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Is this normal?

Assessing mental health in young people

Background

Mental ill-health is a key health issue facing young Australians today. While the physical health of young people has improved in recent decades, their mental health appears to have worsened. Mental health and substance use disorders now account for over 50% of the burden of disease in the 15–25 years age group, and 75% of mental health disorders that will affect people across the lifespan will have emerged for the first time by the age of 25 years.

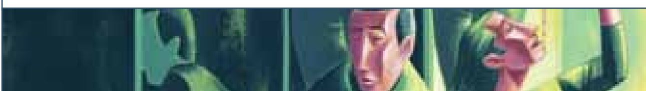
Objective

This article provides the general practitioner with key factors in assessing the young person with a mental illness: when to worry and what the early stages of mental illness look like; and provides guidance and tips for effective treatment.

Discussion

Mental ill-health in young people is all too often accepted as a 'normal' feature of adolescence. However, the short and long term consequences of mental illness include impaired social functioning, poor educational achievement, substance abuse, self harm, suicide and violence. Distinguishing between what represents transitory and normative changes in behaviour and disturbances that may represent the early signs of the onset of a potentially serious mental illness is difficult, particularly in young people, where emotional disturbance and distress is such a common experience. The primary goal of initial assessment is not to make a definitive diagnosis but rather to assess risk and the need for clinical care. The GP has an important role to play in longitudinal assessment and ongoing review, and facilitating access to treatment and mobilising support networks.

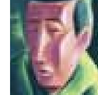
Keywords: mental health; young adult; adolescent



The onset of adolescence heralds a period of tumultuous change for young people; changes that will affect every domain of their lives. The physical changes that come with puberty are accompanied by rapid changes in the young person's cognitive, emotional and social development as they move through adolescence toward independent adulthood. This transition presents unique developmental challenges; young people in this age group are in the process of defining their individuality: establishing their own social networks, beginning intimate relationships, completing their education and moving into employment.[1] It is hardly surprising that mental ill-health, even when brief and relatively mild, can disrupt this developmental trajectory and limit a young person's potential. If more severe and persistent mental illness occurs, the spectre of premature death or long term disability and social exclusion is very real.

Mental ill-health is by far the key health issue facing young Australians today. While the physical health of young people has improved in recent decades, it is a worrying paradox that their mental health appears to have worsened. Mental health and substance use disorders now account for over 50% of the burden of disease in the 15–25 years age group,[2] and 75% of mental health disorders that will affect people across the lifespan will have emerged for the first time by the age of 25 years.[3] The typical pattern is a kaleidoscopic evolution of syndromes and comorbidities, with roots in childhood (particularly early adolescence) and the advent of the more recognisable 'adult' type mental health disorders in the late teens and early 20s. The 12 month prevalence of mental ill-health in adolescents aged 13–17 years is 19%, rising to 27% in young adults aged 18–24 years.[4,5] This means that each year, around one in 4 young Australians experience a diagnosable mental health disorder, most commonly depression, anxiety or substance abuse, or a combination of these.

Mental ill-health in young people is all too often accepted as a 'normal' feature of adolescence – a form of emotional 'growing pains'. Somehow we have come to regard it as acceptable for young people to be distressed and struggling for significant periods without recognising their need for understanding and effective support and care. Mental ill-health is not a trivial or transient threat. There are



many negative short and long term consequences. These include:

- impaired social functioning
- poor educational achievement
- unemployment
- substance abuse
- self harm
- suicide, and
- violence.

These consequences lead to a cycle of dysfunction and disadvantage that is difficult to break.[6] There is good evidence to suggest that mental ill-health in young people produces distress and disability that extends many years into their future.[7] However, they are reluctant to seek help, particularly for their emotional concerns.[8] For those who do seek help, their initial contact with health services is often via a general practitioner, who must then explore these issues with the young person in a sensitive and appropriate way. Yet, despite recent reforms in primary mental healthcare, the culture and style of general practice may render it an ineffective portal for young people with mental health issues.

When to worry?

Distinguishing between what represents transitory and normative changes in behaviour and disturbances that may represent the early signs of the onset of a potentially serious mental illness is difficult, particularly in young people, where emotional disturbance and distress is such a common experience. We are often reluctant to diagnose mental illness in young people, driven by concerns such as the risk of over-medicalising 'normal' human experience, the fear of overuse of psychotropic medications, or stigma. This situation is complicated by the inadequacies of our current diagnostic systems, which fail to acknowledge the complex and evolving nature of the early stages of mental illness, adding to the confusion and anxiety involved in making an initial diagnosis. However, given that 75% of young people with a diagnosable mental disorder have no access to healthcare,[9] overdiagnosis and overtreatment are unlikely, and we therefore need to radically adjust our thinking and the threshold for access.

What do the early stages of mental illness look like?

This is not a trivial question; careful retrospective studies have shown that the major mental illnesses are preceded by a period of nonspecific but increasingly severe symptoms, accompanied by a growing degree of distress and disability. There are two common scenarios: one is where an adolescent has had problems earlier in childhood and after entering adolescence these become more pronounced or evolve into different syndromes as the challenges of life increase and the social environment becomes harsher. Children with developmental disorders such as autism spectrum disorders, conduct disorder, anxiety disorders or ADHD are at risk of additional syndromes and social and vocational derailment and typically need specialist team based mental health referral.

The second, more common scenario is when the young person has had an uneventful prepubertal childhood period, yet begins to struggle during what is best described not as 'adolescence' but as 'emerging adulthood' (see *Case study*).[1] Here, depression, irritability, anxiety, withdrawal, and apathy are common features of the pre-onset phase, along with changes in cognitive functioning such as poor concentration, constant worrying or preoccupation with certain thoughts. Other nonspecific symptoms include sleep and appetite disturbance.

Over time these symptoms may either intensify, eventually coalescing into diagnosable syndromes, or remit and resolve.[10] While many of these symptoms are common in young people, fortunately they are often short lived and much of the associated distress resolves quickly. However, they should not be dismissed as trivial purely because they are so common; subthreshold symptoms strongly predict future illness, and even self-limiting distress and impairment warrants, at least, support. For example, subsyndromal depression is a significant issue in young people, not only because it is a well established risk factor for major depressive disorder, but also because of its prevalence and the impact of depressive symptoms on functioning.[11]

What are the first steps toward effective treatment?

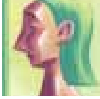
Is it critical to maximise access to an assessment, which can be conducted over a series of contacts and should aim to build trust and an understanding of the young person within their social environment. It is usually not crucial to try to diagnose a particular syndrome as the primary goal, but simply to decide if there is a need for clinical care. This decision should be based purely on the intensity of the young person's symptoms and distress, the degree of disturbance in their relationships and/or functioning, the effectiveness of their coping skills, the availability of social support, the level of risk, and the persistence of distress, risk and impairment. Care should be offered where there is a capacity to benefit from it, and the potential benefits outweigh any risks. Setting the bar on the low side in this way has major benefits: early intervention to resolve symptoms and distress not only gives better clinical and functional outcomes, but may also be more cost effective.

Furthermore, early treatment potentially has a preventive effect in reducing the risk of developing secondary syndromes (such as major depression or substance abuse, complicating social anxiety) and disability. This is an important consideration, particularly when dealing with prevalent and disabling conditions such as depression and anxiety. Provided we are offering stigma-free assessment and care, lowering the threshold has the same tangible benefits as in the early assessment of new skin lesions and breast lumps.

Tips for treating young people presenting with mental health concerns

1. Allow enough time, patience and effort to develop trust

This may be difficult within the parameters of fee-for-service, whole-of-lifespan general practice, and may be one of the reasons why young people have the lowest access and engagement with primary care.



Longer appointments, better listening and interviewing skills, repeat visits and a willingness to begin on the young person's 'turf' by initially addressing the issues they identify as problems, will help to build trust.

2. Use a stepped treatment approach rather than immediate recourse to medication

A stepped or staged approach with assessment, key information, support, shared decision making, cognitive behavioural therapy (CBT) and multiple visits as key features should typically precede prescribing medication for young people unless severe depression, clear-cut psychosis or risk of self harm or violence is apparent.

3. Monitor and reassess risk frequently

Frequent monitoring is crucial, particularly following prescription of an antidepressant. There may be an increased risk of agitation and suicidal ideation may linger or surface during this early period of treatment. Risk assessment is particularly important during the initial presentation as many young people present in crisis.

4. Avoid initiating antipsychotic medications

Antipsychotic medications should not be initially prescribed in primary care unless frank psychosis is present and the situation is urgent. Psychotic-like experiences are common in the community, and it is important that other options are offered in such subthreshold cases. Antipsychotic medications should only be prescribed in mood disorders and other conditions after referral to a psychiatrist. These medications are therapeutically effective yet have long term side effects which mean the risk-to-benefit ratio needs to be carefully assessed in every case.

5. Involve family and friends

While it is crucial to respect the confidentiality of the young person, when the situation is serious or when family support and involvement would be useful (usually the family are the best supports or 'scaffolding' at the young person's disposal), the GP should suggest to the young person that the family be brought into the picture, for specific purposes at least. These could include monitoring safety, securing a safe domestic situation, or dealing with financial and other practical issues, and particularly to provide emotional support. Friends and other key adults can similarly be mobilised, with permission, cutting through the privacy jungle.

The family themselves will typically be worried and concerned to help, and do need some level of involvement; and in most cases young people are happy for this to occur – with safeguards. Obviously where there is a history of neglect or abuse, major conflict with family members or complex blended family situations, finer judgment is required.

6. Refer as necessary

Although generally the initial emphasis for the GP is on building a relationship with the young person, in many situations an extended treatment team with different skills will be required. General practitioners should familiarise themselves with local resources for crisis response teams, support, and specialised treatment. These vary enormously with geography, but the resources listed below and state governments are a good place to start. The management team may involve a psychologist, mental health worker and psychiatrist, particularly for more complex cases (see *Case study*). In situations where moderate to severe mental illness is present, consultation with specialist youth mental health services or a psychiatrist is essential.

Case study

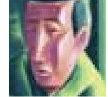
The following case is an idealised snapshot of the immediate future, already in place in some parts of Australia, and within reach of the whole of society. With more extensive 'headspace' coverage and youth mental health reforms, primary care will be able to play a much stronger complementary role in youth mental healthcare. Many of the features described in this stepped approach can be adapted and implemented in general practices that do not have access to the headspace network.

Martin, 19 years of age, is a tertiary student who has become more withdrawn and 'flat' in recent weeks. He is worried himself, but it is his friends who press him to open up, and he shares his experiences of deepening depression with them. After gleaning information from websites such as ReachOut!, *beyondblue* and headspace, Martin talks with his mother and sister and makes an appointment at the local headspace centre.

He feels comfortable at his first visit and is encouraged by the friendly welcome from the young reception staff and the youth access team, who he meets on arrival, the décor and the general 'vibe'. The access team realise he is ambivalent about seeking help so they take him for a coffee and ensure he doesn't have to wait long to see a doctor.

Martin sees a GP who seems to know how to put him at ease, even though he doesn't really feel like talking much. He sees a young psychologist at the same visit and is offered a series of counselling sessions. It is agreed he doesn't need medication at this stage. He gets some advice on use of drugs and alcohol and an appointment is made for him see the vocational counsellor to help him 'hang in there' with his studies, which he has been struggling with recently.

Martin initially improves but the distress persists and gradually worsens after a couple of weeks. He is offered more intensive cognitive behavioural therapy with an on-site clinical psychologist. After 6 more weeks, he becomes more deeply depressed and consideration is given to a trial of antidepressant medication. The GP and access team consult with the weekly sessional youth psychiatrist who is linked to the regional integrated youth specialist mental health service. He suggests a trial of a selective serotonin reuptake inhibitor (SSRI) with careful monitoring of Martin's mental state, especially his levels of agitation and suicidal ideation, by Martin, his family and his GP.



Within a couple of weeks Martin has turned the corner and is on the road back. Martin, his family and friends, and his GP and the 'recovery' team know this remains a risky period so he is monitored carefully, with back-up from the home treatment team of the regional youth mental health service. Martin doesn't need hospital care, but this could have been arranged within the headspace linked specialist youth mental health system.

Conclusion

General practitioners play a central role in the care of adolescents with mental health concerns. Apart from being the first port-of-call for young people who do seek help, GPs not only provide initial care, but also have an important 'holding' role, monitoring the young person's symptoms and functioning over time, and deciding if and when referral to the specialist mental health system is necessary.

General practitioners can also facilitate ongoing conversation between the young person and their family about what is 'normal' during adolescence, and what is of more concern. Providing effective and acceptable mental healthcare for young people may involve modifying our style of practice, but this is certainly within our reach, and given the level of unmet need in our community today, this should be one of our highest priorities.

Summary of important points

- Every year around one in 4 young Australians experiences a diagnosable mental health disorder.
- There are numerous short and long term consequences of mental ill-health in young people.
- 75% of young people with a mental health disorder do not access treatment.
- It can be difficult to distinguish 'normal' developmental changes from the onset of mental illness.
- The primary goal of initial assessment is not to make a definitive diagnosis, but rather to assess risk and the need for clinical care.
- GPs have an important role to play in longitudinal assessment, ongoing review, facilitating access to treatment and mobilising support networks.

Resources

- headspace: www.headspace.org.au
- ReachOut!: http://au.reachout.com/
- beyondblue: www.youthbeyondblue.com/.

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