

# Identification, Diagnosis & Treatment of Adolescent Anxiety Disorders

## A Package for First Contact Health Providers

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## Introduction

This package is provided as an overview of anxiety disorders in adolescents and how first contact health providers can identify and address this issue in an effective, clinically relevant and best evidence-driven manner.

The package is divided into two parts:

### 1) Overview

An informational overview to help first contact health providers understand how to identify, diagnose and treat anxiety disorders in adolescents.

### 2) Toolkit

A toolkit for first contact health providers containing useful resources for assessing and treating anxiety disorders in adolescents

Throughout this package hyperlinked text is highlighted in [blue underline](#) that, when clicked, will link to either a resource within the package or to an external website where additional information can be found.

**This program offers the health care provider a comprehensive, sequential and rational framework for addressing adolescent anxiety. Each health care provider will be able to extract from this program those components that they can best apply in their own practice setting. By building on the information presented in this course and by utilizing those components of the toolkit that best meet the realities of their practice each health care provider can customize their approach to the treatment of the young person with anxiety.**

For health care practices in which there exist family care teams, providers can use the various components of the toolkit, with the team leader being responsible to ensure integrated monitoring of ongoing care.

**Primary health care providers can appropriately deliver effective treatment for anxiety disorders to children. Here's how...**

### Key steps

1. [Identification of youth at risk for anxiety disorders](#)
2. [Useful methods for screening and diagnosis of anxiety disorders in the clinical setting](#)
3. [Treatment template](#)
4. [Suicide assessment](#)
5. [Safety and contingency planning](#)
6. [Referral flags](#)

## Step 1. Identification of children at risk for anxiety disorders

### Child and Adolescent Mental Health Screening Questions

Historical factors:

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

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

Current situation:

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

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

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

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

Remember that some cases of anxiety and depression may demonstrate positive scores on the concentration component of the SNAP. If no hyperactivity components are identified on the SNAP review for ADHD please assess for depression and anxiety using KADS and SCARED.

Next steps:

- If patient is positive for depression and either Anxiety or ADHD and the patient is an adolescent, continue to apply the KADS protocol for Depression.

- If positive for Depression, treat the depression and following remission review for presence of continued Anxiety Disorder or ADHD.
- If positive for Anxiety Disorder at that time, refer to specialty mental health services for specific anxiety disorder psychotherapy (CBT) and continue SSRI medication treatment.
- If positive for ADHD at that time, add a psychostimulant medication following the protocol in the ADHD module or refer to specialty mental health services.

### **Fast Facts about Adolescent Anxiety**

- Adolescence comprises the years from puberty to the mid-twenties
- Anxiety disorders affect 8-10% of adolescents
- Most anxiety disorders begin in childhood and adolescent years.
- Anxiety disorders are hereditary
- Many individuals with anxiety disorders experience physical symptoms and present to their family physician or health care provider.
- An individual can be affected by different anxiety disorders throughout their lifespan. Separation anxiety disorder is a common childhood anxiety disorder and can be a precursor for other anxiety disorders in adolescents and young adults.
- Onset of anxiety can lead to poor economic/vocational/interpersonal outcomes and increased morbidity (comorbid anxiety disorders, major depressive disorder, and alcohol and drug abuse) and mortality (suicide).
- Chronic anxiety can lead to poorer health outcomes and increased cardiovascular morbidity and mortality.
- Effective treatments that can be provided by first contact health providers are available
- Early identification and early effective treatment can decrease short-term morbidity and improve long-term outcomes (including decreased mortality)

### **Identification of Youth at Risk for Anxiety Disorder**

First contact health providers are in an ideal position to identify youth who are at risk to develop an anxiety disorder. The following table has been compiled from the scientific literature and is presented in a format that can be efficiently used by a health provider to identify those young people who should be periodically monitored for onset of anxiety.

## Anxiety Disorder in Youth, Risk Identification Table

Significant risk effect	Moderate risk effect	Possible “group” identifiers (these are not causal for anxiety disorder but may identify factors related to adolescent onset anxiety)
<ol style="list-style-type: none"> <li>1. Family history of anxiety disorder</li> <li>2. Childhood onset anxiety disorder</li> <li>3. Severe and/or persistent environmental stressors in childhood.</li> </ol>	<ol style="list-style-type: none"> <li>1. Children with shy, inhibited and/or cautious temperament (innate personality type).</li> <li>2. Family history of a mental illness (mood disorder, substance abuse disorder)</li> <li>3. Experiencing a traumatic Event</li> <li>4. Substance misuse and abuse (early onset of use including cigarette and alcohol)</li> </ol>	<ol style="list-style-type: none"> <li>1. School failure or learning difficulties</li> <li>2. Socially or culturally isolated</li> <li>3. Bullying (victim and/or perpetrator)</li> <li>4. Gay, lesbian, bisexual, transsexual</li> </ol>

### What to do if a youth is identified as at risk?

#### Educate about risk

An anxiety disorder is not inevitable but it may occur. If it occurs, the sooner it is diagnosed and effectively treated, the better. It is better to check out the possibility that problems may be anxiety related than to ignore symptoms if they occur. Primary care health professionals who provide services to families are well placed to educate parents about potential risks for anxiety in their children. Family members (youth included) should be made aware of their familial risk for mental disorders the same way they are made aware of their family risk for other disorders (eg: heart disease, breast cancer, etc.). It is useful to discuss the issue of confidentiality, what will and what will not be shared with parents if the young person develops an anxiety disorder. This may make early interventions easier. A good time to have this discussion with the youth and parents is during early adolescence. A note describing the discussion and its outcome should be made in the patient record. [Access additional resources for parents about adolescent anxiety.](#)

#### Obtain and record a family history of mental disorder

Primary health care providers should take and record a family history of mental disorders (including substance abuse) and their treatment (type, outcome) as part of their routine history for all patients. This will help identify young people at risk on the basis of family history.

#### Agree on a “clinical review” threshold

If the young person is feeling very anxious, distressed, sad and/or irritable, and they are not functioning as well (avoidance, poor coping) at home, school or socially, for more than several weeks, this should trigger an urgent clinical review. The onset of suicidal ideation, a suicide plan or acts of self-harm must trigger an emergency clinical review.

### **Arrange for a standing “mental health check-up”**

The mental health check-up could be 15-minute office/clinical visits every 3 to 6 months during the teen years in which a clinical screening for anxiety is applied. The Screen for Child Anxiety Related Emotional Disorders (SCARED) is a 41-item anxiety screen with a child and youth self report as well as a parent report found at the links provided in the section below.

A recommended clinician monitoring tool for Social Phobia (the most common anxiety disorder in adolescents) is the Kutcher Generalized Social Anxiety Disorder Scale for Adolescents (K-GSADS-A) which is also found in the next section below.

One potentially useful approach is to ask the young person or parent to bring in the youth’s school reports. Check for a pattern of declining grades, frequent lates or frequent absences. Although not specific for an anxiety disorder, these patterns may indicate a mental health problem.

### **Confidentiality and understanding that treatment is by informed consent**

Part of the education about risk should include a discussion about confidentiality and informed consent to treatment for both the young person and the parents. This information may make it easier for the young person to access care if they become anxious as they may be more comfortable in sharing their distress. For parents, knowing what they can expect in terms of being informed about their child may help them feel more comfortable about how treatment will occur if it becomes necessary.

## **Step 2. Useful methods for screening and diagnosis of anxiety disorders in the clinical setting**

An overall mental health screening should be part of general health visits. As youth generally visit health care providers infrequently, screening should be applied to both high risk and usual risk youth at scheduled clinical contacts. Teen visits for contraception or sexual health issues provide an excellent opportunity to screen for mental health problems and mental disorders. Young people with severe anxiety may be embarrassed to spontaneously report what they are feeling. They frequently complain of vague physical symptoms. Gentle questioning about anxiety may be needed to assist them with raising the issue with their health provider.

An anxiety disorders self-test with good sensitivity and specificity (such as the SCARED) should be used. When appropriate, it is helpful to have a parent report as well, particularly in younger teens. The SCARED has both a [SCARED child self report](#) and a [SCARED parent report](#) and can be used by clinicians at no cost. This instrument has been studied in clinical and population samples and demonstrated excellent sensitivity and specificity. Ensure that you provide the young person with feedback on their result.



- It is helpful to screen highly anxious teens for depression and suicide as well. The [Kutcher Adolescent Depression Screen \(KADS\)](#) is a 6 item screen for depression and the [Tool for Assessment of Suicide Risk \(TASR\)](#) is a useful template for assessing suicide risk.

[The 18-item Kutcher Generalized Social Anxiety Disorder Scale for Adolescents \(K-GSADS-A\)](#) can be filled out by the clinician with the young person and is available in a number of different languages and is helpful for monitoring treatment response in social anxiety disorder. Teens with anxiety disorders have higher risk of depression.

**The 6 item KADS (Kutcher Adolescent Depression Scale) and 18 item K-GSADS-A (Kutcher Generalized Social Anxiety Disorder Scale for Adolescents) may be used by clinicians.**

Clinicians who wish to use the KADS or K-GSADS-A in their work are free to apply it using the directions accompanying the scale. Clinicians who would like training on the KADS, K-GSADS-A, and the tool for assessing teen suicide risk (TASR) are encouraged to contact the office of the Sun Life Financial Chair in Adolescent Mental Health at (902) 470-6598.

## Diagnosis of Anxiety Disorders in Adolescence

Anxiety for some young people may only occur in very specific situations or environments and for others can be more generalized. It is important to distinguish between appropriate and adaptive anxiety and stress (usefully called distress), and an Anxiety Disorder. An Anxiety Disorder is of long duration (usually lasting for many months), significantly interfering with functioning, and often out of synch with the magnitude of the stressor. Anxiety Disorders will usually require health provider intervention, while stress is usually of short duration (less than a couple of weeks) and is likely to resolve spontaneously or be substantially ameliorated by social support or environmental modification alone.

Diagnosis of Anxiety Disorders in adolescents is currently made using [DSM IV-TR criteria](#).

### Distress

- Usually associated with an event or series of events
- Functional impairment is usually mild
- Transient – will usually ameliorate with change in environment or removal of stressor
- Professional intervention not usually necessary
- Can be a positive factor in life – person learns new ways to deal with adversity and stress management
- Social supports such as usual friendship and family networks help
- Counseling and other psychological interventions can help
- Medications should not usually be used

### Disorder

- May be associated with a precipitating event, may onset spontaneously, often some anxiety symptoms predating onset of disorder
- Functional impairment may range from mild to severe
- Long lasting or may be chronic, environment may modify but not ameliorate
- External validation (syndromal diagnosis: DSM\*/ICD\*)
- Professional intervention is usually necessary
- May increase adversity due to resulting negative life events (e.g.: anxiety can lead to school refusal and avoidance of normal developmental steps like independent activities with peers)
- May lead to long term negative outcomes (social isolation, low self esteem, lack of independence, depression, substance abuse, etc.)
- Social supports and specific psychological interventions (counselling, psychotherapy) are often helpful
- Medications may be needed but must be used properly

\* DSM- Diagnostic and Statistical Manual

\* ICD – International Classification of Diseases

## Clinical Screening for Child Anxiety in the Primary Care Setting

Clinical screening can be effectively and efficiently conducted by primary care providers – who are often the first point of contact for concerned parents or school authorities and who may know the young person and family well. Conducting this brief screening question may allow the health provider to recognize if further anxiety investigation is needed or not.

### Who to screen?

- Teen presenting with symptoms of nervousness, frequent and excessive worries and fears, difficulties concentrating, behavioral problems, academic underachievement or sleep problems.
- Teen with numerous physical complaints about being tired, frequent headaches or stomach aches, nausea and light headedness which are not easily explained by a known physical illness and which vary in duration, frequency and intensity over a long period of time.
- Teen at risk. See the [Anxiety Disorder in Youth, Risk Identification Table](#).

Refer to [Child and Adolescent Mental Health Screen Questions](#). These questions can be included in clinic/office registration materials to be completed by parents or patients before visits, or in the waiting room before the evaluation screening.

## Screening Questions for Anxiety and OCD in Primary Care Setting

- Do you worry more than other teens you know?
- What do you worry about?
- Does worry/anxiety ever stop you from doing something that you would like to be able to do?
- Are there any events/activities/people/places that you avoid because of fear or anxiety?
- Describe your sleep routine (where, when, quality, night routine)?
- Have you ever missed school or had to come home from school early due to anxiety?
- Have you ever had anxiety where your heart raced, you couldn't catch your breath, you felt dizzy or lightheaded and thought you might be dying?
- Do you get a lot of stomach aches and headaches?
- Do you have trouble concentrating?
- Do you have ideas or images that come into your mind and you can't control them?
- Do you have any routines or behaviours you need to do to relieve anxiety or distressful thoughts or images? (e.g. ask about germs/dirt worries and handwashing/cleaning, also counting and checking rituals)
- What would be different for you if you didn't have anxiety/worry?

## Diagnosis of Anxiety Disorder in Adolescence using the SCARED

The SCARED is a self-report instrument that can be helpful in the diagnosis and monitoring of anxiety disorders in young people. Information on scoring of the SCARED is found on the instrument itself.

An anxiety disorder in an adolescent should be **suspected** if a SCARED score of 25 or higher is found at screening.

**A high SCARED score (25 or higher) does not mean that a patient has a clinical anxiety disorder; it simply suggests a possible diagnosis and the score/items can be used as a guide for further questioning.**

**If a SCARED score of 25 or higher is found during screening the following is suggested:**

- Discussion about important issues/problems in the youth’s life/environment. Complete or use the [Teen Functional Activities Assessment \(TeFA\)](#) to assist in determining the impact of the depression on the teens functioning.
- Supportive, non-judgmental problem solving assistance – “supportive rapport” (use the [Psychotherapeutic Support for Teens \(PST\)](#) as a guide to this intervention) – strongly encourage and prescribe: exercise; regulated sleep; regulated eating; positive social activities
- Screen for depression- use the [Kutcher Adolescent Depression Screen \(KADS\)](#)
- Screen for suicide risk - use the [Tool for Assessment of Suicide Risk \(TASR\)](#)
- Mental health check-up about 1 week from visit. This visit could also include the TeFA and/or PST so schedule about 15-20 minutes. If concerns about depression or suicide then KADS and TASR should be utilized.
- A third visit 2 weeks later to check in, repeat SCARED and other appropriate screens, and make treatment plan as indicated.

### **Don’t get overwhelmed!**

Yes, there are a number of clinical tools and they address important issues in diagnosis and treatment of adolescent anxiety disorders. However a full assessment of anxiety can be completed in three 15-minute office visits using the suggested framework above. Some clinicians may prefer to integrate the details found in the tools into their assessment interviews rather than using the tools separately. If there is concern about depression and/or suicide risk, then these screening tools should be used at each visit.

## **Types of Anxiety Disorders**

Anxiety Disorders are the most common psychiatric illnesses in children, adolescents and adults. Anxiety is a physiological response that is essential to human beings and survival, involving “fright/flight” neurobiology. In anxiety disorders, this response is no longer adaptive and is either out of proportion to a stressor, or occurs when there is no threat. Due to the physiological mechanisms activated with the anxiety and stress response in the body, individuals with chronic anxiety and stress have more risk of both physical and mental health problems. Individuals with anxiety often present to their primary health care provider with frequent physical complaints, and not necessarily reporting anxiety. There are many types of anxiety disorders, and prevalence varies depending on age group. Four of the most common anxiety disorders with onset in adolescence are social anxiety disorder, generalized anxiety disorder, panic disorder and obsessive compulsive disorder.

### **Social Anxiety Disorder ([Social Anxiety Disorder DSM-IV-TR diagnostic criteria](#))**

Social Anxiety Disorder (Social Phobia) is the most common anxiety disorder in adolescents. Often these youth are identified as “shy” or “introverts”, which is not accurate. Youth who suffer from social anxiety disorder have severe anxiety in social situations that is very distressing and can lead to avoidance and significant deterioration in overall function. Youth with social anxiety disorder describe an overwhelming fear of drawing attention to themselves or saying something stupid or embarrassing around others, especially peers. This can lead to not being able to ask questions in class, not able to talk in front of others, avoidance of using phone, not ordering in restaurants, and not using public bathrooms. When social anxiety disorder is quite severe it can result in isolation to the point where the individual rarely leaves their home, does not have contact with friends and stops attending school. Social anxiety disorder has significant developmental and functional impact on youth at a time when they should be developing their own identity and independence. Without treatment these youth can develop depression, have higher risk of substance abuse and higher rates of not completing school.

### **Generalized Anxiety Disorder ([Generalized Anxiety Disorder DSM-IV-TR diagnostic criteria](#))**

Generalized Anxiety Disorder (GAD) can have onset in childhood and adolescent years. Youth with GAD can be described as “master worriers”. Their anxiety is around everyday events and responsibilities in their life, but their distress and worry is excessive, unrealistic and/or unhelpful, and persists for at least 6 months. GAD sufferers have significant distress both mentally and physically due to their anxiety. Youth may report feeling tense, irritable, frequent muscle aches and pains, and difficulty concentrating due to the intensity and chronicity of the worried thoughts and feelings. These symptoms can make it difficult to fall asleep, or to get restful sleep, and this increases distress. Individuals with GAD may have academic performance anxiety that interferes with starting and completing assignments and taking tests, due to fear of failure or that it will not be “good enough”. A pattern of avoidance can develop to prevent “failure” or “something bad happening”, and the youth may seek excessive reassurance from others that “everything will work out or be okay”. These anxious behaviours lead to increased

anxiety and interfere with overall function, and lead to lack of enjoyment and avoidance of everyday activities.

### **Panic Disorder ([Panic Disorder DSM-IV-TR diagnostic criteria](#))**

Panic disorder has onset in adolescent years, and although not the most common anxiety disorder, can become very debilitating quite rapidly. Panic attacks ([Panic Attacks DSM-IV-TR diagnostic criteria](#)) most commonly first present to an emergency room or urgent care because the physical symptoms are acute and escalate quickly similar to having a heart attack, asthma attack or even stroke or seizure. The individual becomes extremely afraid and believes they are dying or that something terrible is going to happen. Panic attacks can occur in any anxiety disorder or high distress situation. However, in panic disorder these attacks occur “out of the blue” without clear precipitants or warning. This causes extreme fear and anxiety of having another attack, particularly in a place where others might see them or where escape or help might not be possible. Individuals with panic disorder will avoid any situation they associate with feeling panicky, or places where they fear that if they did have an attack they would not be able to manage or get help. In many individuals this can lead to staying closer to home to the point where you will not go to places where there may be groups of people or crowds (agoraphobia). In teens with panic disorder, they may stop all extra curricular activities, refuse to go anywhere without their parent, and may stop going to school (or have extreme distress with school attendance). This deterioration can happen quite rapidly for some individuals even after only one or two panic attacks. Individuals with panic disorder can develop depressive symptoms quite rapidly and have a higher associated risk of suicide than other anxiety disorders.

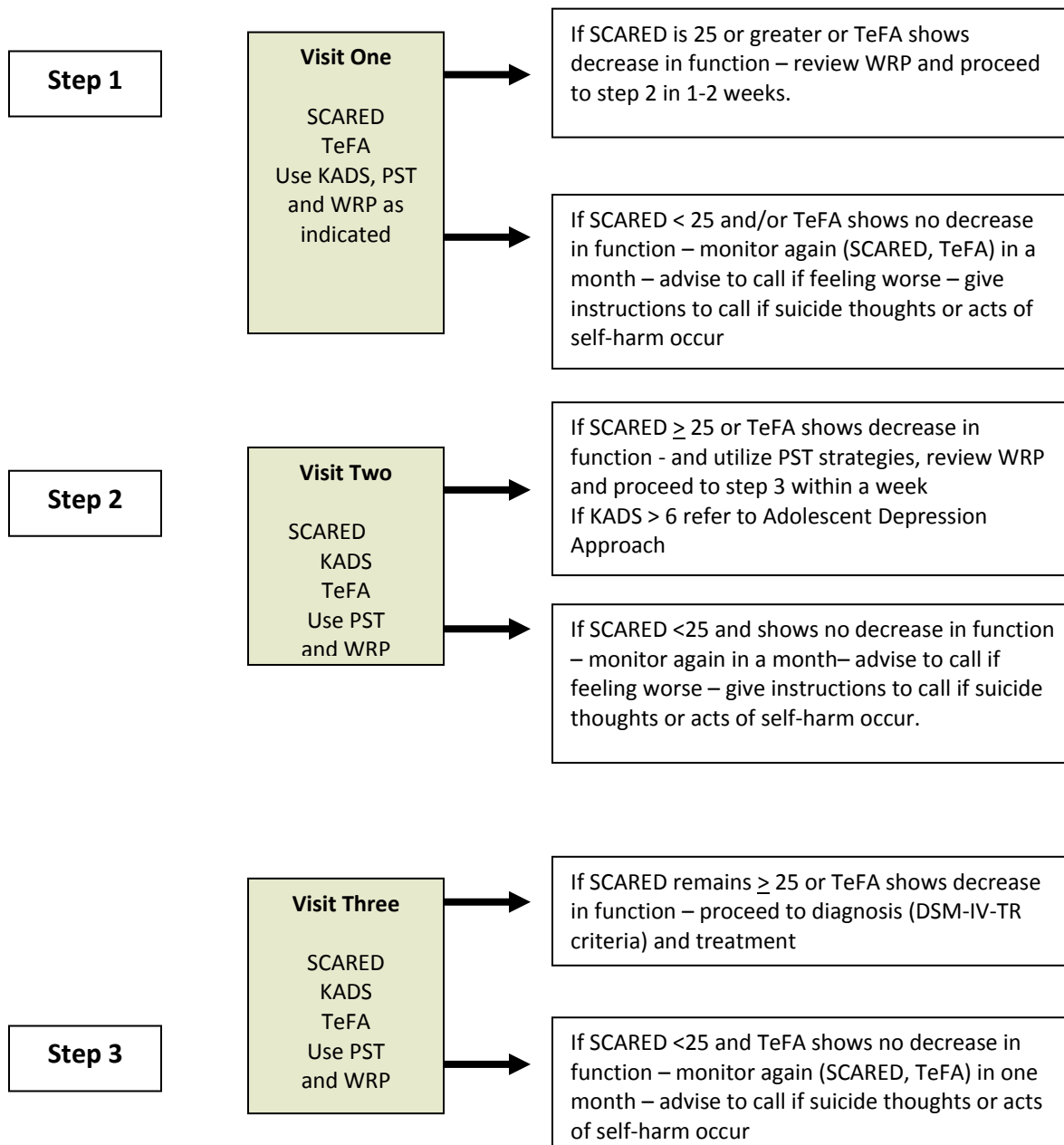
### **Obsessive Compulsive Disorder ([Obsessive Compulsive Disorder DSM-IV-TR diagnostic criteria](#))**

Obsessive Compulsive Disorder (OCD) is an anxiety disorder involving obsessions (distressing intrusive thoughts and/or images) and/or compulsions (repetitive behaviours or rituals performed to relieve distress and anxiety associated with the obsessions) that are unwanted, cause significant anxiety, and interfere with functioning (taking up more than one hour per day). The most common obsession themes are illness and danger related, and the most common compulsions are cleaning and washing rituals, and checking behaviours. Sometimes the illness does not involve any observed compulsions, and the individual could suffer from repetitive images or thoughts (e.g. of violent, religious or sexual nature) which are extremely distressing. The compulsions could be mental rituals such as counting or praying. There could also be avoidance of and distress around things triggering or associated with obsessions (e.g. having all the knives removed from the house for someone who has violent obsessive thoughts) and efforts to try and suppress obsessive thoughts. Individuals suffering from this illness often suffer in silence for many years before seeking help. Parents may notice symptoms that are interfering with functioning at home or school, and bring their child or teen to their health care provider to find out what is wrong.

OCD generally has two peaks of onset, in childhood (pre-puberty) and in later adolescence. Adolescents with OCD generally have some insight into their illness and recognize it is irrational

and does not make sense, which increases their frustration and distress as they continue to feel they do not have control of their thoughts and have to perform the compulsions (in children there may be less insight into the illness). OCD can have sudden onset of symptoms, but generally has a gradual onset with worsening of symptoms over time. Youth suffering from OCD may have trouble going to school, find they are unable to concentrate in class, have difficulty getting out of the house or getting dressed, and have decreased food intake related to obsessions and compulsions. Youth with OCD have higher rates of developing depression as the illness progresses.

## Clinical Approach to Possible Adolescent Anxiety Disorder in Primary Care\*



\* Alternatively, some health care providers may choose to “flush out” the patient’s entrance complaint, determine if any safety or immediate referral issues are present (for example: not eating; not leaving house; suicidal; psychotic – see below for more details), provide the SCARED and KADS to the patient to complete and then schedule a longer visit in the near future to complete the assessment. The key issue here is to ensure patient safety while providing a long enough assessment period to allow for distress to be better differentiated from disorder.

Obsessive Compulsive Disorder may be the one Anxiety Disorder most difficult to treat in Primary Care, particularly if it has been present for a significant length of time (a year or more). In such situations, the primary care practitioner may wish to begin treatment and concurrently refer to specialty mental health services.



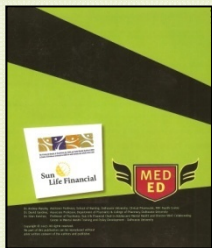
### Step 3. Treatment Template

Treatment of adolescent anxiety includes both specific and non-specific factors. Specific factors are evidence based treatments for anxiety disorders and include: medications and structured psychotherapies (Cognitive Behaviour Therapy (CBT)). Non-specific factors include activities which decrease stress, improve mood and general well-being PLUS supportive psychological interventions (use the PST in the toolkit as a guide) given by the health provider.

When initiating treatment it is necessary to start by educating the patient or caregiver about the disorder and about the treatment. This should be done over two visits about a week apart with the time between visits spent by the patient and parent or caregiver in self-study and research. To initiate the self-study, direct them to websites in section [Suggested Websites](#) and encourage them to search wherever they want (e.g. to “Google” the specific disorder) and then bring a list of the questions and concerns to the next visit.

#### When providing information about a mental disorder:

- 1) Determine what the youth and caregivers know already – about the disorder and the treatment.
- 2) Identify areas of misinformation and provide correct information.
- 3) Identify gaps in knowledge and provide information.
- 4) Be knowledgeable, realistic, clear and helpful.
- 5) Provide written materials to take away or refer parents to [Useful resources](#).
- 6) Ask about the issue of **addiction**. Many teens or parents think that taking medicines will lead to addiction. They will often not bring this up spontaneously – so initiate this topic with them. It is also helpful to know what substances they may be using, as these can have harmful interactions with prescription medications. [Useful information about addiction and medications on the NIDA website](#).
- 7) If prescribed, discuss anticipated duration of medication use. For initial treatment of anxiety this will be for 6-9 months after they get well.
- 8) Discuss how taking medicine will impact their lifestyle (e.g. substances that interact with medication, idiosyncratic reactions to alcohol use; no limits to driving with an SSRI).



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## Non-specific Interventions

Recent neuro-biological research has provided more clues about how a variety of environmental manipulations may change brain functioning in those domains known to be associated with control of mood and stress, such as: serotonin systems; dopamine systems; noradrenaline systems, neurotropic factors (particularly brain derived neurotropic factor (BDNF)); and endorphin systems.

These non-specific interventions include:

- 1) **Exercise** – particularly a minimum of 30 minutes of vigorous aerobic exercise daily. Discuss ways they could incorporate this in their existing routine (e.g. walking to school or work, joining in school program, going with friend or family).
- 2) **Sleep** – teens need 9 to 10 hours of sleep per night to function optimally. Most teens get only 7 to 8 hours per night, due to staying up late and having to wake up for school. Encourage teens to set their bedtime earlier with goal of getting at least 9 hours of sleep. Go over sleep hygiene with them to make it easier to fall asleep at night. Try to keep the same routine even on weekends and holidays. Ask them to try this for a few weeks and see if they feel any difference.
- 3) **Social support** – peer and family interactions - particularly associated with pleasurable activities (even in the face of not going to work or declining grades).
- 4) **Nutrition** – a healthy diet and eating regular meals. Skipping meals, particularly breakfast can increase stress and anxiety. Caffeine and sugar rich drinks (coffee, soda, energy drinks) can increase anxiety and agitation. Foods rich in tryptophan – such as chickpeas – or serotonin – such as chocolate – (unfortunately it seems that eating turkey and bananas does not help), as well as omega-3 may have some mood enhancing properties. Overall, a balanced diet, regular meals and minimal to no alcohol is recommended for health.
- 5) **Music and movement** – particularly rhythmic “upbeat” music and dance can help with stress and improve mood.
- 6) **Bright light** – this is particularly helpful for people who have lower mood and energy in the winter months when there is less daylight. The special lamp is used early morning (between 6 and 9 am) and early evening (between 6 and 9 pm) exposure to 2,000 lux or more during winter months. This should be the amount of outdoor light available during the summer months (in Canada).
- 7) **Avoid drugs (including all recreational drugs)**. If of legal drinking age, use alcohol in moderation. Alcohol can decrease anxiety and thus become a self-medication that could lead to later misuse and abuse. Nicotine is also an effective anxiolytic but

presented in the form of cigarettes can lead to addiction and long term negative health outcomes.

While it is unlikely that application of the above strategies in the absence of medication or psychotherapy will “treat” an anxiety disorder there is no reason not to “prescribe” a wellness strategy that incorporates most or all of these interventions. At the very least the tendency for anxious youth to be more stressed, stay up late, skip meals, and self isolate and avoid others should be actively discouraged.

Applying the strategies above in the absence of medication or psychotherapy will not be sufficient treatment for Anxiety Disorders. However, prescribing the above wellness strategies may be helpful to improve the overall outcome.

### **Eat Breakfast!**

Breakfast is the most important meal of the day, and studies show that eating a healthy breakfast decreases stress and improves how you perform at school and work.

Suggestions: Yogurt plus fruit (berries, bananas, peach etc), fruit smoothie, granola bar, wholegrain cereal/toast.

## Engaging the School

It is essential to engage the school when addressing anxiety disorders in adolescents. This engagement is important for the following reasons:

1. **Diagnosis** – Symptoms of anxiety disorders are present in the school setting. Information from the teen’s teachers is essential for diagnostic purposes.
2. **Treatment** – Treatment of anxiety disorders requires monitoring of outcomes in various domains, including the school.
3. **Adjustments** – Some adjustments in classroom activities, courses or learning engagement styles may be needed to optimize the chances for academic success. This requires the input of teachers and guidance counsellors.

Once a positive diagnosis of Anxiety Disorder is made, (see [Clinical Approach to Possible Adolescent Anxiety Disorder in Primary Care](#)) it is time to contact the school. Prior to contacting the school, ensure that the adolescent and the parent or guardian give informed written consent. Although schools may differ in their contact protocols it is useful to enlist the assistance of the parent or guardian in identifying the school contact person. Usually this will be a member of the senior administrative team, such as a Vice-Principal or a school counsellor. Depending on the school’s policy, the parent or guardian may also have to give consent to the school to speak with the physician. Ensure that this issue is clarified and has been appropriately addressed prior to speaking with the school representative.

It is important to ensure to that there is a single contact person in the school for all issues related to addressing the interventions planned. In some cases it may be necessary to meet with the school contact person (and others as indicated) to ensure that the intervention plan is clear and all issues have been considered. Schools usually have a protocol to follow when medical interventions are underway and it is important for you to be informed about how this protocol is applied and what role you will have in its application.

Schools and school contact persons will differ in their familiarity with addressing anxiety disorders. It is important to take a little more time at the beginning to ensure all parties are comfortable with what needs to be done, as over time this collaborative relationship will become more established and simpler to navigate.

## Worry Reducing Prescription (WRP)

It is useful to provide the young person with a simple outline developed in collaboration with them and the caregiver that clearly specifies what self-regulatory activities they could pursue during the diagnostic and treatment phases of their contact with their health provider. The [Worry Reducing Prescription](#) is a useful and time efficient tool for managing stress that can be used to help the young person identify and plan their daily activities. It is embedded below and also provided in the Clinician’s Toolkit as well. In practice, the clinician can review the WRP with the patient, complete the form and then review it at the next office visit.

### Worry Reducing Prescription

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

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

### Enrolling the Help of Others

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

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

## **Assessment and Monitoring of Functioning**

Functional impairment is an essential component of an ADHD diagnosis. In young people, a functional assessment across four domains is an essential component of treatment monitoring. Functional improvement is a necessary target for treatment outcome.

**The four functional domains that need to be addressed are:**

<b>School</b>	Grades, teacher relationships, attendance
<b>Home</b>	Parental/sibling relationships, home activities
<b>Friends</b>	Peers, down time activities, intimate relationships (when appropriate)

The [Teen Functional Assessment \(TeFA\)](#) has been developed to assist the primary care provider in the evaluation of each of these components. It is embedded below and also provided in the clinician’s Toolkit.

Clinicians can copy and use the TeFA without written permission from the author. Some clinicians may choose to incorporate the essential features of the TeFA into their standard patient monitoring interviews rather than using the tool itself.

## Teen Functional Assessment (TeFA)

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

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

For each of the following categories, write down one of the following options in the space provided – “much better than usual”; “better than usual”; “about the same as usual”; “worse than usual”; “much worse than usual”. You can also give an example if you would like.

**Over the last week how have things been at:**

School: \_\_\_\_\_

Home: \_\_\_\_\_

Friends: \_\_\_\_\_

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

1) \_\_\_\_\_

2) \_\_\_\_\_

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

1) \_\_\_\_\_

2) \_\_\_\_\_

## **Sleep Assessment**

Sleep is often disturbed in youth with anxiety disorders and sleep problems can be a side effect of medication treatment. Therefore it is a good idea to assess sleep during the assessment and before treating.

A useful method for assessing quality and quantity of sleep in an adolescent is by asking the following simple questions:

- What time do you get in bed?
- Do you have trouble falling asleep?
- How long does it take you to fall asleep?
- Once you fall asleep, do you sleep throughout the night?
- What time do you wake up?
- Do you feel rested when you wake up?
- Do you feel tired during the day?
- Do you nap during the day?

## **Sleep Hygiene**

Good sleep hygiene is an important part of healthy development for all young people. Youth with anxiety disorders often require greater attention to sleep hygiene due to the disturbances of sleep commonly seen with anxiety disorders. Here are a few helpful sleep hygiene suggestions.

- Set a reasonable bedtime for both week and weekend days
- Get some exercise after school or before homework but not in the hour before going to bed
- No caffeine containing drinks (such as cola, coffee, tea, etc.) after dinner
- 30 to 45 minutes of quiet time (no video games and no TV) prior to going to sleep



## Psychosocial Interventions

Standard anxiety disorder treatment guidelines recommend the use of cognitive behavioural therapy (CBT), and there are many manualized CBT programs utilized as first-line interventions for children and adolescents with anxiety disorders. In many locations, these interventions are not easily available, or the teen or caregiver may choose not to accept a recommendation for this treatment. For some, cost may be an important factor if this treatment modality is only available through private services.

If CBT is available in the patient's community, it is a strong evidence-based practice to provide that intervention as part of the treatment of anxiety in young people. Many youth have improvement in their anxiety with CBT alone, and do not require medication intervention. However, if waiting lists for these therapies are long or these psychotherapies are not available, treatment may need to be implemented with medications, wellness enhancing activities and supportive rapport. There are also some CBT strategies that can be provided through primary care (see [Psychotherapeutic Support for Teens](#) in the next section below). Remember that although suicidal ideation and suicide attempts are not as common in anxiety disorders as compared to depression, they may occur, and should be monitored in any treatment modality.

Additionally, evidence suggests that CBT has additional positive effects when combined with a medication treatment in severe anxiety disorders. For example, the addition of an SSRI to CBT increases the numbers of youth in treatment that no longer meet criteria for an anxiety disorder.

Some individuals, possibly those with mild symptoms, may find self-help resources useful. These can be obtained by linking to the [Kelty Resource Centre](#) or, alternatively, at other resource sites as identified in the [Suggested Websites](#) section.

### **An Important Clinical Point:**

Medications should not be used to treat young people who have mild symptoms of anxiety or stress. They should be used only for treating moderate to severe anxiety disorders, and usually in those youth with significant impairment in functioning. If you are not sure if it is an anxiety disorder, it is reasonable to institute wellness enhancing activities, stress management strategies and supportive rapport and monitor carefully for symptom change and suicide risk. Do not rush into medication prescribing, but use the medications for which there is good scientific evidence when indicated.

## Psychotherapeutic Support for Teens: Practical Pointers for Primary Care Health Providers Treating Adolescent Anxiety

This tool provides clinicians with guidelines/suggestions that they can use to direct their clinical interactions with the teen. It includes some basic cognitive behavioural therapy strategies.

### Approach

Create a supportive and safe space.

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

### Enhance Motivation

Ask questions to assess and enhance readiness for change – even though anxiety has become such a problem it can still be difficult to engage in change behaviours.

- Ask about the pros and cons of staying the same, of engaging in change.
- Ask about what things were like before anxiety became such a problem.
- Check with youth about what things would be like if the problem is reduced.
- Use solution-oriented language to explore with youth for examples of times when they are already successful in handling their anxiety.
- Examine “what will get in the way?” and “what will help you?”
- For some youth, examine ways that caregivers can play supportive “cheerleading” role/reinforce youth efforts.
- Review motivational issues if youth continues to struggle and is experiencing barriers to use of strategies.

### Provide Education

Provide education about anxiety and education about the treatment (review SCARED and TeFA).

- Anxiety is a necessary feeling for all human beings to survive. It helps protect you in dangerous situations and helps you prepare for challenges. The fright/flight response in your brain is the main signal mechanism in anxiety and this gets activated when there is a threat or stressor.
- The reasons for individuals developing an anxiety disorder are complex, but family history, temperament and exposure to psychosocial and environmental stressors can all contribute.
- Anxiety disorders are disorders caused by changes in the fright/flight signalling in the brain. This leads to the fright/flight mechanism being activated in situations that are not a threat, or over responding to the stressor. This then leads to release of stress hormones and adrenaline in

your body, and is what causes the physical symptoms of anxiety.

- Anxiety disorders lead to extreme distress and changes in behaviour to avoid or decrease the anxiety reaction. The avoidance and reliance more on other people can become extreme and interfere with functioning at home, school, socially and in activities.
- Anxiety gets worse over time the more a person avoids or relies on others to help manage anxiety.
- Anxiety is very treatable and the best treatments include therapy to help with your anxious thoughts and behaviours and sometimes medications to help decrease your overall anxiety/panic response. By helping to change thoughts and behaviours associated with anxiety, the feeling of anxiety and distress improves.
- Without treatment anxiety disorders usually get worse and cause more distress and impairment in function. Untreated anxiety disorders put you at higher risk of developing depression and substance abuse.

**(In OCD thoughts and images (obsessions) that many people without OCD have and discard (garbage thoughts) become recurring and intrusive in people with OCD(recycled thoughts). This leads to significant anxiety and distress, and compulsions or rituals are performed to temporarily relieve anxiety and distress. However, this cycle then strengthens OCD brain communication patterns and makes the obsessions and compulsions stronger and more difficult to ignore.)**

### **Coping Skills**

Youth have both helpful and unhelpful ways of dealing with anxiety. Review the current skills and try to increase coping skills.

- What are your current coping strategies? Identify whether they are helpful or unhelpful in the long term.
- Review wellness strategies for stress management above (healthy eating, regular activity, and good sleep) and make a plan for how to make them work.
- Teach relaxation and calm down strategies (mental imagery, meditation, muscle relaxation and deep breathing).

### **Cognitive Strategy**

Help identify the most important problem at present and identify unhelpful thoughts associated with it. One of the keys in cognitive behavioural therapy is that the teen comes up with solutions and says them or writes them down. Coaching and suggestions are good, but the teen has to practice challenging anxious thoughts on their own or it will not work.

- What is anxiety interfering with the most right now? (e.g. Socially anxious teen who does not spend time with peers outside of school.)
- What are you afraid of or what is the thought that causes the most distress? (e.g. “peers will think I am stupid”)
- How realistic is this anxious thought? (Ask the teen to give evidence for and against, need to give specifics, ask how someone else may feel in the same situation; e.g. is there another way to interpret what happened when you saw two girls laugh after class besides that they were laughing at you?)
- Can you come up with a more realistic thought? (e.g. “There are people

who have talked to me in class and they seem nice, there is no reason this would change outside of school with the same people, this is my anxiety and it will be hard to go out with friends after school but it could be fun once I get over my anxiety”).

**(In OCD the individual usually is aware that the obsessions do not make sense, but they feel compelled to act on them anyway due to distress. The cognitive strategies most employed are around exposure to the thoughts and acceptance of them. For example, accepting that all things are not certain nor can all bad things be prevented and tolerating these thoughts without engaging in compulsions.)**

### **Behavioural Strategy**

Identify anxiety-related behaviours and avoidance. The goal is to **gradually\*** expose the youth to anxious situations and manage their anxiety to decrease avoidance. REMEMBER – just talking about not avoiding situations is usually not very helpful. It is more useful to enlist the assistance of a trusted person such as a friend or responsible adult (family member, religious leader, etc) who the young person nominates to take the youth to settings that they would otherwise avoid. Relearning avoidance behaviours takes time and practice. So this will often need to be repeated many times over. A first cluster of 8 to 10 “sessions” per avoided situation is recommended. The situation is endured until the anxiety decreases substantially at each session.

- What are you currently avoiding or have severe distress with related to anxiety? (e.g. asking a question in class)
- Is this behaviour causing you any problems or difficulties? (e.g. “Yes, because I don’t understand something and I can’t complete homework.”)
- Are there any times you have been able to face your fear and not avoid these situations?
- What would be a next step you could try to face your anxiety/fear and not avoid? (e.g. “I could ask the question of the teacher after class or go to extra help.”)
- When could you try this?

***\*Youth need to take small steps in decreasing avoidance of anxiety situations. The goal is that they tolerate the anxiety they feel and make it through the situation successfully on their own. If the step is too challenging and they are not able to do it on their own, then the next time find an easier step.***

***(In OCD this technique is called Exposure and Response Prevention, it is the core component to CBT in OCD. Youth are exposed to a feared situation related to their obsession and are then not to engage in any rituals or compulsions. This technique requires a clinician trained in this field.)***

### **Medication Intro**

Provide rationale for medication trial, what they can expect, and education about medication.

- Explain how medication works to treat anxiety.
- Give information about potential side effects and Health Canada Warning regarding increase risk of suicidal thoughts and behaviours in youth 18 and under taking antidepressant medication.

- Provide time line for titration of medication and treatment response.

### **Be Realistic**

Discuss expectations and potential obstacles in treatment course.

- Anxiety has the best chance of improving when youth and family are both aware of the anxiety disorder and there is support of treatment plan.
- Anxiety can wax and wane over time, and it is not unusual for anxiety to improve overall while still having brief recurrences often in higher stress times.
- The goal with treatment of anxiety is not to eliminate anxiety, but to have it improve and be manageable without impairment in function or severe distress (i.e. anxiety does not make decisions for you or control your life).

### **Be Responsive**

- Be available for urgent matters within office hours (this depends on individual practitioner's preference and can include phone, email or text messaging).
- Schedule frequent brief face to face visits at times that do not conflict with school (15-20 minutes).
- Monitor and support teen wellness activities (exercise, sleep, healthy diet, etc.).
- Ensure access to professional care during the off hours for emergencies and review crisis plan with teen and parents (as appropriate).

### **Be Collaborative**

- When possible and with youth consent, it is important to include caregivers in the support plan
- Communication, coordination and collaboration are important considerations in situations where care is shared with other mental health providers (e.g., if specialised CBT is being provided for a youth with OCD and you provide the medication management).

## Initiating Pharmacological Treatment for Adolescent Anxiety Disorders

Both CBT and pharmacological management are evidence based treatments in adolescent anxiety disorders. In moderate to severe anxiety disorders, and when individuals are not able to engage or utilize CBT strategies, the addition of medication can be helpful. The best level one evidence for medication treatment of adolescent anxiety disorders are the selective serotonin reuptake inhibitors (SSRI). Cognitive behavioural therapy in combination with SSRI is the recommended first line treatment for moderate to severe anxiety disorders (including OCD). Either fluoxetine or sertraline is recommended as the first line medication treatment for adolescent anxiety in primary care based on scientific evidence base, side effects and half life profile, and ease of use. If a youth does not tolerate an initial trial or there is no improvement, the youth should be referred to secondary/tertiary mental health services.

Not all anxiety disorders require treatment with medication, and we strongly recommend medication not be used alone. Ideally it should be combined with CBT, wellness enhancement activities and supportive rapport. Alternatively, if CBT is not available, or while the young person is waiting for it to become available, medications could be combined with anxiety disorder education, wellness enhancement activities and supportive rapport.

Fluoxetine and sertraline can significantly improve anxiety symptoms and improve depressive symptoms if they are also present. However, some young people may experience suicidal ideation and self harm behaviour or have these increased when treated with antidepressant medication. Therefore systematic assessment of suicide risk must be completed as part of the ongoing treatment with antidepressants (See [Health Canada Advisory for antidepressant medication.](#))

Further information on SSRI use and youth suicide can be accessed below. If fluoxetine, sertraline or another SSRI is used, the following 12 steps of treatment should be considered, customized and integrated into a practical approach that is feasible in your practice.

## Issues to Consider When Monitoring SSRI Treatment

<b>First</b>
Do no harm. This does not mean—do not treat. This means do a proper risk benefit relationship analysis of the situation. And make sure that your evaluation of these risks and benefits has been fully discussed with your patient/ family.
<b>Second</b>
Make sure the patient has an anxiety disorder. This means that the diagnostic criteria are clearly met and that there is clear-cut functional impairment and/or significant distress. Medications should not be used to treat anxiety symptoms, they should be reserved for the treatment of moderate to severe anxiety disorders. Remember that threshold for diagnosis is not only within the total number of criteria met in the syndrome, but also within each criterion. For example, anxiety about upcoming exams without any change in function would

not qualify as excessive worry of at least 6 months duration.

### Third

Check carefully for other psychiatric symptoms that might suggest a different disorder. For example, does the patient have a major depressive disorder, are the symptoms indicative of a psychotic prodromal state that looks like severe anxiety and isolation. If yes .... recommendation

### Fourth

Check for symptoms of agitation, panic and impulsivity. If the patient has these symptoms they may be at greater risk for the behavioral adverse effects of an SSRI. If yes .... recommendation

### Fifth

Check for a past history of mania and for a family history of bipolar disorder. Many youth who develop bipolar disorder report a preceding anxiety disorder diagnosis in childhood or teen years. Also, remember that up to two-thirds of teen onset bipolar disorders present to a mental health professional first with depression. Young people with this background may be more at risk for the behavioral activation effects of SSRIs. If yes .... recommendation

### Sixth

Measure the patient's current somatic symptoms, paying careful attention to such items as restlessness, agitation, stomach upset, irritability and the like—before you begin treatment. A side effects scale (see below for an example) can be used to address this issue.

### Seventh

Measure the symptoms of anxiety, depression and pay special attention to suicidality. The SCARED is a self report scale for anxiety (see above link) and the KADS is a self report scale for depression (see below). Both are easy to use, validated in this population and can provide not only baseline but also treatment outcome information. Remember that SSRI's may occasionally increase suicidal ideation so it is very important for your risk-benefit analysis to determine if there is suicidal ideation at baseline.

### Eighth

Provide comprehensive information about the illness and the various treatment options to the patient and family. Appropriate literature should be available in your office and you should have a list of good websites to which you can direct their attention. Remember, the pharmacotherapy of anxiety is not emergency medical treatment. There is time for substantial research followed by frank and open discussion with the patient and family.

### Ninth

If an SSRI is chosen make sure that you provide the patient and family with appropriate information about possible side effects (both behavioral and somatic) and the expected timelines to improvement. Ideally this should be in written form and if you are concerned

about litigation have the patient and family sign one form and keep it in the patient record. Also make a note in the record as to the discussions and decision.

### Tenth

After doing the necessary laboratory workup as indicated by medical history and review of systems (for an SSRI there are no required blood tests, but some recommend a pregnancy test for females), start with a small test dose of the medication, preferably given at a time when the teen is with a responsible adult who knows about the test dose and who can contact you if there is a problem. Following that begin treatment with a very low dose (often you can cut the smallest dose pill in half or you can have the patient separate a capsule's contents) and ask the patient and parent to monitor for adverse behavioral effects daily. Remember to provide a phone number where you can be reached if any problems develop and arrange to see the patient within about a week of initiating treatment.

### Eleventh

Increase the dose slowly at no more than 1-2 week intervals until your initial therapeutic dose is reached (the expected minimally effective daily dose), then wait for the required 6–8 weeks at this dose to determine efficacy. Never prescribe medication without at least offering supportive wellness and stress management support, as well as some basic CBT strategies (if CBT is not available through services in your community). See the patient **weekly for the first month** and allow for telephone check-in whenever the dose is increased or between visits if concerns arise. Once stable on a dosage and no side effects over a month, then visits can decrease to every 2 weeks and gradually go to every month if doing well. If there is a dosage increase, the risk of side effects increases, and frequency of visits should go back to every week for a few weeks. Always check for and record possible adverse events at each visit (use the form that you used at baseline so that you can compare symptom changes over time) and assess improvement at Weeks 2, 4, 5 and 6.

### Twelfth

Take advantage of the placebo response (found to be high in most adolescent medication trials) That is, invoke a similar approach to patient care as done in studies including frequent face-to-face contact early in the course of therapy, the development of a trusting and supportive relationship, efforts to measure response objectively and subjectively, and careful elicitation of side effects, overall tolerance, ongoing concerns, and satisfaction with treatment. This approach represents good clinical care that is consistent with the “careful monitoring” advocated by the FDA and other organizations. This approach will not necessarily totally ameliorate the occurrence of behavioral side effects but it may cut down their prevalence and will help you quickly identify when they occur so that you can intervene appropriately.

The 12 steps appear in Kutcher, S., Gardner, D. & Virani, A. (2004) *A Suggested Careful Monitoring to SSRI Treatment*. Child and Adolescent Psychopharmacology News, 9 (4): 3-4.

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### Initiating and Continuing Fluoxetine Treatment \*

- Start low and go slow.
- Begin at 10 mg daily.
- Continue 10 mg for one to two weeks then increase to 20 mg.
- Continue 20 mg for a minimum of 8 weeks.
- If side effects are a problem with any increase or initial start at 10 mg- decrease the dosage by 5 mg (example: to 20 mg – decrease the dose to 15 mg daily for 1 week and then increase to 20 mg. If substantial side effects occur again continue the dose at 15 mg for a minimum of 8 weeks).
- OCD treatment may require higher dosages 20-60 mg/day (we recommend referring youth to secondary/tertiary mental health services with severe OCD not responding to 40 mg/day). Treatment response in OCD is not as fast, usually around 12 weeks, and then gradual improvement over many months.
- Youth may try taper off medication after doing well (anxiety in remission) for 6 to 12 months. The taper should occur gradually over several months, preferably in a time of lower stress such as summer vacation.

### Initiating and Continuing Sertraline Treatment \*

- Start low and go slow.
- Begin at 25 mg daily (if significant side effects can decrease to 12.5 mg- pharmacy can help with packaging in smaller dosage).
- Continue 25 mg for one to two weeks then increase to 50 mg.
- Continue 50 mg for a minimum of 6-8 weeks.
- Increase to 75 mg at 6-8 weeks if tolerating well, anxiety improving, but significant anxiety symptoms remain.
- Maximum recommended dosage of sertraline is 200 mg per day, but anxiety disorders in teens generally respond to dosage of between 50-100 mg per day.
- OCD treatment may require higher dosages 100-200 mg/day, and treatment response is not as fast, usually around 12 weeks, and then gradual improvement over many months
- Youth may try taper off medication after doing well (anxiety in remission) for 6 to 12 months. The taper should occur gradually over several months, preferably in a time of lower stress such as summer vacation.

\* The [PST based supportive rapport](#) model should be used at every visit as a framework within which you can structure your interaction with your teenage patient.

**Referral – Red Flag** If the child presents with severe anxiety and/or depression with active suicide intent, immediate referral to specialty mental health services is warranted. The presentation of psychosis or the presence of a suicide plan necessitates emergency referral.

The symptoms of severe anxiety and panic are unlikely to show significant improvement before 2-4 weeks (10-12 weeks for OCD response) following the initiation of either fluoxetine or sertraline intervention or Cognitive Behavioral Therapy. If the patient is markedly distressed by their symptoms small doses of a moderately long-acting benzodiazepine such as clonazepam (0.25 mg - 1 mg twice daily) can be used in the short term (up to 6 – 12 weeks). Clonazepam is

not recommended to treat anxiety disorders or OCD as a primary treatment, but it can help to control some anxiety symptoms and it can provide some relief to the patient as the SSRI is titrated to the optimal target dose and anxiety and/or OCD symptoms show improvement. Once that has occurred clonazepam can be tapered gradually (decrease by 0.25 mg per daily dose every week). A similar pattern of use can be applied if CBT alone is being used as the initial treatment of choice, but this medication should not be maintained long term. If long term medication is indicated along with CBT, then an SSRI should be initiated.

### Clonazepam

- Initiate dose at 0.25 mg BID for three days
- Increase to 0.5 mg BID for three days
- If response not adequate, increase to 0.75 BID in one week
- If response not adequate, increase to 1.0 mg BID for one week
- If symptoms not substantially improved and minimal side effects increase by 0.5 BID per week to maximal dose (3.0 mg per day) or side effect limit.

When discontinuing clonazepam remember to taper very slowly – decrease the total daily dose by 0.25 mg weekly.

Benzodiazepines (including clonazepam) have a potential risk for addiction and abuse and are not recommended to be used long term. Youth should be warned of the risk of combining alcohol and benzodiazepines.

### Monitoring Treatment

Outcomes and side effects should be monitored regularly during treatment\*. The following chart is suggested as a guideline. For treatment outcome evaluation use the SCARED and the TeFA. For side effects assessment use the **Short Chehil-Kutcher Side Effects Scale (sCKS)** as illustrated in the following section.

Tool	Baseline	Day 1	Day 5	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8
SCARED	✓				✓		✓		✓		✓
TeFA	✓				✓		✓		✓		✓
sCKS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

\* The [PST based supportive rapport](#) model should be used at every visit as a framework within which you can structure your interaction with your teenage patient.

## Another way to monitor Treatment Outcomes

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

### Clinical Global Impression – Improvement Scale (CGI)

Compare how much the patient has improved or worsened relative to a baseline state at the beginning of the treatment?

0 = Not assessed

1 = Very much improved

2 = Much improved

3 = Minimally improved

4 = No change

5 = Minimally worse

6 = Much worse

7 = Very much worse

## Side Effects

Treatment emergent adverse effects (side effects) are those problems that arise during medication treatment and are caused by the medication. Side effects can include physical, emotional or behavioural problems. In order to best evaluate side effects a systematic baseline assessment of common problems should be conducted using a combination of structured and semi-structured evaluations.

**Semi-structured:** A useful question that may elicit side effects is *“Have there been changes in your body that you think may be a side effect?”*

**Structured:** A useful side effects scale that could be used at every clinic visit is found below.

## Suicidal ideation or behaviours (Health Canada Warning)

Suicidal thoughts or behaviours with onset or exacerbation once started on medication can be a side effect and requires stopping the medication due to the safety risk of this side effect. This side effect is most common in the first several months of initiating medication.

## Short Chehil-Kutcher Side Effects Scale (sCKS)\*

Item	None	Mild	Moderate	Severe
Headache				
Irritability/Anger				
Restlessness				
Diarrhea/Stomach Upset				
Sexual Problems				
Suicidal Thoughts				
Self Harm Attempt	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes describe: Was this a suicide attempt (intent to die) <input type="checkbox"/> No <input type="checkbox"/> Yes			
Any other problem?	1. 2.			

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

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

[Access the full Chehil Kutcher Side Effects Scale.](#)

### Hypomania

One rare side effect of medication treatment is the induction of hypomania. Some of the observable changes with hypomania include:

1. Decreased need for sleep – subjective feeling that sleep is not needed
2. Increase in goal directed activity (may be idiosyncratic or inappropriate)
3. Increase in motor behaviour (including restlessness), verbal productivity, and social intrusiveness
4. Subjective feeling of “wellness” with grandiose thoughts or increased emotional lability

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

### You have finished the recommended dosage– now what? \*

There will be three possible outcomes – each with a different intervention strategy.

#### ALWAYS CHECK ADHERENCE TO MEDICATION TREATMENT!!

One	Outcome	Strategy
	Patient not better or only minimally improved. SCARED $\geq$ 25 and little or no functional improvement.	<ul style="list-style-type: none"> <li>• Increase medication gradually (fluoxetine to 30 mg or sertraline to 75 mg) and refer to specialty child/adolescent mental health services</li> <li>• Continue weekly monitoring and all other interventions until consultation occurs</li> </ul>
Two	Outcome	Strategy
	Patient moderately improved. SCARED < 25. Some functional improvement (50-60% as determined from the TeFA)	<ul style="list-style-type: none"> <li>• If medication is well tolerated, increase slightly (fluoxetine to 30 mg daily or sertraline to 75 mg per day) and continue monitoring and interventions for two to four weeks then reassess. If no substantial improvement then refer.</li> <li>• If medication is not well tolerated or increase not tolerated continue at current dosage with monitoring and intervention for two more weeks then reassess. If no substantial improvement, then refer for specialty mental health treatment.</li> </ul>
Three	Outcome	Strategy
	Patient substantially improved. SCARED < 25 and major functional improvement.	<ul style="list-style-type: none"> <li>• Continue medication at current dosage</li> <li>• Gradually decrease monitoring and interventions visits to once every two weeks for two months and then monthly thereafter</li> <li>• Educate patients/caregivers about need to continue medications and how to identify relapse if it occurs</li> <li>• If first episode continue medications for 9-12 months before jointly deciding to discontinue. If discontinuing choose a suitable window (low stress period) and decrease gradually (over a period of four to six weeks) monitoring every two weeks.</li> <li>• Agree on “well checks” (for example, once every three months) and how to identify relapse if it occurs</li> <li>• If second or further episode obtain mental health consultation on treatment duration</li> </ul>

\* Treatment response in OCD is not as fast, usually around 12 weeks for response, and then gradual improvement over many months. OCD treatment may require higher dosages (we recommend referring youth to secondary/tertiary mental health services with severe OCD not responding to fluoxetine 40 mg/day or sertraline 150 mg/day).

**Medication doses used in specialty mental health services may occasionally exceed those usually found in primary care. Physicians monitoring youth who have been treated by specialists should discuss medication dose requirements prior to initiating dose changes.**

## **Checking Adherence to Medication Treatment**

Determining medication adherence can be difficult. It may be useful to predict the likelihood of medication non-compliance in advance. Openly recognizing that it is probable that the patient may miss one or more doses of medications is not only consistent with reality, but it allows the patient to miss the occasional dose without guilt, and to return to medication use without seeking permission to do so. Pharmacologically, if this happens occasionally there will be little if any substantive change in fluoxetine serum levels due to the long half-life of fluoxetine and its major metabolite (5 to 7 days). There can be a difference noticed in missing a dosage of sertraline as this medication has a shorter half life (just over 24 hours).

**There are three methods that can be used to monitor and assess treatment adherence.**

- 1) Enquire about medication use from the adolescent patient. Using such prompts as: “How have things been going with taking the medicine?” or “As we talked before, it is not uncommon to forget to take your medicine sometimes. How many times since we last talked do you think you may have not taken your medicine?” It is important not to admonish the adolescent who self-identifies occasional medication non-adherence. Simply acknowledge the difficulty in remembering and ask if there is anything you can help him/her with to improve their remembering. If the compliance with medications is poor it is important to address the issue openly, trying to understand what the reasons for the adherence difficulties may be. Once these have been identified they can be collaboratively addressed.
- 2) Enquire about medication use from the teen’s parents. Some teens and parents may choose to have the parents dispense the medication. However, dispensing is not the same as taking. So even if the parents are dispensing the medication it is important to ask the young person about medication use as described in method one above.
- 3) A pill count may sometimes be useful. Simply ask the young person or parent to bring the pill bottle to each appointment. However, an empty pill bottle does not equal treatment adherence. So, even in this situation it is important to ask the teen about medication use as described in method one above.

## **Duration of Treatment**

Once substantial improvement or recovery has occurred, the issue of duration of continued treatment arises. Maintaining treatment for a defined length of time is undertaken for the following reasons:

1. To allow for further, perhaps longer to develop, improvements in symptoms and functioning to take place
2. To allow for additional or alternative therapeutic interventions to occur: for example the addition of cognitive behavioural therapy to a initial treatment with medication alone
3. To decrease the risk of relapse
4. To decrease the risk of developing a co-morbid mental disorder (for example: substance abuse or major depressive episode)

Currently, there exists insufficient substantive research to allow for good evidence driven guidelines for the duration of ongoing treatment following recovery from the index anxiety disorder episode. Given the data (including clinical experience) currently available the following suggestions can be reasonably made:

1. Continue with the same dose of medication that was used to achieve recovery
2. Continue with the same treatment that was used to achieve recovery for a minimum of six to twelve months
3. Educate the patient about signs and symptoms that may suggest relapse and encourage immediate clinical review should these occur
4. Encourage scheduled mental health monitoring visits (“check up from the neck up”)
5. If a decision to discontinue medication is made, do not discontinue medication during times of increased stress (such as examinations at school or moving to a new city)
6. If a decision to discontinue medication is made, decrease dose gradually over a substantial period of time (for example: three months) and monitor closely for signs or symptoms of relapse
7. Advise adherence to mental wellness activities that include appropriate diet, exercise, and sleep hygiene; discuss risks of substance use.

If a patient relapses while on an adequate treatment regime evaluate the following:

1. Compliance with treatment
2. Onset of recent substance abuse
3. Onset of recent stressors that challenge the patient’s ability to adapt
4. Emergence of an alternative diagnostic possibility (such as: schizophrenia, bipolar disorder)

Referral to a mental health specialist is indicated if relapse occurs despite adequate ongoing treatment.

## Step 4. Suicide Assessment

In young people, unrecognized and untreated mental illness, especially depression, is the single strongest risk factor for suicide. Suicide risk is increased if the following factors are additionally present.

- Family history of suicide
- Substance abuse
- History of impulsivity
- **Hopelessness**
- Legal difficulties
- A previous suicide attempt
- Access to lethal means (such as firearms)

Suicide is more common in males, while self harm attempts are more common in females.

Suicide assessment should occur whenever severe anxiety/panic and/or depression is suspected and at specific points during treatment. Particular attention to suicide risk during treatment and monitoring of depression should occur if:

- A major life stressor occurs
- A friend or acquaintance commits suicide (including contagion in schools)
- A public figure commits suicide
- The media reports on a successful suicide

In these situations, exploration of the impact of the occurrences on suicide risk in your patient must be part of the monitoring and intervention visit.

### Tool for Assessment of Suicide Risk in Adolescents (TASR-A)

Dr. Kutcher and Dr. Chehil have developed a clinically useful tool that can assist the health provider in the evaluation of suicide risk. The [Tool for Assessment of Suicide Risk in Adolescents \(TASR-A\)](#) is available in pdf format and may be reproduced by clinicians treating anxious and/or depressed youth with the written permission of the authors. Information on how to use the TASR –A is also found in the [Toolkit](#).

The TASR-A has been developed for use by physicians and health providers with expertise in assessment and treatment of young people with depressive disorder. The TASR-A is copy written and can not be used for any other purposes other than that noted above without the expressed written consent of the authors.

**Health providers who would like to attend a training session on the clinical use of the TASR-A and suicide assessment in young people can contact the Office of the Chair at (902) 470-6598 for further information.**



## Assessing Suicide Risk

Suicide risk should be assessed at baseline and throughout the treatment period. Particular attention to suicide risk should be paid if any of the items identified as risk enhancers noted above occur. Not all young people who have decided to commit suicide will admit to their plan when asked so no suicide assessment is completely preventive of suicide. However, the assessment of suicide ideation and suicide plans will often identify young people who are at increased suicide risk and appropriate interventions (including hospitalization if suicide plans are in place) can be instituted.

### Suicide ideation

- Ask about ideas of dying, not wanting to live and of committing suicide
- Ask about feeling hopeless – A DEPRESSED YOUNG PERSON WHO FEELS HOPELESS IS AT INCREASED RISK – remember not everyone who has a diagnosis of anxiety or depression feels hopeless.

### Suicide plan

- If the youth admits to suicide ideation or hopelessness ALWAYS ask about suicide plan (e.g., “Have you thought about how you could kill yourself?”)

If the clinical judgement is that the young person is at high risk for suicide, this is a medical emergency. In such a case the young person must be taken by a responsible adult for immediate psychiatric assessment. Please ensure that a copy of the assessment plus information on how to contact the clinician is made available for the mental health specialist conducting the emergency consultation. Many clinicians find that personal contact of the assessing clinician prior to the assessment will facilitate a more useful consultation.

Young people with persistent suicidal ideation and frequent self-harm attempts should be referred to specialty mental health services for ongoing treatment.

## Step 5. Safety and Contingency Planning

The patient's safety is of paramount importance. Safety concerns trump all other considerations. Here are some suggestions for helping the teen being treated to stay safe. If the first contact health care provider is concerned about safety, mental health consultation should be obtained (see below).

**Emergency Contact Cards** – this consists of emergency contact numbers (for example: mental health services, emergency youth mental health services, emergency room service, etc.). Often this is written on a “wallet card” that can be carried by the young person at all times. Other methods such as electronically saved messages can also be used.

**Rapid Health Provider Availability** – often suicide and other safety issues arise in the context of stressful events. Allowing the young person or their caregiver to have easy access to a first contact health care provider (for example: by phone) can be a useful strategy. Clinical experience suggests that most young people or their caregivers rarely overuse this access.

**Help Phone** – while crisis telephone “hot-lines” have not been demonstrated to reduce suicide rates, they can be a valuable resource for young people in crisis. The young person should be provided with the phone number for the appropriate service in their area.

**No Suicide Contract** – this intervention although popular amongst some clinicians has not demonstrated effect on suicide rates. Its use is not recommended.

## Step 6. Referral Flags

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

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

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

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

- Symptoms severe and function significantly deteriorated (e.g. severe OCD, severe panic)
- Relapse from previous positive treatment response
- Persistent suicidal ideation with no intent or suicide plan
- Comorbid major depressive episode and family history of Bipolar Disorder
- History of suicide attempts
- Hypomania

### **Usual Referral:**

- Referral for Cognitive Behavioural Therapy if available
- Persistent school avoidance
- Anxiety disorder not responding to adequate first contact treatment trial

## Suggested Websites

- Resources for youth and families can be found on Anxiety BC website - [www.anxietybc.com/](http://www.anxietybc.com/) and on the [Kelty Mental Health Resource Centre website](#).
- [http://www.anxietybc.com/parent/complete\\_home\\_tool\\_kit.php](http://www.anxietybc.com/parent/complete_home_tool_kit.php) - For parents assisting their anxious children or teens
- Treatment guideline algorithm for health care providers in treatment of anxiety disorders and depressive disorders in youth - [www.bcguidelines.ca/gpac/guideline\\_depressyouth.html#algorithm](http://www.bcguidelines.ca/gpac/guideline_depressyouth.html#algorithm)
- American Academy of Child and Adolescent Psychiatry - [www.aacap.org](http://www.aacap.org)
- Sun Life Financial Chair in Adolescent Mental Health – [www.teenmentalhealth.org](http://www.teenmentalhealth.org)
- Collaborative Mental Health Care - <http://www.shared-care.ca/toolkits-anxiety>
- Healthy Living Toolkits, families and health professional versions, contain information, resources, and tools to help children and youth with mental health challenges develop healthy living habits <http://keltymentalhealth.ca/toolkits>.
- Child and Adolescent Needs and Strengths (CANS) <http://www.praedfoundation.org/About%20the%20CANS.html>

## Suggested Reading

Birmaher, B., Brent, D.A., Chiapetta L., Bridge, J., Monga, S., Baugher, M. (1999) Psychometric Properties of the Screen for Child Anxiety Related Emotional Disorders: A Replication Study. *J Am Acad Child Adolesc Psychiatry*, 38: 1230-1236.

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

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

Kutcher, S., Chehil, S. (2008). *Adolescent Depression and Anxiety Disorders* in Neinstein, L. S. et al *Adolescent Health Care: A Practical Guide*. 5<sup>th</sup> edition. Wolters, Lippincott, Williams & Wilkins. Philadelphia, pp. 994-1017.

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

Kutcher, S., Gardner DM. (2008) *SSRI Use and Youth Suicide: Making Sense of a Confusing Story* *Current Opinion in Psychiatry*. Jan; 21(1):65-9.

Kutcher, S., McDougall, A. & Murphy, A. (2009) *Preventing, detecting, and managing side effects of medication*. In: Rey, J. & Birmaher, B. *Treating Child and Adolescent Depression*. Lippincott Williams & Wilkins, Baltimore, Maryland, pp. 174-193.

Kutcher SP, Szumilas M. *Youth suicide prevention* *CMAJ*. (2008) Jan 29; 178(3):282-5

James A, Soler A, Weatherall R. (2005) *Cognitive Behavioural Therapy for Anxiety Disorders* (Review). *Cochrane Database of Systematic Reviews*, Issue 4.

Mann, J., Apter, A., Bertolote, J., et. al (2005) *Suicide Prevention Strategies: A Systematic Review*, *Journal of the American Medical Association*, Vol. 294, No. 16

Reinblatt, S.P. & Riddle, M.A. (2007) *The Pharmacological Management of Childhood Anxiety Disorders: A Review*. *Psychopharmacology*, 191: 67-86.

Spielmanns G., Pasek L. F., McFall J.P. *What are the active ingredients in cognitive and behavioral psychotherapy for anxious and depressed children? A meta-analytic review* *fClin Psychol Rev*. 2007 Jun; 27(5):642-54.

# Adolescent Anxiety Toolkit

## Index

- **Child and Youth Mental Health Screening Questions**
- **Risk Identification Table**
- **SCARED – Child and Parent versions**
- **Worry Reducing Prescription (WRP)**
- **Teen Functional Assessment (TEFA)**
- **Parenting Overview**
- **Kutcher Generalized Social Anxiety Disorder Scale for Adolescents (K-GSADS-A)**
- **Short Chehil-Kutcher Side Effects Scale (sCKS)\***
- **Clinical Global Improvement (CGI)**
- **Medication Monitoring Algorithm**
- **Sample letter requesting psychoeducational testing**
- **Sample letter regarding school support and accommodation**
- **DSM-IV Criteria for Anxiety Disorders**

## Child and Adolescent Mental Health Screening Questions

Historical factors:

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

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

Current situation:

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

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

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

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

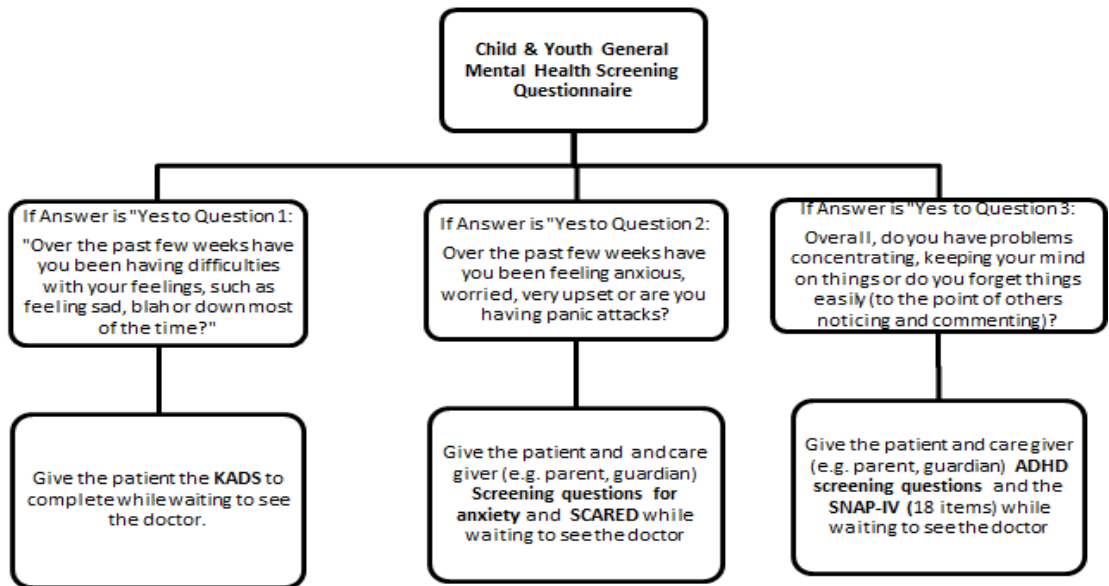
Remember that some cases of anxiety and depression may demonstrate positive scores on the concentration component of the SNAP. If no hyperactivity components are identified on the SNAP review for ADHD please assess for depression and anxiety using KADS and SCARED.

Next steps:

- If patient is positive for depression and either Anxiety or ADHD and the patient is an adolescent, continue to apply the KADS protocol for Depression.
- If positive for Depression, treat the depression and following remission review for presence of continued Anxiety Disorder or ADHD.

- If positive for Anxiety Disorder at that time, refer to specialty mental health services for specific anxiety disorder psychotherapy (CBT) and continue SSRI medication treatment.
- If positive for ADHD at that time, add a psychostimulant medication following the protocol in the ADHD module or refer to specialty mental health services.

## MOA's Child and Adolescent Mental Health Screening



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

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



## Anxiety Disorder in Youth, Risk Identification Table

Significant risk effect	Moderate risk effect	Possible “group” identifiers (these are not causal for anxiety disorder but may identify factors related to adolescent onset anxiety)
<ol style="list-style-type: none"> <li>1. Family history of anxiety disorder</li> <li>2. Childhood onset anxiety disorder</li> <li>3. Severe and/or persistent environmental stressors in childhood.</li> </ol>	<ol style="list-style-type: none"> <li>1. Children with shy, inhibited and/or cautious temperament (innate personality type).</li> <li>2. Family history of a mental illness (mood disorder, substance abuse disorder)</li> <li>3. Experiencing a traumatic Event</li> <li>4. Substance misuse and abuse (early onset of use including cigarette and alcohol)</li> </ol>	<ol style="list-style-type: none"> <li>1. School failure or learning difficulties</li> <li>2. Socially or culturally isolated</li> <li>3. Bullying (victim and/or perpetrator)</li> <li>4. Gay, lesbian, bisexual, transsexual</li> </ol>

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

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

Name:

Date:

### **Directions:**

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

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

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

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

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

### SCORING:

A total score of  $\geq 25$  may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific.

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

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

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

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

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

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

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

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

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

Name:

Date:

### Directions:

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

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

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

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

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

### SCORING:

A total score of  $\geq 25$  may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific.

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

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

## Worry Reducing Prescription (WRP)

It is useful to provide the young person with a simple outline developed collaboratively with them (and caregiver if appropriate) that clearly specifies what self-regulatory activities they should pursue during the diagnostic and treatment phases of their contact with their health provider. The [Worry Reducing Prescription](#) (WRP) is a useful and time efficient tool for managing stress that can be used to help the young person identify and plan their daily activities. It is embedded below and provided in the Clinician's Toolkit as well. In practice, the clinician can review the WRP with the patient, complete the form and then review it at the next office visit.

### Worry Reducing Prescription

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

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

### Enrolling the Help of Others

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

## Teen Functional Assessment (TeFA)

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

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

For each of the following categories, write down one of the following options in the space provided – “much better than usual”; “better than usual”; “about the same as usual”; “worse than usual”; “much worse than usual”. You can also give an example if you would like.

**Over the last week how have things been at:**

School: \_\_\_\_\_

Home: \_\_\_\_\_

Friends: \_\_\_\_\_

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

1) \_\_\_\_\_

2) \_\_\_\_\_

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

1) \_\_\_\_\_

2) \_\_\_\_\_

## Parenting Overview

- |   |  |
|---|--|
| <b>Love and Affection</b>                                 | <ul style="list-style-type: none"><li>• Spending quality time with the child individually; demonstrating physical affection; words and actions convey support and acceptance</li></ul>   |
| <b>Stress Management</b>                                  | <ul style="list-style-type: none"><li>• Parents learn how to manage their own stress and try not to let their stress drive relationships with their children</li></ul>   |
| <b>Strong Relationships</b>                               | <ul style="list-style-type: none"><li>• Demonstrate positive relationships with a spouse or partner and with friends<br/>Good modeling with individuals not related is especially relevant in that it can encourage a heavily stigmatized child/youth to reach out to others and establish their own health/balanced social network in preparation for adulthood</li></ul>       |
| <b>Autonomy/ Independence<br/>Education/<br/>Learning</b> | <ul style="list-style-type: none"><li>• Treat child with respect and provide environment to promote self-sufficiency</li><li>• Promote and model lifelong learning and encourage good educational attainment for the child</li></ul>   |
| <b>Life Management</b>                                    | <ul style="list-style-type: none"><li>• Provide for the needs of the child and plan for the future. Teach comprehensive life skills, especially for youth; avoid enabling and instead focus on youth's strengths, gradually targeting what could be improved upon in terms of personal hygiene, interpersonal skills, cooking, cleaning, organization and goal setting</li></ul> |
| <b>Behaviour Management</b>                               | <ul style="list-style-type: none"><li>• Promote positive reinforcement and punish only when other methods have failed and then consistent with the severity of the negative behavior and not in a harsh manner</li></ul>   |
| <b>Self Health</b>  | <ul style="list-style-type: none"><li>• Model a healthy lifestyle and good habits</li></ul>  |
| <b>Spirituality</b>                                       | <ul style="list-style-type: none"><li>• Provide an appropriate environment in which spiritual or religious components can be addressed</li></ul>   |
| <b>Safety</b>   | <ul style="list-style-type: none"><li>• Provide an environment in which your child is safe, monitor your child's activities; friends; health</li></ul>   |

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



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

### Section A: Fear and Avoidance

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

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

**Section B: Fear/Avoidance - Seminal Items**

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

	<b>Fear</b>	<b>Avoidance (0-3)</b>
1		
2		
3		

**Section C: Distress Quotient**

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

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

**Subscale score and total score**

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

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

## Short Chehil-Kutcher Side Effects Scale (sCKS)\*

Item	None	Mild	Moderate	Severe
Headache				
Irritability/Anger				
Restlessness				
Diarrhea/Stomach Upset				
Sexual Problems				
Suicidal Thoughts				
Self Harm Attempt	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes describe: Was this a suicide attempt (intent to die) <input type="checkbox"/> No <input type="checkbox"/> Yes			
Any other problem?	1. 2.			

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

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

[Access the full Chehil Kutcher Side Effects Scale.](#)

### Hypomania

One rare side effect of medication treatment is the induction of hypomania. Some of the observable changes with hypomania include:

1. Decreased need for sleep – subjective feeling that sleep is not needed
2. Increase in goal directed activity (may be idiosyncratic or inappropriate)
3. Increase in motor behaviour (including restlessness), verbal productivity, and social intrusiveness
4. Subjective feeling of “wellness” with grandiose thoughts or increased emotional lability

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

## Clinical Global Improvement (CGI)

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

### Clinical Global Impression – Improvement Scale (CGI)

Compare how much the patient has improved or worsened relative to a baseline state at the beginning of the treatment?

0 = Not assessed

1 = Very much improved

2 = Much improved

3 = Minimally improved

4 = No change

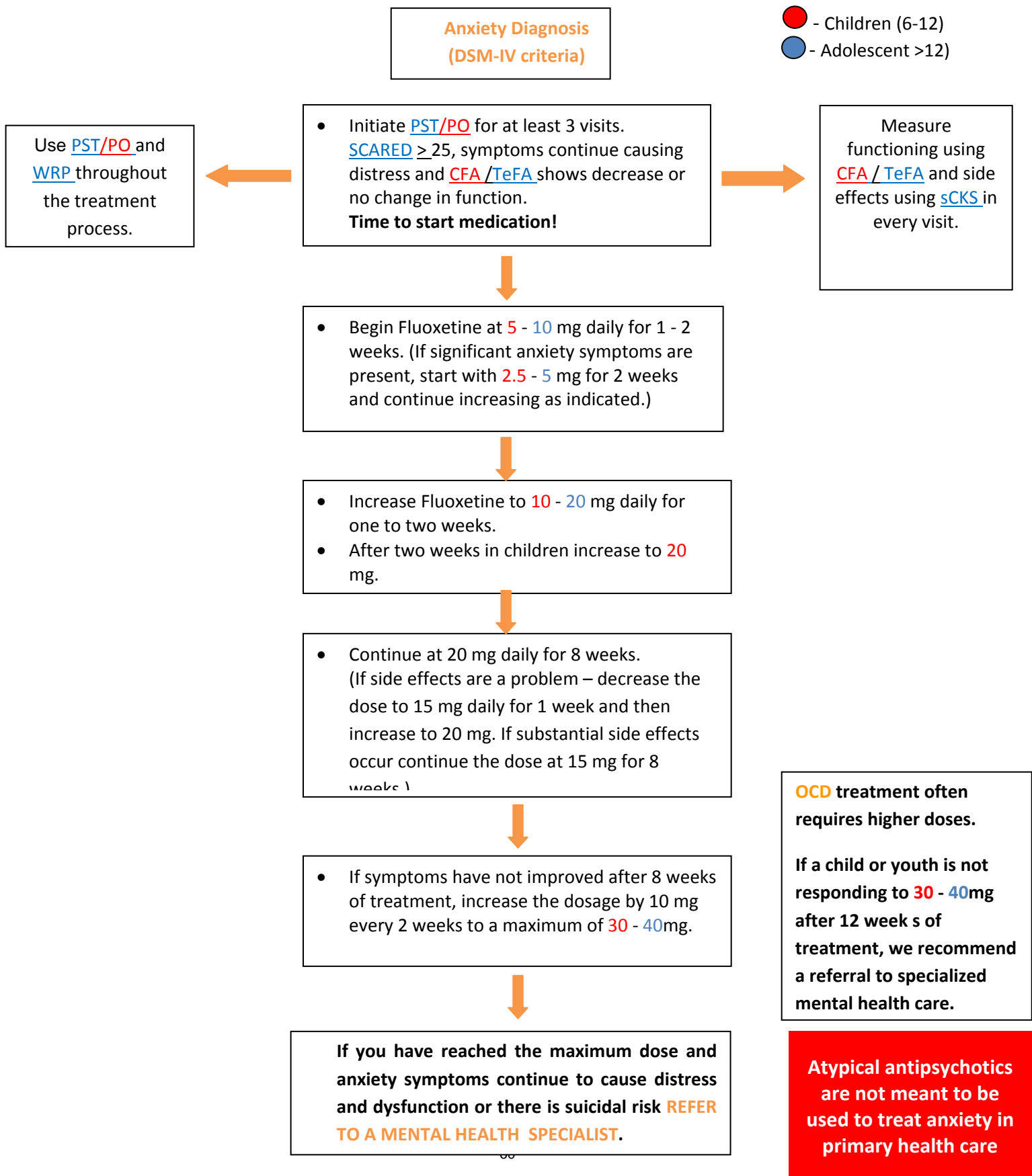
5 = Minimally worse

6 = Much worse

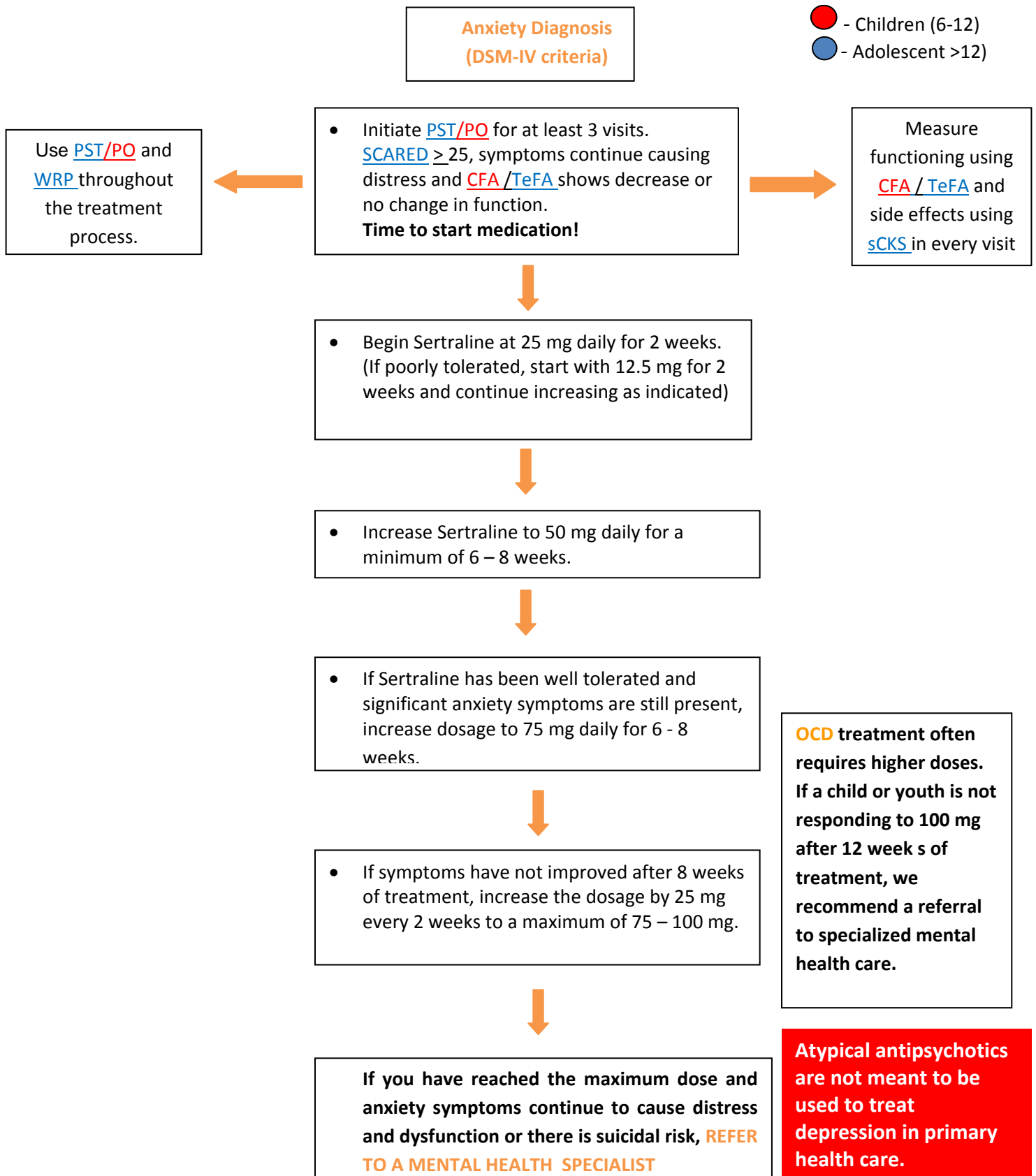
7 = Very much worse

# Medication Monitoring Algorithm

## Initiating and Monitoring Medication for Anxiety Disorders in Children / Youth



## Initiating and Monitoring Sertraline for Anxiety Disorders in Children / Youth



## SAMPLE LETTER REQUESTING PSYCHOEDUCATIONAL TESTING

Date:

Salutation:

**Re: Patient name \_\_\_\_\_ ; Request for psychoeducational testing**

With the permission of \_\_\_\_\_ (parent/guardian) of \_\_\_\_\_ (patient name), I am writing to request psychoeducational testing regarding the possibility of a learning problem concurrent with the diagnosis of ADHD.

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

I look forward to hearing from you soon.

Sincerely;

(Physician name)

## SAMPLE LETTER REGARDING SCHOOL SUPPORTS AND ACCOMODATIONS

Date:

Salutation:

**Re: Patient name \_\_\_\_\_ ; Request for School Support and Accommodation**

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

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

I look forward to hearing from you soon.

Sincerely;

(Physician Name)

Cc: Parent/guardian