EUROPEAN PARLIAMENT INTEREST GROUP ON MENTAL HEALTH, WELL BEING AND BRAIN DISORDERS

MENTAL HEALTH AND WELL BEING IN CHILDREN AND ADOLESCENTS

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BRUSSELS

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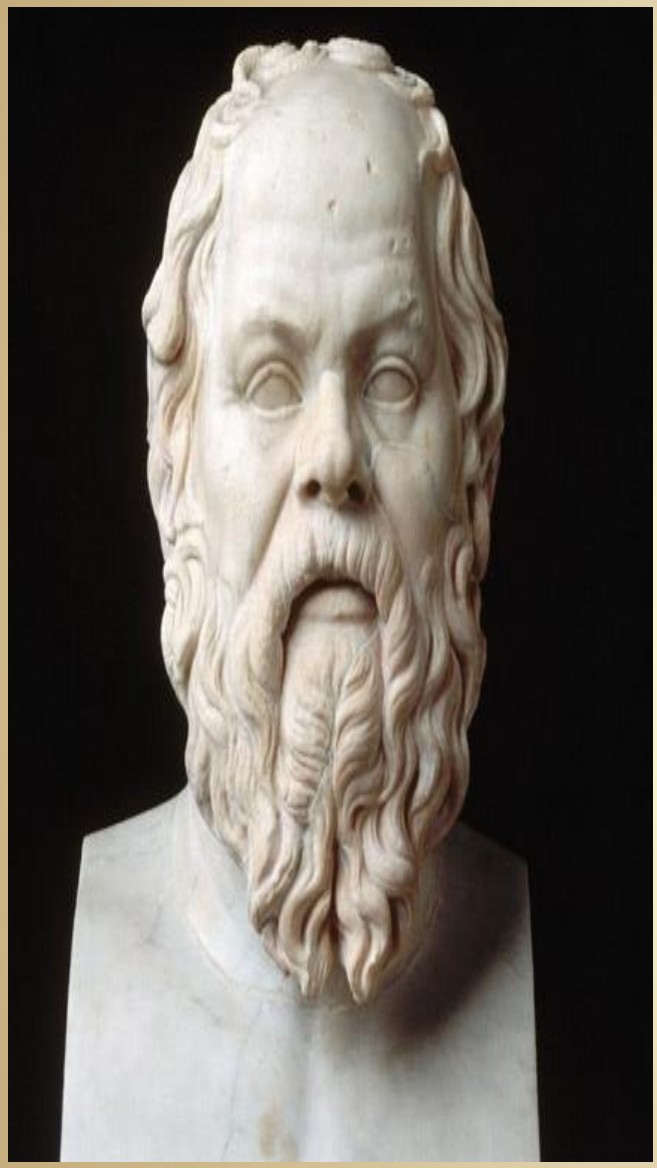
www.professormichaelfitzgerald.eu

(Contains 7 Volumes of Irish Families under stress. (Free))

www.professormichaelfitzgerald.com

www.pressurepointsonirishfamilies.com

(Free E Book Child and Adolescent Psychiatry)



“The trouble with youngsters today...”

The children now love luxury; they have bad manners, contempt for authority..... Children are now tyrants, they contradict their parents, chatter before company, and tyrannize their teachers”.

-Socrates 470-399 BC

SLOW MATURATION OF BRAIN TO 25 YEARS

SHAKESPEARE'S WINTERS TALE

ADOLESCENTS Till AGE 25

EXTENT OF PROBLEM

(All disorders on a spectrum or dimension)

1) **Pre-School 8%**
Pre-Adolescent 12%
Adolescents 15%

2) **Bipolar Childhood – Extremely rare**
Adolescents 1%

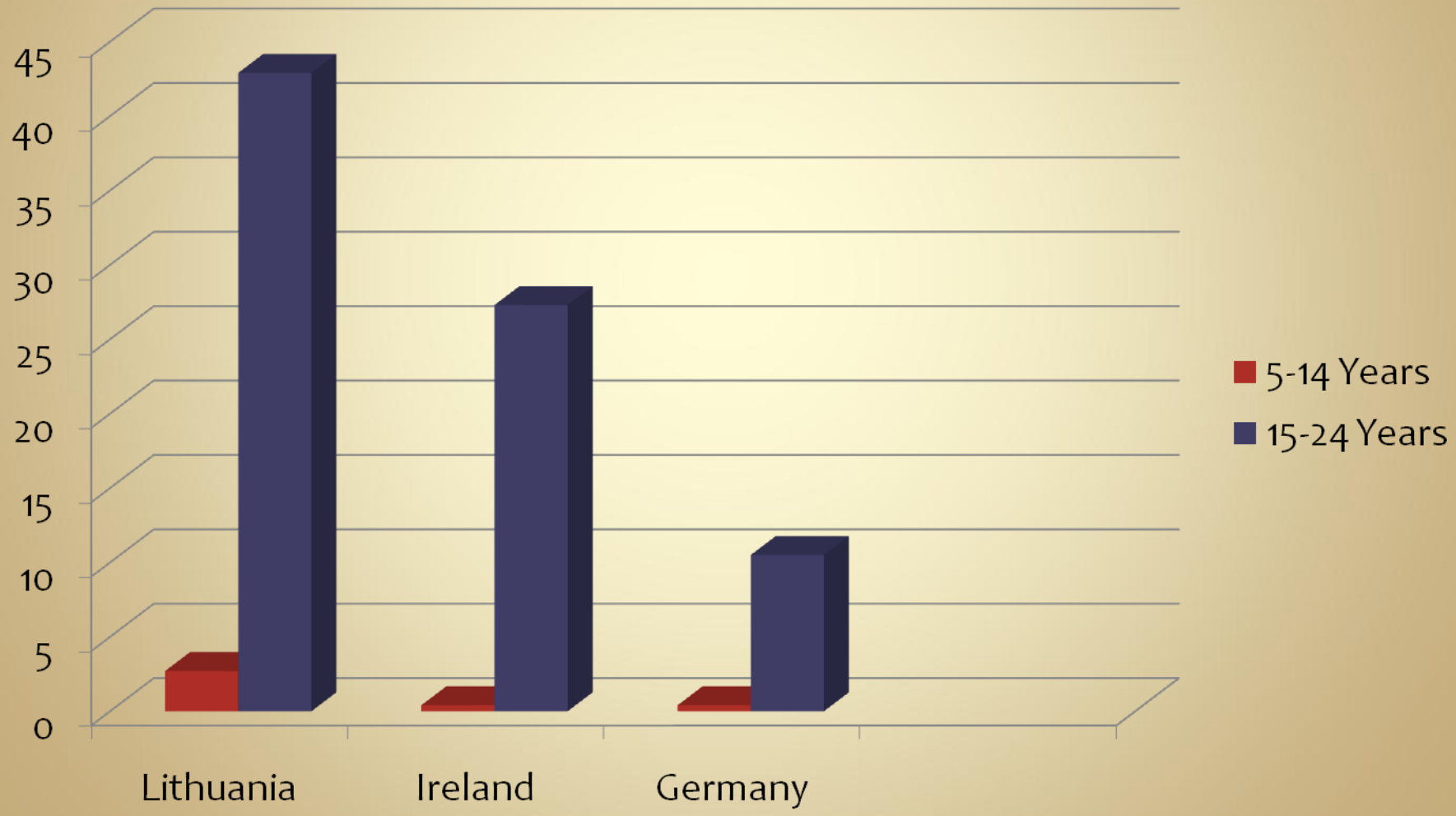
3) **Depression pre Pubertal 1-2%**
Adolescents 3-8% (More common females)

4) Anxiety Disorder – OCD 1.9% Adolescents

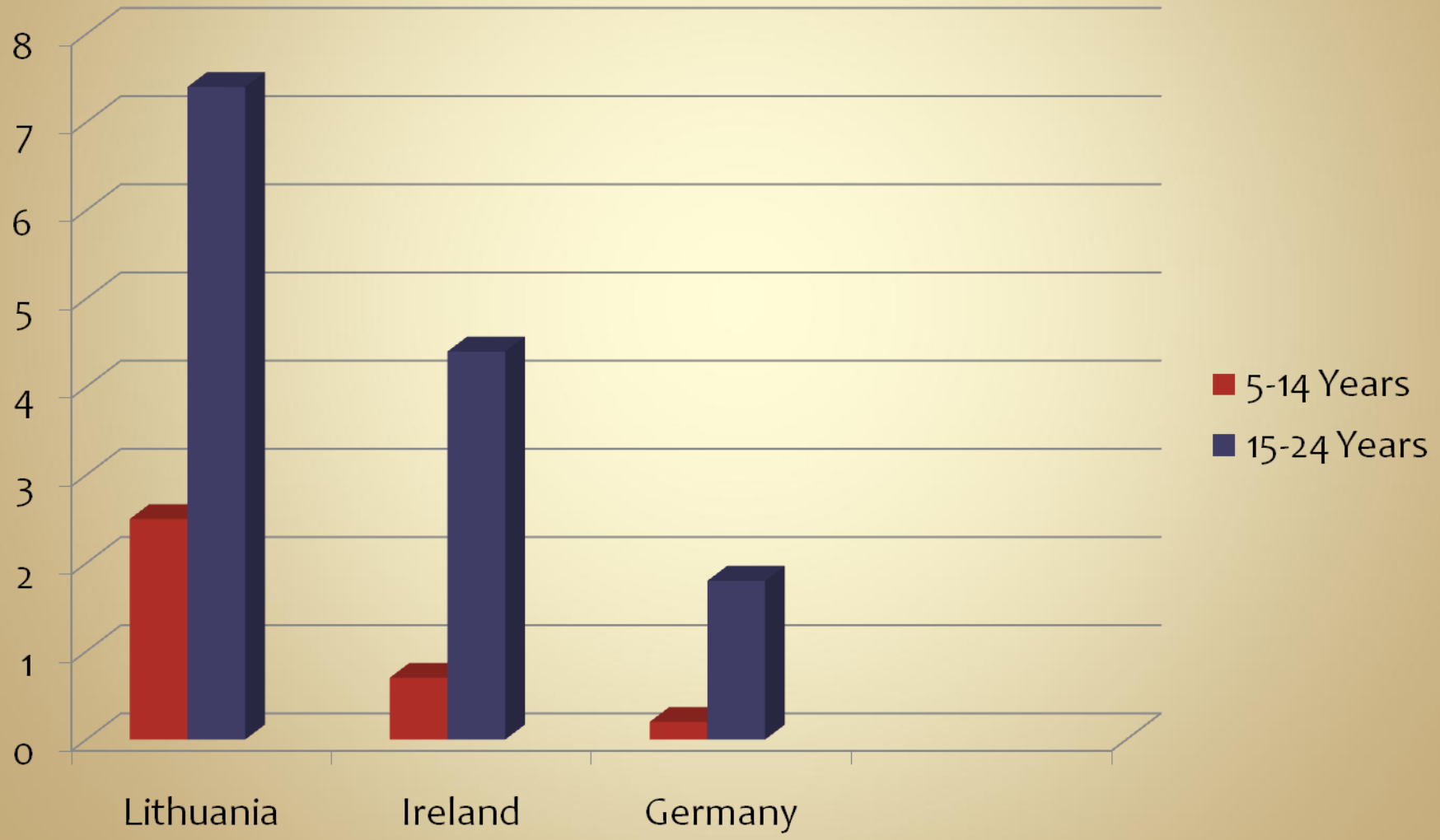
- Social Phobia 1.1% Adolescents

- Generalised Anxiety Disorder 3.6% Adolescents

SUICIDE RATES – MALES (PER 100,000)



SUICIDE RATES – FEMALES (PER 100,000)



EXTENT OF PROBLEM

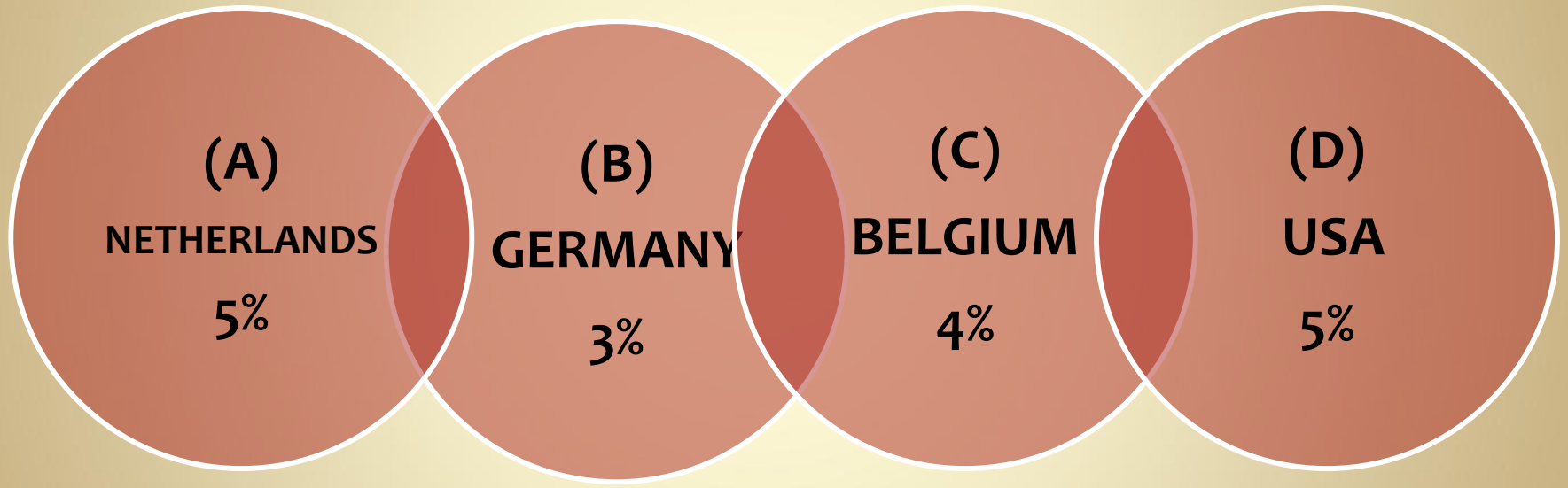
- Deliberate Self Harm/Risk of Repetition 5-15%
- Increase Psychosocial problems since second world war

EXTENT OF PROBLEM

- Autism and Asperger's Syndrome 1-2%

- ADHD 3-6% (50% of my child psychiatric clinic patients meet criteria)

PREVALENCE ADHD (Fayyad et al. 2007)



EXTENT OF PROBLEM

- Young offenders show higher rates of ADHD varying from 20% to 40%

- Conduct Disorder 5-10%

Child Sexual Abuse UK

Contact abuse
- 27% female
- 11% male

Penetrative/coercive abuse
- 4% female
- 2% male

In clinical samples up to 65%.

Figure 1: Conditions that may be found co-existing with ADHD. There is some suggestion that "a speech / language disorder comorbid with ADHD may represent a subtype of speech and language disorder" (Page 94).

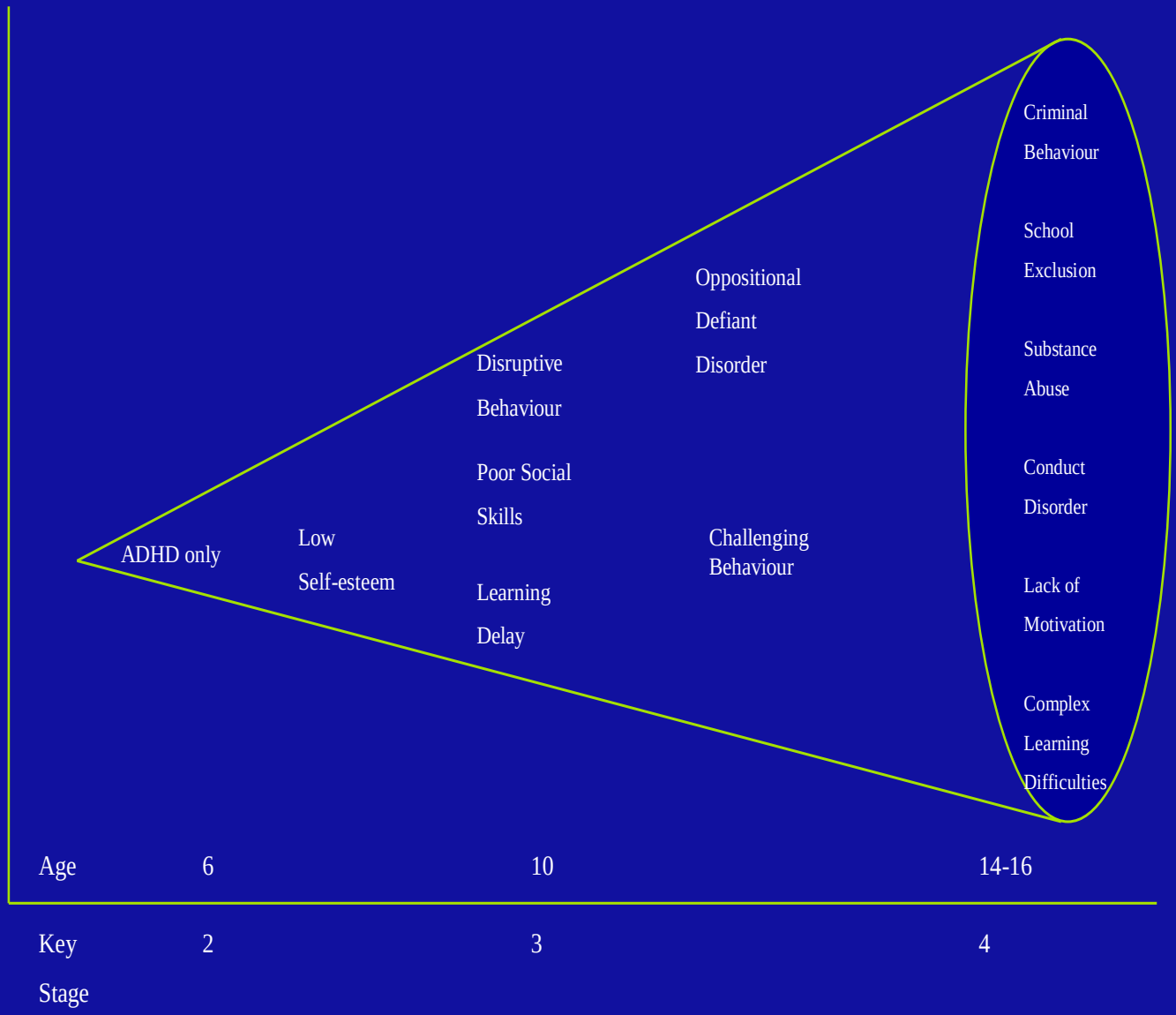


Figure 2 Unmanaged, ADHD can give rise to increasing complications

Risk Factors

(a) RISK FACTORS FOR CHILD AND ADOLESCENT PROBLEMS

(Gene environment interaction)

(1)Genetic	(a)	Adolescent Depression 30-50%
	(b)	ADHD 60-90%
	(c)	Autism/Aspergers 93%

Risk Factors

(d) High risk – Children of parents with depression, Bipolar Disorder, Schizophrenia, ADHD, Asperger Syndrome (also sub-syndromal depression, ADHD etc.)

Risk Factors

(e) Psychosocial adversity, poverty

(f) Bullying, domestic violence, migration, war, child maltreatment.

Risk Factors

(g) ADHD

- Prenatal smoking and alcohol abuse
- Prematurity
-High blood lead
-Psychosocial adversity (poverty)
-“Hardwiring” problems in the brain

Risk Factors – Gender Females

(1) Greater risk of depression in adolescence (Increasing with age) (about 2 males to 1 female).

(2) Hormones plus environmental stresses

(3) Greater risk eating disorders.

DIAGNOSIS OF ADHD

1. Onset Primary SChool

2. Problems with inattention, concentration, hyperactivity, impulsivity and disorganisation

CO-MORBIDITY

Co-morbidity, anxiety, depression, autism, tics,oppositional defiant disorder, conduct disorder, dyslexia, speech and language problems.

Impact of Untreated Attention Deficit Hyperactivity Disorder

Health Care System

50%↑ in bike accidents[1]

33% ↑ in ER visits[2]

2-4 x more motor vehicle crashes[3-5]

Society

Substance Use Disorders 3-5 x ↑

2 x Risk[8]

Earlier Onset

Less likely to Quit[9] in Adulthood[10]

Family

Parental Divorce or Separation[11,12]

2-4 x ↑ Sibling fights[13]

School & Occupation

46% Expelled[6]

35% Drop Out[6]

Lower Occupational Status[7]

Employer

↑ Absenteeism[14]

↓ Productivity[14]

1. DiScala et al., 1998. 2. Liebson et al., 2001. 3. NHTSA, 1997. 4-5 Barkley et al., 1993, 1996. 6. Barkley et al., 1990. 7. Manuzza et al., 1997. 8. Biederman et al., 1997. 9. Pomerleau et al., 1995. 10. Wilens et al., 1995. 11. Barkley, Fischer et al., 1991. 12. Brown & Pacini, 1989. 13. Mash & Johnston, 1983. 14. Noe et al., 1999.

PUBLIC KNOWLEDGE (Mc Leod et al. 2007)

The survey results show that the general public is not well-informed about ADHD, regardless of whether they had heard of the disease or not. Problems with stigma and inappropriate blaming the mothers for children's problems.

TREATMENT AND FOLLOW-UP (ADHD)

1. Psycho education
2. Behaviour therapy, CBT
3. Coaching, Advocacy
4. Family/Systemic Therapies
5. Parent Training

A TREATMENT OF CHILD AND ADOLESCENT MENTAL HEALTH PROBLEMS

(1)Non directive counselling

(2)Formal psychotherapy (CBT, psychoanalysis family/system)

(3)Use of volunteers or mentors

A TREATMENT OF CHILD AND ADOLESCENT MENTAL HEALTH PROBLEMS

(4)Direct group work in schools. (Not chatting between professionals).

(5)Parent training (Parenting “Licence”).

A TREATMENT OF CHILD AND ADOLESCENT MENTAL HEALTH PROBLEMS

(6) Medication & Psychosocial treatment

- ADHD moderate or severe
  (combined medication and
  psychosocial treatment)

- Depression moderately effective in
  adolescence anti depressants except
  very effective OCD and depression

- Psychosis

- Behavioural problems and autism

- Bipolar

CHILD AND ADOLESCENT PSYCHIATRY SYSTEMS DELIVERY PROBLEMS PROBLEMS WITH DOCTOR PATIENT RELATIONSHIP (Brinkman et al. 2011)

1) Different doctors every visit
2) There is room for improvement in patient-physician interactions in the treatment of ADHD and additional interventions are required, for example:

(a) Tailored family education systems
(b) Decision aids to assist physicians
(c) Patient portals (online healthcare-related applications) to facilitate monitoring.

Review: Adler & Nierenberg (2010)

- Non-adherence 13-64% Huge compliance problems in Europe
- - Increased in IR as opposed to Extended R medications.

You need to intervene through your Regulating Authority/Councils of Professionals to deal with this problem. (Continuous professional development issue.)

PREVENTION POLICY

1. Reduce risk factors
2. Reduce poverty
3. Treat parental depression

PREVENTION POLICY

4. Earlier identification of high risk factors
   (Isolated families and families in severe poverty with drug and alcohol addicted parents and parents with severe mental illness)

‘THE POWER OF MENTOR MOTHERS’

(British Medical Journal 2012 344, 43)

(1)‘Peer led parenting support programmes can be as effective as interventions delivered by professionals.’

(British Medical Journal 2012 344, 10)

‘THE POWER OF MENTOR MOTHERS’
(British Medical Journal 2012 344, 43)

(2)The future is empowering, parents empowering communities Day et al 2012 BMJ 344, 19

(3)Delivery centres – schools and children centres in socially deprived areas

(4)Irish example parents of treated ADHD children mentoring new parents with ADHD children

MODELS OF VOLUNTEERISM

Trained volunteering is cost effective model for all countries where financial restraints cause governments to withdraw from providing professional services by financially stressed European countries.

POLICY IMPLICATIONS

FUTURE IS LOW COST EFFECTIVE INTERVENTIONS.

1. Mental health problems are very common.

2. More research in low income countries. Most research has been done in high income countries.

3. Research needs to focus on cost effective programmes.

4. The largest amount of gain in psychotherapy is in the first few sessions. Consider short term psychotherapeutic interventions and chronic care model of intervention.

5. There is little difference in outcome between experienced and less experienced therapists. (Experience possibly more relevant to severe cases).
6. Psychotherapy is effective but there is little difference between expensive and low cost psychotherapies. Future use of volunteers with brief training and supervision by Professional therapist .

POLICY IMPLICATIONS

7. Support volunteer counsellors and therapists who operate under supervision of experienced therapists e.g. Samaritans , Accord, Relate, Rainbow.

8. Challenge myths of child psychiatric clinics and multi disciplinary teams. (1) Benefits of excessively long treatments.)

9. George Bernard Shaw said professionals are in conspiracy against the laity.

10. All referrals should be seen initially by one professional. Then other professionals should come in as necessary educational psychologists, social workers, speech therapists, psychotherapists, occupational therapists etc., on an individual basis.

11. While communication between agencies is critical meetings should be set up for a purpose and not just for the sake of meetings. Often meetings conclude with a decision to have another meeting with a massive wastage of resources. Electronic communication techniques should be used phones, video conference etc. Otherwise massive wastage on time in rural areas of Europe which lead to massively incredible waiting lists.

POLICY IMPLICATIONS

12. Lack of diagnosis of neurobiological conditions e.g. Asperger's Syndrome, Autism and ADHD lead to professionals blaming parents for causing the behavioural problems and causes great pain. This is still occurring not uncommonly e.g. Ireland.

13. Teach children problem solving skills in all schools. Suicide attempt is a dysfunctional problem solving method.

14. Early identification and intervention with behavioural problems leads to better outcome. This makes economic sense. E.g. High risk sample of parents with severe mental illness. I believe this would increase the output in the number of children assessed and treated by 30/40%

15. All services for children should apply evidence based interventions and should be assessed for cost effectiveness, number of children assessed and treated as compared to other similar services. I believe this would increase the output in the number of child assessed and treated by 30/40%. This statement should be seen as a hypothesis needing to be evaluated. This would give more "bang for your euro".

ADHD – RISK FACTORS

1) Genetic – heritability 60%-90% (this should reduce stigma and blaming the mother)

2) Pre-natal smoking increases the risk of ADHD. Studies found that while 22 40% of mothers of children with ADHD smoked during pregnancy, only 8-27% of mothers of non-hyperactive children did. Prenatal exposure to alcohol also increases the risk of developing ADHD.

3) Prematurity, high blood lead psychosocial adversity

4) Delayed maturation of brain until age 25 years.

5) The brains of Children with ADHD are hardwired differently; they are unique.

BEHAVIOUR TREATMENT PLUS MEDICATION TREATMENT AND FOLLOW-UP (ADHD)

NIMH huge American study found that over a 14 month period, tailored medication management, both with and without intensive behavioural treatment, was significantly superior to behavioural therapy or community care involving routine ADHD medication.