The Child and Adolescent Mental Health Toolkits for Primary Care

June 15, 2012
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Disclosures

• Helen Spenser: unrestricted educational grants from Shire, Pfizer, Astra Zenica
• Blair Ritchie: no disclosures
Objectives

• Learn about the need for collaborative child and youth mental health care
• Learn how to navigate toolkits in child and youth mental health care using case examples
• Learn how these toolkits can be used in clinical care and education
Mental Health Epidemiology in Children and Youth

• 1 in 5 youth suffer from mental illness and only 1 in 5 of these get identified

• Teens often turn to peers for advice but when they do seek help from professional, more likely FP than psychiatrist or other mental health professional

• There is a dearth of child and adolescent mental health services in this country
  (Davidson & Manion, 1996; Kataoka et al., Am. J. Psych., 2002; Steele & Wolfe, 1999)
Availability of Child and Youth Psychiatry

- 1 psychiatrist to 6148 children with mental health problems in ON 1999
- Most child psychiatrists practice in large cities with medical schools
- Many approaching retirement
- Rural provider could be trained as local expert (Steele & Wolfe, 1999)
- No child and youth psychiatrists in PEI
Child & Youth Mental Health Toolkits

How do I use the toolkit?

To view a specific toolkit, click on the appropriate petal/leaf, or use the navigation bar on the left.

Please give us your feedback! Click here to complete a brief survey about the toolkits. Thank you!
Toolkit development

• Many useful resources are available so we have set out to compile the best of these into one place on the shared care website http://www.shared-care.ca/

• Epidemiology, information about identification, management, and resources for common mental health diagnoses are covered

• Some non-DSM dx also covered
Target Audience

• While initially designed to be used by clinicians and learners in family health teams - it can be used by others who are involved with children and youth MH care, including the individuals themselves and their families

• Important to only use it within the scope of your training (for example: not appropriate for a school teacher to complete a diagnostic assessment...)

In Development

• The toolkit working group meets regularly to discuss feedback and updates
• We are looking for feedback (survey) after several uses
• We have sought input from experts in the specific areas
Dissemination/Use of website

• The website will be linked from the Canadian College of Family Physicians Website
• Members of our group have presented the multiple provinces (PEI, Nova Scotia, Ontario, Manitoba, Alberta, and now British Columbia)
• Goal is disseminate across the country
Susan — a case modified from Dr. Kutcher

- Susan, 16-year-old presents re birth control
- Sexual relationship for one month and her boy friend has been using a condom
- Past history unremarkable apart from multiple somatic complaints (such as stomach aches and headaches) and two short-term episodes of school refusal (in grade one and in grade three).
- Always shy and a worrier
- Fam Hx:
  - Mother treated for major MDE with fluoxetine 11 yrs ago
  - Father has had difficulties with alcohol misuse
2 months later

• Susan’s mother calls: daughter not herself – moping around the house, lost appetite and unhappy
• Susan broke up with her boyfriend
• You remember something about a toolkit on the shared care website so you Google “shared care” and click the first site that comes up
Please join us in beautiful Vancouver, BC on June 15 and 16, 2012 for the 13th Canadian Collaborative Mental Health Care Conference! Click on the player above to view a sampling of what the city has to offer!

Welcome to the redesigned shared care website which aims to provide up-to-date information on collaborative activities between mental health and primary care providers in Canada and other countries. If you have materials you would like added to this site, or if you wish to be added to the shared care e-mail distribution list, please contact Sari Ackerman.

13th Canadian Collaborative Mental Health Care Conference

Collaboration in Action
June 15th to 16th, 2012 - Vancouver, BC

The 13th Canadian Collaborative Mental Health Care Conference will be held on June 15 and 16, 2012 in Vancouver, BC.

Sponsorship package now available!
Registration now open!
Conference program now available!
Click here for accreditation information.

NEW! 2011 Position Paper on Collaborative Mental Health Care
The Canadian Psychiatric Association and the College of Family Physicians of Canada Collaborative Working Group on Shared Mental Health Care has launched a position paper entitled "The Evolution of Collaborative Mental Health Care in Canada: A Shared Vision for the Future".

Quick Links

Child & Youth Mental Health Toolkits
Child & Youth Mental Health Toolkits

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Child & Youth Mental Health General Screening Questionnaire

Child & Youth Mental Health General Screening Questionnaire (version for parent/caregiver)

Child & Youth Mental Health Screening Questionnaire (version for youth aged 12 and over)

Child & Youth Mental Health Screening Questionnaire Scoring Guide
You have Susan fill in screening tool when seeing in your office.

Dr. Collaboration

Susan

Jul 30, 2010

ADHD >7

1. easily distracted, have trouble sticking to activities
2. fail to finish things you start
3. have difficulty following directions or instructions
4. impulsive, act without stopping to think
5. jump from one activity to another
6. fidget

Total: 6

ODD >7

1. cranky
2. defiant, talk back to adults
3. blame others for your own mistakes
4. easily annoyed by others
5. argue a lot with adults
6. angry and resentful

Total: 6

CD >0

1. steal things at home
2. destroy things belonging to others
3. damage school or other property
4. broken into someone else’s house, building, or car
5. physically attack people
6. use weapons when fighting

Total: 0

GAD >6

1. worry about doing better at things
2. worry about past behaviour
3. worry about doing the wrong thing
4. worry about things that might happen
5. afraid of making mistakes
6. overly anxious to please people

Total: 0

Sep Anx >6

1. worry about being separated from people you are close to
2. scared to go to sleep without parents nearby
3. overly upset when leaving someone you are close to
4. overly upset while away from someone you are close to
5. feel sick before being separated from those you are close to

Total: 0

Dep >5

1. no interest in your usual activities
2. get no pleasure from your usual activities
3. trouble enjoying yourself
4. not as happy as other children
5. feel hopeless
6. unhappy, sad, or depressed

Total: 0

Susan

111-111-1111

susan@hotmail.com
• Screening tool suggests that you consider a mood and anxiety disorder so you go to www.shared-care.ca again
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Mood Disorders

We recommend that you review the information in the Overview first as it is essential to guide your use of the resources listed in each section.

Overview - Understanding, Screening, Treatment

Clinician-Administered Screening Tools

Depression Screens

- Kutcher Adolescent Depression Scale (11-Item)
- Kutcher Adolescent Depression Scale (6-item)
- PHQ-9 Adolescent Depression Questionnaire

Co-morbid Screens

- Anxiety (SCARED Child Version, SCARED Parent Version)
- Substance Use
- ADHD (SNAP-IV Long, SNAP-IV Short)
- Eating Disorders
- Suicide Risk
- General (T-CAPS, Weiss Symptom Record)

Educational Patient Handouts

- Common Signs of Depression
- NAMI Family Guide

Treatment Resources
Mood Disorders
Identification and management for Canadian primary care professionals

Compiled by
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Hamilton Family Health Team
Child & Youth Mental Health Initiative

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Mood Disorders

Understanding Mood Disorders in Primary Care

- Visit 1: History and Information Gathering
- Visit 2: Medical and Physical Exam
- Visit 3: Education
- Visit 4: Treatment Plan
  - Non-medication strategies
  - Medications
  - Self-Help Resources

- Follow Up and Referral
- Online Comprehensive Guides and References
Understanding Mood Disorders in Primary Care

- Epidemiology
- Guidelines for Adolescent Depression – Primary Care (GLAD-PC)
- Youth depression
- Bipolar disorder
Epidemiology

- Rare in children
- Common in adolescents: 4-8% prevalence
- Male to female ratio 1:1 in childhood and 1:2 in adolescence
- 5-10% children and adolescents have subsyndromal MDD
- 20-40% will eventually be diagnosed with bipolar disorder

(Birmaher et al., 2007)
Understanding Mood Disorders in Primary Care

- Epidemiology
- **Guidelines for Adolescent Depression – Primary Care (GLAD-PC)**
- Youth depression
- Bipolar disorder
Management of depression and dysthymia but not bipolar disorder in primary care for those 10-21

Guidelines developed over two years by 80 experts in adolescent health under the leadership of Dr. Peter Jensen at Columbia University
Guidelines for Adolescent Depression – Primary Care (GLAD-PC)

Identification/Surveillance

• Recommendation I: Patients with depression risk factors (such as history of previous episodes, family history, other psychiatric disorders, substance abuse, trauma, psychosocial adversity, etc.) should be identified and systematically monitored over time for the development of a depressive disorder.

Assessment/Diagnosis

• Recommendation I: Primary care clinicians should evaluate for depression in high-risk adolescents as well as those who present with emotional problems as the chief complaint. Clinicians should assess for depressive symptoms based on diagnostic criteria established in the DSM-IV or ICD-10 and should use standardized depression tools to aid in the assessment.

• Recommendation II: Assessment for depression should include direct interviews with the patients and families/caregivers, and should include the assessment of functional impairment in different domains and other existing psychiatric conditions.
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Non-medication strategies  Medications  Self-Help Resources

Follow Up and Referral

Online Comprehensive Guides and References
Visit 1: History and Information Gathering

Depression questions and screening tools

Assessing functional impairment

Assess for co-morbidity

Safety assessment and planning
Depression Questions and Tools

**DSM-IV-TR criteria for depression** apply to children and youth.

Free domain screening tools (unlike CDI and other pay-per-use tools):

- Simple screen: “How is your mood?” “Have there been changes in your interests?” (Cheung, 2007)

- 6-item Kutcher Adolescent Depression Scale (KADS-6) (available in 10 languages)

- Patient Health Questionnaire 9-item (PHQ-9) adolescent modification as per GLAD-PC

**Whenever the issue of self-harm and suicide is on a self-report questionnaire, ensure youth fills out questionnaire in presence of qualified office staff**
Visit 1: History and Information Gathering

Depression questions and screening tools

Assessing functional impairment

Assess for co-morbidity

Safety assessment and planning
Assess functional impairment

• The degree of functional impairment along with the severity of symptoms will guide your management plan. Some free domain tools are listed below:

  - Teen Functional Assessment (TeFA) (self-report)
  - Weiss Functional Impairment Scale (Self-report)
  - Weiss Functional Impairment Rating Scale (Caregiver report)
Visit 1: History and Information Gathering

Depression questions and screening tools

Assessing functional impairment

Assess for co-morbidity

Safety assessment and planning
Safety Assessment and Planning

- Check in about safety at each visit.
- Develop and implement a safety plan when there is a risk of self-harm or suicide. Click here for a guide on developing and implementing a safety plan from “Mental Health in the Primary Care Setting: Addressing the Concerns of Children and Youth, 2nd edition, a Desk Reference”.
- If there are any safety concerns, you can arrange to have the person assessed in the closest emergency department. The options available to have someone assessed vary from province to province. Common options include (1) a physician certifying a patient in their office, (2) the police bringing a patient into hospital, or (3) the family seeking an order from a Justice of the Peace to have an assessment completed. Please check your provincial Mental Health Act to determine what options are available in your province.

- 15-20% of teenagers report suicidal ideation
- 5% attempt suicide
- More attempts in females and more completions in males
- Asking about suicidal ideation does not increase suicidal ideation or suicides
- Free domain suicide risk screening tool. TASR-A
- Click here for a handout for youth about suicide from the GLAD-PC (Guidelines for Adolescent Depression – Primary Care) toolkit
- For more information on SSRIs and suicidal ideation, see treatment section
• 6-item KADS score is 8 (total 18, scores of 6 or above suggest possible MDE) and no urgent issues pertaining to suicide or safety on TASR-A
• Susan feels terrible about her breakup and had a panic episode when saw ex-boyfriend at the mall
• After she leaves you go back to [www.shared-care.ca](http://www.shared-care.ca) and scroll through the anxiety overview. You check out the SCARED, a free domain tool to screen for various anxiety disorder.
Child & Youth Mental Health Toolkits

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Anxiety

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Overview - Understanding, Screening, Treatment

Clinician-Administered Screening Tools

Anxiety Screens

- SCARED Child Self-Report
- SCARED Parent Questionnaire

Co-morbid Screens

- Depression (PHQ-9, KADS-6)
- Substance Use
- ADHD (SNAP-IV Long, SNAP-IV Short)
- Eating Disorders
- Suicide Risk
- General (T-CAPS, Weiss Symptom Record)

Educational Patient Handouts

What Is Anxiety?

Anxiety Problems in Children & Adolescents (Offord Centre)

Problèmes d’anxiété chez les enfants et les adolescents (Offord Centre)

Helping Anxious Children

Separation Anxiety

Childhood Fears and Worries
### SCARED questionaire

**Screen for Child Anxiety Related Disorders (SCARED)**

**Child Version—Pg. 1 of 2 (To be filled out by the CHILD)**

1. **Panic Disorder or Significant Somatic Symptoms** ≥ 7
2. **Generalized Anxiety Disorder** ≥ 9
3. **Separation Anxiety Disorder** ≥ 5
4. **Social Anxiety Disorder** ≥ 8
5. **Significant School Avoidance** ≥ 3

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**Overall Score** 37
1 month later

- Susan comes in for her follow-up appointment
- KADS score is 3 and she is eagerly anticipating her family holiday to the cottage
- You confirm your diagnosis of adjustment disorder with depressed mood
Next Fall – Susan gone to university

- Susan’s mother calls: things were going well at first but last week her student advisor called:
  - Missing most of her classes
  - Staying away from friends
  - Drinking alcohol in her room
- When you see Susan gives a 6 week history of depression and alcohol use to cope
• Her KADS score is 12 and she endorses number of items on the TASR-A (including occasional thoughts that life is not worth living)
• TeFA: significant functional problems in a variety of domains.
• Not psychotic and denies any other drug use.
• Physical exam and review of systems normal.
• Arrange to see her for a longer assessment in 3d
• You impress on her the need to call if things get worse
• Discuss the situation with parents who feel can provide necessary monitoring at home with knowledge of crisis line.
• You go to www.shared-care.ca while she is in the office and find some handouts and resources for her and her family.
  – You give her a one page handout on sleep hygiene (under non-med strategies)
  – Under self-help resources you suggest that she visit www.mindyourmind.ca and give her parents a list of books
Mood Disorders

Understanding Mood Disorders in Primary Care

Visit 1
History and Information Gathering

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Visit 4
Treatment Plan

Non-medication strategies  Medical care  Self-Help Resources

Follow Up and Referral

Online Comprehensive Guides and References
Self-Help Resources

Youth:
“Think Good, Feel Good: A Cognitive Behaviour Therapy Workbook for Children and Young People” by Paul Stallard

http://moodgym.anu.edu.au (click “new users”): A free self-help program to teach cognitive behaviour therapy skills to people vulnerable to depression and anxiety

http://www.mindyourmind.ca: Youth information, resources and tools to help you manage stress, crisis and mental health problems.

http://www.thelowdown.co.nz: Youth depression website. Get all the facts and treatment information. Talk to a trained counsellor and hear other people’s personal stories.

www.kidshelpphone.ca or call 1-800-668-6868: Kids Help Phone.

Parents:

“Helping Your Teenager Beat Depression: A Problem-Solving Approach for Families” by Katharina Manassis

“Mind Over Mood” by Dennis Greenberger and Christine Padesky
• Since your practice has access to the services of a social worker who does CBT you discuss Susan with her and arrange for her to attend the next consultation.

• You decide to read up on the management of depression and go back to www.shared-care.ca
Mood Disorders

Understanding Mood Disorders in Primary Care

Visit 1
History and Information Gathering

Visit 2
Medical and Physical Exam

Visit 3
Education

Visit 4
Treatment Plan

- Non-medication strategies
- Medications
- Self-Help Resources

Follow Up and Referral

Online Comprehensive Guides and References
Visit 4: Treatment Plan

- GLAD-PC Guidelines: Initial Management
- GLAD-PC Guidelines: Treatment
- **Non-medication strategies**
- Medications
- Self-help resources
**Lifestyle:**
- Sleep: see sleep hygiene handout from the GLAD-PC toolkit, p. 111, or [click here](http://moodgym.anu.edu.au).
- Diet
- Exercise
- **Relaxation** and socialization
- Curtailing the use of alcohol and substances

**Active Support & Monitoring:**
- Provide the patient with education on depression and recommended websites
- In cases where the depression is mild, make bi-weekly “check-in” phone calls to the patient to monitor – can also have patient use a mood tracker

**Self-Help Resources:**
Online resources available for youth include:

- “Dealing with Depression: Antidepressant Skills for Teens” is a workbook for teens that explains depression and teaches three main antidepressant skills you can use to help overcome or prevent it. The authors are Drs. Dan Bilsker, Merv Gilbert, David Worling, & E. Jane Garland.
- [http://www.thelowdown.co.nz](http://www.thelowdown.co.nz): Get all the facts and treatment information from this youth depression website.

**Therapy:**
- CBT is an evidence-based practice for the treatment of depression in children and adolescents.
- Practice elements of CBT include:
  - Cognitive restructuring ([Checklist of Cognitive Distortions](http://www.thelowdown.co.nz/toolbox/cognitive-distortions.html))
  - Coping skills
  - Behaviour Activation
  - Problem-solving skills
  - Relaxation
- Creating a safe, supportive environment for teens is important. [Click here](http://moodgym.anu.edu.au) for tips on developing a therapeutic alliance with teens (Kutcher and Chehil, 2009).
Checklist of Cognitive Distortions*

1. **All-or-nothing thinking**: You look at things in absolute, black-and-white categories.

2. **Overgeneralization**: You view a negative event as a never-ending pattern of defeat.

3. **Mental filter**: You dwell on the negatives.

4. **Discounting the positives**: You insist that your accomplishments or positive qualities don’t count.

5. **Jumping to conclusions**:  
   a) **Mind-reading**: You assume that people are reacting negatively to you when there’s no definite evidence;  
   b) **Fortune-telling**: You arbitrarily predict that things will turn out badly.

6. **Magnification or minimization**: You blow things way out of proportion or you shrink their importance.

7. **Emotional reasoning**: You reason from how you feel: “I feel like an idiot, so I really must be one.”

8. **“Should statements”**: You criticize yourself (or other people) with “shoulds,” “oughts,” “musts” and “have tos.”

9. **Labeling**: Instead of saying “I made a mistake,” you tell yourself, “I’m a jerk,” or “a fool,” or “a loser.”

10. **Personalization and blame**: You blame yourself for something you weren’t entirely responsible for, or you blame other people and deny your role in the problem.

*Copyright © 1980 by David D. Burns, MD
Medications

• SSRIs are first line
  • 2009 CANMAT guidelines (Lam, 2009) conclude that fluoxetine (Prozac) and citalopram (Celexa) are first-line agents with moderate effect size in moderate to severe depression.
  • A recent review in the Canadian Journal of Child and Adolescent Psychiatry (Carandang, 2011) concludes that fluoxetine (Prozac) should be considered first line while escitalopram (Cipralex), citalopram (Celexa), and sertraline (Zoloft) should be considered second line
  • None are officially indicated in those under 18 in Canada
  • TCAs not found to be effective for depression in the paediatric population.

• Black Box warning for increased suicidal ideation and behavior
  • Number needed to harm range from 50-143 depending on study.
  • No increased rate of completed suicides observed and, in fact, suicide rate has started to rise again since warning released and prescription rates have fallen.

• There is agreement on close follow-up when antidepressants are started. The guidelines below are copied from the National Alliance on Mental Illness (NAMI):
  • First four weeks seen at least once a week with family contact
  • Weeks five through eight, seen every other week
  • See again at week 12
  • See as clinically indicated after this
  • Face-to-face contact as well as family contact are emphasized as important

- Lam et al. (2009). CANMAT Clinical guidelines for the management of major depressive disorder in adults. III. Pharmacotherapy. 3.21. Which antidepressants can be used for children and/or adolescents? Journal of Affective Disorders, 117(Suppl. 1), S26-S43 (pp. S38-S39).
1 month later

- Susan’s KADS is 14 and she is having more frequent thoughts about dying but no suicidal ideas or plans.
- TASR-A unchanged from the previous visit.
- You perform a medical review of systems and decide to order some screening bloodwork.
- You document DSM-IV criteria of MDE and take more time to rule out co-morbidity.
• You discuss treatment options and Susan agrees to ongoing counseling with the social worker and prescription of fluoxetine
• You advise her to follow-up with social worker weekly to check-in regarding thoughts of self harm and reinforce that she should seek help between these times if has intent to act on thoughts
• Within 6 weeks Susan is feeling much better and is almost back to baseline
Education

• Doug, a medical student working with you, has been asked to provide an evidence based review of the treatment of depression in youth and you suggest starting at www.shared-care.ca for an overview and links to comprehensive guidelines and reviews

• Studies show a paucity of paediatric mental health in family medicine training
John

- 7 year old boy referred at request of the school because of very disruptive behaviour
- Numerous suspensions in last year and at risk for being expelled
- Refuses to do work
- Can become very angry when pushed to work and has hit teachers and peers
- Can read and write well but rushes through his work or refuses to do it if not interested
- On playground enjoys playing with other children but often gets into arguments
John

- At home, has tantrums when he doesn’t get his own way and kicks, screams, throws his toys when frustrated
- They describe “walking on eggshells” and avoid confrontation with him
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Child & Youth Mental Health Screening Questionnaire Scoring Guide
John’s mom fills in screening form when in your office

Dr. Collaboration mother John and parents AN elementary school

Disruptive behaviour and academic struggles

How can we change this behaviour?

<table>
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<th>ADHD &gt;7</th>
<th>ODD &gt;7</th>
<th>CD &gt;0</th>
<th>Sep Anx &gt;6</th>
<th>GAD &gt;6</th>
<th>Dep &gt;5</th>
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<td>distractive, has trouble sticking to an activity</td>
<td>defiant, talks back to adults</td>
<td>steals things at home</td>
<td>worries about being separated from loved ones</td>
<td>worries about doing better at things</td>
<td>no interest in usual activities</td>
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<td>fails to finish things</td>
<td>blames others for his/her own mistakes</td>
<td>destroys things belonging to others</td>
<td>worries about past behaviour</td>
<td>worries about the wrong thing</td>
<td>gets no pleasure from usual activities</td>
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<td>difficulty following directions or instructions</td>
<td>easily annoyed by others</td>
<td>engages in vandalism</td>
<td>worries about things in the future</td>
<td>afraid of making mistakes</td>
<td>trouble enjoying him/her self</td>
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<td>impulsive, acts without stopping to think</td>
<td>argues a lot with adults</td>
<td>broken into a house, building or car</td>
<td>feels hopeless</td>
<td>not as happy as other children</td>
<td>not as happy as other children</td>
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<td>jumps from one activity to another</td>
<td>angry and resentful</td>
<td>physically attacks people</td>
<td>seems unhappy, sad, or depressed</td>
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Child & Youth Mental Health Toolkits

How do I use the toolkit?

To view a specific toolkit, click on the appropriate petal/leaf, or use the navigation bar on the left.

Please give us your feedback! Click here to complete a brief survey about the toolkits. Thank you!
Behaviour Problems in Primary Care

Epidemiology

**Oppositional Defiant Disorder (ODD)**

**Conduct Disorder (CD)**

Identification

Treatment
Oppositional Defiant Disorder (ODD)

- Affects approximately 5 to 15% of children
- Most often co-occurs with ADHD, depression, anxiety
- Boys outnumber girls 2:1
- Hostile, angry, easily annoyed or irritated by others
- Difficulty with authority figures, particularly parents and teachers
- Frequent temper tantrums
- Refuses to obey rules
- Seems to deliberately try to annoy or aggravate others
- Low frustration threshold
- Blames others for their behavior
- Poor peer relationships and low self-esteem
- Difficult pregnancies, premature birth and low birth weight may contribute in some cases to behaviour problems
- Temperamental or aggressive from an early age
- ODD during childhood can manifest into Conduct Disorder later in the child’s life
Ruling out conduct disorder

• You also read through conduct disorder criteria and decide that John does not fit with this diagnosis
Reviewing ADHD

- In the ADHD overview of the toolkit you read about assessment and remind yourself that ADHD symptoms must be present across different environments and that some symptoms must be present before age 7.
- You read that a SNAP-18 can be used to assess ADHD symptoms.
- You read about how important it is to screen for co-morbidity and decide to use a co-morbidity screener instead of SNAP-90.
John

- Interested in a number of sports
- No features of Autistic Spectrum Disorder
- No symptoms of anxiety although parents initially reported anxiety attacks by which they meant the anger outbursts
- Behavioral difficulties noted since he was a toddler but worse this year
• **Past Psychiatric History:**
  – Was seen when in Senior Kindergarten: diagnosis of ADHD made
  – Parents did not agree and were anxious about the use of medication

• **Past Medical Hx:**
  – Healthy

• **Developmental Hx:**
  – Always very active but nothing else of significance
  – Struggled with similar behaviours since starting kindergarten
Interview

• **Parents:**
  – Angry with school for not being able to manage John
  – Minimized John’s outbursts

• **John:**
  – Fairly active in room but was able to settle and colour
  – Related well with parents
  – Talked about school, his friends and his sports with enthusiasm
  – Was able to identify his anger but blamed others for it
ADHD

We recommend that you review the information in the Overview first as it is essential to guide your use of the resources listed in each section.

**Overview - Understanding, Screening, Treatment**

**Clinician-Administered Screening Tools**

**ADHD Screening Tools**

ADHD Screening Questions
SNAP-IV Long (90-Item)
**SNAP-IV Short (18-Item)**
ADHD Online Scales
ASRS-v 1.1 (adult ADHD rating scale)
Cardiac Screen

**Functional Impairment and Co-Morbid Screens**

Weiss Functional Impairment (Parent Report)
Anxiety (SCARED Child, SCARED Parent)
Depression
Substance Use
Suicide Risk
Trauma

**Educational Patient Handouts**

ADHD - What’s That?
ADHD Recommended Treatment Plan
Attention Problems in Children and Adolescents (Offord Centre)
Problèmes d’attention chez les enfants et les jeunes (Offord Centre)
SNAP 18 Questionnaire filled out by mom and send one for teacher

<table>
<thead>
<tr>
<th>Inattentive symptoms</th>
<th>Hyperactive and Impulsive symptoms</th>
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</thead>
<tbody>
<tr>
<td>Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities</td>
<td>Often speaks or acts before being asked to</td>
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<tr>
<td>Often has difficulty sustaining attention to tasks or play activities</td>
<td>Often talks excessively</td>
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<tr>
<td>Often speaks out of turn when speaking to other(s)</td>
<td>Often difficulty staying seated or standing</td>
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<tr>
<td>Often has difficulty organizing tasks and activities</td>
<td>Often blinks or scratches, or causes other injuries to self</td>
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<tr>
<td>Often leaves things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or things)</td>
<td>Often puts hands or objects into other's space</td>
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<tr>
<td>Often is distractible by extraneous stimuli</td>
<td>Often difficulty keeping hands or feet still in position</td>
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<tr>
<td>Often is forgetful or absent-minded</td>
<td>Often difficulty following through on instructions or long enough to complete (e.g., homework)</td>
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<td>Often is physically reckless or engages in dangerous activities</td>
<td>Often difficulty staying in one's seat when sitting down</td>
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<tr>
<td>Often has difficulty with waiting to take turns</td>
<td>Often difficulty playing by rules or engaging in leisure activities</td>
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<tr>
<td>Often difficulty playing with or engaging in leisure activities</td>
<td>Often has difficulty with getting or taking things from people</td>
</tr>
<tr>
<td>Often difficulty playing with or engaging in leisure activities</td>
<td>Often difficulty completing tasks or chores</td>
</tr>
<tr>
<td>Often difficulty completing tasks or chores</td>
<td>Often difficulty playing</td>
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=0.3/3 for inattention and H/I
Also discover following website:
SNAP 18 Questionnaire by Teacher

As well as ADHD symptoms report significant oppositionalism.

Inattentive symptoms

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<tr>
<th>Item</th>
<th>Inattentive</th>
<th>Hyperactive</th>
<th>Impulsive</th>
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John

=2.7/3 for inattention and H/I
Assessment

• After talking to John’s parents about results of questionnaires they say that perhaps they under-rated John on their SNAP

• When you perform a clinical history asking similar questions you are able to make a diagnosis of ADHD and ODD
On toolkit overview find management plan summary and decide to focus on following:

- Review ADHD educational resources and websites
- Parenting Programs for behavioural management
- School Consultation
- Parent Support
- Discuss medication options
- Routine Medication Review
Risks of NOT Treating ADHD

Long-term follow-up studies comparing ADHD youth who were UNTREATED compared to controls revealed INCREASED:

- Teen pregnancies
- Substance abuse
- High school dropout
- Criminal charges
- Motor vehicle tickets
- License suspensions
- Employment dismissal

(Barkley, 2002)

- You review education section of toolkit
- You educate parents about consequences of untreated ADHD and give them handout on parent resources
You review treatments for ADHD and are interested to find specific non-medication strategies and specific information about first and second line medications and their side effects.
Behavioural Problems Treatment

• You next review treatment options for behavioural problems in the behavioural problems toolkit and discover that some of the non-medication strategies overlap with those suggested for ADHD

• You add anger management to your treatment plan for John

• You are reminded that no medications are indicated for management of these problems
Treatment

A multi-modal approach is recommended and depends upon the severity of the issues.

1. **Parental education**: Teaching parents positive parenting practices and strategies to manage their child’s behaviour (when possible, group treatment is effective in helping parents support one another)
   - [http://www.empoweringparents.com](http://www.empoweringparents.com)
   - [http://www.livesinthebalance.org](http://www.livesinthebalance.org)

2. **Family counselling**: To increase communication and problem-solving skills

3. **School collaboration**: Meeting with teachers and school to discuss the child or youth’s difficulties and establishing a plan to support the child/youth

4. **Cognitive behavioural therapy** (CBT): To help the child to control their thoughts and behavior

5. **Recreational Activities**: Opportunities to develop social skills, interpersonal skills and build self-esteem

6. **Social skills training**: Teaches positive communication, expression of feelings, cooperation and problem-solving skills

7. **Anger management**: Emotional regulation, recognizing triggers and positive coping skills are among a range of topics covered

8. **Relaxation** techniques and stress management skills

9. **Bibliotherapy and online resources for parents**

[back to top]
Summary

• Toolkits are concise, up to date, evidence-based, and readily available online
• Use can increase confidence and skill levels
• As demonstrated with case examples they can be used to help direct assessment and management
• Can be used in medical education
• They are being disseminated across the country
• Your feedback will assist us to continue to improve the toolkit
• Spenser H., Gillies A., & Maysenhoelder H. The CHAT project: paediatricians and mental health clinicians: working together for the sake of the children.