

Oxfordshire & Buckinghamshire  
Mental Health Partnership NHS Trust



# Child and Adolescent Psychiatry in General Practice

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# Introduction

- Mental illness is a serious problem among children and young people with 1 in 10 experiencing some form of diagnosable mental disorder
- The incidence of mental health problems, especially more serious conditions, is higher among adolescents than in younger children
- The incidence of mental health problems among children with learning disabilities is 4 times higher than for other children

- **Child and Adolescent Mental Health Services (CAMHS)** include the range of *multi-agency* and *multidisciplinary* services for children, young people and their families which promote and improve mental health and psychological well-being. The services extend from education and community primary care through to highly specialised services.

# Tiered Service Delivery (1)

- Health services for children with mental health problems are subdivided into four tiers of increasing specialisation, complexity and cost.
- The model is intended as a conceptual framework for ensuring that a comprehensive range of services is commissioned and available to meet the mental health needs of children and young people in an area, with clear referral routes between **tiers**.
- Most children and young people will be seen in Tiers 1 and 2.

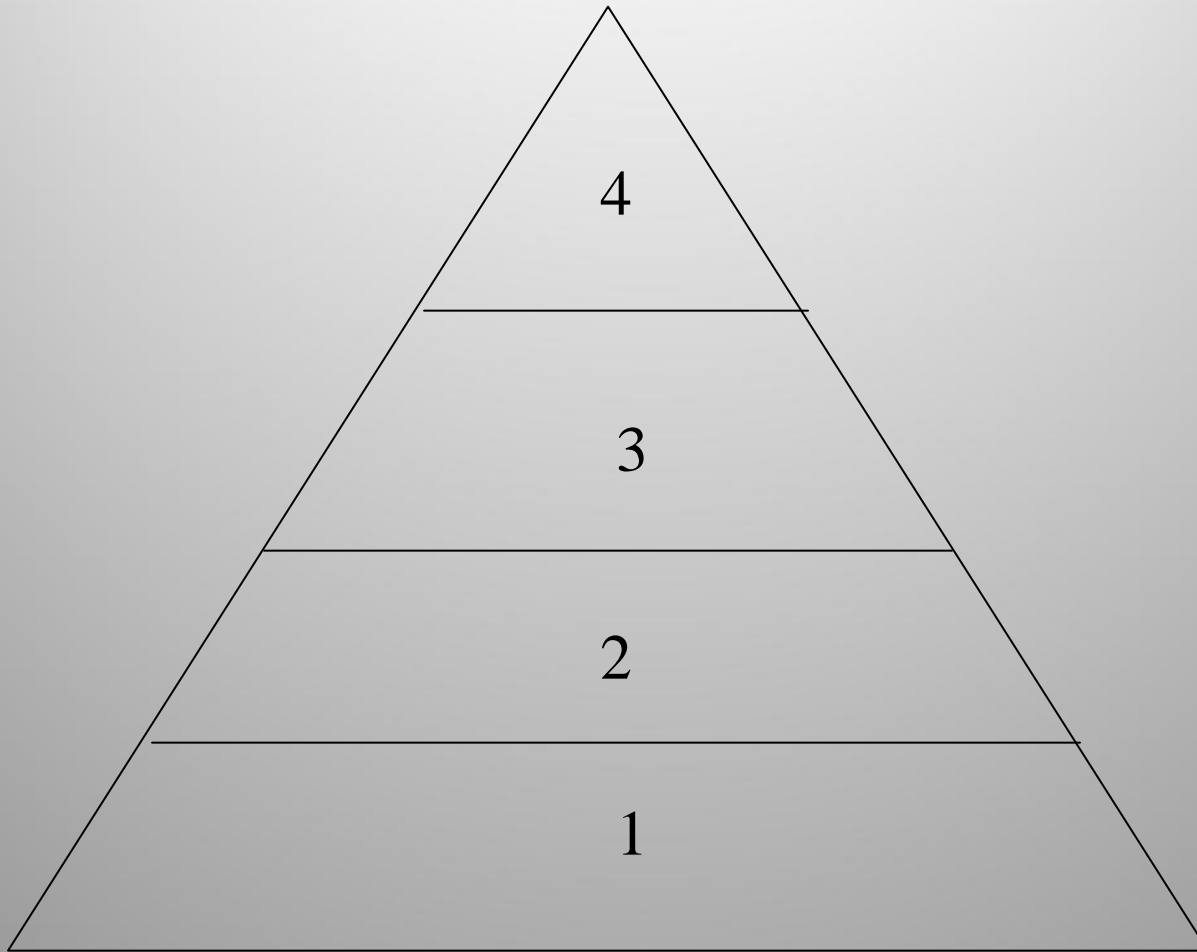
# Tiered Service Delivery (2)

- **Tier 1:** involves practitioners *without* a mental health background (GP's, health visitors, school nurses, teachers, social workers, youth justice workers, voluntary agencies). They offer general advice and treatment for less severe problems, contribute towards mental health promotion, identify problems early in their development, refer to more specialist services
- **Tier 2:** involves CAMHS specialists working in community and primary care settings (primary mental health workers, psychologists and counsellors working in GP practices/paediatric clinics/schools/youth services), offering consultation to families and other practitioners.

# Tiered Service Delivery (3)

- **Tier 3:** Multidisciplinary teams (comprising child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, occupational therapists) working in community mental health clinics or hospital outpatient services, providing specialised service for more severe, complex and persistent disorders.
- **Tier 4:** tertiary level services for children and young people with the most serious problems, such as highly specialised outpatient teams (e.g neuropsychiatric), day units and inpatient units (e.g. eating disorders units, secure forensic adolescent units).

# CAMHS tiered service



# Local Services

- SpCAMHS Banbury – 0-18 service based at Orchard Health Centre
- Social and Health Care (SW, mentor system, foster care, residential homes)
- Education (ESW, EdPsych, Connexions, Behavioural Outreach Team)
- Adolescent Unit JR
- Primary Child and Adolescent Mental Health Service (PCAMHS)
- Youth Offending Team (YOT)
- Face to face counselling
- Highfield inpatient unit
- Drug and alcohol services - Evolve

# PCAMHS

- Early intervention service (Tiers 1-2) for ages 0-18
- Offers short interventions of up to 6 sessions in settings familiar and easily accessible to children/families (schools, children's centres, GP's practices, home)
- Single screening and referral process for all **non-emergency** SpCAMHS services since November 2006

# Risk factors for child and adolescent psychiatric disorder

- **Factors in the child**
  - Genetic
  - Sex
  - Intelligence, temperament
  - Physical illness, developmental delay
- **Factors in the family**
  - Traumatic stress (bereavement)
  - Abuse
  - Parenting style, marital conflict
  - Parental psychiatric disorder
- **Factors in the environment**
  - School difficulties
  - Peer relationships
  - Social deprivation
  - Other stresses

# Common mental health problems in childhood

- Behavioural problems (severe temper tantrums, defiant, disruptive behaviour)
- Sleep problems
- Feeding problems
- Enuresis, Encopresis
- Neurodevelopmental disorders (ADHD, Autism, tics)
- Anxiety disorders with or without psychosomatic problems
- Oppositional-Defiant Disorder and Conduct Disorders

# Common mental health problems in adolescence

- Depression
- Deliberate Self-harm
- Psychosis
- Alcohol and Drug Misuse
- Eating Disorders
- Obsessive-Compulsive Disorder

# Child Psychiatric Treatment Approaches

- Parental Counselling/Training
- Behaviour modification techniques
- Cognitive-Behaviour Therapy
- Family therapy
- Individual Psychotherapy
- Group Therapy
- Medication (ADHD, OCD, Depression, Psychosis, Tics)

## Relevance to General Practice

- The GP is often the first health professional in contact with the child/adolescent with mental health problems
- It is important to get as detailed a picture as possible about the difficulties from interview with the parent as well as observation of young person and their interaction with parent
- In older children/adolescents individual interview may be helpful (to include problems at home, school difficulties, relationships with peers)
- Often psychological difficulties can go unrecognised, especially if clinical picture is dominated by physical symptoms.

# Indications for referral

- Difficulties which do not respond to treatments offered at Tier 1 (by GP's, health visitors or counsellors attached to surgery) warrant referral to more specialist services
- Cases where there is marked symptomatology and disruption to the young person's daily functioning at home and/or school also warrant referral
- Cases where a more specialised assessment is required or where a specific therapeutic approach is recommended (e.g. Cognitive-Behavioural Therapy)

# Case scenario 1

- 13 year old boy
- Refusing to go to school
- Withdrawn, at home, unhappy
- Complains of feeling sick frequently in the morning
- Sleeping poorly
- Parents do not know what to do

What is the differential diagnosis?

How would you manage in general practice?

What would be the indications for referring on to CAMHS?

# Possible causes of low mood

- Physical illness
- Problems at school
  - Bullying, poor peer relationships
  - Learning difficulties
  - Problems with teachers
- Problems at home
  - Family relationship difficulties, abuse
- Psychiatric disorder
  - Anxiety, depression, psychotic state

# Symptoms of depression in adolescents

- Key Symptoms

  - Persistent sadness, or low and irritable mood**

  - Loss of interest and/or pleasure

  - Fatigue or low energy

- Associated symptoms

  - Poor or increased sleep

  - Low self confidence

  - Poor concentration or indecisiveness

  - Poor or increased appetite

  - Suicidal thoughts or acts

  - Guilt or self blame

  - Agitation or slowing of movements

Mild up to four symptoms, moderate 5-6 Severe 7-10 symptoms

# Management (stepped care model)

- Detection (Tier 1)
- Mild depression (Tier 1 or 2)
- Moderate to severe (Tier 2 or 3)
- Unresponsive depression (Tier 3 or 4)

## Criteria for management at Tier 1

- Exposure to single undesirable life event a) in the absence of other risk factors for depression or b) in the presence of two or more risk factors with **no** evidence of depression and/or self-harm
- Exposure to single undesirable life event with multiple family histories of depression **without** any evidence of depression and/or self-harm in the young person
- Mild depression without comorbidity

# Management in primary care

- Risk profiling
- Detection of depression
- Watchful waiting (mild cases who do not wish or warrant intervention, arrange for further assessment within 2 weeks)
- Supportive therapy
- Guided self-help
- Group Cognitive Behaviour Therapy (CBT)
- Attention to diet-sleep-exercise

## Criteria for referral to Tier 2 or 3

- Mild depression with no evidence of response to interventions at Tier 1 after 2-3 months
- Moderate or severe depression (incl. psychotic)
- Signs of recurrence in those who have recovered from previous moderate to severe depression
- Unexplained self-neglect of at least 1 month's duration
- Active suicidal ideation/plans
- Referral requested by young person or parent/carer

# Management at Tier 3

- Cognitive Behaviour Therapy (CBT)
- Interpersonal Therapy (IPT)
- Family therapy
- Medication may be added in
- Fluoxetine is first line drug

## Criteria for referral to Tier 4

- High recurrent risk of acts of self-harm or suicide
- Significant ongoing self-neglect (poor personal hygiene, significant appetite and weight loss that could be harmful to physical health)
- Requirement for intensity of assessment and/or treatment and/or level of supervision that is unavailable at tiers 2 and 3.

# Case Scenario 2

- 14 year old girl
- Poor eating
- Moody, irritable
- Loss of weight

What is the differential diagnosis?

How would you manage in general practice?

What would be the indications for referring on to CAMHS?

# Prevalence of eating disorder

- 1-2% of adolescent girls have eating disorder
- 13% have serious eating control problems or over-concern about weight and shape
- 40-50% diet at some point
- Those that diet are at increased risk of eating disorder

# Anorexia nervosa

- Refusal to maintain body in normal range, with weight deficit of at least 15%
- Intense fear of gaining weight
- Disturbance of the perception of weight and shape
- Hormonal disturbance

# Bulimia nervosa

- Recurrent episodes of binge eating
- Recurrent compensatory behaviour (e.g. self-induced vomiting, laxative misuse, diuretics, fasting, excessive exercise)
- Self-evaluation unduly influenced by body shape and weight

# Risk factors in eating disorders

- Individual

  - Previous history of depression/obesity

  - Low self esteem/perfectionism

  - Early feeding difficulties

  - Female gender

- Family

  - History of eating disorders/obesity/alcoholism/depression

  - Early adverse experience in the family

- Socio-cultural factors

# Management in Primary Care

- Identification of problem and initial assessment (calculation of minimum healthy weight, menstruation, blood tests)
- Dietary advice, provision of education and information (self-help and support groups)
- Coordination of care and monitoring of medical and psychological need based on written agreement with other health care professionals involved

# Case Scenario 3

- 16 year old boy
- Parents ring urgently from home
- Behaving oddly
- Talking in a bizarre way about his special powers
- Hardly slept for last couple of nights
- Eating poorly
- Aggressive if asked to do anything

What is the differential diagnosis?

How would you manage in general practice?

What would be the indications for referring on to CAMHS?

# Causes of psychosis in adolescence

- Drug induced
- Depressive psychosis
- Mania
- Bipolar disorder
- Organic psychosis
- Schizophrenia
- Stress induced psychotic episode

# Case scenario 4

- 15 year old girl
- Parents ring up from home
- Daughter has taken overdose of 10 paracetamol

What is the differential diagnosis?

How would you manage in general practice?

What would be the indications for referring on to CAMHS?

# Risk factors for self harm

- Characteristics of recent attempt
- Current and lifetime suicidality
- Negative life events
- Psychiatric disorder (depression, substance misuse)
- Psychological characteristics (hopelessness, impulsivity, aggression, poor problem solving)
- Gender
- Family factors (family dysfunction, abuse, psychiatric disorder)
- Social/community circumstances
- Availability of lethal agents

# Risk assessment: self harm

- **P** Have you had problems for longer than a month?
- **A** Were you alone in the house at the time?
- **T** Did you plan the overdose for more than three hours
- **HO** Are you feeling hopeless about the future?
- **S** Were you sad for most of the time before the overdose?

## Management of self-harm in Primary Care

- Offer full assessment of physical, psychological and social needs
- Assess risk of further self-harm (consider depression and suicidal intent).
- Consider whether urgent referral to more specialist services is necessary and send full details of assessment.

# Case scenario 5

- 13 year old boy
- Constantly washing his hands and checking the light switches
- Parents have tried to talk him out of it but unsuccessful
- Gets extremely anxious if he cannot check
- On occasions gets his mother to check things for him

What is the differential diagnosis?

How would you manage in general practice?

What would be the indications for referring on to CAMHS?

# Obsessional compulsive disorder in adolescents

- **Obsessional thought**

- intrusive, unwanted thought, image or impulse that causes distress, is time consuming and interferes with functioning

- **Compulsive behaviour**

- repetitive behaviour performed in response to an obsession or according to rigid rules. Purpose is to reduce distress or to prevent a dreaded situation from happening

## **Prevalence**

**1-2% of population in UK**

# Management (Stepped Care Model)

- **Step 1:** Awareness and recognition (individuals, public organisations, NHS)
- **Step 2:** Recognition and assessment (GP's, practice nurses, school health advisors, health visitors, general health settings)  
Detect, educate, discuss treatment options, signpost to voluntary support organisations, provide support to individuals/families/carers/school or refer to pore specialist input

# Stepped Care Model (ctd)

- **Step 3:** Management and initial treatment (GP's, primary care team, primary care mental health workers, family support team, CAMHS Tier 1-2)

Guided self-help, CBT, involve family/carers and consider involving school

- **Steps 4-6 (CAMHS Tiers 2-4):** treatment of cases with poor response to initial treatment/comorbidity or impaired functioning

Thank you for your attention