



Mental Health in the Primary Care Setting: Addressing the Concerns of Children and Youth

SECOND EDITION

A Desk Reference

Healthy Minds / Healthy Children Outreach Services
Southern Alberta Child and Youth Health Network (SACYHN)





FORWARD

The vast majority (nearly 80%) of children who receive mental health services obtain them from their family health care provider. Childhood mental health disorders present a particularly complex challenge to the family practitioner. The typical family physician working in a busy practice must identify the presenting symptoms, make an accurate diagnosis and determine a treatment plan within the span of a few minutes. This desk reference is a compilation of some of the most frequently presenting mental health concerns and provides a useful aid to the busy physician in accurately identifying and treating their young patients.

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Children's Mental Health

Up to one in four Canadian children and adolescents have a mental health concern serious enough to warrant professional attention. Nearly one in ten has contemplated suicide in the past year. One in ten has three or more diagnosable problems. Sadly, 9 out of every 10 of these troubled young people will probably not receive any treatment. Of those able to get help, 80% will receive it from their family doctors, making them the largest source of mental health services in the country.

Although family physicians regularly provide mental health service, surveys have shown that many of them express doubts about their skills to effectively manage mental health concerns and disorders. Furthermore, many physicians are simply too overworked to find enough time to receive regular in-servicing on children's mental health topics.

An easy solution would be to encourage physicians to refer all of their mental health patients to specialized services. However, such services have long waiting times, they are often centralized and far from those in need. Family doctors are likely, therefore, to continue to be the main mental health service providers for most people. Changes in the mandate of social agencies like Children's Protective Services are likely to intensify demands on family doctors as well as specialist mental health resources.

Given the mental health needs of children and adolescents, and the noted constraints on service accessibility and availability, it is vital to develop supports to help physicians effectively identify and treat their young mental health patients. In recent years, many new programs have sprung up designed to provide these supports. These programs go by such names as shared mental health care or collaborative mental health care. They usually consist of allied mental health professionals contacting primary health care providers, consulting with them in their offices, providing them with the most recent information on mental health topics, supporting access to psychiatric consultation, and delivering in-service seminars.

A growing body of evaluation data on these programs and their resources suggests that they can be quite effective. Patients like them because they feel connected to mental health specialists through the convenience of their family physician's office. Physicians like them because they feel less isolated, and more informed and confident about managing children's mental health concerns.

This desk reference is one such resource for the primary health care provider. It has been developed under the auspices of the Healthy Minds / Healthy Children Project, originally an outreach effort of the Southern Alberta Child and Youth Health Network funded by the federal Primary Health Care Transition Fund. Maintenance of this work is now funded by Alberta Health And Wellness' Mental Health Innovation Fund.

Since the typical family physician has only a few minutes with each patient, this desk reference will help quickly pinpoint diagnostic clues to look for in identifying the mental health concerns most frequently seen in children. It will enable the physician to efficiently begin delivering appropriate interventions and/or confirm when a referral to a specialist should be made. It has been designed so that it can easily be expanded and updated when new information comes to light.

Introduction to the Desk Reference

This desk reference is offered to family physicians with the acknowledgement that their efforts are vital in maintaining an effective continuum of care. The more we are able to quickly and successfully intervene in the mental health of young people, the more likely that all of our nation's youth will grow up to lead productive lives.

This resource is meant to be a practical, efficient source of (decision) support for the physician. Towards this end, we have emphasized the identification and management of the mental health concerns/disorders that are most likely to be seen in the primary health care setting.

The reference is arranged in self-contained modules, a majority of which address a single disorder or common mental health concern. Within the modules, there are sets of screens, checklists, Office Action Plans, and Solution Building Forms. As well, the reference has additional sections on promoting change and change tools.

Every effort has been made to ensure the completeness of this reference. However, as with any resource, the information contained herein can become dated and/or incomplete.

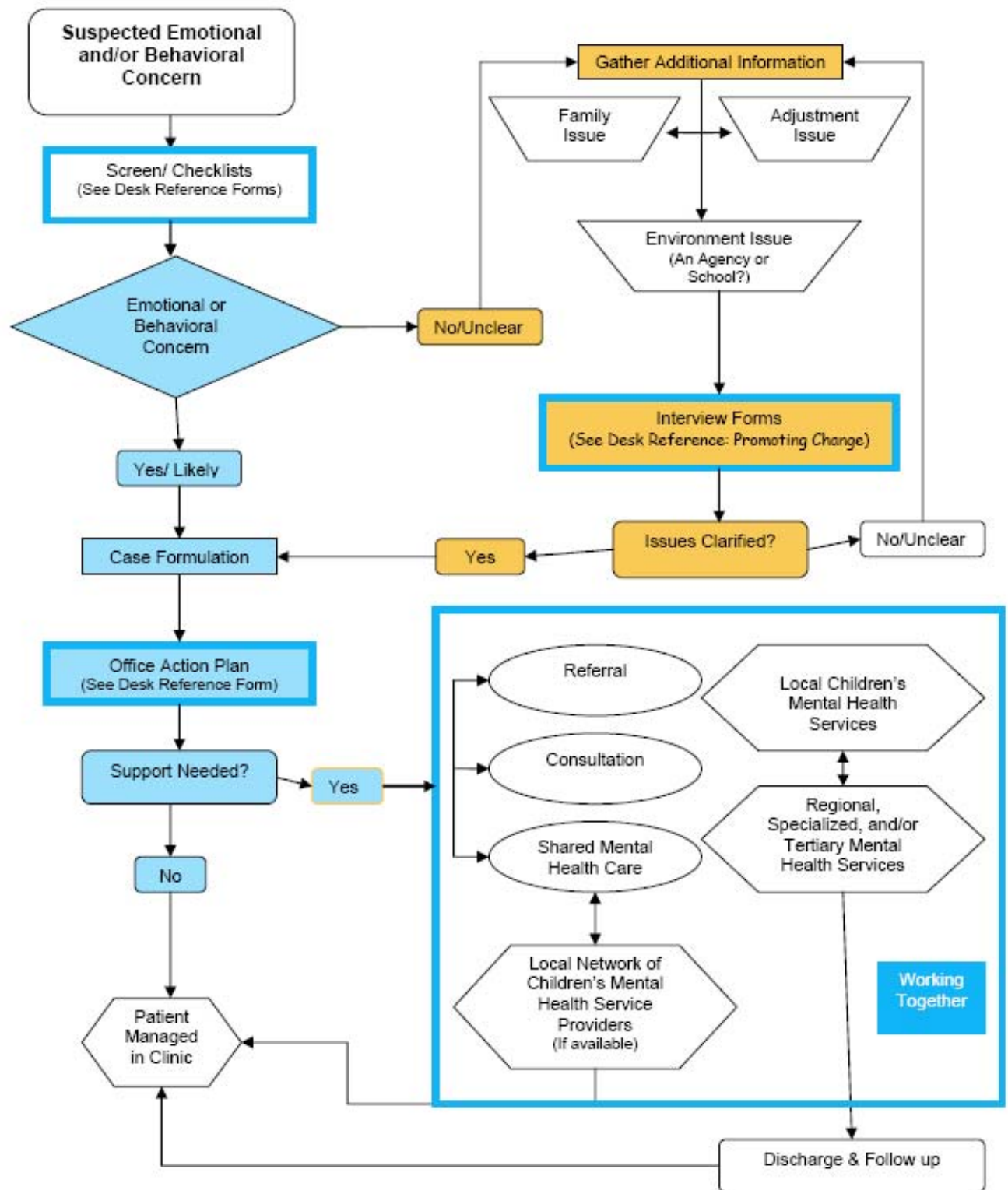
This desk reference should be considered a tool to support a physician's efforts to:

- 1) clarify the presenting clinical picture,
- 2) assist with effective, brief intervention, and
- 3) facilitate the communication of clinical information when consulting with, or referring to, mental health specialists.

Remember, if there are questions or doubts about a clinical presentation, consult or refer to a mental health specialist. Under no circumstances should the desk reference pre-empt or replace such consultations/ referrals.

When diagnosing and treating mental health concerns, rely on your profession's standards, and draw upon multiple tools and sources of information (e.g., several informants, patient/family histories, testing, the desk reference, etc), when developing a working diagnosis and treatment plan. The generic decision tree on the following page may assist your efforts to integrate the Desk Reference's tools into your current clinical practices.

Decision Tree



Desk Reference Feedback Form

1. Was the Desk Reference easy to use? Yes ☐ No ☐
 2. Did it assist you in your work with your patients? Yes ☐ No ☐
 3. Do you plan to continue to use it with your patients? Yes ☐ No ☐
- If no to any of the above, please note why. _____
-

4. Do you have any recommendations regarding the Desk Reference?
(Its organization, its efficiency/ effectiveness, etc?) _____
-

Modules

5. Were the procedures in the Modules clear? Yes ☐ No ☐
 6. Were they easy to follow? Yes ☐ No ☐
 7. Do you have any recommendations regarding the procedures? (e.g., their description, clarity, comprehensiveness, etc?) _____
-

8. Were the Interview, Office Action Plan, and Building Yes ☐ No ☐
 9. Solutions forms easy to use? Yes ☐ No ☐
 10. Were they helpful? Yes ☐ No ☐
 11. Do you have any recommendations regarding the Forms? (e.g., their description, clarity, comprehensiveness, etc?) _____
-

12. Were the Screens and Checklists easy to use? Yes ☐ No ☐
 13. Were they helpful? Yes ☐ No ☐
 14. Do you have any recommendations regarding the Screens and/or Checklists? _____
-
-

Thank you for taking the time to complete this form.

Please fax your responses to 403.229.2184 care of Healthy Minds/Healthy Children
Outreach Service,
or mail to Room 4609A, 1820 Richmond Rd. SW, Calgary AB T2T 5C7

General Mental Health Module

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General Mental Health Module

Procedures

Steps

- Complete Screens.
- Complete the General Interview Form.
- Complete the Office Action Plan.
- Complete, if indicated, the optional Building Solutions Form.

Screen Procedures

General Mental Health Screen (Parent Form)

- This form can be provided to the parent and the results discussed with their physician OR
- The physician can use the screen to assess the patient's mental health concerns.

Note. Some parents may have literacy concerns. Check for difficulties in answering screen items.

- * Use the results with the Specific Concern Interview Form and/or the Office Action Plan.

General Mental Health Screen (Physician Form)

- The physician or staff can use this form to review/confirm the parent's responses to the parent screen.
- The physician can use the screen as an assessment guide in a patient/parent interview.

- * Use the results with the [Specific Concern Interview Form](#) on page 13 and/or the [Office Action Plan](#) on page 15.

Alternative Screen

This screen is very broad in its scope, and it is best used when concerns are multiple or quite vague and an initial starting point for when intervention is needed.

- Have the patient/parent indicate which items are concerns for them, and then ask them to rank order the items in order of importance.
- Ask the patient/parent if there are any concerns/issues in addition to those on the screen that they might like to add.

- * Use the results with the [Complete Mental Health Interview](#) on page 20 and/or the [Office Action Plan](#) on page 15.

Screens:

General Mental Health Screen

Parent Form

Is your child/teen...

- ☐ moody, easily irritated, or is sad, cries easily, and/or seems down or depressed? overly anxious, nervous or a worrier?
- ☐ experiencing sudden difficulties with sleeping, or a recent change in appetite and/or energy level?
- ☐ anxious with peers and/or adults, or avoids contact with them, and/or spends an unreasonable amount of time redoing tasks or doing tasks in a particular order?
- ☐ often losing things necessary for tasks (e.g., school assignments, pencils, etc); does not seem to listen when spoken to; has difficulty organizing tasks, and/or switching between tasks and/or activities?
- ☐ being negative or defiant towards adults and/or peers, including: argues with adults, short-tempered, defies or refuses to agree to adult's (e.g., parent and/or teacher) requests or rules?
- ☐ aggressive toward people and animals; and/or destructive with property; not truthful or involved in theft; breaks parental and/or societal rules?
- ☐ having thoughts of failure, hopelessness, worthlessness, and/or guilt?
- ☐ worrying most of the time (or has unreasonable fears) about events, activities, and/or people?
- ☐ has difficulty paying attention in tasks/play, and/or is easily distracted from tasks, and/or is forgetful in daily activities?

If you have said **YES** to any of the above and the concerns are...

- ☐ persisting, nearly everyday, despite parent efforts to manage and are
- ☐ negatively impacting day to day functioning.

Then discuss your concerns with your doctor.

Ask all items and mark those that apply (Brackets indicate an area to explore)

- ☐ The patient has become/is moody, easily irritated, or is sad, cries easily, and/or seems down or depressed. (Depression)
- ☐ The patient has become/is overly anxious or nervous, a worrier. (Anxiety)
- ☐ The patient is experiencing sudden significant difficulties with sleeping or significant change in appetite and/or energy level. (Depression)
- ☐ The patient appears anxious when interacting with peers and/or adults, or avoids contact with them, and/or spends excessive time redoing tasks, or doing tasks in a particular order. (Anxiety/OCD)
- ☐ Often loses things necessary for tasks (e.g., school assignments, pencils, etc); does not seem to listen when spoken to; has difficulty organizing tasks, and/or transitioning between tasks and/or activities. (ADHD)
- ☐ A pattern of negativistic, hostile and defiant behaviour towards adults and or peers, including: argumentative with adults, ill-tempered, defies or refuses to comply with adult's requests or rules. (ODD/Conduct)
- ☐ The patient is aggressive toward people and animals; and/or destructive with property; deceitful or involved in theft; violates parental and/or societal rules. (ODD/Conduct)
- ☐ Thoughts of failure, hopelessness, worthlessness, and/or guilt. (Depression)
- ☐ Worries excessively (or has excessive fears) about events, activities, or people. (Anxiety)
- ☐ Has difficulty sustaining attention in tasks/play, and/or is easily distracted from tasks, and/or is forgetful in daily activities. (ADHD)

If items endorsed are ...

- ☐ persisting, nearly everyday, despite parent efforts to manage and are
- ☐ negatively impacting day to day functioning

Then refer to the relevant section(s) in the Desk Reference

Signs of a Mental Health Concern

Alternate Screen/Physician Form

A child or adolescent may have a mental health concern(s) when these signs are present:

- ☐ persistently play the victim and/or bully in peer interactions.
- ☐ frequently miss school with truancy, sickness or other excuses.
- ☐ appear rarely to smile, or appear sad, cry easily or seem depressed.
- ☐ appear to lose weight, especially those on diets who believe they are overweight but have developmentally normal body form.
- ☐ openly or persistently talk about suicide, or whose thinking is persistently morbid.
- ☐ appear to have delusions, paranoia, or hallucinations, or their thinking is bizarre.
- ☐ display behaviour that is generally unusual for them and/or their peers.
- ☐ have a pattern of learning/achievement that is one year (or more) behind their peers.
- ☐ display a sudden deterioration in their standard (or volume) of school work.
- ☐ display a significant deterioration in routines, social/family relations, or learning.
- ☐ suddenly lose friends, becomes a 'loner', or becomes isolated/withdrawn.
- ☐ appear to be unusually quiet and solitary in school and/or the community.
- ☐ constantly sleepy or always tired.
- ☐ quickly loses concentration or is distractible.
- ☐ is displaying persistently disruptive behaviour and/or has frequent periods in school detention.

If an item is endorsed, explore it further using the Desk Reference's [Specific Concern Interview Form](#) on page 13 or [Office Action Plan](#) on page 15.

Specific Concern Interview Guide

This Guide is an optional tool that can be used to assist with general patient interviewing, completion of the General Interview Form, the Office Action Plan, and/or the Biopsychosocial Assessment Interview. Please note though, the Guide is a supplement, not a replacement, for your current interview and information-gathering practices.

Once an assessment is complete, you may find that a referral is indicated. If this is the case, you may wish to package the information garnered by the Guide, and the screen/checklist responses, and pass the information/forms directly on to the specialist, as part of a referral package.

Comprehensiveness of the interview

Consider client functioning in three areas: School, Home/Family, and Friends. The table below can be used to systematically look for dysfunction/distress across these areas. When using the table:

Ask about patient functioning in each of the four areas.

Ask how family members are responding to the patient in each area.

Ask how the school and friends are responding to the patient in each area.

	School	Home/Family	Friends	Self
Behaviour				
Feelings				
Thoughts				

Sample question (for patient and/or parent):

"How are things in school? At home, with family? With friends?"

"How do you (others) feel about your behaviour (in each area/column)?"

"What thoughts do you (others) have about your behaviour in (each area)?"

Scaling/rating to obtain a baseline (Pre/post procedure)

Use an informal scale to get a sense of the level of distress the patient and family members, are experiencing. Compare the initial rating with one taken after interventions have occurred. The difference will provide evidence of the effectiveness and efficacy of your intervention with the patient. See a sample script below.

1	2	3	4	5	6	7	8	9	10
No problem (No stress)			Moderate problem (Stressful, but being managed)				Big problem (High stress; not being managed)		

Specific Concern Interview Guide (Cont'd)

Sample Script:

"..Think of a scale of one to ten, where 1 means no problem, 5 means a problem that is stressful but being managed by ____ (the patient/family), and 10 means the problem is not being managed and it is causing high distress in ____ (the patient/family) and those around him/her."

"...How would you rate the problem?"

"...How long has it been this high? "

"...What happened that made it this high?"

"...Does anything make the rating go lower?"

Measuring change

Often it is helpful to obtain information on change in specific aspects of the presentation and/or concern.

Rating/scaling questions can be quite helpful in this regard.

For example, in the area of feelings, you can focus upon a specific feeling (e.g. sadness) and ask the patient to rate it (at each visit) in the following manner:

1-3	= no change, or slight change from the last visit (minimal rating)
3-7	= some recent change from the last visit (moderate rating)
7-10	= very noticeable change in mood from the last visit (high rating).

- This process can also be applied to behavioural (and or cognitive) aspects of the presenting concern.
- For example, to get a better sense of how the patient's behaviour, in general, is impacting others (now and over time), you can ask the patient or another informant to rate patient behaviour (at each visit) as:

1-3	= no disruptiveness, generally compliant (minimal rating)
3-7	= some disruptiveness, but responding to direction (moderate rating)
7-10	= frequent disruptiveness, not responsive to direction, creating risk (high rating)

Generating strategies and solutions*

- During the assessment interview, it is often helpful to look for strategies (or solutions) that are relatively easy and meaningful for the patient and his/her family.
- One way of identifying them is to ask a variety of 'miracle'-type questions.

Sample Questions:

"If I could grant you three wishes about this concern, what would they be?"

"If I waved a magic wand, what would need to be magically different, for the problem to be gone?"

"How would you recognize the change?"

"How could others recognize a difference?"

"If you woke up and the problem was magically gone – what other things would also be different in your life? (in your child's life?)"

* For assistance with solution-finding, see the [Building Solution Form](#) and/or [Guide](#) on pages 16 & 17.

PRESENTING CONCERNS: Specific Concern Interview Form

A. Explore functioning at school, at home with family, and with friends.

(address the following questions to the patient and follow up with the parent)

1. How are things at school? At home with family? With school mates/friends?

2. What are the 3 top concerns?

3. How do you feel about _____ (concern # 1, 2, 3)? Is it any different when you're at school, at home with family, when you're with your friends/school-mates?

4. What thoughts do you have about _____ (concern # 1, 2, 3)? Is it any different when you're at school, at home with family, or when you're with your friends/school-mates?

5. Why do you think _____ (concern # 1, 2, 3) is happening? What do you think might be a solution?

6. What do family (friends, teachers) think/feel about ____ (concern #1, 2, 3)?

B. Assess for levels of distress (check both patient and parent levels)

1. Picture a scale, with the number 1 on the one end, a five in the middle, and a 10 at the other end. The 1 means No problems, no stress; 5 means there is a Medium problem, it is stressful, but it is being managed well by you (a moderate rating); and 10 means it is a Big problem, it is very stressful and it is not being managed very well by anyone (a high rating).

What rating would you give _____ (Concern # 1, 2, 3)? (Ask parent to rate, as well)

1 2 3 4 5 6 7 8 9 10

Little or no problem

Moderate Problem

Big Problem

2a. For each concern: How long has the rating been that high?

2b. For each concern: Did something happen that made the rating this high?

3. What have you tried to do to make the rating(s) go down? What have others tried?

4. What might make the rating(s) go down? (Who would have to do what, when?)

(If the patient and parent give different ratings and/or differing responses, explore the differences.)

C. Looking for solutions and strategies * *

1. Ask a 'miracle'-type question to generate possible solutions/strategies.
Two examples are:

"If I could grant you three wishes about this concern, what would they be?"

OR

"If I could wave a magic wand, what would need to be magically different, for the problem to be gone?"

D. The Office Action Plan

Incorporate the interview information, as well as patient history information, into the [Office Action Plan](#) on page 15.

* If additional solution information is needed, try using the Building Solutions Form

Office Action Plan

Complete the Specific Concern Interview Form and incorporate its information into this Action Plan.

1. Patient concerns

1

2

3

Other:

2. Identify patient resources

Strengths? (E.g., motivation, skills, interests, past successful strategies)

Resources? (E.g., family, extended family, friends, agency supports)

3. Develop solutions (Use case and community resources)

4. Implement a solution (Who will do what, when? Detail the steps to do it)

5. Monitor progress (Who will monitor what? How often and to whom will they report?)

6. Measure outcomes

E.g., ask patient/family before and after an intervention: "On a scale of 1-10, how (e.g. stressful) is _____ [presenting concern]." The difference in rating is a measure of change.

Building Solutions Guide

Use the steps below to guide a conversation with your patient and his/her family. It is very helpful to keep a positive, solution-oriented focus during your conversation/intervention.

1. What is the Goal?

- Be as behavioural and specific as possible in developing your goals. Doing so will make it easier to implement and measure. Ask yourself and your patient and their family: "What specific behaviour needs to stop, and when? What behaviour needs to start, and when?"
- For every negative behaviour you want to stop, try to develop and implement an opposite, positive behaviour (e.g., develop a bedtime story-telling ritual to substitute for bedtime power struggles). Remember, the 'positive' behaviour must be meaningful to the patient (e.g., parent one-to-one time must be desirable for the patient).
- Walk, do not run. Sometimes it is more effective to gradually reduce the frequency and/or duration of behaviours of concern. Remember, some children (and adults) genuinely struggle with change.
- Each goal should involve small, likely-to-be accomplished steps.
- When setting these steps, or timelines/expectations, allow for some flexibility (a minor slip, set back, and/or delay). Sometimes it may be helpful to predict a slip in progress, and/or to prescribe a little slip in progress in order to pre-empt disappointments.

2. When do pieces of that goal already happen?

- You may need to dig for this information, as patients and families may downplay or overlook partial solutions/successes, given their crisis orientation, problem focus, and/or emotional (psychological) exhaustion with their concern.

3. How does the family/patient make the pieces happen?

- Ask yourself, the patient, and/or parent: "Who does what, when?" Encourage the patient and family to be as behavioural and specific as possible in their descriptions. Look for patterns/sequences of events and/or behaviour.

4. What good things result from the pieces that work?

- Be inclusive; survey both patient and each parent/family member for their assessment of the good things.

5. What do we do to make the pieces (and new pieces) happen?

- Ensure each family member helps to generate and implement constructive ideas.
- Measure efforts as concretely as possible.
- Celebrate as each piece of the solution becomes a new family/patient routine.

Building Solutions Form

Use these questions (and the accompanying guide) to develop solutions with your patients.

1. **What is the Goal?** [What set of behavioural changes would address the concern(s)]

a. _____
b. _____
c. _____

2. **When do pieces of that goal already happen?**

3. **How does the patient/family make the pieces happen?**

4. **What good things result from the pieces that work?**

5. **What do we do to make the pieces happen? (Be specific)**

Do not forget to measure the impact of the solution on each family member. Use a simple pre/post rating scale. Rate the severity of the concern before the patient/family does anything, and then when they have completed each part (or all) of the proposed solution.

Interview and Treatment Planning Module

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Interview and Treatment Planning Module

Procedures

The instruments in this module will support, but not replace, your current assessment practices. They will assist with identifying the presence or absence of mental health concerns, the nature of their presentation, and their impact on patient/family functioning. The instruments should be used in conjunction with other sources of patient data (e.g., chart data, patient/family histories, allied health reports, etc).

Note. The instruments cannot be used by themselves to determine a diagnosis.

Instruments

[Complete Mental Health Interview](#) (Supplemental Interview Form) on page 20.

This instrument is based on the Biopsychosocial Model of functioning, which will likely be familiar to physicians and nurses, as well as allied health professionals.

The instrument is wide ranging and fairly comprehensive, including sections on substance use, risk to self/others, mental status, and genogram.

The interview information can be used to complete the [Office Action Plan](#) on page 15.

[BAT-5 Guide and Form; Analysis of Client Concerns](#) (Supplemental Documents) on page 28.

These documents assist with completing a detailed, comprehensive mental health assessment, including a detailed analysis of the presenting concern.

All three documents can be used to inform the [Specific Concern Interview Form](#) on page 13 and the [Office Action Plan](#) on page 15.

Complete Mental Health Interview

This form takes approximately one hour to complete in its entirety. If, however, it is more convenient, it may be completed over multiple sessions.

Complete Mental Health Interview

Page 1

Client Name:	Clinician's Name:	
Age:	DOB:	Sex:
Date of Interview:		
Parent(s)		
Address:		
Home Phone:	Work Phone:	
Legal Guardian(s):		
Address:		
Home Phone:	Work Phone:	

Chief Concern (Record in the patient's own words) **and Referral Source**

History of Present Concerns and/or Illness

- A. Stressors and Symptoms:** (include current stressors and detailed chronologic history of symptoms for each diagnosis on Axes I and II [of the DSM IV TR]. Detail current substance use and/or exposure to violence here).
- B. Recent Suicide and Homicide Information:** (Include all recent [past month] ideation, gestures, and attempts. Record key material such as client-rated level of hopelessness and extent of actions or plans).

Client's Name: _____

Current Symptom Inventory

(All symptoms checked as mild, moderate, or severe must be described in detail in the previous, patient history section.)

Symptom	Not present	Mild	Moderate	Severe	Unknown
Depressed mood					
Sleep disturbance					
Other vegetative symptoms of depression (e.g., appetite)					
Suicidal ideation					
Violent ideation					
Panic attacks, Obsessions					
PTSD symptoms					
Abnormal eating behaviour					
Psychosis					
Substance abuse					
Exposure to violence					
Disruptive behaviour, Non-compliance					

Past History Markers

Marker	Present	Absent	Not Known
Sexual/Physical abuse			
Substance/Alcohol misuse			
Suicide/Self-mutilation			
Violence			
Psychosis			

Past psychiatric and substance use history (Parental and Adolescent Histories)

- A. Episodes and Treatment** [Describe current and previous episodes of misuse. Note attending interventions and their impact; note why relapses occur [using client language]].

Client's Name: _____

B. Past Suicidal/Violent Ideation or Behaviour

Substance Misuse Profile

Substance	Current Amount	Date Last Used
THC		
Cocaine, Crack, Meth,		
LSD, Mescaline, Psilocybin		
Barbiturates, Other Sedatives		
Caffeine/Tobacco		
Other:		
Other:		
Other:		

Psychosocial History

1. Education:
2. Family Relationships/Social Relationships/Abuse History:
3. Developmental History (of the client and of the family):
4. Strengths and Resources of the client and his/her support network:

Client's Name: _____

Family History (History of psychiatric or substance misuse in blood relatives):

Medical History (Significant past illnesses or traumas, current allergies, etc)

Primary Care Physician: _____

Current Medications

Medication	Dosage	Taken as Prescribed?	
		Yes	No
1.			
2.			
3.			
4.			
5.			
6.			

Mental Status

1. Appearance and behaviour:
2. Mood and affect:
3. Speech and thought process:
4. Thought content and perceptions (Include all current [last 24 hours] suicidal/violent ideation):
5. Sensorium, Cognitive and Intellectual functioning:

Client's Name: _____

Narrative Summary and Formulation (Present condition, and support systems, diagnostic and psychosocial formulation and treatment recommendations):

Assessment of Suicide/Violence Risk (stemming from the client and/or family)

Triage and Treatment Recommendations

- ☐ One Time Consultation
- ☐ Referral to _____ Program/service, **no follow-up required**
- ☐ Referral to _____ Program/service, **follow-up is required**
- ☐ Referral for: _____
- ☐ Psychiatric evaluation
- ☐ Psychological testing/consultation
- ☐ Hospitalization
- ☐ Mental Health Clinic
- ☐ Other: _____

Client's Name: _____

Diagnostic Summary**Axis I: Clinical Syndromes:**

	Main Formulation	Codes	Alternatives to be ruled out
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Axis II: Personality and Specific Development Disorders:

	Main Formulation	Codes	Alternatives to be ruled out
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Axis III: Physical Disorders:

	Main Formulation	Codes	Alternatives to be ruled out
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Axis IV: Physical Stressors:**A. Ranked List:**

1.	_____
2.	_____
3.	_____

B. Overall Stressor Severity:

1	2	3	4	5	6	0
None	Mild	Moderate	Severe	Extreme	Catastrophic	Unspecified

Axis V: Global Assessment of Functioning (GAS)

Current GAS: _____ Highest GAS in past year: _____

Clinician's Signature_____
Date

Client's Name: _____

Genogram (Optional)

Formulating an Understanding of Client Concerns

Working through the following areas in a client/patient interview can help to ensure a thorough, systematic examination of client concerns.

Components of the concern?

(Target any problematic responses to these questions for intervention).

- What feelings seem to be associated with the concern?
(Are they problematic or supportive?)
- What behaviours are associated with the concern?
- What thoughts are associated with the concern?
(Are they problematic or supportive?)
- What are the interpersonal aspects of the concern? (who is involved and when are they problematic or supportive?)

Pattern of contributing events

(Can the client identify a pattern/ sequence of events that led to the concern and/or that maintain it?)

- When does the concern occur?
- What is happening at the onset of the concern?
- What is happening just prior to the concern?
- What typically happens just after the concern?
- What makes the concern better? Disappear?
- What makes the concern worse?

Duration of the concern

(Extent to which the concern disturbs the client and/or everyday functioning)

- How long has the concern existed?
- How often does the concern occur?
- How long does the concern last when it occurs?
- What led the client to comment at this time regarding the concern?
- In what ways does the concern interfere with client's daily functioning?

Client coping skills, strengths, resources.

- How has the client coped with the concern (or similar concerns) in the past?
- What resources, strengths, and support systems does the client have to help with change efforts? (e.g., friends, family, community organizations.)

BAT – 5 Interview Guide

The BAT – 5 is an acronym for three general areas of functioning: **Behaviour**, **Affect** (feelings), **Thoughts**, and the five questions of Journalism: **Who**, **What**, **When**, **Where**, and **Why**. The areas and questions are combined to form a table that can guide you, in an organized/efficient manner, through a comprehensive assessment of a mental health concern.

Procedure

Typically, the areas of functioning are rows, and the questions are columns, and each cell suggests questions that may or may not be relevant to your patient's concerns.

- Choose those cells (and questions) that apply, and obtain the information you need to intervene and/or to refer on to a specialist.

The BAT – 5 is a supplement to your normal history-taking/case formulation processes.

Examples

	Who	What	When	Where	Why
Behaviour					
Affect					
Thoughts					

The Who Column:

- Who is **behaviourally** contributing to the concern? (Patient/Parent, Teacher, etc)
- Who is **emotionally** contributing to the concern?
- Who contributes their **comments, opinions, and/or thoughts** regarding the concern?

or The Behavioural Row:

- **Who** is doing **What**?
(identify participants and how they contribute to concerns/solutions)
- **When** are they doing what?
(e.g., time of day, everyday, only when a specific individual is present, etc)
- **Where** are they doing that? (All contexts, at home only, school only)
- **Why?** (your hypothesis)

Hints: When proceeding through the cells, whether by row or by column, **look for patterns** of behaviour, of emotions, of thoughts, and/or of interactions among participants. These patterns generally involve time and/or context (the When and Where columns).

As well, look for resources and exceptions to the patterns and/or the concern:
e.g., What is working well and when, and who is doing it? What is different when the concern is not present or present but manageable?

Once the BAT – 5 information is taken, combine it with information from your patient/family histories and the screens/checklists, and develop your case formulation (see Office Action Plan on page 15).

BAT – 5 Interview Form

	Who	What	When	Where	Why
Behaviour					
Affect (Feelings)					
Thoughts					

Depression Module

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Lets Talk About Emotions (Parent Form)	35
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Depression Module

Procedures

Steps

- ☐ Complete the [general screens](#) on page 8
- ☐ Complete, if depression is indicated, the [supplemental screens](#) on page 36
- ☐ Complete the [Specific Concern Interview Form](#), incorporating the screen information on page 13
- ☐ Complete the [Office Action Plan](#) on 15 and, if indicated, the [Building Solutions Form](#) on page 17

General Screen Procedures

- ☐ Review the results of the General Mental Health Screen with the patient/family (see the [General Mental Health Module](#) on page 6). Check off the applicable items on the [Depression Screen \(Physician Form\)](#) on page 33.
- ☐ Provide the [Emotion Screen \(Parent Form\)](#) on page 32 to the parent/patient. Encourage them to use it to talk further about their concerns. As items are discussed and endorsed, check off the applicable items on the [Depression Screen \(Physician Form\)](#) on page 33.
- ☐ Once the items have been discussed, ask if there are any additional emotion- or depression - related concerns you have not discussed.
- ☐ Transfer the screen and background information gathered above to the General Interview Form.

If Depression is suggested, complete the supplemental screens

Supplemental Screen Procedures

- ☐ Note to the parent/patient that a supplemental exploration of their concerns appears warranted, given their responses to your initial inquiries.
- ☐ Provide the patient with the: [Let's Talk About Emotions](#) (Child-Youth) Form on page 34.
- ☐ Provide the parent with the: [Let's Talk About Emotions](#) (Parent) Form on page 35.
- ☐ Encourage the patient/parent to review each item with you, while you check off the applicable item on the: [Depression in Children and Adolescents \(Physician Screen\)](#) on page 33.

Complete the Physician Screen and incorporate the information into the [Specific Concerns Interview Form](#) on page 13** and, subsequently, the [Office Action Plan](#) on page 15

****Note:** As you gain experience, you may find that omitting the general screens and directly applying the supplemental screens is more efficient.

General Screens:

Emotion Screen

(Parent Form 1)

For most of the day, nearly every day, my child (or teen)...

- ☐ is down, sad, unhappy, or seen by others to be down, unhappy, tearful.
- ☐ has lost interest or pleasure in most activities.
- ☐ has had a significant weight loss/weight gain, or decrease/increase in appetite **OR** has failed to make expected weight gains.
- ☐ has recently become restless or listless, or slowed in his/her motor activities.

Nearly every day, my child...

- ☐ is fatigued or experiencing a loss of energy.
- ☐ is experiencing difficulty settling down at night and/or difficulty sleeping.
- ☐ is experiencing difficulty concentrating at school and/or at home.
- ☐ is reporting thoughts of death (not just fear of dying), recurrent thoughts of self-harm/suicide without a plan, or has made a suicide attempt, or has a specific plan for committing suicide/self-harm.



Discuss the above items with your doctor

For most of the day, nearly every day, the patient...

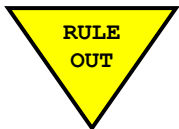
- ☐ is down, sad, unhappy, or seen by others to be down, unhappy, tearful.
- ☐ has a significantly reduced level of interest or pleasure in most activities.
- ☐ has had a significant weight loss/weight gain, or decrease/increase in appetite **OR** the child/patient has failed to make expected weight gains.
- ☐ has recently become restless or listless, or slowed in his/her motor activities.

Nearly every day, the patient...

- ☐ is fatigued or experiencing a loss of energy.
- ☐ is experiencing difficulty settling down at night and/or difficulty sleeping.
- ☐ is experiencing difficulty concentrating at school and/or at home.



- ☐ is reporting thoughts of death (not just fear of dying), recurrent thoughts of self-harm/suicide without a plan, or has made a suicide attempt, or has a specific plan for suicide/self-harm.
- ☐ If above item is confirmed: Complete this screen AND a Suicide Screen (Suicide Section of Desk Reference).



- ☐ The symptoms are the direct effects of substance use, medication, or a general medical condition.

If this item is checked, address substance use and/or review the medical condition before completing this Screen and the General Interview Form.

If **YES** to the **STOP** item, and/or three or more items above, proceed with the Supplemental Screens on page 34 and the Specific Concern Interview Form on page 13

Supplemental Screens

Let's Talk About Emotions

(Child-Youth Form)

Tick as many as are true for you within the past month

1. You feel sad or cry a lot and it does not go away.	
2. Little things make you lose your temper; you over-react to things or people.	
3. You do not feel like doing things you used to like such as music, sports, being with friends and you want to be left alone most of the time.	
4. Your eating pattern changes; you have lost your appetite or you eat a lot more.	
5. Your sleep changes; you are sleeping a lot more; you have trouble falling asleep at night; you wake up early most mornings and cannot get back to sleep.	
6. You sit for hours and do nothing; you cannot sit still anymore, (you need to keep moving/active).	
7. You feel restless and tired most of the time.	
8. You feel guilty for no reason; you feel like you are no good; you have lost your confidence.	
9. It is hard to make up your mind; you forget lots of things; it is hard to concentrate.	
10. It seems to be harder to do your school work; school work does not matter anymore.	
11. It is getting harder to get along with people.	
12. It seems like nothing good is ever going to happen again; you feel negative about things a lot of the time.	
13. Has something big happened to you lately(e.g., death of a relative, friend, pet; loss of a boyfriend/girlfriend)?	
14. You think about death; you feel like you are dying, or you have thoughts about hurting yourself. (If yes, please talk to your doctor about this.)	

After you have completed the checklist, discuss the results with your doctor.

Let's Talk About Emotions**(Parent- Form 2)****Put a check in the box if the sentence is true for your child**

1. Low or sad mood for the last couple of weeks.	
2. Irritable (easily upset) over the last couple of weeks.	
3. Loss of interest or pleasure most days.	
4. Changes in appetite: weight loss; fails to meet expected weight gains.	
5. Sleep problems: too little or too much.	
6. Decreased energy throughout most of the day, most days.	
7. Excessive feelings of guilt and/or worthlessness.	
8. Recent attention/concentration difficulties.	
9. Recent changes in school performance or school refusal	
10. Relationship problems: avoidance, conflict, over-dependency.	
11. Low self-esteem.	
12. Significant loss (e.g., relative, friend, pet).	
13. Other stressful event (e.g. parental divorce).	
If any of the items below are true for your child, please mention this to your doctor	
14. Talks about hurting or killing themselves and/or has tried to hurt themselves before.	
15. Has thoughts of self-harming or suicide.	
16. Has a plan for suicide; has a means and access (e.g. can get pills easily).	

If YES, please talk to your doctor IMMEDIATELY**After you have completed the checklist, discuss the results with your doctor.**

Tick as many as apply to your patient

1. Low or sad mood for the last couple of weeks	
2. Irritable over the last couple of weeks	
3. Loss of interest, pleasure, or a sense of meaning, most days	
4. Changes in appetite: weight loss; fails to meet expected weight gains	
5. Sleep problems: too little/too much	
6. Psychomotor agitation or retardation nearly every day (e.g., sudden, high levels of activity or listlessness)	
7. Decreased energy throughout most of the day, most days	
8. Excessive feelings of guilt and/or worthlessness	
9. Recent attention/concentration difficulties	
10. Talk of self-harm	
11. History of self-harm gestures	
12. Has a plan to self-harm/suicide, a means, and easy access	



(If yes to any of the 3 self-harm items, complete the Suicide Assessment Section, as well as the items below)

- A. Items 1-9 (the symptoms) cause clinically significant distress in important areas of functioning (e.g., at home, school, and/or community).
- B. The symptoms persist longer than 2 months
 - OR 1) there is marked impairment in functioning,
 - OR 2) there is persistent preoccupation with feelings of worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.



- ☐ Symptoms are due to the direct effects of substance use, medication, or a general medical condition.
- ☐ Symptoms are better accounted for by bereavement (e.g., loss of a relative, friend, pet) or adjustment (e.g., recent move, new child in the home, change in parental members).

Depression is likely present if:

Yes to 5 or more of the 12 items; or
 Yes to A and B, and there are no Rule Outs.

If a Rule Out is checked then explore the item and its implications before continuing on with the Depression Screen.

**Complete the Specific Concern Interview Form on page 13
 and the Office Action Plan on page 15**

Suicide and Self-Harm Module

Content

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Suicide and Self-Harm Module

Procedures

Suicide Risk Procedures

If comments by the patient or parent, and/or other interview information suggests the possibility of suicidality, then follow the procedures below.

Complete the [Suicide Risk Screen](#) on page 40.

Use each endorsed item as a point of further enquiry
(e.g., "Can you tell more about.... [the endorsed item]...)

Complete the [Supplemental Interview Form \(Suicide Risk\)](#) on page 42.

Complete the [Suicide/ Self-Harm Risk Worksheet](#) on page 44.

Complete the [Office Action Plan](#) on page 15 and, if indicated, the, [Building Solutions Form](#) (and see Guide), on page 17

Consult with local mental health clinic staff.

If indicated, refer to local mental health specialists.

If a safety plan can be put in place and Mental Health Services in your area are accessed, then management of the patient may be possible in the primary care setting.

This may be particularly likely if you have arranged regular case consultation with local mental health specialists, patient risk is mild to moderate, and the family represents a positive source of support and effective monitoring.

If risk ranges from high to severe and you and/or the patient's family are not confident about maintaining patient safety until mental health specialist resources are accessed, then consideration should be given to having the patient accompanied to the local hospital's emergency department for assessment and possible admission.

Should you have concerns/doubts at any time, you can refer the case to your local hospital resources (e.g., ER or Urgent Services), and/or consult further with a specialist (e.g., your local mental health clinician).

Procedures, Cont

Self-Harm Risk Procedures

Self-Harm is generally defined as a deliberate and often repetitive destruction or alteration of one's own body tissue without the intention to die.

Common terms to describe self-harm include: self-injury, self-mutilation, para-suicide.

Common practices include: cutting, burning, hitting self, interfering with wound healing, hair pulling, and severe skin scratching.

Most adolescents and adults who self-harm report they began the behaviour in early to mid-adolescence.

Most self-harmers know when to stop a session of self-harm and most report they feel, by the end of a session, a sense of calm; soothed and released from distress. These positive feelings address three typical conditions experienced by self-harmers: they replace intense negative feelings; they displace an emotional numbness, or fill an emotional emptiness.

If comments by the patient or parent and/or other interview information suggests the possibility of self-harming behaviour, then follow the procedures below.

Complete the [Self-Harm Risk Screen \(Physician Form\)](#) on page 41.

Complete the [Supplemental Interview Form \(Self-Harm Risk\)](#) on page 43.

If Suicide risk is also indicated, complete the [Suicide Risk Procedures](#) see page 38.

Complete the [Office Action Plan](#) on page 15, consult with local mental health specialists, and refer if indicated.

If a safety plan is indicated and can be put in place and Mental Health Services in your area are accessed, then management of the patient may be possible in the primary care setting.

If management is to be via the primary care setting, then ensure regular case consultation/support with local mental health specialists.

If risk ranges from high to severe (e.g., risk for self-harm is high, in combination with moderate suicidality) and you are not confident about maintaining patient safety until mental health specialist resources are accessed, then consideration should be given to having the patient be accompanied to the local hospital's emergency department for assessment and possible admission.

Should you have concerns/doubts at any time, you can refer the case to your local hospital resources (e.g., ER or Urgent Services), and/or consult further with a specialist (e.g., your local mental health clinician).

Screens:

Suicide Risk Screen

(Physician Form)

1	2	3	4	5	6	7	8	9	10
Feelings not present			Feelings are frequent, but not overwhelming, intrusive, or a pre-occupation.			Feelings are constant, are overwhelming, and/or pre-occupying			

Using the scale above, rate the patient on each of the risk signs below.

High Risk Signs

- ☐ Current threats or gestures for suicide (e.g., a recent suicide attempt).
- ☐ A plausible plan for suicide (e.g. plan includes easy access to a method [e.g., pills] and a timeline [today, tomorrow; on the weekend; sometime before a specific date]).
- ☐ Feelings of hopelessness and helplessness. (have patient rate their feelings)
- ☐ Drug or alcohol misuse/abuse (rate this box only if other High Risk items are checked)
- ☐ Giving away valued possessions or making final arrangements.
- ☐ Lack of a reason to live and/or no meaningful relationships/support.

Risk Signs

- ☐ Prior suicide attempt in the patient's history.
- ☐ Withdrawal from family and friends.
- ☐ Feelings of hopelessness/helplessness, and/or depressive symptoms.
- ☐ Talk of death or despair; preoccupation with thoughts of death.
- ☐ Drug or alcohol misuse/abuse (rate this box, if there are no high risk signs checked above)
- ☐ Suicide of someone close or someone with whom the youth/child identifies.
- ☐ Abrupt behaviour changes (e.g., sudden high after depression, poor school performance, failure to attend school, sudden rebelliousness/aggressiveness).
- ☐ Recent or impending loss (e.g., family break-up, death of a family member/ friend, etc.).
- ☐ Impulsive behaviour (if this item is true, and one or more of the other items are endorsed, then rate this box).



At risk for suicide...

- If rated 4 or higher on at least one High Risk Sign **OR**
- Rated 4 or higher on at least 7 Risk Signs, then

Complete [Depression Screen](#) on page 33 and
Go to [Supplementary Interview Form \(Suicide Risk\)](#) on page 42

Tick as many as apply

One or more overdoses of 'over the counter' or prescribed medications.	
One or more instances of self-injury (e.g. cutting or burning).	
Frequent high risk behaviours (e.g., runs out in front of cars).	
Self-harm gestures produce feelings of relief, soothing, calming.	
History (and/or current signs of) depression, substance misuse/abuse, behaviour problems (non-compliance, acting out).	
Recent stressful event (e.g., conflict at home or with peers, loss of a significant relationship).	
History of (and/or current) poor family and/or peer relationships.	
History of (and/or current exposure to) familial violence.	
Strong feelings (7 or more on a scale of 10) of worthlessness, hopelessness, helplessness, and/or lack of control over their life.	

(If the following items apply, consult with a mental health specialist immediately)

Continuing talk of self-harm	
* Has a clear desire to die and/or to self-harm.	
* Has a plan to self-harm (either to attempt suicide or self-injure).	
* Has a means to self-harm (e.g. knife, pills).	
* Has ready access to methods of suicide/self-harm (e.g., can get the knife/ pills easily and quickly).	
Is using substances.	
Is in active conflict with parents or peers.	
Moderate impulsivity is evident (e.g., a 7 on a scale of 10).	

- * **If your patient said yes to any of the above items, they may be at risk of self-harm. Remember, asking (in a professional, caring manner) about self-harm will not prompt/promote self-harm or suicide.**
- * **If suicidal risk appears to be present (e.g., he/she said yes to one or more of the asterisked items), complete the [Suicide Risk Screen](#) on page 40.**
- * **If self-harm is occurring, complete the Supplementary Interview Form [\(Self-Harm Risk\)](#) on page 43.**



Supplemental Interview Form (Suicide Risk)

Once suicide risk is identified, it is often helpful to gain an understanding of the underlying factors creating/ promoting the risk. This supplemental information can inform your initial case plans and/or assist in your consultations with (or referral to) a mental health specialist.

The literature indicates the following developmental areas often give rise to difficulties, which may then lead to suicidal thoughts and feelings in young people. Explore each area with the patient and parent, and incorporate the information into your case plans/referral information.

- ☐ **Dating-related concerns?** (Violence? Confused about dating? Pressures? etc)

If Yes, "...tell me about these concerns."

- ☐ **Sexual Identity-related concerns?** (Emerging Gay or Lesbian Identity? Pressures?)

If Yes, "...tell me about these concerns."

- ☐ **Peer, School, or Work-related concerns?** (Bullied? Academics? Performance pressures?)

If Yes, "...tell me about these concerns."

- ☐ **Substance use/abuse concerns?**

- ☐ **Family-related concerns?** (Lack of communication? Unrealistic parenting expectations? Harsh disciplining? Loss of a parent? Difficult divorce? Domestic Violence?)

If Yes, "...tell me about these concerns."

- ☐ **Considering all of the above concerns**, which ones are causing you the most stress, at this moment? (Rank the top 3)
(Describe them in behavioural terms, so that specific behavioural interventions can be devised)

Supplemental Interview Form (Self-Harm Risk)

Adolescents and adults who self-harm have chosen an extreme form of coping with distress. Given the danger posed by this behaviour, it is important to identify the specific, underlying stressors prompting the harmful efforts to cope. The questions/rating scales below will assist your efforts to identify general areas of stress typically involved in self-harming cases.

Instructions: 1) review areas with the patient and check those that are true for your patient, 2) obtain some additional, specific information in each area by asking open ended questions, 3) have the patient prioritize the endorsed areas (e.g., most to least stressful), and 4) complete the [Self-Harm Risk Worksheet](#) on page 41.

Ask your patient: **Do you self-harm to:**

- ☐ Release/lower tension and anxiety?
 - ☐ Express self-dislike or guilt?
 - ☐ Manage intense emotional pain?
 - ☐ Regain a sense of control of your body?
 - ☐ Escape feelings of depression and/or emptiness?
 - ☐ Obtain a sense of euphoria (a warm, 'high like' feeling)?
 - ☐ Escape feelings of numbness?
 - ☐ Reduce feelings of isolation?
 - ☐ Reduce anger/aggression?
-

For each endorsed item ask the following question:

"Tell me more about[endorsed item]..." (What triggers the need to lower, release, etc?)

Thinking of all the areas that are true for you, rank them on a scale from most important reasons (e.g., a 10) to least important reasons (e.g., a 1). (List the endorsed areas for the client).

Record the three most important areas.

1.

2.

3.

Complete the [Suicide/ Self-Harm Risk Worksheet](#) on page 44

Suicide/Self-Harm Risk Worksheet (Safety Planning Form)

Once the Suicide Risk Screen is completed and a risk is identified, it is then necessary to develop a safety plan. Completing this worksheet will walk you through a safety plan and assist your interventions/case management:

(Check the items as you complete them)



	1.	Reassure the patient that you
		a) 'take them [their distress] seriously,'
		b) that you understand what it is that is upsetting them
		c) summarize what you have heard the issues to be, seek confirmation that you have heard them correctly.
	2.	Notify the patient's legal guardian/parent of the risk and need for immediate, adult monitoring of the patient.
		a) Reassure the parent that something can be done to reduce the risk
	3.	Create a Safety Plan for the patient and family
		Do not let the patient or family leave until you're reasonably satisfied that the patient can be and will be effectively monitored at home and in the community. Monitoring strategies include:
		a. <u>Arrange</u> responsible, adult monitoring of the patient
		b. <u>Safe-T</u> the home: have the parents remove or lock up items in the home that might easily be used as methods for suicide (e.g., remove or lock up firearms, knives, cleaning liquids, medicine cabinet contents)
		c. <u>Reduce</u> exposure to conflict. Whether familial, peer, or romantic relationships, if they tend to prompt conflict/strong emotions, recommend the relationship (and contact) be minimized until risk is reduced.
		d. <u>Prevent substance use/misuse</u> . Confirm no substance use, as it may increase impulsivity in the patient (and thus the risk of suicide); if the parent is using it, it can create an unstable environment and thus compromise patient safety.
		e. <u>Consult with your local mental health clinic</u> .
		f. <u>Monitoring/supervise</u> : If community monitoring is not indicated, or cannot be effectively implemented, arrange for a referral to the local Hospital ER and/or local mental health clinic
	4.	Develop a treatment plan. Use the information obtained from your interview forms and screen to complete the Office Action Plan on page 15.

Anxiety Module

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General Screens:

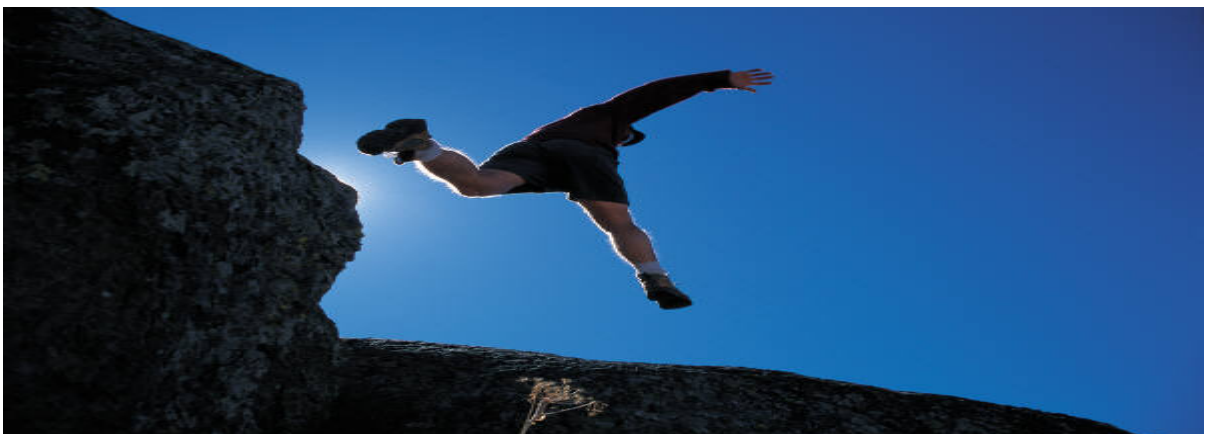
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Anxiety Module

Procedures

The instruments in this module provide a support for your clinical decision making. They will assist with identifying the presence or absence of anxiety, the nature of its presentation, and its impact on patient/family functioning. These instruments should be used in conjunction with other sources of patient data. The screens and checklists can not be used, by themselves, to determine a diagnosis.

STEPS

Distribute the **General Screens** prior to meeting with the patient and family.

Collect and review the screens prior to meeting with the patient and family.

Note. If items are endorsed in the 2nd section of the adolescent screen (i.e., the section beginning with "more days than not, do you: ..."), consider administering a [depression screen](#) (page 33).

During your session with the patient and family, review the endorsed screen items. With each item discussed, ask open ended questions to gather additional information about the item (e.g., "Tell me more about ..."). Complete the physician screens (#1 and # 2) on page 47 and 49.

If indicated (e.g., general screen items are endorsed), administer the checklists and supplemental screen. To aid clarity and efficiency, you can read aloud each item as a question. If the item is endorsed, ask: "Can you tell me more about"

Consolidate the above patient information, and existing patient data, and incorporate it into the [Specific Concern Interview Form](#) on page 13 and/or the [Office Action Plan](#) on page 15.

If indicated (e.g., the patient and family fail to improve as a result of your initial interventions), arrange a consultation with, and/or referral to, local mental health specialists, using the screen and checklist information as the basis of your referral information.

General Screens

#1 Adolescent Form: Do You Worry About Things? (Teen Screen)

Place a checkmark in the box next to the items that are true for you.

Do you:

- ☐ experience repeated, unexpected 'attacks' of overwhelming fear or discomfort for no apparent reason? Or live with a fear of having another 'attack'?
- ☐ have thoughts, impulses, or images you cannot get out of your mind (e.g., worrying about germs or the order of things)?
- ☐ fear social situations (e.g., being around groups of people, being in a crowd, school assemblies, busy malls)?
- ☐ worry a lot about news events or school/family activities?
- ☐ have a fear of places or situations where getting help or escape might be difficult, such as in a crowd or on an elevator?
- ☐ experience shortness of breath or racing heart for no apparent reason?
- ☐ have a fear of an object or situation (e.g., flying, heights, animals, etc.) ?
- ☐ spend time each day doing things over and over again (e.g., hand washing, checking things, or counting)?
- ☐ have dreams or flashbacks of a frightening experience?
- ☐ does your worrying interfere with your daily life?

More days than not, do you:

- ☐ feel restless?
- ☐ get easily tired or distracted?
- ☐ feel sad or depressed?
- ☐ feel worthless or guilty?
- ☐ feel muscle aches or have problems sleeping?
- ☐ notice changes in sleeping or eating habits?
- ☐ feel disinterested in life?

Show your answers to your doctor

#1 Adolescent Form: Do You Worry About Things? (Physician Key)

Place a checkmark in the box next to the items that are true for you.

Do you:

- ☐ experience repeated, unexpected 'attacks' of overwhelming fear or discomfort for no apparent reason? Or live with a fear of having another 'attack'? (*Generalized Anxiety/Panic Disorder*)
- ☐ have thoughts, impulses, or images you cannot get out of your mind such as worrying about germs or the order of things? (*Obsessive/Compulsive Behaviour Disorder*)
- ☐ fear social situations such as being around groups of people, being in a crowd, school assemblies, busy malls? (*Social Anxiety*)
- ☐ worry a lot about news events or school/family activities? (*Generalized Anxiety*)
- ☐ have a fear of places or situations where getting help or escape might be difficult, such as in a crowd or on an elevator? (*Social Anxiety*)
- ☐ experience shortness of breath or racing heart for no apparent reason? (*Generalized Anxiety*)
- ☐ have a fear of an object or situation such as flying, heights, animals, etc.? (*Generalized Anxiety*)
- ☐ spend time each day doing things over and over again such as hand washing, checking things, or counting? (*Obsessive/Compulsive Behaviour Disorder*)
- ☐ have dreams or flashbacks of a frightening experience? (*Posttraumatic Stress Disorder*)
- ☐ does your worrying interfere with your daily life? (*Generalized Anxiety*)

More days than not, do you:

- ☐ feel restless?
- ☐ get easily tired or distracted?
- ☐ feel sad or depressed?
- ☐ feel worthless or guilty?
- ☐ feel muscle aches or have problems sleeping?
- ☐ notice changes in sleeping or eating habits?
- ☐ feel disinterested in life?

#2 Are My Child's Worries A Concern?

(Parent Form)

Check all that apply

- ☐ When asked to try a normal challenge, my child gets overly upset (crying, anger, or frustration); and/or seeks a lot of reassurance.
- ☐ My child has frequent headaches, stomach-aches, racing heart, shortness of breath; is regularly too sick to go to school; has difficulty falling asleep, and/or has frequent nightmares.
- ☐ My child constantly worries about things ahead of time.
- ☐ My child has very high standards; re-does tasks because he/she are overly unhappy with 'less-than-perfect' performance.
- ☐ My child regularly refuses to participate in expected activities (e.g., play at school; attending school).
- ☐ My child often seems anxious when playing or talking with peers and tries to minimize or avoid contact with them.
- ☐ My child has a constant and unreasonable fear of an object or situation, such as an animal, heights, or flying; or is overly fearful of people or events such as burglars or car accidents.
- ☐ My child cries, has tantrums, or refuses to leave a family member or other familiar person when necessary.
- ☐ My child spends too much time each day doing things over and over again such as hand washing, checking things.
- ☐ My child repeats (in play with toys) scenes from a disturbing event they have witnessed and/or with which he/she has been involved in.
- ☐ My child finds day to day activities stressful and difficult to do, such as difficulty with going to friends' houses, to family gatherings, to school, or doing errands in the neighbourhood.
- ☐ As a parent, you find yourself spending a great deal of your time reassuring your child, as he/she get easily distressed in ordinary situations
- ☐ Your child does not understand worry problems, and/or cannot manage effectively work on the problem(s).
- ☐ The worry problems are getting worse, despite your effort and that of your child.

If you have checked off some or any of the items above, please talk with your doctor about your concerns for your child.

#2 Are My Child's Worries A Concern?

(Physician Key)

- ☐ When asked to try a normal challenge, my child gets overly upset (crying, anger, or frustration); and/or seeks a lot of reassurance. *(Generalized Anxiety)*
- ☐ My child has frequent headaches, stomach-aches, racing heart, shortness of breath; is regularly too sick to go to school; has difficulty falling asleep, and/or has frequent nightmares. *(Generalized Anxiety)*
- ☐ My child constantly worries about things ahead of time. *(Generalized Anxiety)*
- ☐ My child has very high standards; re-does tasks because he/she are overly unhappy with 'less-than-perfect' performance. *(Generalized Anxiety)*
- ☐ My child regularly refuses to participate in expected activities (e.g., play at school; attending school). *(Social Anxiety)*
- ☐ My child often seems anxious when playing or talking with peers and tries to minimize or avoid contact with them. *(Social Anxiety)*
- ☐ My child has a constant and unreasonable fear of an object or situation, such as an animal, heights, or flying; or is overly fearful of people or events such as burglars or car accidents. *(Generalized Anxiety- Phobia)*
- ☐ My child cries, has tantrums, or refuses to leave a family member or other familiar person when necessary. *(Separation Anxiety)*
- ☐ My child spends too much time each day doing things over and over again such as hand washing, checking things. *(Separation Anxiety)*
- ☐ My child repeats (in play with toys) scenes from a disturbing event they have witnessed and/or with which he/she has been involved in. *(Post Traumatic Stress Disorder)*
- ☐ My child finds day to day activities stressful and difficult to do, such as difficulty with going to friends' houses, to family gatherings, to school, or doing errands in the neighbourhood. *(Social Anxiety)*
- ☐ As a parent, you find yourself spending a great deal of your time reassuring your child, as he/she get easily distressed in ordinary situations *(Generalized Anxiety or Social Anxiety)*
- ☐ Your child does not understand worry problems, and/or cannot manage effectively work on the problem(s). *(Generalized Anxiety)*
- ☐ The worry problems are getting worse, despite your effort and that of your child. *(Generalized Anxiety or Social Anxiety)*

Transitory or Problematic Anxiety?

(Physician Form)

1. Review parent and patient screen information and discuss the information with them.
2. Respond to the chart items below, based upon the screen information and your knowledge of the patient/family through family history or collateral information.

	Normal, transitory Anxiety		Signs of problematic Anxiety
	Fears and concerns are reasonable and expectable		Fears and concerns are out of proportion with the event
	Patient is responsive to suggestions for change		Patient is easily overwhelmed and may regress in response to suggestions for change
	Questions are plentiful, but your answers, and/or those of the parent, are accepted and the patient is comforted by reassurances		Reassurance is never enough; no answer is good enough. Concerns are taken deeply to heart and create distress in the present and about the future
	Symptoms diminish in intensity over time, and take up less time		Symptoms increase in intensity over time and the worry takes on a life of its own
	Symptoms are limited to a particular situation		Symptoms generalize to increasingly more situations
	Patient understands why he/she needs to face the situation		Patient is more focused on how to avoid the situation rather than how or why face it
	Symptoms prompted positive change		Symptoms interfere with growth and productivity
	The fears/anxieties are consistent with the patient's developmental stage		The content of the fears/anxieties are out of step with the patient's developmental stage

3. If any of the items in the right hand column apply to your patient, then complete steps A, B, and C:
 - A) explore each endorsed item with the patient and parent, using prompts like:
 - "Can you tell me more about..." and/or
 - "What have you tried to do to address the concern"?
 - B) administer the checklists in this module.
 - C) incorporate the checklist and screen information into the [Specific Concern Interview Form](#) on page 13 and/or [Office Action Plan](#) on page 15
4. If items in the left column apply to your patient, then follow steps A and C.

Checklists:

Is your Child Anxious?

(Alternate Parent Form)

Place a check in the box next to the item that is true for your child

My child....

- ☐ always tries to avoid certain normal situations such as attending school or going to a mall.
- ☐ becomes really upset displaying tantrums and/or tears when pressed to participate in certain normal situations (e.g., school).
- ☐ is very clingy when separating from parent or when asked to sleep alone.
- ☐ often withdraws from day to day situations or from familiar people, displaying shyness up to the point of not wanting to be around people or not wanting to talk in normal situations.
- ☐ has vague physical complaints that are not due to an easily identifiable cause (e.g., rapid heart beats, headaches, vague stomach complaints, dizzy/ fainting).
- ☐ worries a lot.
- ☐ repeats behaviours such as frequent hand washing or checking doors/locks.
- ☐ has nightmares/flashbacks about past upsetting experiences.

(If the following apply to your child, talk with your doctor immediately)

- ☐ Your child is fearful/worried about self-harming, and/or you are fearful that your child may self-harm.
 - ☐ Your child's worrying has recently and dramatically disrupted their ability to complete a normal school day and/or to do normal activities around home.
-

Please talk to your doctor about the items that are true for your child.

Ask your patient/parent about each item below, check all those that apply

- ☐ Overly distressed about actual or imagined separations from a family member.
- ☐ Crying, clinging, tantrums, or vomiting when separated from a family member.
- ☐ Nightmares about harm to parents.
- ☐ Reluctance or refusal to leave the house or be apart from parents.
- ☐ Frequent checking or reassurance-seeking about the safety of loved ones.
- ☐ Discomfort or inability to be in a separate room, or on a separate floor from parent.
- ☐ Frequent calling out to parent (s) at home to establish his or her whereabouts.
- ☐ Frequent phone calls home or insistence that parent(s) stay home when child is out.
- ☐ Difficulty or inability to sleep in own bed.
- ☐ Difficulty attending school, frequent calls home or trips to the nurse's office.
- ☐ Unable to go on play dates, field trips, or other outings.
- ☐ Desire for parents to drive in separate cars as a safety precaution.
- ☐ May report unusual experiences like eyes staring at them or discomfort being in a room.
- ☐ Fear of being alone at home and/or in other settings (such as school or day care).
- ☐ Complaints of vague physical symptoms when separated from a family member.

If any of the items above apply to your patient, please discuss them with the patient and parent, and incorporate the information into your Specific Concern Interview Form on page 13 and/or Office Action Plan on page 15.

If 5 or more items are true for your patient, then the scope of the patient concerns is consistent with Separation Anxiety.

Ask your patient/parent each item and check all those that apply

- ☐ Does the patient have a list of worries? Does it change daily?
- ☐ Is there a need to know details of most things ahead of time?
- ☐ Takes offhand comments literally and seriously?
- ☐ Overly future oriented: high school student worried about jobs after college.
- ☐ Anxious about performance: perfectionistic, very afraid of doing the wrong thing, always seeking reassurance, afraid of getting into trouble, fears about failure, and consequences of less than perfect performance
- ☐ Social/interpersonal fears: fear that friends do not like them or that friends are mad at them; overly worried about tests or reports.
- ☐ Concerns about family: keeping tabs on the status of parents' marriage, exaggerating the consequence of a minor argument (e.g., the marriage will end if a minor argument occurs).
- ☐ Unreasonable fears about illness: a minor symptom is thought to be a sign of a major problem or illness.
- ☐ Unreasonable fears about family or personal finances: overly worried about minor household expenses or groceries.
- ☐ Several signs of stress: always on edge, looks tense, difficult to reassure, restlessness, irritability, fatigue, difficulty concentrating, headaches, stomach-aches, unable to enjoy things or overwhelmed by schedule.
- ☐ Sleep patterns disrupted by worry anxiety.

If any of the items above apply to your patient, please discuss them with the patient and parent, and incorporate the information into your Specific Concern Interview Form on page 13 and/or Office Action Plan on page 15.

If 5 or more items are true for your patient, then the scope of patient concerns is consistent with Generalized Anxiety.

Ask your patient/parent each item, check all those that apply

- ☐ Anxiety, worry, or physical tension about unfamiliar people, places, situations (Note: Anxiety must occur in peer settings, not just in interactions with adults).
 - ☐ Paralyzing concern that the patient will do something embarrassing or humiliating in a social or performance situation.
 - ☐ Avoiding eye contact even with familiar people such as relatives, classmates.
 - ☐ Speaking in a very quiet voice, or not speaking at all, e.g., unable to order in a restaurant, talk on the phone, raise hand in class, may even get sick on days when required to do an oral report in class.
 - ☐ Clinging, hiding at school, or avoiding birthday parties.
 - ☐ Chills, shakiness, feeling hot, and/or blushing in social situations.
 - ☐ Painful self-consciousness about appearance: hair, clothes, face.
 - ☐ Hesitant to respond to other children's social overtures or unable to initiate social contact.
 - ☐ May withdraw in unstructured times (lunch times, recess, group activities on the playground) rather than risk rejection.
 - ☐ Exposure to a feared situation provokes significant distress.
 - ☐ Feared situation(s) are avoided or are tolerated with intense distress.
-

If any of the above items apply to your patient, please discuss them with the patient and parent, and incorporate the information into your Specific Concern Interview Form on page 13 and/or Office Action Plan on page 15.

If 5 or more items are true for your patient, then the scope of patient concerns is consistent with Social Anxiety.

Obsessive Compulsive Behaviour Disorder (Physician Checklist)

Ask your patient/parent each item, check all those that apply

- ☐ Child is unable to stop a behaviour when that behaviour is brought to his/her attention.
- ☐ Child feels frustrated and is clearly upset, by the behaviour but is unable to control it.
- ☐ Child feels an intense urge/need to perform the behaviour.
- ☐ Child feels a sense of relief when he/she performs the behaviour.
- ☐ The behaviour causes physical damage – e.g., sore neck or knuckles from tics or bald spots from hair pulling.
- ☐ The behaviour interferes with functioning such as in the middle of a sports event or a test, child needs to interrupt the activity to perform the behaviour.
- ☐ An ordinary habit such as spitting, nail-picking is accompanied by multiple tics or habits, including vocalizations such as humming, throat clearing.
- ☐ The behaviour(s) are overly time consuming.
- ☐ The behaviour causes great distress if interrupted, and the child must start the behaviour over again.
- ☐ The behaviour is connected to unfounded feared consequences, is performed to prevent (imagined) harm or is due to other superstitious beliefs.

See [Supplementary OCD Screen](#) page 59

If any of the items above apply to your patient, please discuss them with the patient and parent, and incorporate the information into your [Specific Concern Interview Form](#) on page 11 and/or [Office Action Plan](#) on page 15.

If 5 or more items are true for your patient, then the scope of patient concerns is consistent with Obsessive-Compulsiveness

- Exposure to a traumatic event involving death or serious injury, or a threat of serious injury to self or others
- The patient's response must involve intense fear, helplessness, or horror

The patient must have concerns present in the past four weeks from each of the following three sets of items:

1. The traumatic event is frequently re-experienced in at least one of the following ways:

- ☐ Distressing recollections of the event or repetitive play in which themes of the trauma are expressed.
- ☐ Recurrent distressing dreams.
- ☐ Feeling as if the traumatic event were recurring or actual trauma-specific event re-enactment.
- ☐ Mental distress when exposed to cues that symbolize an aspect of the trauma.
- ☐ Physiological reactivity when exposed to cues that symbolize an aspect of the trauma.

2. Persistent avoidance of cues associated with the trauma and a lowering of general responsiveness, as indicated by at least three of the following:

- ☐ Efforts to avoid thoughts, feelings, or conversations about the trauma.
- ☐ Efforts to avoid activities, places, or people that are reminders of the trauma.
- ☐ Inability to recall an important aspect of the trauma.
- ☐ Markedly diminished interest or participation in significant activities.

3. Symptoms of increased arousal as indicated by at least two of the following:

- ☐ Sleep disturbance
- ☐ Hypervigilance
- ☐ Irritability or anger
- ☐ Difficulty concentrating
- ☐ Exaggerated startle response

If any of the items above apply to your patient, please discuss them with the patient and parent, and incorporate the information into your [Specific Concern Interview Form](#) on page 13 and/ or [Office Action Plan](#) on page 15.

If the first 2 items are endorsed, as well as one or more in each of the subsequent 3 sets of items, then the scope of patient concerns is consistent with Posttraumatic Stress

As you read the items below, keep in mind your recent parenting efforts with your child. Go through each item and see what is going well and what is not going well. Discuss your responses with your physician and members of your family.

Parenting behaviour that may reinforce anxiety in children:

- ☐ **Over-control.** Examples of parent behaviour include: controlling conversation in the family; meddling in family members activities; being pushy with family members; or interfering in the activities of family members.
- ☐ **Overprotection.** Excessive caution and protective behaviours, in the absence of risk to the child/family. Examples of parent behaviour include: regularly, anxiously hovering over your child, as they engage in little or no risk activities, or in activities that may pose an appropriate challenge to your child's abilities.
- ☐ **Modeling anxiety.** Agreeing with your child's distorted (inappropriately high) sense of risk in a situation. This may accidentally reinforce the idea that normal things in the world are too scary to approach.
- ☐ **Encouraging/tolerating avoidance.** Suggesting or agreeing with not trying something challenging.
- ☐ **Rejection or criticism.** On a regular basis, displaying parenting behaviour that is critical, judgmental, disapproving, or dismissive.
- ☐ **Conflict.** Fighting, arguing, tensions, etc., among family members can quickly create an atmosphere of anxiety.

Parenting behaviour that can reduce anxiety in children

- ☐ **Reward coping behaviour.** Watch for partial successes; look to reward small steps toward a goal; reward/reinforce strategies to cope rather than just focusing on the outcome; reward the acceptance on of challenges.
- ☐ **Extinguish excessive anxious behaviour.** Reduce your child's anxiousness by not responding to it excessively, either with anger or concern.
- ☐ **Manage your own anxiety.** When you are with your children, try to limit your displays of distress, anxiousness, or concerns about the world, the family, and/or about your child. Keep adult concerns and anxieties in the adult world.
- ☐ **Strengthen communication/problem-solving in the family.** Actively build the skills of your family. Develop family routines that support: working out problems, independently and as a family, and openly talk about concerns and issues. Find resources to help (e.g., books in your local library, online material, or professionals like your physician).

OCD Rituals or Habits? (Supplemental Screen for Obsessive & Compulsive Behaviour)

1. Carefully detail the behaviour of concern, noting: the sequence of events, the trigger to the sequence, the thoughts and emotions (e.g., fear, dread, heightened general anxiety), accompanying the sequence.

Review the information above and the items in the chart below. Explore further any endorsed items.

	OCD Rituals		Non-OCD Rituals
	Time consuming		Not overly time consuming
	Child feels like he/she has to do them		Child wants to do them
	Disrupt routine, take on a life of their own		Enhance efficiency or enjoyment
	Create distress, dread, or frustration		Create a sense of mastery
	Appear bizarre or unusual		Appear ordinary
	Cause great distress if interrupted, child must start the behaviour over again		Can be skipped or changed without consequences
	Become increasingly inflexible and elaborate over time		Become less important over time
	Connected to a web of feared consequences, are performed to prevent (imagined) harm or due to other superstitious beliefs		Performed for the sake of the activity itself; comforting, but have no invisible connections to feared situations or superstitious beliefs

2. Incorporate the information above into your [Specific Concern Interview Form](#) on page 13 and/or your [Office Action Plan](#) on page 15.

Anxious Behaviours? (A Supplemental Screen for Obsessive & Compulsive Behaviour)

Ask each item, and check all those that apply.

- ☐ Child is unable to stop when the behaviour is brought to his/her attention.
 - ☐ Child feels frustrated by the behaviour but unable to control it.
 - ☐ Child feels intense anxiety to perform the behaviour.
 - ☐ Behaviour is something the child feels compelled to do, not something he/she chooses to do.
 - ☐ Child feels intense frustration when he resists the behaviour.
 - ☐ Frustration is not relieved until the behaviour is performed.
 - ☐ Child feels sense of relief when he/she performs the behaviour.
 - ☐ Behaviour causes physical damage – sore neck or knuckles from tics, bald spots from hair pulling.
 - ☐ Behaviour interferes with functioning (e.g., in the middle of a sports event or math test, child needs to interrupt the activity to perform the behaviour).
 - ☐ An ordinary habit (e.g., spitting, knuckle-cracking, nail-picking) is accompanied by multiple tics or habits, including vocalizations (e.g., humming, throat clearing).
-

If any of the items above apply to your patient, please discuss them with the patient and parent, and incorporate the information into your Specific Concern Interview Form on page 13 and/or Office Action Plan on page 15.

If 5 or more items are true for your patient, then the scope of patient concerns is consistent with Obsessive-Compulsive behaviour.

Change Tools Module

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Goal Setting Worksheet

Client Name: _____ Date: _____

What would I like to change?

Thoughts: _____

Behaviour: _____

What would I like to be doing instead?

Thoughts: _____

Behaviour: _____

What's the plan?

Thoughts: _____

Behaviour: _____

Timelines: _____

Did the plan work?

What behaviour(s) has changed? Has the change helped? _____

How can this change be maintained/built upon?

*Complete the worksheet with the patient (or assign as homework); monitor progress biweekly or monthly. Use this form with the [Office Action Plan](#) on page 15.

Problem Solving Worksheet

Client Name: _____

Date: _____

What is the problem? (What is the behaviour I need to stop/change? What is the behaviour I need to start?)

Possible solutions

My ideas about what I can do: _____

Other peoples' ideas about what I can do: _____

My favourite solutions:

Other peoples' favourite solutions:

Action

I agree to:

Others agree to: _____

Timeline: _____

Outcome

What happened?

Did this work well? Do others think it has gone well? _____

What would you do differently next time? _____

Behavioural Change Worksheet

Client Name: _____

Date: _____

What's not working?

Identify behaviours that are unhealthy, unhelpful or leading to negative consequences.

Suggestion: (Work on one or two behaviours at a time)

What would work better?

What behaviours would be more helpful or healthy, or would lead to more positive outcomes?

(Suggestion: Work on one or two behaviours at a time)

What's the plan?

Be specific and realistic (e.g., small steps towards a goal); make sure it is easy to measure; have a plan B (just in case):

*****Complete the worksheet with the patient (or assign as homework); monitor progress biweekly or monthly. Use this form with the Office Action Plan on page 15.***

(Negative) Behaviour Diary

List the behaviour of concern and complete the chart below.

Behaviour being tracked: _____ Day: _____

Behaviour of Concern	<u>When</u> and <u>where</u> did it occur?	What occurred <u>before</u> the event?	What occurred <u>after</u> the event?	How did people respond to the behaviour?

Procedure:

Pick one behaviour and track it for a week (by completing the chart above). Implement an intervention (to decrease the behaviour) and complete the chart for a second time. Compare the first and second charts. Is the behaviour occurring less often? If yes, then this may suggest your intervention is working. If there is no difference, you could wait an additional week (or try a new intervention) and chart again.

(Positive) Behaviour Diary

List the positive behaviour of interest, and complete the chart below.

Positive behaviour being learned: _____ Day: _____

Positive behaviour	<u>When</u> and <u>where</u> did it occur?	What occurred <u>before</u> the event?	What occurred <u>after</u> the event?	What positive comments did people (e.g., family member/teacher) make?

Procedure:

Pick one behaviour and track it for a week (by completing the chart above). Implement an intervention (to increase the behaviour) and complete the chart for a second time. Compare the first and second charts. Is the behaviour occurring more often? If yes, then this may suggest your intervention is working. If there is no difference, you could wait an additional week (or try a new intervention) and chart again.

Time-Out Diary

Instructions: Make a note of the day, the behaviour of concern, when and where it occurred, and the length of time in time-out, and your child's response to the time-out.

This time-out is for: 2 minutes ____ 3 minutes ____ 4 minutes ____ 5 minutes ____ Other ____

Day	Problem Behaviour	When and where it occurred	Length of time-out	Response to time-out

Time Sample Record

Time	Mon.	Tues.	Wed.	Thurs	Fri	Sat.	Sun.
7:00 - 7:30							
7:30 - 8:00							
8:00 - 8:30							
8:30 - 9:00							
9:00 - 9:30							
9:30 - 10:00							
10:00 - 10:30							
10:30 - 11:00							
11:00 - 11:30							
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5:00 - 5:30							
5:30 - 6:00							
6:00 - 6:30							
6:30 - 7:00							
Totals							

Instructions: Place an 'X' in the box corresponding to the day and time the behaviour (new or old) occurs. Total the number at the end of each day. Look for patterns showing a decrease or increase in the behaviour of concern.

Tally Sheet

As part of your plan to improve your child's mental health, this sheet can help you keep track of behaviour(s) you are interested in increasing or decreasing.

Week: ____

Day	1	2	3	4	5	6	7	8	9	Total

Week: ____

Day	1	2	3	4	5	6	7	8	9	Total

Instructions: In the first column, write the day of the week. Then, going along the row, place an 'X' in each successive square every time the behaviour occurs. Record the total number of episodes for each day in the column at the end. If the behaviour occurs more than nine times, move down a row, write in the day again, and continue to record.

In the example below, the behaviour occurred four times on Tuesday.

Day	1	2	3	4	5	6	7	8	9	Total
Tues	X	X	X	X						4

In this example, the behaviour occurred 13 times on Tuesday.

Day	1	2	3	4	5	6	7	8	9	Total
Tues	X	X	X	X	X	X	X	X	X	
Tues	X	X	X	X						13

Three Wishes

Write a wish on each line below. Can you think of any changes you can make alone or with help, that will help you realize your wishes?

RELATIONSHIPS

What needs to change to realize my wishes about my relationships?

Parents: _____

Brother/sister: _____

Friend(s) or other(s): _____

What needs to change to realize my relationship wishes?

SCHOOL

What needs to change to realize my wishes about school?

MYSELF

Body: _____

Mind: _____

Feelings: _____

What needs to change to realize my wishes about me?:

Talk with your doctor or clinician about the changes you might be able to make alone or with help to realize your wishes.

Each item below can be given verbally and individually, or in pairs, as interventions. Alternately, this form can be provided to the parent as homework, with some follow up by yourself and/or clinic staff.

Improving the parent-child relationship

- ☐ **Spend quality time with children**
This could involve spending frequent, brief amounts of time (as little as a minute or two) with your child in child-preferred activities.
- ☐ **Talk to your child**
Have brief conversations with your child about an activity or interest.
- ☐ **Show affection**
Provide physical affection (e.g., hugging, touching, cuddling, tickling, patting).

Encouraging desirable behaviour

- ☐ **Using descriptive praise**
Provide encouragement and approval by describing the behaviour that is appreciated.
- ☐ **Giving attention**
Provide positive non-verbal attention (smile, wink, pat on the back; watching).
- ☐ **Providing engaging activities**
Arrange the physical/social environment to provide interesting and engaging activities, materials, and age appropriate toys.

Teaching new skills and behaviours

- ☐ **Setting a good example**
Parent modeling the new skill/behaviour.
- ☐ **Using incidental behaviour**
When interacting with your child, look for opportunities to use questions/prompts to promote learning.
- ☐ **Using Ask, Say, Do**
Ask: What is the first thing we do to wash our hair?
Say: First we get under the tap and get our hair all wet. Show me how you would do that.
Do: Guide the child through it.
- ☐ **Behavioural charts** on pages 65 and 66 .
Use as a short term strategy only. For example, implement charting for two to three weeks (using a regular calendar) to get an increase in a desirable behaviour. Then take a month break before re-using behavioural charts.

Managing Misbehaviour☐ **Establishing ground rules**

Negotiating in advance a set of fair, specific and enforceable rules.

- Use only as many rules as the child can remember.
- Fairness means everyone in the household lives by the rules.
- Rules should be easy to understand and to follow.
- Enforce the rules, using reasonable expectations about compliance.
- When possible, state rules in a positive manner: tell them what they can do versus what they cannot do.

☐ **Using directed discussion for rule breaking**

Identify and rehearse correct behaviour following rule breaking.

- Calmly get child's attention
- Describe behaviour of concern: Say – "You just ran through the house."
- Explain risk/ problem: Say "You might break something or hurt yourself."
- Review rule & correct behaviour: Say "What is our rule?"
- Practice behaviour: Say "Okay, now show me, go back to the door and start again."
- Praise: Say "That's much safer, thank you. I like it when you walk through the house."

☐ **Planned ignoring**

Use this technique for minor behaviour; do not use if the behaviour poses a risk of harm to the child or others. If there is risk, select another technique.

☐ **Give clear and calm instructions**

- Kneel arms length away from the child.
- Make/maintain eye contact and say the child's name (using a calm voice).
- Say exactly what you want the child to do.
(e.g., say "I want you to stop [behaviour A] and start doing [behaviour B]).
- Give the child time to comply.
- Repeat instructions once only.
- If no compliance, apply quiet time or time out, depending upon the seriousness of the behaviour.

☐ **Use quiet time for misbehaviour**

Placing child at the periphery of an activity for a set amount of time

- Start quiet time when the child is quiet.
- Restart quiet time if the child acts up.
- Use up to 2 minutes of quiet time for children ages 2-3; use up to 3 min. for 4-5 year olds, and up to 5 min. for 5 to 10 year olds.

☐ **Use time out for serious misbehaviour**

Removing a child to an area away from others for a set time.

- Use the same time line given for quiet time.

Strategies That Motivate Change

- Give practical, useful advice.
 - Identify and remove barriers and disincentives to change.
 - Provide choices and offer suggestions rather than prescriptions/demands.
 - Decrease the desirability of the current activity by listing pros/cons.
 - Demonstrate empathy.
 - Provide clear feedback.
 - Help clarify goals that are realistic, attainable, and measurable.
 - Maintain an attitude of active helping.
-

¹ adapted from Miller, W.R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behaviour*. New York, NY.: Guilford Press.

Emotion Word Checklist:

Feeling At A Loss For Words?

Emotion Word Checklist

Calm-relaxed

at ease	tame	serene	elated
easy going	soothed	cool	
peaceful	mellow	calm	
safe	quiet	relaxed	

Happy-joyful

amused	carefree	wonderful	humorous
enchanted	jolly	light-hearted	excited
ecstatic	overjoyed	pleased	glad
optimistic	thrilled	elated	merry
excited	cheerful	superb	

Sad – depressed

unhappy	down	blue	gloomy
lonely	sullen	upset	heartsick
sad	depressed	glum	low
tearful	somber	grim	

Tired-apathectic

apathectic	sleepy	run down
bushed	tired	sluggish
fatigued	exhausted	weary

Angry–hostile

agitated	spiteful	combative	angry
furious	vicious	belligerent	bad-tempered
resentful	annoyed	enraged	aggravated
hostile	cruel	harsh	nasty
rude	cross	hateful	stormy

Managing Change Module

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Managing Change Module

This module contains a number of general approaches to promoting change in patients and/or families. As well as descriptions of several basic counselling skills. The reader is encouraged to review the material and implement what you can, given your interest and time constraints.

Should you find the material interesting, and/or wish to pursue additional self-study, the module's material is referenced in the Desk Reference's Resource Section. As well, Googling the authors (Prochaska; Hill & O'Brien) will provide you with a considerable amount of new reading material.

Module Contents

Promoting Change: A Basic Framework

- This document provides a nine step, generic approach to patient change. It walks the reader through identification of concerns, resources/solutions, interventions, and outcome evaluation.

The Prochaska (1994) Model of Change

- This document is a very brief outline of the stages of change in a well-developed, well-known model of patient/client change.
- The outline can be used to prepare clients for change by exploring the model with the patient, and as a framework to guide change, using the above noted instruments and tools in the Promoting Change Modules.
- The reader is encouraged to read the primary source referenced in the Resource Section of the Desk Reference. Alternately, the reader may Google (or Google.scholar) to obtain more complete information on the Prochaska Model.

Basic Attending Skills: 'SOLER' and 'ENCOURAGE'

- These are basic strategies that assist with relationship building.

Basic Skills: Open Questions

- This document provides examples of open-ended questions that can be used to facilitate relationship building, thoughts/feelings, and problem identification.

Hill & O'Brien's (1990) Model of Change

- This document very briefly notes three general processes (Exploration, Insight, and Action) which are key to promoting change.
- A physician or clinician wishing to promote change begins with facilitating the client's efforts to explore issues, resources, potential solutions, etc.
- As exploration is occurring, the reader (or any change agent) begins promoting patient/family insight and lays the groundwork for patient action.

Hill & O'Brien (Cont'd)

- The reader is encouraged to read the primary source, listed in the Resource section of this manual, to obtain a more complete understanding of this model of change. Alternately, the reader can Google (or Google.scholar) the authors.
- The 'Guiding Patients...' document noted below provides a number of questions as a guide for the implementing the 'Action' aspect of Hill & O'Brien's work.
- The 'Supporting Patient...' document integrates Hill & O'Brien's three processes of change and Prochaska's six stages of change.

Guiding Patients Through Change

- This Guide details the 'Action' process of Hill & O'Brien's Model of Change.
- It provides a series of questions embedded in a basic problem-solving framework.
- The reader can use the document as a script or guide to move a client through the process of realizing change.

Supporting Patient Change

- This support document integrates both the Hill & O'Brien and Prochaska's Models of change.
- Within each of the initial Prochaska's stages of change (Precontemplation, Contemplation, and Preparation), there are processes of exploration and insight occurring for the client.
- As insight leads to action, the patient enters the latter stages of Prochaskian change (Action, Maintenance, and Termination).
- Nested within each of the stages and processes are suggestions to assist the physician and/or clinician's efforts to move the patient towards success.
- These range from the use of basic attending skills to use of open-ended questions to completing/evaluating an intervention plan.

Note. This document assumes some experience/familiarity with counselling. If this is not the case, some consultation and practice with basic skills is suggested before attempting to use this document.

Promoting Change: A Basic Framework

There are numerous, well-founded models of patient change in the counselling and clinical literatures. Many of them incorporate the basic problem-solving process detailed below. As an assist to completing the steps below, the reader is encouraged to use the instruments and tools in the Promoting Change Modules.

- Use reflecting skills to identify key client concerns and to understand the client's situation:
- Reflecting feelings: a brief statement about the client's feelings, delivered in a supportive, inquiring manner.

Example: "Jane, it sounds like you are feeling frustrated (sad, etc) about"

- Reflecting experience: responding to the client's experience at a general level (e.g., a brief statement about the client's whole experience, delivered in a supportive, inquiring manner).

Example: "Jane/John, that sounds like it was a terrible experience (incident, etc)"

- Reflecting content: repeating the client's ideas in fresh words or for emphasis.

Example: "John, was that an example of meeting her 'halfway'?"

- Restate concerns in behavioural terms.
- Prioritize the concerns.
- Gather information, including:
 - resources/ strengths of the client and his/her support network.
 - previous solution attempts.
- Develop potential solutions with the client.
- Discuss each solution's effectiveness and the consequences of implementation.
- Choose the best potential solution and create steps to implement it.
- Implement and monitor the solution using jointly developed benchmarks.
- Evaluate outcome and new learning.

The Prochaska (1994) Model of Change

In the 80's, Prochaska, Norcross, and DiClemente (1994) investigated differences in patient 'readiness' (i.e., motivation) to change. They discovered that patients sequentially move through six stages of change: pre-contemplation, contemplation, preparation, action, maintenance, and termination.

Precontemplation Stage:

- patients generally are unaware of both the presence of problematic behaviour and the need to change.
- alternately, they may actively avoid learning about their problem behaviour, engage in denial about their behaviour, and only seek help if pressured.
- at this stage, the patient is not ready to change.

Contemplation Stage:

- patients become aware of and accept responsibility for problems and are less defensive and less resistant to change.
- the evidence they gather prompts self-evaluation and the recognition of the damage caused by the problems, the underlying causes of their problems, a sense of what it would be like to change, and how that change would improve things.

Preparation Stage:

- patients have made a commitment to change and are preparing themselves to begin the change process.
- involves developing a clear view of the self and life without the problems, and a realistic change plan.
- patients recognize both the challenges of change and the small successes/goals that occur along the way to successful change.

Action Stage:

- patients actively begin to modify their behaviours and their surroundings.
- the commitment and preparation done in the Contemplation and Preparation Stages seem to be crucial for success in this stage, in that patients are more aware of what they are striving for and why.
- generally, patients attempt to change several behaviours at once.
- many of these behaviours replace or counter problem behaviours: e.g., exercising during one's traditional snack time; countering negative thoughts with positive ones. As well, patients often implement avoiding strategies, such as, avoiding contexts that would trigger problem behaviour (e.g., avoiding bars).
- patients may use relaxation training/positive thoughts to prepare for/manage stressful events.
- patient change plans often include rewards/incentives to promote the likelihood of, and/or strengthen, change.

The Prochaska (1994) Model of Change (cont.)

Maintenance Stage:

- patients have changed and are trying to consolidate their changes and deal with lapses.
- this stage can last for weeks or months, and severely challenge the patient, as permanent change is difficult and often requires major lifestyle alterations.
- throughout this stage, the availability of supportive relationships is crucial for the patient.

Termination Stage:

- patients no longer feel concerned about the possible return of the original problem behaviours. They have confidence that they can cope without relapse.
- the effort to change and maintain change is no longer salient in their day-to-day living. They come to see themselves in a new light – the new behaviour is incorporated into their identity.

Primary health care providers can facilitate patient change by recognizing where the client is, in terms of the stages, and then supporting the patient's movement forward through the remaining stages of change. This support can be provided via the instruments and tools in the Desk Reference's Promoting Change Modules.

Basic Attending Skills: "SOLER" ¹

S = face the client **squarely**

O = adopt an **open posture**

L = **lean** toward the client

E = maintain consistent **eye contact**

R = **relax**, be natural

This basic strategy, with a little practice, will enhance your ability to quickly and efficiently build rapport with your patient. In doing so, your patient will be more 'at ease' and receptive to your advice and intervention.

¹¹ Egan, G. (1994). *The skilled helper (5th Ed.)*. Pacific Grove, CA.: Brooks/Cole.

Basic Attending Skills: “ENCOURAGES” *²

- E** = maintain moderate levels of **eye contact** (avoid frequently looking away or staring)
- N** = use moderate amounts of head **nods**
- C** = maintain a respect and awareness of **cultural differences** in attending to your patient
- O** = maintain an **open stance** (do not fold your arms on your chest; lean towards your patient)
- U** = **use** acknowledgements such as “umhmm”
- R** = **relax** and be natural in your tone and posture
- A** = **avoid** distracting behaviours (too much smiling; too many gestures when speaking)
- G** = match your patients **grammatical** language style within the limits of your own style
- E** = listen with a third **ear** (attend to both verbal and nonverbal messages)
- S** = use **space** well (do not sit too far away or too close)

This strategy promotes physician and/or clinician attention to detail that impacts the comfort of the client. Having a client ‘at ease,’ and feeling like they are being attended to, builds rapport with the patient. It also enhances the willingness to reflect on your advice and to follow through with change strategies.

² Hill, C.E., & O’Brien, K.M. (1999). *Helping skills: Facilitating exploration, insight, and action*.: Washington, D.C.: APA

Basic Skills: Open Questions³

The list below is comprised of examples of questions that tend to elicit open-ended responses from patients. The reader can use them to facilitate patient assessment.

To encourage/request exploration

- "What would you like to talk about today?"
- "How have things been going for you lately?"
- "Tell more about that."
- "Tell me how your behaviours contribute to you feeling so ____."

To explore thoughts

- "What was your reaction when she said that?"
- "What did you think about that?"
- "Tell me what thoughts you were having about ..."
- "What did you want to say?"
- "Say more about what was going on in your mind."
- "What is the most important question you might ask yourself?"
- "What were you expecting at that point?"

To explore feelings

- "What else have you been feeling?"
- "Say more about how you felt about that"
- "How are you feeling right now?"
- "How did that make you feel about ...?"
- "Tell me what feelings you are aware of"
- "What do those feelings mean to you?"

To explore different parts of problems/concerns

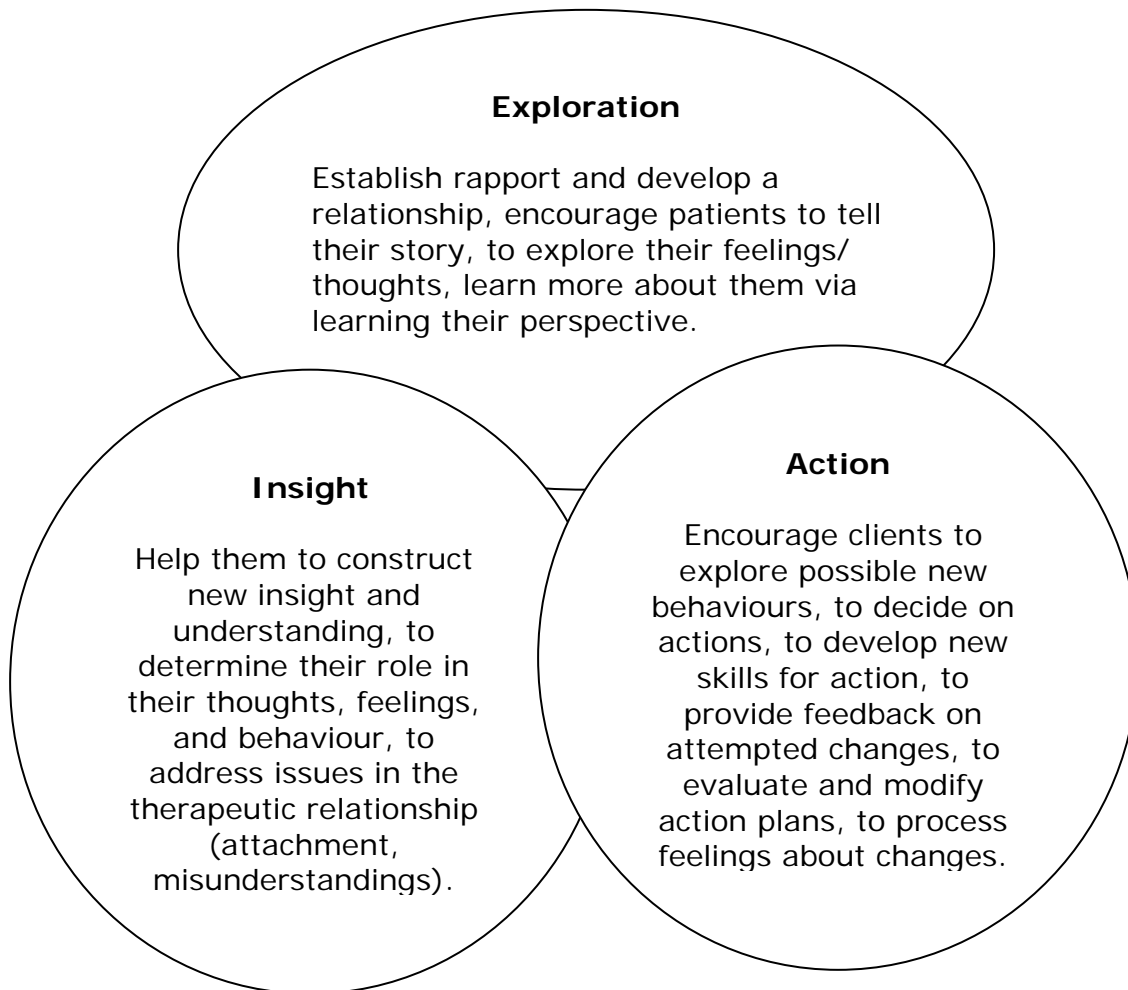
- "How is this situation similar to past experience?"
- "How is this situation dissimilar to other experiences that you have had?"
- "How would you like this situation to be in the future?"
- "How does this affect your relationships with others?"

To clarify or to encourage focus

- "Explain that to me a bit more."
- "What do you mean?"
- "What is your role in those problems?"

³ Drawn from Hill, C.J., & O'Brien, K.M. (1999). *Helping skills: Facilitating exploration, insight, and action*. Washington, D.C.: APA

Hill & O'Brien's (1999) Model of Change



Drawn from Hill, C.J., & O'Brien, K.M. (1999). *Helping skills: Facilitating exploration, insight, and action*. Washington, D.C.: APA

- Hill and O'Brien suggest counselling entails a number of tasks embedded within three general processes: Exploration, Insight, and Action.
 - A counsellor (or physician) would typically begin their session (or patient interview) with Exploration, then move to supporting patient Insight and Action.
 - Each of these processes can be supported via the use of the instruments and tools in the Desk Reference's Promoting Change Modules (e.g., ENCOURAGES to build rapport; open questions; and the Supporting Patient Change document to facilitate insight and action [intervention] plans).
- ★ The 'Guiding Patients Through Change' document provides additional detail to support the implementation of the 'Action' component of the Hill & O'Brien Model.

Guiding Patients Through Change

Hill & O'Brien's (1999) Change Model See the [Procedures Section](#) for Additional Detail

Action Stage: The tasks at this stage are:

- a. to help patients decide what actions to take on the basis of their exploration of and insight into their behaviours of concern;
- b. to support patient efforts to implement their action plans; and
- c. to assist them with evaluating changes and modifying action plans. Asking the following questions will support the patient through the tasks.

1. Explore Action

- "What would you like to do about this problem?"
- "What are the positive and negative aspects of staying as you are?"
- "How would changing make you feel?"
- "What goes through your mind as we talk about change?"
- "What feelings are you having when you contemplate making changes in your life?"

2. Assess what the client has tried before

- "What have you tried before?"
- "Tell me what strategies you have used in trying to change?"
- "What has worked?"
- "What hasn't worked?"
- "What problems did you encounter that made change difficult?"

3. Set specific goals

- "What do you specifically want to change in your life?"
- "What changes would you need to make to ensure that these dreams become a reality?"
- "What are some of the goals that you want to work on here?"

4. Brainstorm possible ways to reach goals

- "What alternatives have you thought about trying?"
- "If there were no restrictions, how would you try to change this problem behaviour?"
- "What would you suggest to someone else in this situation?"

5. Explore the different options

- "Which option seems most appealing? Why?"
- "Which option seems least appealing? Why?"
- "How do your values impact the different alternatives that you might try?"
- "What changes would you not want to try because they go against your beliefs?"
- "What things would help you in making changes?"
- "What things would prevent you from making changes?"

6. Decide on an action

- "What actions would you like to do right now?"
- "What problems do you foresee with this action choice?"
- "How could you resolve the problems that might come up with this action choice?"

7. Implement and evaluate.

If necessary, modify action(s) as needed or suggested.

8. Give feedback on progress.

Target the next concern.

Supporting Patient Change

- ☐ **Precontemplation Stage of Patient Change** (See Prochaska Model)
Exploration and Insight tasks (See Hill & O'Brien Model)
 - **ENCOURAGES** to build relationship.
 - Open ended questions to encourage patient
 - I. to explore issues
 - II. to explore thoughts, feelings
 - III. to clarify or to encourage focus.
- ☐ **Contemplation and Preparation Stages of Patient Change**
Exploration and Insight tasks (Emphasize when opportunities arise).
 - **ENCOURAGES** to build a stronger relationship.
 - Open ended questions to encourage patient
 - I. to explore issues
 - II. to explore different parts of problems
 - III. to clarify or to encourage focus.
 - Develop a solution/action plan
 - I. to explore the possible range of possible options/actions
 - II. to assess what was done before
 - III. to set specific goals
 - IV. to brainstorm options and organize under each goal
 - V. to explore each option
 - VI. to decide an action.
- ☐ **Action Stage of Patient Change**
Insight and Action tasks (Emphasize when opportunities arise).
 - **ENCOURAGES** to maintain relationship.
 - Open ended questions to encourage patient
 - I. to clarify and encourage focus
 - II. to implement a solution
 - III. to evaluate/and or adjust the solution.
 - Go through an action plan
 - I. to implement the action
 - II. to evaluate the action and adjust if necessary.
- ☐ **Maintenance and Termination Stages of patient change**
Insight and Action tasks (Emphasize when opportunities arise).
 - Go through a maintenance plan
 - I. to explore the possible range of barriers to maintenance
 - II. to assess current range of possible actions/options
 - III. to explore what was done before
 - IV. to set specific maintenance goals/timelines
 - V. to explore each option and decide upon an option/action
 - VI. to implement an action, evaluate its effectiveness, and adjust if needed
 - VII. to terminate the episode of care.

Disruptive Behaviour Disorders Module

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Disruptive Behaviour Disorders Module

Procedures

The instruments in this module provide a support for your clinical decision making. They will assist with identifying the presence or absence of a disruptive behaviour (ADHD, ODD, CD), the nature of its presentation, and its impact on the patient/family system. These instruments should be used in conjunction with other sources of patient data. The screens and checklists cannot be used by themselves to determine a diagnosis.

STEPS

1. Distribute the General Screens (refer to the [General Mental Health Module](#) on page 6) prior to meeting with the patient and family.
2. Collect and review the screens, prior to meeting with the patient and family
3. During your session with the patient and family, review the endorsed screen items. With each item discussed, use open ended questions to gather additional information about the item (e.g., "Tell me more about..."). Complete the Physician Screen.
4. If indicated (e.g., general screen items endorse ADHD, ODD or CD items), administer the checklists (Parent and Physician forms). Note: consider completing all three screens, as there is a high rate of comorbidity between these disorders.
5. Consolidate the above patient information, and existing patient data, and incorporate it into the [Specific Concern Interview Form](#) (on page 13) and/or the [Office Action Plan](#) (on page 15).
6. If indicated (e.g., the patient and family fail to improve as a result of your initial interventions), arrange a consultation with, and/or referral to, local mental health specialists, using the screen and checklist information as the basis of your referral information.

The following checklists have been derived from criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR).

Please tick as many as are true for your child:

- ☐ Makes many careless errors and has trouble paying attention?
- ☐ Has difficulty paying attention during tasks or playtime?
- ☐ Does not appear to listen, even when you speak directly to him/her?
- ☐ Has difficulty following instructions or completing schoolwork and other activities?
- ☐ Seems to be easily distracted and unorganized?
- ☐ Loses things necessary for tasks or activities (pencils, toys, assignments) or is forgetful in daily activities?

Does your child:

- ☐ Fidget or squirm and have difficulty staying in his/her seat?
- ☐ Run around or climb at times when he/she shouldn't?
- ☐ Have problems playing quietly?
- ☐ Appear to be constantly moving and has trouble slowing down?
- ☐ Interrupt other conversations?

1. Review parent and patient screen information; discuss the information with them.
2. Respond to the chart items below, based on the screen information and your knowledge of the patient/family system (e.g. patient/family histories, health, etc.)

Signs of Inattention		Signs of Hyperactivity/Impulsivity	
	Fails to pay attention to details or makes careless errors		Fidgets with hands or feet or squirms in seat
	Difficulty sustaining attention in activities		Leaves seat in situations when sitting is expected
	Does not seem to listen when spoken to directly		Runs or climbs excessively in inappropriate situations
	Does not follow through on instructions		Difficulty engaging in leisure activities quietly
	Has difficulty organizing tasks		Is "on the go" or appears "driven by a motor"
	Avoids tasks that require sustained mental effort		Talks excessively
	Losses things necessary for tasks		Blurts out answers before questions are completed
	Easily distracted by extraneous stimuli		Difficulty awaiting turn
	Forgetful in daily activities		Often intrudes or interrupts others

If 6 or more items in the **Signs of Inattention** column apply to your patient and have persisted for at least 6 months, then the scope of the patient concerns is consistent with ADHD, Predominately Inattentive Type.

If 6 or more items in the **Signs of Hyperactivity/Impulsivity** column apply to your patient and have persisted for at least 6 months, then the scope of the patient concerns is consistent with ADHD, Predominately Hyperactive/Impulsive Type.

If 6 or more items in the **Signs of Inattention and Signs of Hyperactivity/Impulsivity** column apply to your patient and have persisted for at least 6 months, then the scope of the patient concerns is consistent with ADHD, Combined Type.

Does your child:

- ☐ Seem to lose his/her temper more often than most for the age group?
- ☐ Often argue with adults?
- ☐ Appear to go out of his/her way to defy adults?
- ☐ Deliberately try to annoy people?
- ☐ Blame people for his/her own mistakes?
- ☐ Tend to be extremely touchy or easily annoyed?
- ☐ Appear angry or resentful?

Check those items that apply to your child:

- ☐ Often bullies, threatens, or intimidates others?
- ☐ Can be physically cruel to people and/or animals?
- ☐ Intentionally destroys property?
- ☐ Lies or "cons" others in order to gain things?
- ☐ Often skips school?
- ☐ Been known to use a weapon that has the potential for serious harm (bat, brick, knife, gun)?
- ☐ Has a history of "fire-setting"?
- ☐ Break into houses, buildings or cars?
- ☐ Stay out all night without parental permission?

Disruptive Behaviours-Oppositional Defiant Disorder (Physician Form)

Ask your patient/parent each item and check all those that apply:

- ☐ Your patient often loses his/her temper?
- ☐ He/she often argues with adults?
- ☐ Actively defies rules or refuse to comply with adult requests?
- ☐ Deliberately attempts to annoy people?
- ☐ Blame others for his/her own mistakes?
- ☐ He/she is often "touchy" or easily annoyed by people?
- ☐ He/she is often angry and resentful?
- ☐ He/she can be spiteful or vindictive?

If 4 or more items are true for your patient, and they have occurred for at least 6 months, then the scope of patient concerns is consistent with Oppositional Defiant Disorder.

Disruptive Behaviours-Oppositional Defiant Disorder (Physician Form)

Page 2

1. Review parent and patient screen information; discuss the information with them.
2. Respond to the listed items below, based on the screen information and your knowledge of the patient/family (e.g. patient/family histories, etc.)
3. Check all that apply.

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., bat, brick, broken bottle, knife, or gun)?
- ☐ Physically cruel to people?
- ☐ Physically cruel to animals?
- ☐ Has stolen when confronting a victim (mugging, extortion, armed robbery)?
- ☐ Has forced someone into a sexual act?

Destruction of property:

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

Deceitfulness or theft:

- ☐ Has broken into someone else's house, building or car?
- ☐ Often lies to obtain goods or favour or to avoid obligations?
- ☐ Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, forgery)?

Serious violations of rules:

- ☐ Often stays out at night, against parent's permission (before 13 years of age)?
- ☐ Has run away from home overnight at least twice?
- ☐ Is truant from school (prior to 13 years of age)?

If three or more of the criteria are true for your patient, and have occurred within the last 12 months, then the scope of patient concerns is consistent with Conduct Disorder.

Attention Deficit\Hyperactivity Disorder

Basic Characteristics of ADHD

- Inattention
- Impulsivity
- Hyperactivity

Additional Characteristics

- Disorganization
- Poor peer/sibling relations
- Aggressive behaviour
- Poor self-concept and self-esteem
- Sensation-seeking behaviour
- Daydreaming
- Poor coordination
- Memory problems
- Persistent obsessive thinking
- Inconsistency

Many individuals with ADHD have a high rate of comorbidity with another mental illness.

- Conduct Disorder (45%)
- Oppositional Defiant Disorder (65%)
- Major Depressive Disorder (29%)
- Bipolar Disorder (11%)
- Anxiety Disorders (27%)
- Tic Disorders (17%)
- Enuresis (30%)

There is a 25-30% chance that if one family member has ADHD, that another family member will have it.

35% of students with ADHD fail to graduate from high school.

25-30% of older adolescents and adults develop substance and drug abuse problems.

Many display behavioural problems such as:

- Fire setting - 20%
- Theft - 30%
- Tobacco and alcohol use at and early age - 40%
- High school expulsion - 25%

ADHD teens are four times more likely to have serious auto accidents.

Based on these statistics, many professionals do not recommend "drug holidays," as many of these concerns are not isolated to school-related activities.

The following was taken from Barkley, R. (2005). *Taking Charge of ADHD: The Complete Authoritative Guide for Parents*. New York, NY Gilford Publications, Inc. According to the above book, pages 146-154, he recommends 14 guiding principals for parents in dealing with their ADHD children.

Another book which supports Dr Barkley's ideas is the following: Flick, Grad L. (2000) *How to Reach and Teach Teenagers with ADHD: A step by step guide to overcoming difficulty behaviours at school and at home*. Toronto, ON.: John Wiley and Sons Ltd

14 guiding principals for parents in dealing with their ADHD children

1. **Provide your children with immediate feedback and consequences:**

Provide children with quick rewards and positive feedback when they are acting appropriately and immediate consequences when they are acting inappropriately.

2. **Give your child more frequent feedback:**

Not only should consequences and feedback occur immediately, but they should also occur often.

3. **Use more significant consequences:**

The nature of ADHD dictates that children require more significant rewards and consequences than average.

4. **Use incentives before punishment:**

Try to encourage behaviour by rewarding positive behaviour more often than punishing for negative behaviour.

5. **Externalize time and bridge time where necessary:**

When a child is required to complete a task within an assigned period of time, provide a timer to give the child a way keeping track of their time during the task. In addition, for larger projects "bridge" time by dividing large tasks into smaller ones that need to be completed each day until the task is finished.

6. **Externalize the important information at the point of performance:**

Barkley identifies the point of performance as "the location where work has to be completed." He suggests that making a list of reminders and placing them in the location of the task, can assist an ADHD who has a poor working memory.

7. **Externalize the source of motivation at the point of performance**

Provide an external reward at the point of performance, in order to increase motivation to complete the task.

8. **Make thinking and problem solving more physical**

When problem solving, encourage the child to brainstorm and write down all possible options, prior to choosing a solution. This prevents them from spontaneously choosing the first solution, rather than the best solution.

14 guiding principals for parents in dealing with their ADHD children

Continued

9. **Strive for consistency**

If you would like consistency in your child's behaviour, remain consistent in your parenting strategies. Do not parent differently at home, than in the public and make sure that both parents apply the same strategies

10. **Act on consequences, do not simply talk about them**

Follow through on consequences when required, as ADHD children respond better to consequences than reasoning and debates

11. **Plan ahead for problem situations:**

When entering a situation that have caused difficulty in the past, prepare your child by outlining expectations, the incentive for positive behaviour, the consequence for inappropriate behaviour and follow through with the established plan

12. **Keep a disability perspective:**

Remind yourself of your child's disability, in order to reduce frustration and increase tolerance

13. **Do not personalize your child's problems due to the disorder:**

Stay calm, keep a sense of humour and remember that not every situation will work out as planned

14. **Practice forgiveness:**

Try hard not to hold on to resentments. Forgive you child and forgive yourself.

If parents are interested in additional information on ADHD, it can be attained through the following resource:

Dr H. Moghadam, *ADHD: Attention Deficit-Hyperactivity Disorder (2006)*, available through The Southern Alberta Family & Community Resource Centre @ 1.403.955.7281.

Parental Mental Illness

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"Children are not born resilient. Children are born malleable."
– Bruce D. Perry, M.D.

Preamble

The total number of children in the general population who have a parent or parents with mental illness is not known. However, the numbers are likely to be high, as women and men with mental illness bear children at the same rate as those without mental illness.

Children whose parents have a mental illness are frequently referred to as a hidden or invisible population because adult service providers are often unaware that their patients are parents. This phenomenon is due, in part, to the categorization and division of general health and mental health services (preschool, child, adult), but it is also mediated by the parent-patient fear that disclosure may lead to Child Welfare involvement.

Families living with parental mental illness have the same basic needs as all families: transportation, clothing, food, social activities, rent and utilities, and medical needs, as well as needs specific to living with a mental illness.

Although a number of longitudinal studies have confirmed that children of parents affected by mental illness are at a greater risk for later psychiatric disorder than the children of non-affected parents, the accumulation of total risk factors is more important than the specific risks to which a child is exposed (Sameroff & Fiese, 2000). Any single risk factor may lead to a variety of outcomes, but the combination of several risk factors provides a strong predictor of negative outcome (Beardslee, Versage & Gladstone, 1998)

Parenting behaviour, the marital relationship, family relationships, and the severity and chronicity of illness are important mediators of the relationship between parental mental illness and child outcomes (U.S. National Mental Health Information Center, 2001).

With appropriate formal and informal supports, parents who have a mental illness can effectively parent.

Parent Characteristics

- ☐ Attitude toward the mental illness
- ☐ Insight is best assessed across a continuum, in that it may be absent, partial or intact.

Consider the patient's:

- ☐ Awareness of having a mental illness.
- ☐ Understanding of factors contributing to the illness
- ☐ Appreciation that various signs and symptoms are part of the disease process.
- ☐ Awareness that their illness may impact other people and society at large.
- ☐ Acknowledgement of the need for treatment.

Frequently asked questions:

1. My client, a mother with mental illness, is resistant and non-compliant with my treatment recommendations. What should I do?

There are many reasons why parents with mental illness may appear resistant or non-compliant. You may be able to make accommodations to overcome these obstacles and engage parents in treatment.

Reasons a parent may not comply with treatment:

Some are afraid that, if they reveal too much, particularly regarding their concerns about parenting or their children, their children will be taken from them - perhaps by a Child Welfare worker or an angry ex-partner.

Many parents have had negative experiences with previous providers, who have made the worst assumptions about them as parents with mental illness without asking the right questions.

Parents may decide not to take medications that make them lethargic in the morning if they have to get up to fix breakfast and send their children off to school.

A mother with mental illness may miss an appointment or "resist" a necessary hospitalization if she has no babysitter.

Evidence of Effective Parenting

Although psychiatric diagnosis alone is insufficient cause for concern regarding parent capacity, some symptoms of mental illness, such as disorientation, delusions, and adverse side effects from psychiatric medications, may warrant concern. Keep in mind, however, that parents may not take medications that interfere with their ability to parent.

When evaluating medication effectiveness and compliance, you may wish to ask about the parent's daily responsibilities as they may impact the treatment regime.

Parent Characteristics continued

2. Should I worry that my client, who is depressed, will abuse her child?

There is no data on the percentage of parents with depression who abuse their children. A diagnosis of mental illness alone does not tell you whether a parent will be abusive.

Ask your client about her daily activities. Get a clear picture of how well she functions as a parent.

Corroborate her report, if possible, by talking with other family members or helping professionals who know her, e.g., a supportive partner, school teacher or paediatrician.

Question your assumptions and form an opinion based on actual knowledge of your client's current functioning.

Postnatal depression in mothers has been shown in some cases to affect maternal sensitivity and thus the quality of maternal care.

Low sensitivity may be indicated by:

- ☐ Failing to adjust the content and pace of interactions according to child's responses.
- ☐ Teasing the child to promote continued interaction.
- ☐ Actively opposing the child's or infant's wishes.
- ☐ Inciting conflict during interactions.

Evidence of Basic Parenting Skill

Practitioners should look for evidence of basic parenting skill and some ability to empathize with the child's experience. Specifically:

- ☐ Are expectations age-appropriate?
- ☐ Is the parent able to acknowledge areas of deficit parenting and accept help?
- ☐ Can the parent recognize the effects of illness on the child?
- ☐ Does the parent hold a negative or positive view of the child?
- ☐ Is there evidence of punitive parenting?

For a parent self-assessment tool that can be given directly to patients go to:

Parenting Well @ <http://www.parentingwell.info/resources.html>

Frequently asked questions:

3. For a person suffering from depression, the day-to-day stresses of parenting can have a big impact. What are some things that depressed parents can do to combat daily stress?

Dealing with parenting and household routines, not to mention work, school, and other demands, is stressful for every parent. Help your patient decide what the priorities are for the family, and then decide what can be accomplished and what can be delegated to others. Encourage the patient to seek out support from friends and family when needed.



If the patient identifies a history of child abuse or if child abuse is suspected, the Child, Youth and Family Enhancement Act requires you to report your concern. A report can be made by calling your local Child and Family Services Authority or **the Child Abuse Hotline at 1-800-387-5437**. This line is available 24 hours a day, seven days a week. When making a report, your name will be kept confidential.

Assessing the child

Any child characteristics which increases family stress, (e.g., extreme prematurity, very low birth weight, genetic or medical conditions that result in repeated illness and/or temperament issues) should be explored in order to determine their impact on the affected parent's mental illness symptoms.

- ☐ **Security of Attachment**
Parental mental illness is one risk factor for insecure attachment. Insecure attachment has been shown to place children at an increased risk for future, behaviour difficulties and relationship problems.
- ☐ **Marital Relationship**
If the non-affected partner is able to buffer the child from the impact of the affected parent's mental illness and if the marital relationship is a legitimate source of support for the affected parent, then outcomes may be improved.
- ☐ **Other Caregivers in the Home**
Other caregivers, who provide appropriate role modeling for the affected parent and assist in the provision of a stable and nurturing environment for the child may serve as a buffer. In order to be effective in their role, alternative caregivers must be committed to supporting the family, be realistic regarding the potential risks to the child, and in a position to intervene on the child's behalf, if necessary.

Frequently asked questions:

4. Are adults with mental illness, with extended social networks, more likely to have positive parenting experiences?
Not necessarily. There are positive and negative aspects to family relationships. Family members may be a primary source of support or experienced as undermining and disempowering by parents with mental illness.

Be sure to investigate the quality of social networks as well as their depth and breadth.

Family Adversity or Other Sources of Support

The accumulation of risk factors is more concerning than the specific risks to which a child is exposed.

When children witness domestic conflict:

- ☐ They are placed in the psychologically untenable position of having nowhere to turn to resolve unmanageable emotional states.
- ☐ These children are unable to rely on the caregiver to help them 'contain' unpleasant emotions such as fear or anger.
- ☐ Over time, these children can develop emotional problems such as anxiety disorders or disruptive disorders.

Indicators of domestic conflict, substance abuse and unsafe or unstable housing should be explored, as they increase parental stress and cumulative risk to the child.

Infant Mental Health

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Infant Mental Health

"There is no such thing as a baby, there is only a baby and someone."

– Donald Winnicott, M.D.

Preamble

Infant Mental Health is defined in three parts, *Infant* referring to children under three, *Mental* referring to the social, emotional and cognitive domains and *Health* referring to the well-being of young children and families (Frailberg, 1980).

Infant mental health cannot be separated from parental mental health

Careful observation of both parent and child is of benefit in recognizing and responding to Infant mental health issues.

Disruption in the caregiver-child relationship almost always begins in pregnancy. The psychological reorganization that is necessary for a healthy adaptation to parenthood is immense (Slade, 2002). Adults who did not have a secure attachment relationship with their own caregivers will find that this undertaking is laden with pitfalls and challenges. In the absence of other mediating influences, they will likely struggle as adults in providing the critical foundation of security to their own children and thus, relational disharmony will be passed forward.

Within the first week postnatally, the infant's limbic system begins to respond to the voice and tone of the mother. When this dyad communicates in a synchronistic manner, with the primary caregiver accurately reading and responding to the infant's cues, a sense of connection and shared meaning emerges. When the flow of communication is continually disrupted or disorganized, however, and the caregiver fails to respond in a sensitive and reliable manner to the infant's cues, the attachment relationship begins to reflect this disorganization (Siegel & Hartzell, 2003).

In order for secure attachment to develop, the primary caregiver must, in a synchronistic manner, amplify states of joy and soften states of negative arousal for the infant. It is through this process of co-regulation that the infant attaches in a secure manner to their caregiver and later develops a tolerance for all emotional states (Schoore, 2003).

Up to three years of age, the infant's brain will continue to organize in relation to the brains of significant adults within its social world. If joy is not amplified or negative emotions are not softened by the caregiver, then the infant will not learn to tolerate, accurately read or express these emotions. In essence, the infant will become dysregulated (Schoore, 2003).

Parental Sensitivity

Sensitive or insensitive caregiving provides the foundation for the emergence of secure or insecure attachment. Parental sensitivity is the ability to perceive and accurately interpret the verbal and non-verbal cues of the infant and to respond in a cogent manner to those cues.

For the purpose of studying maternal sensitivity, a known predictor of attachment security, Pederson & Moran et al. (2006) developed the Maternal Behaviour Q-set a 90-item assessment that describes a wide range of maternal behaviour including interactive style, sensitivity to infant's state, feeding interactions, and the extent to which the home reflects the infant's needs.

The following items are a sample of the Maternal Behaviour Q-set and can be used as a guide in observing parent-infant interactions.



Maternal Behaviour Q-set

High Sensitivity Items:

- ☐ Shows delight in interaction with infant
- ☐ Interventions satisfy infant
- ☐ Responds to infant's distress and non-distress signals even when engaged in some other activity such as having a conversation with visitor
- ☐ Interactions revolve around infant's tempo and current state

Low Sensitivity Items:

- ☐ Teases infant to promote continued interaction
- ☐ Content and pace of interactions set by mother rather than according to infant's responses
- ☐ Interactions characterized by conflict
- ☐ Actively opposes infant's wishes

If a number of low sensitivity items are noted and high sensitivity items are not evident in the parent's presentation, you may also wish to listen for statements indicative of [Low Reflective Functioning](#) (see page 105)

Reflective Functioning

Reflective functioning is defined by Fonagy, Target, Steele & Steele (1998), as the internal qualities that enable a parent to be sensitive. Specifically, the capacity to understand that their own and others' behaviours are linked to internal mental states, often shaped by their own childhood experiences with their own parents.

Also central to reflective functioning is the parent's capacity to recognize that the infant has its own mental states and that the states of the parent and child will interplay in a complex manner.

Low parental reflective functioning may take many forms. Parents may present with little awareness of or insight into their baby's internal world. When questioned regarding their experience of caregiving, as well as the infant's response to caregiving, low reflective functioning caregivers may provide responses that reflect oblivion to their child's feelings, a focus only on personality or behaviour, or in extreme cases, reflections indicative of a hostile attribution bias.

Listen for the following statements/responses, known to be indicators of **low reflective functioning**:



- "I don't know"
- "He's fine"
- "He's pig-headed"
- "She pushes me around"
- "She clings to me, but she's fine"
- "He's just like his father, I have to keep a close eye on him"
- "She's just bad, bad, bad"

If parental responses seem to reflect a lack of awareness to the child's feelings, a focus only on personality or behaviour, or a hostile attribution bias, you may wish to screen the child using the questions below, adapted from the [Ages & Stages questionnaires: Social-Emotional](#) (ASQ:SE). (See page 106)

Infant Considerations

Landy (2002) suggests that during the first 3 months of life infants are acquiring two important capacities: physiological regularity and an ability to self-calm; internal capacities that are mediated by and dependent on the external rhythm and structure provided by the primary caregiver.

The questions below have been adapted from the Ages & Stages Questionnaires: Social-Emotional (ASQ:SE) and are appropriate for infants 3 through 14 months. They provide some insight into the infant's establishment of homeostasis (Squires, J et al, 2002):

RULE
OUT

Adapted Ages & Stages Questionnaires: Social-emotional (ASQ:SE)

- ☐ When upset can your baby calm within 30 min?
- ☐ Does your baby smile at you and other family members?
- ☐ Does your baby like to be picked up and held?
- ☐ Does your baby stiffen and arch her back when picked up and held? *
- ☐ Does your baby let you know when she is hungry or sick?
- ☐ Does your baby cry for long periods of time? *
- ☐ Is your baby able to calm himself down (sucking on his fist or pacifier)?
- ☐ When talking to your baby does he look at you and seem to be listening?
- ☐ Does it take longer than 30min. to feed your baby? *
- ☐ Do you enjoy mealtimes with your baby (including breast or bottle feeding)?
- ☐ Does your baby have trouble falling asleep at naptime or night? *
- ☐ Does your baby sleep at least 10 hours in a 24-hour period?

**Indicates a critical item- if client answers yes to a * question, you may wish to explore further, all other questions require further exploration if answered "no".*

Exploration prompts:

"Would you say that this happens every day, a few times each week, or a few times each month?"

"Has anything that you've tried seemed to help?"

"Has anyone else noticed this or commented on it?"

"Are you worried about this?"



If concern is noted either in the area of parental presentation (Maternal Behaviour Onset and/or statements indicating low reflective functioning) or in the infant's presentation (Ages & stages questionnaires: Social-emotional) proceed to **"Prevention and Intervention"** (See page 107)

Prevention and Intervention

Parental support

Grossmann and Grossman (2005) suggest that parents who demonstrate low sensitivity may require **support in four areas**:

1. Understanding child development in general
2. Understanding the specific signals of emotional well-being for the child, especially if the child has special needs
3. Organizing sufficient time for sensitive interactions
4. Finding an adequate substitute caregiver for times when the parent is unable to provide care.

Without an emotional understanding of the child, traditional behaviourally-based parenting programs, which focus on the acquisition of parenting skills, are unlikely to have any effect on the low reflective functioning parent's overall capacity (Slade, 2002).

Programs that focus on increasing the parent's capacity for insight; as well as their understanding of normal development will have greater impact in this regard.

The programs and resources listed below would be appropriate for patients where concern has been identified in the area of infant mental health.

Resources

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As a parent, you can talk with your doctor about which of the items below you would like to try with your child. Remember to track the item regularly (e.g., on a calendar) and discuss the results with your doctor.

- 1. Improving your relationship with your child**
- 2. Spending quality time with your children.**
This could involve spending frequent, brief amounts of time (as little as a minute or two) with your child in child-preferred activities.
- 3. Talking to your child.**
Have brief conversations with your child about an activity or interest of the child.
- 4. Showing affection.**
Provide physical affection (e.g., hugging, touching, cuddling, tickling, patting).
- 5. Encouraging good behaviour**
- 6. Using descriptive praise.**
Provide encouragement and approval by describing the behaviour that is appreciated.
- 7. Giving attention.**
Provide positive non-verbal attention (smile, wink, pat on the back; watching activities).
- 8. Providing engaging activities.**
Arrange the physical/social environment to provide interesting and engaging activities, materials, and age appropriate toys.
- 9. Teaching new skills and behaviours**
- 10. Setting a good example**
For example, parent modeling the new skill/behaviour.
- 11. Using incidental behaviour**
For example, when interacting with your child, look for opportunities to use questions/prompts to promote learning.
- 12. Using Ask, Say, Do**
Ask: "What is the first thing we do to wash our hair?"
Say: "First we get under the tap and get our hair all wet. Show me how you would do that."
Do: "Guide the child through it."
- 13. Behavioural charts**
Use as a short term strategy only. For example, implement charting for two to three weeks to get an increase in a desirable behaviour. Then take a month break before re-using behavioural charts.

14. Establishing ground rules

(Negotiating in advance a set of fair, specific and enforceable rules).

15. Using only as many rules as the child can remember.

Fairness means everyone in the household lives by the rules.

Rules should be easy to understand and to follow.

Enforce the rules, using reasonable expectations about compliance.

When possible, state rules in a positive manner: tell them what they can do versus what they cannot do.

16. Using directed discussion for rule breaking

Identify and rehearse correct behaviour following rule breaking as follows:

Calmly get child's attention.

Describe behaviour of concern: Say "You just ran through the house".

Explain risk/problem: Say "You might break something or hurt yourself.

Review rule & correct behaviour: Say "What is our rule?"

Practice behaviour: Say "Okay, now show me. Go back to the door and start again."

Praise: Say "That is much safer, thank you. I like it when you walk through the house."

17. Planned ignoring

Use this technique for correcting minor behaviour; do not use if the behaviour poses a risk of harm to the child or others. If there is risk, select another technique.

Give clear and calm instructions

Kneel at arm's length away from the child.

Make/maintain eye contact and say the child's name using a calm voice.

Say exactly what you want the child to do (e.g., say "I want you to stop [behaviour A] and start doing [behaviour B].")

Give the child time to comply.

Repeat instructions only once.

If no compliance, apply quiet time or time-out, depending upon the seriousness of the behaviour

18. Using quiet time for misbehaviour

Placing child at the edge of an activity for a set amount of time.

Start quiet time when the child is quiet.

Restart quiet time if the child acts up.

Use up to 2 minutes of quiet time for children ages 2-3; use up to 3 minutes for 4-5 year olds, and up to 5 minutes for 5 to 10 year olds.

19. Using time out for serious misbehaviour

Removing a child to an area away from others for a set time

Use the same time line given for quiet time.

Strategies That Motivate Change

- ☐ Give practical, useful advice
 - ☐ Identify and remove barriers and disincentives to change
 - ☐ Provide choices and offer suggestions (rather than expectations/demands)
 - ☐ Decrease the desirability of the current activity (listing pros/cons)
 - ☐ Demonstrate empathy
 - ☐ Provide clear feedback
 - ☐ Help clarify goals that are realistic, attainable, and measurable
 - ☐ Maintain an attitude of active helping
-

¹ adapted from Miller, W.R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behaviour*. New York: Guilford Press.

Discuss these options, and their implementation, with your physician and/or your counsellor.

Helping The Suicidal Patient

If someone you know...

- Threatens suicide
- Talks about wanting to die
- Talks about feeling hopelessness, futility, or helplessness
- Shows sudden changes in behaviour, appearance, mood, personality
- Abuses drugs and/or alcohol
- Deliberately injures self
- Gives possessions away
- Appears depressed, sad, or withdrawn

You can help

- Stay calm and listen.
- Remember: talk of suicide must be taken seriously
- Let the individual talk about his/her feelings
- Be accepting; do not judge; identify and re-enforce any positive thoughts the patient may have towards life or a significant other
- Ask:** are you thinking about suicide? Do you have a plan? Do you have the means to complete suicide or easy access to a means? When do you plan to commit suicide?
- Say:** "it is reasonable to feel the way you feel, but I can help you find other solutions."
- Never swear secrecy: tell someone.
- Develop a simple, short safety plan: by arranging parental supervision, booking appointments, and taking the parent/child to the appointment, if necessary

Get support, contact:

- Family members
- Local mental health services/clinic
- Hospital emergency services
- Mobile Response Team (Calgary: 266 -1605)

Helping the Anxious Child

Parents can help their children respond to anxiety and stress in healthy ways. Some things parents can do include:

Provide a safe, secure, familiar, and consistent home.

1. Learn how your child shows stress, and recognize when stress/anxiousness is ongoing and/or building in your child. Act to reduce the stress/anxiety, before it overwhelms your child's ability to cope.
2. Teach your child to recognize the symptoms of stress and anxiety they feel in themselves (e.g. rapid heartbeat, sweaty palms, fast breathing, headaches, tummy aches, tight muscles, nervous panicky feelings).
3. Be selective in the television programs that your child watches, including movies and news broadcasts, as these can produce fear and anxiety.
4. Develop an awareness of situations and events that are stressful for children. These include new experiences, fear of unpredictable outcomes/endings, unmet needs and desires, loss, and unpleasant sensations (e.g. getting a needle).
5. Keep your child informed of major changes such as moving or job changes.
6. Encourage questions and expressions of concerns, worries, and fears.
7. Listen to your child without being critical.
8. Encourage your child's feeling of self-worth. Use support and affection. Try to involve your child in situations where she/he can succeed.
9. Honesty and openness. Talk and encourage children to express feelings and thoughts openly.
10. Security. Try to be consistent in your expectations and parenting techniques.
11. Physical exercise. Exercise helps burn off stressful/anxious feelings.
12. Humour. Help children see the funny side of things.
13. Spend regular calm and quiet times with your child.
14. Balanced diet. Encourage children to eat a healthy, varied diet.
15. Help your child to set realistic expectations. Encourage him/her to do the best possible and to remember nobody is perfect.
16. Find out about any significant events in your child's life. Help him/her to understand the events and the normal stress/anxiety reactions that these events cause.

Anxiety & Anxiety Disorders Handout (Cont'd)

Anxiety is the false alarm of danger. The alarm itself is normal. The problem is that the brain's alarm goes off when there is no real danger. The mind reacts to the alarm by imagining or misperceiving danger, which then prompts further fear. A repeated false alarm causes persistent fear and self-doubt.

Over the course of a lifetime about 1 in 4 people suffer from an anxiety disorder. Females are about twice as likely to suffer from an anxiety disorder as are males. Among children, about 1 in 10 have an anxiety disorder. Far larger percentages of both adults and children have significant anxiety problems that do not reach the level of a "disorder." In children, anxiety problems are most likely to be seen as disruptions in normal developmental patterns¹.

Many studies have confirmed that among children and youth, anxiety disorders are the most common of all mental health problems. The rate of anxiety disorders in children is believed to be between six and ten percent².

Anxiety is genetic and environmental. Genetically, some peoples' brain alarms are set with a 'hair trigger,' while others may rarely trigger, even if danger is present. Environmentally, an individual's experiences and expectations determines how the alarm is interpreted when it sounds and what may then be done.

Type of Anxiety Disorder	Typical Symptom in Children
Panic Disorder/Agoraphobia	Fear of having a spontaneous or situational panic attack; often along with a fear of being away from home; fear of being away from a safe person
Social Anxiety Disorder (SAD)	Severe shyness; fear of talking in a group or class; fear of parties; fear of public speaking
Obsessive-Compulsive Disorder (OCD)	Severe obsessions and compulsions causing the performance of rituals, such as hand washing or repeated checking on things
Generalized Anxiety Disorder (GAD)	Severe, almost continuous, inappropriate worry about many topics
Specific Phobia Disorder	Phobia of cats, dogs, or other animals or bugs; fear of heights; fear of the dark; fear of inanimate objects
Posttraumatic Stress Disorder	Severe anxiety that occurs after a trauma; may feel like the trauma is continuing and/or re-occurring (flashback)

Anxiety Disorders are often accompanied by other mental health issues or problems, most frequently depression. In children, there is a strong link between having a generally negative outlook in life and the likelihood of having anxiety, depression, or both. Having a positive outlook predicts that children may have anxiety, but it is not usually linked to depression³.

¹ March, J., & Albano, A.M. (2002) Textbook of Anxiety Disorders

² McCracken et al., (2002) Journal of Clinical Psychiatry, 63 (6), 8-11

³ Chorpita, (2002), Journal of Abnormal Child Psychology, 30(2; April), 177-190.

Text And Weblinks

Books and Articles

- American Psychiatric Association. (2000). *Diagnostic and statistical manual, version IV (text revised)*. Washington, DC.: APA
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- Barnard, M.U. (2003). *Helping your depressed child: A step-by-step guide for parents*. Oakland, CA.: New Harbinger Publications, Inc.
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- Foxman, P. (2004). *The worried child: Recognizing anxiety in children and helping them heal*. Alameda, CA.: Hunter House, Inc.
- Frailberg, S. (1980). *Clinical studies in infant mental health: The first year of life*. New York, NY.: Basic Books.

Books and Articles

- Goldstein, S., Hagar, K., Brooks, R., & Hallowell, E. (2003). *Seven steps to help your child worry less: A family guide*. Plantation, FL.: Specialty Press/A.D.D. Warehouse.
- Grad L., Ph.D. Flick (2000) *How to Reach and Teach Teenagers with ADHD: A step by step guide to overcoming difficulty behaviours at school and at home*. Toronto, ON John Wiley and Sons Ltd
- Grossman, J.B. (2005). Evaluating mentoring programs. In D.L. Dubois & M.J. Karcher, (Eds.). *Handbook of youth mentoring (pp. 251-265)*. Thousand Oaks, CA: Sage.
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- Landy, S. (2002). *Pathways to competence: Encouraging healthy social and emotional Development in young children*. Baltimore, MD.: Paul H. Brookes Publishing Co., Inc.
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Websites

Additional resources can be located online using the web search engine Google, Google.scholar, and/or by accessing the websites of bookstores (e.g., Chapters, Amazon). The reader is reminded that it is often difficult to establish the quality of resources on the internet or in bookstores.

The resources listed below, as of winter, 2007, were found to be recent, accurate, and practical. The reader is urged to examine carefully the material and establish its relevance for their unique patient/case needs. The author of this Desk Reference is not responsible for the weblinks or texts listed below, or the use of their content by community professionals.

American Academy of Child & Adolescent Psychiatry (July 2004). Information on a wide variety of children's mental health issues.

www.aacap.org

American Academy of Child and Adolescent Psychiatry. (July 2004). Information on a wide variety of children's mental health issues. Website:

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American Academy of Child & Adolescent Psychiatry (Nov 2004). Facts for Families – Anxiety #47. Anxiety Disorders Association of America. Provides parent and professional information on a range of anxiety-related concerns.

<http://www.adaa.org>

Anxiety Disorders of British Columbia. Provides parent and professional information on anxiety.

<http://www.anxietybc.com>

Anxiety Disorders of Ontario. Provides some general information on anxiety and anxiety-related concerns.

www.anxietyontario.com

BC Partners for Mental Health and Addictions Information.

www.heretohelp.bc.ca

Baker, L., & Ashbourne, L. (2002). *Treating child and adolescent depression: A handbook for children's mental health practitioners*. Toronto, ON.: Children's Mental Health, from

www.chmo.org

Bright Futures at Georgetown University. Parent information on children's general health and mental health concerns and development.

<http://www.brightfutures.org>

Canadian Network for Mood and Anxiety Treatments.

www.canmat.org

Websites

Canadian Mental Health Association. Mental health information for families and adults.
<http://cmha.ca/bins/index.asp>

Canadian Pediatric Society. Child health and mental health information for families.
<http://www.caringforkids.cps.ca/behaviour/fears.htm>

Child and Family Services Authority. Provides services to families before they reach crisis as well as those families who are considered "at risk". If you have reason to believe a child is being abused or neglected, call your local Child and Family Services authority or the Child Abuse Hotline at 1-800-387-5473. This line is available 24 hours a day, seven days a week.

If you have reasonable grounds and believe a child is at risk, the *Child, Youth and Family Enhancement Act* requires you to report your concern. When making a report, your name will be kept confidential.

If appropriate, services may be offered to the parent, family and/or child, which may include in-home support or professional counselling. In a case where the child cannot remain in the home, the caseworker must develop a plan for the child. If the removal is temporary, the plan must include helping not only the child, but also the family in overcoming the difficulties they have in caring for the child. If the removal is permanent, a plan for adoption or other permanent arrangements must be made.

www.child.alberta.ca/home/index.cfm

Children's Mental Health Ontario (2002). Evidence-based practices for children and adolescents with depressive disorder.
www.kidsmentalhealth.ca

Freedom From Fear Organization since 1984. Parent, teen, and professional information on a variety of child health and mental health concerns.
www.freedomfromfear.org

Health Canada and Canadian Alliance for Mental Illness and Mental Health. (2002). *A report on mental illnesses in Canada*.
www.hc-sc.gc.ca/pphb-dgspsp/publicat/miic-mmacc/index.html

Information on Mental Illness in Children and Adolescents from a General Pediatrician's View of the Internet.
www.generalpediatrics.com

JJ's Place: The Childhood Obsessive-Compulsive Disorder Project.
www.jjsplace.org

The Minnesota Longitudinal Study of Parents and Children.
<http://education.umn.edu/icd/Parent-Child/default.html>

Mood Disorders Association of Ontario. Provides public information on a variety of mood-related concerns and illnesses.
www.mooddisorders.on.ca

Websites

Mullick, M., Milleer, L.J., & Jacobsen, T. (2001). *Insight into mental illness and child maltreatment risk among mothers with major psychiatric disorder*.
<http://www.psychservices.psychiatryonline.org/cgi/content/full/52/4/488>

National Institute for Health and Clinical Excellence. Clinical Practice Guidelines for a variety of health and mental health conditions.
www.nice.org.uk

National Institute of Mental Health.
www.nimh.nih.gov
<http://www.nimh.nih.gov/health/topics/index.shtml>

Nemours Foundation. Kids health information for parents.
www.kidshealth.org/parent/kh_misc/partners.html

Nemours Foundation. Kids health information for professionals/parents.
www.kidshealth.org/parent/emotions/feelings/anxiety.html

New York University School of Medicine: parent information on child health and mental health related concerns.
www.aboutourkids.org

Obsessive-Compulsive Foundation. Professional and parent information on Obsessive-Compulsive Disorder.
www.ocfoundation.org

The Parent-Child Mother Goose Program®. This program is a group experience for parents and their babies and young children, which focuses on the pleasure and power of using rhymes, songs, and stories together. Parents gain skills and confidence which can enable them to create positive family patterns and healthy early experiences with language and communication during their children's crucial early years. This program is offered in various communities throughout Alberta.
<http://www.nald.ca/mothergooseprogram>

Parent Link Centres. Provides parents and their children with the supports they need to help their children develop to their full potential. Parents can access information about community services, obtain referrals, and meet other parents, children, and families, while taking part in quality early learning activities. This program is offered in various communities throughout Alberta.
www.parentlinkalberta.ca

Parenting Well: Parent Self-Assessment Tool
<http://www.parentingwell.com/resources.html>

Parents as Teachers. Provides parents with child development knowledge and parenting support. This program is sponsored by various community agencies throughout Alberta.
<http://www.parentsasteachers.org>

Websites

Perry, B.D. Bruce D. Perry, M.D., Ph.D., is an internationally-recognized authority on children in crisis. Dr. Perry is the Provincial Medical Director in Children's Mental Health for the Alberta Mental Health Board. In addition, he is the Senior Fellow of the Child Trauma Academy.

www.ChildTrauma.org

Suicide Information and Education Centre (SIEC).

www.suicideinfo.ca

The College of Family Physicians of Canada. Provides public and professional information on a variety of child/adolescent health and mental health concerns.

www.cfpc.ca/english/cfpc/home

The Child Anxiety Network. Provides parent and teen information on anxiety and anxiety-related illnesses.

www.childanxiety.net

The Trichotillomania Learning Centre. Professional and parent information on Trichotillomania.

www.Trich.org

University of British Columbia: Mental Health Evaluation and Community Consultation Unit. Provides professional information on mental health in children, youth, and families.

www.mheccu.ubc.ca

University of Michigan, Depression Center. Provides public and professional information on depression.

www.med.umich.edu/depression

U.S. Department of Health and Human Services, National Mental Health Center. Provides professional information on a wide variety of mental health issues/illnesses.

www.mentalhealth.samhsa.gov

The Worry Wise Kids Organization. Provides teen and parent information on anxiety and anxiety-related concerns.

www.worrywisekids.org

Information Prescriptions

























Depression Information Prescription

Side 1



Family & Community Resource Centre

Here are some suggested resources about: **Depression**

1. **Raising Depression -Free Children: A Parent's Guide to Prevention and Early Intervention**
Panula-Hockey, Kathleen, 2003    
2. **Straight Talk About Your Child's Mental Health**
Faraone, Stephen, 2003   
3. **Adolescent Depression: A Guide for Parents**
Mondimore, Francis Mark, 2000    
4. **Helping Your Teen Overcome Depression: A Guide for Parents**
Kaufman, Miriam, 2000   
5. **Helping Your Teenager Beat Depression: A Problem-Solving Approach for Families**
Manassis, Katharina and Levac, Anne Marie, 2004  
6. **Hand-Me-Down Blues: How to Stop Depression From Spreading in Families** Yapko, Michael, 1999      
7. **Youth Suicide and You: Guidelines for Helping Suicidal Youth**
Centre for Suicide Prevention, Calgary 
8. **Depression: A Teenager's Guide** 2002, Video, 18 min. 
9. **American Academy of Child & Adolescent Psychiatry**
<http://www.aacap.org>
10. **National Mental Health Information Center**
<http://www.mentalhealth.samhsa.gov>
11. **Depression and Selected Affective Disorders Association**
<http://www.drada.org>
12. **Kids' Health** <http://www.kidshealth.org>
13. **Mental Health & High School** www.cmha.ca/highschool/english.htm

Materials can be borrowed through inter-library loan



Family & Community Resource Centre



Calgary Public Library



Drayton Valley Public Library



Lethbridge Public Library



Medicine Hat Public Library



Red Deer Public Library



Vulcan Public Library

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Provide this prescription (Sections 1 and 2) as a handout resource for the patient and/or the family.

Disclaimer

This material is designed for information purposes only. It should not be used in place of medical advice, instruction and/or treatment. If you have specific questions, please contact your doctor or appropriate health care professional.

For additional resources or information regarding **Asthma** please call or visit:

The Southern Alberta Family & Community Resource Centre

Alberta Children's Hospital
2888 Shaganappi Trail NW
Calgary, AB T3B 6A8
Phone: (403) 955-FCRC (3272)

For additional support in child health information needs please contact our Child Health Information Specialist at 955-7745, toll free at 1-877-943-FCRC(3272) or email childhealthinfo@calgaryhealthregion.ca.

Or you can call:

HealthLink

Phone: 943-5465 (Calgary & area)
1-866-408-5465 (toll free within Alberta)

Alberta Mental Health Board Information Line

Phone: 1-877-303-2642

Access Mental Health

Phone: (403) 943-1500

Contributing Partners

Southern Alberta Child & Youth Health Network:
Healthy Minds / Healthy Children Capacity Building Project

Calgary Health Region:
Student Health Partnership, Mental Health Program
Child & Adolescent Shared Mental Health Care Program
Rural South Mental Health Services
School Health Program

Alberta Children's Hospital:
Mood & Anxiety Clinic



All of our Information Prescriptions are available for free download at: www.sacyhn.ca/pages/publications.html

Provide this prescription (Sides 1 and 2) as a handout resource for the patient and/or the family.

Anxiety Information Prescription
































Side 1



Family & Community Resource Centre

Here are some suggested resources for parents and children about:

Anxiety

1. **Freeing Your Child From Anxiety: Powerful, Practical Solutions to Overcome Your Child's Fears, Worries, and Phobias**
Chansky, Tamar E. 2004    
2. **The Worried Child: Recognizing Anxiety in Children and Helping Them Heal** Foxman, Paul, 2004   *This book is also available at over 20 libraries in Southern Alberta; inquire at your local branch.*
3. **The Anxiety Cure for Kids: A Guide for Parents**
Spencer, Elizabeth DuPont, DuPont, Robert L., Dupont, Caroline M. 2003  
4. **Your Anxious Child: Raising a Healthy Child in a Frightening World** Shaw, Mary Ann, 2003    
5. **Helping Your Anxious Child: A Step-by-step Guide for Parents**
Rapee, Ronald M. and others, 2000     
6. **Your Anxious Child: How Parents and Teachers Can Relieve Anxiety in Children** Dacey, John S., Fiore, Lisa B. 2000    
7. **Raising Your Spirited Child: A Guide for Parents Whose Child is More Intense, Sensitive, Perceptive, Persistent, Energetic**
Kurcinka, Mary Sheedy, 1991          
9. **Canadian Paediatric Society** www.caringforkids.cps.ca/behaviour/fears.htm
10. **Anxiety Disorders Association of America**
www.adaa.org/AnxietyDisorderInfor/ChildrenAdo.cfm
11. **American Academy of Child & Adolescent Psychiatry**
www.aacap.org/publications/factsfam/anxious.htm
12. **Kids' Health** www.kidshealth.org/parent/emotions/feelings/anxiety.html

Materials can be borrowed through inter-library loan



Family & Community Resource Centre



Calgary Public Library



Banff Library



Bassano Library



Brooks Library



Canmore Library



High River Library



Hinton Library



Lethbridge Library



Medicine Hat Library



Okotoks Library



Red Deer Library



Taber Library



Three Hills Library



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Provide this prescription (Sides 1 and 2) as a handout resource for the patient and/or the family.

Anxiety Information Prescription

Side 2

Disclaimer

This material is designed for information purposes only. It should not be used in place of medical advice, instruction and/or treatment. If you have specific questions, please contact your doctor or appropriate health care professional.

For additional resources or information regarding **Anxiety** please call or visit:

The Southern Alberta Family & Community Resource Centre

Alberta Children's Hospital
2888 Shaganappi Trail NW
Calgary, AB T3B 6A8

Phone: (403) 955-FCRC(3272)

For additional support in child health information needs please contact our Child Health Information Specialist at 955-7745, toll free at 1-877-943-FCRC(3272) or email childhealthinfo@calgaryhealthregion.ca.

Or you can call:

HealthLink

Toll Free: 1-866-408-5465 (within Alberta)

Phone: (403) 955-5465

Alberta Mental Health Board Information Line

Phone: 1-877-303-2642

Access Mental Health

Phone: (403) 943-1500

Contributing Partners

Southern Alberta Child & Youth Health Network:
Healthy Minds / Healthy Children Capacity Building Project

Calgary Health Region:
Child & Adolescent Shared Mental Health Care Program

Alberta Children's Hospital:
Mood & Anxiety Clinic
Pharmacy Department



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Provide this prescription (Sides 1 and 2) as a handout resource for the patient and/or the family.

Attention Deficit Hyperactivity Disorder

Side 1



Family & Community Resource Centre

Here are some suggested resources for parents and children about: **Attention Deficit Hyperactivity Disorder (AD/HD)**

1. **Attention Deficit - Hyperactivity Disorder**
Moghadam, H. 2006 
2. **Taking Charge of ADHD: the Complete Authoritative Guide for Parents**
Barkley, Russell A. 2005  
3. **100 Questions & Answers about Your Child's Attention Deficit Hyperactivity Disorder**
Nass, Ruth D. and Leventhal, Fern. 2005   
4. **ADHD: A Complete & Authoritative Guide**
The American Academy of Pediatrics. 2004   
5. **The ADHD Book of Lists: A Practical Guide for Helping Children and Teens with Attention Deficit Disorders**, Rief, Sandra F. 2003  
6. **Dr. Larry Silver's Advice to Parents on Attention Deficit Hyperactivity Disorder**
Silver, Larry B. 1999    
7. **Understanding Girls with AD/HD**
Nadeau, Kathleen G., Littman, Ellen B., Quinn, Patricia O. 1999  
8. **Learning to Slow Down and Pay Attention: A Book for Kids About ADD**
Nadeau, Kathleen G., Dixon, Ellen B. 2005  
9. **Cory Stories: A Kid's Book About Living With ADHD**. Kraus, Jeanne. 2004  
10. **Otto Learns About His Medicine: A Story About Medication For Children With ADHD**
Galvin, Matthew. 2001  
11. **Fears and Prejudices About AD/HD (video)**. Brown, Thomas E. 2003 
12. Canadian Paediatric Society www.caringforkids.cps.ca/behaviour/index.htm
13. American Academy of Pediatrics www.aap.org/healthtopics/adhd.cfm
14. Children and Adults with Attention Deficit / Hyperactivity Disorder www.chadd.org
Calgary Chapter www.members.shaw.ca/chaddcalgary
15. **ADDvance: information for parents of children with ADD (ADHD)**
www.addvance.com/help/parents/index.html

Materials can be borrowed through inter-library loan



Family & Community Resource Centre



Calgary Public Library



Canmore
Drayton Valley



Lethbridge
Medicine Hat



Okotoks
Stettler

September 2006

Provide this prescription (Sides 1 and 2) as a handout resource for the patient and/or the family.

Attention Deficit Hyperactivity Disorder

Side 2

Disclaimer

This material is designed for information purposes only. It should not be used in place of medical advice, instruction and/or treatment. If you have specific questions, please contact your doctor or appropriate health care professional.

Caution

It is important to consult with a knowledgeable physician for up-to-date information about medications currently used to treat AD/HD. Canadian readers should be aware that many resources are American. Specific references to educational and medical legislation will not apply in Alberta or Canada.

For additional resources or information regarding **Attention Deficit Hyperactivity Disorder (AD/HD)** please call or visit:

The Southern Alberta Family & Community Resource Centre

Alberta Children's Hospital

2888 Shaganappi Trail NW

Calgary, AB T3B 6A8

Phone: (403) 955-FCRC(3272)

For additional support in child health information needs please contact our Child Health Information Specialist at 955-7745, toll free at 1-877-943-FCRC(3272) or email

childhealthinfo@calgaryhealthregion.ca.

Or you can call:

Calgary Learning Centre

3930 - 20 St. SW

Calgary, Alberta T2T 4Z9

Phone: (403) 686-9300 Fax: (403) 686-0627

Email: info@calgarylearningcentre.com

Calgary Chapter CH.A.D.D. Canada

Support Line: (403) 225-8512

Email: chaddcalgary@yahoo.com

Contributing Partners

Calgary Learning Centre
Alberta Children's Hospital:
AD/HD Specialty Clinic
Developmental Clinic



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Provide this prescription (Sides 1 and 2) as a handout resource for the patient and/or the family.