Edmonton Zone Primary Care and Pediatrics Transition Guidelines

For Child and Adolescent Mental Health

Review Transition Guidelines

Determine the appropriate level of service. If pediatric/CanREACH trained physician care is appropriate, review these guidelines for information on the referral prompts for specific child and mental health conditions/ diagnoses (page 2). There is also helpful information in these guidelines to support your care for patients prior to a referral.

An electronic version of this pathway is available at https://www.pcnconnectmd.com/pathways

Review List of Physicians

A list of Edmonton Zone pediatricians/ CanREACH trained physicians who may be open to receiving child and mental health referrals, and family physicians open to receiving stabilized patients is available at Connect MD.

Call 1-844-633-2263 to request the names of participating physicians.

Non-Urgent Referrals

In the referral letter:

- Indicate the symptoms or suspected diagnosis.
- Describe any functional difficulties or impairments.
- Comment on what has been tried and anything relevant to the referral. A consult note or note from a visit can be provided for context.
- If already completed, attach rating scales or other assessments.
- The above will help with triage/ timing of assessments.

Physician Phone Consultation with a Specialist for Advice

- Contact Connect MD at 1-844-633-2263 or visit https://www.pcnconnectmd.com/
- Royal Alexandra Hospital Pediatric Psychiatry On Call – 780-735-4111 (switchboard)

Urgent/Emergency Care

- Children's Mental Health Crisis Line – 780-407-1000
- Kids Help Phone - 1-800-668-6868
- Canadian Mental Health Association Distress Line – 780-482-HELP (4357)
- Addiction Helpline – 1-866-332-2322
- Access 24/7 – 780-424-2424
- Access Open Minds – 780-887-9781
- Stollery Children's Hospital Emergency Department
- Alberta Health Services Child and Adolescent Mental Health Walk-In Clinics (see resource list for information)

Primary Care Network EDMONTON ZONE

Alberta Health Services

CASA Child, Adolescent and Family Mental Health

Non Urgent Transitions

	Anxiety/Depression/Obsessive Compulsive Disorder	Attention Deficit Hyperactivity Disorder (ADHD)	Behavioural Concerns	Learning Concerns
REFERRAL TO PEDIATRICS/CANREACH TRAINED PHYSICIANS (and interim management)	• Diagnosis uncertain. • Assistance with medication initiation or review/assessment required OR medication has been started with little effect. • Arrangements for counselling (mental health intake (825) 402-6799, PCN mental health resources, private therapy, community resources) should be initiated but does not need to be completed. • It is recommended that the resource list is shared with patients.	• Diagnosis uncertain. • Assistance with medication initiation or review/assessment required. • If there are behavioural issues or aggression, a referral to parenting support should be considered. • It is recommended that the resource list is shared with patients.	• Functional impairment. • Behavioural concerns are not yet diagnosed (diagnosis unclear). • Behavioural interventions have been tried but have not been successful. • Referral to Alberta Health Services child and adolescent mental health programs is recommended. • It is recommended that the resource list is shared with patients.	• Screen for ADHD/anxiety/ mental health contributors and then follow those guidelines. • If not related to mental health, refer to a pediatrician. • Consider psychoeducational testing, if possible. • Investigate school supports. • It is recommended that the resource list is shared with patients.
TRANSFER OF CARE BACK TO PRIMARY CARE PROVIDER (provide ability to consult pediatrician/CanREACH trained physician if possible)	• Patient demonstrates stability/ has met the goals of care. • Patient declines further care.	• ADHD is well controlled. • Patient declines further care.	• Diagnostic/management plan has been developed.	• Diagnostic/management plan has been developed.
SHARED CARE (role clarity and communication between practitioners is recommended)	• Multiple co-mental health conditions that need longer care. • Co-morbid pediatric medical conditions that need longer care.	• Option for follow up with pediatrics/CanREACH trained physician for ADHD with family physician providing other care.	• To be established after diagnosis. • See the guidelines for the diagnosed condition.	• Not applicable.

Primary Care Network EDMONTON ZONE
Alberta Health Services
CASA Child, Adolescent and Family Mental Health

Child and Adolescent Mental Health Rating Scales

General Child and Adolescent Mental Health Rating Scales

Pediatric Symptoms Checklist (PSC-17) and Youth Pediatric Symptoms Checklist (Y-PSC-17) – A psychosocial screen designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible. PSC is the parent-completed version and Y-PSC is the youth self-report version. The PSC is available for parents of children and youth ages 4 and older and the Y-PSC can be administered to adolescents ages 11 and up. Available at: https://childmentalhealth.ca (fillable online) or https://cps.ca/en/mental-health-screening-tools (downloadable)

Anxiety Rating Scales

Generalized Anxiety Disorder 7-Item (GAD-7) – A brief scale for anxiety that scores common anxiety symptoms. Although this questionnaire is used mostly to detect one general anxiety condition, it can also help detect panic disorder, social anxiety disorder, and post-traumatic stress disorder. The GAD-7 is appropriate for adolescents aged 13 and up. Available at: https://www.ementalhealth.ca/index.php?m=survey&ID=3

Screen for Child Anxiety Related Disorders (SCARED, Parent and Child Versions) – A child and parent self-report instrument used to screen for childhood anxiety disorders including general anxiety disorder, separation anxiety disorder, panic disorder and social phobia. It also assesses symptoms related to school phobia. The rating scale is appropriate for children ages 8 to 18. Available at: https://childmentalhealth.ca (fillable online) or https://cps.ca/en/mental-health-screening-tools (downloadable)

Obsessive Compulsive Disorder (OCD) Rating Scales

Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS) – This measure may be used to assess the type and severity of obsessive-compulsive disorder symptoms in children and adolescents, as a screening measure to identify children and adolescents in need of further intervention, or to monitor improvement in OCD symptoms in children and adolescents following treatment/intervention. The rating scale is appropriate for children and youth ages 5 to 18. Available at: https://childmentalhealth.ca (fillable online) or https://projectteachny.org/wp-content/uploads/2017/09/CYBOCS.pdf (downloadable)

Screen for Child Anxiety Related Disorders (SCARED, Parent and Child Versions) – A child and parent self-report instrument used to screen for childhood anxiety disorders including general anxiety disorder, separation anxiety disorder, panic disorder and social phobia. It also assesses symptoms related to school phobia. The rating scale is appropriate for children and youth ages 8 to 18. Available at: https://childmentalhealth.ca (fillable online) or https://cps.ca/en/mental-health-screening-tools (downloadable)

Depression Rating Scales

Columbia Depression Scale – A 22 question rating scale to determine the likelihood that a teen has depression. The rating scale can be completed by teens (age 11 and up) and their parents. It also includes a mood monitoring form. Available at: https://childmentalhealth.ca (fillable online) or https://projectteachny.org/wp-content/uploads/2017/09/columbia_depression_scale_teen_parent.pdf (downloadable)

Patient Health Questionnaire (PHQ-9) – An easy-to-use patient questionnaire which scores each of the nine DSM-IV criteria. It is not a screening tool for depression, but it is used to monitor the severity of depression and to plan and monitor treatment. The rating scale is applicable for adolescents ages 12 and older. Available at: https://childmentalhealth.ca (fillable online) or https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/depression_patient_health_questionnaire.pdf (downloadable)

Attention Deficit Hyperactivity Disorder (ADHD) Rating Scales

Swanson, Nolan, and Pelham (SNAP-IV) – The 26-item scale for parents is an abbreviated version of the SNAP-IV 90 question rating scale. Items from the DSM-IV criteria for ADHD are included for the two subsets of symptoms: Inattention and Hyperactivity/Impulsivity. Items from the DSM-IV criteria for oppositional defiant disorder (ODD) are also included as it is often present in children with ADHD. The rating scale is appropriate for children ages 5 to 18. Available at: https://childmentalhealth.ca (fillable online) or https://www.caddra.ca/wp-content/uploads/SNAP-IV-26.pdf (downloadable)

Vanderbilt ADHD Parent Diagnostic Scale – A psychological assessment tool for parents of children aged 6 to 12 designed to measure the severity of ADHD symptoms. This rating scale also includes items related to other disorders which are frequently comorbid with ADHD and assesses the impact of the ADHD symptoms on learning

(reading, writing, math). Available at: https://childmentalhealth.ca (fillable online) or https://soonersuccess.ouhsc.edu/Resources/Behavior-Rating-Scales (downloadable)

Behaviour Concerns Rating Scales

Pediatric Symptoms Checklist (PSC-17) and Youth Pediatric Symptoms Checklist (Y-PSC-17) – A psychosocial screen designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible. PSC is the parent-completed version and Y-PSC is the youth self-report version. The PSC is available for parents of children and youth ages 4 and older and the Y-PSC can be administered to adolescents ages 11 and up. Available at: https://childmentalhealth.ca (fillable online) or https://cps.ca/en/mental-health-screening-tools (downloadable

After the PSC-17 is completed, please refer to the slide on the next page as to the next recommended step.

Mental Health Screening and Evaluation Tools

Courtesy of Roxanne Swiegers, MD

Edmonton Zone Child and Adolescent Mental Health Resources

Urgent Care Supports

911
Mental Health Helpline - 1-877-303-2642
Access 24/7 - 780-424-2424
Access Open Minds (16-24) – 780-887-9781
Kids Help Phone – 1-800-668-6868
Canadian Mental Health Association Distress Line – 780-482-HELP (4357)

Stollery Children's Hospital
Sexual Assault Support Line – 780-423-4121
Child Abuse Hotline – 1-800-387-5437
Addiction Helpline – 1-866-332-2322

Alberta Health Services, Child and Adolescent Mental Health Walk-In Service

Location	Address	Phone	Hours
Centre Hope Building	4906 49 Ave, Leduc	780-986-2660	Wed, 12:30-4 pm
Northgate Centre	9499 137 Ave, Edmonton	780-342-2700	M-F, 12:30-4 pm
Rutherford Health Centre	11153 Ellerslie Rd SW, Edmonton	780-342-6850	M-F, 12:30-4 pm
St. Albert Provincial Building	30 Sir Winston Churchill Ave, St. Albert	780-342-1410	Wed, 12:30-4 pm
Spruce Grove (11-17, must be living in the Tri-Region area)	101-505 Queen St, Spruce Grove	780-960-9533	Fri, 9 am

Services

Alberta Health Services (AHS), Child Mental Health Intake – 825-402-6799
AHS Child and Youth Mental Health Services
https://informalberta.ca/public/common/viewSublist.do?cartId=1022351
CASA Child, Adolescent, and Family Mental Health https://www.casaservices.org/
Primary Care Network (PCN) Mental Health Services (*Patients with family physicians in PCNs have access to mental health resources, resources vary by PCN, physician referral required*)
https://albertafindadoctor.ca/pcn
Triple P Parenting https://www.triplep-parenting.ca/alb-en/triple-p/
Private community-based child and adolescent psychologists and social workers
https://psychologistsassociation.ab.ca/referrals/
https://www.psychologytoday.com/ca/therapists/ab/edmonton
https://acsw.ab.ca/site/New_Find_A_social_Worker

Low/No Cost Counselling
The Family Centre Counselling https://www.familycentre.org/counselling/
Catholic Social Services https://www.cssalberta.ca/
Jewish Family Services Edmonton https://www.jfse.org/
The Welling Centre (students) https://www.wellingcentre.com/low-cost-counselling-and-affordable-therapy-options/
Cornerstone Counselling (students, sliding scale) https://cornerstonecounselling.com/

Insight Psychological (students) https://www.insightpsychological.ca/counselling/practicum-students-reduced-rates/
School counsellors

Helpful Websites

Children, Youth and Families Addiction and Mental Health https://www.cyfcaregivereducation.ca/
Child Mental Health (includes online rating scales) https://childmentalhealth.ca/
Canadian Mental Health Association https://edmonton.cmha.ca/
ementalhealth https://www.ementalhealth.ca/ (medication information sheets)
Kids Help Phone https://kidshelpphone.ca/

Anxiety Resources

Anxiety Canada https://www.anxietycanada.com/
Mindshift App https://www.anxietycanada.com/resources/mindshift-cbt/

Obsessive Compulsive Disorder (OCD) Resources

Anxiety Canada https://www.anxietycanada.com/disorders/obsessive-compulsive-disorder/

Depression/Suicide Prevention Resources

Depression Hurts https://depressionhurts.ca/en/
Mental Health Literacy https://mentalhealthliteracy.org/mental-disorders/depression/
Canadian Association for Suicide Prevention https://suicideprevention.ca/
Hope by CAMH App https://www.camh.ca/hopebycamhapp
Calm Harm App https://calmharm.co.uk/
Suicide Safety Plan https://www.cheo.on.ca/en/resources-and-support/resources/P5681E.pdf

Attention Deficit Hyperactivity Disorder (ADHD) Resources

Canadian ADHD Resource Alliance https://www.caddra.ca/
Centre for ADHD Awareness, Canada https://caddac.ca/
Rolling with ADHD (parenting course) https://healthymindslearning.ca/rollingwith-adhd/
My Brain Needs Glasses (book)

Behavioural Concerns Resources

Canadian Pediatrics Society, Caring for Kids https://caringforkids.cps.ca/handouts/behavior-and-development
Family Connections http://www.familyconnectionsinc.net/

Learning Concerns Resources

Learning Disabilities Association of Canada https://www.ldac-acta.ca/
ementalhealth https://www.ementalhealth.ca/Canada/Learning-Disabilities/index.php?m=article&ID=16737

TALKING ABOUT ADHD

Knowing what to say and using the correct language when talking about ADHD can be difficult. This guide is designed to help. We recommend using these tips when talking about ADHD, whether in public or in private.

1 BE ACCURATE & OPTIMISTIC

We need to foster a better understanding of ADHD without causing harm or increasing negative perceptions.

2 ADHD IS A NEURODEVELOPMENTAL CONDITION

ADHD is NOT a behaviour disorder. Many people with ADHD also have other co-existing conditions.

3 ADHD IS A DISABILITY

With evidence based treatment, support, and appropriate accommodations people with ADHD can thrive and live a full and rewarding life.

4 IT'S ADHD NOT ADD

Please use the correct term.

5 ADHD PRESENTS....

There are **not** 3 types of ADHD.
ADHD **presents** in 3 ways:

1. **Predominantly inattentive symptoms** like a lack of concentration or focus.
2. **Predominantly hyperactive impulsive symptoms** like speaking or acting without thinking first.
3. A **combination** of both.

Available at: https://www.caddra.ca/talking-about-adhd/

DIFFERENT NOT DUMB

6 DON'T TRIVIALISE ADHD

ADHD is not just about hyperactivity, inattention and acting impulsively. Try and talk about the underlying strengths and challenges people with ADHD experience.

7 THE ADHD BRAIN IS DIFFERENT

People with ADHD display differences in brain structure, connectivity and function. As a result they can struggle to:

- Focus and pay attention
- Control their thoughts words, actions and emotions
- Develop social skills and self-awareness
- Store and recall information
- Make informed decisions
- Manage time effectively
- Be organised and prioritise
- Stay organised

8 ADHD IS NOT ALWAYS A 'SUPERPOWER'

For some people living with ADHD, 'superpower' is a positive description. But for others, it's a negative term and invalidates their experience. What is true, is that many people with ADHD can be creative, spirited, innovative and adventurous. They can also be great problem-solvers and think outside the box.

9 ADHD MEDICATION IS EFFECTIVE

It works by facilitating electrical signal transmission in the brain, improving cognitive function and reducing symptoms of ADHD.

POSITIVE IS POWERFUL

10

DON'T USE MEDICATION SLANG

Please don't refer to Methylphenidate (Ritalin) and Dexamphetamine as "Speed" or "Dexies". Try to use the correct names when talking about medication.

11

WITHOUT MEDICATION

There are non-medication strategies and supports that are known to assist people with ADHD, including psychological therapies, occupational therapy, coaching and other interventions. People affected by ADHD should talk to their doctor about what will work best for them.

12

DO CHILDREN GROW OUT OF ADHD?

ADHD tends to be a life-long condition. We don't know why but occasionally kids stop experiencing symptoms in adolescence. It's important to focus on positive strategies to live successfully with ADHD.

13

ADHD IS NOT AN EXCUSE

Please distance ADHD from immoral, unethical, criminal and sexist behaviour. While ADHD can lead to impulsive decision-making, using it as an excuse to explain away wrongful and dishonest behaviour is inappropriate.

14

YOU CAN'T HAVE A 'BIT OF ADHD'

Occasionally everyone gets distracted. But, for people with ADHD, being constantly distracted or being unable to focus effectively can impair their ability to learn, work and socialise.

WORDS MATTER

First-person language is best practice. Try to use positive phrases:
Children with ADHD or living with ADHD
People with lived experience of ADHD

Avoid language that feeds into stereotypes:
My son is ADHD or she's ADHD
He's got a bit of ADHD

It's good to check how someone likes to talk about themselves and their condition.

AVOID	USE
Suffer Suffering	Live or Lives with Struggles
Label	Diagnosis
Behaviour	Symptoms, Traits Characteristics
Naughty Brat	Unable to self-regulate all the time
Manage a child	Care for Support
Manage behaviour	Scaffold Guide
Deficit	Difference Neurodiverse
Treatable	Thrive with treatment and support

TO BE ACCEPTED

PLEASE REMEMBER THAT EFFECTIVE ADVOCACY FOSTERS EMPATHY AND UNDERSTANDING. IT ALSO PROMOTES ACCEPTANCE AND INCLUSION.

People with lived experience, clinicians and researchers have all contributed to this guide. It will continue to evolve and be updated as needed. We welcome suggestions and feedback.

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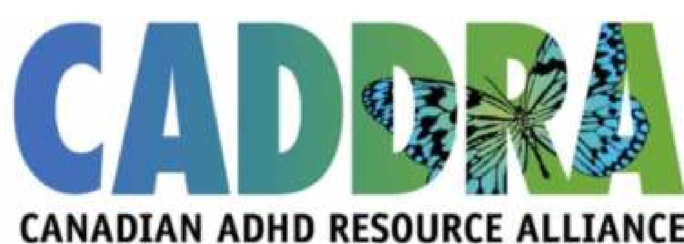
ENDORSED BY:

Australian ADHD Professionals Association
ND Australia
World Federation of ADHD
CADDRA - Canadian ADHD Resource Alliance
The Israeli Society of ADHD
The ADHD Foundation
ADHD Australia
Parents for ADHD Advocacy Australia
Turner Institute for Brain and Mental Health-Monash University
Brain and Mind Centre - University of Sydney
University of Melbourne



CADDRA
CANADIAN ADHD RESOURCE ALLIANCE

ADHD Information & Resources Handout

What is ADHD?

Attention Deficit Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder. Symptoms appear in childhood and may continue into adulthood. People with ADHD find it difficult to focus attention, regulate impulses, and control the urge to be physically active. Even emotions can be hyper- reactive.

ADHD affects about one in twenty children. Over half are still impaired by symptoms as adults. Adults with ADHD are easily distracted, struggling with mental restlessness, disorganization and procrastination. They have difficulty beginning and completing tasks, managing time and controlling behaviours and impulses. Some find it hard to manage their emotions, and may be labelled as “thin- skinned”, “hypersensitive” or “short-fused”. People with ADHD often channel their physical restlessness into work or sports activities. Some self-medicate with stimulants (e.g. caffeine, nicotine) or illicit drugs (e.g. cannabis, cocaine, speed). ADHD symptoms can profoundly affect personal and work lives, leading to a chronic sense of under-achievement and low self-esteem.

What causes ADHD?

While the exact cause is unknown, ADHD is most often inherited. ADHD can also be caused by traumatic brain injury, lack of oxygen, neurological damage, infection, premature birth or prenatal exposure to substances such as alcohol or nicotine.

ADHD is a neurodevelopmental condition. It is not caused by poor parenting or psychological stress. However, the environment can affect the expression and progression of ADHD.

ADHD is characterized by dysfunction in particular neurotransmitter systems (e.g. dopamine, noradrenaline) which are essential to normal brain function. The transmission of information in the nervous system appears to be impaired – as if the “go” and “stop” signals are delayed. Studies of brain function in people with ADHD reveal impairment in regions responsible for regulating certain behaviours, including initiating tasks, inhibiting unwanted behaviour, predicting consequences, retaining information and planning for the future. Appropriate treatment can diminish these symptoms and improve function.

Why have a diagnostic assessment?

People who have difficulty concentrating, or cannot sit still, do not necessarily have ADHD. ADHD is a medical diagnosis, and a full assessment is required. Unfortunately, there is no definitive laboratory test.

People request diagnostic assessments for many reasons: Teachers may recommend an assessment to parents after noticing a student’s difficulty paying attention or sitting still in the classroom.

Increased information on ADHD in the media and online has led to more self-referrals among adults. Once a child is diagnosed, parents may seek assessment for themselves if they recognize ADHD symptoms in their own behaviour. However, an individual comes to a healthcare professional, the first step is to discuss their problems and concerns.

Available at: https://www.caddra.ca/wp-content/uploads/CADDRA-ADHD-information-resources-handout.pdf"

What does a diagnostic assessment involve?

A diagnostic assessment includes an interview with the individual and/or people who know them well (parents, spouse, teachers, etc.) about symptoms and impairments. Psychological evaluations can help assess any learning and/or social issues. Other possible causes (medical or psychiatric) of symptoms are investigated. ADHD is only diagnosed if the symptoms are not caused by another condition and impair function. Exploring associated problems and conditions helps to establish an effective and personalized treatment plan. The affected individual, healthcare professional, and/or family must decide what (if any) treatment is needed.

A diagnosis of ADHD can explain symptoms. It is bittersweet and acceptance may take time, but people with ADHD and their families are often relieved to know the cause of the problem. Parents are freed of the burden of guilt. Raising a child with ADHD can be challenging and difficult, but poor parenting is not the cause.

A diagnosis of a chronic condition is seldom welcome, but it does open the door to treatment.

What is the treatment for ADHD?

Medication can dramatically improve symptoms, but is never enough on its own. When a child or adolescent is affected, the parents, student and school must work together to implement learning strategies and adjust parenting methods. Workplace accommodations may be required for adults. Resources, such as parent training or cognitive behavioral therapy for adults, are slowly becoming more available through the public healthcare system. Clinicians can also recommend academic accommodations. People with ADHD and their families should be empowered to make informed decisions regarding all aspects of treatment.

If these interventions do not reduce ADHD-associated impairments, pharmacological treatment may be helpful. Medication for ADHD can improve ability to focus by facilitating the flow of nerve signals, improving the transmission of information. A trial of more than one medication at more than one dose may be required to find the optimal approach for everyone. No medication decision is forever and it is suggested that regimens should be evaluated at least twice a year.

Several medications are available. The most common and most effective are stimulants – methylphenidate and amphetamines. Each comes in short-, intermediate- and long-acting forms. Common side effects include decreased appetite and sleeping difficulties. Those taking stimulants may be overly quiet or sad if the medication is too strong, or become irritable as it wears off.

If stimulants are not effective or have prohibitive side effects, the non-stimulant options in Canada are atomoxetine and guanfacine XR. Whatever pharmacological treatment is chosen, medication is started at a low dose, and then slowly increased to achieve maximum symptom control with minimal side effects. In some cases, other medications may be helpful if typical ADHD medications are not adequate.

Once the correct medication and the correct dose are determined, further evaluation can identify whether additional interventions are required. Any co-existing mood or anxiety disorder must be considered in the treatment plan. Stimulants can aggravate certain anxiety disorders. Several antidepressants act on noradrenaline or dopamine, and can assist with ADHD symptoms. (The specific effects of these drugs on ADHD have not yet been studied.) When ADHD co-exists with depression or anxiety disorders, treating the most disabling condition takes priority.

ADHD medications are effective in 50-70% of cases. Although generally well tolerated, like all drugs, they can have side effects. Discuss any potential treatment with your clinician and pharmacist. Although your healthcare provider will recommend evidence-based treatment options, each person is unique. Only a supervised medication trial can determine how it impacts your child or yourself.

Additional information on ADHD medications is available on the CADDRA website (http://www.caddra.ca).

Online Resources:

www.caddac.ca (Centre for ADHD Awareness, Canada)

http://www.attentiondeficit-info.com (Quebec, bilingual)

www.associationpanda.qc.ca/ (Quebec, in French)

www.chadd.org (U.S. website)

ADD CLINIC LOGO/PHYSICIAN INFO;CAN BE ADAPTED INTO THE EMR.

REQUEST FOR SCHOOL SUPPORT SERVICES

Date: ________________

Name and Address of School or Institution:

____

____

____

Dear Principal:

Re: Name of Student: ______________________________
Date of Birth: (dd/mm/yr) ______________________________
Name of Parent/Guardian: ______________________________

Signed parent/guardian consent exists for exchange of information with school staff.

The above-named student has been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). Best practices in the assessment and treatment of ADHD recommend a collaborative approach involving school staff and the student's medical care team to fully understand the child's range of challenges and possible explanations when a student presents with both learning and attention problems.

It would be helpful to receive the teacher's observations regarding this student's performance in the classroom, including behaviour, attention, activity level, and social interactions as well as the child's learning strengths and needs to help me in my treatment planning. In turn, my treatment recommendations may be helpful for the school's education plans for this student.

To provide an integrative approach to this student's care, it would be helpful if you would bring this student to the attention of the School Board's team of relevant professional support staff to provide information and consultation as appropriate. Also, I would appreciate knowing if there are any special education services in place currently for this child, and the focus of these supports.

I believe that ______________________________ should have an Education Plan developed to ensure that his/her needs are met as he/she/they proceeds through school. Alberta Education has provided useful guidelines teachers for which can be accessed via this link: https://www.learnalberta.ca/content/inmdict/html/adhd.html

OPTIONAL: [In accordance with Best Practice Guidelines, a psychological evaluation is indicated when there is a concern about academic functioning. I would ask that this be completed by the school board, at your request. While it is understood that psychoeducational assessment puts a financial burden on

the school board, it is an important part of the student's overall assessment to ascertain general intellectual ability, help confirm the absence or presence of specific learning disabilities, obtain a more comprehensive picture of impairments/challenges, and guide the student's individualized learning plan. The minimal assessment required should include the full Wechsler Intelligence Scale for Children, fifth edition (WISC-V) and a standardized measure of individual achievement in areas of literacy and numeracy.]

I wish to thank you in advance for your collaboration on this matter and I would appreciate receiving your feedback. Should you have any questions, please do not hesitate to contact me.

Sincerely,

Signature ______________________________ Telephone No. ______________________________________

Physician Name ________________________ Fax No. ______________________________________

ADD CLINIC LOGO/PHYSICIAN INFO;CAN BE ADAPTED INTO THE EMR.

REQUEST FOR SCHOOL SUPPORT SERVICES

Date: ________________

Name and Address of School or Institution:

____

____

____

Dear Principal:

Re: Name of Student: ____
Date of Birth: (dd/mm/yr) ____
Name of Parent/Guardian: ____

Signed parent/guardian consent exists for exchange of information with school staff.

The above-named student is diagnosed with Oppositional Defiant Disorder (ODD). Best practices in the assessment and treatment of ODD recommend a collaborative approach involving school staff and the student's medical care team to fully understand the child's range of challenges and possible explanations when a student presents with behaviour difficulties.

To provide an integrative approach to this student's care, it would be helpful if we work together. This letter can be used to secure additional school and classroom supports.

It is important to note that this child has many strengths which can be emphasized and enhanced. This diagnosis does not define the child's capabilities. He/She/They can do very well with the right approach and supports.

Alberta Education has provided useful guidelines for teachers which can be accessed via this link:
https://www.learnalberta.ca/content/inmdict/html/oppositional_defiant.html

OPTIONAL: Other comments

____

Thank you for your kind attention to this matter. Should you have any questions, please do not hesitate to contact me. Sincerely,

Signature ______________________________ Telephone No.

____

Physician Name ________________________ Fax No.

____

Primary Care Network EDMONTON ZONE
Alberta Health Services
CASA

Normal Child Behavior

How do I know if my child's behavior is normal?

Parents often have difficulty telling the difference between variations in normal behavior and true behavioral problems. In reality, the difference between normal and abnormal behavior is not always clear; usually it is a matter of degree or expectation. A fine line often divides normal from abnormal behavior, in part because what is "normal" depends upon the child's level of development (/English/family-life/health-management/Pages/Milestones-Matter.aspx), which can vary greatly among children of the same age. Development can be uneven, too, with a child's social development lagging behind his intellectual growth, or vice versa. In addition, "normal" behavior is in part determined by the context in which it occurs - that is, by the particular situation and time, as well as by the child's own particular family values and expectations, and cultural and social background.

Understanding your child's unique developmental progress is necessary in order to interpret, accept or adapt his behavior (as well as your own). Remember, children have great individual variations of temperament, development and behavior.

Three Types of Behavior

Some parents find it helpful to consider three general kinds of behavior:

1. **Some kinds of behavior are wanted and approved**. They might include doing homework, being polite, and doing chores. These actions receive compliments freely and easily.
2. **Other behavior is not sanctioned but is tolerated under certain conditions**, such as during times of illness (of a parent or a child) or stress (a move, for instance, or the birth of a new sibling). These kinds of behavior might include not doing chores, regressive behavior (such as baby talk), or being excessively self-centered.
3. **Still other kinds of behavior cannot and should not be tolerated or reinforced**. They include actions that are harmful to the physical, emotional, or social well-being of the child, the family members, and others. They may interfere with the child's intellectual development. They may be forbidden by law, ethics, religion, or social mores. They might include very aggressive or destructive behavior (/English/health-issues/conditions/emotional-problems/Pages/Disruptive-Behavior-Disorders.aspx), overt racism or prejudice, stealing, truancy, smoking or substance abuse, school failure, or an intense sibling rivalry.

Your Response Plays a Role

Your own parental responses are guided by whether you see the behavior as a problem.

Frequently, parents over interpret or overreact to a minor, normal short-term change in behavior. At the other extreme, they may ignore or downplay a serious problem. They also may seek quick, simple answers to what are, in fact, complex problems. All of these responses may create difficulties or prolong the time for a resolution.

Behavior that parents tolerate, disregard or consider reasonable differs from one family to the next.

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Some of these differences come from the parents' own upbringing; they may have had very strict or very permissive parents themselves, and their expectations of their children follow accordingly. Other behavior is considered a problem when parents feel that people are judging them for their child's behavior; this leads to an inconsistent response from the parents, who may tolerate behavior at home that they are embarrassed by in public.

The parents' own temperament, usual mood, and daily pressures will also influence how they interpret the child's behavior.

Easygoing parents may accept a wider range of behavior as normal and be slower to label something a problem, while parents who are by nature more stern move more quickly to discipline their children. Depressed parents, or parents having marital or financial difficulties, are less likely to tolerate much latitude in their offspring's behavior. Parents usually differ from one another in their own backgrounds and personal preferences, resulting in differing parenting styles that will influence a child's behavior and development.

When There Is No Response

When children's behavior is complex and challenging, some parents find reasons not to respond. For instance, parents often rationalize ("It's not my fault"), despair ("Why me?"), wish it would go away ("Kids outgrow these problems anyway"), deny ("There's really no problem"), hesitate to take action ("It may hurt his feelings"), avoid ("I didn't want to face his anger") or fear rejection ("He won't love me").

Your Pediatrician Can Help

If you are worried about your child's behavior or development, or if you are uncertain as to how one affects the other, consult your pediatrician as early as possible, even if just to be reassured that your child's behavior and development are within a normal range.

Additional Information:

- How to Shape & Manage Your Young Child's Behavior (/English/family-life/family-dynamics/communication-discipline/Pages/How-to-Shape-Manage-Young-Child-Behavior.aspx)
- Components of Good Communication (/English/family-life/family-dynamics/communication-discipline/Pages/Components-of-Good-Communication.aspx)
- Milestones Matter: 10 to Watch for by Age 5 (/English/family-life/health-management/Pages/Milestones-Matter.aspx)

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BEHAVIOUR PROBLEMS IN CHILDREN AND ADOLESCENTS

Nobody's perfect and all children will have bouts of bad behaviour. They may have temper tantrums, or talk back to their parents or teachers. When things start to get out of hand, however, it may be a clue that something in the child or teen's life needs attention.

Children and teens can seem irritable or even hostile when they are tired or aren't feeling well. They may argue with parents or disobey them because they are trying to show that they're growing up.

Young children may lie because they are too young to understand the difference between the truth and a lie. Sometimes they lie to get themselves out of trouble. This is normal. When they act this way all the time, or when this behaviour gets them into trouble all the time at home, at school, or with other kids in the neighbourhood, they may have what we call a disruptive behaviour disorder.

There are two main types of disruptive behaviour disorders – Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD).

A child who has a lot of temper tantrums, or is disobedient or argues with adults or peers on a regular basis, may have Oppositional Defiant Disorder (ODD). More serious problems like frequent physical aggression, stealing or bullying may be a sign of Conduct Disorder (CD).

> Disruptive behaviour disorders can be identified in pre-schoolers.
> If untreated, these children are more likely to fail at school and have difficulty holding a job in later life.

Children with Conduct Disorder often have trouble understanding how other people think. They may have trouble talking to others. They may think that other people are being mean to them or wish them harm when that isn't the case at all. Their language skills may be impaired, which means they have trouble using words and may act out instead. They may not know how to make friends with other children, and may feel sad, frustrated, and angry as a result.

TYPES OF BEHAVIOUR PROBLEMS

Oppositional Defiant Disorder (ODD):
Oppositional Defiant Disorder (ODD) is a type of behavior problem in which children are openly hostile, uncooperative, and irritable. They lose their tempers and are mean and spiteful towards others. They often do things to deliberately annoy other people. Most of their defiant behaviour is directed at authority figures, but they also sometimes behave the same way towards their siblings, playmates, or classmates. Their home life, school life, and peer relationships are seriously negatively affected because of the way they think and behave.

Conduct Disorder (CD):
Conduct Disorder (CD) is sometimes a later, more serious, phase of Oppositional Defiant Disorder (ODD). A child with CD is not just a child being "bad"; CD is a serious psychiatric disorder that requires professional help.

Children with this condition are aggressive all the time in a way that causes problems for them and their family. They may threaten or actually harm people or animals, or they may damage or destroy property. They may steal or shoplift, or even be involved in breaking and entering. They often lie or try to "con" other people. They frequently skip school.

What's normal and what's not?
It is important to understand that children can start acting out when there are other stresses in their lives. It may be that there has been a death in the family, or their parents are having arguments, or they are being bullied at school. Reassuring the child and providing extra care may help to get them through these stressful times. But if the child doesn't feel better and their behaviour doesn't improve, it is important to seek professional help, particularly if the problems last many months and are severe.

What causes behaviour problems?
Many children with Oppositional Defiant Disorder (ODD) have other mental health problems like depression, anxiety, or Attention Deficit/Hyperactivity Disorder (AD/HD). Their difficult behaviours are often a reaction to the symptoms of these conditions.

Children with ODD are more likely than other children to have a family history of behavior problems, mood problems, or substance abuse. Sometimes if caregiving is poor, supervision is lacking, or there is family discord or exposure to violence, children will respond by developing the symptoms of ODD. Having a mother with untreated depression also makes children more likely to have ODD. Both ODD and CD are associated with harsh parenting practices.

Available at: https://mentalhealthdeltadivision.com/wp-content/uploads/2017/12/Offord_Behaviour.pdf

How common are they?

Disruptive behaviour disorders appear to be more common in boys than in girls, and they are more common in urban than in rural areas. Between 5% and 15% of school-aged children have Oppositional Defiant Disorder (ODD). A little over 4% of school-aged children are diagnosed with Conduct Disorder (CD).

How long do they last?

Behaviours that may signal the beginnings of ODD or CD can be identified in preschoolers. Most children with ODD symptoms "grow out of it" but some do not. Some may go on to develop CD. Children and adolescents with CD whose symptoms are not treated early are more likely to fail at school and have difficulty holding a job later in life. They are also more likely to commit crimes as young people and as adults.

What treatment is effective?

Cognitive behavioural therapy (CBT) can help children with Oppositional Defiant Disorder (ODD) improve their mood and control their anger. CBT works by making the child aware of the thinking patterns that fuel their behaviour, and teaching them ways of counteracting that thinking.

Social skills training may also be helpful to the child with ODD. Family therapy that helps change how the family functions can also help.

Good parenting practices can help the child and benefit the family as a whole. Treatment that focuses on new ways of parenting, or that involves family, school and community, can be effective.

Many parents of children with Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) punish their children harshly and are very critical of them, usually because of their own life experience and because they suffer from depression. Changing these parenting practices can help the child and benefit the family as a whole. If the parents, particularly the mothers, are unable to develop new ways of parenting, their children may go on to develop the more serious condition of Conduct Disorder (CD).

In treatment, it is very important to focus on other conditions the child may have. Children who have AD/HD, depression, or anxiety tend to lose symptoms of Oppositional Defiant Disorder (ODD) when their other problems are successfully treated. These are often easier to treat than ODD.

Conduct Disorder (CD) is harder to treat than Oppositional Defiant Disorder (ODD), and becomes worse as a child gets older. This makes early intervention extremely important. Programs that can be effective include parent training, family therapy, and Multisystemic Therapy (MST), an intensive program that treats the whole family and also involves school and community. Programs that are punitive or threatening in nature are not shown to be effective and may even cause more harm than good.

BOOKS

No More Misbehavin': 38 Difficult Behaviors and How to Stop Them by Michele Borba, Jossey-Bass (2003) ISBN: 0787966177

Kids are worth it! Revised Edition : Giving Your Child the Gift of Inner Discipline by Barbara Coloroso, Harper Resource; Rev. Ed. (2002) ISBN: 0060014318

The Difficult Child by Stanley Turecki, Bantam; 2nd Rev. Ed. (2000) ISBN: 0553380362

How to Behave So Your Children Will, Too! by Sal Severe, Penguin USA (2003) ISBN: 0141001933

Your Defiant Child: Eight Steps to Better Behavior by Russell Barkley, Guilford Press (1998) ISBN:1572303212

Discipline: The Brazelton Way by T. Berry Brazelton, Perseus Publishing (2003) ISBN: 0738207837

Making Children Mind Without Losing Yours by Kevin Leman, Fleming H Revell Co. (2000) ISBN: 0800757319

Raising Your Spirited Child: A Guide for Parents Whose Child Is More Intense, Sensitive, Perceptive, Persistent, Energetic by Mary Sheedy Kurcinka, Perennial Press (1998) ISBN: 0060923288

Rage, Rebellion and Rudeness: Parenting in the new Millenium by G. Scott Wooding, Fitzhenry & Whiteside Limited (2003) ISBN:155041755X

Backtalk: Four Steps to Ending Rude Behavior in Your Kids by Carolyn Crowder, Fireside; (Mar. 1998) ISBN: 068484124X

WEB SITES

American Academy of Child and Adolescent Psychiatry
www.aacap.org/publications/factsfam

Canadian Paediatric Society
www.caringforkids.cps.ca/behaviour

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The Centre of Knowledge on Healthy Child Development is a project of the Offord Centre for Child Studies, a leader in helping kids grow and thrive. Go to **www.knowledge.offordcentre.com** for more information on how to identify, prevent and treat child and youth mental health problems.

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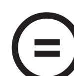
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