Child and Adolescent Mental Health Literacy

Primary Care Interdisciplinary Team

Workbook and Resources

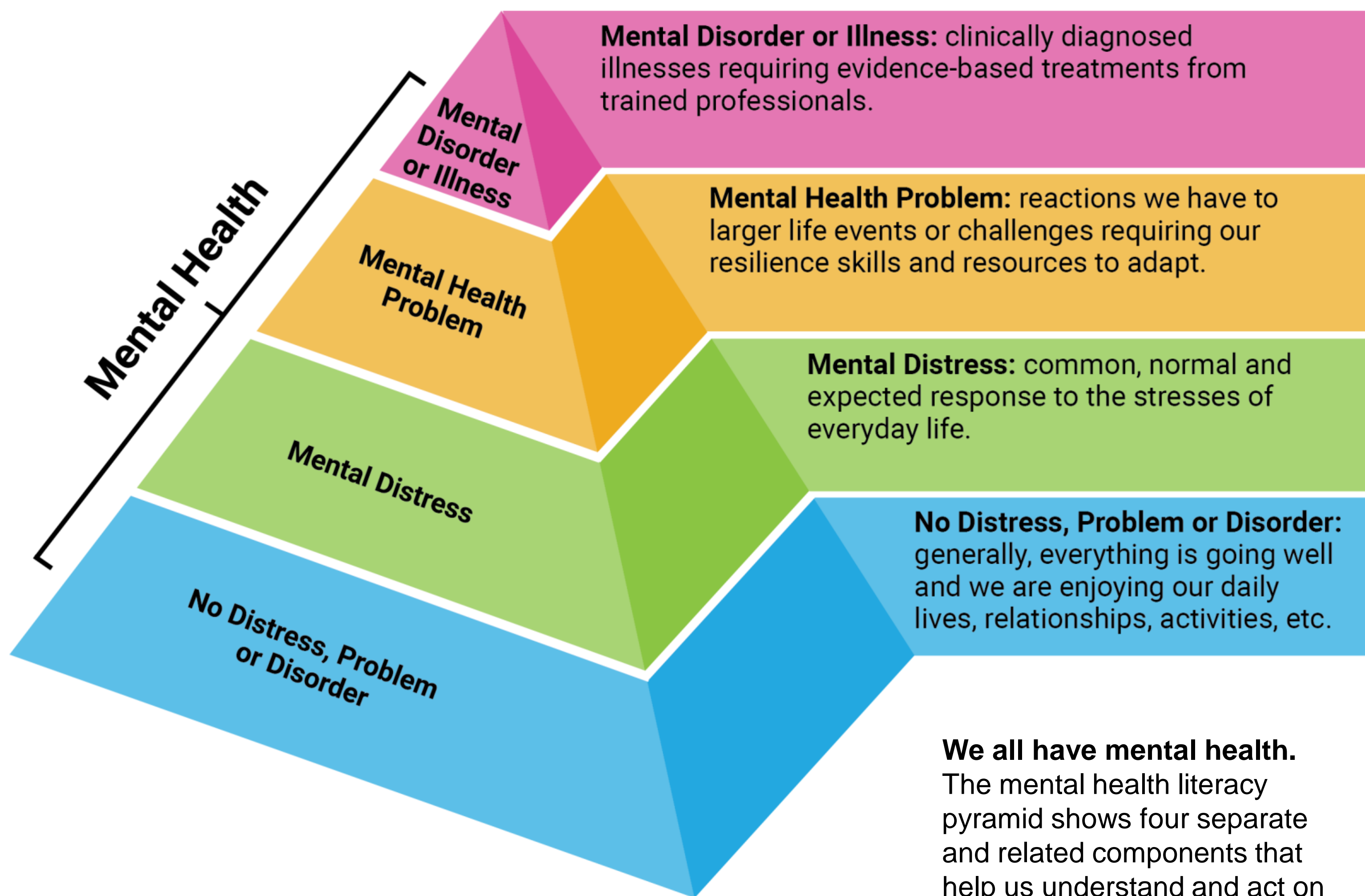
PERSONAL ASSESSMENT AND REFLECTION

My WHY: ____

	I think this area applies to me/my role	I think I need more knowledge or skill	New Knowledge: How this applies to me in my role	New Application: How I plan to apply this into my role
Literacy (learning about mental health language, mental health and mental disorder)				
Brain Function (learning about how brains function, the relation to disorder, and manifestations)				
Assessment (learning about assessment including information sources, symptoms, function, rating scales, severity)				
Treatment (learning about treatment including multi-modal, education, medication, evidence-based practice, the big 5)				
Engagement (learning about engagement including communicating and collaborating with patients and professionals)				
Anxiety (learning about symptoms, assessment, and treatment)				
Depression (learning about symptoms, assessment, and treatment)				
ADHD (learning about symptoms, assessment, and treatment)				
Resources (learning about resources for ongoing personal learning and/or where to direct patients)				

Language Matters

An important part of decreasing stigma and getting help to those who need it is understanding and using appropriate language to discuss mental health and mental illness. This is mental health literacy.



We all have mental health. The mental health literacy pyramid shows four separate and related components that help us understand and act on our mental health.

The pyramid is not a continuum. One experience of mental health does not lead to another, and we can even experience each level of the pyramid simultaneously.

mental health literacy

PEDIATRIC SYMPTOM CHECKLIST-17 (PSC-17)

Child's Name: Emme ______ Date of Birth: ______
Filled out by: ______ Today's Date: ______

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:		Never	Sometimes	Often
◆	Fidgety, unable to sit still	0	**1**	2
■	Feels sad, unhappy	0	**1**	2
◆	Daydreams too much	0	1	**2**
●	Refuses to share	**0**	1	2
●	Does not understand other people's feelings	0	**1**	2
■	Feels hopeless	**0**	1	2
◆	Has trouble concentrating	0	1	**2**
●	Fights with other children	**0**	1	2
■	Is down on him or her self	0	**1**	2
●	Blames others for his or her troubles	0	**1**	2
■	Seems to have less fun	**0**	1	2
●	Does not listen to rules	**0**	1	2
◆	Acts as if driven by a motor	**0**	1	2
●	Teases others	**0**	1	2
■	Worries a lot	0	1	**2**
●	Takes things that do not belong to him or her	**0**	1	2
◆	Distracted easily	0	1	**2**
Total ◆ 7	Total ● 2 Total ■ 4	Grand Total ◆ + ● + ■ 13		

© 1998, M. Jellinek & J.M. Murphy, Massachusetts General Hospital 17-item version created by W. Gardner & K. Kelleher

HEADSS is an acronym to aide in comprehensive assessment:

H Home

E Education and employment, eating and exercise

A Activities and peer relationships, social media

D Drug use, including prescribed medications, cigarettes, alcohol and other drugs

S Sexuality and gender

S Suicide and depression (including mood and possible psychiatric symptoms), safety and spirituality

COLDERR is an acronym for symptoms assessment:

C Characteristics

O Onset

L Location

D Duration

E Exacerbation

R Relief

R Response

Health Canada: Not indicated for use in patients <18 yrs

MEDICATIONS FOR DEPRESSION AND ANXIETY

	GENERIC NAME	(TRADE NAME)	AVAILABLE FORMS	DOSING	DURATION	PEAK EFFECT	FDA INDICATION	SIDE EFFECTS	COMMENTS
SSRI	citalopram	**(CELEXA)**	Tablets: 10, 20, 40 mg Solution: 10mg / 5ml	Start with 10mg given every morning Dose range: 10-40mg daily	24 hours	4-6 weeks	MDD (A)	Common: nausea, dry mouth, somnolence, insomnia, tremor, ejaculatory dysfunction, dyspepsia, decreased libido Serious: serotonin syndrome, increased suicidality / worsening depression, manie	Good side effect profile. Does not usually cause insomnia
SSRI	escitalopram	**(CIPRALEX)**	Tablet: 5, 10, 20 mg Solution: 5mg / 5ml	Start with 5mg (or less) given every morning Dose range: 5-20mg daily	24 hours	4-6 weeks	MDD & GAD (A)		S-isomer of citalopram
SSRI	fluvoxamine	**(LUVOX)**	Tablets: 25, 50, 100 mg	Start with 25mg given at bedtime; doses above 50mg should be divided Dose range: 50-300mg daily	24 hours	4-6 weeks	OCD (A)		Luvox brand discontinued in US
SSRI	paroxetine	**(PAXIL / PAXIL CR)**	Tablets: 10, 20, 30, 40 mg Solution: 10mg / 5ml CR: Tablets 12.5, 25, 37.5 mg ER	Start with 10 (12.5 if CR) mg daily (may be given at night) Dose range: 10-50 (12.5, 37.5 if CR) mg daily	24 hours	4-6 weeks	Paxil: MDD, OCD, Panic, SAD, GAD, PTSD (A) Paxil CR: MDD, panic, PMDD (premenstrual), SAD (A)		Increased risk of withdrawal symptoms if discontinued abruptly
SSRI	fluoxetine	**(PROZAC)**	Tablets: 10, 20, 40 mg Solution: 20mg / 5ml	Start with 5-10mg given every morning Dose range: 1-20 mg in children under 12y/o and 5-40mg (to 80 in some cases) mg in children over 12y/o	24-72 hours	4-6 weeks	MDD, OCD, Bulimia Nervosa, Panic, PMDD (A) MDD (8-17y/o) OCD (7-17 y/o)		Weekly form available. Long half life prevents withdrawal symptoms if dose is missed
SSRI	sertraline	**(ZOLOFT)**	Tablets: 25, 50, 100 mg Solution: 20mg/ml	Start 25mg per day Dose range 50-200 mg daily	24 hours	4-6 weeks	MDD, OCD, Panic, PTSD, PMDD, SAD (A) OCD (6-17 y/o)		
OTHER	venlafaxine	**(EFFEXOR / EFFEXOR XR)**	Tablets: 25, 37.5, 50, 75, 100 mg XR Capsules (Extended release): 37.5, 75, 150 mg	Start 75mg/day in divided doses; XR form can be used once daily Dose Range: 75-225mg (225mg max per FDA indication; however, in adults max frequently up to 375 mg)	8-12 hours XR: 24 hours	4-6 weeks	MDD (A) XR: MDD, GAD, Panic, SAD (A)	Common: nausea, dry mouth, somnolence, insomnia, tremor, ejaculatory dysfunction, dyspepsia, decreased libido Serious: serotonin syndrome, increased suicidality/ worsening depression, mania, HTN, seizures	Monitor BP closely
OTHER	duloxetine	**(CYMBALTA)**	Capsules: 20, 30, 60 mg	Adults: 40-60mg/day for MDD, up to 120 for GAD	24 hours	4-6 weeks	MDD, diabetic neuropathy, GAD (A)	Common: nausea, dry mouth, somnolence, insomnia, tremor, ejaculatory dysfunction, dyspepsia, decreased libido, HTN Serious: serotonin syndrome, increased suicidality/ worsening depression, mania, hepatotoxity, Stevens-Johnson syndrome, seizures	Monitor BP closely
OTHER	bupropion	**(WELLBUTRIN SR)**	Tablets: 100, 150 mg	Start: 100mg PO qam, incr. 100 mg/day qwk, divide dose bid Max: 400mg/day Info: avoid/ minimize alcohol use; do no cut/ crush/ chew	12-24 hours	4-6 weeks	MDD (A)		
OTHER	bupropion	**(WELLBUTRIN XL)**	Tablets: 150, 300 mg	Start: 150 mg PO qam, incr. after 7 days to 300mg/day Max: 450mg/day Info: avoid/ minimize alcohol use; do not cut/ crush/ chew	24 horus	4-6 weeks	MDD & SAD (A)		

CADDRA GUIDE TO ADHD PHARMACOLOGICAL TREATMENTS IN CANADA - FEBRUARY 2020

Line	Medication	Medications & Illustrations	Delivery	Duration of action[1]	Starting dose[2]	Release mode Immediate/ Delayed (%)	Dose titration per product monograph[3]
AMPHETAMINE-BASED PSYCHOSTIMULANTS							
First Line	Adderall XR®	Capsules 5, 10, 15, 20, 25, 30 mg	Granules can be sprinkled	~12 h	5-10 mg q.d. a.m.	50/50	▲5-10 mg at weekly intervals Max. dose/day: Children = 30 mg Adolescents & Adults = 20-30 mg
First Line	Vyvanse®	Capsules 10, 20, 30, 40, 50, 60, 70[4] mg Chewable Tablets 10, 20, 30, 40, 50, 60 mg	Capsule content can be diluted in liquid or sprinkled Chewable tablets should be chewed thoroughly	~13-14 h	20-30 mg q.d. a.m.	Not Applicable (Prodrug)	▲10-20 mg by clinical discretion at weekly intervals Max. dose/day: All ages = 60 mg
Second Line	Dexedrine®	Tablets 5 mg Spansules 10, 15 mg	Scored Tablet Beaded Formulation	~4 h ~6-8 h	Tablets = 2.5 to 5 mg b.i.d. Spansules = 10 mg q.d. a.m.	100/0 50/50	▲5 mg at weekly intervals Max. dose/day: (q.d. or b.i.d.) Children & Adolescents = 20-30 mg Adults = 50 mg
METHYLPHENIDATE-BASED PSYCHOSTIMULANTS							
First Line	Biphentin®	Capsules 10, 15, 20, 30, 40, 50, 60, 80 mg	Granules can be sprinkled	~10-12 h	10-20 mg q.d. a.m.	40/60	▲10 mg at weekly intervals Max. dose/day: Children & Adolescents = 60 mg Adults = 80 mg
First Line	Concerta®	Extended Release Tablets 18, 27, 36, 54 mg	Osmotic-Controlled Release Oral Delivery System (OROS®)	~12 h	18 mg q.d. a.m.	22/78	▲18 mg at weekly intervals Max. dose/day: Children & Adolescents = 54 mg Adults = 72 mg
First Line	Foquest®	Capsules 25, 35, 45, 55, 70, 85, 100 mg	Granules can be sprinkled	~16 h	25 mg q.d. a.m.	20/80	▲10-15 mg in intervals of no less than 5 days Max. dose/day: Children & Adolescents = 70 mg Adults = 100 mg
Second Line	Methylphenidate short-acting Ritalin® SR	Tablets 5 mg (generic) 10, 20 mg (Ritalin®) Tablets 20 mg	Scored Tablet Wax Matrix Preparation	~3-4 h ~8 h	5 mg b.i.d. to t.i.d. Adult = consider q.i.d. 20 mg	100/0 100/0	▲5-10 mg at weekly intervals Max. dose/day: All ages = 60 mg
NON-PSYCHOSTIMULANT - SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR							
Second Line	Strattera® (Atomoxetine)	Capsules 10, 18, 25, 40, 60, 80, 100 mg	Capsule needs to be swallowed whole to reduce GI side effects	Up to 24 h	Children & Adolescents: 0.5 mg/kg/day Adults = 40 mg q.d. for 7-14 days	Not Applicable	Maintain dose for a minimum of 7-14 days before adjusting: Children = 0.8 then 1.2 mg/kg/day 70 kg or Adults = 60 then 80 mg/day Max. dose/day: 1.4 mg/kg/day or 100 mg
NON-PSYCHOSTIMULANT - SELECTIVE ALPHA-2A ADRENERGIC RECEPTOR AGONIST							
Second Line	Intuniv XR® (Guanfacine XR)	Extended Release Tablets 1, 2, 3, 4 mg	Pills need to be swallowed whole to keep delivery mechanism intact	Up to 24 h	1 mg q.d. (morning or evening)	Not Applicable	Maintain dose for a minimum of 7 days before adjusting by no more than 1 mg increment weekly Max. dose/day: Monotherapy: 6-12 years = 4 mg 13-17 years = 7 mg As adjunctive therapy to psychostimulants 6-17 years = 4 mg

Illustrations do not reflect actual size of pills/capsules. Longer-acting stimulants tend to have lower abuse potential than shorter-acting formulations. Non-stimulant formulations have no abuse potential. [1]Pharmacokinetic and pharmacodynamic responses vary from individual to individual. The clinician must use clinical judgment as to the duration of efficacy and not solely rely on reported values for PK-PD and duration of effect. [2]Starting doses in table are taken from product monographs. CADDRA recommends usually starting with the lowest dose available. [3]For specific details on how to start, adjust and switch ADHD medications, clinicians should refer to the Canadian ADHD Practice Guidelines (www.caddra.ca). [4]Vyvanse 70 mg is an off-label dosage for ADHD treatment in Canada. Original version of this sheet developed by Dr. Annick Vincent in collaboration with Direction des communications et de la philanthropie, Laval University. Access provincial and federal formulary information at tinyurl.com/uf3mxrl

Key Websites for Resources Discussed as well as Research and Guidelines Cited and/or Discussed in the Training

Primary Resource Websites Shown

- Mental Health Literacy: https://mentalhealthliteracy.org/
- CanREACH Resources: https://wp.hmhc.ca/canreach/canreach-alumni/
- Child Mental Health: https://childmentalhealth.ca/

Practice Guidelines

- DEPRESSION → GLAD-PC: http://www.gladpc.org/
- ADHD → CADDRA: https://www.caddra.ca/guidelines-free-copy/
- AGGRESSION → TMAY: https://www.ahrq.gov/sites/default/files/wysiwyg/chain/practice-tools/tmay-final.pdf

Key "Landmark" Studies Described

- **ADHD**
  - MTA: "A 14-Month randomized clinical trial of treatment strategies for attention-deficit/hyperactivity disorder (ADHD)". In: Arch Gen Psychiatry (1999) Vol 56 pages 1073-1086. By: The MTA Cooperative Group
  - MTA Cooperative Group: National Institute of Mental Health Multimodal Treatment Study of ADHD follow-up: changes in effectiveness and growth after the end of treatment. *Pediatrics* 2004;113:762-769.
  - PATS: "Efficacy and Safety of Immediate-Release Methylphenidate Treatment for Preschoolers With ADHD". In: Journal of the American Academy of Child and Adolescent Psychiatry (2006) Vol 45(11) pages 1284-1293.
  - Dalsgaard S, et al. Mortality in children, adolescents, and adults with attention deficit hyperactivity disorder: a nationwide cohort study. Lancet. 2015;385(9983):2190–2196.
  - Chang Z, et al. Stimulant ADHD medication and risk for substance abuse. J Child Psychol Psychiatry. 2014 Aug;55(8):878-85.
  - Shaw, P., et a. (2009). Development of cortical asymmetry in typically developing children and its disruption in attention-deficit/hyperactivity disorder. *Archives of general psychiatry*, *66*(8), 888–896.

- **DEPRESSION**
  - TADS: "Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents With Depression Study (TADS) randomized controlled trial". In: JAMA : the Journal of the American Medical Association (2004), Vol 292(7) pages 807-820.
  - Bridge JA et al. JAMA (2007) 297 1683-1696 Meta Analysis of SSRI RCTs
- **ANXIETY**
  - CAMS: "Cognitive Behavioral Therapy, Sertraline, or a Combination in Childhood Anxiety" In: The New England Journal of Medicine (2008). By: John T. Walkup, Anne Marie Albano, John Piacentini, et al.
  - Wang et al (2017) Comparative effectiveness and safety of cognitive behavioral therapy and pharmacology for childhood anxiety disorders: A Systemic Review and Meta-analysis. JAMA Pediatrics, 172.
  - Wynn et al (2015) Child/adolescent anxiety multimodal study: evaluating safety. Journal of the American Academy of Child and Adolescent Psychiatry, 54(3), 180-190

NEXT STEPS - APPLICATION

1) A specific NEW behavior / practice I will implement is:	

2) How you will do it (who, where, when, etc.)	

---

4) Obstacles that could get in the way of this new behavior / practice:	

---

5) Work around plan:	

---

3) Why you chose? Who for / who benefits?	

PEDIATRIC SYMPTOM CHECKLIST-17 (PSC-17)

Child's Name: ________________________ Date of Birth: ________________
Filled out by: ________________________ Today's Date: ________________

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:		Never	Sometimes	Often
◆	Fidgety, unable to sit still	0	1	2
■	Feels sad, unhappy	0	1	2
◆	Daydreams too much	0	1	2
●	Refuses to share	0	1	2
●	Does not understand other people's feelings	0	1	2
■	Feels hopeless	0	1	2
◆	Has trouble concentrating	0	1	2
●	Fights with other children	0	1	2
■	Is down on him or her self	0	1	2
●	Blames others for his or her troubles	0	1	2
■	Seems to have less fun	0	1	2
●	Does not listen to rules	0	1	2
◆	Acts as if driven by a motor	0	1	2
●	Teases others	0	1	2
■	Worries a lot	0	1	2
●	Takes things that do not belong to him or her	0	1	2
◆	Distracted easily	0	1	2
Total ◆ ___ Total ● _____ Total ■ _____		Grand Total ◆ + ● + ■ ___________		

© 1998, M. Jellinek & J.M. Murphy, Massachusetts General Hospital 17-item version created by W. Gardner & K. Kelleher