Anxiety Primary Care Pathway

Quick links: Pathway primer | Provider resources | Patient resources | Take the survey

1. DSM 5 Generalized Anxiety Diagnostic Criteria (x min 6 months)
More info

2. Suspected Generalized Anxiety Disorder (GAD) or high risk for GAD?
No → Connect MD or other appropriate specialist support
Connect MD
Yes

3. Rule out other differential diagnosis:
- History (suicide/self harm assessment)
- Differential diagnosis
- Lab to rule out other causes

Suicide/self-harm risk assessment | Screening tool | More info

Safety concerns →
For care by health practitioners:
- Access 24/7 – 780-424-2424
- AHS Mental Health Help Line – 1-877-303-2642
- Emergency or Urgent Care

For care by non-health practitioners:
- Canadian Mental Health Association Distress Line/Online Crisis Chat – 780-482-HELP
- Canada Suicide Prevention Services – 1-833-456-4566

No; GAD suspected

4. Complete GAD-7
GAD-7 | More info
Mild (5-9) | Moderate (10-14) | Severe (15-21)

5. Non-pharmacology management:
- Refer to PCN mental health services (Behaviour Health Consultant, Mental Health Therapist, etc.)
- Remove possible triggers (caffeine, stimulants, nicotine, alcohol, cannabis, stress, dietary triggers)
- Ensure quality sleep

6. Self-administered psychotherapy (mindfullness exercises):
- Progressive muscle relaxation
- Deep breathing exercises
- Meditation
- Apps

Other
- Self-help books
- Useful websites
- Yoga
- Tai Chi
- Physical exercise: resistance training and aerobic exercise (60-90% Max HR x 20 mins 3x/week)
- Spirituality/religion/support groups

Patient resources

7. Refer to community psychotherapy/counselling

8. Pharmacotherapy management

First line medications should be trialed initially and titrated to a maximum dose. Follow-up should be based on patient condition.
- In severe cases, consider Benzodiazepine short term
- If ineffective, within 4-6 weeks at maximum dosage, consider another first line medication class and/or an augment.

Effective

First line medication ineffective x2

Second line medication should be trialed and titrated to a maximum dose. Follow-up should be based on patient condition.
- If ineffective within 4-6 weeks at maximum dosage, consider another second-line medication class and/or augment. Advice from Connect MD may be helpful for advice on medication management.

Connect MD

Effective

Second line medication ineffective x2

Third line medication should be trialed and titrated to a maximum dose. Follow-up should be based on patient condition.
- If ineffective within 4-6 weeks at maximum dosage, consider referral to psychiatry or advice through Connect MD.

Connect MD

Effective

9. Supplementary Treatments: Although there's evidence botanicals may be effective, preparations are poorly standardized and have substantial variation in proportion of the active ingredient. They should be recommended with caution.

10. Monitoring for treatment efficacy is dependent on the clinical picture and treatment. GAD-7 can be a useful tool to determine the impact.

11. Referral
Access 24/7 (780-424-2424) or Connect MD for non-urgent psychiatry tele-advice.
Connect MD

Adapted from: Calgary and Area Primary Care Network Specialist Link. www.specialistlink.ca/assets/pdf/CZ_Anxiety_pathway.pdf

Primary Care Network EDMONTON ZONE | Alberta Health Services | CASA

Take our (brief) survey: Did this pathway work for you and your patient?

Advice options | Background

Pathway Primer

- With a lifetime prevalence as high as 31% (females > males), anxiety and related disorders are among the most common mental disorders seen in clinical practice[1].
- The pathway is designed for adult patients with suspected Generalized Anxiety Disorder (GAD). It is not indicated for suspected GAD in pediatric/youth, geriatric or pregnant/breastfeeding populations as these subpopulations may have unique considerations -- consider a Connect MD call to psychiatry for advice on this population.
- Anxiety may ALSO be presented as a component of Panic Disorder, Agoraphobia, Specific phobia, Social Anxiety Disorder, Adjustment Disorder, Obsessive-Compulsive Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Post-Traumatic Stress Disorder (PTSD), Substance Use Disorder or major depressive disorder with anxious distress (which is likely the most common presentation of anxiety in family practice).
- This pathway was developed to help guide diagnosis, and provide both non-pharmacologic and pharmacologic management of Generalized Anxiety Disorder (GAD) in the medical home
- Data on diagnosis and treatment were obtained using both the Anxiety Disorders Association of Canada, and the American Academy of Family Physicians (AAFP) guidelines for GAD
- The content was thoroughly reviewed and approved by both psychiatrists and family physicians within the Anxiety Pathway Working Group of the Calgary Zone. The pathway was adapted for the Edmonton Zone with permission from the Working Group.

EXPANDED DETAILS

1. DSM 5 GAD diagnostic criteria for GAD

- GAD often occurs along with other mental health problems, which can make diagnosis and treatment more challenging. Specific DSM 5 GAD Impairment Criteria (X min 6 months) include:
  a. Excessive/persistent worrying about a number of events/activities
  b. Difficulty controlling the worry
  c. **(≥3 of following):**
    - Restless/feeling keyed up/on edge
    - Easily fatigued
    - Irritability
    - Difficulty concentrating/mind going blank
    - Muscle tension (pain in neck/shoulder/back)
    - Poor sleep
  d. Anxiety, worry or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
  e. The disturbance is not attributable to the physiological effects of a substance or another medical condition.
  f. The disturbance is not better explained by another medical disorder.

[1] Kessler RC, Angermeyer M, Anthony JC, R DG, Demyttenaere K, Gasquet I, G DG, Gluzman S, Gureje O, Haro JM, et al: Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. World Psychiatry. 2007, 6: 168-176.

2. Suspected GAD or high risk for GAD

There are certain risk factors that may increase the likelihood of GAD. The following are risk factors associated with a higher prevalence of anxiety disorders:

- Family history of anxiety or mood disorders
- Personal history of anxiety or mood disorders
- Childhood stress/trauma (ACE questionnaire can be found at: https://cfpcn.ca/wp-content/uploads/2020/03/RPMC-ACEs-questionnaire-and-patient-handoutApr2019.pdf)
- Female
- Chronic illness
- Childhood tendency to withdraw or be afraid in new situations

3. Rule out other differential diagnosis

- History
  - Safety assessment:
    - Suicide Risk Assessment, self-harm
    - Substance use/abuse/withdrawal
    - Maladaptive coping (gambling, overeating, shopping etc.)
  - Family history of anxiety or mood disorders
  - Medical/ psychiatric history
  - Prescription history (previous and current use of SSRIs/SNRIs/Benzodiazepines/TCAs/Stimulants)
  - Social history (lifestyle, caffeine intake, sleep, finances, domestic violence, etc.)
- Differential Diagnosis
  - Include a relevant physician exam and appropriate investigations to help rule out differential diagnosis. Screening tools are included in the Provider Resource section.
  - Mental Health related:
    - Panic disorder
    - Agoraphobia
    - Specific phobia
    - Adjustment d/o
    - Social anxiety d/o
    - PTSD
    - Depression
    - Major Depressive Disorder with anxious distress
    - ADHD
    - Obsessive Compulsive Disorder (OCD)
    - Substance and/or alcohol use disorder
  - Organic
    - Hyperthyroidism
    - Pheochromocytoma
    - Hyperparathyroidism
    - Cardiac arrhythmia
    - COPD
    - Temporal lobe epilepsy

- TIA
- Hypoglycemia
- Medication/ Substance related: caffeine, salbutamol, levothyroxine, decongestants

- Most often laboratory investigation is unnecessary; however, based on the clinical picture, you may consider:
  - CBC
  - B12
  - TSH
  - FBG
  - Lipids
  - Electrolytes
  - Liver enzymes: ALT and GGT
  - Urine toxicology

4. Complete GAD 7

- GAD 7: GAD 7 Form
  - GAD 7 use in primary care is intended to support screening, diagnosis, risk stratification, and management evaluation

5. Non-pharmacotherapy management

- Refer to PCN mental health resources such as Behavioural Health Consultants and/or Mental Health Therapists. Contact your PCN to access the mental health resources available to your patients.
- Remove possible triggers which may include caffeine, stimulants, nicotine, alcohol, cannabis, stress, dietary triggers)
- Ensure quality sleep. Many tools are available to support sleep hygiene, some are included in the Patient Resources section.

6. Self-administered psychotherapy

- People with mild GAD (GAD-7 score of 5-9) may benefit from self-directed psychotherapy, including CBT and relaxation therapy
- Self-management is an important component of GAD management. It is important to tailor the recommendations to patient preference. Several different options for resources are included in the Patient Resources section -- these have been collated by mental health professionals in the Calgary and Edmonton Zones.

7. Refer to community psychotherapy or counselling

- If self-administered psychotherapy is ineffective, or the patient desires in-person psychotherapy, you may consider referring to community resources. These resources can be found in the Patient Resources section.

8. Pharmacotherapy management

- First line medications should be trialed initially and titrated to a maximum dosage.
- Initial medication should be trialed for 4-6 weeks (at maximum dosage) to assess treatment response. Extrapolating from evidence in treating depression, a response of < 20% initial improvement is a strong predictor that chosen therapy will not be effective.
- If the initial medication is not effective within 4-6 weeks, a 2nd line should be trialed, or an augment added.
- Benzodiazepines may be useful in short term bridging while titrating first line medications in newly diagnosed anxiety. In these cases, you should do short term follow up (1-2 weeks). Benzodiazepines can also be considered longer term in hard-to-treat cases (see second line therapy boxes).
- Initial follow up in 2 to 4 weeks (virtual or face to face visit) and at least every 6 weeks until treatment goals are reached. Consider more frequent follow up for patients with significant functional impairment, high risk for self-harm or concomitant substance use disorders.

- If medications are ineffective (no change in GAD score) for management, transitioning to a different medication should be done carefully to ensure that there is no exacerbation in symptoms, withdrawal symptoms or medication contraindications. Switchrx.com may be a useful resource to support this transition.
- Medication recommendations in the table below have come from Anxiety Association of Canada and American Academy of Family Physicians (AAFP) Guidelines. Based on discrepancy in medication recommendations between the guidelines, the guidelines the medication recommendation has come from is indicated within the table.

	Medication Class	Medication Name	Dosage	Considerations
The medications that are BOLD are from both AAFP and Anxiety Association of Canada, *Italic* are from AAFP, and Underlined are from Anxiety Association of Canada.				
First line medications	SSRI	**Escitalopram**	**10 mg PO OD** start at 5-10 mg/day, may increase dose after 1 week to max dose of 20mg/day	Consider dosage adjustments in geriatric patients, hepatic or severe renal impairment
		Paroxetine	**20 mg PO qAM** **Paroxetine Hydrochloride:** Start at 20 mg orally daily; may increase by 10 mg/day increments once weekly to a maximum of 50 mg orally daily[1] **Paroxetine Mesylate:** 20 mg; may increase dosage by 10 mg/day increments (no benefit noted with higher doses)[1]	↑wt gain; not 1st line in pregnancy In elderly, no proven additional benefit beyond dose > 20mg/day Caution must be maintained when combining with other drugs that impact CYT 2D6 (such as codeine, tamoxifen)
		Sertraline	**50-200 mg PO OD** Start at 25 mg OD x 1 week then 50 mg OD then may increase by 25-50 mg qweekly to max dose of 200 mg/day	Most male sexual s/e
		Fluoxetine	**20-60 mg PO OD** Start at 10 mg PO qAM x 1 week then increase by 10 mg weekly if needed to max dose of 60 mg/day	High concentration in breast milk
	SNRI	**Duloxetine**	**60 mg PO OD** Start at 30 mg orally once daily for 1 week and then increase to 60 mg orally once daily; may increase further increments of 30 mg once daily; MAX 120 mg once daily[1]	Not recommended with severe renal impairment, ESRD, or in hepatic impairment
		Venlafaxine XR	**75-225 mg ER PO OD** Start at 37.5 to 75 mg orally daily; may increase by 75 mg/day every 4 days to a maximum of 225 mg/day[1]	↓wt gain, ↑w/d effects, high concentration in breastmilk
	Other	*Buspirone*	**20-30 mg/day PO divided bid-tid** Start 5 mg orally 2 to 3 times daily, and increase by 5 mg/day increment every 2 to 3 days, titrating to tolerance and response; usual dosage 20 to 30 mg/day in 2 or 3 divided doses; MAX 45 mg/day[1]	Avoid use in severe renal/hepatic impairment
Second line medications	SSRI	Vortioxetine	5-20 mg PO OD; average dosing 15 mg	Common side effect: nausea. Recommend taking with food. If nausea persists, recommend taking at bedtime.
	Other	**Quetiapine XR**	**50-150 mg ER PO OD** start at 50 mg OD, may increase 50 mg/day to max dose of 300 mg/day	D/C if ANC<1000 or if unexplained ↓ in WBC
		Hydroxyzine	**50-100 mg PO q6h PRN**	
		Imipramine	**75-200 mg PO divided tid**	Max 100 mg/day in elderly

			Start at 25 mg PO TID to max 300 mg/day	
		Amitriptyline	**50-150 mg qhs** Start at 25-75 mg PO qhs, may increase by 25-50 mg/day q2-3 days to max 300 mg/day	Start 10-25 mg po qhs and increase by 10-25 mg/d q2-3 days in elderly patients, may give divided doses
		Nortriptyline	**50-150 mg qhs** Start at 25-50 mg PO qhs, increase by 25-50 mg.day q2-3 days to max 150 mg/day	Start 10-25 mg po qhs and increase by 10-25 mg/d q2-3 days in elderly patients
		Alprazolam	**0.25 mg-0.5 mg PO tid** Start at 0.25 mg orally 2 to 3 times daily; larger initial doses may be needed in severe cases; may increase in 0.25 mg- increments beginning with evening dose before daytime dose; MAX 3 mg/day in divided doses[1]	
		Buproprion XL	**150 mg ER PO BID** Start at 150 mg ER PO qam, increase after 3 days to max 400 mg/day	
		Buspirone	**20-30 mg/day PO divided bid-tid** Start 5 mg orally 2 to 3 times daily, and increase by 5 mg/day increment every 2 to 3 days, titrating to tolerance and response; usual dosage 20 to 30 mg/day in 2 or 3 divided doses; MAX 45 mg/day[1]	
		Diazepam	**2-10 mg PO bid-qid** Start 2 to 10 mg orally 2 to 4 times daily; individualize dosage based on clinical effect[1]	Give for shortest duration as possible- not exceeding 2 to 3 months, including tapering time[1]
		Lorazepam	**2-6 mg/day PO divided bid/tid** Start 2 mg/day orally or SL in 2 or 3 divided doses; may titrate based on clinical response and tolerance to usual dosage of 2 to 3 mg/day[1]	Give for 1 week and reassess need for treatment; use lowest effective dosage for shortest amount of time[1]
Third line medications	SSRI	Citalopram	**20-40 mg PO OD** Start at 20 mg OD, may increase to 40 mg OD after 1 week	Max 20 mg/day in pts >60yo
		Fluoxetine	**20-60 mg PO OD** Start at 10mg PO qAM x 1 week then increase by 10 mg weekly if needed to max dose of 60mg/day	High concentration in breastmilk
	Other	Mirtazapine	**15-45 mg PO qhs** Start at 15 mg qhs to max 45 mg/day	Consider lower dose in elderly
		Trazadone	**50-100 mg PO bid-tid** Start at 25-50 mg bid-tid, may increase by 50 mg/day q3-4 days to max 400 mg/day	
Augment	Other	*Alprazolam*	**0.25-0.5 mg PO tid** Start 0.25 mg tid, may increase dose q3-4 days to max 4 mg/day	Start 0.25 mg po bid-tid in elderly

		Clonazepam	**0.25-0.5 mg PO bid-tid** Start 0.25 mg bid, may increase by 0.25 mg/day q1-2days to max 4 mg.day	Consider lower dose in elderly
		Diazepam	Start 2 to 10 mg orally 2 to 4 times daily; individualize dosage based on clinical effect[1]	Give for shortest duration as possible- not exceeding 2 to 3 months, including tapering time[1]
		Lorazepam	Start 2 mg/day orally or SL in 2 or 3 divided doses; may titrate based on clinical response and tolerance to usual dosage of 2 to 3 mg/day[1]	Give for 1 week and reassess need for treatment; use lowest effective dosage for shortest amount of time[1]
		Aripipazole	**2-15 mg PO OD** Start at 2-5 mg PO OD, increase up to 5 mg/day qweekly to max dose of 15 mg/day	
		Olanzapine	**5-12.5 mg PO qPM**	Start at 2.5 mg PO qpm in non-smoker, elderly or female or if hypotension risk, D/C if ANC<1000 or if unexplained ↓ in WBC
		Quetiapine	**5-150 mg ER PO OD** start at 50 mg OD, may increase 50 mg/day to max dose of 300 mg/day	D/C if ANC<1000 or if unexplained ↓ in WBC
		Risperidone	**1-6 mg/day PO divided OD-BID**	D/C if ANC<1000 or if unexplained ↓ in WBC

Reference:[1]IBM Micromedix. (2021).; rx Files (2021); epocrates (2021)

9. Supplementary Treatments

- Although there is evidence that botanicals may be an effective treatment for anxiety, preparations are poorly standardized and have substantial variation in proportion of the active ingredient in different products, therefore they should be recommended with caution.

Potential Supplementary Treatments	
Botanicals	**Supplements**
• *Ilexan* (lavender oil) • *Passifloraincarnat* (passion flower) • *Piper methysticum (Kava)* • *Hypericum perforatum (St. John's Wort)* • *Valeriana officinalis (Valerian)* • Galphima glauca extract	• 5-Hydroxytryptophan • Inositol • L-theanine • L-tryptophan • S-adenosyl-L-methionine • Vitamin B Complex

10. Monitoring

- Monitoring for treatment efficacy will vary depending on clinical situation and treatment option. Pharmacotherapy is recommended to continue for at least 12-24 months from symptom improvement.

11. Referral

- If a patient is in need of urgent supports, consider support through:
  - **Urgent Services**
    - Urgent Single Session Counselling Services (https://www.dropinyeg.ca/)

- **Crisis Intervention:**
  - Care provided by health professionals
    - Access 24/7 (780-424-2424)
    - AHS Mental Health Help Line (1-877-303-2642)
    - Emergency Departments or Urgent Care
  - Care provided by non-health professionals
    - Canadian Mental Health Association Distress Line/Online Crisis Chat (780-482-HELP)
    - Canada Suicide Prevention Services (1-833-456-4566)
- For additional non-urgent referral services, connect to Access 24/7 (780-424-2424) where a mental health professional will triage referrals

BACKGROUND

About this pathway

- The pathway is designed for adult patients with suspected Generalized Anxiety Disorder (GAD). It is not indicated for suspected GAD in pediatric/youth, geriatric or pregnant/breastfeeding populations as these subpopulations may have unique considerations -- consider a Connect MD call to psychiatry for advice on this population.

Authors and conflict of interest declaration

- This pathway was developed by a multistakeholder working group in the Calgary Zone comprised of primary care and specialty providers. It was adapted for the Edmonton Zone with permission from the Working Group. For more information, contact projectmanager@ezpanpcn.com.

Pathway review process, timelines, feedback

- Primary care pathways undergo scheduled review every three years, or earlier if there is a clinically significant change in knowledge or practice. The next scheduled review will be May 2025. If you have any questions or concerns about this pathway, please email projectmanager@ezpanpcn.com. with “Anxiety Pathway” in the subject line. Alternatively, complete the pathway survey: Anxiety Pathway (alchemer-ca.com).

Copyright information

DISCLAIMER

This pathway represents evidence-based best practice but does not override the individual responsibility of health care professionals to make decisions appropriate to their patients using their own clinical judgment given their patients' specific clinical conditions, in consultation with patients/alternate decision makers. The pathway is not a substitute for clinical judgment or advice of a qualified health care professional. It is expected that all users will seek advice of other appropriately qualified and regulated health care providers with any issues transcending their specific knowledge, scope of regulated practice or professional competence.

PROVIDER RESOURCES

Advice Options

- Non-urgent telephone advice connects family physicians and specialists in real time via a tele-advice line. Family physicians can request non-urgent advice from a psychiatrist, at https://pcnconnectmd.com/ or by calling 1-844-633-2263. This service is available from 9 a.m. to 6 p.m. Monday to Thursday, and 9 a.m to 4 p.m. Friday (excluding statutory holidays). Calls are typically returned within the same day.
- Non-urgent psychiatry advice is also available across the province via Alberta Netcare eReferral Advice Request (responses are received within five calendar days). View the Referring Provider – FAQ document for more information.
- Many PCNs have mental health resources such as Behavioural Health Consultants and/or Mental Health Therapists. Contact your PCN to access the mental health resources available to your patients.

Resource		Location
Anxiety Canada and Mindshift App	Educational resources, group therapy, online courses	http://www.anxietycanada.com/
Canadian Mental Health Association	Educational resources, crisis services, navigation services, education and training, peer support	https://edmonton.cmha.ca/
Centre for Clinical Intervention	Educational resources, training, research	https://www.cci.health.wa.gov.au/
Switchrx.com	Support for medication transitions	Switchrx.com
211	Listings of community, government and social services	https://ab.211.ca/
Anxiety Association of Canada; Katzman et al. (2014). Canadian Clinical Practice Guidelines for the management of anxiety, post-traumatic stress and obsessive-compulsive disorders.		https://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-14-S1-S1
American Family Physician. (2015). Diagnosis and Management of Generalized Anxiety Disorder in Adults.		https://www.aafp.org/afp/2015/0501/p617.html
Screening Tools		
ACE	Adverse Childhood Experiences	https://www.who.int/publications/m/item/adverse-childhood-experiences-international-questionnaire-(ace-iq)

Adult ADHD Self-Report Scale	Attention Deficit Hyperactivity Disorder	https://www.caddra.ca/wp-content/uploads/ASRS.pdf
GAD-7 Scale	General Anxiety Disorder	GAD 7 Form
PHQ 9 Questionnaire	Depression	PHQ 9 Form
Yale-Brown Obsessive Compulsive Scale	Obsessive Compulsive Disorder	https://www.healthfocuspsychology.com.au/wp-content/uploads/2018/03/YBOCS.pdf
Articles		
Drugs and Lactation Database. (2021). Vortioxetine		Drugs and Lactation
Laskey, C. (2021). Antidepressant Use in the Breastfeeding patient.		Antidepressant use in the Breastfeeding Patient
Mother to baby fact sheet. (2020). Duloxetine.		Mother to Baby Fact Sheet - Duloxetine
Turna, J., Patterson, B., and Van Ameringen, M.V. (2017) Is cannabis treatment for anxiety, mood, and related disorders ready for prime time?		https://onlinelibrary.wiley.com/doi/10.1002/da.22664
Non-Urgent Advice		
Connect MD		https://pcnconnectmd.com
eReferral Advice Request		https://www.albertanetcare.ca/eReferral.htm
Urgent Services		
Urgent Single Session Counselling Services		
Drop-In Single Session Counselling		https://www.dropinyeg.ca/
Non-Insured Health Benefits Canada (for Indigenous People with First Nations Status, must have a treaty card)		Phone number: 1-800-232-7301 https://www.sac-isc.gc.ca/eng/1576441552462/1576441618847
Crisis Intervention		
Care Provided by Health Practitioners		
Access 24/7		Phone number: 780-424-2424
AHS Mental Health Help Line		Phone number: 1-877-303-2642; https://www.albertahealthservices.ca/findhealth/Service.aspx?id=6810&serviceAtFacilityID=1047134
Emergency Departments or Urgent Care		https://www.albertahealthservices.ca/findhealth/search.aspx?type=facility&source=ahs
Care Provided by Non-Health Practitioners		
Canadian Mental Health Association Distress Line/Online Crisis Chat		Phone number: 780-482-HELP; https://edmonton.cmha.ca/programs-services/distress-line/; https://edmonton.cmha.ca/programs-services/online-crisis-chat/
Canada Suicide Prevention Services		Phone number: 1-833-456-4566; https://www.crisisservicescanada.ca/en/

PATIENT RESOURCES

General Information on GAD		
Resource Type	**Resource Name**	**URL**
Support Group	Anxiety Counselling Support Group	https://www.familycentre.org/group-therapy/anxiety-support-group
Support Group	Coping with Anxiety and Depression Series	https://momentumcounselling.org/anxiety-and-depression-series/
Website	Anxiety Canada	http://www.anxietycanada.com/
Website	My Health Alberta: Generalized Anxiety Disorder	https://myhealth.alberta.ca/health/Pages/conditions.aspx?hwid=zd1045
Website	Centre for Clinical Interventions	https://www.cci.health.wa.gov.au/Resources/Looking-After-Yourself/Anxiety
Website	Here to Help BC: GAD	https://www.heretohelp.bc.ca/infosheet/generalized-anxiety-disorder
Website	Help Guide Anxiety information and handouts	https://www.helpguide.org/articles/anxiety/generalized-anxiety-disorder-gad.htm
Website/Modules	Kelty's Key: Anxiety	https://www.keltyskey.com/courses/anxiety/
Website/Modules	Kelty's Key: Panic	https://www.keltyskey.com/courses/panic/
Workshops	Anxiety to Calm	https://cfpcn.ca/workshops/anxiety-to-calm/
Workshops	Primary Care Networks	https://albertafindadoctor.ca/workshops/home
YouTube Videos	Reid Wilson PhD	https://www.youtube.com/user/ReidWilsonPhD
YouTube Videos	Therapist Aid	https://www.therapistaid.com/therapy-videos/anxiety/none
YouTube Videos	Therapy in a Nutshell	https://www.youtube.com/c/TherapyinaNutshell
Mindfulness Tools		
Resource Type	**Resource Name**	**URL**
Website	Deep breathing exercises	http://www.psychologytools.com/resource/relaxed-breathing/
Website	The Breath Project	https://thebreathproject.org/
Website	Progressive Muscle Relaxation	https://www.helpguide.org/articles/anxiety/generalized-anxiety-disorder-gad.htm
Website	Palouse Mindfulness	https://palousemindfulness.com/
Website	Mood Gym	https://moodgym.com.au/
Website	Tara Brach (Meditation)	https://www.tarabrach.com/

Website	The Happiness Project	https://thehappinesstrap.com/free-resources/
Website	Together All	https://togetherall.com/en-ca/
Text Messages	Text 4 Hope	https://www.albertahealthservices.ca/topics/Page17019.aspx
App	Mindshift	https://www.anxietycanada.com/resources/mindshift-cbt/
App	ACT Coach	https://apps.apple.com/ca/app/act-coach/id804247934 (also available on google play)
App	Calm	https://www.calm.com/
App	Headspace	https://www.headspace.com/
App	Smiling Mind	https://www.smilingmind.com.au
App	Insight Timer	http://insighttimer.com
App	Deep Breathing	http://www.breathscape.app
Self Help Books		
Author		**Title**
Andrew Seubert		The Courage to Feel: A Practical Guide to the Power and Freedom of Emotional Honesty
Bessel Van Der Kolk		The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma
s		The Feeling Good Handbook
Dennis Greenberger and Christine A. Padesky		Mind over Mood: Change How Your Feel by the Way You Think
Diane Mcintosh		This is Depression: A Comprehensive, Compassionate Guide for Anyone Who Wants to Understand Depression
Jeffrey E. Young		Reinventing Your Life: The Breakthrough Program to End Negative Behavior…and Feel Great Again
Michelle G. Craske		Mastery of Your Anxiety and Worry: Workbook
Sleep Hygiene		
Resource Type	**Resource Name**	**URL**
Website	Anxiety Canada	https://www.anxietycanada.com/
Website	CBT-i(nsomnia)	https://www.cbtforinsomnia.com/
Website	Harvard University	https://sleep.hms.harvard.edu/
Website	Dalhousie University	https://mysleepwell.ca/
Videos	Why Can't I Sleep (PCNs)	https://www.ewpcn.com/why-cant-i-sleep-on-demand-class/
Psychotherapy Supports		
Access 24/7		Phone number: 780-424-2424, fax 780-342-7621
Alberta College of Social Workers		https://www.acsw.ab.ca/

The Family Centre	Phone number: 780-900-6129; https://www.familycentre.org/
Catholic Social Services	Phone number: (780) 432-1137; https://www.cssalberta.ca/
Cure MD	https://www.curemd.ca/mental-health-services
Employee, Family Assistance Programs	Depending on your employer, this may be available through your benefits
Jewish Family Services	Phone number: 780.454.1194; https://www.jfse.org/
Momentum Counselling	https://momentumcounselling.org/
Owlpod (physician referral required)	https://www.owlpod.ca/
PCN Mental Health Services	Dependent on the PCN your doctor is a part of
Private psychologist	https://psychologistsassociation.ab.ca/; https://www.psychologytoday.com/ca
YWCA	https://ywcaofedmonton.org/programs-and-services/counselling-centre/
Urgent Services	
Urgent Single Session Counselling Services	
Drop-In Single Session Counselling	https://www.dropinyeg.ca/
Non-Insured Health Benefits Canada (for Indigenous People with First Nations Status, must have a treaty card)	Phone number: 1-800-232-7301 https://www.sac-isc.gc.ca/eng/1576441552462/1576441618847
Crisis Intervention	
Care Provided by Health Practitioners	
Access 24/7	Phone number: 780-424-2424
AHS Mental Health Help Line	Phone number: 1-877-303-2642; https://www.albertahealthservices.ca/findhealth/Service.aspx?id=6810&serviceAtFacilityID=1047134
Emergency Departments or Urgent Care	https://www.albertahealthservices.ca/findhealth/search.aspx?type=facility&source=ahs
Care Provided by Non-Health Practitioners	
Canadian Mental Health Association Distress Line/Online Crisis Chat	Phone number: 780-482-HELP; https://edmonton.cmha.ca/programs-services/distress-line/; https://edmonton.cmha.ca/programs-services/online-crisis-chat/
Canada Suicide Prevention Services	Phone number: 1-833-456-4566; https://www.crisisservicescanada.ca/en/