Resources and Information for Primary Care Providers (and their patients)

Prepared by: CanREACH

A small thank you to you for taking this training!!!

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Web-Based Resources – Frequently Used Websites for Physicians

We recommend visiting each site and bookmarking it to the computers you use for easy access!

→ CanREACH Website – *Alumni Area
Contains the medication cards, resources, added extra training modules, and so much more.
http://www.hmhc.ca/canreachalumni.html

→ CAPPC – Child and Adolescent Psychiatry for Primary Care
This is an excellent website for finding the rating scales we review during CanREACH
http://www.cappcny.org/home/clinical-rating-scales/

→ Collaborative Mental Health Care
This Canadian based website has fantastic "toolkits" organized by diagnostic area
http://www.shared-care.ca/toolkits

→GLAD-PC and T-MAY
Guidelines shared during the CanREACH training, you can access by the CanREACH Website, or directly as follows
GLAD-PC: http://glad-pc.org/ T-MAY: http://www.t-may.org/

→CADDRA
Canadian ADHD Resources Alliance has resources, rating forms, and practice guidelines
http://www.caddra.ca/

→ CAMESA
CAMESA guidelines provide parents and doctors information about side effects of antipsychotic drugs in children.
http://camesaguideline.org/

→ Alberta Health Services – Addictions and Mental Health Services, Calgary Zone
A comprehensive guide to AHS programs and services for both pediatric and adult populations
http://insite.albertahealthservices.ca/amh/tms-amh-calgary-zone-service-index.pdf

→ KELTY Mental Health, BC Mental Health
Medication Overviews that can be saved/printed as PDF re: various medications and classifications
http://keltymentalhealth.ca/treatment/medications

→ Choosing Wisely Canada
Guidelines and recommendations to ensure high-quality care covering all areas of medicine. Psychiatry Specific:
http://www.choosingwiselycanada.org/recommendations/psychiatry/

Main Principles

We recommend printing this and keeping it in your office along with your mental health card to guide you in your work

Developmental / Contextual Assessment

→ Assess children and adolescents' networks (i.e., family, friends, neighbourhoods, schools, etc.)
→Do a thorough diagnostic and bio-psycho-social evaluation
→Medications cannot replace needs for family support, safety, parenting skills, friends, meaningful hobbies, self-esteem, etc.
→Diagnostic systems (DSM & ICD) have limitations in assessing children and their contexts
→Diagnoses may unfold over time and initial symptoms and diagnoses may differ from later adult diagnoses
→Psychiatric medications are generally just one part of a meaningful, effective treatment plan
→Children are not just little mini-adults
→Ensure case formulation precedes prescription

Team Formation, Communication, and Decision Making

→Fully involve family and child in the decision-making (shared decision making) process.
→Collaboration, conscientiousness, and communication
→Develop an effective working alliance.
→Medication approaches must recognize chronicity of childhood neuropsychiatric disorders by providing:
→Parental and youth support, empowerment, self- management, and patient activation to promote recovery and hope
→Sustained therapeutic alliance and problem-solving
→Treat primary diagnosis (or most urgent or impairing problem) with indicated medication first
→Use systematic rating scale to measure agreed-upon target symptoms at baseline and throughout treatment
→Identify references, resources, readings etc. to help patients and their families

Do No Harm

→Children and youth are different than adults and these developmental differences not only inform assessment, but also efficacy and side effects with treatment
→Children may require proportionately higher doses due to faster metabolism, kidney clearance, and liver-to-body size ratio
→Use medications at appropriate Randomized Controlled Trial (evidence) documented dose and duration before changing or augmenting
→Start low, go slow, taper slow
(exception to this is stimulants which can be discontinued more quickly)
→Use systematic rating method to measure side effects

Evidence-Based Prescribing Practices

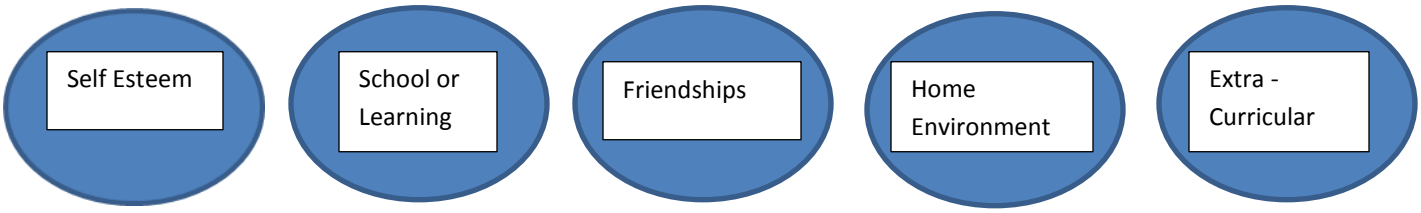
→Evidence-based prescribing practices
→Whenever possible, use mediations supported by double-bling randomized controlled trials for this age group and diagnosis
→Minimize use of multiple medications
→When making changes make only one medication change at a time and monitor the results
→Always consider environmental strategies as alternative or compliment
→Evaluate iatrogenic effects of multiple medications
→When unclear, consider tapering or discontinuing most worrisome medication or the one with the least amount of RCT evidence

Adapted from The REACH Institute PPP mini-fellowship training

Assessment Extras

Impairment – "Spheres of Functioning"

Is there a sense that emotions, behaviors and/or inattention is affecting:



Assessment: Colder Mnemonic

- **C** Characteristics
- **O** Onset
- **L** Location
- **D** Duration
- **E** Exacerbation
- **R** Relief

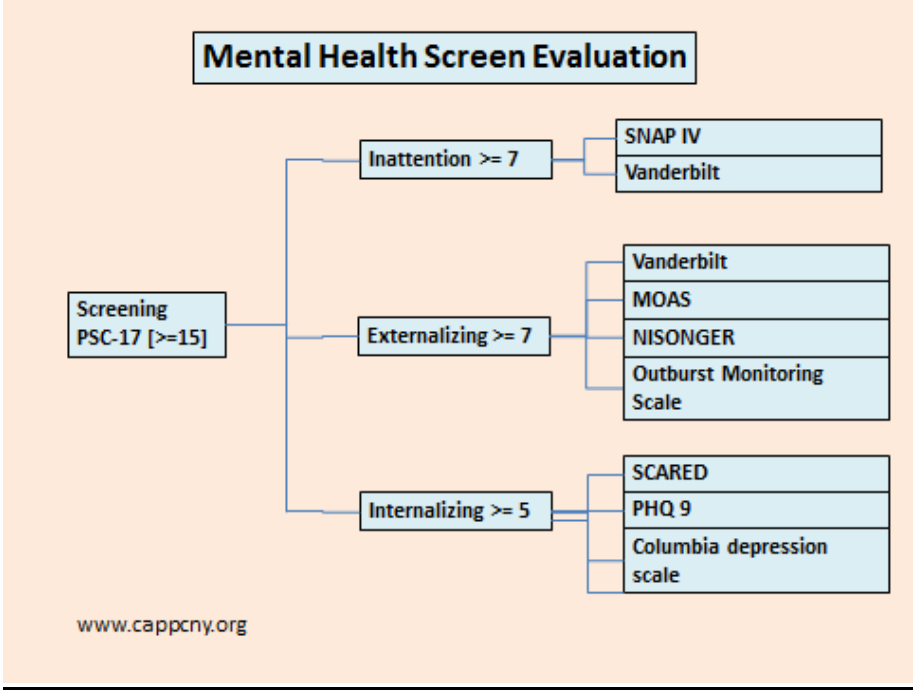
Assessment: Risk Assessment, Sad Persons Mnemonic

- **S** Sex
- **A** Age
- **D** Depression
- **P** Previous Attempts
- **E** Ethanol Abuse
- **R** Rational Thinking Lost
- **S** Social Supports Lacking
- **O** Organized Plan
- **N** No significant others / peers
- **S** Sickness / Stressors

Assessment: Commonly Used Screening Tools **all found for FREE online*

General	PSC-17
Adverse Childhood Experiences	ACEs
ADHD	SNAP ; Vanderbilt
Aggression	Outburst Monitor Scale
Anxiety	SCARED
Depression	PHQ ; Columbia Depression Scale; KADS
Eating Disorders	EAT-26
Functional	WEISS
OCD	YBOCS
PTSD	CPSS
Substance	CRAFFT
Safety Risk	TASR OSI (Ottawa Self Injury Inventory)

Assessment Extras: Mental Health Screenings



Assessment Extras: Conceptualization Chart

	INDIVIDUAL FACTORS			SYSTEMIC FACTORS		
	BIOLOGICAL	**BEHAVIORAL**	**COGNITIVE**	**FAMILY**	**SCHOOL**	**SOCIAL**
PREDISPOSING	-Family hx -Genetics -Pre/post natal -Development	- Hx of reinforcement and punishment - Conditioning	-Dysfunctional assumptions and beliefs	-Family structure, history, communication	-IQ -Learning difficulties -Environment	-Availability -Gender -Social Skills -Cultural
PRECIPITATING	-Trauma -Toxins -Adverse Events (ACEs)	-Loss -Adverse Events (ACEs)	-Negative Automatic thoughts	-Individual or family crisis -ACEs	-Change -Failure	- Change or Loss of social support - ACEs
PERPETUATING	-Substance use -Chronic illness -Disabilities	-Family/social (negative, -) reinforcement	-Lack of insight -Patterns and themes -Primite	-Chronic illness, stress, conflict	-Undiagnosed -Chronic difficulty -Relationship	-Individual and environmental factors
PROTECTIVE	-Good health - Absence of family hx -Temperament	-Absence of ACEs - Variety and availability of + reinforcements	-Capacity and insight - Corrective actions	-Flexible -Adaptable	-Satisfaction -Achievement -Quality -IQ	-Temperament -Ability -Access

Assessing For Adverse Childhood Experiences (ACEs)

Adapted from http://www.albertafamilywellness.org/assets/Resources/CAAMHPP-ACE-TIC-Resource-Guide-Nov-2016.pdf

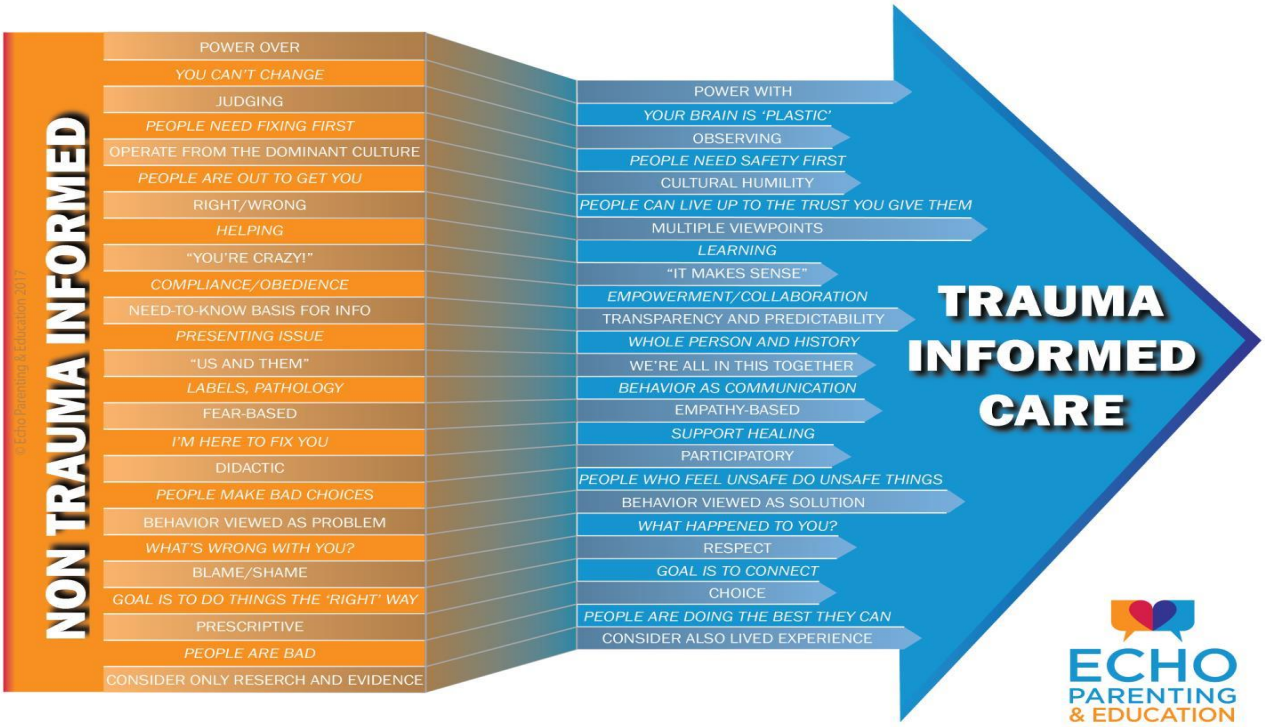
Finding Your ACE Score

	While you were growing up, during your first 18 years of life:	Yes	No
1.	Did a parent or other adult in the household **often or very often**… Swear at you, insult you, put you down, or humiliate you? **or** Act in a way that made you afraid that you might be physically hurt?	☐	☐
2.	Did a parent or other adult in the household **often or very often**… Push, grab, slap, or throw something at you? **or** Ever hit you so hard that you had marks or were injured?	☐	☐
3.	Did an adult or person at least 5 years older than you **ever**… Touch or fondle you or have you touch their body in a sexual way? **or** Attempt or actually have oral, anal, or vaginal intercourse with you?	☐	☐
4.	Did you **often or very often** feel that … No one in your family loved you or thought you were important or special? **or** Your family didn't look out for each other, feel close to each other, or support each other?	☐	☐
5.	Did you **often or very often** feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **or** Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	☐	☐
6.	Were your parents **ever** separated or divorced?	☐	☐
7.	Was a family member: **Often or very often** pushed, grabbed, slapped, or had something thrown at him/her? **or** **Sometimes, often, or very often** kicked, bitten, hit with a fist, or hit with something hard? **or** **Ever** repeatedly hit at least a few minutes or threatened with a gun or knife?	☐	☐
8.	Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	☐	☐
9.	Was a household member depressed or mentally ill, or did a household member attempt suicide?	☐	☐
10.	Did a household member go to prison?	☐	☐
	TOTAL ACE SCORE Each answer of 'Yes' is scored as a '1'. Count the total number of 'Yes' responses.		

Your ACE Score is: _____

Trauma Informed Care:

Acknowledges the role that trauma has played in the patients' lives, shifting the question from:
"WHAT IS WRONG WITH YOU" to **"WHAT HAPPENED TO YOU?"**



Traditional Non-Trauma Informed Approach	Trauma Informed Care Approach
Dominant ideology – what's wrong with you?	Dominant ideology – what's happened to you?
Symptom focused assessment and treatment	Whole person in environment assessment and treatment
Labels & pathology	Behavior as communication
Bio-Medical Assessment	Bio-Psycho-Social Assessment
Didactic	Participatory
Compliance	Collaboration
People need fixing first	People need safety first

Alberta Health Services

Adapted from the Echo Parenting and Education series

Children's Global Assessment Scale

CHILDREN'S GLOBAL ASSESSMENT SCALE

For children 4–16 years of age

David Shaffer, M.D., Madelyn S. Gould, Ph.D.
Hector Bird, M.D., Prudence Fisher, B.A.

Adaptation of the Adult Global Assessment Scale

(Robert L. Spitzer, M.D., Miriam Gibson, M.S.W., Jean Endicott, Ph.D.)

Rate the subject's most impaired level of general functioning for the specified time period by selecting the *lowest* level which describes his/her functioning on a hypothetical continuum of health-illness. Use intermediary levels (e.g., 35, 58, 62).

Rate actual functioning regardless of treatment or prognosis. The examples of behavior provided are only illustrative and are not required for a particular rating.

Specified time period: 1 month

100–91 **Superior functioning** in all areas (at home, at school, and with peers), involved in a range of activities and has many interests (e.g., has hobbies or participates in extracurricular activities or belongs to an organized group such as Scouts, etc.). Likeable, confident, "everyday" worries never get out of hand. Doing well in school. No symptoms.

90–81 **Good functioning in all areas.** Secure in family, school, and with peers. There may be transient difficulties and "everyday" worries that occasionally get out of hand (e.g., mild anxiety associated with an important exam, occasional "blow-ups" with siblings, parents, or peers).

80–71 **No more than slight impairment in functioning** at home, at school, or with peers. Some disturbance of behavior or emotional distress may be present in response to life stresses (e.g., parental separations, deaths, birth of a sib) but these are brief and interference with functioning is transient. Such children are only minimally disturbing to others and are not considered deviant by those who know them.

70–61 **Some difficulty in a single area, but generally functioning pretty well**, (e.g., sporadic or isolated antisocial acts, such as occasionally playing hooky or petty theft; consistent minor difficulties with school work, mood changes of brief duration; fears and anxieties which do not lead to gross avoidance behavior; self-doubts). Has some meaningful interpersonal relationships. Most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern.

60–51 **Variable functioning with sporadic difficulties or symptoms in several but not all social areas.** Disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings.

50–41 **Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area**, such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, frequent episodes of aggressive or other antisocial behavior with some preservation of meaningful social relationships.

40–31 **Major impairment in functioning in several areas and unable to function in one of these areas**, i.e. disturbed at home, at school, with peers, or in the society at large, e.g., persistent aggression without clear instigation; markedly withdrawn and isolated behavior due to either mood or thought disturbance, suicidal attempts with clear lethal intent. Such children are likely to require special schooling and/or hospitalization or withdrawal from school (but this is not sufficient criterion for inclusion in this category).

30–21 **Unable to function in almost all areas**, e.g., stays at home, in ward or in bed all day without taking part in social activities OR severe impairment in reality testing OR serious impairment in communication (e.g., sometimes incoherent or inappropriate).

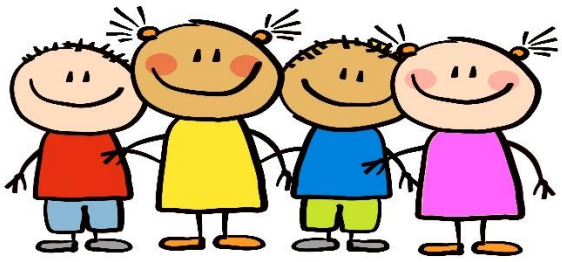
20–11 **Needs considerable supervision** to prevent hurting others or self, e.g. frequently violent, repeated suicide attempts OR to maintain personal hygiene OR gross impairment in all forms of communication, e.g. severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, etc.

10–1 **Needs constant supervision** (24-hour care) due to severely aggressive or self-destructive behavior or gross impairment in reality testing, communication, cognition, affect, or personal hygiene.

Tips for Interviewing Children

CanREACH Adapted from book "How Many More Questions"

Children are NOT little adults	*Children understand and use speech differently than adults, often not mature linguistic, cognitive, and pragmatic skills.*
Young Children do NOT initiate speech with strangers	*Use techniques that encourage young children to speak, act as the communication assistant of the young patient.*
Children do NOT elaborate on conversation topics	*Non-discursive speech (one- to two-sentence responses) is age appropriate in young children.*
Children ARE concrete thinkers	*Monitor your speech to ensure you are using concrete action-based words (verbs) when talking with young children. Learning how to interpret children's concrete use of language is key to understanding the message they are conveying.*
Children have poor perception of chronicity and time	*Parents are better informants of chronology/evolution/duration of symptoms, avoid asking young children these questions.*
Children TRY to please adults	*Children may try answering the interviewers questions (even incorrectly) and an inability to answer makes children tense and resistant (i.e.: repeated "yes/no, maybe, I guess, a little, and not sure" responses).*
Children TRY to figure out what the interview wants	*Watch for leading questions, Children respond to such with the information the interviewer seems to want to hear.*
Children talk IF they feel comfortable	*Use developmentally appropriate language, allow the child to continue an activity while talking, only introduce sensitive topics after rapport is built, reformulate unanswered questions, empathize, normalize, give positive feedback, provide hope.*
Key points for posing questions to	*Consider yes/no questions yield minimal information. Younger children respond well to questions made of short simple sentences. Ask "what" and "how" questions, not "why" questions.*
Work on Understanding	*Listening to every word, make effort to clarify, recruit the child's help when needed, and consolidate rapport.*



Tips for Interviewing Children, cont.

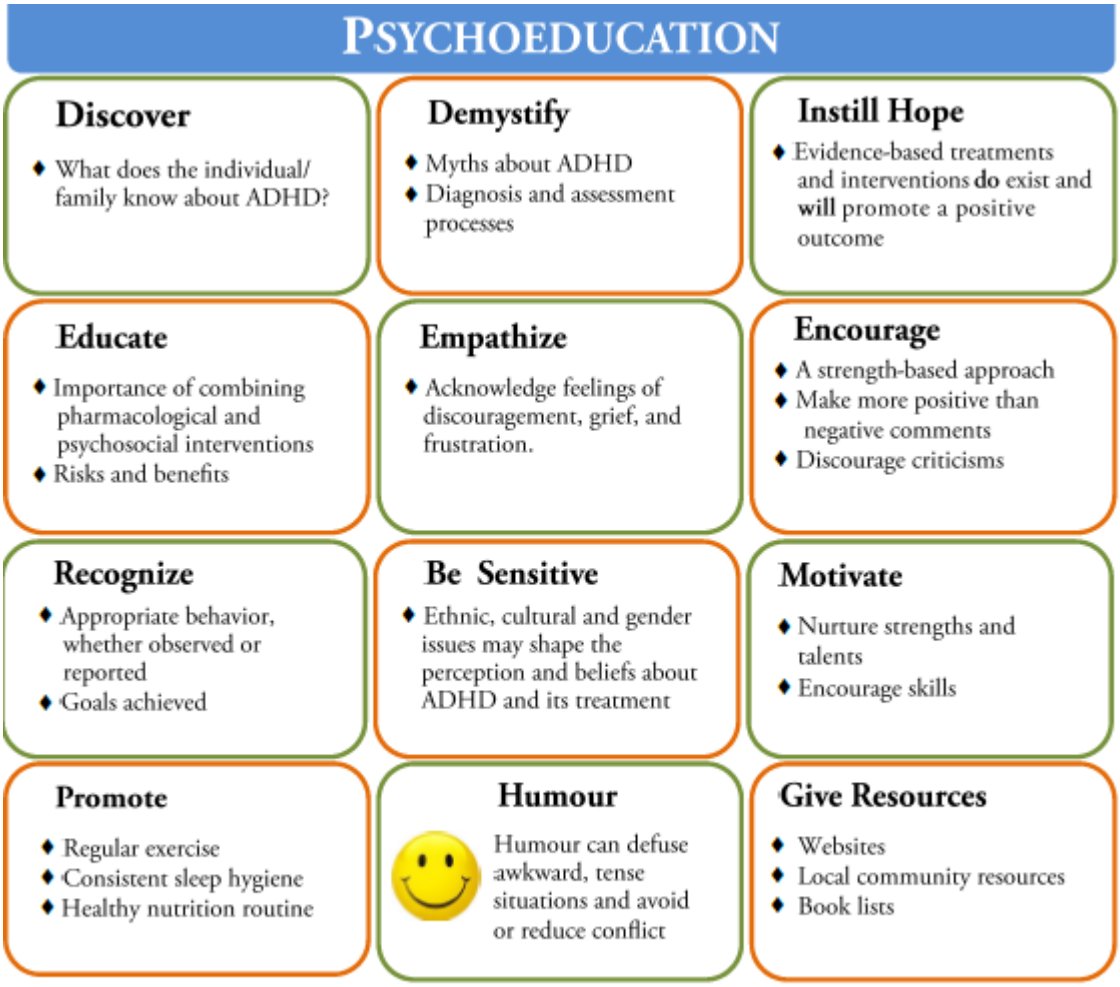
	Action DO	**Action DON'T**
Setting	Interview the child without the parents	See the child with the parents only
Introduction	Tell the child that you want to learn more about them	Tell the child that you will be asking questions
Activities	Encourage non-distracting activities during interview	Ask the child to stop activities and focus
Hyperactive/ Behaviour	Ignore	Comment
Encouragement	Provide periodic positive feedback	Challenge them on not answering
Sensitive Topics	Only bring up once good rapport is established	Say parent told you about the child' "negative"
Questions	Provide options where possible. Check child's understanding, reformulate question, or move on.	Bias questions towards pathology or ask leading questions. Do not repeat questions
Interpretation	Base on information obtained from the child	Do not put words in the child's mouth

Modified Motivational Interviewing (LEAP)

"L" **LISTEN**	→Active Listening →Ask about their view of the problem →Don't worry about your response; there is nothing else to do when you are listening than to listen and try to see the problem from their perspective →Be curious – Use COLDER →Open ended questions →Avoid parental blame of lecturing
"E" **EMPATHIZE, then EDUCATE / ENCOURAGE**	<u>EMPATHIZE</u> → Allow yourself to feel the feeling that is transmitted along with the words → Ask "what has this been like for you" → Identify and restate what they said, and restate the feeling → Recognize their efforts and the challenges they face <u>ENGAGE/EDUCATE/EXCHANGE/ENCOURAGE</u> → Look for shame, stigma, parental mental health → Engage and invite them to work together to find solutions – get permission →Educate and encourage in "first principles" Child Basic needs: To FEEL loved (not just "be" loved) To be IMPORTANT to someone To be GOOD AT something To BELONG to a group of others →Exchange information, share ideas of what might work, "what do you think"
"A" **AGREE**	→ Exchange information, share ideas of what might work, "what do you think" →Be sure you have done psycho-education → Find areas that you both agree on to focus first → Enhance child self-monitoring → Enhance parental support, advocacy; write it out as their "prescription" → "I can't do this without you"
"P" **PARTNER, PLAN and PROCEED**	→ Parent is the vial, most-important team member. Mentoring and building parent's advocacy skills → Shared decision –making → Multiple problems require multiple solutions → Facilitate finding other team members → Ongoing problem solving, modify as needed. → Medication alone is rarely adequate

Psychoeducation in Primary Care

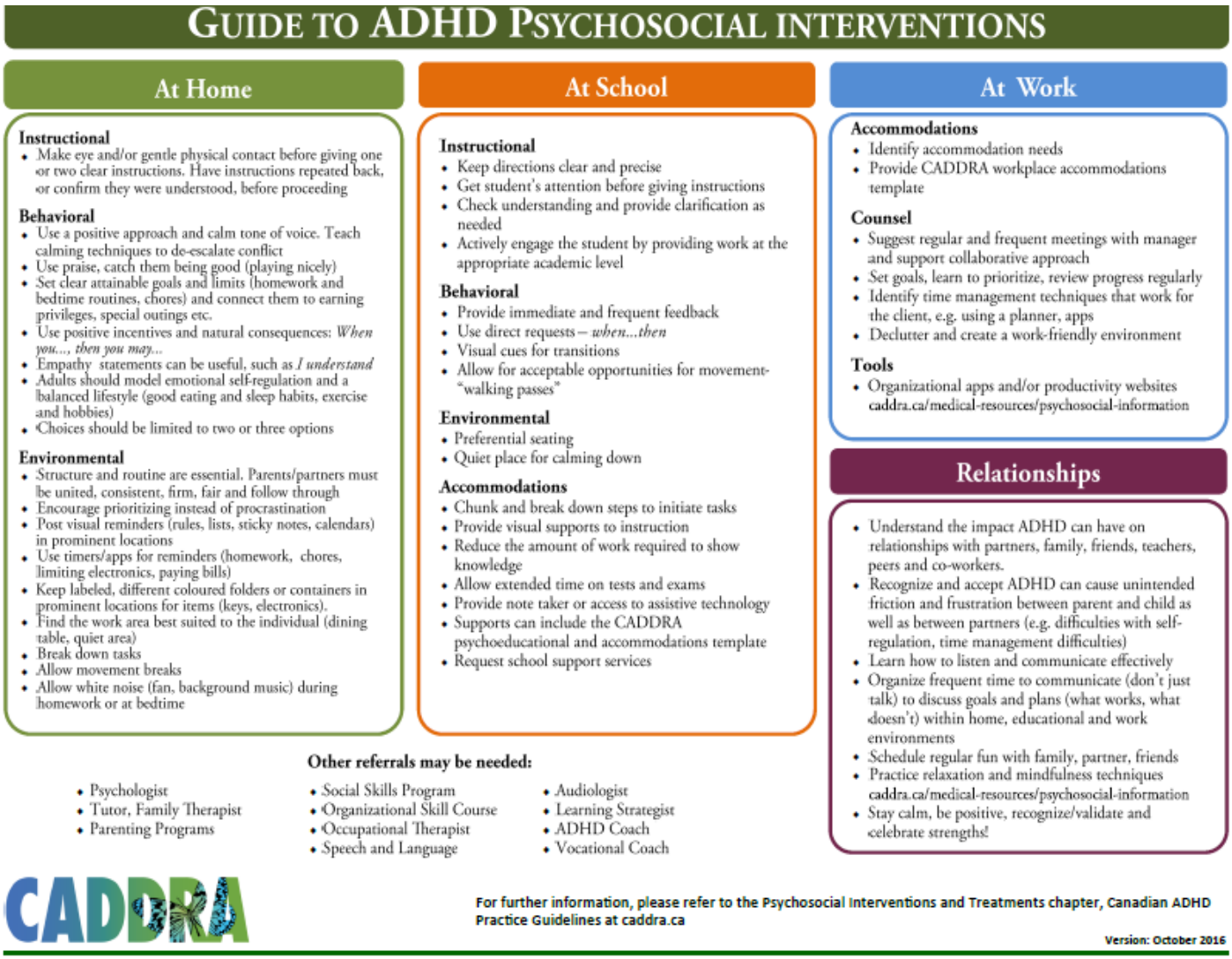
Psychoeducation is an important component to any diagnostic consideration and working relationship. While the following is taken from the CADDRA website specific to ADHD, it is a good visual to remind you how to connect and education around any mental health issue.



For further information, please refer to the Psychosocial Interventions and Treatments chapter, Canadian ADHD Practice Guidelines at caddra.ca

Psychosocial Interventions to Consider

Psychosocial interventions are critical in treating any diagnosis. While there is a role for medication, remember that medications cannot "fix" or "replace" other necessary components to treatment. While the following is taken from the CADDRA website specific to ADHD, it is a good visual to remind the various psycho-social areas to consider intervention when offering comprehensive assessment and treatment.



Promoting Healthy Sleep Practices

PATIENT HANDOUT

Sleep is important to your physical and mental health. It allows your mind to digest and make sense of the day's events. It prepares your brain for learning new things the next day. During sleep your brain even cleans itself! Simply put, sleep is essential for life and getting the proper amount of sleep helps us cope better with whatever life brings our way. Getting enough sleep is essential for your emotional health. You may start to feel out of sorts and like you are not yourself if you're not sleeping well. Noises can seem louder, and colours too bright; small irritations feel like big problems, and even thinking can become a chore. It can get harder to solve problems and you may experience more aches and pains, less energy, and less interest in life. The less you sleep, the more anxious you can become about getting enough sleep, and this might make it even harder to fall asleep. You can end up in a vicious cycle – at the mercy of your over-active mind, feeling unwell, and feeling out of control. But there are things you can do to help break that cycle! Here are a few tested and true strategies that can help!!

YOU CAN CONTROL WHAT YOU EAT AND DRINK FOOD: Don't eat too much food too close to bed time, but also, don't go to bed hungry. A light pre-bed snack can be good, especially one with milk in it. CAFFEINE: Caffeine is found in coffee, tea, energy drinks, soda, cocoa, some over-the-counter medications. In general caffeine should be avoided within 8 hours of sleep. NICOTINE – While it's not a good idea to smoke because of the harmful health effects anyway, nicotine has a stimulating effect on the brain. ALCOHOL – Alcohol can interfere with sleep patterns and should be avoided within 4 hours of going to sleep.	**YOU CAN CONTROL YOUR SLEEP ENVIRONMENT** Make your bedroom a good place for sleeping – low noise, dark and comfortable, with a cooler temperature. Use your bed for sleep only; do not use the bed for homework, talking on the phone, watching TV etc. This helps your brain to link being in the bed with sleep. Keep electronic gadgets out of the bedroom. Remove things like phones, computers, and any other screens from the bedroom at bedtime. Avoid sleeping in other places (i.e., couch, car), making the regular use of the bed in the bedroom your consistent place of sleep.
YOU CAN CONTROL WHAT YOU DO DURING THE DAY AND BEFORE BED Get at least 30 minutes of exercise each day, but avoid vigorous exercise prior to bedtime. Have a regular set and enforced bedtime! This sets your body's inner clock for sleep. Have a pre-bedtime routine that calms you and prepares you for sleep. This should not include looking at bright screens and electronic devices should be a no-go zone for the last 30-minutes at minimum before bed Avoid napping. Increase light exposure in the morning.	**YOU CAN CONTROL WHAT YOU DO WHILE YOU'RE FALLING ASLEEP** Reduce cognitive and emotional stimulation before bedtime. Keep a pen and paper by the bed; if something is nagging you jot it down for the next day, which may help your mind to be freer to relax. Incorporate relaxation / calming activities in to the bedtime routine (i.e., warm bath, relaxation imagery, deep breathing, and muscle relaxation). Do not look at the clock – place it somewhere you cannot easily see from the bed.

Promoting Relaxation

PATIENT HANDOUT

While relaxing may seem like a pretty easy thing to do, a lot of people have difficulty actually getting themselves to do it regularly and successfully. Learning relaxation involves figuring out what is going to give you the best chances of success – otherwise your probably won't keep trying to do it. Find a quiet, safe, comfortable place and remember to practice often. Here are three ways to try.

Progressive Muscle Relaxation:

Start by taking three deep breaths in and out. Clench your fists gently and hold them for 10 seconds and then let go. Rest for 20 seconds and use relaxing self-talk. Tighten your biceps by bending your arms and pulling towards your shoulders (like Popeye!), hold for 10 seconds and release. Tighten your triceps by straightening your arms and locking your elbows, hold, hold, hold, and release. Raise your eyebrows as high as you can, hold it, and relax. Now shut your eyes tightly, hold it, and relax. Open your mouth as widely as you can, hold it for 10 seconds, and relax. Lean your head gently towards your back to tighten the muscles in the back of your neck, hold for five seconds, and now relax. Raise up your shoulders to your ears like a shrug, hold, hold, hold, and release. Deep Breath.

Push your shoulders back towards each other, pinching the shoulder blades together, hold it, hold it, and release. Take a breath. Tighten your stomach muscles, squeeze, hold and release. Now, arch your lower back up, hold it, hold longer, and release. Tighten your buttocks, really squeeze them, hold for 10 seconds, and relax. Tighten the muscles in your hips and thighs, hold for 10 seconds, and release. Take a deep breath. Now, tighten your shin muscles by pulling your toes towards you, hold, and relax. Tighten your calm muscles by doing the opposite, point your toes down, as hard as you can, hold it, and relax. Take a deep breath, and scan your body, anywhere you feel tension still? Go back over your muscle groups and repeat the exercises in areas that remain tense. Take a moment to feel your body all relaxed and notice how it feels.

Imagination / Visualization:

Imagining exercises are used in different ways, but the primary goal is to shift your focus from the stresses of the outside world to a safe place where your mind and body are free to relax. Start with a deep breath, now close your eyes and imagine yourself in a peaceful, safe place – anywhere that appeals to you. It can be real or imaginary. Focus on the scene and all the details in the image. Create the entire scene in your mind. Imagine yourself there. Now, try and use all your senses…what do you see? What do you hear? What do you smell? What do you feel? What do you taste?

Deep Breathing:

One of the most important factors in learning to relax is finding ways to control your breathing. Here are a few ways to try:

Abdominal breathing is a technique that focuses on using your diaphragm to make sure that your lungs are fully expanding, and that you are not just using the top part of your lungs to breathe. Put one hand on your upper chest and the other on your abdomen. Breathe in deeply. Which one moved? Now take several slow, deep breaths and focus on the breath going in to your belly. Be sure that your lower hand moves out as that muscle below your lungs, your diaphragm, moves out and expands.

Box-Breathing involves breathing in a controlled manner, in and out slowly, and maintaining a pattern to the breathing. This pattern involves breathing in slowly for a count of four, holding your breath in for a count of four, slowly breathing out for a count of four, and then holding your breath our for a count of four. To help you can imagine the four sides of a box.

A Physician's Guide to **Eating Disorders**

DETECTION

- Eating disorders can be difficult to detect because patients may keep their behaviours a secret and deny their illness.
- Some patients appear thin and emaciated while others are normal to heavy.
- Eating disorders occur in a wide range of ages in both males and females.

SIGNS AND SYMPTOMS OF A POSSIBLE EATING DISORDER

- Significant weight loss
- Failure to gain weight during a growth period (adolescent)
- Disturbances in the way body weight and shape are experienced
- Severe food/fluid restriction
- Binge eating
- Caloric compensations such as vomiting, laxatives, diuretics and/or fasting
- Amenorrhea or unexplained infertility
- Syncope
- Dehydration
- Electrolyte disturbances
- Lethargy
- Ketones on breath
- Stress fractures and repeated injuries
- Bradycardia
- Postural hypotension
- Parotid hypertrophy
- Chronic abdominal symptoms
- Constipation
- Lanugo hair
- Hair loss
- Blue fingernails
- Feeling cold

RED FLAGS THAT CAN INDICATE A SERIOUS DISORDER

- Rapid and persistent weight loss
- Primary or secondary amenorrhea
- Body temperature less than 36°C
- Abnormal ECG (e.g. QT interval greater than 450)
- Bradycardia less than 40 bpm
- Tachycardia more than 110 bpm
- Marked hypotension
- Electrolyte imbalances
- Hematemesis
- Changes in mental status such as forgetfulness, reduced concentration, irritability
- Poor performance in school/work
- Seizures
- Loss of energy
- Overuse of laxatives
- Calloused knuckles

EATING DISORDER SCREENING TOOL

1. Are you terrified about being overweight?
2. Have you gone on eating binges where you feel you may not be able to stop?
3. Do you feel extremely guilty after eating?
4. Do you vomit or have the impulse to vomit after meals?
5. Do you feel that food controls your life?

A **YES** to any question indicates need for further screening.

(Questions adapted from EAT-26 D.M. Garnder & P.E. Garfinkel (1979) D.M. Garner et al, (1972))

MEDICAL MANAGEMENT

1. **Monitor frequently:** body weight, heart rate, blood pressure and postural changes, temperature, hydration, electrolytes, repeat ECG if deterioration in weight, vitals or severity of symptoms.
2. **Refer** patient for mental health therapy and nutrition counseling.
3. **Assess** need for hospitalization:
   - **A.** Rapid and persistent decrease in intake and/or weight, despite outpatient treatment
   - **B.** Additional stressors that interfere with the ability to eat
   - **C.** Co-morbid psychiatric problems, suicidality
   - **D.** Medical problems such as metabolic abnormalities, hematemesis, vital sign changes, uncontrolled vomiting

SUGGESTED TESTS

- ECG
- BUN
- CBC
- Chest X-Ray
- Electrolytes
- Creatinine
- Thyroid Function
- Pregnancy Test

BONE DENSITY if patient has been underweight for some time

FOR MORE INFORMATION AND HELP YOU CAN CONTACT

1. **Calgary Eating Disorder Program:**
   To speak with a Program Consultant call **(403) 955-8700**
   To Refer:
   Please complete a physician referral form on the CEDP website below.
2. **University of Alberta Hospital**
   Eating Disorder Program
   Edmonton **(780) 407-6114**

WEBSITES

Calgary Eating Disorder Program
www.albertahealthservices.ca/info/page4208.aspx

National Eating Disorder Information Centre
www.nedic.ca

CRITERIA FOR HOSPITAL ADMISSION

CHILDREN AND ADOLESCENTS

- Weight less than 75% of standard or acute weight decline with food refusal
- Heart rate less than 45 bpm
- Blood Pressure less than 80/60
- Orthostatic hypotension with systolic BP change more than 20
- Orthostatic HR change more than 20
- Hypokalemia
- Hypophosphatemia

ADULTS

- Weight less than 75% of standard
- Heart rate less than 40 bpm
- Blood Pressure less than 90/60
- Hypoglycemia
- Hypokalemia (K < 3 meq/L)
- Inability to maintain temperature
- Dehydration
- Hepatic, renal or cardiovascular compromise requiring acute treatment

Alberta Health Services

Mood Enhancing Prescription

Practically, the clinician can review the MEP with the patient, complete the form and then review it at the next office visit. It is useful to provide the young person with a simple outline developed collaboratively with them (and caregiver if appropriate) that clearly specifies what self-regulatory activities they should pursue during the diagnostic and treatment phases of their contact with their health provider. The Mood Enhancing Prescription is a useful and time efficient tool that can be used to help the young person identify and plan their daily activities.

Mood Enhancing Prescription

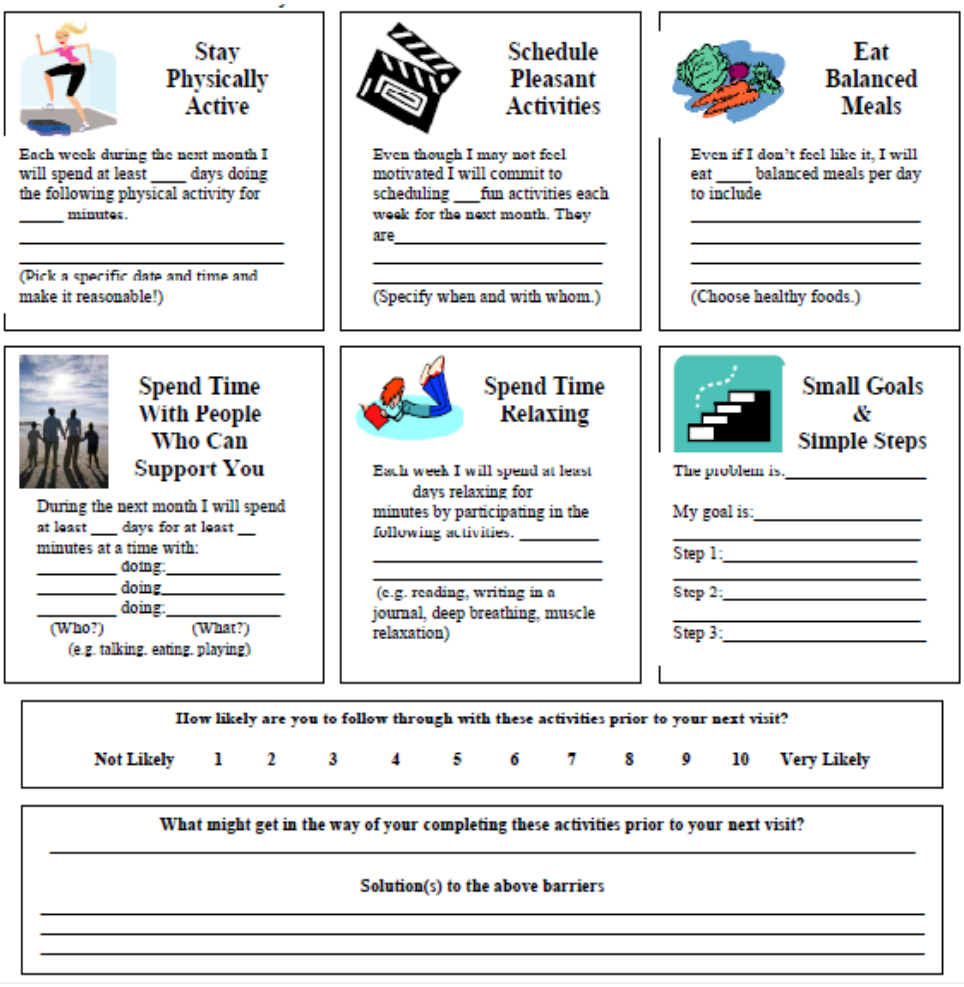
There are many things that you can do to help your mood. Sometimes these activities by themselves will help you feel better. Sometime additional help (such as psychotherapy or medications) may be needed. This is your prescription for what you can do to help your mood. For each activity write in your plan (include what you will do, how often and with whom)

ACTIVITY	PLAN (what, how often, and with whom)
EXERCISE	
EATING WELL	
SLEEPING WELL	
PROBLEM SOLVING	
BEING SOCIALLY ACTIVE	

Self-Care Planning and Goal Setting in the Primary Care Office

Along with the Mood Enhancing Prescription, this graph can act as a guide for you and your patients to set SMART goals to focus sessions and strive towards behavioral activation for those with mood concerns. SMART GOALS are:

- S Specific
- M Measureable
- A Achievable
- R Relevant
- T Time-Bound



Stay Physically Active

Each week during the next month I will spend at least ____ days doing the following physical activity for _____ minutes.

_____

_____

(Pick a specific date and time and make it reasonable!)

Schedule Pleasant Activities

Even though I may not feel motivated I will commit to scheduling ___fun activities each week for the next month. They are_____

_____

_____

(Specify when and with whom.)

Eat Balanced Meals

Even if I don't feel like it, I will eat ____ balanced meals per day to include

_____

_____

_____

_____

(Choose healthy foods.)

Spend Time With People Who Can Support You

During the next month I will spend at least ___ days for at least __ minutes at a time with:

_____ doing:_____

_____ doing_____

_____ doing:_____

(Who?) (What?)

(e.g. talking, eating, playing)

Spend Time Relaxing

Each week I will spend at least ____ days relaxing for ____ minutes by participating in the following activities. _____

_____

_____

(e.g. reading, writing in a journal, deep breathing, muscle relaxation)

Small Goals & Simple Steps

The problem is._____

My goal is:_____

_____

Step 1:_____

_____

Step 2:_____

_____

Step 3:_____

How likely are you to follow through with these activities prior to your next visit?

Not Likely 1 2 3 4 5 6 7 8 9 10 **Very Likely**

What might get in the way of your completing these activities prior to your next visit?

_____

Solution(s) to the above barriers

_____

_____

_____

SSRI Medications in Primary Care

Adapted from the GLAD-PC http://glad-pc.org/

Patient Monitoring For SSRI – Depression / Anxiety

Patient Name:			Collateral Contacts:			
Date of Initial Asssessment (Week 0; depression as working diagnosis)		Initial Target Symptoms	Initial Assessment Tool Used	Baseline score on Assessment Tool	Baseline Suicidality (None, Passive, Active)	Initial Action (ie, Education, Medication, Consultation)
Week	Date (write n/a if pt not assessed in given week)	Assessing Clinician	Mode(s) of interview (i.e., Face-to-face, telephone)	Assessment Tool / Score (i.e., CGAS, PHQ-9)	Change in Target Symptoms / Side Effects (**Ask re SI**)	Action (i.e., Education, Medication, Consultation)
1						
2						
3						
4						
5						
6						
7						
8						
9						

SSRI Medication Changes

When to use a different SSRI: A different SSRI should be used when the maximum dose is reached and maintained for 4-6 weeks without response in target symptoms with a specific SSRI or there are major side effects with a specific SSRI.

When to use a second-line medication: Consider using a second-line medication for depression if a child fails 2 SSRIs and a course of CBT or IPT. A mental health specialist should be consulted regarding second-line medications. A doctor should also re-evaluate a diagnosis and consider a combination of medication if a child fails 3 medication trials.

Table 3 provides information about tapering and switching SSRI medications.

Table 3: SSRI Tapering/Switching Schedule

Medication	Tapering Increments	Time between each taper
Fluoxetine	10 mg	1-2 weeks
Sertraline	25 mg	1-2 weeks
Citalopram	10 mg	1-2 weeks
Escitalopram	5 mg	1-2 weeks
Fluvoxamine	50 mg	1-2 weeks
Paroxetine	5 mg	1-2 weeks

*May start second medication but need to inform patients/families about possible adverse events such as serotonin syndrome

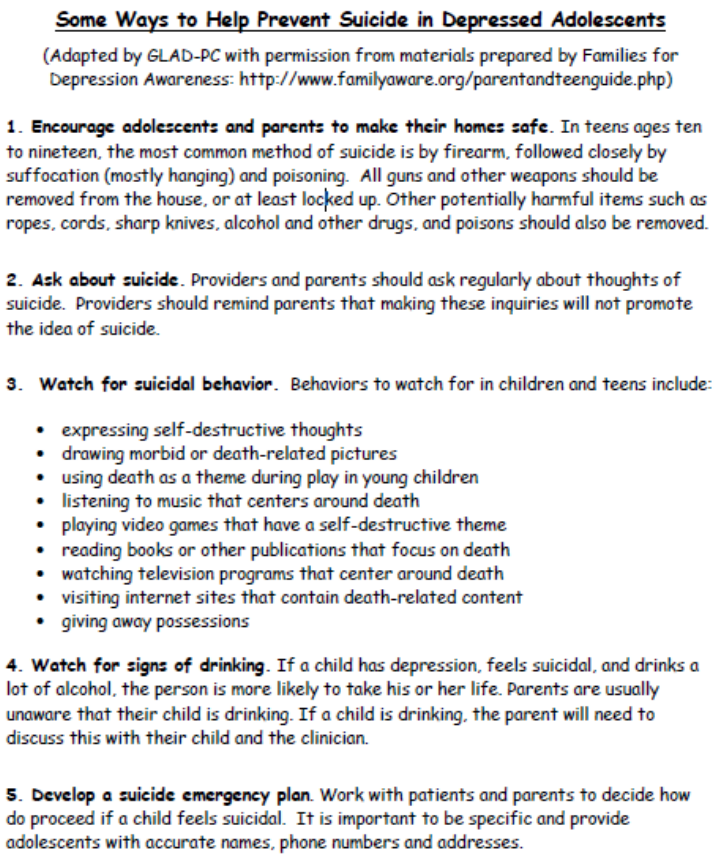
Maintaining Medication
In order to maintain medication the following is recommended:

- Continue on medication for 6-12 months following cessation of symptoms. Some depressed youth may need 2 or more years of maintenance to prevent relapse.
- Once stabilized, follow-up appointments should occur monthly to check efficacy of medication
- Evaluate target symptoms, adverse reactions & medication compliance at each follow-up visit
- Obtain adolescent and parent symptom checklists every 3 months.

Stopping Medication
When discontinuing medication, taper medication slowly.

Suicidal Ideation in Primary Care

The Tool for Assessment of Suicide Risk for Adolescents (TASR-A): http://teenmentalhealth.org/wp-content/uploads/2015/12/TASR-A_Package.pdf



Some Ways to Help Prevent Suicide in Depressed Adolescents

(Adapted by GLAD-PC with permission from materials prepared by Families for Depression Awareness: http://www.familyaware.org/parentandteenguide.php)

1. **Encourage adolescents and parents to make their homes safe.** In teens ages ten to nineteen, the most common method of suicide is by firearm, followed closely by suffocation (mostly hanging) and poisoning. All guns and other weapons should be removed from the house, or at least locked up. Other potentially harmful items such as ropes, cords, sharp knives, alcohol and other drugs, and poisons should also be removed.

2. **Ask about suicide.** Providers and parents should ask regularly about thoughts of suicide. Providers should remind parents that making these inquiries will not promote the idea of suicide.

3. **Watch for suicidal behavior.** Behaviors to watch for in children and teens include:

- expressing self-destructive thoughts
- drawing morbid or death-related pictures
- using death as a theme during play in young children
- listening to music that centers around death
- playing video games that have a self-destructive theme
- reading books or other publications that focus on death
- watching television programs that center around death
- visiting internet sites that contain death-related content
- giving away possessions

4. **Watch for signs of drinking.** If a child has depression, feels suicidal, and drinks a lot of alcohol, the person is more likely to take his or her life. Parents are usually unaware that their child is drinking. If a child is drinking, the parent will need to discuss this with their child and the clinician.

5. **Develop a suicide emergency plan.** Work with patients and parents to decide how do proceed if a child feels suicidal. It is important to be specific and provide adolescents with accurate names, phone numbers and addresses.

Information on Creating a Safety Plan: https://www.verywell.com/suicide-safety-plan-1067524

Crisis Support Services

Calgary Connect Teen	Peer support by phone, text, chat or email http://calgaryconnecteen.com/ Phone: 403-264-TEEN (8336)
Kids Help Phone	https://www.kidshelpphone.ca/teens/home/splash.aspx Phone: 1-800-668-6868
Distress Center	The Calgary Distress Center will come to you / your child when there is a crisis to assess and respond http://www.distresscentre.com/ Phone: 403-266-HELP (4357)

Alternatives to Self-Harm

→Self-Injury Outreach and Support (SIOS) http://sioutreach.org/

→Coping with Urges http://sioutreach.org/coping-and-recovery-self-injury/coping-with-urges/

→Self-Injury Recovery Research and Resources SIRRR http://www.selfinjury.bctr.cornell.edu/

→Distraction Techniques and Alternative Coping Strategies
http://www.selfinjury.bctr.cornell.edu/perch/resources/distraction-techniques-pm-5.pdf

Here are some alternatives to self-harm. This includes alternative actions as well as coping and relaxation. There are better ways to cope, find what works for you!

Self-harm is your way of dealing with feelings and difficult situations. So if you're going to stop, you need to have alternative ways of coping in place so you can respond differently when you start to feel like cutting or hurting yourself.

If you cut to express pain and intense emotions

- Paint, draw, or scribble on a big piece of paper with red ink or paint
- Express your feelings in a journal
- Compose a poem or song to say what you feel
- Write down any negative feelings and then rip the paper up
- Listen to music that expresses what you're feeling

If you cut to calm and soothe yourself

- Take a bath or hot shower
- Pet or cuddle with a dog or cat
- Wrap yourself in a warm blanket
- Massage your neck, hands, and feet
- Listen to calming music

If you cut because you feel disconnected and numb

- Call a friend (you don't have to talk about self-harm)
- Take a cold shower
- Hold an ice cube in the crook of your arm or leg
- Chew something with a very strong taste, like chili peppers, peppermint, or a grapefruit peel.
- Go online to a self-help website, chat room, or message board

If you cut to release tension or vent anger

- Exercise vigorously—run, dance, jump rope, or hit a punching bag
- Punch a cushion or mattress or scream into your pillow
- Squeeze a stress ball or squish Play-Doh or clay
- Rip something up (sheets of paper, a magazine)
- Make some noise (play an instrument, bang on pots and pans)

Substitutes for the cutting sensation

- Use a red felt tip pen to mark where you might usually cut
- Rub ice across your skin where you might usually cut
- Put rubber bands on wrists, arms, or legs and snap them instead of cutting or hitting

Source: *The Mental Health Foundation, UK*

COMMUNITY COUNSELLING SERVICES **Free or Low Cost Therapy Services**

Calgary Counselling Center
Suite 1000, 105 12 Avenue SE Phone: 403.691.5991
Intake telephone lines are open from Monday to Friday 9:00am – 4:00pm at 403-691-5991. An Intake form can be completed over the phone or online at www.calgarycounselling.com. Offer professional counseling to individuals, couples, and families. The Centre is also an educational facility for interns and residents. Group programs in certain areas are also offered. Cost: fees on a sliding scale based on annual income.

CARYA (Formerly Calgary Family Services)
www.caryacalgary.ca Main Reception Phone: 403-269-9888 Client Intake Line: 403-205-5244
Carya offers a continuum of services to actively parenting families of children ages 0-24 years and adults ages 65+. This may encompass issues around mental health, like depression and anxiety, grief and loss, trauma, attachment, relationship challenges, and isolation. Individual counselling and group programs (i.e., CONNECT, BOOST) are offered. Sliding fee scale according to gross household income, however some programs are fully funded and are free of charge to participants. Some programs/groups offered include CONNECT, BOOST (ages 13-16), In-Sync (ages 0-6 and parents play based attachment), Prime Time (ages 0-2 and parents, skill based), Urgent Family Care, Worry Warriors (ages 7-11, 12-15).

Functioning Families Together (Family Therapy)
http://caryacalgary.ca/our-programs/counselling/functional-family-therapy/

Catholic Family Services
250, 707 – 10 Avenue SW Intake: 403.233.2360 https://www.cfs-ab.org/
To provide counselling and educational outreach services to those experiencing difficulty in any area of their life. Counseling formats include: individual, marital/couples, family. Self-referral by contacting Intake. Sliding scale fees; fee will not be a barrier.

Calgary Family Therapy Program
www.familytherapy.org Phone: 403-802-1680
Offering family therapy services for families with children 18-years or younger. Professional therapists work with families whose children are experiencing emotional or behavioural problems, with the primary goal being to enable these families to develop their own methods of managing the problems more effectively. Families can self-refer, or be referred by community professionals, by phone, fax, mail, or e-mail. Required information for intake includes names, address, phone numbers and a brief description of the problems. There is no cost for this service, and wait times depend on service demands.

Eastside Family Center – Counselling
Phone: 403-299-9696 http://www.woodshomes.ca
The Eastside Family Centre offers mental health services for youth, families and individuals experiencing emotional upset that may arise from a variety of situations. Walk-in counselling services are available at no cost and no appointment is necessary. Multidisciplinary teams of professionals, including psychiatric and clinical consultation, are available. The Centre also provides no-cost, legal advice in collaboration with Calgary Legal Guidance.

Mobile Applications for Patients (self-help)

Mind Masters	MindMasters is a research based program that teaches simple and concrete techniques to help children manage stress and frustration, relax and develop a positive perspective. These skills may be incorporated into existing children's services, such as therapeutic, educational and recreational services, or used by parents at home. http://www.cheo.on.ca/en/MindMasters Mini MindMasters – (under 6) http://www.cyhneo.ca/mini-mindmasters MindMasters – (Level 1 Ages 6-9, Level 2 Ages 9-12) http://www.cyhneo.ca/mindmasters MindMasters 2 – (Ages 4-9) http://www.cyhneo.ca/mindmasters-2-dha2r
Booster Buddy	This app guides a series of daily quests designed to establish and sustain positive habits like coping skills and self-care. http://viha.ca/cyf_mental_health/boosterbuddy
Mind Your Mood	The app allows young people to record how they feel each day without drawing unwanted attention from peers. https://mindyourmind.ca/interactives/mind-your- mood
Mind Shift	App designed to help teens and young adults cope with anxiety. Teaches how to relax, develop more helpful ways of thinking, and identify active steps. https://www.anxietybc.com/resources/mindshift-app
ToDoIst	Organization in ADHD: https://en.todoist.com/
Anxiety Coach	Self-help app that addresses fears and worries using CBT strategies. https://itunes.apple.com/us/app/anxietycoach/id565943257?mt=8
Mood Kit	The skills taught include self-monitoring, identifying and changing unhealthy thought patterns, and engaging in mood-enhancing activities. https://itunes.apple.com/ca/app/moodkit-mood-improvement-tools/id427064987?mt=8
Breathe 2 Relax	A simple, intuitive app to teach breathing techniques to manage stress. https://itunes.apple.com/us/app/breathe2relax/id425720246?mt=8
Mood Tools	MoodTools is a self-help app targeting depression. It provides psychoeducation about risk factors and psychosocial approaches to treatment, a depression symptom questionnaire (PHQ-9), a thought diary, a suicide safety plan, and videos such as meditation guides. http://www.moodtools.org/
Breathing Room	BreathingRoom is an online program for youth and young adults aged 13-24, who want to learn new ways to manage symptoms stress, anxiety and depression http://breathingroom.me/

Electronic Online Resources/Modules for Youth

adapted from www.shared-care.ca

TOPIC	TITLE	CONTENT	LINK	TARGET
Anger	"Barometer" (mind your mind)	Identify anger triggers and create a plan	https://mindyourmind.ca/interactives/barometer	Teens / Older Youth
Bullying	Beat the Bully	Strategies to effectively deal with bullying	http://pbskids.org/itsmylife/games/bullies_flash.html	Children
	Bullying (E-Learning)	Understanding and tips	http://www.e-learningforkids.org/life-skills/lesson/bullying/	Ages 8-12
Depression	What To Do (E-Learning)	What it is, what to do	http://www.e-learningforkids.org/life-skills/lesson/depression/	Ages 8-12
	Mind Your Mind	Skills and crisis planning	https://mindyourmind.ca/interactives/alice-all-jacked	Teens / Older Youth
Emotions	Emotions and You	Learn and cope with emotions	http://www.e-learningforkids.org/life-skills/lesson/emotions/	Ages 8-12
General	Tree of Life (Mind your Mind)	Strengths, goals, supports, coping	https://mindyourmind.ca/interactives/tree-life	All Ages
	Quote Bloom	Inspiring quotes	https://mindyourmind.ca/interactives/quote-bloom	All Ages
Self-Esteem	Personal Identity	Images and Influences	http://www.e-learningforkids.org/life-skills/lesson/personal-id/	Ages 8-12
Social Media	ThinkUKnow	Internet Safety	https://www.thinkuknow.co.uk/	All Ages
	Not Cool	Consequences	https://thatsnotcool.com/	Teens
Stress	Squish Em	Game	https://mindyourmind.ca/interactives/squish-em	Teens
	Stress Me Less	Game	https://mindyourmind.ca/interactives/stress-me-less	All Ages

Support and Education for Families (by topic)

*** Information Prescriptions has great information, websites, and readings for families pertaining to many different areas and is organized by topic area: http://fcrc.albertahealthservices.ca/health-information/library/information-prescriptions/

ACEs	Websites: - Center for Disease Control - ACES and the ACE study http://www.cdc.gov/violenceprevention/acestudy/index.html - ACES too High https://acestoohigh.com/ Videos: - Understanding Toxic Stress and the Brain http://developingchild.harvard.edu/resources/toxic-stress-derails-healthy-development/ - Brain Architecture www.albertafamilywellness.org/resources/video/brain-architecture
ADHD	Websites: - CADDRA https://www.caddra.ca/ - ADHD Families http://adhdfamilies.ca/ - CHADD Website http://www.chadd.org/ - "My Child has been diagnosed with ADHD, now what?" from the CDC https://www.cdc.gov/ncbddd/adhd/treatment.html Books: → *"My Brain Needs Glasses"* and "*My Brain Still Needs Glasses"* by Annick Vincent → *"ADD Stole My Car Keys"* by Rick Green and Umesh Jain Videos: ADHD Child http://www.shared-care.ca/vid.aspx?y=rLghxG3mGMM ADHD Teen http://www.shared-care.ca/vid.aspx?y=rIKMo8VuC_c
Aggression	- American Academy of Child and Adolescent Psychiatry - aggression and oppositional behaviors called "A Guide for Families" http://www.aacap.org/App_Themes/AACAP/docs/resource_centers/odd/odd_resource_center_odd_guide.pdf - Practical Tips for Families: http://www.shared-care.ca/files/ODD_Education.pdf - Websites, Resources and Books for Families: http://www.shared-care.ca/files/Behaviour_Problems_Patient_website_and_books.pdf
Anxiety	- Anxiety BC Website https://www.anxietybc.com/ - CBT Guided Sessions Online http://www.llttf.com/ - Websites, Resources and Books for Families: http://www.shared-care.ca/files/Anxiety_Resources_Updated_June_2015.pdf
Depression	- CBT Self-Help - Mood Gym https://moodgym.anu.edu.au/welcome - Workbook http://www.shared-care.ca/files/Dealing_with_Depression_dwd_writable.pdf
Parenting	- Triple P Positive Parenting Program (free online course) http://www.triplep.net/glo-en/home/ - Strongest Families: Online parent coaching management program Toll-free 1-866-470-7111 http://strongestfamilies.com

Tips for Managing Child Abuse Disclosures

TEN TIPS FOR HANDLING CHILD ABUSE DISCLOSURES

1. When faced with a disclosure, community professionals may feel panic, fear, helplessness, disbelief, anger, sadness, or confusion. Initial reactions are critical to the success of a child's disclosure. Personal feelings must be set aside so that a calm, accepting manner is presented.

2. If you do not feel comfortable handling a disclosure, advise the child that the situation is so important that he/she deserves to have the best person to assist him/her. Continue to support and reassure the child as you transition the relationship to another professional in your school.

3. Ensure that discussions with the child occur in a private environment.

4. Begin any discussion with some variation of "Tell me what happened…." such as "You are crying and upset, tell me what is happening" or "You said that you don't want to go home, tell me what happened." The use of such an open ended question is critical.

5. In order to ensure that the disclosure is not contaminated for legal and court purposes, it is critical that the child do most of the talking. The more an adult speaks in the interview, the greater the contamination factor. The child should be doing most of the talking through an "*uninterrupted*" free narrative in response to your invitation to "Tell me what happened…."

6. In order to keep your participation to a minimum, encourage the child to keep talking by the use of attentive silence, vocal encouragers such as "Uh huh…, yes, alright, uh huh…."

7. Do not use any leading questions, which are questions that suggest information to the child that he/she has not volunteered, such as "Did your father hurt you?," "Were you sexually abused?" or "Are you afraid to go home?" Although you might feel you need to know that information, it is essential that the child disclose it without being prompted. Leading questions can be recognized if they can be answered with a yes/no response.

8. When these above strategies do not elicit *sufficient* disclosure, it is then appropriate to ask "And then what happened?" This question can be asked repeatedly.

9. When the disclosure has identified an incident of child abuse, no further questions should be asked. **STOP!! DO NOT PROBE FOR ANY DETAILS.** It is time now to make a child abuse referral to child welfare or the police.

10. The details of the conversation should be documented immediately upon its conclusion because recall and memories are most accurate at this time.

If you are working with children required to testify in court, please check out our Court Preparation Websites (child, adolescent, parent and facilitator) www.childcourtprep.com

CCAA information – contact us at (403) 289-8385 or aliceg@ccaa.org

facebook www.facebook.com/takingaction twitter www.twitter.com/takingaction