PSP
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Child & Youth Mental Health

Visit 1

Monitor for Risk

Elevated Risk?

NO → Stop Assessment but f/u every 3-6 months

YES → Screen

Support

Only some symptoms and/or No Decrease in Function → Consider other explanations, provide non-specific supports and proceed to next visit in one month

Significant Elevation in Symptoms And / Or Decrease in Function

Possible Teen Depression

NO

YES → Contact in 3 days by phone, text or email

Visit 2

Continue assessment and support

Possible Teen Depression

NO

YES → Contact in 3 days by phone, text or email

Visit 3

Complete Assessment

- No continuing dysfunction or distress
- ADHD
- Depression
- Anxiety
- Unclear, severe, complex and requiring support

Referral Flags

Evaluate need throughout involvement

Emergency: Suicidal intent or plan, acute psychosis

Urgent: Severe symptoms & deterioration in function, suicidal ideation, other major psychiatric conditions

Usual: additional therapy, evaluation, treatment non-responders, other medicatl concerns, med side effects, 2nd or further episode

Tools/Resouces

MOA Tasks

MH Screening Questions
Risk Identification Tables

Functional
- *TeFA*
- *CFA*

Evaluation Tools:
- *ADHD*
- *Anxiety*
- *Depression*
- *Suicide Risk*
- *Substance Abuse Screen*
- *CGI Measurement*

Non-Specific Supports

Safety Plan

General Resources
Strongest Families Referral

Ver 4.2 Jan 22 2012

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Child and Adolescent Mental Health Screening Questions

Historical factors:

1. Parent has a history of a mental disorder (including substance abuse/dependence)
2. Family has a history of suicide
3. Youth has a childhood diagnosis of a mental disorder, learning difficulty, developmental disability, behavioural disturbance or school failure
4. There has been a marked change in usual emotions, behaviour, cognition or functioning (based on either youth or parent report)

One or more of the above answered as YES, puts child or youth into a high risk group. The more YES answers, the higher the risk.

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Print Patient Handout

Screening Tools

Current situation:

5. Over the past few weeks have you been having difficulties with your feelings, such as feeling sad, blah or down most of the time?
6. Over the past few weeks have you been feeling anxious, worried, very upset or are you having panic attacks?
7. Overall, do you have problems concentrating, keeping your mind on things or do you forget things easily (to the point of others noticing and commenting)?
8. Do you or others have significant difficulty managing your child's behaviour (e.g., temper tantrums, acting out, disobedience, unprovoked outbursts, physical or verbal aggression, being destructive, impulsivity, inability to sit still or focus)?

If the answer to **question 1** is YES – for adolescents, consider a depressive disorder and apply the KADS evaluation and proceed to the Identification, Diagnosis and Treatment of Adolescent Depression.

If the answer to **question 2** is YES – consider an anxiety disorder, apply the SCARED evaluation and proceed to the Identification, Diagnosis and Treatment of Child or Youth Anxiety Disorders

If the answer to **question 3** is YES – consider ADHD, apply the SNAP evaluation and proceed to the Identification, Diagnosis and Treatment of Child or Youth ADHD.

If the answer to **question 4** is YES, probe further to determine whether the difficulties are on-going or transitory. Problem behaviours that occur erratically typically do not warrant treatment. Consistent behaviour problems at home and/or school may warrant referral to **Strongest Families**.

Child and Youth Health Screening Questions
(Template for Discussion)

Child/Parent or Youth:

- ☐ "Over the past few weeks have you been having difficulties with your feelings, such as feeling sad, blah or down most of the time?"
- ☐ Over the past few weeks have you been feeling anxious, worried, very upset or are you having panic attacks?
- ☐ Overall, do you have problems concentrating, keeping your mind on things or do you forget things easily (to the point of others noticing and commenting)?

Parent Only:

- ☐ Do you or others have significant difficulty managing your child's behaviour (e.g. temper tantrums, acting out, disobedience, unprovoked outbursts, physical or verbal aggression, being destructive, impulsivity, or inability to sit still or focus)?

Once completed, please give this form back to the office staff _____.

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Screening Tools

- MOA's Child & Adolescent Mental Health Screening
- Child Functional Assessment CFA
- Teen Functional Assessment TeFA
- Clinical Global Improvement CGI
- Weiss Functional Impairment Rating Scale - Parent
- Weiss Functional Impairment Rating Scale - Child
- Weiss Functional Impairment Rating Scale - Instructions
- MDD in Youth Risk Identification Table
- Anxiety Disorder in Child Risk Identification Table
- Anxiety Disorder in Youth Risk Identification Table
- ADHD Disorder in Child Risk Identification Table
- ADHD Disorder in Youth Risk Identification Table
- Tool for Assessment of Suicide Risk - Adolescent
- Substance Abuse Assessment

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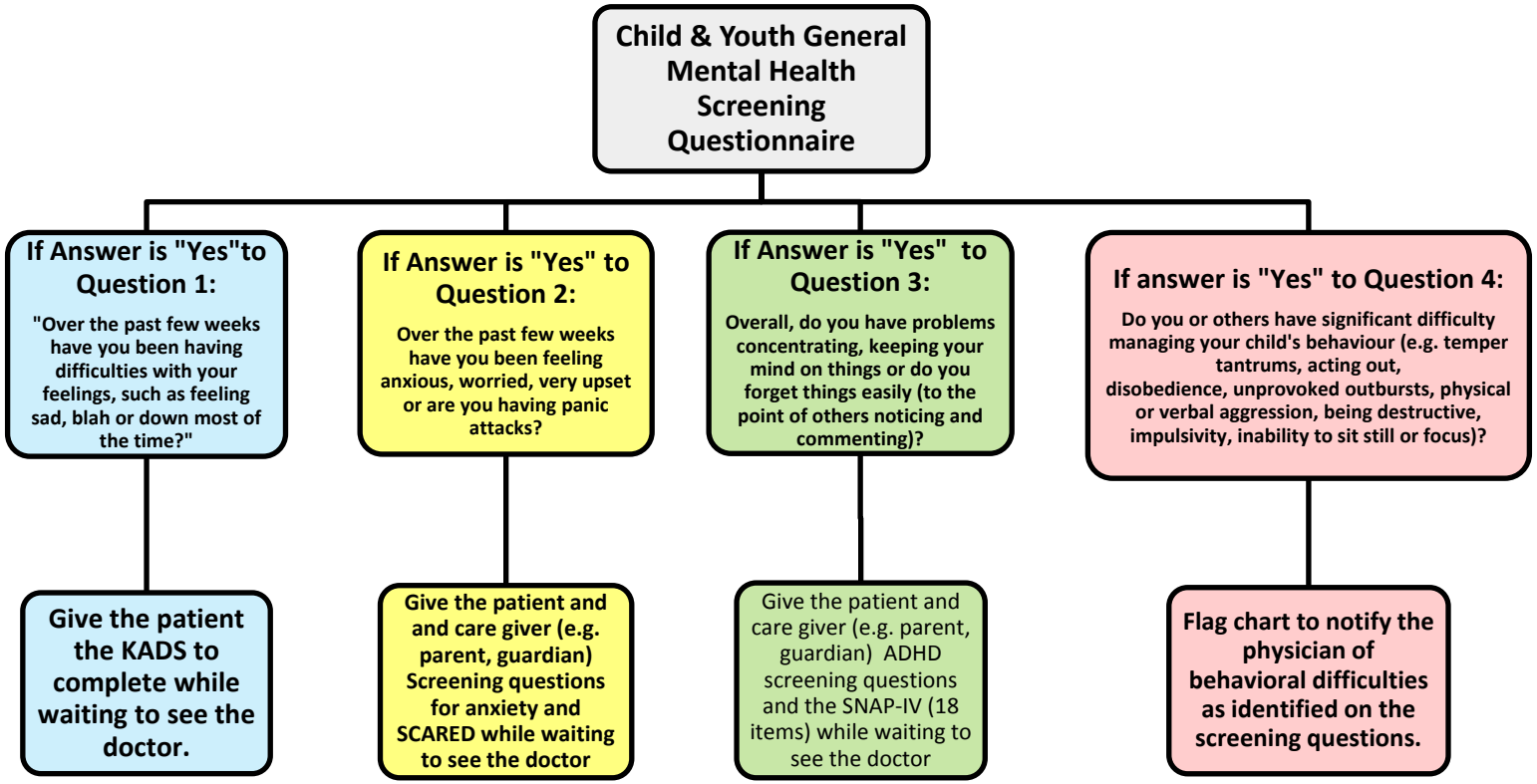
MOA's Child and Adolescent Mental Health Screening



Attach a copy of TASR-A to the clinical file if an adolescent answered YES to any of the General Mental Health Screening Questions (To be filled out by the clinician)

Since comorbidity is frequently found, some children or adolescents and/or their caregivers may respond YES to more than one question. If that is the case, provide them with the screening questions or clinical tools regarding each question.

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Child and Youth Mental Health
PSP Module

MDD in Youth, Risk Identification Table

Well established and significant risk effect	Less well established risk effect	Possible "group" identifiers (these are not causal for MDD but may identify factors related to adolescent onset MDD)
1. Family history of MDD 2. Family history of suicide 3. Family history of a mental illness (especially a mood disorder, anxiety disorder, substance abuse disorder) 4. Childhood onset anxiety disorder	1. Childhood onset Attention Deficit Hyperactivity Disorder 2. Substance misuse and abuse (early onset of use including cigarette and alcohol) 3. Severe and persistent environmental stressors (sexual abuse, physical abuse, neglect) in childhood	1. School failure 2. Gay, lesbian, bisexual, transsexual 3. Bullying (victim and/or perpetrator)

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Anxiety Disorder in Children, Risk Identification Table

Significant risk effect	**Moderate risk effect**	**Possible "group" identifiers** (these are not causal for anxiety disorder but may identify factors related to adolescent onset anxiety)
1. Family history of anxiety disorder 2. Severe and/or persistent environmental stressors in early childhood	1. Children with shy, inhibited and/or cautious temperament (innate personality type) 2. Family history of a mental illness (mood disorder, substance abuse disorder) 3. Have experienced a traumatic event 4. Substance misuse and abuse (early onset of use including cigarette and alcohol)	1. School failure or learning difficulties 2. Socially or culturally isolated 3. Bullying (victim and/or perpetrator)

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Anxiety Disorder in Youth, Risk Identification Table

Significant risk effect	**Moderate risk effect**	**Possible "group" identifiers** (these are not causal for anxiety disorder but may identify factors related to adolescent onset anxiety)
1. Family history of anxiety disorder 2. Childhood onset anxiety disorder 3. Severe and/or persistent environmental stressors in childhood.	1. Children with shy, inhibited and/or cautious temperament (innate personality type). 2. Family history of a mental illness (mood disorder, substance abuse disorder) 3. Experiencing a traumatic Event 4. Substance misuse and abuse (early onset of use including cigarette and alcohol)	1. School failure or learning difficulties 2. Socially or culturally isolated 3. Bullying (victim and/or perpetrator) 4. Gay, lesbian, bisexual, transsexual

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ADHD Disorder in Children, Risk Identification Table

Significant risk effect	Moderate risk effect	Possible "group" identifiers (these are not causal for ADHD but may identify factors related to childhood onset ADHD)
1. A previous diagnosis of ADHD 2. Family history of ADHD 3. Family history of mental disorders (affective, anxiety, tics, or conduct disorder) 4. Psychiatric disorder: Oppositional Defiant Disorder, Conduct Disorder or a Learning Disorder	1. Exposure to severe environmental factors (i.e., lead contamination, prenatal exposure of alcohol and cigarette, birth trauma, low birth weight, head injuries). monitoring team 2. Psychosocial adversity such as maternal depression, paternal criminality, chaotic home environment, and poverty. 3. Substance misuse or abuse (early onset of use – including cigarettes and alcohol)	1. School failure or learning difficulties 2. Socially isolated from peers or behavioural problems at home and at school – accident prone. 3. Bullying (victim and/or perpetrator)

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Child and Youth Mental Health
PSP Module

ADHD Disorder in Youth, Risk Identification Table

Significant risk effect	Moderate risk effect	Possible "group" identifiers (these are not causal for ADHD but may identify factors related to adolescent onset ADHD)
1. A diagnosis of ADHD in childhood 2. Family history of ADHD 3. Family history of mental disorders (affective, anxiety, tics, or conduct disorder) 4. Psychiatric disorder: Oppositional Defiant Disorder, Conduct Disorder or a Learning Disorder	1. Exposure to severe environmental factors (i.e., lead contamination, prenatal exposure of alcohol and cigarette, birth trauma, low birth weight, head injuries). 2. Psychosocial adversity such as maternal depression, paternal criminality, chaotic home environment, and poverty. 3. Substance misuse and abuse (early onset of use including cigarette and alcohol)	1. School failure or learning difficulties 2. Socially isolated from peers, behavioural problems (including gang activity, legal problems) – accident prone (including traffic violations, accidents) 3. Bullying (victim and/or perpetrator)

Child Functional Assessment (CFA)

The CFA is a self-report tool, but in some cases it may require the caregiver to help. It is meant to be completed by the patient/caregiver and should take no more than three minutes to complete for most children. The health care provider can use the information obtained on the CFA to probe for further information – especially in those areas where the young person noted that things are worse than usual and in those domains that the child/caregiver identifies as either self or parental worry.

This form is meant to let your health provider know about how you are doing. All information you give is confidential. Please write your answers to the items on the form.

Over the last week, use the following lines to mark a spot to show how things were in each of these 3 areas. You can also write an example below each if you wish:

School

Place a mark on the line closer to this end if things are much worse than usual

Example:

Place a mark on the line closer to this end if things are much better than usual

Home

Example:

Friends

Example:

Write down the two things in your life that either worry you the most or are causing you the most problems.

1) _____

2) _____

Write down the two things about you that cause your parents or other adults to be concerned about or that you think might concern them if they knew about these things.

1) _____

2) _____

Teen Functional Assessment (TeFA)

The TeFA is a self-report tool. It is meant to be completed by the patient and should take no more than three minutes to complete for most adolescents. The health care provider can use the information obtained on the TeFA to probe for further information – especially in those areas where the young person noted worse or much worse than usual and in those domains that the teen identifies as either self or parental worry.

This form is meant to let your health provider know about how you are doing. All information you give is confidential. Please write your answers to the items on the form.

For each of the following categories, write down one of the following options in the space provided – much better than usual; better than usual; about the same as usual; worse then usual; much worse than usual.

Over the last week how have things been at:

School _____

Home _____

Work _____

Friends _____

Write down the two things in your life that either worry you the most or are causing you the most problems.

1) _____

2) _____

Write down the two things about you that cause your parents or other adults to be concerned about or that you think might concern them if they knew about these things.

1) _____

2) _____

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Child and Youth Mental Health
PSP Module

Clinical Global Improvement (CGI)

Some clinicians like to use the Clinical Global Impression Scale (CGI) to monitor outcomes. This scale can be used in evaluating treatment for **any** mental disorder.

Clinical Global Impression – Improvement Scale (CGI)
Compare how much the patient has improved or worsened relative to a baseline state at the beginning of the treatment?

0 = Not assessed
1 = Very much improved
2 = Much improved
3 = Minimally improved
4 = No change
5 = Minimally worse
6 = Much worse
7 = Very much worse

CADDRA
CANADIAN ADHD RESOURCE ALLIANCE

Patient Name:
Date of Birth: MRN/File No:
Physician Name: Date:

WEISS FUNCTIONAL IMPAIRMENT RATING SCALE – PARENT REPORT (WFIRS-P)

Your name: _____ Relationship to child: _____

Circle the number for the rating that best describes how your child's emotional or behavioural problems have affected each item in the last month.

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
A	**FAMILY**					
1	Having problems with brothers & sisters	0	1	2	3	n/a
2	Causing problems between parents	0	1	2	3	n/a
3	Takes time away from family members' work or activities	0	1	2	3	n/a
4	Causing fighting in the family	0	1	2	3	n/a
5	Isolating the family from friends and social activities	0	1	2	3	n/a
6	Makes it hard for the family to have fun together	0	1	2	3	n/a
7	Makes parenting difficult	0	1	2	3	n/a
8	Makes it hard to give fair attention to all family members	0	1	2	3	n/a
9	Provokes others to hit or scream at him/her	0	1	2	3	n/a
10	Costs the family more money	0	1	2	3	n/a
B	**SCHOOL**					
	Learning					
1	Makes it difficult to keep up with schoolwork	0	1	2	3	n/a
2	Needs extra help at school	0	1	2	3	n/a
3	Needs tutoring	0	1	2	3	n/a
4	Receives grades that are not as good as his/her ability	0	1	2	3	n/a
	Behaviour					
1	Causes problems for the teacher in the classroom	0	1	2	3	n/a
2	Receives "time-out" or removal from the classroom	0	1	2	3	n/a
3	Having problems in the school yard	0	1	2	3	n/a
4	Receives detentions (during or after school)	0	1	2	3	n/a
5	Suspended or expelled from school	0	1	2	3	n/a
6	Misses classes or is late for school	0	1	2	3	n/a
C	**LIFE SKILLS**					
1	Excessive use of TV, computer, or video games	0	1	2	3	n/a
2	Keeping clean, brushing teeth, brushing hair, bathing, etc.	0	1	2	3	n/a
3	Problems getting ready for school	0	1	2	3	n/a

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
4	Problems getting ready for bed	0	1	2	3	n/a
5	Problems with eating (picky eater, junk food)	0	1	2	3	n/a
6	Problems with sleeping	0	1	2	3	n/a
7	Gets hurt or injured	0	1	2	3	n/a
8	Avoids exercise	0	1	2	3	n/a
9	Needs more medical care	0	1	2	3	n/a
10	Has trouble taking medication, getting needles or visiting the doctor/dentist	0	1	2	3	n/a
D	**CHILD'S SELF-CONCEPT**					
1	My child feels bad about himself/herself	0	1	2	3	n/a
2	My child does not have enough fun	0	1	2	3	n/a
3	My child is not happy with his/her life	0	1	2	3	n/a
E	**SOCIAL ACTIVITIES**					
1	Being teased or bullied by other children	0	1	2	3	n/a
2	Teases or bullies other children	0	1	2	3	n/a
3	Problems getting along with other children	0	1	2	3	n/a
4	Problems participating in after-school activities (sports, music, clubs)	0	1	2	3	n/a
5	Problems making new friends	0	1	2	3	n/a
6	Problems keeping friends	0	1	2	3	n/a
7	Difficulty with parties (not invited, avoids them, misbehaves)	0	1	2	3	n/a
F	**RISKY ACTIVITIES**					
1	Easily led by other children (peer pressure)	0	1	2	3	n/a
2	Breaking or damaging things	0	1	2	3	n/a
3	Doing things that are illegal	0	1	2	3	n/a
4	Being involved with the police	0	1	2	3	n/a
5	Smoking cigarettes	0	1	2	3	n/a
6	Taking illegal drugs	0	1	2	3	n/a
7	Doing dangerous things	0	1	2	3	n/a
8	Causes injury to others	0	1	2	3	n/a
9	Says mean or inappropriate things	0	1	2	3	n/a
10	Sexually inappropriate behaviour	0	1	2	3	n/a

SCORING:

1. Number of items scored 2 or 3
   or
2. Total score
   or
3. Mean score

DO NOT WRITE IN THIS AREA

A. Family
B. School
   Learning
   Behaviour
C. Life skills
D. Child's self-concept
E. Social activities
F. Risky activities

Total

CADDRA
CANADIAN ADHD RESOURCE ALLIANCE

Patient Name:
Date of Birth: MRN/File No:
Physician Name: Date:

WEISS FUNCTIONAL IMPAIRMENT RATING SCALE – SELF REPORT (WFIRS-S)

Name: _____ Date: DD MM YY

Date of birth: DD MM YY Sex: ☐ Male ☐ Female
Work: ☐ Full time ☐ Part time ☐ Other _____
School: ☐ Full time ☐ Part time

Circle the number for the rating that best describes how your emotional or behavioural problems have affected each item in the last month.

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
A	**FAMILY**					
1	Having problems with family	0	1	2	3	n/a
2	Having problems with spouse/partner	0	1	2	3	n/a
3	Relying on others to do things for you	0	1	2	3	n/a
4	Causing fighting in the family	0	1	2	3	n/a
5	Makes it hard for the family to have fun together	0	1	2	3	n/a
6	Problems taking care of your family	0	1	2	3	n/a
7	Problems balancing your needs against those of your family	0	1	2	3	n/
8	Problems losing control with family	0	1	2	3	n/a
B	**WORK**					
1	Problems performing required duties	0	1	2	3	n/a
2	Problems with getting your work done efficiently	0	1	2	3	n/a
3	Problems with your supervisor	0	1	2	3	n/a
4	Problems keeping a job	0	1	2	3	n/a
5	Getting fired from work	0	1	2	3	n/a
6	Problems working in a team	0	1	2	3	n/a
7	Problems with your attendance	0	1	2	3	n/a
8	Problems with being late	0	1	2	3	n/a
9	Problems taking on new tasks	0	1	2	3	n/a
10	Problems working to your potential	0	1	2	3	n/a
11	Poor performance evaluations	0	1	2	3	n/a

Next

Return to Screening

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		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
C	**SCHOOL**					
1	Problems taking notes	0	1	2	3	n/a
2	Problems completing assignments	0	1	2	3	n/a
3	Problems getting your work done efficiently	0	1	2	3	n/a
4	Problems with teachers	0	1	2	3	n/a
5	Problems with school administrators	0	1	2	3	n/a
6	Problems meeting minimum requirements to stay in school	0	1	2	3	n/a
7	Problems with attendance	0	1	2	3	n/a
8	Problems with being late	0	1	2	3	n/a
9	Problems with working to your potential	0	1	2	3	n/a
10	Problems with inconsistent grades	0	1	2	3	n/a
D	**LIFE SKILLS**					
1	Excessive or inappropriate use of internet, video games or TV	0	1	2	3	n/a
2	Problems keeping an acceptable appearance	0	1	2	3	n/a
3	Problems getting ready to leave the house	0	1	2	3	n/a
4	Problems getting to bed	0	1	2	3	n/a
5	Problems with nutrition	0	1	2	3	n/a
6	Problems with sex	0	1	2	3	n/a
7	Problems with sleeping	0	1	2	3	n/a
8	Getting hurt or injured	0	1	2	3	n/a
9	Avoiding exercise	0	1	2	3	n/a
10	Problems keeping regular appointments with doctor/dentist	0	1	2	3	n/a
11	Problems keeping up with household chores	0	1	2	3	n/a
12	Problems managing money	0	1	2	3	n/a
E	**SELF-CONCEPT**					
1	Feeling bad about yourself	0	1	2	3	n/a
2	Feeling frustrated with yourself	0	1	2	3	n/a
3	Feeling discouraged	0	1	2	3	n/a
4	Not feeling happy with your life	0	1	2	3	n/a
5	Feeling incompetent	0	1	2	3	n/a
F	**SOCIAL**					
1	Getting into arguments	0	1	2	3	n/a
2	Trouble cooperating	0	1	2	3	n/a
3	Trouble getting along with people	0	1	2	3	n/a
4	Problems having fun with other people	0	1	2	3	n/a
5	Problems participating in hobbies	0	1	2	3	n/a
6	Problems making friends	0	1	2	3	n/a
7	Problems keeping friends	0	1	2	3	n/a
8	Saying inappropriate things	0	1	2	3	n/a
9	Complaints from neighbours	0	1	2	3	n/a

Next

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
G	**RISK**					
1	Aggressive driving	0	1	2	3	n/a
2	Doing other things while driving	0	1	2	3	n/a
3	Road rage	0	1	2	3	n/a
4	Breaking or damaging things	0	1	2	3	n/a
5	Doing things that are illegal	0	1	2	3	n/a
6	Being involved with the police	0	1	2	3	n/a
7	Smoking cigarettes	0	1	2	3	n/a
8	Smoking marijuana	0	1	2	3	n/a
9	Drinking alcohol	0	1	2	3	n/a
10	Taking "street" drugs	0	1	2	3	n/a
11	Sex without protection (birth control, condom)	0	1	2	3	n/a
12	Sexually inappropriate behaviour	0	1	2	3	n/a
13	Being physically aggressive	0	1	2	3	n/a
14	Being verbally aggressive	0	1	2	3	n/a

SCORING:

1. Number of items scored 2 or 3
   or
2. Total score
   or
3. Mean score

DO NOT WRITE IN THIS AREA

A. Family	
B. Work	
C. School	
D. Life skills	
E. Self-concept	
F. Social	
G. Risk	
Total	

Next

WEISS FUNCTIONAL IMPAIRMENT RATING SCALE (WFIRS) INSTRUCTIONS

Purpose

- ADHD symptoms and actual impairment overlap but are distinct concepts. It is important to measure both since some patients are highly symptomatic but not impaired or vice versa.
- This scale contains those items that are most likely to represent the patient's target of treatment. Therefore, the use of the scale before and after treatment can allow the clinician to determine not only if the ADHD has improved, but if the patient's functional difficulties are also better.
- This instrument has been translated into 18 languages. It has been used in many studies and is psychometrically validated. This is the only measure of functional impairment that looks at specific domains and has been validated in the ADHD population.

Design and Validation Information

Scoring The instrument uses a Likert scale such that any item rating 2 or 3 is clinically impaired. The scale can be scored by looking at the total score or by creating a mean score for the total score/number items for each domain, omitting those rated not applicable. For clinical purposes, when defining impairment for DSM-IV, clinicians can consider that any domain with at least two items scored 2, one item scored 3 or a mean score >1.5 is impaired.

Validation The scale has been psychometrically validated with an internal consistency >.8 for each domain and for the scale as a whole. It has moderate convergent validity (0.6) with other measures of functioning (i.e. Columbia Impairment Scale and the Global Assessment of Functioning (GAF). It has moderate discriminating validity (0.4) from symptoms pre-treatment (i.e. ADHD-Rating Scale) and quality of life (CHIP). The domains have been confirmed by factor analysis, although the domain of school functioning separates into learning and behaviour. The scale is highly sensitive to change with treatment and, in particular, significantly correlated to change in ADHD symptoms (40% change) and overall psychopathology. Each anchor point on the Likert scale represents approximately one standard deviation(SD). A total score change of 13 would be considered a significant improvement or about half a SD. The change obtained in treatment is typically one full SD. The mean score for risky behaviour in children is 0.5 but increases with age. For adolescents the mean score is 1.

Copyright Information

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The Tool for Assessment of Suicide Risk for Adolescents (TASR-A: How to use the TASR-A

The TASR-A was developed to assist in the clinical evaluation of young people at imminent risk for suicide. It was created by clinicians with expertise in the area of adolescent suicide assessment and the development and application of various scales and tools in clinical, research and institutional settings. The TASR-A was derived from the Tool for Assessment of Suicide Risk (TASR) that was developed for clinical use in emergency room, hospital and outpatient settings in the assessment of imminent suicide risk in adults. The adult TASR is found in the book: Suicide Risk Management: A Manual for Health Professionals (Kutcher and Chehil; Wiley-Blackwell, 2007).

The TASR is intended for use as part of a comprehensive mental health assessment of a young person considered to be at risk for suicide. The clinician should conduct the assessment in her/his usual manner and then score the TASR–A. If sections of the TASR-A have not been addressed in the interview, then the clinician should then go back and address them with the patient. A notation of the presence or absence of each risk factor identified on the TASR-A should be made in the appropriate space provided. Once the TASR-A has been completed, the clinician comes to a clinical decision as to the level of risk for imminent suicide and notes that in the space provided on the TASR–A.

The TASR-A is not a diagnostic tool since suicide is a behaviour rather than a medical diagnosis. The TASR-A is also not a predictive tool since there is no tool that can be demonstrated to predict suicide. Rather, the TASR-A is a semi-structured instrument that the clinician can follow to ensure that the most common risk factors known to be associated with suicide in young people have been assessed. The tool also provides the clinician with a convenient overview of the entire risk factor assessment, thus allowing the clinician to make a best judgment call as to the level of risk for imminent suicide. Furthermore, the TASR-A provides an excellent documentation of the comprehensiveness of the suicide risk assessment conducted by the clinician and thus may be useful for both clinical record keeping and in medico-legal cases.

The TASR-A also includes a section in which the 6 item KADS score for depression can be recorded. This is important for a number of reasons. 1) Suicide, like behaviours, can often be the entry point for clinical assessment, and depression is a common risk factor for youth suicide. 2) The presence of a depressive disorder increases the probability of suicide in young people. 3) Treatment of depression has been demonstrated to decrease suicide attempts. The 6-item KADS can be accessed on the professionals section of our website.

The 6-item KADS is designed for use in institutional settings (such as schools or primary care settings) where it can be used as a screening tool to identify young people at risk for depression or by trained health care providers (such as public health nurses, primary care physicians) or educators (such as guidance counselors) to help evaluate young people who are in distress or who have been identified as possibly having a mental health problem.

Permission and Training

The TASR-A can be used by expert clinicians (such as child and adolescent mental health staff working in sub-specialty or academic settings) without additional training. Training in the use of the TASR-A for other health providers is advised and can be arranged for groups of 10 or more by contacting the office of the Chair. Depending on the group, the duration of TASR-A training ranges from one to three hours.

The TASR-A is available freely for use but may not be sold, copied or otherwise distributed without the express written consent of Dr. Stan Kutcher.

We appreciate any feedback on the use, outcome or suitability of the TASR-A from any individual or group who is using it. Feedback can be directed to Dr. Stan Kutcher by email at skutcher@dal.ca.

Clinicians, educators, youth workers and others interested in other training programs pertaining to youth depression and suicide offered by the Chair can find further information by visiting the training programs section of our website.

Tool for Assessment of Suicide Risk: Adolescent Version (TASR-A)

Name: _____ **Chart #:** _____

Individual Risk Profile	**Yes**	**No**
Male		
Family History of Suicide		
Psychiatric Illness		
Substance Abuse		
Poor Social Supports/Problematic Environment		

Symptom Risk Profile	**Yes**	**No**
Depressive Symptoms		
Psychotic Symptoms		
Hopelessness/Worthlessness		
Anhedonia		
Anger/Impulsivity		

Interview Risk Profile	**Yes**	**No**
Suicidal Ideation		
Suicidal Intent		
Suicide Plan		
Access to Lethal Means		
Past Suicidal Behavior		
Current Problems Seem Unsolvable		
Command Hallucinations (Suicidal/ Homicidal)		
Recent Substance Use		

6 item KADS Score: _____

Level of Immediate Suicide Risk

High _____
Moderate _____
Low _____

Disposition: _____

Assessment Completed by: _____ Date: _____

Substances use Assessment

Adolescence is the time during which most individuals first experience exposure to alcohol or other substances. Based on the scientific evidence, we know that the brain continues to develop throughout adolescence and into young adulthood, and insults to it during this period may result in unwanted, negative impacts both short and long-term. Substance misuse and substance abuse then become important issues for the health of young people.

Screening for substances use should be part of general health assessments for adolescents. Although every adolescent should be screened for substance use, there are some red flags that should trigger a more comprehensive assessment. These are:

- Adolescents who present with substantial behavioral changes
- Adolescents who present to emergency medical services for trauma
- Adolescents who present medical problems such as accidents, injury, or gastrointestinal disturbance
- Adolescents with significant decline in school grades and a high number of school absences.

Screening for substance use/misuse/abuse provides an opportunity for psycho-education about the risks of substance use (i.e., alcohol related car accidents are the number one cause of death in adolescents, psychosis risk with marijuana smoking) and an approach to safe and moderate use of alcohol.

For those youth whose substance use is harmful or putting them at risk for negative health or social outcomes, screening opens an opportunity for referral to specialized treatment programs that can provide them with the comprehensive evaluation and interventions that they require.

A parsimonious approach to substance use screening in adolescent is the application of the CRAFFT screening tool (CRAFFT = mnemonic acronym of first letters of key words in the six screening questions). The CRAFFT is a valid, reliable, and developmentally appropriate tool.

When using the CRAFFT, begin by asking the adolescent to answer the following questions honestly and reassure him/her that the answers will be kept confidential within the reasonable limits to confidentiality addressed.

Another thing to have in mind when screening or substances in adolescents is that substance use can be masking a mental disorder and it also can be a way of self-medication for a mental disorders

C - Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?

R - Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?

A - Do you ever use alcohol/drugs while you are by yourself, **ALONE**?

F - Do you ever **FORGET** things you did while using alcohol or drugs?

F - Do your family or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?

T - Have you gotten into **TROUBLE** while you were using alcohol or drugs?

Next

Let's be clearer with words - Drug or substance consumption can be categorised into: drug use; drug misuse; drug abuse and drug dependence. The latest is rarely seen during adolescence as it takes many years to develop.

- **Use** - is defined as taking a drug in such a manner that the sought-for effects are attained with minimal hazard
- **Misuse** - refers to inappropriate use of prescribed or non- prescribed substance.
- **Abuse** - repeatedly and willfully use of a substance that result in repeated adverse social consequences related to drug-taking—for example, interpersonal conflicts, failure to meet work, family, or school obligations, or legal problems.

SUBSTANCE USE SCREEN FOR YOUTH

1) What types of substances have you used in the last month or so?.....in the last year? How often do you use the substance? How much of the substance do you typically use?
2) Which substances are you concerned about?
3) Is there anything you'd like to change about your substance use? How would you know if your substance use is getting 'out of control'?
4) Alcohol – In a typical week, how many drinks do you have?
5) Pattern of drinking – Do you usually/always drink to intoxication?
6) Do you tend to binge drink (men- more that 5 drinks at one time, women more than 4 drinks at one time)?
7) Do you notice any difference in your mood when you use substances? Are there some feelings that you only express when you're drinking/using substances?
8) Have any of your friends expressed concern about your use of substances?
9) Have you had any injuries while using substances (falling & hitting your head, fights, seizures, other health concerns – HIV, STD's, hepatitis)?

Screen for mental health concerns – depression, anxiety, panic, ADHD, suicidal impulses, self-harm, level of risk

Concurrent Issues:
Where does your substance use "fit in" with your emotional health (using substances to cope, substance increases/decreases your emotional health concerns)?

Try to identify the overall picture and communicate that it is not just the amounts/frequency of substance use but the "how" and "why" of substance use that is important.

FROM ALTERNATIVES FOR YOUTH

Return to p 1

Non-Specific Support Tools

Psychotherapeutic Support For Children

Psychotherapeutic Support For Teens

Worry Reducing Prescription

Mood Enhancing Prescription

School & Teacher Tools

Parent & Family Tools

Youth Mental Health Care Plan Template - Family

Youth Mental Health Care Plan Template - Professional

CBIS Lifestyle Skills

A GPSC Initiative

Child and Youth Mental Health
PSP Module

Psychotherapeutic Support for Children/Caregivers (PSC): Practical Pointers for Primary Care Health Providers Treating the Child with ADHD

This tool provides clinicians with guidelines/suggestions that they can use to direct their clinical interactions with children and caregivers. It includes some basic cognitive behavioural and interpersonal therapy strategies, as well as some core counselling techniques.

Approach

- Establish a supportive relationship with the caregiver and child.
- Establish a collaborative approach with the caregiver – providing good treatment services for childhood ADHD requires a good working relationship with the caregiver.
- Include the child as is developmentally appropriate and address their perspective on social, family, academic functioning and feeling about self.

Be Present-Focused

- Focus on the current functioning of the child at home and school.
- Help caregivers let go on negative feeling about past interaction with their child. Focus on now, not on the past.
- Help alleviate caregiver's future-oriented worries by refocusing them on the current issues. A successful future is built on solving the problems of today!

Be Solution-Oriented

- Validate caregiver experience of stress/frustration.
- Help parents to identify what leads to successful outcomes.
- Help parents to advocate with the school to implement interventions that can help their child.

Provide Education

- Provide education about ADHD to both the caregiver and child.
- Help the caregiver understand that many behaviours are not wilful disobedience or laziness, and help them learn how to differentiate.
- Provide evidence-based information about ADHD including answering questions about ADHD and treatment.
- Refer them to the family resources links in the Suggested Websites section and suggest they research (i.e. "Google" the topic) followed by a future discussion.

A GPSC Initiative

Child and Youth Mental Health
PSP Module

Coping Skills

- Parenting a child with ADHD can be stressful. When stressed, parents may exhibit negative parenting behaviours such as: yelling, hitting, inappropriate punishment. Help parents understand that such responses, although common, do not help.
- Provide parents with practical suggestions such as time-out strategies and positive reinforcement techniques. Refer the parents to resources for parent effectiveness training or parent counselling if they are available in the patient's community.
- Remind parents that many youth with ADHD grow up to be excellent at their work, in the arts, in sports and in their lives.
- Encourage parents to fit their child's skills to activities. For example, many children with ADHD have difficulty in highly structured team sports (i.e., baseball) but excel at more individual sports (i.e., swimming, tennis)
- Encourage parents to enrol their child in active, structured, pro-social community organizations (e.g., boys / girls clubs).

Cognitive Strategy

- Cognitive strategies that are sometimes useful for teens are largely ineffective with young children.
- Help caregivers better understand their emotional reaction to their child's behaviour.

Don't react, Parenting a child with ADHD is challenging!

What happened?

It's Thursday night, you're tired after a day of work. You sit with your child to supervise their homework, and find out that they have a math exam tomorrow and they didn't bring home any notes or book to study.

YOU GET ANGRY / FRUSTRATED!

Things like this have happened so many times before…

Don't react, "Stop and think".

Children with ADHD receive a tremendous amount of negative feedback. Criticism and nagging are not going to improve the actual situation.

Take time to breath and think!

A GPSC Initiative

Child and Youth Mental Health
PSP Module

How you can do it better…

There is not much that you can do tonight, but at least you can try not to make it worse. You can ask your child to recall what they have been reviewing in class and make some practice exercises together.

Next day, you can ask the teacher to give you the dates of any exams in advance and help your child to write them down on their agenda, as well as some reminders on days before the exam to help them remember to bring the books needed to prepare in advance.

Behaviour Strategy

- Children with ADHD do better in structured environments!
- Establish an organized household routine including meal times, school work and bedtime. This routine should be predictable, but flexible to the child's needs and should not be rigid.
- Help parents to: create simple systems of organization; develop a token economy at home; the use of charts is useful for children under age of 12 years.
- For more tips and information about parenting and behavioural intervention for children with ADHD, refer to the references for families

Token Economy is a behaviour modification technique that aims to increase desirable behaviour and decrcease undesirable behaviour with the use of tokens or small positive rewards at the moment of success, "displaying desirable behaviour".

The tokens (e.g., stickers, other small objects) are collected and later exchanged for a meaningful object or privilege (e.g., choice of meal for dinner, selection of a favorite book during bedtime story time). A token economy should not take the place of, but rather supplement other parenting techniques such as advice, support, etc. Rewards for children need to be more immediate than with adults. Waiting for the weekend to be rewarded for what the child does on Monday is not useful.

Medication Intro

- Provide rationale for using medication to caregivers including the potential benefits, as well as potential risks about the medication.
- Teach parents about how to give medication to children who may have trouble swallowing larger pills that cannot be sprinkled into food. Also discuss with caregivers the need to include the school in medication information if they need to be involved in administering during the school day, as is often the case with short acting medicines (i.e., Ritalin).
- Talk to the child in developmentally appropriate language about the

rationale for using medicine. Answer any and all questions about fears or concerns.

- Talk to the child in developmentally appropriate language about side effects, such as upset stomach or constipation, and encourage them to talk to their caregiver should they experience any difficulties. Encourage caregivers to have a regular dialogue regarding side effects with their children, especially when beginning a new medication.
- Encourage parents to bring you information that is anti-medicine to be discussed with you so that misinformation or disinformation can be corrected.
- Remember to discuss the issue of addiction. Bring it up yourself if the caretaker or child does not do so.

Medications for ADHD are:

- Among the most effective treatment in all medicine
- Usually helpful to most children with ADHD
- Usually able to be used without significant side effects

Medications for ADHD are not:

- Addictive
- Destructive of the child's personality
- A crutch

Be Realistic

- Discuss with parents reasonable parenting expectations and the needs for ongoing support.
- Discuss expectations and potential obstacles in the treatment course.
- ADHD symptoms have the best chance of improving when child and family are both aware of ADHD and there is agreement with the treatment plan.
- The goal with treatment of ADHD is to achieve remission (i.e., reduce symptoms and improve functioning).

Be Responsive

- Be available for urgent matters within office hours (this depends on individual practitioners' preference and can include phone, email or text messaging).
- Schedule frequent, brief face-to-face visits at times that do not conflict with school (15-20 minutes).
- Monitor and support child's wellness activities (exercise, sleep, healthy diet, etc.).

Psychotherapeutic Support for Teens (PST)

Practical Pointers for Primary Care Health Providers Treating Adolescent Depression – Supportive Rapport

This tool provides clinicians with guidelines/suggestions that they can use to direct their clinical interactions with the teen.

Checklist	Type of Support	Guidelines/Suggestions
☐	**Approach**	• Be friendly but not a friend • Create a supportive space • Establish confidentiality and limits of confidentiality (self-harm, danger to others, etc) and be very CLEAR about these
☐	**Be Present-Focused**	• Help identify the most important problems occurring now
☐	**Be Problem-Oriented**	• Help develop and apply practical solutions to ongoing problems
☐	**Provide Education**	• Provide education about depression and education about the treatment (complete KADS, TeFA)
☐	**Be Responsive**	• Be available for urgent matters by phone, email or text messaging within office hours. • Schedule frequent brief face to face visits at times that do not conflict with school (15-20 minutes) • Monitor and support teen wellness activities (exercise, sleep, healthy diet, etc.) • Ensure access to professional care during the off hours for emergencies

Further guidelines to create a supportive environment

Remember to embed these guidelines/suggestions within a supportive, active listening environment. This includes the following:

- ☑ Compassionate and non-judgmental attitude, but be real
- ☑ Active listening: eye contact, verbal (“ah hum”, “go on”), and non-verbal (head nod) clues to listening engagement
- ☑ Clarification (“help me understand”, “could you explain what you were thinking about that”, etc.)
- ☑ Emotional identification (“seems as if you are feeling frustrated”, etc.)
- ☑ Do not understand the young person too quickly – you are likely to be wrong
- ☑ If you do not know what they are talking about – ask
- ☑ If you do not know an answer to a question – admit it and tell them how you will find out.

Remember that parental or caretaker involvement is often necessary during the assessment and treatment of depression in an adolescent. Whenever possible information about the young person’s emotional state and function should be obtained from the parent or caretaker. It is not uncommon for teens and parents/caretakers to have different opinions about the mental state and activities of the young person. When this occurs, joint discussion of the issue will be necessary for clarification and optimal intervention planning. However, it is essential to ensure that appropriate confidentiality is being maintained during this process.

Confidentiality is important but it has its limits. Abuse, suicide intent, harm of others need to be identified as issues that can not be kept confidential. Drug use must be discussed with the youth and an appropriate decision pertaining to the degree of drug involvement must be clarified in terms of at what point does drug use become drug misuse/ abuse that requires informing others.

Mood Enhancing Prescription

There are many things that you can do to help your mood. Sometimes these activities by themselves will help you feel better. Sometime additional help (such as psychotherapy or medications) may be needed. This is your prescription for what you can do to help your mood. For each activity write in your plan (include what you will do, how often and with whom)

Activity	Plan (what, how often, and with whom)
Exercise	
Eating Well	
Sleeping Well	
Problem Solving	
Being Socially Active	

Worry Reducing Prescription

There are many things that you can do to help decrease stress and improve your mood. Sometimes these activities by themselves will help you feel better. Sometimes additional help (such as psychotherapy or medications) may be needed. This is your prescription for what you can do to help decrease stress and feel better. For each activity "write in" your plan (include what you will do, how often and with whom). This can be done by a health team member or the parent together with the child.

Activity	Plan (what, how often, other supports)
Exercise	
Eating Well	
Sleep	
Problem Solving	
Planning / Organizing	
Social Activity	

Enrolling the Help of Others

Family members could be involved in helping with worry reducing strategies. Other significant persons in the young person's life may also be able to play a role (e.g. teacher, school counsellor, coach, neighbour, etc.) It is a good idea to ask the young person about who else can help out and, whenever possible, get the family involved. Always inquire about school performance. Some young people with anxiety disorders may need extra educational interventions or a modified academic approach, since school stress can make anxiety disorders worse. Discussion with a school counsellor (with permission from the patient and parent) is recommended.

Safety Card- Emergency Contact Number

- **Dr. (xxxxxxxx) number and email**
  604-xxx-xxxx xxxxxxx@xxxxxxx.ca
- **Emergency room**
  604-xxx-xxxx
- **Vancouver Child and Youth Mental Health Referral Line**
  604-709-4111
- **Helpline for children**
  Toll-Free in BC (no area code needed) 310.1234
- **Crisis Intervention and Suicide Prevention Centre of BC**
  Lower Mainland 604.872.3311
  Toll Free 1.866.661.3311
- **SAFER (Suicide Attempt Counselling Service)**
  604-675-3985
- **Vancouver Island Crisis Line**
  1-888-494-3888

Mental Health Care Plan Template

Care Plan for _____**Chart Reviewed**___ **Date** _____

Birth Date _____ **Age** _____ **Parent/Guardian** _____

DSM IV Diagnosis: Axis 1: _____

Axis 2: _____ (optional)

Axis 3: _____ (optional)

Axis 4: _____ (optional)

Axis 5: _____ (optional)

Participants in creation of Plan: _____

Medications:_____

_____

Current concerns or problems: _____

_____

_____

Risk Screening Tool Results: _____

_____

_____

Current supports and strengths: _____

_____

_____

Summary of Condition: _____

_____

_____

Activity Plan (goals, sleep, meals, activity, screen time, school attendance, resources recommended):

_____

_____

Plan: _____

_____

_____

_____

Risk Screening: _____

Communication with the following health professionals is approved by client:

_____

What to do if things don't improve: _____

_____

Reassessment will be in _____

Next

DSM-IV™ Multi-axial System

Psychiatric Diagnoses are classified by the Diagnostic and Statistical Manual of Mental Disorders, 4th. Edition. Better known as the DSM-IV, the manual is published by the American Psychiatric Association and covers all mental health disorders for both children and adults. For each condition, it lists the diagnostic criteria, associated features, prevalence, course, familial patterns and differential diagnosis. Mental Health Professionals use this manual when working with patients in order to clarify and standardize diagnosis using a biopsychosocial perspective. Much of the information from the Psychiatric Disorders pages is summarized from the pages of this text. Should any questions arise concerning incongruence or inaccurate information, you should always default to the DSM as the ultimate guide to mental disorders. The DSM uses a multi-axial or multidimensional approach to classifying a patient's mental disorder in order to help the clinician make a comprehensive and systematic evaluation. It helps organize and communicate clinical information and capture the complexity and individuality of a patient's condition. It assesses five dimensions as described below:

Axis I Clinical Disorders

- This is what we typically think of as the diagnosis (e.g., major depressive disorder, schizophrenia, social phobia).
- It includes all the DSM diagnoses except Personality Disorders and Mental Retardation

Axis II Personality Disorders and Mental Retardation

- Axis II can also be used to indicate prominent maladaptive personality features and maladaptive defense mechanisms
- Personality disorders are enduring, inflexible patterns of inner experience and behaviour (thinking, experiencing emotion, relationships, impulse control) that deviate markedly from the expectations of the person's culture and lead to impairment in functioning. They include Paranoid, Antisocial, and Borderline Personality Disorders.

Axis III: General Medical Conditions

- Relevant as they may play a role in the development, continuance, or exacerbation of Axis I and II Disorders

Axis IV: Psychosocial and Environmental Problems

- Can affect the diagnosis, treatment, and prognosis of mental disorders
- Examples are: stressful events in a person's life such as death of a loved one, change in employment, family problems, economic difficulties and legal problems. These events are both listed and rated for this axis.

Axis V: Global Assessment of Functioning

- On the final axis, the clinician rates the person's level of psychological, social and occupational functioning in a given time period (current or highest in the past year). This is useful for tracking clinical progress as well as measuring the overall impact of the mental disorder. Scale is 0-100 and usually recorded in a 10-digit range e.g. 51-60.

ICD9 Psychiatric (DSM IV) Codes Commonly Used in General Practice:

290	Senile And Presenile Organic Psychotic Conditions (Dementia)
291	Alcoholic Psychoses
292	Drug Psychoses
293	Transient Organic Psychotic Conditions (Delirium)
294	Other Organic Psychotic Conditions
295	Schizophrenia
296	Affective Psychoses (Bipolar disorder)
297	Paranoid States
298	Other Nonorganic Psychoses
299	Psychoses With Origin Specific To Childhood (Autism)
300	**Neurotic Disorders (Anxiety, Phobia, OCD, neurotic depression)**
303	Alcohol Dependence Syndrome
304	Drug Dependence
305	Nondependent Abuse Of Drugs
306	Physiological Malfunction Arising From Mental Factors
307	Special Symptoms Or Syndromes Not Elsewhere Classified
308	Acute Reaction To Stress
309	Adjustment Reaction
310	Specific Nonpsychotic Mental Disorders Following Organic Brain Damage
311	**Depressive Disorder, Not Elsewhere Classified**
312	Disturbance of Conduct, Not Elsewhere Classified
313	Disturbance Of Emotions Specific To Childhood And Adolescence
314	Hyperkinetic Syndrome Of Childhood (ADHD)

Mental Health Care Plan Template

Care Plan for _____**Chart Reviewed**___ **Date** _____

Birth Date _____ **Age** _____ **Parent/Guardian** _____

Participants in creation of Plan: _____

_____

Medications:_____

_____

Current concerns or problems: _____

_____

_____

Risk Screening Tool Results: _____

_____

_____

Current supports and strengths: _____

_____

_____

Summary of Condition: _____

_____

_____

Activity Plan (goals, sleep, meals, activity, screen time, school attendance, resources recommended):

_____

_____

_____

_____

Plan: _____

_____

_____

_____

Risk Screening: _____

Communication with the following health professionals is approved by client:

_____

What to do if things don't improve: _____

_____

_____

_____

Reassessment will be in _____

CBIS Lifestyle Skills

Healthy Habits for Sleeping

It's True: You are What You Eat!

Caffeine Chart

Physical Activity

A Healthy Life

Lifestyle Module

This module contains informational handouts on various lifestyle factors that promote mental and physical health including sleep, nutrition, substances, physical activity and a wellness wheel.

Choose the handouts that correspond to patient needs.

Healthy Habits for Sleeping

Depression often causes a disruption in sleep patterns. Poor sleep contributes to daytime fatigue, low energy, irritability, decreased concentration and increased depression. If sleep is a problem for you, practice the following tips.

- Go to bed and get up at the same time everyday regardless of how poorly you slept.
- If you have not fallen asleep after 20 minutes, get up and do something relaxing or boring until you feel sleepy, then try again. (Repeat if necessary throughout the night).
    - Turn your clock's face away from you to avoid over-focusing or fixating on how much time has passed since you first attempted to go to sleep.
    - Try and give yourself a lot of leeway and remember that it sometimes takes longer or shorter periods of lying in bed before the body falls into a sleep state.
    - Remind and reassure yourself that you *will* fall asleep eventually as your body will naturally shut down when it becomes too fatigued to remain awake.
    - Use pre-sleep time as your own to fantasize about what you would like to see in the days to come, visualize you achieving your goals, doing something fun, satisfying or creative.
- Use relaxation exercises or repetitive mental activity (i.e. counting backwards) to promote sleep.
- Avoid naps.
- Create a good sleep environment, preferably a cool, dark, quiet room. Earplugs, eyeshades and white noise may be helpful.
- Develop a bedtime routine. Try a warm bath 90 minutes before bed.
- Save your bedroom for sleep, sickness and sex.
- Get fresh air and exercise regularly, preferably daily, but not within a few hours before bedtime.
- Avoid caffeine, alcohol, and tobacco in the evening, and maybe even the afternoon.
- Have a light snack (milk, bananas or peanut butter are good choices) but avoid eating a large meal close to bedtime.
- Avoid sleeping medication, including over the counter aids, unless prescribed by your doctor.
    - Do not think about falling asleep while you are trying to fall asleep; this can occasionally increase sleep-related anxiety.

It's True: You are What You Eat!

Do the best you can to replace high-fat, high-caffeine, sugary snacks and meals with healthy ones, everyday

Diet

- Depression frequently affects appetite, either increasing or decreasing it.
- Diet (not how much, but what we eat) can affect depression.
- It's important to eat a healthy, balanced diet that is low in sugar, caffeine and junk food.
- Snacks should be nutritious.
- Regular and consistent dietary habits are important.
- Even if you don't feel hungry, it's important to eat healthy meals or snacks several times a day.
- If needed, decrease portion size, but make sure you eat something.

Substance Use

- Although using drugs and alcohol may provide temporary relief of depressive symptoms, they tend to worsen mood.
- Substance misuse contributes to avoiding rather than facing problems. Avoiding emotional problems tends to aggravate them.
- Reducing substance use to moderate levels, or even stopping, is essential to health and recovery.

Caffeine

- Caffeine comes in several popular forms – coffee, tea, soft drinks and chocolate.
- It is a stimulant, acting on our nervous system much like anxiety does.
- Caffeine is also an addictive substance.
- Some of its side effects are similar to symptoms of depression: sleeplessness, digestive problems, headaches and anxiety.
- Withdrawal from caffeine also mimics depression, with irritability, fatigue, appetite problems, and poor concentration.
- It's best to be aware of the effect of caffeine and to consider limiting its use.
- Please refer to the Caffeine Chart on back to determine your caffeine intake.

Caffeine Chart

CAFFEINE CONTENT OF COFFEE, TEA, AND COCOA (MILLIGRAMS PER 6 OZ. CUP)

Coffee, instant	60 – 70 mg
Coffee, percolated	90 – 110 mg
Coffee, drip	120 – 150 mg
Coffee, decaffeinated	3 – 10 mg
Tea bag, 5 minute brew	50 – 60 mg
Tea bag, 1 minute brew	30 – 40 mg
Cocoa	10 – 20 mg
Chocolate (dry, 1 oz.)	5 – 10 mg

CAFFEINE CONTENT OF COLA BEVERAGES (PER 12 OZ. CAN)

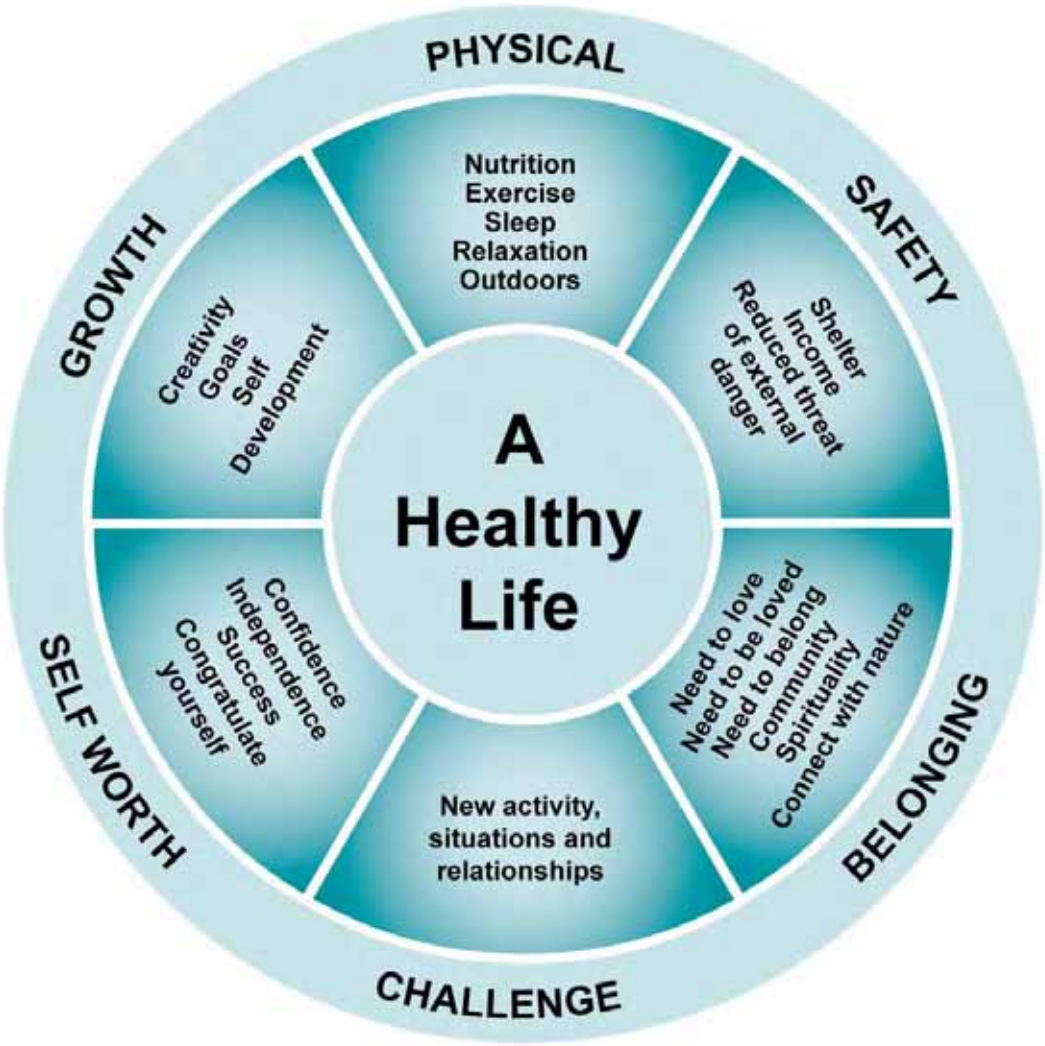
Coca-Cola	65 mg
Pepsi-Cola	43 mg
Dr. Pepper	61 mg
Mountain Dew	50 mg
Red Bull	80 mg
Jolt Cola	72 mg
Monster Energy	160 mg
Spike Shooter	300 mg

Physical Activity

Exercise

- Regular physical activity helps the treatment of depression by brightening mood, increasing energy, and improving sleep.
- Exercise helps increase stamina and reduces the risk of diseases like diabetes, heart diseases, and osteoporosis.
- Exercise can raise the levels of certain chemicals in the brain, including serotonin, which produces happier states of mind, thus helping in the recovery of depression.
- When you are depressed, it is good to know that you are taking positive action for your health.
- A realistic, flexible and fun program has the best chance for success.
- No one form of exercise has been shown to be superior for depression. What is important is to choose a physical activity that you enjoy — and to do it regularly.
- You do not need to push yourself to extremes. In fact, moderate and consistent exercise may improve mood more than excessively long, hard workouts.
- Your goal should be to feel pleasantly tired, a normal feeling after any physical activity.
- The key is to start slowly and be patient with yourself. Just a few minutes of walking (or other exercise) is a good place to start.
- Work towards a fitness goal that resonates for you.
    - Whether you always wanted to pursue training for a long distance race, or if you admire the lightening fast reflexes of masters of the martial arts,
    - Follow a sport or activity that makes you feel alive, in control and powerful
    - Learning a new physical skill often translates into learning a new mental skill in coping with stress and persevering through a difficult section of training/exercise.
    - Many people believe exercising is 75% mental and only 25% physical, and the best part is, anyone can do it

A Healthy Life



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School & Teacher Tools

Tips for Teachers
Of Anxious Students

Tips for Teachers
Of Depressed Students

Letter Requesting
Psychoeducational Testing

Tips for GP's Dealing with
Students at School

Sample Request for School
Support & Accommodation

Support Plan

CADDRA Teacher
Assessment Tool

Practice Support Program...an initiative of the General Practice Services Committee

Tips for Teachers of Anxious Students

What is anxiety?

Human beings have normal anxieties when facing developmental changes, new situations and potential threats. When children's fears and worries become excessive, they may interfere with academic or social functioning. The anxiety response includes physical symptoms (e.g., racing heart, stomachaches, sleep problems), behavioral symptoms (avoidance or tantrums) and anxious thoughts and feelings. The tendency to excessive anxiety runs in families, and is increased by losses, changes, and stresses. Clinical "Anxiety Disorders" take various forms. The name usually explains itself, as in separation anxiety, social anxiety, generalized anxiety, obsessive compulsive disorder, panic disorder and so on. Typically, treatment involves providing practical support, teaching specific coping strategies and sometimes the addition of medications to reduce symptoms.

How common is it?

About 10% of children have symptoms at the mild end of the anxiety continuum at any given time. About 2% have more severe symptoms leading to difficulty functioning, attending school, or participating with peers. At any given time, several children in a classroom will be struggling with some form of anxiety disorder.

What effect does anxiety have on schoolwork?

Anxious children and teens have trouble concentrating, are easily discouraged, will often be tired in class and may be irritable. They are often somewhat perfectionistic. Due to sleep problems, anxious children may miss school or come in late. They may not participate much during class, and grades may drop significantly. Despite these difficulties, anxious children and teens are usually advised by their doctor to attend school because it gives the day structure, prevents "school phobia", and keeps them socially connected. It also keeps them moving along academically. Many children with anxiety are achievement-oriented, and the key to feeling successful is attendance at school.

How can you help?

1. **Check with the counsellor:** If you have concerns that a child or teen in your class may be anxious, talk to the student's counselor, who can give you some guidance as to how serious the problem is and what adaptations are needed. If the counsellor was not aware of the problem, your inquiry could lead to more help being offered.
2. **Communicate with parents:** Be in touch with the parents, in a positive, problem-solving way. Perhaps they can help by getting a tutor, or keeping the child on track with assignments. They will often have ideas for strategies that work for their child.
3. **Take the child's concerns seriously & offer practical support**: Check in with the child regarding how they are managing: is there anything they don't understand, do they need extra help? Express confidence in the child's ability to deal with the situation but if it seems they are overwhelmed, it may be necessary to reduce expectations for a defined time period. Regular class attendance is a lifeline. However, with marked anxiety, it may be helpful for a child or teen to be able to "take a break" to work in a quieter place, such as the resource room or library. You can also quietly remind students to implement whatever coping behaviors have been helpful to them, such as breathing deeply, using distraction techniques, and practicing positive self-talk.
4. **Be consistent:** All children thrive on reliable, consistent schedules, and for the anxious child this need cannot be stated strongly enough. If change is anticipated, cue the child and provide active support for transitions.
5. **Adjusting work expectations**: Short answer, multiple choice and match type questions may be easier, while producing essays may be overwhelming. It helps to break larger tasks such as projects into individual steps. You could help by providing intermediate deadlines, checking how they are coming along, and providing encouragement to keep it up. Anxious children often have perfectionist standards, which results in assignments "not being good enough" to turn in. Encourage submission of any part of an assignment. A doctor's letter may suggest that material be "omitted" for part of a term or that course-load be reduced. At times, a core subject such as math needs to be repeated in summer school or the next year. Please be encouraging in this situation, as students can feel very ashamed and worried about their academic future.
6. **Interaction in the classroom:** Anxious children and teens are easily embarrassed, and do not like to be singled out. This includes having their name put on the board, being selected for special projects, getting disciplined in front of others, or being asked to volunteer for reading aloud. Working with a peer that the anxious child trusts can help them feel more comfortable.
7. **Establish a cue and place for "time out":** Under stress, anxious children may have a "fight or flight" response, with an emotional outburst or angry reaction. If you cannot ignore the behavior, try staying calm, talking quietly and being reassuring, rather than challenging the child. Do not try to physically remove a child from this situation, as this may escalate the panicky reaction. It is helpful if the child has a pre-planned safe place in the school building that they can retreat to, if they feel they are going to lose control. Prepare in advance a system whereby the child can signal the teacher, and quietly leave the classroom in order to go to another safe place in the building.
8. **Work as a team** with parents, counsellor, other teachers and mental health professionals to work out a "plan" together.

Practice Support Program...an initiative of the General Practice Services Committee

Tips for Teachers of Depressed Students

What is depression?

Clinical depression is a "psychobiological reaction" which may be triggered by losses or trauma, and is more common in young people with anxiety, attentional and learning problems. Genetic factors increase risk. The psychological features include hopelessness, irritability, sadness, and suicidal thinking. The biological features include problems in sleep, eating, energy and concentration.

How common is it?

5% of teens have "major depression" at any given time and about 4% have "minor depression". By the end of the teen years, about 1 in 5 teens will have an episode of major depression. In other words, you are guaranteed to have several teens in your various classes who are clinically depressed at any given time. A depressive episode, even with the best treatment response, usually lasts at least three months, and much longer in many cases. This means, at minimum, one school term will be significantly affected.

What effect does depression have on school work?

Depressed teens will have more trouble concentrating, have poor motivation, are easily discouraged, are irritable, and will often be tired in class. Depressed teens have sleep problems and frequently miss first block in the morning. Their grades drop dramatically. They may not participate much during class.

Despite these difficulties, depressed teens are usually advised by their doctor to attend school anyway. Why? It gives the day structure, it prevents "school phobia", and it keeps them socially connected. It also keeps them moving along academically to some degree, so that catch-up is easier later.

How can you help?

1. **Check with the counsellor**: If you have concerns that a teen in your class may be depressed, talk to the student's counsellor. The counsellor will often be aware of what is happening and can give you some guidance as to how serious the problem is and how much the course material may need to be modified. If the counsellor was not aware of the situation, your inquiry could lead to help being offered.

2. **Check in with the teen**: How are they managing, is there anything they don't understand, do they need extra help? If it seems they are overwhelmed, arrange to discuss jointly with the counsellor some ways to reduce expectations for a defined time period. Do not excuse them from class, however! Regular attendance is a lifeline.

3. **Communicate with parents**: You may need to be in touch with the parents, but in a positive, problem-solving way. Perhaps they can help by getting a tutor, or keeping the teen on track with assignments.

4. **Adjusting work expectations**: Short answer, multiple choice and match type testing is easier for depressed teens. Producing essays and answers which require a lot of effort and thinking may be overwhelming. They may need help breaking larger tasks such as projects into individual steps. You could help by encouraging the teen to make intermediate deadlines, checking how they are coming along, and providing encouragement to keep it up.

5. **Subject failures**: It is not uncommon for even a good student to fail a term when they are depressed. Sometimes, a doctor's letter will suggest that material be "omitted" for part of a term, or that the course-load be reduced. Often, a subject, especially math or science, needs to be repeated in summer school or the next year as core material has been missed. Please be understanding and encouraging in this situation, as students can feel very ashamed and worried about their academic future. They may feel they have let you down, too.

LETTER REQUESTING PSYCHOEDUCATIONAL TESTING

Date: _____

Dear: _____

Re: Patient name _____;

Request for psycho-educational testing

With the permission of _____, parent and/or guardian of child _____, I am writing to request psycho-educational testing regarding the possibility of a learning problem concurrent with the diagnosis of _____.

I would be pleased to discuss this matter more fully with the appropriate school representative and with the individual who will do the assessment. I can be reached at: _____ (telephone or by email address).

I look forward to hearing from you soon.

Sincerely,

Physician

Cc: Youth
Parent/guardian

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Supporting Students at School

Introduction

General Practitioners may have children and youth in their practice whose mental health conditions impact on their ability to attend school or engage successfully in the learning process. Additionally, some of these youth may have missed out on significant learning before receiving intervention. Schools may be able to make accommodations in order to support the learning of patients having difficulty meeting educational requirements due to mental heath conditions.

GP Recommendations to Schools

Provision of educational services is under the mandate of the Ministry of Education and is guided by the School Act. The type of educational programming a student receives is usually determined at the school level, but in more complex cases district level staff may also be involved. Information from families and community professionals can be very helpful when teachers are planning strategies to meet a student's educational needs. Typically, the student's school counsellor gathers information from community professionals, and then works with school staff in determining appropriate accommodations and strategies. This may be done through conversations with teachers, school-based team, or as part of the development of a student's Individualized Education Plan (IEP). Ideally, a GP will have an opportunity to speak in person with a patient's school counsellor if there are important considerations which should be taken into account.

Examples of the type of information which can assist schools with planning include:

- Descriptions which enhance current understanding of the patient (e.g. the student may experience periods of fatigue, be more emotionally fragile).
- General suggestions about what may benefit a patient, such as reduction in attendance/courses, opportunities to interact with other students, exploration of student's learning profile (school staff will use this information to determine specific strategies in conjunction with other knowledge of the student).
- Any medical alerts or health information the school should be aware of (e.g. how the condition or medication may alter student presentation, side effects/symptoms for which the school should seek medical attention).
- Anticipated changes in how the patient may present over time.

Example Recommendations

- Student is easily fatigued and is experiencing difficulty completing all his school work, I recommend decreasing the number of classes.
- Student is experiencing difficulty with sustained attention and would benefit from frequent breaks.
- Student is feeling isolated and would benefit from increased social contact.
- Student becomes anxious easily and would benefit from being prepared for transitions and public speaking.
- Student is experiencing memory and concentration difficulties and would benefit from strategies to support learning.
- Student will be returning to school and needs support with transition back into school.
- Student's anxiety prevents him approaching adults for academic assistance, and would benefit from adults checking understanding.
- Student is emotionally fragile, and experiencing periods of irritability
- Student should not participate in strenuous activities, and immediate medical attention should be sought if student experiences difficulty in breathing or other abnormal physical signs.

Schools will follow any recommendations for reduced attendance or restrictions on participation in physical activities due to health reasons.

Recommendations Less Likely to be Followed

It is important to know that very specific suggestions may not always be acted on when considered in terms of educational implications, other students, and availability of resources. Examples of these include:

- Requests for one-to-one support. (This service is provided for low incidence special needs students through targeted funding which comes to the district).
- Specific classroom or program placements (Decisions about placement are based on many factors including student profile, educational needs, and current availability).
- Requests for a psychoeducational assessment (A comprehensive educational assessment is not done on every student below grade level, or students whose poor performance is due to health or attendance difficulties. School-based team determines which students are assessed).
- Specific adjustments to classroom environments (teachers will consider many factors including other students when determining any adjustments made).
- Requests which cost additional money.
- Suggestions using medical jargon or acronyms not understood by educators.

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Glossary
(Adapted from Ministry of Education Special Education Manual)

Accommodations

Accommodations are changes in student programming and expectations which allow the student to successfully achieve the learning outcomes of the subjects or courses they are enrolled in. These include adaptations, which are teaching and assessment strategies especially designed to accommodate a student's needs so he or she can achieve the learning outcomes and demonstrate mastery of concepts. Essentially, adaptations are "best practice" in teaching.

School Counsellor Role

The aim of a school counselling is to support students, their families and educators. Counselling services facilitate the educational, personal, social, emotional and career development of students in schools and in the community. The school counsellor's role includes:

- personal counselling,
- school and district-based consultation and planning to meet student's educational needs;
- course planning, academic guidance, articulation to Grade 8 and post-secondary, and attendance,
- coordination of school, district, and community services for students,
- and consultation with students, families, and community professionals,
- and participation in school-based team.

LETTER REGARDING SCHOOL SUPPORTS AND ACCOMMODATIONS

Date: _____

Dear: _____

Re: Patient name: _____;

Request for School Support and Accommodation

With the permission of _____ parent/guardian of _____ (patient name), I am writing to discuss possible issues of school support and accommodation arising from my recent assessment and concurrent with the probable diagnosis of_____.

I would be pleased to discuss this matter more fully with the appropriate school representative(s). I can be reached at: _____ (telephone or by email address).

I look forward to hearing from you soon.

Sincerely;

(Physician)

Cc: Parent/guardian

PSP
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Support Plan

Date (mm/dd/yy): _____

From (Referral Agency):

Name of Physician/Clinician/Psychiatrist (Agency): _____

Phone: _____ Fax:_____

To:

☐ School Counsellor: _____ School: _____

Fax: _____

(This document will be stored in the school's permanent student record)

☐ Other (e.g. family physician):

Name/Agency: _____ Fax: _____

Name/Agency: _____ Fax: _____

Re: Student's Name: _____

(first) *(last)*

Student's Birthdate: _____

(mm/dd/yy)

Consent provided by: _____

Student has been seen by referral agency ☐ Yes ☐ No, missed appointment ☐ On waitlist

Assessment has been completed (optional) ☐ Yes ☐ No

Referral agency will continue to see student (optional) ☐ Yes ☐ No

Additional referrals to (optional): _____

Recommendations for student school accommodations (optional):_____

Please call referral agency to discuss: ☐ School Counsellor ☐ Referring Physician

(Optional) ☐ Other _____

CADDRA
CANADIAN ADHD RESOURCE ALLIANCE

Patient Name:	
Date of Birth:	MRN/File No:
Physician Name:	Date:

CADDRA Teacher Assessment Form

Adapted from Dr Rosemary Tannock's Teacher Telephone Interview.
Reprinted for clinical use only with permission from the BC Provincial ADHD Program.

Student's Name:	Age:	Sex:
School:	Grade:	

Educator completing this form: _____ Date completed: _____

How long have you known the student? _____ Time spent each day with student: _____

Student's Placement: _____ Special Ed: ☐ Yes ☐ No Hrs per week: _____

Student's Educational Designation: _____ ☐ None

Does this student have an educational plan?: ☐ Yes ☐ No

ACADEMIC PERFORMANCE	Well Below Grade Level	Somewhat Below Grade Level	At Grade Level	Somewhat Above Grade Level	Well Above Grade Level	n/a
READING						
a) Decoding						
b) Comprehension						
c) Fluency						
WRITING						
d) Handwriting						
e) Spelling						
f) Written syntax (sentence level)						
g) Written composition (text level)						
MATHEMATICS						
h) Computation (accuracy)						
i) Computation (fluency)						
j) Applied mathematical reasoning						
CLASSROOM PERFORMANCE	Well Below Average	Below Average	Average	Above Average	Well Above Average	n/a
Following directions/instructions						
Organizational skills						
Assignment completion						
Peer relationships						
Classroom Behaviour						

CADDRA Teacher Assessment Form

Strengths: What are this student's strengths? _____
_____
_____
_____

Education plan: If this student has an education plan, what are the recommendations? Do they work? _____
_____
_____
_____

Accommodations: What accommodations are in place? Are they effective? _____
_____
_____
_____

Class Instructions: How well does this student handle large-group instruction? Does s/he follow instructions well? Can s/he wait for a turn to respond? Would s/he stand out from same-sex peers? In what way? _____
_____
_____
_____

Individual seat work: How well does this student self-regulate attention and behaviour during assignments to be completed as individual seat work? Is the work generally completed? Would s/he stand out from same-sex peers? In what way? _____
_____
_____
_____

Transitions: How does this student handle transitions such as going in and out for recess, changing classes or changing activities? Doe s/he follow routines well? What amount of supervision or reminders does s/he need? _____
_____
_____
_____

Impact on peer relations: How does this student get along with others? Does this student have friends that seek him/her out? Does s/he initiate play successfully? _____
_____
_____
_____

Conflict and Aggression: – Is s/he often in conflict with adults or peers? How does s/he resolve arguments? Is the student verbally or physically aggressive? Is s/he the target of verbal or physical aggression by peers? _____
_____
_____
_____

Academic Abilities: We would like to know about this student's general abilities and academic skills. Does this student appear to learn at a similar rate to others? Does this student appear to have specific weaknesses in learning?
_____
_____
_____

Self-help skills, independence, problem solving, activities of daily living: _____
_____
_____
_____

Next

Motor Skills (gross/fine): Does this student have problems with gym, sports, writing? If so, please describe.

Written output: Does this student have problems putting ideas down in writing? If so, please describe.

Primary Areas of concern: What are your major areas of concern/worry for this student? How long has this/these been a concern for you?

Impact on student: To what extent are these difficulties for the student upsetting or distressing to the student him/herself, to you and/or the other students?

Impact on the class: Does this student make it difficult for you to teach the class?

Medications: If this student is on medication, is there anything you would like to highlight about the differences when s/he is on medication compared to off?

Parent involvement: What has been the involvement of the parent(s)?

Are the problems with attention and/or hyperactivity interfering with the student's learning? Peer relationships?

Has the student had any particular problems with homework or handing in assignments?

Is there anything else you would like us to know? If you feel the need to contact the student's clinician during this assessment please feel free to do so.

Return to p 1

Parent & Family Tools

Parenting Overview

Self Care Success

Getting Up In the Morning

Home Management Of Separation

How You Can Help With Sleep Problems

Support Plan

A GPSC Initiative

Child and Youth Mental Health
PSP Module

Parenting Overview

Love and Affection	• Spending quality time with the child individually; demonstrating physical affection; words and actions convey support and acceptance
Stress Management	• Parents learn how to manage their own stress and try not to let their stress drive relationships with their children
Strong Relationships	• Demonstrate positive relationships with a spouse or partner and with friends Good modeling with individuals not related is especially relevant in that it can encourage a heavily stigmatized child/youth to reach out to others and establish their own health/balanced social network in preparation for adulthood
Autonomy/ Independence	• Treat child with respect and provide environment to promote self-sufficiency
Education/ Learning	• Promote and model lifelong learning and encourage good educational attainment for the child
Life Management	• Provide for the needs of the child and plan for the future. Teach comprehensive life skills, especially for youth; avoid enabling and instead focus on youth's strengths, gradually targeting what could be improved upon in terms of personal hygiene, interpersonal skills, cooking, cleaning, organization and goal setting
Behaviour Management	• Promote positive reinforcement and punish only when other methods have failed and then consistent with the severity of the negative behavior and not in a harsh manner
Self Health	• Model a healthy lifestyle and good habits
Spirituality	• Provide an appropriate environment in which spiritual or religious components can be addressed
Safety	• Provide an environment in which your child is safe, monitor your child's activities; friends; health

**Modified from Epstein, R. What Makes a Good Parent? Scientific American Mind. November/December. 2010: 46 – 49.*

SELF-CARE SUCCESS!

Things you can do to help yourself.

Name:_____ Date: _____

Instructions: When people are depressed they often forget to take care of themselves. By setting self-care goals you can take an active role in helping yourself feel better more quickly. Choose one or two of the areas below and set a goal. Make sure the goal is clear and reasonable. In the space below the boxes rate how likely you are to follow through on the goal(s) you set. If you are not very sure you can follow through on your goal you may want to find alternatives or make some adjustments.

Stay Physically Active

Each week during the next month I will spend at least ____ days doing the following physical activity for _____ minutes.

_____

_____

(Pick a specific date and time and make it reasonable!)

Schedule Pleasant Activities

Even though I may not feel motivated I will commit to scheduling ___fun activities each week for the next month. They are_____

_____

_____

(Specify when and with whom.)

Eat Balanced Meals

Even if I don't feel like it, I will eat ____ balanced meals per day to include

_____

_____

_____

_____

(Choose healthy foods.)

Spend Time With People Who Can Support You

During the next month I will spend at least ___ days for at least __ minutes at a time with:

_____ doing:_____

_____ doing_____

_____ doing:_____

(Who?) (What?)

(e.g. talking, eating, playing)

Spend Time Relaxing

Each week I will spend at least ____ days relaxing for ___ minutes by participating in the following activities: _____

_____

_____

(e.g. reading, writing in a journal, deep breathing, muscle relaxation)

Small Goals & Simple Steps

The problem is:_____

_____

My goal is:_____

_____

Step 1:_____

_____

Step 2:_____

_____

Step 3:_____

How likely are you to follow through with these activities prior to your next visit?

Not Likely 1 2 3 4 5 6 7 8 9 10 Very Likely

What might get in the way of your completing these activities prior to your next visit?

_____

Solution(s) to the above barriers

_____

_____

_____

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Have Trouble Getting Up in the Morning?

Trouble getting up for school is a common problem in teens. There are several common causes, and some less common reasons. A very common cause of sleep problems at any age is not having good sleep habits or "sleep hygiene". There are good ways to prevent this difficulty. Here are some ideas and tips to consider:

The most common causes of trouble getting up in time for school:

1. **Not enough sleep**: Teens actually need at least 9-10 hours of sleep, but studies show they usually get less than 7 hours on average, just because of their busy lives. Some individuals have higher or lower sleep needs.

   Some solutions:
   a) Realistically review your schedule: is there too much on your plate & what can be done to streamline your obligations? What time would you realistically need to get ready for bed to get enough sleep & still get up in time?
   b) Start homework earlier so you aren't up late finishing assignments
   c) "Unplug" from telephone, ICQ, video games etc. at least an hour before sleep time, to give yourself a chance to unwind and prepare for sleep. Usually this means by 10 pm at the latest.

2. **Sleep phase delay**: Teens are prone to the problem of staying up later and later, sleeping in later and later. Their getting up time gets progressively later each day, once this problem gets started. Eventually your sleep can be completely reversed, so you are up at night and asleep during the day.

   Some solutions:
   a) All the ideas above will help avoid overstimulation later at night.
   b) The getting up time actually sets the biological clock, so you should be sure not to sleep in on weekends to "catch up". It is better to be a bit sleep-deprived on the weekend so you are more likely to fall asleep at the right time on Sunday night.

3. **Trouble falling asleep**: This can be due to stressful events in your life, sleep phase delay, or other factors such as lack of exercise, oversleeping on the weekend, or caffeine-containing drinks such as coffee, tea, soft drinks.

   Some solutions: Have a warm bath, and soothe yourself with chamomile tea or warm milk to develop a calming ritual which helps you get ready for sleep. Tending to worry at bedtime can contribute, so try some distractions like mental thought-stopping, relaxation exercises, quiet music or reading a bit before sleep to take your mind off things. You can't "will" yourself to sleep, but you can learn ways to allow your natural sleep process to kick into action.

Other causes of trouble getting up in the morning:

1. **Depression:** This can cause either excessive sleeping, or trouble falling asleep and frequent waking during the night. Seasonal depression can cause extreme problems with oversleeping in the wintertime.

2. **Anxiety Disorders**: Social anxiety, panic anxiety, and generalized anxiety can cause insomnia and fatigue, and also make facing the school day more challenging.

   Solutions: If either anxiety or depression could be a concern, review the situation with your family doctor or with the school counselling and medical staff to find out more about resources to help. Medications used to treat anxiety and depression also tend to improve sleep. For seasonal depression, bright light therapy may help.

3. **Specific Sleep Disorders:** Less common disorders like breathing problems during sleep require a medical diagnosis

4. **Medical causes of fatigue**: Iron deficiency, thyroid problems, and viral infections such as infectious mononucleosis are common examples.

   Solutions: A check-up with your family doctor is a good place to rule out sleep disorders or other medical conditions.

5. **Stress-induced:** Sleep difficulties are common symptoms of stress due to learning or peer problems at school, or problems at home. Sometimes, it's simply hard to face the day because of the stresses it brings. Your natural instinct, often not even conscious, is to shut down and stay in bed.

   Solutions: Start by communicating with parents and teachers about what is stressful for you. Use the supportive adults in your life to work out a plan of action to tackle these problems, and figure out what kinds of supports you need to do so.

AnxietyBC

RESOURCES.RESULTS.RELIEF.

Home Management Strategies for Separation Anxiety Disorder

Step 1: Teaching your child about anxiety

No matter what type of anxiety problem your child is struggling with, it is important that he or she understands the **facts about anxiety**.

Fact 1: Anxiety is a normal and adaptive system in the body that tells us when we are in danger.

Fact 2: Anxiety becomes a problem when our body tells us that there is danger when there is no real danger.

As an important first step, help your child to understand that all the worries and physical feelings have a name: **Anxiety.**

To learn how to explain this to your child, see
How to Talk to Your Child about Anxiety.

Step 2: Teaching your child about separation anxiety

- First, tell your child that it is normal to sometimes feel anxious when alone or away from mom or dad.
- Tell your child that you will give him or her some tools to help cope with anxiety and gradually face his or her fears.
- Help your child identify some of the feelings, thoughts, and behaviors related to his or her separation anxiety. Here's an example of a conversation between a parent and child who has difficulty going to school.

Parent: *One of the problems with anxiety is that it feels like a lot of bad stuff happening in your body for no reason. For example, how do you feel in the mornings before school?*

Child: *Um, bad. Really bad. I have stomach aches. My head hurts too. I hate it…"*

Parent*: Yeah, it feels really terrible, doesn't it? Probably the worst part is not understanding why you are feeling all those things and when it will go away.*

Child: *Yeah, it sucks.*

Parent: *Well, remember what we were saying about anxiety? Anxiety feels like a big confusing ball of bad feelings. However, anxiety actually has three different parts. One of the parts is how you feel when you are scared. For example, having a sore stomach or a headache on the morning of a school day. The second part is what you think, or say to yourself, when you are scared. What are some of the things that you are thinking about in the morning when you don't want to go to school?*

Child: *I don't know, I'm just thinking that I don't want to go.*

Parent: *What do you think might happen if you did go to school?*

Child: *Um. Lots of things I guess. I think something bad will happen to you. Sometimes I feel like puking in the mornings, and I don't want to throw up at school because you won't be there to help me.*

Parent: *That sounds like some pretty scary thoughts. I can understand why your "smoke alarm" is going off if you are having those kinds of thoughts. Those thoughts are examples of that second part of anxiety: what you think, or say to yourself. The third part of anxiety is what you do when you are scared.*

Child: *Like what?*

Parent: *For example, like leaving or avoiding a place like school, or staying with someone you feel close to.*

Child: *Like you and dad?*

Parent: *Yes, exactly.*

Child: *When I feel anxiety, I want to stay home with you. It helps it go away.*

Parent: *That's right. So, your action is staying home with me.*

Child: *Yeah, I guess.*

Parent: *So, let's go back to thinking about anxiety as a broken "smoke alarm." Those three parts of anxiety - your body signals, your thoughts, and your actions - are all part of what is making your "smoke alarm" go off when it doesn't really need to. What do you think we should do to fix your "smoke alarm" so that it only goes off when there is a real danger?*

Child*: I don't know. I guess if I want to fix it so that my "smoke alarm" doesn't go off, then I need to fix those three things...*

Parent*: I'm going to help you build yourself a toolbox. In it, you will have tools for each of those three parts: your feelings, your thoughts, and your actions. For example, let's say you didn't think "I might throw up", but instead you thought "I haven't thrown up at school yet and so what if I do? Lots of kids get sick at school, and I could go to the girls' washroom! How do you think you would feel then?*

Child: *Um, less scared I guess.*

Parent: *Do you think if you didn't have scary thoughts about school, or you had more helpful thoughts, you would feel less scared?*

Child: *Maybe.*

Parent: *Remember, all three parts are connected, so changing one part can help change the other two parts. So, if you change how you think, you can change how you feel and what you do.*

Step 3: Encouraging your child to stop seeking reassurance

Children with separation anxiety often seek excessive reassurance from their parents. They ask questions like: *"Are you sure you won't go further than the neighbor's backyard?" and "Are you sure I won't get sick if I go to school?"* They do this to try to be 100% sure everything is all right. Parents often find this quite tiring and frustrating! When your child is excessively and repeatedly asking for reassurance:

- Tell your child that this is just anxiety talking. Your child is always asking for reassurance because the anxiety is bullying him or her around.
- Make a plan with your child about beating back anxiety by not giving reassurance.
- Tell your child that he or she can only ask you something **once.**

Below is a sample script between a mother and child with separation fears:

Child*: Mom, you are going to be home all day today when I am at school, right?*

Mom: *What did I tell you when you asked me five minutes ago?*

Child: *Please tell me again.*

Mom: *I think you already know the answer.*

Next

Child: *Please, I just want to make 100% sure.*

Mom: *Well, if you weren't 100% sure, what would be so bad about that?*

To learn how to explain this to your child, see
How to Address Excessive Reassurance Seeking .

Step 4: Building your Child's Toolbox

The best way to help your child deal with separation anxiety is to give him or her tools that can be used when facing fears. For separation anxiety, tools in the toolbox include:

Tool #1: Learning to Relax.

One tool involves helping your child learn to relax. Two strategies can be particularly helpful:

1. Calm Breathing: This is a strategy that your child can use to calm down quickly. Explain to your child that we tend to breathe faster when we are anxious. This can make us feel dizzy and lightheaded, which can make us even more anxious. Calm breathing involves taking slow, regular breaths through your nose. For more information, see **Teaching Your Child Calm Breathing**.

2. Muscle Relaxation: Another useful strategy is to help your child learn to relax his or her body. This involves having your child tense various muscles and then relax them. Your child can also use "the flop," which involves imagining that he or she is a rag doll and relaxing the whole body at once. For more information, see **How to Do Progressive Muscle Relaxation.**

Children and teens can use the above tools before school, at school, before bed, or wherever they feel anxious. Both should be practiced repeatedly until your child is comfortable doing them alone.

Tool #2: Making Coping Cards

It's not easy to face fears, so it's a good idea to develop "coping cards" that your child can carry with him or her during the day to help manage anxiety. For tips on how to help your child develop and use coping cards, see **Developing and Using Cognitive Coping Cards with Your Child.** Here are some examples of coping statements that your child can use for Separation Anxiety Disorder:

- *"That's just Mr. Worry trying to bully me! I don't need to listen!"*
- *"I'm feeling anxiety right now. I can do some calm breathing to feel better."*
- *"Mom is okay, it is just my anxiety talking."*
- *"I can handle being alone. I've done it before."*
- *"What is the best thing that could end up happening?"*

Tool #3: Facing Fears

The most important step in helping your child or teen manage separation anxiety is to face fears. This includes avoided situations or places. For children with separation anxiety, some typical fear ladders might involve gradually sleeping alone in his or her own room, staying at school for the whole day, or reducing reassurance seeking. Remember, these steps are gradual, and are created together with your child. For more strategies and tips on conducting these exercises, as well as example fear ladders, see **Helping your Child to Face Fears: Exposure.**

For children who have worries about going back to school, see
Coping with Back to School Worries

For children who have trouble sleeping alone, see
What to do When Your Child Insists on Sleeping in Your Bed with You

How to do these exercises:

It is important to prepare your child for the fact that he or she **will** feel anxious while doing these, but **that is good!** In order to fight back anxiety, it is normal to feel a little anxious in the beginning. It is also very important to **praise** ("great job!") and **reward** (e.g. small inexpensive items, extra TV time, making a favorite dinner) your child for any successes, as well as any attempts at trying to face his or her fears. After all, it is hard work to face anxiety!

Tool #4: STOP Plan or Realistic Thinking

Often, children and teens with separation anxiety have worries that are unrealistic or very unlikely, but when they are anxious it is difficult for them to recognize this. For example, your child may worry excessively about mom and dad being in a car accident if they are late coming home. Below is a dialogue between a parent and a teen who is afraid of something bad happening when dad is gone for the evening:

> ***Teen:*** *What if someone breaks into the house tonight when you are out?*
>
> ***Parent:*** *Has that ever happened before?*
>
> ***Teen:*** *Well, not at our house, but it might.*
>
> ***Parent:*** *Remember when we talked about the difference between possibility and probability? So, what is the probability that someone will break into our house tonight?*
>
> ***Teen:*** *I don't know. It feels very probable.*
>
> ***Parent:*** *But didn't you say it has never happened before?*
>
> ***Teen:*** *Yeah...*
>
> ***Parent:*** *So what do you really think about the chances of tonight being the night that someone decides to break into our house?*
>
> ***Teen:*** *Um, not very much I guess.*
>
> ***Parent:*** *That sounds about right!*

One way to help your child examine his or her thoughts and decide whether the worries are unrealistic is to use the STOP Plan. The STOP Plan helps children recognize their anxiety and unhelpful thoughts, and develop new helpful thoughts. For children, see **Healthy Thinking for Young Children.** For teens, help your child challenge his or her unrealistic or anxious thoughts. See **Realistic Thinking for Teens**.

Step 5: Building on Bravery

Your child's progress comes from hard work. If you see that your child is improving, then you both deserve credit! Learning to overcome anxiety is like exercise – your child needs to "keep in shape" and practice his or her skills regularly. Make them a habit. This is true even after your child is feeling better and has reached his or her goals.

Don't be discouraged if your child has lapses and returns to his or her old behaviors every once in a while, especially during stressful times or transitions (for example, going back to school, or moving). This is normal, and just means that one or two tools in the toolbox need to be practiced again. Remember, coping with anxiety is a lifelong process.

Helpful Tip:

Track Progress! Occasionally, remind your child what he or she was not able to do before learning how to cope with anxiety and face fears. It can be very encouraging for your child to see how far he or she has come! Create a chart that records all of your child's successes!

How Can You Help with Sleep Problems

All of us need enough sleep to function well during the day. Having just one night of poor sleep can make it more difficult to pay attention to our school or work, make us sleepy throughout the day, cause us to make poor decisions, and leave us feeling irritable, grouchy, slowed down or restless. When many nights of little sleep add up, getting through the day can become a losing battle!

Sleep problems frequently occur as a part of depression. In fact, sleeping problems, either sleeping too much or having difficulty sleeping enough, are one of the symptoms of major depression. Although some sleep problems may require medication to get better, there are things **YOU** can do to help improve your sleep. By improving your sleep hygiene (your sleep habits), you can get rid of any habits that are making it harder for you to get a good night's rest.

1. Keep a regular sleep schedule. Try to go to bed and wake up at the same time every day. It can take your body several days to weeks to adjust to a new sleep schedule, so staying up late on weekends and sleeping in really leaves your body confused.

2. Watch what you eat and drink near bedtime. Food or drinks with caffeine (e.g. sodas, tea, chocolate) can keep you up. Avoid eating big meals or being hungry before bedtime. Some people find milk or milk drinks (e.g. Ovaltine) to be helpful in falling asleep. Milk contains tryptophan, which causes sleepiness.

3. Eliminate bad habits. Drinking alcohol and smoking cigarettes both prevent you from getting a good night's sleep.

4. Make sure your bedroom is set up for sleep. Try to make sure the temperature of the room is comfortable, there are few noises, and the room is dark.

5. Exercise regularly. Getting vigorous exercise during the afternoon (but 4-6 hours before bedtime) has been found to result in better sleep.

6. Get outside and see the sun. Sunlight helps the body control its biological clock. This clock lets us know when to feel sleepy and when to be alert.

7. Use your bed only for rest or sleep. Don't watch TV or do homework in bed.

8. If you don't fall asleep within 10 or 15 minutes, get out of bed. Do a quiet, dull activity until you are feeling sleepy and try again.

9. Find a relaxing activity to do before bed. A warm bath, quiet music, and/or talking with a friend can all help you make the change from daytime to nighttime. Find what works best for you.

Reviewed 09-30-03

Texas Department of Mental Health and Mental Retardation
PAC-DEP

Return to p 1

PSP
A GPSC Initiative

ADHD

Support Needed

YES → Refer for Psycho or Behavioural Therapy

NO

Psychotherapy
- Psychoeducation Tools
- Non Specific Supports
- CBIS Tools

Consider Medication

YES

Meds as per protocol

Follow-up & Monitoring

- Continue treatment
- Educate re maintenance & relapse
- Set "well checks" every 3-6 mos

Improvement?

Moderate

Meds Tolerated: Increase & Monitor as per protocol

Meds not Tolerated: Maintain dose x 2wk Refer if not improved

Substantial

2nd or further episode

YES

Minimal or None

If used, increase meds gradually Monitor weekly until consult

Tools/Resouces

MH Screening Questions
Risk Identification Tables

Functional
- *TeFA*
- *CFA*

Evaluation Tools:
- *ADHD*
- *Anxiety*
- *Depression*
- *Suicide Risk*
- *Substance Abuse Screen*

Referral Flags

Evaluate need throughout involvement

Emergency: Suicidal intent or plan, acute psychosis

Urgent: Severe symptoms & deterioration in function, suicidal ideation, other major psychiatric conditions

Usual: additional therapy, evaluation, treatment non-responders, other medicatl concerns, med side effects, 2nd or further episode

Resources

DSM-IV TR criteria

DSM-IV-TR. Primary Inattentive type symptoms

A. At least 6 of the 9 symptoms of inattention listed below must have persisted for at least 6 months to a degree that is maladaptive and inconsistent with the patient's developmental level.

a. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
b. Often has difficulty sustaining attention in tasks or play activities
c. Often does not seem to listen when spoken to directly
d. Often does not follow through with instructions and often fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behaviour or failure to understand instructions)
e. Often has difficulty organizing tasks and activities
f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (eg, schoolwork, homework);
g. often loses things necessary for tasks or activities (eg, school assignments, pencils, books, tools, toys)
h. Often is easily distracted by extraneous stimuli (eg, toys, school assignments, pencils, books, tools)
i. Often is forgetful in daily activities

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment are present before age 7 years
C. Symptoms must be present in 2 or more situations (eg, school, work, home).
D. The disturbance causes clinically significant distress or impairment in social, academic, or occupational function.
E. Behaviour does not exclusively occur during the course of pervasive developmental disorder, premenstrual dysphoric disorder, schizophrenia, or other psychotic disorder. No mood disorder, anxiety dissociative disorder, or personality disorder accounts for the behaviour.

DSM-IV-TR. Primary Hyperactivity / Impulsivity type symptoms

A) At least 6 of the 9 symptoms of hyperactivity (symptoms 1-6) and impulsivity (symptoms 7-9) listed below have persisted for at least 6 months to a degree that is maladaptive and inconsistent with the patient's developmental level.

Hyperactivity

a. Often fidgets with hands or feet or squirms in seat
b. Often leaves seat in classroom or in other situations in which remaining seated is expected
c. Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents and adults, may be limited to subjective feelings of restlessness)
d. Often has difficulty quietly playing or engaging in leisure activities
e. Often on the go or often acts as if driven by a motor
f. Often talks excessively

Impulsivity

g. Often blurts out answers before questions have been completed
h. Often has difficulty awaiting turn
i. Often interrupts or intrudes on others (e.g., butts into conversations or games)

B) Some hyperactive-impulsive or inattentive symptoms that caused impairment are present before age 7 years
C) Symptoms must be present in 2 or more situations (e.g., school, work, and home).
D) The disturbance causes clinically significant distress or impairment in social, academic, or occupational function.

Behaviour does not exclusively occur during the course of pervasive developmental disorder, premenstrual dysphoric disorder, schizophrenia, or other psychotic disorder. No mood disorder, anxiety dissociative disorder, or personality disorder accounts for the behaviour

Next

DSM-IV-TR. Primary Hyperactivity / Impulsivity type symptoms

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- Often leaves seat in classroom or in other situations in which remaining seated is expected
- Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents and adults, may be limited to subjective feelings of restlessness)
- Often has difficulty quietly playing or engaging in leisure activities
- Often on the go or often acts as if driven by a motor
- Often talks excessively

Impulsivity

- Often blurts out answers before questions have been completed
- Often has difficulty awaiting turn
- Often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment are present before age 7 years

C. Symptoms must be present in 2 or more situations (eg, school, work, home).

D. The disturbance causes clinically significant distress or impairment in social, academic, or occupational function.

E. Behaviour does not exclusively occur during the course of pervasive developmental disorder, premenstrual dysphoric disorder, schizophrenia, or other psychotic disorder. No mood disorder, anxiety dissociative disorder, or personality disorder accounts for the behaviour.

Next

DSM-IV-TR. Primary Inattentive type symptoms

A. At least 6 of the 9 symptoms of inattention listed below must have persisted for at least 6 months to a degree that is maladaptive and inconsistent with the patient's developmental level.

a. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
b. Often has difficulty sustaining attention in tasks or play activities
c. Often does not seem to listen when spoken to directly
d. Often does not follow through with instructions and often fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
e. Often has difficulty organizing tasks and activities
f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (eg, schoolwork, homework);
g. often loses things necessary for tasks or activities (eg, school assignments, pencils, books, tools, toys)
h. Often is easily distracted by extraneous stimuli (eg, toys, school assignments, pencils, books, tools)
i. Often is forgetful in daily activities

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment are present before age 7 years
C. Symptoms must be present in 2 or more situations (eg, school, work, home).
D. The disturbance causes clinically significant distress or impairment in social, academic, or occupational function.
E. Behaviour does not exclusively occur during the course of pervasive developmental disorder, premenstrual dysphoric disorder, schizophrenia, or other psychotic disorder. No mood disorder, anxiety dissociative disorder, or personality disorder accounts for the behaviour.

DSM-IV-TR. Learning disorders

A learning disorder is defined as difficulty in an academic area (reading, mathematics, or written expression). The child's ability to achieve in the specific academic area is below what is expected for the child's age, educational level, and level of intelligence. The difficulty experienced by the child is severe enough to interfere with academic achievement or age-appropriate normal activities of daily living. Learning disorders are sometimes called learning disabilities, or specific learning disabilities. Most children with learning disorders have normal intelligence. Types of learning disorders include the following:

- reading disorders (sometimes called dyslexia)
- mathematics disorder
- disorder of written expression

DSM-IV-TR. Conduct Disorder

The DSM-IV categorises conduct disorder behaviours into four main groupings: (a) aggressive conduct that causes or threatens physical harm to other people or animals, (b) non- aggressive conduct that causes property loss or damage, (c) deceitfulness or theft, and (d) serious violations of rules. Conduct Disorder consists of a repetitive and persistent pattern of behaviours in which the basic rights of others or major age-appropriate norms or rules of society are violated. Typically there would have been three or more of the following behaviours in the past 12 months, with at least one in the past 6 months:

Aggression to people and animals

- often bullies, threatens, or intimidates others
- often initiates physical fights
- has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
- has been physically cruel to people
- has been physically cruel to animals
- has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
- has forced someone into sexual activity

Destruction of property

- has deliberately engaged in fire setting with the intention of causing serious damage
- has deliberately destroyed others' property (other than by fire setting)

Deceitfulness or theft

- has broken into someone else's house, building, or car
- often lies to obtain goods or favours or to avoid obligations (i.e., "cons" others)
- has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

Serious violations of rules

- often stays out at night despite parental prohibitions, beginning before age 13 years
- has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
- is often truant from school, beginning before age 13 years

ADHD Assessment Tools

SNAP IV
18 Item

SNAP IV
26 Item

CADDRA
ADHD Checklist

SNAP IV-26
Scoring Instructions

CADDRA
Teacher Assessment Tool

CADDRA
ADHD Assessment Form

SNAP – IV Teacher and Parent 18 - item Rating Scale

Name:_____ Sex:_____ Age:_____

Date:_____

Completed by:_____

For each item, select the box that best describes this child. Put only one check per item.		Not at all 0	Just a Little 1	Quite a Bit 2	Very much 3
Inattention					
1	Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities				
2	Often has difficulty sustaining attention in tasks or play activities				
3	Often does not seem to listen when spoken to directly				
4	Often does not follow through on instructions and fails to finish schoolwork, chores, or duties				
5	Often has difficulty organizing tasks and activities				
6	Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework)				
7	Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)				
8	Often is distracted by extraneous stimuli				
9	Often is forgetful in daily activities				
Hyperactivity					
10	Often fidgets with hands or feet or squirms in seat				
11	Often leaves seat in classroom or in other situations in which remaining seated is expected				

Next

		Not at all 0	Just a Little 1	Quite a Bit 2	Very much 3
12	Often runs about or climbs excessively in situations in which it is inappropriate				
13	Often has difficulty playing or engaging in leisure activities quietly				
14	Often is "on the go" or often acts as if "driven by a motor"				
15	Often talks excessively				
Impulsivity					
16	Often blurts out answers before questions have been completed				
17	Often has difficulty awaiting turn				
18	Often interrupts or intrudes on others (e.g., butts into conversations/games)				
		Sum of Items for Each Scale	Average Rating Per Item for Each Scale	Teacher 5% Cut-off	Parent 5% Cut-off
Average score for ADHD-Inattention (sum of items 1-9/ # of items)		0	0.00	2.56	1.78
Average score for ADHD-Hyperactivity-Impulsivity (sum of items 10-18/ # of items)		0	0.00	1.78	1.44
Average score for ADHD-Combined (sum of items 1-18/ # of items)		0	0.00	2.00	1.67

The 4-point response is scored 0-3 (Not at All=0, Just A Little=1, Quite a Bit=2, and Very Much=3). Subscale scores on the SNAP-IV are calculated by summing the scores on the items in the specific subset (e.g., Inattention) and dividing by the number of items in the subset (e.g., 9). The score for any subset is expressed as the Average Rating Per Item. The 5% cutoff scores for teachers and parents are provided. Compare the Average Rating Per Item score to the cut-off score to determine if the score falls within the top 5%. Scores in the top 5% are considered significant.

Inattention average (cut-off > 2.56 teacher, 1.78 parent)	Hyperactivity average (cut-off >1.78 teacher, 1.44 parent)	Oppositional Defiant average (cut-off > xx)
0.00	0.00	0.00

CADDRA
CANADIAN ADHD RESOURCE ALLIANCE

Patient Name:
Date of Birth: MRN/File No:
Physician Name: Date:

SNAP-IV 26 – Teacher and Parent Rating Scale

Name: _____ Gender: _____ Age: _____

Grade: _____ Ethnicity: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic Other: _____

Completed by: _____ Type of Class: _____ Class size: _____

For each item, check the column which best describes this child:	Not At All	Just A Little	Quite A Bit	Very Much
1. Often fails to give close attention to details or makes careless mistakes in schoolwork or tasks				
2. Often has difficulty sustaining attention in tasks or play activities				
3. Often does not seem to listen when spoken to directly				
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties				
5. Often has difficulty organizing tasks and activities				
6. Often avoids, dislikes, or reluctantly engages in tasks requiring sustained mental effort				
7. Often loses things necessary for activities (e.g., toys, school assignments, pencils, or books)				
8. Often is distracted by extraneous stimuli				
9. Often is forgetful in daily activities				
10. Often has difficulty maintaining alertness, orienting to requests, or executing directions				
11. Often fidgets with hands or feet or squirms in seat				
12. Often leaves seat in classroom or in other situations in which remaining seated is expected				
13. Often runs about or climbs excessively in situations in which it is inappropriate				
14. Often has difficulty playing or engaging in leisure activities quietly				
15. Often is “on the go” or often acts as if “driven by a motor”				
16. Often talks excessively				
17. Often blurts out answers before questions have been completed				
18. Often has difficulty awaiting turn				
19. Often loses temper				
20. Often argues with adults				
21. Often actively defies or refuses adult requests or rules				
22. Often deliberately does things that annoy other people				
23. Often blames others for his or her mistakes or misbehavior				
24. Often touchy or easily annoyed by others				
25. Often is angry and resentful				
26. Often is spiteful or vindictive				

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CANADIAN ADHD RESOURCE ALLIANCE

SNAP-IV 26 RATING SCALE: SCORING INSTRUCTIONS

The SNAP-IV is a revision of the Swanson, Nolan and Pelham (SNAP) questionnaire (Swanson et al. 1983). The items from the DSM-IV criteria for Attention Deficit Hyperactivity Disorder (ADHD) are included for the two following subsets of symptoms: inattention (items 1 to 0) and hyperactivity/impulsivity (items 10 to 18). The scale also includes the DMS-IV criteria for Oppositional Defiant Disorder (items 19 to 26) since this is often present in children with ADHD.

The SNAP-IV is based on a 0 to 3 rating scale: Not at all = 0, Just a little = 1, Often = 2, and Very often = 3. Sub scale scores on the SNAP-IV are calculated by summing the scores on the subset and dividing by the number of items in the subset. The score for any subset is expressed as the Average Rating-Per-Item, as shown for ratings on the ADHD-Inattentive (ADHD-I) subset:

	Not at all (0)	Just a little (1)	Often (2)	Very often (3)	Score
1. Makes careless mistakes			*		2
2. Difficulty sustaining attention				*	3
3. Does not listen				*	3
4. Fails to finish work			*		2
5. Disorganized		*			1
6. Can't concentrate				*	3
7. Loses things		*			1
8. Easily distracted				*	3
9. Forgetful	*				0

Total ADHD-Inattention = 18 Average = 18/9 = 2.0

ADHD-Inattention	ADHD-Hyperactivty/Impusivity	Oppositional Defiant Disorder
#1	#10	#19
#2	#11	#20
#3	#12	#21
#4	#13	#22
#5	#14	#23
#6	#15	#24
#7	#16	#25
#8	#17	#26
#9	#18	
Total	**Total**	**Total**
Average	**Average**	**Average**

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CANADIAN ADHD RESOURCE ALLIANCE

ADHD Checklist Instructions

Scoring Instructions

The ADHD Checklist is a list of the nine DSM items of attention and the nine DSM items of hyperactivity/ impulsivity. Attention and impulsive-hyperactive items are grouped together so that the clinician can easily differentiate with a glance which area is primarily impaired. The number of items rated pretty much (2) or very much (3) are an indicatation that these areas are clinically problematic. Add up the numbers of clinically significant items and determine whether the client has met the threshold which is stated in next to the section heading (e.g. Attention > 6/9). If physicians are suspect but are unsure of whether ADHD is a possibility, the Checklist can be completed in the waiting room prior to assessment.

Comparison to Other Scales

The items are also almost identical to those of the SNAP-IV scale, with the exception that the statement "Often ..." and then rating frequency as sometimes, often or very often has been deleted. Items have also been made generic enough to be appropriate to all age groups and so that they can be completed by any informant and for the past or present. The correlation between the DSM-IV checklists is very high (>.8). Therefore, if a clinician wishes to use an alternative checklist, the rating of number of positive items can be entered into the assessment form in the same way, noting the checklist used.

If Only ADHD

The items on the ADHD Checklist are identical with the attention, hyperactive, and oppositional items at the beginning of the Weiss Symptom Record. This is so that the WSR can be given at baseline, but if the primary disorder is ADHD, follow-up assessments can be done by just using the Checklist and allowing for comparison.

The Checklist Used by Other Informants

The Checklist can also be completed to identify ADHD in adults in childhood, or completed by a collateral informant as well as the patient.

Checklist

CADDRA
CANADIAN ADHD RESOURCE ALLIANCE

Instructions

Patient Name:
Date of Birth: MRN/File No:
Physician Name: Date:

Retrospective assessment of childhood symptoms ☐ Current symptoms ☐
Current medication: _____

ADHD CHECKLIST

SYMPTOMS: Check the appropriate box	Not at all (0)	Somewhat (1)	Pretty much (2)	Very much (3)	Diagnoses
ATTENTION 314.00 (≥6/9)	**SEVERITY**				**TOTAL**
Fails to give close attention to details, careless mistakes					
Difficulty sustaining attention in tasks or fun activities					
Does not seem to listen when spoken to directly					
Does not follow through on instructions and fails to finish work					
Difficulting organizing tasks and activities					
Avoids tasks that require sustained mental effort (boring)					
Losing things					
Easily distracted					_/9
Forgetful in daily activities					≥6/9
HYPERACTIVE/IMPULSIVE 314.01 (≥6/9)					
Fidgety or squirms in seat					
Leaves seat when sitting is expected					
Feels restless					
Difficulty in doing fun things quietly					
Always on the go or acts as if "driven by a motor"					
Talks excessively					
Blurts answers before questions have been completed					
Difficulty awaiting turn					≥6/9
Interrupting or intruding on others					_/9
OPPOSITIONAL DEFIANT DISORDER 313.81 (>4/8)					
Loses temper					
Argues with adults					
Actively defies or refuses to comply with requests or rules					
Deliberately annoys people					
Blames others for his or her mistakes or misbehavior					
Touchy or easily annoyed by others					
Angry or resentful					≥4/8
Spiteful or vindictive					_/8
COMMENTS					

CADDRA
CANADIAN ADHD RESOURCE ALLIANCE

Patient Name:	
Date of Birth:	MRN/File No:
Physician Name:	Date:

CADDRA ADHD ASSESSMENT FORM

Identifying Information

Patient:		**Date of Birth:**	**Date seen:**
Age:	**Gender:** ☐ m ☐ f	**Grade** (actual/last completed):	
Current Occupation: ☐ student ☐ unemployed ☐ disability		occupation:	
Status: ☐ child/adolescent *OR* adult ☐ single ☐ married ☐ common-law ☐ separated ☐ divorced			
Ethnic Origin: (*check all that apply*) ☐ Caucasian ☐ Asian ☐ Hispanic ☐ African-American ☐ Native			
Other person providing collateral:		**Patient's phone no:**	

Demographics

	Biological Father (if known)	**Biological Mother** (if known)	**Spouse/Partner** (if applicable)
Name			
Occupation			
Highest education			
Number of biological and/or half siblings:			
	Stepfather (if applicable)	**Stepmother** (if applicable)	**Other Guardian** (if applicable)
Name			
Occupation			
Highest education			
Number of step-siblings:			
Custody (circle custodial parent)	**Time with bio Father**	**Time with bio Mother**	**Time with step family**
Language	**At home:** ☐ English	☐ Other _____	☐ At school _____
Children (if applicable)	**Number of biological:**	**Number of step children:**	
Names and ages			

Next

Reason for Referral

Referred by:		**Phone:**	**Fax:**
Initiated by:	☐ self ☐ parent ☐ spouse ☐ employer ☐ school ☐ physician ☐ other:		
Chief complaint: (check all that apply)	☐ impulsiveness ☐ disorganization ☐ self esteem ☐ aggression	☐ inattention ☐ mood/anxiety ☐ substance use ☐ other	☐ hyperactivity ☐ procrastination ☐ academic problems
Details:			
Attitude to referral:			

ADHD SYMPTOM HISTORY: (onset, progression, worsening factors, protective factors, adaptive strategies, outcome)

Next

CADDRA
CANADIAN ADHD RESOURCE ALLIANCE

Patient Name:
Date of Birth: MRN/File No:
Physician Name: Date:

Medical History

Allergies: ☐ No ☐ Yes (Details):

Cardiovascular medical history:
☐ hypertension ☐ tachycardia ☐ arrhythmia ☐ dyspnoea ☐ fainting ☐ chest pain on exertion ☐ other

Specific cardiovascular risk identified: ☐ No ☐ Yes (Details):

Positive lab or EKG findings:

Positive medical history:	☐ In utero exposure to nicotine, alcohol or drugs	☐ Stigmata of FAS/FAE	☐ History of anoxia/perinatal complications
☐ Developmental delays	☐ Coordination problems	☐ Cerebral palsy	☐ Lead poisoning
☐ Neurofibromatosis	☐ Myotonic dystrophy	☐ Other genetic syndrome	☐ Hearing/visual problems
☐ Thyroid disorder	☐ Diabetes	☐ Growth delay	☐ Anemia
☐ Traumatic brain injury	☐ Seizures	☐ Enuresis	☐ Injuries
☐ Sleep apnea	☐ Tourette's/tics	☐ Enlarged adenoids or tonsils	☐ Asthma
☐ Sleep disorders	☐ Secondary symptoms to medical causes	☐ Medical complications of drug/alcohol use	

Other/details:

Medication History

Extended health insurance: ☐ No ☐ Yes (Details):

☐ Public ☐ Private insurance Coverage for psychological treatment: ☐ No ☐ Yes

Adherence to treatment/attitude towards medication:
Difficulty swallowing pills: ☐ No ☐ Yes
(If applicable) Contraception: ☐ No ☐ Yes (Details):

Current medications	**Dose**	**Duration Rx**	**Outcome and side effects**
Previous medications	**Dose**	**Duration Rx**	**Outcome and side effects**

Next

CADDRA
CANADIAN ADHD RESOURCE ALLIANCE

Patient Name:	
Date of Birth:	MRN/File No:
Physician Name:	Date:

Physical Examination

Practice guidelines around the world recognize the necessity of a physical exam as part of an assessment for ADHD in order to rule out organic causes of ADHD, rule out somatic sequelae of ADHD, and rule out contraindications to medications. While this physical exam follows all the usual procedures, several specific evaluations are required. These include, but are not limited to:

Rule out medical causes of ADHD-like symptoms

1. Hearing and vision assessment
2. Thyroid disease
3. Neurofibromatosis (cafe au lait spots)
4. Any potential cause of anoxia (asthma, CF, cardiovascular disease)
5. Genetic syndromes and facial or dysmorphic characteristics
6. Fetal alcohol syndrome: growth retardation, small head circumference, smaller eye openings, flattened cheekbones and indistinct philtrum (underdeveloped groove between nose and upper lip)
7. Physical abuse: unset fractures, burn marks, unexplained injuries
8. Sleep disorders: enlarged tonsils and adenoids, difficulty breathing, sleep apnea
9. Growth delay or failure to thrive
10. PKU, heart disease, epilepsy and unstable diabetes can all be associated with attention problems
11. Head trauma.

Medical history/lab work provides information on maternal drinking in pregnancy, sleep apnea, failure to thrive, lead poisoning, traumatic brain injury.

Rule out sequelae of ADHD

1. Abuse
2. High pain threshold
3. Irregular sleep, delayed sleep phase, short sleep cycle
4. Comorbid developmental coordination disorder, evidenced by motor difficulties in doing routine tasks such as getting on the exam table
5. Picky eater: will not sit to eat
6. Evidence of injuries from poor coordination or engagement in extreme sports

Rule out contraindications to medication:

1. Glaucoma
2. Uncontrolled hypertension
3. Any evidence of significant cardiovascular abnormality

Date of last physical exam:	**By who:**
Abnormal findings last exam:	

Current Physical Exam

System	Done		Normal		**Findings** (Details of Abnormality)
	No	Yes	No	Yes	
Skin	☐	☐	☐	☐	
ENT	☐	☐	☐	☐	
Respiratory	☐	☐	☐	☐	
GI and GU	☐	☐	☐	☐	
Cerebrovascular	☐	☐	☐	☐	
Musculoskeletal	☐	☐	☐	☐	
Immunol. & Hematological	☐	☐	☐	☐	
Neurological	☐	☐	☐	☐	
Endocrinological	☐	☐	☐	☐	
Dysmorphic facial features	☐	☐	☐	☐	
Other	☐	☐	☐	☐	

Weight: In children: percentile	**Height:** In children: percentile	**Head Circum:** (In children only)	**BP:**	**Pulse:**

Positive Findings on Observation: (Details)

Next

Psychiatric History

Assessed in childhood/adolescence/adulthood? ☐ No ☐ Yes **By whom:**	
Previous diagnoses:	
Previous suicidal attempts or violent gestures toward others: ☐ No ☐ Yes	**Details:**
Psychological treatments: ☐ No ☐ Yes	
Previous psychiatric evaluation/hospitalization: ☐ No ☐ Yes	

Developmental History

Pregnancy Problems: ☐ No ☐ Yes Delivery ☐ on time ☐ Early (# of weeks: _____) ☐ Late (# of weeks: _____) ☐ forceps used ☐ Caesarean section ☐ breech	**Details:**
Difficulties gross motor: crawl, walk, two-wheeler, gym, sports: ☐ No ☐ Yes	
Difficulties Fine motor: tracing, shoe laces, printing, writing: ☐ No ☐ Yes	
Language difficulties: first language, first words, full sentences, stuttering ☐ No ☐ Yes	
Odd behaviours noted: (e.g. rocking, flapping, no eye contact, odd play, head banging etc) ☐ No ☐ Yes	
Temperament: (eg. difficult, willful, hyper, easy, quiet, happy, affectionate, calm, self soothes, intense)	
Parent description of child's temperament:	
Learning Disorder identified: ☐ No ☐ Yes ☐ dyslexia ☐ dysorthographia ☐ dyscalculia ☐ dsyphasia ☐ other: _____	

Family History in First Degree Relatives

Childhood temperament of the biological parents, if known: (e.g. internalizing versus externalizing)
Father: **Mother:**

Positive family history of:

☐ ADHD (probable)	☐ ADHD (confirmed)	☐ Learning Disorders	☐ Mental Retardation
☐ Autism Spectrum Disorders	☐ Congenital Disorders	☐ Anxiety	☐ Depression
☐ Bipolar	☐ Psychosis	☐ Personality Disorders	☐ Suicide
☐ Sleep Disorders	☐ Tourette's/Tics	☐ Epilepsy	☐ Alcohol/Drug Problems
☐ Legal Convictions			
☐ **History of early cardiac death**		☐ Known arrhythmias	☐ Hypertension

Details:

Next

Functioning and Lifestyle Evaluation

General Habits (depending on the subject's age, some may not apply). **Give frequency and/or details:**	
Exercise	
Nutrition	
Self care, personal hygiene	
Adequate leisure activity	
Sleep Routine and Quality of Sleep	Bedtime: Time to fall asleep: Wake up time: # Sleep hours: Melatonin: ☐ No ☐ Yes Dose:
Sleep Problems? (BEARS)	Bedtime resistance: ☐ No ☐ Yes Regularity: ☐ No ☐ Yes Excessive daytime sleepiness: ☐ No ☐ Yes Snoring: ☐ No ☐ Yes Awakening: ☐ No ☐ Yes

Important Risk Factors to Identify

Identified Risk Factor	No	Yes	Details and Attitude towards Change
Excessive time on computer, TV, video games	☐	☐	
Repetitive accidents or injuries	☐	☐	
Extreme sports (e.g. motorcycle, snowboarding, skateboarding, racing)	☐	☐	
Energy drinks, caffeine	☐	☐	
Nicotine (e.g. including cigarettes, cigars, chewing tobacco)	☐	☐	
Alcohol (e.g. binge drinking, blackouts, seizures, DUI, complaints)	☐	☐	
Drug use/abuse (e.g. cannabis, acid, mushrooms, cocaine, stimulants, heroin, abuse of prescription drugs)	☐	☐	
Financial impulse (e.g. gambling, shopping, stock trading, real estate failure)	☐	☐	
Financial risk (e.g. bankruptcy, poor money management, significant debt)	☐	☐	
Driving problems (e.g. speeding, lost license, accidents, violations)	☐	☐	
Relationship risks (e.g. lack of commitment, infidelity, unprotected sex)	☐	☐	
Parenting problems (e.g. Children's Aid, inconsistent parenting, overwhelmed)	☐	☐	
Disciplinary or legal action(s)	☐	☐	

Next

Current Functioning at Home (depending on age, some may not apply). **Give frequency and/or details:**	
Family/patient strengths	
Stressors within the family	**Past:**
	Present:
Family atmosphere	
Morning routine	
Attitudes towards chores (adult: doing housework)	
Attitudes towards rules (adult: able to set/follow rules)	
Engagement in family fun	
Discipline in the family (adult: parenting abilities)	
Relationship to siblings (adult: partner relationship)	
Parent/spouse frustrations	

Social Functioning (depending on age, some may not apply). **Give frequency and/or details:**	
Patient's strengths:	
Hobbies, activities	
Friends (e.g. play dates, parties, social events)	
Social skills (e.g. social cues compassion, empathy)	
Humour	
Anger management (e.g. aggression, bullying)	
Emotional intelligence (e.g. emotional control, awareness)	
Sexual identity	

Next

Functioning at School (if not at school, indicate where academic history took place and if there were difficulties)		
School name	☐ English Second Language ☐ Individual Education Plan ☐ Specialized Class ☐ Specialized Designation **Details:**	
	Kindergarten to Grade 8	**High School**
Report card grades		
Report card comments		
Behaviour problems		
Peer relations		
Teacher-child relationships		
Teacher-parent relationships		
Homework attitudes		
Organizational skills		
Achieving potential/difficulties		
Written output		
Accommodations		
Tutoring and/or Learning assistance		
Assistive Technology		
College/University		
Accommodations		
Achieving potential/ difficulties		

Functioning at Work (depending on the subject's age, some may not apply) **Frequency and/or details:**	
Current employment status:	☐ FT ☐ PT ☐ Unemployed ☐ Self-employed ☐ Contract ☐ Disability
Vocational Assessment:	☐ No ☐ Yes If yes, suitable jobs:
# of past jobs:	**Length of longest employment:**
Work strengths:	
Work weaknesses:	
Complaints:	
Workplace accommodations:	
Other information about work:	

Next

RATING SCALES: *Administer one or more of the relevant rating scales to the parent, teacher or patient*

STEP ONE: Check the ADHD scale(s) used

ADHD symptoms in childhood:	☐ ADHD Checklist	☐ SNAP-IV	☐ Other
Current ADHD symptoms:	☐ ADHD Checklist ☐ SNAP- IV (for children)	☐ Weiss Symptom Record (WSR) ☐ ASRS (for adults)	☐ Other

The ADHD Checklist can retrospectively be used to assess childhood ADHD symptoms (in adults), for current symptoms and for follow-up (all ages)

STEP TWO: Fill in the result of the scale

SYMPTOM SCREENER (enter the number of positive items for each category, circle the box if the threshold was met or if ODD or CD is a concern)									
Retrospective Childhood symptom screen	IA	/9	HI	/9	ODD	/8	CD*	/15	
Current									
Parent	IA	/9	HI	/9	ODD	/8	CD*	/15	
Self	IA	/9	HI	/9	ODD	/8	CD*	/15	
Teacher	IA	/9	HI	/9	ODD	/8	CD*	/15	
Collateral	IA	/9	HI	/9	ODD	/8	CD*	/15	
Other comorbid dx*									

* Conduct disorder and other comorbid disorder only applies to the WSR

FOR ADULTS: The Adult ADHD Self Report Rating Scale (ASRS) can be used for current ADHD symptoms, part A being the screener section

ADULT ADHD SELF REPORT RATING SCALE (ASRS) (record the number of positive items for Part A and Part B, circle the box where threshold is made)			
Part A (Threshold > 4)	/6	Part B	/12

STEP THREE: Administer the Weiss Functional Inventory Rating Scale (WFIRS)

WEISS FUNCTIONAL INVENTORY RATING SCALE (WFIRS)
(record the number of items rated 2 or 3, circle the boxes where you perceive a problem)

Parent	Family	/10	School	/4	(learning)	/6 (behaviour)	Life Skills	/10	Self	/3	Social	/7	Risk /10
Self	Family	/8	Work	/11	School	/10	Life Skills	/12	Self	/5	Social	/9	Risk /14

OTHER SCALES

Psychometric Evaluation – Done? ☐ No ☐ Yes ☐ Requested **Date(s) of Testing:**					
Intelligence Tests Score: ☐ marked below ☐ above average ☐ borderline ☐ marked above ☐ low average ☐ superior ☐ average					
WISC or WAIS (%ile or scaled score)	**Verbal Comprehension**	**Perceptual Reasoning**	**Working Memory**	**Processing Speed**	**Older IQ tests used %ile/IQ** Full Scale IQ Verbal IQ Performance IQ
Achievement tests Score: -2 (>2 yrs below) -1 (1-2 yrs below) 0 (grade level) +1 (1-2 yrs above) +2 (>2 yrs above)					
Grade level:	Reading	Spelling	Math	Writing	

Next

MENTAL STATUS EXAMINATION (clinical observations of the interview)

SUMMARY OF FINDINGS

(This allows a clinician reflect on the global collection of information in readiness for the diagnosis, feedback and treatment)

Item of Relevance	N/A	Does not indicate ADHD	Marginally indicates ADHD	Strongly indicates ADHD	Comments
Symptoms of ADHD in childhood	☐	☐	☐	☐	
Current ADHD symptoms	☐	☐	☐	☐	
Collateral information	☐	☐	☐	☐	
Clinical observation	☐	☐	☐	☐	
Family history of diagnosed first degree relatives	☐	☐	☐	☐	
Review of school report cards	☐	☐	☐	☐	
Previous psychiatric assessments	☐	☐	☐	☐	
Psychometric/psychological assessments	☐	☐	☐	☐	
	N/A	**Suggesting an alternative explanation is better**	**ADHD is possible but other factors relevant**	**ADHD is still the best explanation of findings**	**Comments**
In utero exposure to substances	☐	☐	☐	☐	
Neonatal insult	☐	☐	☐	☐	
Infant temperament	☐	☐	☐	☐	
Developmental milestones	☐	☐	☐	☐	
Psychosocial stressors before 12					
Accidents and injuries (particularly head injury)	☐	☐	☐	☐	
Major trauma before age 12 (e.g. abuse-physical, sexual, neglect)	☐	☐	☐	☐	
Substance use history	☐	☐	☐	☐	
Other psychiatric problems	☐	☐	☐	☐	
Other medical problems	☐	☐	☐	☐	

_____

_____

_____

_____

_____

Next

DIAGNOSIS

Note: This table helps the clinician understand how the DSM-IV-TR records axial information

Axis I: Actual diagnosis and any learning disabilities
Axis II: Mental retardation, developmental delay and any personality disorders (traits if sub-threshold for an actual disorder)
Axis III: Any medical disorders or any past medical disorders that might be important to note
Axis IV: Severity of psychosocial stressors: Name the stressors and indicate their severity from Mild, Moderate, Severe
Axis V: Global Assessment of Functioning: This is a number given (from the table below) that helps to monitor functioning over time. This is a quick way of being able to record clinical progress.

Axis V	CGAS Anchor Points	Score
91-100	Superior functioning in all aspects of life; active, likeable, confident	
90-81	Good functioning in school, home, peers, transient everyday worries have mild reaction	
80-71	Slight impairment in school, home or peers, transient behaviour and emotional reaction	
70-61	Difficulty in an area of life but functioning well (mood change, sporadic anti-social act)	
60-51	Variable functioning and sporadic difficulties in several areas of life, apparent to others	
50-41	Moderate interference in functioning or severe impairment in school, home or peers	
40-31	Major impairment; unable to function in one area (suicide attempt, persistent aggression, marked withdrawal and isolation, severe mood or thought disturbance)	
30-21	Unable to function in life, severe impairment in communication and reality testing	
20-11	Needs supervision to be safe and for self-care, gross impairment in communication	
10-0	Needs 24 hour supervision for severe aggressive, self-destructive behaviour, affect, thought, reality testing, communication impairment.	

Diagnosis following DSM:
Axis I: DSM Diagnoses
Axis II: Personality/Developmental delay
Axis III: Medical conditions
Axis IV: Stressors (mild, moderate, severe)
Axis V: Global Assessment of Functioning

Important Lifestyle Issues:

Next

Treatment Plan

Patient Name: _____ **MRN/File No.:** _____

	N/A	To Do	Done	Referred to and comments/Details
Psychoeducation				
Patient Education	☐	☐	☐	
Parent Education	☐	☐	☐	
Info to School	☐	☐	☐	
Handouts	☐	☐	☐	
Medical				
Physical Exam	☐	☐	☐	
CV Exam	☐	☐	☐	
Baseline Ratings	☐	☐	☐	
Lab Investigation	☐	☐	☐	
Other	☐	☐	☐	
Pharmacological Interventions				
Review Medication Options	☐	☐	☐	
Medication Treatment	☐	☐	☐	
Non Pharmacological Interventions				
Psychological Testing	☐	☐	☐	
Social Skills Management	☐	☐	☐	
Anger Management	☐	☐	☐	
Addiction Management	☐	☐	☐	
Therapy	☐	☐	☐	
Cognitive Behaviour Therapy	☐	☐	☐	
Parent Training	☐	☐	☐	
OT Referral	☐	☐	☐	
Speech Therapy	☐	☐	☐	
Educational & Vocational				
Psychoeducational Assessment	☐	☐	☐	
Special Education/Accommodations	☐	☐	☐	
Vocational Assessments	☐	☐	☐	
Workplace Accomodations	☐	☐	☐	
Completion of Special Forms				
CRA Tax Credits	☐	☐	☐	
Insurance	☐	☐	☐	
Other	☐	☐	☐	

Physician Signature: _____ **Date:** _____

Copy sent to: _____ **Fax No:** _____

_____

PSP Child and Youth Mental Health – Initiating and Monitoring Dextroamphetamine treatment for Children/ Youth

ADHD Diagnosis (DSM-IV-TR criteria)

- Children (6-12)
- Adolescent (>12)

Use PST and WRP throughout the treatment process.

Use SNAP-IV every week for dose titration

Initiate PST for at least 3 visits. SNAP-IV (18 items)> 18, symptoms continue causing distress and CFA/TeFA or WFIRS-P/WFIRS-S shows decrease or no change in function.
Time to start medication!

Measure functioning using CFA/TeFA or WFIRS-P/WFIRS- and side effects using KESA at every visit.

Begin at 2.5mg – 5mg of dextroamphetamine in the morning and 2.5mg – 5mg at noon for 1 week.

If insufficient effect, tolerable and no significant side effects increase to 5mg – 10mg in the morning and 2.5mg – 5mg at noon for 1 week.

If insufficient effect, tolerable and no significant side effects increase to 5mg – 10mg in the morning and 5mg – 10mg at noon for 1 week.

If insufficient effect, tolerable and no significant side effects, increase **to** 5mg – 10mg in the morning, 5mg – 10mg at noon and 2.5mg – 5mg at 4pm for 1 week.
If substantial side effects occur continue the dose and increase the time between dosages

If symptoms have not improved after the initial 4 weeks of treatment, titrate by 2.5mg – 5mg/dose weekly, to a maximum total daily dose of 20mg - 40 mg/day.

If you have reached the maximum doses and symptoms continue to cause distress and dysfunction, change to methylpneidate (i.e. Ritaline – if not tried yet) or consider referral to a mental health specialist or paediatrician.

If symptoms have substantially improved, switch to a long-acting dextroamphetamine (i.e spansule) or dextro -amphetamine based products long-acting medication (i.e. Aderall XR).

*Doses suggested by Dr. Margaret Weiss

BC Pharmacare requires patients to start on short-acting ADHD medications for the special authority request exemption. CADDRA recommends initiating on long-acting for patients that are insured.

Next

PSP Child and Youth Mental Health – Initiating and Monitoring Methylphenidate treatment for Children/ Youth

ADHD Diagnosis (DSM-IV-TR criteria)

- Children (6-12)
- Adolescent (>12)

Use PST and WRP throughout the treatment process.

Use SNAP-IV every week for dose titration

Initiate PST for at least 3 visits.
SNAP-IV (18 items)> 18, symptoms continue causing distress and CFA/TeFA or WFIRS-P/WFIRS-S shows decrease or no change in function.
Time to start medication!

Measure functioning using CFA/TeFA or WFIRS-P/WFIRS- and side effects using KESA at every visit.

Begin at 2.5mg – 5mg of methylphenidate in the morning and 2.5mg – 5mg at noon for 1 week.

If insufficient effect, tolerable and no significant side effects increase to 5mg – 10mg in the morning and 2.5mg – 5mg at noon for 1 week.

If insufficient effect, tolerable and no significant side effects increase to 5mg – 10mg in the morning and 5mg – 10mg at noon for 1 week.

If insufficient effect, tolerable and no significant side effects, increase to 5mg – 10mg in the morning, 5mg – 10mg at noon and 2.5mg – 5mg at 4pm for 1 week.
If substantial side effects occur continue the dose and increase the time between dosages

If symptoms have not improved after the initial 4 weeks of treatment, titrate by 2.5mg – 5mg/dose weekly, to a maximum of 2mg/kg total daily dose, not to exceed 60 mg/day.

If symptoms have substantially improved, switch to a long acting methylphenidate (i.e. Concerta, PMS)

If you have reached the maximum doses and symptoms continue to cause distress and dysfunction, change to dextromphetamine (i.e. Dexedrine) or consider referral to a mental health specialist or paediatrician.

*Doses suggested by Dr. Margaret Weiss

BC Pharmacare requires patients to start on short-acting ADHD medications for the special authority request exemption. CADDRA recommends initiating on long-acting for patients that are insured.

Next

A GPSC Initiative

Child and Youth Mental Health
PSP Module

Kutcher Side Effect Scale for ADHD Medication (KSES-A)

KUTCHER SIDE EFFECTS SCALE FOR ADHD MEDICATIONS

Name: Age:

Date:

Medication: Dose:

Circle the number which best describes how the patient has experienced each of the following possible side effects over the past week.

Subjective side effects	Never	Somewhat			Constantly
Anorexia	0	1	2	3	4
Weight loss	0	1	2	3	4
Abdominal pain	0	1	2	3	4
Dry mouth	0	1	2	3	4
Nausea	0	1	2	3	4
Vomiting	0	1	2	3	4
Fearful	0	1	2	3	4
Emotional lability	0	1	2	3	4
Irritable	0	1	2	3	4
Sadness	0	1	2	3	4
Restlessness	0	1	2	3	4
Headaches	0	1	2	3	4
Trouble sleeping	0	1	2	3	4
Drowsiness	0	1	2	3	4
Suicidal ideation	0	1	2	3	4
Rash	0	1	2	3	4
Acne	0	1	2	3	4
Dyskinesia	0	1	2	3	4
Tics	0	1	2	3	4
Other movements	0	1	2	3	4
Other:	0	1	2	3	4

Objective side effects (to be determined from the appropriate clinical examination)

Collaborative Prescribing Agreement

Long-Acting Methylphenidate for Pediatric Attention-Deficit Hyperactivity Disorder

This COLLABORATIVE PRESCRIBING AGREEMENT (the "Agreement") is entered into by the Pharmaceutical Services Division (PSD), Ministry of Health Services, B.C., and the undersigned physician.

To obtain a Physician Exemption from completing Special Authority requests for

long-acting methylphenidate (Concerta®), I, _____,
(Name of physician – please print)

agree to prescribe according to the following Limited Coverage criteria:

For patients 6 to 18 years of age diagnosed with Attention-Deficit Hyperactivity Disorder (ADHD) who require 12 hours of continuous coverage for significant and problematic disruptive behaviour or problems with inattention that interfere with learning **AND** have been previously tried on one of the following with unsatisfactory results*: immediate- or sustained-release methylphenidate **OR** immediate- or sustained-release dextroamphetamine.

**Notes: 1.Unsatisfactory results are defined as continuing symptoms of ADHD or functional impairment secondary to ADHD, while on a trial of immediate- or sustained-release ADHD medication of adequate dose and 4-week duration (specific details of dose and duration required, including justification if applicable). 2. Coverage is not intended for "performance enhancement" in children or youth who do not have symptoms or functional impairment.*

Terms of the Agreement:

- PSD reserves the right to: grant physicians exemptions from completing Special Authority requests for prescriptions meeting the above Limited Coverage criteria; require renewals of exemptions; and, as necessary, conduct quality assurance checks of such processes. For quality assurance purposes, the physician with a valid exemption agrees to receive feedback on his/ her prescribing of long-acting methylphenidate, such as de-personalized, aggregate prescribing data.
- Pediatric patients who meet the Limited Coverage criteria and whose prescription is written by a physician with a valid exemption will receive automatic Special Authority coverage for their subsequent claims up to the patient's 19th birthday.
- PharmaCare coverage is not retroactive. Special Authority approval or a current valid Physician Special Authority exemption must be in place before a patient fills a prescription.
- For any patient (regardless of age) who does not meet the Limited Coverage criteria, a physician with a valid exemption is required to do one of the following:
  a) Write the following instruction to pharmacists on the prescription "Submit as zero cost to PharmaCare", indicating that these prescriptions are not to be covered by PharmaCare; or
  b) Apply for exceptional PharmaCare coverage by submitting a Special Authority request with full documentation (via fax to 1-800-609-4884).
- A physician's exemption may be discontinued if the exempted physician prescribes long-acting methylphenidate in a manner inconsistent with the terms of this Agreement.

Name of physician (please print)	College of Physicians & Surgeons ID Number
Physician signature	Medical Services Plan Billing Number
Date submitted	Fax # (to which confirmation of exemption should be sent)

FAX COMPLETED AGREEMENT TO HEALTH INSURANCE BC at 1-250-405-3599

A copy of this agreement will be kept on file at the Ministry of Health Services.

PSD Use Only:

Effective date: _____ Approval period: Indefinite Approved on behalf of PSD: _____ Confirmation sent: (Date) _____	**DBR Operational Information**: ID reference number for CPSBC = **91** Category and subcategory code = **9901-0092** Assumed SA = **Yes**

Referral Flags

Referral of the teen with ADHD to specialty mental health services can occur at three different points. The following referral points are suggestions only. Each first contact care provider must identify their personal comfort level with treatment and management of adolescent ADHD and act accordingly. These suggestions are:

Emergency Referral (prior to treatment initiation by first contact care provider):

- Patients who report suicidal ideation or plans (at the time of assessment or during medication treatment)
- Acute psychosis (presence of delusions and/or hallucinations)

Urgent Referral (treatment may be initiated but referral should be made concurrently):

- Symptoms severe and function significantly deteriorated (severe ADHD)
- Persistent suicidal ideation with no intent or suicide plan
- Patients who have any other major psychiatric condition as: psychosis; bipolar disorder (mania); schizoaffective disorder, Tourette's syndrome or chronic motor or vocal tics.

Usual Referral:

- Referral for Behavioural Therapy, if available.
- Patients who do not show symptoms of improvement despite adequate doses and adherence to medication.
- Patients who demonstrate significant growth (weight or height) difficulties.
- Patients with complex or potentially problematic physical conditions (eg: heart disease, liver disease).
- Patients who demonstrate significant side effects (eg: palpitations, changes in blood pressure) during treatment.

Next

Referral Flags

Referral of the child with ADHD to specialty mental health services can occur at three different points. The following referral points are suggestions only. Each first contact care provider must identify their personal comfort level with treatment and management of child ADHD and act accordingly. These suggestions are:

Emergency Referral (prior to treatment initiation by first contact care provider):

- Patients who report suicidal ideation or plans (at the time of assessment or during medication treatment)
- Acute psychosis (presence of delusions and/or hallucinations)

Urgent Referral (treatment may be initiated but referral should be made concurrently):

- Symptoms severe and function significantly deteriorated (severe ADHD)
- Persistent suicidal ideation with no intent or suicide plan
- Patients who have any other major psychiatric condition as: psychosis; bipolar disorder (mania); Tourette's syndrome or chronic motor or vocal tics.
- Patients with concurrent Conduct Disorder; Opposition Defiant Disorder

Usual Referral:

- Referral for Behavioural Therapy if available.
- Patients who do not show symptoms of improvement despite adequate doses and adherence to medication.
- Patients who demonstrate significant growth (weight or height) difficulties.
- Patients with complex or potentially problematic physical conditions (eg: heart disease, liver disease).
- Patients who demonstrate significant side effects (eg: palpitations, changes in blood pressure) during treatment.

Return to p 1

PSP
A GPSC Initiative

Depression

Support Needed

YES → Refer for Psycho or Behavioural Therapy

NO →

Psychotherapy
- Psychoeducation Tools
- Non Specific Supports
- CBIS Tools

Consider Medication

YES →

Meds as per protocol → Follow-up & Monitoring

- Continue treatment
- Educate re maintenance & relapse
- Set "well checks" every 3-6 mos

Follow-up & Monitoring → Improvement?

Moderate

Meds Tolerated: Increase & Monitor as per protocol

Meds not Tolerated: Maintain dose x 2wk Refer if not improved

Substantial

2nd or further episode

YES → Resources

Minimal or None

If used, increase meds gradually Monitor weekly until consult

Tools/Resouces

MH Screening Questions
Risk Identification Tables

Functional
- *TeFA*
- *CFA*

Evaluation Tools:
- *ADHD*
- *Anxiety*
- *Depression*
- *Suicide Risk*
- *Substance Abuse Screen*

Referral Flags

Evaluate need throughout involvement

Emergency: Suicidal intent or plan, acute psychosis

Urgent: Severe symptoms & deterioration in function, suicidal ideation, other major psychiatric conditions

Usual: additional therapy, evaluation, treatment non-responders, other medicatl concerns, med side effects, 2nd or further episode

DSM IV - Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

> **Note:** Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.
>
> (1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.
>
> (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
>
> (3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.
>
> (4) insomnia or hypersomnia nearly every day
>
> (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
>
> (6) fatigue or loss of energy nearly every day
>
> (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
>
> (8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
>
> (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

6-ITEM Kutcher Adolescent Depression Scale: KADS

NAME :_____ DATE :_____

OVER THE LAST WEEK, HOW HAVE YOU BEEN "ON AVERAGE" OR "USUALLY" REGARDING THE FOLLOWING

1. Low mood, sadness, feeling blah or down, depressed, just can't be bothered.

☐ a) Hardly Ever ☐ b) Much of the time ☐ c) Most of the time ☐ d) All of the time

2. Feelings of worthlessness, hopelessness, letting people down, not being a good person.

☐ a) Hardly Ever ☐ b) Much of the time ☐ c) Most of the time ☐ d) All of the time

3. Feeling tired, feeling fatigued, low in energy, hard to get motivated, have to push to get things done, want to rest or lie down a lot

☐ a) Hardly Ever ☐ b) Much of the time ☐ c) Most of the time ☐ d) All of the time

4. Feeling that life is not very much fun, not feeling good when usually would feel good, not getting as much pleasure from fun things as usual.

☐ a) Hardly Ever ☐ b) Much of the time ☐ c) Most of the time ☐ d) All of the time

5. Feeling worried, nervous, panicky, tense, keyed up, anxious.

☐ a) Hardly Ever ☐ b) Much of the time ☐ c) Most of the time ☐ d) All of the time

6. Thoughts, plans or actions about suicide or self-harm.

☐ a) Hardly Ever ☐ b) Much of the time ☐ c) Most of the time ☐ d) All of the time

TOTAL SCORE: 0

Next

6 - item KADS scoring: NB: If response to question #6 is b), c), or d) consider doing TASR-A

In every item, score:

a) Hardly Ever = 0
b) Much of the time = 1
c) Most of the time = 2
d) All of the time = 3

then add all 6 item scores to form a single Total Score.

Interpretation of total scores:

Total scores at or above 6	Suggest 'possible depression' (and a need for more thorough assessment).
Total scores below 6	Indicate 'probably not depressed'.

Reference

- LeBlanc JC, Almudevar A, Brooks SJ, Kutcher S: Screening for Adolescent Depression: Comparison of the Kutcher Adolescent Depression Scale with the Beck Depression Inventory, Journal of Child and Adolescent Psychopharmacology, 2002 Summer; 12(2):113-26.

Self-report instruments commonly used to assess depression in adolescents have limited or unknown reliability and validity in this age group. We describe a new self-report scale, the Kutcher Adolescent Depression Scale (KADS), designed specifically to diagnose and assess the severity of adolescent depression. This report compares the diagnostic validity of the full 16-item instrument, brief versions of it, and the Beck Depression Inventory (BDI) against the criteria for major depressive episode (MDE) from the Mini International Neuropsychiatric Interview (MINI). Some 309 of 1,712 grade 7 to grade 12 students who completed the BDI had scores that exceeded 15. All were invited for further assessment, of whom 161 agreed to assessment by the KADS, the BDI again, and a MINI diagnostic interview for MDE. Receiver operating characteristic (ROC) curve analysis was used to determine which KADS items best identified subjects experiencing an MDE.

Further ROC curve analyses established that the overall diagnostic ability of a six-item subscale of the KADS was at least as good as that of the BDI and was better than that of the full-length KADS. Used with a cut-off score of 6, the six-item KADS achieved sensitivity and specificity rates of 92% and 71%, respectively—a combination not achieved by other self-report instruments. The six-item KADS may prove to be an efficient and effective means of ruling out MDE in adolescents.

Next

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The Kutcher Adolescent Depression Scale (KADS): How to use the 6-item KADS

The KADS was developed to assist in the public health and clinical identification of young people at risk for depression. It was created by clinicians and researchers expert in the area of adolescent depression and the application of various scales and tools in clinical, research and institutional settings. Work on the KADS was conducted in samples of secondary school students, in clinical settings and in clinical research projects.

There are three different KADS scales: the 6-item, the 11-item and the 16 item. The 16 item is designed for clinical research purposes and is not available on the Sun Life Financial Chair in Adolescent Mental Health website.

The 11-item KADS has been incorporated into the Chehil-Kutcher Youth Depression Diagnosis and Monitoring Tool. This tool is designed for use in clinical settings in which health providers treat young people who have depression.

Researchers interested in using the KADS can contact the office of the Sun Life Chair at (902) 470- 6598 or Dr. Kutcher directly by email at skutcher@dal.ca.

The 6-item KADS is designed for use in institutional settings (such as schools or primary care settings) where it can be used as a screening tool to identify young people at risk for depression or by trained health care providers (such as public health nurses, primary care physicians) or educators (such as guidance counselors) to help evaluate young people who are in distress or who have been identified as possibly having a mental health problem.

The tool is a self-report scale and is meant to be completed by the young person following direction from the health provider, educator or other responsible person. The youth should be instructed that this tool will help the person conducting the assessment to better understand what difficulties they might be having and to assist the assessor in determining if the young person may have one of the more common emotional health problems found in adolescents – depression. The young person should be told that depending what the assessment of their problem identifies (the KADS plus the discussion with the assessor) the use of the KADS will help in the determination of next steps.

The KADS is written at approximately a grade six reading level and is useful in assessing young people ages 12 to 22. It has a sensitivity for depression of over 90 percent and a specificity for depression of over 70 percent – putting it into the top rank of self-report depression assessment tools currently available. It is also much shorter than other available tools and unlike many others, is free of charge. It has been recommended for use in a number of expert reports including the National Institute for Clinical Evaluation (UK) and the GLAD-PC Guidelines (USA and Canada). The KADS has been translated into many different languages and is used globally.

KADS Scoring

The KADS is scored using a zero to three system with “hardly ever” scored as a zero and “all of the time” scored as a three. A score of six or greater is consistent with a diagnosis of Major Depressive Disorder and should trigger a more comprehensive mental health assessment of the young person. The KADS will also often identify young people who suffer from substantial anxiety such as Panic Disorder and Social Anxiety Disorder but it has not been validated for that specific purpose.

Another use of the KADS is for monitoring of symptoms in the young person being treated for depression. This should ideally be done at each visit and the scores recorded and reviewed for evidence of improvement.

The last item on the KADS is very sensitive to suicide risk. Any young person scoring one or higher on the last item should have a more thorough suicide risk assessment. We suggest that this be conducted using the adolescent suicide risk assessment guide – the TASR – A. A copy of the TASR – A can be accessed on the clinical tools section of our website.

The KADS can be used by expert clinicians (such as child and adolescent mental health staff working in sub-specialty or academic settings) without additional training. Training in the use of the KADS for others is advised and can be arranged for groups of 10 or more by contacting the office of the Chair. Depending on the group, the duration of KADS training ranges from one to three hours.

Next

Sun Life Financial Chair in Adolescent Mental Health

Permission to use the KADS

The KADS is available freely for use but may not be sold, copied or otherwise distributed without the express written consent of Dr. Stan Kutcher.

We appreciate any feedback on the use, outcome or suitability of the KADS from any individual or group who is using it. Feedback can be directed to Dr. Stan Kutcher by email at skutcher@dal.ca.

Clinicians, educators, youth workers and others interested in other training programs pertaining to youth depression and suicide offered by the Chair can find further information by visitng the training programs section of our website.

More Information

Further information about the KADS can be found in these sources:

Brooks, S. (2004) The Kutcher Adolescent Depression Scale (KADS). *Child & Adolescent Psychopharmacology News*, 9, 54, 4-6

Brooks, S.J.,& Kutcher, S. (2001). Diagnosis and measurement of adolescent depression: A review of commonly utilized instruments. *Journal of Child and Adolescent Psychopharmacology,* 11, 341–376.

Brooks, S.J., Krulewicz, S.,& Kutcher, S. (2003). The Kutcher Adolescent Depression Scale: Assessment of its evaluative properties over the course of an 8–week pediatric pharmacotherapy trial. *Journal of Child and Adolescent Psychopharmacology,* 13, 337–349.

Kutcher, S., Chehil, S. (2006) Suicide Risk Management: A Manual for Health Professionals. Wiley-Blackwell.

LeBlanc, J.C., Almudevar, A., Brooks, S.J., & Kutcher, S. (2002). Screening for adolescent depression: comparison of the Kutcher Adolescent Depression Scale with the Beck Depression Inventory. *Journal of Child and Adolescent Psychopharmacology*, 12, 113–126.

Return to Depression Page

Psychoeducational Tools

DEPRESSION

- Guide for Parents
- Childhood Depression Handout for Child
- Depression And the Family
- Healthy Thinking for Younger Children
- Child Functional Assessment CFA
- Teen Functional Assessment TeFA
- Clinical Global Improvement CGI
- MDD in Youth Risk Identification Table
- Realistic Thinking For Teens
- Challenge Negative Thinking
- Dealing With Depression Handbook for Teens
- Suicide What Should I Know?
- Tool for Assessment of Suicide Risk - Adolescent
- Substance Abuse Assessment

DEPRESSION IN CHILDREN AND YOUTH

A Guide for Parents

When a child or youth is depressed, support from their family is very important. Family members can help by making sure the young people have opportunities to make positive changes and choices. They can also watch for improvements, reward positive behaviour, and give lots of reassurance.

Parents can help a child or teen by encouraging them to:

Follow Normal Routines

Children and youth who are depressed often postpone activities and withdraw from friends and social situations. They may stay up too late and sleep too much.

- Help your child or teen get into normal routines.
- Make sure they get lots of physical exercise. Even if they say they don't feel like it, exercise will help them feel better.

Set Goals

Depression may cause children and youth to give up on their goals.

- Talk to your child or teen and help them to list some personal goals. Then break these goals down into small tasks they can do each day. This will give them a sense of accomplishment.

Act with Confidence

Depressed children and youth may seem passive and emotionless. They may feel that they have no control over their lives.

- Help your child or teen to become more assertive and take responsibility for daily activities. For example, encourage them to start conversations and organize a daily schedule.

Think Positively

Depression causes children and youth to think negatively about themselves and others. Parents can help them to recognize and avoid these negative thoughts.

- Boost your child's or teen's self esteem. Help them to see their strengths.
- Teach them to focus on daily goals and achievements rather than negative thoughts.

Increase Socialization

Depressed children and youth withdraw and lose contact with friends and family.

- Encourage them to spend time with their friends.
- Keep the children and youth busy. Make sure they don't spend too much time alone. Try to get them to take initiative and set up social activities themselves.

Cope with Physical Symptoms of Depression

Depression causes physical symptoms like tiredness. Children and youth may use these symptoms as excuses to avoid tasks and activities.

- Help children and youth understand that these symptoms are temporary and harmless.
- Teach them to cope by not allowing the symptoms of depression to interfere with activities.

Childhood Depression

Why am I going to the doctor?

You're going to the doctor because you have an illness called depression.

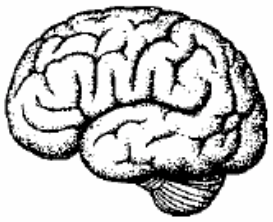
What does depression mean?

Some of the problems a child with depression may have are:

- Feeling sad most of the time
- Feeling mad and grouchy most of the time
- Wanting to be by yourself most of the time
- Not wanting your favorite foods any more OR eating too much just to feel better
- Getting a lot thinner or fatter
- Having a lot of stomachaches and headaches
- Not wanting to play with your favorite toys or friends
- Wanting to die or go away for forever
- Having trouble falling asleep at night or not wanting to get up in the morning
- Worrying a lot or feeling afraid that bad things will happen

Why am I depressed?

- Your brain controls your feelings.
- Sometimes you're happy, sad, angry, excited or worried; that's normal.
- But when you're sad most of the time, your brain isn't working right.
- Depression is not your fault.



What will the doctor do?

- The doctor will ask you and your family special questions about your feelings.
- The doctor will talk to you about how fast you will get better.
- The doctor will want you to come back to talk about your feelings and how your medicine is working.

With help, you can feel better again!

Texas Department of Mental Health and Mental Retardation
Revised 02-27-04
C-DEP

Suicide: What Should I Know?

Why am I having these thoughts?

Many young people with depression think about hurting or killing themselves at some time. In fact, thoughts about death and dying are one of the symptoms of depression. Just like depression is treatable if you recognize it and get help, these feelings and thoughts can be treated and you can feel better. But it is up to you to let people know when you are feeling very depressed or out of control and it is up to you to let people help you through this time.

What are the warning signs?

Learn to recognize your own warning signs. Everybody is different and the things you notice when you begin to feel very depressed may be different from those other people report. But here is a list of some things that may signal a problem:

- ✓ Feeling very hopeless, like nothing will ever get better
- ✓ Not wanting to be around friends or family or take part in fun activities
- ✓ Not caring about anything anymore, like school or how you look
- ✓ Drinking or using drugs
- ✓ Doing risky things, such as driving recklessly or getting into fights
- ✓ Having lots of thoughts or dreams about death and dying
- ✓ Having a lot of stresses or life changes that seem hard to handle
- ✓ Feeling like you have a little more energy than usual

What can I do?

If you feel like things are getting out of control, you need to let someone know. Talk to your parents, your doctor, teacher, counselor, or a good friend! Don't keep these feelings inside. There are things you can do to help yourself get through these tough times. Don't be afraid to ask others to help you do these things as well.

- ✓ Keep your doctor or counselor informed about symptoms. Get symptoms treated early before they become worse.
- ✓ Keep in regular contact with someone on your treatment team. Set up a weekly (or even daily) time to check in with them and let them know how you are doing.
- ✓ Do what you can to reduce stresses. Learn what stressors are likely to really bother you and try to manage those first.
- ✓ Avoid alcohol and drugs. They may make you feel better temporarily but they will eventually make your depression and suicidal feelings worse.
- ✓ Let your parents have responsibility for giving you your medications and keeping all medications in a safe place.
- ✓ Develop a plan with others about what you will do if you feel suicidal. Carry phone numbers of people you can contact and who will stay with you until you are safe.
- ✓ Always try to find something to look forward to.

Suicide is a serious subject. Although it can be difficult, talking about it is an important step to getting better. By letting people know when you are thinking about death or hurting yourself, you can begin to get the help you need.

PEOPLE CAN AND DO GET BETTER!

Reviewed 09-30-03

Texas Department of Mental Health and Mental Retardation
A-DEP

Depression and the Family

Having a family member with depression affects the whole family. Each family member is likely to react in his or her own way, and the response may, in turn, affect other family members. It is important to recognize the ways in which the illness affects your family and to take steps to reduce any negative impact. The depressed child or adolescent will find an easier path to recovery from the illness if the family can continue to be a strong, well-functioning unit.

Possible Ways the Family May React

- The family may begin to change family routines or rules. Family members may choose not to participate in activities that take them away from the home or stop trying to do things that may cause disruption or stress (such as requiring chores).
- Families may begin to avoid contacts with friends or social gatherings. Additionally, friends may begin to avoid members of the family. This can result in the family becoming isolated from others, with little to no support in a time when they need it most.
- Everyone may be walking on eggshells to avoid upsetting the depressed person.
- Family members may be irritable or angry, resulting in more family disagreements or stress.
- Family members may act out to get attention they feel they are not receiving.
- Parents may be stricter or more harsh with non-depressed children.
- There may be more arguments or disagreements between family members, especially around how to handle the depressed person. Having a depressed child can put enormous stress on relationships.
- Family members may blame themselves for the difficulties the depressed child is having. This self-blame can be intensified by messages from others that their parenting skills may be the cause of the child's problems.
- Individuals may feel frustrated and helpless and unable to change things for the depressed individual.
- Family members may feel resentful of the depressed person for the disruption that their illness has caused. Resentment may lead to even more problems in dealing with the depressed individual.
- Individuals may feel ashamed of the child's depression. Brothers or sisters may not want to have friends over or worry that others will find out. Parents may worry that outsiders will judge them.
- Other family members may begin to show signs of stress, even depression.

Most families will have one or even most of these experiences. But changing your family's life to center around your child's depression is not helpful for the family. The following are some suggestions to help lessen the impact that depression has on your family.

Dealing with Depression in the Family

- Take care of yourself and encourage other family members to do so also. You will be better able to help your child if you are healthy and well rested. Recognize when you need a break and arrange to take one, or better yet arrange some time off before you need it.
- Take time to go places and enjoy yourselves as a family, even if the depressed person does not participate.
- Encourage all family members to continue with regular activities. Try to take time to spend with each family member, not allowing the depressed child to monopolize all of the family's attention.
- Give yourself and your family permission to enjoy an activity, even if the depressed person does not.
- No one is able to remain patient and cheerful all the time. If you have a bad day, go easy on yourself.
- Remind yourself and your family that depression is a medical illness. No one in your family, including the depressed child, is to blame.
- Because depression affects the whole family, the family can benefit from treatment. Include family members in the treatment that your child is receiving. Family therapy may be helpful, and families can also benefit from education about the illness and its treatment and working with the child's counselor or psychiatrist to address specific problems in the family.
- Family members need to recognize depression in themselves and get help! Depression tends to run in families. Be a good role model and seek help for any mental health problems that you or other family members might experience.
- Consider joining a support group. Family members can find relief and good ideas by talking with others who have had similar experiences. Even brothers and sisters of the depressed person can benefit from a group with whom to share their feelings.

Reviewed 09-30-03

Texas Department of Mental Health and Mental Retardation
P-DEP

CHALLENGE NEGATIVE THINKING

Questions to ask yourself to help challenge your negative thoughts or self-talk:

- Am I falling into a thinking trap (e.g., *catastrophizing* or *overestimating danger*)?
- What is the evidence that this thought is true? What is the evidence that this thought is not true?
- Have I confused a thought with a fact?
- What would I tell a friend if he/she had the same thought?
- What would a friend say about my thought?
- Am I 100% sure that _____will happen?
- How many times has _____happened before?
- Is _____so important that my future depends on it?
- What is the worst that could happen?
- If it did happen, what could I do to cope with or handle it?
- Is my judgment based on the way I feel instead of facts?
- Am I confusing “possibility” with “certainty”? It may be possible, but is it likely?
- Is this a hassle or a horror?

AnxietyBC

RESOURCES.RESULTS.RELIEF.

Healthy Thinking for Younger Children

***For older children and teens, see* **Realistic Thinking for Teens**.

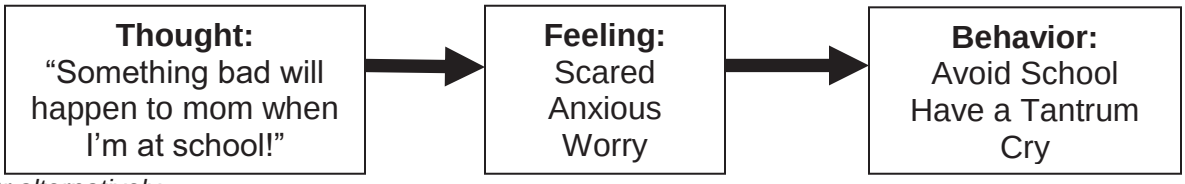
In general, anxious children think differently than other children. For example, they can easily come up with 101 ways that things can go wrong! They also tend to see the world as more **threatening and dangerous**. If a parent is late coming home, an anxious child may think "Mom got in a car accident!" What your child says to himself or herself is called "self-talk". Anxious children tend to have **negative or anxious self-talk**. Some examples include:

- *"I will fail the test."*
- *"What if I can't do it?"*
- *"Things are not going to work out."*
- *"They don't like me."*
- *"I'm stupid."*
- *"I'm going to get sick and die."*
- *"That dog is going to bite me!"*

It is important for children to identify their self-talk, because anxious thoughts lead to anxious feelings, which lead to anxious behavior. For example:

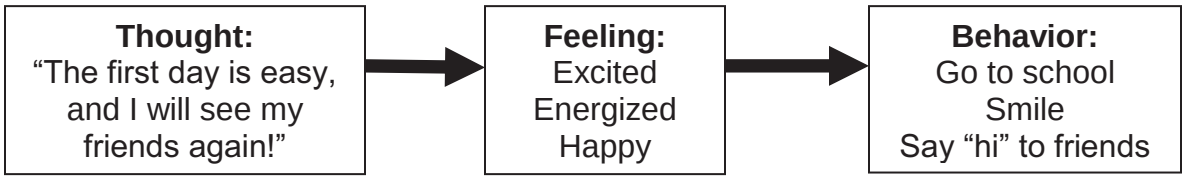
Situation = First day of school

Anxious Thoughts



Or alternatively,

Helpful Thoughts



Thus, the first step is to get your child to start paying attention to his or her self-talk, especially anxious thoughts!

HOW TO DO IT!

Step 1: Teach younger child about thoughts or "self talk"

- Thoughts are the words we say to ourselves without speaking out loud (self talk).
- We have many thoughts each hour of the day.
- Thoughts are private – other people don't know what we're thinking unless we tell them.
- People can have different thoughts about the same thing.

Here is an example of how to explain thoughts:

> *"We all have thoughts about things. Thoughts are words we say to ourselves without saying them out loud. Other people can't tell what you are thinking unless you tell them. Because we have thoughts all the time, we usually don't pay attention to them. They just come to us automatically! Let's try and slow our thoughts down and pay attention to them."*

The **What am I Thinking?** activity can help with this explanation. You can also use picture books or movies to teach your child about thoughts. For example, point to a picture of a character and say, "Hmmm, I wonder what he is thinking?"

Remember, it can be difficult for young children to understand the concept of what a thought is, and it can be especially difficult to tell the difference between a thought and a feeling. For example, your child may say his or her thought is "I'm scared" (which is actually a feeling) versus "That noise is a burglar trying to break in" (which is a real thought). It is important to expose the thoughts underneath the feelings! For example, "What is making you scared? What do you think that noise might be?"

Hint:
One way to describe the difference between a thought and a feeling to a young child is to explain that a thought comes from your head, and a feeling comes from your heart.

Step 2: Help your child identify thoughts (or self-talk) that lead to feelings of anxiety.

- Often, we are unaware of what we are thinking, and it can take time to learn to identify our specific thoughts.
- Questions to ask, in order to help your child identify his or her "anxious" or "worried" thoughts include:

  What is making you feel scared?

  What are you worried will happen?

  What bad thing do you expect to happen in this situation?

For young children, this may be as far as you can progress. Just identifying their thoughts is a big step in a long-term plan to help fight anxiety. One way to get your child to continue to pay attention to anxious thoughts is to use an actual stop sign as a visual reminder to "stop and pay attention".

Next

Remind your child that just because he or she thinks something, doesn't mean it's true! For example, just because your child thinks the elevator will get stuck, doesn't mean it actually will (even though it might feel really scary).

While children can usually describe thoughts that go with feelings of anxiety, in some cases children are unable to identify anxious thoughts, especially children who are very young or not very talkative. At any age, anxiety may be present before there are thoughts about the situation. If you and your child do not identify anxious thoughts, it is best not to press your child about this too much about this. By making too many suggestions, you may create anxious thoughts where there were none before. Instead, watch to see if your child mentions anxious thoughts in the future. The other approaches to managing anxiety work even when anxious thoughts are not identified.

(The concepts below may be too difficult for younger children to grasp)

Step 3: Teach that what we think affects how we feel

- When we expect bad things to happen we feel anxious.
- What we think affects (or controls) how we feel.

For example, imagine you are out for a walk and you see a dog. If you think the dog is cute, you'll feel calm; however, if you think the dog will bite, you'll feel scared. Use the **Thoughts → Feelings** sheet to help explain this idea to your child.

Step 4: Changing unhelpful thoughts to helpful thoughts

- First, explain the difference between a helpful thought and an unhelpful thought:

Thousands of thoughts run through our head every day. Some of these thoughts are helpful thoughts, and some are unhelpful thoughts. A helpful thought makes us feel confident, happy, and brave. An unhelpful thought makes us feel worried, nervous, or sad. Can you think of some examples of helpful and unhelpful thoughts?

- Once your child can identify the difference between helpful and unhelpful thoughts, ask him or her to imagine being in a particular scenario. It is best if the scenario is a bit uncertain. Ask: *What is an unhelpful thought you could have? What is a helpful thought?* For example,

Situation	Unhelpful Thoughts	Helpful Thoughts
A group of kids looking at her and laughing	*Oh no, they are laughing at me. I must look stupid!*	*They are probably laughing about something funny, and I just walked by.* *I don't actually know that they were laughing at me!*
Not being invited to a birthday party	*She doesn't like me. I bet I am the only one who didn't get invited in the whole class.*	*They probably just forgot.* *Or maybe it was just a small party.* *I have other good friends.*
Getting a low grade on a quiz	*I suck. I am never going to do well in spelling.*	*Well, I tried my hardest.* *It's only one grade!* *I will practice more next time.*

- Once your child can come up with his or her own helpful thoughts, refer to the **Developing and Using Cognitive Coping Cards** guidelines, to help your child create, write down, and remember some of these helpful thoughts!

Next

It is very useful to help a child identify unhelpful thoughts and create helpful thoughts. At the same time, anxious thoughts and feelings **are normal**. It is important to communicate that you and your child can accept anxious thoughts and feelings. They are not stupid or foolish. They are just one way of thinking and feeling, and there are lots of other ways of thinking and feeling.

Step 5. Introduce the STOP Plan to your older child:

1. Pay attention to signs of anxiety (= S)
2. Pay attention to anxious thoughts (= T)
3. Think of other helpful thoughts (= O)
4. Praise and Plan for next time (= P)

Scared?	**T**houghts?	**O**ther helpful Thoughts?	**P**raise and Plan
Sore tummy Heart racing Knees trembling	*I might throw up, and mom won't be here to help me.*	*I can ask to go to the bathroom and do my calm breaths.* *I can get a drink of water.* *My teacher cares, he will help me*	Good job for remembering to use the STOP Plan! Next time, I will remember that feeling panicky doesn't last forever, and drinking water helps.

Now, use the **STOP Plan Handout** with your child! You will need to print several copies. First, go through the chart together with your child. You will likely need to do this several times over a couple of days. Once your child gets the hang of it, have your child complete it alone when faced with a scary situation. Eventually, your child will get used to the steps in the plan, and may not even need to write it down. Remember to praise and reward effort!

Dealing With Depression

Antidepressant Skills for Teens

Click anywhere to go to downloadable manual

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BRITISH COLUMBIA | Ministry of Children and Family Development

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CBIS Cognition Skills

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CBIS Lifestyle Skills

CBIS Relaxation Skills

Anti-Depression Activities

The activities below are helpful in recovering from depression. To start working on your recovery, put a check mark whenever you do one of the activities below. Push a little, often, but not to exhaustion. As you persist, day after day, you may gradually find your mood brightening and your energy returning.

	ACTIVITY	MON	TUE	WED	THUR	FRI	SAT	SUN
1	Self-care (shower, shave, teeth etc.)							
2	Eat three meals, however small (check for each)							
3	Sleep (# of hours)							
4	Exercise, however little (# of minutes)							
5	Relaxation (# of minutes)							
6	Accomplish one small task or goal each day							
7	Social contact (enough but not too much)							
8	Pleasure activities/hobbies (check for each)							
9	Do something nice for yourself							
10	Do something nice for someone else							
11	Replace negative thoughts with helpful thoughts (check # times)							
12	Miscellaneous (your choice)							

Small Goals

The concentration, fatigue and memory problems that go along with depression make it impossible for people to keep up their same pace.

Depression feeds on withdrawal and inactivity.

A strategy to help people feel more in charge of their lives and improve their self-esteem is through the attainment of daily small goals.

The emphasis on small goals is important. It slows down the person who pushes too hard so they don't get overwhelmed and gently encourages the withdrawn person to begin taking charge of their life.

Select a Small Goal

- Choose something that you would like to accomplish and are certain you can achieve in the time you set for yourself.
- The task should be easy enough to achieve even if you feel very depressed.
- Have a clear idea of when and how you are going to carry out your goal.
  i.e., "go swimming at the community center pool this Thursday evening for 15 minutes," rather than "go swimming."

If you don't complete the goal don't give up — choose another time or break your goal into smaller parts.

Goals that involve action and thoughts are easier to know you've achieved than those involving emotions.

When you meet your goal, or part of it, congratulate yourself.

Start small — you can always do more when you've achieved your goal.

CONTINUED ON NEXT PAGE

Small Goals Worksheet

GOAL	WHEN	WHERE	HOW	ATTAINED
Talk to mom	I'm feeling hopeless or lost	On the phone or at home	Ask her if she is available for us to talk	Knowing I have my mom as a support helps me gain more hope and relief
Try kickboxing	Once a week, Tuesday nights	Recreation centre	Walk down or ask for a ride	Feeling stronger and energized gives me a break from my negative thoughts
Write down how I'm feeling in a journal	I don't want to talk to anyone and I'm feeling hopeless or when I want to think about things on my own	In my room or outside on a park bench if the weather is ok		Feeling more relieved that the feelings are out on paper, I can read them and try to figure out how they got so bad and what to do next

Problem Solving

Depression can make even everyday problems seem insurmountable. When worry and self doubt set in, people feel stuck. The following problem solving technique will help you change your worry into action.

LIST the specific problem that you are worrying about.
e.g: People are talking about me behind my back

. . . . . .

. . . . . .

BRAINSTORM all possible solutions and options – don't leave any out.
e.g.: talk to them about it, ask a friend for advice, ignore them, pretend not to care and join a club at school away from these people

. . . . . .

. . . . . .

CHOOSE one of the options or solutions you've listed.
Join a club at school

. . . . . .

. . . . . .

. . . . . .

DO IT!
e.g. : Joined after school drama club

. . . . . .

. . . . . .

. . . . . .

EVALUATE results.
e.g.: It's really fun and I've met a whole new group of people that is really funny, interesting and doesn't care what those people think of me. I don't care anymore either.

. . . . . .

. . . . . .

. . . . . .

REPEAT steps 3, 4 and 5 as necessary.
e.g.: I might join yearbook if I have time this year

Opposite Action Strategy

Here is an effective way to start fighting back against depression. Catch yourself acting or thinking the way depression wants you to — then do or think the opposite. By doing so, you DEFY depression and take back some control, even if only for a short while.

ACTIONS OR THOUGHTS THAT STRENGTHEN DEPRESSION	ACTIONS OF THOUGHTS THAT WEAKEN DEPRESSION
Stay in bed when you feel too miserable to get up. Don't attend to hygiene. Don't get dressed.	Make yourself get up even for short while. Attend to hygiene and get dressed each day.
Punish yourself by calling yourself names every time you make a mistake ("stupid," "loser," "useless")	Encourage yourself to learn from the mistake and try again. You will do better in life if you focus on what you do right instead of what you do wrong.
Worry about all your past mistakes, how bad things are now and how things could go wrong in the future.	Set aside a small amount of time per day to worry and distract yourself from worry thoughts at other times. Use problem solving skills on real problems.
Talk excessively about depressing topics or how bad you feel to anyone who will listen.	Deliberately choose lighter topics. Focus on others. Take timeout from depression – talk or limit it to a few minutes at a time.
Withdraw, i.e. don't go out, refuse invitation, ignore the phone.	See or talk to someone for a short time each day, even when you don't feel like it.
Tell yourself that everything you do must be done really well, if not perfectly, or it's not worth doing at all.	Tell yourself that you just need to muddle through, not everything needs to be done perfectly. Dare to be average!
Take on all your usual tasks and expect to do them as well as usual.	Remind yourself that depression seriously limits your energy. Set realistic expectations that take into consideration your depressed state.
Pretend that nothing is wrong and get exhausted by the effort to keep up a good front.	Tell others that your energy is low (or whatever you feel OK sharing) and that this limits what you can do. Say "No!"

Common Thinking Errors

The situations we find ourselves in don't cause our depressed feelings — our ways of perceiving the situations do. Here are some distorted ways of thinking that often increase depression. Check the ones that most relate to you.

FILTERING

Everyone's life has negative aspects. if you focus only on the negative and filter out all positive or neutral aspects, your life will indeed seem depressing. (ie. when someone compliments you and you assume they are lying and immediately reject the compliment and then focus on what you *don't* like about yourself instead)

EMOTIONAL REASONING

"I feel it so it must be true." remember feelings are not facts. Emotions are based on subjective interpretations, not hard evidence. i.e. "It feels like I'm not prepared enough for this test, so I will fail it"

OVER-INCLUSIVE

You think of one problem or demand, then another and another, until you feel completely overwhelmed. i.e. "If don't get my history homework in on time then I'll get a lower grade and then my GPA will fall and I won't be able to get into college/university and I will be stuck working at a fast food restaurant forever!"

BLACK OR WHITE THINKING

You think only in extremes or absolutes, forgetting that most things fall into shades of grey. i.e. "I thought I really liked Jennifer but she embarrassed me at lunch today. She's into emo music, and all emo kids are like this and can't be trusted"

JUMPING TO CONCLUSIONS

You predict a negative outcome without adequate supporting evidence. i.e. "People are going to hate me because I broke up with my boyfriend and none of his friends will talk to me."

MIND READING

You believe that others are thinking and feeling negatively about you and you react as if this is true. i.e. "I know Darren is talking about me because he wouldn't throw me the ball today at gym class. I shouldn't have made us lose last time"

PREDICTING THE FUTURE

You anticipate that things will turn out badly and you feel convinced that your predictions are true. i.e. "No matter how much I study, I'm just not going to pass math this year."

CATASTROPHIZING

You blow things out of proportion and imagine the worse case scenario. This intensifies your fear and makes it difficult for you to cope with the actual situation. i.e. "I can't believe I forgot to buy Matt a birthday present. Everyone else has brought something and he's going to hate me. I might as well just go home."

SHOULD

You make rigid rules for yourself and others about how things "should" be. When these rules are not followed you become depressed and angry. Ie. Everything must always be in the same spot in the bathroom, no one should move anything around because this is the right way."

Self Talk (Mean Talk)

Depression brings on a flood of mean talk. Depressed people blame themselves; they pick out every little flaw; they brood over mistakes, from miniscule to sizeable; they call themselves names (Stupid! Useless!); they psych themselves into failure or giving up ("You know you can't do this; you know you'll blow it; you always screw up").

This kind of mean talk to yourself is guaranteed to keep you depressed and will definitely not help you to be more productive or successful.

To help in your recovery from depression, make a resolution to treat yourself the way you would treat someone else you valued, such as a friend dealing with some problems, a child you wanted to help do better in school, or a partner who is coping with a job failure.

The Talk Back Technique

1 Be Aware: Listen to your own self-talk.

2 Evaluate: Decide if your self-talk is helpful or harmful.

3 Catch yourself: Notice your "mean talk." (You will be surprised how often you do this).

4 Stop: Immediately tell yourself (in a firm gentle voice) "STOP — THAT'S NOT HELPFUL."

5 Ask yourself: "What would i say in this situation to a friend who was feeling down and needed encouragement and support?"

6 Support yourself: Say to yourself what you would say to a friend.

7 Practice, practice, practice: The more you challenge your "mean talk" and replace it with caring respectful talk, the more likely it is that you will improve your mood.

Example:

Instead of "Why can't I get all of my work done in three hours? I'm so slow I'm falling behind!" alter the self talk to congratulate yourself on the work you were able to accomplish and to allow yourself more time in the future so you don't feel rushed: "It's amazing how much I can get through but I didn't complete it all. I'll try again tomorrow and give myself more time."

Thought Stopping

Depression often makes people brood and worry about current problems, things that have gone wrong in the past and things that might go wrong in the future.

When unwanted thoughts won't get out of your head, try the suggestions in Step 1 and Step 2. See which ones work best for you. Remember: success depends on repetition.

Step 1: Stop the thoughts

- Picture a large STOP sign
- Hear yourself shouting "STOP!"
- Count backwards from 100
- Recite a poem
- Sing a song in your head
- Gently snap an elastic band on your wrist and say "STOP"

Step 2: Keep the thoughts away

As soon as the thoughts fade a little, do something to keep your mind and body busy. This will prevent the thoughts from coming back.

- Take a brisk walk and concentrate on what you see around you
- Talk to a friend, as long as you talk about something neutral or pleasant
- Read a book, as long as it keeps your attention
- Play a game, do a jigsaw or crossword puzzle
- Do a household chore that requires concentration
- Listen to a relaxation recording, read one or make one up
- Do crafts or hobby work
- Do something you're passionate about, love doing because it makes you feel heard, special or "you" good additions

PSP Child and Youth Mental Health – Initiating and Monitoring Antidepressants Medication in Children / Youth

Fluoxetine

MDD Diagnosis (DSM-IV criteria)

- Initiate PST for at least 3 visits. KADS ≥ 6, symptoms continue causing distress and TeFA shows decrease in function. **Time to start medication!**

Use PST and MEP throughout the treatment process.

Measure functioning using TeFA and side effects using sCKS in every

- Begin Fluoxetine at 10 mg daily for 1 - 2 weeks. (If significant anxiety symptoms are present, start with 5 mg for 2 weeks and continue increasing as indicated.)
- Increase Fluoxetine to 20 mg daily for one to two weeks. (Could be a split dose if better tolerated.)
- Continue Fluoxetine at 20 mg daily for 8 weeks.
  (If side effects are a problem – decrease the dose to 15 mg daily for 1 week and then increase to 20 mg. If substantial side effects occur, continue the dose at 15 mg for 8 weeks.)
- If symptoms have not improved after 8 weeks of treatment, increase the dosage by 10 mg every 2 weeks to a maximum of 40mg.

If you have reached the maximum dose and depressive symptoms continue to cause distress and dysfunction or there is suicidal risk REFER TO A MENTAL HEALTH SPECIALIST

Atypical antipsychotics are not meant to be used to treat depression in primary health care.

Antidepressant Medication and YOU

How do the medications work?

The brain uses chemical messengers, called neurotransmitters, to send signals to different parts of the brain and the body. In young people with depression certain neurotransmitters may not be working the right way. The antidepressant medications help these neurotransmitters work better. Different antidepressant medications work on different neurotransmitters. That is why sometimes one medication will work better than another, and sometimes more than one medication will need to be tried before finding the one that works best for you. Also new medications and treatments are being developed and tested all the time.

How will medication help me?

Antidepressant medications may help you have:

- Improved mood
- Better concentration
- More normal appetite
- More normal sleeping
- Greater interest in activities
- More energy
- Improved self-esteem

Will taking medication change who I am?

You may be concerned about taking medication. You may think that it will make you different from other young people or that it will change who you are. These things aren't true. Medication will help you get back to the way you were before you became depressed, so you feel like yourself again. Taking medication is really no different than using glasses or wearing braces – it's only a tool to help you.

What are the problems with taking medications?

Like all medical treatments, there can be side effects with these medications. Side effects are usually very mild and tend to disappear as you continue to take the medication or as the dose is changed. Sometimes the side effects may continue, and this usually means that the doctor will change the medication. Some common side effects are:

difficulty sleeping	headaches	irritability
upset stomach	dry mouth	blurry vision

Specific side effects can be found in the individual medication information sheets. Make sure you tell your doctor if you experience any side effects. Your doctor may change the dose or switch to another medication.

How long will I have to take medication?

If the medication is helpful and you have no problems with it, you will probably continue to take the medication for a number of months, even after you feel better, to make sure the depression is gone. If your doctor decides to stop the medication, it will be slowly decreased over a number of weeks. Antidepressant medication should never be stopped without first talking to your doctor. Sometimes young people who have been depressed will become depressed again, so it is important to notice if your symptoms return. If you do become depressed again, you will probably be restarted on medication.

What is my role in taking medication for depression?

It is your responsibility to take your medication in the right amount at the right time. You should not take any other medication (even over-the-counter) without talking to your doctor first. And you should never use alcohol or drugs while taking medication; it is very dangerous and can be deadly. It is also your responsibility to never share your medication with anyone else. It can be harmful, and it is illegal. Most importantly, you should talk openly with your doctor about any problems and work together as a team in making decisions about medications.

Reviewed 09-30-03

Texas Department of Mental Health and Mental Retardation
A-DEP

Short Chehil-Kutcher Side Effects Scale (sCKS)*

Item	None	Mild	Moderate	Severe
Headache				
Irritability/Anger				
Restlessness				
Diarrhea				
Sexual Problems				
Suicidal Thoughts				
Self Harm Attempt	☐ No ☐ Yes If yes describe: Was this a suicide attempt (intent to die) ☐ No ☐ Yes			
Any other problems?	1. 2.			

Clinicians who would like to use the short Chehil Kutcher Side Effects Scale in their individuals or group practice may do so without obtaining written permission from the authors. The short Chehil Kutcher Side Effects Scale may not be used for any other purpose (including publication) without expressed written consent of the authors.

Clinicians working in specialty mental health settings may wish to use the long version of Chehil Kutcher Side Effects Scale (CKS). The CKS may be used under similar circumstances and with similar conditions as outlined for the sCKS.

Hypomania

One rare side effect of medication treatment is the induction of hypomania. This presents symptomatically as:

1. Decreased need for sleep – subjective feeling that sleep is not needed
2. Increase in goal directed activity (may be idiosyncratic or inappropriate
3. Increase in motor behaviour (including restlessness), verbal productivity, and social intrusiveness

If hypomania is suspected the medication should be discontinued and urgent mental health referral initiated. Remember that a family history of bipolar disorder increases the risk of hypomania.

Referral Flags

Referral of the teen with MDD to specialty mental health services can occur at three different points. The following referral points are suggestions only. Each first contact care provider must identify their comfort level with treatment and management of adolescent MDD and act accordingly. These suggestions are:

Emergency Referral (prior to treatment initiation by first contact care provider):

- Suicidal ideation with intent or suicide plan
- MDD with psychosis (presence of delusions and/or hallucinations)

Urgent Referral (treatment may be initiated but referral should be made concurrently):

- Relapse from previous positive treatment response
- Persistent suicidal ideation with no intent or suicide plan
- Family History of Bipolar Disorder
- History of suicide attempts
- Hypomania

Usual Referral:

- MDD not responding to adequate first contact treatment trial

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PSP
A GPSC Initiative

Anxiety

Support Needed

YES → Refer for Psycho or Behavioural Therapy

NO

Psychotherapy
- Psychoeducation Tools
- Non Specific Supports
- CBIS Tools

Consider Medication

YES

Meds as per protocol

Follow-up & Monitoring

- Continue treatment
- Educate re maintenance & relapse
- Set "well checks" every 3-6 mos

Improvement?

Moderate

Meds Tolerated: Increase & Monitor as per protocol

Meds not Tolerated: Maintain dose x 2wk Refer if not improved

Substantial

Minimal or None
If used, increase meds gradually Monitor weekly until consult

2^{nd} or further episode

YES

Resources

Tools/Resouces

MH Screening Questions
Risk Identification Tables

Functional
- *TeFA*
- *CFA*

Evaluation Tools:
- *ADHD*
- *Anxiety*
- *Depression*
- *Suicide Risk*
- *Substance Abuse Screen*

Referral Flags

Evaluate need throughout involvement

Emergency: Suicidal intent or plan, acute psychosis

Urgent: Severe symptoms & deterioration in function, suicidal ideation, other major psychiatric conditions

Usual: additional therapy, evaluation, treatment non-responders, other medicatl concerns, med side effects, 2^{nd} or further episode

DSM-IV TR. Oppositional Defiant Disorder (ODD)

Consists of a pattern of negativistic, hostile, and defiant behaviour lasting at least 6 months, during which four (or more) of the following behaviours are present:

- often loses temper
- often argues with adults
- often actively defies or refuses to comply with adults' requests or rules
- often deliberately annoys people
- often blames others for his or her mistakes or misbehaviour
- is often touchy or easily annoyed by others
- is often angry and resentful
- is often spiteful or vindictive

Each of the above is only considered diagnostic if the behaviour occurs more frequently than is typically observed in children of comparable age and developmental level and if the behaviour causes clinically significant impairment in social, academic, or occupational functioning.

Oppositional Defiant disorder is not diagnosed if the behaviours occur exclusively during the course of a Psychotic or Mood Disorder or if Conduct Disorder is diagnosed.

Learning disorders

A learning disorder is defined as difficulty in an academic area (reading, mathematics, or written expression). The child's ability to achieve in the specific academic area is below what is expected for the child's age, educational level, and level of intelligence. The difficulty experienced by the child is severe enough to interfere with academic achievement or age-appropriate normal activities of daily living. Learning disorders are sometimes called learning disabilities, or specific learning disabilities. Most children with learning disorders have normal intelligence. Types of learning disorders include the following:

- reading disorders (sometimes called dyslexia)
- mathematics disorder
- disorder of written expression

Next

DSM-IV Criteria for Anxiety

Separation Anxiety

A. Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three (or more) of the following:

1. recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated
2. persistent and excessive worry about losing, or about possible harm befalling, major attachment figures
3. persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)
4. persistent reluctance or refusal to go to school or elsewhere because of fear of separation
5. persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings
6. persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
7. repeated nightmares involving the theme of separation
8. repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated

B. The duration of the disturbance is at least 4 weeks.

C. The onset is before age 18 years.

D. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.

E. The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and, in adolescents and adults, is not better accounted for by Panic Disorder With Agoraphobia.

Next

Specify if:

Early Onset: if onset occurs before age 6 years

Specific Phobia

A. Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).

B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed Panic Attack.
Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging.

C. The person recognizes that the fear is excessive or unreasonable. Note: In children, this feature may be absent.

D. The phobic situation(s) is avoided or else is endured with intense anxiety or distress.

E. The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.

F. In individuals under age 18 years, the duration is at least 6 months.

G. The anxiety, Panic Attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as Obsessive-Compulsive Disorder (e.g., fear of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor), Separation Anxiety Disorder (e.g., avoidance of school), Social Phobia (e.g., avoidance of social situations because of fear of embarrassment), Panic Disorder with Agoraphobia, or Agoraphobia Without History of Panic Disorder.

- Specify type:
  - Animal Type
  - Natural Environment Type (e.g., heights, storms, water)
  - Blood-Injection-Injury Type
  - Situational Type (e.g., airplanes, elevators, enclosed places)
  - Other Type (e.g., phobic avoidance of situations that may lead to choking, vomiting, or contracting an illness; in children, avoidance of loud sounds or costumed characters)

Generalized Anxiety
Excessive anxiety about a number of events or activities, occurring more days than not, for at least 6 months. The person finds it difficult to control the worry. The anxiety and worry are associated with at least three of the following six symptoms (with at least some symptoms present for more days than not, for the past 6 months):

- Restlessness or feeling keyed up or on edge
- Being easily fatigued
- Difficulty concentrating or mind going blank

Next

- Irritability
- Muscle tension
- Sleep disturbance

The focus of the anxiety and worry is not confined to features of an Axis I disorder, being embarrassed in public (as in social phobia), being contaminated (as in obsessive-compulsive disorder), being away from home or close relatives (as in separation anxiety disorder), gaining weight (as in anorexia nervosa), having multiple physical complaints (as in somatization disorder), or having a serious illness (as in hypochondriasis), and the anxiety and worry do not occur exclusively during posttraumatic stress disorder. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social or occupational functioning. The disturbance does not occur exclusively during a mood disorder, a psychotic disorder, pervasive developmental disorder, substance use, or general medical condition.

Obsessive-Compulsive Disorder

Obsessions

- Recurrent and persistent thoughts, impulses, or images that are experienced as intrusive and inappropriate, causing anxiety or distress.
- The thoughts, impulses, or images are not simply excessive worries about real-life problems.
- The person attempts to ignore or suppress such thoughts, impulses, or images or to neutralize them with some other thought or action.
- The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind.

Compulsions

- Repetitive behaviours or mental acts that the person feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
- The behaviours or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation.
- These behaviours or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent, or they are clearly excessive.
- At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable.
- The obsessions or compulsions cause marked distress, take up more than 1 hour a day, or significantly interfere with the person's normal routine, occupation, or usual social activities.
- If another Axis I disorder, substance use, or general medical condition is present, the content of the obsessions or compulsions is not restricted to it.

Next

Social Anxiety Disorder

A fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others and feels he or she will act in an embarrassing manner. Exposure to the feared social situation provokes anxiety, which can take the form of a panic attack. The person recognizes that the fear is excessive or unreasonable. The feared social or performance situations are avoided or are endured with distress. The avoidance, anxious anticipation, or distress in the feared situation interferes significantly with the person's normal routine, occupational functioning, or social activities or relationships. The condition is not better accounted for by another mental disorder, substance use, or general medical condition If a general medical condition or another mental disorder is present, the fear is unrelated to it. The phobia may be considered generalized if fears include most social situations.

Anxiety Assessment Tools

Scared Questionnaire
Parent

Weiss
Symptom Record (WSR)

Scared Questionnaire
Child / Youth

Weiss
Instructions

Children's Yale-Brown
Obsessive Compulsive Scale

Social Anxiety Scale
for Adolescents (K-GSADS-A)

A GPSC Initiative

SCARED – Child Version

Pg. 1 of 3 (To be filled out by the CHILD/TEEN) (Birmaher, Kheterpal, Cully, Brent and McKenzie, 1995)

Name:
Date:

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last 3 months.

	0 Not True Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1. When I feel frightened, it is hard to breathe.			
2. I get headaches when I am at school.			
3. I don't like to be with people I don't know well.			
4. I get scared if I sleep away from home.			
5. I worry about other people liking me.			
6. When I get frightened, I feel like passing out.			
7. I am nervous.			
8. I follow my mother or father wherever they go.			
9. People tell me that I look nervous.			
10. I feel nervous with people I don't know well.			
11. I get stomachaches at school.			
12. When I get frightened, I feel like I am going crazy.			
13. I worry about sleeping alone.			
14. I worry about being as good as other kids.			
15. When I get frightened, I feel like things are not real.			
16. I have nightmares about something bad happening to my parents.			
17. I worry about going to school.			
18. When I get frightened, my heart beats fast.			
19. I get shaky.			
20. I have nightmares about something bad happening to me.			

SCARED -– Child Version

Pg. 2 of 3 (To be filled out by the CHILD/TEEN)

	0 Not True Or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21. I worry about things working out for me.			
22. When I get frightened, I sweat a lot.			
23. I am a worrier.			
24. I get really frightened for no reason at all.			
25. I am afraid to be alone in the house.			
26. It is hard for me to talk with people I don't know well.			
27. When I get frightened, I feel like I am choking.			
28. People tell me that I worry too much.			
29. I don't like to be away from my family.			
30. I am afraid of having anxiety (or panic) attacks.			
31. I worry that something bad might happen to my parents.			
32. I feel shy with people I don't know well.			
33. I worry about what is going to happen in the future.			
34. When I get frightened, I feel like throwing up.			
35. I worry about how well I do things.			
36. I am scared to go to school.			
37. I worry about things that have already happened.			
38. When I get frightened, I feel dizzy			
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport.)			
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.			
41. I am shy.			

SCARED Scoring – This page is for office use only – do not distribute to parent/caregiver

SCORING:
A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher that 30 are more specific. 0
A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**. 0
A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**. 0
A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety Disorder**. 0
A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**. 0
A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**. 0
**For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.*

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pgh. (10/95). E-mail: birmaherb@msx.upmc.edu

A GPSC Initiative

Screen for Child Anxiety Related Disorders (SCARED) – Parent Version

Pg. 1 of 2 (To be filled out by the PARENT) (Birmaher, Kheterpal, Cully, Brent and McKenzie, 1995)

Name:
Date:

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last 3 months.

	0 Not True Hardly Ever True	**1 Somewhat True or Sometimes True**	**2 Very True or Often True**
1. When my child feels frightened, it is hard for him/her to breathe.			
2. My child gets headaches when he/she is at school.			
3. My child doesn't like to be with people he/she doesn't know well.			
4. My child gets scared if he/she sleeps away from home.			
5. My child worries about other people liking him/her.			
6. When my child gets frightened, he/she feels like passing out.			
7. My child is nervous.			
8. My child follows me wherever I go.			
9. People tell me that my child looks nervous.			
10. My child feels nervous with people he/she doesn't know well.			
11. My child gets stomachaches at school.			
12. When my child gets frightened, he/she feels like he/she is going crazy.			
13. My child worries about sleeping alone.			
14. My child worries about being as good as other kids.			
15. When he/she gets frightened, he/she feels like things are not real.			
16. My child has nightmares about something bad happening to his/her parents.			
17. My child worries about going to school.			
18. When my child gets frightened, his/her heart beats fast.			
19. He/she gets shaky.			
20. My child has nightmares about something bad happening to him/her.			
21. My child worries about things working out for him/her.			

Screen for Child Anxiety Related Disorders (SCARED) – Parent Version

Pg. 2 of 2 (To be filled out by the PARENT)

	0 Not True Or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
22. When my child gets frightened, he/she sweats a lot.			
23. My child is a worrier.			
24. My child gets really frightened for no reason at all.			
25. My child is afraid to be alone in the house.			
26. It is hard for my child to talk with people he/she doesn't know well.			
27. When my child gets frightened, he/she feels like he/she is choking.			
28. People tell me that my child worries too much.			
29. My child doesn't like to be away from his/her family.			
30. My child is afraid of having anxiety (or panic) attacks.			
31. My child worries that something bad might happen to his/her parents.			
32. My child feels shy with people he/she doesn't know well.			
33. My child worries about what is going to happen in the future.			
34. When my child gets frightened, he/she feels like throwing up.			
35. My child worries about how well he/she does things.			
36. My child is scared to go to school.			
37. My child worries about things that have already happened.			
38. When my child gets frightened, he/she feels dizzy.			
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport.)			
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well.			
41. My child is shy.			

SCORING for SCARED - Parent:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher that 30 are more specific. 0

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**. 0

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**. 0

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety Disorder**. 0

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**. 0

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**. 0

**For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.*

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pgh. (10/95). E-mail: birmaherb@msx.upmc.edu

Kutcher Generalized Social Anxiety Disorder Scale for Adolescents (K-GSADS-A)

Section A: Fear and Avoidance

Scoring: 0 = Never; 1 = Mild; 2 = Moderate; 3 = Severe/Total Avoidance

	Item	Discomfort, Anxiety, Distress (0-3)	Avoidance (0-3)
1	Initiating conversation with a member of the opposite sex		
2	Attending a party or other social gathering with people you don't know very well		
3	Speaking up, answering questions in class/participating in class discussions		
4	Presenting in front of a small group or in a classroom setting		
5	Attending overnight group activities such as camps, school trips, etc.		
6	Speaking to a store clerk, bank teller, etc.		
7	Asking a stranger for directions		
8	Changing in a common locker room		
9	Showering in a common shower room		
10	Using a public toilet facility or urinating in public (score whatever is greater)		
11	Telephoning to ask for information or to speak to someone you don't know very well (score whatever is greater)		
12	Entering a classroom or social group once the class or activity is already underway		
13	Initiating conversation with strangers		
14	Speaking with authority figures: i.e. teachers, counselor, principal, police officers, clergy, physician, etc.		
15	Eating in public		
16	Going to a party alone		
17	Asking someone for a date		
18	Writing your name in public		

Section B: Fear/Avoidance - Seminal Items

What are your three most feared social situations and how strong is the fear/avoidance of each
Scoring: 0 = Never; 1 = Mild; 2 = Moderate; 3 = Severe/Total Avoidance

	Fear	Avoidance (0-3)
1		
2		
3		

Section C: Distress Quotient

In general, how strongly do these items occur to you in most social situations?
Scoring: 0 = Never; 1 = Mild; 2 = Moderate; 3 = Severe/Total Avoidance

	Item	Score (0 - 3)
1	Feeling embarrassed or humiliated	
2	Feeling 'centered out', scrutinized by others	
3	Feeling judged or critically evaluated by others	
4	Wanting to leave the social situation	
5	Anxious anticipation of social situation	
6	Experiences a panic attack	
7	Blushes	
8	Sweats or hot/cold flashes	
9	Urination urges	
10	Gastrointestinal distress	
11	Trembling or shaking	

Subscale scores and Total Score:

SS1: Fear and Anxiety Score (Items A 1-18, anxiety column)	
SS2: Avoidance Score (Items A 1-18, avoidance column)	
SS3: Affective Distress Score (Items C 1-5)	
SS4: Somatic Distress Score (Items C 6-11)	
Total K-GSADS-A Score (SS1 + SS2 + SS3 + SS4)	

Interpretation of scores: There are no validated diagnostic categories associated with particular ranges of scores. All scores should be assessed relative to an individual patient's baseline score (higher scores indicating worsening social phobia, lower scores suggesting possible improvement).

CADDRA
CANADIAN ADHD RESOURCE ALLIANCE

WSR Instructions

Patient Name:
Date of Birth: MRN/File No:
Physician Name: Date:

Weiss Symptom Record (WSR)

Instructions to Informant: *Check the box that best describes typical behavior* ***Instructions to Physician:*** *Symptoms rated 2 or 3 are positive and total count completed below*	Not at all (0)	Somewhat (1)	Pretty much (2)	Very much (3)	N/A	# items scored 2 or 3 (DSM Criteria)
ADHD COMBINED TYPE 314.01						**≥6/9 IA & HI**
ATTENTION 314.00						
Fails to give close attention to details, careless mistakes						
Difficulty sustaining attention in tasks or fun activities						
Does not seem to listen when spoken to directly						
Does not follow through on instructions and fails to finish work						
Difficulting organizing tasks and activities						
Avoids tasks that require sustained mental effort (boring)						
Losing things						
Easily distracted						
Forgetful in daily activities						/9 (≥6/9)
HYPERACTIVE/IMPULSIVE 314.01						
Fidgety or squirms in seat						
Leaves seat when sitting is expected						
Feels restless						
Difficulty in doing fun things quietly						
Always on the go or acts as if "driven by a motor"						
Talks excessively						
Blurts answers before questions have been completed						
Difficulty awaiting turn						
Interrupting or intruding on others						/9 (≥6/9)
OPPOSITIONAL DEFIANT DISORDER 313.81						
Loses temper						
Argues with adults						
Actively defies or refuses to comply with requests or rules						
Deliberately annoys people						
Blames others for his or her mistakes or misbehaviour						
Touchy or easily annoyed by others						
Angry or resentful						
Spiteful or vindictive						/8 (≥4/8)

	Not at all (0)	Somewhat (1)	Pretty much (2)	Very much (3)	N/A	Diagnoses
CONDUCT DISORDER 312.8						**SEVERITY**
Bullies, threatens, or intimidates others						
Initiates physical fights						
Has used a weapon (bat, brick, bottle, knife, gun)						
Physically cruel to people						
Physically cruel to animals						
Stolen while confronting a victim						
Forced someone into sexual activity						
Fire setting with the intent of damage						
Deliberately destroyed others' property						
Broken into a house, building, or car						
Often lies to obtain goods or benefits or avoid obligations						
Stealing items of nontrivial value without confronting victim						
Stays out at night despite prohibitions						
Run away from home overnight at least twice						
Truant from school						/15(≥3/15)
ANXIETY						
Worries about health, loved ones, catastrophe						300.02
Unable to relax; nervous						300.81
Chronic unexplained aches and pains						300.30
Repetitive thoughts that make no sense						
Repetitive rituals						300.01
Sudden panic attacks with intense anxiety						300.23
Excessively shy						
Refusal to do things in front of others						309.21
Refusal to go to school, work or separate from others						300.29
Unreasonable fears that interfere with activities						312.39
Pulls out hair, eyebrows						
Nail biting, picking						
Refusal to talk in public, but talks at home						mutism
DEPRESSION 296.2 (single) .3 (recurrent)						
Has been feeling sad, unhappy or depressed	Yes		No	Must be present		
No interest or pleasure in life	Yes		No	Must be present		
Feels worthless						
Has decreased energy and less productive						
Hopeless and pessimistic about the future						
Excessive feelings of guilt or self blame						
Self-injurious or suicidal thoughts						
Social withdrawal						
Weight loss or weight gain						
Change in sleep patterns						≥5/9>2wks

	Not at all (0)	Somewhat (1)	Pretty much (2)	Very much (3)	N/A	Diagnoses
DEPRESSION (CONT'D)						**SEVERITY**
Agitated or sluggish, slowed down						
Decreased concentration or indecisiveness						
Past suicide attempts	#		Serious			
MANIA 296.0(manic) .6(mixes) .5(depressed)						
Distinct period of consistent elevated or irritable mood		Yes	No		Must be present	
Grandiose, sudden increase in self esteem						
Decreased need for sleep						
Racing thoughts						
Too talkative and speech seems pressured						
Sudden increase in goal directed activity, agitated						≥3 >1wk
High risk activities (spending money, promiscuity)						/3 (≥3)
SOCIAL SKILLS 299						
Makes poor eye contact or unusual body language						
Failure to make peer relationships						
Lack of spontaneous sharing of enjoyment						
Lacks reciprocity or sensitivity to emotional needs of others						
Language delay or lack of language communication						
Difficulty communicating, conversing with others						
Speaks in an odd, idiosyncratic or monotonous speech						
Lack of creative, imaginative play or social imitation						
Intensely fixated on one particular interest						
Rigid sticking to nonfunctional routines or rituals						
Preoccupied with objects and parts of objects						
Repetitive motor mannerisms (hand flapping, spinning)						
PSYCHOSIS 295						
Has disorganized, illogical thoughts						
Hears voices or sees things						
Conviction that others are against or will hurt them						
People can read their thoughts, or vice versa						
Belief that the television is talking specifically to them						
A fixed belief that is out of touch with reality						
Thought sequence does not make sense						
SUBSTANCE ABUSE						
Excessive alcohol (> 2 drinks/day, > 4 drinks at once)						305
Smokes cigarettes						
Daily marijuana use						
Use of any other street drugs						
Abuse of prescription drugs						

	Not at all (0)	Somewhat (1)	Pretty much (2)	Very much (3)	N/A	Diagnoses
SLEEP DISORDERS 307.4						**SEVERITY**
Agitated or sluggish, slowed down						
Has difficulty falling asleep						
Has difficulty staying asleep						
Has abnormal sleep patterns during the day						347
Unanticipated falling asleep during the day						307.4
Sleep walking						307.4
Has nightmares						307.45
Falls asleep late and sleeps in late						3.27
Sleep schedule changes from day to day						
Excessive snoring						
A feeling of restless legs while trying to sleep						
Observed to have sudden kicking while asleep						780.57
Observed to have difficulty breathing at night						
ELIMINATION DISORDERS 307						
Wets the bed at night						
Wets during the day						
Soils self						
EATING DISORDERS 307						
Vomits after meals or binging						
Underweight and refuses to eat						307.1
Distorted body image						
Picky eater						
High junk food diet						
LEARNING DISABILITIES 315						
Delayed expressive language						
Stuttering						
Problems articulating words						315
Below grade level in reading						315.1
Below grade level in math						315.2
Trouble with writing (messy, tiring, avoids writing)						
Variable performance in school						
Underachieves at school relative to potential						315.4
DEVELOPMENTAL COORDINATION DISORDER						
Difficulty with gross motor skills (i.e. gym, sports, biking)						
Clumsy						
Difficulty with fine motor (buttons, shoe laces, cutting)						

	Not at all (0)	Somewhat (1)	Pretty much (2)	Very much (3)	N/A	Diagnoses
PERSONALITY 301						**SEVERITY**
Unstable interpersonal relationships						
Frantic efforts to avoid abandonment						
Recurrent suicidal ideation or attempts						
Intense anger						
Major mood swings						BPD 301.83
Impulsive self destructive or self injurious behavior						
Fragile identity or self image						
Chronic feelings of emptiness						
Transient stress related dissociation or paranoia						/9 (≥5/9)
Self centred or entitled						NPD 301.81
Deceitful, aggressive, or lack of remorse						ASP 301.7
COMMENTS:						

ADHD=attention deficit hyperactivity disorder; IA=inattentive subtype; HI=hyperactive impulsive subtype; BPD=borderline personality disorder; NPD=narcissistic personality disorder; ASP=antisocial personality disorder.

CADDRA
CANADIAN ADHD RESOURCE ALLIANCE

WSR Checklist

Weiss Symptom Record (WSR) Instructions

Purpose

- To collect systematic information from the patient and other informants about various disorders, including learning, developmental and personality difficulties
- To serve as a cross check to assist clinicians in focusing their mental status, assuring that they do not miss relevant but unusual comorbidities, and in differentiating disorders which have significant symptom overlap
- This screener is not 'diagnostic'.

Unique Characteristics

- Since this symptom record can be completed by any informant, it enables a rapid comparison of symptom profiles across settings
- Items scored as 'pretty much' or 'very much' are in shaded columns so that quick scanning of the screener enables rapid identification of problematic symptom groupings
- Items are translated into simple language for ease of use
- Item selection attempted to assure not only sensitivity to identification of comorbid disorders, but also selection of items that would assist in differentiating those symptoms that are specific to one disorder and assist in differentiating it from another overlapping problem
- The formulation of items on the Weiss Symptom Record was based on DSM-IV criteria.[1]

Scoring

This is not a psychometrically validated instrument but a clinical record of the DSM-IV criteria for various disorders. The DSM-IV criteria for diagnosis for each disorder are listed in the column labelled 'Diagnosis'. Answers should be scored as follows: Not at all = 0, Somewhat = 1, Pretty Much = 2, Very Much = 3.

Copyright Information

[1] In the development of this screener DSM-IV diagnostic criteria were used with permission of the American Psychiatric Press.

CY-BOCS Symptom Checklist

Children's Yale-Brown Obsessive Compulsive Scale

Administering the CY-BOCS Symptom Checklist and CY-BOCS Severity Ratings

1. Establish the diagnosis of obsessive compulsive disorder.
2. Using the CY-BOCS Symptom Checklist (below), ascertain current and past symptoms.
3. Next, administer the 10 item severity ratings (other form) to assess the severity of the OCD during the last week.
4. Re-administer the CY-BOCS Severity Rating Scale to monitor progress.

Patient _____ Date _____

Obsessions Checklist

Compulsions Checklist

CY-BOCS Symptom Checklist

Children's Yale-Brown Obsessive Compulsive Scale

CY-BOCS Obsessions Checklist

Check all symptoms that apply (Items marked "*" may or may not be OCD Phenomena)

Current	Past	Contamination Obsessions
☐	☐	Concern with dirt, germs, certain illnesses (e.g., AIDS)
☐	☐	Concerns or disgust with bodily waste or secretions (e.g. urine, feces, saliva)
☐	☐	Excessive concern with environmental contaminants (e.g., asbestos, radiation, toxic waste)
☐	☐	Excessive concern with household items (e.g., cleaners, solvents)
☐	☐	Excessive concern about animals / insects
☐	☐	Excessively bothered by sticky substances or residues
☐	☐	Concerned will get ill because of contaminant
☐	☐	Concerned will get others ill by spreading contaminant (aggressive)
☐	☐	No concern with consequences of contamination other than how it might feel *
☐	☐	Other (describe) _____
		Aggressive Obsessions
☐	☐	Fear might harm self
☐	☐	Fear might harm others
☐	☐	Fear harm will come to self
☐	☐	Fear harm will come to others (maybe because of something child did or did not do)
☐	☐	Violent or horrific images
☐	☐	Fear of blurting out obscenities or insults
☐	☐	Fear of doing something embarrassing *
☐	☐	Fear will act on unwanted impulses (e.g., to stab a family member)
☐	☐	Fear will steal things
☐	☐	Fear will be responsible for something else terrible happening (e.g. ,fire, burglary, flood)
☐	☐	Other (describe) _____

Current	Past	Sexual Obsessions
☐	☐	Forbidden or perverse sexual thoughts, images, impulses
☐	☐	Content involves homosexuality
☐	☐	Sexual behavior towards others (aggressive)
☐	☐	Other (describe) _____
		Hoarding / Saving Obsessions
☐	☐	Fear of losing things
☐	☐	Other (describe) _____
		Magical Thoughts / Superstitious Obsessions
☐	☐	Lucky / unlucky numbers, colors, words
☐	☐	Other (describe) _____
		Somatic Obsessions
☐	☐	Excessive concern with illness or disease *
☐	☐	Excessive concern with body part or aspect of appearance (e.g. dysmorphophobia) *
☐	☐	Other (describe) _____
		Religious Obsessions
☐	☐	Excessive concern or fear of offending religious objects
☐	☐	Excessive concern with right / wrong morally
☐	☐	Other (describe) _____
		Miscellaneous Obsessions
☐	☐	The need to know or remember
☐	☐	Fear of saying certain things
☐	☐	Fear of not saying just the right thing
☐	☐	Intrusive (non-violent) images
☐	☐	Intrusive sounds, words, music or numbers
☐	☐	Other (describe) _____

Compulsions Checklist

Target Symptom List for Obsessions

OBSESSIONS (describe, listing by order of severity, with #1 being the most sever, #2 second most severe, etc):

1. _____
2. _____
3. _____
4. _____

CY-BOCS Symptom Checklist

Children's Yale-Brown Obsessive Compulsive Scale

CY-BOCS Compulsions Checklist

Check all symptoms that apply (Items marked "*" may or may not be OCD Phenomena)

Current	Past	Washing / Cleaning Compulsions
☐	☐	Excessive or ritualized hand washing
☐	☐	Excessive or ritualized showering, bathing, tooth brushing, grooming, toilet routine
☐	☐	Excessive cleaning of items, such as personal clothes or important objects
☐	☐	Other measures to prevent or remove contact with contaminants
☐	☐	Other (describe) _____
		Checking Compulsions
☐	☐	Checking locks, toys, school books / items, etc.
☐	☐	Checking associated with getting washed, dressed, or undressed
☐	☐	Checking that did not / will not harm others
☐	☐	Checking that did not / will not harm self
☐	☐	Checking that nothing terrible did / will happen
☐	☐	Checking that did not make mistake
☐	☐	Checking tied to somatic obsessions
☐	☐	Other (describe) _____
		Repeating Rituals
☐	☐	Rereading, erasing, or rewriting
☐	☐	Need to repeat activities (e.g. in / out of doorway, up / down from chair)
☐	☐	Other (describe) _____
		Counting Compulsions
☐	☐	Objects, certain numbers, words, etc.
☐	☐	Other (describe) _____
		Ordering / Arranging
☐	☐	Need for symmetry / evening up (e.g. lining items up a certain way or arranging personal items in specific patterns)
☐	☐	Other (describe) _____

Obsessions Checklist

Current	Past	Hoarding / Saving Compulsions
		Distinguish from hobbies and concern with objects of monetary or sentimental value.
☐	☐	Difficulty throwing things away, saving bits of paper, string, etc.
☐	☐	Other (describe) _____
		Excessive Games / Superstitious Behaviors
☐	☐	Distinguish from age appropriate magical games (e.g. array of behavior, such as sleeping over certain spots on a floor, touching an object / self certain number of times as a routine game to avoid something bad from happening
☐	☐	Other (describe) _____
		Rituals Involving Other Persons
☐	☐	The need to involve another person (usually a parent) in ritual (e.g. asking a parent to repeatedly answer the same question, making mother perform certain mealtime rituals involving specific utensils) *
☐	☐	Other (describe) _____
		Miscellaneous Compulsions
☐	☐	Mental rituals other than checking / counting
☐	☐	Need to tell, ask or confess
☐	☐	Measures (not checking) to prevent :
☐	☐	harm to self
☐	☐	harm to others
☐	☐	terrible consequences
☐	☐	Ritualized eating behaviors *
☐	☐	Excessive list making *
☐	☐	Need to touch, tap, rub *
☐	☐	Need to do things (e.g. touch or arrange until it feels just right) *
☐	☐	Rituals involving blinking or staring *
☐	☐	Trichotillomania (hair-pulling)
☐	☐	Other self-damaging or self-mutilating behaviors *
☐	☐	Other (describe) _____

CY-BOCS Symptom Checklist

Children's Yale-Brown Obsessive Compulsive Scale

Target Symptom List for Compulsions

COMPULSIONS (describe, listing by order of severity, with #1 being the most sever, #2 second most severe, etc):

1. _____

2. _____

3. _____

4. _____

CY-BOCS Severity Ratings

Children's Yale-Brown Obsessive Compulsive Scale

Administering the CY-BOCS Symptom Checklist and CY-BOCS Severity Ratings

1. Establish the diagnosis of obsessive compulsive disorder.
2. Using the CY-BOCS Symptom Checklist (other form), ascertain current and past symptoms.
3. Next, administer the 10-item severity ratings (below) to assess the severity of the OCD during the last week.
4. Readminister the CY-BOCS Severity Rating Scale to monitor progress.

Patient _____

Date 1st Report _____ Date This Report _____

Obsession Rating Scale (circle appropriate score)

Note: Scores should reflect the composite effect of all the patient's obsessive compulsive symptoms.
Rate the average occurrence of each item during the prior week up to and including the time of interview.

QUESTIONS ON OBSESSIONS (ITEMS 1-5) *"I AM NOW GOING TO ASK YOU QUESTIONS ABOUT THE THOUGHTS YOU CANNOT STOP THINKING ABOUT."*
(Review for the informant(s) the Target Symptoms and refer to them while asking questions 1-5).

1. Time Occupied by Obsessive Thoughts

[Be sure to exclude ruminations and preoccupations which, unlike obsessions, are ego-syntonic and rational (but exaggerated)]

	None	Mild	Moderate	Severe	Extreme
		less than 1 hr/day or occasional intrusion	1 to 3 hrs/day or frequent intrusion	greater than 3 and up to 8 hrs/day or very frequent intrusion	greater than 8 hrs/day or near constant intrusion
Score	0	1	2	3	4

2. Interference Due to Obsessive Thoughts

- How much do these thoughts get in the way of school or doing things with friends?
- Is there anything that you don't do because of them? (If currently not in school, determine how much performance would be affected if patient were in school)

	None	Mild	Moderate	Severe	Extreme
		slight interference with social or school activities, but overall performance not impaired	definite interference with social or school performance, but still manageable	causes substantial impairment in social or school performance	incapacitating
Score	0	1	2	3	4

3. Distress Associated with Obsessive Thoughts

	None	Mild	Moderate	Severe	Extreme
		infrequent, and not too disturbing	frequent, and disturbing, but still manageable	very frequent, and very disturbing	near constant, and disabling distress/frustration
Score	0	1	2	3	4

4. Resistance Against Obsessions

- How hard do you try to stop the thoughts or ignore them? (Only rate effort made to resist, not success or failure in actually controlling the obsessions. If the obsessions are minimal, the patient may not feel the need to resist them. In such cases, a rating of "0" should be given.)

	None	Mild	Moderate	Severe	Extreme
	makes an effort to always resist, or symptoms so minimal doesn't need to actively resist	tries to resist most of the time	makes some effort to resist	yields to all obsessions without attempting to control them, but does so with some reluctance	completely and willingly yields to all obsessions
Score	0	1	2	3	4

5. Degree of Control Over Obsessive Thoughts

	Complete Control	Much Control	Moderate Control	Little Control	No Control
		usually able to stop or divert obsessions with some effort and concentration	sometimes able to stop or divert obsessions	rarely successful in stopping obsessions, can only divert attention with difficulty	experienced as completely involuntary, rarely able to even momentarily divert thinking
Score	0	1	2	3	4

Obsession subtotal (add items 1-5) _____

QUESTIONS ON COMPULSIONS (ITEMS 6-10) *"I AM NOW GOING TO ASK YOU QUESTIONS ABOUT THE HABITS YOU CAN'T STOP"*
(Review for the informant(s) the Target Symptoms and refer to them while asking questions 6-10)

6. Time Spent Performing Compulsive Behaviors

	None	Mild less than 1 hr/day	Moderate 1 to 3 hrs/day	Severe greater than 3 & up to 8 hrs/day	Extreme greater than 8 hrs/day
Score	0	1	2	3	4

7. Interference Due to Compulsive Behaviors

- How much do these habits get in the way of school or doing things with friends?
- Is there anything you don't do because of them? (If currently not in school, determine how much performance would be affected if patient were in school.)

	None	Mild slight interference with social or school activities, but overall performance not impaired	Moderate definite interference with social or school performance, but still manageable	Severe causes substantial impairment in social or school performance	Extreme incapacitating
Score	0	1	2	3	4

8. Distress Associated with Compulsive Behavior

- How would you feel if prevented from carrying out your habits? How upset would you become?

	None	Mild only slightly anxious if compulsions prevented	Moderate anxiety would mount but remain manageable if compulsions prevented	Severe prominent and very disturbing increase in anxiety if compulsions interrupted	Extreme incapacitating anxiety from any intervention aimed at modifying activity
Score	0	1	2	3	4

9. Resistance Against Compulsions

- How much do you try to fight the habits? (Only rate effort made to resist, not success or failure in actually controlling the compulsions.)

	None makes an effort to always resist, or symptoms so minimal doesn't need to actively resist	Mild tries to resist most of the time	Moderate makes some effort to resist	Severe yields to all obsessions without attempting to control them, but does so with some reluctance	Extreme completely and willingly yields to all obsessions
Score	0	1	2	3	4

10. Degree of Control Over Compulsive Thoughts

- How strong is the feeling that you have to carry out the habit(s)?
- When you try to fight them, what happens?

	Complete Control	Much Control experiences pressure to perform the behavior, but usually able to exercise voluntary control over it	Moderate Control moderate control, strong pressure to perform behavior, can control it only with difficulty	Little Control little control, very strong drive to perform behavior, must be carried to completion, can only delay with difficulty	No Control no control, drive to perform behavior experienced as completely involuntary and overpowering, rarely able to delay activity [even momentarily]
Score	0	1	2	3	4

Compulsion subtotal (add items 6-10) _____

CY-BOCS total (add items 1-10) ☐

Total CY-BOCS score: range of severity for patients who have both obsessions and compulsions

0-7	**Subclinical**	**24-31**	**Severe**
8-15	**Mild**	**32-40**	**Extreme**
16-23	**Moderate**		

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ANXIETY

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RESOURCES.RESULTS.RELIEF.

Talking to Your Child or Teen about Anxiety

Why is it important to talk about anxiety?

Children and teens often don't recognize their anxiety for what it is. Instead, they may think there is something "wrong" with them. Children may focus on the physical symptoms of anxiety (e.g. stomachaches). Teens may think they are weird, weak, out of control, or even going crazy! These thoughts might make them feel even *more* anxious and self-conscious. Therefore, the first step is to teach your child about anxiety and how to recognize it. Self-awareness is essential!

The Facts!

Myth: Talking to your child about anxiety will make them even MORE anxious.

Fact: Providing accurate information about anxiety can reduce confusion or shame. Explain that anxiety is a common and normal experience, and it can be managed successfully! Once your child understands this, he or she will feel more motivated to make life easier.

How to do it:

There are three steps to introducing the topic of anxiety to your child:

Step 1: Encouraging your child to open up about any fears and worries

Step 2: Teaching your child about anxiety

Step 3: Helping your child recognize anxiety

Step 1: Encouraging your child to open up about worries and fears:

- Start by describing a recent situation when you observed some signs of anxiety in your child. "*Yesterday, when Sarah came over, you seemed very quiet and you just sat beside Mom. It seemed you may have been a bit nervous about having a visitor in our house. What was that like for you*?"

- Tell your child about some things you were scared of when you were the same age (especially if you shared the same types of fears), and ask if he or she has any similar worries or fears.

- Ask what worries him or her the most. You may have to prompt younger children by offering an example such as: *"I know some kids are scared of ___, do you have that fear too?"* Being specific can help your child sort through confusing fears and feelings.

- When your child expresses anxiety or worry, offer reassurance by saying you believe him or her, and that having those feelings is okay. Remember, your child will take cues from you.

Show acceptance of worry thoughts and anxious feelings. If you stay calm, it will help your child stay calm, too!

- **Tip:** Does hearing "*Don't worry. Relax*!" help you when you're anxious about something? It probably doesn't comfort your child much, either. It's important to acknowledge that your child's fears are real. Your empathy will increase the chances that your child will accept your guidance, and discuss his or her fears with you in the future..

Step 2: Teaching Your Child about Anxiety:

Four important points to communicate to your child:

1. Anxiety is normal. Everyone experiences anxiety at times. For example, it is normal to feel anxious when on a rollercoaster, or before a test. Some teens may appreciate some facts about how common anxiety problems are. For example, "*Did you know that one-in-seven children under 18 will suffer from a real problem with anxiety?*"

2. Anxiety is not dangerous. Though anxiety may feel uncomfortable, it doesn't last long, is temporary, and will eventually decrease! Also, most people cannot tell when you are anxious (except those close to you such as your parents).

3. Anxiety is adaptive. Anxiety helps us prepare for real danger (such as a bear confronting us in the woods) or for performing at our best (for example, it helps us get ready for a big game or speech). When we experience anxiety, it triggers our "fight-flight-freeze" response and prepares our bodies to defend themselves. For instance, our heart beats faster to pump blood to our muscles so we have the energy to run away or fight off danger. When we freeze, we may not be noticed, allowing the danger to pass. This response is also called "anxious arousal". Without anxiety, humans would not have survived as a species!

How you can explain the Fight-Flight-Freeze response to a child:

"Imagine you are hiking in the woods and you come across a bear. What is the first thing you would do? You may run away from the bear, or you may simply freeze. Another reaction is to yell and wave your arms to appear big and scary. There are three ways humans react to danger: fight, flee, or freeze. When we are anxious, we react in one of these ways, too. We may run away or avoid situations that make us anxious. Or we may freeze, such as when our minds go blank and we can't think clearly. Or we may fight, get angry and lash out at people. Can you think of some ways you may fight, flee, or freeze because of anxious feelings?"

How to explain "anxious arousal" to a teen:

Sometimes when we sense something is dangerous or threatening, we automatically go into a state called "anxious arousal". This can happen when there is a real danger, but also when something simply *feels* dangerous, but really isn't, such as giving an oral presentation in class, or…(give an example of something relevant to your child). Anxious arousal makes you feel jittery, on edge, and uncomfortable. It may also make it hard to think clearly. This feeling can become overwhelming enough that anxious people stop doing things or going places that make them feel anxious. Do you think this is happening to you?

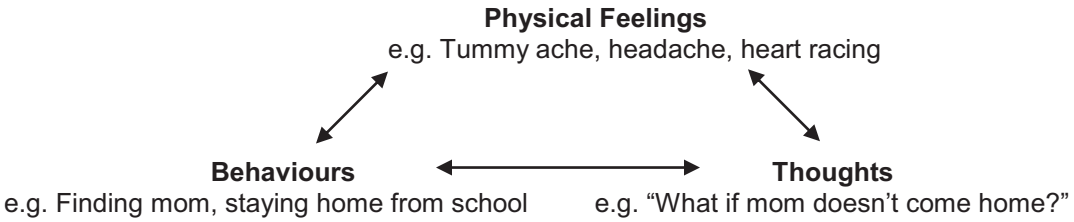
4. Anxiety can become a problem when our body reacts as if in danger in the absence of real danger. A good analogy is that it's like the body's smoke alarm.

Next

How you can explain the "smoke alarm" response:
"An alarm can help protect us when there is an actual fire, but sometimes a smoke alarm is too sensitive and goes off when there isn't really a fire (e.g. burning toast in toaster). Like a smoke alarm, anxiety is helpful when it works right. But when it goes off when there is no real danger, then we may want to fix it."

More about How Anxiety "Works"

Explain to your child the **three parts** of anxiety: **thoughts** (what we say to ourselves); **physical feelings** (how our body responds); and **behaviours** (what we do or our actions). A good way to describe the interconnection of these parts is to draw a triangle with arrows (see figure below). For example:



Step 3: Helping Your Child Recognize Anxiety

For younger children, talk about how you will both be "detectives", and how you will help your child in an "investigation" to find out more about anxiety. As detectives, find examples of how your child experiences anxiety in each of the three parts: physical symptoms, anxious thoughts, and avoidance behaviours.

Being a Detective: Recognizing Physical Symptoms
To help your child recognize physical symptoms, draw a sketch of a body and ask your child to identify where he or she feels anxiety in the body. Prompt your child, if necessary, with an example: "*When I feel anxious, I get butterflies in my tummy, and I get a big lump in my throat. What happens when you feel anxious?"* Have your child lie down on a large piece of paper (e.g. butcher's paper) and trace his or her body. You can also print and fill out **Chester the Cat** for young children, and **Where's Anxiety in my Body?** for older children. Teens may rather just talk about it, or identify their own symptoms from a list of "typical" physical symptoms.

If age-appropriate, ask your child to come up with a name for anxiety (e.g. Mr. Worry, Worry Monsters). Refer to your child's anxiety with this new name, particularly in terms of "bossing back" anxiety (e.g. "*It's just the worry monster talking. I don't have to listen!*"). Older children or teens may respond better to a music analogy, such as that the volume of their anxiety is "turned up" a bit louder than other kids. They simply need to learn to turn down the volume.

These strategies help your child adopt an observer role when dealing with anxiety, giving them a greater sense of control.

Being a Detective: Recognizing Anxious Thoughts

Younger children may sometimes have difficulty identifying their thoughts, and especially anxious thoughts. For more information, see **Healthy Thinking for Young Children.**

Older children and teens will likely be able to identify some of their anxious thoughts, and even challenge their unrealistic thoughts. For more information, see **Realistic Thinking for Teens**.

Regardless of your child's age, help your child understand that anxiety, and not actual real danger, is causing him or her to miss out on important opportunities and fun events.

Next

Being a Detective: Recognizing Avoidance
Ask your child to come up with as many answers as possible to the following:

If you woke up tomorrow morning and all your anxiety had magically disappeared, what would you do?
How would you act?
How would your family know you weren't anxious? (Your teacher? your friends?)

Finish the following sentences:

My anxiety stops me from....
When I am not anxious, I will be able to...

Once your child has gone through these three steps, and is able to understand and recognize anxiety, your child will be better prepared to move on to the next stage - learning how to manage anxiety!

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CBIS Tools

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ANXIETY

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Mindfulness

Mindfulness Meditation

CBIS Cognition Skills

CBIS Lifestyle Skills

Introduction to Relaxation

Stress Response

- Our body has a natural, healthy mechanism for responding to perceived threats (stress), called the Fight, Flight or Freeze response.
- Our body responds by releasing chemicals (e.g., adrenaline) that cause various body systems to change, including our central nervous system. This produces many symptoms including increased heart rate, rapid breathing and increased agitation.
- Our central nervous system has two parts:

  1 The Sympathetic nervous system that stimulates the Fight, Flight or Freeze response.

  2 The Parasympathetic nervous system that triggers the relaxation/calming response.

Why Relax?

- You can't be physically relaxed (parasympathetic response) and physically stressed (sympathetic response) at the same time.
- Abdominal breathing and relaxation techniques trigger the parasympathetic response, calming your body and mind.

Orientation to Relaxation Training

- Relaxation is a skill that can be learned through repeated practice.
- We are aiming to train the relaxation response so that it becomes almost automatic.
- Initially, you may not notice any major difference in how you feel.
- During a practice session, you may experience some unusual feelings in your body, such as warmth, heaviness or a tingly sensation. These sensations are signs that your muscles are loosening and relaxing.
- Feel free to move around as much as necessary in order to maintain comfort.
- It is best to have your eyes closed during a session in order to block out visual distractions.
- Home practice should be carried out once a day. Try to establish regular times for the practice sessions. Many people find it useful to do their practice sessions at bedtime as it helps them to get to sleep easily.

Abdominal/Belly Breathing

Purpose

- Your breathing is directly related to the level of tension you carry in your body.
- If you breathe shallowly, in your chest, you will become more tense and more anxious. This kind of breathing stimulates the sympathetic branch of your nervous system, which is connected to the "fight, flight or freeze" response.
- If you breathe deeply, in your abdomen, you will become more relaxed. This type of breathing stimulates the parasympathetic nervous system, which triggers a relaxing and calming response.

Process

TO DISCOVER HOW YOU ARE BREATHING NOW:

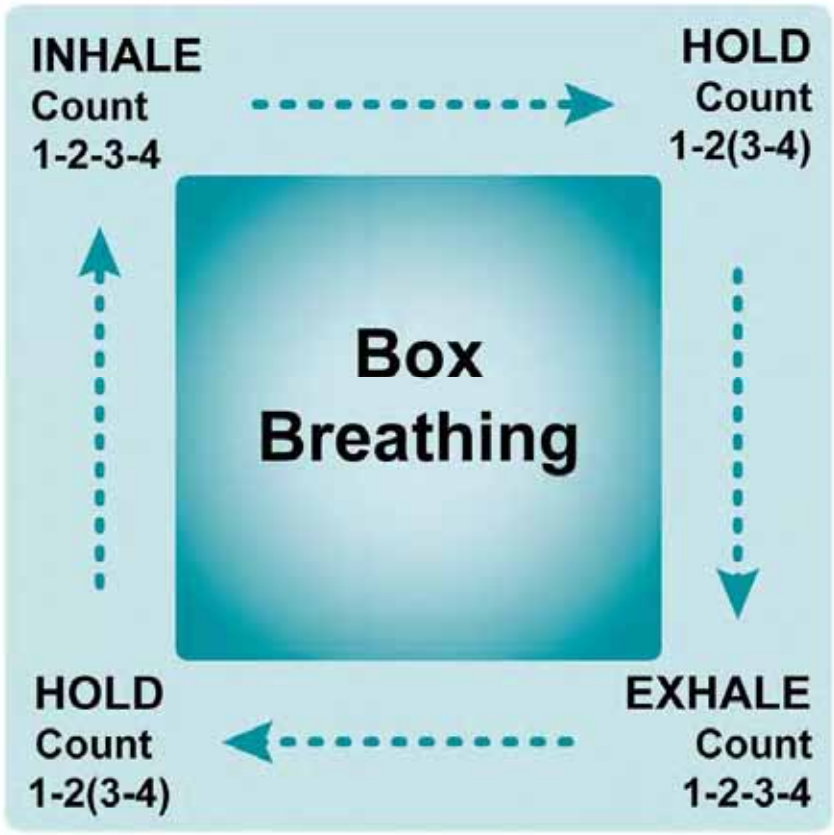
- Put one hand on your chest and one hand on your abdomen (belly). Pay attention to how you are breathing for a few moments. Observe which hand (if any) is moving.
- If it is your top hand, you are breathing mostly in your chest — shallowly. This kind of breathing will increase body tension and stress/anxiety.
- If it is your bottom hand, then you are breathing in your abdomen. This will help you to relax and calm down.
- The idea is to learn to breathe in your abdomen more.

PRACTICING BREATHING: *try listening to some low-energy relaxing music (ie. trance, classical, jazz or meditation tracks)

- When practicing abdominal breathing, put both hands on your abdomen and close or lower your eyes.
- First, breathe out fully. Then, as you breathe in, let your abdomen expand. You can imagine that you are gently filling up a balloon in your belly.
- Then just let go and feel the balloon emptying slowly and your abdomen flattening as you exhale.
- The more fully you breathe out, the easier it is to breathe in deeply.
- Practice breathing this way for 5 minutes twice a day.

Variation – Box Breathing

Box Breathing incorporates brief holding of breath following inhalation and exhalation. This is very useful during severe anxiety or panic to prevent hyperventilation.



Grounding

Purpose

- Grounding is a calming and centering method that helps you to become more focused in your body and on the present moment. It reminds you of your strength and ability to cope in the present.
- Everyone feels overwhelmed at times. It is important to self-sooth and calm your emotions by breathing and grounding.
- Statements that support successful coping help you calm down. You can resume activities when emotions have settled.

Process

- Sit in a chair with your feet flat on the floor and your hands placed palms down on the large muscles of your thighs. Gently press your feet into the floor for a few moments and release. Feel your strength.
- Alternatively, you can ground while walking or standing. Just become aware of your feet firmly planted beneath you.
- To calm the mind and help to focus in the present, take some deep breaths while repeating a calming statement. Choose one thought that you repeat each time you do the grounding, so that saying it becomes a habit. For example,

  "I AM LEARNING TO STAY IN THE PRESENT."

  "THIS IS ME. I AM HERE. I AM ALIVE. I WILL COPE."

  "I AM LEARNING TO COPE."

  "IT'S OK, IT WILL BE ALRIGHT, I AM HERE AND I AM STRONG."

  "I AM OK IN THIS MOMENT."

  "I AM ALIVE AND I WILL SURVIVE."

  "I AM STRONG AND I WILL COPE WITH WHAT COMES MY WAY."

- You could also ground by focusing on a detailed description of an object in your environment (i.e., colour and shape) and breathing.
- We all feel overwhelmed sometimes and it is important to understand that everyone takes care of themselves in stressful situations in different ways. When you are able to breathe normally again, feel less scattered, you are able to resume your activities a lot faster than were you to focus only one what you were frustrated with.
- Do not judge yourself or others for needing to take the time to ground yourself and know that the majority of people self-regulate in this way without even consciously thinking about it. You probably already know how to ground yourself in different ways, these steps are just reminders to help you approach it consciously.

Body Scan

Purpose

- Body scan is a relaxation technique that can be used to quickly check the level of tension in your body and to release it.

Process

- Body scan involves scanning your body from feet to head and doing two steps for each part:

  1 Focus on body area and note tension. (ie. head, neck, shoulders)

  2 Breathing deeply, imagine that your breath goes into that part of the body. as you breathe out, the tension is released with your breath. (visualize as the breath circulates through your body, removing and cleansing your body of the tension, released out of your mouth as you exhale.)

- You can take 5 minutes or 30 seconds to do a body scan, making use of it in a variety of settings and situations.

- A quick internal body scan can be employed anywhere, even in busy public places such as a mall, movie theatre or on a bus, wherever you feel emotionally exhausted or overwhelmed.

- There is nothing abnormal or unusual about experiencing these feelings or their intensity and that doing a body scan is a healthy, direct and effective way of coping with life's stressors.

- Electing to use relaxation and grounding tools to address your stress response is preferable to numbing your sympathetic nervous system with alcohol or drugs as you remain in control of your mind and body and can master these techniques without having to consume substances, which over time can have a negative impact on your overall health and wellbeing.)

Passive Relaxation

Purpose

- Passive relaxation is a relaxation technique that involves taking time to focus your attention on relaxing your body and mind.
- It incorporates deep breathing and body scan.
- It takes approximately 20 minutes.
- This technique is very important in learning to truly relax your muscles and engage the parasympathetic relaxation response.
- This technique needs to be practiced regularly (ideally every day; minimum 3 times per week).
- By regularly practicing a longer technique you will, with time, increase the effectiveness of the shorter techniques.

Process

- Get into a comfortable position. Close your eyes and concentrate on deep breathing for a few minutes.
- Focus your attention on each body part (feet, legs, buttocks, abdomen, back, hands, arms, shoulders, neck, jaw, eyes, scalp) and mind.
- With each part, direct your breathing there. Breathe out any tension and breathe in relaxation. Instruct each part to relax (i.e. relax feet, relax, relax).
- You may wish to listen to relaxing music, make a recording, download or rent one from the library so you can listen as another voice leads you through a relaxation script/exercise.

Variations

- You may incorporate visualization. While you are relaxed, imagine being in a special place in nature. Imagine what you see, hear, smell, taste and feel. Experience all the sensory details of your special place.
- You may also make self-statements (autogenic). Repeat to yourself:

  “My. . . . . .(name body part) is warm.”

  “My. . . . . .(name body part) is heavy.”

  “My. . . . . .(name body part) is relaxed.”

For mind, substitute words *peaceful*, *calm* and *relaxed.*

Stress Busters

Purpose

- Shorter techniques are more flexible than the longer ones. They allow you to relax and/or release tension quickly in a variety of different settings (e.g., at lunch break, at a meeting, while waiting in line at a store, at a red light etc.)
- This flexibility means that you can use these techniques to calm yourself before, during or after stressful situations, or to short-circuit a stress response.
- Different short versions will suit different situations so having a number of short versions offers you the flexibility to choose one that fits the moment best.

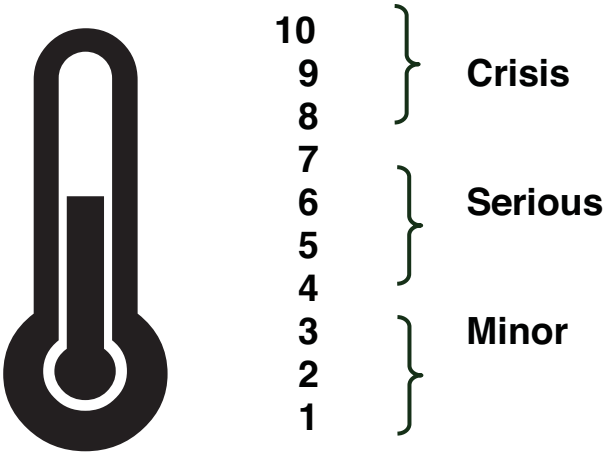
Process

- Take a few deep breaths.
- Sigh.
- Laugh.
- Yawn, unclench or move jaw.
- Shrug your shoulders several times.
- Periodically remind yourself to keep shoulders down and jaw unclenched.
- Massage your temples and the upper back of your neck.
- Raise your eyebrows and hold them up until the count of 3; release and repeat several times.
- To relieve eyestrain, rub your palms briskly together, cup hands and place them over open or closed eyes.
- With open or closed lids — rotate your eyes in circles slowly, top, right side, bottom, left side; relax and reverse. repeat 3 times.
- Neck roll: Always move your neck very gently and slowly. Let your chin drop down to the center of your chest. Keeping your chin close to your body, slowly move your head to look over your left shoulder. Slowly return to center and repeat on the right side.
- Stretch.

One Minute Stress Break

Your Emotional Thermometer

- Imagine a thermometer marked from 0-10. The highest number 10, represents the most anxious you have ever felt, 0 is the calmest, and 5 represents midway. This is your anxiety thermometer.
- The numbers 8,9,10 represent an anxiety level that is only appropriate for the most severe problems and situations. These would be situations that realistically involve a disaster that is about to happen or has already happened, such as serious accidents, fires, and illness. Events that warrant 8-10 are quite rare in most people's lives.
- The numbers 5, 6, 7, are appropriate for moderately serious events that may have significant consequences, such as missing a job interview or your car breaking down on the highway at night. Even events that warrant 5-7 on the anxiety thermometer are still fairly unusual.
- Most of the things we get anxious about on a daily basis are not serious enough to be worth high levels of anxiety. Realistically, everyday events would be somewhere between 1 and 4 on the thermometer. They may feel more intense to anxious people because they tend to react on a much higher level, even to minor events.
- Level 8-10 situations can be thought of as crisis and level 1-7 as different sized hassles.
- The next time you feel your anxiety rising, stop and ask yourself these two questions to help you calm down by putting the event in a realistic context:
  1. How serious is this, really, in terms of life and death?
  2. How much anxiety is it really worth?"



Mindfulness

Mindfulness originally came from Buddhist teachings, which advocated that one should establish mindfulness in one's day-to-day life maintaining as much as possible a calm awareness of one's body, feelings, thoughts and perceptions. Being mindful of yourself and your surroundings is being aware of the wisdom within yourself and all around you. It isn't cutting yourself off in order to 'fit in' when something doesn't feel right, or ignoring your emotions in order to 'just get on with it.' It's about learning to listen to your body, your mind and you soul's desires, your deep passions and motivations and acting in ways that honor this.

Purpose

- Mindfulness is experiencing the present moment in a non-judgmental way. it is paying attention with a welcoming and allowing attitude … noticing whatever we are experiencing in our thoughts, behaviour, and feelings.
- Making changes in our life begins with awareness. Awareness means paying attention to what we are doing, thinking and feeling. We then have the option to either accept things or change things.
- Practicing mindfulness teaches us to relax and remain alert in the midst of the problems and joys of life. It encourages us to pause in the moment and respond to life with curiosity and a welcoming attitude.
- Being mindful teaches you how to tell the difference between reality and irrational or destructive thinking, what decisions appear fine and which could hurt you later on. It's about valuing yourself and keeping things in perspective when stress puts extra demands on how we think and function

Process

- The practice of mindfulness focuses on three areas: mindfulness of bodily sensations, of feelings, and of thoughts.
- A good place to begin the practice is to become aware of your breath, simply noticing its sensations in the nose, throat, lungs, or belly. Follow the breath just as it is — long or short, deep or shallow. The goal is not to change it but only to observe and to be mindful of each breath.
- Mindfulness can then extend to noticing:
  - sensations in the body, noticing pain, pleasure, heat, cold, tension, relaxation.
  - emotions you may be experiencing such as fear, anger, sadness, happiness, etc.
  - thoughts that arise in the mind in the form of sentences, words, fragments, or images.
- The point is to fully experience and be aware of whatever may arise within you.
- This type of practice can then continue as you move through your day, being moreand more aware of your reactions and responses in all of your activities.

Mindfulness Meditation

Purpose

- Mindfulness Meditation is learning to pay attention to whatever is happening in the present moment in your mind and body. Mindfulness = Paying attention on purpose, in the present, non-judgmentally.
- To be “present” in the moment — “Here and Now” — is to be fully alive.
- Since mindfulness meditation also involves breath awareness, the parasympathetic system is stimulated, resulting in the relaxation response.
- It is a relaxation method for learning to work with the mind. It gives us a tool for gaining more perspective on our thoughts, and more acceptance of present moment reality.
- Meditation can contribute to a feeling of inner balance and peace of mind.

Process

THE SITTING PRACTICE OF “MINDFULNESS MEDITATION”

The Position/Posture:

Seat	– find a solid, grounded, stable position on a chair or cushion
	– sit out from the edge of the chair so back can be straight
	– feel body resting on the chair or cushion
	– notice the firm pressure of buttocks
	– let body relax in the position, not too tight and not too loose
Feet	– flat on floor (grounded)
Hands	– hands on thighs, palms down (grounded)
Back	– as straight as possible
Chest	– soft/open
Ears	– above shoulders
Chin	– ever so slightly in towards the chest
Jaw	– relaxed
Mouth	– slightly open, like “ah”
Tongue	– touching roof of mouth, behind teeth (less saliva)
Eyes	– eyes are open and gaze downward about 4’ in front, on the floor, using a soft focus. If you close your eyes there is a tendency to space out.

- Now as you sit there, start noticing your breath going in and out. Not forcing it or changing it — just noticing it, paying attention to it. In and out. In and out.
- Then start putting more emphasis on the out breath. Each time you breathe out, allow yourself to let go and relax.
- Occasionally check your body posture, and then go back to paying attention to your breath.

Mindfulness Meditation

Thoughts

- As you follow your breath, you will notice that thoughts will arise, and your mind will wander. That's okay and natural.
- It may be a thought, an image, or an emotion — just label it all "thinking."
- Just notice that your mind has wandered, label it "thinking" and bring your attention back to the "in and out" of the breath.
- It is important to be very kind to yourself when you notice that your mind has wandered away. Training your mind is a little like training a puppy. It does not help to be harsh with the puppy. What helps is to kindly tell the puppy to "stay" over and over again. Likewise with the mind, just notice it's wandered away, gently and kindly say to yourself "thinking" and bring your attention back to the breath.

Practice

It is helpful to set a special time aside each day to practice sitting meditation. You can start with 5 – 10 minutes a day, increasing to 20 minutes over time. it can also be helpful to practice at the same time and place each day.

Variation *

WALKING MEDITATION

Helpful tip: When you walk a labyrinth, you wander back and forth, turning 180 degrees each time you enter a different circuit. As you shift your direction you also shift your awareness from right brain to left brain. This can only happen during a deep state of relaxation and mental focus and is one of the reasons the labyrinth can induce receptive states of consciousness. Each person's walk is a personal experience and no one way is the right way. How one walks and what one receives differs with each walk; the walk can be a sacred time for you to reflect, or an ordinary time to reflect on your day and think about what lies ahead. You can clear and center your mind, or enter the labyrinth with a question or concern. Once you reach the center you can contemplate the path you walked and your passing thoughts through each circuit. The labyrinth is a physical symbol of self-reflection, honoring your life, your experiences and accomplishments. It is a time just for you and to discover your own sacred inner space. Every person can integrate the quiet meditation they have received and completed on the walk out. Remember what you can learn from yourself; you are a great teacher. Your walk can be a healing and sometimes very profound experience or it can be just a pleasant walk. Each time is different.

- Walk slowly, hands in front or by sides as you would usually walk.
- Pay attention to your body; feel a sense of ease.
- With each step, feel the sensations of lifting your food, moving it forward then placing it on the ground.
- Notice when the mind has wandered away, label it "thinking" and just bring your attention back to your body and to moving each foot.
- You can say "lifting, swinging, placing" to yourself, to help to stay focused on your body.

AnxietyBC

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Developing and Using Cognitive Coping Cards

An important tool in your child or teen's anxiety toolbox is the ability to change anxious thoughts to more relaxed and balanced thinking. However, it can be very difficult for children and teens to remember to use coping tools when they are anxious. They are so focused on their feelings of being in danger that they forget they have a way of telling whether or not danger actually exists (and it usually doesn't).

With practice, however, your child can learn to use coping thoughts on his or her own. This is really helpful as you might not always be there to remind your child to use the tools (for example, when at school, or sleeping over at a friend's house).

A good tool to help your child or teen is Cognitive Coping Cards!

What are Cognitive Coping Cards?

Cognitive coping cards can be small index cards with short sentences of some of the coping skills your child can use when experiencing anxiety. The cards are portable reminders to boss back anxiety!

What sorts of things are helpful to put onto a coping card?

- A reminder that physical symptoms (e.g., sweaty palms, stomach-aches) are just anxiety
- The name your child has given to anxiety (e.g. "Mr. Worry", "the pest", "the bug")
- A reminder that anxiety is not dangerous and doesn't last forever
- Positive coaching statements (e.g. "I can get through this!")
- A reminder to use some coping skills (e.g. I can do relaxed breathing)
- some calming facts your child or teen has used before (e.g. the odds of getting kidnapped are really low)

HOW TO DO IT!

Step 1: Make sure your child is involved

In order for coping cards to be useful, your child needs to feel that the coping statements will actually be personally helpful! Children and teens are more likely to use them if they have been involved in developing them. It is NOT a good idea for you to simply write them up and hand them over.

What to say to get your child involved:
"*You have been really good at bossing back your anxiety these days! Now we can learn another way for you to be the boss. Why don't we try to figure out some things you can tell yourself when your anxiety is acting up? We can write down some things on cards that can help you feel calm. These cards will be another tool in your anxiety-fighting toolbox!*

For teens: Although you should encourage your child to develop coping statements, older children and teens can be more independent when writing out their coping cards. They can decide what skills are most helpful for them. You can explain that when we feel anxious it is sometimes difficult to remember all the skills we've learned to battle that anxiety. Writing out those skills on coping cards might help them remember what has been helpful for them in the past, and what skills they would like to use next time.

Step 2: Make it a game!

Making up the cognitive coping cards should not be a chore! Have fun trying to come up with good statements that your child will find helpful in managing his or her anxiety. Here are some ways you can make this tool a fun task:

- **Get the family involved!** Like all the tools in the anxiety toolbox, the whole family should work together on the goal of tackling anxiety. Parents, brothers, and sisters can all get involved in making these coping cards!

- **Make it an art project!** Decorate the cards with coloured ink, sparkles, stickers, gold stars, and different colours of poster board cardboard. This turns developing and using coping cards into a fun project.

Step 3: Remember to praise your child

As always, it is very important that you give lots of praise whenever your child is successful at managing anxiety, or whenever he or she tried to manage anxiety (but was not quite able to do it). This can include saying, "You are doing a great job! I'm so proud of you", but it might also involve small, simple rewards (story time; playing a fun board game together; having a fun family day; or getting a new video game if your child has been working hard to boss back anxiety for a while).

Some examples of coping cards:

Coping card #1: Billy

Billy has panic attacks, and is afraid he is going to have a heart attack. He has started to boss back his anxiety by doing muscle relaxation, and facing his fears about his panic attack symptoms.

My Coping Card to Beat Anxiety!

1. Anxiety is not dangerous. It can't hurt me! It's just a bully!
2. I can boss back my anxiety. I have done it before!
3. If my heart is racing, I get sweaty, and my tummy hurts. That means that my anxiety is acting up. I'm not in danger.
4. I could do some relaxation now.
5. Am I falling into a Thinking Trap?*

* For more information on Thinking Traps, see **Realistic Thinking for Teens**.

Coping card #2: Susan

Susan gets very anxious when she is at school. She is worried that the other kids don't like her, and that, if they knew she had anxiety, that they would laugh at her and make fun of her. She has been learning to recognize her anxious thoughts and to try to challenge them and think of more realistic thoughts.

My Coping Card to Beat Anxiety!

1. My face is getting hot and my head is getting dizzy! My anxiety is acting up again!
2. Maybe I need to use the STOP plan now! *****
3. If I'm feeling anxious, I could do some calm breathing to calm down.
4. I have lots of friends at school, and they like me even when I get anxious. They told me so.

***** For more information on the STOP plan, see **Healthy Thinking for Young Children.**

This STOP Plan is for:

_____

Scared?

Thoughts?

Other helpful thoughts?

Praise and Plan!

Scared? *What's going on in your body?*	**Thoughts?** *What are you thinking?*	**Other helpful Thoughts?** *What is something else you can think?*	**Praise and Plan!** *What is something nice you can say to yourself? What can you do next time?*

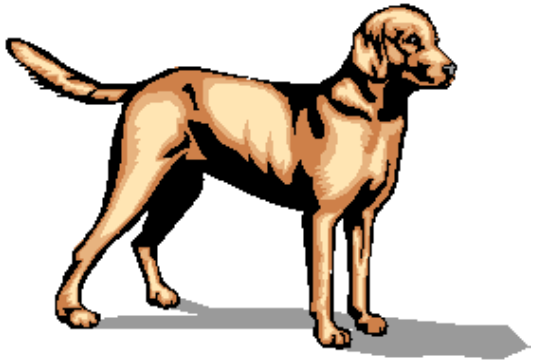
What am I Thinking?

FEELING: _____

FEELING: _____

Thoughts → Feelings!

What feelings would *follow* these thoughts?



That dog is looking at me. He seems interested and friendly. I bet he just wants to play!

FEELING:

That dog is staring at me. He looks mean. I bet he wants to jump on me, or bite me!

FEELING: _____

THINKING TRAPS

Thinking Traps	Examples
Fortune-telling: This is when we predict that things will turn out badly. But, in reality, we cannot predict the future because we don't have a crystal ball!	*"I know I'll mess up."* *"I will never be able to manage my anxiety."*
Black-and-white thinking: This is when we only look at situations in terms of extremes. For example, things are either good or bad, a success or a failure. But, in reality, most events call for a more "moderate" explanation. For example, cheating once on your diet does not mean you have failed completely. You had a small setback, and all you need to do is to get back on your diet tomorrow.	*"Anything less than perfect is a failure."* *"I planned to eat only healthy foods, but I had a piece of chocolate cake. Now my diet is completely ruined!"*
Mind-reading: This trap happens when we believe that we know what others are thinking and we assume that they are thinking the worst of us. The problem is that no one can read minds, so we don't really know what others are thinking!	*"Others think I'm stupid."* *"She doesn't like me."*
Over-generalization: This is when we use words like "always" or "never" to describe situations or events. This type of thinking is not helpful because it does not take all situations or events into account. For example, sometimes we make mistakes, but we don't always make mistakes.	*"I always make mistakes."* *"I am never good at public speaking."*
Labeling: Sometimes we talk to ourselves in mean ways and use a single negative word to describe ourselves. This kind of thinking is unhelpful and unfair. We are too complex to be summed up in a single word!	*"I'm stupid."* *"I'm a loser."*

Over-estimating danger: This is when we believe that something that is unlikely to happen is actually right around the corner. It's not hard to see how this type of thinking can maintain your anxiety. For example, how can you not feel scared if you think that you could have a heart attack any time?	*"I will faint."* *"I'll go crazy."* *"I'm dying."*
Filtering: This happens when we only pay attention to the bad things that happen, but ignore all the good things. This prevents us from looking at all aspects of a situation and drawing a more balanced conclusion.	*Believing that you did a poor job on a presentation because some people looked bored, even though a number of people looked interested and you received several compliments on how well you did.*
Catastrophizing: This is when we imagine that the worst possible thing is about to happen, and predict that we won't be able to cope with the outcome. But, the imagined worst-case scenario usually never happens and even if it did, we are most likely able to cope with it.	*"I'll freak out and no one will help."* *"I'm going to make such a fool of myself, everyone will laugh a me, and I won't be able to survive the embarrassment."*
Should statements: This is when you tell yourself how you "should", "must", or "ought" to feel and behave. However, this is NOT how you actually feel or behave. The result is that you are constantly anxious and disappointed with yourself and/or with others around you.	*"I should never feel anxious."* *"I must control my feelings."* *"I should never make mistakes."*

REALISTIC THINKING FORM (E.g.)

Situation	**Feeling (0 –10)** *0 = no emotion 10 = most intense emotion*	**Anxious Thoughts**	**Realistic Thoughts**	**Feeling <u>after</u> Realistic Thinking** *(0-10)*
Important interview tomorrow	Anxiety – 8	*I always get so nervous about job interviews. I'm going to mess up tomorrow and I'll never get a job.*	*There is a chance that I might not do well in tomorrow's interview, but not performing perfectly on a job interview doesn't mean I won't get the job. Even if I don't get this job, it doesn't mean I will never get a job. I have always been able to find work. I can always get feedback on what I can do to improve my chances of getting another similar position.*	Anxiety - 3

REALISTIC THINKING FORM

Situation	**Feeling (0 –10)** *0 = no emotion 10 = most intense emotion*	**Anxious Thoughts**	**Realistic Thoughts**	**Feeling <u>after</u> Realistic Thinking** *(0-10)*

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Resources. Results. Relief.

REALISTIC THINKING

We can all be bogged down by negative thinking from time to time, such as calling ourselves mean names (e.g., “idiot”, “loser”), thinking no one likes us, expecting something, terrible will happen, or believing that we can’t overcome something no matter how hard we try. *This is normal.* No one thinks positively all of the time, particularly when feeling anxious.

When we are anxious, we tend to see the world as a **threatening** and **dangerous place**. This reaction makes sense, because imagining the worst can help you to prepare for real danger, enabling you to protect yourself. For example, if you are home alone and you hear a strange scratching sound at the window, you might think it’s a burglar. If you believe that it’s a burglar, you will become very anxious and prepare yourself to either run out of the house, fight off an attack, or run to the phone and call for help. Although this anxious response is helpful if there actually is a burglar at the window, it is not so helpful if your thought was wrong: for example, it might be a tree branch scratching the window. In this case, your thoughts were wrong because there was no real danger.

The problem with thinking and acting as if there is danger when there is *no real* danger is that you feel unnecessarily anxious. Therefore, one effective strategy to manage your anxiety is to replace anxious, negative thinking with **realistic thinking**.

> **Realistic thinking** means looking at all aspects of a situation (the positive, the negative, and the neutral) before making conclusions. In other words, realistic thinking means looking at yourself, others, and the world in a *balanced* and *fair* way.

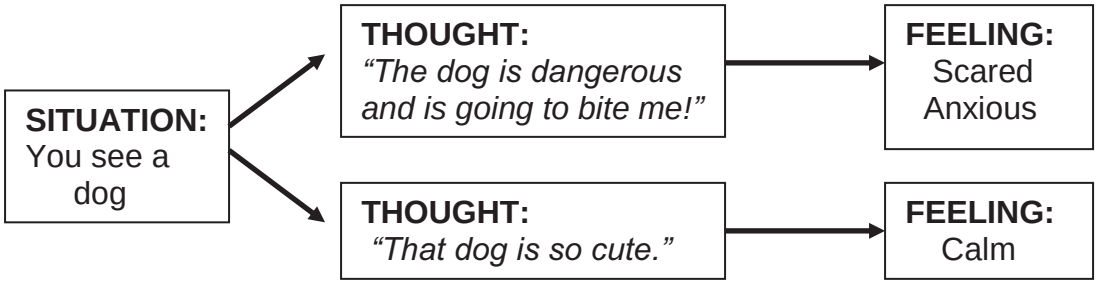
How to Do It

Step 1: Pay attention to your *self-talk*

Thoughts are the things that we say to ourselves without speaking out loud (*self-talk*). We can have many thoughts every hour of the day. We all have our own way of thinking about things, and how we think has a big effect on how we feel. When we think that something bad will happen – such as being bitten by a dog – we feel anxious.

Next

For example, imagine that you are out for a walk and you see a dog. If you think the dog is dangerous and will bite, you will feel scared. But, if you think the dog is cute, you will feel calm.



Often, we are unaware of our thoughts, but because they have such a big impact on how we feel, it is important to start paying attention to what we are saying to ourselves.

Step 2: Identify thoughts that lead to feelings of anxiety

It can take some time and practice to identify the specific thoughts that make you anxious, so here are some helpful tips:

Pay attention to your shifts in anxiety, no matter how small. When you notice yourself getting more anxious, that is the time to ask yourself:

- *"What am I thinking right now?"*
- *"What is making me feel anxious?"*
- *"What am I worried will happen?"*
- *"What bad thing do I expect to happen?"*

Some examples of "anxious" thoughts:

- *"What if I can't do it?"*
- *"I'm going to die of a heart attack!"*
- *"People are going to laugh at me if I mess up during the presentation."*
- *"I'm going to go crazy if I can't stop feeling so anxious."*
- *"Things are not going to work out."*
- *"I'm an idiot."*
- *"What if something bad happens to my child?"*

Step 3: Challenge your "anxious" thinking

Thinking about something does not mean that the thought is true or that it will happen. For example, thinking that a dog will bite you does not mean that it will. Often, our thoughts are just **guesses** and not actual facts. Therefore, it is helpful to challenge your anxious thoughts, because they can make you feel like something bad will definitely happen, even when it is highly unlikely.

Sometimes, our anxiety is the result of falling into **thinking traps**. Thinking traps are unfair or overly negative ways of seeing things. Use the **Thinking Traps Form** to help you identify the traps into which you might have fallen.

Here are some questions to help you challenge your anxious thoughts:

1. *Am I falling into a thinking trap (e.g., catastrophizing or overestimating danger)?*
2. *What is the evidence that this thought is true? What is the evidence that this thought is not true?*
3. *Have I confused a thought with a fact?*
4. *What would I tell a friend if he/she had the same thought?*
5. *What would a friend say about my thought?*
6. *Am I 100% sure that _____will happen?*
7. *How many times has _____happened before?*
8. *Is _____so important that my future depends on it?*
9. *What is the worst that could happen?*
10. *If it did happen, what can I do to cope with or handle it?*
11. *Is my judgment based on the way I feel instead of facts?*
12. *Am I confusing "possibility" with "certainty"? It may be possible, but is it likely?*
13. *Is this a hassle or a horror?*

Here's an example to help you challenging your negative thinking:

> If you have an important interview tomorrow and have been feeling quite anxious about it, you may think: *"I'm going to mess up on the interview tomorrow."*

To challenge this thought, you can ask yourself the following questions:

- ***Am falling into a thinking trap?***

Yes, I have fallen into the trap of fortune-telling, predicting that things will turn out badly before the event even takes place. But I still feel like I'll definitely mess up.

- ***Am I basing my judgment on the way I "feel" instead of the "facts"?***

I might feel like I'm going to mess up, but there is no evidence to support it. I'm very qualified for the position. I have had interviews in the past and generally they have gone well.

- ***Am I 100% sure that I will mess up?***

No, but, what if I mess up this time?

- ***Well, what's the worst that could happen? If the worst did happen, what could I do to cope with it?***

The worst that could happen is that I don't get a job that I really wanted. It'll be disappointing, but it won't be the end of the world. I can always ask for feedback to see whether there is anything I can do to improve my chances of getting another position similar to this one.

Use copies of the **Realistic Thinking Form** to regularly write down thoughts that make you anxious, and use the **Challenging Negative Thinking** handout to help you replace your anxious thoughts with more realistic ones.

Step 4: More on helpful and realistic ways of thinking

More tips on helpful thinking:

Tip #1: Coping statements. Try coming up with statements that remind you how you can cope with a situation. For example, "If I get anxious, I will try some calm breathing", "I just need to do my best", "People cannot tell when I am feeling anxious", "This has happened before and I know how to handle it", or "My anxiety won't last forever".

Tip #2: Positive self-statements. Regularly practise being "kind" to yourself (say positive things about yourself), rather than being overly self-critical. For example, instead of saying, "I will fail", say something like, "I can do it". Or, "I am not weak for having anxiety. Everyone experiences anxiety", "I'm not a loser if someone doesn't like me. No one is liked by everyone!", or "I'm strong for challenging myself to face the things that scare me".

Tip #3: Alternative balanced statements based on challenging negative thoughts. Once you've looked at the evidence or recognized that you've fallen into a thinking trap, come up with a more balanced thought.

Going back to the job interview example, a more balanced thought could be:
"There is a chance that I might not do well in tomorrow's interview, but not performing perfectly on a job interview doesn't mean I won't get the job. Even if I don't get this job, it doesn't mean I will never get a job. I have always been able to find work."

Hint: It can be tough to remember helpful thoughts or realistic coping statements when you are anxious. Try making up coping cards that include helpful statements. To make a coping card, write down your realistic thoughts on an index card or a piece of paper, and keep it with you (i.e., in your purse, wallet, or pocket). It can be helpful to read this card daily, just as a reminder.

AnxietyBC

RESOURCES.RESULTS.RELIEF

Home Management Strategies for Specific Phobia

How To Do It!

Step 1: Teaching your child about anxiety

This is a very important first step, as it helps children and teens understand what is happening to them when they experience anxiety. Let your child know that all the worries and physical feelings he or she is experiencing has a name: **Anxiety.** Help your child understand the **facts about anxiety**.

Fact 1: Anxiety is normal and adaptive, as it helps us prepare for danger.

Fact 2: Anxiety becomes a problem when our body tells us that there is danger when there is no real danger.

To learn how to explain this to your child, see
How to Talk to Your Child about Anxiety.

Step 2: Teaching your child about phobias

- We all have fears, and that is normal.
- A phobia, however, is a very strong fearful reaction to a thing, place, or situation that does not really make sense when the actual risks are considered. For example, if a dog growls at you once, it would not make sense to never go near any dog *ever again*.
- Phobias can stop people from doing important things. Talk with your child about how the phobia is interfering with his or her life, and how it is affecting the family. What is the phobia stopping your child from doing?

Here's a dialogue of a parent explaining the meaning of phobia:

Parent: *So, now that we know more about anxiety, I want to tell you what a phobia is.*

Child: *Is it like anxiety? I think I've heard of it before.*

Parent: *Yes, that's right. Remember when we were talking about anxiety, and I said that we all have fears?*

Child: *Yeah. Even you and dad!*

Parent: *Right. Many of these fears make sense. For example, it is normal to be afraid of a dog if it is growling at you! A phobia is when someone has a really strong fear of something that isn't really dangerous. Sometimes people have a phobia of elevators, heights, or spiders.*

Child: *Ugh, I don't like spiders. But they don't freak me out THAT much.*

Parent: *When Aunt Susan was your age, she had a phobia of dogs. She would cry, scream, or freeze when she saw a dog, or even just hear a dog bark!*

Child: *But some dogs are dangerous and have rabies.*

Parent: *Yes, some are, but most of them are harmless, especially in our neighborhood. Aunt Susan was afraid of very friendly dogs, or even sleeping dogs. She couldn't even look at pictures of dogs. That is a*

phobia – when you are afraid of something even when it isn't really dangerous. It can make life really hard! Aunt Susan had to walk four extra blocks to school just to stay away from the old dog down the block. She wouldn't even go to birthday parties when there was a dog there, even if the dog was locked in the basement.

Child: *That is kinda like me and balloons. I freak out. I don't want to go near them at all!*

Step 3: Building Your Child's Toolbox

You can help by giving your child some tools to manage anxiety. The tools will help your child to accomplish the **most important step** – facing his or her fears. For phobias, tools in the toolbox include:

Tool #1: Learning to Relax.

Two strategies can be particularly helpful to teach your child how to relax:

1. Calm Breathing: This is a strategy that your child can use to calm down quickly. Explain to your child that we tend to breathe faster when we are anxious. This can make us feel dizzy and lightheaded, which can make us even more anxious. Calm breathing involves taking slow, regular breaths through your nose. For more information, see **Teaching Your Child Calm Breathing**.

2. Muscle Relaxation: Another helpful strategy is to help your child learn to relax his or her body. Have your child tense various muscles and then relax them. Then, have your child use "the flop," which involves imagining that he or she is a rag doll and relaxing the whole body at once. For more information, see **How to Do Progressive Muscle Relaxation**.

If your child has a phobia of receiving injections, or seeing blood or injuries, and is afraid of fainting, see

How to Teach Your Child Not to Faint at The Sight of Blood or Needles.

Tool #2: STOP Plan or Realistic Thinking

Often, the anxious thoughts that children and teens have about their phobia are unrealistic or very unlikely; however, when they are very anxious, it is difficult for them to recognize this. For example, a child who has experienced a house fire may believe that a book of matches might start another house fire, even if they are just sitting in the kitchen drawer. Even though this is unrealistic, the child screams if mom or dad brings matches into the house. One way to help your child examine his or her thoughts, and decide whether the worries are unrealistic, is to use the STOP Plan. The STOP Plan can help children see their anxiety and unhelpful thoughts, and to develop new thoughts. For older children and teens, you might want to help your child challenge unrealistic or anxious thoughts.

For a young child, see **Healthy Thinking for Young Children.** For teens, see **Realistic Thinking for Teens**.

Tool # 3: Facing Fears

The most important step in helping your child overcome a phobia is to gradually face the feared object or situation. Remember, these steps are gradual, and created together with your child. For more strategies and tips on conducting similar exercises with your child, see **Helping your Child to Face Fears: Exposure.**

How to do these exercises:

Facing fears in a graduated and consistent manner (i.e., exposure) is the most effective way of reducing fears over the long term. It is important to prepare your child for the fact that he or she **will** feel anxious while doing this, but **that is good!** When fighting back anxiety, it is normal to feel a little anxious, especially in the beginning. It is also very important to **praise** (e.g., "great job!") and **reward** (e.g., small inexpensive items, extra TV time, making a favorite dinner) your child for any successes, as well as any attempts at trying to face his or her fears. After all, it is hard work to face anxiety!

Step 4: Building on Bravery

Your child's progress comes from hard work. If you see that your child is doing better then you both deserve a lot of credit! Learning to overcome anxiety is like exercise – your child needs to "keep in shape" and practice his or her skills regularly. Make them a habit. This is true even after your child is feeling better and has reached his or her goals.

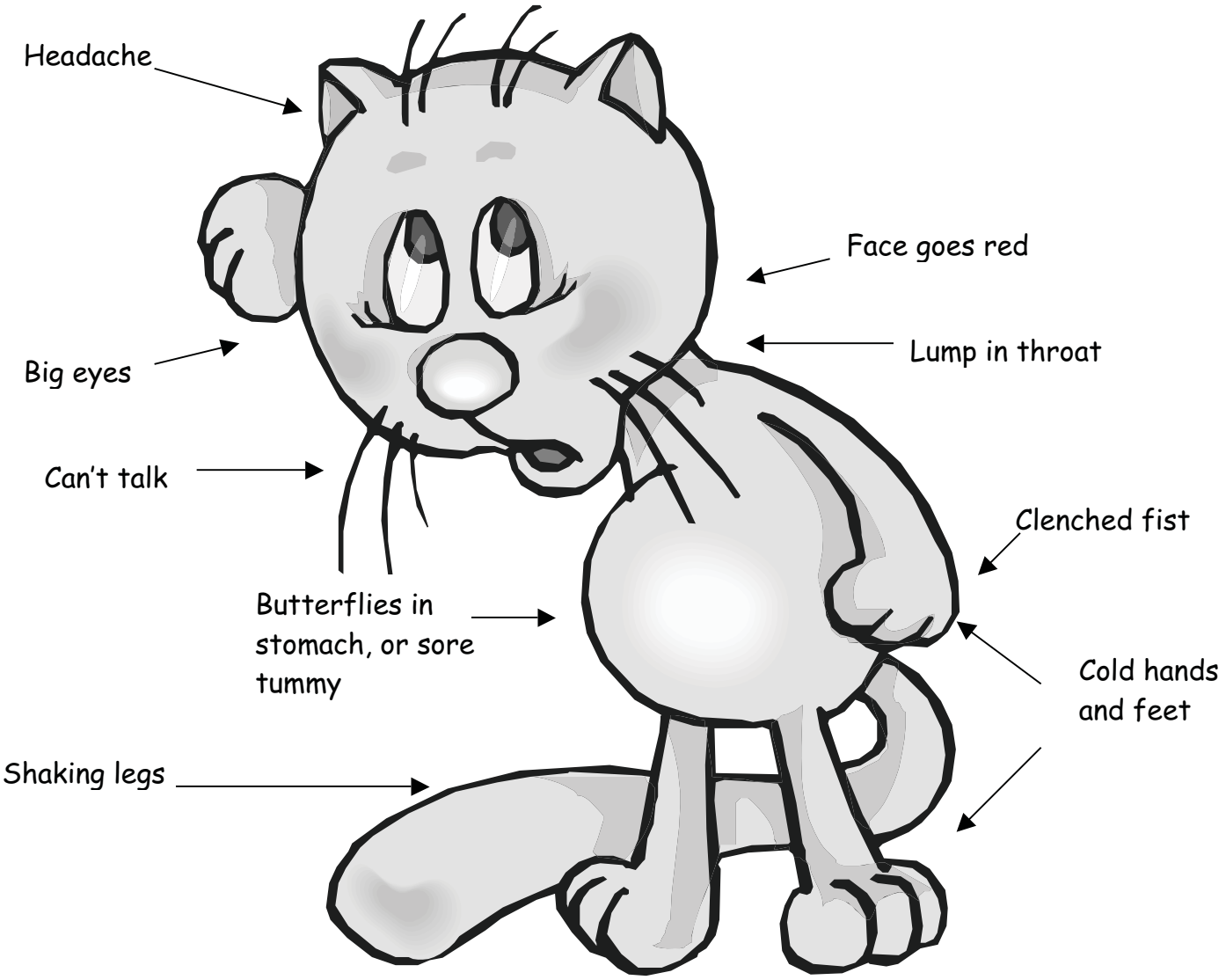
Don't be discouraged if your child has lapses and returns to his or her old behaviors every once in a while, especially during stressful times or transitions (for example, going back to school, or moving). This is normal, and just means that one or two tools in the toolbox need to be practiced again. Remember, coping with anxiety is a lifelong process.

Helpful Tips:

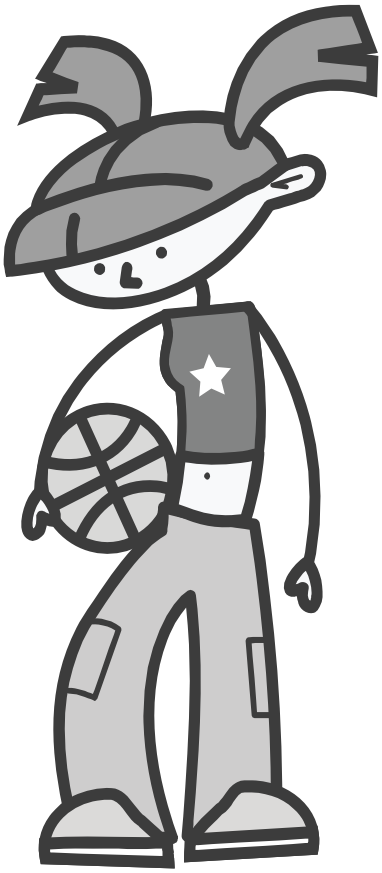
- **Model it!** Model how to face fears, and provide support and encouragement; however, be careful not to push your child too far too fast. Let your child work at his or her own pace.
- **Don't Fight It!** Encourage your child to try and remain calm, rather than try and fight the feelings of anxiety.
- **Track Progress!** Occasionally, remind your child what he or she was not able to do before learning how to cope with anxiety and face fears. It can be very encouraging for your child to see how far he or she has come! This is why it is a good idea to create a chart that records all of your child's successes!

Chester the Cat feels anxious!

How does Chester feel anxiety in his body?



How do YOU feel anxiety in your body?



A GPSC Initiative

Panic Diary

Date	Trigger	Symptoms	Severity (1 – 10)	Duration (minutes)

A GPSC Initiative

Difficult Places to Go and Things to Do

Date	e.g. Go to the mall	e.g. Talk to sales people	e.g. Drive the car alone	e.g. Go to the movie

Rate on scale of 1 to 10 in spaces above

Fluoxetine

PSP Child and Youth Mental Health – Initiating and Monitoring Medication for Anxiety Disorders in Children / Youth

Click here for Sertraline page

MDD Diagnosis (DSM-IV criteria)

- Children (6-12)
- Adolescent >12)

Use PST and SRP throughout the treatment process.

- Initiate PST for at least 3 visits. SCARED > 25, symptoms continue causing distress and CFA /TeFA shows decrease or no change in function
  Time to start medication!

Measure functioning using CFA / TeFA and side effects using sCKS in every

- Begin Fluoxetine at 5 - 10 mg daily for 1 - 2 weeks. (If significant anxiety symptoms are present, start with 2.5 - 5 mg for 2 weeks and continue increasing as indicated.)

- Increase Fluoxetine to 10 - 20 mg daily for one to two weeks.
- After two weeks in children increase to 20

- Continue at 20 mg daily for 8 weeks.
  (If side effects are a problem – decrease the dose to 15 mg daily for 1 week and then increase to 20 mg. If substantial side effects occur continue the dose at 15 mg for 8 weeks.)

- If symptoms have not improved after 8 weeks of treatment, increase the dosage by 10 mg every 2 weeks to a maximum of 30 - 40mg.

If you have reached the maximum dose and depressive symptoms continue to cause distress and dysfunction or there is suicidal risk "REFER TO A MENTAL HEALTH SPECIALIST"

OCD treatment often requires higher doses. If a child or youth is not responding to 30 - 40mg after 12 week s of treatment, we recommend a referral tofs specialized mental health care.

Atypical antipsychotics are not meant to be used to treat depression in primary health care.

Initiating and Monitoring Sertraline for Anxiety Disorders in Children / Youth

Click here for Fluoxetine page

Anxiety Diagnosis (DSM-IV criteria)

- Children (6-12)
- Adolescent >12)

Use PST/PO and WRP throughout the treatment process.

- Initiate PST/PO for at least 3 visits. SCARED > 25, symptoms continue causing distress and CFA /TeFA shows decrease or no change in function.
  Time to start medication!

Measure functioning using CFA / TeFA and side effects using sCKS in every visit

- Begin Sertraline at 25 mg daily for 2 weeks. (If poorly tolerated, start with 12.5 mg for 2 weeks and continue increasing as indicated)

- Increase Sertraline to 50 mg daily for a minimum of 6 – 8 weeks.

- If Sertraline has been well tolerated and significant anxiety symptoms are still present, increase dosage to 75 mg daily for 6 - 8 weeks.

- If symptoms have not improved after 8 weeks of treatment, increase the dosage by 25 mg every 2 weeks to a maximum of 75 – 100 mg.

If you have reached the maximum dose and anxiety symptoms continue to cause distress and dysfunction or there is suicidal risk, REFER TO A MENTAL HEALTH SPECIALIST

OCD treatment often requires higher doses. If a child or youth is not responding to 100 mg after 12 week s of treatment, we recommend a referral to specialized mental health care.

Atypical antipsychotics are not meant to be used to treat depression in primary health care.

Referral Flags

Referral of the teen with an anxiety disorder to specialty mental health services can occur at three different points. The following referral points are suggestions only. Each first contact care provider must identify their own comfort level with treatment and management of adolescent anxiety disorders and act accordingly. These suggestions are:

Emergency Referral (prior to treatment initiation by first contact care provider):

- Suicidal ideation with intent or suicide plan
- Major depressive episode with psychosis (presence of delusions and/or hallucinations)

Urgent Referral (treatment may be initiated but referral should be made concurrently):

- Symptoms severe and function significantly deteriorated (e.g. severe OCD, severe panic)
- Relapse from previous positive treatment response
- Persistent suicidal ideation with no intent or suicide plan
- Comorbid major depressive episode and family history of Bipolar Disorder
- History of suicide attempts
- Hypomania

Usual Referral:

- Referral for Cognitive Behavioural Therapy if available
- Persistent school avoidance
- Anxiety disorder not responding to adequate first contact treatment trial

Next

Referral Flags

Referral of the child with an anxiety disorder to specialty mental health services can occur at three different points. The following referral points are suggestions only. Each first contact care provider must identify their own comfort level with treatment and management of childhood anxiety disorders and act accordingly. These suggestions are:

Emergency Referral (prior to treatment initiation by first contact care provider):

- Suicidal ideation with intent or suicide plan
- Major depressive episode with psychosis (presence of delusions and/or hallucinations)
- Presence of delusions or hallucinations

Urgent Referral (treatment may be initiated but referral should be made concurrently):

- Symptoms severe and function significantly deteriorated (e.g. severe OCD, severe panic)
- Relapse from previous positive treatment response
- Persistent suicidal ideation with no intent or suicide plan
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- History of suicide attempts
- Hypomania

Usual Referral:

- Referral for Cognitive Behavioural Therapy if available
- Persistent school avoidance
- Anxiety disorder not responding to adequate first contact treatment trial

A GPSC Initiative

Child and Youth Mental Health
PSP Module

The Life Span and Mental Disorders: An overview and useful tips for primary care practice

Introduction

Mental disorders are disturbances of normal brain function that lead to defined syndromes. Identified primarily for heuristic purposes, these syndromes are grouped into categories by a presumed primary functional disturbance (e.g., depression as a disorder of mood; ADHD as a disorder of cognition). However, it is self-evident that whatever the identified category for the mental disorder, functional disturbance is never limited to one brain function. Many brain functions are involved for every mental disorder; for example depression is a mood disorder but includes behavioural, cognitive and physical symptoms.

Clearly, the developmental stage of the brain and the maturity of its various functions will colour the presentation of mental disorders, so that there may be some life span differences in how these disorders present depending on an individual's age – a proxy measure for brain development. Similarly, all treatments for mental disorders work by impacting various brain systems that are involved in the control and development of every functional component. It is to be expected that there may be age-related differences in therapeutic efficacy and treatment outcomes for individual treatments, and is therefore important that the proper age-specific diagnostic and therapeutic activities be understood and implemented in the treatment of mental disorders.

To a large degree, the social circumstances of every person are also age-related. For example, the role of the family, the role of institutions (such as school), the workplace, peers, etc. all play a part in addressing mental disorders across the age span. While it is well outside the scope of this brief overview to address the complexities of neurodevelopment and the age-related and ever changing environments that impact on a young person, primary care practitioners may apply a number of useful insights to assist them in better understanding, diagnosis, treatment and management of common mental disorders in the primary health care setting.

Epidemiology of child and youth mental disorders

Using the degree of disability induced by medical conditions as the yardstick, mental disorders are the most burdensome health disorders found in children and adolescents. According to the World Health Organization, these disorders contribute

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about one-third of the GLOBAL burden of disease. This proportion is higher in Canada, because other illnesses, commonly found in low-income or "southern" countries either do not exist in Canada (e.g.. malaria; dengue fever) or are much less common here (e.g., HIV/AIDS; TB).

Child and Adolescent Health: GLOBAL Comparative Burden of Illness for Mental Illness

Table: World: DALYS in 2000 attributable to selected causes by age

	Ages 0-9	Ages 10-19
Neuro-psychiatric conditions (including self-inflicted injuries)	12	29
Malignant Neoplasms	3	5
Cardiovascular Diseases	2	4

Adapted from: World Health Organization (2003). Caring for children and adolescents with mental disorders. Setting WHO directions. Page 3, Figure 1. World: DALYs in 2000 attributable to selected causes, by age and sex.

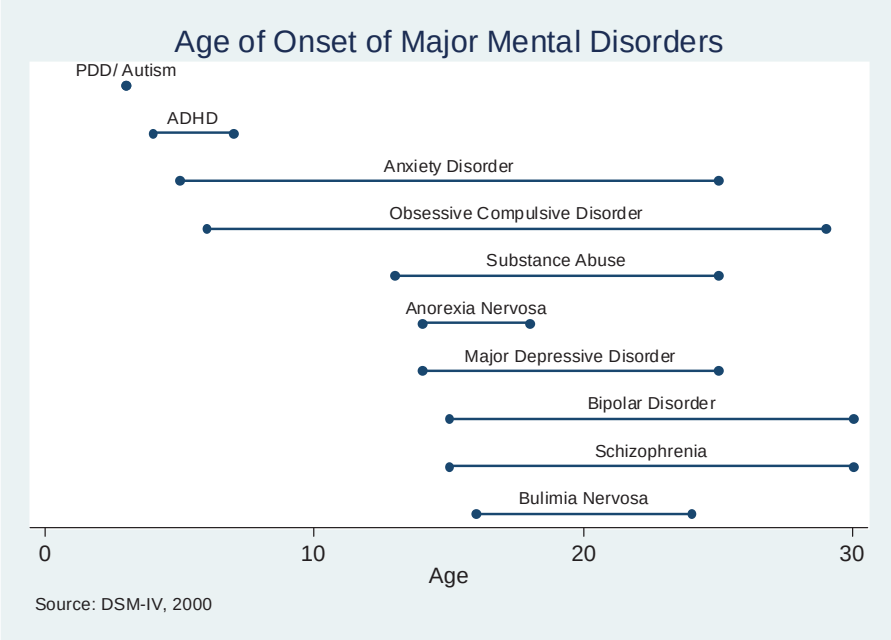
Although not commonly appreciated, the vast majority of mental disorders begin prior to age 25 years, with the bulk of these being able to be diagnosed between the ages of 12 and 25 years. These mental disorders can be diagnosed early in the life span and include but are not limited to the following:

Prior to age 5: pervasive developmental disorders; ADHD; separation anxiety disorder

Those that tend to onset after puberty: depression; obsessive compulsive disorder; social anxiety disorder; panic disorder; schizophrenia; bipolar disorder; anorexia nervosa; bulimia nervosa; substance abuse; etc.

This pattern of illness onset is found globally and is relatively consistent across all Provinces and Territories of Canada. Although numbers vary somewhat depending on location, approximately 15 – 20 percent of young people (ages 1 to 25) will experience a mental disorder requiring professional intervention. The most common disorders over this span of years are the anxiety disorders followed by depression

and ADHD. Disorders of conduct are also common but are not addressed in this overview, as they require interventions that are difficult to adequately provide in primary care settings by primary care providers. The other common disorders (such as anxiety, depression, and ADHD) are not only highly prevalent but are the majority (approximately 60 – 70 percent) and can be properly diagnosed and effectively treated in primary health care settings.



Know your setting

It is important to know what the population prevalence rates for mental disorders in your area are. In most cases, these will be largely similar across Canada; however, in specific situations (such as some isolated communities and inner city low socio-economic neighborhoods) there may be higher rates of specific mental disorders than usual. This is important to know because it will give you an idea of what you should be looking to see in your practice.

Generally, anxiety disorders are the most common mental disorders in Canada (about 10% of the population) followed by depression (about 5 percent) and ADHD (about 4 percent). Taken together, these are the three most common mental disorders that can be effectively addressed in primary care and these will be the focus of the training program.

Child and Youth in Context

Legal Issues

There are age-related differences in legal status that may impact on the treatment of children and youth. Legislated directions may vary from jurisdiction to jurisdiction; therefore it is essential that the health provider be aware of the age-specific legal directives at play in their location. This includes but is not limited to such issues as:

- age of consent to treatment
- guardian status
- involuntary confinement
- duty to report
- etc.

There may also be specific issues pertaining to roles, rights and obligations in custody cases. When in doubt, contact the Provincial/Territorial Professional Association, consult peers who are knowledgeable about your issue of concern, seek a legal opinion, or contact the Canadian Medical Protective Association for advice. If advice has been sought about a certain issue, be sure to document in the patient record the specific actions, plus the details and process of the advice received.

Also see BC specific legislation

Parent-Child Relationships

It is impossible to try and capture every possible permutation of concerns or problems pertaining to parent-child relationships in this overview. Overall, a useful strategy for a health provider to use if an uncomfortable issue arises is to seek advice from peers or a mental health consultant who is familiar with the issue the health provider is facing. The following are some specific issues that have been identified by participants who have prepared these materials.

1. Conflict in Custodial Situations

In families where the biological parents are living apart (through separation, divorce or other reasons) there may be inter-parental conflicts that interfere with care that is in the best interests of the child and which can be expressed through legal complications. In such cases it is often appropriate to refer to mental health services and legal aid where there should be greater expertise and more experience

in dealing with this type of situation. Upon such a decision, explain to all parties with a legal interest in the child as to why this course of action is being followed and make a note of the discussion and outcomes in the patient record.

2. Confidentiality

There are two commonly encountered issues pertaining to confidentiality. One is with teens who wish to keep personal matters confidential from their parents or institutions (such as schools) and another is with parents who wish to keep personal matters confidential from each other or from their children.

In the first situation, it is useful to discuss with the parents and child the privilege and limits of confidentiality.

As a rule, these parameters must comply with legal prescriptions in the health provider's jurisdiction of practice and with expected standards of professional practice; however confidence can be kept unless – in the opinion of the provider – the confidence has the potential to lead to significant harm to self or others.

Make the limits of confidentiality clear to both the parents and their child. Knowing these limits is helpful for all concerned; particularly with teenagers who may be struggling with what information they do or do not want their parents to have. It is also helpful for parents who may find themselves caught in the bind of wanting to know what is happening in the life of their child but at the same time being unsure how much they should be actively involved. In situations where a young person is at imminent risk for self harm or harm to others, legally defined actions will need to be put into place – including involuntary committal if indicated.

This aspect of parent-child relationships is one that may also be strongly culturally influenced, and not only in recent immigrant or refugee families. It is therefore essential that the primary care practitioner be aware of the cultural norms and expectations held by parents and young people, and how they may differ. Additionally, while it is important to be sensitive to the contrasting views and expectations of culturally diverse clients and their families, keeping the best interests of the child should remain paramount. Exhibiting a certain amount of advocacy on the part of the medical professional, express how these conflicting views may adversely affect the child.

Child and parent conflict due to different cultural expectations of the roles and responsibilities of parents in the lives of their adolescents can be particularly

problematic. If unsure of the complexity of these situations, obtain consultation from a peer or colleague who is well versed in these issues.

Parent to parent (or partner) confidentiality or parent to child confidentiality can be another complex issue. Here, again, legal requirements and professional guidelines must be followed. In situations of uncertainty, discuss the issue with peers and obtain advice from professional organizations.
When obtaining informed consent from the patients and their guardians, ensure the limits to confidentiality are discussed. In British Columbia, these limits include:

- If you have reason to believe a child is being abused or neglected, you have a legal duty to report your concern to a local child welfare worker and/or police (in situations of immediate danger). "Reason to believe" simply means that you have observed things or have information leading you to believe a child could be at risk. If you are not sure, or if you have questions, or even if you think that someone else has already made a report, you should still call the Helpline (see number listed below).
- If you have reason to believe that your client might seriously harm them self or someone else.
- If a court order or other legislation legally requires you to provide information.
- If required as part of continuity of healthcare.

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Child and Youth Mental Health
PSP Module

Who to call regarding abuse or neglect concerns...

If it is after hours or you are not sure who to call, phone the Helpline for Children at 310-1234 at anytime of the day or night. The Helpline call is free. You do not need an area code and you do not have to give your name. If the child is in immediate danger, call 9-1-1 or your local police.

Resources:

1. **Ministry of Children and Family Development** site for general information about child protection: http://www.mcf.gov.bc.ca/child_protection/
2. Ministry of Children and Family Development's "**The B.C. Handbook for Action on Child Abuse and Neglect: For Service Providers"** provides detailed information to assist service providers working with children. The guide is available at: http://www.mcf.gov.bc.ca/child_protection/pdf/handbook_action_child_abuse.pdf (See page 57 ("For more information" section) of this guide for phone numbers for contacting a child welfare worker & page 46 (section "The Child Welfare Worker's Role")for information about reporting and confidentiality.)

If you need to break confidentiality and make a child protection report, you should be guided by the following considerations:

- In most situations your relationship with a child or youth will be preserved if you are open with him or her about your obligation to report. However, there may be times when child's or youth's safety and wellbeing are best protected by waiting until you have spoken to a child welfare worker before making a decision about whether to or how to inform them that you have made a report.
- The child welfare worker can often give you guidance on potential next steps, and this can inform your decision making about whether or when you will disclose your reporting to the child or youth.
- You should also consult with the child welfare worker about the process for informing parents/guardians if they are the subject of the report. The child welfare worker can provide guidance about whether it is acceptable to inform them yourself.
- Page 46 of the handbook provides more information about reporting and confidentiality.

3. Engaging the Family

Get people mobilized around the child. Asking for help is a way to diffuse feelings, or blame, or guilt.

Next

In most cases, the family of the child or youth will be involved when a mental health problem has been identified. How much, or in what way the family should be involved will vary from case to case and will be dependent upon many different variables, including but not limited to:

- nature and strength of relationships amongst various family members
- willingness of family members to engage
- understanding of and knowledge about the problem/mental disorder
- acceptance or denial of the condition
- beliefs or strongly held idiosyncratic opinions about the causes, nature and treatment of the problem
- the presence of a mental disorder (similar or different) in another family member
- family expectations of the provider and treatment
- family history of interaction with health/mental care
- cultural or socio-economic factors

Right away it should be obvious that there is no one “right” or “best” way to engage a family. It is paramount that the primary health care practitioner endeavours to reduce stigma and, from the onset of evaluation or diagnosis, attempt to normalize applicable diagnoses/conditions and validate the immediate reaction of the patient and family to receiving such diagnoses. Helping the young patient and their family understand that, while a diagnosis is a way of categorizing and labeling their condition, it is not insurmountable and there are many supports available to them through peer groups as well as professional direct service providers. Introducing social networks through peer-counselling so that the client is introduced to individuals contending with the same issues is especially valuable in reducing co-morbid disorders such as depression or substance use.

Put simply, there is no “one size fits all” when it comes to family engagement. That is why it is useful to consider a set of general principles that could be applied if indicated, rather than a set of rules or specified procedures that must be applied in all cases. These general principles should include: education; clarification of roles and responsibilities; feeling at home; knowing your limits.

Education

Providing family members with easily understandable information about the disorder, treatment details, expected results and a monitoring framework not only helps with treatment adherence but can also provide a focus in which many families can share a common goal. Different family members can take on various “research” tasks, in which they seek and share information with each other and

bring questions to the health provider or qualified mental health support group /association. This type of mutually supportive activity can serve to strengthen the links amongst family members as well as with the health provider in a common purpose.
Having easily available information that can be provided during or immediately following an office visit is a helpful way to improve family engagement. Provide literature in the office plus suggest several internet resources such as www.teenmentalhealth.org and http://www.bcmhas.ca/supportcentre/kelty/default.htm.

Myths about the treatment of mental disorders include the following:
Although a minority of patients may not experience significant improvement in their condition with treatment, these patients represent a small percentage of the mentally ill. In reality, the majority of patients with mental disorders respond well to appropriate pharmacological and/or psychological interventions. Often, failure to respond to treatment is a consequence of treatment non-compliance or poor accessibility to mental health care.

For many patients and their families, the diagnosis of a mental illness carries with it a high social, personal and economic burden and as a consequence there may be resistance to, or denial of, the diagnosis and rejection of recommended treatments. Psycho-education that identifies mental illness as a brain disorder is a useful technique by which to challenge these misperceptions, gain patient and family trust, and redefine understanding of the illness.
Some of the misconceptions regarding psychiatric medications used to treat mental disorders include:

- Medications are detrimental to general health and well-being
- Mental illnesses are too difficult to treat
- Psychiatric medications are addictive
- Medications make patients feel and look worse
- Medications are used to ‘knock patients out’ or turn them into zombies
- Treatments are not usually effective
- People who are mentally ill will not get better
- Vitamins and rest are effective treatments for mental disorders.

In addition, patients may feel that having to take a psychiatric medication means that they are severely ill, abnormal, crazy, or that they are not in control of their

lives. Patients can be helped to understand that taking treatments helps give them more control over the illness.

Clarification of roles and responsibilities

The clarification of roles and responsibilities will vary with the age of the child. The important domains are: taking medication; keeping a record of symptoms; monitoring for side effects; arranging visits with the health care team; instituting emergency interventions if indicated. Discuss each of these items with appropriate family members and ensure that each family member understands and agrees to their role and responsibility. This will not only help engage the family in the treatment process but it may also improve care by improving treatment process.

Feeling at home

The health provider's office should be a place in which all family members feel safe and supported. Having space where a family discussion can happen away from public view and public hearing is important when providing mental health care. Reception and support staff should be trained in basic understanding of mental disorders and in supportive techniques that can help parents and young people feel more calm and welcomed.

Consider the course available at MHFA Canada for Adults who Interact with Youth Course **Error! Hyperlink reference not valid.**http://www.mentalhealthfirstaid.ca/EN/course/descriptions/Pages/MHFAforYouth.aspx) that works with children and youth and is available in Canada through the MHCC.

Remember that there is a great deal of stigma against people and families who are living with a mental disorder. It is essential the health provider and staff do not perpetuate stigma. The supportive environment created in the practitioner's office can go a long way to combat misperceptions and stigma.

Knowing your limits

The reality is that some patients and families present more challenges than others and these families will require more intensive interventions – such as family therapy. Primary care health providers do not usually have the skills or the time to

conduct in-depth family therapy. If the family is demonstrating substantial difficulties that either increase stress in members or impede the effectiveness of interventions, then referral to specialty mental health services is indicated.

Remember that many mental disorders run in families. For example, it is common for at least one parent of children who have ADHD to also have ADHD.

The same is true for anxiety disorders and depression. In some cases, the diagnosis of a mental disorder in the child may shine the light on similar difficulties experienced by a parent but previously not recognized or not treated. This more commonly occurs in ADHD but also with some anxiety disorders, particularly when a parent has a mild form of the illness. In such cases, diagnosis and treatment for the parent(s) or other family members (such as siblings) is indicated.

Establishing a positive rapport and exchange between practitioner and young client that embraces the opportunity of working with the family unit and community support organizations is often essential before pursuing the hereditary link with parents who may be contending with identical symptoms/diagnoses. Without this relationship-building component, young clients, and often their families, will disengage and refrain from continuing treatment options.

Depending on the disorder and its severity, treatment can often be conducted by the same primary care provider who is treating the child. This single provider model may be challenged by some mental health professionals who adhere to non-validated treatment “truths” that demand different mental health providers for different family members. The reality is that there is no a priori reason to demand a different provider for different family members when treating mental disorders in primary care. The same is not done for other chronic disorders – such as diabetes. Indeed, a good argument can be made that a single provider working with different family members will have a much better understanding of both the family and personal issues that arise during the treatment process. In some locations (for example, isolated communities) there will be little or no choice of provider so having a different provider for different family members will not be possible anyway.

4. Parenting Overview

Many parents will experience a number of difficulties and express numerous concerns regarding how to parent a young person who has a mental disorder. There

are no simple answers to many of the questions that could be raised, so it is useful to know what general parenting competencies could be discussed. These are competencies* that have been found to be important for all young people, and they can be used to guide parenting for youth with and without mental disorder alike.

Love and Affection	• Spending quality time with the child individually; demonstrating physical affection; words and actions convey support and acceptance
Stress Management	• Parents learn how to manage their own stress and try not to let their stress drive relationships with their children
Strong Relationships	• Demonstrate positive relationships with a spouse or partner and with friends Good modeling with individuals not related is especially relevant in that it can encourage a heavily stigmatized child/youth to reach out to others and establish their own health/balanced social network in preparation for adulthood
Autonomy/ Independence	• Treat child with respect and provide environment to promote self-sufficiency
Education/ Learning	• Promote and model lifelong learning and encourage good educational attainment for the child
Life Management	• Provide for the needs of the child and plan for the future. Teach comprehensive life skills, especially for youth; avoid enabling and instead focus on youth's strengths, gradually targeting what could be improved upon in terms of personal hygiene, interpersonal skills, cooking, cleaning, organization and goal setting
Behaviour Management	• Promote positive reinforcement and punish only when other methods have failed and then consistent with the severity of the negative behavior and not in a harsh manner
Self Health	• Model a healthy lifestyle and good habits

Spirituality	• Provide an appropriate environment in which spiritual or religious components can be addressed
Safety	• Provide an environment in which your child is safe, monitor your child's activities; friends; health

**Modified from Epstein, R. What Makes a Good Parent? Scientific American Mind. November/December. 2010: 46 – 49.*

5. Developmental Transitions

Primary health care providers are key in facilitating the transition of a young person with a mental disorder to an adult patient care setting. This transitional process represents a challenge to the health care system. Well organized transitions are needed but in many cases do not happen, which results in failure to seamlessly transition to adult-oriented systems as well as higher risk for negative outcomes.

Primary healthcare providers provide longitudinal patient care and facilitate health promotion, disease prevention, health maintenance, counseling, patient education, and diagnosis and treatment of illnesses including mental disorders. Adolescents and family members are often reluctant to end longstanding relationships with their youth mental health provider as they transition to the adult system. Maintaining their relationship with their primary care provider is essential during this time.

An additional transition stressor is moving to a new city to undertake further schooling or for work. Referral to a health provider in the new location can be facilitated by the patient primary care physician. A program called Transitions, designed to assist this process, is available in many Canadian post secondary institutions (for more information about this resource visit www.teenmentalhealth.org) This and others barriers can be overcome by establishing well coordinated transitional process, including: transition planning, good information transfer across teams, working jointly amongst teams and continuity of care following transition.

There is no clear defining point between adolescence and adulthood. Medication management and psychotherapies such as CBT may become more effective with older age. Social, family and economic circumstances will change and their impact

on the patient may bring both positive and negative influences. Therapeutically, the primary care provider should be ready to address these issues as they change over this part of the life span.

Engaging the Adolescent

The reality is that some care providers naturally get along well with young people and others need to work hard to do so. The number one recommendation for health providers working with adolescents is this: *be yourself* – keep an open mind, but not so far open that your brains fall out!

Do not try to be cool, or hip or whatever. If you do, it can be guaranteed that you will be found out to be anything but. You are not a teenager, do not try to act like one. Don't be judgmental but at the same time *be real*.

If you think that having the occasional joint is not a good thing then be clear about it, but be prepared to give good cogent reasons why. If you do not know the answer to a question, then admit it and discuss how you will find out. If you have not heard of the music group that your patient is talking about – ask them. There is no way that you can be more conversant with popular teen culture than they are. Do not come across as THE authority on everything, but do come across as an expert in your field – after all, that is what you are. Using a Socratic approach in which you pose questions and offer alternative solutions to problems is generally more useful and more appreciated than simple, authoritarian pronouncements.

When discussing treatment adherence with teens, it is useful to predict that they will not always remember to do their treatment homework or take their medications. Remember that every teen is an individual and, as such, some may be conscientious and curious about how best to meet their treatment goals and others may be disengaged and find the process tedious and unrelated to their general welfare. This awareness can help in not over-generalizing your experience working with youth. First impressions and stereotyping of young people can be misleading and unfairly bias your interaction with them. That makes it easier for them to be honest with you about what they are actually doing instead of them telling you what they think you think that they should be doing.

Do not be surprised if they bring a friend to meet you – that is one of the highest degrees of compliment that they can bestow on you. However, remember that you

should not discuss treatment of your patient with their friend – if they want to do that, then they should do so on their own. On the other hand, if the friend has questions that your patient would like you to answer, that is fine – as long as your answers do not invade on your patient's privacy. Remember, sometimes youthful exuberance today often leads to youthful regret tomorrow.

Remember that the elephant in the room for some young people – especially girls – is the issue of sexual abuse or another form of substantial adverse experience (such as home violence; parental substance abuse; emotional abuse). In some studies, the presence of these adverse experiences substantially increases the risks for behavioral and emotional disorder. Youth with marked emotional labiality, self harm behaviors or inadequate response to usually effective treatments may be dealing with past or ongoing abuse or other form of persistent adverse experiences.

If you are concerned that this may be an issue it is important to bring forward your concern in a supportive and gentle manner. Be sure to give yourself enough time so that if the young person discloses abuse or other adverse experience that the emotional outpouring that frequently accompanies disclosure can be adequately supported. Make sure that you know the resources available in your community that can support young people who are living this experience. Do not attempt to carry this load on your own.

Engaging the School

In many if not most cases, it will be important to engage the school when dealing with a young person who is living with a mental disorder. There are many aspects to this engagement. It can include but not be limited to:

- data collection (finding out information from the school to assist with diagnosis or treatment planning)
- treatment monitoring (to help determine if a treatment is effective or not)
- curriculum/work-load modifications (to help address cognitive or other problems that can negatively impact on school performance)
- monitoring (receiving feedback on behaviors targeted in the treatment process, such as self – mutilation, SNAP scores with ADHD)

Given the many different components of school engagement, it is not feasible to try and anticipate and describe all possibilities. Instead, a set of general principles to be followed will help guide the health provider.

Do not forget to include the school: Mental disorders can have profound impact on all aspects of a young person's functioning. It is necessary to know how the child is doing at school – academically and socially.

Be clear in what the reason for contact is: Is it for diagnostic purposes, to help evaluate severity of a problem; to monitor treatment; etc? During the course of assessment and treatment the reasons may change. Knowing the reason for contact will help save time and lead to better results.

Develop a single point for contact: Although the student may have more than one teacher it is essential that a single point of contact be established. In many cases this will be a school counselor. This person can then link to other school staff as needed.

Recognize that different schools may have different policies: Schools have many different ways in which they address the needs of students. It is important to know the internal processes of each school.

GPs may see some students for which the school is hoping to get a Ministry of Education Special Needs designation, or already has in the past, in order to access more intensive supports for the student's educational needs. In most cases, they will be the Mental Illness (R) designation schools are seeking, but occasionally they may see a student for who an (H) is being sought, and will certainly do so once the child component happens (Conduct Disorder and ADHD students receive these designations more often than students with depression or anxiety). A description of the requirements for both categories of designation can be found on page 57 of http://www.bced.gov.bc.ca/specialed/special_ed_policy_manual.pdf#page=14

Both these designations require documentation from a qualified professional (for which no school staff meet the criteria) stating they do have a mental illness, if this is the basis for designation, and the creation by the school of an Individualized Education Plan (IEP). A team at the school creates the IEP which describes what the current level of performance is, what adaptations and modifications and supports will be used to support the student, target learning outcomes. The IEP is also shared with the parent who has input, and the student in cases where the student is old enough to take part. For the serious mental illness designation (H) it is also planned with the community service provider(s), as more than one

organization/agency has to be involved to qualify for this designation. Information on the IEP process is found beginning on page 12.

Ensure appropriate confidentiality:Only information pertinent to the school should be discussed. Legal parameters regarding consent need to be followed. Make sure that written consent from the youth and parent (if indicated) has been obtained before communicating with the school. Be careful about sending confidential information by fax or email. Remember that a school fax machine is not necessarily private.

Be appropriately available: In some cases, discussions with the school will be required. It is important to be appropriately available for those. Often the health provider's input can be by telephone.

Keep good records: Ensure notes pertaining to the discussions with the school are put on the patient's record.

Forms: When enlisting the help of school staff in filling out forms (such as the SNAP for assessment of ADHD) it may be necessary to visit the school to meet with teachers and educate them about the use of the tool. Engage the school counselor as a point of contact within the school. The key point is having the contact person at school can explain how that school deals with this type of problem. "What can I expect from you?" "What can you expect from me?"

A single point of contact within the school is very helpful for conduit of info or advocate of having accommodations made.

A testament to the program

Recently I was gratified, despite a late arrival home, following the identification of significant mental health issues in an early adolescent male presenting with poorly managed asthma and abdominal pain .

Further enquiry revealed underlying anxiety, depression and adjustment issues pertaining to a move to a new school, while living part time with an anorexic mother.

His dad, while flabbergasted, was extremely grateful at how fast we were able to hone in on the problem and start treatment in the smooth resolution of the issues at hand.

He, like sixteen others before him has since successfully worked through a copy of the teen "Dealing with Depression" handbook.

His recovery has been quite remarkable.

This last case is yet another testament to this great program.

In my opinion the BCMA's PSP Youth and Adolescent Mental Health Program tools for diagnosis, rapid assessment and expeditious treatment of youth mental health issues, are indeed superb.

Future generations will reap the benefits of this module that seamlessly provides for assessment, diagnosis, and expeditious treatment, while simultaneously inspiring confidence in patients, health professionals and school counselors alike .

Well done to you and all your team whose hard work has made this primary care advance so possible.

Dr. Charles Webb

Appendix

Legislation

BC Infant Act: BC's Infants Act says that children under 19 have the right to consent to their own health care which includes mental health. Parents are almost always informed, but ultimately a child does not need parental consent to seek and receive help if the child is mature enough to understand the risks and consequences of the treatment. The law considers them capable if they understand the need for a medical treatment, what the treatment involves, the benefits and risks of getting the treatment, and the benefits and risks of not getting the treatment. If the doctor or health care provider explains these things and decides that the child understands them, they can treat the child without permission from the parents or guardians. The child might have to sign a consent form.

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Suggested Websites

ADHD

Resources for clinicians

- Attention Deficit Disorder Association: http://www.add.org/?page=ADDA_support_resourc
- American Academy of Family Practice: http://www.aafp.org/afp/2002/0215/p726.html
- American Academy of Child and Adolescent Psychiatry - www.aacap.org
- Canadian ADHD Resource Alliance: http://www.caddra.ca/cms4/
- National Institute of Mental Health http://www.nimh.nih.gov/health/topics/attention-deficit-hyperactivity-disorder-adhd/index.shtml
- Sun Life Financial Chair in Adolescent Mental Health – www.teenmentalhealth.org
- Community Healthcare and Resource Directory (CHARD) - http://info.chardbc.ca
- Healthy Living Toolkits, families and health professional versions, contain information, resources, and tools to help children and youth with mental health challenges develop healthy living habits http://keltymentalhealth.ca/toolkits.
- Child and Adolescent Needs and Strengths (CANS) http://www.praedfoundation.org/About%20the%20CANS.html

Resources for families

- About.com ADD/ADHD: http://add.about.com/
- A Family AD/HD Resource: http://w3.addresources.org/
- American Academy of Child and Adolescent Psychiatry: http://www.aacap.org/cs/adhd_a_guide_for_families/resources_for_families_adhd_a_guide_for_families
- Attention Deficit Disorder Resources: http://www.addresources.org
- Centre for ADD/ADHD Advocacy, Canada http://www.caddac.ca/cms/page.php?2
- Children and Adults with Attention Deficit Disorder: http://www.chadd.org
- Learning Disabilities association of British Columbia: http://www.ldabc.ca/
- Kelty Mental Health Resource Centre: http://www.bcmhas.ca/supportcentre/kelty/default.htm
- Kids Health.org: http://kidshealth.org/parent/medical/learning/adhd.html
- National Institute of Mental Health http://www.nimh.nih.gov/health/topics/attention-deficit-hyperactivity-disorder-adhd/index.shtml
- National Information Center for Children and Youth with Disabilities: http://www.kidsource.com/NICHCY/ADD1.html
- The disorder named ADHD: http://www.help4adhd.org/documents/WWK1.pdf
- Collaborative Mental Health Care - http://www.shared-care.ca/toolkits-adhd
- Healthy Living Toolkits, families and health professional versions, contain information, resources, and tools to help children and youth with mental health challenges develop healthy living habits http://keltymentalhealth.ca/toolkits.
- Learning Disabilities: www.ldonline.org
- The Government of Alberta has a great website for teachers that outlines classroom strategies for ADHD: http://education.alberta.ca/admin/special/resources/adhd.aspx. This resource would be relevant for parents advocating for adaptations at school.

Next

Anxiety

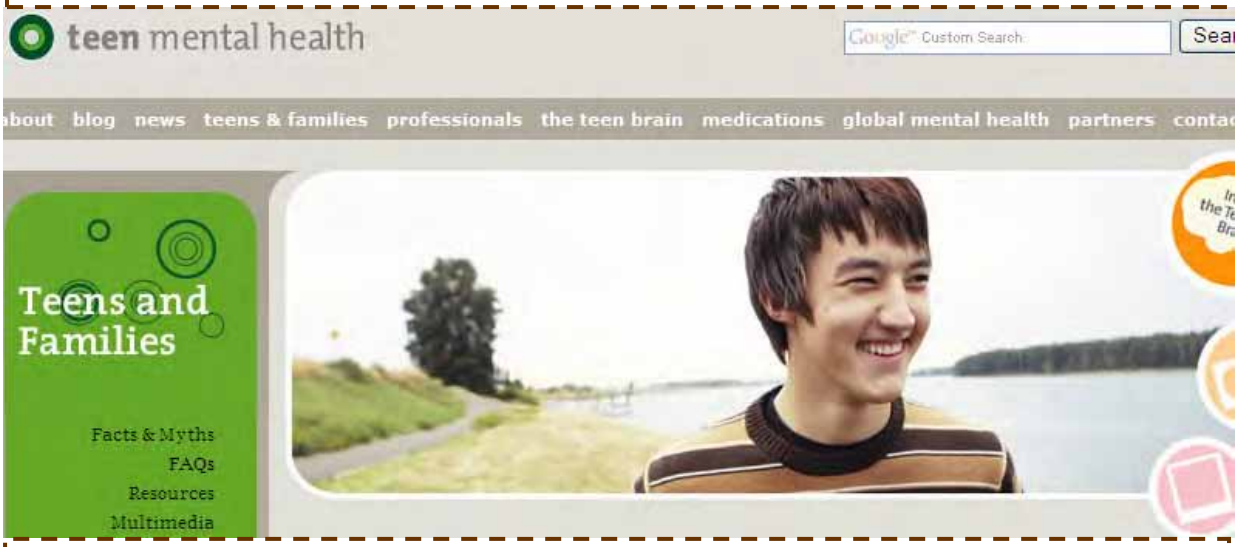
- Resources for youth and families can be found on Anxiety BC website - www.anxietybc.com/ and on the Kelty Mental Health Resource Centre website.
- http://www.anxietybc.com/parent/complete_home_tool_kit.php - For parents assisting their anxious children or teens
- Treatment guideline algorithm for health care providers in treatment of anxiety disorders and depressive disorders in youth - www.bcguidelines.ca/gpac/guideline_depressyouth.html#algorithm
- American Academy of Child and Adolescent Psychiatry - www.aacap.org
- Sun Life Financial Chair in Adolescent Mental Health – www.teenmentalhealth.org
  Collaborative Mental Health Care - http://www.shared-care.ca/toolkits-anxiety
- Healthy Living Toolkits, families and health professional versions, contain information, resources, and tools to help children and youth with mental health challenges develop healthy living habits http://keltymentalhealth.ca/toolkits.
  Child and Adolescent Needs and Strengths (CANS)
  http://www.praedfoundation.org/About%20the%20CANS.html

Depression

- Resources for families and health providers can be found on GLAD PC website – http://www.gladpc.org
- Texas TMAP website, and the Families for Depression awareness has information for families and patients at http://www.familyaware.org
- American Academy of Child and Adolescent Psychiatry - www.aacap.org
- Sun Life Financial Chair in Adolescent Mental Health – www.teenmentalhealth.org
- Collaborative Mental Health Care - http://www.shared-care.ca/toolkits-anxiety
  Healthy Living Toolkits, families and health professional versions, contain information, resources, and tools to help children and youth with mental health challenges develop healthy living habits http://keltymentalhealth.ca/toolkits.
  Child and Adolescent Needs and Strengths (CANS)
  http://www.praedfoundation.org/About%20the%20CANS.html
-

Next

http://www.teenmentalhealth.org/family_multimedia.php



Summary:

- Website includes
- Common myths & facts about mental illness and FAQs
- Links to other sites, blogs, etc.
- Articles and short books for patients & family members that can be downloaded

http://www.heretohelp.bc.ca/

Information and Resources related to:

- Handling Stress
- Depression and Anxiety
- Body Image
- Alcohol and Other Drugs
- Schizophrenia and Psychosis

Next

http://www.comh.ca/publications/pages/dwd/

- **DWD - Dealing with Depression: Anti-Depressant Skills for Teens**, a guide for teens and adults; intended to assist youths who suffer from depression or who believe they have early or mild forms of depression. With:
  - answers to common questions about teen depression.
  - interactive worksheets.
  - links to other sources of information.
  - option to download, save or print the file.

Next

Practice Support Program **Additional Resources – Family/Caregiver**

Online references:

Ministry for Children and Family Development website:
http://www.mcf.gov.bc.ca/mental_health/resource_lists.htm

Summary of site:

- Includes links to booklists that target three common problems affecting many children, youth and families in BC
  - Mood problems and depression
  - Anxiety
  - Behaviour problems
- These books have been through an extensive review process that has included parents, families and professional groups such as the Canadian Paediatric Society.
- Books on the booklists are available at all main library branches in BC

http://www.mcf.gov.bc.ca/mental_health/mh_publications/Parent_Info_Bro_BC_Mood.pdf

Summary of handout (2 pages)

- Recognizing symptoms of depression in young children as well as adolescents,
- Types of mood problems in youth
- Some book references included
- Can be printed

Next

http://www.heretohelp.bc.ca/skills/supporting-family

For parents, caregivers, siblings and other family members.

- When a family member suffers from a mental illness, one of the most important things to do is to take the time to learn about the disorder.
- By educating yourself as much as you can about the mental or substance use disorder, you can take an active role in your family member's recovery.

http://www.bcmhas.ca/SupportCentre/Kelty/default.htm

Summary:

- Provides information to link children, youth and their families with appropriate resources in all areas of mental health and addictions.
- Parent peer volunteers available to speak to parents

Print

Return to p 1

CANADIAN MENTAL HEALTH ASSOCIATION
ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE
BC DIVISION

Strongest Families BC Referral Form

Strongest Families

Referral Checklist: Disruptive Behaviours ages 3 - 12

Strongest Families BC is a parent training program for disruptive behaviour in children aged 3 to 12.

Please print:

Child's Name: _____ DOB: ____ /____ /_____ Gender: _____ PHN#: _____
mm dd yyyy

Parent/ Guardian Name: _____ Phone number: _____

Mailing address: _____

_____ Postal Code: _____

Referring physician: _____ Phone: _____ Fax: _____

Inclusion Criteria	**Ineligible**	**Eligible**
1. Is the child 3–12 years of age?	No ❑	Yes ❑
2. Does this child exhibit symptoms of disruptive, defiant or oppositional behaviour/ conduct or attention/concentration problems at home or school/daycare?	No ❑	Yes ❑
3. Are these symptoms a regular feature of the child's behavior (not isolated instances)?	No ❑	Yes ❑
4. Is the child's behaviour problem considered mild or moderate?	No ❑	Yes ❑
Exclusion Criteria		
1. Does this child have any of the following: Autistic spectrum disorder, early psychosis?	Yes ❑	No ❑
2. Does this child have significant intellectual impairment that would interfere with a skill focused intervention program?	Yes ❑	No ❑
3. Is the child's behaviour problem considered severe (i.e. child is at imminent risk of harming self; extreme conduct issues; or multiple severe co-morbid conditions)?	Yes ❑	No ❑
DO NOT refer if any answer appears in shaded column	do not refer ✗	ok to refer ✓

Date: _____

Comments: _____

_____

_____

_____

Fax completed/signed referral to: 1-877-688-3270

Strongest Families BC is offered in partnership with the Strongest Families Institute in Nova Scotia
Funding for Strongest Families BC provided by the Province of British Columbia

CMHA BC Division
Strongest Families BC
Toll-Free Fax: 1-877-688-3270
Toll-Free Phone: 1-855-297-4777
Strongestfamilies@cmha.bc.ca
Strongestfamiliesbc.ca

Return to Algorithm

PSP CYMH Module

Referral Flags

Emergency

- Suicidal intent with plan, or moderate to serious suicide attempt including overdose, hanging, choking or excessive bleeding as a result of deep cutting etc. – go to ER
- Acute psychosis – go to ER; if possibly manageable in community/by parents, consult with or refer to Early Psychosis Intervention (EPI) Program.
    a. To give patient information about EPI
    b. For physician referral to EPI

Urgent

- If first time presentation of psychotic symptoms or suspected psychosis, refer to Early Psychosis Intervention (EPI) Program
    a. To give patient information about EPI
    b. For physician referral to EPI

- For other acute mental health crises, severe symptoms & deterioration in function, suicidal ideation, other major psychiatric conditions, refer to Child & Youth Crisis Program

Usual

- For additional therapy etc, refer to MCFD Child and Youth Mental Health (This link will connect to MCFD's website where you can search for the local CYMH office. For Surrey region, call Integrated & Screening Team)
- For specialized psychiatric consultations, refer to
    - the Infant Psychiatric Clinic,
        - To give patient information about Infant Psychiatric Clinic
        - For physician referral to Infant Psychiatric Clinic
    - the Child & Youth Neuropsychiatric Clinic,
        - To give patient information about Child & Youth Neuropsychiatric Clinic
        - For physician referral to Child & Youth Neuropsychiatric Clinic
    - and the General Teaching Clinic.
        - To give patient information about the General Teaching Clinic
        - For physician referral to the General Teaching Clinic

What is Psychosis?

When people have difficulty coping, it can take various forms. Anxiety, depression, or stress can often be signs of difficulty. It could also be psychosis.

The word "psychosis" is used to describe conditions affecting the mind, in which there is some loss of contact with reality. It affects thoughts, feelings and behaviours. Hallucinations (perceptual distortions of the senses), delusions (false beliefs), paranoia and disorganized thoughts and speech are symptoms of psychosis. These symptoms can seem so real that the person may not realize that they are experiencing psychosis.

Approximately 3% of people will have a psychotic episode at some stage in their life, although a first episode usually occurs in adolescence or early adult life. Psychosis occurs across all cultures and levels of socioeconomic status and affects males and females.

There are multiple causes of psychosis, which can include inherited or acquired medical conditions, substance abuse or withdrawal, or exposure to severe stress.

Psychosis varies greatly from person to person. Individuals may have very different experiences or symptoms.

What is EPI?

EPI stands for 'Early Psychosis Intervention'

The EPI Program is aimed at enhancing the recognition of early signs of psychosis so that effective support and treatment can be started as soon as possible.

The objective is to improve services for young persons who are in the early stages of psychosis. The program bridges youth and adult mental health services, as well as the hospital and community.

Early intervention is prevention

- Early intervention is key to a successful recovery
- Treatment is most effective when it is started early
- For many, the first episode is also the last

Who can be referred to EPI?

The program offers services for persons age 13 to 30 who:

- are experiencing a first psychotic episode or have a suspected psychosis and/or
- have a family history of psychotic disorder and are experiencing a recent deterioration in function at school, work, or home

Please note that **drug use does not disqualify** from referral, when combined with the above criteria.

Who can make the referral?

We welcome referrals from anybody.

How is the referral made?

Initial contact is made by telephone to the EPI Intake Clinician who will gather details to determine if EPI intervention could be helpful. Sometimes other services are recommended.

Who do you call for help?

Don't be afraid to ask for help, for yourself, or for someone you know. If you've noticed some unusual changes in thinking or behaviour, social isolation, and/or feelings of suspiciousness, depression or anxiety, contact your local EPI Program within Fraser Health:

Fraser South
White Rock / Langley / Delta
Surrey
604.538.4278

Fraser North
Burnaby / Tri-Cities / Maple Ridge
New Westminister
604.777.8386

Fraser East
Chilliwack / Abbotsford / Mission
Agassiz / Hope
1.866.870.7847

epi

Early Psychosis Intervention Program

www.psychosissucks.ca

Psychosis SUCKS.

fraserhealth

BRITISH COLUMBIA
Ministry of Children and Family Development

What does EPI provide?

The EPI Program offers clinical services to individuals and their families. The program aims to promote wellness, reduce socially isolating behavior and restore previous levels of functioning.

EPI Clinicians and Psychiatrists work in the Youth and Adult Community Mental Health Centres. EPI Clinicians provide and coordinate all aspects of treatment, counseling, education, case management, support and referrals to adjunct services located in the community. EPI Psychiatrists offer assessment and medical treatment.

Group sessions are held in various locations and are facilitated by group therapists. Groups provide a safe environment in which to meet others who have been through similar experiences. Groups offer education about psychosis through videos, presentations, written material and discussion.

Programs for clients and families may include some of the following:

- Client youth groups
- Client adult groups
- Family education and support groups
- South Asian family education group in Punjabi and Hindi
- Sibling education group
- Family therapy
- Peer Recreational Events

Specialized program components are offered in Fraser South:

- Vocational Rehabilitation services include assisting with return to work, developing work skills, college/university planning, career interest testing, volunteer work crews

Education and Training

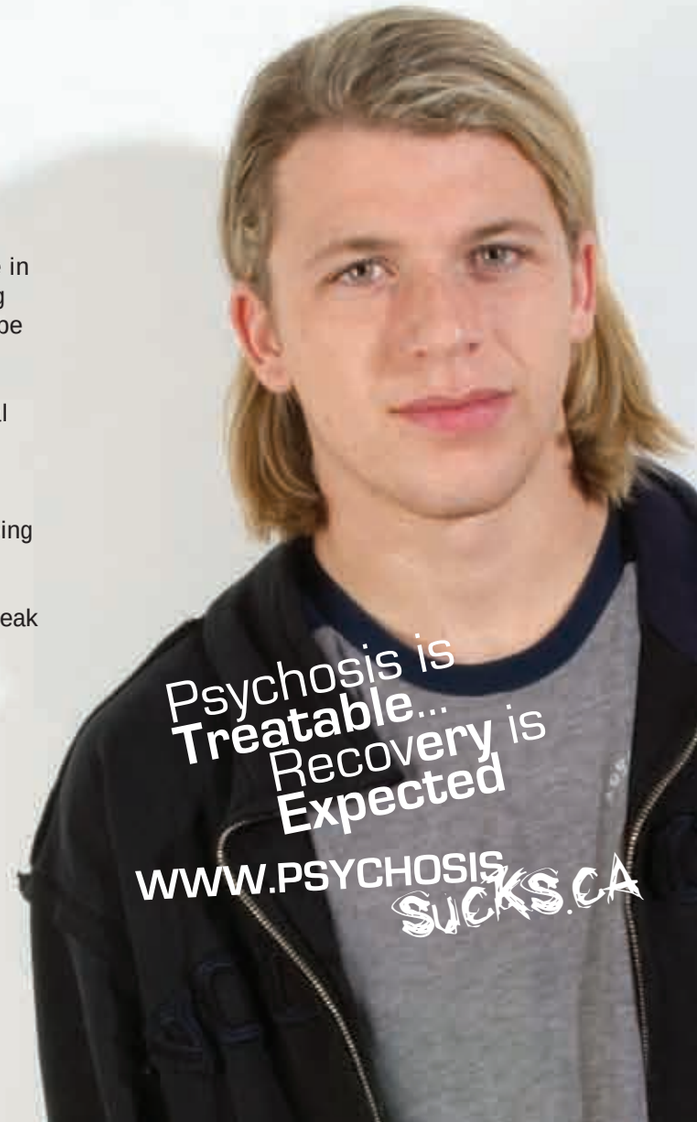
Professionals and community agencies who work with young people play an integral role in the awareness, program referral and ongoing support of youth and young adults who may be experiencing mental health concerns.

The Fraser EPI Programs provide, educational presentations, workshops and information about psychosis, early detection, causes, referral and treatment.
We also provide tools and resources for ongoing support.

Contact your local EPI Program and ask to speak to the Educator.

Having Difficulty Coping?

...it could be psychosis



General Physician Referral Form
Fraser Early Psychosis Intervention Program

epi Early Psychosis Intervention Program

Fax to EPI Intake:

☐ Fraser South	☐ Fraser North	☐ Fraser East
Fax: 604-538-4277	**Fax: 604-520-4871**	**Fax: 604-851-4826**
White Rock	Burnaby	Chilliwack
Surrey	Tri-Cities	Abbotsford
Delta	Maple Ridge	Mission
Langley	New Westminster	Hope and Agassiz
Ph: 604-538-4278	**Ph**: 604-777-8386	**Ph**: 1-866-870-7847

Referral Date: _____

Family Doctor: _____ Billing No._____

Tel. No._____Address:_____

Client Information:

☐ **No prior treatment for psychosis.** ☐ **Client is 13-30 years old**

Client's Legal Name:_____Date of Birth:_____
(dd/mm/yy)

☐**M** ☐**F** PHN: _____ Client Telephone No._____

Client Address: _____

Next of Kin: _____ ☐ Client aware of referral

Current Medication_____

Referral information: Relevant history/ presenting problems/ known risks

_____

_____

_____

_____

_____

_____

_____

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BRITISH COLUMBIA
Ministry of Children and Family Development

Child and Youth Crisis Program

Program Description

The Child and Youth Crisis Program (CYCP) is a **collaborative initiative between Fraser Health and the Ministry of Children and Family Development**, serving children, youth and their families living in the Fraser Health region.

CYCP provides crisis response to children and youth between 6-18 years of age who are in an acute mental health crisis.

These children or youth may display behaviours, thoughts and feelings that are considered by the individual, family or others to be markedly different from their normal state and which seriously interfere with their activities of daily living.

These behaviours, thoughts or feelings may include suicidal/homicidal ideation, changes in mood, symptoms of psychosis, and/or self-injurious behaviour, which may or may not be induced by substance misuse.

Services Provided

The CYCP provides assessment, brief crisis intervention and resource coordination including a referral to other relevant agencies when required.

The crisis clinician will assess and intervene with the child or youth and their family as soon after the initial referral as possible. CYCP is able to offer up to six subsequent follow-up sessions with the child or youth and their family.

In addition, following an assessment by CYCP, if further psychiatric consultation is required, arrangements can be made for the child or youth to see a psychiatrist through the program.

Referral Process

Referrals to the Child & Youth Crisis Program are made by telephone.

At the time of initial referral, basic demographics, presenting problem(s) and relevant collateral information will be gathered. If the referral does not meet the program mandate, possible alternate referral sources can be discussed.

If the referral is appropriate and telephone resolution does not occur, the crisis clinician will meet with the child or youth and their family as soon as possible.

When possible, the child or youth and their family will be seen in their own community or at a mutually agreed upon, safe location.

CYCP currently accepts professional referrals only

In Partnership with the Ministry of Children and Family Development
- Child and Youth Mental Health -

Who Can Refer?

- Hospital Emergency Departments
- Ministry of Children and Family Development (All Teams)
- Family Physicians
- Other Mental Health and Substance Use Providers
- Suicide Prevention Programs
- Schools
- Community Service Agencies
- Police
- Crisis Lines
- Other Health Care Providers

CYCP South

Delta, Langley, Surrey, White Rock

Intake hours:
Mon-Fri: 9:00 am-9:00 pm
Sat-Sun: 12:00 pm-10:00 pm

Phone: 604-585-5561

CYCP North

Burnaby, New Westminster, Tri-Cities, Maple Ridge & Pitt Meadows

Intake hours:
Mon-Fri: 9:00 am-9:00 pm
Sat-Sun: 11:30 am-9:00 pm

Phone: 604-949-7765

CYCP East

Abbotsford, Mission, Chilliwack, Agassiz, Hope & Boston Bar

Intake hours:
Mon-Fri: 10:00 am-9:00 pm
Sat-Sun: 12:00 pm-9:00 pm

Phone: 604-557-2095
Pager: 1(888) 413-9181

Child and Youth Crisis Program

Serving Children, Youth and their Families

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Fraser Health Child and Youth Neuropsychiatry Clinic

Are you concerned about your child or adolescent?

- Concerned about his or her emotional or social development?
- Concerned about his or her behaviour?
- About problems he or she is having with school?
- Has your child had a head injury and now has problems?
- Has your child been diagnosed with Autism Spectrum Disorder and has additional emotional problems?
- Has your child had meningitis and now has problems he or she didn't have before?
- Does your child have tics or Tourette's Disorder?
- Does your child struggle with Obsessive Compulsive Disorder?
- Is your child developmentally delayed and has additional emotional problems?
- Does your child have a genetic disorder?
- Does your child have a seizure disorder?

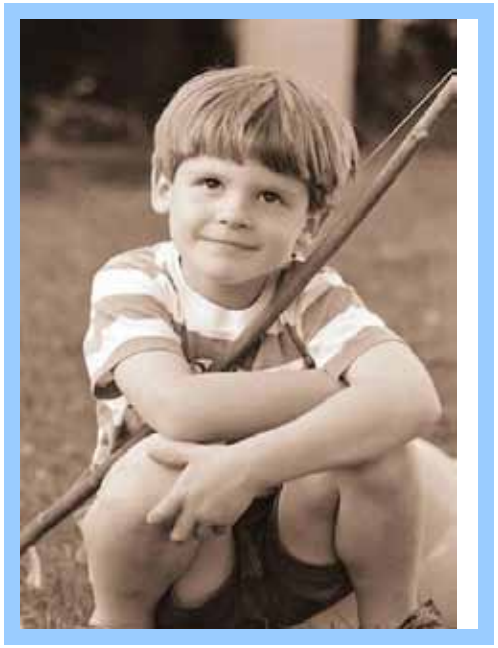
Have you spoken to a community professional who shares your concerns about your child?

Please know help is available through a variety of services, including the **Fraser Health Child and Youth Neuropsychiatry Clinic.**

This Clinic is for **children and youth aged 5 to 18 years old** and their families who live in Fraser Health.

The Clinic, staffed by psychiatrists and a mental health clinician, **offers specialized assessments, consultation and short-term treatment.**

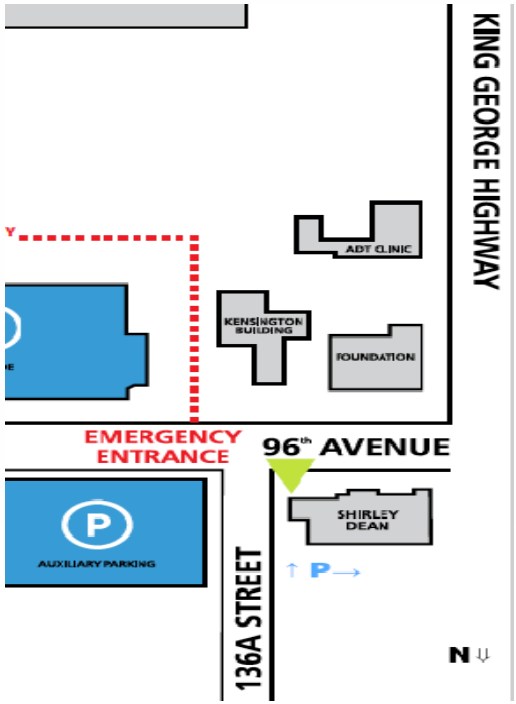
Participation in the clinic is voluntary.



Referral Process/Info

- A referral from your **family doctor** or other **medical specialis**t is required to have an appointment at this clinic.
- Information from other professionals already working with the child or youth is welcome.
- Once the appointment has been scheduled, your doctor or medical specialist will be notified of the day and time of the appointment. Your doctor or medical specialist will let you know the details of your appointment at the clinic.
- If is **your responsibility to confirm** the appointment with the clinic.
- If a referral is received and it seems that the clinic is not the best service for your child or youth, you will be redirected to more appropriate services.
- Children and youth who need longer-term support will be referred to appropriate resources in the community.

Map



Parking and Transit:
Pay parking is available throughout the Surrey Memorial Hospital site.

The Shirley Dean Pavilion is located four blocks south of the King George Sky Train Station and is accessible by bus.

Contact Information

Address:

Shirley Dean Pavilion
Surrey Memorial Hospital
9634 King George Boulevard
Surrey, BC, V3T 0G7

Main Number: 604-587-3814
Fax Line: 604-587-3857

Directions:
The **Fraser Health Child and Youth Neuropsychiatry Clinic** is located on the ground floor of the **Shirley Dean Pavilion.** The **Shirley Dean Pavilion** is across the street from the main entrance to Surrey Memorial Hospital.

To get to the **Shirley Dean Pavilion**, enter the parking area outside of the building on 96th Avenue.

In collaboration with Ministry of Children and Family Development & Child and Youth Mental Health

www.fraserhealth.ca

Fraser Health Child and Youth Neuropsychiatry Clinic

Serving children and youth 6 to 18 years old and their families

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respect · caring · trust

Return to Referral Flags

Fraser Health Child and Youth Neuropsychiatry Clinic

Our services:

- The **Fraser Health Child and Youth Neuropsychiatry Clinic** serves families with children aged **five to eighteen years** old who live in Fraser Health.

- The clinic is a tertiary service for specialized child and youth neuropsychiatric and neuro-developmental disorders. Specialized assessment, and consultation and treatment are offered. In addition to consultation, evaluation, and diagnoses, short-term treatment is available in some situations. This clinic will provide the opportunity to help stabilize the child or youth on medications.

- The clinic will make referrals to appropriate community agencies and other services as needed to work collaboratively for the best interest of the child or youth. Liaison with the school and family work will be offered through the clinic.

- Participation in the clinic is **voluntary**.

Our team:

- The Child and Youth Neuropsychiatry Clinic team members include psychiatrists, a mental health clinician and psychiatric residents/medical students.

Referrals:

- **Referrals** will be accepted from physicians and we welcome collateral information from other professionals involved with the child and youth.

- Referrals can be made for children and youth with the following disorders: previously diagnosed Autism Spectrum Disorder with co-morbid psychiatric symptoms, Seizure Disorders, post-meningitis conditions, head injuries, Complex Attention Deficit and Hyperactivity Disorder, Tourette's Disorder, Fetal Alcohol Spectrum Disorder, Alcohol-related Neurodevelopmental Disorder, severe Obsessive-Compulsive Disorder, and/or Genetic Disorders with psychiatric symptoms. Other neuropsychiatric disorders will be considered as well.

- Referrals not deemed appropriate for the clinic will be returned to the referral source with a suggestion as to another suitable service for the child or youth.

- Once the appointment day and time are made, the referral source will be notified. It is the responsibility of the referral source to let the family know about the appointment. It is the family's responsibility to confirm the appointment with the clinic.

- Please fax referrals to 604 587-3857. Please contact the clinic if you have any questions.

Fraser Health Child and Youth Neuropsychiatry Clinic
Shirley Dean Pavilion- Surrey Memorial Hospital
9634 King George Boulevard
Surrey, BC, V3T 0G7

Phone: 604-587-3814
Fax: 604 567-3857

Respect, Caring, Trust

www.fraserhealth.ca

Fraser Health Child and Youth Psychiatry General Teaching Clinic

Concerned about your child or teen?

- Have you noticed a change in your child's behaviour?
- Does your child's mood seem unusually irritable or depressed?
- Is your child excessively worried or anxious?
- Has your child become increasingly isolated from friends and family?
- Does your child have difficulty coping with problems and daily activities?
- Have you noticed a significant change in your child's sleeping or eating habits?
- Does your child display frequent outbursts of anger or rebellion?
- Is your child experiencing intense nightmares or flashbacks from a traumatic event?
- Does your child have intense mood swings or feelings of extreme highs and lows?
- Does your child have difficulty with concentration and attention?
- Does your child have specific fears that get in the way of his/her daily activities?
- Has your child lost interest in activities he/she used to enjoy?
- Does your child avoid social activities or have excessive concern about social embarrassment?
- Has your child refused to go to school or have you noticed a significant decline in school performance?

Please know help is available through a variety of services, including the **Fraser Health Child and Youth Psychiatry General Teaching Clinic.**

The General Teaching Clinic is **for children and youth** from ages **six to 18** years who live in Fraser Health.

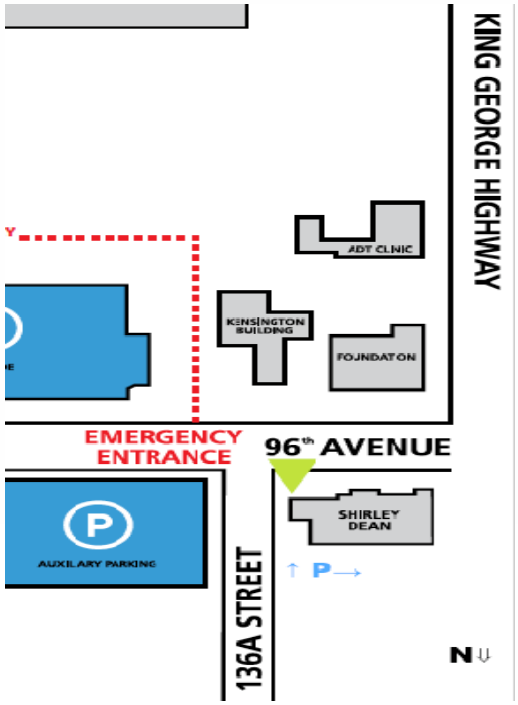
The clinic, staffed by psychiatrists, a clinical social worker, psychiatric residents and medical students, **offers specialized assessments, consultation, and short term treatment.**

Participation in the clinic is voluntary.

Referral Process / Info

- A referral from your **family doctor** or other **medical specialist** is required for a clinic appointment.
- Information from other professionals already working with your child is welcome.
- The clinic provides a teaching environment for residents and medical students. **Families referred to the clinic must be willing to have their child or teen seen by a psychiatric resident and/or a medical student.**
- If a referral is not accepted to this clinic, you will be redirected to more appropriate services.
- Children or adolescents who need longer-term support will be referred to appropriate resources in the community.
- Once the appointment has been scheduled, your doctor or medical specialist will be notified of the day and time of the appointment. Your doctor or medical specialist will let you know the details of your appointment.
- It is **your responsibility to confirm** the appointment with the clinic.

Map



Parking and Transit:
Pay parking is available throughout the Surrey Memorial Hospital site.

The Shirley Dean Pavilion is located four blocks south of the King George Sky Train Station and is accessible by bus.

Contact Information

Address:

Shirley Dean Pavilion
Surrey Memorial Hospital
9634 King George Boulevard
Surrey, BC, V3T 0G7

Main Number: 604-587-3814
Fax Line: 604-587-3857

Directions:
The **Fraser Health Child and Youth Psychiatry General Teaching Clinic** is located on the ground floor of the **Shirley Dean Pavilion.** The **Shirley Dean Pavilion** is across the street from the main entrance to Surrey Memorial Hospital.

To get to the **Shirley Dean Pavilion**, enter the parking area outside of the building on 96th Avenue.

In collaboration with the Ministry of Children and Family Development, Child and Youth Mental Health

FRASER HEALTH CHILD AND YOUTH PSYCHIATRY GENERAL TEACHING CLINIC

Serving children and youth 6 to 18 years old and their families

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Return to Referral Flags

Fraser Health Child and Youth Psychiatry General Teaching Clinic

Our services:

- **The Fraser Health Child and Youth Psychiatry General Teaching Clinic** serves families with children from ages six to 18, who live in Fraser Health.

- The General Teaching Clinic provides **initial assessment and consultation for children and youth with a broad range of child and adolescent mental health problems** which may include **depression, anxiety**, **general mood and behaviour disorders.** The General Teaching Clinic also offers a **tertiary service** for children and youth with **complex or treatment resistant mental health disorders.**

- **The General Teaching Clinic serves children and youth in a teaching environment** with psychiatric residents and medical students. **Short term treatment**, including medication management and therapeutic interventions are offered. Brief family therapy may also be available.

- Participation in the clinic is **voluntary.**

Our team:

- The team members include psychiatrists, a clinical social worker and psychiatric residents/medical students.

Referrals:

- The clinic accepts referrals from general physicians, paediatricians and other medical specialists by fax to 604-587-3814. **Please contact us for further information.**

- Children and youth accepted to the clinic will be assigned to a psychiatrist and to the clinical social worker and/or to a resident as appropriate. **Families referred to this clinic must be willing to have their child or teen participate in a teaching environment for psychiatric residents and medical students.**

- Once the appointment day and time are made, the referral source and the parents/guardians will be notified. It is the family's responsibility to confirm the appointment with the clinic.

- Referrals not deemed appropriate for the General Teaching Clinic will be redirected to other suitable services in the community.

Our location:

Fraser Health Child and Youth Psychiatry
General Teaching Clinic
Shirley Dean Pavilion, Surrey Memorial Hospital
9634 King George Boulevard
Surrey, BC, V3T 0G7

Phone: 604-587-3814
Fax: 604-587-3857

Respect, Caring, Trust
www.fraserhealth.ca

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FRASER HEALTH CHILD AND YOUTH PSYCHIATRY CLINICS
SERVING ALL OF THE FRASER HEALTH REGION

Located at the Shirley Dean Pavilion, Surrey Memorial Hospital
Outpatient Psychiatry, Shirley Dean Pavilion, 9634 King George Boulevard, Surrey, B.C. V3T 0G7
Telephone: 604.587.3814; Fax: 604.587.3857

REFERRAL FORM:

Please check one of the following:

☐ **CHILD AND YOUTH NEUROPSYCHIATRY CLINIC**

☐ **CHILD AND YOUTH PSYCHIATRY, GENERAL TEACHING CLINIC**

☐ **URGENT REFERRAL** ☐ **NON-URGENT REFERRAL**

PART 1 – PATIENT INFORMATION

Child's surname: _____ **Child's first name**: _____
DOB: month _____day ____year _____ Gender: male ____ female ____ transgender _____
PHN: ____ ____ ____
Address: _____
City_____ Postal Code_____
Day phone_____ Cell phone _____ Other phone_____

Please check preferred method of contact: ☐ day phone ☐ cell phone ☐ other phone

PART 2 – PHYSICIAN INFORMATION

Referring Physician: _____ Billing # _____
Phone: _____ Fax: _____
Family Physician: _____
Phone: _____ Fax: _____
Additional physicians: _____
Phone: _____ Fax: _____

PART 3 – CONSENT

It is essential that consent is obtained from both custodial parents prior to the referral. Please confirm that consent has been obtained: ☐ yes ☐ no

Who should we contact to book the appointment? Name: _____
Contact number: _____ Relationship to the patient: _____
If MCFD is involved, please provide the name and phone number of the social worker:
_____
Is there a need for an interpreter? If so, please indicate the preferred language: _____

PART 4 – PARENT AND LEGAL GUARDIAN INFORMATION

Please list all parents and/or legal guardians:
Surname: _____ first name: _____ Phone number_____
Relationship to child: _____ Legal guardian: ☐ yes ☐ no
Surname: _____ first name: _____ Phone number_____
Relationship to child: _____ Legal guardian: ☐ yes ☐ no
Surname: _____ first name: _____ Phone number_____
Relationship to child: _____ Legal guardian: ☐ yes ☐ no

Please indicate if there are any ongoing custody and/or access issues:
_____
_____
_____
_____

Return to Referral Flags

PART 5 – REASONS FOR REFERRAL – PLEASE COMMENT IN ALL SECTIONS

Psychiatric reason for referral:

_____
_____
_____
_____
_____
_____

Brief history of Psychiatric concerns:

_____
_____
_____
_____
_____
_____

Safety concerns including past or present risk of harm to self or others:

_____
_____
_____
_____
_____

Any history of violence or ongoing family violence?

_____
_____
_____
_____
_____

Substance use concerns including past or present alcohol use and drug use:

_____
_____
_____
_____
_____

PART 6 – MEDICAL INFORMATION

Current medications including dose and date began:

_____
_____
_____
_____

Allergies and known medical conditions:

_____
_____
_____
_____

Please attach additional information if available.

REFERRAL SIGNATURE: _____ DATE: _____

PLEASE FAX ALL RELEVANT CONSULTATION REPORTS AND ANY ADDITIONAL INFORMATION TO 604-587-3857

Fraser Health Infant Psychiatry Clinic

Are you concerned about your infant or child?

- *about their emotional or social development or challenging behavior.*
- *about difficulties they are experiencing as a result of trauma or extreme stress.*

Have you spoken to a community professional who shares your concerns about your child?

Please know **help is available** through a variety of services including **Fraser Health's Infant Psychiatry Clinic**.

This clinic is for infants, young children and their families who live in the communities of Fraser Health.

About our clinic

Our specialists, a psychiatrist and therapist, provide assessments, consultations and short-term treatment to support the developmental, social and emotional needs of infants and young children, from birth to five years of age.

All participation is **voluntary**.

Families who require longer-term support will be referred to appropriate resources in the community as needed.

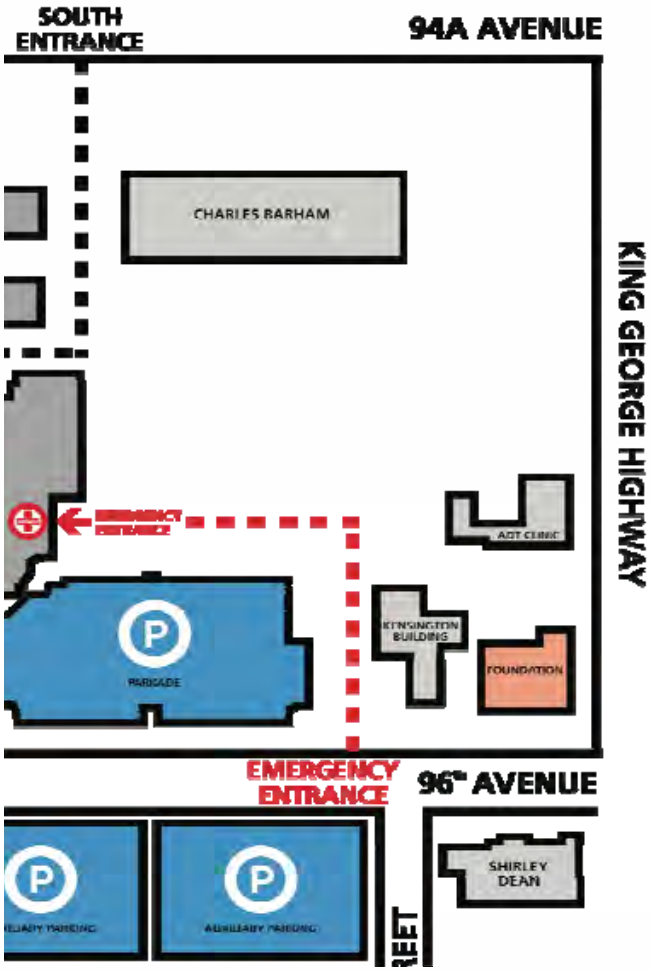
Referral Process

- A referral from **your family doctor or medical specialist** is **required** in order for you to participate in this clinic.
- Once the appointment has been scheduled, your doctor/medical specialist will be notified of the day and time, and he/she will let you know about the appointment details.
- It is your responsibility to **confirm** the appointment with the clinic.

If it is determined that this clinic is not the best service to meet your child/family's needs you will be redirected to other suitable services in your community.

Return to Referral Flags

Map



Enter at Emergency entrance and turn right for the Kensington Building. Purchase your parking ticket at the ticket machine behind the Kensington Building, next to another modular building. You need to remember your parking stall number to purchase your parking ticket.

Contact Information

Address:

Surrey Memorial Hospital
Outpatient Psychiatry, 1st Floor
KENSINGTON BUILDING
13750 – 96th Avenue
Surrey, BC V3V 1Z2

Directions:

The Infant Psychiatry Clinic is located in the Kensington building on the Surrey Memorial Hospital site. The Kensington building is a modular building located west of the main hospital entrance at the emergency entrance on 96th Ave.

Phone: 604-585-5666, local 778263
Fax: 604-587-3943

Parking and Transportation:

Pay parking available.
On public transit routes. four blocks south of the King George Sky Train Station.

In collaboration with Ministry of Children & Family Development, Child & Youth Mental Health

FRASER HEALTH INFANT PSYCHIATRY CLINIC

Serving infants and young children 0-5 years old and their families

fraserhealth Better health. Best in health care.

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FRASER HEALTH
INFANT PSYCHIATRY CLINIC

- **Fraser Health's Infant Psychiatry Clinic** serves families with infants/young children from **birth to age five years** who live in the communities of Fraser Health.
- The clinic is on the main floor of the Kensington Building, located west of the main entrance of **Surrey Memorial Hospital**.
- The clinic is a tertiary service for **specialized infant/child mental health consultation**.
- In addition to consultations, short-term intervention is available.
- The clinic will also make referrals to appropriate community agencies as needed.

- Participation in the clinic is **voluntary**.
- Infants/young children may be referred when parents have concerns about their **child's emotional or social development** or if the infant/young child has **challenging behaviour**.
- Infants/young children may be seen if they have **difficulties as a result of trauma or extreme stress**.
- Appropriate referrals are **infants/young children** whose parents have spoken to a community professional who shares their concerns about the child.
- Referrals are also accepted when parents have concerns about **their relationship** with their child.

- **Referrals** will be accepted **by fax** from family doctors or medical specialists.
- At a weekly meeting, clinic team members will review the referrals for appropriateness and to determine priority. Families accepted to the program will be assigned to the psychiatrist and to the other clinician as appropriate. Families not accepted will be redirected to other suitable services in their home community.
- Once the appointment day and time are made, the referral source will be notified. It is the responsibility of the referral source to let the family know about the appointment.
- It is the family's responsibility to confirm the appointment with the clinic.

Infant Psychiatry Clinic
Surrey Memorial Hospital
Kensington Building
Outpatient Psychiatry
13750 – 96th Avenue
Surrey, BC V3V 1Z2

Phone: 604-585-5666 local 778263
Fax: 604-587-3943
Website: www.fraserhealth.ca

Respect, Caring, Trust

FRASER INFANT PSYCHIATRY CLINIC
SERVING ALL OF FRASER HEALTH
Located at the Surrey Memorial Hospital
Outpatient Psychiatry, KENSINGTON BUILDING, 13750 96th Avenue, Surrey, B.C. V3V 1Z2
Telephone: 604.585.5666, local 778263; Facsimile 604.587.3943

REFERRAL FORM: FRASER HEALTH INFANT PSYCHIATRY CLINIC
Please check one of the following: □ URGENT REFERRAL □ NON-URGENT REFERRAL

Child's surname: _____ Child's first name: _____

DOB: month _____day ____year _____ Gender: male_____ female_____

Child's Personal Health Number (PHN): _____

Child's address: apartment/unit number_____ street address_____

city_____ postal code_____

Day phone_____ cell phone _____ other phone_____
Please check preferred method of contact: □ day phone □ cell phone □ other phone

Please list all parents and/or legal guardians:
Surname: _____ first name: _____ Phone number_____

Relationship to child: _____ legal guardian: □ yes □ no

Surname: _____ first name: _____ Phone number_____

Relationship to child: _____ legal guardian: □ yes □ no

Surname: _____ first name: _____ Phone number_____

Relationship to child: _____ legal guardian: □ yes □ no

Please indicate if there are any ongoing custody and/or access issues:

_____

It is essential that consent is obtained from both custodial parents prior to the referral. Please confirm that consent has been obtained: □ yes □ no
If MCFD is involved, please provide the name and phone number of the social worker:

_____
Is there a need for an interpreter? If so, please indicate the preferred language:

_____

Referring physician: _____ **Billing#**_____

Phone:_____ **Facsimile:** _____

Family physician, if not referring physician: _____ phone: _____

Additional physicians: _____ phone: _____

Reason for referral: _____

_____

_____

Relevant medical and developmental information including additional reports:

_____

Current medications: _____

Are there any safety concerns about which we should be aware? _____
A history of parental substance use, including past or present alcohol and drug use?

_____
Any history or ongoing family violence? _____
Please note other professionals involved with the child and family:

_____
If appropriate, would you like this patient booked for follow-up appointments? □ yes □ no
Please attach additional information if available.
REFERRAL SIGNATURE: _____ **DATE:** _____