms have included:**

Check off those that apply to you. Use blank spaces to add additional triggers you have experienced.

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

**Early warning signs**

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

My early warning signs include:

*Remember: sometimes warning signs will be the same as they were before the first episode; however, sometimes these warning signs can be completely different. Therefore, be alert to all early warning signs.*

**With your family physician and family develop a plan outlining what to do if warning signs are present**

*Example: What to do if you experience an increase in panic attacks and urge to avoid things*

*Example: What to do if you begin to hear voices or see things that are not actually there.*

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

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Consider including in this relapse prevention plan:

- making an appointment to see your doctor
- ways to reduce your level of stress or helpful coping behaviours
- changes to medication approved by your doctor

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

*Example: What to do if you overdose during a relapse in your problematic drug or alcohol use*

*Example: What to do if you become extremely depressed and suicidal*

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

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Consider including in this emergency plan:

- address for nearest hospital
- contact information for other emergency resources
- contact information for family or other people who can help provide

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

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