
Moderators

Tina Nicholson
Any direct financial payments, gifts, in-kind compensation or honoraria
- Medical Director for CME & PD and PLP offices
- CanReach Program Faculty Member
- Medical Head Health Home Community
Membership on advisory boards or speakers' bureau
- Purdue/Elsevier: Speakers bureau, advisory board

Heather Armson
Any direct financial payments, gifts, in-kind compensation or honoraria
- Assistant Dean for CME & PD and PLP offices

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Territorial Acknowledgement

Housekeeping

- Multiple speakers will address various aspects of the topic
- There will be a Q&A after all the presentations
- Use the Q&A box to enter questions by text. No spoken questions.
- Refer to this how-to-guide for info on Questions, Chat, etc.
- We get lots of questions: scan the list and give a thumbs up if you are interested in a question already posed.
- Formal notices, copyright, declarations and disclaimers will be offered throughout the presentation and within the chat box
Disclosure of Financial Support

- The program was developed and planned to achieve scientific integrity, objectivity and balance
- This program has received educational grants from the College of Physicians Surgeons of Alberta, Alberta Health Services and Calgary Health Trust

COVID CORNER Webinar:
COVID Consequences - The Shadow Pandemic: Impact on the vulnerable family

Presenters:
Shirley Chan MD FRCP
April Elliott MD FRCP(C) FSAHM
Tami Masterson MD FRCP
Tacie McNeil RN BScN MPH
Monty Ghosh BSc MBT MSc MD FRCP DM-EMDM ISAM(C)
Suzanne Squires MD CCFP

June 10, 2020

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Office of Continuing Medical Education
and Professional Development. COVID
Corner June 10 - COVID
CONSEQUENCES The Shadow
Pandemic: Impact on the vulnerable
family.

Learning Objectives

- Describe the risk of substance misuse in adult and adolescent populations
- Summarize screening methods and case finding tools for adult and adolescent
  populations
- Identify the red flags of child abuse within virtual and limited interaction
  setting
- Summarize resources and supports relevant for your patient population

COVID PANDEMIC AS DISASTER

Mortality - COVID and Non COVID
Psychological Impact
Economic Loss
Social Disruption
Health Service Disruption


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Vulnerable Populations in a Pandemic

Pre-Pandemic
- Severe Mental Illness
- High Rates of Smoking
- Unstable housing
- Poor social supports

Pandemic
- Difficulties with access to Virtual Care (Digital Divide)
- Higher risk of experiencing homelessness
- Job loss and financial strain

Post-Pandemic
- High risk of worse Health Outcomes

IMPACT OF PANDEMIC ON SUICIDE RATES

"Maintaining and enhancing mental well being of the public over the period of epidemic is as important as curbing the spread of the epidemic. Attention and effort should also be made to enhance the community's ability to manage fear and anxiety, especially in vulnerable groups over the period of epidemic to prevent tragic and unnecessary suicide deaths”

Evidence shows that the impact of natural disaster/epidemic lasts beyond the initial event – suicidal rates may not rise for 12- 18 months post natural disaster
The Shadow Pandemic: Violence Against Women and Girls and COVID-19

Globally, 243 million women and girls aged 15-49 have been subjected to sexual and/or physical violence perpetrated by an intimate partner in the previous 12 months. The number is likely to INCREASE as security, health, and money worries heighten tensions and strains are accentuated by cramped and confined living conditions.

Emerging data shows that since the outbreak of COVID-19, violence against women and girls (VAWG), and particularly domestic violence, has INTENSIFIED.

- In France, reports of domestic violence have increased by 20% since the lockdown on March 17.
- In Cyprus and Singapore, helplines have registered an increase in calls of 35% and 33%, respectively.
- In Argentina, emergency calls for domestic violence cases have increased by 50% since the lockdown on March 20.

As stay-at-home orders are imposed to contain the spread of the virus, women with violent partners increasingly find themselves isolated from the people and resources that can help them. Violence against women and girls is pervasive but at the same time widely under-reported. Less than 40% of women who experience violence report these crimes or seek help of any sort.

- 87,000 women were intentionally killed in 2017. The majority of these killings were committed by an intimate partner or family member of the victim.

The global cost of violence against women had previously been estimated at approximately US$1.5 trillion. That figure can only be rising as violence increases now, and continues in the aftermath of the pandemic.

Domestic violence shelters are reaching capacity or unable to take new victims due to lockdown and social distancing measures. In other cases, they are being repurposed to serve as health centers.

The surge in COVID-19 cases is straining even the most advanced and best-resourced health systems to the breaking point, including those at the frontline in violence response.

National responses to COVID-19 must include:

- Services to address violence against women and girls, including increased resources to support shelters, hotlines, and online counselling. These essential services should be expanded and adapted to the crisis context to ensure survivors’ access to support.
- A strong message from law enforcement that impunity will not be tolerated. Police and Justice actors must ensure that incidents of VAWG are given high priority and care must be taken to address the manifestations of violence emerging in the context of COVID-19.
- Psychosocial support for women and girls affected by the outbreak, gender-based violence survivors, frontline health workers and other frontline social support staff must be prioritized.

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25% of Canadians (aged 35-54) are drinking more while at home due to COVID-19 pandemic; cite lack of regular schedule, stress and boredom as main factors

CCSA March Omni | Summary Report
Conducted by Nanos for the Canadian Centre on Substance Use and Addiction, April 2020
Submission 2020-1621


211 Alberta
Daily Emerging Needs Summary – April 8, 2020

211 Alberta and hub partners CMHA, Calgary & Edmonton Region Distress Centres received 5300 contacts since March 8, 2020 related to COVID-19.

<table>
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<th>Top 10 Needs</th>
<th>Top 10 Unmet Needs</th>
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<td>9. Public Assistance Programs</td>
<td>9. Legal Services</td>
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Blended Family Genogram

TERRY – since pandemic
Lost job / socially isolated
Financial insecurity
Lock down with family
ALCOHOL IS AN ESCAPE FROM
HIS MULTIPLE STRESSORS

Increased alcohol use leads to
Anger and irritability
Unpredictable behavior
Risk to family- verbal / physical abuse
Reduced functioning
Low self esteem and increasing despair
Case Study

- Patient presents to Peter Lougheed Centre Emergency Department in distress.
- He discloses that his drinking has gotten out of hand to the ED physician, who subsequently consults ARCH (Addiction Recovery and Community Health).
- The intent is to discharge the patient following ARCH consult.
- The ARCH MD completes a thorough assessment of substance use and the social determinants of health and makes recommendations and referral to community supports. This assessment can be found in Netcare.
Assessment

- Meets the DSM-5 criteria for moderate AUD
- No history of AWD seizures but does need a drink to treat AWD in the morning. PAWSS = 3
- Currently CIWA 0, lucid but smells strongly of ETOH
- Stage of change: contemplative (is considering change to use)
- No previous addiction treatment, denies psychiatric history
- SDOH:
  - Unemployed
  - Financial stressors
  - Family/marital tension/conflict (vague)
  - Isolated
  - Lacks health benefits/medication coverage
  - Does not have family doctor

Prediction of Alcohol Withdrawal Severity Scale (PAWSS)

The PAWSS has been found to be the most useful screening tool for predicting a patient's risk of developing severe complications of alcohol withdrawal. It is important to carefully assess and work with the patient and interdisciplinary care team to determine the best option for their care.

- The PAWSS is a 10-item risk assessment tool that combines simple yes/no questions about a patient's medical history with clinical examination findings.
- It can be used before a patient stops or reduces their drinking to determine if they are at high or low risk of severe complications of alcohol withdrawal (seizures, delirium tremens) that would require a higher intensity of monitoring and supportive care.

**Modified* Prediction of Alcohol Withdrawal Severity Scale (PAWSS)**

**PART A: THRESHOLD CRITERIA - Yes or No, no point**

Have you consumed any amount of alcohol (i.e., been drinking) within the last 30 days?

**OR**

Did the patient have a positive (+) blood alcohol level (BAL) on admission?

If the answer to either is YES, proceed to next questions.

**PART B: BASED ON PATIENT INTERVIEW - 1 POINT EACH**

1. Have you been recently intoxicated / drunk within the last 30 days?

2. Have you ever undergone alcohol use disorder rehabilitation treatment or treatment for alcoholism?

3. Have you ever experienced any previous episodes of alcohol withdrawal, regardless of severity?

4. Have you ever experienced blackouts?

5. Have you ever experienced alcohol withdrawal seizures?

6. Have you ever experienced delirium tremens or DTS?

7. Have you combined alcohol with other "downers" like benzodiazepines or barbiturates, during the last 90 days?

8. Have you combined alcohol with any other substance of abuse, during the last 90 days?

**PART C: BASED ON CLINICAL EVIDENCE - 1 POINT EACH**

9. Was the patient's blood alcohol level (BAL) greater than 200 mg/dL (5 units 40.5 mmol/L) OR
   - For men: Have you consumed more than 3 standard drinks in the past 12 hours?
   - For women: Have you consumed more than 2 standard drinks in the past 12 hours?

10. Is there any evidence of increased autonomic activity?
    - e.g., heart rate > 120 bpm, tremor, agitation, sweating, nausea

Interpretation: Maximum score = 10. This instrument is intended as a screening tool. The greater the number of positive findings, the higher the risk for the development of alcohol withdrawal syndrome (AWS).

A score of 4 or more suggests high risk for moderate to severe (complicated) AWS, prophylaxis and/or inpatient treatment are indicated.

A score of 3 or less indicates low risk and outpatient management is suitable.

A score of 4 or more indicates a patient might be at high risk for developing complications of alcohol withdrawal and should be admitted to an inpatient setting.

It is also important to note that benzodiazepines should be used cautiously and for outpatient withdrawal management, alternative medications should be considered (e.g., gabapentin, carbamazepine).

**Intervention**

- Brief intervention/motivational interviewing
  - 5 As (Ask, Advise, Assess, Assist, Arrange)
- Teaching about alcohol withdrawal/safety
- Discuss anti-craving pharmacotherapy options
- Discuss options for treatment (peer supports, inpatient vs outpatient detox, outpatient counseling vs residential treatment)
- Provide information about financial supports
- Based on assessment and patients' wishes, a referral to University of Calgary/Alberta Health Services RAAM is made

**Patient continued...**

- Patient relapses day after discharge back home.
- Re-commences 26oz vodka/ day of hard liquor.
- Family becomes increasingly frustrated with him at home.
RAAM Follow up

- Referral sent from ARCH
- Staff at AHS RAAM contacted patient and left messages x 2 but client did not reply.
- Staff at RAAM was finally able to get through on 3rd try nearly two weeks later and speak with patient.
- Virtual appointment set up with RAAM physician and addiction counsellors at AASC/RAAM
- Review of the patient’s medical conditions and blood work conducted.

Rapid Access Addiction Medicine (RAAM)

Drop-in intake Monday to Friday at 12:30pm
- Next business day access to programs following intake
- Medical services including anti-craving pharmacotherapy for alcohol, opioids, gambling, and stimulant use disorder.
- Concurrent psychiatric and pain management.
- Home detoxification services
- Educational, skill, and support group programs,
  Monday – Friday during the day and four evenings (Monday-Thursday) per week

- A four-week, intensive day treatment program for those committed to abstinence
- Short-term, outpatient counselling
- Supports for sexually transmitted infections testing, Hepatitis C treatment,
- Medical and mental health assessments for residential treatment facilities.

(403) 367-5000 or email: monty.ghosh@ahs.ca
Addiction During COVID - 19

- May worsen due to the following:
  - Housing and income instability.
  - Reduced access to health care and recovery support services.
  - Less access to peer run recovery addiction resources including SMART meeting and AA.
- Individuals who are isolated and stressed may turn to substances to alleviate stressors.
- Peers, family members, and addiction treatment providers should be alert to this possibility.


AUD during COVID

- Decreased patient capacity at residential detoxification and treatment facilities
- Increased wait times
- Increased acute withdrawals with closure of liquor stores.
  - India
  - South Africa

Additional addiction provisions during COVID

- Virtual supports via phone and zoom.
- Virtual Group sessions
- Home detoxification services partnered with community paramedics.

Assessment of Client

- Based on PAWS score or SADQ, a home withdrawal protocol is started with daily visits by the community paramedic team.
- Patient attends virtual appointments during COVID and is successfully detoxified.
- Thiamine – 200 mg orally per day (for 5 days) then 100mg for 3 months
- Folate (5 mg) and multivitamin (1 tab per day PO for 3 months)
- Multivitamin pill x 3 months.

Original Investigation
Pharmacotherapy for Adults With Alcohol Use Disorders in Outpatient Settings
A Systematic Review and Meta-analysis

Daniel E. Jonas, MD, MPH; Halle R. Amick, MSPH; Cynthia Feltner, MD, MPH; Georgiy Bobashev, PhD; Kathleen Thomas, PhD; Roberta Wines, MPH; Mimi M. Kim, PhD; Ellen Sharahan, MA; C. Elizabeth Gass, MPH; Cassandra J. Rowe, BA; James C. Garbutt, MD

CONCLUSIONS AND RELEVANCE Both acamprosate and oral naltrexone were associated with reduction in return to drinking. When directly compared with one another, no significant differences were found between acamprosate and naltrexone for controlling alcohol consumption. Factors such as dosing frequency, potential adverse events, and availability of treatments may guide medication choice.


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Pharmacotherapy Intervention is

- Treatment Options:
  1st: Naltrexone
  2nd Long Acting Naltrexone***
  3rd Acamprosate
  4th Gabapentin vs Topiramate

- Barriers:
  - Cost?
  - Availability?
  - Prescriber awareness?
  - Education re: effectiveness?

Evidence for Pharmacotherapy

- Anti craving medication is considered by some as the new standard of care.
  Consider for all patients with alcohol use disorder immediately post detox. Efficacy requires counseling and/or frequent physician monitoring.

- Underutilized
  - <1/3 of those with AUD receive treatment\(^1\) and <10% with AUD receive pharmacotherapy\(^2\)
  - Should be considered for all patients with moderate or severe alcohol use disorder\(^2,3,4,5,6\) who:
    - Have current, heavy use and ongoing risk for consequences\(^4\)
    - Motivated to reduce intake\(^4\)
    - Prefer medication along with (ideally) or instead of psychological intervention\(^4\)
    - Have no medical contraindications\(^4\)
  - Modeling study estimated that if 40% of all individuals with alcohol use disorder (mod-severe) received pharmacotherapy, there would be a 13% reduction in alcohol-attributable mortality in the European Union\(^1\)

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\(^1\) Hasin D, Stinson F, Ogburn E, Grant B.  Prevalence, correlates, disability, and comorbidity of DSM-IV alcohol abuse and dependence in the United States: results from the National Epidemiologic Survey on Alcohol and Related Conditions.  Arch Gen Psychiatry. 2007;64(7):830-842.


\(^3\) Uptodate.  Pharmacotherapy for alcohol use disorder.  2015.

Additional Psychosocial Support

• Evaluation of appropriateness for residential treatment conducted.
• Group therapy sessions started through Zoom.
• A recovery capital assessment is done, and patient starts to work on key aspects of their life.

Assessment of Client Continued

• Patient and his partner attend virtual addiction counselling with one of our counsellors.
• Counsellor informs physician that they believe the patient’s spouse has been the victim of violence but also, they may have addiction concerns as well.
• A referral for the client’s wife is also sent to the physician for further exploration via virtual appointment.
Tools at our Disposal:

• SBIRT: Screening, Brief Intervention, and Referral for Treatment

Why is SBIRT important?

• Treatment does work.
• Every interaction with a health care provider is an opportunity for intervention.
• Timely referral is important and overall it can help with:
  • Improves Morbidity and mortality.
  • Improves Quality of Life
  • Decreases Harm to Self and Others
  • Saves costs to our health care system.

Screening widens our net:

- ABSTAINERS & MILD DRINKERS (70%)
- MODERATE (20%) at risk drinkers
- SEVERE (10%)

Screening vs. Assessment

- Screening: Determines the possibility a condition exists.
- Assessment: Confirms the existence of a condition and its severity.
Pre-Screening

• Screening can take time to do....
• Pre-screen for Alcohol:
  • How many times in the past year have you had “X” or more drinks in one sitting?
    • Where X = 5 for men, and 4 for women or anyone older than 65.
• Drug Pre-Screens: How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?
  • If >1, then you must do a full screen.

Alcohol Use Disorder

• 2 Main Screens:
  • Audit (10 question screening tool valued at 4 points each)
    • Maximum points 40
    • If greater than or equal to 8, then identifies a hazardous problem.
  • CAGE: - 4 questions asked during history taking.
Audit Questionnaire:

1. How often do you have a drink containing alcohol?
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
3. How often do you have 6 or more drinks on 1 occasion?
4. How often during the past year have you found that you were not able to stop drinking once you had started?
5. How often during the past year have you failed to do what was normally expected of you because of drinking?
6. How often during the past year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
7. How often during the past year have you had a feeling of guilt or remorse after drinking?
8. How often during the past year have you been unable to remember what happened the night before because you had been drinking?
9. Have you or someone else been injured as a result of your drinking?
10. Has a relative, friend, or a health care professional been concerned about your drinking or suggested you cut down?

AUDIT score >8

- Abuse or Dependence
  - Sensitivity 61-96%
  - Specificity 85-96%
- Hazardous or harmful drinking:
  - Sensitivity 57-95%
  - Specificity 78-96%
AUDIT C

• First 3 questions of AUDIT
• Maximum score is 12
  • >3 in women and >4 in men indicate a risk for AUD.

CAGE Questionnaire:

• Have you ever felt you should Cut down on your drinking?
• Have people Annoyed you by criticizing your drinking?
• Have you ever felt bad or Guilty about your drinking?
• Have you ever taken a drink first thing in the morning (Eye Opener) to steady your nerves or get over a hangover?

☐ If two or more questions are positive:
  • Sensitivity = 60 – 95%
  • Specificity = 4 – 95%
  • Note you, can miss binge drinkers....
Additional pieces and Brief Intervention

• Assess readiness to change and enhance motivation.
• Provide menu of options
• Listen to them and provide feedback when necessary.

Referral:

• Last step in the process:
• Provide assistance in finding resources in their community for not only additional addiction management but social supports as well.
• Provide the following:
  • A current listing of substance abuse treatment centers?
  • Information about 12-Step and other recovery programs in your area?
  • Harm reduction services including supervised consumption sites.
References & Resources


QUESTIONS??

Email:

Monty Ghosh (RAAM) - smghosh@gmail.com  monty.ghosh@albertahealthservices.ca

Tacie McNeil (ARCH) - tacie.mcneil@albertahealthservices.ca

CINDY – Holding family together – but FEARFUL
- Husband’s addiction and health
- Safety herself and children
- Housing and financial security
- Social isolation, embarrassment, feels trapped
Injury is last straw – needs to see her doctor
Cindy’s Stitches: The problem behind the problem

Suzanne Squires MD CCFP
General Practitioner, Edmonton; Assistant Clinical Professor, Department of Family Medicine, University of Alberta; Delegate, AMA Representative Forum; Steering Committee Member, CanReach

Disclosures
• Grants and Clinical Trials: In the near future but hasn't started yet. Through Westview PCN and University of Alberta just received the grant for this research: Mobilizing Knowledge on the Use of Virtual Care Interventions to Provide Trauma-Focused Treatment to Individuals and Families At-Risk of Domestic Violence during COVID-19—with Dr. Stephanie Montesanti and Dr. Peter Silverstone

The virtual visit

• Cindy calls to discuss her recent laceration on her face, needs sutures removed in a few days
• Also wants to discuss a few things about her daughter—bedwetting at night, acting anxious and withdrawn, new behaviours in the past few weeks.
• Sounds stressed on the call; only vague answers to questions. Has no COVID symptoms or sick contacts so book a live appointment for ROS. Separate phone visits for children’s issues.
The live visit

• Sutures removed, healing well, bruising remains around her eye
• Cindy isn’t making eye contact, seems bothered, isn’t her usual self.

You sense something is wrong...What can you ask? How can you best support her?

Supportive, non-judgmental questions

• COVID restrictions have been tough on a lot of families, how has it been going for you? Cindy breaks down...Listen, don’t interrupt.
• Questions should be behavior specific. Documentation should be clear. Support/resources should be given. Support, educate, and validate. Find out what she wishes to do. Give options, not orders.
COVID messaging challenges

• “Compounding barriers to safety specific to the pandemic may also emerge. For instance, messages that individuals need to “sacrifice” to reduce the burden on emergency services (e.g. hospital, police) may discourage women from seeking assistance. Women’s experiences of violence may also be excused as “stress” related to the pandemic and not taken seriously.” vawlearningnetwork.ca

• Messaging: if home is unsafe, it is OK to leave, even during COVID

Questions for Domestic Violence “SAFE” tool

• S “How would you describe your Spousal relationship?” (I ask, Is your partner supportive?)
• A “What happens when you and your partner Argue?”
• F “Do Fights result in you being hit, shoved, or hurt?”
• E “Do you have an Emergency plan?”

• Ask about the safety of the children. Be aware of ACE’s and how IPV affects children’s mental health as well.
Stats

- According to the WHO:
- Globally, 1 in 3 women worldwide have experienced physical and/or sexual violence by an intimate partner
- ACWS: mid-March calls to crisis centres plummeted, but those who called shelters or police had increased severity of violence
- Eastern part of Alberta calls to RCMP went up 40%
- 11 women and girls were killed during the pandemic in Alberta

Safety planning & follow-up

- You may be the only person she tells for awhile
- Book regular follow-up  ?in-person vs. virtual?-be aware of new virtual billing codes
- Discuss confidentiality—especially if you are her partner’s physician
- Discuss safety of children and duty to report to Children’s services
- Safety planning—code-word or question, when to call police, extended family supports, where to go if violence escalates, etc.
- The most dangerous time for a woman is when she tells her partner she’s leaving—refer to social services or shelter hotline to help make a safety plan
Resources

- Know your local resources—shelters or counselling groups
- Alberta Council of Women’s Shelters: 1-866-331-3933 acws.ca
- Alberta Health Abuse Hotline: 1-855-4HELPAB (1-855-443-5722)
- Family Violence Info Line: 310-1818

The children

- Behavioural changes and bedwetting may be due to psychological stress of conflict in home
- Educate and support—order reasonable investigations, speak directly to the kids, ask about their safety
- Book separate time for kid’s visits, document in correct chart
- Refer for further supports as necessary, report to children’s services either with mom or outside of the visit. If any concerns of child safety, it is best to report.
Further reading:


- SOGC clinical practice guideline:

CARTER – 15YRS:
Social isolation
Lack of sport, friends, school
Concern and disgust over Dad’s behavior – Angry
Family interactions - oppositional
Self isolating from family
Increased screen time
Risk taking behavior – breaks curfew
Can’t see a way forward

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Addressing the Needs of Youth during and Beyond the Pandemic

April Elliott MD FRCP(C) FSAHM, CEC
Clinical Associate Professor, Chief, Adolescent Medicine Section, Department of Pediatrics, University of Calgary

Disclosures
• Other: AMHSP with AHS and University of Calgary

Addressing the Needs of Youth* during and Beyond the Pandemic

• Strength-based approach to the adolescent
• How to take a coaching stance
• Vulnerable youth – lack of shelters, safe spaces & support
• Technology and youth during Covid19
Developmental Tasks of Adolescence

- Development of self-esteem and a healthy identity
- Emancipation from parents to autonomous behaviors
- Formation of a sexual identity
- Meaningful social and peer relationships
- Seeking vocational goals
- Establishing moral and ethical values

Setting the Stage

- Confidentiality
- Forming an alliance/building rapport
- Coaching Stance vs. Medical Stance
- Strength-based assessment
  - Trauma-Sensitive
  - Resilience-Building Communication

“The single biggest problem in communication is the illusion that it has taken place.”
– George Bernard Shaw

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Office of Continuing Medical Education
and Professional Development. COVID
Corner June 10 - COVID
CONSEQUENCES The Shadow Pandemic: Impact on the vulnerable family.

The Coaching Stance is the “How” of coaching

Requires the provider to act authentically and intuitively

Does not require specific training, but is intentional

Involves the expression of 5 factors:

- **Non-Judgement**: “If there is no right or wrong explanation, how would you describe this situation to your best friend?”
- **Curiosity**: “How do YOU think things are going?”
- **Empathy**: “It seems like a difficult situation all around!”
- **Openness**: “What other factors should we consider?”
- **Flexibility**: “What else do you think is important here?”

Works in conjunction with Coaching techniques: “right questions” and “engaged listening”

Strength-Based Approach

• “All youth deserve to be seen in terms of what they are doing right”. – Dr. Kenneth Ginsburg

  • Find out what they are good at
  • See as a whole person, not just a problem behavior
  • Praise when praise is warranted
  • Don’t assume negative behaviour – this can be harmful and insulting
  • Start from neutral – allows disclosure without shame
Risk and Protective Factors

- 5 different domains:
  - Individual, Family, Peers, School, Community
- Threats to Healthy Development
  - Family instability and challenges
    - Frequent moves
    - Parental substance abuse or mental illness
  - Abuse (physical, sexual, emotional)
  - Chronic illness and disabilities
  - Homelessness & running away

Strengths-Based Assessments: Risk and Protective Factors

HEEADSSS assessment
- Home
- Education
- Eating
- Activities
- Drugs
- Depression
- Sex
- Suicide
- Safety

SSHADESS Assessment
- Strengths
- School
- Home
- Activities
- Drugs/Substance Use
- Emotions/Depression
- Sex
- Safety

Ginsburg KR. Adol Health Update. 2007; 19(2)
Ginsburg & Kinsman, eds. Reaching Teens (AAP, 2014)

Adapted from Dr. Dzung Vo

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D: Drugs

- “We ask all young people about things like smoking, drugs, and alcohol, because those things can affect your health. Can we talk about that?”
- “Sometimes when young people are stressed out, they do things like smoke, drink, or take drugs, to help themselves feel better. What about you?”
- Use of slang?

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The CRAFFT Interview (version 2.0)

1. Drink more than a few sips of beer, wine, or any drug containing alcohol? Say “0” if none.
2. Use any marijuana (pot, weed, hash, or in foods) or “synthetic marijuana” (He “M2” or “Spice”)? Say “0” if none.
3. Use anything else to get high (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff or “huff”)? Say “0” if none.
4. Would you say you have ever used alcohol or drugs?
5. Have you ever used alcohol or drugs while you are by yourself, ALONE?
6. Have you ever used alcohol or drugs while you are “high” or had been using alcohol or drugs?
7. Did your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?
8. Have you ever gotten into TROUBLE while you were using alcohol or drugs?
9. Use of slang?

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The Center for Adolescent Substance Abuse Research (CASAR) at Boston Children’s Hospital. 617-305-5433. www.casar.org

https://crafft.org/

Societal determinants:  
• Pro-youth social policies  
• Child rights orientation  
• Universal health care  
• Income distribution

Community determinants:  
• Social regime  
• Child rights policies, early childhood development  
• Educational opportunity  
• Housing availability  
• Health system access

Street/School/Vocational determinants:  
• Youth services, structural-competence *  
• Transportation options  
• Community economics  
• Job availability

Family/Peers determinants:  
• Poverty  
• Connections to caring parents, adults  
• Pro-social peer behaviors  
• Familial abuse/neglect history

Individual determinants:  
• Genetic predisposition  
• Trauma history  
• Resilience/coping skills  
• Risk/protective behaviors  
• Safety/food insecurity  
• Transition to adulthood


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**IDENTIFIES STRUCTURAL INEQUITIES DURING COVID19**

- Lack of access to the usual medical home and associated social support systems.
- CFS wasn’t deemed an essential service
- Schools that support PPY have been closed – Braemar and Louise Dean
- Precariously housed youth or YEH that don’t have CFS status are engaging in further risk behaviour to survive temporary rough sleeping, trading sex for shelter
- Limited access to medications and mental health supports
- Limited access to technology that could support E-therapies

Youth experiencing homelessness (YEH)
Youth and Children in Care (YCC)
Pregnant & Parenting Youth (PPT)

**SUGGESTED STRATEGIES - RECOGNIZING AND REMOVING STRUCTURAL INEQUITIES!**

- Adequate safe Shelter in place for YEH that are COVID positive with or without CFS status in various geographic regions in Alberta
- Access to rapid testing for YEH accessing shelters
- Recognition that not everyone has the basic ability to wash their hands or have access to hand sanitizer and making this more accessible.
- Recognition and additional resources for basic needs/social determinants of health such as housing supports, mental health/addictions supports and employment programs
- Advocacy for YCC that are at risk for delay of assessments or intervention as a result of CFS not being deemed essential service and placements breaking down because of a lack of support for children and caregivers
Any effective plan to fight Covid-19 must be shaped by an understanding of its spread and impact among communities of color and others marginalized in society. If we ignore structural inequities, we will ultimately increase the burden of disease not just for those most marginalized but for everyone.”

Dr. Maybank, chief health equity officer at the American Medical Association.

Key Youth Resources


Adapted from Dr. Dzung Vo
Substance Use and Covid19


References

- Internet Use & CoVID19
- WHO general health guidelines
  - [https://www.who.int/news-room/campaigns/connecting-the-world-to-combat-coronavirus/healthyathome](https://www.who.int/news-room/campaigns/connecting-the-world-to-combat-coronavirus/healthyathome)
- Mental Health
DOMESTIC VIOLENCE EFFECT ON YOUNGER CHILDREN
Amy - 7 yrs old
Emotionally labile
Regressive behaviours
Withdrawal, fear
Bedwetting

Tami Masterson MD FRCPC
Pediatrician, Gray Nuns Community Hospital; Founder, Covenant Health Foster Care Clinic

Disclosures
• Employee, University of Calgary

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Learning Objectives

- Review the concepts of:
  - Toxic Stress and Adverse Childhood Events (ACEs)
  - Trauma Informed Care

Case Presentation

- Amy is a 7 yo who is socially isolated from her teachers, family members, community supports and friends
- She presents as afraid and has been hiding from her family members within her home
- Has begun bedwetting again after previously being dry at night
- She is having nightmares and sleep disruption
CONSEQUENCES The Shadow Pandemic: Impact on the vulnerable family.

Levels Of Stress

- **Positive Stress**
  - Mild changes in heart rate and stress hormones

- **Tolerable Stress**
  - Manageable with protective relationships

- **Toxic Stress**
  - Disrupts neurodevelopment

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Understanding Trauma

- **Toxic stress** occurs when adverse childhood events (ACEs) result in “strong, frequent, or prolonged activation of the body’s response systems in the absence of the buffering protection of a supportive, adult relationship”


Understanding Trauma

- ACEs result in events that harm or threatens harm to the child’s physical or emotional well-being or the well-being of someone close to the child
- These are extraordinarily frightening events that overwhelm the child’s ability to cope
- Resulting in intense emotional and physical reactions during or after the event (flight, fight or freeze)
Adverse Childhood Experiences (ACEs)

- Emotional, sexual and physical abuse
- Emotional and physical neglect
- Household violence, substance abuse and mental illness
- Parental separation or divorce
- Incarcerated household member

Adverse Childhood Experiences are Common

KEY FINDINGS

- In California, 61.7% of adults have experienced at least one ACE and one in six, or 10.7%, have experienced four or more ACEs. The most common ACE among California adults is emotional (or verbal) abuse.
- 38.3% Emotional (or verbal) abuse
- 21.7% Physical abuse
- 16.7% Parental separation or divorce
- 12.5% Substance abuse by household member
- 11.4% Sexual abuse
- 9.3% Incest
- 8.6% Incarcerated household member

89

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Understanding Trauma

- Neglect is profoundly harmful and is the ACE most predictive of lifelong dysfunction and disability

Ecology-Biology-Developmental Health Model

Foundations of Healthy Development and Sources of Early Adversity
- Environment of Relationships: Physical, Chemical, Built and Nutrition

Cumulative Effects Over Time
- Gene-Environment Interaction
- Physiologic Adaptations and Disruptions

Lifelong Outcomes
- Health-Related Behaviors, Education and Economic Productivity and Physical and Mental Health

Biological Embedding During Sensitive Periods

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The Impact of ACEs

- Early Death
- Disability, Disease and Social Problems
- Adoption of Health-Risk Behaviors
- Social, Emotional and Cognitive Impairment
- Disrupted Neurodevelopment
- Adverse Childhood Experiences

Traumatized Children have Special Healthcare Needs

- Childhood toxic stress also contributes to adult onset illnesses:
  - Addictions
  - Depression
  - Eating disorders
  - Heart disease
  - Diabetes
  - Cancer
  - Other chronic diseases

Middlebrooks JS, Audage NC. The Effects of Childhood Stress on Health Across the Lifespan. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2008.
The Impact of ACEs

<table>
<thead>
<tr>
<th>Probability of Outcomes</th>
<th>Given 100 American Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No ACEs</strong></td>
<td><strong>1-3 ACEs</strong></td>
</tr>
<tr>
<td>33</td>
<td>51</td>
</tr>
<tr>
<td>WITH 0 ACEs</td>
<td>WITH 3 ACEs</td>
</tr>
<tr>
<td>1 in 16 smokes</td>
<td>1 in 9 smokes</td>
</tr>
<tr>
<td>1 in 69 are alcoholic</td>
<td>1 in 9 are alcoholic</td>
</tr>
<tr>
<td>1 in 480 uses IV drugs</td>
<td>1 in 43 uses IV drugs</td>
</tr>
<tr>
<td>1 in 14 has heart disease</td>
<td>1 in 7 has heart disease</td>
</tr>
<tr>
<td>1 in 96 attempts suicide</td>
<td>1 in 10 attempts suicide</td>
</tr>
</tbody>
</table>

Traumatized Children have Special Healthcare Needs

- The AAP has recognized the public health consequences of ACEs/toxic stress
- A position statement on the role of the pediatrician in modifying the effects of ACEs was published in *PEDIATRICS* Vol. 129 No. 1 January 1, 2012
- Most traumatized children have been parented by adults who have experienced early adverse childhood events
- Inter-generational trauma affects a greater number of individuals in each subsequent generation
Trauma Informed Care

- Trauma informed paradigm shift to ‘what happened to you’ not ‘what is wrong with you’
- Trauma informed care is an established practice that can dramatically improve outcomes by engaging individuals with trauma
- Recognizes presence of trauma symptoms and the role trauma plays in the lives of traumatized individuals
- Shift allows for a public health model of preventative care

ACEs alone do not dictate the future of the child

- Children survive and even thrive despite trauma when ACEs are counter balanced with protective factors
- Positive Relationships can be protective against the effects of tolerable and toxic stress
- Positive relationships demonstrate the concept of ‘serve and return’
Trauma Informed Care

- Resilience factors include:
  - Cognitive capacity
  - Healthy attachment in relationships
  - Motivation and ability to learn and engage with the environment
  - Ability to regulate emotions and behavior
  - Supportive environmental systems
  - Education
  - Cultural beliefs
  - Faith-based communities
  - ‘Success begets success’

References and Resources

- Pediatrics July 1, 2002 vol. 110 no. 1 184-186
- Addiction Science & Clinical Practice Vols. 4 to 9; 2007 to 2014
- ACEs Too High News link, [http://acestoohigh.com/got-your-ace-score/](http://acestoohigh.com/got-your-ace-score/)
- [www.samhsa.gov](http://www.samhsa.gov)
- [www.ahs.ca/helpintoughtimes.ca](http://www.ahs.ca/helpintoughtimes.ca)
Case Presentation

- Amy’s ACE Score is at least 3/10
- She is being exposed to parental addictions, mental health challenges, domestic violence and neglect and potential abuse

Shirley Chan MD FRCPC
CAT Physician, Calgary; Clinical Lecturer, University of Calgary

Disclosure
- None to Disclose

Learning Objectives

- Recognize possible signs of early child abuse
- Be comfortable with basic steps to support children at risk of child abuse during COVID times
- Know when and how to connect with Children’s Services
- Be familiar with community resources for physicians and patients

Calgary & Area Child Advocacy center

Our Partners
- Alberta Health Services
- Alberta Justice & Solicitor General
- Calgary Police Services
- Royal Canadian Mounted Police
- Children’s Services

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Children's Advocacy Center

Numbers by Gender

- **67%** Female
- **32%** Male
- **1%** Transgender and Unknown

Between April 1, 2013 and March 31, 2019, the CCAC assessed over 8,760 infants, children and youth (average of 133 cases per month).

https://calgarycac.ca/the-issue/

Types of abuse experienced

- **71%** Sexual Abuse
- **14%** Physical Abuse
- **2%** Neglect
- **2%** Witness of Domestic Violence
- **11%** Other**

Because the CCAC assesses ALL cases of sexual abuse, a higher rate of sexual abuse is represented at the CCAC than is seen in the general population.

**Other** includes emotional abuse, medical child abuse and sexual exploitation.

https://calgarycac.ca/the-issue/
Recognizing signs of child abuse

- Sudden changes in behavior or school performance
- Unexplained physical injuries, particularly those not in keeping with their development
- Sexual knowledge or behavior beyond what is expected for their development
- Signs of neglect: always sick, missing multiple appointments, not suitably dressed, hunger

Consider your differential

- 15 year old male
  - Substance abuse
  - ADHD, ODD
  - Bullying
  - Depression, anxiety
  - Chronic medical illness
  - Hypothyroidism
  - Sleep deprivation
  - Emotional abuse/neglect

- 7 year old female
  - UTI
  - Constipation
  - Dysfunctional bladder
  - Kidney disease
  - Diabetes mellitus/diabetes insipidus
  - Spinal dysraphism
  - OSA
  - Primary polydipsia
  - Emotional abuse/neglect
LOOK and LISTEN

- Ask open ended questions
  - What is like being at home
  - What are some sad things that happened this week?
  - Tell me more about...
  - Describe what was going on when...

- Be a safe place to talk

Sentinel injuries

- Previous sentinel injuries are common in infants (<12 months) with severe physical abuse and rare in infants for those ultimately found not to be abused
- Bruising (80%), intraoral injury (11%)


Duty to Report

Section 4 of the Child, Youth and Family Enhancement Act (“CYFEA”)... If any person has reasonable and probable grounds to believe that a child is in need of intervention then that person has a duty to report the matter forthwith to a director of Child and Youth Services (“CYS”).

It is important to know that the duty to report is a positive duty on the individual. A failure to report is an offence under the Act.

https://www.albertahealthservices.ca/info/Page3939.aspx
#:~:text=If%20any%20person%20has%20reasonable%20grounds%20to%20believe%20that%20a%20child%20is%20in%20need
of%20intervention%20then%20that%20person%20has%20a%20duty%20to%20report%20the%20matter
forthwith%20to%20a%20director%20of%20Child%20and%20Youth%20Services%20(“CYS”).

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A child is in need of protection for the purposes of the CYFEA when:

- the child has suffered physical harm or there is substantial risk that the child will suffer physical harm whether it was inflicted by the guardian or resulted from the guardian’s failure to care or protect the child;
- the child has been sexually molested or sexually exploited or there is substantial risk that the child will be sexually molested or exploited either by a guardian or as a result of that guardian’s failure to protect the child;
- the child requires essential medical, surgical or other remedial treatment that is necessary for the health or well being of the child and the guardian does not provide or refuses or is unavailable to consent to the treatment;
- the child has suffered emotional harm demonstrated by severe anxiety, depression, withdrawal or self-destructive behaviour, or there is substantial risk that the child will suffer such emotional harm and the person having charge of the child does not provide or refuses or is unavailable to consent to the treatment to alleviate the harm; or the child suffers from a mental emotional or developmental condition that if not remedied could seriously impair the child’s development and the person having charge of the child does not provide, refuses or is unavailable to consent to the treatment.

https://www.albertahealthservices.ca/info/Page3939.aspx#:~:text=If%20any%20person%20has%20reasonable%20cause%20to%20suspect%20abuse%2C%20the%20Services%20%28%20CYS%20%29%20should%20be%20notified.

What’s next?

- Once you have reasonable ground to suspect abuse or child discloses, stop and let the professionals do further questioning
- Report should come from person who received the information.
- Document!
Office of Continuing Medical Education
and Professional Development. COVID
Corner June 10 - COVID
CONSEQUENCES The Shadow Pandemic: Impact on the vulnerable family.

Who to call

- CHILD ABUSE HOTLINE: 1-800-387-5437
- SOUTHERN ALBERTA CHILD INTERVENTION SERVICES 403-297-2995
- Phone consultation with Child Abuse Physician:
  - Call ACH switchboard at 403 – 955 – 7211 and ask for Child Abuse Physician on call
- Child abuse service (CAS)
  - Phone: 403 – 428-5301 Fax 403 – 428-5307
  - Medical team: referral only (MD, Children’s Services, CPS/RCMP)
  - Therapy (i.e. Crisis Intervention, Problem Sexual Behaviours, etc)

Resources

- Kids Help Phone 1-800-668-6868
- Family Violence Information Line 310-1818
- Alberta Provincial Abuse Helpline 1-855-443-5722
- Community and Social Services Help Line 211 Texting available to 211
- Access Mental Health 403-943-1500
- Mental Health Helpline 1-877-303-2642
- Distress Centre 403-266-4357
- Calgary Communities against Sexual Assault (ages 12+): 403 257 6905
- Calgary Counselling Centre 403-691-5991 https://calgarycounselling.com/counselling
- Calgary Connecteen https://calgaryconnecteen.com
- Catholic Family Services 403-205-5295 intake@cfs-ab.org
- Rapid Assess Counselling 403-233-2360
- Eastside Family Centre 403-299-9696 ethera@woodshomes.ca
- Wood’s Crisis Response Team 403-299-9699 Text 587-315-5000
- Calgary and Area Child Advocacy Centre https://calgarycac.ca/
- The Calgary Food Bank 403-253-2059 https://www.calgaryfoodbank.com/
- Calgary Women’s Emergency Shelter 403-234-7233
- YW Sheriff King Home (Domestic Violence Shelter) 403-266-0707
- Awo Taan Healing Lodge (emergency women’s shelter) 403-531-1972

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Questions to the Panelists

- What are some of the various opportunities for intervention?
- How would you address a youth experiencing homelessness?
- How to connect family members with safe places if needed?
- How to build collaborative connections between providers to create strong service for families?
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