An Overview of
CHILD & ADOLESCENT PSYCHIATRY

Dr Jim Boylan BSc MB BS MRCPsych
Part 1

A Historical Perspective on Childhood and Influential Theories of Child Development
6th - 15th centuries - Medieval period

- Preformationism: children seen as little adults.
- Childhood is not seen as a unique phase.
- Children were cared for until they could begin caring for themselves - around 7 years old.
- Children then treated as small adults (e.g. their clothing, worked at adult jobs, could be married, were made into kings, were imprisoned or even executed as adults.)
16th Century - Reformation period

- Puritan religion influenced how children were viewed.
- Children were born evil, and must be civilized.
- A goal emerged to raise children effectively.
- Special books were designed for children.
17th Century
The Age of Enlightenment

• John Locke believed in *tabula rasa*

• Children develop in response to nurturing.

• Forerunner of behaviorism
18th Century –
The Age of Reason

Jean-Jacques Rousseau

• Children were noble savages, born with an innate sense of morality; the timing of growth should not be interfered with.

• Rousseau used the idea of stages of development.

• Forerunner of maturationist beliefs
19th Century – Industrial Revolution

Children at work

Charles Darwin

• Theories of natural selection and survival of the fittest.
• Darwin made parallels between human prenatal growth and other animals.
• Forerunner of ethology
20th & 21st Century

Proliferation of Theories about children's development

Legislation to protect children
Outline of 20th Century Theories

• Psychoanalytical Theories
  – Psychosexual: Sigmund Freud
  – Psychosocial: Erik Erikson

• Behavioral & Social Learning Theories
  – Behaviorism: Classical Conditioning - John Watson
    Operant Conditioning - B.F. Skinner
  – Social Learning - Albert Bandura

• Biological Theories
  – Maturationism: G. Stanley Hall & Arnold Gesell
  – Ethology: Konrad Lorenz
  – Attachment: John Bowlby
Outline of 20th Century Theories

- Cognitive Theories
  - Cognitive Development: Jean Piaget
  - Socio-cultural: Lev Vygotsky
  - Information Processing

- Systems Theories
  - Ecological Systems: Urie Bronfenbrenner
Sigmund Freud

Psychosexual Theory

• Was based on his therapy with troubled adults.
• He emphasized that a child's personality is formed by the ways which his parents managed his sexual and aggressive drives.
Erik Erikson

Psychosocial Theory

- Expanded on Freud's theories.
- Believed that development is life-long.
- Emphasized that at each stage, the child acquires attitudes and skills resulting from the successful negotiation of the psychological conflict.
- Identified 8 stages:
  - Basic trust vs mistrust (birth - 1 year)
  - Autonomy vs shame and doubt (ages 1-3)
  - Initiative vs guilt (ages 3-6)
  - Industry vs inferiority (ages 6-11)
  - Identity vs identity confusion (adolescence)
  - Intimacy vs isolation (young adulthood)
  - Generativity vs stagnation (middle adulthood)
  - Integrity vs despair (the elderly)
John Watson

- Early 20th century, "Father of American Behaviorist theory."
- Based his work on Pavlov's experiments on the digestive system of dogs.
- Researched classical conditioning
- Children are passive beings who can be molded by controlling the stimulus-response associations.
B. F. Skinner

- Proposed that children "operate" on their environment, operational conditioning.

- Believed that learning could be broken down into smaller tasks, and that offering immediate rewards for accomplishments would stimulate further learning.
Social Learning Theory

Albert Bandura

• Stressed how children learn by observation and imitation.
• Believed that children gradually become more selective in what they imitate.
Ethology

• Examines how behavior is determined by a species' need for survival.
• Has its roots in Charles Darwin's research.
• Describes a "critical period" or "sensitive period," for learning
Konrad Lorenz

• Ethologist, known for his research on imprinting.
Attachment Theory

• John Bowlby applied ethological principles in his theory of attachment.

• Attachment between an infant and their caregiver can insure the infant’s survival.

• Secure and insecure attachment
Jean Piaget

Cognitive development theory

• Children "construct" their understanding of the world through their active involvement and interactions.

• Studied his 3 children to focus not on what they knew but how they knew it.

• Described children's understanding as their "schemas” and how they use:
  – assimilation
  – accommodation.
Piaget’s Cognitive Development Stages

• Sensory-motor
  – 0 - 2: the infant uses his senses and motor abilities to understand the world

• Preoperational
  – 2-7: the child uses mental representations of objects and is able to use symbolic thought and language

• Concrete operations
  – 7-11: the child uses logical operations or principles when solving problems

• Formal operations
  – 12 up; the use of logical operations in a systematic fashion and with the ability to use abstractions
Lev Vygotsky

Socio-Cultural Theory

• Agreed that children are active learners, but their knowledge is socially constructed.
• Cultural values and customs dictate what is important to learn.
• Children learn from more expert members of the society.
• Vygotsky described the "zone of proximal development", where learning occurs.
Urie Bronfenbrenner

Ecological Systems Theory
- The varied systems of the environment and the interrelationships among the systems shape a child's development.
- Both the environment and biology influence the child's development.
- The environment affects the child and the child influences the environment.
Bronfenbrenner’s Ecological Model

- The Microsystem
- The Mesosystem
- The Exosystem
- The Macrosystem
- The Chronosystem
Physical Growth and Development
Neuronal density and dendritic connections in the developing brain

Neuro-anatomical correlates to behavioural development
Pruning –
Grey Matter Maturation

• Constant “Push and Pull” – some pathways grown while others pruned back
• Pruning greatly influenced by experience – so it really is a case of “Use it or lose it”
• This makes the Adolescent brain very versatile and able to make changes depending upon the environment
Synaptic Pruning

- Researcher Jay Giedd compares this pruning to Michelangelo with a block of marble. He begins to sculpt away until David emerges.

- This is precisely what is going on in the adolescent brain, starting around 11. The brain is pruning away, sculpting away excess material, excess connections, to make a more refined, more efficient, more adult brain.
Wellbeing in Childhood

• Emotional wellbeing – this includes being happy and confident and not anxious or depressed
• Psychological wellbeing – this includes the ability to be autonomous, problem-solve, manage emotions, experience empathy, be resilient and attentive
• Social wellbeing – has good relationships with others and does not have behavioural problems, that is, they are not disruptive, violent or a bully

NICE – Framework for Wellbeing in Childhood 2013
A Child’s Needs

• Basic Physical care
• Affection
• Security
• Stimulation of innate potential
• Guidance & control
• Acquisition of Responsibility
• Ultimate Independence
Adaptability & Resilience
Development and Differentiation

we all diversify & develop differently
Well maybe not all of us!
“We do not grow absolutely, chronologically. We grow sometimes in one dimension, and not in another; unevenly. We grow partially. We are relative. We are mature in one realm, childish in another. The past, present, and future mingle and pull us backward, forward or fix us in the present. We are made up of layers, cells, constellations.”

Anais Nin
Part 2
An Overview of some of the Major Mental Health Disorders affecting Children and Young People
HARRY

“THE ROOT OF ALL EVIL!!”
Being a Parent is a real challenge!...

These..
.... can produce these!
What mental health disorders do we see in CAMHS?

**Early / Neurodevelopmental**

- Sleep disorders
- Pre-school behavioural / emotional problems
- Attachment problems
- Autism Spectrum Disorders (ASD)
- Attention Deficit Hyperactivity Disorder (ADHD)
- Learning Difficulties (and Disability)
- Tourette’s Syndrome & other tic disorders

**Middle Childhood / Adolescence**

- Anxiety Disorders - GAD, OCD, Social and other Phobias, PTSD, School Refusal
- Mood Disorders (Depression & Bipolar)
- Deliberate Self-harm & attempted suicide
- Psychosomatic disorders
- Chronic Fatigue Syndrome/ME
- Eating Disorders
- Psychosis
- Substance Misuse and Behavioural Conduct Disorders
## Prevalence of Mental Disorders in Young People

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Prevalence (approx)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>6%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>1%</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>10%</td>
</tr>
<tr>
<td>ADHD</td>
<td>4%</td>
</tr>
<tr>
<td>Anorexia Nervosa</td>
<td>1%</td>
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<tr>
<td><strong>Totals:</strong></td>
<td><strong>15-20%</strong></td>
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<table>
<thead>
<tr>
<th>Disorder</th>
<th>Translation to average classroom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Depression (2)</td>
</tr>
<tr>
<td>Psychosis</td>
<td>Psychosis (rare)</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>Anxiety Disorders (3)</td>
</tr>
<tr>
<td>ADHD</td>
<td>ADHD (1)</td>
</tr>
<tr>
<td>Anorexia Nervosa</td>
<td>Anorexia Nervosa (rare)</td>
</tr>
<tr>
<td><strong>Totals:</strong></td>
<td><strong>(4-5)</strong></td>
</tr>
</tbody>
</table>
Sex ratio

- Before puberty: M > F After puberty: F > M
- Variation depending on condition:

**Male**
- ASD
- Hyperactivity
- CD/ODD
- Completed suicide
- Tic disorders
- Speech & language delay

**Male=Female**
- Depression (pre-pubertal)
- Selective mutism
- School refusal

**Female**
- Specific phobias
- Diurnal enuresis
- DSH (post-pubertal)
- Depression (post-pubertal)
- Eating Disorders (AN & BN)
Age of Onset of Major Mental Disorders

- PDD/ Autism
- ADHD
- Anxiety Disorder
- Obsessive Compulsive Disorder
- Substance Abuse
- Anorexia Nervosa
- Major Depressive Disorder
- Bipolar Disorder
- Schizophrenia
- Bulimia Nervosa

Source: DSM-IV, 2000
Cross-national Comparisons of the Onset of Psychiatric Disorders

Age of onset distributions of any anxiety disorders*

Age of onset distributions of any mood disorders*

Age of onset distributions of any substance use disorders*

*Data for Germany were omitted because of the narrow age range of the sample
Age of onset

Early onset
- ASD
- Hyperactivity
- Attachment disorders
- Selective mutism
- ODD
- Separation anxiety
- Specific phobias
- Enuresis
- Generalised LD
- Developmental delays

Adolescent onset
- Depression
- Mania
- Psychosis
- Suicide & DSH
- Eating Disorders
- Panic Disorder & Agoraphobia
- Substance misuse
- Conduct Disorder
General Aetiology

• Combination of psychosocial, genetic and neurological factors
  – rates of conduct, emotional & reading disorders in inner-city children vs Isle of Wight children (Rutter 1970)
  – ? Due to psychosocial stressors in inner-cities
    • e.g. marital breakdown, parental illness & criminality, social disadvantage, schools with high turnovers of pupils & teachers.
  – Twin & adoption studies show a significant genetic component for e.g. ADHD, ASD, Bipolar, Schizophrenia, Tic disorders.
  – Association between childhood psychiatric disorders & low IQ/LD - ?causal
ADHD
Classification and Clinical Features

• DSM V (AD/HD) and ICD 10 (HKD)
• 3 core symptoms:
  Hyperactivity
  Impulsivity
  Inattention
• Onset before 7 yrs (DSM 5 changed to 12 years)
• Pervasive
• Impairing
Hyperactivity

- Fidgety / Restless
- Leaving seat / Moving around
- Running / Climbing
- Noisy in Play
- Persistent excessive activity across situations
Impulsivity

• Blurt out answers
• Difficulty waiting / taking turns
• Interrupting and intrusive
• Excessive talking
Inattention

- Poor with details / Error prone
- Poor with sustained tasks
- Not listening / Fails to follow instructions
- Poor organiser / Losing things
- Easily distracted / Forgetful
Autism Spectrum Disorders
Core Clinical Characteristics

• Impairment of receptive and expressive language
• Problems with reciprocal social interaction
• Restricted, repetitive interests & behaviour
ASD - Language / Communication

• Many autistic children are non-verbal
• Conversational abilities limited
• Literal and concrete in understanding
• Repetitive, self interest focused, echolalia
• Non-Verbal - facial expression, gesture, eye contact
• Unusual pitch, stress, rhythm, intonation
ASD - Reciprocal Social Interaction

• Reduced empathic abilities – “Theory of Mind”
• Difficulties in peer relationships – collaboration / play
• Reduced interest in others
• Reduced comfort-giving and seeking
• Reduced sharing of enjoyment
ASD - Restricted/Repetitive Interests & Behaviours

• Specific preoccupations & interests
• Stereotyped movements
• Repetitive and non functional use of objects
• Unusual sensory reactions & interests
• Rituals
• Routines, sameness – “Catastrophic Reactions”
Anxiety Disorders - ICD 10

- Separation Anxiety Disorder, excessive anxiety on separation from those whom child is attached.
- Phobic Anxiety, developmental appropriate age period, anxiety level high.
- Social Anxiety, arise before age 6, significant problems with social functioning.
- Sibling Rivalry, abnormal in degree or persistence.
Separation Anxiety

- Anxiety apparent from six months of age
- Commonest anxiety disorder in prepubertal children 2-4%
- Females > males, lower social economic groups
- High morbidity in families
Separation Anxiety (2)

- Harm befalling major attachment figure
- Preoccupied with untoward event
- School refusal.
- Refusal to sleep, nightmares about separation.
- Physical symptoms- nausea, headache vomiting.
- Excessive recurrent distress on being separated
Generalised Anxiety Disorder

- Restlessness,
- Fatigue
- Muscle tension
- Sleep disturbance
- Research in USA is on ‘overanxious’ disorder, excessive worry about future and past events, competence and self consciousness.
Co-morbidity with Anxiety

DEPRESSION

• Major depression rates range from 28-69 %.
• Usually older at presentation.
• Have increased severity of anxiety.

ADHD

• 15-24 % with separation anxiety meet criteria for ADHD.
Obsessive Compulsive Disorder

- Population prevalence < 18yrs = 1%
- Male = Female
- 50% of adults with OCD have symptoms as child
- Age of onset: 9-13
- Under-recognized and potentially intensely disabling
Phobias

• Excessive, specific, persistent fear in response to real or imagined danger

• Developmentally phase appropriate
  age 2-4yrs - animals
  age 4-6yrs - dark & imaginary creatures
  adolescence - death

• Phobias affect 2-4% of children and adolescents, (usually mild)

• Girls more than boys

• Severe phobias may continue into adulthood
# Depression in Young People

<table>
<thead>
<tr>
<th>KEY SYMPTOMS</th>
<th>ASSOCIATED SYMPTOMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>persistent sadness, or low or irritable mood:</strong></td>
<td>• poor or increased sleep</td>
</tr>
<tr>
<td>AND/OR</td>
<td>• poor or increased appetite</td>
</tr>
<tr>
<td>• loss of interests and/or pleasure – social withdrawal</td>
<td>• low self-confidence</td>
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<tr>
<td>• fatigue or low energy</td>
<td>• suicidal thoughts or acts</td>
</tr>
<tr>
<td>• Problems impairing and present persistently over two weeks at least</td>
<td>• agitation or slowing of movements</td>
</tr>
<tr>
<td></td>
<td>• guilt or self-blame</td>
</tr>
</tbody>
</table>
Depressive disorders: Background Aetiology

- Temperamental factors
- Adverse life-events
- Viral illnesses e.g. glandular fever
- Family history of depression
- Home environment where child does not feel valued
Anorexia Nervosa

• **Diagnosis**
  
  • Underweight - less than 85% of expected body weight because of weight loss or failure to gain weight – BMI 17.5
  
  • Cognitive and behavioural abnormalities
    
    – morbid fear of fatness
    – Distorted body image
    – Deliberate dietary restriction with or without excessive exercise, appetite suppression or purgatives
  
  • Endocrine consequences
    
    – Amenorrhoea
    – In male loss of sexual drive and potency
    – Delayed puberty with early onset
Anorexia Nervosa - 2

• Other features:-
  • Rigidity of thinking
  • Obsessionality
  • Restricted interests especially food!
  • Low self-esteem
  • Loss of social contacts
  • Irritability / mood swings / major depression
Anorexia Nervosa - 3

• Aetiological factors
  • **Individual**, temperamental eg perfectionism
  • **Familial**, reports of raised OCD, alcoholism, affective disorders and physical illness rates
  • **Socio-cultural**, peer and media pressures, occupational (ballet, athletics etc)
  • **Biological**, no clear view on genetic factors
Substance misuse - 1

- Experimental Illicit drug use by older adolescents common, 50-70% - compared with heavy / regular use in 5%
- Uncommon under 12yrs – early use associated with longer term hazardous using behaviours and complications
- Gender rates about equal but boys more likely to use alcohol
- Associated with poor scholastic achievement
Substance misuse - 2

- Alcohol, nicotine most common
- Cannabis
- Glue and inhalants
- Stimulants
- Opiates

But.... usage is determined by complex factors including availability and supply

- 20-40% multiple use – “Cafeteria use”
- Less dependency syndromes - more bingeing than adults
- Risks include:
  - Sudden death (Acute Intoxication)
  - Suicide
  - HIV and Hep C
  - Psychosis (Cannabis)
Deliberate self harm (DSH) and Attempted Suicide (AS) - 1

- Deliberate self harm
  - UK 15-16 yrs, by self report (similar US figures)
    - Suicidal ideation - 22% in the last year
    - Actual Self harm - 7% within the last year
    - Approx. 1 in 8 received medical attention

- Below 12 yrs - boys >> girls
- Above 12 yrs - girls:boys ratio of 2:1 (or higher)
- Self poisoning commonest in clinical populations
- Incidence peaked in 1980s, now steady decline
DSH & AS - 2

- Background Aetiology
  - Lack of family support or confiding relationship
  - FH of psychiatric disorder, substance/alcohol misuse
  - Most have psychiatric symptoms eg mood or substance use /but most not major depression
  - Educational factors – bullying, academic difficulties
  - Past history or continuing abuse, sexual or physical
  - “Contagion” effects - family, friends, media
  - 10-20% are repeated attempts
  - Impulsive in most cases
• Background to Presenting episode
  • Precipitant in two thirds within last 2 days
  • Often minor stress on multiple other factors
  • Acute events may precipitate DSH in previously well individuals
  • Rows with family/friends/boy or girl friend commonest
  • Sexual or physical abuse may sometimes precipitate
Risk factors suggesting high suicidal intent

- DSH in isolated circumstances
- Timing to reduce likelihood of discovery
- Precautions to avoid discovery
- Preparations in anticipation of death
- Disclosure of intent to others beforehand
- Extensive premeditation
- Note left
- Failure to alert others after the event
Completed Suicide

- Rare under 12 yrs – but 3rd leading cause of death in adolescence.
- Male excess at all ages – more violent methods
- Serious suicide attempts occur in approximately 3% of adolescents.
- A prior suicide attempt is one of the best predictors of both a repeat attempt and eventual completed suicide.
- Depression, Conduct disorders, and Substance-use – multiple disorders further increasing risk.
- High Risk Groups – homosexual and bisexual youths, imprisoned and homeless/runaway teens.
Part 3
The Assessment of Mental Health Disorders in Children and Young People
Assessment

• Careful family and developmental history
• Symptoms
• Impact
• Risks
• Strengths / Resilience factors
• Explanatory Model
• Confidentiality and consent
• Medical Examination
Child/Adolescent Psychiatry History

- Introduction – confidentiality and consent
- Presenting Concerns & their recent history
- Ideas and expectations
- Developmental History – including pregnancy and early milestones and temperament
- Family History (including genogram) – history of psychiatric disorder – key relationships – current household
- Educational History
- Social History (including forensic, substance use, financial /employment history of parents)
- Past Medical History – medication and allergies
- Past Psychiatric History – in or out of service
Mental State on Interview

- Appearance & Behaviour – interaction with other family members / carers
- General developmental level
- Speech (form & content) – drawing and writing
- Mood (subjective & objective)
- Thought (form & content)
- Perceptual abnormalities (hallucinations)
- Cognition (including orientation)
- Insight
Assessment

• Four key areas
  – Symptoms
    – Impact
    – Risks
    – Strengths
Assessment - Symptoms

• Combination from four main areas:
  – Emotional symptoms
  – Conduct problems
  – Developmental delays
  – Relationship difficulties
Assessment - Impact

• Needs to be present to meet diagnostic criteria

• Social impact
  – Family
  – School
  – Friendships
  – Leisure activities

• Distress for child

• Disruption for others
Assessment - Risk

• Presence of
  – Predisposing factors
  – Precipitating factors
  – Perpetuating factors

• Absence of
  – Protective factors
Assessment - Risk

• Risk factors in
  – Child
  – Family
  – Community
Assessment - Risk

• Risk factors in child
  – Genetic
  – Low IQ/LD
  – Specific developmental delay
  – Communication difficulties
  – Difficult temperament
  – Physical illness (esp if chronic and/or neuro)
  – Academic failure
  – Low self-esteem
Assessment - Risk

- Risk factors in family
  - Overt parental conflict
  - Family breakdown
  - Inconsistent or unclear discipline
  - Hostile or rejecting relationships
  - Failure to adapt to child’s needs
  - Abuse – physical, sexual, emotional
  - Parental psychiatric illness
  - Parental criminality, alcoholism, personality disorder
  - Death and loss
Assessment - Risk

• Risk factors in community
  – Socio-economic disadvantage
  – Homelessness
  – Disaster
  – Discrimination
  – Other significant life-events
Specialist assessment tools and Rating Scales

- IQ – WISC, WAIS
- Functional ability – ABAS
- General Mental Health – CBCL, SDQ, YSRS
- ADHD – Connors
- ASD – ADI and ADOS
- Mood / Anxiety – CDI, R-CADS, CYBOCS
- Eating Disorders – EDI, SEDS
- Psychosis - CAARMS
Physical Growth and Development
Formulation

• Following an assessment it is important to formulate the case.

• A formulation is a compact summary of relevant aspects of:
  i) presenting features
  ii) aetiological factors
  iii) diagnosis
  iv) management plan
  v) prognosis.
## Formulation Grid

an example of Anxious School Refusal

<table>
<thead>
<tr>
<th>FACTORS TO CONSIDER</th>
<th>Biological</th>
<th>Psychological</th>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>Predisposing</td>
<td>e.g.</td>
<td>e.g.</td>
<td>e.g.</td>
</tr>
<tr>
<td></td>
<td>• Small Stature</td>
<td>• Introverted/ Shy Temperament</td>
<td>• Unsupportive or Overprotective Parents</td>
</tr>
<tr>
<td></td>
<td>• Stammer</td>
<td>• Learning Difficulties</td>
<td></td>
</tr>
<tr>
<td>Precipitating</td>
<td>e.g.</td>
<td>e.g.</td>
<td>e.g.</td>
</tr>
<tr>
<td></td>
<td>• Physical Illness</td>
<td>• Panic attack in school</td>
<td>• Parental split</td>
</tr>
<tr>
<td></td>
<td>• Loss of physical control event (enuresis)</td>
<td>End of school break</td>
<td>• Change of School</td>
</tr>
<tr>
<td>Perpetuating</td>
<td>e.g.</td>
<td>e.g.</td>
<td>e.g.</td>
</tr>
<tr>
<td></td>
<td>• Chronic Disorder – eczema or epilepsy</td>
<td>• Feeling less anxious at home</td>
<td>• Bullying at school or on social media</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Depression</td>
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</table>
Diagnosis

- There are two major diagnostic systems:
  - ICD-10 Classification of Mental and Behavioural Disorders
  - DSM-V Diagnostic and Statistical Manual of Mental Disorders
- Both systems multi-axial.
- In ICD 10:
  - Axis I Clinical Syndrome
  - Axis II Disorders of Psychological Development
  - Axis III Mental Retardation
  - Axis IV Medical Illness
  - Axis V Psychological Disability
Part 4
Approaches to Treatment of Mental Health Disorders in Children and Young People
Who sees and treats the patients?

- C&A Psychiatrist
- Paediatrician
- Clinical Psychologist
- Psychodynamic Psychotherapist
- Occupational Therapist
- Nurse – CAMHS trained
- Social Worker
- Family Therapist
- Cognitive behaviour therapist
- Support Workers
- Art/Music/Drama Therapist
- Dietitian
The 4-tier model for CAMHS

Tier 1
GPs, Paediatricians, Teachers, Health Visitors, Social Workers etc

Tier 2
Individual Professionals Trained in Children and Young People’s Mental Health eg Psychiatrists, Psychologists, Therapists etc

Tier 3
Specialist Multi-disciplinary Teams

Tier 4
Very specialist Services, often children away from home

Four Tier Model: Together We Stand, Health Advisory Service, 1995
The 4-tier model for CAMHS

Tier 1
Mild early stage problems

Tier 2
Moderate problems requiring attention from professionals trained in child mental health

Tier 3
Severe and complex problems requiring multi-disciplinary team working

Tier 4
Very serious problems – life threatening or very specialist treatment
Treatment approaches in Child Psychiatry

- Parental counselling / skills training
- Psycho-education
- Individual psychotherapy
- Behaviour therapy
- Cognitive-behavioural therapy
- Family therapy - systemic
- Pharmacotherapy
- Group therapy
- Liaison with other agencies
  - (education, social services, Paediatrics)
Depressive disorders: Management and Outcome

- Psycho-education
- Reduction of environmental stresses
- Individual work including
  - cognitive therapy
  - inter-personal therapy
- Anti-depressant medication (SSRIs)
- Family work

Most recover from initial episode but recurrence is common
Treatment

- Biological
- Psychological
- Social

Management
Biological Interventions

- **Medication**
- Stimulants & Non-stimulants – ADHD
- Antidepressants – Depression, Anxiety disorders, OCD
- Antipsychotics – Psychosis, ADHD, Behavioural problems (ASD, CD, LD), Tic disorders
- Others – clonidine for tics, melatonin for sleep problems, mood stabilisers (anti-convulsants, antipsychotics) for bipolar disorder
Psychological Interventions

Both Individual and Group approaches:

- Behavioural Therapies – star charts to structured specialised programmes to shape behaviour
- Cognitive Behavioural Therapy (CBT)
- Interpersonal Therapy (IPT)
- Exposure-Response Prevention (ERP)
- Systematic Desensitisation
- EMDR and Trauma Focused CBT
- Psychodynamic Psychotherapy
- Family and Systemic Therapies
- Other therapies – Play therapy, DBT
Social Interventions

• Encompass a wide range of interventions
• Work with other agencies e.g. education, social services, health visitors, school nurses, speech & language therapists, voluntary sector
The Finish Line!..
.....we made it!!
Recommended Reference and Websites

• “An Introduction to Child and Adolescent Mental Health” – Maddie Burton et al. Sage 2014
• http://www.rcpsych.ac.uk/healthadvice/problemsdisorders.aspx
• http://www.youngminds.org.uk/
i'm a big kid now!

Dr Jim Boylan  BSc  MB BS  MRCPsych
jimboylan@hotmail.com