



# **Mental Health in the Primary Care Setting: Addressing the Concerns of Children and Youth**

*THIRD EDITION*

A Desk Reference

## FORWARD

The vast majority (nearly 80%) of children who receive mental health services obtain them from their family health care provider. Childhood mental health disorders present a particularly complex challenge to the family practitioner. The typical family physician working in a busy practice must identify the presenting symptoms, make an accurate diagnosis and determine a treatment plan within the span of a few minutes. This desk reference is a compilation of some of the most frequently presenting mental health concerns and provides a useful aid to the busy physician in accurately identifying and treating their young patients.

## ACKNOWLEDGEMENTS

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The original desk reference was the creation of Dr. Michael Enman, former Clinical Consultant to the Healthy Minds/Healthy Children Project. The Second Edition was produced with the efforts of Deena Nessman and Marlene O'Neill-Laberge, clinicians who have worked with Healthy Minds/Healthy Children Outreach Services. The Third Edition was produced through the efforts of Monique Lawrence, Shelley Hanna, Angela Lounsberry, Karen Gibb, Lindsay Hope-Ross and Pamela Klein, clinicians who have also worked with Healthy Minds/Healthy Children Outreach Services. As well, input was provided by Maureen Johnson and Robyn Englund of the Calgary Eating Disorder Program.

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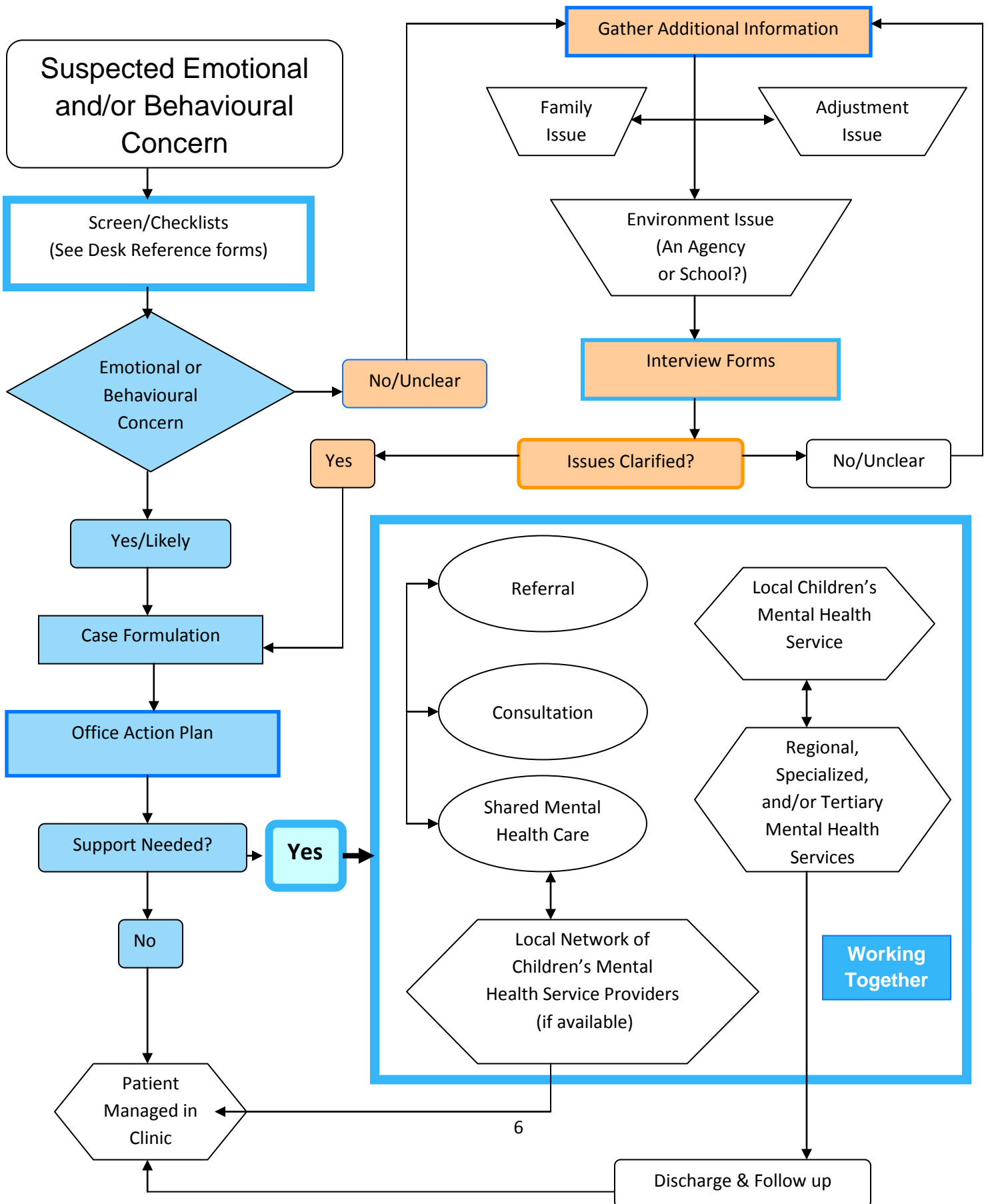
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# Decision Tree



## Desk Reference Feedback Form

1. Was the Desk Reference easy to use? Yes  No
2. Did it assist you in your work with your patients? Yes  No
3. Do you plan to continue to use it with your patients? Yes  No

If no to any of the above, please note why. \_\_\_\_\_

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4. Do you have any recommendations regarding the Desk Reference?  
(Its organization, its efficiency/effectiveness, etc?) \_\_\_\_\_
- 

### Modules

5. Were they helpful? Yes  No
  6. Do you have any recommendations regarding the Forms? (e.g., their description, clarity, comprehensiveness, etc?) \_\_\_\_\_
- 

7. Were the Screens and Checklists easy to use? Yes  No
  8. Were they helpful? Yes  No
  9. Do you have any recommendations regarding the Screens and/or Checklists?
- 
- 

**Thank you for taking the time to complete this form.**

Please fax your responses to 403.955-8184 care of Healthy Minds/Healthy Children  
Outreach Services

For additional information and resources please go to our website: [www.hmhc.ca](http://www.hmhc.ca)

# Fetal Alcohol Spectrum Disorder (FASD) Module

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## What is Fetal Alcohol Spectrum Disorder (FASD)?

FASD is a term used to describe the problems a baby could have if its mother drank alcohol while pregnant. It is also the leading known cause of mental retardation.

### There are four types of FASD

- Fetal Alcohol Syndrome (FAS)
- Partial Fetal Alcohol Syndrome (pFAS)
- Alcohol-Related Neuro-developmental Disorder (ARND)
- Alcohol-Related Birth Defects (ARBD)

A mother is more likely to have a baby with FASD if she

- is an older woman who drinks while pregnant
- has a long history of alcohol use and drinks while pregnant
- is dieting, overly thin or lacks nutrition and drinks while pregnant
- drinks heavily and frequently while pregnant
- uses alcohol together with other substances (sleeping pills, painkillers, marijuana, etc.) while pregnant

Nobody knows exactly how much alcohol causes damage in an unborn baby. Every mother and every fetus is different, but all babies' brains are sensitive to alcohol. Some babies are affected by very little alcohol. The only way to ensure a baby will not have FASD is for the mother not to drink any alcohol while pregnant.

Drinking during pregnancy is the only way for a baby to develop FASD. It is not genetic. That means it cannot be transferred from a mother with FASD to an unborn baby. It is not passed on through breast milk, but alcohol itself can be passed through breast milk. So, it is best to avoid alcohol while breastfeeding too.

### For Men

A father's drinking will not cause FASD in a child. Only a mother's alcohol consumption can affect the development of a fetus. However, men can help women who are pregnant by making it easy for them not to drink. This could be as simple as not drinking when you are around a mother-to-be; or, it could mean joining the mom-to-be in quitting drinking altogether during the pregnancy and breastfeeding stages.



## Is FASD is a consideration ?

### Parent Handout

These are some things to look for if there is cause to suspect that someone you know may be affected:

**Infants:** Low birth weight; sensitivity to light, noise and touch; irritability; unable to suck effectively; slow to develop; ear infections; poor sleep/wake cycles.

**Toddlers:** Poor memory; hyperactivity; no fear; no sense of boundaries; need for lots of physical contact.

**School-Aged Children:** Easily distracted; short attention span; poor coordination; trouble with large and fine motor skills; need lots of one-on-one attention; poor memory; lack of skill generalization.

**Older Children:** Low self-esteem; trouble keeping up in school; poor impulse control; difficulty with public versus private environments; must be reminded of concepts on a daily basis; poor personal boundaries.

These signs may also be present in children without FASD. However, you will notice that "typical" parenting will not result in changes in behaviour for children prenatally exposed to alcohol.

Unfortunately, FASD cannot be cured. The brain damage that occurs to an unborn baby when a pregnant woman drinks alcohol cannot be changed or reversed. However, people with FASD can function very well in life when given the right supports. These include a stable and loving home, and a job coach and placement program.

What we cannot change about FASD are called Primary Disabilities and include:

- Facial features associated with FAS;
- Height and weight (small in stature);
- Brain damage (learning disabilities, memory problems, poor impulse control).

Secondary characteristics are the ones that can be prevented when we deal with the Primary Disability properly. Secondary characteristics can include:

- Mental health problems;
- Disruptive school experience;
- Trouble with the law;
- Confinement (includes jail, mental health and chemical dependency treatment);
- Inappropriate sexual behaviour;
- Alcohol/drug problems;
- Dependant living;
- Employment problems.

## Benefits of an FASD Diagnosis

### Parent Handout

Having a diagnosis of Fetal Alcohol Spectrum Disorder may be helpful, as it can provide:

- Facilitation of appropriate referrals
- Another way to understand difficulties
- New strategies for home and school
- Better medical management
- Prevention of future alcohol-affected children
- The opportunity to build a circle of support and understanding
- Prevention of secondary disabilities

Protective factors that have resulted in lower rates of secondary disabilities:

- Living in a stable nurturing home environment for over 72% of life
- Fewer changes in living arrangement (average of more than 2.8 years without change)
- Not being exposed to violence from others or violence toward oneself
- Receiving services for developmental disabilities
- Being diagnosed before the age of six years
- Good quality home from age six to twelve years
- Having the full diagnosis of FAS rather than FAE
- Having basic needs met for at least 13% of life

## FASD- Some other tips you can try at home include

### Parent Handout

- Maintain a calm, structured home environment (e.g., practice relaxation, develop routines)
- Keep your routines the same (morning, for school, homework, bedtime)
- Provide clear expectations, limits, and consequences
- Help your child learn about and identify feelings
- Pay attention to your child's feelings
- Remain calm when your child is anxious
- Hold realistic expectations for your child's age; change them if you need to
- Plan for transitions (e.g., getting to school)
- Focus on the here and now – use the body's senses to notice what is going on in the moment (e.g., your child describes what they hear, see, smell, etc.)
- Show your child the way you identify and accept your feelings
- Show your child how to solve problems
- Take care of your own needs – parenting an FASD child can be challenging
- Talk to others for support, and ask for help when you need it
- Be aware of, and manage, your own reactions. Seek help if you are struggling with this
- Praise effort and provide rewards for effort

Research has shown that healthy living, like regular exercise, relaxation, a balanced diet, healthy relationships, healthy coping skills, good sleep, community involvement, and social support, is very important in managing stress and in promoting wellness.

## FASD Diagnostic Referral Criteria

Clinical indicators requiring a **referral to an FASD clinic or a specialized clinician to confirm/disconfirm an FASD diagnosis** (FASD diagnoses require specialized training and should not be diagnosed without this training; therefore, the following indicators are to be used **for referral purposes only**):

- A known or suspected history of maternal alcohol consumption during pregnancy
  - Establishing the history of alcohol consumption can be difficult. Many are not forthcoming or cannot recall specific quantities or timing of their alcohol uses
  - Children may already be out of their biological mother's care.
- Prenatal and/or post-natal growth retardation
- Neuro-developmental and behavioural characteristics
  - FAS results in a continuum of abnormalities of cognition, language, motor coordination and behaviour which change in expression over the course of birth to adulthood
  - **0-5 years** - delayed developmental milestones, poor sleep patterns, attention deficits, impulsivity, and difficulty adapting to change
  - **6-11 years** - significant learning disabilities, cognitive delay, an inability to appreciate cause and effect, poor understanding of social expectations, and executive functioning deficits
  - **Adolescence and adulthood** – difficulties with independent living, competitive employment, social integration, risk-taking behaviours that may lead to victimization and/or involvement with the legal system.

### Treatment

Medications may be used for children with FASD, in conjunction with psycho-social intervention to manage behaviour, mood, sleep problems, and to regulate activity, impulsivity, and inattention.

### Referral Information:

**FASD Clinics:** Use the following link to access FASD clinics in Alberta (please note this list can change without notice):

[http://www.seafan.ca/downloads/2010\\_fasd\\_clinic-jun10.pdf](http://www.seafan.ca/downloads/2010_fasd_clinic-jun10.pdf)

<http://www.albertahealthservices.ca/services.asp?pid=service&rid=1025263>

Public Health Agency of Canada [www.publichealth.gc.ca](http://www.publichealth.gc.ca)

## Childhood Trauma Module

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## What is Post-Traumatic Stress Disorder (PTSD)?

Post-Traumatic Stress Disorder (or PTSD) is an anxiety disorder that your child can develop after experiencing or witnessing a threatening event (called a trauma). This event may have, or could have, led to serious injury or death to your child or to other people. As a result, your child may have felt overwhelming fear, helplessness, or horror.

Here are some examples of traumatic events:

- Community violence (e.g., shooting, mugging, burglary, physical or sexual assault, bullying)
- Sexual and/or physical abuse
- Natural disaster such as a hurricane, flood, fire, or earthquake
- Being in, or witnessing, a serious car accident
- Sudden unexpected or violent death of someone close (e.g., suicide, accident)
- Serious injury (e.g., burns, dog attack), major surgery (e.g., heart surgery), or life-threatening illness (e.g., childhood cancer)
- Domestic or family violence, dating violence
- War or political violence (e.g., civil war, terrorism, torture)

Children exposed to the same trauma may react very differently, even if they are in the same family. Although many children will experience some form of trauma in their lives, not all will develop PTSD. The chance of developing PTSD increases with how severe the trauma is. For example, a child who is the victim of sexual violence or who has witnessed the sudden violent death of a parent is at high risk of developing PTSD.

**Children with PTSD continue to suffer the effects long after the trauma is over.**

Parents or caregivers can do many things to help a child recover from distressing or frightening experiences. Time and support can help a child to cope with trauma. If you are concerned about a child, or feel that you are not coping yourself, seek professional advice.

There is a variety of things you can do to help your child or teenager recover from a distressing experience. Examples of such events can include life-threatening car accidents, bushfires, floods, sudden illness or death in the family, crime or violence. When a distressing or frightening experience occurs, time and support will help with the recovery process.

If you are concerned about your child in any way, or feel that you are not coping yourself, always seek professional advice. A good place to start is your local doctor.

### **Children React Differently**

A child's response to a distressing or frightening experience will depend on a wide range of factors, including age, stage of development and personality, as well as the impact of the crisis on parents or significant others. Your child may not react in the ways you expect.

Trauma reactions may include:

- **Withdrawal** – such as loss of interest in activities, loss of confidence, not wanting to talk or regressing to more 'babyish' ways of behaving.
- **Preoccupation** – needing to relive the experience, for example, through repetitive play or drawings. The child may be overly concerned about the possibility of future events or may have nightmares.
- **Anxiety** – such as problems with concentrating or paying attention, clingy behaviour, separation anxiety, sleep problems and irritable behaviour.
- **Physical symptoms** – such as headaches and stomach aches.

Allow for a delayed reaction. Some children seem to cope well at first, but can experience reactions to the stress days, weeks or even months later.

### Talk About the Event

Be open to talking about the event. Suggestions include:

- Reassure your child that the event is over and he/she is safe (but only if this is the case). You may have to reassure him/her over and over again.
- Listen to your child. Take him/her concerns and feelings seriously.
- Let your child know that you would like to hear about how things are for him/her.
- Tell your child about what happened in a way that is appropriate to his/her level of understanding and without going into frightening and lurid detail. Use language he/she understands. If you keep accurate information from them, children will fill in the blanks using their experiences, available information and their imaginations.
- Make sure your child has not jumped to any wrong conclusions. For example, younger children may think that tragedies are their fault because they were naughty or thought bad things about someone.
- Talk about the event as a family. Allow everyone to have their say, including children. This helps everyone to overcome isolation, to understand each other, and to feel supported and heard.
- Talk to your child about how people may react to distress. Tell children their feelings are normal in these circumstances and reassure them that they will gradually feel better.

### Your Response is Important

How the crisis impacts you and your reactions to your child's feelings and behaviour can have an impact on your child's ability to cope and recover.

Things to keep in mind include:

- Be understanding. Recognise that changes in behaviour, such as tantrums or bedwetting, may be the way your child reacts to distressing or frightening events.
- Give your child extra attention, particularly at bedtime and at other times of separation, if this is an issue for her/him.
- Children look to their parents or caregivers to understand a crisis and find ways to respond and deal with it. They need the adults around them to be able to 'tune in' to their fears and distress, and to comfort and support them. If you are distressed and having difficulty with your feelings, reactions or relationships, it is important to seek support and help for yourself. If you don't, the child's fear and distress will increase.
- Talk about your feelings in an appropriate way with your child and allow him/her to talk about his/hers.



- Remember that everyone is different and may have different emotions. Do not expect your child to feel the same way you do.
- Give your child a sense of control over his/her life. Even minor decisions, such as allowing him/her to choose between two sandwich fillings at lunch, makes the child feel more in control. This is especially important after the chaos of a crisis. Children who feel helpless tend to experience more severe stress symptoms.
- Try not to be overly protective of your child. It's natural to want to keep your family members close after a crisis, but you also want them to feel that their world is a safe place to be.

## Family Routines

Suggestions include:

- Keep to your regular routine as much as possible. The predictability of the family's day-to-day schedule is reassuring for children.
- Reassure your children that their routines will be back to normal as soon as possible. They may not be able to manage their usual routine for a while, such as attending school or performing household chores. Do not push it.
- Do not introduce changes such as new routines or stricter standards of behaviour. Leave that for another time.
- Maintain family roles if you can. For example, do not insist that your child take on more responsibility around the house than usual or expect him/her to meet the emotional needs of a distressed parent.

## Practical Strategies

Suggestions include:

- Allow your child plenty of time to play and enjoy recreational activities such as sport, particularly favourite games and activities with 'best' and familiar friends.
- Allow time for fun. Laughter, good times and shared pleasure can help all family members to feel better.
- Do not insist on three main meals if your child's appetite is affected. If he/she does not feel like eating at mealtimes, offer him/her regular snacks throughout the day instead.
- Make sure your child gets enough rest and sleep.
- Involve children in some sort of physical exercise – it will help them to burn off stress chemicals and improve their sleep.
- Limit stimulants like sugar, coloured foods, colas and chocolate.
- Help your child to physically relax – warm baths, massages, story times and lots of cuddles can help relieve muscle tension.

- Intervene if an activity makes your child upset or anxious – for example, a television show that reminds the child of the trauma or promotes feelings of worry, alarm or fear. Do not be afraid to switch off the television if the program content is not supporting the child's recovery.

### **Where to get help**

- Your doctor
- Your local community health centre
- Counsellor
- Psychologist

### **Things to remember**

- Children and adults can recover from distressing or frightening experiences given time and support.
- How you deal with the crisis yourself and how you react to your child's feelings and behaviour can have an impact on his/her ability to cope.
- Tell your child the facts about what happened, in a way that is appropriate for his/her level of development and using language the child can understand.

## PTSD Signs and Symptoms During Different Stages of Child Development

Parent Handout page 1

<i>Stage</i>	<i>Symptoms</i>
Early childhood	<ul style="list-style-type: none"> <li>• fear of strangers, family, or situations (e.g., clingy, avoiding, crying)</li> <li>• replay trauma through play and/or artwork</li> <li>• more alert to the environment (easily startled, very aware of danger)</li> <li>• act younger or no longer use previously gained developmental skills (e.g., stop using the potty, start sucking thumb)</li> <li>• body complaints (e.g., stomach aches, headaches, aches and pains)</li> <li>• sleep problems</li> <li>• eating problems</li> <li>• irritable</li> </ul>
School-aged children	<ul style="list-style-type: none"> <li>• fear of being separated from caregivers (don't want to be apart, trouble sleeping alone)</li> <li>• loss of trust (e.g., mistrusting of caregiver to keep safe)</li> <li>• negative view of the world (e.g., think of world as dangerous)</li> <li>• replay trauma through play and/or artwork</li> <li>• difficulty concentrating</li> <li>• lose appetite</li> <li>• do more things without thinking first (impulsive, e.g., fighting without thinking about the consequences)</li> <li>• defiant, or have intense anger outbursts or aggression</li> <li>• mood changes, be unhappy or depressed</li> <li>• lose interest in activities that they used to enjoy</li> <li>• body complaints (e.g., stomachaches, headaches, aches and pains)</li> <li>• sense of not having a future</li> </ul>

<p>Teenagers/young adults</p>	<ul style="list-style-type: none"><li>• may fear separation from caregivers (clingy, resists being alone, tries to be near)</li><li>• loss of trust (e.g., mistrusting of caregiver)</li><li>• negative view of the world (e.g., think of world as dangerous)</li><li>• very irritable, angry outbursts</li><li>• impulsive behaviour (e.g., substance use, self-harm)</li><li>• defiant, aggressive</li><li>• repeated thoughts of death and dying, including thoughts of killing themselves</li><li>• risky behaviour such as self-injury (e.g., cutting themselves), alcohol and drug use, unprotected sexual behaviour</li><li>• mood changes, seem unhappy or depressed</li><li>• lose appetite</li><li>• lose interest in activities that used to be enjoyed</li><li>• body complaints (e.g., stomach aches, headaches, aches and pains)</li><li>• sense of not having a future</li></ul>
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# Child Stress Disorders Checklist (CSDC)

Physician Form

## Child Stress Disorders Checklist (CSDC) <sup>1</sup>

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Child's Name (or ID #): \_\_\_\_\_ Age: \_\_\_\_\_ Sex: **M**  **F**

Person Completing Questionnaire: \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Has your child experienced or witnessed an event that caused, or threatened to cause, serious harm to him or herself or to someone else? Please check any and all events (and age(s) of your child at the time of the event or events) below-

- |                   |       |              |                     |       |              |
|-------------------|-------|--------------|---------------------|-------|--------------|
| 1) Car Accident   | _____ | Age(s) _____ | 5) Physical Illness | _____ | Age(s) _____ |
| 2) Other Accident | _____ | Age(s) _____ | 6) Physical Assault | _____ | Age(s) _____ |
| 3) Fire           | _____ | Age(s) _____ | 7) Sexual Assault   | _____ | Age(s) _____ |
| 4) Storm          | _____ | Age(s) _____ | 8) Any Other Event  | _____ | Age(s) _____ |

Please provide any details about this (or these) events in the box below. For example- Where did the event occur? Who was with your child? Who hurt your child? How often did this happen? How long did it last? How badly was your child hurt? Did he or she require medical care?

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<sup>1</sup> Glenn N. Saxe, M.D. National Child Traumatic Stress Network & Department of Child and Adolescent Psychiatry, Boston University School of Medicine [http://www.childadvocate.net/Recognizing\\_Posttraumatic\\_Stress\\_Disorder.htm](http://www.childadvocate.net/Recognizing_Posttraumatic_Stress_Disorder.htm)

The Child Stress Disorders Checklist (CSDC) was designed to be used as a measure of Acute Stress Disorder (ASD) symptoms when administered within one month of trauma, or as a measure of Post-Traumatic Stress Disorder (PTSD) symptoms when administered after one month. The CSDC takes approximately ten minutes to administer and may be completed by psychologists, social workers, counsellors, teachers, nurses, doctors or parents/caregivers.

**Directions:** Below is a list of feelings and behaviours that children sometimes have immediately after a frightening event (or after he or she regained consciousness from such an event). For each item that describes your child immediately after the event, please circle 2 if the item is **VERY TRUE** of your child. Circle 1 if the item is **SOMEWHAT TRUE** of your child. If the item is **NOT TRUE** of your child, circle 0.

Please **answer all items** as well as you can even if some do not seem to apply to your child. For children who have experienced more than one event, choose the event that was most distressing to him or her.

**0 = Not True (as far as you know) 1 = Somewhat True 2 = Very True**

- 0 1 2 1) Child felt terrified (extreme anxiety or fear).
- 0 1 2 2) Child felt horrified (extreme feelings of revulsion, disgust, or shame).
- 0 1 2 3) Child felt helpless.
- 0 1 2 4) Child's behaviour became agitated. For example, his or her behaviour became hyperactive, impulsive, or difficult to control.
- 0 1 2 5) Child's behaviour became disorganized. For example, his or her behaviour became very different than is usual or his or her behaviour did not make sense.

**Directions:** Below is a list of behaviours that describe children. For each item that describes your child **NOW** or **WITHIN THE PAST MONTH**, please circle **2** if the item is **VERY TRUE** or **OFTEN TRUE** of your child. Circle **1** if the item is **SOMEWHAT** or **SOMETIMES TRUE** of your child. If the item is **NOT TRUE** of your child, circle **0**. Please **answer all items** as well as you can even if some do not seem to apply to your child. The term "event" refers to the **most** stressful experience that you have described above.

**0 = Not True (as far as you know)**

**1 = Somewhat or Sometimes True**

**2 = Very True or Often True**

- 0 1 2** 1) Child reports uncomfortable memories of the event.
- 0 1 2** 2) Child startles easily. For example, he or she jumps when hears sudden or loud noises.
- 0 1 2** 3) Child gets very upset if reminded of the event.
- 0 1 2** 4) Child seems numb or distant from his or her feelings.
- 0 1 2** 5) Child avoids doing things that remind him or her of the event.
- 0 1 2** 6) Child seems irritable or angry.
- 0 1 2** 7) Child has difficulty remembering details about the event.
- 0 1 2** 8) Child has difficulty falling asleep or staying asleep.
- 0 1 2** 9) Child seems detached or distant from other people.
- 0 1 2** 10) Child has difficulty getting along with friends, schoolmates or teachers.
- 0 1 2** 11) Child does things that he or she outgrew. For example, thumb sucking, bed wetting, nail biting, or requests to sleep with parents.
- 0 1 2** 12) Child reports feeling as if the event were happening again.
- 0 1 2** 13) Child is restless and doesn't sit still.
- 0 1 2** 14) Child avoids places that remind him or her of the event.

**0 = Not True (as far as you know)**

**1 = Somewhat or Sometimes True**

**2 = Very True or Often True**

- 0 1 2** 15) Child has difficulty getting along with family members.
- 0 1 2** 16) Child appears confused about things that he or she should know.
- 0 1 2** 17) Child seems "on edge" or nervous.
- 0 1 2** 18) Child seems "spaced out" or in a daze.
- 0 1 2** 19) Child acts as if the event were happening again.
- 0 1 2** 20) Child has trouble keeping track of time. He or she may become confused about the time of day, the day of the week, or when something really happened.
- 0 1 2** 21) Child avoids talking about the event.
- 0 1 2** 22) Child reports bad dreams.
- 0 1 2** 23) Child reports more physical complaints when reminded of the event. For example, headaches, stomach aches, nausea, difficulty breathing.
- 0 1 2** 24) Child has difficulty performing activities such as schoolwork or chores.
- 0 1 2** 25) Child plays about the event (child expresses what happened to him or her with toys, games, drawings, or other fantasy play).
- 0 1 2** 26) Child appears slowed down. It takes him or her a long time to respond to things.
- 0 1 2** 27) Child reports that his or her environment seems different than it used to be. For example, he or she may report that things look or sound different.
- 0 1 2** 28) Child avoids people who remind him or her of the event.
- 0 1 2** 29) Child has trouble concentrating.
- 0 1 2** 30) Child reports that he or she does not want to think about the event.



## The Child Stress Disorders Checklist

The Child Stress Disorders Checklist (CSDC) assesses a child's post-traumatic symptoms based on observer report. Observers respond to an inventory of symptoms by indicating **0** (Not True), **1** (Somewhat or Sometimes True), or **2** (Very True) based on their observations of their child. Scores are calculated by adding the responses within a variety of dimensions of post-traumatic symptoms.

The first page of the CSDC gathers descriptive information about the traumatic event or events. This page is not meant to be scored, but yields information about the type(s) of traumatic events that the child may have experienced, his or her age(s) at the time of the event(s), as well as a qualitative description of the circumstances of the event(s).

The second to fourth pages of this instrument gather quantitative information about a child's post-traumatic symptoms.

The first five items of the CSDC asks about a child's immediate responses to the event. The Immediate Response Score is calculated by adding the scores (0, 1, or 2) for these five items. Items with Very True and Sometimes/Somewhat True scores should be explored further with the client.

The remainder of the CSDC assesses the thirty different post-traumatic symptoms on five dimensions: 1) Re-experiencing, 2) Avoidance, 3) Numbing and Dissociation, 4) Increased Arousal, and 5) Impairment in Functioning, and can be used in treatment planning. The items that measure these five dimensions are:

- 1) Re-experiencing: Items 1, 3, 12, 19, 22, 23, 25
- 2) Avoidance: Items 5, 14, 21, 28, 30
- 3) Numbing and Dissociation: Items 4, 7, 9, 16, 18, 20, 26, 27
- 4) Increased Arousal: Items 2, 6, 8, 13, 17, 29
- 5) Impairment in Function: Items 10, 11, 15, 24

The score for each dimension is calculated by adding the responses for each item in that dimension. The total Post-Traumatic Symptom Score is calculated by adding the responses for all 30 items.

### SCORES

- 1) Immediate Response Score:** \_\_\_\_\_
- 2) Post-Traumatic Symptom Scores:**
  - 1) Re-experiencing: \_\_\_\_\_
  - 2) Avoidance: \_\_\_\_\_
  - 3) Numbing and Dissociation: \_\_\_\_\_
  - 4) Increased Arousal: \_\_\_\_\_
  - 5) Impairment in Functioning: \_\_\_\_\_
- 3) Total Post-Traumatic Symptom Score:** \_\_\_\_\_

## Childhood Trauma

### Physician Form

This is an example of some questions regarding traumatic incidents that you can modify to fit the developmental level of the child.

#### Question:

**On a scale from 0 to 10, how scary or worrisome was this event to you, with 0 being not scared or worried and 10 being very scared or worried?**



\*\*Note: with younger children you can use hand signals. Hands together = not scary/not worrisome to hands wide apart = very scary/worrisome

0      1      2      3      4      5      6      7      8      9      10

---

Not Scared/Worried

Moderately Scary/  
Worrisome

Very Scary/  
Worrisome

In order to establish which type of trauma a child may have experienced, it is always important to ask about prior trauma:

**Question: Sometimes events like this can remind people of previous bad times. Have some other bad things happened to you in the past?**

- No       Yes

**If Yes:**

• **What?**

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▪ **What is the scariest thing that you ever experienced?**

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▪ **Have you ever had any person/pet close to you die?**

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▪ **Do you ever have a scary memory, image or thought that keeps popping into your mind even when you don't want to think about it?**

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▪ **Is there anything else that we have not covered that you are concerned about or want to share with me?**

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# Autism Spectrum Disorder (ASD) Module

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<a href="#">Autism Questionnaire (Parent Handout)</a> .....	31
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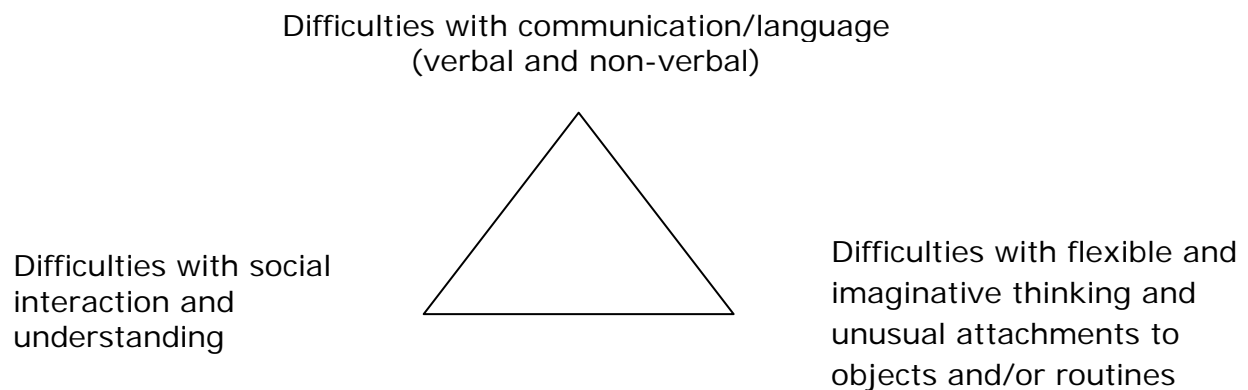


## What is Autism Spectrum Disorder ?

Autism Spectrum Disorder (ASD) is a term used to cover the five types of Pervasive Development Disorders (PDD) that are categorized in the DSM IV:

- Autism
- Asperger's Syndrome
- PDD-NOS
- Rett's Disorder
- Childhood Disintegrative Disorder

Autism Spectrum Disorder (ASD) is a complex neurological disorder that affects the functioning of the brain and impacts normal brain development, affecting a person's social relationships, communication, interests and behaviour. Individuals who have ASD vary widely in their needs, skills, sensory processing and abilities, but most have common types of characteristics including:



The effects of ASD may not even be visible to most people.

Autism Spectrum Disorders cause people to experience the world differently from the way most other people do. It is hard for individuals with ASD to have a dialogue with other people and express themselves using words. People who have a form of ASD usually keep to themselves and many cannot communicate without special help. They also may react to what is going on around them in unusual ways. They may experience heightened sensitivity to their environment, especially to sight, sound and touch. People with autism often cannot make connections that other people make easily. They often have difficulty understanding expressions of emotion (happiness, anger, frustration). A child who has ASD usually has trouble linking words to their meanings. ASD causes people to act in unusual ways. They might do things in a certain order, flap their hands, repeat certain words over and over, have temper tantrums, or have a particular attachment to one toy. Most individuals with autism do not like changes in their routines; they need to have a schedule that is consistent. These individuals may also insist that their toys or other objects be arranged in a certain way and become agitated if these items are moved or disturbed.

## Detecting the Early Signs of Autism: What Should We Be Most Concerned About?

Autism is a complex disorder that is diagnosed based on observation of behaviour. Parents may worry, but they also know their children better than anyone, so they are the ones who are best equipped to notice when something seems just not right with their child. There are many complex symptoms of autism, but knowing what the “red flags” at particular stages are will help parents to know what to discuss with their physician.

Since a large component of autism is difficulty in communication and expression, a lack in these areas may be a sign that your baby has an autism spectrum disorder (ASD).

While diagnosis is complex, and not all delays are indicative of an ASD, **if you find your answers to the following questions are “no,” then bring your concerns to your doctor right away.**

### Age 4 Months:

Does baby react to movement and bright colors? Does he turn toward sounds? Are faces interesting to your baby? Does she smile back at you?

### Age 6 Months:

Does your baby show joy and smile often when playing with you? Does he babble and coo when happy, but cry when unhappy?

### Age 9 Months:

Does your baby make faces and sounds with you in reaction to those you make? Does she make gestures that mirror yours (e.g. giving and taking)?

### Age 12 Months:

Does your baby use a few gestures (such as reaching, waving, pointing) one after the other in order to get his needs met? Does your baby play social games such as peek-a-boo? Does she turn to the speaker of her name? Does your baby make sounds like “ba,” “na,” “ga,” and “da”?

### Age 15 Months:

Does your baby use different sounds to draw attention to things of interest and to get his needs met? Does your baby point or use other gestures to show interest in something? Does he use at least 3 words (like “bye-bye,” “mama,” “dada”)?

## Age 18 Months:

Does your baby combine gestures and words to get what he wants? Does she understand and use at least 10 words? Does he engage in simple make-believe games like feeding a doll?

## Age 24 Months:

Does your toddler use and understand at least 50 words and use at least two together (like "more milk")? Does she seem to enjoy being with other children of the same age? Does he play pretend games that involve more than one action, such as pretending to eat and then pretending to wash the dish?

## Age 36 Months:

Does your child enjoy pretend play that involves talking for different characters, like dolls or action figures? Does he answer questions that start with "what?" "who?" or "where?" easily? Does she speak about thoughts and actions together in ways that make sense (such as, "Tired; go to bed")?

This list is certainly not a comprehensive checklist for developmental delays or for signs of autism, but rather a good starting point for knowing what should concern you most about your child's emotional and language development. <sup>2</sup>

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<sup>2</sup> <http://www.earlysignsofautism.com/detecting-the-early-signs-of-autism-what-should-we-be-most-concerned-about/>

## Developmental Screening for Autistic Spectrum Disorders (ASD)

Physicians Screening Tool Page 1

(a) Ask the caregivers these questions:

- Do you have any concerns about your child?

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- Is there a family history of Autistic Spectrum Disorder (ASD)?

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(b) Does the child fail to meet the following developmental milestones or present with any of the following behaviours?

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A single missed milestone may/or may not be cause for concern, but pay particular attention when more than one of the following milestones has not been met and/or the child presents with a number of the following behaviours.

### **Social Differences**

- Does not snuggle when picked up, but instead arches back
- Does not keep eye contact or makes very little eye contact
- Does not respond to caregiver's smile or other facial expressions
- Does not look at objects or events caregivers are looking at or pointing to
- Does not point to objects or events to get caregivers to look at them
- Does not bring objects to show to caregivers just to share his interest
- Does not often have appropriate facial expressions
- Is unable to perceive what others might be thinking or feeling by looking at their facial expressions
- Does not show concern (empathy) for others
- Is unable to make friends
- Exhibits parallel, rather than reciprocal, play

### **Communication Differences**

- Repeats exactly what others say without understanding its meaning (parroting or echolalia)
- Does not say single words by 15 months or two-word phrases by 24 months
- Diminished, atypical, or no babbling by 12 months
- Diminished, atypical, or no gesturing (e.g., pointing, waving bye-bye,) by 12 months



## **Communication Differences (continued)**

- Lack of response to his or her name by 12 months of age
- No single words by 16 months
- Diminished, atypical, or no two-word spontaneous phrases (excluding echolalia or repetitive speech) by 24 months
- Loss of any language or social skill at any age
- Lack of shared attention
- Does not respond to his or her name being called, but does respond to other sounds (like a car horn or a cat's meow)
- Refers to self as "you" and others as "I" (pronominal reversal)
- Often does not seem to want to communicate
- Does not start or cannot continue a conversation
- Does not use toys or other objects to represent people or real life in pretend play
- May have a good rote memory, especially for numbers, songs, TV jingles, or a specific topic
- Loss of language milestones, usually between the ages of 15 to 24 months in a few children (regression)

## **Behavioural Differences (Stereotypic, Repetitive, And Restrictive Patterns)**

- Rocks, spins, sways, twirls fingers, or flaps hands (stereotypic behaviour)
- Likes routines, order, and rituals
- Obsessed with a few activities, doing them repeatedly during the day
- Plays with parts of toys instead of the whole toy (for example, spinning the wheels of a toy truck)
- May have splinter skills, such as the ability to read at an early age, but often without understanding what it means
- Does not cry if in pain
- Seems to have no fear
- May be very sensitive or not sensitive at all to smells, sounds, lights, textures, and/or touch
- Unusual use of vision or gaze; that is, looks at objects from unusual angles
- May have unusual or intense, but narrowed, interests

## Physician's Autism Referral Information

- Preschool Autism Assessment and Resource Team web page  
Child Development Centre  
2888 Shaganappi Trail NW,  
Calgary, Alberta T3B 6A8  
403-955-5945
- Glenrose Rehabilitation Hospital  
10230 111 Avenue NW,  
Edmonton, Alberta T5G 0B7  
780-735-8285

This is the link to the [Glenrose Rehabilitation Hospital Children's Referral Form](#)

- Brooks Health Centre  
440 3 Street E,  
Brooks, Alberta T1R 1B3  
403-501-3300
- Medicine Hat Regional Hospital  
Rehabilitation Wing of Medicine Hat Regional Hospital  
Main Floor, 666 - 6 Street SW,  
Medicine Hat, Alberta T1A 4H6  
403-529-8966

# Eating Disorders

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## Disordered Eating Defined

### Parent Handout Page 1

Eating disorders are mental illnesses with grave physical consequences. Eating disorders are multi-determined by a combination of:

- Societal/Media Influences
- Individual Factors
- Family Factors
- Genetic Factors

Eating Disorders are not about food. They are about underlying struggles with identity and self-concept. They are a coping mechanism.

**Anorexia Nervosa:** an eating disorder in which there is: significant weight loss; a drive for thinness; extreme fear of weight gain; poor/distorted body image; self-esteem is dependent on bodyweight. There are two subtypes: Restriction subtype and Binge/Purge subtype. Bingeing is characterized by eating enormous amounts of food in a short period of time. Purging is the effort to rid body of food and excess calories and then ridding the body of these by vomiting, over-exercising, and/or using laxatives or diuretics.

**Bulimia Nervosa:** an eating disorder characterized by: a strong desire for thinness; preoccupation with food and weight; marked by frequent episodes of bingeing and purging; and feelings of loss of control. Bingeing is characterized by eating enormous amounts of food and excess calories by vomiting, over-exercising, and/or using laxatives or diuretics.

**Eating Disorder Not Otherwise Specified:** diagnosed when the individual has an eating disorder but does not meet the full diagnostic criteria for Anorexia or Bulimia (for example, someone who meets all criteria for Anorexia except they are having regular menses).

**Binge Eating Disorder:** an eating disorder that is characterized by: the frequent consumption of unusually large amounts of food and a feeling of loss of control during these bingeing episodes, but not compensating, or purging, for the binge.

Here are some signs and symptoms of an eating disorder to watch for:

- Significant changes in eating habits.
- Withdrawal from usual activities and relationships with family and friends.
- Preoccupation and need to control things such as grocery shopping and food preparation.
- Extreme participation in physical activity that takes priority over most other activities and guilt may be experienced if missed.
- Obsession with body weight, shape, and calorie counting.
- Extreme sensitivity to questions about her/his eating patterns.
- Feeling “fat” even when normal or underweight.
- Constantly seeking reassurance about appearance.
- Judging self-worth based on weight and body size.
- Constantly feeling tired, cold, or faint.
- Concealing behaviours and beliefs around food and weight.
- Might spend a lot of time thinking and talking about food.
- Might think about dieting and her/his weight all the time.
- Your daughter might start missing her menstrual periods.
- Might visit the bathroom many times after eating.
- Might avoid eating even when hungry and skips meals saying that he/she is not hungry. He/she might also be eating in secret.
- Might be exercising all the time and wearing baggy clothes to hide her/his weight loss.

It's very important to get help for an eating disorder because this issue can cause many serious health problems. Eating disorders are very treatable, and many children recover with support from different health experts. Regular medical check-ups are important to treat physical health problems.

Counselling is beneficial as it will help your child understand her/his thoughts, her/his feelings and why she/he acts the way he/she does. Family counselling can help the entire family understand the disorder and what it is doing to the family.

A dietician can help you and your child learn about food and help your family create healthy meal plans.

Support groups for you and your child can help you see that you are not alone. You can learn new ways of coping and find support from others.

If your child weighs too little or starts to develop serious health problems, he/she may need to be treated in the hospital.

Medication is not usually the first option. Some research suggests that certain drugs can help people living with eating disorders.

There are many things you can help your child do at home to cope.

Here are a few things to try:

- Help your child to discuss his/her feelings, thoughts, and emotions.
- Make sure your child is getting enough sleep.
- Help your child learn to manage stress and solve problems.
- Make sure you help your child keep in touch with family and friends.
- Help your child with relaxation techniques.
- Spend time with your child doing the things he/she enjoys.
- Talk to your doctor about other useful things to try at home.

Where to from here?

Talk to your family doctor. Also, check out the reference web sites for more information about eating disorders.

## Detection of Disordered Eating

### Physician Questionnaire Handout Page 1

- 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.

#### 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. Garner & P.E. Garfinkel (1979;); D.M. Garner et al, (1972)]*

#### Signs and Symptoms of a Possible Eating Disorder

- Failure to gain weight during a growth period (adolescence)
- 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
- Significant weight loss
- 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
- Over-use of laxatives
- Calloused knuckles



## Medical Management for Eating Disordered Patients

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

### Suggested Tests:

- ECG
- BUN
- CBC
- Chest X-Ray
- Bone Density (if patient has been underweight for some time)

## 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

## Referral Process for Calgary Eating Disorder Program

1. Referrals are received:

- a) From a family physician.
- b) Internal transfer from another AHS program
- c) ACCESS Mental Health - ACCESS informs the client that a physician referral must be completed.

Referral forms can be found at the following website address:

<http://www.albertahealthservices.ca/4208.asp>

Or call 403- 955-7700 for more information.

## Information For Eating Disorder Programs and Help

1. Program Consultant(s)  
Calgary Eating Disorder Program  
Alberta Children's Hospital  
**(403) 955-7700**
  
2. University of Alberta Hospital  
Eating Disorder Program  
Edmonton  
**(780) 407-6114**

### Websites:

#### Calgary Eating Disorder Program

<http://www.albertahealthservices.ca/services.asp?pid=service&rid=1018201>

#### University of Alberta, Eating Disorder Program

<http://www.albertahealthservices.ca/services.asp?pid=saf&rid=1005216>

#### National Eating Disorder Information Centre

[www.nedic.ca](http://www.nedic.ca)

#### National Eating Disorders Association

<http://www.edap.org/>

## Online Resources and References



## Resources that were used to create this reference book

- American Academy of Pediatrics <http://www.aap.org/>
- Anxiety B.C. <http://www.anxietybc.com/parent/post.php>
- Autism Canada Foundation <http://www.autismcanada.org/>
- Autism Treatment  
<http://www.autismtreatment101.com/are-you-concerned-that-your-child-has-autism-22-signs-and-symptoms-of-autism-to-look-out.html>
- Autism Treatment Center of America  
[http://www.autismtreatmentcenter.org/information/autism\\_symptoms.php](http://www.autismtreatmentcenter.org/information/autism_symptoms.php)
- Autism Calgary Association [www.autismcalgary.com/whatisautism.asp](http://www.autismcalgary.com/whatisautism.asp)
- Better Health Channel  
[http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Trauma\\_and\\_chi ldren\\_tips\\_for\\_parents](http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Trauma_and_chi ldren_tips_for_parents)
- British Columbia Ministry of Education <http://www.bced.gov.bc.ca/specialed/fas/>
- Calgary Eating Disorder Program [www.calgaryhealthregion.ca/eatingdis](http://www.calgaryhealthregion.ca/eatingdis)
- Canadian Mental Health Association. Mental health information for families and adults <http://cmha.ca/bins/index.asp>
- Child Advocate  
[http://www.childadvocate.net/Recognizing\\_Posttraumatic\\_Stress\\_Disorder.htm](http://www.childadvocate.net/Recognizing_Posttraumatic_Stress_Disorder.htm)
- Child Trauma Academy <http://www.childtrauma.org/>
- Eating Disorder Education Organization [www.edeo.org](http://www.edeo.org)
- E Medicine Health [http://www.emedicinehealth.com/post-traumatic\\_stress\\_disorder\\_ptsd/article\\_em.htm](http://www.emedicinehealth.com/post-traumatic_stress_disorder_ptsd/article_em.htm)
- Fetal Alcohol Disorders Society <http://www.faslink.org/FASbook2.pdf>
- Fetal Alcohol Syndrome Support Network <http://www.fassn.org/>
- Fetal Alcohol Syndrome: Support, Training, Advocacy and Resources  
<http://www.fasstar.com/>
- Journal of the American Academy of Pediatrics  
<http://pediatrics.aappublications.org/cgi/reprint/115/1/39>
- Keltly Mental Health Resource Centre <http://keltlymentalhealth.ca/substance-use/fetal-alcohol-spectrum-disorder-fasd-0#view-tab-2>
- Kid's Health [http://kidshealth.org/kid/health\\_problems/brain/autism.html](http://kidshealth.org/kid/health_problems/brain/autism.html);  
<http://kidshealth.org/parent/medical/brain/fas.html#>
- McCallum Place <http://www.eatingdisordertreatmentinformation.com/what-are-eating-disorders.html>
- Medical Journal of Australia  
<http://www.mja.com.au/public/mentalhealth/articles/yellowlees/yellowlees.html#box2>
- National Center for Children Exposed to Violence <http://www.ncccev.org/>
- National Child Traumatic Stress Network  
<http://www.nctsn.org/content/child-stress-disorders-checklist-csdc>

- National Eating Disorder Information Centre [www.nedic.ca](http://www.nedic.ca)
- National Eating Disorders Association <http://nationaleatingdisorders.org/>
- Ontario Centre of Excellence for Child and Youth Mental Health  
<http://www.ementalhealth.ca/>
- University of Alberta Eating Disorder Program  
<http://www.albertahealthservices.ca/services.asp?pid=saf&rid=1005216>
- Public Health Agency of Canada  
<http://www.phac-aspc.gc.ca/hp-ps/dca-dea/prog-ini/fasd-etcaf/>
- Sunfield Autism Organization <http://www.sunfield.org.uk/asd.htm>
- Web4Health <http://web4health.info/en/answers/ed-dia-classification.htm>