Paediatric Mental Health in the Primary Care Setting CME

Collected Presentation Notes and Resources

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Nanaimo Division of Family Practice
A GPSC initiative

Key Points for Assessment, Diagnosis, & Treatment for Youth with Suspected ADHD

PEARLS

1. Start with the 18 DSM-V criteria but don't forget to screen for mimics and co-morbidities
    a. sleep problems, hearing loss, trauma/anxiety, learning difficulties
2. Symptoms have to present in more than one environment - home, school, social skills
3. ADHD criteria can be normal developmental behaviours for 3-5 year olds
4. Youngster being "consistently inconsistent" a hallmark feature.
5. Hyperactivity may settle as children age
6. Response to medication DOES NOT make the diagnosis of ADHD
7. "Pills don't build skills" - environmental & behavioural strategies are equally important
8. Poor self esteem/mental health issues emerge commonly
9. Very high rate of addiction, MVA & injuries, STIs, and justice system involvement
10. Significant stigma around the diagnosis

SCREENING TOOLS

1. Quick & easy: SNAP-IV
2. Quick-ish & comprehensive: Weiss Symptom Record
3. CADDRA Teacher questionnaire

NON-PHARMACOLOGICAL TREATMENT

1. Parent Behaviour Training - eg. BCCH Rolling with ADHD, Confident Parents Thriving Kids
2. Environmental modifications at home & school - eg. CADDAC.ca
3. Cognitive Behavioural Therapy, Mindfulness, or ADHD Coaching for youth
4. Sleep hygiene, physical activity (individual better than team for some), CPS screen guidelines
5. No evidence for CBD, Gingko Biloba, St. John's Wort, L-Theanine, GABA, dietary changes

MEDICATIONS

1. Stimulants are first line, long acting preferred over short acting
2. Methylphenidate best for inattention, dextroamphetamine for kids with other disabilities
3. Stimulant side effects: loss of appetite, insomnia, increased BP, worsening of tics
4. Risk of cardiac problems very rare, ECG if personal or strong family history of arrhythmia
5. Start low and go slow, no set weight-based dosing, and higher doses are not always better.
6. Consider delivery form (granule vs pill vs powder vs chewable)

RESOURCES

1. www.oceanviewpaediatrics.com/resources -links to Rolling with ADHD, CADDRA, etc
2. Books: Driven to Distraction, Taking Charge of ADHD, Smart but Scattered

Resources:

- **BounceBackBC.ca:** skill building program to help youth age 15+ and adults with mild/mod depression/low-mood, anxiety/stress. Access 6 phone-call sessions with a coach, or complete an online/self-guided approach. Free, no wait period, no travel required. https://bouncebackbc.ca/what-is-bounceback-youth/

- **Anxietycanada.com** – specifically the My Anxiety Plan section. Provides an 8-video series on anxiety management strategies for children, youth, and adults https://maps.anxietycanada.com/en/

- **MindShift App:** CBT on your own phone/computer

- **Where You Are Podcast:** Tackling Anxiety Practical Strategies for Children and Youth. Podcast by BC Children's Hospital and Kelty Mental Health on anxiety management strategies https://keltymentalhealth.ca/podcastanxiety

- **School Anxiety and Attendance Challenges for Parents and Caregives Webinar Series**: Video series on school related anxiety and anxiety-related attendance issues. Provides practical approaches to manage this in children and teenagers. https://keltymentalhealth.ca/school-attendance-webinars

Anxiety in Children…DON'T PANIC!

When to consider:

- Separation anxiety and ****school avoidance
- Behavioural issues at home or school (avoidance, resistance, tantrums, crying, excessive question asking and need for reassurance)
- Somatic symptoms (***abdominal pain, headaches, irritability, difficulty falling asleep)
- Inattention and difficulties in the classroom
- Selective mutism
- Perfectionism, rigidity (OCD)
- Persistent/intrusive worries

What to do?

- **See in person and examine.** With somatic complaints and missed school, parents need the reassurance that there is no medical concern underlying symptoms. Ask what parent is worried about and ensure that you specifically rule this out if possible.
- Low threshold to check CBC, ferritin, TSH- esp if diet poor, somatic symptoms
- Ask about family history as Anxiety disorders are strongly heritable. Parents can often relate.
- Screening questionnaires: SCARED Q's (parent and children) https://compassbc.ca/toolkits. Scores>25 suggestive of AD, >40 more specific.
- Review basics: sleep, diet, exercise, screen time, outside physical activity (so important for mental health)
- Parent education and support: See resources below.
- CYMH for more severe cases (when children are not attending school or having panic attacks). Long wait so if parents can afford some private counselling in meantime, early CBT esp helpful in mid childhood and up (>age 7)
- SSRI Medications are often highly effective - Fluoxetine and Sertraline are approved for use in children. Start low and titrate slowly. Fluoxetine comes as liquid (4mg/ml). Start at 0.5-1ml!
- ****Referral to Pediatrician** if starting medication, severe, or complex mental health

Resources for caregivers:

- Confident Parents Thriving Kids: FREE telephone based education and coaching for parents https://welcome.cmhacptk.ca/ ***needs physician referral
- ANXIETY CANADA: https://www.anxietycanada.com/learn-about-anxiety/anxiety-in-children/
- Kelty Mental Health (BCCH resource)- lots of great tools for recognizing and managing stress in children: http://keltymentalhealth.ca/toolkits
- Podcasts: https://keltymentalhealth.ca/podcastanxiety
- Taming Worry Dragons (CBT): https://keltymentalhealth.ca/twd Parent led CBT for young children
- Apps -Stresslr: https://keltymentalhealth.ca/info/stresslr (for 9-11yr olds!) and Mindshift anxietycanada.com

Continued on reverse…

Community resources:

- School counsellors
- CDC for preschool age/Family resource navigator at CDC: https://nanaimocdc.com/family-resource-navigator/
- Check out BC counsellors (refine search by city, and play based approach): https://bc-counsellors.org/counsellors/

Primary care resources:

- Pediatricians!
- COMPASS https://compassbc.ca/toolkits or call 1-855-702-7272

Behaviour Dysregulation in Young Children

NORMAL OR PATHOLOGICAL – Parent-child and the attachment relationship contribute to the child's emotional regulation and externalized behavior.
https://cps.ca/documents/position/positive-parenting

KEY AREAS TO REVIEW -

- **Sleep** – Bedtime. Sleep onset time. Sleep duration (10-12hr/night)
    - https://cps.ca/documents/position/positive-parenting

- **Nutrition** – sugar and general processed versus whole foods. Food security. Regular meals and snacks throughout day
    - https://cps.ca/en/documents/position/nutrition-healthy-term-infants-6-to-24-months

- **Activity** – social engagement opportunities and time for gross motor play, cognitive development, and opportunities to practice emotional regulation.
    - https://cps.ca/en/documents/position/physical-activity-guidelines

- **Screens** – how much is too much. Consider rough guide of <2hr
    - https://cps.ca/en/tools-outils/digital-media-and-screen-time

RED FLAGS TO CONSIDER -

- Non-verbal/speech delay
- Repetitive behaviors/stereotypic movements
- Rigidity and intensity of emotional response
- Regression of speech or other milestones
- Substance history in utero
- Parental mental health concerns related to Infant mental health

SCREENING TOOLS -

- MCHAT (weblink)
- ASQ < 6years

See any of the local Pediatric office websites for these forms:

- redcanoepediatrics.com
- oceanviewpaediatrics.com
- thebabydoc.com

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NEXT STEPS AND RESOURCES -

1. **General online resource** covering variety of childhood mental health and behavior concerns: Kelty mental health (BC Children's Hospital). https://keltymentalhealth.ca

2. **Behavior concerns WITHOUT suspected or confirmed neurodevelopmental diversity/diagnosis:**
   - Family Resource Navigator @ CDC (Kim Howland) Cell: 250-618-5640. Email: Kimberlee@nanaimocdc.com
     - CDC provides *early intervention* up to age 6y AND *resource navigation and family support* 0-19y
     - Various parent groups are offered through CDC, and in partnership with external agencies (Parent support services society, Family support institute, Triple P)
   - Confident Parents Thriving Kids – any doctor can refer. This is intended for children *without* additional neurodiverse diagnosis. Behavior and Anxiety stream. Must be referred by physician – primary care or Pediatrics can refer. See weblink to obtain referral forms - https://welcome.cmhacptk.ca

3. **Behavior concerns WITH neurodevelopmental diversity –** These families can be seen by Kim Howland (above) or can directly contact the services below
   - "Family Support Institute" - https://familysupportbc.com. (Provincially funded by MCFD). Extensive database for resources.
     - Peer to peer Local Rep: Saima Ijaz phone sijaz@fsibc.com.
   - "Parent support services". https://www.parentsupportbc.ca – Kinship care, grandparents raising grandkids, Legal advice, aboriginal branch (in part Prov support MCFD).
     - Local contact: Sandie Halvorson. Sandie.halvorson@parentsupportbc.ca.
   - **With Autism Diagnosis** (Pending or confirmed) – see Autism BC: https://www.autismbc.ca
     - Physician (including primary care) can initiate VICAN referral if concerned about ASD: https://www.islandhealth.ca/our-services/children-youth-rehabilitation-services/vancouver-island-childrens-assessment-network

Pediatric and Adolescent Eating Disorders

What you need to know:

Medical Instability (Call Peds on Call)

Look For	Why
HR ≤ 50 bpm	Cardiac dysfunction, decr. cardiac muscle, increased risk of arrhythmias
Glucose or electrolyte abnormalities	Risk of arrhythmia, seizure
Arrhythmia or QTc >450 msec	Risk of arrhythmia, heart failure
Hypotension (<0.4% for age/sex)	Acute dehydration and vascular instability

** A patient can have a normal BMI and still be medically at risk
** Most children will have normal labs - this DOES NOT exclude medical compromise

High Risk (i.e. Call Peds on Call or BCCH Adolescent Medicine on call 604-875-2161)

Wt loss >25% of premorbid wt OR <75% of median BMI for age and sex (i.e patient BMI/50%ile BMI x100)

Typical presenting complaints:

Unexplained weight loss	Cold-intolerance	Hair loss	Lab abnormalities including low-normal WBC, anemia
Constipation and abdo pain	Early satiety	Poor energy	
Amenorrhea	Dizziness/fainting spells	Anxiety/depression	

Clues to disordered eating:

Sudden change to vegan diet	Abnormally long time to complete meals
Sudden obsession with being "healthy" including cutting out carbs, fats, oils, sugar, dairy	Persistent exercising despite being sick, feeling unwell, lacking energy
Cutting food into small pieces, obsessive food rules, refusal to eat in front of people	Going to bathroom directly after eating
Obsession with food (food shows, baking, etc), serving others but not eating food themselves	Baggy sweaters, warm clothes out of keeping with environmental temperature

…continued on reverse

Treatment - best evidence is Family Based Therapy

Phase 1 - rapid weight restoration (heavy focus on parents - responsible for all meal preparation, planning, observation at EVERY meal and snack), focus on 3 meals/3 snacks/day (parents may need time off work)

Phase 2 - gradual return of feeding responsibility to child/adolescent as age appropriate

Phase 3 - focus on normalization of adolescent milestones

While waiting for further assessment/treatment:

1. Ask parents to be present for every meal/snack possible (provide resources below)
2. Completely stop or significantly decrease physical activity if patient unable to meet metabolic needs
3. Lab investigations CBC, lytes, BUN, Cr, glucose, Mg, PO4, Ca, Zinc, CK, 25-OH Vitamin D, CRP, TSH, anti-TTG, LH, FSH, estradiol and testosterone (as appropriate); ECG
4. Remove weight scales from home
5. Follow-up patient closely if medical symptoms present - medical instability can happen quickly and without warning. Aim for 0.2-0.5 kg/week weight gain as outpatient

Key Resources for Parents and Caregivers:

1. Kelty Eating Disorders Website (www.keltyeatingdisorders.ca)
2. CHEO Eating Disorder modules for parents and caregivers (www.canped.ca)
3. Kelty Meal Support Video: www.youtu.be/pPSLdUUITWE (How to teach parents to feed their child)
4. Book: Help your Teenager Beat an Eating Disorder by James Lock and Daniel Le Grange

Resources for Providers:

- Primary Care Toolkit (43 pages)
  - http://www.phsa.ca/transcarebc/Documents/HealthProf/Primary-Care-Toolkit.pdf
- UBC CPD Webinar https://ubccpd.ca/learn/learning-activities/course?eventtemplate=101-genderaffirming-primary-care
- Trans Care BC's Clinical Mentorship Call qThursday at 1210h – email trans.edu@phsa.ca
- *The Transgender Child: A handbook for families and professionals* By Brill and Pepper
- For support staff (26pages) : https://www.lgbthealtheducation.org/wp-content/uploads/2016/12/Affirmative-Care-for-Transgender-and-Gender-Non-conforming-People-Best-Practices-for-Front-line-Health-Care-Staff.pdf
- RACE line – "transgender care" option: 1-877-696-2131

Presentation Tips

- Worsens around puberty
- Comorbidities: Autism, suicidality, depression, decreased "wellness"
- Treatment may include guidance around safe chest binding, genital tucking, hormones, surgery
- Hormonal treatment may involve: menstrual suppression (IUD, OCP), Lupron, estrogen or testosterone therapy
- Treat mental health, support family

Referrals

- Consider pediatric referral for prepubertal or older child with multiple other issues (mental or physical health)
- If patient or family keen to pursue further, consider referral to local pediatrician or if family CERTAIN they want to review hormones, refer to either BCCH or Dr Sue Stock:
  - BCCH Gender Clinic:
    - http://www.bcchildrens.ca/health-professionals/refer-a-patient/gender-referral
    - 3 step process: Intake with nurse and SW, Hormone readiness assessment with mental health worker (you can get list from them for local providers), Hormone treatment consultation with endocrinologist
    - NOTE: No counselling available at BCCH Gender clinic
  - Dr Sue Stock – Pediatric Endocrinologist travels to Nanaimo - Fax: 604-980-8393
    - Labs before: fasting lipids, insulin, glucose, HbA1C, AST, ALT, LH, FSH, testosterone, estradiol, CBC, ferritin, 25OH vit D
- Urgent Referrals: peri-pubertal, Tanner 2
- Counselling
  - Local hormone readiness assessments:
    - Joanne Saraceno (RCC –Nanaimo: phone: 250-816-0924)
    - Joanna Morrison (RCC – Victoria and Nanaimo: phone: 250-816-4716)
    - Dr Magali Brulot (Psychologist - Victoria) phone: 250-888-5645
    - Dr Mazaheri (GP – Courtenay – will see kids) fax: 250-338-0605
  - https://www.psychologytoday.com/ca/therapists/transgender/bc/nanaimo
  - https://www.uvic.ca/research/transchair/contact/resources/index.php#mid2

Resources for Transgender Children, Youth and Families

For Youth

- Nanaimo Family Life Programs: Gender Journeys (Support Group and Outreach work)
  - https://www.nflabc.org/programs/gender-journeys/
- Emotional Vitality and Happiness for Transgender Adolescents and Adults
  - email for zoom link – cpstasiuk@gmail.com
- Nanaimo Generation Q Program: group youth aged 13-18 at Southside Teen Centre – Thursdays
  - generationqinfo@gmail.com / 250-754-3215

For Families

- Pathways: In Resources search "Transgender" in ALL DIVISIONS- BC Children's Hospital
  - http://www.cw.bc.ca/library/pdf/ResourceLists/TransgenderBiblio.pdf
- Transhealth – Parents and Children / Youth sections
  - http://transhealth.phsa.ca/support/families/parents-and-caregivers
  - http://transhealth.phsa.ca/support/children-youth
- School supports:
  - http://transhealth.phsa.ca/for-service-providers-2/schools
  - http://bctf.ca/socialjustice.aspx?id=17990 – BCTF resource for teachers on how to educate about LGTBQ+ and support students
- Family Acceptance Project: from California, helpful videos
  - http://familyproject.sfsu.edu/

Key points: (From 2018 BC Adolescent Health Survey – Central Island Results)

- Alcohol still the most used substance in Central Vancouver Island, 52% of youth had tried alcohol (vs. 44% provincially). 22% tired alcohol before they were 13 years old. Canadian Low Risk Drinking Guidelines suggest not exceeding two drinks on any one occasion. However, among those who had tried alcohol, 29% of local students had more than two drinks at least once in the week before taking the survey, and 4% did so on at least three days that week.
- Where Central Vancouver Island youth got alcohol the last time (among those who had tried alcohol) Adult gave it to me 41% At a party 32% Gave someone money to buy it for me 27% Youth gave it to me 15% Took it without permission 13% Bought it 7%
- 26% Vape with nicotine
- The 2018 BC AHS was completed a month before marijuana was legalized for adults in Canada. A third (33%) of youth in Central Vancouver Island had ever used marijuana, with no gender differences.
- Central Vancouver Island youth who had used substances other than alcohol or marijuana Prescription pills without a doctor's consent 10% Mushrooms 7% More of my own prescription than prescribed 6% Ecstasy/MDMA 3% Hallucinogens (excluding mushrooms, ecstasy/MDMA and ketamine) 3% Cocaine 3% Inhalants 2% Amphetamines (excluding ecstasy/MDMA and crystal meth) 1% Crystal meth <2% Heroin <2%
- BC coroner data. Illicit Drug Toxicity Deaths by Age Group,
  - 2020: <19 years: 18 19-29 years: 307
  - 2021(Up to Sep 30 2021) <19 years: 22 19-29 years: 213

Favourite Tools:
HEADSS Interview
The CRAFFT Interview (version 2.1) (ATTACHED)

Favourite medication for opioid use:
Suboxone is first line for opioid use (any FP can prescribe, no "exemption" needed) (don't forget plan G!).
Sublocade (one a month SC injection, needs special authority and not always approved in youth)

Initial workup (recommended, but keep in mind this can be a live saving intervention and so I wouldn't wait to start unless history of severe liver disease.)
CBC, Electrolytes, Renal, Liver, pregnancy test, urine drug screen, Hep A/B/C serology, HIV
Caution with alcohol and benzodiazepines (but note high contamination of benzo in heroin/fentanyl supply)

Micro induction well tolerated, no need to obtain withdrawal to start. (…continued on reverse)

Day	Buprenorphine/Naloxone	
1	0.5mg BID	
2	1mg BID	
3	2mg BID	
4	3mg BID	
5	4mgBID	
6	4mg TID	

7	12mg Once Daily	Stop Other Opioids
8	Titrate to symptoms up to 24mg (Up to 32mg US dosing)	

BLISTER PACK. If support can give full week, if concern can do 3 days at a time. First dose recommend witnessed ingestion at pharmacy as sublingual and needs to fully dissolve (education)
Counselling and treatment options for youth and families:

Discovery Youth and Family Substance Use Services (Island Health)

- Counselling for youth (12-19) and their families and referral to higher levels of care (withdrawal management / supportive recovery residential resources)
- **Physicians encouraged to call central island Intake Counsellor for all referrals or for service consultation: 250 739 5790**
- Service is family centered and endeavours to engage with parents and caregivers if possible
- Referral by phone or form (see website)
- New enhance concurrent service (2022)
- Access to Psychiatry consultation (CICAPP)
- Discovery provides counselling support to Wellness Centers at Barsby and NAC

Discovery Youth & Family Substance Use Services (Island Health)
https://www.islandhealth.ca/our-services/youth-family-substance-use-services/youth-family-substance-use-services/discovery-youth-family-substance-use-services

Discovery Youth & Family Substance Use Services brochure
https://www.islandhealth.ca/sites/default/files/children-youth-family/cyf-mhsu/documents/yfsus-brochure.pdf

Discovery Youth & Family Substance Use Services Organization List
https://www.islandhealth.ca/sites/default/files/children-youth-family/cyf-mhsu/documents/yfsus-org-list.pdf

https://foundrybc.ca/virtual/

Family Physician resources:

RACE APP
COMPASS https://compassbc.ca/toolkits or call 1-855-702-7272
24/7 Addiction Medicine Clinician Support Line
& speak to an Addiction Medicine Specialist, call 778-945-7619.

The CRAFFT Interview (version 2.1)

To be verbally administered by the clinician

Begin: *"I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."*

Part A

During the PAST 12 MONTHS, on how many days did you:

1.	Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Say "0" if none.	☐ # of days
2.	Use any **marijuana** (cannabis, weed, oil, wax, or hash by smoking, vaping, dabbing, or in edibles) or "**synthetic marijuana**" (like "K2," "Spice")? Say "0" if none.	☐ # of days
3.	Use **anything else to get high** (like other illegal drugs, pills, prescription or over-the-counter medications, and things that you sniff, huff, vape, or inject)? Say "0" if none.	☐ # of days

Did the patient answer "0" for all questions in Part A?

Yes ☐ → **Ask 1st question only in Part B, then STOP**

No ☐ → **Ask all 6 questions in Part B**

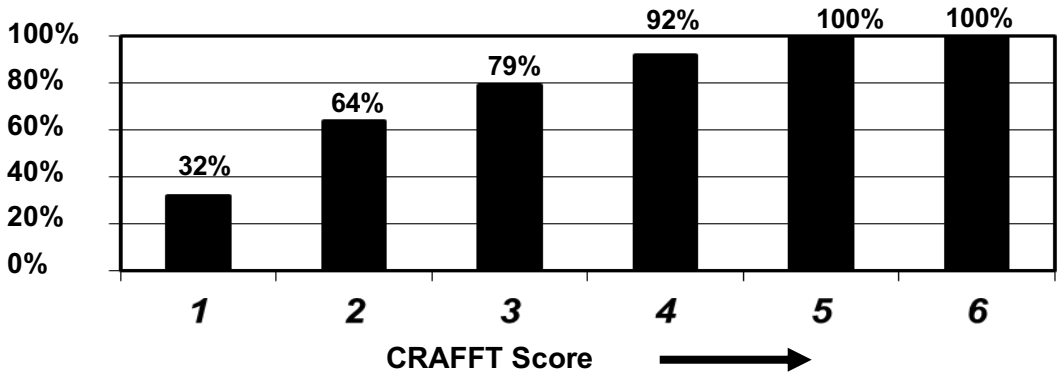
Part B

		Circle one	
C	Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	**No**	**Yes**
R	Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	**No**	**Yes**
A	Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	**No**	**Yes**
F	Do you ever **FORGET** things you did while using alcohol or drugs?	**No**	**Yes**
F	Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	**No**	**Yes**
T	Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	**No**	**Yes**

***Two or more YES answers in Part B suggests a serious problem that needs further assessment. See back for further instructions** →

CRAFFT Score Interpretation

Probability of a DSM-5 Substance Use Disorder by CRAFFT score*



*Data source: Mitchell SG, Kelly SM, Gryczynski J, Myers CP, O'Grady KE, Kirk AS, & Schwartz RP. (2014). The CRAFFT cut-points and DSM-5 criteria for alcohol and other drugs: a reevaluation and reexamination. Substance Abuse, 35(4), 376–80.

Use the 5 R's talking points for brief counseling.

1. **REVIEW** screening results
   For each "yes" response: *"Can you tell me more about that?"*

2. **RECOMMEND** not to use
   "As your doctor (nurse/health care provider), my recommendation is not to use any alcohol, marijuana or other drug because they can: 1) Harm your developing brain; 2) Interfere with learning and memory, and 3) Put you in embarrassing or dangerous situations."

3. **RIDING/DRIVING** risk counseling
   "Motor vehicle crashes are the leading cause of death for young people. I give all my patients the Contract for Life. Please take it home and discuss it with your parents/guardians to create a plan for safe rides home."

4. **RESPONSE** elicit self-motivational statements
   Non-users: *"If someone asked you why you don't drink or use drugs, what would you say?"* Users: *"What would be some of the benefits of not using?"*

5. **REINFORCE** self-efficacy
   "I believe you have what it takes to keep alcohol and drugs from getting in the way of achieving your goals."

Give patient Contract for Life. Available at www.crafft.org/contract

crafft@childrens.harvard.edu www.crafft.org

For more information and versions in other languages, see www.crafft.org.

Crisis Resources*:

24/7 Phone lines
- 1-800-SUICIDE (Nationwide)
- 1-800-494-3888 (Vancouver Island Crisis Centre)
- 1-800-668-6868 (Kids Helpline)

SMS TEXT FROM 6:00PM-10:00PM
- 1-250-800-3806 (Vancouver Island Crisis Centre)

KUU-US Crisis Line Society 1-800-588-8717
- KUU-US Crisis Line Society works and operates on the unceded territory of Tseshaht and Hupacasath providing support to callers within the Port Alberni area, as well as Indigenous people throughout the province of British Columbia

In-person Walk in Counselling 10:00AM-6:00PM Monday-Friday
- Nanaimo at Brooks Landing, located at 203-2000 Island Hwy North, Nanaimo (250-739-5710)
- Parkville's Oceanside Health Centre, located at 489 Alberni Hwy, Parksville (250-951-0550)

***If you or someone you know is in imminent danger, go to your nearest hospital or call 9-1-1**

Self-Harm Web Based Resources:
- Foundry Online https://foundrybc.ca/resource/self-injury/
- Self-Injury Outreach and Support http://sioutreach.org/
- Non-Suicidal Self Injury in Youth https://insync-group.ca/
- Here to Help https://www.heretohelp.bc.ca/visions/young-people-self-injury-vol13
- 'Calm Harm' – PHONE APP – Provides tasks to help you resist or manage the urge to self-harm.

Why is it important? Canada's 2nd leading cause of death for ages 15-34.

Definitions
Suicidal ideation – wishes, plans, consequences
Self-harm – all nonfatal acts (then define motive, suicidal intent, lethality); cutting is part of a continuum sometimes linked with suicide death; one-year adolescent prevalence=6%
"A history of self-harm is one of the most powerful and clinically relevant predictors of eventual suicide"- Rutter, 6th ed

Risk factors (same for the past 50 years)
Genetic FH of suicidal behaviour increases risk of suicide death. Inherited risk shown in twin studies. Hemingway family.
Demographic - Age 12-15: rapid increase of self-harm in early teenage years; Inuit, First Nations, Métis; Black/Hispanic (US Data) LGBTQ, low SES
Biological – poor physical health; Females attempt more, males die more (except China, possibly India).
Psychological – hopelessness, black-and-white thinking, negative bias, external locus of control, defeated, trapped, burden; impulsive versus planned
Psychiatric – depressive, bipolar, anxiety, psychotic, substance use, eating, adjustment, ADHD, and conduct disorders, previous attempt
Social – Family low levels of attachment, communication and caring; childhood physical/sexual abuse, incl. increased risk of attempts in offspring of parents who were sexually abused as children; exposure via peer group; (cyber)bullying; racism/racial discrimination, lack of behavioural health care
Environmental – stressful life events (loss/death, rejection, breakup); school dropout, acute intoxication; media – sensationalizing; internet communities; access to means
Warning signs – notes, saying goodbye, giving things away, means seeking, no reason to live
Protective Factors – future orientation, relationships, religious beliefs, behavioural health care access, life skills, self-esteem

Assessment
Risk quantification is next to impossible, so the goal is risk assessment and management.
Establish an interactive, dynamic relationship to respond to distress and offer hope for the future.
Uncertain? – seek more input.
Mitigate modifiable risks: Immediate safety – Form 4, inpatient? Reduce access to methods.
Safety planning: understand triggers, warning signs, distraction, soothing, hotlines/text, role of responsible adults
Risk assessment and safety plan vs. safety contract
There is little empirical evidence to support the use of safety contracts. Further, they confer little to no medicolegal protection. Nothing replaces a risk assessment and engaging the patient and caregivers in planning for safety, to mitigate modifiable risk factors.
https://pubmed.ncbi.nlm.nih.gov/19767501/ https://pubmed.ncbi.nlm.nih.gov/28142085/
https://pubmed.ncbi.nlm.nih.gov/24847995/
Measures: Low base rates make for low PPV and NPV values for all rating scales (including the BHS). In general they are *not an alternative to psychosocial assessment*. Evidence indicates that commonly used instruments may cause harm.

Treatment- treat underlying psychiatric disorder esp mood disorder, psychosis, substance use. Family therapy, individual/group therapy, CBT, DBT.

…continued on reverse

ASSESSMENT OF SUICIDE AND RISK INVENTORY

THIS INVENTORY IS FOR DOCUMENTATION PURPOSES ONLY

Suicide risk assessment may be performed by many methods, including patient & collateral interviews, review of documentation, and the use of standardized screening tools.

PATIENT IDENTIFICATION

SCREENING FOR SUICIDE

A simple, three-step method to screen for suicidal thinking can be naturally applied in a caring and considerate way:

1. *"Have you felt that you are under a lot of stress lately?"* (You can ask any question about stress)
2. *"Have you felt that life is not worth living?"* (The important concept here is hopelessness)
3. *"In the past month, have you considered suicide?"* (Pointed question about suicide behaviour)

EVIDENCE-INFORMED **CHRONIC RISK FACTORS**

These are suicide risk factors that are not changeable and will likely remain throughout the lifespan of the person.

History of Suicide Attempt**:** *A* **major suicide attempt** in which life was threatened or non-intervention would have resulted in death.

Prior History of Suicidal Thinking or Behaviour**:** Suicidal behaviours of **low lethality**, parasuicide, utterances, writings, etc.

History of Psychotic / Major Affective Disorder: Major Depressive Disorder, Bipolar Disorder, Schizophrenia, Prodromal Psychosis, etc.

History of Aggression**:** Prior aggressive acts directed at self, harming others; history of bullying behaviours, etc.

Ethnic or Cultural Risk Group**: Aboriginal Peoples** (reserve/isolated), **Gay/Lesbian/Bisexual/Transgendered**, **Street Youth Culture**.

Chronic Illness with Severe Pain or Disability**:** Any chronic (or likely to be chronic) illness with significant impact on daily functioning.

Family History of Mental Health Disorder**:** Any mental health disorder identified in family members, "Unknown but suspected" is included.

Family History of Suicide**:** Any completed/attempted suicides or unexplained suspicious deaths in the family.

History of Parental or Sibling Loss**:** A death or traumatic loss of a parent/primary caregiver or sibling/habituated relative.

History of Trauma, Abuse, or Neglect**:** Accidental trauma, intentional abuse (physical, sexual, emotional, verbal), neglect, **and bullying**.

History of Frequent Change of Address**:** More than 5 major moves or changes of address before adolescence.

EVIDENCE-INFORMED **ACUTE RISK FACTORS**

These are suicide risk factors that are able to change and only exist during certain times for, or states of, the person.

Recent Suicidal Thinking or Behaviour**:** A current presentation of suicidal thinking or behaviours. **This must represent a recent change**. Chronic self-injury that has not changed in quality, even if recent, should not be included as an acute risk factor.

Active Suicidal Ideation**:** Active is defined as having a "formed method, time, or location" in the ideation. Not passive (abstract) ideation.

Accessibility to Suicidal Means**:** Has a realistic opportunity to acquire the suspected means of suicide. **Check if any access to firearms.**

Lethality of Suicidal Plan or Attempt**:** The suicidal planning or behaviours exhibited carry a **high chance of lethality**.

Current Psychiatric Illness**:** An ongoing mental illness that causes impairment in occupational, social, educational, or familial function.

Current Substance Misuse**:** Any ongoing use or current intoxication by alcohol or illicit substances.

No Compliance or Response to Treatment**:** Current treatments are not mitigating the symptoms of mental illness, even if compliant.

Impulsivity**:** Impatience, acting without forethought, difficulties planning or prioritizing, or unpredictable behaviour.

Hopelessness: Despair that the future will not get better, or that there is no reason to continue living. Severe negative thinking about the future.

High Anxiety/Agitation on Interview**:** Any demonstrated or suspected anxiety or agitation that significantly impacts the interview process.

Recent Loss or Major Life Change**:** Include deaths, separations, major relocations, relationship losses, educational transitions, etc.

Lack of Social Supports**:** Significant loss or lack of peer supports or opportunities to develop relationships with peers.

Lack of Professional Supports**:** Limited or no access to physicians, counsellors, social workers, community resources, etc.

Caregiver Unavailable or Inappropriate**:** A primary or attached caregiver is unavailable or inappropriate to provide care.

EXAMPLES OF "OTHER RISK FACTORS" (EVIDENCE INFORMED)

severe hopelessness	**command hallucinations**	**declining school performance**
suicide pacts / groups	**copycat suicidal behaviour**	**increasing withdrawal from peers**

EXAMPLES OF "PROTECTIVE RISK FACTORS" (EVIDENCE INFORMED)

supportive family network	**oriented to the future**	**excellent therapeutic rapport**
pertinent negatives	**secondary gain for suicidal behaviour**	**good problem-solving skills**
strong positive cultural identity	**personal success**	**effective established treatments**

ASSESSMENT OF SUICIDE AND RISK INVENTORY

THIS INVENTORY IS FOR DOCUMENTATION PURPOSES ONLY

Suicide risk assessment may be performed by many methods, including patient & collateral interviews, review of documentation, and the use of standardized screening tools.

PATIENT IDENTIFICATION

SCREENING QUESTION **O DENIES SUICIDAL THINKING** **O ENDORSES SUICIDAL THINKING**

SEE REVERSE for an example of a screening pathway. An example screening question could be, "In the past month, have you considered suicide?"

Collateral Sources

CHRONIC RISK FACTORS	
Suicide Specific	
Prior Suicide Attempt	O
History of Suicidal Thinking or Behaviour	O
Patient Related	
History of Psychotic or Major Affective Disorder	O
Male Sex	O
History of Aggression	O
Ethnic or Cultural Risk Group	O
Chronic Illness Causing Severe Pain or Disability	O
System Related	
Family History of Mental Health Disorder	O
Family History of Suicide	O
History of Parental or Sibling Loss	O
History of Trauma, Abuse, Neglect	O
History of Frequent Change of Address	O

ACUTE RISK FACTORS	
Suicide Specific	
Recent Suicidal Thinking or Behaviour	O
Active Suicidal Ideation	O
Accessibility to Suicidal Means	O
Lethality of Suicidal Plan or Attempt	O
Patient Related	
High Anxiety / Agitation on Interview	O
Current Psychiatric Illness	O
Current Substance Misuse	O
No Compliance or Response to Treatment	O
Impulsivity	O
Hopelessness	O
System Related	
Recent Loss or Major Life Change	O
Lack of Social Supports	O
Lack of Professional Supports	O
Caregiver Unavailable or Inappropriate	O

Acuity Assessment of Suicide Risk

O N/A **O CHRONIC** **O CHRONIC with ACUTE Exacerbation** **O ACUTE**

Suicide Risk Assessment Rationale *(should also include protective or other factors used in assessing risk)*

Subjective assessment of Suicide Risk *(Based upon above and other sources, rate the subjective sense of suicide risk)*

O LOW **O MODERATE** **O HIGH**

Treatment/Interventions O No specific interventions recommended as risk felt to be baseline / low

O Admit to hospital unit:
O Consultation:
O Notification:
O Discussed safety planning
O Discussed removing lethal means

Follow-Up

Completed By **Signature** **Date** DD MM YY

Additional Central Island Resources

MENTAL HEALTH		
Child and Youth Mental Health (CYMH), Ministry of Children and Family Development AND **Aboriginal Child and Youth Mental Health (ACYMH), Ministry of Children and Family Development**	Support children and youth (0-18) experiencing significant difficulties related to their thoughts, feelings and behaviours. Call for intake	488 Albert St, Nanaimo, BC V9R 2V7 250-741-5701
SUBSTANCE USE		
Discovery Youth & Family Substance Use Services Island Health	Free community-based counselling services and access to residential care and treatment for youth ages 13-19. Available to anyone in the community directly or indirectly impacted by substance use.	Multiple Locations on Central Island 250-739-5790 discovery@viha.ca.
GENERAL		
COMPASS	Phone and web-based consultation. Supports community care providers with information, advice and resources needed to deliver appropriate and timely care to children and youth with mental health and substance use concerns.	BC Children's Hospital 1-855-702-7272
Walk-in Crisis Counselling Clinic Brooks Landing Island Health	Crisis response, counselling, and emergency services. Mental health and substance use services for all age groups.	#203 - 2000 Island Hwy, Nanaimo, B.C. 250-739-5710
Nanaimo Family Life Association	Offer both individual and group counselling to youth. Call for intake	1070 Townsite Road Nanaimo, BC 250-754-3331 https://www.nflabc.org

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Additional Central Island Resources

NARSF (Nanaimo and Area Resource Services for Families)	NARSF Programs Ltd. provides a range of health, harm-reduction, and counseling services to individuals, children, youth and families. Programs: Eating disorder, sexual abuse intervention, Living in Families with Teens, and Transitions detox.	#201-170 Wallace Street Nanaimo, BC V9R 5B1 250-754-2773 Email: admin@narsf.org http://www.narsf.org
Nanaimo Community Hospice	Children, youth and family counselling for bereavement/terminal illness.	250-591-8811
Rainbows Nanaimo – Grief Counseling	Provides support to children, teens and their parents as they grieve and deal with changes in family life. Small groups. Call for intake	Phone: 250-751-7888 rainbowsnanaimo@gmail.com Facebook: Rainbows Nanaimo
Nanaimo Family Life Association	Offer both individual and group counselling to youth. Call for intake	1070 Townsite Road Nanaimo, BC 250-754-3331 https://www.nflabc.org
Tillicum Lelum Aboriginal Friendship Center	Programs, services, and counseling for children, families, and adults.	602 Haliburton St, Nanaimo, BC Phone: (250) 753-6578 http://www.tillicumlelum.ca
LGBTQ2S+ Supports	LGBTQ2 Group: Boys and Girls Club. Generation Q. Youth Support group. QMUNITY BC's Queer, Trans, and Two Spirited Resource Center	250-754-3215 x1 250-713-5787 https://qmunity.ca/

Compiled by Miranda Bradley (Social Worker, CICAPP clinic) and Sharon Fitzgerald (Acting Program Coordinator, Child, Youth and Family Mental Health Acute Care, Island Health)