Adolescent Health GP Resource Kit

Practice Points

section two - chapter ten

Adolescent Mental Health

Features of Adolescent Mental Health Problems

- Up to 25% of adolescents experience a mental health disorder at any given time
- **Mood disorders** such as **depression, and anxiety** are the most prevalent mental health problems in adolescents
- Co-morbidity is common – there is a strong association between mental health problems and the incidence of other risk-taking and behavioural problems – especially substance use, school and family problems
- Many mental health disorders have their initial onset in adolescence – e.g. depression, schizophrenia, eating disorders
- CALD young people may be at risk of poor mental health as a result of the stresses associated with the experience of migration and resettlement

The GP's Role *see page 104*

- Use consultations to screen for depression and other mental health concerns
- Provide early intervention and treatment
- Assist young people to access specialised mental health services
- Actively promote young people's mental health and resiliency by teaching positive coping strategies and problem solving skills
- Educate parents and family members and involve them in management plans
- Use the new **Medicare mental health item numbers** to coordinate a collaborative treatment approach with other mental health professionals

Screening and Assessment *see page 105*

- Routinely enquire about psychological distress, depression and risk behaviours
- Use the ***HEEADSSS*** psychosocial assessment for detecting the presence of risk factors and mental health problems
- A more in-depth assessment may be needed to diagnose specific disorders – this may require referral to a psychologist, psychiatrist or mental health service
- If a young person presents repeatedly with vague or non-specific complaints, consider the possibility of depression or other mental health problem
- Screen for **co-morbid health problems** – e.g. substance abuse; mood disorders
- Take into account the young person's cultural background – enquire about any cultural factors and experiences that may impact on their mental health – e.g. the experience of torture or refugee trauma

Management of Depression *see page 107*

- Developing a trusting relationship is essential for the effective diagnosis and management of depression
- Counselling or psychotherapy, such as Cognitive Behavioural Therapy (CBT), is recommended as the first line of treatment for adolescents
- Medication is the second line of treatment – but should be used judiciously, especially with younger adolescents
- A collaborative treatment approach involving other mental health professionals is crucial
- Use the new Medicare Mental Health Item Numbers to develop a Mental Health Care Plan to facilitate referral to a Psychiatrist or Psychologist

Young People with Psychosis *see page 111*

- The peak age of onset of psychotic disorders is in the early to mid-twenties for males and mid to late-twenties for females
- Early recognition and intensive intervention in early psychosis increases the likelihood of positive outcomes for young people
- If a young person is experiencing significant psychosocial difficulties, and/or displaying symptoms of depression, anxiety or substance misuse – screen for the possibility of a psychotic disorder
- Management of a young person with psychosis requires a multidisciplinary approach through collaboration with specialist mental health services
- Use the **Medicare Mental Health Item Numbers** to develop a care plan for the young person and coordinate a collaborative treatment approach

Managing Suicide Risk and Self Harm Behaviour *see page 115*

- Build a therapeutic alliance with the young person
- Clarify confidentiality – the presence of serious or imminent threat in this situation overrides the need to maintain confidentiality
- When the young person is at ***moderate to high risk***, it is important to ensure the young person's immediate safety:
  - develop a management plan for ensuring the young person's safety
  - contact and mobilize family and social supports
- Consider the use of a *'no suicide' contract* with the young person to seek help before self harming *(use only in conjunction with other therapeutic interventions)*
- Consider hospitalization (if risk is assessed as very high)
  - treat as medical emergency if acutely suicidal
- Refer for specialist treatment if no safety agreement can be reached
- Young people engaged in self-harm behaviour (e.g. cutting arms, legs, body) should be screened for depression and suicide risk

See Section 4 – for contact details of mental health services and resources.

chapter ten
Adolescent Mental Health

Facts about Adolescent Mental Health[1,2,3]

- Up to 25% of adolescents experience a mental or substance use disorder at any given time
- The overall mental health of young people appears to be worsening
- Anxiety and depression are the leading mental health problems among adolescents – accounting for 17% of the male disease burden and 32% for the female
- Behavioural disorders, such as ADHD and Conduct Disorder (CD) are common, especially among young males – 8% of young people aged 12-17 years had ADHD and 3% had conduct disorder, with around 16% of those with ADHD or CD having both disorders

Adolescence and Mental Health

- Adolescence is marked by increased exposure to risk factors and risk-taking behaviours that may predispose young people to poor mental health outcomes – e.g. substance use; peer conflicts
- The rapid social and emotional changes of adolescence can complicate the presentation and recognition of mental health problems in young people:
  - behavioural and emotional turmoil is often a part of adolescent development and may be easily dismissed as 'transient'
  - mood changes, irritability, poor school performance, or interpersonal conflicts may mask emotional distress or an underlying mental health problem
- Adopt a broad view of mental health with adolescents
  - be alert to other stressors which increase vulnerability to adverse mental health outcomes – such as family breakdown, bullying, stress, school difficulties
- Many mental health disorders have their onset in adolescence – such as anxiety, depression, eating disorders

Mental Health in CALD Young People

Some CALD young people may be at risk of poor mental health outcomes as a result of the stresses associated with the experience of migration, resettlement and acculturation. CALD adolescents also under-utilise mental health services[4].

See also Chapter 7 – Culturally Competent Practice

- The mental health of CALD young people may be adversely affected by:
  - language difficulties
  - intergenerational and intercultural conflicts
  - exposure to traumatic experiences – e.g. torture, refugee trauma
  - isolation
  - resettlement experiences
  - racism and discrimination
- **Refugee young people** are at high risk of mental health problems such as depression, anxiety, post-traumatic stress disorder (PTSD) – arising from the loss of family, friends and home, and the trauma of the refugee experience
- many refugees are recovering from the effects of torture, trauma or witnessing violence
- For specialist assistance in treating young people and families from non-English speaking backgrounds in NSW – contact the **Transcultural Mental Health Centre (TMHC)**

resources

- **TMHC** is a free, state-wide service that provides a range of clinical and consultation services including assessment, short term intervention and over the phone telephone advice and consultation on mental health issues
  these can be provided in the language of the client by **qualified bilingual health professionals**
- **TMHC** welcomes referrals from GPs and provides reports on the referred case as well as recommendations regarding care plans
- Contact on: **(02) 98403800** or Clinical Services **1800 648 911** (toll free) or Website go to Diversity Health website www.dhi.gov.au click link to Transcultural Mental Health Centre
- **Each state has an organisation providing services equivalent to TMHC.**

Features of Adolescent Mental Health Problems

- **Mood disorders** such as **depression, and anxiety** are the most prevalent mental health problems in adolescents
- **Co-morbidity is common** – there is a strong association between mental health problems and the incidence of other risk-taking and behavioural problems – especially substance use; school and family problems[5]
  - e.g. the existence of a depressive disorder raises the risk of substance use, sexual risk-taking and suicidal behaviour
  - co-morbid mental health conditions are common – e.g. ADHD and anxiety or depressive disorders
- **Mental health problems often go undetected in adolescents:**
  - young people are generally ill-informed about their mental health
  - less than 25% of young people with a mental health problem will seek help[6]
- **The presentation of mental health problems** in adolescents can differ greatly from adults
  - e.g. signs such as anger, aggression, acting out, drug use, risk behaviours, non-attendance at school – may all be indicators of a mental health problem
- **A high level of morbidity and mortality** is associated with adolescent mental health problems including:
  - damaging lifestyles and behaviour (e.g. substance abuse, self harm)
  - impaired development
  - school failure
  - progression into adult disorders

Psychiatric disorders in adolescence consist of:

- **Chronic conditions** – that have their onset during childhood – including conduct disorder; attention-deficit/hyperactivity disorder (ADHD); anxiety disorders (e.g. obsessive compulsive disorder)
- **Disorders that have their initial onset during adolescence** – including depressive disorder, anxiety, schizophrenia, eating disorders

The GP's Role

More than half of all adolescents who attempt suicide will have visited a GP within the previous month[6]. GPs therefore play a key role in the detection, diagnosis, treatment and provision of continuing care to young people with mental health problems by:

- Using consultations to **screen for depression and other mental health concerns**
- Assisting young people to **access specialised mental health and other appropriate services**
- Actively promoting young people's mental health and resiliency:
  - **teach positive coping strategies** – help the adolescent to identify 'things that get them through.' – e.g. a hobby, sports, friendships, spiritual beliefs
  - **strengthen their connectedness** to family, school, peers and community
  - **teach problem solving skills** for more effectively dealing with school, relationship, family and peer problems
- Help the young person to **develop competencies:**
  - **social competency** – communication and interpersonal skills to build relationships
  - **cognitive competence** – identifying negative thinking patterns and irrational beliefs; and developing more optimistic and realistic thinking
  - **emotional competence** – identifying and appropriately expressing their emotions, and managing their moods

See also Chapter 5 – Risk Taking and Health Promotion

- Educating and **supporting parents and family** members and involving them, as appropriate, in any treatment plans
- Sensitize the young person, and their family, to the need for referral to specialist mental health services
- **Collaborating with other mental health professionals** in the provision and coordination of comprehensive, multidisciplinary care – use the new **Medicare mental health item numbers** to develop a coordinated approach to treatment *(see below)*
- Identifying associated **co-morbid health problems** (e.g. substance use) and risk factors and providing appropriate treatment and referral

resources

There are a number of website and services offering information and support for young people on mental health:

- **Reachout** provides information and resources for both young people and GPs
  www.reachout.com.au
- **YBBLUE** a website to help young people, developed by the Beyond Blue project to reduce stigma and encourage young people to seek help
  www.beyondblue.org.au/ybblue
- **Young People Prevention and Early Intervention** a site containing some excellent resources for young people
  http://www.yppicentre.com/Young_People
- **Kids Help Line** – 24 hours, 7 days a week – 1800 551 800

See Section 4 for contact details of mental health resources and services

Using the Medicare Mental Health Item Numbers

The new Medicare item numbers of the **Better Access to Mental Health Care** initiative allow GPs to access Psychologists who use evidence based treatments, as well as other specialist mental health care providers:

- The GP has a critical role in initiating a collaborative treatment approach by developing a **Mental Health Care Plan** for the young person
- This enables the GP to refer to a Psychiatrist or Psychologist for specialist mental health **assessment** and/or provision of **focused psychological treatment** for a range of mental health disorders
- The approved focused psychological treatments that can be provided by a Psychologist or Social Worker under the Medicare scheme include:
  - Cognitive Behavioural Therapy (CBT), including both behavioural and cognitive interventions
  - Psycho-education (including motivational interviewing)
  - Relaxation strategies – progressive muscle relaxation; controlled breathing
  - Skills training – problem solving skills and training; anger management; social skills training; communication training; stress management
  - Interpersonal therapy (especially for depression)

See Chapter 13 – Collaborative Care – for relevant Medicare item numbers

Screening And Assessment

- Routinely enquire about psychological distress, depression and health risk behaviours with adolescent patients
- The ***HEEADSSS*** psychosocial assessment provides a broad framework for detecting the presence of risk factors and mental health problems

See Chapter 2 – Conducting a Psychosocial Assessment

- A more in-depth assessment may be needed to **diagnose specific disorders** – this may require referral to a psychologist, psychiatrist or mental health service
- If a young person presents repeatedly with vague or non-specific complaints consider the possibility of depression or other mental health problem
- Clarify the role that **risk behaviours** play in the young person's life – e.g. alcohol and drug use may be a means of relieving emotional distress
  - this can provide a guide to intervention strategies – e.g. teaching appropriate coping skills for dealing with emotional distress (instead of substance use)
- It is important to assess any presenting complaint within the **overall context of the young person's functioning** in key areas of their life – e.g. family, school, peer relationships. Where possible, obtain history from other key sources such as parents and teachers
- Adolescents may not always present with obvious symptoms – be sensitive to behavioural **presentations** such as **anger, risk raking, acting-out, truancy, moodiness** – which *may* be indicative of an underlying mental health problem
- Screen for **co-morbid health problems** – e.g. substance abuse; mood disorders concomitant with behavioural conditions such as ADHD and Conduct Disorder
- Be aware of the young person's cultural background and enquire sensitively about any **cultural factors and experiences** that may impact on their mental health – e.g. the experience of torture or refugee trauma[7]
  - clarify cultural norms and beliefs about mental illness and the cultural meaning attached to any particular symptoms

- Adopt a non-judgemental approach when inquiring about the young person's mental health. Be sensitive but direct in your questioning and use language that the young person can relate to:

Example:
"Have you been going through a tough time lately?"
"Can you talk about what's been happening inside you lately (your thoughts and feelings about yourself and your life)?"

Specific Conditions

The following section provides **general guidelines only** for the identification, assessment and management of some major adolescent mental health problems. There are a number of excellent resources which provide more specific information about the assessment, diagnosis and treatment of adolescent mental health disorders. Selected resources are highlighted in the following sections.

See Section 4 – for further information on mental health resources and services

Depression in Young People[8,9]

- Adolescence is a key period for the onset of depression – up to 24% of adolescents will have suffered an episode of major depression by the age of 18
- Major depressive disorder and dysthymic disorder are common disorders in adolescents
- Depression in adolescents is often masked by other symptoms – e.g. anger; irritability; anxiety; poor school performance; marked changes in mood or behaviour
- Adolescents, therefore, may not show obvious signs of depression – GPs need to be proactive in enquiring about depressed mood in adolescent patients
- Depression is a major contributing factor in adolescent suicides
- Depression in young people often goes unrecognised and therefore untreated
- Psychosocial development in young people may be compromised by untreated depressive illness[10]

Assessment and Diagnosis

- A **trusting relationship** forms the basis for the effective diagnosis and management of depression:
  - Establish rapport
  - Define the terms of confidentiality
  - Adopt a non-judgmental approach

See Chapter 1 – Conducting a Youth Friendly Consultation – for approaches to engaging the young person

- **Conduct a psychosocial assessment** using the ***HEEADSSS*** tool – in particular, screen for:
  - **marked changes in usual mood or behaviour** – e.g. sleep/appetite disturbance; persistent irritability
  - **underlying risk factors** or **precipitating events** for onset of depression – e.g. substance use, bullying and victimisation, difficulties in sexual orientation, issues of loss, family conflict, trauma, stress, illness
  - **relationship difficulties** – withdrawal/ isolation, conflicts with peers
  - **family history** of depression or other mental illness
  - deterioration in **school performance;** loss of interest in activities and recreational pursuits

See Chapter 2 – Conducting a Psychosocial Assessment

- Where depression is suspected, a careful **clinical history** should be obtained from the young person, with supportive evidence gained from family, friends, teachers, etc. – this requires scheduling a longer consultation
- Where possible, use diagnostic interviews, self-report questionnaires or rating scales to assist in establishing diagnosis[11] – e.g. **K10** (Kessler Psychological Distress Scale); **DASS 21** (Depression Anxiety Stress Scale)
  (See Black Dog Institute website for assessment tools: www.blackdoginstitute.org.au – go to *'Health Professionals Website'*)
- Consider the **differential diagnosis** of depressive disorders and **comorbidity** – identify the presence of comorbid problems – e.g. substance use, anxiety, other behavioural or mental health problems, sexual abuse

- A useful approach is to ask the adolescent to **rate their own level of depression** on a scale from **0 to 10** – where **'0'** means no depression and **'10'** means *severe depression*[9]

> ***Example:*** *"On a scale of 0 to 10, where 0 means no depression and 10 being the most depressed you could possibly be, where would you rate yourself at the moment?"*

- A score of up to 5/10 can usually be considered mild depression. A score above 5 may indicate more severe depression
- It is important to ask the young person what that particular score means for them:

> ***Example:*** *"You said that right now you rate yourself as being 6 out of 10. A six to me sounds like you're feeling pretty down a lot of the time, and that maybe you're finding it hard to get out of that feeling of being down or sad. Is that how it is for you at the moment?"*

- When using a self-rating scale, it is useful to follow it up with questions that translate the young person's rating into behavioural descriptions:

> ***Example:*** *"What is happening in your life right now that makes you feel like it is a six?"*
> *Or*
> *"What is happening inside yourself right now (your thoughts, feelings) that makes it feel like a six?"*

- A score of 7 and above demands a careful screening for the risk of suicidality[9]
- Where uncertain, refer to a **Child and Adolescent Psychiatrist or Psychologist** for more in-depth assessment to assist with diagnosis and treatment options
  - this is especially important in distinguishing between depression and other mood disorders such as Bipolar Disorder and Psychotic Depression

See 'Referral Options' (below)

Depression - Diagnostic Signs

According to the **Diagnostic and Statistical Manual for Mental Disorders (DSM-IV), a major depressive disorder** is indicated if at least **five** of the following symptoms are present during the same **2-week period** most of the day, nearly every day; *and* at least one of the symptoms is either *depressed mood* or *loss of interest* or pleasure in activities; or in the case of adolescents, *irritability*:

- Depressed or irritable mood; persistent sadness
- Markedly diminished interest or pleasure in most activities
- Significant change in weight or appetite
- Change in sleep patterns – insomnia, broken sleep, sleeping too much
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or inappropriate guilt
- Impaired ability to think, concentrate or make decisions
- Recurrent thoughts of death or suicide, or suicide attempt

Management Approaches

- Developing a **trusting relationship** with the adolescent is a key component in the management of their depression
- Listening to their concerns and providing support builds a **therapeutic alliance** which in itself can help the young person to combat their depressed mood
- Such a relationship will also help to facilitate **referral to other professionals**
- The treatment of depression in adolescents, particularly severe depression, should ideally involve a **collaborative partnership** between the patient, the GP and a specialist mental health service provider (e.g. Psychiatrist; Psychologist; adolescent mental health worker)
- Use the new **Medicare Mental Health Item Numbers** to develop a comprehensive **Mental Health Care Plan** for the young person – thisenables the GP to refer to a Psychiatrist or Psychologist for specialist assessment and treatment

See Chapter 13 – Collaborative Care – for relevant Medicare item numbers

Treatment Options

Treatment plans should be based on a thorough assessment – including the type, severity and duration of the depressive episode, and any stressors that contributed to the episode[11]:

i. Psychological Treatments

- Evidence-based **counselling or psychotherapy** therapies are generally considered the first line of treatment for adolescents[8, 9, 11] – although their effectiveness may be enhanced when used in conjunction with appropriate medication. Evidence-based psychological treatments include:
  - **Cognitive Behavioural Therapy (CBT)** has proven efficacy in the treatment of depression
  - **Interpersonal Psychotherapy (IPT)** may be helpful for older adolescents
  - **Family Therapy**
- Use the new **Medicare Mental Health Item Numbers** to refer to a Psychologist or other counsellor trained in evidence-based psychological treatments

ii. Anti-Depressant Medication

- Recently the role of medication in the treatment of depression in adolescents has been under review, with reports of increased risk of agitation and suicidal behaviour in this age group with the use of **Selective Serotonin Reuptake Inhibitors (SSRIs)**[12]
- The potential of these **negative side-effects** suggests the need for a cautious and judicious use of medication – especially with younger adolescents
- Nevertheless, available evidence suggests that for selected patients, **antidepressants are an effective component** of the successful treatment of certain depression and anxiety disorders in children and adolescents[10]
- The Australian Adverse Drug Reactions Advisory Committee (ADRAC) has released **three recommendations on the use of SSRIs** with children and adolescents[10]:
  - any **SSRI** use in adolescents with major depressive disorder (MDD) should be undertaken only within the context of **comprehensive management** of the patient – such management should include careful monitoring for the emergence of suicidal ideation and behaviour
  - the choice of SSRI for adolescents should be made taking into account the recent evaluations of **clinical trial data and product information**
  - adolescents who are currently being treated for MDD with an SSRI should not have their medication ceased abruptly
- Other criteria that should be considered in prescribing medication include recommendation from the *NHMRC Clinical Practice Guidelines for Depression in Young People*[8] that medication should only be prescribed if:
  - counselling alone is insufficient or is unsuccessful
  - the depression is so severe that it interferes with the young person's capacity to engage in counselling
  - the depression is life-threatening
- The key to successful antidepressant drug treatment in adolescents is **frequent review** by the GP to monitor response, compliance and side effects, preferably with the use of a depression symptom checklist in the context of providing psychological support[12]

See the box below for more specific guidelines on the use of anti-depressant medications with adolescents

resources

- **The Black Dog** Institute provides a range of assessment tools, resources and management guidelines for GPs in the treatment of depression and other mood disorders
  www.blackdoginstitute.org.au
- **The Royal Australian College of General Practitioners (RACGP)** provides guidelines on the use of antidepressant medications in children and adolescents. RACGP. 2005.
  www.racgp.org.au/guidelines/antidepressants
- **The Royal Australian and New Zealand College of Psychiatrists** has developed clinical practice guidelines for the treatment of depression and other disorders
  www.ranzcp.org/publicarea/cpg.asp go to **'Clinical Practice Guidelines'**
- **DepressionNet** provides information and resources to patients about causes, symptoms and various treatment options in managing depression – www.depressionet.com.au
- **beyondblue** the National Depression Initiative has resources for professionals and the public, including a specific site for young people
  www.beyondblue.org.au
- **Reachout** provides information, resources and support for both young people and GPs
  www.reachout.com.au

Guidelines for Use of Anti-Depressant Medication[8,9,10,12]

- Prescription of medication to adolescents should be based on a **comprehensive assessment** of the young person, taking into account factors such as:
  - severity of condition
  - lifestyle
  - co-morbid conditions – e.g. substance use and other risk factors
  - developmental age of young person and their capacity to understand and comply to treatment regime
  - degree of family and social support available to them
- When prescribing antidepressants for adolescents, GPs should:
  - discuss the medication with the young person and/or parent to ensure they are comfortable with the treatment
  - **explain potential side effects** including suicidality
  - discuss the importance of taking the medication as prescribed and the impact that other substances may have
- Where uncertain, prescription of medication should be done in **consultation with, or referral to a psychiatrist** – especially if the depression is severe
- **Selective serotonin re-uptake inhibitors (SSRIs)** – are preferred with adolescents because they are quicker acting, have fewer side-effects, are relatively safe in overdose and have lower cardiotoxicity than tricyclics.
- **Specific recommendations** for commencement of an adolescent on SSRIs are *(adapted from the RACGP clinical guidelines[10]):*
  - **Start with a low dose** and build up gradually
  - Carefully **monitor** the patient, especially in the early weeks, for the emergence of **behavioural activation**, suicide risk and harmful side effects
  - Be available for contact in case of emergence of adverse reactions – where possible, **see the young person on a weekly basis** for the first few weeks of treatment
  - **Sensitize patients, parents and others** living with the young person to be aware of potential activation symptoms and other warning signs – including the possible emergence of suicidal thoughts early in treatment
  - In the case of **non-response** or significant deterioration, **consult**, where possible, with a child and adolescent psychiatrist or developmental paediatrician
  - Following recovery, the antidepressant should be continued for a period of six to twelve months to prevent relapse or recurrence
  - Sudden cessation of SSRIs should be avoided in order to avoid discontinuation syndrome
  - **Tricyclics and MAOIs** have a generally higher risk of adverse effects and much greater toxicity in overdose. Prescribing of these antidepressants to children and adolescents should not be initiated by general practitioners
- Consult with a Psychiatrist and/or Psychologist about how long the young person needs to remain on medication and develop a strategy for withdrawal from medication

iii. Referral

- Referral to other specialist services is a crucial part of providing a shared care approach
- Referral should be discussed sensitively with the young person and the reasons clearly explained
- Obtain their permission to share information with the other referral body
- Reassure them that they are welcome to return if the referral does not work out, so that other options can be explored
- The role of counsellor/psychologist may need to be explained to adolescents and families from CALD backgrounds as these services may not exist among some cultural groups
- Use the new **Medicare Mental Health Item Numbers** to develop a **Mental Health Care Plan** to facilitate referral to a Psychiatrist or Psychologist

See Chapter 13 – Collaborative Care – for relevant Medicare item numbers

Referral Options

- Referral to a **Psychiatrist** or community **mental health services** is recommended where there is:
  - uncertainty about diagnosis
  - severe major depression, particularly with suicidal ideation
  - depression with psychosis
  - family history of bipolar affective disorder
  - serious co-morbidity
  - failure of initial treatment
- Referral to a **Psychologist** or **counsellor** is recommended for:
  - assistance with assessment and diagnosis
  - provision of specialised counselling – e.g. CBT; drug and alcohol counselling where substance use is an issue; dealing with grief or loss
  - family therapy
- **Transcultural Mental Health Centre** is a state-wide (NSW) resource centre, offering clinical and consultation services including assessment, short term intervention and over the phone telephone advice and consultation on cross cultural mental health issues
  - Contact on: **(02) 98403800** or Clinical Services **1800 648 911** (toll-free)

See Section 4 – for contact details of other mental health services

iv. Education and Mental Health Promotion

- Young people who are depressed can benefit from education about the nature of their illness, its possible causes and effects on them, and proposed treatments
- Education in the following areas can greatly assist the young person in addressing psychosocial factors contributing to their depression and in developing positive coping skills:
  - social and interpersonal skills
  - appropriate problem-solving and goal setting skills
  - enhancing self-esteem
  - emotional self-management
- Consider referral to a Psychologist or counsellor to provide psycho-education strategies to the young person on how to manage their depression, moods and negative cognitive styles

v. Monitoring Daily Activities

- Withdrawal from pleasurable or routine activities is a common feature of depression
- Set the young person homework tasks to identify and monitor their daily activities over the period of a week
- Encourage the young person to increase the amount of time spent engaged in doing pleasurable and active things, e.g.:
  - exercise and sport
  - participation in social and recreational activities

vi. Family Work

- Educate and support parents and family members in understanding their adolescent's depression
- Where the young person is amenable, actively involve the family in the treatment regime
- Refer for specialist family counselling, where family issues/conflicts are a major contributing factor in the onset and maintenance of the depression

vii. Collaborative Care

- The management of adolescent depression requires a collaborative approach
- The GP can take a lead role in the provision of collaborative care
  - either through coordinating the young person's case management
  - or as part of a treatment team including psychologist; psychiatrist or other mental health specialist, school counsellor, youth workers, etc.
- It is critical to involve other key people in the adolescent's life in supporting the management plan – e.g. family members, teachers, peers
- The GP has a crucial role in monitoring the young person's progress – if there is no improvement it is important to:
  - review the diagnosis
  - check compliance with the treatment plan
  - consider other treatment options
- Use the new **Medicare Mental Health Item Numbers** to develop a comprehensive **Mental Health Care Plan** for initiating a collaborative treatment approach.

See Chapter 13 – Collaborative Care – for relevant Medicare item numbers

practice points

- Depressed adolescents may present in general practice with physical complaints – headaches, tiredness, abdominal pains, or with behavioural signs – such as anger, risk behaviours, truancy
- Consider emotional issues in young people who present frequently to general practice with vague or minor complaints
- **Co-morbidity** is a common feature of adolescent depression – it is important to screen for depression in young people with anxiety and other mental health issues, substance abuse, behavioural disorders and medical illnesses
- Treatment plans should be based on a thorough assessment of the depressive symptoms and the young person's history and current circumstances
- Development of a trusting therapeutic relationship is the key to successful treatment of depression in adolescents
- Develop a **Mental Health Care Plan** to coordinate a collaborative treatment approach and facilitate referral to mental health specialists

Young People With Psychosis

The following section has been adapted from a publication of the St George Division of General Practice, NSW.

The peak age of onset of psychotic disorders is in the early to mid-twenties for males and mid to late-twenties for females.

Early Intervention

- Early recognition and intensive intervention in early psychosis has been shown to increase the likelihood of positive outcomes for young people and their families
- GPs are often the first point of contact for young people with mental health problems and can play a critical role in ensuring that delays in intervention are kept to a minimum

The Prodrome to Psychosis

- Psychotic disorders are generally preceded by a gradual change in psychosocial functioning over an extended period of time
- Some of the changes seen during this phase include:
  - Changes in **affect** such as anxiety, irritability and depression
  - Changes in **cognition** such as difficulty in concentration or memory
  - Changes in **thought content** – such as preoccupation with new ideas often of an unusual nature
  - **Physical changes** such as sleep disturbance and loss of energy
  - **Social withdrawal** and impairment of **role functioning**
- The person may also experience some **attenuated** positive symptoms such as mild thought disorder, ideas of reference, suspiciousness, odd beliefs and perceptual disorders that are not quite of psychotic intensity or duration

The Acute Phase of Psychosis

- The acute phase of psychosis is characterized by the presence of positive psychotic symptoms which include thought disorder, delusions and hallucinations:
  - **Hallucinations** – are sensory perceptions in the absence of external stimulus
  - **Delusions** – are fixed, false beliefs out of keeping with the person's cultural environment
  - **Thought disorder** – refers to a pattern of vague or disorganized thinking.
- An underlying psychological disturbance should always be considered in a young person presenting with persistent or ill-defined somatic complaints such as tiredness, repeated headaches or insomnia in the absence of demonstrable physical pathology on examination

Screening for Psychosis

- If a young person is experiencing significant psychosocial difficulties, and displaying symptoms of depression, anxiety or substance misuse, it is important to consider the possibility that such symptoms are part of a psychotic disorder
- ***The following prompts may be helpful in screening for psychosis:***
  - *Have you ever had any trouble with your thought processes recently? Do they seem speeded up or confused?*

Checking for thought disorder

- *Have you ever been concerned about any unusual events recently, or thought that there were strange things happening around you, or to you? Have you ever been feeling as if something bad is happening to you, or that people have turned against you in some way?*
  Checking for delusions
- *Have you ever experienced any strange or unpleasant experiences involving your senses, for example hearing things or seeing things that others could not?*
  Checking for hallucinations

Assessment

- Where possible, conduct a thorough psychiatric and medical assessment
- Obtain a collateral history from family/friends etc.
- Assess for co-morbid issues requiring treatment – especially substance use
- In any psychiatric assessment it is essential to assess for **suicide risk** and whether the person is at **risk to others**
- Refer to specialist mental health services and/or psychiatrist for more in-depth assessment

Management

- Effective management of a young person with psychosis requires a **multidisciplinary approach** through collaboration between primary care and specialist mental health services
- The GP's main role may be to coordinate a collaborative treatment approach and facilitate referral to specialist services
- Discuss referral to specialist mental health services with the young person and/or their family – where possible involve the young person, family and friends in treatment planning
- Use the **Medicare Mental Health Item Numbers** to develop a care plan for the young person and to facilitate referral

See Chapter 13 – Collaborative Care – for relevant Medicare item numbers

- The initial focus of treatment is the control of positive psychotic symptoms and secondary symptoms such as insomnia, and agitation
- Specialist mental health services will generally be responsible for initiating treatment and making significant changes to the medication regime
- The GP may be responsible for maintaining treatment and adjusting medication in consultation with the psychiatrist
- For **acute symptoms** of psychosis – a referral should be made to your **Area Mental Health service** and/or a private psychiatry service

Psychiatric Emergency

- Contact your local **Mental Health (Acute Care) Crisis Service**
- Consider other options, including:
  - Filling out a Scheduling form
  - Referral to local **Emergency Department** with appropriate escort

See Section 4 – for contact details of mental health services and resources

Suicide And Self Harm

Facts about Suicide in Young People[1,2,6]

- The rate of young male deaths from suicide declined by over 50% from 1997 to 2004
- In 2004, 272 young people aged 12-24 committed suicide
- There has been a large rise in young females needing hospital treatment for suicide attempts in NSW
- Hospitalisation rates for suicide attempts are up to three times higher in young females than in males, while death rates from suicide are about 3-4 times greater in males than in females – this is mainly due to males using more lethal methods than females
- Depression is a major precipitating factor in adolescent suicide
- More than half of all adolescents who try to kill themselves will have visited a GP within the previous month
- In 2002 a survey of young people in year 10 and 11 found 6% had deliberately self harmed in the past 12 months and 12% reported having done so at some point in their life

Suicidal and Self Harming Behaviour in Young People

Suicidal and self harming behaviour are maladaptive solutions to emotional, psychological, interpersonal and developmental problems.

- **Suicidal ideation** – refers to conscious thought about ending one's life

- **Suicidal behaviour** – consists of threats and actions involving the intention to kill oneself, which if enacted may lead to serious injury or death. It is useful to distinguish between suicidal and self-harming behaviour
- **Self-harming behaviour** – involves directly and deliberately inflicting bodily harm or injury – including cutting, scratching, burning, abrasions
  - it is a way of dealing with overwhelming feelings and situations
  - alters the person's mood state and reduces psychological tension
  - self-harming often repetitive in nature
  - in some cases, it may be associated with personality disorder
  - self-harm behaviour is generally not intended as suicidal – however, involvement in self-harm behaviour may predispose the young person to increased risk of suicide
  - young people engaged in self-harm behaviour should be screened for depression and suicide risk

Assessing Suicide Risk

- A comprehensive psychosocial risk assessment using the ***HEEADSSS*** screening tool can help to identify presence of suicidal ideation and behaviour – it also allows you to determine risk and protective factors in the adolescent's life

See Chapter 2 – Conducting a Psychosocial Assessment

- If the young person presents as depressed or if there are indicators of suicidal risk, it is important to enquire directly about suicidal thoughts or behaviour:

Example: *"I'm wondering because you have been feeling so depressed, whether you have had any thoughts about hurting or killing yourself?"*
"Have you ever felt so bad you've wanted to hurt or kill yourself?"
"Have you thought of harming yourself?"
"Have you ever thought that life was not worth living?"

- If the answer to these questions is **"yes"**, it is important to conduct a **systematic assessment** to identify whether the young person is at **Low; Moderate; or High Risk**
- Ask questions that graduate from exploring current feelings and thoughts to identifying specific plans and actions
- **Direct questioning** is important – most young people feel relieved to have their distress acknowledged – it allows the depressed or suicidal adolescent to express their worries and to feel heard and understood
- Once the assessment of suicidal risk is completed, an appropriate management plan can be put in place

i. Explore thoughts and feelings:

- The main contributing factors in adolescent suicide are **depression and loss of hope**
- Empathise with the young person and show your concern and interest – use reflective listening to encourage them to express their thoughts and feelings about their current situation

Example: *"It sounds like you're feeling pretty down about your life at the moment…"*
"You seem to feel like it's all too much for you right now and that you're not going to find a way out of this…"
"When you're feeling so down, what sort of thoughts and feelings do you have about yourself and your life?"

- Common thoughts and feelings include:
  - *sense of hopelessness and/or helplessness*
  - *persistently thinking things will never get better and no-one can help*
  - *feeling overwhelmed by the expectations of others*
  - *loneliness, fear, feelings of abandonment and not being heard*
  - *consistent high levels of anxiety and/or anger*
- It is important to know how frequently their thoughts are centred on killing themselves
  - ask whether thoughts are persistent and/or intrusive – if *yes*, enquire about plans

ii. Explore background risk factors

Identify any **background factors or precipitating events** that may increase their level of distress and put the young person at higher risk, for example:

- stressful life events – such as loss or grief; relationship break up
- family conflict

- cultural issues – e.g. acculturation problems; experience of racism/discrimination; non-acceptance/bullying by peers because of ethnicity
- bullying
- substance abuse and other high risk-taking behaviour
- underlying mental health problem – e.g. depression or anxiety
- previous history of suicide attempts – explore history of any previous attempts:
  - the frequency of attempts
  - severity and lethality of attempts
  - intention of previous attempts
- history of self-harm behaviour
- school performance – e.g. failure at school
- peer relationship difficulties

Example: *"What has happened recently that has made you feel so awful?"*
"What things are really worrying you now?"
"Do you know anyone who has ever killed or tried to kill themselves?"
"Have you ever tried to harm/kill yourself before?"
"What triggered your previous attempts?"

- The ***HEEADSSS*** assessment can also help in identifying these risk factors

iii. Explore plans and actions:

- Explore the extent to which the young person has formulated a **clear plan** of how they intend to take their lives:
  - what sort of plans has the young person made?
  - are the means available to them?
  - what is their lethality? (e.g. tablets, firearms)
  - what steps has the young person taken to implement the plan?

Example: *"Have you thought about how you would hurt or kill yourself?"*
"Have you actually done anything to harm yourself?"
"Have you made plans or preparations?"
"Have you actually taken any steps towards getting the pills (or gun; car; etc.)?"
"On a scale from 1 to 10 (where 1 is the lowest and 10 is the highest) how strong is the feeling of wanting to kill/harm yourself at the moment?"
"What things might stop you from trying to kill yourself?"
"What has stopped you from acting on your thoughts so far?"

- Seek permission to obtain relevant history from significant others – parents, family members, teachers

iv. Identify supports, resources and protective factors

- Establish who are the important people in the young person's life and how available are they to support them
- Identify protective factors:
  - family support
  - access to or belonging to a community or group of peers
  - strong cultural identity
  - positive coping behaviours – e.g. problem-solving skills, self esteem, interpersonal skills
  - spiritual beliefs or faith
  - active help-seeking behaviour

Example:
"Who do you usually share problems with?"
"Who do you think could support you through this time?"
"What do you think they would say or do if they knew about your plans?"
'Who would you like to have support you through this?"
"What is helping you to keep going right now?"
"If you could look to the future, what do you think you could look forward to?"
"What are your thoughts about staying alive?"

Risk Factors for Suicide

- Previous suicide attempt/self harm
- History of previous attempts in family/friends
- Concrete suicide plan
- Underlying mental disorders – e.g. depression, anxiety
- Substance abuse
- Co-morbid conditions – e.g. eating disorder, conduct disorder
- Recent stressful life events
  - relationship breakdown
  - loss, disappointment or humiliation
  - school or work difficulties
- Ongoing family problems
- Victim of bullying
- Gay, lesbian or bisexual orientation
- Cultural conflicts or concerns

Management of Suicidal Behaviour

- Build a **therapeutic alliance** with the young person
- Establish level of risk
- **Clarify confidentiality** – the presence of serious or imminent threat in this situation overrides the need to maintain confidentiality
  - deal with the situation of confidentiality sensitively but openly and firmly. It is important not to agree to secrecy:

"Mark, you've said that you don't want anyone to know about this. However, I'm very concerned about you at the moment and my first duty really is to make sure that you are safe. In order to make sure you are safe, I need to contact some other people who can help you so that we can get you through this difficult time."

If the young person is at moderate to high risk:

- It is important to ensure the young person's immediate safety:
  - develop a management plan for ensuring the person's safety
  - contact and mobilize family and social supports
  - remove or limit access to the means of self harm if possible
- Consider the use of a *'no suicide' contract* with the young person to seek help before self harming *(only to be used in conjunction with other therapeutic interventions)*

'No Suicide' Contract

- A no-suicide contract is a verbal or written agreement between a practitioner and young person to undertake certain tasks to keep the young person safe until the next scheduled appointment[9]. For example:

  "Michael, I want to make sure that you are safe until our next appointment. So I'd like to make a contract with you that if you have thoughts of harming or killing yourself before I see you again, that you will immediately telephone (…… the GP; or Helpline; or Mental Health Crisis Team; etc.). Are you willing to agree to that?

- A contract may be used for periods from a few hours to a few days, but should not be used for periods longer than one week without reassessment
- If a patient at moderate to high risk cannot agree to a no-suicide contract, hospitalisation may be required

For young people at significant risk:

- **affirm the person**
- affirm the problem
- negate the maladaptive solution (i.e. suicide)
- Consider hospitalization (if risk is assessed as very high)
  - treat as medical emergency if acutely suicidal
- Refer for specialist treatment if no safety agreement can be reached
  e.g. local **Mental Health Crisis Service**

See Section 4 – for contact details of mental health services

- Diagnose and **treat any underlying mental disorder** (if present)
  - consult with Psychiatrist/Psychologist
  - use of medication if necessary
- Young people engaged in **self-harm behaviour** (e.g. cutting arms, legs, body) should be screened for depression and suicide risk
  - self-harm behaviour is generally not intended as suicidal
  - however, involvement in self-harm behaviour may predispose the young person to increased risk of suicide or accidental death
  - therefore it is important to assess whether the young person is also suicidal
- Once suicidal thoughts/behaviours have been effectively addressed – it is important to **address the underlying or precipitating problems** that the suicidal behaviour is attempting to resolve
  - manage the main life problems by providing counselling and support
  - teach cognitive, behavioural and problem-solving skills for better coping
  - develop plans for the future
  - refer for specialist counselling where necessary

Example: *"Right now I know you're feeling that everything is hopeless. But I also know that some of these feelings will pass and that you can get through this difficult time. Then, I'd like to help you look at ways of dealing with some of these problems that you're feeling bad about."*

Management of the suicidal adolescent

- Always take the situation seriously
- Alert parents or guardians – they need to be aware and involved
- Address safety issues – being alone; take steps to limit access to drugs or other means of self harm (consider making a contract around safety with the young person)
- Assess available supports (family, friends, school or work)
- Ascertain further information (from family, friends, school or work)
- Ask for help – seek input from a mental health professional and consider referral if the situation seems unstable or unsafe
- Refer to appropriate support services to provide effective management of suicide risk and ongoing treatment of underlying problems
- Consider hospitalisation in cases of severe risk

Specific Indications for Referral

Depending on availability of services (e.g., adolescent physician, psychiatrist, mental health team), always refer when there is:

- Serious risk of self harm
- An unsupportive or high risk environment
- Failure to respond to initial treatment
- Bipolar disorder or other major psychiatric condition

Warning Signs for Suicide[9]

- ***Changes in behaviour***
  - isolation or withdrawal from others
  - loss of interest in activities
  - risk taking
  - putting affairs in order
  - giving away personal effects or prized possessions
- ***Changes in mood***
  - hopelessness
- ***Changes in thinking***
  - inappropriate feelings of guilt
  - strange or bizarre thoughts
- ***Preoccupation with death***
- ***Talk of suicide***
  - plans for suicide
  - asking about methods of suicide
- ***Stressful life situations***
  - perceived intolerable loss or stress
- ***Apparent resolution***
  - sudden appearance of happiness and/or calmness after a period of some of the characteristics listed above

resources

- If a patient is at high risk of suicide or self harm or in an emergency situation, contact your local **Mental Health (Acute Care) Crisis Service**
- In NSW, each Area Health Service has a **24-hour mental health contact line**
  This service will put you directly into contact with a local Mental Health Worker, or they will take a referral for follow-up
- Alternatively, contact the **Emergency Department** of your local hospital and ask to be put in touch with the Mental Health Crisis Service
- For contact details of mental crisis services in other states contact your **local Department of Health or Area Mental Health service**
- See the following for resources on managing depression and suicide risk in young people:
  The **Black Dog Institute**
  www.blackdoginstitute.org.au
  The Royal Australian and New Zealand College of Psychiatrists
  www.ranzcp.org/publicarea/cpg.asp
  – go to **'Clinical Practice Guidelines'**

See Section 4 – for contact details of mental health services

Case Study - Mark

Mark is a 16 year old brought in to see you by his mother. She is concerned because Mark seems to have lost interest in school. She is worried that he will drop out and not finish his HSC. She is also concerned because he has no friends; spends most of his time in his room and is irritable most of the time. You haven't seen Mark for almost 2 years and you are surprised by how quiet and withdrawn he seems. You remember him as a bright and active adolescent. You spend some time alone with Mark and discover that he has been feeling down for the last few months.

He says he feels like an outsider at school because his best friend recently rejected him and won't talk to him any more. He now hates going to school because he doesn't fit into any peer group. He has missed more than 30 days of school this year with numerous minor ailments. He says he feels bored most of the time outside of school and has dropped out of all his usual sporting and social activities. You also discover that he and his girlfriend split up 2 months ago. They still see each other at school which is hard for him especially as she is now dating someone else. Mark has constant conflicts with his father over his school work. He has fallen so far behind in his studies that he thinks it is too hard to catch up. He feels tired all the time and doesn't sleep well. He says that his parents don't really care about him – all they worry about is his grades. He can't see any future for himself.

Assessment

- Based on Mark's presentation, you conduct a more in-depth screen for depression taking a clinical history and exploring further for both risk and protective factors in his life
- Mark displays a number of features of depression including:
  - depressed mood and persistent sadness
  - irritability
  - sleeplessness
  - withdrawal from social and pleasurable activities
  - family conflicts
  - difficulty concentrating
- It is vital to conduct a **suicide risk assessment** in any young person who is depressed – enquire about:
  - **thoughts of suicide** – How often? Have they told anyone?
  - **plans for suicide** – Do they have concrete plans? Access to means?
  - **past attempts** – their lethality and intent?
  - **self-harm** – have they attempted to harm themselves in any way?
- Mark admits that he has had thoughts about killing himself, but has never made any attempts. He says that he would never really try to kill himself because he knows how upset his mother would be.

Management

You determine that although Mark is a low suicide risk, he his seriously depressed. You share your concerns with him and ask for his permission to discuss the issue with his mother so as to work out a management plan in collaboration with them. Your interventions include the following:

- Develop of a **Mental Health Care Plan** to refer Mark to a Psychologist/Social Worker for **counselling** to develop strategies for reducing his depression and addressing family conflict
- Contact with the **school counsellor** to engage the school's support in addressing his social and academic difficulties
- Schedule a longer **follow-up consultation** to further assess and monitor Mark's condition and consider the use of medication

Bipolar Disorder

- **Bipolar 1 disorder (BP-1)** affects around 1% of the population[13]
- Recently, there has been increasing recognition of a so called milder condition, **Bipolar II disorder (BP-II)**, where the lifetime prevalence may be up to 5%[13]
- Bipolar disorder is associated with high rates of morbidity and mortality, high suicide rates and high levels of social disruption[14] (employment;,relationships, etc)
- The **initial presentation** of Bipolar disorder usually occurs in **young adults** – therefore GPs have a key role in early identification and intervention with young people developing Bipolar disorder
- **Co-morbidity** – anxiety disorders and substance abuse are common in people with bipolar disorder
- There appears to be a strong **genetic component** in Bipolar disorder – about 50% of people with bipolar disorder have a first degree relative with a mood disorder[13]

Assessment and Diagnosis[13, 14]

- Patients with Bipolar disorder may have periods of mania, hypomania, as well as depressive episodes or mixed episodes over many years
- **BP-I** is distinguished from BP-II by the intensity of its **manic highs** – which may include psychotic features – and which tend to last longer and/or necessitate hospitalization
- In **BP-II**, the individual has episodes of **'hypomanic'** highs – less severe, not associated with psychotic features, and not necessarily distinctly impairing, sometimes even enjoyable
- **Bipolar highs** are usually high energy states, although some people will describe irritability or anger
- **Depressive episodes** occur in both types – the depressive phases are usually marked by the biological features that underpin melancholic and psychotic depression – no energy, a non-reactive and anhedonic mood; and diurnal variation with mood and energy worse in the morning[13]
- People with Bipolar disorder are **commonly misdiagnosed** – it can be difficult to distinguish between other presentations such as anxiety, schizophrenia and personality disorders
- Correct diagnosis is crucial in providing effective treatment – **referral to a Psychiatrist** is recommended to assist with differential diagnosis

resources

- **The Black Dog Institute** website has a range of tools for **assessment and screening** including a 27 item bipolar self-assessment test with high sensitivity (74%) and specificity (98%), which differentiates bipolar or unipolar disorder accurately in about 90% of cases
  www.blackdoginstitute.org.au

Management Approaches

- Treatment involves a mix of both medication and psychological therapies
- Medication is the primary course of treatment
- **Mood stabilisers** (eg. lithium, valproate, carbamazepine, lamotrigine) – have proven effectiveness in the management of Bipolar disorder[14]
- Anti-depressants **(SSRIs)** are typically used in the management of Bipolar depression and may also have mood stabilizing properties[13]
- **Note –** the use of medication with adolescents should be carefully assessed – as in the treatment of adolescent depression (see **Guidelines for Use of Anti-Depressant Medication**, above)
- Consultation with a **Psychiatrist** for assistance with diagnosis and prescription of medication is recommended
- **Psychological therapies** are also an essential component of the treatment – Cognitive Behavioural Therapy (CBT), psycho-education and Interpersonal Therapy (IPT) are useful in assisting the patient with:
  - symptom management and prevention of relapse
  - mood monitoring and management
  - reducing stresses that often trigger episodes
  - managing interpersonal relationships
- It is also important to provide education and support to family members

The Black Dog Institute has a range of excellent resources for both professionals and the public in the management of Bipolar disorder *(see below)*.

- As with other adolescent mental health problems, a **collaborative, multidisciplinary approach** is recommended
- GPs can take a key role in this by formulating a **Mental Health Care Plan** for initiating a shared care approach involving a Psychiatrist, Psychologist or other relevant mental health professionals

See Chapter 13 – Collaborative Care – for relevant Medicare item numbers

resources

- **Much of the material presented above is drawn from the following articles** (accessed through the **Black Dog** website):
  Parker, G. (2007). Bipolar disorder: Assessment and management. *Australian Family Physician* 36(4):193-288.
  Mitchell, P. and Gould, B. (2004). Bipolar disorder: What the GP needs to know. *Medicine Today* 5(8): 46-51.
- **The Black Dog Institute** website has a range of tools for assessment, screening and management of Bipolar disorder, plus a full range of patient fact sheets and support materials including medication guidelines; mood monitoring charts; and a 'stay well' plan
  www.blackdoginstitute.org.au
- **The Royal Australian and New Zealand College of Psychiatrists (RANZP)** has recently published comprehensive clinical practice guidelines for the treatment of Bipolar Disorder
  www.ranzcp.org/publicarea/cpg.asp

Anxiety Disorders

- An estimated 10% of young people 18–24 years old experience anxiety disorders[1]
- Anxiety disorders often have their onset in childhood or early adolescence
- Common anxiety disorders in adolescents include – social anxiety, generalized anxiety disorder, Obsessive-Compulsive Disorder (OCD)
- Co-morbidity is common with anxiety – particularly depression; substance abuse; ADHD
- Many adolescent patients display features of more than one anxiety disorder

Assessment and Diagnosis

- Adolescents with anxiety often present in general practice with somatic complaints, or complex family or school problems
- **Conduct a psychosocial assessment** using the ***HEEADSSS*** tool – in particular, screen for:
  - **risk factors** or **precipitating events** that may have contributed to the onset and maintenance of anxiety – e.g. peer conflicts; bullying and victimisation; issues of loss; family difficulties; illness; trauma
  - the presence of **co-morbid conditions**
  - family background – as there is often a strong **family history** of anxiety or affective disorders

See Chapter 2 – Conducting a Psychosocial Assessment

- It is important to understand the **psychosocial context** of the young person's anxiety. Explore the situations in which the anxiety symptoms occur – e.g. peer relationships; school refusal; social situations
- It is important to rule out **medical conditions** or other physical causes of symptoms
- Where uncertain, refer to a **Child and Adolescent Psychiatrist or Psychologist** for more in-depth assessment to assist with diagnosis and treatment options

Symptoms of Anxiety Disorders

Anxiety disorders are characterized by the following:

- **Generalized Anxiety disorder** – 6 months of anxiety/worries
- **Social Phobia** – interpersonal sensitivity; fear of making a fool of oneself
- **Specific Phobia** – specific fear stimulus (e.g. fear of traveling on planes)
- **Panic disorder** – panic attacks with characteristic cognitions such as fear of dying; fear of losing control or suffering a personal catastrophe
- **Obsessive Compulsive Disorder (OCD)** – presence of obsessive thoughts and accompanying compulsive behaviours – e.g. fear of contamination and hand washing; fear of catastrophic consequences and ritualized behaviours (e.g. stepping over cracks in a specific pattern; counting in particular patterns)
- **Cognitive symptoms** – worry about the future, one's health, one's relationships, decreased attention and concentration
- **Behaviours** – avoidance, withdrawal, self-medication with drugs or alcohol
- **Somatic symptoms** – palpitations, tachycardia, flushing, hyperventilation, tiredness, nausea, sleep difficulties, sweats, shortness of breath, muscular tension
- Symptoms are present at a level that markedly impairs interpersonal, social, academic and occupational functioning

Management Approaches

- As with other adolescent health problems, development of a caring, **trusting relationship** with the adolescent is a key component in the management of their anxiety
- Key management strategies include **psychological and pharmacological approaches**
- Psychological treatments, especially **Cognitive Behavioural Therapy (CBT)**, are effective in the treatment of anxiety
  - e.g. Exposure and Response Prevention treatment is the recommended treatment psychological treatment for OCD
- The use of **medication** for anxiety, while having proven effectiveness, should be used judiciously with adolescents (as in the treatment of adolescent depression) and should be based on a **comprehensive assessment** of the young person symptoms and circumstances

See 'Management Approaches' for depression (above) – for approaches to managing anxiety in adolescents

- A multidisciplinary approach to treatment, incorporating referral to a **Psychiatrist** and/or **Psychologist** input is recommended
  - use the new **Medicare Mental Health Item Numbers** to develop a comprehensive **Mental Health Care Plan** for initiating a collaborative treatment approach

See Chapter 13 – Collaborative Care – for relevant Medicare item numbers

resources

- The following websites contain information for consumers and health professionals on anxiety:
  'beyondblue' the National Depression Initiative www.beyondblue.org.au
  Anxiety Disorders Association of Victoria provides resources and detailed information about panic disorder, social phobia, agoraphobia, generalised anxiety and depression – www.adavic.org

Attention Deficit Hyperactivity Disorder

- Up to 8% of young people aged 12-17 years have Attention Deficit Hyperactivity Disorder (ADHD)[1] – ADHD is much more common in boys
- ADHD is a developmental behavioral disorder characterized by persistent patterns of inattention, poor concentration, hyperactivity and impulsivity
- Symptoms usually appear before the age of seven and cause significant disruption to both home and school environments
- If not treated, ADHD is associated with a high risk of future problems, including school difficulties, work difficulties, relationship problems, substance abuse and adult mental health disorders

Diagnosis

- ADHD can be difficult to diagnose – there is no specific psychological test for ADHD, and it often requires detailed assessment
- **Co-morbidity** is common – ADHD frequently co-occurs with anxiety and depressive symptoms, as well as other behavioral disorders such as oppositional-defiant or conduct disorders
- Common **presentations of ADHD** include:
  - **inattention symptoms** – difficulty concentrating and sustaining attention; difficulty organizing tasks; easily distracted; not listening when spoken to
  - **hyperactivity symptoms** – fidgeting; inability to remain seated; poor impulse control runs about or climbs in inappropriate situations
- Most often, the diagnosis of ADHD is made by a Pediatrician or Child Psychiatrist
- Information should be gathered from both the school and family to assist in assessment and diagnosis

Management

- **Stimulant medications** are usually the first line of treatment for ADHD – such as methylphenidate (e.g. Ritalin; Concerta)
- There is also growing evidence for the effectiveness of **psychological interventions** – such as **Cognitive Behavioural Therapy (CBT)**, which can assist in addressing issues such as self-esteem, impulse control, behavioural management, social skills and organisational difficulties
- Counselling interventions can also assist in the treatment of co-morbid conditions such as anxiety and depression

- Young people with ADHD usually also require intensive learning interventions at school to assist them with attention and learning difficulties, as well as behavioural management
- The GP has a significant role to play in assessment and coordinating a multidisciplinary approach to treatment – this can include referral to a Psychiatrist and/or Pediatrician for assistance in diagnosis and prescription of medication
- Use the new **Medicare Mental Health Item Numbers** to develop a comprehensive **Mental Health Care Plan** for initiating a collaborative treatment approach – incorporating referral to a **Psychiatrist** and/or **Psychologist** for assessment and treatment

See Chapter 13 – Collaborative Care – for relevant Medicare item numbers

- It is also important to provide education and support to the family, as well as possible referral for family counseling – as ADHD can be severely disruptive to the family environment

resources

- **The Royal Australian College of Physicians (RACP)** is currently redeveloping comprehensive treatment guidelines on ADHD see the RACP website – www.racp.edu.au
- See also the **Australian Psychological Society (APS)** for treatment guidelines regarding ADHD – www.psychology.org.au

Eating Disorders

Eating or dieting disorders are **nutritional, medical and psychological conditions** that affect body image, personality and physical health and disrupt family life and relationships.

The three major eating disordered patterns are:

- **Anorexia nervosa**
- **Bulimia nervosa**
- **Eating disorders not otherwise specified (EDNOS)**

Facts about Eating Disorders[15,16]

- ***Anorexia nervosa***
  - affects 0.5-1% of adolescent girls
  - third most common chronic illness in adolescent girls
  - affects girls at a ratio of 10:1
  - severe medical and psychiatric morbidity and mortality rate of 20% at 20 year follow-up
  - peaks in the early teens (12-14 years) and again around 17 years
- ***Bulimia nervosa***
  - affects 1-5% girls/young women
  - tends to occur in slightly older age group
- ***EDNOS***
  - prevalence unknown
  - 30-60% young women believed to engage in unhealthy weight losing behaviours

Assessment and Diagnosis

- ***Consider an eating disorder in a young person if they:***
  - engage in unhealthy weight-control or restrictive dieting practices
  - demonstrate obsessive or rigid thinking about food, weight, shape, body image or exercise
  - suddenly convert to vegetarianism
  - have irregular menstrual cycles or delayed menarche
  - exhibit change in personality and social interests, e.g. withdrawal
  - display evidence of vomiting
  - have unexplained weight loss while – denying dieting or hunger; needing to eat less than others; being reluctant to display weight loss; wearing unusually baggy clothes
- The identification of an eating disorder is often complex, as the initial presentation may be subtle – young people often present to GPs with other physical or emotional complaints
- It is important to spend time establishing rapport and a trusting relationship with the young person

See Chapter 1 – Conducting a Youth Friendly Consultation – for approaches to engaging the young person

- Conduct a general psychosocial assessment using the ***HEEADSSS*** screening tool to identify the risk of an eating disorder

See Chapter 2 – Conducting a Psychosocial Assessment

- If you suspect the young person may have an eating disorder, it is essential to allow time for a thorough medical, nutritional and psychosocial assessment
- **'Normal'** dieters are happy when they achieve their desired weight and show off their newly attained body. They are proud of their achievements and they generally become happier and socially more active. Conversely, **eating disorder sufferers** always want to lose more weight and are not satisfied with weight loss achieved thus far
- Refer to **DSM IV diagnostic criteria** for signs of eating disorders ***(see Table below)***
- Refer to a Psychiatrist, Paediatrician or specialist eating disorders service (where available) where there is uncertainty about diagnosis or management
- Initiate early referral to optimise treatment outcomes

DSM IV Diagnostic criteria - Eating Disorders:

Anorexia nervosa (AN)

- Refusal to maintain body weight at or above 85% of expected weight for height and age
- Intense fear of gaining weight or becoming fat, even though underweight
- Distorted body image (weight or shape), denial of being underweight
- Amenorrhea – i.e. the absence of at least three consecutive menstrual cycles
- *Restricting type AN* – restrictive eating and dieting behaviours
- *Binge-eating/Purging type AN* – regularly engaging in binge eating and/or purging behaviours (e.g. self-induced vomiting; misuse of laxatives)

Bulimia nervosa (BN)

- Recurrent episodes of binge eating, characterised by:
  - eating a large amount of food in a discrete period of time (e.g. a 2-hour period) ***and***
  - a sense of lack of control over the eating during the episode
- Recurrent inappropriate compensatory behaviour to prevent weight gain (e.g. self induced vomiting; use of laxatives/medications; fasting)
- The binge eating and inappropriate compensatory behaviours both occur at least twice a week for three months
- Self evaluation is unduly influenced by body shape and weight
- BN does not occur exclusively during episodes of anorexia nervosa
- *Purging type BN* – patient regularly engages in purging behaviours to maintain weight (e.g. self-induced vomiting or misuse of laxatives, diuretics or enemas)
- *Non-purging type BN* – patient uses other inappropriate compensatory behaviours, such as fasting or excessive exercise to maintain weight – but does not regularly engage in purging

History

If an eating disorder is suspected, a comprehensive case history should be taken exploring the following areas:

- ***Nutritional history***
  - weight history – e.g.

    "How much do you weigh now?" (Young person with eating disorder often knows their weight precisely, however be aware that they may feign a lack of interest in or knowledge of their weight)

    "Has your weight increased or decreased at all over the past year?" – if yes, explore the nature of this. (Young person with eating disorder will often be able to give a vivid description of changes or fluctuations in weight over recent months or even years)
  - nutritional intake – e.g.

    24 hour dietary recall – enquire about avoidance of particular foods or food groups (eg 'junk food', 'meat')
  - weight loss and methods used – e.g.

    "Have you ever tried to lose weight?" "What have you done to try to lose weight?"

- eating and purging behaviours and patterns – e.g.

  "In the past few months have you ever been on a diet to try to control your weight?"

  "Have you cut out certain foods in your diet to control weight, what specifically?"

  "Have you started skipping meals?" "How often do you skip meals?" "Which meals do you skip?"

  "Have you ever binged on food, by that I mean eaten much more than you consider a normal amount and felt like it was a bit out of control?" "How often have you binged?"

  "Have you ever made yourself vomit, or used laxatives, or done excessive amounts of exercise after you've eaten, because you feel guilty about eating?"

- exercise and activity

  "Can you tell me about your exercise patterns and whether they've changed in the past few months?"
  "Do you do sit ups or other exercises in your bedroom? How many a day?"

◆ *Medical assessment*

- Menstruation – ask about amenorrhoea or change in menstrual patterns
- Symptom review to exclude organic disease such as inflammatory bowel disease, peptic ulcer disease and hyperthyroidism

◆ *Physical Examination*

- height, weight and BMI
- vital signs (e.g. **indications for admission include – hypothermia < 36 degC ; orthostatic change HR <50bpm or > 100bpm; BP < 80/50 or postural drop > 20mmHg**)
- signs of dehydration
- skin changes such as fine downy body hair and cool mottled extremities
- signs of vomiting – callused fingers, parotidomegaly, altered dentition, muscle weakness
- systems review to exclude other organic illness

◆ *Investigations*

- full blood count
- electrolytes, urea, creatinine
- blood sugar
- amylase
- ECG
- thyroid Function Tests; T3RIA is depressed with protein calorie malnutrition

◆ *Psychological assessment*

- body image – 'ideal' weight'; specific body parts; fear of weight gain – e.g.

  "What's your ideal weight?"
  "If you got to that weight, how do you think you'd feel?"
  A young person with an eating disorder will often say that they would probably want to lose more weight; You can continue this line of questioning – e.g.

  "So you think you'd still think you were fat, how much more would you want to lose then?" "And how do you think you'd feel if you got to that weight?"
  A young person with an eating disorder may reach an 'ideal weight' that is clearly unrealistic; if they have established anorexia nervosa, their 'ideal weight' may in fact not be compatible with life

  "Are there specific parts of your body you are unhappy with?"

- presence of **co-morbid conditions** – e.g. depression, anxiety, obsessive compulsive disorder, substance abuse, self-harm
- interpersonal relationships and family functioning

Management[15, 16, 17]

Treatment and management requires a comprehensive, multidisciplinary approach to address the complex biological, psychological and social aspects of eating disorders. Collaboration with other health professionals is essential to the treatment approach:

- ◆ Refer to a **Dietitian** – to assist with nutrition and diet regimens
- ◆ Refer to a **Psychologist/Psychiatrist** – for assessment and treatment of underlying psychological problems
  - low self-esteem
  - dysfunctional eating and thinking patterns
  - co-morbid psychological issues
  - family dysfunction

- Use the **Medicare Mental Health Item Numbers** to develop a **Mental Health Care Plan** for initiating a collaborative treatment approach

See Chapter 13 – Collaborative Care – for relevant Medicare item numbers

- Contacting a specialist **eating disorders service** is recommended where this is available – these provide a comprehensive, shared care approach

resources

- The **Eating Disorder Service in the Department of Adolescent Medicine, Children's Hospital Westmead** can provide assistance with assessment and treatment – telephone **(02) 9845 2446**
- The **Eating Disorders Foundation** provides a range of information and support for families:
  in **NSW** www.edf.org.au
  in **Victoria** www.eatingdisorders.org.au

The GP's Role

GPs have a critical role in the early recognition and assessment of eating disorders, and in initiating treatment. **One of the main goals for the GP is to help the young person realise the seriousness of their disorder and to motivate them to participate in treatment. GPs also play a key role in case management and coordinating multidisciplinary care:**

- Establish the need for intervention – through diagnosis, explanation, engagement of the young person
- **Address the diet** – simple dietary counselling, correct misinformation about food, dieting and exercise
- **Institute a food diary**
  - Gives patients a positive method of observing and controlling their eating
  - look for dietary patterns and triggers to disordered eating
- **Monitor physical signs** – weight, vital signs, electrolytes
- **Explore psychosocial issues** – provide counselling where appropriate to help build self-esteem; improve communication skills; develop coping skills
- **Engage the family as partners in care** – provide education and support; address their questions and concerns; enlist their help with a resistant adolescent; involve them in the management plan
- Facilitate referral to specialist services and/or **coordinate a multidisciplinary treatment team:**
  - provide regular medical assessment
  - counselling and support to patient and family
  - ensure a clear management plan is followed by all members of treatment team

Psychological Treatments

- Psychological treatments are vital as well as medical monitoring
- **Psychotherapy** is often the psychological treatment of choice in anorexia nervosa
- **Cognitive behaviour therapy** is the first line psychological treatment for bulimia nervosa
- Use the **Medicare Mental Health Item Numbers** to initiate referral to a Medicare-registered Psychologist or Social Worker

Prevention

GPs can also play a major role in prevention:

- Monitor the young person's growth and development – plot their growth on standardised growth charts (over time if young person is known to the practice)
- Deviations from normal can be used to educate them about healthy growth and development – a useful strategy for both anorexia and obesity

Hospitalisation

One of the most important roles of the GP is to ensure the young person's safety. **Be alert to specific warning signs that may indicate the need for hospitalisation.**

Hospital referral should be considered in the following cases:

- Abnormality of vital signs – e.g.
  - **hypothermia < 36 degC**
  - **orthostatic change HR <50bpm or > 100bpm**
  - **BP < 80/50 or postural drop > 20mmHg**
- BMI approaching 5th percentile – e.g.
  - **approaching 14 in a 12 year old female, < 18 in an 18 year old female**
  - **refer to growth charts in Appendices of this Kit**

- Electrolyte abnormality (e.g. serum potassium < 3.0mmol/L)
- Psychological need or family crisis
- Significant depression
- Other co-morbid condition – e.g. diabetes
- Failure of outpatient treatment

Case Study - Martina

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Lorraine comes to see you as she is worried about her daughter, Martina, aged 14 years, who has been losing weight. Lorraine says Martina is 'not eating much' and refuses to eat meat. She is worried there may be something 'going on' because Martina is irritable and moody at home and refuses to see you. You know Martina (and Lorraine) quite well, and are aware that she is a bright girl currently in year 8 of secondary school.

Given Lorraine's concerns, you ask to see Martina so you can find out more about the weight loss. Lorraine brings Martina in the next day but Martina protests nothing is wrong with her and says she 'doesn't need to see a doctor'. When you ask about Martina's weight loss she says she 'just wants to be healthier'. She has cut out junk food (such as chips, chocolate and soft drink) from her diet and become a vegetarian. She also jogs on most days for up to 1 hour and does sit ups.

Initial Management Approaches

- Seeing Martina alone is important to establish rapport and to begin gentle interrogation about her eating, exercise and body image concerns. Acknowledging her reluctance to being there is also helpful.
- Given the presentation a thorough history and physical examination as outlined above are important.

Further history and examination

- Martine admits during your individual interview she is worried her hips are too big. She also feels guilty after eating certain foods and needs to exercise straight away
- She denies vomiting or using laxatives to lose weight. She feels tired and lethargic most of the time. Martina also mentions she has not had her period for several months
- Martina has lost 10kg in the previous 6 months. On examination she looks thin – her BMI is 17. Her heart rate is 78 bpm and her blood pressure is 110/70mmHg.
- She is well hydrated and there is no postural drop. Her hands are cool and capillary refill slightly greater than 2 seconds
- There are no stigmata of other systemic disease and no skin abnormalities
- Abdominal examination is unremarkable, with the abdomen being somewhat scaphoid, although soft and non-tender with no organomegaly

Further investigation and management

- Investigations at this stage should include FBC, EST, UE&C, liver function tests, thyroid stimulating hormone and ECG
- Martina meets the diagnostic criteria for anorexia nervosa but is currently medical stable and outpatient management can be attempted first
- Early referral to a dietitian if feasible, and to psychological services are both important
- The GP's role is to conduct symptom and medical review while coordinating care with other health professionals

practice points

- A young person with an eating disorder may naturally be secretive or reluctant to discuss eating, exercise or weight issues. However a sensitive and careful history, which is crucial, often reveals distorted body image and fear of gaining weight
- Managing eating disorders is almost always a multidisciplinary effort and the GP can play a central role in coordinating care and providing long term continuity of care

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