Innovative Child and Youth Mental Health Models of Collaborative Mental Health Care Across Canada: Increasing quality and accessibility of mental health care for Children and Youth

Helen R Spenser  MD CCFP FRCPC C&A psychiatrist, Ottawa
Sabina Abidi  MD FRCPC C&A psychiatrist, Halifax
Stacey Espinet  PhD Psychology, London
Peter Kondra  MSc MD FRCPC C&A psychiatrist, Hamilton

June 20th 2014, Toronto On.
Outline of Presentation

Four Models used to provide child and youth mental health shared mental health care to primary care will be summarized:

1. The OCFP Network mentorship groups for FP’s, H. Spenser
2. The CAPA Model, Halifax, Dr. S. Abidi
3. PTCAP, A Cross Canada education program based on an extensive national survey of rural primary care physicians, Dr. S. Espinet, London On
4. An on line C&A Mental Health Toolkit, Dr. P. Kondra, Hamilton

Break out groups followed by discussion of models with regional applicability
Speakers Declaration of Conflict of Interest

- Dr’s Spenser, Abidi, Kondra and Espinet have no conflicts of interest to declare with the exception below:

- Dr. Kondra has affiliations with Johnson and Johnson, Lily, Purdue and Shire

- Most medication discussed in child and adolescent psychiatry is used off label except for Stimulants used for the treatment of Attention Deficit Hyperactivity Disorder
Driving Forces behind Shared Mental Health Care Movement

- Shortage of services
- Long wait times
- Isolation of Rural Family doc’s
- When consult needed
- Patient preference to be treated in Primary Care Setting with trusted doc
- Family medicine Trainees report Lack of preparedness To diagnose and Rx

Shared Care
Shared care in Canada

- Pre 1997 – Isolated examples of Collaborative projects
- 1997 - 1st Position paper : Guidelines for shared care
- 1997 - Establishment of CPA / CFPC Working ,meets twice a year till now
- 2000 - First Shared Care Conference in Toronto
- 2001 - Establishment of shared-care.ca website
- 2003 - CCMHI 12 organizations in Federal initiative ( including C&A toolkit)
- 2005 - Out of the Shadows – identified need for collaborative care
- 2006 – Family Health Teams in Ontario – Integration of MH teams
Shared care in Canada

- Increasing number of projects, including focus on specific populations / workplace / students
- 2010 - New training guidelines requires shared care experience/rotation for all Canadian psychiatry residents
- Increasing evidence as to the benefits of these initiatives
- 2010 Child and Youth Toolkit on shared-care website
- Increasing involvement of integrating MH services in Primary Care in Provincial planning
- Increasing acceptance of CMHC as part of clinical practice
- 2011 – 2nd. Position paper on Collaborative Mental Health Care in Canada
- 2014 - 1st. Award for excellence in CMHC
Goals of Shared Care:

- work more collaboratively
- increase PCPs detection, triage skills
- increase PCPs knowledge of treatment
- increase PCPs knowledge of community
- manage more early illness to decrease wait time for specialist care of complex illness
“We couldn’t get a psychiatrist, but perhaps you’d like to talk about your skin. Dr. Perry here is a dermatologist."
Rationale for Shared Care in Child Psychiatry

- Small number of psychiatrists to children with mental health problems (1:6,148) (Ontario data Steele and Wolfe 1999)
- Most child psychiatrists practice in large centers with medical schools
- Significant portion of child psychiatrists approaching retirement
- Community prevalence of mental illness in children and youth 10 to 25%
- Only small proportion of mental illness in Children and Youth detected
- Children and youth most likely to visit family physician
- Survey of all family medicine programs by Davidson et al revealed few opportunities in residency to learn about C &Y M.H.
Problems with relationships with children’s mental health and primary care services

- Access
- referral processes
- waiting lists
- coordination child / adult
- lack of resources
- Two ministries Health and Community and Social Services with different goals and funding strategies
- Initial Shared Care conference only dealt with adult collaborations
- Breakfast meetings at conferences to bring together child and youth clinicians to brainstorm re relevant collaborative models
Person Youth Would Most Likely Discuss a Problem With

- Friend: 43.0%
- Parent/Family: 23.9%
- No one: 31.8%
- Other: 1.3%

(Davidson & Manion, 1996)
Professionals Children and Youth Most Likely to Approach with Mental Health Concerns

- Family Doctor: 32%
- Psychologist/Psychiatrist/Social Worker: 25%
- Cousellor: 21%
- Hot Line/Teen Health Clinic: 8%
- Other: 3%
- Family/Friends: 4%
- No one: 7%

(Davidson & Manion, 1996)
Ontario Collaborative Mental Health Care Network: A Mentoring Program

Helen R Spenser MD CCFP FRCP C, Child and Adolescent Psychiatrist
Children’s Hospital of Eastern Ontario, Assistant Professor University of Ottawa
June 20th 2014, Toronto Shared Care Conference

A fourteen year experience mentoring family physicians through Ontario College of Family Physicians Innovative Model
Collaborative Mental Health Network (CMHCN)

- A unique mentoring program using GP psychotherapists and psychiatrists to help FP members deliver mental health care to their patients
- Launched 2001 after 1999 Needs assessment of clinical and educational needs of 50 GP members of OCFP
- Participants recruited via OCFP newsletter and invitation to family medicine departments
- Mentors commitment expected to be one hr per week
- Program began with 100 FP’s and 10 mentors
- Funded by Ontario Ministry of Health and Long Term Care
Background to Program

• Needs Assessment 1999 family physicians needs (N=50)
• Knowledge of mental health
• Access to psychiatry/community resources
• Desire for more knowledge re: addictions, schizophrenia personality and eating disorders
• Pharmacotherapy support for mental health treatment
• Overwhelming support catapulted network into existence
Ottawa Region Statistics 2012

• Population one million

• Family Physicians 1,517

• Psychiatrists, community and hospital, 312

• Child psychiatrists 25
Objectives and Goals

Objectives:
- Enhance quality of mental health care delivery
- Support family physicians in service provision
- Family physician/specialist collaboration from a distance

Goals:
- Improve physician satisfaction with consultation/collegial relationships
- Reduce time to consultations
- Reduce time to patient receiving optimal treatment
- Enhance patient care ↓ symptoms and ↑ physician knowledge and confidence
Network Organization and Process

- Steering Committee at Ontario College of Family Physicians with FP’s, GPP’s, Psychiatrists and OCFP staff
- Mentor Mentee Groups matched by geography/clinical interest
- Original idea mentors were one psychiatrist one GP psychotherapist
- Three small group face to face meetings a year in region email contact in between
- One conference a year with all groups in Toronto, academic program offered based on needs assessment
- College monitored success with ongoing evaluation/feedback questionnaires
CMHN FUNCTIONS

- ONE-on-ONE Mentoring
- SMALL GROUP (case based)
- CONFERENCES – Regional/Provincial
- MENTOR DEVELOPMENT
- CME MODULES
- EVALUATION
- OUTREACH
CMHN Reported Use

Number of consultations

Mentee: what I receive

- Quick practical clinical support: email, telephone, fax
- Formal consultation/mentoring face to face
- Access to all mentors in Network for expertise outside own group
- CME large and small group, and individual relevant and practical to needs of primary care physician
- Increased mental health knowledge with tools to make consultation more relevant to primary care
- Increased confidence in treating mental health patients
- A professional, supportive community
- Personal support/collegiality “burnout prevention”
Mentor: What do I provide

- Recommendations for assessment and management of specific case
- General information regarding assessment and treatment
- Consolidated experience professional wisdom
- Moral support
- Reassurance
- References for literature

*ALSO VERY REWARDING RELATIONSHIPS FOR MENTOR BUILT OVER TIME WITH KNOWLEDGE THAT WE ARE WORKING AS A COMMUNITY TEAM FOR IMPROVED MENTAL HEALTH CARE*
Membership in the CMHN

• Access to 58 mental health and addictions specialists
• Access to timely clinical advice
• Professional/personal support
• Collegial community
• MHA CPD: conferences, workshops, modules, portal
• CE credits
The story of one group:

Group 10 “Spencer Squared”

• 14 years in existence, with same core group and 5 new
• GP psychotherapist retired one of guest speakers invited to co-mentor
• Mentors are child psychiatrist, and adult (Spenser and Spencer) psychopharmacologist and act team psychiatrist
• Face to face local meetings at least three times with either mentee chosen speaker/topic or case discussion with mentors
• Interim email case based questions and answers with total group participation
• Mentors available by email to all mentors in network
Summary Data

• **Sample:** 14 Group Ten Members surveyed May 2014
• **Number of years with group:** \( M = 8.5 \) years
• **Days per week in primary care:** \( M = 4 \) days
• **MH care practice:** 60%
• **MH children and youth seen (months):** \( M = 4 \)
• **Time to obtain psychiatry consult (months):**
  - **adult:** 7.9
  - **child:** 7.4
  - **adolescent:** 7.2
• **Questions asked of mentors per year:** 6
• Thanks to Jacub for preparation of graphs
Comfort Level Dealing with MH Problems

- Phamacological Rx
- ADHD
- Depression
- Anxiety
- PTSD
- Psychosis
Some qualitative comments from Group 10 Mentees

• The group feels like a safe place to talk about clinical questions and insecurities
• It's nice to have a group (on email even) of peers and mentors to discuss issues and offer opinions and expertise around cases. I learn a lot even from reading about others’ cases
• Now more comfortable with anxiety and bipolar disorder, feel somewhat intimidated at times by drug combinations
• The original meetings in Toronto with a mix of lecture and small group meetings were great!
References


Physician Training in Child and Adolescent Psychiatry

Stacey D. Espinet, Ph.D., Postdoctoral Fellow
Margaret Steele, M.D.

June 20, 2014
Canadian Collaborative Mental Health Care Conference
OUTLINE

1. Rationale for training primary care physicians (PCPs) in child and youth mental health?

2. Do PCPs’ need and want training?

3. How best can we package training to move desired outcomes?
1. Rationale for training primary care physicians (PCPs) in child and youth mental health?
What the research indicates...

An estimated 14% of Canadian children/adolescents (i.e. over 800,000) suffer from significant mental health conditions that are predicted to increase 50% by 2020.
(Canadian Pediatric Society, 2007)

The prevalence of mental health issues exceeds treatment capacity; fewer than 25% of Canadian children/adolescents receive the specialized treatment services they need.
(in Waddell et al., 2005, Can J Psychiat)
What the research indicates…

The ratio of child psychiatrists to children/youth with mental health needs is 1:6148, in contrast, the estimated need for child psychiatrists is 1:1390.  

Significant barriers to accessing rural child/youth mental health care include: difficulties recruiting & retaining health care workers & specialists; access to care only outside community; disconnection from social & cultural supports; costs due to travel & time off work. (In Pignatiello, 2008, *Can J Psychiat*)
What the research indicates...

PCPs can play a pivotal role in supporting child/youth mental health given that approximately 75% of difficulties are first seen in primary care settings. (In Miller 2007, Primary Care)

PCPs are in a unique position to support paediatric mental health: lack of stigma associated with PCP Tx; trusted relationship; opportunity to detect parent-child difficulties & promote mental health early on. (In Steele et al., 2012, J Can Acad Child Adolesc Psychiat)
2. There is opportunity to build mental health care capacity in primary care setting but do PCPs’ need and want training?
A national collaborative group (PTCAP) established to investigate rural/remote PCP mental health training that includes representatives from all Canadian provinces and the North including Nunavut, Yukon, and Northwest Territories.

**Objectives:**

1) Assess PCPs’ need for and interest in pediatric mental health training.
2) Develop a comprehensive, evidence-informed, curriculum for rural PCPs across Canada.
3) Evaluate its impact on physician practice & child/family mental health outcomes.
The majority of PCPs report **NO** formal pediatric mental health training.
Do Canadian PCPs express a need and desire for training?

1. PCPs reported **mid-range** levels of confidence in their **knowledge**.

2. BUT, PCPs reported the **lowest** rates of confidence in their **skills**, ranging from somewhat lacking to mid-range.

3. **87.8%** of rural physicians across Canada indicated a need for training: a) ADHD, b) mood/anxiety, c) behavioral problems, d) suicide.

4. **70.9%** reported having no opportunities for training, but would attend if available & prefer small group teaching in community by family physician/psychiatrist pair.  
   (Steele et al., 2012)
3. How best can we package the training to move desired outcomes?
Avoiding the pitfall: considering research from the beginning

Suggested Design Based on the Needs Assessment
1) Small group teaching, in the community, delivered by a rural family physician/psychiatrist pair.

1) Knowledge/recommendations? Skills training?

Are recommendations alone sufficient?
Do PCPs need a focus on skills?

**A. What learning needs remain regarding your approach and management of child/adolescent ADHD, OCD, and CD? (n = 31)**

- **Skills:**
  - time management, behavior management, handling difficult cases, interviewing, family counseling

- **Knowledge:**
  - differential Dx, diagnostic protocol, prescribing medications, ongoing education

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**B. Areas of Uncertainty**

- **Skills**
- **Knowledge**
- **Many**
- **None**
- **No Response**

** recruiter question**

- **B. Are there any situations you are still unsure how to resolve? (n = 32)**
PCPs need and desire a focus on skills!

“…back in my training, both in psychiatry and interview skills workshop we had never really talked about interviewing kids…really valuable because I have little background or CME on those topics…” (Stretch et al, 2009).
Proposed evidence-informed curriculum design

Based on Brown and Wissow (2012): tripartite framework for conceptualizing the types of skills primary care staff can use to have therapeutic encounters with patients with mental health problems:

- **Common Factors**: Communication and interaction skills to build trust, elicit mental health concerns, problem-solve, and develop a mutual plan.

- **Common Elements**: Frontline approaches to major symptom clusters based on shared features of different evidence-based treatments (e.g., depression = problem solving / coping skills).

- **Guidelines**: Evidence-based guidelines/treatment for common, easily diagnosable mental health disorders (ADHD, mood/anxiety, behavioral problems, suicidality).
Proposed evidence-informed curriculum and evaluation design

**Curriculum**
1. CME in community – onsite at family health clinics
2. Small group, interactive teaching led by rural family physician/psychiatrist pair
3. Multiple training sessions (3-5), tailored content, region-specific resources to support referral and coordination
4. Comprehensive, whole-office approach, including entire team (Brown & Wissow, 2012)

**Evaluation:**
1. Change in PCP practice & attitude: audiotaped sessions of a real patient visit
2. Change in child/youth attitude & mental health: multi-informant
3. Change in referrals to specialists and children’s mental health agencies
4. Mixed methods
## THANK YOU TO OUR FUNDER AND COLLABORATORS

### Children’s Health Foundation

### PTCAP National Collaborative

<table>
<thead>
<tr>
<th>Southwestern Ontario</th>
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THANK YOU

For Questions or PDF of Presentation
Contact:
Stacey D. Espinet
Stacey.Espinet@lhsc.on.ca
Choice and Partnership Approach (CAPA): Building Collaborations with Primary Care in Nova Scotia

Sabina Abidi MD FRCPC
Child/adolescent psychiatrist
Division Head, Outpatient Services
IWK Mental Health & Addictions Program
Division of child/adolescent psychiatry
Dalhousie University
Child/adolescent psychiatric services in Nova Scotia

• Population: 300,000
  o Maritime provinces population:
• Under 19:
• With mental health concerns:
  o Urban
  o Rural
  o Primary care
• IWK Health Centre
  o 17 FTE child/adolescent psychiatrists - not one full time clinical staff
• Historical: prolonged wait times, difficulty seeing psychiatry, silos of care, lack of collaboration with colleagues
  o Inefficient (ineffective) system of care provision
I need help with cases. We can't get Psychiatry to see our patients. We refer and never hear another thing. Why can't I refer to groups? Why do my cases get seen by a SW? Why don't I get notified if my patient doesn't come? Can't I get a curbside consult from Psych? There's never any follow-up. Ho do we get kids into IWK MH? Don't take my patients away. Your wait time is a terrible problem. Where are you when we need you?
Here is Edward Bear, coming downstairs now, bump, bump, bump, on the back of his head, behind Christopher Robin. It is, as far as he knows, the only way of coming downstairs, but sometimes he feels that there really is another way, if only he could stop bumping for a moment and think of it.
**Collaboration Report Card**

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<thead>
<tr>
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<th>Then</th>
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<td>Improve Wait times</td>
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<td>Improve Access to Services</td>
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<td>Better Communication</td>
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<td>Improve Access to Psychiatry</td>
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<td>Clear Documentation</td>
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August 2011...
We started a transformation
3. Changed outpatient system.

- Choice and Partnership Approach (CAPA) is a clinical system widely used in UK, New Zealand, Australia.
- Goals are to provide services to kids and families that are:
  - user-friendly
  - designed around their needs
  - fast
  - accessible
  - safe
  - effective
Goals to Methods

• Better match the treatment options to the clinical needs of client.
Shared Decision Making

Patients have expertise

a) their issues/difficulties
b) their needs/goals
c) their strengths abilities (working capacity & motivations)
d) motivations
e) they are responsible for change

Clinicians have expertise

a) to engage (think MI)
b) to clarify goals about programs (and outcomes)
c) provide opinion re: Dx / risk
d) share about Tx outcomes & research

Concepts taken from York & Kingsbury, 2013, p. 52
• CAPA principles
  o Open process
  o Monitoring
  o Accountability
  o Weekly Supervision (peer)
  o Education & training (can now recognize the gaps)
  o Skill-specific
    • Choice appt allows for better understanding of needs
    • Better assignment of skilled clinician
    • Improved time management for patient/family
    • Allows for most severe to be triaged to psychiatry
  o Partnership of care (no silos)
Has CAPA improved wait times?

Wait times for regular referrals

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<th>2012-13</th>
<th>2013-14</th>
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<td>245</td>
<td>70</td>
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<td>Q2</td>
<td>382</td>
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<td>Q3</td>
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</tr>
<tr>
<td>Q4</td>
<td>202</td>
<td>150</td>
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Waits:
- **2011-2012**
  - Families were waiting 9 months on average
- **2013-14**
  - Families waiting 3 months on average to Choice
• What changed for psychiatry?
  o CAPA process/philosophy/getting rid of silos to improve our own collaboration first
  o Improved accountability/efficiency (remove the feeling of treading water)
  o Better triaging processes (HEADS ed, SDQ, outcome measures) – those only needing a psychiatry consult will not go in regular wait list
  o More options for our MD partners
  o Specific psychiatrists devoted to in-house consults
  o Job planning psychiatrist time – we know what we are all doing, meeting expectations
  o Open access process/working relationship
  o Process of improved collaborative care within CAPA system – allowing psychiatrists to see the most severe in partnership
Improved Access to Psychiatry

- **Improved efficiency of service**
  - Allowed for creation of innovative methods of collaborative care provision with psychiatry

- **Telephone (curbside) consultation**
  - Same day
  - Easy access

- **One-time psychiatric consultation with collaborative approach to follow up**
  - 8-11 week wait
Further initiatives...

- In collaboration with the Children’s Health Program, have requested of EELT an external review of the Autism Service, where families routinely wait years before being seen
- Began analysis of how MDs are allocating their time
- Holding psychiatrists accountable and emphasizing the need for more collaborative efforts
• Some interesting positive outcomes so far...
  o 30% of referrals are closed after the initial choice appt
  o Psychiatry is often not required at initial stage of referral
  o Psychiatry is not left “carrying the ball” (“what do psychiatrists do”?)
  o Education with partners re appropriate psychiatry referral and how to better utilize our MD partners (e.g. ADHD diagnostic referral)
  o Clinicians given autonomy/permission to make decisions
Some interesting other outcomes...

- Poor uptake on telephone consult
- Frustration with process of CAPA
- Growing pains assoc with dramatic paradigm shift both in house and externally despite improved numbers (central referral)
- Recognition of what our infrastructure needs are
  - IT system
  - Dictating system
  - Administrative support
  - Need for cheerleaders in leadership
Section VI: Resources

- All of the CAPA ideas and concepts presented have been developed by Drs. Steve Kingsbury and Ann York.
- Please see the [http://www.capa.co.uk/](http://www.capa.co.uk/) website for more information or refer to their publication:
Goals for FY15

• Access & Capacity:
  o Reduce Psychiatry Consult wait time to 4 weeks,
  o Have 60% of telephone consult slots for MDs filled
  o Complete job planning for all MDs
> 150 Primary Care Physicians
  - serving over 300,000 patients
  - Hamilton population over 600,000
  - Tertiary CYMH care at McMaster Children’s Hospital
  - Outpatient care wait times vary 7 days to 2 years
  - Child psychiatry consult 3 to 6 months
Models of Mental Health Service Delivery
Direct Service at Primary Care Site
Mental Health Professionals
Consulting Psychiatrists
Centralized Service
Indirect Consultation
Goals of Indirect Consultation

- Increase system capacity: use current resources differently / more efficiently
- Improve access to care and reduce wait times
- Enhance the experience for the person receiving care with trusted familiar physician
- Enhancing experience for Primary Care Providers (PCPs) by building personal relationship based in trust
- Capacity building for Primary Care Providers
Improve the Referral Process

• Direct simple access and contact
• No duplication of information
• Rapid indirect consultation response that addresses referral concerns in 1 to 2 weeks
• Rapid repeat access when required
• Consistent Child and Adolescent Psychiatrist
Goal of Capacity Building

• To increase PCPs detection and triage skills
• To increase PCPs knowledge of treatment options
• To increase PCPs knowledge of community resources
Indirect Consultation

- PCP completes brief referral form and faxes/emails along with additional clinical information during week
- Monday, Psychiatrist reviews information, identify referral issues and additional information
- Telephone discussion between PCP and Psychiatrist
- Consultation note with recommendations completed same day and faxed/emailed back to PCP
Indirect Consultation

• Started in 2009 at HFHT
• Past year – consultations/assistance to over 90 of 150 physicians practices
• In 30 working days over past year (2013/2014) completed 109 consultations plus many brief calls regarding specific questions (diagnosis or treatment), triage, navigating CYMH network
• Full DSM 5 spectrum of diagnoses
Child & Youth Mental Health Consultation Request

This Section (Pg 1) to be completed by the Family Practice and faxed to 905-667-4873

Child & Youth Psychiatrist – Dr. Peter Kondis
(Tel) 905-667-4874 ext 143 (Fax) 905-667-4873
Attention: Dr. Kondis

Child & Youth Mental Health Counselor – Brenda Mill
(Tel) 905-667-4874 (Fax) 905-667-4873

<table>
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<th>Patient Name</th>
<th>DOB: MM/ DD/ YY</th>
<th>Date of Consultation: DD/ MM/ YY</th>
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Name of Practice: ____________________________
Facilities: ____________________________

Person Requesting the Consultation:
Who have you discussed this patient with (check yes):
- Physician
- Nurse
- Psychiatrist
- Other: _____________

Physician: ____________________________
License No: ____________________________
Date: ____________________________

Primary Presenting Concern:
1. _____________
   Where is the problem occurring:
   _____________
2. _____________
   Home School Community Peers Other: _____________
3. _____________

Brief Family History:
Family Cancellation: single parent: separation issues:

___________________________
___________________________
___________________________

Life Events:

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<th>Date of Event</th>
<th>End</th>
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Past Assessments/Service Providers:

Child & Youth Psychiatry Questionnaire Completed: Yes No
Other Assessment Tools: Yes No
Past or Present Inpatient (CAH, Chronic, McSorley) Yes No

Diagnostic & Medications:

Current Drg. _____________ Yes _____________
Medication Management _____________
Dosage _____________

Reason for Request:
- Medication
- Diagnosis
- Case Support
- Medication Management
- Dorsit Recommendations

8/20/2019

Child & Youth Mental Health Consultation Request.doc
Relevant History: Mary is 20 year old first year McMaster Social Science student who was referred for possible ADHD. Psychological assessment completed September 2011 revealed extensive history. Most noteworthy were Mary’s past history of academic challenges including repeating Grade 3 and ADHD symptoms. This report confirmed the diagnosis of **Learning Disability** as well as documenting **ADHD**. Mary’s brother has ADHD and similar language based Learning Disability. Mary was started on Celexa 10mg for **Depression** on November 21, 2011.

Recommendations:

**Depression**
Rating Scales such as PHQ 9 may be used to diagnose as well as in the periodic monitorin of treatment response in the management of Depression. This could contribute to determining whether her dose is adequate after at least 3 weeks, although full effect of SRI’s is usually seen after 4 weeks. If she has not had an adequate response her dose could be increased to 15 or 20 depending upon her weight. Please ensure that she has been informed of rare risk of intrusive suicidal ideation per Black Box Warning and document this in her chart.
ADHD
Concurrent with the treatment of her Depression, cardiac screen should be completed to ensure there are no contraindications to starting stimulant medication. This consists of ensuring that Mary does not have a history of syncope with exercise, exertional chest pain, family history of sudden death under the age of 50 or personal history of structural cardiac defects. A positive response to these should prompt consultation with cardiologist. Rating scales such as SNAP or ASRS should be used to assist in the diagnosis and monitoring treatment response. WFIRS can assess severity of functional impairment resulting from ADHD. These are all available from [www.caddra.ca](http://www.caddra.ca) or on Child and Youth Mental Health Toolkit [http://www.shared-care.ca/toolkits](http://www.shared-care.ca/toolkits) and clicking on ADHD petal.
Concerta (No Subs) is generally well tolerated and effective starting at 18 mg and gradually increasing until therapeutic response is achieved. Generally therapeutic dose range is between .5 to 1.5 mg/kg qam. It is essential to specify No Subs as generic ‘Concerta’ does not have slow releasing mechanism of name brand Concerta.
Learning Disorder
Recent psychological report indicates significant weakness in reading and need for remediation. The following are a list of useful websites for Mary and her family regarding approaches to addressing her LD. She should contact Student Services at McMaster and provide a copy of her psychological assessment if she has not already done so. She is entitled to a wide range of accommodations and supports.

www.ldac-taac.ca   L. D. Canada
www.ldao.ca   L. D. Ontario
www.childrenwithlearningdisabilities.ncjrs.org   Information about LD
www.allkindsofminds.org   LD website
www.ncld.org   US based National Center for Learning Disabilities
www.ldonline.org   Resource for teachers and parents

Thank you for this interesting and complex case.
Relevant History: John is 16 year old with past history of ADHD presently taking Vyvanse 40mg with some amelioration of symptoms and recurrence of his episodic Tics. Consultation is requested regarding management of Tics. His current weight is estimated to be 90 kg. Family History is significant on both sides of family for ADHD as well as Maternal side with Depression.

Impression

Tics – I would recommend trial of Clonidine .05mg po qam and qpm (after school). If this is not sufficient I would increase dose to .1 mg BID. Initially there may be some sedation but this should taper within one week. If this is inadequate and side effects are minimal, you could increase Clonidine to .15 and then to .2 BID. Higher doses of clonidine may result in increased sedation and hypotension. If Clonidine is not effective next medication I would recommend is Risperidone .5 mg po qam for 1 week that could be increased by .5mg every 2 weeks thereafter up to maximum of 2 to 3 mg. Monitoring of Tic and irritability/temper response at each dose increase with either Clonidine or Risperidone is essential by speaking with John and his parents. This is required before dose increases should be implemented. Sometimes longer intervals are required. I would concur with our discussion that John has Tourettes as these Tics predate any prescription of stimulant medication, have been long standing and episodic in nature.
Sleep Hygiene
ADHD individuals classically have difficulty with falling asleep. Switching off electronic games and TV at least 30 minutes prior to HS is MANDATORY! John may use somewhat higher single doses of Clonidine .1mg up to .4mg either PRN or QHS to facilitate sleep onset. Clonidine is short acting and does not produce morning sedation.

Exercise
Regular cardiovascular workouts are key for ADHD/ Tourettes individuals to promote good quality sleep as well as reduced irritability and frustration tolerance. This cannot be underestimated. These sleep and exercise recommendations are the two single most important interventions that John needs to do for his own benefit. Please do not hesitate to contact me regarding this patient for ongoing assistance. Thank you for this interesting and complex case.
Relevant History: Cody is 9 year old starting Grade 4 with past diagnosis of ADHD (Combined) by Dr. M. Allan who completed psychological testing in Grade 1. Cody has been followed by an experienced paediatrician, Dr. J. Peer, who is experienced in treating ADHD. Cody is currently on Strattera 10mg and Vyvanse 50mg daily. Parents have discontinued Justin’s medications and his behavior has been extremely difficult. His current weight is 27.5kg and height 137cm. Justin’s height used to be at the 90th %ile and currently is at 75%ile while his weight was at 75%ile and now is at the 50%ile. Parents are questioning whether Justin has ADHD or some other condition and would like a second opinion regarding Justin’s current medications.
Recommendations:
School: Cody may require school based testing (WRAT or W-J) by learning resource teacher to determine if his academic levels are commensurate with his previous intellectual functioning as Cody may have Learning Disorder in addition to his ADHD as these are frequently comorbid. Also split classes are the worst possible setting for ADHD students as this exacerbates their inattention and distractibility. If he cannot be moved to regular (not split) class then he should be accessing learning resource teacher/room so that he can complete his seat work with fewer distractions
Parent Education ADHD: Apparently parents have discontinued his medication with negative results. This indicates that they require better understanding of ADHD as well as how medications treat ADHD. I would suggest they enroll in COPEing with your ADHD child that is offered in the community by McMaster Children’s Hospital Community Education Program and is an evidence based treatment for parenting the ADHD child. The diagnostic test for ADHD is primarily through rating scales such as the SNAP 18 or 26 or 90 item versions. Seventy per cent of ADHD cases are genetically inherited and medications are required as treatments, not cures - similar to diabetes or seizure disorders. Also his Vyvanse at 50mg would need to be tapered to 25mg for several days, not just stopped to prevent rebound effects from confusing the evaluation of any resulting behaviour.
Side Effects: Parents may have concerns regarding side effects such as moodiness, loss of appetite, initial insomnia, head/stomach aches and slowed growth rate. This can happen especially as the dose of stimulant increased. At 27.5kg his average therapeutic dose range of Vyvanse would fall between 20mg to 30mg. The only way to properly assess therapeutic dose response is for teachers and parents to complete SNAP 26 rating scales. This could be done at the end of September when teacher has had time to become familiar with Cody. It does seem incongruous that Cody is on a high dose of very effective medication such as Vyvanse and also on a low dose of a weakly effective medication such as Strattera.
Second Opinion: You may refer Cody to McMaster Children’s Hospital for a one time psychiatric consultation with wait time of around three to six months. I would suggest that you have parents complete Child and Youth questionnaire that can be accessed on your desktop at the bottom of Community Resource Tool icon. This Child and Youth questionnaire is also accessible on the central portion of ‘flower’ at http://www.shared-care.ca/toolkits along with information on ADHD for parents and caregivers in the ADHD petal. Another excellent site for ADHD is CADDRA site www.caddra.ca Following completion of Child and Youth questionnaire it may be appropriate to complete SCARED rating scale (on toolkit site) as Cody also seems to present with some anxiety symptoms. Then we could treat possible comorbid disorders if indicated.
These toolkits were developed and compiled collaboratively by Helen Spenser MD, CCFP, FRCPC, and Blair Ritchie MD, FRCPC, Children's Hospital of Eastern Ontario, Ottawa, Ontario, and Peter Kondra, MSc, MD, FRCPC, and Brenda Mills, C&Y MHC, Hamilton Family Health Team - Child & Youth Mental Health Initiative.
• Q1. Which of these models would be a best fit for your community/service? Why? Why not?

• Q2. What are the potential barriers to provision of care to children & adolescents with mental health concerns in your community/service/area?

• Q3. What are your suggestions for improving collaborative care?