The Ottawa Hospital RESEARCH INSTITUTE | L'Hôpital d'Ottawa INSTITUT DE RECHERCHE

Patient Decision Aids

Français

Welcome

Patient decision aids are tools that help people become involved in decision making by making explicit the decision that needs to be made, providing information about the options and outcomes, and by clarifying personal values. They are designed to complement, rather than replace, counseling from a health practitioner.

How can I find decision aids?

- A to Z Inventory allows you to search for decision aids on particular health topics.
- Ottawa Personal/Family Decision Guides can be used for any health or social decision.
- Decision Aid Library Inventory (DALI) allows developers to enter informaton about their decision aids for inclusion in our inventories.

Where are the online tutorials?

- The Ottawa Decision Support Tutorial (ODST), to help practitioners develop knowledge in shared decision making (SDM) and decision support.
- The Ottawa Patient Decision Aid Development eTraining (ODAT) to help people create a patient decision aid using the Ottawa development process.
- The Implementation Toolkit provides tools and training for incorporating decision support in practice centres.

What's the evidence?

- An international research group updates the systematic review of trials of patient decision aids for treatment or screening decisions using Cochrane review methods.
- The International Patient Decision Aid Standards (IPDAS) Collaboration established a set of internationally approved criteria for determining the quality of patient decision aids.
- Report on The Ottawa Decision Support Framework: Update, Gaps and Research Priorities.
- Several evaluation measures (e.g. Decisional Conflict Scale, Decisional Needs Assessment in Populations) are available with user manuals.

Last modified: 2015-04-17.

Email questions or comments to decisionaid@ohri.ca.

Additional Privacy Statement for this site.

U.S. English

Complex behavior problems in children and youth: treatment options

Use this decision aid to help you and your healthcare professional talk about how to treat complex behavior problems in youth ages 5 to 18. These problems include being unable to control anger, aggression, or hyperactivity, and may be related to the following diagnoses: oppositional defiant disorder, disruptive behavioral disorder, disruptive mood dysregulation disorder, post-traumatic stress disorder (PTSD), attention-deficit hyperactivity disorder (ADHD), or depression.

It is best to use other treatments like behavioral therapy before trying medication. Not all medications listed have Food and Drug Administration (FDA) approval, so please check with your healthcare professional.

Frequently Asked Questions ↓	**Behavioral therapy**	**Stimulant medication**	**Non-stimulant ADHD medication**	**Antidepressant medication**	**Atypical antipsychotic medication**
What does this treatment involve?	Weekly, 1-hour visits for up to 6 months. Parents learn positive ways to manage child's behaviors.	30 to 90 minute evaluation and monthly visits. Child usually takes medication for 1 year.	30 to 90 minute evaluation and monthly visits. Child usually takes medication for 1 year.	30 to 90 minute evaluation and monthly visits. Child usually takes medication for 1 year.	30 to 90 minute evaluation and monthly visits. Child usually takes medication for 1 year. This medication is only used for extreme aggression.
What options might be offered?	Parent Child Interaction Therapy, Positive Parenting Program, Incredible Years, and others	Methylphenidate (Concerta, Ritalin) and amphetamines (Adderall)	Alpha-agonists, such as clonidine (Catapres) and guanfacine (Intuniv), and non-stimulant atomoxetine (Strattera)	Fluoxetine (Prozac), sertraline (Zoloft), escitalopram (Lexapro), and venlafaxine (Effexor)	Risperidone (Risperdal), quetiapine (Seroquel), and aripiprazole (Abilify)
How well does this treatment work?	About 60 out of every 100 children (60%) have fewer behavior problems in a few months.	Up to 90 out of every 100 children (90%) are less hyperactive and impulsive in a week or less.	Up to 80 out of every 100 children (80%) are less hyperactive, impulsive, and aggressive in a few weeks.	About 60 out of every 100 children (60%) are less moody and sad in a few weeks.	About 80 out of every 100 children (80%) are less moody and have fewer behavior problems in a few weeks.
What are some problems with this treatment?	Behavior change may take a few months. Behavioral therapies may not be available in all areas.	- 25 out of every 100 children (25%) are less hungry and have sleep problems. - 6 out of every 100 children (6%) have a higher heart rate. - 3 out of every 100 children (3%) have higher blood pressure. - Very rarely, children have heart problems that can cause death (3 out of every 100,000 children, 0.003%). Children should be screened for heart problems before being given medication. Long-term effects and side effects are not known.	- **Alpha-agonists**: 30 out of every 100 children (30%) feel sleepy. 40 out of every 100 children (40%) feel dizzy. - **Atomoxetine (Strattera)**: 15 out of every 100 children (15%) have problems falling asleep. 10 out of every 100 children (10%) have higher blood pressure. 10 out of every 100 children (10%) feel sleepy. Rarely, children think about self-harm or suicide (about 4 out of every 1,000 children, 0.4%) . Very rarely, serious liver problems occur. Long-term effects and side effects are not known.	- 10 out of every 100 children (10%) have sleep problems, feel drowsy, or have trouble waking. - 4 out of every 100 children (4%) gain weight. - 4 out of every 100 children (4%) think about self-harm or suicide. Long-term effects and side effects are not known.	- Most children gain weight, usually between 8 and 32 pounds per year. - 60 out of every 100 children (60%) feel sleepy. - 30 out of every 100 children (30%) have abnormal movements. - 20 out of every 100 children (20%) have higher cholesterol. - 3 out of every 100 children (3%) have higher blood sugar levels. - **Risperidone (Risperdal):** 40 out of every 100 children (40%) have higher levels of the hormone prolactin. Long-term effects and side effects are not known.

Editors: Erin Barnett (Lead Editor), Elizabeth Boucher, William Daviss, Stacey Carloni, Maureen Kaplan, Scott Kessler, Emily Marsh, Manish Mishra, Glyn Elwyn
Editors have declared no conflicts of interest.
Publication date: 2016-11-01 **Expiry date:** 2018-11-01 **ISBN:** 978-1-941487-21-1

Introduction to OSA

Obstructive sleep apnea (OSA) causes breathing difficulties while sleeping. Diagnosing children with OSA is more difficult than in adults. A narrowing of the throat and/or nasal passages during sleep causes the child to start and stop breathing during sleep. This is referred to as apnea.

Description of OSA

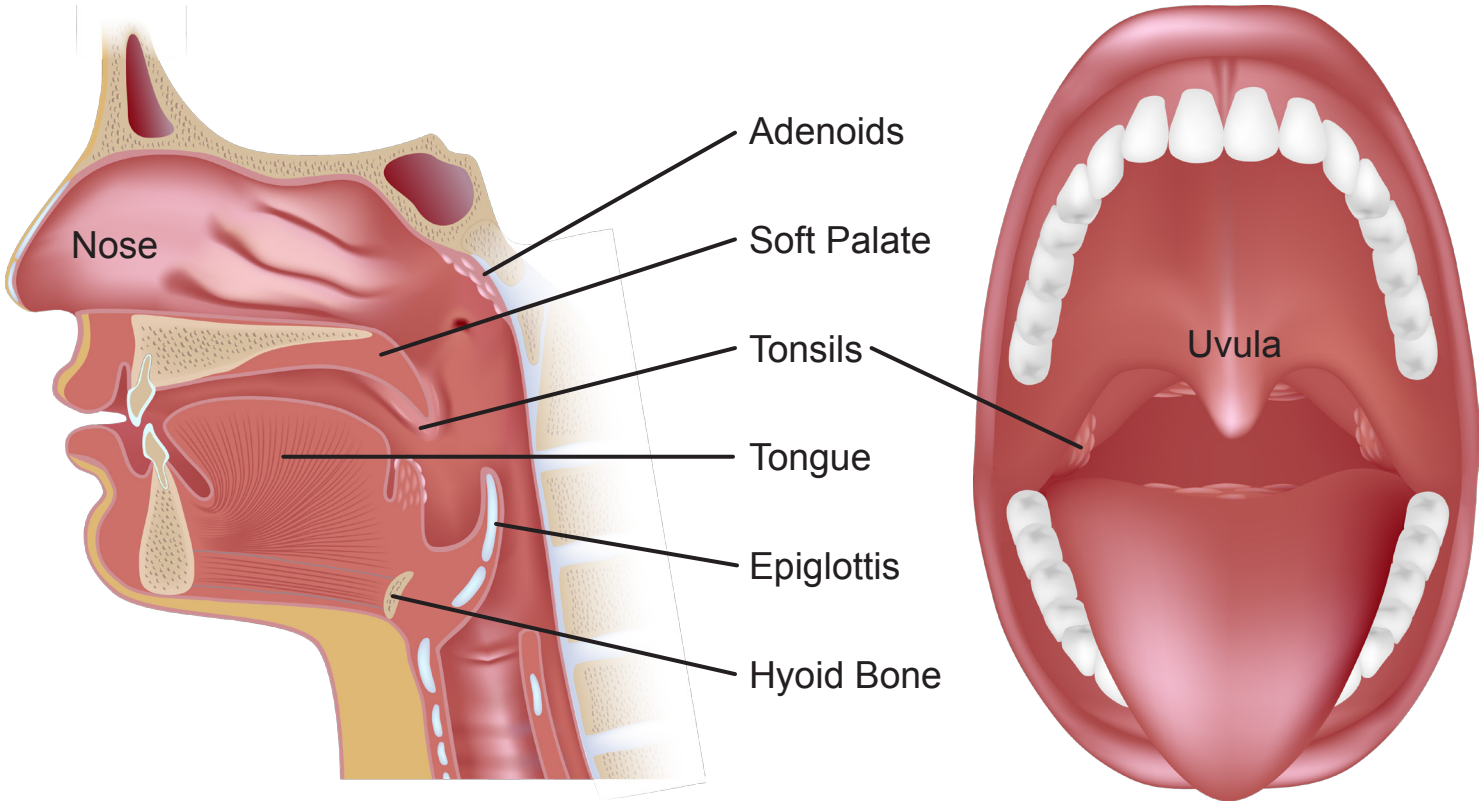
Muscles used to breathe become more relaxed during sleep than they are during the day. In some children, they become so relaxed that it interferes with breathing.

Symptoms of a Child with OSA

- Odd positions during sleep
- Loud and continuous snoring
- Stopping breathing during the night
- Having school or behavior problems
- Sweating heavily during sleep

Factors that Increase Risk of OSA

- Enlarged tonsils and adenoids
- Abnormality in face or jaw
- Down Syndrome and other congenital abnormalities
- Overweight and/or obesity



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MILD

Obstructive Sleep Apnea

OBSERVATION

BENEFIT

- 45% may resolve

SIDE EFFECT

- Continued symptoms
- OSA may worsen over time

FOLLOW-UP

- 3-6 months or with change in symptoms

MEDICAL TREATMENT

BENEFIT

- About 90% respond
- Improve nasal breathing
- Covered by most insurance

SIDE EFFECT

- Nasal Spray
  - 1% nosebleeds
- Singulair
  - 10% do not respond
  - < 1% mood issues
  - Duration unclear

FOLLOW-UP

- 3-6 month clinic visits
- Recommend repeat sleep study
- Evaluate need to continue medication

OXYGEN

BENEFIT

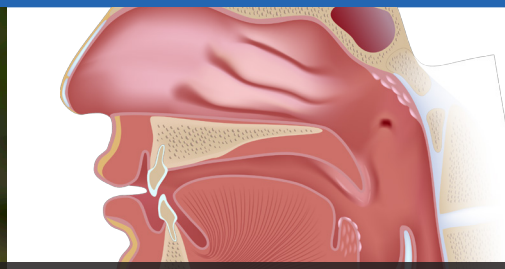
- About 50% respond
- Can treat central apneas too
- Temporary solution
- Covered by most insurance

SIDE EFFECT

- Skin irritation / dry nose
- Not tolerated well in toddlers
- Harder to travel with than medication

FOLLOW-UP

- 3-6 months clinic visits
- Recommend oxygen sleep study
- Recommend repeat sleep study off oxygen in 3-12 months



SOFT TISSUE SURGERY

BENEFIT

- 50-60% respond
- Can be long-term solution
- Covered by most insurance

SIDE EFFECT

- Limited activity for 2 weeks
- Pain up to 2 weeks
- Risk of bleeding

FOLLOW-UP

- 2 clinic visits if resolved
- Recommend repeat sleep study

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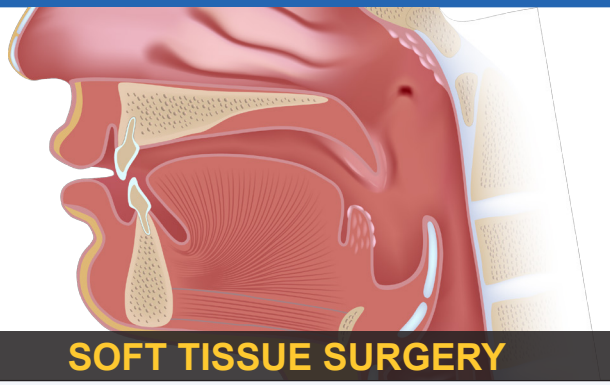
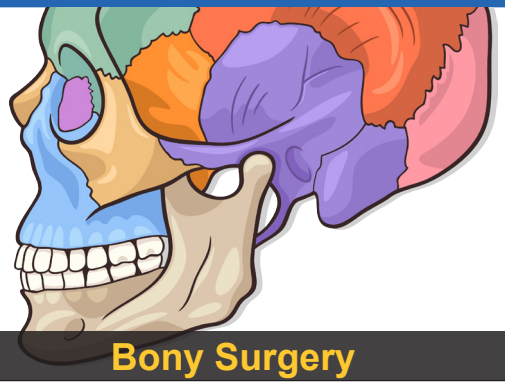
MODERATE/SEVERE

Obstructive Sleep Apnea





	POSITIVE PRESSURE	SOFT TISSUE SURGERY	Bony Surgery
BENEFIT	• 95% effctive if used • Effective immediately	• 50-60% respond • Can be long-term solution • Covered by most insurance	• 90% responders for 2 jaw surgery • Can be long-term solution • Covered by most insurance
SIDE EFFECT	• Skin irritation • 40-50% able to tolerate • Long-term bony changes	• Pain up to 2 weeks • Risk of bleeding • Limited data	• Limited activity for 4 weeks • Pain up to 4 weeks • Jaw often wired • Changes facial appearance
FOLLOW-UP	• 3-6 month clinic visits • Long-term use • Monthly downloads • Sleep studies every 1-2 years	• 2 visits after surgery • 1 sleep study if successful	• 4 visits after surgery • 1 sleep study if successful

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James M. Anderson Center for Health Systems Excellence

Decision Aids to Facilitate Shared Decision Making in Practice

Decision aids are evidence-based tools to augment patient-parent-clinician communication to ensure that:

- Patients and parents receive standardized information on the pros and cons of the medically reasonable options in a way that can be easily understood
- Patient and parent preferences are elicited about important trade-offs among the various options
- The option selected is congruent with the families' well-informed preferences

Tools and Resources

ADHD Treatment for the School-Age Child

Shared Decision Making Tools

- Card guide
- ADHD medication choice cards
- Parent booklet
- Parent pre-visit cards
- Printing instructions

Evidence

- AAP: clinical practice guideline
- AHRQ: clinical practice guideline

Presentations / Publications

- Cincinnati Children's Pediatric Grand Rounds, Sept. 11, 2012 (Discussion of SDM starts on slide 35)
- Physicians' shared decision-making behaviors in attention-deficit / hyperactivity disorder care
- Shared Decision Making to Improve ADHD Care

Decision Aid Development Team

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Funding Source

- Cincinnati Children's: Place Outcomes Research Award

Conflict Disclosure

- No conflicts to disclose

OPTION 5 Modified Version (Barr et al., 2015)

The following items form the Observer OPTION 5Mod. Items should be scored independently of each other. Scoring should be summed, yielding a total score between 0 and 20, and then rescaled to lie between 0 and 100.

Item	No Effort	Minimal Effort	Moderate Effort	Skilled Effort	Exemplary Effort
Item 1: **Affirm need for a decision** For the health issue being discussed, the clinician **draws attention to or re-affirms** that alternate treatment or management options exist or that the need for a decision exists. If the ***patient*** rather than the clinician draws attention to the availability of options, the ***clinician responds*** by agreeing that the options need deliberation.	0	1	2	3	4
Item 2: **Support education and deliberation process** The clinician reassures the patient, or re-affirms, that the clinician will support the patient to **become informed and to deliberate** about the options. If the ***patient*** states that they have sought or obtained information prior to the encounter, the ***clinician supports*** such a deliberation process.	0	1	2	3	4
Item 3: **Describe options, exchange views** The clinician **gives information, or checks understanding, about the pros and cons of the options** that are considered reasonable (including taking 'no action'), to support the patient in comparing the alternatives. If the ***patient*** requests clarification, explores options, or compares options, the ***clinician supports*** the process.	0	1	2	3	4
Item 4: **Elicit preferences** The clinician makes an **effort to elicit the patient's preferences** in response to the options that have been described. If the ***patient*** declares their preference(s), the ***clinician is receptive/supportive***.	0	1	2	3	4
Item 5: **Integrate preferences and decisions** The clinician makes an **effort to integrate** the patient's preferences as decisions are made. If the ***patient*** indicates how best to integrate their preferences as decisions are made, the ***clinician is supportive***.	0	1	2	3	4

Total Score _____ (0–20)
Total Score - Rescale _____ (Total Score X 5; 0-100)

Scoring Guide

Score	Description
0 = No effort	Nothing observed or heard.
1 = Minimal effort	Short phrases used that indicate the ideas/issue is being raised.
2 = Moderate effort	Substantive (basic/reasonable) phrases/sentences used to convey the ideas and issues.
3 = Skilled effort	Substantive phrases/sentences used to convey the ideas and issues, with checks on understanding.
4 = Exemplary effort	Excellent, careful attention to communication around the ideas and issues, with checks on understanding.

Barr PJ, O'Malley AJ, Tsulukidze M, Gionfriddo MR, Montori V, Elwyn G. The psychometric properties of Observer OPTION5, an observer measure of shared decision making. *Patient Education and Counseling*, 2015, Aug:98(8): 970-6.