Recognition and assessment of **common mental disorders** in young people

Key Points

- A young person with serious suicidal intent, psychotic symptoms or severe self-neglect should be referred immediately to secondary care mental health services
- In a young person, hopelessness is recognised as a strong prognostic indication for severe depression and warrants urgent referral. Other indications of severe depression are persistent symptoms, other serious mental or substance use disorders and significant functional impairment
- Every interaction with a young person in primary care should be regarded as an opportunity to assess their psychosocial as well as physical wellbeing
- In a young person presenting with mental health problems, assessment of suicide risk should form part of the initial consultation and be re-evaluated during on-going monitoring
- Psychosocial wellbeing in adolescents can be assessed using a standardised questioning format such as the HEEADSSS (page 11)
- Practitioners involved in the assessment of young people for mental health disorders should endeavor to build a supportive and collaborative relationship with the young person and their family/whānau
- Practitioners should be aware of the cultural identity and health care preferences of young people in their care.

In this section the clinical features of the common mental disorders are outlined along with a discussion of suicidal behaviours. Assessment of the potential for suicide is an essential part of initial and on-going management. In the final part of this section a number of psychosocial and brief assessment tools are described. These are also included in the *bestpractice* Decision Support module and can be used to assist in the diagnosis, assessment of severity and monitoring of treatment.

The clinical features of the most common disorders are briefly described here. For more information please refer to the New Zealand Guidelines.[1]

Recognising common mental disorders

Anxiety disorders.[1]

Separation anxiety is defined as developmentally inappropriate and excessive worry concerning separation from parent and home, refusal to go to school, reluctance to be home alone, nightmares and/or physical complaints, for at least four weeks. Refusing to go to school differs from truancy in that parents are often aware of the child's absence from school and the child is compliant in other respects.

Generalised anxiety disorder is defined as excessive or uncontrolled worry, difficulty concentrating, restlessness, irritability, sleep problems, fatigue and or muscle tension, for at least six months.

Panic disorder is defined as spontaneous recurrent episodes of panic, with palpitations, sweating, trembling or dry mouth and other physiological and psychological symptoms.

Separation anxiety is more common in young children, while generalised anxiety disorder and panic attacks are more common in adolescents. Related disorders include phobias, obsessive compulsive disorder and post traumatic stress disorder (PTSD). Symptoms often overlap and many young people will meet the criteria for more than one type of anxiety disorder.

Anxiety disorders often present with somatic symptoms and other conditions such as hypoglycaemia, migraine, seizures and other problems must be excluded.

Depressive Disorders.[1]

Depression

The DSM-IV criteria for depression in children are as follows:

- Persistent sad or irritable mood
- Loss of interest in activities once enjoyed
- Substantial change in appetite or body weight, failure to make expected weight gain
- Oversleeping or difficulty sleeping
- Psychomotor agitation or retardation
- Loss of energy
- Feelings of worthlessness or inappropriate guilt
- Difficulty concentrating
- Recurrent thoughts of death or suicide

Five or more of the DSM symptoms (including at least one of the first two) must persist for two weeks or more and must cause clinically significant distress or functional impairment before major depression can be diagnosed. However, symptoms can be more unstable in young people and some days of normal mood within the two week period does not negate the diagnosis.

Although not specifically listed in the DSM criteria, hopelessness is considered by many practitioners in this area to be the most important prognostic symptom in adolescents in both genders across all ethnic groups.

Irritability and frustration are very important symptoms of depression in children and adolescents and may be more important than low mood. In depression, persistently feeling "grumpy and cross" is commonly reported by both genders. This must be distinguished from normal teenage grumpiness and angst which is usually of short duration. Girls tend to report more internal symptoms such as

loneliness, unhappiness and self-hate, while boys report changes in more overt behaviours such as reluctance to talk, sleeping problems, difficulty in concentrating and decision making.

Somatic complaints are very common in children and adolescents who meet the diagnostic criteria for depression, especially in the younger age group. Adolescent depression is more similar to the adult form, with a greater likelihood of mood symptoms at presentation, but these may still be masked by behavioural problems, substance misuse or somatic symptoms.

Dysthymia

Dysthymia is a chronic lowering of the mood that does not fulfill the criteria for recurrent depressive disorder in terms of either severity or duration of individual episodes. There are variable phases of minor depression and comparative normality but in diagnosing dysthymia it is important to establish that the young person does not meet the criteria for current depression. If depression has preceded the onset of dysthymia, then there must have been full remission of all depressive symptoms for at least two months before the development of dysthymia, to make the diagnosis. By contrast, episodes of depression can be superimposed on dysthymia, in which cases both diagnoses can be given.[1]

Bipolar Disorder

Symptoms of depression with marked melancholic or manic/hypomanic features may signal bipolar depression, especially is there is a family history.

Substance misuse

Substance use and misuse are strongly associated with puberty and uncommon in young children, though the age of initiation is steadily dropping. It is common to underestimate the use of alcohol, tobacco and drugs. Substance use disorder is under-recognised in adolescents despite occurring in approximately 40 % of young people attending mental health services.[8] Young people who disclose that they have used substances during a routine HEEADSSS interview (see next page) should be questioned more directly to determine their level of use.

Conduct Disorder

Conduct disorder consists of a repetitive and persistent pattern of behaviours in which the basic rights of others or major age-appropriate norms or rules of society are violated. Features include bullying, starting fights, cruelty to people and animals, truancy, stealing and damage to property.

Attention-deficit hyperactivity disorder

ADHD, especially when associated with conduct disorder, increases the risk of behavioural problems and substance use disorders in adolescents. ADHD is six times more common in boys than girls. The diagnosis requires information from external sources, such as teachers, and caregivers, and usually involves specialist assessment.

Suicidal behaviours

Suicidal behaviours in young people comprise a spectrum ranging from thoughts and ideas about suicide through suicide attempts of varying severity, to completed suicide.

Suicidal ideation

Suicidal ideation is relatively common. About 16% of the New Zealand population reports a lifetime history of suicidal ideation, with the onset most likely in late adolescence.[2] For most young people, suicidal ideation does not lead to a subsequent suicide. However, those with risk factors and persistent ideation in association with mental health problems are at significantly increased risk of suicide.[9]

Suicidal attempt

A suicide attempt may range from a relatively minor event to a medically severe and life threatening event. Most suicide attempts in young people only result in minor physical harm and do not represent a serious attempt to

die. Females are more likely to make suicide attempts than males of the same age and are more likely to be admitted to hospital following an attempt. This may be due to the higher rate of depression and anxiety in young females compared to males.

Completed suicide

The completed suicide rate is higher in young males than females and the disparity is approximately 3 to 1. The gender difference may in part be due to the fact that males tend to use more lethal methods of suicide attempt such as hanging, carbon monoxide or firearms.[9]

Very few children (under 15 years) die by suicide, but care should still be taken when assessing for suicide and in ensuring their mental health and psychosocial needs are best met.

Assessing common mental disorders

Psychosocial assessment of young people[1]

Mental disorders are highly prevalent in young people and every interaction should be viewed as an opportunity to enquire about psychosocial well-being regardless of the presenting complaint. Such enquiries require good communication skills, empathy, cultural awareness, a willingness to discuss sensitive issues and a non-judgmental approach. Young people may not be forthcoming with their problems and issues, but sensitive questioning can identify the need for further assessment.

Structured clinical assessment

The HEEADSSS and HEARTS are structured question prompting tools to assist in the identification of problems and protective factors. In the *bestpractice* decision support module these are available as a pop-up with a notes field to add details of the assessment.

HEEADSSS

The HEEADSSS is designed for use in adolescents.

Home: relationships, communication, anyone new?

Education/Employment: ask about school grades, work hours, responsibilities

Eating; body image, weight changes, dieting and exercise

Activities: with peers, with family

Drugs: tobacco, alcohol, other drugs – use by friends, family, self

Sexuality: sexual identity, relationships, coercion, contraception, pregnancy, sexually transmitted infections (STIs)

Suicide and depression: sadness, boredom, sleep patterns, anhedonia

Safety: injury, seatbelt use, violence, rape, bullying, weapons

Issues of ethnic identity may also be important particularly among adolescents from minority cultures.

HEARTS

The HEARTS acronym has been suggested as method of psychosocial assessment for young children and their family/whānau.[1]

Home: conduct, general behavior, "manageability"

Education: any concerns about behaviour/progress?

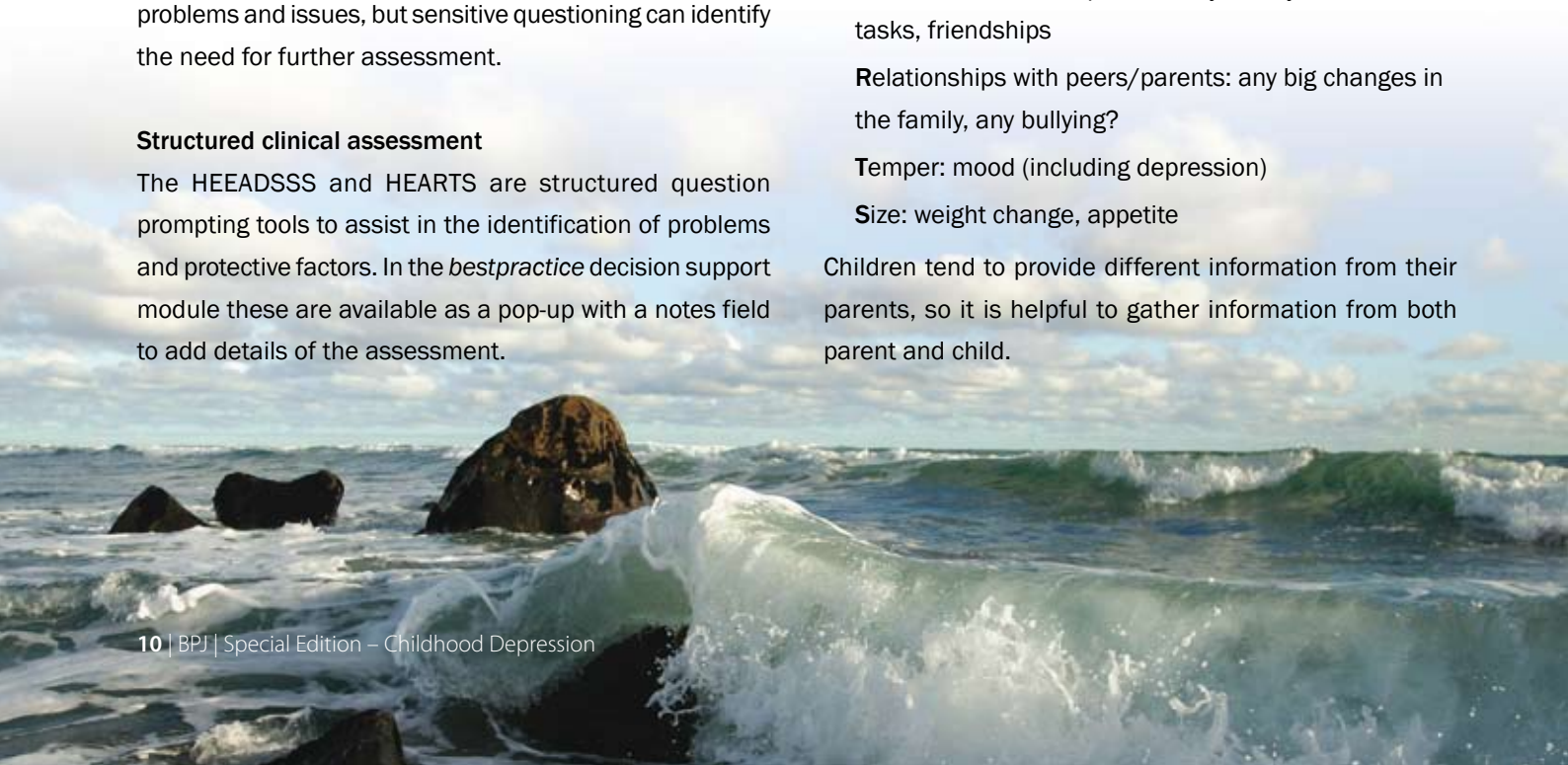
Activities: attention span, anxiety, ability to finish tasks, friendships

Relationships with peers/parents: any big changes in the family, any bullying?

Temper: mood (including depression)

Size: weight change, appetite

Children tend to provide different information from their parents, so it is helpful to gather information from both parent and child.



Other aspects to consider during assessment are:

- **Hopelessness and Helplessness**

  A strong emphasis should be placed on the presence and assessment of these feelings. What is the context of their feelings of hopelessness and how do they view their future? Profound hopelessness is strong risk factor for depression, suicidal ideation and suicidal intent.

- **Family/whānau involvement**

  Assessment of a young person involves working with parents or caregivers and consideration of the wider family/whānau network.

- **Availability of a supportive network.**

  The ability of family/whānau and others to support the young person may be influenced by many factors such as socioeconomic, geographical, relationships and deprivation. Childhood depression is very strongly associated with difficulties within the family and these should be addressed first.

- **Confidentiality**

  A careful discussion of confidentiality helps to build trust between the practitioner and the young person. The practitioner should discuss with a young person their right not to have personal information disclosed without their permission, along with the limits to this right. See box for an example statement that could be used to explain the limits of confidentiality.

Sample confidentiality statement

What we talk about will be kept private and I won't tell other people what you say. The only time this would change would be if I thought you might hurt yourself or someone else, or if I thought someone else might hurt you. If I was worried about you I would do what I needed to do to keep you safe. So I might need to talk to your Mum and Dad, or to other people. If I can I will talk to you about this first.

(**adapted from**[1])

Assessment tools for specific situations

Structured psychosocial assessment may signal a potential mental disorder and problems which warrant further investigation. For example, while using HEEADSSS, an adolescent indicates the presence of family breakdown, poor self-image, lack of motivation at school and regular alcohol use. This would prompt further exploration of the person's ability to function and cope, assessment of feelings of hopelessness and helplessness and direct questioning about suicidal thoughts or attempts. The mention of regular alcohol use would prompt the possible use of SACS or CRAFFT (over page) which specifically evaluate drug and alcohol use.

Assessment of suicide risk.[1]

Assessment of suicide risk can be challenging as there is no evidence of absolute markers that indicate the presence or intensity of suicide risk. Assessment only provides a snapshot of risk at a given time. Therefore assessment of suicide should be on-going during treatment as new triggers can emerge even if a person's mental state is improving or staying the same. For example, chronic risk factors such as family dysfunction or history of physical or sexual abuse remain static, but an acute stressor such as relationship breakdown or alcohol/drug binges may rapidly elevate a person's risk of suicide.

The most important factors to consider are triggers and current mental state:

- Intent/definite plan
- Lethality of likely method
- Access to means
- Presence of risk factors (e.g. mental or physical illness, chronic pain, alcohol use)
- Hopelessness
- Psychosocial triggers
- Lack of protective factors

Deliberate self–harm, such as cutting, refers to behaviours that may or may not result in serious injury, but are not intentionally fatal. There are many explanations for these

behaviours, a common one is that it is used as an attempt to regulate emotions which often occurs as a response to frustration and anger. The emotional distress that leads to self-harm can also lead to suicidal thoughts and actions.

Two assessment tools to assist in assessing suicide risk are available. The simplest tool (available in the *bestpractice* decision support module and in Appendix 1) is not specific for young people but the principles apply to all age groups. A more complex assessment tool and management plan designed for young people is reproduced in Appendix 2.

It is recommended that a broader psychosocial assessment (e.g. HEEADSSS) is carried out in conjunction with these questions.

Strengths and Difficulties Questionnaire (SDQ) – Appendix 3

The SDQ is a brief behavioural screening questionnaire that can be completed by children, adolescents or their parents to assess overall mental health and general functioning. It includes assessments of strengths as well as weaknesses and difficulties. It may be useful in the following situations:

- If HEEADSSS or HEARTS identifies a problem that requires further assessment
- If the patient presents with symptoms suggestive of a mental disorder
- Where it is possible or beneficial to involve parent / caregiver or teacher in the assessment

The *bestpractice* decision support module includes the parent versions of the SDQ for four to ten year olds and 11 – 17 year olds.

The SDQ does not assess substance use behavior and its consequences and therefore may underestimate the prevalence of substance use in adolescents.

Substances and Choices Scale (SACS) – Appendix 4

SACS is used for assessing and monitoring the pattern of use and impact of alcohol and drugs in young people. It can identify problem areas that warrant further in-depth assessment. As it measures behaviour over the last month, it can also be used on a frequent basis to assess progress during treatment and measure outcome. Completion of the SACS helps young people and clinicians to plan treatment goals and review progress. For more information see **www.sacsinfo.com/Questionnaires.html**

SACS is available in a community and clinician version. The community version is shorter and may be less intimidating to complete than the clinician version which provides a comprehensive list of substances that can be misused.

The *bestpractice* decision support module includes the shortened community version. However, clinicians are encouraged to enquire about the use of other substances such as party pills, herbal highs and sedatives.

The SACS is preferred to the CRAFFT (see below) as it was developed and validated in the New Zealand population and also has a scoring and rating system.

CRAFFT – Appendix 5

CRAFFT is an acronym for a set of questions that has been validated for the detection of alcohol and substance abuse in adolescents in primary care.

The CRAFFT tool is designed specifically for adolescents for detecting alcohol and substance abuse, and dependence. The disadvantage with CRAFFT is that it does not have a scoring system and therefore cannot be used to monitor treatment outcome.

PHQ-9 – Appendix 6

The PHQ 9 is specific for depression and can be used following psychosocial assessment or a more general brief assessment tool such as the SDQ. Although the PHQ-9 has not been formally validated for use in adolescents and children, there is no lower age cut off for its use.

Brief assessment tools may be helpful as an aid to diagnosis but do not replace the need for a full clinical evaluation.

Recognising risk of suicide in young people

The risk of suicide is comprised of background risk factors which are mainly static, and changeable risk factors which can increase overall vulnerability.

Background risk factors

- Social and educational disadvantage
- Past trauma including physical or sexual abuse
- A history of exposure to a dysfunctional family life
- Identity issues e.g. ethnicity, sexual orientation
- Development of significant mental health problems and/or personality difficulties

(Adapted from [9,10])

Dynamic (changeable) risk factors

The risk of suicide is sensitive to dynamic factors which can increase vulnerability. For example, a male with a history of sexual abuse has background risk factors for suicide which might be increased by onset of alcohol or drug binges, or relationship breakdown.

Accumulative risk of suicidal behaviour

Suicidal behaviour in young people is unlikely to be solely due to a stressful life event or psychiatric disorder, but rather, a response to an unhappy or adverse life course which has been characterised by the accumulation of risk factors during childhood and adolescence.[9]

Ethnicity and suicide risk

Māori ethnicity is associated with increased suicide risk and practitioners should be aware of the possibility of heightened risk.[9] For assessment of suicide risk see page 11.

Previous suicide attempt increases on-going risk[1]

If there has been previous attempt at suicide the risk of subsequent suicide is increased.

Risk factors include:

- older males
- current mental disorder
- disordered mental state (e.g., mood disorder, particularly when complicated by substance misuse or dependency)
- issues around sexual identity
- continued wish to die
- use of a method other than drug ingestion or superfi cial cutting
- signs of instability, agitation or psychosis