Module 11

Adult and Paediatric Acute and Chronic Behavioural Health and Addictions assessment, Behavioural Health Emergencies, Sexual Assault, and Child abuse and neglect.

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CANADIAN HEALTH CARE AGENCY

EXPERIENCE THE NORTH

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Part 1: Introduction

- Behavioural Health Assessment
- Common Behavioural Health, Psychiatric and Related Problems
  - Anxiety Disorders
  - Mood Disorders
  - Psychotic Disorders
  - Family Violence
  - Substance Misuse and Additions

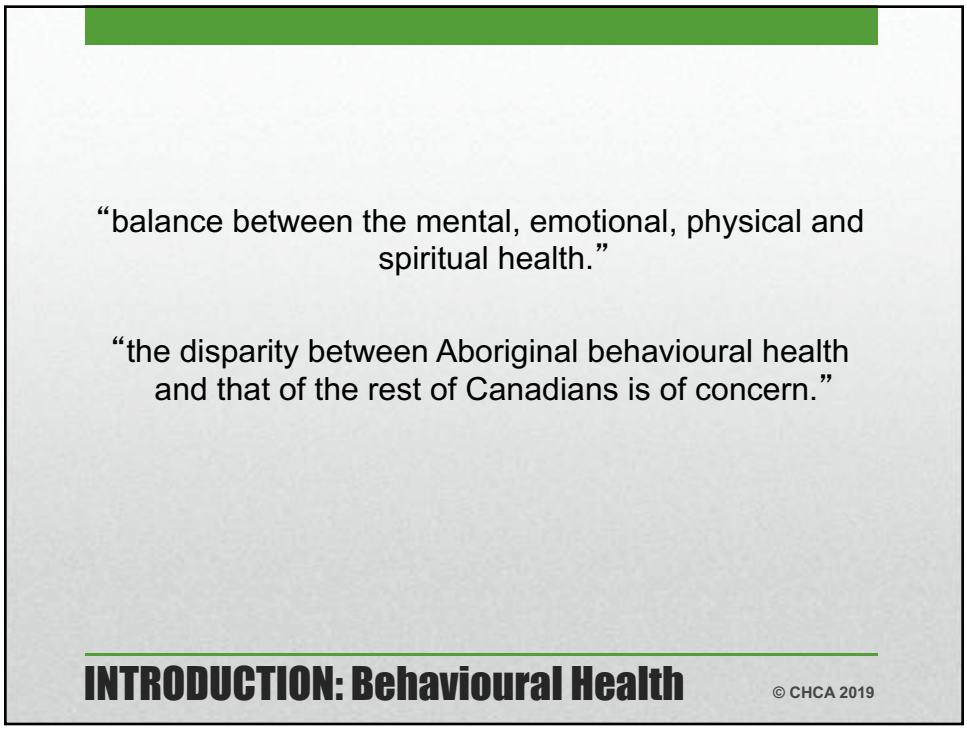
Part 2: Behavioural Health Emergencies

- Alcohol Withdrawal and Delirium
- Cognitive Impairment
- Sexual Assault
- Child Abuse and Neglect

Suicide will be covered in the next module

Outline

2


"balance between the mental, emotional, physical and spiritual health."
"the disparity between Aboriginal behavioural health and that of the rest of Canadians is of concern."
INTRODUCTION: Behavioural Health
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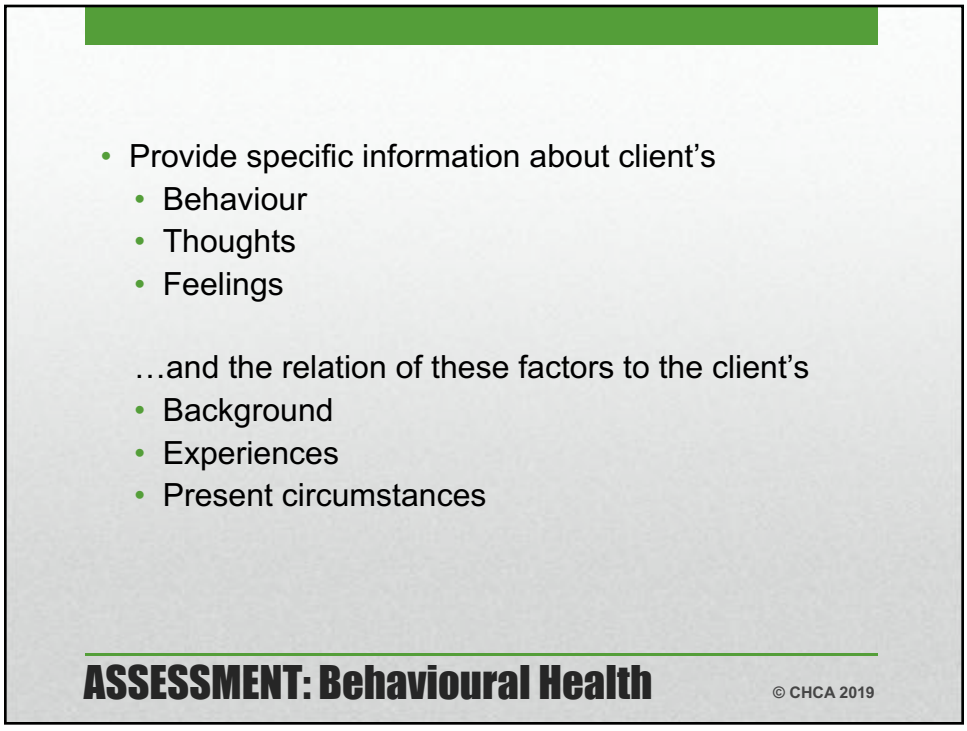
• Provide specific information about client's
• Behaviour
• Thoughts
• Feelings
…and the relation of these factors to the client's
• Background
• Experiences
• Present circumstances
ASSESSMENT: Behavioural Health
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BATHE

- **B**ackground: "what is happening in your life?"
- **A**ffect: "how do you feel about the situation?"
- **T**rouble: "what worries you the most?"
- **H**andling: "what resources do you have?"
- **E**mpathy: "your response is reasonable."

ASSESSMENT: Behavioural Health

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HISTORY

- General description
- History of presenting problem
  - Chief concern
  - Difficulties or changes
  - Increased feelings
  - Somatic changes
  - Integrative patterns/client's perception
- Relevant History

ASSESSMENT: Behavioural Health

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MENTAL STATUS EXAMINATION (MSE)

- Appearance
- Behaviour
- Speech
- Mood and Affect
- Thought processes
- Thought content
- Perception
- Cognition
- Insight and Judgment

ASSESSMENT: Behavioural Health

7

- Make a provisional diagnosis
- Determine need for emergency actions
  - Homicidal or violent impulses
  - Potential suicide
  - Inability to function independently
  - Acute psychotic symptoms
  - Delirium

"treatment goals should be identified and driven by clients."

ASSESSMENT: Behavioural Health

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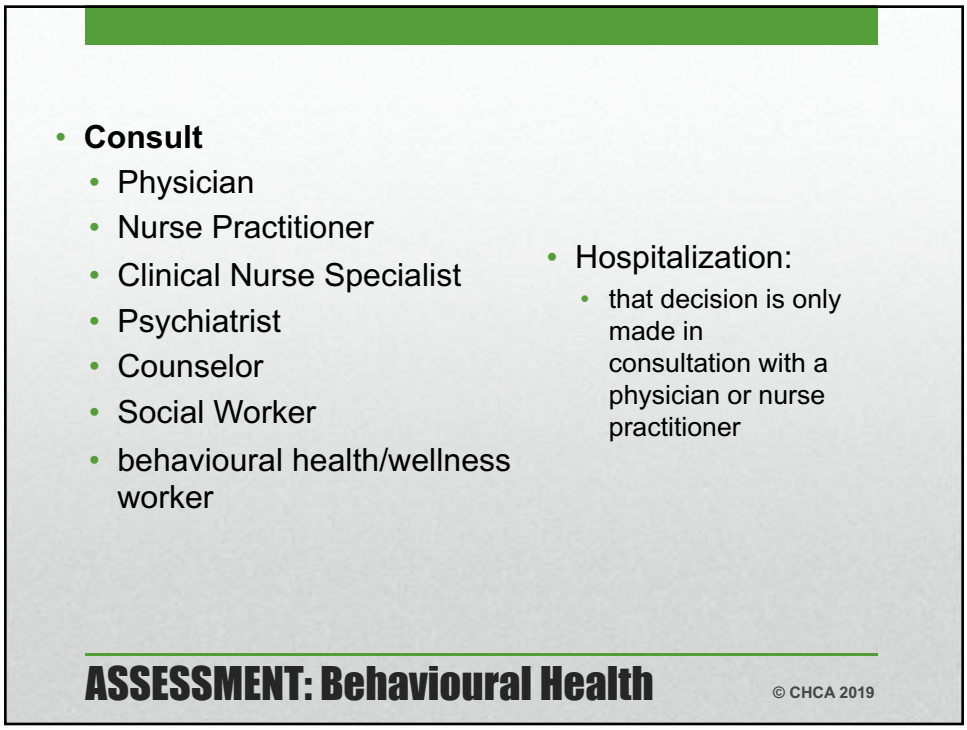
• Consult
• Physician
• Nurse Practitioner
• Clinical Nurse Specialist
• Psychiatrist
• Counselor
• Social Worker
• behavioural health/wellness worker
• Hospitalization:
• that decision is only made in consultation with a physician or nurse practitioner
ASSESSMENT: Behavioural Health
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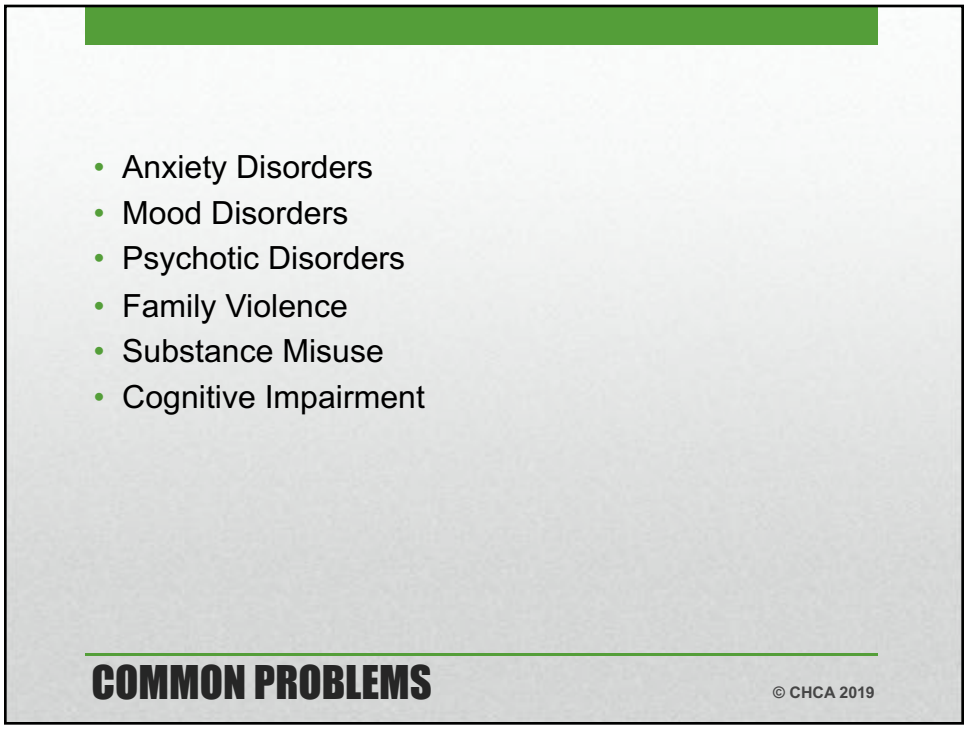
• Anxiety Disorders
• Mood Disorders
• Psychotic Disorders
• Family Violence
• Substance Misuse
• Cognitive Impairment
COMMON PROBLEMS
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- Generalized anxiety disorder
- Obsessive compulsive disorder
- Panic disorder
- Post-traumatic stress disorder
- Social anxiety disorder
- Specific phobias

"…symptoms that persist, are of a greater intensity than expected, and impair daily functioning…"

Anxiety Disorders

11

Risk Factors

- Family history of mental illness
- Personal history of childhood anxiety
- Stressful or traumatic event
- Female
- Comorbid psychiatric disorder

History

- BATHE
- GAD-7 Questionnaire
- Review symptoms
- Use of stimulants
- Use of substances
- Review medications
- ROS
- Other sources?

Anxiety Disorders

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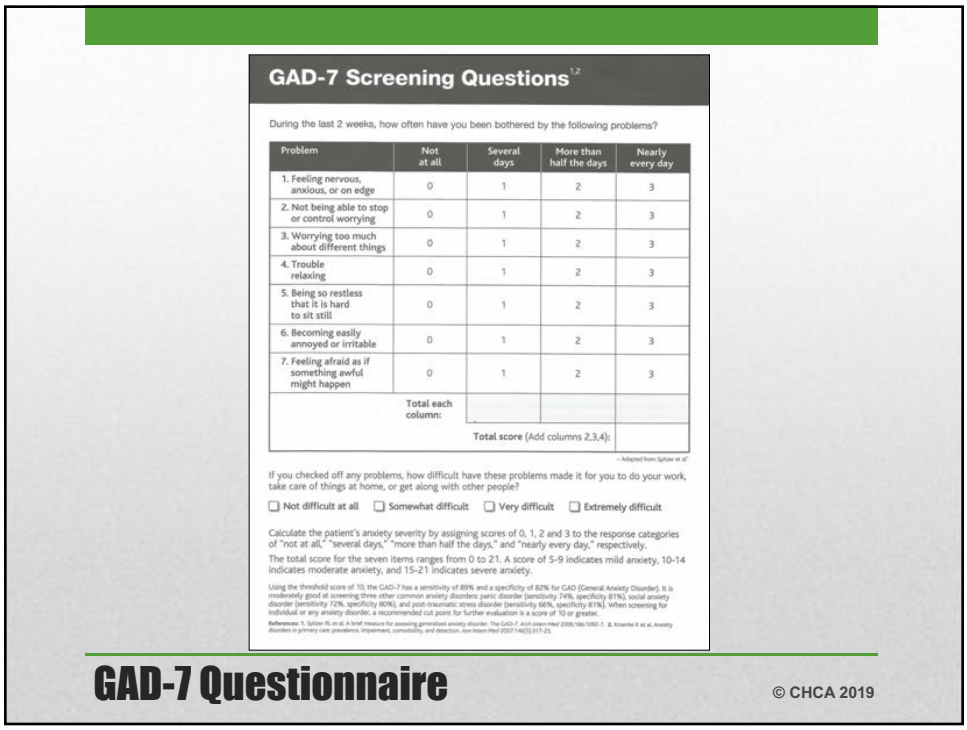
GAD-7 Screening Questions
During the last 2 weeks, how often have you been bothered by the following problems?
Problem
Not at all
Several days
More than half the days
Nearly every day
1. Feeling nervous, anxious, or on edge
2. Not being able to stop or control worrying
3. Worrying too much about different things
4. Trouble relaxing
5. Being so restless that it is hard to sit still
6. Becoming easily annoyed or irritable
7. Feeling afraid as if something awful might happen
Total each column:
Total score (Add columns 2,3,4):
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
Not difficult at all
Somewhat difficult
Very difficult
Extremely difficult
Calculate the patient's anxiety severity by assigning scores of 0, 1, 2 and 3 to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively.
The total score for the seven items ranges from 0 to 21. A score of 5-9 indicates mild anxiety, 10-14 indicates moderate anxiety, and 15-21 indicates severe anxiety.
GAD-7 Questionnaire
© CHCA 2019

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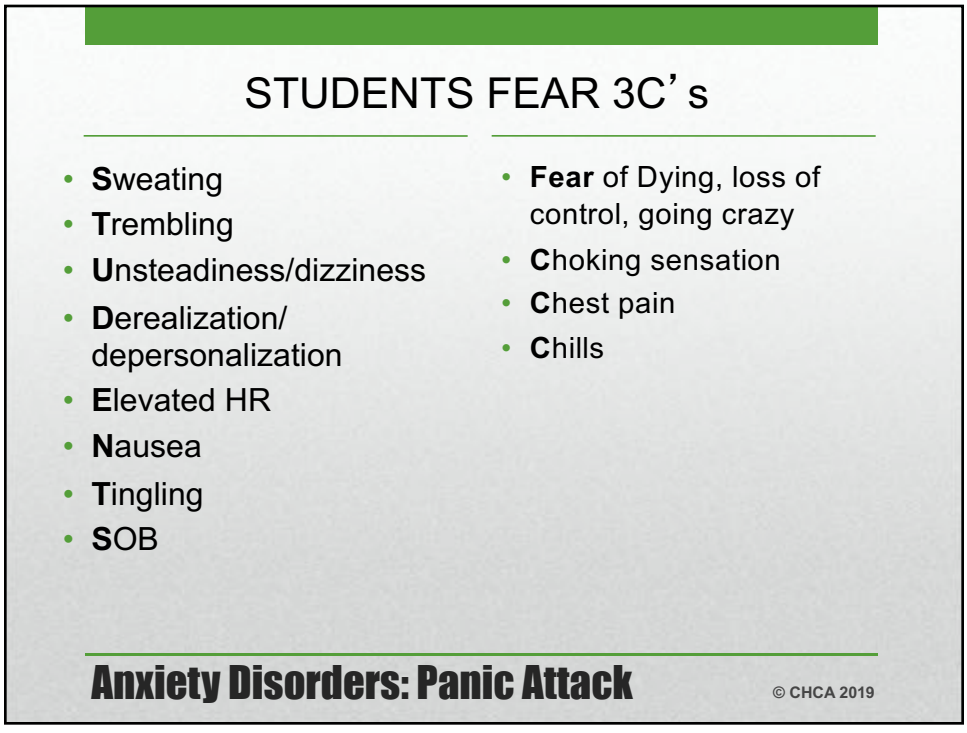
STUDENTS FEAR 3C's
Sweating
Trembling
Unsteadiness/dizziness
Derealization/ depersonalization
Elevated HR
Nausea
Tingling
SOB
Fear of Dying, loss of control, going crazy
Choking sensation
Chest pain
Chills
Anxiety Disorders: Panic Attack
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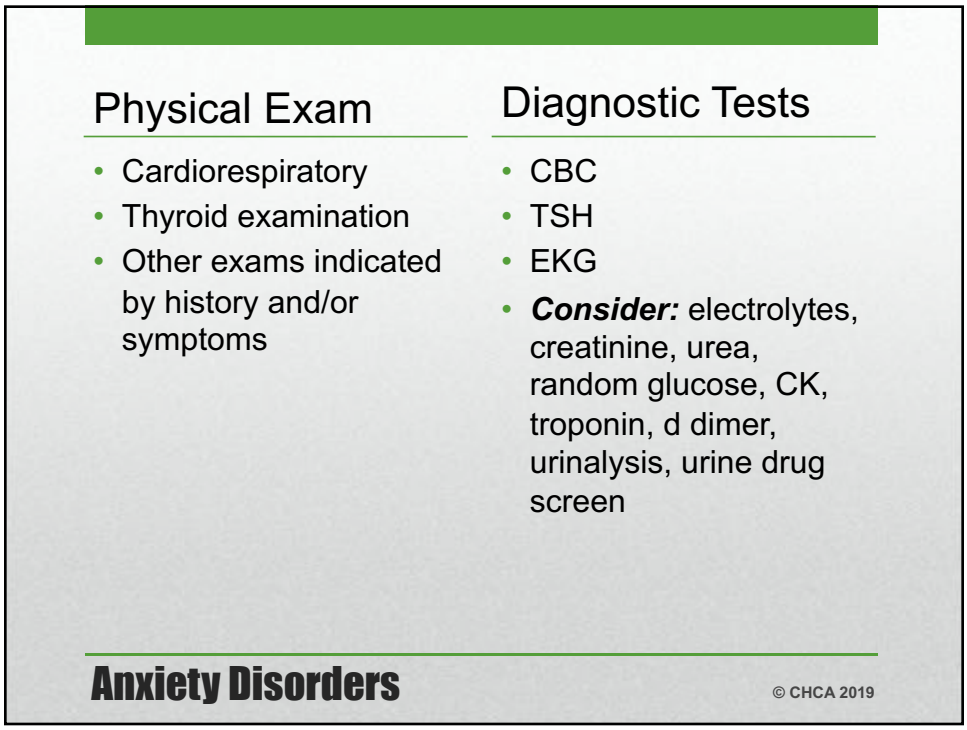
Physical Exam
Cardiorespiratory
Thyroid examination
Other exams indicated by history and/or symptoms
Diagnostic Tests
CBC
TSH
EKG
Consider: electrolytes, creatinine, urea, random glucose, CK, troponin, d dimer, urinalysis, urine drug screen
Anxiety Disorders
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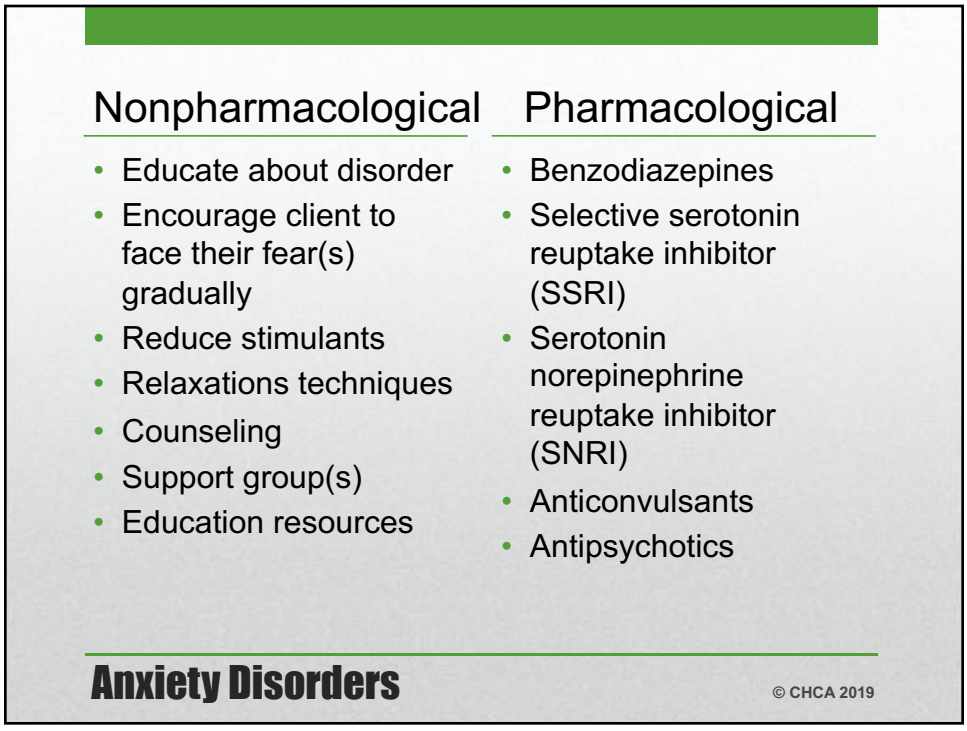
Nonpharmacological
Educate about disorder
Encourage client to face their fear(s) gradually
Reduce stimulants
Relaxations techniques
Counseling
Support group(s)
Education resources
Pharmacological
Benzodiazepines
Selective serotonin reuptake inhibitor (SSRI)
Serotonin norepinephrine reuptake inhibitor (SNRI)
Anticonvulsants
Antipsychotics
Anxiety Disorders
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- **Monitoring and Follow up**
  - FU weekly until seen by physician; otherwise Q3months
  - If medication started; FU in 1 week, then 2 weeks for 6 weeks, then monthly
  - Assess degree of anxiety, suicidal ideation, weight, tolerance of medication, adherence, adverse effects

Anxiety Disorders

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- Major depressive disorder
- Seasonal affective disorder
- Postpartum depression
- Sub-syndromal/ minor depression
- Dysthymic disorder
- Bipolar I
- Bipolar II

Mood Disorders

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Risk Factors

- History of depression
- Family history of depression
- Mental illness
- Substance abuse
- Trauma
- Psychosocial adversity
- Chronic conditions
- Hormonal changes

History

- BATHE
- "Have you felt depressed?"
- "Have you felt hopeless?"
- PHQ-9 Questionnaire
- Mood Score (Likert scale)
- Review symptoms
- Use of substances
- Review medications
- ROS

Depression

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✔" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____ =Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

PHQ-9 Questionnaire

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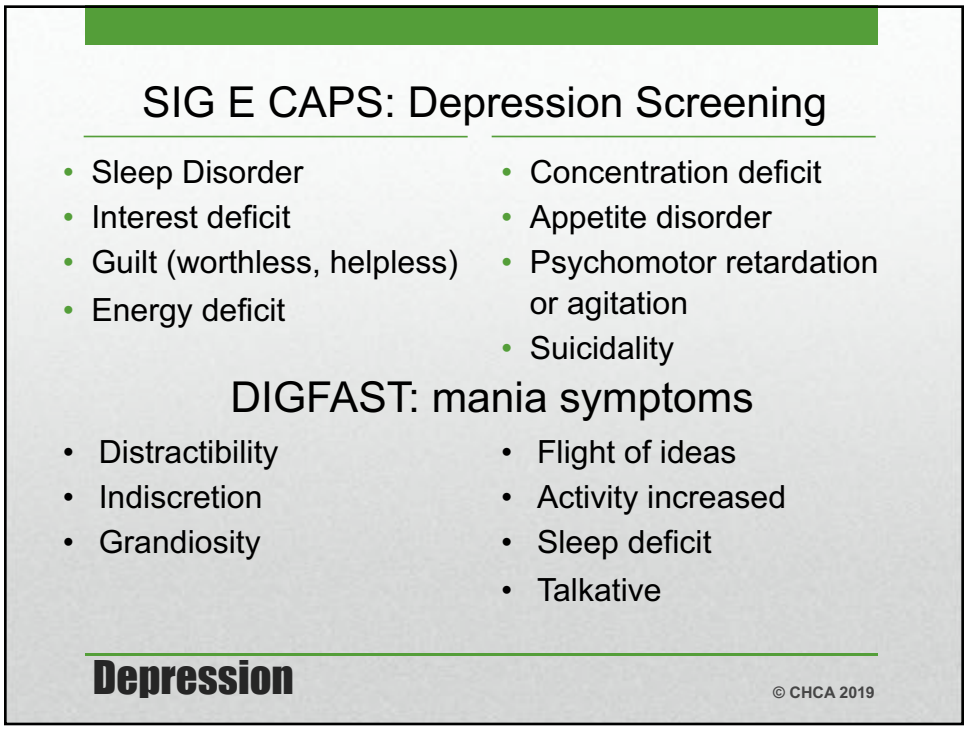
SIG E CAPS: Depression Screening
Sleep Disorder
Interest deficit
Guilt (worthless, helpless)
Energy deficit
Concentration deficit
Appetite disorder
Psychomotor retardation or agitation
Suicidality
DIGFAST: mania symptoms
Distractibility
Indiscretion
Grandiosity
Flight of ideas
Activity increased
Sleep deficit
Talkative
Depression
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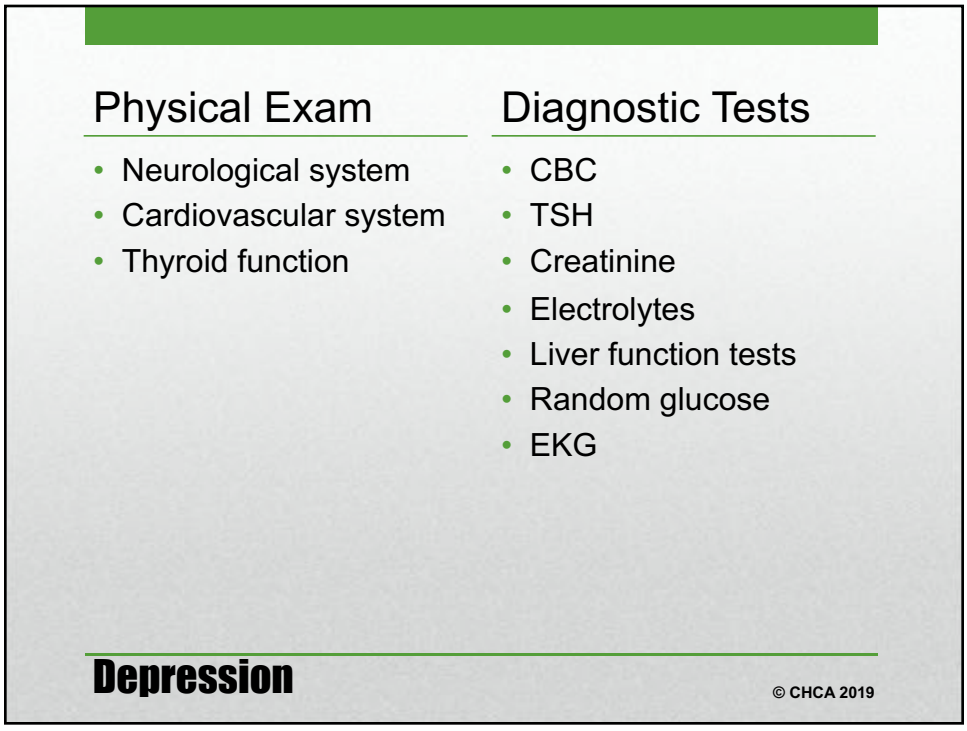
Physical Exam
Neurological system
Cardiovascular system
Thyroid function
Diagnostic Tests
CBC
TSH
Creatinine
Electrolytes
Liver function tests
Random glucose
EKG
Depression
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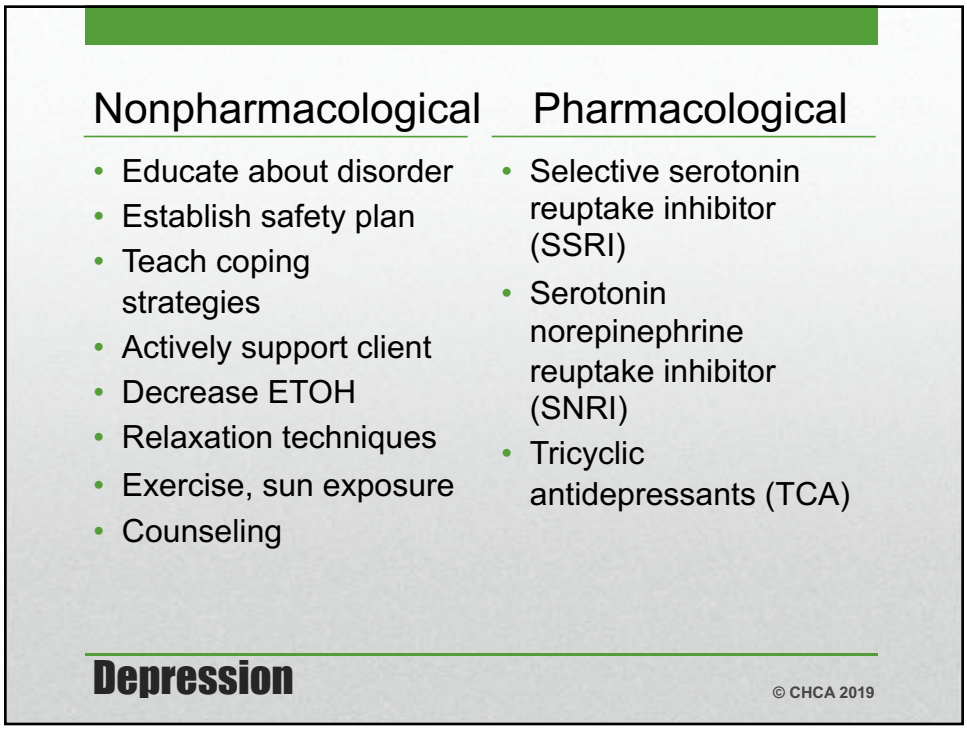
Nonpharmacological
Educate about disorder
Establish safety plan
Teach coping strategies
Actively support client
Decrease ETOH
Relaxation techniques
Exercise, sun exposure
Counseling
Pharmacological
Selective serotonin reuptake inhibitor (SSRI)
Serotonin norepinephrine reuptake inhibitor (SNRI)
Tricyclic antidepressants (TCA)
Depression
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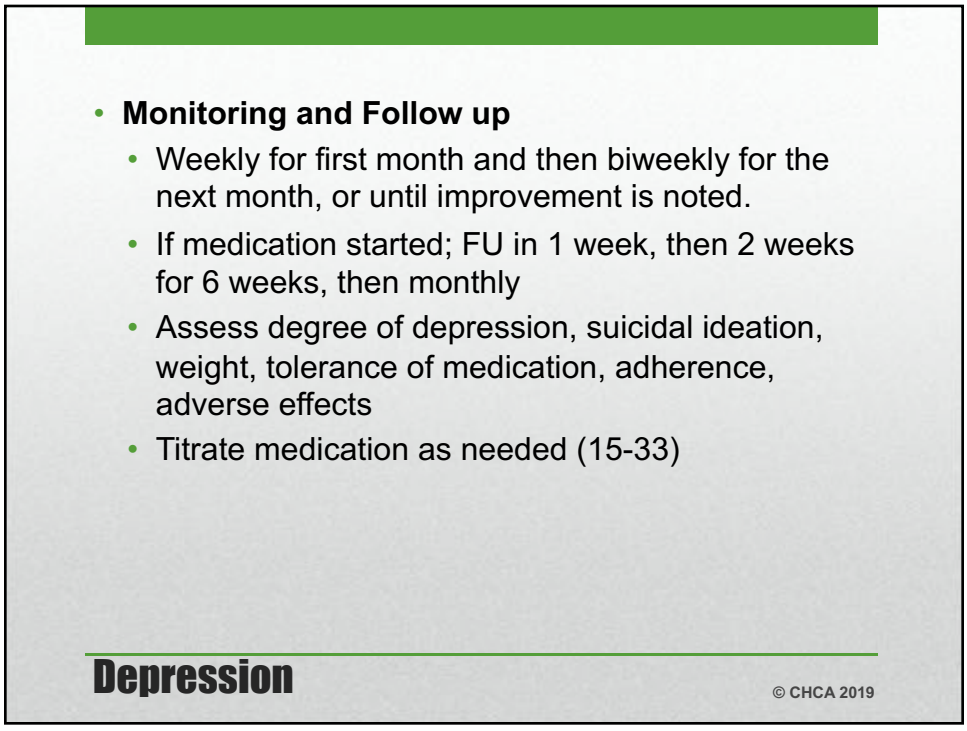
Monitoring and Follow up
Weekly for first month and then biweekly for the next month, or until improvement is noted.
If medication started; FU in 1 week, then 2 weeks for 6 weeks, then monthly
Assess degree of depression, suicidal ideation, weight, tolerance of medication, adherence, adverse effects
Titrate medication as needed (15-33)
Depression
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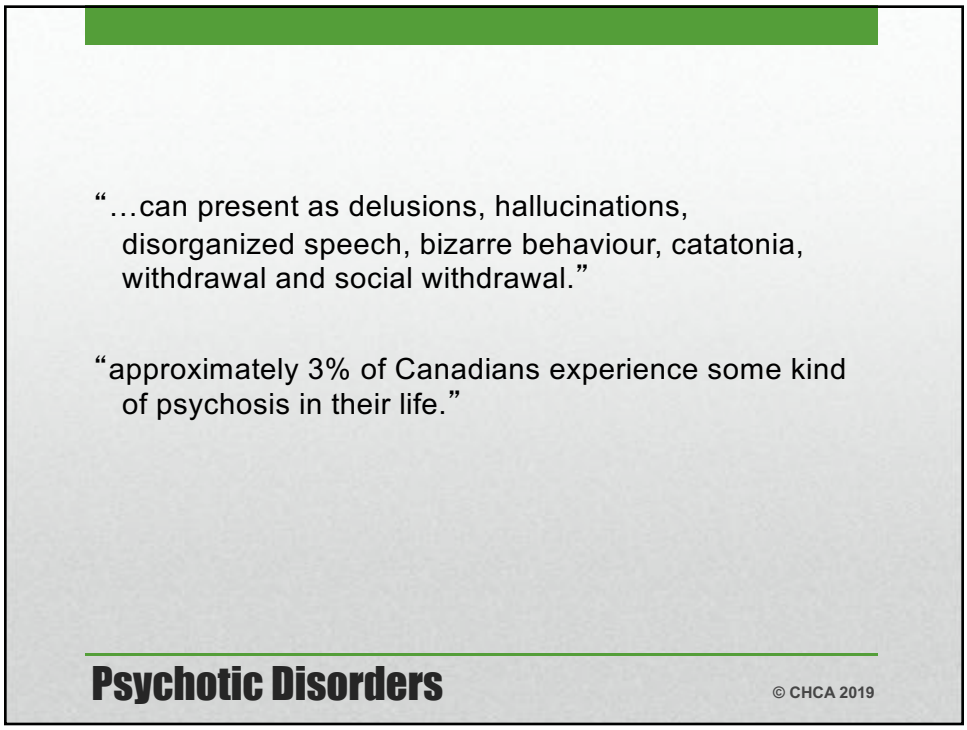
"…can present as delusions, hallucinations, disorganized speech, bizarre behaviour, catatonia, withdrawal and social withdrawal."
"approximately 3% of Canadians experience some kind of psychosis in their life."
Psychotic Disorders
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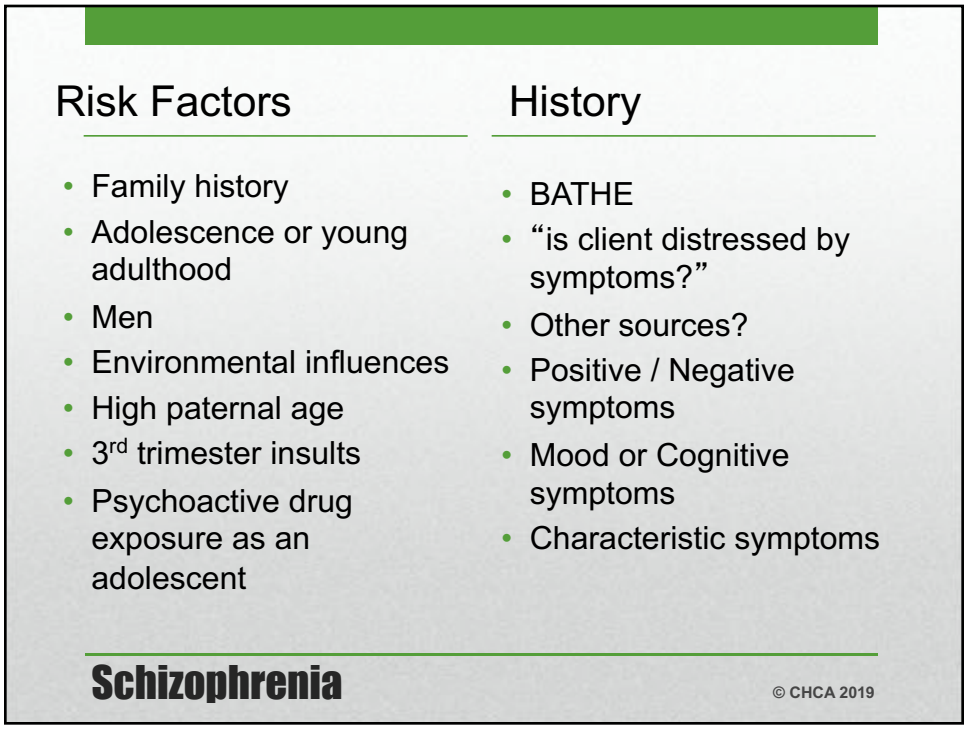
Risk Factors
Family history
Adolescence or young adulthood
Men
Environmental influences
High paternal age
3rd trimester insults
Psychoactive drug exposure as an adolescent
History
BATHE
"is client distressed by symptoms?"
Other sources?
Positive / Negative symptoms
Mood or Cognitive symptoms
Characteristic symptoms
Schizophrenia
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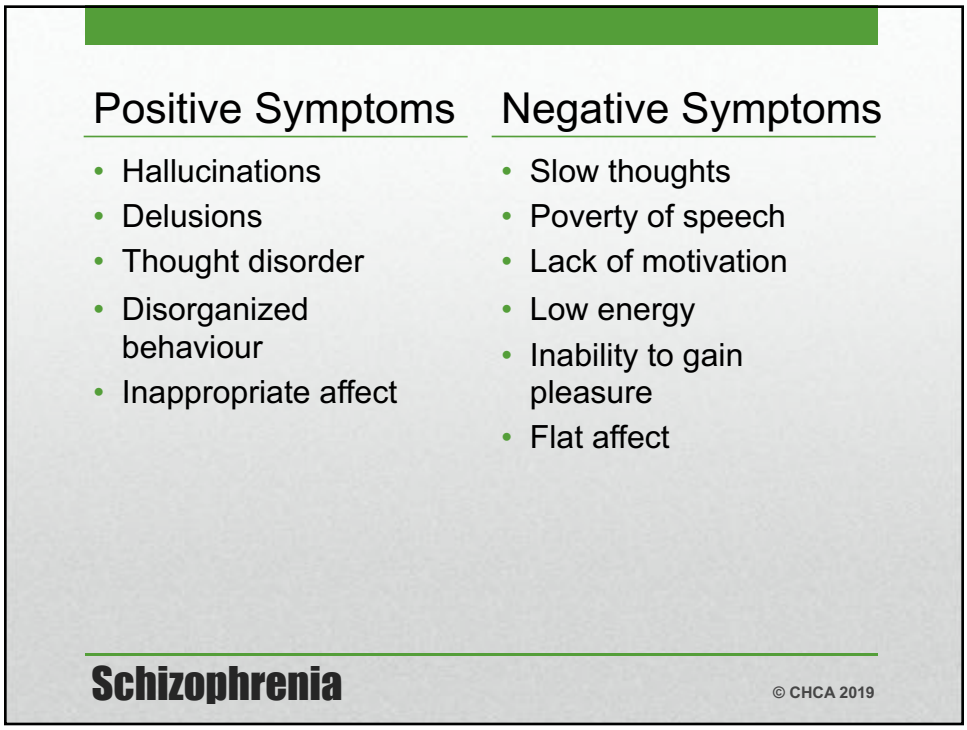
Positive Symptoms
Hallucinations
Delusions
Thought disorder
Disorganized behaviour
Inappropriate affect
Negative Symptoms
Slow thoughts
Poverty of speech
Lack of motivation
Low energy
Inability to gain pleasure
Flat affect
Schizophrenia
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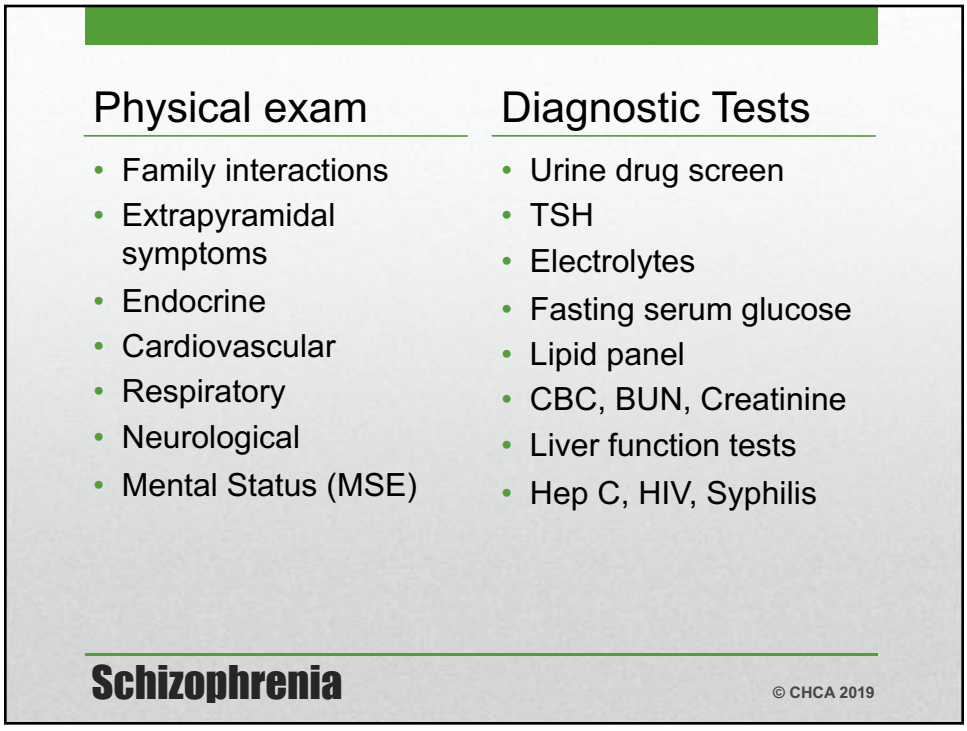
Physical exam
Family interactions
Extrapyramidal symptoms
Endocrine
Cardiovascular
Respiratory
Neurological
Mental Status (MSE)
Diagnostic Tests
Urine drug screen
TSH
Electrolytes
Fasting serum glucose
Lipid panel
CBC, BUN, Creatinine
Liver function tests
Hep C, HIV, Syphilis
Schizophrenia
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Nonpharmacological

- Develop positive relationship
- Crisis intervention services
- Place in room which client can be observed
- Educate about disorder

Pharmacological

- Antipsychotic medications
  - Olanzapine
  - Risperidone
  - Lithium

"obtain baseline EKG, CBC, Liver function tests if possible."

Schizophrenia

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- **Monitoring and Follow up**
  - Often treatment is a life-long proposition
  - Visits should be regular and frequent to assess for drug compliance, effectiveness, side effects, assess social supports

Schizophrenia

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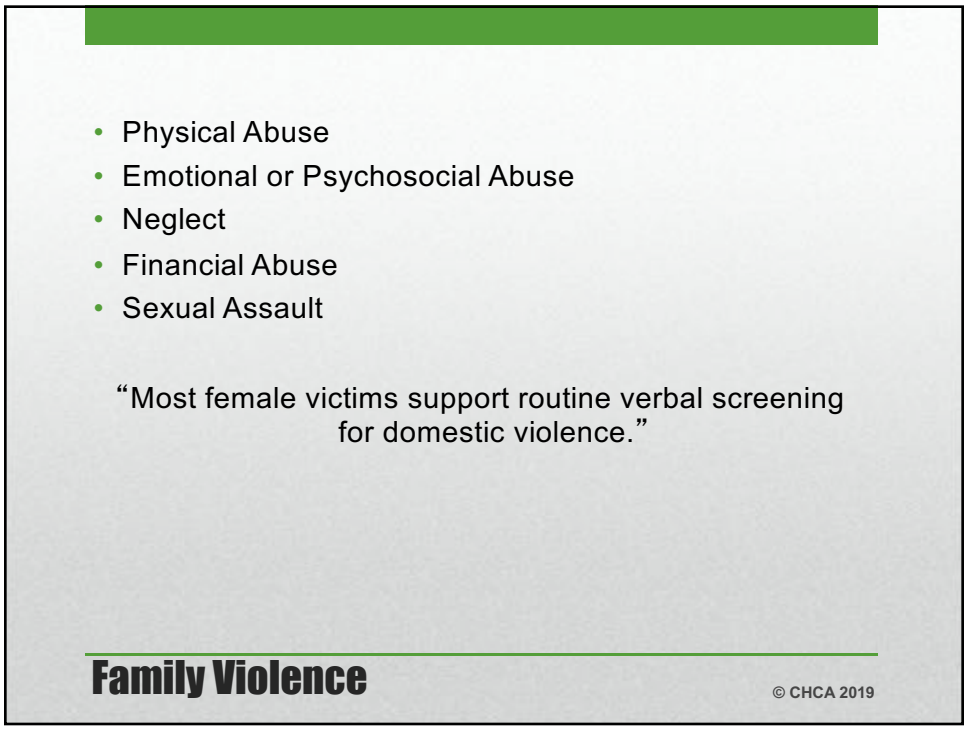
Physical Abuse
Emotional or Psychosocial Abuse
Neglect
Financial Abuse
Sexual Assault
"Most female victims support routine verbal screening for domestic violence."
Family Violence
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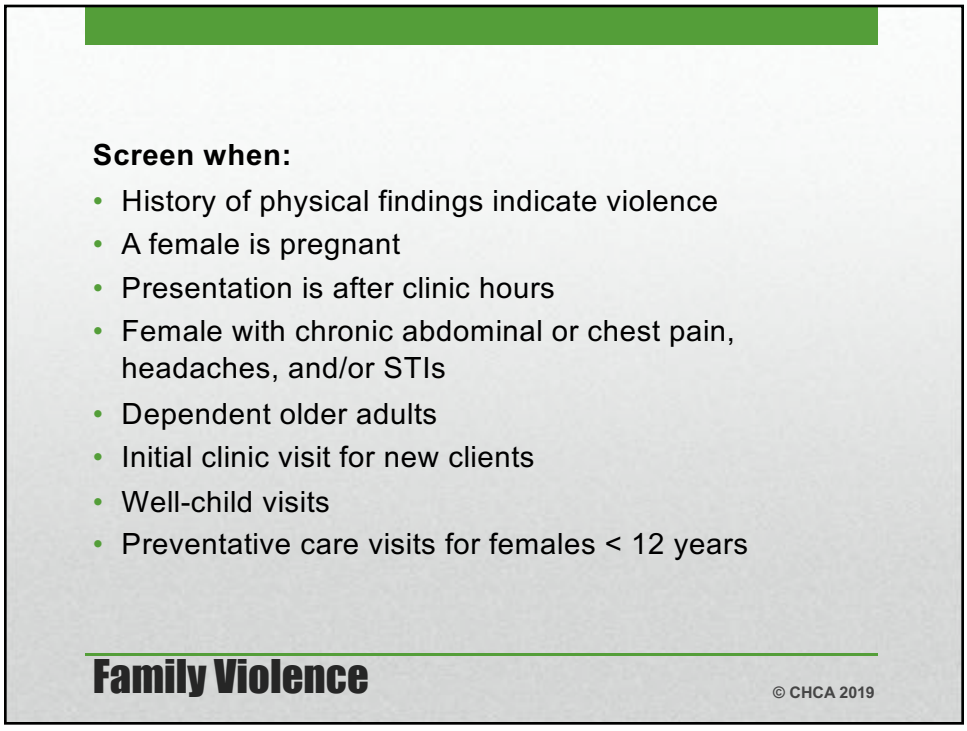
Screen when:
History of physical findings indicate violence
A female is pregnant
Presentation is after clinic hours
Female with chronic abdominal or chest pain, headaches, and/or STIs
Dependent older adults
Initial clinic visit for new clients
Well-child visits
Preventative care visits for females < 12 years
Family Violence
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History taking tips:

- states injuries are a result of trauma
- do not put down the abuser
- states that behaviour is unacceptable
- do not reassure the client that "everything will be alright"
- help client be objective
- verbalize client priorities
- encourage use of "I" messages with abuser
- assess for danger to children

Family Violence

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- **Cannabis**
  - Marijuana, Hashish
- **Depressants**
  - Barbiturates, Benzodiazepines
  - ETOH
  - Opioid analgesic
  - Inhalants
- **Stimulants**
  - Amphetamines, Ritalin, Cocaine, Crack,
  - Caffeine, Tobacco
- **Hallucinogens**
  - LDS, Mescaline, Peyote

"Of Aboriginal people, 26.3% report substance misuse a concern."

Substance Misuse

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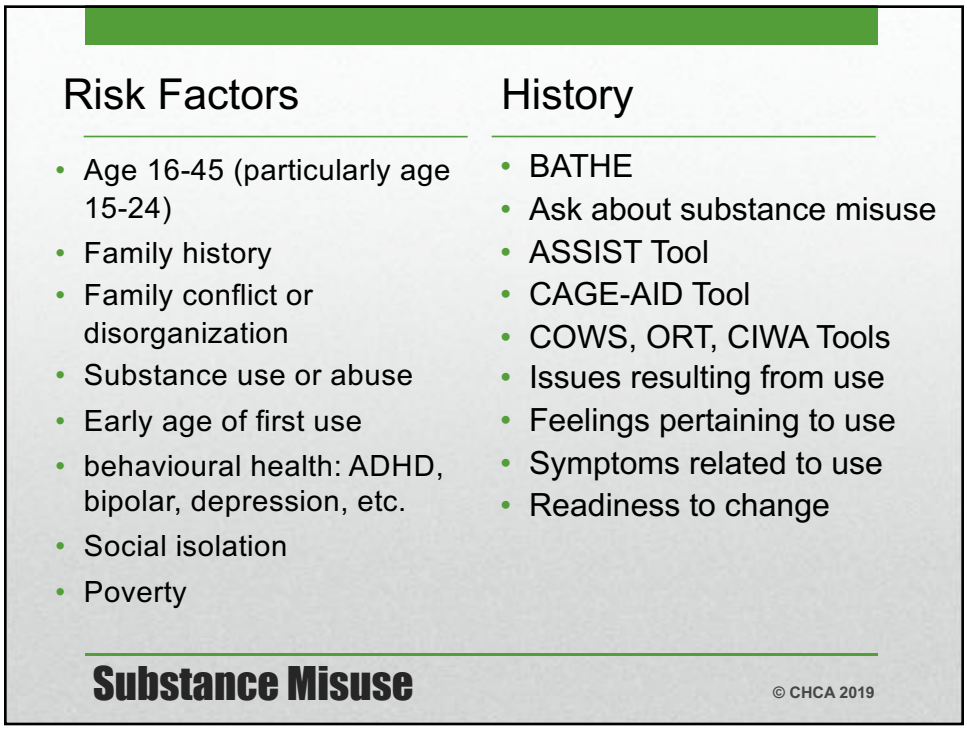
Risk Factors
Age 16-45 (particularly age 15-24)
Family history
Family conflict or disorganization
Substance use or abuse
Early age of first use
behavioural health: ADHD, bipolar, depression, etc.
Social isolation
Poverty
History
BATHE
Ask about substance misuse
ASSIST Tool
CAGE-AID Tool
COWS, ORT, CIWA Tools
Issues resulting from use
Feelings pertaining to use
Symptoms related to use
Readiness to change
Substance Misuse
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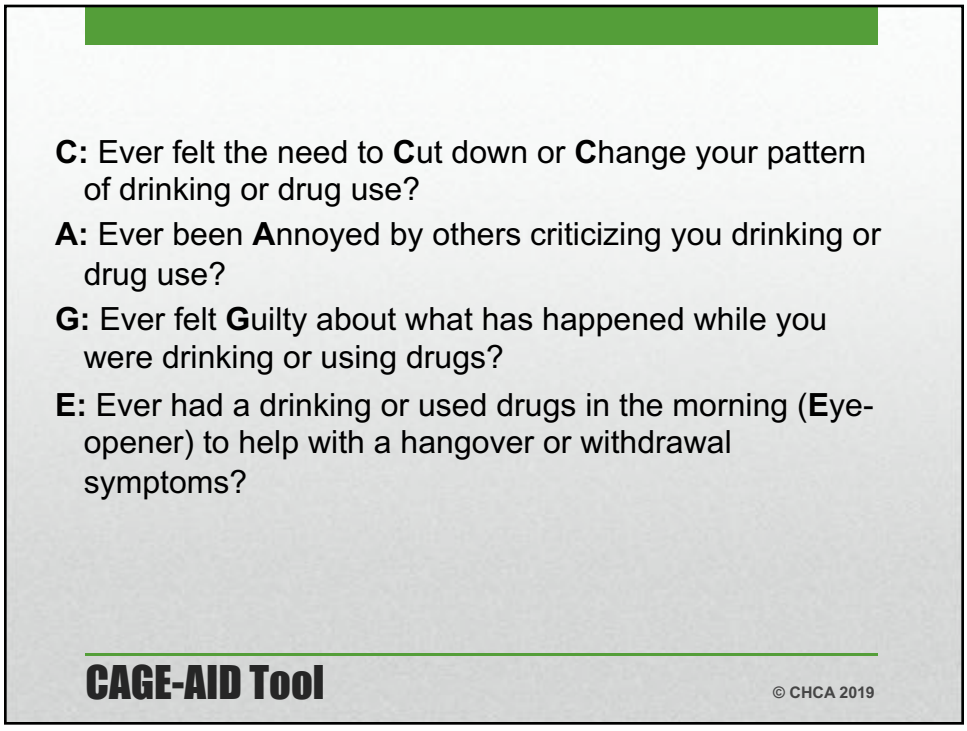
C: Ever felt the need to Cut down or Change your pattern of drinking or drug use?
A: Ever been Annoyed by others criticizing you drinking or drug use?
G: Ever felt Guilty about what has happened while you were drinking or using drugs?
E: Ever had a drinking or used drugs in the morning (Eye-opener) to help with a hangover or withdrawal symptoms?
CAGE-AID Tool
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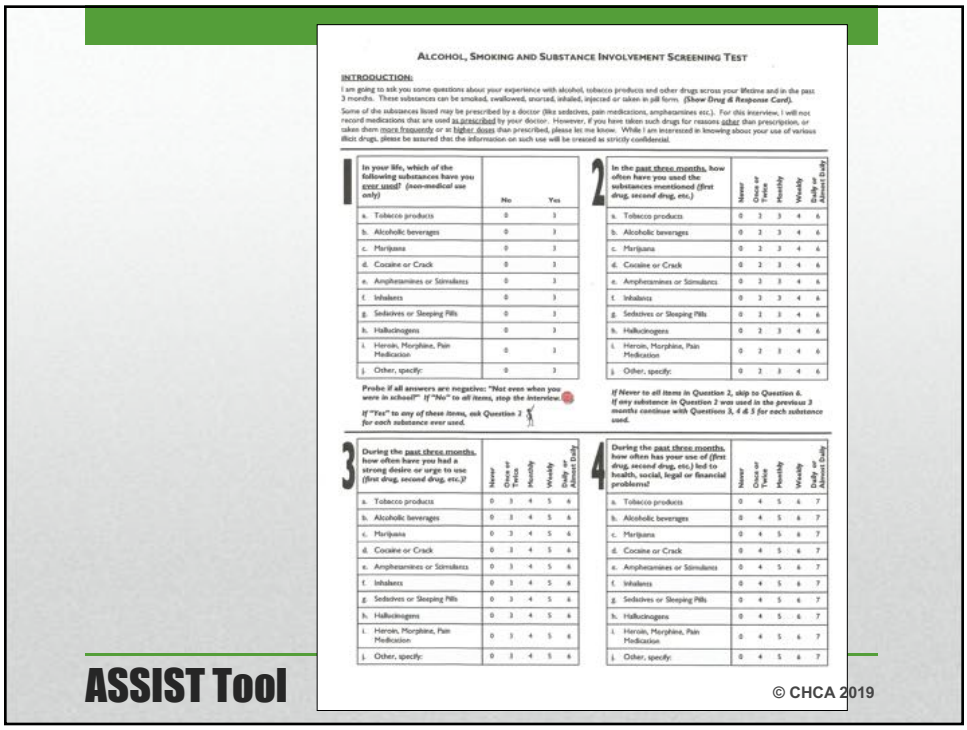

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- **Pre-contemplation**
  - Raise awareness
  - Provide education
  - Encourage change; Harm reduction
- **Contemplation**
  - Discuss ambivalence to change; future
  - Encourage change
- **Preparation and Action**
  - Discuss treatment options
  - Introduce Harm Reduction strategies
  - Assist to develop an “Action Plan”

Substance Misuse

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- **ASK** about use
- **ADVISE** them to quit
- **ASSESS** their willingness to make a quit attempt
- **ASSIST** them by arranging/providing counseling and pharmacologic treatment
- **ARRANGE** follow up

Five A's

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Nonpharmacological	Pharmacological
• Set positive goal; include family and friends • Counselling • 12 step program • Watch for increased ETOH and tobacco use if undergoing withdrawal • Provide education • Cognitive Behavioural Therapy	• Treat co-existing and/or misdiagnosed medical or psychiatric concerns Benzodiazepine • Replacing usual dose with long half-life benzodiazepine then tapering Opioid • Methadone, naloxone or buprenorphine (Suboxone)

Prescription Drug Misuse

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- **Monitoring and Follow up**

  Prevention
  - Screen annually
  - Create clinic policies
  - Education

  Chronic
  - Assess monthly for 1 year

Prescription Drug Misuse

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Sioux Lookout First Nations Health Authority

NEEDLE DISTRIBUTION PROGRAM LOG

COMMUNITY & MONTH

DATE	GENDER M / F	AGE (years)	DRUG OF CHOICE	NEW (N) OR RETURNING (R) CLIENT	IN: APPROX # OF NEEDLES RETURNED	OUT: # OF NEEDLES GIVEN (1 KIT = 50 NEEDLES)	OUT: # OF SNORTING PACKAGES	OUT: CONDOMS (✓)	# DISPOSAL CONTAINERS GIVEN OUT	COMMENTS / REFERRALS	NAME OF PROVIDER
Example MM/DD/YY	*F*	*26*	*Morphine*	*R*	*10 needles*	*10 needles*	*1*	✓	*1*	*Referred to counselling*	*John Doe*

Ask clients to put returned needles in the sharps container themselves. It is okay to estimate the number of needles returned.

FAX COMPLETED LOG TO **THE NEEDLE DISTRIBUTION SERVICE** AT **807-737-6195** AT THE END OF EACH MONTH.

DATE FAXED _____

54 Queen Street | Phone: (807) 737-6191 | Fax: (807) 737-6195

Harm Reduction Strategies: Needle Exchange Program

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Naloxone Take-Home kits

- Available to anyone with an OHIP number.
- Requires training at a pharmacy
- Injectable and intranasal formulations available

See ISC Opioid Overdose and Naloxone Policy

Harm Reduction Strategies: Naloxone Take-Home kits

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- First Nations and Inuit Health Branch Clinical Practice Guidelines for Nurses in Primary Care (2011); Health Canada
- First Nations and Inuit Health Branch Pediatric Clinical Practice Guidelines for Nurses in Primary Care (2010); Health Canada
- GAD-7 Screening Questions
- PHQ9 Screening Questions
- ASSIST TOOL

References

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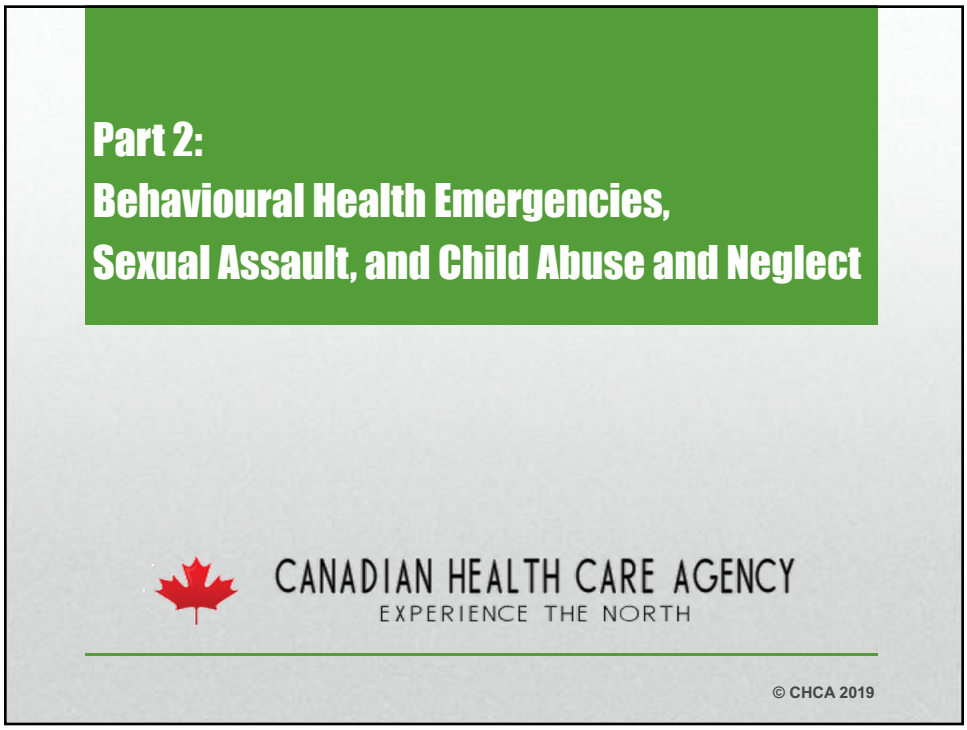
Part 2:
Behavioural Health Emergencies,
Sexual Assault, and Child Abuse and Neglect
CANADIAN HEALTH CARE AGENCY
EXPERIENCE THE NORTH
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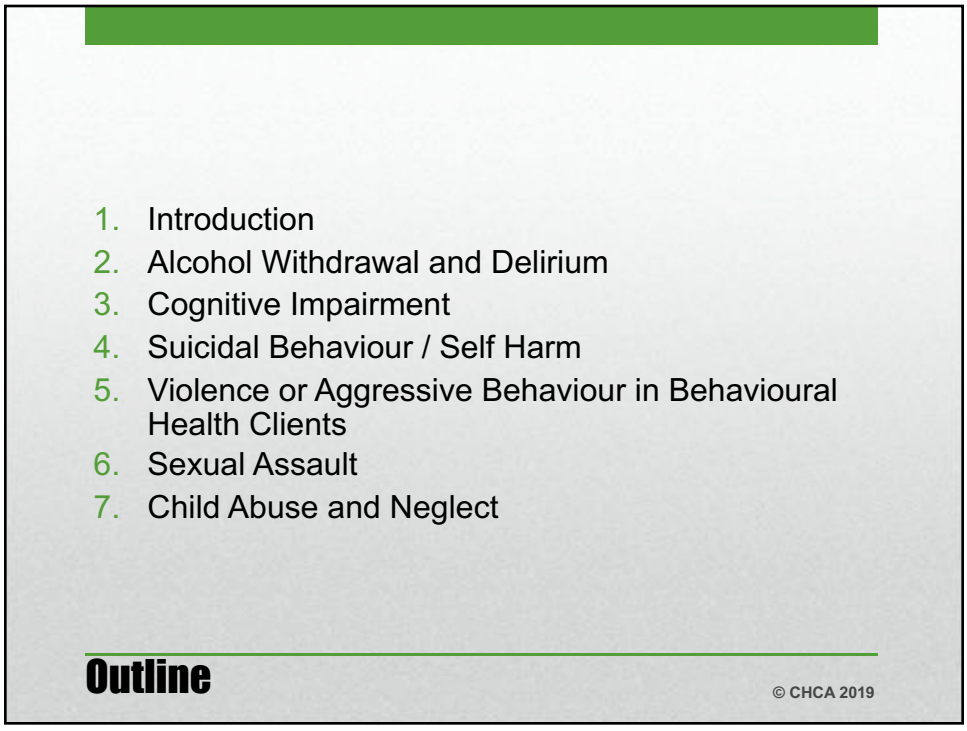
1. Introduction
2. Alcohol Withdrawal and Delirium
3. Cognitive Impairment
4. Suicidal Behaviour / Self Harm
5. Violence or Aggressive Behaviour in Behavioural Health Clients
6. Sexual Assault
7. Child Abuse and Neglect
Outline
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Physical Exam

- VS, Height and Weight
- MSE
- Signs and symptoms of acute intoxication
- Signs and symptoms of chronic substance use
- Enlarged liver, malnutrition, tremor, poor hygiene, easy bruising, ascites, telangiectasia, etc.
- Signs of withdrawal

Diagnostics

Chronic:

- Liver function tests
- Random blood glucose
- Albumin, INR/PTT, bilirubin (if cirrhosis is suspected)

Withdrawal:

- CBC, LFTs, Lytes, Mg, Phos, RBG, BUN, Creat, βHCG, Urine drug screen, Urinalysis

Alcohol Misuse

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Nonpharmacological

- Ask client about opinions about substance use
- Provide education
- Healthy friendships
- Extra-curricular activities
- Counseling
- Community resources
- 5 A's
- Motivational Interviewing

Pharmacological

- Occasionally medications are used to decrease the likelihood of relapse
- Treatment for withdrawal
- Acute intoxication
  - thiamine

"…pharmacological treatment is only helpful when combined with counseling…"

Alcohol Misuse

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DSM-5: cessation of or reduction in ETOH ingestion after drinking for several days and experiencing 2 of the following symptoms

- Tremor, anxiety, autonomic hyperactivity (early ETOH withdrawal)
- Visual hallucinations
- ETOH withdrawal seizures
- Delirium tremens: autonomic hyperactivity, confusion/delirium (chronic)

Acute Alcohol Withdrawal

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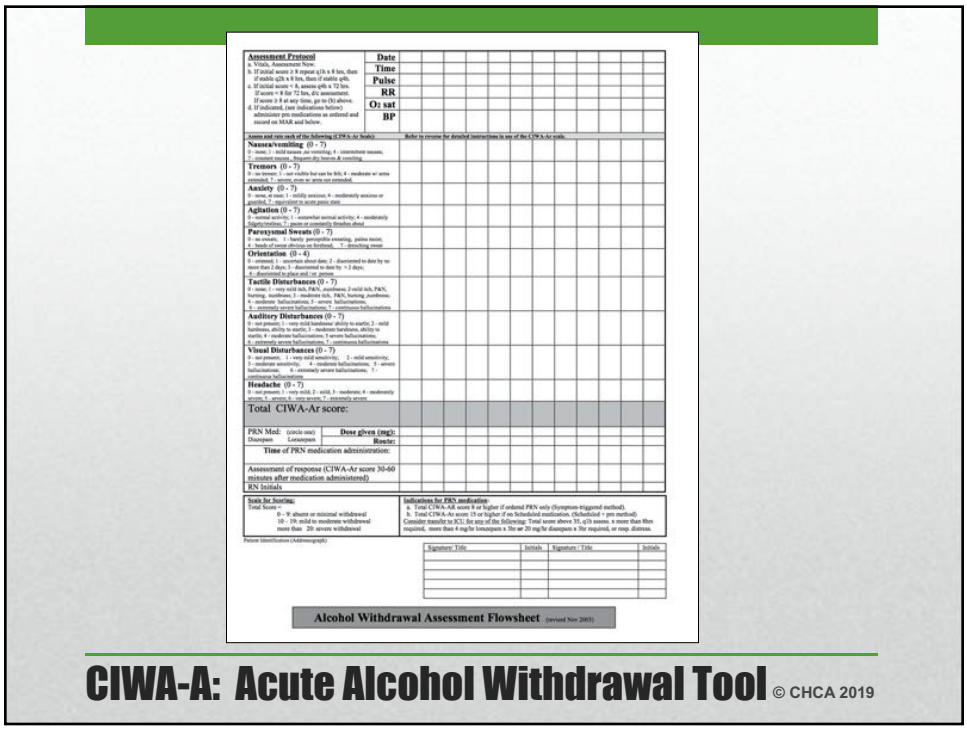
Clinical Institute Withdrawal Assessment for Alcohol-revised (CIWA-Ar)

- Severity of ETOH withdrawal
- Determine appropriate care
- Monitor client during detoxification

"complete on suspected ETOH withdrawal; who can talk and who have drank in the past 5 days."

Acute Alcohol Withdrawal

50



CIWA-A: Acute Alcohol Withdrawal Tool © CHCA 2019

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Nonpharmacological

- Increased rest
- Hydration and nutrition
- Monitor intake and output
- Correct blood glucose (if needed)
- Intravenous (CIWA>15)
- Psychological support
- Provide education

Pharmacological

CIWA score </= 15

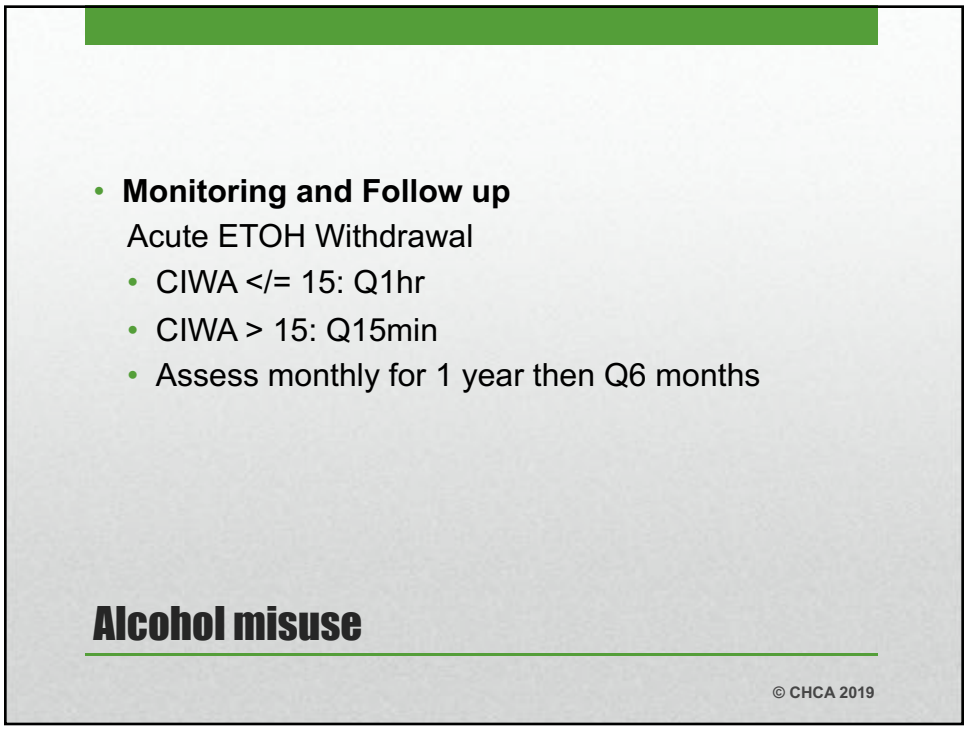
- Diazepam 10mgPO Q1hr PRN until s/s improved
- OR lorazepam 2mg SL Q1hr PRN, x 3 doses
- Thiamine 100mg IM/IV daily x 3 days
- Multivitamin PO with thiamine and folate daily

CIWA > 15

- Diazepam 10mg IV Q20minutes until clinical improvement (not for kidney or liver concerns)
- Thiamine 100mg IM/IV daily x 3 days (give before glucose)
- Multivitamin PO with thiamine and folate

Acute Alcohol Withdrawal

52


• Monitoring and Follow up
Acute ETOH Withdrawal
• CIWA </= 15: Q1hr
• CIWA > 15: Q15min
• Assess monthly for 1 year then Q6 months
Alcohol misuse
© CHCA 2019

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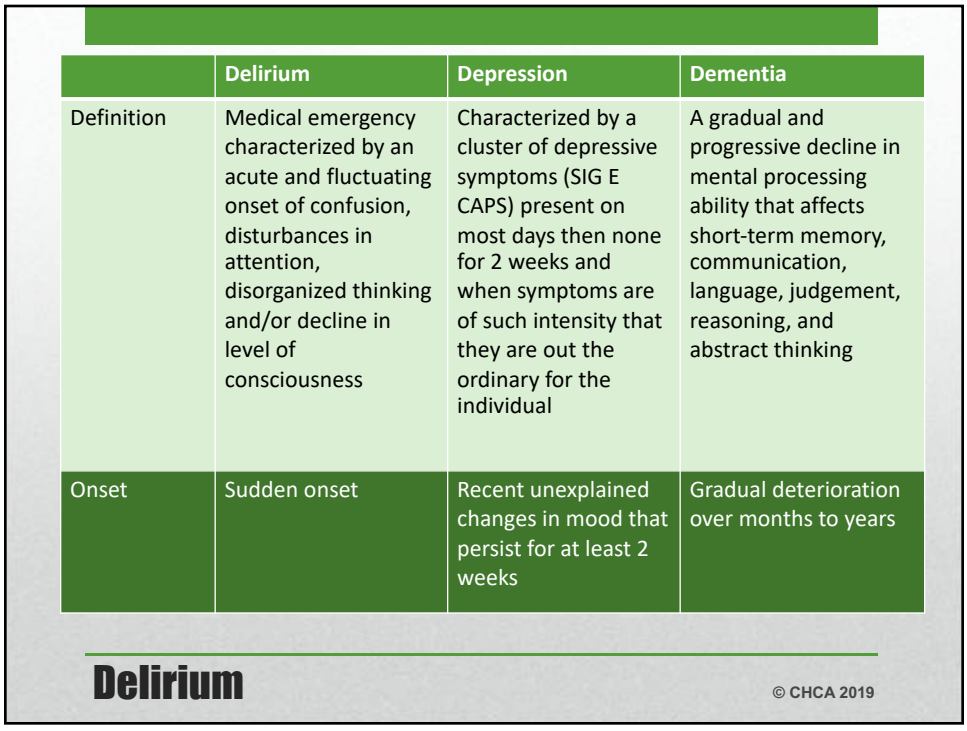
Delirium
Depression
Dementia
Definition
Medical emergency characterized by an acute and fluctuating onset of confusion, disturbances in attention, disorganized thinking and/or decline in level of consciousness
Characterized by a cluster of depressive symptoms (SIG E CAPS) present on most days then none for 2 weeks and when symptoms are of such intensity that they are out the ordinary for the individual
A gradual and progressive decline in mental processing ability that affects short-term memory, communication, language, judgement, reasoning, and abstract thinking
Onset
Sudden onset
Recent unexplained changes in mood that persist for at least 2 weeks
Gradual deterioration over months to years
Delirium
© CHCA 2019

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I WATCH DEATH

- **I**nfections
- **W**ithdrawal
- **A**cute metabolic
- **T**oxins, drugs
- **C**NS pathology
- **H**ypoxia
- **D**eficiencies
- **E**ndocrine
- **A**cute vascular
- **T**rauma
- **H**eavy metal toxicity

Delirium – potential causes

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- Verbal and Non verbal techniques
- De-escalation
- Security
- Physical restraints
- Pharmacological interventions

- In extreme danger – lock yourself in the pharmacy and call police.

Aggressive Behaviour

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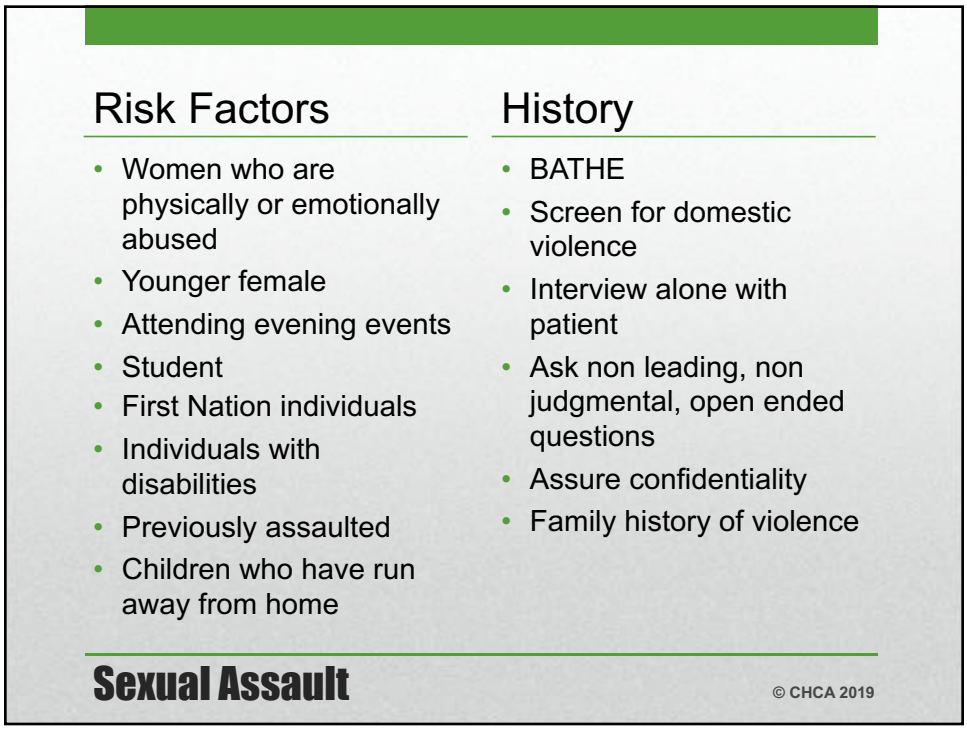
Risk Factors
Women who are physically or emotionally abused
Younger female
Attending evening events
Student
First Nation individuals
Individuals with disabilities
Previously assaulted
Children who have run away from home
History
BATHE
Screen for domestic violence
Interview alone with patient
Ask non leading, non judgmental, open ended questions
Assure confidentiality
Family history of violence
Sexual Assault
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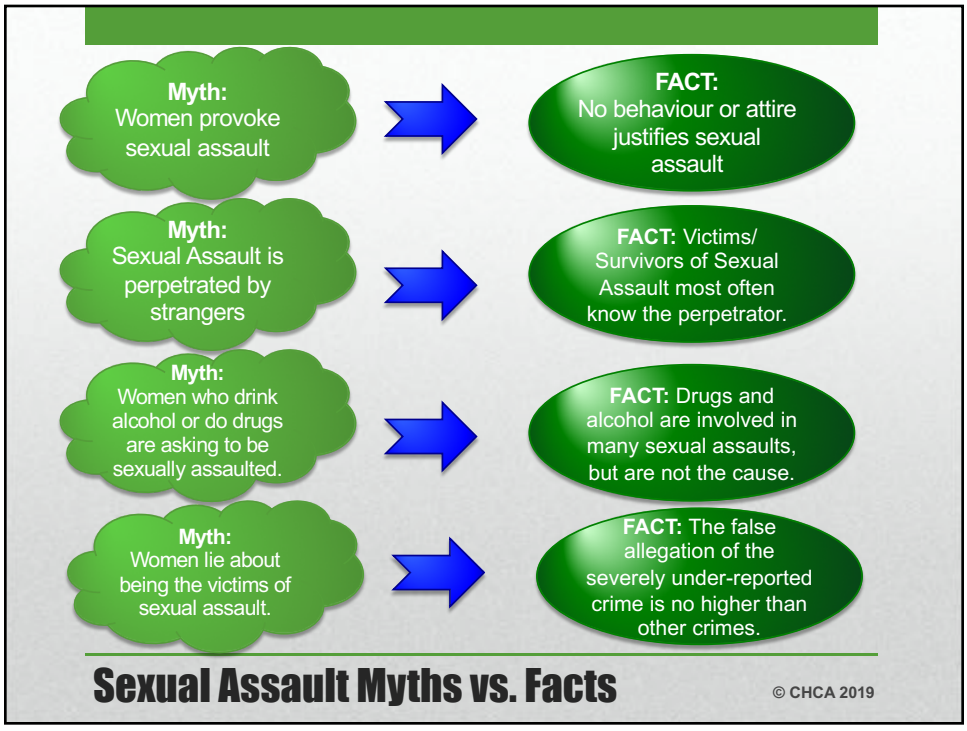
Myth: Women provoke sexual assault
FACT: No behaviour or attire justifies sexual assault
Myth: Sexual Assault is perpetrated by strangers
FACT: Victims/ Survivors of Sexual Assault most often know the perpetrator.
Myth: Women who drink alcohol or do drugs are asking to be sexually assaulted.
FACT: Drugs and alcohol are involved in many sexual assaults, but are not the cause.
Myth: Women lie about being the victims of sexual assault.
FACT: The false allegation of the severely under-reported crime is no higher than other crimes.
Sexual Assault Myths vs. Facts
© CHCA 2019

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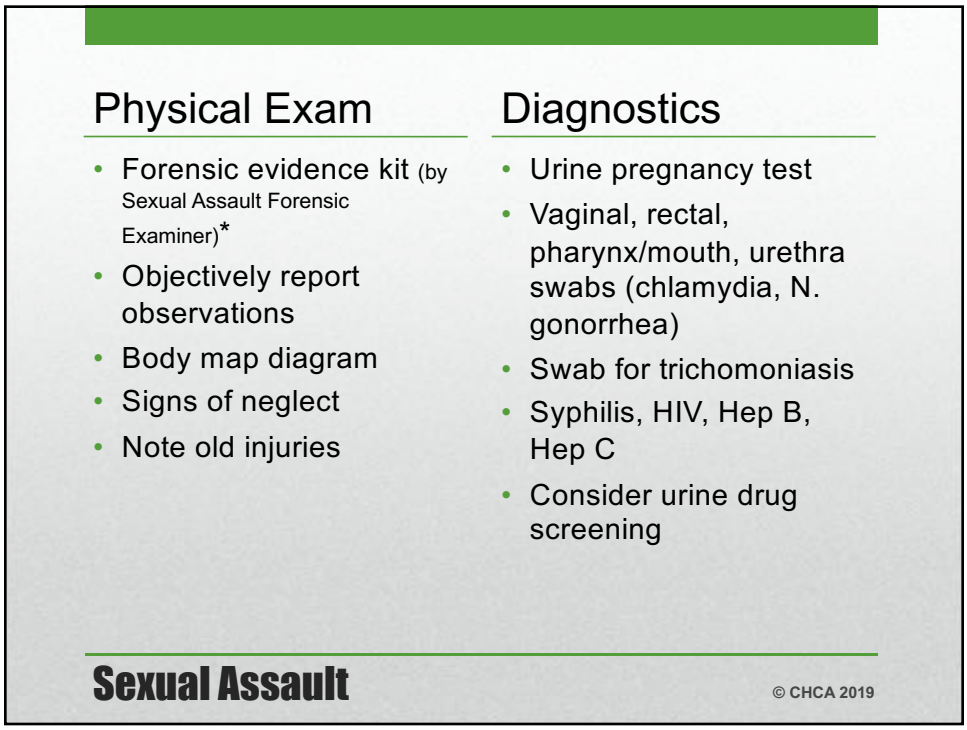
Physical Exam
Forensic evidence kit (by Sexual Assault Forensic Examiner)*
Objectively report observations
Body map diagram
Signs of neglect
Note old injuries
Diagnostics
Urine pregnancy test
Vaginal, rectal, pharynx/mouth, urethra swabs (chlamydia, N. gonorrhea)
Swab for trichomoniasis
Syphilis, HIV, Hep B, Hep C
Consider urine drug screening
Sexual Assault
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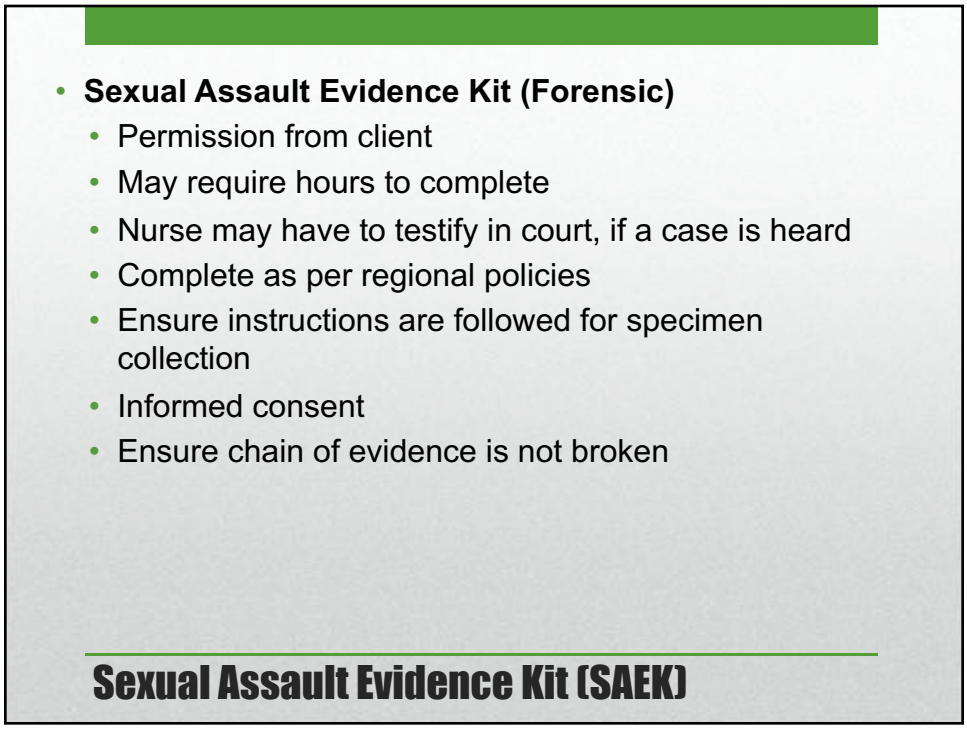
Sexual Assault Evidence Kit
Permission from client
May require hours to complete
Nurse may have to testify in court, if a case is heard
Complete as per regional policies
Ensure instructions are followed for specimen collection
Informed consent
Ensure chain of evidence is not broken
Sexual Assault Evidence Kit (SAEK)

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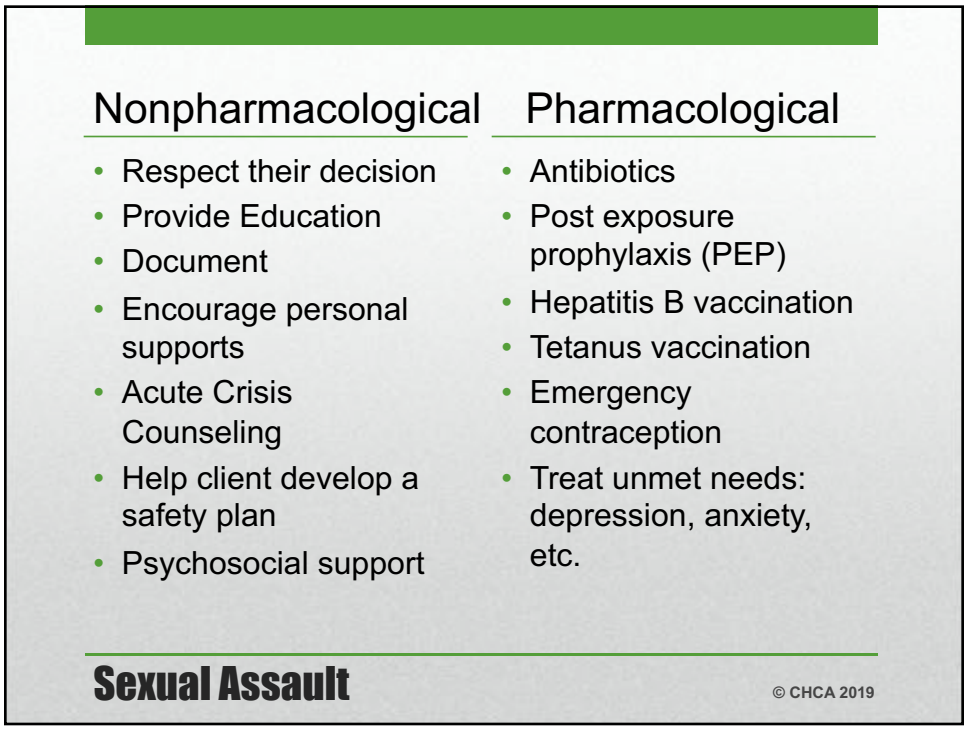
Nonpharmacological
Respect their decision
Provide Education
Document
Encourage personal supports
Acute Crisis Counseling
Help client develop a safety plan
Psychosocial support
Pharmacological
Antibiotics
Post exposure prophylaxis (PEP)
Hepatitis B vaccination
Tetanus vaccination
Emergency contraception
Treat unmet needs: depression, anxiety, etc.
Sexual Assault
© CHCA 2019

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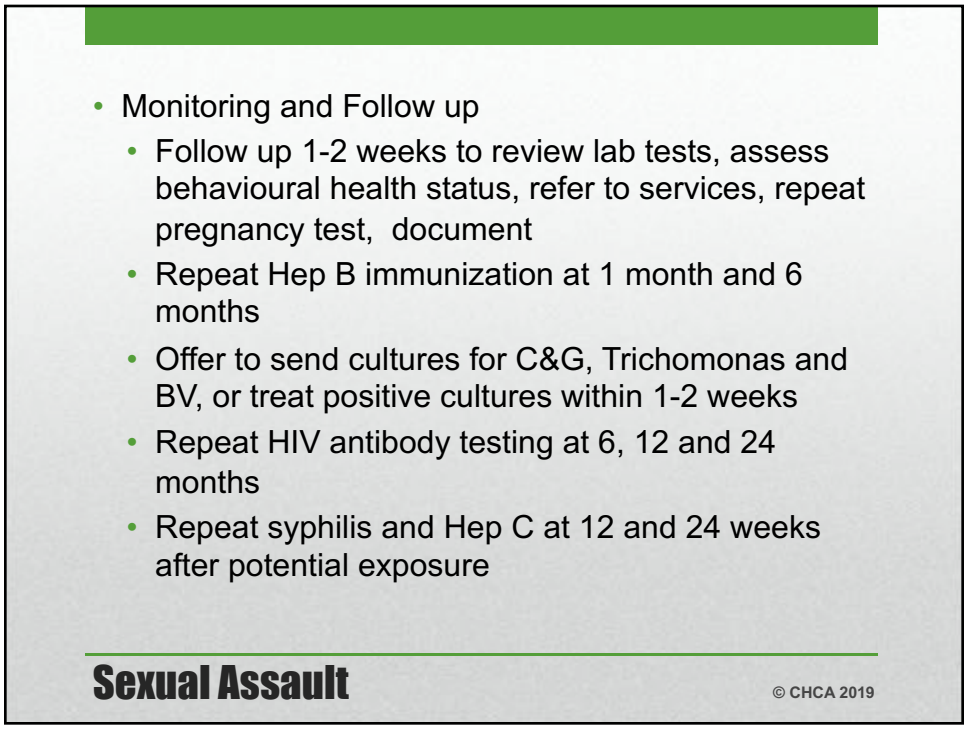
Monitoring and Follow up
Follow up 1-2 weeks to review lab tests, assess behavioural health status, refer to services, repeat pregnancy test, document
Repeat Hep B immunization at 1 month and 6 months
Offer to send cultures for C&G, Trichomonas and BV, or treat positive cultures within 1-2 weeks
Repeat HIV antibody testing at 6, 12 and 24 months
Repeat syphilis and Hep C at 12 and 24 weeks after potential exposure
Sexual Assault
© CHCA 2019

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- Types of Maltreatment
  - Physical
  - Sexual (exploitive and non exploitive)
  - Emotional
  - Neglect
  - Munchausen syndrome by proxy
  - Abusive head trauma (formally “shaken baby” syndrome)

“Provincially legislated Child Protection Act”

MAMAWI AWASIS SOCIETY

Child Abuse and Neglect

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- Physical assessment findings
  - Head and CNS injuries
  - Skin injuries
  - Bone injuries
  - Genitourinary/Gastrointestinal injuries

Child Abuse and Neglect

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Reporting

- Caregivers should be made aware
- Obtain written consent from parent, guardian or child him/herself to release information
- Notify provincial child and welfare services ASAP
  - Providers information
  - Demographic information
  - Contact information
  - History of presenting child abuse
  - Witnesses
  - Aspects of family social history

Child Abuse and Neglect

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First Nations and Inuit Health Branch Clinical Practice Guidelines for Nurses in Primary Care (2011); Health Canada

First Nations and Inuit Health Branch Pediatric Clinical Practice Guidelines for Nurses in Primary Care (2010); Health Canada

CIWA-A and COWS

GAD-7 Screening Questions

PHQ9 Screening Questions

ASSIST TOOL

References

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