Anxiety and depression in children and young adults

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Challenges as a GP in dealing with this topic.

- Current waiting times for CAMHS are very long.
- An urgent appointment if referred today would be seen at the end of October.
- CAMHS resources are very stretched.
- Restrictions in prescribing as a GP can be very difficult as patients and their parents feel like we are not doing anything.
- The inbetween stage 16-18 can often be difficult as general adult and camhs may both decline to see
- Private consultations can cost > £300 for an hour for a zoom call – not many of our patients can afford this

Case Study based on an Oaktree Patient

- Mr Saen Xerxes Kazak 18 Dec 2002 (17 y 7 m) M
- Had a childhood history of ADHD but had been relatively stable for sometime.
- The lockdown made him depressed and hopeless – he was having one online lesson a week and was set tasks he couldn't do as he had no formal teaching.
- He became hopeless about the future and his chances of getting into university
- Had biological features of depression – problems sleeping at night then coming down at 6pm hardly eating, losing weight and feeling hopeless.
- He was too young for iapt and as mentioned previously very long waiting times for CAMHS

Case study cont'd

- I did however send camhs an email expressing my concerns about this patient
- **nem-tr.rbcypspa@nhs.net**
- A psychiatrist rang me back and with his authorisation I was able to commence an ssri as patient felt too hopeless to consider talking therapies.
- However a number of resources were sent which I could forward to the patient
- I have put these on our watsapp group and these are very helpful. But they are require a lot of self motivation which if you are already feeling low and depressed can be challenging to get young people to engage

Thinking Traps

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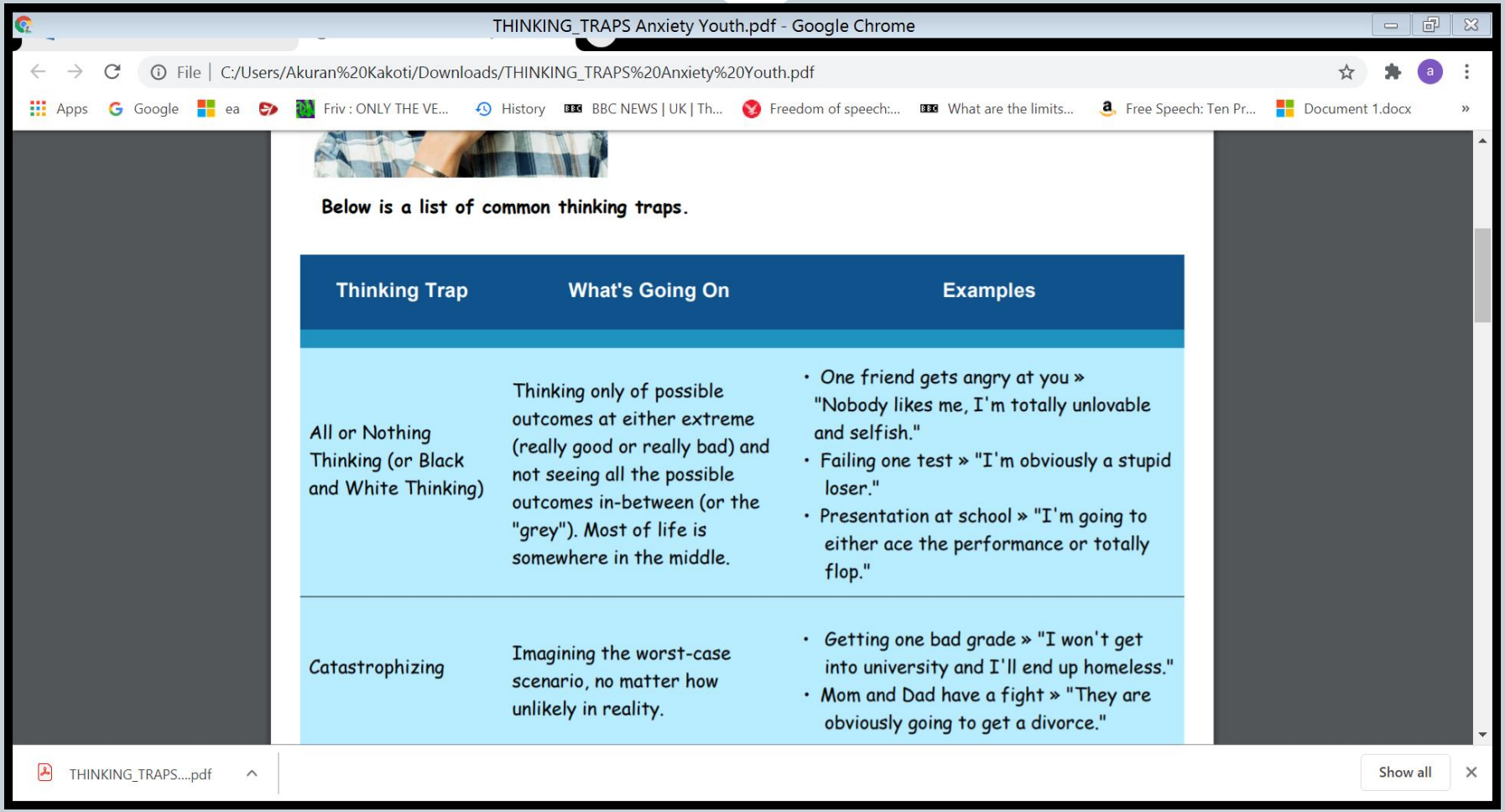
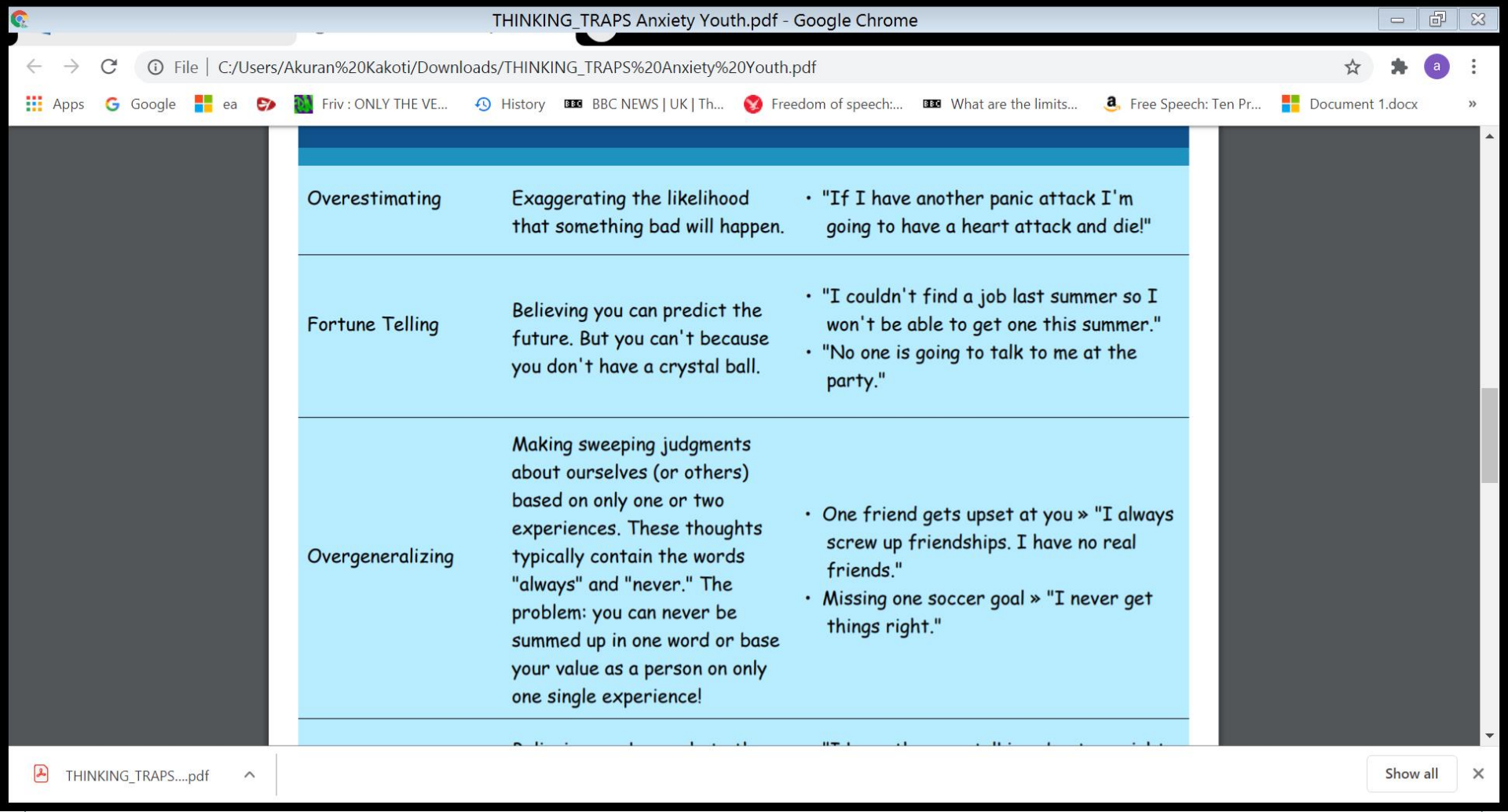
Thinking Traps

Certain types or patterns of thoughts tend to trap us in anxiety. These are called Thinking Traps. Some teens have lots of anxious thoughts about the future. Some focus more on what other people are thinking. Some think about wanting to stay safe and see danger lurking around every corner. Others seem to always imagine the worst possible scenario!

Whatever thinking traps you tend to fall into, the first important step is to **recognize your personal traps**.

Thinking Traps cont'd

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Overestimating
Exaggerating the likelihood that something bad will happen.
"If I have another panic attack I'm going to have a heart attack and die!"
Fortune Telling
Believing you can predict the future. But you can't because you don't have a crystal ball.
"I couldn't find a job last summer so I won't be able to get one this summer."
"No one is going to talk to me at the party."
Overgeneralizing
Making sweeping judgments about ourselves (or others) based on only one or two experiences. These thoughts typically contain the words "always" and "never." The problem: you can never be summed up in one word or base your value as a person on only one single experience!
One friend gets upset at you » "I always screw up friendships. I have no real friends."
Missing one soccer goal » "I never get things right."
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	your value as a person on only one single experience!	
Mind Reading	Believing you know what others are thinking (and assuming it's negative), without any real evidence. The problem: you can't read minds, so stop trying.	• "I know they are talking about me right now. They are thinking about how weird I look." • "Everyone is wondering what I'm doing at this party." • "I know she thinks my gift is lame."

AnxietyBC® youth

Thinking Traps

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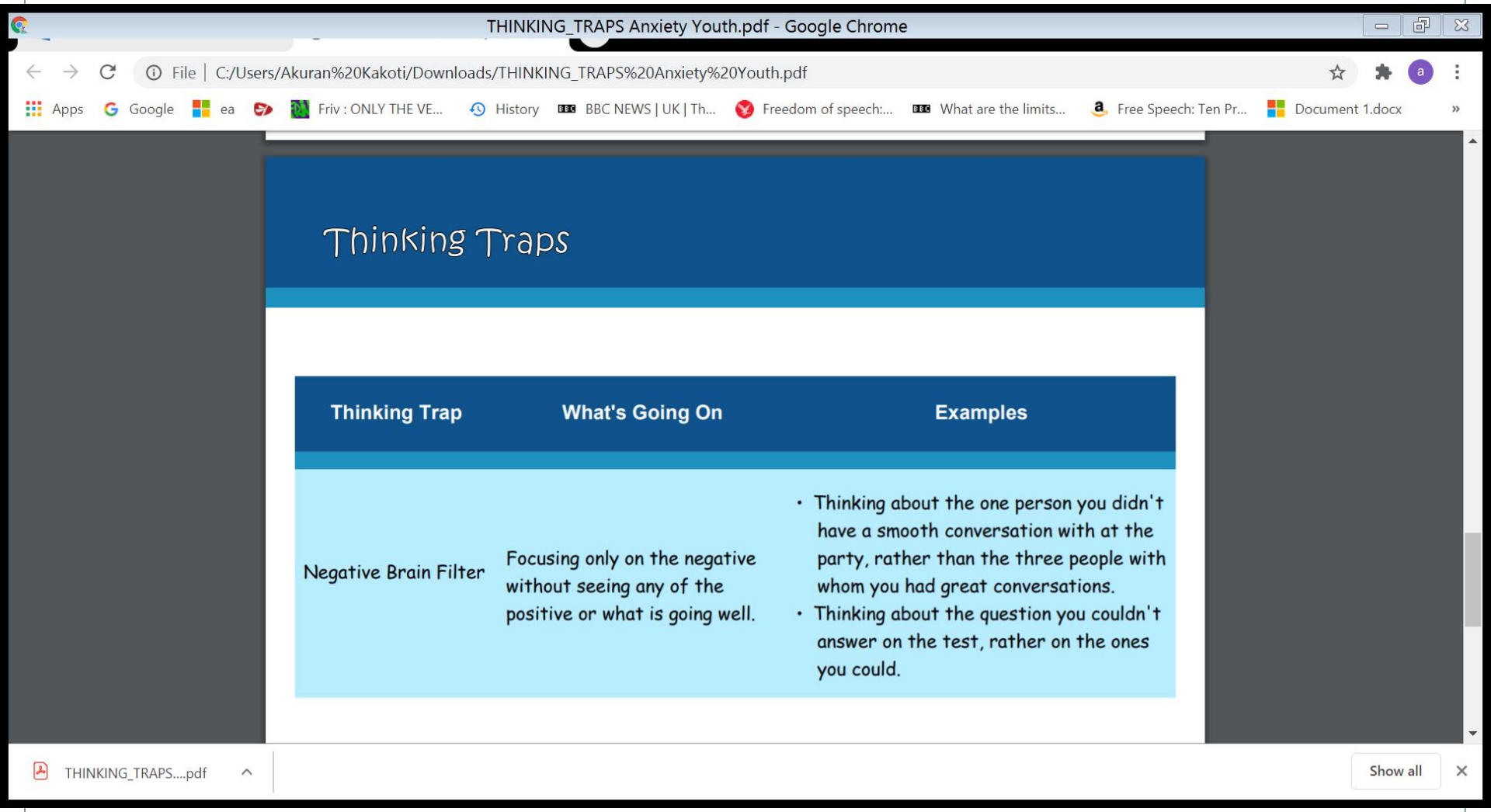
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Thinking Traps
Thinking Trap
What's Going On
Examples
Negative Brain Filter
Focusing only on the negative without seeing any of the positive or what is going well.
• Thinking about the one person you didn't have a smooth conversation with at the party, rather than the three people with whom you had great conversations.
• Thinking about the question you couldn't answer on the test, rather on the ones you could.
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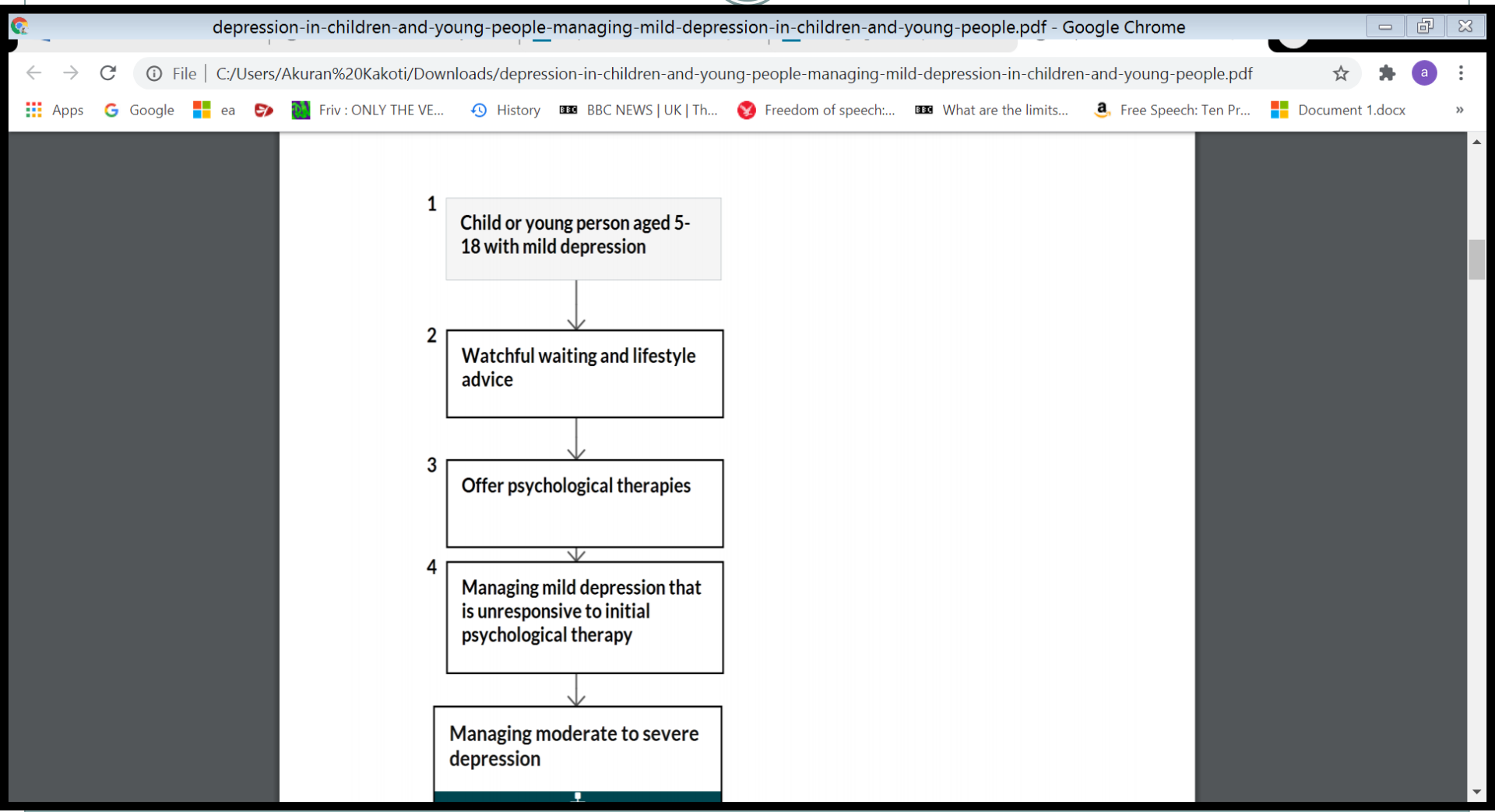
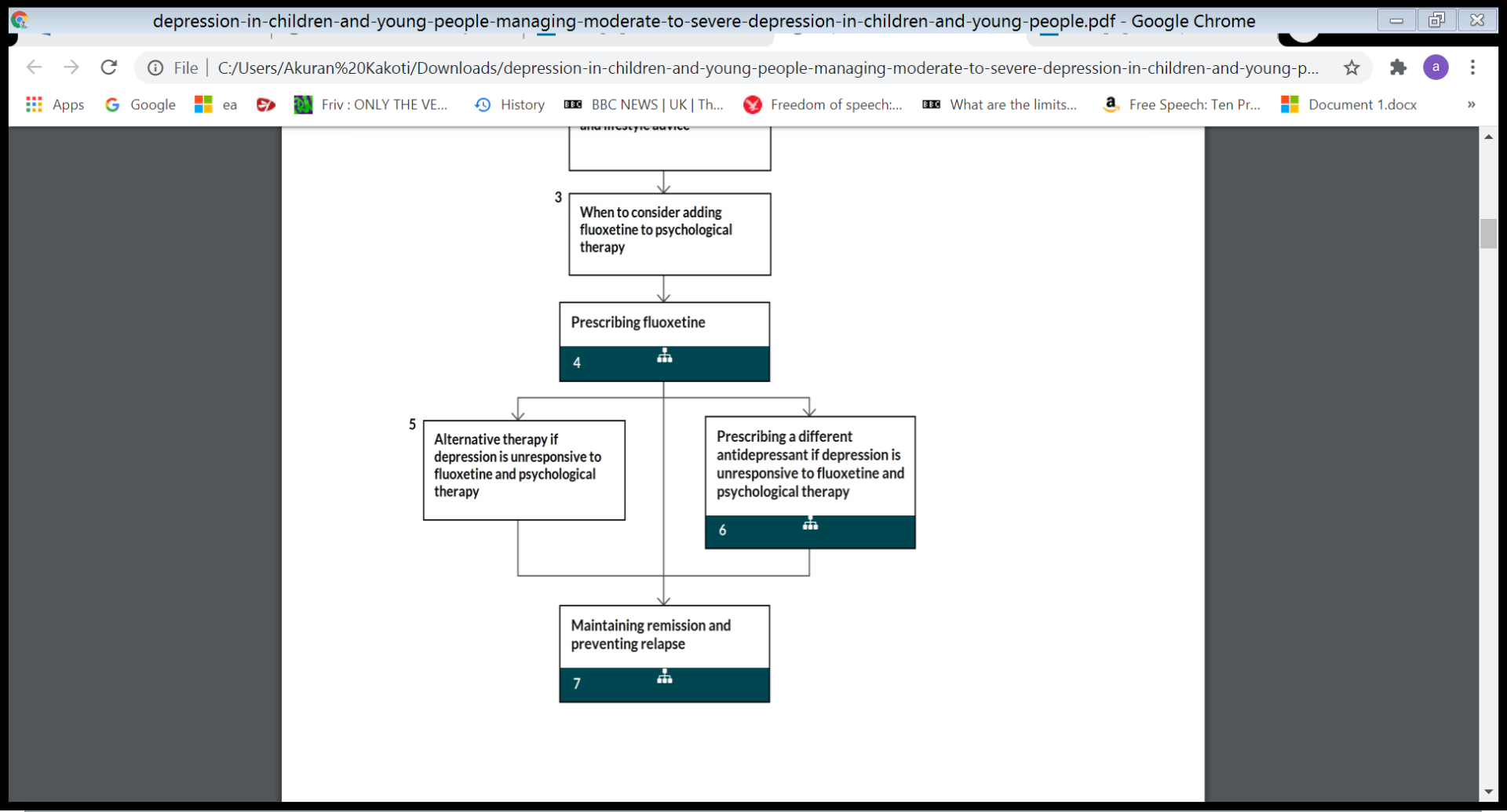
Managing mild depression



Managing moderate to severe depression



No additional information

2 General considerations before prescribing an antidepressant

Do not offer antidepressant medication to a child or young person with moderate to severe depression except in combination with a concurrent psychological therapy. Specific arrangements must be made for careful monitoring of adverse drug reactions, as well as for reviewing mental state and general progress; for example, weekly contact with the child or young person and their parents or carers for the first 4 weeks of treatment. The precise frequency will need to be decided on an individual basis, and recorded in the notes. In the event that psychological therapies are declined, medication may still be given, but as the young person will not be reviewed at psychological therapy sessions, the prescribing doctor should closely monitor the child or young person's progress on a regular basis and focus particularly on emergent adverse drug reactions.

If an antidepressant is to be prescribed this should only be following assessment and diagnosis by a child and adolescent psychiatrist.

Providing information

If a child or young person is started on antidepressant medication, they (and their parents or carers, as appropriate) should be informed about the rationale for the drug treatment, the delay in onset of effect, the time course of treatment, the possible side effects, and the need to take

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3 Prescribing fluoxetine as the initial antidepressant

When an antidepressant is prescribed to a child or young person with moderate to severe depression, it should be fluoxetine[1] as this is the only antidepressant for which clinical trial evidence shows that the benefits outweigh the risks.

Dose of fluoxetine

When fluoxetine is prescribed for a child or young person with depression, the starting dose should be 10 mg daily. This can be increased to 20 mg daily after 1 week if clinically necessary, although lower doses should be considered in children of lower body weight. There is little evidence regarding the effectiveness of doses higher than 20 mg daily. However, higher doses may be considered in older children of higher body weight and/or when, in severe illness, an early clinical response is considered a priority.

Drug interactions

As with all other medications, consideration should be given to possible drug interactions when prescribing medication for depression in children and young people. This should include possible interactions with complementary and alternative medicines as well as with alcohol and 'recreational' drugs.

4 Monitoring for suicidal behaviour, self-harm or hostility

No additional information

2 Prescribing sertraline or citalopram and treatments not to be used

If treatment with fluoxetine is unsuccessful or is not tolerated because of side effects, consideration should be given to the use of another antidepressant. In this case sertraline or citalopram are the recommended second-line treatments[1].

Criteria for use

Sertraline or citalopram[2] should only be used when the following criteria have been met:

- The child or young person and their parents or carers have been fully involved in discussions about the likely benefits and risks of the new treatment and have been provided with appropriate written information. This information should cover the rationale for the drug treatment, the delay in onset of effect, the time course of treatment, the possible side effects, and the need to take the medication as prescribed; it should also include the latest patient information advice from the relevant regulatory authority.
- The child or young person's depression is sufficiently severe and/or causing sufficiently serious symptoms (such as weight loss or suicidal behaviour) to justify a trial of another antidepressant.
- There is clear evidence that there has been a fair trial of the combination of fluoxetine and a psychological therapy (in other words, that all efforts have been made to ensure adherence to the recommended treatment regimen).
- There has been a reassessment of the likely causes of the depression and of treatment

2 Managing psychotic depression

For children and young people with psychotic depression, augmenting the current treatment plan with a second-generation antipsychotic medication[1] should be considered, although the optimum dose and duration of treatment are unknown.

Children and young people prescribed a second-generation antipsychotic medication should be monitored carefully for side effects.

Also see what NICE says on choice of antipsychotics and how to use them in psychosis and schizophrenia in children and young people.

3 When to consider inpatient care

Inpatient treatment should be considered for children and young people who present with a high risk of suicide, high risk of serious self-harm or high risk of self-neglect, and/or when the intensity of treatment (or supervision) needed is not available elsewhere, or when intensive assessment is indicated.

When considering admission for a child or young person with depression, the benefits of inpatient treatment need to be balanced against potential detrimental effects, for example loss of family and community support.

Other ways of getting advice

- Try advice and guidance line and ask to speak to a doctor (psychiatrist) if your query is about medication.
- Redbridge CAMHS Dr Farhana Ahmed
- Waltham forest CAMHS Dr Colin Welch/Dr Amber Sadiq/Dr Nu Nu Yi and Dr Sara Kundu