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PEER REVIEWED FEATURE
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Mental ill-health in young people

Assessment and early treatment

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A stepped-care approach should be used for young people with mental health issues with the key features being assessment, information, support, shared decision-making, cognitive behavioural therapy and multiple visits. This approach should typically precede prescribing medication unless severe depression, clear-cut psychosis or the risk of self-harm or violence is apparent.

Key points

- **Mental health issues are very common in young people, with about 25% of Australian adolescents experiencing a diagnosable mental illness in any given year.**
- **Anxiety, depression and substance abuse are the leading mental health problems in young people.**
- **Early intervention with a preventive focus is appropriate wherever there is a need for clinical care. This can be assessed based on the intensity of the young person's symptoms and distress and the degree of disruption to relationships and functioning.**
- **A stepped-care approach should be used, with education, support and simple evidence-based interventions chosen as the initial therapeutic strategy.**
- **Decisions on management should be made with the young person and his or her family, if possible. Use of medications should be reserved for severe stages of mental ill-health and for those who do not respond to psychosocial therapies.**

The key health issue facing young people in Australia today is mental ill-health, accounting for approximately 50% of the burden of disease in the 15 to 25 year age group.[1] Currently, one in every four young people in Australia will experience a diagnosable mental disorder in any year. These mental disorders most commonly include depression, anxiety or substance abuse, or a combination of these.

Cohort studies show that 50% of young people experience threshold levels of mental disorders at some stage during the transition from childhood to adulthood, with a direct relation to later social impairment and a failure to reach their full potential in human and economic terms.[2] Mental ill-health should not be regarded as 'teen angst' or 'growing pains' but as genuine distress and a need for understanding, support and care.

WHY ARE YOUNG PEOPLE SO VULNERABLE?

There are complex biological and sociological reasons why young people are uniquely vulnerable to, and often heavily impacted by, the onset of mental illness. Adolescence and early adulthood is a time of dynamic structural and functional change in the brain, driven by a series of maturational processes that result in the refinement of the neuronal circuitry, particularly in the frontal cortex.[3] Furthermore,

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the challenges presented by the transition from childhood to independent adulthood must be met against the background of these highly dynamic changes in brain architecture. Young people are in the process of defining their individuality and autonomy, which includes establishing and negotiating their own social networks, beginning sexual relationships, completing their education and moving into employment.[4] 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.

Although we all too often accept and minimise mental health issues in young people as a normal part of adolescence, this should not be the case. Common does not necessarily mean 'normal'. Why should it be considered 'normal' for young people to be distressed and struggling for significant periods without recognising their need for understanding, effective support and care?

Mental health issues are not a trivial threat. They have numerous negative consequences in both the short and long term, including impaired social functioning, poor educational achievement, unemployment, substance abuse, self-harm and suicide.[5] This is illustrated in a recent cohort study in which the authors have shown that 50% of young people will be diagnosed with a mental disorder between the ages of 18 and 25 years, and that these disorders impact on economic and social outcomes at age 30 years.[2] More than half of these disorders are multiple or recurrent.

Mental illness, due to its pattern of onset over the lifespan and its impact on the most productive years of life, has recently been calculated to pose the greatest threat to the gross domestic product of the developed and developing nations over the next 20 years, equal only to cardiovascular disease among the noncommunicable diseases.[6] Mental ill-health is not a case of 'troubled teens' or the 'worried well' but a genuine health and social problem to be responded to in an effective manner. This does not necessarily mean specialised or prolonged psychiatric intervention and use of medication. Often it is just a case of someone to turn to, understand and provide information, support, simple interventions and hope. In other cases, however, more assessment and expert help is necessary.

IS IT THE 'TROUBLED TEENS' OR SOMETHING MORE SERIOUS?

How can we tell if a young person is merely going through a transiently stressful period or if they are in the early stages of developing a mental health disorder for which

intervention is required? It is difficult to distinguish between what represents transitory and normative changes in behaviour and disturbances that may represent the early signs of onset of a potentially serious mental illness. This is particularly difficult in young people in whom emotional disturbance and distress is such a common experience.

There is often a reluctance to diagnose mental illness in young people and this is driven by concerns such as the risk of over-medicalising normal human experience or the fear of overuse of psychotropic medications or of stigma. This situation is not helped 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 that is often involved in making an initial diagnosis. We are a long way from over-diagnosis and over-treatment given that 75% of young people with a diagnosable mental disorder have no access to health care.[7] We therefore need to radically adjust our thinking and the threshold for access to care and create stigma-free portals that enable access without any shame or harm.

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.[8,9] There are two common scenarios as outlined below.

The first scenario 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, particularly high school, becomes harsher. Children with intellectual disabilities or developmental disorders, such as the autism spectrum disorders, conduct disorder, anxiety disorders or attention deficit hyperactivity disorder, are at risk of additional syndromes and social and vocational derailment and usually need specialist team-based mental health referral.

The second, more common scenario is where a young person has had an uneventful prepubertal period, yet begins to struggle during what is best described not as 'adolescence' but as 'emerging adulthood'.[4] Depression, irritability, anxiety, withdrawal, apathy, transient suicidal ideation and low-lethality self-harm are common features of the early stages of evolving mental illness, along with changes in cognitive functioning, such as poor concentration, constant worrying or preoccupation with certain thoughts, and other non-specific symptoms, including sleep and appetite disturbance.

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Over time these symptoms may either intensify, eventually cohering into diagnosable syndromes or remit and resolve.[10,11] Although many of these symptoms are common in young people, fortunately they are often short-lived and much of the distress associated with them resolves quickly. However, they should not be dismissed as trivial purely because they are common; subthreshold symptoms strongly predict future illness, and even self-limiting distress and impairment warrants care or, at the very 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 even subthreshold depressive symptoms on functioning.[12]

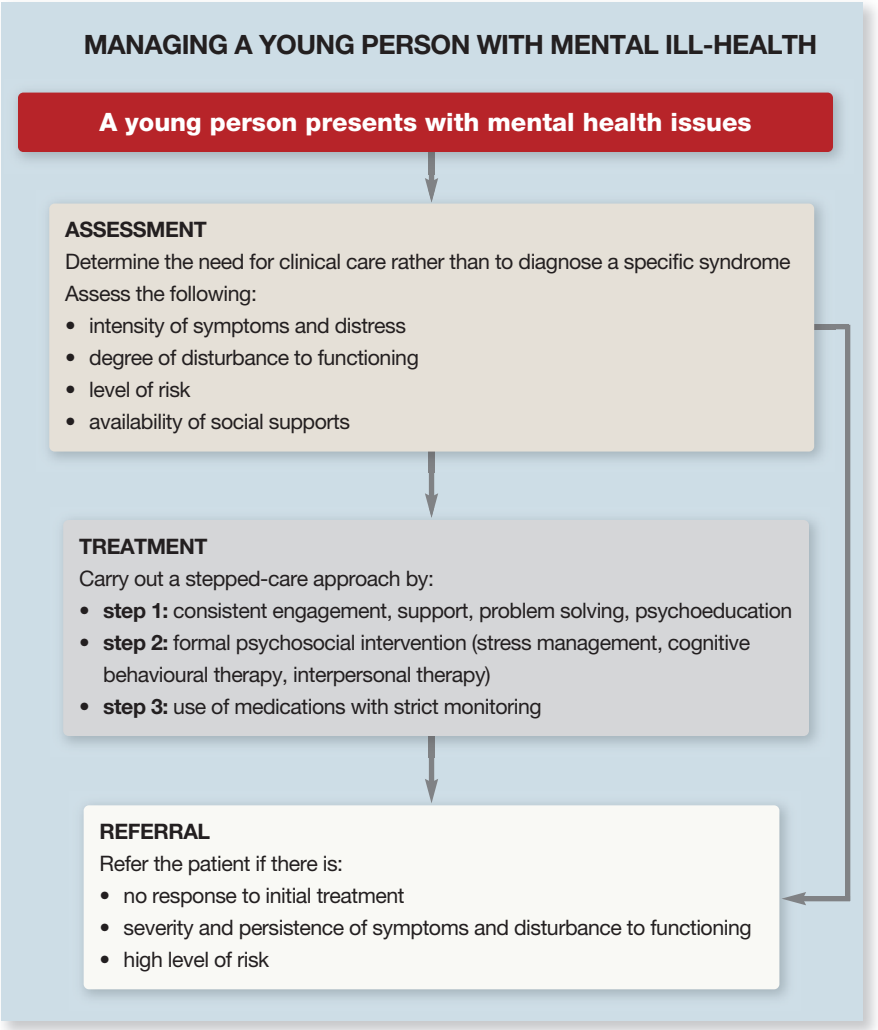
ENGAGING AND UNDERSTANDING YOUNG PEOPLE

Assessment of mental health issues in young people can often be challenging, but it is an important first step in building trust and an understanding of the young person within his or her social environment before establishing a care plan. This can be conducted over a series of contacts, with the primary goal not necessarily being to diagnose a particular syndrome but 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 his or her relationships and/ or functioning, the effectiveness of the person's coping skills, the availability of social support, the level of risk, and the persistence of distress, risk and impairment.

Care should be offered to the young person if there is a capacity to benefit from it and if the potential benefits outweigh any risks. Care involves listening, support, problem solving and consistent engagement. Additional layers may include more specific psychosocial interventions and in some cases use of medication. Setting the bar on the low side in this way has major benefits because early intervention to resolve symptoms and distress gives better clinical and functional outcomes and may also be more cost effective.

In addition, 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 for care has the same tangible benefits with minimal risk as in the early assessment of new skin lesions and breast lumps.

Building a therapeutic relationship with a young person takes time, patience



and often considerable effort. Young people are likely to be using the health-care system independently for the first time and are often extremely reluctant to visit a GP, let alone discuss emotional concerns. The relative lack of flexibility in our fee-for-service, office-based generic primary care system is one of the reasons why access and engagement for young people is the lowest across the lifespan in primary care. Nevertheless, good listening skills, longer appointment times, repeat visits, outreach if relevant and a willingness to begin on the young person's 'turf' by initially addressing the problem issues as they see them will help to build trust.

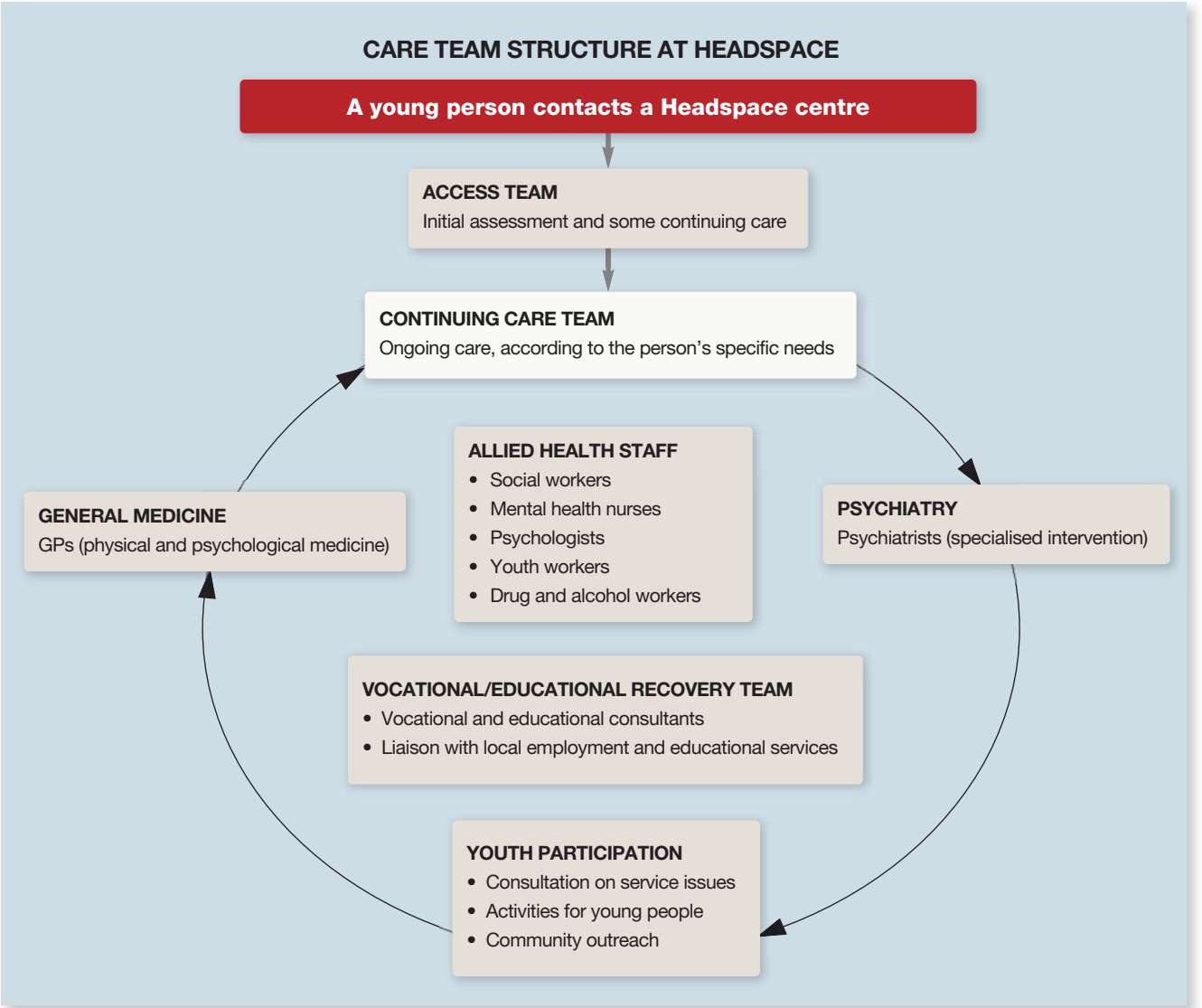
TREATMENT APPROACHES

A stepped-care or 'staged' approach should be carried out for young people with mental health issues with key features being assessment, information, support, shared decision-making, cognitive behavioural therapy and multiple visits (see the flowchart on this page). This approach should typically precede prescribing medication for young people unless severe depression, clear-cut psychosis or the risk of self-harm or violence is apparent.

Frequent monitoring of patients is crucial, particularly in the days and weeks following prescription of an antidepressant or other psychotropic medication. An increased risk of agitation and suicidal ideation may linger or surface during this early period of treatment, either as a reflection of the underlying mood disturbance or as an early adverse event. 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, particularly in this age group, and even if distress and impaired functioning co-occurs, it is important that other options, notably psychosocial care, are offered to help-seekers in such sub-threshold cases. Antipsychotic medications should only be prescribed for young people after referral to a psychiatrist. These medications are therapeutically effective but have longer-term side effects, meaning the risk-to-benefit ratio needs to be carefully assessed in every case.

Young people who do not respond to these initial treatment approaches and those with moderate-to-severe mental illness should be referred to specialist youth mental health services (see the box on page 52) or a psychiatrist. Ideally, GPs should be part of a team that may involve psychologists, mental health workers and psychiatrists, particularly for more complex cases. Co-operative, multidisciplinary care facilitates engagement as well as the effective provision of mental health care appropriate for the unique and complex needs of this age group. Specialist youth mental health services, such as Headspace, are designed with these needs in mind and offer a flexible, youth-friendly approach in a 'one-stop-shop' model of integrated care for mental health and substance use issues.

Headspace is a federally-funded national organisation offering support, advice and information to young people aged 12 to 25 years with mild-to-moderate mental health issues. Currently, there are 37 Headspace centres nationally, with funding set aside for the establishment of a further 43 centres over the next 5 years.



Allied health professionals, GPs and psychiatrists are available at each of the centres and work closely together to provide care for young people with mental health difficulties. No formal referral is necessary for young people to access the centres, and their first contact will be with a member of the access team, who will assess their needs and refer them to a member of the continuing care team depending on their specific needs. For many young people, this will be a mental health clinician, whereas others will require more specialised interventions from either a GP or psychiatrist (see the flowchart on this page).

It is important to respect the confidentiality of the young person; however, if the situation is serious or the GP believes family support and involvement would help (usually the family are the best supports or 'scaffolding' at the young person's disposal), the doctor should suggest to the young person that the family be brought into the picture, for specific purposes at least. These purposes could include monitoring safety, securing a safe domestic situation, or dealing with financial and other practical issues, and above all to provide emotional support. Friends and other key adults can similarly be mobilised with permission, which also helps to cut through the privacy jungle. The family themselves will typically be worried and concerned to help and so need some level of involvement. In most cases young people are more than happy for this to occur with safeguards. If there is a history of neglect or abuse, major conflict with family members or complex blended family situations, then finer judgement is required.

ONLINE YOUTH MENTAL HEALTH SERVICES

Headspace
- www.headspace.org.au

Reachout
- http://au.reachout.com

Youth Beyondblue
- www.youthbeyondblue.com

THE ROLE OF THE GP

GPs play a crucial role in the care of young people with mental health issues. They 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 appropriate.

As GPs are often the first port of call for young people who do seek help, they have a unique opportunity to offer preventively oriented mental health care at a time of life when it has the most potential for long-term benefits. However, standard primary care settings and mindsets are often not well configured to engage young people and allow them to communicate their problems, hence the need for specialised enhanced primary care youth services such as Headspace.

GPs can often formulate creative and practical strategies to reduce risks of self-harm and manage emotional pain and distress. Finally, and not least, they can also facilitate the ongoing conversation between the young person and his or her family about what is normal during adolescence and what should be of more concern.

CONCLUSION

Mental illness is now recognised as a major and preventable threat to human health, well-being and economic productivity. The burden of disease associated with mental illness is largely due to the timing in the life cycle when symptoms and illness first emerge, with the vast majority appearing during the developmentally critical years of adolescence and young adulthood.

If we are to shrink the avertable burden of the mental disorders, reduce suffering and improve productivity across the adult years of life, one of the highest priorities for doctors should be providing effective and acceptable mental care for young people. This major public health issue is finally being addressed with changes in clinical practice and health service structures, with GPs having a key role to play in this process. These changes may involve modifying our style of practice and/or working in close multidisciplinary liaison, either with a specialist youth mental health centre or more organically, as a crucial aspect of managing young people with mental health issues. MT

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