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Webinar

**An interdisciplinary case study panel discussion**

**Adolescent mental health: depression, suicidality and cyber-bullying.**

Wednesday 1st December 2010

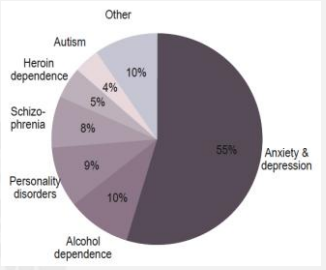
"Working together. Working better."

Supported by The Royal Australian College of General Practitioners, the Australian Psychological Society, the Australian College of Mental Health Nurses and The Royal Australian and New Zealand College of Psychiatrists

## Adolescent mental health

- 75% of all mental illnesses begin before 25 years of age
- 1 in 4 young people will have a mental health problem
- 30% seek professional help
- 50% of the students with the most serious issues never get recognized

## Depression & anxiety - the greatest burden of mental disorders (AIHW 2007)




## Depression

- Most common in mid adolescence
- 1 in 5 experience a diagnosable depressive disorder by 18
- most sufferers report delays of 5 to 15 years before they received treatment and care

## What does teenage depression look like?

- persistently sad and downhearted
- when a painful or stressful event is over and s/he doesn't bounce back, even though s/he wants to pick himself up, but can't
- s/he remains tearful, sullen and out of sorts for two weeks or more

## What else?

- teenagers appear to lose interest in life
- take little pleasure in activities they used to enjoy and generally become apathetic
- have trouble thinking and concentrating
- decline in academic performance at school is a dead giveaway

## And still more signs....

- withdraw from other people
- spend a lot more time in their room or on their computer
- may self medicate with alcohol, cannabis and/or other drugs.

## Any physical signs?

- depressed young people are often physically unwell
- headaches, other aches and pains
- excessive tiredness and a lack of energy
- gain or lose a lot of weight

## Who provides the care?

**There are:**

- ~25,000 GPs in Australia
- ~ 22,000 psychologists
- ~ 3,500 psychiatrists
- ~ 1,100 Medicare registered social workers
- ~ 130 mental health Medicare registered OTs

## Who provides the care

- **GPs are fairly well distributed**
  - ~95 FTE per 100,000 in major cities & ~ 84 FTE in rural areas
- **Psychologists are unevenly distributed**
  - ~90 FTE per 100,000 in major cities & ~33 FTE in inner regional cities
- **Psychiatrists are very unevenly distributed**
  - ~22 FTE per 100,000 in major cities and 6, 3, and 3 FTE in inner regional, outer regional, remote areas respectively

## Who provides the care

- **In 2007-2008**
  - 3.5% of the Australian population saw a GP for mental health treatment
  - 1.3% saw a private psychiatrist
  - 0.6% saw a private psychologist
  - 1.6% attended a public mental health service
- **Most people seeking mental health care will see a GP**
- **Many will also need help from an allied mental health worker and/or psychiatrist**

## GP role in mental health care

- **First port of call, any and every health problem, life long care**
- **Mental health assessment**
  - Needs time (long consultations preferred)
- **Diagnosis**
  - Sometimes clear from start, sometimes apparent over time
- **Management**
  - Depends on issue complexity and risk assessment

## GP role in mental health care

- **Treat patient yourself and/or refer**
- **Current referral options include**
  - Private psychologist or other allied mental health (Better Outcomes or Better Access)
  - Private psychiatrists
  - headspace (in some locations)
  - Community health services
  - Public mental health services
- **Problems include: patient preference, local availability, waiting time, cost, eligibility**

## Role of psychologist: adolescent mental health treatment and care

Psychologists are mental health professionals who diagnose and provide psychological therapies and treatments.

- **Common effective types of psychotherapy are**
  - Cognitive Behaviour Therapy (CBT)
  - Interpersonal Therapy

## Role of psychiatrist

- Liaise with the GP, psychologist, other health providers, school staff as indicated
- Provide a comprehensive biopsychosocial assessment to help formulate and accurately diagnose cases
- Provide a management plan
- Help with risk assessments
- Provide opinion and follow-up about medication options
- Provide feedback on formulation to family, psychoeducation, psychotherapy, family therapy etc as indicated or if unavailable elsewhere

## Collaboration - Does it matter?

- **Pros**
  - Multiple inputs are integrated
  - Each person adds value to the next
  - Each person knows what the other is doing
  - Address multiple needs simultaneously rather than sequentially
- **Cons**
  - Time consuming
  - Uncertain evidence of benefit in mental health care
- **Do competent professionals need to work together or just do their own job well?**

## Collaboration

**Mental health collaboration:**

- **What helps?**
  - Knowing the other professional
  - Easy to contact
  - Concise, prompt feedback
  - Case conference items, but not easy to use
- **What doesn't help?**
  - Not knowing the other professional
  - Little or no feedback
  - Inadequate role clarification, Mx advice, or contingency plan

## Tim: a case study

# ADOLESCENT MENTAL HEALTH

## Tim at the GP

- 17 year old year 11 student
- Reluctant attendee
- Mo thinks he is irritable, argumentative, poor academic performance
- No PH but sensitive
- FH Mo tense, father heavy drinker, paternal uncle bipolar

## Tim at the GP

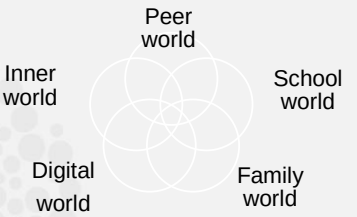
- Tim thinks Mo is a nag
- Some tension with father
- Some tension with a school teacher
- Recent fall out with friends
- No interest in school
- No clear sense of future
- Complains of fatigue

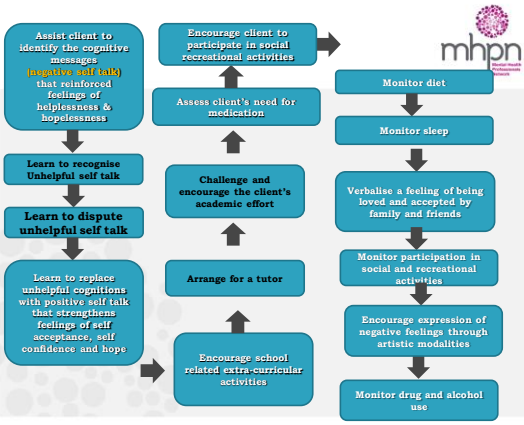
## Tim at the GP

- Low risk of self harm
- Review one week
- Organise pathology in between
- Schedule longer appointment

## Tim at the psychologist

**What is the balance of risk and protective factors in his 5 Worlds of an adolescent**




## Tim at the psychologist

**Short term goals**

- **Psychological testing to evaluate the depth of the depression** with feedback to client & family
- **State the connection between rebellion, self destructive behaviours or withdrawal and the underlying depression** – assess client's understanding **acting out as avoidance of the real conflict involving unmet emotional needs**
- **Teach the client the connection between angry, irritable behaviours and feelings of hurt and sadness**
- Reinforce client's open expressions of underlying feelings of hurt, anger and disappointment
- **Specify what is missing in life to cause the unhappiness**
- **Specify what in the past or present life contributes to sadness**
- **Express emotional needs to significant others**
- **Implement positive self talk (CBT) to strengthen feelings of self acceptance, self confidence and hope**

## Tim at GP for review

- Tim progressing slowly
- Brings up issue of voices
- Some soft paranoia when using cannabis
- Has FH of bipolar
- Refer for psychiatrist opinion re diagnosis and medications

## Tim at the psychiatrist

- **Almost always a mixed bag**
- **Presentations similar to Tim are common**
- **Limitations of diagnosis compared to bio-psychosocial developmental dynamic case formulation.**
  - i.e. understanding Tim in context of his life
- **Safety is always a paramount concern**
  - But so is therapeutic rapport & alliance
  - Tim has increasing suicidal ideation without plan or intent thus far
- **Repeat thorough Maudsley style history to check for other symptoms**

## Tim at the psychiatrist

**Biological aspects:**

- Family history – alcoholic "unhappy" father and "tense" mother. Paternal uncle bipolar. Tim has "sensitive" temperament.
- Anxious temperament as predisposition
- Lack of sleep
- Disrupted circadian rhythm
- Vit D. deficiency
- Junk food oriented diet
- Limited exercise, overweight
- Alcohol intoxication monthly, cannabis occasionally
- Does he know how to relax?

## Tim at the psychiatrist

**Psychological aspects**

- **What is developmental history?**
- **Think in terms of Erikson's lifecycle tasks**
  - Infancy – basic trust (attachment patterns)
  - Toddler – autonomy, confidence
  - Preschooler – initiative, imagination, identity
  - Preadolescent – industry, work ethic
  - Adolescence – self-identity
    - Early – separation from parents
    - Middle – peer relationships, sexuality
    - Late – personal beliefs and affiliations.
- **What is Tim's life story in context of these developmental tasks?**

## Tim at the psychiatrist

**Social aspects:**

- **Relationship with parents**
  - Father "unreliable", unhappy and self-focussed
  - Mother "tense", "nagging", "drove Fa away"
- **Falling out with best friend "Max"**
- **Humiliation and ambivalence re girl involved in the cyber bullying**
- **Less social time with friends**
- **Feels alienated from school, in particular a certain teacher**
- **No extracurricular activities**

## Tim at the psychiatrist

**Interventions**

- **Psycho-education – evolutionary perspective**
  - Nature of stress response and need for relaxation techniques
  - Benefits of sleep, regular circadian rhythm, healthy food – incl omega-3, exercise
  - All above are anti-inflammatory = "natural antidepressants"
- **Attachment/grief/rank theory**
  - Why social relationships can both cause depression and relieve depression/bring happiness
  - Talking therapy, family therapy
- **Thus Behaviour Activation Therapy – get out and do it!**
- **SSRI – debatable and not first line**
- **Temazepam PRN 3 nights/week.**

**Thank you for your contribution and participation**