COMMON CAMHS PRESENTATIONS IN PRIMARY CARE

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- Mental Health of Children and Young People in England, 2017 -Date range:01 Jan 1999 to 31 Dec 2017

-Funded by the Department of Health and Social Care

-Commissioned by NHS Digital

- Carried out by the National Centre for Social Research, the Office for National Statistics and Youth in mind.

- One in eight (12.8%) 5 to 19 year olds had at least one mental disorder when assessed in 2017.
- Specific mental disorders were grouped into four broad categories: emotional, behavioural, hyperactivity and other less common disorders.
- Emotional disorders were the most prevalent type of disorder experienced by 5 to 19 year olds in 2017 (8.1%)

- Rates of mental disorders increased with age.
- **5.5% of 2 to 4 year old** children experienced a mental disorder, compared to **16.9% of 17 to 19 year olds** (NB diff in data collection)
- Data from this survey series reveal a slight increase over time in the prevalence of mental disorder in 5 to 15 year olds (the age-group covered on all surveys in this series).
- Rising from **9.7% in 1999** and **10.1% in 2004**, to **11.2% in 2017**

- Emotional disorders have become more common in 5 to 15 year-olds – going from **4.3% in 1999** and **3.9% in 2004** to **5.8% in 2017.**
- All other types of disorder remained similar since 1999.

- Hinrichs S, Owens M, Dunn V, et al. **General practitioner experience and perception of Child and Adolescent Mental Health Services (CAMHS) care pathways: a multimethod research study.** BMJ Open 2012;2:e001573. doi:10.1136/bmjopen-2012001573

- Pilot study with the objective of investigating general practitioner (GP) perceptions and experiences in the referral of mentally ill and behaviourally disturbed children and adolescents.
- Gp’s were chosen from the five localities that deliver CAMHS within the local Trust (PeterboroughCity, Fenland,Huntingdon,Cambridge City and South Cambridgeshire).

- The likelihood of a referral from GPs rejected by CAMHS -> 3X higher compared to all other referral sources combined within the Cambridge and Peterborough NHS Foundation Trust.
- Interviews showed that detecting the signs and symptoms of mental illness in young people is a challenge for GPs.

- There is no standardised specialised-knowledge base nor protocol-driven decision-making tool from which GPs can develop their clinical decision-making skills in this area.

- GPs ?to refer on a mixture of the presenting conditions and their perceived likelihood of acceptance by CAMHS
- The criteria for referral appeared poorly understood by the interviewed GPs.

Why am I here?

- To provide a perspective on CAMHS presentations
- What works
- What does not work
- Any suggestions re: the interface
- Answer your questions

Objectives:

1. Identification of common CAMHS presentations to primary care
2. When to refer
3. To hear what is the expectation from primary care of a Tier 3 service

Mental health: it’s a big problem!

- 10% of children and young people (5-16 y)
- 20% of adolescents in any given year.
- 50% established by 14y, 75% by 24.2y
- 70% inappropriate interventions at a sufficiently early age.

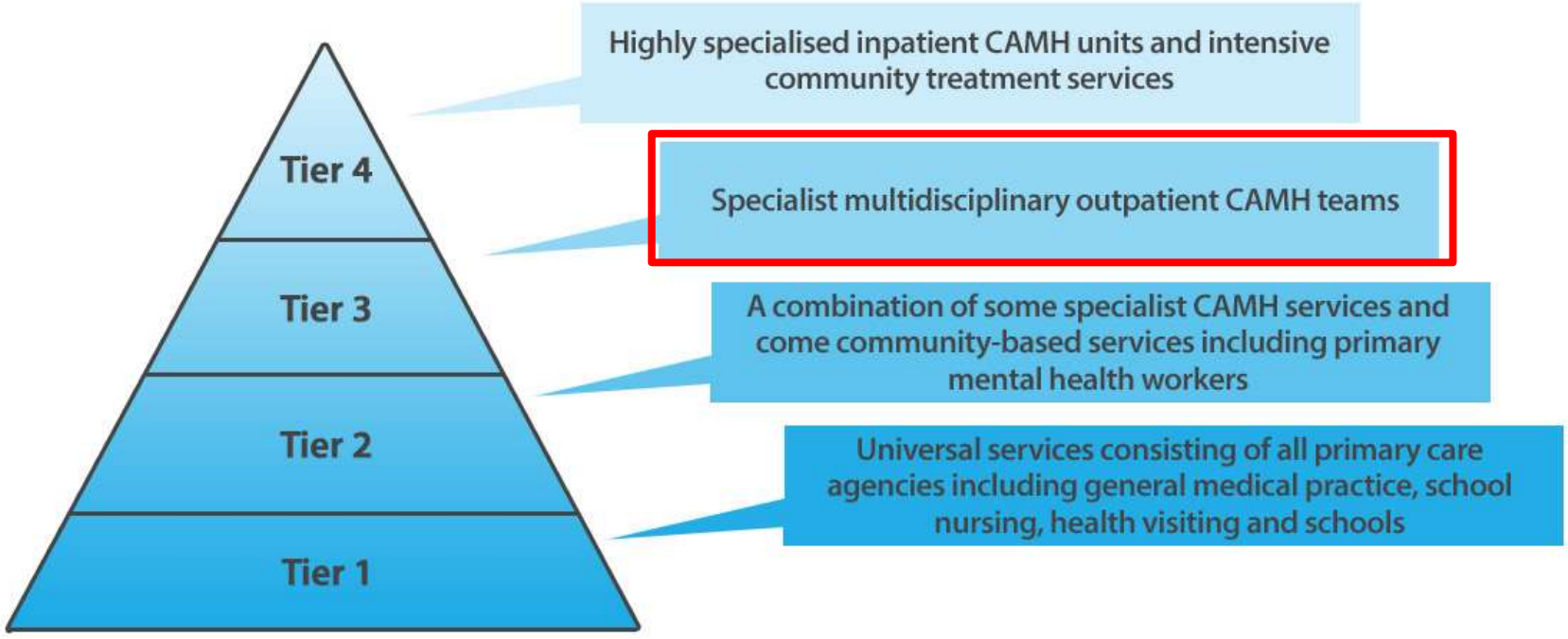
- Route of Referral into CAMHS

❑A

❑B

A

B


Tier 4
Tier 3
Tier 2
Tier 1
Highly specialised inpatient CAMH units and intensive community treatment services
Specialist multidisciplinary outpatient CAMH teams
A combination of some specialist CAMH services and come community-based services including primary mental health workers
Universal services consisting of all primary care agencies including general medical practice, school nursing, health visiting and schools

Common presentations

- Depressive Disorders
- Anxiety Disorders
- Challenging Behaviour:- Attention deficit hyperactivity disorder
- Eating Disorders

Mood Disorders

Depressive Disorders

- Depression is thought to occur in about 1-3% of children and young people. Anybody can suffer from depression and it affects people of all ages, ethnicities, and social backgrounds.

- It is more common in older adolescents, particularly teenage girls, but can affect children of any age.

- Persistent depression → serious complications

Depressive Disorders

- Depressed mood
- Irritability
- Loss of interest and enjoyment
- Reduced energy leading to increased fatigability and diminished activity.
- Marked tiredness after only slight effort is common.
- Reduced concentration and attention
- Reduced self-esteem and self-confidence
- Ideas of guilt and unworthiness
- Bleak and pessimistic views of the future
- Ideas or acts of self-harm or suicide
- Disturbed sleep
- Appetite changes

Psychosocial risk factors:

- family discord
- bullying
- physical, sexual or emotional abuse,
- comorbid disorders, including drug and alcohol use
- history of parental depression
- homelessness
- refugee status and living in institutional settings.

NICE

- **For children and young people, the following factors should be used by healthcare professionals as indications that management can remain at tier 1:**
- exposure to a single undesirable event in the absence of other risk factors for depression
- exposure to a recent undesirable life event in the presence of 2 or more other risk factors with no evidence of depression and/or self-harm
- exposure to a recent undesirable life event, where 1 or more family members (parents or children) have multiple-risk histories for depression, providing that there is no evidence of depression and/or self-harm in the child or young person
- mild depression without comorbidity.

NICE

- **For children and young people, the following factors should be used by healthcare professionals as criteria for referral to tier 2 or 3[1] CAMHS:**

- depression with 2 or more other risk factors for depression
- depression where 1 or more family members (parents or children) have multiple-risk histories for depression
- mild depression in those who have not responded to interventions in tier 1[1] after 2–3 months
- moderate or severe depression (including psychotic depression)
- signs of a recurrence of depression in those who have recovered from previous moderate or severe depression
- unexplained self-neglect of at least 1 month's duration that could be harmful to their physical health
- active suicidal ideas or plans
- referral requested by a young person or their parents or carers. [2005]

NICE

- When a child or young person is exposed to a single recent undesirable life event, such as bereavement, parental divorce or separation or a severely disappointing experience, in the absence of other risk factors for depression, healthcare professionals in primary care, schools and other relevant community settings should offer support and the opportunity to talk over the event with the child or young person.

NICE

- Following an undesirable event, a child or young person **should not normally be referred** for further assessment or treatment, as single events are unlikely to lead to a depressive illness.

Depressive Disorders

Assessment:

- duration of low mood
- precipitating /perpetuating factors
- biological symptoms
- risk

Mild depression

- Watchful waiting- further assessment should be arranged, normally within 2 weeks ('watchful waiting‘)
- Healthcare professionals should make contact with children and young people with depression who do not attend follow-up appointments.
- Offer psychological therapy (e.g. CBT)
- NO Antidepressant drugs 

Moderate / severe depression

- Psychological therapy ± antidepressant drugs
- Careful monitoring
  - adverse drug reactions
  - mental state and general progress

- No response -MDT review.
- Co-existing factors, co morbidity, perpetuating factors
- Consider family work

- Fluoxetine - **only antidepressant licensed for use in depression in young people**
- (12-18 years) if unresponsive to a psychological therapy .
- (5-11 years) -evidence not established.
- Under 8 years - outside of the licensed indications.

- The current NICE Guidelines recommend that in young people under the age of 18 if an antidepressant is to be prescribed ***this should only be following assessment and diagnosis by a Child and Adolescent Psychiatrist.***

We are here to help!

- Discuss cases with the Child and Adolescent Psychiatrist in the local Specialist CAMHS Clinic
- Seek advice if unsure.
- No urgency in starting antidepressant medication.

Risk Assessment

- Associated Self harm
- Act
- Intent
- Trigger
- Help sought
- Suicidal intent

Bipolar Disorder

- Alternating periods of depression and mania.
- Bipolar disorder is extremely rare in young children, but there are quite a few studies that suggest that it may start in teenage years and in early adult life.
- It affects about one in 100 adults.

BPAD Symptoms

- feeling incredibly happy or 'high' in mood, or very excited
- feeling irritable
- talking too much -increased talkativeness
- racing thoughts
- increased activity and restlessness
- difficulty in concentrating, constant changes in plans
- over confidence and inflated ideas about yourself or your abilities
- decreased need for sleep
- not looking after yourself
- increased sociability or over-familiarity
- increased sexual energy
- overspending of money or other types of reckless or extreme behaviour.

- Emotional Dysregulation might present as fluctuations in mood.
- BPAD “trendy diagnosis”

Anxiety disorders

- Most common psychiatric disorder in childhood
- Affect 5 – 18% of children
- Strikingly common, strikingly disabling
- Can cause serious disruption to children's lives
- Often persistent over time
- They are associated with an increased risk of subsequent mental health problems, substance misuse, and poor educational attainment, and have a high economic and societal burden. As such, there is a need for early access to evidence-based intervention.

Anxiety Disorders

- Past personal or family history of anxiety disorders.
- Increase in stressful psychosocial life events.
- Lack of social support network.
- Lack of or maladaptive coping strategies.
- Unresolved grief.
- Advanced or terminal illness.
- Acute or chronic pain.

Anxiety Disorders

- Differentiate between normal fears, worries, and shyness and pathological anxiety.
- Understand normal developmental anxiety. Eg older children and teens are often worried about social competence, health matters and school performance.
- ?Interfere with functioning and development.

AGE	Psychological & social competencies	Principal source of fear	Principal anxiety disorders
2-4 years Pre-school	•Pre-operational thinking •Capacity to imagine but inability to distinguish fantasy from reality	Imaginary creatures •Potential burglars •The dark	Separation anxiety
5-7 years Early childhood	Concrete operational thinking •Capacity to think in concrete logical terms	•Natural disasters •Injury •Animals •Media-based fears	•Animal phobia •Blood phobia •Separation anxiety
8-11 years Middle childhood	•Self-esteem centres on academic and athletic performance	•Inadequate academic and athletic performance	•School phobia •OCD
12-18 years Adolescence	•Formal operational •Peer rejection thought •Capacity to anticipate future dangers •Self-esteem derived from peer relationships	•Peer rejection	•Social phobia Later adolescence •Agoraphobia •Panic disorder

Anxiety disorders

Assessment

- Young people with anxiety disorders are unlikely to present for help independently, with parents commonly raising concerns to GP's.
- As anxiety disorders represent an extreme presentation of normal events, this distinction is essentially made on the basis of the severity and persistence of symptoms and the degree of associated impairment.
- -Common symptoms: worried, upset, feeling sick, feeling shaky/dizzy
- -Feeling like you might faint /pass out
- -Thinking unpleasant thoughts
- -Thinking that you might "go crazy"

Classification Anxiety Disorders

- Generalised Anxiety Disorder
- Separation Anxiety Disorder
- Social Anxiety Disorder
- Specific Phobias
- Selective Mutism
- Body Dysmorphic Disorder
- Obsessive Compulsive Disorder
- Post-Traumatic Stress Disorder

Generalized Anxiety Disorder

- GAD is characterized by chronic and excessive worries about multiple areas such as school, home, future, health, natural disasters.
- Worries are accompanied by somatic complaints.
- As those symptoms are internal, parents and teachers are often not aware of the magnitude.

Social Anxiety Disorder

- Patients with Social anxiety show severe discomfort in one or more social setting.
- They are very self-conscious and are very afraid of being scrutinized and judged.
- They may have a lot of avoidance. They may be afraid to answer questions, start conversations, eat in front of others, answer the phone, accept peer invitations.
- Social anxiety often peaks in teenage years.

Panic Disorder

- They are characterized by sudden recurrent panic attacks. Some symptoms include feeling very anxious, pounding heart, sweating, shortness of breath, dizziness, chest pain, tingling, feelings of unreality, fear of loss of control…
- Patients who have panic attacks often are afraid of having another attack and may avoid situations or setting where the attacks have occurred.

Mild anxiety

- Psychological intervention

Moderate / severe anxiety

- Psychological intervention ± medication

- NICE guidelines
- All interventions should be delivered by competent practitioners who receive regular, high-quality supervision that is informed by routine monitoring of treatment progress from each treatment session.
- The content of treatment should be based on relevant evidence-based treatment manuals, and adherence to these manuals should be monitored and evaluated in supervision, for example, using video or audio recordings of treatment sessions

School Refusal

- Irrational fear of school attendance
- School refusal is differentiated from other attendance problems such as truancy – absence concealed

School Refusal

- Usually at a time of change of school, or period of absence.
- Openly express unwillingness to go to school or physical symptoms.
- Absence of symptoms over weekends, school holidays, still able to go out with friends.
- School refusal affects approximately 1% of school children across the primary and secondary school levels.
- Severe school refusal in less than 1 per 1000 aged 10-11years , more common in 14 yr. olds (Rutter et al)
- Peaks at school transition, also in adolescence -5, 11 ,14-15 yrs most common.
- No particular social class trend, boys and girls affected equally

School Refusal

- Previous Personality
- Family History
- School factors

School Refusal

- Assessment
- Investigate physical symptoms
- Thorough history looking at psychosocial factors
- Consider psychiatric presentations and family role

School Refusal

- Management
- Return to school
- Family support
- Consistent boundaries

School Refusal

Outcome

- Mild cases resolve.
- More severe cases esp in older children with personality problems, do not have such a good outcome(Berg 1970)
- 1/3 go on to have significant psychiatric disorders of depressed /anxious type in adolescence and adulthood.
- Majority grow into healthy adults without any difficulties.

Medication for anxiety disorders

- SSRIs -first-line pharmacological treatment.
- Safety and efficacy of medications other than SSRIs not been established.
- TCAs not often used in children -need for close cardiac monitoring and greater medical risks with overdose.

- **Pregabalin** 
- **Benzodiazepines** have not shown efficacy in controlled trials in children with anxiety disorders. Clinically, they are sometimes used short term to achieve acute reduction in severe anxiety symptoms while an SSRI is started or to permit initiation of the exposure phase of CBT for children who refuse to go to school or who have panic disorder or specific phobia. Not to be initiated at primary care
- **Propranolol** 

ADHD

Presentation to Primary care:

-Behavioural difficulties, school exclusions, aggression, parents unable to manage

ADHD

Assessment:

- History from parent
- History from school and school report
- Observation of child
- Screening questionnaires

ADHD

- One of the most common childhood-onset psychiatric disorders.
- “persistent” or on-going pattern of inattention and/or hyperactivity-impulsivity interferes with daily life or typical development.
- Difficulties with maintaining attention, executive function and working memory.

Presentations of ADHD

- Inattentive
- Hyperactive-impulsive
- Combined inattentive & hyperactive-impulsive

Inattentive

- Fails to give close attention to details or makes careless mistakes.
- Has difficulty sustaining attention.
- Does not appear to listen.
- Struggles to follow through on instructions.
- Has difficulty with organization.
- Avoids or dislikes tasks requiring a lot of thinking.
- Loses things.
- Is easily distracted.
- Is forgetful in daily activities

Hyperactive-impulsive

- Fidgets with hands or feet or squirms in chair.
- Has difficulty remaining seated.
- Runs about or climbs excessively in children; extreme restlessness in adults.
- Difficulty engaging in activities quietly.
- Acts as if driven by a motor; adults will often feel inside like they were driven by a motor.
- Talks excessively.
- Blurts out answers before questions have been completed.
- Difficulty waiting or taking turns.
- Interrupts or intrudes upon others

Inattentive and Hyperactive-impulsive

- Has symptoms from both of the above presentations.

ADHD: treatment

NICE Guidelines

- Behavioural Intervention
- Medication
- Shared Care and concerns around this

Eating disorders

- Morbid preoccupation with weight and shape and manifests through distorted or chaotic eating behaviour.
- Differentiates these disorders-other types of psychological problems associated with abnormal eating behaviour—such as extreme faddy (selective) eating.

- 1.6 million people in the UK are affected by an eating disorder
- 11% of the 1.6 million are male
- 14-25 year olds are most affected by an eating disorder
- There are up to 18 new cases of bulimia per 100,000 people, per year
- 1 in 100 women aged between 15 and 30, are affected by anorexia
- 10% of people affected by an eating disorder suffer from anorexia

- **Anorexia nervosa** - 3rd commonest chronic illness of adolescence, affecting 0.5% of adolescent girls

- **Bulimia nervosa** - secretive nature of the disorder and adolescents' reluctance to seek help mean that it is often hidden

- Take into consideration context of normal pubertal growth and adolescent development

- Assessment of the young person on their own- establish diagnosis, risk, and attitude to help

- Diagnostic criteria helpful
- Intervention in adolescents with abnormal eating attitudes and behaviours :

❖ those who vomit or take laxatives regularly but do not binge

❖ whose rate of weight loss is of more concern than degree of underweight

Presenting Features Eating Disorders

Anorexia nervosa

- At least 15% below that expected or body mass index is 17.5 or lower
- Weight loss is self induced by :

❖avoidance of “fattening foods” plus one or more of:

❖ self induced vomiting; self induced purging; excessive exercise; use of appetite suppressants or diuretics

- Body image distortion
- Widespread endocrine disorder
- If onset is pre-pubertal, puberty is delayed or arrested. With recovery, puberty is often normal, but the menarche is late

Bulimia Nervosa

- Persistent preoccupation with eating;
- Overeating episodes in which large amounts of food are eaten in short periods of time
- Counteract the “fattening” effects of food by one or more of:

1. self induced vomiting or purgative abuse;
2. alternating starvation and eating;
3. use of appetite suppressants, thyroid preparations, or diuretics

- BMI centiles must be used to define underweight
- A BMI lower than the ≤2nd centile indicates serious underweight
- Expected weight for height and age
- Consider also if an adolescent fails to attain or maintain a healthy weight, height, or stage of sexual maturity for age

Assessment

- How much would you like to weigh?
- How do you feel about your weight?
- Are you or is anyone else worried about your eating or exercising?)
- Anorexic cognitions
- Behaviours

- Asked in a non-judgmental manner—can be helpful in deciding whether further assessment is needed
- An adolescent's distress about being asked about weight and food should heighten concern

Concerns

- Is a reluctant attender at the surgery or clinic
- Seeks help for physical symptoms
- Resists weighing and examination
- Covers body
- Is secretive or evasive
- Has increased energy (and in some cases agitation- standing ,moving about)
- Gets angry or distressed when asked about eating problems

Physical Assessment

- Height, weight
- Physical Examination
- ECG
- Blood Investigations

Physical signs of malnutrition and purging:

- thinning hair
- parotid gland swelling
- enamel erosion
- hypothermia
- bradycardia
- lanugo hair
- dry skin
- hypotension
- underweight
- amenorrhea

- constipation,
- cold hands and blue/mottled peripheries, poor capillary return,
- carotenaemia,
- insensitivity to pain
- shrunken breasts

- Growth retardation and short stature
- Impairment of bone mineral acquisition, leading to osteopenia or osteoporosis
- Psychological sequelae—anxiety and depression

- Admission to hospital - acute physical compromise, high psychiatric risk, or after an adequate trial of outpatient treatment

Case 1

- 14y old girl low mood, superficial self harm, with suicidal ideation and a previous undisclosed overdose.

Case 2

- 8y old boy disruptive in class , very anxious and easily distressed. Poor concentration and falling behind academically.

Case 3

- 16y old boy low mood, anxiety, difficulties with sleep and appetite. Self harm and passive suicidal ideation.

Case 4

- 12y old girl restrictive pattern of eating, occasional vomiting with weight loss, physical symptoms of tiredness, dizziness.

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