CARIBOU-2 Pathway Manual

Integrated Care Pathway for Adolescents with Depression

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The CARIBOU-2 Integrated Care Pathway for Adolescents with Depression: Pathway Manual

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Contents

Introduction

The purpose of this manual

The CARIBOU-2 pathway manual was developed to outline the steps of an integrated care pathway (ICP) for adolescents with depression. ICPs are structured, multidisciplinary care plans that map a treatment process from start to finish. The ICP was developed for youth ages 13 to 18, inclusive, though has potential for use in youth up to age 24. In this manual, the terms adolescent, youth and client are used interchangeably. Caregivers refers to parents, step-parents or other adults in a caregiving role for the youth participant.

What is the CARIBOU-2 Pathway?

This second iteration of the **C**are for **A**dolescents who **R**eceive **I**nformation '**B**out **OU**tcomes (The CARIBOU-2 pathway) ICP for adolescents with depression has seven components:

1 Assessment	2 Mood Foundations (Psychoeducation)	3 Psychotherapy Options	4 Caregiver Support (if desired)	5 Medication Options (if desired)	6 Team Reviews	7 Pathway Graduation
Determines whether a youth presenting to care is appropriate for the CARIBOU pathway and how the pathway might be further personalized to meet their treatment needs and wants, including risk management.	A single session for youth and their caregivers that provides information about depression, how sleep, eating, and exercise can impact mood and what treatment may look like for youth with depression.	Up to 16 sessions of Cognitive Behavioural Therapy or Brief Psychosocial Intervention tailored for youth with depression.	Up to eight support sessions for caregivers (e.g. parents or guardians) of youth who are experiencing depression	Medication options provided that follow a plan based on what researchers have found most effective for youth.	Meetings every four weeks with youth, their care team, and other important people to the young person to track progress and personalize treatment further.	Youth and team discuss a relapse prevention plan and engage in discharge planning, depending on the youth's needs.

These components are described in more detail in the Pathway Components section of this manual.

The CARIBOU-2 pathway spans up to 52 weeks of care after the initial assessment and attendance at Mood Foundations education session (Components 1 and 2) with enough time to provide the main treatment components. Of course, youth may exit the pathway prior to 52 weeks if they are in remission or the pathway is no longer a fit for their needs.

The CARIBOU-2 pathway is intended to apply to ≥80 percent of youth presenting for outpatient care with depression as a primary concern recognizing that some youth with depression may require specific alternate care to address life circumstances or co-occuring difficulties.

The main outcomes of interest for youth in the CARIBOU-2 pathway are:

1. Decrease in depressive symptoms
2. Improvement in impact of symptoms on daily life.

Why consider adopting a care pathway for adolescents with depression?

Clinicians who treat adolescents with depression are struggling with increasing wait times, high need, lack of symptom improvement and needing multiple episodes of care. The CARIBOU-2 pathway aims to improve care for adolescents with depression by resourcing, organizing and training clinical teams to provide the best available care.

Who is this manual for?

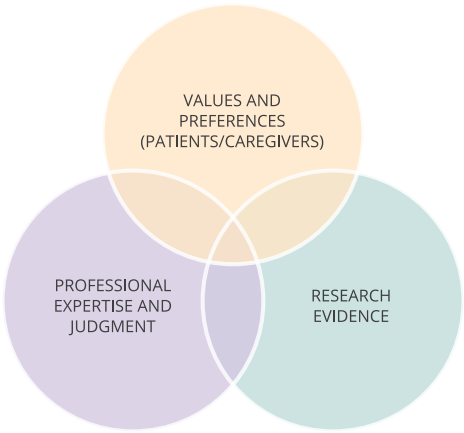
This manual is intended for clinicians (or mental health professionals), administrators and researchers who are interested in the evidence-based treatment of adolescents with depression. Clinicians may include social workers, social service workers, registered therapists, occupational therapists, nurses, psychologists, psychiatrists and/or supervised students in each of these disciplines.

How should this manual be used?

This manual is intended to be used by clinicians and administrators in conjunction with a structured training program provided by the CARIBOU development team. It is anticipated that this clinician training program can take up to 50 hours over 12 weeks (see Appendix N for breakdown of hours), which is comparable to other intensive training programs in mental health. Reading the manual is not sufficient on its own to provide the pathway.

Initially, we recommend readers familiarize themselves with the broad content of the manual so they can refer to detailed information when needed at a later time. Components 1, 2, 3 and 4 (Assessment, Psychoeducation, Psychotherapy Options and Caregiver Support) each have corresponding manuals which provide further details. The current manual is the main reference for the overall pathway as well as guidance for Components 5, 6 and 7 (Medication Options, Team Reviews and Pathway Graduation).

The CARIBOU-2 ICP was developed through reference to best research evidence as well as clinician, administrator, youth and caregiver (e.g. parents) input.[1,2] Reference to the relevant National Institute of Health and Care Excellence (NICE) guidelines were made as these have been appraised as being high quality.[3,4,5,6] The aim is to provide evidence-based care, as defined by Sackett and colleagues (1996, see Venn diagram below).[7] Treatment of depression in adolescents is complex and not every situation can be anticipated and guided by the CARIBOU manuals. When faced with decisions that need to be made for youth in the pathway, it is important that clinicians refer back to the principles of evidence-based care.



"The practice of evidence-based medicine means integrating individual **clinical expertise** with the best available external clinical **evidence from systematic research**..." and the "use of individual **patients' predicaments, rights, and preferences** in making decisions about their care."

—Sackett et al.

What will you learn in this manual?

The pages that follow will:

- outline the seven components of the CARIBOU-2 pathway for adolescents with depression
- describe people, materials and training required for each component.

After the component descriptions, this manual also discusses implementation considerations.

Pathway Components

1	Assessment	1a: Screening Assessment 1b: Detailed Assessment
2	Mood Foundations (Psychoeducation)	
3	Psychotherapy Options	3a: Management of Self-Injurious Thoughts and Behaviours 3b: Group Cognitive-Behavioural Therapy 3c: Individual Cognitive-Behavioural Therapy 3d: Individual Brief Psychosocial Intervention
4	Caregiver Support	
5	Medication Options	
6	Team Reviews	
7	Pathway Graduation	

COMPONENT

1a Screening Assessment

People Involved

- Youth participants
- Caregiver(s) (if the youth agrees)
- Trained intake worker or clinician

Materials Needed

- Eligibility Screening for CARIBOU Pathway (Appendix D)
- Mood and Feelings Questionnaire — Childhood Long Version (MFQ)[8] (Appendix M)
- Pathway Summary to assist in introducing youth to the pathway (Appendix I)
- CARIBOU Pathway Video

Clinician Training Required

One hour with CARIBOU development team.

Component Description

Youth, ages 13 to 18 years old (inclusive), presenting to clinical care undergo a program eligibility screening for the pathway to be completed by an intake worker and/or clinician. The screening usually takes about 5-10 minutes. The screening form is available in Appendix D.

Youth are offered the CARIBOU-2 pathway if:

- the youth and/or clinician believe that depressive symptoms are requiring clinical attention; and
- the Mood and Feelings Questionnaire score ≥ 22.

Do not offer youth the pathway if the following exclusion criteria are known or highly suspected:

- acute florid psychosis (delusions with no insight, persistent and impairing hallucinations, severely disorganized thinking);
- bipolar I or II (e.g., elevated mood and energy outside typical presentation and changes observable by others lasting for 4 consecutive days or more);
- severe eating disorders (e.g., restrictive eating patterns, associated with preoccupation with body image, leading to weight loss and associated medical complications and/or bingeing and purging at least 2 times a week);
- severe substance use disorders (e.g., daily cannabis use throughout the day, heavy alcohol/benzodiazepines use 3 or more times a week, cocaine/opiate use several days a month or more);
- intellectual disability;
- inability to speak, read or write English; and/or
- imminent risk (e.g., active suicidal ideation) requiring hospitalization.

When offering youth the CARIBOU-2 pathway, the clinician will describe the further components of the pathway in youth-friendly language. The Youth-facing CARIBOU Pathway summary can be provided to youth (see Appendix I). Clarification questions are invited. Youth partners have developed a video describing the pathway that youth and caregivers can watch (view video).

All eligible youth are offered:

- Detailed Assessment (Component 1b)
- Mood Foundations Group (Component 2)
- Psychotherapy options (Component 3). If the youth is experiencing suicidal ideation and/or self-harm, youth are offered 1-4 sessions on the management of these symptoms (Component 3a).
- Team reviews every 4 weeks where Measurement-Based Care and Shared Decision-Making take place (see Component 6 for more details)
- Pathway Graduation meeting at the conclusion of the program (Component 7).

If youth agree to caregiver involvement, caregivers are offered:

- Mood Foundations Group (Component 2)
- eight-session Caregiver-Adolescent Relationship Enhancement Group (Component 4).

If the clinician determines that the depression is moderate-to-severe , the youth may be offered medication options (see Component 5). The following information is used to assess severity:

- youth and caregiver perspective
- clinician judgment
- an MFQ score (with a cut-off of ≥ 43 indicating likely moderate-to-severe depression), and/or
- evidence of functional impairment (e.g., depression is interfering with school involvement, peer/family relationships or self-care).

The most responsible clinician adds the youth and caregivers to the corresponding waitlists. At the detailed assessment (Component 1b), it may occasionally be found that the adolescent is not an appropriate candidate for the pathway as more details arise (e.g., more severe substance use than initially known). In these situations, the clinician may support the youth to connect with services that would better meet their needs and advise youth to seek other care.

COMPONENT

1b Detailed Assessment

People Involved

- Youth
- Caregiver(s) (if youth agrees)
- Trained clinician

Materials Needed

- CARIBOU Initial Assessment Guide (2023)
- Measurment-Based Care Package (Appendix M)
  - Mood and Feelings Questionnaire — Childhood Long Version (MFQ) [8]
  - Revised Childhood Anxiety and Depression Scale — 25 item version, anxiety subscale only (RCADS-25-anx)[9]
  - Childhood Anxiety and Depression Life Interference Scale (CADLIS)[10]
  - Goals-Based Outcome Measure (GBO)[11]
  - Patient Global Impression — Severity Subscale (PGI-S)[12]
  - Columbia Suicide Severity Rating Scale — Revised (CSSRS)[13]
- CARIBOU Pathway Flow Diagram (Appendix A)
- CARIBOU Psychotherapy Stream (Appendix B)
- CARIBOU Medication Stream (Appendix C)

Clinician Training Required

CARIBOU development team will provide 2 hours of training to clinicians and local senior consultants through live videoconference.

Component Description

Once the adolescent has been screened as "eligible" in Component 1a, they can be booked for a more detailed assessment to further understand their unique needs. The detailed assessment can take up to two sessions of 90-minutes each (shorter for less complex presentations, or more experienced clinicians).

The *CARIBOU Initial Assessment Guide* is the main reference document and outlines a structured series of questions to get an understanding of the youth. As part of this assessment, the clinician will ask about acute safety issues and manage these as a priority; this may include evaluation of self-injurious thoughts and behaviours, aggression, concerns about driving, pregnancy-related considerations, child abuse, neglect, high-risk substance use and other high-risk activities. The clinician will also note factors that may influence treatment recommendations, such as: bullying, parental mental illness, or minority-related stress (i.e., stress associated with being part of a marginalized group). The clinician will also

present a biopsychosocial formulation and discuss this with the youth (and caregiver, if appropriate), adjusting the formulation according to feedback from the youth (and caregiver) to see that it fits their perspective. This formulation can be used in any of the types of psychotherapy provided in the pathway.

During the assessment process, youth will complete the associated measures within each of the following domains:

Domain	Measure
Depression	MFQ
Anxiety	RCADS-25-anx
Function	CADLIS
Personalized Goals	GBO
Global Mental Health	PGI-S

These measures can be completed before or after the initial assessment. During the first or second appointment, the clinician presents the results of these measures to the youth (and caregiver), being sensitive to the possibility that youth can interpret the scores in different ways (as validating, neutral or pathologizing)—and supportively responding to their reaction. If suicidal ideas are endorsed on the MFQ (items 16-19), the clinician would complete a measure of suicidal ideas and behaviours (C-SSRS) with the youth.

COMPONENT

2 Mood Foundations (Psychoeducation)

People Involved

- Clinician facilitators
- The youth
- Caregiver(s) (if the youth agrees)
- Optional: youth advisor engagement specialist or youth advisor who has been through the pathway.

Materials Needed

- Mood Foundations Youth Handouts
- Mood Foundations Facilitator Guide, including Mood Foundations Survey
- Option to use online "Mood Matters" videos (video 1 and video 2)

Clinician Training Required

CARIBOU development team will provide 2 hours of live training through videoconferencing.

Component Description

All youth and caregivers are offered a one-time, 90-minute, group education session called CARIBOU Mood Foundations. In a structured and interactive seminar format, attendees are provided information about the nature of depression, as well as the benefits of healthy sleep, exercise and eating habits.

Youth are provided with handouts summarizing this information. The "Mood Matters" videos also convey the same information, in a different modality. These can be used to support the education session.

The facilitator is responsible for calling youth and caregivers on the waitlist to give a brief overview of the rationale of the group and invite them to attend at the appropriate location and time. The Mood Foundations Facilitator Guide provides instruction on how to run the session.

The session starts with a discussion of how to use the information. Participants learn that it is difficult to make all of these changes at once and are encouraged to choose which lifestyle changes are going to be easiest and most effective for youth to work on first. Caregivers are asked to take a supportive (rather than punitive) stance as the material is covered. Caregivers are also encouraged to model these lifestyle behaviours at home.

Youth have given us feedback that they prefer that youth and caregivers are in separate groups. Sessions for youth and for caregivers can also be held on separate weeks if needed.

There is the option of having a selected youth who has been through the pathway attend and discuss their prior experience in the pathway (e.g. a youth engagement specialist or youth advisor). This may help engage new youth (and caregivers) with the material. Working with youth engagement specialists and youth advisors in this way will likely benefit from a structured approach and training. The CARIBOU development team can provide further details on how to support this process.

There is also a satisfaction survey for the Mood Foundations Group to improve youth and caregiver experiences in future sessions. This can be found at the end of the Facilitator Guide.

If needed, the Mood Foundations sessions can also be conducted individually (i.e., between the youth and/or caregiver and clinician).

For in-person Mood Foundations sessions, the agency can provide nutritious snacks to model the food choices encouraged in the session.

COMPONENT

3 Psychotherapy Options

Psychotherapy options are described in the following pages and Appendix B. Options include:

- 3a: Individual Management of Self-Injurious Thoughts and Behaviours (SITB)
- 3b: Group Cognitive Behavioural Therapy (CBT)
- 3c: Individual CBT or
- 3d: Individual Brief Psychosocial Intervention (BPI).

SITB management sessions are 1:1 sessions with a trained clinician. They are only done if the youth endorses suicidal ideation and/or self-harm. It involves 1-4 sessions that can be applied flexibly. These sessions are typically done prior to other psychotherapies to address risk. SITB may fluctuate throughout treatment, so the clinician and youth can return to these modules as needed.

After SITB management is optimized, the main clinician and youth can use the Psychotherapy Decision Aid to support Shared Decision-Making in choosing the therapy option (see Appendix J).

The CARIBOU development team recommends using the following order of preference as a default (for example, if the youth does not have much opinion on which one to choose).

1. Group CBT: Relatively moderate evidence, very resource efficient, likely shortest wait time.
2. Individual CBT: Relatively strongest evidence, resource intensive.
3. Individual BPI: Relatively moderate evidence, resource intensive (though less so than individual CBT).

Youth and clinicians may decide to offer individual over group CBT based on multiple factors, including the following:

- youth expressing limited willingness to attend group therapy
- youth did not previously respond to group CBT, but the youth and clinician perceive that individual CBT may be more beneficial and
- availability of therapy resources.

BPI may be particularly indicated if the youth has tried CBT, but did not engage in the model, or did not have important symptom improvement after 8 sessions.

COMPONENT

3a Management of Self-Injurious Thoughts and Behaviours

People Involved

- Youth
- Trained Clinician
- Caregiver (if youth agrees)

Materials Needed

- CARIBOU Youth Handouts for the Management of Self-Injurious Thoughts and Behaviours
- CARIBOU Clinician's Guide for the Management of Self-Injurious Thoughts and Behaviours

Clinician Training Required

The CARIBOU development team will provide 2 hours of live training by videoconference.

Component Description

Youth are offered up to 4 sessions of individual therapy based on NICE Guideline recommendations for the management of self-harm (2022).

Session topics include:

a. Planning for Life
- Strategies to try out when struggling with thoughts and behaviours related to self- harm.

b. Ramping Up: Getting ready for change
- Addressing motivation to change thoughts and behaviours related to self-harm.

c. Riding the Wave
- Sitting with and distracting oneself from thoughts and urges to self-harm.

d. Breaking the Chain
- Understanding specific situations, behaviours, thoughts and actions related to self-harm.

COMPONENT

3b Group Cognitive-Behavioural Therapy

People Involved

- Group of youth
- Two clinician facilitators

Materials Needed

- CARIBOU Group CBT — Youth Handouts
- CARIBOU Group CBT — Facilitator's Manual
- Cognitive Therapy Rating Scale; Self-report [14]
- Group Norms (Appendix K)

Clinician Training Required

- Foundations in CBT training (e.g. recognized university-affiliated CBT training; for example, CAMH Provincial System Support Program web-based course).
- CARIBOU CBT Manual-specific training provided by CARIBOU development team.
- Total of about 18 hours of training.

Component Description

Youth are offered 16-sessions of structured group CBT. If the youth agrees, they are invited to an orientation session with one of the group facilitators prior to starting group, where the basic theory of CBT, structure of the group and group norms are discussed. The orientation may also be done at the Mood Foundations session in group format.

The CARIBOU Group CBT content is based on the Adolescent Coping with Depression Course by Dr. Gregory Clarke;[15] however, the content has been reorganized to be deliverable in a modular format. The language has been updated, and new examples thought to fit better with today's youth have been added (e.g., examples including social media, texting, LGBTQ-related issues).

The group is presented in four four-week modules:

a. Power Up: Behavioural activation

b. Multiplayer: Communication and relationships

c. Level Up: Problem solving

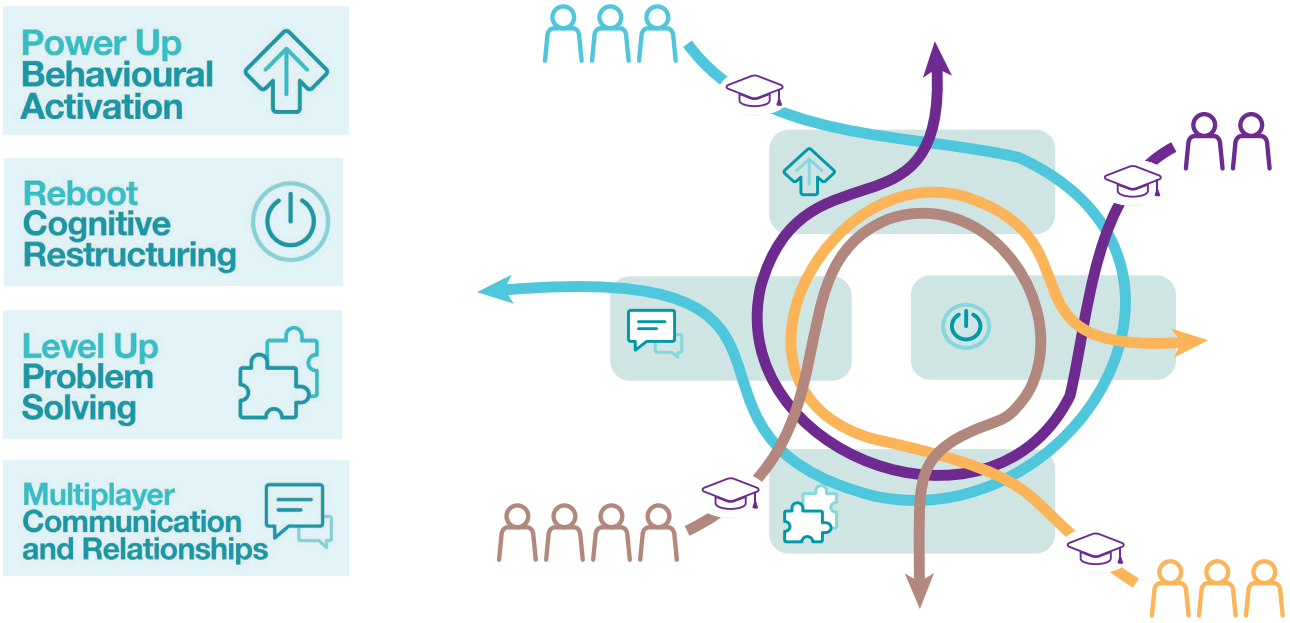
d. Reboot: Cognitive restructuring

Rolling Entry in the CARIBOU CBT Groups

The modular format allows for "rolling entry" where each youth can start the group at the beginning of any of the modules, and the group can run continuously. This helps with timing being flexible for entry into the group.

Every cohort of youth starts with a "Mood Foundations" session, held every 4 weeks.

There are 4 modules that each cohort of youth is offered.



Each module has 4 weekly sessions,
for a total of 16 sessions.

The CARIBOU Group CBT — Facilitator's Manual outlines the modules in detail and provides instructions for facilitators. Youth are provided with handouts that correspond to each module (CARIBOU Group CBT Youth Handouts).

COMPONENT

3c Individual Cognitive-Behavioural Therapy

People Involved

- Youth
- Clinician (therapist)

Materials Needed

- CARIBOU Individual CBT — Youth Handouts
- CARIBOU Individual CBT — Therapist Manual
- Cognitive Therapy Rating Scale; Self-report

Clinician Training Required

- Training is identical to Component 3b and only needs to be done once.

Component Description

The individual CBT manual is very similar to the Group CBT manual with some small modifications.

Up to 16 weekly sessions are recommended. The 4 modules can be delivered in whichever order is collaboratively determined by the youth and the therapist.

COMPONENT

3d Individual Brief Psychosocial Intervention

People Involved

- Youth
- Clinician (therapist)

Materials Needed

- Brief Psychosocial Intervention (BPI) — Youth Handouts (available through the CAMH development team)
- Brief Psychosocial Intervention (BPI) — Clinician Manual (available through the CAMH development team)
- The BPI Session Adherence Scale Short form (Appendix G)

Clinician Training Required

The CARIBOU development team will provide up to 12 hours of training, over 2 days.

Component Description

Up to 12 sessions of individual therapy through BPI are permitted within the pathway. Many youth require fewer than 12 sessions, and sessions can be spaced out as needed (whereas CBT is typically delivered in weekly sessions).

In BPI, the following are discussed as the main themes in therapy:

- how to understand depression given the youth's experiences
- ways to increase meaningful activities in the youth's life
- how to problem-solve through stressful situations in the youth's life
- ways to increase the youth's sense of connection in relationships
- ways to work directly with the youth's supports (e.g., family and school)—and sometimes even bring family members into the session—to discuss how to create an environment where depression symptoms can get better.

BPI (up to 12 sessions) was studied in a large clinical trial of adolescents with depression. It was found to be just as effective as CBT (up to 20 sessions) and Short-Term Psychodynamic Therapy (up to 28 weeks).[16]

COMPONENT

4 Caregivers-Adolescent Relationship Enhancement (CARE) Group

People Involved

- Caregivers
- Two clinician facilitators

Materials Needed

- CARE Group — Caregiver Handouts (available through the CAMH development team)
- CARE Group — Facilitator Manual (available through the CAMH development team)

Clinician Training Required

8 hours of training over two days by Dr. Madison Aitken or delegated member of the CARIBOU development team.

Component Description

Caregivers of youth with depression are invited to participate in a weekly eight-session group program.

The group uses cognitive-behavioural principles and addresses three main areas:

1. Psychoeducation about youth depression and the cognitive-behavioural model
2. Caregiver-youth communication
3. Problem solving.

Session structure follows a CBT framework, consisting of a check-in, review and discussion of home practice, introduction of skills and strategies, and home practice assignment. Sessions also include opportunities to role-play and practice the communication strategies, and for discussion among caregivers. For more details of findings from our pilot study of this component, see Aitken and colleagues (2023).[17]

If there are not enough caregivers to form a group session, this intervention can be provided by one clinician to a caregiver/couple.

Tip from caregiver representative: as the youth moves along this pathway, caregivers may benefit from hearing that it's ok to step back, to let go a bit, and allow their youth to speak their truth, even if they feel uncomfortable.

Providing examples of situations, case studies, or anecdotal stories might help alleviate caregiver fears at this early stage. If the caregiver feels their youth is being cared for the benefits likely filter down to the rest of the family (e.g., the youth's siblings)

COMPONENT

5 Medication Options

People Involved

- Youth
- Caregiver(s) (if the youth agrees)
- Prescriber (e.g., psychiatrist, pediatrician, nurse practitioner, physician assistant, family doctor, resident trainees)

Materials Needed

- SSRI Information Handout for Youth
- Measurement-Based Care package (Appendix M)
- CARIBOU Medication Stream (Appendix C)

Clinician Training Required

The CARIBOU development team will provide 2 hours of training to the prescribers once they are identified.

Component Description

Youth may be offered medication treatment in the following situations:

1. The youth has been assessed as having moderate-to-severe depression using the Mood and Feelings Questionnaire with a suggested cut-off score of ≥ 43, CADLIS and clinical judgment.
2. The youth's symptoms have not been responding to eight weeks of psychosocial interventions.
3. The youth (and caregivers) are agreeable to a trial of medications.

Please see the third page of the treatment pathway for the medication stream (Appendix C).

If the youth agrees, caregivers should be involved in discussions about antidepressant medications. Potential benefits and risks of the medications should be discussed with youth and caregivers—including the potential for increased self-injurious thoughts and behaviours, and agitation with these medications.[18] The prescriber needs to monitor for these side effects particularly within the first 7 to 10 days of being on the medication and have a safety plan should these side effects occur.

The titration schedule in the pathway is based on NICE guideline recommendations.[5] The schedule is suggested and not rigid. Measures are used to complement the clinical impression. The next section on Measurement-Based Care provides suggested definitions of response.

If the youth has had an adequate trial of fluoxetine prior to the pathway, sertraline would be tried first. If the youth has already had adequate trials of fluoxetine and sertraline, the prescriber may offer escitalopram (maximum 20mg/d) as third line and duloxetine (maximum120mg/d) as fourth line medication options.[19,20]

Note, that there is little evidence regarding medication prescriptions after the first trial of medications.[21] As a result, the case could be made for prescribers to offer the youth the option of not being on medication, if the youth has not tolerated or responded to a trial of fluoxetine. Medication trials may also be considered for moderate-severe co-occuring anxiety.[22,23,24]

COMPONENT

6 Team Reviews

People Involved

- Youth
- Caregiver(s) (if youth agrees)
- Main clinician involved in psychosocial interventions
- Any other mental health professionals currently involved (e.g., CBT group facilitator, CARE group facilitator, therapist)
- Ideally, the prescriber is also present if the youth is on medications. If the prescriber cannot be present, efforts should be made to ensure good communication between the prescriber and the remainder of the treatment team.

Materials Needed

- Data collection and visualization system for Measurement-Based Care (described below).
- CARIBOU Team Review Checklist (includes documentation from multiple disciplines) (version 2.0) (Appendix F)
- Psychotherapy Decision Aid (Appendix J)
- Medication Decision Aid
- Measurement-Based Care package (Appendix M)
- CARIBOU Pathway Flow Diagram (Appendix A)
- CARIBOU Psychotherapy Stream (Appendix B)
- CARIBOU Medication Stream (Appendix C)

Clinician Training Required

The CARIBOU development team will provide 2 hours of live videoconference training.

Component Description

Multidisciplinary team reviews are held every 4 weeks, up to 52 weeks. The team reviews are based on NICE guideline recommendations and are particularly helpful if there has been non-response to treatment. Team reviews involve the use of Measurement-Based Care and Shared Decision-Making, each described below.

MEASUREMENT-BASED CARE

Measurement-based care (MBC) "entails the systematic administration of symptom rating scales and uses the results to drive clinical decision making at the level of the individual patient."[25] To incorporate MBC, team reviews are held every four weeks over a span of up to 52 weeks. Youth complete the MBC package just prior to the team review. All members of the team review and discuss changes in scores of the measures and decide to continue or change the current treatment plan at the

indicated decision points according to the treatment algorithm, youth/caregiver values and clinician judgment. The scores and changes over time are presented using data collection and visualization software. Software options are constantly changing and being updated. Implementing agencies can discuss software options with the CARIBOU development team.

Fortney and colleagues have outlined evidence for optimizing measurement-based care:[25]

- Higher frequency of measurement and review (even up to once every two weeks) corresponds to better outcomes in adults.
- Focusing on percentage change since baseline, rather than cross-sectional scale score, leads to better results.
- Having clinical appointment soon after measurement is done leads to better improvement in mental health symptoms.

Considerations for being efficient with timing:

- If youth needs to be seen more frequently than once every four weeks, keep team reviews in mind so that meetings are not scheduled too closely together, or bundle a team review with a therapy session to be efficient with time.
- Use team reviews to incorporate pathway orientation, address acute stressors individually, follow-up on psychoeducation learning and encourage use of skills learned in therapy (including skills caregivers have learned).
- Consider having one clinician assigned for 50 minutes (if in active treatment) and the others for just 20 minutes (rather than everyone for 50 minutes).

In team reviews, it can be helpful to review and discuss the symptom change experienced by youth using cut-off change scores, which help with interpreting response to treatment. The definition of "response" is variable in the literature.[26] For the purposes of CARIBOU:

- a **response** is considered:
  - a 20% decrease in MFQ score at four weeks since the last major change in treatment,
  - or a 40% decrease in MFQ score at eight weeks since the last major change in treatment, coinciding with decision points used by Gunlicks-Stoessel et al.[27]
- **Remission** is defined as an MFQ score < 22[28] for a sustained period and adequate functioning on the CADLIS (no specific cut-off as of yet, need to prioritize clinical judgment here).
- Preliminary evidence from the CARIBOU development team suggests that a cut-off score of ≥ 43 on the MFQ represents moderate-to-severe depression (manuscript in development).

Typically, if a response or remission has occurred, treatment is continued as is. If there is no response, options for changing treatment are discussed; this may include starting, continuing, intensifying, tapering, combining, switching and/or stopping treatment components. More specific examples include:

- changing the dose or switching medications (or alerting the prescriber to nonresponse)
- changing the type/modality of psychotherapy
- providing further caregiver support
- addressing comorbid conditions
- targeting specific stressors (e.g., bullying, LGBTQ related-stressors) more directly.

Changes in functioning are also considered in the Team Review discussions. Sustained remission (i.e. over 8 weeks) may also be an indicator of appropriateness to discharge the youth to primary care.

Please see the CARIBOU Team Review Checklist (Appendix F) for more guidance on what to cover in Team Reviews.

SHARED DECISION-MAKING

Shared Decision-Making is also a key component of Team Reviews.[29,30,31] Decisions may include starting, continuing, intensifying, tapering, combining, switching and/or stopping treatment components. Principles of Shared Decision-Making include:

a. the youth and clinician are involved in the decision (a third person, such as a parent or caregiver, may also be involved)

b. all individuals exchange important information; most often, the clinician provides information on treatment options, while the youth (and caregiver/parent) provide information on context and values

c. a decision is made where all individuals agree to next steps (note that the clinician or caregiver may not agree that it is the best option, but an acceptable one).

Shared Decision-Making is thought to improve health outcomes by improving service user trust in the clinician, leading to greater adherence to the treatment.[32]

PROS AND CONS OF TEAM REVIEWS

There are pros and cons of this model that are important to acknowledge. Potential downsides of this model:

- requires considerable administrative co-ordination
- risks using more clinician time that might otherwise be used for other therapeutic work.

Potential benefits of this model:

- care is co-ordinated between disciplines; everyone can be updated on the youth's progress through the pathway (or updated on waitlist time)
- opportunity to promote engagement with treatment, including increasing engagement of caregiver(s)
- opportunity to prime youth and caregiver(s) on upcoming material to be learned in groups
- opportunity for youth to take material learned in group and apply it to life
- opportunity to review missed material (including Mood Foundations, CBT or CARE group)
- opportunity to see if severity of symptoms or risk of self-harm has changed
- evidence shows that active monitoring improves outcomes[25]
- opportunity to make collaborative decisions around medication
- potential for more efficient use of resources.

Remember, "clinical judgment" is a component of Sackett's model of evidence-based care, and if clinical judgment suggests that the next team review is not indicated, the meeting can be postponed with an 8 week interval between reviews.

COMPONENT

7 Pathway Graduation

People Involved

- Youth
- Caregiver(s) (if youth agrees)
- Main clinician involved in psychosocial interventions
- Any other mental health professionals currently involved (e.g., CBT group facilitator, CARE group facilitator, therapist).
- Ideally, the prescriber is also present if the youth is on medications. If the prescriber cannot be present, efforts should be made to ensure good communication between the prescriber and the remainder of the treatment team.

Materials Needed

- Measurement-Based Care symptoms trajectory graphs (method will be site-specific depending on resources)
- Youth-Oriented Discharge Summary (YODS) (Appendix H)
- Measurement-Based Care package (Appendix M)

Clinician Training Required

2 hours of training with Dr. Darren Courtney, or delegate from the CARIBOU development team.

Component Description

For sustained improvement in symptoms and functioning, it is important to have a coordinated approach to the end of the pathway. Discussions about the end of treatment can start early on in the course (i.e, during each Team Review), to help prepare for this transition.

Our group has created a "Youth-Oriented Discharge Summary" (YODS) to assist with structuring the process of completing the pathway (see Appendix H). The YODS helps structure the pathway graduation meeting with each section completed to create a clear plan for next steps. This approach was based on the work by Hahn-Goldberg and colleagues (2021).[33] Youth research partners and caregiver research partners also provided feedback on the components of the specific YODS being used.

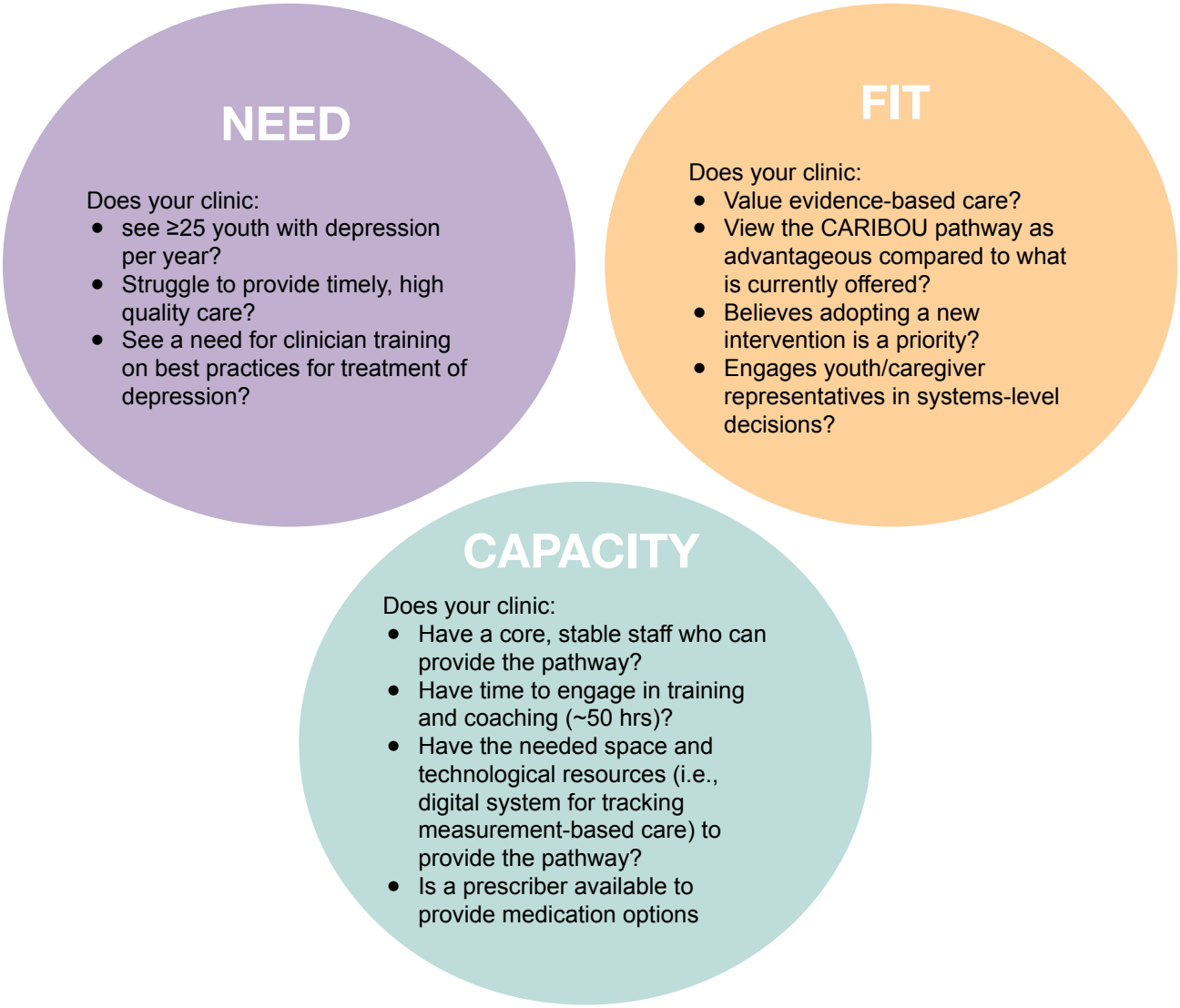
If the youth has achieved remission at the end of the pathway, discharge back to primary care is indicated. If the youth has not responded or remitted at the end of the pathway, the most responsible clinician and rest of the care team may offer alternative treatments or referrals elsewhere. Enrolment in research studies is ideal, if the youth is eligible, given that the evidence does not guide further care beyond this pathway to a rigorous degree and there is a need to build further evidence to inform treatment. The CARIBOU development team may be able to recommend current relevant research projects.

Implementation Principles

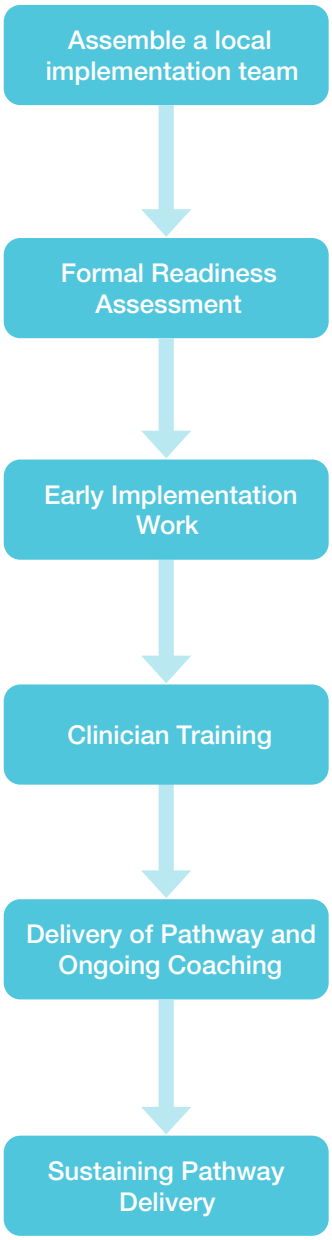
Preliminary Implementation Considerations

Before deciding to implement the CARIBOU-2 pathway, organizations must consider whether it is a good fit for them and if it is feasible to deliver.[34] Reference to this manual is not sufficient to implement the pathway. Implementation tools and support are needed (see implementation resources). The CARIBOU by CAMH development team will also need to support implementation (reach out to Cundill.Centre@camh.ca for more information).

Some key preliminary considerations are as follows:



Implementation Process



This may consist of:

- Managers,
- Senior Clinicians,
- Quality Improvement/ Data Specialist
- Youth representatives
- Caregiver (e.g. parent) representatives

One member leads and coordinates the team as the "champion".

This involves:

- Two 90-minute meetings between the CARIBOU development team and the agency's local implementation team to discuss agency need, fit and capacity to deliver the CARIBOU-2 pathway.
- Goal: The agency will decide whether to adopt the CARIBOU-2 pathway.

About 3 months before clinician training begins, the local implementation team will:

- Assign clinicians to roles in the pathway
  - At least 3 trained clinicians are recommended, with 1 local senior consultant for every 3 active clinicians.
- Arrange for clinician training
- Arrange for technological platforms (e.g., for measurement based-care or video-conference)

Clinicians will have up to 50 hours of training over 3 months:

- ~50% is asynchronous learning (e.g., web-based or readings)
- ~50% is synchronous learning (e.g., through interactive Webinars)
- see Appendix N for breakdown of hours by component

After launching the pathway in clinical care, clinician coaching will occur every 2 weeks:

- 2-hour webinar-based meetings between local clinicians, local senior consultant and the CARIBOU development team to discuss successes and barriers to implementation and delivery.

Local implementation teams will:

- Oversee fidelity to the pathway components and its implementation. (see Appendix E)

"Fidelity" is the extent to which an intervention is delivered as intended by the developers.

After 6 months of coaching, efforts to sustain the pathway locally are made:

- Local senior consultant continue to run coaching sessions every 2 weeks
- "Community of practice" meetings are held several times a year across CARIBOU-2 pathway implementing sites .
- The CARIBOU development team offers training for new staff being on-boarded in the event of staff turnover.
- As needed, meetings with the local implementation team and CARIBOU-2 development team are held.

Other helpful information

Deviations from the pathway

Deviations from the pathway are to be expected from time to time. These are permitted; however, clinicians are responsible for documenting such deviations in the clinical record using a Variance Recording Framework;[35] that is, clinicians should:

a. use the term "pathway deviation" in the chart when it arises for clear identification in chart review processes
b. describe the nature of the deviation
c. describe the cause or rationale of the deviation
d. describe anticipated outcomes of the deviation and follow-up plan to check that the deviation has been effective once implemented.

Continuous improvement plan, updates to the pathway and its materials

The original version of the CARIBOU pathway underwent a pilot study.[36] There is a community-based controlled clinical trial in process to further inform clinical and implementation effectiveness of the CARIBOU-2 pathway (manuscript in development). Further quality improvement initiatives will be created with further iterations of the pathway informed by this research.

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Glossary

Abbreviations

BPI
Brief Psychosocial Intervention

CADLIS
Childhood Anxiety and Depression Life Interference Scale

CAMH
The Centre for Addiction and Mental Health

CARE
Caregiver-Adolescent Relationship Enhancement

CARIBOU
Care for Adolescents who Receive Information 'Bout Outcomes

CBT
Cognitive-Behavioural Therapy

CSSRS
Columbia Suicide Severity Rating Scale

GBO
Goals-Based Outcome Measure

ICP
Integrated Care Pathway

MBC
Measurement-Based Care

MFQ-C
Mood and Feelings Questionnaire — Childhood Long Version

NICE
National Institute of Health and Care Excellence

PGI-I
Patient Global Impression - Improvement Subscale

PGI-S
Patient Global Impression — Severity Subscale

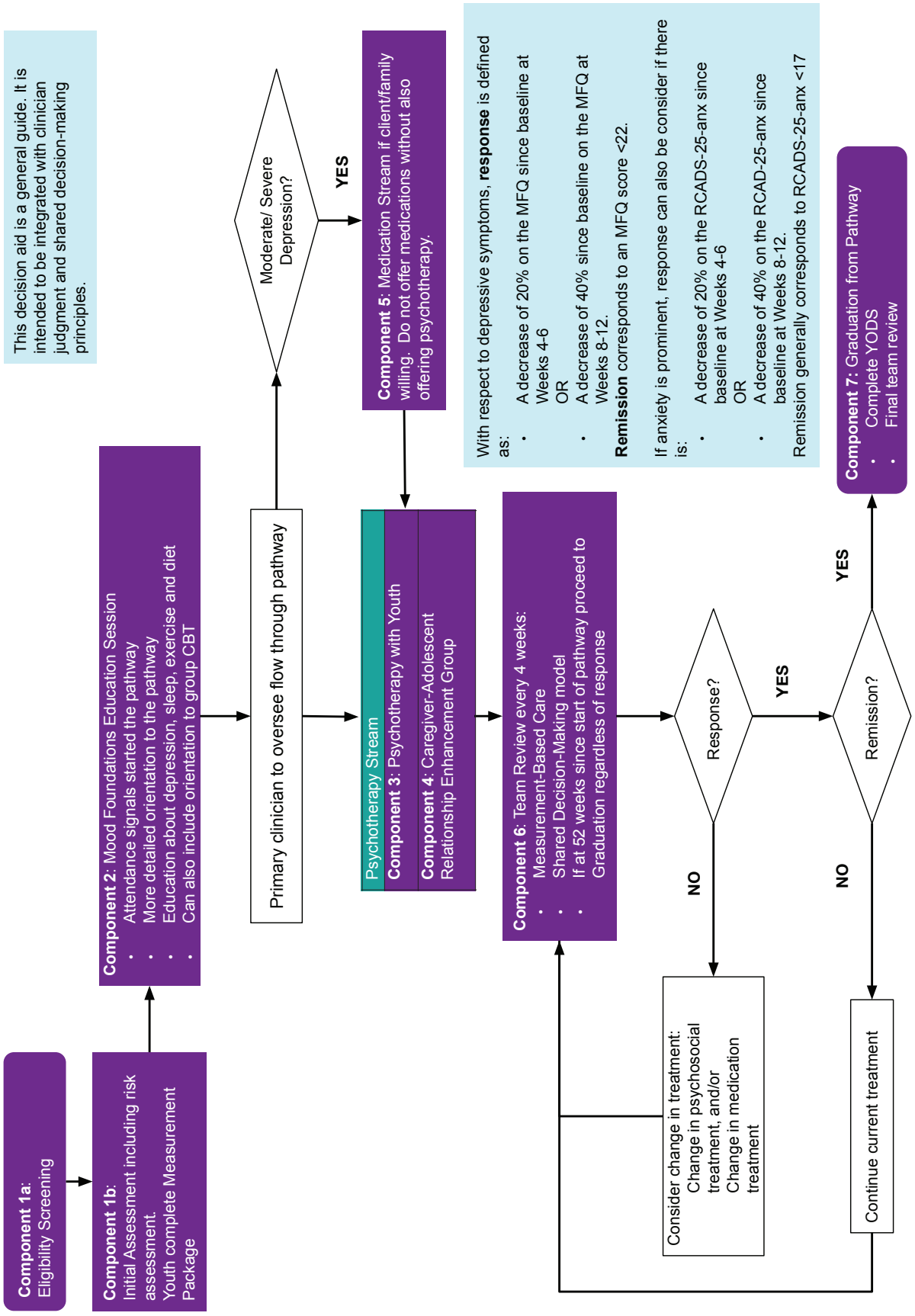
RCADS
Revised Childhood Anxiety and Depression Scale

SITB
Self-Injurious Thoughts and Behaviours

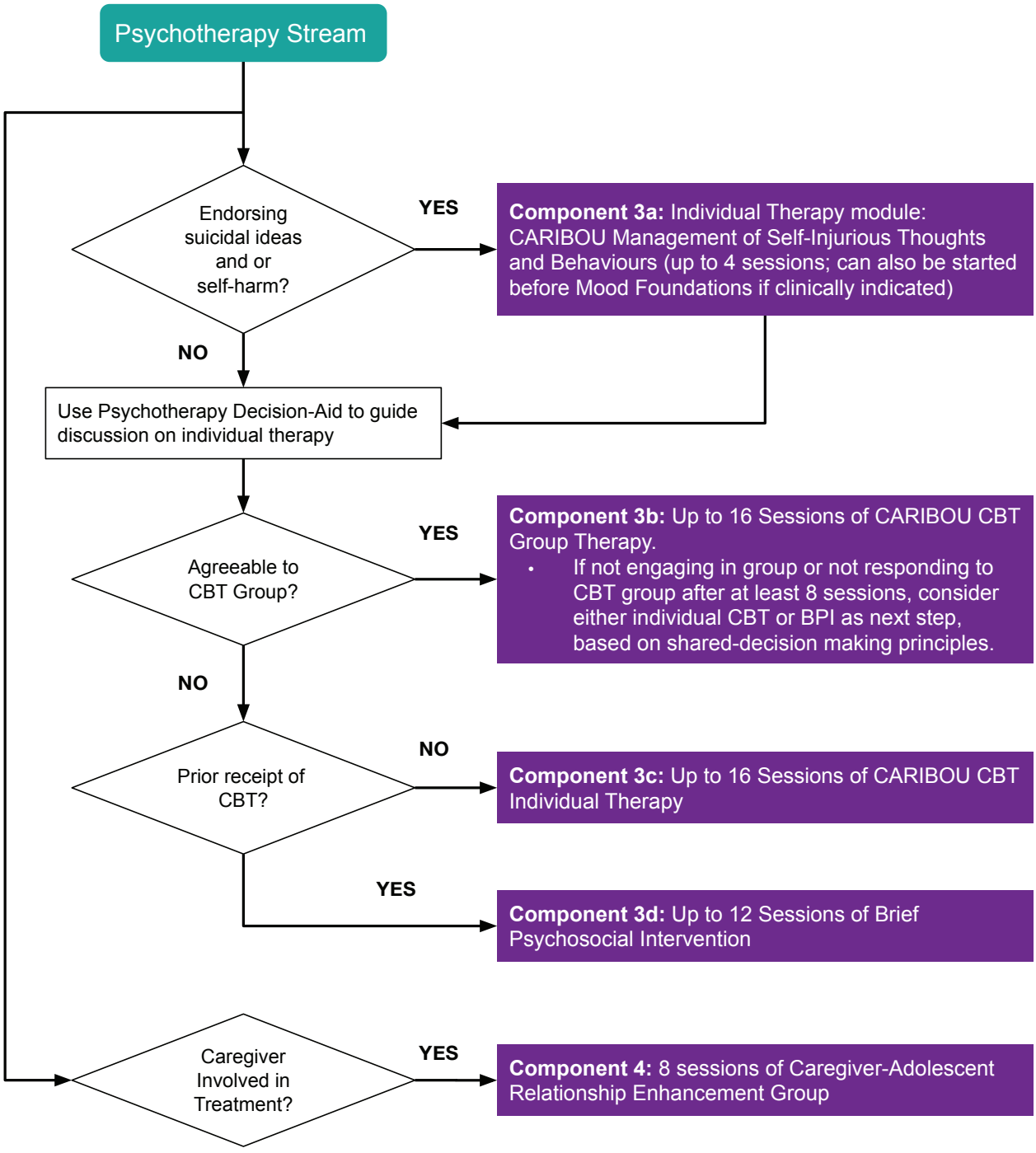
SSRI
Selective Serotonin Reuptake Inhibitor

YODS
Youth-Oriented Discharge Summary

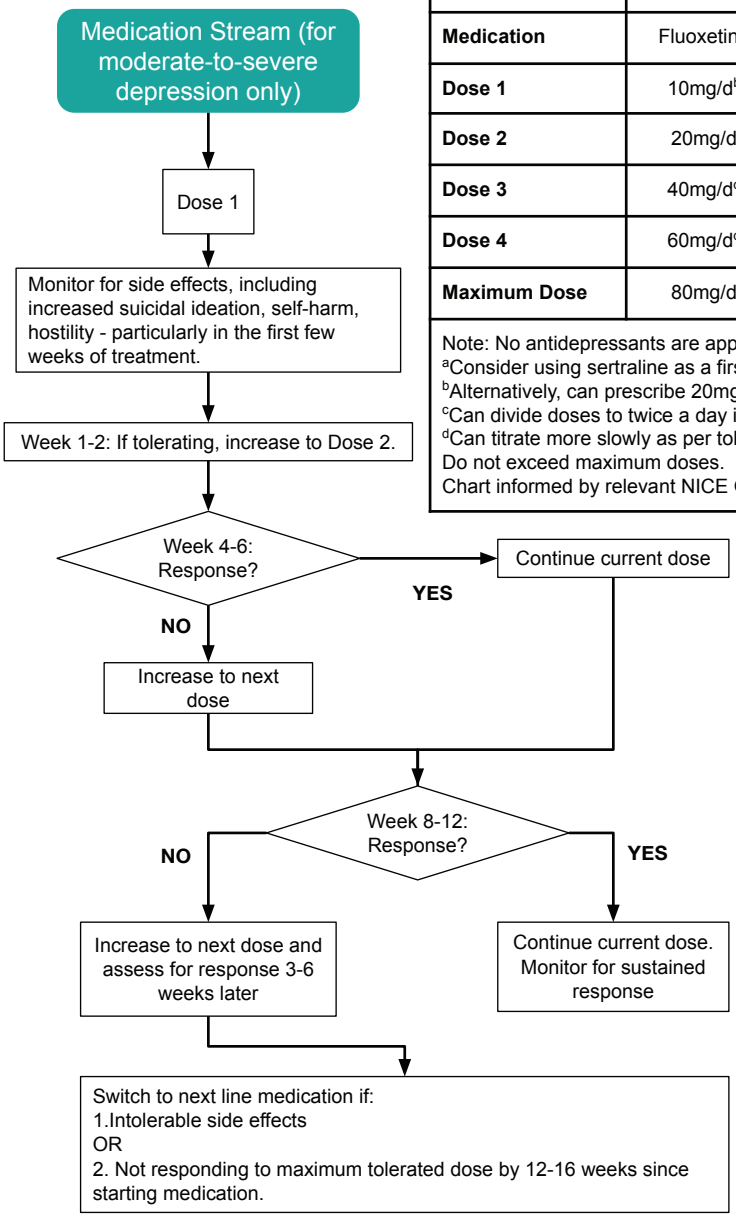
Appendix A: CARIBOU Pathway Flow Diagram



Appendix B: CARIBOU Psychotherapy Stream



Appendix C: CARIBOU Medication Stream



	1st line	2nd line	3rd line	4th line
Medication	Fluoxetine	Sertraline[a]	Escitalopram	Duloxetine
Dose 1	10mg/d[b]	25mg/d	5mg/d	30mg/d
Dose 2	20mg/d	50mg/d	10mg/d	60mg/d[c]
Dose 3	40mg/d[d]	100mg/d[d]	15mg/d	90mg/d[c]
Dose 4	60mg/d[d]	150mg/d[d]	20mg/d	120mg/d[c]
Maximum Dose	80mg/d	200mg/d	20mg/d	120mg/d[c]

Note: No antidepressants are approved by Health Canada for use in people under 18.
[a]Consider using sertraline as a first line medication is anxiety is key target for youth.
[b]Alternatively, can prescribe 20mg every other day or liquid form for insurance coverage.
[c]Can divide doses to twice a day if preferred.
[d]Can titrate more slowly as per tolerabiilty.
Do not exceed maximum doses.
Chart informed by relevant NICE Guideline (2019) and Hetrick et al's Cochrane Review (2021)

Do not offer paroxetine, venlafaxine, tricyclic antidepressants or St. John's Wort.

With respect to depressive symptoms, **response** is defined as:

- A decrease of 20% on the MFQ since baseline at Weeks 4-6
  OR
- A decrease of 40% since baseline on the MFQ at Weeks 8-12.

If anxiety is prominent, response can also be consider if there is:

- A decrease of 20% on the RCADS-anx since baseline at Weeks 4-6
  OR
- A decrease of 40% on the RCAD-anx since baseline at Weeks 8-12.

This decision aid is a general guide. It is intended to be integrated with clinician judgment and shared decision-making principles.

Appendix D:
Eligibility Screening for CARIBOU Pathway

Screening Question:	If the following is true, the **youth is not eligible**
Agency:	
Has the youth been assigned a Clinician?	
Please provide us with the Clinician's Initials:	
Date:	
Youth's Initials:	
Youth's Chart #:	
Youth's current gender identity:	N/A
Youth's age:	<13 or >18 years old
Youth and/or caregiver is expressing that "depression" is a concern?	No
Clinician agrees that depressive symptoms are a treatment target?	No
Youth is fluent in English (i.e., comprehension, read, write, communication)?	No
Youth is new to receiving treatment at the agency within the past 3 months?	N/A
Youth has had a period of 3 months or more of treatment at the agency within the past 6 months ?	Yes
Youth is attending, or will soon be attending, a Day Treatment Program?	Yes
Youth has a known or highly suspected... Intellectual disability?	Yes
Youth has a known or highly suspected... Presentation of psychotic symptoms that are persistent and have observable effects on behaviour (i.e., consistent with schizophrenia)?	Yes
Youth has a known or highly suspected... Severe substance use disorder (e.g., daily cannabis use throughout the day, heavy alcohol/ Benzodiazepines use 3 or more times a week, cocaine/opiate use several days a month or more)?	Yes

Youth has a known or highly suspected... Bipolar disorder (e.g., elevated mood and energy outside typical presentation and changes observable by others lasting for 4 consecutive days or more)?	Yes
Youth has a known or highly suspected... Severe eating disorder (e.g., restrictive eating patterns, associated with preoccupation with body image, leading to weight loss and associated medical complications and/or bingeing and purging at least 2 times a week)?	Yes
Youth is at imminent risk of suicide requiring hospitalization as per judgment of the assessing clinician?	Yes
Youth is able to provide informed consent to the study for any reason (e.g., there is no language barrier, nor intellectual disability, nor severe psychosis that would be a barrier to informed consent)?	No
Youth's MFQ score:	MFQ score is less than 22
Youth is agreeable to be contacted by RA to describe the project?	No

Appendix E:
Clinician-Rated CARIBOU-2 Pathway Fidelity Form

Component 1: Assessment

	Applicable?		Offered?		Completed?		Date:
	Yes	No	Yes	No	Yes	No	DD/MM/YY
Initial Detailed Assessment	x						
Baseline Measurement-Based Care Package	x						

Component 2: Mood Foundations (Psychoeducation, Lifestyle Interventions)

	Applicable?		Offered?		Attended?		Date:
	Yes	No	Yes	No	Yes	No	DD/MM/YY
Mood Foundations Group – Youth Version	x						
Mood Foundations Group – Caregiver Version							

Component 3: Psychotherapy Options

3a. **Management of Self-Injurious Thoughts and Behaviours**	Applicable? Y ( ) N ( ) If NOT applicable or offered, reason: Offered? Y ( ) N ( ) Number of sessions attended: ____	Completed? Y ( ) N ( ) If yes, date completed (DD/MM/YY): If not completed, reasons why (X): 1. Did not engage in treatment model ( ) 2. Participant withdrew ( ) 3. Did not respond after 8 sessions ( ) 4. Another reason ( ) : _____
3b/c/d. **CBT or BPI**	Applicable? Y ( ) N ( ) If NOT applicable or offered, reason: Offered? Y ( ) N ( ) Number of sessions attended: ____	Completed? Y ( ) N ( ) If yes, date completed (DD/MM/YY): If not completed, reasons why (X): 1. Did not engage in treatment model ( ) 2. Participant withdrew ( ) 3. Did not respond after 8 sessions ( ) 4. Another reason ( ) : _____

Component 4: Caregiver-Adolescent Relationship Enhancement Group

Caregiver group	Applicable? Y ( ) N ( ) If NOT applicable or offered, reason: Offered? Y ( ) N ( ) Number of sessions attended: _____	Completed? Y ( ) N ( ) If yes, date completed (DD/MM/YY): If not completed, reasons why (X): 1. Did not engage in treatment model ( ) 2. Participant withdrew ( ) 3. Did not respond after 8 sessions ( ) 4. Another reason ( ) : _____

Component 5: Medication Options

(Only applicable if youth has moderate-to-severe depression and is open to hearing more about medication options).

Referred to psychiatry?	Applicable? Y ( ) N ( ) If NOT applicable or offered, reason: Offered? Y ( ) N ( ) Number of sessions attended: _____	Completed? Y ( ) N ( ) If yes, date completed (DD/MM/YY): If not completed, reasons why (X): 1. Did not engage in treatment model ( ) 2. Participant withdrew ( ) 3. Did not respond after 8 sessions ( ) 4. Another reason ( ) : _____

Component 6: Team Reviews

Team Review Week	Applicable? (Y/N)	Offered? (Y/N)	Date Completed DD/MM/YY	MBC scores discussed? (Y/N)	Shared Decision-Making? (Y/N)	If not completed, reason (X)?
Week 4						
Week 8						
Week 12						
Week 16						
Week 20						
Week 24						
Week 28						
Week 32						
Week 36						
Week 40						
Week 48						
Week 52						

MBC= Measurement-Based Care. Examples of reasons Tearm Reviews not completed (1) No need to meet; (2) Youth away and unable to attend; (3) Youth felt good and did not want to meet; (4) Youth could not be reached; (5) Clinician's schedule did not allow; (6) Clinician omission.

Component 7: Graduation

	Date: DD/MM/YY	Caregiver present? (Y/N)	Graduation summary provided to youth? (Y/N)
Structured Graduation Meeting			
	Reason for graduation (first item on list that applies): 1. In sustained remission ( ) 2. Completed/offered all components of pathway and not in remission ( ) 3. Pathway components not a fit for youth (from youth's perspective) ( ) 4. Pathway components not a fit for youth (from clinician's perspective) ( ) 5. 52 weeks have passed since Mood Foundations ( ) 6. Lost to follow-up ( ) 7. Other reason, details:		

Appendix F: CARIBOU Team Review Checklist

(includes documentation from multiple disciplines) (version 3.0)

Client: _____ Clinician: _____ Date: _____ Time: _____

Discussion Area	Minimum Requirements for the ICP	Optional Details	Notes
☐ Introductions		· Who is present? · What are their roles? - An involved allied health professional (i.e., group leader)? · Any recent stressors? · Any acute safety concerns that need to be addressed immediately (including self-harm, suicide attempts, suicidal ideation or aggression)? · Any topics you want to make sure we cover?	
☐ Review steps in treatment so far		· Which components of the pathway have been completed so far? - Multi-family education group (Mood Foundations) - Any group or individual CBT? - CBT Activation skillset - CBT Communication skillset - CBT Problem-solving skillset - CBT Cognitive strategies skillset - Brief Psychosocial Intervention (BPI) - Caregiver-Adolescent Relationship Enhancement-group (CARE) - Medication management	
☐ Multi-family psycho-ed group	☐ Offered "Mood Foundations" group	· Which parts of the education session has the youth been working on? Has it been helpful? - Sleep hygiene - Exercise - Diet	
☐ If has suicidal ideation/ self-harm	☐ Offered individual SITB management	· How has SITB management been going? Is it helpful?	
☐ If wiling to attend group CBT	☐ Offered "group CBT"	· How have you found the group? · What do you like about it? What should we keep doing? · What do you not like about it? What should we stop doing? · What skills have you found most helpful/least helpful? · Have you been using the skills? Which ones? · Does anything get in the way of using the skills?	
☐ If not in CBT group	☐ Offered individual therapy	· How has individual CBT/BPI been going?	
☐ If caregiver interested in support	☐ Offered CARE group to caregiver	· How have you found the group? · What do you like about it? What should we keep doing? · What do you not like about it? What should we stop doing? · What skills have you found most helpful/least helpful? · Have you been using the skills? Which ones? · Does anything get in the way of using the skills?	

Discussion Area	Minimum Requirements for the ICP	Optional Details	Notes
☐ Measures	☐ Clinician and client discussed MBC measure scores	· Review baseline scores of MFQ, RCADS-25-anx and CADLIS · Review scores at last major change in treatment (if applicable) · Review percent change in score from last major change (or baseline if no change) · Does the change in score accurately represent youth's and caregiver's perceptions? · If there is a change, what does the youth and caregiver believe the change is from? Do they agree with the change? · Does the course of symptoms lead any member of the meeting to think about changing treatment? What change? · How can the youth use the tools for implementation?	
☐ Medication review (only relevant if psychiatrist available)	☐ If no previous medication trial and moderate-to-severe depression, fluoxetine offered as first-line ☐ If failed fluoxetine, sertraline offered as second-line ☐ If indicated, escitalopram offered as third line ☐ If indicated, duloxetine offered as fourth line ☐ If tolerated, medication allowed to continue until "team review corresponding to at least 8 weeks since medication initiation" even if no response ☐ If no response at "team review corresponding to 12-16 weeks since medication initiation," discussion around switching medication ☐ Not offered any other antidepressant as 1st or 2nd line medication for depression	· Which medications is the youth taking? - What dose? · Does the youth and caregiver believe it is helping? - It is making things worse - No change - Slightly better - Moderately better - A lot better · Are there any side effects with the medication? · Which side effects? - How severe? - Is it tolerable? - Is there anything that can be done to limit side effects? - Does it lead to the youth stopping the medication? · Does anything get in the way of taking it regularly? · Do you have thoughts about stopping the medication? · Has the youth had any change in symptoms over 4 weeks? · Has the youth tried the medication for 8 weeks without any change? · Medication decision: - Stop medication - Reduce dose - Remain at same dose - Increase dose to_____ - Start new medication _____ - If not following algorithm, reason for deviation? _____	

Discussion Area	Minimum Requirements for the ICP	Optional Details	Notes
☐ "Flags" to address from initial assessment		· Parental mental illness? · Bullying? · Gender/sexual identity issues identified by youth as a stressor? · Bereavement?	
☐ Suicide risk		· Complete clinical assessment and document in chart (if severe, follow local risk management protocols).	
☐ Any outstanding items?			
☐ Next team meeting?		Date and time?	
☐ Readiness for graduation?		· Is the youth ready for graduation from the pathway? (Particularly after 52 weeks of treatment?) · If not, what are barriers to graduation? · If so, what is the follow-up plan?	N/A

Appendix G: BPI Adherence Scale – Short Form

Session Date: Therapist Name: Client ID Number:		
BPI building blocks delivered today?	**Circle the answers**	
1) Interpersonal effectiveness (i.e, therapist was kind, compassionate, warm, collaborative, authentic).	yes	no
2) Attention to mental state (e.g. thoughts, emotions, urges)- current presentation or diagnosis.	yes	no
3) Psychoeducation: what is depression?	yes	no
4) Discussed activation and/or problem solving strategies.	yes	no
5) Attention to vulnerability and protective factors	yes	no
6) Setting case management within a BPI framework (e.g. liaised with caregiver/parents, other supports)	yes	no
7) Attending to the social context of the client (e.g., discussed family and peer relationships and how they affect mental state).	yes	no
8) Making an effort to help the client find the session manageable	yes	no
Free Text: any comments		

- This brief scale should be completed as soon as possible after every session
- It helps to support adherence to delivery of BPI
- You should aim to deliver at least 4 building blocks of BPI to be adherent in any one single session….don't worry, this should not be challenging!
- All 8 building blocks should have been delivered over the course of a whole treatment

Appendix H: Youth-Oriented Discharge Summary

Name:	Date of Entry into the Pathway:
Date of Birth:	Date of Exit from the Pathway:
Agency where I received this service:	
My primary clinician through this pathway was: Primary clinician discipline (circle): SW/OT/RN/Psychology/MD/Registered Therapist	

While I was in the pathway, I received:

Check	Pathway components (some may not apply to everyone)
	A mental health assessment of my situation and how I am feeling by a local clinician
	An education session about depression, sleep, exercise and diet (Mood Foundations)
	Up to 16 sessions of Cognitive Behavioural Therapy (number of sessions:____)
	Up to 12 sessions of Brief Psychosocial Intervention (number of sessions:____)
	Monthly "Team Reviews" where we track changes in symptoms over time using questionnaires and collaboratively make decisions around my care including discussions around readiness for discharge (number of sessions: ___).
	If medication was being considered, an assessment with a psychiatrist
	Medication Treatment (see below)
	Other treatment: _____
	A pathway graduation meeting

While I was in the pathway, my caregiver (e.g. parent/s) received:

	An education session about depression, sleep, exercise and diet (Mood Foundations)
	Up to 8 sessions of a group to support caregivers (number of sessions:____)
	Monthly "Team Reviews" where we track changes in symptoms over time using questionnaires and collaboratively make decisions around my care including discussions around readiness for discharge (number of sessions: ___).
	Other treatment: _____
	A pathway graduation meeting

My understanding is that I am currently prescribed the following daily medications for my mental health:

Medication					
Generic name	Brand name	Dose	Timing	Regular or As needed?	Reason

The person prescribing my medications on follow-up is: _____.
Check here if no medication currently prescribed: ____.

(continued on next page)

The following are steps I can take if I am feeling like I am in crisis, in distress or overwhelmed:

1.
2.
3.
4.
5.

I should seek out assessment right now if the following occurs:

1.
2.
3.
4.

This is where are I can go for an assessment right now:

	Option 1:	Option 2:
Organization Name:		
Address:		
Phone number:		

I should seek out non-urgent assessment again if the following occurs:

1.
2.
3.
4.

This is where are I can go for a non-urgent assessment:

	Option 1:	Option 2:
Organization Name:		
Address:		
Phone number:		

Strategies I can use to minimize the chances I will get depressed again include:

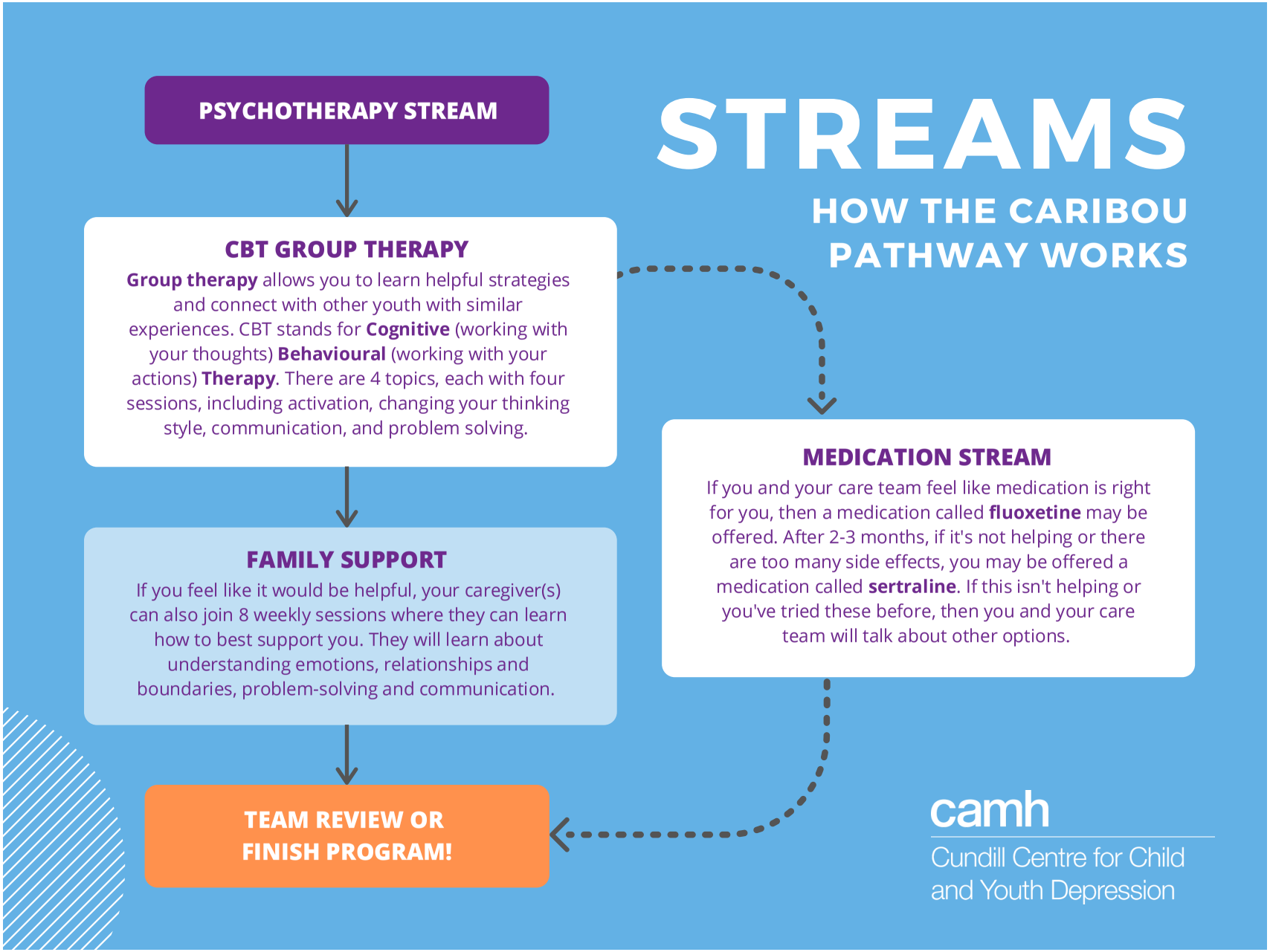
1.
2.
3.
4.

I have follow-up appointments with the following organizations/people:

Organization/Person:	Phone Number:	Date of the appointment (if arranged)	Who calls to make the appointment? (if not arranged.

Check here if no follow up appointments arranged: ___

Appendix I: Youth-Facing Materials Summary


PSYCHOTHERAPY STREAM
STREAMS
HOW THE CARIBOU PATHWAY WORKS
CBT GROUP THERAPY
Group therapy allows you to learn helpful strategies and connect with other youth with similar experiences. CBT stands for Cognitive (working with your thoughts) Behavioural (working with your actions) Therapy. There are 4 topics, each with four sessions, including activation, changing your thinking style, communication, and problem solving.
FAMILY SUPPORT
If you feel like it would be helpful, your caregiver(s) can also join 8 weekly sessions where they can learn how to best support you. They will learn about understanding emotions, relationships and boundaries, problem-solving and communication.
MEDICATION STREAM
If you and your care team feel like medication is right for you, then a medication called fluoxetine may be offered. After 2-3 months, if it's not helping or there are too many side effects, you may be offered a medication called sertraline. If this isn't helping or you've tried these before, then you and your care team will talk about other options.
TEAM REVIEW OR FINISH PROGRAM!
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Appendix J: Psychotherapy Decision Aid

Psychotherapy and YOUth

A RESOURCE FOR YOUTH, BY YOUTH

"Psychotherapy" involves talking with a qualified therapist. Cognitive-Behavioural Therapy (CBT) and Brief Psychosocial Intervention (BPI) are two types of psychotherapy for depression.

Cognitive-Behavioural Therapy

What is CBT?

CBT involves 8 to 16 weekly sessions to help challenge thoughts and actions that contribute to depression. Clinicians often recommend CBT for depression since it has the most research to support its benefits.

What does a typical CBT therapy session look like?

Sessions start with a check-in where you talk about how your mood has been and recent events in your life. Next, the previous week's home practice is discussed. This is followed by a discussion of new skills and strategies to practise over the next week.

For Group CBT: Each session lasts 90 minutes and is offered in a group of up to 12 people. Sessions start with an icebreaker to help participants get to know each other.

For individual CBT: Sessions last 50 minutes and are one-on-one with a therapist.

Which is a better fit for me?

Check the three most important values for you.

Group CBT	Individual CBT
☐ Being with a therapist and group where I can **meet, support and learn** from other youth who share similar concerns.	☐ Meeting with a therapist **one-on-one** to help me feel more comfortable sharing my experience.
☐ Learning **many skills** that can be used in different situations.	☐ Getting support to work on the **specific mental health concerns and skills** that apply to me.
☐ Starting therapy **sooner**.	☐ **Flexibility** when scheduling my sessions.

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Brief Psychosocial Intervention

What is BPI?

BPI aims to reduce stressors in your life that contribute to depression and increase activities in your life that make you happier. The therapist also helps you explore ways to get support from others.

If CBT is not a fit for you, then BPI is another option that can be just as effective. With BPI, you focus less on challenging negative thoughts the way you do with CBT.

What does a typical BPI therapy session look like?

With BPI, you discuss:

- how to **understand your depression** given your experiences
- **ways to increase meaningful activities** in your life
- how to **problems-solve** through stressful situations in your life
- ways you can increase your sense of **connection in relationships**
- **ways to work directly with your supports** (e.g., family and school)—and sometimes even bring family members into the session—to discuss how to create an environment where your depression can get better.

FREQUENTLY ASKED QUESTIONS

What should I know before starting therapy?

- Therapy involves attending **regular sessions plus applying the newly learned skills in your daily life**. This means dedicating time each week to practise new skills. Although this can take time away from other things in your life, many youth find the time investment worth it.

- Therapy involves **exploring situations or experiences that can bring up strong emotions.** This can feel uncomfortable at first. If therapy is overwhelming, please let your clinician(s) know; they can help guide you through the next steps.

- **Your relationship with your therapist is important**. If you don't feel comfortable with your therapist, you are encouraged to bring this up in session. You can also ask your supports (e.g., parent, teacher or other members of your care team) to help express how you want to address your concerns with your therapist, such as writing down what you want to say and role-playing.

How will I know if therapy is working for me?

You may start to notice you are:

- recognizing your emotions more easily
- working through difficult situations effectively
- problem-solving in times of stress
- identifying more useful thoughts in your daily life.

Remember, it can take months to notice shifts. If you don't notice any improvement after eight weeks of therapy, or if your symptoms get worse, talk to your care team about your treatment options.

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Appendix K: Group Norms

Appendix L: Medication and YOUth

Medication and YOUth

A RESOURCE FOR YOUTH BY YOUTH

Research has shown that a type of antidepressants, called selective serotonin reuptake inhibitors (SSRIs), can help to reduce the symptoms of depression in young people. This resource will tell you more about SSRIs.

What are SSRIs?

They are a group of medications that can help with symptoms of depression and are also commonly used to relieve symptoms of anxiety. SSRIs include fluoxetine (Prozac), citalopram (Celexa), escitalopram (Cipralex) and sertraline (Zoloft).

While medication has been shown to be effective, other options can help too, like therapy and doing activities that you enjoy or find relaxing.

When will I know if this medication is working for me?

It can take at least three to six weeks, and occasionally as long as eight weeks, to feel the benefits of the medication.

Between half and two-thirds of youth find it helpful. You'll need to take them every day to see a benefit.

What are some of the side-effects?

Many young people don't notice any side-effects, but they are possible. Some common side- effects are listed below. If you do experience side-effects, they may lessen over time. If you do not notice a benefit from your medication or experience many side-effects, talk to your doctor.

Common Side-Effects If you are experiencing...	Some Tips Try to...
Difficulty sleeping, or having more energy than usual and feeling restless	Avoid caffeine or take your medication in the morning
Tiredness or drowsiness	Take your medication in the evening
Headaches or dizziness	Take time to rest or relax or drink water
Nausea or decreased appetite	Take your medication with food or eating smaller meals more often during the day
Some other symptoms may include sweating, diarrhea, increased heart rate, vivid dreams, or changes in sexual drive and function.	

Some people may also start to feel emotionally numb, but this isn't the goal of this medication. Please let your therapist or doctor know if this is happening.

There are also some less frequent but more severe side-effects.

- Many people experience a decrease in suicidal thoughts after taking SSRIs, but about five per cent of youth can have *increased thoughts of suicide or self harm*. If you notice this happening, you should speak to your doctor right away. The doctor may have you stop taking your medication, or advise a change to your medication. **If you're concerned about your own safety, go to an emergency room for immediate support.**
- People may rarely experience *mania*, where they might notice having more energy, having trouble sleeping, feeling very irritable or having an extremely high mood.

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What happens if I take an SSRI with other medications or substances?

If you are taking other medications (prescription, over the counter or herbal), talk to your doctor or pharmacist to see how this combination might affect you.

Combining substances like alcohol, cannabis or other recreational drugs with SSRIs can:

- reduce the chances that the medication will work
- make the effects of the drug more unpredictable (e.g., you may feel drowsy, have memory problems or act impulsively)
- exaggerate the effect that the drug would normally have for you.

If you are taking an SSRI while using other substances, you may want to use a smaller amount of the substance to see how it affects you. If you do use substances, be sure there is a trusted friend around, you are in a familiar location, or have a supportive adult who you can call if something unexpected happens.

Will I become dependent on this type of medication?

SSRIs are not addictive. If your medication is working and you stop taking it, you are more likely to have your symptoms of depression return. It can take weeks or months for this to happen – though some people might notice discomfort immediately after stopping.

There are many different ways to help treat depression. If you wish to stop taking medication, talk to your doctor about gradually decreasing the dose.

Are there any other tips that I should know?

❒ **Try to take your medication at a set time to help you remember, and avoid taking doses too close together.** It can help to set an alarm as a reminder.

❒ **Remember to have enough medication when you will be away from home.** If you're travelling, keep medication in the original bottle. If you're away for the day, you can use a discreet container to keep it in.

❒ **Ask your pharmacist if your medication is affected by grapefruit.** Grapefruit can prevent your body from breaking down some SSRIs.

❒ **Try to store your medication outside of the kitchen and bathroom.** Changes in temperature may impact the effectiveness.

❒ **Keep medications out of reach of young children.**

❒ **Talk to your doctor or pharmacist if you want more information.** They can also tell you what may be covered by insurance. Most pharmacies offer a refill reminder. Talk to your therapist or doctor about using a rating scale to track your symptoms so it will be easier to notice if they are changing. Rating scales are like surveys that ask how you are feeling. Two common ones are the "Mood and Feelings Questionnaire" and "Revised Child Anxiety and Depression Scale."

If you have depression, figuring out what may be helpful for you is an individual process and may look different for everyone. Medications can be one way of supporting yourself.

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Appendix M: Measurement-Based Care Measures

Mood and Feelings Questionnaire – Child version, Long (MFQ)[1]

This form is about how you might have been feeling or acting **recently**.
For each question, please check how you have been feeling or acting *in the past two weeks*.
If a sentence was not true about you, check NOT TRUE.
If a sentence was only sometimes true, check SOMETIMES.
If a sentence was true about you most of the time, check TRUE.

	Not true	Sometimes	True	Prefer not to answer
1. I felt miserable or unhappy.				
2. I didn't enjoy anything at all.				
3. I was less hungry than usual.				
4. I ate more than usual.				
5. I felt so tired I just sat around and did nothing.				
6. I was moving and walking more slowly than usual.				
7. I was very restless.				
8. I felt I was no good anymore.				
9. I blamed myself for things that weren't my fault.				
10. It was hard for me to make up my mind.				
11. I felt grumpy and cross with my parents.				
12. I felt like talking less than usual.				
13. I was talking more slowly than usual.				
14. I cried a lot.				
15. I thought there was nothing good for me in the future.				
16. I thought that life wasn't worth living.				
17. I thought about death or dying.				
18. I thought my family would be better off without me.				
19. I thought about killing myself.				
20. I didn't want to see my friends.				
21. I found it hard to think properly or concentrate.				
22. I thought bad things would happen to me.				
23. I hated myself.				
24. I felt I was a bad person.				
25. I thought I looked ugly.				
26. I worried about aches and pains.				
27. I felt lonely.				
28. I thought nobody really loved me.				
29. I didn't have any fun in school.				
30. I thought I could never be as good as other kids.				
31. I did everything wrong.				
32. I didn't sleep as well as I usually sleep.				
33. I slept a lot more than usual.				

Score the MFQ as follows: Not True = 0; Sometimes = 1; True = 2
Sum all items to provide a total score.
Items 16-19 relate to suicidal ideation (shaded), if endorsed, the clinician is to complete the Columbia Suicide Severity Rating Scale (below).
If the response is "prefer not to answer", this item is ignored in the scale and mean imputation is applied:

- Imputed score = (sum score/ number of responses scored) x 33

In CARIBOU, a score greater than or equal to 22 is considered a clinical level of depressive symptoms[2].
There are no clear severity cut-offs from the literature yet.
As a "rule of thumb" a score of: 22-30 is considered **mild**, 31-40 is **moderate** and greater than 41 is **severe**.

Permission to reprint obtained on December 5th, 2023 from brian.small@duke.edu.

Revised Children's Anxiety and Depression Scale – 25-item, Anxiety Subscale (RCADS-25-anx)[3]

The RCADS is not available for reprint; but free to use with permission from the purveyors. The measure is housed here: https://www.corc.uk.net/outcome-experience-measures/revised-childrens-anxiety-and-depression-scale-rcads/

Permissions for clinical and research use can be requested here: https://rcads.ucla.edu/node/13

The RCADS full version is available here: https://www.corc.uk.net/media/1225/rcads-childreported_8-18.pdf

The 15 items of the RCADS-25-anx consists of items 2, 3, 5, 6, 7, 9, 11, 12, 14, 17, 18, 20, 22, 23, 25 from the full version.

Further guidance on its use can be sought from the CARIBOU-2 development team.

For CARIBOU-2, we have added the time interval of "past 2 weeks" to the stem to clarify time frame for measurement-based care.

The following scoring suggestions are based on:
Ebesutani, C., Korathu-Larson, P., Nakamura, B. J., Higa-McMillan, C., & Chorpita, B. (2017). The Revised Child Anxiety and Depression Scale 25–Parent Version: Scale Development and Validation in a School-Based and Clinical Sample. Assessment, 24(6), 712-728. https://doi.org/10.1177/1073191115627012

Score the RCADS-25-anx as follows: Never = 0; Sometimes = 1; Often = 2; Always =3.
The total score is the sum of all answers. If the response is "prefer not to answer", this item is ignored in the scale and mean imputation is applied:

- Imputed score = (sum score/ number of responses provided) x 15

Imputed score cut points based on gender and grade based on Hawaiian sample. NB: No data yet on gender diverse adolescents.

	5th percentile	2nd percentile
Boys grades 9-10	≥19	≥21
Boys grades 11-12	≥17	≥19
Girls grades 9-12	≥20	≥22

Child Anxiety and Depression Life Interference Scale – Youth[4]

Some young people experience high anxiety or may also feel depressed.

Depression can include feeling: sad, worthless, irritable, like things are not fun anymore.
Anxiety can include feeling: fearful, worried, nervous.

In the past two weeks…

	Not at all	Only a little	Some	Quite a lot	A great deal	Prefer not to answer
1. how much has feeling anxious or depressed made it difficult for you to get along with your parents or caregivers?						
2. how much has feeling anxious or depressed made it difficult for you to get along with other family (e.g. your brothers, sisters or grandparents)?						
3. how much has feeling anxious or depressed made it difficult for you to be with friends outside of school/work?						
4. how much has feeling anxious or depressed made it difficult for you to get your work/schoolwork done?						
5. how much has feeling anxious or depressed made it difficult for you to be with other people at school/work?						
6. how much has feeling anxious or depressed made it difficult for you to take part in activities like sport, dance, music or art?						
7. how much has feeling anxious or depressed made it difficult for you to do enjoyable things like going to parties, movies or vacation?						
8. how much has feeling anxious or depressed made it difficult for you to complete daily activities such as getting ready for school, getting chores done and homework?						
9. how much has feeling anxious or depressed made it difficult for you to get to sleep, stay asleep or wake up on time?						

NB: We have added the time interval of "past 2 weeks" to clarify time frame for measurement-based care.

Score the CADLIS as follows: Not at all = 0; Only a little = 1; Some = 2; Quite a lot =3, A great deal =4.
The total score is the sum of all answers. The range of possible scores is 0 to 36. If the response is "prefer not to answer", this item is ignored in the scale and mean imputation is applied:

Imputed score = (sum score/ number of responses provided) x 9

There are no established cut-points for the CADLIS yet; research is ongoing. Clinicians can use the responses to explore areas of life interference. Clinicians can also use change scores to note change/ lack of change with treatment.

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Patient Global Impression -Severity Subscale (PGI-S)[5]

The severity of my **overall mental health symptoms** over the past 30 days has been:

(1) Not present	
(2) Very mild	
(3) Mild	
(4) Moderate	
(5) Moderately severe	
(6) Severe	
(7) Extremely severe	
(.a) Prefer not to answer	

Patient Global Impression – Improvement Subscale (PGI-I)[5]

Since the **beginning of my treatment in this clinic**, my overall mental health is:

(1) Very much better	
(2) Much better	
(3) A little better	
(4) Not changed	
(5) A little worse	
(6) Much worse	
(7) Very much worse	
(.a) Prefer not to answer	

Since **30 days ago,** my overall mental health is:

(1) Very much better	
(2) Much better	
(3) A little better	
(4) Not changed	
(5) A little worse	
(6) Much worse	
(7) Very much worse	
(.a) Prefer not to answer	

NB: The PGI-I is not asked at baseline.

These subscales are single item scales to contextualize the other measures. The scores are not summed.

The PGI-S and PGI-I are in the public domain and does not require permissions to reprint or use.

Goals-Based Outcome[6]

Please identify up to three goals you want to work on. Think about things you would hope would be different in the future from how they might be now.
On a scale from zero to ten, select the number that best describes how close you are to reaching your goal today.
Remember: zero is as far away from your goal as you have ever been, and ten is having reached your goal completely.

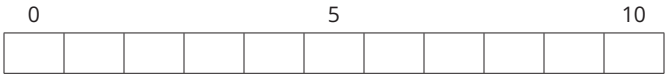
Use this menu/table to see some **examples:**

- ◯ Interpersonal Relationships
- ◯ School, Work, or Hobbies
- ◯ Mental Health/Substance Use
- ◯ Quality of Life

Goals for Interpersonal Relationships 1. To improve my relationship with my parent/caregiver/ siblings 2. To improve my relationships with my peers 3. To feel like I can be myself around others 4. To communicate more assertively 5. To feel more connected to my community	Goals for School, Work or Hobbies 1. To feel more independent 2. To have better school attendance 3. To improve my performance at school 4. To improve my performance at work 5. To get a job 6. To engage in activities that I enjoy 7. To reduce impulsive behaviours
Goals for Mental Health/ Substance Use Improvement 1. To reduce symptoms of depression 2. To have more control over my anxiety 3. To have more control over my anger 4. To reduce my substance use 5. To stop using substances 6. To be more safe when I am using substances 7. To limit substance use to social situations 8. To reduce self-harm behaviours 9. To reduce suicidal thinking	General Quality of Life Improvement 1. To understand myself better 2. To increase my enjoyment of life 3. To experience a greater sense of meaning in my life. 4. To feel more in control of my emotions 5. To be able to set goals more effectively 6. To reduce racing thoughts 7. To think in a more balanced way 8. To think more optimistically 9. To tend to my self-care

Goal #1: (You may rate your progress on your previous goal OR add a new goal if it is no longer relevant.)

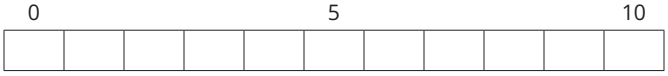
Progress on Goal #1



(Place a mark on the scale above)

Goal #2: (You may rate your progress on your previous goal OR add a new goal if it is no longer relevant.)

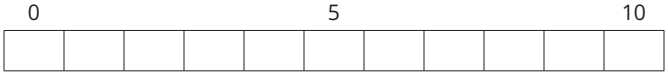
Progress on Goal #2



(Place a mark on the scale above)

Goal #3: (You may rate your progress on your previous goal OR add a new goal if it is no longer relevant.)

Progress on Goal #3



(Place a mark on the scale above)

The GBO does not have a sum score. It is used to align treatment with the adolescent's treatment goals.

As per Law and Jacob, 2015, the GBO is not copyrighted and free to use.

Columbia Suicide Severity Rating Scale (C-SSRS)[7]

This is the one measurement-based care measure rated by the clinician as opposed to self-report. It is only completed if the adolescent endorsed at least "Sometimes" on any of items 16-19 of the MFQ (see above).
There are 4 subscales included here:

- Suicidal Ideation Severity Subscale
- Intensity of Ideation Subscale (1-item version)
- Suicidal Behaviours Subscale
- Lethality Subscale (only included if there is suicidal behaviour present)

Some versions of the C-SSRS included a 5-item version of the Suicidal Ideation Intensity Subscale – we have omitted it here for simplicity of use.

For the purposes of measurement-based care in CARIBOU, the assessment period is the **past 4 weeks.** If the youth was not assessed 4 weeks prior due to a missed team review
(and it is not the baseline assessment, the clinician can use the period **since the last assessment**.

Each subscale is scored separately, there is no overall "total score".

The following questions will be used to determine the youth's highest rating since the last assessment. Youth should think of a time when they felt the most suicidal since the last assessment.

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.

Indicate time frame:

- ☐ Past 4 weeks: ___
- ☐ Since last assessment: ____

Suicidal Ideation Severity Subscale:

	Yes	No	Prefer not to answer
1. Wish to be dead. Definition: Adolescent endorses thoughts about a wish to be dead, or not alive anymore, or wish to fall asleep and not wake up. Questions: • Have you thought about being dead or what it would be like to be dead? • Have you wished you were dead or wished you could go to sleep and never wake up? • Do you wish you weren't alive anymore? If yes, describe:			
2. Non-Specific Active Suicidal Thoughts Definition: General, non-specific thoughts of wanting to end one's life/commit suicide (e.g., I've thought about killing myself) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. Questions: • Have you thought about doing something to make yourself not alive anymore? • Have you had any thoughts about killing yourself? If yes, describe:			

3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Definition: Adolescent endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it and I would never go through with it. Questions: • Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)? • What did you think about? If yes, describe:			
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Definition: Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to I have the thoughts but I definitely will not do anything about them. Questions: • When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do? This is different from (as opposed to) having the thoughts but knowing you wouldn't do anything about it. If yes, describe:			
5. Active Suicidal Ideation with Specific Plan and Intent Definition: Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. • Have you decided how or when you would make yourself not alive anymore/ kill yourself? • Have you planned out (worked out the details of) how you would do it? • What was your plan? • When you made this plan (or worked out these details), was any part of you thinking about actually doing it?			
Indicate Highest Rating within the assessment period: (0 to 5):			

The Suicidal Ideation Severity Subscale is scored on a scale from 0 (no suicidal ideation) to 5 (active suicidal ideation with specific plan and intent) as the per the above descriptions; with the most severe suicidal ideation (i.e. highest number) experienced during the assessment period identified. There is no "sum score". Scores of 3 and above should be promptly reviewed with a supervisor/senior clinician.

Intensity of Ideation Subscale
The following feature should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe).

	Only one time	A few times	A lot	Always	Not applicable/ Prefer not to answer
1. Frequency. How many times have you had these thoughts?					

For the purposes of CARIBOU, the Intensity of Ideation Subscale is a single item measure to get a sense of how frequent the suicidal thoughts are.

Suicidal Behaviour Subscale

	Yes	No	Prefer not to answer
1a. Actual Attempt: Definition: A potentially self-injurious act committed with at least some wish to die, as a result of the act. Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is any intent/desire to die associated with the act, then it can be considered an actual suicide attempt. There does not have to be any injury or harm, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. Questions: Did you do anything to try to kill yourself or make yourself not alive anymore? What did you do? Did you hurt yourself on purpose? Why did you do that? Did you_____as a way to end your life? Did you want to die (even a little) when you___? Were you trying to make yourself not alive anymore when you _____? Or did you think it was possible you could have died from_____? Or did you do it purely for other reasons, not at all to end your life or kill yourself (like to make yourself feel better, or get something else to happen)? (Self-Injurious Behavior without suicidal intent) Total number of actual attempts during assessment period: If yes, describe:			
1b. Indicate here if the adolescent engaged in Self-Injurious Behaviour without intent. On how many days during the assessment period? (e.g. once, 2-5 days, 6-20 days, ≥20 days. What methods were used?			

1c. Indicate here if the adolescent engaged in Self-Injurious Behaviour with unknown intent. On how many days during the assessment period? (e.g. once, 2-5 days, 6-20 days, ≥20 days. What methods were used?			
2. Interrupted Attempt Definition: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act (if not for that, actual attempt would have occurred). • Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. • Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. • Jumping: Person is poised to jump, is grabbed and taken down from ledge. • Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. Questions: Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do? Total number of interrupted attempts during assessment period: If yes, describe:			
3. Aborted attempt (or Self-interrupted attempt) Definition: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. Questions: Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do? Total number of aborted attempts during assessment period: If yes, describe:			

4. Preparatory Acts or Behaviour: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). Questions: Have you done anything to get ready to make yourself not alive anymore (to end your life or kill yourself)- like giving things away, writing a goodbye note, getting things you need to kill yourself? Total number of preparatory acts during assessment period: If yes, describe:			
Indicate here is there has been any suicidal behaviour:			

The Suicidal Behaviour Subscale a series of separate items to describe the behaviours and assist with risk management. There is no sum score.

Lethality Subscales (only rated on most lethal actual attempt)

Rate actual lethality:

Describe reference attempt here: _____	
(0) No physical damage or very minor physical damage (e.g., surface scratches).	
(1) Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains).	
(2) Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel).	
(3) Moderately severe physical damage; medical hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures).	
(4) Severe physical damage; medical hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area).	
(.a) Not applicable	
(.b) Prefer not to answer	

Only if actual lethality is "0", rate potential lethality:

Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over).	
(0) Behavior not likely to result in injury.	
(1) Behavior likely to result in injury but not likely to cause death	
(2) Behavior likely to result in death despite available medical care	
(.a) Not applicable or prefer not to answer	
(.b) Prefer not to answer	

The Lethality Subscales are separate item measures for the purposes of describing the events and assisting with risk management only. There is no "total score".

Permission to reprint obtained on December 15th, 2023 from Dr. Kelly Posner (scale developer).

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Appendix N: Estimated Training Time

Estimated Training Time in Hours per Component

Component	Reading	Webinar	Online Learning	Total Hours
Overall pathway	1	1	1	3
Assessment	1	2	0	3
Mood Foundations	1	1	0	2
SITB Management	1	1	0	2
CBT	3	3	12	18
BPI	0	8	0	8
Caregiver group	0	8	0	8
Medications	1	1	0	2
Team Reviews	1	1	0	2
Graduation	1	1	0	2
Totals	10	27	13	**50**

SITB Self-Injurious Thoughts and Behaviours
CBT Cognitive Behavioural Therapy
BPI Brief Psychosocial Intervention

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