CHILD AND ADOLESCENT MENTAL HEALTH

MOOD DISORDERS

	Depression	Generalised Anxiety Disorder	Obsessive Compulsive Disorder
PP	Common in any age group	XS and disproportionate anxiety and worry that negatively impacts ADL ➢ Can be a daily basis or months at a time	Behaviour characterised by **daily** 1) **Obsessions** – *unwanted and uncontrolled thoughts and intrusive images difficult for pt to ignore* 2) ***Compulsions*** - repetitive actions patients feel urged to do to avoid being anxious
RF	• Recent significant life events (e.g. death of loved one, new terminal diagnosis, family divorce etc.)	FHx	➢ A+D ➢ Eating disorders ➢ ADHD ➢ Phobias
Sx	• Low mood • Anhedonia ***PLUS*** • Suicidal ideation • Insomnia • Guilt • Low energy • Poor concentration • LoA	➢ Irritable ➢ Poor concentration ➢ Anxious ➢ Nervousness ➢ Time > 6/12 ➢ Restlessness ➢ Reduced energy ➢ Impaired sleep ➢ Tension in muscles	Vicious cycle ➢ Obsessions → anxiety → compulsive behaviour (temporarly improves anxiety)
Comp.	➢ Suicide	Suicide	Suicide or harm to others
Ix	➢ HEADDSSS ➢ DASS-21	➢ HEADDSSS ➢ GAD-7	➢ HEADDSSS
Mx	**Mild or low mood**: Watchful waiting and advice: ➢ Eat healthy, adequate sleep, ➢ Avoid alcohol and cannabis ➢ F/U in 2 weeks **Mod-severe**: **Psychotherapy – CBT, family therapy** ➢ SSRI = 10mg fluoxetine (max = 20mg) ➢ 2nd line - sertraline, citalopram **If responsive to Rx** ➢ Continue for 6/12 after remission **Suicidal risk**: **Admit and observe overnight** ➢ Mental health Act 2009	**Mild**: **Watchful waiting and advice:** ➢ Eat healthy, adequate sleep, ➢ Avoid alcohol, caffeine and drugs ➢ Check environmental triggers (e.g. bullies, peer pressure, drugs usage) ➢ F/U in 2 weeks **Mod-severe**: **Psychotherapy – CBT, family therapy** ➢ SSRI = 10mg fluoxetine (max = 20mg) ➢ 2nd line - sertraline, citalopram **If responsive to Rx** ➢ Continue for 6/12 after remission	**Mild OCD**: ➢ Patient and carer education ➢ self-help resources ➢ Psychologist referral **Mod-severe OCD**: **Psychotherapy – CBT, family therapy** ➢ SSRI = 10mg fluoxetine (max = 20mg) ➢ 2nd line - sertraline, citalopram

EATING DISORDERS

	ANOREXIA NERVOSA	Bullemia Nervosa	Binge Eating	General Mx
PP	Feel overweight despite evidence indicating they are normal or low weight ➢ **U**nderweight ➢ **N**ervousness to gain weight ➢ **D**istorted perception about wt ➢ **E**xercise, purging ➢ **R**estricted intake	**Normal body weight that FLUCTUATES all the time** ➢ **B**inging ➢ **O**ffsetting (purging, laxatives) ➢ **W**eekly for ≥3/12 ➢ **L**inked to self-esteem to weight (e..g overweight = rejection)	Patient excessively overeats usu. due to psychological distress ➢ Overweight patients (not restrictive)	**Patient and carer education (key)** ➢ *MDT: Psych, paediatrician, dietician, nurses, supporting family* ➢ Self-help resources ➢ Counselling ➢ CBT ➢ Address social issues (e.g. relationships, past experiences) **Medical Mx (if conservative fails)** ➢ SSRI (under specialist supervision) ➢ Admit to observe for **refeeding syndrome** **Refeeding syndrome** ➢ Eating after severe nutritional deficit ➢ Lower the BMI = lower period of malnutrition = higher the risk ➢ Eating after prolonged starvation period causes cells to finally process glucose, proteins and fats (consuming electrolytes) → o hypoMg, HypoK, hypoPO4 o arrythmias, HF and fluid overload ➢ **Slow re-introduction** (restricted calories) → via NGT, PEG or Oral *Aim for 3-4000 calorie intake/day (1-2kg wt gain/week)* ➢ **EUC and fluid balance monitor** ➢ **ECG monitor** (Arrhythmias) ➢ **Vit suppl**. (e.g. B1, B9 and B12)
RF	• Personality disorders • OCD • Anxiety • Girls	• Personality disorders • OCD • Anxiety • Girls		
Sx	• XS weight loss • Amenorrhoea • Lanugo hair (fine soft hair) • **Altered mood, anxiety and depression**	➢ Swollen **salivary glands (parotid and submandibular)** ➢ Mouth ulcers ➢ Teeth erosion ➢ Russell's sign – *Calluses on knuckles which have scraped across teeth* ➢ GORD	• Planned binge • Eating very quickly • Eating when not hungry or satiety • Eating in dazed state	
Comp.	➢ Cardiac → arrythmias, cardiac atrophy and sudden cardiac death		Obesity – T2DM	
Ix	➢ HypoTN ➢ Hypothermia (**red flag)** ➢ HypoK ***Admit to hospital if haem unstable:*** ➢ Postural hypoTN, bradycardia, hypothermia, hypoglycaemia, QT prolonged (low Ca, Mg, K) ➢ *Rapid severe wt loss* ➢ *Unsafe behaviour*	➢ HypoK	➢	

BEHAVIOURAL DISORDERS

	AUTISM SPECTRUM DISRODER (ASD) → 1 in 70	ATTENTION DEFICIT HYPERACTIVITY DISORDER → 1 in 20	PERSONALITY DISORDERS (PSD)
PP	Spectrum of diseases in patients with difficulty in social interaction, communication and flexible behaviour ➢ **Aspergers (mild autism)** – normal intelligence but difficulty reading emotions and responding to others ➢ **Severe autism** – cannot function in normal environments	**Extreme end of "hyperactivity" spectrum and inability to concentrate ("attention deficit")** ➢ Sig. impact on ADL ➢ Present in ALL settings (NOT just school) → if isolated only to school suggests environmental problem not ADHD	**Umbrella term for variations in maladaptive personality traits** ➢ Causes psychosocial distress and interferes with ADLs ➢ Difficult relationships, reduced QoL and poor physical health
RF.	➢ *genetics, autoimmune, infections* ➢ *associated w/ NF2, Tuberous sclerosis, fragile X*	➢ *genetics of catecholamine imbalance.* ➢ *FHx, [re-term, LBW, brain injury, ante-natal* ➢ *EtOH & drugs exposure*	➢ Genetics ➢ Environmental factors (e.g. childhood trauma)
Sx	➢ Poor eye contact ➢ Delayed smiling ➢ Avoids physical contact ➢ Cannot read non-verbal cues or gestures ➢ Difficulty establishing relationships Communications ➢ Delayed or regressed language development ➢ Lack of smiling, eye contact, gestures ➢ Repetitive use of words or phrases Behaviours ➢ More interest in objects, numbers than people ➢ **Self-stimulating movements are comforting** (e.g. hand-flapping, rocking) ➢ Rigid interests + repetitive behaviour/ routine ➢ Restricted food preferences	**DSM 5 diagnostic criteria** (2x types) Child < 12 yo presents w/ > 6 mths of pervasive (≥2 settings) – and not during another psychotic disorder (e.g. schizo) **FIDGETY** ➢ Functional impairing of ➢ Inattention ➢ Disinhibition ➢ Greater than normal ➢ Exclude other disorders ➢ Two or more settings ➢ Young at onset (<12 yo) **Type** / **Daydreamers = inattention** / **Disrupters = *hyperactive + impulsive*** **Cognitive**: ➢ careless, not listening, ➢ loses objects, ➢ Inattention ➢ slow thinkers / ➢ fidgety, restless, ➢ XS talk, cannot sit still – must do something **Social Issues**: Cannot form relationships (poor social skills) / Peer rejection → low self-esteem + poor academics **Adult Sx**: Inattentive / Impulsive behaviour	**Suspicious personality disorder** ➢ **Paranoid** – *difficulty trusting and revealing personal info* ➢ **Schizoid** → lack of interest to form relationships as feels no benefit ➢ **Schizotypal** – *unusual beliefs, thoughts and behaviours makes forming relationships difficult* **Anxious personality disorder** ➢ **Avoidant** – *severe anxiety about rejection and avoids social interactions* ➢ **Dependent / passive** → heavy reliance on others to make decisions and take responsibility over their own lives ➢ **OCD** – *unrealistic expectations about how things should be done and catastrophising if expectations not met* **Depressive/emotional/impulsive** ➢ **Borderline** – *strong emotions and difficulties maintaining identity* ➢ **Histrionic** → yearns for centre of attention and performs to maintain it ➢ **Narcisstic** – *feels special and needs others to recognise that they are. Puts themselves 1st*
Ix	Clinical Dx by paediatric psychiatrist	➢ Clinical Dx by paediatric psychiatrist ➢ ***DSM V criteria for formal dx***	➢ Clinical Dx by paediatric psychiatrist ➢ ***DSM V criteria for formal dx***
Mx	**MDT approach = NO CURE – improve working environ.** ➢ Paediatrician ➢ Speech and language specialists ➢ Social workers ➢ Child psychologists ➢ Specially trained educators and schools ***Pharmacological for symptoms ONLY:*** ➢ Stimulants (ADHD) ➢ Antipsychotic (anxiety) ➢ SSRI (for OCD)	***Non-pharm (behavioural)*** ➢ Parental education - short instructions (both pts and families) ➢ Maintain healthy diet and exercise (food diary, eliminate triggers) ➢ clear routines + rest breaks + organised environment ➢ immediate consequences for any wrongdoings ***Pharm (if conservative Mx fails)*** ➢ CNS STIMULANTS: Methylphenidate (**RITALIN**) or Dexamphetamine [*regulated prescription – start on Short-acting to test effectiveness before using long acting*] ➢ **A/E:** poor appetite, insomnia and HTN, psychosis	➢ **Patient and carer education** ➢ **CBT and psychotherapy** – will take to change as thoughts/behvaiours deeply ingrained **Avoid any medical treatments** ➢ **Only give concurrent A or D**

UNUSUAL BEHAVIOURS

	Tourette's and Tics	Infantile Colic	Fussy eaters
PP	**Tics** = **Transient irreversible contraction** or sounds child performs repetitively throughout day ➢ More obvious when excited **Tourette's syndrome** = persistent tics over a year (2x forms of tics – motor and vocal)	➢ **Dx of exclusion** ➢ **Unexplained Persistent Unsettled crying HEALTHY baby** for: **> 3hr/day** for **≥ 3days /week** for **≥3 weeks**	➢ **common** in toddlers = 50% (but may **flag** Autism Spectrum Disorder ➢ restricted intake, rejected food, consume inadequate variety, food preferences
RF.	➢ *5 year olds* ➢ *OCD* ➢ *ADHD*	➢ *1-5 month olds*	LBW, advanced maternal age, smoking, lower pregnancy BMI
Sx	*Simple tics* ➢ Clear throat ➢ Blinking ➢ Head jerking ➢ Sniffling ➢ Grunting ➢ Eye rolling *Complex Tics* ➢ Perform physical movements – twirl on spot or touch objects ➢ **Copro**praxia – make obscene gestures ➢ **Copro**lalia - say obscene words ➢ **Echo**lalia – repeat other people's words	➢ *knees drawn up to chest,* ➢ *arched back,* ➢ *hypertonia (clenched fist, facial flushing, grimace)* ***DDx:*** ➢ **infection** – meningitis, ENT, LRTi, GITi, UTI, sepsis, torsion ➢ **acute abdomen** – ISS, appendicitis ➢ **cow's milk or soy protein allergy** (GORD or lactose intolerance)	Depends on def: **Fe**: Pale, low energy, FTT, FTG **Vit D**: hypoCa = seizures, rickets/osteomalacia =bowed legs **B12**: Subacute SC deg **Iodine**: Hypothyroidism, Cretinism
Ix	Clinical Dx by paediatric psychiatrist	**ABCDEFG**+/- UA + Stool M/C/S ➢ Ht, wt, length, milestones	➢ Child eating behaviour questionnaire (CEBQ) or Paediatric nutrition screening tool
Mx	**Mild - reassurance and monitoring** ➢ Reduce stress, anxiety and triggers **Severe and troublesome tics** ➢ Paediatric specialist referral ➢ Habit reversal training ➢ Exposure with response prevention ➢ **Anti-psychotics** ➢ Rx co-morbidities – OCD, ADHD	**Comfort distressed baby** ➢ Sleep hygiene ➢ Warm baths **Reassure parents** to prevent risk of: ➢ *NAI,* ➢ *post-partum depression* ➢ *stop BF*	**Educate** that fussy eating **DOES NOT** equal eating disorder ➢ limit snacks, family meals, ➢ parental modelling ➢ , avoid negativity and pressure to eat ➢ Dietician referral ➢ Screen for underlying cause (e.g. coeliac, thyroid disease)