Quality in Practice Committee

Child and Adolescent Mental Health: Diagnosis & Management

Authors: Dr Nikki O'Keeffe, Dr Blanaid Gavin, Professor Walter Cullen & Professor Fiona McNicholas

Whilst every effort has been made by the Quality in Practice Committee to ensure the accuracy of the information and material contained in this document, errors or omissions may occur in the content. This guidance represents the view of the ICGP which was arrived at after careful consideration of the evidence available. The guide does not however override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of individual patients in consultation with the patient and/or guardian or carer.

Evidence-Based Medicine

Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.

In this document you will see levels of evidence (Level 1 – 5) and grades of recommendations (Grades A-C), which have been adapted to reflect the revised Oxford Centre 2011 Levels of Evidence.

Levels of evidence

Level 1: Evidence obtained from systematic review of randomised trials
Level 2: Evidence obtained from at least one randomised trial
Level 3: Evidence obtained from at least one non-randomised controlled cohort/follow-up study
Level 4: Evidence obtained from at least one case-series, case-control or historically controlled study
Level 5: Evidence obtained from mechanism-based reasoning

Grades of recommendations

A Requires at least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation. (Evidence levels 1, 2)

B Requires the availability of well-conducted clinical studies but no randomised clinical trials on the topic of recommendation. (Evidence levels 3, 4).

C Requires evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities. Indicates an absence of directly applicable clinical studies of good quality. (Evidence level 5).

ICGP Quality in Practice Committee 2012

Dr Paul Armstrong (Chair), Dr Patricia Carmody, Dr Sheena Finn, Dr Susan McLaughlin, Dr Grainne Ni Fhoghlu, Dr Raymond O'Connor, Dr Maria O'Mahony, Dr Margaret O'Riordan, Dr Benedict Parmeter, Dr William Ralph, Dr Philip Sheeran Purcell.

Table of Contents

Introduction

1.1 Background

Approximately, 10% of children aged 5-15 year have a mental disorder[1] (**Level 5, Grade C**). Research has shown that almost 50% of all lifetime psychiatric disorders start by mid adolescence and 75% by the mid twenties[2] (**Level 5, Grade C**). Many disorders can persist into adulthood, causing long-term morbidity. A delay in treatment can have an adverse impact on treatment response and outcome. Thus it is critical that mental health disorders are diagnosed early and appropriate timely treatment interventions are put in place.

1.2 Aim of the Document

The aim of this document is to provide General Practitioners (GPs) with guidance on diagnosing and managing mental health difficulties in children and adolescents.Mental health difficulties in children can be complex and range from psychiatric (Axis 1) disorders to non-psychiatric disorders. In all cases a holistic approach to the management of the child and the family is paramount. The contribution of social and environmental supports is central to recovery.

The initial part of this document deals with the most common psychiatric (Axis 1) disorders presenting in childhood and adolescence. Aids are provided for the diagnosis of each of these disorders aswell as for the diagnosis of deliberate self-harm and suicidality. These aids take the form of common concerns parents may present with about their child and key questions that the GP can ask the parents or youngster as an aid to making the diagnosis.

The following part of this document provides an overview of the referral options for children and adolescent with mental health disorders. Guidelines are provided for the referral of Children and Adolescents to local Child and Adolescent Mental Health Services (CAMHS). This is reserved for children and adolescents who have been diagnosed with a psychiatric (Axis 1) disorder. Many children, however, present with emotional difficulties, which do not constitute Axis 1 disorders but are significantly debilitating to require referral to other services. These referral options are also discussed. It is acknowleged that there is a great deal of variability in access to both CAMHS and other services including social services throughout the country, therefore these guidelines do not explicitly provide information on individual local services in each catchment area.

For the purpose of this document, a 'child' is defined as someone who is under the age of 18 years. In addition, a 'child' will be referred to using male gender only.

Section 2 Common Psychiatric Disorders and deliberate self-harm

The initial part of this document deals with the most common psychiatric (Axis 1) disorders presenting in childhood and adolescence including the topic of deliberate self-harm as follows:

- Attention Deficit Hyperactivity Disorder (ADHD)
- Depression
- Deliberate Self Harm
- Anxiety disorders
- Eating Disorders
- Substance Misuse
- Schizophrenia and psychotic spectrum disorders

Aids are provided for the diagnosis of each of these disorders. These aids take the form of common concerns parents may present with about their child and key questions that the GP can ask the parents or youngster as an aid to making the diagnosis. It must be noted that these are simply diagnostic aids and a full list of items that should be included in the history and mental state examination are listed in Appendix 2 and 3 respectively.

A complete list of Axis 1 disorders is available in Appendix 1. It must be noted that deliberate self-harm is not an Axis 1 psychiatric disorder per se, but is discussed in this section as all children and adolescents who self-harm will require referral to child and adolescent mental health services.

2.1 Attention Deficit Hyperactivity Disorder (ADHD)

Attention Deficit Hyperactivity Disorder (ADHD) is one of the most common neurodevelopmental disorders, affecting 3-5% of the school age population[3] (**Level 5, Grade C**). It is characterized by inattentiveness, over-activity, impulsivity, or a combination of all to meet the diagnostic criteria. Impairing symptoms persist into adulthood in up to 60% of cases, but the overt hyperactivity is replaced by emotional deregulation, inner restlessness and impatience[4] (**Level 5, Grade C**).

Parents may present with the following concerns:
'My son is always on the go / cannot sit still / unable to focus his attention / is always daydreaming".
'His teachers report that he is constantly disruptive in class and distracting others'
Useful Questions to ask parents:
Q: Is your child easily distracted / disorganized / forgetful in daily activities?
Q: Does your child have difficulty sustaining his attention / completing tasks?
Q: Does your child lose things necessary for tasks?
Q: Does your child fidget with his hands / squirm in his seat / have difficulty waiting his turn / frequently interrupt others / climb about or run excessively?
Q: Does your child talk excessively / blurt out answers before questions are completed / seem to be continuously 'on the go' or 'driven by a motor?'

Treatment of ADHD

Referral to the local Child and Adolescent Mental Health Service (CAMHS) is advised for the treatment of ADHD. Treatment involves a multimodal approach including psychoeducation, educational support, parenting programmes and medication. Resources available such as support groups and parenting programmes are listed in Appendix 4. Psychostimulant medication is the first line medication for ADHD[5] (**Level 5, Grade C**). Methylphenidate is the most common stimulant and is available in short acting and long acting forms. Other options include Atomoxetine, a non-stimulant medication, with a once daily dosage. Treatment in adults is similar, although licensed indications are for continuation rather than denovo treatment.

Section 2.2 Depression

Major Depressive Disorder (MDD) affects 2% of children and the prevalence increases significantly during adolescence [6, 7] (**Level 5, Grade C**). Depressed children and adolescents often present with marked irritability rather than a history of pervasive low mood. Other presentations include social withdrawal, academic deterioration, school refusal, mood swings and vague non-specific physical symptoms. Given the increased risk of suicidal behaviour, the identification and treatment of childhood depression is essential.

Parents may present with the following concerns:

'He is not himself / seems constantly irritable and argumentative/ no longer goes out with his friends / is more withdrawn / spends all his time in bed'
'His grades have deteriorated / he is unmotivated / he has no interest in anything / not involved in his usual hobbies'

Useful questions to ask parents:

Q: Does your child seem more moody / irritable for most of the day?
Q: Does your child seem more tearful or withdrawn / complain of fatigue / have poor motivation / suffer from sleep disturbance?
Q: Has your child tried to harm himself or spoken about wanting to be dead?

Useful questions to ask youngsters:

Q: Do you feel sad or down more than usual / have trouble getting to sleep or concentrating?
Q: Do you find yourself spending less time with your friends / have you lost interest in things that you used to really enjoy?
Q: Have things been so difficult that you have considered ending it all / Do you think you would be better off dead?

Treatment of Depression

Children and adolescents with moderate to severe depression should be referred to the local Child and Adolescent Mental Health Service where they will be considered for Cognitive Behavioral Therapy (CBT) and / or medication[8] (**Level 5, Grade C**). Fluoxetine is now the only antidepressant medication approved by the FDA for use in treating depression in children and adolescents. Ideally, and according to international literature, medication should only be started by a Child Psychiatrist due to the increased risk of suicidal behaviour and in order to monitor the individual's response closely[8] (**Level 5, Grade C**). However, it is recognised that in some cases GPs do start antidepressant medication without psychiatric supervision, for example in the case of a patient or their parent refusing to attend for psychiatric evaluation and/or treatment.

Section 2.3 Deliberate Self Harm

An Irish survey of 15-17 year olds found that the lifetime history of deliberate self-harm was 12.2% [9] (**Level 5, Grade C**). Deliberate self-harm is a major risk factor for completed suicide and the rate of repetition is high.

Parents may present with the following concerns:

'My child has started to cut himself, but I think he may be doing it to get attention'
'My child threatens to harm / kill himself whenever he becomes distressed / angry'

Q: Useful questions to ask parents:

Q: Has your child tried to harm himself in any way e.g. poisoning, cutting, scratching, or punching walls?
Q: Does your child speak about suicide or threaten to harm himself?

Useful questions to ask youngsters:

Q: Have things been so difficult that you have felt that life was not worth living / considered ending it all?
Q: Have you considered ways that it could be done / which ways in particular / have you made efforts to organise it / have you a date, time or place in mind?
Q: Have you ever tried to end your life or hurt yourself?
Q: What has stopped you from doing it until now?

Management of Deliberate Self Harm

All young people who have self-harmed should be referred to either their local CAMHS or to hospital for an urgent assessment. If the individual has taken an overdose or if his attempt is potentially harmful, he should be assessed in hospital where he can be have a full medical assessment and psychosocial assessment by a psychiatrist or other mental health professional.

Section 2.4 Anxiety Disorders

Anxiety disorders are one of the most common psychiatric disorders affecting children, with a prevalence rate of approximately 3% [10] (**Level 5, Grade C**). Anxiety disorders in children incorporate a range of subtypes including Generalized Anxiety Disorders, Obsessive Compulsive Disorders, Separation Anxiety Disorders, Selective Mutism, Post Traumatic Stress Disorders, Panic Disorders and Social Phobia. To be characterised as a disorder, the anxiety disorder needs to be associated with significant distress and functional impairment e.g. not going to school, unable to pursue usual activities.

Parents may present with the following concerns:

'My child is having recurrent nightmares / panic attacks / is very clingy'
'My child becomes very distressed whenever we leave the house / refuses to go to school / avoids going out'
'My child is constantly worried that something will happen to us / worries about everything / is always looking for reassurance'
'My child is constantly washing his hands and tapping his arm repetitively to prevent something bad from happening'
'My child is preoccupied about how his peers perceive him and has stopped going out with his friends'

Useful question to ask parents:

Q: Is your child constantly worrying that something bad is going to happen to you / afraid to go to sleep at night / refusing to attend school and worrying excessively about going to school / worried even about trivial matters?
Q: Is your child fearful that he is losing control/ unable to speak in certain situations?
Q: Does your child have repetitive rituals (e.g. hand washing) / complain of recurrent nightmares or intrusive images?
Q: Does your child have episodes of difficulty breathing or palpitations?
Q: Does your child become very anxious about social situations / worry about what others think of him and avoid social situations as a result?

Useful questions to ask youngsters:

Q: Do you find that you are constantly worrying about things that are happening everyday / feel compelled to carry out certain rituals repetitively / worry about separating from your parents / social situations?
Q: Are there times when you notice that you feel really scared and that you notice a number of changes in your body e.g. butterflies in your stomach, dizziness, your heart is racing, difficulty breathing, sweating, your hands are shaking?
Q: Do you become very anxious about social situations and constantly think about what others think of you or what you have said / find it difficult to speak in certain situations e.g. at school?

Treatment for Anxiety Disorders

In more severe cases, a referral to the local Child and Adolescent Mental Health Service may be required. Individual CBT is the treatment of choice for children with anxiety disorders[11] (**Level 5, Grade C**). Medication may be required if the child's anxiety symptoms have not responded to CBT. Ideally medication should only be started by a child psychiatrist[8] (**Level 5, Grade C**), however, it is recognised that in some cases GPs do start medication without psychiatric supervision, for example in the case of a patient or their parent refusing to attend for psychiatric evaluation and/or treatment. There is strong evidence that SSRI's are effective for the management of anxiety disorders[12] (**Level 5, Grade C**). Fluoxetine is the medication of choice for children and adolescents with an anxiety disorder. Sertraline is also licensed for the management of OCD in children (from age 6 years) Benzodiazepines are not usually prescribed to children.

Section 2.5 Eating Disorders

The prevalence of anorexia nervosa in adolescents has been found to be 0.3% and 0.9% for bulimia nervosa[12] (**Level 5, Grade C**). Anorexia Nervosa and Bulimia Nervosa are both characterised by a disturbance in perception of body shape and weight. Individuals with eating disorders often have comorbid disorders such as depression, OCD and a history of self-harm[13] (**Level 3, Grade B**). Anorexia Nervosa is associated with significant morbidity and mortality.

Anorexia Nervosa (AN) is characterized by an intense fear of gaining weight, a preoccupation about body image and shape, refusal to maintain body weight at or above a minimally normal weight for age and height, body-image distortion, disrupted endocrine function (such as amenorrhea, delayed or arrested puberty).

Bulimia Nervosa (BN) is characterised by episodes of binge eating, a sense of a lack of control during these episodes, recurrent inappropriate compensatory behaviours including self- induced vomiting, starvation or misuse of laxatives.

Parents of children with eating disorders may present with the following concerns:

'My child seems preoccupied about losing weight and is skipping meals / dieting/ making himself sick after eating / has started to exercise excessively / avoids eating meals / goes through periods of eating excessively followed by rigid dieting'

Useful questions to ask parents:

Q: Does your child seem preoccupied about losing weight?
Q: Has your child lost weight? How much weight loss? In what space of time?
Q: Has your child been dieting / skipping meals / exercising excessively / making himself sick after meals?

Useful questions to ask youngsters:

Q: Have you lost weight recently / how much / in what space of time?
Q: Do you do anything to lose weight e.g. exercise, diet, skip meals, make yourself sick?
Q: Do you worry a lot about your weight? What is your ideal weight?
Q: How do you see yourself- normal in size / overweight / thin?
Q: When was your last period?

Treatment of Eating Disorders

Individuals who are suspected of having an eating disorder should be referred to their local Child and Adolescent Mental Health Services. It is necessary to plot an individual's weight, height, BMI on age and gender appropriate centile charts. Children can lose weight dramatically and have less reserves. In Anorexia Nervosa, physical complications are potentially life threatening, therefore it is imperative to carry out a physical examination and to consider taking blood tests and an ECG[14].

Treatment for Anorexia Nervosa involves psychoeducation, family intervention and in some cases, individual CBT[14] (**Level 5, Grade C**). First line treatment for Bulimia Nervosa is individual CBT. Fluoxetine may be considered for individuals with Bulimia if there is no response to psychological interventions or if there is a co-morbid mood disorder[14] (**Level 5, Grade C**). Ideally, fluoxetine should only be started by a Child Psychiatrist because of the risk of side effects including suicidal behaviour[7]. However, it is recognised that in some cases GPs do start medication without psychiatric supervision, for example in the case of a patient or their parent refusing to attend for psychiatric evaluation and / or treatment.

Section 2.6 Substance Misuse

Substance misuse has become increasingly common among Irish teenagers. In 2011, the European School Survey Project on Alcohol and Other Drugs (ESPAD) showed that 50 per cent of all Irish 15- and 16-year-olds surveyed had consumed alcohol in the previous 30 days[15] (**Level 5, Grade C**). A total of 18% of Irish students had tried cannabis at one point in their lives and 9% had tried inhalants. In some cases, experimentation can lead to abuse and dependence. In individuals who present with a sudden change in their behaviour or the onset of psychotic symptoms, it is always important to consider the possibility of substance misuse.

Management of Substance Misuse

All children and adolescents who are involved in substance misuse should be referred to the local child and adolescent mental health services. There are several specialised drug and addiction centres located in Dublin, such as YODA and SASSY (see Appendix 4), which specialise in youth drug addiction and have a child psychiatrist in attendance at the centre.

Section 2.7 Schizophrenia and Psychotic Spectrum Disorders

Schizophrenia affects approximately 1% of the population and is equally as common in males and females[16] (**Level 3, Grade B**). The onset of schizophrenia during adolescence is often more insidious than adult onset. Symptoms may be preceded by a prodromal period where there is a change in an individual's behaviour e.g. social withdrawal, academic deterioration, odd or uncharacteristic behaviour that may begin a year before the onset of positive symptoms. In individuals who present with a sudden change in their behaviour or the onset of psychotic symptoms, it is always important to consider the possibility of substance misuse (as discussed in Section 2.6).

Parents may present with the following concerns:

'My child seems quite suspicious and is refusing to leave the house'
'My child is complaining of hearing / seeing things that other people do not hear / see'
'My child is preoccupied that someone is following him and cannot sleep at night'

Useful question to ask parents:

Q: Have you noticed your child has become more suspicious?
Q: Have you noticed that your child is talking to himself / exhibiting unusual behaviour?

Useful questions to ask youngsters:

Q: Do you ever think that your mind is playing tricks on you / think that there are odd or unusual things going on that you cannot explain / think that things happening around you have a special meaning for you?
Q: Do you sense something strange might be happening / believe that someone is trying to harm you or plot against you?
Q: Do you ever hear noises or voices when no one is speaking to you / what do they say?

Management of Schizophrenia and Psychotic Spectrum Disorders
***Please refer to separate ICGP Reference Guidelines on 'Early Psychosis - Diagnosis and Management'**
http://www.icgp.ie/go/in_the_practice/quality_initiatives/guidelines/FD09EDBA-19B9-E185-8349ED80970D1B62.html

Section 3 Referral Guidelines for children and adolescents with mental health disorders

Referral to the local Child and Adolescent Mental Health Service (CAMHS) is generally reserved for children and adolescents who have been diagnosed with a psychiatric disorder. Many children and adolescents experience mild emotional difficulties, which are often transient, and do not require specialist CAMHS intervention but do require support from other services. These referral options are discussed in Section 3.2 below. In some cases, children may present with both psychiatric and non-psychiatric mental health disorders requiring referral to several services including CAMHS.

3.1 Referral to Child and Adolescent Mental Health Services (CAMHS)

CAMHS work as a multidisciplinary team with a wide range of professionals providing a variety of assessment and therapeutic interventions including cognitive behavioral therapy, group therapy, pharmacological and family therapy. The availability of services can vary throughout the country. In addition, the provision of 'out of hours' CAMHS is still not available nationwide. Therefore, in the case of an emergency outside of usual working hours (9am -5pm, Monday to Friday), referral to the local Accident and Emergency Department may be warranted. To date, there are no nationally agreed protocols with regard to the definition of the appropriate age at which to refer a child or an adolescent to a paediatric versus an adult Accident & Emergency service. There are however, local protocols in place; thus, GPs should refer the young person to their local Accident and Emergency Department, as per local protocols.

If queries arise regarding the potential need to certify a person under the age of 18 years old, the local Child and Adolescent Mental Health Service should be contacted for advice. In the event of a situation occurring 'out of hours' and where there are concerns about the young person being an acute risk, the GP is advised to refer the young person to their local Accident and Emergency Department.

For routine referrals to most CAMHS in Ireland, the child must be referred by a medical doctor (GP, Medical Officer or Paediatrician). The child is then placed on the waiting list for assessment. Urgent cases (such as children who are suicidal or psychotic) are prioritised.

The following website provides details of local CAMHS:
http://www.hse.ie/eng/services/Find_a_Service/Children_and_Family_Services/Child_and_Adolescent_Health/CAMHSContact.html

Referral Process

In the case of referring an individual to the local CAMHS, the following points need to be considered:
- Have you met with the parent or legal guardian and child?
- Is the carer or legal guardian aware of you making the referral and do they agree with the referral?

Basic information

- Name and date of birth
- Address and contact details of carer +/- legal guardian
- Who is the legal guardian i.e. biological parent or foster parent?
- Are both parents and child happy to attend the clinic?

Reason for referral

- What are the main difficulties that you want the local CAMHS Team to address?
- Duration of difficulties and why is the family seeking help now?
- Previous concerns (if any) and / or previous contact with CAMHS? What was the outcome?
- Any additional information including other professionals / agencies currently or previously involved?
- Are there any risk issues e.g. risk of self-harm?
- What is your understanding of the problem and working diagnosis?

Further Information

- Who else is living at home and details of separated parents if appropriate?
- Name of school?
- Who else has been or is provisionally involved in the child's care and in what capacity?
- Any relevant history e.g. family history of psychiatric illness, life events, and /or developmental factors?

Initial Assessment by CAMHS

At the initial assessment, families are interviewed by members of the multidisciplinary team. This 'assessment phase' determines the nature of the individual's underlying mental health difficulties and whether the service is able to provide a therapeutic intervention, which is most appropriate for the individual's needs. The 'treatment phase' can involve a range of interventions including individual, group or family therapy and in some cases, the use of medication.

3.2 Referral to other services

Many children and adolescents present with emotional difficulties which do not constitute Axis 1 disorders (and thereby do not require specialist CAMHS intervention) but are significantly debilitating to require referral to other services. Examples of emotional difficulties and the services available to help deal with these are listed below. Full details of all of the services listed below are available in **Appendix 4**. It must be noted that any children or adolescents who have a co-morbid psychiatric disorder should be referred to the local CAMHS.

School based problem:

If problems are primarily school based (in the absence of mental health difficulties) parents should be advised to seek a consultation with the National Educational Psychology Services (N.E.P.S.) (see Apendix 4)

Social Communication Difficulties including speech and language difficulties and Autistic Specturm Disorders (ASD)

Children and adolescents with speech and language difficulties should be referred to the local Speech and Language Therapy Services in the community.
ASD is no longer considered to be primarily a psychiatric disorder. Early intervention and assessment services for children with ASD should include comprehensive multidisciplinary and paediatric assessment.
If a child with autism has a comorbid psychiatric condition i.e. an Axis I diagnosis, then consider referring the child to the local Child and Adolescent Mental Health Service.

Developmental delay

Children who present with a history of developmental delay should be referred to the local paediatric service.

Behavioural difficulties

In cases of behavioural difficulties, where there is no mental health component, community services such as Parenting Courses should be considered (see Appendix 4).

Aggressive behaviour

In cases where individuals have a history of aggression or risk taking behaviour which cannot be contained by parents, referral to local community services which offer parenting courses should be considered (see Appendix 4). Children and adolescents can also be referred for support through local child welfare services.

Child Protection Concern

If there is a suspicion that a child is being abused (emotional, physical or sexual abuse) or neglected (emotional or physical) or is at risk of abuse, the practitioner has a responsibility to report their concerns to the health board immediately[18].

Each clinician has a statutory duty to report any concerns about a child's welfare and safety to the Child Welfare and Protection Services of the HSE. A child protection concern can be reported in person, by telephone or in writing. The contact number for all HSE offices nationwide are provided in the Children First guidelines[17] and the HSE website (www.hse.ie).

The following information should be included in the report:

- Details of referrer
- Details of child: age, address, school
- Parents' details; Care and custody arrangements
- Household composition
- Details of concerns, allegations or incident including dates, times, who was present, description of any injuries, parent's and child's view if available
- Details of person allegedly causing concerns: age, address, and occupation
- Relationship to child

*For further details, please refer to Children First National Guidelines for the Protection and Welfare of Children (2011): http://www.dcya.gov.ie/documents/child_welfare_protection/ChildrenFirst.pdf

Appendix 1: Axis I Disorders

Axis 1 disorders include all psychiatric conditions except personality disorders or intellectual disabilities.

The clinical conditions include the following:

- Adjustment Disorder
- Anxiety Disorders
    - Panic Disorder
    - Posttraumatic Stress Disorder
    - Obsessive Compulsive Disorder
    - Specific phobia
    - Social phobia
    - Agorophobia
    - Separation Anxiety Disorder
- Attention Deficit Hyperactivity Disorder/ Attention Deficit Disorder
- Dissociative Disorder
- Eating Disorders (Anorexia Nervosa / Bulimia Nervosa)
- Factitious Disorders
- Gender Identify Disorder
- Mood Disorders (Major Depressive Disorder / Bipolar Affective Disorder)
- Psychotic Disorders
- Somatoform Disorders
- Substance Related Disorders
- Sleep Disorders
- Tic Disorders

Appendix 2: History Taking

Presenting Problem:

- Who initiated the referral and why?
- History of problem? Context, frequency, intensity and the reason for seeking help now?
- Precipitating factors / perpetuating factors?
- Is there functional impairment?

When taking a history, consider using the following pneumonic **IFME (Individual, Family, Medical and Environmental Factors)** as a tool for eliciting salient information and for organising a comprehensive management plan.

Individual Factors:

Ask about:
-low mood, sadness, boredom, disinterest, futility feelings, suicidal thoughts or acts
-other co-morbid states e.g. anxiety, mania, substance misuse.
-History of problem: Context, frequency, intensity and the reason for seeking help now?
-Precipitating factors / perpetuating factors?
- functional impairment?
-Pre-morbid personality and behaviour
-Coping styles

Family Factors:

- Family environment and style of parenting (critical, dysfunctional, harsh or abusive parenting)
- Any stressors affecting parents which have impact on child, eg Parental acrimony / separation
- Family history of psychiatric disorders / physical illness
- Siblings and their well being

Medical Factors:

- Change in appetite / weight, poor sleep, low energy, concentration difficulties
- Any co-occurring medical condition e.g. viral infection or thyroid problems which may be contributing to problem or any medical complications as a result of disorder e.g. dehydration, malnourishment, and stunted growth
- Medications, including cigarettes, alcohol and substances

Environmental Factors:

• Progress at school- academic deterioration, learning difficulties, attendance, behaviour
• Bullying / peer group / confiding relationships
Any other stressors

Comorbid problems:

Psychiatric comorbidity is very common in most childhood disorders, therefore it is imperative to screen for other psychopathology.

Past psychiatric history?

Has it happened before? What interventions were implemented? Is there a history of deliberate self-harm? Is there any other mental health problem?

Developmental history

- Pregnancy History
- Maternal health
- Consumption of alcohol, nicotine or drugs
- Birth trauma or perinatal complications
- Postnatal depression

Developmental Milestones

Substance use history

Risk Assessment

Mental State Examination

Formulation of presenting problem and differential diagnosis

Points to note during assessment

It is helpful to interview older children alone as well as with their parents.

It is important to discuss the issue of confidentiality with adults present and if necessary when the individual is on their own at the outset of the assessment. Adolescents are often inclined to talk more honestly when they are on their own and to seek health care from physicians who discuss confidentiality with them.

It must be explained that confidentiality **MUST** be breached if there is any suggestion during the meeting that the individual may be at risk or if there are any risks posed to others.

Appendix 3: Mental State Exam

Appearance:

- Unkempt / agitated / suspicious / presence of physical anomalies or scars?
    - In young children, observe their level of attention and activity, interaction with parents, fine and gross motor skills, speech and language skills

Behavior:

- Stereotypical behavior, interest in environment
- Rapport
- Poor eye contact / unusual postures / tearfulness
- Depending on age, observe capacity to engage in symbolic (make believe) play, adjustment to change, attention and concentration

Mood:

- Ask how they subjectively describe their mood, then make a note of your objective description. Are they congruent?
- Affect:
    - Reactive / blunted / labile/ hostile ?

Thoughts:

Suggested questions:

- 'Have you been feeling frightened or fearful recently?'
- 'Have you felt like something is going on behind your back?'
- 'Have you been concerned for your safety?'
- 'Have you felt that people are taking special notice of you or trying to hurt or harm you in some way?'
- 'Have you felt that inconsequential things are linked in some way or have a new special significance for you?'
- 'Have you felt that your thoughts were not your own, that thoughts are inserted or removed from your mind?'

Thought form:

- Are the patient's sentences making sense to you?
- Is the flow of conversation logical and easy to follow?
- Is the flow speeded up or slowed right down?
- Is there a loss of rational connection between one thought and the next? If so, there could be formal thought disorder present? (this is a psychotic symptom)

Perception:

- 'Have your heard noises or voices when no one is around?'
  Try to normalise this question by explaining that this is not unusual, especially when falling asleep, awakening or when anxious?
- 'Is there more than one voice?'
- 'Do you hear them inside or outside your head?'
- 'Do they talk to you or about you?'
- 'Do the voices tell you to do things?'
- 'Can you resist doing what they tell you?'
- 'Do they ever comment on what you are doing as you are doing it?'
- Other modalities to be checked – visual, tactile, olfactory and gustatory (very rarely seen in functional illness)

Insight:

- 'What do you think is behind all of these difficulties you are having?'
- 'What is your understanding of your current difficulties? Could it be due to your mind playing tricks on you?'
- 'Could it be due to stress?'
- 'Do you agree that a specialist opinion is a good idea?'

Appendix 4: Resources

Addiction Services:

SASSY- Substance Abuse Service Specific to Youth
22, Mountjoy Square
Dublin 1
Tel: 01 877 2300

YoDA- Youth Drug and Alcohol Service
Glenabbey Building,
Belgard Rd,
Tallaght,
Dublin 24
Tel 01 466 5040

ADHD Support Groups:

H A D D is a volunteer family support group. Dublin branch at Carmichael Centre for voluntary groups, Brunswick Street, Dublin 7 Tel: 01-8748349
Website: http://www.hadd.ie/

ADDISS is a UK based charity providing information and resources on ADHD
Website:www.addiss.co.uk/

CHADD- American non-profit organization providing education, advocacy and support
www.chadd.org/

Affective Disorders: Support Groups

Aware – Irish support group for Depression and Bipolar Illness
Website: www.aware.ie
Helpline Tel: 1890303302

The Samaritans: 24-hour crisis service Helpline1850 609090 (ROI);
e-mail: jo@samaritans.org
http://www.samaritans.org/talk_to_someone/find_my_local_branch/ireland.aspx

Autism Support Groups:

The Irish Society for Autism. Headquarters at Unity Building,
16/17 Lower O'Connell Street, Dublin 1. Tel: 01-8744684
Website: http://www.autism.ie/

ASPIRE - Asperger Syndrome Association of Ireland, Main office, Carmichael house, North Brunswick Street, Dublin 7.
Tel: 01-8780027
Website: http://www.aspire-irl.org/

National Autistic Society – UK based website
Website: www.nas.org.uk

Bereavement Services:

Rainbows Ireland: Rainbows is a peer-support programme to support children, youth and adults who are grieving a death, separation or other painful transition in their family
Rainbows Ireland, (National Office),
Loreto Centre, Crumlin Road, Dublin
12Tel: (01) 473 4175
Fax: (01) 473 4177; Website: www.rainbowsireland.com

Eating Disorders Support Groups:

BEAT – UK based charity for people with eating disorders and their families
Website: www.b-eat.co.uk/Home

Spunout – Irish website for youth
Website : www.spunout.ie/health/Healthy-mind/Eating-disorders/Eating- disorders

Bodywhys – Irish national voluntary support group o
Website: www.bodywhys.ie/
Telephone:1890 200 444 (lo-call helpline)

General Information on Childhood Psychiatric Disorders:

Royal College of Psychiatrists (UK) website with factsheet on various childhood psychiatric disorders– for parents and teachers
http://www.rcpsych.ac.uk/mentalhealthinfoforall/mentalhealthandgrowingup/13

National Institute of Mental Health – American government website
http://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml

National Institute of Clinical Excellence: www.nice.org.uk

FRIENDS in the United Kingdom and Ireland – school / clinic based website
http://www.friendsinfo.net/uk.htm

Abut Our Kids – Child Study Center of New York University

http://www.aboutourkids.org/

Headspace – Australian website covering wide range of mental health issues
http://www.headspace.org.au/knowledge-centre/
American Association of Child and Adolescent Psychiatrists o Facts for families and Practice parameters for clinicians http://www.aacap.org

Shine – Irish support group for disorders including Bipolar Affective Disorder and schizophrenia
Website: http://www.shineonline.ie/

Rethink – UK based charity for mental illness
Website: www.rethink.org/

Young Minds provides information and advice on child mental health issues. 102-108, Clerkenwell Road, London EC1M 5SA.
Parent's information service 08000182138.
Website : www.youngminds.org.uk

NEPS: National Educational Psychological Services:

24-27 North Frederick Street, Dublin 1

Tel 8892700; Email:neps@neps.gov.ie

Parenting Programmes:

Barnardos National Database of Parenting Programmes
Website: www.barnardos.ie/training_and_resources/parenting.html

Incredible Years :Evidence based prevention and intervention program
Website: www.incredibleyears.com

Psychosis:

DETECT – Dublin East Pilot Programme – Information on psychosis
Website: www.detect.ie/

Tourette's Syndrome:

Tourette Syndrome Association of Ireland Irish Support Group. Email: info@tsai.ie. Helpline:0872982356
Website: www.tsai.ie/ - under construction
Tourettes Action – UK support group
Website: www.tourettes-action.org.uk/

National Tourette Syndrome Association – American group o
Website : http://tsa-usa.org/

Appendix 5: References

1. Green, H. Mc Ginnity A. Meltzer H, Ford T, and Goodman R. Mental health of children and adolescents in Great Britain 2004. Palgrave Macmillan, 2005.
2. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Arch.Gen.Psychiatry 2005 Jun;62(6):593-602.
3. American Psychiatric Association (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: American Psychiatric Association.
4. McGough JJ, Barkley RA. Diagnostic controversies in adult attention deficit hyperactivity disorder. Am.J.Psychiatry 2004 Nov;161(11):1948-1956.
5. National Institute for Health and Clinical Excellence. Attention Deficit Hyperactivity Disorder: Diagnosis and Management of ADHD in Children, Young People and Adults, 2008. P 231.
6. Jellinek MS, Snyder JB. Depression and suicide in children and adolescents. Pediatr.Rev. 1998 Aug;19(8):255-264.
7. Kessler RC, Avenevoli S, Ries Merikangas K. Mood disorders in children and adolescents: an epidemiologic perspective. Biol.Psychiatry 2001 Jun 15;49(12):1002-1014.
8. National Institute for Health and Clinical Excellence. Depression in Children and Young People: Identification and Management in Primary and Secondary Care, 2005; P. 127.
9. Sullivan C, Arensman E, Keeley HS, Corcoran P, Perry IJ. Young People's Mental Health: A report on the findings from the Lifestyle and Coping Survey, The National Suicide research Foundation and Department of Epidemiology and Public Health, University College Cork, 2004.
10. Connolly SD, Bernstein GA, Work Group on Quality Issues. Practice parameter for the assessment and treatment of children and adolescents with anxiety disorders. J.Am.Acad.Child Adolesc.Psychiatry 2007 Feb;46(2):267-283.
11. Birmaher B, Axelson DA, Monk K, Kalas C, Clark DB, Ehmann M, et al. Fluoxetine for the treatment of childhood anxiety disorders. J.Am.Acad.Child Adolesc.Psychiatry 2003 Apr;42(4):415-423.
12. Swanson SA, Crow SJ, Le Grange D, Swendsen J, Merikangas KR. Prevalence and correlates of eating disorders in adolescents. Results from the national comorbidity survey replication adolescent supplement. Arch.Gen.Psychiatry 2011 Jul;68(7):714-723.
13. Paul T, Schroeter K, Dahme B, Nutzinger DO. Self-injurious behavior in women with eating disorders. Am.J.Psychiatry 2002 Mar;159(3):408-411.
14. National Institute for Clinical Excellence. National Collaborating Centre for Mental Health. Eating Disorders. Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa and Related Eating Disorders. London, 2004.
15. Hibell, B., Guttormsson, U., Ahlström, S., Balakireva, O., Bjarnason, T., Kokkevi, A. and Kraus, L. The 2011 ESPAD Report: Substance use among students in 36 European countries, 2012.

16. Regier DA, Narrow WE, Rae DS, Manderscheid RW, Locke BZ, Goodwin FK. The de facto US mental and addictive disorders service system. Epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. Arch.Gen.Psychiatry 1993 Feb;50(2):85-94
17. Children First National Guidelines for the Protection and Welfare of Children. Department of Health and Children, 2011.