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Youth Health

Rotorua

Maintaining Youth Mental Health - Keeping Youth Well - Concurrent Workshop Repeated

Sunday, 23 June 2013	Start 8:30am	Duration: 55mins	Skellerup
	Start 9:35am	Duration: 55mins	Skellerup

Managing Mild – Moderate Mental Health Problems in Adolescence

Dr Tania Pinfold
Clinical Leader
Rotovegas Youth Health
June 2013

Remember this!

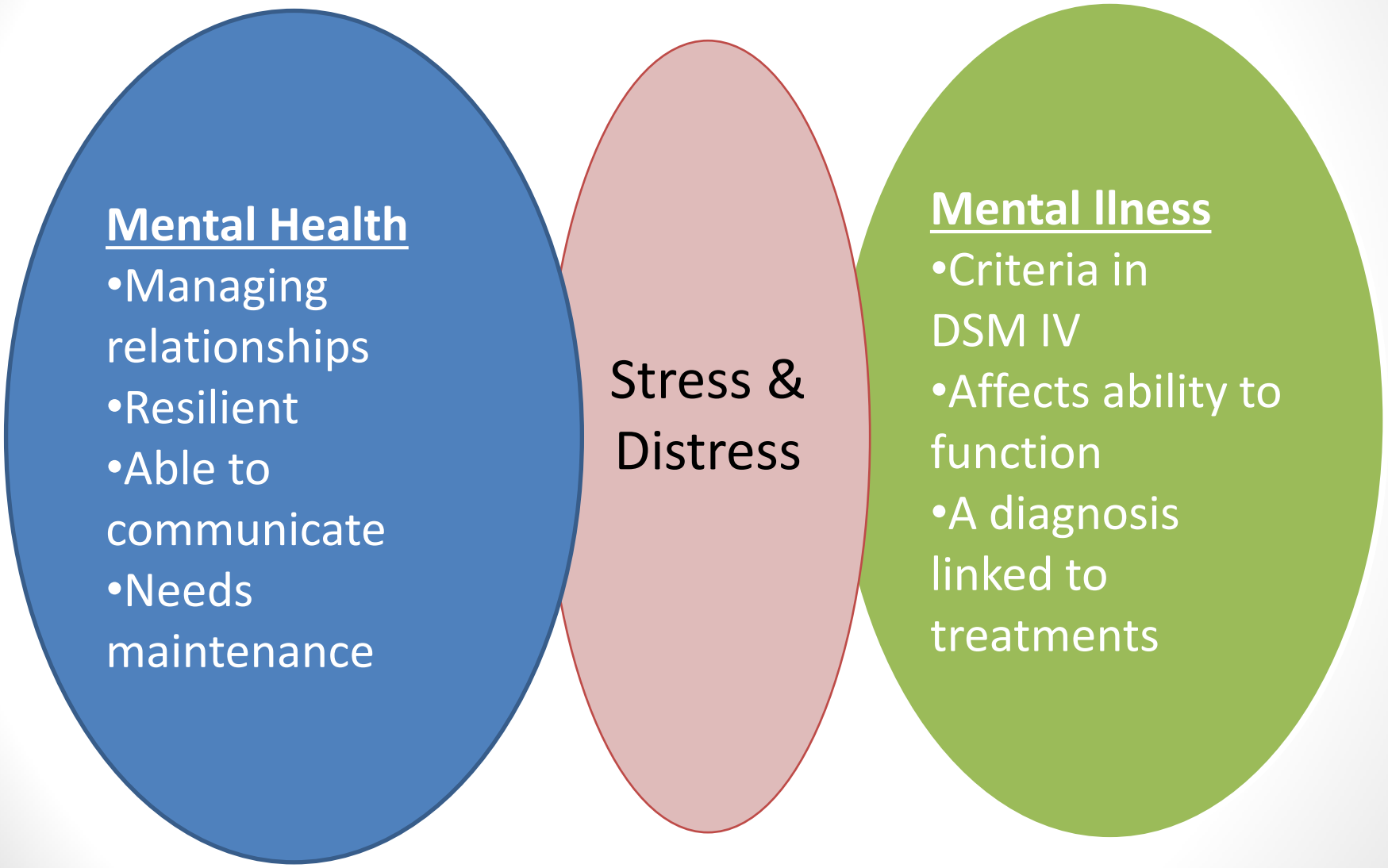
- Every interaction with a young person in primary care should be regarded as an opportunity to assess their psycho-social as well as physical wellbeing.
- Developing a strong working relationship with a young client when there ISN'T a mental health problem, gives you better access when there IS a mental health problem.

Definition of "Youth"

World Health Organisation

- Adolescents = 10-19
- Youth = 15-24 yrs
- Young people = 10-24 yrs

The Continuum



Mental Health

- Self confidence
- Feelings of competency
- Positive thinking
- Turning mistakes into opportunities
- Controlling mood and behaviour
- Sense of humour

Mental Illness

- Lack of self worth
- Altered body image
- Feeling overwhelms thought
- Negative thinking – guilt, catastrophising, personalising, etc

Prevalence data

- 28.6% of 16-24yo had a mental health disorder

- Of 18yo with a mental health disorder, 40% also had another disorder (e.g. AoD, Conduct Disorder)

(Oakley Browne 2006. Te Rau Hinengaro: The. New Zealand Mental Health Survey. Wellington: Ministry of Health.)

Key points - communication

- Essential to keep in mind the cognitive developmental situation for this young person at this time, and stay in that frame

  (choice of language, pace, treatment planning)
- Your working relationship is with the young person, not the parent
- Follow the “parentectomy” script – together, apart, together.

PM's Youth Mental Health Project

- 22 workstreams, 4 Ministries. (MOH,MOE, MSD, TPK)
- W2: "Expand the use of the HEEADSSS wellness check in primary care settings"
- W5: "Improve the responsiveness of primary care to Youth"

HEEADSSS An essential developmentally appropriate bio-psycho-social assessment

- Provides an chance to develop rapport
- Makes sure you leave out nothing important
- Gives a clear clinical impression of risk and resilience factors
- Ensures intervention and follow up is appropriate and maximally effective

(see trainings referred to at end of presentation)

HEEADSSS

The Adolescent Psychosocial Assessment

- H-Home
- E-Education/employment
- E-Eating
- A-Activities (peer group)
- D-Drugs
- S-Sexual health / contraception
- S-Suicide/depression
- S-Safety
- S-Savagery (violence)

Goldenring and Rosen
Contemporary Paediatrics Jan 2004; 21:64


Sometimes, my greatest accomplishment is just keeping my mouth shut.
someecards
user card

What makes a difference?

Vulnerability/risk factors

- Parental ill health
- Parental alcohol & drug use
- Poverty
- Personality factors
- Antisocial peers
- Lower intelligence
- Disability
- Mood problems

Protective/ resiliency factors

- Connectedness to family
- Connectedness to other caring adults
- Connectedness to school
- Higher grade point average (IQ)
- Feeling safe in school
- Religiosity

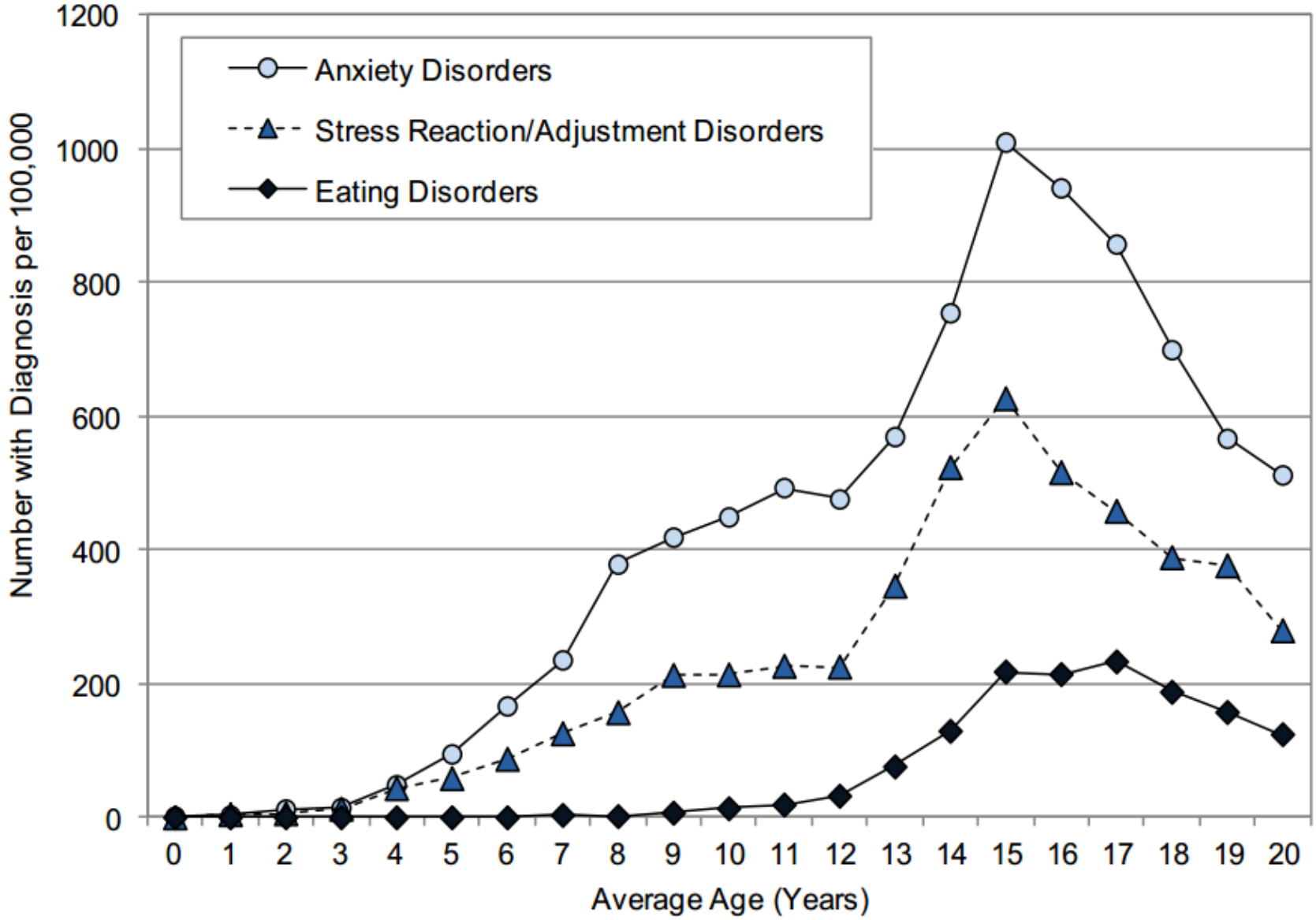
Psychosomatic Presentations

- Headache
- Tummy ache
- Joint and muscle pains
- Frequent URTIs
- Frequent ECP

When it just doesn't add up easily ...

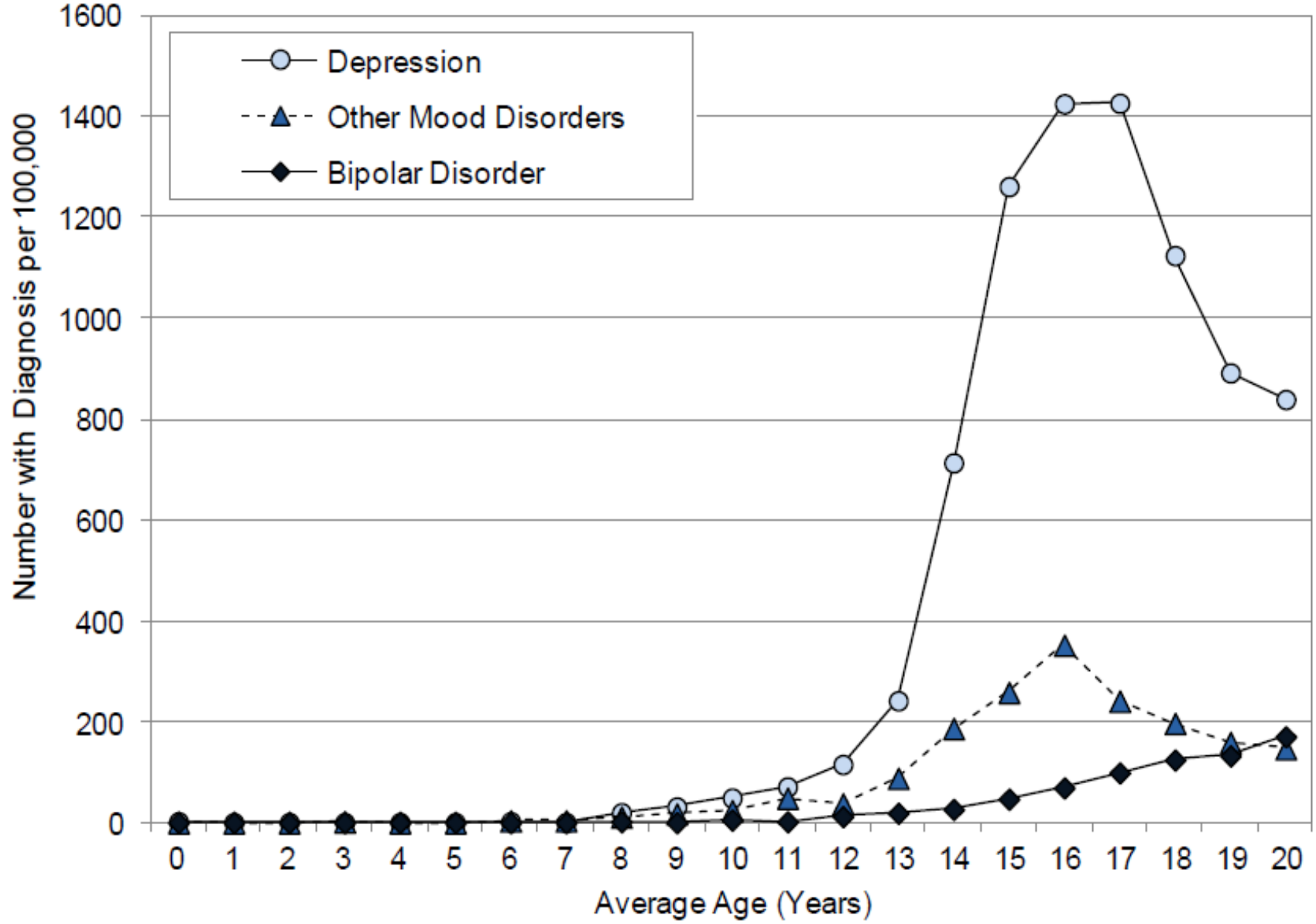
ask about stress and mood

Figure 131. Children and Young People Accessing Mental Health Services with Anxiety, Stress Reaction/Adjustment, or Eating Disorders by Age, New Zealand 2009–2011



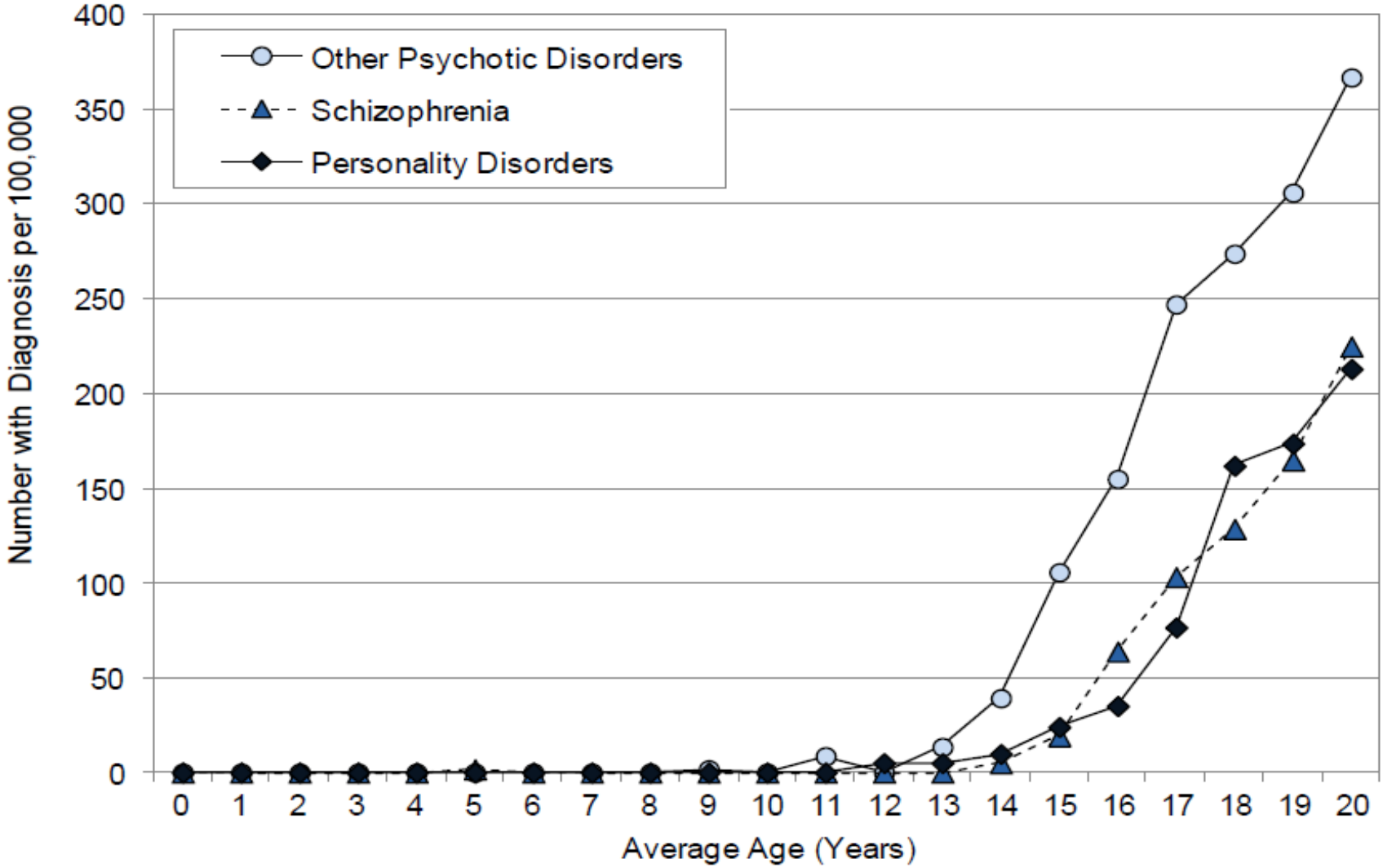
Source: Numerator: PRIMHD (individuals attending Mental Health Services who had ever been assigned these diagnoses); Denominator: Statistics NZ Projected Population (2010 = mid-point of 2009–2011)

Figure 133. Children and Young People Accessing Mental Health Services with Depression, Bipolar Disorder or Other Mood Disorders by Age, New Zealand 2009–2011



Source: Numerator: PRIMHD (individuals attending Mental Health Services who had ever been assigned these diagnoses); Denominator: Statistics NZ Projected Population (2010 = mid-point of 2009–2011)

Figure 132. Children and Young People Accessing Mental Health Services with Schizophrenia, Other Psychotic Disorders or Personality Disorders by Age, New Zealand 2009–2011



Source: Numerator: PRIMHD (individuals attending Mental Health Services who had ever been assigned these diagnoses); Denominator: Statistics NZ Projected Population (2010 = mid-point of 2009–2011)

Figure 133. Children and Young People Accessing Mental Health Services with Depression, Bipolar Disorder or Other Mood Disorders by Age, New Zealand 2009–2011

Serious MH diagnoses are evolving through adolescence

- Heed the flags “this kid is different” – if appropriate, talk to experienced teachers.
- Psychosis will probably be obvious at first presentation, bipolar disorder might only be apparent after careful watching over time.
- Obviously, severe presentations require referral to CAMHS.
  Mild-mod = core GP work.

Anxiety

- Uncontrolled worrying
- Difficulty concentrating
- Restlessness, irritability
- Sleep problems (DSM >6/12)
- +/- features of panic disorder, OCD, social phobias

Commonly presents with somatic symptoms (but exclude hyperthyroidism, hypoglycaemia, migraine, tachyarrhythmia etc.)

Depression - screening

- **S** sleep: insomnia, hypersomnia
- **A** appetite or weight change
- **D** dysphoria: bad mood, irritabiltiy, sadness
- **F** fatigue: e.g. difficulty completing tasks
- **A** agitation / retardation
- **C** concentration and memory
- **E** esteem= low, guilt, dwelling on past events
- **S** suicidal ideation

- Best practice is for clients <18yo to see Psychiatrist before initiating antidepressants.

K10 (Kessler) score:

Gives more objective assessment, allows review over time, supports referral.

10 - 19	Likely to be well
20 - 24	Likely to have a mild disorder
25 - 29	Likely to have a moderate mental disorder
30 - 50	Likely to have a severe mental disorder

Please tick the answer that is correct for you:	All of the time (Score 5)	Most of the time (Score 4)	Some of the time (Score 3)	A little of the time (Score 2)	None of the time (Score 1)
In the past 4 weeks, about how often did you feel tired out for no good reason?	☐	☐	☐	☐	☐
In the past 4 weeks, about how often did you feel nervous?	☐	☐	☐	☐	☐
In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down?	☐	☐	☐	☐	☐
In the past 4 weeks, about how often did you feel hopeless?	☐	☐	☐	☐	☐
In the past 4 weeks, about how often did you feel restless or fidgety?	☐	☐	☐	☐	☐
In the past 4 weeks, about how often did you feel so restless you could not sit still?	☐	☐	☐	☐	☐
In the past 4 weeks, about how often did you feel depressed?	☐	☐	☐	☐	☐
In the past 4 weeks, about how often did you feel that everything was an effort?	☐	☐	☐	☐	☐
In the past 4 weeks, about how often did you feel so sad that nothing could cheer you up?	☐	☐	☐	☐	☐
In the past 4 weeks, about how often did you feel worthless?	☐	☐	☐	☐	☐

Suicide

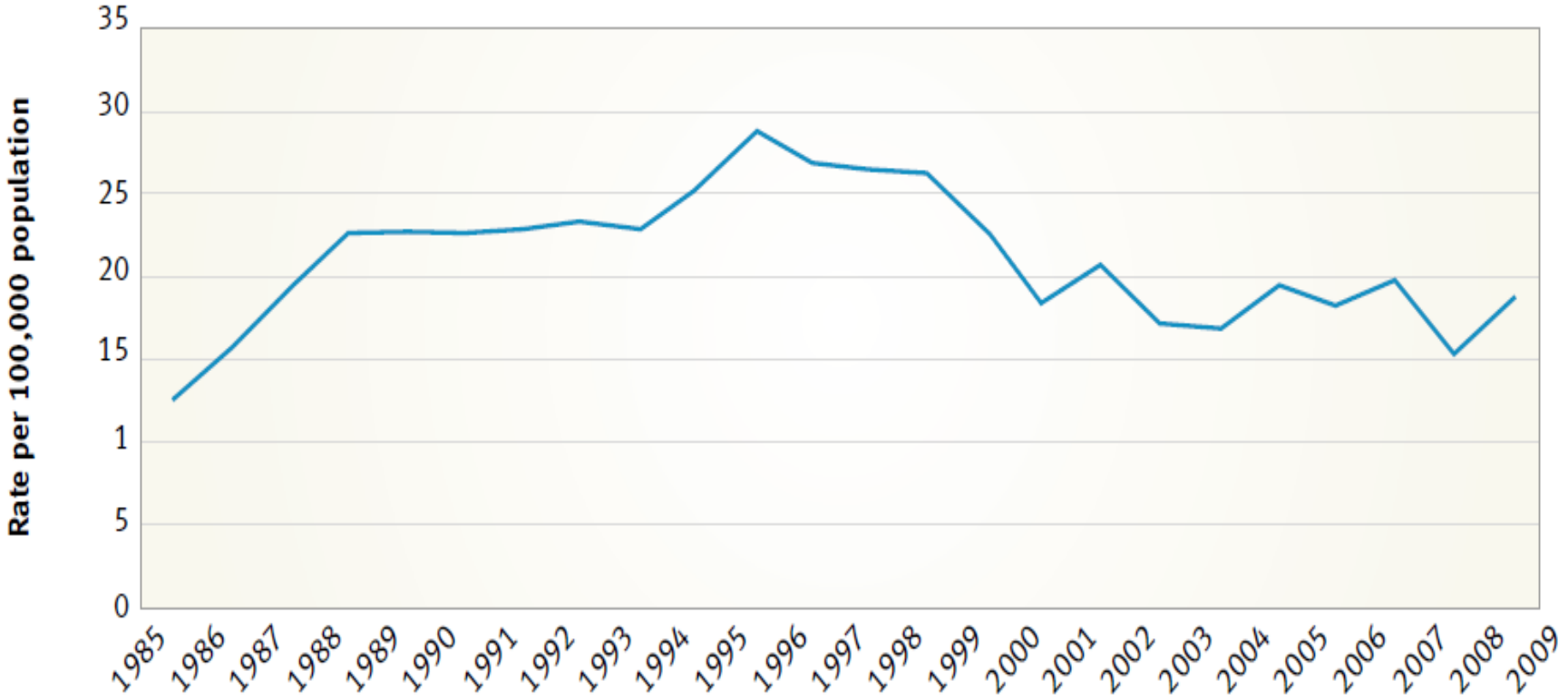
- 1997: 25% of all suicides consult a GP in the week before. 40% consult in the month before.
- GPs fail to recognise 50% of cases of severe depression

(Mental Health in New Zealand from a Public Health perspective. Wellington School of Medicine)

- Every year ~100 NZers aged 15-24 die by suicide
- **Teenage suicide is not always preceded by major depression. Commonly associated with sudden change or loss, impulsivity, AoD, lack of emotional regulation, lack of resilience.**

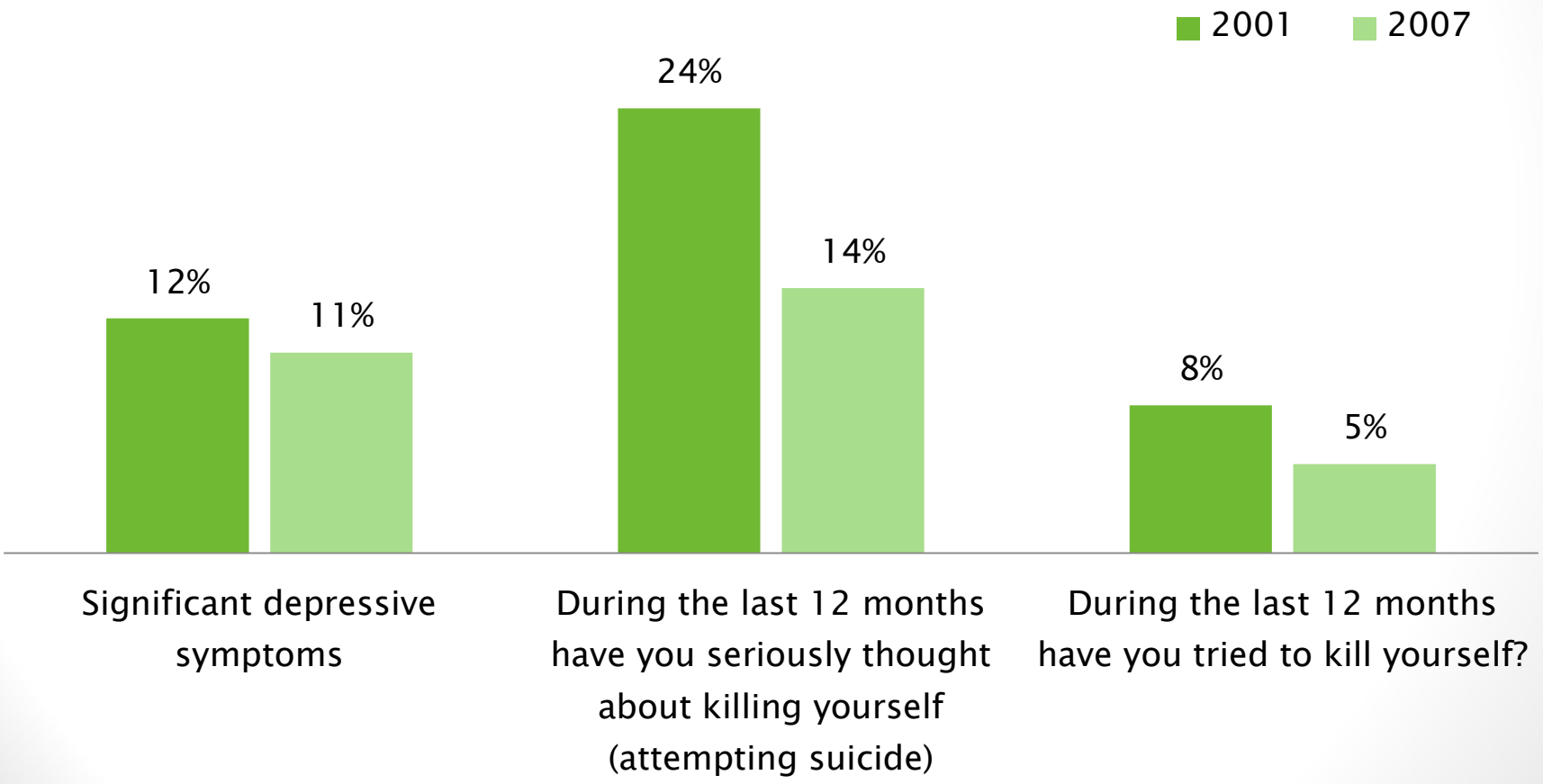
Youth (15–24 Years)

FIGURE 46: YOUTH SUICIDE RATES PER 100,000 POPULATION, 1985–2009



Source: Ministry of Health Mortality Collection.

School Students: Depression Symptoms, Suicidal Thoughts and Suicide Attempts 2001 and 2007



www.youth2000.ac.nz

Assessing suicidality – red flags

- V low mood/high stress, distress/hopelessness
- Definite plan
- Lethality of method, access to means
- Other risk factors (e.g. chronic illness, AoD)
- Lack of protective factors
- Friend or relation who suicided

=> Refer PET team / CAMHS

Depression mmt strategy - Scheduling

- Each night, plan the next day on paper. Beats the de-motivation.

	MONDAY	TUESDAY
Need to:	Get groceries Update CV	Do washing Pay power bill
Ought to:	Phone Mum	Tidy cupboard
Want to:	Coffee with mate	Finish my book
Exercise:	Walk the dog	Redwoods with friend

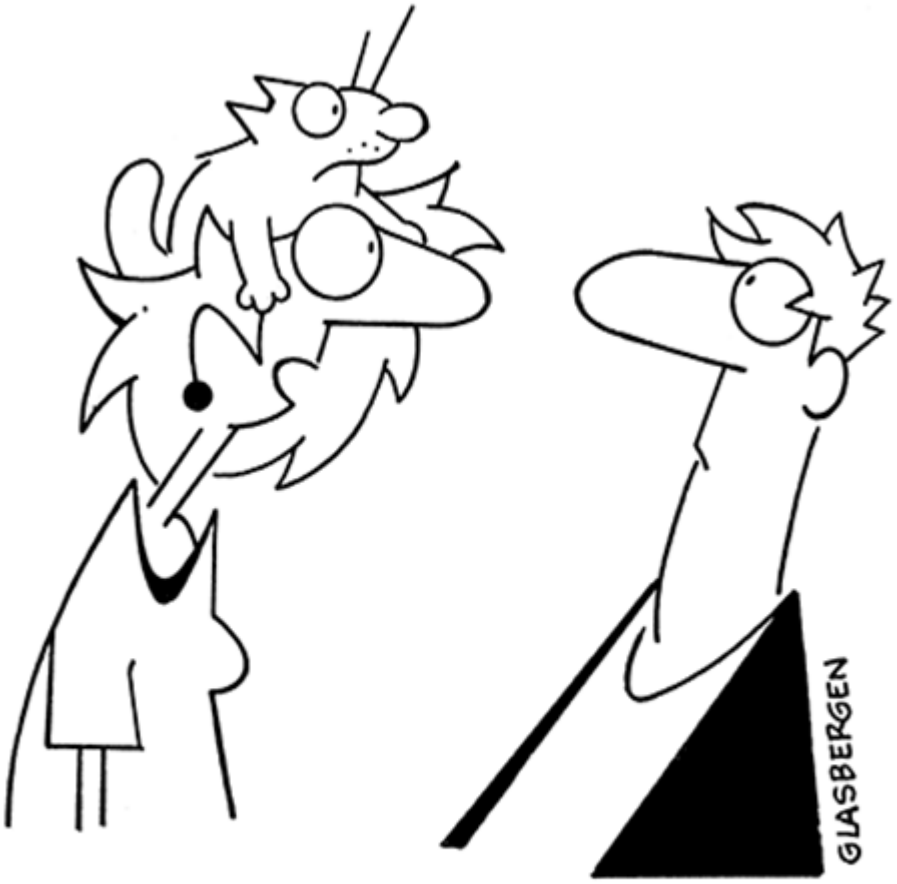
Anxiety mmt strategy– Break it down

- Overwhelmed by everything that needs doing (eating an elephant)
- Write a list of it all
- Break it down (spread it out)
  - Need to do / solve today
  - " tomorrow
  - " next week
  - " next month
  - Ignore it / let it go
  - Get someone else to do it

Mmt strategies – Substitute activities

- Have a hot drink
- Have a soak in bath
- Go for run
- Go to a special place
- Cuddle the cat
- Phone a friend
- Listen to music
- Write stuff down
- Chop firewood

***Have the list at hand ready to use prn.**



"When I'm stressed, I pet the cat.
When the cat is stressed, she pets me."

Refer, or maybe learn some skills in CBT – effective for depression and anxiety.

- How we think and how we act influences how we feel

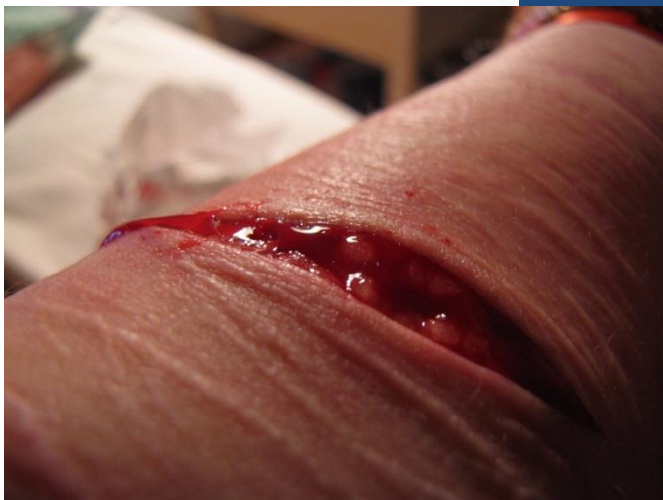
- CBT skills help someone to recognise unhelpful thought patterns, re-evaluate them, and replace them with healthier thought patterns. Goal focussed.
- Tools: Reframing. Example - someone ignores you in the street . . .
- "Look after your BFF":

Grief – a major game changer

- Almost always causes negative change in life trajectory / schooling / focus
- Diverse signs – emotional, cognitive, behavioural, physical, self-medicating.
- Not just following a death – may be after parental divorce / end of an important relationship / other. Be vigilant, anticipate, seek out problems.
- Make the most of your existing relationship with YP

Self harm

- Cutting / burning
- **Intention is relief of internal distress, not death**
- Why? To regulate / manage emotions; to feel alive; to punish self or others; to communicate; to have control; to self-soothe; to “see the pain”
- Things to do:-
  - Listening and caring
  - Acknowledge/validate/ respectful curiosity
  - Assess for suicide risk
  - Replacement skills
  - Includes exercise, communication, diversion
  - Specialist support e,g CBT
- Myths
  - It is just attention seeking (usually it is hidden)
  - Self-harmers want to die
  - Minor cutting = minor problem



Eating disorders

- Anorexia nervosa, Bulimia nervosa, ED n.o.s. (40-60% of cases)
- Distorted body image, distorted belief systems around food. Catch it and refer early.
- Be ready for the long haul!
- Essential to develop caring trusting relationship
- Need to cover medical, nutritional, psych aspects
- Regional specialists and MDT are essential

Eating Issues - screening

The SCOFF questions

- Do you make yourself **s**ick because you feel too full?
- Do you worry you have lost **c**ontrol over how much you eat?
- Have you recently lost more than **o**ne stone (6kg) in 3 months?
- Do you think you are **f**at when others say you aren't?
- Would you say that **f**ood dominates your life?

A score of 2 is considered a positive screen

Eating disorders

- Not all presentations are true ED, some are cognitive-developmentally determined, trying new things (eg vegetarianism), testing boundaries.
- *Eating difficulties education network - www.eden.org.nz*
- *Eating disorders association of NZ – www.ed.org.nz*

Indications for admission to hospital

- Weight is dangerously low <75%of ideal body weight
- Weight loss is rapid, acute food refusal
- Uncontrollable purging and binging
- Dehydration
- Electrolyte disturbance severe
- Cardiac dysrhythmia
- Complications of malnutrition – syncope, seizures, pancreatitis, cardiac failure
- Physiological instability bradycardia, hypotension and hypothermia
- Acute psychiatric emergencies
- Arrested growth and development
- Failure of outpatient treatment

Conduct disorder

- Repetitive behaviours where the rights of others or social norms are violated.
- Symptoms: verbal and physical aggression, cruelty to people and pets, destructive behaviour, lying, truancy, vandalism, stealing.
- Youth with conduct disorder not only inflict serious physical and psychological harm on others, but are at greatly increased risk for incarceration, injury, depression, substance use, death by homicide/suicide.

- Important to refer (the sooner the better)
- Good parenting is critical to bring about change
- Parents often have their own social and Justice problems; parenting programmes can be very helpful
- Structure and boundaries are essential, reinforcement for pro-social choices
- Monitoring of activities reduces chances of harm
- Structured and supervised peer activities are helpful (sport, kapa haka etc)

Substance misuse

- Use of tobacco, alcohol & other drugs is commonly underestimated
- Age of initiation is steadily dropping
- 40% of young people attending mental health services also have substance use (self medicating – "what we see as a problem they see as a solution")
- SACS: Substances and Choices Scale – assesses and monitors use and impact of AoD in previous 1/12 *www.sacsinfo.com/Questionnaires*

If available, use youth specialty AoD services

Motivational Interviewing

BEARDS

- Button up (listen well – you have 2 ears, 1 mouth!)
- Express empathy (“it feels bad when . . .”)
- Avoid arguing (only entrenches conflicting views)
- Roll with resistance (find another angle)
- Deploy discrepancy (cognitive dissonance)
- Support self efficacy (“you can do it!!”)

Grow some more Youth Health skills

- Find a way to do high school clinics
- Look out for your nearest YOSS (Youth One Stop Shop)

cfyh@middlemore.co.nz

YOUTH HEALTH WORKSHOP

The Youth Health Workshops provide practical programmes to enhance professional skills when working with young people in clinical and community settings. The Centre for Youth Health is happy to consider additional training for health providers if requested.

WHERE:

Youthline Manukau

145 St George Street, Papatoetoe

THE HEEADSSS ASSESSMENT

14 FEBRUARY 19 MARCH 20 JUNE 6 AUGUST

A one day introduction to clinical practice in youth health including: communication and engagement in youth health and using the HEEADSSS assessment model.

FEE: $75 (Free for CMDHB and ADHB Staff)

WHO SHOULD ATTEND? Anyone working with young people.

WHAT COMES AFTER HEEADSSS?

16 APRIL 22 OCTOBER

This one day course gives an introduction to intervention skills when working with young people such as problem solving, motivational interviewing and discussing principles of behaviour change in young people.

FEE: $75 (Free for CMDHB and ADHB Staff)

WHO SHOULD ATTEND? Those who have completed the HEeADSSS Assessment training.

Bookings are essential and confirmation will be given on receipt of payment.

For bookings or further information please contact the Centre for Youth Health

Phone: (09) 261 2272
Fax: (09) 261 2273

E-mail:
cfyh@middlemore.co.nz

We regret that CfYH is unable to give refunds.

Arrangements can be made for credits for future training

Please check our website for updates on times, dates and information about our courses.

Website: http://www.healthpoint.co.nz/default,23135.sm

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Centre for Youth Health

POSTGRADUATE STUDY IN

YOUTH HEALTH

The Centre for Youth Health is delighted to continue supporting Youth Health training with The University of Auckland. This postgraduate degree aims to integrate the best of academic, research and real world experience for health professionals and others wanting to work at an advanced level with youth. For 2013 the following courses are available:

CLINICAL YOUTH HEALTH 1 (PAEDS 712)

Semester One: Core skills in youth health including: effective engagement, assessment and intervention skills for working with young people in a range of clinical or community settings.

TEACHING DAYS: **15 MARCH, 12 APRIL, 10 MAY, 31 MAY**

WHO SHOULD ATTEND? Anyone working with young people.

POPULATION YOUTH HEALTH (POPLHLTH 732

Semester One: This course aims to prepare students for a role in youth health in a variety of locations and sectors. In doing this, students are exposed to current research and practice relating to population youth health and evidence-based health care.

TEACHING DAYS: **18 MARCH, 8 APRIL, 6 MAY, 27 MAY**

HEALTH, EDUCATION AND YOUTH DEVELOPMENT (PAEDS 719)

Semester Two: This course offers insights and strategies to work with young people in the rapidly developing health and education sector interface.

TEACHING DAYS: **2 AUGUST, 23 AUGUST, 27 SEPTEMBER, 18 OCTOBER**

WHO SHOULD ATTEND? Health Professionals working within school settings.

YOUTH HEALTH LEADERSHIP (PAEDS 720)

Semester Two: This course aims to extend participants knowledge of youth health and well-being and prepare participants for leadership roles in youth health. Participants will expand their knowledge of the theory of youth development and study examples of effective youth development programs.

For further information, see The University of Auckland website:

http://www.health.auckland.ac.nz/population-health/study

and click Youth Health in the subject list.

From here you can fill out an expression of interest and we will contact you.

Alternatively, send academic enquiries to

Dr Simon Denny

Email:

s.denny@auckland.ac.nz

THE UNIVERSITY OF AUCKLAND

FACULTY OF MEDICAL AND HEALTH SCIENCES

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Children's Hospital & Community Health

Also: SYHPANZ conference

- Society for Youth Health Professionals Aotearoa NZ
- www.syhpanz.org.nz
- 11,12 October 2013 Wellington

Also: Werry Centre

- HEEADSSS trainings – look out for promos