BC Partners for Mental Health and Addictions Information

Visions

BC's Mental Health and Addictions Journal

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Medications

background

experiences & perspectives

web-only articles

available at www.heretohelp.bc.ca/publications/visions

bc partners

Seven provincial mental health and addictions agencies are working together in a collective known as the BC Partners for Mental Health and Addictions Information. We represent the Anxiety Disorders Association of BC, British Columbia Schizophrenia Society, Canadian Mental Health Association's BC Division, Centre for Addictions Research of BC, FORCE Society for Kids' Mental Health Care, Jessie's Hope Society and the Mood Disorders Association of BC. Our reason for coming together is that we recognize that a number of groups need to have access to accurate, standard and timely information on mental health, mental disorders and addictions, including information on evidence-based services, supports and self-management.

visions

Published quarterly, *Visions* is a nationally award-winning journal which provides a forum for the voices of people living with a mental disorder or substance use problem, their family and friends, and service providers in BC. Visions is written by and for people who have used mental health or addictions services (also known as consumers), family and friends, mental health and addictions service providers, providers from various other sectors, and leaders and decision-makers in the field. It creates a place where many perspectives on mental health and addictions issues can be heard. To that end, we invite readers' comments and concerns regarding the articles and opinions expressed in this journal.

The BC Partners are grateful to BC Mental Health and Addiction Services, an agency of the Provincial Health Services Authority, for providing financial support for the production of Visions

alternatives & approaches

regional programs

I never knew him, but my granduncle was institutionalized for 'melancholia' in the 1920s or 30s. His depression left him catatonic toward the end of his life and he never left that facility. When, 75 years later, I needed psychotropic medication as part of my treatment plan, I thought of him whenever the cycle of medication trial-and-error sapped all my mental and physical reserves. I was lucky, I reminded myself; I could have been shut away like he was, for what is now considered a very treatable condition. Along with medicine, other therapies, lifestyle changes, and self-care, recovery has been very real for me and for hundreds of thousands of people in this province. Like broadcaster, Rafe Mair, I, too, never say I'm 'on drugs.' I'm taking medicine. It's how we talk about other conditions. Why do we have so many different rules when the medicine is for mental illness or addiction?

In planning this issue, I was surprised at how emotional this topic can be. And why shouldn't it be? As many of the writers in this issue discuss so passionately, medications are often a double-edged sword. The right medications can help lift symptoms of mental illness or addiction so we can finally do all the other hard work needed for recovery. For many of the same people, however, there are lots of simultaneous and more challenging realities: disabling side effects and reactions, tapering and withdrawal, multiple meds and interactions, trial-and-error roller coasters, medications that don't help, inappropriately medicating, affordability and access, fear, shame, daily restrictions and inconveniences of meds-taking, and/or possibility of dependence. As one doctor once told me, being on meds is like a hangover in reverse: you usually feel worse before you feel better.

Many people turn to other solutions. In fact, many submissions for this issue, which we didn't publish, described pathways to alternative or non-medication-based treatments. Although these were out of scope for this edition, we hope to address some of these other treatment choices in future *Visions*.

In the end, I think you'll find that the most enduring theme in this issue of *Visions* has little to do with medication itself or the biological model of mental illness. People and programs that are finding success are the ones that help people with mental illness or addictions feel empowered, engaged, informed, respected as experts in their own health. And as whole human beings. As always, we hope you find this issue relevant and insightful. i

Sarah Hamid-Balma

Sarah is Visions Editor and Director of Public Education and Communications at the Canadian Mental Health Association's BC Division. She also has personal experience with mental illness

subscriptions and advertising

If you have personal experience with mental health or substance use problems as a consumer of services or as a family member, or provide mental health or addictions services in the public or voluntary sector, and you reside in BC, you are entitled to receive *Visions* free of charge (one free copy per agency address). You may also be receiving *Visions* as a member of one of the seven provincial agencies that make up the BC Partners. For all others, subscriptions are $25 (Cdn.) for four issues. Back issues are $7 for hard copies, or are freely available from our website. Contact us to inquire about receiving, writing for, or advertising in the journal. Advertising rates and deadlines are also online. See www.heretohelp.bc.ca/publications/visions.

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Medications for Mental Illness

Are we there yet?

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In 1996, two Harvard researchers with the World Health Organization (WHO) published a landmark book, *The Global Burden of Disease*.[1] For the first time, the cost of illness was estimated using disability-adjusted life years (DALYs), which is the sum of years living with a disability and years lost due to premature death. One DALY is equal to the loss of one year of full health for one person.

This book identified five of the 10 leading causes of disability in the world as psychiatric disorders. Major depression was identified as the costliest illness in the world. The other four mental illnesses included alcohol use, self-inflicted injuries (i.e., suicide), manic-depressive illness and schizophrenia.[1]

These findings were a surprise because, historically, emphasis in medicine was placed on the effect and management of acute rather than chronic physical illness. In addition, many people are confused about the nature of mental illness. Some believe these disorders are diseases of the soul and spirit. Others understand that psychiatric symptoms are the result of disordered processes in the brain.

Modern psychiatry, however, views mental illness as a combination of genetic, biological, cultural and social effects, resulting in psychological symptoms. These factors result in an individual who is both the producer and the product of complex chemical events in their brain.

Development of specific medications for mental illness has paralleled the increase in our understanding of chemical events that occur during abnormal brain function.

The journey

Since the early 1950s, management of psychiatric disorders has included medication. For over 60 years, mental health and addictions researchers have been searching for 'ideal' medications.

Medications identified during the first 30 years were far from ideal. They did offer significant relief to individuals suffering from mental illness and worked quickly to calm individuals. However, they were not effective on all symptoms and were associated with a number of side effects.

The best medication is the one that works. For some people, it's the older meds; for others, the newer. Side effects in newer medications are different, but not always better.

What makes an 'ideal' medication?

Regardless of the disorder, the characteristics of an ideal medication include:

- effective on all symptoms
- works quickly
- no side effects
- no drug interactions
- doesn't wear off
- non-addictive
- affordable

Medications aid in deinstitutionalization

In 1913, British Columbia officially opened the Hospital for the Mind, later renamed Riverview Hospital. Riverview Hospital held more than 5,000 patients at its peak, but by 2007, patient numbers were less than 500.[2]

What happened? Medications that helped with psychiatric symptoms were identified—though researchers did not discover the cause or cure for mental illness.

Improving symptoms enabled individuals to participate in supportive programs. As a result, some individuals with mental illness could be completely managed within their community, while others only required hospitalization for stabilization of their symptoms. Many avoided the prolonged periods of institutionalization that had occurred in the past.

footnotes

visit **heretohelp.bc.ca/publications/visions** for Debbie's complete footnotes or contact us by phone, fax or email (see page 3)

Present-day challenges

Today's clinicians are increasingly aware of the issues and challenges in using medication. There are now more medications to try and more combinations of medications are used.

A patient's age, sex and the presence of other medications and medical conditions affect treatment options and management. Medication use—in the young, the elderly and pregnant females, particularly—should be approached with caution, evaluating risks versus benefits. In some situations, the risks of not using medication are greater than exposure to medication.

These young, elderly and pregnant patient populations are rarely included in controlled clinical trials, because they pose additional risks to research studies. The elderly have numerous illnesses and medications; the young may not respond the same as an adult; and in pregnant women there is the risk of harm to the developing fetus. Therefore, evidence supporting medication use in these patients is frequently limited.

Are we there yet?

No. But we have come a long way. We are at a unique time in the management of mental illness. New evidence (see articles by Ric Procyshyn and Sylvia Zerjav) and a better understanding of psychiatric illness permit us to optimize treatment and to provide the best fit of medications to a patient, within an individual treatment plan. Future treatment management may include an individual's ideal medication, along with the always necessary support to attain the goal of a healthy, active lifestyle.

Within this journal, you will discover articles on the past, the present and the future of medication use in mental illness. This issue of *Visions* offers a wide spectrum of practical information and professional and consumer perspectives on the challenges of medication use in mental illness. It also offers some hope for the future, as the discoveries of scientific and medical research accelerate. i

Wow, the Housing and Homelessness Visions has got to be the best, most inspiring issue I have read. I believe I have read them all since 1998 or 1999. I agree with the editor about feeling it is, in many ways, a landmark issue. Way to go. The Experiences and Perspective portion was to me very humbling. Hopefully the people in power will do the right thing and open the doors to help the most vulnerable in our communities. Thank you so much and I look forward to more focus on housing in the future. *—Wanda Johnson, Langley*

I would like to compliment you on the Housing/Homelessness issue of *Visions* magazine. This issue came at such a great time for our community as we were in the midst of preparing a supplement on this very subject for our local newspaper. Like every other community in the province, ours is suffering from a lack of safe, affordable homes for Canadian Mental Health Association (CMHA) clients, and for other individuals with barriers to housing. The recent, dramatic increase in property values has put a tremendous strain on local resources. Your publication provides leadership to all of us in responding to the social needs of citizens who are at the greatest risk. *—Maggie Patterson-Dickey, CMHA 100 Mile House branch*

we want your feedback!

If you have a comment about something you've read in Visions *that you'd like to share, please email us at bcpartners@heretohelp.bc.ca with 'Visions Letter' in the subject line. Or fax us at 604-688-3236. Or mail your letter to the address on page 3. Letters should be no longer than 300 words and may be edited for length and/or clarity. Please include your name and city of residence. All letters are read. Your likelihood of being published will depend on the number of submissions we receive.*

Correction: We would like to clarify that the photo that appeared near Claire Hurley's name on page 19 of our last issue was for illustrative purposes only and not a depiction of the writer or any people in the article, and apologize for any confusion this may have caused. Please see the note below about our use of stock photography.

Photography disclaimer: *Please note that photographs used in the print issue of Visions and online at HeretoHelp.bc.ca are stock photographs only for illustrative purposes. Unless clearly captioned with a descriptive sentence, they are not intended to depict the writer of an article or any other individual in the article. The only regular exception is the guest editor's photo on page 4.*

medications glossary

Disclaimer *These definitions are adapted from trustworthy sources. We hope they will help readers to better understand some of the special terms used in this issue. They are purposely brief and in plain language. As such, these definitions may not include all nuances or variations of a term, and alternate or expanded definitions may be used by some organizations. These have been developed by editorial staff and may not be definitions in use by members of the BC Partners or its funder.*

if you see this symbol (†) next to a term in an article, the term is in this glossary

Antidepressant medication	medication designed to treat depression. Common antidepressant families include SSRIs, SNRIs, MAOIs and TCAs.
Antipsychotic medication	medication designed to treat psychotic symptoms. Also called neuroleptics.
Anxiolytic medication	medication designed to treat anxiety.
Black box warnings	warnings that appear on prescription medications informing patients of serious side effects.
Central nervous system (CNS)	is made up of the brain and spinal cord. It controls all body and cognitive function.
Cognitive decline	a decrease in the ability of the brain to perform regular functions like judgement, reasoning, memory, learning and understanding. This is often the result of mental illnesses such as dementia but can also be (to some extent) a normal part of aging.
Compliance/adherence	how closely patients follow treatment programs given to them by their doctor or practitioner such as taking medications, following diet or exercise plans, or doing psychotherapy "homework." Adherence is being increasingly used as the preferred term because it implies and recognizes patient choice in treatment.
Depot injection	medication that is injected with a needle that is designed to release slowly into your system.
Dossette	single doses of medication packaged individually to help make taking medication easier. Examples: blister packs (each pill individually sealed within a plastic bubble with a peel-off or push-through backing) or pill boxes.
Monograph	a factual document on a drug product agreed on by Health Canada and the drug manufacturer that scientifically describes what the drug is, how it is designed to work, side effects, why and when it's to be used, and other information for the safest and most effective use of the drug.
Negative symptoms	symptoms of an illness that decrease normal experiences a person has such as loss of interest in things they used to enjoy, lack of emotion or loss of concentration.
Neurotransmitter	chemicals that act as messengers between nerve cells. Common neurotransmitters affected by mental health or addictions medicines include serotonin, norepinephrine (noradrenalin), and dopamine. Most mental health or addictions medications affect the way the brain processes one or more of these messengers.
Off-label use	when doctors prescribe a medication for health issues other than those the medication is intended for. Also known as off-label prescription.
Pharmaceuticals	if substances have medicinal properties, they are considered pharmaceuticals.
Pharmacology	the study of how drugs affect functioning in living things.
Pharmacotherapy	treating a health condition with medication.
Placebo	sugar pills or other non-medicinal pills given to people in medication trials to help determine if the medication that is being tested is actually working or if the same effects can be reached simply by the power of suggestion. This allows researchers to better measure the effects and side-effects of the medication.
Positive symptoms	symptoms of an illness that are added to what a person normally experiences. Examples: hallucinations, delusions or strange thoughts.
Psychoactive drug	a chemical substance that affects brain function, resulting in changes in perception, mood, consciousness and behaviour.
Psychotropic medication	any medication capable of affecting the mind, emotions, and behaviour.

How Antidepressant and Antipsychotic Medications Work

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Depression and schizophrenia are two of the many mental illnesses that a physician can treat with effective medications. Knowing how medications work can increase your understanding of mental illness and encourage compliance—that is, consistently sticking to your medication treatment plan so that the medications are given a chance to be effective. This article will explain how antidepressant and antipsychotic medications work in the brain to treat these disorders.

How our brains work

The central nervous system (CNS), made up of the brain and spinal cord, controls our actions, thoughts and emotions. These functions are controlled by chemicals called neurotransmitters.† Neurotransmitters travel between different regions of the brain via nerve cells called neurons.

There are several different neurotransmitters that act on parts of these nerve cells called receptors. This produces effects that can influence memory, emotion, voluntary movement of muscles, appetite, temperature regulation and more. Figure 1 shows how this process works.

What is depression?

Although the exact cause of depression is not known, biological, genetic and environmental factors are thought to play a role. Depression is often associated with various conditions including emotional upset (e.g., divorce, death in the family, major financial problems), co-existing medical conditions (e.g., stroke, heart attack, cancer), hormonal disorders (e.g., underactive thyroid, menopause) and problem substance use (i.e., alcohol and other drugs). Depression also often co-occurs with other mental illnesses, including bipolar disorder, schizophrenia and anxiety disorders.

Whatever the trigger, it is believed that the underlying biological basis of depression is a depletion in the levels of neurotransmitters such as serotonin, norepinephrine, and/or dopamine in the central nervous system.

Antidepressants

All antidepressants† work in a similar way, though there are various types of antidepressants—often called "families"—that each work a bit differently. They all, however, increase the brain's concentration of various neurotransmitters.

One of the older antidepressant families, tricyclic antidepressants (TCAs), increase both norepinephrine and serotonin concentrations, generally speaking. However, some TCAs will increase serotonin concentrations more than they increase norepinephrine (e.g., clomipramine), and others increase norepinephrine concentrations more than serotonin concentrations (e.g., nortriptyline and desipramine).

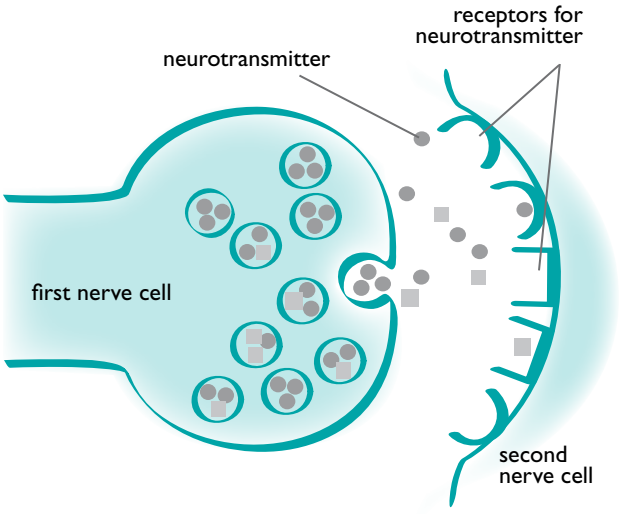
Monoamine oxidase inhibitor antidepressants (MAOIs) comprise another family. It includes medicines like phenelzine, isocarboxazid and moclobemide. MAOIs work by stopping the breakdown of monoamine neurotransmitters, which helps keep the brain's concentration of neurotransmitters at levels that help improve mood.

Side effects often associated with TCAs and MAOIs include drowsiness, weight gain, dry mouth, constipation, blurred vision, dizziness and sexual dysfunction. Because of these side effects, doctors will usually prescribe a newer antidepressant first.

These older drugs remain on the market because, in some people, newer medications don't work as well as the older medications.

Newer antidepressants act in a similar way to treat depression, with the advantage of fewer side effects. The most commonly prescribed group of antidepressants is selective serotonin reuptake inhibitors (SSRIs), including fluoxetine, paroxetine, fluvoxamine,

Figure 1
How neurotransmitters work between nerve cells



related resource

scared to try antidepressants? See our online-only Visions article on myths and facts

sertraline and citalopram. The main action of SSRIs is to increase the concentration of serotonin.

The antidepressant venlafaxine is described as a serotonin norepinephrine reuptake inhibitor (SNRI); it increases serotonin and norepinephrine concentrations. At higher doses, venlafaxine also increases dopamine concentrations.

If an antidepressant increases serotonin concentrations, side effects can include nausea, changes in appetite and sexual dysfunction.

Bupropion is an antidepressant that doesn't increase serotonin concentrations, but does increase levels of norepinephrine and dopamine.

Lastly, the antidepressant mirtazapine enhances neurotransmission by increasing the concentrations of both serotonin and norepinephrine. Unlike the SSRIs, mirtazapine blocks specific serotonin receptors, reducing the potential to cause side effects such as sexual dysfunction and nausea.

Antidepressants are often very effective; however, it is important to realize that it takes time for them to take effect. Some people suffering from depression may notice an improvement in symptoms after two weeks of treatment. But, most people will require at least four to eight weeks of treatment before noticing a positive response. Unfortunately, side effects usually appear before the benefits of antidepressant medications are recognized. Discussing these side effects with your doctor or pharmacist may provide you with a better understanding of what is happening and how to manage it.

As a side note: antidepressants are prescribed to treat and manage other illnesses. TCAs, for example, have local anesthetic-type properties and have been used to treat chronic pain due to nerve injury. SSRIs, on the other hand, are commonly prescribed to treat various anxiety disorders that share a common underlying cause involving serotonin.

What is schizophrenia?

Schizophrenia is a chronic psychotic disorder with onset typically occurring in late adolescence or young adulthood. The symptoms of schizophrenia can be divided into positive† and negative† symptoms. Positive symptoms can be described as an excess or distortion of normal functions, such as hallucinations, delusions and thought disorders. Negative symptoms can be described as a reduction or loss of functions; they include slowed thoughts or speech, loss of expressed emotions, lack of motivation, attention deficits and loss of social interest.

Schizophrenia is associated with an increase in dopamine activity in an area of the central nervous system called the mesolimbic pathway. The mesolimbic pathway is one of four major dopamine-related pathways in the brain that is associated with pleasurable feelings, with addiction—and with psychosis.

Antipsychotics

Generally speaking, antipsychotic medications work by blocking a specific subtype of the dopamine receptor, referred to as the D2 receptor. Older antipsychotics, known as conventional antipsychotics, block the D2 receptor and improve positive symptoms. Unfortunately, these conventional antipsychotics also block D2 receptors in areas outside of the mesolimbic pathway. This can result in a worsening of the negative symptoms associated with the illness. Conventional antipsychotic medications include chlorpromazine, haloperidol, trifluoperazine, perphenazine and fluphenazine.

A second generation of antipsychotics, commonly referred to as the atypical antipsychotics, block D2 receptors as well as a specific subtype of serotonin receptor, the 5HT2A receptor. It is believed that this combined action at D2 and 5HT2A receptors treats both the positive and the negative symptoms. The atypical antipsychotics currently available in Canada include clozapine, risperidone, olanzapine, quetiapine, paliperidone and ziprasidone.

Like all medications, antipsychotics have side effects. Side effects from blocking the D2 receptor can include tremors, inner restlessness, muscle spasms, sexual dysfunction and, in rare cases, tardive dyskinesia, a disorder that causes repetitive, involuntary, purposeless movements. These side effects are more often associated with the older conventional antipsychotics—which, again, may still work better for some people—but that is not to say that atypical medications don't have side effects. Side effects associated with the atypical antipsychotics include weight gain, diabetes and lipid disorders. These side effects are more often associated with clozapine and olanzapine.

Note that antipsychotic agents are also prescribed to treat other conditions apart from schizophrenia. This is referred to as "off-label"† prescribing and includes conditions such as Tourette's syndrome, substance abuse (e.g., cocaine and methamphetamine), stuttering, obsessive-compulsive disorder, post-traumatic stress disorder, depression, bipolar disorder and personality disorders.

It is important to keep in mind that, like antidepressants, antipsychotic medications do not work immediately; it may take up to eight weeks to see the therapeutic benefits. And the side effects tend to occur before improvement in the symptoms of the illness is experienced. However, anyone experiencing troublesome side effects should consult their doctor or pharmacist.

To conclude

Clearly, depression and schizophrenia are very complex and debilitating disorders. Fortunately, medications like antidepressants and antipsychotics can help treat the core symptoms. Knowing how these drugs work and what effects they can have will be an important step in using them properly and effectively.

Medications Used in Recovery From Addiction

Jennifer Melamed, MD

Jennifer is an addiction physician practising in Metro Vancouver and the Fraser Valley. She is certified with the Canadian Society of Addiction Medicine, the American Society of Addiction Medicine and the International Society of Addiction Medicine

The core symptoms of drug addiction are a powerful and unexplainable compulsion and a craving to use a drug. Compulsions can cause you to continue using a drug even when you don't want to, and cravings can cause you to start using a drug again after all your best efforts to quit. These are the key focus areas that we addiction physicians pay most attention to in terms of treatment.

New medications in the field of addiction medicine are providing us with ways to help our patients stay drug and alcohol free. Therapy has always involved a combination of psychological and social healing. We now have a growing number of pharmacological treatments aids to add to—not replace—the standard therapies.

The type of addiction medication used varies according to which substance a patient is addicted.

Alcohol

- Disulfiram (Antabuse) causes a very unpleasant reaction (e.g., aggressive vomiting) when a person drinks even a tiny amount of alcohol. This is a form of aversion therapy. A patient must take disulfiram daily until they're able to establish permanent self-control.
- Naltrexone (Revia) is usually used to reverse an opiate overdose when used intravenously, but when taken orally, it may reduce the craving for alcohol. The major side effects are nausea and abdominal pain.[1]
- Acamprosate (Campral) has also been shown to reduce alcohol cravings. It has recently become available in Canada. Acamprosate has been used in Europe for many years and is a welcome asset in craving management. It has minimal side effects.

Nicotine

- Nicotine replacement systems (NRS) are well known to everyone and include patches, gum, oral inhalers and lozenges. These contain nicotine and are designed to minimize withdrawal symptoms. They can even be used in combination, in pregnancy, in young people ages 12 to 17 and in people who have heart disease.[2]
- Bupropion (Zyban) was initially introduced as an antidepressant, but has been shown to reduce cravings and some of the discomfort of withdrawal.[3] Bupropion can be used together with any of the NRS applications.
- Varenicline (Champix) is a new oral tablet that has recently become available in British Columbia. It also works by reducing the craving for nicotine.[4] It is important to note that varenicline will cause stomach problems of varying degrees in all patients, but this will settle.

Using bupropion and an NRS together or individually will double your chance of quitting smoking. If varenicline on its own is used instead of bupropion and/or NRSs, you have a four times greater chance of quitting compared to using no aids.

Opiates

Opiates are a group of medications used to relieve pain. However, in some people they can become addictive. They can induce a euphoric-type high. Opiates are either derived from the seeds of the opium poppy or manufactured synthetically. The opiate group includes both legal prescription opiates (Dilaudid, morphine, oxycodone) and illegal street drugs (heroin).

All opiates are addictive and, when prescribed by a doctor, should only be used as recommended.

- Methadone is an opiate drug that has proven over the last three decades to be a remarkable treatment for opiate addiction. Methadone acts chemically on the brain's receptors for opiate drugs. It fills these receptors, relieving the need for other opiate drugs.[5] As you get used to methadone, it doesn't change behaviour, feelings or thoughts. There is no high from taking methadone properly; hence, it doesn't fuel addiction. Although you will be physically dependent on methadone, you will be free from some of the compulsions of addiction.
- Buprenorphine (Suboxone) is also an opiate medication that has the same effect as methadone, but is different in some ways. Suboxone is a combination of buprenorphine and naloxone (a compound that, if injected, blocks the effects of pain-killing opiates).

- Suboxone is a very safe drug, with minimal risk of overdose. An optimal dose can be achieved in a very short period of time: Suboxone usually takes less than one week, whereas methadone dosage needs to be increased slowly and carefully over a longer period of time. Suboxone won't be sufficient for anyone using larger opiate doses, however, because it has no further benefit beyond a certain dosage. Depending on the dosage, Suboxone may only need to be taken every second or third day. It will be available in Canada shortly.

It's important to remember that drug addiction is often associated with other mental illnesses. And it is important to treat these mental health conditions with the medications prescribed by your doctor. These may include antidepressants, antianxiety drugs and drugs to treat schizophrenia, bipolar disorder and other illnesses. The benefits of these additional medications should not be minimized. These treatments—plus ongoing support and counselling—are needed to ensure that your mental well-being is at its healthiest.

It is important to note that these new drugs are not a replacement for existing, well-recognized therapies for addiction, such as counselling, acupuncture and 12-step groups, to mention just a few. These drugs are additional tools that can be used in your recovery.

footnotes

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major addiction medicine approaches

Aversion Therapy

Provides an unpleasant reaction to counteract the pleasurable effects of using a substance, in an attempt to discourage cravings. For example: giving a patient a medication that makes them nauseous if they ingest alcohol.

Craving Reduction Therapy

Helps control the urge and impulses of returning to addictive behaviour. For example: using an antidepressant to reduce cigarette cravings.

Replacement Therapy

Legal substances are used to replace more harmful substances. For example: giving methadone to heroin users.

All About Benzos

Nicole Pankratz

Nicole is the Publications Officer with the Communication and Resource Unit of the University of Victoria's Centre for Addictions Research of BC

Benzodiazepines, or benzos, are a type of medication that "depresses" or slows down your central nervous system.† Benzos include tranquilizers and sleeping pills. In the medical world, they are called sedatives or anxiolytic agents.

A wide variety of benzos are manufactured by drug companies and sold in many countries around the world. Some of the most well-known types (and their trade names) are:

- alprazolam (Xanax)
- chlordiazepoxide (Librium)
- diazepam (Valium)
- flunitrazepam (Rohypnol)
- lorazepam (Ativan)

There are three types of benzos: short-acting, medium-acting and long-acting. This relates to the length of time the drug affects your body.

How benzos work

Benzos usually come in the form of pills or tablets and are either swallowed, dissolved under the tongue or administered as a suppository. They also come in liquid form and can be injected.

When benzos reach your brain, they increase the calming effects of a naturally occurring chemical (neurotransmitter) called gamma amino butyric acid (GABA). GABA's natural function is to slow things down in the body.

Because benzos decrease activity in the central nervous system, they affect your emotional reactions, mental skills and physical abilities. For this reason, they are useful in treating anxiety disorders, insomnia, seizures and muscle spasms.

Reasons people use benzos

Doctors prescribe benzos to people who need help coping with anxiety or sleeping problems. These disorders are often the result of social or personal problems, such as grief, sexual assault, domestic violence, stress or mental health issues.

The drug is also given to people who suffer from headaches, high blood pressure, menstrual problems, skin conditions and injuries related to accidents. Benzos have proven effective in helping people through severe alcohol and other drug withdrawal.

People with age-related problems are most likely to use benzos. These problems may include

arthritis, muscle pain, menopausal problems, sleeping difficulties and dementia.

Some people use benzos for recreational reasons. They may steal or borrow from someone else's prescription because they like experiencing the feeling of extreme calmness or near sedation.

There are people who use benzos on others in order to commit a crime. Home invaders have been known to use flunitrazepam to drug victims during a robbery. The drug is also well known as a date rape drug.

Benefits and health risks

The way benzos affect you depends on your weight, age, mood and method of administration.

With the proper dosage, benzos can stop seizures or movement disorders. You may also experience a feeling of relaxation and contentment, reduced symptoms of panic or agitation, and reduced symptoms of alcohol withdrawal.

Some of the side effects that may occur include:

- feeling drowsy and having no energy
- becoming confused or dizzy
- slurring words or stuttering
- blurred or double vision
- memory problems

For older people, using benzos comes with special risks. Age-related changes in their bodies can make short- and medium-acting medication last longer. This can increase a person's risk of overdosing. Other problems include:

- impaired balance
- impaired blood pressure regulation
- memory loss
- emotional changes and worsening symptoms of depression
- respiratory problems in people with emphysema and chronic bronchitis

Using benzos can be especially dangerous if you are:

- *Suffering from breathing problems.* Because benzos slow down breathing, people with emphysema and sleep apnea are at increased risk of accidental death.
- *Mixing substances.* When you mix benzos with alcohol and other depressants, you can become dangerously sedated or fall into a coma.
- *Pregnant.* Babies born to mothers who regularly used benzos during pregnancy can develop learning and behavioural problems. A baby with large quantities of these drugs in its system suffers from severe withdrawal symptoms.[1]
- *Operating a vehicle.* Driving under the influence of any drug, including prescription medications that are used illegally, is dangerous and against the law. Having high levels of benzos in your body can impair your ability to drive carefully.

Risk of addiction and related issues

Benzos are meant to be a temporary solution to a mental or physical health problem. When you take them for longer periods, they become less effective. This can cause you to start using higher amounts of the drug in order to get the desired effect. Over time, repeated use of higher and higher doses can lead to dependency.

Long-term use of benzos to soothe anxiety is likely to produce the opposite effect. This is because long-term use creates dependency, and dependency brings about withdrawal symptoms. Ultimately, you will become anxious about not taking your anxiety medication.

Benzos that are used as sleeping pills are only effective for one or two weeks. Longer use may cause an increase in the number of times you wake up in the night and a decrease in the amount of deep sleep you get.

Last word on benzos

Benzos have proven effective as a short-term method of managing or overcoming certain problems. People who understand the risks involved with extended or excessive dosages stand to benefit the most from this useful medication.

benzos warning

Severe withdrawal symptoms can occur if you suddenly quit taking benzos. If you want to stop taking benzos you must talk to your doctor first.

sources

visit **heretohelp.bc.ca/publications/visions** for the main source material for Nicole's article or contact us by phone, fax or email (see page 3)

did you know?

- Women are twice as likely as men to be prescribed benzos.[2]
- A recent Canadian study reports that half of elderly patients who were prescribed benzos for the first time in hospital were still using the drug six months after being released.[3]

Medications
A quagmire of approaches and attitudes

Bob Krzyzewski

Bob is a Vancouver-based healer and conscious community networker. He performs with guitar at local events; facilitates workshops in yoga, meditation and dietary practices; offers personal sessions in foot reflexology, body and energy work, and addictions and transpersonal counselling; and writes on various themes for local publications

My encounters with the mental health and medical systems substantially confused my recovery path. Ten years ago, I experienced a number of losses. The worst was losing both my parents to sudden illness, followed by a close friend who committed suicide shortly after we had spent significant time together. I became severely depressed and suicidal. I didn't have a concrete plan to kill myself, but thought I'd better get professional help before things escalated to self-destructive levels.

Route 1: Addiction services

I had been in recovery for an alcohol addiction problem for some years, and didn't want to go backwards toward the chaos and pain of active consumption. So, I thought an addictions counsellor might best be able to assess my situation. Rallying my resolve, I went into my local addiction services outpatient clinic for an assessment.

A barrage of questions came at me from the intake worker there, who took notes "to determine the severity of my risk." She felt I needed continuing outpatient counselling, and wanted me to sign a service user agreement. This document outlined the parameters of counselling, including that I would not accept medications from any doctor, or outside referral source. I asked, "What if I had to go into emergency at a hospital in the middle of the night, for severe anxiety, or suicidal feelings?" She said that would violate, and therefore terminate, our service agreement.

I was shocked at her reply. "Well," I stammered, "where else could I go to get help?"

She suggested I go across the street to the mental health services office, and she proceeded to set up an immediate intake appointment for me.

Route 2: Mental health services

A little confused, I crossed the street and announced myself. Soon I was in a private office with a social worker. I went through much the same scenario as I had with the addictions intake worker—and received the same evaluation: I was "at risk," and should attend ongoing counselling sessions.

Another service agreement contract was produced, only this time it required that I agree to inherently comply with the recommendations of the staff doctor, including the medications prescribed for, exactly as written. Feeling uncomfortable about this, I asked, "Do you have an addictions specialist on call as a staff physician?"

"Well, not really. They're trained psychiatrists; they know their medications really well. But medications only work if you take them as prescribed; otherwise, you're in non-compliance with his recommendations, and your counselling and all services will be terminated."

"Well, what if I feel I'm creating cravings for my street drugs by taking his prescription?"

"He'd give you another medication to deal with that symptom, then."

"How many medications does he have?" I naively asked.

"Oh, he's got lots," she said, "and you'd have to take them all if he wanted you to."

I really panicked at the authority this staff psychiatrist was going to have over me. I felt very confused and frustrated: all my feelings of rejection from my friend's suicide were now complicated with a feeling of being unacceptable to both these helping institutions.

"I think I'd better get a second opinion from a private psychiatrist," I replied, as I walked out of her office.

It felt like metal doors to rehabilitation were closing forcefully behind me. It seemed a great irony that these 'helping professionals' were asking me to give up my right to inform myself and make my own way through the treatment experience. My anxiety was definitely on the rise.

Route 3: Private psychiatrist

I put the word out that I was looking for a psychiatrist. A trusted friend recommended one she felt would understand my spiritual 'ravings'—I see visions, receive visitations and experience astral projection. I met this doctor in a comfortable office, in my neighbourhood. He was Indo-Canadian, and wore a silver wrist band, which looked the same as one my yoga teacher, who practises a form of Sikh yoga, wears. I asked the doctor if he practised this faith, and he replied that he did. This opened a whole area of conversation, and he seemed enthusiastic to discuss these spiritual matters.

So when this psychiatrist prescribed antidepressants, I, keeping an open mind, was willing to comply. I started on a dose of a popular SSRI medication. After two days, I called and said I was experiencing side effects, including rushes, palpitations, hot flashes and tremors. He said, "These drugs don't take effect for two to three weeks. You must be mistaken."

I replied, "I never waited two to three weeks to get high on a street drug, and I know what it feels like to be getting stoned!"

"How am I supposed to help you then?" he asked.

"How about we sit down and talk to each other?" I suggested.

"I don't have time for that," he retorted.

So I said, "How about I read about the natural herbs, vitamins and other holistic alternative treatments for depression and report them to you, and you evaluate them according to your accepted medical criteria?"

"Affirmative, Einstein," he chuckled.

Route 4: Alternative treatments

Since then, I have spoken to many alternative health/healing practitioners and have explored many herbs, vitamins and other holistic treatments. Much has been very beneficial, and I have managed to establish a recovery program of well-being modalities, including massage and reflexology, chi kung and yoga (kundalini, ashtanga and restorative), as well as singing and accompanying myself on guitar.

This route has had its own issues. One thing particularly relevant to me has to do with a recommended practice of a holistic program: cleansing your blood and digestive tract of toxins. One of the components of an often-suggested kit for this purpose is a herbal formula in tincture form, which is taken internally. Tinctures, however, can contain as much as 70% alcohol. While there are tinctures without alcohol (glycerin based), they usually have to be special-ordered.

Luckily, I noticed the alcohol content before opening the box and asked for a refund or exchange. When the sales clerk asked why I was returning the kit, I told him that I had abstained from alcohol for 23 years and that I believed my system would be intolerant of any amount or form of alcohol.

The previously friendly and supportive clerk lashed into my remarks, stating that tinctures don't contain any "active alcohol" and "couldn't hurt a flea."

I replied that I wasn't worried about a flea, but about myself, and I wasn't going to take any chances at this stage of my recovery.

Words of wisdom

The well-being modalities that I learned and practise demand much more time and energy than simply taking medication does. They are active forms of self development and, in some cases, have thousand-year-old philosophies behind them, adding to their usefulness as a resource for daily living.

Preferably these practices would be combined with cognitive-behavioural therapy, or other forms of therapy, including medication regimes.

If you are taking medications, I would suggest that you do as much background research as you can, read labels carefully and ask questions fearlessly. It's not a perfect world, and rough spots, mistakes and even disasters still occur despite precautions taken. But it's better than sitting back and not looking out for your own well-being!

related resource

for another personal meds story, see Simone's online-only Visions article

Medication Madness

V.J.

V.J. is a 50-year-old divorced mother of three adult children: one daughter and two sons. She lives in northern BC, where she works part-time as a mental health advocate at the local peer development office

Medication can be a 'tough pill to swallow.' I am currently on two mood stabilizers, an antipsychotic, an antidepressant, an antianxiety med and a sleeping pill. The balancing act of getting the most benefit and the least side effects from my medication has been difficult and can be very frustrating, to the point of not wanting to take them anymore. My frustration has built up over 18 years. Let me fill you in on my ride over an ever so bumpy road.

A rocky road downhill

My trip down medication alley began in 1989 with my very first breakdown. I was flown from my home town to Vancouver, where I spent six weeks in St. Paul's Hospital psychiatric ward. There I was given antianxiety and tricyclic antidepressant medications for a major depressive episode.

By the time I applied for Canada Pension Disability in 1991, I had seen five different psychiatrists and had five varying diagnoses. Because of conflict between family members, who lived in Vancouver, and my psychiatrist at St. Paul's, I was shipped off by ambulance to the psych unit in Kamloops—to put distance between us. The doctor there saw some other symptoms and gave me an additional diagnosis, along with a change in pills. After two weeks on the new medications, I was sent home. A day or two later I cut my wrist and was sent to Prince George Regional Hospital. Guess what? They saw something else, which meant my diagnosis and medications were altered once again. Every doctor I encountered had a new diagnosis for me. By about 1993, I had been given all the following DSM[1] 'labels': dissociative disorder not otherwise specified, borderline personality disorder, post-traumatic stress disorder, traits of bipolar II disorder and traits of obsessive compulsive-disorder.

Seeking 'comatose'

Over the next five years or so I became increasingly

addicted to Ativan. I also struggled with cutting for 15 years.

I had a lot of emotional pain because of a very traumatic childhood. I felt that feeling physical pain would alleviate my emotional pain, so I used to walk or hang out in dangerous areas or situations, hoping someone would rape or beat me. On one of these walks, I started the cutting. I used a nail file and cut myself so badly I needed stitches. I became addicted to the pain. I felt so ugly on the inside that I felt I should be ugly on the outside. I would punch walls to try and break my fists. I became obsessed with X-acto knives. If I saw one in a store I couldn't leave without buying it, then I'd take it home and cut myself with it.

I was first given Ativan by my GP, back before my breakdown, to help me cope with panic attacks I was having. Because, where I live, there is a high turnover of doctors, it was easy to keep getting it prescribed and to stockpile it.

I wanted to dull my emotional pain by becoming comatose, so would take six Ativan at a time for no other reason than to go back to bed and sleep away my life. I'd wake up, have a meal, take six more Ativan and then it was off to bed again. The cutting was also easier to do while under the influence of that favourite little pill of mine.

In my efforts to become comatose, I frequently overdosed on the Ativan and other meds accidentally and wound up in the emergency room. When a psychiatrist—who I've now been seeing for about five years—recognized what I was doing, he took me off the Ativan cold turkey and replaced it with gabapentin. This is an anticonvulsant medication, but it helps with my anxiety and mood.

With the Ativan gone, I then began taking my sleeping pills during the day to try and achieve a comatose state with them. Once again my psychiatrist took my source of solace away from me.

A few years later I was put back on sleeping pills under the close watch of my psychiatrist—I had to check in weekly. Despite his supervision, though, some of my bad habits returned. I still craved Ativan and the wonderful stoned feeling that came with it, so I again attempted to get the same feeling from my sleeping pills. One day, I took one sleeping pill, then another and another and another. I thought it was no big deal. Boy, was I wrong! I woke up the next morning in the intensive care unit, not knowing why I was there. This was extremely frightening. Apparently I awoke during my sleeping pill stupor and consumed the contents of five other bottles of my psych meds. I was very lucky that my son found me unconscious and 911 was called.

Dying from an accidental overdose is a definite possibility. It truly hit home when I returned to my house and saw the disposable oxygen masks the paramedics had left on my bedroom floor.

Either way, damned—and yet . . .

So what can I say about meds after all these years? You're damned if you take them, and you're damned if you don't.

Today I still have my ups and downs, but I'm in a far healthier place. The psychiatrist is still juggling the amount of each individual chemical I ingest—I'm on six different meds right now. Without this concoction, my personality and nerves unravel rather quickly. I start to lose control of my emotions and dissociate. I also start cutting to numb my emotions.

There will always be some side effects. My body's latest run-in with Epival (also an anticonvulsant) landed me in the emergency ward with acute gastrointestinal distress. Two days later, I was given yet another pill to help ease the trouble caused by the Epival.

Up here in northern BC, we have trouble seeing a psychiatrist on a regular basis and this can make the medication madness even messier. I didn't see a psychiatrist at all for a number of years. There is no psychiatrist based in my town; the town relies on monthly visits. And there are too many people in the mix who aren't communicating. If it's left up to the patient, they won't tell one doctor if they're getting meds from another doctor.

It is easy to become addicted to drugs that seem to help you climb the mountainous terrain of healing by making it easier to forget. But be careful, because there is a dangerous, slippery slope.

I'm grateful to my GP, counsellor and psychiatrist. I've had this team, talking to each other and working with me for the past five years. It's important to always make notes of your side effects and any other drug-related issues to share with your physician, psychiatrist and therapist. When you work together as a team, it makes drug treatment more user friendly, which makes everyone happier—and you healthier. i

footnote

visit **heretohelp.bc.ca/publications/visions** for V.J.'s complete footnotes or contact us by phone, fax or email (see page 3)

"The balancing act of getting the most benefit and the least side effects from my medication has been difficult and can be very frustrating"

Medications

Helping me enjoy the world go by

Howard Dempster

Howard was born in Vancouver. He has three children, works in construction and is in a relationship he really hopes will work

I've been in the mental health care circle for almost 15 years, trying to get to the bottom of what is going on with me. Five years before that, I was a full-blown drunk and cocaine user.

I took care of my ills, when it came to feeling sadness and emotional pain, by getting loaded—I'd had periods of unexplainable ups and downs since I was a kid. At the time, this worked for me. I did quit drinking for a while to save a relationship, but that didn't do the trick; she still sent me packing. So I started drinking again. And because I worked in an industry where I was out of town a lot and drug use was part of the scene, I got drunk and stoned more and more.

Then, on one day, I got two impaired charges. I thought I'd be going to jail for sure. As the time grew closer to my court date, I became increasingly concerned that I would die in jail with no booze or drugs—so I checked myself into Pender Street detox for 21 days. And I went to court, and my lawyer got me off with no jail.

I never went back to drinking because, after that close call with jail, I got sober for me. I was pretty grateful for evading jail. And I kind of knew there had to be something better for me, though I didn't know what.

After I quit drinking, though, I was left with this tremendous anger, depression, a feeling of not belonging and the most incredible feeling of loneliness. So I started on my journey to find out what was going on with me.

I sought out counsellors, psychologists and a psychiatrist. They all basically said it was the way I lived my life. My life was a mess. I didn't eat properly, didn't wash, didn't clean my place on a regular basis, and was in a relationship I shouldn't have been in because the lady was still actively using.

I had to agree with some of what they said, because I really didn't know how to live my life sober. But I also had this sense of not belonging, of being all alone. And I had this feeling of doom and gloom—what will happen next?—and that cloud that shrouds it all.

The psychiatrist said it was depression and prescribed numerous varieties of prescription drugs.

As hard as I tried to convince myself that these drugs were working, nothing had really improved. So I parted company with the psychiatrist, and took time off from seeking help. But as the days went by, I was getting worse. Talking to my sister one day, I said I'd had enough of this life and all it had to offer. She got quite worried about my well-being and phoned Tri-Cities Mental Health. I didn't know she'd done this, so was surprised when they phoned me, but I took the appointment.

And I started on yet another journey, hoping it would go somewhere different and not to the same old place.

When I got there, the first thing they said was that I was depressed. And, once again I was given the same meds that didn't work for me the last time. I almost went my own way yet again, but, like a good boy, I took my meds and went for the ride. I really believed this was my last stop to get help, and I was determined that someone would hear me.

I'm not sure how long I'd been going to Tri-Cities when it came time to have my 15 minutes with the psychiatrist. I guess my behaviour wasn't up to her standards, because she asked me to check myself into Royal Columbian Hospital psychiatric unit for a stay. Well, whatever it was that I did to end up there, I sure as hell won't do it again!

Going there was a hard road to travel. But it was a road nevertheless, and the beginning of a new life. Before my stay was over, I was diagnosed with full spectrum bipolar disorder, and my meds were changed again, to lithium, Zyprexa and lamotrigine. I have been on this round of drugs for two years now, and let me tell you, with these pills, I have a chance of getting my life in order.

I thought that once I started this journey to recovery the cloud over my head—the one I'd been trying to get rid of by drinking and doing drugs—would finally go away. Well, I've been clean and sober for 20 years, and after 20 years this cloud is still over my head.

My counsellors say I've been making strides, though. Without my meds I don't think I would be in the position that I'm in today. I wouldn't be in a

position to even learn how to live, or to try to be in a relationship. I wouldn't have a chance to function like a human being. Now, I can take my lady out for dinner and really enjoy the dinner with her. I'm able to go out and watch the world go by, and enjoy it.

Today I also speak to groups about mental illness and addiction. I may not always make the best lifestyle choices, but I get to make my choices now instead of my illness making them for me.

I don't want to be on this stuff for the rest of my life, but I think I will be because when I miss them I know there is something wrong. My whole sense of well-being changes.

I think that anybody who is taking prescription drugs for their mental health should have a counsellor to help them on their road to recovery. In most cases, we are pretty screwed up prior to being diagnosed with our mental health problems. I know that when I started taking my meds, I didn't have much of a clue how to live. If it weren't for my counsellors, I wouldn't have bothered taking any meds.

Now we have these wonderful drugs—but what do we do with them? Nothing—because we don't know how to live! Counsellors can help us work through this.

So, what is the point of taking our meds? Well, without them our minds wouldn't be able to figure out how to live.

I really don't know where I am today, but I do know one thing: it's better than where I was. Now I'm trying to live life on life's terms, not my own. I'm trying to make me proud of me.

So, to sum it up, take your meds and keep taking them and don't be afraid to tell your care worker if you think the meds aren't working. And keep going to counselling.

Tardive Dyskinesia—A Side Effect of Stigma

Susan Katz

Susan was first diagnosed with a mental illness in 1985. She resides in Vancouver

I have tardive dyskinesia (TD), a brain disorder that causes its victims to have uncontrollable muscle movements or tics. My movements are mostly in my throat and head area. My symptoms increase and decrease in an odd cycle every couple of weeks and include difficulty breathing and swallowing. I have to constantly sip liquids, suck on lozenges and clear my throat by softly grunting. I have learned not to raise my voice or sing for more than a short time because I will become hoarse or develop a throat infection.

The tics cause me to grimace, raise my eyebrows and lick my lips, which can create confusing or inappropriate facial expressions when I'm talking with people. My tongue takes on a life of its own, and uncontrollably explores hiding places between my teeth after I eat, which has drawn stares in restaurants. Because of all these movements, the inside of my mouth and the surface of my tongue are usually scraped, blistered and sore. At times I feel very self-conscious about my appearance.

Tardive dyskinesia is a potential side effect of the antipsychotic medication I was on for almost 15 years, and it is usually permanent. The TD didn't appear until after I had stopped taking this medicine. That's when I was told that while you're taking antipsychotic drugs, they commonly hide the symptoms of TD.

I first started taking the medication because I was experiencing some of the social problems caused by stigma and discrimination toward people with mental illness. For example, after mentioning to a neighbour over coffee that I suffered from post-partum depression, she stopped her daughters from playing with my daughter and stopped our regular coffee dates.

This type of emotionally painful rejection made me fear behaving in ways that might be socially unacceptable. My fear of rejection was greater than any concerns about possible physical damage the side effects of a medicine

might have. The stigma attached to people with mental illness is real.

Grasping at straws

I am a very high-functioning, middle class woman with a daughter, and my husband is a working professional. But I had too many emotional pressures. I had become weepy, confused and depressed shortly after the birth of my daughter. I was also so physically tired that I couldn't meet the high expectations that I and others close to me had for me to take care of my daughter, run the household, be socially active, and employed. This made me extremely anxious and fearful that I was ruining my life and the lives of the ones I loved most.

Fuelled by the fear of rejection for being 'mentally ill, I began to have disabling anxiety and nightmares. I also suffered confusion and memory lapses due to my depression, which was embarrassing and interfered with my work and social relationships. This lowered my self-esteem even more and increased my depression and anxiety until it became intolerable.

I struggled to find the right psychiatric care, but the supportive and skills-based therapies I was offered weren't designed to address the reasons underlying my feelings of inadequacy. So I finally came to believe what I was being told by my doctors: that medication was my only hope. I believed what I was advised, that by numbing myself from my worries with medications, no one would know I was 'mentally ill' and I could fight my increasing need for social isolation.

My acceptance of medications as "the only hope" for relief led to taking an increasing number of medications. For five years I took various antidepressants. Unfortunately, these medicines numbed all my emotions, not just the depression, and their side effects increased my tiredness and ability to think clearly. My anxiety grew to be intolerable. As a "short-term" solution, I was prescribed a tiny amount of thioridazine (an antipsychotic and sedative medication), which was replaced by trifluoperazine (an antipsychotic and antianxiety medication) to control nightmares, anxiety and my increasing anger and frustration. I continued taking the 'short term' trifluoperazine for 15 years.

Eventually, I developed unusual finger-tapping movements and head bobbing. I was told that, because my dose of antipsychotic medication was low, I didn't have tardive dyskinesia, but rather, some "Parkinsonism." I was prescribed benztropine (an antiparkinsonian medication) to control the movements—and continued to take my other meds as directed.

My very numb and limited existence only added to my depression and sense of low self-worth, and I finally reached a personal crisis because of this constant effort to hide my mental illness. I lost hope and attempted suicide.

'Coming out' has been the best medicine

Friends and family rallied to support me after my suicide attempt. With their love and support, and a new team of more enlightened care providers, I've come to realize that I am the one in charge of my life and how I behave. This has led me to a sense of self-empowerment and a reconnection with humanity.

I now use a range of therapeutic options for self-improvement, including peer friendships, group therapy, a personal psychologist, and correcting chronic physical conditions, such as low thyroid and reproductive hormone levels.

With my new sense of self-worth and self-esteem, I no longer take psychiatric medications. Getting off the drugs has had many interesting results. I no longer have memory or concentration problems, and I can feel a full and normal range of emotions. Of course, after 20 years of feeling numb, there has been a biblical flood of feelings to cope with!

A very important change is that I now have relationships with my care professionals that are based on working together to find the best treatments, and I do a lot of the work to find what options to choose from, rather than just letting them make decisions for me.

Most importantly, however, I no longer stigmatize myself, or fear being stigmatized by others. I've thrown off the yoke of stigma's straw man and have 'come out' about my illness. I've learned to tell people that having a mental illness isn't any different from other obstacles life throws in people's way from time to time.

Now I have the challenge of living with tardive dyskinesia—a new set of behaviours that stigmatize me as a person with mental illness. Because I have reclaimed my former sense of self-esteem, though, I can openly share what the disfiguring facial movements are. I use the questions I get about TD as an opportunity to tell others what mental illness really is—and to share with them who I really am.

For me, my TD is a visible symptom of the harmful power stigma can hold in our lives if we let it, whether the stigma comes from society, our professionals or ourselves.

> My fear of **rejection** was greater than any concerns about possible physical damage the side effects of a medicine might have.
>
> The **stigma** attached to people with mental illness is **real**

related resource

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Medications and Youth on the Street

Don McGinnis

Don is a psychiatric nurse who has worked in the addictions and mental health field for over 20 years. He has recently worked as the Clinical Nurse for the Matrix Program, a mobile home detox program for youth ages 16 to 24 in the Maple Ridge-Pitt Meadows area

** fictionalized characters that represent common trends*

John* and Angela*

John is 17 years old. He's spent the last two years couch surfing or living on the street or in a youth shelter. His parents are divorced; he's angry with his dad; and his mother is at her wit's end.

John has mixed feelings about stopping his use of meth. When he's on a run (i.e., a binge), he doesn't want to stop. He wants to prolong the feelings of euphoria and (false) mastery and the sense of drama and adventure, and to avoid the negative effects of stopping (e.g., exhaustion, remorse, depression, anxiety, irritability, paranoia, psychosis). But at the end of a run—when he hasn't slept for four days, his anxiety level is high and he feels depressed and suicidal—John drops into a clinic and tells them how he's feeling. This has become part of the cycle for John, and for many other youth on the street.

Angela knows which doctors will give her what she wants and which doctors won't. All of her medication comes from one clinic. She is on two different antidepressants, one antipsychotic and another medication that she says is for her nervous stomach.

Angela will go back to the same doctor at the same walk-in clinic and will report no improvement in her symptoms. She may not be telling the doctor that she is coming down from a run, that she has been trying to stop using speed for months and is stuck.

Over the past year, John has seen several doctors. He has a family doctor, but he also visits the walk-in clinics when the family office is closed. I encounter him on the street and ask him to show me what medications he's on. He shows me a bag full of prescription drugs, including trazodone, gabapentin, Seroquel and Ativan. He can't remember what each one is for; he just remembers that he's "supposed to be taking them."

Angela's prescription use depends on her circumstances. When she is off the street and in a youth bed, her medications are administered and regular. When back on the street and bingeing, she won't remember to take her medication. Abruptly stopping her antidepressants can worsen her depression and increase her suicide risk. She sometimes exchanges sexual favours for 'free' drugs, including street-market prescriptions drugs.

John is telling the truth when he lets a doctor know that he's depressed and anxious. He may or may not tell a doctor that he's using meth. If he's feeling remorseful and depressed about his use, he may admit to using; if he wants to continue his use, he may hide the truth. But, the longer he uses meth, the worse his panic attacks get, the more depressed he becomes, and the more prone he is to psychosis.

John may have the best intentions to stop using meth and to use his medications as prescribed, but he'll probably sell them, share them, or take them now and again, when he remembers, or when he is feeling badly.

Shopping for a safer landing

When most people hear the term "doctor shopping," they think of people who go from clinic to clinic trying to get prescriptions for medications they are addicted to. A trend we're seeing more of, however, is youth who doctor shop to get medications to help them come down from a high. They do this to relieve the bad side effects of speed and cocaine, and to make the down easier. They may also be coping with some of the obsessive-compulsive disorder associated with their use of speed, or with hallucinations after a run. Benzodiazepines, alcohol and opiates can offer some relief.

footnotes

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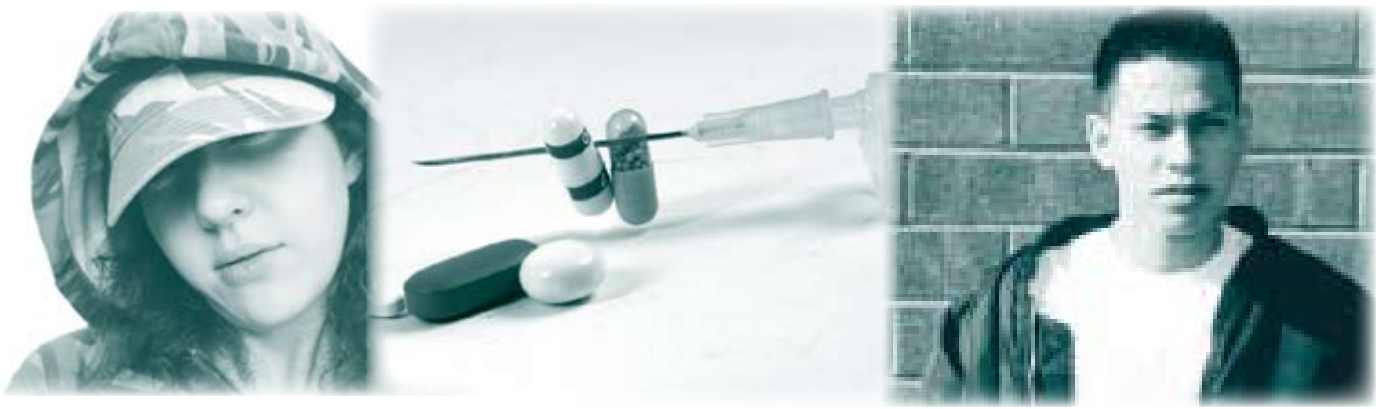

Mental health problems are common

Depression, anxiety, obsessive-compulsive disorders, attention deficit disorders, psychotic disorders and learning disorders are common to youth on the street. Some of these problems existed before drug use and street life; some of them were caused by drug use. Most all conditions are worsened by drug use.

Young people may be using street drugs to get relief from their symptoms, and they may also receive prescriptions for these symptoms. Using street drugs and prescription medications together wreaks havoc on their nervous systems. Indiscriminate and unmonitored use of antidepressants increases their risk of suicide.[1-2]

Youth may leave clinics with a month's supply of powerful antipsychotic medication, antidepressants or antianxiety medications.In my experience, there is often very little follow-up—even when youth let a doctor know about their drug use. Most youth don't have a regular family physician, and they attend walk-in clinics on an irregular basis. They generally don't trust the medical profession and tend not to come to follow-up appointments. They see doctors on a crisis basis.

Youth recovery

The pattern of recovery for youth is different from that of adults. Youth are in and out, loving the drama of the lifestyle and hating the valleys of depression, anxiety and 'crazies.'

Youth will tell adults and authorities that they want to, or are ready to, quit, when in fact they aren't. They may be ready, however, to begin to face their problems and to talk about what is important to them—their lost identity, feeling cared about and valued, value of their life, forming and maintaining positive relationships. This talk may ultimately help them make a decision to change their life.

When youth do stop using, they go through a post-acute withdrawal phase, with symptoms including strong cravings, absence of pleasure, depression, insomnia and psychoses. This can last up to a year, while the nervous system stabilizes. Medication can help youth cope with these symptoms.

Our goal with Angela and John is to help them get medical help and to be honest with their doctors about where they are in the recovery cycle.[3] We know that uncertainty and relapse are the norm. We can create an environment where youth are comfortable talking about their drug use. We can offer the right medications and ultimately support them during recovery.

To Take or Not to Take?
The problem of compliance

Fiona McGregor

Fiona is a psychiatrist in Vernon and Salmon Arm. She trained in psychiatry in Glasgow, Scotland, and her interest is in mental health service delivery. Fiona is vice-chair of the BC Alliance on Mental Health and Addiction Services, which advocates for better mental health services

A Google search on "patient compliance" generates 5.5 million returns in 0.13 seconds. This speaks to the enormous concern of doctors, health care workers and patients about following treatment programs. From taking medications, to following through on recommended exercise programs, to doing homework for a psychotherapy program—compliance is a hot-button issue.

A commonly used definition of compliance is "the extent to which the patient's behaviour (in terms of taking medications, following diets, or executing other lifestyle changes) coincides with medical recommendations."[1] Or, in simpler terms: patients doing what health professionals want them to do. These definitions seem somewhat paternalistic, and the term *patient adherence* is being used more often nowadays, given that "non-compliance" is often understood to mean irrational or wilful behaviour.

Compliance, or adherence, to treatment is an issue in all forms of medical treatment, not just in the mental health field. Research articles have focused on the difficulty of getting patients to adhere to treatment, whether for diabetes, heart disease or many other ailments. In this article, I focus on medication non-compliance.

The extent of the problem

Reports of medication non-compliance have varied from 80% to 20% in the scientific literature.[2] The real-life problem of medication non-adherence for people with mental illness is enormous: non-adherence to treatment is the major cause of relapse in illness. Even relatively short gaps of medication treatment in patients with schizophrenia are linked to an increase in hospitalization.[3]

So how do we know if someone is not taking their medications? Research has uncovered a very interesting fact: doctors do not know when their patients are not adhering to medication programs. In one study, 95% of doctors thought their patients were treatment adherent, when in fact slightly less than 40% followed through precisely. More interestingly, in that same study, 67% of the patients thought they were adhering to treatment when in fact computer chips on their medication bottle showed that this was not the case.[4-5]

Other studies have shown that self-reported non-compliance (i.e., people admitting to not taking medication) is accurate, but self-reported adherence (i.e., people saying they are taking medication as prescribed) is not accurate.[6-7] This shows that medication adherence is not just about patients arguing with their doctor about

> "if medication treatment is effective and stops illness, why is there such a problem with taking it?"

the need to take treatment; it is a much more complex problem. Sometimes the consumer is not aware of what is going on.

Why does this happen?

If treatment is effective and stops illness, why is there such a problem with taking it?

Common reasons include:

- Not understanding *how* the medication should be taken—"I didn't realize I had to take it all the time"
- Not understanding *why* the medication should be taken—"I thought it was only for when I had hallucinations"
- Misunderstandings—"I don't want to become addicted to the medication"
- Side effects—can be real or perceived (sometimes symptoms of the illness or a reason for the illness can be mistaken for a side effect)
- Not seeing the treatment as helpful or necessary
- Stigma—not wanting others to know that medication is being taken for a mental illness, and/or facing stigma from friends and relatives who have negative opinions about the illness and treatment
- Financial—are the medications affordable?
- Inconvenience—having to take this medication with food/without food/ two hours after food/ four times a day/etc.

What can be done?

Research has been directed toward dozens of ideas, from simplifying medication routines, to telephone reminders, mail-in reminders, education groups, special packaging for medications and so on. The results are contradictory and show that there is no one reliable method. Not surprisingly, the best results come from the most personalized, intensive approaches.[2,8]

Contributing factors from the illness

In my experience, one of the common reasons for not wanting to take medications anymore is that the patient sees an improvement in their illness. The patient thinks that because they are feeling better they no longer need the treatment. For example, in a study of people being treated for post-traumatic stress disorder, patients who took antidepressants for less than a year had a much greater chance of relapse, even if they no longer had symptoms.[9]

With many mental illnesses, memory becomes a problem. Concentration and motivation may also be impaired. When this happens, simplifying the medication routine is essential. Once-daily medications, blister packing or dosettes† are possible solutions. Reminders from family members or mental health professionals are also helpful.

If there is psychotic illness, it can add other factors as well. For example, if there are remaining positive† symptoms like delusions or hallucinations or thought confusion, sticking to a treatment schedule can be challenging.

Another factor is lack of insight or self-awareness that one has a mental illness. This may be due to a variety of factors: symptoms of the illness that affect thinking and judgment, denial or differing beliefs about the cause of the illness or the reasons for improvement.

Contributing factors from the medication

The nature of medications can also make it difficult to keep taking them. Side effects are often cited as a reason for stopping treatment. Some side effects only become apparent over time. Other side effects are present early on and dissipate with time. Because we live in such a "quick fix" society, many people become frustrated when they experience side effects before the benefits of the medication take effect. And in some cases, other medications need to be added to control side effects that linger.

The way medications are prescribed can be important. Fewer doses during the day or depot injections† may be helpful. The most important factor, however, is that the patient is involved in deciding how medications will be taken, and that they understand how to take them properly.

Encouraging adherence

It is imperative that patients understand why medication is required, how long medication is required, and what the benefits and side effects are.

People vary in what they want to know about their medications. For some, knowledge about potential side effects is not at all helpful (and may be overwhelming), while others feel prepared when informed. Besides differing amounts of information being appropriate for different people, differing amounts of information may be appropriate at different stages of the illness. A good relationship with a health professional who can explain or reassure is crucial.

Patients should know what resources are available to them. They should also know who is an appropriate support. Are family members helpful, or are they perceived as nags? Patients should try new strategies, such as setting a timer as a reminder. Cell phones and wrist watches can be invaluable aids.

Patients should know what to do if any problems arise. Do they know what to do if they begin to experience side effects? Do they know what to do if they miss a dose of their medication?

Not complying with medication can lead to relapse of symptoms, a reduction in quality of life and increased suffering. Armed with knowledge and ideas, the road to recovery can be much smoother and quality of life greatly improved.

footnotes

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A Pill for Every Ill—Or an Ill for Every Pill?

Barbara Mintzes

Barbara is an Assistant Professor in Anesthesiology, Pharmacology & Therapeutics at UBC. She has researched the effects of direct-to-consumer advertising on prescribing and, with the Therapeutics Initiative, systematically reviews drug effectiveness and safety. She works with women's health and consumer groups, including Women and Health Protection and DES (diethylstilbestrol) Action Canada

Jason* first went on antidepressants at age 18 when his girlfriend left him. It was his idea: he felt bad and wanted help. His parents agreed. They were concerned, because after the breakup he had sometimes been coming home drunk. Jason's doctor asked if he'd felt bad for over two weeks. He had, so the doctor prescribed the antidepressant.

The story is so familiar that it's unremarkable. We all know someone who is unemployed, divorced, stressed out or lonely who ends up on antidepressants. Sadness from a relationship breakup or a job layoff is an understandable human reaction. But is it really a medical problem?

Should we use medicines for normal life problems?

There are three main concerns about taking a medicine for a normal life event. First, the medicine is being prescribed for an untested use, for which it may not work. The same medicine that treats symptoms of major clinical depression may not provide relief for normal sadness after an upsetting event. This is an untested off-label† use—or unapproved use—of a medicine.

Second, any decision to take a medicine is a balancing act, because all medicines have side effects. The likelihood of benefit needs to be weighed against the likelihood of harm. With conditions like AIDS or a heart attack, the decision is easy. Even severe side effects may be worth risking, if the untreated disease is life threatening or is much worse than the side effects—which can also be the case with mental illnesses. However, if you don't have a health problem in the first place, a medicine won't help, and no side effect, no matter how mild, is worth risking.

Third, treating a life problem as a medical problem can distract from real solutions. Jason wanted help. He was offered a medicine as a gesture of help. But perhaps he needed help in learning to feel better about himself and finding his way in life. A person—not a medicine—can provide this kind of help.

A strong advertising message: Ignore the context for your problem

Advertisements for prescription medications are illegal in Canada, but we are still exposed to them because of the number of American television programs and magazines we see every day.

Advertising medicines blurs the boundaries between normal life and medical problems. The late American journalist Lynn Payer coined the term "disease-mongering" to describe attempts to "convince essentially well people that they are sick, or [to convince] slightly sick people that they are very ill" in order to sell treatments.[1]

Ads for antidepressants don't just sell drugs. They also sell the idea that depression "may be related to the imbalance of natural chemicals between nerve cells in the brain," and that the drug "works to correct this imbalance."[2] These biological explanations remove the social or personal context, even for mild problems or for distress that is clearly related to an event.

Researchers Jeffrey Lacasse and Jonathan Leo recently reviewed the evidence on the link between depression and brain chemistry. They found no scientific articles to support this theory; in fact, they state even more broadly: "There is not a single peer-reviewed article that can be accurately cited to directly support claims of serotonin deficiency in any mental disorder…"[3] When the United States Food and Drug Administration (FDA) allows companies to say in ads that depression "may be related" to a chemical imbalance, "may" is the key word. However, these ads—often accompanied with scientific-looking diagrams of chemicals and receptors—can be made to look misleadingly scientific.

Antidepressants do affect brain chemistry, but that doesn't mean depression is *caused* by an imbalance of brain chemicals. A beer or a glass of wine can help shy people loosen up, but nobody claims that shyness is caused by alcohol deficiency. Effects on brain chemistry are thought to be the reason that antidepressants can improve mood and symptoms of depression. Published studies of patients with depression in primary care (family doctors' offices) have found that around six out of every 10 patients who took an antidepressant felt considerably better, as compared to four out of 10 patients on a placebo (or 'sugar pill').[4]

> "Advertising medicines blurs the boundaries between normal life and medical problems"

* *pseudonym*

"Millions of sufferers . . ."

Promotional messages aiming to sell drugs often exaggerate how common or serious a condition is. This is not limited to mental health. Dartmouth University researchers Steve Woloshin and Lisa Schwartz tracked US news reports over a two-year period when the first drug for restless legs syndrome was being launched. Restless legs is defined as an unpleasant urge to move the legs that gets worse at rest. Symptoms are usually mild, but a few people are more strongly affected, most often experiencing difficulties sleeping.

Two thirds of news stories included exaggerated reports of how many people are affected, with statements such as '12 million Americans' or '1 in 10' are affected. These estimates were based on a single flawed study, which used a positive answer on a single question to classify people as having restless legs syndrome, rather than the usual use approach to diagnosis, which involves at least four symptoms. Most news stories also described the experiences of an extreme sufferer. They didn't explain that most people are much less troubled. The drug was often presented as a 'miracle cure,' although only one in eight users do better on the drug than on a placebo.[5]

footnotes

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Promotion—not science—is the name of the game

When public relations companies get a new drug into the news, readers don't always realize this is not neutral reporting, but part of a promotional campaign. The problem is that these ads have been shown to affect prescribing. And unnecessary use of a medicine can lead to serious harm.

The same companies that advertise Coca Cola or Budweiser are creating these ads. The image of the happy, treated patient—like the glowing housewife in 1960's "whiter than white" detergent ads—has little to do with what the product is like, and everything to do with making it look like something you need.

Anxiety sells. Although prescription drug advertising is illegal in Canada, drug companies are allowed to run ads that don't mention product names. We had ads for a cholesterol-lowering drug that didn't mention its name, but featured a tagged toe of a corpse. The message was that without testing and treatment, you can die of a heart attack at any time. That's not true for most people. The same is true of ads saying that your mild sore throat may be the sign of a more serious condition.

Ads like this should make you pause and remember who's telling you this and why. The best cure may be a little healthy skepticism. i

Medication in the Press

Evaluating media coverage of psychiatric and addiction drugs

Donna Panitow

Donna is completing her undergraduate degree in Communication at Simon Fraser University. She is currently on a co-op term at Canadian Mental Health Association, BC Division

Today we're turning to a broader range of media sources than ever before for information. About 67% of Canadians tune into television news, and 42% read a newspaper on a daily basis.[1]

Studies on new medical treatments and medications, headlines announcing breakthrough discoveries, medical horror stories, and everything in between are regularly featured in the news. Because we so often turn to mass media first for news, there is huge potential for it to influence our attitudes and behaviours about health and medicine.[2]

Because health news is commonly covered in the mass media, it is important to be media literate—to ask why and how medical stories are covered. When we are able to separate facts from hype in the news, we can be more informed consumers.

It's also important to keep in mind that, whether we see it on television or read it in the newspaper, news coverage rarely reports on a medical issue in a balanced way. A study published in 2003 found that Canadian newspapers generally stress either the risks or the benefits of a medication instead of discussing both.[2] This creates a black-and-white view, which appears much simpler and more one-sided than it should be. Important points—such as other medications and therapies used to treat the same condition, or consumer characteristics such as age, sex and health—are often left out.[3]

> "often, in the media, the **negative** effects of medications are made to sound *far more common than they actually are*"

There are many reasons for this unbalanced perspective. Space in the news—either on the printed page, or in time for television—is limited. Journalists often don't have enough time to research a topic completely. There is also pressure to "sell" news by presenting sensational stories.

In addition, most media outlets are co-owned by the same parent corporation, which means that corporate owners' agendas and perspectives can often greatly influence the slant in which stories are presented. And the same news story is often seen and heard via many media outlets because these outlets have purchased the story from a news service. Such a wide distribution of the same content gives the story an impression of widespread authority.

The bad news

Because psychiatric medications are the second most dispensed of all medications,[4] and because there can still be debate surrounding their use,[5] stories on psychiatric medications often make their way into the news. And often, in media, the negative effects of medications are made to sound far more common than they actually are.

In June 2004, a series of stories by journalist Sharon Kirkey ran in eight major Canadian newspapers, all owned by CanWest MediaWorks Inc. The stories ran under alarming headlines such as Are Antidepressants Endangering Our Children?[6] and A Six-year-old Filled with Rage.[7] These articles reported, in a very grim way, on prescribing SSRIs to children with depression and anxiety disorders. They focused on reports of increased suicidal thinking, as well as on rare cases of extremely aggressive behaviour allegedly brought on by the medication.

Reports such as Kirkey's can encourage negative social attitudes towards psychiatric medications and those who use them. For example, parents may be less willing to consider psychiatric medications for their kids after reading a story like Kirkey's, or youth already on medication may not want to continue taking their medication or may feel ashamed for taking it.

Studies have shown that the public is not as accepting of medication used for mental disorders as it is of medication used for physical disorders, even though evidence proves that both are equally effective in treating illness.[5,8] This applies to medications for addiction as well; for example,

studies have proven that methadone maintenance is an effective way of treating heroine dependency.[9] Yet, through unbalanced reports in the media, we tend to hear more about the few people with complex problems who abuse methadone.

In February 2003, a story titled Methadone, Once the Way Out, Suddenly Grows As a Killer Drug, written by Pam Belluck, ran in the *New York Times*. The article cited a large jump throughout the United States, seemingly overnight, in the number of methadone overdoses leading to death. Articles like this lead to social stigma toward methadone users by creating the impression that they are violent or have nothing to contribute to society because they are completely fixated on their addiction. This also sparks debates about the safety of the drug.[9]

The good news

There are also some upsides to medical reporting in the media. Press reports warning the public about the negative effects of certain medications have the power to push consumers toward safer and more appropriate medication options. They can also effectively reach a broad public to advise about drug recalls.

Accurate reporting can also be useful in linking the mass readership with information about research evidence and practice. Without resorting to sensationalism to grab readers' attention, the popular media can simplify complex scientific research into terms we can all understand.

The wisdom to know the difference

So what is a consumer to do? Arm yourself with information. Here are some steps to help you get a balanced view of medications in the news:

- Get a second opinion from reputable, up-to-date health information sources online such as Health Canada's website (www.hc-sc.gc.ca).
- Determine whether the news report mentions who raised the story in the first place. A journal press release, a research firm or an advocacy group can all slant the issue in different ways to reflect their respective interests.
- Evaluate the balance and scope of the topic presented. Are all sides of the debate covered, or is something left out?
- Be wary of article length. A really short story will simplify information, while a longer report may present a more balanced view on a study. Keep in mind, however, that a long investigative piece may also try to sway you toward its own opinion.
- Try to find several pieces from different sources and different media outlets/companies.
- Watch for channels and publications that are co-owned and may be sharing the same story. The Canadian Newspaper Association provides a comprehensive list of the nation's newspaper ownership (www.cna-acj.ca; go to the blue menu, click on "Ultimate Guide" and then click on "Ownership" in the drop-down menu choices).
- Consider the questions a story addresses. Is anything important not brought up?
- Check out Media Awareness Network (www.media-awareness.ca) or other media literacy sites that offer resources and tips on good questions to ask about any media story.

Most importantly, if you see something in the media that worries you about a medicine you are taking, do not stop taking it without consulting your doctor. Your pharmacist is also a good source for new medication information and drug warnings. But always discuss your concerns with your doctor, who can help you make informed medication choices.

www.mediadoctor.ca

is an online project that attempts to improve media coverage of medications. It originated in Australia and has spread to several countries, including Canada. On the website, medical stories found in major newspapers are reviewed and rated on their reliability, using a five-stars rating system. The ratings are based on an in-depth list of criteria, depending on story type, such as harm stories, health scare reports and stories about access. These criteria provide excellent guidelines for news readers to assess stories, offering a variety of relevant questions to ask about a particular report on medications.

footnotes

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Using Mental Health Medications in Children and Youth

Some thoughts . . .

Lorne Brandt

Lorne is a psychiatrist, recently transplanted from the Prairies, who works with children and adolescents in Richmond

The use of medication for mental health problems in children and youth has skyrocketed in the last 15 years. This is an issue that alarms many people, and not without reason.

Not enough research

There is a significant lack of research on the use of drugs in children and adolescents. One reason for this is the issue of consent. You can't get informed consent from a child, and not many parents want to subject their children to research. Another reason is that children are not the best reporters of what is happening to them.

Furthermore, the research that has been done on medications used on young people is often quite vague about the benefits of these medications. The lack of a stable pattern of problems over time—since children are constantly changing—makes it hard to describe and evaluate what is happening.

Because there is little research with decisive results supporting the effectiveness of psychiatric medication in this population, there is little government approval for the use of these drugs for children and adolescents. This results in a lot of non-approved or 'off-label'† prescribing. Most applications of these drugs to this young age group are based on the a drug's effectiveness in adults, with dosage adjustments made for use in children and youth.

Not "little adults"

Children's bodies are different than adult bodies; children are not little adults. Their smaller size causes us to think that they just need a smaller dose, when, in fact, a larger dose may be needed.

In newborns and infants a smaller dose is often needed because their immature liver and kidneys process drugs more slowly. Also, the so-called blood-brain barrier is more permeable, so a greater proportion of the drug circulating in the blood enters the brain of a younger person.

After six months of age, on the other hand, a child's metabolic rate increases and the organ–total body ratios for liver and kidneys is larger. In other words, these organs are larger relative to the child's body size than an adult's corresponding organs are relative to the adult body size. This can mean larger doses are necessary for young people, because drugs can be cleared out of their systems much more quickly.

The "quick fix"

There is a lot of pressure from society to medicate. Psychosocial problems can be treated with individual and family therapy and changes in the child's environment (e.g., home and/or school). Our society, however, wants an instant fix—the 'pill for every ill,' 'mother's little helper' thinking.

There are several reasons for the allure of medication. Sometimes its effects are felt sooner than the effects of behavioural methods. Also, because it's difficult for people to commit the effort and time needed for behavioural methods, these methods sometimes fail. In other cases, the symptoms, or disorder, seem too severe to try and treat with only non-pharmacologic means.

Drugs are also resorted to because there is often a lack of human resources for the first-line non-drug treatment that is recommended in guidelines and protocols. There just aren't enough professionals and care workers to deal with all the mental health problems in our modern world.

However, a number of factors should lead us to try behavioural changes first:

- the demands of making sure children are taking the medication properly
- issues of safety and security of drugs around children, both at home and in the community
- the high cost of the newer drugs
- the risk of potentially serious long-term side effects

Black box warning kickstarts new research

There has been a lot of publicity given recently to so-called black box† warnings. These are warnings about the risks associated with certain medications in certain uses, which are required by government approval agencies to appear on the packaging of pharmaceutical drugs. ▶

Antidepressants in Pregnancy and Lactation
Let's look at the facts

Wende Wood, BA, BSP, BCPP

Wende is a Board Certified Psychiatric Pharmacist currently working at the Centre for Addiction and Mental Health in Toronto, Ontario. She is co-editor of the booklet Is it Safe for My Baby?

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Generally speaking, I'm a big fan of irony, but not when it comes to important clinical issues. Despite all of the focus these days on evidence-based medicine, I'm continually shocked and disturbed by all the pronouncements that are made about the risk of antidepressants in pregnancy and lactation without, in my opinion, any appropriate evidence to back up those claims.[1,2] I've lost track of the number of times I've had to reassure women who've been admonished by family members or even their healthcare providers—including their psychiatrists and/or pharmacists—for continuing an antidepressant while they were pregnant or breastfeeding. Please tell me, exactly what evidence is this based on?

In 2001, Motherisk published a small study that mirrors my experience and frustration. When consulted by patients regarding the use of medication in pregnancy, more than 90 per cent of pharmacists referred patients to their physicians, 60 per cent consulted the product monograph,† and only 14 per cent referred to current medical literature.[3] Is this the best we can offer??

We need to remember that a monograph is a legal document reflecting agreed to facts between Health Canada and the pharmaceutical manufacturer, and is often a poor reflection of current literature and clinical practice. Fetal Risk Factor* assignments (A,B,C,D,X) decided upon by the U.S. Food and Drug Administration (FDA) and commonly cited by clinical textbooks are widely recognized as oversimplifications, and this system of rating safety is currently under review. Lastly, pharmacists can often interpret the medical literature for patients as well as—if not better than—physicians can. We can also give the woman some unbiased and up-to-date information to take with her to discuss with her physician.

So what do we know about the safety and risks of antidepressants

Medications in Children and Youth | *continued from previous page*

The warnings that began to come out in Britain in 2003 and in the USA the following year about the use of antidepressants in children and adolescents are a case in point. According to the media, the warning was that suicidal thinking might increase with the use of these drugs.[1]

It had been known since antidepressants came into use 50 years ago that suicidal thinking can increase temporarily during the early phase of treatment. What was new was that this phenomenon was being reported for the first time with respect to antidepressant use in minors. The most disturbing part was that pharmaceutical firms bringing out the most recent drugs had this information from their studies, but had not reported it. Indeed, just as had been known to occur among adults before, suicidal thinking did increase in some youths on these drugs. Reassuringly, the overall suicide rate did not increase; however, this important detail was largely obscured by the media.

Some good did come out of this warning. Doctors, especially the psychiatrists, appear to have heeded new recommendations on advising patients of these risks. They have increased the frequency of initial follow-up visits, thus monitoring of their patients has increased.[2]

More research is being conducted on the use of psychiatric medications in children and adolescents. Parties concerned about the use of these drugs in children and adolescents, such as the Canadian Paediatric Society,[3] are urging government regulatory bodies to make changes. They would like to see investigators required to study the use of the drug in young people as well as in adults if their products are to be used in this younger age group. This should result in more appropriate, evidence-based and safer use of medications in our children and youth.

footnotes

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in pregnancy? There does not appear to be any teratogenic* risk in terms of major deformities. Yes, a small percentage (probably less than five per cent) of babies can be born with withdrawal symptoms. This is more likely when multiple medications are involved and, even in the most severe cases, the symptoms resolve within days with no known long-term sequelae.* And while it's true that we don't know what effect, if any, antidepressant use will have on long-term intellectual development in children, so far, no problems have been identified.

And what do we know about the risks of untreated depression? We know that some common consequences include increased risk of miscarriage, premature delivery, low birth weight and low Apgar* scores. Moreover, a mother who is depressed may not be able to properly interact with her baby, and we know that poor bonding and lack of infant stimulation can lead to intellectual and emotional problems both in infancy and in later life. Depression in the mother can also lead to malnutrition and substance use for self-medication, which clearly have consequences for both the woman and baby. In severe cases, untreated depression, including postpartum depression, can be devastating. Yet, despite media reports of tragic cases of untreated or undertreated postpartum depression, people still don't seem to comprehend the importance of this issue.

Of course, it is best if a woman can be treated with some form of psychotherapy or supportive counseling instead of an antidepressant, but this isn't always appropriate or possible. We need to look at the risk/benefit ratio and weigh a small chance of treatable withdrawal symptoms and a very theoretical concern of mild intellectual delay against very known, very real, possibly devastating effects of untreated or undertreated depression.

If a decision is made to try going without an antidepressant, one of the more useful approaches I have found is for the woman to make an informal contract with herself, in which she writes down a list of symptoms that she would consider severe enough to restart antidepressant treatment. Indecisiveness can be an important symptom in depression, and it can be next to impossible to decide whether or not to restart an antidepressant while having moderate to severe symptoms. If, at that time, she can read her own words written when her symptoms were mild, it can help the process.

Often the mother feels she is being made to decide between her health and that of her baby. She may think, or even be told, that she should just 'put up' with the depressive symptoms rather than expose her baby to psychotropic medications. This whole mindset is based on the completely false assumption that the mother can disassociate her health from that of the baby. It must be emphasized that the most important determinant of health for a baby is the health of the mother.

In the end, of course, each case must be evaluated on an individual basis, and all treatment options should be considered. Depression is a serious and multifaceted disorder, and treatment should usually involve more than one modality. The last thing I want to imply is that all women with depression during pregnancy or lactation should take an antidepressant. Rather, my sincere hope is that they can have access to all of the facts and treatment options without the stigma, shame and guilt many of them currently face.

mini-glossary

* *Fetal risk factor assignment*—a 5-category system used by the US Food and Drug Administration to assess the impact of certain drugs on a fetus

* *Teratogenic risk*—risk of birth defects

* *Sequelae*—a condition caused by another disease, injury or other trauma

* *Apgar score*—a method to assess the health of newborns right after birth. Lower overall scores mean poorer health of the infant

footnotes

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Medication Research in Psychiatry

New trends and discoveries

People often think that there are many different kinds of medications available to treat mental illnesses. But in reality, there are not very many truly "novel" psychotropic† medications. Many of the so called "new drugs" work much the same way as the older drugs. If you look at antidepressants for example, there are currently 23 antidepressants available in Canada. However, you can group all of these into just six categories based on how they work in the body. All the antidepressants within each category are really pretty similar in both how effective they are and the side effects they cause.

So, is there anything really "new" on the horizon?

Depression

There are some interesting drugs for depression in the development stage. One area is the discovery of brain-derived neurotropic factor (BDNF). We now know that the brain is capable of repairing nerve cell damage and can even generate new neurons (brain cells that send and process information). Scientists first discovered the creation of new neurons (called neurogenesis) in animal brains in the 1960s, but did not find evidence of it in humans until the late 1990s. BDNF is actively involved in repairing damaged cells and generating new ones.

It appears that one of the problems people with depression have is that they're less able to turn on BDNF

Sylvia Zerjav, PharmD, BCPP

Sylvia is a psychopharmacology consultant for the BC Mental Health Society and a Clinical Professor in Pharmaceutical Sciences at the University of British Columbia

related resource

for a look back at the history of mental health medications, see Debbie's online-only Visions article

than those who don't have depression.[1] People who suffer from depression are more likely to experience cognitive decline† (a decline in normal brain functions such as memory and thinking skills) as they get older than those who have never had depression.[2-4] This decline is the result of gradual brain cell loss over the years.

Stressful life events can cause the onset of episodes of major depression in those with a genetic predisposition and in children who experience early life stress.[5]

We also know that stress can cause the destruction of brain cells, which may lead to cognitive decline if BDNF does not effectively generate new brain cells.

So there is a lot of research focused on BDNF and into agents that may act similarly to BDNF. There is hope that these agents will prevent depression and some of the consequences that extended stress has on our brains.

Schizophrenia

Schizophrenia is an illness that can wreak havoc with an affected person's life because of the impairment associated with symptoms of the illness. Symptoms can include hearing voices inside one's head, having bizarre beliefs that aren't based on any facts, feeling paranoid, withdrawing socially, and being unable to concentrate and think clearly.

All of the currently available drugs used to treat schizophrenia (antipsychotics) reduce symptoms by reducing dopamine's effects on nerve impulse transmission in specific areas of the brain. There are many side effects from these drugs, including significant weight gain and movement problems, such as tremors.

Research is now being conducted on a brain amino acid called glutamate. Interest in glutamate began when a street drug, PCP, also called "angel dust," was found to cause symptoms similar to those in people with schizophrenia. By the 1980s, scientists discovered that PCP blocks the effects of glutamate on specific brain receptors. It was therefore logical to assume that stimulating glutamine receptors might improve schizophrenia.

There are many different glutamate receptors, and researchers are now focusing on those located in the prefrontal cortex, which is that part of the brain linked to learning and personality. Agents that are developed as a result of this research will really be the first truly novel antipsychotics, because they don't affect dopamine directly, as all current antipsychotics do.

Alzheimer's disease

One of the areas of greatest promise is in the treatment of Alzheimer's disease. Alzheimer's disease, an illness first described by German physician Alois Alzheimer almost a century ago, robs people of their memory and reason and results in progressive cognitive decline and a lingering death.

In Alzheimer's diseases, masses of protein form in the brain and these masses, known as senile plaques, destroy brain cells (neurons). Some researchers have found that these senile plaques are linked to two substances: cholesterol and a chemical called ganglioside GM-1, found in the brain cells the disease attacks.[6] Brain cell damage occurs when the proteins that make up these plaques attach to neurons. The plaque protein, called beta-amyloid, comes in different sizes, and they get larger as they age. Beta-amyloid's ability to bind to neurons seems to depend on the amount of cholesterol and ganglioside GM-1 in the cell. The binding doesn't occur if either one of the cholesterol or the ganglioside GM-1 is removed.

One of the drugs being studied, Caprospinol, has shown promise in removing beta-amyloid plaques and restoring memory in rats.[7] Other drugs being studied, ANAVEX 1-41 and ANAVEX 2-73, may have neuroprotective and memory-promoting effects on Alzheimer's disease.[8]

Other ideas include lowering cholesterol levels with anticholesterol drugs, such as lovastatin, because reducing cholesterol in brain cells should block the ability of beta-amyloid to bind the cells. Currently, it is not certain that lowering cholesterol levels will actually reduce the incidence of Alzheimer's disease, but research is ongoing and some scientists believe that Alzheimer's will become a disease of the past within the next 10 years. i

footnotes

visit **heretohelp.bc.ca/publications/visions** for Sylvia's complete footnotes or contact us by phone, fax or email (see page 3)

Working With Your Partner in Health

Patrick McGowan

Patrick is an Associate Professor with the University of Victoria's Centre on Aging. For 25 years he has focused on education for people with chronic health conditions. He has researched and implemented self-management programs for diabetes, arthritis, osteoarthritis, and tuberculosis, and has trained health care professionals in self-management support techniques

I can't speak for everyone, but I'm a lot happier when I feel I have an active role in my own health treatment and am not just a "helpless" patient. I have a lot of confidence in my doctor and the health professionals I deal with, but realize that I only get to see them once in a while. I'm the one who has to manage my health on a daily basis. Also—and this is the most important reason—I know that whether I do well or not depends on my own behaviours. For example, do I take my medications the way I am supposed to?

We are the ones who manage our health, but there are ways that health providers can work with us. These days, doctors attend "self-management" workshops to learn skills and techniques that promote our role as active participants. In fact, the new philosophy at the BC Ministry of Health is "patients as partners." It's great to have acknowledgement that we patients have knowledge and expertise in managing our own health!

How to be active in your health care

The following tips are useful for any kind of questions you may have for health professionals, but can be especially useful for inquiring about medications.

Be prepared

The next time you go for an appointment, let your doctor know that you want to be a partner in managing your health. Make sure you take a written list, in point form, of your concerns and questions. Don't just tell the doctor what is happening right now, but also include what's been happening during the last few weeks and what you've been doing to cope.

It's always good to give your doctor a copy of the written list, because sometimes things that may not be obvious to you may mean something else to the doctor, especially if the doctor sees the whole list.

There may not be enough time to deal with all your questions during a visit, but a follow-up appointment could be made. Tell the receptionist that you have quite a few things to discuss and that a longer appointment time may be necessary.

Ask questions

Always make sure you clearly ask the doctor what you want to know. Oftentimes, people don't get the information they are after, don't understand the information they get, or are simply overwhelmed by it. For example: clearly say, "Doctor, I want to know why I feel so badly after I take this medication, and isn't there a different type that doesn't make me feel so sick?"

After you get the information, always repeat it back in your own words. In this way, both of you can be sure you've understood what was said. Sometimes people ask a friend to come to the appointment with them.

Have a plan

Another really important way of being a partner with your doctor is to ask your doctor to participate in making an action plan with you. This is a simple but effective technique for getting started on making changes.

Start off by telling your doctor something you want to accomplish in the next three to six months or so. Next, make a small, doable, "bite-size" action plan of what you are going to do in the next week to start working towards this goal. For example: "I am really unhappy with my weight, and my six-month goal is to lose 20 pounds." Everyone knows that it's not easy to lose weight, especially when you consider lifestyle factors such as medication. An action plan could be as straightforward as: "During the next two weeks I am going to go for a walk 10 times, for at least 30 minutes each time."

Then, tell your doctor how confident you are that you're going to accomplish your action plan goal. Use a "0" to "10" scale, where "0" is very uncertain and "10" is completely certain. You should be a "7" or higher on the scale, because the more confident you are, the greater the chance you will accomplish your goal.

This technique is really effective, because success builds on success, and each step is a step in the right direction. Soon you may find yourself using the method in other areas of your life.

Problem solve

Another technique you want to use with your doctor is problem solving. Sometimes we have problems and have difficulty figuring out what to do to solve them.

There is a step-by-step process to problem solving, and when you follow these steps, you can usually overcome the issues

try the interactive problem-solving wellness module at:

heretohelp.bc.ca

you have. Problem solving is not a technique to be "used on you"; it is a process they can teach you to "use on yourself," to deal with problems as they arise.

Let's say, for example, that you are having a problem understanding the information your doctor is giving you. Here are some steps you could take to solve this problem:

- **Step 1** Clearly identify the problem (e.g., can't understand what my doctor is telling me).
- **Step 2** Make a list of ideas that may solve the problem (e.g., ask for written information; take a friend with me; tell the doctor I don't understand; look up the information on the Internet; ask friends; etc.).
- **Step 3** Select one of the ideas to see if it solves the problem (e.g., decide to take a friend with me when I visit my see my doctor).
- **Step 4** Assess whether this idea solved the problem. If it did—you've succeeded! But, if you still have the problem, try another idea from your list. The nice thing about your list is that you can keep adding new ideas whenever you think of them.

If you've tried all the ideas and still can't solve the problem, it's time to ask for help from someone you think can help (e.g., a family member, friend, health professional, a counsellor, etc.).

If you still can't solve the problem, accept that maybe the problem can't be solved at this time—but try again in a few weeks. Sometimes problems can't be solved right now, but do get solved at a later time.

Be informed

Lastly, ask your doctor about resources in your area. Programs like the Chronic Disease Self-Management Program may be useful to you.

Chronic Disease Self-Management Program

This is a free group course offered throughout British Columbia to anyone experiencing chronic health conditions. It is delivered by the Centre on Aging at the University of Victoria and supported by the BC Ministry of Health.

Led by pairs of trained lay leaders, the course runs for six weeks in a row, and each week's session is two and a half hours long. Content includes: how to develop a suitable exercise program, using your mind to manage the disease symptoms, healthy eating, breathing exercises, problem solving, communication skills (with family, friends and health care providers), use of medication, and how to deal with the emotions of chronic illness (e.g., anger and depression).

to find out where the Chronic Disease Self-Management Program is offered and to register, call the **toll-free line, 1-866-902-3767**

www.coag.uvic.ca/cdsmp

Between Dusk and Dawn—Who Ya Gonna Call?

The BC NurseLine Pharmacist Service

Barbara Gobis Ogle, BSc(Pharm), MScPhm

Elaine Chong, BSc(Pharm), PharmD, BCPS

Barbara is Vice-President of Clinical Services, and Elaine is the Clinical Services Specialist at Network Healthcare, a health services company formed in 2002. Network Healthcare manages virtual health care networks, and specializes in integrating innovative services into primary care practices. The Pharmacist Network, a service delivery arm of Network Healthcare, uses pharmacists to provide the BC NurseLine Pharmacist Service

It's shortly after midnight. As you were getting ready for bed earlier, you noticed a rash on your arm. You start to worry. You've recently started taking a new medication that your doctor prescribed. Is it the new medication? Could this be a side effect? Does the new medication interact with any of your other medications? And, most importantly, who can you speak with at this time of day to get some much-needed peace of mind?

Access point—NurseLine

In a perfect world, health care professionals would be readily available to everyone at all times. However, the reality is that our demand for health services may far exceed the system's capacity to deliver. But it's clear that we need more ways to ensure that health care professionals are more accessible to those in need, no matter where they live or what time of day it is.

The BC NurseLine (BCNL) is using technology and creative thinking to increase access to nurses, dietitians and pharmacists for BC residents. The BCNL is a toll-free, 24-hour-a-day, seven-day-a-week, 365-day-a-year provincial telehealth service. Every British Columbian can reach a registered nurse or pharmacist for confidential health advice, free of charge. This line provides interpretation services for people who speak different languages, helping them to access the information they need. There is also a separate line that accommodates people who are hearing impaired.

While nurses are on standby around the clock, pharmacists are only available between 5 p.m. and 9 a.m. During the day, callers are referred to a pharmacist in their home community. At night, after a nurse has assessed any symptoms the caller may have, callers with medication ques-

tions are transferred to the BCNL Pharmacist Service (BCNL-PS). A caller from Castlegar could be connected to a pharmacist located in Vancouver or in Langley.

Pharmacist Service—helping with adverse reactions

The Pharmacist Service is provided through a network of specially trained pharmacists who work in pharmacies located around the province. This service not only provides people with after-hours access to pharmacists, but it also ensures that your pharmacist stays where he or she is needed—in your community.

Of the more than 40,000 callers who have received medication advice since the launch of the BCNL-PS in 2003, the majority were seeking general information or advice regarding home treatment and non-urgent care. Over two-thirds of callers are female, mostly between the ages of 18 and 50. Although most callers are adults seeking medication advice for themselves, approximately one-quarter are parents calling on behalf of their children.

Adverse reactions are a common topic of discussion between callers and pharmacists. In fact, in one internal study[1] we found that one in every 10 calls to the BCNL-PS involves a potential or actual adverse reaction, usually concerning a prescription medication. Not surprisingly, people who are taking multiple medications for chronic health conditions may be at higher risk for adverse reactions.[1] Medications that affect the central nervous system—including those usually taken for mental health or addictions treatment—account for approximately 25% of all adverse reaction calls.[1]

The possibilities of "virtual" technology networks

At this point in time, BCNL-PS is unlike any other health line in the world. Instead of putting health care professionals in a call centre, which is the common staffing model, the Pharmacist Service "virtual" network connects pharmacists, wherever they are in the province, by technology. This approach widens the possibilities for medication-related services such as monitoring for safety and effectiveness, support for chronic diseases, and medication "coaching."

Networks of health care providers are well suited to provide scheduled follow-up services (by appointment), via outbound calls to clients, using the same health professional for all calls to a particular client. These same professionals can also provide a combination of face-to-face care and telephone-based care (depending on where the clients are located). The technology network concept is flexible enough to overcome geographical and time barriers, and clients can be directly connected to ongoing services with minimal inconvenience. This means that coaching and follow-up monitoring that involve a relationship between the client and the health professional can be easily accomplished.

Follow-up service trial in BC

Just such an enhanced service has recently completed pilot testing in BC. Pharmacists within the network are now helping certain BC health authorities provide support and coaching by telephone to people who want to be more actively involved in their medication care.

One of these people is a woman who suffers from depression and chronic pain. Despite the fact that she was a health care professional herself, she had spiralled downward to become very isolated and low functioning. Using strategies tailored to help her manage her specific situation, her pharmacist coached her through the process of breaking down her health goals into smaller action plans. She and her pharmacist worked together to make taking her medications easier. The pharmacist supported her to complete bite-sized action plans—putting her meds in a dosette[†] and tying the timing to a regular event such as brushing her teeth, for example—in progressive steps.

With this extra support, the woman's health has improved dramatically, and she has regained her confidence to be in control of her own health. In the past, only one-time caller support was provided. This expanded service, however, allows the client and pharmacist to develop an ongoing relationship and to work together at all stages of a client's recovery.

No 'one-size-fits-all'

Given the range of challenges that people with chronic health conditions have, a one-size-fits-all approach doesn't work for all people. On some days, an individual may be fine and have no need to contact a health care professional. One night, however, this person may need to call the BCNL-PS for medication advice. Other people may need additional self-management support or coaching to deal with their medications.

The key is to find the help that works—that provides the right information, to the right person, at the right time. The BC NurseLine is the place to start.

bc nurseline & pharmacist service

Toll free in BC
1-866-215-4700

In Metro Vancouver
604-215-4700

Deaf & hearing-impaired
1-866-889-4700

Talk to a registered nurse 24 hours a day, 7 days a week

Pharmacist available 5 pm to 9 am daily

Interpretation services available in 130 languages

www.bchealthguide.org

footnote

visit **heretohelp.bc.ca/publications/visions** for Barbara and Elaine's complete footnotes or contact us by phone, fax or email (see page 3)

summary of medication advice categories requested by callers[1]

28.4%	interactions between medications	8.5%	adherence to medication directions as prescribed
15.7%	clarifying the dose of a medication	6.5%	other
15.3%	medication use while pregnant or breastfeeding	1.6%	identification of a medication
12.5%	specific recommendation regarding a medication	0.7%	storage
10.4%	adverse reactions	0.4%	availability of a medication

Plan G

Financial Assistance for Psychiatric Medications

Daryn

Daryn is currently the Plan G Administrator for Vancouver and Richmond

Did you know that British Columbia's PharmaCare program includes a specific plan to provide financial assistance for most psychiatric medications?

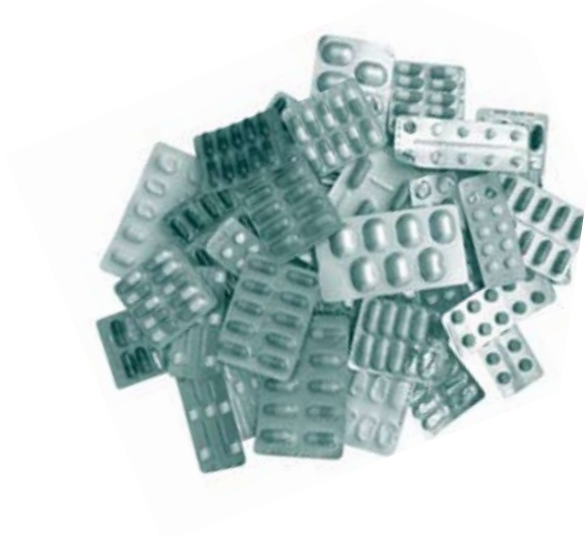
It's the No-Charge Psychiatric Medication Plan, also known as Plan G. It's available to individuals of any age who are registered with a mental health service centre and who demonstrate clinical and financial need.

Registration for Plan G is simple. Your doctor may already be familiar with the process. Both you and your doctor must complete and sign a form called the Application for Psychiatric Medication Coverage. This form is available online at www.health.gov.bc.ca/pharme/plans/.

You will need to phone your local mental health centre to determine where to send your completed application. Look under "Health Authorities" in the blue pages of your telephone book and find the "Mental Health & Addiction Services" section.

Each mental health centre may have a different procedure for processing registrations, so be sure to phone ahead to find out about any special requirements the centre may have, such as in-person registration and verification of income. For residents of Vancouver and Richmond only, your doctor should fax the completed application to 604-874-7698.

A signed Plan G application form is valid for up to one full year from the date that it is processed. A new application form must be signed each year in order for you to remain on Plan G. Ensure that your address and telephone number are current on the application form, in case the mental health centre needs to contact you about your registration.



Frequently asked questions about Plan G

Q: "I think I earn more than the family income limit stated on the form, and I still can't afford to pay for my medications. Can I be registered under Plan G?"

A: Talk to your doctor. If you feel the cost of your prescription will make it difficult to continue treatment, your doctor could request a clinical exception by explaining this in section B of the application form.

Q: "Yesterday I went to the pharmacy to pick up my prescription and was told that my Plan G has expired. I have been on Plan G for the past couple of years, so why did this happen now?"

A: There are two reasons why your Plan G coverage may have ended:

- A new application form must be submitted for every year. If you haven't applied in the past couple of years, your registration would have expired. Contact your doctor to reapply.
- If you began to receive British Columbia Benefits (Income Assistance or Disability Benefits) after being registered for Plan G, you would have been removed from Plan G and registered under another PharmaCare plan called Plan C. Plan C pays for all prescription medications, including those covered by Plan G. If your BC Benefits are discontinued, the Plan C coverage ends, and you are not automatically re-registered for Plan G. You should let your doctor know that a new Plan G application form must be submitted.

Q: "How long will it take to complete registration once I've submitted my application?"

A: Processing time can vary from centre to centre. Usually, there is a quick turnaround time of a few days, but you can phone to follow-up with your centre if it appears that your application hasn't been processed within about a week.

Q: "I asked my doctor about Plan G, but he's never heard of it and he doesn't have the application forms. What should I do?"

A: Tell your doctor to contact your local mental health centre for more information on Plan G. Mental health centres are listed in the telephone directory's blue pages under "Health Authorities." Or, if you reside in Vancouver or Richmond, ask your doctor to call the Vancouver/Richmond Plan G office at 604-874-9113.

your doctor can also find out more about Plan G and the medications it covers by visiting the PharmaCare web page

www.health.gov.bc.ca/pharme/plans/index.html

I Can't Access or Afford the Medication I Need: Now What? Government programs are there to help . . .

Megan Dumas

Megan is a Communications Officer at the Canadian Mental Health Association, BC Division, and Editorial Assistant for Visions

It's no secret that the health care system isn't always easy to figure out. People don't usually try to make sense of the system until they really need it. By then, an individual or their loved one is sick, and the last thing they feel like doing is focusing energy on looking up government programs.

As someone living in BC and in no way affiliated with the government, I thought I'd explain the programs as best I can. I've summarized information that I found on the various program websites.

Province of BC—helping with costs

Living with a mental illness can be hard, not only mentally and physically, but financially as well. And prescriptions can be pricey. The provincial government has several programs that can help ease financial concerns.

PharmaCare

Made up of a number of programs that lower the cost of prescription medications for people living in BC who are registered with the Medical Services Plan.* Two of these programs are Fair PharmaCare and Plan G.

- *Fair Pharmacare*—Assists low-income households by paying all, or a portion of, their prescription medication expenses. Depending on your household net income, you may have to pay the full cost of your family's medications until a certain amount is spent (this amount is called your deductable). After the deductable amount has been used up by your household, the government will then pay 70% of your medication expenses. And, if you spend more than a certain percentage of your income on medications, the government may pay the entire cost of your family's medications for the remainder of the year. For more information about Fair Pharmacare, visit www.health.gov.bc.ca/pharme
- *Plan G*—Pays for the entire cost of psychiatric medications based on your income and clinical need. Plan G is also known as the No-Charge Psychiatric Medication Plan. For more information on this program, see Daryn's article on the previous page.

Provincial and federal programs —helping with access and costs

Two programs exist to help you access medications that you may not be able get otherwise: BC's PharmaCare Special Authority program and Health Canada's Special Access Program.

PharmaCare Special Authority

You go to the pharmacy with your prescription, only to be told that PharmaCare doesn't cover the cost of your medication, even if you've reached your deductable. Plan G doesn't cover it either. But it's so expensive!

Why won't PharmaCare or Plan G pay for your medication? These programs cover most prescriptions, but not certain "limited coverage" medications (see sidebar below). They may not cover your prescription if:

- a less expensive, generic drug has the same chemical makeup as a brand name one
- the medication is too expensive to be considered a first option for treatment

mental health medications that need special authority/approval for coverage[7]

generic drug name	brand name
bupropion (an antidepressant)	Wellbutrin, Wellbutrin SR, Wellbutrin XL
clobazam (an antianxiety medication)	Frisium
cyproterone (reduces aggressive sexual drive)	Androcur, Cyprostat, and others
gabapentin (an anticonvulsant used off-label† for bipolar disorder)	Neurontin
hydroxyzine (an antianxiety medication)	Atarax, Vistaril
lamotrigine (an anticonvulsant and mood stabilizer)	Lamictal
leuprolide (reduces aggressive sexual drive)	Lupron
olanzapine (an antipsychotic)	Zydis, Zyprexa
risperidone (an antipsychotic)	Risperdal
verapamil (a mood stabilizer)	Calan, Covera-HS, Isoptin, Isoptin SR, Verelan, Verelan PM
zopiclone (a sleeping aid)	Lunesta
zuclopenthixol (an antipsychotic)	Acuphase, Cisordinol, Clopixol

for more information on PharmaCare, see:
www.health.gov.bc.ca/pharme/generalinfo/generalinfoindex.html

The provincial government, however, does have a program under PharmaCare that may provide financial assistance for limited coverage drugs. It's called the Special Authority program.[1] If you are allergic to the generic brand of a drug, or all other cheaper treatment options have failed to work for you, and your doctor has prescribed a limited coverage medication, you can apply to the Special Authority program for assistance. This program also gives pharmacies and hospitals permission to dispense medications free of charge.

Each limited coverage medication has its own set of conditions that must be met in order to qualify for coverage. These conditions can include certain diagnoses, for example, or that the patient has tried certain other medications and they didn't help. Although each drug has a different length of time it will be approved for, most mental health medications are approved indefinitely.

If your application is approved, and you are registered under Fair PharmaCare, you will receive the same amount of coverage that you do under Fair Pharmacare.[2] If you are covered by Plan G and the Special Authority application is approved, 100% of the cost of the medication will be covered.[2]

> "Living with a mental illness can be hard, not only *mentally* and *physically*, but financially as well"

Those who do not qualify for Fair Pharmacare or Plan G, but have medical benefits through work or through a family member's work, often have to apply for special authority.[3] This is because many insurance companies that provide workplace benefits cover only the same medications PharmaCare does.[3]

Not all drugs are eligible for Special Authority. Some that aren't include:[4]

- drugs that are part of a private clinical trial
- smoking cessation aids
- diet therapy drugs
- drugs classified as or used for cosmetic purposes
- new drugs under review by PharmaCare

To apply for Special Authority, have your doctor fill out and fax in a Special Authority form. Forms are available online at www.health.gov.bc.ca/pharme/sa/criteria/mentalhealth/mentaltable.html

footnotes

visit **heretohelp.bc.ca/publications/visions** for Megan's complete footnotes or contact us by phone, fax or email (see page 3)

Health Canada Special Access Program

You are diagnosed with a mental illness. You and your doctor start to explore different treatments, including medication. Through a painstaking process of trial and error, you try all of the available medications for your condition, but nothing seems to be working. Your condition is getting worse and is becoming very serious.

One night, you turn on the TV and see a commercial for a new drug used to treat your condition. Excited, you call your doctor, only to find out that this new medication isn't available in Canada. The commercial was from the US, and the Food and Drug Administration has already approved sale of the drug in that country.

Why isn't this drug available in Canada? Because Health Canada hasn't approved it yet.

So, if you find yourself in this situation, is there anything you can do about it? Yes, if your condition is extremely serious or life-threatening, there is something you can do. Health Canada has a special program called the Health Canada Special Access Program (SAP). You can apply to SAP for access to a drug not yet available in Canada.

If you have tried everything available, or can't try everything available because you are allergic to one of the compounds, your doctor can apply on your behalf to have the drug approved just for you. Your doctor needs to show that you have an extreme need for this medication because you are out of other options.

If the medication is approved, it must be administered by your doctor or a hospital. Retail pharmacies are not allowed to distribute this special medication. Access to the medication is only given for six months, and then your doctor must reapply.

"Intractable depression" is listed on the Health Canada website as one of the conditions that may qualify under SAP.[5] Your doctor must provide evidence that your depression is intractable. ▶

how often are drugs available in the usa but not available in canada?

A study out of Toronto looked at 37 new medications that were under evaluation for approval in Canada.[6] Thirty-two out of the 37 drugs were already available in the US. Pharmacologists reviewed all 32 drugs and found that between nine and 11 of them offered moderate to advanced therapeutic advantages; yet, they were unavailable for sale in our country.

this list is not comprehensive and does not imply endorsement of resources

Medication Help

- Your prescribing doctor
- Your pharmacist
- BC NurseLine: 24-hour, confidential health information and advice. Anywhere in the province, call the BC NurseLine to speak to a registered nurse 24-hours or a pharmacist from 5 pm to 9 am every day. 1-866-215-4700 or 604-215-4700.

General Information

- BC HealthGuide Medications Library: Information on uses, side effects and how to take certain medications. www.bchealthguide.org/medications.asp
- National Institute of Mental Health (US) booklet on Medications: A detailed resource that lists and describes medications for treating mental disorders. www.nimh.nih.gov/health/publications/medications/summary.shtml
- BC Mental Health Information Line: Information about mental disorders and referral resources or publications. 1-800-661-2121 or 604-669-7600.
- College of Pharmacists of BC: Tips and FAQs. www.bcpharmacists.org/youandyourpharmacist/
- Canadian Health Network: Search for information on types of medications. Also includes guidelines on how to evaluate health information on the internet. www.canadian-health-network.ca
- BC Ministry of Health: Basic information on pharmacare programs, Medical Services Plan, Plan G forms: www.gov.bc.ca/health or contact Enquiry BC at 604-660-2421, 1-800-663-7867 or EnquiryBC@gov.bc.ca
- Drug monographs.† Health Canada will start publishing medication monographs in 2008. Watch Health Canada's Drug and Health Products site for updates. www.hc-sc.gc.ca/dhp-mps/index_e.html (In the meantime, www.mentalhealth.com and www.healthyplace.com do have monographs in their Medications section).

Medication Safety

- Health Canada's MedEffect Canada section for drug and health product safety: Features advisories, warning, and recalls—for consumers and professionals. Also includes a link to the national Adverse Drug Reaction database. www.hc-sc.gc.ca/dhp-mps/medeff/index_e.html
- Worstpills.org: Prescription drug information from a US nonprofit group. www.worstpills.org
- Institute for Safe Medication Practices Canada: Independent, national, non-profit agency committed to the advancement of medication safety in all healthcare settings. www.ismp-canada.org
- National Association of Pharmacy Regulatory Authorities: Founded by Canada's pharmacy regulatory bodies, has drug warnings for consumers. www.napra.org/docs/0/509.asp

Training

- JoinTogether: From Boston University's School of Public Health, includes a free online course for professionals on medications for alcohol dependence. www.jointogether.org/keyissues/medications/continuing-ed/medicationintro
- Interactions between Psychiatric Medications and Drugs of Abuse and Basic Pharmacology in Mental Health and Substance Use: Online courses offered by the Centre for Addiction and Mental Health in Ontario. www.camh.net/education/Online_courses_webinars/index.html

I Can't Access or Afford the Medication I Need: Now What? | *continued from previous page*

If you feel as though you've run out of options, talk to your doctor. The application forms for the Special Access Program, and tips for your doctor on how to fill the forms out can be found at www.hc-sc.gc.ca/dhp-mps/acces/drugs-drogues/index_e.html.

For more information about SAP, phone 613-941-2108 (in Ottawa) or e-mail SAPdrugs@hc-sc.gc.ca.

***Medical Services Plan (MSP)**

Provides financial coverage of basic medical services for British Columbians. There is a monthly premium (fee) charged for this coverage. Premiums are charged according to the size of your family. To learn about the benefits provided by MSP, visit. www.health.gov.bc.ca/msp/infoben/benefits.html. There is a program in place called Premium Assistance that helps families pay their monthly MSP premiums, depending on financial need. If your family receives full and partial premium assistance, you may be eligible for additional health care services through the Healthy Kids program of the Ministry of Employment and Income Assistance. For more information on premium assistance, visit www.health.gov.bc.ca/msp/infoben/premium.html#assistance

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