

Sad and bad



Picking up significant child and adolescent emotional and behavioural problems in a general practice setting

Louise Webster

Child and Adolescent Psychiatrist

Starship Children's Hospital and University of Auckland

Prevalence rates of psychiatric disorder in community samples

- Preschool -16%
- 11 years of age -18% (Dunedin study)
- 15 years of age - 22%
- 18 years of age - 36.0%
- 5% of children and adolescents have severe psychiatric disorder requiring specialist mental health service input

The major disorders

- Children
 - Anxiety
 - Conduct
 - ADHD
- Adolescents
 - Anxiety
 - Depression
 - Conduct/antisocial
 - Substance



What about children with chronic medical illness?

- Chronic illness not involving the CNS
 - 2-3X increase in psychiatric disorder
- Chronic illness involving the CNS
 - 10X increase in psychiatric disorder

(Rutter 1970, Cadman 1987)

Where are children and adolescents with mental health problems seen?



Presentation to family doctors and paediatric services

- 1 - 2% for overt mental health problems

BUT

- 20% of school aged children attending GP have psychiatric disorders
- 40% of adolescents attending GP have psychiatric disorder
- **Parental request** is the strongest predictor of referral to specialist psychiatric services

GP frequent fliers

- Children and adolescents with mental health problems present more frequently to GPs, usually with somatic complaints
- Children with frequent somatic complaints and medically unexplained symptoms have high rates of anxiety/depression

In summary

- The majority of children and adolescents with psychiatric disorder are **NOT** seen in mental health services.
- They are however more likely to be seen in primary care and general paediatric settings, where they present with **somatic symptoms**.

Why bother to pick them up?

- Childhood conduct problems are precursors of multiple adverse outcomes
 - crime, imprisonment, mental health problems, suicidal behaviour, physical health problems
- Childhood anxiety commonly precedes
 - adult depression, anxiety, and substance abuse
- Early intervention is the most effective especially with conduct disorder

So how do you pick them?

- **Play to your strengths**
 - You have often known these families for years
 - You know the parents and siblings
 - You have longitudinal knowledge that most child psychiatrists would give their eye-teeth for
 - You notice changes in the child and the family and wonder what's up

You know the parents

- Anxious parents have anxious kids
- Depression runs in families
- Antisocial parents with coercive parenting style have children with conduct problems
- Substance abuse is often multi-generational
- Marital discord, domestic violence, abuse and neglect associated with psych. problems

You know these children

- Difficult infant temperament – colic, crying, unsettled
- Difficult attachment relationship with parent
- Always anxious, missing lots of school
- Already been expelled from kindy
- Your receptionist warns you that they have destroyed the waiting room

When should you check

- When meeting child/adolescent for the **first time**
- If things have '**changed**' for young person
 - Change in presentation to you (eg withdrawn)
 - Medically unexplained symptoms
 - Major family stresses
- Child or parent raise **concern**
- **Red flags** – eg self-harm, intoxication, injuries, pregnancy, truanting etc

What do you need

- To have (or to build) a relationship with the child/adolescent that is
 - Trusting and positive
 - Non-judgemental
 - Able to talk about feelings and sensitive issues
- This will mean
 - Relating directly to the child in the parent's presence
 - Spending part of the consultation with the adolescent by him or herself

The main focus is on function

- Is this young person **functioning OK** in the various important areas of her/his life?
- Have there been any **significant changes** in function?
- Symptoms that are **not** accompanied by functional disability are more likely to mild and self-limiting

With children - **HEARTS**

- **Home** - conduct, general behaviour and manageability
- **Education** - progress and behaviour at school
- **Activities** - attention span, ability to finish tasks
- **Relationships** - with parents/peers, bullying
- **Temper** - tantrums, mood
- **Size** - appetite, weight gain or loss



With adolescents - **HEEADSSS**

- **Home** - relationships, communication, anyone new?
- **Education/Employment** - actual marks, hours, responsibilities
- **Activities** - with peers, with family
- **Drugs** - tobacco, alcohol, tobacco, other drugs – use by friends, family, self
- **Sexuality** - identity, relationships, coercion, contraception, pregnancy, STIs
- **Suicide** and depression – sadness, boredom, sleep patterns, anhedonia
- **Safety** - injury, seatbelt use, violence, rape, bullying, weapons

- For Maori tamariki and rangatahi well-being cannot be separated from the wellbeing of whanau, hapu and iwi (whare tapa wha model)
- Cultural identity may also be a critical domain for young people from minority cultures

The major disorders

- Children
 - Anxiety
 - Conduct
 - ADHD
- Adolescents
 - Anxiety
 - Depression
 - Conduct/antisocial
 - Substance

Depression

- **Persistent sad or irritable mood**
- **Loss of interest or enjoyment in activities**
 - Difficulty sleeping or oversleeping
 - Substantial change in appetite or body wt.
 - Difficulty concentrating
 - Loss of energy
 - Psychomotor agitation or retardation
 - Feeling worthless or inappropriate guilt
 - Recurrent thoughts of suicide or death

In depressed children and adolescents

- **Irritability** often more prominent
- Symptoms more **unstable** – may have a ‘good’ day, or retain some isolated interest
- **Somatic symptoms** prominent in children and in those with anxiety as well as depression
- **Hopelessness** an important prognostic sign for suicidal ideation and attempts

Risk for suicide

- Approx. 90% have a **mental disorder**
 - depression, anxiety disorders, substance use disorders, antisocial and offending behaviours, schizophrenia, and bipolar disorder
- exposure to **recent stress** or life difficulty
- exposure to **childhood adversity** and trauma
- tendency to be **impulsive** and aggressive when stressed
- socioeconomic and educational disadvantages.

Youth 2000 survey mood symptoms and suicide

- **Depressive symptoms**

18.3% females 9% males

- **Suicidal thoughts in 15 year olds**

34% females 20% of males

- **Suicide attempt**

14% females 6% males

Assessment of suicidal adolescent

- Suicidal intent and plan
- Lethality
- Access to means
- Risk factors eg intoxication, impulsivity
- **Hopelessness**
- Psychosocial triggers
- Psychiatric diagnosis and history
- Presence or lack of protective factors

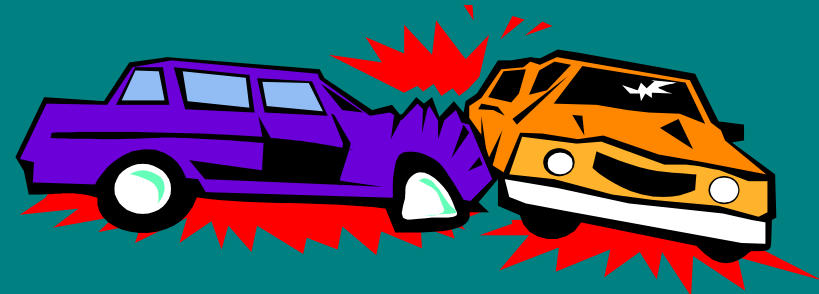


Remember that....

- Adolescents are often poor assessors of potential lethality
- You have **not** completed an assessment until you have a corroborative history from family/friends
- Limits to confidentiality must be clearly articulated

Conduct Disorder

- Repetitive and persistent pattern of behaviour in which the basic rights of others or major age appropriate societal norms or rules are violated
 - aggressive conduct to people/animals
 - harm to property
 - deceitfulness or theft
 - serious violations of rules



Separation Anxiety Disorder

- Developmentally inappropriate and excessive anxiety concerning separation from parents and home
 - Often have fears of monsters, kidnappers, car accidents, etc. which threaten integrity of family
 - School Refusal common
 - Often demanding, intrusive and in need of constant attention
 - Often have somatic complaints
 - May have associated Depression

Attention Deficit Hyperactivity Disorder

- **Inattention**
- **Hyperactivity**
- **Impulsivity**
 - Symptoms before 7 years of age
 - In two or more settings
 - Causes dysfunction
 - ADHD subtypes Inattentive, Hyperactive or Combined

- Using an assessment tool
 - **SDQ**
 - Strengths and Difficulties Questionnaire covers range of disorders
 - ages 4-11yrs, 11-17yrs, parent version
 - **CRAFT** for substance abuse
- Available from NZGG website
 - <http://www.nzgg.org.nz/CMD-assessmenttools>



What then

- **Immediate referral** to secondary care mental health services for anyone who has
 - Serious suicidal intent
 - Psychotic symptoms
 - Severe self neglect
- **Urgent referral** to secondary care for
 - Severe depression
 - Suspected bipolar disorder

For mild to moderate problems

- Initial management in primary care setting
- Involve others
 - Practice nurse
 - Practice psychologist
 - School guidance counsellor
 - RTLB resource teacher for behaviour and learning
 - GSE group special ed.
- Schedule regular reviews
- Refer on to community mental health services CAMHS if not improving

Depression

- Mild to moderate initially managed with
 - Active listening
 - Problem identification and simple problem solving
 - Simple self-management – exercise, activity routines, good sleep
 - Enlisting/strengthening other supports eg family, SGC
 - Regular review 1-2 weekly

What next

- If worsening, or no improvement after 6 weeks refer to secondary care mental health
- Antidepressants
 - On advice of child and adolescent psychiatrist for moderate to severe depression
 - Fluoxetine has best evidence base in young people
 - Start low with 5-10 mg mane **after** food
 - Must warn about early increase in anxiety/agitation and in suicidal ideation. Family and GP monitoring important.
 - No evidence of increased suicide with fluoxetine

Conduct Disorder

- Mainstay of early treatment is **parent management training**
- **Incredible Years Program**
 - Available through Ministry of Education via GSE, CAMHS and many NGOs such as Barnados
- **Triple P** – also available in Primary Care module
 - Early detection and brief behavioural counselling
 - 0-12 years and teenagers (13-16 years)
 - info.nz@triplep.net www.triplep.net

Anxiety

- Simple behavioural and cognitive strategies
 - parents must be on board
 - Simple relaxation
 - Graduated exposure to things the child is anxious about eg return to school
 - Treatment of comorbid depression helps
- Resources include 'Coping Cats', 'How to help your anxious child', RTLBs

ADHD

- Good **parent management** for co-morbid ODD and Conduct problems – Incredible Years
- Do better in **structured setting** at school/home
- **Stimulants** still most effective for moderate to severe and require child psychiatrist or paediatrician to approve application
- Methylphenidate short acting 2-3 x daily or one of the sustained release formulations Concerta
- **Monitor** height weight BP and effectiveness

In summary



- Build evaluation of mental health into routine consultation
- Use the knowledge you already have about these children and their families
- **HEARTS** and **HEAADSSS**
- Focused enquiry if problems
- Immediate referral on if serious suicidal intent, psychotic symptoms, self-neglect

Useful web-sites for young people with depression or anxiety

- www.thelowdown.co.nz
- <http://moodgym.anu.edu.au>
- <http://ecouch.anu.edu.au>
- Beyondblue website in Australia





11 year old children (Dunedin Study)

- **Any disorder** **18%**
- Conduct/oppositional 9%
- ADHD 7%
- Separation anxiety 4%
- Overanxious 3%
- Depression/dysthymia 2%

Types of disorder at 15 years

Christchurch Health and Development Study

- **Any disorder** 22%
- Anxiety disorders 13%
- Mood disorders 6%
- Substance abuse 6%
- Conduct 5%
- ADHD 3%