# Child mental health CoP Session 1: Anxiety

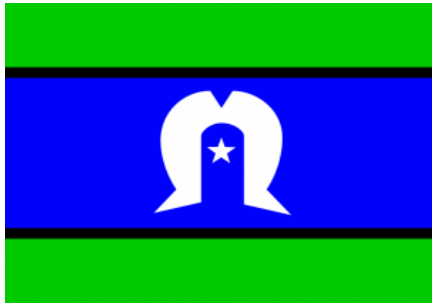
**Tuesday 30 April 2024**

***The content in this session is valid at date of presentation***

# *Acknowledgement of Country*

North Western Melbourne Primary Health Network would like to acknowledge the Traditional Custodians of the land on which our work takes place, The Wurundjeri Woi Wurrung People, The Boon Wurrung People and The Wathaurong People.

We pay respects to Elders past, present and emerging as well as pay respects to any Aboriginal and Torres Strait Islander people in the session with us today.

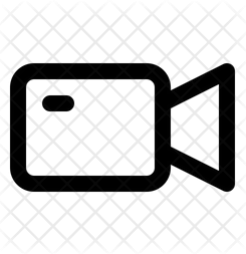


# CoP guidelines
## We agree to…

Stay on **mute** unless speaking

Raise your **hand** to speak

Keep conversations **confidential**



If possible, keep **camera on**

**Introduce yourself** and your role when speaking

Share **ideas** & promote everyone's **participation**

Acknowledge that we have **varied learning needs & interests**

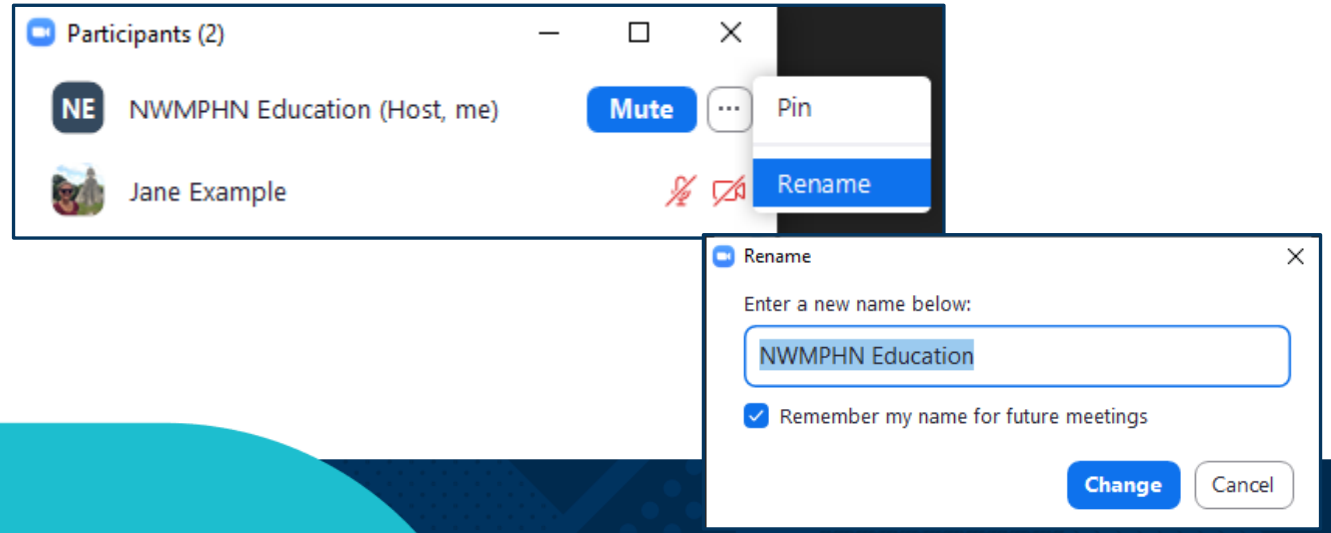
Ask **questions**

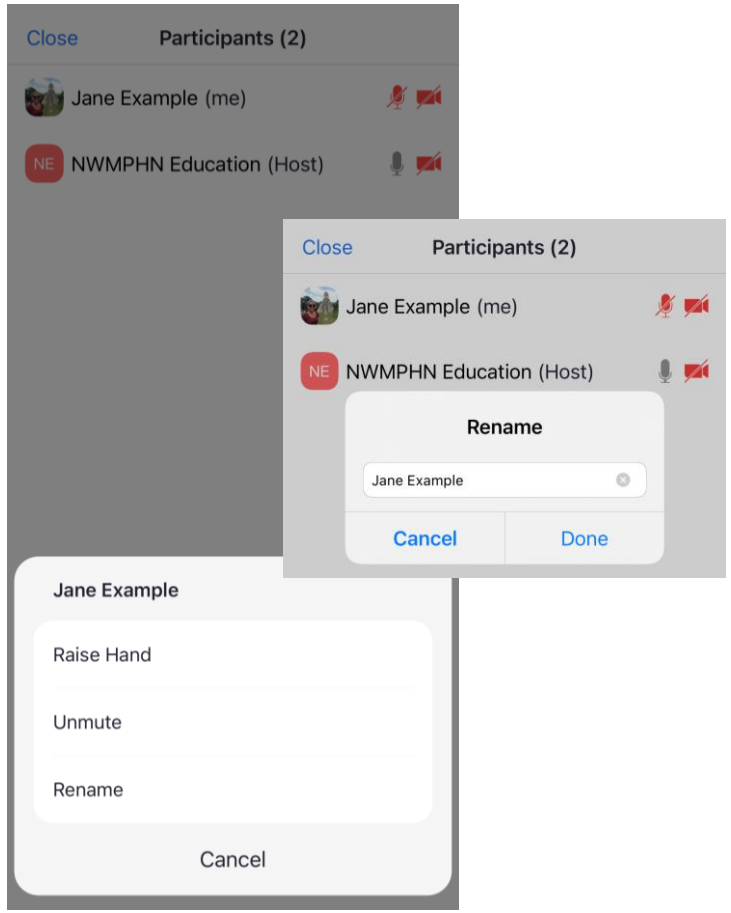
*No question is silly*

# *Please ensure you join the session using the same name you registered with and add your role next to your name*

## How to change your name in Zoom Meeting

1. Click on ***Participants***
2. **App:** click on your name
   **Desktop:** hover over your name and click the 3 dots
   **Mac:** hover over your name and click *More*
3. Click on ***Rename***
4. Enter the name you registered with and click
   ***Done / Change / Rename***



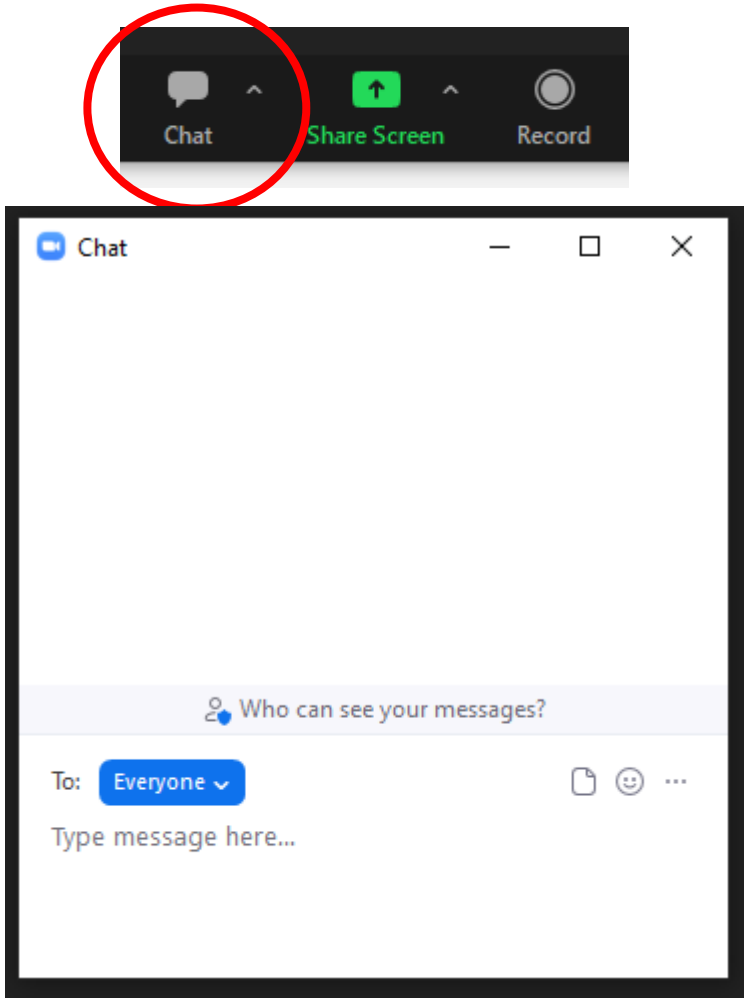
# *Housekeeping – Zoom Meeting*

**During the education component, please ask questions via the Chat box**

**This session is being recorded**

**Please ensure you join the session using the name you registered with so we can mark your attendance**

Certificates and CPD will not be issued if we cannot confirm your attendance



# *Psychiatrist – Dr Chidambaram Prakash*

- Dr Chidambaram Prakash is a senior consultant child and adolescent psychiatrist at the RCH with over 20 years' experience.
- Prakash has worked in, and managed, general and specialist clinics within child psychiatry in metropolitan and regional public mental health services.
- Prakash has worked with children and adolescents from 4 to 18 years of age assessing and managing a variety of mental health issues.

# *GP Facilitator - Dr Sahar Iqbal*

- Practicing as a GP at Goonawarra Medical Centre for the past 11 years

- Sahar's areas of interest are child and adolescent mental health and chronic disease management

# *Agenda*

| | |
|---|---|
| **Introduction and housekeeping** | 5 minutes |
| **Education component: Anxiety**<br>*Psychiatrist Dr. Chidambaram Prakash* | 30 minutes |
| **Health Pathways** | 5 minutes |
| **Case discussion Part 1 – Breakout room** | 20 minutes |
| **Case discussion Part 2 – Breakout room** | 20 minutes |
| **Initial Assessment and Referral Decision Support Tool (IAR-DST) presentation** | 5 minutes |
| **Conclusion** | 2 minutes |

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# *Education component: Anxiety Disorders and OCD*

CHIDAMBARAM PRAKASH

# ANXIETY DISORDERS AND OCD

COMPASS PROGRAM COP 2024

CHIDAMBARAM PRAKASH

# Definitions

**Emotion:** A Brain state that is associated with the perception of either a reward or punishment

**Fear:** A family of brain states (emotions) resulting from a perception of danger

**Anxiety:** Brain states associated with fear that is inappropriate to context (either in focus or extent or both)

**Pathological anxiety:** Is an exaggerated fear state in which hyperexcitability of fear circuits that include the amygdala and extended amygdala (i.e., bed nucleus of the stria terminalis) is expressed as hypervigilance and increased behavioural responsivity to fearful stimuli.

# Hypotheses on the causes of anxiety

Cortical projections from amygdala

Prefrontal cortex (VLPFC)

Amygdala nuclei-Basolateral & central

Cue specific (specific stimulus or trigger) associated with fear conditioning develops into anxiety

Context (situation, people, relationships) specific fear conditioning developing into anxiety

# Worry

Verbal or linguistic in nature (rather than images) (Borkovec, Freeston)

Mostly relates to real-life triggers, is future orientated

Sensitisation to future problems, person remembers the worry and desperately avoids it.

Useful for problem solving

Planning the process of coping

# Prevalence

- 3-5% children suffer from anxiety disorders (not counting OCD)
- 4%-9% lifetime prevalence in children
- The risk of developing an anxiety disorder in children between the ages of 3–17 years is 3-7 times more likely if a parent has/had an anxiety disorder or if a parent had a substance abuse disorder vs parents with no psychiatric diagnosis
- Twin studies: 30–40% heritability for anxiety disorders. Multiple genes involved

The non-genetic factors: 1. parenting style, 2. social learning and childhood adversity & maltreatment, 4. lower socioeconomic status, 5. neuroticism in temperamental trait

# Incidence of anxiety in children and young people with intersectionality

The findings, based on a community sample of 4459 ASD youth, suggest that 1 in 3 experience clinically elevated anxiety symptoms whilst 1 in 5 are diagnosed with a disorder, most commonly specific phobia, social anxiety, and/or generalised anxiety.

In a 2022 Trevor Project poll of 34,000 LGBTQ+ youth between the ages of 13 and 24 years old, 73 percent reported feeling symptoms of anxiety, and 58 percent reported symptoms of depression

# Comorbid conditions

- Depn in Anx: 17% (Anderson), 13 % (McGee), 14% (Costello), 49 % (Lewinsohn)
- Anx in Depn: 71% (Anderson), 44 % (Costello)

Clinic

- OCD (70%), PTSD & Others (30-50%)
- Anxiety (7.2 yrs), DD (10.8 yrs), MDD(13.8 yrs)
- Anderson:23% anxious children had ADHD & 32% had CD or ODD
- Rates of anxiety in DBD: 15-30%

# Evidence-Based Treatments for Anxiety Leveling on Symptoms

| Treatment Family | Wins/Ties[a] | Year[b] | Effect Size[c,d] | % With Follow-Up Measure | Minimum Length Successful Follow-Up |
|---|---|---|---|---|---|
| ***Level 1: Best Support/Well-Established Treatments*** | | | | | |
| CBT | 46 | 2011 | 1.19 (0.94) | 49% | 1 year |
| Exposure | 32 | 2009 | 1.05 (1.05) | 26% | 1 year |
| Modelling | 9 | 2001 | 1.42 (0.78) | 31% | 1 month |
| CBT With Parents | 7 | 2010 | 1.25 (0.92) | 60% | 1 year |
| Education | 3 | 2009 | 1.26 (1.13) | 50% | 2 months |
| CBT Plus Medication | 1 | 2008 | 2.37 | 0% | — |
| ***Level 2: Good Support/Probably Efficacious Treatments*** | | | | | |
| Family Psychoeducation | 2 | 2009 | 0.40 | 100% | 1 year |
| Relaxation | 2 | 1970 | — | 0% | — |
| Assertiveness Training | 1 | 1987 | — | 0% | — |
| Attention Control | 1 | 2010 | 0.72 | 50% | 1 year |
| CBT for Child and Parent | 1 | 2003 | — | 100% | 1 year |
| Cultural Storytelling | 1 | 1994 | — | 0% | — |
| Hypnosis | 1 | 1994 | 2.29 | 100% | 6 months |
| Stress Inoculation | 1 | 1994 | 1.10 | 100% | 1 month |
| ***Level 3: Moderate Support/Possibly Efficacious Treatments*** | | | | | |
| Contingency Management | 1 | 1970 | — | 0% | — |
| Group Therapy | 1 | 1970 | — | 0% | — |
| ***Level 4: Minimal Support/Experimental Treatments*** | | | | | |
| Biofeedback | 1 | 1996 | — | 0% | — |
| CBT with Parents Only | 1 | 2011 | 0.68 (0.98) | 33% | 1 year |
| Play Therapy | 1 | 1982 | — | 0% | — |
| Psychodynamic | 1 | 1972 | 1.53 | 100% | 2 months |
| Rational Emotive Therapy | 1 | 1984 | 1.38 | 67% | 1 month |

# Treatment

CBT requires verbal linguistic skills, motivation and application so it is not for all.

In younger children parent work/dyadic parent-child work must be combined with 1:1 child therapy otherwise it will not work.

**Prescribe when:**

1. There is lack of response to CBT after min 12 sessions (ensure first that it is CBT that they are receiving, as it is a skills training therapy they should be able to describe what they are doing in therapy)

2. Severe symptoms needing conjoint treatment from the start

SSRIs are the first choice: safety, effectiveness in paed age group

All have black box warnings

Dosing depends on diagnosis: using Fluoxetine and Sertraline as examples

1. For gen anxiety/social anxiety: Flx 5 mgs Sert 12.5 mgs 2. For depression Flx 10 mgs Sert 25 mgs for OCD Flx upto 80 or even 100 mgs if tolerated Sert 250 mgs

# More on the SSRIs: adverse effects specifics

Fluoxetine may activate the already heightened child/teen so start very low (5 mgs) and titrate very slowly (every 6-8 weeks)

Paroxetine, fluvoxamine, and sertraline: discontinuation syndrome

Fluvoxamine may have greater potential for drug-drug interactions.

Citalopram may cause QT prolongation associated with Torsade de Pointes, ventricular tachycardia, and sudden death at daily doses exceeding 40 mg/d and should be avoided in patients with long QT syndrome.

Paroxetine has been associated with increased risk of suicidal thinking or behavior compared to other SSRIs.

# SNRIs and buspirone

Duloxetine is the only SNRI to have an FDA indication for the treatment of any anxiety disorder (specifically, generalized anxiety disorder in children and adolescents 7-17 years old). Be aware that it can affect liver functions so do a baseline and repeat after 4 weeks into the drug.

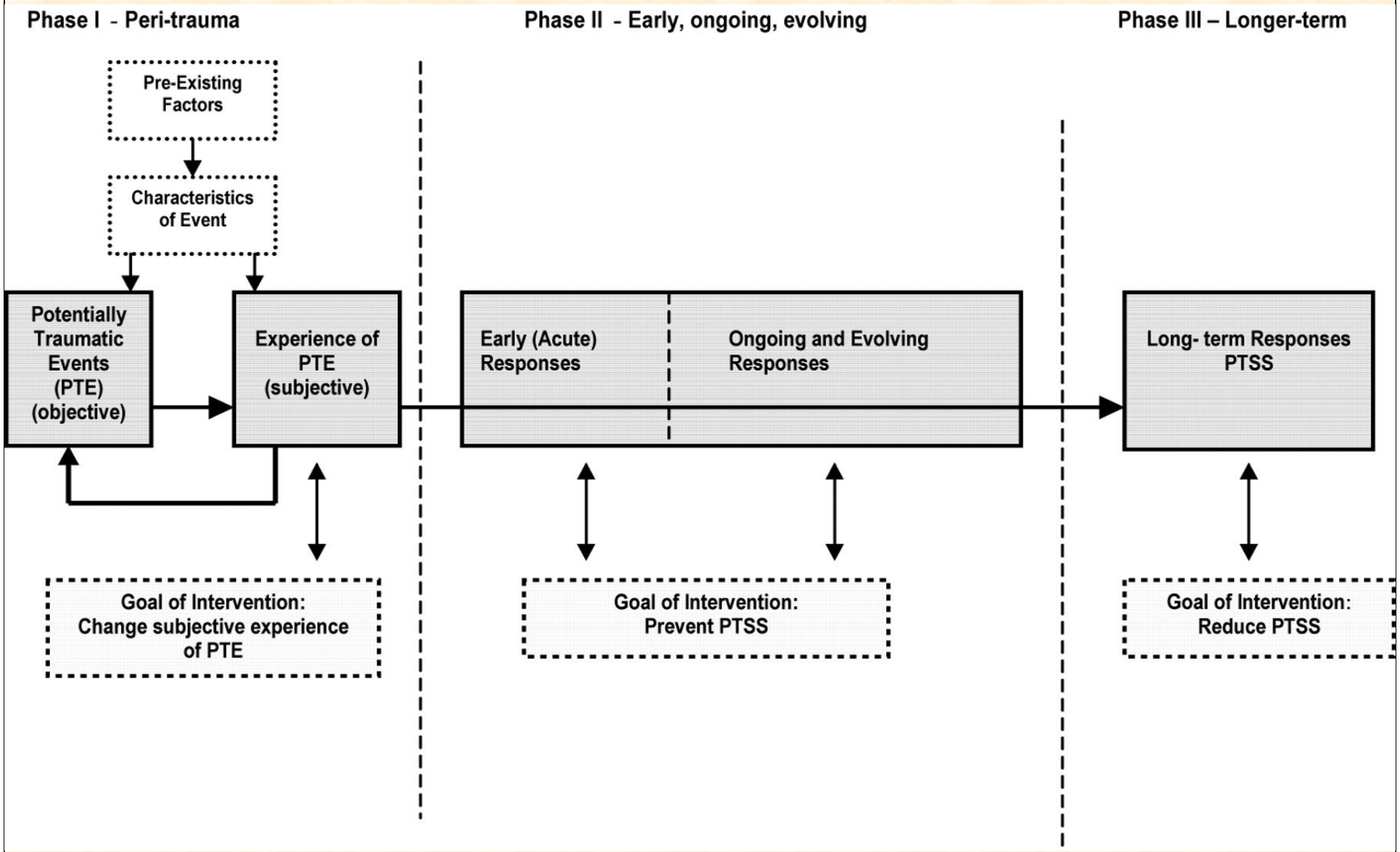
Limited data are available on drug pharmacokinetics and pharmacodynamics of SNRIs for young people. Venlafaxine extended release, desvenlafaxine, and duloxetine have sufficiently long elimination half-lives to permit single daily dosing.

Because of its short elimination half-life, venlafaxine immediate release may require twice- or thrice-daily dosing.

Buspirone is well tolerated in pediatric patients with GAD, although two randomized controlled trials were underpowered to detect small effect sizes\

10–40 mg/day, mean dose 25 mg/day) over an average follow-up of 2.5 months

# A model of pediatric medical traumatic stress (PMTS) for pediatric patients and their families




Kazak, A. E. et al. J. Pediatr. Psychol. 2006 31:343-355; doi:10.1093/jpepsy/jsj054



Journal of PEDIATRIC PSYCHOLOGY

# Prevalence-OCD

Community

- 3 month prevalence 0.17% (Costello)
- Point prevalence 0.06% (Lewinsohn)
- Life time prevalence 2-4% (Douglas, Valleni-Basile et al)
- Co-morbid: SAD, SOP, AGOR, GAD
- Males > Females

Clinic

- 7% Incidence

Co-morbid: SP (Lenard) GAD, SAD, SOP (Biederman)

# OCD COURSE AND COMORBIDITY WITH adhd

23-70% chronic course

12-50% remit in 1-7 years

Poor prognosis-Earlier or much later age of onset, increased duration of sx, more severe sx, hoarding compulsions, absence of tics, presence of co morbid ODD, female gender

Maintenance: after 3-4 mild relapses or 2-3 severe relapses

Gradually taper over 1-2 years-reduce by 25% wait for 2 months before next decrease. Continue monthly CBT

Prevalence estimate of 25.5% for co-morbid ADHD

Co-morbid OCD–ADHD from a young age was associated with greater OCD severity

# ASD and OCD

| Age Distribution of Specific Diagnoses of Autism Spectrum Disorders in Relation to a Prior Diagnosis of Obsessive-compulsive Disorder (OCD; 1994-2012) | | | | | | |
|---|---|---|---|---|---|---|
| | | Autism cases in general | | | Autism cases with prior OCD | |
| **Diagnosis** | | Mean | Standard Deviation | | Mean | Standard Deviation |
| | | | | | | |
| **Childhood Autism** | | 9.42 | 7.13 | | 13.94 | 8.90 |
| | | | | | | |
| **Atypical Autism** | | 12.37 | 7.01 | | 15.23 | 5.32 |
| | | | | | | |
| **Asperger's Syndrome** | | 14.90 | 8.56 | | 19.08 | 9.02 |
| | | | | | | |
| **Other Pervasive Developmental Disorder** | | 11.09 | 5.50 | | 14.75 | 5.88 |
| | | | | | | |
| **Unspecified Pervasive Developmental Disorder** | | 11.56 | 6.81 | | 18.01 | 9.11 |

# Treatment-OCD

- Prepubescent children-CBT first. Adolescents-CBT for milder OCD, CBT+ SRI for severe OCD
- Contamination, symmetry, counting, hoarding, aggressive: Ex/RP (March, Mulle, Rey, Franklin)
- Scrupulosity, moral guilt, pathological doubt: CT
- If inadequate response to CBT or SSRI alone then combine
- SRI: Inadequate response to ave dose-push to max in 4-9 wks of starting, then after 4-6 wks if inadequate response switch to another SRI

After 2-3 trials of SSRI +CBT then Clomipramine

If still no response then augment with another medication (depending on symptom)

Maintenance treatment:  after 3-4 mild relapses or 2-3 severe relapses

Stopping treatment on remission: Gradually taper over 1-2 years-reduce by 25% wait for 2 months before next decrease. Continue monthly CBT

Where medical contraindications present then use CBT only or mainly with low dose SSRI

# Evidence Base Update of Psychosocial Treatments for Paediatric Obsessive-Compulsive Disorder: Evaluating, Improving, and Transporting What Works.

Findings again converge in support of cognitive-behavioral therapy (CBT) as an effective and appropriate first-line treatment for youth with obsessive-compulsive disorder.

Family-focused CBT is now well-established.

A number of other treatments including CBT+ D-Cycloserine, CBT+ Sertraline, CBT+ positive family interaction therapy, and technology-based CBT are now probably efficacious.

Demographic, clinical, and family factors are consistent predictors of CBT outcome with conflicting findings for neurocognitive predictors.

# Summary

Anxiety is due to genetic, cognitive, behavioural causes maintained by neurophysiological mechanisms

It is higher in incidence in children who are neurodiverse, have a history of psychological trauma and suffer social discrimination (LGBTQI +)

In children anxiety disorder occurs more as a dimensional disorder

The main stay of treatment in children and adolescents is CBT or modified CBT and in young children dyadic (parent-child) or family based CBT

Some evidence for SSRIs in social anxiety disorder

# Useful free online resources

Spence anxiety scale https://www.scaswebsite.com/

Assessment of anxiety in children with ASD https://research.ncl.ac.uk/cargo-ne/Scoring%20Guidelines%20ASC-ASD%20Parent%20%20Child%20versions.pdf

Clinician resource for OCD

https://www.psychologytools.com/professional/problems/obsessive-compulsive-disorder-ocd/

Parent resource for OCD:

https://adaa.org/sites/default/files/How-to-Help-Your-Child-A-Parents-Guide-to-OCD.pdf

https://childmind.org/guide/parents-guide-to-ocd/

Clinician resources for anxiety disorders

https://depts.washington.edu/uwhatc/PDF/TF-%20CBT/pages/cbt_anxiety.html

# Useful free online resources

CBT resource for kids and teens

https://www.hpft.nhs.uk/media/1655/wellbeing-team-cbt-workshop-booklet-2016.pdf

Trauma Focused CBT resource for adolescents

https://tfcbt.org/wp-content/uploads/2019/02/Revised-Dealing-with-Trauma-TF-CBTWorkbook-for-Teens-.pdf

# HealthPathways – Anxiety in Children and Adolescents

## melbourne.healthpathways.org.au

# Pathways are written by GP clinical editors with support from local GPs, hospital-based specialists and other subject matter experts

- clear and concise, evidence-based medical advice
- Reduce variation in care
- how to refer to the most appropriate hospital, community health service or allied health provider.
- what services are available to my patients

# Anxiety in Children Relevant and Related Pathways

## Relevant Pathways

Anxiety in Children and Adolescents
Child and Youth Mental Health
Self-harm
Suicide Prevention

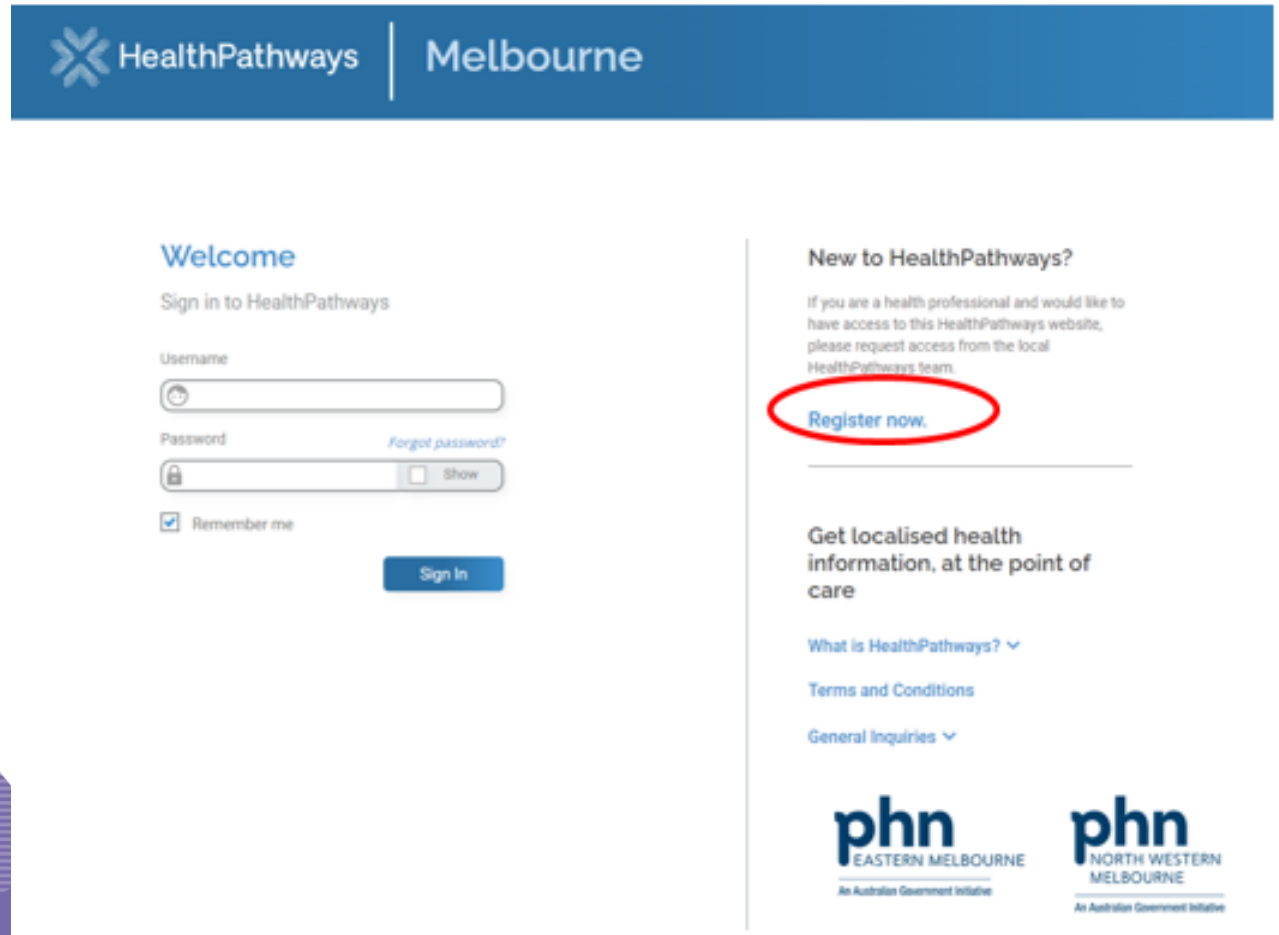
## Referral Pathway

Acute Child and Adolescent Psychiatry Referral or Admission (Same-day)
Child and Adolescent Eating Disorders Specialised Referral
Child and Youth Mental Health Support Services
Non-acute Child and Adolescent Psychiatry Referral (> 24 hours)
Paediatric Psychology and Counselling Referral
Transgender Health and Gender Diversity Referral

## Related Pathways

Carer Support - Mental Health
Depression in Children and Adolescents
E-Mental Health Services
GP Mental Health Treatment Plan
LGBTIQA+ Mental Health
Mental Health Community Support Services

# Accessing HealthPathways: Go to melbourne.healthpathways.org.au




Register via QR code

info@healthpathwaysmelbourne.org.au

Disclaimer: For presentation purposes only

# 2

# *Case studies*

# Breakout 1 – Case study

Tina comes to see you with her mother. She is 12 years old and has just started high school this year. She presents with **recurrent headaches and tummy pains**. She has had a **vision check which is normal**. In the past, the school has said **she is quiet but has a good circle of friends**. She is an average student but struggles with maths and can feel bad about this. Tina has a history of heightened sensory sensitivity to sounds, texture of clothes and struggles with initiating and maintaining social interactions. More recently she has expressed concerns about her body image and stated that she wanted to become a boy.

So far this year she has missed 2 weeks of school due to her tummy pains and her mother has had to take time off work to look after Tina at home. She also **presented to her local ED** and they could find **no organic cause for her tummy pain or headaches**.

*What else do you want to know?* ***What would you do next? What assessment and what treatment options should you explore…?***

**Take a photo**

# Breakout 2 – Case study

You diagnose Tina with **generalised anxiety and refer her to a psychologist for CBT**. Miraculously she gets in to see someone quickly but after 6 sessions, **her symptoms have not shifted a lot and she has had a couple of panic attacks.**

***What would you do next? What treatment options would you explore now…?***

**Take a photo**

# *Paid CPD training for GPs*

**NWMPHN and EMPHN are providing training for GPs, mental health clinicians and nurses interested in learning about the Initial Assessment and Referral Decision Support Tool (IAR-DST).**

The IAR-DST provides a standardised, evidence-based and objective approach to assist GPs and mental health clinicians with mental health care recommendations.

- 2 RACGP Education Activity CPD hours
- Online or face-to-face at your practice
- $300 GP incentive payment

**The tool is designed to provide advice relating to initial assessment and intake, across 8 diagnostic domains:**

- symptom severity and distress
- risk of harm
- impact on functioning
- impact of co-existing conditions
- treatment and recovery history
- social and environmental stressors
- family and other supports
- engagement and motivation.

**Register your interest for IAR training**

# *Session Conclusion*

*Next session on Aggressive and challenging behaviours – Tuesday 28th May (same time)*

*You will receive a post session email within a week which will include slides and resources discussed during this session.*

*Attendance certificate will be received within 4-6 weeks.*

*RACGP CPD hours will be uploaded within 30 days.*

*To attend further education sessions, visit,*

https://nwmphn.org.au/resources-events/events/

*This session was recorded, and you will be able to view the recording at this link within the next week.*

https://nwmphn.org.au/resources-events/resources/

We value your feedback, let us know your thoughts.

Scan this QR code